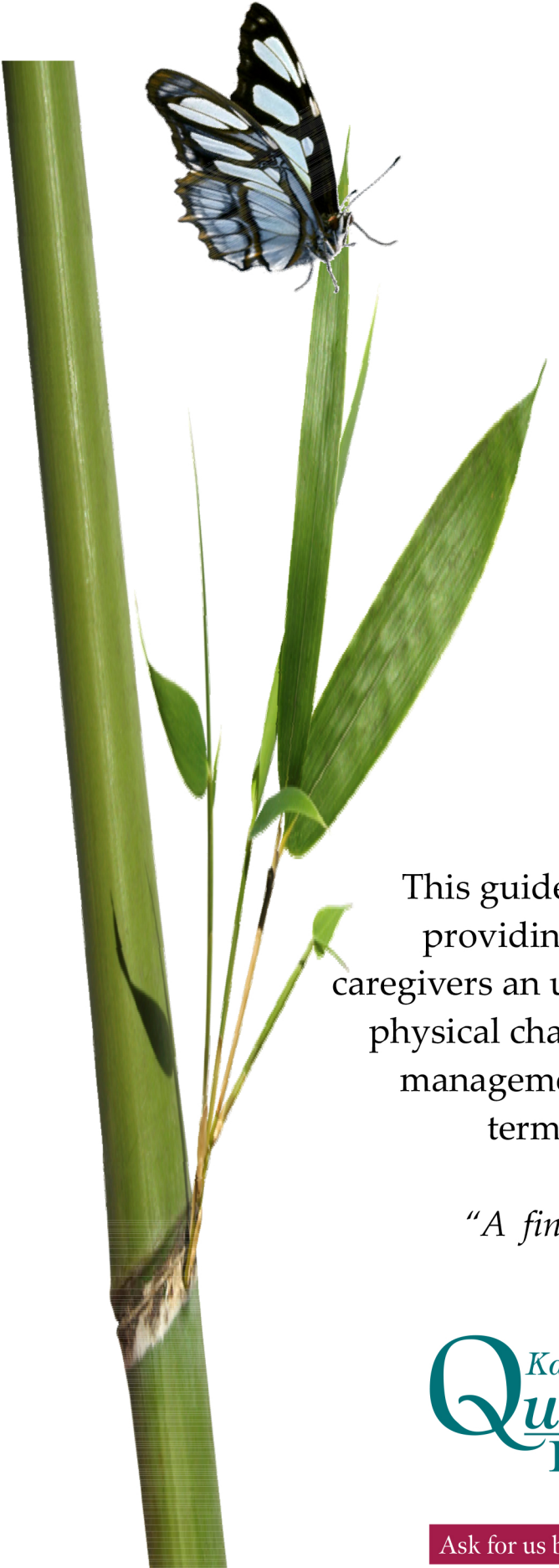

The Whisper of Wings

This guide is a collection of resources providing dying patients and their caregivers an understanding of emotional and physical changes, and pain and symptom management issues that occur during terminal illness and death.

"A final gift to your loved one."

Karen Ann Quinlan Hospice
Home for Hospice

Ask for us by name...there is a difference. SINCE 1980

In Summary:

Caring for a dying person evokes numerous feelings and situations. They will vary depending on the caregiver, the dying person, and the relationship that the caregiver has with the dying person. Understanding what to expect during the dying process is the first step to providing comfort and care.

This booklet draws upon information presented by the Hospice Foundation of America, Hospice nurses, Health Professionals and Bereavement Counselors.

For more information on the Hospice Foundation of America visit www.hospicefoundation.org.

For more information on Hospice and Palliative Care visit the National Hospice and Palliative Care Organization. www.nhpco.org.

For more information on Karen Ann Quinlan Hospice visit www.karenannquinlanhospice.org

Other valuable readings include: Crossing the Creek, Key Elements of Transitions, and Dying to Know by Michael Holmes available at www.crossingthecreek.com

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Please see the Back cover: A quick review of the Final Stages:

"There will come a time when you believe everything is finished.
That will be the beginning."—Louis L'Amour

"Death is too upsetting to talk about."

