CASE STUDY

Improved quality of life is achieved through successful communication

An individualized plan of care that kept the patient's dementia in mind helped to produce an excellent outcome for this elderly patient.

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CASE

This 93-year-old woman first came to our hospital via the emergency department (ED). She was transported by local paramedics called by the Department of Senior Services, who made a visit to the patient's home and found that she could no longer safely remain in her home and care for herself. Following an ED assessment, the patient was admitted to a medical/oncology unit.

She was confused and somewhat combative. She had five children but no power of attorney of any kind. Upon admission, a psychiatric evaluation was ordered and the patient was found to be not competent to make decisions for herself. A daughter was established as power of attorney. During this admission, a small lesion on the patient's forehead was also noted. Vital signs were normal, and her weight was 130 lb. The history included arthritis, and radiology studies showed a previous right knee fracture. Diagnosis included dehydration, dementia, and failure to thrive. The patient was treated and discharged after 3 days to a nursing home.

One month later, the patient was readmitted to the hospital because the lesion on her forehead had increased in size. In the past 3 weeks, it had grown rapidly into a 3½×2-inch fungating lesion. The tumor invaded the anterior orbital space and infringed on the patient's vision in her right eye (**Figure 1**). A biopsy was done, and the pathology report showed stage III squamous cell carcinoma. CT verified that the lesion had not yet invaded the brain. A surgeon was called in for consultation and said that excising the lesion would leave a large deficit and most probably involve enucleation of the right eye. A radiation oncologist was consulted and recommended external beam radiation for 20 treatments.

At the time of this second admission, the patient was disoriented and combative at times. Her weight had decreased to 106 lb. The primary care physician and radiation oncologist informed the patient's family that external beam radiation therapy would require the patient to be under anesthesia for each treatment and that foregoing treatment would mean that the lesion would invade the brain and continue to grow onto a larger portion of the face.[1] The family decided that the patient should be discharged back to the nursing home to return to the radiation therapy department daily to receive external beam therapy under anesthesia.

Treatments were provided to the patient over the next month. Because IV access was poor, a peripherally inserted central catheter (PICC) was required midway through the treat-

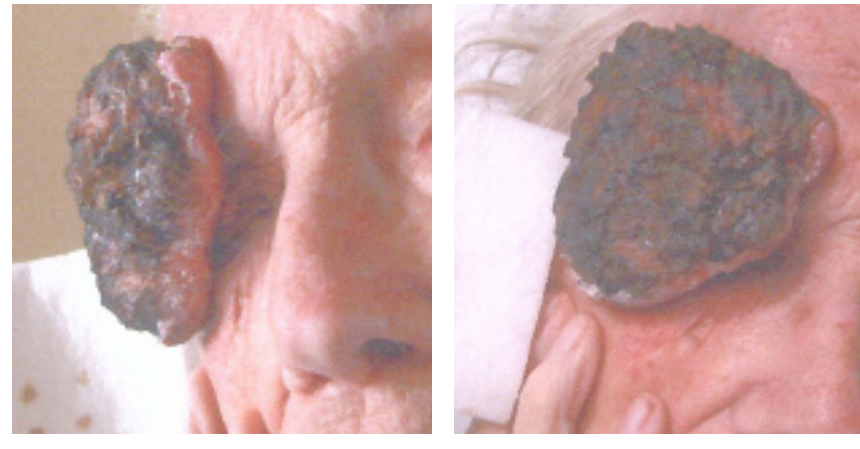

FIGURE 1. Two views of the patient's fungating lesion

ments. The daily treatments were administered in the early afternoon because the anesthesiologists were involved in surgical procedures in the morning. The patient was NPO from 6 AM until the treatment was completed and was taken to the recovery room afterward. During the month of radiation therapy, her weight declined further and a gastric tube was inserted.

The patient returned for follow-up 3 months after treatment had ended with the lesion healed (**Figure 2**). Although she was still slightly confused, she was noncombative and pleasant. Her weight had increased by 8 lb, and the vision in her right eye had returned.

DISCUSSION

In this patient's case, a decision needed to be made regarding treatment in conjunction with the patient's and family's wishes. In addition to a very unpleasant odor, fungating tumors are often associated with pain, itching, and bleeding. This patient's tumor was growing rapidly and, if left untreated, would have caused further morbidity after extensive spread with necrosis and other fungating symptoms.

Medical decision and ethics Although elderly cancer patients often do not receive the standard of care in cancer treatment, no clinical data support the common assumption that elderly patients cannot tolerate radiation therapy.[2] This patient had no comorbid conditions, and age should not be a primary deciding factor in the decision for or against treatment. Compared with chemotherapy or surgery, radiation was less invasive and more tolerable for this patient. Because she lived in a nursing home, the patient was in a controlled setting where monitoring of any side effects could be more easily achieved.[3] Overall, the benefits outweighed the risks, and the organizational culture supported the ethics of the treatment decision.

