FUNDAMENTALS OF NURSING · STUDY GUIDE

Exam 10 Study Guide

This guide covers chapters 19 and 20, the psychosocial chapters. Chapter 19 is about the person behind the diagnosis: how illness threatens self concept, how stress and anxiety change the body and the mind, how to tell delirium from dementia, and how to care across cultures, faiths and families. Chapter 20 is about loss: how grief looks, how to talk with people who are grieving, how palliative and hospice care differ, how to manage symptoms at the end of life and how to care for the body and family after death. Many questions here test the best response, so read the tables of helpful and unhelpful words closely.

WHAT THIS GUIDE COVERS

- Chapter 19 · identity, body image, role performance and self esteem, stressors and appraisal, the sympathetic response and HPA axis, the general adaptation syndrome, problem and emotion focused coping, defense mechanisms, crisis types and intervention, anxiety levels and the perceptual field, physical causes of anxiety, delirium and dementia, sensory overload and deprivation, cultural humility, stereotyping and bias, social determinants, interpreters, spirituality, spiritual distress, religious practices, family structures, caregiver strain and sexual health.
- Chapter 20 · types of loss, grief, mourning and bereavement, grief theories and their limits, normal, prolonged, delayed and disenfranchised grief, presence and therapeutic responses, children and death, cultural practices, palliative care, hospice eligibility and team, advance care planning and code status, pain and dyspnea at the end of life, terminal secretions and agitation, signs of approaching death, pronouncement, algor, livor and rigor mortis, postmortem care, medical examiner cases, organ donation and compassion fatigue.

CHAPTER 19

Psychosocial Health, Culture and Spirituality

Read it in full: **Chapter 19 in the textbook**. Practice it in the lab: **Anxiety Level Reader** and **Interpreters and Beliefs**.

What to know

Self concept is the mental picture a person holds of who they are. It has four parts: **identity** (a distinct, continuous self), **body image** (feelings about the body's appearance and function), **role performance** (meeting the expectations of roles such as parent or worker; conflict, ambiguity and overload are role problems) and **self esteem** (overall sense of worth). Amputation, ostomy, mastectomy, burns, hair loss, job loss and dependence for toileting all threaten it. Cues: avoiding looking at a changed body part, refusing to take part in care, negative self talk, withdrawal. Some reluctance early is expected; offer gradual exposure (look, then touch, then participate) and peer support.

A **stressor** is any demand seen as threatening, and **appraisal** decides how stressful it feels. The **sympathetic** system acts within seconds (epinephrine and norepinephrine raise heart rate, BP, breathing, glucose and alertness). The **HPA axis** follows (CRH, then ACTH, then **cortisol**, which raises glucose and suppresses inflammation and immunity), and aldosterone and ADH retain sodium and water. That explains stress hyperglycemia after surgery, low urine output on the first postoperative day and slow healing. The **general adaptation syndrome** runs alarm, resistance and exhaustion; unending stress ends in illness.

Problem focused coping changes the situation; **emotion focused coping** changes the feeling. Coping is adaptive when it lowers distress without harm and maladaptive when it trades short relief for long harm (alcohol, isolation, denial that blocks treatment). Defense mechanisms are mostly unconscious: denial, displacement (anger at the diagnosis aimed at the nurse), projection, regression (bedwetting in a hospitalized 4 year old), repression (no memory), sublimation and **suppression**, which is the only conscious one ("I'll think about it after the wedding").

A **crisis** is a stressor that overwhelms usual coping. It is time limited, usually about **4 to 6 weeks**, and the person comes out higher, the same or lower. Types are maturational, situational and adventitious (disasters). Crisis intervention is short term, directive and present focused, and it starts with **safety**: ask directly about thoughts of harming self or others. Asking about suicide does not plant the idea. Then assess the event, supports and coping, plan concrete steps, mobilize supports and evaluate.

Anxiety is vague dread about an unclear threat; fear responds to a specific danger. As anxiety rises the **perceptual field** narrows. **Mild**: alert, the best time to teach. **Moderate**: focus narrows; short, clear explanations still work. **Severe**: scattered details, cannot solve problems, tachycardia and hyperventilation; stay, calm low stimulus setting, short simple sentences, no teaching yet. **Panic**: perception distorted; safety first, firm calm directions, quiet space, medication if ordered. Do not ask "why." Rule out physical causes first: hypoxia, hypoglycemia, pain, PE, heart attack, hyperthyroidism, withdrawal and drugs such as bronchodilators and steroids.

Delirium is an acute (hours to days), fluctuating disturbance of **attention** and awareness with an underlying medical cause, often worse at night and often reversible. It can be hyperactive, **hypoactive** (quiet and easily missed) or mixed. Causes: infection, dehydration, electrolytes, hypoxia, low glucose, pain, urinary retention, constipation, sleep loss, withdrawal and drugs (anticholinergics, benzodiazepines, opioids, some antihistamines). The Confusion Assessment Method looks for acute onset and fluctuation, inattention, and disorganized thinking or altered consciousness. **Dementia** is gradual and progressive with normal attention early and is usually irreversible. A person with dementia is at high risk of delirium, so a sudden change is never "just the dementia." Depression can mimic dementia but develops over weeks.