We have been isolated from death, which has been hidden away in the back rooms of hospitals or other facilities. Often we are prohibited or are afraid to talk about death even though death is a normal part of life. Anyone or anything that lives, dies...but we all still fear death. We can help make death a more positive experience not only for the dying person but also for family and friends by understanding we all fear the unknown and no one is exempt from the in-depth life review that comes with the dying process. To do this we must be familiar with the needs of dying persons as well as the needs of their caregivers. We must realize that the entire dying process is not frightening, but that fear is just a part of the overall progression. The best thing for the dying or their caregivers to do is to make sure that feelings are allowed to be expressed and to seek or give the support needed. If fear is denied, it will only manifest itself in other areas, such as more acute pain, a sense of foreboding, or increased anxiety.

"People die as they have lived."

As some people approach death they may change if they feel the need. Often with the premise that we "are returning home," we may get a sense of seizing final opportunities. If people receive loving and good care during their last weeks or months of life, that time can serve as a great opportunity to reminiscence and to seek forgiveness or spiritual growth. This is only possible if there is good communication and openness among patient, caregivers, and family.

"Dying is always painful."

This is one of the most universal misunderstandings about dying. The pain that may accompany illness or disease today can be relieved safely without any danger of causing death or addiction. Hospice caregivers and physicians are familiar with the proper use of analgesic drugs. When given in the correct dose at the right time, drugs can relieve pain without sedating the patient. When pain is relieved, patients can experience a good quality of life until the time that death occurs. Good pain management does not shorten the course of life. On the contrary, patients who receive excellent pain management tend to live longer than expected.

"While dying, people see a light, a tunnel, people who have gone before, etc."

We have all heard stories of dying people seeing or talking to some one who has passed before, or they experience unusual light. Whether it is true or not, or whether it can be explained is irrelevant; it happens, and it happens consistently. We should pay attention to it. When dying persons speak about seeing relatives who have previously died, in almost all instances, these last visions are usually pleasant and offer comfort to the dying person, especially regarding the prospect of reuniting with deceased loved ones. These experiences of the dying person should be seen as normal and potentially very wondrous. The dying process, when not interrupted by an unexpected tragedy, is a gradual one with the dying person moving to and from "the other side."

The sadness in anticipation of one's own death is a normal and expected response and may be compounded by the sustained anxiety and fear of dying. In these cases it is difficult to separate this normal sadness from true clinical depression.

Truly depressed persons will have a negative outlook and see no good in anything. They have given up and also see no reason to hope. They may experience shame, guilt, and self-recrimination and may be overwhelmed by fear, and exhausted from anxiety. This prevents them from taking comfort in the support provided them. They may express a desire to die or even talk about suicide.

The classic behavior of depressed persons includes withdrawal, isolation, decreased communication and lack of interest. They may also exhibit a generalized slowing of thinking and acting and weight loss.

Ways to Help:

- Assess pain and make sure it is identified and being controlled. **Unmanaged pain is the most common source of depression in dying persons.**
- Identify the source and extent of depression. What else may be bothering the patient? Is there some unfinished business? Is there some unresolved conflict or dispute with another member of the family or other persons?
- **Review medication**. Make sure all symptoms are being treated.
- **Consider supportive psychotherapy**. Your hospice nurse can help you with seeking support from professionals: physicians, nurses, social workers, or clergy. Consider supportive psychotherapy sessions for affected persons in the family. Family members are influenced by depression in the dying person and they may need an opportunity to talk about their response to the depression.
- **Examine the way the person deals with loss**. Dying persons may not just be grieving over their own death, but fear for those they leave behind. Talk to them about all their losses, this may be an opportunity they welcome. They may be equating depression with loss.
- **Consider social, psychological, and spiritual needs**. Examine and discuss what is going on in the family, perhaps unfinished business or what is being said, what is not being discussed, or what worries have not been addressed.

Pain and Suffering.

This is a catch phrase in that it is used without considering its origin or what it really means. Suffering is a word used to describe something that has to be endured.

- **Skin color changes** from normal to a duller, darker grayish hue.

- **The fingernail beds** become bluish rather than the normal pink.

- **Speaking decreases**. The person ceases to respond to questioning and no longer speaks spontaneously. The patient may be confused about time, place, and people.