One challenge that had to be addressed was the need for daily anesthesia for 20 treatments. Monitored anesthesia care (MAC) would be needed to ensure patient safety and treatment accuracy.[4] The complexity of the treatment also included the location of the tumor, the reproducibility of the patient's position daily, and the safety of leaving the patient alone in the treatment vault during radiation.

Communication and teamwork Because outpatient anesthesia would be required daily in the radiation department, a multitude of questions arose. These questions included where the chart would reside, what documentation was necessary, who would recover the patient and where, how the patient's nutrition would be maintained, whether the procedures would be reimbursed, and how the patient's treatment would be scheduled in several different scheduling systems. In an attempt to answer these concerns, an e-mail describing the intent and nature of treatment was sent to various department heads. A conference call followed that included team members representing surgery, risk management, nursing, medical records, pastoral care/ethics, radiation therapy, and finance. The call drew upon the experience and knowledge of the entire health care team with the focus not on if the treatment could be given but rather on how it could be successfully accomplished.

Another challenge was communication with the nursing home facility. Daily transport from the facility was needed, after which the patient had to be brought to the radiation department and later picked up from the recovery area. Ongoing communication would need to include the daily patient status. The patient would need to be NPO from 6 AM, which would result in two missed meals at the facility. Weight, calorie counts, and fluid intake needed

TEACHING POINTS This case reinforced two important nursing concepts.

Individualize the nursing plan of care:

- Assess individual patient needs in relation to the treatment
- Prioritize and assign responsibilities; standardize a logistical plan
- Communicate in a consistent, timely, methodical fashion that prioritizes patient needs; this is the core of effective nursing care.

Provide appropriate care for patients with dementia:

- Use direct, everyday language
- Minimize external stimulation and approach the patient in a nonthreatening manner
- Use humor and draw on the patient's experiences
- Know who your patient is and what matters to the patient. Otherwise we would not have known about the horse named Bob. It is all really just about the patient.

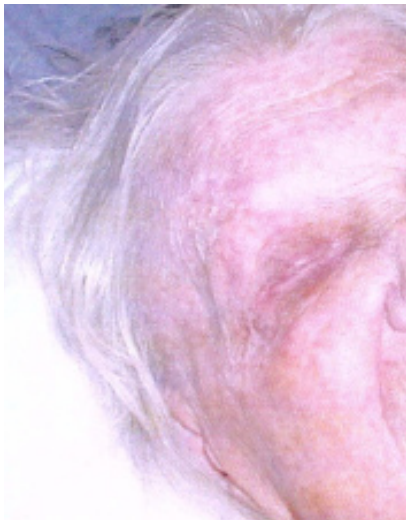

FIGURE 2. Healing of the lesion 3 months after treatment

to be closely monitored to maintain the patient's physical and mental status.

Regular communication with the family was also essential. At times, one of the patient's adult children came to the radiation department to be with her before her treatment and during recovery.

A successful hand-off results in the transfer of the necessary patient information and the turnover and acceptance of the patient's care.[5] To facilitate a smooth transition, the situation, background, assessment, and recommendations—known as SBAR—are needed.[6] The Joint Commission reports that 65% of sentinel events are brought about by inadequate or missing communication.[5] Development of the nursing plan of care with communication hand-offs was the principal challenge in this case.

The radiation nurses would start early in the morning with conversations with the nursing home staff. They would discuss the patient's weight, her vitals, what kind of a night she had, her intake, and the status of the wound. The nursing home would hand off to the ambulance service. The paramedics who staffed the ambulance were usually those who transported her daily. They were cheerful, kind, and gentle with the patient. She often remarked how the boys would wrap her in a warm blanket when they came to pick her up. The next handoff was to the nurses in radiation. They would complete a nursing assessment and initiate an IV before summoning anesthesia. The patient was treated under sedation and then taken to the recovery room accompanied by anesthesia and the radiation nurse. The next hand-off was to the nurses in recovery, who also tried to minimize external stimuli and limit the number of staff caring for the patient. She was discharged from the recovery room to the paramedics and back to the nursing home. The recovery room nurses would communicate to the radiation nurses how the recovery had gone. Throughout the entire process, the nurse was the hub of the communication complex. At the completion of therapy, the nurses followed up with the nursing home staff concerning dressing changes for the wound.

Consistency in personnel is important for patients with dementia as it gives them a feeling of security. The same nurses in the radiation department cared for the patient each day. The patient was placed in a holding room with minimal external distractions.[7] Vitals were taken and an IV was started. One nurse spoke with the patient while another performed the tasks. The nurses told the patient jokes and questioned her about her past. Dementia patients often retain long-term memory and as they speak of past events, they become more engaged with their caregivers and retain a sense of self.[8] In this way, the nurses learned that the patient's mother was also a nurse and that the patient had a horse named Bob when she was young. A daily routine was established with a minimal amount of staff change; this helped create consistency in care and helped the patient remain at ease. At no point during treatment did the patient refuse therapy or any procedures.

At follow-up visits, the wound was healing well. After 3 months, no drainage, odor, or lesion remained. The forehead had healed. The patient remembered the nurses who took care of her. They told her the same jokes, and she still laughed. ■

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