Sensory overload (ICU alarms, constant light, interruptions, pain) causes irritability, poor concentration and confusion; cluster care, dim lights at night, silence nonessential alarms per policy and explain sounds. **Sensory deprivation** (isolation, bed rest, vision or hearing loss) causes boredom, depression, disorientation and even hallucinations; give meaningful contact, glasses and hearing aids, clocks, calendars and visits. Both feed delirium.

Culture is shared, learned values, beliefs, language and customs, and everyone belongs to several cultural groups. **Cultural humility** is lifelong self reflection plus treating each patient as the expert on their own life: ask rather than assume. **Ethnocentrism** treats one's own ways as correct. A generalization can open a question; a **stereotype** replaces asking. **Implicit bias** shows up in unequal pain treatment. **Social determinants** (income, housing, food, transportation, discrimination) shape outcomes, and **health equity** removes unjust barriers. Explanatory model questions: What do you call this problem? What caused it? What do you fear? What have you

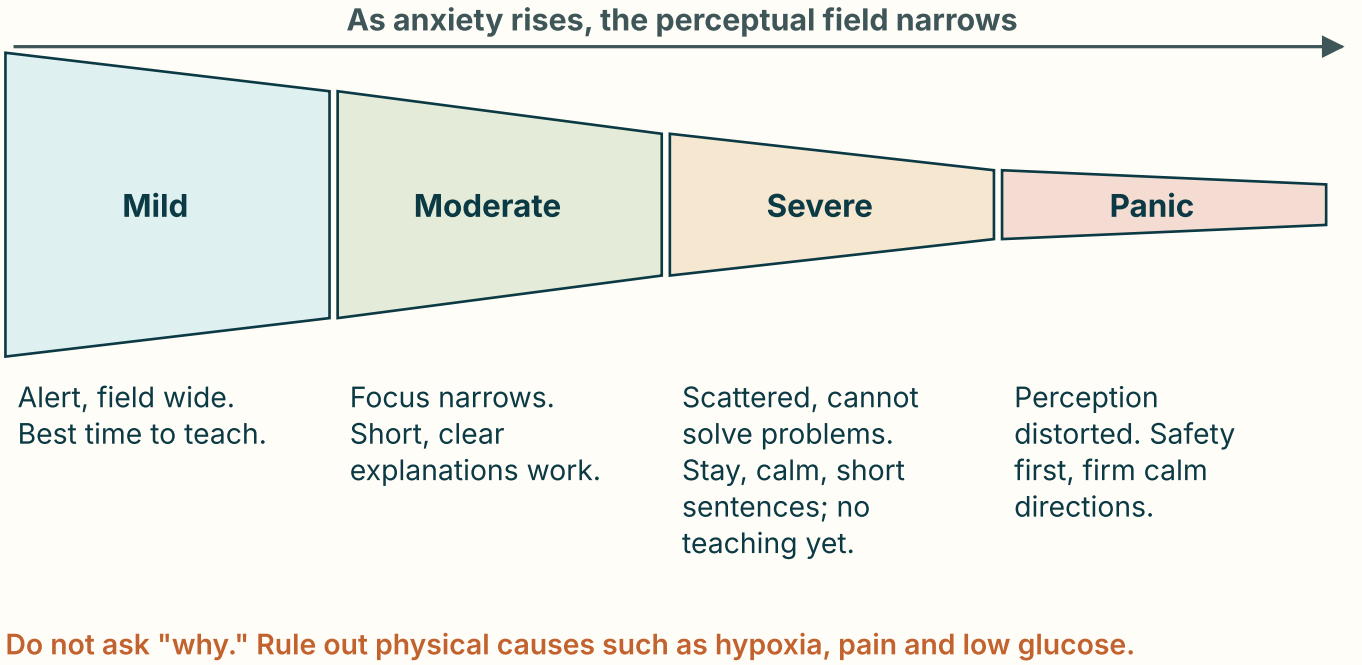
tried? Who should be involved? Coining and cupping marks can resemble abuse, so ask and document objectively.

Patients with limited English proficiency or who are Deaf have a legal right to language help. Use a **qualified medical interpreter** in person, by video or by phone, never a child and not family for clinical content; document an adult's refusal of a free interpreter. Speak to the patient in the first person, short sentences, one question at a time, confirm with teach back, and document the interpreter's name or ID.

Spirituality is the search for meaning, purpose, connection and hope, with or without religion. **Spiritual distress** shows as "Why me?", anger at God or feeling abandoned, guilt, hopelessness, or no longer finding comfort in past practices. Assess briefly on admission and with changes ("What helps you cope? Would you like a chaplain?"). Support with presence, privacy for prayer, respectful handling of religious items, chaplain referral, prayer only if the patient asks, and realistic hope. Never impose personal beliefs.

Religious practices some members observe (always ask the individual): **Jehovah's Witnesses** refuse whole blood and major components, with individual choices on fractions; **observant Judaism** kosher diet, Sabbath Friday to Saturday sundown, quick burial; **Islam** halal diet (check medicines for gelatin or alcohol), prayer five times a day, Ramadan fasting, modesty and same gender care; **Hinduism** often vegetarian, no beef; **Buddhism** may prefer a clear mind at death; Latter-day Saints may wear sacred undergarments; **Sikhism** uncut hair and religious articles. A competent adult may refuse any treatment, including blood, after being informed.

