BEST PRACTICES IN BEREAVEMENT CARE

INTRODUCTION

Home is deeply personal. Serious illness is frightening, and loss of home due to illness is a transition unlike any other. Long-term care facilities blend the concept of home with skilled medical care. Initially, staff and other residents are strangers, but eventually they become familiar. Relationships formed in this setting shape the day to day experience and are critical to the overall health and well-being of residents.

On the one hand, a long-term care facility is a place where death is an expected part of the environment. As one resident stated, "we know that we come here to die." On the other hand, not everyone comes to a facility with a life-threatening illness. As one director of nursing stated, "residents come here now for short-term rehab." This mix of attitudes ranging from 'I am here to die' to 'I am here to get better and go home' creates challenges for the culture of a long-term care facility.

More than sixty hours of interviews with members of nine long-term care facilities in middle Georgia led to the development of this guide, which we hope will promote change in the culture of death and dying. Participants identified practices used to support residents, families, and staff during critical end of life transitions. They also identified areas of unmet need for care. Their insights reflect their experiences with advance care planning and bereavement care.

ACKNOWLEDGEMENTS

The Georgia CMP Fund (2016-04-GA-0205) supported the work going into development of this guide. Thanks to Carol Babcock and Amanda Lucas (Navicent Health) for their assistance, support, and encouragement. We also wish to acknowledge the Macon-Bibb SNF Collaborative, Walter Coffey (Culture Change Network of Georgia), Richard Cohen (Georgia POLST Collaborative), Jennifer Holt for her guidance throughout the production of this booklet, and the participating facilities of Carlyle Place and within the Ethica Healthcare group. Thanks also to Bulldog Print and Design for their assistance in the design and production of this booklet. A final word of thanks to all readers of each draft. The best practices discussed in this booklet come directly from the voices of residents, families, and caregivers in facilities across middle Georgia. Their insights are amazing, and the environment they create to care for bereaved persons is quite special. The team (Amanda A. Brown and Toni P. Miles) is grateful for their time.

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BEREAVEMENT CARE

Grieving persons need care-bereavement care. This care includes the dying person's friends and family. It can also include staff, such as dietary workers and housekeeping, and anyone who spends time with the dying person on a regular basis.

Grief often begins long before a death occurs, so bereavement care should not be limited to the time following death. Quality bereavement care promotes healing and addresses the emotional needs of all persons involved.

> *One dear friend developed dementia. When she died, that was expected, and in an interesting sort of way it was a relief.*
>
> — **Resident**

> *The residents are like family. There is one that passed recently that really got to me.*
>
> — **Housekeeping**

> *I've been here for five years, and so I have gotten to know residents. They have become like family. So, I am deeply affected when I know someone is at the end of life.*
>
> — **Dietary Manager**

I'm not going to lie. Often, I am relieved when patients die, because I don't have to watch them suffer. The hardest part of death is usually watching the decline.

— Nurse

To me, death has never been just part of the job. It bothers me every single time. If I ever get used to it, I will know that it is time to get out of this field.

— Nurse

I need a grief counselor. I just lost my baby, and I have patients pass on me too. All I can do is pray.

— CNA

Caring for the Deceased

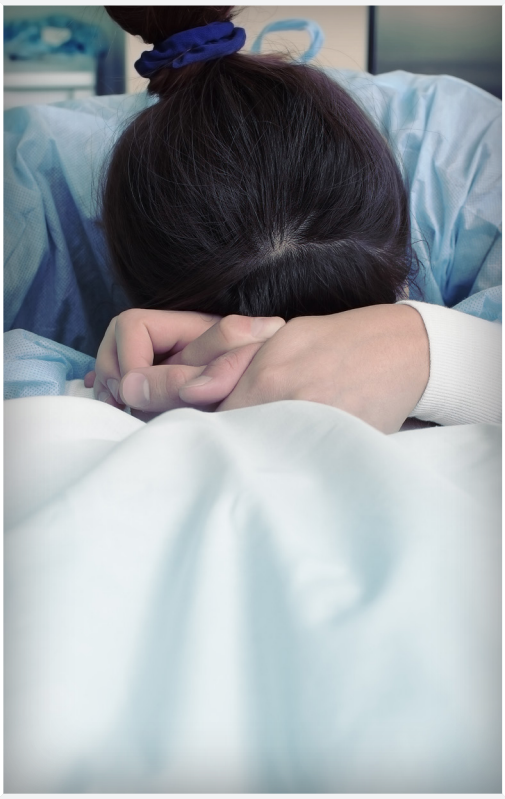
Caring for the resident's body facilitates the grieving process for family and staff.

