Abuse, grief and end-of-life care

Mandated reporting, red flags, partner violence, de-escalation, grief, hospice, advance directives, DNR and care after death

ON THIS SHEET 1 At a glance 2 Priority and safety calls 3 Exam anchors 4 Self-quiz 5 Sources ★ high yield

1 AT A GLANCE

Nurses are often the first to see the signs of abuse, and the law expects us to act on a suspicion, not proof. When cure is no longer the goal, nursing means easing suffering and helping families say goodbye.

Mandated reporting

- Nurses are mandated reporters of suspected abuse or neglect of children, older adults and adults at risk.
- ★ **The standard is reasonable suspicion: proof isn't required.**
- ★ Report promptly to the agency your state names, such as Child or Adult Protective Services, or the police. Be as specific as possible about what you saw and heard.
- Document objectively: the client's own words in quotes, and exact descriptions of injuries.
- Trauma-informed care builds safety, trust, collaboration, and the client's voice and choice. Introduce yourself and your role every time.

Partner violence: asking safely

- Screen everyone routinely, and always ask in private, with the partner out of the room. Explain confidentiality and its limits under your state's reporting laws.
- Ask a few open questions about being hurt or treated badly, not about being abused.
- ★ **Never share your concerns with the partner, and don't ask why the client hasn't left.**
- Deadliest risks: past strangulation, a gun in the home, a suicidal abuser.
- ★ **Leaving is the most dangerous time**; the danger stays high after separation, especially in the first months, so safety planning continues. Before discharge: referrals and a personal safety plan.

Red flags

	Red flags	Nurse's action
★ **Child**	Injuries that don't fit the story. Bruises on the face, neck, back, abdomen or inner thighs; injuries shaped like an object, such as a belt or cord. Burns on palms, soles or back, cigarette burns, immersion lines at wrists, ankles or buttocks. Shaken baby syndrome may show no outside marks. Neglect: constant hunger, stealing food, unmet medical needs, left alone for long periods	Report promptly to the agency your state names, such as Child Protective Services. Document objectively
Older or at-risk adult	Fear of a caregiver, withdrawal, frequent emergency visits. Bruises on the face, inner arms or torso; injuries at different stages of healing. Neglect: poor hygiene, malnutrition, dehydration, pressure injuries, untreated conditions	Interview the older adult alone. Report to the agency your state names, such as Adult Protective Services
★ **Partner violence**	A partner who answers for the client or refuses to leave the room. Delayed care for injuries, frequent emergency visits, missed appointments, late prenatal care. Injuries to the head, neck, teeth or genitals; defensive wounds on the forearms; bruises of different ages	Ask in private; make a safety plan

Hotline: The National Domestic Violence Hotline is 1-800-799-7233.

Violence toward staff

- Warning signs: loud speech, clenched fists, gripping the rails, pacing, throwing things. Violence can erupt without warning, especially with medical illness or dementia.
- ★ **Verbal de-escalation first**: speak calmly, honestly and simply. Ask what they want, listen, restate it. Set a clear limit that violence isn't allowed, and offer choices.
- ★ Stand at least two arm's lengths away, hands relaxed, not from behind. **Keep a clear path to the door.** No stethoscope or badge around your neck.
- Arguing, condescending, ordering them to calm down, or threatening security can escalate things. Never lie; take every threat seriously. If talking fails, step out and get help.
- Restraints follow protocol, never for convenience or punishment, and come off as soon as possible.

Grief, palliative and hospice care

- Grief is the personal response to loss; mourning is the outward, cultural expression. Anticipatory grief starts before the loss; disenfranchised grief isn't recognized by others; complicated grief is prolonged and intense.
- Grief isn't orderly or predictable, and it can take months or years. It follows any loss, not only death.
- Kubler-Ross: denial (this can't be happening), anger (may be aimed at staff; it isn't personal), bargaining (a deal for more time), depression, acceptance.
- ★ **The most important intervention is active listening and a supportive presence.**
- Report signs of depression, suicidal thoughts, or symptoms lasting more than 6 months.
- ★ Palliative care relieves suffering in serious illness, alongside other treatment. **Hospice: expected to live 6 months or less, and curative treatment stops.**

Educational use only. Not a substitute for clinical judgment, your facility's policy or the provider's orders. Where practice varies, follow facility policy and state law. No patient information.

