Service of Geriatric Medicine and Geriatric Rehabilitation & Chaplaincy Service,

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SPIRITUAL ASSESSMENT AND CARE PLAN

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CONFLICT OF INTERESTS DECLARATION

The authors do not report any conflict of interest

THIS PRESENTATION IS PART OF A SET

- Our research team (S. Monod, E. Rochat, E. Rubli Truchard, AV Dürst) will present 3 complementary oral communications:

  - Spiritual Assessment and Care Plan, E. Rubli Truchard (Session 3)
  - Spiritual Distress and Psychological Distress in Elderly Patients: Joint Intervention ? AV Dürst (Session 3)
  - What does the SDAT bring to the Health Team ? E. Rochat (Session 5)

Don’t hesitate to ask us about the content of these presentations

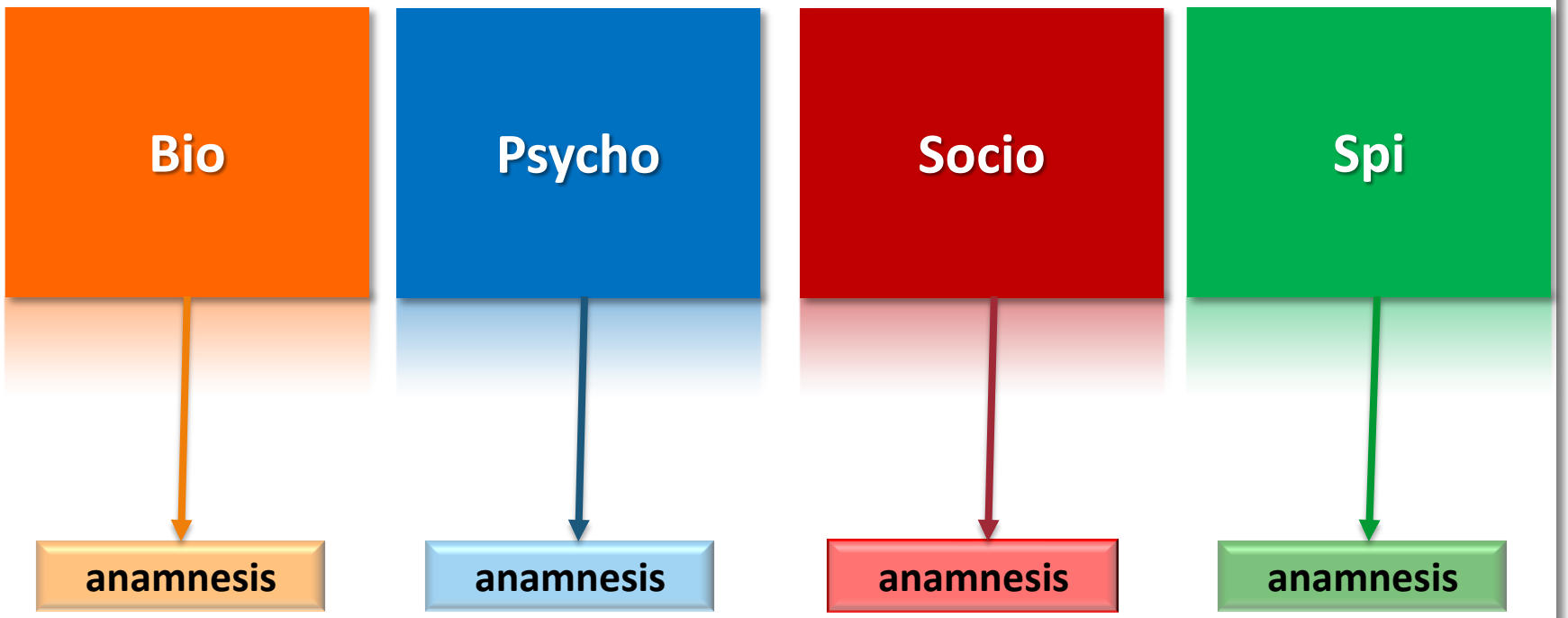
OVERVIEW

- A geriatric patient's clinical history rendering difficult for the health team to make a decision despite taking charge multidimensionally…
- Spiritual Distress Assessment with the SDAT by the chaplain
- Recovery of history by integrating the SDAT
- Necessary elements to propose an ethical debate & to structure the discussion
- Decision and conclusions
- Questions

Clinical case

Ms P., 93 year-old, admitted to hospital for dysphagia, cough, and recidivant pneumoniae

Technical model



Clinical case (1)

Bio

Ms P., 93 year-old

- Decline in general health, cough for several weeks, antibiotic treatment without improvement
- Cachexia, dysphagia
- ENT specialist: **swallowing incoordination and reduced swallowing** reflex salivary stasis in valécules, no swallowing reflex DD : presbyoesophagus or tumor ?

