CASE STUDY ASSESSMENTS
How to use the Case Studies

There are 4 case studies based on real patient stories and scenarios:

1. Inpatient palliative care service
2. Community palliative care service
3. Consultative palliative care service
4. Symptom Assessment Scale transcribed

The first three case studies provide a snapshot of the patient. Use the details provided to assess each patient using the PCOC assessment tools, especially the Phase.

Consider the following questions in determining scores for each assessment:

- What do you think is happening for the patient and or the family or carer?
- What is causing the problem, symptom or issue?
- Are problems, symptoms or issues adequately controlled by current management?
- Is an urgent change in the management plan required?
- When should the care plan be reviewed?
- When should effectiveness of interventions be reviewed?
- Is death likely in a matter of days?

The fourth Case Study: A Symptom Assessment Transcribed includes

1. The story of the patient’s journey.
2. An initial Symptom Assessment Scale.
3. A follow up Symptom Assessment Scale.

This activity may be useful in understanding how to integrate the SAS into your routine communication with patients however it is only one part of the assessment of symptoms. In practice some of the answers to questions may lead to further questioning and assessment of individual symptoms.
Case Study: Inpatient Palliative Care Service

The Patient’s Journey

Mr George Callis is an 89-year-old man who was diagnosed with metastatic lung cancer. George has experienced increasing symptom distress and gradual functional deterioration. His wife can no longer care for him at home and his prognosis is short. During the first week of George’s admission the focus is on symptom management, support for the family and care planning with George and his family. George’s functioning continues to deteriorate but his symptoms improve. In the second week George develops new symptoms and his functioning becomes worse. It is obvious that George is approaching the end of his life. At the end of the third week of the admission George enters the terminal phase and he dies with his wife and daughter present.

Summary of the clinical notes

Week 1

George is alert, orientated and mobilising with the use of a walking aid. He requires some assistance for other ADLs. The main issue is a dull, aching, and persistent pain. The pain has significantly worsened. George is also experiencing breathlessness but he says it has not got worse. He is experiencing some nausea, usually after eating, and his appetite is poor. Nevertheless, George says he is not bothered with eating. George has had some trouble sleeping, which he says is due to pain. George also feels fatigued but says it is due to lack of sleep and getting old. George is constipated on admission. His wife, Christella, is relieved that her husband has been admitted. She is, however, feeling exhausted and worried about George’s decline and increasing issues with his bowels and nausea. A new plan of care has been commenced to address these symptoms. George’s daughter states that all family members understand life limits of her father’s prognosis and the family wish for him to die here rather than at home.

Week 2

George’s pain is now well controlled and symptoms of nausea, insomnia and constipation have improved. Breathlessness is present but slightly improved. Fatigue has not changed. However George has developed confusion and disorientation especially in the evenings. The causes are complex and related to the progression of his disease. Comfort measures to manage the new symptoms are put in place. This includes discussing the symptoms with his family. George’s functioning has deteriorated and he requires the assistance of two for ADLs and is spending more time in bed. George is less communicative with staff and his wife Christella expresses concern over changes in George’s condition and that it means he is approaching the end of life. She feels that he is comfortable.

Week 3

At the end of this week George is experiencing fluctuating levels of consciousness, at times responding to voice, but he is not communicating. At other times, he is not rousable. George is unable to tolerate oral diet or medications. He requires full care by two persons. George is restless intermittently, at times pulling at the bed sheets. There are no signs of pain, such as grimacing, on movement. Terminal respiratory secretions are present. Christella and her daughter are accepting of changes once explained. George dies in the palliative care unit.
Case Study: Community Palliative Care Service

The Patient’s Journey: Community

Mrs Kathleen Davis is a 77-year-old woman diagnosed with Metastatic Endometrial Cancer. She is living at home with her daughter, Ann. Ann is happy to care for her mother but acknowledges that Kathleen will become more dependent over time and it may become difficult for her to manage at home. Kathleen was referred to the Palliative care Community Team for symptom management and supportive care. On admission to the service Kathleen is receiving radiotherapy. Following the course of radiotherapy she experiences a number of new symptoms relating to the treatment. She has a period of increased symptom distress and increased care needs. This is a difficult time for her and her daughter. By the end of the 3rd week the symptoms either resolve or improve and the overall distress levels of Kathleen and Ann diminish. However, Kathleen’s functioning and performance has decreased and it is anticipated that this trend will continue and these and other symptoms will be experienced in the near future. Kathleen remains under the care of the palliative care team for ongoing assessment and management. A period of planned respite care in the local palliative care unit is arranged.

Summary of the clinical notes

Week 1
Kathleen is self-caring with some ADL’s but requires assistance to shower and dress, she experiences mild pain in the lower abdominal region and back pain. Her appetite is poor but her intake is reasonable; 3 small meals every day with snacks. Ann prepares her meals. Kathleen reports recent weight loss of 3kgs. She sleeps reasonably well. Her bowels are open every 1-2 days with regular aperients. She is not experiencing fatigue, nausea or breathlessness at this time. She is currently undergoing radiotherapy.

