LPN CERTIFICATION PREP COURSE CLASS #4 SKIN, MEDICATION, RESIDENT ASSESSMENT, DEATH AND DYING

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OBJECTIVES

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- Explain the importance of Metabolism, Absorption and Excretion of Medication in older adults.
- Discuss the Stages of Pressure Ulcers and proper documentation and treatment.

DISCLOSURE STATEMENT

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- This nursing continuing professional development activity was approved by the Ohio Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. (OBN-001-91) 2022-0000000716 Approval valid 2 years from Dec.19, 2022. Expires on Dec. 19, 2024.

Medications/Absorption/Side Effects/Herbals

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- There is a wide variety of factors that place the community-dwelling older adult at risk for problems in medication management. The young-old (ages 66–74) have been found to be more adherent to medication regimens than middle-aged older adults, but after age 75, older adults present decreased comprehension of medication instructions and adherence. Living arrangements influence the older person's ability to manage medications, and older adults who live alone were found to be more prone to medication errors.
- A study of older adult outpatients who took five or more medications found that 35 percent experienced adverse drug events. In addition, individuals with complex regimens had difficulty naming and explaining the purposes of medications and appeared to be at high risk for nonadherence.
- It is not only the number of medications but also the number of doses per day and actions related to taking medications that contribute to complexity of a medication regimen. In a study of medication compliance, the compliance rate was 87 percent for daily dosing, 81 percent for twice a day, 77 percent for three times a day, and 39 percent for four times a day. In addition, a change in prescribed drug regimen has been found to be a predictor of medication nonadherence in older adults.

MEDICATIONS (Cont'd)

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- **Poor vision and low manual dexterity are associated with poor medication self-management. The inability to read medication labels has been associated with nonadherence to long-term medications in the elderly. One study found 28 percent of community-based older adults did not keep their medication bottles properly closed so that they could open them, and 47 percent admitted that labels on their medications were unclear, and they could not read them due to poor eyesight, inability to read English, or small writing on the label.**
- **In studies of persons with chronic obstructive pulmonary disease (COPD), 38 percent used their inhaled medications with poor technique, and poor hand strength was associated with nonadherence in inhaler use. In another study of COPD patients, more than 50 percent had difficulties with their inhalers.**
- **Medication-container modification is one area of intervention for older adults who have difficulty opening or reading containers. Use of non-childproof containers is one option for older adults. However, blister packs or other variations of unit dose packaging have resulted in increased compliance.**
- **Finally, talking medication containers and large-print labels are modifications that can be useful for persons with visual impairment.**

MEDICATIONS (Cont'd)

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- **Poor cognition is associated with both over adherence and under adherence of a prescribed medication regimen. A study of community-dwelling women found that 22 percent were unable to accurately perform a routine medication regimen; however, only 2 percent self-identified that they had difficulty with their medications. Forgetting is a major reason medication doses are missed.**
- **Compliance aids such as pill box organizers have been found to increase medication adherence. Medication schedules and calendars are helpful, especially in combination with education and use of a pill box. In addition, electronic monitoring that provides feedback to the user increases adherence. Older patients using a voice-reminder-message medication dispenser were significantly more compliant than those using a pill box or self-administering medications.**

Medication Absorption Including Distribution, Metabolism, and Excretion in Older Adults

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The Process involved in taking medication:

- **Absorption**
- **Distribution across body compartments**
- **Metabolism**
- **Excretion**

- **With aging, there are changes in all these areas; some changes are more clinically relevant. The metabolism and excretion of many drugs decrease, requiring that doses of some drugs be decreased. Toxicity may develop slowly because concentrations of chronically used drugs increase for 5 to 6 half-lives, until a steady state is achieved.**

Medication Absorption Including Distribution, Metabolism, and Excretion in Older Adults

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- **Absorption: Despite an age-related decrease in small-bowel surface area, slowed gastric emptying, and an increase in gastric pH, changes in drug absorption tend to be clinically inconsequential for most drugs. One clinically relevant exception is calcium carbonate, which requires an acidic environment for optimal absorption. Thus, increases in gastric pH—which may be age-related (such as with atrophic gastritis) or drug-related (such as with proton pump inhibitors)—can decrease calcium absorption and increase the proton pump inhibitors)—can decrease calcium absorption and increase the risk of constipation. We also know absorption can be inhibited by taking certain medications together, such as antacids and thyroid medication or digoxin.**

Distribution/Metabolism/Excretion of Medication and Use of Herbals

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- Distribution: With age, body fat generally increases and total body water decreases. This can cause and increased half life for certain medications.
- Metabolism: Overall hepatic metabolism of many drugs through the enzyme system decreases with age. For drugs with decreased hepatic metabolism, clearance typically decreases 30 to 40%. Theoretically, maintenance drug doses should be decreased by this percentage; however, rate of drug metabolism varies greatly from person to person, and dose adjustments should be individualized.
- Excretion: One of the most important changes associated with aging is decreased renal elimination of drugs. After age 40, glomerular filtration rate (GFR) decreases an average of 8 mL/min, however, the age-related decrease varies substantially from person to person.