- **Terminal Restlessness**. As patients get closer to death, they may experience a period of restlessness or agitation which usually occurs at night. You might see them trying to climb out of bed, tossing and turning, incessantly speaking, flailing arms, etc. You have to remember that there is no night or day for dying people and sleep patterns are virtually the same as for newborns. They no longer have normal sleep cycles and can sleep 24 hours a day. Or patients may be up for as long as 72 hours. This may be very exhausting for the caregiver, and your hospice nurse will guide you as to what medications might help in alleviating these symptoms. At this time it is important to set up "shifts," so care does not fall on one person. When periods of sleep increase during the day it is important to note that the extra sleep and dreams are very important to the dying process, as it is the time for resolution of many life issues. This is an enormous task and requires a great deal of effort. All this aids the patient in getting ready for the next phase of life.

- **Bedsores:** One of the main complications of decreased circulation is the potential to develop bedsores. Bedsores are decubitus ulcers caused by prolonged pressure. Moving or repositioning the patient on a regular basis, every two hours, will help to prevent bedsores. The patient does not have to be moved very far, just enough to change pressure points. Keeping the skin clean and dry and gently massaging with a good lotion are also preventative measures. Despite best efforts, bedsores still may occur during the dying process. Some patients are so debilitated that even mild pressure for short periods of time can lead to bedsores. If you see a bedsore developing (i.e. a persistent reddened area or blister), be sure to alert or contact your hospice nurse. Also your nurse can help you determine a balance between the patient's comfort and potential risks.

- **Coma ensues** and may last from minutes to days before death occurs.

with recurrent episodes of pain. Such sleeping patients are easily roused by calling their name or touching them. Tolerance develops rapidly to this initial, sedative side-effect, and patients on even large doses of narcotic analgesics can be clear-headed, aware of all that is happening, and be involved in all decisions affecting their care.

Slowed Breathing Rate. Slowed rate of breathing is rarely a problem as a side effect, as the respiratory rate of patients in pain is usually higher than normal. Patients receiving narcotic analgesics usually breathe less frequently, but take deeper breaths. Like the sedative side effect, slowed respiratory rate is a transient side effect and if present, fades after several days.

Constipation. A major side effect of narcotic analgesics is constipation which must be managed not only with stool softeners but with laxatives, like senna derivatives, that stimulate bowel activity. Laxatives must be provided on a regular basis as long as patients are receiving narcotic analgesics.

In summary, there is always something that can be done to relieve severe, chronic pain in advanced illness. Hospice work has taught us that chronic, severe pain is a complex psycho-physiological process that is best treated by a number of approaches that include narcotic analgesics, psycho-social and spiritual support and the use of a wide variety of therapies ranging from massage to nerve block.

Emotions and Psychological concerns:

We know now about physical symptoms of approaching death and why they are so important. But it is also essential to understand the psychological journey that dying persons go through. With this understanding, we as loved ones and caregivers can help relieve the worries and stresses of the person who is dying. This should make the journey less painful, both physically and emotionally, for all.

Anxiety:

Most people have either experienced or observed anxiety at some time in their lives. The awareness that one is dying is dramatic and usually brings forth anxieties related to the fact that one has only a limited time to live. The anxiety of dying persons also relates to practical concerns about what will happen and how dependent survivors will be cared for, as well as spiritual concerns, fear of the unknown, and all that is related to what happens with the death experience.

Suctioning should be avoided as it can often irritate and cause more discomfort than the rattling itself. The reason is that in addition to it being traumatic for the patient, no matter how skillfully the suction is performed, the sensitive nature of the windpipe is cause for concern. Even when the suctioning is performed with maximum success, the rattling is still likely to return within ten to twenty minutes. At this stage of the life and death process, the primary goal is the patient's comfort, even though the caregiver may feel the rattling is unpleasant.

Consciousness:

Some patients are unconscious for hours or even days before death, while others may be alert until the last moments. You may ask your hospice nurse how to assess for signs and symptoms of pain in a non-verbal patient. Usually there is a gradual development of confusion and semi-consciousness over a few minutes or hours. Pain is one of the first senses to decline in death, but even though patients may not be able to express their pain, it is important to continue medication up to the end of life.

Persons in a coma may still hear what is said even when they no longer seem to respond to verbal or even painful stimuli, and caregivers, family, and physicians should always act as if the dying patient is aware of what is going on and is able to hear and understand voices. Your own words of endearment and support may still be understood and appreciated. Touching, caressing, and holding are all appropriate.

