**DRAFT: “HUDDLE” SCRIPT - Concordia Place**

By Chelsy and Adrienne, Dietetic Interns

**INTRODUCTION:**

Hi my name is \_\_\_\_\_\_\_, and this is \_\_\_\_\_\_\_\_. We are both Dietetic Interns working with Jean Helps these next few weeks. Thank you for being here.

Today, we will be discussing the Journey of Nutrition Decline initiative that was completed in September 2018. This initiative was designed to help **Personal Care Home staff** engage in meaningful conversations with residents and families on the anticipated nutrition decline their loved one may experience during Personal Care Home admission.

Some sites have adopted these resources, however, others may be unaware of the initiative. So we will be discussing that today.

At the end we’ll leave some time for questions!

**What is the purpose?**

The purpose is to prompt recognition and communication of resident decline between health care team members.   The LTC End of Life Committee recommended this work to prevent “crisis management” which may occur when family is stressed and concerned about their loved one not eating as they approach end of life.

* This is to allow for early engagement of the team
* to provide educational resources (which we will go over) for all members of the team regarding the anticipated changes over the course of residents’ stay in PCH
* These resources are intended to facilitate conversation, to support shared vision between members of the health care team and consistent language when communicating with residents/family.
* Any member of the team can use them as they see fit. The focus is on conversation.

**1.**

**Health Care Professional Resource: Changes in Food Intake and Nutrition in the Older Adult**

**Health Care Professional Resource: Feeding and Swallowing Concerns**

Purpose:

* Provides evidence based information for PCH staff with references for background information when having a conversation with resident and/or family
	+ Regarding a) changes in food intake and nutrition in residents, and b) resident feeding and swallowing concerns

Suggested Use:

* To be used as reference tools for health care disciplines (such as RD’s, SLP’s, and Nurses) who may need to engage in meaningful conversations with residents and/or family.

**2.**    **Meals in Long Term Care Homes:**

Purpose:

* To be provided soon after admission, to provide basic information about the food and mealtime experience in the long term care setting
* To gently introduce the potential for nutrition decline during admission
* To provide information about how an RD can help and the actions taken when nutrition decline occurs
* To acknowledge the role that food has in nurturing an individual beyond the nutrition it contains
	+ For example: the resource discusses how there may be times when a resident has difficulty eating, and how food can be used as an expression of love and care.

Suggested use:

* Provided by the clinical dietitian when completing the initial nutrition assessment.  This resource may be provided to both the resident and family. However, in situations where the resident is unable to comprehend this information, and family is not present at the time that the nutrition assessment is being completed, it may be left at the bedside for the resident's family. There is less concern that this resource be provided without conversation as compared to other resources.
* Provided by nursing and other members of the team as needed.

**3.**    **Difficulties with meals for people with dementia:**

Purpose:

* To provide information regarding the anticipated changes a resident may face during mealtimes if they are diagnosed with dementia.
	+ For example: information about anticipated changes at the early, middle, and late stages of dementia and how it can affect resident meals.
		- Provides information regarding comfort based nutrition for residents with dementia towards the end of life.

Suggested use:

* Any member of the team may provide this information as needed.

**4.**    **When a person has trouble eating and swallowing:**

* The purpose is to provide information regarding expectations whenever difficulties with eating occur.
* This handout addresses- why residents often have a difficult time eating- which could either be related to swallowing issues, acute illness, and progressive conditions.
	+ - For example: if someone has a UTI, they typically may not feel well, which may lead to them eating less, and which may causes concern to the family if their nutrition is affected
	+ *As the health care provider, this resource can be used to guide conversations such as:*
		- *how to identify if their love one has difficulties swallowing*
		- *why feeding/ swallowing issues are such a concern*
		- *what does the care team do to help loved ones when difficulties come up*
		- *what do I (as the family member) need to know about when a loved one has difficulties eating.*
	+ Overall, the suggested use for this handout is to be Provided by SLP, clinical RDs and/or nursing when difficulties occur.  And this handout, may be provided multiple times over the course of admission.

