> **PRACTICE BOX: CLINICAL HIGHLIGHTS**
>
> • Education of families about the process of dying and what to expect after a death is a key element of nursing interventions.
> • Information about the significance and probable sequence of the physical signs of dying and the interventions that may be used to address the symptoms must form the basis for education.
> • Discussion of families' expectations regarding who will be present at the time of death is helpful.
> • While it is not usually possible for a staff member to be constantly in attendance with a dying individual, families require reassurance that staff will check on the individual regularly.
> • Individuals and caregivers prefer honest and accurate information that is provided with empathy and understanding.

Dying individuals experience fear of pain, indignity, abandonment and the unknown (Chochinov, 2002). Involving individuals and their family members in discussions regarding these fears may strengthen relationships within the family and reduce the isolation experienced by the dying person (Herrmann & Zulisn, 2008).

Recognition of the importance of emotional support and nurturance at the end of life implies that nurses must be equipped with sufficient human resources and knowledge to adequately address this need. Other guidelines reviewed by the development panel that met the AGREE criteria (an internationally recognized tool to assess the quality of clinical practice guidelines, Appendix B), indicate that the individual's transition to the dying phase should be consistently communicated by all members of the health-care team. Mixed messages should be avoided as they can lead to loss of trust, miscommunication, conflict and poor care management (NCI, 2002; NCCN, 2003). As well, nurses should be aware that the focus of hope at this stage often shifts from cure and prolongation of life to quality of living and dying (Singer et. al., 1999; Stajduhar et al., 2008).

> **SPIKES: A SIX-STEP STRATEGY FOR DELIVERING BAD NEWS** (BAILE ET AL., 2000, P. 305-307)
>
> **1. S – Set up the Interview**
>   a. Arrange for a private location to meet.
>   b. Involve significant others.
>   c. Sit down and try not to have barriers between you and the patient.
>   d. Make connection through eye contact and touch.
>   e. Manage time constraints and interruptions.
>
> **2. P – Assess the individual's perception**
>   a. Use open-ended question, i.e. "What have you been told about …" or "What is your understanding of …"
>   b. Correct misinformation and tailor bad news to the individual's understanding.
>
> **3. I – Obtain the individual's invitation**
>   a. A person's desire for information may lessen his/her anxiety associated with the bad news.
>   b. If information is not desired, offer to answer any questions.
>
> **4. K – Give knowledge and information to the individual**
>   a. Provide warning that bad news is coming, to lessen the shock that follows the disclosure of bad news.
>   b. Assess the level of comprehension and vocabulary of the individual.
>   c. Use non-technical terms.
>   d. Avoid excessive bluntness.
>   e. Give information in small chunks and check periodically regarding patient/caregiver understanding.

5. E – Address the individual's emotions with empathic responses

    a. Observe for any emotion experienced by the individual.

    b. Identify emotions experienced by the individual.

    c. Identify the reason for the emotion.

    d. Connect the emotion by making a connecting statement, such as "I am sorry about _____.
       I know this is not what you want to hear. I wish the news were better."

6. S – Strategy and summary

    a. Establish clear plan for the future, to lessen feeling of anxiety and uncertainty.

Limitations of the Evidence and Future Directions

There is a paucity of data to support various interventions during the last days and hours of life, largely due to the difficulty in recruiting individuals who are dying into research studies. In addition, few tools regarding care of people who are dying have been validated in the non-cancer population. There is also a lack of evidence regarding the knowledge and skills required to provide care for these individuals. Further research is clearly required in these areas. Thus, much of the evidence supporting these recommendations is based upon expert clinical consensus, consensus guidelines and standards of practice.

RECOMMENDATIONS