Alzheimer's LOS ANGELES

End-of-Life Planning

Identify the Problem	**PROBLEM:** End-of-Life Planning **GOAL/EXPECTED OUTCOME**: To increase understanding of preserving dignity at the end-of-life
Explore	**ASSESS FURTHER:** • Does the person have capacity to make end-of-life plans? If so, engage the person in this process as much as possible to plan ahead • What is the *person's* understanding of hospice care? How does the person feel about hospice? • What is the caregiver's understanding about the *person's* wants and needs for end-of-life care? Did the person ever discuss this with the caregiver? • What are the *caregiver's* wants and needs for the person he/she is caring for? • Does the person have a POLST (Physician Order for Life Sustaining Treatment) on file with the medical team? • Does the person have an Advanced Healthcare Directive? • Does the person have a Durable Power of Attorney for Healthcare to make end-of-life medical decisions? If so, who is making these decisions? • Is there someone the caregiver trusts and feels comfortable discussing these questions with? • Is the caregiver overwhelmed? • Is the caregiver confused about end-of-life care options? • What are the caregiver's cultural/religious beliefs about end-of-life?
Adjust Problem solve with interventions and actions	**TEACH PROBLEM-SOLVING STRATEGIES TO CAREGIVER:** • Complete necessary paperwork (POLST, Advanced Directives, etc.) • Discuss medical care decisions with family and doctors • Learn about hospice care (hospice is provided to people with a life expectancy of 6 months or less and offers many supportive services to the person and family that focus on comfort and enhancing quality of life) • Speak to trusted family, friends or clergy about your concerns
	CLINICAL SUPPORT: • Refer to PCP to discuss POLST, Advanced Healthcare Directive, Durable Power of Attorney for Healthcare, etc. • Refer to doctor for discussion about end-of-life care needs for the person • Refer to social worker for social/emotional support, counseling and assistance with end-of-life planning • Refer family to PCP for hospice referral • Suggest caregiver speak to hospice about pain/discomfort management • Encourage self-care for caregiver

Best Practice Care Plans have been adapted from the Alzheimer's Disease Coordinated Care for San Diego Seniors (ACCESS) Project

	CAREGIVER SUPPORT AND COMMUNITY RESOURCES:
	• Listen empathically to caregiver and evaluate for level of distress
	• Identify possible informal community support systems (church/clergy, neighbors, friends, family, etc.)
	• Refer to local hospice services
	• Refer to Alzheimer's Los Angeles for support groups, disease education, and care consultation
	  o ALZ Direct Connect® referral
	  o Provide Helpline #: 844.HELP.ALZ | 844.435.7259
	  o Website: www.alzheimersla.org
	• Local Community Resources: _____
	_____
	• Send literature/refer to website:
	  o http://www.caringinfo.org/i4a/pages/index.cfm?pageid=3277 (Advanced Directives)
	  o http://www.nhpco.org/about/hospice-care (Discussing hospice care)
	  o http://capolst.org/ (POLST form in English and Spanish)

	FOLLOW UP: • Schedule a phone call with caregiver to discuss outcomes and provide additional support
	NOTES: _____ _____ _____ _____

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