Care of Imminently Dying Patient
"Comfort Care"

Theresa Kristopaitis, M.D.

Objectives

- Explain physiologic changes that occur in the last hours/days of life
- Develop a treatment plan for the last hours/days of life
- Effectively communicate with the loved ones of dying patients

My Perspective

- Time of intensive “caring”

A Dying Patient

- in bed
  - Flat, HOB elevated, sitting upright
- sleepy, unarousable, alert
- nonverbal, mumbling, moaning, verbally communicative
- breathing pattern “normal”, shallow, rapid, slow, apneic, Cheynne-stoking
- unable to swallow, swallowing bits of food or liquids or pills
- tachycardic, bradycardic
- hypotensive, hypertensive
- in pain, no pain

- We all live differently
- We all die differently

- No one quite takes the same road

The “Usual Journey”

Appetite
Oral food/fluid intake

- Decrease/inability is normal
- Associated with many fears and misconceptions
  - ?starve to death
- Reaffirm this is natural
- Well-being from secreted cytokines, catecholamines
- Parenteral fluids may be harmful
- New tubes generally uncomfortable
  - What if they have a tube?
- Mouth care q 2 hours
  - Swab, lubricant

Loss of ability to swallow

- Swallowing is complex
  - Sick, weak lose ability
  - Natural
  - Limit PO intake to avoid aspiration
    - Sips of liquid if able
    - Ice chips
- Saliva/secretion pooling – “Death Rattle”
  - Bothers observers more than patients?
  - Positioning
  - Anticholinergics
    - Scopolamine patch 1.5mg behind ear q 72 hours
    - Glycopyrrolate 0.2mg IV
  - Avoid suctioning

Changes in Respiration

- Tachypnea
- Apnea
- Cheyne-Stokes respiration
- Accessory muscle use

- All or none or some of the above

Changes in respiration

- Oxygen
  - May relieve dyspnea
  - May not relieve dyspnea
  - May prolong dying process
- Discontinue Pulse Ox Checks!
  - Titrate O2 to patient's comfort
- Air hunger
  - Opiates
  - Repositioning

Changes in respiration

- Explain to the family
- Last reflex breaths
  - “Fish out of water breathing”

Increasing weakness, fatigue

- Decreased ability to move
- Joint position fatigue

- Increased need for care
  - reposition q 2 hours

- What about decubitus ulcers?

Communication Issues

- Awareness>ability to respond
  - Too weak to talk
- Assume patient hears everything!

Communication

- “Near Death Awareness”
  - Dying patients see and speak to deceased relatives and friends
  - Prepare for travel
  - Describe a place they see in another realm

Nonverbal communication

- Touch, hand-holding

- *“If they didn’t like touchy-feely and huggies before, they’re probably not gonna’ like it now”*

  T. Kristopaitis

Decreasing Perfusion

- Tachycardia, hypotension
- Peripheral cooling cyanosis
- Skin mottling
- Diminished urine output

