CASE STUDY

This case study illustrates the significant contribution occupational therapy plays in enabling people receiving palliative care to continue to participate in the roles and activities they value.

Case study – Jane

Jane is a 42-year-old woman who was diagnosed with breast cancer in 2009. In late 2013, her disease became metastatic, having spread into her thigh, rib and back bones. Jane recently developed some back pain and leg weakness and was admitted to an acute hospital for management of her spinal cord compression and pain. She had some radiotherapy to her lumbar spine and was transferred to an inpatient palliative care unit for restorative care and management of her pain. The doctors have told Jane that her cancer is progressing and she may not regain all of her mobility and strength. On admission to the palliative care unit, Jane was referred to members of the multidisciplinary team, including the occupational therapist, for assessment and intervention.

Occupational therapy assessment

Jane agreed to participate in an initial assessment. Jane is married to Rob. They have two children aged nine and seven years. Jane’s sister lives nearby and provides practical support and her elderly parents live in regional Victoria. Jane worked part time as a gymnasium instructor, until six months ago when she went on leave without pay as her sick leave ran out. Rob works full time. His employer is aware of Jane’s illness and is supportive of Rob working from home when necessary. Jane has a good social network through the children’s school. This has become more important to her since she left work.

Until a few weeks ago, Jane was showering and dressing independently, she shared the meal preparation with Rob, and her sister provided some meals. Jane did some of the laundry. She has employed a private cleaner for the last year. Most days Jane walked the children a short distance to and from school. While Jane did some light shopping, Rob did the heavy shopping. Each evening Jane helped the children read their readers.

Following her admission, Jane spent most of the day in bed. She reported that her back pain was still significant, but slightly better than it was. Jane’s pain was made worse by standing for more than a few minutes and bending forward. Her legs were still weak. She continued to experience significant fatigue. Jane needed assistance to get out of bed and to get in and out of a chair. She could walk a few metres with a frame and some assistance from a nurse. The nurses helped with showering and dressing. Jane expressed anxiety at the thought that she might not walk independently again and worried that this would impact her ability to care for her children. Jane was concerned that Rob was doing too much. Jane wanted to support Rob, as she did before. She was concerned that her cancer was getting on top of her and acknowledged that her future was uncertain.
The occupational therapist worked with Jane to identify some realistic goals:

**Short term**
- Be able to sit out of bed for approximately one hour, when the children come to visit
- Be independent getting in and out of the bed and a chair
- To shower and dress independently
- Begin work on her legacy for her children
- Be discharged home as soon as possible.

**Medium term**
- Explore ways for Jane to take her children to school and connect with other parents
- To return to reading each evening with the children
- Resume some light tasks around the house.

The occupational therapist undertook the following interventions to assist Jane in achieving her goals:

- Thorough assessment of Jane’s current physical abilities and how this impacts the way she manages tasks such as showering
- Prescription of an adjustable bedside chair and wheelchair to maximise postural support and comfort
- Prescription of a pressure relieving cushion to
  - maximise Jane’s comfort when sitting out of bed, and
  - prevent pressure injuries
- Education provided on the prevention of pressure injuries
- Provision of a bed stick and education on use of bed mechanics to support Jane’s independence with getting in and out of bed
- Education on alternative ways to shower and dress that will help her manage her pain and fatigue
- Supportive counselling to support Jane’s adjustment to her reduced independence and to identify those activities and roles it is most important for her to return to
- Prescription and trial of a motorised wheelchair on the ward and in the immediate community to support Jane’s independence. Arrangements made to hire the wheelchair with funds that had been raised by the school community
- Education on fatigue management
- Home assessment and provision of equipment and small modifications to support Jane on her return home
- Referral to outside services for assistance with showering and dressing on discharge
- Referral to a community occupational therapist for home-based rehabilitation to optimise Jane’s independence with
  - showering in the home environment
  - resuming some light domestic tasks, and
  - using the motorised wheelchair around her home and in the community to enable her to confidently pick the children up from school.
Jane was discharged home after three weeks in the palliative care unit. She was able to walk 20 metres with a frame and showered and dressed with someone nearby, just in case she needed a hand. Jane was able to sit out of bed for longer periods and was becoming more confident in her use of the motorised wheelchair when needing to go longer distances. Jane was beginning to understand her limits but was determined to try to achieve more.

She was enjoying the visits from her children more, as she was more comfortable and had more energy. Jane had started making “memory boxes” for her children, with the assistance of her sister. Jane had made some opportunities to reconnect with Rob and to explore together how they might manage when Jane went home and ensure Rob was well supported.

The occupational therapist rang Jane one week after discharge to see how she was going. Jane said she was showering with a personal carer nearby but was hopeful that she would be independent before long. She had been reviewed by the community occupational therapist and they had done the walk to school together, with Jane using the motorised wheelchair. Jane was planning to pick the children up from school with Rob that afternoon and was hopeful she would go by herself in the next day or so. Jane commented that it was more difficult walking in the house than hospital and that she felt more tired since returning home. Jane had resumed her role of assisting the children with their readers in the evening. Jane had not yet attempted any cooking or laundry. A few friends had dropped meals in. She had not found the time and energy to do more work on the memory boxes for her children, but was hopeful she would soon.

Author: Rebekah Boffa, Occupational Therapist, Caritas Christi Hospice, St Vincent’s Melbourne

CareSearch Resources

There are resources within CareSearch that could help allied health professionals in the care and support of Jane and her family. Some of them have been highlighted here:

- In the Clinical Evidence section, there are pages on Fatigue and Social Support
- In the Allied Health Hub, there is a page on Adapting Goals that may be helpful
- In the Patients, Carers and Families section there is a section on Living With Illness that may be of interest to Jane and Rob. It includes pages such as Changes Over Time and When Someone You Care About Is Seriously Ill. There is also a section that Rob may be interested in as he slowly takes on more of a caring role: the How To Care section, which includes pages on Looking After Someone and Paid Careworkers In The Home.
- There are Systematic Reviews on Exercise, Fatigue and Mobility
- PubMed Topic searches can also be found on Fatigue, Social Support. There is also a PubMed topic search on Occupational Therapists