Introduction: No One Dies Alone

This story begins with one patient and one nurse. Sandra Clarke is that nurse and she tells the story like this:

“One rainy night at Sacred Heart Medical Center in Eugene, Oregon, I had a brief encounter with a man whose name I cannot recall, a man I shall never forget. He was one of my seven patients, near death and a DNR. During my initial rounds, he asked, barely audible, “Will you stay with me?” He was so frail, pale, old and tremulous. I said, “Sure, as soon as I check my other patients.”

Vital signs, passing meds, chart checks; assessments and bathroom assistance for six other patients took up most of the next hour and a half. When I returned he was dead. I reasoned he was a DNR, no family, very old, end-stage multi-organ disease; now he was gone, and I felt awful. It was okay for him to die, it was his time – but not alone.

I looked around; scores of people were nearby providing state-of-the-art patient care. For this man, state-of-the-art should have been dignity and respect.

Since that night I have on occasion mentioned to peers and administrators my idea for putting together a group of volunteers made up of hospital employees who would be willing to sit with the alone and dying. Usually this is met with “Good idea,” and sometimes, “I already give this place enough of my time!” For 16 years my vision quest remained only conversation.

The past 14 years I have worked where no one dies alone – the intensive care unit. Speaking with nurses from other ICUs, there seems to be an unwritten universal protocol for the patient who is dying without the presence of friends or family. One’s other patients’ care will be taken over by nearby nurses. Rituals of passing are acted out: I’ve seen nurses quietly singing, holding the hand of the dying, and, in other manners of behavior, showing care and respect while an individual passes on to death. Nurses know the awe of being present at the birth or the death of another human being. I believe awe and privilege is an innate human response at these times – the very essence of humanity.”

Sandra Clarke and her colleagues began their No One Dies Alone program in 2001 and they have served as the role model for many other hospitals throughout our country.

Now, standing proudly on the shoulders of Sandy Clarke and her colleagues, we at Santa Rosa Memorial Hospital and Petaluma Valley Hospital have our own No One Dies Alone program.

Ultimately we hope that any member of our staff or any volunteer who is interested will be afforded the opportunity to serve as a “compassionate companion”. We, too, want to be able to say, “In our facility No One Dies Alone.”
I. VALUES CONTEXT

Practicing within the context of our core values of Dignity, Excellence, Service and Justice ensures the provision of respect for each person, accountability, commitment to quality, opportunities to serve each other and a sense of community among all persons.

II. PURPOSE\EXPECTED OUTCOME(S)

Through the efforts of volunteers, No One Dies Alone (NODA) will provide a reassuring presence to dying patients who would otherwise be alone. With the support of the nursing staff, compassionate companions will help to offer patients the most valuable of human gifts: a dignified death.

III. POLICY

Once a nurse or physician identifies a patient who, for whatever reason, does not have family or friends to be with them and whom they believe have entered the dying process; will refer that patient to the No One Dies Alone Program. This program will be completely voluntary and anyone, SRM employee or SRM volunteer may participate after achieving the following: each must have been either an employee or volunteer for a full 90 days and have completed the 2.0 hour NODA orientation. The orientation will be provided free of charge and attendance will be voluntary. While no guarantee can be made, it is the goal of the NODA program to have a compassionate companion at the bedside as soon as possible after the patient is identified and to continue the vigil for the anticipated last 72 hours of life.

IV. PROCEDURE (Scope/Responsible Persons):

1. Primary Care Nurse or Shift Lead
   - Nursing staff, noting a dying patient on comfort care does not have family or friends or whose family must travel a significant distance will notify the Spiritual Care Department at x6105 to notify him/her of the identified need. The spiritual care department will confirm need and activate a vigil by contacting the NODA telephone coordinator who is on call.
   - Activation of NODA can only occur between 8:00 AM and 8:00 PM. Requests received after 8:00 PM will be responded to after 8:00 AM the following day.

2. Chaplain
   - The chaplain will review the pertinent patient information with either the shift lead
or the primary care nurse.
- The chaplain staff will serve as a resource for the compassionate companion and for staff.

