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Death and Dying Education Bundle for Nurses

End of Life Nursing Care: *Physiological Changes*



Target Audience

Nurse

Learning Objectives

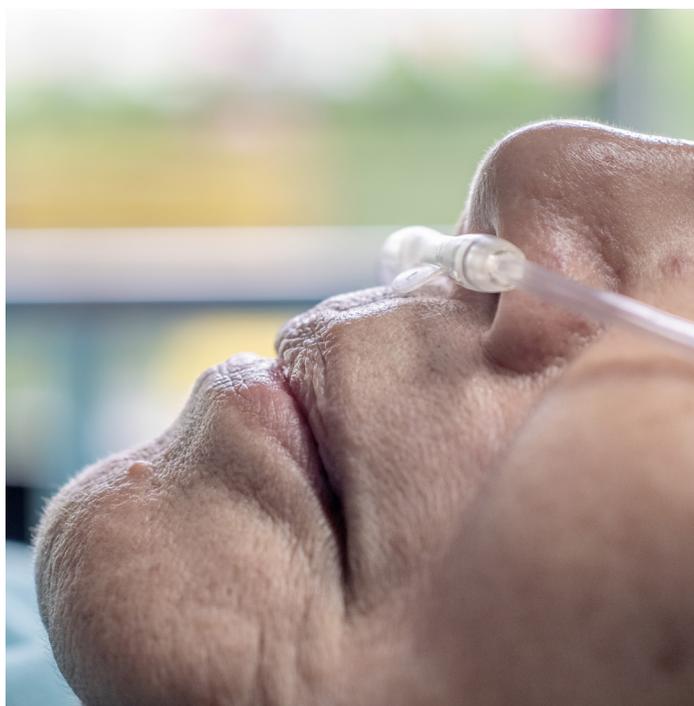
- Recognize symptoms of imminent death
- Select appropriate nursing interventions that meet the physiological needs of a resident who is dying

Directions

Read through the handout below and answer the quiz questions at the end.

Anorexia

Appetite is diminished, resulting in poor intake and, subsequently, weight loss due to a loss of muscle and fat. The temples and eyes may gain a sunken appearance. Enteral or parenteral feeding when death is imminent is not helpful and often causes more discomfort for residents. Forcing oral intake could result in aspiration and distress for residents. Ketosis, which is the production of ketone bodies when stored fat is used for energy instead of carbohydrates, accompanies the lack of food intake and has the benefit of reducing discomfort. Dehydration is common; frequent oral hygiene and the application of a thin layer of petroleum jelly to the lips provides comfort. As oral candidiasis is a common development, prompt detection and treatment of this infection are important.



Changes in Vital Signs

Cardiac output and intravascular volume decrease at the end of life, and there is diminished peripheral blood perfusion. The dysfunction and decline of the heart cause tachycardia, but the pulse becomes weaker and eventually slows. Initially, there is a rise in blood pressure followed by hypotension. Respirations are rapid initially and then slow. Cheyne-Stokes respirations may occur. These are characterized by cycles of rapid breathing, followed by less-frequent breaths and, finally, periods of apnea with a return to rapid breathing.

NORMAL

Regular rate and rhythm



CHEYNE-STOKES

Irregular rate, rhythm, and depth with periods of apnea



Impaired Circulation

Cyanosis, a bluish discoloration of the skin usually noted at the tips of the fingers and around the mouth, may develop. Skin mottling, a blotchy, red-purplish marbling of the skin, may also occur. It most frequently appears first on the feet and then moves up the legs. Mottling occurs because the heart is no longer able to pump blood effectively, and the blood pressure drops. When this occurs, the extremities will also begin to feel cool.

Impaired Elimination

As kidney function declines, urine becomes more concentrated. Oliguria (a very small amount of urine production) or anuria (no urine production) may occur. When sphincter control is lost, urinary and fecal incontinence result. Catheters may be used to aid in keeping residents dry; however, with the diminished output, management without an indwelling catheter may be easily possible. The inability to adequately metabolize and excrete drugs can require that medications be reduced in dosage and quantity.

Impaired Communication

Verbal communication becomes difficult. Responses may be delayed, and finding the right words to use can be difficult for residents. A communication board may be beneficial. Talking can become so taxing that residents begin using monosyllabic words; in time, residents become verbally unresponsive. Although the degree to which unconscious residents can hear is unknown, it remains important to talk to these residents as though they can hear. Use, and encourage family members to use, touch as a means of communicating affection.

