Palliative Care
Case Study and Discussion

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The Coleman Palliative Medicine TRAINING PROGRAM

Disclosure

There are no relevant conflicts of interest to disclose for presenters associated with this presentation.

HIPAA

- Information in this case study is not to be shared outside learning environment.
- Patient/family information has been altered to protect their identify.

Objectives

1. Describe impact of informed consent on patient outcomes
2. Explain the importance of honoring Advance Directives
3. Demonstrate influence of multicultural background of health care providers and the care perspective
4. Explain how an interdisciplinary Palliative Care Team utilizing a transdisciplinary approach impacts patient outcomes

Transdisciplinary Team Approach

"A transdisciplinary team allows members to contribute their own knowledge and expertise, but efforts are collective in determining best ideas or approaches, according to the North Central Regional Educational Laboratory overview of the topic. When transdisciplinary teams are used in health care, providers from multiple disciplines collaborate and share ideas from the beginning to create a total health care plan that covers all necessary diagnoses and treatment for a patient."

*Neil Kokemuller, Demand Media, www.**smallbusiness.chron.com** ,*

Presenters

- Judith Burke, LCSW
  - Married
  - Middle aged
  - Caucasian
  - Protestant faith
  - Master's Trained Licensed Clinical Social Worker
  - Completed fellowship in advanced psychoanalytic theory and practice
- Anna Lee Hisey Pierson, MDiv, BCC-HPCC
  - Married
  - Protestant faith
  - Middle aged
  - Parent
  - Caucasian
  - Master's Trained
  - Board Certified Hospice and Palliative Chaplain
  - Background in nursing and social work

Hospital Culture

- Level I Trauma Center
- Community, non-academic hospital
- Licensed for 333 beds
- Heterogeneous physicians
- Homogenous clinical staff
- Located in a wealthy suburban county in Illinois
- Interdisciplinary Palliative Care Team (Palliative certified or in process=Physician, Nurses, Social Worker, Chaplain)

Case Study

- Patient Demographics
  - Age Mid 80+ female
  - Lutheran
  - Three children
  - Retired Academic
  - Grandparent, great grandparent

  Caucasian
  Divorced
  Independent
  Middle Class

  - Activities
    - Family
    - Cards
    - Dancing

    Lunch with friends
    Church involvement

Medical History

- Chronic Atrial Fibrillation
- C-Diff
- Hypertension
- Hyperlipidemia
- 1954 Hysterectomy
- 1970 Lumpectomy bilateral breast

Chronology of Events

Day 1 – Emergency Room – Ambulance admit

Unresponsive to verbal commands, not in acute distress

-CT head-acute appearing infarct viewed

-MRI-very large cerebral infarct

-MRA-showed occlusion of left middle cerebral artery

Day 2 – Inpatient Admission Telemetry

Chest x-ray-cardiomegaly with large pleural effusion bilaterally

NG-feeding placed

Events continued

Day 3 – Code status- **No Intubation/No CPR**

Day 4 – Rapid Response Team(RRT)-Rapid VR and high BP- Family at bedside

Ist Ethical Dilemma

Palliative Care Triggered consult- await CCU bed

Poor prognosis documented

Day 5 – RRT-Hypoxia, 70% O2, copius secretions

Events continued

Day 6 –CCU

Health Care Power of Attorney provided by family, naming daughter as agent

Day 7 – Family refusing Palliative Care Consult

Patient opened eyes for first time

Day 8 – Palliative Care Goals of Care phone conference

Day 9 - Restraints placed

Events continued

Day 10 –Follows no commands

Day 11 – Palliative Care Meeting Scheduled

New Cardizem Drip-Atrial Fibrillation

Day 12 – Family requested DNR, hospice

Day 13 – Hospice meet with family

Attending physician reports improvement and denies hospice

Events Continued

Day 13 – Pneumonia diagnosis

Day 15 – Ethics Consult

Hospice reconsulted per daughter request

Peg tube placement on hold-atrial Fibrillation

Day 16 – Hospice evaluation

Cancelled Peg Insertion

POLST-Full DNR, comfort

Attending physician agreed with hospice

Events Continues

Day 17 – Transferred to Skilled Nursing Care Facility on Hospice

Palliative Care

"Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."

http://www.who.int/cancer/palliative/definition/en/

Palliative Care

- ”Provides relief from pain and other distressing symptoms;
- Affirms life and regards dying as a normal process;
- Intends neither to hasten or postpone death;
- Integrates the psychological and spiritual aspects of patient care;
- Offers a support system to help patients live as actively as possible until death;”

http://www.who.int/cancer/palliative/definition/en/

Palliative Care

- “uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.”

