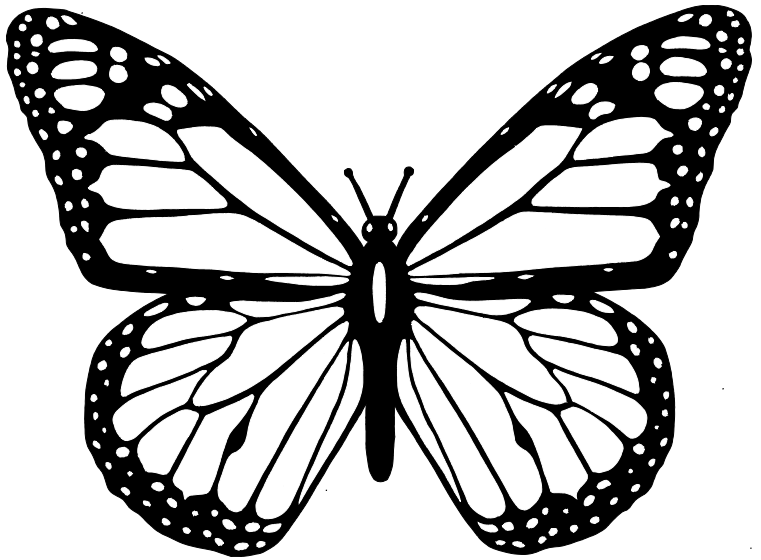
References

- Campbell, M. L., Templin, T., & Walch, J. (2010).A respiratory distress observation scale for patients unable to self-report dyspnea. *Journal of Palliative Medicine*, *13*(3), 285–290. https://doi.org/10.1089/jpm.2009.0229
- Cronin, J., Arnstein, P., & Flanagan, J. (2015).Family members' perceptions of most helpful interventions during end-of-life care: *Journal of Hospice & Palliative Nursing*, *17*(3), 223–228. https://doi.org/10.1097/NJH.0000000000000151
- Makic, M. B. F., Martinez-Kratz, M. R., Ackley, B. J., & Ladwig, G. B. (2023). *Ackley and Ladwig's nursing diagnosis handbook: An evidence-based guide to planning care* (Thirteenth edition). Elsevier.
- Ontario Centres for Learning, Research & Innovation in Long-Term Care. (2020). *Communication at end-of-life eLearning series* [Ontario centres for learning, research, and innovation in long-term care]. Retrieved January 28, 2024, from https://clri-ltc.ca/resource/ceol-elearning/
- Pallium Canada. (n.d.). *LEAP™ personal support worker*. https://www.pallium.ca/course/leap-personal-support-worker/
- Plach, N. (n.d.). *McMaster palliative care pain & symptom management guide*. Retrieved January 28, 2024, from https://palliativeezguide.ca/
- Pooler, C., & Olsen, K. (2020). Hospice, palliative, and end-of-life care. In *Brunner & Suddarth's Canadian textbook of medical-surgical nursing* (Fourth Canadian Edition, pp. 238–263). Wolters Kluwer.
- Temel, J. S., Greer, J. A., Muzikansky, A., Gallagher, E. R., Admane, S., Jackson, V. A., Dahlin, C. M., Blinderman, C. D., Jacobsen, J., Pirl, W. F., Billings, J. A., & Lynch, T. J. (2010).Early palliative care for patients with metastatic non–small-cell lung cancer. *New England Journal of Medicine*, *363*(8), 733–742. https://doi.org/10.1056/NEJMoa1000678
- WHO. (2020, August 5). *Palliative care*. https://www.who.int/news-room/fact-sheets/detail/palliative-care

Palliative Care for Nursing Students

Shawn Nock <shawn@nurse.win>



What is Palliative Care

> *Palliative care improves the quality of life of patients and that of their families who are facing challenges associated with life-threatening illness, whether physical, psychological, social, or spiritual. The quality of life of the caregivers improves as well. (WHO, 2020)*

Palliative care (Pallium Canada, n.d.):

- focuses on managing symptoms of disease and improving quality of life.
- is appropriate for anyone living with advanced illness.
- can take place at the same time as disease control treatments.
- can be provided by any health professional.
- is just good healthcare.

As importantly, palliative care is not:

- a diagnosis
- a descriptive patient category
- a process to hasten death
- the end of hope

In a study of patients with lung cancer, Temel et al. (2010) found that early palliative care increased quality of life, but also decreased depression symptoms and increased median survival length.