Family is whoever the patient says it is, but confirm the legal decision maker. A **genogram** maps members and health conditions across generations; an ecomap maps outside supports. **Caregiver strain** (fatigue, neglected health, "I can't do this anymore," anger at the care recipient) raises risk of depression and mistreatment; ask the caregiver directly, teach skills, refer to social work, respite care and adult day programs. **Sexual health**: sex assigned at birth, gender identity and orientation are separate; give permission to discuss, then limited information, specific suggestions and referral. Antihypertensives, SSRIs, antipsychotics and opioids can affect function; never tell a patient to stop them. Erectile dysfunction drugs are never combined with nitrates. Set calm limits on inappropriate sexual behavior and look for unmet needs in delirium or dementia.



Do not ask "why." Rule out physical causes such as hypoxia, pain and low glucose.

Teach only while the field is open. As anxiety climbs, what the person can take in shrinks. Teach at mild or moderate; at severe or panic, stay and keep it safe and simple.

LOCK THESE IN

- Self concept: identity, body image, role performance, self esteem.
- Stress: sympathetic in seconds, cortisol over hours; hyperglycemia, low urine, slow healing.
- GAS: alarm, resistance, exhaustion. Suppression is the only conscious defense mechanism.
- Crisis lasts about 4 to 6 weeks; first action is safety, including asking directly about suicide.
- Teach at mild and moderate anxiety; stay and lower stimulation at severe and panic.
- Rule out hypoxia and hypoglycemia before calling a patient anxious.
- Delirium: acute, fluctuating, inattention, reversible. Dementia: gradual, progressive.
- Ask, do not assume. Qualified interpreter, first person, never a child.

Key terms and comparisons: anxiety levels and cognition

Item	Perception and cues	Nursing approach
Mild anxiety	Alert, wide field, problem solving works	Teach now; invite questions
Moderate anxiety	Narrowed focus, faster pulse and speech	Short clear explanations; help the person focus
Severe anxiety	Scattered details, hyperventilation, dread	Stay, calm low stimulus room, simple sentences, no teaching
Panic	Distorted perception, cannot function	Safety first, firm calm directions, medication per order
Delirium	Acute, fluctuating, inattention, altered consciousness	Report; find the cause; safety; avoid restraints
Dementia	Gradual, progressive, attention intact early	Routine, simple communication, caregiver support
Sensory overload	Too many stimuli: irritability, confusion	Cluster care, dim lights, explain sounds
Sensory deprivation	Too little meaningful input: boredom, disorientation	Contact, glasses and hearing aids, clocks, visits

Priority rules: defense mechanisms and religious practices

Item	Example or rule
Denial	New chest pain called "just indigestion"
Displacement	Anger at a diagnosis aimed at the nurse
Regression	A toilet trained child wets the bed in hospital
Suppression (conscious)	"I'll think about the biopsy after the wedding"
Repression (unconscious)	No memory of a traumatic event
Jehovah's Witnesses	Ask and document specific blood product choices; respect refusal
Islam	Halal diet, prayer privacy, Ramadan timing of medicines, same gender care
Observant Judaism	Kosher diet, Sabbath scheduling, quick burial
Every faith	Ask the individual; never persuade or impose beliefs

Worked cases

WORKED CASE 1 · ANXIETY OR HYPOXIA

Mr. Calloway, 58, is two days after a hip replacement. He suddenly grips the rails and says, "Something terrible is happening." RR 28, HR 118, SpO2 88% on room air. His family says he has always been a worrier.

STEP 1 · RECOGNIZE

Sudden dread with tachypnea, tachycardia and low saturation after orthopedic surgery.

STEP 2 · ANALYZE

This points to a physiologic emergency such as pulmonary embolism, not simple anxiety.

STEP 3 · ACT

Raise the head of the bed, apply oxygen per protocol, stay with him and call the rapid response team or provider.

RULE

Anxiety is a diagnosis of exclusion when vital signs are abnormal. An anxiolytic could hide the cause.

WORKED CASE 2 · DELIRIUM ON TOP OF DEMENTIA

Mrs. Duval, 81, admitted with pneumonia, was conversational yesterday. Tonight she picks at the air, tries to climb out of bed and calls the nurse by her late sister's name. At home she has mild memory problems. Temperature is 38.6 C and she has not voided in 8 hours.

STEP 1 · COMPARE WITH BASELINE

The change is acute and fluctuating over mild baseline memory loss.

STEP 2 · NAME IT

Delirium superimposed on possible dementia.

STEP 3 · LOOK FOR CAUSES

Fever (worsening infection) and possible urinary retention; check SpO2 and glucose and scan the bladder.

STEP 4 · KEEP HER SAFE AND REPORT

Close observation and notify the provider.

RULE

Restraints or a sedative first can worsen delirium. "It's just her dementia" is wrong because the change is sudden.

WORKED CASE 3 · CRISIS AND SAFETY

Ms. Ferreira, 34, lost her apartment in a fire 10 days ago. She cannot sleep, cries during the visit and says, "I can't think straight. Sometimes I wonder what the point of any of this is."

STEP 1 · RECOGNIZE

A situational crisis, impaired functioning and a possible statement of hopelessness.

STEP 2 · ASK DIRECTLY

"Are you having thoughts of killing yourself?"

STEP 3 · FOLLOW PROTOCOL

Act on her answer with the clinic's suicide risk protocol.

