

The PoET (Prevention of Error-Based Transfers) Project

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Abstract

The PoET (Prevention of Error-based Transfers) Project is one of the Ethics Quality Improvement Projects (EQIPs) taking place at William Osler Health System. This specific project is designed to reduce transfers from long-term care to hospital that are caused by legal and ethical errors related to consent, capacity and substitute decision-making. The project is currently operating in eight long-term care homes in the Central West Local Health Integration Network and has seen a 56% reduction in multiple transfers before death in hospital.

Introduction

Mr. Brown is an 82-year-old long-term care resident in Ontario. Many years ago, his wife died of early onset dementia and as she declined he became her primary caregiver. When she became incapable of making her own treatment decisions, he became her substitute decision-maker. Mr. Brown found the experience of making end-of-life decisions on his wife's behalf extremely emotionally challenging, and he hoped nobody would ever have to make similar decisions for him; so when he was later diagnosed with dementia, he visited his lawyer to record his wishes in a Power of Attorney for Personal Care document. Mr. Brown stated in this document: "With the full understanding of the fact that I have been diagnosed with a terminal disease, I state the following wishes for my future care. Under no

circumstances do I want cardiopulmonary resuscitation. If the circumstances arise such that I am no longer capable of consenting to medical decisions related to my care and my physician believes there is no reasonable expectation that I will regain this capacity, I ask that I be allowed to die by whatever natural means arise. Under such circumstances I would not want my life prolonged by any medical means. To be clear, I would not want: (1) to be fed or hydrated artificially (including by use of intravenous fluids), (2) to have invasive tests or procedures carried out on my body, nor would I want (3) to be medically treated for illness or infection, except to relieve my pain and suffering." Mr. Brown named his two sons as his substitute decision-makers. Unfortunately, his sons did not get along well, and Mr. Brown never felt it was the right time to speak with them about his wishes.

Two years after completing his Power of Attorney for Personal Care document, Mr. Brown was living in a retirement home. He had a fall, and was admitted to the hospital for surgery. His sons became engaged as substitute decision-makers. Mr. Brown waited in the hospital for four months, and was then admitted to a long-term care home. On admission to the home Mr. Brown's sons were presented with a form and were asked to select a "Level of Care" for their father; their options ranged from palliative care in the home

with no transfers to hospital and no resuscitation (“Level 1”) to full treatment, including transfer to hospital and resuscitation (“Level 4”). Wanting their father to do well in the home, and being optimistic, his sons selected “Level 4” as their father’s treatment plan. No physician was present during the admission.

Mr. Brown continued to decline over the next year; his dementia increased and he was unable to speak. He developed swallowing problems and a feeding tube was inserted after one of the numerous transfers to hospital. Healthcare providers had many discussions with Mr. Brown’s sons, but these discussions never ended with a decision to change the treatment plan from “Level 4.” Sometimes, one son would agree to change the form while the other refused; sometimes both refused; sometimes they agreed to discuss the matter again soon. Mr. Brown suffered aspiration pneumonia frequently and after six emergency transfers to hospital in the past four months of his life, he experienced cardiac arrest in the ambulance on his seventh transfer to hospital. Cardiopulmonary resuscitation was initiated, but Mr. Brown was pronounced dead on arrival at the hospital.

Intervention

Mr. Brown’s end of life was shaped by transfers between locations to receive treatment that he had stated he did not want. Why did this happen? At William Osler Health System (Osler) Ethics Quality Improvement Projects (EQIPs) are a new innovation co-designed with partners and patients to identify and respond to such cases. EQIPs focus on opportunities to improve the culture of decision-making by identifying legal and ethical errors that contribute to episodes of care where scarce healthcare resources are used for unwanted and non-beneficial treatment (Oliver and Chidwick 2014a). Please see Box 1 for a list of the legal and ethical errors that occur most frequently.

BOX 1.

