“Is my elderly patient safe to stay at home?”

A clinical framework

Workshop G-02, Wed. Nov 28th 2018 @11-12h

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Disclosure statement

- I have no conflicts of interest to declare.

- NB: Any trade names mentioned during case discussions are purely for ease of recognition.

- *With thanks to Dr C Ferrier, MGH Geriatrics for input*

Learning objectives

In this workshop, the participant will:

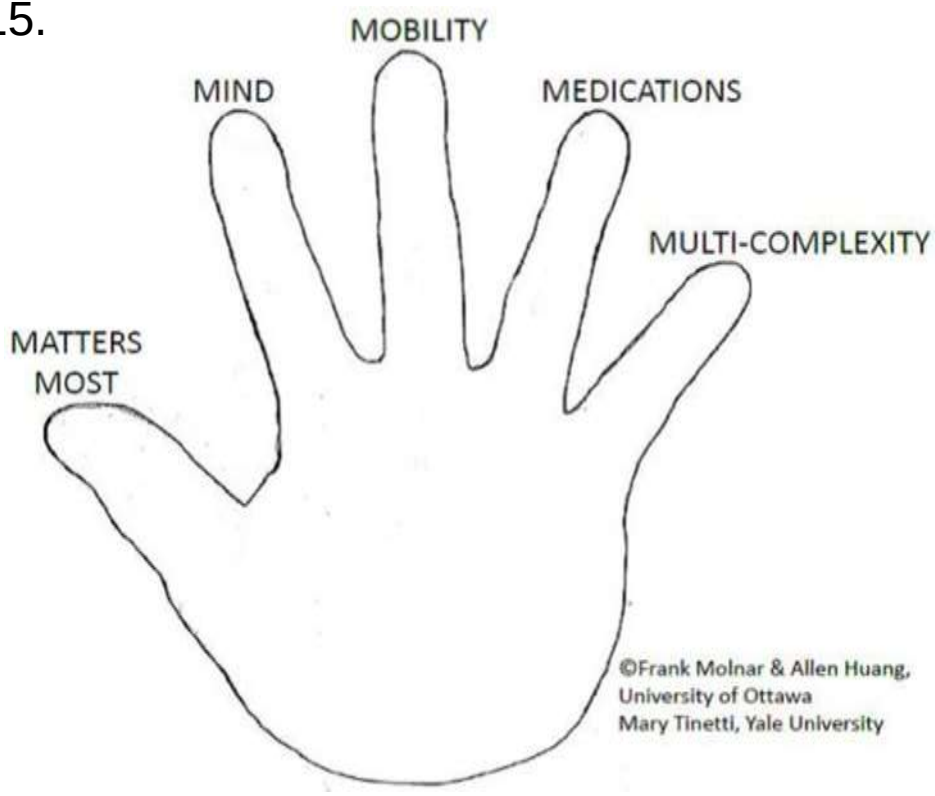
- Obtain a general clinical framework for the holistic assessment of elderly patients
- Review the framework specifically for the basic assessment of an elderly patient’s choice to live at home
- Apply this framework to specific “cases” (from own clinical practice or examples) – see also “Worksheet”

“The Geriatrics 5M's:

A New Way of Communicating What We Do.”

J Am Ger Soc 2017 Sept; 65 (9)**:** 2115.

“Mobility” = Functional autonomy in daily tasks (ADL [incl walking], IADL)



The 5 M's, modified for Q:

"Is my elderly pt safe to stay at home?"

