Care of the Dying Patient: Frank's Case Study

Introduction

Glioblastoma multiforme (GBM) is the most common type of malignant brain tumors that affects adults. It mostly occurs in the brain, but may also sometimes be found in the brain stem, spinal cord, and cerebellum. The median age for occurrence of GBM is 64; however, GBM may be diagnosed at any age. Additionally, its incidence is found to be higher in men than women, and in Caucasians as compared to other ethnicities (Davis, 2016). This paper presents a case study of Frank who was diagnosed with GBM and died in the Palliative Care Unit shortly after his diagnosis. It specifically examines the Clinical Practice Guidelines (CPGs) for the care of a dying patient keeping in mind the Palliative Care Standards, NSQHS Standards, and NMBA Standards and how these relate to Frank's case.

Care Required for a Dying Patient

Palliative care of patients revolves around several Clinical Practice Guidelines (CPGs) for providing care to terminally ill and dying patients. The main objective of palliative care is to improve the quality of lives of patients and their families by taking appropriate care of their physical, emotional, and spiritual needs (Schroeder and Lorenz, 2018). End-of-life care is required to be compassionate, sustainable, affordable, and of the highest possible quality to address the multi-dimensional requirements of patients and their families. If holistic palliative care is not provided, it can lead to undue physical and emotional stress and suffering for the dying patient as well as the family (Sekse et al., 2017).

Palliative care for a dying patient varies depending on several factors such as the diagnosis of a terminal illness, treatments and/or medications, and the healthcare wishes of the patient. The specific choices of treatment for terminal illnesses need to encompass the quality-of-life factor for the dying patient. It is every healthcare provider's obligation to ensure that the patient is comfortable, free of pain to the best extent possible, and free of other debilitating symptoms (Doody et al., 2018). In order to ensure this, Australia has several standards such as the Palliative Care Standards, NSQHS

Standards, and NMBA Standards to direct healthcare providers in their provision of palliative care services to dying patients.

Palliative Care Standards with respect to the Case Study

The Palliative Care Standards are aimed at providing holistic care to a patient suffering from a terminal illness and his/her family members keeping in mind their physical, emotional, spiritual, and psychosocial requirements. These Standards direct healthcare providers to provide the most optimum palliative care to dying patients (Palliative Care Australia, 2018). As per Palliative Care Standard 1, a healthcare provider needs to perform a comprehensive assessment of patients keeping in mind their physical, emotional, and spiritual requirements. This was largely lacking at the Palliative Care Unit, where only the basic assessments were completed. Despite Frank's diagnosis of GBM, the relevant diagnostic assessments were not done to determine the extent and areas to which the tumour had spread (Szopa et al., 2017).

Standard 2 was also not followed for Frank, which expects the healthcare provider to determine goals of care and take informed decisions based on these goals. However, there was no clear documentation of Frank's condition nor was an action plan prepared that could direct the nurses to take appropriate care of Frank (Al-Mahrezi and Al-Mandhari, 2016). Needs assessment of the family members was not done at all, which is in direct contrast to the directive in Standard 3 (Zaider and Kissane, 2017). Based on Standard 4, although the care provided was based on the needs of the patient, it was not evidence-based and consistent with patient preferences, which compromised the quality of palliative care services delivered to the patient (Pergolizzi et al., 2020).

As Frank's death was quite rapid and unexpected, his family was heavily distressed as can be expected in this type of cases. However, there is no information of provision of bereavement support services as per Standard 6 to Frank's family members who were unable to understand what went wrong so quickly (Hudson et al., 2017). In contrast to Standard 8, an active effort to improve the quality of palliative care

services was largely lacking as most of the care services of nurses were in response to the patient's symptoms rather than to Frank's specific diagnosis and its management.

NSQHS Standards with respect to the Case Study

The NSQHS Standards have been developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC, 2017) to protect dying patients from stress and suffering and to improve the quality of palliative care services in Australia. The first standard describes clinical governance concerning the reliability, quality, and safety of palliative care services. However, Frank's case study demonstrates sub-optimal care with respect to quality as there is no proper documentation of needs assessment, diagnostic assessments, goals of care, or action plan. As per the second standard, patients and their family members should be active players in the provision of healthcare services. Again, this was lacking as Frank and his family were not really a part of a specific action plan nor were Frank's healthcare preferences of dying with dignity honoured at the time of his death (Brennan, 2017).

