

# *Assessment and Care Planning Of The Palliative Client*

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Anne Ediger R.N. BScN, C.H.P.C.N.(C)

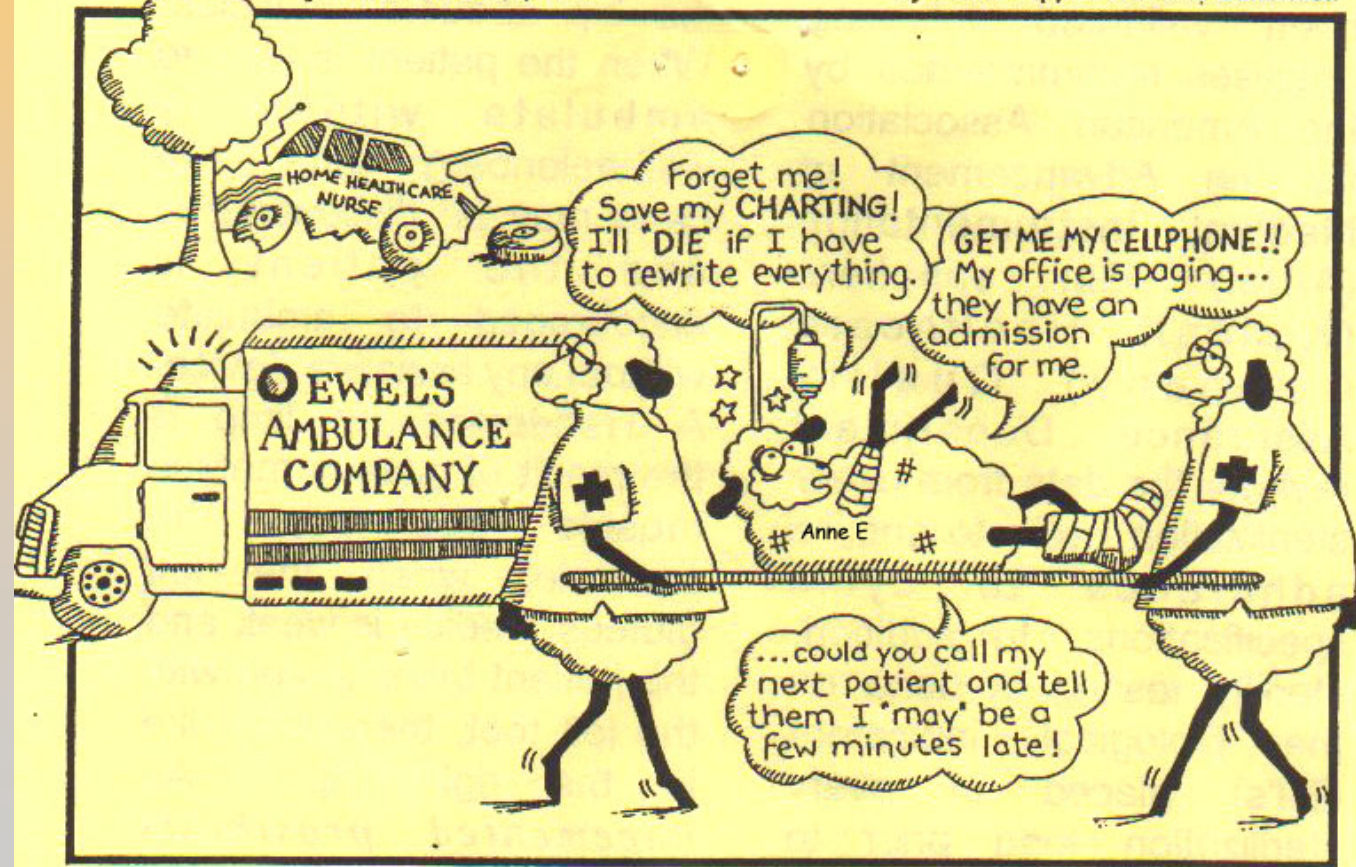
Tammie-Lee Rogowski R.N., C.H.P.C.N.(C), C.C.H.N.(C)



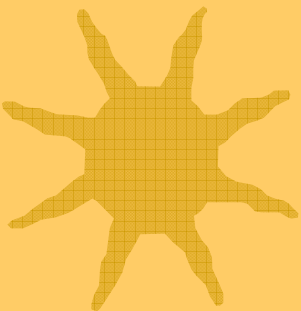
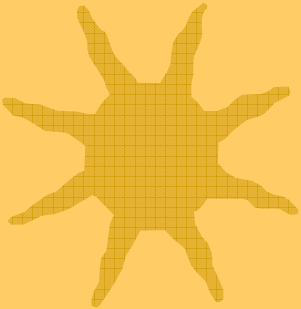
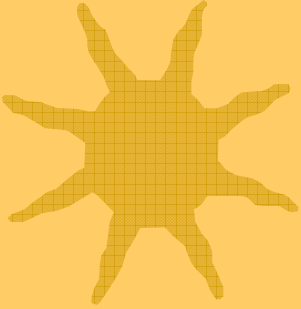
# The Home Care Nurse

Q.I. Homecare, R.N.

by Sheila Nipper & Laurie Baxendell



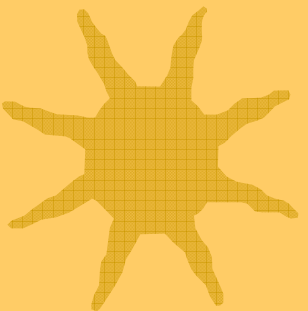
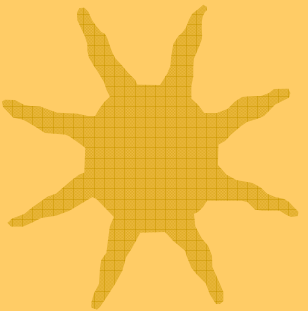
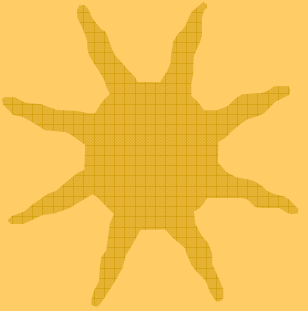
*Ewell assures the new ambulance attendant that this is a typical home healthcare nurse's response to an accident: patients and paperwork before self.*



# *Learning Objectives*

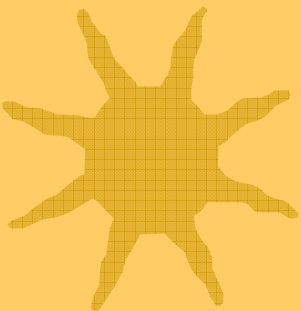
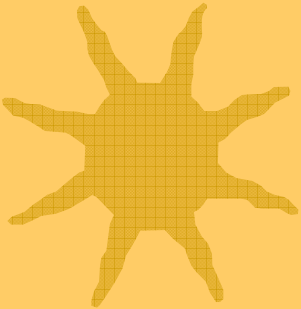
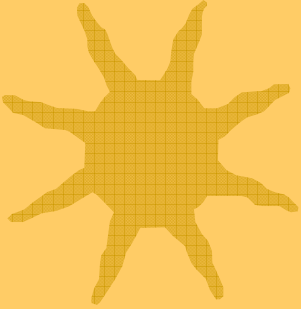
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- ★ Understand what is unique to a Palliative assessment
- ★ Gather information in an organized manner
- ★ Familiarize ourselves with assessment tools
- ★ Identify potential problems and possible interventions
- ★ To gain specialized knowledge and skill as set out by the core competencies



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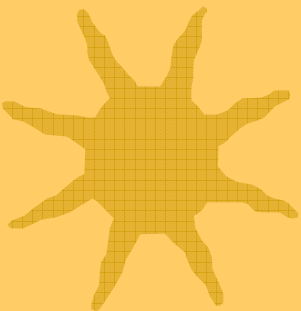
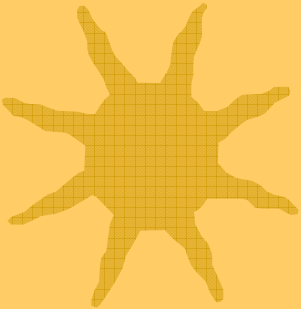
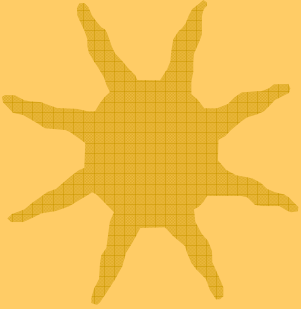
*Assessing the Palliative Care  
Client*



# *Assessment of the Palliative Patient*

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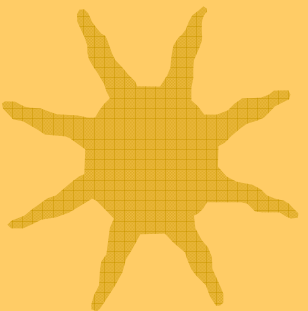
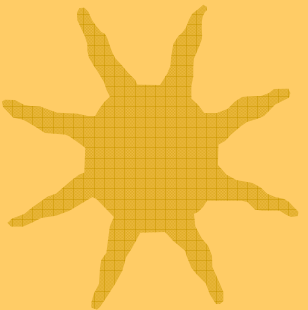
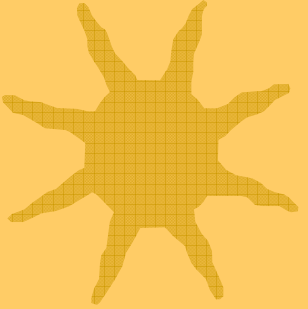
- ★ Includes all aspects of a basic health assessment
- ★ Focus is on philosophy of care
- ★ Goals of care are identified
- ★ Continual effort in consensus building



