Community Case Study

MRS WHITE

Clinical History

Mrs White is a 70 year old lady diagnosed with carcinoma of breast. Initial treatment involved a mastectomy and axillary clearance. Eighteen months post diagnosis she presented to her GP with pain in her humerus. He ordered a bone scan which revealed wide spread bone metastases. She was treated with radiotherapy. Six months later she was admitted to the palliative care inpatient unit with pain and mild confusion. She was diagnosed with hypercalcaemia and was commenced on regular Pamidronate infusions. On discharge she was referred to the community palliative care team for ongoing care.

Day 1 - Home visit (1st assessment)

Mrs White was recently discharged home from the palliative care inpatient unit. During this admission she was commenced on regular morphine.

She lives alone in a large house having been widowed 6 months. Supportive son lives nearby. He is becoming increasingly anxious about her well being and feels her health has deteriorated since his fathers' death.
The discussion with her son present included the options for assistance with her personal hygiene, provision of some pre-prepared cooked meals and advice in taking her medications to minimise side effects.

Assessment

- Difficulty mobilising outside of house – requires the use of a frame.
- Complaining of nausea at various times during the day, poor appetite - not preparing meals and eating only snack food every so often.
- Constipated, bowels not opened for 4 days
- Minor cognitive impairment – inappropriate responses to some questions
- No complaints of pain, Tolerating MS Contin
- Looks tired, says sleeping well but feeling "flat"

Medications

MS Contin 20mg BD

Diclofenac 150mg daily

Ranitidine 150mg BD

Coloxyl plus senna 1-2 PRN

Maxalon 10mg TDS PRN

Regular Pamidronate infusions

Management Plan

1. Contact GP to discuss regular coloxyl plus senna and the addition of movicol for constipation. Also schedule blood tests to check calcium levels.
2. Contact the community nurse to commence regular visits to assess and monitor Mrs White's condition.
3. Contact social worker regarding assessment re: carer support, meals on wheels and family support.

Day 5 Home visit (2nd assessment)

- Constipation resolved
- Nausea improved and tolerating small meals
- Continues medication regime – no breakthrough analgesic required
- Continues to use the frame to mobilise
- Remains vague, but answers questions appropriately
- Not currently hypercalcaemic
- Feeling well supported but worried about the extra burden on her family
- Family are feeling content because their mother is now more comfortable, and support services are in place

Management Plan

1. Continue current management plan.
2. Phone call to the community nurse to discuss visit.

Day 10 Phone call (3rd assessment)

No changes reported by Mrs White, managing with support services and family continue to support her and happy with current plan of care.

Management Plan

1. Continue current management plan.
2. Phone call to the community nurse to discuss visit.

Day 20 Home visit (4th assessment) following phone call from son requesting visit

- Onset of severe back pain, requiring a family member to assist her to get out of bed and mobilise from the bedroom to the lounge room.
- Unable to sleep due to pain (Has not slept for 2 nights)
- Poor appetite, tolerating small amount of soup only, denies nausea
- Complaining of breathlessness and becoming anxious whilst resting
- Complaining of fatigue and obvious weakness, staying in bed most of the time,
- Continues to get herself to the toilet with the use of the frame
- Confused at intervals (has received Pamidronate infusion recently)
- Talking about her husband – became quite upset
- Son and his family are worried about her living alone and have asked to talk to someone about alternative living arrangements. Mrs White would prefer to try and stay at home with support

Management Plan

1. Contact GP to request visit today to review severe back pain and other symptoms including breathlessness, fatigue, weakness and anxiety
2. Discuss admission to the Palliative Care Unit
3. Phone call to community nurse to increase carer visits, help with medication and increase assistance with personal hygiene as of this afternoon or at the latest tomorrow morning

Day 21 Phone call next day (5th assessment)

- GP has visited, pain improving each day, still periods of confusion.
- Walks with frame but needs someone to stand by as she is unsteady on her feet. Son staying with her to assist her mobilising as concerned she may fall.
- Needs encouragement with meals – eating small amounts
- Increased carer assistance in home has reduced Mrs White's anxiety and also the family stress

Management Plan

1. Contact GP to discuss ongoing pain management
2. Discuss with son strategies to maintain diet and fluids
3. Phone call to community nurse to feedback assessment following visit

Day 25 Home visit (6th assessment)

- Mrs Whites condition has changed, very weak and drowsy
- In bed all the time
- Carers attending to all personal hygiene
- Difficulty swallowing medications, oral intake minimal, tongue very dry requires frequent oral hygiene
- Remains disorientated, breathless on exertion
- Talking about joining her husband – not distressed at all, quite comforted by this
- Son and his family are in constant attendance, upset in the change in condition
- Discussed probability that she will die within a few days

Management Plan

1. Contact GP – inform change in condition, suggest administration of medications via a syringe driver
2. Discuss with the family their mother is dying and assist them in preparing for a home death
3. Contact with community nurse to reassess personal care needs

Day 27 Home visit (7th assessment)

- Mrs White calling is out for her son. She is restless and agitated and is expressing fear of what happens after death. Her expressions of grimace when touched required review of Syringe driver medications.
- Son is upset in mothers' condition. He is having difficulty comprehending what is happening and that his mother is dying.

Management Plan

1. Contact GP to review medication, suggest midazolam to settle restlessness and agitation.
2. Social Worker or pastoral care to arrange visit with son.

Day 28 Home visit (8th assessment)

- Not responding to external stimuli
- Respiration shallow, Pulse weak
- Resting comfortably, no obvious signs of distress
- Syringe driver continued
- Family aware that Mrs White is dying, is in the terminal phase and does not have long to live
- Family satisfied that she is comfortable and not distressed
- GP aware of condition

Management Plan

1. Contact to GP to report Mrs White's condition and the anticipated home death
2. Explain to the family Mrs White's condition and impending death
3. Talk to the family regarding arrangements following the death

Day 29 phone call from son

Mrs White died during the night in the presence of her son and his family. The palliative care nurse explained the bereavement program to the son and said she would call in 2 weeks.