ABCD's of Advance Directive

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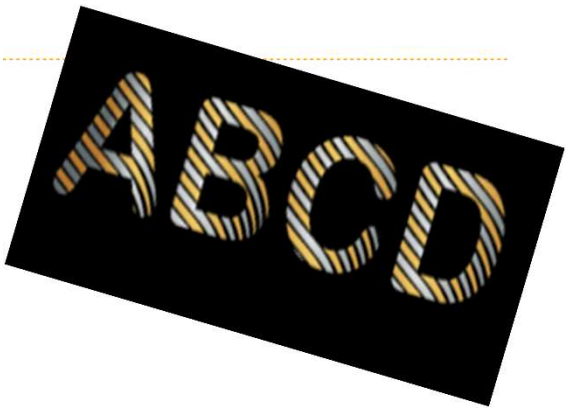
- Advance
- But
- Current
- Directive



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YOU CHOOSE -

- Resident A shows signs of slow decline. Has an advance directive in place and has discussed with her family. Her PCP recognizes the decline and implements hospice. After two months on hospice the resident passes surrounded by her family.
- Resident B shows signs of decline. She has an advance directive requesting to not be resuscitated. The DPOA for healthcare does not agree with those wishes. An order for 'No Code' was written. The resident continues to decline and stopped breathing with the DPOA present. No code was called . The DPOA screams at the staff and facility leadership, "You let my mother die". The DPOA hotlines the facility. The complaint was found to be unsubstantiated.

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F578
REQUEST/REFUSE/DISONTINUE TREATMENT FORMULATE ADVANCE DIRECTIVE

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F578 ADVANCE DIRECTIVES

- **Definitions**:
- **§483.10(c)(6), (c)(8), (g)(12) "Advance care planning"** is a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions.

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DEFINITIONS

- **Health care decision-making:** consent, refusal to consent, or withdrawal of consent to health care, treatment, service, or a procedure to maintain, diagnose, or treat a resident's physical or mental condition.
- **Health care decision-making capacity:** possessing the ability (as defined by State law) to make decisions regarding health care and related treatment choice.

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F 578 ADVANCE DIRECTIVES

- **Regulations: F 578**
- **§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.**

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F 578 ADVANCE DIRECTIVES

- **Regulations: F 578**
- **§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.**

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F578 ADVANCE DIRECTIVES

- **Regulations: F 578**
- **§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).**
- **(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.**
- **(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.**
- **(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.**

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F578 ADVANCE DIRECTIVES

- **(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.**
- **(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.**

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Advance Directive Guidance

- **Guidance**
- The facility is required to establish, maintain, and implement written policies and procedures regarding the residents' right to formulate an advance directive, *including the right to accept or* refuse medical or surgical treatment. In addition, the facility management is responsible for ensuring that staff follow those policies and procedures.

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Advance Directive Guidance

- The facility's policies and procedures delineate the various steps necessary to promote and implement these rights, including, but not limited to:

- If the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents must be obtained and maintained in the same section of the resident's medical record readily retrievable by any facility staff. Facility staff must communicate the resident's wishes to the resident's direct care staff and physician. If the resident does not have an advance directive, facility staff must inform the resident or resident representative of their right to establish one as set forth in the laws of the State and provide assistance if the resident wishes to execute one or more directive(s). Facility staff must document in the resident's medical record these discussions and any advance directive(s) that the resident executes.

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Advance Directive Guidance

- **Guidance**
- The resident has the option to execute advance directives but cannot be required to do so. As required by 42 C.F.R. §489.102(a)(3), the facility may not condition the provision of medical care or discriminate against a resident based on whether he or she has executed an advance directive. Facility staff are not required to provide care that conflicts with an advance directive. In addition, facility staff are not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive and State law allows the provider to conscientiously object.
- Facility staff should periodically review with the resident and resident representative the decisions made regarding treatments, experimental research and any advance directive and its provisions, as preferences may change over time.

