Clinical Judgment in Caring for Adult Patients and their Families

This module focuses on the APRN's use of the nursing process to perform a comprehensive, multidimensional assessment of patients and families living with serious illness, as the basis for an interdisciplinary plan of care to achieve desired outcomes. Included is an emphasis on the role of the patient's and family's prognostic awareness, goals of care, and definitions of quality of life in developing palliative care plans. The module provides an overview of the etiology, specific assessment parameters, as well as evidenced based pharmacologic and non-pharmacologic management strategies for symptoms commonly experienced by patients with serious illness.
## Objectives

1. Describe a comprehensive multi-dimensional (physical, emotional, social, cultural, and spiritual) approach to the assessment of patients and families living with an advanced illness
2. Discuss the management of physical and psychological symptoms associated with advanced illness using pharmacological and non-pharmacological interventions

## Clinical Judgment in Caring for Adult Patients and their Families

### A. 34% of examination content
- Approximately 60 questions

### B. Content focus

1. APRN Assessment
   - Data Collection
   - History taking of the patient including problems, past medical history, social history, spiritual history, cultural history, pharmacological and non-pharmacological therapies, and a review of systems
   - Physical examination including mental status and functional status which are key elements in palliative care
   - Advanced care planning – the process and documents (surrogate decision makers, advanced directives, and out of hospital orders for live sustaining treatments [MOLST/POLST])
   - Coping and support of the patient and family

### Clinical Judgment in Caring for Adult Patients and their Families

2. Diagnosis and planning
   - Use of findings to develop diagnosis(es), a care plan, and mutually established patient, family, and team goals
   - Use of interdisciplinary team members in the care plan
   - Address physical, psychological, spiritual, and emotional aspects through the use of pharmacological and non-pharmacological interventions and, as appropriate, other technological interventions

3. Special situations
   - Withdrawal/withholding of life sustaining treatments
   - Palliative sedation
   - Hastening death

4. These will be covered under professionalism content where ethical principles are discussed
Assessment

History of Present Illness (HPI)
- Chief concern
- Reason for admission/visit
- Palliative review of systems
- Symptom review:
  - Location
  - Quality
  - Severity
  - Onset
  - Duration
  - Context
  - Modifying or exacerbating factors

History
- Past medical history
- Family medical history
- Social history
- Habits
  - Tobacco use
  - Alcohol use
  - Recreational drug use
  - Illicit substances use
Palliative Care Review

- Pain and Symptom History
  - Intensity (0-10)
  - Description
  - Interference with daily life (0-10)
  - Worst it's been in last 2 weeks (0-10)
  - Best in the last 2 weeks (0-10)
  - Medications and effect
- This assessment informs diagnosis and management

Question #1

Mr. Green is a 65-year-old gentleman with a history of CHF, COPD, and NSCLC Stage II. He comes to see you in the clinic for shortness of breath and pain in left shoulder. Your initial focus should be on:

A. His complaint of shortness of breath
B. His complaint of pain
C. Gathering more information with a review of systems
D. What his wife adds to his complaints


Additional Reading

Core Curriculum for the Advanced Practice Hospice and Palliative Registered Nurse, 2nd Edition

Chapter 18 – Neoplastic Conditions: Advanced Lung Cancer (p. 280)
Chapter 19 – Heart Failure: Assessment (p. 314)
Chapter 20 – Pulmonary Conditions: Staging of COPD (p. 334)
A Comprehensive Palliative Review of Systems

Constitutional: anorexia, drowsiness, fatigue, fever, weight loss, functional level, activity intolerance

Eyes: diplopia or other vision changes

Ears, nose, mouth, throat: secretions, xerostomia, mucositis, thrush, dysphagia, taste alterations

Cardiovascular: chest pain, LE swelling, paroxysmal nocturnal dyspnea, orthopnea, lymphedema

