LLDH Home

Quality Improvement Collaborative

QI Outcomes Congress Presentation, October 2019

About us . . .

The mission of the Lisner-Louise-Dickson-Hurt Home is to provide extraordinary health and life care services to low and modest income seniors of the District of Columbia, empowering them to live their lives to the fullest. The Home is recognized as a tax exempt public charity under section 501(c)(3) of the Internal Revenue Code.

The Lisner-Louise-Dickson-Hurt Home family is committed to seeing the truth and beauty of growing older. The Home cares for the whole person, always remembering that ours is not a relationship of a moment but, rather, a relationship built upon a history of living life to the fullest. Time and age need not be a gift of the past but a promise of a full and well-spent future.

The Home is pleased to celebrate 80 years of serving elders through the Abraham and Laura Lisner Trust.

About us . . .

The Home provides a wide spectrum of health and life care services to its residents all in a home like environment. The Home has the capacity to serve 60 residents with skilled services including skilled nursing care, skilled rehabilitation therapy, wound care, psychosocial and family support, community activities, and the day to day assistance required to live life to the fullest.

While the Home also operates an assisted living facility (ALR) and community residential facility (CRF), the skilled nursing unit is the heart of the Home's operation housing the most residents, complying with the most stringent regulatory requirements and generating operating income via Medicare and/or Medicaid reimbursements.

Approach to quality …

At the Home, quality improvement activities emerge from a systematic and organized framework for improvement utilized throughout the facility. Key to results is the continuous education and involvement of staff at all levels and the belief that small incremental changes do make an impact.

The Lisner Home's approach to quality improvement is based on the following principles:

- ✓ Customer Focus
- ✓ Employee Empowerment
- ✓ Strong Leadership
- ✓ Expanding Choice
- ✓ Data Informed
- ✓ Prevention Over Correction

Our quality story . . .

In January 2018, the End-Of-Life (EOL) Program team was formed to develop and implement a formalized system to support the needs of residents, families (or Responsible Parties), and staff in preparation for and following a resident's death.

The initial aim of this project included:

- ✓ Capturing resident individual preferences, spiritual needs, wishes and expectations around end-of-life in a clear and accessible format.
- ✓ Developing a way to honor those that have died while informing and supporting the living after this death.
- ✓ Transitioning policy and translating preferences/needs into an End of Life Narrative

Team members . . .

Seniors Leaders and Clinical Champions included:

- ✓ Administrator
- ✓ Director of Social Services
- ✓ Director of Nursing

System Leaders and Day-To-Day Leaders included:

- ✓ Long-Term-Care Social Workers
- ✓ Director of Admissions

Other Team Members included:

- ✓ Residents and Family Members
- ✓ Care Plan Team
- ✓ Human Resources
- ✓ Chaplain
- ✓ Physicians
- ✓ Hospice Provider

Scope and Focus . . .

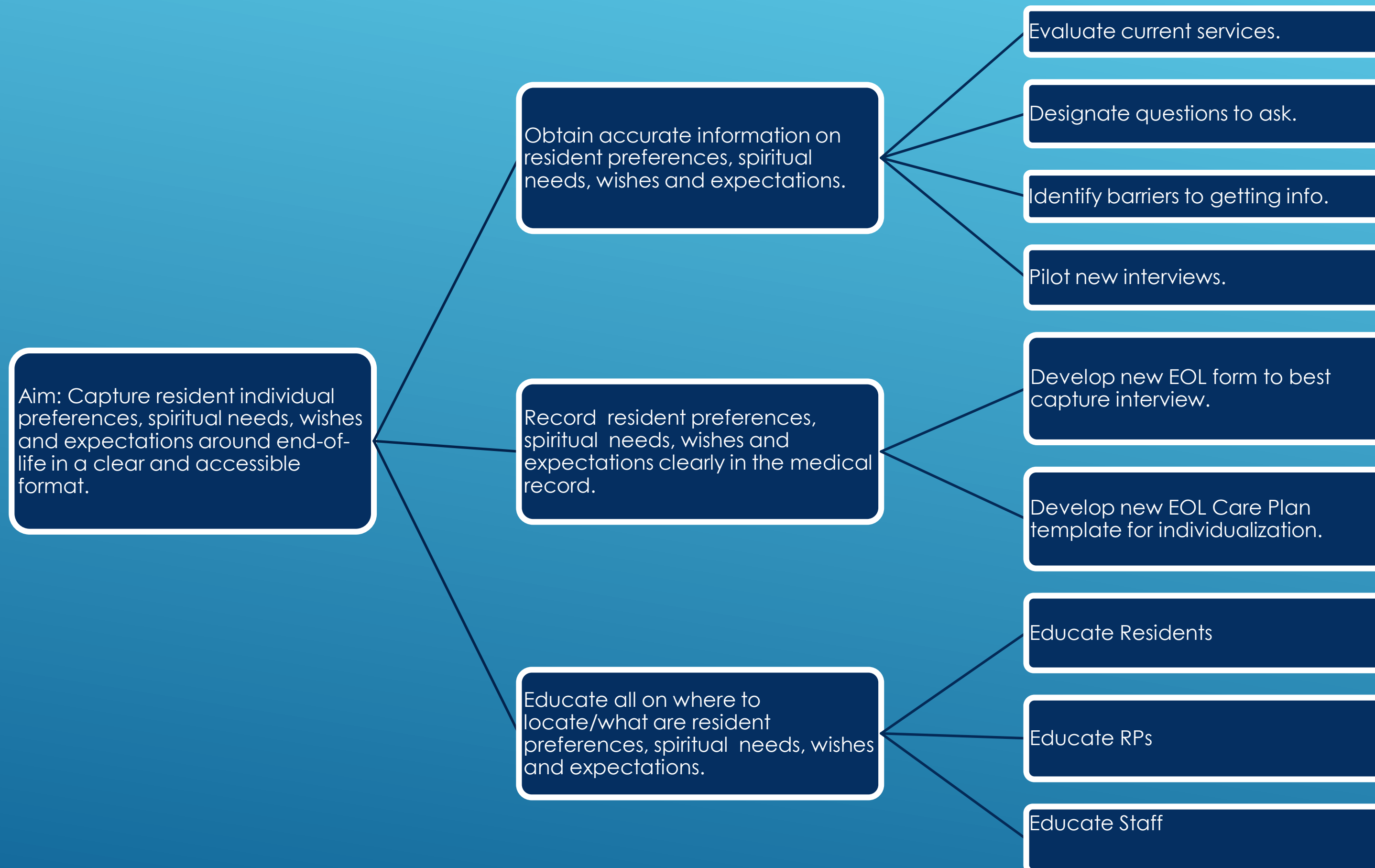
The project scope included:

