Cynthia Smith, RN, BA, MSN, AOCN
Oncology Clinical Nurse Specialist
Harrison Medical Center

The Cancer Control Continuum

Overview of Palliative Care

- To Palliate – to alleviate or to lessen the severity of, without curing (Webster’s)
- World Health Organization (WHO) defines palliative care:
  - The active, total care of patients whose disease is not responsive to curative treatment.
  - Control of pain, of other symptoms, and of psychological, social, and spiritual problems is paramount.
  - The goal of palliative care is to achieve the best possible quality of life for patients and their families.
  - Many aspects palliative care are applicable earlier in course of illness, in conjunction with other anti-cancer treatments.
Common Symptoms During Terminal Illness

- Fatigue (90%)
- Anorexia (85%)
- Pain (75%)
- Dyspnea (79%)
- Nausea (68%)
- Constipation (65%)
- Sedation & Confusion (60%)
- Death rattle (56-92%)
- Xerostomia (10%)

“The art of palliative care encompasses creative strategies to manage pain and deleterious symptoms so that patients can experience a dignified death and focus on more pertinent psychosocial and spiritual issues...”

- Jeannine M. Bryant

Objectives – By the end of this session, attendees will be able to:

- Identify 6 common signs / symptoms of patients with end of life challenges: dyspnea, chronic N/V unrelated to chemo, fatigue, delirium, dry mouth, and secretions
- List the 7 promises of palliative care
- Describe strategies to assist patients / clients to reach their best quality of life – from the perspective of nurses, aides, and family
- Explore physical symptoms that indicate death is approaching and ways to deliver patient-centered comfort care measures

Seven Palliative Care Promises
Making Promises to Patients & Families

1. You will receive good medical treatment

2. You will never be overwhelmed by symptoms

Making Promises to Patients & Families

3. Your care will be delivered with continuity, coordination and comprehensiveness.

4. You & your loved ones will be well-prepared and will not surprised by what occurs.

Making Promises to Patients & Families

5. Your care will be customized to reflect your preferences

6. We will provide you with resources, including: financial, practical and emotional

Making Promises to Patients & Families

7. We will do all that we can to see that you and your family will have the opportunity to make the best of every day.
   - You will be treated as a person, not a disease: what is important to you is important to the care team.
   - Your care team will respond to the physical, social, psychological and spiritual needs of patient / family.
   - Family will receive support before, during, and after the patient’s passing.
Respect Patient Goal, Preferences and Choices

- Palliative care is an approach to care that is patient-centered; address pt. needs in context family, community.
- Recognizes that family constellation is defined by the pt. encourages family plans, provide care to extent pt. desires
- Identify & honor preferences patient / family. Pay careful attention: values, goals, priorities, cultural / spiritual issues
- Assists patient establish goals of care: promote diagnosis, prognosis understanding; clarify priorities, enhance informed choices; provide opportunity to negotiate provider care plan.

Respect Patient Goal, Preferences and Choices

- Strives to meet patient preferences about care settings, living situations and services, recognizing the uniqueness of these preferences & barriers to accomplishing them.
- Encourages advance care planning, including ADs, through ongoing dialogue among providers, patient and family.
- Recognizes potential for patient, family, providers & payor conflict; develops processes to work toward resolution.

Comprehensive Caring

- Appreciates that dying, while a normal process, is a critical period in the life of patient & family, and responds aggressively to the associated human suffering while acknowledging the potential for personal growth.
- Places a high priority on physical comfort and functional capacity, including, but not limited to: expert management of pain & other symptoms, diagnosis / treatment of psychological distress; assist to remain independent as possible or desired.

Supportive Care Topics Seen In Dying & Death

- Hospice and palliative care
- Pain
- Elimination
- Dyspnea
- Anorexia / cachexia
- Nausea and vomiting
- Dehydration
- Depression and anxiety
- Delirium
- Social support
- Spiritual and cultural
- Bereavement
Hospice and Palliative Care

- Hospice and palliative care involve a team-oriented approach to expert medical care, symptom management, emotional and spiritual support (NHPCO, 2003).