Medical antecedents:

No hospitalisation since 2005

Chronic renal failure stage 4, abnormal gait and balance without falling, normocytic normochromic anemia, hearingloss without prosthesis

Mastectomy on breast cancer

No current medication.

Clinical case (2)

Bio

Evolution:

- Can not take any food or drink, nor swallow any medication
- Laboratory : metabolic disorders
- Significant functional weakness, ADL 0/6
- Patient expresses wish to die, suicidal ideation

Clinical case (3)

Bio

- **Dysphagia with high risk of bronchial aspiration, little chance of improvement**
- Cachexia with significant weight loss for 4 months, significant metabolic disorders
- Cognitive impairment screening (miniCog): positive
- Screening mood disorders (GDS-4): positive
- Suicidal ideation

Specialist's proposal : placement of a nasogastric tube
or accompagnying the patient until death

Problem: no capacity of discernment concerning this clinical decision

Clinical case (4)

Psycho

- No history of depression
- At the start of the stay, the patient reported sadness, anxiety, suicidal thoughts, no real urgent consideration after the psychiatric clinic exam
- Quickly reassured by doctor and health team
- Ambivalent: fluctuates rapidly from a state of distress to the desire to return home if she recovers

Clinical case (5)

Socio

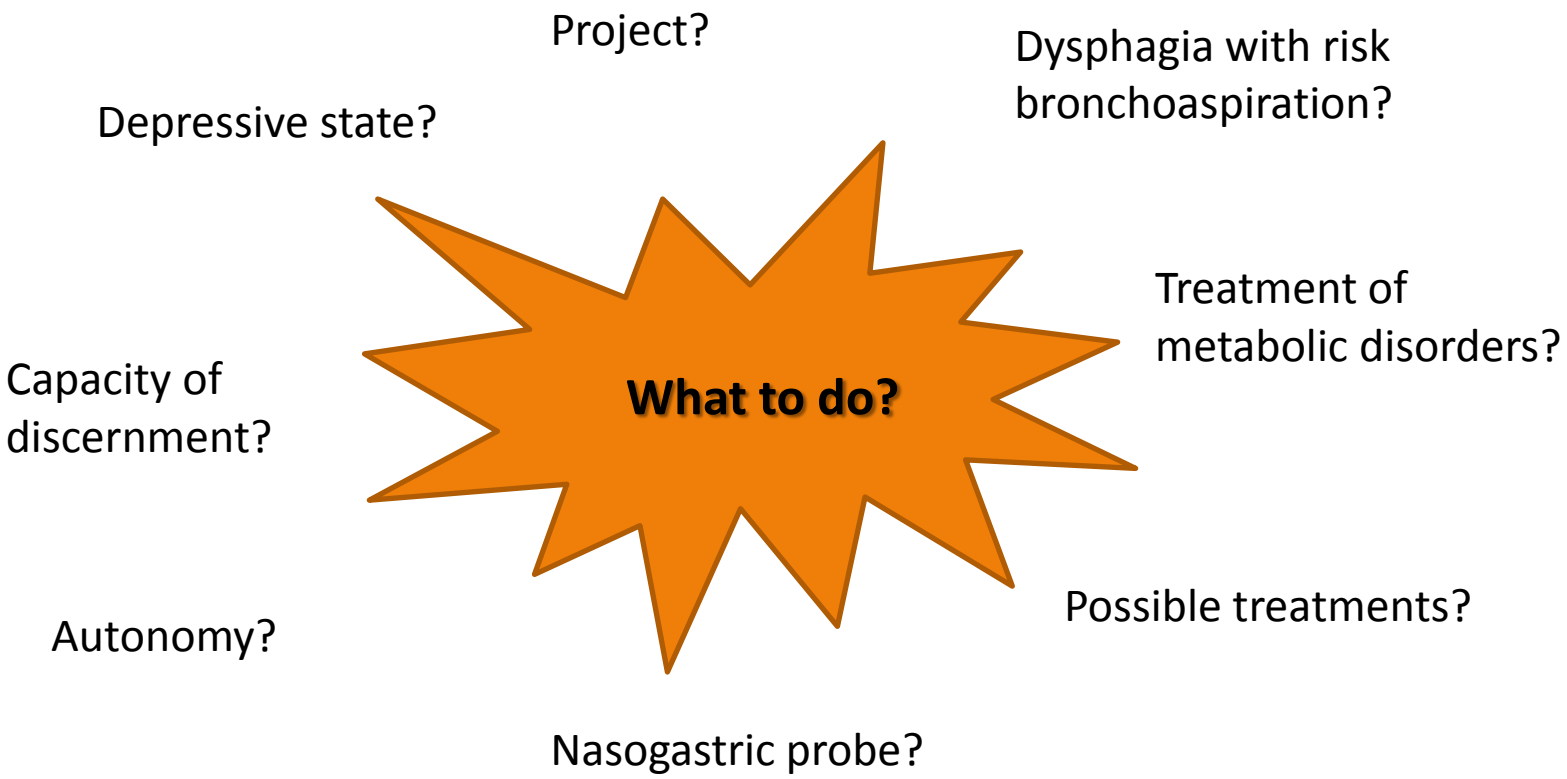
- Lives alone, widow for 20 years, no children, 1 niece
- Activities of daily living at home (according to Katz) 6/6
- Instrumental activities of daily living (according to Law) 1/8: she prepares meals
- Home care for administrative tasks and household ; niece does laundry, helps with transportation and shopping, sometimes brings meals .
- Does not use the phone because deafness + +
- Small entourage, rarely sees her doctor, difficulties to accept external aid

