HOSPICE DOCUMENTATION: PAINTING THE PICTURE OF THE TERMINAL PATIENT

OBJECTIVES

At completion the participant will be able to:

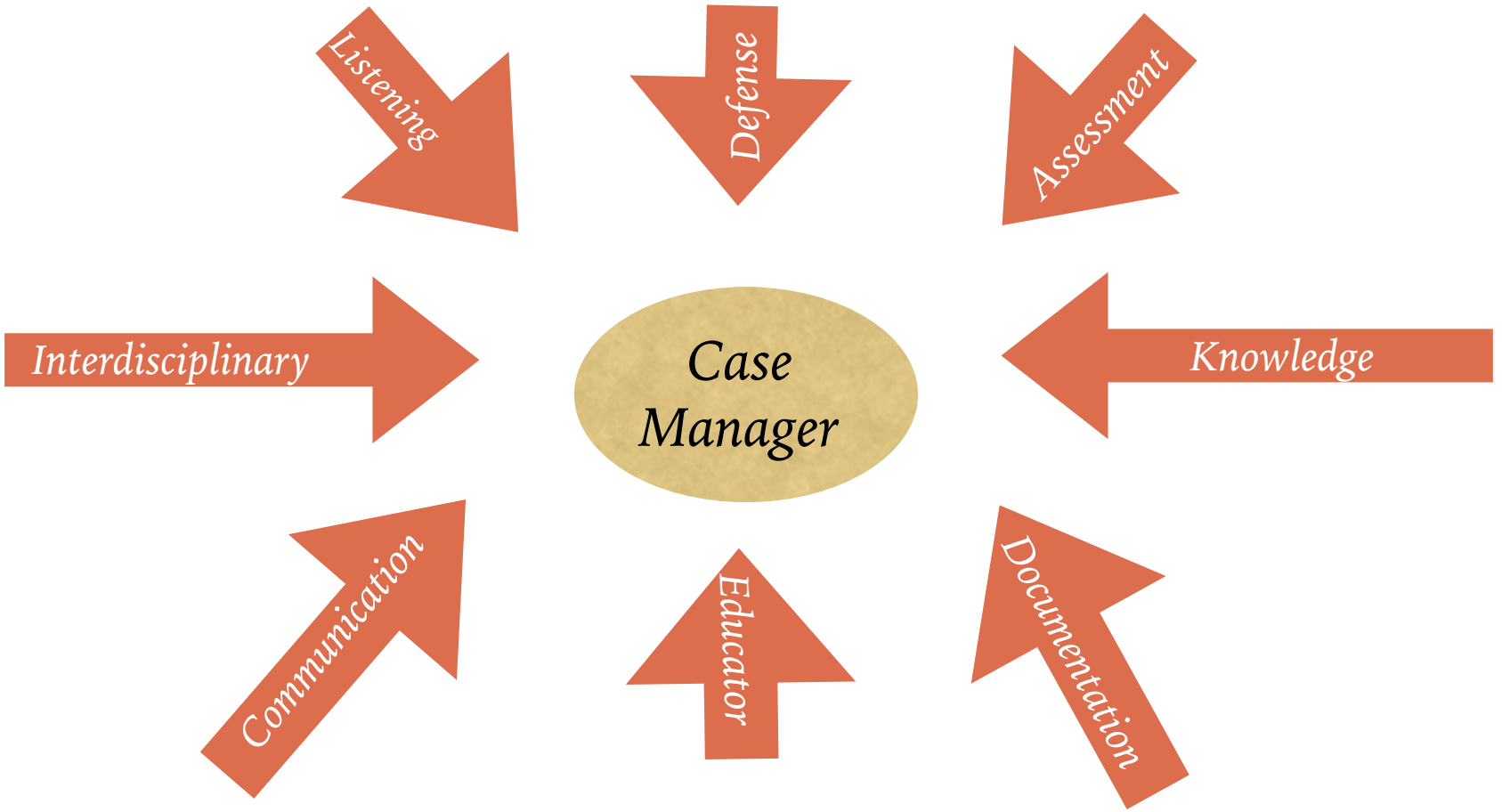
- Identify 2 components of a hospice note
- Describe 3 parts of the routine note that need to be documented with each visit
- Define documentation of pain assessment to include 2 types of standardized pain scales.
- List the important areas of documentation that are the best indicators of decline.
- State 3 terms to avoid when documenting in a hospice chart

