PROFESSIONAL PROCESS

GOALS/OUTCOMES:

A. Patient will demonstrate outcomes below:
   1. Comfort/Pain control.
   2. Peace and preservation of dignity during the dying process.
B. Patient/family/significant other (S.O.) will verbalize and/or demonstrate an understanding of teaching/learning goals listed below:
   (Document evaluation on Education Outcome Record).
   1. Personal signs/symptoms related to the dying process.
   2. Methods to promote comfort.
   3. Techniques to modify and/or prevent distressing symptoms.
   4. Healthy coping methods (e.g., verbalize feelings, problem solving techniques).
   5. Lifestyle alterations, present and future (e.g., family role changes, life review).
   6. Generic Goals (room/unit routine, pain, medication, diagnostic tests/procedures, dietary modification, hygiene/infection prevention, rehabilitation, medical equipment/supplies, tobacco cessation, resources for support).

ASSESSMENT/INTERVENTIONS/CLINICAL REASONING/DECISION-MAKING:

A. Assess and document readiness and ability to learn, learning needs and preferences. (Refer to Teaching/Learning Assessment on Education Outcome Record).
B. Collaborate with resources related to significant changes in patient status and for the continuum of care (e.g., Family Members, Nursing, Physician, Pastoral Care, Social Work/Services, Pharmacy, Palliative Care Team, Advanced Practice Nurse, Ethicist, Hospice Liaison, Child Life, Medical Interpreter).
C. Mutually plan/develop goals, assess and document progress toward goals.
D. Implement appropriate interventions as follows and document:

1. Correlate physical status and presence of distressing symptoms to disease process, medications and baseline assessment data. Provide comfort and manage distressing symptoms:
   - Pain: Develop plan for pain control including pharmacologic and nonpharmacologic measures (e.g., medications, positioning, heat/cold applications, music, guided imagery, environmental adjustments).
   - Dyspnea: Evaluate respiratory status and provide supportive interventions [e.g., fan to face for air movement; position to promote ventilation/perfusion, mobilization or reduction of secretions; evaluate the need for medications/oxygen (O2)].
   - Dysphagia: Evaluate safety of oral intake and the need for dietary modifications (e.g., ice chips, fluid sips, hydration; patient request for favorite foods).
   - Gastrointestinal Distress:
     - Nausea and vomiting (N/V): prevent and/or treat [e.g., elimination of noxious odors, provide adequate oral care, dietary consultation, reassurance to patient that opioid-induced nausea can be temporary, antiemetics chemoreceptor trigger zone (CTZ) inhibitors, agents to promote gastric emptying, 5HT3-receptor antagonists], possible opioid rotation, adjustments to IV fluids/enteral feeding, evaluate the need for nasogastric tube].
     - Constipation: prevent constipation, obstipation/fecal impaction via appropriate levels of hydration, providing privacy for defecation, scheduled use of stool softeners and laxatives.
     - Diarrhea: review use of laxatives and other medications (e.g., magnesium-containing antacids, antibiotics, chemotherapeutic agents) as patient nears end of life. Assess for fecal impaction.
     - Ascites: anticipate sodium restricted diet, fluid restriction, diuretic management and paracentesis.
   - GI/genitourinary (GU) elimination:
     - Incontinence: support GU/GU elimination with appropriate measures to protect skin (e.g., skin barrier cream, padding for incontinence, indwelling catheter, male external catheter)

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• Urinary retention: assess via physical examination or postvoid residual ultrasound. May be caused by denervation disorders, spinal cord compression and/or by bladder outlet obstruction. Condition may be exacerbated by various medications. Provide for complete emptying of bladder via either intermittent or indwelling urinary catheter.

• Bladder spasms: may be caused by irritation of bladder trigone, radiation, infection, blood/clots, stones, catheters, or tumor invasion. Cause-directed interventions include deflation of catheter balloon, treatment of urinary tract infection (UTI) with antibiotics, increased fluids (if possible) to relieve discomfort, or antispasmodics.

• Delirium:
  – Develop plan to relieve symptoms of delirium [e.g., evaluate current psychoactive medications; hydration status; adjust environmental stimuli (e.g., provide familiar objects/persons, soothing music, reduce noise, lighting)].
  – Evaluate the need for pharmacologic management.
  – In patients suffering delirium due to underhydration, anticipate bolus IV hydration or hypodermoclysis (HDC-subcutaneous hydration method).

• Opioid-related side effects:
  • Pruritis and flushing: anticipate need for antihistamines.  
  • Myoclonus: assess for presence of multifocal myoclonus and provide comfort measures (e.g., positioning, pillow support, anticipate the need for pharmacologic management with benzodiazepines and/or opioid rotation).

2. Correlate patient/family/S.O. psychosocial and spiritual needs to dying process and provide supportive interventions:
• Support patient expression of end-of-life care choices (e.g., termination of life sustaining measures, hospice care, dying at home).
• Identify with patient/family/S.O. any unresolved personal or spiritual issues and the need for spiritual assistance based on patient’s associations/beliefs.
• Identify behaviors that demonstrate ineffective coping and assist patient/family/S.O. with decision making/coping strategies.
• Support family in their interactions with dying person (e.g., providing privacy, assist in personal care, presence according to patient preference).
• Facilitate life review bringing emphasis to dying person’s positive contributions and place in the family.
• Provide factual information about patient’s status to patient and/or family, along with appropriate printed materials suitable to developmental level, cultural preferences and communication patterns.
• Utilize counseling to promote discussion of fears/concerns and impact of this person’s dying.
• Support the family/S.O. in maintaining own health (e.g., eating well, adequate rest, physical activity, routine).

Clinical Practice Guidelines represent a consistent/standardized approach to the care of patient’s with specific diagnoses. Care should always be individualized by adding patient specific information to the Plan of Care and by identifying psycho-social, cultural, sexual, age-appropriate, developmental, and spiritual needs related to the person’s human response

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GENERAL INFORMATION: ACTIVELY DYING PATIENT

A. DEFINITION: Patient has life expectancy of only a few days or hours and is expected to die during this hospitalization. Changes are largely physical, but the process influences, and is influenced by, all spheres of personhood and relationships.

B. RELATED/RISK FACTORS ASSOCIATED WITH A DIFFICULT DYING PROCESS:

PERSONAL
- Age/developmental level
- Personality (e.g., optimist, accepting, controlling)
- Values/beliefs (e.g., mortality)
- Culture/religion (e.g., hope, future beyond dying, fatalist)
- Emotional state (e.g., depression, anxiety, grief history, fear, denial, anger)
- Emotional bonds/support, completion of relationships
- Unresolved personal conflicts
- Family role (e.g., decision maker, provider, caregiver, parent or child)
- Family dependencies (e.g., financial, care giving, leadership)
- Spiritual or existential distress
- Self-worth, life review
- Family communication patterns

ENVIRONMENTAL
- Intensive care (e.g., sensory overload, limited visiting opportunity, philosophical stance of staff in delivery of care, staff level of comfort conveying “bad news”)
- Inconsistencies of personnel in enforcement of hospital’s “house rules” (e.g., visiting hours, overnight stays, number of visitors in room)
- Lack of/ separation from interpersonal or spiritual support systems

PHYSIOLOGICAL
- Complexity of condition
- Ventilator-dependent
- State of consciousness
- Unmanaged distressing symptoms (e.g., pain, shortness of breath, intractable N/V)

TREATMENT RELATED
- Medication induced delirium
- Body chemistry alterations (e.g. fluid/electrolyte imbalance) due to drugs, disease or treatments (e.g., radiation, chemotherapy).

C. SIGNS AND SYMPTOMS:

Common Symptoms:
- Profound weakness
- Dependency in all activities of daily living
- Reduced awareness, insight, perception
- Drowsiness for extended periods of time
- Shortened attention span
- Frequently disoriented regarding time and place
- Disinterest in/withdrawal from daily routines and social contacts
- Disinterest in/withdrawal from food or fluid intake
- Progressive difficulty swallowing
- Gaunt and pale or gray physical appearance
- Vital sign changes: dropping BP, increased heart rate, cool extremities/mottling of dependent areas, erratic variations in body temperature
- Irregular respiratory pattern, variations of rate/depth with compromised oxygenation
- Inability to clear oral secretions
- Bowel incontinence/constipation/impaction.
- Bladder incontinence/spasm/urinary retention
- Heightened awareness of life transition

Distressing Symptoms:
- Pain
- Dyspnea
- N/V
- Delirium
- Terminal agitation/restlessness
- Multifocal myoclonus
D. PATHOPHYSIOLOGY OF SYMPTOMS:

- Delirium: sudden, fluctuating, and usually reversible cognitive disorder characterized by disorientation, the inability to pay attention, the inability to think clearly, and a change in the level of consciousness. Delirium is an abnormal mental state, not a disease. It may be caused by tumor, cerebral edema, presence of opioid metabolites, renal or hepatic failure. Hyperdelirium presents with agitation or restlessness. Hypodelirium presents as confusion or sedation.\(^5\) \(^6\)

- Pruritis and flushing: severe itching related to opioid-induced histamine release.

- Ascites: pathologic accumulation of fluid in peritoneal cavity resulting in abdominal pain/discomfort, anorexia, dyspepsia, dyspnea and lower extremity edema.\(^7\)

- Myoclonus: twitching or clonic spasm of a muscle or group of muscles.

E. SAFETY CONSIDERATIONS AND INITIATIVES:

1. Pain:

   The Joint Commission 2009 Hospital Accreditation Standards:

   - Provision of Care: **Standard PC.01.02.07**: The hospital assesses and manages the patient’s pain.
   - **Standard PC.02.03.01**: The hospital provides patient education and training based on each patient’s needs and abilities.
   - Rights and Responsibilities of the Individual: **Standard RI.01.01.01**: The hospital respects patient rights.

   The Joint Commission International Accreditation Standards for Hospitals, 3\(^{rd}\) ed:

   - Patient and Family Rights: **Standard PFR.2.4**: The organization supports the patient’s right to appropriate assessment and management of pain.
   - Assessment of Patients: **Standard AOP.1.8.2**: All patients are screened for pain and assessed when pain is present.
   - Patient and Family Education: **Standard PFE.4**: Patient and family education include the following topics, as appropriate to the patient’s care: the safe use of medications, the safe use of medical equipment, potential interactions between medications and food, nutritional guidance, pain management and rehabilitation techniques.


2. End of Life/Palliative Care:

   The Joint Commission 2009 Hospital Accreditation Standards:

   - Provision of Care: **Standard PC.02.02.13**: The patient’s comfort and dignity receive priority during end-of-life care.
   - Rights and Responsibilities of the Individual: **Standard RI.01.05.01**: The hospital addresses patient decisions about care, treatment, and services received at the end of life.

F. Refer to Grieving, Actual/Anticipatory; Acute Pain and Spiritual Distress Clinical Practice Guidelines.

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Clinical Practice Guideline:  
**ANXIETY**  
Type:  
Human Response  
Target Population:  
Child/Adolescent/Adult/Geriatric

**PROFESSIONAL PROCESS**

**GOALS/OUTCOMES:**

A. Patient will demonstrate outcomes below:
   1. Anxiety reduction/resolution.

B. Patient/family/significant other (S.O.)/caregiver will verbalize and/or demonstrate an understanding of teaching/learning goals listed below: (Refer to Education Outcome Record)
   1. Personal risk factors and signs/symptoms related to anxiety.
   2. Coping strategies for anxiety.
   3. Effective social interactive behaviors.
   4. Lifestyle alterations, present and future (e.g., healthy sleep patterns, stress reduction, exercise, monitor caffeine intake, resources for support and follow-up).
   5. General Goals (room/unit routine, pain, medication, diagnostic tests/procedures, dietary modifications, hygiene/infection prevention, rehabilitation, medical equipment/supplies, tobacco cessation, resources for support).