BEST PRACTICE

Create a protocol to prepare the body for final viewing by family.

We remove all tubes, IVs, PICC lines, etc. We clean them up like they are going to church. We do mouth care, look under their necks, and give them a bed bath to freshen up because there are smells. Sometimes we put on a little bit of cologne. We also put clean clothes on them. Then we look around the room and put away stuff like toothbrushes so that the room looks fresh. When the family walks in, there should be a fresh smell, clean person, not a dead body. This is the last memory many will have.

— Head of Nursing



BEST PRACTICE

Create a caring and respectful process for handling the deceased.

> ***The difference between the nursing home where I used to work and this one is how they handle the dead. In a person-centered nursing home, we know all the residents and their families. We send someone to their funerals. Their relatives come back and visit. One of the CNAs even has a grandmother here.***
>
> **— Nurse**

Memorials

They used to do a ceremony each month. It was really helpful. The reverend used to come down and preach over the ceremony, and then we lit candles.

— CNA

My friend was diagnosed with terminal cancer and she gave herself a farewell party in the grand room and invited everybody in the place. She had her son play the piano. She gave me an example to follow; she did it beautifully.

— Resident

BEST PRACTICE

Memorials should be scheduled to honor the lives of those who have passed and to honor those who have cared for them. Consider asking residents, "If you could plan a service honoring you, what would it look like?"

We do a memorial service once a year to honor the residents who have passed away. We light candles, and we have an official program honoring them. We also play a video that shows pictures of the residents with their families and pictures of them when they were younger.

— Former CNA

The chaplains use essential oils, and they wash the hands of the staff. And they do a ceremony to help them get through the grieving process and let them understand that the work that they do doesn't go unnoticed, and that it is for the good. It allows staff to take pride in the care that they gave.

— Admissions Director

This past year we did a memorial service for everybody that had passed away during that year. We had it out on the front lawn. The activities director read a little passage, I read a poem. One of the secretaries sang and the head chef played the guitar. At the end, we released a butterfly for every resident that passed away. So it was really, really sweet, and it seemed very appreciated.

— Social Services Director

Grief Has Many Causes

Residents, staff, and families repeatedly mention that grieving doesn't happen only at the end of life. Grief occurs at different points in a stay.

An individual may experience multiple grief-related events while in long-term care. For example, there is grief related to moving into a facility. Residents may grieve losses of pets, independence, health, well-being, identity, hopes, dreams, companionship, or the comforts of home.

In other words, grieving is very much a regular and ongoing part of the long-term care experience. Recognizing the variety of causes helps to develop care plans.

> ***When I arrived, I knew no one and while everyone was kind, my grief was invisible. No one had ever known my fine husband or knew anything about me.***
>
> **— Resident**

A woman who lost her husband seven months ago just moved in next door to me. She is as confused as I was, wondering how the heck she's going to be a single woman again. She needs someone to talk to, to help walk her through the pieces.

— Resident

A few years ago, I lost some keepsakes that had a lot of sentimental value to me. Some of them had been inherited from family, and others were items that I collected over my life. I don't think it is reasonable to grieve over physical objects, but I did. I started crying and I couldn't stop.

— Resident

A man here watched his wife die about three months before arriving here. He was crying and crying and crying for weeks. There's nobody to talk to. People are just left here. There is no one to sit down with and no group to talk to.

— Resident

This isn't the same person I married. I can't share my thoughts and feelings with him anymore. We used to talk about everything.

— Resident

When my wife became needful of assisted living, we had to separate. One of my hardest memories is that when I went to the door to leave her room, she was hurting too. And I was hurting, and she said to me: "We'll never be able to stay together again." I closed the door and left. That was hard. That was the beginning of the end.

— Resident

Rehabilitation and Younger Residents

Not all residents enter care facilities to stay for a long period of time. Some may come for rehabilitation, and some are young adults. Unfortunately, a temporary stay can become a permanent stay. In this case, residents may feel that their freedom was ripped away from them.

