

CHAPTER Nursing Care of 5 Clients Experiencing Loss, Grief, and Death

LEARNING OUTCOMES

- Differentiate loss, grief, and mourning.
- Compare and contrast theories of loss and grief.
- Explain factors affecting responses to loss.
- Discuss legal and ethical issues in end-of-life care.
- Describe the philosophy and activities of hospice.

CLINICAL COMPETENCIES

- Identify physiological changes in the dying client.
- Provide nursing interventions to promote a comfortable death.
- Provide individualized care for clients and families experiencing loss, grief, or death.

MEDIALINK



Resources for this chapter can be found on the Prentice Hall Nursing MediaLink DVD-ROM accompanying this textbook, and on the Companion Website at <http://www.prenhall.com/lemone>

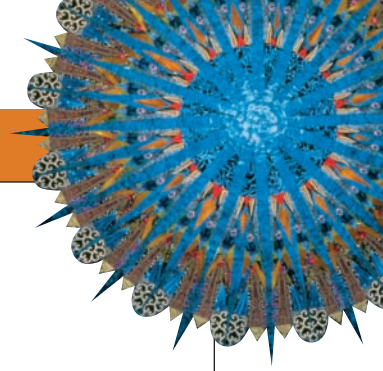


KEY TERMS

anticipatory grieving, 86
bereavement, 92
chronic sorrow, 97
death, 85
death anxiety, 97
do-not-resuscitate order, 91

durable power of attorney, 90
end-of-life nursing care, 89
euthanasia, 91
grief, 85
grieving, 85
healthcare surrogate, 90

hospice, 91
living will, 90
loss, 85
mourning, 85
palliative care, 92



Loss may be defined as an actual or potential situation in which a valued object, person, body part, or emotion that was formerly present is lost or changed and can no longer be seen, felt, heard, known, or experienced. A loss may be temporary or permanent, complete or partial, objectively verifiable or perceived, physical or symbolic. Only the person who experiences the loss can determine the meaning of the loss. Although the order of importance varies with the person, people most commonly fear the losses listed in Box 5–1.

Loss always results in change. The stress associated with the loss may be the precipitating factor leading to physiologic or psychologic change in the person or family. The effective or ineffective resolution of feelings surrounding the loss determines the person's ability to deal with the resulting changes.

Grief is the emotional response to loss and its accompanying changes. Grief as a response to loss is an inevitable dimension of the human experience. The loss of a job, a role (e.g., the loss of the role of spouse, as occurs in divorce), a goal, body integrity, a loved one, or the impending loss of one's own life may trigger grief. Loss is also integral to death. Although death is the ultimate loss, losses that occur in any phase of the life cycle may produce grief responses as intensely painful as those observed in the death experience.

Grieving may be thought of as the internal process the person uses to work through the response to loss. **Mourning** describes the actions or expressions of the bereaved, including the symbols, clothing, and ceremonies that make up the outward manifestations of grief. Both grieving and mourning are healthy responses to loss because they ultimately lead the person to invest energy in new relationships and to develop positive self-regard.

Death is defined in many ways. One commonly used definition of death is an irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brainstem. With the current life support systems available, the most often used criterion for determining death is whole-brain death (permanent irreversible

cessation of the functioning of all areas of the brain). The criteria for whole-brain death are listed in Chapter 11 ∞.

Although death is an inevitable part of life, it is often an immensely difficult loss for the person who is dying and for his or her loved ones. Death may be accidental (such as from trauma) or come at the end of a long and painful struggle with a terminal illness such as cancer or AIDS. It may also be intentional, if a person commits suicide.

THEORIES OF LOSS AND GRIEF

Medical-surgical nurses often care for clients exhibiting responses typical of various stages of the grieving process. Highly individual in quality and duration, the grief process may range from discomforting to debilitating, and it may last a day or a lifetime, depending on what the loss means to the person experiencing it. Although each person experiences loss in a different manner, knowledge of some of the major theories of loss and grief can give the nurse a framework for holistic care of the client and family anticipating or experiencing a loss. Table 5–1 summarizes the theories discussed next.

Freud: Psychoanalytic Theory

Freud (1917/1957) wrote about grief and mourning as reactions to loss. Freud described the process of mourning as one in which the person gradually withdraws attachment from the lost object or person. He observed that with normal grieving, this withdrawal of attachment is followed by a readiness to make new attachments. In comparing melancholia (prolonged gloominess, depression) with the “normal” emotions of grief and its expression in mourning, Freud observed that the “work of mourning” is a nonpathologic condition that reaches a state of completion after a period of inner labor.

Bowlby: Protest, Despair, and Detachment

Bowlby (1973, 1980) believed that the grieving process initiated by a loss or separation from a loved object or person successfully ends when the grieving person experiences feelings of emancipation from the lost object or person. He divided the grieving process into three phases and identified behaviors characteristic of each phase.

■ **Protest.** The protest phase is marked by a lack of acceptance of the loss. All energy is directed toward protesting the loss. The person experiences feelings of anger toward self and others, and feelings of ambivalence toward the lost object or person. Crying and angry behaviors characterize this phase.

BOX 5–1 Types of Losses

- Death
- Health
- Body part
- Social status
- Lifestyle
- Marital relationship (i.e., through divorce)
- Reproductive function
- Sexual function

TABLE 5–1 Summary of Theories of Loss

| THEORIST | DYNAMICS |
|-------------|---|
| Freud | Grief and mourning are reactions to loss. Grieving is the inner labor of mourning a loss. Inability to grieve a loss results in depression. |
| Bowlby | The successful grieving process initiated by a loss or separation during childhood ends with feelings of emancipation from the lost person or object. |
| Engel | After the person perceives and evaluates the loss, the person adapts to it. Shock and disbelief, developing awareness, and restitution occur during the first year following the loss; in the months following, the person puts the lost relationship into perspective. |
| Lindemann | A sequence of responses is experienced following a catastrophic event; concepts of anticipatory grieving and morbid grief reactions are defined. |
| Caplan | Periods of psychologic crisis are precipitated by hazardous circumstances; successful resolution of grief involves feelings of hope and engaging in activities of ordinary living. |
| Kübler-Ross | Five stages define the response to loss: denial, anger, bargaining, depression, and acceptance. Stages are not necessarily sequential. |

- **Despair.** The person's behavior becomes disorganized. Despair mounts as efforts to deny the loss compete with acceptance of permanent loss. Crying and sadness, coupled with a desire for the lost object or person to return, result in disorganized thoughts as the client recognizes the reality of the loss.
- **Detachment.** As the person realizes the permanence of the loss and gradually relinquishes attachment to the lost object, a reinvestment of energy occurs. Both the positive and negative aspects of the relationship are remembered. Expressions of hopefulness and readiness to move forward are characteristic of this phase.

Engel: Acute Grief, Restitution, and Long-Term Grief

Engel (1964) related the grief process to other methods of coping with stress: After the person perceives and evaluates the loss (the stressful event), the person adapts to it. Engel's recognition of the impact of cognitive factors on the grieving process was an important contribution to our understanding of grieving.

Engel described three main stages in the grief process: an acute stage, a restitution stage, and a long-term stage. The acute stage is initiated by shock and disbelief and is manifested by denial, which may help the person to cope with the overwhelming pain. As the shock and disbelief begin to fade, the loss becomes a reality, and pain, anguish, anger, guilt, and blame surface.

Culturally patterned behaviors, such as maintaining a stoic pose in public or weeping openly, characterize this phase.

The acute stage is followed by a stage of restitution, in which the mourning is institutionalized. Friends and family gather to support the grieving person through rituals dictated by the culture. The mourner continues to feel a painful void and is preoccupied with thoughts of the loss. The mourner may join a support group or seek other social support for coping with the loss. This stage lasts about 1 year, after which the mourner begins to come to terms with the loss and interests in people and activities are renewed.

Lindemann: Categories of Symptoms

Lindemann (1944) interviewed people who had lost a loved one during the course of medical treatment, disaster victims, and relatives of members of the armed forces who had died. Lindemann's research led him to describe normal grief, anticipatory grieving, and morbid grief reactions. He placed symptoms characteristic of normal grief into categories of somatic (physical symptoms without an organic cause) distress, preoccupation with the image of the deceased, feelings of guilt, hostile reactions, and loss of patterns of conduct.