Symptom Management

Secretions

At end-of-life, clients may be unable to clear secretions from the mouth, pharynx, and lungs. Some secretions may be drained by positioning a client on their side. If a client is choking or vomiting, position the client in .recovery position and call for help.

Medication supports include (Pooler & Olsen, 2020):

atropine 1% ophthalmic	anticholinergic	1-3 drops po q4-6h prn
glycopyrrolate	antimuscarinic	1mg po tid prn 0.1mg sc tid/prn
scopolamine	anticholinergic	1 patch top q72h 0.4-0.6mg sc q4h prn

Symptom Management

Dyspnea

Some clients will feel that it is difficult to breathe. Raising the head of the bed and positioning a fan to blow on their face can reduce the sensation of breathlessness.

hydromorphone	opioid analgesic	0.5-1mg po q4h 0.25-0.5mg sc q4h
morphine	opioid analgesic	2-5mg po q4h 1-2.5mg sc q4h
Reduces respiratory centre's sensitivity to hypoxia and hypercapnia		
lorazepam	anxiolytic	1mg prn
clonazepam	anxiolytic	0.5mg prn
Reduces the anxiety associated with difficult breathing		

Providers may also continue to treat some underlying conditions where the treatment is expected to reduce dyspnea, including CHF and COPD.

furosemide	diuretic	20-40mg po/sc prn
May ease breathing in cases of CHF and pulmonary edema		
dexamethasone	glucocorticoid	4-8mg po/sc qAM
Reduces inflammation in COPD		

Unresponsive clients can be assessed for dyspnea by observing the effort of breathing (use of accessory muscles, the rise of the clavicle), agitated limb movement, and facial grimacing. These symptoms are tachycardia or respiratory rates above 20/min. Are suggestive of insufficient palliation. See Campbell et al. (2010).

Students are Important

There are several reasons a student might feel uncomfortable in a palliative care rotation. Being present with a client and their family during this time is an intimate experience.

Cronin et al. (2015) interviewed persons during ongoing palliative care of their loved one. They found four themes emerged as most important to the families:

- Family derived comfort and relief from the dedicated time nurses spent addressing their loved one's needs.
- A nurses presence and reassurance during one-on-one time established trust and relieved anxiety.
- Participants want to understand the process, be included, and receive validation.
- Attention to the environment promoted rest, peace, and helped the family relax.

All four require time and energy, something that can be in short supply among the nurses on the unit. We students often have the time. Let's use it! A first term nursing student can quickly gain the knowledge, skill, and judgment to provide care in all four areas which families identified as most important.

Palliative care can be a rewarding placement for students. One in which we can make a difference in the final days of our clients, and help their families begin the grieving process.

Communication Strategies

Clients and their families appreciate the opportunity to talk. Cronin et al. (2015) found that approaching family is "not only appropriate, but welcomed". Here are a few ways to get the ball rolling:

Introduce yourself and your role.

Introduce yourself and describe some of the care you are performing.

Example

"Good morning Catherine (greet client, even if unresponsive, then address family). Hi, my name is Shawn. I've been caring for Catherine this morning. I combed her hair and gave her a bit of water to help her dry her mouth. Do you have any questions?"

Offer respite to the family.

If you notice that a family member has been with their loved one for a long time, you can offer to stay with them while they do some self-care.

Example

"Hi Julie. It's about lunchtime. I can stay with Catherine if you want to go to the cafeteria or get a cup of coffee."

Validate their feelings

Some clients and their families may come to you in anger. Acknowledge their feelings and ask an open-ended question. This will help you assess their needs and help the other person think about or clarify their feelings.

Example

I understand that you are angry about how your mother's care has been conducted. What would you like to see us do to make her more comfortable?

Symptom Management

Dry Mouth

Dry mouth is a common symptom in palliative care due to mouth breathing, anticholinergic medications and oxygen therapy. Continue to provide fluids by mouth. Small amounts of fluid can be placed in the client's mouth by taking up some liquid in a straw with a gloved finger over the tip to maintain the vacuum.

Frequent oral care is essential. Oral hygiene sponges can provide liquid, gently remove films and crusts, and moisten the client's lips. Avoid glycerin and ETOH mouthwash (Plach, n.d.).