Herbal or natural/organic medications have become very popular and are widely used. It is a good practice to be sure the physician is aware of any Herbal medications a tenant is taking to assure there is no risk of interaction with a prescribed medication.

MEDICATION ADMINISTRATION

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- You have probably been taught the 5 Rights of medication administration. Some institutions have added 3 more Rights to complete a safe and accurate medication pass.
- 1. Right patient
- Check the name on the order and the patient.
- Use 2 identifiers.
- Ask patient to identify himself/herself.
- 2. Right medication
- Check the medication label.
- Check the order.

MEDICATION ADMINISTRATION (Cont'd)

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- **3. Right dose**
- Check the order.
- Confirm appropriateness of the dose using a current drug reference.
- If necessary, calculate the dose and have another nurse calculate the dose as well.
- **4. Right route**
- Again, check the order and appropriateness of the route ordered.
- Confirm that the patient can take or receive the medication by the ordered route.

MEDICATION ADMINISTRATION (Cont'd)

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- **5. Right time**
- Check the frequency of the ordered medication.
- Double-check that you are giving the ordered dose at the correct time.
- Confirm when the last dose was given.
- **6. Right documentation**
- Document administration AFTER giving the ordered medication.
- Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug.

MEDICATION ADMINISTRATION (Cont'd)

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- **7. Right reason**
- Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication?
- Revisit the reasons for long-term medication use.
- **8. Right response**
- Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant?
- Be sure to document your monitoring of the patient and any other nursing interventions that are applicable.

MEDICATION ADMINISTRATION (Cont'd)

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- Safe medication administration and reducing medication errors should be a goal of everyone involved in healthcare. The rights of medication administration help ensure patient safety and consistency in nursing practice.
- Reminder: If you are using a Unit Dose system, which most facilities use, you are setting up the medication right before you administer it. There is no "Pre-setting" up of medications due to risk of errors.
- With this Unit Dose system, you have one hour prior and one hour after to administer the medication according to the time it is ordered to be given. (example: Lasix ordered at 8am can be administered between 7am and 9am.) If it is given prior to the one hour before rule or after the one hour after rule, it is considered a medication error.
- Rights of Medication Administration Reference:
- Nursing2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania.

SKIN CARE FOR OLDER ADULTS

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- **Reasons To Bathe Less Frequently As We Age**
  - Dry Skin: There seems to be an unofficial consensus among doctors that bathing dries a person's skin. As we age, skin normally gets dryer and more vulnerable to injury. Showering less frequently may offset that problem.
  - Skin Infections: Dry skin can lead to cracking. Cracking invites infection. In particular, older adults have weaker immune systems, so keeping infections outside the skin becomes important.
  - Fall Injuries: When elderly people are at risk for accidental falls and fall injuries, the shower / bathtub ranks as the number one risk area. If bathing daily is unnecessary, then it also invites unnecessary risk for fall injuries.
  - Immune Theory: Robert Shmerling MD, a professor of medicine at Harvard, writes that over-bathing may even compromise a person's immune system. One theory is that the microorganisms on our skin stimulate our immune systems.

SKIN CARE (Cont'd)

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- Immune Theory: Cleaning away too many of them may leave our immune system unprepared for future infections. A complimentary theory is that the microorganisms on our skin form a microbiome where the bacteria we want are in balance with those that we don't want. Over-bathing may throw that balance off from time to time, interfering with our much older system for dealing with harmful skin bacteria.
- As we age, our skin produces less oil, and we are less likely to get sweaty during strenuous activity. Therefore, bathing just to avoid odor becomes less necessary.
- In short, there's no set recommendation for how often healthy people should bathe. It's common for people to bathe less frequently as they age, and international comparisons suggest this may not be unhealthy. In fact, doctors commonly suggest to patients that they should bathe less frequently than daily for skin health.