**ASSESSMENT/INTERVENTIONS/CLINICAL REASONING/DECISION-MAKING:**

A. Assess and document readiness and ability to learn, learning needs and preferences. (Refer to Pre-Teaching Assessment on Education Outcome Record)
B. Collaborate with interdisciplinary resources related to significant changes in patient status and for the continuum of care (e.g., Physician, Nursing, Family/Caregiver, Child Life Specialist, Pastoral Care, Social Work/Services, Palliative Care Services, Hospice Care Services).
C. Identify psychosocial, cultural, sexual, age-appropriate, developmental and spiritual well-being related to the human response of the patient/family.
D. Mutually plan/develop goals, assess and document progress toward goals.
E. Identify risks to safety.
F. Implement appropriate interventions as follows and document:

1. Provide a calm environment that facilitates an open, trusting relationship between healthcare provider and patient/family (e.g., nonthreatening/nonjudgmental physical presence, calm affect/voice/smile, touch).  (3; 8; 11; 13; 17; 19) {Grade C}
2. Correlate anxiety level, physiologic manifestations and type of perceived threat to cognitive status, source of anxiety, current situation, decision-making ability, defining characteristics, past experiences, history of anxiety, medications, pain level and baseline assessment data. (14; 19) {Grade C}
3. Anticipate anxiety related to being in the hospital; normalize feelings related to this. (11; 13; 14; 17) {Grade C}
4. Identify behaviors that demonstrate ineffective coping (e.g., substance use/abuse). (2; 4; 14-16; 18; 20; 24) {Grade A}
5. Assist patient/family with use/development of positive coping strategies [e.g., relaxation, exercise, massage, acupuncture, meditation, aromatherapy, healing touch, music, play, guided imagery, diversion, cognitive behavioral therapy (CBT)]. (1; 4; 7-10; 13; 16; 18; 19; 23-25) {Grade A}
6. Mutually develop realistic short/long-term goals, assisting patient in identifying strategies which enable them to manage role/lifestyle demands. (8; 11; 13; 14; 17) {Grade C}
7. Observe and document interaction between patient, family and other healthcare professionals. (17; 23) {Grade C}
8. Provide factual information about illness based on readiness to learn and developmental level (anticipatory guidance). Encourage patient/support system to ask questions/discuss feelings that are present. (3; 8; 11-13; 16; 17; 19) {Grade C}
9. Explain the importance of empowering the patient; focus on including them in the decision making process. (3; 8; 9; 13; 17; 19) {Grade B}
10. Provide patient/family/caregiver with education; empower patient/family/caregiver to seek out information regarding anxiety triggers, treatment options, benefits/risks/side effects of medications and lifestyle changes. (5; 7-9; 12-14; 16-19) {Grade B}
11. Facilitate discussion with patient/family that treatment takes time, persistence and patience to change patient’s established response patterns. (8; 9; 14; 23) {Grade B}
12. Use honesty and give daily progress reports to patient and family. (3; 13; 19) {Grade C}
13. Evaluate the need for Psychiatric consult for possible medication assessment/further biopsychosocial consultation/assessment with the potential for other treatment modalities. (4; 5; 8; 12; 14; 16; 18) {Grade B}

Clinical Practice Guidelines represent a consistent standardized approach to the care of patient’s with specific diagnoses. Care should always be individualized by adding patient specific information to the Plan of Care.
GENERAL INFORMATION: ANXIETY

A. CLINICAL DESCRIPTION: A persistent fear and nonspecific worry not associated with a particular issue/event; often accompanied by repetitive, intrusive and inappropriate thoughts/actions. (14; 15; 17; 18; 26)

B. RELATED/RISK FACTORS: (21; 22)

PERSONAL
- loss of control
- sense of uncertainty
- situational/maturational crisis/unmet needs
- knowledge deficit
- past experiences
- developmental stage
- ineffective coping patterns
- underlying fear, grief, values, conflict, guilt
- substance abuse
- lack of trust in healthcare professionals
- early separation from parent
- family history
- difficulties in school
- female gender

Lifestyle Impairments:
- physical/emotional impairments
- educational/employment impairments
- familial/marital/relationship impairments
- financial/income impairments
- health impairments
- increased risk of suicide

ENVIRONMENTAL
- change in physical surroundings

Environmental stressors:
- noise
- light
- constant stimulation
- personal space limitations
- separation from family/caregiver

TREATMENTRELATED
- invasive procedures
- length of regimen
- communication with other healthcare professionals
- inexperience with treatments
- physiologic effect of treatment

C. SIGNS AND SYMPTOMS: (6; 7; 21; 22)

Person states feelings of:
- nervousness/tension/restlessness/feeling “on edge”
- apprehension/feeling worried
- distress/panic
- uncertainty/wariness/doubt/worry/helplessness
- perceived danger/fears
- irritability/overexcitement/jitteriness
- sense of impending doom/catastrophic thinking
- regret/inadequacy

Behavioral:
- overwhelmed, immobilized, inability to carry out activities
- altered body language (e.g., posture, mannerisms, extraneous movement)
- voice quivering/tremor/pitch changes
- excessive talking/quietness
- crying
- diminished productivity/withdrawal
- joking/acting-out/angry outbursts

Physical complaints/symptoms:
- headache
- gastrointestinal (GI) disturbances (e.g., nausea/heartburn/gas/vomiting/abdominal pain/diarrhea)
- dry mouth
- fatigue/weakness
- urinary (e.g., urgency, frequency or hesitancy)
- sharp pericardial pain, change in BP, change in heart rate, increased respiratory rate, increased pulse, palpitations
- muscle tension/pain
- dizziness, faintness, shakiness

Cognitive:
- awareness of physical symptoms
- confusion/forgetfulness/disorientation
- decreased concentration, preoccupation, impaired attention, difficulty making decisions
- blocking thoughts/avoidance
- decreased perceptual field
- tendency to blame others/anger
- difficulty learning/problem-solving
- decreased motivation
- avoidance
D. ADDITIONAL INFORMATION: Note: Older individuals experience anxiety differently than younger individuals (4; 10)

Anxiety Disorders:
- Social anxiety disorder: Comprises a marked and persistent fear of social/performance situations in which embarrassment may occur. Exposure to the feared situation provokes an immediate anxiety response. The patient recognizes that fear is excessive and unreasonable. Avoidance is common, but may be endured with dread and avoidance fear/anxious anticipation of a situation interfering significantly with the patient’s daily routine, occupational functioning and social life.
- General anxiety disorder: characterized by excessive, uncontrollable worry, accompanied by symptoms of motor tension, vigilance and scanning; and has been present for at least six months. The anxiety and worry is centered on a number of day-to-day life events, including family life, work, health and finances and is associated with feelings of restlessness/feeling on edge, easily tired, poor concentration, irritability, muscle tension and sleep disturbances

Anxiety Disorders:
- Post-traumatic stress disorder: consists of re-experiencing trauma and distressing recollections, dreams, flashbacks, and psychological/physical distress; persistent avoidance of stimuli that might invite traumatic memories/experiences and increase arousal.
- Obsessive-compulsive disorder: characterized by persistent, intrusive thoughts and/images (obsessions) and repetitive, ritualistic behaviors that the individual feels that he/she must complete (compulsion).
- Panic disorder: characterized by recurrent, unexpected panic attacks, defined as discrete periods of intense anxiety and feelings of fearfulness, terror and often impending doom. Patients typically avoid being outside the home alone, avoid being in a crowd/on a bridge/travel on a bus, train or in a car.

Phobias:
- Specific phobia: defined by excessive and persistent fear that is cued by presence or anticipation of a specific stimulus. (e.g., small animals, natural environment, situational)
- Social phobia: marked and persistent fear of social performance situations due to an excessive fear of embarrassment/humiliation. Individuals with social phobia typically fear and avoid public speaking, participating in small groups, dating, speaking to authority figures, attending parties and speaking with and meeting strangers.

E. PATIENT/FAMILY RESOURCES:

F. SAFETY CONSIDERATIONS AND INITIATIVES:
1. Assessment/Communication:
   The Joint Commission 2009 Hospital Accreditation Standards:
   - Rights and Responsibilities of the Individual: RI.01.01.01: The hospital respects patient rights.
   - RI.01.01.03: The hospital respects the patient’s right to receive information in a manner he or she understands.
   - Provision of Care: Standard PC.01.02.01: The hospital assesses and reassesses its patients.
     Standard PC.01.02.03: The hospital assesses and reassesses the patient and his or her condition according to defined time frames.
     Standard PC.01.03.01: The hospital plans the patient’s care.

G. This guideline could potentially be used in conjunction with any Medical Diagnosis and/or Human Response Clinical Practice Guideline.
References

Clinical Practice Guideline:
FEAR
Type: Human Response
Target Population: Neonate/Newborn/Infant/Child/Adolescent/Adult

PROFESSIONAL PROCESS

GOALS/OUTCOMES:

A. Patient will demonstrate outcomes below:
   1. Fear control.
B. Patient/family/significant other (S.O.) will verbalize and/or demonstrate an understanding of teaching/learning goals listed below.
   (Document evaluation on Education Outcome Record).
   1. Personal risk factors and signs/symptoms related to fear.
   2. Cause of fear, what makes it better, what makes it worse.
   3. Effective coping strategies (e.g., communication enhancement, biofeedback, grief work, self-esteem enhancement, relaxation skills).
   4. Real and imagined fears.
   5. Lifestyle alterations, present and future (e.g., counseling, confrontation skills).
   6. Generic goals (room/unit routine, pain, medication, diagnostic tests/procedures, dietary modifications, rehabilitation, hygiene/infection prevention, medical equipment/supplies, tobacco cessation, resources for support).

ASSESSMENT/INTERVENTIONS/CLINICAL REASONING/DECISION-MAKING:

A. Assess and document readiness and ability to learn, learning needs and preferences. (Refer to Teaching/Learning Assessment on Education Outcome Record).
B. Collaborate with resources related to significant changes in patient status and for the continuum of care (e.g., Physician, Family, Pastoral Care, Social Work/Services, Child Life, Volunteer Companion, Nursing, Physical Therapy).
C. Mutually plan/develop goals, assess and document progress toward goals.
D. Implement appropriate interventions as follows and document:

1. Correlate expressions of fear to developmental level, mental status, age, physiological status, prior stressors/coping strategies/strengths, environment and baseline assessment data.
2. Utilize counseling to develop a therapeutic relationship and enhance discussion regarding cause(s) of fear and coping strategies to be utilized.
3. Help patient/family recognize effectiveness of coping strategies used to ↓ fear (e.g., relaxation, thought-stopping, imagery, exercise, music, play, rocking).
4. Utilize presence as a therapeutic mechanism to ↓ fear (e.g., family involvement, smile, touch, continuity of care).
5. Acknowledge fear (especially with children) and help patient learn coping strategies by enhancing sense of control and security, adjusting the environment/removing fearful stimulus (e.g., night lights, move away from fearful objects, dispel imaginary thoughts, presence of support people or objects/toys).
6. Monitor basic and instrumental activities of daily living (BADL/IADL) pattern and assist as needed.
7. Provide a physically and emotionally safe/secure environment.
8. Explore persistence of fear; precipitating events of fear.
9. Attempt to desensitize patient to phobic object/situation.
10. Assist/educate patient with alternative responses (other than fear) to situation.
11. Explore cultural influences in an attempt to understand fear; incorporate common practices/rituals into current care to relieve fear.

Clinical Practice Guidelines represent a consistent/standardized approach to the care of patient’s with specific diagnoses. Care should always be individualized by adding patient specific information to the Plan of Care and by identifying psycho-social, cultural, sexual, age- appropriate, developmental, and spiritual needs related to the person’s human response.

2 Ibid.,p.58-59.
3 Ibid.,p.58.
4 Ibid., p.59.
5 Ibid., p.56.
GENERAL INFORMATION: FEAR

A. DEFINITION: Fear is a self-preservation signal in response to a specific perceived threat of danger that stimulates physiological and emotional responses. A phobia is an irrational fear that causes a persistent strong desire to avoid the source of the fear.

B. RELATED/RISK FACTORS:

PERSONAL:
- Perceived inadequate control or power
- Decreased self-esteem
- Age
- Knowledge deficits/unknown past experiences
- Assault upon body image
- Bodily injury: illness/specific diseases, physical danger, physical assault
- Δ role relationship responsibilities (e.g., divorce, death)
- Ineffective coping patterns
- Language barrier/Impaired communication
- Natural/innate origin (e.g., pain, sudden noise, height)
- Learned response (e.g., dark, animals, strangers, monsters)
- Loss of income/financial insecurity
- Psychotic state (e.g., hallucinations, delusions)
- Pre-existing phobia
- Cultural differences/practices

ENVIRONMENTAL:
- Δ physical surroundings/unfamiliarity (e.g., home, hospital, unit to unit transfers)
- Separation from support group/“protectors” (e.g., family, friends)
- Dark room/environment
- War, car accidents, airplane crashes

PHYSIOLOGICAL:
- Addiction to analgesics
- Prognosis (e.g., fear of dying/loss of body part or function)
- Neurotransmitters/innate releasers
- Sensory-motor deficit/impairment

TREATMENT RELATED:
- Treatment (e.g., uncomfortable procedures)
- Length of treatment regimens

C. SIGNS AND SYMPTOMS:
- Identifies object of fear, preoccupation with identified fear
- Expresses feelings of fright, terror, apprehension, increased tension, decreased self-assurance, excitement, being scared, jitteriness, alarm, panic, dread, helplessness, aggressiveness
- Deficits in attention, performance and control (e.g., forgetfulness, ↓ concentration, diminished: problem solving, learning ability, productivity)

PHYSIOLOGICAL:
- Sharp precordial pain/palpitations/tachycardia/↑ BP
- Diaphoresis
- Hot and cold sensations/paresthesia, cool extremities
- Flushing/pallor
- Dizziness and faintness/light headedness
- Dry mouth/throat
- Body aches and pains, facial tension, headache

Gastrointestinal Disturbances:
- Nausea/heartburn/gas
- Anorexia/↑ appetite
- Vomiting
- Diarrhea/constipation
- Fatigue and weakness
- Smothering sensations, choking
- Dilated pupils
- Insomnia
- Shortness of breath/dyspnea/↑ respiratory rate/hyperventilation

BEHAVIORAL:
- Disabling immobility
- Excessive talking/quietness
- Clinging to family/objects
- Touching, stroking, massaging body parts/thumb sucking
- Impulsiveness/compulsive mannerisms
- Panic/panic attacks
- Inner conflict (e.g., guilt, shame, anger)
- Depression
- Regression/dependency
- Irritability, hyper-alertness
- Crying
- Trembling/foot shuffling
- Δ speech patterns, voice tremors/pitch
- Change in BADL/IADL, (e.g., play, sleep, eating)
- Deny/pretend not to be fearful
- Act silly, make sarcastic remarks
- Phobias (e.g., agoraphobia, simple phobia, social phobia)