Respiratory: dyspnea, cough

GI: nausea/vomiting, abdominal pain, constipation, diarrhea, dyspepsia

GU: urinary retention, urinary incontinence, dysuria

A Comprehensive Palliative Review of Systems

Musculoskeletal: bone pain, joint pain, muscle pain, weakness, stiffness

Skin: pruritus, decubitus ulcers, dry skin, rash, bruising

Neurological: delirium, agitation, sedation, balance or gait issues, cognitive issues

Psychiatric: anxiety, depressed mood, hallucinations, insomnia, coping

Endocrine: steroid side effects, cold/heat intolerance

Allergic/Immunologic: immunosuppression, neutropenia

Hematological/Lymphatic: bruising, bleeding, anemia, lymphedema, lymphadenopathy

All other ROS have been reviewed and are negative

Question #2

Ms. Scarlett is a 36-year-old with ALS. She has been losing weight. In the morning, she consistently wakes up with headaches and confusion. After discussing symptom management, what would be an appropriate next step?

A. Talking to her spiritual counselor
B. Referring her to a psychologist
C. Referring her to a psychiatrist
D. Initiating advance care planning

Advance Care Planning

1) Healthcare surrogate: healthcare proxy, durable power of attorney for healthcare
   - Who is it? Does this person know the patient’s wishes?
   - Location of surrogate document – copies in the current chart, the primary care clinician’s office, with the family are all important

2) Advance directive: completed or not
   - Durable power of attorney for finances: different from healthcare surrogate

Advance Care Planning

3) Medical orders for life-sustaining treatment (MOLST/POLST, comfort care orders): patient may have different wishes about code status
   - In hospital
   - Out of hospital and at home

4) Other information
   - Attitude towards place of death: home or other place
   - Funeral arrangements/wishes: if any in place

Additional Reading

Core Curriculum for the Advanced Practice Hospice and Palliative Registered Nurse, 2nd Edition

Chapter 5 – Communication: Advance Care Planning (p. 65)
Question # 3
A 60-year-old gentleman with early dementia is admitted for chest pain and dyspnea. Work up reveals he may have CAD and pulmonary hypertension. After more education about his condition, he and his family would like to discuss the future. On which issue should the APRN first focus this discussion?

A. The APRN’s comfort and experience with end-of-life care  
B. His eligibility for the Medicare Hospice Benefit  
C. His and his family’s understanding of his illnesses  
D. In hospital do not resuscitate orders and out of hospital order for life-sustaining treatments


Additional Reading

Core Curriculum for the Advanced Practice Hospice and Palliative Registered Nurse, 2nd Edition

Chapter 15 – Psychosocial Issues  
Chapter 19 – Heart Failure  
Chapter 20 – Pulmonary Conditions  
Chapter 23 – Neurological Conditions

Information Sharing

• Patient’s awareness of illness: life-limiting, serious, not serious, no understanding  
  May need to consider cognitive limitations  
• Family’s awareness of illness: life-limiting, serious, not serious, no understanding  
• Cultural considerations to information sharing: if appropriate  
• Language considerations to information sharing: if interpreter is needed  
• This guides communication to palliative care team and the whole circle of care
Question # 4
You have been asked to talk with Mrs. White, a 56-year-old female with a new diagnosis of a brain tumor after she experienced a severe seizure. She tells you she does not want her family told. Your response is:

A. Tell her you will talk to the family privately to relieve her of that burden.
B. Explore her thoughts and feelings about family involvement.
C. Refer her to the psychologist since she may be incompetent to make these decisions.
D. Bring the family in when you meet with her the first time to identify the “elephant in the room.”


