

# NURSING CARE OF A PATIENT IN TERMINALLY ILL CANCER- CASE STUDY

## Opieka pielęgniarska nad pacjentem w terminalnej fazie choroby nowotworowej- studium przypadku

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**Key words:** nursing care, patient, terminally ill, cancer, case study.

### Summary

*The aim was to show the nurses and hospice care as a member of the team over the patient in a hospice for terminally ill cancer resident in the house. Nurse choosing to work with patients who die must know that not only medical knowledge will be needed in carrying out its duties but also a lot of love, patience and above all humility toward life and death. Characterized range of palliative care and its residents. The paper presents a description and policies for hospices and home desktops and volunteers working in them. Material - the subject of research - the case of a patient with pancreatic cancer he cultivated to the last moments of life. Test method - method of individual cases, which applies to nursing, is a qualitative description of the passage of reality and its interpretation. Used to collect all kinds of information about the case, in particular about the family situation, social, environmental, material and existential, psychological, physical or other person examined. This is a descriptive study undertaken by type of research problem, which requires the use of methods relating to a single case or small their number.*

*Research problems:*

1. How long the patient has symptoms associated with cancer diagnosed?
2. Have there been cases of death from cancer in the family sick?
3. Have you previously was treated oncological?
4. When the first signs of disease?
5. Does the patient know about his condition?
6. Are they symptomatic treatment introduced hospice doctor brings relief from symptoms?
7. Is recommended to take the product (Megace) improves the appetite, gives the desired effect?
8. Is your oxygen therapy brought relief in breathing?
9. How effective were notmorphotic painkillers?
10. Do you sick of the constant care exercised a family?
11. Is the hospice team visits took place at regular intervals or whenever the call of the family?
12. Is the patient dying in dignity, surrounded by kin?

*The goal of the research work presented, a description of the patient (the subject of research), research problems and the method of research, technology and research tools, describes the results of research. Presented in a special way and meaningful roles of a nurse who has the care of the patient in the terminal stage of cancer, staying at home. The problem of mental, spiritual, and emotional problems of the patient and the environment. Based on the literature of the subject and based on scientific study, the following conclusions:*

1. In view of the cancer patient who is not eligible for treatment at the forefront the problem of cancer pain and other ailments of the digestive and respiratory systems, and greatly reduced physical fitness.
2. The patient was the biggest problem was lack of appetite and emaciation of the body related to it which greatly limited its self-care, and in a later stage, prevented completely.
3. Above the patient in the terminal who will remain in the home should be planned nursing care consulting and communicating with members of her family, educating them in implementing the active care, care and assist.
4. The nurse takes action on dying nursing care aimed at improving the quality of life, eliminating pain, psychological comfort, elimination of other ailments associated with the disease, assist.

**Słowa kluczowe:** opieka pielęgniarska, pacjent, terminalna faza, choroba nowotworowa, studium przypadku.

### Streszczenie

*Celem pracy było ukazanie opieki pielęgniarki hospicyjnej będącej członkiem zespołu hospicyjnego nad pacjentką w terminalnej fazie choroby nowotworowej przebywającą w domu. Pielęgniarka decydując się na pracę z chorymi którzy umierają musi wiedzieć że nie tylko wiedza medyczna będzie potrzebna w wykonywaniu jej obowiązków ale także wiele miłości, cierpliwości a przede wszystkim pokory wobec życia i śmierci. Scharakteryzowano zakres opieki paliatywnej i jej podopiecznych. Przedstawiono opis i zasady działalności hospicjów stacjonarnych i domowych oraz pracujących w nich wolontariuszy.*

*Material - przedmiot badan - przypadek chorej na nowotwór złośliwy trzustki którą pielęgnowałam do ostatnich chwil życia. Metoda badawcza - metoda indywidualnych przypadków, która ma zastosowanie w pielęgniarstwie, jest jakościowym opisem fragmentu rzeczywistości oraz jej interpretacją. Służy do zbierania wszelkiego rodzaju informacji na temat przypadku, a w szczególności o sytuacji rodzinnej, społecznej, środowiskowej, materialno-bytowej, psychicznej, fizycznej czy innej badanej osoby. Jest to badanie opisowe podejmowane ze względu na rodzaj problemu badawczego, który wymaga wykorzystania metody odnoszącej się do pojedynczego przypadku lub niewielkiej ich liczby.*

*Problemy badawcze:*

1. Od jak dawna chora ma dolegliwości związane z rozpoznaną chorobą nowotworową?
2. Czy były przypadki śmierci z powodu nowotworów w rodzinie chorej?
3. Czy wcześniej leczyla się onkologicznie?

4. Kiedy pojawiły się pierwsze oznaki świadczące o chorobie?
5. Czy chora wie o swoim stanie?
6. Czy leczenie objawowe jakie wprowadził lekarz hospicyjny przynosi ulgę w dolegliwościach?
7. Czy zalecane przyjmowanie preparatu (Megace) poprawiającego apetyt przynosi pożądany efekt?
8. Czy wprowadzona tlenoterapia przyniosła ulgę w oddychaniu?
9. Na ile skuteczne były niemorfotyczne leki przeciwbólowe?
10. Czy opiekę stałą nad chorą sprawowała rodzina?
11. Czy wizyty zespołu hospicyjnego odbywały się regularnie czy każdorazowo na wezwanie rodziny?
12. Czy chora umierała w godnych warunkach w otoczeniu najbliższych?

*W części badawczej przedstawiono cel pracy, opis chorej (przedmiot badań), problemy badawcze oraz metodę badania, techniki i narzędzia badawcze, opisano wyniki badań. Przedstawiono w sposób szczególny i wnikliwy rolę pielęgniarki sprawującej opiekę nad pacjentem w terminalnej fazie choroby nowotworowej, przebywającym w domu. Problemy psychiczne, duchowe i emocjonalne chorego oraz problemy otoczenia. W oparciu o literaturę tematu oraz na podstawie przeprowadzonego badania naukowego sformułowano następujące wnioski:*

1. W związku z chorobą nowotworową pacjentki, która nie kwalifikuje się do leczenia na pierwszy plan wysuwa się problem bólu nowotworowego oraz innych dolegliwości ze strony układu pokarmowego i oddechowego, oraz znacznie ograniczonej sprawności fizycznej.
2. U chorej największy problem stanowił brak apetytu i wycieńczenie organizmu z nim związany co znacznie ograniczyło jej samoopiekę, a w późniejszym etapie uniemożliwiło całkowicie.
3. Nad pacjentką w stanie terminalnym przebywającą w domu należy zaplanować opiekę pielęgniarską konsultując się i komunikując z członkami jej rodziny, edukując ich w wdrażając do czynnej opieki, pielęgnacji i asystowania.
4. Pielęgniarka nad umierającą podejmuje działania pielęgnacyjno-opiekuńcze mające na celu poprawy komfortu życia, niwelowanie bólu, komfort psychiczny, eliminowanie innych dolegliwości związanych z chorobą, asystowanie.

Palliative medicine is a specific medical specialty, aimed, inter alia, to develop guidelines and standards of structure - organization of palliative care and medical treatment guidelines, to ensure its effectiveness, particularly in mitigating the problems and needs of dying patients and their families. It is used to identify the type of care, taking into account all the elements that compose it. WHO defines it as a comprehensive, holistic care of patients suffering from incurable causal uncontrolled progressive disease, usually exercised during the end of life, an operation which improves the quality of life of patients and their families struggling with life-threatening, incurable disease through prevention and relief of suffering through early identification and assessment and treatment of pain and other problems of physical, psychological, social and spiritual. [1, 16, 34, 45, 46].

This care includes prevention, pain and other somatic symptoms, alleviating mental, spiritual and social as well as supporting patients' families during the illness and after patient's death during the so-called bereavement. The purpose of these multi-action, performed by the multidisciplinary team is to improve the quality of life of patients and their families. Both patients and family do not bear the cost of care, which shows up regardless of age, gender, race or religion. Care that may be covered by each applicant (or reported by others) the patient, which is in the terminal phase of illness and, if necessary, members of his family. [1, 16, 34, 47].

From nurses working in palliative care unit is required to specialize in palliative care or to complete a qualifying course (or perfected in the field of palliative care.) It is recommended that other members of the multidisciplinary team, with specialist training, have received training in palliative care for working with seriously ill and their families. Palliative care as specialist nurses can choose one. [45, 48, 49].

The period before the terminal phase is a disease in which treatment has stopped extending life, but the patient is in quite good condition overall - no complaints and is quite physically fit. This period usually lasts several weeks or months, sometimes it can take several years. The period begins in the terminal when the patient symptoms occur, leading to an irreversible deterioration of general condition and mobility, which prevents usually leave the house. It is responsible for palliative care and usually lasts about 6-8 weeks [1, 16, 34].

There are physical stages of dying and they can determine when a person dies due to illness or old age. The patient refuses to acknowledge that he was dying. Believe that it is a mistake, that his is not applicable. Patients dominates reluctance to meet with others, physicians, staff, family and friends to escape in his own world where the disease is not. Often ask themselves "Why is this happening to me, and not to drunk from Six?". Anger at the injustice of fate, to God. Anger at the people around you that can walk, they are not paralyzed, seeing, hearing, are healthy and their "health" annoy. Wrath of the dependence on others, especially when the patient was a vigorous and ruled others. The desire to conclude the agreement, which will stave off the moment the patient's death. "If you get well / I will not die, I will do this and that." Loss of power, medical expenses, painful and often disfiguring surgery, long-term stay in the hospital - it all leads to a lowering of mood. Even more depressing is regret for things you do not have time to do, regret that you have to already depart from this world. Regret that some things do not enough time has already solved. Quiet waiting for the approaching death, but without any joy or serenity. Rather, it is without feeling. Accepting his fate extinguishes a lot of emotions and desires of interest of the patient. [3, 34].