**5.**    **Nourishing the Whole Person**

**Purpose:**

* The purpose of this resource is to identify non-food related ways of being “nourishing” and providing care. Food has a multifaceted purpose in our society, and in situations where eating and drinking become difficult, this resource is used to address other ways to show care to your loved one.
* *For example this includes:*
	+ *Nourishing the body (through movement, taking walks together, enjoying nature)*
	+ *Nourishing the mind  (reading, watching family videos sharing stories)*
	+ *Nourishing the heart (being with loved ones, listening to good music)*
	+ *Nourishing the soul and spirit (scripture, praying together, hymns)*
* *​​Spiritual Health and Social Work team members may find this tool particularly helpful. We want to ensure the family knows that we are not abandoning their loved one* ***when a person is eating less or not eating****, but we are changing the focus of our care.*

**6.**    **Nutrition and Swallowing at End of Life**

**Purpose:**

* This resource would most likely be provided to a *substitute decision maker* and/or family, rather than to the resident.
* The purpose is to increase the family’s understanding of the anticipated changes that occur as a resident approaches the end of life.
	+ *For ex. As people approach the end of life it is not uncommon for loved ones to become weaker, become more drowsy, and lose their ability to swallow food and drink.*
	+ *Here they highlight the importance of keeping the person comfortable at this time.*
	+ This resource aims to support conversation regarding the common impact being at the end of life may have with regards to nutrition and swallowing.

**Suggested use:**

* This handout can be provided by nursing, clinical nutrition and/or speech language pathologist and other members of the team, as a resident approaches the end of life.
* It’s important to remember that these handouts should not be given without prior discussion.

**Conclusion:**

**The Journey of Nutrition Decline resources provide the following information:**

**Best care is supported by:**

* Understanding resident status, including resident decline, by all members of the health care team.
* Including resident, substitute decision maker and family in this understanding of resident status.
* Having appropriate skills to communicate messages surrounding nutrition decline to residents, substitute decision makers and family.
* All members of the HCT having an understanding of the resident’s status – communication is obviously crucial for this to happen
	+ One of our biggest challenges is communication (both between the HCT and with resident/family).
* In this presentation, we have had a number of conversations about who this practice is intended for:
	+ To reiterate, these conversations are intended for any resident and their family **when identified to be valuable. In other words, not all family would necessarily need these conversations when they are comfortable with changes in the resident.**
	+ While you may only need to check in with some residents/family; with others you may have a longer conversation earlier in the person’s stay in the facility, depending on the residents health status.

**We hope we have:**

1. **Increased awareness of this plan**
2. **encouraged conversation of the plan to increase desire for staff to use this plan**
3. **given knowledge the purpose and rational for this initiative**
4. provided tools which supports staff ability understand the plan and to have these conversations
5. Provided ideas for reinforcement of the initiative, such as huddles, education fairs

**Having:**

1. **consistent messaging between all team members, and**
2. **having meaningful conversations is important to help families understand that there are expected changes and can help reduce their anxiety when their loved one is approaching end of life.**

**COMMON QUESTIONS**:

1. **Where do staff have access to these?**
* shared drive?
* website?
* Will unit staff / managers have to have resources handy for any member of the team to have access to
1. **When will these resources be implemented?**
* TBD
1. **How do we use these? In what situations will we have to use these?**
* **For example #1:** if families are insistent that a resident be fed, despite them being in their EOL stages. At this point, body systems typically will be shutting down, and food can cause more harm/discomfort.
	+ Resources #5: *Nutrition and Swallowing at EOL*
* ***For example#2:*** *Intake decline once in a personal care home*
	+ *Resource# 1: Meals of Long Term Care*
1. **If HCA, nurses, or other allied health miss the presentations/ huddles…. who is responsible for sharing this information?**
* From our assumption, there will be future huddles/ presentations to be done, pass our work as interns. This is a question, I could pass to our clinical manager, Jean.