



Care Of The Dying Patient Procedure

Procedure Number

CHC-PG-0066

Version Nos:

1

1. Purpose

This Procedure is performed to preserve and enhance the dignity of the dying patient by allowing the patient and family members to maintain control and participate in end-of-life care whenever possible.

2. Application/Responsibilities

This Procedure is to be followed by all West Coast District Health Board (WCDHB) clinical staff members.

3. Definitions

There are no definitions associated with this Procedure.

4. Responsibilities

All WCDHB Staff Members are required to ensure they abide by the requirements of this Procedure.

5. Resources Required

This Procedure requires:

- i) Clinical Record

6. Process

1.00 Introduction

- 1.01 When facing death, patients/consumers /consumers differ in what they consider important (e.g. some consider quantity of life more important than quality; some accept pain or disfigurement more readily than others). The patient's preferences are paramount, and care must be planned accordingly. Some patients/consumers find an appropriate time and way to bring life to a satisfying close; others do not.
- 1.02 Patients/consumers with a terminal illness commonly experience physical discomfort and mental distress. Many fear that their discomfort will be protracted and that no one will control it. Relieving discomfort and reassuring patients/consumers that their discomfort will be controlled enables them to live as fully as possible and to focus on the unique issues presented by the approach of death.
- 1.03 When survival is expected to be brief, the severity of symptoms often dictates initial treatment choices. When a symptom is less distressing than the fear that the symptom will worsen, reassurance that effective treatment is available may be all the patient needs. If a symptom is severe, immediate therapy may be required. Whether diagnostic tests are appropriate depends on how burdensome the test is and how useful the findings may be.



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2.00 Pain Management

- 2.01 The approach to pain management is the same regardless of what the terminal illness is.
- 2.02 Treatment must be individualized because patients/consumers perceive pain differently, depending in part on such factors as fatigue, insomnia, anxiety, depression, and nausea. A supportive environment can also help manage pain.
- 2.03 The most available and appropriate analgesic given by the least invasive route possible should be chosen.
- 2.04 Choice of an analgesic depends largely on pain intensity. Analgesics should be administered regularly rather than as needed; controlling pain after it recurs is more difficult than preventing it, partly because pain generates anxiety.
(See also the *WCDHB Pain Management Procedure*)

3.00 Dyspnea

- 3.01 For dying patients/consumers /consumers , dyspnea is one of the most feared and most distressing symptoms. Its cause should be treated if it can be identified--e.g. antibiotics for pneumonia or thoracentesis for a pleural effusion.
- 3.02 Dyspnea in terminally ill patients/consumers /consumers should be suppressed when its physiologic origins cannot be relieved.
- 3.03 When breathlessness occurs, an opioid can be used to slow respiration and relieve mild chronic symptoms, enabling the patient to sleep more comfortably. Oxygen may also be psychologically comforting to the patient and to family members even when it is not physiologically beneficial.
- 3.04 Useful non-medication measures include ventilation from an open window or a fan at bedside, relaxation techniques, and massage. Caregivers with a calming presence can help patients/consumers /consumers stay calm.

4.00 Anorexia

- 4.01 Anorexia, common among dying patients/consumers, is usually more distressing to family members than to the patient. Counselling may be needed to help family/whanau members accept anorexia and understand the futility of tube feedings or parenteral nutrition.
- 4.02 Some steps can be taken to increase a patient's food intake. For example, if a full meal tray is overwhelming, small portions, specially prepared foods, and a flexible meal schedule are recommended. A small amount of a favourite alcoholic beverage served 30 minutes before meals may help. Foods with strong flavours or smells sometimes stimulate the appetite.

