GOALS/OUTCOMES:

A. Patient will demonstrate outcomes below:
   1. Comfort/Pain control.
   2. Peace and preservation of dignity during the dying process.

B. Patient/family/significant other (S.O.) will verbalize and/or demonstrate an understanding of teaching/learning goals listed below: (Document evaluation on Education Outcome Record).
   1. Personal signs/symptoms related to the dying process.
   2. Methods to promote comfort.
   3. Techniques to modify and/or prevent distressing symptoms.
   4. Healthy coping methods (e.g., verbalize feelings, problem solving techniques).
   5. Lifestyle alterations, present and future (e.g., family role changes, life review).
   6. Generic Goals (room/unit routine, pain, medication, diagnostic tests/procedures, dietary modification, hygiene/infection prevention, rehabilitation, medical equipment/supplies, tobacco cessation, resources for support).

ASSESSMENT/INTERVENTIONS/CLINICAL REASONING/DECISION-MAKING:

A. Assess and document readiness and ability to learn, learning needs and preferences. (Refer to Teaching/Learning Assessment on Education Outcome Record).
B. Collaborate with resources related to significant changes in patient status and for the continuum of care (e.g., Family Members, Nursing, Physician, Pastoral Care, Social Work/Services, Pharmacy, Palliative Care Team, Advanced Practice Nurse, Ethicist, Hospice Liaison, Child Life, Medical Interpreter).
C. Mutually plan/develop goals, assess and document progress toward goals.
D. Implement appropriate interventions as follows and document:

1. Correlate physical status and presence of distressing symptoms to disease process, medications and baseline assessment data. Provide comfort and manage distressing symptoms:
   - Pain: Develop plan for pain control including pharmacologic and nonpharmacologic measures (e.g., medications, positioning, heat/cold applications, music, guided imagery, environmental adjustments).
   - Dyspnea: Evaluate respiratory status and provide supportive interventions [e.g., fan to face for air movement; position to promote ventilation/perfusion, mobilization or reduction of secretions; evaluate the need for medications/oxygen (O₂)].
   - Dysphagia: Evaluate safety of oral intake and the need for dietary modifications (e.g., ice chips, fluid sips, hydration; patient request for favorite foods).
   - Gastrointestinal Distress:
     - Nausea and vomiting (N/V): prevent and/or treat [e.g., elimination of noxious odors, provide adequate oral care, dietary consultation, reassurance to patient that opioid-induced nausea can be temporary, antiemetics chemoreceptor trigger zone (CTZ) inhibitors, agents to promote gastric emptying, 5HT3-receptor antagonists], possible opioid rotation, adjustments to IV fluids/enteral feeding, evaluate the need for nasogastric tube].
     - Constipation: prevent constipation, obstitution/fecal impaction via appropriate levels of hydration, providing privacy for defecation, scheduled use of stool softeners and laxatives.
     - Diarrhea: review use of laxatives and other medications (e.g., magnesium-containing antacids, antibiotics, chemotherapeutic agents) as patient nears end of life. Assess for fecal impaction.
     - Ascites: anticipate sodium restricted diet, fluid restriction, diuretic management and paracentesis.
   - GI/genitourinary (GU) elimination:
     - Incontinence: support GI/GU elimination with appropriate measures to protect skin (e.g., skin barrier cream, padding for incontinence, indwelling catheter, male external catheter)

• **Urinary retention**: assess via physical examination or postvoid residual ultrasound. May be caused by denervation disorders, spinal cord compression and/or by bladder outlet obstruction. Condition may be exacerbated by various medications. Provide for complete emptying of bladder via either intermittent or indwelling urinary catheter.

• **Bladder spasms**: may be caused by irritation of bladder trigone, radiation, infection, blood/clots, stones, catheters, or tumor invasion. Cause-directed interventions include deflation of catheter balloon, treatment of urinary tract infection (UTI) with antibiotics, increased fluids (if possible) to relieve discomfort, or antispasmodics.

• **Delirium**:
  - Develop plan to relieve symptoms of delirium [e.g., evaluate current psychoactive medications; hydration status; adjust environmental stimuli (e.g., provide familiar objects/persons, soothing music, reduce noise, lighting)].
  - Evaluate the need for pharmacologic management.
  - In patients suffering delirium due to underhydration, anticipate bolus IV hydration or hypodermoclysis (HDC-subcutaneous hydration method).

• **Opioid-related side effects**:
  - **Pruritis and flushing**: anticipate need for antihistamines.\(^4\)
  - **Myoclonus**: assess for presence of multifocal myoclonus and provide comfort measures (e.g., positioning, pillow support, anticipate the need for pharmacologic management with benzodiazepines and/or opioid rotation).

2. **Correlate patient/family/S.O. psychosocial and spiritual needs to dying process and provide supportive interventions**:
   - Support patient expression of end-of-life care choices (e.g., termination of life sustaining measures, hospice care, dying at home).
   - Identify with patient/family/S.O. any unresolved personal or spiritual issues and the need for spiritual assistance based on patient’s associations/beliefs.
   - Identify behaviors that demonstrate ineffective coping and assist patient/family/S.O. with decision making/coping strategies.
   - Support family in their interactions with dying person (e.g., providing privacy, assist in personal care, presence according to patient preference).
   - Facilitate life review bringing emphasis to dying person’s positive contributions and place in the family.
   - Provide factual information about patient’s status to patient and/or family, along with appropriate printed materials suitable to developmental level, cultural preferences and communication patterns.
   - Utilize counseling to promote discussion of fears/concerns and impact of this person’s dying.
   - Support the family/S.O. in maintaining own health (e.g., eating well, adequate rest, physical activity, routine).

