

Case Report

Best Care for the Dying, Right Plan at the Right Time: A Case Report

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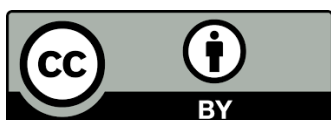
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Abstract

The growing number of individuals with palliative care needs has led to an increased demand for specialized palliative care teams.. However, these teams often struggle to meet the demand, requiring all nurses to recognize and provide appropriate care during a patient's last hours and days of life (LHDL). This case report aims to highlight the importance of identifying the LHDL and implementing individualized and adjusted care plans based on the 10/40 model of care. A descriptive-reflective case report following the CARE guidelines (for Case Report)



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focused on a 72-year-old male patient diagnosed with lung cancer with bone metastases, who exhibited eminent death signs. The early recognition of impending death signs – unconsciousness, shallow breathing with apneic episodes, mandibular breathing, imperceptible radial pulse, and pronounced peripheral cyanosis – enabled anticipatory symptom management, family preparation, and dignified death at home. The case highlights the effectiveness of nursing care grounded in the 10/40 model and Transitions Theory, demonstrating that even without specialized teams, generalist nurses can ensure a dignified end-of-life (EOL). This case reinforced the nurse's central role not only in managing symptoms but also in supporting the family, facilitating shared decision-making, and ensuring a dignified death at home.

Keywords

Attitude to death; case report; hospice care; palliative care; terminal care

1. Introduction

Palliative care is a holistic approach aimed at improving the quality of life for individuals and their families facing a life-threatening illness. It relieves suffering through early identification, proper assessment, and symptom control. Palliative care is a philosophy that celebrates life and acknowledges death as an integral component of the natural cycle of life [1, 2].

However, one of the most complex stages in the care of people with palliative needs is the last hours and days of life (LHDL). During this period, there is often a marked daily decline, typically longer in younger individuals or those with unresolved issues, ranging from 12 to 14 days [3].

The most prevalent symptoms in the LHDL are confusion/delirium, death rattle, pain, dyspnea, and nausea/vomiting [3, 4]. Regarding signs, several studies have sought to identify the most common signs of impending death. The earliest signs of approaching death are generally loss of appetite and decreased oral intake, changes in consciousness, and a rapid decline in functional status (Palliative Performance Scale – PPS < 20%) [5, 6].

Approximately three days before death, more obvious signs of impending death appear, including periods of apnea, respiration with mandibular movement, Cheyne-Stokes breathing, death rattle, imperceptible radial pulse, peripheral cyanosis, and decreased urine output [5, 7].

Nurses are the closest professionals to patients and are often the ones making the most clinical decisions [8, 9]. Nurses are key in providing end-of-life (EOL) care [10]. Through the art of caring combined with strong communication skills, the nurse establishes a therapeutic and trusting relationship, playing a decisive role in patient and family support, symptom management, developing individualized care plans, and advance care directives [11].

The ability to provide palliation and manage symptoms should be a core competency shared by all nurses. The nurse's role is to optimize end-of-life care and ensure person-centered care through shared decision-making and honouring the patient's wishes. Comfort should remain the central focus of any intervention. Therefore, all nurses must be prepared to address the physical, psychological, social, and spiritual needs of the patient and their family, in alignment with the principles of bioethics [8, 10, 12].

Although it is impossible to precisely determine the remaining lifespan, identifying signs and symptoms of the LHDH allows for the anticipation of needs and preferences. This enables the planning of an individualized care plan and consequently leads to better end-of-life care for the patient and their family, by aligning expectations and providing support through the grieving process [13].

Failure to recognize the LHDH jeopardizes the adequacy of care for the patient and family and may also lead to therapeutic obstinacy [3]. Therefore, it is essential to identify the LHDH and the clinical signs of impending death in any practice setting.

Recognizing the importance of best practices at the EOL, the International Collaborative for Best Care of the Dying Person, comprising clinicians and researchers from 22 countries across 6 continents, developed the 10/40 model. This model aims to extend the palliative care framework to other clinical contexts and to improve outcomes through a guide for EOL care, ensuring that care provided is safe and of high quality. The 10/40 model has recently achieved international consensus as a best practice approach to care for the dying [14]. The model is composed of 10 basic guiding principles [15].

