Healing Touch:
A Non-Pharmacological Modality
for Pain Management

Ginny Green, BSN, RN
Bridget Klein, BSN, RN, RN-BC, CHTP
Deborah Day Laxson, PMP, CHTP

FINANCIAL DISCLOSURE

• Bridget Klein is a Registered Nurse at the St. Cloud Hospital, within the CentraCare Heart & Vascular Center. She also is a Certified Healing Touch Practitioner and owner of Earth to Sky Healing LLC, which offers Healing Touch Services.
• Deborah Day Laxson is a Certified Healing Touch Practitioner and owns 7th Light Energy Therapy, which offers Healing Touch services. (Healing Touch volunteer at St. Cloud Hospital (past) and Quiet Oaks Hospice House.
• Ginny Green is Director of Nursing at Quiet Oaks Hospice House.

LEARNING OBJECTIVES

At the end of this session, the participate will be able to:
Objective #1: Explain Healing Touch to staff and patients
Objective #2: Determine when Healing Touch is an appropriate non-pharmacological pain management modality.
Objective #3: Discuss the evidence-based research outcomes for Healing Touch.
AGENDA

- INTRODUCTION / HEALING TOUCH (DEB AND BRIDGET)
  - Healing Touch Research Project, St. Cloud Hospital / CentraCare (Bridget)
  - Case Studies from Hospice, Quiet Oaks (Ginny)
  - Conclusion (Deb)
  - Discussion (All)

WHAT IS HEALING TOUCH?

- Founded in 1989 as a continuing education program
- Bio-field Therapy and Nursing Intervention (National Institutes of Health)
- Nursing Intervention to address NANDA-1 (North American Nursing Diagnosis Association) diagnosis of “Imbalanced Energy Field”
- Heart-centered energy therapy that uses gentle, intentional touch on or near the body to assist in balancing physical, emotional, mental, and spiritual well-being (Healing Beyond Borders)

INCREASING YOUR ENERGY AWARENESS

EXERCISE #1
INCREASING YOUR ENERGY AWARENESS
EXERCISE #2

AGENDA

- Introduction / Healing Touch (Deb)
  - HEALING TOUCH RESEARCH PROJECT, ST. CLOUD HOSPITAL / CENTRACARE (BRIDGET)
  - Case Studies from Hospice, Quiet Oaks (Ginny)
  - Conclusion (Deb)
  - Discussion (All)

PUBLISHED RESEARCH

Published Research has correlated Healing Touch to the following:
- Reducing stress (Cotton, 2014)
- Improving anxiety and depression (Foley 2016; Anderson, 2015, MacIntyre, 2008)
- Decreasing pain (Gentile, 2018; Foley 2016; Anderson, 2015; Wardell, 2006; Cotton, 2014)
- Enhancing post-surgical recovery (Foley, 2016; Anderson, 2015)
- Supporting cancer care (Guerrero, 2001; Wong, 2012)
PUBLISHED RESEARCH

A single previous research study involving Healing Touch on the CABG patient population (MacIntyre (2008))
- Significantly reduced anxiety
- Significantly reduced length of stay

RESEARCH QUESTION & APPROVAL

Does the addition of healing touch, to the standard treatment of patients undergoing coronary artery bypass grafting, affect cost per case, anxiety level, and the following post-operative factors: delirium and atrial fibrillation occurrences?

Obtained Nursing Research Review Board (NRRB) and Institutional Review Board (IRB) Approval of study

INCLUSION & EXCLUSION CRITERIA

Inclusion Criteria
- Patients undergoing CABG surgery at the St. Cloud Hospital

Exclusion Criteria
- Not able to answer study-related questions
- Previous heart surgery
- Emergent CABG patients
- Concurrent valve surgery
**RESEARCH DETAILS**

- N = ~80
- March 1, 2018–November 30, 2018
- Participants randomly assigned to a control or treatment group

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**RESEARCH DATA POINTS**

- Anxiety/Distress
  - Subjective Units of Distress Scale (SUDS)
- Post-operative Atrial Fibrillation Rates
- Post-operative Delirium Rates
- Cost/Case

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**RESEARCH DESIGN**

- Participants randomly assigned to one or the other of the following:
  - Control group
    - Received standard care
  - Treatment group
    - Received standard care
    - Also received a Healing Touch session on each of the following days:
      - Pre-op
      - Post-op Day 1
      - Post-op Day 2
**RESEARCH DESIGN**