- **Hospice**
  - Provides care for client and family when client is terminally ill
  - Provides interdisciplinary support and care

- **Palliative care**
  - Approach that improves quality of life for client and family when dealing with life-threatening disease (WHO, 2003)
  - Focuses on symptom management, comfort, and support

Assessment

- Collaborate with physician.

- Evaluate client’s understanding of the disease trajectory and treatment options.

- Determine if client has advance directive or surrogate decision maker.

- Evaluate goals for care; emphasize symptom management.

- Assess symptoms.

Interventions: Hospice & Palliative Care

- Establish a therapeutic relationship

- Complete holistic assessment

- Consult palliative care team

- Provide symptom management

- Ensure client & family recognize the possibility of hospice care

- Inform client, family of appropriate agencies; complete referral

- Obtain informed consent from client for hospice care

Pain

- Cancer pain may be acute, chronic, or intermittent (American Pain Society, 1999).

- **Barriers**
  - Family / patient
  - Provider
  - System

- **Assessment**
  - Use pain assessment tools; non-verbal as indicated
  - Checklist of Non-verbal Pain Indicators (CNPI)
  - Pain Assessment in Advanced Dementia (PAINAD)
  - Numeric Rating Scale; Faces; Modified Faces
  - Critical Care Pain Observation Tool
  - Obtain history of drugs used & extent of pain control
  - Assume pain present with painful procedures
Management of Pain

- Pharmacologic interventions (opioids, adjuvant medications, and injections)
- Other invasive interventions (radiation, radiopharmaceuticals)
- Non-pharmacologic interventions i.e. physical, behavioral, and psychiatric. Multi-modal therapy is the new buzz word
- Be on the alert for opioid-induced neurotoxicity; may see hyper-algesia and/or allodynia. Opioid rotation / excess hydration may be required to manage myoclonic / dystonic reactions, seizures and uncontrolled pain.

Interventions: Pain

- Instruct client and family on pain control regimen.
- Collaborate with physician regarding drug treatment.
- Consult physician regarding invasive interventions.
- Consider referral to pain team or clinic.
- Teach and evaluate psychologic interventions.
- Use complementary interventions.

Dyspnea (Breathless Sensation)

- “Uncomfortable awareness of breathing or shortness of breath”
- Occurs days to weeks before death in up to 79% patients
- Similar to pain
  - “Multi-dimensional”: complex issue, many causes
  - “Subjective” – occurs when the patient says it does
- Subjective symptoms often occur without measurable changes in oxygen or carbon dioxide saturation values

Causes of Dyspnea (Breathless Sensation)

- Something blocking the airways
  - Tumors, fistulas
  - Chronic bronchitis or bronchospasms / infection
- Reduced capacity of lung
  - From surgery, tumor, fibrosis
  - Fluid pooling (effusions), pneumothorax (lung puncture), infection
- Poor ventilation
  - General or chest wall weakness
  - Motor impairment
  - Pressure on diaphragm RT fluid build-up (ascites) / enlarged liver
- Anemia
- Anxiety
Identifying and Assessing Dyspnea (Breathless Sensation)

• Count respirations – too fast or too slow – both are problems for patient (not enough O2; too much CO2)
• Evaluate respiratory pattern (regular, irregular, apnea)
• Obtain history
  – Did this start suddenly or was it a slow, gradual onset?
  – Impact on activity – Can they walk, care for self, eat, bathe, dress?
  – Frequency, duration – How long does it last?
  – Do they have a cancer that has spread to or started in the lungs?
• Subjective symptoms (What the patient expresses / says)
  – Do they feel weak?
  – Do they feel like they are suffocating or that an elephant on chest?
  – Describe chest as “tight”?
  – Is the shortness of breath creating feelings of anxiety or panic?

