

Assisting with End-of-Life Planning

Presented by
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and
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Nursing Home Social Work Network
Webinar Series

This webinar series is made possible through the generous support of the
Retirement Research Foundation



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Dr. Jean Correll Munn received her Ph.D. and Master's in Social Work from the University of North Carolina at Chapel Hill and her B.A. in Psychology from Duke University. As a doctoral student, she was awarded a John A. Hartford Doctoral Fellowship to complete her dissertation: *Defining a Good Death for Residents in Long-Term Care*. She received additional dissertation support from the Duke Institute on Care at the End of Life. In 2007 Dr. Munn became a John A. Hartford Geriatric Social Work Faculty Scholar and a College of Palliative Care Scholar. Dr. Munn was promoted to Associate Professor and awarded tenure in 2012. Currently, she is directing the multi-disciplinary Certificate in Gerontology at FSU.

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Jeannine Wilson earned her LSW, Bachelor degree in Social Work from University of Southern Maine. Director of Social Services of an 86 bed nursing and rehabilitation facility in Southern Maine. Member of the Maine POLST coalition.

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Objectives

Upon completion of this webinar, participants will be able to:

1. Interpret the role of the social worker in long-term care at the end of life;
2. Identify advance directives including the POLST; and
3. Understand the role of documentation.

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OVERVIEW

- Defining the Social Work Role
- Initiating the Conversation
 - Barriers
 - Timing
- Describing Advance Directives
 - Types
 - Challenges
- Introducing The POLST
 - Description
 - Legal Implications
 - Clinical Implications
- Documenting
 - Principles of good documentation
 - Specifics related to end of life
 - Continuity of Care
- Continuing the Conversation
- Case Study

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Defining the Social Work Role

- NASW Standards
- Regulatory Requirements
- The Interdisciplinary Team
- Empirical Studies
- The Real World



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- The NASW directive states that social workers involved in end-of-life or palliative care should: “advocate for the needs, decisions, and rights of clients” and “ensure that people have equal access to resources to meet their biopsychosocial needs in palliative and end of life care.”

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Initiating the Conversation Barriers

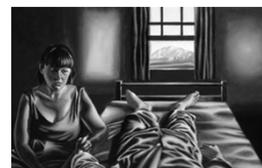
- Personal Concerns: Values
 - Social Worker
 - Resident
 - Resident Family
- Facility Policies
- Legal Concerns



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Initiating the Conversation Timing

- Pre-admission Goals
 - Home
 - Home with services
 - Palliative Care
 - Hospice care
 - Long term care
 - Palliative care
 - Hospice Care



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Advance Directives Types

- Surrogate
 - Health Care Power of Attorney (HCPOA)
 - Legal hierarchy (state specific)
- Instructional
 - Living will
 - Do Not Resuscitate (DNR)

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Initiating the Conversation Stakeholders

- Goals
- Advanced Directives/ Living Will
- MPOA
- Guardian
- DHHS Guardian
- Representative
- Capacity
- Shared Decision Making



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Advance Directives Challenges

- Residents without advance directives
- Interpretation and applicability disagreements
- Document portability problems
- Enforcement shortcomings

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The POLST *Physicians Order for Life Sustaining Treatment* An Alternative

- What is the POLST?
 - Originated in Oregon
 - Medical order signed by a doctor
 - With concurrence of resident or resident's surrogate
 - Instructing health care providers of resident's wishes under factual conditions.
 - Delineates specific circumstances
 - Works in conjunction with other ADs
 - Voluntary rather than mandated

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The POLST Legal Implications

- POLST provides more precise information regarding specific treatment options in unique medical circumstances.



