End of Life, Hospice, Pain and Sleep

Signs that death is near, comfort in the last days, around-the-clock opioids, fentanyl patches and PCA, pain without self-report, sleep, fatigue and postmortem care for the NCLEX

PALLIATIVE CARE AND HOSPICE

	PALLIATIVE CARE	HOSPICE
When	Any age, any stage of serious illness	Prognosis about 6 months or less if the illness runs its usual course
Disease treatment	Continues alongside	Stopped; comfort and quality of life are the goal
Where	Hospital, clinic, home	Mostly home; also nursing home, hospital, hospice unit
Family	Supported throughout	Team on call 24/7, respite, bereavement support for about a year after the death (up to 13 months, CaringInfo)

EXAM TIP PN role: collect data (pain, breathing, intake, output, skin), give scheduled and as-needed doses as prescribed, reinforce the RN's teaching and report changes. Hold a dose only for an adverse effect, then report; dose changes belong to the prescriber.

SIGNS THAT DEATH IS NEAR

NCI PDQ: late signs are specific but often absent, and many clients keep normal vital signs into the last 12 hours.

TIMING	SIGNS
Weeks to days (early)	Sleeps more, harder to rouse; eats and drinks less; trouble swallowing liquids
Last hours to about 3 days (late)	Cheyne-Stokes breathing or pauses; jaw moves with each breath; noisy secretions; no radial pulse; urine 200 mL a day or less; nonreactive pupils; cool, blue or gray hands and feet

- Hearing may last: speak calmly, touch, explain care as if the client hears
- Eating less is expected: offer tastes and sips only when wanted; forcing food risks aspiration
- IV fluids near death did not ease symptoms or prolong life; large volumes add secretions

COMFORT IN THE LAST DAYS

PROBLEM	NURSING CARE
Noisy secretions (death rattle)	Side-lying, head raised; gentle mouth suction only; prescribed anticholinergic (benefit unproven); limit IV fluids; explain the sound to family
Restlessness, moaning, picking	First check pain, full bladder, constipation, drug effects; calm quiet room with a soft light, familiar voices; haloperidol or benzodiazepine as prescribed; no restraints
Dyspnea	Head up, fan on the face, calm room; opioid as prescribed; oxygen only if it helps
Dry mouth, lips, eyes	Moist swabs, ice chips or sips if wanted, lip balm; keep open eyes moist

SAFETY Slow breathing with pauses on a stable opioid dose, without pinpoint pupils, is the dying pattern: give the scheduled comfort dose and explain it. Titrated opioids have not been shown to shorten survival.

OPIOIDS: AROUND THE CLOCK AND BREAKTHROUGH

- Constant pain: scheduled or long-acting doses, not as-needed only
- Flare: give the prescribed immediate-release dose now; reassess within 1 hour
- Breakthrough doses needed often, or pain plus intolerable side effects: report for a regimen change
- Tolerance and physical dependence are expected; addiction is uncommon in cancer pain

EFFECT	NURSING ACTION
Constipation (no tolerance)	Stimulant laxative (senna, bisacodyl) from the first dose while the opioid continues; softener alone is not enough; no bulk fiber
Nausea	Antiemetic; tolerance usually builds within days, NCI says within 1 week
Sedation	Common at start and after increases; rising sedation comes before slow breathing: hold, report
Respiratory depression	Rare with careful titration; stimulate, support breathing, naloxone titrated slowly
Neurotoxicity	Jerking, hallucinations, pain from light touch or rising with each increase: hold escalation, report; kidney failure raises the risk with morphine

FENTANYL PATCH, PCA AND SPINAL PUMPS

- Patch: opioid-tolerant clients with constant pain only; never for acute or postoperative pain
- Levels rise over 12–24 h, peak at 20–72 h; change every 72 h; first increase no sooner than 3 days
- Clip hair, do not shave; clean with water only; press 30 s; new site each time
- Used or loose patch: fold sticky sides together and flush; keep away from children
- PCA: only the client presses the button, never family or nurse; check settings and amount used at every handoff
- Intrathecal or epidural catheter: new leg weakness or numbness is reported at once

SAFETY Heat over a fentanyl patch has caused fatal overdoses: no heating pad, electric blanket, heat lamp, hot tub, sauna or hot bath. Fever raises levels too (about one-third at 40 °C): plain blankets, watch sedation and breathing, report for a dose review.

PAIN WITHOUT SELF-REPORT; NON-DRUG COMFORT

Self-report first. When it is not possible, watch behavior: face, sounds, body tension or guarding, breathing, consolability, change from routine (refusing food, agitation). Ask family about the person's own pain behaviors and add them. PAINAD (advanced dementia) scores five behaviors 0–2 each, total 0–10. Treat, then rescore with the same tool.

Non-drug measures add to prescribed analgesics and antiemetics; they do not replace them.

MEASURE	HOW
Heat	5–20 min as tolerated; never over a fentanyl patch
Cold	No longer than 20 min, wrapped
Touch, position	Massage a few minutes; support limbs; move slowly
Chronic pain	Physical therapy and gentle activity may improve pain and function (NCI); stretching; not strict bed rest
Mind-body	Relaxation breathing, guided imagery, music, distraction, prayer
Nausea	Small bland room-temperature meals, no strong odors, acupressure wrist bands, relaxation; ginger evidence mixed

SLEEP, INSOMNIA AND FATIGUE

- Hospital: cluster night care, dim lights, less noise, earplugs or eye mask, home routines
- Sleep hygiene: same wake time; cool, dark, quiet room; no screens; caffeine, nicotine, alcohol not near bedtime; avoid naps
- Chronic insomnia: CBT-I first (AASM, strong); sleep hygiene alone is not enough
- CBT-I: bed only when sleepy; get up when unable to sleep; time in bed cut to actual sleep time, then lengthened
- Older adults: avoid diphenhydramine PM products and benzodiazepines (sedating, anticholinergic)
- Cancer fatigue is not fully relieved by rest: treat causes (anemia, pain, depression, poor sleep, drugs); moderate activity; key tasks at peak-energy times with short rests

AT AND AFTER DEATH

- Confirm death per policy (apical pulse for 1 full minute); note time, who was present, provider notified
- Every death and imminent death is referred to the OPO; only the OPO or a trained requester asks the family
- Family time first, unrushed; honor cultural and religious practices
- Body supine and aligned, head on a pillow, eyes and mouth closed, dentures in; clean, pad, dress wounds
- Tubes and lines out unless a coroner case (then left in per policy); ID tags after the family leaves
- Rigor mortis peaks at 12–18 h, gone by 48 h

EXAM TIP Grief: presence and listening are the core intervention; denial, anger, bargaining, depression and acceptance come in any order. Report suicidal thoughts or grief that disables daily life.

Sources (23) are listed with links at rnbasics.com/sheets/end-of-life-ward.html. For education and exam preparation only. Not medical advice; follow current guidelines and your institution's protocols. RN Basics is an independent study aid not affiliated with any certifying body.