STEP 4 · THEN PLAN

Sleep, housing resources and supports come after safety.

RULE

"Everything happens for a reason" closes the conversation. Never assume a vague remark is harmless.

WORKED CASE 4 · CONSENT THROUGH A SON

Mr. Joseph, 45, speaks Haitian Creole and is scheduled for a cardiac catheterization. His 15 year old son offers to translate the consent talk so they do not have to wait.

STEP 1 · IDENTIFY THE PROBLEM

Consent needs real understanding of risks, benefits and alternatives.

STEP 2 · RULE OUT THE SHORTCUT

A minor child may be inaccurate, the role burdens him and the father may hold back questions.

STEP 3 · ACT

Thank the son and get a qualified interpreter (phone or video if needed); the provider explains through the interpreter.

STEP 4 · DOCUMENT

Record the interpreter's ID and method.

RULE

A short delay for an interpreter is right in a nonemergency. An English form alone does not make consent valid.

TRAPS PEOPLE FALL INTO

- **Calling sudden restlessness with low SpO2 anxiety.** Check airway, breathing and oxygen first.
- **Teaching during severe anxiety or panic.** Lower the anxiety first; learning is not possible.
- **Asking an anxious patient "why."** It cannot be answered and feels accusing.
- **Blaming new confusion on dementia.** Sudden change is delirium until proven otherwise.
- **Missing hypoactive delirium.** Quiet, drowsy and withdrawn can be delirium too.
- **Assuming beliefs from ethnicity or religion.** Ask the individual what they observe.
- **Letting a child interpret.** Use a qualified interpreter and speak to the patient.
- **Saying "God never gives us more than we can handle."** False reassurance dismisses spiritual distress.
- **Telling a patient to stop a drug that causes sexual side effects.** Encourage discussion with the provider instead.

Chapter 19 self-test · ten items

1. A patient decides not to think about her biopsy results until after her daughter's wedding. Which defense mechanism is this?

A. Repression
B. Displacement
C. Denial
D. Suppression

D. Suppression Suppression is the only common defense mechanism that is conscious.

2. Which finding reflects the stress response through cortisol?

A. Blood glucose of 210 mg/dL after surgery in a patient without diabetes
B. Urine output that rises sharply on the first postoperative day
C. Pupils that constrict to light during the bedside assessment
D. A wound that heals faster than expected after the stressor

A. Blood glucose of 210 mg/dL after surgery in a patient without diabetes Cortisol raises glucose and slows healing; ADH and aldosterone lower urine output.

3. During which level of anxiety is patient teaching most effective?

A. Severe anxiety
B. Mild anxiety
C. Moderate to severe
D. Panic level

B. Mild anxiety At mild anxiety the perceptual field is widest and learning is easiest.

4. A patient in panic is screaming and running in the hall. What should the nurse do first?

A. Leave the patient alone until the panic has passed
B. Ask the patient to explain why they are so frightened
C. Keep the patient safe and give short, calm directions
D. Teach slow breathing exercises with a written handout

C. Keep the patient safe and give short, calm directions At panic level, safety and a calm, low stimulus approach come first.

5. Two older adults are both confused. Which finding points to delirium rather than dementia?

A. Memory loss that a family member reports at home
B. Older age and a history of high blood pressure
C. Trouble finding words during a long conversation
D. Sudden onset with impaired attention that fluctuates

D. Sudden onset with impaired attention that fluctuates Delirium is acute, fluctuating and impairs attention. Dementia is gradual with attention intact early.

6. A patient in isolation for two weeks has become withdrawn and disoriented. What is the most likely contributor?

A. Sensory deprivation
B. Role performance
C. Caregiver strain
D. Sensory overload

A. Sensory deprivation Isolation and too little meaningful input cause sensory deprivation.

7. A nurse is admitting a patient from a culture the nurse knows little about. Which approach reflects cultural humility?

A. Ask the family how people from their country usually behave
B. Ask what the illness means to the patient and who should be involved
C. Look up a list of beliefs for the group and apply it to care
D. Follow the routine plan because good care is the same for everyone

B. Ask what the illness means to the patient and who should be involved Humility means asking the individual rather than applying group traits.

8. How should the nurse speak during an interpreted conversation?

A. To the interpreter, about the patient
B. Loudly and slowly to the patient in English
C. Directly to the patient, in the first person
D. To the family member who speaks English

C. Directly to the patient, in the first person Face the patient, speak in the first person and let the interpreter voice the words.

9. A patient says, "God has abandoned me. I can't even pray anymore." What is the best initial response?

A. "God never gives us more than we can handle, you know."
B. "It sounds like you feel very alone with this. Tell me more."
C. "You should try praying again tonight before you sleep."
D. "Let's focus on your pain medicine schedule for now."

B. "It sounds like you feel very alone with this. Tell me more." Acknowledging the feeling and inviting more is therapeutic. The others dismiss, redirect or impose.

10. A caregiver of a spouse with dementia says, "I haven't slept in weeks. Sometimes I just yell at him." What should the nurse do first?

A. Suggest that she simply try to be more patient with him
B. Report her right away to the state for elder abuse
C. Tell her she is doing a great job and to hang in there
D. Assess her stress and the safety of both of them

D. Assess her stress and the safety of both of them Acknowledge the strain, assess safety, then arrange respite and referrals. Reporting follows the law if mistreatment is found.

