Whole Person Assessment: A Palliative Care Approach
Learner Packet

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Description
Aging, illness, dying, and grief are life-cycle processes are not pathological events. Palliative care involves not simply care of the physical body, but also care of a person’s mind, spirit, heart and soul. Participants will be equipped with generalist palliative care skills including how to complete a whole person assessment focusing on physical, psychosocial, and spiritual symptoms and interventions. This workshop is intended to broaden participants’ conceptual and practical understanding of holistic care through interactive and experiential engagement.

Objectives:
- Attitude: learners will be able to identify personal misconceptions concerning their understanding of palliative, hospice, and end of life care.
- Knowledge: learners will be able to correctly identify the three major components of the holistic, total person assessment process (body, mind, and spirit).
- Skill: learners will practice conducting a generalist palliative care assessment including screening for common physical, psychological and spiritual symptoms.

Agenda:
- Define and explain concepts of palliative, hospice, and end of life care.
- Provide an overview of the palliative care approach.
- Make a case for holistic assessment of body, mind and spirit of clients with serious illness.
- Assessment methods and management of: physical symptoms including pain, dyspnea, and others; grief, loss, bereavement (depression screening); and spiritual distress using FICA.

Video #1 “You have cancer…”

1. What was your reaction to the interaction between the physician and Vivian?

2. How do you think Vivian felt? How could this “bad news” have been delivered better?
What is Palliative Care?

An approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain, physical, psychosocial and spiritual, and other problems

1. Provides relief from pain and other distressing symptoms;
2. Affirms life and regards dying as a normal process;
3. Intends neither to hasten or postpone death;
4. Integrates the psychological and spiritual aspects of patient care;
5. Offers a support system to help patients live as actively as possible until death;
6. Offers a support system to help the family cope during the patient’s illness and in their own bereavement;
7. Uses a team approach to address the needs of patients and their families, including bereavement counseling if indicated;
8. Will enhance quality of life, and may also positively influence the course of illness; is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications. (World Health Organization)

Specialized medical care for people with serious illnesses

It is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis. (CAPC)

Palliative care generally refers to patient and family-centered care that optimizes quality of life by anticipating, preventing, and alleviating suffering across the continuum of a patient’s illness. (National Quality Forum)
Models of Care:

<table>
<thead>
<tr>
<th>ACTIVE AGGRESSIVE INTENT</th>
<th>PALLIATIVE INTENT</th>
<th>DEATH</th>
<th>BEREAVEMENT</th>
</tr>
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</table>

OLD

NEW – Even when receiving curative intervention...

Traditional and proposed palliative care services. (A) Traditional palliative care services. (B) Proposed palliative care services. From “Pediatric palliative care: building the model, bridging the gaps,” by G. Frager, 1996, Journal of Palliative Care, 12 (3):9-10.

What is Hospice?

Palliative Care at the end of life

Video #2 “What is Palliative Care”

1. What role does Palliative Care have in Vivian’s journey?

2. What would be the benefit for Vivian?

Palliative care vs. hospice care

Palliative care is aimed at anyone who has been diagnosed with a life-threatening illness. Hospice care is mostly aimed at patients who have been diagnosed with a terminal illness.

Palliative care helps maintain quality of life and reduce illness symptoms – and recent findings suggest that cancer patients who receive palliative care alongside standard treatments can live longer. Hospice care is aimed at providing patients with a dignified, pain-free death – in the U.S., hospice care is mostly meant to be administered inside the patient’s home, while in Russia, the concept of hospice care is just beginning to gain ground.

Source: The Mayo Clinic (mayo clinic.com) and Oncology Nurse Advisor.com
Whole Person Assessment: Body, Mind, and Spirit

Define the assessment techniques used:

The Body – Physical Domain

1. Multidimensional assessment

2. Total Pain:
   the suffering that encompasses all of a person’s physical, psychological, social, spiritual, and practical struggles

3. Importance of treating pain

Video #3 “Pain assessment”

1. What was positive and negative about that interaction between the resident and Vivian?

2. What tools would you have used?

Video #4 “Total Pain”

1. Describe what you observed as elements of Vivian’s total pain experience?
**Dyspnea**

impaired breathing; "a subjective experience of breathing discomfort that consists of qualitatively distinct sensations that vary in intensity" American Thoracic Society

Distinct sensations include effort/work, chest tightness and air hunger - the feeling of not enough oxygen.