Anticipatory grieving was defined as a cluster of predictable responses to an anticipated loss. These responses include the range of feelings experienced by the person or family preoccupied with an anticipated loss. The term *morbid grief reaction* described delayed and dysfunctional reactions to loss; a variety of debilitating health problems were seen in people who displayed excessive or delayed responses to loss.

Caplan: Stress and Loss

Caplan's (1990) theory of stress and its relationship to loss is useful in understanding the grief process. He expanded the focus of the grief process to include not only bereavement but also other episodes of stress that people experience, such as the stress that can result from surgery or childbirth. Caplan described three factors that influence the person's ability to deal with a loss:

- The psychic pain of the broken bond and the agony of coming to terms with the loss
- Living without the assets and guidance of the lost person or resource
- The reduced cognitive and problem-solving effectiveness associated with the distressing emotional arousal.

He believed these factors might cause distress for a year or more following the loss.

Caplan described the process of building new attachments to replace those that have been lost. This process involves two elements: a feeling of hope and the assumption of regular activity as a form of participating in ordinary living.

Kübler-Ross: Stages of Coping with Loss

Kübler-Ross's (1969, 1978) research on death and dying provided a framework for gaining insight about the stages of coping with an impending or actual loss. According to Kübler-Ross, not all people dealing with a loss go through these stages, and those who do may not experience the stages

in the sequence described. In identifying the stages of death and dying, Kübler-Ross (1978) repeatedly stressed the danger of prematurely labeling a “stage” and emphasized that her goal was to describe her observations of how people come to terms with situations of loss.

Some or all of the following reactions may occur during the grieving process and may reappear as the person experiences the loss:

- **Denial.** A person may react with shock and disbelief after receiving word of an actual or potential loss. After receiving a terminal diagnosis, notification of a death, or other serious loss, people may make such statements as “This can’t be happening to me” or “This can’t be true.”
- **Anger.** In the anger stage, the person resists the loss. The anger is often directed toward family and healthcare providers.
- **Bargaining.** The bargaining stage serves as an attempt to postpone the reality of the loss. The person makes a secret bargain with God, expressing a willingness to do anything to postpone the loss or change the prognosis.
- **Depression.** The person enters a stage of depression as the full impact of the actual or perceived loss is realized. The person prepares for the impending loss by working through the struggle of separation. While grieving over “what cannot be,” the person may either talk freely about the loss or withdraw from others.
- **Acceptance.** The person begins to come to terms with the loss and resumes activities with an air of hopefulness for the future. Some dying people reach a stage of acceptance in which they may appear to be almost devoid of emotion. The struggle is past, and the emotional pain is gone.

FACTORS AFFECTING RESPONSES TO LOSS

A variety of factors affect a person’s responses to loss. These include age, social support, families, cultural and spiritual practices, and rituals of mourning.

Age

The understanding of and reaction to loss is influenced by the age of the person experiencing the loss. In general, as people experience life transitions, their ability to understand and accept the losses associated with the transitions increases. From the age of 3 years, the development of the concept of death as a loss proceeds rapidly. Table 5–2 outlines the development of the concept of death throughout the life span.

Social Support

Grieving is painful and lonely. One’s social support system is important because of its potentially positive influence on the successful resolution of grief. Some losses may lead to social isolation, placing clients at high risk for dysfunctional grief reactions. For example, loved ones of people who die from AIDS often report feeling excluded by the deceased person’s family and by healthcare providers. Characteristic factors that can interfere with successful grieving include the following:

- Perceived inability to share the loss
- Lack of social recognition of the loss

TABLE 5–2 Development of the Concept of Death

| AGE | BELIEFS/ATTITUDES ABOUT DEATH |
|--------------|--|
| 3 | Fears separation; lacks comprehension of permanent separation. |
| 3 to 5 | Believes death is like sleeping and is reversible. Expresses curiosity about what happens to the body. |
| 6 to 10 | Understands finality of death. Views own death as avoidable. Associates death with violence. Believes wishes can be responsible for death. |
| 11 to 12 | Reflects views of death expressed by parents. Expresses interest in afterlife as an understanding of mortality develops. Recognizes death as irreversible and inevitable. |
| 13 to 21 | Usually has a religious and philosophic view of death but seldom thinks about it. Views own death as distant or a challenge, acting out defiance through reckless behavior. Previously held developmental awareness of death may still be present. |
| 22 to 45 | Does not think about death unless confronted with it. Emotionally distances self from death. Attitude toward death influenced by religious and cultural beliefs. |
| 46 to 65 | Experiences the death of parents or friends. Accepts own mortality. Experiences waves of death anxiety. Puts life in order to prepare for death and decrease anxiety. |
| 66 and older | Fears lingering, incapacitating illness. Views death as inevitable but from a philosophical view point: that is, as freedom from pain and illness or as a spiritual reunion with deceased friends and loved ones. |

- Ambivalent relationships prior to the loss
- Traumatic circumstances of the loss.

A move, a divorce, or even the death of a pet can cause a person to feel extremely isolated, yet the person experiencing these types of loss does not ordinarily receive the same social support offered to the person mourning the death of a loved one. A woman having an abortion or giving up a child for adoption seldom receives the same social support as the mother of a child who died at birth. It is therefore especially important for the nurse *not* to place a value on the client’s loss when assessing the need for support.

The painful nature of grief can cause the client to withdraw from a previously established social support system, thereby increasing the feelings of loneliness caused by the loss. A recently widowed woman, for example, may refuse invitations involving married couples with whom she had socialized while her husband

was alive. The client's needs for social interaction, however, remain similar to those established before the loss.

Families

A well-functioning family usually rallies after the initial shock and disbelief and provides support for each other during all phases of the grieving process. After a loss, the functional family is able to shift roles, levels of responsibility, and ways of communicating.

The family may have negative as well as positive effects. For example, the dying client may request that someone the family perceives as an outsider be near, and the family may respond with anger to the perceived "intrusion." Similarly, certain family members may express hurt feelings or anger if the client is unresponsive to other family members. Well-meaning family members also may try to shield the client from the pain of grieving. It is rare for the family and the client to experience anger, denial, and acceptance in unison. While one member is in denial, another may be angry because "not enough is being done."

Cultural and Spiritual Practices

The influence of culture and ethnic identity on communication, family values, and beliefs about and practices related to illness and death are important considerations when providing nursing care. As described by Spector (2004), there are countless ethnocultural and religious differences in the way people observe dying, death, and mourning. For example, regional differences in the way death is expressed in the United States include "passed away," "died peacefully," "departed this life," "went home to be with God," and "passed from this life." Objects such as masks, statues, and photos are also used to express death and death rituals. Examples of cultural rites related to death (Spector, 2004) include:

- *China*: Initial burial is in a coffin; after 7 years, the body is exhumed and cremated, and the urn is reburied in a tomb.
- *Iraq*: Iraqis follow Muslim rites, with the body generally cared for, washed, and wrapped in a white cloth. The body generally remains at home.
- *Israel*: Relatives remain with the dying person and the body is never left alone. The eyes must be closed at death. The body is buried in the ground within 24 hours except on the Sabbath (Saturday).
- *Mexico*: Family members stay with the dying person around the clock and their grief may be expressive.

Clients who are dying often ask questions of themselves and others as to what their life has meant, why this illness has affected them, and what will happen to them when they die. They may feel abandoned by God, or worry that their behavior caused the illness resulting in death. These questions and concerns lead to spiritual distress, which if unresolved may lead to hopelessness, anxiety, and depression. When spiritual distress is resolved, clients can die more peacefully.

Spirituality is at the core of human existence, integrating and transcending the physical, emotional, intellectual, and social dimensions (Reed, 1996). The principles, values, personal philosophy, and meaning of life by which the client has pursued goals and self-actualization may be called into question when

the client responds to an actual or perceived loss. Because of a fear of intruding on the personal spiritual beliefs and practices of the client, the nurse often feels at a loss in implementing interventions that would be helpful to the client responding to a loss. The following questions (using the mnemonic FICA) may be used to assess a client's spiritual or religious practices (Lynn, Schuster, & Kabcenell, 2000).

- *Faith*. What is your faith or belief? Do you consider yourself a spiritual or a religious person? Does religious faith or spirituality play an important part in your life? What do you believe gives your life meaning?
- *Influence*. How does your religious faith or spirituality influence your thoughts about health? How does it affect the way that you take care of yourself?
- *Community*. Do you consider yourself part of a spiritual or religious community or congregation? How is that community or congregation a source of support for you?
- *Address*. Do you have any special religious or spiritual issues or concerns that you would like me to address with you? Is there someone else you would like to speak to about these matters?

