Journal of Life Care Planning, Vol. 1, No. 2, 153-156.

Life Care Planning for Successful Outcomes: A Ten Year Case Study

Sharon L. Reavis, RN, MS, CRC, CCM

In the winter of 1992, Kristen Taylor, a 29-year old female, and her three children, ages 6 years, 4 years, and 18 months were on their way to work, school and daycare, respectively. Kristen stopped to fuel her car; and when leaving the station, her vehicle was hit head-on by another vehicle. Kristen experienced a Grade III head injury with secondary quadriparesis, multiple fractures, and internal injuries. Her 18-month old daughter sustained a significant brain injury, and her two sons experienced multiple injuries including mild brain trauma.

Kristen and the children were taken to the local medical university for trauma care, and they subsequently received acute care. The Case Manager/Life Care Planner was contacted and the case management process ensued. Arrangements were made to have Kristen transferred to a larger metropolitan area where her father resided because she was estranged from her husband and had no other family in the area. Her estranged husband, who had been out of the country, returned and relocated with the children to the same area. After discharge planning, Kristen was transferred to an appropriate rehabilitation center in that area. At the time of admission, she had a tracheostomy and feeding tube and was unresponsive to painful stimuli. Medical stability had not been obtained and a number of surgical interventions were necessary; the patient also required additional medical management.

After nine months of acute and subacute care, Kristen began a more progressive rehabilitation program. She was awake and responding to verbal commands, and able to perform visual and auditory tracking. Her arousal level was improved with medication, and depression was addressed with psychological intervention. Eventually, Kristen was able to communicate with augmentative communication equipment, she achieved medical stability; and though she had difficulty attending to lengthy or complicated conversations, she was able to comprehend simple questions and engage in limited conversation. She continued, however, to remain aphasic. She no longer required her tracheostomy, and recreational feedings were introduced to supplement the PEG feedings.

After several months of rehabilitation, the family and the Life Care Planner met to begin the life care planning process. The preliminary request of the family was that Kristen be placed in a skilled nursing rehabilitation facility pursuant to her estrangement from her husband and the failing health of her parents. After seven months of rehabilitation, discharge planning was initiated in conjunction with the discharge planner at the rehabilitation center, the family, and the Life Care Planner. It was Kristen's father's desire to remain as close to Kristen as possible so that he could visit her on a regular basis; therefore, onsite evaluations to rec-

ommend placement and services were obtained from selected skilled care facilities. A well-known nursing center was chosen by her father and the discharge planner at the rehabilitation facility, with consideration to the services provided by this facility and the facility's geographic proximity to the family. Kristen was then transferred after seven months of rehabilitation. Her medical status at discharge was excellent.

After a number of months of settling into the nursing center, the Life Care Planner re-evaluated Kristen's status to finalize the Life Care Plan. The nursing center presented with adequate staff to patient ratio and superior plant facilities. All therapies were available in house with excellent availability of equipment. The administrative staff appeared to be knowledgeable and cooperative. Unfortunately, upon observation and review of records, the Life Care Planner determined that Kristen had deteriorated significantly since the time of her placement. She demonstrated a sacral decubitus that would eventually require plastic surgery, and her nutritional status had deteriorated. Communication skills had regressed, and she demonstrated pain behavior. Moreover, although Kristen's hygiene appeared adequate, her personal care needs were not met with meticulous care; for example, her hair was unkempt, her nails untrimmed, and she was dressed in a hospital gown with limited attention to her personal care. Upon further review of this situation with Kristen's father, who visited her frequently, he reported minimal attention by the staff, inappropriate repositioning, and a persistent failure by the staff to compel Kristen to use the wheelchair. Kristen appeared distraught and uncomfortable, and she was significantly less responsive.

As a result of these issues, a family conference was held and the Life Care Planner initiated a search for a more appropriate placement. A number of skilled care centers with the appropriate patient/staff ratio and in house therapeutic requirements were identified, and onsite visits were accomplished. Together, the family and Life Care Planner, after comprehensive research, identified several centers as being appropriate. On-site inspections of the facilities were carried out. The family and Life Care Planner ultimately chose a small privately-owned center that had a long history of providing services and displayed many positive attributes. Although a geriatric population was included, the center also had a dedicated TBI wing with approximately 30 patients from ages five to forty. There was low turnover among both the administrative and nursing staff, and the director had been with the facility since its inception. The staff displayed an excellent understanding of the needs of traumatic brain injury patients and had within their staffing, the appropriate therapists and equipment. More importantly, there was ample evidence that the center's staff were both competent and respectful to the patient population. Kristen was subsequently transferred to this center, which appeared extremely appropriate for her needs; and although it's location was not quite as accessible for her father, he continued to have the ability to visit with her.

Outcome

Kristen was transferred to this center in 1993, and she has been continuously followed by this Case Manager and Life Care Planner since this time. The benefits establishing a life care plan combined with ongoing case management have produced tremendous results. Onsite, unannounced evaluations have found Kristen to be meticulously cared for in every way. Complications have been infrequent, and her cognitive status has improved from her status at the time of her discharge from rehabilitation. Her skin integrity remains excellent, and she continues to receive appropriate therapeutic interventions with no contractures or significant orthopedic disabilities. There continues to be excellent staff and patient interaction, and

Kristen is given assistance with communication on a daily basis. She no longer suffers from depression, and unannounced visits have consistently revealed that she is content and usually involved in activities.

Of specific interest is the cost analysis of care, which demonstrated that Kristen's care at the current center is actually less costly than her care at the previous center. Her current facility also provides additional services. The Life Care Plan that was completed in 1993 remains in effect with appropriate funding. Actual utilization of resources has been remarkably consistent with the outline contained in the original plan. Although Kristen's disability is tragic, and she will always remain totally dependent upon others for her health and well-being, the careful planning, evaluation, and follow-up case management has significantly improved her quality of life. This case illustrates that future needs can be accurately projected, thereby allowing for appropriate resource allocation and service implementation. It also demonstrates that a Life Care Plan is a dynamic creation that must evolve in response to changing needs and situations.