Mrs. Jones Can’t Breathe!

(How) Can a Resilience Framework Help?

The Resilient Health Care Net
Summer Meeting
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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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