NCLEX MENTAL HEALTH · PSYCHOSOCIAL INTEGRITY · END-OF-LIFE CARE

Hospice *vs* Palliative *vs* Comfort Care

A side-by-side decoder for the three end-of-life pathways NCLEX loves to confuse. Built for clinical judgment, priority setting, and the comfort-vs-cure trap.

2026 Test Plan

Topic · End-of-Life Care
Domain · Psychosocial Integrity
Format · Master Comparison

CARE MODEL · 01

Palliative Care

- **Any serious illness, any stage**
- Given **alongside** curative treatment
- No prognosis requirement
- Focus: quality of life + symptom relief

`WHEN: Diagnosis day → forever`

CARE MODEL · 02

Hospice Care

- Terminal illness, **prognosis ≤ 6 months**
- Curative treatment is **stopped**
- MD must certify prognosis (Medicare)
- Includes 13 months of bereavement support

`WHEN: Last 6 months of life`

CARE MODEL · 03

Comfort Care

- Used during **active dying** (days/hours)
- No labs, no vitals, no IV fluids for cure
- Sole goal: **relieve suffering**
- Honors DNR / POLST / advance directive

`WHEN: Final days → hours of life`

01 · OVERVIEW

Definition & Why It Matters

Three overlapping — but legally and clinically *distinct* — care models. The NCLEX tests whether you can name the right one for the right phase of illness.

PALLIATIVE

Specialized care for anyone with a serious illness — cancer, CHF, COPD, ESRD, ALS, dementia. Given **at any age, at any stage,** together with curative therapy. Improves QOL for patient *and* family.

HOSPICE

A **subset of palliative care** for patients whose physician certifies a **life expectancy of 6 months or less** if the disease runs its expected course. Curative interventions are discontinued; comfort + dignity take priority.

COMFORT

Care focused **solely on relieving symptoms** during the **active dying phase**. Routine assessments (vitals, labs, weights) are **discontinued**. Every action is justified only by whether it reduces suffering.

02 · CONCEPTUAL FLOW

The Illness Trajectory

Not a disease — a *care philosophy spectrum*. As prognosis worsens, the balance shifts from cure → comfort. Hospice and comfort care are both subsets of palliative care.

PHASE 1
Diagnosis
Serious illness identified. Curative treatment begins.

→

PHASE 2
Curative + Palliative
Both run in parallel. Symptoms managed alongside treatment.

→

PHASE 3
Hospice (≤6 mo)
Curative therapy stops. Comfort + family support intensify.

PHASE 4
Active Dying / Comfort Care
Hours to days. No vitals, no labs. Symptom management only.

→

PHASE 5
Death
Postmortem care. Honor cultural/spiritual rituals.

→

PHASE 6
Bereavement
Hospice provides 13 months of grief support to family.

KEY CONCEPT

Palliative care is the umbrella. Hospice is palliative care + terminal prognosis. Comfort care is palliative care + active dying. A patient can move between them — and even leave hospice to resume curative treatment.

03 · CLINICAL FINDINGS

Eligibility Criteria & Active Dying Signs

For NCLEX you need to recognize *which patient qualifies for which care* — and the cardinal signs that someone is actively dying so you can shift to comfort-only goals.

Qualifies for PALLIATIVE

- Any serious or chronic illness — cancer, CHF, COPD, ESRD, ALS, advanced dementia
- Active treatment ongoing (chemo, dialysis, surgery OK)
- Uncontrolled symptoms: pain, dyspnea, nausea, fatigue, anxiety
- Frequent ED visits or readmissions

Qualifies for HOSPICE

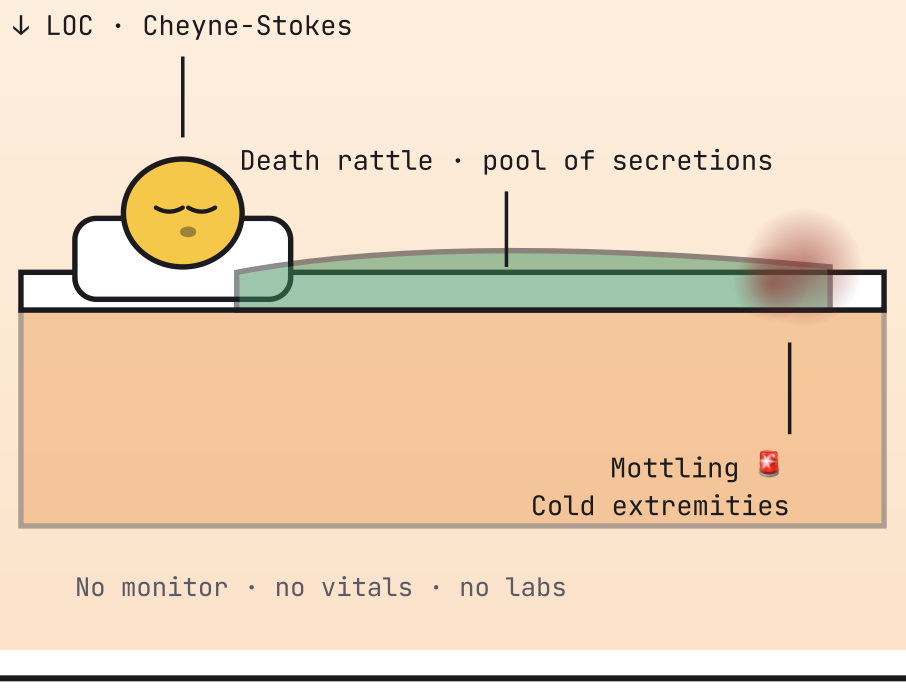
- **MD-certified prognosis ≤ 6 months** if disease runs course
- Patient/family agrees to **forego curative** treatment
- Decline in functional status (Karnofsky < 70%, weight loss, ↑ ADL dependence)
- DNR / advance directive usually in place