- Mind
- Mobility
- Multi-complexity
- Medications
- "Matters most"

-PLUS-

- Milieu
- Manpower
- Medical capacity

Keep in mind: 4 ethical principles

- Autonomy
  - Right to refuse/choose
    - Own body, future…
- Beneficence
  - “Best interests”
- Non-maleficence
  - *Primum non nocere*
- Justice
  - Distribution of health resources
    - CanMEDS role: Leader

Info sources

- Patient (frailer elderly)
- Family
  - 1°caregiver = the person most present and actively involved in pt's daily activities in home setting
    - Private caregiver (PAB) vs. family
      - Friends, neighbours if actively involved
- CLSC home care – SW, rehab professionals (OT, PT)
- MD & other professionals re: Multi-complexity
  - Diagnoses - how severe, stability, prognosis etc.
  - Treatment plan - how complicated (can pt do it?), "time to benefit", "patient goals-directed care" etc.
- More than one visit…

The 5 +3 M's: Basic considerations

See Appendix for some assessment tools

- Mind
  - Cognition: Dementia (major NCD)
    - Memory
    - Insight, judgment
    - BPSD
    - Safety – main concerns: Stove left on (fire), wandering, driving
    - Other concerns: Meals/eat, financial exploitation, social isolation
  - Psych: Delusions (paranoia), anxiety

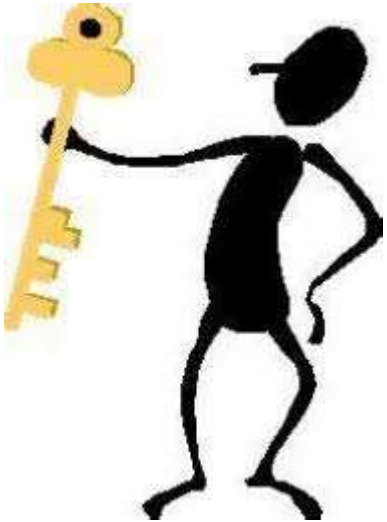
- Multi-complexity
  - Diseases – type, stability, risk of serious sequelae, prognosis

- Mobility
  - Falls risk – seek modifiable risk factors
  - Mobility aids
  - Functional autonomy (ADL, IADL)

- Milieu
  - Accessibility
  - Safety
  - Cleanliness (hoarding)

- Medications
  - "Poor compliance"
    - Forget (memory) – miss or overtake doses
    - Physical limitations (to obtain, packaging)
    - Complicated regimen - Simplify:
      - Frequency of doses (incl. PRNs)
      - Route (non-PO)
      - Type of meds – *Essentials*
      - Dispensing

- Manpower
  - Family
    - 1º caregiver? Live w/ pt?
    - Caregiver's own health & coping status?
  - Friends, neighbours…
  - Public home care resources
    - CLSC
    - Community groups, Volunteers
  - Private home care resources
    - Affordable? (and willing to pay)



Manpower, cont.

- "Interval of need" (Isaacs & Neville 1976)
  - Length of time person could manage living at home w/o human assistance
    - Long – weekly ($, shop)
    - Short - daily (self care)
    - Critical – more than daily, unpredictable (toileting)
    - Intensive - constant (falls, wandering) (WHO 1990)

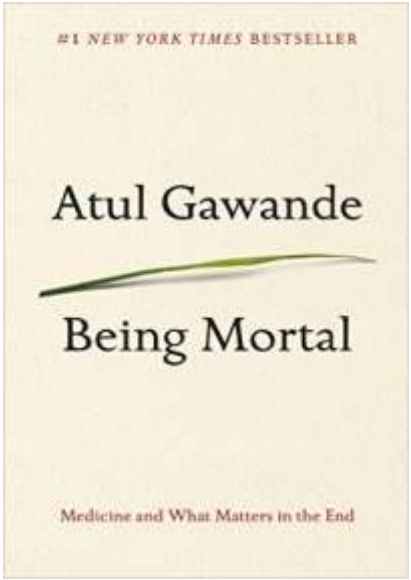
- Medical capacity
  - Informed consent / refusal to move to LTC
    - Diagnosis(es) - Reason(s) for discussing move to LTC
    - Risks : benefits - of refusing to move to LTC
    - Alternative(s)? – and the risks : benefits
    - Consequences – if move, if do not move
  - Assessing Capacity for Admission to Long-Term Care Homes http://www.ontla.on.ca/library/repository/mon/24004/300799.pdf

