

ELNEC- For Veterans

**END-OF-LIFE NURSING EDUCATION
CONSORTIUM**

Palliative Care For Veterans

Module 1 Introduction to Palliative Nursing Care

CASE STUDIES

Module 1: Introduction to Palliative Nursing Care

Case Studies

Module 1

Case Study #1

Mr. S: “I Want Everything Done Until My Last Breath”

The palliative care consult team was called to make recommendations to the cardiologist and nursing staff to improve symptom management for Mr. S. is a 72 year-old African American male who served in the Army for eight years, including two tours in Vietnam. He is well-known to the staff on the medical floor, as he has had frequent admissions for severe shortness of breath and fatigue related to his end-stage heart failure. After being discharged from the Army, he went to work in the auto industry for 10 years, but became disabled, due to a work-related injury. He is married, and lives with his wife in a one story apartment. He has had five admissions for heart failure in the past four months.

On seeing the patient, the team was aware that in addition to symptom management, there was a need for psychological, social, and spiritual support. The Veteran reported that he was afraid to die because he was worried about how his family would manage financially without his disability income. He did not want to talk about hospice as an option for care and stated “I want everything done until my last breath of life.” The palliative care team, composed of the nurse practitioner, physician, social worker, psychologist, and chaplain provided symptom management, emotional and spiritual support to Mr. S. and his spouse and revisited advance care planning conversations.

Discussion Questions:

1. What assessments are essential in providing quality palliative care as a consult team?
2. How does the palliative care team revisit the topic of advance care planning?
3. What interventions are critical to initiate at the initial consult visit?
4. How might Mr. S’s experience in Vietnam affect his end-of-life concerns and perception?

Module 1
Case Study #2
Kevin: Homeless and Non-Compliant

Kevin is 33 years old, single, and served in Operation Iraqi Freedom for seven months before he was severely injured in a war-related incident. He spent two months in an Army hospital in the US receiving treatment for 2nd and 3rd degree burns on his lower extremities. Two weeks after arriving in the US, it was determined that the left leg had to be amputated (above-the-knee). Kevin began to socially withdraw and as soon as he was released from the VA rehabilitation facility, he moved home with his parents. After several months at home, his parents told him he had to move out, because they suspected he was drug-seeking and he had become abusive to them. He refused to keep any medical and psychiatric appointments at the VA community-based out-patient clinic and took very poor care of the left stump, which became frequently infected. He became homeless and lived on the streets of a large metropolitan city. One day, visitors to the city saw him on the side of the street where his homeless friends were trying to awaken him. The visitors knew there was something terribly wrong. They called 911 and an ambulance took him to the local VA facility (his homeless friends stated he was a Veteran). The emergency department staff found Kevin to be septic and his toxicology report was positive for numerous drugs. It was determined that Kevin's family should be called immediately (the VA had contact information about Kevin's parents from previous visits to the VA), because his condition was very critical and deteriorating quickly. The nurse practitioner called the palliative care team and asked them to meet the family in the ICU waiting room once they arrived.

Discussion Questions:

1. Why would the palliative care team be called?
2. What services could the Palliative care team offer Kevin and his family?
3. As a staff nurse in the ICU, how could you support Kevin's family? What could you do or say?
4. If Kevin survives, what services at your VA would be of assistance to him and to his family?

Module 1
Case Study #3
Mrs. M: Poor Pain Management

The Palliative Care Program at the local VA offers a consult service using advanced practice nurses (APN's). A referral has been made from a Community Living Center (CLC) for help with a Veteran who is receiving dialysis for chronic renal failure and is suffering with poorly controlled pain. The Veteran, Mrs. M. is 85 years-old and served as an Air Force nurse in the Korean War. The facility's physician is reluctant to order pain medication because of Mrs. M's renal status. Mrs. M., her family, and the nursing staff are very distressed by the lack of pain management.

Discussion Questions:

1. What is the role of the APN from the palliative care program in addressing Mrs. M's pain?
2. What strategies might the APN use in conversation with the facility physician to advocate for Mrs. M to receive palliative care?
3. What additional referrals may be necessary for this Veteran (Mrs. M.), family, and staff?
4. How would you assess Mrs. M., using the Quality-of-Life Model?
5. Using the *Making Promises* document, what "promises" would be important to keep for Mrs. M?
6. How might her Korean War experience affect her pain?