Active Dying — switch to COMFORT

- **Mottling** of extremities (purplish blotchy skin)
- **Cheyne-Stokes** respirations / long apneic pauses
- **Death rattle** — terminal secretions in oropharynx
- Cold extremities, decreased urine output, hypotension
- Decreased LOC, terminal restlessness, eyes glassy/half-open
- Loss of swallow, no oral intake

Signs of Active Dying

SHIFT TO COMFORT CARE



04 · PRIORITY NURSING ACTIONS

ABCs Adapted for End-of-Life

At end-of-life, ABCs become **A**irway comfort, **B**reathing ease, **C**omfort & **C**onnection. Every intervention must answer: *does this reduce suffering?*

A Airway & Secretions

- **Position lateral** to drain secretions
- Suction **sparingly** — only oropharyngeal, only if visible distress
- Scopolamine patch or **glycopyrrolate** for death rattle
- Educate family: rattle distresses them, not the patient

B Breathing & Dyspnea

- **Morphine** = first-line for dyspnea (yes, even with low RR)
- Fan to face — activates trigeminal nerve, eases air hunger
- HOB elevated 30–45°
- Cool room, loose clothing, no restrictive bedding

C Comfort: Pain

- Opioids on a **scheduled (ATC)** basis — not PRN at this stage
- Add PRN breakthrough doses
- Assess **nonverbal pain cues**: grimace, brow furrow, moaning, guarding (PAINAD scale)
- Never withhold for fear of addiction

C Connection & Family

- Allow **presence**; encourage talking/touch (hearing persists last)
- Offer chaplain, social work, music, photos
- Permit grief; **silence is therapeutic**
- Honor advance directive, DNR, POLST, cultural rituals

S Skin & Mouth

- Reposition q2h **until burdensome**, then comfort positioning only
- Oral swabs q2h; lip balm; ice chips if able to swallow
- Pressure relief; do not force ROM

N Nutrition & Fluids

- **Do NOT force food or fluids** in active dying — ↑ aspiration, edema
- Offer sips/swabs if alert & able to swallow
- Educate family: anorexia is a natural part of dying

A Agitation / Delirium

- Rule out reversible causes: pain, full bladder, constipation
- **Haloperidol** for terminal delirium
- **Lorazepam** for anxiety / restlessness
- Dim lights, soft voices, familiar faces

D Documentation

- Code status & advance directive on chart
- Goals of care discussion documented
- Time of death, who notified, postmortem care
- Referrals: chaplain, bereavement, organ donation if applicable

PRIORITY TRIAGE

SAFETY → COMFORT → DIGNITY → FAMILY. In active dying, the highest priority is no longer airway patency for survival — it's *relief of distress*. A morphine dose that slightly lowers RR but eases air hunger is the correct nursing action.

05 · PHARMACOLOGY

The End-of-Life Drug Kit

The "comfort kit" — common medications kept at the bedside or in the home for hospice symptom control. Most are given **SL, buccal, or rectally** once the patient can no longer swallow.

MORPHINE

Opioid · pain & dyspnea

- SE: constipation, sedation, ↓ RR, pruritus
- Give **around the clock**; bowel regimen always
- **Do not** withhold for fear of hastening death (Doctrine of Double Effect)

LORAZEPAM (ATIVAN)

Benzo · anxiety & restlessness

- SE: sedation, paradoxical agitation (esp. elderly)
- SL route useful when swallow is lost
- Pair with haloperidol if delirium present

HALOPERIDOL

Antipsychotic · terminal delirium

- SE: EPS, QT prolongation, sedation
- Low dose (0.5–2 mg) SC/SL
- Preferred for hallucinations & agitation

SCOPOLAMINE PATCH

Anticholinergic · death rattle

GLYCOPYRROLATE

Anticholinergic · secretions

ACETAMINOPHEN (RECTAL)

Antipyretic · fever

- SE: dry mouth, urinary retention, confusion
- Apply behind ear; takes hours to peak
- Alt: glycopyrrolate (less CNS effect)

- Less CNS penetration than scopolamine
- SC or IV; good for delirium-prone patients
- Watch for tachycardia, dry mucosa

- Comfort-focused — don't pursue infection workup
- PR route when oral lost
- Max 3 g/day in older adults