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Advance Directive Guidance

- **Guidance**
- The ability of a dying person to control decisions about medical care and daily routines has been identified as one of the key elements of quality care at the end of life. The process of advance care planning is ongoing and affords the resident, family, and others on the resident's interdisciplinary health care team an opportunity to reassess the resident's goals and wishes as to have decision-making capacity; the resident's medical condition changes. Advance care planning is an integral aspect of the facility's comprehensive care planning process and assures re-evaluation of the resident's desires on a routine basis and when there is a significant change in the resident's condition. The process can help the resident, family and interdisciplinary team prepare for the time when a resident becomes unable to make decisions or is actively dying.

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Advance Directive Guidance

- **GUIDANCE §483.10(c)(6), (c)(8), *and* (g)(12)** The resident has the right to request treatment; however, facility staff are not required to provide medical treatment or services if the requested treatment or services are medically unnecessary or inappropriate. While the resident also has the right to refuse any treatment or services, the resident's refusal does not absolve facility staff from providing other care that allows him/her to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. For example, facility staff would still be expected to provide appropriate measures for pressure injury prevention, even if a resident has refused food and fluids and is nearing death.

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Advance Directive Guidance

- **Guidance**
- If a resident (directly or through an advance directive) declines treatment (such as refuses artificial nutrition or IV hydration, despite having lost considerable weight), the resident may not be treated against his or her wishes. If a resident is unable to make a health care decision, a decision by the resident's legal representative to forego treatment may, subject to State requirements, be equally binding on the facility. A resident may not be transferred or discharged for refusing treatment unless the criteria for transfer or discharge are otherwise met. Facility staff should attempt to determine the reason for the refusal of care, including whether a resident who is unable verbalize their needs is refusing care for another reason (such as pain, fear of a staff member, etc.), and address the concern, if possible. Any services that would otherwise be required, but are refused, must be described in the comprehensive care plan. See F656, Comprehensive Care Plans, for further guidance.

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Advance Care Planning

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Times They are a Changing

	2013	2018
Had an EOL discussion	27%	32%

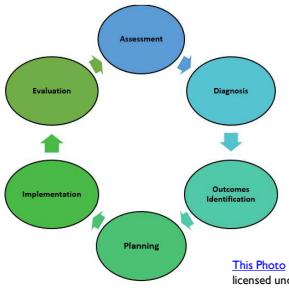
53% would be relieved if a loved one started "The Conversation"

Theconversationproject.org

18

What is Advance Care Planning?

- Discussing and preparing for future decisions about medical care
- Conversations with family, friends
- Putting wishes in writing
- Enacted only when a resident cannot communicate their wishes



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Advance Care Planning

2 common components

- Healthcare Directive (aka Living Will)
- Assigning an Agent: Durable Power of Attorney for Health Care

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ADVANCE DIRECTIVE: LEGAL

Legal guarantees

- Legally recognized but not legally binding (against health care provider's conscience, against facility policy or accepted health care standards)
- Is a lawyer required to create an advance directive?
  - Not necessary but could be helpful

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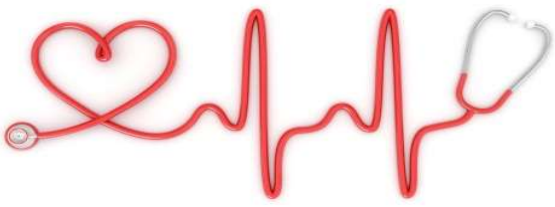
MISCONCEPTIONS OF ADVANCE DIRECTIVES

- DNR means no care
- POA means you can speak for the resident at any time
- The advance directive is the legal document
- A financial POA translates to healthcare
- Quality of life is improved if FULL Code is used



