

Striving for Continuous Improvement in End of Life Advanced Care Planning

Affinity Health Services, Inc.
942 Philadelphia Street
Indiana, PA 15701
Candace McMullen, RN, NHA, MHA, CLNC

Where We Have Been

- The nursing home is the last stop for all our residents
- All nursing home residents were considered “end of life”
- Lack of maintenance or curative approaches
- Discharges from the nursing home **ONLY** happened with death

We Are We Currently...

- Since OBRA, our focus has been on maintenance and curative approaches
- Increased regulatory pressure to rehab and maintain function for all residents
- We put residents through a multitude of exhaustive procedures and interventions to “prove” that any decline was “unavoidable”
- The pendulum certainly moved

Where We Aim to Be...

- Communications regarding end of life care occur BEFORE death is imminent
- Preparation for end of life occurs on admission
- Resident care goals and wishes are integrated into the care planning process
- We recognize death and dying in time to give the resident and family a meaningful experience

Advanced Care Planning

- An on-going, dynamic process
- Discusses values and goals of care among the resident, family, physician, and care planning team
- A way to ensure end of life care wishes are honored

***Ideally.....Advanced Directives are part of the
Advanced Care Planning Process***

- Nursing Homes are *de facto* Hospices
- 30% of our residents rehab and go home AND
- 30% of our residents die each year
- High quality end of life care and quality of life cannot be adequately achieved when the diagnosis of dying occurs only hours or days before death

WE HAVE A LOT OF ROOM FOR IMPROVEMENT!!

Opportunities for Improvement

- Identifying clinical indicators of mortality
- Staff Development and Training Programming
- Content and scope of physician communication
- Content and scope of resident and family member/decision-maker communication
- Support of the decision-maker throughout the process
- How we demonstrate “We Care” to residents and family members at the end of life and after

Identification of Clinical Indicators

First Layer of Consideration:

- Evidence of disease process
- Resident’s presentation (typical vs. atypical?)
- Momentum of decline/rate of decline
- Comorbidities and their resulting impact
- Medications
- Lab values
- Vital signs

Identification of Clinical Indicators

Second Layer of Consideration:

- Deterioration of cognitive status
- Increasing dependence with ADL's
- Increasing incontinence
- Dysphagia
- Weight loss with poor appetite and/or dehydration
- Abnormal Lab Values
- Respiratory infection/pneumonia/SOB
- CHF, Renal Failure, Cancer
- Bedfast

- Many times, people die not directly from their primary diagnosis but from multi-system organ failure that results from the body's natural responses to the symptom progression coupled with the comorbid presentation and symptoms
- We often fail to identify these symptoms until really late in the process
- Gets REALLY TRICKY with our short term "rehab" residents who quickly decline and never "rehab"

Result

- Surprised family members
 - Inadequate time to prepare
 - Guilt in placement to nursing home
 - Anger at staff for not identifying, communicating, and treating
 - Thoughts of negligent or inappropriate care
 - Bad Will against the nursing home
- Contact
 - DOH
 - Plaintiff attorney
 - AAA/Ombudsman
 - ETC., ETC., ETC.

Quality Improvement Goals

- Reduced or no complaints from family members that they felt unaware of, and unprepared for, the impending death of their loved one.
- Reduced or no complaints from family members that they felt a lack of clear communication about the impending death of their loved one.
- Positive feedback from family members that they had good communication with nursing home staff and the physician and felt the resident had a good death for which family members were prepared.

