Service Priorities and Programmes

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A pilot individualized end-of-life care service in a medical convalescent ward

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Introduction

In Hong Kong dying with dignity is lacking for older patients who constitute the major proportion of death. We describe a pilot individualized end-of-life care (EoL) service in a medical and geriatric convalescent ward.

Objectives

To test the feasibility of implementing individualized EoL care in a convalescent ward.

Methodology

We adopted a team-based (including case doctor, senior geriatrician, ward manager, and patient's relatives) and non-pathway-driven care planning to manage dying older patients in the last 24-48 hours. We identified the signs of dying by the presence of coma, inability to eat, and deteriorating vital signs. Then we discussed about EoL care plan with the next-of-kin. After obtaining understanding and agreement, we implemented EoL care by considering the following domains: 1) distressing symptoms identification, 2) medication review, 3) nutrition and hydration, and 4) general nursing care. Nurses then provided care according to the EoL plan. The team reviewed the patients regularly for the continuation and adjustment of EoL care. Flexible visiting hour was allowed to relatives. The patient will be relocated to a single room when available. Vital sign monitoring was adjusted to minimize discomfort. Nurse acceptance for the program was evaluated.

Result

Ten patients were recruited since November 2013. Four of them were male. Mean age was 84.8 years. Nine patients had more than 3 comorbidities. The chief complaints for admission were heart failure (3 patients), poor oral intake (2 patients), convulsion (2 patients), chest infection (2 patient) and hypercalcemia (1 patient). The mean number of days that the patient died after recruitment was 10.6 days. Major distressing symptoms identified were sputum sound (30%), pain (20%), and dyspnea (10%). Medications used for symptoms relief were intravenous buscopan in 4, intravenous

tramadol in 2, and intravenous morphine in 1 patient. Four patients were relocated in a single room. Vital signs monitoring were adjusted in six patients. Thirteen nurses were invited to evaluate the program. All nurses commented that it was helpful to patients and relatives. Conclusions: Individualized EoL care is feasible in convalescent ward. The patients were very old with multiple co-morbidities. The dying process duration was variable and longer than 2 days. Nurses highly rated the program which provided a solid foundation for future development.