The Fault In Our Stars: End of Life Care for the Critically Ill Patient.

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Cassius:
"The fault, dear Brutus, is not in our stars,
But in ourselves, that we are underlings."

Julius Caesar (I, ii, 140-141)

Fate is not what drives men to their decisions and actions,
but rather the human condition.
ANA Code of Ethics

Alleviation of Suffering

Nurses have a particularly vital role in the care of patients and families at the end of life to prevent and relieve the cascade of symptoms that commonly are associated with dying (ANA, 2015).
Dying in America

IOM Recommendations and Next Steps for Stakeholders

Findings—Clinician-Patient Communication

• Most people nearing the end of life are not physically, mentally, or cognitively able to make their own decisions about care.
• Of people who indicate their EOL care preferences, most choose care focused on alleviating pain and suffering.
• Frequent clinician-patient conversations about EOL care values, goals, and preferences are necessary to avoid unwanted treatment.
• Incentives, quality standards, and system support are needed to promote improved communication skills and more frequent conversations.

The Critical Care Nurse Practitioner is:

• Frequently exposed to death
  ➢ 540,000 Americans die each year in the ICUs
  ➢ 1 in 5 patients receive care in ICUs before death
  ➢ 59% of all hospital deaths occur in ICUs

McAdam & Puntillo, 2015
Essential actions: The ICU Nurse Practitioner

• Discuss benefits and burdens of ICU interventions with patient and family based on realistic goals of care.
• Consider discussions of time-limited trials of treatment, if appropriate.
• Collaborate with the team to promote a calm environment with as little initiation of technology as possible.
• Review the impact of care within ICU settings. This is critical in order to demonstrate the impact of palliative care on patient/family, as well as the utilization of scarce resources.
NP Interventions: Support

- Collaboration with physician/team
- Reassurance and education
- Role model comforting
- Physical comforting
- Spiritual care
- Honor culture
Families need support as many have never been with a dying person or witnessed a death and do not know what to expect.
The 5 Cs of end-of-life care for patients and families

- Comfort
- Control
- Communication with loved ones
- Continuity of care
- Completion of life tasks

Lynch, 2013
Families Remember the Last Moments

Therefore the NP must:
• Manage physical symptoms
• Attend to the psychological, emotional, social and spiritual needs
• Honor the family’s culture
• Prepare them for the death
• Communicate with other interdisciplinary team members as needed
• Listen
• Provide a therapeutic presence
• Bear witness

Krammer et al., 2011
Lynch & Dahlin, 2007
Specialist vs. Generalist Palliative Care

**Specialists:** Professionals with specific palliative care training/certification

**Generalist:** Professionals from other specialties with training in palliative care concepts/content

**Goal:** Generalist PC professionals see most patients; refer to PC specialists when needed

Fast Facts: The Cost of Healthcare

Today, 18% of the United States’ gross domestic product (GDP) is spent on healthcare:
- $3 trillion is spent on healthcare annually in the US—twice the amount spent on food.
- 33% is spent on hospitalization costs

By 2037, that percentage is expected to increase to 25%
- Spending is unsustainable.
- Despite these high expenditures, health outcomes in the U.S. are not considerably better than other high-income countries.


Preparing for a Good Death: The Important Role of the Nurse Practitioner

- Hydration?
- Resuscitation?
- Deactivation of cardiac technology?
- Dialysis?
- Organ/tissue donation?
- Hasten death request?
Common Terminal Conditions in Critical Care Settings

- Global cerebral ischemia s/p cardiac arrest
- Multiple system organ failure
- Refractory single organ failure
- Ischemic or hemorrhagic stroke
- Sepsis
- Neurological trauma
Describe a Recent Death You Have Observed

What went well?

– Were the patient and family’s wishes honored?
– Describe any cultural traditions that were honored
– Was pain controlled, as well as other symptoms?
– Was interdisciplinary care evident?

What could have been improved?

– What issue(s) could have been prevented?
– Are there policies/procedures that need to be developed to provide better direction?
Dying: An Individualized, Personal Experience

- There is no typical death
- Patient preferences
- Nurses advocate for choices
  - Setting of death
  - Support
- Psychological & emotional considerations
Advocacy for Optimum End-of-Life Care in Critical Care

- Advocate for patient/family in any setting.
- Provide supportive physical environment for patient and family.
- Avoid changes at final stage.
- Provide privacy for patient away from bedside.
Honoring Dying Patients: Dignity Conserving Care

The A, B, C, & D of dignity conserving care

– Attitude
– Behavior
– Compassion
– Dialogue

Chochinov, 2007
What About Artificial Nutrition & Hydration at End of Life?

