PALLIATIVE CARE
CASE OF THE MONTH

"Is My Mom Comfortable?"
Assessing Dyspnea at the End of Life
by
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Volume 16, No. 61 **April 2016**

Case: An 85-year-old, previously independent woman with COPD and HTN presented to the emergency department after being found on the floor at home by her daughter. The patient demonstrated decreased level of consciousness, left-sided weakness and aphasia. Imaging confirmed a large right middle cerebral artery stroke. The patient was admitted to the ICU. Over the next 48 hours her condition worsened with continued poor neurologic status and now with fevers, cough and chest x-ray consistent with aspiration pneumonia. The neurology team met with the patient's family and discussed the limited treatment options and overall poor prognosis for good neurological recovery. The decision was made to focus the patient's care on comfort based on discussions the patient had with her family previously. The patient was transferred to a regular floor bed with "Comfort Measures Only" orders which included Morphine 2 mg intravenously as needed for pain or respiratory distress and Lorazepam 0.5 mg intravenously as needed for agitation. The patient was minimally responsive, intermittently opening her eyes and moving her right arm but was nonverbal and not interactive. Her respiratory rate was noted to be 30 breaths per minute with some congestion, grunting, and facial grimacing. The patient's daughter was keeping vigil at her bedside and stated to the nurse that she worried that her mother seemed uncomfortable and wondered if she needed medication.

Discussion: Many patients die in hospitals after decisions are made to forego further life-sustaining treatments. Patients' families are frequently concerned about their loved ones' comfort in their final hours.[1] Assessing the comfort of a patient who is minimally responsive or unresponsive near the end of life is challenging. In other settings, decisions to administer "as-needed" medications are based on a patient's self-report of symptoms; however, dying patients usually cannot report what they are experiencing as their level of consciousness decreases as death approaches.[2] Management decisions in this setting must be made based on observations of the patient by family and clinical caregivers. Clinical caregivers make subjective assessments about a patient's comfort when deciding to use a medication as needed for pain, dyspnea or restlessness in a patient who cannot self-report his or her symptoms. Family and clinical staff may have limited experience caring for a dying person and may be unsure how best to assess patient comfort. While some changes that occur as death approaches are expected and likely do not signify distress or discomfort, other signs may be more indicative of patient discomfort or may appear disturbing to loved ones. For example, dyspnea and signs of respiratory distress can be very distressing to both patients and family members.

Providing objective assessment methods and parameters for interventions can help clinical staff make decisions regarding need for comfort medications when caring for dying patients. The Respiratory Distress Observation Scale (RDOS) (Figure 1) is a validated instrument3 that can be used to assess respiratory distress in patients who cannot self-report their symptoms, including patients who are approaching death. Validity of the RDOS instrument was initially established by comparing patient self-report of dyspnea to clinician observations in various patient groups.[4] The scale includes observations of heart rate, respiratory rate, restlessness, paradoxical breathing pattern, accessory muscle use, grunting, nasal flaring, and a look of fear. Each parameter is rated using a 0 – 2 point scale and a total score can be used to guide decisions about the need for a clinical intervention such as administering medication to improve comfort. Scores greater than or equal to 3 suggest the need to treat for respiratory distress. Scores from 3-6 suggest mild-moderate distress, while scores greater than or equal to 7 suggest more severe distress.[5] Bedside nurses can use this instrument to guide decisions about patient comfort when the patient cannot communicate. Using such an instrument may provide better guidance to staff and more consistent assessments in caring for patients approaching death. The scale can also be used to assess the effectiveness of an intervention by repeating assessments after medication administration. Families can use a version of this scale to assess patients being cared for in a home setting.[6]

Resolution of Case: The bedside nurse used the RDOS instrument as part of her assessment. The patient's RDOS score was greater than 3, and the nurse suggested that a dose of morphine be administered to improve the patient's comfort. When the nurse re-assessed the patient 30 minutes after the morphine was given her respiratory rate had slowed to 18 breaths per minute, the grunting had stopped and the patient's face appeared more relaxed without grimacing (RDOS <3). The patient's daughter felt the patient seemed more comfortable. The nurses continued to assess the patient regularly and administered morphine as needed if signs of respiratory distress recurred. The patient died comfortably 24 hours later.

Figure 1: RDOS Instrument

Respiratory Distress Observation Scale © (Margaret L. Campbell, PhD, RN 2/19/09)

Variable	0 points	1 point	2 points	Total
Heart rate per minute	<90 beats	90-109 beats	≥110 beats	
Respiratory rate per minute	≤18 breaths	19-30 breaths	>30 breaths	
Restlessness: non-purposeful movements	None	Occasional, slight movements	Frequent movements	
Paradoxical breathing pattern: abdomen moves in on inspiration	None		Present	
Accessory muscle use: rise in clavicle during inspiration	None	Slight rise	Pronounced rise	
Grunting at end- expiration: guttural sound	None		Present	
Nasal flaring: involuntary movement of nares	None		Present	
Look of fear	None		Eyes wide open, facial muscles tense, brow furrowed, mouth open, teeth together	
Total				

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