“But I said No!” Adherence to Advance Directives in Long-Term Care

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Presenter Disclosure

- **Presenter:** Leah Nemiroff
- **Relationships with financial sponsors:**
  - None
- **Potential for conflict(s) of interest:**
  - None
Objectives

- Advance Directives (ADs) in LTC
  - Hospital transfers
  - Effect of new model of care on transfers
- Why are residents being transferred against their explicit ADs?
Advanced Directives
What is an Advanced Directive?

- Written direction for future care if pt unable to communicate wishes (lacks capacity)

- **Legal document**
  - 1) **Instructional Directive**
    - What (or how) health care decisions are to be made if pt unable make decisions
  - 2) **Proxy/Delegate Directive**
    - Specify who will make decisions
      - delegate must > 19 years (unless the spouse)

Personal Directives Act, 2010
End of Life Policy in Canada, 2015
What’s in an AD?

- Resuscitation instructions
- “hospitalization” directives
- ‘No transfer to hospital’ orders:
  - Recognize that some transfers are unlikely to increase survival or quality of life
  - Improve resident & family experiences at end-of-life
What about in LTC?

- **LTC residents**
  - Amongst the highest users of health care resources
    - > 75% transferred to hospital emergency departments (ED) per year (Dwyer et al. 2014)
  - Often least able to communicate their wishes
- Hospitalized LTCF residents > community dwelling seniors:
  - Higher risk of transfer distress
  - Falls
  - Delirium
  - Pressure injuries
  - Infection
  - Mortality
  - EHS resources
  - Cost

Vertesi 2017
Dwyer et al 2014
Jensen et al. 2009
Our study

- What is the prevalence of ‘No transfer to hospital’ ADs in LTC?
- Are they being followed?
- If not….why not?

Mixed methods approach
- Quantitative: Research database (LTC network)
- Qualitative: Review of transcribed notes from EHS records
• Care by Design in LTC in NS
Methods

- Retrospective chart reviews - 748 residents across 10 participating LTCFs in Halifax

- Data spanned three time periods
  - (T1) pre-CBD implementation – 2009
  - (T2) the transition period (CBD + but before ECPs started) – 2010 – 2011
  - (T3) post-CBD implementation – 2011 – 2012
Results

748 Total residents

Excluded:
- 48 No AD
- 9 Content of AD recorded as “Other”

691 Residents with documented ADs (92.4%)

100 Active treatment, transfer to hospital, full resuscitation (14.5%)

103 Active medical treatment on-site, no transfer to hospital (14.9%)

253 Comfort measures on-site, no transfer to hospital (36.6%)

235 Active treatment, transfer to hospital, no resuscitation (34.0%)

356 No – do not transfer to hospital

335 Yes – transfer to hospital
Table 1: Resident characteristics, compared between time periods.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>All</th>
<th>T1</th>
<th>T2</th>
<th>T3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender, n (%)</td>
<td>n = 691</td>
<td>n = 181</td>
<td>n = 127</td>
<td>n = 383</td>
</tr>
<tr>
<td>Female</td>
<td>494 (71.9)</td>
<td>130 (71.8)</td>
<td>101 (79.5)</td>
<td>263 (68.7)</td>
</tr>
<tr>
<td>Age (years)</td>
<td>n = 691</td>
<td>n = 181</td>
<td>n = 127</td>
<td>n = 383</td>
</tr>
<tr>
<td>Mean (+/- SD)</td>
<td>83 (+/- 12.05)</td>
<td>84.8 (+/- 11.60)</td>
<td>83.0 (+/- 11.47)</td>
<td>82.1 (+/- 12.37)</td>
</tr>
<tr>
<td>Median</td>
<td>85</td>
<td>86</td>
<td>85</td>
<td>85</td>
</tr>
<tr>
<td>Cognition, n (%)</td>
<td>n = 631</td>
<td>n = 177</td>
<td>n = 107</td>
<td>n = 347</td>
</tr>
<tr>
<td>WNL</td>
<td>204 (32.3)</td>
<td>71 (40.1)</td>
<td>36 (33.6)</td>
<td>97 (27.9)</td>
</tr>
<tr>
<td>Dementia</td>
<td>427 (67.7)</td>
<td>106 (59.9)</td>
<td>71 (66.4)</td>
<td>250 (72.1)</td>
</tr>
<tr>
<td>MMSE score (/30)</td>
<td>n = 402</td>
<td>n = 97</td>
<td>n = 49</td>
<td>n = 256</td>
</tr>
<tr>
<td>Mean (+/- SD)</td>
<td>17 (+/- 8.31)</td>
<td>18 (+/- 7.55)</td>
<td>17 (+/- 9.68)</td>
<td>17 (+/- 8.31)</td>
</tr>
<tr>
<td>Median</td>
<td>19</td>
<td>19</td>
<td>19</td>
<td>18</td>
</tr>
<tr>
<td>Frailty(^d)</td>
<td>n = 306</td>
<td>n = 28</td>
<td>n = 278</td>
<td></td>
</tr>
<tr>
<td>Mildly Frail</td>
<td>32 (10.5)</td>
<td>-</td>
<td>2 (7.1)</td>
<td>30 (10.8)</td>
</tr>
<tr>
<td>Moderately Frail</td>
<td>117 (38.2)</td>
<td>-</td>
<td>14 (50.0)</td>
<td>103 (37.1)</td>
</tr>
<tr>
<td>Severely Frail</td>
<td>136 (44.4)</td>
<td>-</td>
<td>10 (35.7)</td>
<td>126 (45.3)</td>
</tr>
<tr>
<td>Very Severely Frail</td>
<td>18 (5.9)</td>
<td>-</td>
<td>2 (7.1)</td>
<td>16 (5.8)</td>
</tr>
<tr>
<td>Terminally ill</td>
<td>3 (1.0)</td>
<td>-</td>
<td>0 (0.0)</td>
<td>3 (1.1)</td>
</tr>
</tbody>
</table>