CHAPTER 20

Loss, Grief and End of Life Care

Read it in full: **Chapter 20 in the textbook**. Practice it in the lab: **Grief Response Coach** and **The Last Hours and After**.

What to know

Loss is any change that takes away something valued. Types: **actual** (seen by others), **perceived** (felt by the person, such as lost independence), **maturational** (expected with development, such as retirement), **situational** (sudden, such as a crash), **anticipatory** (grief before the loss, as with terminal illness or advancing dementia) and **ambiguous** (unclear, such as a loved one with dementia who is present but not the same). **Grief** is the inner response, **mourning** its outward, cultural expression, and **bereavement** the state of having lost someone.

Grief theories help recognize responses but are not timetables: **Kübler-Ross** stages (denial, anger, bargaining, depression, acceptance) can be skipped, repeated or mixed; Bowlby's attachment theory; **Worden's tasks of mourning** (accept the reality, process the pain, adjust to the world without the person, find an enduring connection while moving on); the **dual process model** (moving back and forth between loss oriented and restoration oriented activity is normal); and continuing bonds. Most models come from Western populations, and many people are resilient.

Normal grief comes in waves: sadness, yearning, anger, guilt, poor sleep and appetite, chest tightness, and even briefly sensing or hearing the person who died. It eases over months and flares at anniversaries. **Prolonged grief disorder** is intense yearning or preoccupation with impairment lasting commonly at least **12 months** in adults (6 months in children). Delayed, exaggerated and **disenfranchised** grief (miscarriage, an ex spouse, a pet, suicide or overdose, a nurse's grief for a patient) need attention. Grief keeps self esteem; depression brings pervasive worthlessness. Any hopelessness prompts a direct suicide question.

Support grief with **presence**: sit down, listen, tolerate silence. Acknowledge the loss with the person's name and the word "died," reflect feelings, use open prompts ("Tell me about him"), normalize reactions, offer practical help and accept each person's way of grieving. Avoid "I know exactly how you feel," "She's in a better place," "At least...," "Be strong," "Don't cry" and "Why didn't you...?" Anger is often displaced onto staff; acknowledge it without defending, offer privacy and stay safe.

Children: preschoolers think death is reversible and may believe they caused it; school age children come to see it as final; adolescents understand it like adults and may show risk taking or withdrawal. Use concrete, honest words ("Grandpa died. His body stopped working"), not "went to sleep" or "we lost him." Reassure young children they did not cause it and will be cared for, answer repeated questions, offer choices about seeing the person with preparation, keep routines and expect regression.

Ask every family early about rituals, who should be present, who decides, who may touch or wash the body, burial timing and views on autopsy and donation, and find respectful compromises when policy conflicts. **Palliative care** relieves symptoms and supports decisions at any stage of serious illness, alongside curative treatment. **Hospice** is palliative care when the prognosis is about **6 months or less** if the illness runs its usual course and the patient chooses comfort focused care for that illness. It is mostly at home, needs certification by the attending physician (if any) and the hospice medical director, allows recertification, revocation and re enrollment, does not require a DNR order, has four levels of care (routine, continuous, general inpatient, respite) and gives the family bereavement support for about 13 months.

Hospice uses an interprofessional team: provider, RN case manager (assessment, symptoms, teaching, coordination), LPN, aide, social worker, chaplain, bereavement counselor, volunteers, pharmacist and therapists. Facilities that receive federal funds must ask adults about **advance directives** on admission. A **living will** states treatment wishes; a **durable power of attorney for health care** names an agent who uses substituted judgment; a **DNR** order means no CPR only, never "do not treat"; portable medical orders travel across settings. A patient with capacity decides even if family disagrees, and a verbal wish does not change code status until the provider writes the order.

Pain at the end of life: around the clock dosing plus breakthrough doses, opioids titrated with no ceiling, a stimulant laxative with every opioid, oral or buccal routes first, then subcutaneous or IV, never IM. Tolerance and dependence are not addiction. Sedation precedes respiratory depression, which is uncommon with gradual titration. The **principle of double effect** makes comfort dosing ethical even if an unintended effect could hasten death; titrated opioids have not been shown to shorten life. Medical aid in dying is a separate practice that follows state law, and a nurse may decline to take part while still giving care.

