Assessment and Care Planning Of The Palliative Client

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The Home Care Nurse

Ewell assures the new ambulance attendant that this is a typical home healthcare nurse’s response to an accident: patients and paperwork before self.
Learning Objectives

- Understand what is unique to a Palliative assessment
- Gather information in an organized manner
- Familiarize ourselves with assessment tools
- Identify potential problems and possible interventions
- To gain specialized knowledge and skill as set out by the core competencies
Assessing the Palliative Care Client
Assessment of the Palliative Patient

- Includes all aspects of a basic health assessment
- Focus is on philosophy of care
- Goals of care are identified
- Continual effort in consensus building
Some Reminders

- Be organized
- Give patient/family a brief outline of what to expect
- Allow the patient to choose the location
- Allow the patient to decide who else should be present
- May start with medications that are current
Some Reminders

- Acknowledge that some questions may be emotionally difficult
- Show respect, kindness, and compassion
Barriers To Assessment

- Poor communication
- Fear of the word “Palliative”
- Fear of advancing disease
- Patient/family trying to “protect” each other
- Fear of taking “strong medications”
- Fear of running out of medications, and dying in pain
- Concerns of medication side effects
**ESAS**

**Edmonton Symptom Assessment Scale (ESAS)**

<table>
<thead>
<tr>
<th>Date of completion</th>
<th>Time</th>
</tr>
</thead>
</table>

**Please circle the number that best describes:**

- **0** = No pain
  - **10** = Worst possible pain
- **0** = Not tired
  - **10** = Worst possible tiredness
- **0** = Not nauseated
  - **10** = Worst possible nausea
- **0** = Not depressed
  - **10** = Worst possible depression
- **0** = Not anxious
  - **10** = Worst possible anxiety
- **0** = Not drowsy
  - **10** = Worst possible drowsiness
- **0** = Best appetite
  - **10** = Worst possible appetite
- **0** = Best feeling of well being
  - **10** = Worst possible feeling of well being
- **0** = No shortness of breath
  - **10** = Worst possible shortness of breath

**Other problem**

ESAS completed by:
- ☐ Patient
- ☐ Health professional
- ☐ Family
- ☐ Assisted by family or health professional

Version date December 17, 2002
**ESAS**

*Edmonton Symptom Assessment System*

**Purpose**
- Quantifies the experience and helps develop a care plan
- To assess the nine symptoms that are common to palliative patients
- Severity is rated at the time of assessment
- The patient's opinion
- Provides a clinical profile over time
- Only *one part* of a holistic clinical assessment
- A tool used across program/agencies
When to do ESAS

- On a regular basis
- More often if symptoms are not well controlled
- To evaluate effectiveness of medication changes
Who Should Complete ESAS

- Ideally the patient
- A caregiver
- If completed by caregiver, can omit depression, anxiety, well being
- The person completing ESAS must be indicated
Symptoms Identified in ESAS
Pain

- Severity
- Location
- Duration
- Characteristic
- New pain
- Aggravating/relieving factors
- Medications/treatments presently using
- What meaning does it have to patient and family
Tired

- It is subjective
- Severity
- Duration
- Assess reversible causes
- What meaning does it have to patient/family?
- How does it effect quality of life/safety?
- Helps us to assess for needed support services/equipment
Nausea

- Severity
- Assess for possible causes
- Frequency
- Onset and duration
- Aggravating/alleviating factors
- What medications are already in place
- Description of emesis
- Assess bowels and bowel sounds
Depression

- Severity
- Ask “Are you depressed?”
- Differentiate between feeling sad and feeling depressed
- Past history of depression, how was it treated
- Assess recent changes in antidepressant medications
- Assess for suicidal thoughts, and ask if they have a plan
- Assess signs and symptoms of hypoactive delirium
Anxiety

- **Severity**
  - Ask “Are you Anxious?”
  - Assess for specific fears and causes of anxiety
  - Help patient and family to name fears
  - Patient/family may respond with crying. Do not try to stop it
  - Explore past coping mechanisms
Anxiety

- Explore what support systems they have in place
- Assess for need of psycho/social support/spiritual care
- Assess for signs and symptoms of delirium or Opioid toxicity
Drowsy