Onset of Delirium

The dysfunctions of various body systems often lead to delirium. Residents may be agitated, restless, or confused, and they may have inappropriate responses and behaviors. This can be devastating for family members, who may misinterpret a resident's agitation or confusion to be a result of something harmful being done to the resident. The nurse can prepare families for the possibility of terminal delirium and inform them that managing residents' symptoms is part of the care that will be provided.

Decreased Level of Consciousness

Residents become increasingly drowsy and difficult to arouse. There is less responsiveness to verbal and tactile stimuli.

Peripheral Edema

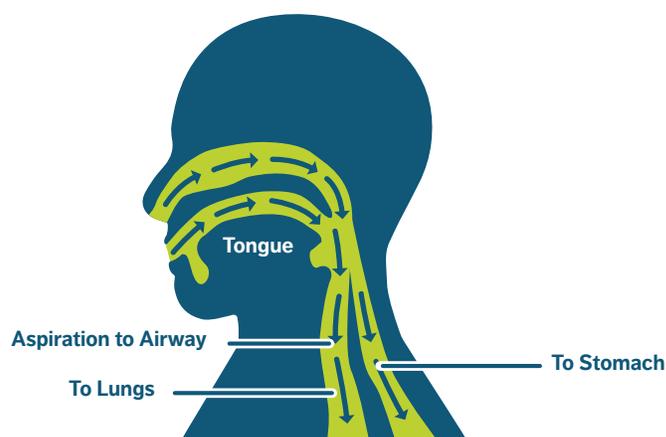
Hypoalbuminemia, which is low albumin in the blood, and the inability to change positions independently contribute to edema. These factors, in turn, promote skin breakdown.

Pain

Pain may be present, evident through restlessness, groaning, and facial grimacing. It is important to differentiate these symptoms from those that accompany delirium. If opioids (codeine, morphine, oxycodone, or hydromorphone) are used, they need to be carefully monitored. As residents get closer to death and hepatic function and renal perfusion decline, there can be higher serum concentrations of active metabolites. These changes lead to toxicity and an increased risk of delirium. It is important to assess on an ongoing basis the need for medications. Only those drugs that assist in promoting comfort (e.g., those that address symptoms such as pain, dyspnea, excess secretions, and delirium) should be used, at the lowest possible dosage and least invasive route of administration.

Increased Risk for Aspiration

Weaker muscles, dysphagia, the loss of a gag reflex, the accumulation of secretions, and the inability to maintain an upright position all heighten the risk for choking and aspiration. Oral intake typically is discontinued when residents are no longer able to swallow. Family members need to be aware of the rationale for discontinuing oral intake (i.e., risk for aspiration that would cause greater discomfort for residents). Oropharyngeal suctioning is not recommended, as the secretions often are lower than the catheter can reach; also, the procedure can be very distressing. Elevating the head of the bed may provide comfort and ease breathing.



Inability to Close Eyes

Residents may not be able to close their eyelids. Their eyes may roll back so that a greater portion of the whites of their eyes becomes visible. In addition, with the loss of retro-orbital fat that accompanies general wasting, the eye slips back within the socket. Often, the eyelid is unable to fully cover this additional area of the eye, leaving the conjunctiva exposed while residents sleep and leading to dryness. Artificial tears and ophthalmic lubricants may prove useful to combat this.

KNOWLEDGE CHECK QUESTIONS

1. **Enteral and parenteral feedings do which of the following for the resident who is near death?**
 - a. Lessen pain
 - b. Prevent terminal delirium
 - c. Can cause more distress than benefit
 - d. Increase the risk for aspiration
2. **Why might oropharyngeal suctioning not be beneficial for residents who are near the end of life?**
 - a. Secretions are a normal physiological change associated with dying.
 - b. Secretions are often lower than the catheter can reach.
 - c. Secretions are managed with anti-anxiety medications.
 - d. Suction may only be performed by a physician.
3. **Which of the following describes blood pressure as a person is dying?**
 - a. It increases and then decreases.
 - b. It decreases and then increases.
 - c. It increases and remains high.
 - d. It decreases and remains low.
4. **Which of the following is not included in nursing care that promotes the resident's comfort?**
 - a. Administering analgesics
 - b. Providing frequent oral care and keeping lips moisturized
 - c. Administering moisturizing eye drops
 - d. Encouraging the resident to eat at least 75% of meals
5. **Which of the explanations below might the nurse use to help the family understand terminal delirium?**
 - a. Delirium is part of dementia.
 - b. The consumption of calories causes delirium and that is why the resident doesn't want to eat.
 - c. As body systems begin to slow, delirium may occur, but nursing care will be provided to keep the resident comfortable.
 - d. If terminal delirium occurs, the resident must be transported to the hospital for IV antibiotics.

