Physical and psychosocial needs of palliative clients

ASSIGN BUSTER

Addressing Physical and Psychosocial needs of Palliative Clients

- Jaweria Bano

Death and dying are certainly unescapable events in human’s life. Palliative is patient and family centered care that enhances quality of life. It is an approach that enhances life of an individual and their families challenging the issues connected with life-debilitating sickness, through the curative action and help of suffering. Palliative mind all through the continuum of sickness includes tending to physical, scholarly, enthusiastic social, and otherworldly needs and to encourage understanding self-sufficiency, access to data, and decision of consideration According to Loscalzo (2008), Institute of Medicine (IOM) report defines palliative care as “ prevention and relief of suffering through the meticulous management of symptoms from the early, through the final stages of an illness. Palliative care attends to the emotional, spiritual and practical needs of patients and those close to them.”

A case scenario related with providing palliative care to an adolescent client was encountered in an Ibn-e- Zuhr building. A 16 year old boy was suffering B-cell lymphoblastic leukemia and was admitted in daycare for his third chemotherapy cycle. While taking his interview I came to know that he was in his usual state of health 4 years back, suddenly he developed fever for 4 months on and off, cough at midnight for 1 month and shortness of breath for 2 week for this he went to nearby hospital in Lahore. Where many diagnostic procedures like CBC and bone marrow biopsy were done and doctor referred him in Karachi for chemotherapy. While interviewing, he verbalized that due to chemotherapy he felt nauseated, and had many episodes of vomiting. Moreover, he had complained of weight loss, fatigue,

dyspnea and alopecia. He also verbalized that he had feeling of loneliness and anxiety due to the disease. Patient‘ s family said that he is not interact in family and isolate himself.

This issue caught my attention; I began to feel the same feeling and concern which my patient was going through at that time. My emotions had totally exceeded my ability to think. As a nursing student, it is my obligation to give comprehensive consideration to the patient and also his family. During patient care I recognized many domains which were affected, like psycho-social, spiritual, physical and communication. Here all spaces of palliative consideration are interrelated to one another yet I will highlight the two most influenced areas: psycho-social and physical. These papers will high light on the concerns, interventions and recommendations regarding physical and psycho-social domains of palliative care.

Patient history revealed physical suffering that is like paling of eyes, dryness of skin and mouth, dyspnea. Diseased process or medications effects on his activity level and decreased appetite. Due to reduced activity and side effects of treatment her appetite had also decreased. As a consequence of decreased appetite and frequent hospitalizations he had lost significant weight in last six months (5-6kg). The difficulty in breathing did not let him sleep peacefully which in turn caused frequent mood swings and irritability in his personality. He also felt embarrassment in socializing and stayed at home due to alopecia.

Referring to the case, symptom relief is the most evident need of the physical domain of palliative care. This is due to the fact that physical

problems are closely related with psychological, spiritual and social issues and thus may adversely affect the overall quality of an individual’s life whereas palliative care chiefly aims to improve the quality of life rather than the length of life (Stevens, Jackson & Milligan, 2009). For that reason, I approached the patient by focusing my care on the most discomforting issue that is of dyspnea. Firstly, patient’s dyspnea was managed by non-pharmacological methods that include performing deep breathing, pursed lip breathing and coughing exercises for 10 minutes every hour (Viola et al., 2008). Anemia is also a possible cause of dyspnea and fatigue (Borneman, 2013) which was also evident in the current case where hemoglobin level was just 10. 3 mg/dl. Patient was positioned in semi fowlers’ position and spirometry exercises were taught to the patient. Since pain was due to physical exertion so it also improved once dyspnea was settled.

To reduce patient suffering and enhancing quality of life I educate patient besides, a teaching session was delivered to client and family members on importance of good nutrition, in which it was emphasized to take high energy, high protein diet not just to correct dyspnea but also to minimize weight loss and fatigue by promoting repair of damaged tissues (Holmes, 2011). Frequent water intake was also encouraged in order to minimize dryness of mouth. Issue of maintaining functional independence was handled by planning activities and rest periods according to energy level. Assistance was provided in self-care activities (Kumar & Jim, 2010).

Psychosocial area of palliative consideration alludes to the nearby relationship between the individual and the aggregate parts of any social. The patient was also experiencing psychological distress, anxiety and

depression. The suffering was intolerable for the patient. Additionally, he was unable to tolerably cope with him condition as evidenced by him social isolation compromising the psychosocial aspect of patient's wellbeing. Though the family was not well managed financially, patient's family constantly kept worrying about the cost implications due to his frequent hospitalizations, treatment procedures, medications and chemotherapy etc. Similarly, humans as social beings, share their joys and burdens through social interactions. The family members of the patient also reported their observation that he doesn't want to get involved in family gatherings and other such activities and would prefer isolation. However, I encouraging my patient to ventilate and verbalize his feelings, thoughts and views. Similarly, a teaching activity regarding emotional coping was practiced that included anxiety managing and guided imagery (Onyeka, 2010). I also guide the family that welfare is available in AKU. Family was given passionate help and was stressed on own wellbeing support. It is commonly observed that member who is in hospital with patient has distinctive stress related to household chores, children's and families critical for life. Anxiety may also arise in response to sickness related stressor as saw for our situation that not just patient, family was additionally on edge about support persistent, difficulty process and it disgusting reality (Alacacioglu et al., 2013).

The whole journey of palliative care is no doubt a most challenging aspect of nursing profession. Yet, the essence of both palliative care and nursing are fundamentally similar and that is to relieving suffering of mankind by all possible means. In the same way, the task of caring the palliative client was in fact a difficult task. Despite of all the nursing efforts, holistic care was still

lacking few aspects due to certain boundaries like time limitation, problem while communicating to patient's which was resolved to an extent and in capability in dealing with cultural influences on client's well-being. Furthermore, lack of resources and limited theoretical knowledge also caused hindrance in care and it is the central problem in developing countries.

To conclude palliative consideration nursing is another idea. It is additionally developing in our nation yet on a moderate step and uncommon endeavors are obliged to enhance this field. More mindfulness projects and explores ought to be directed to approach comprehensive consideration amid the days ago of an understanding's life Nurses must also join this specialty in hospital and community settings to enhance the quality of lives of patients suffering from terminal illnesses.

References

Alacacioglu, A., Tarhan, O., Alacacioglu, I., Dirican, A., & Yilmaz, U. (2013). Depression and anxiety in cancer patients and their relatives. J BUON, 18(3), 767-774.

Borneman, T. (2013). Assessment and management of cancer-related fatigue. Journal of Hospice & Palliative Nursing, 15(2), 77-86.

Holmes, S. (2011). Importance of nutrition in palliative care of patients with chronic disease.

Primary Health Care. 21(6), 32-38

Kumar, S. P., & Jim, A. (2010). Physical therapy in palliative care: from symptom control to quality of life: a critical review. Indian journal of palliative care, 16(3), 138.

Loscalzo, M. (2008). Palliative Care and Psychosocial Contributions in the ICU. Pain Management and Supportive Care for Patients with Hematologic Disorders. Pp. 481-490.

Onyeka, T. C. (2010). Psychosocial issues in palliative care: A review of five cases. Indian journal of palliative care, 16(3), 123.

Stevens, E., Jackson, S., & Milligan, S. (2009). Palliative nursing across the spectrum of care.

United Kingdom, UK: Wiley-Blackwell.

Viola, R., Kiteley, C., Lloyd, N. S., Mackay, J. A., Wilson, J., & Wong, R. K. (2008). The management of dyspnea in cancer patients: a systematic review. Supportive Care in Cancer . doi: 10. 1007/s00520-007-0389-6.