- ✓ The creation of a narrative to explain the EOL planning process
- ✓ The introduction of the program to residents and families
- ✓ The development and placement of updated EOL preferences in the medical record
- ✓ The training of all staff on the End of Life Program

The project focus would include:

- ✓ All residents and their families or responsible parties
- ✓ All staff

END OF LIFE PROGRAM …
DRIVING TOWARDS A SUCCESSFUL OUTCOME.



Time Frame . . . 2018

Due Date	Monthly Agenda/Task
March 2018	Evaluate current services, write narrative, design initial EOL form. Update care plans to reflect current Advanced Directives/EOL preferences and services (April – June).
April 2018	Pilot new form. Meet with Family Councils to introduce program and solicit feedback.
May 2018	Meet with Resident Council to introduce program Train staff on aims of program and EOL services
June 2018	Evaluate effectiveness of narrative, form and make edits as required.** Notify all residents and responsible parties of finalized form and narrative.
July – October	Use updated form during each MDS and update care plan for individualized wishes
December	Audit charts for effectiveness and consider changes to narrative, form and process.

** DHCF Onsite Review June 27, 2018

Pre-measures . . .

In January 2018, Social Services conducted a chart audit to note the following:

EOL Component	Measurement	Goal for Change
Code Status	56/56 charts had codes status orders	Add to EOL Care Plan and individualized EOL Form
Funeral Home	36/56 residents had pre-arranged funeral	Add to EOL Care Plan and individualized EOL Form
Advanced Directive	14 /56 residents had no AD 8/56 residents had Guardians and lacked competency to make AD 34/56 residents had AD	Add to EOL Care Plan and individualized EOL Form
EOL Individualized Preferences	EOL Care Plan was general and new EOL Form was not in place	Add to EOL Care Plan and individualized EOL Form

END OF LIFE PROGRAM …
Identifying individual decisions.

Advanced Directives/End of Life Planning

Resident Name:	Medical Record Number:
Responsible Party:	Attending Physician:

Advance Directives are documents outlining a resident's end-of-life wishes to be used in the event that he/she is unable to speak those wishes directly. Residents of the LLDH Home have the right to formulate an advance directive and for that right to be carried out. Staff are available to provide more information or assist you in formulating an advance directive.

Advance Directives

(1) Do you have a Living Will, Healthcare and/or Financial Power of Attorney?

_____ No _____ Yes, who have you appointed?

_____ POA for Healthcare _____ Living Will _____ Financial POA

Were copies provided to the facility? _____ No _____ Yes

(2) If not, have you discussed end-of-life decisions with a family member or friend?
_____ No _____ Yes, with whom and what have you discussed?

Advanced Directives help a resident to also express wishes and preferences about end-of-life care. In the box below, please take a moment to express any wishes or preferences the resident wishes staff to know during this time.