> *They've had to give up the dog and personal stuff to be here. They've worked so hard thinking that the goal is to go home, only to have someone at home say "I'm sorry I just can't take care of you anymore; I just can't."*
>
> — Director of Nursing

> *A lot of our residents come in first for rehab and then transition. We often see anger, disappointment, or grief after this failure to return home from therapy. There is anger involved because family members are telling folks "Nope, sorry. You worked hard but you still can't go home."*
>
> — Admissions Director

Help for Grief

Each person experiences grief differently. Every practice does not work for everyone. For example, some residents have benefited from support groups, while others prefer one-on-one conversations.

> ***I would have liked somebody who had been through a similar circumstance to assure me that someday it's going to be over. "I see you're working hard at it. I can't really tell you what will work for you but I can tell you if you keep looking you'll find it, and I will be here to talk to you about it all the way."***
>
> **— Resident**

BEST PRACTICE

Consider grouping support for residents and family members according to the diagnosis or length of stay of the resident.

There were support groups that I didn't take full advantage of, I didn't take much advantage at all actually. I lost Mom in the late 90s, and of course a lot of things have improved, and the Alzheimer's Association has grown since then. It offers so much that I wasn't aware of. But when I finally took advantage of the support groups, they were really good.

— Resident

Families need a support group. We see them get mad because their parents, who have dementia, exhibit a behavior like busting up a laundry basket. The family gets really upset about the destruction of a $10 laundry basket. That's stress and denial, and they really need a support group.

— CNA

BEST PRACTICE

Clearly publicize resident and family support services.

Some family members have cared for a relative with Alzheimer's for years. They might take advantage of a support group, because they are extremely battle weary and fatigued. They have fallen into this routine that has become so rigid for them, and all of a sudden everything changes and they really don't know how to put their lives back together. So they are the ones that often seek counseling.

— Chaplain

BEST PRACTICE

Encourage residents and family members to take advantage of both facility and community supports.

BEST PRACTICE

Allow and encourage residents to make as many choices about their care as possible. To the greatest extent possible, try to make them feel like they can maintain some control over their lives.

I think the thing that we try to always focus on is choices. There are some things that are in your control to choose no matter what your situation is. For example, you may be able to make choices about your room or your diet. You may not be able to make all of the choices that you want to make, but you can at least make some decisions. It's not easy though.

— Director of Admissions

Hurdles Encountered by Staff

Helping a grieving person is challenging for staff. Each person can express grief differently. In addition to crying or sadness, persons can shout, argue, or scream. Staff may be left wondering how to respond to families, residents, or coworkers.

> *Everyone handles death differently. Some people want a person to blame. There are so many different feelings of grief that we're not equipped to handle, that I was not equipped to handle.*
>
> — Nurse

> *Sometimes you run into the deceased's family members on the street. They'll remember you. A lot of times people say "I'm sorry," and that's the only thing you can really say.*
>
> — CNA

BEST PRACTICE

Train staff to talk to emotional family members. They should avoid phrases like "I know how you feel," or "they are in a better place now." Simply saying "I'm sorry for your loss" or quietly standing by may be best.

It's harder for me to try to comfort the family afterwards, because I feel like I've done what I need to do for the resident.

— Nurse

To me the worst part is dealing with the families. It's not the actual death. For example, sometimes if a loved one is unlikely to make it through the night, family members ask me if they should stay here. I'm not sure I'm the one who should answer that.

— Nurse

His mother had just died, and when I asked him, "hey, how are you, and what's going on?" he told me that he thought his mom had died because a nurse had taken a smoke break. He felt that he needed to go in there and just shoot everybody in there. I said 'oh' and then the security guard came up and started talking to him; and then he just left. What bothered me the most is that the nurses in that unit had been taking care of his mother, doing everything they could, but the one time he asked for s specific nurse, she was out smoking. I honestly don't know why anyone gave him that much detail.

— Nurse

Death affects people in different ways. After a resident dies, the caregiver may still have five other patients to take care of, and usually that's when we work together as groups.