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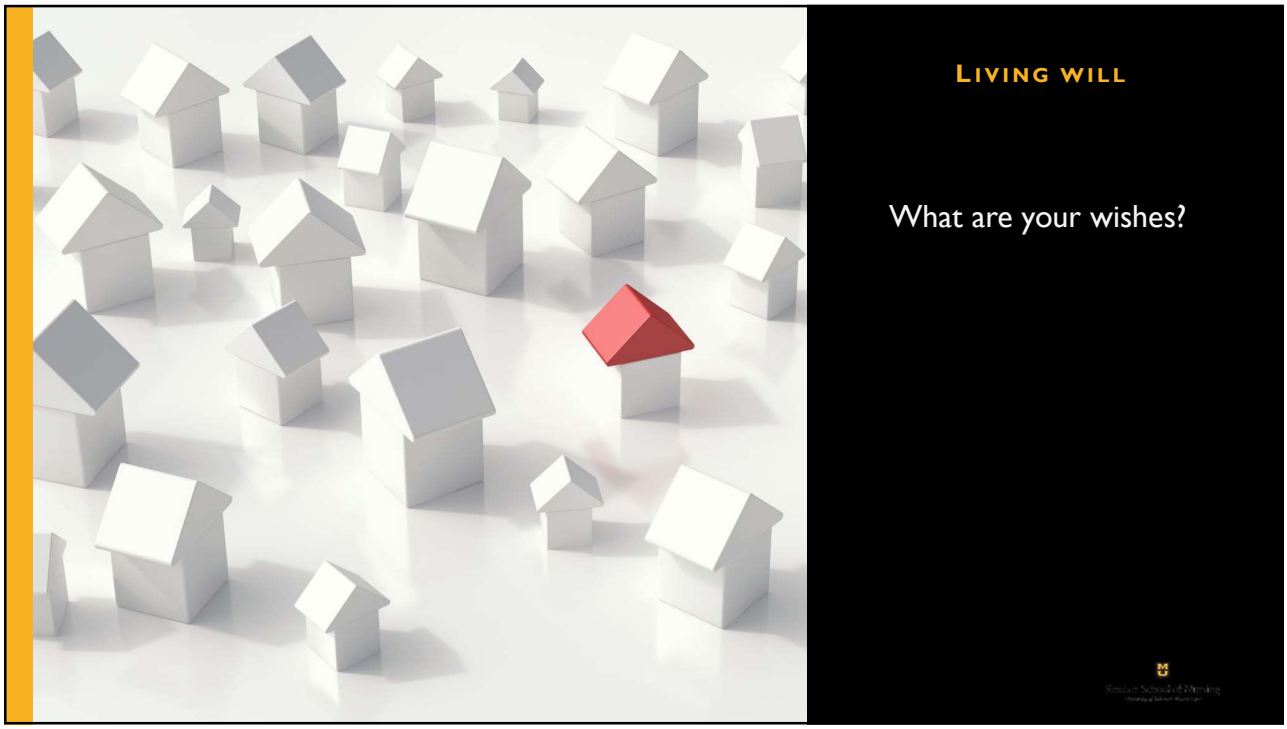

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LIVING WILL

Purpose: To specify particular treatments that should or should not be administered under specific circumstances.

- What specific circumstances could happen
- What treatments should or should not occur

24

Living will

- First proposed in 1969
- Only about 20% of adults in US have a living will (2020)
- Requirements in Missouri:
  1. Must be dated and in writing
  2. Principal must be legally competent
  3. Principal must sign with 2 witnesses (not family, beneficiaries, or anyone responsible for healthcare expenses)
  4. Won't take effect if principal is pregnant
  5. Takes effect only if the principal is incapacitated or terminal

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Living Will/Health Care Directive

- Likely completed prior to admission
- Making wishes known
- Designating a decision maker who will carry the resident's wishes when they cannot speak for themselves.
  - If wishes are known or unclear, use principle of Best Interest
  - No surrogate – review regulations, guardianship may be needed, have a policy
- Facility and providers should know content and review with resident and family
- Caring Conversations (https://www.practicalbioethics.org/featured-resources/caring-conversations/)

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Living will

Reduces burden of decision-making for family during a difficult time.

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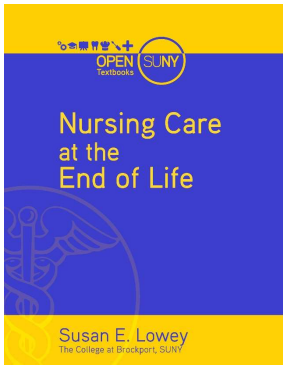
Living will

Items that may be included:

- CPR
- ICD (implantable cardioverter defibrillator)
- Mechanical ventilation
- Tube feeding
- Dialysis
- Antibiotics or antiviral medications
- Hospitalization
- Radiation
- Surgery
- Organ transplant



28

Living will

Factors to consider:

- Level of dementia/cognitive status
- Degenerative disease (e.g. Lou Gehrig's, Parkinsons)
- Brain damage
- Intense pain
- Highly agitated
- Must be restrained to prevent injury

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Living will

Palliative care: Withholding specific treatments doesn't prevent pain management or comfort care.