D. SAFETY CONSIDERATIONS AND INITIATIVES:

1. Assessment/Communication:
   The Joint Commission 2009 Hospital Accreditation Standards:
   - Rights and Responsibilities of the Individual: RI.01.01.01: The hospital respects patient rights
   - RI.01.01.03: The hospital respects the patient’s right to receive information in a manner he or she understands
   - Provision of Care: Standard PC.01.02.01: The hospital assesses and reassesses its patients.
   - Standard PC.01.02.03: The hospital assesses and reassesses the patient and his or her condition according to defined time frames.
Clinical Practice Guideline:  
**GRIEVING**

**Type:** Human Response  
**Target Population:** Infant/Child/Adolescent/Adult/Geriatric

### PROFESSIONAL PROCESS

#### GOALS/OUTCOMES:

A. Patient will demonstrate outcomes below:
   1. Knowledge of grief and grieving.

B. Patient/family/significant other (S.O.)/caregiver will verbalize and/or demonstrate an understanding of teaching/learning goals listed below: (Refer to Education Outcome Record)
   1. Personal risk factors and signs/symptoms related to grieving.
   2. Personal areas of loss and what the loss means to them.
   3. Phases of the grieving process.
   5. Personal grieving style.
   6. Safety, self-care, and survival needs [e.g., basic activities of daily living (BADL)/instrumental activities of daily living (IADL), nutrition, sleep/rest, social interactions].
   7. Progress in dealing with feelings (e.g., sadness, anger, guilt, fear, uncertainty).
   8. Signs/symptoms and treatment of potential physical problems (e.g., nausea, pain, headache, sleep pattern disturbance).
   9. Possible developmental stagnation due to loss.
   10. Appropriate resources for support and follow-up.
   11. Lifestyle alterations, present and future (e.g., change in role/responsibilities, establishing new “normal” daily routines, relocation).
   12. General goals (room/unit routine, pain, medication, diagnostic tests/procedure, dietary modifications, hygiene/infection prevention, rehabilitation, medical equipment/supplies, tobacco cessation, resources for support).

#### ASSESSMENT/INTERVENTIONS/CLINICAL REASONING/DECISION-MAKING:

A. Assess and document readiness and ability to learn, learning needs and preferences. (Refer to Pre-Teaching Assessment on Education Outcome Record)

B. Collaborate with interdisciplinary resources related to significant changes in patient status and for the continuum of care (e.g., Physician, Nursing, Social Work/Services, Palliative Care Services, Hospice Care Services, Dietitian/Nutrition Services, Pastoral Care, Pharmacy, Respiratory Therapy, Occupational Therapy, Physical Therapy, Child Life, Speech Language Pathology, Home Care Services).

C. Identify psychosocial, cultural, sexual, age-appropriate, developmental and spiritual well-being related to the human response of the patient/family.

D. Mutually plan/develop goals, assess and document progress toward goals.

E. Identify risks to safety.

F. Implement appropriate interventions as follows and document:

1. Correlate grieving style to risk factors, developmental status, previous grief/loss experiences, recent life events and baseline assessment data. (2; 5; 14; 19) {Grade C}
2. Discuss the stages of grief and various grieving styles with patient/family; explore their unique response/feelings associated with loss. (2; 10; 13-16) {Grade C}
3. Counseling and/or therapeutic/medical play (based on developmental and cognitive ability of patient/family): (1; 2; 10; 13; 14) {Grade C}
   - create an environment that is safe, secure, culturally and spiritually conducive for self-expression. (1; 2; 5; 10; 13; 14) {Grade C}
   - identify the grieving process as healthy, normal and essential. (2; 10; 14; 15) {Grade C}
   - acknowledge appropriateness of feelings related to loss; normalize patient/family response. (10; 19) {Grade C}
   - encourage self-exploration/reflection regarding personal grieving style/process (e.g., journaling, art, verbalization). (10; 19) {Grade C}
   - recognize that living through loss requires a process of integration, which may take time. (2; 13; 14) {Grade C}
4. Evaluate current coping strategies; assist with developing new strategies. (2; 15) {Grade C}
5. Discuss personal strengths and ways to enhance/utilize them. (2; 13; 15) {Grade C}
6. Discuss and implement constructive methods to release emotions (e.g., exercise, journaling, art). (13; 19) {Grade C}
7. Encourage activities that promote self-care (e.g., nutrition/rest, relaxation techniques). (2; 13; 14) {Grade C}
8. Identify activities that were previously gratifying but have been neglected; encourage gradual reparticipation. (2; 13; 14) {Grade C}
9. Mutually develop realistic short and long-term goals, assisting patient/family to identify problem-solving strategies to manage role changes/lifestyle demands as the result of loss. (13; 14; 22) {Grade C}
10. Assist family/significant other in obtaining medical intervention, if appropriate, for physical complaints related to grieving (e.g., nausea, pain, headaches). (1) {Grade C}
11. Monitor for signs/symptoms of mental illness as a result of the grieving process (e.g., depression, post-traumatic stress disorder, separation anxiety disorder, addiction). (21) {Grade C}

12. Identify cultural beliefs/issues/rituals regarding grief. (2; 5) {Grade C}

13. Provide factual information regarding medical situation/prognosis and grieving process based on readiness to learn and developmental level (e.g. anticipatory guidance, meetings with healthcare team). (2; 7; 15; 17) {Grade C}

14. Advocate for patient wishes regarding treatment choice and extraordinary life support (informed consent/competency assumed). (15; 23) {Grade C}

15. Support family/significant others in being an active participant with patient care activities (e.g., bathing, feeding, diversional activities). (3; 15; 19) {Grade C}

16. Support and encourage family to provide an environment of honesty and openness with other family members/friends during the grieving process. (1; 2; 10; 13-15; 17) {Grade C}

17. Mutually identify available resources for support that patient/family will access (e.g., family, friends, support groups, spiritual community). (10; 14; 15; 19) {Grade C}

18. Facilitate communication with healthcare team and family following loss, if desired (e.g., acknowledgement of loss/celebration of life, acknowledgement of change in relationship with patient/family and medical team, attendance at funeral, send sympathy card). (2; 14; 15; 17) {Grade C}

Clinical Practice Guidelines represent a consistent/standardized approach to the care of patient's with specific diagnoses. Care should always be individualized by adding patient specific information to the Plan of Care.
A. CLINICAL DESCRIPTION: A natural and essential emotional/physical/intellectual process, which occurs in response to the actual and/or perceived loss of a highly valued person, place, object, role, body part/function. This process requires integration/adaptation of the loss/grief for a healthy resolution. (11; 15)

Note: It is important to recognize that individual experiences with grief vary considerably in duration, intensity and expression. Thus, grieving should be viewed as a complex syndrome in which many reactions may be present, but none of which are necessarily true and may not continuously or consistently occur months and/or years following the loss. (11)

a. Gender: Grieving is gender-neutral. People of all ages (birth through death) grieve in their own unique way given various situations. (11)

b. Culture: Grieving occurs in all cultures/races; however, the way in which grief is expressed varies from one culture to another. (5)

B. RELATED/RISK FACTORS: (1; 2; 5; 11; 13-16; 19; 22)

Note: Present loss or threat of loss may trigger feelings of grief related to past losses.

PERSONAL

- Actual/perceived loss:
  - significant relationship (e.g., family member, pet, self, friend)
  - transitional developmental points (e.g., childhood, adolescence, mid-life, retirement, aging)
  - lifestyle changes (e.g., occupation, childbirth, marriage, separation, divorce, loss of independence)
- Altered pregnancy outcome:
  - pregnancy loss
  - fetal death
  - birth of an infant with congenital anomalies or genetic disorder(s)
  - unwanted/unplanned pregnancy
  - unexpected gender
  - premature birth
- Loss of social support system

PERSONAL

- Loss of self-determination:
  - change in self-esteem
  - change in self-identity
  - change in spirituality
  - change in body image
  - change in plans, goals, dreams, aspirations
- Loss of safety:
  - abuse (e.g., physical, sexual, emotional, cognitive, social, spiritual)
  - violence (e.g., robbery, assault)
  - natural disaster (e.g., hurricane, tornado, fire)

PHYSIOLOGICAL

- chronic or terminal illness
- loss of body part or function
- infertility/impotence
- chronic pain
- mental illness (e.g., bipolar disorder, schizophrenia)

ENVIRONMENTAL

- Actual/perceived loss:
  - personal possessions (e.g., home, financial, material objects)
  - control over environment (e.g., fire, flood, natural disasters)
- loss is socially unspeakable, negated or neglected (e.g., human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), incest)

TREATMENT RELATED

- acute loss of function or body part(s) related to acute/chronic/terminal illness and treatments, surgery or trauma (e.g., mastectomy, colostomy, amputation, chemotherapy).
  
  Note: The greater the assault on the body image, the higher the risk.
  - actual/potential activity limitations

C. SIGNS AND SYMPTOMS: (1-6; 8; 8-11; 13; 14; 16; 18-20; 22)

<table>
<thead>
<tr>
<th>Physical reactions</th>
<th>Affective reactions</th>
<th>Cognitive reactions</th>
<th>Spiritual reactions</th>
<th>Behavioral reactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>loss of appetite</td>
<td>feelings of:</td>
<td>suicidal thoughts</td>
<td>searching for meaning of loss</td>
<td>crying</td>
</tr>
<tr>
<td>headaches</td>
<td>- powerlessness</td>
<td>sense of deceased’s presence</td>
<td>changes in:</td>
<td>searching behaviors</td>
</tr>
<tr>
<td>nausea</td>
<td>- hopelessness</td>
<td>obsessive thinking</td>
<td>- spiritual behavior</td>
<td>avoiding reminders of loss</td>
</tr>
<tr>
<td>muscular aches</td>
<td>- helplessness</td>
<td>apathy</td>
<td>- spiritual beliefs</td>
<td>seeking reminders of loss</td>
</tr>
<tr>
<td>tiredness and exhaustion</td>
<td>fear</td>
<td>disorientation</td>
<td>growth and transformation</td>
<td>obsessive activity</td>
</tr>
<tr>
<td>pains</td>
<td>relief</td>
<td>confusion</td>
<td></td>
<td>social withdrawal</td>
</tr>
<tr>
<td>insomnia</td>
<td>sadness</td>
<td>rehearsing, reviewing loss</td>
<td></td>
<td>increase in/relapse of addictive behaviors (e.g., gambling, substance use, eating)</td>
</tr>
<tr>
<td>menstrual irregularities</td>
<td>anger</td>
<td>disbelief</td>
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<tr>
<td>functional impairment</td>
<td>guilt</td>
<td>self-blame</td>
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<td></td>
<td>anxiety</td>
<td>blame others</td>
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<td></td>
<td>ambivalence</td>
<td>shock</td>
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<td></td>
<td>irritability</td>
<td>denial</td>
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<td></td>
<td>vulnerability</td>
<td>increased distress</td>
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<td></td>
<td>overwhelmed</td>
<td>following loss</td>
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<td></td>
<td>loneliness</td>
<td>yearning</td>
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<td></td>
<td>resentment</td>
<td>decreased self-esteem</td>
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<td></td>
<td>abandonment</td>
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</tbody>
</table>
ADDITIONAL INFORMATION: The family unit is a system based on an interdependency and interconnectedness between members/patterns that provides structure and support. One family member’s loss/grief may disrupt these relationships and patterns; the behavior of each individual affects all of the others. (13)

<table>
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<th>Stages or Phases of the Dying Process:</th>
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**Denial:** Allows time for the person to gather inner and outer resources. Cushions the impact of awareness of the loss.

**Anger:** Anger about loss may be misdirected onto nursing and medical staff, family or God.

**Bargaining:** Beginning to accept the loss, but still looking for a way out.

**Depression:** Withdrawal, apathy, sadness are common feelings as the individual accepts the reality of the loss.

**Acceptance:** Not the same as resignation. Indicates resolution of that loss.

*Note:* Stages are not meant to be interpreted in a time-limited or sequential manner.

Process in children may be somewhat different from above stages. *Resembles that of separation and has three phases:* Protest, despair and detachment. Children experience episodes of grieving that are usually brief, but intense. They tend to show grief more behaviorally than emotionally or verbally.

**Protest phase:** child has strong desire for lost loved one and cries for his/her return.

**Despair phase:** child begins to feel hopeless regarding the return of the lost loved one.

**Detachment phase:** child begins to relinquish some of the emotional attachment to the lost loved one and begins to show a reawakening of interest in current surroundings.

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"These patterns vary in two general ways: by the griever’s internal experience of his loss and the individual’s outward expressions of that experience."

**Intuitive Griever:** feels losses deeply, comfortable with disclosure, demands a place and time to grieve, without energy and motivation, needs consistent validation, expressions mirror inner experience, without energy for BADL/IADL.

- Primary adaptive strategy: “going with their grief”: “support group work” is an ideal intervention for this style of grief.
- Secondary adaptive strategies: “channeling grief”: setting aside structured time to grieve and staying within a time limit on a daily basis. (Strategy allows for emotional control).

