End of Life Care

FOR CHO/SN






LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

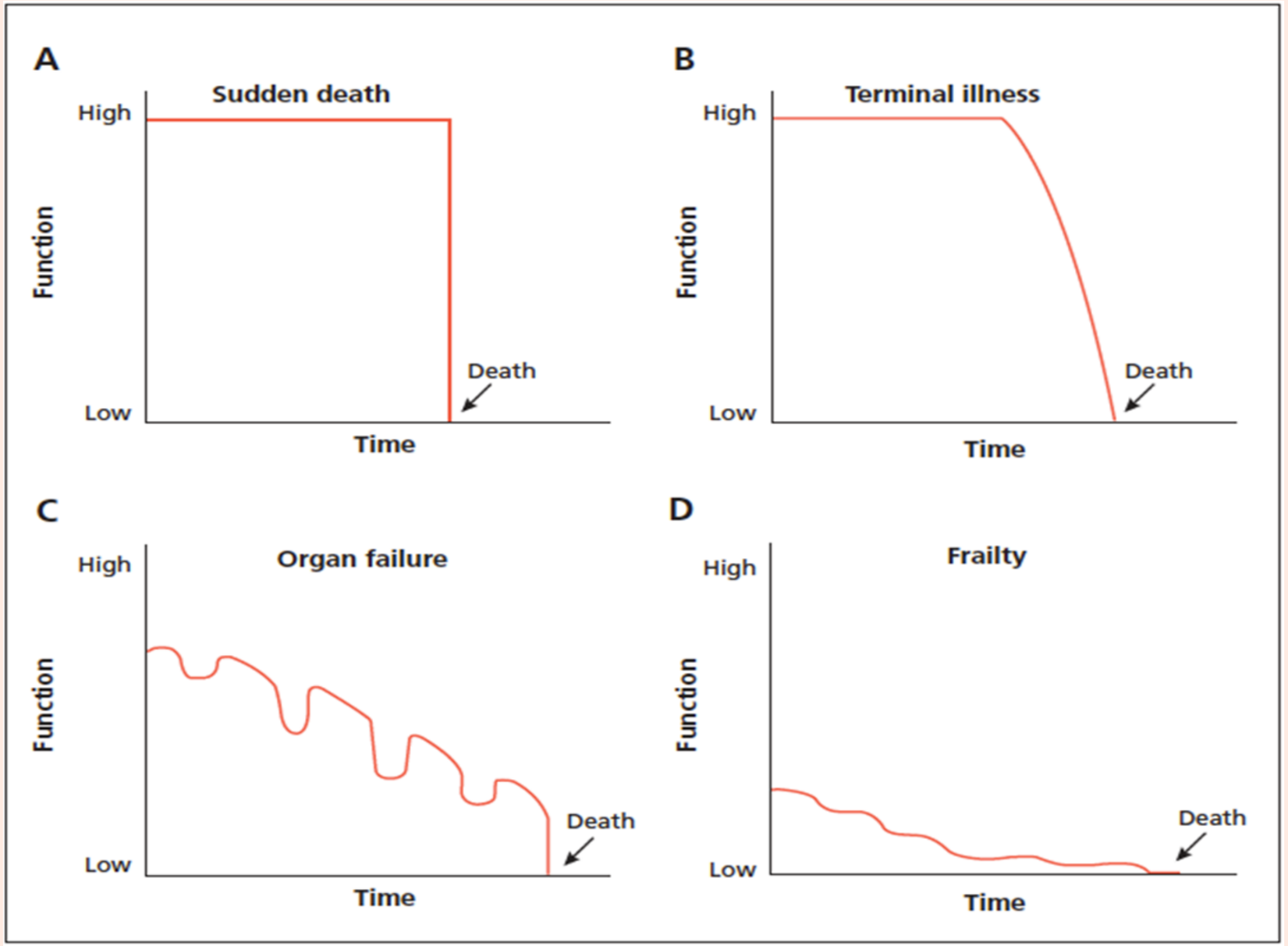
1) Elaborate on how to recognize that a patient may be dying, aware of general principles in looking after a dying patient

2) Explain how to provide death care.

REFLECTION

- Have you ever imagined your own death scene?
- Can you remember the death of someone close to you?
- What are the physical problems that you see in a dying person?