Reflect on values, wishes

Talk to physician

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Living will

- Revocable at any time
- Directions of declarant shall at all times supersede declaration

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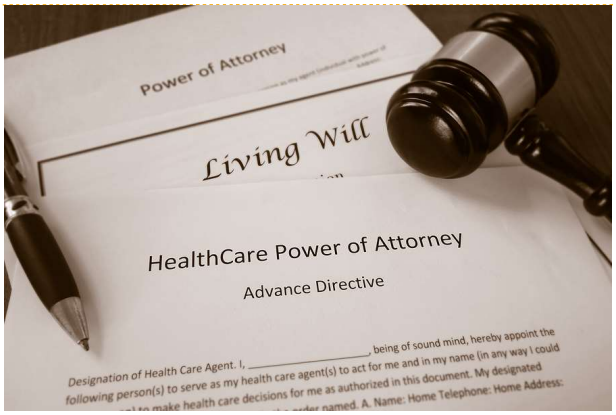
Durable power of attorney for healthcare (DPOA)



32

Durable power of attorney for healthcare

- **F551**

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.

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Durable power of attorney for healthcare

- (i)The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative.
- (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.

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Durable Power of Attorney for Healthcare

§483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

§483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

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Durable Power of Attorney for Healthcare

§483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law.

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DURABLE POWER OF ATTORNEY FOR HEALTHCARE

§483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.

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DURABLE POWER OF ATTORNEY FOR HEALTHCARE

(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority.

(ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.

(iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.

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DURABLE POWER OF ATTORNEY FOR HEALTHCARE

"Resident representative" For purposes of this subpart, the term resident representative may mean any of the following:

1. An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
2. A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; or

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DURABLE POWER OF ATTORNEY FOR HEALTHCARE

3. Legal representative, as used in section 712 of the Older Americans Act; or
4. The court-appointed guardian or conservator of a resident.
5. Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.

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Survey Considerations

PROCEDURES §483.10(b)(3)-(7)

Surveyors must check whether there has been a delegation of resident rights or designation of a resident representative. Surveyors must also determine, through interview and record reviews, whether or not the resident's delegation of rights has been followed by facility staff. Determine through interview and record review if the resident has been found to be legally incompetent by a court in accordance with state law.

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Survey Considerations

KEY ELEMENTS OF NONCOMPLIANCE §483.10(b)(3)-(7)

To cite deficient practice at F551, the surveyor's investigation will generally show that the facility failed to do any one or more of the following:

- Ensure a competent resident's choice for a representative is honored **or**
- Ensure that treatment of a same-sex spouse was the same as treatment of an opposite-sex spouse; **or**
- Ensure the resident representative did not make decisions beyond the extent allowed by the court or delegated by the resident; **or**
- Ensure the resident's wishes and preferences were considered when decisions were made by the resident representative; **or**

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Survey Considerations

KEY ELEMENTS OF NONCOMPLIANCE §483.10(b)(3)-(7)

- Ensure the decisions of the resident representative are given the same consideration as if the resident made the decision themselves; or
- Honor the resident's authority to exercise his or her rights, even when he or she has delegated those rights, including the right to revoke a delegation of rights; or
- Ensure the resident representative was reported as State law required when not acting in the best interest of the resident; or
- Ensure a resident who was found incompetent by the court is provided with opportunities to participate in the care planning process.

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Durable Power of Attorney for Healthcare

Medical power of attorney: a person (agent) authorized to make healthcare-related decisions for a person who cannot do that for themselves.

