

# Loss, Grief, and the Dying Patient

## Objectives

Upon completing this chapter, you should be able to:

### Theory

1. Correlate the stages of grief and of dying, with their associated behaviors and feelings.
2. Discuss the concept of hospice care.
3. Identify three common fears a patient is likely to experience when dying.
4. Describe four expected symptoms related to metabolic changes at end-of-life stages.
5. List the common signs of impending death.
6. Illustrate the difference between the patient's right to refuse treatment and assisted suicide.
7. Explain how the *Code of Ethics for Nurses* provides guidelines for the nurse's behavior regarding the patient's right to refuse treatment, euthanasia, and assisted suicide.

### Clinical Practice

1. Identify ways in which you can support or instill hope in the terminally ill patient and his family.
2. Demonstrate compassionate therapeutic communication techniques with a terminally ill patient and/or his family.
3. Describe one nursing intervention for comfort care that can be implemented in a hospital or a nursing home for a dying patient for each of the following problems: pain, nausea, dyspnea, anxiety, constipation, incontinence, thirst, and anorexia.
4. Explain the reason for completing an advance directive to a terminally ill patient, and what "health care proxy" and "DNR" mean in lay language.
5. Prepare to provide information regarding organ or tissue donation in response to family questions.
6. Assist with postmortem care for a deceased patient.

## Skill

### Skill 15-1 Postmortem Care

## Key Terms

**acceptance** (p. 195)  
**advance directive** (p. 200)  
**anticipatory grieving** (ān-TĪ-sī-pā-tō-rē, p. 190)  
**assisted suicide** (SŪ-ī-sīd, p. 200)  
**autopsy** (p. 201)  
**bargaining** (p. 195)  
**bereavement** (bē-RĒV-mīnt, p. 190)  
**brain death** (p. 192)  
**Cheyne-Stokes respirations** (SHĀN-stōks rēs-pī-RĀ-shūns, p. 199)  
**closure** (KLŌ-zhūr, p. 199)  
**comfort care** (p. 195)  
**coroner** (KŌR-ō-nēr, p. 201)  
**death** (p. 191)  
**denial** (p. 195)  
**durable power of attorney for health care** (DŪ-rā-bŭl, p. 200)

**dysfunctional** (dīs-FŪNK-shŭn-āl, p. 191)  
**euthanasia (active, passive)** (ū-thā-NĀ-zhē-ā, ĀK-tīv, PĀ-sīv, p. 200)  
**grief, grieving process** (p. 190)  
**health care proxy** (PRŌX-ē, p. 200)  
**hope** (p. 194)  
**hospice** (HŌS-pīs, p. 192)  
**loss** (p. 190)  
**obituary** (ō-BĪ-chū-ēr-ē, p. 199)  
**palliation** (pāl-ē-Ā-shŭn, p. 195)  
**postmortem** (pōst MŌR-tēm, p. 201)  
**rigor mortis** (RĪ-gŏr MŌR-tīs, p. 202)  
**shroud** (SHRŌWD, p. 202)  
**thanatology** (thān-ā-TŌL-ō-jē, p. 193)

Loss, grief, and death are universal facets of life. Loss involves change, and some loss is necessary for normal growth and development; for example, a child loses baby teeth to make way for permanent teeth. Other losses do not seem to have positive outcomes, such as loss of health, loss of a significant other, or loss of life. People adjust to loss through the grieving process, and coping with loss is learned from childhood on. **A person's reaction to loss is influenced by the importance of what was lost and the culture in which the person is raised.**

According to the National Center for Health Statistics (2009), life expectancy increased from 77.9 years in 2007 to 78.2 years in 2009, mainly because of advances in treatment of heart disease, cancer, AIDS, and stroke. Heart disease and cancer are responsible for 50% of all deaths in the United States. HIV/AIDS is no longer one of the 15 leading causes of death. Alzheimer disease has moved from 11th to 7th place. Accidents rank number 5 and diabetes number 6. Life expectancy for white females is highest (80 years), followed by African American females (76.5 years), white males (75.7 years), and African American males (69.8 years). The most recent death statistics indicate approximately 2,436,682 deaths in the United States annually (National Vital Statistics Report, 2009).

Death is a universally shared event. All cultures and religions have beliefs and rituals to explain and cope with death, loss, and grief. It is common in American society to avoid talking about death and to be unable to imagine our own death. Expressions such as “passed away” or “went to his reward” are used instead of “died.” Children are often kept away from funerals, and most people have little contact with the dying. Many adults can state they have never seen a dead body, and more can say they have not been present during a death. Only in recent years has there been a move away from silence and denial toward a willingness to examine a universal life event: death.

Nurses and other health care professionals may have similar fears and anxieties about the end of life. Because so many deaths occur in hospitals and nursing homes, health care workers see more of death and dying than other people do. They are responsible for providing the best care possible to their dying patients. However, to meet the emotional and physical needs of patients and their significant others, nurses must first take the time to look at their own views of death and come to terms with its reality.

### Think Critically

What are your earliest memories of death—a pet, a relative, a friend? How was the death explained to you? Was it frightening, confusing, reassuring?

## CHANGE, LOSS, AND GRIEF

### CHANGE

Satir views loss, grief, and mourning as life changes (Blevins, 2008). These changes are natural and ongoing throughout people's lifetimes. She notes that, when people experience these changes, they progress through six stages: status quo, introduction of a foreign element, chaos, integration, practice, and new status quo. These are similar to the stages that Kübler-Ross, Maciejewski, and others have described as stages of grief and loss. The nurse must recognize and acknowledge patients' processes of change in order to successfully administer to patients' needs.

### LOSS

**Loss** is to no longer possess or have an object, person, or situation. It is a familiar occurrence in everyday life, for example, losing money, a job, one's health, or life. One's own death is often described as the most difficult loss for a person to accept. A loss can be physical, such as the amputation of a leg or inability to speak or walk after a stroke. A loss can also be psychosocial. Disfiguring surgery or scarring from burns may result in an altered self-image and emotional problems. A person may lose the ability to carry out the role of homemaker or wage earner as a result of illness. A familiar environment and independence may be lost with a move to a nursing home. Often loss consists of both physical and psychosocial aspects.

Loss can be viewed as ranging from minor to catastrophic. A person's reaction to loss depends not so much on the size of the loss but on the person's value of what was lost, plus the influence of previous experiences and the ability to cope. A sudden, traumatic death of a loved one may be viewed very differently from an older family member's death after a long illness. **Only the person experiencing the loss can define the value of the loss;** you must put aside your own values regarding loss and accept the patient's meaning of loss.

### GRIEF

**Grief** is the total emotional feeling of pain and distress that a person experiences as a reaction to loss. The **grieving process** occurs over time. People who are dying and their loved ones experience loss and grief when faced with a terminal diagnosis. **Bereavement** is the state of having suffered a loss by death. A person who is grieving may experience physical and emotional symptoms, such as crying, fatigue, changes in appetite, sleep disturbances, loneliness, and sadness (Box 15-1). When a person thinks or knows that a loss is going to occur in the future, **anticipatory grieving** may occur. This happens when patients and their families face a serious or life-threatening illness, and it is believed to improve their ability to cope with the loss when it occurs.

**Box 15-1** Symptoms of Grief

- Depression, sadness, crying, mood swings
- Fatigue, apathy, lack of interest and motivation, inability to concentrate, inability to complete tasks
- Loneliness, isolation
- Sleep alterations: sleeping more, insomnia (inability to sleep)
- Loss of appetite, weight loss or weight gain, nausea
- Change in sexual interest
- Anxiety, shortness of breath, chest pains, rapid heart-beat, sighing, heaviness in chest
- Feelings of helplessness, restlessness, anger, guilt, irritability
- Forgetfulness, tendency to make mistakes, accident prone
- Confusion, disorientation (especially in the elderly), indecisiveness
- Symptoms of the same illness that the deceased suffered
- Sensing the loved one's presence, hearing the voice, seeing the face, expecting the person to walk in the door
- A need to tell and retell and remember things about the loved one and the death experience

Grieving may also be **dysfunctional** when it falls outside normal responses. In prolonged grieving the person seems trapped in a stage and unable to progress. However, there is no actual time frame for completion of grieving, and a major loss may result in grieving for 1 to 2 years. Visible absence of grieving may be viewed by others as a good adjustment, but it often results in later psychosomatic illness.

**STAGES OF GRIEF**

It has long been thought that the grieving person goes through stages. Each stage has identifying behaviors and feelings, and each person moves through the stages at his own pace and may skip a stage or return to an earlier stage. Nurses have always been taught to recognize the great individuality of the grieving person and offer supportive care for the symptoms or behavior the person demonstrates, rather than anticipating what grieving response is the right one.