It is often difficult for clients with an incurable illness to maintain hope and a sense that their lives have had meaning. To meet spiritual needs, nurses can help clients accept the uncertainty that comes with their illness and future death, and respect the spiritual beliefs and practices of clients and their families. Clients who are religious need opportunities for prayer, devotions, and religious rituals. Other resources for spirituality include meditation, guided imagery, music, and art. Privacy and space for these activities should be provided without question.

Rituals of Mourning

Through participation in religious ceremonies such as baptism, confirmation, and bat or bar mitzvah, people joyously celebrate progression to a new stage of life and loss of a former way of being. The funeral ceremony serves many of the same purposes in meeting the needs of the bereaved as people gather to share loss. Through the ceremony, people symbolically express triumph over death and deny the fear of death. Culture is the primary factor that dictates the rituals of mourning. See Focus on Cultural Diversity on the following page for examples of terminal illness care in selected cultures.

Nurses' Response to Clients' Loss

Nurses care for clients and families at various stages of the grief process and may feel that crisis situations are not the time for self-reflection. However, because the nurse's conscious or unconscious reactions to the client's responses to the loss will influence the outcome of any interventions, nurses need to take time to analyze their own feelings and values related to loss and the expression of grief. The nurse can promote self-awareness by reflecting on the following questions:

- What are my personal feelings about how grief should be expressed?
- Am I making judgments about the meaning of this loss to the client?
- Are unresolved losses in my own life preventing me from relating therapeutically to the client?



FOCUS ON CULTURAL DIVERSITY

Cultural Aspects of Terminal Illness Care

| Culture/Ethnicity | Nursing Interventions |
|------------------------|---|
| American Indian | Some tribes prefer not to openly discuss terminal prognosis and DNR decisions, because negative thoughts may make inevitable loss occur sooner. Suggest a family meeting to discuss care and end-of-life issues. If the family feels comfortable, all members of the family and close friends may remain 24 hours a day (eating, joking, singing). Mourning is done in private, away from the dying person. After death, the family may hug, touch, sing, and stay close to the deceased. |
| Black/African American | Suggest that the family have a family meeting or talk with a minister or family elder. Client may decide to have older family member disclose a poor prognosis. Care for the dying family member is often done at home until death is imminent. |
| Chinese American | Ensure the head of the family is present when terminal illness is discussed. The client may not want to discuss approaching death. Special amulets or cloths may be brought from home. Family members may prefer to bathe the body after death. |
| Iranian | Information about a terminal illness should be presented by a trusted member of the healthcare team to the family, and never to the client when he or she is alone. Most Iranians believe in tagdir (will of God) in life and death as a predestined journey. When death occurs, notify the head of the family first. DNR decisions are often made by the family. The family may want to bathe the body. |
| Mexican American | Based on the belief that worry may make health worse, the family may want to protect the client from seriousness of illness. The information is often handled by an older daughter or son. Extended family members are obligated to pay respects to the sick and dying, although pregnant women do not care for dying persons or attend funerals. May prefer the client die at home. Prayers, amulets, and rosary beads are used, and the priest should be notified. Death is seen as an important spiritual event. The family may bathe the body and spend time with the body. |
| Vietnamese | Consult head of family before telling client about a terminal illness. Entire family will make DNR decision, often with assistance from a priest or monk. Clients often prefer to die at home. Family should have extra time with the body, and may cry loudly and uncontrollably. Spiritual/religious rites are often conducted in the room. |

Source: Adapted from *Culture & Nursing Care: A Pocket Guide* by J. G. Lipson, S. L. Dibble, & P. A. Minarik (Eds.), 1996, San Francisco: UCSF Nursing Press; *Cultural Diversity in Health & Illness*, 6e, R. E. Spector. 2004, Upper Saddle River, N.J.: Prentice Hall Health.

The following resources may be useful in helping nurses provide care to dying clients:

- DyingWell
- National Hospice and Palliative Care Organization
- International Association for Hospice and Palliative Care
- National Foundation for Treatment of Pain.

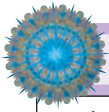
END-OF-LIFE CARE

End-of-life (the final weeks of life when death is imminent) **nursing care** that ensures a peaceful death was mandated by the International Council of Nurses (1997) and further supported by the AACN (1999). Following are selected competencies necessary for nurses to provide high-quality end-of-life care as defined by the AACN (1999):

- Promote the provision of comfort care to the dying as an active, desirable, and important skill, and an integral component of nursing care (Figure 5–1 ■).
- Communicate effectively and compassionately with the patient, family, and healthcare team members about end-of-life issues.
- Recognize one's own attitudes, feelings, values, and expectations about death and the individual, cultural, and spiritual diversity existing in those beliefs and customs.



Figure 5–1 ■ The nurse helps the client visualize the hospital room as a safe, comfortable place to die by surrounding the client with familiar pictures and objects.



NURSING RESEARCH Evidence-Based Practice: End-of-Life Care

End-of-life care is emerging as a major concern in the United States. Although many people die in the hospital, little research has been done about deaths in the critical care unit (CCU). Clients are not admitted to the CCU to die, but approximately 20% of critical care clients do not live to be discharged from the hospital. Most deaths in the CCU occur in undesirable situations, for example, when clients do not respond to the advanced technology and decide to forgo further treatment, or are comatose or receiving mechanical ventilation. In most instances, clients dying in the CCU are isolated from family members. The purpose of this study (Kirchhoff et al., 2000) was to address the largely unstudied area of CCU nursing care by conducting focus groups of CCU nurses.

IMPLICATIONS FOR NURSING

Regardless of the setting for end-of-life care, nurses need to ensure that clients are as free from pain as possible, and that the comfort and dignity of the client are maintained. In addition, family members should be given time to begin to accept the dying process. This may be facilitated by having the family member pro-

vide physical care and lie in bed with the client, and by providing time and space for family rituals and saying good-bye. Nurses also need to show the family that they care and are involved. However, nurses face the dilemmas of sometimes having a less optimistic outlook than physicians, of approving or not approving the use of extraordinary measures to preserve life, and of not wanting to share feelings following a death or sharing too much.

CRITICAL THINKING IN CLIENT CARE

1. What environmental differences are present between a regular hospital unit and a critical care unit that might make quality end-of-life care more difficult for nurses?
2. The family of a client in the CCU says to you, "Uncle Al is going to die, isn't he?" What would you need to know before responding? How would you respond?
3. A CCU client who previously had been improving suddenly dies. The staff are saddened, and several are in tears. A more experienced nurse says, "Oh, you just have to go on. There's nothing else to do." Do you agree? Why or why not?

Source: Data from Kirchhoff, K., Spuhler, V., Walker, L., Hutton, A., Cole, B., & Clemmer, T. (2000). Intensive care nurses' experiences with end-of-life care. *American Journal of Critical Care, 9*(1), 35–42.

- Demonstrate respect for the patient's views and wishes during end-of-life care.
- Use scientifically based standardized tools to assess symptoms (e.g., pain, dyspnea, constipation, anxiety, fatigue, nausea/vomiting, and altered cognition) experienced by patients at the end of life.
- Use data from symptom assessment to plan and intervene in symptom management using state-of-the-art traditional and complementary approaches.
- Assist the patient, family, colleagues, and one's self to cope with suffering, grief, loss, and bereavement in end-of-life care.

Nursing Considerations for End-of-Life Care

Nurses care for the dying client in critical care units, emergency rooms, hospital units, long-term care facilities, and the home. (See Nursing Research: Evidence-Based Practice above for research about intensive care nurses' experiences with end-of-life care.) Regardless of the setting, the client's wishes about death should be respected. The Dying Person's Bill of Rights states that each person has "the right to be cared for by caring, sensitive, knowledgeable people who will attempt to understand my needs and will be able to gain some satisfaction in helping me face my death" (Barbus, 1975).

Legal and Ethical Issues

Issues such as those involved in advance directives and living wills, euthanasia, and quality of life are especially important to nurses in upholding the specific care requests of their clients.

ADVANCE DIRECTIVES Advance directives are legal documents that allow a person to plan for health care and/or finan-

cial affairs in the event of incapacity. They include living wills, healthcare surrogates, and durable power of attorney.