4. Compassionate Companion Volunteer
- The compassionate companion will arrive as scheduled.
- He/She is encouraged to wear comfortable business casual attire.
- In keeping with the hospital dress code policy, he/she must not wear perfume or cologne.
- He/She MUST wear their SRM badge.
- He/She will report to the patient’s room.
- He/She will be provided access to the Emergency Department office to access NODA supply bag.
- Once with the patient, the volunteer companion is expected to behave as a family member would, within their comfort range and guided by the patient. There is no ‘right way’ to be with a patient. Some examples include holding the patient’s hand, reading or singing to them playing music. Prayer may be appropriate but the companion should bear in mind the patient’s spiritual and religious preferences. Other examples include applying lip balm or lotion.
- The compassionate companion is not expected and should not function in their primary role. For instance, a nurse serving as a compassionate companion may not give medications or change dressings.
- The compassionate companion should share observations with the primary nurse; for instance, one might observe the patient becoming restless or moaning and these signs would guide the care provided.
## NO ONE DIES ALONE

Compassionate Companion Orientation

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<td>SRM No One Dies Alone Mission Statement</td>
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<td>Personal Experience: Death and Dying</td>
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<td>Your Role as a Compassionate Companion</td>
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<td>Commissioning Ritual and Closing</td>
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Please complete the Availability Schedule and return to Spiritual Care Department
1165 Montgomery Drive, Santa Rosa, CA 95405
brian.plaugher@stjoe.org
Fax 707-522-1280
NO ONE DIES ALONE
ORIENTATION MANUAL

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No One Dies Alone: Background

It’s the 21st century, and we live in a high-tech world. Sonoma County has its share of high-tech companies. Santa Rosa Memorial Hospital and Petaluma Valley Hospital can boast of state-of-the-art medical care in many areas of treatment. These hospitals are on the cutting edge of one of the most important areas of patient care: the end of life.

Ask someone, anyone, what he or she most fears about dying. The universal response is dying in pain and dying alone. We all wish for a painless death in the presence of someone who cares. Santa Rosa Memorial Hospital and Petaluma Valley Hospital recently developed protocols for Palliative Care, which is care focused on the needs of someone in the dying process with attention to dignity, respect and comfort. Thus families can be at the bedside of their loved ones and not watch them suffer.

But what happens to the person who has outlived his family and friends, or the lone traveler, passing through our community, who comes to Memorial Hospital or PVH after an accident? What of the individual who comes here from a shelter, or has been homeless, who—by choice or circumstances—has lived life away from family and mainstream society? Why should these people die without human companionship?

Mother Teresa said, “No one should die alone. . . Each human should die with the sight of a loving face”. We can make this a reality at Santa Rosa Memorial Hospital and Petaluma Valley Hospital. We can provide companionship to patients in the dying process who are truly alone, and in so doing, provide a gift of respect and dignity to another human being at the end of life.

For thousands of generations the family of man has given comfort to those leaving this life. The modern medical community is beginning to recognize the need to give attention to end-of-life issues and to provide this kind of care as well.

The plan is simple. Any employee of Santa Rosa Memorial Hospital and Petaluma Valley Hospital or any hospital volunteer may be an end-of-life “compassionate companion”. The companion may choose the time, date, and number of hours he or she will be available. A staff nurse notifies the charge nurse that a patient who has no family or friends is in the dying process. The volunteer phone coordinator checks to find out if a companion is available; if so, he or she is called. Example: Volunteer signs up for Wednesdays, 3 PM to midnight. If a patient were in need on Wednesday, the volunteer would be called in.

The expectation is simple: quiet reading, perhaps holding a hand. Being there is the most important thing. As the CEO of Sacred Heart Medical Center in Oregon, where this program originated, put it, “we create moments of grace in a world that does not expect kindness”. Santa Rosa Memorial Hospital and Petaluma Valley Hospital believe this to be true as we strive to create a sacred space for this last stage of life.
The Dying Person’s Bill of Rights

✧ I have the right to be treated as a living human being until I die.