5.00 Nausea and Vomiting

- 5.01 Many dying patients/consumers experience nausea, often without vomiting. Nausea and vomiting may be caused by constipation, reduced gastric emptying, bowel obstruction,



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central opioid effects, increased intracranial pressure, gastritis, peptic ulcer, hypercalcemia, uremia, or toxic drug effects

- 5.02 Specific treatment may be warranted if the cause is easy to treat (as for hypercalcemia or constipation), especially if treatment makes a patient more comfortable. As with analgesics for pain management, antiemetics should be given regularly (not "as needed" when symptoms are severe) to prevent nausea and improve patient comfort.

6.00 Constipation

- 6.01 Constipation is common among dying patients/consumers because they are inactive, consume little dietary fibre, are dehydrated, or are receiving opioids or anticholinergic drugs.
- 6.02 Laxatives should be given prophylactically to prevent faecal impaction. A stool softener (soluble or insoluble fibre or docusate sodium) is usually given first. However, most patients/consumers receiving opioids also may require a stimulant laxative.

7.00 Diarrhea

- 7.01 If diarrhea occurs, an abdominal examination is to be performed to rule out impaction.
- 7.02 All laxatives, including stool softeners, are to be discontinued. If diarrhea is severe, the patient should be given clear liquids and bland carbohydrates. Other foods can be added as symptoms permit. For severely dehydrated patients/consumers, electrolytes may be given to make the patient comfortable more quickly.

8.00 Pressure Sores

- 8.01 Many dying patients/consumers are immobile, poorly nourished, and cachectic; therefore, they are at great risk of developing pressure sores. The most important preventive measure is rotating the patient every 2 hours using a specialized mattress or a continuously inflated air-suspension bed.

9.00 Confusion

- 9.01 Confusion is common during the terminal stage of illness. Causes include drug therapy, hypoxia, metabolic disturbances, and intrinsic central nervous system disease.
- 9.02 Confusion is to be treated if the cause can be determined, and if treatment enables the patient to communicate more meaningfully with family/whanau and friends.

10.00 Depression and Sadness

- 10.01 Most dying patients/consumers experience sadness. Sadness may be due to regrets about life or preoccupation with legal, social, or financial problems.
- 10.02 Providing psychological support and allowing a patient to express concerns and feelings is the best and simplest course of action. Helping a patient/consumer and family/whanau members settle unresolved matters may also be helpful.



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10.03 Antidepressants are to be reserved for the few patients/consumers who have persistent, clinically significant depression.

11.00 Anxiety and Agitation

11.01 Anxiety and agitation can result from treatable conditions such as pain, respiratory distress, sleep deprivation, a full bladder, faecal impaction, and nausea or from medication.

11.02 Supportive therapy, including listening and talking to patients/consumers, should precede and supplement drug therapy. Sometimes symptoms of anxiety and agitation can be managed with gentle reassurance. Meditation, guided imagery, prayer, music therapy, and massage are often helpful.

12.00 Insomnia

12.01 Insomnia is a symptom, not a diagnosis. Depression and anxiety are the leading causes of insomnia; other causes include a noisy environment, pain, lack of activity, metabolic disturbances, and medication.

12.02 Underlying causes and environmental factors should be determined and treated or altered if possible.

13.00 Stress

13.01 As death approaches, patients/consumers may feel stress due to fear of abandonment and separation, anxiety, feelings of hopelessness, or loss of self-esteem because their body image is altered.

13.02 Stress is greatest when death is unexpected or when interpersonal conflicts keep patients/consumers /consumers and family/whanau members from sharing their last moments together. Such conflicts can cause anguish for patients/consumers and can lead to excessive guilt or an inability to grieve among family/whanau members.

13.03 Staff members should identify these high-risk situations so that they can mobilize the resources needed to prevent undue stress and dysfunction. The best treatment for the dying patient/consumer and family/whanau with stress is compassion, information, counselling, and, occasionally, time-limited psychotherapy. In addition to medical staff, workers, nurses, and chaplains, can also provide assistance. Sedatives should be used sparingly and only briefly.

