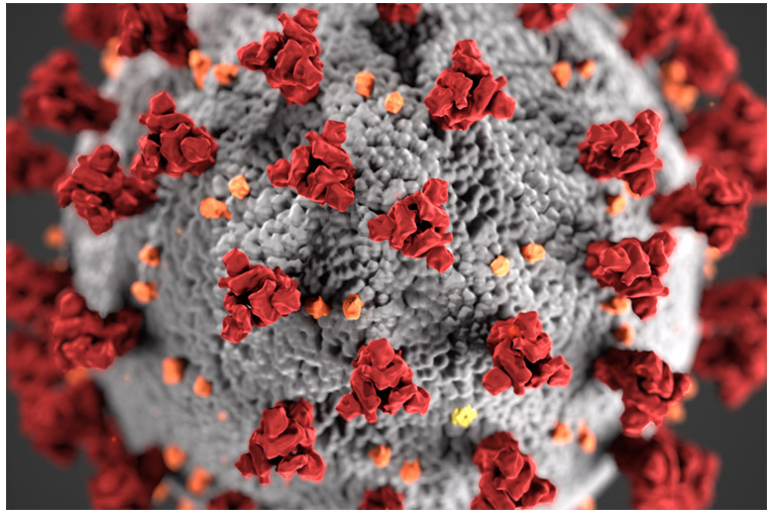
Advance Care Planning During a Crisis

Key Information for Nursing Facility Staff

COVID-19 – A Overview



- The COVID-19 virus is spreading in our communities.
- Nursing facility residents are at high risk of getting COVID-19 and needing treatment and support.
- Symptoms include fever, cough, shortness of breath, and fatigue.
- About 80% of residents with COVID-19 will get sick but survive.
- About 15-20% of residents with COVID-19 will get really sick and die.
- Residents who are the most frail and/or who have advanced chronic health conditions will have an even higher risk of death regardless of the type of treatment they receive.

Talking with residents and families about values, goals, and treatment preferences ahead of time is called advance care planning (ACP).

ACP is especially important during a crisis like COVID-19.

COVID-19 and Advance Care Planning

- The more severe complications of COVID-19 require urgent decision-making.
- Advance care planning conversations can prepare residents and families for these decisions.
- Proactively identifying and documenting resident/family preferences to *avoid* invasive life-prolonging treatment will help ensure treatments are provided only when aligned with resident wishes.

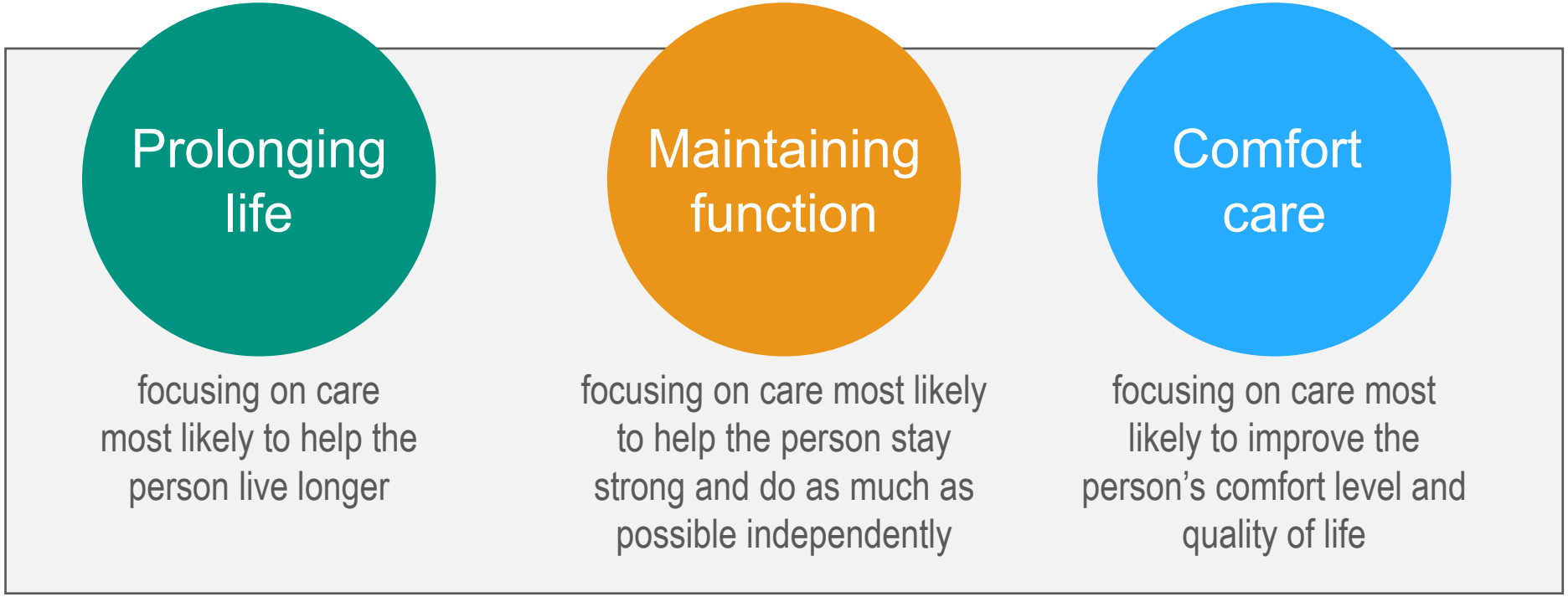
Talking about goals of care and treatment preferences is not always easy. It can be uncomfortable and stressful.