PRESSURE ULCERS

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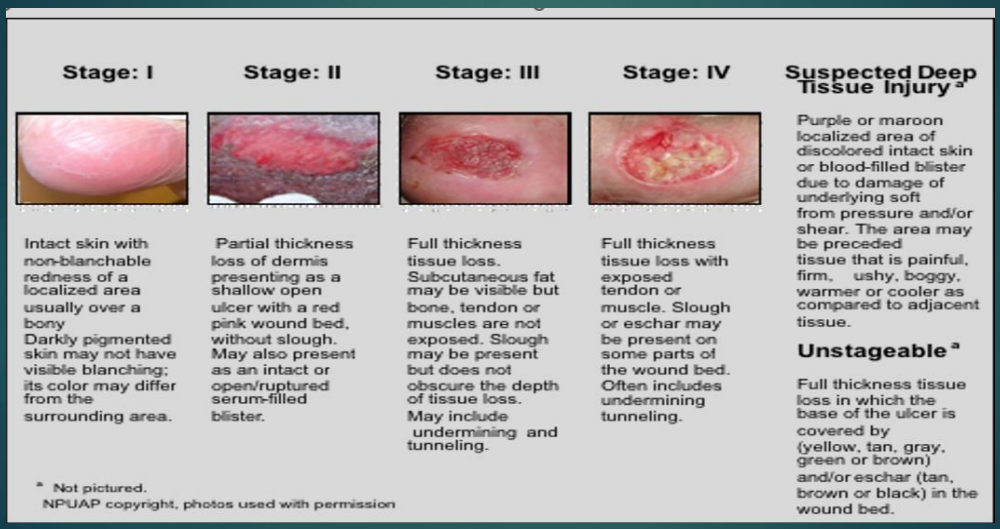

Stage: I	Stage: II	Stage: III	Stage: IV	Suspected Deep Tissue Injury [a]
Intact skin with non-blanchable redness of a localized area usually over a bony Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.	Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.	Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.	Full thickness tissue loss with exposed tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining tunneling.	Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft from pressure and/or shear. The area may be preceded tissue that is painful, firm, ushy, boggy, warmer or cooler as compared to adjacent tissue.

Unstageable [a]

Full thickness tissue loss in which the base of the ulcer is covered by (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

[a] Not pictured.
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PRESSURE ULCER TREATMENT

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Stage One:

- **The first step to treating an ulcer in this stage is to remove pressure from the area. Any added or excess pressure can cause the ulcer to break through the skin surface.**
- **It's also important to keep the affected area clean and dry to reduce tissue damage. Assure the tenant stays well hydrated, and add foods high in calcium, protein, and iron to the diet. These foods help with skin health.**
- **If treated early, developing ulcers in stage one can heal in about three days.**

Stage Two:

- **Similar to treating stage 1 pressure ulcers, you should treat stage 2 pressure ulcers by removing pressure from the wound. Assure the resident is on a repositioning routine. You must notify the MD for proper treatment orders, including how to clean, treat and cover. Often a Hydrogel is ordered to cover the wound and provide a moist healing environment. Also need to manage pain.**
- **It's also important to monitor the wound for any signs of infection including: worsening pain, purulent drainage, red skin, fever.**

PRESSURE ULCERS (Cont'd)

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- **Stage 3**: You must seek immediate medical treatment if a resident has a stage 3 pressure ulcer. These sores need special attention. The doctor will direct the treatment and could debride the wound to remove any dead tissue to promote healing and to prevent infection.
- The doctor may recommend a special mattress or bed to relieve pressure from the affected areas. Ulcers in this stage usually need at least one to four months to heal. Pain needs to be managed and wound observed for infection. A turning schedule would be mandatory. Treatment include a Hydrogel dressing or could require an Alginate or Foam dressing.
- **Stage 4:** Stage 4 ulcers are the most serious. These sores extend below the subcutaneous fat into the deep tissues like muscle, tendons, and ligaments. In more severe cases, they can extend as far down as the cartilage or bone. There is a high risk of infection at this stage. IV antibiotics are typically warranted along with narcotic pain medication. Again, a specialty mattress or bed is warranted.
- These sores can be extremely painful. You can expect to see drainage, dead skin tissue, muscles, and sometimes bone. The skin may turn black, exhibit common signs of infection, and you may notice a dark, hard substance known as eschar (hardened dead wound tissue) in the sore.

