Student Guidelines for Care Plan Development

Your pain management plan should adopt a patient-centred, comprehensive, team-oriented/ collaborative approach. The care plan should be accurate, evidence-based, comprehensive, realistic, and practical. It should document information about pain assessment and management, including appropriate medication(s) and other strategies that address physical, spiritual, psychological, social, socioeconomic, and/or cultural issues as appropriate.

The care plan should capture/illustrate the following:

- Clear goals that are relevant to patient and family needs
- A comprehensive approach to address patient and family needs (e.g., consideration of psychosocial needs)
- Evidence of interprofessional collaboration
- Multidisciplinary assessment (i.e., input from all professions)
- A coordinated management plan, including a variety of strategies
- Clear monitoring parameters and follow-up strategies

The format of the care plan is flexible and should indicate how the team will **collaborate** on the identified **patient-centred goals**. Subheadings/sections can be helpful in organizing the plan.

Care Plan Guidelines for Students

Please present your care plan ensuring that the following components are included. There should be evidence that the care plan is:

- Patient- and family-centred: Goals should be clear and based on interprofessional assessment
- Interprofessional: Have clinicians representing different professional backgrounds been represented? Is there evidence of a shared plan of care or are all the professions working independently?
- Psychosocial determinants: Are there considerations of how inclusion, equity and diversity factors affect your care plan?

Feel free to be creative in your presentation! You may wish to prepare a dialogue that demonstrates your team's thought process. Other important elements to include are:

Case Presentation

- Medical History
- Current & Past Medications/Treatments
- Pain History and Assessment
- Pain Features
- Symptoms

- Whole Person Considerations: Activity and Participation
    - Work/school, home, family routine, leisure, mobility, ADLs, sleep
    - Self: (role interference, mood, self-image, perceived coping, age/development, culture/ethnic/religious background)
    - Relationships: roles, support, sexual relationships
- Relevant Past Pain Experience (childhood, family members, past success)
- Relevant Physical Exam Findings

Management Plan

- Physical
- Pharmacological
- Psychological/emotional
- Other factors affecting care plan:
    - Social/socioeconomic
    - Cultural
    - Spiritual
- Educational component for patient and family about pain management
- Plans to prevent further pain and disability

Follow-up and Monitoring

THE CASE OF GERALD ROBERTSON (TEAM A)

WHO:

Gerald Robertson (he/him) is a 54-year-old male, first diagnosed with squamous cell lung cancer 2 years ago. He is currently being prepared for discharge from a rehabilitation hospital.

BACKGROUND HISTORY:

- Right upper lobectomy two years ago; no report on lymph node sampling available, no chemotherapy given.
- Recently Gerald went to the dentist for a routine check-up. The dentist noticed limited opening of the jaw, palpable, firm, and sensitive submandibular nodes. A click of the left temporomandibular joint was present on opening (without pain). On intraoral examination, the dentist noted a firm, nontender swelling with ill-defined borders measuring 1.5cm × 1.0 cm
- The dentist ordered an immediate panoramic radiograph, which showed a radiolucent lesion with undefined borders within the left mandible, in the region of teeth 35 – 38

- Knowing that nearly 90% of metastatic tumors occur in jaw bones, the dentist suspected a metastasis of the squamous cell carcinoma and made an urgent referral to Gerald's family practitioner.
- Further investigation, subsequent to the dental visit, showed additional metastases in the lumbar spine, left humerus and the left femur.
- On his way to a cancer clinic for further assessment, Gerald tripped getting off the bus, but did not fall. However, he had sudden excruciating pain over his left hip. Gerald was taken by ambulance to hospital where he was found to have a pathological subcapital fracture of the left hip. His hip was repaired by an orthopaedic surgeon, using a pin and plate.
- Following his hip repair Gerald was scheduled for a follow-up with an oncologist for further assessment and treatment of his metastases. Chemotherapy and therapy with bone-targeting medications were discussed.
- Gerald was then sent to a cancer care hospital for treatment and post-operative musculoskeletal rehabilitation care.
- While in hospital, he began to develop more pain.

CURRENT PAIN MANAGEMENT CHALLENGE:

Gerald has had a complicated course in hospital over the last three months and continues to struggle with pain despite his medication regime listed in the Medications section.

- Gerald has a dull pain over the left side of his face (rated 7/10) that worsens with eating and any pressure on that side of his face (rated 9/10); this pain interferes with his eating and sleep.
- Gerald also has persistent pain over the left humerus and hip. He describes this pain as a constant dull ache (rated 7/10); due to this pain he cannot reach up or carry things.
- Since his lobectomy 2 years ago, any clothing coming into contact with his thoracotomy scar remains painful. This pain is severe (rated 9/10) and often has a burning, stabbing quality.
- Gerald realizes that there will be a lot of health care appointments and is concerned about the cost of transportation and parking at these appointments

PSYCHOSOCIAL/FAMILY HISTORY:

- Gerald has been with his partner, Joseph (he/him), for 30 years. They have one son, Martin (he/him), who is 18 years-old and lives with them. Martin assists Gerald in their family diner after school and in the summertime.
- Martin has chronic migraine headaches that leave him unable to work at times.
- Joseph no longer works as a health inspector as he is on long term disability secondary to chronic health issues. He is very supportive of Gerald. They have no major family problems however are financially strained. They are unsure about what their medical and dental coverage is now that Joseph is on LTD.