Temperature:

As circulation decreases the dying person's body, starting with the outer extremities, begins to lose color and cool. Although the skin may be cold, dry, or damp, the patient is usually not conscious of feeling cold, and light bed coverings are usually sufficient. The patient may also have a high temperature as death approaches; this can be treated with Tylenol suppositories and cool compresses.

Involuntary Movements:

Occasionally involuntary or reflex movements may take place. These are rare, but may involve muscles, particular an arm, leg, or face muscle. In addition there may be a loss of control of the bladder or the bowels as these muscles relax.

When Death Occurs:

When breathing and the heartbeat have stopped, the eyes become fixed in position and the pupils dilate. After death there is no rush to do anything and you may sit with your loved one as long as you want. Many families find this a significant time to pray or talk together and reconfirm your love for each other as well as for the person

The dying person may renew a quest for answers to great existential questions. It is not unusual for the person dying to find deep reservoirs of faith that were never suspected before. There is much that a dying person can hope for.

PAIN MANAGEMENT: Myths about Pain

Again let's first look as some myths and try to dispel their messages.

"Dying is always painful."

Many people die without experiencing pain. If pain does occur, it can be relieved safely and rapidly.

"Once you start taking morphine, the end is always near."

Morphine does not initiate the final phase of life or lead directly to death. Morphine provides relief of severe, chronic pain; and it also provides a sense of comfort. It makes breathing easier. It lets the patient relax and sleep. It does not cloud consciousness or lead to death. When used properly morphine does not kill.

There are also several obstacles that often lead us to misunderstanding effective pain management in advanced disease. Narcotics, while dangerous when used for recreational purposes or as a coping substitute, **are very safe when used to control pain.**

Some obstacles are:

- Inadequate education of health care professionals in the use of analgesics;
- Cultural fears about the use of narcotic analgesics;
- Fear of addiction; and
- Fear of overdose.

Consequences of the Failure to Manage Pain

When severe and chronic pain is not managed, the consequences are accompanied by anxiety, fears, impaired sleep, reduced appetite, frustration, depression, memories of past pain, anticipation of pain yet to come and, in some instances, thoughts of suicide. Chronic pain has a strong emotional component that fades as soon as the pain is relieved.

Unmanaged pain gets in the way with the person's ability to address one's place on earth in addition to issues of spirituality or unfinished business. Pain control must come first. Once pain is effectively dealt with, dying people can turn to the more vigorous issues of dying, such as religious or spiritual matters.

who has passed. At home, call us and we will assist you with the final arrangements for your loved one.

The Basic Needs of Dying Persons

- *Assurance* that they will be cared for, that they will not be abandoned.
- *Assistance* in developing and finalizing documents pertaining to terminal care.
- *Information* that will be accurate, timely, and reliable.
- *Communication* that is timely, honest, and open with family, friends, and caregivers: people who will listen. Opportunity to discuss their impending death (if desired) with selected family and caregivers.
- *Excellence* in the delivery of physical care, comfort, privacy, intimacy, sleep, and rest.
- *Management* of pain and other symptoms that is responsive to changing conditions.
- *Permission* to express feelings, both positive and negative; to say "thank you, I love you, I forgive you," as well as to express dissatisfaction, anger, resentment.
- *Opportunity* to explore their finiteness and the spiritual dimensions of life.
- *Opportunity* to discuss preferences about funeral arrangements as well as the impact of dying on survivors.
- *Time* to reflect on the implications of the diagnosis and prognosis, to identify and attend to thoughts, feelings and needs, time to tell their story, to re-affirm their identity and value of their life. Time to reflect on and to grieve prior as well as current losses. Time with selected family and friends. Time to attend to unfinished personal business. Time to plan for distribution of assets and to address their financial responsibilities.

Expanding Goals of Care…….

Dying is not primarily a medical condition, but a personally experienced, lived condition.—William Bartholomew, M.D. 1997, Kansas City (died of esophagus cancer, 2001)

Once the desires of dying persons are understood and accepted, we are then able to refocus the goals of care. Instead of hoping for a cure, the dying person has a right to hope for a comfortable death, free of pain and discomfort. The dying person can retain the hope of finding or re-finding the value of his or her life; of resolving what was previously not able to be resolved; discovering or re-discovering spirituality.