Management of Dyspnea (Breathless Sensation)

• Goal: Change or reduce breathless sensation
• General symptom measure: Consider O2 therapy
• Non-pharmacologic interventions
  - Position patient upright
  - Use overhead / bedside table to support arms and upper body
  - Raise head of bed or add pillows
  - Pace activities: rest periods, change times
  - Cool fan blowing breeze on patient

Dyspnea: General Symptomatic Measures (Non-pharmacologic)

• Breathing Techniques
  – Pursed lip breathing
  – Diaphragmatic breathing
• Distraction - massage, music, movie, internet, progressive relaxation exercise
• Reassurance – very frightening experience like drowning
• Treat Pain

Dyspnea: Pharmacologic Management

Opioids
– Morphine Sulfate & other opioids are the most useful drugs in treatment of dyspnea
– Obtain order for morphine 5-10 mg PO / IV / SQ q 4 hr; titrate to effect
– Pt. already on morphine—increase dose by 25-50%
– Nebulized morphine or hydromorphone (Dilaudid)
  • Works to block vagus nerve receptors / Fast onset (2.5 min.)
  • Morphine 5-20 mg in NS nebulized with air or O2 q 4 hr
  • Titrate to effect
  • Add albuterol if wheezing; may experience bronchospasms
### Dyspnea: Pharmacologic Management

**Obtain order for corticosteroids**
- May improve dyspnea associated with cancer in lungs
- Start with larger doses so do not miss a therapeutic effect; however, wean to minimum effective dose in a few days

Examples of corticosteroids and doses
- Prednisolone 40-60 mg/d PO
- Dexamethasone 8-12 mg/d PO

---

**Anxiety:**
- Benzodiazepines may reduce dyspnea (anxiolytic and sedative effect)
  - Diazepam 2 mg po q 8 h (5-10 mg at HS)
  - Lorazepam 0.5-2 mg PO / IV / SL

---

**Anticholinergics (for excessive secretions)**
- Scopolamine 0.4-0.8 mg IM q 4 h; 0.8-2.4 mg/d SC infusion or injections
- Scopolamine patch (NOTE: onset of action delayed for several hours)

---

### Anorexia / Cachexia

**Anorexia:**
- Decrease in appetite resulting in weight loss (Abrahm, 2000)

**Cachexia:**
- Metabolic syndrome associated with cancer that results in loss of fat, muscle, and bone minerals (Kemp, 2001)

**Assessment**
- Explore the meaning of not eating with the client and family.
- Identify factors that discourage eating.
- Obtain dietary history.
Interventions: Anorexia / Cachexia

• Help family understand nutritional limitations (Kemp, 2001).
• Explain possible causes of anorexia/cachexia.
• Inform caregiver that the client is not able or is unwilling to eat.
• Suggest small meals, liquid supplements.
• Treat symptoms that may contribute (e.g., nausea).
• Consider appetite stimulant if appropriate (Abrahm, 2000) e.g. Marinol, Cesamet, Megace. Prokinetic stimulant e.g. Reglan.

Chronic Nausea and Vomiting Unrelated to Chemotherapy

• N/V affects up to 70% of patients with advanced cancer; however, nausea is more common.
• Chronic nausea is defined as lasting more than 1 week without identifiable precipitating factors.
• Causes include underlying cancer and its progressive effects as well as medication use (e.g. opioids).

Assessment
• Ask about duration, frequency of vomiting episodes, and the ability of the patient to keep fluids down: all affect selection of drug route.
• Delayed N/V due to chemotherapy is possible.

Chronic Nausea and Vomiting Unrelated to Chemotherapy: Mechanisms

• Nausea and vomiting reflex found in the medulla; relays stimulus to the dorsal motor nucleus of the vagus to cause vomiting.
• Afferent input comes from the chemoreceptor trigger zone, vagus nerve, cortex, and vestibular pathways.
• Neurotransmitters found in areas critical to emetic reflex include: dopamine, serotonin, histamine, substance P, & acetylcholine; blocking these neurotransmitters is the basis of antiemetic therapy.

• Large-volume emesis suggests gastric or bowel obstruction, whereas polydipsia, polyuria, and cognitive changes suggest metabolic causes.
• Constipation can also cause nausea.
• Papilledema suggests brain metastasis, whereas orthostatic changes suggest autonomic insufficiency.
Management: Chronic Nausea / Vomiting unrelated to Chemotherapy

Non-pharmacological.
• Surgery may be considered in cases of mechanical bowel obstruction. However, surgery should be individualized, with physicians weighing risks / benefits of the procedure.
• Use of acupuncture to treat N/V in advanced illness has not been conclusively proven as best practice
• Lavender aromatherapy & use of ginger are being studied
• Cold compresses on neck (sides, back) may be helpful
• Some people wear copper bracelets to manage N/V

Management: Nausea and Vomiting

• Palliative treatment most often consists of anti-emetics, dietary manipulation, and behavioral interventions.

