# Facilitating a "good" death: Tools for expert end of life care for the dying hospitalized patient

Hannah Farfour DNP, APRN, AGNP-c
Center for Palliative Medicine
Mayo Clinic, Phoenix, AZ

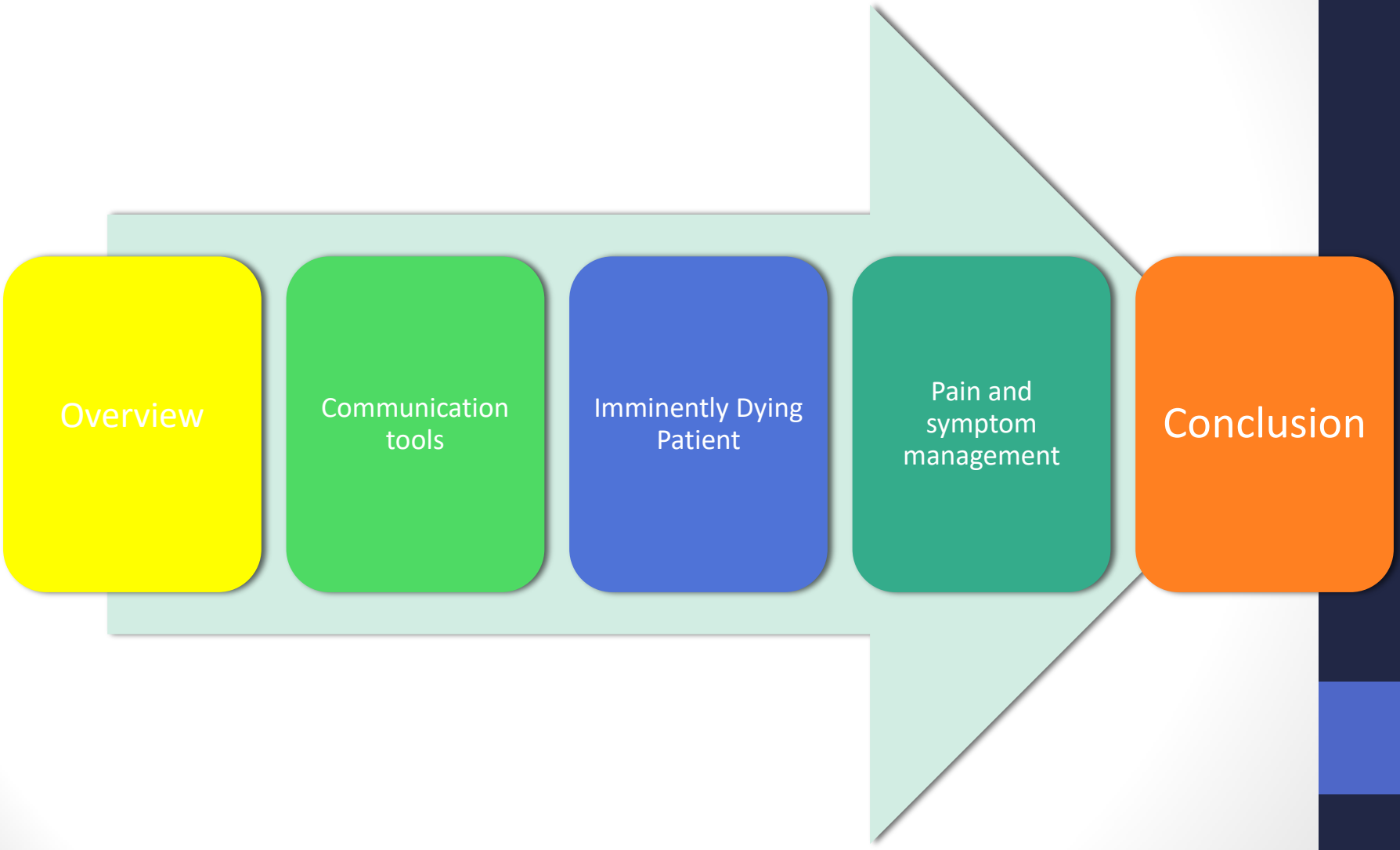
# Disclosure:

I have no relevant financial or non-financial disclosures

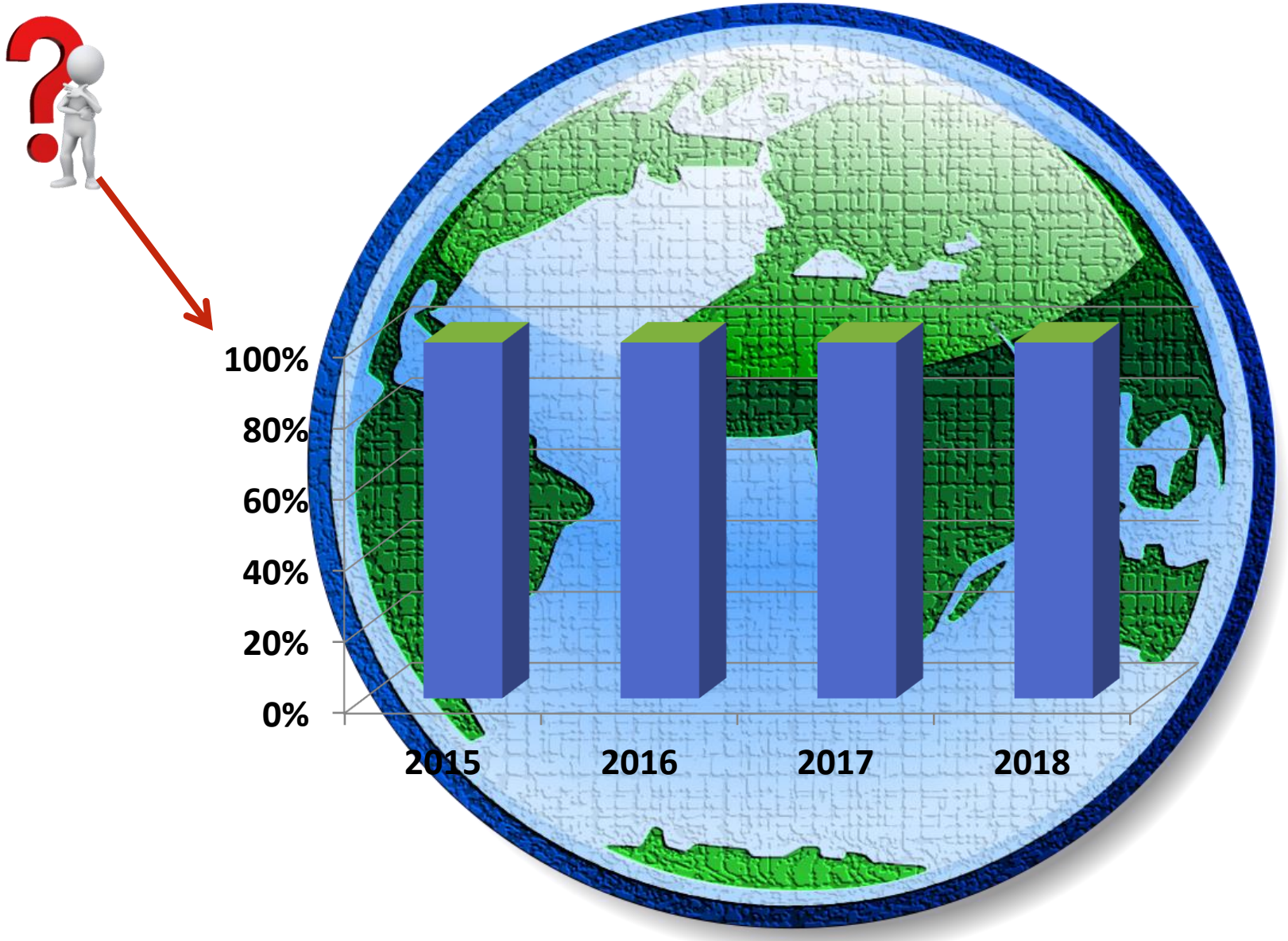
# Learning Objectives:

