This module requires the learner to have read chapter 6 of the CAPCE Program Guide and the other required readings associated with the topic. See the CAPCE Program Guide required and recommended reading list for more information.

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Please reference as follows:

GETTING STARTED

This e-Learning Module has been designed to consolidate key concepts from the required readings and provide an opportunity to begin applying these concepts through self-directed reflection and scenario-based work, in preparation for the case-based discussions, in-person, with other learners.
GETTING STARTED

In this module, you will review the content highlights associated with Care Planning.

You may be asked to write down your thoughts or ideas during this module. You can do so in the Notes section at the end of Chapter 6 in your Program Guide. Have your Program Guide with you as you complete this module.

These notes are just for you; you won’t be required to submit them. However, you may be prompted to use your notes for discussion in your Peer-to-Peer Exchange and Coaching Sessions. Please be respectful of confidentiality.
TOPICS COVERED

✓ Care Planning: Critical Concepts
✓ Care Planning
✓ Emergencies
✓ Planning Care at End-of-Life
✓ Bereavement Care
CARE PLANNING: CRITICAL CONCEPTS

Key concepts associated with Care Planning include:

✓ Care planning is the integration of the information gathered during assessment and information sharing, as well as the knowledge of choices made during decision making.

✓ Anticipating and identifying issues and emergencies in hospice palliative care requires skill, knowledge and a well-developed understanding of the person and family throughout the illness progression.

✓ Care planning for managing end-of-life care may differ from earlier care planning; however, must be completed as thoroughly

✓ Bereavement care includes care for the family as well as yourself.
CARE PLANNING

The plan of care is negotiated and developed with the person, family, and members of the team to address goals and expectations of the person and family.

The plan must be customized, flexible, and support the person and family’s need for autonomy and control and allow for the person and family to be cared for in the setting of their choice with the required support.

Interventions and actions are developed using critical thinking skills. A process must be in place for ongoing assessment, monitoring, and documenting efficacy of all interventions.
CARE PLANNING

Hospice palliative care can take place in any setting. The settings listed in your Program Guide include hospital, home, residential hospice, long term care home, and palliative units.

Developing a plan of care takes critical thinking, creative reasoning, a high-functioning team, and an excellent support system for the person being cared for.
CARE PLANNING

How might the considerations vary when developing a plan of care in different care settings?

In your Notes section, list the care settings and one example of a unique consideration for each that may impact the care planning process.
EMERGENCIES

Emergencies in hospice palliative care should be expected and anticipated. When they do happen, calm, quick, aggressive, and immediate management is required.

Once an emergency has been identified what two critical questions must be answered? (Use your Program Guide to help answer the question)
As a Nurse in palliative care, it is important that you have a thorough understanding of the person’s diagnosis and possess a high suspicion index to anticipate and even expect potential emergencies. As part of the person-centered plan of care, you must have a plan in place to prevent emergencies or intervene quickly and effectively when they occur.

It is important that all team members, including the person and family, are aware of potential emergencies and the plan of care, should they occur.
Consider the role of the nurse in palliative care and your place of work. Think about your response to the following questions, and then write down your answers in the Notes section at the end of Chapter 6 in your program guide:

1. Provide an example of how you have collaborated with a health care team to develop individualized plans of care for a person and his or her family.

2. Identify one specific way you can advocate for improved delivery of hospice palliative care within your organization.
Consider Stacie’s story below, take notes as you read and answer the questions in your Notes section. Be prepared to discuss this case with your CAPCE coach at the next Coaching Session.

1. Stacie is a 54-year-old female with metastatic cancer of the kidney. Her PPS is 50% and you’ve been seeing her in her own home. She is married, and her daughter lives out of town. She has been managing well; her husband goes to work every day and stays in touch by cell phone. Last week when she saw her Resource Nurse, her ESAS-r scores did not indicate any unmanaged concerns. Her pain has been at a 3-4/10, but this is a rating she has identified as acceptable to her. She has no respiratory or GI issues, and her bowels are moving regularly.
The nurse got a call today from her husband, Steve, who is at work, and he is concerned. He said that Stacie woke up a few days ago with worse pain in her back. She told him it was an 8/10 when she was lying in bed, but she got up, walked about a bit, took a BT dose, and it improved to a 4/10. She’s been taking the BT dose, and it improved to a 4/10.

What would be your response to Steve?
The nurse asks Steve if there are any other issues and he says no, so the nurse tells him she will see Stacie tomorrow, but to call right away if anything else needs her attention. When she arrives at Stacie’s home the next day, she is sitting in a chair, and she tells the nurse that the back pain is “really bad today”. She looks at the nurse and asks, “do you think the tumor on my kidney is growing?” Stacie hates to be fussed over, but the nurse tells her that she needs to do a thorough physical and pain assessment.
Here are her findings for Stacie:

- Pain level at its best: 4/10
- Pain at level at its worst: 9/10
- Pain worse when she is in bed – sitting in chair much of the day. Slept in chair last night.
- Pins and needles in right foot, but assumed since her cancer is on the right side and the pain is worse, it must mean the tumor is growing.
- No bowel movement for three days.
- This morning, after Steve left for work, she got up to walk to the bathroom, and noticed her right leg was really weak.
- She had a difficult time initiating a urine stream.
Any of these symptoms, on their own, are manageable. However, with this picture, what do you suspect?
EMERGENCIES

The Nurse suspects a Spinal Cord Compression, an Oncological emergency, and needs to act quickly. She sits calmly with Stacie and tells her what her thoughts are and asks her to phone Steve at work to come home. While Stacie calls Steve, the nurse phones the palliative care physician.

The nurse reports Stacie’s progression of symptoms to the physician, as well as the details of her assessment, and he agrees. He directs the nurse to call an ambulance and have Stacie transferred to the hospital immediately for evaluation and treatment.
Use the information in your Program Guide and the Pallium Palliative Pocketbook to help answer the following questions:

- When reading Stacie’s reporting of symptoms, which symptom(s) do you think triggered the nurse in the case to consider Spinal Cord Compression?
- Why can Spinal Cord Compressions be difficult to identify?
- As a hospice palliative care nurse, have you ever experienced an emergency situation? Briefly describe it and how you handled it.
Planning for and managing care at end of a person’s life is a privilege and a great responsibility. As a Nurse, you assist in helping the person and family establish a plan of care that will meet their needs:

- What decisions(s) would you help the person make?
- What tools can guide care planning at end-of-life?
- Who else might need to be informed of the person’s plan?
- How can you plan for alternatives?
- How would you educate the person and family regarding end-of-life plans? How might this differ from other palliative care planning education?
BEREAVEMENT CARE

Hospice palliative care doesn’t end with the person’s death.

Nurses have a key role in the supporting the person and family as they deal with losses throughout the illness journey as well as following the death of the person.

How can you as the Nurse continue to care for the family after a death? How would you care for yourself?
BRINGING IT TOGETHER

Developing a person-centered plan of care takes skill and practice, and for the nurse in hospice palliative care, is an integral part of ensuring the wishes and decisions of the person and family are realized.
WHAT HAPPENS NEXT

To prepare for the next e-Learning Module, you will need to read the associated Program Guide chapter in advance.

In order to complete the next e-Learning Module, you will need to have the Program Guide and the Pallium Palliative Pocketbook with you.
This e-Learning resource is the property of:

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