Key Points

1. The Goals of Care in the last hours of life are comfort, support, and protection from iatrogenic harm.

2. Continuing to "do everything" for the patient can contribute to physical, emotional, social, and spiritual/existential suffering. Common interventions at Life's End include:
   - IV fluids and central lines; blood work, arterial blood gas and imaging studies
   - Nasogastric tubes, peg tubes, and TPN; bladder catheters and rectal tubes
   - Oxygen therapy mask, non-rebreather, and BiPAP
   - Intubation, suctioning, nasal trumpet, nebulizations, oxygen saturation monitoring, arterial line, and telemetry
   - CPR and attempted resuscitation; restraints
   - Separation from family and loved ones

3. DNAR (Do Not Attempt Resuscitation) or AND (Allow Natural Death) are preferable to DNR (Do Not Resuscitate) as orders.
   DNR suggests that medical personnel can successfully resuscitate at Life's End but choose not to do so. Resuscitation is not an effective treatment in End-of-Life Care.

4. Assist the family by advising when to call other family members in, writing orders to facilitate visiting or staying, and educating them about physical markers of life's final days.
   Arrange visits for military relatives by contacting the Red Cross and for incarcerated relatives by contacting prison wardens. Give families the pamphlet *Gone from My Sight* as a guide to the last days of life.

Last Hours of Life (I)

The Palliative Response

Mr. Edward Johnson Is Dying

- 75-year-old widower
- Diagnosed with stage IV non-small-cell lung cancer six months ago. Now has progressive disease despite chemotherapy and radiation therapy.
- Brought to the ER
  Uncontrolled pain
  Has not been getting out of bed

Physical Exam
of Mr. Johnson

- Thin male with temporal wasting
- Blue tinged lips and nail
- BP 80/40 P140 RR30 T100.2
- 4x4cm lymph node in R supraclavicular space
- Coarse breath sounds in all lung fields and dullness R base
- Liver 10cm below the R rib margin
- Tender 3+ edema to the knees

Assessment
of Mr. Johnson

- Mr. Johnson is terminally ill with progressive lung cancer, an illness man cannot cure
- Mr. Johnson is not responding to disease-modifying treatments

Goals of Care
for Mr. Johnson

- Comfort
- Support
- Protection from iatrogenic harm

Reflection
Suffering Paradigm

Make a list of symptoms or problems that you anticipate might cause suffering for Mr. Johnson and his family during this phase of his illness.

Reflection
Physical Suffering

What *Physical Suffering* do you anticipate during this phase of Mr. Johnson's illness?

Reflection
Emotional Suffering

What *Emotional Suffering* do you anticipate during this phase of Mr. Johnson's illness?

Reflection
Social Suffering

What *Social Suffering* do you anticipate during this phase of Mr. Johnson's illness?

Reflection
Spiritual/Existential Suffering

What *Spiritual/Existential* Suffering do you anticipate during this phase of Mr. Johnson's illness?

"Do Everything"

- Your team has been called to the ER to admit Mr. Johnson
- ER physician informs you that the family has already left

  Before they left, she asked them if they wanted the doctors to "do everything"

  They said "Yes"
- She has called for a bed in the ICU

ICU Interventions

- Reflect on the kinds of treatments and interventions that might be anticipated in the ICU when you "do everything"
- List anticipated interventions

Impact of Interventions

What impact do you anticipate that these interventions will have on Mr. Johnson's suffering at Life's End?

- Physical
- Emotional
- Social
- Spiritual/Existential

Sources of Suffering at Life's End

Physical

- Pain
- Dyspnea
- Anorexia
- Nausea/Vomiting
- Constipation
- Asthenia
- Skin breakdown
- Dysphagia
- Problems with secretions
- Incontinence

Sources of Suffering at Life's End

Emotional

- Delirium
- Depression
- Anxiety

Social

- Lack of financial resource
- Inadequate housing
- Lack of full-time caregiver

Spiritual/Existential

- Spiritual anguish
- Loss of meaning

Common Interventions at Life's End

- IV fluids and central lines
- Blood work, arterial blood gas, imaging studies
- Nasogastric tubes, peg tubes, TPN
- Bladder catheters and rectal tubes
- Oxygen therapy mask, non-rebreather, BiPAP

Common Interventions at Life's End

- Intubation, suctioning, nasal trumpet, nebulizations, oxygen saturation monitoring, arterial line, telemetry
- CPR and attempted resuscitation
- Restraints
- Separation from family/loved ones

To be continued in

Last Hours of Life (II)

Last Hours of Life (II)

Annotated Orders for Comfort Care

Admission

- Admit and initiate Comfort Care Order Set or
- Transfer and initiate Comfort Care Order Set or
- Initiate Comfort Care Order Set
- Diagnosis: Metastatic Lung Cancer/Pain Crisis
- Condition: Grave
- Status: Do Not Attempt Resuscitation (DNAR)
- Orders: Focus on what you can do that may be helpful

Do Not Attempt Resuscitation

Resuscitation is not an effective treatment at Life's End

- DNAR terminology preferable to DNR
- DNR (Do Not Resuscitate) suggests that one can successfully resuscitate at Life's End but chooses not to do so

Diet

- Order a diet
  Patient may improve and desire the taste of food
- Full liquid instead of clear liquid
  More palatable
  Easier to swallow, less likely to cause aspiration
  Can advance if tolerated
- May have food brought in by family
- Allow patient to sit up for meals; assist to eat
  Use dietary and nursing care text orders in CCOS to select most appropriate orders

Activity

- Allow patient to sit in chair if desired
- Allow patient to use bedside commode if safe
- Allow family to stay in room with patient
  Use nursing care text orders to select theses or other appropriate orders for patient and family comfort.
  Avoid orders for strict bed rest.