Residents and families may need help in identifying their goals. They may be afraid because of what they see in the news or because they are not allowed to see each other due to COVID-19 visitor restrictions. They may already have family or friends who are sick with the virus.

What can we say to residents and families?

- You know this virus is going around. Have you thought about what it means for you?
- What goal of care is most important to you now?
- Not many older people who are sick enough to need a ventilator to breathe will survive. If you get a bad case, would you want to go to the hospital and potentially be treated in an ICU on a ventilator?
- We will do our best to honor your preferences.

A framework for thinking about Goals of Care



Understanding which goal is most important to a resident and/or the family will help them make treatment decisions that reflect these goals.

Cardiopulmonary Resuscitation (CPR)

Involves firm chest compressions administered when a person's heart and breathing stop. The goal is to restart cardiopulmonary functioning. Medical orders written to reflect CPR preferences include Full Code (attempt resuscitation) and DNR (do not resuscitate).

CPR – Key Information

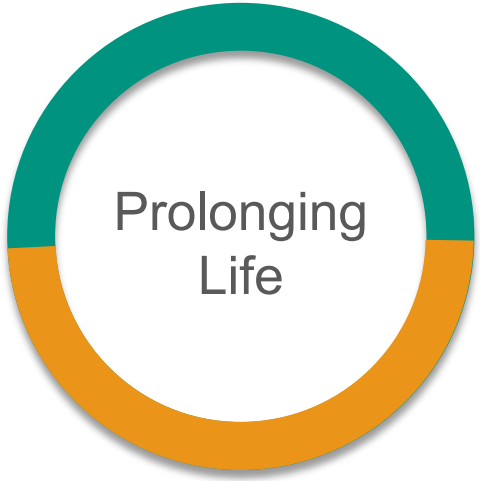
CPR survival rates are low in the nursing home. Overall, just 3 out of 100 residents (3%) will survive. CPR survival rates are believed to be lower for residents with COVID-19.

Risks of CPR include:

- brain damage,
- broken ribs, and/or
- organ damage.

Requires intubation and ventilator support.

Cardiopulmonary Resuscitation and Goals of Care



If the main goal is to prolong life, CPR can be attempted if a person's heart and breathing stops.

OR

If the main goal is to improve comfort or maintain function, resuscitation should not be attempted.