Wishes and Preferences

(1) It is my wish …

(2) It is my wish …

(3) It is my wish …

(4) It is my wish …

1

In the box below, please take a moment to express any spiritual needs you would want met at end of life (ie *Blessing of the Sick*, pastoral visit, funeral service planning).

Spiritual Needs

Code Status

Residents with or without an Advanced Directive have the right to designate Full Code and Do Not Resuscitate (DNR). Below, please designate one or the other:

____ Full Code: Yes, attempt CPR and advanced cardiac life support

____ DNR: No, do not attempt CPR or advanced cardiac life support

Funeral Home

The LLDH Home is not responsible for funeral costs and burial at the time of death. In the event of death, the LLDH Home must release a resident's remains within 3 hours to either a funeral home* of choice or the DC Medical Examiner's office. Should the staff be unable to contact a representative within the designated timeframe, the release of remains is hereby authorized. Please indicate the preferred funeral home below:

Name of Funeral Home, Address, Phone Number

*A list of funeral homes can be obtained from the Social Work staff.

Additional Information:

I have met with staff of the LLDH Home to review this form and complete my End-of-Life Plan. I understand that I may amend this form at any time. I will be offered additional support on request or periodically throughout my stay.

Resident/Responsible Party **Date**

LLDH Staff Member **Date**

2

END OF LIFE PROGRAM …
Capturing the individual in the CP Process

CARE PLAN EXAMPLE:

Resident and RP have compiled a list of people RP will call upon resident's death. RP to be notified and will notify others.
Resident will have Physician Orders that reflect end of life wishes to include DNR, DNI, DNH where requested. Resident and RP wish for resident to remain FULL CODE and to be hospitalized as needed.
Resident will have spiritual support during end of life planning or at end of life as requested. Resident identifies as Romanian Orthodox Christian. She requests pastoral visits from Romanian Orthodox Priest Cosmin Antonescu (503)756-7219.
Resident will select a funeral home and create a funeral plan. Resident and RP have been provided information and resources on funeral homes and DC government burial assistance. Family has inquired with Hysongs but has not made prepaid arrangements.

CARE PLAN EXAMPLE:

Resident will be offered the opportunity to express individualized preferences concerning his/her end of life wishes. RESIDENT STATES NO BLOOD TRANSFUSION DUE TO RELIGIOUS BELIEFS.
Resident will have Physician Orders that reflect end of life wishes to include DNR, DNI, DNH where requested. Resident elects for FULL CODE at this time.
Resident will have spiritual support during end of life planning or at end of life as requested. Resident identifies as Jehovah's Witness. (202) 723-7666

CARE PLAN EXAMPLE:

Resident will be offered the opportunity to express individualized preferences concerning his/her end of life wishes. Resident wishes to donate his body to science through Georgetown Anatomical Donor Program.
Resident will have Physician Orders that reflect end of life wishes to include DNR as requested.
Resident will have spiritual support during end of life planning or at end of life as requested. Resident states he is not a spiritual person and has no preferences/requests at this time.
Resident does not wish to have a funeral. Resident wishes to donate his body to science through Georgetown Anatomical Donor Program. RP/resident also encouraged to identify a funeral home of choice in the event that donor program is unable to collect body at time of death.
Resident's end of life plan will be updated as resident's condition changes.
Resident/RP will be educated on facility process for removal or remains and may be transferred to DC Morgue if Georgetown Anatomical Donor Program is unable to collect body and no funeral home choice is made in advance.

Post-measures . . .

In December 2018, Social Services conducted a chart audit to note the following:

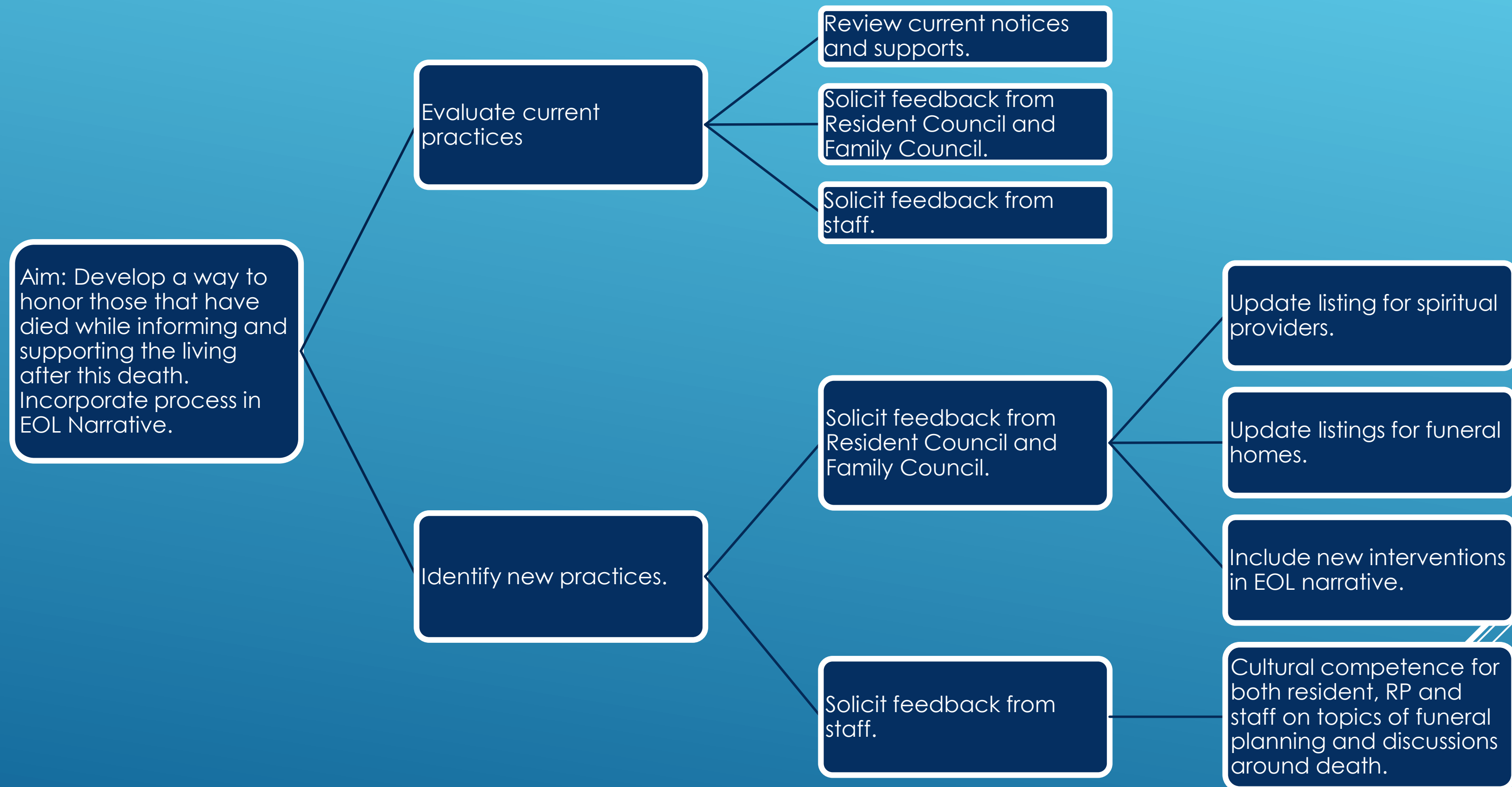
EOL Component	Pre-Measurement	Post-Mesurement
Code Status	56/56 charts had codes status orders	50/50 charts had code status noted on EOL form and CP
Funeral Home	36/56 residents had pre-arranged funeral	41/50 residents had pre-arrangements on EOL form and CP
Advanced Directive	14 /56 residents had no AD 8/56 residents had Guardians and lacked competency to make AD 34/56 residents had AD	38/50 residents had Advanced Directives on the EOL form and CP 12 residents had a reason why AD was not completed on EOL form and CP
EOL Individualized Preferences	EOL Care Plan was general and new EOL Form was not in place	50/50 residents had completed the EOL form and CP

Additional outcomes . . .

- Policy and Procedures were translated into an End of Life Narrative to be submitted to DHCF
- All staff were trained on EOL Planning in a series of education seminars in April/May
- Mailings were sent to all residents and responsible parties to educate and encourage completion of an EOL plan
- An “Advanced Directives Day” was hosted in April, 2018 at which time 4 residents completed an Advanced Directive and the EOL was updated

END OF LIFE PROGRAM …

DRIVING TOWARDS A SUCCESSFUL OUTCOME.



Barriers and re-designs . . .

The Team noted several barriers during the EOL Program implementation and have determined to bring these back to the drawing board for further quality improvement in 2019.

- Residents who lacked competency or cognition to complete advanced directives or state preferences
- Short-term residents who did not wish to make End of Life plans due to the nature of their stay
- Cultural Competence and Funeral Planning
- Resources and Funeral Planning

Time Frame . . . 2019

Due Date	Monthly Agenda/Task
January 2019	Evaluate and maintain success of 2018 into 2019 Clarification with DC Ombudsman and Guardianship program about completion of Advanced Directives after appointment of Guardian.
April 2019	Provide annual in-services to all staff. Update EOL program for staff in regards to cultural competence. Host Family Council on End of Life Planning and Advanced Directives. Translate EOL form to MOST or other transfer document.
June 2019	DHCF visit and outcomes reviewed.
July – October 2019	Increase funeral home planning/pre-paid contracting by long-term residents. Update funeral contacts and distribute. Survey short-term/short-stay residents on use of form.
December 2019	Re-evaluate outcomes and consider future goals.