Patients have a Right to Pain Relief

Today, under new regulations of the Joint Committee on Accreditation of Health Care Organizations (JCAHO), hospitals and health care facilities must regularly assess, monitor and manage pain in all patients, or risk losing their accreditation.

Pain is now a fifth vital sign to be recorded with blood pressure, pulse rate, respiratory rate and temperature. However, the sophisticated techniques of pain control developed by hospice physicians need to be known and shared throughout the medical system. Hospice experience testifies that some patients who were bedridden with severe, chronic pain have been able to return to a higher level of physical activity once their pain is properly managed.

Understanding Pain Medications—OPIOIDS (Narcotics)

At one time it was believed that patients would become tolerant to opioids, reducing the drug's effectiveness in controlling pain. Clinical experience shows that patients can take opioid drugs for months or even years, and still obtain adequate relief.

It is true that while patients can become physically dependent if opioids are taken for a long period of time that simply means that they may show signs of withdrawal if taken off the drug abruptly. **This is not an issue for the dying.** Addiction is a term used only to characterize the harmful behaviors of compulsive drug users. Tolerance and physical dependence are often confused with addiction. That confusion is often translated to patients and threatens their right to quality pain management.

There is also the incidence of "pseudo-addiction." Patients in pain may seem to acquire behaviors that are misinterpreted as drug seeking behaviors. They may request increased doses or take more medicine than prescribed. The reality is that studies of cancer patients have linked these behaviors to inadequate dosages of pain medications. Once pain is properly managed, these behaviors stop.

Side Effects:

Opioids and narcotic analgesics have different side effects when administered orally verses through an IV:

Sedation. When properly used, orally administered opioid analgesia brings with it a normal period of sleep. Narcotics exert a calming, relaxing effect through direct sedative action on the brain as well as through relief of pain. Patients often sleep after receiving pain relief because they have been sleep-deprived for days or weeks

When Death is Approaching;

Fluids:

The decreased intake of food and fluids is not painful. On the contrary: the administration of food and fluids to dying patients can add to their general discomfort and frustrate their desire to let go and allow nature to take its course. Allow the patient to dictate his or her desire or lack of desire for food and fluids.

In cases where people cannot swallow, it is standard care to apply moisture in some form to the lips and mouth regardless of whether or not the patient is ever able to swallow again. Ice chips, water, or juice may be given as requested but should be stopped if there is difficulty in swallowing. Care of the mouth is important and part of basic oral hygiene. Vaseline or an other lubricant applied to the lips will prevent drying. Secretions from the mouth can be removed with the tip of a towel by turning the person to the side. Also, running a vaporizer in the patient's room can ease breathing when lung secretions are dry. Fluids that may accumulate in the lungs (pulmonary congestions) can most often be avoided by not forcing fluids on the patient. This includes IV fluids.

When it is determined that the person is actively dying and it is further determined that hydration would only increase the patient's discomfort, the elimination of fluids is not a painful process. Even patients with total bowel obstruction who had been unable to retain any oral fluids and who voluntarily declined intravenous fluids do not complain of thirst or hunger.

There is a side effect of food and fluid decreasing in which one's metabolism changes and the resulting elevated level of ketones produces a mild sense of euphoria, so that hunger and thirst are not the problem we would imagine.

Respiratory: Airway Rattling

As excess fluid accumulates in the patient's lungs, the mucous in the airway makes a "rattling" sound when the patient breaths. Once referred to as "the death rattle," we now have certain drugs to help the patient clear up the rattling. But these drugs can cause discomfort for the patient, such as very dry skin, mouth, and eyes. It is more natural to limit the patient's fluids in the first place. If airway rattling does occur, it can be very loud and often frightening to the caregivers, but is seldom taxing to the patient. This is because by the time the rattling manifests, the patient is often in a coma or semi-coma state and is unaware of any discomfort.

Ways to Help:

Identify the causes; that is the first step to relieving the anxiety. When dying persons know they have trusted people to answer their questions and they know they will be cared for, anxiety diminishes.