DOCUMENTATION OF THE NOTE

NURSING DOCUMENTATION

- The Hospice Nurse is responsible for management of the patient as a whole. The nurse has to know everything that is going on with the patient at any given time. Even if the LPN/LVN is seeing the patient on the majority of the visits, it is still the responsibility of the RN to ensure that he/she knows all aspects of the patients care and improvement/ decline.
- It is the responsibility of the LPN/LVN to report any and all changes on the patient on a weekly basis and when changes occur at each visit.

CASE MANAGEMENT APPROACH



DOCUMENTATION REQUIREMENTS

Hospice nursing documentation must be very descriptive. This requires the nurse to look at the patients improvements and declines from visit to visit. Some items will need to be documented at least weekly:

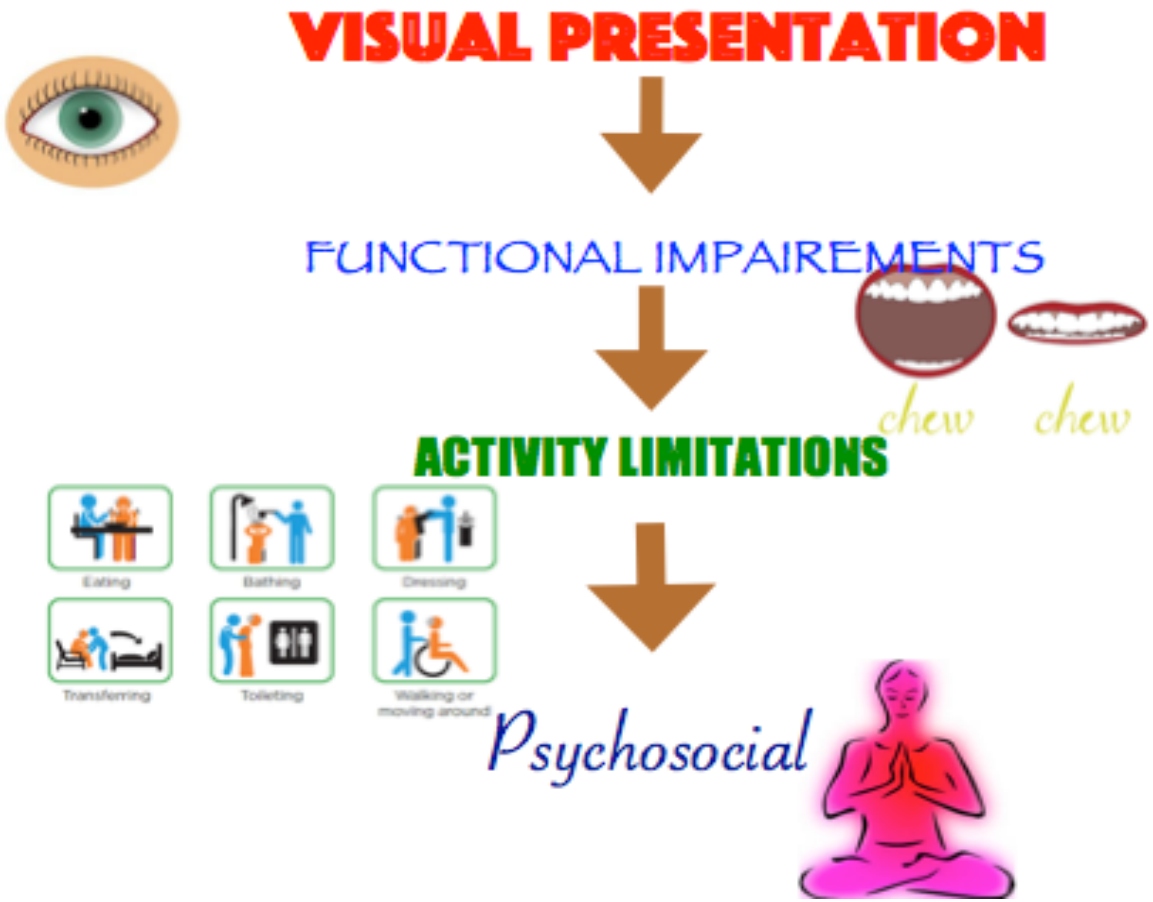
- Mid-arm circumference and weight if able to stand safely on scales
- Any wound characteristics to include: size, drainage, odor, wound bed, peri-wound, tunneling/undermining
- Use of a standardized tool depending on the patients terminal illness. This can include: FAST, Karnofsky, PPS, New York Heart Association Class