FAST FACTS

Types of Advance Directives

- **Living will:** A document that provides written directions about life-prolonging procedures to provide instructions when a person can no longer communicate in a life-threatening situation.
- **Healthcare surrogate:** An individual selected to make medical decisions when a person is no longer able to make them for himself or herself.
- **Durable power of attorney:** A document that can delegate the authority to make health, financial, and/or legal decisions on a person's behalf. It must be in writing and must state that the designated person is authorized to make healthcare decisions.

A living will is a legal document that formally expresses a person's wishes regarding life-sustaining treatment in the event of terminal illness or permanent unconsciousness. It is not a type of durable power of attorney and usually does not designate a substitute decision maker. It is the responsibility of the nurse as client advocate to request and record the client's preference for care and include it in the plan of care. The nurse's documentation helps communicate these preferences to the other members of the healthcare team.

All facilities that receive Medicare and Medicaid funds are required to provide all clients with written information and counseling about advance directives and the institution's policies governing them. The specific terms of this requirement are found in the Patient Self-Determination Act (PSDA). A

copy of the signed advance directive must be kept in the client's medical record, but clients do not have to sign it in order to be treated. Nurses are the ones in close contact with clients, so they are often left with unresolved feelings about the moral, ethical, and legal aspects of their actions. Although advance directives do not ease the pain of seeing clients die, they do help nurses provide clients with the care that the clients have chosen.

DO-NOT-RESUSCITATE ORDERS A **do-not-resuscitate** (DNR, or “no-code”) **order** is written by the physician for the client who has a terminal illness or is near death. This order is usually based on the wishes of the client and family that no cardiopulmonary resuscitation be performed for respiratory or cardiac arrest. A comfort-measures-only order indicates that no further life-sustaining interventions are necessary and that the goal of care is a comfortable, dignified death. Agency protocols should be established that define “comfort care” for consistency in nursing care. Confusing or conflicting DNR orders create dilemmas, because nurses are involved in resuscitation and either begin CPR or ensure that unwanted attempts do not occur. The American Nurses Association (ANA) has made specific recommendations related to a DNR order (Box 5–2). The ANA further recommends that guidelines and policies be developed to help resolve conflicts between clients and their families, between clients and healthcare professionals, and among healthcare professionals.

BOX 5–2 The ANA Position on Nursing Care and Do-Not-Resuscitate Decisions

- The choices and values of the competent patient should always be given highest priority, even when these wishes conflict with those of healthcare providers and families.
- In the case of the incompetent or never competent patient, any existing advance directives or the decisions of surrogate decision makers acting in the patient's best interest should be determinative.
- The DNR decision should always be a subject of explicit discussion among the patient, the family, any designated surrogate decision maker acting in the patient's best interest, and the healthcare team. The decision should include consideration of the efficacy and desirability of CPR, a balancing of benefits and burdens to patients, and therapeutic goals.
- DNR orders must be clearly documented, reviewed, and updated periodically to reflect changes in the patient's condition.
- Nurses have a responsibility to educate patients and their families about various forms of advance directives such as living wills and durable power of attorney.
- If it is the nurse's personal belief that his or her moral integrity is compromised by professional responsibility to carry out a particular DNR order, the nurse should transfer the responsibility for the patient's care to another nurse.

Source: From *Task Force on the Nurse's Role in End of Life Decisions* by ANA Board of Directors, 1992.

EUTHANASIA **Euthanasia** (from the Greek for painless, easy, gentle, or good death) is now commonly used to signify a killing prompted by some humanitarian motive. There are many arguments for and against euthanasia, and nurses have often found themselves at the center of the debate. As a result, nurses have pushed for the development of appropriate guidelines and procedures for DNR orders. When no such orders exist, the nurse faces a dilemma. Certainly, there are situations in which the nurse's role is clear. For example, it is considered malpractice to participate in “slow codes” (in which the nurse does not hurry to alert the emergency team when a terminally ill client who does not have a DNR order stops breathing).

The natural death laws seek to preserve the notion of voluntary versus involuntary euthanasia. In voluntary euthanasia, the competent adult client and a physician, nurse, or adult friend or relative make the decision to terminate life. Involuntary euthanasia (“mercy killing”) is performed without the client's consent. Because care settings offer many complex and technologic interventions, it is not likely that the ethical aspects of euthanasia will soon be resolved. However, advance directives do give clients a much more active role in decisions about their own care.

Settings and Services for End-of-Life Care

Settings and services for end-of-life care range from the critical care unit in a hospital to the client's own home. Two methods of providing end-of-life care—hospice and palliative care—are described in this section.

Hospice

Hospice is a philosophy of care rather than a program of care. It is “comprehensive and coordinated care for clients with limited life expectancy, provided both at home and in institutional settings” (Fine, 2004, p. 1) that reaffirms the right of every client and family to fully participate in the final stages of life. Provided by hospice agency nurses and other members of a healthcare team (including social workers, ministers, home health aides, and volunteers), it is based on a philosophy of death with comfort and dignity, encompassing biomedical, psychosocial, and spiritual aspects of the dying experience. Although most hospice care is provided in the home, it may also be provided in hospitals, long-term care facilities, or other community-based settings.

The American hospice movement was originally led by volunteers (many of whom were nurses) who wanted to make life better for those who were dying. These devoted volunteers promoted the dignity of patients during their death and decreased their institutionalization. In 1986, Congress passed the Medicare Hospice Benefit and also gave states the option of including hospice services in their Medicaid programs.

There are approximately 2,500 hospice agencies in the United States, with most services and care reimbursed by a Medicare hospice benefit (National Association for Home Care & Hospice, 2004). Services are reimbursed by Medicare for an initial 90-day period, followed by a subsequent 90-day period, and an unlimited number of 60-day periods as long as the

patient continues to meet eligibility requirements. The average length of service is 47 days (CDC, 2006). Hospice services usually begin when the patient has 6 months or less to live and ends with the family 1 year after the death of the patient. This continuation of care for the family is called bereavement care (**bereavement** is the time of mourning experienced after a loss).

To be eligible for hospice benefits from Medicare or Medicaid, the client must have a serious, progressive illness with a limited life expectancy. In most cases, a family (or other) caregiver must be continuously in the home with the client. The client must have Medicare, waive traditional Medicare benefits for the terminal illness, have physician certification of a terminal illness, and care must be provided by a Medicare-certified hospice agency or program.

Palliative Care

Palliative care is an area of care that has evolved out of the hospice experience, but exists outside of hospice programs, is not restricted to the end of life, and is used earlier in the disease experience. Palliative care, which can be used in all types of healthcare settings, is focused on the relief of physical, mental, and spiritual distress for individuals who have an incurable illness. The goal of palliative care is to prevent and relieve suffering by early assessment and treatment of pain and other physical, psychosocial, and spiritual needs to improve the client's quality of life.

Although palliative care may be provided by a single person, it usually involves the combined efforts of an interdisciplinary team, including physicians, nurses, social workers, chaplains, home health aides, and volunteers. Care is provided in the client's home (or long-term care facility, senior living facility, or hospital). The expected outcomes of care are directed by interventions to manage current manifestations of the illness and to prevent new manifestations from occurring.

Physiologic Changes in the Dying Client

Death is a highly individualized process, and may occur rapidly or slowly. Physiologic changes are a part of the dying process. These changes result in any or all of the manifestations listed in the box below as death nears. Although each person responds differently, certain manifestations are common in the dying process, regardless of the trauma or disease process that

is causing death. The discussion that follows includes treatments and related nursing care.

Pain

A common problem for clients at the end of life, pain is what people often say they fear the most. Pain, a subjective experience, is influenced by the client's emotions, previous experiences with pain, and family and culture. Unfortunately, pain is often undertreated at the end of life (Tierney et al., 2004), because physicians and nurses fear they will cause addiction or cause harm from the high dose of opioids necessary to control pain at the end of life. However, nearly all pain at the end of life can be managed without causing addiction or hastening death through respiratory depression. It is of utmost importance to keep the client comfortable through general comfort measures (Box 5–3) and by administering ordered medications for pain, neuropathic pain (which is rarely relieved by opioids), seizures, and/or anxiety. The pathophysiology, treatment, and nursing care of clients experiencing pain are fully described in Chapter 9 ∞.

PRACTICE ALERT

There is no maximum allowable dose at end of life for opioids such as morphine sulfate; the dose should be increased to whatever is necessary to relieve pain. Meperidine (Demerol) is not useful for chronic pain because it has a short half-life and a toxic metabolite that can cause irritability and seizures (Tierney et al., 2004).

