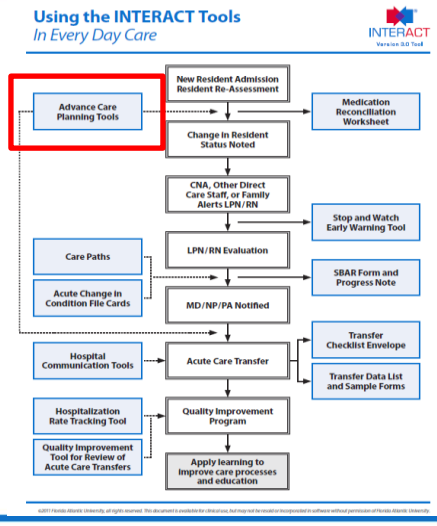
ADVANCE CARE PLANNING

The **INTERACT Version 3.0** tools are meant to be used together in your daily work in the nursing home

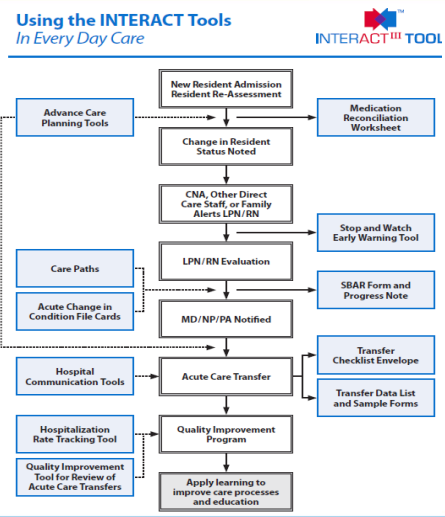
http://interact2.net



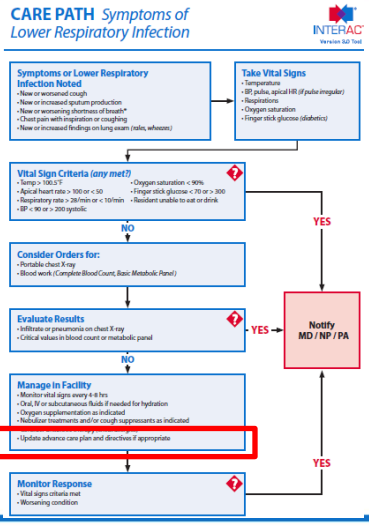
ADVANCE CARE PLANNING TOOLS

Advance Care Planning

- ACP should occur at some time shortly after admission
- Decisions should be reviewed regularly and at times of acute changes in condition



ADVANCE CARE PLANNING TOOLS



ADVANCE CARE PLANNING

Audience Response Question

Do you have an Advance Directive?

1. Yes
2. No

ADVANCE CARE PLANNING TOOLS

Video Clip:

Advance Care Planning (1)

Available in the Medline INTERACT eCurriculum

ADVANCE CARE PLANNING TOOLS

Who?

- The MD is responsible for discussing the illness, future issues, risks and benefits of various treatments and writing orders consistent with preferences
- But, **ACP is an interdisciplinary team responsibility**
  - Good decisions that honor resident preferences must be made with a health care team the resident and their decision makers trust

ADVANCE CARE PLANNING TOOLS

Advance Care Planning Tracking Form

INTERACT Version 3.0 Tool

Resident Name _____

Residents and/or their responsible health care decision makers should be provided the opportunity to discuss advance care planning with appropriate staff members and medical providers within the first few days of admission to the facility, at times of change in condition, and periodically for routine updating of care plans. The purpose of this form is to provide a tool to document that these discussions are taking place.

At Admission *(within about a week of admission or readmission)*

Check one of the following:

☐ Resident and/or responsible party did NOT want to have this discussion

☐ Discussion about advance care planning held with *(check one or both of the following)*:

_____ Resident

_____ Resident's surrogate; name: _____

Staff or healthcare provider completing form:

Name _____ Title _____

Signature _____ Date of discussion _____/_____/_____

Location of Advance Care Plan documentation *(i.e. advance directive tab, plan of care, progress notes, etc…)*:

_____

_____

_____

Use Continuation Pages to document additional Advance Care Planning Reviews and Discussions

Adapted from: Advancing Excellence

http://www.nhqualitycampaign.org/files/impguides/6_AdvanceCarePlanning_TAW_Guide.pdf

ADVANCE CARE PLANNING TOOLS

Identifying Residents who may be Appropriate for Hospice or Palliative/Comfort Care Orders

INTERACT Version 3.0 Tool

I. Residents with Selected Diagnoses who may be Appropriate for Hospice

Congestive Heart Failure

- Symptoms of CHF at rest *(New York Heart Association class IV)*
- Serum sodium level < 134 mmol/L or creatinine level > 2.0 mg/dL due to poor cardiac output
- Intensive care unit admission for exacerbation

Chronic Obstructive Pulmonary Disease

- Cor pulmonale *(right-sided heart failure associated with COPD)*
- Intensive care unit admission for exacerbation
- New dependence in two activities of daily living (ADLs) due to COPD symptoms
- Chronic hypercapnia *(PaCO2 > 50 mm Hg)*