✧ I have the right to maintain a sense of hopefulness, however its focus may change.

✧ I have the right to be cared for by those who can maintain a sense of hopefulness, however its focus may change.

✧ I have the right to express my feelings and emotions about my approaching death in my own way.

✧ I have the right to participate in decisions concerning my care.

✧ I have the right to expect continuing medical and nursing attention even if “cure” goals must be changed to “comfort” goals.

✧ I have the right not to die alone.

✧ I have the right to be free from pain.

✧ I have the right to have my questions answered honestly.

✧ I have the right not to be deceived.

✧ I have the right to have help from and for my family in accepting my death.

✧ I have the right to die in peace and with dignity.

✧ I have the right to retain my individuality and not to be judged for my decisions, which may be contrary to the beliefs of others.

✧ I have the right to discuss and enlarge my religious and spiritual experiences, regardless of what they mean to others.

✧ I have the right to be cared for by caring, sensitive, knowledgeable people who will try to understand my needs and will be able to gain some satisfaction in helping me face my death.

This Bill of Rights was created at a workshop on “The Terminally Ill Patient and the Helping Person” in Lansing Michigan, sponsored by the Southwestern Michigan Inservice Education Council and conducted by Amelia J. Barbus, associate professor of nursing, Wayne State University, in 1975.
### STAGES OF DYING

#### Early Stage

<table>
<thead>
<tr>
<th>What You See</th>
<th>What Is Happening</th>
<th>What You Can Do To Help</th>
</tr>
</thead>
<tbody>
<tr>
<td>A decrease in both eating and drinking which may last from days to weeks.</td>
<td>The body naturally begins to conserve energy and requires less nourishment.</td>
<td>Ask the nurse to:</td>
</tr>
<tr>
<td>Less interest in food; eating may become more of a burden than pleasure.</td>
<td>There is no “hunger” and no “suffering” with this process.</td>
<td>• Moisten the patient’s mouth with toothettes and swabs frequently.</td>
</tr>
<tr>
<td>Occasional choking fluids. Feeling full quickly.</td>
<td>IV fluids and artificial feeding will NOT promote comfort or prevent death.</td>
<td>• Offer sips of fluid or chips of ice.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Offer bits of food if desired.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Follow the patient’s wishes about taking food and fluids.</td>
</tr>
</tbody>
</table>
# STAGES OF DYING

## Mid-Stage

<table>
<thead>
<tr>
<th>What You See</th>
<th>What Is Happening</th>
<th>What You Can Do To Help</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in physical appearance may last a few hours or days. Often the patient’s hands and feet may feel cool and may darken in color.</td>
<td>The circulation is slowing down and the blood is being reserved for the major internal organs.</td>
<td>Because of circulation changes, the patient will often throw off the covers. Offer blankets if the patient seems uncomfortable or expresses a desire for one. Never use electric blankets or heating pads.</td>
</tr>
</tbody>
</table>
| Patient will respond less and less to you and his/her surroundings. Eventually the patient is completely unable to speak or move. This usually happens during the last few days of life. | Patient is preparing for release and detaching from surroundings and relationships. This is a physical and spiritual response to the dying process. | Talk gently and frequently. Assume that the patient can hear.  
- Talk softly  
- Say your name  
- Don’t ask questions  
- Prayers or meditation can be helpful |
## STAGES OF DYING