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The POLST Clinical Implications

- Residents with POLSTs are more likely to:
 - Have care more consistent with their desires and values
 - Have consistent care across settings of care
 - Remain in the nursing home
- Reduces stress on care providers and family members

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The POLST Conversation

- Reviewing the Advanced Directives
- Explaining the POLST terms
- Accurate information
- POLST Brochure
- Explaining the Dying Process
 - Pain
 - Hunger
 - Thirst

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DHHS Guardian POLST Process

- Conversation
- Advanced Directives/ Prior code Status
- Letter from Doctor
- Completed POLST signed by doctor
- SASE

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MDS 3.0

- Include Advance Directive review:
 - At the annual assessment;
 - During assessments for significant changes;
 - Upon discharge; and
 - Upon re-admission.

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Documentation Purpose

- The purpose of documentation “to provide the team with the necessary information to care with and for the resident” and for clinical, ethical, and legal accountability
- While utilizing sensitive information only to the extent that it is necessary for optimal resident care (Beaulieu, 2012) .

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Documentation The Medical Chart

- Legal Documents in the Medical Chart:
 - Admissions Agreement
 - Living Will
 - Health Care Proxy
 - Durable Power of Attorney
 - Guardianship



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Documentation The Medical Chart

- Social Worker
 - Reviews on a regular basis;
 - Assesses for current appropriateness;
 - Examines for expirations; and
 - Continues the conversation.

This is a process!

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Documentation Substance

- Good documentation (Sidell, 2011):
 - Focuses on service delivery;
 - Includes assessments that are objective, comprehensive, and fair;
 - Is information focused;
 - Identifies important cultural factors;
 - Is written as if the client and others involved have access; and
 - Is organized, current and well-written.

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Documentation Specific to End of Life

- Ensure that the wishes of the resident are heard throughout the initial and ensuing conversation(s).
- Acknowledge the clinical and legal decisions that have been made.
 - Initiation of or
 - Changes to advance directives.
- Provide consistent information to all members of the health care team regardless of resident capacity or location.

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Documentation Continuity of care

- Example of Process
 - Have POLST policy in place for facility
 - 5 copies in front of chart (on lime green #24)
 - Original in doctor's orders section
 - Orange stickers inside cover (DNR, DNH)
 - Standard Doctor's order for MAR
 - See POLST for further instructions
 - Update Demographics' Sheet

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Continuity of Care Discharge or Transfer

- POLST is to accompany resident on discharged to the hospital
- POLST is to accompany resident when making a visit to a specialist
- POLST is to accompany resident when transferred by ambulance
- POLST is to accompany resident when going home
 - Copy sent to PCP on discharge (Mailed)

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The Conversation continues...

- Conflicting opinions
- Family wants to decide for capacitated person
- Does not match Advanced Directive
- Guardianship

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Case Study

Mrs. Parkhurst, age 80, was admitted to a Dementia Care Center by her son. She was now in the middle stages of dementia and not able to make decisions for herself. Her son Michael is her Medical Power of Attorney. He was asked by the social worker to meet with her about completing a POLST. Michael showed Mrs. Parkhurst Advanced Directive to the social worker that she had completed when she was 67, that indicated full code.

He also spoke to the SW in detail about a dinner he had had with his mother about two years earlier and she said to him at the time if she ever had dementia and wasn't able to make decisions for herself she did not want to have any extraordinary means taken to extend her life. He remembered the date of the dinner and the name of the restaurant where they had this conversation.

1. Who should be included in this decision?
2. How should Mrs. Parkhurst's son complete her POLST?
3. What should be documented in the SW notes?

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Case Study Questions for Reflection

1. How should Mrs. Parkhurst's son complete her POLST?
2. Who should be included in this decision?
3. What should be documented in the SW notes?

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Key Resources

Beaulieu, E.M. (2012). A guide for nursing home social workers. New York: Springer.

Kapp, M. (2012). The nursing home as part of the POLST paradigm. 36 *Hamline Law Review*, Symposium Edition.

Munn, J.C. & Adorno, G.F. (2008). By invitation only: Social work involvement at the end of life in long-term care. *Journal of Social Work in End-of-Life and Palliative Care*, 4(4), 333-357.

POLST Physicians Order for Life Sustaining Treatment <http://www.polst.org/>

Sidell, N.L. (2011). Social work documentation: A guide to strengthening your case recording. New York: NASW Press

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