Resuscitation & COVID-19 Considerations

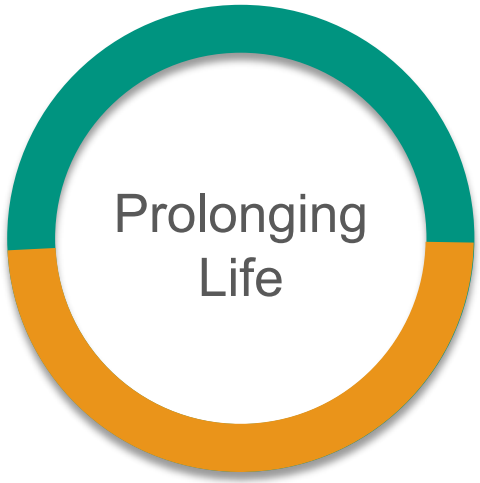
Attempt Resuscitation:

- We should assure residents and families we will do all we can to honor their preferences.
- There may be other factors outside our control such as hospital capacity or ventilator supply that may limit options in some circumstances.

Hospitalization

Hospital care for evaluation, stabilization of medical conditions, or treatment intended to prolong life.

Hospitalizations & Goals of Care



If the goal is to prolong life, the hospital may be the right place to get the treatments that are only offered in that setting.

If the goals are focused on maintaining function, hospitalization may be appropriate for selective treatments.

If the goals are focused on comfort care, hospitalization should be avoided unless intensive comfort interventions are needed that cannot be provided with available resources in place.

Hospitalizations & COVID-19 Considerations

Goal = Comfort Care

- For residents who prefer comfort care, transfer should be avoided if at all possible.
- Residents with possible or confirmed COVID-19 may be moved in order to isolate them from other residents.
- Reassure residents and families that there is a plan to treat residents in place for symptoms including cough, shortness of breath, and fever.

Hospitalizations & COVID-19 Considerations

Goal = Maintaining Function

- Residents who transfer to the hospital for any reason may not be able to return quickly due to the risk of exposing other residents to the virus.

Goal = Prolonging Life

- We should assure residents and families we will do all we can to honor their preferences.
- There may be other factors outside our control such as hospital capacity or ventilator supply that may limit options in some circumstances.

Documentation is important to help ensure the care team can access information about the resident's goals of care and treatment preferences.

If a resident transfers out and EMS or emergency department providers cannot find the resident's advance care planning documents, **the resident's preferences may not be honored.**

Advance Care Planning Documentation Tools

There are two kinds of advance care planning documentation tools:

Advance Directives

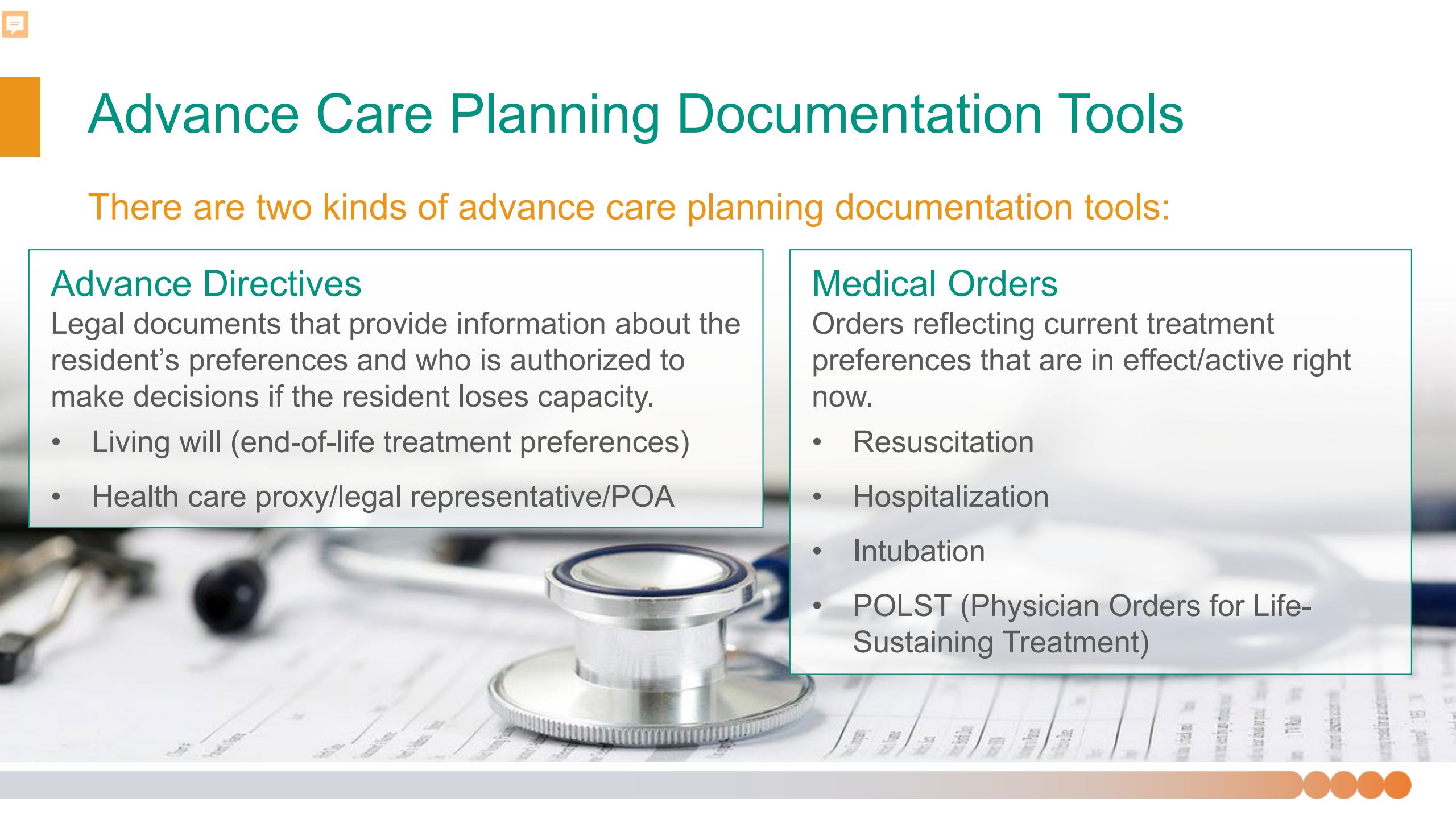
Legal documents that provide information about the resident's preferences and who is authorized to make decisions if the resident loses capacity.

- Living will (end-of-life treatment preferences)
- Health care proxy/legal representative/POA

Medical Orders

Orders reflecting current treatment preferences that are in effect/active right now.