- Identify helpful communication tools to use with patients and families at end of life.
- Identify ways to facilitate goal setting.
- Describe approaches to enhance code status discussions.
- Recognize commonly used medications for end of life symptom management.

# Roadmap


Overview
Communication tools
Imminently Dying Patient
Pain and symptom management
Conclusion

# Worldwide Mortality Rate:



# What is a "good" death?

A good death is *"one that is free from avoidable distress and suffering, for patients, family, and caregivers; in general accord with the patients' and families' wishes; and reasonably consistent with clinical, cultural, and ethical standards."* (IOM, 1997)

# Overview

- 15% of people die suddenly
- 85% die of prolonged illness
- 29% of deaths occur in hospital
- Death in the hospital is associated with
  - **increased** physical and emotional distress
  - **decreased** quality of life
  - prolonged grief disorder
- **Hospital providers are at the front-line in facilitating a "good" death**

# Where to start?

- Start the “conversation” early and at each transition in care
- Advance directives:
  - Legal documents determine healthcare proxy
  - May include a living will
- Medical orders
  - POLST/MOLST forms
  - DNR orders

# Goals of Care Conversations 101

- Helpful frameworks and communication tools are available
  - SPIKES Protocol
  - NURSE
  - I wish/I worry statements
  - Best Case/Worst Case Scenario

# **SPIKES** Protocol

**S**- **Set** up the interaction

**P**-Assess **perception**

**I**- Obtain the patient's/family member's **invitation**

**K**- Give **knowledge** and information

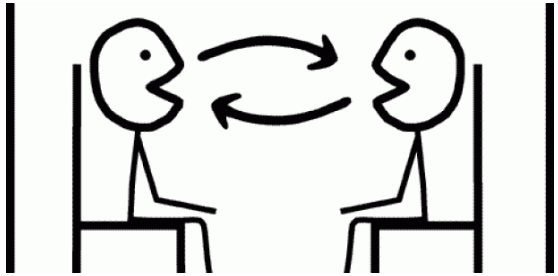
**E**- Address **emotions** with empathic responses

**S**- **Strategy** and **Summary**

(Baile, W.F., 2000)

# SPIKES: Set up the interaction

- Acknowledge own emotions.
- Arrange for some privacy.
- Involve significant others. Sit down. Make connection with the patient.
- Manage time constraints and interruptions.



(Baile, W.F., 2000)

# SPIKES: Assess Perception

- Use open ended questions to assess patient/family perception of current clinical status
  - *"Tell me about what is going on in your medical care."*
  - *"Tell me more……"*

(Baile, W.F., 2000)

# SPIKES- Obtain an **invitation**

- Warning shot
  - *"I have some serious news to share, is this an okay time to talk?"*
- Ask how they want the information
  - *"How would you like me to give the information about the test results? Would you like me to give you all the information or sketch out the results and spend more time discussing the treatment plan?"*
- Ask how they make decisions
  - Physician lead- make a recommendation
  - Shared decision making- outline options

(Baile, W.F., 2000)

# SPIKES- Give **knowledge**

- Start at the level of comprehension and vocabulary of the patient.
- Try to use nontechnical words.
- Avoid excessive bluntness.
- Give information in small chunks and check periodically as to the patient's understanding.
- When the prognosis is poor, avoid using phrases such as *"There is nothing more we can do for you."*

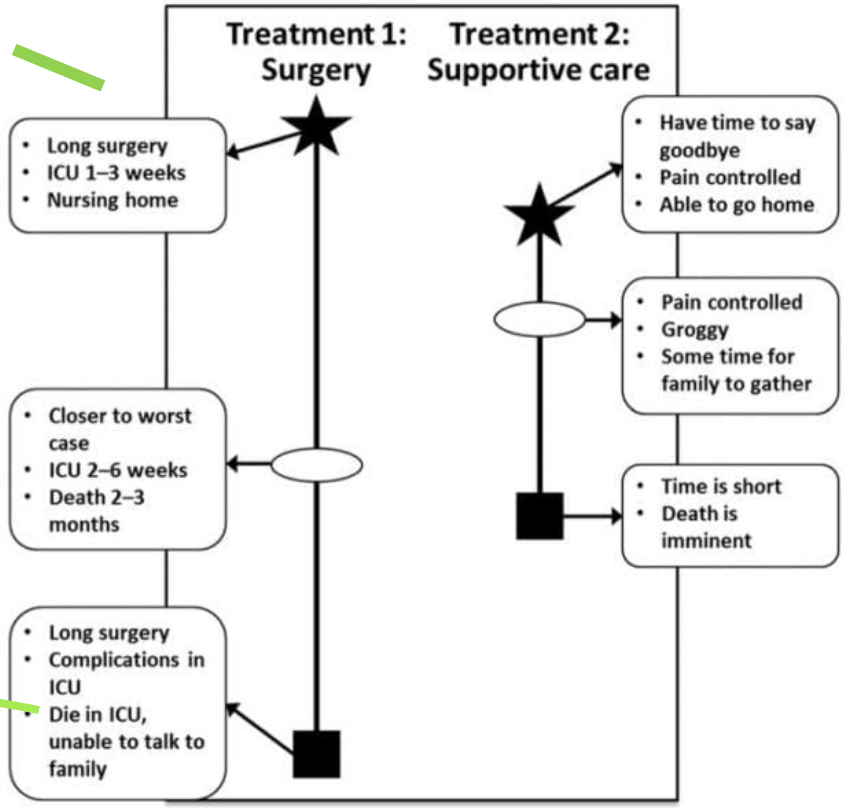
Other option:

*"We can aggressively focus on comfort knowing that time is shorter than any of us want."*

(Baile, W.F., 2000)