### Late Stage

<table>
<thead>
<tr>
<th>What You See</th>
<th>What Is Happening</th>
<th>What You Can Do To Help</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermittent disorientation and restlessness occur in most patients. This may increase in the last days.</td>
<td>This is due to changes in the patient’s metabolism.</td>
<td>• Touch the patient&lt;br&gt;• Talk reassuringly&lt;br&gt;• Remain calm</td>
</tr>
<tr>
<td>There will be a gradual decrease in the patient’s urine output. If the patient has a catheter, the urine may appear very dark. Patient may become incontinent and bowel movements may stop.</td>
<td>As circulation decreases, kidneys and bowel function may be reduced. Muscles may relax causing incontinence for the patient.</td>
<td>Call the nurse if patient needs underbody pads or diapers</td>
</tr>
<tr>
<td>Breathing may be shallow and have long pauses, which become more frequent and longer in duration as death approaches. Increasing sounds of congestion in the chest and a rattle in the throat may be heard during the last hours.</td>
<td>Circulation of internal organs will decrease especially the heart and lungs. Throat muscles will begin to relax and the lungs will lose their ability to clear fluids.</td>
<td>Ask the nurse to:&lt;br&gt;• Raise the top of the bed or use pillows to elevate the head&lt;br&gt;• Turn the patient on his/her side to increase comfort&lt;br&gt;• Provide mouth care</td>
</tr>
</tbody>
</table>
Nursing Assistance for Comfort

You want your companion to pass from this world in peace and comfort.

How will you know if he or she requires nursing assistance to achieve this goal?

✧

- Winces when moved

✧

- Moans

✧

- Holds body tense and stiff

✧

- Breathing is labored

✧

- Restless or agitated
Things You Can Do To Help Make Your Person More Comfortable

- Quietly witness.
- Turn on Channel 20, if at Memorial Hospital (The Spiritual Care Channel).
- Play music on a CD player or phone
- Bring favorite poems, stories.
- Don’t be afraid to be yourself – cry, laugh, carry on conversations, read, eat.
- Remember hearing and touch are the two senses that remain until death.
- Your companion will feel comforted by your presence.
- You may adjust pillows, moisten lips, add or subtract blankets, adjust the room temperature as you think beneficial for your companion.
- You should call nursing staff, using the call light, if you feel your companion is in pain, is uncomfortable, or is anxious.
- You may wish to give your companion “permission” to go to the light or beyond this existence.
- Our hope is for a peaceful, dignified death. Do not hesitate to sit quietly with patient, particularly if that makes them the most peaceful. Talking is not always needed.
How You Will Know That Your Person Has Died

- The person will have no pulse or heartbeat.
  - The person will not breathe.
  - The person will not respond to your voice.
- The eyelids may be slightly open and the eyes fixed.
  - The jaw may be relaxed.

Please feel free to stay with your patient-companion for a while.

Call the nurse if you need assistance.
Let Me Die Laughing

We are all dying, our lives always moving toward completion.

We need to learn to live with death, and to understand

That death is not the worst of all events.

We need to fear not death, but life—

empty lives,
loveless lives,
lives that do not build upon the gifts that each of us has been given,
lives that are like living deaths,
lives which we never take the time to savor and appreciate,
lives in which we never pause to breathe deeply.

What we need to fear is not death, but squandering the lives we have been miraculously given.

So let me die laughing, savoring life’s crazy moments. Let me die holding the hand of one I love, and recalling that I tried to love and was loved in return. Let me die remembering that life has been good, and that I did what I could. But today, just remind me that I am dying, so that I can live, savor and love with all my heart

Mark Morrison-Reed
An Old Ladies Poem

What do you see nurse, what do you see?
What are you thinking when you’re looking at me?
A crabby old woman, not very wise,
Uncertain of habit, with faraway eyes?
Who dribbles her food and makes no reply
When you say in a loud voice, “I do wish you’d try!”
Who seems not to notice the things that you do,
And forever is losing a stocking or shoe...
Who, resisting or not, lets you do as you will,
With bathing and feeding, the long day to fill....
Is that what you’re thinking? Is that what you see?
Then open your eyes, nurse; you’re not looking at me.
I’ll tell you who I am as I sit here so still,
As I do at your bidding, as I eat at your will.
I’m a small child of ten...with a father and mother,
Brothers and sisters, who love one another,
Young girl of sixteen, with wings on her feet,
Dreaming that soon now a lover she’ll meet.
A bride soon, at twenty—my heart gives a leap,
Remembering the vows that I promise to keep.
At twenty-five now, I have young of my own,
who need me to guide, and a secure happy home.
A woman of thirty, my young now grown fast.
Bound to each other with ties that should last.
At forty, my young sons have grown and are gone,
But my man’s beside me to see I don’t mourn.
Fifty - once more, babies play around my knee,
Again we know children, my loved one and me.
Dark days are upon me, my husband is dead;
I look at the future, I shutter with dread;
For my young are all rearing young of their own,
And I think of the years and the love that I’ve known.
I’m now an old woman...and nature is cruel;
Is jest to make old age look like a fool.
The body, it crumbles, grace and vigor depart,
There is now a stone where I once had a heart.
But inside this old carcass a young girl still dwells,
And now and again my battered heart swells.
I remember the joys, I remember the pain,
And I’m loving and living life over again.
I think of the years...all too few, gone too fast,
And accept the stark fact that nothing can last.
So open your eyes, nurses open and see....
Not a crabby old woman; look closer....
See Me!

