

# Concepts of end of life care



**ASSIGN  
BUSTER**

1. Patients and families often struggle with many decisions during terminal illness. What are some decisions that patients can make about their end-of-life wishes?

Patients have right of autonomy and make any decision that they seem fit during terminal illness about their treatment course. Patients have right to withdraw from any therapies at any time. Also, they have legal right to refuse any treatment or never start a therapy, as long as all the information is provided, this is called decisional capacity. Other decisions that patients need to make during end of life (EOL) care includes – organ and tissue donations, advance directives, resuscitation, mechanical ventilation and feeding tube placement (Lewis, Heitkemper, Bucher, Harding, Kwong & Roberts, 2017). Patient can make living will when they are able to make decisions that will tell physicians exactly what kind of treatment or how invasive treatment patient wishes to have. For example: Patient may choose to be DNR or DNI but willing to receive chemical treatments or tube feedings. Patient's wishes must be addressed by the healthcare provider and family members regardless of what they feel is better for the patient. Nurses play huge role when it comes to educating patient and family regarding their options for EOL care.

2. What legal documents are available to guide A. N.'s daughter in making decisions about A. N.'s care should she become unable to make her own decisions?

Documents that are used in EOL care that can assist A. N.'s daughter in decision making includes – advance directives, allow natural death (AND),

directive to physicians (DTP), do not resuscitate (DNR), power of attorney for health care (POAH), living will, medical power of attorney (MPOA), physician order of life-sustaining treatment (POLST) or medical order of life-sustaining treatment (MOLST) (Lewis et al., 2017). Federal law mandates healthcare providers and institutions to give patients advancedirective forms and the ANA Code of Ethics with Interpretive Statements requires nurses to offer patient education about advance care planning and advance directives (Miller, 2017). A. N. already has an order for DNI as a part of her advance directive which tells physicians not to intubate if she stops breathing. However, the daughter is the power of attorney for this patients and orders like DNR/DNI are reversible, meaning she can change DNI anytime she prefers. Legally, she might have the right to change any document, but morally or ethically she should respect patient's wishes of no heroic measures and let her die peacefully.

### 3. How would you provide end-of-life care in the intensive care unit?

EOL care requires repetitive teaching on ways to cope with dying process and shift their focus from quantity of life to quality of life. Nurse should address psychosocial aspect like feelings of anxiety and depression, anger, hopelessness and powerlessness, fear and communication. Most patients with terminal illness and their family have anticipatory grief that may disable their lives. Some of the ways a nurse can alleviate caregiver burnout is by providing practical support and respite care, increasing the preparedness through interventions, facilitating communication in the family about dying, and ensuring that prognostic information is adapted to the needs of the family (Nielsen, Neergaard, Jensen, Vedsted, Bro & Guldin (2017). Using non-  
<https://assignbuster.com/concepts-of-end-of-life-care/>

pharmacological management like relaxation breathing, music and imagery may help alleviate symptoms of anxiety and depression. If a patient is in the anger or denial stage, help them with expression of their feelings and acknowledging the change. Making them feel important by involving them in decision making and plan of care gives them some control when is important for their self-esteem. Terminally ill patients are afraid of so many things like pain, being alone, shortness of breath which can be managed by medication, therapeutic touch, providing company, respecting and accepting their life values and positive qualities without being judgmental (Lewis et al., 2017). Nurses should also focus on physical care towards EOL which includes managing pain, delirium, dysphagia, weakness and fatigue, dehydration, dyspnea, myoclonus, skin breakdown, bowel patterns, urinary incontinence, anorexia, nausea and vomiting, candidiasis. Some of the nursing management for physical care are – administering pain meds in timely manner, providing quiet, well-lit room and reorienting patient to person, place and time, providing modified diet and suctioning when necessary, cluster care with frequent rest periods, provide oral care and hydration therapy if tolerated, keep head of the bed elevated and check respiratory status frequently, provide skin care and avoid shearing forces, assess for fecal impaction and urinary function, prevent skin breakdown by using absorbent pads, provide patient's favorite foods in small portions and frequent intervals, clean dentures and promote oral hygiene (Lewis et al., 2017). It is equally important to be culturally competent and respect patient's religious values and provide spiritual assistance when possible.