— Social Worker

I think that we need a bereavement team. You may have sat next to the deceased person or talked to that person for months. And then a doctor might come and speak with the family, but after that he's pretty much gone, and there are so many steps you have to take: calling the funeral home, taking care of the body postmortem. It affects people in different ways.

— Social Worker

BEST PRACTICE

Create a bereavement team to assist the primary staff caregiver when a resident dies.

BEST PRACTICE

Consider making bereavement care a part of the overall care plan.

We schedule a time to do in-service for the staff about the integration, the wholeness of the person. Our care is about the entire person and their family, so we want our staff to make certain they are aware that it's just not the flesh and the bones, it's the spirit too.

— Director of Nursing

Nobody experiences grief exactly the same way. We all have very different backgrounds, and we are from different areas of the country. Some of us are from other countries. And so we can't always classify everybody's grief into one category. We have to look at it situationally and individually; it's a very individual experience.

— Social Worker

I spend time with residents, check on them, check on their families. I talk to them about if they've lost a loved one, about that person, and about their feelings. A lot of times, talking about the one they just lost helps a lot with the grieving process. If they have a pastor that they want to talk to, I contact that minister, or I offer to contact the minister that works for our company. And then we do a grieving care plan, things to watch for, and we alert the CNAs too.

— Social Worker

Caring for Staff

Staff members suffer grief from losses in both their professional and personal lives. Addressing their grief plays a significant role in their overall well-being and their capacity to provide the best care for residents.

> ***I think the most important thing is trying to get some kind of support for long-term care workers. It might not be every month; maybe every three months. The people in long-term care get attached to the residents; they become their second family. We have CNAs that still have relationships with the families even after the residents die. So I think it would be a good idea to offer support. Most people need it at one time or another.***
>
> **— Nurse**

BEST PRACTICE

It is important to provide support for staff. This may include regular meetings or other easily accessible opportunities for counseling.

We give individual counseling not just to patients and family members, but also to facility staff who may be going through grief issues of their own that are not remotely related to the facility. They may have had personal losses; they may have lost a mother or father or grandparent. They may have had a sudden loss and are out of work for a certain period of time, and so they will often ask us if we don't mind spending time with them, and most of us are always glad to do it.

— Hospice Chaplain

We were doing a group counseling session for employees who had lost a fellow staff member. We would meet with that care group for the last fifteen minutes of one shift and the first fifteen minutes of the next shift. It was a little thirty minute window that we could have to talk about how they felt. It affects their jobs, so we try to make sure we are there for them.

— Hospice Chaplain

BEST PRACTICE

To reduce staff members' stress, allow them to rotate their responsibilities. This could involve switching up weekly schedules, modifying existing workloads, or even allowing individuals to move between positions or departments. Be sure to involve staff members in decision making about best courses of action.

At one point, I got burned out: I felt that I could not handle my job anymore. My supervisor found an opportunity for me to go into another job area, so I made the move. I was worried that I might not be able to spend time with my residents, but I've been doing it for two years now and I actually spend more time with the residents.

— Former CNA

In my ten years, I've been jumping all around here. I've worked all three shifts, then for a while I was the spa coordinator, then lead CNA, then a restorative aide, and I do that now. Doing different things in this building keeps me sane.

— CNA

END OF LIFE PLANNING

Planning

Planning is key to reducing stress and ensuring that a resident's wishes are respected. Advance Care Planning (ACP) and preparing Physician Orders for Life Sustaining Treatment (POLST) forms help residents share their wishes with their families. This can reduce family members' doubts about treatment decisions. POLST forms also provide a record of the plan which can help facility staff know what to do if a resident is found unresponsive.

> ***I had a friend that died. Her kidneys failed, everything went wrong. She died in a hospital in horrible shape, terrible breathing; everything was awful. Her children were there, and she kept saying "I just want to die. Will they just let me die?" She was alive enough to say "I want to die, let me die. Take all these things off of me and let me die." And finally the children said okay. But it took weeks. She was in too much pain; she was in agony.***
>
> **— Resident**

Advance Care Planning (ACP)

On January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) began reimbursing physicians for time spent discussing and documenting patients' wishes and preferences for future care. This is called Advance Care Planning (ACP). It can occur in the outpatient setting, the hospital, or within a long-term care facility.