# Best case/worst case scenario

- Tell the story!
  - Best case

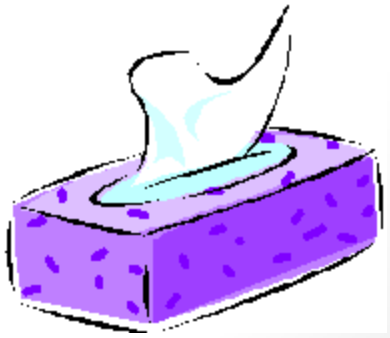




  - Worst case

https://www.youtube.com/watch?v=FnS3K44sbu0

# SPIKES- Address **emotions**

- Patient's can feel shock, isolation, and grief.
  - Offer support.
  - Observe for emotion.
  - Identify the emotion experienced by the patient by naming it to oneself.
  - Identify the reason for the emotion.
  - Allow a brief period of time to express feelings, then make an empathetic statement.
    - *"I wish things were different."*



# I wish/I hope statements

| | Example | Notes |
|---|---|---|
| I wish/I worry statements<br><br>I hope/I worry | "I wish I could say that chemotherapy always works. I worry that the burdens of chemotherapy may be greater than the benefits."<br><br>I hope that this line of chemotherapy provides you more time with your family. I worry that the side effects associated with it may be burdensome. | Enables you to align with the patient while acknowledging the reality of the situation. |

# NURSE Technique


## Recognizing emotion

| | | |
|---|---|---|
| **Naming** | "You look sad today."<br>"You look angry." | In general, naming the emotion turns down the intensity |
| **Understanding** | "This helps me to understand what you are thinking" | Shows that you acknowledge the emotion, but don't have to understand everything. |
| **Respecting** | "I can see that you have really been trying to follow our instructions." | You have done a great job with this. |
| **Supporting** | "I will do my best to make sure that you have what you need." | A powerful statement of support. |
| **Explaining** | "Could you share more in what you mean by that……?" | Asking a focused question prevents this from being too obvious. |

# SPIKES- Strategy


- Assess what is the most important **goal** for patient.
  - *What are you hoping for now?*
  - *Who do you need to see in the time that is left?*
- Create a plan consistent with patient goals as well as what is available medically.
  - Make recommendations regarding interventions/care based on goals
    - Hospitalizations, ICU admission, labs, radiology
    - Current/future use of blood products, antibiotics, artificial hydration/nutrition.
    - If present, the potential continuation or stopping of dialysis or cardiac devices.
    - Role of a second (or third) opinion or experimental therapy.
    - Exploration of treatment options the patient or family may bring into the conversation.
    - Disposition options to best meet the goals (e.g. home hospice referral).

# SPIKES- Strategy

**Long Shot Goals**

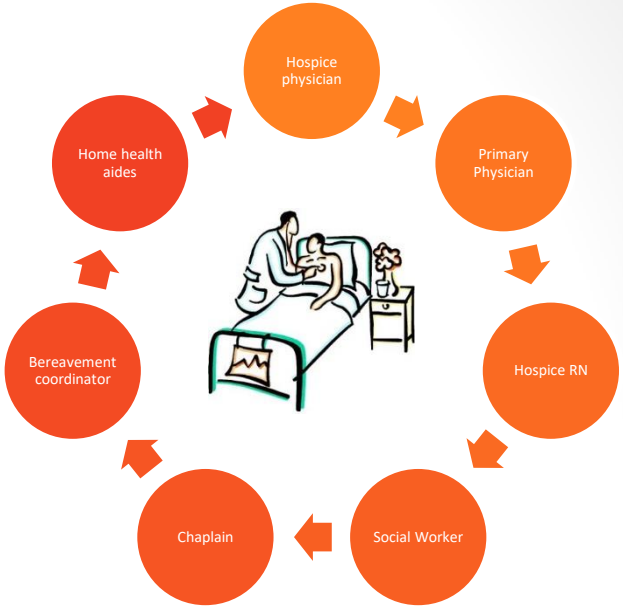
- Reinforce the respect for the decision, and wish to make sure the treatment has the best possible chance of working.
- Maximize quality of life *in the present*, including the best possible pain, symptom management and support.
- Reinforce that the team will not abandon the patient and family even if the decision is not what is being recommended.
- Encourage the patient and family to prepare in case treatment is not successful and the patient dies sooner rather than later.
  - *"I'd encourage us all to hope for the best, but prepare for the worst."*
  - *"Plan A and Plan B"*

# The “H” word

*A model and philosophy of care that focuses on providing palliative care to patients with life-limiting illness, focusing on palliating patients’ pain and other symptoms, attending to their and their family’s emotional and spiritual needs, and providing support for their caregivers.*

(Meier, D., McCormick, E. and Lagman, R. , 2018)

# The “H” word




- Interdisciplinary team:
  - Hospice Physician
  - May keep Primary Physician
  - Hospice RN
  - Social worker
  - Chaplain
  - Bereavement coordinator
  - Hospice aides (only a few hours per week)

# Who qualifies?

- Prognosis of 6 months or less.
- When **patients and their families decide to forego disease-modifying therapies with curative/life-prolonging intent in order to focus on maximizing comfort and quality of life.**
- 2 physician certification

# Benefits of Hospice

- Psychosocial, spiritual, and symptom support
- Support in home
- **Short-term** intensified care within inpatient Hospice units
- Respite care
- Medical equipment, supplies, and medications delivered to home
- Bereavement support

# Limitations of Hospice

- Does not provide custodial care
- Does not provide 24 hr caregiving
- No frequent transfusions
- Due to reimbursement, patients may be limited from seeing outside providers and seeking palliative interventions
- Larger and non-profit Hospice agencies may be more flexible paying for quality of life interventions such as routine lab work

# Communication Pearl

- If you think that a patient would benefit from hospice, talk about the services that they would receive before saying the word.
  - Helpful phrases:
    - *"It sounds like it is becoming more difficult for you to come to your appointments. Perhaps it may be easier for you to have a nurse visit in the home and have your medications delivered to you. Hospice would be able to provide this service."*
    - *"Now that the focus is on comfort, there is an insurance benefit which will give increased support in the home."*