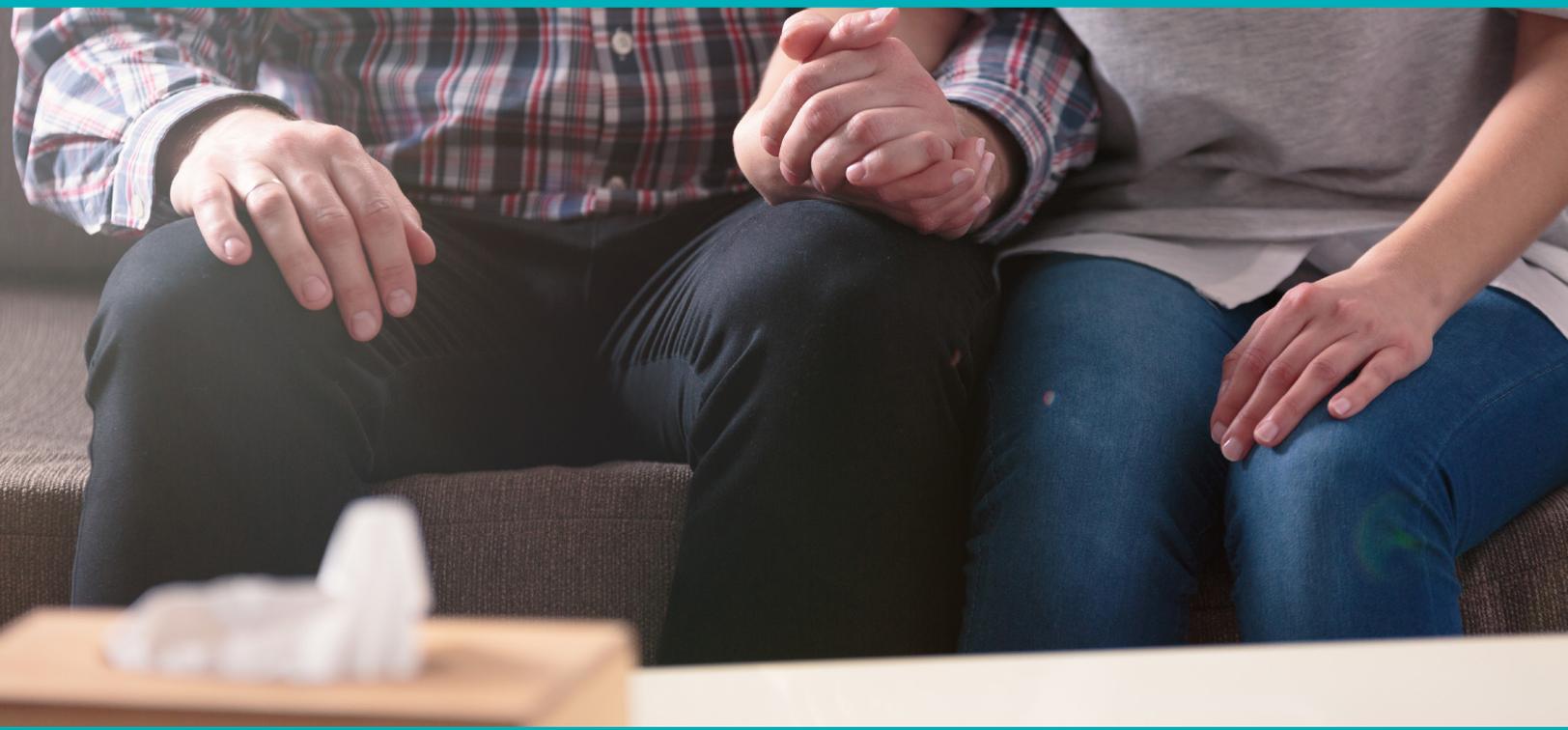
1. c 2. b 3. a 4. d 5. c
KNOWLEDGE CHECK ANSWERS



