

DEMONSTRATING RESPECT FOR RESIDENT CHOICES

Revisions to F-155
September 27, 2012

REGULATORY LANGUAGE

42CFR §183.109(b)(4)

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advanced directive....



NEW OPERATIONAL DEFINITIONS

- Advance Care Planning
- Cardiopulmonary Resuscitation
- Durable [Medical] Power of Attorney for Health Care
- Health Care Decision-making
- Health Care Decision-making capacity
- Life-sustaining Treatment
- Legal Representative
- Experimental research
- Investigational or experimental drugs

FOUR INTENTS

1. Establishing and maintaining *policies and procedures* regarding these rights.
2. Informing and *educating each Resident* about these rights and facility policies regarding these rights.
3. *Helping each Resident* to exercise these rights.
4. *Incorporating each Resident's choices* regarding these rights into the Resident's treatment, care, and services.



INTENT #1: POLICIES & PROCEDURES

Establish and maintain Policies and Procedures:

- Determine *at admission* whether the Resident has an advance directive or other vehicle to convey his or her instructions in the event that he or she becomes incapacitated;
- Determine *whether the Resident wishes* to formulate an Advance Directive;
- Periodically assess the Resident for *decision-making capacity*
- *Identify and invoke the Resident's Legal Representative* if the resident is determined to be without capacity;



INTENT #1: POLICIES & PROCEDURES

- *Define and clarify medical issues and how information will be presented* to Residents and the Legal Representative;
- Identify, clarify, and *periodically review, as part of the comprehensive care planning process, the existing care instructions* and whether the Resident desires to change them;
- *Identify situations when health care decision-making is needed* due to decline or improvement in the Resident's condition;

INTENT #1: POLICIES & PROCEDURES

- *On-going review of the Resident's condition and existing choices and continuing or modifying approaches as appropriate;*
- *Establishment of mechanisms for documenting and communicating the Resident's choices to the IDT [all personnel, all departments, and all shifts; and*
- *Development of Facility processes [as provided by State Law] for handling situations in which the Facility and/or physician do not believe that they can provide care in accordance with the resident's Advance Directive or wishes.*



INTENT #2: INFORMING & EDUCATING

42 CFR § 489.100 requires that Facilities provide verbal review of *written information* for the Resident at admission concerning:

- *The Resident's Right to make decisions regarding medical care, including the Right to accept or refuse medical or surgical treatment and*
- *The Resident's Right to formulate Advance Directives;*
- *The Facility's policies that govern the exercise of these Rights.*



INTENT #3: ASSISTING RESIDENTS



At admission, the Facility must determine if the Resident has executed any form of advance directive [Living Will, Directive to Attending Physician, Durable PoA for Health Care, Medical PoA, DNR, Portable, Enduring Order Form, Five Wishes, etc.]

- The Facility must obtain copies of all existing Advance Directives and incorporate them all into the same section of the clinical record where they are retrievable by any facility staff members and communicate to the Resident's physician and direct care staff that these documents exist and identify their location

INTENT #3: ASSISTING RESIDENTS

If the Resident *has not* executed an Advance Directive, the Facility is required to:

- *Advise* the Resident and family *of the right to establish* Advance Directives according to State laws
- *Offer assistance* if the Resident wishes to execute one or more Advance Directives;
- *Document* in the Resident's clinical record the content of discussions regarding the *Resident's wishes and any Advance Directives the Resident executes.*

The Facility **may not compel** the Resident execute Advance Directives.

The Facility **may not discriminate** against Residents based on whether or not the Resident has executed an advance directive.



INTENT #4: INTEGRATING RESIDENT CHOICES

- The Facility is *required* to keep the Resident or Legal Representative *informed*, in language they can understand, of the *Resident's health status*, treatment options, and anticipated outcomes;
- The Facility must *document the content of the discussion* with the Resident/Legal Representative regarding the Resident's choices about future health care, whether or not the Resident executes an Advance Directive
- This discussion should take place *during the initial comprehensive assessment and care planning meeting and periodically thereafter during regular advance planning meetings*



INTENT #4: INTEGRATING RESIDENT CHOICES

- If a Resident's refusal of treatment results in a significant change of condition, the *Facility is expected to assess the resident for decision-making capacity* and invoke the Legal Representative if it is determined that the Resident does not have decision-making capacity
- The Resident's *refusal of treatment does not absolve the Facility from providing other care* that allows the Resident to maintain his or her highest practicable physical, mental, and psychosocial well-being