Additional Reading
Core Curriculum for the Advanced Practice Hospice and Palliative Registered Nurse, 2nd Edition

Chapter 4 – Ethical Considerations: Confidentiality (p. 42)

Spiritual History
Religious/spiritual orientation: ask if they practice a particular faith
Involvement in faith or spiritual community: yes or no
Desire for further chaplaincy support: yes or no
Social History

Marital status  Support system
Living situation  Patient/family coping
Employment  Financial issues
Education  Hobbies/joys

Social history may affect treatment

Social History and its Impact

Patient is a young mother  Patient is an older adult

• No family support  • Family support
• Lives in a shelter  • Lives in senior housing
• Is on state assistance  • Is on federal assistance

Physical Examination

Vital signs: T, HR, RR, BP, O, Sat
General appearance: development, nutrition, body habitus, attention to grooming, presentation
Eyes: EOMI, vision intact, sclera clear
Ears, nose, mouth, throat: hearing, examination of mucosa, teeth and gums, moistness, color, appearance of thrush/ulcers/redness/plagues, neck appearance, masses, position, thyroid examination
Cardiovascular: RRR S1S2, murmurs, rubs
Pulmonary: breath sounds, audible throughout, respiratory effect
Physical Examination

Gastrointestinal: bowel sounds present, soft or distended, non-tender, no HSM, no rebound, presence of ostomy or tubes, rectal exam as appropriate
Genitourinary: urination on own or use of Foley, or nephrostomy tubes
Lymphatics: neck, axillae, groin
Musculoskeletal: joint deformities, strength, pain/tenderness on palpation
Skin: rash, sores, bruises
Neurologic: II-XII grossly intact, strength and reflexes symmetrical
Psychiatric: orientation to person, place, and time; memory, mood, and affect

Question #5

An APRN assesses Professor Plum who has a history of heart failure. Which of the following symptoms would suggest worsening of his heart failure?

A. Fever, productive cough, chest pain
B. Constipation, dysgeusia, fatigue
C. Bradypnea, agitation, fever
D. Orthopnea, tachypnea, dyspnea


Additional Reading

Core Curriculum for the Advanced Practice Hospice and Palliative Registered Nurse, 2nd Edition

Chapter 19 – Heart Failure: Stages and Classification of Heart Failure (p. 314)
Chapter 19 – Heart Failure: Assessment (p. 314)
Diagnostics
Laboratory and Radiology

APRN must consider the risk/benefit/burden ratio of tests and procedures

Laboratory

• Blood Values
  - Important to know ranges

• Examples:
  - The CBC might look different in a patient with cancer vs a geriatric patient with anemia
  - Renal studies such as BUN, CRE, GFR may be different in a geriatric patient versus a patient with chronic kidney failure

Considerations

• What will the test do?
  - Diagnostic or treatment formulation
• Will it change the outcome?
• Is the procedure tolerable?
Question # 6
Mary is a 68-year-old woman who presents with increasing forgetfulness and declining executive function. What finding on a diagnostic brain CT as a part of her evaluation would most clearly suggest a diagnosis of dementia?
A. Brain swelling
B. Brain injury
C. Brain atrophy
D. Brain infections

Question # 7
Initial diagnostic tests to determine the etiology of altered mental status changes would include:
A. Urine cultures, serum electrolytes, and brain MRI
B. Mini-Mental Status exam and EEG
C. CBC, serum electrolytes, TSH, B12, and folate
D. Blood cultures, blood gases, and brain CT scan
Impression

- Age and sex of patient
- Pertinent palliative diagnoses and symptoms including etiologies

Example:
Ms. J is a 45-year-old female with stage IV breast cancer, dyspnea related to lung metastases, mucositis related to chemotherapy, skin rash at right axilla from radiation with new left shoulder bone pain from bone metastases

Intervention and Evaluation

Interventions and ExpectedOutcomes

- Identify resources
- Consider special populations – underserved or under-resourced:
  - Immigrants
  - Homeless
  - Dual diagnosis
  - Prisoners
  - Disabled
- Consider setting and realistic ability to implement the intervention
Recommendations/Plan

Ms. J is a 45-year-old female with stage IV breast cancer, dyspnea related to lung metastases, mucositis related to chemotherapy, skin rash at right axilla from radiation with new left shoulder bone pain from bone metastases.