- Parenteral fluids will not reverse

- Patients may die with “normal” blood pressures and pulses

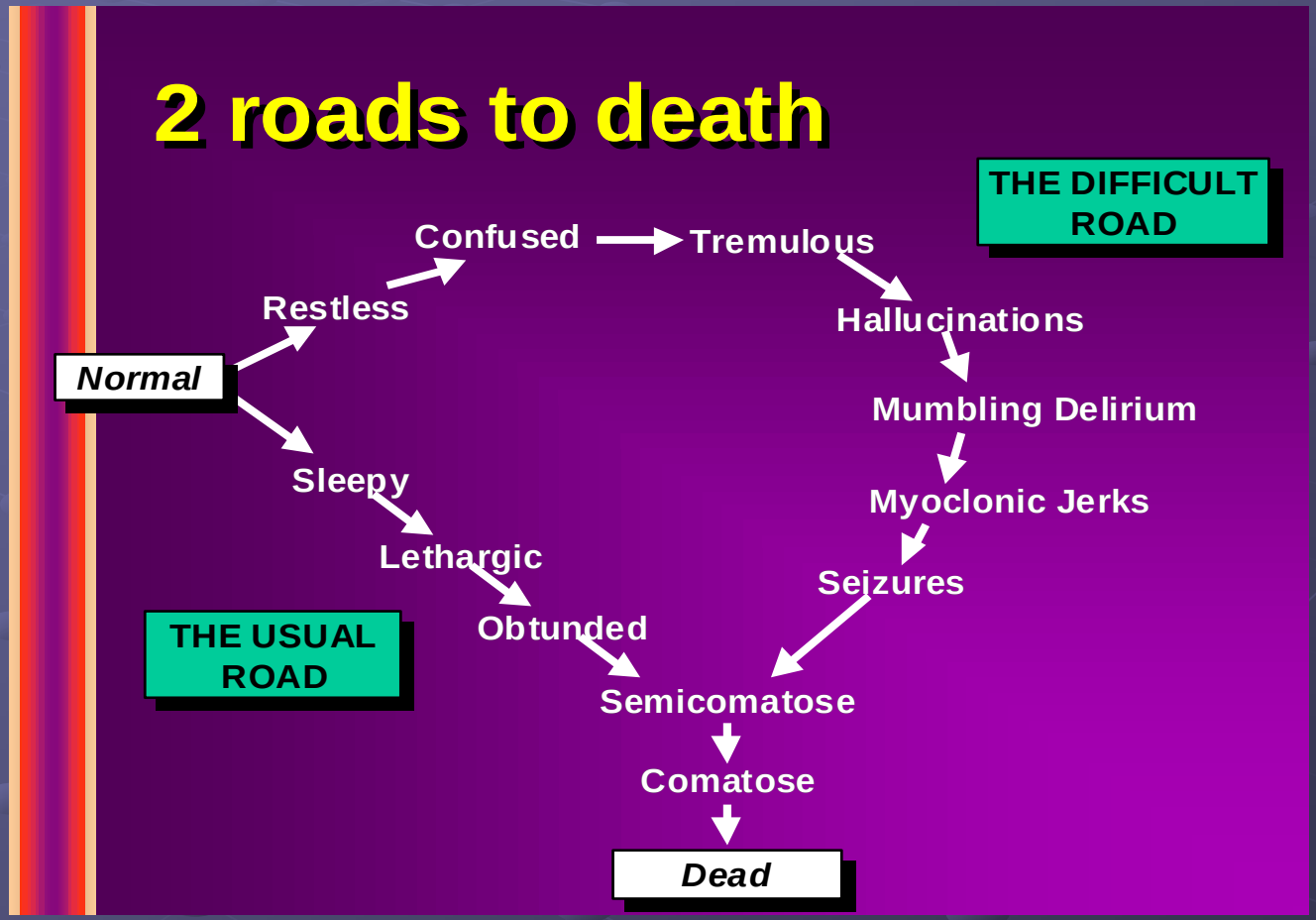
“Why is he/she sleeping with eyes open?”

- Loss of ability to close eyes
  - Loss of retro-orbital fat pad
  - Insufficient eyelid length
  - Conjunctival exposure
    - Lubricant

Comfort Care

- Medications
  - Limit to essential medications
    - Comfort
    - Does not mean “stop everything”
  - Use clinical judgement for each individual patient and each of their medications