## *Some Reminders*

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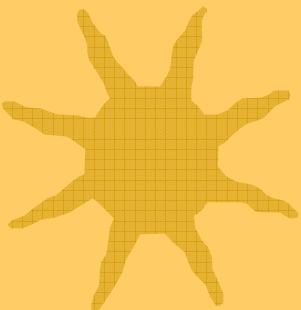
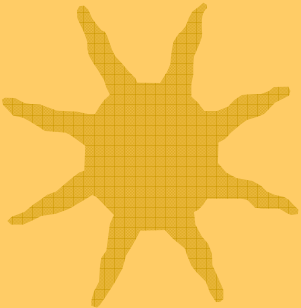
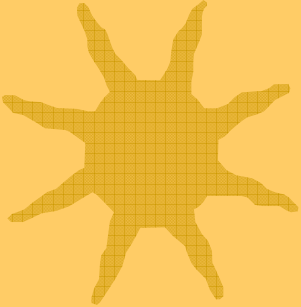
- ★ Be organized
- ★ Give patient/family a brief outline of what to expect
- ★ Allow the patient to choose the location
- ★ Allow the patient to decide who else should be present
- ★ May start with medications that are current



## *Some Reminders*

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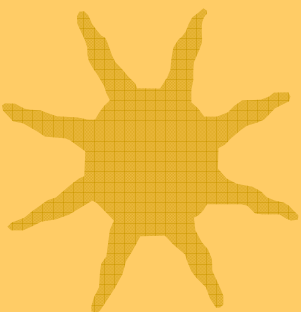
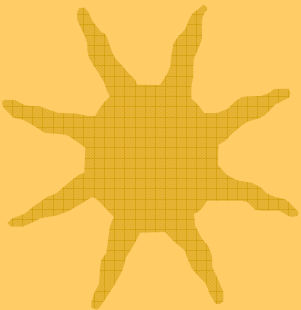
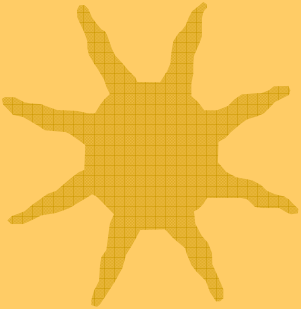
- ★ Acknowledge that some questions may be emotionally difficult
- ★ Show respect, kindness, and compassion



## *Barriers To Assessment*

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- ★ Poor communication
- ★ Fear of the word “Palliative”
- ★ Fear of advancing disease
- ★ Patient/family trying to “protect” each other
- ★ Fear of taking “strong medications”
- ★ Fear of running out of medications, and dying in pain
- ★ Concerns of medication side effects



# ESAS

## Edmonton Symptom Assessment Scale (ESAS)

Date of completion

Time

Please circle the number that best describes:

0 1 2 3 4 5 6 7 8 9 10

No pain

Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

Not tired

Worst possible tiredness

0 1 2 3 4 5 6 7 8 9 10

Not nauseated

Worst possible nausea

0 1 2 3 4 5 6 7 8 9 10

Not depressed

Worst possible depression

0 1 2 3 4 5 6 7 8 9 10

Not anxious

Worst possible anxiety

0 1 2 3 4 5 6 7 8 9 10

Not drowsy

Worst possible drowsiness

0 1 2 3 4 5 6 7 8 9 10

Best appetite

Worst possible appetite

0 1 2 3 4 5 6 7 8 9 10

Best feeling of wellbeing

Worst possible feeling of wellbeing

0 1 2 3 4 5 6 7 8 9 10

No shortness of breath

Worst possible shortness of breath

0 1 2 3 4 5 6 7 8 9 10

Other problem

ESAS completed by:

Patient  Health professional  Family  Assisted by family or health professional

Version date December 11, 2002



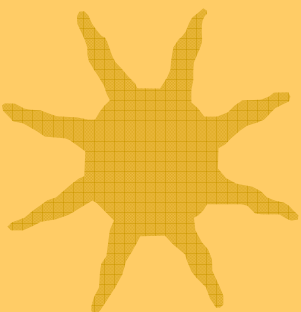
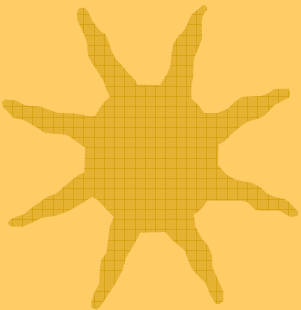
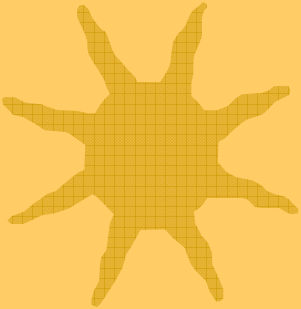
# ESAS

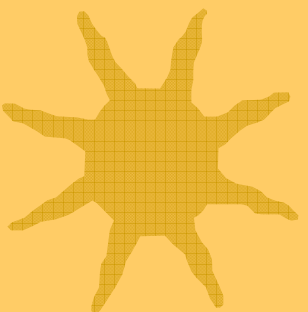
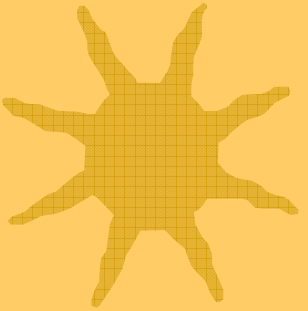
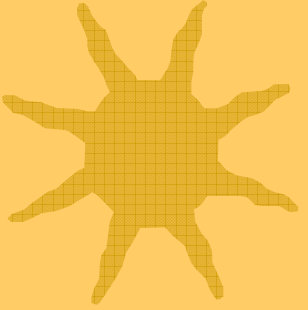
## *Edmonton Symptom Assessment System*

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### Purpose

- ★ Quantifies the experience and helps develop a care plan
- ★ To assess the nine symptoms that are common to palliative patients
- ★ Severity is rated at the time of assessment
- ★ The patients opinion
- ★ Provides a clinical profile over time
- ★ Only one part of a holistic clinical assessment
- ★ A tool used across program/agencies





## *When to do ESAS*

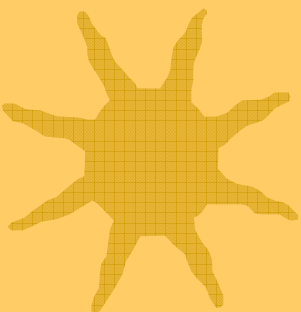
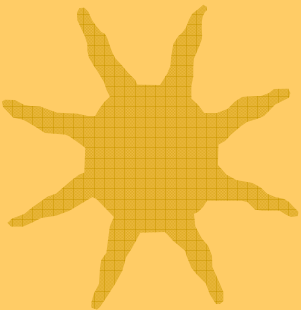
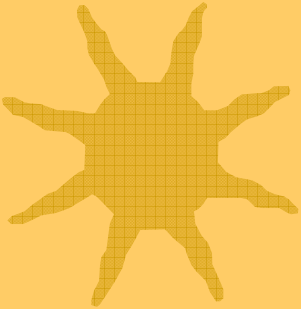
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- ★ On a regular basis
- ★ More often if symptoms are not well controlled
- ★ To evaluate effectiveness of medication changes

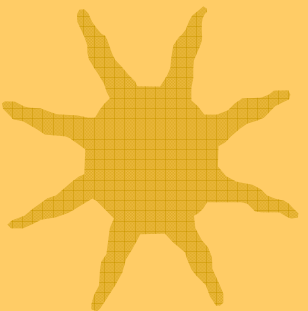
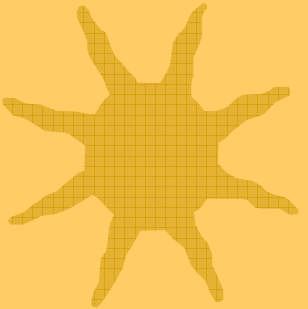
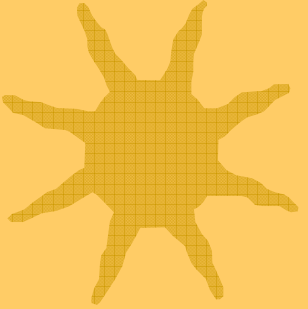


## *Who Should Complete ESAS*

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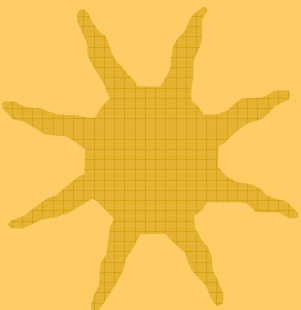
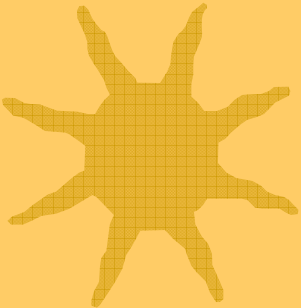
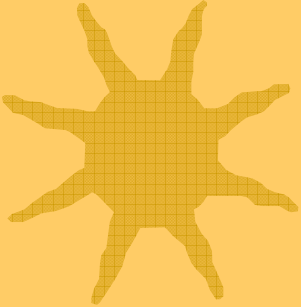


- ★ Ideally the patient
- ★ A caregiver
- ★ If completed by caregiver, can omit depression, anxiety, well being
- ★ The person completing ESAS must be indicated



