

**Long Term Care
Intensive Train-The-Trainer Series**

Imminent Death

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Imminent Death (Slide 1)

Module Overview: (Slide 2)

This module provides an overview of care requirements at the time death including physical, psychological and spiritual care of the patient as well as support of family members. Emphasis will also be placed on the death event, recognizing death, and after death care.

Definition of Terms: (Slide 3)

Catheterization: insertion of tube into patient's bladder to facilitate removal of urine

Pulmonary edema: fluid accumulation in the tissues of the lungs

Terminal anguish: state prior to death where patient is unable to suppress or repress painful, unresolved psychological issues.

Terminal restlessness: Prior to entering semicomatose state patient becomes restless, confused and develops seizures.

Objectives: (Slide 4)

1. Describe the process of active dying and death.
2. Identify psychological and spiritual symptoms of active dying.
3. Describe physical signs of death.
4. Describe the signs and symptoms of **imminent** death.
5. Differentiate between “usual road” and “difficult road” to death.
6. Identify the signs of death.

7. Identify actions to take when death occurs.

Teaching Cues	Content	Resources
Describe the process of active dying and death.	<p>What's death all about?</p> <p>1.0 Everyone will die</p> <p>1.1 Less than 10% will die suddenly</p> <p>1.2 More than 90% of us will die due to a prolonged illness</p> <p>1.3 There is no typical death. Each person dies in their own way, own time, with their own culture, belief system, values, and unique relationships with others.</p> <p>1.4 The time of death cannot be predicted</p> <p>2.0 The final days and hours before a patient dies is the last opportunity for growth and development to occur in the patient/family unit.</p> <p>2.1 The final hours allow for patient and family to say good-by and complete end-of-life closure</p> <p>2.2 Emphasis should be placed on facilitating a comfortable death that honors patient/family choices.</p>	<p>Slide 5</p> <p>Explore with participants' "feelings" regarding death experience. Discuss what it feels like to be with someone dying. Emphasize the importance of being present and "bearing witness."</p>
	<p>Dying is a physical, psychological, social, and spiritual event.</p> <p>1.0 Patient/family must continue to be seen as the unit of care.</p> <p>2.0 Emphasis must be place on optimizing patient comfort, dignity, choice, acceptance, final tasks, and life closure</p> <p>3.0 All aspects of care need to intensify in order to minimize suffering.</p> <p>4.0 The interdisciplinary team must remain focused in order to:</p> <p>4.1 Help patient achieve dignified death</p> <p>4.2 Identify emerging problems</p>	<p>Slide 6</p>

	<p>4.3 Help family deal with immediate care needs up to and including the moment of death as well as after the death event.</p> <p>4.4 Arrange for privacy and intimacy if possible</p>	
	Active Dying: Last Few weeks of Life	
Continue the discussion of active dying.	<p>5.0 Process of active dying</p> <p>5.1 No one can predict exact time of death</p> <p>5.2 Some patient instinctively know when death will occur</p> <p>5.3 Signs and symptoms of the dying process only serve as a guideline. Not all patients experience all symptoms and the signs and symptoms do not necessarily occur in sequence.</p> <p>5.4 The dying process is a natural slowing down of physical and mental processes.</p> <p>5.5 Can occur days or weeks before death or may be present only hours/minutes prior to death</p>	Slide 7
<p>Identify psychological and spiritual symptoms of active dying.</p> <p>Ira Byock, M.D. has published extensively on this subject – use as a reference or additional materials</p>	<p>6.0 Some or all of these may be present</p> <p>6.1 Fear of dying</p> <p>6.2 Fear of abandonment</p> <p>6.3 Fear of the unknown</p> <p>6.4 Dreams and visions with powerful themes and symbols (bridge or river to cross, etc.)</p> <p>6.5 Withdrawal from family/friends: patient may speak very little to family</p> <p>6.6 Increased focus on spiritual issues</p> <p>6.7 Terminal anguish: As death approaches, some patients are unable to repress painful, unresolved psychological events. Become restless, moan or exhibit similar behaviors.</p>	<p>Slide 8</p> <p>Usually participants have witnessed these findings in their own life experiences. Ask them to discuss. Have them identify which symptoms they found most prevalent.</p>

