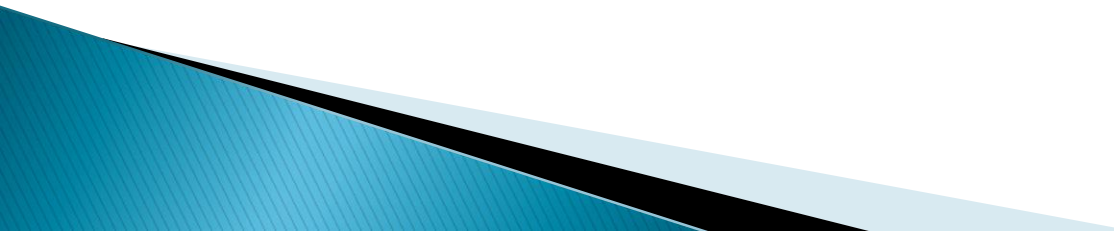


Maintaining Integrity

Case Study : End of life care for a patient with
metastatic SCC.

Objectives of presentation

- ▶ History
 - ▶ Focussed assessment
 - ▶ Developing a care plan
 - ▶ Implementation and challenges
 - ▶ IDT support
- 

History– Mrs Kirk

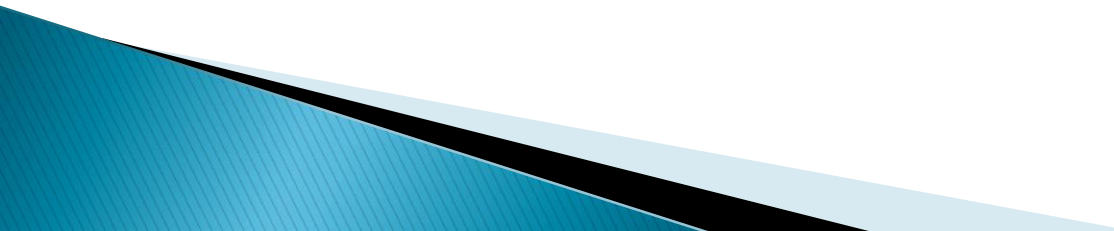
- ▶ 83 years of age

Lived independently with her husband of 67 years in villa within aged care village

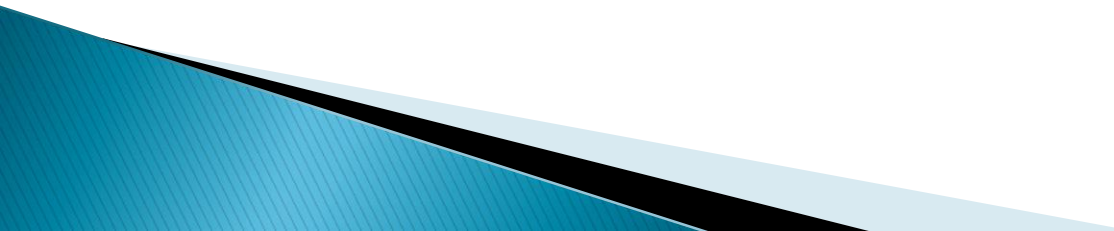
- ▶ Diagnosed with rapidly growing SCC 2014

- ▶ PHX: CABG 2002, Pacemaker 2010 CHF, Hypertension.

Clinical History

- ▶ April 2015 extensive Intra inguinal and supra inguinal block dissection of right groin of extensive metastatic spread of original lesion.
 - ▶ Referred for Radiotherapy
 - ▶ May 2015 further surgical debridement of R)groin dissection, as wound edges non viable.
 - ▶ Rx commenced July 2015
- 

