17.6: Applying the Nursing Process at End of Life

This section will summarize the steps of the nursing process when caring for a patient who is actively dying and their family members.

Assessment

Assessments are generally limited for those patients at the end of life with the overall treatment goal of providing comfort. The goal in any performed assessment is to help ease the patient’s discomfort as the body begins to fail and facilitate a peaceful transition. If end-of-life care is occurring within the hospital setting, the nurse may need to remind members of the care team that “normal” care routines are not required. This may include collection of vital signs, intake and outputs, laboratory blood draws, and full physical assessment. It can feel challenging to switch modes of care in the inpatient setting where so many of our actions are focused on intervention and restoring a patient to health. However it is important to remember that our interventions take a different, but no less important, form. Providing comfort care at the end of life is one of the most important interventions a nurse can do to help ease patient and family suffering.

Subjective Assessment

Many individuals at the end of life may be nonverbal. Some may experience times of reminiscence as they progress toward death. It is important for the nurse to inform the family that communication can be quite variable as the patient progresses toward death, but the sense of hearing may still be intact. Family members and friends should be encouraged to share their thoughts and feelings with the patient, taking time to relate stories of comfort and feelings to the patient. This can be a therapeutic exchange for both the patient and the family.
Objective Assessment

Physical assessments should be limited and focused on providing patient comfort and creating a supportive environment for a therapeutic transition. Signs of pain such as grimacing, moaning, furrowing brow, and physical guarding should be noted and addressed. Many patients may experience increased respirations, labored breathing, and increased secretions that produce an audible respiratory “rattle.” The patient typically has a significant decline in circulation as they progress towards death, evidenced by cool and clammy skin, mottled extremities, and diminished pulses. The nurse should continue to monitor for signs of skin breakdown and urinary retention.

Notify the provider of unexpected findings on assessment, such as severe pain not relieved by pain management protocol, acute labored breathing, terminal secretions, or urinary retention resulting in bladder distention.

Diagnosis

As the patient progresses toward death, diagnosis statements are focused on provision of comfort for the patient. Identification of acute pain and ineffective breathing are areas that typically become priority as patients near their final transition. Additionally, attention to family coping and caregiver role strain remain areas of focus as the nurse assists family members in coping with the dying process.

When planning care, review a nursing care planning source for current NANDA-I approved nursing diagnoses and evidence-based nursing interventions. See Table 17.6 for the definition and defining characteristics regarding the NANDA-I diagnosis Death Anxiety.

Table 17.6 NANDA-I Nursing Diagnoses Death Anxiety

<table>
<thead>
<tr>
<th>NANDA-I Diagnosis</th>
<th>Definition</th>
<th>Defining Characteristics</th>
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<tbody>
<tr>
<td>Death Anxiety</td>
<td>Vague, uneasy feeling of discomfort or dread generated by perceptions of a real or imagined threat to one’s existence.</td>
<td>• Concern about strain on the caregiver</td>
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<td></td>
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<td>• Deep sadness</td>
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<td></td>
<td>• Fear of loss of mental abilities when dying</td>
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<td></td>
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<td>• Fear of pain related to dying</td>
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<td>• Fear of prolonged dying process</td>
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<td></td>
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<td>• Fear of suffering related to dying</td>
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<td></td>
<td></td>
<td>• Negative thoughts related to death and dying</td>
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<td></td>
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<td>• Powerlessness</td>
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</table>
Outcomes

An overall goal for a patient who is actively dying is, *The patient will experience dignified life closure as evidenced by:*

- Expression of readiness for death
- Resolution of important issues
- Sharing of feelings about dying
- Discussion regarding spiritual concerns

An example of a SMART outcome for a patient actively dying is, "*The patient will express their fears associated with dying by the end of the shift.*"

Nursing goals for care focus on the provision of comfort. For example, a common nursing goal is, "*The patient will experience adequate pain management based on their expressed goals for pain relief and alertness.*"

Planning and Implementing Interventions

Many patients require pain medications to assist with a therapeutic transition as they near death. These medications often include morphine and lorazepam to help ease pain, dyspnea, and anxiety. It is important for the nurse to be conscientious of the appropriateness of the medication’s route of administration, recognizing that patient condition can change rapidly. Concentrated oral solutions are absorbed through the buccal membranes, but if pain management needs are high, it may be necessary to contact the provider regarding a subcutaneous pump. Many patients in the imminent phase have terminal secretions so anticholinergic medications such as atropine or scopolamine may be administered. See the following box for a summary of other nursing interventions in the last days and hours of a patient’s life.

Interventions in the Last Days and Hours of Life

- Honor the patient’s preferences for end-of-life care.
- Be respectful of the environment. Physical assessment and cares should be provided with the utmost respect and attention to comfort. Shielding the patient from harsh light or loud voices is encouraged to help provide a respectful environment.
- Reinforce the steps of the dying process so that family remains cognizant of what to expect. Although this can feel redundant, this conversation and anticipatory planning are very helpful due to the emotional nature of the situation and challenges that they may experience with information retention.
- Be present and attentive. Use active empathetic listening.
• Encourage the family to create a quiet and comfortable environment.
• Assess the patient for pain and provide pain relief measures based on their preferences.
• Assess the patient for fears related to death.
• Assist the patient with life review and reminiscence.
• Provide music of the patient’s choosing.
• Provide social support for families and guide them through end-of-life issues.
• Recognize the spiritual needs of the patient and their family members. Support religious beliefs, rituals, and prayer.
• Encourage family members to be physically close to their loved one and give them permission to touch them.
• When death occurs, allow appropriate time for closure. Provide information regarding the next steps of physical care and transporting the patient.

Evaluation

It is always important to evaluate the effectiveness of interventions based on the outcome criteria established for each patient. The nurse should closely monitor for escalating signs of patient discomfort that is not managed by the current treatment plan. It is helpful to educate the family regarding whom to contact if additional concerns arise.