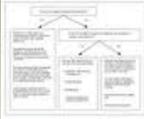
INTENT #4 EXPERIMENTAL RESEARCH

- Be fully informed of the nature and consequences of participating
- Give full informed consent to participate
- Right to participate before and during the research
- Process for approving and overseeing research



IMPLEMENTATION PROCESSES

- Gathering information
- Maintaining information
- Updating information
- Educating Resident based on Resident's life events
- Communicating choices to physician and staff
- Incorporating Resident choices into Plan of Care
- Accurately updating Caregiving documents
- Quickly identifying Resident's wishes in the event of a health crisis
- Quickly involving Resident's Responsible Party



INVESTIGATIVE PROTOCOL

- Surveyor *objective*: to assure four Intents are met
- *Scope*: all Sample Residents
- *Methods*:
 - Record Review
 - Resident wishes
 - Executed Advance Directives
 - Responsible party
 - Decision-making capacity



INVESTIGATIVE PROTOCOL

- Observations-
 - Does care given match Resident's documented wishes?
 - Are processes in place to support the required practices?
- Interviews
 - Resident/Responsible party
 - Caregivers
 - Members of advance planning care team
 - Physician



COMPLIANCE CRITERIA

Implemented policies and procedures regarding advance directives and the right to accept or decline treatment modalities.

- *Educated* Residents about rights and facility policies.
- *Determined* existing advance directives *or assisted* Resident to formulate.
- *Documented* Resident decision-making capacity and when decisions are transferred to Responsible Party.
- *Explained* risks and benefits of accepting or declining treatments.



COMPLIANCE, CONTINUED

- *Incorporated* Resident's choices into medical record, physician orders, and caregiving documents.
- *Consistently maintained* advance directives and Resident goals in same, easily-retrievable location.
- *Monitored* care and services to assure consistency with advance directives and Resident goals.



GUIDANCE ON SCOPE & SEVERITY

- Level IV:
 - Has, or is likely to, cause serious injury, harm, impairment, or death and
 - Requires immediate correction.
- Level III:
 - Actual or potential harm, that is not immediate jeopardy
 - May not be limited to clinical compromise.
- Level II:
 - No actual harm
 - Potential for more than minimal harm, that is not immediate jeopardy.
- Level I:
 - No actual harm
 - Potential for minimal harm.

SUCCESS

- *Developing* policies
- *Involving* staff members
- Thoughtfully *designing* processes
- *Educating* staff members
- Consistently *implementing* processes
- *Practicing* CQI
 - Monitoring compliance
 - Problem solving
 - Re-educating



QUESTIONS?



**CMS REGULATION
UPDATE
F309- End Of Life Care**

**LEARNING
OBJECTIVES**

Following this presentation members of the audience will be able to:

- Identify 3-4 new definitions related to care at end-of-life
- Describe the ABCDE Mnemonic
- Describe essential elements of assessment and management of care at end-of-life
- Describe updated information related to the election of the hospice benefit

**F309 (483.25)
END OF LIFE**

~ Each resident must receive and the facility must provide:

- ~ Necessary care and services to attain or maintain the highest practicable (possible) physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.



DEFINITIONS RELATED TO CARE AT END OF LIFE

Advanced care planning Palliative care
Hospice Terminally Ill
Imminently dying

FACTORS FOR A GOOD DEATH

- Control over decisions
- Symptom and pain management
- Trusting relationship with physician
- Not being subjected to intrusive/unnecessary procedures, and a prolonged death
- Being kept clean
- Comfort with staff providing care
- Knowing what to expect regarding physical condition
- Strengthening relationships with loved ones
- Having someone to listen to you and be present
- Maintaining dignity

BARRIERS TO THE ASSESSMENT AND MANAGEMENT OF END-OF-LIFE CARE

- Residents, staff, and physician discomfort
- Family Expectations
- Limited staff time
- Cultural and ethnic diversity
- Inadequate coordination and communication
- Concern related to substitute decision-makers



**E-O-L
RESIDENT
ASSESSMENT/ONGOING
RE-ASSESSMENT**

History of present illness (co-morbid medical, psychiatric disorders, and current interventions)

Physical, cognitive, and functional status

Symptoms needing management; are there remedial causes of a residents current symptoms?

**E-O-L
RESIDENT
ASSESSMENT/ONGOING
RE-ASSESSMENT**

Psychological, emotional, spiritual issues, that may effect the resident's physical or psychological discomfort.

