Hospice Symptom Management

Common Symptoms and Recommended Treatments

Symptom	Clinical Signs	Recommended Starting Dose	Cautions
Dyspnea* **Pain***	Respiratory rate >30 breaths / minute Sustained facial grimacing or motor posturing Retractions (intercostal or abdominal)	Opioid Naïve: a) Morphine 2 mg IV q1 hour prn b) Hydromorphone 0.2 mg IV q1 hour prn c) Fentanyl 25 mcg IV q1 hour prn Opioid Tolerant: If the patient is comfortable on an opioid regimen in place prior to initiating the ventilator withdrawal, continue the existing regimen. Otherwise, consider Palliative Care consult.	Caution with morphine and hydromorphone in renal failure --active metabolites can accrue. *Goal RR <24 with titration of opioid If requiring frequent prn doses, consider ordering a PCA (discuss with hospice RN)
Anxiety*	Fidgeting Twitching Restlessness Scared facial appearance	Lorazepam 1-2 mg IV q1-2 hours prn Midazolam 1-2 mg IV q1-2 hours prn	Benzodiazepines can precipitate delirium, especially when bolus dose wears off.
Delirium	Agitation, Picking at imaginary objects, Inattention Hallucinations	Haloperidol 1 mg IV q1 hour prn or Lorazepam 1-2 mg IV q2 hours prn if goal of treatment more sedating in nature	Increased risk of extrapyramidal symptoms with haloperidol doses > 3 mg/day
Excess Respiratory Secretions	Audible upper airway rattle leading to signs of patient distress – e.g. secretions trigger uncomfortable coughing fits for the patient	1st Step → reposition patient Glycopyrrolate 0.2 mg IV q2 hours prn Atropine 1% eye drops, 2 drops SUBLINGUAL q4 hours prn AVOID Scopolamine patch	Current evidence is not clear that patients suffer from this symptom. Therefore, family education, stopping IV fluids, removing NG tubes, and/or stopping all iatrogenic contributors to the symptoms should be the initial management steps.

Symptom	Clinical Signs	Recommended Starting Dose	Cautions
Volume Overload	JVD, dyspnea, edema	Diuretics ex. Furosemide, Bumetanide, etc.	Ok to use diuretics as part of hospice plan if indicated, regardless of terminal diagnosis.
Fever	Temp ≥ 101 F Myalgias / Arthralgias	Acetaminophen 500 mg PO, suppository 650 mg q6 hours PRN Ketoralac 30 mg IV q8 hours prn Dexamethasone 4 mg IV BID prn Ice packs, fan, cool washcloths	Determine if acetaminophen suppository is more harmful than beneficial or if family have preference
Constipation	Abdominal distention or discomfort	Bisacodyl 10 mg suppository daily PRN	
Nausea & Vomiting		Prochloperazine 10 mg PO or IV q6 hours prn Haldol 1 mg PO or IV q4 hours prn Ondansetron 4 mg PO or IV q6 hours prn Dexamethasone (unless contraindicated)	Prochlorperazine, Haldol, Ondansetron prolongs QTc & can be constipating

For additional symptom management education visit https://www.mypcnow.org/fast-facts/

**It can be difficult to distinguish respiratory distress, pain, and anxiety from each other in non-verbal patient. When in doubt, involve family members who may be able to discern the patient's distress cues*

***This table was modified from the fourth edition of The Ohio State University Wexner Medical Center Palliative Ventilator Withdrawal Guideline published by Lauren Goodman MD, MSc, Jillian L Gustin MD, and Ellin Gafford MD in 2014; Walling, A.M., et al., Assessment of Implementation of an Order Protocol for End-of-Life Symptom Management. 2008. 11(6): p. 857-865.*

Other Helpful Tips

Interdisciplinary Support	• Chaplain or Spiritual Services • Child-life services for visit support, legacy tools or bereavement resources • Music Thanatology • Hospice RN, SW (Horizon employed) • Palliative Care • Ethics
Comfort Orders	• Minimize vitals to temperature daily • Minimize medications / orders to those which focus on comfort • Adjust nursing orders for repositioning if needed • If IV no longer working, subcutaneous button can be placed and most comfort meds infused via this route
Anticipatory Guidance: Stages of Active Dying	Patients and families need to feel they will not be abandoned. Utilize active listening with patients and families. Offer to provide anticipatory guidance about expected changes in cognition and physical exam. Inquire if family are interested in prognosis. If so, estimate in windows of time (ex. hours to days vs. days to short weeks). <u>Early Stage</u> • Bed bound • No longer taking PO • Cognitive changes ☐ hypo or hyperactive delirium, sleeping more <u>Mid Stage</u> • Worsening mental status <u>Late Stage</u> • Pooling oral secretions (death rattle) due to loss of swallowing • Comatose • Cool extremities, mottling extremities, cyanosis • Alternating respiratory pattern – fast, slow, pauses (Cheyne-Stokes)

continued

Anticipatory Guidance: Stages of Active Dying	*Rally → Dying patients can sometimes experience a "rally" or surge of energy which might allow them to be interactive and lucid for hours or days after a period of unresponsiveness. This can confuse families or be contradictory to what they expected. It is important to encourage families to use this time meaningfully to interact with the patient, while remaining realistic about prognosis and comfort goals.