Flexing Your Core: the Palliative Workout ECHO

Domain 4: Comfort & Quality of Life

Oct 29, 2024

AGENDA ITEM	NOTES
Introductions, Objectives	Session Facilitator: Leanne Drumheller, MSW **Learning objectives:** 1. Apply the steps of symptom management and supporting wellness to a case study
Session Key Points and discussion	<u>Steps of Care</u> Using your heart, eyes & ears, brain, hands, and mouth: 1. Goals of care conversation • How can we make the transition in your health journey as comfortable and stress free as we can • Listening and being present • Asking about religion/culture with this 2. Assessment • Where is this going? What's happening right now? • Are they ready to discuss deeper questions? 3. Determine possible cause(s) • Asking: What do you think is happening? How do you feel about that? • Exploring management options 4. Interventions • What are they open to receiving in goals of care • Discussing ACP, and their understanding of their illnesses **https://www.bc-cpc.ca/publications/symptom-management-guidelines/**

	Case Study discussion: Mrs. Lin is a 68 year-old woman with metastatic lung cancer. Her goal is to stay at home and enjoy time with her family. So far, she has been able to dress and do the household cooking herself. Over the past few weeks, she has noticed that she is getting tired more easily. When climbing stairs to her bedroom, she has to pause several times. She has stopped showering and does a sponge bath instead. Her family is worried she seems "down" and doesn't engage like she used to. She has also complained of nausea and is not eating as much and has lost weight. The family is encouraging her to eat and be active. 1) What questions would you want to ask Mrs. Lin and her family? • Do you want assistance / PSW to come in? • Is it ok if we talk, is there anyone you would like with you for this conversation? • What do I need to know about you as a person to give you the best care possible? • Explore cultural practices/beliefs around illness and end of life care. **WSÁNEĆ Journey Home** (W̱SÁNEĆ First Nations and Island Health staff working together to support end of life care within W̱SÁNEĆ communities) 2) What could you suggest to help with her fatigue? • Home care services, outside help, personal aid/nurse, home set up for ease of movement throughout space • Re-arrange the space for keeping things closer together to manage doing what she wants to keep doing on her own as independently as possible 3) How could you support her individual and family's wellness? • How can we help with nausea – medications (either causing or med to help ease) • Explore "down" as perceived by family versus concerns to the client. Is it fatigue related? Anxiety? Something we can explore to understand where she is at • **Changing-ability-to-eat-and-drink-brochure-updated-2023.pdf**. Educate family on the natural dying process. • Explore is hospice at option at some point? What is capacity of family and what supports can be brought in • Does family fully understand the situation/disease process? • How are they coping with the changes in their loved one? What kind of support do they need in order to support Mrs. Lin? • She still has dignity and choice, need to foster that, fear of being a burden 4) Are there other team members you would like to bring into Mrs. Lin's care? • Are there community groups/people that we can engage in this conversation? (Church, social friends, family)

	• Does family come by often, do they live close by? How might each of these team members contribute to a care plan for Mrs. Lin? 1) **Health Care Assistant** – how can I assist you best with your personal care? 2) **Social Worker or counsellor** - stages of grief, how can we help work through that and acceptance of situation. What does a good day look like to you? And then we can figure out how to help in making that happen 3) **Nurse** – Advocacy, support/encourage, education, working closely with HCAs/CHWs and delegate tasks, aiding in coordination of care when there may be a change in condition that warrants a new plan 4) *Important to consider **volunteers/community groups** and their role in providing care to pts/families – volunteers are often a safe place for pts/families to share what's going on. Provide important support and important for HCPs to remember their role as part of the care team. Nav-CARE | Nav-CARE (Navigation, Connecting, Advocating, Resourcing, Engaging) volunteer hubs also within some communities/organizations. 5) **Physician** - the MD would assist with medications, treatments, palliative measures, pain management, EDITH form possibly, they sign the referral for palliative involvement, fill out palliative benefits and sign off on the recommendations from our palliative coordinators, facilitation of referral to required/desired services.
Next session info	Next Flexing Your Core ECHO Session: ***Domain 5: Care Planning & Collaborative Practice*** **Nov 5th 9am-10am PDT. Register here!** **Other upcoming ECHO sessions listed here**