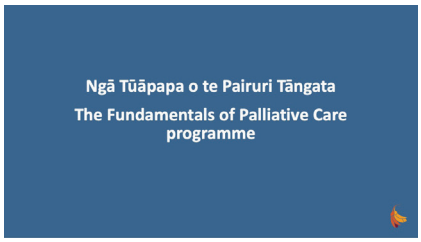
Ngā Tūāpapa o te Pairuri Tāngata

# Fundamentals of Palliative Care

## FACILITATORS NOTES

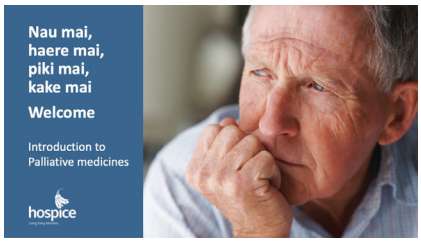
SLIDE 1




# Introduction to Palliative Medicines

## WORKSHOP

SLIDE 2




*Note: The participants should have all completed the Managing pain and long-term illness workshop before they attend this. This session is mainly for registered nurses and anyone interested in Palliative medicines.*

**Welcome and introductions section – approx. 25 mins (4 slides)**

Welcome the participants as they settle in.

If this is the participants' first workshop in the Fundamentals programme, welcome them with a karakia or pepeha.

Otherwise, welcome them and introduce yourself.

You might want to consider greetings in other languages depending on your participants.

## SLIDE 3




Before getting started, cover the following.

### Involvement in the workshop

- Talk about how everyone should honour other cultures, and respect the different perspectives everyone brings to the session
- Encourage everyone to get involved in the workshop
- Talk about phone use

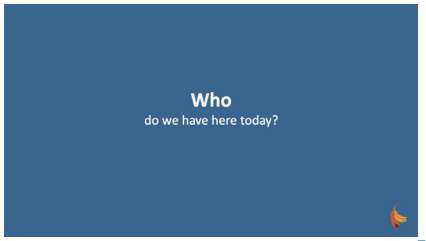
### Self care

- Toilets
- Drinks
- Acknowledge that the content covered can be difficult so if anyone needs to leave or have a break at any point they are welcome to. Explain that this workshop will talk about death and dying and might trigger memories that cause emotional distress. Reinforce that they can leave at any point of the workshop if they start to feel upset

### Emergency plans

- Fire and earthquakes
- Assembly points

## SLIDE 4




Ask the participants to introduce themselves with:

- their name
- the workplace they work at
- a short explanation of their journey into this role.

## SLIDE 5



SLIDE 6




**Introduce the topic.**

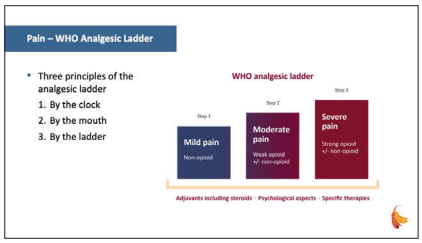
### Key points

- This presentation focuses on understanding the common medications used for pain and symptom management.
- This presentation is in line with the goals of the Fundamentals programme – complex symptom management and prescribing has not been addressed, consider a masterclass for this.
- We acknowledge there may be local variance in prescribing, so make sure you follow and share local guidelines and practice.
- Specifically refer to the New Zealand Palliative Care Handbook (8th Edition).
- See final slide for a list of resources that support this presentation.
- Check the repository.

### Note:

Many medications (~25% from UK data) used in palliative care are used outside their normal approved use.

SLIDE 7




**Types of drugs and dosages – approx. 1 hour 30 mins (26 slides)**

### By the clock

To maintain freedom from pain, drugs should be given “by the clock” or “around the clock” rather than only “on demand” (i.e., PRN). This means they are given on a regularly scheduled basis. The frequency will depend on whether it is a long- or short-acting preparation.

### By the mouth

The oral route is usually the preferred route for ease of use in a variety of care settings. However, it may not be possible for all patients (e.g., end-of-life, unconscious, swallowing issues). When the oral route is not feasible, the least invasive route should be considered (e.g., sub-lingual or sub-cutaneous before intra-venous). The intra-muscular route should never be used.