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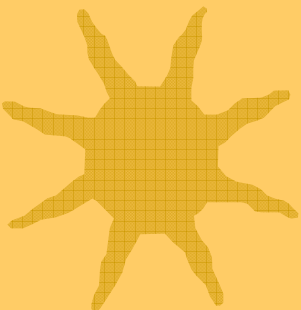
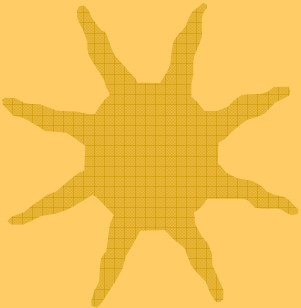
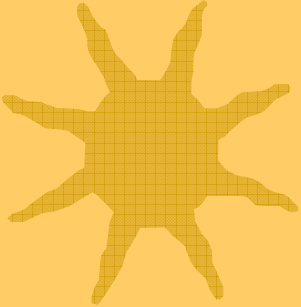
## *Symptoms Identified in ESAS*



# *Pain*

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- ★ Severity
- ★ Location
- ★ Duration
- ★ Characteristic
- ★ New pain
- ★ Aggravating/ relieving factors
- ★ Medications/treatments presently using
- ★ What meaning does it have to patient and family



# *Tired*

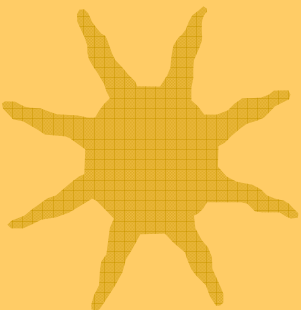
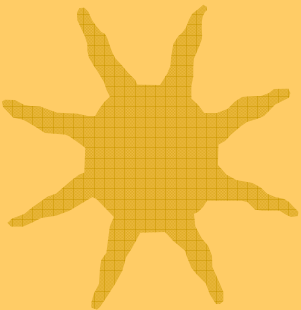
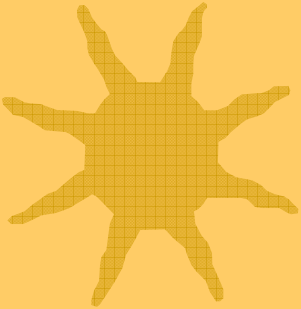
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- ★ It is subjective
- ★ Severity
- ★ Duration
- ★ Assess reversible causes
- ★ What meaning does it have to patient/family
- ★ How does it effect quality of life/safety
- ★ Helps us to assess for needed support services/equipment



# *Nausea*

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- ★ Severity
- ★ Assess for possible causes
- ★ Frequency
- ★ Onset and duration
- ★ Aggravating/alleviating factors
- ★ What medications are already in place
- ★ Description of emesis
- ★ Assess bowels and bowel sounds



# *Depression*

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- ★ Severity
- ★ Ask “Are you depressed?”
- ★ Differentiate between feeling sad and feeling depressed
- ★ Past history of depression, how was it treated
- ★ Assess recent changes in antidepressant medications
- ★ Assess for suicidal thoughts, and ask if they have a plan
- ★ Assess signs and symptoms of hypoactive delirium



# *Anxiety*

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- ★ Severity
- ★ Ask “Are you Anxious?”
- ★ Assess for specific fears and causes of anxiety
- ★ Help patient and family to name fears
- ★ Patient/family may respond with crying. Do not try to stop it
- ★ Explore past coping mechanisms



# *Anxiety*

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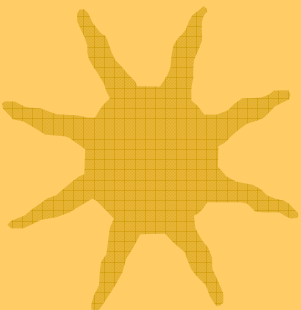
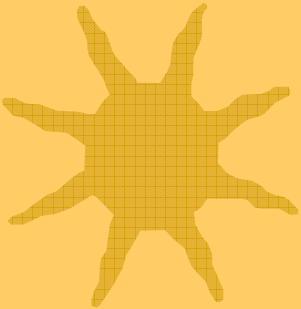
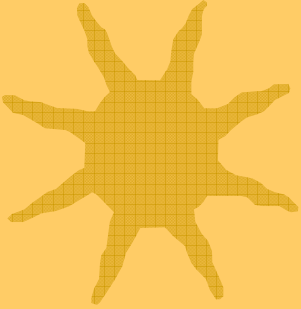
- ★ Explore what support systems they have in place
- ★ Assess for need of psycho/social support/spiritual care
- ★ Assess for signs and symptoms of delirium or Opioid toxicity



# *Drowsy*

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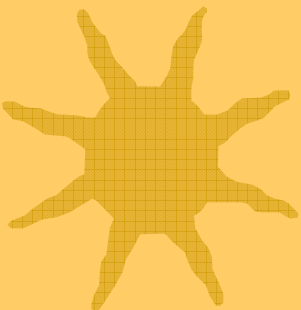
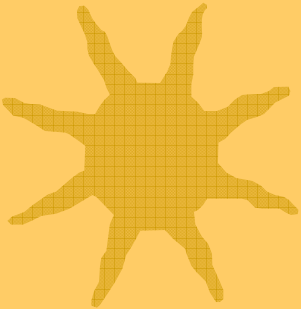
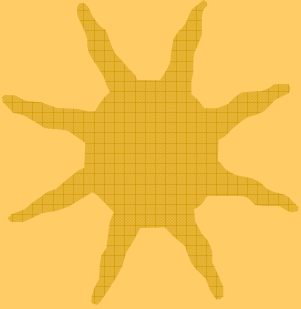
- ★ Severity of “sleepiness”
- ★ How many hours of sleep in 24 hours
- ★ Is it difficult to stay awake
- ★ Assess for possible causes
- ★ Assess for changes in Opioids
- ★ Perform a medication review
- ★ Assess respiratory rate and pattern
- ★ Assess patients safety in mobilizing
- ★ Use or need of safety equipment



# *Appetite*

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- ★ Lack of appetite
- ★ Differentiate between appetite and amount eaten (food and liquids)
- ★ Assess for possible causes
- ★ Assess present and past interventions
- ★ How does the decrease in intake affect the caregiver/family
- ★ Assess the patients/families understanding of the causes of anorexia/cachexia
- ★ Help patient/family to think of food as a comfort measure



## *Feeling of Wellbeing*

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- ★ Ask “How are you?” and mean it
- ★ May indicate general state of comfort
- ★ If all other scores on ESAS are low, but “wellbeing” is high, may indicate potential changes of decline
- ★ Good days/bad days



# *Dyspnea*

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- ★ Severity
- ★ Subjective experience
- ★ At rest/with activity
- ★ Aggravating/relieving factors
- ★ Assess for possible causes/complications of metastatic disease
- ★ How is dyspnea affecting the patient/family
- ★ Assess for recent changes in respiratory rate/chest sounds

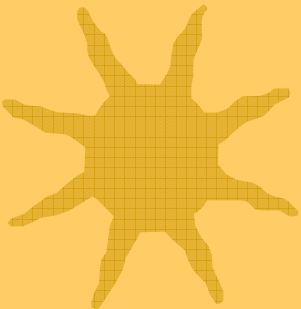
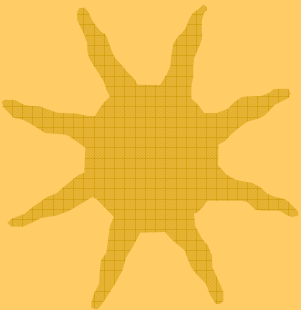
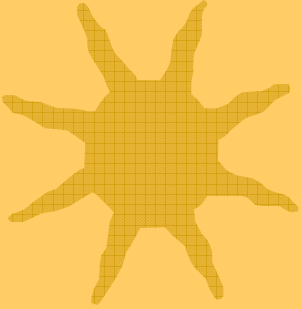


# *“Other”*

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## Bowels

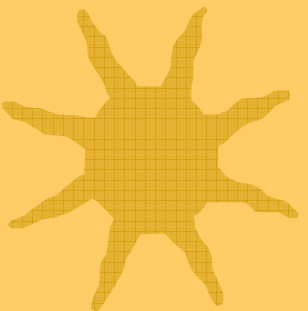
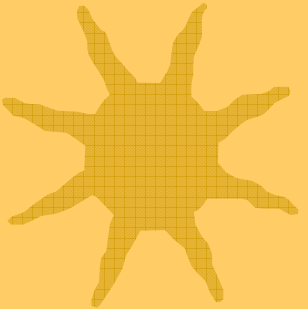
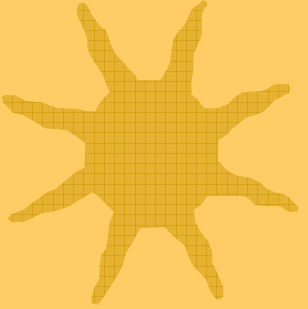
- ★ Date of last BM
- ★ Amount
- ★ Consistency
- ★ Abdominal distention
- ★ Rectal fullness
- ★ Use of stool softeners/laxatives
- ★ Incontinence of bowel/bladder



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## Oral Disorders

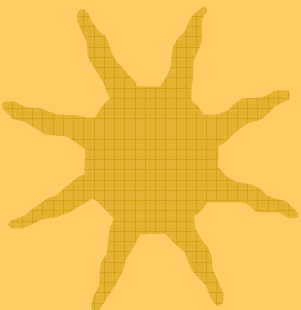
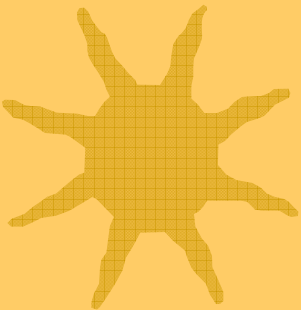
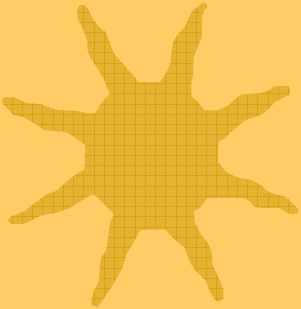
- ★ Dry mouth/hydration
- ★ Oral Candidiasis/stomatitis
- ★ Loose fitting dentures
- ★ Dysphagia
- ★ Hiccups