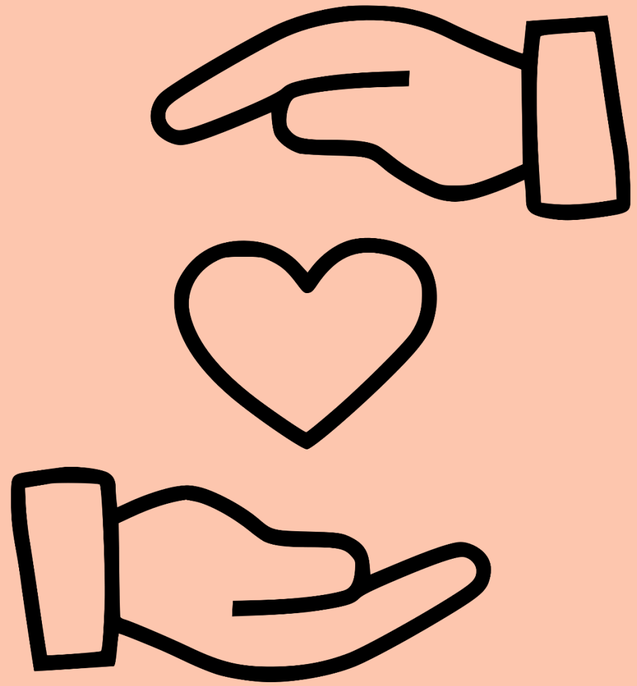
HOW WE DIE: FOUR ROADS TO DEATH.