Nausea

Common pharmaceutical interventions for nausea and vomiting include (Plach, n.d.):

domperidone	opioid antiemetic	10mg po tid
nabilone	cannabinoid antiemetic	1-2mg po bid/tid
ondansetron	antiemetic	4-8mg po/pr/sc tid
First-line for nausea due to chemotherapy/radiotherapy		
dexamethasone	glucocorticoid	4-8mg po/sc daily-bid
Effective for nausea due to increase intracranial pressure		

Symptom Management

Pharmaceutical recommendations and doses courtesy of McMaster Palliative Care Pain & Symptom Management Guide (Plach, n.d.).

Anorexia/Cachexia

Clients will tend to lose appetite and weight as their terminal disease processes progress. You can provide education to clients/family that:

- Loss of appetite and weight loss is normal in end-of-life
- The body is using stored fat and protein, but clients do not feel "starving"
- Tube/parenteral feeding does not increase the quality or quantity of life.

If anorexia is distressing to the client, several classes of medication may be used to increase appetite, including glucocorticoids and cannabinoids.

Delirium

Delirium is often treated through its underlying cause. Assess for infection (fever), urinary retention (bladder scan), and dehydration (skin turgor).

You may consult with the nurse about reducing opioid doses if the pain is well controlled, or the nurse may speak to the provider about rotating to a different opioid.

Neuroleptic therapy may also be employed, esp. if the root cause cannot be treated before end-of-life:

haloperidol	antipsychotic	1-2mg po/sc bid-tid +1mg po/sc prn
olanzapine	antipsychotic	2.5-5mg sl qhs
quetiapine	antipsychotic	25-50mg po daily-bid
Blocks dopamine and/or serotonin receptors to reduce nervous system activation		

Communication Strategies

Follow up on Emotional Moments

Suppose you hear a heated exchange or an emotional outburst. Take a few beats, then assess the client/family's needs. Clearly state your concerns, but allow for doubt or deniability if they're not ready to talk (Ontario Centres for Learning, Research & Innovation in Long-Term Care [CLRI], 2020). Follow with an open-ended question.

Example

Excuse me. I thought I heard yelling at this end of the hall. I may have been mistaken. How are you feeling right now?

Involve the family in care.

There can be long, quiet stretches in palliative care. It may seem like a good idea to leave the family in peace. However, by providing care while the family is present, you can demonstrate that they are being cared for. You should educate and delegate care to the family; it's therapeutic for the family and client.

Example

"Good morning. I was just about to wipe Catherine's face with a warm cloth. Would you like to do it? I can show you how."

Signs of Approaching Death

Pooler and Olsen (2020) report experiences from the Hospice of Philadelphia:

Reduced intake	Offer, but do not force fluids and medications
Decreased output	Urine and stool decline in amount and frequency.
Incontinence	
Sleepiness	Allow clients to sleep.
Detachment	Educate the family that withdrawal is normal and not a rejection.
Confusion	Upon waking, gently remind the client where they are and who is present in a conversational way.
Impaired vision	Maintain lighting in the room according to client's wishes
Impaired hearing	Speak only as loud as necessary. Always speak as if the client can hear you; hearing may be the last sense to lose function.
Secretions	The client becomes unable to clear secretions. They may rattle in the throat.
Irregular breathing	Client may have periods of apnea and alternating periods of deep and shallow breathing (Cheyne-Stokes)
Restlessness	Due to reduced oxygenation of brain tissues.
Loss of thermoregulation	Provide and remove blankets as needed.
Reduced circulation	Cold, bluish extremities and pooling blood on the underside of the body
Delerium	Some clients experience an urgency to get out of bed or leave. You can gently reassure them.

Nursing Diagnosis and Interventions

Impaired Comfort

"Perceived lack of ease, relief, and transcendence in physical, psychospiritual, environmental, cultural, or social dimensions."
(Makic et al., 2023, p. 226)

- Use hand massage or healing touch
- Heated blankets can increase comfort rt. impaired thermoregulation
- Assess client comfort by asking them, or using a validated scale for non-responsive patients (i.e. Campbell et al. (2010))

Compromised Family Coping

An usually supportive primary person [...] provides insufficient, ineffective, or compromised support, comfort assistance, or encouragement that may be needed by the client [...] to manage his or her health challenge.

(Makic et al., 2023, p. 302).

- Encourage family members to speak about their feelings.
- Provide education about coping strategies, like mindfulness and CBT, for addressing grief.
- Refer the family to other resources, social worker, spiritual support