ACP is designed to be available to older adults and everyone involved in their care. It is a helpful tool for understanding resident wishes for treatment. Increasingly, doctors do ACP with patients before they are admitted to long-term care facilities.

BEST PRACTICE

The event of admission may not be the first moment when a resident has been asked about Advance Care Planning or end of life treatment preferences. Ask residents' prior physicians about ACP, or look for written evidence of ACP from other sites of care.

Physician Orders for Life-Sustaining Treatment (POLST)

The POLST form is a document designed to help older adults with planning. It also makes physician orders clear to staff. Georgia's POLST form was developed in 2012 by the Georgia Department of Health. In 2015, a Georgia law was passed providing legal protection to medical professionals who follow its directions. Similar forms exist in many other states. Although the forms are new, they are gaining popularity in Georgia and nationwide. Numerous government and nonprofit organizations are working together to teach people about them. They are particularly helpful in long-term care facilities.

> *We use the POLST here and I really prefer that to the traditional DNR, because it gives residents the ability to describe which treatment measures they want. And our doctors are all on board; they're in agreement. They sign off on it.*
>
> — Admissions Director

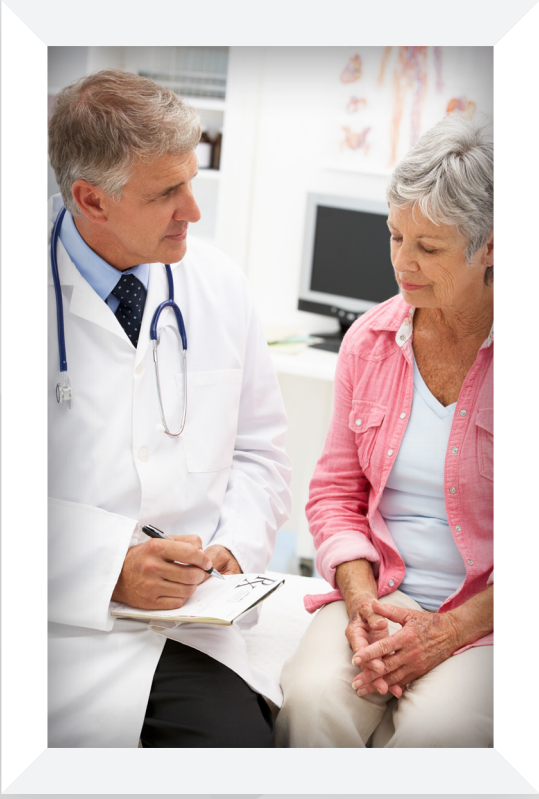
> *I would say that the nurses are familiar with the POLST; the CNAs are not.*
>
> — Nurse

> *The hardest death that I ever had to deal with was when a man was coding, and part of the family wanted him resuscitated and the other part did not. He had not put his wishes in writing, so I had to do a full code, but some of the family members were begging me to stop.*
>
> — Nurse

POLST forms are not for everyone. They were designed to meet the special concerns of persons with serious illnesses or frailty. These individuals' current health status indicates the need for standing orders for emergent medical care. For healthier persons, ACP is the appropriate tool for making future end of life wishes known to loved ones.

Conversations about POLST are likely to happen in long-term care. This may be the first time anyone asks about specific procedures that residents want or do not want. The conversation can be daunting. Reluctance to discuss the POLST may come from a fear of causing harm to loved ones.

> ***We're learning not to say "do not resuscitate," but instead to say "allow natural death." I think that works better.***
>
> **— Nurse**



BEST PRACTICE

Emphasize that dying is a natural process. The POLST framework will facilitate resident and family communication.

BEST PRACTICE

Ensure that POLST forms are readily available and easy to access.

> *POLSTs are logged on the computer; I can track them. I actually keep a spreadsheet of everybody that we have in the building, what their POLSTs are, and what the wishes are on the POLST. That way if somebody calls, I don't have to hunt down the chart and go find it.*
>
> — Social Services Director

> *We have only recently started including CNAs in the care planning meeting. It helps them to know what to do when a person is found unresponsive. They are the ones who see the most deaths.*
>
> — CNA Supervisor

BEST PRACTICE

Include CNAs in all care plan meetings. This will help them understand POLST instructions and patients' care preferences.