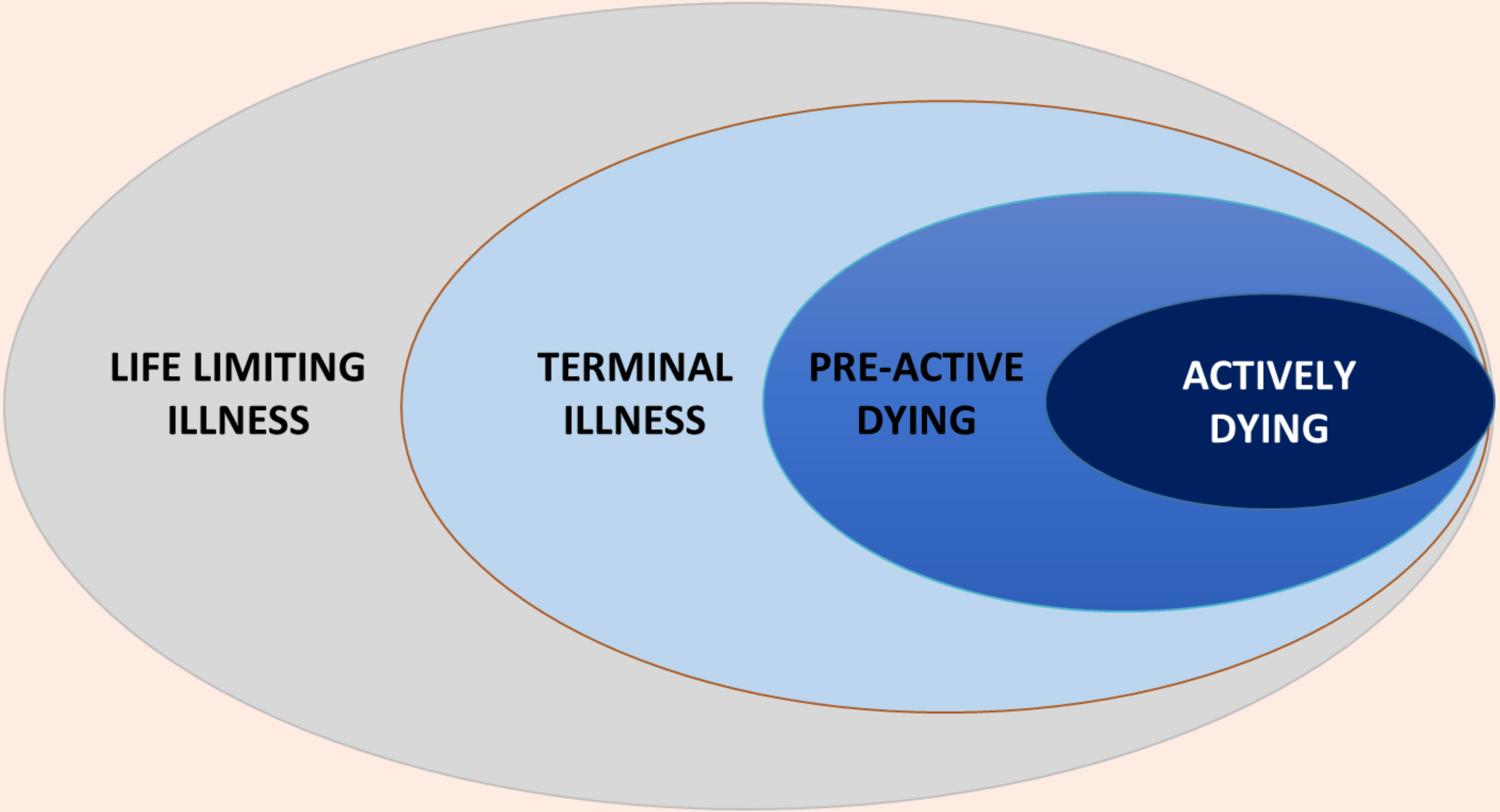


FOCUS OF TERMINAL CARE

- The main aim of terminal care is to make the dying process comfortable for the patient.

- This will mean shifting the goal of care from preserving life to providing comfort in dying




LIFE LIMITING ILLNESS
TERMINAL ILLNESS
PRE-ACTIVE DYING
ACTIVELY DYING

DEFINITIONS

- Terminal Care refers to the management of patients during their last few days, weeks or months of life, from a point at which it becomes clear that the patient is in a progressive state of decline.

- Progressive state of decline

- End of Life Care: an approach to a terminally patient that shifts the focus of care to symptom control, comfort, quality of life and quality of dying; with support for the family. Treatments aimed at cure and/or prolongation of life can be stopped.

GOOD DEATH- POSITIVE DEATH

- “Is free from avoidable distress and suffering for
  - patients,
  - families and
  - caregivers;
- In general accord with patients’ and families’ wishes and
- Reasonably consistent with clinical, cultural and ethical standards.”

CASE PRESENTATION - 1

- Mrs. Tina, 79 years, female
- Difficult to control diabetes, on insulin
- June - Aug 2017: Developed multiple skin abscesses: Treated with Intravenous antibiotics (admitted twice). Discharged for home care with daily dressings and pain control
- Sept 2017: Reduced activities: in bed most of the time. Needing help with all basic activities of daily living (bathing, toileting, dressing) except feeding. Reduced appetite, intake of food and water
- The second week Nov 2017: Confused, a little restless. Moans even on turning over in bed. Cold hands and feet. Incontinent: small quantities of dark urine.
- Three days later: stops speaking, Stops breathing later the same day.

CASE PRESENTATION
(LIFE LIMITING ILLNESS, TERMINAL ILLNESS, PREACTIVE DYING, ACTIVE DYING)

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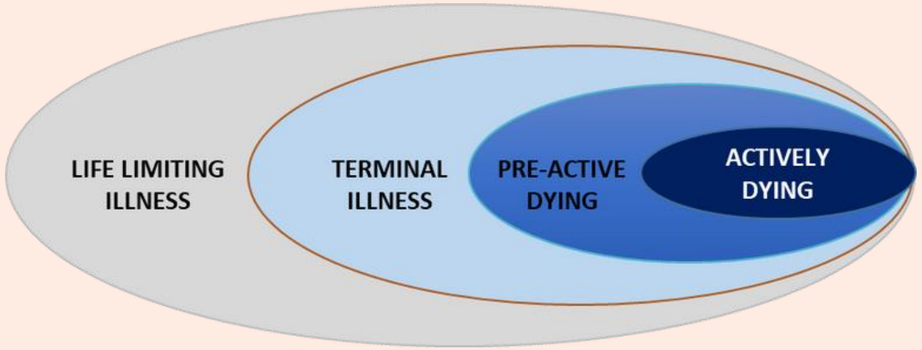