- **Establish clear communication;** Patients have a right to know their diagnosis, the prognosis, the treatment alternatives, the side effects of the proposed treatments, and the site of care. Most dying persons, given the choice, prefer to spend their last weeks and months at home. If hospice is not already a part of their care, then this is a good time for the matter of hospice to be raised and discussed. The patient should be involved in this decision and should have all necessary information about hospice.
- **Present options**; when options are communicated, anticipatory anxiety can be reduced. The passage from a "non-dying" person to one who now has limits set on his or her life may take several weeks or months to adjust plus considerable effort for all involved. Knowing the options can help relieve the tension, however anxiety may reappear as the illness progresses.
- **Consider social, psychological and spiritual** needs.

Anxiety that appears more severe than the "normal" anxiety may not be resolved without prescribed medication. There are anti-anxiety medications available in a variety of forms. Some are more sedating than others. The "sedating" anti-anxiety medications are usually reserved for persons with persistent, disabling anxiety.

DEPRESSION

Depression is "a mood disorder lasting at least several weeks in which there is a depressed mood and loss of interest in nearly all activities plus several of the following: change in appetite, weight, and psychomotor activity; decreased energy, feelings of guilt or worthlessness, difficulty thinking, concentrating or making decisions; recurrent thoughts of death, or thoughts or plans of suicide."

Depression in dying persons may be either a result of the person's response to stress or a result of the disease itself, i.e. the treatments designed to halt the disease or the medications prescribed to modify the side-effects of the treatments.

Practical Guidance for Caregivers about the Human Body and the Dying

Bodily Changes of the Dying and What to Do.

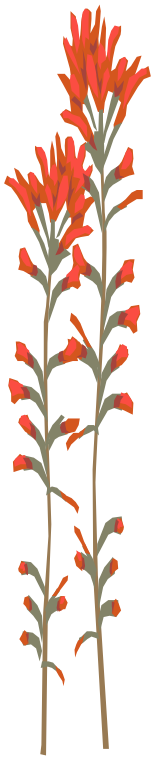
Below are common images of what one may expect when death is approaching. The signs will vary according to the cause of death, the person's general health, medications, and other significant factors.

- **Activity decreases**, with less movement, less communication, less interest in the surroundings. When spending time with the patient remind the patient who you are and what day and time it is, then begin your conversation.

- **Interest in food and water diminishes;** this is a natural occurrence. *We do not die because we stop eating; we stop eating because we are dying.*

- **Vital signs and sensory changes may vary.** Vision may become blurry or dim. Hearing may decrease, but always keep in mind most patients are able to hear you even after they can no longer speak. As vision decreases, leave indirect lights on. Continue to speak and touch the patient with reassuring and soothing words and caresses.

- **Bowel and bladder changes**. Urine may become darker in color and decrease in amount. If the patient has a catheter, your nurse will teach you how to care for it.



- **Circulation is diminished**, and as the blood flow begins to decline, the hands and feet are the first to be affected. They may become darker and more pale than usual and they also may be cold. You may keep patient warm with blankets, but avoid electric blankets and heating pads. They are not necessary for the patient's comfort.

- **Breathing changes** from a normal rate and rhythm into a new pattern, alternating between rapid and slow. Rattling or gurgling with each breath is from secretions in the back of the throat. This may be distressing to listen to, but causes no discomfort for the patient. Ten to thirty second periods may occur with periods of no breathing (apnea). Raising the patient's head may give some relief, with the use of pillows to prop the head and chest at an angle. Hospice nurses have medications to help relieve this symptom which is not distressing to the patient.

It characterizes pain as incapable of relief. That is not true today and the two words should not be so casually partnered.

Suffering is the emotional dimension of pain and an indication that something is seriously wrong. If unmanaged pain at first seems to be the culprit, but the suffering persists even after the pain is relieved, then it is necessary to look elsewhere. Severe pain is not an indispensable part of suffering. Sometimes the fear of the unknown contributes to suffering, or the feeling that one deserves pain as a punishment. In medical circles the assumption that suffering can make you a better person is generally dismissed. The concept of to suffer for the "sake" of good is not a customary conviction.