Vital Signs

- Minimum frequency allowed by policy (usually not more than once a shift)
- Limit notification orders to those necessary
  Frequent monitoring can alarm patient and family
  Numbers can distract staff/family from patient
  The goal at Life's End is symptom control, not getting a number
  Use the notification orders in CCOS to review options such as
  Call MD if pain not controlled or family needs to speak to physician

IV Considerations

- Starting is often difficult and painful
- Often has no benefit for patient
- Many patients have fluid overload, edema, and pulmonary congestion
- Many patients have limited movement in bed and are restrained to protect the IV
- Oral hydration is a reasonable compromise. If IV fluids are used, suggest a limited time trial, such as a 1000–1500cc D5½ NS over 6 hours.
- Presence of edema indicates that patient is not dehydrated

Subcutaneous (SQ) Line

- Small IV needle inserted directly under the skin, often on the abdomen or thigh
- Small volumes of many medicines can be injected when the oral route is not available
- Avoids burden of finding and maintaining IV access

Hypodermoclysis

- Technique for giving ½NS at 30–45 cc/hour continuous for rehydration, using the SQ route when an IV route may be burdensome

Use nursing care text and IV order options in CCOS to select patient

Dyspnea

- Oxygen 2–4l nasal prong
- Usually do not use mask
- Usually do monitor oxygen saturation

Use respiratory care options in CCOS to select patient-specific orders

Persistent Dyspnea

- Blow air on face with bedside fan
- Morphine for dyspnea such as MS 2–4 mg IV/SQ q2 hours respiratory rate > 20/minutes
- Turning, repositioning, sitting up
- Nebs may help

  But can lead to tachycardia and anxiety from the beta agonist
- Avoid face mask

  Most patients will not tolerate
  Interferes with communication
  Increases use of restraints
  Use nursing care text and opioid order options in CCOS to select patient-specific orders

Hygiene

- Avoid Foley catheter if possible

  Try diapers and cleansing instead
  Delirious patient may pull on bladder catheter
  May be helpful for hygiene (e.g., obesity) but same thing may be accomplished with diapers. Catheters may be more appropriate if patient is in significant pain with movement (e.g., multiple bone lesions or fractured hip)
- Check all patients for impaction

  Suppository may be helpful
- Consider evaluation by skin-care nurse

  Use nursing care text and medication order options in CCOS to select patient-specific orders

Pain and Dyspnea

- Opioids usually most effective
- Calculate morphine equivalents used in recent past; adjust as needed
- Usually will want to stop sustained-release medicines and use immediate-release medications

Morphine concentrate 20mg/ml

- Start with MS 5mg–20 mg q2 sub-lingual hours (*Offer/Patient May Refuse*)
- Or Morphine Sulfate SQ/IV q2 hours (1/3 the oral dose) (*Offer/Patient May Refuse*
- Or Morphine Sulfate continuous infusion 1–3 mg/hour (titrate to patient's comfort)

  Use opioid medication order options in CCOS to select patient-specific orders

Pain, Dyspnea, Anorexia, Asthenia, and Depression

Dexamethasone

- Can have multiple beneficial effects
- Most complications are long-term (over a year or more) and not a concern in patients at Life's End
- Less mineral-corticoid effect than Prednisone
- Does not have to be given in multiple doses

  Dexamethasone 4mg PO/SQ/IV BID at breakfast and lunch

  Use Dexamethasone medication order options in CCOS to select patient-specific orders

Nausea and Delirium

Haloperidol

- Excellent antiemitic
- Chemically related to chloropromazine but less sedating
- Helpful with delirium common at Life's End

  a. Haloperidol 2mg PO or 1mg SQ/IV q2 hours, x 3 doses or until settled, then q6–8 hours PRN

  b. Patient > 65 years: Haloperidol 1mg PO or 0.5 mg SQ/IV q2 hours, x 3 doses or until settled, then q6–8 hours PRN
- Nausea usually requires less frequent doses

  Use Haloperidol medication order options in CCOS to select patient-specific orders

Anxiety and Seizures

Lorazepam

- May be helpful with anxiety
- Exercise care as delirium can sometimes be mistaken for anxiety; benzodiazepines may make delirium worse
- Effective against seizures only as IV or SQ not PO

  a. Lorazepam 1mg PO or SQ q6–8 hours PRN

  b. Patients > 65 years old Lorazepam 0.5–1mg PO or SQ q6–8 hours PRN

  Use Lorazepam medication order options in CCOS to select patient-specific orders

Death Rattle

- Turn and reposition to the side
- Stop IV fluids or tube feeding
- Scopolamine patch topical behind ear q3 days
- Atropine eye drops 2–3gtts in mouth q4 hours or until patch effective
- Avoid deep suctioning but Yonkers might help with mouth care
- Sponge sticks with soda wash to cleanse mouth every 2–4 hours. Family can be engaged to help.

  Use secretion medication order options in CCOS to select patient-specific orders

Tips for Comfort and Safety

Comforting Measures

- Reposition
- Massage
- Quietly sit with and speak to patient
- Soft music

Minimize Discomfort

- Avoid sensory overload (e.g., TV)
- Use bed-minder in lieu of restraints to alarm if patient gets up

Assisting Family

- Advise family about alerting other loved ones about the gravity of patient's status
- Facilitate family presence

  Order permission for family to visit or stay

  Arrange visits for military (contact Red Cross) and incarcerated relatives (contact warden)
- Consult Pastoral Care and Social Work
- Provide family with pamphlet on dying process

  Use consult order options in CCOS to select patient-specific orders

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