Neurologic dysfunction



Comfort Care

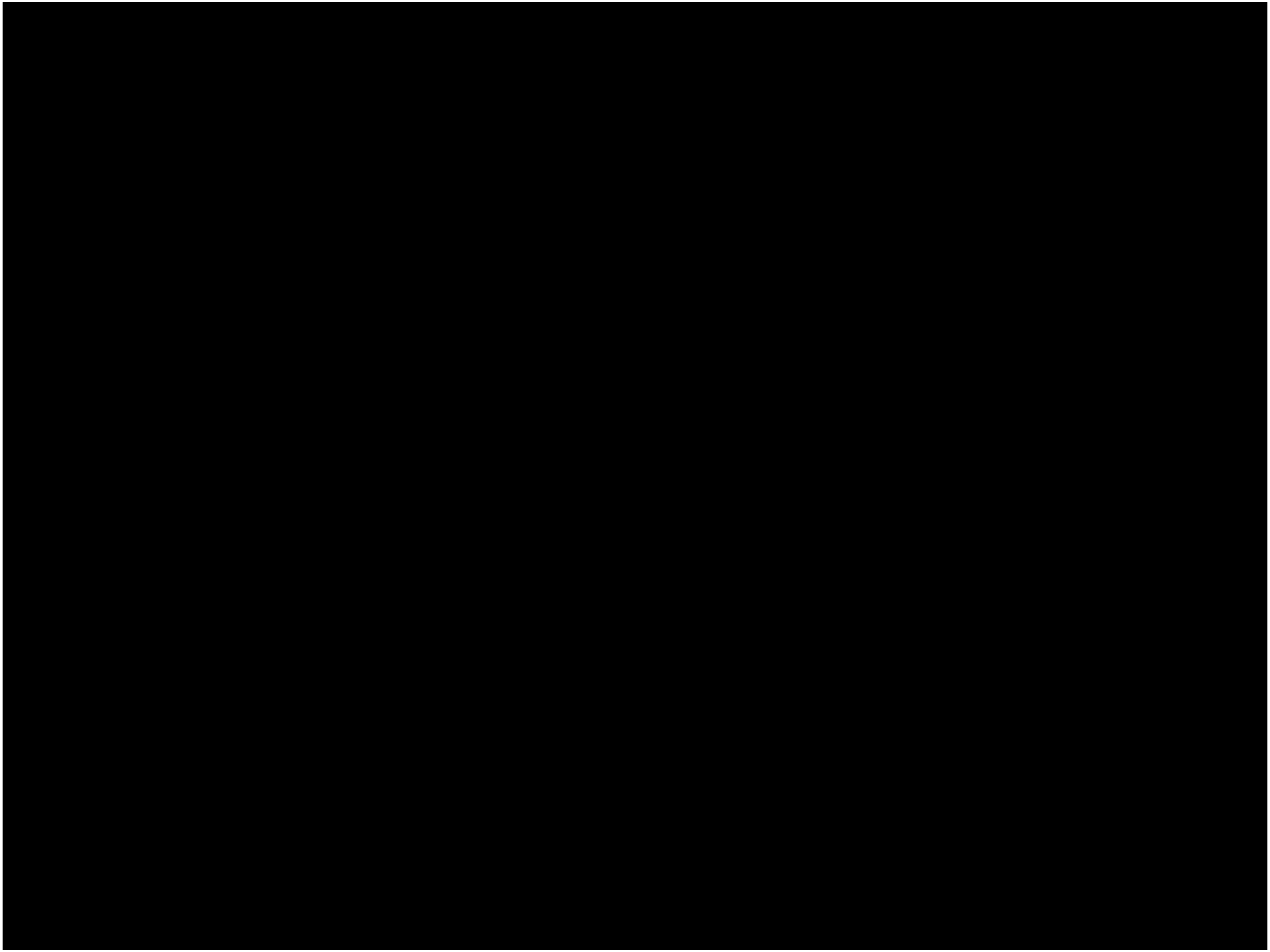
- Pain
  - Continue to treat if pain was an issue
    - Dose, route adjustments
- Grimacing, groaning, moans
  - May not indicate pain
  - May err on the side of treating for pain

Care for the Actively Dying

- Stop unnecessary procedures, monitoring
  - d/c telemetry
  - d/c pulse ox checks
  - d/c accuchecks
  - d/c TEDs and SCD's
  - Vitals daily and PRN (ie fever)
  - ?Dobhoff tubes
  - ?Nasogastric tubes
  - Keep bladder catheter

Keeping Vigil

- Individual decision
  - Loved ones have to go to bathroom, eat, sleep, (smoke), work, take care of others
    - Sometimes they need permission to do so
- Dying can be a private event
- The precise hour of death CANNOT be predicted



Questions?