Hospice is an institution whose aim is to cover medical, psychological, spiritual and social people in the terminal (pre-death) phase of the disease and the delivery of similar assistance to families of those persons. The purpose of hospice care is to give the patient the most complete survival of the terminal stage of disease by symptomatic treatment, care and support of patients and their families. As envisaged in the organizational home hospice for adults should be in every county. This is the recommended and preferred form of palliative care. The patient lives at home, but can use equipment borrowed from the hospice. Members of the interdisciplinary team to visit him, depending on your needs. [45]. There are seven "gold standards" of palliative home care [50]: 1 Communication - regular team meetings to gather information, prepare the patient records, care planning, preparing for the transfer of patient information and

auditing. 2. Coordination - to appoint a coordinator, conduct registration, organizing meetings and preparing educational materials and aids. 3. Control symptoms - diagnosis, treatment and monitoring symptoms. 4. Follow-up care outside working hours - 24-hour access to care, effective transfer of patient information, access to medicines and equipment. 5. Continuation training - continuous upgrading of skills, critical analysis of the cases. 6. Support - practical, financial and emotional support after the loss of a loved one. 7. Care in the dying stages - the preparation and carrying out the protocol of care for physical, emotional and spiritual needs of patients in this period. [1, 16, 34, 45, 50].

Hospice so do not try to cure the patient, such as cancer, but to strive to relieve the pain accompanying the disease, physical, mental and spiritual. For this purpose pursued jointly, hospice team, consisting of doctors, nurses, physiotherapists, psychologists, chaplains, hospital halls workers, social workers and medical and non-medical volunteers. Hospice can be either domestic, or caring for the sick in his house, as well as stationary, a host under his roof a person who can not provide sufficient care in their homes. While many hospices are called by church institutions, the care they can count every patient, regardless of their relation to faith and religion. Do not change the fact that underlying value of hospice care are Christian, and many people make up hospices and working in them, guided by religious motivation. In awareness there is a widespread belief that hospice is a simple "extension" of a hospital or place where one gets a patient, the hospital or the family want to get rid of "hopeless case". But the reality is different. Hospitals and hospice and palliative centers are primarily medical institutions to adhere to the provisions of the Ministry of Health, signing contracts with the NHF, which is controlled pharmaceuticals, etc., however, differ among themselves that, hospitals tend to treat the patient, and hospices provide him with the best quality of life and support to its environment. Activities include prevention hospice pain, other troublesome symptoms of the terminal stage of disease, as well as easing the discomfort in the face of impending death. So explicit goal sets a holistic, or comprehensive care model. Its essence is to satisfy, as far as possible the widest range of needs of the patient and his family. [4, 7-9, 17, 21, 25, 29, 30, 32, 40, 43].

Partnership model for the relation doctor - patient in hospice care, but also the cooperation of all professionals holding the interdisciplinary care, as well as volunteer activities, provide a greater commitment to the patient and his environment. The complex, set for a quick resolution purposes, anonymous and depersonalized hospital care is fundamentally different from a simple, focused on improving the quality of life and friendly palliative and hospice care. Very important is the role of volunteers who help implement elements of the most awaited by patients and their families - the presence, vigilance and concern for their various needs at the end of life. The tasks of palliative care include: the fight against overwhelming pain, symptomatic treatment of other ailments and somatic care, alleviating psychological and spiritual help in solving social problems, family support during illness and bereavement, health education under the care of people, their families and employees hospice. [5].

Most patients in terminally ill cancer patients prefer to stay in their homes under the care of relatives. The majority of families - as long as you receive adequate assistance from outside, is ready to take care of the end of their loved ones at home. The house is the natural and the best place of human existence. Patient after intensive treatment has ended causal, may be referred by a medical specialist or primary care physician for the symptomatic treatment under the care of a hospice home. The patient or his family members can register in person or by telephone at the headquarters of the hospice. After registration, the patient can count on regular and professional assistance Hospice home care team. During the first visit, be submitted by the physician and nurse coordinator to collect information about illness, previous treatment, the test is carried out carefully, determine the cause of pain and other ailments, and planned to continue the proceedings for assistance. Family members also receive guidance and advice on the exercise of professional home care for your loved ones. The needs of patients and their families depend on the frequency of subsequent visits so, and what kind of person performing them: a doctor, nurse, priest, psychologist, or non-medical volunteer. Sick all the time take care of the same people. Guardianship weekend - Sunday night and the person on duty exercise. During the visits, carried out the necessary medical treatment, observing the results of treatment, if necessary, it shall be amended. Hospice Services not only handles the accompanying pain management developing the disease and its unpleasant symptoms, but also tries to help the patient and his family all the problems associated with severe disease. The presence of friendly people, professionally prepared, can free the patient from pain, reduce other troublesome symptoms of the disease developing, but also to endeavor to master the mental pain, fear and loneliness. Hospice care is a help in overcoming daily difficulties, the support for the patient and his family, is the presence in the most difficult moments. Families of patients themselves to ensure that the patient had the necessary drugs and care. However, if possible hospice can provide patients with certain drugs, disposable equipment, specialized dressings and materials for maintenance. Sometimes people simply beneficiaries carries prescription and other necessities of life products. Hospice offers its inventory of equipment, leasing it to charge their patients, which facilitates their daily existence. The patient may also opt out of hospice care if you have such a request, including where in the course of home care and hospice patient's condition improved and he will not have to benefit from intensive home care. Early cancellation will not close the door to readmit the patient for home care and hospice. Home hospice care is completely free for the patient and his family. For example, the Hospice Home of the Queen of the Apostles in Radom, has signed a contract with the National Health Fund, which allows you to cover part of costs of the hospice. The remainder of the funding comes from membership fees, voluntary donations of patients, their families and others who depend on maintaining the activities of our hospice. [6, 21, 40, 43].

Trained volunteers (not medic), among whom are people of different professions, visit the sick in their homes, fulfilling their various functions, among others.: Primary care and treatments such as washing, bed-making and feeding,

regular monitoring of drug use, keeping the sick society, periodic replacement of a very tired family responsibilities to the patient, supporting the mental and spiritual patients, supporting family members, preparing them for the inevitable losses and comforting the bereaved. Only with great effort of the patient and all those involved in the exercise of care in an atmosphere of mutual goodwill and understanding you can achieve a common goal to improve the quality of life of the patient and the achievement by all stakeholders of maturity, allowing run decently at that stage where the future is currently live. Many volunteers are familiar with the suffering and pain among the family members, so they are aware how important it is to help the needy, not only physically but also mentally ill people but also their families who are preparing for the moment of parting. When a patient comes in the final stage of the disease, family support is especially needed. First of all it has to be prepared for the departure of a loved one. Often families do not realize that the agony has already begun (especially if the patient was a long time without contact). Sometimes also, so that caregivers, aware that the patient dies, do not want to accept this message. They want to save at any cost: the additional injections, drips, etc. You have made a lot of tact and skill to convince the wife or husband in despair that such actions are unlikely to prolong life, the most difficult to drag the dying and, therefore, in the name of good patient, the better give them up. [7, 31, 42, 43].

Mostly you need to teach the family care when dying: to convince of the need for peace and quiet, with the administration of painkillers to end (despite the fact that the patient is unconscious, and it seems to us that does not suffer), the quiet presence of a dying (without forcing him, calling " ", crying, etc.) Sometimes the question is asked: "What else can you do for him? ", dictated by a sense of helplessness, ignorance, how to behave. Then note the role of touch, which of all the senses is the longest felt. One of the most important tasks of palliative care is a comprehensive assistance to families of people dying. Psychooncological Numerous studies have revealed that the most difficult period for the patient, causing most of the kinks and despair during the first relapse-for his family but turns out to be the most difficult period of terminal. This is quite understandable. Family (especially if the family is "good" and connected emotionally with the patient) at that time experiencing a particularly difficult moments. Heavy burden on a patient's usual symptoms. For pain and dyspnea, occurring in a loved one, they react with fear and depression carers, both flowing out of compassion, and with a sense of helplessness. Strong emotions also cause mental disorders occurring at times the patient, especially the symptoms of delirium, or changes in behavior that deprive the carers 'bonus' as a good contact with the patient, his gratitude, smile, etc. For many people who come into contact with a man seriously ill for the first time in life, but does not accustomed to working from home, need to take over household duties connected with the inability to care a very great stress. The thought of separation-of-the departure of a loved one is undoubtedly the most loving family members, especially for the spouse, father or mother, the greatest source of suffering. This feeling is all the harder to bear, it is often hidden. If the patient does not know its status - it certainly happens fairly often - keeper hides his sadness, trying to show on the outside, "a cheerful face, which is not an easy thing. Many people are afraid of death. In an interview with the hospice team often asking these questions: "How will it at the time of departure? What did you expect? How do I behave? ". The conversation usually ends with a request that someone from the team was present when "it" happens. Fear of dying is just a very heavy burden for the carer. Not without significance is the trajectory of the disease - varies widely. Sometimes the disease is a chronic, slowly preparing both the patient and family to leave. This is the course of the "best" because it facilitates the process of adaptation. However, if you leave "extends" over, it exhausts the power of a guardian. It is said in this connection about the "right" time to leave, adapted to the adaptability of the patient and his family, come on the other hand, the subjective assessment guardians mostly the "right" time is not. Undoubtedly the worst disease is to prevent the habit of thinking about retirement, and death of a sharp downturn after a period of relative alignment of the disease or fulminant course, immediately after diagnosis. Reactions of caregivers and their ability to cope with stress are also dependent on their own physical and mental, as well as on their capabilities and size of support from the immediate environment. In a much better situation are large, zzyte with each family, whose members account for each other source of consolation. Play a role and financial conditions of living, especially housing. Paucity and narrowness, difficulty finding a quiet corner for a patient then constitute a serious problem. On the other hand, it is clear from our experience, the isolation of patients from the family by locking them in a separate room, while life goes by, it is not the best solution. It seems that this case involves individual decisions. In a particular situation are the so-called family. physical load. This applies especially to daughters caring for mothers with cancer of the breast or genital organs. As well as risks of cancer in this group of people, hence the care of the terminally ill can often wakes her daughter's association with his own situation in the future, exacerbating anxiety and depression. [8, 9, 12, 15, 18, 23].