Until recently, the hypothesis of these stages had not been investigated empirically. However, the stages of grief theory was put to the test by Maciejewski and others (2007). Their examination of the stage theory of grief has revealed that denial is not the first grief indicator. Instead, the loss is readily accepted, and yearning is the dominant grief indicator. This is followed by anger and depression. The five grief indicators—denial, yearning, anger, depression, and acceptance—peak within 6 months after the loss. The nurse should reevaluate and create additional nursing plans for patients who continue to score high in these areas after 6 months.

You can assist people who are grieving by accepting their feelings and behaviors and validating their loss.



**FIGURE 15-1** The nurse provides caring and comfort to the patient who experiences grief.

To **validate** the loss is to reassure the grieving person that the loss was important and understood. Quiet presence, a warm caring concern for the person's well-being, and the ability to listen to the person speak about the pain and loss are supportive (Figure 15-1). Encourage grieving individuals to tell you what the person (or lost object) was like and what the loss means to them. Avoid the use of clichés like, "You'll forget all about this after awhile," and do not minimize the loss. Observe the patient's nonverbal communication, and use appropriate nonverbal language such as a smile or a gentle touch. Crying may be embarrassing for the patient, and a simple act of handing a tissue acknowledges the acceptability of weeping. You may be uncomfortable in a situation in which you feel like crying along with the patient. The patient will not be offended by your crying and may draw support from a shared experience. You can acknowledge feelings of sadness and loss, but should avoid saying, "I know just how you feel" or "Don't cry," because this minimizes the patient's feelings.

As a person moves through and adjusts to the stages of the grieving process, there is a continuing decline in function. Finally, with the stage of acceptance, the level of daily function begins gradual improvement. Successful movement through the grieving stages allows the person to emerge with realistic memories of the event and the deceased; to find renewed energy and a sense that life has meaning; and to again experience pleasure, social relationships, and activities. The time it takes to move through the stages depends on the loss and its meaning to the person.

**DEATH AND DYING****THE NATURE OF DEATH**

**Death** is an event marked in different ways. The absence of a heartbeat and breathing is a historic and still widely accepted definition of death. In today's

high-tech hospital environment, however, a ventilator can support the patient's breathing and thereby provide oxygen to the heart when it would not continue unassisted. So a definition of death that has been used since the 1970s is **brain death** (the permanent stopping of integrated functioning of the person as a whole as evidenced by the absence of electroencephalogram [EEG] waves).

Except for suicide, a person has no control over when or how death occurs. Death may be sudden, unexpected, and instant, as when a person is killed in an accident or dies of a massive heart attack or stroke. Death may also be the end of a long battle against a chronic disease such as cancer or heart disease, or **simply** the diminished function of multiple systems in old age. Death is also encountered in situations in which the outcome could be either death or survival, as in an acute severe infection or trauma. Nurses who work in an emergency department, intensive care unit, medical-surgical unit, nursing home, or hospice will each have different experiences of patients' death and dying. In these different cases and situations, the individuals who die and those who care about them will experience different emotions and physical reactions.

#### Box 15-2 Standards of Care for the Terminally Ill

1. You must consider the terminally ill patient's preferences, personality, and lifestyle when planning care. Rigid rules, routines, and agency regulations should not be automatically applied.
2. Every effort is made to maintain functional capacity and to relieve discomfort through the control of symptoms, regardless of the expected length of time until death.
3. Pain control is a major goal of treatment.
4. The patient's preferences and intentions regarding health care as set out in an advance directive, or by durable power of attorney for health care, will take precedence as far as the law will allow.
5. The patient should feel safe and secure with the care that is provided and with the level of communication regarding this care.
6. The patient will have ample opportunities to finish business with loved ones and to say goodbyes.
7. Opportunities will be provided for the dying patient to spend final moments in a personally meaningful way with people who are important to the patient.
8. Family members and significant others will have opportunities to discuss the patient's imminent death and their emotional needs with the staff.
9. Family members and significant others will be provided private time with the patient before and after death as desired.
10. Family members will be allowed to perform rituals and carry out cultural customs regarding the body after death.



#### Cultural Considerations

##### Cultural Views About Disclosure

Many people think they have the right to know if they are dying, and nurses often do not like it if that fact is being hidden from a patient. However, cultural factors need to be considered. For example, Mexican Americans and Korean Americans are less likely to want to be told if they have a terminal illness. They also believe that the family, not the patient, should make decisions about life-sustaining treatments. These beliefs need to be considered before speaking to a patient about a terminal prognosis.

Each death and dying experience is unique, although some commonalities can help you provide truly satisfying care to the patient and the family (Box 15-2).

#### END-OF-LIFE CARE WITHIN THE HEALTH CARE SYSTEM

The focus in our health care system has been one of cure and the development of diagnostic, technical, and chemical interventions to treat disease and injury that often have been fatal in the past. As a result, patients may be viewed as failures of the system if they die in spite of the health care team's best efforts. Those with terminal illness who refuse life-prolonging (or death-delaying) treatment may believe their needs will not be met in the acute care environment (Box 15-3).

#### HOSPICE AND PALLIATIVE CARE

**Hospice** is a philosophy of care for the dying and their families. It was developed in England in the early 1960s as a reaction to the dying person's need for care and comfort. A *hospice* originally was a medieval guest house or

#### Box 15-3 Rights of the Dying Patient

*The person who is dying has the right to:*

- Be treated as a person until death
- Caring human contact
- Have pain controlled
- Cleanliness and comfort
- Maintain a sense of hope, whatever its focus
- Participate in his care or the planning of it
- Respectful, caring medical and nursing attention
- Continuity of care and caregivers
- Information about his condition and impending death
- Honest answers to questions
- Explore and change religious beliefs
- Maintain individuality and express emotions freely without being judged
- Make amends with others and settle personal business
- Say goodbye to family members and significant others in private or with the assistance of the nurse
- Assistance for significant others with the grief process
- Withdraw from social contact if desired
- Die at home in familiar surroundings
- Die with dignity
- Respectful treatment of the body after death

stopping place for travelers. Now the name “hospice” is also used to describe the specialized care provided to the dying in small clinics, houses, long-term care facilities, or the patient’s (or patient’s family’s) own home. Currently, a hospice is not necessarily a special facility but rather a program of care to meet the needs of the terminally ill and their families in their home or a health care facility.

The intent of hospice care is to help patients in the end stage of life, and their families, experience the process of death with the highest quality of life and least amount of disruption as possible. Too often, though, the hospice team is not called until just weeks or even days before death occurs. To receive the greatest support and most compassionate care possible, discussion of hospice should take place as soon as the patient or the patient’s medical team realizes that there is no cure for the patient’s condition and the patient is in a dying process.

The hospice philosophy is based on the acceptance of death as a natural part of life and emphasizes the quality of remaining life. Patients with incurable illnesses are faced with suffering on a daily basis. They not only suffer from the physical aspects of the disease, such as pain, but they suffer from psychological, spiritual, and emotional discomfort as well. The needs of the patients and their significant others are met through a multidisciplinary team approach where the team provides **palliative care**. Palliative care is concerned with treating symptoms, providing comfort measures, and promoting the best quality of life possible day by remaining day (Nursing Care Plan 15-1). Nurses who care for dying patients have a unique opportunity to become an intimate part of their lives. Nurses can support dying patients physically and emotionally while maintaining a professional role.

Whether the nurse is assisting the patient in the hospital or at home, the primary goal of palliative care is to improve patient outcomes, such as quality of life, and satisfaction with care. To achieve satisfactory outcomes, certain comfort measures are required. Palliative care requires a specialized body of knowledge and skills that can be difficult to learn, since it isn’t focused on “cure.” Family members are involved in this planning, and necessary support is provided to meet the needs of all those affected by the impending death (Figure 15-2, pg. 195). Registered nurses (RNs) and LPNs or home health aides provide nursing and personal care; trained volunteers are used to provide a variety of respite (relief) or socialization services. Hospice care may be provided in the patient’s home, nursing home, hospital, or hospice unit. Follow up of the family during the year after the death provides assistance with the grieving process.

Palliative care is a fairly new field, and many nurses have chosen to undertake this specialty. The palliative care nurse is specifically trained in management of the patient’s symptoms, provision of education for patient and family, and psychological and spiritual support—important elements for the patient’s and family’s comfort

during this transition. In September 2004 a certification examination for LPN/LVNs was launched by the National Board for Certification of Hospice and Palliative Nurses (NBCHPN). Detailed information is available by calling (888) 519-9901 or visiting [www.nbchpn.org](http://www.nbchpn.org).