Recommendations/Plan

• Separate out by symptom to demonstrate the complexity of decision-making and management
  – This also assists in more effective billing and reimbursement
• Include patient and family education/counseling, diagnostic testing, pharmacological and nonpharmacological interventions, referrals, follow up care

Example of Documentation for Mrs. J

1) Pain – probable bone pain r/t cancer
   • Will initiate a trial of opioids – morphine 5 – 10 mgs every 4-6 hours, prescription given for morphine elixir 10mg/5 ml solution for the amount of 100 mls given to husband
   • Patient will also try heat to area at night
   • Side effect of opioids explained to patient including drowsiness, constipation, and potential interference with cognition, counseled not to drive or operate equipment
   • Patient to call in 2 days to inform me how she is tolerating medication
   • If no relief in 5 days, return next week
Example of Documentation for Mrs. J

2) Constipation – opioid induced
   • Will initiate 2 senna tablets BID
   • If no consistent results within 3 days, will add polyethylene glycol 17 gms or 1 heaping teaspoon or capful with an 8 oz glass of water each morning

Example of Documentation for Mrs. J

3) Goals of care – patient wants to focus on quality of life
   • Will focus care and treatment on pain and symptom relief and not prolonging life

Example of Documentation for Mrs. J

4) Advance care planning
   • Counseled patient on the importance of a healthcare surrogate decision-maker, she will consider who this should be
   • Gave her the form to complete, I will follow up on this
   • Patient also wanted to explore advance directives, counseled on various forms and gave her website to download forms
   • She did not want to discuss out of hospital medical orders (POLST), will discuss next time
Example of Documentation for Mrs. J

5) Follow up plan
   • Time line of intervention and when it will change
   • Phone call, clinic, or home visit by visiting nurse, hospice nurse, or APRN

APRN Palliative Care Expertise

• High dose IV opioids
  ▪ When to use
  ▪ Considerations when IVs in place (e.g., limits of orders and concentration rates of pumps)
  ▪ Examples:
    • Morphine 20-50 mg/1 mL D5W
    • Hydromorphone 10-20 mg/1 mL D5W
    • Fentanyl drip
    • Lidocaine drip
  ▪ Conversion rates are given on exam
    • PO and IV rates
    • Morphine to hydromorphone
    • Morphine to methadone
Pain

- Identification of components of a pain assessment: history, physical examination, and diagnostic testing
- Develop a pain diagnosis, type of pain based on etiology and characteristics that impact management strategies
- Understand key terms used in pain management
- Utilize safe pain management practices

Pain

- Medical history
- Current medications
- Pain definition
- Pain etiologies
- Assessment of pain
- Physical examination
- Diagnostics
- Pain diagnosis
- Management

Pain Management

- Pharmacological interventions – understand the use of medications (opioids, non-opioids, adjuvants) for pain and how to prescribe them
- Interventions – understand the use of kyphoplasty, vertebroplasty, pain blocks, injections, and when appropriate for use
- Nonpharmacological interventions – understand the use of the variety of therapies and how to utilize them
Question # 8

Mrs. Peacock, is admitted to your hospice from home with past medical history of treatment for NSCLC with bony metastasis to the spine. She was discharged two weeks ago on morphine ER, 30 mg by mouth twice a day and morphine IR, 15 mg by mouth, every 4 hours as needed for breakthrough pain. She has a runny nose, tremors, goose flesh, irritability, diarrhea, and insomnia. Based on these symptoms, you would immediately assess for:

A. Fever and history of contact with people with the flu
B. Patterns of opioid escalation and frequent requests for drug renewal
C. Patterns of opioid use while at home and other of signs of opioid withdrawal
D. Additional signs of bony metastasis


Additional Reading

Core Curriculum for the Advanced Practice Hospice and Palliative Registered Nurse, 2nd Edition

Chapter 6 – Pain
Chapter 33 – Substance Abuse

Question # 9

Constipation is a frequent issue for patients with serious illness, particularly those receiving opioid medications. When constipation is present, which constipation/obstipation assessment is potentially harmful to a patient with a neutrophil count less than 500/mm³?

