# Communication in chronic obstructive pulmonary disease palliative care nursing es...

The following is an evaluation of enhanced communication techniques in palliative care for patients with chronic obstructive pulmonary disease (COPD) with reference to a case study.

COPD is a debilitating terminal condition that is distinguished by a progressive airflow obstruction, primarily caused by smoking. It is usually not fully irreversible (NICE, 2010).

For an airflow obstruction to qualify, post bronchiodilation FEV1/FVC is less than 0. 7 ( FEV: forced expiratory volume in one second, FVC: forced vital capacity). The course of COPD is highlighted as being an illness characterised by a long inexplorable disease, punctuated with protracted periods of disabling breathlessness, reducing exercise tolerance, causing recurrent hospital admissions and premature death (Buckley, 2008). Diagnosis of COPD is not entirely dependent on severity of breathlessness but also history, physical examination and also spirometry confirmation of airway obstruction (Buckley, 2008; NICE, 2010). Because of the difficulty with the prognosis of COPD, it presents a challenge for physicians and healthcare practitioners to provide adequate care to patients (Curtis, 2006; NICE, 2010).

Due to the nature of symptoms associated COPD (such as dyspnoea), patients more often die with COPD or related than from it (NICE, 2010) with mortality rate for men steadily reduced from 1970 while women’s has seen a small but steady rise, although COPD mortality is on the general rise. Buckley (2008) reported that there was a relatively higher proportion, (72%) of COPD who die in hospital care, compared with 12% at home and none in hospices.

Palliative Care

Palliative care has several definitions but has similar concepts according to Campbell (2009). NICE (2010) guidelines define palliative care as active holistic care of patients with advanced progressive illness. Curtis (2006) defines palliative care as the goal being to prevent and relieve suffering and support the best possible loyalty of life for patients and their families and their families, regardless of the state of disease or the need for other therapies.

The general aim of palliative care is to improve the quality of care through alleviation of symptoms and promoting comfort over treatment as some treatment involve mechanical aids which patients might find taxing (Curtis, 2006). This has brought about the suggestion for the need of specialised centres (Curtis, 2006) considering how little attention palliative care quality has received. Curtis (2006) then went on to report that there was a very low number of patients who talked about end of life care with their physicians, which can be made even more difficult with loss of emotional control or fear of having little training (Wittenberg-Lyles et al., 2008). There is also a need for patients to show more confidence in their carers (Curtis, 2006).

The Gold Standards Framework GSF (2006) Prognostic Indicator Guidance (PIG) lists the criteria that would assist in making a prognosis for requirement of palliative care as:

Severity of disease, such as FEV1 being less than 30% predicted

Recurrent hospital admissions

Long term oxygen therapy

Shortness of breath with 4/5 grade on the Medical Research Council (MRC) Dyspnoea scale

Signs and symptoms of right heart failure

Other factor such as non invasive ventilation (NIV)

The GSF (2006) PIG summarises which three steps are key to determine which patient needs palliative care. They are

Identifying patient based on criteria

Assessing needs

Planning administration

The above steps are dependent on patients satisfying chronic condition criteria listed earlier.

Communication

Communication is the process of enhancing thoughts or information between individuals through different media: spoken or written and through body language gestures (Payne et al., 2004).

Buckley (2008) states that good communication is the key to the delivery of effective supportive palliative care services as it has an interpersonal perspective that is about health professionals and patients engaging emotionally (Wittenberg-Lyles et al., 2008).

Delivering bad news is not an easy or comfortable feat. The United States EPEC (Education for Physicians on End of life) is a training program based on SPIKES model (Setting, Perception, Invitation, Knowledge, Empathy, and Strategy/Summary), that has listed steps to follow that in the delivery of bad news, summarised below:

Preparing to meet i. e. location setting

Assess what patient knows about condition

Determine amount of information to give patient

Delivery of news

Respond to any questions from patient and/ or family

Make follow up plan

Case Study: Patient profile

The subject used in the case study was an eighty year old man in a nursing home who presented as generally quiet, with long standing chronic obstructive pulmonary disease (COPD). Consent was obtained from him to participate in the study with the potential benefits explained to him. The subject had history of chain smoking and was diagnosed with heart murmurs in 1986. Long term smoking causes the damage to the lung tissues and repeated chest infections (NICE, 2010) and is a major contributor to COPD. The subject was prescribed bronchodilator salbutamol 2. 5mg/2. 5ml nebuliser liquid unit dose vial, administered by mask one or two ampoules

four times a day. It was used as and when it was required although he did not usually exceed three doses daily.

The subject had shortness of breath with basic living tasks and dependent on staff. The subject had several GP visits for COPD associated chest infections in the last twelve months and had to be supported by pillows in an almost upright position to sleep to reduce the discomfort caused by the dyspnoea. The subject was chosen as he satisfied most of the criteria from the GSF (2006) in terms of shortness of breath, reliance on the bronchiodilator, several GP visits for chest infections and long history of smoking. The do not resuscitate (DNR) forms were filled in passed on to the multidisciplinary team that include the Ambulance service with the family aware.

Communication in Palliative care with COPD

Different communication techniques were employed when it came to dealing with the subject to reassure him and the family skills i. e. maintaining appropriate eye contact, low tone of voice is the key to the delivery of effective supportive palliative care service (Buckley, 2008). A SPIKES model approach was employed with the current case study.

Discussion

It is essential for nurses to establish a therapeutic relationship with patients as they interact more with the patient, employing strategies such as empathy, spending more time listening and being more initiative (Edwards, et al 2006). Communication sometimes can also been limited by workplace policies or insufficient training (Edwards, et al 2006), which raises the need

for proper training to better these relationships (Davidson et al., 2002). The current case study was able to overcome the difficulties of communicating with the patient and family as they had been there already offering support, and hence during the meeting to discuss the end of life they stated that they were satisfied with the progress as part of the continued care.

The subject did not seem to be happy with the nebulisation therapy at first and he expressed fear and anxieties because it was a new therapy, which was not unusual (Stevens et al., 2009). Curtis (2006) study argues that health care for patients with COPD was often initiated proactively based on a previously developed plan for managing their disease. The subject was given a choice if he wanted a member of his family to be present and if the time was appropriate to which he had no objection, being emotionally functional and able to make his decisions (Lemmens et al. 2008). It was also noted that the subject became more relaxed when the nebulisation therapy was explained to him that it would reduce the dyspnoea, rattly chest, symptoms that he acknowledged made his breathing difficult and other symptoms such as wheezing and sleep disturbance.

It is important to have a suitable location where there would be few disturbances when breaking bad news (Stevens et al, 2009; Wittenberg-Lyle, 2006). In the case study, the subject’s family was contacted in order to arrange a meeting to discuss his diagnosis, the way forward regarding his treatment and control of his symptoms and also make them aware of any changes that would need to be made in terms of his care. This afforded the subject and family to be to be reassured that the patient would be made as

comfortable as possible to alleviate the symptoms of his condition through to end of life and bereavement.

## Conclusion

Palliative care for COPD has not received much attention until recently. Communication is a very important aspect for high standards of care particularly in end of life care. Nurse to patient relationships are even more important as they play a major role; liaising with the family and multidisciplinary team to make the end of life as comfortable as possible. There is still much to be done in terms of communication training for nurses and also getting more physicians involved. The role of a multidisciplinary team is highly valued as it helps streamline the planning and administration of palliative care. The current case study found that the patient was happy with the way that the way that his care was planned.