## THE DYING PROCESS

### Kübler-Ross and the Five Stages of Coping with Impending Death

In the late 1960s, Elisabeth Kübler-Ross, a psychiatrist, began talking with terminally ill patients and identifying their needs. She also began educating medical students, nurses, and physicians about death and the stages through which she saw terminally ill patients progress. She transformed the way the health care community and much of the public view death, and she promoted much additional research into the areas of loss and death. As a result of her pioneering work, nurses and physicians are much more sensitive to the needs of the dying patient and family. Other researchers have added to her work, and the field of **thanatology** (the study of death) continues to grow.

Kübler-Ross’s identification of the stages a dying person moves through has been the foundation for understanding the dying process. Five stages, similar to those of the grief process, are described as being characteristic of dying: denial, anger, bargaining, depression, and acceptance (Kübler-Ross, 1969) (Table 15-1, pg. 195). The stages overlap, and as with the grieving process, the patient may move back and forth or even skip stages. In some cases the patient may “get stuck” in one stage and not move through to acceptance. Family members are often at different stages from the patient and each other. Nurses, too, move through the stages when they care for patients who are dying.

### Other Theories of the Dying Process

Theories of the dying process have identified other emotions that are commonly seen: fear of dying, yearning, guilt, hope, despair, and even humor. Some professionals point out that an individual’s reaction to the threat of death is consistent with the way the person coped with difficulties in the past, and that rather than experiencing stages, a person reacts with denial, anger, bargaining, hope, despair, and so forth in a fluctuating pattern. Coping with death takes many forms and is not limited to the dying person. It involves all who are connected with the dying person’s experience: family, friends, and caregivers. Coping with death may also involve tasks or actions that the dying person must work on in the physical, social, psychological, and spiritual arenas. An example of a physical task would be to minimize physical distress such as pain. A social task might be to enhance or restore a relationship that is important to the dying person. Other examples would be updating a will, making amends, and saying goodbye to friends and loved ones.

### Nursing Care Plan 15-1 Care of the Dying Patient

**SCENARIO** Mrs. Rodney is in the palliative care unit, actively dying from breast cancer with metastases. She is receiving pain medication, complains of thirst, and is expressing considerable pain.

**PROBLEM/NURSING DIAGNOSIS** *Pain is not adequately controlled/Pain related to breast cancer process and metastases.*

**Supporting Assessment Data:** *Subjective:* Pain at a level of 8/10. *Objective:* Grimacing with movement, holding body rigid; advanced breast cancer with metastases.

#### Goals/Expected

Outcomes	Nursing Interventions	Selected Rationales	Evaluation
Patient and family will verify patient has adequate pain control. Patient will verbalize relief, control of pain.	Assess characteristics of pain: location, severity on a scale of 1-10, frequency, precipitating factors, and factors that relieve the pain.	Pain management is most successful when the underlying cause of pain is identified and treated.	Is pain controlled adequately? Patient reports adequate control of pain and does not have increased BP, P, or R; no diaphoresis, dilated pupils, guarding, facial mask of pain, crying or moaning, abdominal heaviness, or cutaneous irritation.
	Eliminate factors that precipitate pain (e.g., excessive noise, wrinkled bed sheets, joint discomfort from positioning, thirst, wet bed and gown, cluttered environment, interrupted rest).	Pain may be aggravated by many factors.	
	Offer analgesics on a set around-the-clock schedule per physician orders.	Scheduled dosing controls pain better than PRN dosing.	Gave additional analgesia at 3:30 P.M. for escalating pain.
	Teach patient to request more analgesia before breakthrough pain becomes severe.	It is easier to prevent severe pain than to curtail it once the cycle begins.	
Explore nonpharmacologic methods for reducing pain and promoting comfort: <ul style="list-style-type: none"> <li>• Back rubs</li> <li>• Foot rubs</li> <li>• Slow, rhythmic deep breathing</li> <li>• Imagery exercises</li> <li>• Relaxation exercises</li> <li>• Repositioning</li> <li>• Diversional activities such as music, TV, games</li> <li>• Restful intervals between care or treatments</li> </ul>	Combination of analgesia and nonpharmacologic measures yields the best pain control.	Using imagery and breathing techniques. Refused back rub. Repositioned every hour. Watching TV. Body posture more relaxed. Continue plan.	

#### Critical Thinking Questions

1. What are some ways to help Mrs. Rodney with her pain? Should she be given additional pain medication (opioids)?
2. Some of the family members are afraid that additional opioids will hasten Mrs. Rodney's death. What can you say to the family members?

Key: BP, Blood pressure; P, pulse; PRN, as needed; R, respirations.



### Cultural Considerations

#### Cultural Views About Death

Certain cultures believe that talking about death can bring it on. This belief is found in some people from Greece, China, Italy, Korea, Mexico, and the southern African nations. American Indian culture includes a fear of death, and it is thought that truth-telling about a terminal prognosis violates traditions and taboos and can lead to harmful outcomes (Mitty, 2001). The nurse needs to consider the patient's cultural orientation before broaching the subject of death or terminal illness.

#### Hope and the Dying Process

**Hope** is an inner positive life force, a feeling that what is desired is possible. It takes many forms and changes as the patient declines. At first there is hope for cure, then a hope that treatment will be possible, next a hope for prolonging life, and finally hope for a peaceful death. Open-ended questions such as "What are you hoping for from this admission?" or "What are you hoping for today?" can allow patients to talk about their needs. You can always be supportive of hope by recognizing and affirming the wish the patient is expressing.



**FIGURE 15-2** The hospice nurse assists the family in saying goodbye to the dying patient.

**Table 15-1** Kübler-Ross's Stages of Coping with Death

STAGE	DESCRIPTION
<b>Denial</b>	"No, not me." The person cannot believe the diagnosis or prognosis. Denial serves as a buffer to protect the patient from an uncomfortable and painful situation. A patient may seek other opinions or believe there has been an error.
Anger	"Why me?" The person looks for a cause or fixes blame. Displaced anger may target physicians, nurses, family, and even God. Powerlessness to control the disease and events is an underlying issue.
<b>Bargaining</b>	"If I'm good, then I get a reward." The wish is for extension of life, or later for relief from pain, and the person knows from past experience that "good behavior" is often rewarded.
Depression	"It's hopeless." There is a sense of great loss, of the impending loss of being. People mourn losing family, possessions, responsibilities, all they value.
<b>Acceptance</b>	"I'm ready." The pain is gone, the struggle is over, the patient has found peace. There is withdrawal from engagement in everyday activities and interests. Verbal communication is less important, and touch and presence are most important.

## NURSING AND THE DYING PROCESS

Patients express many fears when they know they are dying: fear of pain, loneliness, abandonment, the unknown, loss of dignity, and loss of control. There may also be unfinished business that occupies the patient's thoughts. The concept of **comfort care** focuses on identifying symptoms that cause the patient distress and adequately treating those symptoms. **Palliation** is the relief of symptoms when cure is no longer

possible, and treatment is provided solely for comfort. **This concept can be applied in any health care setting.** Prevention of many symptoms is possible by anticipating their likelihood. The application of the nursing process to care of the dying patient uses skills and knowledge from physical, emotional, social, and spiritual contexts.

Throughout the nursing process, therapeutic communication is an important skill the nurse uses to promote communication. Beginning students and new graduates are often fearful of not knowing what to say or of saying the wrong thing. The first step in addressing these fears is for you to become comfortable with your own beliefs, values, and attitudes about death and dying. Second, read and learn about the actual dying process and observe experienced nurses talking with dying patients and grieving relatives. Third, be open to the difficult questions of life and death that permit patients to discuss their feelings and needs. Patients are usually sensitive as to how caregivers (and family members) react to uncomfortable subjects. Often, a patient will not bring up a subject with family members or staff who avoid conversations that are painful or anxiety provoking. Time and experience are the best teachers. Chapter 8 discusses specific therapeutic communication skills in greater detail.

A trusting relationship with the patient occurs as you are able to meet the identified needs. Listening skills; observation; and use of nonverbal communication, touch, and presence all contribute to the patient's sense of acceptance. Fears of isolation or loneliness decrease with nursing care that seeks to treat the patient with compassion and individuality. The family's anxiety decreases as they see the patient responding to the care and attention of the team.

### **?** Think Critically

What questions that a dying person might ask would be most difficult for you to respond to? Think about what you might say in response to such questions.

## ❖ APPLICATION OF THE NURSING PROCESS

### ■ Assessment (Data Collection)

A baseline assessment and continuing data collection are essential to identify the problems and needs of the patient and his family. An admission history should determine what they have been told by the physician regarding the illness and its expected course. Asking "What has your doctor told you about your condition?" may help identify knowledge the patient needs to make informed decisions. Questions about advance directives regarding treatment options, resuscitation, advanced life support, and organ donation can provide information about the patient's attitude toward death and the stage of his grief or dying reaction (denial,

anger, etc.). Asking questions about religious beliefs and practices, as well as asking directly “What do you hope for during this admission?” and “What are your concerns?” elicits data for the provision of comprehensive comfort care. **At no time should the patient be pushed to discuss something he is obviously avoiding.** A question such as “Is there anything else you’d like to talk about?” opens the door for issues the patient may wish to discuss.