**Instrumental Griever:** focus on cognition, deal intellectually with feeling, desire to master environment, not comfortable with disclosure, report they have problems crying, focused on “doing” as a means of grieving, fact finders, reserved people, dominating.

- Primary adaptive strategy: channeling grief into activities (becoming or remaining active). Action is key for channeling excessive affective energy. “Journaling” is an ideal intervention for this style of grief.
- Secondary adaptive strategies: planning an activity (provides a way to express feelings, while maintaining mastery over them).

**Dissonant Griever:** complicated grief, suppression of primary style of grieving, expressing grief differently than is felt, possible inability to alter initial strategy causing long-term maladaptive grief style.

- Primary adaptive strategies: choosing an adaptive strategy that doesn’t fit or complement one’s innate grieving style.
- Secondary adaptive strategies: eventually reverting to primary style of grieving. “Grief therapy” is a form of intervention for those who experience the inability to revert (complicated grief).

**Blended Griever:** Combination of Intuitive grieving and instrumental.

*Intuitive Griever) ------------------- (Blended Griever) -------------------- (Instrumental Griever)

"Children experience grief much like adults do. They have intense emotions (that may come and go more quickly than for an adult), feel a connection to the person who died and are comforted by being able to talk about their grief and loss. As with an adult, grief in children can be transformative. Talking with children requires understanding their growth and development. (12)
E. PATIENT/FAMILY RESOURCES (Include the names and websites for appropriate patient/family resources)

2. Children’s Hospice International http://www.chionline.org/
4. Perinatal Hospice http://www.perinatalhospice.org
5. The Compassionate Friends http://www.compassionatefriends.org
6. Local grieving support groups/resources (e.g., Gilda’s Club, Multiple Sclerosis Support Group)
7. Canadian Hospice Palliative Care Association http://www.chpca.net/home.html
8. Hospice Association of Ontario http://www.hospice.on.ca/

F. SAFETY CONSIDERATIONS AND INITIATIVES:

1. Assessment/Communication:
   The Joint Commission 2009 Hospital Accreditation Standards:
   • Rights and Responsibilities of the Individual: RI.01.01.01: The hospital respects patient rights.
     RI.01.01.03: The hospital respects the patient’s right to receive information in a manner he or she understands.
   • Provision of Care: Standard PC.01.02.01: The hospital assesses and reassesses its patients.
     Standard PC.01.02.03: The hospital assesses and reassesses the patient and his or her condition according to defined time frames.

G. This guideline could potentially be used in conjunction with any Medical Diagnosis and/or Human Response Clinical Practice Guideline.
References


PROFESSIONAL PROCESS

GOALS/OUTCOMES:

A. Patient will demonstrate outcomes below:

B. Patient/family/significant other (S.O./caregiver will verbalize and/or demonstrate an understanding of teaching/learning goals listed below: (Refer to Education Outcome Record)
   1. Personal risk factors and signs/symptoms related to unresolved grieving.
   2. Personal areas of loss and what the loss means to them.
   3. Stages of the grieving process.
   4. Personal grieving style.
   5. Current negative coping/grieving patterns (e.g., substance use/abuse, isolation) and potential consequences on health (e.g., depression, regression).
   6. Changes created by the loss and strategies to reinvest in life.
   7. Outcomes of effective coping/grieving patterns (e.g., enhanced relaxation/sleep/eating habits, ability to meet life's demands/roles, decreased anxiety/fear/concerns).
   8. Progress in dealing with feelings (e.g., anger, fear, sadness, blame).
   9. Signs/symptoms and treatment of potential physical problems (e.g., nausea, pain, sleep pattern disturbance, depression).
   10. Possible developmental stagnation/regression due to unresolved grief issues.
   11. Appropriate resources for support and follow-up.
   12. Lifestyle alterations, present and future (e.g., insomnia, depression, change in appetite, change in spiritual beliefs).
   13. General Goals (room/unit routine, pain, medication, diagnostic tests/procedures, dietary modifications, hygiene/infection prevention, rehabilitation, medical equipment/supplies, tobacco cessation, resources for support).

ASSESSMENT/INTERVENTIONS/CLINICAL REASONING/DECISION-MAKING:

A. Assess and document readiness and ability to learn, learning needs and preferences. (Refer to Pre-Teaching Assessment on Education Outcome Record)

B. Collaborate with interdisciplinary resources related to significant changes in patient status and for the continuum of care (e.g., Physician, Nursing, Social Work/Services, Behavioral Health, Palliative Care Services, Dietitian/Nutrition Services, Pastoral Care, Pharmacy, Respiratory Therapy, Occupational Therapy, Physical Therapy, Recreational Therapist, Child Life, Speech Language Pathology, Home Care Services).

C. Identify psychosocial, cultural, sexual, age-appropriate, developmental and spiritual well-being related to the human response of the patient/family.

D. Mutually plan/develop goals, assess and document progress toward goals.

E. Identify risks to safety.

F. Implement appropriate interventions as follows and document:

1. Correlate grieving style to risk factors, developmental status, previous grief/loss experiences, medications/substance use, coping patterns/strategies, recent life events and baseline assessment data. (3; 5; 13; 24) {Grade C}

2. Discuss the stages of grief and various grieving styles with patient/family; explore their unique response/feelings associated with past loss(es). (3; 8; 12; 13; 16; 17) {Grade C}

3. Counseling and/or therapeutic/medical play (based on developmental and cognitive ability of patient/family). (1; 3; 8; 12; 13) {Grade C}
   - Create an environment that is safe, secure, culturally and spiritually conducive for self-expression. (1-3; 5; 8; 12; 13; 15) {Grade C}
   - Identify the grieving process as healthy, normal and essential. (2; 3; 8; 13; 16; 23) {Grade C}
   - Acknowledge appropriateness of feelings related to past loss(es); use nonjudgmental approach in discussing how patient has coped with these feelings. (2; 8; 15; 23; 24) {Grade C}
   - Encourage self-exploration/reflection with regards to personal grieving style/process (e.g., journaling, art, verbalization). (8; 15; 23; 24) {Grade C}
   - Recognize that successful grieving requires a process of integration. (2; 3; 12; 13) {Grade C}

4. Identify behaviors that demonstrate ineffective coping/grieving (e.g., substance use, resistance to help). (3; 15; 16) {Grade C}

5. Assist with using/developing positive coping/grieving strategies (e.g., relaxation, imagery, music, exercise, counseling, therapeutic/medical play, role rehearsal). (3; 15; 16) {Grade C}

6. Discuss personal strengths and ways to enhance/utilize them. (3; 12; 15; 16) {Grade C}

7. Discuss and implement constructive methods to release emotions (e.g., exercise, journaling, art). (12; 15; 24) {Grade C}

8. Encourage activities that promote self-care (e.g., nutrition/rest, relaxation techniques). (2; 3; 12; 13) {Grade C}

9. Identify activities that were previously gratifying but have been neglected; encourage gradual reparticipation. (2; 3; 12; 13) {Grade C}
10. Mutually develop realistic short and long-term goals, assisting patient/family to identify problem-solving strategies to manage role changes/lifestyle demands as the result of past loss(es). (12; 13; 21; 23; 26) {Grade C}
11. Recognize/positively reinforce healthy behavior(s)/choices/actions. (2) {Grade C}
12. Assist patient in obtaining medical intervention, if appropriate, for physical complaints related to grieving (e.g., nausea, pain, headaches). (1) {Grade C}
13. Assess for signs/symptoms of mental illness (e.g., depression, post-traumatic stress disorder, separation anxiety disorder, addiction). (15; 25) {Grade C}
14. Assess for suicidal ideation/thoughts/attempts. (1; 12; 15; 20) {Grade C}
15. Evaluate the need for a Psychiatry consult for potential medication assessment, further biopsychosocial consultation/assessment and the potential for other treatment modalities. (15; 25) {Grade C}
16. Identify cultural beliefs/issues/rituals regarding grief. (2; 3; 5; 15; 18; 21) {Grade C}
17. Mutually identify available resources for support that patient will access (e.g., family, friends, support groups, spiritual community). (8; 13; 15; 16; 24) {Grade C}

Clinical Practice Guidelines represent a consistent/standardized approach to the care of patient's with specific diagnoses. Care should always be individualized by adding patient specific information to the Plan of Care.
GENERAL INFORMATION: GRIEVING, UNRESOLVED

A. CLINICAL DESCRIPTION:
   1. Definition: Grief that has been affected by complex physical, psychological, sociocultural and/or spiritual factors which have complicated/prolonged the process of integration/adaptation of the loss. (9; 22)
      a. Four types of unresolved grief have been identified: (22)
         - Chronic grief: a grief reaction continuing for a longer period of time than would be expected for the loss.
         - Delayed grief: The loss is so significant that the bereaved is unable to deal with it and may try consciously or unconsciously to avoid the pain of the loss.
         - Exaggerated grief: The bereaved tries to overcome the loss by engaging in self-destructive behavior.
         - Masked grief: The bereaved may not have dealt with the loss and becomes nonfunctional.
   2. Gender: Unresolved grief is gender-neutral. People of all ages (birth to death) suffer from unresolved grief. (Shear, 2005)
   3. Culture: Unresolved grief occurs in all cultures/races. The way that grief is expressed varies from one culture to another; therefore, it is important to be aware of these differences prior to assessment (e.g., what may be considered a symptom of unresolved grief in one culture could be a healthy ritual in another culture). (2; 5)

B. RELATED/RISK FACTORS: (2-5; 7-13; 15-18; 21; 23; 24; 26)

   PERSONAL
   - Actual or perceived loss:
     - significant relationship (e.g., family member, pet, self, friend)
     - transitional developmental points (e.g., childhood, adolescence, mid-life, retirement, aging)
     - lifestyle changes (e.g., occupation, childbirth, marriage, separation, divorce, loss of independence)
   - Altered pregnancy outcome:
     - pregnancy loss
     - fetal demise
     - birth of an infant with congenital anomalies or genetic disorder(s)
     - unwanted/unplanned pregnancy
     - unexpected gender
     - premature birth
   - Loss of self-determination:
     - change in self-esteem
     - change in self-identity
     - change in body image
     - change in plans, goals, dreams, aspirations

   PHYSIOLOGICAL
   - loss of safety:
     - abuse (e.g., physical, sexual, emotional, cognitive, social, spiritual)
     - violence (e.g., robbery, assault)
     - natural disaster (e.g., hurricane, tornado, fire)
     - loss of/lack of social support system
     - dysfunctional family system
     - nature of the attachment to actual/perceived loss; dependency
     - lack of resolution with/incorporation of past grief
     - lack of spiritual beliefs
     - emotional instability/difficulty expressing feelings
     - multiple stressors
     - multiple losses

   ENVIRONMENTAL
   - actual/perceived loss:
     - personal possessions (e.g., home, financial, material objects)
     - control over environment (e.g., fire, flood, natural disasters)
   - loss is socially unspeakable, negated, or neglected (e.g., human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS), incest)

   TREATMENT RELATED
   - acute loss of function or loss of body part(s) related to acute/chronic/terminal illness and treatments, surgery or trauma (e.g., mastectomy, colostomy, amputation, chemotherapy).
     Note: The greater the assault on the body image, the higher the risk.
   - actual/potential activity limitations

C. SIGNS AND SYMPTOMS: (1-4; 6-9; 11; 12; 15-18; 20; 21; 23; 24; 26)

   1. Physical:
      - loss or gain of total body weight since time of loss
      - change in appetite/eating habits
      - headaches
      - nausea
      - muscular aches
      - prolonged decrease in energy level that interferes with life functioning
      - pain
      - prolonged alteration in sleep patterns (e.g., severe insomnia, early morning waking, sleeping more than usual, alteration in dream pattern)
      - serious functional impairment
      - chest tightness
      - acquisition of symptoms belonging to the last illness of a deceased loved one
      - anxiety disorder
      - post-traumatic stress disorder
      - adjustment disorder
      - major depression
      - separation anxiety disorder

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2. **Affective:**
   - feelings of powerlessness
   - feelings of hopelessness
   - feelings of purposelessness regarding future
   - feelings of helplessness
   - fear
   - prolonged expression of guilt, anger, distress, sadness, blame
   - pervasive and paralyzing feelings of loneliness
   - numbness
   - avoidance
   - pervasive despair
   - vulnerability
   - irritability
   - overwhelmed
   - resentment
   - abandonment
   - ambivalence
   - labile/flat affect
   - extreme mourning

3. **Cognitive:**
   - suicidal thoughts/ideations/attempts
   - sense of deceased’s presence
   - hallucinations
   - intrusive thoughts of deceased
   - excessive reliving of past experiences
   - alterations in concentration and/or pursuit of task
   - disorientation
   - confusion
   - preoccupation with loss; idealization of lost object (e.g., person, place or thing)
   - disbelief
   - self-blame
   - blame others

(Cognitive continued)
   - shock
   - denial
   - increased distress following loss
   - profound yearning
   - low self-esteem
   - difficulty acknowledging death
   - expression of unresolved issues
   - verbalizes lack of acceptance of death
   - grief avoidance

4. **Spiritual:**
   - searching for meaning of loss
   - changes in spiritual behavior
   - changes in spiritual beliefs

5. **Behavioral:**
   - crying
   - searching behaviors
   - excessive avoidance and escape from feared/loss stimuli
   - seeking reminders of loss
   - obsessive activity
   - extreme and progressive family and/or social isolation
   - inability to renew and maintain relationships or form new ones
   - increase in alcohol use
   - increase in tobacco use
   - increase in chemical use
   - increase in gambling
   - low levels of intimacy
   - school problems
   - developmental regression
   - complete absence of grief reaction/mourning
   - decreased functioning in life roles
   - gross disruption of patient’s daily life

C. **ADDITIONAL INFORMATION:**

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<td>Note: Current research is beginning to question the relevance of the Stages of the Grieving Process. (17)</td>
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**Denial:** allows time for the person to gather inner and outer resources; cushions the impact of awareness of the loss.