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## Skin Disorders

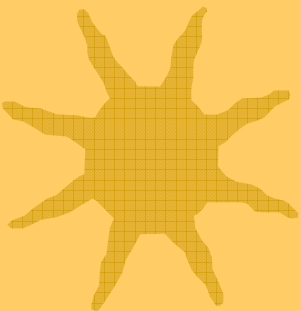
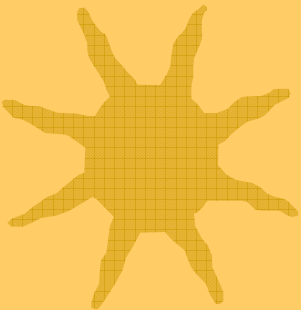
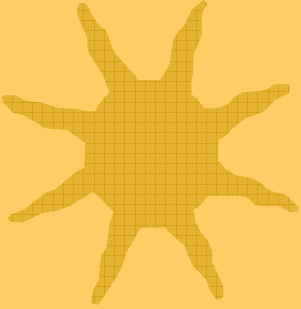
- ★ Pressure ulcers
- ★ Tumor necrosis/odor
- ★ Puritis
- ★ Jaundice
- ★ Edema



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## Fever and Sweats

- ★ Assess for potential infection
- ★ Fever can be tumor related
- ★ Sweats can also be caused by malignancies



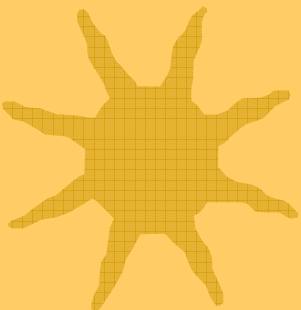
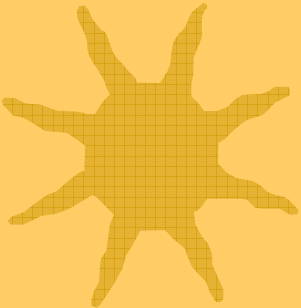
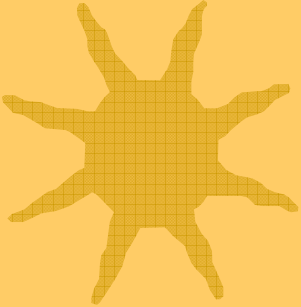
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## Vital Signs

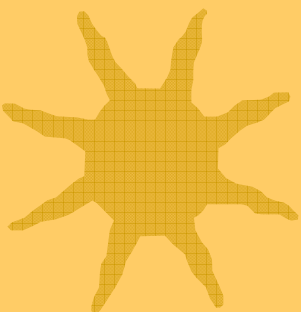
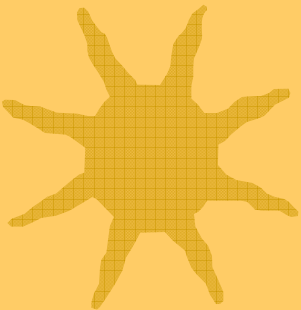
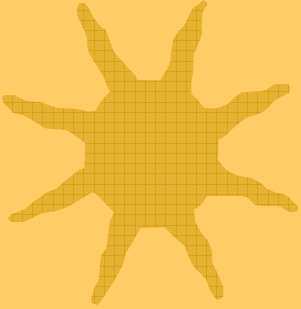
- ★ When to take Blood Pressure
- ★ Pulse
- ★ Respiratory rate
- ★ When not to take vital signs



# *Palliative Performance Scale*



PPS Level	Ambulation	Activity & Evidence of Disease	Self care	Intake	Conscious
100%	full	normal, no evidence of disease	full	Normal	full
90%	full	normal, some evidence of disease	full	Normal	full
80%	full	Normal act with effort	full	Normal/ Reduced	full
70%	reduced	unable normal work, significant	full	Normal/ Reduced	full or confusion
60%	reduced	unable hobby, housework	occ assistance	Normal/ Reduced	full or confusion
50%	sit/lie	unable to do any work;ext disease	much assistance	Normal/ Reduced	full/drowsy/conf
40%	bed	unable to do most activity	mainly asst	Normal/ Reduced	full/drowsy/conf
30%	total bed	unable to do any activity	total care	Normal/ Reduced	full/drowsy/conf
20%	total bed	unable to do any activity	total care	min to sips	full/drowsy/conf
10%	total bed	unable to do any activity	total care	min to sips	drowsy or coma
0%	death				



## *PPS*

# *Palliative Performance Scale*

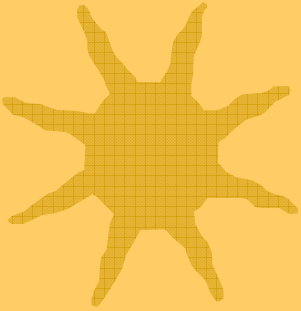
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- ★ Excellent communication tool for health care providers
- ★ It may have prognostic value
- ★ Helps assess patient safety, level of care/resources needed
- ★ Helps identify/prioritize assessment and care planning

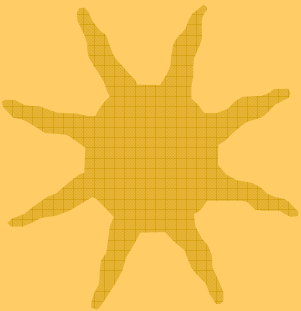


## *Summary of Assessment*

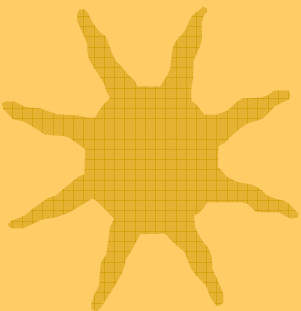
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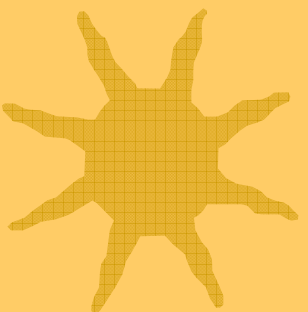
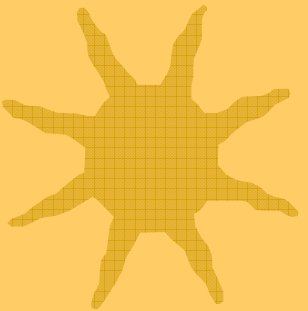
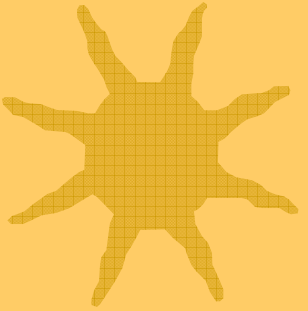
- ★ What are the presenting problems
- ★ What interventions are presently in place
- ★ What options are available



- ★ Establish goals of care

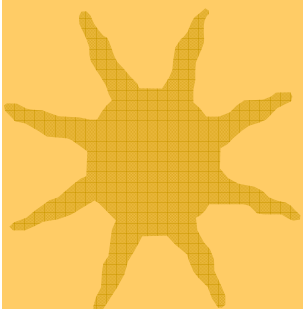
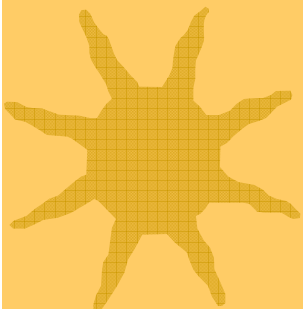
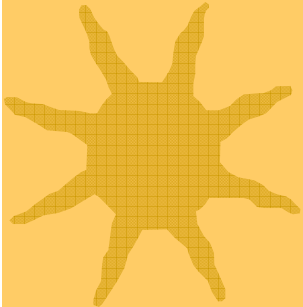


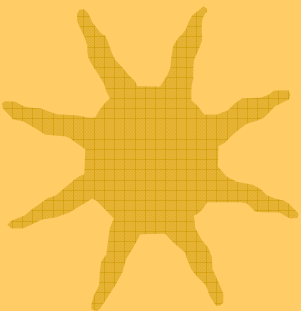
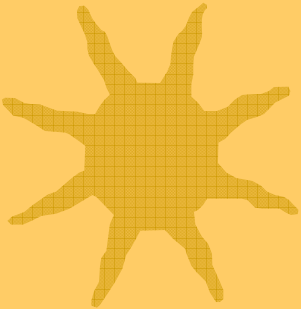
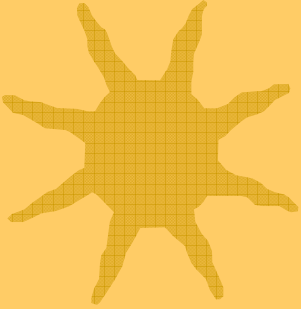
- ★ Care planning



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*Care Planning For The  
Palliative Care Client*