A. Plain abdominal (flat plate) x-ray
B. Rectal exam for hemorrhoids or impaction
C. Abdominal exam (e.g., presence of distention, firmness, bowel sounds)
D. Lab tests such as blood urea nitrogen, calcium, potassium, and thyroid stimulating hormone

Question # 10

Your elderly patient, Mr. Wood, reports recurring nausea, anorexia and abdominal pain over last week. He is under your care for Stage IV CHF, with an EF=15%. He is taking lisinopril 40 mg PO, QD; furosemide 60 mg, BID; and metoprolol 75 mg PO, BID. Mr. Wood has a pacemaker, is on 4L home O2, and hydrocodone 2.5 mg/acetaminophen 500 mg, 2 tabs PO every 4 hours for arthritis pain. His labs indicate: K 3.1, Na 138, BUN 43, Cr 4.2, bill < 2. Based on the abnormal findings, you suspect that the patient is showing signs of :
A. Overuse of acetaminophen
B. Fluid and electrolyte imbalance
C. Escalation of the arthritis pain
D. Hepatorenal syndrome


Question # 11

Substance abuse in palliative and hospice care is a growing problem. Of the following, which is an indication of substance use disorder in a palliative care patient making frequent requests for escalation in opioid pain medication?
A. The patient is opioid naïve and is reluctant to try any medications
B. The patient has a condition that contributes to the escalation of pain
C. The patient exhibits anxiety and depression in association with his/her pain
D. The patient requests one specific type or brand of opioid medication stating all others fail


Non-Pain Symptoms
### Common Symptoms by System

- **HEENT** – diplopia, thrush, mucositis, dysphagia
- **Cardiac** – angina, edema, dysrhythmias
- **Respiratory** – dyspnea, cough, secretions, sleep apnea, orthopnea
- **Gastrointestinal** – constipation, diarrhea, anorexia, ascites, hiccups, bowel obstruction, nausea/vomiting, taste changes
- **Genitourinary** – bladder spasm, urinary retention, incontinence, dysuria

### Common Symptoms by System

- **Musculoskeletal** – pathological fractures, spasms, weakness
- **Skin and mucus membranes** – pruritus, mucositis, stomas, fistulas, fungating wounds, pressure ulcers, edema
- **Neurological** – seizure, myoclonus, encephalopathy, impaired communication, dysphagia, paresthesias, paralysis

### Common Symptoms Across Conditions

- **Psychiatric/psychological** – anxiety, depression, delirium, fear, suicidal ideation, agitation/restlessness
- **Spiritual/existential** – distress, hopelessness, death anxiety, grief, suffering
- **Nutrition and metabolic** – anorexia/cachexia, dehydration, electrolyte imbalance
- **Fatigue/asthenia**
- **Insomnia**
- **Lymphedema**
- **Complications of therapy** (e.g., drug reactions, radiation, chemotherapy, surgery)
ACHPN Review Course – Clinical Judgment in Caring for Adult Patients and their Families
Hospice and Palliative Nurses Association

Symptoms
• Critical components of a symptom assessment including potential etiologies, history, physical examination, and diagnostic testing
• Develop a plan based on etiology and characteristics that impact management strategies
• Appreciate the use of pharmacological therapies, nonpharmacological symptom management and interventional strategies as appropriate
• Appreciate symptom management practices from an evidence-based perspective

Dyspnea Potential Etiologies
• Heart failure, pulmonary edema
• Superior vena cava syndrome
• Pulmonary conditions
  • Asthma, COPD
• Pulmonary embolism
• Stroke
• Neurological conditions
  • ALS, MS
• Anemia
• Tracheal compression
• Acute renal failure
• Pneumonia
• Obesity
• Deconditioning
• Lung cancer
  • Pleural effusions

Dyspnea Diagnostic Work Up
• Laboratory studies:
  • CBC, electrolytes
• Pulse oximetry
• Chest radiograph
• Chest MRI
• Blood culture;
Dyspnea

- Pharmacologic treatments
  - Opioids
  - Bronchodilators
  - Diuretics
  - Steroids
  - Transfusion

- Other treatments depending on diagnosis
  - Radiation
  - Stent

Dyspnea

- Nonpharmacological Interventions
  - Oxygen
  - Counseling
  - Pursed lip breathing
  - Energy conservation
  - Fans, elevation

Question #12

Patient self-report of dyspnea is considered the “gold standard” in history and assessment. However, patients will not commonly use the term “dyspnea.” The most informative assessment question an APRN can ask an alert palliative COPD patient is:

A. Are you gasping for breath frequently today?
B. How well are you able to breathe on your 6-minute walk each day?
C. Can you rate your breathing on a scale of 1-10; 1 being no shortness of breath and 10 being the most breathless you can imagine?
D. Are you short of breath?