The last period in the terminal stage of cancer are dying. It is difficult to determine the time when it begins and when it ends. In medical terminology the process of dying is distributed in time at which the disappearance of vital signs, there are also deficiencies in the functional nervous system, circulatory and respiratory systems. Death is often preceded by the death of the biological psychological and social death. Death is a psychological condition in which the patient is conscious, but mentally absent, no interest in people, their issues, not talking, not eating, not reacting to external stimuli as if they "died for the world." Social death affects the patient, which is biologically alive, but the other person is treated as absent. Nobody is not interested in him, no visits, treatments with the patient are performed instrumentally. When you fail ways to master the medical physiological dysfunction can we talk about 'the agony. It is part of dying. The agony is life and death struggle. The agony of the body of the patient is unable to return to the dynamic equilibrium called homeostasis. Contact textual logic is temporarily or permanently impeded, the heart rate becomes more rapid, irregular, poorly discernible, irregular breathing, with brief interruptions in breathing, there is a

snarling breath "before death rattle "is cool upper and lower extremities. Muscle tension changes facial expressions, cracks grow more acute (the Hippocratic face), skin changes color, becomes pale or waxy. Agony is often accompanied by a condition called ante-euphoria. The patient asked about the mood states that he feels better or very good. This condition is bad prognosis and indicates that the body has ceased to defend and run out of forces seeking to restore homeostasis. In addition to euphoria, drowsiness occurs. Sen. dying is shallow, the patient wakes up with him several times. Agony may also be accompanied by disturbances of consciousness or arousal. More often, however, the patient is aware of what is happening to him and about him. In the process of dying can see some common characteristics, symptoms of dying, which allow to better understand and support the dying and they are the weakness in the physical realm, the patient stays in bed all the time, he loses the mood for eating and drinking. Therefore, there is difficulty in swallowing, he loses control over urine and faeces - to complete their cessation, reducing the cognitive - the patient becomes drowsy, difficult to wake up periodically, it can be tangled, befuddled, anxious and excited. Deteriorating sight and hearing. May have trouble concentrating, sees people and objects that are not there, does not recognize their loved ones, not versed in the time and place, she can not work with carers. [9, 21, 29, 40, 41, 43].

The patient in the terminal stage of the disease, showing symptoms of imminent death, they develop over a few dozen weeks. Sudden deterioration in the patient's health status occurs over a period of several days or hours. For this fact, prepare the patient and his family. In the care of patients terminally there is an overriding need excellent skills of observation. Please see all the needs of the patient - including those not indicated verbally. This applies to persons seriously ill, the dying - too weak to communicate. This ability is based on careful observation of facial expressions and body gestures often scarce. This is essential in bringing relief. Such accommodating the needs of the patient, his anticipatory requests will help to ensure maximum patient comfort. Implementation of the needs of the patient and family should always proceed with their consent. Do not promise a positive impact of our actions - we do not say "for sure" - we say we will. " We have made the right promises. The assertion that "everything will be fine" is unfair, because patients in the terminal stage of cancer can be achieved only periodic improvements being. It does not promise a return to health is not tantamount to accepting hope. Honestly offering alleviate patient discomfort, the presence in difficult times and support for him and loved ones - we introduce an atmosphere of trust. If you offer the patient what we can actually give - it will be our most precious gift. Pursuing the needs of the patient and the family have to provide comfort during this difficult time. To comfort was the maximum we need to implement quickly, efficiently, and preferably jointly with the family. Particular attention should be paid to the speed and effectiveness. Sick man tired of the disease and suffering has a different sense of time. Us healthy people, it seems that a few moments, the patient forever. Active participation of families in care brings many benefits both for the short as well as for themselves and also for caring for the team. Family participation in care is an essential building block to ensure comfort. Only well-trained family members can give the patient a sense of security and help you avoid difficult situations. To tutored by a team of family was well organized in the care we choose the person leading. This will be someone who meets a managerial team, formed by caregivers. Many times we encounter resistance from their families in the form of fear to cause harm to the patient, physical aversion associated with the destruction and the presence of external cancerous changes or even the fear of infection. Such an attitude is a task for the person training, consisting of patient awareness and conviction to help care. You should also keep in mind the feelings of the patient - who often afraid to not professionalism their loved ones. You must then follow the steps with her family, being the person does not support the supervisor and try to prove to the patient that his caregivers are doing well. Education family is also talking about ending the lives of their loved one. This comprehensive discussion of the time when I need to say goodbye. This offering by enabling seamless phone contact 24 hours a day, 7 days a week. Very important is to leave written instructions, all information was communicated. Family Education is an important task in palliative care - hospice care. The causes of suffering patients in the terminal phase of incurable diseases are many and feeling each subsequent increases. Everyone is different and everyone else is experiencing his illness and dying, but everyone is a whole bio-psycho-spiritual and social. Another extremely important function of a hospice worker in palliative care is a function of psychological and spiritual. It is often a nurse during the nursing of the patient, listens to his "confession of life." The close contact which establishes a nurse with the patient while performing multiple functions produces a special kind of bond. The patient often continues to increase confidence is to this person who spends a lot of time with him - the time used for activities related to feeding, bathing, changing dressings, etc. All these activities is accompanied by touch - a touch of instrumental and expressive. Among other things, thanks to him the patient feels accepted and treated as his nurse, custodian, broker with his family, a priest, a psychologist. This unique relationship makes that, over time the nurse is an integral part of the environment of the patient. Such a situation is ennoblement - that's what the nurse was selected to accompany the end of life. Each patient is benefiting from palliative care sooner or later die. So you feel satisfaction from work if: every patient dies, despite our best efforts, many times we are unable to protect him from many ailments, we can not give hope for life and health, child or young person dies, it remains a family in despair, we have our own fears for our families and ourselves. In the face of these problems, the ability to derive satisfaction from working with the terminally ill is difficult and requires re-evaluation of their own expectations. If we can not hope to restore the health and preservation of life in return we give what we can give you: support, accompaniment, excellent care, effective mitigation of ailments, caring for loved ones, to meet many needs, preparing families to care. It is crucial also to realize that knowledge and experience we have and ever expanding, helping people to die in a dignified manner - without suffering. Job satisfaction is associated in a very meaningful way with our attitude in life. Just the fact that close contact with human suffering, the dying, reevaluates our personal reactions and desires. Every patient is our repository of

knowledge - a separate book of wisdom. Important role in shaping our satisfaction, and personality meet patients' families. From them we learn what was good and what is bad. Thanks to them we learn how to live, how to enjoy, how to cry, how to be humble. [1-3, 14-16, 21, 29, 34, 37, 40-43, 50].

Aim. According to Z. Skorny, the determination to research and requires the formulation of problems, "realizing what we take the test and what can be obtained from them useful results." The objectives defined in relation to the nursing diagnosis, formulated on the basis of the results and analysis of the patient's situation. Determination of the objective precedes determine answers to questions. [10].

Aim of this study is to describe the nurses as a member of the team holding the hospice patient care in terminally ill cancer staying at home. The nurse, being mostly the sick dying, he knows the most about him. It knows best how to meet the constant changing needs depending on the course of the disease and symptoms. Therefore, it is she should be the leader of an interdisciplinary team, which deals with the patient in different organizational units. She often visited him at home, is in the hospital, he meets his preferences, habits and beliefs. The nurse can most accurately assess the changing situation in the state of health of the patient. Can read the nonverbal communications. Being a frequent visitor to the patient's home, can gain his trust is in the hands of the patient gives up his sick body in order to perform all necessary operations.

Material - the subject of research. As a subject of study presents the case of a patient with pancreatic cancer he cultivated to the last moments of life, and her mother was the first author. In June 2006, after ultrasound and abdominal CT unresectable pancreatic cancer were diagnosed with metastatic numerous other digestive organs. Doctors on the results of the research outcomes up to 3 months of age. Also excluded the possibility of consultation oncological chemotherapy, since too large an area was already affected by cancer. At that time my mother was already very weak and emaciated, disease process proceeded very quickly. She was referred to hospice home of Queen of Apostles in Radom, which as of the declaration and supported assist suffering from symptoms of disease my mother and all the members of our family. I was accompanied by an emotional time as her daughter, helplessness, hopelessness, anger, despair and awareness of impending death. Hospice team (doctor, nurse, volunteers notmedics) become part of our home and family surrounding her mother not only medical care, psychological and spiritual but also all of us. The doctor who has performed care has become a model to follow. Mother of first author died in the first author dn. 12 August 2006 with 64 liters in the environments of those for whom it was most important and which she loved, surrounded by family.