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Death and Dying Education Bundle for Nurses

**End of Life Nursing Care:
*Psychosocial and Psychological
Support for Residents and Families***



Target Audience

Nurse

Learning Objectives

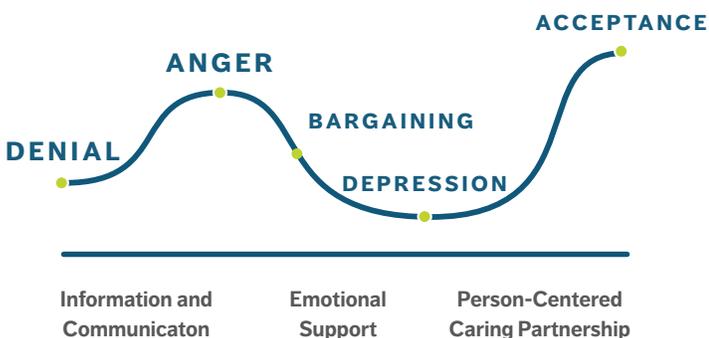
- Classify behaviors associated with each of the Kübler-Ross stages of death
- Select appropriate nursing interventions to meet the psychosocial and psychological needs of residents and their families

Directions

Read through the handout below and answer the quiz questions at the end.

Stages of Death and Dying

Although the dying process is a unique experience for each individual, there are some common reactions that have been observed to occur, as described by the Kübler-Ross stages of death and dying. Not all dying persons will progress through these stages in an orderly sequence. Neither will every dying person experience all of these stages. However, an awareness of Kübler-Ross's conceptual framework can help the nurse support residents and families.



Denial

On becoming aware of their impending death, most individuals initially react by denying the reality of the situation. “It isn’t true” and “There must be some mistake” are common examples that reflect this denial. Denial serves several useful purposes for the dying person. It is a shock absorber after learning the difficult news that one has a terminal condition; it provides an opportunity for people to test the certainty of this information; and it allows people time to internalize the information and mobilize their defenses. Although the need is strongest early on, dying persons may use denial at various times throughout their illness. They may fluctuate between wanting to discuss their impending death and denying its reality. Although such a contradiction may be confusing, staff must be sensitive to the person’s need for defenses while also being ready to participate in discussions on death when the person needs to do so. Staff need to accept the dying person’s use of defenses rather than focus on the conflicting messages. An individual’s life philosophy, unique coping mechanisms, and knowledge of the condition determine when denial will be replaced by less radical defense mechanisms. Perhaps the most important nursing action during this stage is to accept the dying individual’s reactions and to provide an open door for honest dialogue.

Anger

The stage of denial is gradually replaced, and the “No, not me” reaction becomes instead “Why me?” This second stage, anger, is often extremely difficult for individuals surrounding the dying person, because they are frequently the victims of displaced anger.

In this stage, the dying person expresses the feeling that nothing is right. Nursing assistants don’t answer the call light soon enough; the food tastes awful; the doctors don’t know what they are doing; and visitors either stay too long or not long enough. Seen through the eyes of the dying person, such anger is understandable. Why would a person resent not getting what they want immediately when they won’t be around much longer? Why wouldn’t they envy those who will enjoy a future they will never see? Their unfulfilled desires and the unfinished business of their life may cause outrage.

During this time, the family may feel guilt, embarrassment, grief, or anger as a result of the dying person’s anger. They may not understand why their intentions are misinterpreted or their actions unappreciated. It is not unusual for them to question whether they are doing things correctly.

The nurse should help the family gain insight into the individual's behavior, which can relieve the family's discomfort and, thus, create a more beneficial environment for the dying person. If the family can come to understand that the person is reacting to impending death and not to them personally, it may facilitate a more supportive relationship.

Staff should also guard against responding to the dying person's anger as a personal affront. Even the best nursing efforts may receive criticism for not being good enough; cheerful overtures may be received with scorn; the call light may go on the minute the nurse leaves the room. It is important that the nurse assess such behaviors and understand that they may reflect the anger of the second stage of the dying process. Instead of responding to the anger, staff should be accepting, communicating to the dying person that it is fine to vent these feelings. Anticipating needs, remembering favorite things, and maintaining a pleasant attitude can counterbalance the anticipated losses that are becoming more apparent to the dying individual. It may be useful to encourage staff to discuss their feelings about the resident's anger with colleagues who can serve as a sounding board.