## *Learning Objectives*

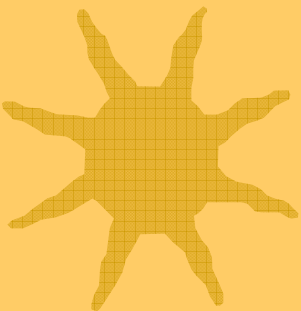
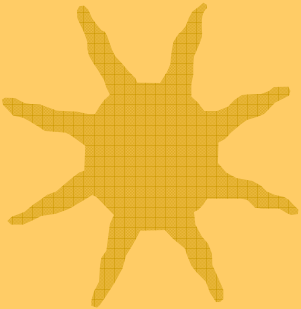
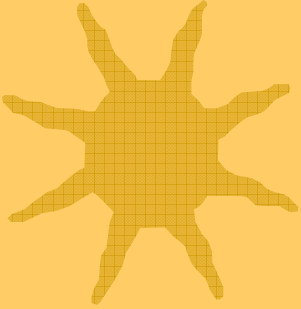
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- ★ Components of a care plan
- ★ Nursing diagnosis
- ★ Management of a Palliative client outside of a care facility
- ★ Management of common symptoms experienced by Palliative care clients
- ★ Follow the “Hospice Palliative Care Nursing Standards of Practice”



# *Care Planning*

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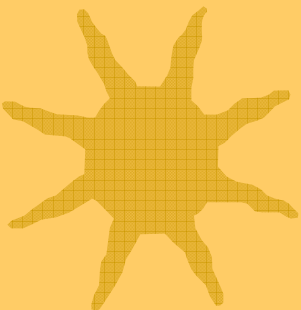
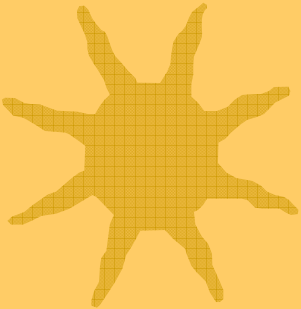
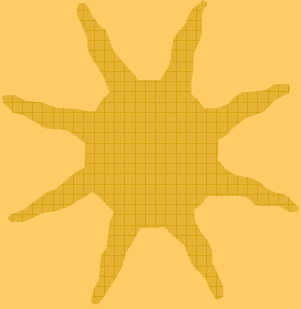


- ★ The development and maintenance of a individualized plan of care
- ★ NANDA approved
- ★ Involve the client
- ★ Involve the family
- ★ Involve the Palliative Care Team

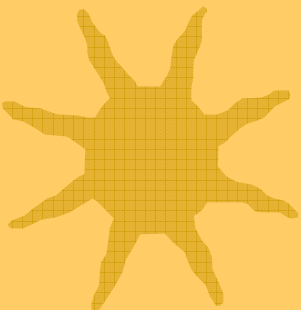
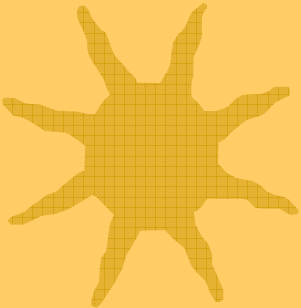
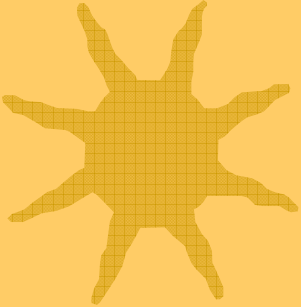


## *Purpose of the Care Plan*

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- ★ To communicate the clients specific care needs to staff who caring for the client
- ★ A plan of nursing care that changes as the clients care needs and condition change
- ★ It is based on identifiable health concerns that the client is experiencing
- ★ Client specific!!! With a holistic focus
- ★ Pain and symptom management



## *How Are Care Plans Formed?*

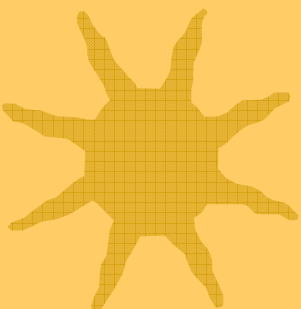
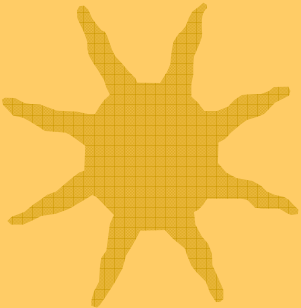
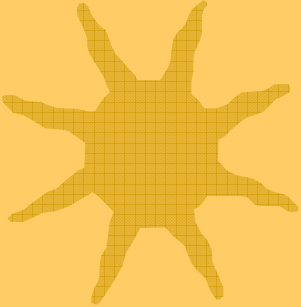
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- ★ Use the nursing process: the process by which nurses deliver care to their clients
- ★ Collect subjective and objective data
- ★ Identify actual problems the client is experiencing
- ★ Think about potential problems that may arise
- ★ Identify the areas that the client needs nursing care



# *How Are Care Plans Formed?*

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- ★ Assessment
- ★ Make a Nursing Diagnosis
- ★ Include relating factors (R/T)
- ★ Include evidence that supports the diagnosis (your objective data that supports the diagnosis)
- ★ State the expected outcomes, or Goals
- ★ Should include a Evaluation Date (not in Palliative Care)
- ★ Establish specific nursing Interventions

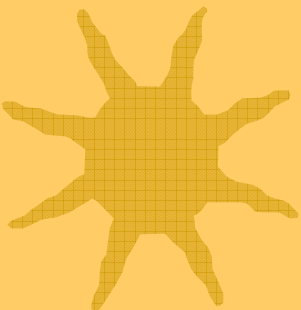
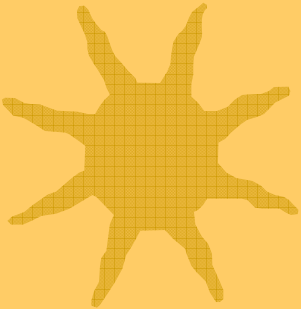
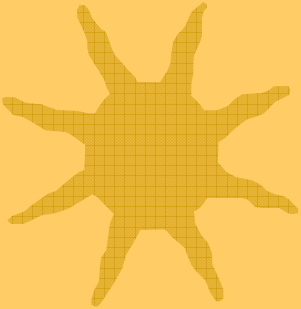


# *NANDA Nursing Diagnosis*

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## Health Function/Maintenance

- ★ Alteration in Health Maintenance
- ★ Alteration in Home Maintenance
- ★ Impaired/Ineffective Coping
- ★ Impaired /Ineffective Family Coping
- ★ Caregiver Role Strain
- ★ Risk for Powerlessness/Hopelessness
- ★ Insufficient Support System
- ★ Alteration/Disturbed Body Image



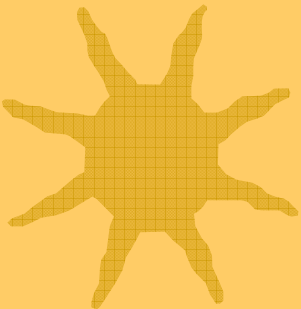
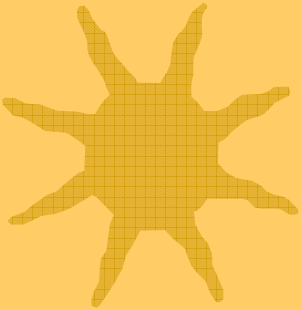
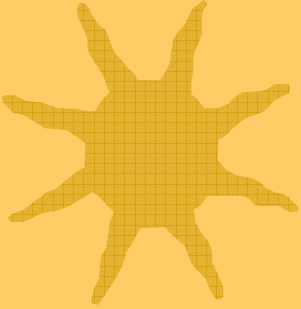


# *NANDA Nursing Diagnosis*

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## Nutrition

- ★ Impaired Swallowing
- ★ Alteration in Appetite
- ★ Alteration in Nutrition
- ★ Knowledge Deficit





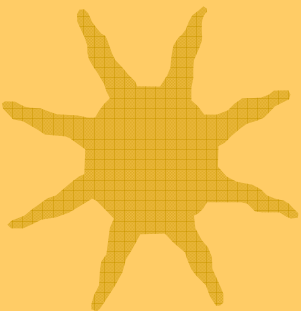
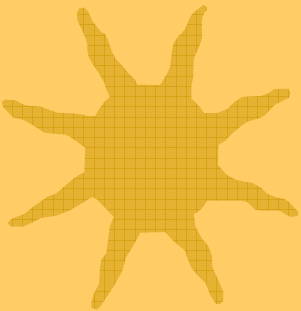
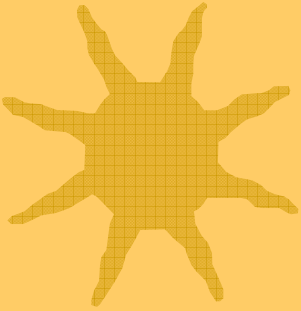
# *NANDA Nursing Diagnosis*

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## Nutrition

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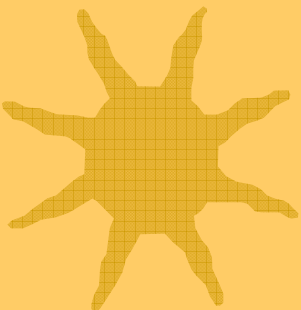
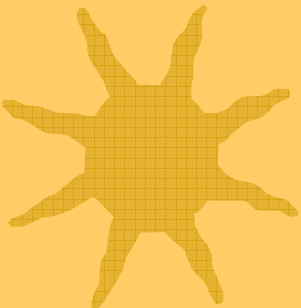
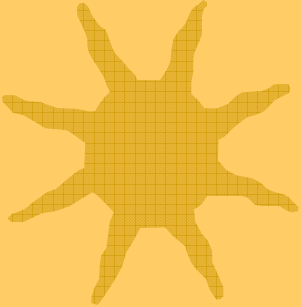
Knowledge Deficit R/T Changes In  
Nutritional Requirements