Abuse, grief and end-of-life care

1 AT A GLANCE, CONTINUED

Advance directives and code status

	What it means
Living will	Which treatments the person would want or refuse, and when: for example CPR, a ventilator, tube feeding
Health care power of attorney	Names a proxy to decide when the person can't. **The proxy decides the way the client would**, not as the proxy would want
★ **DNR order**	A medical order, not an advance directive: no CPR if breathing or the heart stops. Written with the client's agreement or, if they can't decide, a legal decision-maker. **Antibiotics, pain medication and oxygen are still given when indicated**, per the care plan and the client's wishes
POLST or MOLST	Portable medical orders that travel with the client: home, nursing home, ambulance
No directive	State law names who speaks for the client, and the order varies by state

Capacity: Advance directives guide care once legal capacity and activation rules are met. Trouble communicating doesn't, by itself, mean a lack of capacity.

Admission and family conflict

- On admission, ask whether the client has an advance directive, get a copy for the chart, and put it in the plan of care. Care can't depend on whether they have one.
- ★ **A valid directive speaks for the client; family wishes don't override it.** Bring it to the provider, support the family, involve social work or the ethics committee.
- A living will refusing CPR doesn't settle it alone: law, valid portable orders and policy govern whether staff resuscitate.
- A nurse never changes code status herself. A provider who won't follow a directive must promptly tell the proxy, arrange transfer, and keep caring until then.

Comfort, final hours, after death

- Dyspnea doesn't always match the oxygen level: a fan or open window, head of the bed raised, a calm, cool room.
- ★ **Morphine relieves pain and air hunger**, by mouth or under the tongue until the end. Double effect: relieving suffering is right even if it might hasten death.
- ★ **Death rattle: reposition on the side, give anticholinergics like atropine or scopolamine; suctioning isn't recommended.**
- Death is near: cool, mottled skin, a rapid or irregular pulse, little urine, noisy or Cheyne-Stokes breathing. Death may follow within hours to a few days, but no one can predict the exact time.
- After death: apical pulse for a full minute; document the time and who was present. Remove tubes unless the coroner must review.

2 PRIORITY AND SAFETY CALLS

★ Her partner answers every question and won't leave: find a way to see her alone, then ask privately about being hurt.

★ Pacing, fists clenched, shouting: speak calmly from two arm's lengths, with a clear path to the door. Orders and threats escalate.

★ DNR client with a fever and new cough: assess and report it, and treat as ordered.

Son asks to "do everything" against her valid living will: tell the provider about the living will and the son's request.

Families must be offered the chance to donate organs and tissues, at no cost to them.

3 EXAM ANCHORS

1. Traps: asking why she stays, confronting the abuser, waiting for proof, blocking your own exit.
2. Hospice: life expectancy of 6 months or less, can continue past it; comfort, not cure. Breathlessness: fan, head raised, morphine as prescribed, with monitoring.
3. Traps: clichés, suctioning the death rattle, withholding morphine, forcing food, rushing the family.
4. "If I can just make it to my grandson's wedding" is bargaining: a deal for more time.
5. Traps: DNR read as do not treat, family overriding a valid directive, a living will treated as a DNR order.

4 SELF-QUIZ

1. The reporting standard is reasonable _____, not proof.
2. Stand at least _____ arm's lengths from an agitated client.
3. Hospice is for clients expected to live _____ months or less.
4. Confirm death with the apical pulse for a full _____.
5. A health care power of attorney names a _____.
6. The Patient Self-Determination Act took effect in _____.

ANSWER KEY 1. suspicion · 2. two · 3. 6 · 4. minute · 5. proxy · 6. 1991

5 SOURCES

1. Open RN, Mental Health, 15.4 Abuse and neglect. wtcs.pressbooks.pub/nursingmhcc/chapter/15-4-abuse-and-…
2. Child Welfare Information Gateway, Mandatory Reporting of Child Abuse and Neglect (2023). artifacts.childwelfare.gov/public/documents/mandatory-reportin…
3. Open RN, Nursing Fundamentals 2e, 17.5 Final hours of life. wtcs.pressbooks.pub/nursingfundamentals/chapter/17-5-nu…
4. NIA, Advance Care Planning: Advance Directives for Health Care. nia.nih.gov/health/advance-care-planning/advanc…
5. MedlinePlus, Do-not-resuscitate order. medlineplus.gov/ency/patientinstructions/000473.htm

Built from RN PocketPal course lessons: Abuse, neglect and violence (c19-l08); Grief, loss, end-of-life and postmortem care (c19-l09); Advance directives and code status (c01-l06). Every line on this sheet comes from those lesson scripts.

Educational use only. Not a substitute for clinical judgment, your facility's policy or the provider's orders. Where practice varies, follow facility policy and state law. No patient information.