• Combining anti-emetics from different classes seems to improve efficacy of the individual drugs.

• Bowel obstructions may be treated conservatively with anti-emetics, stool softeners, and soft or liquid diets.

Interventions: Nausea and Vomiting

• Treat causes of nausea and vomiting.
• Use anti-emetics.
• Educate client and family on medications.
• Suggest dietary changes.
• Limit sights, sounds, smells that affect vomiting.
• Provide fresh air.
• Provide distraction and relaxation.
• Report signs of bowel obstruction and treat.
Hiccups: Causes

• Diaphragmatic Irritation
  – Malignant infiltration
  – Inflammation/infection
  – Hepatomegaly, ascites

• Gastric distention obstruction/compression
  – Obstruction, gastric tumor

• Esophagitis

• Phrenic nerve irritation (mediastinal tumor)

• Intracranial disease (cerebellar or medullary tumor)

• Metabolic (uremia, hyponatremia, hypocalcemia)

• Meds (Benzodiazepines, Barbiturates, IV corticosteroids)

Hiccups: Nursing Interventions

• Vagal, pharyngeal stimulation
  – Swab, NG tube
  – Massage external auditory meatus
  – Sneezing

• Elevation of pCO₂

• Reduce gastric distention
  – Aerated drink
  – Peppermint water
  – Metoclopramide
  – NG tube

• Pharmacological
  – Chlorpromazine (10-25 mg PO Q 6 h)
  – Baclofen
  – Haldol
  – Midazolam (if sedation not a concern)

Dehydration

• Dehydration in terminally ill clients may be considered predictable (McAulay, 2001).

• “There is no consensus among experts on whether it is physically, psychologically, socially, or ethically appropriate to provide artificial hydration or nutrition to a terminally ill patient” (Kedziera, 2001).

Assessment: Dehydration

• Assess client’s intake and output.

• Evaluate client’s and family’s wishes for intervention.

• Assess condition of client’s mouth.
Interventions: Dehydration

- Recognize complex issue of whether to hydrate.
- Recognize family needs and respect wishes re: hydration.
- Initiate hydration if appropriate.
- Teach oral care every 2 hours (Kedziera, 2001).
- Provide small amounts of fluids or ice chips for comfort.
- Describe possible positive effects of dehydration.
- Discuss disadvantages of hydration.

Terminal Dehydration

- As patient approaches death, desire to consume food decreases
- Dehydration predictable
- Emotional & ethical dilemma in palliative care
  - Families/care providers find it difficult to hold
  - May feel they are starving patient or causing suffering
  - Experience sense of guilt, frustration, lack of control over death
- However, may lead to enhanced comfort

Terminal Dehydration: Interventions

- Describe possible positive effects of dehydration
- Discuss disadvantages of hydration (invasive procedure, increased heart & lung workload, possible need for Foley catheter, may decrease comfort)
- Recognize family needs and respect wishes if they choose hydration
- Oral care every 2 hours to moisten mouth and protect mucous membranes

Terminal Dehydration: Nursing Interventions

- Describe possible positive effects of dehydration
- Discuss disadvantages of hydration (invasive procedure, increased cardio/pulmonary load, possible need for catheter, may decrease comfort)
- Recognize family needs and respect wishes if they choose hydration
- Oral care every 2 hours to moisten mouth and protect mucous membranes
Delirium

- Characterized by an alteration in the level of consciousness that may occur abruptly and may fluctuate throughout the day (Sivesind & Baile, 2001)

- Possible causes (disease, medications, infection, and metabolic changes) (Block, 2001)

- **Assessment**
  - Assess for delirium, which may be manifested as agitation and restlessness.
  - Review medications that may contribute to delirium & agitation.
  - Note degree of agitation and the effects on the family.
  - Assess for safety.

---

Delirium: Identification and Treatment

- Delirium is a clinical emergency characterized by changes in consciousness, hallucinations, and changes in the sleep–wake cycle and language.

