Critical thinking when caring for the patient and family at end of life: A nursing perspective

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May 1st, 2015

Objectives

- Explore the concept of a ‘good death’
- Understand comprehensive assessment of physical and psychosocial needs of patient and family at EOL
- Understand pharmacological and non-pharmacological interventions at EOL
- Understand the decision making process around implementing interventions at EOL
- Review UHN resources and policies

Critical Thinking

Critical thinking is the ability to
- recognize problems and raise questions
- gather evidence to support answers and solutions
- evaluate alternative solutions
- and communicate effectively with others to implement solutions for the best possible outcomes (patient safety/satisfaction)

- Holistic care including patient and family goals

A Good Death

Historically
- In the home with family present and the clergy assisting with an orderly death scene
- Traditional death in the home guided by community members, religious beliefs and values
- Shifted to control of the dying process by the physician
- Death takes on a technical quality- possibly a longer process

A Good Death

- Conflict arises in the care of patients in hospital at end of life- leads to the rise of hospice and palliative care
- Awareness of care beyond the physical needs
- Now defining a ‘good death’ comes from the person and their families in collaboration with the health care team

A Good Death

- How would you define a good death?
‘Good Death’: Participant contribution

- Family present
- Comfortable, pain and symptoms managed
- Will, POA, affairs in order
- Wishes, decisions fulfilled
- Autonomy maintained/honoured
- Family conflicts resolved
- Able to say Good-bye
- In preferred location: home, hospital, palliative care
- Spiritual and religious concerns addressed, rituals completed

A Good Death

- Literature search – more articles on the topic of a good death and very little on a bad death (Why?)
- Less interest in bad deaths
- Provide clinical practice education on how to support a good death
- Uncomfortable discussing when things go wrong (litigation?)

A Good Death

- Patient and family are free of avoidable distress and suffering
- Dignity and autonomy for the person dying
- Management of pain and other physical symptoms based on the person’s values
- Preparation for the family
- Ensure person’s physical and psychological needs are met

A Good Death

- A time to say goodbye
- Closure to unresolved issues
- Place of death
- Opportunity to complete a life review and possibly some legacy work

Jeopardy!

Case Study Group Discussions

- Review the Case Study
- Join your group to review the physical and/or psychosocial needs of Laurie and her family
- Identify what would be involved in your assessment and what interventions could be done
- Report back to the larger group
Pain

Laurie is reporting back, chest and leg pain, abdo tender to palpation
How to assess Laurie?
Comprehensive assessment?

- Spinal cord compression (neuropathic pain)
- Vertebral #s (nociceptive pain)
- Pedal edema (nociceptive pain)
- Pulmonary edema (visceral pain)
- Chronic post mastectomy pain? (neuropathic)
- Urinary retention (visceral)
- Constipation (visceral pain)
- Existential, emotional, spiritual pain

Pain Interventions

Interventions depend on Goals of Care

Etiology of Laurie’s Pain

- Spinal cord compression - dexamethasone, opioids, rectal or buccal methadone, lidocaine infusion, ketamine (restricted to PCU), XRT
- Vertebral #s - opioid, acetaminophen, dexamethansone (time limited due to adverse effects)
- Pedal edema - decrease/stop IVF, positioning
- Pulmonary edema - decrease/stop IVF
- Chronic post mastectomy pain?
- Urinary retention - foley?
- Constipation - suppository, enema?
- Existential, emotional, spiritual pain

Facts: crt 160, elevated liver enzymes, delirium

Pain

Laurie’s Pain:

Nociceptive, neuropathic, visceral, ‘total pain’.
Acute on chronic pain?

Morphine 2mg IV q 4 hours and 2mg IV q 4 hours PRN, used 6 PRNs in 24 hours.

New order: Hydromorphone 1mg subcut q 4 hour routine and 0.5mg-1mg q 30 min PRN

Pain Interventions

Non-pharmacological

- Distraction
- Hot/Cold
- Positioning
- Acupuncture
- Massage
- Therapeutic Touch
- Music Therapy

Patient and family education, reassurance

Emotional, spiritual support

Respiratory
Dyspnea Assessment

Etiology

- CHF
- Pulmonary edema
- Anxiety
- Pain
- Lung mets?
- Infection?
- Lab values?
- Pain
- Audible secretions: EOL

Laurie

02, 3L via NP, saing 90%
RR 28
IVF 75cc/hr
Crt 160

Dyspnea Interventions

- Treat the underlying cause if fits with Goals of Care
- CHF- Lasix, decrease/stop IVF
- Pulmonary edema- Lasix, decrease/stop IVF
- Anxiety- Benzodiazepine’s, non-pharm
- Pain- titrate opioids, non pharm
- Hypoxemia- 02 if <90%, trial of 02, NP/FM may irritate pt. contribute to restlessness
- Audible secretions- glycopyrrolate, scopolamine 0.4mg sc q3 hours PRN,

Dyspnea Interventions

Mild Dyspnea

- Hypoxic patients (<90% SpO2) use supplemental oxygen via nasal prongs or facemask continuously or prn
- Systemic opioids for mild, continuous dyspnea; limited benefit for intermittent SOB

Dyspnea Pharmacological Interventions

Moderate to Severe Dyspnea

- Opioids as first line treatment. For opioid naïve patients start low; for patients already on systemic opioids increase by 25%
- Benzodiazepines (midazolam) as second line treatment. Most effective in combination with opioids. Usually added if there is an anxiety component.
- Lasix, antibiotics, anticoagulation: depends on cause.