Anonymous
The Ship

I am standing upon the seashore. A ship at my side spreads her white sails to the morning breeze and starts for the blue ocean.

She is an object of beauty and strength, and I stand and watch her until at length she is only a speck of white cloud just where the sea and sky meet and mingle with each other. The someone at my side exclaims, “There, she is gone!”

Gone where? Gone from my sight, that is all. She is just as large in hull and mast and spar as she was when she left my side, and just as able to bear the load of living freight to her destined port. Her diminished size is in me, not in her.

And just at the moment when someone at my side says “There, she is gone,” there are other eyes watching out for her coming and other voices ready to take up the glad shout, “Here she comes!”

And that is dying.

--Henry Van Dyke
No One Dies Alone

Compassionate Companion Volunteer Agreement

NAME _______________________________________________________________________

ADDRESS ____________________________________________________________________

CITY ____________________CA, ZIP________

PHONE Preferred contact number: __________________________

# we can text (if different from primary): _______________________

E-MAIL ADDRESS that you check regularly: _______________________

SRMH/PVH HOSPITAL: □ EMPLOYEE   □ VOLUNTEER

□ Memorial Hospice/HOP Volunteer   □ Community Member

LAST DATE OF TB TEST _______________________________________________

Volunteers will be contacted once patient goes into active dying, and will be asked to volunteer in 3 hour shifts during non-work hours. What would your availability be to volunteer on an ‘on call’ basis during non-work hours?

Please check all that apply:

□ Monday    □ Tuesday    □ Wednesday    □ Thursday    □ Friday    □ Sat.   □ Sunday
□ 9AM-12 PM, □12-3 PM, □3-6 PM, □6-9 PM, □9-midnight, □12 -3 AM, □ 3-6 AM, □6-9 AM. □Other:__________________________

I, the undersigned, understand that I am offering my services as a Compassionate Companion in the role of volunteer. I will not receive nor expect financial compensation for my time. I understand I am in no way acting in my roles as an employee of Santa Rosa Memorial Hospital or Petaluma Valley Hospital. I will not perform or assist in any usual and customary patient care done by medical personnel. If the date and time I have chosen has no need for a “Compassionate Companion,” my obligation is finished.

Signature__________________________________ Date_________________
COMPANION EVALUATION

Patient’s Name____________________________________

Unit__________   Date___________  Time___________  Room#__________

Patient’s Nurse: ______________________

2. Did the staff make you feel welcome? Comfortable? ________________

3. When you arrived, did the patient appear comfortable? ________________

4. If you had any questions and/or concerns regarding the patient, did the staff address them satisfactorily? _______________________________

5. Did you feel you were prepared for your role as a Compassionate Companion once you arrived at the bedside? _______________________________

6. What could be done to improve the role of Compassionate Companion?

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

7. Was this a valuable experience? What was this like for you?

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Any comments or suggestions? _______________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

PRINT NAME ______________________       DATE _________
Staff Evaluation of Compassionate Companions

Patient Name: _____________________________ Time: ____________

Unit: ____________________ Room#__________ Date: ____________

Nurses, please fill out one evaluation per shift and send in interoffice mail to Spiritual Care at MS 1W21

