An Enhanced Ethics Culture Can Improve Clinical Outcomes and Reduce Moral Distress

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Learning Objectives

• Describe the role and function of the PACE Organization of RI ethics consult service and enhancements involved

• Use the specific components of PACE enhancements as a template for enhancements in participant’s respective programs

• Gain a working knowledge of moral distress and strategies to alleviate ethical conflict using the ethics committee resources
Components of Our Ethics Service

- Ethics Committee
- Consult activity
- End-of-Life Care Initiative
- Education & training/committee member orientation
- New employee orientation
- Library & resources
- Collaboration with Hospital Ethics Committees
- Staff Support (Ethics for Lunch)
Committee & Consult Activity

- Role of the committee (consultation; education; policy & procedure input)
- Quarterly to bi-monthly
- Topics discussed
- Membership
- Ethics champions

- Increasing with more emphasis in IDT, Care Plan meetings, etc.
- Education regarding framework
- Tools, such as the ethics app
- Core competencies – skills & knowledge necessary to run an ethics consult (ASBH)
End-of-Life Care Initiative

- Comfort Care Committee
- Values Based Conversations about Goals of Care
- EMR documentation audit project
- Enhancements with spiritual care
Education & Training

• Orientation and competencies training for new committee members
• New employee orientation – brief intro; video
• Interns orientation – part of new employee orientation or in department
• Library & Resources
Specific Components of an Enhanced Service

- Values based discussions
- Core competencies (ASBH) for ethics consultations
- Benchmarking
- Policies and Standard Operating Procedures
- Care partner relationships (HEC presentations)
Values Based Discussions

**Proposal:** To introduce values based discussion about personal values and goals of care with prospective participants and their families at the time of enrollment and use a standardized outline to guide the discussion.
Policies & Procedures

• Code of Conduct
• Professional Codes of Ethics
• Conflict of Interest
• Participant Rights
• End-of-Life Care
• Decision Making Capacity
Care Partner Relationships

• Outreach to Hospital Ethics Committees
• Requesting ethics consultations when ppt. is admitted
• Invitations to case management/social work meeting
Case Study
Case # 1

• 73 y/o Guatemalan female
• End stages of: COPD, CHF, CKD
• Super morbidly obese BMI > 65, Afib, DM 2, non ambulatory, rt femur fracture and non union, HTN, HLD, OSA
• Admitted to the hospital with cough/dyspnea
• CT chest with contrast to rule out PE
• Diuresis
• RSV on nasal swab
Case # 1

- Acute complications: AKI, fluid overload, acute CHF
- Requiring emergent hemodialysis
- Intubated and extubated several times
- Sacral decubitus stage 3 >> severe pain
- Palliative consulted and morphine advised for pain
Case # 1

• Family opposed to morphine --> Hasten death
• Growing distrust with the medical team as complications worsen
• Medical team struggling with futile care and goals not aligned with participant’s prognosis
• Son = HPOA threatening medical staff
• Demanding to be discharged to home
• Medical uncomfortable with her management at home
• Reassurance to medical that PACE could manage her at home
Case # 1

**Background:**

- Similar events 2 years prior with home discharge
- Comprehensive home care with PACE support
- Multiple family meetings to address code status- 3 MOLSTs with DNR reversed
- “Caregiver home” = shared living program
- 2 ER visits in 2 years
- No pressure ulcers in 2 years
- Family’s prior experience of hospice
Case # 1
Moral Distress:

- Family’s distrust of medical team/ confrontational

- Medical team distrust of family – questioned if elder abuse case due to with-holding morphine for pain.

- Skeptical about PACE’s ability to provide appropriate services at home to meet needs

- Hospital Ethics team consulted

- PACE team explained to son and family the plan

- Hospital team reassured of PACE’s capabilities and resources to manage ppt. at home and knowing how involved family is with her care

- Ppt. discharged to home. Code status changed to DNR/DNI.

- Ppt. passed away after a month at home
Thank You!
Questions?

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