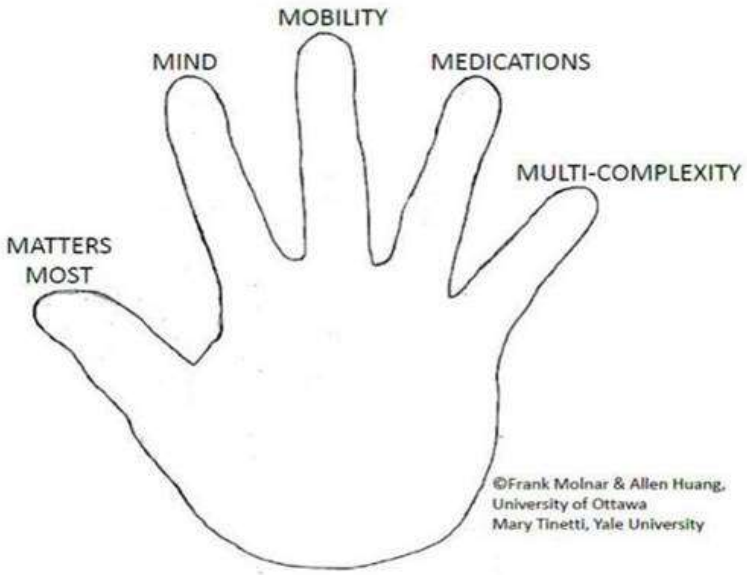
Medical capacity, cont.

- Risk taking – ethical considerations
  - https://www.bcmj.org/articles/when-patients-choose-live-risk-what-ethical-approach-intervention
- “Harm reduction”…?
- Beneficence ←→Non-maleficence

- [What] “Matters most” – to the pt
  - The “magic wand” question
  - Not necessarily in pt’s “best interest”…
  - Expressing an informed decision or expressing *fear*?

(of dying, suffering, loss of control, being a burden on family…)




MOBILITY
MIND
MEDICATIONS
MULTI-COMPLEXITY
MATTERS
MOST
©Frank Molnar & Allen Huang,
University of Ottawa
Mary Tinetti, Yale University


MANPOWER
MEDICAL CAPACITY
MILIEU

Home?

Appendix:
Some assessment tools (just FYI)

- The Hartford Institute of Geriatric Nursing – “Try This”
  https://consultgeri.org/tools/try-this-series
  - Mind - Cognition: MiniCog
  - Mobility - Gait: Timed Up & Go
    - Functional autonomy: Katz ADL, Lawton IADL
  - Manpower - Caregiver coping: Modified caregiver strain index

- Medical capacity – Excerpt from
  “Assessing Capacity for Admission to Long-Term Care Homes (2010)”

- Matters most - “Patient goals-directed care” – Serious Illness Conversation Guide

Examples of questions to assess capacity for LTC placement*

- **Can you help me understand why you've decided to accept / refuse placement?**

1. <u>Able to understand care needs</u>

- What health problems are you having right now?
- What problems are you having at home?
- What help do you receive at home on a daily basis?
- Who provides you with help at home and how often?

---ADL: Mobility---

- What problems are you having when you walk?
- What do you use to help you walk (i.e., cane/walker/person)?
- Have you had any falls? How often do you fall?
- What happened the last time you fell?
- What help do you need when getting in and out of bed / a chair? for going to the bathroom? bath/shower? getting dressed? eat?

---IADL---

- What help do you need with cleaning/doing laundry? shopping/buying groceries? transportation (e.g. to doctor's appointment today)?
- What help do you need when preparing meals?
- What help do you need with getting/taking medications?

---Cognition---

- What problems do you have with your memory?
- When/how often do you feel confused? forgetful?
- What concerns do you have if you are alone at home?
- What concerns do you have about your safety at home?

2. <u>Able to understand proposed long-term care placement</u>

- What do you know about any long-term care facility/nursing home?
- What kind of help/care is available at LTC?
- Who needs to live at LTC and why?

