

CHCA Project ECHO Integrated Seniors Care

All Teach, All Learn

Bridging the Knowledge Gap in Home and Primary Health Care



Optimizing Comfort and Quality of Life: Integrated Palliative Approaches to Symptom Management in Complex Chronic Conditions

Meet Carole Carter

Age: 79 years

Location: Charlottetown, Prince Edward Island (HealthPEI)

Carole is a retired postal worker whose health and independence have declined over several months. She lives with her husband and primary caregiver, David, in their home of 42 years. Their son, Michael, lives nearby, visits most days, and helps with care, groceries, and appointments. Their daughter, Sarah, lives out of province, calls several times a week, and joins care discussions by phone. No other relatives provide regular care. Worsening breathlessness, fatigue, and pain limit Carole's daily activities and contribute to increasing isolation. Her priorities are to remain comfortable at home, spend meaningful time with her family, and attend her granddaughter's wedding in six weeks. The effect of her symptoms on her physical, emotional, social, and spiritual well-being points to the need for a coordinated palliative approach alongside ongoing treatment.

Medical History and Functional Status

- Carole lives with advanced chronic obstructive pulmonary disease, heart failure, chronic kidney disease, and osteoarthritis. Over the past three months, she has had two emergency department visits for breathlessness and fluid overload; the most recent resulted in medication changes and follow-up with several providers.
- She uses home oxygen continuously at 2 L/min by nasal cannula, along with prescribed maintenance and rescue inhalers. Her oxygen saturation is usually 91-93% at rest on oxygen and falls to 86-88% with exertion.
- She can walk short distances (10-15m) with a walker before stopping because of breathlessness and fatigue. Her breathing and oxygen saturation return to baseline after three to five minutes of seated rest. She needs help with bathing, dressing, meal preparation, housekeeping, and medication organization but has not had a recent physiotherapy or occupational therapy reassessment.
- She receives nursing visits twice weekly and personal care three mornings each week. Her family physician, respirologist, home care team, and community pharmacist are involved in her care.

Current Concerns

- Carole rates her breathlessness as 4/10 at rest and 8/10 with activity. Activity triggers severe episodes three or four times most days. She responds by stopping, sitting upright, using her rescue inhaler, pacing activities, and practising pursed-lip breathing, but these measures provide only partial relief. The family has no clear plan for managing worsening symptoms or knowing when to contact the care team.
- She rates her fatigue as 8/10 and her back and knee pain as 3/10 at rest and 6/10 with movement. Prescribed acetaminophen as needed and occasional heat provide limited relief, and her pain has not been comprehensively reassessed. She sleeps four to five hours, interrupted by breathlessness, discomfort, and worry.
- She is eating about half of her usual intake and has unintentionally lost approximately 4 kg over two months. Despite a prescribed bowel regimen, she has a bowel movement only every three to four days, often with straining.
- During breathlessness episodes, her anxiety reaches 7/10. She fears being alone and worries another hospital visit will keep her from home or the wedding.
- Carole says some days are 'not worth the effort,' but no one has explored what she means. She feels guilty about relying on David and Michael and worries she is becoming a burden.
- She misses her faith community and questions why this is happening, but has not shared these concerns with the care team.
- Providers document and discuss symptoms and medication effects separately. The team has not brought Carole's physical, emotional, social, spiritual, and practical concerns into one shared assessment and plan.

Caregiver and Care Team Perspectives

- David is committed to caring for Carole at home but is exhausted, sleeps lightly while monitoring her breathing, and is unsure whom to call when symptoms worsen.
- Michael worries that David is overwhelmed and wants clear guidance and one plan for the family to follow.
- Sarah views hospital as the safest response to worsening breathlessness, while Carole wants to avoid hospital when symptoms can be managed safely at home. This is creating family tension.

Challenge

How can the interdisciplinary team address Carole's total pain, align symptom management with her goals for comfort and quality of life, and give her family clear guidance as her condition changes?



Project ECHO Integrated Seniors Care (ISC) is a transformative initiative to enhance primary and home care providers' skills, knowledge, and attitudes to deliver integrated, patient-centered care for seniors with complex chronic conditions. Project ECHO ISC offers collaborative, expert-led presentations and case-based learning to bridge these gaps.

The Canadian Home Care Association (CHCA) is a national non-profit association focused on strengthening integrated home-based care. Representing public and private organizations across the country the CHCA partners with members to address pan-Canadian priorities through advocacy, awareness, innovation, and knowledge exchange. CHCA Website / X / LinkedIn