Supplementary 2 – End-of-life Nursing Care Bundle

Pilot

End-of-life Nursing Care Bundle

This documentation focuses on the nursing care provision for the dying patient in the last hours or days of life. An assessment of the following symptoms should be performed each shift and documented in the nursing assessment flowsheet.

		Symptom	Assessment	Nursing Interventions	Suggested Pharmacological Interventions
1	**NEUROSENSORY**	**Restlessness/ Agitation**	- Assess and treat reversible causes (e.g. constipation, urinary retention, pain/discomfort).	- Familiar faces at bedside, reassurance, re-orientation and avoid restraints.	SC Haloperidol 1-2.5 mg bolus followed by 1. SC Haloperidol 1-2.5 mg 6 hrly PRN OR 2. SC Haloperidol infusion 5-10 mg/24 hrs
		Seizure	- Note the onset, duration and manifestation (e.g. generalised, focal)	- Maintain patent airway, position patient laterally and remove sharp objects at bedside	SC Midazolam 2.5 mg prn Rectal Diazepam 5 mg prn
2	**RESPIRATION**	**Rattling/ secretions**	- Signs of fluid overload (e.g. Positive net balance, worsening peripheral oedema) - Review use of supplemental feeds (e.g. NGT feeding) and IV fluids	- Position patient laterally - Gentle oral suctioning if positioning and SC Buscopan injection are not effective	SC Hyoscine Butylbromide (Buscopan) 20 mg 6 hrly PRN
		Dyspnoea	- Use of accessory or diaphragmatic muscles and increased respiratory rate	- Position patient in semi-fowler's or as tolerated - Oxygen therapy for comfort (Nasal prongs may be better tolerated than face/non-rebreather mask) - Use of a fan directed at face (either on table or handheld)	<u>Patient on PO Morphine</u> 1. PO Mist morphine current dose 4 hrly + (1/6 of total daily dose) PRN up to 4 hrly for breakthrough; OR 2. Continuous infusion SC Morphine (1/3 of total daily dose of oral morphine) over 24 hrs <u>For liver/renal impairment/elderly</u> SC Fentanyl 10-30 mcg bolus, followed by 1. SC Fentanyl 10-30 mcg 2-3 hrly PRN; OR 2. SC Fentanyl infusion 10-20 mcg/hr
3	**COMFORT**	**Pain**	- If patient is uncommunicative, assess for frowning/grimacing, groaning, changes in breathing and resistance on movement.	- Warm or cold compress - Gentle repositioning - Presence of incident pain: Administer pre-emptive analgesia before major activities (e.g. sponging, wound dressing)	
4	**GASTROINTESTINAL**	**Dry mouth/ Thrush/ Ulcers**	- Presence of dry mucosa, crust, red or yellow sores and white patches in mouth/inner cheeks/tongue/palate. - Increase frequency of assessment and oral toileting for patients who are on high flow oxygen.	- Perform oral toileting at least once/shift - Moisten mouth and lips regularly with wet cotton ball/gauze.	PO Oral 7 Mouth Wash PRN (Dry mouth) PO Nystatin 10000u 6 hrly PRN (Thrush) PO Bonjela / Oracort E (Ulcers)
		Nausea/ Vomiting	- Aggravating (e.g. smell/sight of food) and relieving factors (e.g. application of peppermint oil) - Vomitus: Monitor amount, characteristic and associating symptoms (e.g. colicky pain)	- Avoid aggravating factors - Elevate head of bed - Provide oral gargle post vomiting	1. SC Metoclopramide 10 mg 6 hrly PRN (only if no intestinal obstruction) 2. SC Haloperidol 1 mg 6 hrly PRN (for centrally-mediated causes e.g. uremia)
		Hematemesis	- Identify at risk patients (e.g. head and neck cancers, haematological cancers, tumours invading or at proximity to major vessels)	- Prepare vomit bowls, dark towels, yankauer suction and plastic bags at bedside (Dark towels to disguise large volumes of blood and decrease associated distress).	
				- Provide immediate support and reassurance to family, caregivers and staff present.	
5	**ELIMINATION**	**Urinary retention**	- Presence of palpable bladder and constipation - Perform bladder scan to assess for residual urine (RU). Inform Dr if RU > 500 ml	- Clear bowels if patient is constipated - Insert IDC if RU > 500 ml	
6	**ELIMINATION**	**Constipation**	- Assess for spurious diarrhea - Check clinical chart for last bowel movement	- Ensure bowel clearance once every 3 days (Not applicable to patients with medical conditions such as intestinal obstruction)	Suppository Bisacodyl 10 mg PRN
7	**SKIN/ TEMPERATURE**	**Fever**	- Monitor patient's temperature once per shift/PRN - Assess for chills or rigours	- Apply cold compress or tepid sponge when necessary	Suppository Paracetamol 650 mg 6 hrly PRN
8	**PSYCHOSOCIAL SUPPORT (Family/Others)**	**Grief/ bereavement**	- Recognise that death is imminent - Express understanding of measures taken to maintain patient's comfort - Express understanding of plan of care	- Provide booklet on *'Spending the last days together'* - Involve medical social worker if family or caregivers display symptoms of complicated grief	
9	**SPIRITUAL SUPPORT**	**Spiritual/ religious needs**	- Identify spiritual/religious needs and discuss with family (e.g. 8 hours non-touch post patient's demise)	- Propose the use of quiet room where applicable - Provide booklet on *'When your loved one passes away'*	
10	**Monitoring**		- Review need and frequency of monitoring	- Check parameters once per shift (Do not place patient on continuous SpO2 monitoring) - Stop hypocount - Discontinue daily weight and strict I/O charting. Monitor for constipation and urinary retention.	

NB: If you require further clarification or assistance, please consult NUH Palliative Care Nursing team.