### Safety Alert

#### Use Analgesia Cautiously

Does your patient have renal or hepatic dysfunction? Administration of opioid pain medication may need to be altered to avoid respiratory depression, hypotension, or central nervous system (CNS) toxicity. Consider the dosage recommendations given when a patient with renal dysfunction is prescribed an opiate.

An assessment of the patient’s **physical** condition includes such measures as weight (with attention to usual weight), mobility and the ability to perform activities of daily living, weakness or energy level, appetite (nausea, indigestion, gas), bowel and bladder function, and respiratory function. Pay special attention to assessing pain: location, nature, and what relieves it or makes it worse. Pain should be assessed using a 0-to-10 scale or similar method of measuring the patient’s report of pain. The frequency of pain assessment depends on many factors, such as the severity of pain and whether pain is increasing or well controlled on the current treatment regimen (see Chapter 31).

The patient’s **emotional** condition can often be observed during the interaction, and symptoms such as anxiety, agitation, confusion, or depression may be obvious. Validating your observation with the patient allows him to speak about his feelings. Stating “Tell me how you are coping with all this” begins to identify strengths and needs. **Spiritual** assessment can begin with questions about the patient’s religious affiliation and whether he would like to meet with a spiritual advisor (chaplain, rabbi, religious leader). Even when a patient indicates “none” for religious affiliation, he may have spiritual needs. Clues regarding spiritual distress may be found in questions such as “Why is God punishing me?” or what the meaning in his life has been.

#### ■ Nursing Diagnosis

Nursing diagnoses for the dying patient vary, depending on the disease process. For example, a patient dying of end-stage renal disease will have problems with fluid excess, whereas a patient dying of chronic obstructive pulmonary disease (COPD) will have problems with ineffective airway clearance. Certain nursing diagnoses are common at some point to most dying patients (Box 15-4).

### Box 15-4 Nursing Diagnoses for the Patient Who Is Dying

- Activity intolerance
- Death anxiety
- Deficient knowledge
- Fatigue
- Fear
- Grieving
- Imbalanced nutrition: less than body requirements
- Impaired physical mobility
- Impaired skin integrity
- Pain
- Risk for loneliness
- Self-care deficit

*Nursing Diagnoses—Definitions and Classifications 2012–2014* © 2012, 2009, 2007, 2005, 2003, 2001, 1998, 1996, 1994 NANDA International. Used by arrangement with Wiley–Blackwell Publishing, a company of John Wiley and Sons, Inc.

#### ■ Planning

It is important to include the patient and his family in planning care and establishing goals or outcomes. Planning should be a team effort, with all members of the team aware of the patient’s goals and needs. **Giving the patient control is the first priority at a time when it seems that he has no control.** As far as possible, agency rules and routines that are geared toward cure should be relaxed to recognize that the goal is comfort. These would include relaxing restrictive visiting hours; eliminating routine vital signs and laboratory work; and avoiding rigid schedules for getting up, bathing, or sleeping.

#### ■ Implementation

The nurse promotes self-care as long as the patient is able. Family members can derive much satisfaction in learning to provide physical care when the patient is no longer able to be independent. Be sensitive to patient or family member reluctance to provide (or receive) what is uncomfortable for either one, such as performing perineal care for a parent.

#### **Common Problems of the Dying Patient and Nursing Management**

**Anticipatory Guidance.** Anticipating death assists in preparing the family and patient by giving them guidance about physical changes, symptoms, and complications that may arise. This may also aid the patient and family in deciding about possible hospice care.

**End-Stage Symptom Management.** Many expected symptoms, such as pain, gastrointestinal distress, dyspnea, fatigue, cough, death rattle, and delirium, are related to metabolic changes at the end of life. The last few days of patient life have been studied extensively. The nurse must recognize these symptoms and be able to either alleviate them or help explain them to the patient and family.

**Pain Control.** Although nursing research has demonstrated safe and effective principles of pain control, many terminally ill patients unnecessarily die with uncontrolled pain. It is perhaps the first fear patients have regarding dying. Several myths still contribute to inadequate pain relief. The patient may fear becoming an addict or the medication not working when he needs it if he takes it for minimal pain. Nurses may fear that the pain medicine will hasten the patient's death by depressing respirations. Another misconception is the reliance on PRN (as-needed) medication for end-of-life pain rather than around-the-clock dosing. **A truly compassionate nurse studies and learns about pain management and applies those principles in daily practice.**



### Health Promotion

#### WHO's Three-Step Ladder for Pain Relief

The World Health Organization (WHO) has developed a three-step ladder to follow for adequate pain relief. According to this ladder:

1. Start with nonopioid drugs +1 adjuvant therapy.
2. If pain persists or increases, add an opioid designated for mild to moderate pain.
3. If pain persists or increases, change to an opioid designated for moderate to severe pain.

The pain ladder is additive to the first step. In other words, when changing from one step to the next, always continue the previous step(s) as well.

Pain can be controlled (eliminated) in almost all cases when the medical and nursing teams work together (see Nursing Care Plan 15-1). **Regularly scheduled pain medication with PRN backup for breakthrough pain is one of the most effective methods of controlling pain.** Carefully assess pain location, intensity, and response to medication every 2 to 4 hours, or more often if needed, to determine the necessity for increases in dosage. **There is no risk of becoming addicted or of reaching a safety or effectiveness limit when narcotics are increased in response to pain for the dying patient.** Patients with severe pain can receive huge doses of narcotics without respiratory depression or tolerance when the dose has been increased in response to increasing pain. Since comfort is the goal of palliative care, administering only oral medications, when feasible, is the preferred choice. However, this may not be possible as death draws near, and it is also the goal to allow a pain-free death. In some cases it may be possible to administer transdermal or rectal pain medications. The oral route and long-acting transdermal patches can also avoid the necessity of injections. **Even when the patient is no longer taking fluids by mouth, small amounts of concentrated pain medication can be inserted in the buccal cavity**

Table 15-2 Opioid Use in Patients with Renal Impairment

DRUG	RECOMMENDATION
Morphine	Use cautiously with dose adjustment and careful monitoring
Hydrocodone	Use cautiously with dose adjustment and careful monitoring
Oxycodone	Use cautiously with dose adjustment and careful monitoring
Codeine	DO NOT USE
Methadone	Safe
Fentanyl	Appears safe, reduce dose
Meperidine	DO NOT USE
Propoxyphene	DO NOT USE

(cheek) (Table 15-2). Transdermal fentanyl (patch) has helped eliminate the burden of pain at the end of life. You may have read that this method of pain relief carries high risk, but remember that patients in severe pain may receive higher doses of pain medication safely. Sometimes this regimen is supplemented with rescue doses of morphine if pain is not controlled. Whatever the regimen for pain control, pain relief—either total or at least to a tolerable level—is possible 75% to 97% of the time.

Nonchemical approaches to pain relief include visualization and guided imagery, relaxation and breathing exercises, massage, music therapy, meditation, religious healing, biofeedback, hypnosis or self-hypnosis, transcutaneous electrical nerve stimulation (TENS), and hydrotherapy (e.g., whirlpool). Teach the patient one or more of these simple techniques as adjuncts to drug therapy. Provide a quiet environment and assist the patient as necessary (see Chapter 31). Some patients do not respond to the standard medicines or adjunct therapy. In these cases, radiation treatment, nerve blocks or implanted pumps, or surgery may be required.

**Constipation, Diarrhea.** Constipation is predictable for a patient receiving opiates, experiencing decreased fluid intake and mobility, and having certain abdominal diseases. In addition to classic nursing measures for preventing constipation (increasing fiber, fluids, and exercise; see Chapter 30), consult with the physician for orders for stool softeners and a standing laxative order. Suppositories and enemas, or manual disimpaction, can be avoided in most cases with careful monitoring and adherence to a laxative schedule.