DOCUMENTATION ON ALL NURSING NOTES

The Hospice Nurse must document on every note the following items:

- The terminal diagnosis
- Pain and pain medications used/available
- Appetite
- Current abilities to perform ADL's and how this is different then the last visit. (this can be improvement or decline from visit to visit)
- Education
- Review of medications and response for symptom management
- Any dyspnea
- Edema
- Changes in cognition and level of consciousness
- Appearance
- Ascites
- Signs and symptoms of depression
- Use of any oxygen to include increase use/amount/ frequency Sleep

DOCUMENTATION OF DECLINE



SPECIFIC FOCUS AREAS OF THE NURSES NOTE

- Pain
- Appearance
- Weight
- Appetite
- Activities of daily living
- Sleep

PAIN ASSESSMENT

All areas of the pain assessment need to be completed. This includes:

- Pain score using a standardized tool that is appropriate for the patients cognitive status. Numeric, FLACC, PAINAD, Baker-Wong FACES scale, etc….
- Medications available to the patient to include the name and how often the patient is utilizing/ response to medication/s (each note)
- Need to change the type/route/mg strength with rationale and patient/cg agreement.
- Education if needed regarding administration

PAIN PRINCIPLES- THE 5TH VITAL SIGN

Pain:

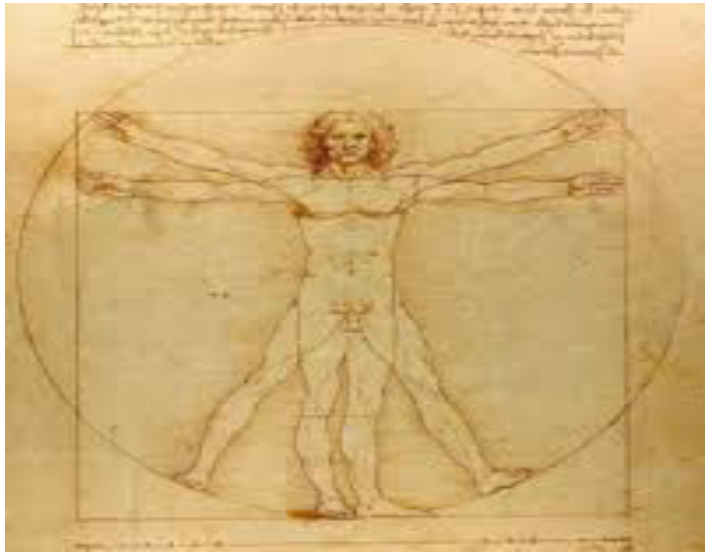
- Is subjective
- Is a patient right to have pain relieve/pain free
- Can exist even if no physical cause is found
- Patients with chronic pain are more sensitive to pain and other factors in the environment
- That is unrelieved can cause not only physical but psychological issues

THE 5TH VITAL SIGN

- Pain type
- Intensity
- Location
- Duration
- Aggravating/alleviating factors
- Description

DOCUMENTATION OF APPEARANCE

The hospice nurse needs to describe what they "see" when they come into the home. This can include the patients dress, color, cleanliness, tired/sleepy, sad, affect, where found during visit (bed/chair), still in pajamas in the middle of the day, etc….