- Severity of “sleepiness”
- How many hours of sleep in 24 hours
- Is it difficult to stay awake
- Assess for possible causes
- Assess for changes in Opioids
- Perform a medication review
- Assess respiratory rate and pattern
- Assess patients safety in mobilizing
- Use or need of safety equipment
**Appetite**

- Lack of appetite
- Differentiate between appetite and amount eaten (food and liquids)
- Assess for possible causes
- Assess present and past interventions
- How does the decrease in intake affect the caregiver/family?
- Assess the patients/families understanding of the causes of anorexia/cachexia
- Help patient/family to think of food as a comfort measure
Feeling of Wellbeing

- Ask “How are you?” and mean it
- May indicate general state of comfort
- If all other scores on ESAS are low, but “wellbeing” is high, may indicate potential changes of decline
- Good days/bad days
Dyspnea

- Severity
- Subjective experience
- At rest/with activity
- Aggravating/relieving factors
- Assess for possible causes/complications of metastatic disease
- How is dyspnea affecting the patient/family
- Assess for recent changes in respiratory rate/chest sounds
“Other”

**Bowels**
- Date of last BM
- Amount
- Consistency
- Abdominal distention
- Rectal fullness
- Use of stool softeners/laxatives
- Incontinence of bowel/bladder
Oral Disorders

- Dry mouth/hydration
- Oral Candidiasis/stomatitis
- Loose fitting dentures
- Dysphagia
- Hiccups
Skin Disorders

- Pressure ulcers
- Tumor necrosis/odor
- Puritis
- Jaundice
- Edema
Fever and Sweats

- Assess for potential infection
- Fever can be tumor related
- Sweats can also be caused by malignancies
Vital Signs

- When to take Blood Pressure
- Pulse
- Respiratory rate
- When not to take vital signs
# Palliative Performance Scale

<table>
<thead>
<tr>
<th>PPS Level</th>
<th>Ambulation</th>
<th>Activity &amp; Evidence of Disease</th>
<th>Self care</th>
<th>Intake</th>
<th>Conscious</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>full</td>
<td>normal, no evidence of disease</td>
<td>full</td>
<td>Normal</td>
<td>full</td>
</tr>
<tr>
<td>90%</td>
<td>full</td>
<td>normal, some evidence of disease</td>
<td>full</td>
<td>Normal</td>
<td>full</td>
</tr>
<tr>
<td>80%</td>
<td>full</td>
<td>Normal act with effort</td>
<td>full</td>
<td>Normal/Reduced</td>
<td>full</td>
</tr>
<tr>
<td>70%</td>
<td>reduced</td>
<td>unable normal work, significant</td>
<td>full</td>
<td>Normal/Reduced</td>
<td>full or confusion</td>
</tr>
<tr>
<td>60%</td>
<td>reduced</td>
<td>unable hobby, housework</td>
<td>occ assistance</td>
<td>Normal/Reduced</td>
<td>full or confusion</td>
</tr>
<tr>
<td>50%</td>
<td>sit/lie</td>
<td>unable to do any work; ext disease</td>
<td>much assistance</td>
<td>Normal/Reduced</td>
<td>full/drowsy/conf</td>
</tr>
<tr>
<td>40%</td>
<td>bed</td>
<td>unable to do most activity</td>
<td>mainly asst</td>
<td>Normal/Reduced</td>
<td>full/drowsy/conf</td>
</tr>
<tr>
<td>30%</td>
<td>total bed</td>
<td>unable to do any activity</td>
<td>total care</td>
<td>Normal/Reduced</td>
<td>full/drowsy/conf</td>
</tr>
<tr>
<td>20%</td>
<td>total bed</td>
<td>unable to do any activity</td>
<td>total care</td>
<td>min to sips</td>
<td>full/drowsy/conf</td>
</tr>
<tr>
<td>10%</td>
<td>total bed</td>
<td>unable to do any activity</td>
<td>total care</td>
<td>min to sips</td>
<td>drowsy or coma</td>
</tr>
<tr>
<td>0%</td>
<td>death</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PPS
Palliative Performance Scale

- Excellent communication tool for health care providers
- It may have prognostic value
- Helps assess patient safety, level of care/resources needed
- Helps identify/prioritize assessment and care planning
Summary of Assessment

- What are the presenting problems
- What interventions are presently in place
- What options are available
- Establish goals of care
- Care planning
Care Planning For The Palliative Care Client
1 Admit Pack = 60 pieces of paper.