Despite the negligence of the palliative care nurses in certain aspects, prompt action was taken when the patient sustained a fall and all the necessary assessments and medication administration changes were made appropriately. This is in line with the third and fourth NSQHS Standards which deal with healthcare-associated infections and medications respectively (Kennedy, 2016). However, several aspects of the fifth standard which deals with comprehensive palliative care was lacking with respect to integrated screening, risk identification, and assessment, and using these to develop a personalized care plan considering Frank's diagnosis. The sixth standard which revolves around communication between healthcare providers, patients, and their families too was not followed completely as the palliative care nurses did not communicate with Frank's medical team at the hospital for appropriate care of the patient (Brighton et al., 2017). The eigth and final standard deals with recognition and responsiveness of acute deterioration in a dying patient, which was, to a large extent, done properly by the nurses. Following Frank's fall, his condition deteriorated rapidly and the nurses implemented all appropriate interventions to manage his condition.

NMBA Standards with respect to the Case Study

The NMBA Standards released by the Nursing and Midwifery Board of Australia (NMBA, 2016) aims to promote evidence-based patient-centered palliative care for dying patients. These standards are specifically directed towards registered nurses as they are the primary caregivers for a dying patient. Considering the first standard, the nurses in Frank's case study largely lack critical thinking and clinical reasoning skills, as they did not carry out any diagnosis-specific assessments, did not prepare an action plan for the patient, and did not complete the Advanced Care Directives (ACD) as recommended by the medical team. Additionally, it was Frank's wish to die with dignity unlike his father who suffered tremendously towards the end, and this wish could not be honoured completely due to the palliative care nurses' lack of evidence-informed nursing practice (Sahan and Terzioglu, 2017).

The second standard states that the palliative care nurse must engage in therapeutic relationships with other healthcare providers, patients, and their family members. However, this too was lacking in this case study because the patient and his family were not involved in any documentation, planning, or preparation of Frank's goals of care and action plan (Ringdal and Andre, 2014). Based on Standard 3, the nurses did respond to Frank's deteriorating condition with the appropriate interventions thereby maintaining the capability of practice. However, Standard 4 was not appropriately maintained which states that comprehensive patient assessments need to be conducted for provision of quality healthcare services. The assessments that were conducted were in response to patient symptoms such as inability to walk independently and numbness in the feet; however, no assessments were done for identifying the extent of tumour metastases in the body at the time of admission of the patient at the Palliative Care Unit (Taleghani et al., 2018). As per Standard 7, a nurse is required to evaluate patient health outcomes in order to inform future practice. However, in Frank's case, there was no proper documentation or assessment of his condition at the time of admission thereby resulting in the absence of any information that could be used to inform future practice (Dudgeon, 2018).

Clinical Practice Guidelines (CPGs) with respect to the Case Study

As palliative care is an extremely sensitive topic where dying patients and their families are quite vulnerable, there are several CPGs that have been formulated to guide palliative care nurses in their provision of healthcare services. According to these guidelines, two things that need to be taken care of at all times are patient's dignity and comfort. In Frank's case, he had specifically expressed that he wished to die with dignity unlike his father who had terribly suffered towards the end of his life. Despite several efforts taken by the palliative care nurses, they were not able to achieve this to a complete extent thereby violating his last wishes.

For the benefit of the patients as well as the nurses, the CPGs recommend filling in the Symptom Observation Chart (SOC) and the Care of the Dying Patient Plan (CDPP); however, there is no evidence in the case study that these two documents have been filled out by the nurses. Also, as per the CPGs, the patient's vital signs need to be monitored at least on a 4-hour basis which has not been done as per the case details. The CPGs also require documentation of Goals of Care and ACDs in collaboration with the medical team; however these have also not been done by the palliative care nurses.

Conclusion

In conclusion, this paper threw light on the palliative care services provided to Frank and his family, and the extent to which these services were in accordance with the Palliative Care Standards, NSQHS Standards, NMBA Standards, and CPGs. Several points were identified that were found to be in violation of the above mentioned standards. There was no clear documentation of the patient's condition upon admission to the Unit, diagnostic assessments carried out, vital signs on a regular basis, goals of care, action plan, and ACDs. The palliative care nurses made no effort to contact Frank's medical team to find out more about his condition along with better management interventions. Most of the interventions implemented at the Palliative Care Unit were in response to Frank's deteriorating condition rather than a consequence of the risks of his GBM. On the other hand, the nurses took care of Frank's spiritual needs

by requesting pastoral care for him. They also made referrals to physiotherapy and allied health services that would have improved his quality of life had he survived long enough to take advantage of them. However, lack of evidence-based practice was evident from this case study and non-adherence to several palliative care standards was identified.

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