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- Incurable illness: Cancer, Kidney/heart/lung failure, Dementia, Old age
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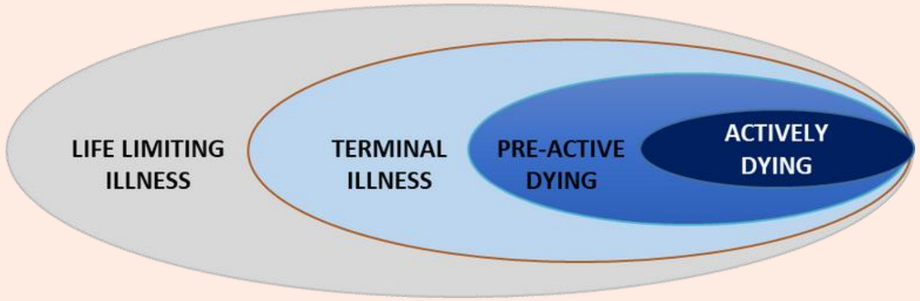

- Any patient
- Incurable illness: Cancer, Kidney/heart/lung failure, Dementia, Old age
- Terminal Illness: Variable period: under 1 year: Repeated admissions. Needing daily care. The increasing burden of symptoms - abscesses: Treated with Intravenous antibiotics (admitted twice).
- Sept 2017: Reduced activities: in bed most of the time. Needing help with all basic activities of daily living (bathing, toileting, dressing) except feeding. Reduced appetite, intake of food and water
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SETTING GOALS OF CARE

- Explaining and communicating: Patient and caregivers
- How much do they understand?
- How much do they want to know?
- Explain uncertainty about exact time line: focus on trend
- Find out patient’s wishes about place of care: does the caregiver agree?
- Wishes and plans may change

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- Terminal Illness: Variable period: under 1 year: Repeated admissions. Needing daily care. Increasing burden of symptoms.....abscesses: Treated with Intravenous antibiotics (admitted twice).
- Active Dying- Initial: One to three months: Reduced activities: in bed most of the time. Needing help with all basic activities of daily living..... Reduced appetite, intake of food and water
- Second week Nov 2017: Confused, a little restless. Moans even on turning over in bed. Cold hands and feet. Incontinent: small quantities of dark urine.
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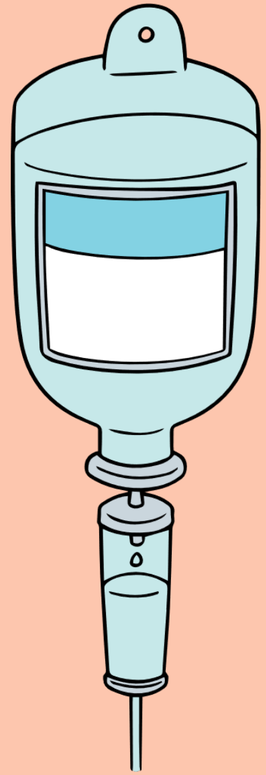
FOOD AND FLUIDS

- Remember the body is shutting down and intake is going down accordingly: not the other way around
- Decreased appetite and thirst
- Reassure caregivers and encouraging them to provide sips of water
- Apply moist swab on lips can promote the comfort of the patient,
- Forcing feeds may increase the patient distress with little to no benefit.

FOOD AND FLUIDS

- Total fluid requirement is about 1 litre per day
  - If needed can be given subcutaneously
- No Ryle's tube
  - Discomfort
  - Does not reduce risk of aspiration
- No IV fluids
  - Risk of pulmonary edema
- Hand feeding or with spoon
  - Aspiration risk is manageable



SYMPTOM CONTROL

- PAIN
  - Check with doctor for medication

- BREATHLESSNESS
  - Fan the face
  - Stroking on the back
  - Medications like morphine, lorazepam
  - No oxygen

- ANXIETY, RESTLESSNESS, CONFUSION
  - Look for causes like pain
  - If bladder is full: catheterize
  - Medications like Haloperidol, diazepam
  - Avoid restraints

MEDICATION REVIEW

- Stop all medicines that are **not** required for symptom control
- Important medicines that need to be continued or are required for symptom control: to be given **subcutaneously**

ORAL CARE, DEATH RATTLE

- Noisy secretions (death rattle) are due to collected secretions at the back of the throat when patient is too weak to swallow them. They do not cause discomfort to the patient but relatives may be worried that he is choking or in pain.

- Explain to caregivers that it does not cause distress to the patient

- Try non-drug measures: Position the patient in recovery position.