Dementia

- Dependence in all ADLs, language limited to just a few words, and inability to ambulate
- Acute hospitalization *(especially for pneumonia or hip fracture)*
- Difficulty swallowing with recurrent aspiration
- Has feeding tube due to dementia or swallowing difficulty related to dementia

Cancer

- Poor physical performance status as a result of cancer *(dependence in multiple ADLs)*
- Multiple tumor sites
- Metastatic cancer involving liver or brain
- Bowel obstruction due to cancer
- Pericardial effusion due to cancer

II. Residents at High Risk of Actively Dying who Should be Considered for Palliative or Comfort Care Orders *(if not already on Hospice)*

- Frequent Emergency Room visits and/or hospitalizations over the last 6 months
- Sudden, major decline in functional status with no identified reversible causes
- Primary diagnosis of metastatic cancer with chronic pain and/or poor ADL function, not on chemotherapy
- Semi-comatose or comatose state with no identified reversible causes
- Inability or difficulty taking oral medicines
- Minimal oral intake *(or receiving continuous or intermittent IV hydration)*
- Mottling of extremities related to poor oral intake or volume depletion

ADVANCE CARE PLANNING TOOLS

Advance Care Planning Communication Guide: *Overview*

INTERACT Version 3.0 Tool

The INTERACT Advance Care Planning Communication Guide is designed to assist health professionals who work in nursing homes to initiate and carry out conversations with residents and their families about goals of care and preferences at the time of admission, at regular intervals, and when there has been a decline in health status.

The Guide can be useful for education, including role-playing exercises and simulation training.

Communicating about advance care planning and end-of-life care involves all facility staff

- Physicians must communicate with residents and families about advance directives, but all staff need to be able to communicate about goals of care, preferences, and end-of-life care

This Guide should therefore be useful for:

- Nursing staff
- Primary care physicians, nurse practitioners, and physician assistants
- Social workers and social work designees
- Administrators and others who discuss goals of care with residents and family

The Guide may be helpful in discussions on:

- Advance Directives – such as a Durable Power of Attorney for Health Care document, Living Will, and POLST and other similar directives
- Plans for care when a sudden, life-threatening condition is diagnosed – such as a stroke, heart attack, pneumonia, or cancer
- Plans for care when a resident's health is gradually deteriorating – such as progression of Alzheimer's disease or other dementia; weight loss without an obvious medical cause; and worsening of congestive heart failure, kidney failure, or chronic lung disease
- Considering a palliative or comfort care plan or enrolling in a hospice program

ADVANCE CARE PLANNING TOOLS

Comfort Care Interventions *Examples*

INTERACT Version 3.0 Tool

Some nursing home residents and/or their families are reluctant to enroll in hospice but would like a comfort care plan. The examples of comfort care orders below may be helpful for these residents, who will not have hospice order sets.

Order Type	Examples and Helpful Tips
Diet	1. Order a diet *(it may improve the desire to taste food)* 2. Full rather than clear liquid if liquid diet necessary 3. May have food brought in by family 4. Allow resident to sit up for meals
Activity	1. Allow resident to sit in chair and use a bedside commode if capable and desired 2. Other activities as tolerated 3. Allow family to stay in room
Vital Signs	1. Minimum frequency allowed by policy a. Frequent monitoring and numbers can alarm resident and family b. Limit MD/NP/PA notification parameters
IV Orders	1. If IV fluids are needed, use a time limited trial *(e.g. 1000cc of D5 ½ Normal Saline over 6 hrs)* a. Starting IV is often difficult and painful – and usually of limited benefit 2. Subcutaneous injections of small volumes of medicines using a small butterfly needle under the skin of the thigh or abdomen may avoid the need for IV therapy
Orders for Dyspnea and Shortness of Breath	1. Oxygen 2 - 4 L by nasal cannula; avoid mask if possible 2. Avoid monitoring oxygen saturations 3. Blow air on face with a bedside fan or open window 4. Nebulizers may be helpful 5. Consider steroids if wheezing present 6. Use opioids for persistent dyspnea 7. Use antibiotics if a bacterial infection is exacerbating dyspnea and treatment may improve symptoms
Hygiene	1. Avoid bladder (Foley) catheter if possible a. May be helpful in selected residents who are immobile and have pain with toileting or movement 2. Check regularly for stool impaction a. Suppositories may be helpful 3. Monitor for oral thrush 4. Petroleum jelly to lips may be helpful for dry mouth 5. Allow family to cleanse mouth with sponge sticks