1. Recognition that the person is in the last few days and hours of life should be made by the multidisciplinary team (ideally a doctor and a nurse) and documented by the senior healthcare professional responsible for the person's care.
2. Communication of the recognition of dying should be shared with the person, where possible and deemed appropriate, and with those important to them.
3. The dying person and those important to them (relative, carer, or advocate) should have the opportunity to discuss their wishes, feelings, faith, beliefs, and values.
4. Anticipatory prescribing for symptoms that can be expected (e.g., pain) should be available.
5. All clinical interventions are reviewed in the best interests of the person.
6. There should be a review of hydration needs, including the commencement, continuation, or cessation of clinically assisted (artificial) hydration.
7. There should be a review of nutrition needs, including the continuation or cessation of clinically assisted (artificial) nutrition.
8. There should be a complete discussion of the care plan with the dying person, where possible and deemed appropriate, and with those important to them.
9. There should be regular reassessments of the dying person at least every four hours, or at each contact in the community setting. Review by the multidisciplinary team at least every 48 hours.
10. Care for the dying person and those important to them immediately after death is dignified and respectful.

Through the principles of the 10/40 model, it is possible to summarize and guide the intervention of the healthcare professional who identifies LHDH, with this diagnosis serving as the starting point for care planning.

2. Materials and Methods

2.1 Case Report

This is a descriptive-reflective case report following the CARE guidelines (Case Report) [16]. The purpose is to reflect on the importance of recognizing the signs of impending death and to emphasize the need for health professionals to be trained in identifying these signs. This report is based on a case from clinical practice, the principles of the 10/40 Model, and Afaf Meleis' Transitions Theory, while adhering to the International Classification of Nursing Practice.

Afaf Meleis, through her mid-range nursing theory, Transitions Theory, asserts that individuals undergo various transitions throughout the life cycle. Meleis classifies transitions into four types: health/illness, developmental, situational, and organizational [17]. In any kind of transition, it's imperative that nurses, as health professionals supporting individuals from conception to bereavement, must be aware of these transitions in order to intervene effectively and have a significant impact on the health of both the person and their family [9].

When applying Transitions Theory to the LHD, two phases of transition are considered: the health/illness transition, due to the worsening health condition, and the situational transition, as the impending death of a family member leads to a redefinition of roles within the family [9].

Consent to participate in the case report was obtained from the patient's wife several weeks after the patient's death. Confidentiality and anonymity were fully guaranteed. It was explicitly stated that there were no risks or direct benefits for participants, apart from contributing to research to improve specialist nurses' knowledge of LHD. No identifying information was recorded in this case.

2.1.1 Selection Criteria

The selection criteria for this case report were adult patients in LHD showing any sign of impending death (periods of apnea, respiration with mandibular movement, Cheyne-Stokes breathing, death rattle, imperceptible radial pulse, peripheral cyanosis, and decreased urine output).

2.1.2 Measuring Instruments

The PPS [18] instrument was used to assess the patient's performance; Pain Assessment in Advanced Dementia (PainAD) [19] was used to evaluate pain.

2.1.3 Patient Information

Male patient, Mr. E., 72 years old, diagnosed with lung cancer with bone metastases. He lived with his retired nurse wife and used to receive support from several family members who were present daily. He was referred for palliative care and was awaiting the first assessment. Due to nausea from oral chemotherapy and severe pain, he attended a private medical appointment. He was seen by a Palliative Care physician, who adjusted his analgesic therapy and prescribed antiemetics. He improved significantly over the following days, with no nausea and controlled pain.

At the beginning of the following week, he experienced occasional confusion and intermittent oral intake due to reduced appetite. Suspecting dehydration, and following the doctor's prescription, a primary health care nurse administered 0.9% saline via hypodermoclysis and Haldol. The family

was aware of the patients's decline but was satisfied with the control of nausea and pain. A home appointment by the nurse was scheduled for the following day. The nursing intervention was initiated on November 20 and completed on November 21. An overview of clinical events and palliative interventions is shown in Figure 1.