- Remove the secretion from angle of mouth using finger wrapped in a gauze piece by ‘hooking’ the finger and ‘swiping’

- Ask the doctor for medication

(video for death rattle - https://www.youtube.com/watch?v=ysSIjklb6D4)

INCREASING WEAKNESS

- As the person moves closer to death, weakness becomes more and more profound.
- As the weakness increases general activity decreases.
- Towards the late terminal stage, they may find it challenging to continue conversations and even tolerate personal care.
- The goal now is to avoid routines that make the person uncomfortable and provide care that is aimed at improving comfort.

INCREASING DROWSINESS

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- As the weakness increases general activity decreases.
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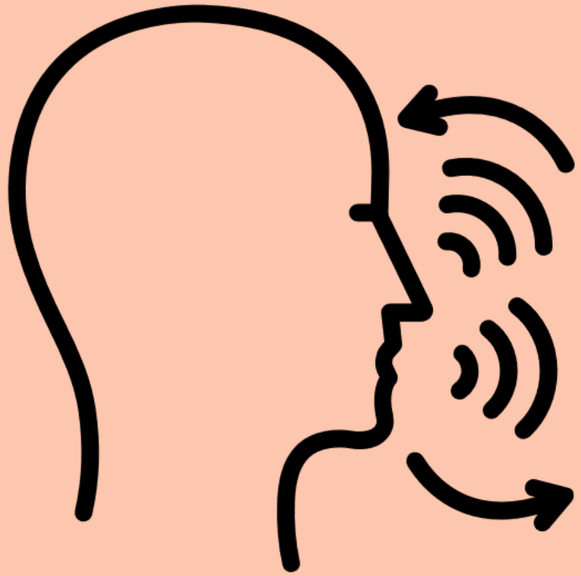
- The goal now is to avoid routines that make the person uncomfortable and provide care that is aimed at improving comfort.

CHANGES IN RESPIRATION

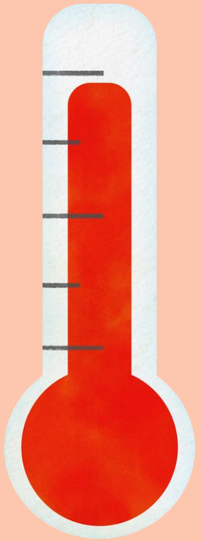
- As a person approaches the terminal phase, the respiration becomes shallow.
- In some patients, the respiratory rate may increase, but usually, the respiration becomes shallow and spaced out.
- Jaw breathing can be seen in some patients.



- Care givers should be reassured that this is a typical process of dying - it is **not distressing to the patient**.

TEMPERATURE

- During the terminal stage, the body temperature drops. This may be due to reasons like decreasing metabolism and slowing down circulation.
- The feet and hands may appear pale, cold and clammy.
- An extra blanket may be required if the person indicates that he/she is feeling cold.
- At this point, the room should be well ventilated and less crowded.



CHANGES IN EXCRETION

- Urinary and faecal incontinence is observed in only a few patients during end of life phase.
- The urinary output decreases drastically; the urine may appear dark and brown.
- There may be oedema due to fluid retention.

- It is vital to keep patients' comfort as a priority at this point.
- Maintaining good perineal hygiene and prevention of pressure sores is crucial to maintain comfort.

PREPARING FOR THE END

- Stops breathing and/or heart beat stops

- Fits/Epileptic seizures:
  - All neuro cases and even other illnesses
  - Prevent harm: do not force objects into mouth
  - No oral medication: ask doctor for subcutaneous midazolam or anti-epileptic drug
  - Patient will gradually become unconscious, quiet and will stop moving

- Blow-out Hemorrhage
  - Occurs with oral malignancy because of infiltration of neck arteries
  - Must be discussed in advance with caregivers
  - Apply steady pressure with dark towels (preferably green)
  - Sedate the patient quickly with midazolam, etc.

SUPPORTING THE FAMILY

- Family may be suffering as much and maybe even more than the patient

- Address social, spiritual, religious needs

- Involve doctor as needed

CASE PRESENTATION

- Any patient
- Incurable illness: Cancer, Kidney/heart/lung failure, Dementia, Old age
- Terminal Illness : Variable period: under 1 year: Repeated admissions. Needing daily care. Increasing burden of symptoms.....abscesses: Treated with Intravenous antibiotics (admitted twice).
- ACTIVE DYING - Initial: One to three months: Reduced activities: in bed most of the time. Needing help with all basic activities of daily living.....Reduced appetite, intake of food and water
- ACTIVE DYING: One to three days: maximum one week: Change in breathing. Reduced consciousness. Increasing pain. Cold hands and feet.
- Three days later: stops speaking, Stops breathing later the same day.