Important Role of Staff Development

- Not all nurses are EQUAL in regards to education, training, and experience
- It is our job to make sure that we provide our clinical team with the tools they need to meet our expectations
- Our success is dependent on our front line
- Education and Training Needs Identified:
 - Clinical indicators of dying
 - Communication skills with residents and family members
 - Communication through chain of command for clinical indicators

Getting Started

- Recurrent hospitalizations data can identify clinical conditions/syndromes that precipitate frequent hospitalizations
- Complaint/ concern/ grievance logs
- Morning meeting / nursing report symptomatology
- Caretracker data for changes in cognition, ADL's, incontinence, etc.
- Other Electronic Medical Record Data

Staff Training on Common Disease Processes

- Congestive Heart Failure
- Chronic Obstructive Pulmonary Disease
- Dementia Conundrum
- Progressive Deterioration and Debility

Changes To Report

- Edema
- SOB or noisy respirations or cough
- Decrease in appetite
- Decrease in ADL performance
- Change in cognition
- Less or no urine production

Content and Scope of Communication Resident and Family

- Frame discussion based on resident-centered goals for care AND quality of life
- Be straightforward and use layman's terms
 - Metastatic = Incurable
 - Respond to treatment = Cured
- Goal: Informed Decision-Making
- Maintain and Maximize Health and Independence at Every Stage in the Disease Process

Content and Scope of Communication Resident and Family

- Focus on:
 - What the RESIDENT has expressed as his/her goals
 - What is in the best interest of the RESIDENT in regards to comfort and quality of life
- Recognize that goals change as residents move through the continuum of care
 - Healthy and Independent
 - Chronic Disease/Functional Decline
 - Multiple Comorbidities/Increasing Frailty
 - Death and Dying

6-Step Protocol: SPIKES

S	Setting
P	Perception
I	Invitation
K	Knowledge
E	Emotion
S	Subsequent steps and follow up

Excerpted from: Communicating Diagnosis and Prognosis to Patients With Cancer: Guidance for Healthcare Professionals
www.medscape.com; posted 1/7/2011

Physician Communication

- Physicians, by training, have curative approaches to care
- Physician may be unsure of how involved the residents condition really is
- Physician may not be aware of advanced directives or POLST form completed
- Clear, concise, and accurate communications with MD is CRITICAL to appropriate advanced care planning

Advanced Care Planning Process

- Key is to **RECOGNIZE** as the resident progresses through the various stages
- **REVISIT** the Advanced Directive, POLST Form, and treatment goals
- Show **COMPASSION** by recognizing the difficult role of the decision-maker
- Provide **SUPPORT** by opening the lines of communication and approaching difficult discussions
- **EDUCATE** on the normal / typical progression of the disease process and what the resident and/or family members can expect moving forward with all available treatment options

Advance Planning Tools

Guides to Resident Directed Care	Physician Orders
Health Care Power of Attorney	POLST Form
Health Care Agent	DNR Orders
Living Will / Advanced Directives	Do Not Hospitalize Orders/No Feeding Tube Orders
Requires MD or NH Staff Intervention to have any immediate impact on care	Immediate Impact on Care

Limitations In Advanced Directive

- May not be available when needed
- May not be specific enough or prompt the needed discussion
- May be overridden by the treating physician
- Do not automatically translate into MD orders
- Require the facility staff and MD to understand what they mean and what their purpose is
- Require the facility staff and MD to interpret and take action
- Dictates care for “what if” situations

Medical Orders

- Turns resident treatment preferences and advanced directives into medical orders
- Are actionable immediately upon being written by MD
- Still requires conversations with resident and/or decision-maker
- Ensures everyone is on the “same page” with the residents advanced care planning decisions
- Dictates care for the resident at the time they are written

When To Initiate Advanced Care Planning

- On Admission
- With Each Care Plan Meeting
- With Changes in Condition
- When the Opportunity Presents

Value of Advanced Care Planning

- Improved Resident Quality of Life and Care
- Improved Family/Decision-Maker Satisfaction
- Prevents Unnecessary Hospitalizations
- Prevents Futile Care Interventions
- Prevent Litigation
- Prevent Complaints

Demonstrating WE CARE

- Resident has a voice in end of life care
- Family has ongoing understanding of residents clinical situation and prognosis
- Empathy for the death and dying process from all staff
- Care of Resident
- Care of Family

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