



## Hospice Case Study: COPD

**For patients with Chronic Obstructive Pulmonary Disease (COPD), our hospice care provides customized plans of care and palliation for optimal outcomes, with focus on clinical interventions for patient comfort, education and support for caregivers, and hospitalization reduction.**

63 year old Mr. B was admitted to hospice service with a primary diagnosis of Chronic Obstructive Pulmonary Disease. He resided in a skilled nursing facility and his primary caregiver was a niece, who was unable to visit due to COVID-19 restrictions. His medical history included Sickle Cell Anemia with his last transfusion 6 months prior to admission, possible Alzheimer's Dementia, and Bi-Polar 1 disorder.

Upon admission Mr. B greeted the hospice staff enthusiastically and easily engaged in conversation. He was alert and oriented X 3, with only short term recent memory loss notable. Physical assessment revealed respirations mildly labored at rest, and increased effort with exertion with breath sounds diminished throughout. He was dependent on oxygen at 2 L via nasal cannula. He presented thin and malnourished with obvious cachexia. The facility staff reported he consumed LESS THAN 25% OF 3 MEALS. His MUAC was 18 cm; PPS 40%; FAST 6B. Mr. B chose to remain a Full Code with his niece in agreement.

Facility staff reported he required assistance with ADLs, yet was reluctant to allow staff to help and often refused. Mr. B. (and his niece) accepted hospice nursing and social work services, but aide, chaplain, and volunteer services were declined.

Mr. B reported that his pain regimen was adequate, but just days into care he shared that his current prescription was not managing his pain. The hospice team coordinated with the attending physician and facility staff to increase Mr. B's Percocet from 5/325 mg every 4 hours to Percocet 10/325mg every 4 hours. The hospice RN visits the next two days revealed an additional order for Tramadol was needed for breakthrough pain. Mr. B also requested a wheelchair; which was supplied immediately.

Within one month of hospice admission, Mr. B exhibited dyspnea with minimal exertion including talking, and progressed to total assistance with ADLs. His appetite remained very poor, his pain was controlled with Percocet and Tramadol, and he consented to assistance with bathing. The hospice staff, facility staff, and his niece continued to coordinate care to ensure Mr. B's needs were met while being respectful of his wishes.

The facility reported Mr. B was declining. He exhibited increasing weakness, not eating well, and difficulty swallowing his evening medication. He was still responding, but looked drowsy. There were no changes in breathing, pain was controlled, and his vital signs were stable. He denied pain, but had not eaten in two days and was only accepting small sips of liquid. The hospice RN and social worker updated Mr. B's niece by phone, educating on what the signs of decline may mean. After discussion, the patient and niece were in agreement with implementation of a Do Not Resuscitate order.

The hospice RN visits the following day noted further decline. New onset dysphagia required medications to be crushed. His breath sounds were diminished with scattered Rhonchi and his oxygen saturation was 88%. His oxygen was increased to 4 LPM. He did not get out of bed and willingly consented to personal care being performed. Severe pain required the addition of liquid Oxycodone and Lorazepam for agitation.

Mr. B passed away at the facility comfortably and peacefully. Mr. B's niece received bereavement services from the hospice staff to address the grief related to losing her uncle as well as grief associated with not being able to visit due to facility COVID-19 restrictions.

### Our Care Matters

- Mr. B's hospice care was provided in the skilled nursing facility where he resided.
- Coordination of care with facility staff provided prompt response to changes in Mr. B's condition.
- Effective pain and symptom management resulted in Mr. B accepting bathing and personal care, which had previously been refused.
- Education on signs of decline and expectations allowed for the patient and family decision for a DNR order.
- Mr. B sometimes refused assistance and services; Patient choice is always honored.

### When Life Matters Most

- Pain management is adjusted as needed for improved outcomes and comfort.
- Continued assessment/frequency of patient visits provide opportunity for necessary changes to the plan of care.
- The family was appreciative for the care of their loved one and for the communication as they were unable to visit due to COVID restrictions.
- Bereavement care will continue for the family for 13 months, which includes community referrals.

**Contact us to begin the hospice conversation or to address specific questions regarding hospice care for patients with COPD. We Are Here.**