Effective Communication Strategies for Long Term Care: LTC team, hospice team and families

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Learning Objectives

By the end of the session, participants will be able to:

- Appreciate the importance of advance care planning and goals of care discussions within the context of the long-term care setting
- Discuss what makes a family meeting successful and review a step-wise method for a family meeting
- Practice communication skills for a successful family meeting

THANK YOU
FOR NOT
DYING
CALLAHAN

Who Lives (and Dies) in Nursing Homes?

- 2004 – 1.5 million nursing home residents
  - 88% aged 65 years and older
  - 45% aged 85 years and older
  - 71% female
  - 86% white
- 25% Americans die in nursing homes
- Projected that by 2030 >3 million Americans will reside in institutional long-term care

www.capc.org

http://www.cdc.gov/nchs/data/series/sr_13/sr13_167.pdf

Where Do You Plan to Die?

- Home?
- Nursing Home?
- Hospital?
- Inpatient or Residential Hospice?

Why discuss goals of care?

- Cure of disease
- Maintenance or improvement of function
- Quality of life
- Prolongation of life
- Relief of suffering

What are some of the barriers to completing advance care planning?

- Surrogate decision-makers
- Comfort level of the nursing home and the interdisciplinary team members
- Difficult to navigate medical record
- Forms that are too limited or cumbersome
- Goals may vary or be inconsistent
- Goals may change over time

I want a Pepsi!!!

My father entered a well-known university medical center mid-April 2009 for ***elective*** spinal stenosis surgery. He chose this facility because they specialized in people over 80 years old; Dad was 84…

The surgery was a total success. Milt was up in rehab the next day. He was pain free for the first time in many months. He was discharged to a skilled nursing facility (SNF)home after a 4 day hospital stay…

Upon admission to the SNF, Milt and his wife were asked about their goals of care…

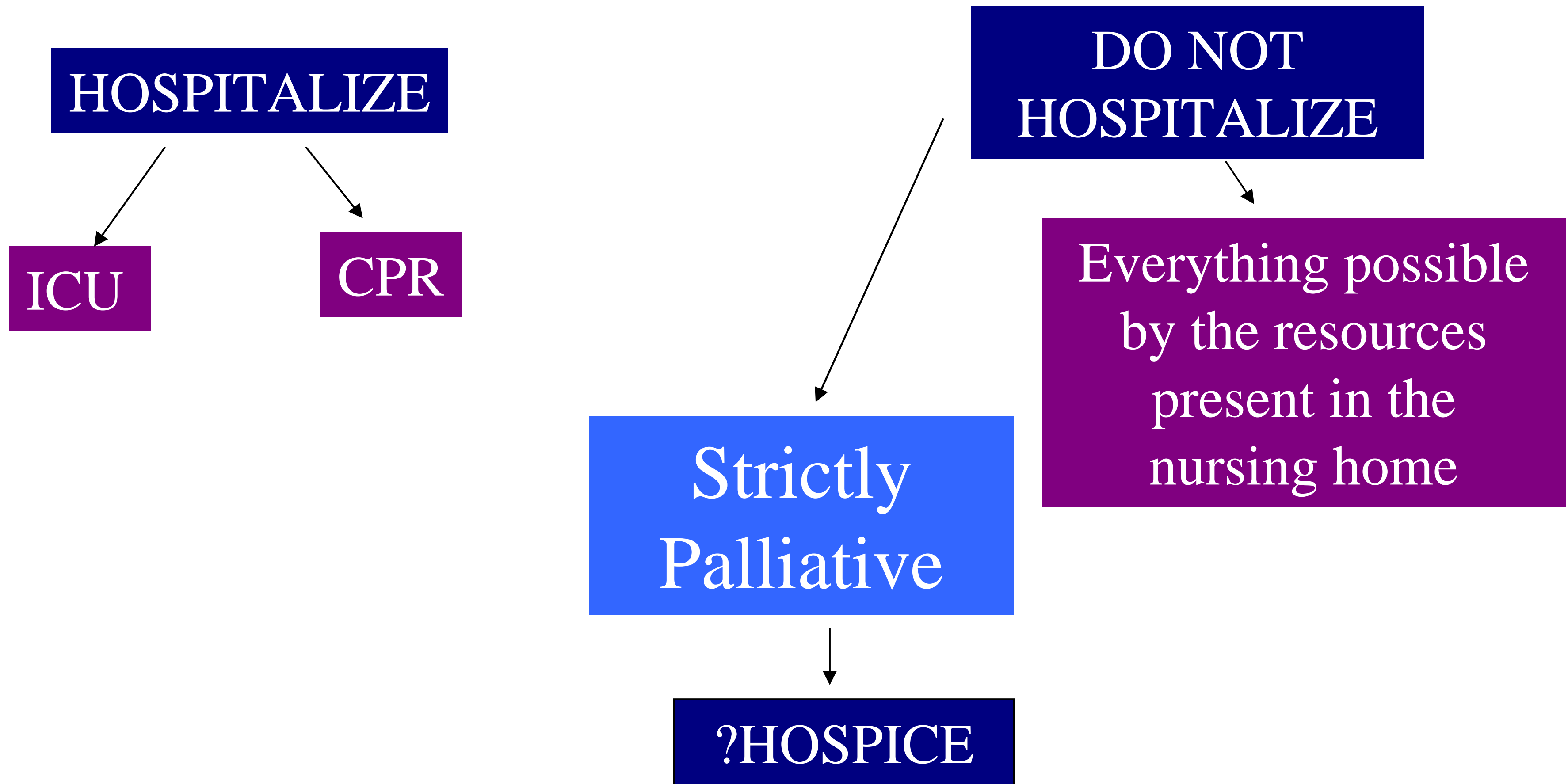
What are some of the successful approaches you have all used?