# *NANDA Nursing Diagnosis*

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## Elimination

- ★ Alteration in Urinary Elimination
- ★ Alteration in Bowel Elimination
- ★ Urinary Incontinence
- ★ Risk for Constipation
- ★ Perceived Diarrhea
- ★ Bowel Incontinence

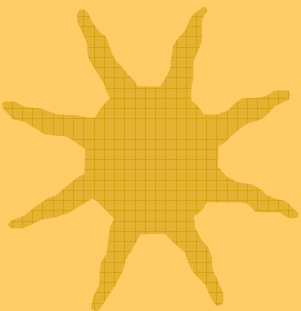
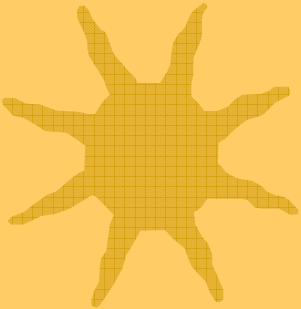
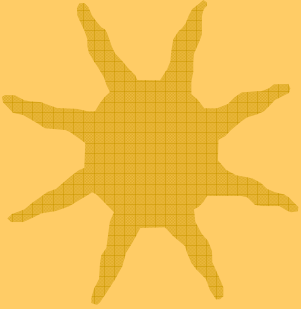


# *NANDA Nursing Diagnosis*

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## Activity/Rest

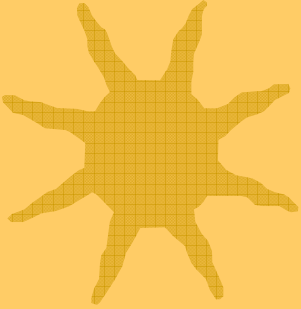
- ★ Disturbed Sleep Pattern
- ★ Impaired Physical Mobility
- ★ Self Care Deficit: Dressing, Bathing, Feeding, Toileting
- ★ Fatigue
- ★ Activity Intolerance



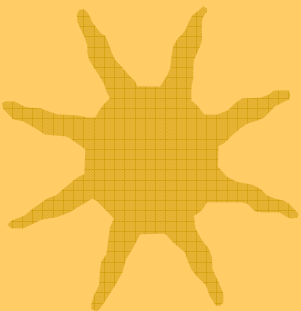
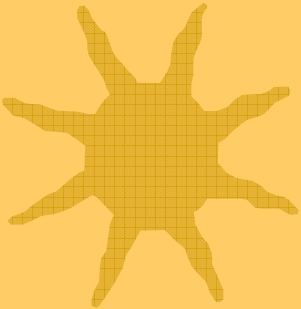


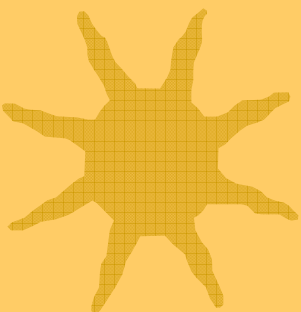
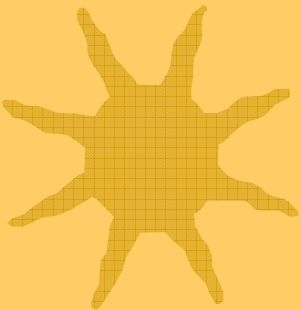
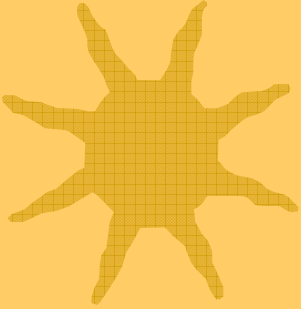
## *Goals for Palliative Clients*

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- ★ Client will be supported by the entire Palliative Care team
- ★ Client will receive optimal palliative care
- ★ Clients pain will be managed
- ★ Clients symptoms will be controlled
- ★ Clients quality of life will be maintained
- ★ Care giver stress will be minimized





# *Nursing Interventions*

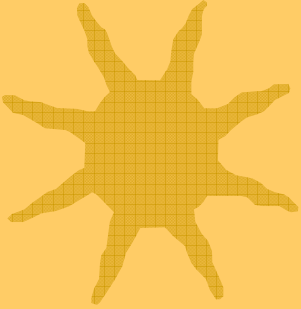
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- ★ Based on our assessment
- ★ Based on actual or potential health concerns that we have identified
- ★ Group interventions by:
  - Home Management
  - Health Status
  - Symptoms



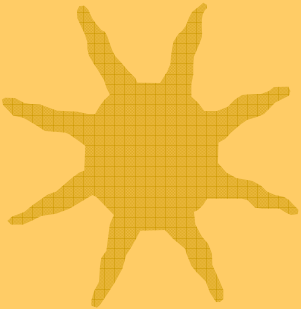
# *Management of the Palliative Client at Home*

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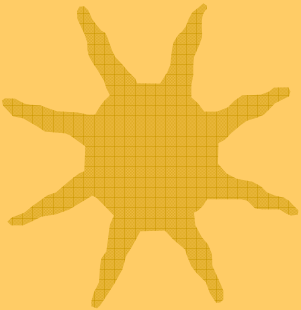
- ★ Identify the primary physician willing to care for client at home

- ★ Identify the Home Care Case Coordinator

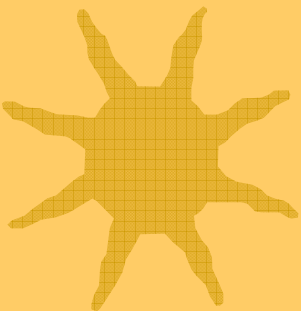
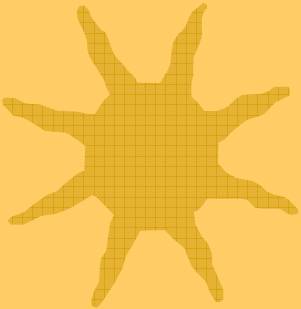
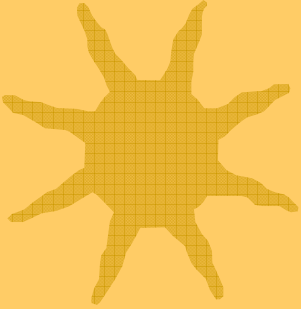


- ★ Teach client and family after hours/ on-call accessibility

- ★ Always re-assess care plan, clients care needs, and medication management



- ★ Always include client and family in decision making



# *Management of the Palliative Client at Home*

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- ★ As the clients PPS declines, their needs change
- ★ Monitor changes in your client
- ★ Increase visits
- ★ Reassess the appropriateness and route of medications



# *Interventions*

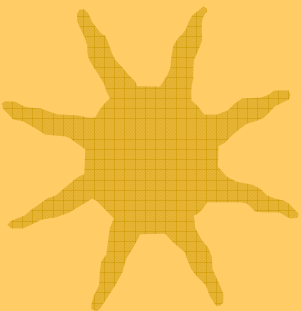
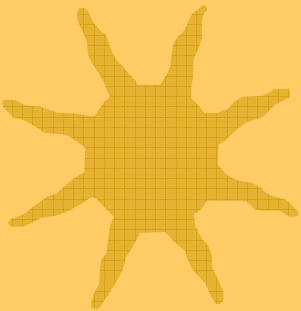
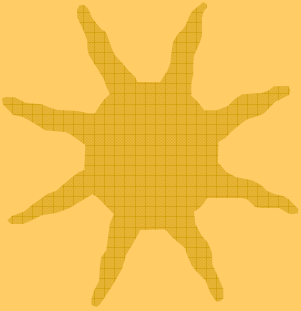
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- ★ Psycho Social
- ★ Spiritual
- ★ Physical Care/Symptom management
  - Pain
  - Dyspnea
  - Elimination
  - Nutrition
  - Nausea/Vomiting
  - Delirium
  - General/other concerns
  - End of life
  - Palliative Care Emergencies



# *Psycho Social*

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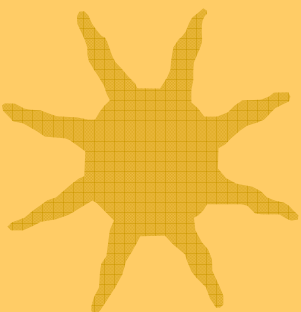
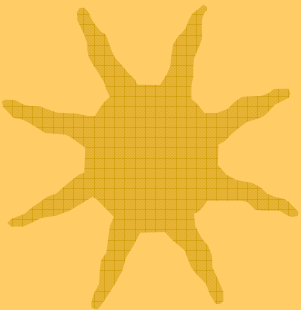
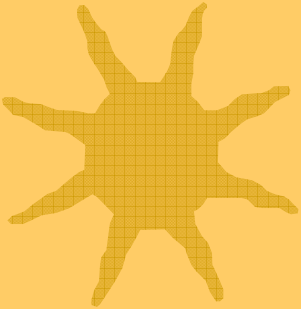


- ★ Important to gain an understanding of the meaning and preparedness of the client and family
- ★ Identify quality of life issues for client
- ★ Identify the care givers, support systems, coping mechanisms
- ★ Ensure proper documents are in order:
  - POA
  - HCD
  - ACP
  - LAD

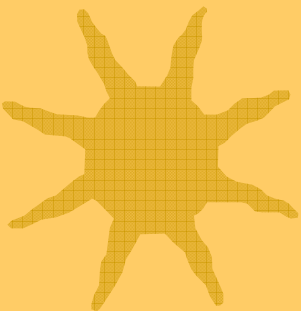
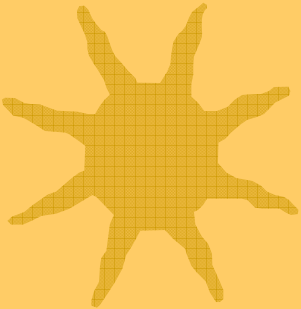
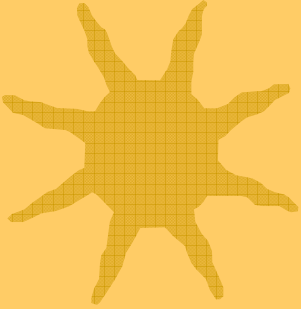