Describe physical signs of death	7.0 Managing physical signs requires an interdisciplinary approach 7.1 Medications and other forms of therapies may be required.	Slide 9
Review each of the following physical signs with participants. Encourage discussion based on participants' level of experience.	8.0 Increased weakness and fatigue 8.1 Weakness and fatigue generally progress to point patient is unable to move muscles and joints independently. 8.2 Turning may be painful. Head may need to be supported and/or positioned for patient. All activities of daily living must be completed for patient.	Slide 10 Use for caregiver information
	9.0 Loss of appetite, physical wasting May begin earlier in dying process. Tends to intensify during active phase of dying. 9.2 Loss of appetite may be protective mechanism of body. Results in chemical imbalance which, in turn, creates a greater sense of well-being in the patients as well as a diminished perception of pain.	Slide 11
	10.0 Nausea and vomiting 10.1 Along with loss of appetite may come nausea -vomiting 10.2 Needs to be managed aggressively in order to promote and maintain patient comfort.	Slide 12

	<p>11.0 Dehydration/decreased fluid intake</p> <p>11.1 Like food, patients usually stop drinking fluids before the phase of active dying</p> <p>11.2 Giving fluids can prevent kidney failure with subsequent electrolyte imbalance and some elements of confusion and restlessness.</p> <p>11.3 HOWEVER, as death approaches, aggressive hydration therapy can actually hasten death due to pulmonary edema, worsened breathlessness, and increased oral/bronchial secretions.</p> <p>11.4 Oral care is essential during this time to minimize sense of thirst, avoid bad odors in mouth, prevent painful cracking of lips.</p>	Slide 13
	<p>12.0 Changes in kidney and bladder functions</p> <p>12.1 Urine output usually diminishes gradually in response to decreased fluid intake.</p> <p>12.2 Incontinence and/or retention may occur. Retention may require catheterization to promote comfort.</p>	Slide 14
	<p>13.0 Changes in bowel functions</p> <p>13.1 Constipation may continue as a problem due to decreased food intake, decreased activity of gut due to continued pain medication routines.</p> <p>13.2 Impaction may need to be addressed if contributing to marked patient discomfort.</p>	Slide 15
	<p>14.0 Pain</p> <p>14.1 Like other symptoms, pain must continue to be managed with the same vigor as at any point in the illness</p> <p>14.2 Although pain intensity may decrease and/or may not</p>	Slide 16

	<p>be self reported due to altered states of consciousness, pain therapy may need to be adjusted to accommodate for changes in level of consciousness or respiratory rate.</p>	
	<p>Last Hours of Life</p>	
<p>Describe the signs and symptoms of imminent death. Discuss the fact primary, irreversible organ failure is occurring.</p>	<p>As death approaches the heart, lungs, and nervous system begin to fail. The patient becomes semicomatose and the following signs and symptoms will be evident.</p>	<p>Slide 17</p>
	<p>15.0 Semicomatose State</p> <p>15.1 Eyes become sunken and glazed; often are half open</p> <p>15.2 Sense are generally dulled except for hearing may not be lost; sensitivity to light remains</p> <p>15.3 Ability to move decreases, beginning in legs and progressing to the arms</p> <p>15.4 Body becomes stiff and joints painful when moved</p>	<p>Slide 18</p>
	<p>16.0 Impaired heart and renal functioning</p> <p>16.1 Cardiac output decreases with a corresponding decrease in peripheral and renal perfusion</p> <p>16.2 Pulse rate increases initially and then weakens and becomes irregular. Radial pulse may be so faint as nonpalpable.</p> <p>16.3 Blood pressure decreases</p>	<p>Slide 19</p>

	<p>16.4 There is peripheral pooling, bluish coloring and mottling of skin</p> <p>16.5 Patient may perspire. Peripheral swelling may occur.</p> <p>16.6 Body temperature may increase due to the result of infection and/or increased tumor activity.</p>	
	<p>17.0 Respiratory dysfunction</p> <p>17.1 Breathing may become shallow or labored</p> <p>17.2 Respirations may increase in rate and then decrease, increase in rate again and then slow.</p> <p>17.3 Secretions may increase. Patient may have difficulty coughing, clearing secretions and swallowing effectively.</p> <p>17.4 Feelings of “lack of air” and breathlessness may increase as death approaches.</p> <p>17.5 “Death rattle”: Terminal congestion occurs due to changes in respiratory rate and inability of patient to clear secretions. Very distressing to family but often less troublesome to patient.</p>	Slide 20
	<p>18.0 Neurologic dysfunction</p> <p>18.1 Result of multiple factors: metabolic imbalances, kidney failure, infection, reduced blood flow to brain</p> <p>18.2 Leads to “2” road to death: “The Usual Road” or “The Difficult Road”</p>	Slide 21
Differentiate between “usual road” and “difficult road” to death.	<p>19.0 The “Usual Road”</p> <p>19.1 The majority of patients “travel this road”. They experience increasing drowsiness and eventually become unarousable.</p> <p>19.2 Eventually become comatose and die.</p>	Slide 22