**Anorexia, Nausea, Vomiting.** Anorexia, or loss of appetite, may be due to nausea, drug side effects (especially a sore mouth), the disease process, or the slow-down that occurs naturally in the dying process. Antiemetics are the first choice to eliminate nausea and

vomiting. Small servings, home-prepared food favorites, and attention to eliminating unpleasant sights and odors at mealtime may stimulate a poor appetite. A bad taste can be improved by frequent oral care, mouthwashes, or hard candies (sour balls). A nutritionist may be helpful in suggesting food choices that are appealing and easily digested. You can do a great deal to support the patient and the family with an explanation of the dying process: that decreased intake is more comfortable for the patient than having food to digest and move through a system that is slowing down. There is also some evidence to suggest that starvation decreases the patient's awareness of pain by producing chemicals that act as pain relievers. Weight loss is commonly seen in dying patients, but few patients complain of feeling hungry. **Dysphagia** (difficulty swallowing) may also be a problem. Moistening the mouth with fluids or artificial saliva may be helpful. Additional care of the dysphagic patient is presented in Chapter 27.

**Dehydration.** As death nears, patients spend more time sleeping or in a semiresponsive state. They take in fewer and fewer fluids until the question arises about providing intravenous (IV) fluids or tube feedings out of concern for dehydration. Research has shown that dehydration results in less distress and pain and that hydration does not improve comfort. Dry mouth and thirst are the most common complaints, which may be induced by the drugs being administered, and these can be alleviated by small sips of fluids, ice chips, and lip lubrication. Resulting decreased urine output means less effort to use a commode or less incontinence. This is an issue that is best discussed before it arises, at the time advance directives are being established. It is an emotional issue, and families often have a difficult time accepting that withholding fluids is more comforting than administering them. Families can be comforted with an explanation of how the dying person is indeed made more comfortable by withholding fluids. The nurse must help educate the patient and family as to both the benefits and burdens of hydration. Many times the course is for patients to choose what to take and be allowed to refuse further nourishment. This is referred to as "patient-endorsed intake."

**Dyspnea.** Difficult breathing may be seen early in the dying process in certain lung or heart disorders. It is also seen shortly before death, when respirations may become noisy, irregular, or labored. Secretions in the lungs accumulate and block the airways to contribute to noisy or rattling respirations. The patient is usually not responsive, or not aware of the dyspnea, but it is *upsetting to family members*. Suctioning is not effective in clearing the secretions, but medications such as a scopolamine patch or morphine can decrease secretions and ease breathing. Administering oxygen by nasal prongs may provide comfort.

**Death Rattle.** Noisy respirations are heard when patients can no longer clear their throats of normal secretions. Family members are often alarmed and are afraid the patient will choke to death. In these cases, scopolamine or morphine, drugs that are known to reduce secretions, may be used to quiet the patient and bring breathing back to normal.

**Delirium.** Dying patients may experience hallucinations or altered mental status. Nurses must first search for causes such as pain, positional discomfort, or bladder distention and address those physical problems. Next, nurses should discuss the delirium with the patient's family and encourage the family to talk to the patient in quiet tones while remaining calm.

**Impaired Skin Integrity.** Weight loss, decreased nutrition, incontinence, and inactivity all contribute to the risk of skin breakdown. Turn and position the patient; use protective measures such as an air pressure mattress, heel or elbow protectors, and sheepskin or foam pads; and keep the skin clean and dry. An indwelling or condom catheter may be indicated to conserve the patient's dwindling energy and to prevent skin breakdown.

**Weakness, Fatigue, Decreased Ability to Perform Activities of Daily Living.** Increasing weakness eventually results in the patient's becoming bed-bound. Accept the patient's wishes regarding walking, sitting up in a chair, or remaining in bed. **The dying patient is not going to get stronger or better; he gets weaker and weaker, not because he is lying in bed, but because he is dying.** Allow the patient to do as much as possible for himself, and provide physical care when he is no longer able.

**Anxiety, Depression, Agitation.** Emotional or psychological symptoms may be treated with appropriate drugs with good effect. Listen and use good therapeutic communication skills to allow the patient to express his fears, feelings, and needs and to convey nonjudgmental acceptance (see Chapter 8). Skillful assessment of these symptoms may identify physical pain or spiritual distress that can be treated.

**Spiritual Distress, Fear of Meaninglessness.** Each person needs to believe that his life has had meaning; this is the spiritual nature of the dying process. A life review allows the patient to put his life in perspective. Reminiscing is one way of starting a life review. Encourage the patient to tell about family photographs or albums. Ask "What was it like when you were a child [or worked on the farm, lived in the city, met your wife]?" **It is more important to listen than to talk.**

#### ■ Evaluation

*Evaluation is based on the specific expected outcomes written for the patient. The outcomes depend on which nursing diagnoses are pertinent to the patient's situation. In most cases the degree of comfort obtained for the patient by the nursing interventions needs to be*

evaluated. Was pain adequately controlled? Was tissue integrity protected? Were actions to facilitate the patient's and family's grieving process effective? Was the patient's fear alleviated? Did interventions for a self-care deficit make the patient more comfortable? Answers to these questions help determine whether expected outcomes have been met. If the care plan is not effective, the plan must be revised.

## SIGNS OF IMPENDING DEATH

### PHYSICAL SIGNS

As death approaches, the patient grows physically weaker and begins to spend more time sleeping. Body functions slow, appetite decreases, and the patient may refuse even favorite foods and later fluids as well. Explain to the patient and the family what to expect. Moistening the patient's lips and mouth, and providing oral hygiene, will be more comforting than "pushing" food or fluids.

Urine output decreases, and urine becomes more concentrated. There may be edema of the extremities or over the sacrum. Incontinence may occur as patients become less aware of their surroundings. However, be alert to the possibility of urinary retention and the need for catheterization.

Vital signs change as death approaches. The pulse increases and becomes weaker or thready. Blood pressure declines, and the skin of the extremities becomes mottled, cool, and dusky. Respirations become shallow and irregular. Secretions may pool in the lungs, causing respirations to sound moist. Often at the time of death, a "death rattle" of those secretions occurs. **Cheyne-Stokes respirations**—respirations that gradually become shallower and are followed by periods of **apnea** (no breathing) may be noted. Body temperature may rise, and the patient (if responsive) may complain of feeling hot or cold, although the extremities are cool to the touch as circulation slows. Blankets should be used as the patient desires.

### PSYCHOSOCIAL AND SPIRITUAL ASPECTS OF DYING

As outlined in Kübler-Ross's stages of coping with dying, it is hoped that the patient will have reached the stage of acceptance as death draws closer. During this time the patient will talk about making funeral arrangements and "putting my affairs in order." To die with **closure** is to say goodbye to those people and things that are important. It may also involve saying, "I'm sorry, forgive me," "I forgive you," and "I love you." It is a time when the patient may give to family and friends special memories or possessions. A life review can assist patients in telling their story and putting their life in perspective. Helping the patient write or share his life story with significant others allows them to keep special memories of their loved one.

As individuals approach death, their spiritual needs take on greater importance. As patients ponder the meaning of their life, their beliefs about what happens to them in death take on new meaning. Religious practices and rituals have great significance for some patients. It is important for you to be familiar with those beliefs (see Chapter 14). **Rather than impose your own religious beliefs on dying patients and family, you should assist patients in finding comfort and support in their own belief systems.** An assessment of the patient's spiritual needs is outlined in Chapter 14, and when indicated, you may collaborate with the patient's religious representative or hospital chaplain to provide spiritual care.

As life ebbs, the patient becomes less verbal and more withdrawn. Everyday activities and news are not of interest, and nonverbal communication becomes most important. Sitting with patients and using touch, such as holding their hand or stroking their hair, are most meaningful. Even when patients appear to be sleeping or nonresponsive, physical touch and presence are comforting. **Always be aware of remarks you make in the presence of an unresponsive patient because they DO hear. Hearing is believed to be one of the last senses to be lost before death, and "dying" patients have awakened to report conversations by family and health care workers that they were not meant to overhear.**

Dying patients may exhibit confusion and disorientation. They may report dreams or visions of deceased relatives, and they usually are not frightened by these experiences. Often this is comforting, and they may speak of preparing for a journey to join loved ones. At times patients may become restless and agitated. Adequate pain and anxiety medication can ease the distress of these symptoms. Keep soft lights on in the room. Assurance that it is "O.K. to go" and that family members will take care of each other may ease dying individuals' anxiety about leaving their responsibilities.

### Think Critically

What would you wish to include in your **obituary** (a notice of the death published in newspapers)? Write your own obituary, imagining at what age you would die, and what will have happened in your life (education, jobs, family) between now and the time of your death. What funeral arrangements will you make?

### LEGAL AND ETHICAL ASPECTS OF LIFE AND DEATH ISSUES

The health care system is still grappling with care of the dying. The patient's rights to make decisions about end-of-life situations, advance directives, and the designation of a health care proxy have gained legal and public acceptance.