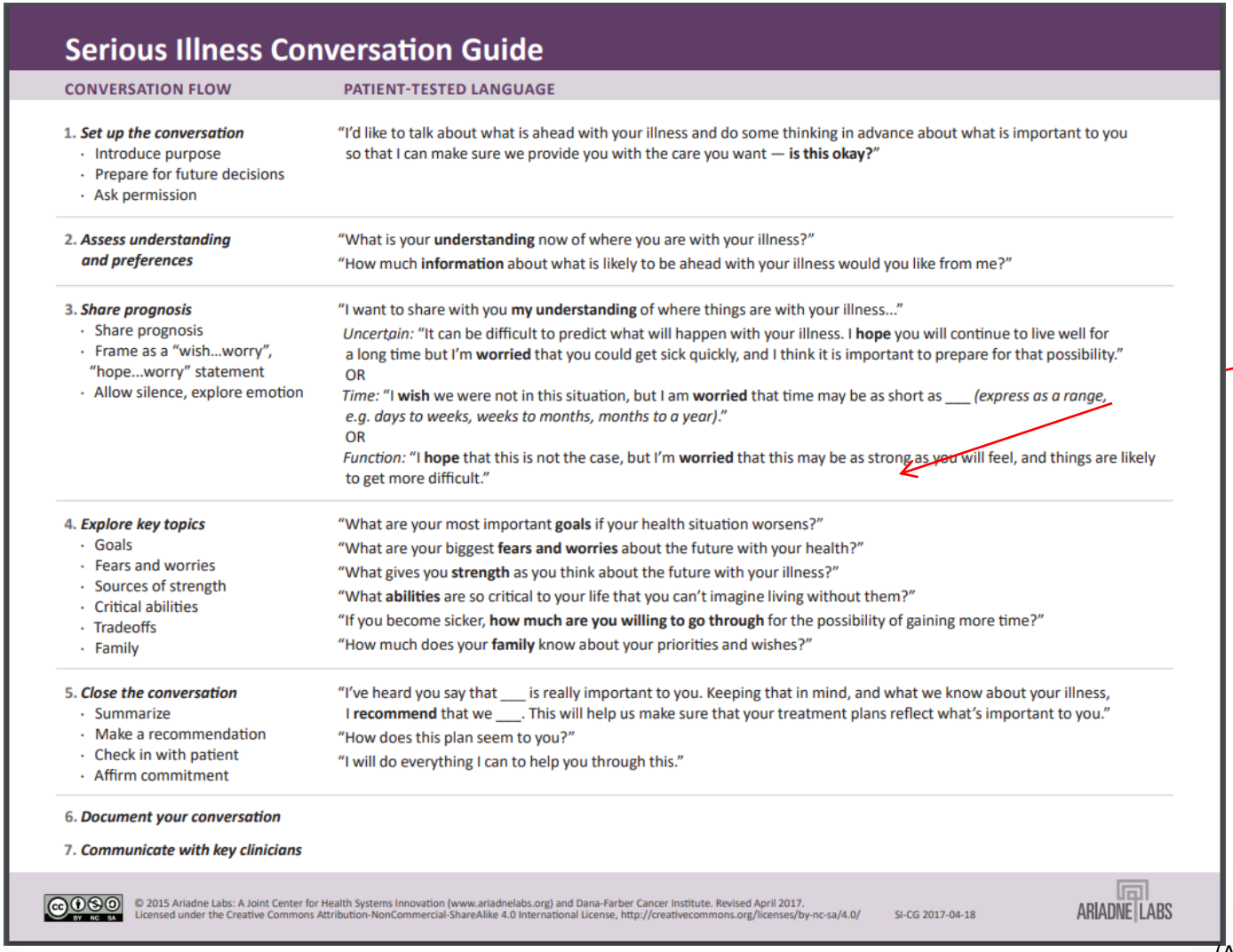
# SPIKE**S**- **Summary**

- Be clear on what the patient should expect.
- Summarize the conversation.
- Acknowledge that the patient or family may not remember all of the information shared, so document and/or write it down.

# Common Pitfalls

- Expecting too much too soon
- Trying to deliver serious news and goals in one sitting
- Biased conversation
- Disparate goals

# Cheat sheet!



## Serious Illness Conversation Guide

| CONVERSATION FLOW | PATIENT-TESTED LANGUAGE |
|---|---|
| 1. ***Set up the conversation***<br>· Introduce purpose<br>· Prepare for future decisions<br>· Ask permission | "I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — **is this okay?**" |
| 2. ***Assess understanding and preferences*** | "What is your **understanding** now of where you are with your illness?"<br>"How much **information** about what is likely to be ahead with your illness would you like from me?" |
| 3. ***Share prognosis***<br>· Share prognosis<br>· Frame as a "wish…worry", "hope…worry" statement<br>· Allow silence, explore emotion | "I want to share with you **my understanding** of where things are with your illness…"<br>*Uncertain:* "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility."<br>OR<br>*Time:* "I **wish** we were not in this situation, but I am **worried** that time may be as short as ___ *(express as a range, e.g. days to weeks, weeks to months, months to a year)*."<br>OR<br>*Function:* "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult." |
| 4. ***Explore key topics***<br>· Goals<br>· Fears and worries<br>· Sources of strength<br>· Critical abilities<br>· Tradeoffs<br>· Family | "What are your most important **goals** if your health situation worsens?"<br>"What are your biggest **fears and worries** about the future with your health?"<br>"What gives you **strength** as you think about the future with your illness?"<br>"What **abilities** are so critical to your life that you can't imagine living without them?"<br>"If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?"<br>"How much does your **family** know about your priorities and wishes?" |
| 5. ***Close the conversation***<br>· Summarize<br>· Make a recommendation<br>· Check in with patient<br>· Affirm commitment | "I've heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your treatment plans reflect what's important to you."<br>"How does this plan seem to you?"<br>"I will do everything I can to help you through this." |
| 6. ***Document your conversation*** | |
| 7. ***Communicate with key clinicians*** | |



SI-CG 2017-04-18

ARIADNE LABS

(Ariadne Labs, 2015)

https://www.ariadnelabs.org/wp-content/uploads/sites/2/2018/04/Serious-Illness-Conversation-Guide.2017-04-18CC2pg.pdf

# Discussing Code Status

<u>5 Step Approach</u>

- Establish an appropriate setting for the discussion
- Ask patient what they and the family understand
- Find out what they expect will happen
  - Discuss a DNR order, including context
    - Helpful phrases:
      - *"If you should **die** despite all of our efforts, do you want us to use "heroic" measures to attempt to bring you back?"*
      - *"How do you want things to be when you die?"*

(von Gunten & Weissman, 2015)

# Discussing Code Status

- Respond to emotions
  - Silence or a tissue
    - Helpful phrase:

    "*I can see that this makes you sad*."
- Establish and implement the plan
  - Helpful phrase:
    - *"It sounds to me like you would like to focus on comfort. Based on these wishes* ***it is my recommendation*** *that we place a DNR status in the chart*."