Week 2
Kathleen has developed oral thrush and her lower abdominal pain had increased significantly. She begins to feel fatigued and her activity level has decreased, she requires more assistance for personal hygiene. Ann begins to feel distress relating to her mother’s changed condition and increased care needs. She is worried for her mother during this time. Kathleen’s care plan is no longer adequate and urgent intervention is required.

Week 3
Kathleen’s pain has improved with the change in management plan. Her oral thrush is treated and resolved, an ongoing mouth care regime is required. There is an overall improvement in the severity of symptoms experienced and Ann is feeling less concerned. Kathleen however does not regain her previous mobility and activity at this time and is generally requiring more assistance from her daughter. Ann expresses concern about what to do if she cannot manage her mother’s future care needs at home.
Case Study: Consultative Palliative Care Service

The Patient’s Journey

Mr John Cleary is a 46-year-old man with Stage 4 pancreatic cancer diagnosed six months ago after presenting to emergency with severe abdominal pain. John received chemotherapy but his oncologist told him two weeks ago that further chemotherapy was unlikely to be effective. John decides it is best to focus on the time he has at home, however severe nausea and abdominal pain forces him to present to his local Accident and Emergency one evening. John is admitted to the oncology ward where a referral is made to the Consultative Palliative Care Team. On admission a new care plan is implemented to manage the symptoms he is experiencing. During the first few days Interventions are focused on managing and assessing these symptoms as well as focusing on John and Lisa’s psychosocial care needs including advance care planning. By day 5 John’s symptoms are greatly improved and he wants to return home to spend as much quality time with his wife as possible. It is expected that John will need ongoing care with likely admissions to palliative care. He is referred to the community palliative care team to provide support.

Summary of the clinical notes

Day 1

John is admitted to the medical ward with increasing abdominal pain described as sharp across his abdomen and lower back. John says the pain is unbearable and he has had a lot of trouble sleeping. John has no strength and says he feels tired even after he wakes from a reasonable sleep. He feels he cannot make plans because he is so tired. John is experiencing nausea and tolerates only a small diet. He is not too concerned about appetite or the amount of food he is eating. John has had difficulty regulating his bowel motions. In the last two months, John has had episodes of diarrhoea and constipation which is related to chemotherapy and the commencement of opioid medications. John is independent with ADLs and, able to do most activities by himself. Lisa and John were told by the oncologist to expect John to get worse in the next few months. Lisa expressed sadness and has trouble “coming to terms with what is happening”. Lisa is teary during the assessment and she says it has been really difficult watching John in pain.

Day 2-4

In the first 48 hours, John has responded well to a new opioid and medication regime. Pain has improved and John is sleeping better. Nausea is mostly improved; however, there are still times – especially after meals – where nausea is worse. By day 4 the new regime for bowel management is working well and pain is well controlled. While John is able to do most activities by himself, he feels his “days are up and down” and he has no strength. Lisa expresses much relief over John's improved symptoms.

Day 5

John feels quite good today and would like to return home. His symptoms have improved. He experiences mild pain and mild nausea. There is no change to John’s functioning and activity level. Fatigue is his main concern. John is aware that the cancer is progressing and is feeling that his remaining time is short. He wants to focus on his family. Lisa is pleased that John is feeling that his pain is better controlled. She says it was such a worry for her to see him in so much pain. John was discharged home under the care of the community palliative care team.
The Patient’s Journey

Mrs Kathleen Davis was admitted to the palliative care service today. She has been seen by the palliative care doctor who assessed her symptoms and current needs. Mrs Davis is experiencing increased pain as well as constipation and fatigue. The Registered Nurse uses the SAS to determine the level of distress associated with these symptoms. The SAS forms one part of the overall assessment process.

The Initial Assessment

**Palliative Care Nurse:** Hi Mrs Davis my name is Karen I’m the Registered Nurse. I just wanted to talk to you today about how you are feeling. I know one of your main concerns is pain.

**Kathleen Davis:** Yes, it has been getting worse over the last little while.

**Palliative Care Nurse:** Can you tell me where the pain is?

**Kathleen Davis:** It’s mainly low down (puts her hands over her lower abdomen and pelvic region)

**Palliative Care Nurse:** Can you tell me more about the way it feels.

**Kathleen Davis:** Oh it’s a heaviness and a pressure. I’m pretty much aware of it all the time, even at night time when I sometimes wake up because of it.

**Palliative Care Nurse:** (The nurse asks detailed questions about the pain described and documents on the findings on a pain assessment chart) Ok, so I’d like you to try to think of a number from 0-10 that tells me how much distress that pain is causing you. I want you to think 0 as not causing any distress or not bothering you and 10 being the most distress possible.

**Kathleen Davis:** I’d probably say it is between a 6 and 7 area, because it is there all the time even after medication. The medication does help but it seems to still be there.

