F309 Resident at or Approaching End of Life

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Review of a Resident at or Approaching End of Life

Assessment and Management of Care at End of Life – In order to promote the physical, mental, and psychosocial well-being of a resident who is approaching the end of life, the facility and the practitioner must:	**Yes**	**No**	**Comments**
Was the resident's prognosis identified with supporting documentation?			
Were discussions/considerations initiated with the interdisciplinary team regarding advance care planning and resident choices to clarify resident goals and preferences regarding care as the resident is approaching the end of life.			
Are preferences reviewed and explored but not limited to, i.e., controlling pain and other symptoms; maintaining mental, physical, spiritual, and psychosocial functions.			
Is there evidence of advanced care planning to address the resident's wishes regarding the treatment of acute illness; and hospitalization treating acute illness; and hospitalization?			
With a decline in condition was the resident and/or the resident's legal representative advised when the resident was approaching the end of life? If the resident is not already receiving palliative care, was palliative care options advised and educated including hospice care, if appropriate and when care might include a more palliative focus?			
Is the resident plan of care, periodically reviewed addressing services, and support that accommodate and honor the resident's choices and rights, manage pain and other physical, mental and psychosocial symptoms and strive to meet the resident's physical, mental, psychosocial, and spiritual needs?			
Have staff been trained on death with dignity and aspects of palliative care?			
Since many residents lack a legal representative to speak for them and cannot readily make their needs and goals known, it is important for the interdisciplinary team to identify a substitute decision making method in accordance with state law. Was a decision making plan put into place?			
Was family education provided on disease progression and palliative cares?			
Are policies and procedures in place to identify, assess, and manage palliative care conditions?			
Was the resident's prognosis and the resident's decision-making capacity, values, goals, and social support systems assessed at the time of admission?			

Resident Name:_____ Room#_____

Evaluator:_____ Date:_____

Overview Addressing Care at End of Life

The **ABCDE** mnemonic is an example of an approach that can be adapted for use to manage symptoms and meet the resident's physical and emotional needs at the end of life:

- **A:** Ask the resident or his or her legal representative about (and screen for) pain and other symptoms related to the resident's end of life status on admission and periodically thereafter;
- **A:** Assess regularly and systematically for symptoms (such as dyspnea, fatigue, declining function, anorexia/eating difficulties/weight loss, pain, loneliness, anxiety/apprehension, depression, constipation, and delirium) and their impact on the resident;
- **B:** Believe the resident's report of pain or other symptoms, what precipitates it or makes it worse, and what relieves it; what has worked in the past?
- **C**: Choose symptom control options that are appropriate for the resident;
- **D:** Deliver interventions in a timely, logical, and coordinated manner;
- **E:** Empower the resident to participate in defining the goals of treatment and planning the interventions to the extent possible; and
- **E:** Evaluate the effectiveness of the chosen interventions.

Assessment of the Resident Approaching End of Life

Assessment of a resident approaching the end of life should identify remediable symptoms and identifying ways to optimize comfort and relieve suffering. Information obtained during the assessment is used to manage the dying process and the disease process. If the resident lacks health care decision-making capacity, the staff, including nurse aides and others (e.g., family members) who are most familiar with the resident.

❒ Resident's habits and preferences
❒ Symptoms of pain or discomfort *(e.g., anxiety, confusion, agitation, nausea/vomiting)*
❒ History of present illness
❒ Co-morbid medical and psychiatric disorders, and summary of current interventions;
❒ Physical, cognitive, and functional status (e.g., ability to communicate and ADL capacity); symptoms needing management
❒ Psychological, emotional, spiritual and environmental issues that may affect the resident's physical and/or psychological comfort (e.g., unresolved interpersonal and family issues; anxiety about dying alone and loss of independence or control; or high noise levels);
❒ Appropriateness and resident's desire for hospice or palliative care services;
❒ Goals, strengths and available supports;
❒ Other diagnostic tests and measures, as necessary (e.g., pain scales, blood tests, or the Minimum Data Set (MDS) Cognitive Performance Scale (CPS) Exam).

Care Planning for the Resident Approaching End of Life

A resident's goals and preferences for care, provide the basis for selecting and implementing care and services at the end of life. When the resident is nearing the end of life, it is important for the MD/NP and interdisciplinary team to review or update the prognosis with the resident and/or representative. It is also important for the team to review and revise the care plan as necessary to address the resident's situation, including expectations and management of specific symptoms and concerns.

For a resident receiving hospice care, the nursing facility coordinates care planning with the hospice.