Dyspnea

Respiratory changes, including dyspnea, are normal as death nears. Dyspnea is a subjective experience, and the client often reports having a feeling of suffocation, shortness of breath, or tightness in the chest. Up to 50% of dying clients have severe dyspnea, especially those with lung tumors (primary or metastatic), restrictive lung disease, or pleural effusion (Tierney et al., 2004). Regardless of the terminal illness or fatal injury, the final cause of death is a lack of oxygen to the brain.

BOX 5–3 Providing Comfort for the Client Nearing Death

- Maintain clean skin and bed linens.
- Use a draw sheet to turn the client as often as possible so the client is comfortable.
- Position the client to promote comfort and protect bony areas with padding. Reposition the client and raise the head of the bed if fluids accumulate in the upper airways and back of the throat.
- Use bed pads or insert a Foley catheter (if ordered) for urinary incontinence.
- Use gentle massage to improve circulation and shift edema.
- Provide small, frequent sips of fluids, ice chips, or Popsicles.
- Provide oral care, using a soft moist brush or glycerin swab.
- Clean secretions from the eyes and nose.
- Administer ordered pain medications as needed to maintain comfort.
- Administer oxygen as prescribed to relieve dyspnea.



MANIFESTATIONS of Impending Death

- Difficulty talking or swallowing
- Nausea, flatus, abdominal distention
- Urinary and/or bowel incontinence, constipation
- Decreased sensation, taste, and smell
- Weak, slow, and/or irregular pulse
- Decreasing blood pressure
- Decreased, irregular, or Cheyne-Stokes respirations
- Changes in level of consciousness
- Restlessness, agitation
- Coolness, mottling, and cyanosis of the extremities.

As death nears, respirations often become fast or slow, shallow and labored. The client may have apnea or Cheyne-Stokes respirations (regular periods of deep, rapid breathing followed by no breaths for 5 to 30 seconds). Fluid may accumulate in the lungs causing rales and rhonchi, especially in clients who are well hydrated and are having difficulty swallowing or coughing. These sounds are not painful for the client, but they may be treated with oxygen, opioids (to improve respirations and decrease anxiety), and medications to decrease secretions (atropine, scopolamine, hyoscyamine, or glycopyrrolate). Note that oxygen and suctioning are only temporary measures, and (especially with suctioning) may even be traumatic for the client. Nursing care to improve respirations includes keeping the head of the bed elevated. Keeping the room cool and providing a breeze from a fan often makes the client more comfortable.

PRACTICE ALERT

Morphine is the medication of choice for palliative treatment of dyspnea. Nebulized morphine may be used, and is often more effective than that given by other routes, but it increases the risk of bronchospasm. Nebulized morphine is contraindicated in clients with chronic obstructive pulmonary disease because of the risk of respiratory depression and increasing hypercapnia.

Anorexia, Nausea, and Dehydration

Although anorexia and a decrease in food and fluid intake are normal in the dying client, the family often views this as “giving up.” Anorexia may be a protective mechanism; the breakdown of body fats results in ketosis, which leads to a sense of well-being and helps decrease pain. Parenteral or enteral feedings do not improve symptoms or prolong life and may actually cause discomfort. As weakness and difficulty swallowing progress, the gag reflex is decreased and clients are at increased risk for aspiration if oral foods or fluids are given.

Nausea, with or without vomiting, is a common problem in dying clients. Nausea and vomiting may be caused by reduced gastric emptying, constipation, bowel obstruction, a side effect of morphine, uremia, or hypercalcemia. If the client is conscious and complains of nausea, antiemetics such as prochlorperazine (Compazine) or ondansetron (Zofran) should be administered.

Dehydration is less of a problem than overhydration. Forcing fluids or initiating intravenous fluids for hydration may in turn increase fluid in the lungs, peripheral edema, ascites, and vomiting. Dehydration in the client nearing death primarily causes discomfort from dry mouth and thirst. The client should be given small sips of water, or an atomizer can be used to spray the inside of the mouth. Oral care should be given at least every 2 hours, and more often if the client is breathing through his or her mouth. Glycerin swabs may be used to keep the lips less dry.

Altered Levels of Consciousness

Neurologic dysfunction results from any or all of the following: decreased cerebral perfusion, hypoxemia, metabolic acidosis, sepsis, an accumulation of toxins from liver and renal failure, the effects of medications, and disease-related factors. These changes may result in a decreased level of consciousness or ag-

itated delirium. Clients with terminal delirium may be confused, restless, or agitated. Moaning, groaning, and grimacing often accompany the agitation and may be misinterpreted as pain. Level of consciousness often decreases to the point where the client cannot be aroused. Although decreased consciousness and agitation are both normal states at the end of life, they are very distressing to the client’s family.

If possible, confusion or agitation is treated based on its cause; for example, by relieving pain or dyspnea. Other medications include low doses of neuroleptics, tranquilizers, or antianxiety medications. A client near death often has altered cerebral function, so the nurse must stand near the bedside and speak clearly. Hearing is thought to be the last sense a dying client loses, so the nurse should never whisper or engage in conversation with the family as if the client were not there. Nursing care for the comatose client includes:

- Using artificial tears if the client does not blink
- Keeping lights at a low level
- Keeping skin clean and dry
- Covering only with a light blanket
- Using adult incontinence pads or pants for incontinence
- Turning every 2 hours and maintaining joint positions.

Hypotension

As death nears, the cardiac output decreases, as does intravascular blood volume. As a result, blood pressure gradually decreases and the pulse is often rapid and irregular. The extremities are cooler, and cyanosis is present in nail beds, skin, and lips. The skin on the legs and in dependent areas may become mottled in color. Renal perfusion decreases and the kidneys cease to function. Urinary output is scanty. The client will have tachycardia, hypotension, cool extremities, and cyanosis with skin mottling.

Support for the Client and Family

As the client’s condition deteriorates, the nurse’s knowledge of the client and family guides the care provided. It may be necessary to provide opportunities for clients to express personal preferences about where they want to die and about funeral and burial arrangements. If the family feels that this is morbid, the nurse explains that it helps clients to keep a sense of control as they approach death.

The client needs the opportunity to say good-bye to others. The nurse encourages and supports the client and family as they terminate relationships as a necessary part of the grief process. The nurse acknowledges that termination is painful and, if the client or family desires, stays with them during this time. Family members are often afraid to be present at the moment of death, yet dying alone is the greatest fear expressed by clients.

Death

The manifestations listed on page 94 are seen after death occurs, and are the basis for pronouncing death. They appear gradually and not in any special order. Pronouncement of death is legally required by a physician or other healthcare provider to confirm death. The time of death, with any related data, is documented in the client’s chart.

MANIFESTATIONS of Death

- Absence of respirations, pulse, and heartbeat
- Fixed and dilated pupils; eyes may stay open
- Release of stool and urine
- Waxen color (pallor) as blood settles to dependent areas
- Body temperature drops
- Lack of reflexes
- Flat encephalogram

The nurse may also fear being present at the moment of the client's death. In fact, Kübler-Ross (1969) noted that the nurse's fear of death frequently interferes with the ability to provide support for the dying client and family. Thoughts such as "Please, God, don't let him die on my shift" are common, and they express the nurse's emotional turmoil in dealing with the task. Nurses who have worked through their own feelings about death and dying are more at ease in assisting the dying client toward a peaceful death.

After the death, the family is encouraged to acknowledge the pain of loss. The nurse's presence and support as the bereaved express their sorrow, anger, or guilt can help them resolve their grief. It is important for the bereaved not to suppress the pain of grieving with drugs. By accepting variations in the expression of grief, the nurse supports the family's grief reactions and helps prevent dysfunctional grieving. Dysfunctional grieving is an extended and unsuccessful resolution of grief.

Resolution of grief begins with acceptance of the loss. The nurse can encourage this acceptance by maintaining open, honest dialogue and by providing the family with the opportunity to view, touch, hold, and kiss the person's body. As family members realize the finality of the death, they are often comforted by the presence of the nurse who cared for the client during the final days.

Postmortem Care

The nurse documents the time of death (required for the death certificate and all official records), notifies the physician, and assists the family (if needed) in choice of a funeral home. If the client dies at home, death must be pronounced before the body is removed. In some states and in some situations, nurses can pronounce death; for specifics, consult state practice acts, laws, and agency policy. All jewelry is removed and given to the family unless they ask that it be left on. The body is kept in place until the family is ready and gives permission. If an autopsy is required or requested, the body must be left undisturbed (e.g., do not remove any tubes) for transportation to the medical examiner.