Appropriateness and resident's desire for palliative or hospice services

Goals for care and treatment

**E-O-L
RESIDENT
ASSESSMENT/ONGOING
RE-ASSESSMENT**

Resident strengths and available resources

Other diagnostic tests and measures as needed



**MANAGEMENT OF CARE
AT E-O-L**

The goal of palliative care is to relieve suffering and provide the best possible quality of life for the resident and his or her family.

Ongoing discussions amongst the resident, family, the attending physician or primary healthcare practitioner, and other members of the interdisciplinary care team help clarify the goal of care.

**MANAGEMENT OF
RESIDENT
AT E-O-L/ADVANCE
DIRECTIVE**

- Whether or not the resident has as an advanced directive or not the facility is responsible for:

- Giving treatment support

- Providing care consistent with medical and psychological standards of practice



**MANAGEMENT OF
RESIDENT
AT E-O-L/ CARE
PLANNING**

When resident is nearing end of life it is important for:

Physician and interdisciplinary team to review or update the prognosis with the resident/legal representative.

Revise care plan as needed to reflect resident's current situation

**MANAGEMENT OF
RESIDENT
AT E-O-L**

- Ongoing consistent oral care
- May require increased re-positioning
- Diagnostic testing and monitoring as needed
- Symptom management to include cause specific interventions
- Use of medications consistent with goals of comfort, control of symptoms and resident's desired level of alertness
- Previous dietary restrictions may be unnecessary for the resident
- Increase support for activities of daily living; involve family if possible

**MANAGEMENT OF
RESIDENT
AT E-O-L**

- Identify approaches that are appropriate to the resident's psychosocial needs.
- Identify relevant approaches to supporting the resident.



**MANAGING THE
RESIDENT AT E-O-L
MONITORING**

Individualized care requires monitoring and reassessment. Close monitoring of a dying individual's symptoms helps assess the effectiveness of the plan of care and also helps identify possible adverse consequences associated with inappropriate, non-palliative approaches to end of life care

**MANAGEMENT OF
RESIDENT
AT E-O-L. ELECTION OF
HOSPICE BENEFIT**

Medicare/Medicaid residents with a terminal illness and a prognosis of 6 months or less to live have the "right" to elect the hospice benefit.

If the resident requests hospice and the facility does not offer it or have a contract, the facility must assist the resident in obtaining hospice services.



**COORDINATED
PLAN OF CARE**

The CMS update includes verbiage that is more detailed related to the joint responsibility of the facility and hospice for developing a coordinated plan of care for the resident; based on their assessment and the resident's needs and goals.

**WHAT SURVEYORS WILL
INVESTIGATE**

Did staff accommodate resident needs, goals and levels of functioning during end of life?

Did staff consistently implement care plan according to the resident's needs and goals?

Whether the facility discussed advance directives, the right to make treatment choices (including refusing treatment), available resources and state-required documents related to end of life care or substitute decision making?



WHAT SURVEYORS WILL INVESTIGATE

Whether the resident is currently having or has been having symptoms, and whether the symptoms and extent of relief have been addressed to his/her satisfaction and consistent with his/her preferences and choices.

Whether the resident or his/ her legal representative was involved in the development of the care plan.

Whether the care plan accommodates the residents needs and goals

WHAT SURVEYORS WILL INVESTIGATE

If interventions were declined, whether information about alternatives and consequences of such refusal were offered and documented.

During interviews of direct care staff, the surveyor will determine if staff are aware of residents goals at E.O.L.; when and how to offer each intervention, and how to monitor and document the effectiveness of the intervention.



REFERENCES

State Operations Manual
Appendix PP
Revision To:
483.25
F309 End of Life

Hope does not lie in a way out...but a way through- David Frost



**STATE OPERATIONS
MANUAL
APPENDIX PP
REVISIONS TO
483.25 NASO-GASTRIC TUBES
F-322 FEEDING TUBES**

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CMS FEDERAL REGULATORY LANGUAGE F-322

483.25 (g) Naso-Gastric Tubes

Based on the comprehensive assessment of a resident, the facility must ensure that:



- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that the use of a naso-gastric tube was unavoidable; and

CMS FEDERAL REGULATORY LANGUAGE F-322

- (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.



WHAT ELSE IN THE REGULATION CHANGED??

- The term "Naso-Gastric" tube used in the title of the regulation was clarified to include "any feeding tube used to provide enteral nutrition to a resident by bypassing oral intake".

