

# Caring for the dying patient in the hospital setting...

Cathy Gallagher, RN, CHPN

Hospice Liaison

Halifax Health Hospice of Volusia/Flagler

HALIFAX HEALTH  
**HOSPICE**  
OF VOLUSIA/FLAGLER  
Licensed since 1979

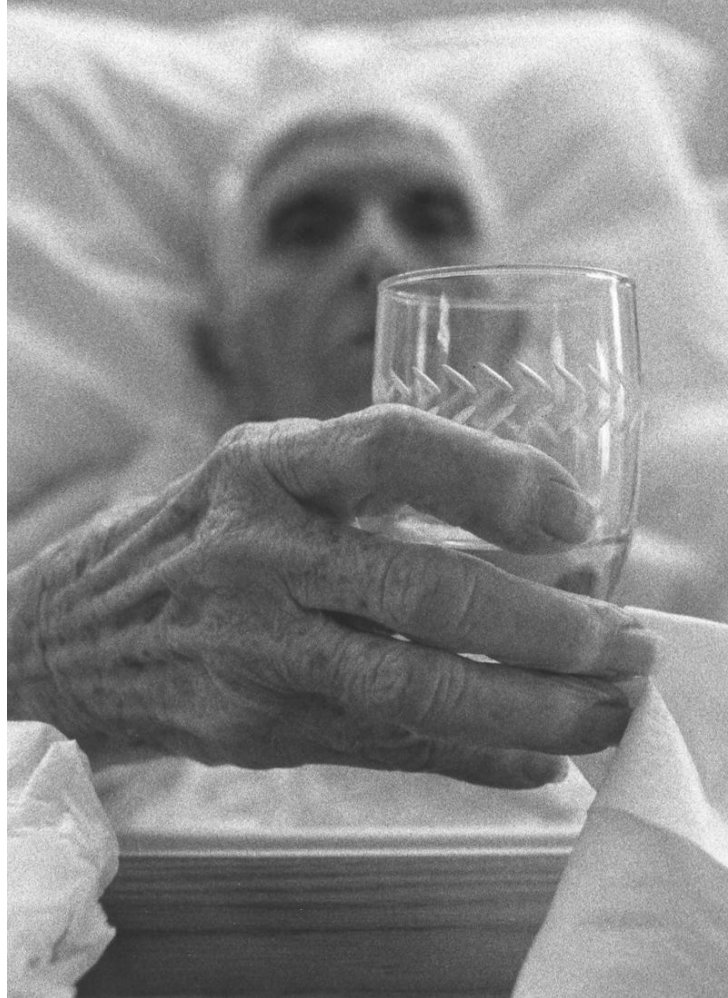


CELEBRATING LIFE.

# Indicators of Imminent Death

The last days and hours of life pose challenges for all involved in care of the dying patient

A Dying Patient needs love...



“ Tell them not to be afraid of the dying.”

“It is very simple. The dying need tender loving, nothing more.”

Mother Teresa

From David Kessler’s “The Needs of the Dying”

# In-patient Hospice in the hospital

- Why would we offer this to a family?
- Criteria: symptom mgmt
- Time frame: varies
- Plan of care: comfort care vs. curative
- Teamwork involved
- Pt may be moved to another setting once symptoms are controlled

# ANA Code for Nurses:

- **“ nursing care extends to anyone requiring the services of the nurse for the promotion of health, the prevention of illnesses, the restoration of health, the alleviation of suffering and the provision of supportive care of the dying.”**

# **WE NURSES ARE THE TEACHERS**

- **THE DYING PROCESS IS SIMILAR IN CHRONIC ILLNESS REGARDLESS OF DIAGNOSIS**
- Hypoxia, malnutrition, hepatic and renal failure, fluid/electrolyte imbalance, and in cancer pts, tumor burden, gradually exhaust the body's coping mechanisms, resulting in death.
- HPNA 2002