Bargaining

After recognizing that neither denial nor anger changes the reality of impending death, dying persons may attempt to negotiate a postponement of the inevitable. They may agree to be a better Christian if God lets them live through one more Christmas; they may promise to take better care of themselves if the physician initiates aggressive therapy to prolong life; they may promise anything in return for an extension of life. Most bargains are made with God and usually kept a secret. Sometimes such agreements are shared with members of the clergy. Staff should be aware that dying persons may feel disappointed at not having their bargain honored or guilty over the fact that, having gained time, they want an additional extension of life even though they agreed that the request would be their last. It is important that these often-covert feelings be explored with the resident.

Depression

As the resident's condition declines and the reality of near-death is realized, depression often follows. Urging dying persons to cheer up and look at the sunny side of things implies that they should not contemplate their impending death. It is unrealistic to believe that dying people should not be deeply saddened by the most significant loss of all—their life. The depression of the dying person is usually a silent one. It is important for staff to understand that cheerful words may be far less meaningful to dying individuals than holding their hand or silently sitting with them. Being with the dying person who openly or silently contemplates the future is a significant nursing action during this stage. Finally, an interest in prayer and a desire for visits from clergy are commonly seen during this stage. Staff should be particularly sensitive to the dying person's religious needs and facilitate the clergy-resident relationship in every way possible. The nurse may need to help the family understand this depression, explaining that their efforts to cheer the dying person can hinder the resident's emotional preparation rather than enhance it. The family may require reassurance for the helplessness they feel at this time. The nurse may emphasize that this type of depression helps the individual approach death in a state of acceptance and peace.

Acceptance

For many dying persons, a time comes when the struggling ends and relief ensues. It is as though a final rest is being taken to gain the strength for a long journey. This acceptance should not be mistaken for a happy state; it implies that the individual has come to terms with death and has found a sense of peace. During this stage, residents may benefit more from nonverbal than verbal communication. It is important that their silence and withdrawal not result in isolation from human contact. Touching, comforting, and being near the person are valuable nursing actions. An effort to simplify the environment may be required as the dying person's circle of interests gradually shrinks. It is not unusual for the family to need a great deal of assistance in learning to understand and support their loved one during this stage. Significantly, hope commonly permeates all stages of the dying process. Hope can be used as a temporary but necessary form of denial, as a rationalization for enduring unpleasant therapies, and as a source of motivation. Realistically facing impending death does not negate the presence of hope.

Support of Family and Friends

Just as dying persons experience different reactions while coping with the reality of their impending death, so too may family and friends pass through the stages of denial, anger, bargaining, and depression before they are ready to accept the fact that a special person in their lives is going to die.

Denial. In this stage, family and friends may discourage residents from talking or thinking about death; visit residents less frequently; state that residents will be better as soon as they return home, start eating, have their intravenous tube removed, and so forth; or shop for a doctor or hospital to find a special cure for the terminal illness.

Anger. Reactions may include criticizing staff for the care they are giving, reproaching a family member for not paying attention to the resident's problem earlier, and questioning why someone who has led such a good life should have this happen.

Bargaining. Family and friends may tell the staff that if they could take the resident home, they know they could improve his or her condition. Through prayers or open expression, they may agree to take better care of the resident if given another chance. They may consent to some particular action (e.g., going to church regularly, volunteering for good causes, giving up drinking) if only the resident could live to a particular time.

Depression. Family and friends may become more dependent on the staff. They may begin crying and limiting contact with the resident.

Acceptance. In this stage, people may react by wanting to spend a great deal of time with the dying person and telling the staff of the good experiences they have had with the resident and how they are going to miss the person. They may request the staff do special things for the resident (e.g., arrange for favorite foods, eliminate certain procedures, provide additional comfort measures). They may frequently remind the staff to be sure to contact them "when the time comes." They may begin making specific arrangements for their own lives without the resident (e.g., change of housing, plans for property, strengthening other relationships for support).

The type of nursing support needed will vary depending on the stage at which the family member or friend is assessed to be. Although the nursing actions described for the dying individual during each stage may also apply to family and friends, the stages experienced by those involved may not coincide with the resident's stages. The nurse must be aware of these discrepancies in states and provide individualized therapeutic interventions. While providing appropriate support to family and friends as they pass through the stages, the nurse can offer opportunities for dying people to discuss their death openly with a receptive party.