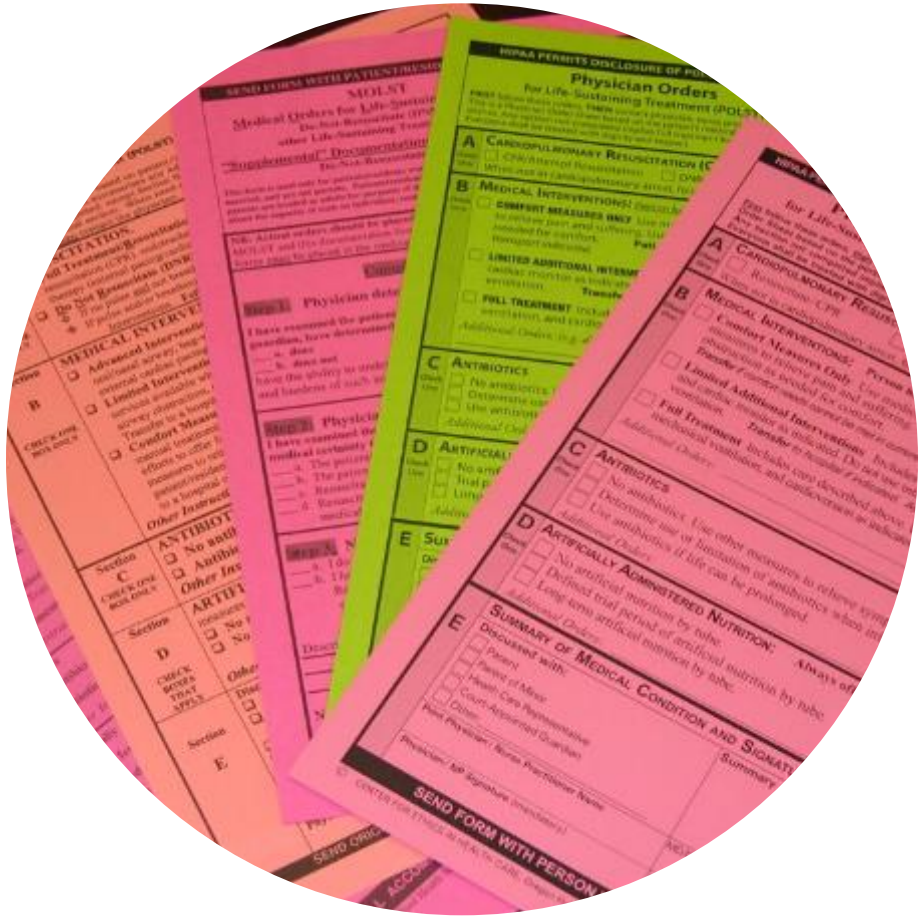
- Resuscitation
- Hospitalization
- Intubation
- POLST (Physician Orders for Life-Sustaining Treatment)



The POLST* Program

POLST is used to document treatment preferences as medical orders. Key features include:

- Records treatment preferences as actionable medical orders that EMS can follow
- Permits documentation of preferences to have or decline treatments
- Transfers across treatment settings with resident



*Name varies by state (e.g., POST, MOST, MOLST) but concepts are the same. See www.polst.org for more information.

COVID-19 and Advance Care Planning Documents

Sending advance care planning documents **with** residents needs to be a high priority when transferring to another facility or the hospital

- There is a heightened risk that resident preferences may not be known by other health care providers because of staffing changes and the need to move patients to different care settings.
- It is especially important to document and communicate if a resident has a preference to *avoid* treatment (e.g. intubation, ventilation, or ICU care). This increases the likelihood preferences will be honored in an emergency.
- Include the name and phone number of the resident's health care proxy/representative and family members.

CALMER Conversation Guide (adapted)

Check in

Take a deep breath (yourself!).
“How are you doing with all this?” (Take their emotional temperature.)

Ask about COVID

“What have you been thinking about COVID and your situation?” (e.g., living in a nursing home, your Mom living in a nursing home) (Just listen)

Lay out issues

“Here is something I want us to be prepared for.”

“You mentioned COVID. I agree.”

“Is there anything you want us to know if you/your loved one got COVID OR if your/your loved one’s COVID gets really bad?”

Motivate them to choose a proxy and talk about goals of care

“If things took a turn for the worse, what you say now can help your family / loved ones”

“Who is your backup person–who helps us make decisions if you can’t speak? Who else? (having 2 backup people is best)

“We’re in an extraordinary situation. Given that, what matters to you? (About any part of your life? About your health care?)

“What is your treatment goal? (explain goals of care: comfort care, maintaining function, prolonging life)

Expect emotion

Watch for this – acknowledge at any point
“This can be hard to think about.”

Record the discussion in the medical record.

Use POLST if available and appropriate.

Any documentation – even brief — will help other health care providers and your resident.
“I’ll write what you said in the chart. It’s really helpful, thank you.”

VITAL talk

Summary

1) ACP is essential for person-centered care in the best of times. It is critical now as we face unprecedented challenges because of COVID-19;

2) Identifying overall goals for care can help guide resident and family decision making about treatments including CPR and hospitalization;

3) Record preferences using ACP documentation tools and send this information with residents upon transfer or the information may be lost; and

4) Have a guide in front of you when you have these conversations.

Brought to you by

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