Research problems. The research problem is some question or set of questions to which answers have to provide the test. [11]. 1. How long the patient has symptoms associated with cancer diagnosed? 2. Have there been cases of death from cancer in the family sick? 3. Have you previously was treated oncological? 4. When the first signs of disease? 5. Does the patient know about his condition? 6. Are they symptomatic treatment introduced hospice doctor brings relief from symptoms? 7. Is recommended to take the product (Megace) improves the appetite, gives the desired effect? 8. Is your oxygen therapy brought relief in breathing.? 9. How effective were notmorphotic painkillers? 10. Do you sick of the constant care exercised a family? 11. Is the hospice team visits took place at regular intervals or whenever the call of the family? 12. Is the patient dying in dignity, surrounded by kin?

The methods, techniques and research tools The specificity of nursing lies in the fact that it can not, like other fields of medicine, based solely on scientific knowledge. It is explicitly interdisciplinary and builds on the achievements of natural science, and social. This is also used in life science research methods. This chapter will present a method of individual cases, which applies to nursing.

The case study is a qualitative description of the passage of reality and its interpretation. Used to collect all kinds of information about the case, in particular about the family situation, social, environmental, material and existential, psychological, physical or other person examined. What is important is the impact of social and environmental situation of the sort of life of the unit. The method of individual cases is a descriptive study undertaken by type of research problem, which requires the use of methods relating to a single case or small their number. The method of individual cases is also a way of research involving the analysis of individual human lives, entangled in specific situations with a focus on the development of case diagnosis or phenomena in order to take therapeutic measures. The final stage of this work is the description of the case. This analysis may be of detailed or generalization. Analysis detailing. be carried out if made a description of the case is the basis for identifying the causes of disease entities that may arise during an individual's life. Generalizing analysis should be applied when an individual made a description of the case or a number of cases as the basis for generalizations, to point to their shortcomings, or even to create a theory based on various cases. Please note that the problem of "individual case" is rarely independently existing case - a state. It is mostly the result of many factors, many situations, events and circumstances acting in the living person. It is one of many elements of the syndrome of factors affecting individual and therefore can be properly evaluated and interpreted in the totality of the circumstances and taking into account the context in which it occurs. [10, 11].

The result of the study is a description of the patient including physical, mental, social, emotional, causes illness, family problems, pathology, financial situation, social, etc. In nursing, as in other disciplines engaged in empirical studies used different research techniques. The use of this or any other technique determines the type of material and information which are considered to be important for answering the research questions. [10, 11].

The technique is a practical set of concrete actions relating to the collection and production of materials necessary to study and put forward on the basis of the conclusions and generalizations. The use of specific techniques in

research requires mastery of a range of practical skills, simple and homogeneous, relating, inter alia, planning and organizing research, carry them out, to develop appropriate research tools and use them to collect materials and information or to make the measurement, classification and evaluation. Research techniques can be divided according to the adopted criterion. Given the way in which researchers gather information, they can be divided into direct and indirect techniques. A direct survey techniques we say when researchers gather information directly. The direct techniques for the collection of materials can include all types of interviews, both individual and collective, and all types of direct talks. If you find information is through someone or something, then we speak of indirect techniques. This will include any work or products of activities examined, and examination of documents. Depending on the means test as applied by the researcher in the process of collection, all research techniques can be divided into standardized and non-standardized. Standardized techniques are those in which all measures related to acquisition of research materials and information are far from uniform and standardized. These tools include: history of the disease, the card observational survey anesthesia, nursing process, etc. The most commonly used in standardized testing techniques include: controlled observation, interview questionnaired, non-standardized questionnaire, etc. Technology is one in which research funds are not uniform . This fact affects a much greater freedom in collecting data relating to the phenomena and in developing them. For non-standardized research techniques include: casual observation - uncontrolled, the interview is free, all kinds of information contained in the documents, the products of action, notes, etc. [10, 11]. To gain as complete, reliable and objective information, the study used the following techniques: interview, observation, nursing, measurements, analysis of documents. [12]. Nursing history is planned, focused conversation with a single patient or group of people such as family, which has lead to the assembly of reliable data (objective and subjective. [13]. Is used most often to gather information about matters of interest to the investigator or the phenomena occurring in the past or those that may arise. There are two types of intelligence in clinical nursing: community interview with the main objective is to collect the largest possible facts about the environment, interview caring, you gather information about the needs of the ward, its difficulties and infirmities. [14]. Observation of care is the most valuable and most commonly used technique for research. It is a permanent element of the nursing process. By monitoring we mean a set of activities involving the deliberate, planned and selective accumulation of information by observations on their natural course without any interference of the observer. [11] can be used in to complement their existing information, confirm what is already known on the body to verify the reliability of health data collected previously from, for example an interview with the patient. [13]. The documentation is the source of information about people, objects and events that took place in a particular time. With it you can know precisely the slice of reality researcher's interest. [14]. Data on health status ward cards provide preventive medical examinations, the preliminary tests, cards, health and illness, and laboratory tests and specialized. Using the documentation, you must first ensure its authenticity and credibility. special value to the work of nurses are those documents that contain not only descriptions of dry facts, but also point to the cause. By doing so you can more accurately direct its actions. Measurements allow observe what changes occur in the human body, and whether these changes moving in the right direction, for example, whether weight loss is a parameter, positive or on the contrary, evidence of pathological processes in the body of the patient. [14]. For the measurements are specialized tools, scaled appropriately. These include: growth measured, weight, and sphygmomanometer others. is to read the measurement units on the appropriate scale. The nurse makes various measurements to assess the functioning of the body as a whole or some part of it. The measurements are: mass, height, and body temperature, capacity, chest, muscle strength, vision, hearing , size, blood pressure, heart rate, etc. In order to derive the data to assess the efficiency of the functioning of a system, you can compare them with the relevant standards such as BMI, blood pressure standards, tables etc. correct heart rate measurement, referred to, relate to the way research distort the functioning of the body of the audited entity. [11]. Discussed techniques enable account the context in which coincided with a person to live, grow up, work, work. Analysis of the documents refers to the materials collected and developed by others and found in numerous documents, including particularly in the notes and documents drawn up during visits to doctors and nurses at the hospital, as well as during visits to the family doctor's office. For sources of these nurses are excerpts from the hospital, documentation of care, family doctor, specialist, laboratory tests, X-ray and other. [14]. All of them document the activities of these institutions at different periods of time. Thanks to them, if they were reliable and accurately drawn, we can better understand the problems of the prior period, as well as we can describe and explain the past happening over time changes in patient health status. They can also be used for comparative purposes. [11]. Have been analyzed by the following documents: the result of abdominal ultrasound patients, CT of the abdomen and the disease card of notification to the hospice home until his death. The aforementioned documents provide a full range of information on : patient personal data, health status, cancer stage, the ability to self-service, complaints relating to the course of the disease, treatment with medication, mental state, family and social situations. Research tools are concretized ways to implement those objectives. [13]. Defined also as an adjuvant, used in the collection of empirical materials, useful in solving the problem of research undertaken. [15].

Research tool prepared for the purpose of this study is to medical records maintained by the home hospice team, which allowed to collect key information from the disease and the health status of the patient. This documentation includes patient personal data, general health status on the basis of intelligence and observation. It also contains a description of the problems that occurred in a patient due to weakening by the day of the organism. It shows also the mental and emotional problems, not only patient but also family. [15].

**Nurse role in patient care of terminally ill resident at home - mental problems, emotional and spiritual. problems of patient and environment care.**

Needs of the patient at the end of life. Patients in the terminal stage of any chronic somatic disease is in a similar situation, clinical and psychosocial, which are characterized, growing physical ailments, a progressive impairment of mobility and the ensuing social isolation, restricted social roles hitherto carried. The reactions of patients with this state of affairs, in response to failing to provide their basic needs are also pretty similar. Need to be understood by the state of uncomfortable sensation caused by lack of some important human values. Along with the general psychological development, those needs over a lifetime are staged FOR development. The first - the "lowest" - stage of development of human needs and the level of biological needs, food, drink, sleep, overall physical comfort. A characteristic feature of this period is also a need for security. [16, 17, 40, 41, 43].

As you grow a man enters the next phase, which is characterized by two main needs, need for esteem, the need to maintain good community relations. Both the first and second stage have a common characteristic, which is self-centeredness, or self-treatment as the main reference point in all relations with the environment. The highest level of development achieved in the way of mental maturity is the attitude heterocentric, expressing the fact that a man can look from a distance on their problems and "set up in a series of" jointly with others. Social needs are not yet expressing the desire "to me, loved, approved, and listened to" transform themselves in the need for giving something to others in the "need to be needed." Come to the fore here as spiritual needs, expressing the desire to achieve the value of the immortals, truth, goodness, justice, beauty. God (at this point, we speak of religious needs.) Each man felt the need for emotional causes a specific reaction, in response to the meeting (if there is contentment, pleasure, joy) or lack of satisfaction (dissatisfaction, distress, sadness, anger). The situation of the terminal, with all its limitations are fundamentally changing the elaborated hierarchy of values - is completely reverse their proportions. The most important is again becoming a biological needs, food, sleep, and especially physical comfort. Another very important during this period need to become self-esteem., So it is very important demands respect and subjective treatment of the patient by medical personnel, emphasizing the dignity and rights. [6, 32, 41-43].