Documentation of the death is completed by sending a completed death certificate to the funeral home (for a death in the home), or by completing the required paperwork and sending the body to the morgue or funeral home (for a death in the hospital or long-term care setting).

Nurses' Grief

The nurse who has developed a close relationship with the client who has died may experience strong feelings of grief. Sharing grief with the family after the death of a loved one helps both the



Figure 5-2 ■ Nurses who work with dying clients need support from their colleagues to work through their often overwhelming feelings of grief.

nurse and family to cope with their feelings about the loss. Taking time to grieve after the death of a client provides a release that can help prevent "blunting" of feelings, a problem often experienced by nurses who care for clients who are terminally ill.

PRACTICE ALERT

Crying with families, at one time considered unprofessional, is now recognized as simply an expression of empathy and caring.

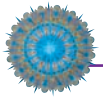
Nurses working with clients who are critically or terminally ill should be aware that witnessing a client's death and the family's grief may reactivate feelings about some unresolved grief in their own lives. In these cases, nurses may need to reflect on their responses to their own losses. Also, nurses who work with dying clients need support from peers and other professionals to work through the often overwhelming feelings that result from dealing with death, grief, and loss (Figure 5-2 ■).

Interdisciplinary Care

Interventions for loss and grief may be planned and implemented by any or all members of the healthcare team. Nurses and social workers provide interventions to help clients or families adapt to a loss. They also make referrals to mental health professionals (grief counselors, social services), support groups, chaplains, or legal or financial assistance agencies.

Grieving clients frequently enter the healthcare system with significant somatic symptoms. In some cases, the symptoms of grief and loss are overlooked until the client reaches a crisis state requiring psychiatric medical intervention. Collaborative care by the physician and the nurse early in the normal grieving process

can help the client achieve an early and effective resolution of grief and avoid physical or psychiatric health problems.



Nursing Care

Nurses practicing in all types of settings care for clients who are in various stages of the grieving process. Grief is highly individual. The grief process may range from uncomfortable to debilitating, and it may last for a day or a lifetime, depending on what the loss means to the person experiencing it.

Health Promotion

In planning and implementing nursing care for the client experiencing a loss, the nurse considers the individual responses, which may vary greatly. In an era of short acute care stays for clients, nurses may feel that an elaborate grief assessment is impossible or, at the least, impractical. But research and clinical experience suggest that clients who delay the grieving process after a loss are prone to have health problems that may last a lifetime. See Nursing Care of the Older Adult below for an end-of-life checklist for older adults.

Assessment

Knowledge of the expected physical reactions to loss provides the nurse with a basis for identifying reactions that require further assessment. To assess the extent of somatic distress, the nurse observes for changes in sensory processes and asks questions about the client's sleeping and eating patterns, activities of daily living, general health status, and pain.

Physical Assessment

Clients may experience one or more predictable somatic symptoms as they become aware of a loss. Gastrointestinal

symptoms occur frequently and may include indigestion, nausea or vomiting, anorexia, weight gain or loss, constipation, or diarrhea. The shock and disbelief that accompany a loss may cause shortness of breath, a choking sensation, hyperventilation, or loss of strength. Some clients also report insomnia, preoccupation with sleep, fatigue, and decreased or increased activity level.

Crying and sadness are observed during normal grief states. Crying may make the client feel exhausted and interfere with carrying out activities of daily living. However, a person who is unable to cry may have difficulty completing the mourning process. If the client does not express feelings of grief, somatic symptoms may increase.

It is imperative that the client's concerns about pain be assessed, especially if the client has cancer or another painful illness. Knowledge of pain theories and pain assessment can help the nurse assess the need for pain medication (see Chapter 9 ∞). During the last stages of dying, the client usually becomes very weak, and sensations and reflexes decrease; these changes call for careful assessment of the client's physical needs.

Reactions to loss are not always obvious. For example, in clients who experience an illness following a serious loss, assessment may reveal somatic complaints related to the grief state as well as the illness. When a person who has been healthy begins to develop patterns of increased illness, the nurse should be aware that this may signal dysfunctional grieving. This is especially common in the loss and grieving associated with a change in body image. In addition to making a physical assessment, assess the client's perception of the alteration in body image. The loss of a body part, weight gain or loss, and scars from surgery or trauma can be difficult for the client to accept. Some clients may grieve hair loss that accompanies chemotherapy used in cancer treatment.

NURSING CARE OF THE OLDER ADULT

End-of-Life Checklist

- Take time a day or so before appointments with your healthcare provider to think about the questions you need answered and concerns you want to discuss. It is often a good idea to keep a pad of paper and a pen handy so you can write down things as they come to you.
- Do not hesitate to have your doctor explain your diagnosis again if you didn't understand the explanation the first time or if you missed some key points. The same goes for details about using medications and possible side effects.
- You may wish to have a friend or family member go with you to medical appointments.
- When you visit the doctor, take an up-to-date list of all the medications (prescribed and over-the-counter) you are currently taking.
- If you have physical pain, tell your healthcare provider. You will probably be asked to rate your pain on a scale of 1 (no pain) to 10 (severe pain). Your rating helps determine what pain relief measures are appropriate.
- It is a good idea to ask your healthcare provider about hospice services well before you are likely to need them.
- Your family and close friends should be aware of your treatment preferences (such as the existence of a DNR order). You might consider documenting your wishes in a living will.
- Think about asking and appointing someone you trust to make your healthcare decisions, in case the moment comes when you can no longer make them yourself.
- If you are feeling depressed or anxious or need emotional support, consider talking to a pastor, chaplain, rabbi, or other trusted person in your faith community. If necessary, ask your healthcare provider to recommend someone to help you sort out your feelings.
- Avoid withdrawing from social activities. Keep communicating with your family, friends, and the people who help care for you. If you are open with them you are more likely to get the care you need.

Source: Data from the United States Senate Special Committee on Aging. (2000). *End-of-Life Care Checklist for Seniors*. Retrieved from www.advancedseniorsolutions.com/end_of_life_care%20v2.htm

Spiritual Assessment

Because spiritual beliefs and practices greatly influence people's reaction to loss, it is important to explore them with the client when assessing a loss. The spiritually healthy client has inner resources that help work through the grief process. Faith, prayer, trust in God or a superior being, perception of a purpose in life, or belief in immortality are examples of the inner resources that may sustain the client during an actual or perceived loss.

Assessing the client's spiritual life and its significance to the client and family helps identify spiritual support systems. Some nurses are uncomfortable with assessing the client's spiritual needs; the following questions may be helpful:

- What are the spiritual aspects of the client's philosophy about life? Death?
- Are the values and beliefs about life and death congruent with those of people who are important to the client?
- Which spiritual resources and rituals have significance for the client?

Belief systems that are incompatible with those of family members can be an additional source of stress for clients dealing with a loss. The anger and resentment often observed among families faced with decisions concerning dying members may be avoided if the nurse assesses the potential effect of differing beliefs.

Clients coping with a loss often perceive that it is a punishment from God for their wrongdoing or for their failure to remain faithful to their religious practices. Therefore, it is important to assess the level of guilt the client or family expresses. Assessing the client's comments regarding feelings of responsibility for the loss helps determine whether these feelings are an expected phase of grieving or indicate dysfunctional grieving.

Clients who had not considered themselves religious before the actual or perceived loss often turn to religion to seek comfort or to cope with feelings of despair, helplessness, hopelessness, or guilt. They may utter anguished statements such as "Why, God?" or "Please help me, God." The nurse continues to assess the client's verbalization of such feelings to determine the best interventions to help the client cope with the loss.

Psychosocial Assessment

When working through the grief process, clients can be overwhelmed by the fears associated with the loss and the changes it will produce. The client responding to an actual or perceived loss commonly expresses anxiety (fear of the unknown). An extreme level of anxiety can threaten the client's well-being. Assessment includes helping clients openly acknowledge their fears. Some clients may fear the feelings they experience while proceeding through the grief process more than the loss itself. The most common fear expressed by clients facing a loss is that of losing self-control.