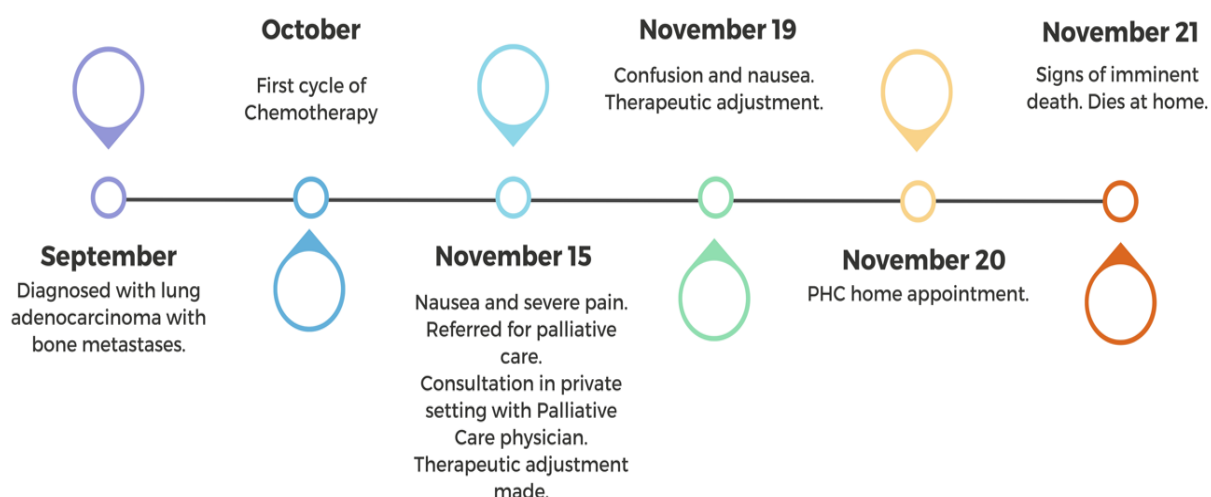


Figure 1 Timeline of clinical events and palliative care interventions.

2.1.4 Clinical Findings

About an hour before the nursing appointment, the family contacted the Primary Health Care (PHC) nurse, reporting that Mr. E. was unresponsive and sniffing with a 'bubbling' sound. The nurse instructed them to close the 0.9% saline drip and said they would arrive at their home immediately.

Upon the nurse's arrival, Mr. E. was lying in bed in the dorsal decubitus position, showing several signs of impending death, including unconsciousness, shallow breathing with short periods of apnea, respiration with mandibular movement, an imperceptible radial pulse, and pronounced peripheral cyanosis. PainAD: 0.

Several family members were present (with his wife, a retired nurse, being the closest). It was evident that she was experiencing a high anxiety response, but she maintained her presence at her husband's side.

Signs of impending death were identified, marking the starting point for nursing intervention. The family was gathered in the living room and informed that death was impending. Although they were aware of the approaching end, they remained anxious and expressed concern. The wife immediately returned to her husband.

At the same time, the physician who had previously attended to Mr. E. was consulted to update him of his current clinical condition, to prescribe PRN medication for expected symptoms (pain, dyspnea, delirium, death rattle, nausea), and to review the current therapy.

While communicating with the physician on the phone, the wife asked for confirmation of the absence of vital signs. Mr. E. passed away in the presence of his wife, without any signs of suffering, and at home, as he had wished. From that moment on, all attention and support were directed toward the family, focusing on the wife.

Based on the nursing interventions, two nursing diagnoses were formulated – one for the patient and the other for the family, both by the ICNP (2019). Initially, the diagnosis "Risk for compromised

comfort” was considered, as at the time of observation, Mr. E. was calm, without signs of pain, but there was a risk of developing symptoms that could cause discomfort. However, according to the ICNP (2019), comfort is defined as “sensation of physical ease and bodily well-being”. This does not fully encompass the patient’s psycho-socio-emotional and spiritual aspects. Therefore, given that care during LHDH requires addressing specialized needs and promoting dignity and quality of life, the diagnosis “Risk for Compromised Dignity in Dying” was deemed more appropriate. This diagnosis highlights the proximity of death while acknowledging the patient as a holistic being. According to the ICNP (2019), dying is defined as the “gradual or sudden decrease in body processes leading to the EOL,” and dignity is recognized as a fundamental human right.

For the family, the nursing diagnosis of “Death Anxiety” was chosen based on the evidence. Death is defined by the ICNP (2019) as “negative emotion: feelings of threat, danger, or distress”, while anxiety is described as a “emotion: Psychological process: conscious or subconscious feelings, pleasurable or painful, expressed or unexpressed; may increase with stress or disease” [20].