KNOWLEDGE CHECK QUESTION

- 1. The daughter of Mr. Tully, who is terminally ill, approaches you in tears because her father has accused her of being selfish for not visiting enough. The daughter says that she doesn't understand this as she visits daily and her father knows she is missing time at work and with her children to do so. Most likely, Mr. Tully's behaviors are consistent with which stage described by Kübler-Ross?**
 - a. Denial
 - b. Anger
 - c. Depression
 - d. Acceptance

- 2. Several weeks later, Mr. Tully's daughter mentions to you that her father now tells her not to worry about visiting because he is doing better and will be around for a long time. Which stage could Mr. Tully now be experiencing?**
 - a. Denial
 - b. Anger
 - c. Depression
 - d. Acceptance

- 3. The CNA tells the nurse that Mr. Tully repeatedly turns on his call light immediately after each time she provides the care he requested and leaves his room. Upon re-entering the room, he yells at her for ignoring him. The CNA expresses this makes her feel worthless and not good enough to care for Mr. Tully. Which of these is the nurse's best response?**
 - a. Re-assign Mr. Tully's care to a different CNA.
 - b. Request a psychological consult and medication to treat Mr. Tully's behavioral expression.
 - c. Tell the CNA she needs to do her best because everyone is very busy caring for residents.
 - d. Explain to the CNA that Mr. Tully is likely feeling very angry, which is a normal response to facing the end of life. Assure her that the resident's anger is not personal and she can best help him by continuing to care for him and anticipate his needs.

- 4. The nurse notices Mr. Tully has become very quiet and withdrawn in recent days. The nurse recognizes Mr. Tully may be in the depression stage. What is the most appropriate nursing intervention?**
 - a. Encourage Mr. Tully to cheer up by reminding him to be thankful for his loving family.
 - b. Give Mr. Tully his space and avoid disturbing him as much as possible.
 - c. Be sensitive for spiritual and religious needs and offer emotional support.
 - d. Remain cheery and only talk about positive, happy topics.

- 5. Mr. Tully's daughter approaches the nurse and states she may take her father home because she can provide better care for him than what he is currently receiving. The nurse can best respond to the daughter by:**
 - a. Instructing her to speak with the social service director about discharge planning.
 - b. Explaining that she does not have the clinical skills to provide the care Mr. Tully needs.
 - c. Calling the physician and requesting an order to discharge Mr. Tully to the daughter's care.
 - d. Understanding that she is likely in the bargaining phase and encouraging her to express her feelings.

