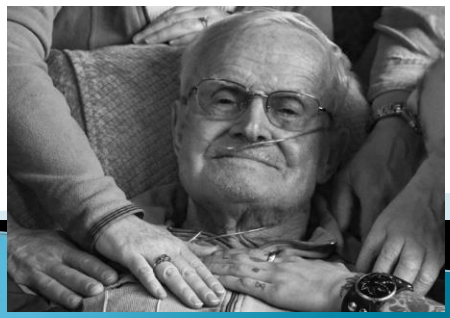
Palliative Care

Meeting the Physiologic Needs of the Dying Client



Meeting the Physiologic Needs of the Dying Client

- The physiologic needs of people who are dying are related to a slowing of body processes and to homeostatic imbalances.

- Interventions include providing personal hygiene measures
- controlling pain
- relieving respiratory difficulties
- assisting with movement
- nutrition,
- Hydration and elimination
- providing measures related to sensory changes

Meeting the Physiologic Needs of the Dying Client

- Airway clearance
  - Fowler's position: conscious clients
  - Throat suctioning: conscious clients
  - Lateral position: unconscious clients
  - Nasal oxygen for hypoxic clients
  - Anticholinergic medications may be indicated to help dry secretions

Meeting the Physiologic Needs of the Dying Client

- Air hunger
  - Open windows or use a fan to circulate air
  - Morphine may be indicated in an acute episode

Meeting the Physiologic Needs of the Dying Client

- Bathing/hygiene
  - Frequent baths and linen changes if diaphoretic
  - Mouth care as needed for dry mouth
  - Liberal use of moisturizing creams and lotions for dry skin
  - Moisture-barrier skin preparations for incontinent clients

Meeting the Physiologic Needs of the Dying Client

- Physical mobility
  - Assist client out of bed periodically, if able
  - Regularly change client's position
  - Support client's position with pillows, blanket rolls, or towels as needed
  - Elevate client's legs when sitting up
  - Implement pressure ulcer prevention program and use pressure-relieving surfaces as indicated (discussed at the end)

Meeting the Physiologic Needs of the Dying Client

- Nutrition
  - Antiemetics or a small amount of an alcoholic beverage to stimulate appetite
  - Encourage liquid foods as tolerated

Meeting the Physiologic Needs of the Dying Client

- Constipation
  - Dietary fiber as tolerated
  - Stool softeners or laxatives as needed

Meeting the Physiologic Needs of the Dying Client

- Urinary elimination
  - Skin care
  - Catheterization
- Sensory/perceptual changes
  - light or dark room
  - Hearing is not diminished; speak clearly and do not whisper
  - Touch is diminished, but client will feel pressure of touch
  - IMPLEMENT PAIN MANAGEMENT PROTOCOL IF INDICATED

Pain control

- morphine, heroin, methadone
- Can be given orally, intravenous infusion, sublingually, or rectally, rather than subcutaneously or intramuscularly
- Clients on narcotic pain medications also require implementation of a protocol to treat opioid-induced constipation

Providing Spiritual Support

- Although not all clients identify with a specific religious faith or belief, most have a need for meaning in their lives, particularly as they experience a terminal illness.
- ensure that the client's spiritual needs are attended to, either through direct intervention or by arranging access to individuals who can provide spiritual care

Providing Spiritual Support

- Do not impose your own religious or spiritual beliefs on a client but to respond to the client in relation to the client's own background and needs

- Communication skills are most important in helping the client articulate needs and in developing a sense of caring and trust

Providing Spiritual Support

Specific interventions may include

- facilitating expressions of feeling
- Prayer
- Meditation
- reading
- discussion with appropriate clergy or a spiritual adviser.

Supporting the Family

- using therapeutic communication to facilitate their expression of feelings
- an empathetic and caring presence
- as a teacher, explaining what is happening and what the family can expect
- Encourage family to participate in the physical care
- After the client dies, the family should be encouraged to view the body, because this has been shown to facilitate the grieving process (Rich, 2005). They may wish to clip a lock of hair as a remembrance. Children should be included in the events surrounding the death if they wish to.