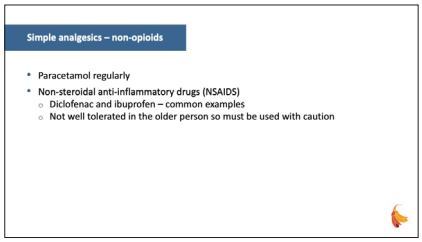
### By the ladder

If pain occurs there should be prompt administration of drugs in the following order:

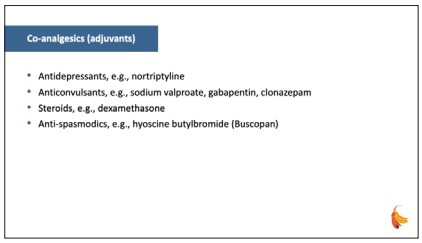
- non-opioids (e.g., acetaminophen)
- as necessary, mild opioids (e.g., codeine)
- then strong opioids (e.g., morphine or oxycodone) until the patient is free of pain.

Drug selection should be appropriate to the severity of the pain. It may be most appropriate with severe pain to begin at the top of the ladder with a strong opioid; it is not always necessary to start at step one. When pain is controlled, the patient should be maintained on the dose that is effective. It is usually not necessary to step down the ladder unless the cause of pain is believed to have been resolved.

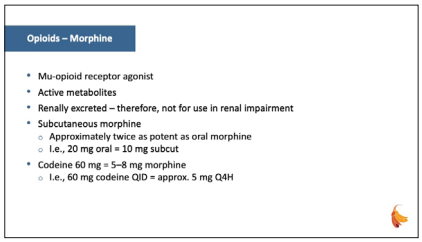
## SLIDE 8



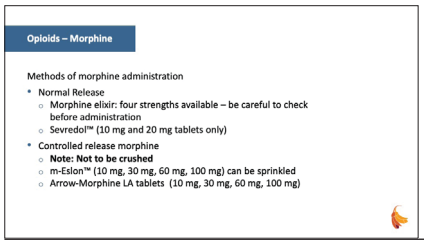

## SLIDE 9



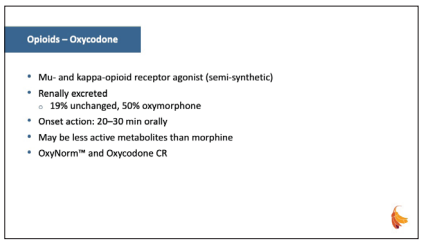

## SLIDE 10




## SLIDE 11



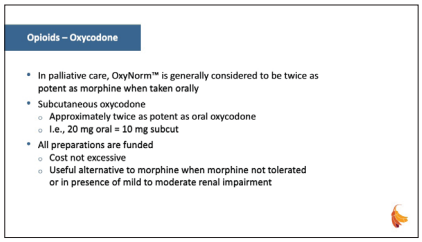

## SLIDE 12



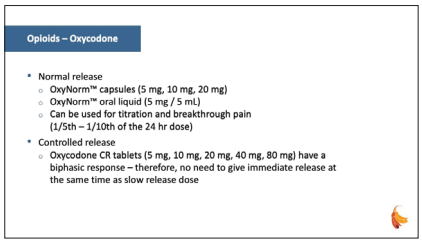

**Notes:**

- Side effects as per morphine, may be less vomiting (anecdotally)
- Use if there is mild-moderate renal impairment, although dose reduction should be considered

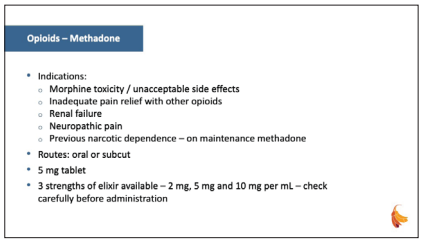
## SLIDE 13



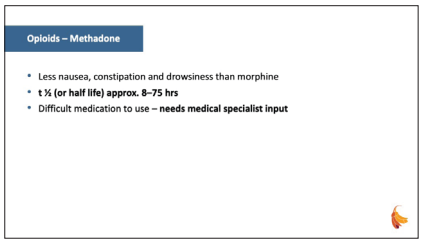

## SLIDE 14



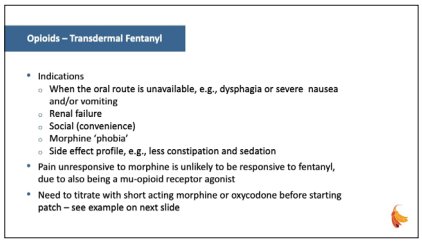

## SLIDE 15




## SLIDE 16



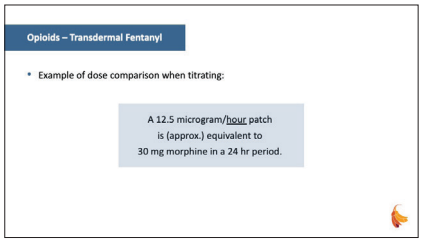

## SLIDE 17



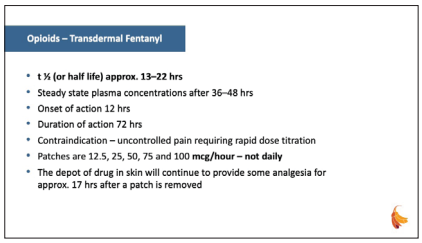

### Notes:

- Point out the risk of serotonin toxicity as a result of interaction between Fentanyl and SSRIs
- Don't forget to mention need for breakthrough/prn medication