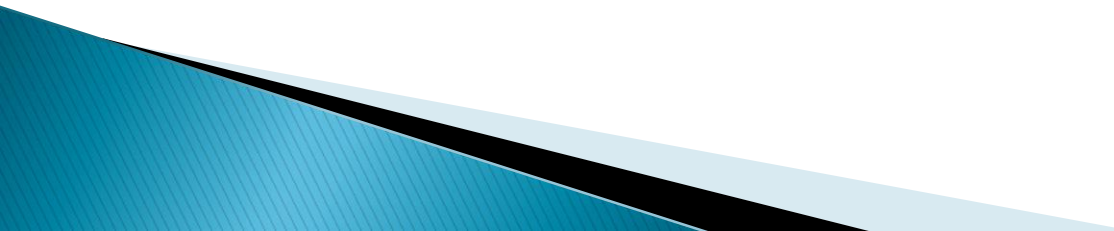
History continued.

- ▶ October admitted to hospital for the drainage of infected seroma. R) lower abdomen.
 - ▶ February 2016, admitted to Hospice for discharge planning following a fall from home and hospital admission, treated for urosepsis.
- 

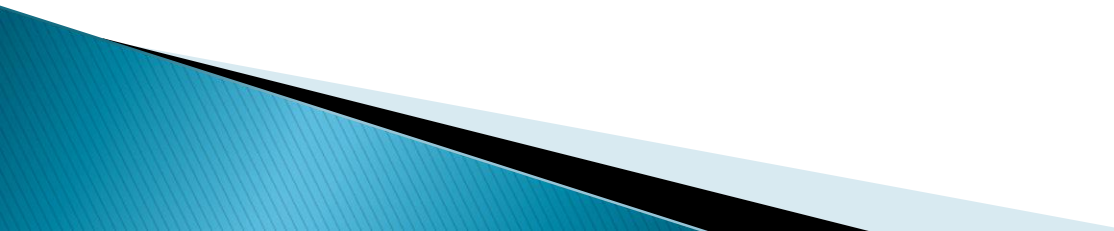
Admission to hospice –9/2/16

- ▶ Provide IDT team input to enable a safe discharge home .

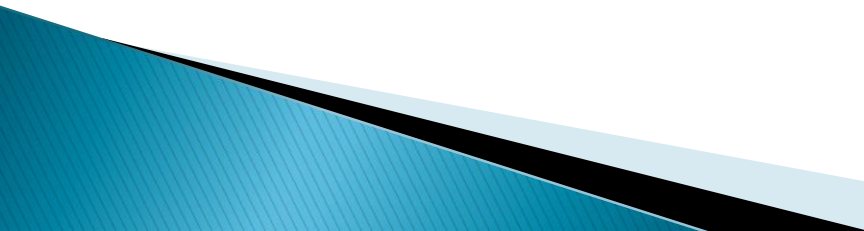
Focus for this presentation will be on:

- ▶ Control of right groin/lower abdo pain
 - ▶ Management of wounds
 - ▶ Pressure area care
- 

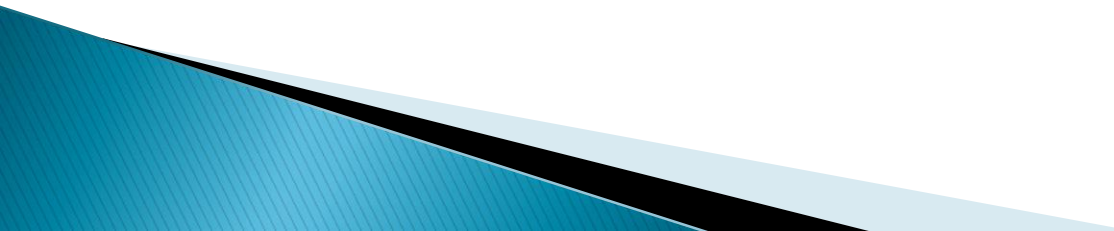
Initial assessment findings– IDT

- ▶ Family Support : spiritual support, social work
EPOA/Will
 - ▶ MOCA
 - ▶ INTERRAI
 - ▶ CNS Tissue viability
 - ▶ CNS Stomal Therapy
 - ▶ Lymphoedema Service
- 

