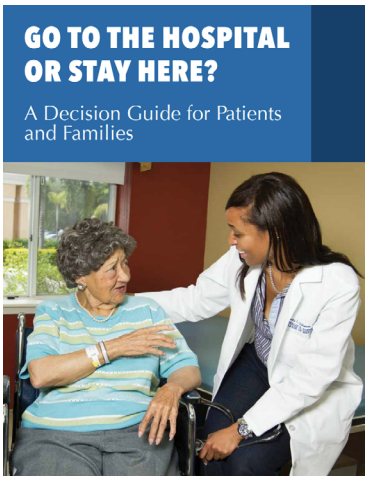
Week 9: Purposeful Conversations

Monday

Having purposeful conversations with residents and family members is a best practice and can strengthen admission and care planning processes, increase resident and family participation in care, and reduce avoidable transfers back to the hospital.

Purposeful conversation refers to intentional and meaningful communication that serves specific objectives or goals. It goes beyond casual chitchat and aims to achieve specific outcomes.

Print and discuss with the team the following resource, Go to the Hospital or Stay Here. Social services staff or nurses can use this decision guide to facilitate clear and informative conversations of a resident's choice to "Go to the Hospital or Stay Here."

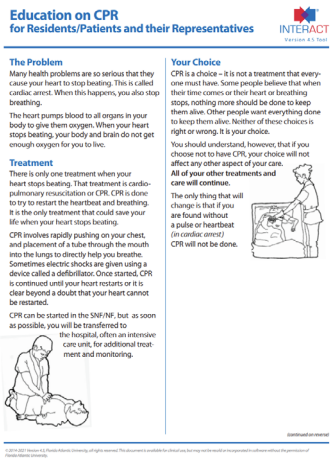


Tuesday

End of Life Purposeful Conversations – What are the Residents Wishes?

Do all of your residents have a documented advanced directive? **Review which residents are a full code, and which are a Do Not Resuscitate (DNR). Discuss how staff know which residents are DNR and what the current process is to communicate this to all staff.**

Print and discuss Education on CPR for Residents/ Patients and their Representatives **with the clinical team to guide conversations when providing education for residents and their family.**


Education on CPR for Residents/Patients and their Representatives

INTERACT Version 4.5 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 is continued until your heart restarts or it is clear beyond a doubt that your heart cannot be restarted.

CPR can be started in the SNF/NF, but as soon as possible, you will be transferred to the hospital, often an intensive care unit, for additional treatment and monitoring.

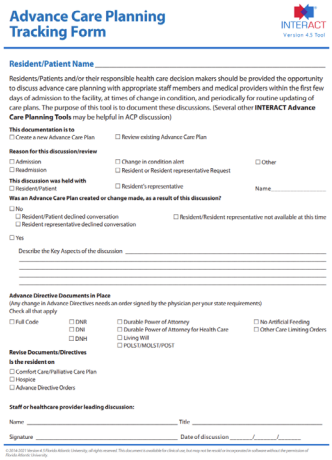
Your Choice

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.

(continued on reverse)


Advance Care Planning Tracking Form

INTERACT Version 4.3 Tool

Resident/Patient Name _____

Residents/Patients 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 tool is to document these discussions. (Several other **INTERACT Advance Care Planning Tools** may be helpful in ACP discussion)

This documentation is to
☐ Create a new Advance Care Plan ☐ Review existing Advance Care Plan

Reason for this discussion/review
☐ Admission ☐ Change in condition alert ☐ Other
☐ Readmission ☐ Resident or Resident representative Request

This discussion was held with
☐ Resident/Patient ☐ Resident's representative Name _____

Was an Advance Care Plan created or change made, as a result of this discussion?
☐ No
☐ Resident/Patient declined conversation ☐ Resident/Resident representative not available at this time
☐ Resident representative declined conversation
☐ Yes

Describe the Key Aspects of the discussion _____

Advance Directive Documents in Place
(Any change in Advance Directives needs an order signed by the physician per your state requirements)
Check all that apply
☐ Full Code ☐ DNR ☐ DNI ☐ DNH ☐ Durable Power of Attorney ☐ Durable Power of Attorney for Health Care ☐ Living Will ☐ POLST/MOLST/POST ☐ No Artificial Feeding ☐ Other Care Limiting Orders

Revise Documents/Directives
Is the resident on
☐ Comfort Care/Palliative Care Plan
☐ Hospice
☐ Advance Directive Orders

Staff or healthcare provider leading discussion:

Name: _____ Title: _____

Signature _____ Date of discussion ____/____/____

Advanced directives should be reviewed upon admission, quarterly, and if a change in condition would warrant it. Use this Advance Care Planning Tracking Form **to assist with tracking these reviews.**

Wednesday

It is often helpful to involve the physician or healthcare provider, in addition to the resident and their family in purposeful conversations during care plan meetings.

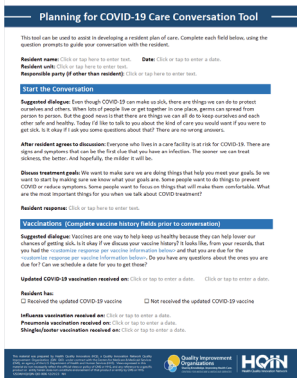
You may want to have an ad hoc care plan meeting if a decline in condition is noted. **Discuss with the team the importance of being proactive with change in condition.** Consider inviting the physician or nurse practitioner to participate in a care plan meeting to participate in difficult conversations.

Print and discuss A Patient's Guide to Serious Illness Conversations **from the Institute for Healthcare Improvement to guide these conversations.**

Thursday

Advanced care planning for vaccinations is a best practice. The Planning for COVID-19 Care Conversation Tool can assist with having purposeful conversations centered around vaccinations upon admission and at quarterly care plan meetings.

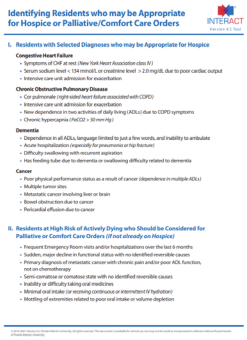
Print and share the same resource with the admissions and clinical care plan team and discuss how it can be incorporated into current practice.



Friday

Disease process education for residents and families is important. It may be appropriate to conduct purposeful conversations regarding palliative care and/or hospice care during these conversations.

Print and share Identifying Residents Who May be Appropriate for Hospice or Palliative/ Comfort Care Orders **to identify residents who may be appropriate for this type of care.**



Also, print and share Myths about Palliative and Hospice Care Infographic **with your social service and clinical team to guide conversations regarding certain myths about palliative care and hospice.**