4. What is the difference between hospice care and palliative care? What are the criteria for admittance to a hospice program?

Palliative care is a treatment that focuses on alleviating symptoms of the disease. It regards dying as a normal process and patients receive curative and restorative care that aims towards extending life. Patients with chronic illness like heart failure, COPD, dementia or ESRD feel incapacitating in many ways like with finances, activities of daily living and can be a burden for caregiver. Palliative care aims at improving quality of life, decrease cost of healthcare and alleviate burnout for caregivers. Hospice care is part of palliative care which is provided towards end of life when curative care is not an option. Thus, the main difference between palliative care and hospice care is palliative care allows for curative care while hospice care does not, it only focuses on symptom management that allows patient to die pain-free and with dignity (Lewis et al., 2017). Admittance to hospice program has two criteria: First, patient must want the services and agree in writing that only symptom management and not curative care can be used for their treatment. Second, patient must be eligible for hospice services which is determined by 2 physicians certifying that patient is terminally ill with less than 6 months to live. Patients under hospice care can receive treatment for health issues not related to terminal illness but it may not be covered by the insurance. Also, patient has right to withdraw from hospice services at any time or if their condition improves (Lewis et al., 2017).

5. Providing care for patients and families at the end of life can be both rewarding and challenging. It is important for you to be aware of how grief affects you personally and to alleviate your stress. What are some

interventions that can help you alleviate your stress from caring for patients at the end of life?

Taking care of a dying patient can be challenging and often leads to burnout in caregivers including medical staff. Nurses spend most time with the terminally ill patients than any other healthcare worker and therefore it is crucial to consider self-care and promotion and recognizing own values and feeling about death. It is obvious that you form a bond with a patient when you work with them for so long and it is alright if you feel grief personally. No one is immune to feelings of helplessness and sorrow and therefore, expressing feeling by reflecting or journal writing can be beneficial. Nurses should get involved in hobbies like art therapy, music or meditation, “ art-therapy-based supervision has the potential to reduce burnout for EOL care workers by decreasing exhaustion, fostering emotional awareness, and promoting comfort in thinking and talking about death (Potash, Y. Ho, Chan, Xiao Lu Wang & Cheng, 2014). Maintaining good support system like family or peers can also help with emotional coping.

## References

- Lewis, S. L., Heitkemper, M. M., Bucher, L., & Harding, M. M., Kwong J., Roberts D. (2017). *Medical-Surgical Nursing: Assessment and Management of Clinical Problems* (10th ed.). St. Louis: Elsevier.
- Miller, B. (2017). Nurses in the Know: The History and Future of Advance Directives. *Online Journal of Issues in Nursing*, 22(3), 1. <https://doi-org.chamberlainuniversity.idm.oclc.org/10.3912/OJIN.Vol22No03PPT57>

- Nielsen, M. K., Neergaard, M. A., Jensen, A. B., Vedsted, P., Bro, F., & Guldin, M.-B. (2017). Preloss grief in family caregivers during end-of-life cancer care: A nationwide population-based cohort study. *Psycho-Oncology*, 26(12), 2048–2056. <https://doi-org.chamberlainuniversity.idm.oclc.org/10.1002/pon.4416>
- Potash, J. S., Y. Ho, A. H., Chan, F., Xiao Lu Wang, & Cheng, C. (2014). Can art therapy reduce death anxiety and burnout in end-of-life care workers? A quasi-experimental study. *International Journal of Palliative Nursing*, 20(5), 233–240. Retrieved from <https://chamberlainuniversity.idm.oclc.org/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=103953350&site=eds-live&scope=site>