Family Members and Coordination of Care Plan Meetings

Presented by
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Nursing Home Social Work Network
Webinar Series

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Elise Beaulieu, MSW, LICSW, ACSW is currently a PhD Candidate at Simmons College. Her undergraduate work was at Suffolk University with a Master's in Social Work from Boston College.

She has over 25 years of clinical social work practice experience with older adults and those with disabilities in nursing homes, housing, rest homes, and visiting nurses. In addition, she has taught full-time and lectured at a number of Massachusetts's colleges and universities.

She currently serves as the Chair of the Nursing Home Shared Interest Group for Massachusetts Chapter.

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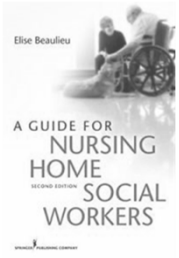
Elise Beaulieu's book (2nd edition)



She is the author of a number of published articles and *A Guide for Nursing Home Social Workers*, 2nd Ed. Springer Publishing Company 2012

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Deb Beringer LBSW, Director of Social Services

Education:

- BA Degree in Recreation Education with Therapeutic Emphasis University of Iowa
- **BS in Social Work** from the University of Northern Iowa

Employment:

- Home Day Care: 1982 -1991
- 1991 to present – Director of Social Services in a retirement center/nursing home in Iowa.

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Objectives

At the end of this seminar participants will:

1. Understand the background of NH Family Meetings
2. Identify a family systems theory approach to understanding families
3. Cite specific Federal Regulations for care plan meetings
4. Understand the best practice & realities for care plan meetings
5. Understand a sample of care plan documentation
6. Define Special Care Plan Meetings
7. Experienced critical thinking regarding a case vignette

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Family Meetings in the NF

Drivers:

- Leadership
- Purpose of the meeting
  - Care planning
  - Specialized
- Attendees
  - Family representation, resident representation, attending staff
- Expectations and goals
  - Information provision, e.g. care being given, conflict resolution, discharge planning

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Systems theory approach to understanding families

- Residents & families roles past/present
- Cultural differences
- Impact of change, e.g. admission to a nursing facility
- Healthy and not so healthy responses

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Bowen Family Systems Theory

Interaction and relationships of family members

Eight Components:

1. Levels of differentiation of self
2. The nuclear family
3. Family projection process
4. Multigenerational transmission
5. Sibling position
6. Triangles
7. Emotional cut off
8. Societal emotional process

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Facility Staff

- Role with the family
  - Consistent
  - One voice
  - Pro-active instead of reactive
- Communication (telephone, email, person to person, mail)
  - Type of interaction
    - Frequent, detailed
    - Crisis only

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Federal Regulations for care plan meetings

- 483.20 Resident Assessment
- Comprehensive assessment of all residents with the Resident Assessment Instrument (RAI)
- MDS 3.0 gives the dates for the assessments 14, 30, 60 and then 90 days
  - Significant change in status
- Federal regulations: Resident has the right to attend care planning

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Meetings: Best Practice & Realities

Best Practice:

Care plan meetings correspond to MDS
Formal invitations are sent
All participants are included: (resident, family, staff, ancillary staff, etc.).
Care plan is resident-focused and in lay language

Realities:

Meetings are irregularly scheduled
Invitations are irregularly sent out
Staff and/or families rarely attend
Meetings are completed remotely

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Documentation

- **Purpose of documentation**
  - Provide a record of what has been discussed
  - Share pertinent information with those who have not attended
  - Provide goals for future follow-up
- **Recording the meeting**
  - At the time of the meeting
  - Following the meeting

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Sample Note:

Dalton Family Meeting

Date: 11/12/13

Present:

Sandy Dalton (resident), Mary Dalton (sister), Penelope Sanderson (sister), Jamie Curtis, RN, Helen Regan, Dietician, George Wilson, PT, Bronwyn Gray, Activities Director, Susan Atler, SW

Discussion: Resident has concerns about her diet at the facility. She has expressed a wish to return to her apartment with services and the help of her family.

Staff currently provide Ms. Dalton (resident) with assistance for all her ADL's, bathing, dressing, and supervise her transfers from the bed to chair. PT is working with Ms. Dalton (resident) to improve her strength and endurance. OT is working with Ms. Dalton (resident) to improve her self-care functional abilities. Rehab anticipates that they will reach their goals by 11/30/13.

The diet was discussed. The resident is currently on a low salt, diabetic diet. She expressed that she didn't like the choices and that her food was cold, and the ice cream was melted. Ms. Regan said that she would meet with Ms. Dalton (resident) after the meeting to address preferences and to follow-up about the food temperature.

Discharge plan was discussed. The resident's family said that they were limited in their ability to help once she was discharged. Ms. Mary Dalton works full-time and Ms. Sanderson is caring for her mother-in-law. PT feels that Ms. Dalton will be independent for most of her care needs once therapy is completed. The resident stated that she was uncomfortable being at home alone at night and wanted to have someone nearby.

Home care services preferences discussed: Golden Home Care VNA, Wayside Senior Services for homemaker, volunteer visiting, and meals on wheels, additional night private services from Quality Care Inc., and Life line for an emergency call system.