Perceptions of “starving to death”.

Enteral feeding does not reduce risk of aspiration or mortality.

Hydration does not decrease “dry mouth”.

Patients who fasted to end their lives experience a peaceful death.

Gabriel & Tschanz, 2015; HPNA, 2011; Prince-Paul & Daly, 2015
Resuscitation

• Sudden, unexpected event

• No advance planning

• Unrealistic beliefs regarding survival

• Outcomes are usually poor

• Hypothermia

• Family presence
Outcomes after Resuscitation

- 18% of adults survive to discharge
- 6.60% survive 1 year post-discharge
- 27% pediatric survive to discharge
- Average length of stay for survivors of IHCA = 2 weeks

*Morrison et al., 2013*
CARDIAC DEACTIVATION PROCEDURES
• It is important to talk with patients and families about the possibility of deactivating these cardiac devices when treatment is no longer successful and/or when it is no longer needed.

• Discussions around DNR may have occurred, but at times conversations about deactivating these devices are neglected.

• Interdisciplinary discussions need to take place with the patient and family members, as well as a review of advance directives and code status.

• All conversations must be carefully documented.

• The deactivation of any of these devices is legal and ethical, when patients/families request it.
Pacemakers

• If pacer dependent, patient/family need to be prepared for an immediate death after deactivation.
  • The patient should be pre-medicated with an anxiolytic or sedative, to prevent distress/suffering
  • Most patients are not pacer dependent, especially during the active stages of dying, where tachycardia is observed more frequently than bradycardia and the myocardium is too weak to respond to the pacemaker.
  • Therefore, routine deactivation of a pacemaker is not recommended, as it can lead to bradycardia, dyspnea, etc.
  • Remind families that pacemakers do not prolong the dying process or suffering (Gomez & Gomez, 2011)
Implantable Cardioverter Defibrillator (ICD)

• Deactivating an ICD does not decrease the quality of life or create pain.
• The cardiologist/electrophysiologist and device company must make arrangements for have the ICD deactivated.
• When a patient is dying, the firing of the ICD can be distressing for the patient, family, and the healthcare team.
• If the patient is to be cremated, the funeral director will need to know that this patient has an ICD.
Left Ventricular Assist Devices (LVAD)

- Device used to improve function of the left (LVAD), right (RVAD), or both (BiVAD) ventricles.

- Patient and family should be fully informed about the occurrences following the VAD being stopped.

- Silence all alarms, assure pt is given diuretics prior to device discontinuation and have opioids, anxiolytic available to decrease symptoms of impending heart failure.
Discontinuation of Dialysis

When should dialysis be discontinued?

• When burdens outweigh benefits and/or,

• When dialysis is no longer prolonging life or only prolonging death
Pain in “Brain Death”

Clarity of term “brain death”
- Irreversible, cerebral motor response to pain, loss of brain stem reflexes, apnea

Pain perception believed to occur in cortex, although brainstem pathways exist

Withdrawal of opioids – diarrhea, agitation, piloerection, seizures, yawning, tearing
Organ/Tissue Donation

• Regulations
• Talking to the family about organ/tissue transplantation
• What can be donated?
• Death declared on the basis of cardio-pulmonary criteria vs neurological criteria in “brain death”.
• Can cause ethical and moral angst for healthcare providers witnessing this.
Hastened Death Request

• Statement made by patient
  – Progressive incurable illness
  – Judgment not impaired

• Intervention to cause death more immediately than if illness took its natural course
  – Assisted suicide/dying
  – Clinician assisted
  – Stopping eating and drinking
  – Other means
Common End of Life Symptoms

Respiratory
• Dyspnea, cough

GI
• Nausea/vomiting, nutrition & hydration, constipation, diarrhea, xerostomia

Psychological
• Anxiety, post-traumatic stress disorder, depression, delirium/agitation/confusion

General/Systemic
• Pain, wounds, seizures, sleep disturbances, urgent syndromes
Most Common End of Life Symptoms

- Confusion: 50.10%
- Terminal Secretions: 51.40%
- Pain: 52.40%
- Dyspnea: 56.70%

*Kehl & Kowalkowski, 2013*
Why is Dyspnea important?