- Did the companions arrive in a timely manner? □ yes □ no

- Did the presence of the companions help your ability to care for the patient? □ yes □ no
  How? ___________________________________________________

- Did the presence of the companion hinder your ability to care for the patient? □ yes □ no
  How? ___________________________________________________

  What suggestions would you give to the volunteers to improve their vigiling with the dying?
  _______________________________________________________

- What could be done to improve this service for the staff?
  _______________________________________________________
  _______________________________________________________

- Would you like to see this service continue? □ yes □ no

- Further comments or suggestions
  _______________________________________________________
  _______________________________________________________

Send this evaluation through interoffice mail to the Spiritual Care Dept at MS #1W21
No One Dies Alone
Compassionate Companion Volunteer Guide
Main phone number for NODA is 525-5300 x6103

1. NODA is being activated about an average of twice per month. Please be aware of emails, texts, and phone calls from our telephone coordinators asking you to fill in. By far the most commonly used method to ask for vigilers is by email.

2. Our Telephone Coordinators are: Ann Huber, cell 481-5601
   Jerry Jaramillo, cell 239-1811
   Collette Cunningham, cell 494-8519
   Gudrun Reiter-Hiltebrand, cell 495-4540

3. When the need for a volunteer companion occurs, the phone coordinator will likely send an email announcing the activation. In some cases they may also call or text. Please return this phone call or e-mail ASAP.

4. If you are called and you agree to come in, you will be provided with the following information: patient name, room number and room phone number, nursing unit and unit phone number, current condition of the patient (including whether the patient is in isolation), religious affiliation, any family details, and information about volunteers coming before or after you.

5. COMPASSIONATE COMPANION SUPPLY BAG In the past, we had a supply bag but found it difficult to keep track of. If you need any sort of supplies, check with the spiritual care office (x6105) or ask the nurse.

6. MEALS Show volunteer badge to cashier in cafeteria and $7 will be covered towards your meal. The badge needs to have a red dot for this purpose, and Kathy Exelby is the provider of red dots.

7. PARKING At Memorial: From 8 AM to 8 PM please park in the parking Garage (marked B on your map). After 8 PM volunteers may park in the front lot (A) as hospital doors begin to be closed. After hours the all hospital doors are locked and the volunteer needs to gain entrance through the emergency department. (Employees park as usual.) At Petaluma: you may park in the front lot until 8 PM and gain entrance through the main doors. After 8 PM, you will need to enter through the Emergency Department located on the North side of the building.

8. COMPASSIONATE COMPANION NAME BADGE Introduce yourself as a Compassionate Companion. Wear your hospital id badge and your Compassionate Companion badge. Please be sure to wear it at all times when vigiling.

9. LATE NIGHT ARRIVALS /ESCORT If you arrive after 8:00 p.m. go to the Emergency Department. Ask for an escort to the hospital lobby (through the emergency room at night), then proceed to the patient’s room.
10. Go to the Nursing Unit assigned to and introduce yourself to the patient’s primary nurse

11. Proceed to patient’s room

12. Look for all signs outside of patient’s room, particularly for those that say “Contact Isolation.” **Contact Isolation requires that all visitors wear a gown and gloves, and sometimes a mask, at all times inside patient’s room.** The patient has a bacteria or “bug” that is passed by touch. Before leaving the patient’s room, take off the protective equipment and dispose of them in the trash inside the patient’s room.

13. Follow guidelines and procedures as outlined in the NODA Orientation Handbook.

14. Volunteers will not perform or assist in any usual and customary patient care done by medical personnel.

15. Observe patient for signs of discomfort and report this or any change in condition to the staff.

16. Adhere to SRMH & PVH Privacy /Confidentiality Guidelines

17. Compassionate companions may help in any way the staff requests as long as the task is something the volunteer is comfortable with and has been trained to do and it does not endanger his or her physical or emotional well-being.

