Project ECHO Palliative Care - Canada BY Pallium Canada

BC Centre for Palliative Care

Flexing Your Core – Domain 5: Care Planning & Collaborative Practice
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Case Study for anticipatory planning

You are caring for Alex, an 80-year-old man with heart disease that lives with his daughter and her husband, who both work full time, and 3 young grandchildren.

Alex currently receives home support for a shower once a week. The home care nurse visits once a month. He has a family physician who he last saw 6 months ago.

He is tired and recently noticed he gets short of breath walking up the stairs but otherwise feels "OK"

His daughter approaches the home care nurse privately and shares that she has seen his energy and stability decline significantly in the last few weeks. She has suggested he use his walker, but Alex has declined. His daughter is concerned how she will support him as he declines

Things to ensure are part of a care plan

- ✓ Dynamic – not carved in stone, flexivilbity as needs and goals change, moveable
- ✓ Person-centred -
- ✓ Proactive -
- ✓ Shared – acp workshops in health orgs. Power chart notes

To create an anticipatory care plan:

1. **What questions do you want to ask Alex?**
    - How is he feeling?
    - What is important to you and to be able to do?
    - Who are people you see as supports in your life?
    - Is the shortness of breath (SOB) distressing to you? Asking to gauge his tolerance and severity of SOB
    - What are your goals?
    - Do you have any concerns that maybe I can help you with?
2. **Which members of the health care team would you want to bring into the care planning discussion?**
    - RT, Physician, Pharmacist, OT/PT to support modifications in the home and assist with energy conversation, equipment, grab, bars,etc.

- Home care nurse, Social worker to check how he's feeling about all this and to support family and check how they are experiencing this

3. **What issues do you anticipate could happen for Alex?**
    - Increase care needs
    - He may not want to think and plan for future – asking how much do you want to know? If he doesn't want to talk about it, maybe we could use the wish, worry, wonder discussion or variation of
    - Worsening SOB
    - Anxiety
    - Maybe he would like to discuss a plan as to what they will do if symptoms get worse
    - Lack of appetite and increase fatigue
    - He lives with his daughter and her husband - perhaps is he open to involving them in conversations about planning for when his symptoms get worse.
    - Will the full time working kids be able to support more. Is there other family available?
    - Edema, wounds

Comments: Would be helpful to see care plan examples from other settings. In LTC document on paper chart for various members of team caring for Alex and those without access to electronic chart. This plan focuses on comfort and what patient wants. Different settings have different requirement for care plans and want needs to be included, would be helpful to see how other settings lay there care plan templates out.