ONDANSETRON / PROCHLORPERAZINE

Antiemetics · nausea

- ODT or PR formulations available
- Monitor for QT prolongation (ondansetron)
- Add stool softener if opioid-induced

SENNA + DOCUSATE

Stimulant + softener · opioid bowels

- Start **with** opioids — don't wait for constipation
- Avoid bulk-formers (Metamucil) in dying pts

DEXAMETHASONE

Steroid · adjuvant

- Helps bone pain, brain mets edema, appetite, fatigue
- SE: hyperglycemia, insomnia, mood

06 · NCLEX TEST TRAPS

What Students Get Wrong

Every classic trap on this topic comes from confusing the three levels, fearing opioids, or treating "comfort care" as "no care." Memorize the corrections.

✕ MYTH · "HOSPICE = GIVING UP"

✓ **Truth:** Hospice is **intensive comfort care**, not abandonment. It includes 24/7 RN access, social work, chaplaincy, and bereavement support for the family.

✕ MYTH · PALLIATIVE CARE = END-OF-LIFE ONLY

✓ **Truth:** Palliative care can begin **at diagnosis** of any serious illness and run alongside curative treatment. No prognosis cutoff required.

✕ MYTH · "MORPHINE WILL KILL THE PATIENT"

✓ **Truth:** The **Doctrine of Double Effect** permits adequate symptom relief even if it may shorten life. Untreated dyspnea/pain is the bigger harm.

✕ MYTH · DNR = "DO NOT TREAT"

✓ **Truth:** A DNR only prohibits CPR/intubation. **Comfort, oxygen, meds, hydration, dignity** all continue.

✕ MYTH · THE FAMILY DECIDES THE PROGNOSIS

✓ **Truth:** Hospice requires **physician certification of ≤6 months**. Patient/family choose enrollment; they don't define eligibility.

✕ MYTH · ONCE IN HOSPICE, YOU CAN'T LEAVE

✓ **Truth:** A patient can **revoke hospice at any time** and resume curative care, then re-enroll later if they meet criteria.

✕ MYTH · "PUSH FLUIDS" TO PREVENT DEHYDRATION

✓ **Truth:** In active dying, IV fluids and forced feeding **worsen edema, secretions, and dyspnea**. Oral swabs & sips only if comfortable.

✕ MYTH · THE DEATH RATTLE IS SUFFERING

✓ **Truth:** The rattle distresses the **family**, not the unconscious patient. Educate & reposition before suctioning.

07 · PATIENT & FAMILY EDUCATION

What to Teach the Family

End-of-life teaching reduces fear, prevents 911 calls during expected dying, and supports anticipatory grief. The nurse is the calm voice in the room.

Choosing the Right Care

- Explain palliative ≠ hospice; can have palliative *during* chemo
- Discuss advance directives, POLST/MOLST, healthcare proxy **early**
- Hospice is covered 100% by Medicare Part A when criteria met
- Hospice can be delivered **at home, in a facility, or inpatient unit**
- Patient can revoke hospice anytime to resume curative care

What the Dying Process Looks Like

- Decreasing appetite, sleeping more — normal, **not** a sign to force food
- Cool mottled extremities, irregular breathing — expected
- "Death rattle" — not painful for the patient; reposition rather than suction
- Hearing is the **last sense** to leave — keep talking, playing music
- Terminal lucidity / "rallying" can occur — enjoy the moment, prepare for return to decline

Permission & Presence

- Reassure family it's OK to leave the bedside — patients often die when alone
- It's OK to say "I love you," "I forgive you," "Goodbye"
- Touch, music, prayer, scripture — honor cultural & spiritual practices
- Children should be allowed to visit if they wish; prepare them age-appropriately

After Death & Bereavement

- Hospice provides **13 months of bereavement support** to the family
- Grief is non-linear — anger, guilt, numbness are all normal
- Resources: support groups, counseling, chaplaincy
- Red flags for complicated grief: persistent functional impairment > 12 months, suicidal ideation, severe withdrawal — refer for mental health evaluation

08 · MEMORY BOOSTERS

Mnemonics & Pattern Recognition

3 Levels — "P · H · C"

P Palliative = Parallel to treatment (any stage)

H Hospice = Half-year prognosis (≤6 mo, no cure)

C Comfort = Closing chapter (active dying)

"COMFORT" — EOL Nursing

C Communicate honestly & compassionately

O Opioids around-the-clock

M Mouth care q2h

F Family presence + permission to grieve

O Oxygen, positioning, environment

R Reposition gently (skin care)

T Touch, spiritual, therapeutic listening

"PALS" — Active Dying Signs

P Pallor / mottling of extremities

A Apnea / Cheyne-Stokes respirations

L Loss of consciousness / no swallow

S Secretions (death rattle) + cold/cyanotic skin

PATTERN OF THE NCLEX

If the stem says "improve survival" → wrong care goal. If the stem says "promote comfort, dignity, quality of life" → right care goal. When the patient is actively dying, **the correct answer is almost always the one that reduces suffering, not the one that monitors a number.**