## ADVANCE DIRECTIVES

An **advance directive** spells out patients' wishes for health care at that time when they may be unable to indicate their choice. A **durable power of attorney for health care** is a legal document that appoints a person (**health care proxy**) chosen by the patient to carry out his wishes as expressed in an advance directive. Discussing advance directives with patients opens the communication path to establish what is important to them and what they view as promoting life versus prolonging dying. Patients determine under which situations they would agree to **do-not-resuscitate (DNR)** orders. Their choices regarding artificial feeding and fluids, ventilators, and administration of antibiotics are documented.

### Elder Care Points

- When competent elderly individuals have not completed an advance directive before admission, even though it may be difficult to communicate with them, they should be included in discussions and decisions about end-of-life care.
- Confusion about time or place does not automatically make patients incapable of expressing their wishes and preferences.

Patients with advanced chronic progressive illness can have a "Physician Orders for Life-Sustaining Treatment" form initiated by their health care providers. The form provides orders for emergency medical personnel regarding end-of-life wishes and summarizes a person's advance directives. The forms are available for nine states at [www.ohsu.edu/polst/programs/sample-forms.htm](http://www.ohsu.edu/polst/programs/sample-forms.htm). Much of the debate in health care today deals with end-of-life decisions such as euthanasia, assisted suicide, adequate pain control, and death with dignity. Nurses must keep up to date on legal decisions related to these issues and continue to learn and apply new nursing theory and procedures regarding end-of-life care. They must also deal with their own feelings and values regarding patient choices to seek life-prolonging or death-seeking treatment.

## EUTHANASIA

**Euthanasia** is the act of ending another person's life to end suffering, with (voluntary) or without (involuntary) his consent. It may be called "mercy killing." Some distinction is also made between active and passive euthanasia. **Passive euthanasia** occurs when a patient chooses to die by refusing treatment that might prolong life. An example would be withholding artificial feeding or parenteral (IV) fluids when the patient is unable to take them orally. It would also include not treating pneumonia with antibiotics. **Honoring the refusal of life-prolonging treatment of a patient with a terminal illness is legally and ethically permissible.** **Active euthanasia** is generally defined as administering a drug or treatment to end the patient's life. **Active**

**Table 15-3** Legal and Ethical Considerations for Euthanasia

VOLUNTARY EUTHANASIA	INVOLUNTARY EUTHANASIA
<b>Arguments For</b>	
<ul style="list-style-type: none"> <li>• Respects individual liberty and rights</li> <li>• Provides more dignified death</li> <li>• Reduces suffering</li> <li>• Demonstrates mercy</li> <li>• Supports constitutional right to privacy</li> <li>• Demonstrates right of self-determination</li> <li>• Upholds right to autonomy</li> </ul>	<ul style="list-style-type: none"> <li>• Reduces depletion of financial resources</li> <li>• Allows the patient dignity</li> <li>• Reduces suffering</li> <li>• Demonstrates mercy</li> <li>• Supports right to die</li> </ul>
<b>Arguments Against</b>	
<ul style="list-style-type: none"> <li>• Exploits the terminally ill</li> <li>• Breaks the Hippocratic oath</li> <li>• Unnecessary—nature will take its course</li> <li>• Morally wrong</li> </ul>	<ul style="list-style-type: none"> <li>• Ignores informed consent</li> <li>• Violates right to life</li> <li>• Unnecessary</li> <li>• Morally wrong</li> </ul>
<b>Legal Considerations</b>	
<p>The courts have approved the withholding of treatment in both voluntary and involuntary euthanasia cases if the parties can demonstrate that it is in the best interest of the patient and the family requests it. However, be aware that "assisted suicide" is illegal in most states and legal consequences may follow. In addition, active euthanasia is never legal or permissible.</p>	

**euthanasia is not legal or permissible in the United States.** The arguments for legal and ethical considerations regarding euthanasia are presented in Table 15-3.

**Assisted suicide** is distinguished from active euthanasia. It is making available to patients the means to end their life (such as a weapon or drug) with knowledge that suicide is their intent. **Both active euthanasia and assisted suicide are considered to be violations of the American Nurses Association's Code of Ethics for Nurses.** Their position statements regarding active euthanasia state that "the nurse does not act deliberately to terminate the life of any person" and that "nurses must . . . not participate in assisted suicide" (American Nurses Association, 1995).

Assisted suicide has generated a great deal of debate and dialogue in health care as nurses witness firsthand their patients' despair, pain, and debilitation. Assisting the patient's death may be seen as a compassionate and humane response. Although an individual case may be compelling, there is a large potential for abuse of this solution for difficult care problems, especially for the elderly, the disabled, and the poor. Oregon passed a law legalizing assisted suicide in 1998; Montana and Washington state also allow assisted suicide in limited cases. The courts in other states continue to decide cases involving assisted suicide and active euthanasia that may change the legal status of such acts.

## ADEQUATE PAIN CONTROL

Adequate pain control is another issue that affects the comfort of the dying. Physicians may be reluctant to prescribe large enough doses of pain medication for fear of legal action under the Controlled Substances Act. They may also be concerned about being viewed as prescribing lethal doses in an assisted suicide effort. National legislation (the Lethal Drug Abuse Prevention Act of 1998) was proposed to prevent physicians from prescribing controlled substances for the purpose of assisting suicide. The bill failed. If passed into law, it could have had a negative effect on the physician's willingness to prescribe adequate pain medication.

Nurses must be advocates for compassionate end-of-life care. Knowledgeable and skillful symptom management; the relief of suffering; and the promise of presence, of not abandoning the patient, become the cornerstones of end-of-life care that can eliminate the person's desire to choose euthanasia or suicide.

## ORGAN AND TISSUE DONATION

Kidneys, livers, hearts, and lungs are organs that can be transplanted from one person to another. Other tissues such as corneas, bone, and skin can also be transplanted. The need for organs and tissues for transplantation far exceeds the supply. Every day people die waiting for a transplant. People can indicate their wish to be donors on their driver's license or in advance directives, but the next of kin must give permission to remove the organs or tissues of a dead person. Organs such as hearts, lungs, and livers can only be obtained from a person who is on mechanical ventilation and has suffered brain death but still has perfusion to the organs. Other tissues can be removed for several hours after death, such as after a massive heart attack or stroke. The donor must be free of infectious disease and cancer. The criteria are set by the United Network for Organ Sharing (UNOS).

Physicians are usually the people to request organ donation from family members, but you may be in a position to answer questions the family raises about organ donation. You should know that donation of organs does not delay funeral arrangements, there is no obvious evidence that the organs were removed when the body is dressed, and there is no cost to the family for the removal of organs donated.

## POSTMORTEM (AFTER DEATH) CARE

When the patient stops breathing, the heart may continue to beat for several minutes. (When the heart stops, death is said to have occurred, unless the person is on a ventilator.) When a patient is being mechanically ventilated, brain death must be established to determine death. In a hospital or nursing home a physician is usually designated as the person responsible for pronouncing the death. However, in some institutions midlevel providers, such as physician assistants and nurse prac-

tioners, may perform this function. When a patient dies at home, the pronouncement of death may be delegated to an undertaker, RN, or coroner. A **coroner** is a person with legal authority to determine cause of death. A coroner investigates any deaths that occur under suspicious circumstances, including deaths that result from injury, accident, murder, or suicide. Any death within 24 hours after admission to the hospital or during surgery, or death of a person who has not been under a physician's care, is reported to the coroner. In the health care setting, if a death is a coroner's case, no tube or line is removed from the body to prevent removal of evidence of wrongdoing. IV lines and associated tubing are simply cut and tied off, with the catheters left in place.

A death certificate is completed by the physician, the undertaker, and a pathologist if an autopsy is done. An **autopsy** is an examination of the body, organs, and tissues to determine the cause of death. Consent for autopsy must be obtained from the next of kin, except in a coroner's case, when no permission is needed.

As the nurse, you are responsible for **postmortem** (after death) care of the body. Family members may wish to assist with or perform the preparation of the body as their last service to the patient, especially if they have been present throughout the dying process. If family members were not present when the patient died, the body may be prepared for the family to come to say goodbye and for removal to the morgue or undertaker (Skill 15-1). It is comforting for the family to have you indicate such things as "he died very peacefully" and to explain the final care the patient received. Ask if the family wishes to be left alone with the body for their final goodbyes. You should return any of the patient's personal belongings to the family, especially jewelry or valuables. The family members' reactions become your focus, and a private, quiet place should be provided for them to begin the grieving process until they are able to leave. Unused drugs are returned to the pharmacy according to agency policy. Unused drugs are never given to the family. It is not recommended to flush the drugs down the toilet.