Tasks:

- Nursing to encourage resident greater independence around self-care, safety, and cooperation with overall plan of care. Nursing to discuss discharge with attending MD and have encounter form signed for VNA.
- Dietary to address resident food preferences, food temperature (11/12/13).
- PT/OT work on current goals with discharge anticipated for 11/30/13.
- Walker to be delivered to Ms. Dalton's home at discharge, PT to call equipment company.
- Mary Dalton to look into life line and discuss services and costs from Quality Care Inc. She will let social service know decisions about these services.
- Social worker to contact VNA, Wayside Sr. Services for anticipated discharge date and coordinate with staff to ensure all paperwork is complete and faxed.
- Mrs. Sanderson to transport resident home day of discharge.

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Special Meetings

Meetings held outside the scheduled care planning meetings:

Change in resident status
- decline in health, discussion of hospice
- improvement in resident status

Discharge planning meetings
- Behavioral problems
- Advance Directives
- Financial changes

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Helpful Meeting Strategies

Team Planning:
- Determine meeting leader
- Clearly outline problems, solutions, interventions
- Identify who will be present at the meeting
- Identify who will carry out interventions
- Identify how interventions will be monitored
- Identify a time-frame

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Family Members and Coordination of Care Plan Meetings

A Case Study of a Care Plan Conference

By Deb Beringer, LBSW

Key Elements

Family aware of resident's cognition and wishes:
- Intermittent ability to make appropriate decisions
- Inclusion in the plan her plan of care
- Demonstrated great distress about going to wound clinic
- Refusal of wound clinic care

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Conflicts

- Wound clinic treatment continuation at recommendation of the staff
- Concerns about quality of life
- Decisions about treatment continuation and referral to hospice

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Education & Clarification

- Nursing intervention:
  - Recommendation of dual care: Hospice and Wound Clinic
  - Discussion with resident/family about pain and care issues
  - Nursing concern about ceasing treatment to cause increased pain and distress that would be preventable
- Social work intervention:
  - Validation of difficult decision making, encouragement of right to make decisions
- Family understanding:
  - Care should be based on an ongoing evaluation and change when necessary

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Family Perspective

Problem from family's perspective:

- Loss over loved one's decline
- New caregivers at clinic confuse and cause distress to loved one
- Guilt about decisions made in light of nursing department's treatment recommendations
- Not feeling heard or respected

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Resident Perspective

Problem/Concerns from resident's perspective:

- Wound Clinic trips painful, scary
- Trips disagreed with her wishes
- Did not want strangers involved
- Liked trusted staff involved in care

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Staff Perspective

Problem from nursing staff perspective:

- Worries about best practice for wound care
- Proper pain management
- Compliance with regulations
- Informed decision making
  - Cognition loss
  - Substitute decision making

Social Worker perspective:

- Resident and family autonomy
- Compromised relationship with family
- Need for staff education

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Social Work Preferred Outcomes

What were the preferred outcomes/options considered?

- Respect for family/resident wishes
- Comfort care and wound care to be managed by familiar staff
- Increased awareness of resident/family autonomy

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Interventions

Increase quality communication between staff and family:

- Care plan meeting
  - social work support for resident family rights for decision making
- Additional meeting time
  - build trust
- Administration involved for problem-solving
- Social Work to educate staff about:
  - Self directed care
  - Legal authority and responsibility of surrogate decision makers
  - Effective listening techniques and communication with families

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Effective Interventions

- Speaking with family individually
  - Positive comments about trusting staff
  - Sharing institutional perspective of care
- Staff education
  - Nursing accepting comfort care and wound care responsibility
  - Managed Risk Agreement

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Unintended Consequences

- Concerns about the reputation of the facility by the Administrator
- Facility not meeting care goals, particularly around wound care and treatment
- Concerns about care post-mortem
  - Concerns about abuse reporting
  - E.g. Neglect

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Care Plan Modification

Care Planning Strategies:

- Increase everyone's awareness of disease progress, treatment choices and clarity of roles.
- Care plans are inclusive instruments of resident, family and staff input.
- Reflect good care through understanding the wishes of resident and family.
- Adjusting care plans to reflect changing needs of resident.

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Regulations Guiding this Case Study

- Resident Rights – The 1987 Nursing Home Reform Law
- Public Law 501 Self-Determination Act
- Psychosocial Severity Guide
- Advance Directives – F-tag 155

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Lessons Learned

- Improved communication and listening skills
- Improved caregiving skills at end of life
- Awareness about:
  - Role and power of the Health Care Power of Attorney
  - Right to autonomy
  - Meaning and importance of advance care planning

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Possible Questions

- How was this case similar or different from situations in your own facility?
- The family in this example was united and consistent but what if the family was fragmented and inconsistent how might you utilize the team and care planning to help the resident.

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Resources

Bowen:

- http://www.thebowencenter.org/pages/theory.html
- http://www.youtube.com/watch?v=J8f8BjhHx1k

Federal Guidelines:

- http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

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Thank you.

A recording of this webinar is available through the ***National Nursing Home Social Work Network*** website:

http://clas.uiowa.edu/socialwork/nursing-home/webinars