Cognitive responses to situations of terminal. We must realize that the image created by the patient's illness is generally different from the image received by medical personnel. The doctor image creates a specific disease entity based on medical knowledge, intelligence, research results and their interpretation of the data. The patient would use for this purpose the general, circulating information about the disease, but about his or her own requests to the verbal and nonverbal messages from doctors, family members or friends (eg, behaviors such as increased tenderness, anxiety being ill, etc.). A further observation of symptoms and their own perceptions and judgments about their causes, prognosis, etc. The most important thing is also played by early contacts with patients with cancer in the family. Image of the disease is sometimes exaggerated, sometimes less, usually distorted, and very rarely reflects reality. Picture of the disease and their situation very much depends on the patient's emotional state-so often it makes. cognitive reworking of the disease, which is the basis to adapt to it. [1, 3, 6, 7, 9, 16, 21].

Emotional reactions to situations of terminal. The most common cause of adverse reactions is emotional stress of the diagnosis of disease, uncertainty of prognosis or poor prognosis as well as physical complaints associated with the progression of the disease. Other causes include: lack of support and good relationships with family and poor communication with medical personnel. Very important also appear to personality traits of the patient (prone to pessimism, passivity and helplessness) and lived in the past psychiatric or neurotic. Occurrence of negative emotions also contribute to other severe concomitant survival of the disease or its predecessors. In younger patients, there is typically more intense unpleasant emotional reaction than in the elderly. [1, 7, 9, 25, 40].

Attempts to reduce the intensity of negative emotions or preventing them usually come down to: inform the patient about the treatment, encouraging the patient to make decisions about treatment and care, the incentive to express their feelings, control and monitoring of psychiatric symptoms on a par with the physical. Among the most common unpleasant feelings, which are observed in patients in the terminal, replace the anxiety, depression, anger, guilt and humiliation. [1, 4, 7, 9, 40, 42].

Anxiety. It is a sad state of emotional arousal, a sense of threat caused by the loss of some values (health, life, beauty, etc.). It should be distinguished from fear, which is a reaction to the expected, specific "danger" (eg, surgery, painful injections, etc.). Anxiety is very common in cancer, but paradoxically it is the burden of disease is rarely reported by the patient: first of all, because it is not always realized (not the habit of introspection and self-analysis). In addition, patients are often too embarrassed to admit to anxiety ("not proper", "I'm an adult"). Therefore express it indirectly, such as over-emphasizing the (disproportionately to the state in question), somatic symptoms, or by a special behavior (avoiding glances, tricky questions, cautious speech, the use of symbols, the alleged carelessness or unconcern). Anxiety manifests itself also by physiological signs: rapid heartbeat and breathing, tense muscles, difficulty sleeping or nightmares, and sometimes-elevated pressure. Anxiety can have different causes. The most common is to anticipate events, such as further worsening of the disease and dying process, which will be accompanied by pain and shortness of breath. Sometimes the fear of being rejected by relatives or care for them, and fear of death as something "unknown" (existential anxiety). Anxiety may also be caused by factors beyond the psychological, must be remembered that fear, like pain, is a human need. As a warning against the dangers of defensive action stimulates and healthy to take up and continue the treatment, etc. It is also feeling very strong and unpleasant, which in the process of adaptation is usually treated and alleviated. [1, 9, 17, 21, 40-43].

Anger. It is the emotional reaction to an obstacle in achieving the objectives of the emergence of anomalies (this is something that should not exist.) Health status is a normal state is a disease of disturbances. Anger is manifested in this case as a reaction to the "irregularity" of the disease. There are different forms such as anger - anger of the

"general" (the injustice of fate, claims to God's) wrath "transferred" (eg medical staff), the proper cause is his own fear or guilt, anger, hidden (expressing the outside the negative attitude, refusing cooperation, depression, somatic complaints exaggerated emphasis, etc.), suppressed anger (not accepted by the patient's disclosure raises feelings of guilt). Anger, like fear, can act as a positive force-often is mobilizing to fight (eg disease), as well as the source of activity and energy. However, uncontrolled anger can take the form of aggression against the environment or facing each other. Like fear, this feeling should be conscious and processed in the adaptation process. [9, 17, 21, 25].

Depression. It is an unpleasant emotional reaction, which is a response to the certainty of losing some important values (or remedy the forecast.) Under this concept, you can extract the grief caused by losing a certain value (eg, mobility, beauty) and actually depressed, which is a long state of sadness caused by a variety of summing to one another "loss." Depending on the duration and severity of depression may contain explicit form (eg, crying, complaints, pessimistic courts) or latent, expressed as "body language" (general slowdown curved, 'closed attitude', downcast eyes, sad facial expression) and other indirect signs, such as anhedonia (the inability to enjoy), loss of interest, difficulty concentrating, functional impairment of memory (some authors believe that depression is an expression of aggression against himself: "The worse the better"). Physiological signs of depression include loss of appetite, early waking, or tiles, interrupted sleep and nightmares. Depression is an important element in the psychological treatment of the disease. Depression can be good, if it is a prelude to adapt to illness, or bad, the worse the patient unsuitable for your condition. Depression "good", anticipative, precedes the expected events and prepares patients for grief and gradual habituation to the loss of important values for them. Depression worse, as an expression of incompatibility, take the form of pathological, expressing the despair set of symptoms, suicidal ideation (rarely performed) and the complete isolation from its surroundings, combined with the refusal to cooperate, taking medication, etc. is often accompanied by a sense of frustration for small value and guilt associated with the negative attitudes to each other. Feelings of guilt is sometimes quite often the consequence of magical thinking (the illness is a punishment for sin, to be an inappropriate way of life). Awaken them to the suppressed feelings of jealousy towards a healthy and efficient friends of friends. It also happens that patients are irritable, explosion, have mood swings. Lack of or insufficient control of these emotions can also be a source of guilt. Sometimes the guilt stems from the conviction of his own inadequacy, the awareness of being a burden on the environment, etc. In some patients, particularly prone to perfectionism and excessive self-criticism, the phenomenon becomes very large. [9, 17, 40-43].

Hope. Emotional reactions described above belong to the so-called influenza. Negative emotions, and so unpleasant, disturbing the well-being. Opposing force, which reduces the consequences of these feelings, there is hope. It is defined as a state of expectation on the future of something good (eg good outcome, the return of fitness, etc.) associated with a feeling of contentment or joy. Hope lies at the basis of an optimistic attitude to life and motivates action, and if it is coupled with the will to live is an extremely important element of adaptation to the disease. [9, 17, 21, 25, 40-43].

Adaptation to the disease. Adaptation, ie adaptation to mental illness is a process consisting primarily by restoring the patient's mental equilibrium, and thus to reduce the emotional discomfort and reaching as far as mental health. "The 'adaptation to cope with the problem of disease and the changes that it causes in your life. This is done on two levels: cognitive and emotional. Decrease in the intensity of unpleasant feelings and increase positive emotions (hope) is a result of consciously or unconsciously taken "cognitive processing", sometimes called strategies or defense mechanisms. The most common subconscious strategies are: to deny, reduce or distort the image of the disease (although I have cancer, but the current pain is radical and is not related to cancer "). Others, opposed to the types of strategies are conscious focus on the illness, successful selective search of information, often arousing unrealistic hopes, or the fight against disease by taking magical activities, such as the use of "miracle" of non-medical with blind faith in their efficacy. Very often the attitude is also seen cleavages, namely a simultaneous recognition of the possibility of death and the possibility of recovery. Effective mechanism of adaptation is also a habit that occurs especially when the disease takes a long time and gradually progresses. Habituation is the taming of the situation and recognize their limitations and problems as "normal." A vibrant produce a negative reaction then only new or very unpleasant symptoms (eg pain, shortness of breath). Explains the mechanism of such habits frequently observed discrepancy between the assessment of the situation carried out by the patient and the assessments of observers from the "outside" (the latter are usually worse). Conscious adaptation take various forms. The least effective is to avoid: Although the patient knows his status, but does not want to talk about it, I want to live "normally", supplanting thinking about your situation. In this group fall well developed attitudes resignation stoicism under the belief that "everyone must die sometime, so you have to accept it. It seems that the best attitude accept patients who during the past life or under the influence of the disease developed in a strong system of values over personal (eg, religious, family), allowing them to focus on the content and submission to their own personal goals. [6, 16, 17, 22, 37, 38, 46].

Patient's family problems - emotional and spiritual support. One of the most important tasks of palliative care is a comprehensive assistance to families of people dying. Psychooncological Numerous studies have revealed that the most difficult period for the patient, causing most of the kinks and despair during the first relapse-for his family but turns out to be the most difficult period of terminal. This is quite understandable. Family (especially if the family is "good" and connected emotionally with the patient) at that time experiencing a particularly difficult moments. Heavy burden on a patient's usual symptoms. For pain and dyspnea, occurring in a loved one, they react with fear and depression carers, both flowing out of compassion, and with a sense of helplessness. Strong emotions also cause mental disorders occurring at times the patient, especially the symptoms of delirium, or changes in behavior that deprive the

carers 'bonus' as a good contact with the patient, his gratitude, smile, etc. For many people who come into contact with a man seriously ill for the first time in life, but does not accustomed to working from home, need to take over household duties connected with the inability to care a very great stress. The thought of separation-of-the departure of a loved one is undoubtedly the most loving family members, especially for the spouse, father or mother, the greatest source of suffering. This feeling is heavier to bear, it is often hidden. If the patient does not know its status - it certainly happens fairly often - keeper hides his sadness, trying to show on the outside, "a cheerful face, which is not an easy thing. Many people are afraid to refuse. In an interview with the hospice team often asking these questions: "How will it at the time of departure? What did you expect? How do I behave? ". The conversation usually ends with a request that someone from the team was present when "it" happens. Fear of dying is just a very heavy burden for the carer. Not without significance is the trajectory of the disease - varies widely. Sometimes the disease is a chronic, slowly preparing both the patient and family to leave. This is the course of the "best" because it facilitates the process of adaptation. However, if you leave "extends" over, it exhausts the power of a guardian. It is said in this connection about the "right" time to leave, adjusted to the possibility of adaptation of the patient and his family, come from other carers in the subjective assessment usually such a "right" time is not. Undoubtedly the worst disease is to prevent the habit of thinking about retirement, and death of a sharp downturn after a period of relative alignment of the disease or fulminant course, immediately after diagnosis. Reactions of caregivers and their ability to cope with stress are also dependent on their own physical and mental, as well as on their capabilities and size of support from the immediate environment. In a much better situation are large, lived with each family, whose members account for each other source of consolation. Play a role and financial conditions of living, especially housing. Paucity and narrowness, difficulty finding a quiet corner for a patient then constitute a serious problem. On the other parties, as is clear from our experience, the isolation of patients from the family by locking them in a separate room, while life goes by, it is not the best solution. It seems that this case involves individual decisions. [1, 3, 8, 21].