EXAMPLE OF DOCUMENTATION OF APPEARANCE

Patient visit made today to assess terminal dx of COPD. Pt found sitting on the side of the bed in underwear only at 1:00 pm, taking a breathing treatment. Patient leaning forward using accessory muscles for inspiration. Color is gray and appears tired with dark circles under eyes and bedsheets piled up in the middle of the bed.

WEIGHT

- Weight loss/gain is an excellent determinant of decline. Almost all terminal diagnosis does have some degree of sudden weight loss or gain. This is why it needs to be documented weekly at a minimum.
- Also, on admit and during visits, if the patient cannot safely stand on scales, the nurse needs to document a mid-arm circumference (MAC).
- Documentation at the time of admission, if the patient cannot stand on scales, query the family to see how clothing fits today as compared to 3 and 6 months ago.
- The agency also has to have some standard for measuring the MAC so that all clinicians are uniform when taking this measurement.

EXAMPLE OF DOCUMENTATION OF WEIGHT AT START OF CARE

Patient is being admitted today for end stage Alzheimers Disease. The patient is unable to be weighed on scales due to bed bound but MAC is 18cm to the right upper arm. During the interview with the daughter, who has been caring for the patient over the past year, she said that mother has lost weight in the past 3 months but unable to state how much. The daughter states that she has been wearing clothing in a size 16 women's but now she had to get mother new clothing gradually over the past few months due to her clothing "falling off of her". The patient is now able to wear size 10 women's clothing.

DOCUMENTATION OF APPETITE

Appetite usually is a good indicator of decline in a hospice patient. Avoid documentation of good, fair or poor appetite. This cannot be measured. Instead give the number of meals that the patient ate per day along with the % of intake of each meal. Get down to even describing the meal provided in order to gauge the amount eaten/not eaten.

EXAMPLE OF DOCUMENTATION OF APPETITE

Patient is seen today for assessment of terminal diagnosis of CHF. The patient has been eating 4-6 meals per day but has only eaten about 25% of each meal. This consists of 2 slices of bacon, 3 bits of grits for breakfast. She had a 1/3 of an Ensure supplement, then for lunch she had a few bites of homemade soup and a popsicle. The patient and caregiver were encouraged to supplement as much as possible when she is unable to eat a meal.

ACTIVITIES OF DAILY LIVING

Nurses are typically more comfortable documenting this as it is easier and more tangible to assess. The Hospice Nurse needs to document a baseline ADL at the time of admission and then with each nursing visit. Point out any changes in ability of the patient to manage ADL's. This is also a very good indicator of decline. When a nurse is admitting any hospice patient, it is also good to document what the patient was doing 3 and 6 months ago as compared to what the patient is able to do now. This assists in proving decline of the patients status.

EXAMPLE OF DOCUMENTATION OF ACTIVITIES OF DAILY LIVING

Patient was admitted today for the terminal diagnosis of pancreatic cancer. The patient requires assistance of another for bathing at the sink, dressing his lower body and now uses a walker for all ambulation inside and outside of the home. The patient was completely independent with all ADL's. He was also driving and working every day until 3 months ago when he was diagnosed.

DOCUMENTATION OF SLEEP

Some patients will experience increase in sleeping as their terminal condition progresses. This is important to document the number of hours that the patient sleeps and whether this is during the night and during the day.

EXAMPLE OF DOCUMENTATION OF SLEEP

Patient seen today for assessment of terminal diagnosis of Alzheimer's Dementia. The daughter reports that the patient is spending more time during the day sleeping. When asked about the amount of time, the daughter further describes the patient is sleeping 8-10 hours at night and then takes a 3-4 hour nap during the day. The daughter also states that when the patient is up in the chair for more than an hour, she is frequently dosing off. This is a change from just 2 months ago when the patient was not even sleeping during the night and was having sundowners syndrome and sleeping a few hours during the day only.

KEY WORDS TO USE WHEN DESCRIBING A PATIENT

- Anorexic
- Cachectic
- Dyspneic at rest/with minimal exertion
- Frail
- Follow descriptions with "as evidence by" and then describe what you see with examples.

INCONSISTENCIES

Inconsistent documentation must be explained and addressed as they occur.