ADDITIONAL REVISIONS

- Intent of the regulation was expanded:
 - A feeding tube is used only after an adequate assessment justifies it as medically necessary;
 - A feeding tube is used according to current clinical standards of practice & services are provided to prevent complications; and,
 - Services are provided to restore normal eating skills to the extent possible.



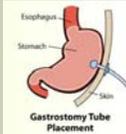
DEFINITIONS ADDED

Avoidable vs. Unavoidable

- Avoidable** - There is NOT a clear indication for using a feeding tube or there is insufficient evidence that it provides a benefit that outweighs the risks;
- Unavoidable** - There IS a clear indication for using a feeding tube or there is sufficient evidence that it provides a benefit that outweighs associated risks.

DEFINITIONS (CONT.)

- Bolus Feeding
- Continuous Feeding
- Enteral Nutrition
- Gastrostomy Tube
- Jejunostomy Tube
- Nasogastric Feeding Tube
- Transgastric Jejunal Feeding Tube
- Tube Feeding



FEEDING TUBE CONSIDERATIONS

- The decision to use a feeding tube has a major impact on a residents quality of life;
- Should be based on resident's clinical condition & wishes;
- Federal & State laws/regulations r/t life sustaining treatments must be considered.



**FEEDING TUBE CONSIDERATIONS
RESIDENT RIGHTS**

- Each resident has the right to be fully informed about care and treatment;
- The resident has the right to continue or refuse treatment and to have advance directives;



**CLINICALLY PERTINENT RATIONALE
FOR USE OF A FEEDING TUBE**

- Every other viable alternative to maintain adequate nutrition has been tried without success;
- The decision is consistent with the clinical objective of maintaining nutritional & hydration parameters;
- Desire to prolong life and/or comfort;



**ASSESSING FOR
CLINICALLY PERTINENT RATIONALE
FOR USE OF A FEEDING TUBE**

The IDT assessment of the resident should include:

- Nutritional status
- Clinical status
- Underlying medical condition
- Factors affecting appetite or taste
- Prognosis;
- Functional & psychosocial factors;
- Prior interventions & response.

**BENEFITS & RISKS
MUST BE WEIGHED**



Benefits	Risks
<ul style="list-style-type: none"><input type="checkbox"/> Addresses malnutrition & dehydration<input type="checkbox"/> Promotes wound healing<input type="checkbox"/> May allow time for resident to gain strength and receive rehab to restore ability to take oral feedings again.	<ul style="list-style-type: none"><input type="checkbox"/> Diminished interactions & potential for social isolation<input type="checkbox"/> Can't experience the taste & texture of food<input type="checkbox"/> Complications r/t tube feeding<input type="checkbox"/> Restricts movement

DECISION MAKING

- There must be **on-going** assessment, review, evaluation & re-evaluation regarding the use, continuation and/or discontinuation of the tube feeding, and the treatment and approaches to care.



TECHNICAL ASPECTS

- Care of the feeding tube;
 - Securing it externally;
 - Providing skin & oral care;
 - Monitoring insertion site;
 - Using infection control precautions;
 - Flushing as ordered;
- Feeding Tube placement;
 - When to replace/change;
 - What to do if it becomes plugged or dislodged;
 - Who can replace - in house or in another setting;
 - Notifying practitioner of concerns.



NUTRITIONAL ASPECTS

- Type of formula;
- Nutritional needs > caloric value & volume;
- The duration and method of feeding (gravity vs. pump);
- Frequency & amount of flush.
- Has not exceeded the expiration date;
- Calibration & accuracy of pumps (including periodic maintenance);



FEEDING TUBE COMPLICATIONS

<ul style="list-style-type: none"> <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Cramping <input type="checkbox"/> Aspiration <input type="checkbox"/> Insertion site leakage <input type="checkbox"/> Stomach or intestinal perforation <input type="checkbox"/> Abdominal wall abscess 	<ul style="list-style-type: none"> <input type="checkbox"/> Reduced effectiveness of medications <input type="checkbox"/> Metabolic complications <input type="checkbox"/> Erosion at the insertion site <input type="checkbox"/> Peritonitis <input type="checkbox"/> Esophagitis <input type="checkbox"/> Strictures <input type="checkbox"/> Tracheoesophageal fistulas
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MANAGEMENT OF COMPLICATIONS

- ❑ Facility staff are **expected** to identify and address actual or potential complications related to the feeding tube, and;
- ❑ To notify the physician so that he/she can evaluate, manage care and address any risks or complications.