Postmortem Care

- **Rigor mortis**
  - is the stiffening of the body that occurs about 2 to 4 hours after death.
  - It results from a lack of adenosine triphosphate (ATP), which causes the muscles to contract, which in turn immobilizes the joints.
  - Rigor mortis starts in the involuntary muscles (heart, bladder, and so on), then progresses to the head, neck, and trunk, and finally reaches the extremities.

Postmortem care

- Rigor Mortis
  - position the body, place dentures in the mouth, and close the eyes and mouth before rigor mortis sets in.
  - Rigor mortis usually leaves the body about 96 hours after death.

Postmortem care

- **Algor mortis**
  - the gradual decrease of the body's temperature after death.
  - When blood circulation terminates and the hypothalamus ceases to function, body temperature falls about 1°C (1.8°F) per hour until it reaches room temperature.
  - Simultaneously, the skin loses its elasticity and can easily be broken when removing dressings and adhesive tape.

Postmortem care

- After blood circulation has ceased, the red blood cells break down, releasing hemoglobin, which discolors the surrounding tissues. This discoloration, appears in the lowermost or dependent areas of the body
- bodies are often stored in cool places to delay this process

- **livor mortis**

dependent lividity

Postmortem care

- Hospital policy
- Religious laws
- View the body
- Making body clean and pleasant
- Remove equipments
- Supine position, palms down or on abdomen
- Soiled areas to be washed
- One pillow under the head and shoulders
- The eyelids are closed and held in place
- Dentures are usually inserted to help give the face a natural appearance.
- The mouth is then closed.

Postmortem care

- **Mortician** (also referred to as an **undertaker**
- Absorbent pads are placed under the buttocks
- A clean gown is placed on the client
- the hair is brushed and combed
- All jewelry is removed, except a wedding band in some instances, which is taped to the finger
- the deceased's wrist identification tag is left on and additional identification tags are applied

Postmortem care

- Shroud الكفن
- The body is wrapped in a **shroud,** a large piece of plastic or cotton material used to enclose a body after death
- Identification is then applied to the outside of the shroud
- The body is taken to the morgue if arrangements have not been made to have a mortician pick it up from the client's room
- have a duty to handle the deceased with dignity and to label the corpse appropriately.
- Mishandling can cause emotional distress to survivors. Mislabeling can create legal problems if the body is inappropriately identified and prepared incorrectly for burial or a funeral.

Pressure ulcers

- Previously called decubitus (lying down) ulcers, pressure sores, or bed sores.
- Is localized injury to the skin and/or underlying tissues usually over bony prominences, as a result of pressure, or pressure in combination with shear.

Etiology of pressure ulcers

- Ischemia: compression greater than 32 mm Hg → ↓ O_2 and nutrients to the cells and waste products accumulate in the cells → tissue dies.
  - Reactive hyperemia: when pressure relieved, skin becomes bright and flush due to vasodilation.

Risk factors

- Immobility and inactivity
- Inadequate nutrition: ↓ weight, muscle atrophy, and loss of subcutaneous tissue → padding between the skin and bones.
- Fecal and urinary incontinence:
- Decreased mental status (less able to respond to pain)
- Diminished sensation
- Excessive body heat: ↑ metabolism → ↑ need for O_2