Government required forms for one employee file: 20 pages

Average home care medical record content: 250 pages

After overhearing two nurses say that home care documentation is responsible for the death of the Rainforests Anne attempts to find an area to decrease documentation needs.

Unable to bring herself to reduce the amount of documentation, Anne comes up with an alternative plan.
Learning Objectives

- Components of a care plan
- Nursing diagnosis
- Management of a Palliative client outside of a care facility
- Management of common symptoms experienced by Palliative care clients
- Follow the “Hospice Palliative Care Nursing Standards of Practice”
Care Planning

- The development and maintenance of a individualized plan of care
- NANDA approved
- Involve the client
- Involve the family
- Involve the Palliative Care Team
Purpose of the Care Plan

- To communicate the clients specific care needs to staff who caring for the client
- A plan of nursing care that changes as the clients care needs and condition change
- It is based on identifiable health concerns that the client is experiencing
- Client specific!!! With a holistic focus
- Pain and symptom management
How Are Care Plans Formed?

- Use the nursing process: the process by which nurses deliver care to their clients
- Collect subjective and objective data
- Identify actual problems the client is experiencing
- Think about potential problems that may arise
- Identify the areas that the client needs nursing care
How Are Care Plans Formed?

- Assessment
- Make a Nursing Diagnosis
- Include relating factors (R/T)
- Include evidence that supports the diagnosis (your objective data that supports the diagnosis)
- State the expected outcomes, or Goals
- Should include a Evaluation Date (not in Palliative Care)
- Establish specific nursing Interventions
NANDA Nursing Diagnosis

Health Function/Maintenance
- Alteration in Health Maintenance
- Alteration in Home Maintenance
- Impaired/Ineffective Coping
- Impaired /Ineffective Family Coping
- Caregiver Role Strain
- Risk for Powerlessness/Hopelessness
- Insufficient Support System
- Alteration/Disturbed Body Image
NANDA Nursing Diagnosis

Nutrition
- Impaired Swallowing
- Alteration in Appetite
- Alteration in Nutrition
- Knowledge Deficit
NANDA Nursing Diagnosis

Nutrition
- Impaired Swallowing
- Alteration in Appetite
- Alteration in Nutrition
- Knowledge Deficit

Knowledge Deficit R/T Changes In Nutritional Requirements
NANDA Nursing Diagnosis

Elimination
- Alteration in Urinary Elimination
- Alteration in Bowel Elimination
- Urinary Incontinence
- Risk for Constipation
- Perceived Diarrhea
- Bowel Incontinence
NANDA Nursing Diagnosis

Activity/Rest

- Disturbed Sleep Pattern
- Impaired Physical Mobility
- Self Care Deficit: Dressing, Bathing, Feeding, Toileting
- Fatigue
- Activity Intolerance
Goals for Palliative Clients

- Client will be supported by the entire Palliative Care team
- Client will receive optimal palliative care
- Clients pain will be managed
- Clients symptoms will be controlled
- Clients quality of life will be maintained
- Care giver stress will be minimized
Nursing Interventions

- Based on our assessment
- Based on actual or potential health concerns that we have identified
- Group interventions by:
  - Home Management
  - Health Status
  - Symptoms
Management of the Palliative Client at Home

- Identify the primary physician willing to care for client at home
- Identify the Home Care Case Coordinator
- Teach client and family after hours/ on-call accessibility
- Always re-assess care plan, clients care needs, and medication management
- Always include client and family in decision making
Management of the Palliative Client at Home

- As the clients PPS declines, their needs change
- Monitor changes in your client
- Increase visits
- Reassess the appropriateness and route of medications
Interventions

- Psycho Social
- Spiritual
- Physical Care/Symptom management
  - Pain
  - Dyspnea
  - Elimination
  - Nutrition
  - Nausea/Vomiting
  - Delirium
  - General/other concerns
  - End of life
  - Palliative Care Emergencies
Psycho Social

- Important to gain an understanding of the meaning and preparedness of the client and family
- Identify quality of life issues for client
- Identify the care givers, support systems, coping mechanisms
- Ensure proper documents are in order:
  - POA
  - HCD
  - ACP
  - LAD
Psycho Social