Agent:

- Trusted
- Will honor wishes
- Typically a family member or close friend
- Mentally competent adult
- Able to handle conflicting opinions of others involved

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DPOA Decisions

Decisions an agent can make for you:

- Which doctors or facilities to provide care for you
- What medical tests to perform
- What medicines you take
- If/when you have surgery
- How aggressively to treat a disease
- Whether to authorize your participation in medical research related to your condition
- Whether to disconnect life support
- Whether to authorize organ donation or an autopsy after death

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DPOA CANNOT

Agent **cannot** make the following decisions:

- Agree to an abortion
- Agree to hospitalize for mental health services
- Agree to psychosurgery or ECT
- Refuse care that will keep the resident comfortable

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Enacting DPOA for Healthcare

How to enact a medical POA:

- Complete the POA for healthcare form
- Have form witnessed and notarized
- Make copies for your agent, physician and other healthcare providers

Remember the POA only becomes active when a physician (or 2) documents that you are unable to communicate your wishes

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Durable power of attorney for healthcare

Limits of Medical POA in Missouri:

- Your agent must make decisions within the terms of the legal POA document
- The agent is not allowed to make decisions that break the agreement and can be held liable for any fraud or negligence
- Two certified physicians (or one if you choose) must declare you incapacitated before the POA can take effect
- Your agent can't designate another person to act as your agent unless you authorize it in the form
- A POA can only be signed when the principal is of sound mind

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DNR Order

GUIDANCE §483.24(a)(3)

- Just because a resident has an advance directive/living will, they do not always have a DNR order.
- Evidence in record of discussion leading to DNR order.
- Document resident choices (admission and changed) with signed order.
- Documented discussions of CPR refusal should be made if there is a delay in getting orders. Verbal declination should have 2 staff witnesses.

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Communicating DNR Status

- Have a plan and carry it out
- Alerts in EMR, clipboard at the desk
- Magnets on the door

- But what about the dining room, activities, therapy?

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POLST/TPOPP

Physician Orders for Life Sustaining Treatment - POLST

Transportable Physician Orders for Patient Preferences – TPOPP

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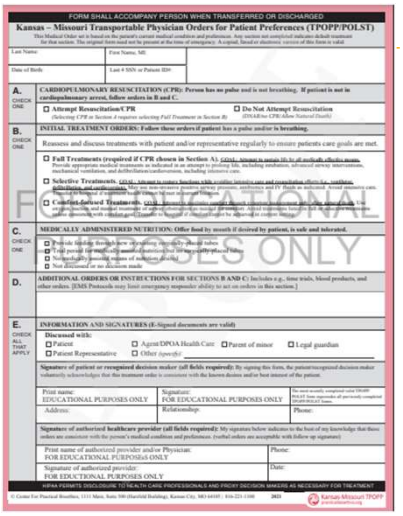
POLST/TPOPP


FORM SHALL ACCOMPANY PERSON WHEN TRANSFERRED OR DISCHARGED

Kansas – Missouri Transportable Physician Orders for Patient Preferences (TPOPP/POLST)

FOR EDUCATIONAL PURPOSES ONLY

- An order set for seriously ill and medically fragile
- Transforms personal wishes into medical orders
- Includes: CPR, Medical Interventions, and Medically Administered Nutrition
- Signed provider and resident/designee
- Revised 2022

https://www.practicalbioethics.org/programs/transportable-physician-orders-for-patient-preferences-tpopp-polst/

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Advance Directive vs TPOPP/POLST

ADVANCE DIRECTIVE (LIVING WILL)	TPOPP/POLST
• All adults	• Those with advanced, chronic, progressive disease or terminal condition
• Initiated by an individual about their preferences and who may make decisions about care	• Initiated by provider for those who are frail or have chronic progressive illness
• Future oriented	• Applies to current situation
• Effective when unable to make decisions for self	• Not tied to decision making capacity
• No actionable orders	• Actionable medical orders
• Not available in all setting	• Can be used across settings

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OHDNR – Purple Form

OHDNR – PURPLE FORM	TPOPP/POLST
• Used in out of hospital settings	• All settings
• Addresses only CPR	• Full range of treatment – CPR, medical interventions, & medical nutrition

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Advance Care Planning in LTC Not Always Simple

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Being Proactive

- Encourage resident and families to read advance directives
- Review them often
- Speak to the resident first if cognition is intact
- Explain conditions, current care plan, and what may happen in the future
- Involve all health care team members (SW, therapy, nursing, medicine)
- Review all paperwork (facility-wide) to make sure everything matches (quarterly at the minimum)