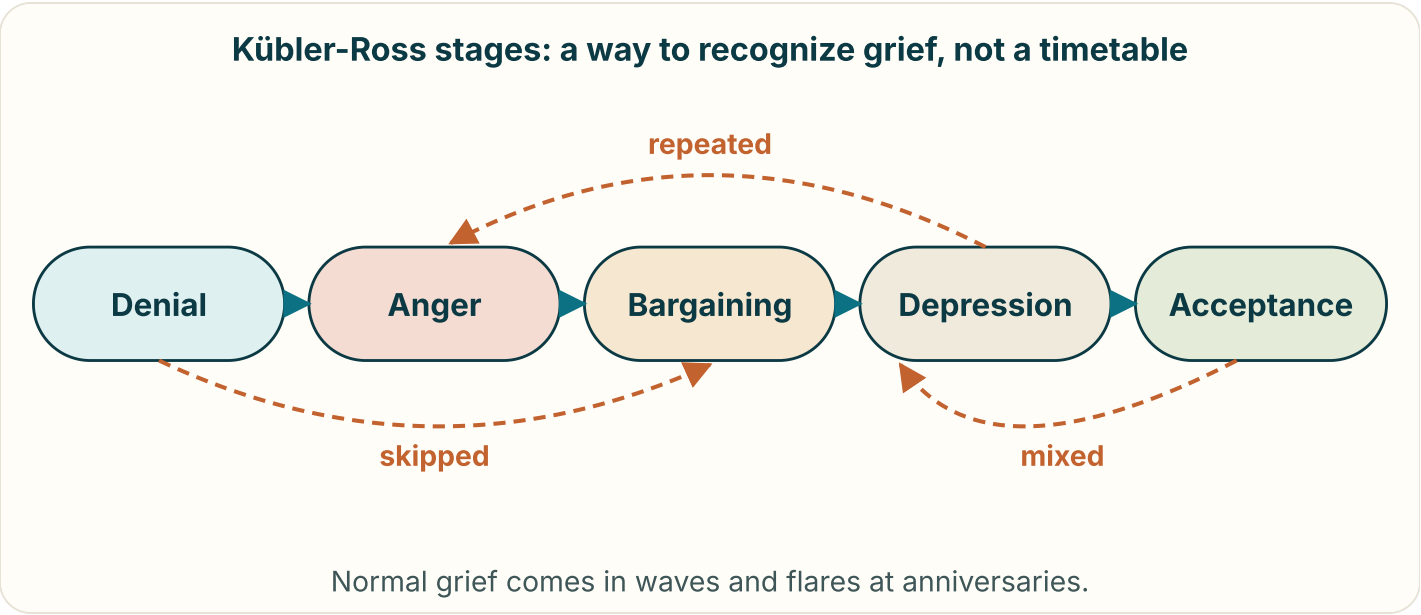
Dyspnea is what the patient reports, even with a normal SpO2. Sit upright or lean forward, use a **fan across the face**, keep the room cool, give low dose opioids (the most effective drug), oxygen if hypoxemic, anxiolytics when anxiety adds to it, and calm presence. **Terminal secretions** (death rattle): side lying with the head slightly raised, gentle oral suction only, anticholinergics (glycopyrrolate, scopolamine, atropine drops) started early, fewer IV fluids, and reassurance that the patient is usually not distressed; deep suctioning is avoided. **Terminal agitation**: check pain, full bladder, constipation, hypoxia and drugs first. Decreased intake is natural; mouth care relieves thirst better than fluids, and artificial nutrition in the last days does not improve comfort.

Signs of approaching death: cool, **mottled** skin starting at knees and feet, cyanosis, weak irregular pulse, falling BP, irregular breathing with **Cheyne-Stokes** pattern and apnea, secretions, more sleep, less responsiveness, sometimes a brief surge of alertness, little concentrated urine and incontinence. Hearing likely persists, so speak as though the person can hear. Encourage family to talk and touch, offer comfort items, ask whether to call them overnight and prepare them that

breathing may stop and start before it ends. Comfort is the priority; hourly vital signs, daily weights and pushing food are not.

Death is pronounced by circulatory and respiratory criteria or, in ventilated patients, by neurologic criteria (brain death), by those authorized under state law. Document the time, who was present, notifications, care of the body, belongings and release. **Algor mortis**: cooling about 1 C per hour to room temperature; handle skin gently. **Livor mortis**: blood settles in dependent areas within about 20 minutes to a few hours, so place the body supine with the head on a pillow. **Rigor mortis**: stiffening begins about 2 to 4 hours after death in the face and jaw and passes after 2 to 4 days, so close the eyes and mouth, insert dentures and position limbs first.

Before postmortem care, ask whether it is a **medical examiner** case (sudden, unexpected, violent or suspicious deaths, trauma or falls, deaths within 24 hours of admission or surgery in many places) or an autopsy is planned; if so, **leave tubes and lines in place**. Otherwise: privacy, gloves, supine with head elevated, eyes and mouth closed, tubes removed per policy, wash, clean gown, jewelry per family wish, unhurried family time, tags and transfer, belongings inventoried. Notify the **organ procurement organization** of every death or imminent death; trained requesters approach the family, not the bedside nurse alone. Tissue donation is possible for many more people. Nurses protect themselves from **compassion fatigue**, burnout and moral distress with debriefing, rituals, breaks, boundaries and support such as the employee assistance program.



The stages are not a timetable. People skip, repeat and mix the stages. Name what you see and support it; do not push anyone to the next box.

LOCK THESE IN

- Grief inner; mourning outward; bereavement the state of loss.
- Theories describe grief; they are not schedules.
- Prolonged grief: intense yearning with impairment about 12 months or more in adults.
- Presence and open questions; no clichés, "at least" or "why."
- Preschoolers think death is reversible; say "died," not "went to sleep."
- Palliative at any stage with treatment; hospice at 6 months or less with comfort goals.
- DNR means no CPR, not no care; a capable patient decides.
- Examiner case or autopsy: leave tubes in. Notify the OPO for every death or imminent death.