- All participants were asked to rate their anxiety/distress (using the SUDS tool)
  - Pre-op, Post-op Day 1, Post-op Day 2
  - Participants in the treatment group were asked to rate their anxiety/distress before and after the Healing Touch sessions

**HEALING TOUCH SESSIONS**

- Performed by a small number of St. Cloud Hospital employees and volunteers who were trained and experienced in Healing Touch
- Utilized a standardized Healing Touch technique list
- Obtained both pre and post Healing Touch session anxiety/distress scores

**RESEARCH PROGRESS & NEXT STEPS**

- Data Collection is complete
- Statistical analysis will be completed in partnership with St. Cloud State University
- Anticipate dissemination of results via publication submission, posters and presentations
RESEARCH TEAM

- CentraCare Heart & Vascular Center
- Integrative Health Services
- Performance Excellence
- Volunteer Services

WHAT HAVE WE LEARNED?

- An appreciation for the rigor involved in patient research
- An appreciation for the support of nursing research
- Deepest gratitude for those who were willing to participate in this study!!

REFERENCES

AGENDA

• Introduction Healing Touch (Deb and Bridget)
• Healing Touch Research Project, St. Cloud Hospital / CentraCare (Bridget)

➤ CASE STUDIES FROM QUIET OAKS (GINNY)

• Conclusion (Deb)
• Discussion (All)

PUTTING QUIET OAKS (QQ) HOSPICE HOUSE IN CONTEXT

• Is located in St. Cloud on 10 wooded acres
• Started as a private residence, donated in 2006
• 8 resident rooms added
• Staffed with around the clock with nurses
• Three private bedrooms available for overnight family stay
• Meals are provided for whoever is visiting in keeping with the "family" concept
• "Patients" are called "residents" keeping in context with the family home

QUIET OAKS HOSPICE HOUSE – HEALING TOUCH CASE STUDIES

• Two case studies where Healing Touch was used
• Both challenging cases
• Both arrived with significant disconnect between their "physical" journey and the emotional, mental, and spiritual journey
• Traditional medicine provided some physical relief of physical symptoms
HOSPICE CASE STUDY #1 – NURSING OBSERVATIONS

DAY 1:
• 52 year old female arrives at QO by stretcher; alert and oriented x3; all vital signs within normal range; able to breathe room air; is bedbound
• Presenting with Dx breast cancer and extensive bone metastases;
• Support system consists of husband, teenage twins, parents, and siblings.
• Pain Scale is reported at 4/5 out of 10 for general pain;
• Experiencing searing pain (8 out of 10) right thigh and right forearm
• Refuses all care and repositioning; has quarter size decubitus on her coccyx
• Refuses to discuss dying or advanced directives; has previously agreed to DNR / DNI, no tube feedings and antibiotics for comfort only

MEDICATIONS AT ADMISSION
• PICC line on narcotic medication pump for pain control:
  • Dilaudid 2.5 mg Basal with 2mg bolus dose Q 10 minutes PRN (attempting 50 boluses in 24 hour period)
  • Ketamine 10mg/hr
OTHER MEDICATIONS
• Lorazepam 0.25-1ml SL Q 2 hr PRN
• Amiodarone, 8 complex vitamins, Bisacodyl, Brimonidine, Cholecalciferol, Dorzolamide – timolol, Exemestane, Fluoresamide, HCTZ, Lactulose, Loperamide, Tylenol, Prednisolone acetate, Prochlorperazine malate, Sennasides docusate, Vitamin E, Lovenox, Magnesium, Miralax (was interested in staying on numerous vitamins)

HOSPICE CASE STUDY #1 – NURSING OBSERVATIONS

• Needed control
• Allowed Healing Touch
• Consumed with fear
• Listened to “The Four Things That Matter Most” (husband read aloud)
• Started making peace with her life and building relationships for her final journey
HOSPICE CASE STUDY #1 – A HT VOLUNTEER’S OBSERVATION

- Heart-centered energy therapy that uses gentle, intentional touch on or near the body to assist in balancing physical, emotional, mental, and spiritual well-being (Healing Beyond Borders)
- Patients / residents feel your energy (Bolle Taylor, Jr, PhD. My Stroke of Insight, 2006, Penguin Books, New York, NY, pg 153)
  - #5 – Approach me with an open heart and show your energy down. Take your time.
  - #11 – Protect my energy. No talk radio, TV or nervous visitors!
- Healing Touch volunteers can be ‘neutral’ – not staff, not family