Clinical case (6)

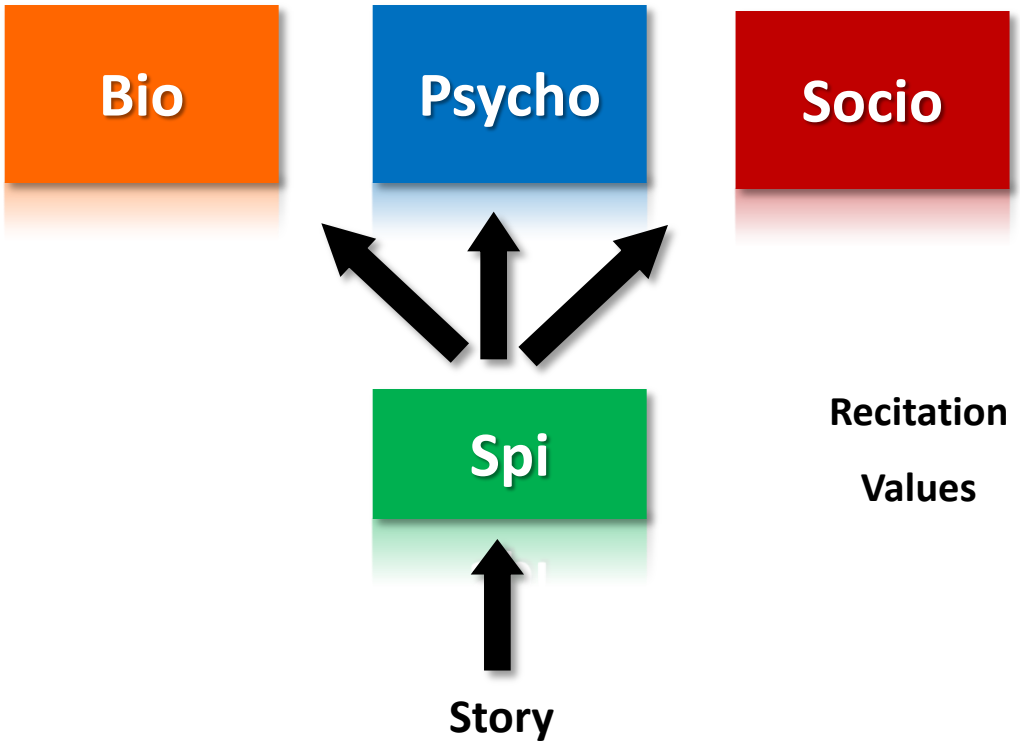
Spi

- Does not speak of religious beliefs
- Does not ask for a specific intervention of the chaplain

Mrs P., 93 year-old



Narrative approach?



