

## Leveraging Patient Cues in End-of-Life

How could we help nursing homes recognize opportunities to revisit goals and Advance Health Care Directives? What are the cues?

Aside from the true emergencies that warrant an urgent return to acute care, most patients will give the care team cues of some sort that indicate that it's time to revisit the goals and care and the subsequent care plan.

1. Patients may communicate that they no longer find life worth living. Some patients may say so in as many words, others may use language that is less direct, e.g. "I don't enjoy anything these days" or repeated refusals to do things that once brought some enjoyment, e.g. eating, watching TV in the day room, etc. Family members may say such things on their behalf, e.g. "My mom just wishes this were over," or "I just wish I could find something that makes her smile." When patients are using these cues, it is important to rule out depression. In the nursing home setting, where multiple permanent disabilities and a poor prognosis for improvement are the rule, such cues are powerful indicators that a patient will probably not appreciate the burdens and intent of "usual" medical care which is designed to keep them alive longer.
  
2. Frail patients will get sick again. A recurrent UTI, pneumonia, trip to the ER or hospital are inevitable for the vast majority of nursing home patients. Most of the time a new illness comes in the setting of waning quality of life; and "usual care" will be rendered, which may in fact not be what the patient really wants. Many patients are "robbed" of the opportunity of a comfortable release from an intolerable life by antibiotics and IV fluids.
  
3. All nursing home patients will decline over time, sometimes in rapid or dramatic fashion, sometimes subtly. Functional declines usually correlate with poorer quality of life and an attendant wish to limit the burdens of life, among which "usual care"—pills, lab tests, various treatments, and ambulance rides to the ER—is a major contributor.

Nursing home staff have strategic opportunities to show great respect to the patient's condition and values by recognizing these cues and taking some very simple actions.

### **Cue: "Life is not worth living."**

<b>Who notices</b>	<b>Response 1</b>	<b>Response 2</b>	<b>Response 3</b>	<b>Response 4</b>
Aide/Therapist	Tell RN	Ask: "Tell me more"	Ask: "What would help?"	Don't give advice
RN	Ask: "Tell me more"	Ask: "What would help?"	Tell MD, DON, Social Services, Chaplain, family	Review AD and care plan with patient & family
MD/NP	Ask: "Tell me more"	Ask: "What would help?"	Tell MD, DON, Social Services, Chaplain, family	Revisit AD and care plan, align with goals

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### Cue: Recurring Illnesses

Who notices	Response 1	Response 2	Response 3	Response 4
Aide/Therapist	Tell RN			
RN	Tell MD, family	Ask pt/family “do you want us to do what we usually do (tests, return to hospital, etc) or would you like to talk about other options?”	Ask about recent quality of life, share prognosis, ask about goals.	Describe a “comfort care” plan, emphasizing all we can do to address dignity and comfort
MD/NP	Ask pt/family “do you want us to do what we usually do (tests, return to hospital, etc) or would you like to talk about other options?”	Ask about recent quality of life, share prognosis, ask about goals.	Describe a “comfort care” plan, emphasizing all we can do to address dignity and comfort	

### Cue: Steady Decline

Who notices	Response 1	Response 2	Response 3	Response 4
Aide/Therapist	Tell RN			
RN	Ask MD to clarify prognosis	Make goals of care the focus for the next interdisciplinary & family meeting	Review POLST in light of goals	Describe a “comfort care” plan, emphasizing all we can do to address dignity and comfort
MD/NP	Make goals of care the focus for the next conversation with patient & family	Review POLST in light of goals	Describe a “comfort care” plan, emphasizing all we can do to address dignity and comfort	