(CCO, 2010; Gomulbutra et al., 2012)

Non-Pharmacological Interventions: Dyspnea

Medical

- Oxygen therapy?
- Stop or decrease IVF

Complimentary

- Acupuncture
- Acupressure

Environmental

- Positioning
- Room/environment
- Equipment- pillows

Other options

- Fan and cool facial temperatures
- Education: Reassurance to patient and family
- Supportive Counselling: explore the meaning of the symptom (suffering)
- Teach family or caregiver how to support patient
- Relaxation techniques
- Distraction techniques

Emotional and Spiritual
Emotional

- Assessment for Emotional Issues
- What issues is Laurie dealing with?
- What about her family?

Anxiety, fear, feeling disconnected from patient, helpless, frustrated, anger, shock.

- Assess understanding, past/present coping behaviours
- Previous deaths

Emotional Interventions

1. Listening
   - Being Attuned, Being Present, Exploring meaning, showing empathy
2. Have Discussion using Open Ended Questions
   - So the Patient can tell their story
   - What the patient understands and what they are experiencing, feeling, worrying about etc.
   - Interpret medical information
3. Reducing uncertainty
   - Educating patient/family about palliative care
   - Being Comfortable with Not Being Comfortable

(Dea Moore, 2005)

Spiritual and Religious

Case: Anglican, active in church.
“Am I Dying?”

FICA Spiritual Assessment Tool
An acronym which can be used to remember what to ask in a spiritual history is:
F: Faith or Beliefs
I: Importance and Influence
C: Community
A: Address

FICA Spiritual Assessment Tool

F: What is your faith or belief?
   - Do you consider yourself spiritual or religious?
   - What things do you believe in that give meaning to your life?
I: Is it important in your life?
   - What influence does it have on how you take care of yourself?
   - How have your beliefs influenced in your behavior during this illness?
   - What role do your beliefs play in regaining your health?
C: Are you part of a spiritual or religious community?
   - Is this of support to you and how?
   - Is there a person or group of people you really love or who are really important to you?
A: How would you like me, your healthcare provider to address these issues in your healthcare?

Spiritual Assessment Tool

H Sources of hope, strength, comfort, meaning, peace, love and connection
O The role of organized religion for the patient
P Personal spirituality and practices
E Effects on medical care and end-of-life decisions

American Family Physician 2001: 63p. 81-89
http://qqqwww.aafp.org/afp/20010101/81.html

Empathetic Response

- Name the emotion: “it sounds like…”
- Understanding: “I’m hearing you say…”
- Respecting: “I am impressed that…”
- Supporting: “I’ll be available for you…”
- Exploring: “Tell me more about…”

(Pollack et al, 2007)

**Non-verbal communication
S.P.I.K.E.S.

- S etting, listening Skills
- P atient’s Perception
- I nvite patient to share Information
- K nowledge transmission
- E xplore Emotions and Empathize
- S ummarize & Strategize
  
  (Buckman, 1998)

Neurological

Case study: Neurological changes
Drowsiness
Assessment

- Transient
  - Initiating or titrating an opioid
- Persistent
  - Causes may be medication, physical changes, infection or approaching death

Using the Acronym
- O- onset
- P- provoking
- Q- Quality
- R- Region
- S- Severity
- T- Treatment
- U- Understanding/Impact on You
- V- Values

Case study: Neurological changes
Delirium
Assessment

Ongoing assessment including:
- Interviewing patient and/or family
- Physical assessment
- Medication review
- Psychosocial review
- Diagnostic testing
- Screening tool -CAM

Using the Acronym
- D- drugs, dehydration, depression
- E- electrolyte, endocrine dysfunction, (ETOH) alcohol or drug abuse or withdrawal
- L- liver failure
- I- infection
- R- respiratory problems, urinary retention, constipation
- I- increased intracranial pressure
- U- uremia (renal failure), untreated pain
- M- metabolic disease, malnutrition, metastasis to brain

What is the overall plan or goal of care?
- Investigate and treat the cause
- No investigation except medication adjustments
- Keep Laurie comfortable

Case study: Neurological changes
Drowsiness
Intervention

Screening tool - CAM

Causes of Delirium
(adapted from Capital Health)
Case Study: Pharmacological causes

- A few Common Drugs implicated in delirium
  - Benzodiazepines e.g. lorazepam
  - Anticholinergics e.g. diphenhydramine (Benadryl), dimenhydrinate (Gravol)
  - Opioids e.g. morphine, hydromorphone, meperidine (Demerol)
  - Corticosteroids e.g. dexamethasone, prednisone
  - Many others