Key terms and comparisons: palliative care, hospice and directives

Item	Palliative care	Hospice
When it starts	Any time after a serious diagnosis	Prognosis about 6 months or less if illness runs its course
Curative treatment	Continues alongside	Stops for the terminal illness; comfort care continues
Setting	Hospital consults, clinics, home programs	Mostly home; also facilities and inpatient units
Family support	Included	Included, plus bereavement for about 13 months
DNR required?	No	No, though most choose one
Living will	States wishes for specific situations	Takes effect only when the person cannot decide
Health care agent	Named in a durable power of attorney	Decides using the patient's known wishes
DNR order	No CPR if heart or breathing stops	All other wanted care continues

Priority rules: end of life symptoms and after death

Item	Rule
Pain	Around the clock plus breakthrough; titrate opioids; laxative always; no IM
Dyspnea	Upright, fan across the face, low dose opioid, oxygen if hypoxemic
Terminal secretions	Side lying, mouth suction only, anticholinergic early; no deep suction
Terminal agitation	Check pain, bladder, bowels, hypoxia, drugs first
Approaching death	Mottling, Cheyne-Stokes, apnea, less urine; hearing may persist
Algor mortis	Cools about 1 C per hour; handle skin gently
Livor mortis	Supine, head on a pillow
Rigor mortis	Begins about 2 to 4 h; close eyes and mouth, dentures in first
Examiner case	Leave tubes and lines in place
Donation	Notify the OPO; trained requesters approach the family

Worked cases

WORKED CASE 1 · NORMAL GRIEF OR SOMETHING MORE

Mr. Haldane, 58, comes to clinic 18 months after his wife died in a car crash. He still sets her place at the table, cannot enter their bedroom, has stopped seeing friends and has not returned to work. He says, "There's no point to anything without her."

STEP 1 · CHECK THE TIME

Eighteen months is beyond the commonly cited 12 months for adults.

STEP 2 · CHECK THE IMPACT

Intense yearning, avoidance, loss of meaning and major impairment after a sudden, violent death.

STEP 3 · NAME IT

Consistent with prolonged grief disorder.

STEP 4 · ACT ON SAFETY

He voices hopelessness, so ask directly about suicidal thoughts, then refer to the provider and a grief specialist.

RULE

"Time heals all wounds" is false reassurance, and calling this a normal stage ignores the impairment.

WORKED CASE 2 · A CAPABLE PATIENT ASKS FOR DNR

Mr. Okonjo, 79, with advanced heart failure and full capacity, tells the nurse he wants a DNR order. His daughter says, "Dad, no. You have to let them try everything." The current order is full code.

STEP 1 · WHO DECIDES

He has capacity, so his wishes guide care.

STEP 2 · RESPOND TO BOTH

Acknowledge the daughter's fear and explain that the decision is his.

STEP 3 · NOTIFY

Tell the provider promptly so a goals of care conversation can happen and an order can be written.

STEP 4 · UNTIL THEN

He remains full code; a nurse cannot change code status from a verbal statement.

RULE

DNR means no CPR, not no treatment.

WORKED CASE 3 · TERMINAL SECRETIONS

Mrs. Ibarra, 72, in her last days with pancreatic cancer, has loud gurgling respirations. She is unresponsive with a relaxed face. Her son asks the nurse to "suction her lungs so she can breathe."

STEP 1 · RECOGNIZE

Terminal respiratory secretions in a patient showing no distress.

STEP 2 · POSITION

Turn her to the side with the head slightly raised.

STEP 3 · TREAT

Gently suction the mouth only if secretions are visible and give the ordered anticholinergic.

STEP 4 · TEACH

Explain that the sound is saliva in the throat, she is not choking, and deep suctioning would hurt without lasting benefit.

RULE

Deep suctioning or more IV fluid adds discomfort or more secretions.

WORKED CASE 4 · TIMING AFTER DEATH

Mr. Petrie dies at 0200 with a temperature of 37.0 C. The family will arrive at 0500. No examiner case or autopsy applies.

STEP 1 · ESTIMATE COOLING

At about 1 C per hour, by 0500 (3 hours) his body may be near **34 C** if the room is cooler, so the skin will feel cool and fragile.

STEP 2 · BEAT RIGOR

Rigor begins about 2 to 4 hours after death, so close the eyes and mouth, insert dentures and position the limbs soon after 0200.

STEP 3 · PREVENT LIVOR IN THE FACE

Place him supine with the head on a pillow.

STEP 4 · PREPARE THE ROOM

Wash, clean gown, tidy and dim the room so the family has unhurried time.

ALSO

Notify the organ procurement organization per policy; tissue donation may still be possible.

TRAPS PEOPLE FALL INTO

- **Calling a widow who briefly hears her husband's voice psychotic.** That can be a normal grief response.
- **Treating grief stages as a checklist.** People skip, repeat and mix them.
- **Telling a child that Grandpa "went to sleep."** Use the word "died"; euphemisms cause fear and confusion.
- **Mixing up palliative care and hospice.** Palliative care fits any stage with treatment; hospice needs about 6 months or less and comfort goals.
- **Reading DNR as "do not treat."** Only CPR is withheld.
- **Changing code status from a verbal wish.** The provider must write the order.
- **Deep suctioning terminal secretions.** Position, mouth suction and anticholinergics instead.
- **Removing tubes in an examiner case.** Leave them in place as evidence.
- **Asking the family about donation yourself.** Notify the OPO; trained requesters ask.