Georgia Department of Public Health

POLST GEORGIA
PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

PHYSICIAN ORDERS FOR LIFE- SUSTAINING TREATMENT (POLST)

Patient's Name _____ _____ _____
(First) (Middle) (Last)

Date of Birth _____ **Gender**: Male ☐ Female ☐

A **CODE STATUS** Check One	**CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.** ☐ **Attempt Resuscitation (CPR).** ☐ **Allow Natural Death (AND) - Do Not Attempt Resuscitation.** *** Signature of a concurring physician is needed for this section to be valid* ***if*** *this form is signed by an Authorized Person who is not the Health Care Agent. See additional guidance under III on back of form.* **When not in cardiopulmonary arrest, follow orders in B, C and D.**
B Check One	**MEDICAL INTERVENTIONS: Patient has pulse and /or is breathing.** ☐ **Comfort Measures**: Use medication by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. *Do not transfer to hospital for life-sustaining treatment.* ☐ **Limited Additional Interventions**: In addition to treatment and care described above, provide medical treatment, as indicated. DO NOT USE intubation or mechanical ventilation. *Transfer to hospital if indicated. Generally avoid intensive care unit.* ☐ **Full Treatment**: In addition to treatment and care described above, use intubation, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.* Additional Orders (e.g. dialysis):
C Check One	**ANTIBIOTICS** ☐ No antibiotics: Use other measures to relieve symptoms. ☐ Determine use or limitation of antibiotics when infection occurs. ☐ Use antibiotics if life can be prolonged. Additional Orders:
D Check One In Each Column	**ARTIFICIALLY ADMINISTERED NUTRITION/FLUIDS** **Where indicated, always offer food or fluids by mouth if feasible**
	☐ No artificial nutrition by tube. ☐ Trial period of artificial nutrition by tube. ☐ Long-term artificial nutrition by tube. Additional Orders:
	☐ No IV fluids. ☐ Trial period of IV fluids. ☐ Long-term IV fluids. Additional Orders:

DISCUSSION AND SIGNATURES

The basis for these orders should be documented in the medical record. To the best of my knowledge these orders are consistent with the patient's current medical condition and preferences and comply with the requirements of applicable Georgia law.

Physician Name: License No.: State:	Physician Signature:	Date: Phone:
Concurring Physician Name (*if needed; see III.i. on back of form*): License No.: State:	Concurring Physician Signature (if needed):	Date: Phone:
Patient or Authorized Person Name: ****authorized person may NOT sign if patient has decision making capacity*	Patient or Authorized Person Signature:	Date: Phone:

Relationship to Patient (check all that apply):

☐ Self ☐ Health Care Agent ☐ Spouse ☐ Court-Appointed Guardian ☐ Son or Daughter ☐ Parent ☐ Brother or Sister

GUIDANCE FOR COMPLETING THE POLST FORM

1. Completion of a POLST form is always voluntary**.**
2. Any section of a POLST form which is not completed implies full treatment for interventions discussed in that section.
3. A POLST form may be executed/created:
   a. when a patient has a serious illness or condition and the attending physician's reasoned judgment is that the patient will die within the next 365 days OR
   b. at any time if a person has been diagnosed with dementia or another progressive, degenerative disease or condition that attacks the brain and results in impaired memory, thinking, and behavior.
4. **If the patient has decision making capacity**, that patient chooses whether to complete and sign the POLST form with his or her physician. An authorized person may NOT sign the POLST form for a patient who has decision making capacity.
5. **If the patient lacks decision making capacity**, the POLST form may be signed by an "authorized person", which includes, in the following order of priority:
   a. the agent named on the patient's durable power of attorney for health care or a health care agent named on the patient's advance directive for health care
   b. a spouse
   c. a court-appointed guardian
   d. son or daughter (age 18 or older)
   e. parent
   f. brother or sister (age 18 or older)
6. If an authorized person completes and signs the POLST form, treatment choices should be based in good faith on what the patient would have wanted if the patient understood his or her current circumstances.

ADDITIONAL GUIDANCE FOR HEALTH CARE PROFESSIONALS

I. When a POLST form is signed by the Patient and Attending Physician**,** all orders may be implemented without restriction.

