



Hospice & Palliative Care Federation of Massachusetts

Best Practice Protocols Short Length of Stay Admitting/ Assessment Practice

A Report of the Standards/ Best Practices Committee Hospice and Palliative Care Federation of MA Fall 2003

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This best practice paper is offered as guidance and not legal authority.

Introduction

The Best Practices Task Force of the Hospice and Palliative Care Federation of Massachusetts wanted to develop Best Practices or Evidence Based Practices for patients who have a very short length of stay with hospice prior to death (7 days or less). The subcommittee reviewed literature to find relevant research to support best practices in this area. Unfortunately, no research has been found measuring patient and family outcomes related to care provided and assessments performed with short length of stay patients. With the lack of such evidence based practice, the committee then reviewed the regulations governing hospice admissions and is suggesting an abbreviated admitting practice for such patients. Attached is a policy statement that would address such a practice. With the abundance of various computer programs in hospice, we did not develop the abbreviated assessment tool but rather provided you with the parameters as well as some examples.

Short Length of Stay Task Force Report Admitting/Assessment Practice

Hospice admitting practices are based on a projected length of stay in months. We are faced with the challenge of patients with a length of stay of 2 weeks or less who require rapid assessment of their physical, psychosocial and spiritual needs. Once their primary needs are identified, then a plan will be developed and implemented to meet their needs.

Clinical indicators that would suggest a short length of stay include but are not limited to the following:

Disengagement with the environment and lethargy	Decreased respirations – apnea
Disorientation	Irregular respiratory rate with changes in rate and pattern, and periods of apnea
Semi responsive or non-responsive	Tracheal secretions
Increased sleeping – sleeping most of the time	Karnofsky of ≤ 30
Minimal food and fluid intake	Mottled skin
Minimal and decreasing urinary output < 700 cc's in 24 hours	Sudden, rapid, non-reversible decline

The admitting clinician will modify or abbreviate the assessment based on his/her clinical judgment to identify and meet the needs of the patient. For example, a patient who will die within a day should not be questioned about preventive health habits and nutritional status. The table below reflects the JCAHO necessary areas of assessment which the committee then divided into “most likely” and “less likely” to include in an abbreviated nursing assessment as appropriate to the patients’ status, time to death and most pressing needs.

More Likely Necessary	Less Likely Necessary
<ul style="list-style-type: none"> • Relevant medical history related to the current disease 	<ul style="list-style-type: none"> • The patient's medical history not related to the terminal disease
<ul style="list-style-type: none"> • The patient's problems, needs and strengths 	<ul style="list-style-type: none"> • Age specific and gender specific findings
<ul style="list-style-type: none"> • The home environment 	<ul style="list-style-type: none"> • Laboratory results
<ul style="list-style-type: none"> • The patient's diagnosis 	<ul style="list-style-type: none"> • The patient's nutrition status
<ul style="list-style-type: none"> • Pertinent physical findings 	<ul style="list-style-type: none"> • The patient's dental function
<ul style="list-style-type: none"> • Prescribed and over the counter medications 	<ul style="list-style-type: none"> • Preventive and periodic health screening
<ul style="list-style-type: none"> • Any identified symptoms or pain 	<ul style="list-style-type: none"> • Anticipated discharge needs
<ul style="list-style-type: none"> • The patient's functional status 	<ul style="list-style-type: none"> • The patient's prognosis
<ul style="list-style-type: none"> • The patient's psychosocial status 	
<ul style="list-style-type: none"> • History of chemical dependency 	
<ul style="list-style-type: none"> • Cultural and religious practices • Religious connection • Values beliefs or practice • Interest in meeting with the chaplain 	
<ul style="list-style-type: none"> • The patient's wishes regarding care, treatment and end of life decisions 	
<ul style="list-style-type: none"> • Equipment 	
<ul style="list-style-type: none"> • The patient's family or support system and the care they are capable and willing to provide 	
<ul style="list-style-type: none"> • The patient's and family's educational needs, abilities, motivation and readiness to learn 	
<ul style="list-style-type: none"> • Past history of coping with death by the family, increased risk of high risk bereavement 	
<ul style="list-style-type: none"> • allergies 	

During the intake process, if a patient is identified with a short prognosis of 7 days or less, it is suggested that both psychosocial and nursing staff make a joint visit to admit the patient. Intake staff should notify the team prior to admission of the short length of stay to assist in having both Psychosocial staff and nursing staff making the visit.

Additionally, nursing staff may want to incorporate the following questions into their patient/ family assessment to identify patients at risk for and need for social work and pastoral care services:

- Do you have a belief in a higher power that supports you?
- Who could you call if you started to feel really sad?
- Who can support you when the patient dies?
- Did the pt ever tell you what they wanted for themselves? (to get at funeral planning- this can be used to normalize the process, that some people do this as a matter of course)
- Is there anyone you think the pt would like to see?
- Is there anyone you'd like us to call? (if death seems imminent)
- Have you/your family been through something like this before? How did family react/cope?
- Can you anticipate any potential areas of concerns for you and your family?

References:

Medicare Conditions of Participation

418.56C The plan of care must include an assessment of the individuals needs and identification of services including the management of discomfort and symptom relief.

418.68 The IDG must conduct an ongoing assessment of each patients and families needs

418.88 The patient and family must receive an assessment of their psychosocial needs.

JCAHO

PE1 The hospice defines in writing the activities that comprise the patient assessment function

PE2 The assessment is appropriate to the type of care and services provided by the hospice and the patient's needs. The assessment contains the following if applicable:

- The patient's problems, needs and strengths
- The patient's prognosis
- The patient's diagnosis
- Pertinent physical findings
- The patient's medical history
- Age specific and gender specific findings
- Laboratory results
- Prescribed and over the counter medications
- Any identified symptoms or pain
- The patient's nutrition status
- The patient's dental function
- The patient's functional status
- The patient's psychosocial status
- History of chemical dependency
- Cultural and religious practices
- The patient's wishes regarding care, treatment and end of life decisions
- The home environment
- Equipment
- Preventive and periodic health screening
- The patient's family or support system and the care they are capable and willing to provide
- The patient's and family's educational needs, abilities, motivation and readiness to learn
- Anticipated discharge needs