Skin Integrity

- ▶ Open wound Right groin/lower abdomen, covered with dressing
 - ▶ Right thigh– old drain site , dressed with wound drainage bag draining lymph
 - ▶ Stage one pressure area to sacrum
 - ▶ Stage one pressure areas both heels
 - ▶ dressing to skin tear on L)elbow from fall at home
 - ▶ Grossly oedematous right leg
- 

Right Thigh

- ▶ Puncture wound covered with urostomy pouch.
 - ▶ Skin indurated and tender to touch
 - ▶ –Management –
 - ▶ Change every three days/prn
 - ▶ Wash skin with non ionic cream, pat dry.
Apply cavilon spray x1, allow to dry.
 - ▶ Apply warmed urostomy pouch.
- 

Right Lower Abdominal/ groin wound-assessment

Size– approx 8cm x 3 cm

T – 100 % thin necrotic eschar with 1 cm aperture at distal margin.

Wound surface was fluctuant beneath eschar.

‘Leaves’ of transparent tissue were apparent within the wound.

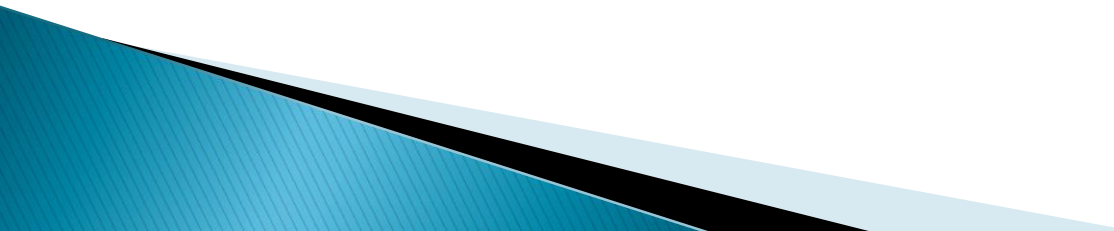
I – Exudate brown/yellow with faecal malodour, infection present –on oral Augmentin.

M – High volume exudate – frequent dressing leakage. Skin at medial aspect – macerated.

E – Surrounding skin fragile and erythematous.

No signs of healing at surgical margins.


Continued –

- ▶ Significant pain in right groin described as an ache at 7/10 – regular OxyContin 20 mgs bd.
 - ▶ Reducing to 3/10 with prn Oxynorm 5 mgs.
 - ▶ Pain increased with mobilising.
 - ▶ Other pain meds – Gabapentin 100 mg tds.
 - ▶ Paracetamol 1 gm tds.
 - ▶ In addition on oral Augmentin 625 mg tds.
- 

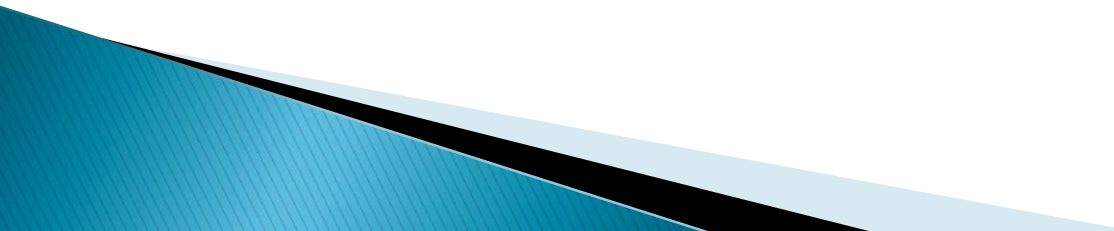
CNS-TVS review 10/2/16



11/2/16

- ▶ Transferred back to the hospital where investigations identified at least two fistulae – decision made in consultation with Mrs Kirk to not further investigate because of her deteriorating condition – surgical risk.
 - ▶ 4 days later Mrs Kirk was transferred back to hospice with Eakin wound pouch in situ – leaking.
 - ▶ Review by CNS–stomal therapy planned for next morning.
 - ▶ Lymphoedema therapist had applied compression bandaging to right leg
- 