## *Psycho Social*

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- ★ Always ensure a calm peaceful environment
- ★ Equipment needs
- ★ Ensure the clients primary location in the home is comfortable for client and family
- ★ Anticipatory Grief



# *Anticipatory Grief*

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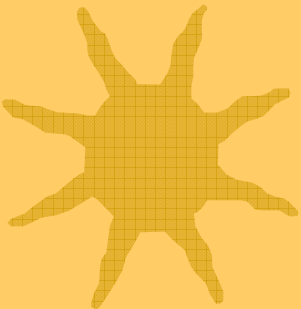
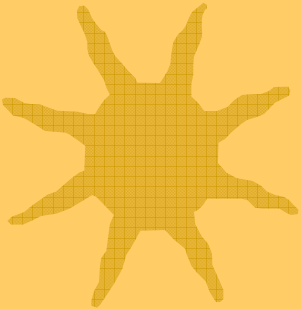
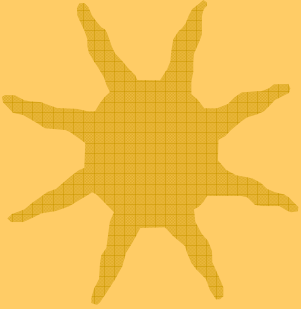
- ★ Roles are being re-defined
- ★ Personal affairs must be put into order
- ★ Life review
- ★ Fear
- ★ Funeral



# *Spiritual*

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- ★ Spirituality as opposed to religion
- ★ Encourage client to find meaning and purpose in remaining life
- ★ Awareness and understanding of illness, of death and dying: beliefs, hopes, strengths, fears
- ★ Ask client or family if they would like to be referred to a spiritual care provider, social worker, counseling
- ★ Always hope



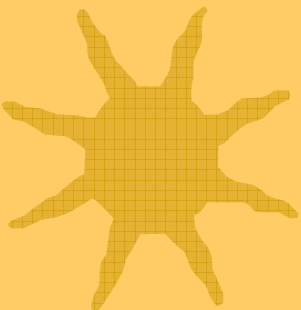
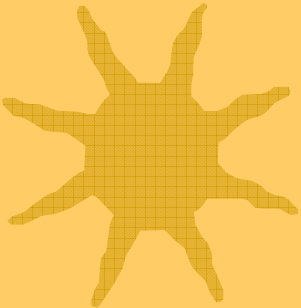
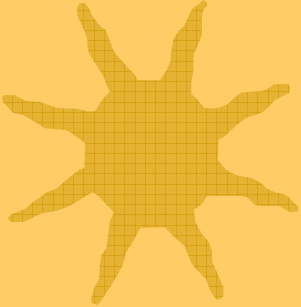
# *Physical Care/Symptom Management*

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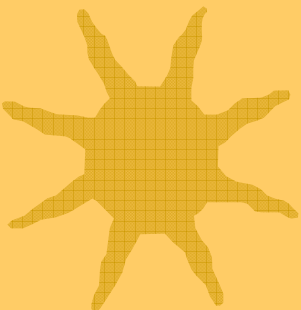
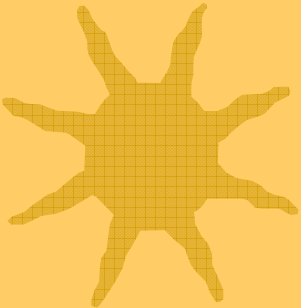
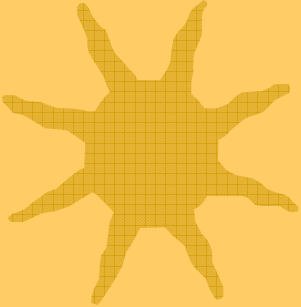
- ★ Pain
- ★ Dyspnea
- ★ Elimination
- ★ Nutrition
- ★ Nausea/Vomiting
- ★ Delirium



# *Pain*



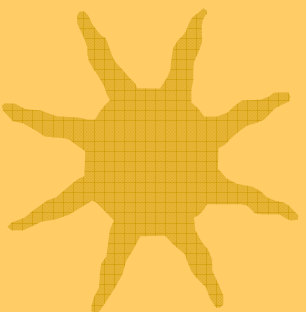
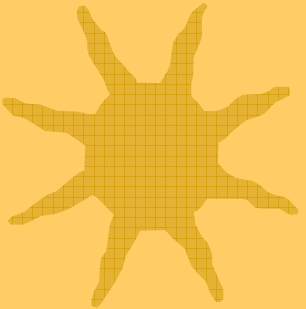
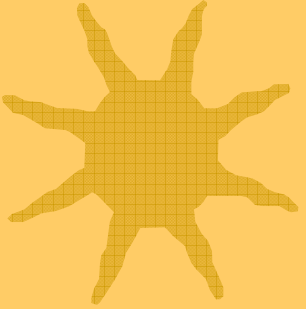
- ★ Pain assessment is done each visit (tools)
- ★ Each persons pain experience is unique
- ★ Have client rate pain ?/10, type, location, radiation, relieving/aggravating factors
- ★ Teach client/family use of long acting, short acting and breakthrough analgesic
- ★ Teach what Breakthrough Pain is
- ★ If client increasingly requires more BTA, liaise with MD to increase LA opioids
- ★ Incident Pain



# *Pain*

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- ★ Assess need for adjuvant therapies
  - Drugs (NSAID, steroids, antidepressants)
  - Medical (radiation, nerve blocks, acupuncture)
  - Psychological (relaxation, imagery, touch, ... music)
  - Physiotherapy (heat, cool, massage)
  - Spiritual (prayer, meditation, scripture)
- ★ If medication adjustment was made, follow up!  
Increase visits, change your care plan



## *Pain*

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- ★ Answer questions/teach re: side effects of opioids and their management (nausea, tiredness, constipation)
- ★ Dispel myths related to opioid use
- ★ Monitor need for opioid rotation
- ★ Monitor need to change route of administration (severe nausea, dysphagia)



# *Dyspnea*

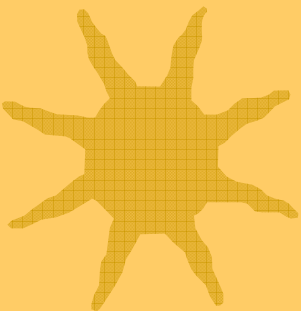
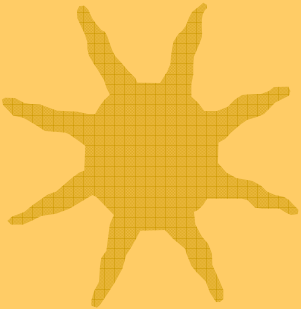
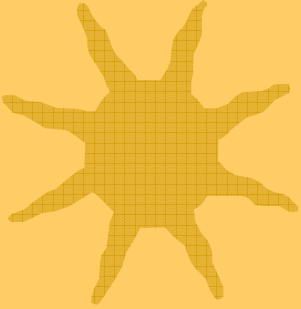
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- ★ Dyspnea is a subjective experience that requires an objective assessment and proper interventions
- ★ Auscultation, use of accessory muscles, pursed lips, cyanosis, cough, oral mucosa, agitation
- ★ Positioning
- ★ Minimize energy expenditure
- ★ Increase ventilation
- ★ Provide reassurance
- ★ Medications to relieve SOB
- ★ Oxygen



## *Elimination/Bowel*

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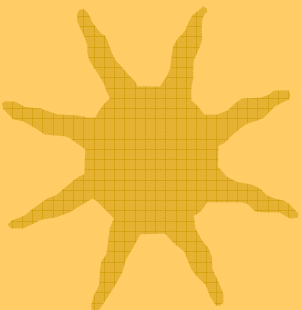
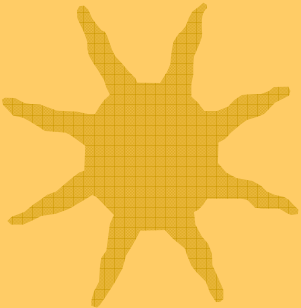
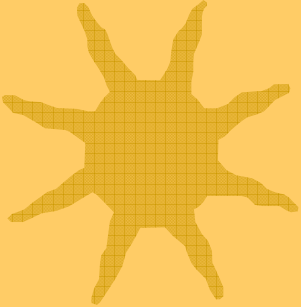


- ★ Constipation #1 issue
- ★ Monitor BM's: frequency, amount, consistency
- ★ Encourage client to record BM's on a calendar
- ★ Monitor use of laxatives and softeners
- ★ Increase water intake
- ★ Auscultation of bowel sounds
- ★ Perform rectal checks



## *Elimination/Bowel*

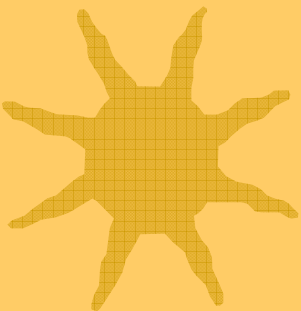
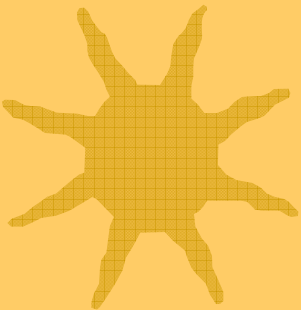
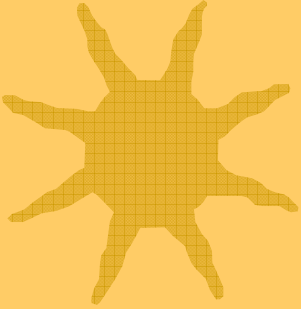
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- ★ Opioids/Laxatives go hand in hand

