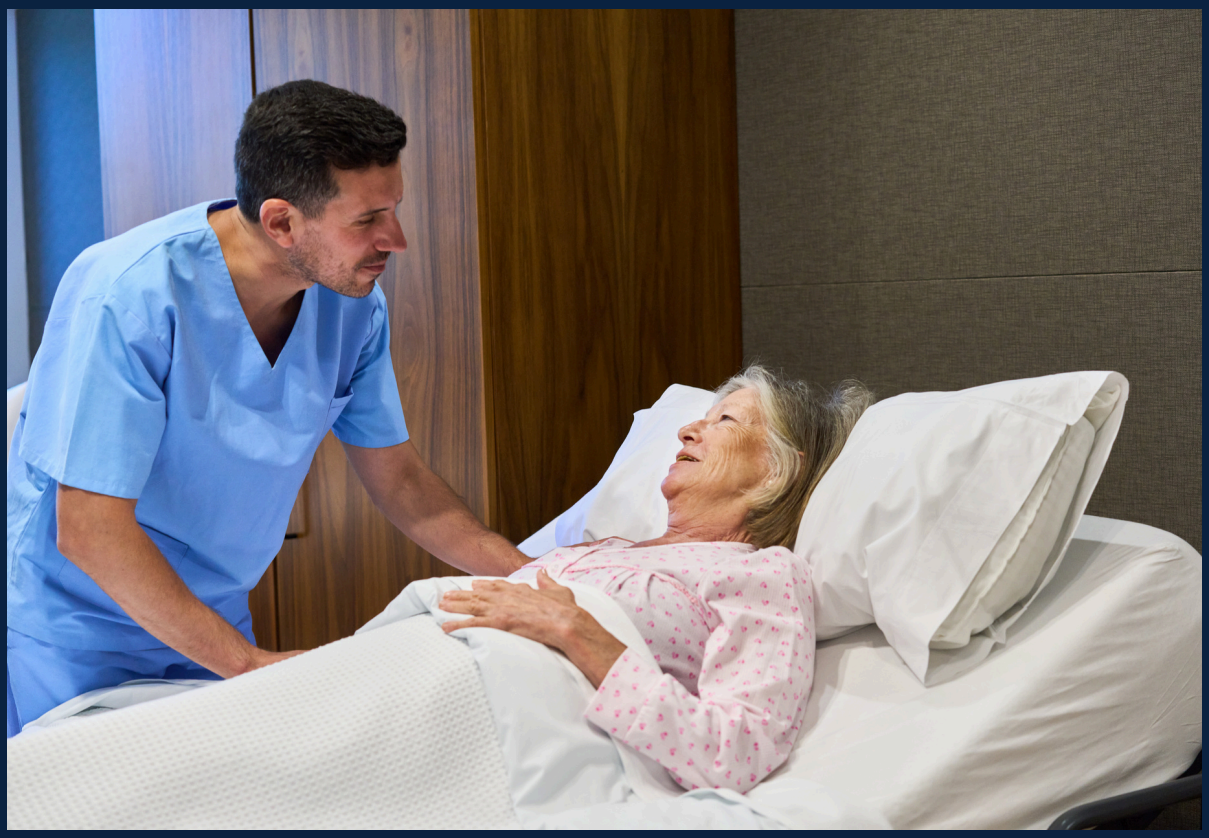


PALLIATIVE CARE, HOSPICE, AND PLANNING AHEAD

STAFF TOOLKIT
(INTERNAL USE)

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Purpose

This toolkit aids clinicians, nursing, and social work staff in initiating advance care planning discussions with residents and families. Its goals include:

- Early conversation initiation
- Prevention of crisis-driven decisions
- Alignment of care with resident values
- Consistency in packet usage across settings

Clinical Momentum

What It Is

Clinical momentum is the healthcare system's tendency to continually add treatments and interventions, often without intentional decisions, potentially leading to care that doesn't align with a patient's goals.

Why It Matters

In complex care environments, particularly for progressive conditions like dementia, care decisions can become increasingly complicated:

- Temporary interventions may turn permanent
- One clinical issue can result in multiple treatments
- Decisions might rely on system routines instead of individual preferences

Example: Feeding Tubes in Advanced Dementia

Feeding tube placement exemplifies clinical momentum, particularly in residents with advanced dementia. Research indicates these residents often:

- Spend more time in hospitals
- Experience increased medical complications
- Undergo additional interventions like nasogastric tube placement

Initial interventions may address short-term issues but can become permanent due to systemic processes, leading to care that may not align with best practices or residents' wishes.

