EMOTIONAL AND SPIRITUAL SUPPORT

The restlessness that commonly occurs during the dying process is also called terminal or agitated delirium. It can also result from pain, bladder distention or stool impaction.

• The patient must be protected from injury and the family needs to be supported.
• Consider the following:
  - Give a trial dose of opioids to rule out pain.
  - Assess for bladder distention and insert indwelling catheter if needed. Assess for impactation if appropriate.
  - Consider antipsychotics: haloperidol or chlorpromazine.
  - Consider benzodiazepines: lorazepam or midazolam.
  - Maintain calm environment.
  - Minimize bright lights.
  - Play patient’s favorite music.
  - Talk softly to patient; maintain touch and presence.
  - Comfort patient by saying: “You are safe. We are with you. We love you.”
  - Consider aromatherapy.
  - Unfinished business may cause restlessness. Discuss with family possible causes of anxiety.
  - Review with the family the importance of saying goodbye and to give permission to stop life support.
  - Question family about an important family event or anniversary.
  - Educate the family:
    - Patient lacks awareness of behavior.
    - Possible to be peacefully confused

Other activities and methods of support to consider:

• Your humanity is needed the most now. Always be available.
• Your very presence is reassuring to the family.
• The family is an important part of your patient care and becomes your focus as the patient becomes more unresponsive.
• Be supportive care medicine team members for assistance.
• Be specific if resources are for patient, staff or both.
• Always work to retain the patient’s dignity and feelings of value.
• Remember every family is unique and grieves differently.
• Communication is essential:
  - Ensure communication exists with the family and all disciplines.
  - Take your cues from the family. Do not assume you know what they are thinking or feeling.
  - Clarify how much the family wants to know.
  - Clarify goals of care.
  - Clarify privacy needs.
• Patient lacks awareness of behavior.
• Possible to be peacefully confused

The health care provider must allow themselves to be human and expect some personal emotional response to the death of their patient and for the grieving family.
• Palliative/Supportive Services are also available to staff.
• Often a review and debriefing can assist with professional growth and promote emotional health by:
  - Recognizing the stressful event and thanking supportive team members.
  - Reviewing what went well and what challenges need to be addressed.
  - Sharing bereaved family comments.
  - Addressing moral distress issues.
  - Expressing issues of death anxiety and obtaining support.
  - Exploring challenges and privileges of watching a fellow human being through the dying process.
  - Acknowledging the spiritual impact of witnessing death.
  - Exploring how your care made a difference to the grieving family.
  - Reviewing effective communication techniques, available resources and support.

Puchalski and Ferrill, 2010
**CARES Tool**

**Pain Management**

- You must act as an advocate for your patient to control their pain. Pain control is an essential need for all dying patients. The usual treatment determines the time to maximum effect:
  - IV peak effect is 15 minutes
  - Sub-q 30 minutes
  - Transdermal 4 to 6 hours
- Terminal pain/pain during dying is best managed by around the clock, scheduled or a continuous infusion of opioid such as a PCA pump and additional doses (boluses) given as needed for breakthrough pain.
- There is no maximum dose of opioids for pain control.
- Nurses are often frightened the opioid they give a patient will cause them to die prematurely.
- There will always be a last dose when caring for a dying patient. Keep in mind the legal and ethical concepts of intent.
- The patient is dying because of their disease process, not from the opioid.
- Assessments in dosage or type of opioid may be required in the presence of renal failure, and if the pain medication does not help to control the patient's pain.
- Considerfantasy if the patient is in renal failure and if the patient is having small seizures (ictal phenomena).
- Opioids stay in the system longer with renal failure. Dosage is usually smaller.
- Consider changing the type of opiate if pain remains uncontrolled.
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**COMFORT**

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**COMFORT (CONTINUED)**

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**AIRWAY**

The use of supplemental oxygen during the dying process is often ineffective but may help to minimize the family’s fears of their loved one suffering.
- Review goals of care established by the patient and family for supplemental oxygen.
- Consider use of a fan.
- Provide nasal cannula per M.D.’s orders.
- Reposition patient as needed.

The dying process results in irregular breathing with periods of apnea. Serosions often pool in the back of the patient’s throat resulting in loud congestive sounds. Patients can become restless and anxious. Consider the following orders for:...

- Glycopyrrolate, scopolamine patch or Atropine 1% ophthalmic solution...
- Morphine IV or Sub-q: The patient is dying and will stop breathing due to their disease and the dying process, and not from receiving morphine...
- Consider using anti-anxiety agents and/or antipsychotics.
- Provide education as needed. Some common issues to address are...
  - Breathing patterns of the dying. Breathing becomes progressively shallow, stomach and bodily movements.
  - Ears and nose of apnea will extend. This is all from brain stem activity. It is involuntary and the patient is not suffering...
  - Emphasize the calming effects of touch and talking to the patient.

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