Ongoing challenges

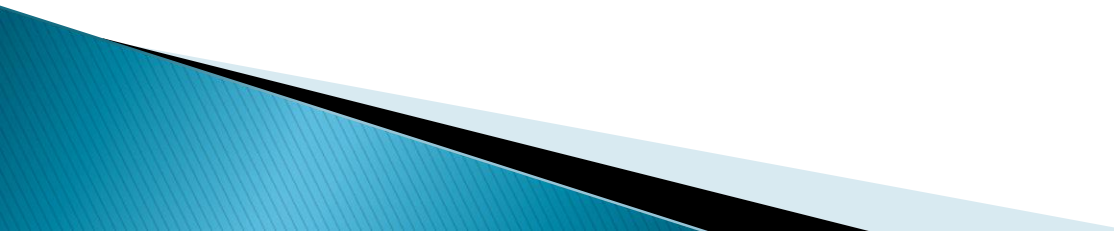
- ▶ Ongoing leakage of pouches, 1–2 x daily
 - ▶ Type 5 faecal would not ‘drain’ into pouch.
 - ▶ Wound margins extending
 - ▶ The skin/wound opening was not attached to the underlying tissues.
 - ▶ Cellulitis developing on right thigh– A/B started
 - ▶ Pain – Oxycontin Increased to 40mg BD
- 

Trial and error

- ▶ used a template for nurses to cut the pouch opening however with the 'floppy' edges of the wound it was awkward to get a neat fit
- ▶ Frequent changes were painful
- ▶ Movement: COP/Mobilising exacerbated leaking



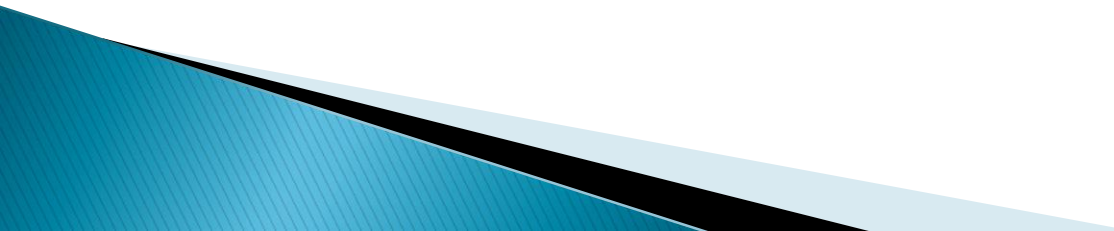
Deterioration– 22/2/16

- ▶ Hallucinations
 - ▶ Further support from Lawrence , pouches with a larger flange.
 - ▶ Albumin count falling (17)
 - ▶ declining renal function
 - ▶ Jenny, Lymphoedema therapist re-started compression on right leg as the leaking started again.
- 

End of Life Care

- ▶ Now bedfast, and family staying
- ▶ Myoclonic jerks (seizures),
- ▶ SCP commenced
- ▶ Pain medication still required continuing adjustment
- ▶ Output slowed from fistula, as food and fluids now stopping.
- ▶ Mrs Kirk passed away late evening following a large bleed from her fistula 4 /3/16

Learnings

- ▶ When in doubt, go back to basic principles
 - ▶ exemplary communication and documentation
 - ▶ Identify your resource people for support.
 - ▶ Listen to your patient
- 

Acknowledgements

- ▶ Caring for Mrs Kirk was a team effort
- ▶ thanks esp. to support of Lawrence, Desley, and Jenny Collett and Mr Coutts for their ongoing support, willingness to respond quickly, education and ideas.
- ▶ Acknowledge the work of the DNS who had spent many months working Mrs Kirk prior to her admission with Hospice.
- ▶ The wider hospice IDT team as we supported Mrs Kirk and her family.