Additional Reading

Core Curriculum for the Advanced Practice Hospice and Palliative Registered Nurse, 2nd Edition

Chapter 7 – Dyspnea: Dyspnea Assessment (p. 98)
Chapter 20 – Pulmonary Disease

Question # 13

For dyspnea in the palliative care patient with COPD, which of the following are considered first line, medical management?

A. Antibiotics
B. Inotropes and diuretics
C. Oxygen, bronchodilators, and anti-inflammatory drugs
D. Calm, supportive presence, elevation of the head of the bed, and use of a fan


Additional Reading

Core Curriculum for the Advanced Practice Hospice and Palliative Registered Nurse, 2nd Edition

Chapter 7 – Dyspnea: Dyspnea Assessment (p. 98)
Chapter 20 – Pulmonary Disease: Table 1: Assessment Findings in COPD (p. 334)
Chapter 20 – Pulmonary Disease: Table 3: COPD Treatment Recommendations (p. 337)
Fatigue

- Medical history
- Current medications
- Symptom definition
- Symptom etiologies
- Assessment of symptom
- Physical examination
- Diagnostics
- Symptom diagnosis
- Management

Fatigue Potential Etiologies – Multifactorial

- Cancer related fatigue – reported in 60% to 90% of patients
- Sleep disorders
- Anemia
- Electrolyte imbalances
- Malnutrition
- Infection – fever
- Pain
- Organ failure (heart, lungs, kidneys, liver)
- Adverse environment (heat or cold extremes)
- CNS injury
- Medication
- Deconditioning – immobility
- Dehydration
- Hypoxia
- Endocrine alterations:
  - Thyroid function
  - Testosterone levels


Fatigue Potential Etiologies – Multifactorial

- Treatment related – drug therapy, radiation, and surgery
- Unrelieved symptoms (such as diarrhea, constipation, and vomiting)
- Insomnia from anxiety
- Psychological response to illness can lead to impaired ability to participate in activities of daily living (e.g., sense of loss, loss of role)
- Psychological and spiritual distress, and/or depression
Treatment of Fatigue

• Treat other symptoms such as depression or insomnia
• Stimulants
• Transfusion
• Oxygen
• Thyroid replacement
• Rehabilitation referral – PT, OT

Question #14

While there are many causative and complex etiologies in regard to fatigue, initiation of pharmacological treatment should be based on:

A. Fatigue symptom burden and patient/family goals of care
B. The patient’s psychological adaptation to illness
C. The degree to which fatigue impacts the family’s daily activities
D. Treatment of the patient’s underlying anxiety and depression

Nausea and Vomiting

• Medical history
• Current medications
• Symptom definition
• Symptom etiologies
• Assessment of symptom
• Physical examination
• Diagnostics
• Symptom diagnosis
• Management
### History

- Pattern, frequency and duration of nausea
- Consistency, frequency, volume and contents of emesis, presence of blood
- Emesis associated with position changes
- Vomiting occurring without nausea
- Presence of contributing factors to nausea and/or emesis (i.e., vertigo, changes in blood sugar levels, odors, medications, pain, distention)
- Initiation of new treatments

### History

- Relationship of nausea and/or vomiting to food intake or medications
- Evaluation of the presence of constipation or impaction
- Presence of uncontrolled pain or infection
- Presence of anxiety and other emotional symptoms

### Pharmacologic Treatment of Nausea and Vomiting

- Anticholinergics
- Antihistamines
- Steroids
- Prokinetic agents
- Serotonin agonists
- Phenothiazine
**Question # 15**

Nausea and vomiting history is important for understanding causation and treatment. Which of the following causative factors are associated with nausea and vomiting with position changes?

