Partnering to Change the Culture of Palliative Care in Long Term Care

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Avera Nursing Conference
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Objectives

1. Discuss the formation of the partnership between ASL Palliative Care Program and the Four Nursing Homes in Aberdeen.

2. Describe the process for the delivery of Palliative Care in the Nursing Home, the roles of the PC staff and the roles of the nursing home staff.

3. Describe the outcomes for Palliative Care in the Nursing Home.

4. Identify future opportunities for Palliative Care in the Nursing Homes.
Starting the Journey of Palliative Care for Avera St. Luke’s
April 2006

160 patients the first year

315 FY 2012

Transition from Hospital to SNF
Statewide collaboration

Vision - serve as Dynamic Link among those promoting education, research, and provision of quality patient care at End of Life (EOL)
“South Dakota’s Dying to Know” Research

- Explore EOL experiences in SD who experienced the death of a loved one
- Bethesda & Mother Joseph Manor/Hospice attend - mtg - form Aberdeen Collaboration
Purpose:

The purpose of the project is for Avera St. Luke’s Palliative Care program to partner with nursing homes to enhance present care processes for persons with services and/or life threatening illness and their families.
Consultations

- September 2005 to July 2008
  - 124 consults
  - 665+ resident/family visits and/or chart reviews
  - 749 total PC staff hours
Evolution of Present Structure

- Partnered with 3 Aberdeen Nursing Homes to enhance provision of PC thru
  - Education
  - Community Development
  - Consultation
  - Program Development
Gaining acceptance and changing culture

“We all live in our own Worlds”

Takes time to change culture from a we/they to an US ~ with true partnership
Multiple Approach

- Inservices - 101 on Palliative Care
- Next year 2-hr inservice
- 1 on 1 education
- Advanced Directive Inservice
Community Development

- Community Forums - “Making Choices Along Life’s way”
- Community Forums on Advanced Care Planning
- “Let’s talk Turkey” Campaign
- Community Grief Sessions x3 yearly
Consultation - Strong part of Partnership

- Assist Nursing Home in ID residents appropriate Palliative Care
- Utilization of Palliative assessment tools
- Resolving complex care problems
- Integrating PC into culture of Nursing Home care
Program Development

- Goals of care
- Advance care planning
- Symptom control
- Education
- Assist dying process
Chronic illnes

Symptoms management

Serious life-limiting illness

Debility/decline symptoms

Goals of Care to be addressed
Referrals

- *Nursing Home staff*
- *Hospital discharges*
- *Family*
- *Need physician order*
Roles of Palliative Program

- Resource for symptom management
- Determine goals of care
- Assessment
- Emotional support
- Care conferences
Care Planning Process

- Symptom managements
- Treatment options
- Recommendation to Medical Doctor
Goals of Care

- Resident
- Family
- Care Conferences
- Staff
End of life planning

- Hospice
- No further hospitalization
- No further treatment/diagnostics
Communication

- Purple information sheet
- Differ from Hospice
- Brochure
Future Opportunities

- Satisfaction surveys
- Bereavement process
- Earlier referrals to Hospice
- Telemedicine
- Transition from care points
Outcomes...

- Resident
  - Symptom management
  - Resident autonomy
  - Outside pair of eyes
  - Update to loved ones
  - Resident advocate
The Palliative Care Program has given residents and their families the opportunity to receive valuable information and education about choices with their health condition/status. In today’s complex medical care a resident/family can feel overwhelmed by their condition and the options available to them. The Palliative Care Nurse often assists the resident/family over a “hump” with their medical status in providing education to them.

The facility sees the Palliative Care Nurse as a “new set of eyes” to assist with resident, family and facility staff in managing the resident’s care. This often prevents unnecessary hospitalizations for the resident.

Julie Schmidt, SW
Bethesda Home
SNF Staff

Palliative Care is a great resource for patients and family struggling to navigate complicated medical situations. Palliative Care staff are wonderful at explaining treatment options and possible outcomes in terms that people without medical backgrounds can easily understand. It’s such a huge help in guiding patients and families through decision making when someone is facing a serious health problem.

Josh Rhoden, SSD
Aberdeen Health and Rehab
### Hospice Referrals

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Outcomes...

- **Decreasing Hospital Transfers**
  - Inpatient Palliative Care Consult
  - Resident/Family Care Conferences
    - Part of Grant was Education on Care Conference
    - Palliative Nurse Participates
    - SNF culture
  - “Bridges the Gap” for those Hospice appropriate but MCR skilled
Joy of Palliative Care at Nursing Homes

RESIDENT STORIES


“Butterflies are Free - One Nursing Home’s end-of-life program.” by the Staff Associates at Life Care Center of Sarasota, Sarasota, Florida

Center to Advance Palliative Care [www.capc.org](http://www.capc.org)


[www.usd.edu/lifecircle.sd](http://www.usd.edu/lifecircle.sd)