Risk factors

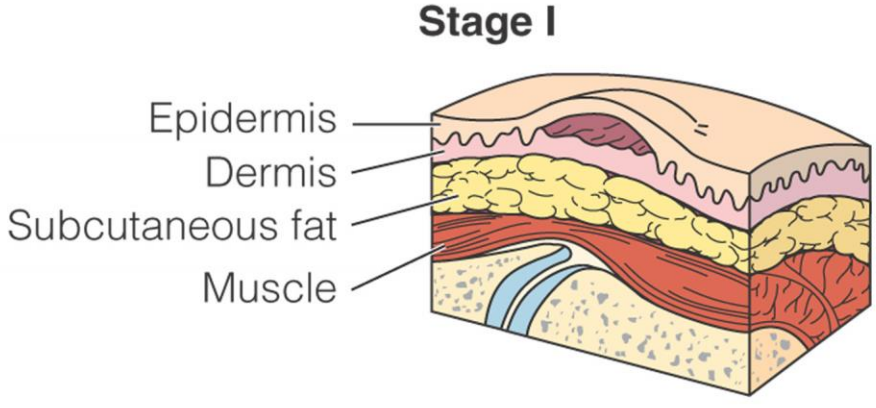
- Advanced age
- Chronic medical condition: e.g. DM
- Friction and shearing
  - Friction: force acting parallel to skin surface.
  - Shearing force: friction with pressure (e.g. Fowlers position)

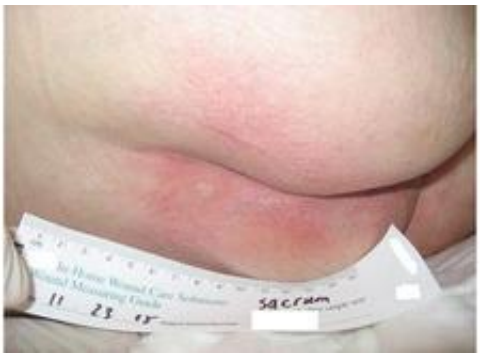
- Other factors: poor lifting and transferring techniques, incorrect positioning, hard support surfaces, incorrect application of pressure relieving devices.

Stages of Pressure Ulcers

Stage I: Nonblanchable Erythema of Intact Skin

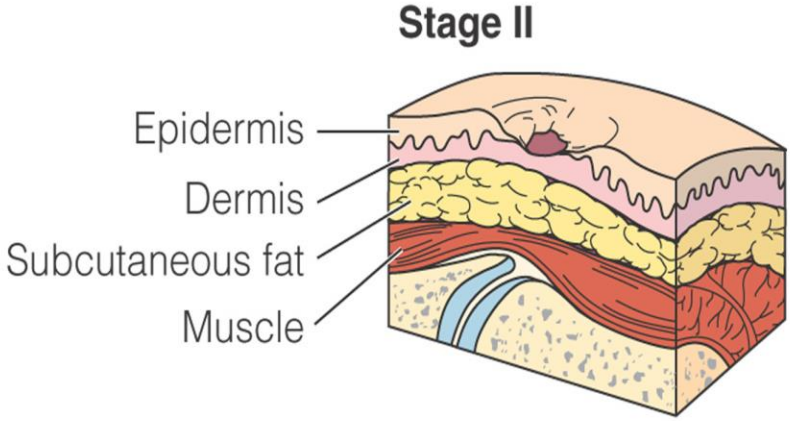
Blanching/Blanchable - An erythematous lesion that loses all redness when pressed

