

Mrs. Jones Can't Breathe!

(How) Can a Resilience Framework Help?

The Resilient Health Care Net
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Some Questions

- What is the relationship between *individual* resilience & *system or organizational* resilience?
- How could a resilient care pathway help Mrs Jones and others who live with progressive chronic life-limiting illness?





Mrs. Jones.....

- 77 year old widow; living in LTC
- Hx MI, HF, Diabetes, Hip arthroplasty; daughter usually able to take to medical appointments when required
- over past few weeks ↑ SOB, ↓ activity, difficulty sleeping, ↑ edema in legs
- “sudden” decompensation one night
- night nurse calls ambulance, sent to ED
- stabilized: admitted to hospital (2nd time in 6 months); not known to care team
- D/C'd home to LTC in 3 days



Heart Failure (HF)

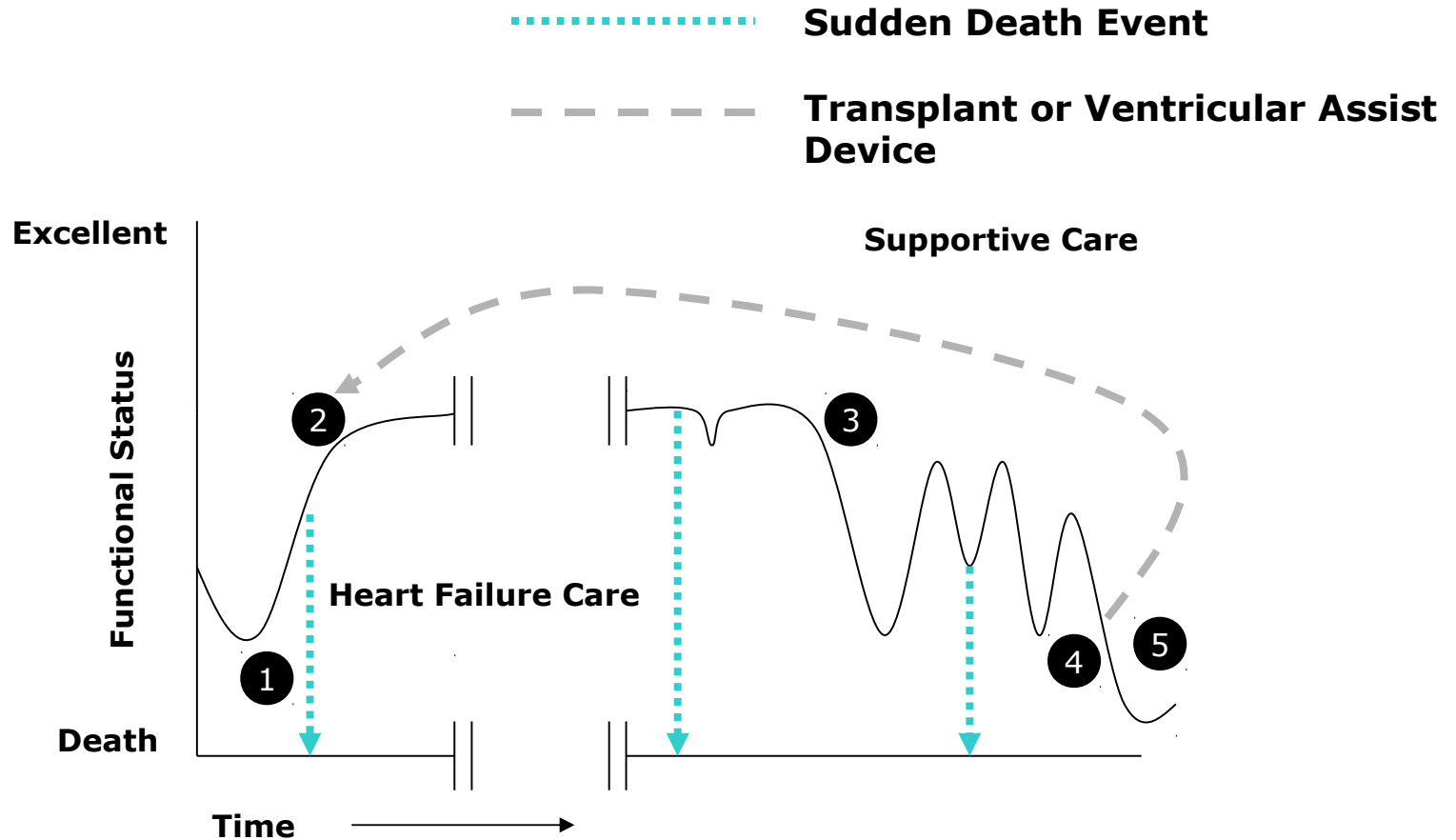
- a progressive life-limiting complex chronic syndrome
- ↓ ability of heart to meet metabolic demands
- major cause of morbidity & mortality
- most common reason for hospitalization of older adults
- high readmission rate (poor prognostic indicator)
- associated with suffering & ↓ QOL

Human suffering results from

- Fatigue, shortness of breath, sleep problems, ↓ activity tolerance, limitations in ADL, fluid retention
-Altered cognitive function, nausea, abdominal distention & discomfort
- Unrelieved/poorly managed symptoms
 - Caregiver strain & burden
 - Suboptimal death experiences