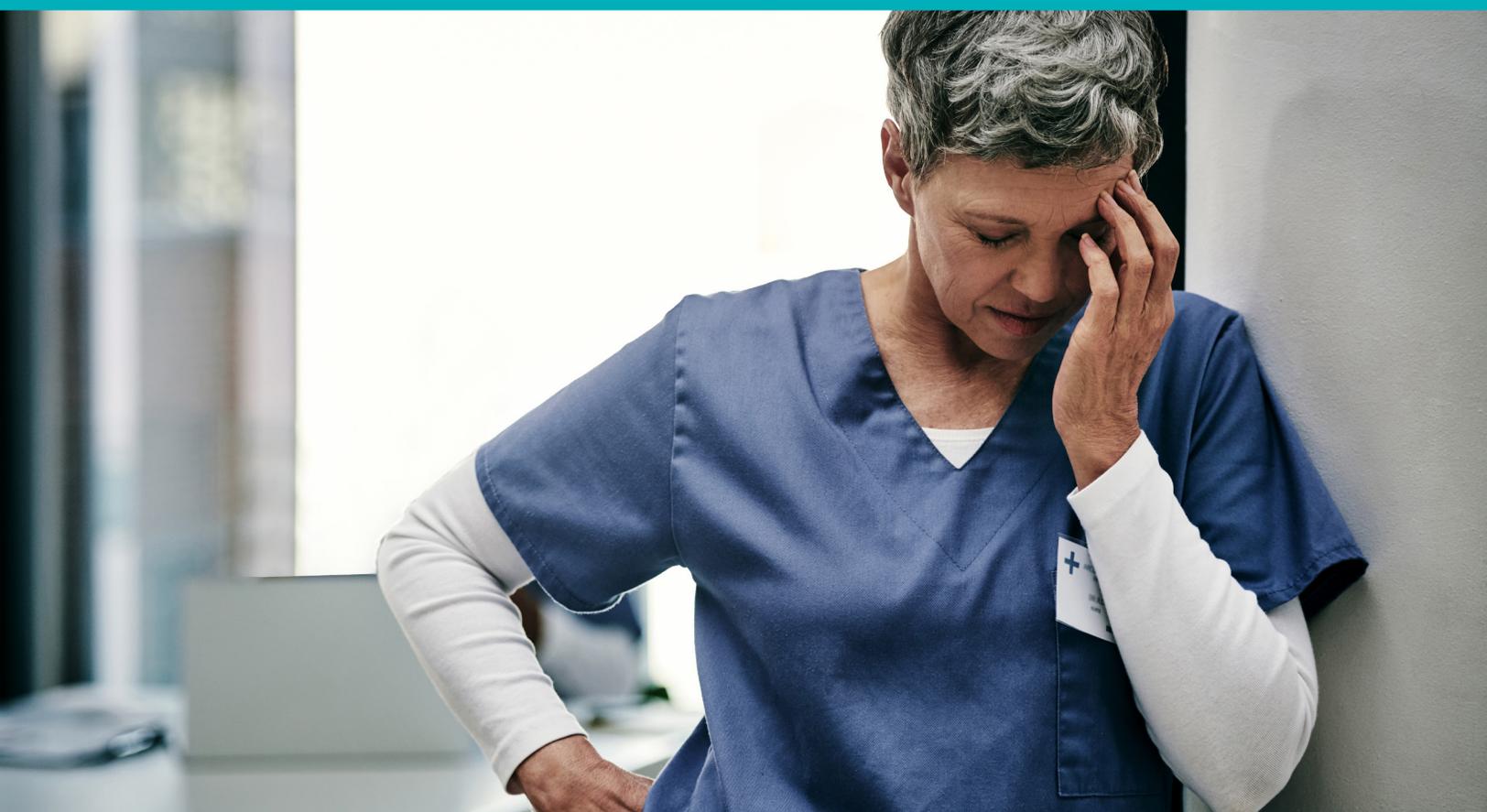
1. b 2. a 3. d 4. c 5. d
KNOWLEDGE CHECK ANSWERS



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Death and Dying Education Bundle for Nurses

End of Life Nursing Care: *Caring for the Caregiver*



Target Audience

Nurse and Certified Nurse Assistant (CNA)

Learning Objectives

- Discuss the support that could be offered to help care for the caregivers who are grieving the loss of a resident

Directions

The staff development coordinator or other nurse leader will facilitate discussion with a group of caregivers (nurses and CNAs) using the talking points and discussion questions.

Talking Point

Many of you have your own experience caring for someone who is dying, whether it be a resident or even a family member. Some of you may have only experienced death through exposure to the subject in nursing or CNA school. In either case, we often have different ideas, concerns, and even fears related to death.

Discussion Questions

- What are three to five common concerns or fears caregivers experience?
- Have you felt these yourself or seen another caregiver experience this? If so, how would you describe what this felt like?

Talking Point

It is not unusual for a caregiver who is involved with a dying resident to also experience the stages of the dying process described by Kübler-Ross. Staff members are commonly observed to avoid contact with dying residents, tell a resident to “cheer up” and not think about death, continue to practice “heroic” measures although a resident is nearing death, and grieve at the death of a resident.

Discussion Questions

- Can you share an example of a time you felt or recognized that another caregiver was experiencing one of the stages of dying while caring for a resident?
- If you were supported in a way that helped you during that stage, please share what the person did to support you and how it helped you.

Talking Point

We develop very close relationships with the residents in our care. Sometimes we feel we are losing a family member when they are dying. It is normal to grieve, exhibit our emotions of sadness, and even sometimes feel overwhelmed or not good enough because we feel as if we should have done more.

Discussion Questions

- What signs might a caregiver show that they are not coping well and need help?
- What actions can fellow caregivers do to support their teammate?
- How can we honor the resident and grieve their loss?

Talking Point

I want everyone to know that the love, care, and compassion you have for the residents and their families makes you very special. The tenderness and kindness you bring for some of the most vulnerable in our society shows what amazing hearts you have. It is normal to feel as if your heart is broken. If at any point you need to talk to someone, please come to me or use our Employee Assistance Program (EAP), so that a trained counselor can help you work through your feelings anonymously and at no cost.

Note: Make sure your company offers an EAP before making this statement.