• Dying patients fear dyspnea and pain → therefore, symptom control is one cornerstone of pulmonary palliative care.

• **Dyspnea** is a prominent symptom of the patient with advanced respiratory disease of any cause:
  
  • Nearly all patients with COPD had dyspnea during the last 3 days of their lives.

Case Study

Mary L. was found unresponsive and pulseless at her desk at work. Three days after her cardiac arrest, in spite of bystander CPR, Mary remained comatose. The consulting neurologist indicated that the prognosis for functional neurologic recovery was “nil.” On physical exam, Mary had no response to deep pain, her pupils were non-reactive, and corneal reflexes were absent. Mary’s cough and gag reflexes were intact. She is hemodynamically stable, and is supported with intravenous hydration and mechanical ventilation.

Mary’s family agreed with the ICU team recommendation to withdraw ventilation, and they want to proceed immediately after the family meeting.
Questions

• What preparations should be made by the healthcare team before beginning ventilator withdrawal?
• What preparations should be made with and for the family before beginning ventilator withdrawal?
• What pre-medication, if any, would be recommended prior to withdrawal?
• What support can be given to the family after the death?
• for the healthcare team?
Withdrawal of Mechanical Ventilation

Decisions are made when:

- Further aggressive treatment is not capable of meeting patient’s goals.
- Interdisciplinary decision process.
- The capable patient requests withdrawal.
- Prognosis for recovery to acceptable baseline is poor.
- Death is near and inevitable.
- Coma expected to persist.

Terminal weaning:

- Stepwise process of gradual reduction in oxygenation and ventilation.
- No comparative evidence to support terminal weaning vs terminal extubation.
Withdrawal of Mechanical Ventilation

Prepare in advance:

• Notify organ procurement organization
• Negotiate time of withdrawal
• Interdisciplinary – primary team, palliative team, chaplain, others
• Does family wish to be present – no right or wrong
• Religious or cultural rituals
• Educate family - uncertain outcome, several possible outcomes: rapid death in minutes; lingering death – hours to days; hospice discharge in hemodynamic, respiratory stable
Sample Ventilator Withdrawal Protocol

Create Peaceful Surroundings:

• Remove unnecessary equipment, creating bedside space for the family.
• Provide tissues and comfortable chairs.
• Remove mitts and poseys, lower bedrails, and set bed height to facilitate family-patient touching or handholding.
• Discontinue monitors and alarms in the room, including but not limited to: oximeters, vital sign/monitor, ECG recording, unneeded pumps, and vent alarms.
• Discontinue inappropriate television or radio distractions.
Ventilator Withdrawal Protocol

Gather Family:

- If they stay in the room, review the process of what they might see.
- Allow time for any rituals and for saying a final goodbye.
- Address particular needs of young children.
- Social worker, nurse, or chaplain may stay with the family by the bedside or in the waiting room.
- Check family perception of the level of patient comfort, and address appropriately to incorporate their wishes about sedation and analgesia.
Ventilator Withdrawal Protocol

• Determine if premedication is necessary.
• Most common symptoms – breathlessness and anxiety.

• Paralytics have been stopped and patient exhibits muscle movement to stimuli
• Administer glycopyrrolate 0.2 - 0.4mg q 20-30 min prior to extubating to minimize secretions.
  • If glycopyrrolate is not an option, use Levsin 0.25- 0.25mg IVP 15 min prior then q3-4h prn
  • Add scopolamine patch for excessive/heavy secretion: begin with 1 patch behind the ear, can titrate up daily as needed
• Have on hand prn doses of medications for comfort
Ventilator Withdrawal Protocol

- Administer opioid bolus dose and benzodiazepine for dyspnea/air hunger and anxiety is anticipated 15-30 minutes prior to withdrawal: treat pt as if they were awake:
  - morphine sulfate 2-10mg IVP or
  - hydromorphone 0.5-1mg 15 min prior then q5 min prn air hunger, resp distress or pain.
  - Consider continuous infusion if needed.
  - lorazepam 1-2mg IVP

- For patients on pre-existing agents such as propofol, this can be continued as medication for relief of symptoms with vent withdrawal.

- Always know your institutional protocols.
Ventilator Withdrawal Protocol

• With assistance of respiratory therapist – decrease FiO2 to 21% (room air), observe for signs of respiratory distress. Medicate as needed with prn opioid.