**Anger:** anger about loss may be misdirected onto nursing and medical staff, family or God.

**Bargaining:** beginning to accept the loss, but still looking for a way out.

**Depression:** withdrawal, apathy, sadness are common feelings as the individual accepts the reality of the loss.

**Acceptance:** not the same as resignation; indicates resolution of that loss.

*Note: Stages are not meant to be interpreted in a time-limited or sequential manner.

Process in children may be somewhat different from above stages. Resembles that of separation and has three phases: Protest, despair and detachment. Children experience episodes of grieving that are usually brief, but intense. They tend to show grief more behaviorally than emotionally or verbally.

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**Detachment phase:** child begins to relinquish some of the emotional attachment to the lost loved one and begins to show a re-awakening of interest in current surroundings.
Grieving Styles:
(As identified by Terry L. Martin and Kenneth J. Doka, PhD)(19)

*These patterns vary in two general ways: by the griever’s internal experience of his loss and the individual’s outward expressions of that experience.*

**Intuitive Griever:** Feels losses deeply, comfortable with disclosure, demands a place and time to grieve, without energy and motivation, needs consistent validation, expressions mirror inner experience, without energy for basic and instrumental activities of daily living (BADL and IADL).
- **Primary Adaptive Strategy:** “going with their grief”; “support group work” is an ideal intervention for this style of grief.
- **Secondary Adaptive Strategies:** “Channeling grief”; setting aside structured time to grieve and staying within time limit daily. (Strategy allows for emotional control).

**Instrumental Griever:** focus on cognition, deal intellectually with feeling, desire to master environment, not comfortable with disclosure, report they have problems crying, focused on “doing” as a means of grieving, fact finders, reserved people, dominating.
- **Primary Adaptive Strategy:** Channeling grief into activities (becoming or remaining active). Action is key for channeling excessive affective energy. “Journaling” is an ideal intervention for this style of grief.
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- **Primary Adaptive Strategies:** choosing an adaptive strategy that doesn’t fit or complement one’s innate grieving style.
- **Secondary Adaptive Strategies:** eventually reverting to primary style of grieving. “Grief Therapy” is a form of intervention for those who experience the inability to revert (complicated grief).

**Blended Griever:** Combination of Intuitive grieving and instrumental.
- (Intuitive Griever) ------------------- (Blended Griever) -------------------- (Instrumental Griever)

**D. PATIENT/FAMILY RESOURCES**
4. National Alliance for Grieving Children
6. Perinatal Hospice [http://www.perinatalhospice.org](http://www.perinatalhospice.org)
8. Local grieving support groups/resources (e.g., Gilda’s Club, Multiple Sclerosis Support Group)

**E. SAFETY CONSIDERATIONS AND INITIATIVES:**
1. **Assessment/Communication:**
   The Joint Commission 2009 Hospital Accreditation Standards:
   - Rights and Responsibilities of the Individual: RI.01.01:01: The hospital respects patient rights.
   - RI.01.01:03: The hospital respects the patient’s right to receive information in a manner he or she understands.
   - Provision of Care: Standard PC.01.02:01: The hospital assesses and reassesses its patients.
   - Standard PC.01.02:03: The hospital assesses and reassesses the patient and his or her condition according to defined time frames.
2. **Suicide:**
   - The Joint Commission Hospital Accreditation Standards. 2010 National Patient Safety Goal 15: The organization identifies safety risks inherent in its patient population. NPSG.15.01.01: Identify patients at risk for suicide.
   - National Quality Forum Serious Reportable Events in Healthcare 2006 Update, Patient Protection Events: patient suicide, or attempted suicide resulting in serious disability while being cared for in a healthcare facility.
3. **Depression:**

**F. This guideline could potentially be used in conjunction with any Medical Diagnosis and/or Human Response Clinical Practice Guideline.**
References


Clinical Practice Guideline:  
**NEAR DEATH EXPERIENCE**  
Type: Human Response  
Target Population: Child/Adolescent/Adult

### GOALS/OUTCOMES:

A. **Patient will demonstrate outcomes below:**

1. Integration of experience into life/Spiritual well-being.

B. **Patient/family/significant other (S.O.) will verbalize and/or demonstrate an understanding of teaching/learning goals listed below.**
   (Document evaluation on Education Outcome Record.)
   1. Personal risk factors and signs/symptoms related to near-death experience.
   2. General information about near-death experience.
   3. Integration of a near-death experience into an existing life is a long term process.
   4. Healthy coping methods (e.g., verbalization, use of resources, spiritual support, problem-solving).
   5. Impact of a near-death experience on personal life, values and feelings.
   6. Effects of near-death experience on health status (e.g., sleep patterns, dietary habits, stress level).
   7. Lifestyle alterations, present and future (e.g., reprioritization of how personal time is spent, relaxation techniques).
   8. Generic goals (room/unit routine, pain, medication, diagnostic tests/procedures, dietary modifications, hygiene/infection prevention, rehabilitation, medical equipment/supplies, tobacco cessation, resources for support).

### ASSESSMENT/INTERVENTIONS/CLINICAL REASONING/DECISION-MAKING:

A. **Assess and document readiness and ability to learn, learning needs and preferences.** (Refer to Teaching/Learning Assessment on Education Outcome Record)

B. **Collaborate with resources related to significant changes in patient status and for the continuum of care** (e.g., Social Work/Services, Pastoral Care, Nursing, Physician, Family/Caregiver, Child Life).

C. **Mutually plan/develop goals, assess and document progress toward goals.**

D. **Implement appropriate interventions as follows and document:**

1. Correlate response to near-death experience with knowledge regarding phenomena, present health status, health history, spirituality, opportunities to discuss event, support system and personal coping strategies.
2. Utilize counseling to promote discussion of the experience and identify fears/concerns/after effects about the experience.
3. Validate person’s right to personal perceptions and reinforce the importance of identifying strategies for long-term integration of this experience (e.g., talking with S.O., art therapy, play therapy, role play, journal).
4. Reinforce that this is a common phenomena and that many people of diverse ages, cultures, spiritual values and beliefs have had these experiences. Normalize the experience in an attempt to decrease fear.  
5. Facilitate patient communication with family/S.O. and mutually identify and establish an individualized support system.
6. Explain that characteristics of near-death experiences vary greatly for each person (e.g., different types, intensity and number of characteristics).
7. **Mutually plan strategies to address physical, psychosocial, spiritual, cultural responses to event** (e.g., sleep/rest.relaxation enhancement, emotional and spiritual support).

Clinical Practice Guidelines represent a consistent/standardized approach to the care of patient’s with specific diagnoses. Care should always be individualized by adding patient specific information to the Plan of Care and by identifying psycho-social, cultural, sexual, developmental, and spiritual needs related to the person’s human response.

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Near Death Experience; Fall release 2009
GENERAL INFORMATION: NEAR-DEATH EXPERIENCE

A. DEFINITION: A phenomena associated with an acute traumatic experience in which a person remembers impressions/experiences during a real/perceived physical, psychological, emotional and/or spiritual death.

B. RELATED/RISK FACTORS:

**PERSONAL**
- Attempted suicide
- Trauma/injury
- Accidents
- Assault

**ENVIRONMENTAL**
- Catastrophic event (e.g., flood, fire, tornado, earthquake)

**PHYSIOLOGICAL**
- Abrupt Δ in physiological parameters:
  - Fever
  - Hypovolemia
  - Hypothermia
  - Seizure
  - Cardiac arrest
  - Coma/unconsciousness
  - Anaphylactic shock

**TREATMENT RELATED**
- Difficult delivery
- Cardioversion
- Anaphylactic reaction
- Anesthesia
- Surgery

C. SIGNS AND SYMPTOMS:

**Person may express one or more of the following characteristics common to Near-death syndrome:**
- Feeling that the "self" (spirit) has left the physical body, moves over and watches efforts to revive body.
- Person can describe who was there and exactly what happened and what was said, even in adjoining rooms, sometimes other places.
- Relief from pain as patient is leaving physical body.
- Sensation of peace, contentment.
- Surrounded by a warm, radiant light/"presence", sense of unconditional love, peace and safety, many describe the light as "God".
- Encountering a "presence," of "Higher Intelligence" that loved and cared for them.
- Moving through a dark space or tunnel, sometimes toward a source of white light, sometimes toward extreme darkness.
- Feeling at one with the universe, "knowing how the world works,"
- Seeing and communicating with deceased family and friends.
- Panoramic review of one's life.
- Experiencing intense emotions.
- Reaching boundary and may not cross if one is to return to life.
- Entering a world of supernatural beauty.
- Sense of falling into a dark pit, seeing "hellish" images and people in torment/tortured by elves, giants, and demons.
- Hearing unusual music.
- Getting a message, pondering a choice to return or not, being told to return or feeling they made a choice to return reluctantly to earth.
- Going back through tunnel and eventually back into physical body.
- Sense of timelessness.

**Immediate reactions:**
- Look for empathetic listener.
- Intense emotional feelings of joy, anger, "why me" and fear.
- Difficulty discussing experience, even when they want to discuss it.
- Fear that health care provider will reject, deny, or think they have mental problems.
- Patient's values, beliefs and lifestyle frequently changes.

**Long-term, the person may:**
- Have significantly different affect after clinical crisis (may look unusually calm).
- Be unable to communicate with nursing staff, may appear frightened, sad, upset, elated or overwhelmed.
- Accurately describe conversations, behaviors of personnel during unconscious period, arrest or operative procedure.
- Express anger about being resuscitated.
- Ask questions to test environment to see if they feel free to discuss.
- Appear unconcerned about impending death or criticalness of their clinical condition. Will say they are no longer afraid to die.
- Have difficulty sleeping.
- Have many questions about how long they were dead, out
- Have conscious recall of the event.
- Feelings associated with this event continue after clinical crisis.
- Develop Post Traumatic Stress Disorder.²

D. SAFETY CONSIDERATIONS AND INITIATIVES:

1. Assessment/Communication:
   The Joint Commission 2009 Hospital Accreditation Standards:
   - Rights and Responsibilities of the Individual: **RI.01.01.01**: The hospital respects patient rights.
     **RI.01.01.03**: The hospital respects the patient’s right to receive information in a manner he or she understands.
   - Provision of Care: **Standard PC.01.02.01**: The hospital assesses and reassesses its patients.
     **Standard PC.01.02.03**: The hospital assesses and reassesses the patient and his or her condition according to defined time frames.
Clinical Practice Guideline:  
**POWERLESSNESS**  
Type: Human Response  
Target Population: Child/Adolescent/Adult

**PROFESSIONAL PROCESS**

A. Patient will demonstrate outcomes below:
   1. Increased sense of control.
   2. Increased assertiveness.

B. Patient/family/significant other (S.O.) will verbalize and/or demonstrate an understanding of teaching/learning goals listed below. (Document evaluation on Education Outcome Record)
   1. Personal risk factors and signs/symptoms related to powerlessness.
   2. Impact of powerlessness on self-esteem and health beliefs.
   3. Factors contributing to powerlessness that can and cannot be controlled.
   4. Participation in care routines and decision making.
   5. Realistic mutual goals and state future plans to achieve goals.
   6. Lifestyle alterations, present and future (e.g., goal setting, increased independence, assertive communication).
   7. Generic Goals (room/unit routine, pain, medication, diagnostic tests/procedures, dietary modifications, hygiene, infection/prevention, rehabilitation, medical equipment/supplies, tobacco cessation, resources for support).

**ASSESSMENT/INTERVENTIONS/CLINICAL REASONING/DECISION-MAKING:**

A. Assess and document readiness and ability to learn, learning needs and preferences. (Refer to Teaching/Learning Assessment on Education Outcome Record).

B. Collaborate with resources related to significant changes in patient status and for the continuum of care (e.g., Physician, Pastoral Care, Occupational Therapy, Child Life, Dietitian/Nutrition Services, Social Work/Services).