Focusing on the meaning of the loss to the client is more important than attempting to place the client in a sequence or phase of grief. The degree of caring and sensitivity shown when asking questions about the meaning of the loss influences the amount of information the client will be willing to reveal. Asking questions such as "Why do you feel this way?" or "What does this loss mean to you?" is less helpful than making a statement such as "This

must be difficult for you." The latter more effectively conveys a genuine interest in hearing how the client feels about the loss.

Awareness of the altered sensorium observed during the stage of shock and disbelief provides parameters for assessment. The nurse may note in the client feelings of numbness, unreality, emotional distance, intense preoccupation with the lost object, helplessness, loneliness, and disorganization. As awareness of the loss begins to develop, preoccupation with the lost person or object may increase, and self-accusation and ambivalence toward the lost person or object may follow.

Nursing Diagnoses and Interventions

A variety of nursing diagnoses may be appropriate for the client experiencing loss and grief, as well as for the client who is nearing death. Nurses practicing medical-surgical nursing will most often provide interventions for *Anticipatory Grieving*, *Chronic Sorrow*, and *Death Anxiety*.

Anticipatory Grieving

Anticipatory grieving is a combination of intellectual and emotional responses and behaviors by which people adjust their self-concept in the face of a potential loss. Anticipatory grieving may be a response to one's own future death; to potential loss of body parts or functions; to potential loss of a significant person, animal, or possession; or to potential loss of a social role. Nursing interventions are designed to assist with grief resolution.

- Assess for factors causing or contributing to the grief. Ask about support systems, how many losses have occurred, relationship with the lost person, significance of the body part, and previous experiences with loss and grief. *Grief and mourning occur when a person experiences any type of loss.*
- Use open-ended questions to encourage the person to share concerns and the possible effect on the family. *Grief resolution cannot occur until the client acknowledges the loss.*
- Promote a trusting nurse–client relationship: Allow enough time for communications; speak clearly, simply, and concisely; listen; be honest in responses to questions; do not give unrealistic hope; offer support; and demonstrate respect for the person's age, culture, religion, race, and values. *An effective nurse–client relationship begins with acceptance of the client's feelings, attitudes, and values related to the loss. If the client is ready to talk, listening and being present are the most appropriate interventions.*
- Ask about strengths and weaknesses in coping with the anticipated loss. *Current responses are influenced by past experiences with loss, illness, and death. Socioeconomic and cultural background, as well as cultural and spiritual beliefs and values, affect a person's ability to adapt to loss.*
- Teach the client and family the stages of grief. *This helps them to be aware of their emotions in each stage and reassures them that their reactions are normal.*
- Provide time for decision making. *In periods of stress, people may need extra time to make informed decisions.*
- Provide information about appropriate resources, including support from family, friends, and support groups, community resources, and legal/financial aids. *Support from others decreases feelings of loneliness and isolation and facilitates grief work.*

Chronic Sorrow

Chronic sorrow is a cyclical, recurring, and potentially progressive pattern of pervasive sadness experienced in response to continual loss, throughout the trajectory of an illness or disability. It is triggered by situations that bring to mind the person's losses, disappointments, or fears. It may be experienced by a client, parent or caregiver, or person with chronic illness or disability.

- Explain the difference between chronic sorrow and chronic grieving. *Grieving is time limited and ends in adaptation to the loss. Chronic sorrow may vary in intensity, but it persists as long as the person with the disability or chronic sorrow condition lives.*
- Encourage verbalization of feelings about the loss, and about the personal relevance of the changes to hopes for the future. *Expressing feelings is normal and necessary to decrease the emotional pain.*
- Help identify triggers that intensify the sorrow, such as birthdays, anniversaries, and holidays. *When triggers have been identified, role-playing may make the events less painful.*
- Refer to appropriate community support groups. *Participating in support groups with others experiencing grief is helpful in coping with loss.*
- Encourage use of personal, family, significant other, and spiritual support systems *to facilitate coping with loss.*

Death Anxiety

Death anxiety is worry or fear related to death or dying. It may be present in clients who have an acute life-threatening illness, who have a terminal illness, who have experienced the death of a family member or friend, or who have experienced multiple deaths in the same family.

- Explore the client's knowledge of the situation. For example, ask, "What has your doctor told you about your condition?" *This informs you of the client's knowledge base about the condition and about his or her ability to make informed decisions.*
- Ask the client to identify specific fears about death. *This provides data about any unrealistic expectations or misperceptions.*
- Determine the client's perceptions of strengths and weaknesses in coping with death. *Identifying past strengths can help the client cope with loss, illness, and death.*
- Ask the client to identify needed help. *This determines whether available resources are adequate.*
- Encourage independence and control in decisions about treatment and care. *This promotes self-esteem, decreases feelings of powerlessness, and allows the client to retain dignity in dying.*
- Facilitate access to culturally appropriate spiritual rituals and practices. *This provides spiritual comfort.*
- Explain advance directives and assist with them if necessary. *Advance directives help ensure that the client's wishes for end-of-life care are carried out.*
- Encourage life review and reminiscence. *Life review is self-affirming.*
- Encourage activities such as listening to music, aromatherapy, massage, or relaxation exercises. *These activities decrease anxiety.*
- Suggest keeping a journal or leaving a written legacy. *A written document provides continuing support to others after death.*

Using NANDA, NIC, and NOC

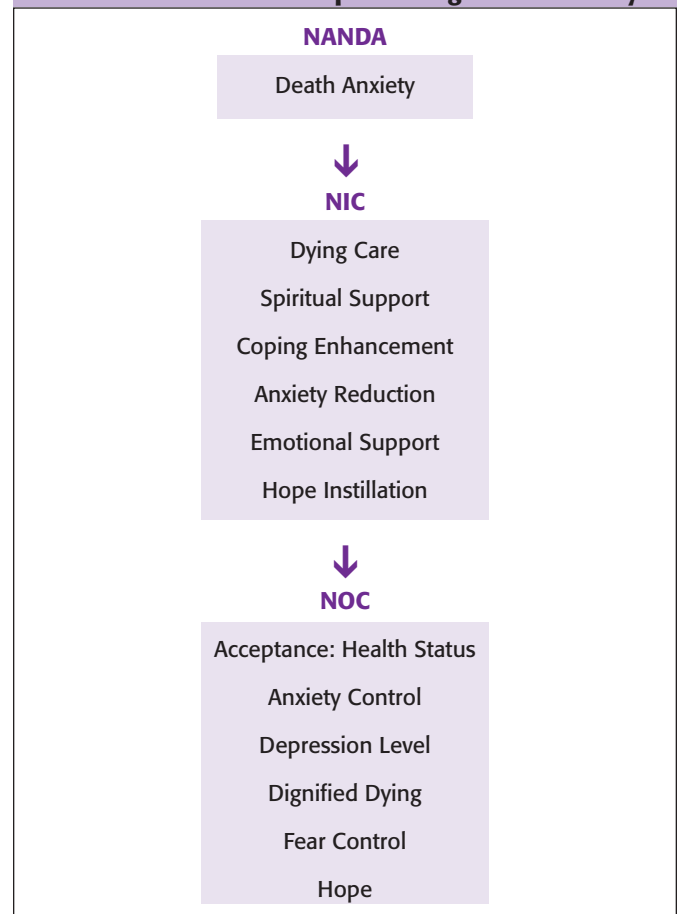
Chart 5–1 shows linkages between NANDA, NIC, and NOC when caring for the client experiencing loss, grief, and death.

Community-Based Care

In addition to teaching clients and families to carry out the physical skills that are necessary to the client's care, nurses also provide information on identifying signs of deterioration and additional sources of support. General guidelines for teaching clients and families about grief include those suggested in the Meeting Individualized Needs box on page 98. In addition, suggest the following resources:

- Hospice
- Home health agencies
- Support groups
- Public health departments
- Church, synagogue, or mosque
- Pastoral counseling centers
- Mental health agencies.

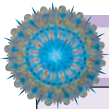
NANDA, NIC, AND NOC LINKAGES
CHART 5–1 The Client Experiencing Death Anxiety



Data from NANDA's *Nursing Diagnoses: Definitions & Classification 2005–2006* by NANDA International (2003), Philadelphia; *Nursing Interventions Classification (NIC)* (4th ed.) by J. M. Dochterman & G. M. Bulechek (2004), St. Louis, MO: Mosby; and *Nursing Outcomes Classification (NOC)* (3rd ed.) by S. Moorhead, M. Johnson, and M. Maas (2004), St. Louis, MO: Mosby.

