HOSPICE

My lecture outline

- Objectives:
  - Describe a brief history of the development of hospice care
  - Describe the hospice philosophy of care
  - Describe the referral process
  - Describe hospice services
  - Describe reimbursement in hospice care
  - Recognize hospice myths

- Course outline based on Objectives:
  - Describe a brief history of the development of hospice care, especially in the United States
    - Dame Cicely Saunders, MD and Elizabeth Kubler-Ross, MD
      - St. Christopher's Hospice – 1967 – birthplace of modern hospice movement
        - Dame Saunders died at St. Christopher's July 14, 2005
      - On Death and Dying – 1969
        - Briefly review the 5 stages
    - Connecticut Hospice Care Inc.
      - First hospice in United States – 1974
    - VNA of Texas, Inc.
      - First hospice in Texas – 1978
      - Received government grant to provide hospice care
      - Not for Profit
      - Bridge Program – home care with palliative focus and "bridge" to hospice when patient/family is ready
    - Medicare Legislation
      - 1983
      - VNA was asked to assist Medicare in writing hospice guidelines
      - Hospice is the only entity for which Medicare pays 100% of services provided
  - Describe the hospice philosophy of care
    - Holistic concept
      - Emotional, physical, social, and spiritual comfort
    - Family unit
      - The dying person & his/her family as the unit of care
    - Palliative care
      - Emphasis on comfort not cure; benefit vs. burden; Quality of Life ("majority of patients are over treated with technology but pain is under treated")
      - W.H.O. definition: compassionate care directed at improving quality of life for people with life-limiting illness

Created 07/09/07 by Ryan Shaw, RN
Updated: 07/25/07; 07/39/07

not responding to curative treatment; encompasses last 2 – 2.5 years of life (hospice care – usually refers to last 6 months of a person's life)

- Affirms life and prepares for death
  - Regards dying as a normal process
  - "You matter to the last movement of your life, and we will do all we can, not only to help you die peacefully, but to live until you die".

o Describe the referral process
- Patient/family
  - Physician discusses hospice with pt/family
  - Pt/family wishes to further pursue hospice options
- Physician
  - Writes Order for "hospice consult"
  - Order sent to social worker per hospital policy
- Social worker
  - Confirms pt/family wishes to pursue hospice services
  - Provides hospice agency options
  - Notifies hospice agency chosen by pt/family
- Nurse
  - Provides additional support to pt/family
  - Assists with discharge planning
- Hospice agency
  - Completes evaluation and intake process
  - Meets with pt/family to discuss hospice services
  - Plans and assists with discharge;
  - Or, coordinates inpatient admission

o Describe hospice services
- Criteria for admission
  - Terminal diagnosis
  - Life expectancy of less than 6 months
  - Desire to have treatment focused on comfort rather than curative interventions
  - Some may require a caregiver present in the home
- Cancer and non-cancer diagnoses
  - Cancer diagnosis with life expectancy of less than 6 months
  - General Guidelines
  - End-state AIDS
  - Amyotrophic Lateral Sclerosis (ALS)
  - CVA and Coma
  - End-stage Dementia
  - End-stage Heart Disease
  - End-stage Liver Disease

- End-stage Lung Disease
- End-stage Renal Disease
- Atherosclerotic Cardiovascular Disease (ASCVD)

- Symptom control
  - Physical – pain, respiratory distress, fever, nausea and vomiting, hemorrhage, oral-pharyngeal secretions, etc.
  - Emotional – anxiety, fear, restlessness, agitation, denial, depression, etc
  - Spiritual – lack of or faltering spiritual aspect of life, need for reassurance
  - Social – unresolved issues, life reviews, "still grandma"
- Levels of care
  - Routine home care, wherever the patient lives
    - Home
    - Nursing home
    - Residential home
  - Inpatient care, usually in a contracted hospital
    - Patient is actively dying
    - Acute symptom management
    - Not covered by Medicaid, considered duplication of services
  - Respite care, in a contracted nursing home facility
    - To provide a break or rest for the family and/or caregiver
    - Medicaid covers a total of 5 days for entire time patient is on hospice
  - Continuous care, wherever the patient lives
    - Crisis care for acute symptom management
    - For other crisis within the home
- Ancillary services
  - Medications related to hospice diagnosis and symptom control
  - Durable medical equipment
  - Medical supplies
  - Specialty and therapy services needed for symptom control
    - OT, PT, ST, RD
- Interdisciplinary Team
  - Provided by professional team primarily in the home setting
  - Personalized, comprehensive services based on patients and family's individual needs
  - Team members:
    - Patient and family