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A. DEFINITION: Patient has life expectancy of only a few days or hours and is expected to die during this hospitalization. Changes are largely physical, but the process influences, and is influenced by, all spheres of personhood and relationships.

B. RELATED/RISK FACTORS ASSOCIATED WITH A DIFFICULT DYING PROCESS:

PERSONAL
- Age/developmental level
- Personality (e.g., optimist, accepting, controlling)
- Values/beliefs (e.g., mortality)
- Culture/religion (e.g., hope, future beyond dying, fatalist)
- Emotional state (e.g., depression, anxiety, grief history, fear, denial, anger)
- Emotional bonds/support, completion of relationships
- Unresolved personal conflicts
- Family role (e.g., decision maker, provider, caregiver, parent or child)
- Family dependencies (e.g., financial, care giving, leadership)
- Spiritual or existential distress
- Self-worth, life review
- Family communication patterns

ENVIRONMENTAL
- Intensive care (e.g., sensory overload, limited visiting opportunity, philosophical stance of staff in delivery of care, staff level of comfort conveying “bad news”)
- Inconsistencies of personnel in enforcement of hospital’s “house rules” (e.g., visiting hours, overnight stays, number of visitors in room)
- Lack of/separation from interpersonal or spiritual support systems

PHYSIOLOGICAL
- Complexity of condition
- Ventilator-dependent
- State of consciousness
- Unmanaged distressing symptoms (e.g., pain, shortness of breath, intractable N/V)

TREATMENT RELATED
- Medication induced delirium
- Body chemistry alterations (e.g. fluid/electrolyte imbalance) due to drugs, disease or treatments (e.g., radiation, chemotherapy).

C. SIGNS AND SYMPTOMS:

Common Symptoms:
- Profound weakness
- Dependency in all activities of daily living
- Reduced awareness, insight, perception
- Drowsiness for extended periods of time
- Shortened attention span
- Frequently disoriented regarding time and place
- Disinterest in/withdrawal from daily routines and social contacts
- Disinterest in/withdrawal from food or fluid intake
- Progressive difficulty swallowing
- Gaunt and pale or gray physical appearance
- Vital sign changes: dropping BP, increased heart rate, cool extremities/mottling of dependent areas, erratic variations in body temperature
- Irregular respiratory pattern, variations of rate/depth with compromised oxygenation
- Inability to clear oral secretions
- Bowel incontinence/constipation/impaction.
- Bladder incontinence/spasm/urinary retention
- Heightened awareness of life transition

Distressing Symptoms:
- Pain
- Dyspnea
- N/V
- Delirium
- Terminal agitation/restlessness
- Multifocal myoclonus
D. PATHOPHYSIOLOGY OF SYMPTOMS:

- **Delirium**: sudden, fluctuating, and usually reversible cognitive disorder characterized by disorientation, the inability to pay attention, the inability to think clearly, and a change in the level of consciousness. Delirium is an abnormal mental state, not a disease. It may be caused by tumor, cerebral edema, presence of opioid metabolites, renal or hepatic failure. Hyperdelirium presents with agitation or restlessness. Hypodelirium presents as confusion or sedation.\(^5\) \(^6\)

- **Pruritis and flushing**: severe itching related to opioid-induced histamine release.

- **Ascites**: pathologic accumulation of fluid in peritoneal cavity resulting in abdominal pain/discomfort, anorexia, dyspepsia, dyspnea and lower extremity edema.\(^7\)

- **Myoclonus**: twitching or clonic spasm of a muscle or group of muscles.

E. SAFETY CONSIDERATIONS AND INITIATIVES:

1. **Pain**:
   - **The Joint Commission 2009 Hospital Accreditation Standards**:
     - **Provision of Care**: Standard PC.01.02.07: The hospital assesses and manages the patient’s pain.
     - **Rights and Responsibilities of the Individual**: Standard RI.01.01.01: The hospital respects patient rights
     - **Assessment of Patients**: Standard AOP.1.8.2: All patients are screened for pain and assessed when pain is present.
     - **Patient and Family Education**: Standard PFE.4: Patient and family education include the following topics, as appropriate to the patient’s care: the safe use of medications, the safe use of medical equipment, potential interactions between medications and food, nutritional guidance, pain management and rehabilitation techniques.


2. **End of Life/Palliative Care**:
   - **The Joint Commission 2009 Hospital Accreditation Standards**:
     - **Provision of Care**: Standard PC.02.02.13: The patient’s comfort and dignity receive priority during end-of-life care
     - **Rights and Responsibilities of the Individual**: Standard RI.01.05.01: The hospital addresses patient decisions about care, treatment, and services received at the end of life

F. Refer to Grieving, Actual/Anticipatory; Acute Pain and Spiritual Distress Clinical Practice Guidelines.

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