CONFIRMING DEATH AT HOME

- Introduce yourself: family may or may not remain present
- Wash hands
- Confirm identity
- Watch for signs of life: especially breaths
- Response: voice, pain, pupils
- Feel for pulse
  - Auscultate for heart beat, breath sounds: 3 minutes
- Wash hands, exit
- Document
  - Family member informed
  - Inform AHM/CHO/RMP

CARE AFTER DEATH

1. Family can feel sadness but also a deep sense of relief, especially if the patient has 'suffered'.

2. If possible,encourage the familytohavetimeandspace

3. When the moment is right, remove any medical equipment such a syringe driver, catheter,nasogastric tube.

4. Replace dentures if the patient has been using dentures.

5. Give a thorough bath and remove secretions, discharge and bloodstains.

CARE AFTER DEATH

6. Apply a jaw bandage so that the mouth is kept closed.

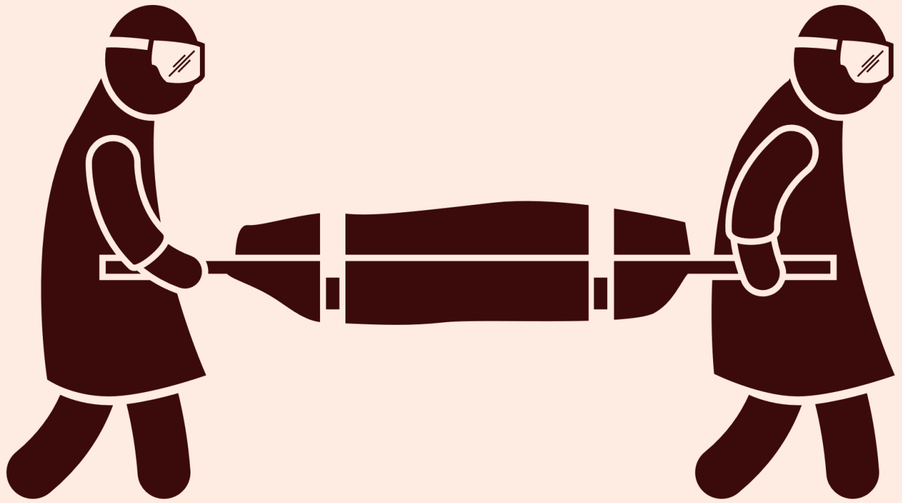
7. Plug orifices (nose, mouth, vagina, and rectum) with absorbent cotton followed by non–absorbent cotton.

8. Close your eyes by keeping a wet cotton ball on closed lids.

9. Facilitate any religious, spiritual or cultural needs.

10. Clear room of unnecessary clutter and use a clean cloth to cover the patient

BEREAVEMENT SUPPORT



- After death: bereavement visit
- Collect back unused opioids
- Family needs support: explain grief wave character
- Normal grief: upto 6 months
- Complicated grief: depression: may need medical help

EVALUATION

1.The Purpose of caring for the dying is to cure the palliative care person.

2.A positive death is free from avoidable distress and suffering for patients, families and caregivers.

3.We must let the person know approximately when he or she can expect to die.

4.It is good to ensure good nutrition through force feeding when a person is actively dying.

5.When a person is dying he or she may have fits and bleed profusely.

EVALUATION

1.The Purpose of caring for the dying is to cure the palliative care person.

False

2.A positive death is free from avoidable distress and suffering for patients, families and caregivers. True

3.We must let the person know approximately when he or she can expect to die. False

4.It is good to ensure good nutrition through force feeding when a person is actively dying. False

5.When a person is dying he or she may have fits and bleed profusely. True

EVALUATION

WORDS THAT CAN BE SAID TO A PERSON WHO IS DYING. STATE YES OR NO.

6. “Do you want to know more about your illness?”
7. “I hope you know you are dying,. It could happen any day now”
8. “ Let me check with the doctor how I can make you more comfortable…with less pain”
9. (to the family) “ Try focus on what you have done for the loved one who is dead, instead of what more you could have done”
10. “If your grief is not allowing you to carry on your daily works even after 6 months , please come to the HWC for some help”

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Thank You