Example:

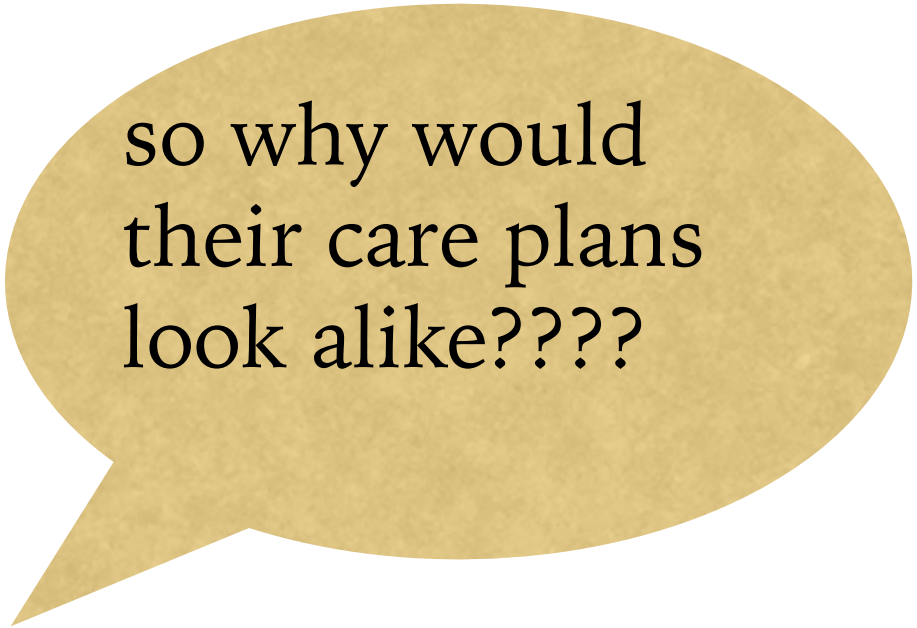
Patient with Alzheimers is alert today and able to answer 1-2 word answers. Report by the family states that the patient woke up this morning and able to eat breakfast of 2 eggs and 1 piece of toast. This is the most alert the patient has been in >1 month and usually only able to eat 1-2 bites of meals with encouragement. Patient MAC has decreased from 18cm-14cm in the past 2 months.

TERMS NOT TO USE IN HOSPICE DOCUMENTATION

- Stable
- No change
- Eating well
- No issues noted
- All of these terms describe lack of decline or stabilization

Care Planning

ONE SIZE FITS ALL……..



CARE PLANNING & CASE MANAGEMENT RESPONSIBILITIES

418.56 Interdisciplinary group (IDG), care planning, and coordination of services

The nurse is designated as the coordinator of the plan of care. This include creation and revisions to the plan of care using continuously updated comprehensive assessments of the patient and family status.

The interdisciplinary team is responsible for continuously coordinating care and services based on assessed needs.

The plan of care is the most important document in hospice care.

CARE PLANNING

Name: pain

Description: Pain

Goal: Patient's pain will remain at a tolerable level throughout benefit period as verbalized by patient or as determined by RN through use of verbal/non verbal cues.8/30/16__x_ Goal Met, ___ Goal Unmet, ___
Progressing Towards Goal: pt and staff report current pain medication regimen is effective

Problem: Pain

Reason: ongoing with intervention

Identified: _____

Resolved:

Intervention Type: Assess pain every visit, Teach med regimen, Assess pain meds and encourage compliance.
Discipline: HRN

CARE PLANNING

Name:

Description: Care plan for Decreased PO intake

Goal: Patient/patient caregiver will make informed decision regarding nutrition/ hydration

Problem: Nutrition

Reason:

Identified: 09/24/2016

Resolved:

Intervention Type: Diet/Fluids as tolerated, Teach oral hygiene, Teach comfort/symptom control, Other

CARE PLANNING

Name: Anxiety/Coping Skills

Description: Emotional Support

Goal: _____ and her family will utilize coping skills discussed to help cope with grieving process

Problem: Psychological

Reason:

Identified: 07/22/2016

Resolved:

Intervention Type: Other: Hospice SW Counseling / visits to assess patient and spouses needs and to provide support.