How to Help:

- Check with your hospice nurse to assure pain management has been instituted.
- Encourage the patient to talk about his/her worries, fears, regrets, and hopes.
- Support the patient in identifying any "unfinished business".
- Create opportunities for communication between patient and hospice team.
- Have the patient develop a "personal history" or "life review."
- Ask your clergy or the hospice chaplain to help identify and assist in spiritual and religious concerns.
- Consider all social, psychological and spiritual needs.

ANGER

Anger is a common emotion observed by those who work with dying persons. The anger may be focused on a person or on the disease itself and may also be diffused through many different situations.

Some persons will seek excuses to express anger or it may be a reflection of the unfairness or powerlessness due to the underlying disease. The fear of pain and death may awaken latent feelings of worthlessness and anger…and suicide may be contemplated.

- Try to develop alternative expressions of anger.
- Identify the sources of anger.
- Evaluate the use of anger with respect to the personality.
- The patient may see the disease as punishment, and be angry at God or the world in general.
- Anger may just be a part of the underlying personality structure of the patient and the stance they have always used when confronting the world.

Death is simply a shedding of the physical body like the butterfly shedding its cocoon. It is a transition to a higher state of consciousness where you continue to perceive, to understand, to laugh, and to be able to grow.
—Dr. Elizabeth Kubler Ross *On Death and Dying*

Most of us have never witnessed someone dying, so it is difficult, both physically and emotionally, to know and accept that someone we are caring for is near death. In general, the human condition portrays definitive physical and emotional symptoms that are a sign of approaching death. As caregivers, if we are alert to these symptoms, we will be better prepared to give our loved one the best possible care in the final days. Knowing these signs will also help caregivers prepare the rest of the family as to what to expect and when.

Let's first try to dispel some myths so we are able to begin with a fresh start on this human process of dying. We must try to keep in mind that death is a personal journey that each individual prepares for in his or her own unique way.

While there are many different paths one can take on this crossing.... they all lead to the same destination...a journey from the known to the unknown.

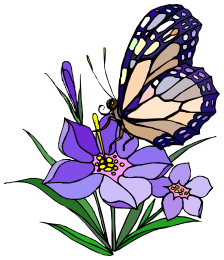
As one comes close to death, a mental and physical process begins. As that process is set in motion, a person starts on a path of discovery, trying to comprehend that death will indeed occur, and that the journey will ultimately lead to the physical departure from the body.

We will discuss what has been found on this topic through research, interviews with hospice nurses, other personnel and general current medical information. Again, as we explore the paths most take; keep in mind that the journey is unique to the traveler taking it.

Myths about Dying

Cultural misconceptions about dying can get in the way with people receiving the best possible care at the end of life. Revealing these as only folklore will help you understand the realities that can allow you to better support the dying person and loved ones.

THREE MONTHS OR LESS:



Your loved one will recognize he or she is dying:
Withdrawal from the world or people.
Loss of appetite, an increase in sleep, and more introspection.

TWO WEEKS OR LESS:

Your loved one will begin to exhibit the acute stages of the dying process:
Disorientation, confusion, and agitation and talking to unseen persons.
Blood pressure decrease. Pulse and temperature increase or decrease.
Color change in skin to a bluish or paling.
Increase in perspiration.
Breathing irregularities and congestion.
Sleeping much more, but still somewhat responsive, body heavy and tired.
Not eating and drinking very little.

DAYS OR LESS:

Two-week signs more pronounced.
A surge of energy, sitting up and talking.
Eyes will become glassy or tear up and may only be half open.
Some may continue to be agitated, while others may cease activity altogether.
Knees, feet, and hands may become purplish and the rest of the skin blotchy.
Pulse weakens and urine slows. Wetting or stooling the bed is not uncommon.

MINUTES:

Breathing sporadically. Cannot be awakened.

While you may have prepared for the final process, you may not be prepared for the actual time. If you think your loved one is close to death or has died, call the Hospice immediately and the nurse who normally visits you or the on-call nurse will come to assist.

Once death has occurred you do not need to call 911 and nothing has to be done before the staff arrives.

The Hospice nurse will notify the physician (and medical examiner if your are in PA). The nurse will call the funeral home once the pronouncement of death has been made.

We're only a phone call away:

Karen Ann Quinlan Hospice

973-383-0115 or 800-882-1117

(If after numerous rings, there is no answer,
please call the answering service directly at 866-574-4112)