INVESTIGATIVE PROTOCOL

- Investigative protocols provide guidance to surveyors on how to conduct an investigation for a particular regulation.
- Facilities must ensure that the intent of the regulation is being met for each resident with a feeding tube.



INVESTIGATIVE PROTOCOL OBSERVATIONS

Provision of care for feeding tubes:

- ❑ Providing mouth care;
- ❑ Proper positioning;
- ❑ Interventions to prevent isolation and minimize negative psychosocial impact;
- ❑ Medication administration;
- ❑ Cleanliness of feeding tube/equipment, insertion site, type, amount & rate of enteral formula and flush;
- ❑ Following practitioner orders, manufacturer guidelines & current standards of practice.



INVESTIGATIVE PROTOCOL INTERVIEWS

Resident or Legal Representative

- Did the use of the feeding tube reflect the resident's wishes?
- Were they informed of the benefits/risks and were they involved in care planning and decision making?
- What care was provided to increase food intake prior to insertion of the feeding tube?
- Has there been an ongoing discussion and reassessment regarding the continued appropriateness/need for the feeding tube?



INVESTIGATIVE PROTOCOL INTERVIEWS (CONT.)

Facility Staff

- Did staff establish a cause of the decreased intake/wt. loss and what attempts were made to address the issues prior to the tube insertion?
- How are staff determining that the resident's nutritional status and parameters are being met?
- Where is there evidence that the resident has been involved in the decision making, care planning and has received on-going re-assessment for continued use of the feeding tube?

INVESTIGATIVE PROTOCOL RECORD REVIEW

- Physician orders & progress notes
- Multi-disciplinary progress notes
- Nutritional assessment
- Weight logs, food acceptance records
- Care plan interventions, goals & revisions
- Speech therapy notes
- Documentation of on-going re-assessment/evaluation
- Advance directives
- Facility's policies, procedures & practices
- Staffing, staff training



NON-COMPLIANCE WITH F-322

Failure to:

- Assess** - Resident's nutritional status;
- Diagnose** - identify a clinical rationale for the feeding tube;
- Plan** - Develop interventions & monitor to ensure that the resident is meeting his/her nutritional needs;
- Implement** - Follow clinical standards of practice, physician orders and/or manufacturer's recommendations, including management & prevention of feeding complications and risks;
- Evaluate** - To restore normal eating function if possible.

DETERMINING THE SEVERITY KEY ELEMENTS

- The Presence of Harm/Negative Outcomes (or potential) because of lack of appropriate care & services.
- The Degree of harm (actual or potential) related to the non-compliance.
- The Immediacy of Correction required.

SCOPE AND SEVERITY GRID

LEVEL 4 Immediate Jeopardy	J	K	L
LEVEL 3 Actual harm that is not IJ	G	H	I
Level 2 No actual harm, but potential for greater than minimal harm	D	E	F
LEVEL 1 Potential for minimal harm	A	B	C
	Isolated	Pattern	Widespread

**SEVERITY LEVEL 4 EXAMPLES
IMMEDIATE JEOPARDY**

- The facility failed to train staff on how to verify proper placement of a feeding tube & as a result the resident developed peritonitis and died.
- The facility failed to ensure that the resident was correctly positioned during tube feeding and the resident aspirated and developed aspiration pneumonia.

**SEVERITY LEVEL 3 EXAMPLES
ACTUAL HARM THAT'S NOT AN IJ**

- The facility failed to monitor for tube feeding (TF) complications and the resident experienced significant (not life threatening) complications.
- The facility failed to assess the resident's nutritional needs/parameters and adjust the TF accordingly, resulting in the resident losing a significant amount of weight that can't be attributed to other medication conditions.

**SEVERITY LEVEL 2 EXAMPLES
NO ACTUAL HARM WITH POTENTIAL FOR
MORE THAN MINIMAL HARM**

- Due to staff failure to secure the feeding tube, the resident had leakage around the stoma that required treatment and resolved without complications.
- The resident did not receive the correct amount of TF though there was not a significant weight loss or other complication.
- Staff was not consistently flushing the resident's feeding tube as ordered, resulting in a clogged tube that required replacement.

SEVERITY LEVEL 1
NO ACTUAL HARM WITH POTENTIAL FOR MINIMAL HARM

- Any failure to provide appropriate care and services for feeding tubes places the resident at risk for more than minimal harm;
- Severity Level 1 does not apply for this regulation.

Questions??