✦ Always ensure a calm peaceful environment
✦ Equipment needs
✦ Ensure the clients primary location in the home is comfortable for client and family
✦ Anticipatory Grief
Anticipatory Grief

- Roles are being re-defined
- Personal affairs must be put into order
- Life review
- Fear
- Funeral
Spiritual

- Spirituality as opposed to religion
- Encourage client to find meaning and purpose in remaining life
- Awareness and understanding of illness, of death and dying: beliefs, hopes, strengths, fears
- Ask client or family if they would like to be referred to a spiritual care provider, social worker, counseling
- Always hope
Physical Care/Symptom Management

- Pain
- Dyspnea
- Elimination
- Nutrition
- Nausea/Vomiting
- Delirium
Pain

- Pain assessment is done each visit (tools)
- Each persons pain experience is unique
- Have client rate pain ?/10, type, location, radiation, relieving/aggravating factors
- Teach client/family use of long acting, short acting and breakthrough analgesic
- Teach what Breakthrough Pain is
- If client increasingly requires more BTA, liaise with MD to increase LA opioids
- Incident Pain
Pain

- Assess need for adjuvant therapies
  - Drugs (NSAID, steroids, antidepressants)
  - Medical (radiation, nerve blocks, acupuncture)
  - Psychological (relaxation, imagery, touch, music)
  - Physiotherapy (heat, cool, massage)
  - Spiritual (prayer, meditation, scripture)

- If medication adjustment was made, follow up! Increase visits, change your care plan
Pain

- Answer questions/teach re: side effects of opioids and their management (nausea, tiredness, constipation)
- Dispel myths related to opioid use
- Monitor need for opioid rotation
- Monitor need to change route of administration (severe nausea, dysphagia)
**Dyspnea**

- Dyspnea is a subjective experience that requires an objective assessment and proper interventions
- Auscultation, use of accessory muscles, pursed lips, cyanosis, cough, oral mucosa, agitation
- Positioning
- Minimize energy expenditure
- Increase ventilation
- Provide reassurance
- Medications to relieve SOB
- Oxygen
Elimination/Bowel

- Constipation #1 issue
- Monitor BM’s: frequency, amount, consistency
- Encourage client to record BM’s on a calendar
- Monitor use of laxatives and softeners
- Increase water intake
- Auscultation of bowel sounds
- Perform rectal checks
Elimination/Bowel

- Opioids/Laxatives go hand in hand
- Teach:
  - Body still produces stool despite oral intake
  - Watery stool does not mean diarrhea
  - If obstructed = hospital admission
Nutrition

- Dehydration
- Assess oral mucosa every visit
- Look for signs and symptoms of infection
- Assess swallowing every visit
- Changes in taste contribute to decreased appetite
Nutrition

- Teach client and family normal processes and loss of appetite
- Anorexia/cachexia
- Teach family: weight loss, smells, change in taste
- Fluids over solids
- Teach mouth care
Nausea/Vomiting

- Severity of the symptom
- Think of the underlying cause
- Think of the target receptor zones
- Add a second agent before switching agents
- Medication review
- Alternate route
Nausea/Vomiting

- Eat/drink small amounts often
- Ensure adequate hydration
- Eat in a pleasant environment
- Relax after meals, sitting up
- Avoid food odors
- Avoid greasy, spicy foods
- Relaxation, imagery
Delirium

- Distinguish delirium from dementia
- Delirium when not at end of life is reversible
- Delirium at end of life is manageable
Delirium

- Ask the client about hallucinations
- Think of the underlying cause
- Treat the underlying cause
- Teach the family signs and symptoms of delirium/confusion/agitation
- Comfort and safety measures
- Minimize family distress
General

- Fatigue/sleep disturbances, general malaise
- Wounds
- Skin breakdown
  Braden scale
- Bladder spasms/urinary retention
Care Planning at End Of Life

- Mouth care every hour or more
- Anxiety of client and family
- Terminal respiratory secretions
- Lots of teaching required, provide family with “When Death Is Near”
- Skin break down/ mottling
Care planning for Palliative Care Emergencies

- Spinal Cord Compression
  signs and symptoms
- Superior Vena Cava Obstruction
  signs and symptoms
- Hypercalcemia
  signs and symptoms
- Teach family/client
- Review how to access after hours on call nurse
Conclusion

- Assess the client
- Monitor care
- Teach the family
- Support family and client
- Prepare them for death