Module 1
Case Study #4
Ms. T: Need for Palliative Care at the Time of Diagnosis

Ms. T. is 53 years-old and served as a distribution officer during the Gulf War. She has just been diagnosed with pancreatic cancer and her oncologist at the VA has asked the palliative care team to visit her at the clinic today before she goes home. The palliative care physician and nurse met with Ms. T. following her first office visit for newly diagnosed pancreatic cancer. Ms. T. lives alone and her only family is a son who lives out of state.

Discussion Questions:

1. At the team's first visit, Ms. T. says "What do I need a team like this for? I am here at the cancer center to be cured." "My oncologist told me that she was optimistic about giving me chemo and that it should cure me." How does the team introduce the concept of palliative care to a patient with newly diagnosed advanced stage cancer?
2. How does the team provide care to the patient and her son?

The team follows Ms. T. throughout the course of treatment, seeing her at doctor visits, chemotherapy treatments and radiation therapy. It has been eight months and the disease has progressed to the point that chemotherapy is no longer an option.

Discussion Questions:

3. When is the appropriate time to introduce the concept of hospice care? How can the team explain this type of care to Ms. T?
4. What type of settings could Ms. T receive hospice care? Would the VA cover all hospice expenses, even if she chose to have in-home hospice?

Module 1
Case Study #5
Mr. J: Shifting from Treatment to Palliative Care

Mr. J. has been a patient in the medical intensive care unit for the past four days. He is an 86 year-old male World War II Veteran with a two year history of dementia and newly diagnosed small cell lung cancer, with metastasis to the femur. When he came into the emergency department with shortness of breath, his respiratory status became so compromised that he required intubation and was admitted to the MICU. Although he is no longer on the ventilator, he has become increasingly confused and agitated. His non-verbal behaviors suggest he is in pain. His daughter, who is the power of attorney for health care, has requested that the goals of care shift from a plan for chemotherapy, to “keeping him comfortable.” The nursing staff and clinical nurse specialist in the MICU are suggesting to the physician that the palliative care team visit Mr. J and his daughter.

Discussion Questions:

1. What are the benefits of a palliative care consult for this patient and his daughter?
2. What are the potential barriers that may interfere with the palliative care referral for this patient?
3. What strategies might be helpful to overcome those barriers?
4. How might this Veterans agitation relate to his WWII experience?

Module 1
Case Study #6
Mike: What's the Point?

Mike, a 46-year-old Veteran and former injectable drug user, was diagnosed with AIDS two years ago. He is admitted to the medical unit for pneumonia (3rd admission for pneumonia in the past five months), nutritional support and abdominal pain. Three months ago, he moved from his apartment to a nursing home because of increasing weakness and inability to care for himself. Mike has been unemployed for six years. As the nurse takes the nursing history, Mike appears anxious. He is unshaven. His hair is uncombed and his nails are dirty. The nursing home staff reported that he repeatedly refuses to bathe. He answers questions without making eye contact, frequently commenting "What's the point?" Mike is divorced and has one teen-aged daughter, who lives with her mother. He has not seen his daughter because he doesn't want her to see him "like this." Other family includes an older sister, who helped him move to the nursing home. Mike relates that he no longer sees friends, because he did not tell them he was moving, and doesn't want them to know that he is living in a nursing home. When the nurse has finished taking the history, he asks her to pull the curtains, shut the door and leave him alone. When she returns to give Mike his medications, he screams "I thought I told you to leave me alone!"

Discussion Questions:

1. Assess aspects of the quality of life (QOL) using the QOL Model of physical, psychological, social and spiritual well-being.
2. What members of the interdisciplinary team might be most helpful to contact? Why?
3. Discuss the unique role of nursing in caring for Mike. Discuss collaboration with Mike's physician.
4. What other information would be helpful to assess in planning care for Mike?
5. How do you create a safe and trusting environment for Mike?
6. Could Mike benefit from palliative care? Please explain your answer?