  - Physician
  - Registered nurse
  - Medical social worker
  - Chaplain
  - Home health aide
  - Volunteers
  - Bereavement coordinator

- Routine inpatient hospice orders (discuss and provide handout)
  - Admit to VNA Inpatient Hospice per services of *John Doe, MD* with diagnosis of *End Stage CHF*
  - DNR
  - Diet: "NPO with mouth care q6h and prn comfort"; or "Comfort Foods as long as no dysphagia and mouth care q6h and prn comfort"
  - Vital Signs q shift
  - Maintain foley per hospital policy – or – May insert and maintain foley per hospital policy
  - Reposition q4h and prn comfort (I usually do q4h for dying pts instead of q2h because they seem to remain more comfortable and it causes less agitation and/or restlessness)
  - Maintain current O2 protocol; if there isn't current O2, "O2 2 – 6 liters prn"
  - No O2 sats or lab draws, nor any other type of diagnostics, procedures, and/or consults.
  - If they have a peripheral IV, "Do not re-site IV and DC for s/s of infection and/or infiltration"
  - If they have a PICC, central line, or port, "Maintain – *whichever one it is* – per hospital policy"
  - If they have a morphine or dilaudid drip, "Continue morphine drip at *(the current rate)* and titrate to comfort"
  - Morphine 1 – 4 mg IVP q2h prn pain/sob/respiratory distress and titrate to comfort (Presby cannot give 5mg IVP on the floor, pt must be in ICU for that dosage)
  - Or – Dilaudid 1 – 2 mg IVP q2h prn . . . . . .
  - Ativan 1 – 2 mg IVP q3h prn restlessness/agitation and titrate to comfort (or, substitute haldol if ativan isn't effective)
  - Phenergan 12.5 mg IVP or 25 mg supp q4h prn n/v; or, Zofran 4 mg IVP q4h prn n/v
  - Tylenol 650 mg supp, 1 PR q4h prn fever
  - Atropine Opth Gtts 2 gtts SL q2h prn oral-pharyngeal secretions

- Scopolamine Patch 1 TD behind ear and change q72h
- If they have a peripheral IV site that we might lose, "Roxanol 20mg/ml, 5 – 20 mg SL q2h prn pain/sob/respiratory distress and titrate to comfort" and "Lorazepam Intensol 2mg/ml, 1 – 2 mg SL q3h prn restlessness/agitation and titrate to comfort"
- If they have IVF's, slow them to a TKO of 10 ml/hr
- If they have PEG or NG feedings, for the family's emotional sake, slow them to ½ of current rate and then DC the following day
- May suction prn, but only if Atropine and/or Scopolamine are not controlling oralpharyngeal secretions
- Please call VNA Hospice with any change in condition and when pt expires 214-689-2648.
  TO/Dr.JDoe/RShaw,RN,VNAHospice

o Describe reimbursement in hospice care
  - Per diem
  - Medicare
  - Medicaid
  - Insurance
  - Community Funds

o Recognize hospice myths
  - Hospice is for cancer patients
    - Hospice is for any end-stage disease
  - Hospice is a place to die
    - Hospice care is a type of care, not a place
    - Hospice cares for patients where they live
  - Hospice means giving up hope
    - Hospice helps to redefine Hope
  - Hospice is a "last ditch" effort
    - Hospice works best when there is time to build trust and relationships
  - Hospice hastens the moment of death
    - Recent study shows patients on hospice care live longer