(von Gunten & Weissman, 2015)

# Discussing Code Status

Checklist discussions:

- *"You have been admitted to the hospital for (insert reason) and you have the following chronic conditions (insert conditions). If you were to **die** despite our best efforts to treat your diseases would you like chest compressions, cardioversion, and intubation or would you like us to **allow a natural death?**"*

# Discussing Code Status

- Additional tips:
  - Know the statistics
    - Only 10-15% of individuals that code while hospitalized survive to discharge
    - Statistics even poorer for those with advanced cancer, dementia, ESRD, etc.
  - Speak general and then become more specific
  - Talk about what life looks like if one might survive a code

(von Gunten & Weissman, 2015)

# Discussing Code Status

- Additional tips:
  - Do not badger, then code status becomes a battle ground
  - Explore emotions and feeling
    - Helpful phrases:
      - *“What does code status mean to you? “*
      - *“It sounds like you don’t trust the medical system, could you share why?”*
      - *“What could have been done differently if you did code? “*
  - Use innovative tools such as videos on code status

(von Gunten & Weissman, 2015)

# Goals of care - COVID-19

| *What They Say* | *What You Say* |
|---|---|
| How bad is this? | From the information I have now, your loved one's situation is serious enough that your loved one should be in the hospital. **We will know more over the next day**, and we will update you. |
| Is my mother going to make it? | **I imagine you are scared.** Here's what I can say: because she is 70, and is already dealing with other medical problems **it is quite possible that she will not make it out of the hospital. Honestly, it is too soon to say for certain.** |
| Shouldn't she be in an intensive care unit? | You/your loved one's situation does not meet criteria for the ICU right now. We are supporting her with treatments (oxygen) to relieve her shortness of breath and we are closely monitoring her condition. **We will provide all the available treatment we have that will help her and we'll keep in touch with you by phone.** |
| What happens if she gets sicker? | If she gets sicker, we will continue to do our best to support her with oxygen and medicines for her breathing. If she gets worse despite those best treatments, she will be evaluating for her likelihood of benefiting from treatment with a ventilator. I can see that you really care about her. |
| How can you just take her off a ventilator when her life depends on it? | Unfortunately her condition has gotten worse, even though we are doing everything. She is dying now and the ventilator is not helping her to improve as we had hoped. This means that we need to take her off the ventilator to make sure she has a peaceful death and does not suffer. I wish things were different. |

(CAPC, 2020)

# Goals of care -COVID-19

| *Resuscitation Status COVID-19* | *Example Language* |
|---|---|
| Approach to when your clinical judgment is that a patient would not benefit from resuscitation | Given your overall condition, **I worry that if your heart or lungs stopped working, a breathing machine or CPR won't be able to help you live longer or improve your quality of life**. My recommendation is that if we get to that point, we use medications to focus on your comfort and allow you to die peacefully. This means we would not have you go to the ICU, be on a breathing machine, or use CPR. I imagine this may be hard to hear. |
| If in agreement: | These are really hard conversations. **I think this plan makes the most sense for you.** |
| If not in agreement: | These are really hard conversations. **We may need to talk about this again.** |

# You can bill!

**Advance Care Planning CPT Codes**

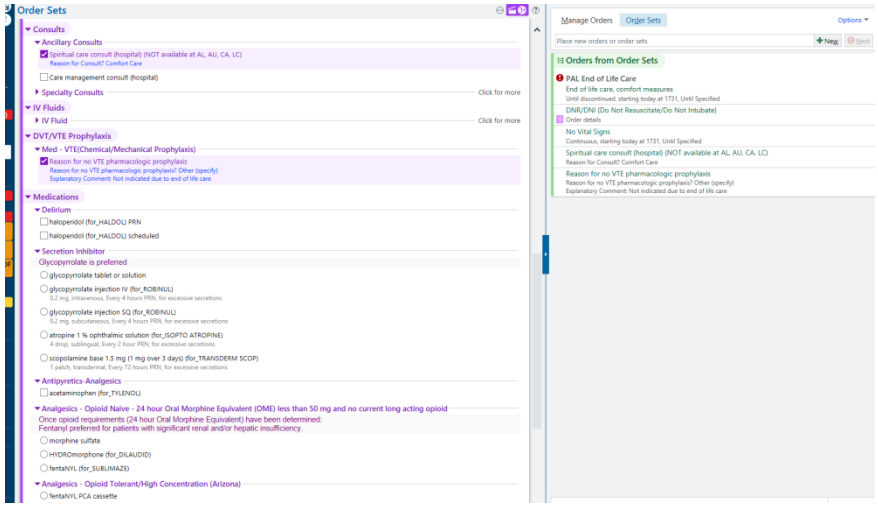
- **99497**: "Advance Care Planning including the explanation and discussion of advance directives such as standard forms (including the completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family members and/or surrogate"
- **99498** *(add-on)*: Each additional 30 minutes

(Sudore, Lum, You, et al., 2017)

# Managing the imminently dying patient

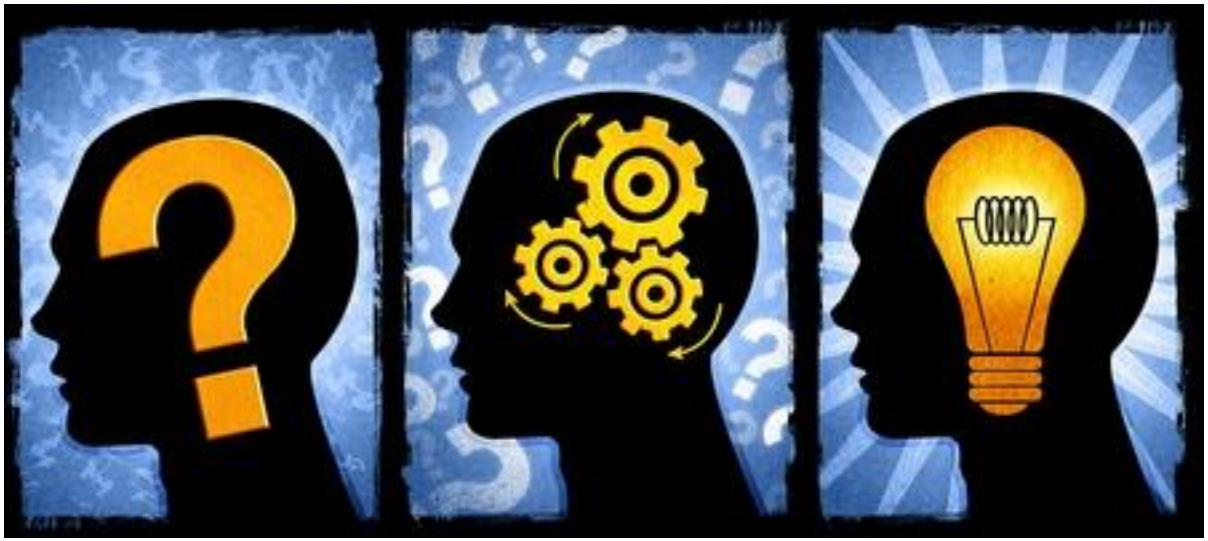
# End of Life Order Set

- Most hospitals have a End of Life/Comfort care Order set that integrates nursing interventions as well as medical management.
- Early and appropriate implementation ensures that the care team has the tools needed for expert end of life care.
- Focus on simplifying medications, discontinuing non-comfort associated interventions, and treating symptoms.



# Beyond the Order Set

- What do you say?
- What does the dying process look like?
- How do I effectively manage the symptoms?