- http://www.who.int/cancer/palliative/definition/en/

Domains of Palliative Care

Domain 1: Structure and Processes of Care

Domain 2: Physical Aspects of Care

Domain 3: Psychological and Psychiatric Aspects of Care

Domain 4: Social Aspects of Care

Domain 5: Spiritual, Religious and Existential Aspects of Care

Domain 6: Cultural Aspects of Care

Domain 7: Care of the Imminently Dying Patient

Domain 8: Ethical and Legal Aspects of Care

*www.qualityforum.org/Projects/**Palliative_Care**_and_**End-of-Life_Care**...*

Psycho-Social

- Obtaining information from the patient regarding who the patient perceives to be their most important support person(s)
- Identify the primary caregiver(s)
- Discuss Advanced Care Planning with patient, family, friend(s), and/or caregiver(s)
- Explain to patient/family/caregiver(s) what services and resources can be provided by the palliative team
- Conduct a needs assessment, including social, psychological, spiritual, cultural, financial, vocational, and practical aspects of functioning
- Link patient and family to needed community resources, i.e.: public assistance, food pantries, clothing and utilities assistance etc…

Spirituality

Spirituality refers to the way we seek and express ultimate meaning and purpose in our lives. It is also the way we experience our connectedness to others, to nature, and to God or the sacred.

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Pamela Baird, A.A., al, “Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference”, Journal of Palliative Care, Vol. 12, Number 10, 2009

Psycho-Social /Spiritual Identifiers

Needs	Interventions	Outcomes
Conflicted Belief System	Discussed faith tradition and God's Plan Explored impact of Physicians beliefs on informed consent	Family discussing plan of care together though varied beliefs
Complicated grief with death of estranged brother	Explored integration of sense of guilt and loss of brother Validated sense of sadness of mother's loss functionality	Glimpse of grief and dialogue of impending loss
Expressed importance of prayer, scripture and music	Explored source of strength Provided scripture, prayer, music	Comforted through sharing prayer, scripture and music

Psycho-Social /Spiritual Identifiers

Needs	Interventions	Outcomes
Existential Concerns	Explore understanding of Suffering Discuss God's Plan	Reduced feeling of God's punishment Restored belief in God
Anger at Physicians	Diffused anger Explored sense of health realities	Reduced shock of altered functioning Coping realistically with prognosis

Psycho-Social /Spiritual Identifiers

Needs	Interventions	Outcomes
Physician/associate cultural/religious Influences	Explored physician/associate belief system Facilitated Ethics Consult Supported nursing/management associates	Physician communicated informed consent Congruent medical information provided by all physicians and associates Associate moral distress reduced
Lack of informed consent	Explored meaning of patient's Advance Directive wishes Educated on role of agent Facilitated Ethics Consult Facilitated consensus of medically indicated	Agent able to act on patient's Advance Directives wishes Desired quality of life respected

Impact of Transdisciplinary Palliative Care Team

- Interdisciplinary trained Palliative Care Professionals
- Daily Morning Huddle
- Palliative program longevity and continuity of staff
- Transdisciplinary engagement-patient/family interventions
- Recognition of Palliative Care as integral aspect of patient care
- Ethical awareness and integration of cultural/religious diversity
- Comprehensive, trust-filled, valued interdisciplinary team of experts challenging one another and continuing to learn

Conclusion

- Aligned patient's plan of care with values
- Agent followed patient's Advance Directives
- Physicians provided informed consent
- Physicians supported medically indicated plan of care
- Supported faith and values
- Moral Distress of associates resolved

Questions

Thank You


FACILITIES
MANAGEMENT
CHAPLAIN
NAUSEA
HOSPITAL
NURSING
SIMILAR
CHRONIC
FELLOWSHIP
RELIEF
AGENCY
PHYSICAL
LIFE
PSYCHOLOGICAL
PHYSICIAN
PROGNOSIS
PALLIATIVE CARE
DYSPNEA
SYMPTOM
SOCIAL
CONCERNS
CANCER
PATIENT
SPECIALTY
MORPHINE
HEALTH
ANTICONVULSANTS
CURATIVE
SUFFERING
PALLIATIVE
NURSES
HOSPICE
DISTRESS
MULTIDISCIPLINARY
CARE
RANGE
INPATIENT
BEDS
INTERDISCIPLINARY
IMMINENTLY
MEDICAL
PAIN
SERVICE
QUALITY
PROFESSIONAL
CHEMOTHERAPY

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