HOSPICE PHILOSPHY & CARE

Skilled Nursing Facility Orientation

Developed by:
Hospice & Palliative Care Committee
CT Association for Healthcare at Home
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INTRODUCTION TO CT STANDARD HOSPICE ORIENTATION FOR SNF

- Training developed by the Hospice and Palliative Care Committee for the CT Association for Healthcare at Home
- Goal to meet the hospice orientation/training requirements as mandated through both federal Medicare and state Dept of Public Health

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GUIDANCE FOR SNF HOSPICE TRAINING

- Training is presented as a standardized **recorded webinar along with a post-test** making it easy for Staff Development within the SNF to include in orientation for all interdisciplinary team SNF staff (nursing, therapy, social work, CNAs, SNF medical director)
- Since training meets all licensing requirements, it only needs to be completed once—***not repeated for each hospice contracted agency.***

GUIDANCE FOR SNF HOSPICE TRAINING

- Should the SNF have any Hospice contracts, the expectation is any one of the Hospices can provide the training information for the SNF to incorporate into orientation.
- Once the staff member completes the training, it is the responsibility of the SNF (usually the Staff Development Coordinator) to track each staff member's completed training.
- The completed training log will need to be provided to the Hospice agency on a consistent basis (process to be determined through communication between SNF and Hospice). The suggested time frame is at least quarterly.
- Each SNF may also choose to hold a staff meeting of current staff to offer the webinar and hold post-discussion.

ADDITIONAL HOSPICE IN-SERVICE TOPICS

- The standard orientation and annual training as presented today meets all federal and state requirements
- HOWEVER…
  - There are additional topics that may be requested and offered to the SNF staff by individual hospice providers.
  - These additional topics would be beyond the standard training
  - Examples may include:
    - Specific Pain and Symptom Management treatment or equipment training
    - Perhaps a new treatment
    - Reminders or reinforcement of standard training

HOSPICE REGULATORY REQUIREMENTS

- Both Skilled Nursing Facility (SNF) and Hospice Medicare Conditions of Participation require SNF direct care staff to receive Hospice training during orientation and annually—when hospice care is provided within the SNF through contract
- CT Dept of Public Health licensure requirements for hospice
  - "all direct service staff receive in-service education including **two hours specific to hospice care**"
- Refer to Handout summarizing all regulations

TOPICS TO BE COVERED

- Hospice Philosophy
- When is Hospice Care appropriate?
- Patient rights
- Attitudes toward death and dying
- Hospice Interdisciplinary Team
- Pain Management including Comfort Care Measures
- Symptom Management
- Principles of death and dying
- Bereavement
- Hospice/SNF care coordination and optimal communication
- Documentation and Record Keeping

HOSPICE PHILOSOPHY: WHAT IS HOSPICE CARE?

- Hospice care affirms life and focuses on improving the quality of life for persons and their families facing a life-limiting illness.
- The primary goals of hospice care are to provide comfort, relieve physical, emotional, and spiritual suffering, and promote the dignity of terminally ill persons.
- Hospice care neither prolongs nor hastens the dying process.
- Care is palliative (not curative) to control pain and symptoms associated with the terminal illness.

HOSPICE PHILOSOPHY: WHAT IS HOSPICE CARE?

- Hospice treats the whole person, not just the disease.
- It focuses on the needs of both the patient and the family.
- Care is provided by an interdisciplinary team of expert clinicians
- Hospice addresses patient and family needs such as:
  - **Pain and symptom management**
  - **Emotional, psychosocial, and spiritual support**
  - **Help with funeral planning and arrangements**
  - **Bereavement for family/ caregivers after the patient's death**

WHERE IS HOSPICE CARE PROVIDED?

- Hospice care is a philosophy or approach to care rather than a place.
- Care may be provided in a person's home, nursing home, hospital, or independent facility devoted to end-of-life care.
- Hospice was originally designed to be a non-institutional benefit. However, it is possible to receive Medicare covered hospice care while residing in a nursing home.

WHEN IS HOSPICE CARE APPROPRIATE?

- A patient is eligible for hospice care if two physicians (hospice medical director and pt's attending physician) determine that the patient has a prognosis of six months or less to live.
- Patients must be re-assessed for eligibility at regular intervals, but there is no limit on the amount of time a patient can spend under hospice care as long as they meet eligibility.

