Palliative Care in the Acute Care Hospital:

Working together to help Mr. K

Flexibility, collaboration and a timely response are the keys to effective care

By Elizabeth J. Latimer, MD, CCFP, FCFP

Mr. K, age 78 years, is referred to the palliative care team by a specialist in internal medicine. He had been admitted to hospital two days previously with chronic obstructive pulmonary disease (COPD) and a serious bilateral pneumonia which is likely related to aspiration. The internist has started cure-oriented treatments. Mr. K is quite frail and seriously ill. The internist isn't sure that Mr. K will do well. In fact, she is concerned that he may die. The referral request is for "general assessment" symptom control and onging support.

Team Activity

Mr. K is seen first by the nurse clinician. She ascertains that he requires:

- Medication and medical assessment for shortness of breath, confusion and agitation, bowel care, nausea and vomiting.
- Psychosocial care. Mr. K lives alone in a rooming house. It isn't clear who is his next of kin or whether there is any family at all.
- Nutritional support. Mr. K has had poor nutrition and cannot eat in the hospital.
- Assesment of his functional ability.
- Spiritual care, once his confusion resolves.

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The nurse clinician contacts her other team members (a physician and a social worker). She also makes referrals to nutrition services, occupational therapy and physiotherapy and talks with these professionals concerning goals of care and reasons for referral.

The palliative care social worker begins to assess Mr. K's needs. She learns from his close friend that he is divorced and estranged from his ex-wife and their two adult children. The friend advises the social worker that Mr. K would not want any of his family contacted.

His friend wants to help Mr. K, but has no power of attorney for finance or personal care. She would be happy to assume these roles if Mr. K were able to appoint her power of attorney, once he is less confused. Mr. K's living situation is quite fragile. His friend says that he hasn't been managing well at home and she wonders if he can ever live alone again.

The palliative care physician and the nurse clinician see Mr. K. They develop a plan for physical care involving orders for:

- Bowel care;
- Skin care;
- Breathing difficulty;
- Confusion and agitation; and
- Mouth care.

Also, they make a referral for the hospital chaplain to see Mr. K and his friend, to add support and explore issues of possible reconciliation with his family.

As well, they arrange for a referral for palliative care volunteers to become involved as Mr. K improves and for the support of his friend, who visits regularly and seems to be alone.

Progress

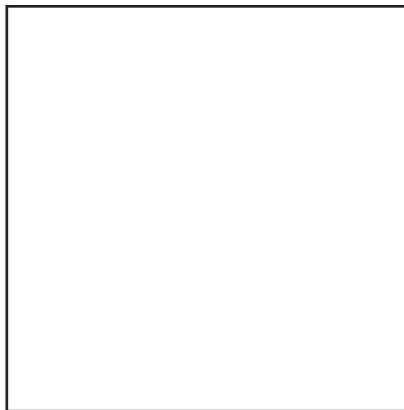
Mr. K improves over the next 10 days. The whole team continues to visit him regularly. The social worker arranges a meeting of the team regarding future care planning. Although Mr. K is independent and wants to live on his own, he is very frail. Over time, he comes to see that he needs on-going care and help. Applications are made for a long-term care facility, although the team isn't sure if, perhaps, a palliative care unit might be more appropriate. It is difficult to determine how long Mr. K might live, as chronic lung disease can be stable one minute and life-threatening the next.

The palliative care team continues regular involvement with Mr. K and his friend at the hospital while awaiting a long-term care bed for Mr. K.

- The nurse and the physician monitor physical comfort and symptoms and overall functioning. They establish goals of care with the internist and the patient, including no CPR, but treatment of infections and other problems.
- The social worker provides on-going psychosocial support and future care planning. The social worker listens to Mr. K's life story and supports him.
- Palliative care volunteers provide companionship for quality of life.

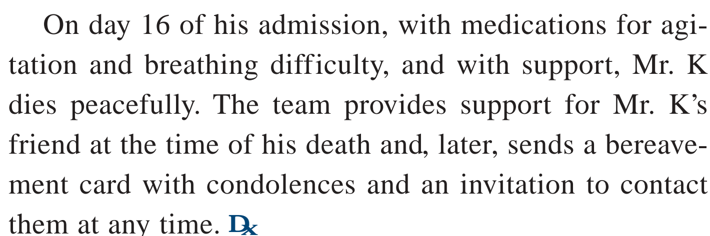
Collaborative care with members of the broader health-care team:

- The chaplain helps Mr. K explore his reflections on the meaning of his life and his spiritual beliefs.
- The nutritionist for optimizing food intake and foods of preference.
- The occupational therapist/physiotherapist, for energy conservation, enhanced strength and daily living activities.
- The pharmacist, for symptom control medication advice to the team and for literature searches about allergies to medications and other issues.



Palliative care team goals

- Prepare Mr. K, and his friend, for the impending death.
- Ensure that Mr. K and his friend are as peaceful as can be expected from a physical and psychosocial viewpoint.
- Work in a supportive role with hospital staff and the internist as they deliver primary 24- hour care to Mr. K and his friend.



On day 16 of his admission, with medications for agitation and breathing difficulty, and with support, Mr. K dies peacefully. The team provides support for Mr. K's friend at the time of his death and, later, sends a bereavement card with condolences and an invitation to contact them at any time. Dx

Outcome

Mr. K appears to be improving, but on day 14 of his admission he takes a turn for the worse, with a fever and severe breathing problems. Despite medical treatment from the internist, he does not improve. The palliative care team moves to an end-of-life care mode:

- Physician and nurse care — Intensive symptom control with daily, or twice daily, visits.
- Social worker — Intensive support for Mr. K's friend, who now stays 24 hours a day.
- Chaplain — Daily prayers and support with Mr. K's friend.