Comfort Care Interventions *Examples (cont'd)*

INTERACT Version 3.0 Tool

Order Type	Examples and Helpful Tips
Pain and Dyspnea	1. Opioids usually most effective 2. Use small, frequent doses as needed for opioid-naive residents 3. Consider stopping sustained preparations and switching to immediate release Morphine concentrate 20 mg/ml 4. Start with equivalent dose as previous regimen – at least 5 mg PO every 2 hrs 5. Offer routinely, and let the resident refuse 6. Use short-acting benzodiazepine if anxiety is present
Anorexia, Asthenia, Fatigue, Depression, Pain, Dyspnea	1. Corticosteroids can have beneficial effects a. Use Dexamethasone 4 - 8 mg PO or subcutaneous at breakfast and lunch *(avoids the mineralocorticoid effects of Prednisone)* 3. Employ sleep hygiene measures to facilitate optimal nighttime sleep
Nausea and Delirium	1. Review underlying cause(s) of delirium and nausea, and eliminate if possible 2. Haloperidol 0.25 - 2 mg PO or 0.5 - 1 mg subcutaneous every 2 hrs for 3 doses or until symptoms relieved, then every 4 hours PRN
Anxiety and Seizures	1. Lorazepam for anxiety 0.5 - 2 mg PO or subcutaneous every 6 - 8 hrs a. Must be given IV or subcutaneous for seizures
Sleep	1. Trazodone 25 - 100 mg PO or Zolpidem 5 - 10 mg PO qhs
Skin, Pruritus, Wounds	1. Keep skin moist; use moisturizing soap or lotions 2. Hydrocortisone creams may be helpful 3. Benadryl 25 - 50 mg PO ever 4 hours for pruritus 4. Lidocaine 2% gel PRN to painful wounds
'Death Rattle'	1. Keep back of throat dry by turning head to the side 2. Stop IV fluids or tube feedings 3. Use a Scopolamine patch; Atropine drops 2 - 3 in the mouth every 4 hrs until patch is effective a. Use glycopyrrolate, 1 - 2 mg PO or 0.1 - 0.2 mg IV or subcutaneous every 4 hrs; or 0.4 - 1.2 mg/day continuous infusion is an alternative 5. Avoid deep suctioning 6. Allow family to cleanse mouth with sponge sticks
Comfort, Counseling, Safety	1. Sit with resident and talk to avoid isolation 2. Reposition and massage regularly 3. Avoid sensory overload *(e.g. loud TV)*; use soft music 4. Avoid use of restraints, bedrails, and alarms 5. Religious counseling should be considered if acceptable

INTERACT Interventions to Reduce Acute Care Transfers

ADVANCE CARE PLANNING TOOLS

Deciding About Going to the Hospital *(cont'd)*

INTERACT Version 3.0 Tool

Benefits of Staying in the Nursing Home

There are benefits of staying in the nursing home when a new symptom or condition occurs – assuming it is safe to treat the condition in the nursing home and staying in the nursing home is consistent with the preferences of the resident and her or his family. Treatment in the nursing home allows residents to:

- Have continuity of care – this means that residents continue to receive care from staff members who know them, and who are able to respond to their individual preferences and needs
- Remain in a familiar environment with their personal possessions, and keep their individual routines as much as possible
- Avoid what is often an uncomfortable trip to the hospital and long delays waiting in the emergency room
- Avoid potential problems due to miscommunication between the hospital and the nursing home
- Avoid other hospital-related complications

What Can Residents and Their Families Do?

There are several things that residents and their relatives can do to make sure the right decisions about hospital care are made in their best interest, including:

- Participating in care planning *(deciding on treatment preferences)* with the nursing home staff and their primary care provider *(doctor, nurse practitioner, or physician's assistant)*
- Discussing the risks and benefits of a hospital transfer vs. treatment in the nursing home when a new symptom or condition is recognized
- Completing an **Advance Directive** document, such as a **Durable Power of Attorney for Health Care** that expresses preferences for care in emergencies and at the end of life
- Understanding the resources available in the nursing home to treat the new symptom or condition *(for example, oxygen, lab tests, intravenous (IV) fluids and medications)*
- Understanding the financial and other issues, such as bed-hold policies, of treatment in the hospital vs. in the nursing home

ADVANCE CARE PLANNING TOOLS

Education on CPR for Residents and Families

INTERACT Version 3.0 Tool

The Problem

Many health problems are so serious that they cause your heart to stop beating. This is called cardiac arrest. When this happens, you also stop breathing.

The heart pumps blood to all organs in your body to give them oxygen. When your heart stops beating, your body and brain do not get enough oxygen for you to live.

Treatment

There is only one treatment when your heart stops beating. That treatment is cardio-pulmonary resuscitation or CPR. CPR is done to try to restart the heartbeat and breathing. It is the only treatment that could save your life when your heart stops beating.

CPR involves rapidly pushing on your chest, and placement of a tube through the mouth into the lungs to directly help you breathe. Sometimes electric shocks are given using a device called a defibrillator. Once started, CPR

Your Choice

CPR is a choice – it is not a treatment that everyone must have. Some people believe that when their time comes or their heart or breathing stops, nothing more should be done to keep them alive. Other people want everything done to keep them alive. Neither of these choices is right or wrong. It is your choice.

You should understand, however, that if you choose not to have CPR, your choice will not affect any other aspect of your care. **All of your other treatments and care will continue.**

The only thing that will change is that if you are found without a pulse or heartbeat *(in cardiac arrest)* CPR will not be done.

ADVANCE CARE PLANNING TOOLS

Video Clip:

Advance Care Planning (2)

Available in the Medline INTERACT eCurriculum

The INTERACT Program

- Questions?
- Comments?
- Suggestions?