Key Takeaway

Advance care planning helps interrupt clinical momentum by ensuring decisions are intentional and based on what matters most to the resident.

CONVERSATION GUIDE

Quick prompts to support meaningful palliative care discussions

WHEN TO USE

- Admission
- Decline after hospitalization
- Weight loss
- Recurrent infections
- Dementia progression
- Family distress

NEXT STEPS

1. **Document**
2. **Notify provider/ social work**
3. **Schedule follow-up**

WHAT TO SAY

> ***"What matters most to you?"***

> ***"What worries you most?"***

> ***"What would a good day look like?"***

Small conversations today can lead to care that honors what matters most.

WHAT NOT TO DO

- Don't rush decisions
- Don't overload with medical detail
- Don't frame hospice as "giving up"

CONVERSATION REMINDERS

- Listen more than you speak
- Allow silence
- Focus on goals not just treatment
- Revisit the conversation over time

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The Typical Path



Hospitalization



Feeding Tube



Rehospitalization



Infection



ICU



More Decline

The Palliative Care Path



Advance care planning



Comfort-focused care



Fewer burdensome interventions

When to Introduce the Family Packet

The packet should be used proactively, not reactively.

Primary Triggers

- Admission
- Change in condition
- Post-hospitalization return
- Care plan meeting
- Hospice or palliative care discussion
- Dementia progression trigger

Who Introduces the Packet?

Primary Options

- Social worker
- Nurse
- Provider
- Care coordinator

Suggested Lead

Social work introduces the packet, nursing reinforces, provider addresses treatment decisions.

Suggested Script

“We give this packet to help families think through future care decisions before a crisis happens. It explains palliative care, hospice, and advance care planning in a simple way. You do not need to complete it all today. We just want to help start the conversation.”

How to Guide the Conversation

Start Simple

- Focus on values, not procedures
- Ask open-ended questions
- Normalize that decisions may evolve over time

Core Questions to Ask

- What matters most to you right now?
- What are you most worried about?
- Who should make decisions if you cannot?
- What would a good day look like?

Avoid

- Overloading with medical detail
- Forcing decisions in one conversation
- Leading the resident toward a specific choice

Documentation Expectations

Chart the Following:

- packet provided
- who received it
- primary decision maker identified
- follow-up planned
- key concerns or values discussed

Example Documentation

Advance care planning packet reviewed with resident/family. Health care proxy discussed. Follow-up planned for next care conference on _____.

Follow-Up Workflow

Admission

Give packet, highlight 2 pages, schedule follow-up within 7–14 days

Care Conference

Review values and priorities, confirm or identify health care proxy, discuss code status and treatment preferences

Change in Condition / Hospitalization

Reintroduce packet if needed, focus on palliative vs hospice discussion, reassess goals of care

Dementia Progression Trigger

Introduce or revisit planning discussions, use the family questionnaire if needed, address expected disease progression, align care with resident values.

Family Questionnaire

Thinking and Mood Changes

Please complete this if you have noticed changes in memory, thinking, mood, or daily function.

Changes I Have Noticed

- □ More forgetfulness
- □ Repeating questions
- □ Trouble managing medications
- □ Trouble paying bills or handling finances
- □ Increased confusion
- □ Changes in mood
- □ Anxiety or fearfulness
- □ Withdrawal from activities
- □ Changes in sleep
- □ Changes in eating
- □ Falls or mobility decline
- □ Personality changes

My Biggest Concern

_____

_____

_____

When Did This Start?

_____

_____

_____

Who Has Noticed It?

_____

_____

_____

Additional Resources

Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

https://reference.medscape.com/calculator/538/informant-questionnaire-on-cognitive-decline-in-the-elderly-iqcode

Edmonton Frail Scale

https://reference.medscape.com/calculator/595/edmonton-frail-scale

Fracture Risk for Women with Known Bone Mineral Density (BMD)

https://reference.medscape.com/calculator/736/fracture-risk-for-women-with-known-bone-mineral-density-bmd

MDS Specific Frailty Scale

https://reference.medscape.com/calculator/696/mds-specific-frailty-scale

Geriatric Depression Scale

https://reference.medscape.com/calculator/277/geriatric-depression-scale

GAD-7 Anxiety Scale

https://reference.medscape.com/calculator/317/gad-7-anxiety-scale

Diagnosis of Dementia with Lewy Bodies (DLB)

https://reference.medscape.com/calculator/556/diagnosis-of-dementia-with-lewy-bodies-dlb

