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.