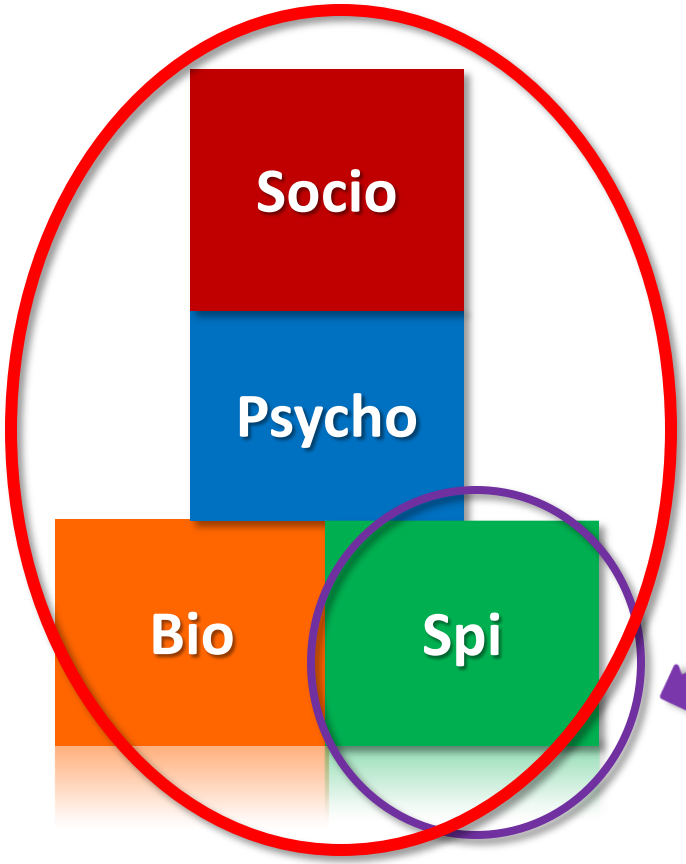
A dead end ?

Technical model

Relational model

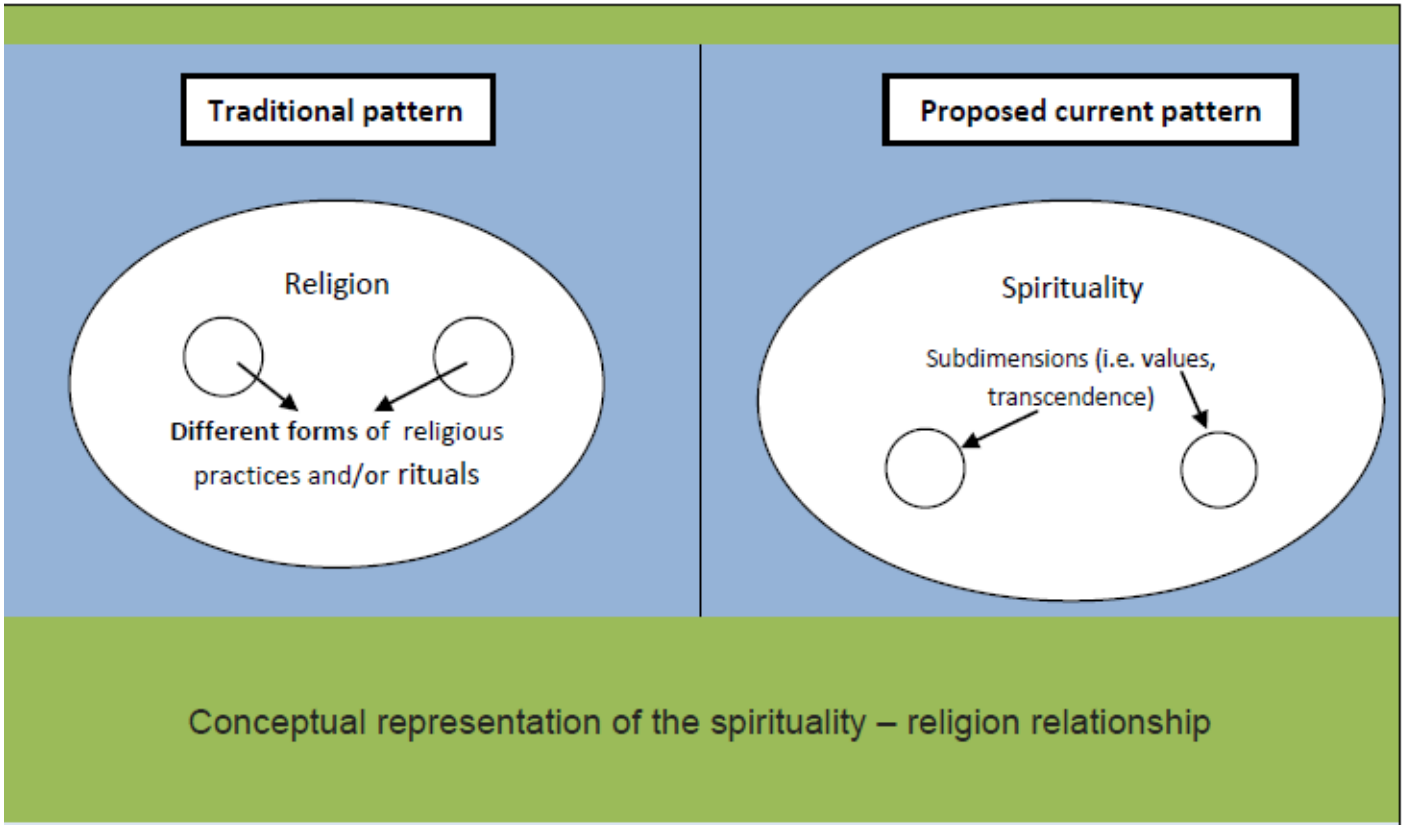
Integrated biopsychosocial and spiritual experimental approach