3. Results

The application of the 10/40 model began upon the suspicion of the LHDH during the phone call with the primary healthcare nurse. At this stage, principles 5 and 6 were applied: the nurse acting in the patient’s best interest, advised reducing the flow of subcutaneous saline.

During the home nursing visit, the nurse identified signs of impending death, confirming the LHDH, an action aligned with Principle 1. The nurse then gathered the family and informed them of the LHDH situation, implementing principle 2. Simultaneously, principle 4 was applied by contacting the attending physician to inform the patient’s current clinical status and to prescribe anticipatory medication, further reinforcing the application of principle 5. Finally, principle 10 was implemented by providing immediate post-mortem support to the family.

Due to the limited time between the recognition of LHDH and the patient’s death, the remaining principles could not be applied.

These actions were consistent with the 10/40 model and demonstrate how the nurse’s role contributed to managing the transitions experienced by both the patient and the family, in line with Meleis’ framework [9].

Identifying impending death signs (unconsciousness, shallow breathing with short periods of apnea, respiration with mandibular movement, imperceptible radial pulse, and pronounced peripheral cyanosis) enabled anticipatory symptom management, family preparation, and a dignified death at home.

A few days later, the patient’s wife contacted the PHC nurse to express her gratitude for the care and immediate support provided.

4. Discussion

The clinical case highlights how nursing intervention during LHDH requires both active technical care and compassionate presence, where symptom control and comfort must remain central care goals [3, 21].

The findings indicate that a timely and skilled nursing response can facilitate a peaceful and dignified death at home, a context often preferred by patients and families [22]. The nurse played a key role in preparing the family for the dying process, providing education about the common

symptoms and signs of LHD, how they can prevent and alleviate them, always prioritizing comfort and dignity. Empowering families with this knowledge helped reduce anxiety and fostered acceptance, contributing to healthier bereavement outcomes [3, 14, 22].

The 10 basic principles of the 10/40 model help systematize and guide the nurse's interdisciplinary interventions, ensuring good practices at the EOL. In situations of impending death, it is not always possible to apply all the principles. The applied principles were crucial in promoting dignity and aligning care with the patient's and family's wishes and needs. This reinforces the 10/40 model as a valuable tool, not only for specialized palliative care teams but for generalist nurses as well.

The case also exemplifies a successful application of Afaf Meleis' Transitions Theory. The nurse's intervention contributed to an appropriate transition in health/illness for the patient and situational transition of the family, particularly the wife, who moved from caregiver to bereaved partner. Grounding clinical practice in a nursing theory supported delivering care that was holistic, timely, and responsive to emotional and existential needs [9].

This case also reveals the limited availability of specialized palliative care teams. When such teams are unavailable or overburdened, it becomes even more essential that all health professionals are trained in basic palliative competencies, especially when the focus of care shifts from cure to comfort. This ensures that all professionals are equipped to promote dignity for the patient and their family at the EOL – by recognizing individual needs and preferences, providing symptom control, respecting advance care directives, and facilitating a peaceful environment for dying, regardless of the care setting [15].

5. Conclusion

Based on the case report, it was possible to reflect on the nurse's competence in recognizing and responding to signs of impending death. The objective of the case study was achieved, demonstrating that the development of specific palliative care nursing skills, combined with clinical experience, contributes to a specialized ability to identify individuals in the LHD and to implement individualized, timely care plans aligned with the 10/40 model.

This case reinforced the nurse's central role not only in managing symptoms but also in supporting the family, facilitating shared decision-making, and ensuring a dignified death at home. The early recognition of impending death signs allowed for anticipatory interventions and emotional preparation of the family, in line with the 10/40 model and Meleis' Transitions Theory.

In addition, the process revealed limitations in the current ICPN framework when applied to palliative care contexts. The document *"Palliative care for a dignified dying - International Classification for Nursing Practice Catalogue"*, developed by the International Council of Nurses, seeks to standardize nursing language in this field. However, a document revision is recommended, as key terms are missing to accurately describe the scope and objectives of palliative care nursing interventions, such as the term "comfort".

Author Contributions

Ana Santos, responsible for identifying the case report subject and drafting the article; Elsa Abreu, responsible for drafting the article; Márcia Assunção, responsible for identifying the case report; Catarina Simões, conducted analysis and performed revisions of the article; Rita Figueiredo, carried

out the final revision of the article. All authors reviewed, approved, and gave their final consent to the article before its submission.

Competing Interests

The authors have declared that no competing interests exist.

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