II. When a POLST form is signed by the patient's Health Care Agent and Attending Physician:
   i. If Section A indicates Allow Natural Death – Do Not Attempt Resuscitation, this order may be implemented when the patient is a "candidate for non-resuscitation"* as defined in Georgia Code Section 31-39-2(4). However, a concurring physician signature is NOT required per Georgia Code Section 31-92-4(c).
   ii. Orders in Sections B, C and D may be implemented without restriction.

III. When a POLST form is signed by an Authorized Person (other than the patient's Health Care Agent) and Attending Physician:
   i. If Section A indicates Allow Natural Death – Do Not Attempt Resuscitation, this order may be implemented when the patient is a "candidate for non-resuscitation"* as defined in Georgia Code Section 31-39-2(4). A concurring physician signature is REQUIRED per Georgia Code Section 31-39-4(c).
   ii. Orders in B, C, or D may be implemented when patient is:
      a. in a terminal condition OR
      b. state of permanent unconsciousness OR
      c. diagnosed with dementia or another progressive, degenerative disease or condition that attacks the brain and results in impaired memory, thinking and behavior.

IV. The status of resuscitation orders during surgery or other invasive procedures should be reviewed by the physician with the patient or patient's "authorized person" (as defined above).

V. Copies of the original POLST form are valid.

VI. The POLST form shall remain effective unless revoked by the attending physician upon the consent of the patient or the patient's authorized person.

VII. An attending physician who issues an order using the POLST form and who transfers the patient to another physician shall inform the receiving physician and the health care facility, if applicable, of the order**.**

VIII. A health care facility may impose additional administrative or procedural requirements regarding a patient's end of life care decisions, including the use of a separate order form. If the patient is in a health care facility, the attending physician should check with the facility to ensure these orders are valid.

***** Georgia Code Section 31-92-2(4) defines a "candidate for non-resuscitation" to mean a patient who, based on a reasonable degree of medical certainty:

(A) has a medical condition which can reasonably be expected to result in the imminent death of the patient;
(B) is in a non-cognitive state with no reasonable possibility of regaining cognitive functions; or
(C) is a person for whom CPR would be medically futile in that such resuscitation will likely be unsuccessful in restoring cardiac and respiratory function or will only restore cardiac and respiratory function for a brief period of time so that the patient will likely experience repeated need for CPR over a short period of time or that such resuscitation would be otherwise medically futile.

SUBSEQUENT REVIEW OF THE POLST FORM

This form should be reviewed when (i) the patient is transferred from one care setting or care level to another (ii) released to return home (iii) there is substantial change in the patient's health status, or (iv) the patient's treatment preferences change. If this POLST is voided, replaced, or becomes invalid, then draw a line through sections A though D, write "VOID" in large letters with date and time, and sign by the line. After voiding the form, a new form may be completed. *If no new form is completed, full treatment and resuscitation may be provided.*

Date/Time of Review	Location of Review	Print Name of Reviewer	Outcome of Review	Physician Signature
			☐ **No Change** ☐ **Form Voided, new form completed** ☐ **Form Voided, no new form**	
			☐ **No Change** ☐ **Form Voided, new form completed** ☐ **Form Voided, no new form**	

Summary: Best Practices at Long-Term Care Facilities

CARING FOR THE DECEASED

1. Create a protocol to prepare the body for final viewing by the family.
2. Create a caring and respectful process for handling the deceased.

MEMORIALS

3. Memorials should be scheduled to honor the lives of those who have passed and to honor those who have cared for them. Consider asking the resident "if you could plan a service honoring you, what would it look like?"

HELP FOR GRIEF

4. Consider grouping support for residents and family members according to the diagnosis or length of stay of the resident.
5. Clearly publicize resident and family support services.
6. Encourage residents and family members to take advantage of both facility and community supports.
7. Allow and encourage residents to make as many choices about their care as possible. To the greatest extent possible, try to make them feel like they can maintain some control over their lives.

HURDLES ENCOUNTERED BY STAFF

8. Train staff to talk to emotional family members. They should avoid phrases like "I know how you feel" or "they are in a better place now." Simply saying "I'm sorry for your loss" or quietly standing by may be best.
9. Create a bereavement team to assist the primary staff caregiver when a resident dies.
10. Consider making bereavement care a part of the overall care plan.