3. <u>Able to understand option of refusing proposed long-term care placement</u>

- I/the healthcare team/your family think you need to move to a nursing home.
  → Please tell me if you agree or disagree.

4. <u>Able to appreciate reasonably foreseeable consequences of accepting proposed long-term care placement</u>

- What will happen if you move to a nursing home?
- What kind of help could you receive if you live in a nursing home?

5. <u>Able to appreciate reasonably foreseeable consequences of refusing proposed long-term care placement</u>

- What will happen if you refuse to move to a LTC facility?
- What would you do If you felt sick or unsafe? had a fall? there was a fire?
- What could happen if you do not take your medication?
- What could happen if you do not have 24 hour care and supervision?

6. <u>Able to understand alternative to proposed long-term care placement</u>

- Who will help take care of you on a daily basis? (Be specific re: care needs/concerns identified by health care team assessment or by family or by other informants such as [CLSC], EMS, police, etc.)?
- Where/how can you get the help you need? (Note: identify and confront conflicts if expectations do not meet reality of what formal/informal supports are able/willing to provide)
- Where/how can you get the help you need that your family/friends/[CLSC] cannot provide (i.e. insurance benefits, privately hired help to supplement family/[CLSC])?

**Excerpted from the "Assessing Capacity for Admission to Long-Term-Care" document*

Serious illness conversation guide

Conversation flow	Patient-tested language
1. Set up the conversation • Introduce purpose • Prepare for future decisions • Ask permission	"I'd like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want—**is this okay?**"
2. Assess understanding and preferences	"What is your **understanding** now of where you are with your illness?" "How much **information** about what is likely to be ahead with your illness would you like from me?"
3. Share prognosis • Share prognosis • Frame as a "wish...worry," "hope...worry" statement • Allow silence, explore emotion	"I want to share with you **my understanding** of where things are with your illness..." Uncertain: "It can be difficult to predict what will happen with your illness. I **hope** you will continue to live well for a long time, but I'm **worried** that you could get sick quickly, and I think it is important to prepare for that possibility." OR Time: "I **wish** we were not in this situation, but I am **worried** that time may be as short as ___ (express as a range, eg, days to weeks, weeks to months, months to a year)." OR Function: "I **hope** that this is not the case, but I'm **worried** that this may be as strong as you will feel, and things are likely to get more difficult."
4. Explore key topics • Goals • Fears and worries • Sources of strength • Critical abilities • Tradeoffs • Family	"What are your most important **goals** if your health situation worsens?" "What are your biggest **fears and worries** about the future with your health?" "What gives you **strength** as you think about the future with your illness?" "What **abilities** are so critical to your life that you can't imagine living without them?" "If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?" "How much does your **family** know about your priorities and wishes?"
5. Close the conversation • Summarize • Make a recommendation • Check in with patient • Affirm commitment	"I've heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I **recommend** that we ___. This will help us make sure that your treatment plans reflect what's important to you." "How does this plan seem to you?" "I will do everything I can to help you through this."
6. Document your conversation	
7. Communicate with key clinicians	

(This guide is for use in discussing goals of care in chronic disease e.g. COPD, CHF, ESRD (Q: dialysis?), neurodegenerative diseases.

But the type of wording as in the "Pt-tested language" examples may be useful for LTC discussion, too.)

Workshop “cases”

- From your practice…
- …or from mine
  - Mr. Y (GDH)
  - Mr. G (GDH)
  - Mme. G (clinic)
  - Mrs. H (clinic)
  - Mrs. C (ER)
  - Mme. P (ER)
  - Mrs. C (ER)
  - …

5 (+3) M's	Name: Date:	“Interval of need”? *L = long (weekly)* *S = short (daily)* *C = Critical (X/day)* *I = Intensive (constant)*
Mind		
Mobility		
Multi-complexity		
Medications		
Milieu		
Manpower		
Medical capacity		
Matters most		
CONCLUSION		
PLAN		

Working tool