Teach:

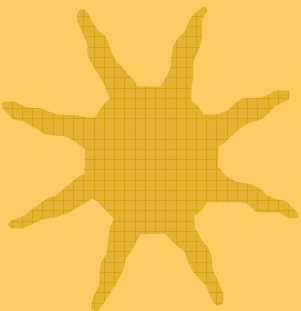
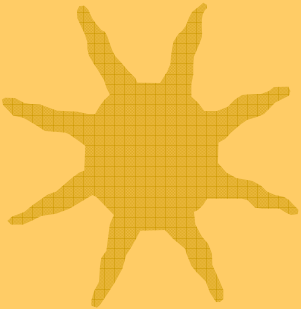
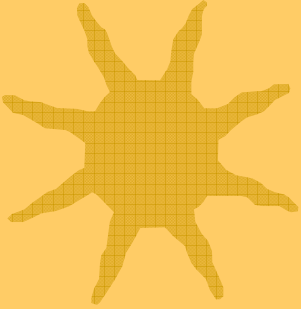
- ★ Body still produces stool despite oral intake
- ★ Watery stool does not mean diarrhea
- ★ If obstructed=hospital admission



# *Nutrition*

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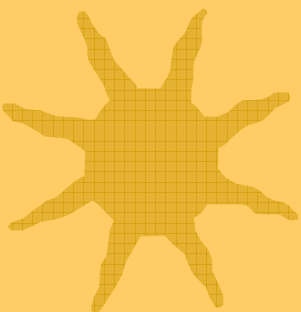
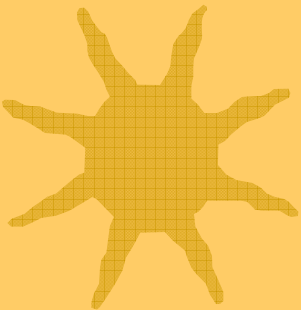
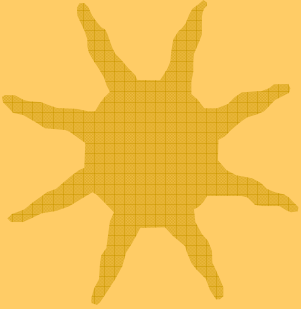
- ★ Dehydration
- ★ Assess oral mucosa every visit
- ★ Look for signs and symptoms of infection
- ★ Assess swallowing every visit
- ★ Changes in taste contribute to decreased appetite



## *Nutrition*

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- ★ Teach client and family normal processes and loss of appetite
- ★ Anorexia/cachexia
- ★ Teach family: weight loss, smells, change in taste
- ★ Fluids over solids
- ★ Teach mouth care



## *Nausea/Vomiting*

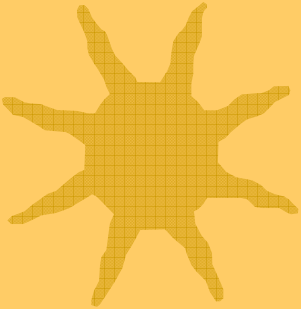
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- ★ Severity of the symptom
- ★ Think of the underlying cause
- ★ Think of the target receptor zones
- ★ Add a second agent before switching agents
- ★ Medication review
- ★ Alternate route



## *Nausea/Vomiting*

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★ Eat/drink small amounts often

★ Ensure adequate hydration

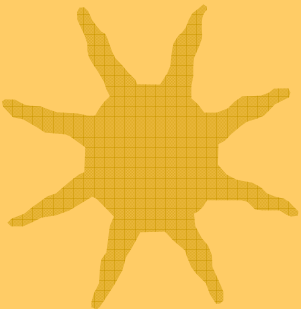
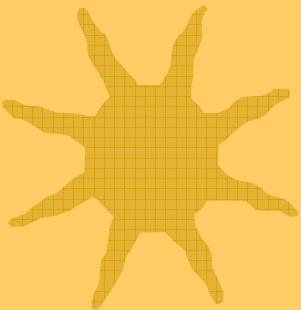
★ Eat in a pleasant environment

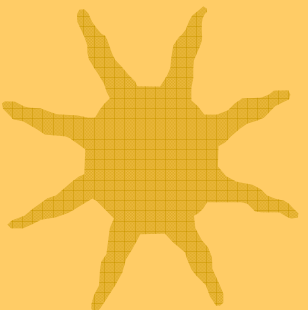
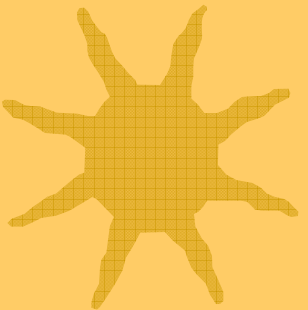
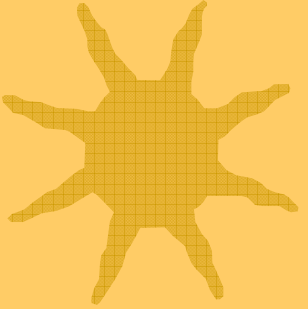
★ Relax after meals, sitting up

★ Avoid food odors

★ Avoid greasy, spicy foods

★ Relaxation, imagery





# *Delirium*

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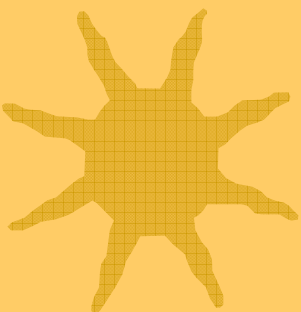
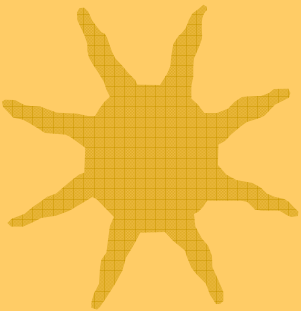
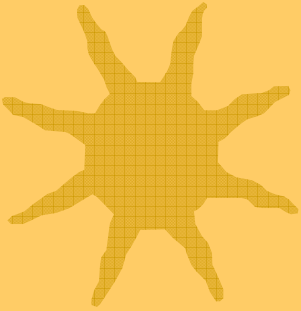
- ★ Distinguish delirium from dementia
- ★ Delirium when not at end of life is reversible
- ★ Delirium at end of life is manageable



# *Delirium*

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- ★ Ask the client about hallucinations
- ★ Think of the underlying cause
- ★ Treat the underlying cause
- ★ Teach the family signs and symptoms of delirium/confusion/agitation
- ★ Comfort and safety measures
- ★ Minimize family distress





# *General*

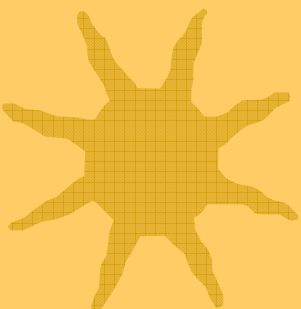
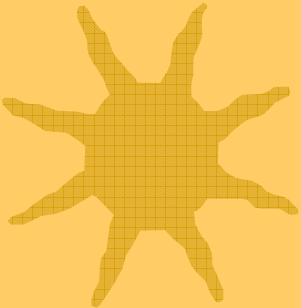
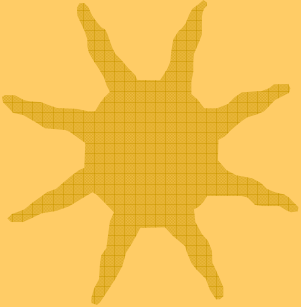
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- ★ Fatigue/sleep disturbances, general malaise
- ★ Wounds
- ★ Skin breakdown  
Braden scale
- ★ Bladder spasms/urinary retention



## *Care Planning at End Of Life*

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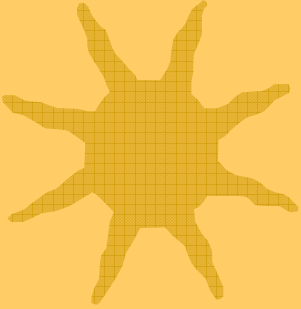


- ★ Mouth care every hour or more
- ★ Anxiety of client and family
- ★ Terminal respiratory secretions
- ★ Lots of teaching required, provide family with “When Death Is Near”
- ★ Skin break down/ mottling

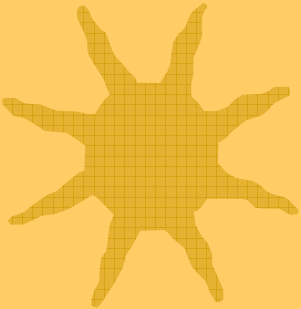


# *Care planning for Palliative Care Emergencies*

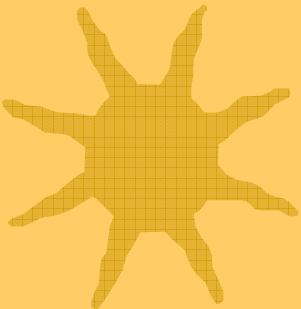
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★ Spinal Cord Compression  
signs and symptoms



★ Superior Vena Cava Obstruction  
signs and symptoms



★ Hypercalcemia  
signs and symptoms

★ Teach family/client

★ Review how to access after hours on call nurse



# *Conclusion*

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- ★ Assess the client
- ★ Monitor care
- ★ Teach the family
- ★ Support family and client
- ★ Prepare them for death