CARING FOR STAFF

11. It is important to provide support for staff. This may include regular meetings or other easily accessible opportunities for counseling.
12. To reduce staff members' stress, allow them to rotate their responsibilities. This could involve switching up weekly schedules, modifying existing workloads, or even allowing individuals to move between positions or departments. Be sure to involve staff members in decision making about the best course of action.

PLANNING

13. The event of admission may not be the first moment when a resident has been asked about Advance Care Planning or end of life treatment preferences. Ask residents' prior physicians about ACP, or look for written evidence of ACP from other sites of care.
14. Emphasize that dying is a natural process. The POLST framework will facilitate resident and family communication.
15. Ensure that POLST forms are readily available and easy to access.
16. Include CNAs in all care plan meetings. This will help them understand care preferences and POLST instructions.

Next Steps:

HOW MANY OF YOUR STAFF MEMBERS AND RESIDENTS ARE FAMILIAR WITH THE POLST? WHAT SORT OF EDUCATION MIGHT YOU OFFER ABOUT IT?

WHAT TYPE OF BEREAVEMENT CARE IS OFFERED AT YOUR FACILITY? CAN YOU THINK OF ANY ADDITIONAL PRACTICES WHICH MIGHT BE HELPFUL TO STAFF OR RESIDENTS?

NOTES

Appendix: Background Research on the Impact of Grief on Health

1. *The Impact of Mid- and Late-Life Loss on Insomnia: 2010 HRS Cohort.* Simpson et al (2014). Family & Community Health, 37(4): 317-326.

   This study examines insomnia after loss of a loved one. Insomnia is responsible for $6.6 billion in healthcare-related costs each year. It also increases one's risk for heart disease, diabetes, anxiety, and depression. Adults who have lost a spouse, child, or more than one family member are the most likely to suffer insomnia. The highest rates of insomnia after loss occur in women aged 50 to 59 years and men aged 65 to 70 years. Any kind of physical activity - like walking - reduces this risk by one-third.

2. *In a Longevity Society, Loss and grief are Emerging Risk Factors for Health Care Use:* 2010 HRS Cohort Aged 50 to 70 years. Miles et al. (2016). American Journal of Hospice & Palliative Medicine, 33(1): 41-46.

   This study examines the risk for being hospitalized after death of a parent, spouse, sibling, or child among persons aged 50 to 70 years. Loss is associated with a 20-30 % increased risk for an overnight hospital stay.

3. *Population-level impact of loss on survivor mortality risk.* Allegra et al. (2015). Quality of Life Research, 24(6): 2959-2961.

   This study shows that the loss of close relative (parent, spouse, sibling, or child) is an independent contributor to risk for mortality of the bereaved. It also suggests that physical activities – like walking - "strongly reverses" the risk.

4. *Refusing to Admit Defeat: Physicians' Reluctance to Discuss End of Life Care.* Brown & Miles. (2016). Palliative Medicine & Care, 2(1): 1-2.

   This is a thoughtful piece derived from an interview with a retired surgeon who is also a nursing home resident. He suggests that physicians' reluctance to have frank end of life discussions with patients stem from a need to avoid 'failure'. His commentary and the reports of others suggest a broader range of views within the physician community about end of life care. His discussion has implications for the use of POLST as a therapeutic tool and training future physicians.

5. *Indicators of resilience and healthcare outcomes: 2010 HRS Cohort*. Ezeamama et al. (2016). Quality of Life Research, 25: 1007-1015.

   The other studies in this list indicate that there is an increased risk of insomnia, hospitalization, or death after the loss of a parent, spouse, or adult child. There are factors, however, that clearly show the positive effects that prior experience with adversity can have to build resilience. Persons aged 50 to 70 years draw on this experience to buffer the negative health impact of loss. Once again, mild physical activity – like walking - was shown to have a consistently protective effect on health outcomes.

Grief begins long before a death occurs.
Grieving persons need care
– Bereavement Care.

FUNDED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES
CIVIL MONEY PENALTY FUND GRANT NO. 2016-04-GA-0205

CREATED BY THE UNIVERSITY OF GEORGIA SCHOOL OF PUBLIC HEALTH
ATHENS, GA 30602
2017