## SLIDE 18



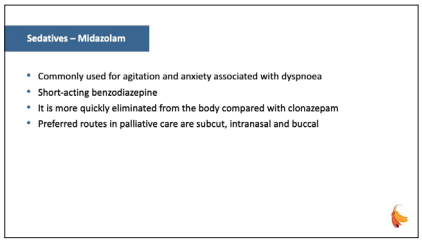

## SLIDE 19



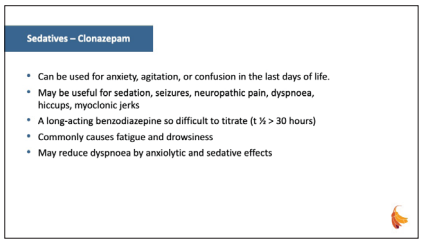

**Notes:**

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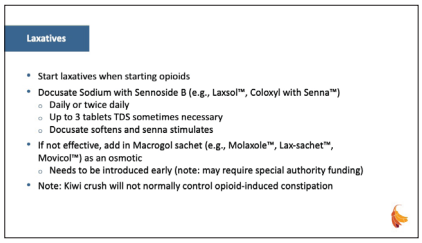
## SLIDE 20



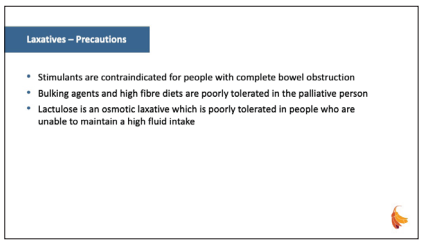

## SLIDE 21



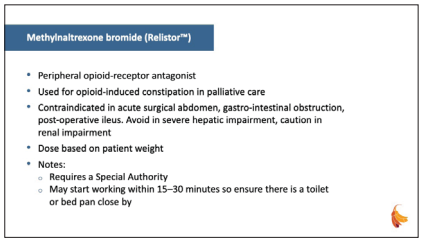

## SLIDE 22



## SLIDE 23




## SLIDE 24




**Reference:**

Larkin, P. et al. (2008). The management of constipation in palliative care: clinical practice recommendations. *Palliative Medicine*, 22(7), 796–807.

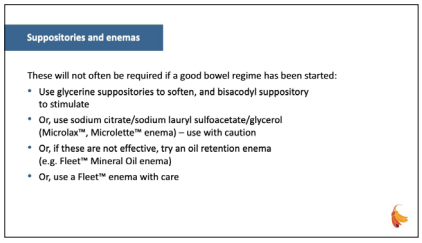
**Link:**

Philip Larkin's palliative care lecture in May 2017

"Palliative approaches to the management of constipation – evidence and clinical implications for practice."

Available on the HNZ website: www.hospice.org.nz/palliative-care-lecture-series/listen-to-lectures

## SLIDE 25




**Reference:**

Larkin, P. et al. (2008). The management of constipation in palliative care: clinical practice recommendations. *Palliative Medicine*, 22(7), 796–807.

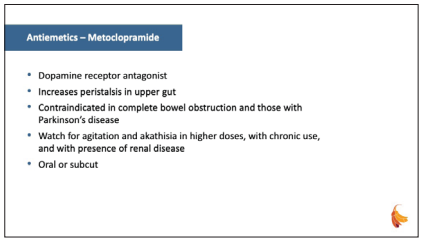
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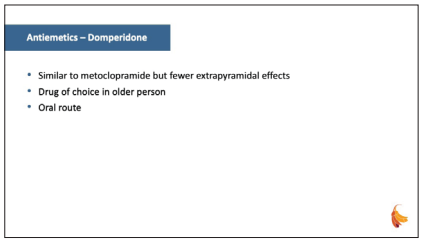
## SLIDE 26




**Reference regarding metoclopramide caution – agitation/akathisia/ tardive dyskinesia**

Currow, D. C. et al. (2012). Pharmacovigilance in hospice/palliative care: Rapid report of net clinical effect of Metoclopramide. *Journal of Palliative Medicine*, 15(10), 1071–1075.