- Delirium is frequently seen in advanced cancer patients: drugs, infection, brain metastasis, and underlying dementia may all play a role.

- Experiencing delirium causes family distress, as delirious patients cannot communicate pain levels or other symptoms and may be unable to take part in health care decisions.

---

Delirium: Identification and Treatment

- Delirium differs from dementia: dementia does not have acute alterations in consciousness.

- Delirium is classified according to level of agitation; for example, an agitated patient has hyperactive delirium; patient who is withdrawn / somnolent has hypoactive delirium. Commonly see mix of both.

- Prevalence rates for delirium range from 30% to 50% for hospitalized patients and is typical in the hours or days before death. May be reversed 50% of time.

---

Causes of Delirium

- Delirium results from underlying disorders that cause imbalances in brain neurotransmitters.

- Neurotransmitters involved in delirium include dopamine, glutamate, norepinephrine, acetylcholine, γ-aminobutyric acid, & serotonin.

- Cytokines (interleukin-1, IL-2, tumor necrosis factor, interferon) produced by immune system, tumor, or cancer treatment may create central nervous system effects, e.g. somnolence, agitation & cognitive decline.
**Delirium: Identification and Treatment**

- A history of patient’s baseline mental status prior to symptom onset should be obtained from his or her family, caregivers, or both parties.
- Fluctuating consciousness is hallmark of delirium. Assessment tools can screen and/or rate delirium

Commonly used tools for screening:
- Mini Mental State Examination
- Confusion Assessment Method

Commonly used tools to rate severity
- Memorial Delirium Assessment Scale
- Disability Rating Scale

**Delirium: Establish Cause**

- **Non-pharmacological.**
  - Identify reversible causes (50% of cases)
  - Includes: infection, dehydration, drug and metabolic abnormalities, fecal impaction, UTI
- Evaluate cancer patients for brain metastasis.
- Common drugs that may precipitate delirium episodes include: opioids, anticholinergics, benzodiazepines, steroids, and some chemotherapy agents.

**Delirium: Management Approaches**

CIWA interventions / algorithm
- Inquire about alcohol intake, as alcohol withdrawal can precipitate delirium
- Responds to benzodiazepines, clonidine.

Other non-pharmacological approaches to delirium are:
- Keeping room lights on
- Have calendars and pictures at the bedside
- Frequent redirection
- Allow patients to participate in their care.

**Delirium Management: Common Drugs**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage</th>
<th>Adverse Events</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol</td>
<td>0.5 mg orally 2–3 times a day (oral) or 1–2 mg intravenous / subcutaneous every 30 min to 1 h until agitation resolved</td>
<td>Acute extrapyramidal events (eg, torticollis, oculogyric crisis, tongue and laryngeal spasm)</td>
<td>Moderate to moderately agitated elderly patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Severe agitation in patients aged &lt; 60 y</td>
<td></td>
</tr>
<tr>
<td>Risperidone</td>
<td>1 mg orally each day or every other day</td>
<td>QT interval and cardiac arrhythmia</td>
<td>Potent dopamine blocker</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>2.5–11 mg daily</td>
<td>QT interval and cardiac arrhythmia</td>
<td>Very anticholinergic</td>
</tr>
<tr>
<td>Quetiapine</td>
<td>25–75 mg orally every day</td>
<td>QT interval and cardiac arrhythmia</td>
<td></td>
</tr>
<tr>
<td>Lorazepam</td>
<td>0.5–1 mg intravenous/subcutaneous</td>
<td>Do not use alone. Useful for severe agitation in conjunction with haloperidol</td>
<td></td>
</tr>
</tbody>
</table>
### Interventions: Delirium
- Treat reversible causes.
- Provide a calm environment and minimize disturbances.
- Teach family safety precautions.
- Support family with additional help.
- Provide respite in a facility for client and family.
- Use medications when appropriate.
- Minimize disturbances in the environment.
- Provide explanations and support to family.

### Depression and Anxiety
- Factors related to psychologic distress (anxiety, depression, and neurocognitive changes) (Sivesind & Baile, 2001).
- Clients at the end of life may experience anxiety (Pasacreta et al., 2001).
- Depression and anxiety are appropriate to the stress of having a serious illness (Pasacreta et al., 2001).