- Gerald had to cut back on work after he was diagnosed with cancer two years ago. Martin has just started managing the family business on his own, but is leaving for university in one month.
- Gerald is very concerned about the business now that Martin is heading off for school. They have reliable staff, but no one has managerial experience.
- Gerald also has a mother who lives nearby, but no siblings. His father died of lung cancer two years ago.
- Given that he is in relatively good shape apart from the cancer, it is expected that Gerald will live at least 9 months to a year. He is aware of the seriousness of his diagnosis. The medical oncologist who consulted in the hospital discussed the possibility of chemotherapy, but said that she was reluctant to offer it, as it may not significantly prolong survival. Joseph wants Gerald to get another opinion.
- It is important to note that Gerald's father died of lung cancer about 5 years ago and at that time his family was told that doctors were reluctant to offer treatment as it would not significantly prolong his father's life. Gerald has always secretly thought that his father's death was premature. As a result of his family history, Gerald is somewhat reluctant about the oncologists recommendation for his own care, but he does not want to go against his treatment team, because he believes it may affect his care.
- The couple has difficulty speaking about Gerald's illness and prognosis. Martin finds it hard to talk about the situation as well, but he is very concerned about his dad's pain. He recalls that his grandfather suffered quite a lot of pain before he died.
- Given that Gerald expressed some anxiety and very low mood since finding out about his metastasis, psychiatry assessed him and his PHQ-9 score was 9.

PHYSICAL ASSESSMENT:

- Mildly cachectic, appears fatigued.
- Hard, 4 cm. mass just below the left TMJ (temporomandibular joint).
- Skin on either side of the thoracotomy scar is very sensitive, even to very light touch.
- No jaundice.
- Hard stool in rectum and stool palpable over the left side of the abdomen; abdomen otherwise normal; bowel sounds are quiet.
- Restricted range of motion of left shoulder (frozen shoulder type of restriction, i.e., can abduct 75°, flex 90°; has very limited external and internal rotation, so that he cannot reach behind his back.
- Left hip ROM (range of motion) – flexion = 90°, Abduction = 25°, IR (internal rotation) = 10°, Knee ROM = flexion = 130°, Extension = 0°.
- Full permanent dentition, Overjet 1mm, Overbite 3 mm, opening pattern is straight, pain free opening is 35 mm. Maximum unassisted opening is 42 mm. Maximum assisted opening is 46 mm. Left TMJ clicking on opening (not painful). Protrusion is 6 mm, lateral movements are 8 mm(left) and 9 mm (right). Palpation of the masseter and temporalis muscles (1 Kg), and the TMJ (0.5 Kg) are negative.

CURRENT STATUS / ACTIVITIES OF DAILY LIVING:

- Gerald's current status described below is based on his current treatments including medications as listed in the section below.
- Currently in hospital, Gerald can walk up to 10-15 metres, using a high-wheeled walker, without major fatigue during the first hour after pain medication.
- Gait, using a step-to pattern, partial weight bearing on the (L) side.
- Gerald has moderate to severe pain in his non-dominant left arm while getting dressed and bathing requires assistance. He bathes using a tub rail and tub chair.
- Gerald states that he is not sleeping well, feels weak and irritable, tires easily, and has to take frequent naps.
- He reports having a poor appetite and that eating is a problem because of his jaw and facial pain.
- He reports constipation.
- Gerald lives in a 2-bedroom apartment, in a 2-storey walk up in Toronto. The front entrance has 3 steps and a handrail on the left. He has no assistive equipment (except in the bathroom) at home. He has not been home since being admitted to hospital.
- He believes that it is God's will that he must suffer pain.

MEDICATIONS:

While in hospital, Gerald was initially prescribed a 2-week course of diflunisal for his jaw pain. Due to GI upset, this prescription was changed to acetaminophen (300 mg) with codeine (30 mg) and caffeine (15 mg) tablets. Although this combination tablet was not helpful in the past, Gerald was encouraged to try it again, and again it was unsuccessful.

Currently:

- Gerald is being prescribed acetaminophen (325 mg) with oxycodone (5mg). He takes one tablet about 3 or 4 times a day. He was told that it is a "very strong drug" and that he "should not ask for too many". He was also instructed to watch how much he takes at home once he is discharged.
- One acetaminophen (325 mg) with oxycodone (5mg) tablet produces minimal relief of his hip and facial pain or improvement in his function; this pain relief lasts for an hour; the medication also makes him quite tired. Gerald believes he should "tough it out" and take the medication only when the pain becomes too severe.
- Gerald is also on gabapentin, 600mg orally tid for his post-thoracotomy pain, with minimal effect on function and pain.
- Other current medications include:
    - Senna tablets, 2 qhs PRN (as needed at bedtime for constipation)
    - Lorazepam 1 mg, 1 tablet qhs PRN (uses it 4 nights a week).
    - Chondroitin tablets (over the counter, dose unclear)
    - Calcium 500 mg TID
    - Vitamin D 1000 IU, daily

Gerald has been told that he will need to contact his family practitioner for more pain medication upon discharge, as he will only be provided a 2-week supply.
Prior to discharge, Gerald's lab work was completed and his eGFR, CBC and extended lytes were all within normal range.

PLAN:

You are a member of the team planning his discharge and you are going to meet with your team to organize Gerald's discharge and pain care plan. When asked about discharge, Gerald said, *"I am really looking forward to going home, but I think I should be better than I am now before I go. I still have quite a bit of pain and I need help. I am not sure how we're going to be able to manage. I thought my pain would be better than this."*

References for Case A: Gerald Robertson (Squamous Lung Cell Cancer)

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