T1 = pre-CBD, 2 = transition, and 3 = post-CBD. WNL = within normal limits. SD = standard deviation.

\(^a\) Pearson chi-square
Shapiro-Wilk normality test for continuous variables
\(^b\) Kruskal-Wallis test
What happened?

- **335 Yes – transfer to hospital**
  - 272 Paramedics involved (911 call) (81.2%)
  - 284 Paramedics involved (911 call) (79.8%)
  - 199 Transferred to hospital (73.2%)
  - 155 Post-CBD (T3) (77.1%)

- **356 No – do not transfer to hospital**
  - 284 Paramedics involved (911 call) (79.8%)
  - 84 Pre-CBD (T1) (80.8%)
  - 69 Transition (T2) (98.6%)
  - 131 Post-CBD (T3) (72.0%)
Transferred against AD

Diagnostic Categories:
- Cardiac
- Respiratory
- Gastrointestinal
- Neurologic
- Injury
- Epistaxis
- Psychiatric/behavioural
- Sick - other
- Scheduled transfer

40.48% Cardiac
14.76% Respiratory
13.81% Gastrointestinal
5.71% Neurologic
2.86% Injury
1.43% Epistaxis
1.43% Psychiatric/behavioural
10.48% Sick - other
9.05% Scheduled transfer
Managed on-site (as per AD)
Frailty

Reason for EHS Assessment

- Injury
- Medical illness

Patient transferred to hospital?
- No
- Yes

Clinical Frailty Scale
Qualitative

- **Themes:** Tx to hospital against AD
  - (1) unclear care plans
  - (2) team communication
  - (3) inadequate symptom control on-site
  - (4) perceived need for investigations/procedures
• **Unclear care plan – communication:**
  • “Continued to decline, SOB, cough, increased respirations, weakness. Transfer to ER. Returned to LTC as advanced care directives are for comfort.”

• **Symptom control – Ix:**
  • “Pt fell, injured knee. A lot of pain, concern re hip fracture, unable to move pt. ECP in and pt taken to ER.”
Discussion

- ADs: extremely high completion rates
- Large proportion of residents transferred to hospital *against their explicitly documented wishes.*
  - Driven by injury
  - Then medical illness
Why?

- **Barriers to establishing the AD:**
  - Fear of limited care
  - Prognostic uncertainty
  - Limited contact with physicians
  - Health care professionals’ personal preferences

Mann et al. 2013
Why?

- **Barriers to following the AD:**
  - Lack of standardized terminology & documentation
  - Lack of detail, unclear wishes, overabundance of detail -> difficulties with interpretation and flexibility
  - Discordance between family and the resident’s previously expressed wishes
  - **Unpredictable situations**

Biola et al. 2010
Vogel 2011
Are falls an unpredictable situation?

- **Gryfe et al. (1977):**
  - 45% of LTC residents fall annually
  - 17.5% of those falls result in serious injury

- **Dwyer et al. (2014):** most common = tx for fall-related presentations & fractures/ortho injuries
  - Transfers to hospital = imaging, invasive testing and procedures, and admission
Injury: What do we do?

- Ignore AD: Risk unwanted transfer
- Follow AD: Risk worse QoL
Same goal, different pathway

Goal = comfort measures

Acute event

Injury

- Yes, transfer for Ix & specialist intervention (e.g. ortho)
- No, conservative measures and/or palliate on-site

Medical illness

- Treat on-site + palliation if deterioration
- Palliate on-site

Transfer back to LTC
Summary & Conclusion

- Emergency transfers of residents against their ADs
  - Often lead to poor outcomes
  - Use limited acute health care resources

- Many transferred to ED have explicit ADs to the contrary

- Injury and access to diagnostic imaging and orthopedic services are main drivers of transfers

- Future research:
  - Improve early identification and documentation of resident and family wishes with regards to injury management
  - Develop relevant action plans and policies
  - Consultation with key stakeholders to further identify perceived barriers to advance care planning (particularly with regards to transfers)
References

- Andrew, Melissa (2015). Unpublished Data from Poster: A Long-Term Care-Comprehensive Geriatric Assessment Tool: Improving care for frail older adults?
Thank You!

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Dr Barry Clarke
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Jan Jensen
LTC staff and residents

Questions?
Comments?
Same goal, different pathway

Acute event

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Goal = comfort measures

Transfer back to LTC
Injury: What do we do?

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Follow AD: Risk worse QoL