HOSPICE CASE STUDY #2 – NURSING OBSERVATIONS

HISTORY AT TIME OF ADMISSION

- 54 year old female diagnosed with squamous cell carcinoma of the trachea in the prior year. Had undergone chemo, radiation, stents x 2 to the trachea and an esophageal stent due to tumor pressure on the esophagus.
- Prior to admission at QO had been having increasing difficulty with breathing and was admitted to a hospital for shortness of breath and wheezing. During this hospital stay, code blue and respiratory arrest necessitating an emergency tracheostomy (for which her husband gave permission) and was followed by thoracic surgery and palliative care service.
- Elected comfort care and was admitted to Quiet Oaks within the next week. Her wishes are DNR/DNI, comfort care, antibiotics if it would help her comfort and does not wish to return to the hospital.

HOSPICE CASE STUDY #2 – NURSING OBSERVATIONS Continued

- Non-smoker
- Husband and 3 grown children in the military, Two grandchildren on the way
- Alert and oriented x 3, port access in Lt chest, although resident refuses narcotic medication pump for pain control.
- Rates pain a 4/10 which is her “baseline”.
- Up in room independently with O2 5l on via mask to trach.
- Resident chooses to eat small amounts even though coughing spells are triggered with eating and understands the risks of aspiration pneumonia.
- Uses pen and paper to communicate
MEDICATIONS AT TIME OF ADMISSION

- Morphine 2-4mg IV Q 2 hr PRN for pain
- Lorazepam 0.5–1 mg IV Q 3 hr PRN for anxiety
- Lidocaine 5% patch 1 patch applied every 24 hr
- Fentanyl 25mcg/hr 72 hr patch – 1 patch applied every 72 hr
- Compazine 5-10mg IV Q 6 hr PRN nausea/vomiting
- Zofran-ODT 4mg PO Q 6 hr PRN nausea/vomiting
- Albuterol 2.5 mg/ml 0.083% neb solution 1 vial per nebulization Q 2 hr for SOB
- Sodium chloride 3% neb solution TID
- Dextrose 5% and 0.45% NaCl 5-45% infusion IV 75ml/hr
- Hypromellose-dextran ophthalmic solution 1-2gtts in both eyes Q 8 hr PRN dry eyes
- Atarax syrup 25-50mg Q8 hr PRN pain

HOSPICE CASE STUDY #2 – NURSING OBSERVATIONS

- Wanted prognosis/time frame "I want to die" vs "I want to live"
- Challenging family dynamics "I want to be alone" vs "I don't want to be alone"
- Healing Touch introduced very successfully at the beginning of third month at QO
- Resident prepares for discharge to have further treatment / staff have mandatory meeting to debrief
- Resident readmitted and passes with unresolved physical, emotional and spiritual concerns

HOSPICE CASE STUDY #2 – A HT VOLUNTEER’S OBSERVATION

- Heart-centered energy therapy that uses gentle, intentional touch on or near the body to assist in balancing physical, emotional, mental, and spiritual well-being (Healing Beyond Borders)
- One HT technique developed by a hospice nurse who requested anonymity affords increased ease in releasing that which is no longer needed. Used during transitions such as changing jobs, moving, birth, marriage, divorce, graduation and dying. (Healing Beyond Borders)
- Healing Touch is not simply an application of a treatment or intervention but an act of compassionate service with a shared meaning. (Healing Beyond Borders)
AGENDA

- Introduction Healing Touch (Deb and Bridget)
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- Case Studies from Hospice, Quiet Oaks (Ginny)

➢ CONCLUSION (DEB)
- Discussion (Presenters and Participants)

AGENDA

- Introduction Healing Touch (Deb and Bridget)
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- Conclusion (Deb)

➢ DISCUSSION (ALL)

CONCLUSION

- Healing Touch is a nursing intervention that is a heart-centered energy therapy using gentle, intentional touch (on, or near the body) to assist in balancing physical, emotional, mental, and spiritual well-being
- If a client is having pain, Healing Touch is an appropriate non-pharmacological pain management modality to consider.
- Research studies have illustrated the many benefits of Healing Touch, including but not limited to pain management, anxiety reduction.
APPENDIX

- Quiet Oaks Case Study #1 Details
- Quiet Oaks Case Study #2 Details

HOSPICE CASE STUDY #1 - DETAILS

WEEK ONE
- Lorazepam increased to 1mg TID and 1.5mg Q 4 hr PRN. Resident on call light very frequently and does not want to be alone at all. PCA 50 bolus/day. Family with her practically round the clock. But if they aren't in room, staff called in many times for small requests. Yet resident does not want to be repositioned for fear of pain and only wants specific staff to be with her. Behaviors increasing. At night, sleeps well and moving, being on call light much or using bolus from PCA.
- Pain 2 out of 10, Resident continues to not want to speak about dying, family care conference without her present – family will write letters to her focusing on their gratitude and thanks. Resident agrees to Healing Touch. (Day 7)

WEEK TWO
- Has agreed to repositioning using 4 to assist and a ‘rigid body posture. Aromatherapy with Lavender initiated.