# What do you say?

- Honest communication using simple words in a compassionate manner that allows the family to express fears, hopes, and goals of care, guided by your expertise.
- Do not use false dichotomy between aggressive care vs. comfort care.
  - Helpful phrase:
    - *“We will aggressively manage patient’s symptoms.”*

# How do we die?

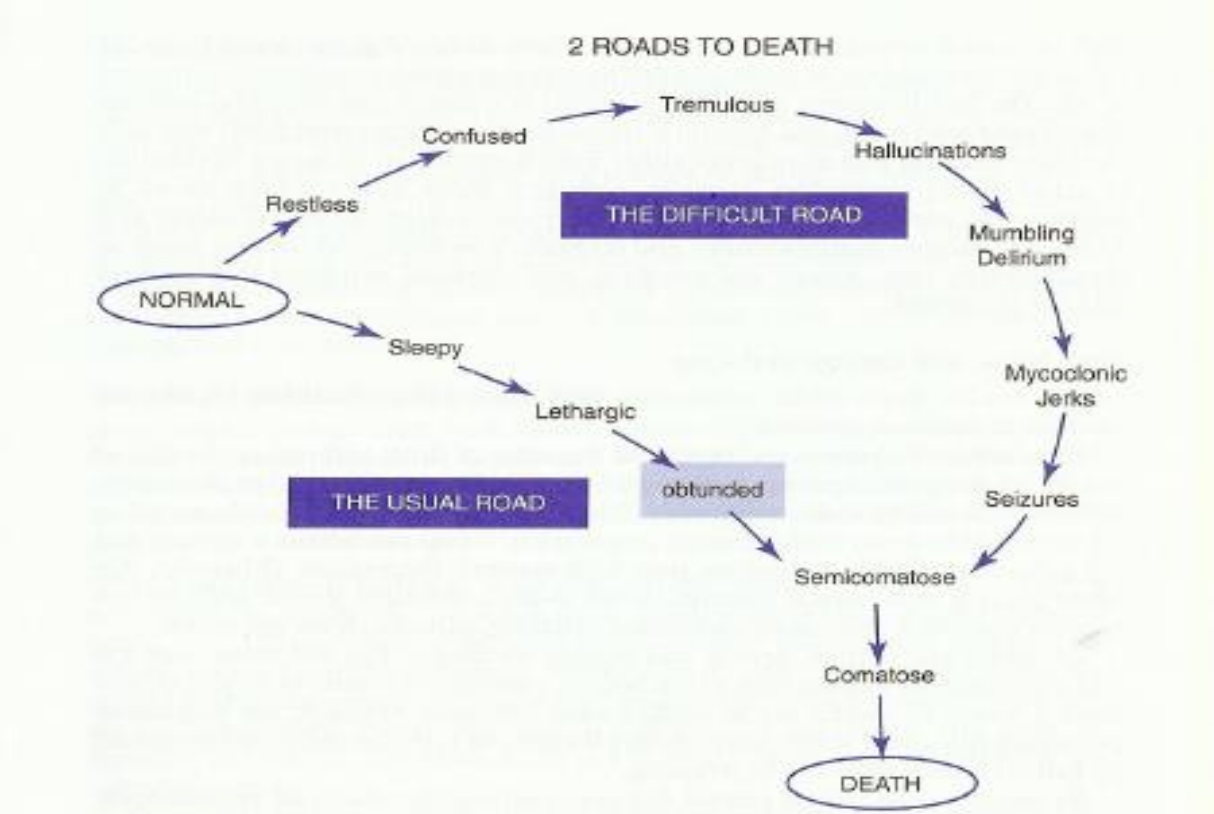



**Figure 23-2.** The two roads to death. (Modified from Ferris FD, Flannery JS, McNeal HB, et al editors: *Palliative Care*, vol. 4. In A Comprehensive Guide for the Care of Persons with HIV Disease. Toronto, Mount Sinai Hospital and Casey House Hospice, 1995, pp. 118–120.)

(The EPEC Project, 2003)

# Syndrome of Imminent Death

| EARLY STAGE | MIDDLE STAGE | LATE STAGE |
|---|---|---|
| Bed Bound | Further decline in mental status (obtundation) | Death rattle |
| Loss of interest/ability to eat or drink | | Coma |
| Cognitive changes (increased sleeping/delerium) | | Fever- (usually aspiration pneumonia) |
| | | Altered respiratory pattern (apnea, hyperapnea, or irregular breathing) |
| | | Mottled extremities |

# Predictable symptoms

| Signs | Mean (Median) time to death in hours |
|---|---|
| Death rattle | 57 (23) |
| Respiration with mandibular movement | 7.6 (2.5) |
| Cyanosis of extremities | 5.1 (1.0) |
| Lack of radial pulse | 2.6 (1.0) |

(Morita et al, 1998)

# How long?

- Once active dying begins, the time course is variable and hard to predict
  - Range: 24 hours to 10-14 days
- “Lingering” can be distressing to families
- Communication can help with these uncertainties
- Continue to engage with family and conduct a physical exam of patient
- Document that “patient is dying” not “prognosis poor”

# What do you say?

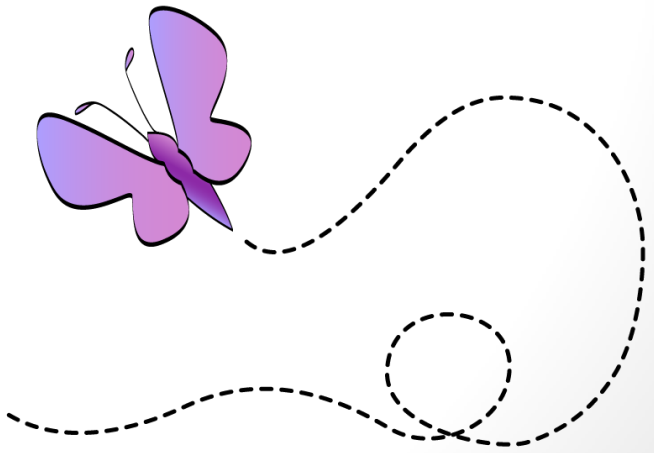
- Provide education about what is “normal”
  - Progressive unresponsiveness
  - Noisy breathing
  - Inability to tolerate food and drink
  - Purposeless movements or facial expressions
- Explain changes as they occur
  - Helpful phrase:
    - “*Is there anything you are seeing that worries you?*”

# What do you say?

- Encourage family to nurture the patient
  - mouth swabs, ice chips, lip care, eye care
  - loss of senses: hearing, touch lost last
- Reframe
  - Helpful phrase:
    - "*He's starving to death*" becomes "*Fortunately, he's no longer feeling hungry or thirsty*."
- Closure
- Rituals

# End of life symptoms

- Pain
- Dyspnea
- Nausea
- Noisy breathing
- Terminal restlessness
- Hemorrhage
- Seizures



# Pain

- Pain can escalate or lessen at end of life
- Mild pain/discomfort can be treated with acetaminophen PO/PR.
- If pain is moderate or severe then opioids preferred.