PRESSURE ULCERS (Cont'd)

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- People with stage 4 pressure ulcers need to be seen by the doctor immediately, and often are seen in the ER. The doctor will likely recommend an MRI to determine the depth and surgery to debride the wound of slough/eschar. Recovery for this ulcer can take anywhere from three months to two years to completely heal.
- Treatment often includes Irrigation, an Alginate, Hydrogel or Foam dressing to pack the wound, and in some cases a wound vac.
- Unstageable pressure ulcers are also hard to diagnose because the bottom of the sore is covered by slough or eschar. The doctor can only determine how deep the wound is after clearing it out.
- The ulcer may be yellow, green, brown, or black from slough or eschar. If there is extensive tissue damage, it will need to be surgically removed. However, in certain areas of the body, if the covering is dry and stable, it shouldn't be touched. This dry eschar is the body's natural layer of protection.
- Ulcers that form from suspected deep tissue injury can be difficult to diagnose. On the surface, it may resemble a stage 1 or 2 sore. Underneath the discolored surface, this ulcer could be as deep as a stage 3 or stage 4 wound. This pressure ulcer may also form as a blood blister or be covered with eschar.

DOCUMENTATION REQUIRED FOR PRESSURE ULCERS

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When documenting regarding a pressure ulcer, it is important to include:

- **Stage**
- **Site**
- **Size: Width, length, depth**
- **Color**
- **Drainage**
- **Odor**
- **Treatment**
- **Improvement or decline-the standard of practice is to notify the MD/NP if the wound does not show improvement in 2 weeks as they may or may not change the treatment orders.**

WHAT TYPE OF RESIDENT RESIDES IN A NURSING HOME?

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- **Statistically more women who are in their 80's and widowed live in a communal setting than any other demographic. Part of the reason is due to women usually outliving men and therefore there are more women in this age group than men.**
- **However, the number of people who are able to live at home is still higher than any other statistic and has increased dramatically over recent years due to all the services available to be provided at home.**
- **In most cases, families have tried to provide or hire home care services for their loved one before they have ever considered placement in a communal setting such as a Nursing Home.**
- **The majority of the population will not spend time in a Nursing Home as they would rather remain at home if possible.**
- **It is important to remember those who do enter a communal setting such as an Assisted Living or a Nursing Home usually experience some sadness over the changes and sense of loss.**

Couples sharing a Room

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- It is important to know, should a couple moving into the LTC Facility inquire about sharing a room, you need to accommodate this request if both consent, there is a double room available, and there is no contraindication for that arrangement.
- There is no requirement that states a couple must be married to share a room. It is also not ok to deny a LBGTQ couple the right to share a room.

Personal Protective Equipment

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- **Standard Precautions are followed when providing certain care for residents in a nursing home:**
- **Standard precautions consist of the following practices: hand hygiene before and after all patient contact. the use of personal protective equipment, which may include gloves, impermeable gowns, plastic aprons, masks, face shields and eye protection, depending upon the task and the risk assessed of being exposed to blood, pathogens, or bodily fluids, and the safe use and disposal of sharps to avoid being exposed.**

- **Contact: Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission.**
- **Droplet: Use Droplet Precautions for patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking.**
- **Airborne: Use Airborne Precautions for patients known or suspected to be infected with pathogens transmitted by the airborne route (e.g., tuberculosis, measles, chickenpox, disseminated herpes zoster).**

Summary of Recent Updates (July 12, 2022)

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- **Added additional rationale for the use of Enhanced Barrier Precautions (EBP) in nursing homes, including the high prevalence of multidrug-resistant organism (MDRO) colonization among residents in this setting.**
- **Expanded residents for whom EBP applies to include any resident with an indwelling medical device or wound (regardless of MDRO colonization or infection status).**
- **Expanded MDROs for which EBP applies.**
- **Clarified that, in the majority of situations, EBP are to be continued for the duration of a resident's admission.**

ENHANCED BARRIER PRECAUTIONS: Standard of Practice recommended but not a regulation.

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Enhanced Barrier vs. Contact Precautions

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	Enhanced Barrier Precautions	Contact Precautions
Applies to	All residents with any of the following: • Infection or colonization with an MDRO when Contact Precautions do not otherwise apply • Wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status	All residents infected or colonized with a MDRO in any of the following situations: • Presence of acute diarrhea, draining wounds or other sites of secretions or excretions that are unable to be covered or contained • For a limited time period, as determined in consultation with public health authorities, on units or in facilities during the investigation of a suspected or confirmed MDRO outbreak • When otherwise directed by public health authorities All residents who have another infection (e.g., C. difficile, norovirus, scabies) or condition for which Contact Precautions is recommended in Appendix A (Type and Duration of Precautions Recommended for Selected Infections and Conditions) of the CDC Guideline for Isolation Precautions
PPE used for these situations	During high-contact resident care activities: • Dressing • Bathing/showering • Transferring • Providing hygiene • Changing linens • Changing briefs or assisting with toileting • Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator • Wound care: any skin opening requiring a dressing	Any room entry
Required PPE	Gloves and gown prior to the high contact care activity (Change PPE before caring for another resident) (Face protection may also be needed if performing activity with risk of splash or spray)	Gloves and gown (Don before room entry, doff before room exit; change before caring for another resident) (Face protection may also be needed if performing activity with risk of splash or spray
Room restriction	None	Yes, except for medically necessary care