C. Mutually plan/develop goals, assess and document progress toward goals.

D. Implement appropriate interventions as follows and document:

   1. Correlate level of powerlessness to evidence of self-worth, self-responsibility, locus of control, patient capability/strengths, attempts to participate in care, decisions and personal growth, ability to verbalize feelings, and related risk factors.
   2. Encourage expression and promote a therapeutic alliance with patient/family/friends (e.g., scheduled time, presence, active listening).
   3. Involve patient in problem-solving and decision-making processes as soon as capable.
   4. Reinforce small gains with honest praise, discussion, and recognition.
   5. Encourage as much control as possible in planning and scheduling care, diversional activities and arranging environment.
   6. Prepare for any procedures, tests, and transfers using language the patient/family understands.
   7. Encourage questions and expansion of knowledge base.
   8. Explain options for increasing sense of mastery (e.g., relaxation exercises, imagery, role-playing, play therapy, journaling).
   9. Respect personal space (e.g., knock before entering room and ask permission to move personal belongings).
  10. Focus on abilities and encourage participation in care. Avoid doing things for patient they are capable of doing for themselves and hold parents accountable to allow child to perform self-care according to capability. Establish a “routine” daily schedule when/as much as possible. This brings some sense of normalcy.
  11. Offer emotional support through words and touch when appropriate, so they will understand that healthcare provider is a support. Provide consistent approach through their experience.
  12. Identify patient’s strengths and empower patient to utilize these strengths regarding their care/situation.
  13. Assist patient/family in conservation of energy for healing.
  14. If patient has primary caregiver at home, convey concern and acceptance of the caregiver’s feelings. Discuss options available to help caregivers.

Clinical Practice Guidelines represent a consistent/standardized approach to the care of patient’s with specific diagnoses. Care should always be individualized by adding patient’s specific information to the Plan of Care and by identifying psycho-social, cultural, sexual, age-appropriate, developmental, and spiritual needs related to the person’s human response.
A. DEFINITION: Perception of a person that his or her own behavior will not significantly affect or determine the desired outcome and there is a lack of control over current situations/events.

B. RELATED/RISK FACTORS:

PERSONAL
- Lifestyle of helplessness resulting from traumatic experience (abuse, loss, chronic illness)
- Multiple losses
- Interpersonal interactions: chronic family conflict, history of oppression (e.g., feelings not heard/suppressed)
- Fear or dislike of authority figures
- Language barrier
- Intense need for control
- Cognitive distortions
- Loss of wages/financial issues
- ↓ self-esteem
- ↓ self-worth

ENVIRONMENTAL
- Excessive restrictions
- Catastrophic stressors (e.g., natural disaster)
- Healthcare environment

PHYSIOLOGICAL
- Severe fatigue
- Dependence on medications
- Cognitive deficits (e.g., memory loss)
- Paralysis
- Immobility
- Loss of sensory function (e.g., vision, hearing)
- Inability to speak
- Inability to perform usual activities of daily living
- Inability to meet role demands
- Progressive loss of function
- Depression
- Infertility

TREATMENT RELATED
- Lack of privacy
- Physical restraint/restrictive environment
- Sedation
- Insufficient information/explanations
- Not allowed to make decisions
- Illness related regimen
- Inadequate insurance to cover cost of treatment
- No improvement despite adherence to plan
- Dependence on machines to live (e.g., ventilator, dialysis)
- Neuromuscular blockade

C. SIGNS AND SYMPTOMS:

LOW:
- Expressions of uncertainty about fluctuating energy levels
- Passivity

MODERATE:
- Nonparticipation in decision making and care when opportunities are provided
- Resentment, anger, guilt
- Reluctance to express true feelings
- Passivity
- Dependence on others that may result in irritability
- Fearing alienation from caregivers
- Expressions of dissatisfaction and frustration over inability to perform previous tasks/activities
- Expression of doubt regarding role performance
- Does not monitor progress

SEVERE:
- Verbal expressions of having no control or influence related to care, situations or outcomes
- Apathy
- Depression over physical deterioration that occurs despite patient compliance with regimens
- Does not defend self-care practices when challenged
- Inability to seek information regarding care
D. SAFETY CONSIDERATIONS AND INITIATIVES:

1. Assessment/Communication:
The Joint Commission 2009 Hospital Accreditation Standards:

- Rights and Responsibilities of the Individual: **RI.01.01.01**: The hospital respects patient rights.
  - **RI.01.01.03**: The hospital respects the patient’s right to receive information in a manner he or she understands.

- Provision of Care: **Standard PC.01.02.01**: The hospital assesses and reassesses its patients.
  - **Standard PC.01.02.03**: The hospital assesses and reassesses the patient and his or her condition according to defined time frames.
Clinical Practice Guideline:  
SELF-CONCEPT DISTURBANCE  
Type: Human Response  
Target Population: Child/Adolescent/Adult

GOALS/OUTCOMES:

A. Patient will demonstrate outcomes below:
   1. Psychosocial coping/Adjustment.
   2. Improved body image (e.g., able to look at self, touch altered body part, accept appearance).
   3. Improved self-perception.

B. Patient/family/significant other (S.O.) will verbalize and/or demonstrate an understanding of teaching/learning goals listed below.
   (Document evaluation on Education Outcome Record.)
   1. Personal risk factors and signs/symptoms related to self-concept disturbances.
   2. Relationship between physiological complaints/symptoms and disturbance in self concept (↑ physiological complaints, ↓ self concept).
   4. Reimaging process (assimilation, accommodation, interpretation) with outcome of reconciliation, new image, and lifestyle normalization.
   5. Importance of self-care (e.g., grooming, feeding, dressing).
   6. Lifestyle alterations, present and future [e.g., role responsibilities: home, work, social, occupation, activity patterns, diet and basic/instrumental activities of daily living (BADL/IADL) patterns].
   7. Generic Goals (room/unit routine, pain, medication, diagnostic tests/procedures, dietary modifications, hygiene/infection prevention, rehabilitation, medical equipment/supplies, tobacco cessation, resources for support).

ASSESSMENT/INTERVENTIONS/CLINICAL REASONING/DECISION-MAKING:

A. Assess and document readiness and ability to learn, learning needs and preferences. (Refer to Teaching/Learning Assessment on Education Outcome Record).
B. Collaborate with resources related to significant changes in patient status and for the continuum of care (e.g., Social Work/Services, Family, Pastoral Care, Physical Therapy, Occupational Therapy, Speech Language Pathology, Nursing, Physician).
C. Mutually plan/develop goals, assess and document progress toward goals.
D. Implement appropriate interventions as follows and document:
   1. Correlate self-concept perceptions to personal strengths, coping skills, current/past relationships, body image Δ, activity Δ role responsibilities, cultural factors, and physiological status.
   2. Offer counseling (active listening, rapport building, privacy) to discuss feelings related to self-concept, role Δ, physiological condition, treatment and prognosis.
   3. Identify readiness to discuss feelings, to look at Δ body part or function and reinforce the importance of the grieving process as a component of reimaging and reconciliation/adjustment.
   4. Provide opportunity for children and adults, as appropriate, to draw a picture of how they visualize themselves.
   5. Explore perceptions, misperceptions, and answer questions regarding all normal developmental, physiological, and pathology related changes in body structure, appearance and function.
   6. Facilitate personal values clarification about most important aspects that contribute to feelings of personal value, worth, and purpose in life that are not associated with appearance.
   7. Discuss strategies to reduce the impact of any disfigurement, involving the patient/significant other in identifying what they think will enhance appearance.
   8. Explore ways to learn to live with changes and clarify what the changes mean to self and others.
   9. Build upon patient/family strengths, appropriate socialization patterns, and coping skills.
10. Identify readiness and plan for opportunities to resume role responsibilities and place in society (e.g., work, home), incorporating new body image.
11. Provide opportunities for successful participation in social interactions and self-care. Build confidence through caring positive feedback after successful attempts.
12. Provide for continuity of care with minimal Δ caregiver.
13. Discuss with family/significant other the importance of avoiding the use of negative criticism and/or teasing and the importance of giving genuine positive reinforcement for behaviors such as goal setting, risk taking, and other indicators of positive self esteem.
14. Encourage expression of feelings/thoughts, verbal and nonverbal.¹

GENERAL INFORMATION: SELF-CONCEPT DISTURBANCE

A. DEFINITION: a negative state of change about the way one feels, thinks, believes or views oneself. The changes affected are in the realms of body image, self-esteem, role performance or personal identity resulting from a variety of health problems, life experiences, and the perceived reactions of others.

B. DEFINITION OF TERMS:
- **Self-esteem**: Alteration in the individual's perception of self-worth and personal accomplishments/capabilities.
- **Body image**: Disturbance in an individual's concept of the shape, size, and appearance of his body and its parts (Flynn).
- **Role performance**: Disruption in the way a person perceives role performance.
- **Personal identity disturbance**: Inability to distinguish between self and nonself. The fundamental aspects of self (moral, ethical, spiritual).

C. RELATED/RISK FACTORS:

**PERSONAL**
- **Appearance**: Disturbed body image (e.g., disfigurement, trauma, surgery, birth defects, obesity, height, and weight disproportions, pregnancy, old age)
- **Life experiences**:
  - Success/failure
  - Loss: spouse/family, social role change (e.g., death, divorce, children leaving home)
  - Unemployment
  - Financial problems
  - Inability to work/job loss
  - Position in family (sibling rank)
  - Family occupation (e.g., children of police, armed forces)
  - Relationship problems
  - History of abusive relationships
- **Self perception**:
  - worth
  - Alterations/restriction/loss in another life process (goals, values, beliefs, ideals)
- **Self-expectations**
- **Failure in school**
- **Perceived repeated failure** (e.g., relationship; employment; financial)

**ENVIRONMENTAL**
- **Absence of support**:
  - New surroundings
  - Sensory deprivation
  - Sensory overload
  - Loss of privacy
  - Peer pressure/disruption of peer relationship
  - Deprivation (e.g., social, education, economic)
  - Ethnic group difference
- **Societal expectations**:
  - Learned helplessness
  - Institutionalization (e.g., mental health facility, jail, orphanage)
  - Sexual abuse
  - Rape
  - Parental or other rejection
  - Inconsistent punishment
  - Repeated negative feedback
  - Sexual identity

**PHYSIOLOGICAL**
- Functional impairment: (e.g., ↓ musculoskeletal control/immobility)
- Loss of physical self/body part [e.g., real (hysterectomy, mastectomy, limb), imagined, symbolic]
- Loss of function (e.g., menopause, sexuality, memory, energy level)
- Psychoses
- Pain
- Anorexia nervosa, bulimia
- Severe trauma
- Central nervous system disease
- Terminal illness
- Chronic illness
- Puberty
- Aging

**TREATMENT RELATED**
- **Alteration in mobility**:
  - (e.g., Hospitalization, nursing home placement, bed ridden)
  - Medications (e.g., chemotherapy, radiation, steroids)
  - Assistive devices
  - Surgery (disfiguring)

D. SIGNS AND SYMPTOMS:

- Negative expressions of self
- Powerlessness
- Hopelessness
- Depression
- ↓ participation in activities, sexual experiences, self care, socialization
- Denial
- Expressions of shame/guilt
- Lack of/or poor problem-solving/decision-making
- Self-negating verbalization
- Evaluates self as unable to deal with Δ life events
- Rejects positive feedback
- Exaggerates negative feedback about self
- Hypersensitive to slight criticism
- Projection of blame/responsibility for problems
- Seeks approval/reassurance excessively
- Self-abusive behaviors (e.g., substance abuse, mutilation, becoming a victim)
- Insomnia
- Poor body presentation (e.g., posture, eye contact, movements)
- ↓ wellness state (e.g., ↑ ill episodes, hypochondria)
- Anger
- Isolation
- ↓ motivation
- Nonalliance with medical regime
- ↑ use of symbolism when referring to self
- Hesitant to try new things/situations
- Rationalizing personal failures
- Inability to set goals
- Grandiosity
- Eating disorders (e.g., anorexia, bulimia)
- Speech disorders (e.g., blushing, stammering)
- Altered sensory functions
- Altered GI function (e.g., diarrhea, constipation)
- Withdrawn
E. **SAFETY CONSIDERATIONS AND INTIATIVES:**

1. **Assessment/Communication:**
   The Joint Commission 2009 Hospital Accreditation Standards:
   - Rights and Responsibilities of the Individual: **RI.01.01.01:** The hospital respects patient rights.
     **RI.01.01.03:** The hospital respects the patient’s right to receive information in a manner he or she understands.
   - Provision of Care: **Standard PC.01.02.01:** The hospital assesses and reassesses its patients.
     **Standard PC.01.02.03:** The hospital assesses and reassesses the patient and his or her condition according to defined time frames.
Clinical Practice Guideline:
SENSORY/PERCEPTUAL ALTERATION
Type: Human Response
Target Population: Infant/Child/Adolescent/Adult/Geriatric

GOALS/OUTCOMES:
A. Patient will demonstrate outcomes below:
   1. Improved functional ability/safety.
   2. Balanced response to appropriate sensory input.
   3. Modification of environment to allow patient to function optimally.
B. Patient/family/significant other (S.O.)/caregiver will verbalize and/or demonstrate an understanding of teaching/learning goals listed below: (Refer to Education Outcome Record)
   1. Personal risk factors and signs/symptoms related to sensory/perceptual alteration.
   2. Compensation strategies for sensory perceptual impairment and maintenance of personal safety.
   3. Environmental and sensory stimuli adjustments needed to achieve sensory balance (e.g., lighting appropriate for time of day, eliminate/reduce excess noise, appropriate social contacts, music, television, reading, games, appropriate activity).
   4. Expected growth and development standard.
   5. Lifestyle alterations, present and future (e.g., identify comforting/noxious stimuli, self-scheduling of sensory stimuli experiences, monitor personal safety related to sensory impairments).
   6. General Goals (room/unit routine, pain, medication, diagnostic tests/procedures, dietary modifications, hygiene/infection prevention, rehabilitation, medical equipment/supplies, tobacco cessation, resources for support).

