NSMHPCN
North Simcoe Muskoka Hospice Palliative Care Network

Mississauga Halton Palliative Care Network

Ontario

Acclaim Health

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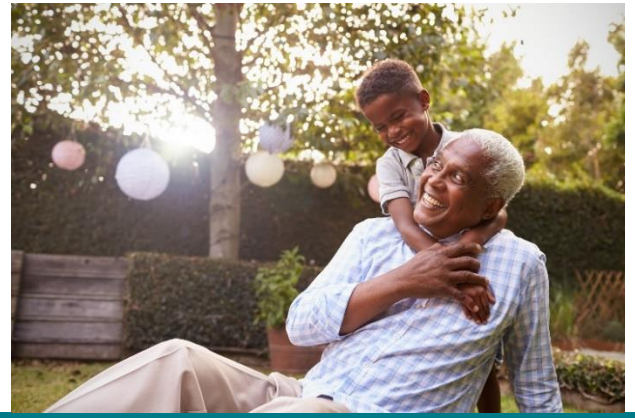
Week 4

Plan & Manage – Symptom Management



Learning Objectives

1. Plan/Manage: Symptom Management
    - Non-pharmacological

Materials:

1. Symptom Management Guidelines

A Palliative Approach to Care – Manage

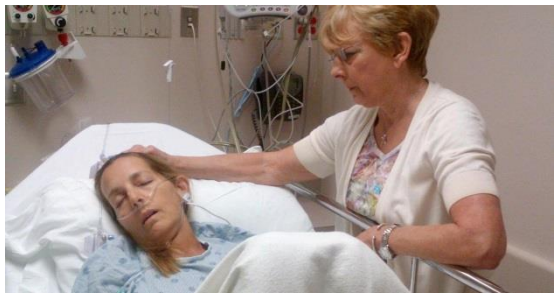
Managing Symptoms at EOL

Urine output decreases & may become tea-coloured

Decreased awareness, insight and perception

Heart rate - increased, irregular, thready

Incontinence of urine or stool may occur



Restlessness & agitation

Sleeping increases, patient may appear uncommunicative, with decreased socialization

Changes in skin temperature and colour (e.g., cold, blue “mottled” extremities)

Eating & drinking decrease or stop

Eyes might be slightly open

Breathing shallow, apnea, terminal secretions

Oral & ocular mucosal dryness

Vitals and Monitoring at EOL

Routine vitals aren't needed/helpful. Reassure the family that assessment focus is the patient's comfort

- What we can see/feel/hear?
- Explain:
  - the oxygen level doesn't tell us if SOB
  - the BP doesn't tell us if in pain
  - these numbers do not prognosticate and will fluctuate

Food and Fluid

Loss of appetite and thirst is common and natural as the body begins to shut down. Natural endorphins kick in and patients don't feel hungry. Adding extra fluid can overload the organs forcing them to work harder and create more discomfort

Interventions:

- Offer small amounts of favourite foods (1-2 bites)
- If able to swallow, offer ice chips.
- Educate and support family
- Goals of care discussions

Swallowing

Dysphagia (difficulty to swallow) is a common symptom at EOL. Related to loss of strength, level of consciousness and diminished gag reflex.

Assess oral cavity; loose dentures; pocketing; sores; thrush

Interventions:

- Educate family on the risk of aspiration
- Small portions
- Elevate head
- Offer mouth care to moisten mucosa
- Assess mouth for sores, infections (thrush)

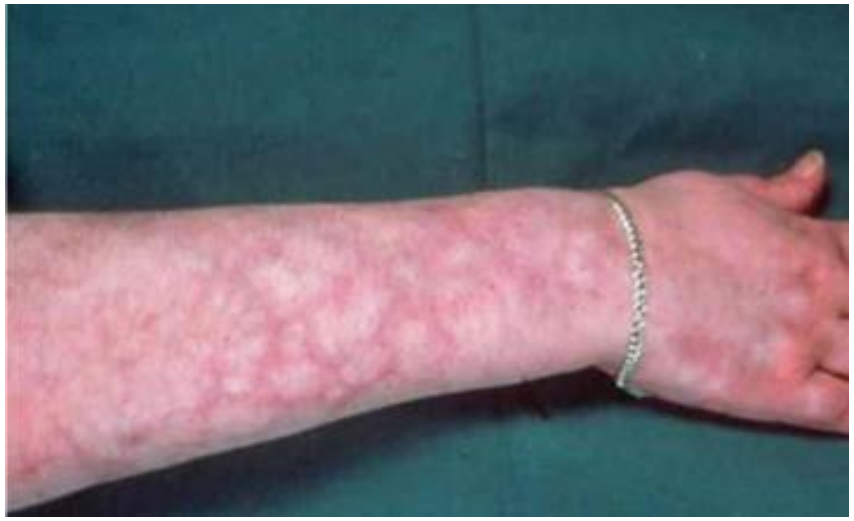
Dry Mouth (xerostomia)

Common causes of dry mouth are the reduction of salivary secretion and dehydration. Mouth and lips can become very dry

Interventions:

- Assess mouth for pocketing food, sores, dryness
- Mouth care with sponges
- Moisten lips with some sort of lip therapy.
- PRN with artificial saliva (i.e. Biotene).
- Avoid Vaseline/petroleum jelly

Skin



Blood is diverted to major organs. Skin turns cool, clammy, gray/blue in colour.