Moving On to Immunizations

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- **Influenza (flu):** Get a flu vaccine every year.
- **Tetanus-diphtheria-pertussis (Tdap):** Get 1 dose of Tdap vaccine if you did not get it as an adolescent. Then, get Td (tetanus-diphtheria) vaccine every 10 years after that.
- **Varicella (chickenpox):** If you never had chickenpox and were never vaccinated against it, you need 2 doses of varicella vaccine.
- **Human papillomavirus (HPV):** For women through age 26, men through age 21, and certain men through age 26
- **Measles-mumps-rubella (MMR):** If you were born in 1957 or later, you need at least 1 dose of MMR. Those going to school, travelers, and health care workers need 2 doses.
- **Zoster (shingles):** People 50 years or older need 2 doses. Talk to your doctor if you have already received shingles vaccine; you may need additional vaccine for better protection.
- **Pneumococcal:** Everyone 65 and older needs two types of pneumococcal vaccine. PCV13 and PPSV23. PCV 13 needs only given x1 and should not be given with PPSV23. May need to repeat PPSV23, or commonly called pneumovax, every 5 years, depending upon health factors.

Immunizations (Cont'd)

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- With COVID 19 and variants being such a relatively new virus to the US, there is still more information to come on the vaccine intervals.. Currently the recommendation is 2 injections a month apart for Pfizer and Moderna, one dose for J&J, and then Boosters after 6 months for certain age groups and immune compromised.
- As more time passes and more research and outcomes are studied, there will be information on what intervals this vaccine must be repeated after 2 Boosters given. There an updated Booster be available to include the latest protection added for the Omicron Variants which are highly contagious.
- There is a direct link to a list of each state's immunization site by logging onto immunize.org and clicking on your state.

Activities of Daily Living (ADL's)

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- Activities of Daily Living or ADL's consist of dressing, bathing, grooming, toileting, repositioning, transferring, eating, and ambulation or mobility.
- In a healthcare setting, an assessment of the resident's level of performance as well as the assistance needed is completed at scheduled intervals or with a change in condition to determine a plan of care or Care Plan.
- Examples may be staff assistance with bathing or showering or assisting with dressing and grooming. Maybe they have some slight urine incontinence and need assistance with changing incontinence pads, or taking to the toilet, or both.
- If a resident is admitted to a short term stay or rehab bed, their need for assistance should decrease over a short period. Most long stay residents require assistance from staff for most ADL's.
- Medication management would also be assessed if the resident wants to have any medications at the bedside. This self administration would require an agreement by the Interdisciplinary Team that concurs the resident is safe to self-administer and would require a locked box/drawer as well as an MD order.

Care Conference and Assessments

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- **A resident is assessed upon admission using various Tools from all departments to determine the resident's overall health status, including nutritional status, emotional status, as well as physical status.**
- **Depending upon their payment source for the stay, they would get assessed again at intervals, such as quarterly, annually and with a change of condition. Residents who come in for a short stay for rehab may only be assessed upon admission and then discharge to home in a week or so when therapy ends.**
- **Care Conferences are required for any admission, and then also at intervals of quarterly, annually and with a change in condition. Leadership staff, Department heads, Therapy staff, floor nurse, nursing assistant, family, and the resident are examples of those who may attend Care Conference.**

RESTORATIVE NURSING

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- "Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning."

Some examples of a Restorative Nursing Program might be:

- Resident A. has osteoarthritis, and her arms and shoulders are stiff and sore in the mornings but as the day goes on, she is much improved. The nursing assistant/Restorative Aide assists Resident A. with range of motion exercises in the am 3x weekly which have helped her to continue to dress herself each morning.
- Resident B. has had some difficulty with balance and endurance when walking. Nursing staff/Restorative Aide walk 300 feet with Resident B. 5x weekly has helped maintain his ability to continue to walk to meals independently using a walker.
- Activities held such as trivia, current events, music and exercise class are some examples of programs that can assist in mental and psychosocial functioning as they promote socialization as well as brain stimulation. Depending upon the size of the group, and number of leaders of the group, some of these programs may be also considered Restorative. Need to have a 4:1 ratio, and evaluation and Plan to code on MDS as Restorative.