Nurses can gain a great deal of satisfaction in caring for the dying patient and his family. Helping patients attain their goal of dying with dignity, without pain, and with a sense of closure is a tremendous challenge, but one that is rewarding. You should realize that you will also grieve for the dying patient. Many hospitals and health care agencies provide for support sessions after a particularly difficult death or when a unit has a succession of unexpected or challenging losses. You need to take care of yourself in order to continue taking care of your patients, and this includes recognizing the normal feelings that occur with loss and allowing yourself to move through the grief rather than trying to avoid it. Talking with the chaplain, co-workers, and other experienced nurses can support and heal the grief. Seeking professional assistance may be indicated if grieving becomes dysfunctional.

## Skill 15-1 Postmortem Care



After death, you will prepare the body for transport to the morgue or funeral home. Always check records to see whether the patient is a designated organ donor. If so, initiate the organ donation process according to agency policy.

### Supplies

- **Shroud** (sheet used to wrap body after death) pack or body bag (depending on your facility's preference)
- Death care kit (shroud/body bag, gauze 4 × 4 dressings, and protective pads if not in shroud pack)
- Gloves
- Bag for belongings
- Valuables list
- Bathing supplies
- Comb and brush
- Tape and large safety pins
- Body tags or labels
- Gurney or morgue cart

Review and carry out the Standard Steps in Appendix D.

### ACTION (RATIONALE)

#### Assessment

1. Verify the patient's identification. (*Ensures that the patient is properly identified.*)
2. Determine whether an autopsy will be done; check for signed autopsy consent. (*Drainage or other tubes are not removed if an autopsy is planned.*)
3. Determine whether the family wishes to assist with bathing or caring for the body, or if they wish to view the deceased after the nurse prepares the body. (*Family may gain closure from this last act of care for their loved one.*)

#### Planning

4. Gather equipment, and prepare the working space by raising the bed to proper height and positioning the over-the-bed table for use. (*Promotes work efficiency and prevents back strain.*)
5. Close the door and/or privacy curtains. (*Protects privacy and dignity.*)

#### Implementation

6. Perform hand hygiene and don gloves. (*Protects you from contact with body fluids.*)
7. Position the patient in supine position with a pillow under the head and the head of the bed elevated 15 to 20 degrees. Close the eyelids, if necessary, by grasping the eyelashes and gently

pulling lids down over the cornea. (*Raising the head prevents pooling of blood, which might discolor the face. Closing the eyelids protects the eyeballs.*)

8. Replace the dentures if they are out of the mouth if hospital policy requires it. Close the mouth. A small rolled towel may be placed under the chin if needed to keep the mouth closed. Depending on agency policy, dentures may be placed in a labeled denture cup without water and sent with the body so that the mortician does not have to remove the dentures again to embalm the body. (*Closing the eyelids and mouth protects the eyes and keeps the face in the most natural position during rigor mortis [rigidity of muscles that occurs after death].*)
9. Remove any jewelry and clothing. List all personal articles on the valuables list. Place in bag to be returned to the family and handle according to agency policy. (*This provides for return of personal property to the family.*)
10. Wash all areas of the body soiled with blood, feces, urine, or drainage. Place protective pads under rectum and between the legs to protect from drainage from rectum, vagina, or urethra. (*After death, sphincter muscles relax, allowing leakage of stool, urine, or body fluids.*)
11. Comb the hair and arrange neatly. (*Combing the hair improves the appearance of the body and prevents matting or tangling.*)
12. Deflate any balloons and remove all tubes (IVs, catheters, nasogastric) unless an autopsy is planned, if this is agency policy. Otherwise, convert IV catheters to intermittent locks. To secure tubes left in place, remove the drainage bag or IV fluid container, cut the tubing, and fold over twice. Secure with a rubber band. (*Properly deflating balloons before tube removal prevents tissue damage. Leaving the IV catheter in place prevents leaking during embalming. Prepares body for coroner or undertaker.*)
13. Change any soiled dressings and remove adhesive marks with appropriate solvent. Place small dressings over wounds and secure with paper tape. (*Improves appearance of the body.*)
14. Dress the body in a clean gown if family will be viewing the body, and remain with them unless they wish to be alone. The gown may be removed before wrapping the body. (*Dressing the body preserves dignity, and remaining with the family provides emotional support.*)

**Skill 15-1** Postmortem Care—cont'd

15. After the family leaves, attach identifying tags, usually on the big toe or ankle and the wrist. *(Proper identification ensures that the body will be transported to the correct mortuary.)*
16. Place padded ties around the ankles; crisscross the wrists over the abdomen and secure; and place a gauze tie or chin strap under the jaw to keep the mouth closed. Some mortuaries prefer that the limbs not be tied together. In this case, position the arms in a natural position at the sides of the body and keep the legs straight and together. *(Ankles and wrists are sometimes secured to prevent the arms and legs from being damaged during transport. However, the ties can damage the skin and make embalming more difficult.)*
17. Place the body on the shroud or in the morgue bag and check for placement of drainage pads. Fold the shroud according to agency procedure using the numerical order indicated. Secure the shroud at the chest, waist, and knees, and place an identification (ID) tag on the outside. *(The shroud covers the body and prevents unnecessary exposure. The ID tag ensures correct disposal of the body. Some mortuaries prefer the body not be shrouded.)*
18. Transfer the body to the stretcher or morgue cart. Secure the body with straps that are secure but not so tight as to cause bruising. Remove gloves and perform hand hygiene. Transport the body to the morgue in the service elevator unless the mortuary will come to the room to transport it. *(Transport to the morgue is done quickly and with as little notice as possible, since it may upset other patients or visitors to see the body. Doors to patient rooms may be closed and the elevator held ready for transport. In some agencies the face may be left uncovered so passersby think the person is just unconscious. Some mortuaries come directly to the room to transport the body.)*

**Evaluation**

19. Ask yourself: Was the procedure carried out in a quiet, respectful way? Was the family supported and helped to say goodbye? Did the deceased appear clean, peaceful, and well cared for? *(Determines whether expected outcomes have been met. Indicates whether the way in which the procedure was carried out needs to be changed.)*

**Documentation**

20. Note the care provided in the chart. *(Documentation is legal proof of the nursing care provided.)*

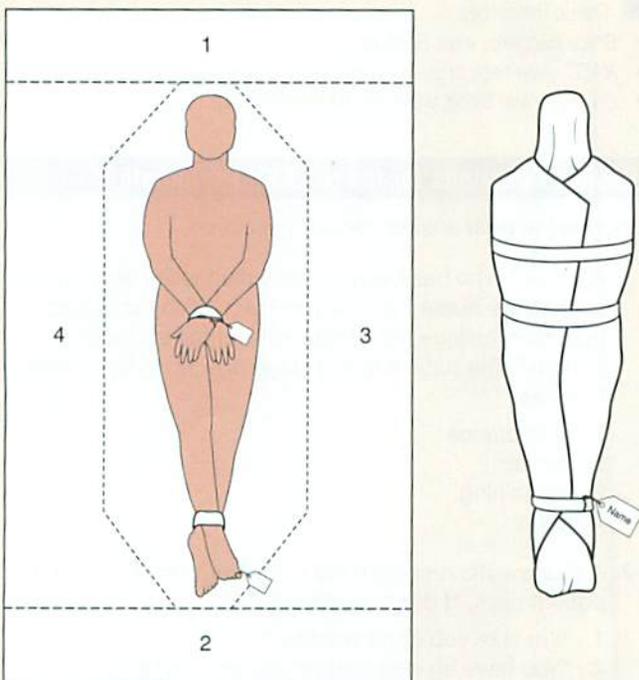
**Documentation Example**

2/17 1030 Pt stopped breathing.  
 1033 No apical pulse detected. Dr. Grover notified.  
 1040 Pronounced dead by Dr. Grover. Family present and assisted in washing and preparing the body for transport to morgue. Foley catheter removed. ID tags attached to right toe, right wrist, and outside of shroud. Transported to morgue at 1120.

\_\_\_\_\_  
*(Nurse's signature)*

**? Critical Thinking Questions**

1. Catherine Baumgartner has just died from complications as a result of extensive drug-resistant tuberculosis. The patient has been in isolation with minimal visitor contact, and the family has had to follow isolation precautions to visit the patient.
  - a. Would you perform postmortem care differently than you would for a patient who died from cancer? If so, what would you do differently?