# **A REMINDER TO OURSELVES:**

- **IT IS IMPERATIVE TO REMEMBER THAT THE DISEASE OR TERMINAL EVENT IS CAUSING THE PATIENT'S DEATH...**

# SIGNS AND SYMPTOMS

- **Vary with each pt and each diagnosis**
- **We must teach the family members that the patient may experience any number of symptoms or none at all.**
- **Updating the family about changes and offering support is most important**

# Goals of Care during last days

- **Keep patient as comfortable as possible**
- **Maintain pt's sense of dignity**
- **Avoid actions that may hasten death or prolong life.**
- **Prepare family for pt's final hours**



# Qualities Of A Good Death

- Confidence that pain and non-pain s/s will be managed well
- Control over who is present to share the end and where the death occurs
- Dignity and privacy preserved and respected
- To be able to issue advance directives and have them honored
- Access to spiritual and emotional support
- To be able to leave when it is time to go and not have life prolonged needlessly.

# Changes in Plan of Care

- D/C meds no longer necessary, such as hypoglycemic, pressors, etc.
- D/C labs and tests
- Continue meds for pain, seizures, nausea
- Change oral meds to sublingual, rectal or SQ.
- Frequent oral care
- Reposition q2-3h

# FREQUENTLY USED MEDICATIONS

- Roxanol (20mg/cc) 0.25cc – 0.5cc by mouth or sublingual every 3 hours prn for pain, restlessness or shortness of breath.
- \* (conversion: 30mg Roxanol = 10mg IV Morphine)
- Ativan 0.5mg to 1 mg. PO/SL every 6 hrs for restlessness; agitation; SOB; nausea
- Levsin 0.125mg- 1 to 2 PO/SL every 4 hrs prn congestion.
- Tylenol 650mg supp. (1 Q6hrs prn)
- Dulcolax supp. 1 QD prn constipation.

# GRADUAL HYPOXIA

- S/S OCCUR WHEN O<sub>2</sub> SAT < 80%
- S/S AT 65-80%; sensory perception decreases; disorientation, restlessness, increased pulse, apnea, light sensitivity, < urinary output, > weakness begins in legs then to arms resulting in immobility.
- S/S AT 60% and <; UNRESPONSIVENESS, heart rate may double, Irregular HR, faint pulse, Pt is diaphoretic yet cool to touch, extremities may be mottled, eyes remain half open, absent blink reflex. HEARING REMAINS INTACT and slowly <

# THE MOST COMMON SYMPTOMS

- Noisy/moist breathing (death rattle)
- Pain
- Urinary dysfunction
- Restlessness and agitation
- Dyspnea

# TREATMENT OPTIONS:

- Assess and teach regarding normal dying process
- Catheter if appropriate
- Medication changes (retention > with anticholinergics)
- Frequent peri-care and use of moisture barriers.
- Observe, reassure, teach

# DYSPNEA

- Tx options: Morphine sulfate (pf) 5mg in 2cc NS via nebulizer; use of SL morphine as ordered. Ativan SL to < anxiety. Valium IV/SC for acute stridor. Cool room, fan, O2 via nc prn comfort/psychological benefit, calm presence of loved ones. TEACH regarding dyspnea mgmt and normal dying process.

# RESPIRATORY CONGESTION

- Caused by inability to clear pharyngeal and tracheal secretions; occurs frequently prior to death. This symptom may be very disturbing to family members.
- Tx: O2 for comfort, high fowlers position, anticholinergic- use at first sign of death rattle (scopolamine, levsin), gentle suctioning, reassure and teach.

# Pain in the terminal phase

- Causes: Disease progression; impaired absorption of opioids (rectal); withholding of medication by caregiver; joint stiffness due to immobility in the dying process.
- TX: Continue previous opioid dosage unless s/s of opioid toxicity. AVOID abrupt d/c of opioids-give at least 25% of previous dose.; pre-medicate prior to any procedure; gently and slowly reposition. Reassure and teach family.