RESTORATIVE NURSING AND THE LPN

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- The Restorative Nursing Program must be overseen by a Registered Nurse.
- The LPN, however, may be designated as the Restorative Nurse who works with the Restorative Aide to assure Programs are being conducted as designed for the residents on a Restorative Program. Often times the LPN Restorative Nurse also participates in providing the resident their Restorative Program.
- The LPN is allowed by regulation to write a weekly note in the resident's medical record, addressing their Program content, frequency, and the results noted. (improvement, decline, or maintaining current status).
- The RN, however, must summarize the resident's progress in a note written no less than quarterly and what changes will be made to their Program if necessary.

Advance Directives

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- **An Advanced Directive is a document that reflects the person's choice for care at a future time.**
- **A common term for an Advanced Directive is a Living Will.**
- **Many states also use a POLST or Physician Ordered Life Sustaining Treatment form. This Form validates the wishes many have stated earlier in an Advanced Directive and serve as the Physician order for their code status.**
- **A POLST can be signed by the physician or the nurse practitioner/P.A.**

Sample of an Advance Directive Sometimes called a Living Will

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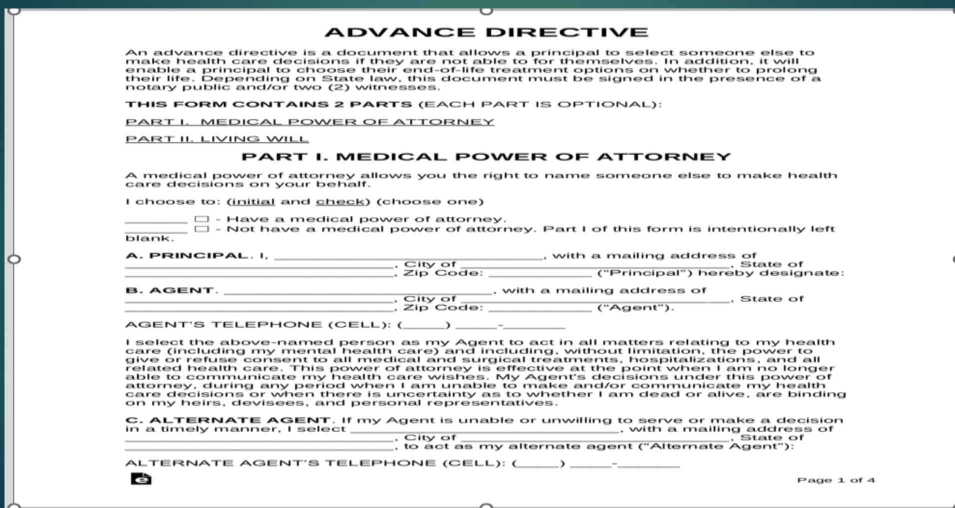

ADVANCE DIRECTIVE

An advance directive is a document that allows a principal to select someone else to make health care decisions if they are not able to for themselves. In addition, it will enable a principal to choose their end-of-life treatment options on whether to prolong their life. Depending on State law, this document must be signed in the presence of a notary public and/or two (2) witnesses.

THIS FORM CONTAINS 2 PARTS (EACH PART IS OPTIONAL):

PART I. MEDICAL POWER OF ATTORNEY

PART II. LIVING WILL

PART I. MEDICAL POWER OF ATTORNEY

A medical power of attorney allows you the right to name someone else to make health care decisions on your behalf.

I choose to: (initial and check) (choose one)

_______ ☐ - Have a medical power of attorney.
_______ ☐ - Not have a medical power of attorney. Part I of this form is intentionally left blank.

A. PRINCIPAL. I, _______________________, with a mailing address of _______________________, City of _______________________, State of _______________________, Zip Code: _____________ ("Principal") hereby designate:

B. AGENT. _______________________, with a mailing address of _______________________, City of _______________________, State of _______________________, Zip Code: _____________ ("Agent").

AGENT'S TELEPHONE (CELL): (_____) _____-_______

I select the above-named person as my Agent to act in all matters relating to my health care (including my mental health care) and including, without limitation, the power to give or refuse consent to all medical and surgical treatments, hospitalizations, and all related health care. This power of attorney is effective at the point when I am no longer able to communicate my health care wishes. My Agent's decisions under this power of attorney, during any period when I am unable to make and/or communicate my health care decisions or when there is uncertainty as to whether I am dead or alive, are binding on my heirs, devisees, and personal representatives.