MEETING INDIVIDUALIZED NEEDS Teaching for Clients Experiencing a Loss

- Encourage both children and adults to discuss expected or impending loss and to express feelings.
- Teach problem-solving skills: Define what the possible changes and problems are related to the predicted loss, develop potential strategies for dealing with problems, list pros and cons of each strategy, and decide which strategies might be most useful to try first to solve potential problems associated with loss.
- Teach individuals and families how to support a person who is dealing with an impending loss.
- Explain what to expect with a loss: sadness, fear, rejection, anger, guilt, loneliness.
- Teach signs of grief resolution:
 - No longer living in the past, becoming future oriented
 - Breaking ties with the lost object or person (Acute stage often shows signs of resolving in 6 to 12 months.)
 - The possibility of having painful “waves” of grief years after the loss, especially on the anniversary of the loss and in response to “triggers” such as pictures, events, songs, or memories.



NURSING CARE PLAN A Client Experiencing Loss and Grief

Pearl Rogers is a 79-year-old African-American woman who is admitted to the Methodist Home Nursing Center. Mrs. Rogers lived with her husband of 58 years until his death 9 months ago. She had one son who died in an auto accident 2 years ago, and she has one daughter who lives nearby. After her husband's death, Mrs. Rogers lived with her daughter until her admission to the nursing center. Mrs. Rogers has become increasingly agitated and helpless, complaining constantly of pain. Her daughter states that Mrs. Rogers is chronically constipated, has difficulty sleeping, and has stopped engaging in all social activities, including weekly church services. She cries frequently. Extensive medical testing prior to her admission to the nursing center revealed Mrs. Rogers has arthritis but no other pathologic disorder.

ASSESSMENT

On admission to the nursing center, Mrs. Rogers says, “I’m a sick woman, and no one will listen to me! I can’t walk, I’m so weak. My head hurts, and I’m always sick at my stomach. I haven’t had a bowel movement in a week, and I never sleep more than 3 hours a night.” Physical assessment findings include swollen knees and ankles, with limited mobility of the lower extremities.

DIAGNOSES

- *Dysfunctional Grieving* related to stress of husband’s death
- *Disturbed Sleep Pattern* related to grieving
- *Constipation* related to inactivity

EXPECTED OUTCOMES

- Engage in normal grief work: Work through grief process, discuss reality of losses, use nondestructive coping mechanisms, and discuss positive and negative aspects of the loss.
- Experience adequate and restful sleep: Fall asleep 20 to 30 minutes after retiring and awaken feeling rested after 7 to 8 hours of sleep.
- Have a bowel movement with soft formed stools at least every other day.

PLANNING AND IMPLEMENTATION

- Promote trust: Show empathy and caring, demonstrate respect for her culture and values, offer support and reassurance, be honest, engage in active listening.

- Assist in labeling her feelings: anger, fear, loneliness, guilt, isolation.
- Explore previous losses and the ways in which the client has coped.
- Encourage review of her relationship with her dead husband.
- Reinforce expressions of behaviors associated with normal grieving.
- Encourage participation in usual spiritual practices.
- Encourage participation in a grief group that meets at the facility.
- Consult with the physical and recreational therapist to help the nursing staff provide afternoon activities.
- Provide measures that assist in bowel evacuation: Encourage exercise as tolerated, including walks and rocking in a rocking chair. Offer foods that stimulate bowel movements. Offer privacy: Close the door, ensuring that the emergency call bell is within reach, and do not interrupt.
- Administer a mild laxative and/or stool softener, if necessary, but discontinue as soon as possible.

EVALUATION

After 4 weeks at the nursing center, Mrs. Rogers states, “I don’t feel any better, but I know I have to accept my situation.” Although Mrs. Rogers states that she doesn’t feel better, she is walking the length of the hall, sleeping better, and having regular bowel movements. Mrs. Rogers is also less withdrawn and has openly discussed her feelings related to her husband’s death, including her anger at the loss of her son and her husband less than 2 years apart. She has attended the grief group once and has attended chapel services on Sunday for the past 2 weeks. Her daughter visits her each Saturday and takes her in a wheelchair to the shopping mall.

CRITICAL THINKING IN THE NURSING PROCESS

1. What common physical manifestations of grief did Mrs. Rogers experience?
2. How might Mrs. Rogers’s daughter be more involved in developing and implementing her mother’s plan of care?
3. Suppose Mrs. Rogers says that she does not want any help, that she just wants to be left alone to die. How would you respond?

See Evaluating Your Response in Appendix C.

EXPLORE MEDIA LINK

Prentice Hall Nursing MediaLink DVD-ROM



Audio Glossary
NCLEX-RN® Review

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Audio Glossary
NCLEX-RN® Review
Care Plan Activity: Anticipatory Grieving
Case Study: Do-Not-Resuscitate
MediaLink Applications
DNR Regulations
Explore Your Feelings about Death
Grieving Process
Hospice: Purpose and Benefits
Links to Resources



CHAPTER HIGHLIGHTS

- Grief is the emotional response to a loss, experienced by a person as grieving. Bereavement, a form of depression accompanied by anxiety, is a common response to loss of a loved one by death. Death, although inevitable, is an immensely difficult loss.
- There are many different theories of how people respond to loss and grief. These theories are useful when providing nursing care to clients and their families.
- A person's response to loss is influenced by age, social support, family members, cultural and spiritual beliefs, and rituals of mourning. Nurses need to assess the way in which they respond to loss to better care for clients.
- Legal and ethical issues involved in end-of-life care include advance directives (living wills, healthcare surrogate, and durable power of attorney), do-not-resuscitate orders, and euthanasia.
- Hospice, a model of care for clients and their families when faced with limited life expectancy, supports a dignified and peaceful death. Palliative care is focused on the relief of physical, mental, and spiritual distress for people with an incurable illness.
- To provide knowledgeable and compassionate care at the end of life, nurses must recognize physiologic changes as the client nears death, support the client and family, provide postmortem care, and resolve their own grief.
- Nursing care of clients experiencing an actual or potential loss includes accurate physical, spiritual, and psychosocial assessment; and interventions for the human responses of anticipatory grieving, chronic sorrow, and/or death anxiety.

TEST YOURSELF NCLEX-RN® REVIEW

- 1 Which of the following statements best describes loss?
 1. It is determined by one's cultural values.
 2. It is largely dependent on support of family and friends.
 3. It can be determined only by the person who experiences it.
 4. It is the same as grief and mourning.
- 2 Kübler-Ross believed that one usually first responds to a situation of loss with:
 1. anger.
 2. bargaining.
 3. depression.
 4. denial.
- 3 What is an important factor in the successful resolution of grief?
 1. social isolation
 2. support systems
 3. triggers of grief
 4. loss acknowledgment
- 4 What is the primary factor that dictates the rituals of mourning?
 1. culture
 2. age
 3. gender
 4. religion
- 5 What document expresses a person's wishes for life-sustaining treatment in the event of terminal illness or permanent unconsciousness?
 1. durable power of attorney
 2. living will
 3. no-code order
 4. healthcare surrogate
- 6 Which of the following statements is true of hospice?
 1. Hospice is a special place of care.
 2. Hospice care is a lifelong type of care.
 3. Hospice is a model of care rather than a place of care.
 4. Hospice is designed for clients with serious chronic illness.
- 7 A client nearing death requests that no medication be given that would cause a loss of consciousness, including pain medication. What would a nurse do to provide the best end-of-life care in this situation?
 1. Give the medication; comfort is the highest priority.
 2. Give half the ordered dose to provide compassionate care.
 3. Discuss this with family members and follow their wishes.
 4. Respect the client's wishes and withhold pain medications.

- 8** Which of the senses is believed to be the last one lost as a person nears death?
1. hearing
 2. vision
 3. touch
 4. smell
- 9** Which of the following statements best describes the treatment of pain at the end of life?
1. As client nears death, no pain is perceived and no medications are necessary.
 2. It is important to withhold pain medications if the client has respiratory changes.
 3. There is no maximum allowable dose for opioids during end-of-life care.
 4. Nurses should not administer opioids to the dying client.

- 10** A woman, recently widowed, tells the nurse, "I just can't even get out of bed in the mornings anymore." What response would be most helpful in resolving her grief?
1. "I don't know why you feel that way."
 2. "This must be a difficult time for you."
 3. "Why do you think you feel this way?"
 4. "After you get up, you will feel better."

See *Test Yourself answers in Appendix C.*

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