Part 4: 2014 Clinical Practice Series

Considerations for Excellence in End of Life Care
Advance Care Planning

Objectives

• Identify critical domains and competencies for Advance Care Planning and End of Life Care

• Examine the process flow map for implementation of Advance Care Planning and End of Life Care

• Review scenarios that support having “end of life conversations”

• Contrast the difference between an Advance Care Plan and Advance Directive
**HATCh Framework Domains**

- **Care Practices**: Improve lives through Advance Care Planning and End of Life Care practices
- **Workplace Practices**: Maximize performance in Advance Care Planning and End of Life Care
- **Environment**: Create an environment that supports those who are dying
- **Leadership**: Model leadership
- **Family/Community**: Engage families and communities
- **Regulatory**: Observe regulatory mandates
**Providing Advance Care Planning and Care at End of Life (EOL)**

**Domain 1: CARE PRACTICES**

Definition: Refer to the contributions and actions of all staff to acknowledge and honor individual wishes and to bring comfort, relief and solace to those whose worsening physical condition can or will lead to decline or death. This domain specifically focuses on the competencies exhibited by staff that have a direct impact on the individual and the family.

**Competency 1.1 Demonstrate effective advance care planning**

Staff will/can:

1. Determine with IDT (including physician, CRNP and/or PA) resident’s capacity to make health care decisions.
2. Anticipate planning based on potential or likely disease scenarios and future medical care options.
3. Allow the individual and/or family to reflect about their preferences and discuss and share, or develop, related legal documents.
4. Recognize how cultural differences influence the level of involvement and choices made in advance care planning (see reference under 2.3 Cultural Competency).
5. Identify health care agent or proxy, consistent with applicable laws and regulations.
6. Identify decisions that reflect informed decisions based in part on guidance from treating physician. NOTE: Physician should be involved in discussing treatment options with staff and residents / families.
7. Ensure informed decisions are incorporated into medical decisions.

**Resources/Tools:**

- Advance Illness Management - American Hospital Association, August 2012: [Advance Illness Management Strategies - American Hospital](www.aha.org/content/12/aims_strategies.pdf)
Process Framework Steps

1. Identify Individuals with existing documents/decisions
2. Identify individuals who wish to complete advance care planning and situations where advance care planning is indicated
3. Review and clarify existing information
4. Clarify factors affecting physical condition, function, QOL, prognosis and decision-making capacity
5. Define and try to optimize decision making capacity
6. Clarify an individuals values and goals
7. Identify the primary decision maker for health care decisions
8. Guide and support new or additional advance care planning, as needed
9. Discuss specific treatment options
10. Obtain medical orders and implement treatment and care choices
11. Periodically reevaluate advance care plan
12. Periodically reassess or confirm decision making capacity

Merging HATCH and Process Frameworks

1. Identify Individuals with existing documents/decisions
   - **Domains:** Care Practices, Workplace Practices, Environment
2. Identify individuals who wish to complete advance care planning and situations where advance care planning is indicated
   - **Domains:** Care Practices, Workplace Practices
3. Review and clarify existing information
   - **Domains:** Care Practices, Workplace Practices
4. Clarify factors affecting physical condition, function, QOL, prognosis and decision-making capacity
   - **Domains:** Care Practices, Workplace Practices
5. Define and try to optimize decision making capacity
   - **Domains:** Care Practices, Leadership, Family & Community, Regulatory
6. Clarify an individuals values and goals
   - **Domains:** Care Practices, Workplace Practices, Family and Community
Merging HATCH and Process Frameworks

7. Identify the primary decision maker for health care decisions
   - Domains: Care Practices, Workplace Practices, Family & Community

8. Guide and support new or additional advance care planning, as needed
   - Domains: Care Practices, Workplace Practices, Family & Community

9. Discuss specific treatment options
   - Domains: Care Practices, Workplace Practices, Environment, Family & Community

10. Obtain medical orders and implement treatment and care choices
    - Domains: Workplace Practices, Regulatory

11. Periodically reevaluate advance care plan
    - Domains: Care Practices, Workplace Practices, Leadership, Family & Community, Regulatory

12. Periodically reassess or confirm decision making capacity
    - Domains: Care Practices, Workplace Practices, Regulatory

Approach to Implementation

✓ Recognition/Accessment
   - Identify advance care planning as an area for improvement
   - Identify authoritative information available about advance care planning
   - Identify current process and practices in the facility related to advance care planning
   - Identify areas for improvement in processes and practices
Approach to Implementation

✓ Cause Identification
  - Identify causes of any issues, root cause analysis of variations in performance and practice

✓ Management
  - Reinforce optimal practice and performance
  - Implement necessary changes

Tough Decisions
Decision – Making Capacity

- Define or confirm an individual's decision-making capacity
  - Decision making capacity is not the same as legal competence or mental status
  - Affected by delirium, medications, recent illness
  - May fluctuate over time
- Document basis for conclusions
- Reassess periodically

Decision-Making Capacity

- Address underlying factors affecting the individual's ability
- Define the individual's role in decision making
- Individual versus primary decision maker
  - Primary decision makers take into account:
    - Individual's wishes and best interest
    - Discuss and consider relevant medical information
    - Not to impose personal values or choices
Scenario: Admissions Assessment
Listen in!

Key Elements to Successful Admission Assessments

- Show compassion
- Clarify expectation on the part of the dying person
- Listen to resident’s goals
- Support the family members through education, support and compassion
Advance Care Plan vs. Advance Directive

- Advance Care Plan
- Advance Directive

Implementation Challenges

- Lack of effective policies
- Lack of community support
  - Clergy, advocates
- Attaining a systematic approach
- Lack of QAPI process
- Family dynamics
- Staff lack of confidence in the process
Scenario: Starting the Care Conversation
Listen in!

Key Elements to Starting the Care Conversation

- Ensure the family knows the progression of the disease process
- What they can expect in the coming days or months
- How to support their loved one
Tips for Success

- Involve the entire facility
- Establish trust with the resident and family
  - Answer questions honestly
- Recognize resident and family concerns
- Do not force decisions
- Attend to emotions
- Focus on the positive
- Take the time the resident and family needs

Scenario: IDT Team Meeting – Advance Care
Listen in
Key Elements to Interdisciplinary Team Meeting

- Resident advocacy—the team supports the resident
- Help family member come to grips with resident choices

Conclusion

- qualityinitiative@ahca.org
The Clinical Practice Committee
End of Life Subcommittee

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