### Assessment: Depression and Anxiety
- Recognize evidence of depression such as hopelessness, helplessness, worthlessness, guilt, and sustained suicidal ideation (Block, 2001).
- Assess for anxiety (Sivesind & Baile, 2001).
- Review medications for drugs that may contribute to anxiety such as steroids.
- Assess for suicide plan.

### Interventions: Depression and Anxiety
- Use antidepressants or antianxiety medications.
- Consider need to refer to mental health care provider.
- Use holistic communication skills e.g., active listening (Klagsbrun, 2001).
- Seek immediate help if suicidal ideation.
- Identify support systems and referrals to community agencies.
- Discontinue medications or change doses of drugs that may contribute to anxiety or depression.
Social Support

Seven dimensions
- Redefining roles within family, dealing with burden of caring for the family member, struggling for paradox of living and dying, contending with daily life, searching for meaning, living day to day and attempting to enjoy the time left, and preparing for death in concrete ways (e.g., legal, financial)

• Important to assess the family as a system (Goetschius, 2001).

Assessment: Social Support

• Assess family functioning and structure.
  - Assess strengths such as members with health care training or weaknesses such as frail caregiver.
  - Assess knowledge deficits in end-of-life care.
  - Collaborate with the social worker to complete a family assessment

Interventions: Social Support

• Strengthen family
  - Encourage communication among family
  - Respect the privacy of family
  - Provide access to resources for family needs
  - Spend time with family (Goetschius, 2001)

• Teach caregiving skills to primary caregiver
  - Teach and demonstrate technical skills

• Help client redefine long-term goals, set immediate goals

• Families desire a few basic interventions from the nurse.

Spiritual and Cultural

• Spirituality involves finding meaning, finding hope, defining relatedness, finding forgiveness.

• Spirituality and religion are complementary but not identical concepts (Highfield, 2000).

• Culture identifies a group of people with similar values, norms, lifestyles, rules, language, beliefs.

• Spirituality and culture overlap (Taylor, 2001).
Assessment: Spiritual and Cultural

• Assess for spiritual distress and needs.
• Identify religious practices that have meaning for the client.
• Assess for cultural values that may impact the client’s terminal care.
• Assess for personal beliefs and practices that the client regards as important.

Interventions: Spiritual and Cultural

• Recognize spiritual and cultural values of client and family.
• Allow client to talk about spiritual concerns (actively listen, remain non-judgmental).
• Encourage family to remain present with client.
• Share information about fears, guilt, doubts.

Imminent Death

• Continuous process since multi-organ failure occurs and physical signs may occur gradually over weeks or months or rapidly over days

• Factors related to imminent death
  - Pain, dyspnea, restlessness, and agitation are the physical symptoms requiring maximum care in the hours and days before death occurs (Berry et al., 2002).
  - Support the family during dying process (Berry & Gribbie, 2001).
  - Dying is a continuous process once multi-organ failure occurs (Arnold, 2001).
  - Emotion, cognition, thinking behaviors, and autonomic function all slowly deteriorate; coma usually occurs before death (Berry & Gribbie, 2001).

Assessment: Imminent Death

• Assess for signs of impending death (Berry & Gribbie, 2001; Matzo & Sherman, 2001).
• Assess caregiver knowledge related to recognition of impending death.
• Assess for symptom control.
• Assess for unrelieved pain and suffering not controlled with usual interventions.
Interventions: Imminent Death

• Ensure all comfort measures are provided (e.g., medications, mouth and skin care).
• Use medications to relieve symptoms.
• Consider sedation if appropriate.
• Educate family on symptoms of impending death.
• Plan with the family for the death event.

Family Teaching: How Tell Death is Imminent?

• Although we can never predict the exact time a person will die, we know when the time is getting close by a combination of signs & symptoms
• Not all of these signs will appear at the same time, some may never appear
• All of the signs described are ways the body prepares itself for the final stages of life.

