

Three Links Care Centre



Betty's Story



as told by
Gary Steeves (RSW)
Kelly Marshall (Team Leader)
Faria Ali (Asst DOC)
Rita Steeple (DOC)



Highlights



- 2 day education to RN/LPN staff end Sept'07
- 1st PD admission Nov '07
- Betty 2nd PD admission (Jan '08)
- Staff still nervous about their PD skills
- Challenging resident behaviours an added stress

Personal/Social History



- 69yr female
- Born in Ontario
- Lived in Winnipeg, Montreal finally settling in Vancouver
- Limited formal education
- Considered herself “world wise”

Social History



- She worked at the
 - Red Cross Blood Donor Clinic
 - furniture store in Montreal
- She enjoyed collecting, rebuilding old cars from the 30's and 40's and turning them into Hot Rods which was a passion shared by her late husband

Social History



- Lost son and husband in a tragic MVA, did not like to discuss this subject
- Alcohol was her coping mechanism. Her alcohol consumption would increase around holidays and special occasions

Social History



- Didn't trust people easily but once she befriended you she shared more of herself
- Lived in a one bedroom apartment and got around in her scooter.

Social History



- She was very skilled in making friends within her apartment and community that would assist her with various chores (e.g. taking her to money mart to cash her cheques)
- These friends supported her but also enabled her poor lifestyle choices

Social History



- Very “colourful character”



Medical Diagnosis



- Chronic Renal Failure-PD
- Hypertension
- Diabetes-non insulin dependent
- Hepatic Cirrhosis
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Ischemic Heart Disease
- Agoraphobia

Hospitalization (pre-TLCC)



- Admitted to SPH December 2007 for failure to thrive.
- Forgetting to do PD @ home

Preadmission “Jitters”



- Constant negotiations:
- Wanted to bring scooter-facility could not accommodate due to storage issues and space constraints



Preadmission “Jitters”



- Did not have ID or bankbook-How will she pay for the rent?
- Can she bring all her furniture and belongings with her?



1st 24 hours - 'the big denial'



- I don't have:
 - Renal failure
 - Cirrhosis
 - Diabetes
- Everybody's "OLD"
- "Tough Love"
 - permission to leave



“trying for control”



- Feeling betrayed by both time and the world
- Ended a relationship with a long term friend/advocate
- Intoxicated



“Are you sure you know what you’re doing”



- During hospitalization, was started on cyclor. Was discharged home for one day, she reverted back to the twin bag (IPD)
- 1st day of admission, cyclor was alarming as drain volume was lower than expected.

“Are you sure you know what you’re doing”



- Increased Betty’s anxiety. She would constantly question staffs knowledge and skill around managing PD/cycler.
- Frequency of the cycler alarms was also disrupting her sleep pattern

Are you sure you know what you are doing?



- Awake most of the night and sleep during the morning hours
- She had managed to convince RCA staff to wheel her to the smoke room for a smoke and return to pick her up

immediate concerns



- Alcohol Use
 - Needed to set limits
 - Remove the supply
 - Remove the supply source
- Dry Heel Ulcer

immediate concerns



- No Designated Contact or advocate
- Finances
 - No identification
 - No bank account

Continued Negotiations



Week one:

Medication times:

- Wanted meds at very specific times, not necessarily when the nurse was able to provide them

Meals & times:

- Fresh squeezed o.j., please
- Daily fruit plates
- Meal plan of: full breakfast and then just a bowl of cereal later in the evening.

Care staff:

- Would only allow certain care aides to provide care.

Coping



- **Anxiety:**
 - New environment
 - Multiple recent losses – control, health, etc.
- **Agoraphobia**
 - Fearful of leaving comfortable environments
- **Depression**
 - Undiagnosed/untreated
- **ETOH use**
 - Lengthy hx,
Desire to use again



House call



- Betty was supposed to be seen in the SPH PD clinic for assessment, however each time an appointment was made she changed her mind. Eventually the Nephrologist had to see her at TLCC

‘Am I staying?’ (week2)



- Began to form relationships with other residents, eg getting a ‘piggy back’ from another resident in an electric wheelchair to the smoke room
- Friend began to visit regularly
- Began to develop trust in some staff members – i.e. dietitian, social worker, pastoral care

Am I staying? (Week 2)



- Requested a female house physician
- Need for control continued – changing appointments, making own handidart appt.



TLCC Surprise's



- Thought she was being transferred from hospital to TLCC (but had been discharged home prior to admission)

More Surprises



- Betty had used IPD at home prior to admission instead of the cycler. Most of the dialysate had been reabsorbed therefore her last fill volume was lower than expected.

Surprises



- Betty revealed that she did IPD when she “felt like it” likely cause of complications
- Discovered that her blood glucose levels were climbing with regular dialysis and blood glucose monitoring

More Surprises



- The frequent alarms “reload cassette”, “ reload set and lines”, “low drain volume” and “check patient line” were a daily occurrence. Discovered that the cyclor malfunctioned-losing pressure. Alarms resolved once cyclor was replace.
- Discovered that Baxter does not deliver PD solutions within 24hrs

More Surprises



- Discovered that she was not taking her oral medications as prescribed when she was at home, often choosing not to take them at all.
- Was not taking iron medication at home, refused same at TLCC. Iron infusion was ordered which she initially refused. Agreed reluctantly when nephrologists made a house call to TLCC

Ethical Dilemma's



- Three Links Philosophy
 - Assist the resident and family to obtain as much information as possible to make an informed decision.
- Use of the VCH Ethics model and framework to guide decision making process

Ethical Dilemma's



Poor Safety Awareness

- Smoking & falling asleep

Ethical Dilemma's



Heel ulcer

- History of Diabetes
- Becoming progressively worse
- Conservative treatment not working
- Ulcer becoming necrotic
- Fearful of surgery but more scared about loosing a foot



PLAN

- ABI studies → PVD
- Vascular assessment
- ? surgery

Pain Management



- Heel ulcer becoming increasingly more painful
- Reluctance to take analgesics
- Few analgesic options available to PD residents



Admitted to Acute Care

Ethics Plan- Following Discharge



To have an ethical discussion
with Betty

- Focus on Betty's
 - Values, Wishes & Beliefs
- End of Life Care Planning
 - What did Betty want?
- Who did Betty want as her
 - Advocate/Spokesperson?

Lesson's Learned



1. The Brown bag test has even more value: remember to include the PD
2. Co-Morbid Disease may not have been well managed prior to admission
3. End of Life Care Planning has frequently not fully addressed prior to admission

Lesson's Learned (cont)



4. Need to enhance communication between the acute and facility teams

LTC team now sends

- 1 mth CAPD log sheets
- MAR
- Relevant documentation (physician and nursing)

Lessons Learned (cont)



5. Acute Team needs to do “House Calls”

Can't always get the Resident to the Clinic

6. Ambulance Service

Need to be aware of need to transfer PD Residents to an acute care facility with PD services

Lessons Learned



7. Baxter Delivery

- Established quotas for bi-monthly delivery
- Need to establish emergency dialysis supplies

Still Outstanding



Ethical Dilemma

Dementia Residents who pull out or disconnect PD tubes

Sedation is not a long term plan

?????