Case study: Neurological changes

- Delirium Interventions

Pharmacological
  - Treat the underlying cause
  - Review all medications
  - Keep person well hydrated
  - Haloperidol is the gold standard for management of delirium
  - Alternative medications (antipsychotics) to haloperidol
    - Risperidone
    - Olanzapine
    - Methotrimeprazine
    - Chlorpromazine

Non-Pharmacological
  - Provide safe environment
  - Physical restraints not recommended
  - Educate family and provide emotional support
  - Communication: simple, slow and clear language
  - If the person is hallucinating it is best not to reorient them

Case study: Neurological changes

- Restlessness at end of life

Assessment
  - Physical- pain, constipation, urine retention, organ failure, hypoxia, fever, etc.
  - Medication- EPS, opioid-induced neurotoxicity
  - Psychosocial- worry, grief, spiritual distress, fear
  - Delirium

Interventions
  - Treat the physical cause
  - Relaxing and supportive environment
  - Complete the ongoing delirium assessment and provide interventions in keeping with the plan of care
  - Medications:
    - May require use of benzodiazepines in addition to antipsychotics
    - Palliative sedation may be considered if the patient is not responding to the above treatments

Case study: Gastrointestinal/Genitourinary

Assessment

Gastrointestinal
  - Mouth
  - Appetite
  - Hydration
  - Abdomen
  - Bowel function
  - Nausea/vomiting
  - Lab values?
  - Medications- causing any problems?

Genitourinary
  - Retention
  - Incontinence
  - Lab values
  - Pain?
  - Medications- causing any problems?
Case study: Gastrointestinal Intervention

- Mouth-oral care
- Appetite- education to family, medications to stimulate?
- Hydration- what is the goal? Set the parameters before starting
- Bowel function- constipation- increases pain, delirium, overall comfort and diarrhea- overall comfort, need for investigation?

Case study: Genitourinary Intervention

- Incontinence/retention- urinary catheter?
- Change in medications?
- Lab values- renal failure
- Discussion with family- Patient’s values, wishes

Skin Care

Screening tool- Braden scale  
Skin integrity  
Pitting edema?  
Pruritus

Case study: Skin Care Assessment

- Braden score- implement recommended interventions  
- Change mattress surface  
- Edema  
  - Pharmacological- Furosemide  
  - Non-pharmacological- stockings? Lotions- lanolin base, positioning

Case study: Skin Care Intervention

- Pruritus  
  - Hydration  
  - Cool environment  
  - Medications- antihistamines (Benadryl), antidepressants (Doxepin, TCA)  
  - Rotate opioid to a non-histamine releasing opioid such as fentanyl or methadone  
  - Steroid creams- hydrocortisone 1%
Cultural

‘Culture influences a person’s behaviours, attitudes, values and beliefs’ (Downing, 2006)

Develop an understanding of the patient’s:
- Beliefs regarding their illness
- Values and beliefs regarding their physical symptoms and how they are managed
- Grief, mourning and bereavement practices
- Traditional healing practices

Case Study: Cultural Assessment

Case Study: Cultural Interventions
- Open-ended questions
- Understand what is the role of the family and friends
- Documentation of any rituals at time of death

Case Study: Last hours

A few hours later, Laurie’s respirations are 5 per minute, the nurse checks for peripheral pulses which are absent. The nurse informs the family that Laurie is now in the last moments of her life. A few minutes later Laurie dies.

Decrease response to verbal and visual stimuli
- Hyperextension of the neck
- Inability to close eyelids
- Grunting of the vocal cords
- No radial pulses
- Respirations with mandibular movement
**Last hours clinical signs**
- Noisy rattling breathing
- Decreased urinary output
- Cheyne-stoke breathing
- Nonreactive pupils
- Skin colour changes- mottling

**The Family Needs at the Time of Death**
- Care and emotional validation of the family
- Information giving and receiving, to ensure understanding and make sense
- Support for ritual and mourning customs
- Care for the body
- Explanation of legal +/- medical interventions, ie, tissue donation, coroner
- Future self care and support. Talk about bereavement support

*(Kinghorn, S. & Gamlin, R. 2001)*

**Care of the Body**
- Pronouncing
  - Auscultate for heart rate- apically
  - Observe for absent respirations
  - Assess that pupils are fixed and dilated
- Care team to demonstrate a willingness to be with the body and the family
- Ask if they wish to touch the body, sit quietly, leave shortly after the death
- Identify any religious or cultural rituals to be completed with the body
- Answer any questions of next steps: preparing the body for transport

**Summary and key points**
- The time before death is a time of living which requires ongoing assessment and intervention
- End of life care is complex
- Ongoing education, support and actively listening to the patient and family will support a ‘good death’
- A ‘good death’ decreases development of complicated grief for family and loved ones

**Thank you**
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References


