

**C**omfort

**A**irway

**R**estlessness

**E**mootional support

**S**elf care



City of  
Hope™

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The following are recommendations for care of the dying based on the End of Life Nursing Education Consortium (ELNEC) project and the second edition (2009) National Consensus Project for Palliative Care Clinical Practice Guidelines for Quality Palliative Care. The recommendations are arranged in the acronym CARES (Comfort, Airway, Restlessness, Emotional support, and Self care) to organize the most common needs and education requirements to support the dying patient and their family. The tool is intended to prompt nurses to obtain orders for symptom management, increase awareness of resources and promote communication with the ultimate goal of achieving a peaceful death for their patient and family.

*"...there are worse things than having someone you love die. Most basic, there is having the person you love die badly, suffering as he or she dies. Worse still is realizing later on that much of his or her suffering was unnecessary."*  
- Ira Byock, 2012

Permission to reproduce can be obtained from Bonnie Freeman at [bofreeman@coh.org](mailto:bofreeman@coh.org).

# Comfort

## Pain Management

You must act as an advocate for your patient to control their pain. Pain control is an essential need for all dying patients.

- The route of the medication determines time to maximum effect:
  - IV peak effect is 15 minutes
  - PO in 60 minutes
  - Sub-q in 30 minutes
  - Transdermal 4 to 6 hours
- Terminal pain/pain during dying is best managed by around the clock, scheduled, or a continuous infusion of opioid (such as from a PCA pump) and additional doses (boluses) given as needed for breakthrough pain.
- There is no maximum dose of opioids for pain control.
- Nurses are often frightened the opioid they give a patient will cause them to die prematurely.
  - There will always be a last dose when caring for a dying patient. Keep in mind the legal and ethical concepts of intent.
  - The patient is dying because of their disease process not the opioid.
- Adjustments in dosage or type of opioid may be required in the presence of renal failure, and if the pain medication does not help to control the patient's pain.
  - Consider fentanyl if the patient is in renal failure and if the patient is having small seizure like tremors (myoclonus).
  - Opioids stay in the system longer with renal failure. Dosage is usually smaller.
  - Consider changing the type of opiate if pain remains uncontrolled.

## Comfort (continued)

The focus of care for the dying patient is comfort. All unnecessary procedures, tests and activities should be evaluated. Providing as much time for the patient and family to be together should be the priority. Consider obtaining orders as appropriate for the following:

- Stop or modify vital signs
- Stop oral medications if unable to swallow and all nonessential medications.
- Clarify IV options: stop or reduce.
- Stop or reduce tube feedings.
- Turn off monitors and alarms.
- Stop or decrease labs per physician and family preference.
- Discontinue isolation.

You can provide the following comfort measures without an order:

- Turn and position patient only for comfort.
- Modify bathing or stop per family request.
- Consider re-enforcing dressings only.
- Provide frequent oral care.
- Provide oral suctioning if family requests.
- Provide temperature comfort measures such as a cool wash cloth and ice packs.
- Explain mottling and cyanosis as part of dying process and not from being cold.

# Airway

The use of supplemental oxygen during the dying process is often ineffective but may help to minimize the family's fears of their loved one suffering. Review goals of care established by the patient and family for supplemental O2.

- Consider use of a fan.
- Provide nasal cannula per M.D.'s orders.
- Reposition patient as needed.

The dying process results in irregular breathing with periods of apnea. Secretions often pool in the back of the patient's throat resulting in loud congestive sounds. Patients can become restless and anxious. Consider obtaining orders for:

- Glycopyrrolate, scopolamine patch or Atropine 1% ophthalmic solution.
- Morphine IV or Sub-q: The patient is dying and will stop breathing due to their disease and the dying process, and not from receiving morphine.
- Consider using anti-anxiety agents and/or antipsychotics.

Provide family education as needed. Some common issues to address are:

- Breathing patterns of the dying. Breathing becomes progressively irregular, shallow and slowed. Episodes of apnea will extend. This is all from brain stem activity. It is involuntary and the patient is not suffering.
- Emphasize the calming effects of touch and talking to the patient.