WEEK THREE
- Resident states she is appreciative for Healing Touch. (Day 18)

WEEK FOUR
- Resident has always avoided frank conversations, according to family members. Has been refusing care by certain nurses, PCA 70 times per shift. Spoke with Ginny about her fears: fear of what lies beyond this life, fear for her family, fear of dying process. Asked if there is anything to read to understand this better. Will ask for the book again in a week. Resident not keen to have her husband being given to her to read to her. Continues to be very groggy at night with using bolus.
- Avoid discussion of progress, fearful, hasn’t started book. Anxiety continues and dictating which staff may turn her.

WEEK FIVE
- At care conference said she has had ¾ of the book read to her and states it has been helpful. Will sign POLST soon. Agrees to youth counselor meeting with twins. Tolerating repositioning with pain medication being given ahead of time and 1 month of relationship building on our staff’s part. Decreasing number of bolus/day.
HOSPICE CASE STUDY #1 - DETAILS

WEEK SIX
- Prefers Healing Touch to massage (Day 43)
- Lorazepam changed to 1mg Q AM and 2mg QHS and 1-2mg Q 4 hr per resident request to not be so sleepy during the day. Taking Q 1 - 3 per nc to sleep at night occasionally now and 1000mg Tylenol for generalized aching. Resident states she is more comfortable at QO now. (Day 44).

WEEK SEVEN
- Rough morning, requesting no new staff take care of her. (Day 47) Reassured that all new staff work with a senior staff during orientation. All our staff are competent and compassionate.

HOSPICE CASE STUDY #2 - DETAILS

FIRST MONTH
- Oxyfast 5mg PO Q 3 hr PRN pain
- 1 LITER OF NORMAL SALINE Q 24 hrs
- Resident request CT from U of MN for better idea of time frame for prognosis
- Many hours of discussion and teaching with resident and husband
- Massage therapy initiated
- Palliative Sedation discussed and resident will consider that option if needed
- Receiving MS 2mg/hr BID every 6 hrs continues to refuse continuous infusion for pain medication
- 12 mcg and 25 mcg Fentanyl Patches Q 72 hr
- Couple refuses counseling
- Wanted small amounts of PO liquid to continue – if choking staff instructed to use Ativan and MS for comfort – resident feels she is swallowing better than in June 2017
- Prognosis 1-2 months
HOSPICE CASE STUDY #2 -DETAILS

SECOND MONTH
• Continued neck, back, ribs and shoulder pain
• MS increased to 4mg IV Q 2 hr – helps with pain but it never goes away, continues to refuse narcotic medication pump for pain control
• Added humidity to O2 heated for sleeping
• Frightened to sleep and struggling emotionally – although appears to be more comfortable and trusting staff
• Encounters severe constipation problems, severe discomfort
• (Dulcolax, Milk of Magnesia, Citrus 100mg BID, Miralax, Coconut oil in tea)
• Tired from so much company but doesn’t want to turn them away
• Encourage family video conference – Residents states “it is too hard to schedule”. Husband states, “I keep the kids updated.”

HOSPICE CASE STUDY #2

THIRD MONTH
• Cold Air irritates breathing – mask given when resident leaves for a few hours with husband.
• Low grade fever treated with Levaquin 500 mg IV x 7 days. Constipation better
• Many concerns about not being able to get inner cannula back in after trach care – reassured that inner cannula may stay out and she would still have breathing access.
• Prognosis – told death will be probably from malnutrition, infection or sudden bleeding from tumor – fearful of choking to death – wants to know life expectancy.
• MS increased to 6mg IV Q 2 hr – helps with pain but it never goes away, continues to refuse narcotic medication pump for pain control (in 3 out of 10 with 1-4 hours regularly)
• Pain increases to spread upper back, skull, left sternum, shoulders, neck.
• Increased use of Lorazepam for sleep.
• Encourages to focus on present and to read with husband The Four Things That Matter Most by Ira Byock. Contacted Red Cross for support to get kids home to see resident.