Chapter 20 self-test · ten items

1. A family member whose father has advancing dementia says, "He is here, but he is not really here." Which type of loss is this?

A. Situational loss
B. Ambiguous loss
C. Actual loss
D. Maturational loss

B. Ambiguous loss Ambiguous loss is unclear or unresolved, such as a person who is physically present but psychologically absent.

2. Two weeks after her husband died, a widow says she sometimes hears his voice. What is the best response?

A. "Many people sense their loved one after a death. Tell me about it."
B. "That is your mind playing tricks, so try to ignore it."
C. "I will ask the provider to arrange a psychiatric evaluation."
D. "You should be past that by now, so keep busy instead."

A. "Many people sense their loved one after a death. Tell me about it." Briefly sensing the deceased is a normal grief response. Normalize it and invite talk.

3. Which response is most therapeutic for a daughter whose mother just died?

A. "I know exactly how you feel, I lost my mother too."
B. "At least she did not suffer for very long at the end."
C. "She is in a better place now, so try not to cry."
D. "I am so sorry your mother died. Tell me about her."

D. "I am so sorry your mother died. Tell me about her." Acknowledging the death by name and inviting memories is supportive. The others minimize, shift focus or impose beliefs.

4. A 4 year old asks when her brother who died is coming home. What should the nurse say?

A. "He went away on a long trip and is very happy there."
B. "He went to sleep and will wake up again some day."
C. "He died. His body stopped working, and he cannot come back."
D. "You will understand all of this when you are older."

C. "He died. His body stopped working, and he cannot come back." Preschoolers think death is reversible. Plain, concrete words help; euphemisms confuse.

5. A patient receiving chemotherapy needs help with nausea and pain. Which service fits?

A. Palliative care
B. Respite care
C. Hospice care
D. Bereavement care

A. Palliative care Palliative care accompanies curative treatment at any stage. Hospice requires comfort focused care.

6. A patient with a DNR order develops pneumonia. What should the nurse expect?

A. Comfort care only, since DNR is in place
B. Transfer to hospice for the rest of the stay
C. Antibiotics and other wanted treatment continue
D. No treatment unless the family requests it

C. Antibiotics and other wanted treatment continue DNR covers CPR only. All other care the patient wants continues.

7. A dying patient is breathless with an SpO2 of 95%. Which measure is most likely to help?

A. Lying the patient flat to rest
B. Raising the oxygen to 10 L/min
C. Holding all opioid medication
D. A fan blowing across the face

D. A fan blowing across the face A fan, upright position and low dose opioids relieve dyspnea, which the patient reports even with normal saturation.

8. Which sign suggests death is approaching within hours to days?

A. A stronger and slower pulse
B. Mottled, cool knees and feet
C. Rising hourly urine output
D. Warm, flushed hands and face

B. Mottled, cool knees and feet Mottling, cool extremities, falling urine output and a weak pulse appear as circulation fails.

9. A patient dies 3 hours after arriving in the emergency department after a fall. What should the nurse do about the tubes and lines?

A. Leave them in place for the examiner
B. Remove them before the family visits
C. Remove only the endotracheal tube
D. Remove them after the family leaves

A. Leave them in place for the examiner Deaths after trauma soon after arrival are medical examiner cases. Tubes stay as evidence.

10. A patient has just died on the unit. Who should first approach the family about donation?

A. The unit clerk when forms are signed
B. The bedside nurse at the time of death
C. A trained organ procurement requester
D. The chaplain during the first visit

C. A trained organ procurement requester Hospitals notify the OPO, and trained requesters approach families.

ONE PAGE

Cram sheet

Chapters 19 and 20 on one page. Many items test the best response, so practice saying the right words aloud.

Psychosocial health, culture and spirituality

Item	Rule
Self concept	Identity, body image, role performance, self esteem
Stress response	Sympathetic seconds; cortisol hours; glucose up, healing down
GAS	Alarm, resistance, exhaustion
Coping	Problem focused vs emotion focused; suppression is conscious
Crisis	About 4 to 6 weeks; safety first; ask about suicide
Anxiety	Teach at mild and moderate; safety at severe and panic
Physical causes first	Hypoxia, hypoglycemia, pain, PE, withdrawal, drugs
Delirium vs dementia	Acute and fluctuating vs gradual and progressive
Sensory	Overload: cluster care, dim lights; deprivation: contact, aids
Culture	Humility; ask, do not assume; social determinants
Interpreter	Qualified, first person, never a child, document ID
Spirit and family	Presence, chaplain, ask about practices; caregiver strain needs respite

Loss, grief and end of life

Item	Rule
Terms	Grief inner; mourning outward; bereavement state
Prolonged grief	About 12 months or more with impairment in adults
Responses	Presence, name, "died," open prompts; no clichés
Children	Preschool thinks reversible; reassure they did not cause it
Hospice	6 months or less; comfort goals; no DNR required; about 13 months bereavement
Directives	Living will; health care agent; DNR is CPR only
Pain	Titrate opioids; laxative; double effect
Dyspnea	Fan, upright, low dose opioid
Secretions	Side lying, anticholinergic, no deep suction
Signs	Mottling, Cheyne-Stokes, apnea, less urine
After death	Algor 1 C per h; livor head up; rigor 2 to 4 h
Examiner and OPO	Leave tubes in; notify OPO for every death

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