CASE STORY – Social Work

The following case story demonstrates the importance and benefits of Social Work for palliative patients.

Medical Situation:

Peter is a 58 year old gentleman, diagnosed 6 months prior to referral, with metastatic lung cancer. His symptoms included fatigue, anxiety and shortness of breath. Peter has received 3 cycles of chemotherapy, however recent scans showed disease progression, which prompted the referral to palliative care.

Peter was reviewed in the palliative care multidisciplinary clinic for admission to the service and symptom review. Peter attended the clinic with his wife Shelley and their adult son Brent. The consultant, clinical nurse and social worker were present.

Social Situation:

Peter and Shelley have recently moved into a granny flat at the back of Brent’s property. Peter recently resigned from his job in telecommunication repairs, as he was unable to continue working and had exhausted his sick leave.

Peter and Shelley reported some financial distress; Shelley has stopped working to care for Peter, their daughter in-law Kylie is 8 months pregnant and works part time at the local coffee shop and Brent often works away in his job as a long-haul truck driver.

During the initial appointment Peter advised he had not yet considered his wishes for end of life care. Shelley advised that the referral to palliative care had come as a shock to them as they had thought there were more treatment options available. Peter and Shelley had completed their wills and appointed enduring power of attorneys (EPOA), about 3 years ago before an overseas trip.

Assessment/Intervention:

In the clinic appointment, the social worker connects with the patient and family, explains their role, identifies early areas of need, and offers support. For many patients, early intervention is essential to ensure they have time to plan for their end of life care across multiple domains including financial, legal, social and psychological.

The initial clinic appointment can often take up to 1 hour and be a highly emotional and physically draining visit for the patient. The appointment includes symptom assessment, introduction to the service, exploration of the family and patient’s understanding of palliative care and discussing the reason for their referral to palliative care in the context of their situation. Resuscitation wishes are also discussed at this appointment. Follow up appointments with the social worker are instrumental in supporting meaningful discussions regarding advance care planning.
A home visit was booked with Peter to further discuss the role of the social worker, advance care planning and to complete a psychosocial assessment.

At the home visit Peter initially met with the social worker on his own, and was later joined by Shelley and Brent. The social worker checked with Peter to review his feelings about the initial clinic visit and whether he had any questions about the information given to him. Peter requested further support with discussions around end of life and to review his current enduring power of attorney.

Utilising a person-centred care approach the social worker focused on empowering Peter to choose how he would like to discuss planning for future health and financial decision making and for his care at the end of life.

The social worker utilised grief and loss theories in the discussion around advance care planning through first acknowledging the shock of the referral and the changing focus of care from curative to palliative.

Peter’s existing enduring power of attorney had appointed both Brent and Shelley to make health and financial decisions should he be unable to make them himself. Peter felt that Brent and Shelley would benefit from having each other’s support if they were ever placed in that position and both consented to continue in these roles.

Peter had completed an Acute Resuscitation Plan during the clinic appointment but had not yet considered whether he would like his end of life care at home or in hospital. The social worker introduced Peter to the Statement of Choices (1) which is an advance care planning document used in Queensland Health, to record a patient’s wishes for their end of life care. The document includes medical interventions, place of care, family to be involved in decision making and noting what is important to that person as they approach the end of their life.

This document opened discussion with Peter and his family about things that were important to him now and what he would like when he is nearing death. It also documents the place in which Peter would like to die, home or inpatient Palliative Care Unit.

Peter and his family, with the support of the social worker, completed this paperwork together. Copies were made for Peter, Shelley, Brent, his general practitioner, the local hospital and the palliative care team.

This process raised many issues for Peter, Shelley and Brent and with the use of the Statement of Choices, they were more able to have an open conversation about Peter’s end of life care.

Shelley and Brent advised that they both felt they were more aware of Peter’s end of life wishes and would feel less pressure to make the ‘correct decision’. Peter felt relieved that his family were aware of his wishes and that they would not feel in the dark about what he would like. Some months later Peter died at home surrounded by his family.

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References


CareSearch Resources

There are resources within CareSearch that could help social workers in the care of palliative patient and their families. Some of them have been highlighted here:

CareSearch website: Information and PubMed searches on Advanced Care Planning and Systematic Reviews.

The Clinical Evidence pages provide information regarding:

- Fatigue
- Anxiety
- Breathing
- Social support
- Carer support.

The Review Collection contains articles on chemotherapy.

In the Allied Health Hub there are pages on:

- Communication
- Working with patients, carers and families

In the GP Hub information on:

- Following up the bereaved

In the Residential Aged Care Hub there is some excellent information on:

- Recognising resident’s needs for all allied health working in residential aged care.
- In the section for Residents and families are pages on information to assist in caring for palliative family member.