Physiologic Changes

• Skin becomes cooler (hands, arms, feet & legs); skin color may change to a bluish color / purplish splotches
  – Normal indication that circulation is decreasing to extremities and being reserved for vital organs
  – Keep warm with blankets (no electric)
• Respiratory Congestion (“Death Rattle”)
  – Gurgling (“as though marbles rolling around”)
  – Normal due to decreased fluid intake, lack of effective cough
  – Suctioning may increase secretions & discomfort
  – Gently turn patient’s head to side
  – Sound of congestion does not indicate pain

Physiologic Changes

• Incontinence
  – May lose control of urine and/or bowels as the muscles in that area begin to relax
  – Discuss measures to keep patient clean & dry
• Decreased urine output
  – Urine output normally decreases and becomes tea color (concentrated urine)
  – Due to decreased fluid intake & decrease circulation through the kidneys
Physiologic Changes

- Breathing pattern changes
  - Apneic periods: spaces 10-30 seconds where there is no breathing at all
  - Cheynes-Stokes respirations: irregular shallow breaths with periods of up to 5-30 seconds and up to full minute of no breathing
  - Common, indicate decrease circulation in internal organs
  - Elevating head and/or turning may increase comfort

Changes in Mentation / Affect / Cognition

- Increased sleeping
- Disorientation
- Restlessness
- Withdrawal
- Vision-like experiences

How Family Can Help With Care

- Music
- Assist with turning every few hours, reposition head on pillows
- Massages, lotion rubs
- Washcloths placed inside patient’s hand
- Avoid bright lights, loud noises
- Moisten lips, lip salve or lip balm / Oral care

Plan with Family for Death Event

- Who does the family want to notify? (make list with phone numbers)
- Notify chaplain or social worker?
- Requirements regarding pronouncement at time of death
- Funeral arrangements made?
Bereavement

• Bereavement is a human experience occurring with the death of a loved one (Corless, 2001).

• Tasks of bereavement include accepting the reality of the loss, experiencing the pain of grief, and adjusting to the new environment.

• Manifestations of grief associated with loss of loved one are many.

Assessment: Bereavement

• Assess family for risk factors associated with unresolved grief – creates “complicated” grief.

• Evaluate family members for manifestations of grief.

• Assess social support available to family.

Interventions: Bereavement

• Encourage family and friends to say good-bye to client.

• Provide time for family and others to relive traumatic event of death.

• Add to stability of the family’s social world.

• Ensure bereavement follow-up.

References


### Nursing Diagnoses: Death and Dying

- Impaired Comfort/Pain
- Constipation, diarrhea, or urinary elimination
- Deficient Knowledge related to pain, dyspnea
- Ineffective Role Management
- Impaired Skin Integrity
- Deficient Fluid Volume
- Impaired Gas Exchange
- Imbalanced Nutrition
- Anxiety, fear

### Nursing Diagnoses: Death & Dying (continued)

- Acute Confusion
- Spiritual Distress
- Impaired Oral Mucous Membrane
- Activity Intolerance
- Ineffective Client and Family Coping
- Deficient Knowledge RT care of client with terminal disease
- Caregiver role strain
- Anticipatory Grief

### Outcome Identification: Death and Dying

- Client will have symptoms controlled.
- Client will choose a hospice/palliative care program.
- Client will receive care appropriate for client & family goals.
- Client will meet goals for pain relief.
- Client has adequate knowledge related to pain regimen.
- Client will participate in ADLs.
- Client will have normal bowel and urinary elimination pattern.

### Outcome Identification: Death & Dying (continued)

- Client will have moist / intact oral mucous membranes.
- Client will report a reduction in level of anxiety.
- Client will be able to manage episodes of dyspnea.
- Client will eat what he or she wants.
- Client avoid inappropriate parenteral / enteral nutrition
- Client will control nausea and vomiting.
- Client will be adequately hydrated.
Outcome Identification: Death & Dying (continued)

- Client will be comfortable at time of death.
- Client will verbalize a reduction in fear and anxiety.
- Client will be calm and suffer a minimum amount of agitation before death.
- Client receives adequate support & is prepared for death.
- Client will die with dignity.
- Family will complete the tasks of bereavement.

Evaluation

- Oncology nurse systematically and regularly evaluates client’s and family’s responses to interventions to determine progress toward the achievement of expected outcomes.
- Relevant data are collected, and actual findings are compared with expected findings.
- Nursing diagnoses, outcomes, and plans of care are reviewed and revised as necessary.