Diagnosis of Multiple System Atrophy (MSA)

https://reference.medscape.com/calculator/563/diagnosis-of-multiple-system-atrophy-msa

Hamilton Depression Rating Scale (HAM-D or HDRS)

https://reference.medscape.com/calculator/146/hamilton-depression-rating-scale-ham-d-or-hdrs

About the Authors

Manda Ayoub, NHA

Manda has over 30 years of healthcare experience. As the Chief Operating Officer at Pomeroy Living, she oversees facility operations, clinical outcomes, and regulatory compliance. Since joining in 2011, she has helped open Pomeroy's assisted living communities and implemented initiatives that improved patient outcomes and care quality. Manda is a licensed nurse and nursing home administrator in Michigan, with diverse roles in the post-acute healthcare industry, including Infection Control Nurse and Risk Manager.

Beth Carroll, BSN, RN

With a nursing career spanning more than a decade, Beth has been a registered nurse since 2015 with extensive experience across long-term care, acute care, and palliative and hospice settings. The majority of her professional journey has been rooted in skilled nursing, where she has held progressive leadership roles including Director of Nursing and Regional Nurse Consultant. In these positions, she has provided clinical oversight, operational leadership, regulatory guidance, and mentorship to interdisciplinary teams across multiple facilities. Beth is known for her strong clinical judgment, commitment to quality outcomes, and passion for guiding teams through complex patient care and compliance environments, while maintaining a patient-centered and compassionate approach to care delivery.

Melanie Flachs, RN

Melanie L. Flachs is a nurse leader with 41 years of experience, including over 30 years in long-term care. She has served as Director of Nursing, MDS Coordinator, and Clinical Consultant. Currently, she is the Chief Clinical Officer at The Peplinski Group, overseeing 10 skilled nursing communities. Her expertise includes clinical operations, regulatory compliance, and reimbursement. Melanie's consulting work covers survey compliance, plans of correction, facility turnaround, and reimbursement optimization. She has hands-on experience with Interact III care pathways and has led various initiatives, including electronic medical record implementation and clinical education. A frequent speaker, she is committed to advancing clinical excellence in long-term care.

Anne Shelley, MBA, BSN, RN

With 27 years of experience in hospice and 16 in home health, Anne began her career as a staff nurse at Hospice of Memorial Hospital in 1988, later advancing to patient care coordinator and director by 1994. She expanded her responsibilities in 1997 to include the hospital's home health agency, forming Memorial Home Health and Hospice. In 2008, she transitioned to become the CEO of Hospice of North Central Ohio for two years, and later served as CEO of Universal Home Health and Hospice until March 2016. Actively involved with the Ohio Hospice and Palliative Care Organization (OHPCO), Anne served on its board for nine years, holding roles such as Chair and Public Policy Committee Chair, and she presented on legislative matters at various meetings. Following the merger of Midwest Care Alliance and LeadingAge Ohio in 2015, she became the Director of Professional Development and Home Health and Hospice Regulatory Relations for ten years and now works as a consultant. Anne holds a BSN from Bowling Green State University (1988) and an MBA from Tiffin University (2001).

Angie Szumlinski, LNHA, RN, GERO-BC, RAC-CT, BS

Ms. Szumlinski is a nationally-recognized leader in long-term care with experience as an Owner/Provider, Administrator, Director of Nursing, Corporate Quality Assurance Coordinator and independent consultant. Ms. Szumlinski conducts risk management visits at facilities across the country, touching every acuity level within the post-acute care spectrum. Ms. Szumlinski served as an Associate Board Member for NCAL, is a member of the AHCA/NCAL Survey/Regulatory committee, NCAL Quality committee, HCAM Legal/ Clinical Committee and served as a Senior Examiner/Team Leader for the AHCA/NCAL Quality Award Program for 7 years. Ms. Szumlinski is a Nurse Planner for the HealthCap® RMS ANCC accredited education program.

Marea Trotter, BSN, RN

Marea serves as Vice President of Clinical Services for The Peplinski Group, overseeing clinical operations and risk management initiatives across ten skilled nursing facilities in Michigan. With extensive experience in long-term care leadership, clinical compliance, infection prevention, and quality improvement, she has held roles including Director of Nursing, Regional Nurse Consultant, and Clinical Compliance Specialist. Marea's diverse healthcare background includes critical care nursing, nursing education, and military service as a decorated U.S. Army combat veteran. She brings a practical, systems-focused approach to risk management, patient safety, and regulatory compliance.