POLST CALIFORNIA

Case Study #2 – Transitions in Care
Facilitating a Care Conference or Family Meeting

Narrative case study for individual reading

Rose Tu, an 87 year old female is admitted to your facility following an admission to the acute hospital for difficulty swallowing, where she was diagnosed with esophageal cancer. She has CHF, COPD (on oxygen at home) and has lost over 10 pounds in the last 6 months.

She shares that her quality of life is declining. She lives alone, as her husband died three years ago. Two children are at the care conference and are anxious about her new diagnosis. She has no Advance Health Care Directive. Transfer orders from the hospital indicate **Full Code**. She was admitted to your facility for physical therapy and pain and symptom management.

Mrs. Tu's care conference is an opportunity to address many issues:

- She has a serious, new diagnosis which will certainly affect her overall health.
- Her family is caring and concerned and also wants to learn more about her illness.
- She has no AHCD. While Mrs. Tu is able to make decisions, we need to encourage her to complete an AHCD to name her agent/decisionmaker.

As you discuss her goals of care and complete the POLST, this is an opportunity to have a rich discussion of Mrs. Tu's values and treatment preferences:

- You can facilitate sharing thoughts and feelings between the resident and her children.
- You can explain transitions in medical care and how important palliative care is, especially as individuals become more fragile and more burdened by their illness.

1. Introductions: Have everyone present introduce themselves, and how they are related to Mrs. Tu. Staff members can also share something special about her.

- It is helpful to ask each person to share something special about their mother; this builds rapport and trust and can give staff insight into the family.
- It is also helpful to ask the patient or family if Mrs. Tu's strength or activities have changed in the past 3 to 6 months, asking "what activities were you able to do a month ago…what were you able to do six months ago?"

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2. Ask what Mrs. Tu knows about her diagnosis of esophageal cancer and about her other illnesses (CHF, COPD, weight loss).

- What has the doctor told her?
- What does the family want to know?

3. Ask the resident, "What are your goals, your hopes and expectations?"

- With her new diagnosis and her family members' questions, it is likely that they will need to meet with her doctor to discuss her multiple illnesses, medical goals, potential treatment plans, etc.

4. POLST Conversation: The resident may be ready to complete a POLST, but in this situation, she probably needs further discussion with her physician to clarify the many issues she is facing.

- You can discuss POLST and give the patient brochure to the resident and family.
- POLST can be completed later with the physician or after the resident has met with her doctor.

5. Transitions and Goals of Care:

- As you discuss POLST with this 87 year old resident who has several serious illnesses, it is beneficial to describe how the individual's goals of care can change over time.
- Palliative care, the management of pain and symptoms (one of the reasons Mrs. Tu has come to your facility) is an important part of the care of every resident.
- You can state, "*we want to be sure you are comfortable and feeling as good as possible each day. Please tell us if you are having any discomfort or troublesome symptoms*."
- Explain that as people become more fragile or their illness progresses, the focus on palliative care and comfort measures may become more important than on-going intensive medical treatments.
- In the future, if Mrs. Tu were to change her goals for care, your facility will work with her and her doctor to meet her wishes. A POLST form can be revised, if Mrs. Tu wants to change her choices or if her physician wants to discuss the goals of care.

(see Cue Card: Facilitating Care Conferences & Family Meetings)
Facilitating a meeting is a learned process, which benefits your patients/residents and their family. Residents and families want to have timely, honest, understandable information. Good communication increases resident and family satisfaction and increases participation in decision-making. Good communication facilitates the grieving process.

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Facilitating Care Conferences & Family Meetings – Cue Card

Family meetings occur in the home, hospital and skilled nursing facility with patients and family members. The following steps help make care conferences and family meetings more meaningful:

- **Prepare for the meeting**:
  - Review the resident's history
    - If you are missing information or the resident/family has questions, write down questions for follow-up with resident's physician.
  - Does the resident have an AHCD?
  - Is he or she decisional? If not, who is the agent/decisionmaker?
  - Have the meeting in a comfortable room, with <u>no</u> distractions.
  - Consider meeting location to enable resident participation (at bedside?)

- **Introductions** – have everyone introduce themselves. Ask family members to state their relationship to the resident. Identify legal or family designated decisionmaker.
  - Build relationship by saying something like "*I know about Mrs. Tu's illness, but tell me something special about her*." (family & staff)

- **Review your plan/goals for meeting**. For example, to discuss goals of care and complete POLST. Ask if the resident or family has other issues they want to discuss during this meeting.
  - May need to identify a time frame and plan a follow-up meeting if needed.

- **Ask what the resident and/or family knows** about the resident's current medical condition? What have the doctors told them? How do they feel things are going? ASK THEM how things have been in the past three to six months – what changes have they noticed in the resident's physical condition and functioning? What do they want to know?

- **Present medical information clearly. Discuss the BIG PICTURE** with current condition. Speak slowly. No medical phrases or terms. Check for understanding. Do not minimize the problem. Well-intentioned efforts to "soften the blow" may lead to vagueness and confusion.
  - Identify current diagnosis and problems
  - What is the medical treatment plan, e.g.
    - resident is at facility for rehabilitation and plan is to go home,
    - versus a long-term resident who has just returned from acute hospitalization for new or worsening serious illness,
    - versus resident who is having on-going declining health or functional status.
    - Is treatment plan in accordance with patient's previously stated wishes/values?
  - Discuss POLST (use POLST Communication Script or Cue Card)

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- With a decisional resident and family members are present – the resident will make his or her own decisions. You can ask the family if they have questions or concerns, but the resident is the decisionmaker (see POLST Conversation Points). Ask, "how can you support your Mom's decision?"
- For the Non-decisional resident – Ask "what do you believe your Mom *(Dad)* would choose if she could speak for herself?" Another way to phrase this question is "if 10 years ago, your Mom knew what her life was like today or what her physical illnesses were today, what would she have wanted?" Although the agent/decisionmaker will make the decisions, you can ask the family members for their thoughts.
  - If the family cannot reach consensus, restate the goal of decision-making, "what would your Mom say to us if she knew her situation and could speak to us?"

- **Reactions & Questions**. Allow silence; give resident and family time to react. Acknowledge and validate reactions before further discussion. Invite questions.
  - If resident or family has questions about the treatment plan, or if they ask questions you cannot answer, it is important to write down these issues and **plan for the primary care doctor to talk with them**.
  - If the resident or family misunderstood something and you are comfortable clarifying the issue, you can respond. If you are uncomfortable or unsure, refer them to the physician.
  - Be prepared to respond to emotions. Have Kleenex available. Remind them their responses are normal.
  - Hope and Truth Telling: talk about how hope means different things as someone moves through the stages of illness. In serious illness or when close to death, hope focuses on short-term or spiritual goals – feeling valued, meaningful relationships, reminiscence, pain and symptom relief. Factors that decrease hope include feeling devalued, abandoned, isolated (instead of "there is nothing that can be done" explain all that we will do to take care of them and manage any pain and symptoms). **We will continue to provide excellent care.**

Conclusion – Review and summarize decisions and issues that need follow-up.

- If POLST is completed, obtain signature of resident or decisionmaker.
- Plan for the next step or next meeting. Reviewing goals of care and POLST are routinely done at quarterly care conferences.
- Follow-up on any identified issues and keep resident and/or family and doctor informed.

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