The most frequently occurring legal and ethical errors (Sibbald et al. 2011)

1. Turning to the substitute decision-maker or family when the patient is capable
2. Not documenting incapacity
3. Not identifying the legally correct substitute decision-maker
4. Allowing families to make advance care plans or not asking about pre-existing advance care plans
5. Knowing of a prior expressed wish but not following or aligning Rx plan with it
6. Not asking about beliefs and values (i.e., religious values)
7. Not documenting patient values
8. Allowing family members to propose treatment plans

These errors are reduced or eliminated through EQIPs (Oliver and Chidwick 2014a, 2014b). In particular, the

PoET (Prevention of Error-based Transfers) Project, promotes both (1) treatment that long-term care residents want and can benefit from regardless of their location in the healthcare continuum, and (2) careful stewardship of shared healthcare resources. PoET achieves these things by minimizing error-based transfers from long-term care to hospital and the treatment(s) that these transfers entail.

Error-based transfers and treatments can result even though: (1) the resident is capable and is refusing transfer to hospital; and/or (2) the healthcare providers involved suspect or know that the substitute decision-maker is not following the principles of substitute decision-making from Ontario’s *Health Care Consent Act*; and/or (3) the healthcare providers involved suspect or know that the substitute decision-maker is incapable and/or uninformed; and/or (4) the healthcare providers involved expect no medical benefit, or even believe that the transfer and treatment are not indicated, are outside the standard of care and/or have great potential to cause harm.

Our root-cause analysis of error-based transfers showed us that they are driven by the “Level of Care” form such as the one completed by Mr. Brown’s sons (2014a). These forms are central to the culture of decision-making that affects transfers and treatments of Ontario’s long-term care residents, both in their homes and in the hospital. In Mr. Brown’s case, the Level of Care form (rather than Mr. Brown’s current or prior expressed capable wishes) would have been taken into consideration before each transfer to hospital and when determining the course of treatment in hospital. PoET’s fundamental change idea was to work with long-term care homes to remove this form from the decision-making process. In its place we introduced the “Individualized Summary,” a tool that has been co-designed to allow healthcare providers, residents and substitute decision-makers to align decision-making with Ontario’s *Health Care Consent Act*, and thereby, with the wishes, values and beliefs of the residents. The Individualized Summary was developed to assist in the change in culture away from error-based decision-making, which the Level of Care Form promoted. The Individualized Summary has a number of important functions, including: (1) revealing the resident’s current or prior capable wishes on admission to the home; (2) directly involving residents in decision-making by including their wishes, values and beliefs related to such things as treatment decisions, code status and transfer to hospital; (3) providing an opportunity to share information with substitute decision-makers so they understand their role according to the *Health Care Consent Act*; and (4) helping us to support physicians in proposing treatment plans that they believe are appropriate for the residents they care for. Ultimately, the Individualized Summary helps to ensure that Ontario’s long-term care residents receive care in line with their wishes, values

and beliefs and the patient-centred consent legislation that we have in this province.

Methodology/Change Process/Results

The PoET Project began with an assessment in 2011 that identified errors that preceded transfers from long-term care to hospital in the Central West Local Health Integration Network (CWLHIN) (see Figure 1 for a history of the project) (Oliver and Chidwick 2012). Our first EQIP attempted to reduce errors by developing ethics-related consults and education for staff (Oliver and Chidwick 2014a). This approach had limited success because, as we found, the real driver for error-based transfers lay at a systemic level, in the use of the Level of Care form (Oliver and Chidwick 2014a). In 2013, we worked with early adopter long-term care homes to remove and replace the Level of Care form with the Individualized Summary for those residents who were thought to be at risk of being transferred multiple times before their death (Oliver and Chidwick 2014b). In 2014, we began the IDEAS (Improving and Driving Excellence Across Sectors) Advanced nine-day learning program, and further collaborated with the early adopters to use the Individualized Summary on admission. Through the IDEAS Advanced Learning Program, we gained the knowledge, skills and tools to lead quality improvement initiatives, including knowledge about adaptive leadership, change management, knowledge transfer, PDSA cycles, sustainability, spread and scale. This knowledge was instrumental in integrating our change ideas and change concepts towards transforming and improving quality care for long-term care residents. Our initial aim statement was, “by the end of August 2016, 90% of new admissions at participating homes will have an Individualized Summary in place instead of a Level of Care form.” We are happy to say that we achieved our aim and the PoET Project is spreading. In 2015, we received an IDEAS Alumni Award and further spread the PoET Project in the CWLHIN. Currently, 40% or eight homes in our CWLHIN are actively involved in PoET, and we are working with two long-term care companies, Sienna Senior Living and Schlegel Villages, that together will enable spread to 8% of the 76,982 long-term care residents in Ontario (OLTCA 2015). We have recently launched a website to support scale at www.poetproject.ca, so access to resources is available to anyone in Ontario and Canada, including a video called “What is your role in Health Care Decision-making in Ontario?” (available at: <https://www.youtube.com/watch?v=T7s9xOR-xo0>).