(Bailey and Harma, 2018)

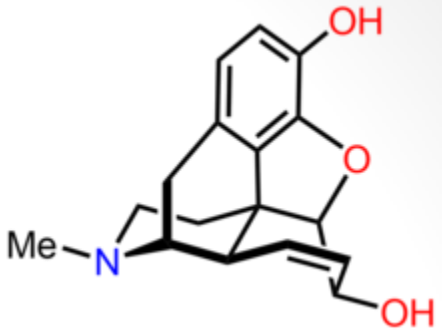
# Pain- Opiates

Starting doses in the Opioid-Naïve Patient

| | | |
|---|---|---|
| Drug Name | Oral dose | Intravenous Dose |
| Morphine | 5 mg PO/SL<br>7.5 mg (15 mg pill cut in half) | 2 mg |
| Hydromorphone | 1 mg (2 mg pill cut in half) | 0.2 mg |
| Oxycodone | 2.5 mg (5 mg pill cut in half) | - |
| Hydrocodone | 5 mg | - |

(CAPC,2020)

# Pain- Opiates




**Time to peak effect / Duration of Action**

- **PO Opioids: 30-60 minutes / 3-4 hours**
- **IV Opioids: 5-15 minutes / 2-4 hours**
- Time to peak effect is the same for analgesia, relief of dyspnea, and sedation

**<u>Other Opioid Principles</u>:**

- **If initial dose of IV opioid is ineffective** after 2 doses at least 15 minutes apart, double the dose
- Typically **need 6-8 hours of controlled symptoms to calculate a continuous opioid infusion**
- **If starting a continuous infusion**, do not change more often than every 6 hours. Adjust infusion dose based on the 24 hour sum of PRNs

(CAPC,2020)

# Pain- Equianalgesics

| Equianalgesic Conversion Table | | | |
|---|---|---|---|
| Drug Name | Equianalgesic Dose | | Oral to Parenteral Ratio |
| | Oral (mg) | Parenteral (mg) | |
| Morphine | 25 | 10 | 5:2 |
| Hydromorphone | 5 | 2 | 5:2 |
| Oxycodone | 20 | n/a | n/a |
| Hydrocodone | 25 | n/a | n/a |
| Oxymorphone | 10 | 1 | 10:1 |

**Potency ratios:**

- → oral morphine: oral hydromorphone is 5:1
- → oral morphine: oral oxycodone is 1.25:1
- → oral morphine: IV hydromorphone is 12.5:1
- → transdermal fentanyl 25mcg/hr: oral morphine 50mg/24hr

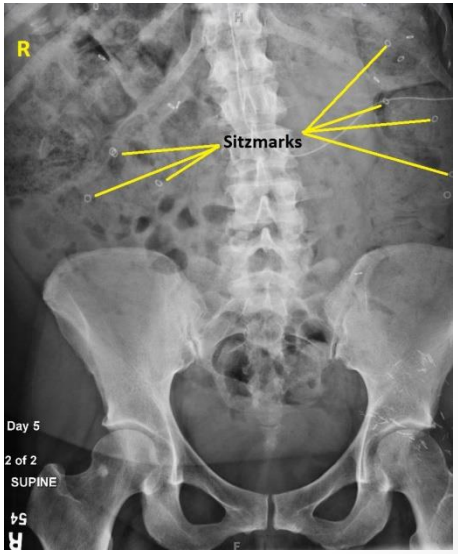
**Oral hydromorphone is 5 times as potent** (mg per mg) **as oral morphine**

This conversion table is adapted from: *McPherson ML. Demystifying Opioid Conversion Calculations: A Guide for Effective Dosing, 2nd ed. American Society of Health-System Pharmacists, Bethesda, Maryland, 2018.*

# Constipation

**<u>If Using Opioids, Start a Bowel Regimen</u>:**

- Goal is 1 BM QD or QOD, no straining
- Senna 2 tabs q HS, can increase to 4 tabs BID
- Add Miralax 17 gm daily, can increase to BID
- Bisacodyl 10 mg suppository if no BM in 72 hrs
- Relistor

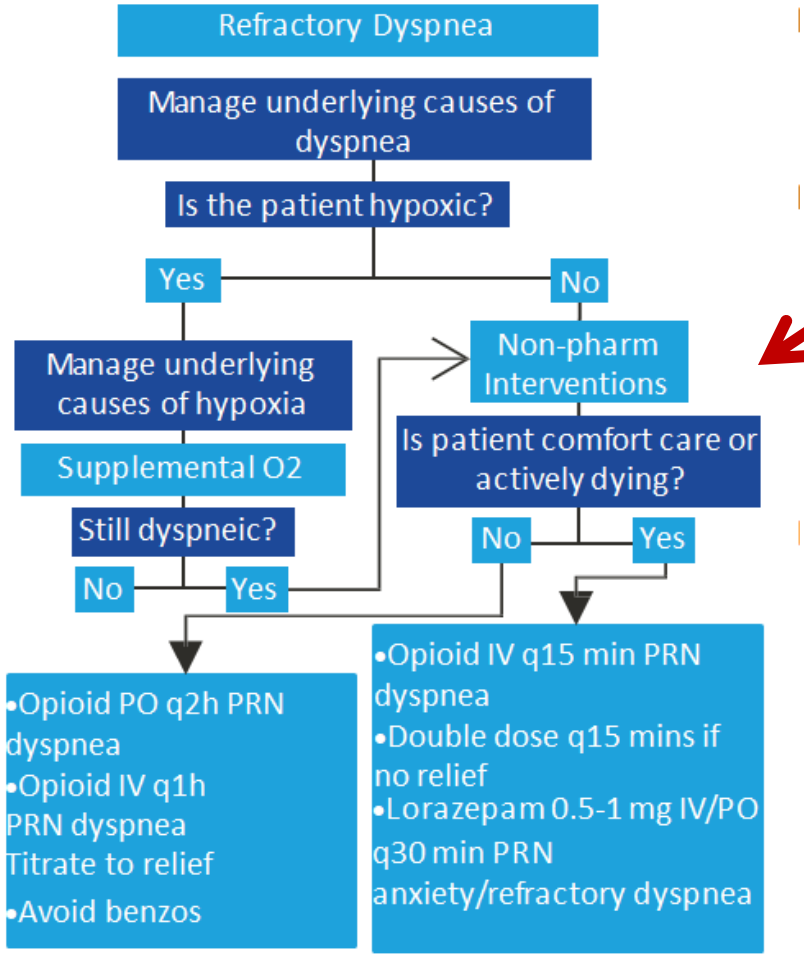


# Dyspnea

- Opioids are first line
  - Opioid naïve dosing:
    - Morphine 5-10mg mg PO/SL q 2 hrs prn or 2-4mg IV q 1 hr prn
    - Hydromorphone 1 mg PO q 2 hrs prn or 0.2 mg IV/SQ q 1 hr prn
    - Oxycodone 2.5 mg PO/SL q 2 hrs prn
    - Titrate dose pending response
- May need higher dosing for opioid tolerant patients
- Anxiolytics
  - Lorazepam 0.25mg or 0.5mg PO/SL q 2-4 hrs or IV/SQ q 30 mins