• When patient appears comfortable, prepare to remove ET tube

• Deflate the ETT cuff and turn off the ventilator, remove ETT and keep covered with towel to collect secretions, suction prn.

• Be prepared to spend time with patient and family discussing concerns, providing support.
PAIN, SYMPTOM AND END OF LIFE CARE IN THE ICU
PAIN, SYMPTOM AND END OF LIFE CARE IN THE ICU
Pain During the Final Hours of Life

• Diminished ability to self report.

• Behavioral cues – grimacing, muscle tension, clenched fists, moaning, “silent scream” when intubated.

• Dosing of opioids in last hours:
  ✓ Titration
  ✓ Intractable pain/palliative sedation
Pain - Pharmacological Therapies

- Nonopioids
- Opioids
- Adjuvants
- Anesthetics

APS, 2008; Pasero & McCaffery, 2011
Non-Opioids

- Acetaminophen
  - 500-1000mg po q 4-6 hrs
  - 1000mg IV q 6 hr (ofimver)
  - Max 4000mg/24 hrs
  - Contraindicated liver disease

- NSAIDs
  - Ibuprofen, naproxen, indomethacin
  - Ketorolac - potent, limit to 5 days use
    - PO (not initial dose), IM, IV
    - Decrease dose in geriatric and renal disease
  - Contraindicated in advanced renal disease

Paice, J., 2015
Pasero & McCaffery, 2011
Opioids: Issues in Critical Care

• Routes of administration:
  • IV (primarily), Subq, IM (not recommended), spinal (epidural, intrathecal)

• Assessment of pain in cognitive failure
• Balancing sedation with analgesia
• Opioid use and neurological evaluation

McAdam & Puntillo, 2015
Opioids

• Moderate to Severe Pain; Moderate to severe dyspnea or air hunger
• Bind to mu, kappa, sigma or delta receptors in nervous system.
• Analgesia - mu and kappa binding
• Full agonists act on mu, kappa, possibly delta
  • morphine, hydrocodone, hydromorphone, fentanyl, methadone, codeine, oxycodone
• Weak agonist of all receptors – Tramadol – inhibits norepinephrine reuptake and increases serotonin release
• Activate mu = great analgesia
• Activate mu = respiratory depression, euphoria, mydriasis, sedation

Archangelo & Peterson, 2011
Opioids: Most Commonly Used in Palliative Care

- Buprenorphine
- Codeine
- Fentanyl – no metabolite, parent accumulates in fatty tissue, less hypotension, accumulates in hepatic impairment, muscle rigidity
- Hydrocodone
- Hydromorphone – active metabolites hydromorphone 3 & 6 glucuronide, accumulates in hepatic and renal impairment
- Methadone

- Morphine – morphine 3 & 6 glucuronide, bradycardia, hypotension, bronchospasm, accumulate in hepatic and renal impairment
- Oxycodone
- Oxymorphone
- Tapentadol
- Tramadol

- Most commonly used in the ICU

McAdam & Puntillo, 2015
Opioids and Renal Failure

**Not Recommended**
Meperidine, Codeine, Morphine

**Use with Caution**
Oxycodone, Hydromorphone

**Safest**
- Fentanyl - no drug accumulating, not dialyzed
- Methadone - no known active metabolites; eliminated from feces, not dialyzed
- Buprenorphine – mainly GI clearance, elimination not influenced by renal function, ceiling effect on respiratory depression

Davis, 2012
Maxwell, 2015
Adjuvants

• **Antidepressants:**
  - Tricyclics, SNRI’s - amitriptyline, nortriptyline, duloxetine
  - Block reuptake of norepinephrine, increasing pain modulating pathway activity

• **Anticonvulsants: neuropathic pain**
  - gabapentin, pregabalin
  - Increase concentration of GABA

• **Local anesthetics:**
  - Lidocaine gel, lidoderm, diclofenac gel
  - Block sodium channels – inhibit pain signals

• **Skeletal muscle relaxants:**
  - cyclobenzaprine, baclofen, meloxicam
  - No more effective than NSAIDS or acetaminophen

• **Steroids:** IV, PO, SPINAL
Adjuvant Analgesics: Anticonvulsants

- Older agents have significant adverse effects (carmazepine)
- Gabapentin (Neurontin®)
  - First line, efficacy in 4-6 weeks
  - Dose: 100 mg po TID and titrate gradually
  - Titrate to maximum 1800-3600mg / day in 3-4 divided doses
- Pregabalin (Lyrica®)
  - Better tolerated than gabapentin
  - Dose: 50 mg TID x 1 wk then 100 mg BID or TID ; max 600mg/day
  - Efficacy in 1 week
- Common side effects: sedation, dizziness, fatigue, ataxia
- Reduce dose in renal failure

Archangelo & Peterson, 2011
Principle of Double Effect?