Step 17

## Get Ready for the NCLEX® Examination!

### Key Points

- Loss is to no longer possess or have a person, object, or situation. Grief is a normal reaction to loss. Death is the most difficult loss human beings experience.
- The grieving process consists of feelings and acts that move to eventual recovery. The symptoms of the grieving process include crying, depression, loss of appetite, changes in sleep, loneliness, and sadness. The grieving person may be the patient, loved one, or caregiver.
- Each person who grieves does so in a unique way that depends on the value of the loss to them, their previous experiences with loss, and their learned coping skills.
- Nurses assist the grieving person through validation of the loss, teaching of adaptive coping skills, and caring support.
- Therapeutic communication techniques—active listening, avoiding clichés, and attention to nonverbal communication—are invaluable in dealing with the person who is experiencing loss.
- Death may occur in different ways, and each person's reaction to death will also be different.
- Hospice is a concept of care for the dying and their families that focuses on symptom control, comfort measures rather than cure, and a team approach to meeting the expressed needs of the patient and the family.
- Kübler-Ross's theory of the stages of dying includes denial, bargaining, anger, depression, and acceptance.
- The dying person may experience fear of pain, of the unknown, and of loss of control, as well as guilt, hope, and despair.
- Hope is a positive life force that can be nurtured in different ways for the dying.
- Palliative care is a concept of providing care that relieves symptoms when cure is no longer possible. This concept can be applied in any setting.
- The nursing process identifies the physical, emotional, social, and spiritual aspects of the dying patient's care and provides care using a comprehensive team approach.
- Patients may have tasks to complete before death, such as saying goodbye, making amends, reconciling with family or friends, and doing a life review.
- Research and practice provide effective ways of controlling pain and managing symptoms of nausea, constipation, anorexia, dyspnea, anxiety, or spiritual distress.
- Terminal dehydration has been shown to be palliative in reducing pain. IV hydration is not indicated unless it is a patient's choice.
- Signs of impending death include decreasing level of consciousness, decreasing urine output, mottling of skin, cool extremities, Cheyne-Stokes respirations, death rattle, and incontinence. Hearing and touch are among the last senses to be lost before death.
- Nurses must be aware of patients' religious beliefs and assist them in the practice of those religious rituals that are important to them.
- Advance directives indicate a patient's choices about end-of-life decisions such as DNR orders and artificial hydration or tube feedings.

- Euthanasia and assisted suicide are legal and ethical issues for health care professionals.
- Assisted suicide is ethically not acceptable for health care professionals. Legally it is being tested in the courts, and new laws are constantly being proposed.
- Donation of organs from a dying person is possible if relatives give permission. Nurses have an important role in explaining the aspects of organ donation.
- Nurses are responsible for care of the body after death (except in some religions).
- Caring for patients in the final stage of life can be rewarding and satisfying. Nurses will recognize signs of grieving in themselves after a patient's death.

### Additional Learning Resources

**SG** Go to your Study Guide for additional learning activities to help you master this chapter content.

**Evolve** Go to your Evolve website (<http://evolve.elsevier.com/deWit/fundamental>) for the following FREE learning resources:

- Animations
- Answer Guidelines for Think Critically boxes and Critical Thinking Questions and Activities
- Answers and Rationales for Review Questions for the NCLEX® Examination
- Glossary with pronunciations in English and Spanish
- Interactive Review Questions for the NCLEX® Examination and more!



#### Online Resources

- *Grace Happens*, [www.Griefnet.org](http://www.Griefnet.org)
- *NACC*, [www.nacc.org/resources/links/death.asp](http://www.nacc.org/resources/links/death.asp)
- *On Death and Dying*, [www.WhatMattersNow.org](http://www.WhatMattersNow.org)

### Review Questions for the NCLEX® Examination

Choose the **best** answer for each question.

1. A patient who has been recently diagnosed with cancer says to the nurse, "If I can just live until my son graduates from college, I'll donate 10% of my estate to the church." The patient is in a stage described by Kübler-Ross as:
  1. acceptance.
  2. denial.
  3. bargaining.
  4. anger.
2. A therapeutic response the nurse could make when a patient says, "I don't want to die" is:
  1. "I'm sure you don't want to die."
  2. "You have an excellent physician, maybe you won't die."
  3. "None of us wants to die."
  4. "I'm sorry you are going through this; would you like to talk about it?"

3. Carolyn is in the active phase of death and her family approaches you about Carolyn's breathing. The family fears that the mucus they hear rattling as she breathes will cause her to choke. They want you to perform suction. How do you respond?
  1. You gently explain to them that this is a natural process and mucus gathers as dying patients are less able to clear their throat. You also explain that deep suctioning will only serve to put Carolyn in pain, but you suggest that you could do some light suctioning to ensure there will not be blockage.
  2. You are also alarmed that Carolyn might choke and rush to perform deep suctioning.
  3. You tell the family that they are being unreasonable and Carolyn will not choke to death.
  4. You know that Carolyn is going through a natural death process, but perform the suctioning anyway, even if it puts Carolyn in pain. The family is what is important now.
4. Comfort care for a terminally ill patient would include:
  1. magnetic resonance imaging (MRI) to determine whether metastases are causing bone pain.
  2. use of medication to relieve nausea.
  3. insertion of an intravenous line to provide fluids.
  4. a gastrostomy tube to provide nutrition when the patient is unable to eat normally.
5. The priority of palliative care is to:
  1. control symptoms and promote comfort without the hope of cure.
  2. prevent the recurrence of cancer when it is first diagnosed.
  3. control costs of terminal illness by avoiding expensive treatments or drugs.
  4. keep the patient at home rather than in a hospital or nursing home.
6. Validation of loss can be of great comfort to a grieving individual. A patient states, "I am so depressed! I didn't know it would be so difficult to cope after losing my mother." To validate the loss, the nurse would respond:
  1. "Yes, but time is a great healer and you will eventually adjust."
  2. "I am sorry you are having such a hard time. Tell me a little about your mother and what she meant to you."
  3. "Would it help to see a grief counselor?"
  4. "Have you ever lost a loved one before?"
7. Certain cultures believe that talking about bad things like death can bring it on. Your patient is an American Indian with advanced breast cancer whose family is at her bedside. The family has asked that you only discuss plans for a cure, and not discuss palliative measures. How do you plan for the patient's care during the final stages of her illness?
  1. The nurse ignores end-of-life issues and continues to treat the patient for a cure, even though the treatment is painful.
  2. The nurse discusses palliative measures with the family, being careful to discuss "comfort" and not "death."
  3. The nurse tells the family that their family member cannot receive hospice care if she does not know about her impending death.
  4. If the family asks questions, refer them to the physician.
8. An assigned patient has prostate cancer and is declining rapidly. He is frightened by the progression and asks you if there is any hope. What is the nurse's best response?
  1. "Your prostate cancer is incurable. We have exhausted our treatment measures, but I can discuss comfort measures with you."
  2. "Would you like me to call a chaplain for you? Maybe it's time to put your trust in a higher power."
  3. "There is always hope. Let's look at how we can address your issues together. What is it that you are hoping for at this point?"
  4. "You cannot give up! A positive attitude helps effect a cure."
9. Ashley is in the terminal stages of pulmonary fibrosis. You open a conversation with him, asking about his wishes for care, and he says, "Why bother talking about my care anyway? The outcome will be the same—death!" The nurse responds by saying:
  1. "You are right. Let's just talk about the present because it is much more comfortable for you to visualize."
  2. "You never know what the outcome is going to be. Only God knows, so you have to keep trying."
  3. "Many people experience their final months of life with comfort, the ability to cope with symptoms, and the ability to make their own decisions regarding pain and symptom relief. What are your plans for this time in your life?"
  4. "I just hope the pain doesn't get too bad for you."
10. After receiving palliative care for several months, your patient has died. The family is feeling deep grief. The nurse feels saddened also, and knows that:
  1. crying is inappropriate because you are not even a family member or a close friend.
  2. it is appropriate for the nurse to shed some tears also, allowing movement through the grief rather than trying to avoid it. The nurse may also need to seek professional assistance.
  3. the nurse needs to ignore feelings and stay strong for the family in order to provide better nursing care.
  4. the nurse should avoid the family and allow them to grieve in private. the nurse is no longer needed, and the nurse's presence just reminds them of their loss.

### Critical Thinking Activities

Read the clinical scenario and discuss the questions with your classmates.

Lynn Nuñez, a 45-year-old woman with advanced breast cancer that has spread to her lungs and bones, is admitted to your unit for terminal care and palliation. She has draining sores on her left breast. She is experiencing a great deal of pain when she moves, but she does not want to be sedated. Her wish is to spend her last days with her family, which includes her husband, mother and father, and two teenage daughters. The family is close and supportive, but is having a hard time seeing Lynn suffer. She is Roman

Catholic, and the parish priest has visited daily. She has indicated she does not wish to have extraordinary measures, including feeding tubes, IVs, or antibiotics. She has a DNR order.

1. What do you think are Lynn's prioritized needs for care?
2. If she were assigned to you for care, what might you suggest for:
  - Frequency of vital signs measurement
  - Personal care: bathing, mouth care, skin care
  - Feeding: what, when, how much
  - Activity level
3. What might your response be if Lynn were to ask you, "Why do I have to suffer like this?"