

**Peter – a case study**

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|  | **Case study** | **Considerations** |
| **Within PP** | Peter is an 85 yo gentleman who has recently moved into a care home He has dementia and Type 2 diabetes and had a heart attack 5 years ago. He had been living at home with his family until his wife fell ill and he came to the care home for respite before converting to a permanent residential placement |  |
| **Rule One: eating or swallowing difficulties** |
| **Within PP** | He has lost weight over the last 6 weeks and isn’t eating very much. Despite the best efforts of the chef and his family, he still seems disinterested in his food. He is diagnosed with depression and things do improve when he starts sertraline. He is observed laughing together with another resident, Malcolm. In spite of this the volume that he eats reduces gradually and his daughter is frightened he will starve to death | Why do people have difficulties with eating and swallowing?Symptom of dementia progressionNatural part of the body shutting downReversible causes |
| Decision: Comfort feeding  |
| **Rule Two: agitation and restlessness** |
| **Within PP** | Peter seems really settled for a few months and even joins in with the visiting choir and church services. One day he refuses breakfast and when his daughter comes with some lunch for him he pushes the plate onto the ground. Over the next few days he is very noisy and causing distress to other residents. He seems angry and everyone is on edge | What is agitation and restlessness?A means of communication |
| **Within PP** | When staff come in to help he continues to shout and kicks Flo who is trying to clear up. She rings the GP and says they need an urgent visit to provide sedation. GP cannot see any sign of infection and Peter is now on regular painkillers. The chef asks if he could be missing Malcolm who has been admitted to hospital the previous day | What can you do?How do you keep yourself and other staff safe?Who can help?Don’t overlook our social and emotional needs |
| **Use this information to update group**  | This new thought helps staff to understand what Peter is trying to express and they feel better able to look after him. Peter continues to have altercations with other residents, going into their rooms at night and eventually it is agreed to try a small dose of risperidone in the evening. This is done because of balance of risk to peter and the other residents. Keeping ourselves safe and balancing risk. Frequently reviewed: after six weeks Peter’s risperidone is reduced and stopped and he returns to his usual self. |  |
| **Rule Three: reviewing treatment and interventions** |
| **Within PP** | Peter’s swallowing difficulties continue and he starts to choke when trying to swallow his atorvastatin capsule. What are the options? Covert medication? Review goals of treatment and stop atorvastatin?How can we make these decisions?Benefits risks and burdensBest interests | **Carers** emotions: sense of sadness and worry, we are doing our very best and he is still losing weight**Family** emotions: Don’t let him starve to deathPrior knowledge of his wishes and preferences**GP:** factual knowledge and personalised medical risk assessment too frail for procedure and r/o aspiration pneumonia and increased distress, prolongs dying process **OT:** practical help…try altering his position or using a smaller spoon**Dietician:** other ways to increase his calorie intake: fortifying the food he does eat, adding supplements**SALT:** there are risks with every option |
| **Complete activity 3** |
| **Use this information to update group following discussion of activity 3** | It is agreed to stop most of his prevention medications A Treatment Escalation Plan is drawn up (Respect) which reflects his ACP and his previously known wishesPreferred Place of Death = care homeDNACPRFor hospital admission if appropriate but not for ICU (ward level care) |
| **Within PP** | As the months go by, Peter continues to lose weight and becomes more frail His swallow worsens and he is bed bound; GP and care home feel he is reaching the end of his life. His family find this hard to take on board. All of his medications are discontinued and we start to focus on symptom management: for example pain relief, regular turning and good mouth care His Treatment Escalation Plan is adjusted to reflect the new priorities of care: not for hospital admission (except for fractures, serious head injuries or intractable symptoms) |
| **Rule Four: routine care in the last days and hours** |
| **Within PP** | As things progress how can we adapt our care to make it just right for Peter? (Personalisation)What are the priorities?Our previous knowledge of him means we know he would like a priest to visit and that he will enjoy some choral music. His family can visit as often as they wish and staff encourage them to share their memories. The staff hate to turn Peter when he is peaceful What are the risks benefits and burdens?Who can help? |  |
| **Conclusion** |
| **Within PP** | Things do not go as planned and one night when agency staff are present Peter chokes on some thickened fluids and an ambulance is called. Peter is taken to hospital and sadly dies in A&E.This generates a lot of emotion for the family and the staff and Malcolm is very tearful As part of shared learning a review is planned and all staff involved get a chance to think about what we did well and what we could have done better for Peter. How might you reflect on this case? | Communication? Did we get the right skill sets at the right time?Did we personalise our care for Peter?Did we look after his physical social environmental and spiritual/emotional needs?How can we involve the family?What about Malcolm? |