In a particular situation are the so-called family. physical load. This applies especially to daughters caring for mothers with cancer of the breast or genital organs. As well as risks of cancer in this group of people, hence the care of the terminally ill can often wakes her daughter's association with his own situation in the future, exacerbating anxiety and depression. [8, 21].

Support the family during the dying. When a patient comes in the final stage of the disease, family support is especially needed. First of all it has to be prepared for the departure of a loved one. Often families do not realize that the agony has already begun (especially if the patient was a long time without contact). Sometimes also, so that caregivers, aware that the patient dies, do not want to accept this message. They want to save at any cost: the additional injections, drips, etc. You have made a lot of tact and skill to convince the wife or husband in despair that such actions are unlikely to prolong life, the most difficult to drag the dying and, therefore, in the name of good patient, the better give them up. [8, 24, 25, 29, 32, 41].

Mostly you need to teach the family care when dying: to convince of the need for peace and quiet, with the administration of painkillers to end (despite the fact that the patient is unconscious, and it seems to us that does not suffer), the quiet presence of a dying (without forcing him, calling, crying, etc.). Sometimes the question is asked: What else can you do for him? Dictated by a sense of helplessness, ignorance, how to behave. Then note the role of touch, which of all the senses is the longest felt. We had a patient in a coma, which betrayed great agitation. Despite the administration of analgesics continued state of arousal. The patient calmed only when one of her favorite daughter was holding her hands. Over the last five hours old daughter in her arms she held her mother constantly, until it died quite peacefully. The period of prolonged and long hours of agony for the family of the patient is particularly heavy. Believers can be offered to families in this time of prayer (people needlessly afraid to withdraw from such an initiative). Believers can be encouraged to talk about dying. I recall a situation that I experienced with my wife dying young man. At his bedside told me the history of their love-good and bad, and at the end of toil common "tear up" for a period of illness. She said how her husband was a brave and courageous in illness, which is proud of him. I think it was good goodbye. [18, 40-42].

The fight against pain and other ailments. Approximately three quarters of patients with cancer pain, and most of them also reported two types of pain, and even more than three. Some types of tumors are often associated with the onset of pain than others. Among patients with cancer: esophagus, pancreas and bone more than 80% report pain. Approximately 70-80% of sufferers of cancer: lung, stomach, biliary tract, prostate, breast and ovarian feel pain during the disease. Cancers: larynx, colon, urinary tract and the brain is accompanied by pain in approximately 60-70% of cases, and the lymphomas, leukemias and soft tissue tumors - in about 50-60%. [17, 19].

The definition of pain is that it is an unpleasant sensory and emotional sensation associated with actual or potential tissue damage. Talking about chronic pain in the stocks of over half a year. Chronic pain is one of the most unpleasant sensations. On his feelings are influenced by the experience of past and current state of physical, mental and so-called. a person's pain threshold. The pain is compounded by fatigue, fear, anger, depression, sadness, lack of sleep and feelings of isolation. So, be careful that the pain is dependent on what the patient feels. [17, 19, 20].

Cancer pain can be acute, chronic and breakthrough. Acute pain is rapidly growing pains, generally of high intensity, as defined at the start and disappear. I do not usually take longer than six months. Then they disappear or turn into chronic pain. Often accompanied by vegetative symptoms, such as nausea or excessive sweating. By understanding the concept of chronic pain, the pain lasts a long time, usually over 6 months, or accompanying chronic diseases. Not always possible to determine its cause. It leads to changes in personality and lifestyle of the patient. Breakthrough pain

is acute pain, seizure and transient. It overlaps the previously existing, permanent problems or appear in an effective analgesic therapy. Is much stronger than basic pain. Its main features are paroxysmal (from a few to several episodes per day), short duration (approx. 30 min) and high intensity. The most common is caused by body movements, coughing, swallowing, or defecation. The occurrence of this type of pain significantly reduces the daily life and shows that the applied pain therapy is inadequate. Cancer pain is very different from the pain accompanying other diseases. This is due to the specificity of the disease, which interferes with all spheres of life of the patient. Pain is just one of many factors causing or increasing pain. The other factors are physical symptoms, such as side effects of treatment (nausea, vomiting, weakness, diarrhea), psychological problems (an unfavorable change in appearance, mutilation, depression, anger, irritability, suicidal tendencies), social factors (loss of employment and earnings, the deterioration living conditions, loss of social position, the withdrawal from friends and limited social and cultural life, loneliness), fear: pain, death, being a burden, concerns about family, guilt, insecurity. [17-20, 36].

Particularly important is the relationship between pain and anxiety. Anxiety is a response to threat and increases the sensation of pain, fear and the pain intensifies. Pain exacerbated by other causes physical ailments and mental problems. Sense of security allows better control of physical ailments. Therefore, it is extremely important to the healing process of cancer attended the family and friends of the patient. For the effective treatment of chronic pain is necessary for a proper identification. During the first visit, the doctor will ask about the beginning of the pain, its duration, as well as increasing factors of current treatment. It will then assess the pain using the VAS scale. This is a scale with values from 0 to 10, often a 10 cm ruler, where 0 means no pain and 10 - the strongest pain imaginable. Patients should also tell you about other symptoms such as nausea, vomiting, insomnia, loss of appetite. [18-20, 36].

Current treatment of pain, but uses a different method, based on the effective and safe pharmacotherapy. Experts from the World Health Organization (WHO) developed a method of administration of analgesics, which has become a global standard for treatment. This is the so-called three-stage analgesic ladder. It is characterized by the use of analgesics for various groups depending on the severity of pain. Analgesics, namely analgesics, were divided into three levels (groups): Simple analgesics: acetaminophen and nonsteroidal anti-inflammatory drugs, simple analgesics in combination with weak opioids: codeine or tramadol, simple analgesics combined with strong opioid: pethidine, morphine, buprenorphine or fentanyl. [19, 20, 36].

The rule is getting stronger drug administration, with a higher degree of the ladder as soon as the weaker drugs cease to be effective, or pain persists or intensifies. If NSAIDs or paracetamol cease to be effective, the drug should be added to the group of weak opioids. After exhausting Grade II doses are given a strong opioid. Drugs third degree theory can be administered in unlimited doses, because the ladder ends at this level. In addition to the use of these medications is usually necessary to supplement the treatment therapies. [19, 20, 36].

WHO schema was designed so that it can be applied in all circumstances and by any doctor. Then the patient can receive effective treatment at home. With prolonged use of opioids, sometimes called narcotic analgesics should be expected of two phenomena: tolerance and physical dependence. But they can not be confused with addiction mental characteristic of drug addiction. Misunderstanding this problem by physicians, patients and their families creates a lot of concern, and consequently leads to avoidance of their use and administration of too small doses. Physical dependence is manifested by the appearance of withdrawal syndrome after abrupt discontinuation of treatment. It is characterized by: anxiety, articular pain, tearing, runny nose, nausea, vomiting, abdominal pain and diarrhea. Physical dependence but does not provide a psychological addiction. If in the course of treatment due to other activities (eg, radiotherapy), reduced levels of pain, opioids can be discontinued by going to a lower level of analgesic ladder. Tolerance is the need for increasingly larger doses to achieve similar analgesic effect. Increasing the dose of opioid is usually a symptom of disease progression. Effective pain management is such a dose adjustment that it gave pain relief without adverse reactions. But when they appear reduced dose, administered drugs that inhibit vomiting, changes in drug or route of administration. At each step analgesic ladder is used supportive therapy, consisting of the administration, where necessary, sedatives, hypnotics, antidepressants, anticonvulsants and corticosteroids. These drugs enhance the action of analgesics and to alleviate the side effects of primary treatment. [20, 23, 33, 46, 48].

Malnutrition in cancer may be caused by many factors. Lack of appetite can be caused by stress, fever, poisoning metabolites in case of tumor lysis syndrome, persistent diarrhea or vomiting, abdominal pain enterocolitis after irradiation, increased metabolism after surgery, and other factors. Painful inflammatory lesions in the mouth (after radiotherapy, fungal infection as a complication of chemotherapy, etc.) cause impairment of the possibility of food intake in a natural way. Common feature of these states is that the implementation of nutritional therapy or elimination of the causative agent allows for improved nutrition, and thus, the general condition of the patient. Improving the identification of fistula can result in feeding with inoperable tumors of the esophagus or gastric cardia, hydration of the patient and administration of electrolytes in diarrhea or vomiting, the inclusion of drugs to improve appetite and tissue metabolism (corticosteroids, progestogens), administration of drugs to improve the mobility of the intestine (metoclopramide), the temporary inclusion of nutrition parenteral (intravenous). Classifying the patient to radiation, chemotherapy or surgery, remember that the better nutritional status, the less likely complications of treatment. [21, 25].

