Adopted: 11/89
Reviewed/Revised: 8/93, 12/96, 9/99, 9/02, 10/04, 12/08, 11/11, 1/15, 2/18, 2/21

NEW IN THIS UPDATE:
Reviewed

POLICY:
To assist patient in maintaining dignity during end stages of life

PURPOSE:
To guide the care of patients who are dying

REFERENCES:
HS-415 Patient Care After Expiration

RESPONSIBILITY STATEMENT:
All staff caring for the dying patient

DEFINITIONS:
None

SUPPORTIVE DATA:
Healthcare Providers have a specific responsibility toward patients who are dying. That responsibility includes continually adjusting care to meet the changing needs of the patient as death approaches. The health care provider must seek a level of care that optimizes comfort and dignity.

CONTENT:
Central Hospital does not provide inpatient medical/surgical services to dying patients. It is understood that having a dying patient in one of the outpatient services is likely to be an extremely rare occurrence. Central Hospital does however provide supportive and palliative services to terminally ill patients and this protocol exists to provide assistance and guidance in the event that a patient requires care at this stage of their life.

Narcotics or other pain medications should be given in whatever dose and by whatever route is necessary for relief. The proper dose of pain medication is the dose that is sufficient to relieve pain and suffering (as defined by the patient), even if it affects the patient's level of consciousness.

Assessment:
The physical, psychosocial, and spiritual concerns of the patient and family will be assessed.

A. *Physical Concerns*:

1. **Pain**. Have patient establish a comfort goal which should include assessment of the pain location, character, frequency, duration, and intensity (using 0-10 or a developmental or age appropriate scale) of pain and responses to interventions for pain relief.

2. **Nausea and vomiting**. Possible causes include metabolic abnormalities, electrolyte imbalances, drug effects, bowel obstruction, ulcer, intracranial pressure, stress, constipation, late stage cancer.
3. **Respiratory distress**. Including the need for oxygen or removal of excessive airway secretions or medications to reduce dyspnea or secretions.
4. **Signs of approaching death**, including:
    - Decreasing social interaction
    - More time spent sleeping
    - Difficult speaking
    - Possible confusion or forgetfulness about time, place and identity of close and familiar people
    - Restlessness, pulling at bed linen or having visions of persons or things not present
    - Slight decreases in vision and hearing
    - Incontinence of urine and feces
    - Irregular breathing including periods of apnea
    - Increased congestion with inability to clear oral or airway secretions
    - Arms and legs become cool to the touch and the underside of the body becomes much darker in color

B. *Psychosocial Concerns*

1. Patient and family reaction to dying and the grieving process including:
    - Feelings, e.g., shock, anger, guilt, sadness, despair, misplaced blame
    - Physical sensations, e.g., fatigue, weakness, dizziness, loss of appetite
    - Thought patterns, e.g., confusion, inability to concentrate
    - Behaviors, e.g., crying, withdrawal, restlessness, anger, insomnia
    - Social changes, e.g., role changes, need for rituals, marital difficulties
2. Source and adequacy of psychosocial support including any need for support services.

C. *Spiritual Concerns*. The nurse assesses the need for spiritual counseling and/or other spiritual issues and takes measures to meet those needs. Measures may include referral to MSW or notification of clergy as appropriate or requested.

D. Contact Organ Donation Team within one hour of death for potential for organ donation.

E. Assess funeral home/burial plans PRN.

F. Assess whether routine vital signs, medical tests, or potentially distressing treatments need to be discontinued.

REPORTABLE CONDITIONS:

The following conditions should be reported to the appropriate person:

- Patient death to the physician, the family when appropriate, medical examiner (when applicable), funeral home of patient/family choice, the AOD, and Admitting.
- Inadequate pain relief to the physician.
- Concerns regarding psychosocial responses of patient or family to the social worker.
- Concern regarding terminal care decision making or a conflict in care or treatment decision.
- Spiritual/cultural concerns to a person of the patient/family's choice. (A hospice spiritual counselor is available to those in the hospice program.)
- Signs and symptoms of disease advancement that may be causing concern and anxiety for patient and family to the physician.

NURSING INTERVENTION:

A. Facilitate Grief Process
1. Identify and review choices with patient/family regarding "DO NOT RESUSCITATE" orders, living wills, organ donation, and funeral planning.
2. Be open and sensitive to patient/family grief reactions recognizing there are diverse ways to exhibit grief.
3. Acknowledge the patient/family's feelings and give them permission to express them.
4. Communicate understanding of the grief process.
5. Listen; be gentle and patient.
6. Provide control to the dying person by offering options, choices, and inclusion in decision-making. When necessary, assist in limiting visitation.
7. Allow time to talk. Avoid generalities such as "everything will be okay." Acknowledge fears and concerns. Don't assume you know what they are.
8. Plan conversation times when the person seems more alert. Allow sleep as needed.
9. Encourage the patient, family, and friends to say their final goodbyes while the person is still alive.
10. Talk calmly and gently. Avoid startling or frightening the person. Remind the person of where they are who is with them and what day it is.
11. Explain to the family that the patient may be able to hear them and to feel their presence even when s/he may be too weak to respond. Never assume the person cannot hear you.
12. Maintain soft or indirect light in room.
13. Share information with the family, including signs of approaching death.
14. Provide reassurance.
15. Encourage involvement in a social and/or spiritual network.

B. Pain Management
1. Provide routine pain medications. Medicate with prn medication for breakthrough pain and notify the physician for an increase in routine medications if needed. The goal of intervention is maximum comfort from the patient's point of view.
2. Physicians may consider the addition of psychopharmacologic agents to manage pain (i.e. antidepressants, anticonvulsants).
3. Utilize alternative, non-pharmacologic pain management strategies as appropriate, e.g., therapeutic touch, visualization, hypnosis, heat, cold.

C. Comfort Measures
1. Supportive care as desired including back rubs, moist washcloth to forehead, repositioning.
2. Turn person on side or elevate head of bed if excess secretions become a problem. (Obtain an atropine order for further assistance in minimizing secretions and/or suctioning to reduce airway secretions.) Otherwise, only turn for comfort if patient appears imminently terminal.
3. Mouth care: Swab mouth with water or saline. Provide ice chips or moist washcloth. Gentle tooth brushing and good oral hygiene may be helpful. Apply Vaseline to dry lips.
4. Offer small serving of a favorite food or drink, being careful not to make eating an issue.
5. Administer anti-nauseates and/or antiemetic as indicated and assess for effectiveness. Consult with physician for any needed medication changes.
6. Hypo tears are helpful for dry eyes.

EMERGENCY MEASURES

Profuse bleeding may require medical intervention.

DOCUMENTATION

Documentation of care will be completed in patient's medical record (EPIC/Paper). Document contact and outcome of conversation with Organ Procurement in EPIC.