• An act has 2 foreseen outcomes – one good and one harmful.
  – Example: Justification of analgesia at End of Life

• Four key conditions in moral defensibility:
  1. The act is not bad in itself.
  2. The agent intends as an end only the good effect.
  3. The agent does not intend the bad effect as a means to the good.
  4. The good effect is as least equivalent in importance to the bad effect; and there is not better route to the good effect.

Spielthenner, 2008
Wiegand & Russo, 2013
Principle of Double Effect?

- The administration of analgesia in response to a patient’s pain at the end of life, even though unwanted effects are possible is considered an act of beneficence and ethically justified.
- IF harm is not intended, then the act is morally defensible.

There will always be a last dose.

Spielthenner, 2008
Wiegand & Russo, 2013
Myoclonus

- Series of brief, uncontrolled, irregular muscle twitches.
- Disturbance of CNS
- Diffuse or localized
- May lead to grand mal seizure if left untreated
- Nursing care – focus on patient safety
- Assessment – patient, medications, laboratory studies

Wilson & Weissman, 2015
Schwartz, 2015
Myoclonus etiologies

- **Medications** – opioids, lithium, haloperidol, phenothiazine, cyclosporine, beta-lactam antibiotics (penicillin, cephalosporins), antidepressants (SSRI’s and tricyclics)

- **Metabolic** – hepatic failure, renal failure, and other metabolic deficiency

- **Inflammatory disorders** – thyroiditis

- **Infectious diseases** – herpes zoster myelitis, tetanus, others

- **CNS disease** – hypoxic brain injury, brain tumor, multiple sclerosis, Parkinson's disease, advanced dementia, encephalitis, other neurodegenerative disease

*Wilson & Weissman, 2015
Schwartz, 2015*
Myoclonus treatment

• Treat the underlying cause: – ie: gentle hydration
• Observation – talk with patient and family
• Opiate dose reduction – not at expense of good pain management
• Opiate rotation – to other opioid structural class, methadone and fentanyl usually better tolerated due to no active metabolite
• Adjuvant therapy – anticonvulsant - gabapentin
• Benzodiazepines –
  • clonazepam 0.5-1mg po q HS or 0.5mg po tid
  • lorazepam 1-2mg po, sublingual q 8 hrs
  • Continuous infusion of midazolam – subcutaneous or IV

Wilson & Weissman, 2015
Schwartz, 2015
Nausea/Vomiting

• Common
  • Oncology – up to 80% receiving chemotherapy; ESRD – 59% last month of life; Chronic disease – up to 17% in last days of life

• Causes
  • MANY - Biochemically induced, stasis, GI, increased ICP, vestibular, psychological
  • Assess cause for focused treatment

• Neurotransmitters:
  • Serotonin, Dopamine, Muscarinic cholinergic, Substance P, Acetylcholine, Histamine

• Treatment - etiology
  • Haloperidol 0.5mg PO/IM/IV q 4 hrs – dopamine antagonist, dystonia
  • Metoclopramide 5-10mg PO/ODT/IV q 4-6 hrs – prokinetic, dopamine antagonist, contraindicated in ileus
  • Dexamethasone 2-4mg PO/IV q 6-8 hrs - reduce serotonin?, insomnia, anxiety
  • Ondansetron 4-8mg PO/IV q 6 hrs – serotonin antagonist central and peripheral
  • Try 1 drug at a time

Hawkins & Lynch, 2013
Terminal Secretions

• Distressing, no evidence patients find this disturbing
• Prevalent in last days to hours of life
• Associated more commonly with primary lung pathology
• Types:
  • Type 1 – salivary secretions
  • Type 2 – bronchial secretions primarily

Bickel & Arnold, 2015
Dudgeon, 2015
Terminal Secretions treatment

- **Non-pharmacologic**
  - Reposition patient on side or semi-prone
  - Gentle oropharyngeal suctioning
  - Reduce oral intake
  - Communicate with family – assess fears, interpretation