Altered state is cancer cachexia (cachexia). It is a condition not resulting from protein-calorie malnutrition, but the tissue metabolism due to metabolic abnormalities caused by the action of the tumor. In this case, increase the supply of calories in the nutritional treatment did not lead to the improvement of general condition of the patient. It manifests itself not only weight loss but also loss of strength, anemia, fatigue, weakness and intellectual. Application of the measures described above for improvement of malnutrition does not lead to recovery of the state before the illness, but

can stop or slow down the metabolic changes caused by advanced cancer. The improvement can bring surgical resection of primary tumor when it is technically possible and clinically. [21, 23, 25, 32, 37].

Nausea and vomiting are common symptoms in patients with advanced cancer. The cause may be mechanical obstruction (blockage) in the esophagus, stomach or colon. Obstruction of the upper gastrointestinal tract causing vomiting, stomach contents, sometimes with a greenish tint. Obstruction of the lower gastrointestinal tract (large intestine) is brought to vomit fecal content. Another cause of nausea / vomiting may be increased intracranial narrowness, for example due to tumor metastasis to the brain or taking medications that cause vomiting (eg, digitalis, opioids, iron preparations, antibiotics, nonsteroidal anti-inflammatory drugs (NSAIDs)). Such drugs also include medications anti-cancer (cytotoxic drugs). Before and at their administration should be given antiemetics (mostly 5-HT antagonists). These symptoms are also present in the case of poisoning metabolic disorders with or uremic acidosis). The increase in abdominal pressure, impaired motility at different levels and can lead to nausea / vomiting (eg, high tumor weight, ascites). [21, 23, 32, 37].

Insomnia in patients with advanced cancer may have multiple causes. We can divide them into causes associated with somatic symptoms (for body) and mental health. For objective reasons, we can include somatic pain - the effective treatment of this symptom allows the elimination of the causes of insomnia. Treatment of other symptoms, causing sleep disturbances (malaise related to the administered drugs, nausea and vomiting, respiratory disorders, etc.) is also the treatment of sleep disorders. Other causes, acting together with the causes of physical, psychological causes. Depression, fear of illness and death, fear of shortness of breath, fear of pain, lack of self-acceptance of illness, worries about the future of loved ones, fear of the dark - are states often require pharmacological assistance. Very important is the presence of close and direct, regular contact with a sick man. Often, to avoid discussions on the disease and "artificial" behavior in the presence of the patient deepens his depression and insomnia spiral winds. Insomnia, sleep disturbances cause the patient feels worse, reduced tolerance for treatment, dosage, effective earlier, are insufficient. It should be emphasized that the treatment of insomnia and sleep disorders in patients with cancer helps achieve a greater therapeutic effect of medications and the symptoms associated with the same disease are better tolerated. [22, 23, 32, 37].

Breathing disorders are the condition requiring rapid diagnosis of the cause and implement appropriate treatment procedures. The reason for this may be a mechanical closure of the airways by a growing tumor (eg cancer of the larynx, trachea cancer, cancer of the tonsils, throat cancer). An additional problem disabling breathing is flowing into the lower respiratory tract secretions from the tumor, saliva, bleeding. These symptoms cause the patient distress, tachypnea, rapid fatigue, whistling sounds of breathing air, which increases the patient's fear of suffocation. Partial closure of the upper respiratory tract requires them to be opened below the obstruction (tracheostomy), removal of bronchial secretions, administration of oxygen. Causal treatment is resection, laser irradiation, assuming prosthesis tightening as a result of tumor growth light airways. Another cause of dyspnea can be damage to the lungs (which restricts their breathing capacity) caused by anticancer agents (eg, bleomycin, busulfan, cyclophosphamide and others) or ionizing radiation (radiotherapy). [23, 37, 50].

Pleural effusions (fluid in the pleural cavity) are present in metastatic cancer of the pleural wall (lamina epithelial covering on the outside of the lung and the chest wall from the inside). Treatment consists of aspiration of fluid (pleural puncture and aspiration of fluid) in varying amounts (preferably not to exceed a single 1500 ml, but it is the discretion of the practitioner of aspiration, because of the substantial amount of fluid that may be present in the pleural cavities). You can specify the drugs in the pleura irritant to induce inflammation and limited by the "sticking up" the pleural cavity, which prevents the accumulation of ascites fluid. [23, 38].

Shortness of breath may be due to changes in infectious (pneumonia) occurring in Patients with lowered immunity (malignant disease, treatment with bone marrow damaging cells). The treatment of choice is antibiotic therapy (the best known. Targeted: the result of a specific micro-organism According to antibiogram). Remember to treat retained secretions from the respiratory tract (drainage of the assembly, suction), Which further and lungs and reduces bleed creates conditions for the development of infection. Difficulties in coughing secretions can be caused by Dehydration in the airways. Give the patient oxygen-Enriched water vapor, or allow the inhalation of humid air (air humidifiers). [22, 50]. Often in advanced cancer is difficult to determine a cause of breathlessness. Symptomatic treatment in this situation is about placing the patient in a reclining position, the administration of oxygen (in a home with an oxygen concentrator) and the administration of morphine, which reduces the sensation of breathlessness and an analgesic. Sedatives are useful in states of panic from suffocation, but they can not be the only means used in dyspnea. [22, 38, 46, 50].

The last moments of life of the patient - agony. The last period in the terminal stage of cancer are dying. It is difficult to determine the time when it begins and when it ends. In medical terminology the process of dying is distributed in time at which the disappearance of vital signs, there are also deficiencies in the functional nervous system, circulatory and respiratory systems. Death is often preceded by the death of the biological psychological and social death. Death is a psychological condition in which the patient is conscious, but mentally absent, no interest in people, their issues, not talking, not eating, not reacting to external stimuli as if they "died for the world." Social death affects the patient, which is biologically alive, it is treated by others as a person absent. Nobody is not interested in him, no visits, treatments with the patient are performed instrumentally. When you fail ways to master the medical physiological dysfunction can we talk about 'the agony. It is part of dying. The agony is life and death struggle. The agony of the body of the patient is unable to return to the dynamic equilibrium called homeostasis. Contact textual logic is temporarily or

permanently impeded, the heart rate becomes more rapid, irregular, poorly discernible, irregular breathing, with short pauses in breathing appears snarling breath 'before death rattle "is cool upper and lower extremities. Muscle tension changes facial expressions, to sharpen features, skin color changes, it becomes pale or waxy. Agony is often accompanied by a condition called ante-euphoria. The patient asked about the mood states that he feels better or very good. This condition is bad prognosis and indicates that the body has ceased to defend and run out of forces seeking to restore homeostasis. In addition to euphoria, drowsiness occurs. Sen. dying is shallow, the patient wakes up with him several times. Agony may also be accompanied by disturbances of consciousness or arousal. More often, however, the patient is aware of what was happening around him. In the process of dying can see some common characteristics, symptoms of dying, which allow to better understand and support the dying. These include: - Weakness in the physical realm is normal all the time in bed, is like the food and drink, forget about swallowing. They appear, therefore, difficulty swallowing, he loses control over urination and bowel-to complete their cessation, reduction in the cognitive - the patient becomes drowsy, difficult to wake up periodically, it can be tangled, befuddled, anxious and excited. Deteriorating sight and hearing. May have trouble concentrating, sees people and objects that are not there, does not recognize their loved ones, not versed in the time and place, she can not work with carers. [9, 37, 40, 43, 46, 50].

The patient in the terminal stage of the disease showing symptoms of imminent death developed over several dozen weeks. Sudden deterioration in the patient's health status occurs over a period of several days or hours. For this fact, prepare the patient and his family. The task of nurses is the explanation of all the possible problems and ways to conduct at the time of their appearance. Palliative care nurse to identify the needs of the patient at each visit or call in sick, conducting an interview assessing its status must take into account the problems that may arise - in particular those relating to pain, nausea, vomiting, shortness of breath, pressure sores. [9, 25, 32, 41, 43, 46, 48, 50].

Issues of bereavement. Understand the situation of orphaned by a man who has lost because of death important for you person. In turn, the social expression of grief is the reaction to the loss of a loved one, typical sanctioned mores of the community (to wear appropriate clothing, avoiding the playground, etc.). Grief does not necessarily entail unpleasant emotional reaction, while bereavement is expressed mainly through the grief. Grief is an emotional reaction to the loss of important human values (such as a loved one). Bereavement is not a state - a process that takes place rather in stages and with a peculiar dynamics, individual varies and depends on many factors. "The correct course of bereavement," especially difficult personality traits: a tendency to pessimism, passivity and breaking under stress, previously experienced mental disorders, or neurotic, and hard life experiences that take place in the recent past. Is also influenced by the lack of preparation on the person's death close (especially when the death is sudden or where the guardian is not permitted until the end of thinking about its possibilities.) bereavement harder to tolerate those who remained in conflict with the deceased or have had an ambivalent attitude to it. [9, 24, 25].