## SLIDE 27

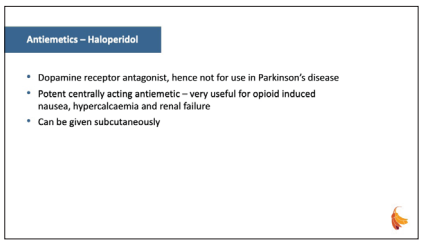



**Note and reference:**

Often used to treat delirium due to its ability to be given subcut and to treat multiple symptoms. However, need to be aware that recent studies have recommended against its use for delirium. See reference below:

Agar, M.R., et al. (2017). Efficacy of oral risperidone, haloperidol or placebo for symptoms of delirium amongst patients in palliative care: A randomised clinical trial. *JAMA Intern Med*. 177(1), 34–42.

## SLIDE 28

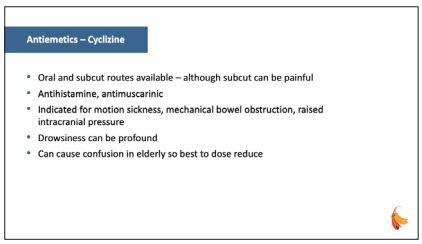



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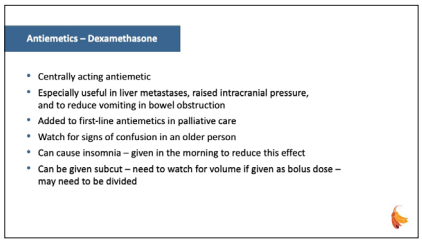
## SLIDE 29




**Note:**

Choice of first or second line anti-emetic is often the choice/ preference of the doctor prescribing.

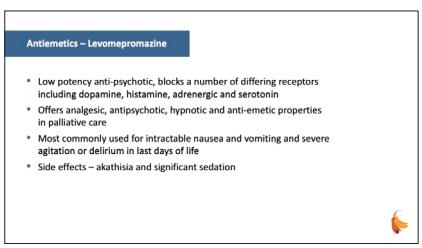
## SLIDE 30




**Notes:**

- Need to consider and plan for reduction and stopping over time.
- There are other indications for Dexamethasone, including:
  - > appetite stimulant
  - > anti-inflammatory properties (adjuvant pain relief)
  - > relief of symptoms in spinal cord compression and superior vena cava obstruction
  - > site protector for subcut line.

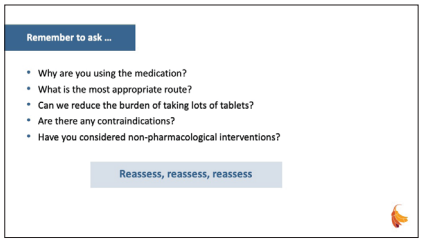
## SLIDE 31



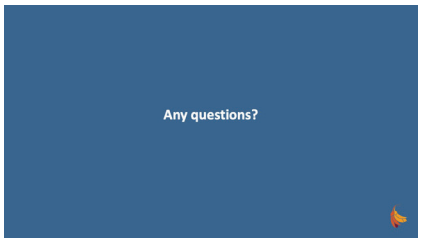

**Note:**

Choice of anti-emetic is often the choice/preference of the physician.

## SLIDE 32




## SLIDE 33

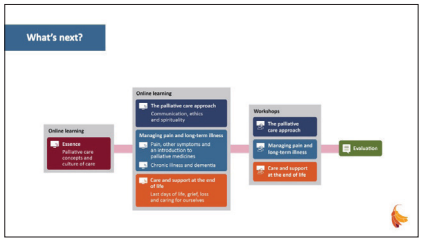



**Wrap up section – approx. 15 mins (3 slides)**

Recap what you've talked about today.

Ask the participants if they have any last questions.

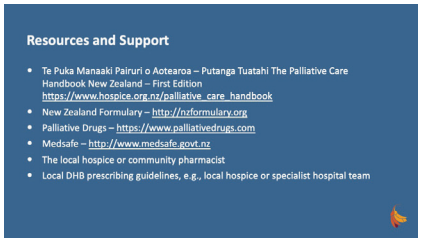
## SLIDE 34




Show the learner journey for the ***Fundamentals of Palliative Care*** programme and encourage participants to continue on with it.

***Remember: This An introduction to Palliative Medicines session is part of the Managing pain and long-term illness package within the programme.***

## SLIDE 35




Leave this slide up as the participants pack up and head out.