14.00 Grieving

14.01 Grieving is a normal process that usually begins before an anticipated death.

14.02 For patients/consumers it often starts with denial caused by fears about loss of control, separation from loved ones, an uncertain future, and suffering. Staff members can help patients/consumers /consumers accept the prognosis by listening to their concerns, helping them understand that they can remain in control, explaining what the future probably holds, and assuring them that their pain and other symptoms will be controlled.



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14.03 Family/whanau members may need support in expressing and dealing with grief. Any staff member who has come to know the patient/consumer and family/whanau may help them through this process and direct them to professional services if needed. Staff members should also develop regular procedures that ensure follow-up of grieving family/whanau members.

15.00 Spiritual Concerns

15.01 Patients/consumers /consumers who are dying often ask what their life means, who they really are, why the illness has affected them, and what will happen to them when they die. Patients/consumers /consumers who are religious may question God's existence and love or may feel abandoned by God. Unresolved spiritual distress can lead to despair and hopelessness, which in turn can lead to anxiety, depression. Patients/consumers /consumers need help working through this distress so that despair can be transformed into hope and serenity.

15.02 Dying patients/consumers /consumers may review their lives; this process may elicit positive and negative emotions as they try to resolve past hurts, re-examine relationships, and recount accomplished goals. They need to find meaning and purpose in their lives and in their illness. They often need to reconcile themselves with themselves, with others, and, for some, with God or a Higher Power. Belief in an afterlife and possible reunion with loved ones can comfort patients/consumers and family/whanau members.

15.03 Staff members, chaplains, family/whanau members, and friends can listen and offer support; doing so may help them deal with their own feelings of loss.

16.00 Concerns at the Time of Death

16.01 The last moments of life can have a lasting effect on family/whanau, friends, and caregivers. Therefore, when death is imminent, staff members should try to make the death as comfortable and as meaningful as possible and to help family/whanau members prepare for it.

16.02 Family/whanau members are to be told exactly what will happen when the patient/consumer dies. If the patient/consumer is expected to die at home, family/whanau members are told whom to call. They are also told how to arrange burial services and obtain legal advice (if required).

16.03 The setting should be peaceful, quiet, and physically comfortable. Stains or tubes on the bed are to be covered, and any odours masked.

16.04 Family/whanau members should be encouraged to touch the patient/consumer (eg, hold hands) as well as to talk with the patient/consumer, pray, or sing if desired. Depending on the desires of the patient/consumer and family/whanau on feasibility, supporters such as clergy and friends are encouraged to be present, and cultural, spiritual, religious, or ethnic rites of passage are performed.

16.05 A Doctor should make the official determination of death as quickly as possible to lessen family members' anxiety and uncertainty.



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- 16.06 Staff members should ensure that family/whanau psychological and spiritual needs are met by providing appropriate counselling and ensure that family/whanau members have a comfortable environment where they can grieve together and have adequate time to be with the body. Friends, and clergy may also provide psychological and spiritual support.
- 16.07 Staff members should be aware that there are cultural differences in behaviour at the time of death. (See also *WCDHB Tikanga Best Practice Guidelines*, *WCDHB Immediate Care Of Relatives Following Patient Death Procedure* and *WCDHB Patient Death and Laying Out Procedure*)

7. Precautions And Considerations

- ➔ Relieving discomfort and reassuring patients/consumers that their discomfort will be controlled enables them to live as fully as possible and to focus on the unique issues presented by the approach of death.
- ➔ Relieving discomfort and reassuring patients/consumers that their discomfort will be controlled enables them to live as fully as possible and to focus on the unique issues presented by the approach of death.
- ➔ Staff members should ensure that family/whanau psychological and spiritual needs need to be met

8. References

There are no references associated with this Procedure

9. Related Documents

WCDHB Clinical Documentation Procedure

WCDHB Immediate Care Of Relatives Following Patient Death Procedure

WCDHB Patient Death and Laying Out Procedure

WCDHB Pain Management Procedure

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