Regardless of the level of preparation in a sense, death is always a shock. At first, followed by emptiness: the message arrives as if in a dream. While the bereaved person understands the significance of the fact, however, is emotionally stricken: do not feel anything beyond the experience of unreality and disbelief: "It can not be true." This state lasts from several minutes to several days, and serves as a defensive mechanism as a partial denial. If extends beyond a period of 14 days, it becomes a pathological response. As you become aware of the reality of loss is acute grief reaction. Its intensity is usually very large and clear from the emotional ties with a close person. The close relationships with people are part of our natural, biological equipment, facilitate survival. The loss of such ties between spouses or parents of children affect the important biological and psychological balance. Evidence of this is anxiety as a response to instability, the expected change of life and associated with this sense of danger. In the adult, and fully independent in life is not the dominant feeling anxiety, grief or anger, but (to God, doctors, fate, etc.). Sometimes the sense of guilt (because of their own impatience, negligence, etc.). often is accompanied by autonomic dysfunction: insomnia, anorexia, weight loss, fatigue, rapid heart beat, pressure spikes, etc. Paroxysms grief and despair, expressed predominantly on the outside complaints, crying, agitation motor (or less - freezing), there are initially very often - every few minutes. Gradually, usually after a period of 7-14 days, weakened and occur less frequently. An orphaned by the first week focused on his late, isolating from the living and often cast off any attempt to help. This intense focus makes sometimes sense the presence of the deceased. Orphaned hear his voice and trying to make contact with him. Try also penetrate more deeply into a deceased person, acquires its interest, meets with her friends, etc. A sense of absence of a loved one, yearning becomes particularly overwhelming shortly after the funeral. Sam and funeral ceremonies and formalities associated with it generally operate calming, bringing relief. First, distract attention from the causes of sorrow, directing toward the external affairs that need to be sorted out. Second, improve the well-being to some degree by the thought that there is still something of a deceased person to do in carrying out her wishes, for example, the details of the funeral at the cemetery site, etc. Besides tribute to the deceased, providing "magnificent" funeral reduce some feelings of guilt, they are kind of offsetting debt. The funeral is an opportunity to meet long-seen family members, exchanging experiences, as well as in some way distracted grief. Pain usually occurs several days after the funeral when the family leaves, and all "back to normal." Bereaved person "looks" then close the deceased, visited him at the cemetery, watching photos, reading lists, she says. Sometimes change their existing views of the world, asks a question about the meaning of life, looking for answers in religion, philosophy, etc. Two people close to each other - over the years to approximate tightens more and more - in time become One "- then one of them dies - bereaved person feels as mutilated and incomplete: deprived of its "second part" - the process of "recovery" means the gradual restoration of self as a whole, with the proper progression of mean enrichment of personality, which is higher than at the beginning. Expert help bereaved people is especially in these times of need. Historically, the neighbors have provided such

assistance (there were stricter than the current neighborhood associations), as well as extended family. Now, relations with neighbors and extended family are more relaxed and people are alone in their suffering. [16, 24, 25].

Psychological assistance should begin the preparation, ie the notice of the impending death of a loved one. It is also valuable when the support of the death and emotional support. Help in later stages of bereavement should be taken shortly after the funeral. Some people should be invited to "have begun to regret" (not denying or suppressing feelings), the other should help in returning to the world of the living. The essence of the aid is to recognize the principle that the mourner must always experience grief and sorrow of separation, should be given time to settle the richness of the past, on the balance of communal living with the deceased - and only after this stage should be able to tell the person close to "thank you" and "goodbye." Working with grief in bereavement is the gradual shift from a process of regret to the process of adaptation to the internal new situation. Some specify four "tasks" bereavement process: 1 Accepted the reality of loss. 2. The experience of emotional grief and vegetative. 3. Adapting to the environment. 4. Renewal of forces and invest them in new systems and situations. Help is often on the fact that the bereaved person knew the reality of loss and that she could give out his grief. Sometimes you have to make a "normal" reaction of pseudohallucinations (hearing the voice of a deceased person), to encourage the memories to specific forms of activity, such as writing letters, organizing memorabilia, etc. It is also important to prevent the danger beforehand desadaptation Persons giving up the alcohol abuse or drugs. [9, 24, 25].

The final stage of assistance should be orphaned in the accompaniment of gentle moving away from a deceased person and start a new life. In addition to reactive depression (situational), which are found in 20% of widowed, sometimes observe inhibition of pathological forms of grief in the form of seeking oblivion in excessive activity (artificial search classes) or premature replacement of the deceased another person. Other forms of this chronic grief - expressing, for example, the creation of "Chamber of memory," spiritualist practices, categorical rejection of any new contacts and cultivating conscious grief, usually combined with the idealization of the deceased. There are also, especially among males, suicide. Death of a parent is usually a very big shock for each child with long-term and serious consequences. Young children's parents are needed for physical and mental health, older role models for life. In the dying father or mother and small child usually feels abandoned and neglected. afraid of silence, does not understand the mood of sadness, sense the unusual situation, which often responds stubbornness, disobedience, an attempt to draw attention to themselves, etc. It's best that when a person enters a calm and warm, which will take care proxy and will try to deal with a child, trying to explain to him why accessibly Adult grief. As far as possible the child should remain in their own home, or at least have your favorite toys (because of animism toys are often the real comforters.) behavior of a small child on the news of the death is fairly typical: Gravity for a moment, sometimes cry, and then returns to their games. It is generally unpleasant surprises adults (such insensitive "). Meanwhile, the child uses the same repressive defense mechanism, as adults, but in its own way (displacement). This behavior does not mean that the child does not feel the loss, and may not be deprived of this experience. Should see the deceased person (unless it is very distorted.) It should also be involved in at least part of the funeral ceremonies. Bilingual adults crying or other expressions of grief are a pattern for a child to become part of a general behavior in the life sciences. Adults usually do not understand the thinking and psychological separateness of the child, that using such wishful thinking style, often long and believes in the possibility of returning a deceased mother or father. In addition, the reaction of grief in a child is different than in adults. His grief is sometimes change the symbols sometimes repeated in a game (this is a special way abreaction of feelings, called spontaneous retaliatory measures). There are moments when the lone regret is not usually noticed by the environment. Adults who have been orphaned in childhood, sometimes reminiscent of his own weeping in the toilet or on the pillow at night when no one saw. [15, 25, 37, 40-43].

Depression also expressed in young children differently than adults. It is usually non-verbal and often are not conscious. The main problems usually relate to the sphere of psychomotor drive, dominant at this age. The child becomes a tight-lipped, slowed down, avoided contact and play, it is not spontaneous, passive. Sometimes they had crying spells and arousal, sleep disturbances, appetite, nail biting, it starts to soak or manifests other neurotic symptoms. In older children, in addition to a general apathy, we observed a further loss of interest, impaired attention, memory, reflecting on the results in science. Quite often there are also behavioral problems: anger, aggression, phobias and fears sometimes night hypochondrisation. As a result of emerging conflict situations the child may feel a negative attitude to the surviving father or mother, but upon the death of one of them is the idealization, and the depression is sometimes accompanied by guilt. By their very nature self-centered, the child is willing to see the cause of death of a loved one. In other situations, sometimes there is anger at the deceased person had left and gone. Often there are signs of regression. Mild form of regression is normal, severe, long-term may give rise to developmental disorders. It happens that this reaction causes the surviving parent - or overprotective, saying: "Now you have to replace his father (or mother), which raises some children have a fear of excessive burden of responsibility and defensive forms of behavior. To facilitate the proper conduct of the orphaned child of grief, remember a few basic things: we must strive to make your child a sense of security, ensuring them that they will be the same as usual care, housing and other living conditions. When a child exhibits fear for their lives, and even more about the life of another parent, it is necessary to dispel the concerns in this regard. It is important to also provide emotional warmth, while also creating the possibility of abreaction natural sorrow and grief for the memories, photographs, souvenirs, etc. It is to facilitate the child's expression of sorrow, not suppress it, or even more to criticize ("Boys Do not Cry, behave like a woman "). It is good to talk to your children about eternal life, God, look back in your faith, provided that the person talking about the same believes. Only if the certificate is genuine and effective assistance. Sometimes, there is an attempt to compensate for the child in the form of identification

with the deceased ("My dad lives in me"). The child then takes interest, way of life of the deceased. This reaction is sometimes good to some extent - and sometimes may result in loss of authenticity and requires tactful correction. Undoubtedly, the best, the most effective conditions for the abreaction of grief and a sense of lack of a deceased person is to develop closer relationships substitute for communication with the surviving parent or other close person. Sometimes you have to reassure the child while reducing their feelings of guilt because the alleged betrayal of the deceased father or mother. [25-28, 30-35].

**Conclusions.** Based on a literature topic [1-50] and on the basis of the study the following conclusions:

1. In view of the cancer patient who is not eligible for treatment at the forefront the problem of cancer pain and other ailments of the digestive and respiratory systems, and greatly reduced physical fitness.
2. The patient was the biggest problem was lack of appetite and emaciation of the body related to it which greatly limited its self-care, and in a later stage, prevented completely.
3. Above the patient in the terminal who will remain in the home should be planned nursing care consulting and communicating with members of her family, educating them in implementing the active care, care and assist.
4. The nurse takes action on dying nursing care aimed at improving the quality of life, eliminating pain, psychological comfort, elimination of other ailments associated with the disease, assist.
5. Medical documentation of palliative care / hospice is conducted on the basis of the Minister of Health of 10.08.2001 (Journal of Laws No. 88, item. 996) on the nature of medical records in health care, the manner of its conduct and the specific conditions of its sharing. Should be conducted fairly, accurately in systematically.

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