PLAN WELL

A Novel Decision Aid to Help Plan for Serious Illness

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Improving the Quality of End-of-life Care in Long-Term Care (LTC)

COMMON BACKGROUND & RATIONALE

Improving communication, decision-making, and documentation about what a LTC resident would want when they become seriously ill is an important care gap that needs to be addressed in LTC.

DECIDE-LTC Study[1]

What do Long-Term Care clinicians think are the barriers to having Goals of Care (GoC) discussions?

ACCEPT-LTC Study[2]

Are substitute decision-makers (SDMs) aware of their loved one's prior advance care planning (ACP) documentation? And how satisfied are SDMs with the care provided their loved ones in LTC?

METHODS

DECIDE-LTC Study[1]

- **8 WEEKS** ONLINE BARRIERS SURVEY
- **34 LTC HOMES** FROM ONTARIO THAT PROVIDED CLINICIAN FEEDBACK
- **49% CLINICIAN RESPONSE RATE** (MD, NURSING, ALLIED HEALTH PROFESSIONAL)

ACCEPT-LTC Study[2]

- **4 MONTHS** MAIL-OUT SURVEY
- **27 LTC HOMES** FROM ACROSS ONTARIO THAT PROVIDED SDMs
- **25% SDM RESPONSE RATE**

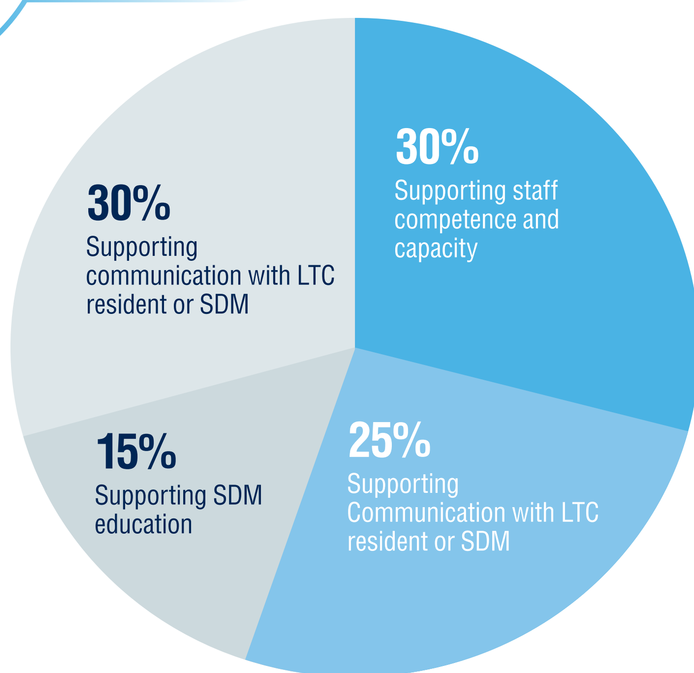
RESULTS

DECIDE-LTC Study[1]

5 BIGGEST CLINICIAN BARRIERS

1. SDM's difficulty accepting their loved one's poor prognosis
2. SDM's difficulty understanding the limitations and complications of life-sustaining therapies
3. LTC resident not having any form of ACP
4. Not having adequate time to have conversations with LTC residents or SDM
5. Lack of adequate documentation of prior discussions with LTC resident or SDM

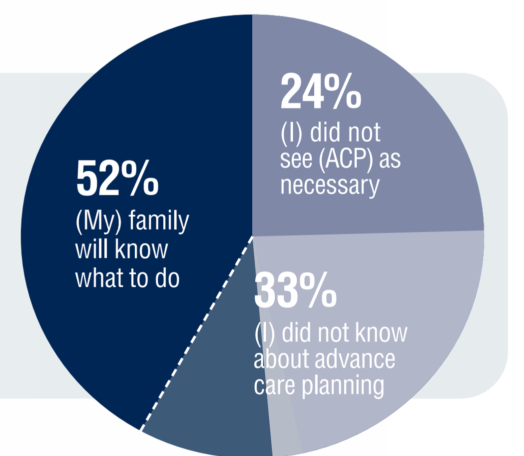
4 BIG SUGGESTIONS TO IMPROVE GOC DISCUSSIONS



Physicians initiated ACP discussions only 10% of the time.

ACCEPT-LTC Study[2]

THE MAIN REASONS WHY LTC RESIDENTS DID NOT HAVE ANY ACP WERE:



LTC RESIDENTS VALUES

- **88%** SDMs indicated that their loved ones values for EOL are to maximize comfort, minimize suffering and avoiding a prolonged death
- **25%** SDMs indicating that prolonging life was an important value for EOL

LTC RESIDENTS CARE DESIGNATION

- **54%** LTC residents had a care designation consistent with supportive care
- **46%** LTC residents had a care designation consistent with transfer to acute care for more intensive interventions

By comparing importance and satisfaction ratings on the CANHELP-Lite questionnaire, EOL care could be improved by:

- Better illness management
- Better cooperation amongst LTC staff providing care
- Receiving consistent information about the resident's condition from LTC staff
- LTC staff listening to SDM's concerns
- Improving trust and confidence of the SDM in the LTC physician looking after their loved one

OVERALL CONCLUSIONS

- LTC residents are at risk of 'over-treatment' during times of serious illness and acute clinical change.
- The health care system needs to encourage all clinicians and patients to start engaging and documenting GoC and ACP discussions well before LTC admission so that documentation is readily available and accessible in LTC.
- Decision aids, like the "Plan Well Guide" (www.planwellguide.com) improve older adults' and their family's knowledge and preparedness to make health care decisions and could reduce the barriers to engagement by clinicians .
- Developing and evaluating interventions that address SDM-identified areas for care improvement could inform local quality initiatives and influence corporate policies to improve the EOL care provision for LTC residents.

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1 - Siu, H. Y. H., Elston, D., Arora, N., Vahrmeyer, A., Kaasalainen, S., Chidwick, P., Howard,M., Heyland, D. K. (2020). A Multicenter Study to Identify Clinician Barriers to Participating in Goals of Care Discussions in Long-Term Care. J Am Med Dir Assoc, 21(5), 647-652.

2 - Siu, H. Y. H., Elston, D., Arora, N., Vahrmeyer, A., Kaasalainen, S., Chidwick, P., Borhan, S., Howard, M., Heyland, D. K. (2020). The Impact of Prior Advance Care Planning Documetnation on End-of-Life Care Provision in Long-Term Care. Can. Geriatr. J., 23(2), 1-12.