A. Intra-abdominal cancers and constipation  
B. Motion sickness and vestibular problems  
C. Biliary obstruction and hypercalcemia  
D. Abnormal blood sugar levels and sepsis


---

**Depression**

- Medical history  
- Current medications  
- Symptom definition  
- Symptom etiologies  
- Assessment of symptom  
- Physical examination  
- Diagnostics  
- Symptom diagnosis  
- Management

---

**SIG-E-CAPS or SIG: Energy Capsules**

Adapted from Carey Gross, MD., 1998

S Sleep disorder (either increased or decreased sleep or altered), sexual function (loss of interest)  
I Interest deficit (anhedonia, loss of engagement or pleasure in life)  
G Guilt (worthlessness, hopelessness, regret, or inappropriate guilt)  
E Energy deficit (loss of energy not due to illness) with fatigue  
C Concentration deficit (inability to carry out cognitive tasks) resulting in inability to work  
A Appetite disorder (either decreased or increased with changes in weight)  
P Psychomotor alteration (retardation or agitation)  
S Suicidalty (ideation, plan, or attempt)
### Depression Assessment

- **Question 1:** Are you depressed?
- **Question 2:** Have you felt down or blue in the last month?

- **Other Questions:**
  - How have your spirits been lately?
  - How would you describe your mood today?
  - How are you sleeping lately?
  - What is your energy level?
  - What do you see in your future?
  - What is the biggest problem you’re facing?
  - Can you concentrate as well as you usually could?

### Suicide Risk Assessment

- Do you ever think that life is not worth living?
- Do you find yourself wishing you would die more quickly?
- Have you thought about killing yourself?
- Have you discussed this with anyone?
- Are you thinking of that now?
- How have you thought you would do this?
- Do you have a plan?

### If YES to any questions

- Need to explore further
- **Must assess safety of patient**
- Call mental health colleagues for consultation
Treatment

• Pharmacological for palliative care
  - Antidepressants – citalopram, sertraline, mirtazapine, TCAs
  - Stimulants – methylphenidate, dextroamphetamine
• Electroconvulsive shock therapy
• Cognitive behavioral therapy
• Spiritual support
• Other

Question #16

Depression in life-limiting illness is common and can be associated with many medications. Of the following, which medication category most often precipitates depressive symptoms?

A. Steroids
B. Antipyretics
C. Atypical psychiatric medications
D. Opioids


Question #17

For the patient with only hours to days to live, what intervention by the APRN would most likely be effective for managing depression?

A. Aggressive treatment of pain and other distressing symptoms
B. Introduction of a serotonin-specific reuptake inhibitor such as sertraline or escitalopram
C. Introduction of a psychostimulant such as dextroamphetamine or methylphenidate
D. Patient and family education and reassurance

Clinical Judgment Summary

- APRNs must have expert assessment and management skills and incorporate palliative care specific areas in the following:
  - History taking
  - Obtaining a palliative specific review of systems
  - Performing a comprehensive physical examination
  - Attending to the range of palliative symptoms
  - Ordering and interpreting diagnostic testing appropriate to the patient's situation and goals of care
  - Developing an impression of diagnoses with differentials
  - Implementing treatment plans that are specific to the patient, his/her underlying disease/condition, the symptom and its etiology

Resources


HPNA Compendiums

For more detail:
- Dementia
- Heart Failure
- Hepatic
- HIV/AIDS
- Neurological Diseases and Trauma
- Pulmonary
- Renal
Resources

HPNA POSITION STATEMENTS
http://hpna.advancingexpertcare.org/education/position-statements/
• The Nurse’s Role in Advance Care Planning
• Complementary Therapies in Palliative Care Nursing Practice
• Pain Management
• Ethics of Opiate Use Within Palliative Care
• The Use of Medical Marijuana
• Spiritual Care