Common Heart Failure Trajectory

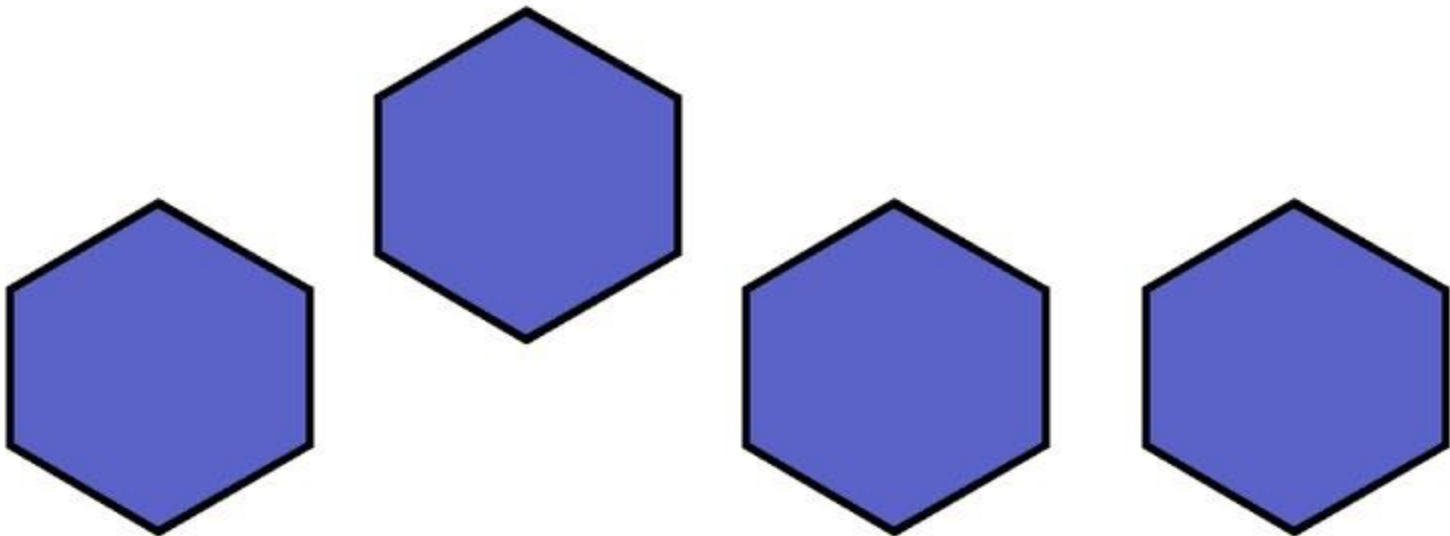


Schematic Course of Stage C and D Heart Failure

Goodlin et al., J. Cardiac Failure 2004; 10:200-209

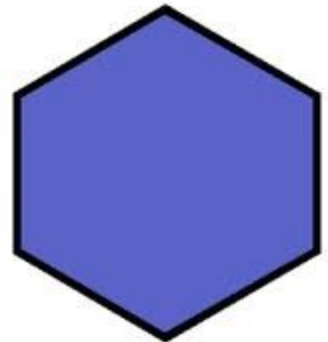
How would you evaluate resilience at the level of....

- the individual patient (Mrs. Jones)?
- the long term care home?
- the ED?
- the hospital?



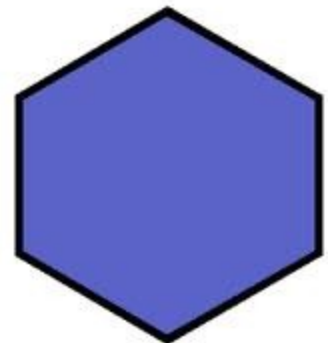
How did the system RESPOND?

- Emergency recognized, ED care
- Symptom relief
- Admitted to hospital
- D/C home with medication changes
- Follow-up appt with GP



What MONITORING activity occurred?

- LTC: noticed ↑ symptoms but no record
- #s of (new and repeat) HF patients admitted to ED in acute HF is tracked
- Length of stay in ED and duration of admission is tracked
- At regional/provincial/national levels HF recognized as problematic

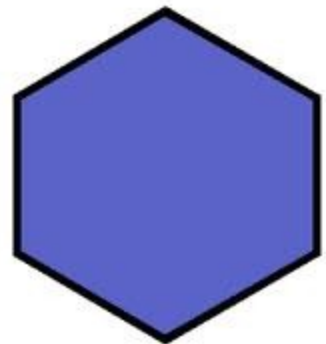


What does not (usually) get MONITORED?

- Patient suffering, weights
- Caregiver
contribution/burden/needs
- Advance care plans
- Relational issues are not routinely
monitored

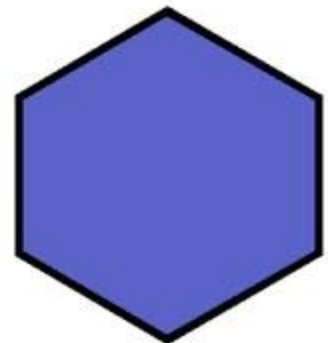
How did the system ANTICIPATE potential future events?

- ?
- Some emergency medication kits in LTC settings
- How could this occur?



Is there evidence that LEARNING occurred?

- LTC: no evidence: continue to “watch (not monitor in a meaningful way such as daily weights) and wait”
- ED/hospital protocols for acute Rx, care pathways for CHF including self-care/management [diet, weights, medications]



Lessons learned....

- Individual ability to (potentially) rebound from crisis coupled with the ED system ability to respond to creates conditions for harm.
- Harm occurs when learning serves to silence conversations with patients and families about the need for advance care planning (including goals of care, symptom monitoring & management, resuscitation choices)



What learning is valued?

- About the patient, family caregiver
- About the system/sub-systems
(acute and chronic care)

Thank You!



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