C. ALTERNATE AGENT. If my Agent is unable or unwilling to serve or make a decision in a timely manner, I select _______________________, with a mailing address of _______________________, City of _______________________, State of _______________________, to act as my alternate agent ("Alternate Agent"):

ALTERNATE AGENT'S TELEPHONE (CELL): (_____) _____-_______

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SAMPLE OF A POLST DOCUMENT

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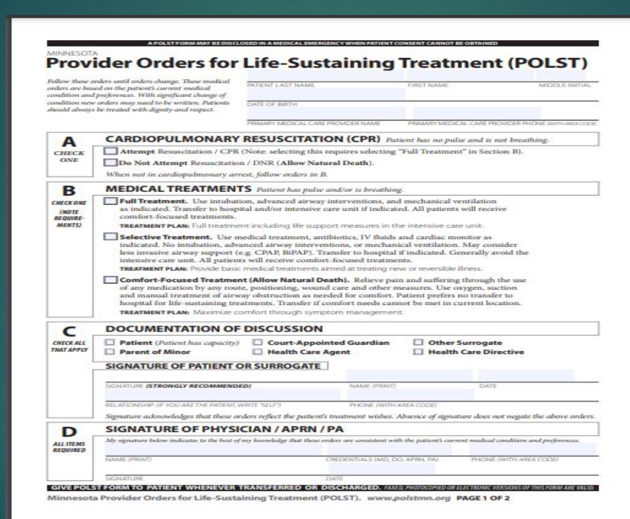

A POLST FORM MAY BE DISCLOSED IN A MEDICAL EMERGENCY WHEN PATIENT CONSENT CANNOT BE OBTAINED

MINNESOTA

Provider Orders for Life-Sustaining Treatment (POLST)

Follow these orders until orders change. These medical orders are based on the patient's current medical condition and preferences. With significant change of condition new orders may need to be written. Patients should always be treated with dignity and respect.

PATIENT LAST NAME | FIRST NAME | MIDDLE INITIAL

DATE OF BIRTH

PRIMARY MEDICAL CARE PROVIDER NAME | PRIMARY MEDICAL CARE PROVIDER PHONE (WITH AREA CODE)

A CHECK ONE — **CARDIOPULMONARY RESUSCITATION (CPR)** *Patient has no pulse and is not breathing.*

☐ **Attempt** Resuscitation / CPR (Note: selecting this requires selecting "Full Treatment" in Section B).
☐ **Do Not Attempt** Resuscitation / DNR (**Allow Natural Death**).

When not in cardiopulmonary arrest, follow orders in B.

B CHECK ONE (NOTE REQUIREMENTS) — **MEDICAL TREATMENTS** *Patient has pulse and/or is breathing.*

☐ **Full Treatment.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. All patients will receive comfort-focused treatments.
TREATMENT PLAN: Full treatment including life support measures in the intensive care unit.

☐ **Selective Treatment.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. All patients will receive comfort-focused treatments.
TREATMENT PLAN: Provide basic medical treatments aimed at treating new or reversible illness.

☐ **Comfort-Focused Treatment (Allow Natural Death).** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.
TREATMENT PLAN: Maximize comfort through symptom management.

C CHECK ALL THAT APPLY — **DOCUMENTATION OF DISCUSSION**

☐ **Patient** *(Patient has capacity)* ☐ **Court-Appointed Guardian** ☐ **Other Surrogate**
☐ **Parent of Minor** ☐ **Health Care Agent** ☐ **Health Care Directive**

SIGNATURE OF PATIENT OR SURROGATE

SIGNATURE *(STRONGLY RECOMMENDED)* | NAME (PRINT) | DATE

RELATIONSHIP (IF YOU ARE THE PATIENT, WRITE "SELF") | PHONE (WITH AREA CODE)

Signature acknowledges that these orders reflect the patient's treatment wishes. Absence of signature does not negate the above orders.