HOSPICE CASE STUDY #2 -DETAILS

FOURTH MONTH
• Children came to visit and wrote letters to their mom. Resident states felt much relief when they all left.
• Very resentful on both resident and spouse.
• Trouble sleeping – thinks Lorazepam is causing weird dreams.
• Fentanyl patch increased to 100mcg Q 72 hrs.
• Choked on corn and anxiety increased. Fear staff may think she is a “diva” but relies on staff to keep her alive.
• Running fever but refuses Tylenol. Continues with Massage and Healing Touch.
• Doesn’t feel oral MS will work as it didn’t work at the U of M in June.
• Care conference called to discuss hopes, fears, concerns. Decline pain pump due to mechanics and heaviness. Palliative sedation discussed (unable to control pain with IV meds. Clear about wanting no feeding tube). Husband encouraged to reach out to friends at work for support.
FIFTH MONTH

- “Life nothing but mucus and Morphine since August” states resident.
- Husband ill – resident fear of being alone. Increased blood in cannula – “I want to die”
- Care conference – has decided to stop IV fluids and this discussed with her. Discussed that port is becoming more difficult to access. Angry that she has a trach, discussed how that occurred and possibly why. Wants to be “pain free and go to sleep”. DR encouraged resident to write to her children, discussed forgiveness for her husband and the time they have had together since she received the trach.
- Tried Oral MS but 2 hours later still had no relief.
- Morphine 10mg Q 1 hr
- Fentanyl patch increased to 100mcg Q 48 hr
- Healing Touch and Massage weekly.
- Prognosis – 1-2 months.
- Tired and weak.
- Has sensation of being choked.

HOSPICE CASE STUDY #2 -DETAILS

SIX MONTH discharge to home
- Decadron started for throat tightness. Although Decadron makes her hungry, feels parched and soup not going down well.
- Feels like second airway has developed around trach. Masters changing her own trach dressing and suctioning herself. Becomes irritated easily.
- Sadness due to loss of friend to CA.
- Feels like staff don’t want to care for her. Depressed. Frustrated. House is quieter on weekends and doesn’t like that. Bored, not enough to do.
- Considering going off hospice to treatment. Interested in PD-L1 testing after speaking with her mother who has lung cancer. Has an appt on 3/2 to discuss possibility of testing and immunotherapy for her cancer. She will need a NM PET scan and MRI brain with a possibly bronchoscopy.
- Discharged to home on with home hospice to meet them at their house. (Day 198)

MEDICATIONS AT READMISSION
- Morphine 30mg PO Q 3 hr and Q 1 hr PRN
- Haldol 0.5mg TID, 1mg BID from 12midnight – 4am. 0.5 – 1mg Q 3 hr PRN confusion, delirium, nausea
- Lorazepam 1mg Q 6 and 1 mg Q 3 PRN
- Levsin 0.125mg PO Q 4 hr prn for increased secretions
- Zofran 4 mg PO Q 8 PRN nausea
- Decadron 4mg PO Q AM

HEALING TOUCH In-service done for Staff
- Two weeks later Resident Readmitted
- Quiet, weak, very weak, pain somewhat controlled on 30mg Q 3 hr, confusion increased, able to respond yes/no.
HOSPICE CASE STUDY #2 - DETAILS

SEVENTH MONTH

- 17 new drug orders or changes to current med list
- Resident sent text to husband to take her home. Called friend Judy at 0430. Nursing staff reassured husband, friend she is safe and being cared for. Requiring 1:1 care, slid to floor. Husband wondering if IV fluids should be restarted again to decrease confusion. Resident sleeping in a slumped over sitting position. Husband wonders why she is back at DD. (Day 1)
- Wants to leave – staff found her out on deck with clothes packed, calling husband to come get her. Even when dozing off, nurses observe her fighting sleep. Healing Touch initiated. (Day 2)
- Wants to leave house, staff had to hold her back. Tried to pull out trach. Husband brought her home for a short time. Resident became combative at home. (Day 3)
- 1:1 staff needed. Staff spoke to resident about holding onto anger or dying peacefully. Resident calmer after conversation. (Day 4)
- Refusing care and meds. Loss of feeling in hands, combative with staff. Healing Touch, calmer after. (Day 10)

THANK YOU!!