**Assessment tools:** MRC Scale and Modified Borg Scale

<table>
<thead>
<tr>
<th>MODIFIED DYSPNEA SCALE</th>
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<tbody>
<tr>
<td><strong>Grade</strong></td>
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<td>0</td>
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<td>0.8</td>
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<tr>
<td>1</td>
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**MRC Dyspnea scale**

- Grade 0: Not troubled by breathlessness except on strenuous exercise
- Grade 1: Short of breath when hurrying or walking up a slight hill
- Grade 2: Walks slower than contemporaries on the level because of breathlessness, or has to stop for breath when walking at own pace
- Grade 3: Stops for breath after walking about 100m or after a few minutes on the level
- Grade 4: Too breathless to leave the house, or breathless when dressing or undressing

**Management:**

**Table 1—Assessment of Dyspnea: Do and Don’t**

<table>
<thead>
<tr>
<th>Do</th>
<th>Don’t</th>
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<tbody>
<tr>
<td>Ask about the qualitative experience of dyspnea (such as chest tightness, work of breathing).</td>
<td>Relate on blood gases for assessing the severity of dyspnea.</td>
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<tr>
<td>Ask about associated affective states (anxiety, panic, depression).</td>
<td>Relate on orders such as “Call physician for 90%” as a trigger for the reevaluation of dyspnea. Consider an order such as “Assess dyspnea intensity q shift. Call physician for dyspnea &gt; 6 (0-10 scale).”</td>
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<tr>
<td>Try to quantify the intensity of dyspnea and associated suffering (eg, use a 0-10 scale).</td>
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<td>Ask how dyspnea is affecting the patient’s life (reduced activity, sleep disorder, etc).</td>
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<td>Ask about concerns for the future (fear of suffocation, greater disability).</td>
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The Mind

Depression –

Patient Health Questionnaire - PHQ2 (96% sensitivity & 57% specificity)
1. “Over the past 2 weeks have you ever felt down, depressed, or hopeless?”
2. “Over the past 2 weeks have you felt little pleasure or interest in doing things”

Delirium –

Confusion Assessment Method (CAM)
For a diagnosis of delirium by CAM, the patient must display:
1. Presence of acute onset and fluctuating discourse
   AND
2. Inattention
   AND EITHER
3. Disorganized thinking
   OR
4. Altered level of consciousness

Table 5. Pharmacologic Management of Delirium: Usual Starting Doses*

<table>
<thead>
<tr>
<th>Predominantly neuroleptic effects</th>
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<tbody>
<tr>
<td>Haloperidol, 0.5–1 mg every 30 minutes orally (0.5–1 mg every 30 minutes subcutaneously or intravenously, titrate to effect, usual maximal dose not to exceed 3 mg/24 hours)</td>
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<tr>
<td>Olanzapine, 2.5–5 mg orally once daily</td>
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<td>Risperidone, 0.5 mg orally twice daily</td>
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<th>Predominantly sedative effects</th>
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<td>Lorazepam, 0.5–1 mg every 4 hours orally, subcutaneously, or intravenously</td>
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<td>Propofol, 10-mg bolus followed by 10 mg/h intravenously</td>
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<tr>
<td>Midazolam, 1–2 mg/h subcutaneously or intravenously</td>
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* Titrate dose to effect in all regimens.
The Spirit
Spiritual Assessment

We recommend the following for healthcare providers taking a patient’s spiritual history:

1. Consider spirituality as a potentiality important component of every patient’s physical well-being and mental health.

2. Address spirituality at each complete physical examination and continue addressing it at follow-up visits if appropriate. In patient care, spirituality is an ongoing issue.

3. Respect a patient’s privacy regarding spiritual beliefs; don’t impose your beliefs on others.

4. Make referrals to chaplains, spiritual directors, or community resources as appropriate.

Be aware that your own spiritual beliefs will help you personally and will overflow in your encounters with those for whom you care to make the doctor-patient encounter a more humanistic one.


Video “Runny Away Bunny”

1. Record your feelings here.

2. How did the visitor address Vivian as a “whole person”? What interventions did she use?