In each PoET LTC Home, there is at least one PoET Change Leader who is the local project expert within his or her home. PoET Change Leaders collect and report data on a family of measures (Table 1) and participate in group check-ins on a monthly basis. Change Leaders, organizational support and Osler Ethicists work collaboratively to identify further opportunities for improvement and ideas to test. Change Leaders have access to a number of tools to assist with the project including posters on substitute decision-making, information sheets on consent and capacity, scripts for using the Individualized Summary on admission (both when a resident can communicate and when he or she cannot), and the ACES (Ask–Clarify–Examine–Summarize) tool for speaking to residents about wishes.

TABLE 1.
PoET’s family of measures

	Type	Measure
1	Outcome	Percentage of new admissions that have an individualized summary in place
2	Process	Number of short-stay admissions
3	Outcome	Number of level of care forms completed
4	Process	Number of resident deaths in the home
5	Process	Number of transfers to hospital
6	Process	Number of resident deaths in the hospital
7	Process	Number of resident deaths in transfer to hospital
8	Balancing	Number of project-related complaints and/or concerns received

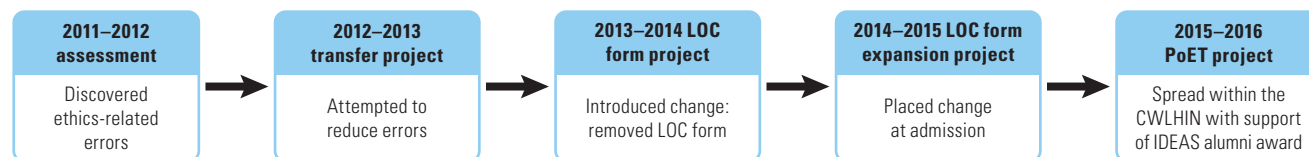
PoET = Prevention of Error-based Transfers.

In addition to our family of measures, the PoET Project also tracked the number of long-term care residents who were admitted to and died in hospital and also had at least one other transfer in the two-month period before death. The PoET project has successfully been able to reduce transfers in this cohort by 56% (Figure 2). We believed that this cohort (which Mr. Brown belonged to) would be most directly affected by the changes we and the long-term care team were trying to make.

Discussion/Conclusion

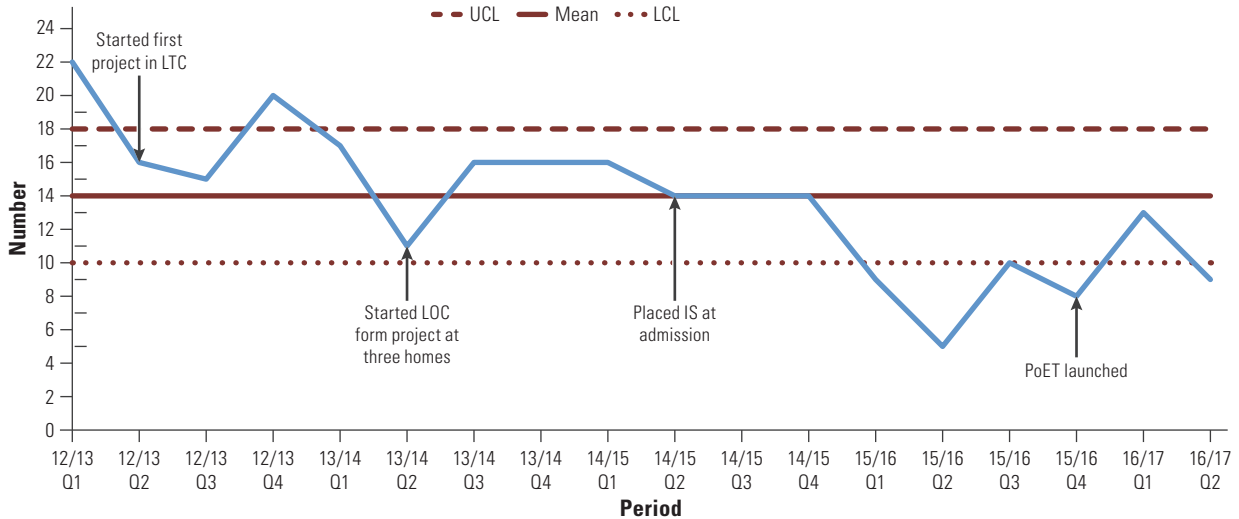
How would the PoET project have helped Mr. Brown? If Mr. Brown had been admitted to a long-term home participating in the PoET Project, he would have been directly asked