D ALL ITEMS REQUIRED — **SIGNATURE OF PHYSICIAN / APRN / PA**

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

NAME (PRINT) | CREDENTIALS (MD, DO, APRN, PA) | PHONE (WITH AREA CODE)

SIGNATURE | DATE

GIVE POLST FORM TO PATIENT WHENEVER TRANSFERRED OR DISCHARGED. *FAXED, PHOTOCOPIED OR ELECTRONIC VERSIONS OF THIS FORM ARE VALID.*

Minnesota Provider Orders for Life-Sustaining Treatment (POLST). *www.polstmn.org* **PAGE 1 OF 2**

DEALING WITH DEATH AND DYING

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- Some LTC have residents who are at end stage disease and are enrolled in Hospice.
- It is important for people who are dealing with a terminal illness to be able to talk about it. Staff working with these residents need to be trained on how to listen and respond to their questions and comments. One rule of thumb is to be positive and not judgmental. Different people discuss their illness in different ways. As a caregiver we need to just be there to provide support and listen.
- An example of the training needed would be a resident with end stage disease says she hopes to go to Europe next year. The most appropriate response would be to say something like "that sounds like fun" or "where in Europe would you like to go"?. It would not be appropriate to discuss their illness and the likelihood they would not be able to take a trip in the future. The lead for listening and discussion needs to be directed by the resident. Sometimes they want to discuss their illness in frank terms and others want to be hopeful and positive and have visions of the future they express. Each method is a coping mechanism and as caregivers we should not judge which method is the best.
- As an LPN, you could be the nurse in charge on some shifts and would need to assure staff are comfortable and guidance given to them on dealing with death and dying.

Death and Dying (Cont'd)

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- Death is a natural process and one that comes to us all. Hospice is a unique form of support for the patient and patient's loved ones, with the goals of easing pain and discomfort and providing spiritual and emotional support. Hospice neither hastens nor prolongs death.
- Studies have shown that patients live longer when they receive support and care from hospice than other patients with the same prognosis who do not opt for hospice.
- Hospice may feel overwhelming and frightening to some people, but it needn't be. Accepting hospice services does not mean you have given up. It only means you have chosen to focus on quality of life.
- In general, hospice care is available when a physician has indicated a patient has a life-limiting illness and has a life-expectancy of 6 months or less. Accepting hospice services means you will not be pursuing curative treatment for your illness, although you can ask about palliative care at any point.

Signs of dying

- Changes in the way the body works are a normal part of the dying process. Your hospice care team can help you understand what changes to expect and how the pain and stress of dying can be minimized.

Death and Dying (Cont'd)

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- Some of the natural changes that occur include:
  - Less appetite or interest in food
  - Loss of bladder and bowel control, change in color or consistency
  - Breathing rate
  - Body temperature
  - Skin appearance
  - Mental state or behavior
  - Sleeping more or being unresponsive

- Some patients or caregivers report of dying people seeing visions, frequently of loved ones who have died previously. Sometimes the patient may speak of going on a journey or "going home". These are not uncommon experiences and should not cause you concern.

A Pamphlet from Hospice

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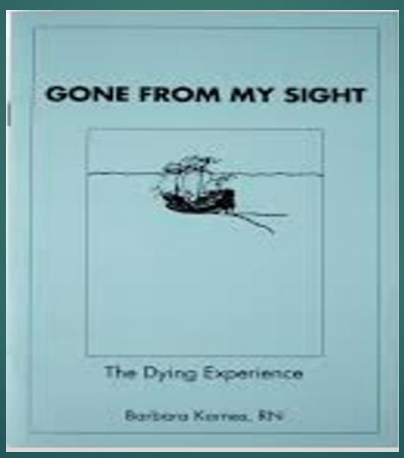

"GONE FROM MY SIGHT", Barbara Karnes

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- An excerpt from 'Gone from my Sight' by Barbara Karnes:
- "I am standing upon the seashore. A ship at my side spreads her white sails to the morning breeze and starts for the blue ocean. She is an object of beauty and strength. I stand and watch her until at length she hangs like a speck of white cloud just where the sea and sky come to mingle with each other. Then someone at my side says: 'There she is gone!'
- 'Gone where?'
- Gone from my sight. That is all. She is just as large in mast and hull and spar as she was when she left my side, and she is just as able to bear the load of living freight to her destined port.
- Her diminished size is in me, not in her. And just at the moment when someone at my side says: 'There, she is gone!' there are other eyes watching her coming, and other voices ready to take up the glad shout: 'Here she comes!'

END OF CLASS #4

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- **QUESTIONS?**
- **Nancy Tuders, nancy@nadona.org**
- **Cindy Fronning, cindy@nadona.org**
- **NEXT PLEASE GO TO AND TAKE THE QUIZ FOR CLASS #4.**
- **I LOOK FORWARD TO TALKING TO YOU IN CLASS #5!**