Mottling (buttocks, back and legs) is a sign of eminent death

Interventions:

- Reposition only for comfort/cleanliness – small adjustments such as moving the pillows, elevating the knees slightly will keep them just as comfortable
- If signs of pain when turning, administer analgesic before care
- Moisturize the skin /gentle massage/ teach family if appropriate
- Fevers can be common at EOL – keep skin dry and sheets dry Use tepid cloths to forehead and groin

Terminal Delirium

It is estimated between 25 - 85% of patients who are dying experience symptoms associated with **restlessness** before death. It is thought to be result of metabolic encephalopathy resulting from organ failure, electrolyte imbalance, nutritional abnormalities or sepsis.

Interventions – goal is to control the distress, not to correct the cause

- Gentle, repeated reassurance; Reorientation
- Reduce stimulation' Low ambient light – natural light
- Avoid restraints, Limit noise and activity around resident, visitor
- 1st line: Haldol 0.5 – 1 mg (0.1 – 0.2 mL from 5 mg /mL vial) sub cut Q 4 hr prn

Terminal Secretions

- Accumulation of terminal secretions can cause a noise in the upper airway at the back of the throat that often causes distress for family members
- But like “snoring’ – usually NOT distressing to patient – need to educate families
- If you cover your ears and look at their face, do you see any signs of distress

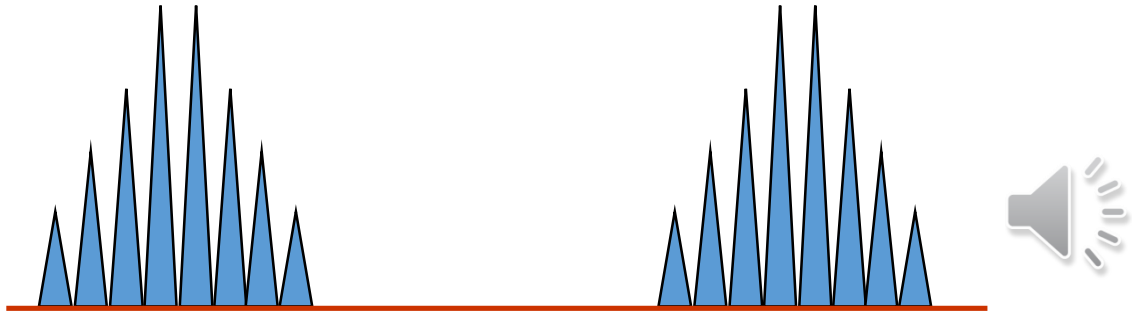
- Occurs in 23% - 92% of patients in their last hours before death
- Suctioning- may create more sections and not beneficial at EOL

Interventions:

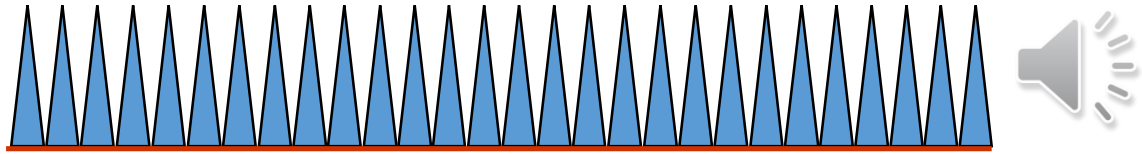
- Repositioning – into recovery – to drain secretions out
- Reassurance and education
- Scopolamine 0.4 mg SC Q4HPRN

Respiratory Changes: Common Breathing Patterns in the Final Hours

Cheyne-Stokes



Rapid, Shallow



“Agonal” / Ataxic

How to Help the Family

- Giving them permissions to take breaks
- Encouraging them to speak with their loved ones
- Providing gentle massages
- Oral care
- Providing support for the family i.e. Counselling support

When Death Occurs

- No breathing or heartbeat (no pulse at apex)
- Sometimes a loss of control of bowel and bladder
- The eyes may become fixed on a certain spot
- The eyelids may be open, or closed
- Often the jaw will relax and the mouth will be slightly open
- There may be fluid from the mouth

- Allow family to spend time with the person. Allow for privacy.
- Allow family to perform any cultural or religious rituals.
- Sometimes your presence is helpful….**ASK THEM**

Spiritual Care & Bereavement

F – Faith or Beliefs	What is your faith or belief? Do you consider yourself spiritual or religious? What things do you believe in that give meaning to your life?
I – Importance or influence	Is it important in your life? What influence does it have on how you take care of yourself? How have your beliefs influenced your behavior during this illness?
C – Community	Are you part of a spiritual or religious community? Is this of support to you and how?
A – Address	How would you like me, your healthcare provider, to address these issues in your healthcare

Spiritual Care & Bereavement (cont'd)

- Bereavement – loss of a loved one
- Grief- response to the loss of someone; anticipatory grief; acute grief
  - Complicated Grief- persistent grief, unable to function, stuck in levels of grief
  - Risk factors- multiple losses, poor coping, attachment, mode of loss, social supports, elderly males

"What would be most useful for you right now"

"Do you want to talk about it?"

"What are your supports?"

Self Care

"The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet. This sort of denial is no small matter. The way we deal with loss shapes our capacity to be present to life more than anything else. The way we protect ourselves from loss may be the way in which we distance ourselves from life and help. We burn out not because we don't care but because we don't grieve. We burn out because we've allowed our hearts to become so filled with loss that we have no room left to care."

Rachel Naomi Remen: "Kitchen Table Wisdom: Stories that Heal" Penguin, New York,1996.

Changing My Practice

- ✓ Assess spiritual care and bereavement needs regularly
- ✓ Manage symptoms at EOL and educate families about what to expect
- ✓ Recognize burnout and identify ways of self care

Thank you

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