ASSESSMENT/INTERVENTIONS/CLINICAL REASONING/DECISION-MAKING:
A. Assess and document readiness and ability to learn, learning needs and preferences. (Refer to Pre-Teaching Assessment on Education Outcome Record)
B. Collaborate with interdisciplinary resources related to significant changes in patient status and for the continuum of care (e.g., Physician, Nursing, Family/Caregiver, Social Work/Services, Dietitian/Nutrition Services, Physical Therapy, Occupational Therapy, Audiologist, Pharmacy, Child Life, Pastoral Care).
C. Identify psychosocial, cultural, sexual, age-appropriate, developmental and spiritual well-being related to the human response of the patient/family.
D. Mutually plan/develop goals, assess and document progress toward goals.
E. Identify risks to safety.
F. Implement appropriate interventions as follows and document:
   1. Correlate sensory perception ability to level of orientation, sleep pattern, developmental level, current environmental stimuli, pain level, medications, physical status (e.g., trauma/disease process), personal safety risks [e.g., effects drug toxicity, decreased balance due to middle ear involvement, impaired pain awareness/visual perception, abnormal laboratory values related to electrolytes, arterial blood gases (ABGs), chemical profiles, increased intraocular pressure following eye surgery], coping patterns, pertinent past history and baseline assessment data.  (2; 6; 10) {Grade C}
   2. Identify and document factors causing sensory impairment/altered sensory perception.  (3) {Grade C}
   3. Observe and document patient’s behavioral responses to environment and sensory stimuli (e.g., hallucinations/delusions, hostility, agitation, crying, withdrawal from environment, disorientation/ confusion, paranoia).  (3; 6; 10) {Grade C}
   4. Determine sensory perceptual strengths, impairments, vulnerabilities, thresholds of tolerance and level of disorganization (intolerance).  (6; 10) {Grade B}
   5. Adjust environment to decrease excess sensory stimuli/increase appropriate sensory stimuli to promote sensory balance and organization. Introduce one source at a time to facilitate careful assessment of response and to prevent overstimulation: (6; 7; 10) {Grade C}
      • decrease the amount of noise, light and unnecessary activity in patient’s room.
      • coordinate care with all providers to promote regular and adequate rest and to decrease the amount of general activity (e.g., cluster care).
      • speak directly to the patient when in their room and near them. Do not have conversations around or about the patient without involving them; avoid conversations held just out of hearing range as it may cause/increase patient paranoia.
      • approach patient within eyesight range to avoid flight/fright response; use deep pressure (avoid light touch) as deep pressure is calming.  (5) {Grade C}
      • use therapeutic, expressive touch to enhance communication with the patient and reassure them caregivers are focused on them and not on technology.
• communicate frequently with patient to offer simple explanations for procedures, equipment, noises. Explaining procedures and equipment using dolls with individuals with communication deficits and/or cognitive issues increases understanding and allows for decreasing anxiety.
• utilize relaxing stimuli based upon patient preferences (e.g., massage, positioning, relaxation techniques, favorite television/radio, family presence, fidget item for calming). (10) {Grade C}

6. Encourage participation in activities and exercise based on patient’s sensory-perceptual capacity, responses, strength, coordination and ability [e.g., basic activities of daily living (BADL), instrumental activities of daily living (IADL), position change, recreation/diversion]. (5; 9) {Grade C}

7. Provide for maximum Stage IV and rapid eye movement (REM) sleep (e.g., incorporate bedtime rituals, pain control, darken room, avoid unnecessary care interventions that cause sleep interruptions). (6) {Grade C}

8. Assess patient’s ability to communicate effectively with family/care providers/means used for communication. (6) {Grade C}

9. Coordinate with family/care providers to decrease patient isolation (emotionally and/or physically) which may increase sensory deprivation and increase patient confusion. (6; 10) {Grade C}

10. Provide continuity of care providers; provide feedback to patient/caregivers to assist in separating fantasy and reality; reorient patient as necessary related to person, time and place and to care providers. (2) {Grade C}

**Impaired Noncortical Sensation (e.g., pain, light touch, vibration, heat and cold):**

11. Assess sensation using the following methods (all testing must be done comparing both sides as well as a normal sensation benchmark area such as the patient’s forehead); (5; 9) {Grade C}

   Note: Some patients may be weary of testing with these type of objects; in order to ease anxiety, use caregiver or bring second individual into room to allow patient to observe testing with someone else before they are asked to perform.

   • Pain: test with a sharp object (e.g., safety pin, sharp probe)
   • Light touch: lightly touching the skin with a tissue or a cotton ball
   • Vibration: touch skin with a tuning fork (128 hertz if possible)
   • Temperature: test tubes, one filled with cold water, one filled with hot water

12. Assess patient’s awareness of sensory impairment, if present. (2; 10) {Grade C}

13. Collaborate with patient/family to determine appropriate lifestyle alterations related to identified sensation impairments (e.g., careful monitoring of water temperature, careful monitoring of feet and other insensate areas for signs of injury/infection, caution related to choice of clothing/shoes). (2; 10) {Grade C}

**Impaired Cortical Sensation (e.g., kinesthetic sensation, tactile localization, tactile discrimination, graphesthesia, stereognosis).**

Note: Some patients maybe weary of testing with these type of objects; in order to ease anxiety, use caregiver or bring second individual into room to allow patient to observe testing with someone else before they are asked to perform.

14. Assess sensation using the following methods: (5; 9) {Grade C}

   • Kinesthetic sense: ability to detect the movement and position of the body in space. Test by having patient close their eyes and move the patient’s joints from position to position. Patient tells examiner what position extremities are in.
   • Graphesthesis: sensing written patterns on the skin. Patient closes eyes, examiner writes numbers/letters on patient’s skin with their finger.
   • Stereognosis: ability to determine what an object is by touch. Place object (e.g., coin, ball, screw, comb) in patient’s hand with their eyes closed.
   • Tactile location/discrimination: ability to tell examiner where touch is occurring with eyes closed. Have patient close eyes and touch patient in various areas. Have patient describe where the touch is occurring (be sure to test both sides).

15. Assess patient’s awareness of sensory impairment, if present. (2; 10) {Grade C}

16. Collaborate with patient/family to determine appropriate lifestyle alterations related to identified sensation impairments (e.g., caution when performing activities in decreased light or where visual assistance is not possible, prevention of falls by removal of objects that could be obstacles on the floor, use of assistive device if balance is significantly effected, installation of grab rails in bathroom). (9) {Grade C}

**Impaired Vision**

17. Assess visual impairment/visual perception deficits to determine how it will affect patient’s functional performance and safety. (2; 6) {Grade C}

18. Adjust illumination to enhance visual performance. (5) {Grade C}

19. Collaborate with patient/family to determine appropriate lifestyle alterations related to visual impairment (e.g., use of large print publications, writing aids, assistive devices, rearrange room so that personal articles/bed/food trays are positioned for functional vision enhancement, neon paints to accent changes in depth at stairs, referral to community agencies that can offer low vision services and training). (2) {Grade C}

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Sensory Perception, Fall release 2009
**Impaired Hearing**

20. Assess hearing impairment/auditory processing disorder to determine how it will affect patient's functional performance and safety. (1) {Grade C}

21. Recognize emotional reactions such as changes in attitude, seeming inattentiveness/disinterest as symptoms of isolation related to hearing impairment. (1) {Grade C}

22. Collaborate with patient/family to determine means of optimal communication and personal safety (e.g., visual icons, sign language, communication device). (1) {Grade C}

**Impaired Gustatory/Olfactory Senses (Taste/Smell)**

23. Assess gustatory/olfactory impairment to determine how it will affect patient's functional performance and safety. (9) {Grade C}

24. Collaborate with patient/family to determine appropriate lifestyle alterations related to gustatory/olfactory impairment (e.g., determining methods for identifying spoiled food without use of smell, as well as detection of smoke/fire). (5; 9) {Grade C}

Clinical Practice Guidelines represent a consistent/standardized approach to the care of patient's with specific diagnoses. Care should always be individualized by adding patient specific information to the Plan of Care.
GENERAL INFORMATION: SENSORY/PERCEPTUAL ALTERATION

A. CLINICAL DESCRIPTION: Change in perception of/reaction to incoming sensory stimuli. Response may be exaggerated, diminished, impaired or distorted and impacts the patient’s ability to perform functional tasks. (2; 5; 9; 10)

B. RELATED/RISK FACTORS: (2; 4; 6; 7; 10)

PERSONAL
- environmental stimuli that is either insufficient or excessive
- therapeutic environment which restricts/alters sensory stimuli (e.g., intensive care unit, bed rest, incubator, skeletal traction)
- social environmental restriction (e.g., homebound due to illness/injury, chronic illness, bereavement, dying, confusion, physical impairment, inability to coordinate)
- alterations in ability to receive, transmit or integrate sensory stimuli related to:
  - trauma, disease or deficits with neurological involvement
  - altered status of sense organs
  - biochemical imbalance causing sensory distortion [e.g., electrolyte imbalance, elevated blood urea nitrogen (BUN), hypoxia]
  - drug-induced sensory distortion (e.g., mind-altering drugs, hallucinations)
- psychological stress (e.g., narrowed perception caused by fear or anxiety)
- poor personal hygiene
- past experiences

PHYSIOLOGICAL
- neurological dysfunction (e.g., cerebral anoxia, stroke, level of consciousness, trauma)
- neurological immaturity
- chronic illness
- chronic disability that limits mobility
- biochemical imbalances [e.g., sensory distortion (illusions, hallucinations)]
- pain/impaired or delayed response to pain

ENVIRONMENTAL
- excessive, unusual, meaningless, ambiguous noise in patient’s immediate area (e.g., ICU environment)
- decreased/increased sensory stimulation/lack of sensory stimuli in the environment
- ineffective assistance devices (e.g., glasses, hearing aids)
- numerous visitors
- numerous different caregivers
- half-heard conversations
- little/no privacy

TREATMENT-RELATED
- recumbent position (e.g., visual restriction)
- limited mobility (e.g., traction, restraints, side rails)
- medications (e.g., anesthesia, tranquilizers, mood-altering drugs, narcotics, analgesics, hypnotics)
- technical language
- isolation
- ineffective assistance devices (e.g., glasses, hearing aids)
- verbal communication (e.g., positive statements)
- side effects of medications (e.g., thyroid, caffeine, amphetamines, bronchodilators)
- intense itching (e.g., casts, bandages)
- increased response to tactile stimuli
- toe walking
- gravitational Insecurity
- fears of BADL/IADL/space/movement
- aggression
- noninvasive and invasive lines
- mechanical ventilation
- paranoia/delusions
- neonate “time-out” signals:
  - gaze aversion
  - hiccups
  - sneezing
- finger/toe splays
- autonomic signs of distress in children:
  - change in skin color
  - irregular breathing
  - sweating
  - gagging
- behavioral signs of distress in children:
  - startling
  - stiffening
  - arching back
  - staring into space
  - rocking back and forth
  - crying
  - coughing
  - vomiting
  - flatus
D. ADDITIONAL INFORMATION: (9; 10)
1. **Useful sensory tools for patients with sensory alterations:**
   a. Weighted blanket
   b. Fidget item/toy
   c. Foam ear plugs/earphones
   d. Visual photos of simple commands (Yes, No, More, Stop) to assist with communication with nonverbal patients
   **Note:** Pediatric patients can become very agitated with excessive noise (e.g., ambulance sirens, bells, ICU noises); foam ear plugs/head phones may increase patient cooperation.

E. PATIENT/FAMILY RESOURCES:

F. SAFETY CONSIDERATIONS AND INITIATIVES:
1. **Functional Status:**
   The Joint Commission 2009 Hospital Accreditation Standards:
   - Provision of Care: **Standard PC.01.02.01.** The hospital assesses and reassesses its patients
     **Standard PC.01.02.03.** The hospital assesses and reassesses the patient and his or her condition according to defined time frames
   The Joint Commission International Accreditation Standards for Hospitals, 3rd ed., Assessment of Patients, **Standard AOP.1.6.** patients are screened for nutritional status and functional needs and are referred for further assessment and treatment when necessary.

2. **Assessment/Communication:**
   The Joint Commission 2009 Hospital Accreditation Standards:
   - Rights and Responsibilities of the Individual: **RL.01.01.01.** The hospital respects patient rights.
     **RL.01.01.03.** The hospital respects the patient’s right to receive information in a manner he or she understands.
   - Provision of Care: **Standard PC.01.02.01.** The hospital assesses and reassesses its patients.
     **Standard PC.01.02.03.** The hospital assesses and reassesses the patient and his or her condition according to defined time frames.

