Enhancing LPN-Family Communication to **Reduce Avoidable Transfers** of LTC/AL Residents to the ED

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Around twenty percent of transfers of long-term care (LTC) residents to emergency departments (ED) via 911 calls are avoidable (Trahan, Spiers, & Cummings, 2016). Often, the resident's clinical situation is ambiguous and a range of factors influences the decision to transfer. Licensed practical nurses (LPNs) are in a key position to prevent avoidable transfers (AT) in community facilities, including LTC and Assisted/Supportive Living (AL).

Transfer decision making (DM) is complex because stakeholders, resources, and the clinical environment influence the decision. Working with families was identified in a previous study to be a key modifiable factor. In this study, we explored experiences and perceptions of LPNs who work with families in the AT context. We then developed and tested simulation scenarios to enhance LPNs' confidence and skills in these challenging interactions.

The study had two phases. First, we recruited LPNs who self-identified as having experience with at least one AT with dominant family challenges. We conducted nine focus groups and one interview with 26 LPNs.

The LPN participants immediately recognised the concept of AT. In the example below, the resident's chronic disease trajectory is evident while the nurse questions the risk/benefit balance of a transfer:

- *You have people where… they're 90 – [They] have all these conditions… it could be at any time – these people are very fragile. But they would bounce back, so you don't know. They get these second, third chances, but one of these times, it will be their time. So you're guessing sometimes, because the family will say, "Well, last time they treated her UTI and she was fine,"…So this is going to happen again. We're going to rally and give her everything we can…and…we'll - hydrate. You get that a lot from family – even though in your gut, you know their odds are not great…and the resident is often, "Just let me die. Just let me die, I'm ready." And the family's like, "No! Not going to happen." So I think that's a huge obstacle a lot of times… you know, they have that hope. They're not ready.*

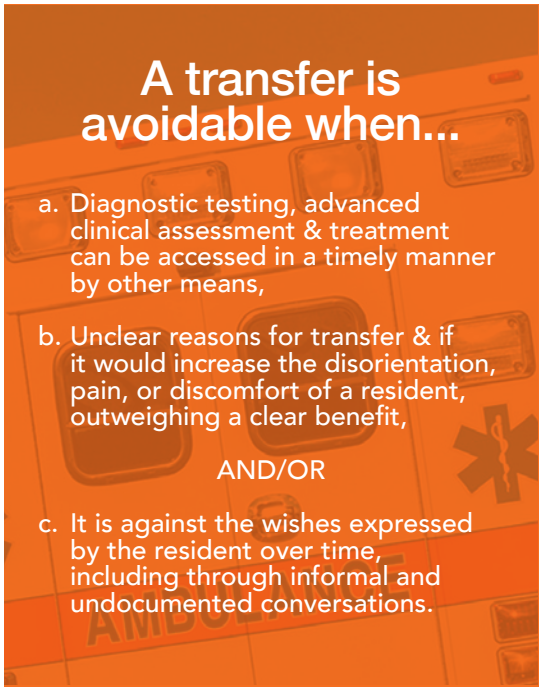
Participants thought that a family's challenges in accepting a loved one's declining condition complicated an AT decision. Families were described as being unaware of the current or developing situation, reacting with shock, grief, denial, and having unrealistic hope. Conflict in family dynamics, whether or not one member is the legal decision maker, were common. A prevalent assumption that the ED has superior staff, equipment, and treatment tended to underlie family insistence on AT.

Goals of Care Designations (GCDs) and Advanced Care Planning (ACP) are areas of confusion and tension. While few participants had formal roles in GCD discussions, LPNs commonly engaged in these conversations at time of transfer. Helping families understand implications of GCD and to ensure there is a timely review of GCD following a change of condition are important advocacy roles for LPNs.

LPNs spoke about the importance of a comprehensive clinical assessment to differentiate between a reversible condition and the start of end of life. However, a pervasive concern among participants was perceived liability and risks from complaints about making a decision that later had adverse outcomes, including family, physician or management complaints. One strategy to reduce this risk is to interpret a GCD that prioritizes the location of care rather than the goal of care:

- *It – it goes back to the legalities, right? It's that M1. No matter how much we talk about person-centred care and all these feelings, it's what's written on paper. If it says, "Send to hospital for treatment," that's where they're going. It seems very difficult to change that. … And I find that nobody wants to take that responsibility of saying, "You know what, let's not send him. Let's keep him comfortable here." You know, we are so afraid of being sued, or being charged with neglect that… that we are afraid to be nurses. I find that we have lost our common sense. We have lost the way to handle people. You know, we are so scared of laws and… families.*

Figure 1: Defining Avoidable Transfers



From: Cummings & Spiers (2016)

The participants used many strategies to align values, expectations, and goals. They stressed the importance of hearing families' concerns and of giving voice to the residents' preferences. They emphasized the need to ensure all health professionals are "all on the same page" so that information is consistent, and feuding family members cannot "play one nurse against another." Having others present, including peers or other staff, was also a useful strategy in presenting information in different ways, to help the family understand the clinical recommendations.

LPNs who said they have AT experiences spoke about the importance of entering any conversation with a *professional aura* of competence, concern, openness, and a plan. LPNs spoke about ways to communicate what is known, what is happening, and what is likely to happen, including how they can keep the resident comfortable at the facility. Dispelling myths about the quality of care in overcrowded EDs is important so family can start to understand advantages of staying in the facility where the resident is known. The approach to working through decision-making reflects principles of person-centred care, but when family needs dominate the discussion, LPNs worry that the resident's voice is overwhelmed.

Based on Phase 1 findings, we then created a workshop with three standardized patient (SP) scenarios in Phase 2 with actors portraying residents and/or family members. We first discussed the nature of AT, overview of ACP/GCD, and communication principles. Pairs of participants then participated in each scenario for 15 minutes followed by debriefing discussion with the SP and researchers. We concluded with a group discussion of how the workshop might/would influence their future family communications. 26 LPNs participated in one of four workshops with equal representation from LTC and AL.

We used two measurement tools: self-reported confidence in communication measured by the Health Professional Communication Skill Scale (HP ComSkill) (Leal-Costa, Tirado-González, Rodríguez-Marín, & vander-Hofstadt-Román, 2016) and a Visual Analogue Scale, which

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were administered pre-scenario, post-scenario, and one month later. 17 LPNs returned the one-month survey. There was a significant increase of confidence in communication skills between pre-workshop ($\bar{x}$=58.6, 95% CI=54.7 - 62.6) and immediate post-scenario surveys ($\bar{x}$=65.3, 95% CI=63.6 - 67.0). Confidence had not significantly declined between the post-scenario measure and one month later. Participants stated the scenarios were realistic, and helped to practice family communication skills in a safe environment where they could see the effects of different strategies and receive feedback from Standardized Patients. As LPNs and registered nurses (RNs) often work closely together, the workshop was regarded as applicable to RNs.

In summary, challenging conversations are inevitable experiences in LTC for all nurses. Person-centred care becomes substantially more complex when needs and emotions of families overshadow the residents' needs and preferences. LPNs demonstrated greater communication confidence in our simulation-based workshops. ■

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