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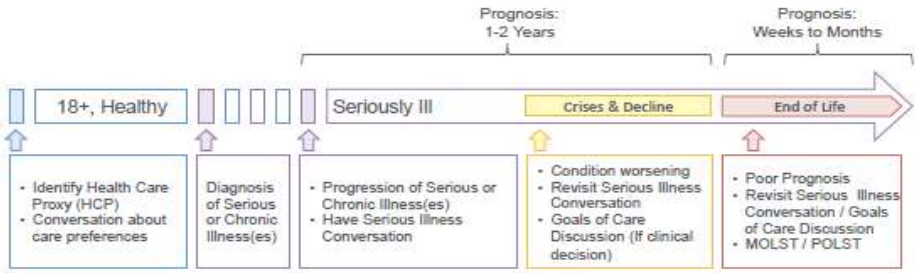
Advance Care Planning Terminology



Advance Care Planning = Planning in Advance of Serious Illness

Serious Illness Care Conversation = Planning in the context of progression of serious illness

Goals of Care Discussion = Decision making in context of clinical progression / crisis / poor prognosis

DANA-FARBER CANCER INSTITUTE

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Nursing & Social Work

- Common goals with varying approaches
- Is *not* standardized
- Education and skills vary among SW and nurses
- Expectations in role differ
- DO NOT wrongly assume what the other person is handling
- Communicate!

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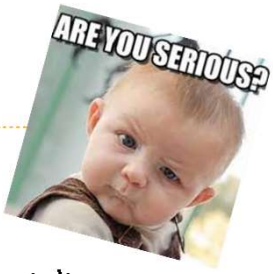
Streamline Care – Care Plans



- A well-run care plan process is efficient and multi-disciplinary
- Often overlooked as paper compliance, but can be very useful in helping in
  - providing person-centered care and
  - streamlining services to fit the "whole picture" of the resident.

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Care Plan Benefits

An effective CARE PLAN PROCESS, can result improved:

- quality measures
- recognition of resident wishes
- customer satisfaction
- documentation processes

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Having the Conversation Early

- Before there is a crisis
  - Observe for subtle indicators of decline
  - What are some indicators?
- Decisions are hard to make during a crisis
- Helps the resident be able to have his/her wishes honored
- Enhances a spirit of teamwork and trust between the family and facility
- May be able to identify solutions before a crisis (palliative care, hospice)

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PALLIATIVE CARE

- Does not replace primary treatment; collaborates with curative treatment with a focus on pain, symptoms, and stress of illness.
- Not time limited
- Any care setting
- Payor: Private Insurance/Medicare Part B/Medicaid (always exceptions)

HOSPICE CARE

- Focuses on pain, symptoms, and stress of serious illness
- Must have a terminal prognosis
- Most care settings (not LTAC)
- Payor: Private Insurance/Medicare Hospice Benefits/Medicaid (always exceptions)

https://www.nhpco.org/wp-content/uploads/2019/04/PalliativeCare_VS_Hospice.pdf

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Having THE Conversation

- Use your Sunday Best communication skills
- Do not force a decision
- "What is your understanding of your current situation with {disease}?"
- Restate "as I understand it, you want_____ and do not want _____. Is that correct?"
- "Based on our conversation and your goals, our will plan will be to _____. Is that OK?"
- Offer to speak to family; chaplain services

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Family Engagement

- Allow families to vent concerns, offer reassurance that concerns are heard
- Openly discuss resident wishes & expectations and family expectations
  - Do they match the healthcare team?
- If their expectations do not align, educate and discuss alternatives
- Educate the family about their loved one's condition and current status – be HONEST
  - Hospital care may not be the solution
- Engage families in the care of their loved ones; this will give some sense of control
- Help the families find ways to enhance their visits; help them to be able to have special moments within their visits
  - Hand massage, touch, being present, assisting staff as able
  - Reminiscing, stories – events, TV shows, etc.
- Provide updates

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Decision Making Capacity

- At what point is the resident unable to make decisions for themselves?
- Gradual
- Sudden