Integrates the spiritual dimension with other dimensions



Significant spiritual history

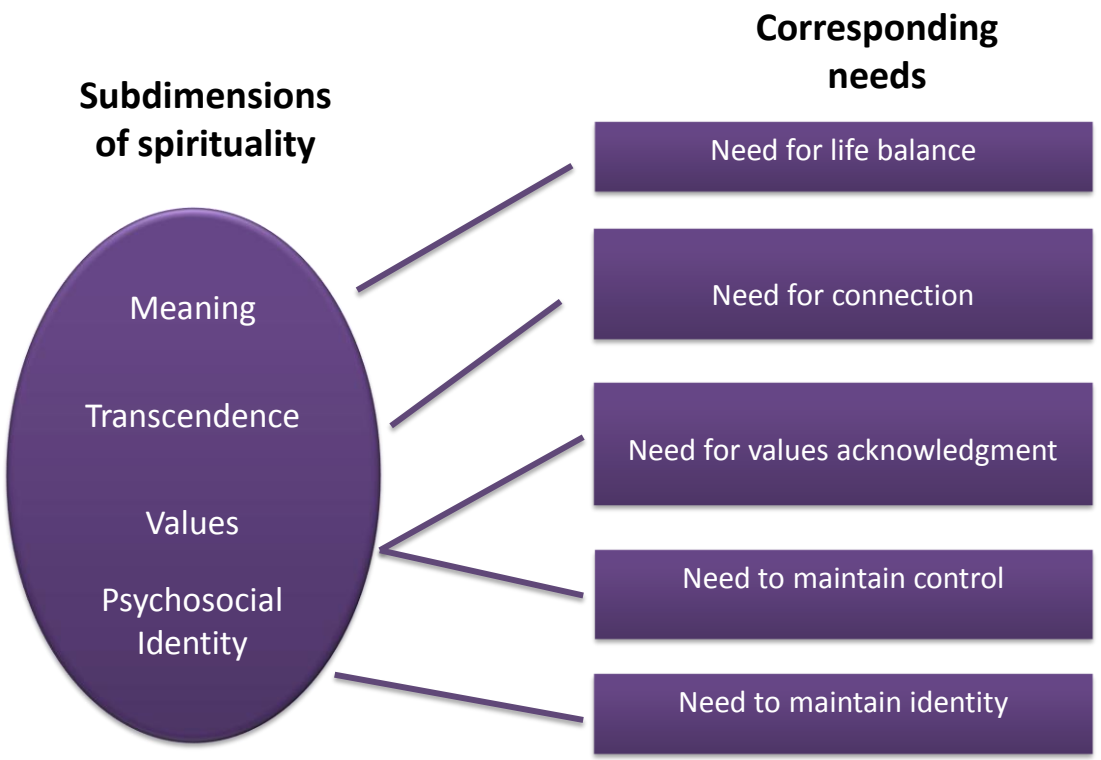
Monod S, Soins aux personnes âgées. Intégrer la spiritualité ? coll. Soins & Spiritualités, Lumen vitae Ed., Bruxelles, 2012.