(Bailey and Harma, 2018)

# Refractory Dyspnea




Often seen in patients with Covid-19

(CAPC, 2020)

# Dyspnea

- Nonpharmocologic interventions:
  - Fan or open window
  - Sit upright
  - O2 trial
  - Discontinue fluids

(Weissman, D., 2015)

# Nausea

**Why are they nauseated?**

- Gastroparesis *(metoclopramide)*
- Increased ICP *(dexamethasone)*
- Bowel obstructions *(dexamethasone, octreotide, and haloperidol)*
- Constipation *(bowel regimen)*
- Non-specific nausea
  - **Haloperidol** 1mg PO/SL q 6- 8 hrs or 0.5mg IV/SC q 6-8 hrs
  - Can titrate these doses upward
  - Dose reduction by 50% in adults > 65
- Rectal prochlorperazine can also be helpful in refractory nausea/bowel obstructions

(Bailey and Harma, 2018)

# Why haloperidol?

- Inexpensive medication that has been used for the off-label treatment of nausea for > 40 years
- High affinity to D2- receptors
- Used in lower doses (0.5 mg – 2 mg)
- qtc prolongation is thought to be dose related and only occurs in IV administration**
- No documented cardiac arrythymias
- 1 mg PO = 0.5 mg IV
- We can use these doses to help with delirium as well, thus streamlining medications in end of life care

# Anti-emetic cheat sheet

capc Center to Advance Palliative Care

**Drug Classes and Medications for Treatment of Nausea and Vomiting**

| Class | Mechanism | Indications | Drugs | Side Effects | Cost |
|---|---|---|---|---|---|
| **Antidopaminergic therapies** | • Block emetic pathways originating from the GI and CTZ<br>• Antidopaminergic ($D_2$)<br>• Direct pro-kinetic effect (metoclopramide) | Opioids, chemotherapy, toxins or drugs associated nausea and vomiting | • Prochlorperazine<br>• Promethazine<br>• Metoclopramide<br>• Haloperidol | • Extra-pyramidal effects<br>• Sedation<br>• Hypotension<br>• Contraindicated in bowel obstruction | Low |
| **Serotonin receptor antagonists** | Block emetic pathways occurring through vagal stimulation, 5-$HT_3$ receptors in the GI tract, and/or the CTZ | Chemotherapy, toxins (CTZ, GI tract) associated nausea and vomiting | • Ondansetron<br>• Granisetron<br>• Dolasetron<br>• Tropisetron<br>• Palonosetron (second generation) | • Constipation<br>• Headache | Moderate |
| **Antihistamines** | Uncertain action at the vomiting center | Inner ear pathology, adjuvant to other agents | • Diphenhydramine<br>• Hydroxyzine<br>• Meclizine<br>• Doxepin | • Sedation<br>• Constipation<br>• Confusion<br>• Orthostatic hypotension<br>• Dry mouth | Low |
| **Anxiolytics – Benzodiazepines** | Works via the cerebral cortex pathway | • Anxiety, PTSD post-chemotherapy<br>• Useful as an adjunct | • Lorazepam<br>• Oxazepam<br>• Diazepam | • Sedation<br>• Confusion<br>• Falls and fractures | Low |
| **Corticosteroids** | • May relieve cancer associated nausea through effects on reducing inflammatory mediators, tumor edema, pressure on GI tract, and reducing intracranial pressure from tumor mass.<br>• The exact mechanism in nausea and vomiting is unknown. | • Bone pain<br>• Stimulate appetite | • Dexamethasone<br>• Methylprednisolone<br>• Prednisone | • Fluid retention<br>• Increased blood pressure<br>• Mood swings<br>• Weight gain<br>• Increased risk of infections<br>• Thinning bones (osteoporosis) and fractures | Low |
| **Cannabinoids** | Cannabinoid receptors are widespread in the central nervous system and the mechanism of action is unknown | • Nausea unresponsive to conventional treatment<br>• May be used in combination with other antiemetic therapies<br>• Combination antiemetic therapy with dronabinol and prochlorperazine may result in synergistic antiemetic effects and minimize the toxicities | Dronabinol | • Tachycardia<br>• Low blood pressure<br>• Blood shot eyes<br>• Muscle relaxation<br>• Slowed digestion<br>• Dizziness<br>• Depression<br>• Hallucinations<br>• Paranoia | Moderate |

# Noisy breathing

- “Death rattle”
- Pooled oral secretions
- More distressing to family than the patient*
- Often no treatment needed
  - Helpful phrase:
    - *“I know that the breathing may sound uncomfortable, but [insert name] is not suffering*.”

(Bickel and Arnold, 2015)

# Noisy breathing

- Nonpharmacologic interventions:
  - Reposition pt on side to allow drainage
  - Suctioning not helpful and adds to discomfort
  - Discontinue artificial hydration (IV/PEG) as these may contribute to respiratory secretions
- Medications:
  - Atropine Ophth Soln 0.1% 2 drops **PO** Q4hr prn
  - Scopolamine transdermally or SC
  - **Glycopyrrolate 1 mg po or 0.2 mg IV TID PRN**

(Bickel and Arnold, 2015)

# Terminal delirium

- Can be hyperactive or hypoactive
- If bothersome, can treat medically
- Address potential causes
- Medication choices:
  - Haloperidol 0.5mg-2mg PO/IV/SQ q 1 hr PRN until settled then schedule q 6-8 hrs
  - Benzodiazepines can be helpful
  - If delirium is refractory, can use chlorpromazine
    - Dosing 25-50mg q 2 hrs prn (up to 2,000mg) once find therapeutic dose, can give in BID dosing

(Bailey and Harma, 2018)

# Terminal delirium

- Nonpharmocologic interventions:
  - Decrease sensory stimulation
  - Crowd control
  - Quiet room or soothing music familiar to patient
  - Familiar faces

# Harder to treat symptoms

- Seizures
  - Individualize care based on seizure history
  - Lorazepam SL, SQ, IV, or PR if needed

- Hemorrhage
  - Reverse coagulopathies if able
  - Dark sheets/towels
  - Midazolam 2-10mg IV/SQ
  - Communicate with family/bedside staff to stay with patient in acute event

(Bailey and Harma, 2018)

# Final thoughts

- Effective communication is key to facilitating a “good death”
- Encourage all health care providers to complete communication courses to enhance skills.
- Expert symptom management is integral for a good end of life experience
- Many of the needs of a dying hospitalized patient can be expertly addressed with existing communication tools and medications

# Resources (including on COVID-19)

- Palliative Care Fast Facts- University of Wisconsin
  - https://www.mypcnow.org/fast-facts
- VitalTalk
  - http://vitaltalk.org/
- Ariadne Labs
  - https://www.ariadnelabs.org/areas-of-work/serious-illness-care/
- Center to Advance Palliative Medicine (CAPC)
  - https://www.capc.org/
- BEACON Project
  - https://www.uab.edu/medicine/palliativecare/training/resources/beacon

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