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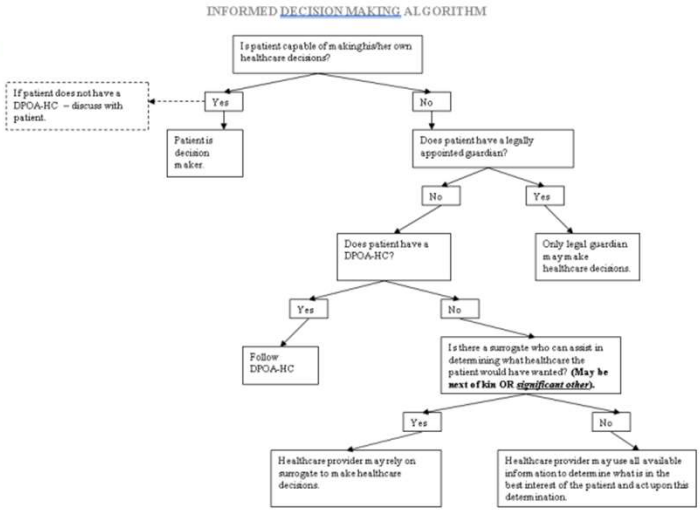
Decision Making Algorithm



https://www.practicalbioethics.org/programs/accelerated-advance-care-planning-in-long-term-care/

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Determining Decisional Capacity

- Have a general conversation with resident
- Feedback from others (staff, family, etc.)
- **Resident must be able to**:
  - Take in information
  - Understand what is happening
  - Deliberate pros and cons of options
  - Communicate their wishes
- Clinical tools
  - Mini-Mental Status Examination
  - MacArthur Competence Assessment Tools for Treatment

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Challenges with Carrying Out Resident Wishes

- Hospitals do not always have copies of documentation
- Families do not always have copies of documentation
- Paper copies are easily lost
- Families do not always know what is in the POA/AD document
- Patients and families have not had an advanced care planning conversation, and can be ill-prepared

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End of Life/Advance Care Planning
&
Hospital Transfers
Missouri Quality Initiative for Nursing Homes (MOQI)

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Audit of Advance Directives in Medical Record: Numbers over Time

Year	N	Percent
2013	1876	49%
2014	1711	65%
2015	1730	96%
2016	1544	90%

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ADVANCE DIRECTIVES CORRELATION WITH TRANSFERS

% Transfers with AD	% Transfers without AD	Odds Ratio	95% Confidence Limits	P value
30.26	36.33	1.29	1.030 1.615	<.02

- The results indicate a 29% higher odds of transfer for those without an AD relative to those with an AD.
- Conclusion: Residents who did not have AD are more likely to be transferred than residents who had AD.

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What Can You Do?

- Promote discussions among residents and family members
  - Identify staff champions
- Encourage completion of a health care directive/DPOA for healthcare and/or TPOPP
- Policies and procedures - including <u>strong record keeping practices</u>
  - Chart audits
  - Communication of code status

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More - What Can You Do?

- Educational programs for staff, residents, and family members
  - Newsletter, email blasts, posters
- Community education & awareness activities such as National Health Care Decisions Day (April 16)

73

SUMMARY

Advance

But

Current

Directives

- ❑ Policies consistent with regulations
- ❑ Consistent with resident status & wishes
- ❑ Communication

74

Any Questions???

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76

Resources & Forms

- Alzheimer's Association alz.org
- Ariadne Labs – Serious Illness Care https://www.ariadnelabs.org/serious-illness-care/
- Center for Practical Bioethics (Caring Conversations, TPOPP) https://www.practicalbioethics.org/programs/advance-care-planning/
- Caring Info https://www.caringinfo.org/
- Missouri Bar Association https://missourilawyershelp.org/legal-topics/durable-power-of-attorney-for-health/
- Missouri DPOC HC & AD https://health.mo.gov/seniors/resources/pdf/durable-power-of-attorney-health-care-directive-hipaa-privacy-authorization.pdf

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Resources & Forms

- MU Health Care https://www.caringinfo.org/
- Prepare for Your Care https://prepareforyourcare.org/en/welcome
- State Operations Manual https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf
- The Conversation Project https://theconversationproject.org/
- VITALtalk https://www.vitaltalk.org/resources/quick-guides/

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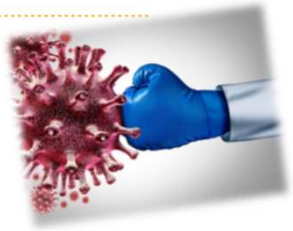

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81