18. Once you are in the patient’s room, you assume the role of a compassionate companion. If you have any questions about the patient, ask the nurse. Have the staff call Spiritual Care if you or the patient has any spiritual needs.

19. During the vigil, simply be yourself, but focus on sustaining a peaceful environment. It is ok to sit quietly. Treat the patient as you would one of your own friends or family members, with respect for the patient’s individuality. Whatever your own beliefs, if possible allow the patient to initiate any religious behavior rather than initiating it yourself.

20. If the phone rings, answer it. Feel free to direct persons to the nurse for medical information.

21. If family arrives, prepare to exit as quietly and gracefully as possible. Simply say “I was keeping [patient’s name] company until you could arrive”. Let the telephone coordinator know of this development so that he/she may cancel upcoming volunteer shifts. Advanced: get a sense from family/friends whether they are coming to stay and vigil, or whether they are only staying for a short time, and would like the NODA volunteers to resume once they’ve left.

22. **Call the telephone coordinator if the patient dies while you are present.** If after hours please leave a message.
**Principles of Palliative Care**

**Symptom Management**

**General**
The care of the terminal patient requires a different approach than that of the acutely ill patient. The emphasis is on comfort and fulfilling the needs of the patient as the patient perceives them. All lab tests should be minimized or discontinued to avoid trauma to the patient. Fluid needs in the dying patient are considerably less. IV fluids may actually cause distress by causing edema in the extremities and fluid accumulation in the lungs. Thirst and dry mouth are not accurate indicators of the state of hydration. Similarly, metabolic changes at the end of life decrease nutritional needs. The family can be reassured that the lack of appetite and intake is a normal part of the process.

**Analgesia**
Pure opioid agonists in single-agent form are preferred for treating terminal pain. These include morphine, the backbone of pain management, and fentanyl, hydromorphone, levorphanol, methadone, and oxycodone. There is no ceiling effect with opioids, and the dosage may be increased until the desired effects and toxicity. Opioid partial antagonists such as buprenorphine and mixed agonist-antagonists such as butorphanol, nalbuphine, and pentazocine have no place in the treatment of terminal pain nor is meperidine appropriate in this group of patients. Patients who require opioids in high doses or for a prolonged time or who develop renal insufficiency may manifest signs of toxicity, which may respond to hydration and opioid rotation.

**Agitation and Delirium**
Agitation and delirium are common in palliative care patients and should not be overlooked. Pharmacological treatment of anxiety should be used cautiously because of the potential for synergy with opioids. Insomnia may be aggravated by pain, and the resulting fatigue and exhaustion may further worsen pain and should be treated aggressively. Mistakenly interpreting agitation and the accompanying grimacing and moaning of delirium as signs of poor pain control may result in inappropriately increasing opioid doses. In cases of delirium, one might consider a major tranquilizer like haloperidol.

**Nausea and Vomitting**
The primary pathway of opioid-induced nausea is via the dopaminergic receptors. Metoclopramide has both peripheral actions promoting gastric motility and dopamine-blocking action in the central nervous system. Droperidol also has a dopamine-blocking action. Scopolamine patches allow transdermal administration and work at vestibular and medullary centers, and also decrease secretions. Dexamethasone may exert excellent antiemetic effects. Constipation must be ruled out as a cause of nausea and vomiting. Consider a PEG tube for reverse drainage of intestinal fluids caused by mechanical obstruction. Serotonin antagonists, while effective for chemotherapy-induced emesis, are minimally effective of opioid-induced nausea and vomiting.

**Urinary / Bowel**
Constipation affects up to 95% of patients taking opioids, and may present with atypical symptoms, such as nausea or abdominal distension. For inpatients presenting with diarrhea, always exclude overflow diarrhea secondary to impaction. An ongoing preventative program will be easier on both the patient and the care team.

**Dyspnea**
Dyspnea is subjective and unrelated to respiratory examination findings such as tachypnea, wheezing or accessory muscle use. The goal of treatment of dyspnea is relief of subjective dyspnea from the patient’s perspective, not elimination of physical signs of respiratory distress.