CARE PLANNING

Name:

Description: Care plan for altered Breathing patterns.

Goal: Communicate desires/choices for health/palliative care

Problem: Respiratory

Reason:

Identified: 09/12/2016

Resolved:

Intervention Type: Oxygen, Nebulizer, Comfort and symptom control, Other: Assess respiratory status
Discipline: HRN
Auscultate breath sounds
Discipline: HRN
Instruct patient/family in medication/treatment regimen

IDENTIFIED DECLINE AND CARE PLANNING

Scenario:
Patient seen today for terminal dx of lung cancer. Patient living with her spouse and is a good support system. Patient has been reluctant to use pain med (MSO4) as it makes her "loopy" but pain has gotten to the point where she is now using the liquid MSO4 at least 3 x day over the past 3 days for pain management. When asked, pt and cg are now agreeable to the use of a time released morphine for more continuous pain management. Called MD and obtain script for morphine ER 30mg q12 hr with morphine immediate release 5mg q4hr prn for breakthrough pain. When asked, pt states acceptable level of pain is 4/10.

CARE PLANNING FOR SCENARIO

<u>This is what the care plan says:</u>

Name: pain

Description: Pain

Goal: Patient's pain will remain at a tolerable level throughout benefit period as verbalized by patient or as determined by RN through use of verbal/non verbal cues.8/30/16___ Goal Met, ___ Goal Unmet, _X__
Progressing Towards Goal: pt and staff report current pain medication regimen is effective

Problem: Pain

Reason: ongoing with intervention

Identified: _____

Resolved:

Intervention Type: Assess pain every visit, Teach med regimen, Assess pain meds and encourage compliance.
Discipline: HRN

CARE PLANNING FOR SCENARIO

This is the modified care plan:
Name: pain

Description: Pain

Goal: Patient's pain will remain at a tolerable level (4/10) on new pain medication regiment throughout benefit period as verbalized by patient or as determined by RN through use of verbal/non verbal cues.

Progressing Towards Goal: Current pain management no longer fits patients pain needs (Roxanol 20mg/ml 0.5ml 1-3 x day) and quality of life. Changed med regiment per MD on 100216. Will assess med action and effectiveness over the next 2 wks and ongoing.

Problem: Pain

Reason: ongoing with intervention

Identified: 100216

Resolved:
Intervention Type: Assess pain every visit, Assess and teach new pain med MSER 30mg po q12hr and MSIR 5mg po q4hr prn for breakthrough pain and encourage compliance. Educate patient and cg on use of morphine and when to use the breakthrough medication.
Discipline: HRN

SCENARIO

Pt with a terminal dx of CHF. Pt is complaining of increased sob. When asked what change he has noticed, he says that he has to get up in the middle of the night and sit on the side of the bed due to the SOB waking him up. He already sleeps with the HOB up 30 degrees at night. There has been no weight gain as per scales today at steady 164 lbs. Also no increase in pedal edema at 1+ bilateral feet and calves. He is complaint with the Bumex 2mg bid and has noticed no increase in urination. Patient already uses O2 during the day but has not used it at night. Educated patient to begin using O2 at night and to make sure to take a neb tx every night before bed and if he wakes up in middle of night with SOB to take another neb tx. Pt verbalized understanding of above education along with his wife who is his primary caregiver.

Modified CP:

Name: SOB

Description: Care plan for altered Breathing patterns.

Goal: Communicate desires/choices for health/palliative care

Problem: Respiratory

Reason:

Identified: 09/12/2016

Resolved:

Intervention Type: Oxygen, Nebulizer, Comfort and symptom control, Other: Assess respiratory status
Discipline: HRN
Auscultate breath sounds
Discipline: HRN
Instruct patient/family in medication/treatment regimen

Name: Increased SOB secondary to CHF

Description: Care plan for altered Breathing patterns.