Conceptual representation of the spirituality – religion relationship

In the traditional pattern, spirituality is confounded with religiosity. In the proposed current pattern, spirituality is conceptualized as having subdimensions . The person's spiritual dimension does or does not include traditional religious resources.

The Spiritual Needs Model



Monod S BMC Geriatrics 2011; Monod S BMS Geriatrics 2012

Step 1

Evaluation of the spiritual dimension

- chaplain
- Model of spiritual needs **STIV**

Step 2

Integration of the spiritual dimension with other dimensions

- Interdisciplinary team (including chaplain)
- **Interdisciplinary seminar**
- **Ethical discussion**

Step 3

Construction of a coordinated care plan

- Every member of the interdisciplinary team (including chaplain)
- Taking charge of coordinated medical care

Mrs. P‘s spiritual evaluation results

Evaluation n°1

Subdimensions of:

- **Meaning** : need for life balance severely unmet
- **Transcendance** : need for connection moderately unmet
- **Values** :
  - V1 : *need for values acknowledgment severely unmet*
  - V2 : *need to maintain control severely unmet*
- **Psychosocial Identity** : need severely unmet
- Conclusion**:** Severe spiritual distress with centration of the patient on the Values subdimension.

Evaluation n°2

Disturbances also fluctuate between M and V , but spiritual distress remains severe.

Mrs. P‘s spiritual evaluation results

- Data generated by the SDAT (Spiritual Distress Assessment Tool) :
  - Ms. P does not see how to reconstruct an overall life balance, and above all she does not want to do it.
  - Ms. P‘s spiritual dimension is not centered on the Meaning subdimension, but on Values -> centration on "telling a story" and "discussing"
- After analysing these data, the chaplain recommends:
  - To compare these results with the other data in an ethical deliberation involving all members of the care team.

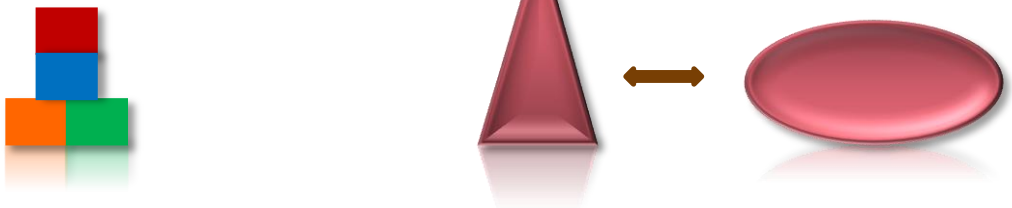
Elements necessary for the ethical debate

- Autonomy
- Ambivalence
- Tube for refeeding

- Bad pronostic
- SDAT results
- No naso-gastric tube
- Comfort care

emergency!

From the SDAT to ethical debate



- Objectives of the debate: attempt to reconstruct the presumed will of Mrs. P with the data generated by the spiritual evaluation.
- It implicates all the interdisciplinar clinical care team

Results of the ethical debate

- Mrs P. doesn’t want to go on with living in this health state
- It is not possible for her to reconstruct a global life balance and she certainly doesn’t want to
- Her relatives (niece and GP) are of the same opinion, they don’t have other constructive elements

- **Decision:** not to put a nasogastric tube, comfort care
- **Practical application**: patient, niece, multidisciplinar team
- **Coherence**
- **Responsibility** of the different members of the team

- **Evolution:** Mrs P. dies a few days afterwards

Conclusion

- Improvement in the overall care
- Care plan discussed more adequately
- Better self esteem of the caregivers

Thank you for your attention!