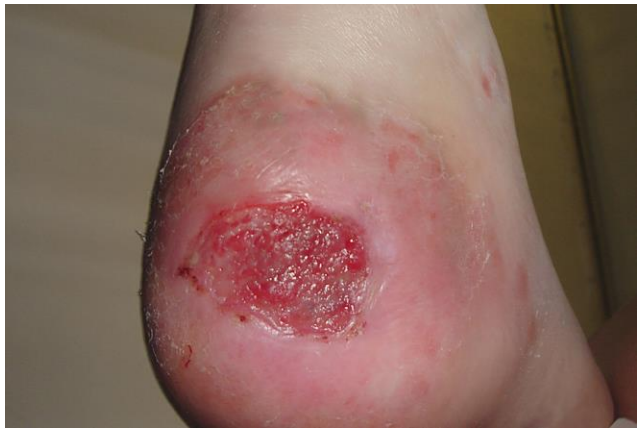




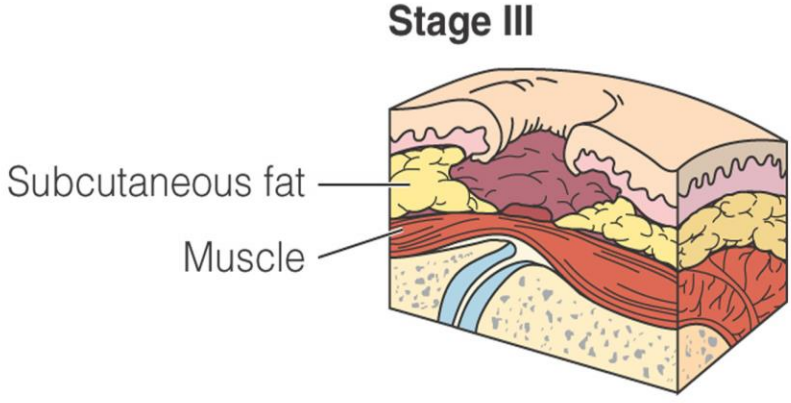
Characterized as a defined area of redness that does *not* blanche (become pale) under applied light pressure. This finding is consistent with a Stage 1 pressure ulcer.

Stage II:
Partial – Thickness Skin Loss Involving Epidermis and / or Dermis

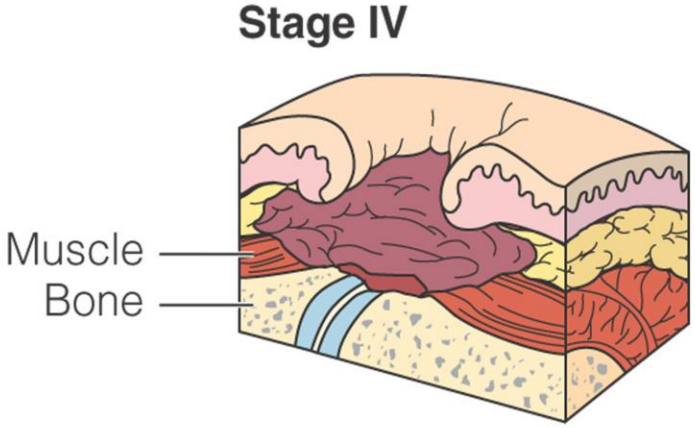


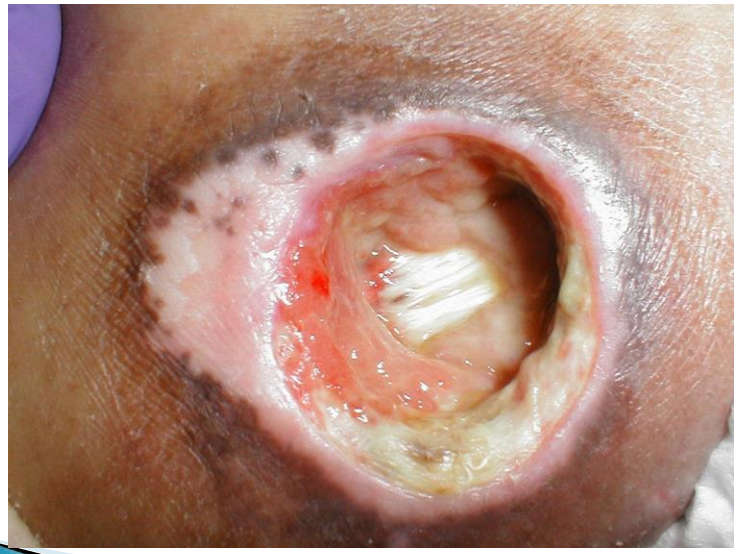


Stage III: full-thickness skin loss involving damage or necrosis of subcutaneous tissue



stage IV: full-thickness skin loss with tissue necrosis or damage to muscle, bone, or supporting structures, such as tendon






Thank you!