G. **This guideline could potentially be used in conjunction with any Medical Diagnosis and/or Human Response Clinical Practice Guideline.**
References

GOALS/OUTCOMES:

A. Patient will demonstrate outcomes below:
   1. Social involvement/Engagement.

B. Patient/family/significant other (S.O.) will verbalize and/or demonstrate an understanding of teaching/learning goals listed below.
   (Document evaluation on Education Outcome Record.)
   1. Personal risk factors and signs/symptoms related to social isolation.
   2. Current level of socialization.
   3. Effective social interaction behaviors.
   4. Strategies to ↑ socialization and meaningful relationships.
   5. Personal strengths and resources in resolving socialization needs.
   6. Lifestyle alterations, present and future (e.g., counseling, assertiveness, living situation, role/responsibilities, hobbies/interests).
   7. Generic Goals (room/unit routine, pain, medication, diagnostic tests/procedures, dietary modifications, hygiene infection/prevention, rehabilitation, medical equipment/supplies, tobacco cessation, resources for support).

ASSESSMENT/INTERVENTIONS/CLINICAL REASONING/DECISION-MAKING:

A. Assess and document readiness and ability to learn, learning needs and preferences.  (Refer to Teaching/Learning Assessment on Education Outcome Record).
B. Collaborate with resources related to significant changes in patient status and for the continuum of care (e.g. Dietitian/Nutrition Services, Social Work/Services, Family, Pastoral Care, Occupational Therapy, Physical Therapy, Child Life).
C. Mutually plan/develop goals, assess and document progress toward goals.
D. Implement appropriate interventions as follows and document:
   1. Offer counseling (e.g., active listening, eye contact, touch, rapport) to discuss patient expectations, socialization patterns previously used and reason(s) for perceived isolation.
   2. Correlate current socialization patterns to age, developmental stage and functioning, lifestyle, available support system/resources, disease process, behaviors, communication patterns, self-esteem, stressors, history of traumatic events and recent losses.
   3. Provide patient and family factual information about imposed isolation.
   4. Identify and confront behaviors that are detrimental to health and socialization.
   5. Explore alternative strategies with patient/family to diminish ineffective behaviors and/or improve socialization (e.g., goal-setting, personal strengths/resources inventory, seeking opportunities to socialize).
   6. Use positive reinforcement with effective use of selected strategies (e.g., praise, encouragement, rewards).
   7. Include patient in conversations with medical team, when able/appropriate (e.g., do not allow family to answer for patient).

Clinical Practice Guidelines represent a consistent/standardized approach to the care of patient’s with specific diagnoses. Care should always be individualized by adding patient’s specific information to the Plan of Care and by identifying psychosocial, cultural, sexual, age-appropriate, developmental and spiritual needs related to the person’s human response.

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GENERAL INFORMATION: SOCIAL ISOLATION

A. DEFINITION: Lack of interpersonal contact/involvement with other individuals or groups who provide support/socialization, which is perceived by the individual as imposed by others and as a negative or threatening state.

B. RELATED/RISK FACTORS:

PERSONAL
- Altered mental status
- ↑ Dependency
- Inability to engage in satisfying personal relationships
- Developmental delay
- Underdeveloped interpersonal skills
- Immature interests
- Grieving
- Overweight/underweight
- Disfigurement
- Lack of personal hygiene
- Lifestyle choices:
  - Geography
  - Retirement
  - Family responsibilities
  - Unaccepted social values or behavior
- Unresolved loss, triggered by anniversary date of loss
- Threatened self-image

PERSONAL
- Disadvantaged/inadequate personal resources (educationally, economically, socially)
- ↓ communication skills
- ↓ self-esteem
- ↓ self-concept
- Abusive behavior
- Aggressive behavior
- Shyness

ENVIRONMENT
- ↓ Resources (persons, possessions, transportation, finances)
- Unemployment
- New environment/culture
- Inclement weather
- Negative feedback from others
- Avoidance by others

PHYSIOLOGICAL
- Acute/chronic illness
- Terminal illness
- Functional impairment
- Congenital anomaly
- Surgery/trauma
- Sensory organ impairment (hearing)
- Incontinence
- Cognitive impairment
- Mental/psychological disorders
- Nutritional alterations
- Sexually-transmitted infections
- Communicable disease

TREATMENT RELATED
- Hospitalization
- Isolation/infection/technology
- Extended care facility/nursing home
- Immobility
- Mutilating surgery/trauma

C. SIGNS AND SYMPTOMS:

Objective:
- Absence of supportive significant other(s) (e.g., family, friends)
- Seeks to be alone
- Exists in a subculture
- Makes excessive demands or no demands
- Projects hostility in voice, behavior
- Restlessness
- Excessive sleep or insomnia
- Regression to behaviors of an earlier developmental stage
- Uncommunicative
- Altered state of wellness, physical and/or mental
- Repetitive meaningless actions
- Does not initiate verbal contact
- Avoids eye contact
- Withdrawn
- Sad, dull affect
- Depression, anxiety, anger
- Preoccupied with own thoughts/memories

Subjective:
- Reports of insecurity in social situations
- Expresses feelings of loneliness/rejection by others/alienation/abandonment
- Feelings of uselessness
- Desire for more contact with people
- Absence of significant purpose in life
- Expresses values acceptable to the subculture but unacceptable to the dominant cultural group
- Expresses:
  - feelings of differences from others
  - interests inappropriate to developmental age/stage
  - inability to meet expectations of others

D. SAFETY CONSIDERATIONS AND INITIATIVES:

1. Assessment/Communication:
   - The Joint Commission 2009 Hospital Accreditation Standards:
     - Rights and Responsibilities of the Individual: RI.01.01.01: The hospital respects patient rights.
       RI.01.01.03: The hospital respects the patient’s right to receive information in a manner he or she understands.
     - Provision of Care: Standard PC.01.02.01: The hospital assesses and reassesses its patients.
       Standard PC.01.02.03: The hospital assesses and reassesses the patient and his or her condition according to defined time frames.
Clinical Practice Guideline:
SPIRITUAL DISTRESS, RISK/ACTUAL
Type: Human Response
Target Population: Child/Adolescent/Adult/Geriatric

PROFESSIONAL PROCESS

GOALS/OUTCOMES:
A. Patient will demonstrate outcomes below:
   1. Spiritual well-being.
B. Patient/family/significant other (S.O.)/caregiver will verbalize and/or demonstrate an understanding of teaching/learning goals listed below: (Refer to Education Outcome Record)
   1. Personal risk factors and signs/symptoms related to spiritual distress.
   2. Personal values, beliefs, spiritual practices, choices and intentions.
   3. Sources of comfort/strength in times of anxiety, fear and insecurity (e.g., significant others, reading, silence, humor).
   4. Outlets of spiritual expression (e.g., music, prayer, scripture, rituals, meditation, faith with relaxation response, reaching out to others, journaling).
   5. Peace or acceptance of situation and/or renewed sense of self/purpose/meaning.
   6. Lifestyle patterns, which support spiritual practices or activities.
   7. Importance of the relationship between body, mind and spirit for well-being and balance in life.
   8. Lifestyle alterations, present and future (e.g., change in priorities, self-care techniques, stress management).
   9. General Goals (room/unit routine, pain, medication, diagnostic tests/procedures, dietary modifications, hygiene/infection prevention, rehabilitation, medical equipment/supplies, tobacco cessation, resources for support).

ASSESSMENT/INTERVENTIONS/CLINICAL REASONING/DECISION-MAKING:
A. Assess and document readiness and ability to learn, learning needs and preferences. (Refer to Pre-Teaching Assessment on Education Outcome Record)
B. Collaborate with interdisciplinary resources related to significant changes in patient status and for the continuum of care (e.g., Family, Pastoral Care, Social Work/Services, Physician, Nursing). (5; 7; 12)
C. Identify psychosocial, cultural, sexual, age-appropriate, developmental and spiritual well-being related to the human response of the patient/family. (7; 11; 14)
D. Mutually plan/develop goals, assess and document progress toward goals.
E. Identify risks to safety.
F. Implement appropriate interventions as follows and document:
   1. Create a safe, secure and private environment for self-expression to enhance expansion and integration of personal story and spirituality. (2; 3; 5-7; 9; 11-14) {Grade C}
   2. Develop trust and rapport with patient/family through presence, active and empathetic listening, sensitivity to nonverbal, body language and affect. (2-7; 9; 11; 12) {Grade C}
   3. Facilitate the patient's personal exploration/expression of spirituality and/or spiritual coping skills (Vachon, 2008; Scarinci, 2009; Mosby, 2002; Tucker, 2000; Burton, 2003; Stone, 1994; Switzer, 1993) [e.g., sources of meaning and purpose, strength, faith, hope, love/relatedness, trust, courage, creativity and peace (family, higher power/God, nature, centeredness)]. (3-5; 7; 8; 10-12; 14) importance of self-reflection and self-awareness (2; 5; 7-9; 11; 14) identification of barriers to personal awareness and growth, (5) usual patterns of dealing with crisis, emotional expression and decision-making skills, (9; 11) purpose and meaning of present events or illness and connection with greatest accomplishments, purposes and meaning of life, (2-5; 7; 10; 11; 14) beliefs related to health and healing (body, mind and spirit), (5; 8; 14) relationship with family/friends). (2; 5; 11; 14) {Grade C}
   4. Provide counseling for any areas that patient/family identify as barriers to spiritual health; assist in developing a plan that will reinforce strengths and strategies to address areas for personal growth. (2; 5; 7; 9; 11; 14) {Grade C}
   5. Coordinate patient's schedule to provide opportunity and privacy for spiritual practices; place on Plan of Care, as appropriate (e.g., visits, reading, time for meditation, confession, communion, laying-on of hands). (2; 5; 7; 9-11) {Grade C}
   6. Maintain an open mind/attitude regarding spiritual practices from other cultures; assist patient with requested spiritual activities as needed (e.g., read for them or provide resource, music, positioning, connect with other supports, chapel attendance, prayer and meditation, baptism, relaxation, affirmation). (2; 4; 5; 7; 9-11) {Grade C}
   7. Provide hospital clergy/chaplain services or patients own community minister, if appropriate and desired. (2-5; 7; 10-13) {Grade C}

Clinical Practice Guidelines represent a consistent/standardized approach to the care of patient's with specific diagnoses. Care should always be individualized by adding patient specific information to the Plan of Care.
A. CLINICAL DESCRIPTION: Actual/risk for distress of the human spirit due to impaired ability to experience and integrate most valued relationships with God/higher power, self, others, nature and/or creative interests that give purpose and meaning to life. (1)

B. RELATED/RISK FACTORS: (2-5; 7; 11-14)

PERSONAL
- anxiety (e.g., death, afterlife)
- self-alienation
- low self-esteem
- loneliness/social alienation
- sociocultural deprivation
- poor relationships
- disrupted belief and/or value system
- excessive stress
- substance abuse
- remoteness from God/higher power and/or disrupted spiritual trust
- significant personal loss (e.g., death, divorce, financial)
- inability to forgive

PERSONAL
- life change, inability to carry out lifelong skills/ambitions
- unresolved feelings about lifestyle change
- ineffective coping strategies, mental illness
- loss of choices

PHYSIOLOGICAL
- intense suffering/pain; Burton, 2003)
- terminal illness
- debilitating/chronic illness (self/others)
- victimization (e.g., rape, incest, assault)
- trauma (e.g., burns, car accident, natural disasters)
- sudden acute illness

ENVIRONMENTAL
- separation from family, cultural, spiritual or usual support system
- unable to obtain specific foods and/or participate in usual spiritual, religious, cultural or ethnic practices/rituals
- natural disasters
- terrorism

C. SIGNS AND SYMPTOMS: (2; 3; 5; 7; 11-13)

1. Expresses lack of or questioning:
   - meaning and purpose in life/illness/suffering
   - relationship with God/deity
   - faith
   - forgiveness of self/others
   - peace/serenity
   - hope
   - connectedness with self/acceptance of self
   - connectedness with others to share feelings, beliefs
   - ability to give and receive love
   - courage and personal growth
   - feeling anger toward God
   - view illness as punishment from God
   - inner conflict about beliefs
   - Spiritual pain: feeling of loss or separation from one’s God or deity and spiritual supports/community, sense of personal sinfulness or inadequacy before man and God, loneliness of spirit that is pervasive, experience with evil and feeling confused about God and why bad things happen to good people
   - sudden change/inability/refusal to participate in usual spiritual practices (e.g., to pray, worship, meditate, read scripture)
   - disturbance in concepts/perception of God or belief system

2. Subjective Comments:
   - "My life has no meaning "
   - "Why did God let this happen to me?"
   - "How could God ever forgive me?"
   - "I’m afraid of dying"
   - "What do you believe?"

D. PATIENT/FAMILY RESOURCES:
E. SAFETY CONSIDERATIONS AND INITIATIVES:

1. **Spiritual Support:**
   **Standard RI.01.01.01:** The hospital respects patient rights.
   The Joint Commission International Accreditation Standards for Hospitals, 3rd ed., Patient and Family Rights. Standards PFR.1: The organization is responsible for providing processes that support patients’ and families’ rights during care. Reduce the risk of health care-associated infections
   - PFR.1.1: Care is considerate and respectful of the patient’s personal values and beliefs
   - PFR.1.1.1: The organization has a process to respond to patient and family requests for pastoral services or similar requests related to the patient’s spiritual and religious beliefs.

F. This guideline could potentially be used in conjunction with any Medical Diagnosis and/or Human Response Clinical Practice Guideline.
References


7 *Mosby's clinical nursing*(2002). (Mosby ed.) St. Louis, MO. Retrieved from Nursing Consult