**Palliative Care Nurse:** Ok, sounds like it is causing you quite a bit of distress. If you could pick one overall number what would it be?

**Kathleen Davis:** Yes it is. I think I’d say a 6.

**Palliative Care Nurse:** You’ve started on some new pain medications today and we will monitor you and aim to reduce that pain (the nurse further explains breakthrough and the monitoring process). You also said to the Dr that you had some trouble sleeping and I know you’re taking a sleeping tablet at night but is lack of sleep or difficulty getting to sleep causing you any distress?

**Kathleen Davis:** No not really, I go off to sleep easy enough and maybe once or twice during the night I wake up being uncomfortable or with pain.

**Palliative Care Nurse:** Ok so again a number for that 0-10. 0 being not causing distress and 10 being the most distress.

**Kathleen Davis:** Probably just light maybe a 2.
Palliative Care Nurse: Ok I know you’ve also had some changes in your diet and appetite but I want to know if your appetite is a problem for you or you’re not getting enough or you are concerned about what you are eating?

Kathleen Davis: No, I might be losing a bit of weight but I don’t feel like eating much.

Palliative Care Nurse: So it doesn’t trouble you? Is that a 0 then?

Kathleen Davis: Yes. I don’t have an upset tummy I just don’t want to eat a lot.

Palliative Care Nurse: Alright, so is it 0 for nausea too?

Kathleen Davis: Yes.

Palliative Care Nurse: Um, any trouble with your bowels? I know you are taking regular laxatives but I want to know if it is an issue for you or a concern for you.

Kathleen Davis: I’ve always had a little bit of trouble with constipation over the years and I’ve taken medication at times and sometimes even though I am taking medication I feel a little bit bloated or crampy so it is something that bothers me.

Palliative Care Nurse: So it’s bothersome? Could you give me a number that matches how you feel?

Kathleen Davis: A 4.

Palliative Care Nurse: Ok so it might be more that just bothersome.

Kathleen Davis: Yeah it’s not just slight.

Palliative Care Nurse: Ok yes well I think we will need to look at your medications and adjust them, especially since you are getting that bloating.

Kathleen Davis: That would be good.

Palliative Care Nurse: Breathing, any trouble with breathing? Breathlessness, tightness in the chest...

Kathleen Davis: No.

Palliative Care Nurse: Nothing there?

Kathleen Davis: No.

Palliative Care Nurse: Ok, Fatigue, do feel fatigued or tiredness?

Kathleen Davis: I have no energy. I used to be a very active person and now I find myself unable to do very much at all. It’s has gotten worse in the last few months.

Palliative Care Nurse: How much distress does this cause you 0-10?

Kathleen Davis: Oh I’d give that a 5, yeah.

Palliative Care Nurse: So this lack of energy is quite troublesome for you?

Kathleen Davis: yes, I don’t like feeling this way.

Palliative Care Nurse: What you are describing is common and it may be made worse by the pain you are experiencing. I’ll make note of what you have said and we can talk about some strategies once your pain has improved.
Palliative Care Nurse: Hello Mrs. Davis it’s Karen again I just want to ask you a few questions about how you are feeling today. How much distress is pain causing you today?

Kathleen Davis: Well I actually think the new medications have made a difference, I don’t feel the pressure quite as much from what I was feeling before so I think it probably has improved.

Palliative Care Nurse: Ok so yesterday you said your distress was 6 for pain. What about today.

Kathleen Davis: Maybe, oh, it would be a 4

Palliative Care Nurse: Oh so a bit of an improvement.

Kathleen Davis: Yeah.

Palliative Care Nurse: Eating and appetite problems, yesterday you said 0, is it still 0.

Kathleen Davis: Still 0.

Palliative Care Nurse: Ok no nausea, no changes there?

Kathleen Davis: No.

Palliative Care Nurse: Bowel trouble, you said 4 yesterday? We tried a new medication last night and I see you had your bowels open. Do you feel less distressed about constipation today?

Kathleen Davis: No I feel a bit better about that but I’d still say 3 as I feel a bit worried about it.

Palliative Care Nurse: Ok we will keep working on it. Nurse discusses options for treatment. So no breathing trouble today?

Kathleen Davis: No.

Palliative Care Nurse: Has your tiredness or fatigue changed?

Kathleen Davis: No, ah, it’s still the same.

Palliative Care Nurse: Yesterday you said 4.

Kathleen Davis: Still 4.

Palliative Care Nurse: Ok so any changes with sleeping? You said 2 yesterday.

Kathleen Davis: Well not really not yet. I was a bit more comfortable last night so maybe I’ll score it 1 instead of 2 today.

Palliative Care Nurse: Ok. Is there anything new today?

Kathleen Davis: No nothing new. I just want the pain to improve and I think that will make a difference to how I am feeling.

Palliative Care Nurse: Well we will continue to tailor this new pain medication to you.