THERAPEUTIC NURSING FOR MANAGING BREATHLESSNESS

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ABSTRACT Maxwell, L. (2007) Therapeutic nursing for managing breathlessness. Nursing Times; 103: 22, 28–29. Efforts to manage breathlessness have so far focused on the treatment of underlying causes or on pharmacological strategies. This article discusses broader rehabilitative goals in relation to the nurse’s role to improve symptomatic relief and enhance patients’ quality of life, by exploring holistic approaches. It considers the value of therapeutic nursing in the nurse-patient relationship.

Dyspnoea (or breathlessness) is the sensation of difficulty or distress in breathing. It occurs in about a third of all patients in palliative care (Potter et al, 2003). It is a subjective term and many patients will describe it as an uncomfortable sensation where they have difficulty breathing. However, if it encompasses suffering, as some argue, it is much more than this.

Our need for oxygen is constant and it can be frightening when the demand for oxygen is greater than the body’s ability to supply it, especially if dyspnoea occurs at rest when no respite can be found. Its severity may not correlate with pathology, and so must be judged by patients’ expression of distress. Non-pharmacological treatment of breathlessness involves helping patients to adjust and cope with the loss of their physical abilities and to reassure them that breathlessness, in itself, is not harmful or life-threatening (Barnett, 2006).

Breathlessness most commonly occurs when the lungs are affected by cancer (Vickers et al, 2005). It can also be present as a result of radiotherapy treatment to the lungs or if chemotherapy has caused scarring (fibrosis) in the lung tissue. It is important for nurses to be aware of the various causes of dyspnoea to accurately assess patient needs with the medical team (Box 1).

THERAPEUTIC NURSING

Patient empowerment involves nurses working interactively with patients to understand, assess and teach them about the altered physiology of the body, and to comprehend the experience of this as described by the patient and family as they try to make sense of the illness. In clinical areas such as palliative care it may be particularly important for patients to feel empowered as they attempt to cope with loss of control in other aspects of their lives.

The nurse-patient relationship

This relationship is central to the nurse’s role in palliative care and in forming an effective partnership. The type of relationship very much depends on the duration of the contact between nurses and patients and can fall into the categories of clinical, connected, therapeutic or over-involved.

A therapeutic relationship is commonly the type of relationship that is likely to occur when providing palliative care, which aims to promote patient autonomy and to care holistically for both the patient and her or his family (World Health Organization, 2003). There is trust between the patient and nurse and nurses may serve as a patient advocate regarding future care. Such relationships require effective communication skills and the appropriate use of non-verbal communication. Understanding, empathy and the ability to be supportive while caring for patients and families are essential and will help when discussing treatment options and agreeing priorities and goals.

THE USE OF PATIENT NARRATIVES

Skilbeck and Payne (2005) suggested that nurses’ relationships with patients who have dyspnoea is a reciprocal one. Dyspnoea is

LEARNING OBJECTIVES

- Know the causes of dyspnoea and understand how it affects patients
- Be aware of the importance of the nurse-patient relationship in managing dyspnoea
- Understand how to use patient narratives to improve symptom relief
- Know the importance of holistic care and looking after family and carers

BOX 1. CAUSES OF DYSPNEA

- Disease of the lungs may disturb blood gases and pH for physical reasons. This includes lung cancer (both primary and secondary), COPD and pleural effusion
- Ascites may push up the diaphragm and prevent adequate ventilation, as may any abdominal mass
- Neurological or muscular disease such as motor neuron disease, muscular dystrophy or cystic fibrosis can prevent adequate ventilation
- Pulmonary fibrosis or tumour infiltration make the lungs more rigid and induce dyspnoea. Congestion of the lungs does the same
- Cardiovascular disease such as congestive heart failure and cardiac arrhythmia induce dyspnoea
- Rapid deterioration may indicate infection including pneumonia. Sudden deterioration may indicate pulmonary embolism or pneumothorax
- Other causes include diabetic ketoacidosis, tuberculosis, anaemia, thyroid problems, obesity, anxiety, panic attacks, stress and pregnancy
GUIDED LEARNING

- List the various causes of dyspnoea
- Outline the role of a therapeutic nursing relationship in the management of dyspnoea
- Explain the use of patient narratives to help patients cope
- Demonstrate understanding of the importance of holistic care

viewed as a problem about which both patient and nurse have a mutual interest and, as such, they need to work together to achieve ways to manage it effectively.

The importance of encouraging and listening to the patient’s story of her or his illness and experience is central to the nurse’s intervention. This begins with assessment and becomes an ongoing part of care. Kleinman (1988) discussed ‘illness narratives’ and the importance of working with them when caring for patients who have chronic health problems. Fundamental to this is the recognition that much of what is therapeutic in listening to patients’ stories is hearing and ‘holding’ fear and distress associated with the symptom.

Munhall (1989) has suggested that to ‘be authentically present to a patient’ nurses need to take an open stance and recognise they do not know the person and her or his subjective world. Assuming knowledge of a thing or person gives us confidence to act, yet our actions may be inappropriate if they are based on what we presume to know rather than what we have allowed the patient to teach us about her or his experience and subsequent needs. Phenomenological accounts of lived experiences of illness present the subjective, the personal and the authentic – experiences from the inside.

Madjar and Walton (1999) pointed out that medical language is the only one relying on diagnostic labels to sort people and their needs into manageable categories. Nursing also has its formal and informal ways of simplifying the complexities of human experience by using names that form a ‘shorthand’. This hides the complex reality of the experience of illness and encourages nurses to see order where there is disorder.

HOLISTIC CARE

Some patients may share their thoughts and feelings with those caring for them. By listening to what is said, nurses may be able to identify underlying concerns or psychological issues. Practitioners can show care and provide emotional support by listening to patients in an engaged and empathic way. It is an important way for nurses to make a difference to patient outcomes.

The primal link between breathing and life, and ceasing to breathe and dying, is often central to the fear of dyspnoea and may evoke or exacerbate attacks. Exploring experiences of breathlessness should help patients understand why and how such associations and fears occur and help them to cope with these. As a professional, it is important to demonstrate empathy, honesty and understanding.

Tactics such as reassurance, relaxation techniques and breathing control may also benefit patients and are things carers can be taught to help patients overcome panic attacks. This demonstrates the importance of taking a multidisciplinary approach; for example, occupational therapists may be involved to provide equipment to enable the patient to keep exertion to a minimum, while physiotherapists may help manage dyspnoea by teaching patients breathing control techniques, relaxation, positioning and how to pace activities.

Nurses should assess whether referral to a counsellor or psychiatrist might be appropriate and discuss possibilities with the multidisciplinary team. If patients have religious beliefs, sharing concerns with a representative of their faith may give both the patient and family support and comfort.

FAMILIES AND CARERS

The WHO (2003) definition of palliative care for adults emphasised the importance of a support system to help families cope both during a patient’s illness and with their own bereavement. The onset of a life-threatening illness presents a tough challenge to the emotional stability and physical boundaries of a relationship so looking after carers alongside patients is of paramount importance.

This may involve referral to relevant services such as social workers or counsellors. Nurses, however, are in a good position to facilitate understanding and to promote methods of coping, and should be sensitive to the needs of families and carers.

CONCLUSION

Managing symptoms using this approach is about nurses helping people to manage the problems for themselves. Therapeutic nursing should be geared towards illness and its meaning by encouraging illness narratives from the patient. This may mean restructuring services to allow for such an approach – something that may well need careful investigation with current staff shortages and lack of resources.

REFERENCES


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