- **Pharmacologic – Anticholinergics**
  - Hyoscine hydrobromide transdermal (Scopolamine) 1.5mg q 72 hrs (onset 12 hrs)
  - Hyoscyamine (Levsin) PO, SL, IV 0.125mg q 4 hrs prn (onset 30 min)
  - Glycopyrrolate (Robinul) PO 1mg q 8 hrs prn (onset 30min)
  - Glycopyrrolate (Robinul) SubQ, IV 0.2mg q 4 hrs prn (onset 1 min)
  - Atropine sulfate SL (1% opth soln) 1-2 gtts q 4 hrs prn (30 min)

*Bickel & Arnold, 2015; Dudgeon, 2015*
Terminal Delirium

- Delirium in a patient in the final days and weeks of life where treatment of the underlying cause is impossible, impractical, or inconsistent with the goals of care.

- Types – hyperactive / agitated or hypoactive, or mixed

- Hallmarks – acute change in level of arousal, altered sleep/wake cycle, mumbling speech, disturbance of memory and attention, perceptual disturbances with delusions and hallucinations

- Most common cause in hospital is drugs: anticholinergics, benzodiazepines, and opioids, metabolic derangement, infection, CNS pathology, or drug/alcohol withdrawal

- Degree of work up depends on understanding of disease process and goals of care.

*Weissman & Rosielle, 2014*
Terminal Delirium

• Treatment
  • Start with Haloperidol 0.5-2mg po or IV q 1 hr prn
  • Benzodiazepines should be avoided as they can cause paradoxical worsening of delirium and agitation
  • Non-pharmacologic treatment
    • Reduce or increase sensory stimulation in the environment as needed, presence – sitter with patient, frequent reorientation to place and time.

Weissman & Rosielle, 2014
Palliative Sedation at End of Life

- Consult Palliative Medicine.
- Should NOT be attempted by those without Palliative training and experience.
- Controlled sedation for intractable distress in the dying
- Legal and ethical basis
  - intent to relieve intractable suffering, not to hasten death
- Refractory or Intractable symptom
  - Aggressive efforts fail to provide relief
  - Additional treatments are incapable of providing relief
  - Additional therapies associated with excessive or unacceptable morbidity, or unlikely to provide relief within a reasonable time frame.

Salacz & Weissman, 2015
Palliative Sedation - Checklist

✓ Terminal illness
✓ All other palliative treatments exhausted – treatment for refractory symptoms - delirium, depression, anxiety, pain
✓ Psychologic assessment by clinician
✓ DNR order in effect
✓ Informed consent obtained and documented
✓ Nutrition / hydration issues addressed prior to sedation
✓ Interdisciplinary – provider, nurse, nurses aide, chaplain, others

Salacz & Weissman, 2015
Palliative Sedation - treatment

• Opioids - continued with the sedating drug to avoid withdrawal

• Institutional policy

• Suggested starting dose:
  • Midazolam (SC, IV) 2mg bolus, 1mg/hr gtt. Titrate to comfort.
    • Considered drug of choice
      – Sedating, amnesia, lack of active metabolites, short half life, rapid onset of action facilitates rapid titration
  • Lorazepam (SC, IV) 2-5mg bolus, 0.5-1.0mg/hr gtt. Titrate to comfort.
  • Others: Barbituates (pentobarbital, phenobarbital), Neuroleptics (haloperidol, chlorpromazine, ketamine, propofol.

*Salacz & Weissman, 2015*
Spiritual Considerations When Death is Imminent

Baird, 2015
Mazanec & Panke, 2015
The Death Vigil

- Family presence
- Common fears
  - Painful death
  - Being alone with pt
  - Time of death
- Provide comfort
- Be present
Bereavement Care

• Care and respect of the body
  • Reflects values of the patient
  • Respect family rituals
  • Allow family to participate in physical care
• Attend to family.
• Respectful care of the body.
• Remember the children.
• Bereavement support

Limbo & Davies, 2015
Conclusion

We only die once.

Family members will always remember the last days, hours, and minutes of their loved one’s life. Nurses have a unique opportunity to be invited to spend these precious moments with them and to make those moments memorable in a positive way.
be strong
when you are weak
be brave
when you are scared
be humble
when you are victorious
be badass
everyday
References


References