# OTHER SYMPTOMS

- Dysphagia
- Impaired corneal reflexes
- Edema
- Mottling, cool extremities, cyanosis
- Hypothermia
- Hyperthermia
- Diaphoresis

# HELPING THE FAMILY

- Reassure and provide guidance
- Prepare them for what to expect...
- Educate on signs and symptoms and Tx prn
- Enhance comfortable environment...
- Avoid whispering – remind family of pt ability to hear...
- Respect cultural, religious or spiritual rituals
- Offer support
- Encourage touch and speaking to patient
- Just be there...be present...

**“ Don’t try to be too wise; don’t always try to search for something profound to say. You don’t have to do or say anything to make things better. Just be there as fully as you can.”**

The Tibetan Book of Living and Dying Sogyal Rinpoche

# Presence Means...

Being where one is... in body, mind and spirit.

- Full attention
- Listening
- Self-giving...
- Meaningful support

# Presence is a Process

- Being in touch with self
- Appropriate boundaries
- Following patient's needs
- Effective Listening
- Use of appropriate verbal and nonverbal communication
- Powerlessness

**“ It may well NOT be what we do, but rather how we are that matters most.”**

Ira Byock, MD 2001. Spirituality & Medicine  
CONNECTION. 4(4):1

# Palliative Care/Hospice Consults

## Our Nurses are in-house everyday

- Physician Order required
- Guidance for the patient /family
- Education on Choices
- Conversations about Possibilities
- Support
- Quality of Life Focus
- Presence

# You can say the “H” word...

- Hospice is the next step...when treatment for cure is no longer possible you can still offer treatment for comfort and thus insure quality of life...
- Patient's may think of hospice as something that is used when they are very near death...we must explain that the focus is about LIVING with comfort, dignity and respect!
- The patient directs the care provided.
- This is end-of-life care with the patient first!



# Doctor, please don't say “there is nothing else we can do”.

When a disease becomes terminal, say what you CAN do:

- We can provide aggressive comfort treatment.
- We can address your suffering and pain.
- We can improve the quality of the time you have remaining, making your last days or months as pleasant as possible...
- And when the time comes, we can manage your dying, just as YOU want it.
- Speak in the positive.

“The Needs of the Dying” by David Kessler, 1997

“Contrary to fears that discussions of prognosis will destroy patients hope, such discussions can refocus hope more realistically and prevent false hope.”

JAMA, May 26, 2004

# Hospice Care

- Includes the elements of palliative care
- Prognosis of 6 months or less expected if disease follows its anticipated course
- Focus on controlling symptoms, alleviating pain
- Promoting comfort and quality of life
- Support for loved ones even beyond pt death...bereavement care goes on...

# Hospice Services provided

- Wherever the patient lives:
  - Home
  - Assisted Living Facility
  - Nursing Home
  - Hospital
  - Care Center/Hospice Houses

# Hospice of Volusia/Flagler: In-pt Admissions

- On call 24/7 - CALL US!!!
- Staff will visit every day.
- Call us 322- 4701 with questions.
- Call us if you feel family needs more support. It is ok to request SW or chaplain.
- Call when s/s are not managed.
- Call when patient dies.

(Follow Hospital protocol at time of death)

# WE ARE ON THE SAME TEAM!!!

- THE HOSPICE OF  
VOLUSIA/FLAGLER IS AN  
AFFILIATE OF HALIFAX  
HEALTH.

# Lessons From The Dying

- Healthcare staff die too
- Make your wishes known re: EOL care
- Choose an assertive POA / Surrogate
- EOL care is NOT abandonment of care – it’s “intensive care” with a different focus
- EOL care is true family medicine
- Participating in the deaths of others helps us to live prioritize our own lives

# The End



*HOVF Orange City Care Center – OPENS  
NOVEMBER 2007*