FIGURE 1.
The history of the PoET project



CWLHIN = Central West Local Health Integration Network; IDEAS, Improving and Driving Excellence Across Sectors; LOC = level of care; PoET = Prevention of Error-based Transfers.

FIGURE 2.
The number of LTC residents who die in hospital and had been admitted there at least one other time in the two-month period before death



IS = individualized summary; LCL, lower control limit; LOC = level of care; LTC = long-term care; PoET = Prevention of Error-based Transfers; UCL = upper control limit; Q = quarter.

about his wishes on admission. If he were not able to communicate at that time, the staff assisting with his admission would have looked to see if he had recorded his wishes in his Power of Attorney for Personal Care (or any other) document. Whatever wishes, values or beliefs that were found or shared on admission would have been documented on the Individualized Summary, which would have then been placed in his chart. In this case, all of Mr. Brown’s wishes would have been identified and documented. There would also have been a discussion with the sons to ensure that they, as Mr. Brown’s substitute decision-makers, were aware of his wishes, their role as substitute decision-makers and also of the resources available to them if they could not agree on decisions. His sons would also be asked if they were aware of any more recent wishes that Mr. Brown had expressed related to resuscitation; if they were not, then the paperwork would be put in place to respect his stated wish. Had Mr. Brown been admitted to a PoET long-term care home, no “level” would have been selected for him; instead any decisions about treatments and transfers to hospital would have been made as they arose, and would have included the physician’s treatment proposal and the substitute decision-makers’ consent. Treatment would be offered that would both be in line with wishes and provide some benefit clinically. If this required a transfer, then Mr. Brown would be transferred; if it did not, then he would not be transferred and treatment would be provided in place.

To remove the Level of Care form requires fundamental changes in the culture of decision-making, in the information we gather about the resident, and in what we do with that information. In other words, to affect the culture of decision-making, staff and family and residents need to think differently about the process so that we can begin to do things differently (please see a summary of PoET’s change ideas and change concepts in

Table 2). The outcome, we believe, is that treatment and transfers will be more closely aligned with the wishes, values and beliefs of the resident. The PoET Project’s goal to influence the culture of decision-making around transfer of long-term care residents to hospital emergency departments has been successful and supports treatment that the resident both wants and can benefit from and, at the same time, promotes system efficiency. **HQ**

TABLE 2.
The PoET project’s change concepts and change ideas

Change concepts	Change ideas
A resident’s wishes are always significant	We will ask about residents’ wishes and document them on admission
The substitute decision-maker needs to understand the role	We will provide the substitute decision-maker with information about the role
Consent is obtained when something is proposed, not before	We will make transfer decisions as needed
A resident’s capacity can come and go, so can the role of the substitute decision-maker	We will seek consent from the resident whenever he or she is capable
The healthcare practitioner is responsible for proposing the treatment plan	We will ask and allow the healthcare provider to propose a plan based on the current situation
Usually location is not relevant, goals are	We will identify the location of care only when relevant
Tools don’t facilitate decision-making, people do	We will use a tool that allows for critical thinking, professional judgment and application of the consent framework

PoET = Prevention of Error-based Transfers. Health Quality Ontario’s (2016) Quality Compass defines *change concept* as “a general notion or approach to change” and *change ideas* as “specific and practical changes that focus on improving specific aspects of a system, process or behaviour.”

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