Goal: Patient will report a decrease work of breathing at night with use of O2 at 2-3L/NC ongoing. Patient will sleep undisturbed by SOB for a total of 6 hr/night by 1 wk and ongoing. Patient will be compliant with use of neb treatment right before bed and q4hr prn for increase SOB.

Problem: Respiratory

Reason: Pt with report of increase SOB at night

Identified: 100316

Resolved:

Intervention Type: Assess respiratory status with each SN visit. Patient will use O2 2-3L/NC continuously due to increase SOB. Patient will correctly use neb treatment (Albuterol & Ipratropium Bromide 2.5-0.5mg/3ml) q4hr and prn for increase SOB.

SCENARIO

Pt dx with end stage Alzheimer's Dz. The patient is bed confined and her daughter is the primary cg. The daughter notes that it has been very hard seeing her mother die such a slow death and sometimes feels like her mother is already dead. She has been able to give her mother small bites of food and fluids but now has noticed that she is no longer able to get her mother to swallow food. Daughter states that she knows that this time would come that her mother would not take anything by mouth but still is very distressing. The daughter appears very sad and crying during visit. Told daughter that she is doing the right thing by just being her with her mother. She can do mouth care on her mother since she is no longer taking anything by mouth. Provided active listening and emotional support to the daughter. Prayed with her daughter and the patient. Will plan to notify the MSW today to report decline and possibly increasing MSW visits for support of the daughter.

CARE PLANNING

Name: Anxiety/Coping Skills

Description: Emotional Support

Goal: _____ and her family will utilize coping skills discussed to help cope with grieving process

Problem: Psychological

Reason:

Identified: 07/22/2016

Resolved:

Intervention Type: Other: Hospice SW Counseling / visits to assess patient and spouses needs and to provide support.

Modified CP:

Name: Anxiety/Coping Skills of caregiver

Description: Emotional Support

Goal: patients daughter, primary cg, will be able to verbalize her feelings and emotions more effectively through support groups/ journaling/ and through physical visits in the home by 2 wks and ongoing. Daughter will attend at least 1 support group meeting for Alzheimer's caregivers by 6 wks.

Problem: Psychological

Reason:

Identified: 07/22/2016

Resolved:

Intervention Type: Hospice SW will visit patient/daughter weekly to allow daughter to verbalize her worries and concerns. MSW will provide active listening. MSW will assist and encourage the daughter to attend a support group from the Alzheimer's Society. Will encourage daughter to journal her experience with being her mothers caregiver to assist with coping.

Recertification

RECERTIFICATION

All recertifications must contain enough information to support the patient's terminal diagnosis/status. Documentation should include observation, measurable data not just conclusions/opinion.

Also all clinical information and indicators of decline must be in the recertification documentation to include scores/scales and comparisons to the last recert or admission.

Example:

Patient PPS score was 40% on admission 60 days ago and now patients PPS score is 20%.

Patient has no pain at the time of admission 90 days ago and now at the time of recert, the patient has to take morphine every 2 hours.

CUSTODIAL VS TERMINAL

Be very careful to distinguish between those patients who have become custodial instead of terminal.

Just because the patient continues to need the services does not mean that they continue to "*qualify*" for the services.

The entire IDG team has to make the decision of whether to recertify the patient.

The Certification of Terminal Illness

PHYSICIAN DOCUMENTATION ON THE CTI

Quick review of the CTI:

- Based on the MD's clinical judgement regarding the normal course of the patients illness and must be supported by the clinical information in the medical record.
- CTI cannot be check boxes or have standard language
- Must include a brief narrative description

NEEDS OF THE CTI NARRATIVE

- The terminal diagnosis
- Must include documentation of patients medical prognosis consistent of 6 months or less
- Any history that has lead to the hospice admission such as any failed treatments, medication changes with little/no response
- Any laboratory results that support terminal diagnosis
- Any signs or symptoms patient is exhibiting
- Oral intake
- Weight loss or gain over time

CONCLUSION

- Painting the picture of the hospice patient is the difference between being paid for the good care that you provide to your patient and seeing the patient for free.
- Good documentation with focus on the terminal diagnosis is the key to having a clean claim.