	<p>20.0 The “Difficult Road”; Terminal restlessness</p> <p>20.1 The nervous system is highly agitated prior to entering the semicomatose state. The following occurs: confused and starts to tremor.</p> <p>21.2 Experiences hallucinations and mumbling delirium. May progress to muscle jerking and seizures before progressing to coma and death.</p>	<p>Slide 23</p> <p>Encourage discussion of feelings among participants. Ask them to describe the challenges they have faced caring for a patient experiencing terminal restlessness.</p>
	Signs that death has occurred	
Identify the signs of death.	<p>21 With death the following will be noted:</p> <p>21.1 Absence of heart beat/respirations</p> <p>21.2 Pupils fixed</p> <p>21.3 Release of stool and urine</p> <p>21.4 No response to stimulation</p> <p>21.5 Body color waxy and pale as blood settles</p> <p>21.6 Body temperature drops</p> <p>21.7 Eyes remain open</p> <p>21.8 Jaw may fall open</p>	Slide 24
	What to do when death occurs	
Identify actions to take when death occurs.	<p>22 Care shifts from patient to family/ caregiver. Some points to consider include:</p> <p>22.1 Know who to call. Goal in hospice is not to call 911.</p> <p>22.2 Follow traditions, rites, rituals; prepare body accordingly</p> <p>22.3 Know whether patient has requested organ donation – how to proceed.</p> <p>22.4 Follow procedures as outlined per agency</p> <p>22.5 Initiate bereavement support.</p>	Slide 25

	Last Thoughts!	
	<p>23 Dying is a unique experience. Consider these thoughts drawn from working with dying patients:</p> <ul style="list-style-type: none"> 23.1 Stay with me. 23.2 Walk with me. 23.3 Help me to “fear no evil”. 23.4 Comfort me. 23.5 Facilitate my closure 23.6 Help me leave my legacy in peace. 	<p>Slide 26</p> <p>Discuss case study.</p>

Case Study

Imminent Death

Mrs. Hauf was a 93 year old woman with dementia and decreased renal function. She has been a resident of the nursing facility for 12 months. When she was admitted, she was able to feed herself and dress herself with assistance. She frequently attended activities in a wheelchair. She ate approximately 80% of her meals on the days when her favorite foods were served. Mrs. Hauf was pleasant but had difficulty remembering recent events. After residing in the facility for three months, she began to recognize nursing assistants who frequently care for her.

About three months ago, her appetite started to diminish. She would eat approximately 30% of her meals and often declined her favorite foods. She frequently fell asleep during activities and requested to be put to bed. She began sleeping approximately 16 hours a day. She complained of pain in her lower legs which were slightly swollen. She was no longer able to do any of her care. She continued to smile and chat with staff who cared for her.

About 2 months ago, Mrs. Hauf became too weak to get out of bed. When placed in a wheelchair, she would slump over and sleep. She began sleeping 18 hours a day. She ate approximately 10% of her meals. She developed a decubitus ulcer on her right heel.

She became more confused and disoriented but remained pleasant when awake. She was incontinent day and night. She seemed calm when her minister visited and prayed with her.

Three days ago, Mrs. Hauf seemed to withdraw from those providing her with care. She refused food and accepted only teaspoons of ice chips. She was running a low grade fever. She repeatedly stated that she wanted to go home with her mother. Her respirations were noisy and congested. Her feet were cold and blue.

On day ago, Mrs. Hauf became comatose. She has no swallow reflex. Her respirations are shallow with 5 second periods of no breathing. Her neck is rigid and slightly extended backward. Her B/P is 60/40.

Discussion Questions:

1. When do you think the active process of dying began? Describe the signs and symptoms that were present.
2. What evidence indicates Mrs. Hauf is facing imminent death?
3. What do you think should have been included in this resident's plan of care when she began to actively die?
4. What concerns you the most regarding this resident's quality of life prior to death?

Resources

Berry, P., Griffie, J. (2001). Planning for the actual Death. In B. R. Ferrell, & N. Coyle, N. (Eds.) Textbook of Palliative Nursing. New York, NY: Oxford University Press.

Doyle, D., G.W.C. Hanks, MacDonald (Eds.). Oxford Textbook of Palliative Medicine. 2nd ed. New York, NY: Oxford University Press.

Emanuel, L. L., Von Gunten, C. F., Ferris, F. D. (1999). The Education for Physician on End-of-Life Education. 222.Epec.net: The EPEC Project.

Lipson, J., Dibble, S., Minarik, P. Culture and Nursing Care: A Pocket Guide. San Francisco, CA: UCSF Nursing Press.

Lindley-Davis, B. (1991). Process of dying. Cancer Nursing, 6 (4), 328-333.