Ask – Tell - Ask

- ***Ask*** the patient to describe his/her current understanding of the issue (e.g. "What is the most helpful thing for us to talk about today?"
- ***Tell*** the patient in straightforward language what you need to communicate
- ***Ask*** the patient if he/she understood what you just said.

Back AL *CA Cancer J Clin* 2005

"Levels of care"
Specific to Long-term Care



Gillick, MR JPM 2004

Surrogate Decision-Making

- When the patient is not able to participate:
  - *“if your father were sitting here, what would he say”*
  - *“did you ever have conversations about his/her wishes with her prior to her cognitive decline?”*
  - *“do any of these options sound like something your loved one would want?”*

Milt continued…

- Re-hospitalized with MRSA urinary tract infection from indwelling foley
- Hospital course complicated by delirium (confusion) and found to have multiple strokes
- I went to South Carolina to visit my father. My mother and brother introduced me to his physician. I remember quite clearly the physician asking my mother if my father had an advance directive.

My father's condition continued to worsen. He was on continuous O2, on a percussion bed, had a continuous IV, and a foley catheter. He remained incontinent of bowel. Eventually he lost the ability to swallow and was fed via a naso-gastric tube.

The last coherent words my father said to me; quite emphatically, were "***I want a Pepsi!!***"

Step-wise Approach
to
Family Meetings

Family Meeting
10 Key Steps

1. Pre-meeting planning or “pre-game”
2. Proper environment
3. Introductions/Build relationship
4. What does the patient/family know?
5. Medical review
6. Silence, respond to emotions
7. Present options
8. Managing conflict
9. Transform goals into a medical plan
10. Summarize and document

Adapted from EPERC

Common reasons for conflict?

- The Patient/Family
  - Lack of accurate information
  - Guilt/Fear/Anger
  - Grief—Time
  - Lack of trust
  - Cultural/Religious conflict
  - Dysfunctional family system

Other contributing causes

- The physician or healthcare provider
  - Inaccurate information
    - Overly optimistic prognosis
  - Guilt-Anger-Fear
    - Fear of malpractice
    - Fear of ethical impropriety
    - Fear of mistakes
    - Prognostic uncertainty
  - Cultural conflict between team values and patient values

Communicating with Hope

- **Hope for the Best But Prepare for the Worst**
  - "Have you thought about what might happen if things don’t go as you wish? Sometimes having a plan that prepares you for the worst makes it easier to focus on what you hope for most."
- **Reframe Hope**
  - "I know you are hoping that your disease will be cured. Are there other things that you want to focus on?"
  - "I wish, too, that this disease would just stay in remission. If we can not make that happen, what other shorter-term goals might we work toward?"

Tulsky JA JAMA 2005

Focus on the Positive

- "We’ve been talking about some treatments that are really not going to be effective and that we don’t recommend you use. But there are a lot of things we can still do to help you—let’s focus on those."
- "What sorts of things are left undone for you? Let’s talk about how we might be able to make these happen."

Tulsky JA JAMA 2005

Introducing Hospice

- “Have you heard of hospice?”
- “Hospice is able to provide more services and support in the nursing home”
- “The hospice team has a lot of experience in caring for those who are seriously ill in the nursing home”

Role-play!!!!

Review of Role-play

- How did it feel to play your role?
- What went went well?
- What would you like to do differently next time? Re-do?

Take home points

- Take the time to address goals of care in the nursing home
- Prepare and pre-plan for the meeting
- Listen to what the patient and family understand
- Be present and acknowledge emotions
- Negotiate goals of care
- Make plan for follow-up or trial therapies
- Summarize for all present to hear
- Documentation with transitions in mind!

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