HOSPICE CARE DIAGNOSES

- Hospice care is not just for patients dying of cancer
- Other hospice diagnoses MAY also include:
  - End stage heart disease
  - End stage pulmonary disease
  - End stage renal disease
  - End stage liver disease
  - Dementia due to Alzheimer's Disease and Related Disorders
  - HIV disease
  - Stroke & Coma, other neurological diseases such as Parkinson's, ALS

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BREAK

PAYMENT FOR HOSPICE

- There is a Medicare hospice benefit for Medicare part A beneficiaries
- Several states including CT have a Medicaid hospice benefit
- Many commercial insurances also cover hospice care as well
- Most hospices are committed to caring for all patients, regardless of an individual's ability to pay

HOSPICE CORE SERVICES

- Hospice core services must be routinely provided by the hospice, and cannot be delegated to the facility.
- Hospice core services include:
  - **Physician services (Hospice Medical Director)**
  - **Nursing services**
  - **Social work services**
  - **Counseling services**
    - Bereavement and Spiritual
    - Dietary

ALSO COVERED BY HOSPICE

As determined by the hospice **and** related to the terminal illness:

- Provision of medical supplies
- Durable medical equipment
- Drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and
- All other hospice services that are necessary for the care of the resident's terminal illness and related conditions.

******Call hospice for prior approval of above services******

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HOSPICE INTERDISCIPLINARY TEAM

The hospice team is an ***interdisciplinary team (IDT)*** and together, they coordinate and develop the patient's plan of care.

- Members of the **hospice** team include:
  - The patient and/or family/caregiver (including facility staff)
  - The patient's attending physician
  - Hospice physician
  - Nurse
  - Social worker
  - Chaplain/Spiritual Counselor
  - Hospice aide
  - Volunteers
  - Bereavement counselor
  - Additional team members may include dietician, occupational or physical therapist, pharmacist

- The IDT is required to update and periodically review the plan of care

PATIENT RIGHTS

Patients have the right to be notified of their rights and responsibilities:

- Verbally and in writing -- In a language and manner that the patient /family understands
- During the hospice assessment visit in advance of hospice care being furnished Including information about advance directives

PATIENT RIGHTS

Patients have the right to:

- Exercise his or her rights as a patient
- Have his or her property and person treated with respect
- Voice grievances
- Be protected from discrimination or reprisal for exercising their rights.
- Receive effective pain management and symptom control
- Be involved in developing his or her plan of care
- Refuse care or treatment
- Choose his or her attending physician
- Have a confidential clinical record/HIPAA
- Be free from mistreatment or any type of abuse
- Receive information about their hospice benefit
- Receive information about the scope and limitations of hospice services

ATTITUDES TOWARD DEATH AND DYING

- Each person has his or her own view of death and attitude towards it
- Society, family, caregivers and friends have a huge impact on people's perception of death
- Fear is usually one of the most common attitudes towards death
- Attitudes toward death also tend to change over the lifetime of the person

ATTITUDES TOWARD DEATH AND DYING

- American society tends to deny the reality of death
  - Previous experiences with death
  - Circumstances of death
  - Some medical professionals view death as a failure
- Cultural factors can significantly influence patients' reactions to their illness and the dying process.
- There are many different religions and belief systems across the world. Each holds an individual view of death and mourning.
- Consider using a self-assessment on attitudes toward death and approach to patients

PAIN MANAGEMENT

- Medication dosages used in hospice patients may be *higher* and/or given *more frequently* than those routinely used for skilled nursing facility patients. **This allows for optimal pain & symptom control.**
- Pain medications in hospice may be administered in a variety of ways, including:
  - Sublingual meds
  - Patches
  - Infusion Pumps
  - Creams/gels
  - Tablets
  - Liquids
  - Suppositories

PAIN MANAGEMENT

- Spiritual and emotional pain is also addressed by the hospice team.
- Methods used to address these types of pain may include:
  - Bereavement Counseling
  - Spiritual Counseling
  - Music therapy
  - Aroma therapy
  - Relaxation
  - Massage
  - Reiki

SYMPTOM MANAGEMENT

- One goal of the hospice team is to initiate a quick response to any symptom that causes the patient discomfort.
- For this reason, the hospice staff is available 24 hrs/day and should be called by facility staff when symptoms arise.
- Symptoms that are managed by hospice may include, but are not limited to:
  - Pain
  - Anxiety
  - Nausea and vomiting
  - Constipation
  - Restlessness or agitation
  - Shortness of breath
  - Depression

CALL YOUR HOSPICE PARTNER WHEN…

- Any significant change in condition or symptoms requiring a change in the plan of care
- For example:
  - Current interventions not effective—increased pain, anxiety, nausea/vomiting
  - Requires more frequent prn medication without relief
  - Shortness of breath
  - Agitation/restlessness
  - Falls

METHODS OF COMFORT

- Hospice implements a variety of comfort methods for both the patient and family.
- Nurses, physicians, medical social workers and spiritual counselors each complete assessment used to identify appropriate interventions.
- These interventions are then implemented as needed to help bring added comfort to both patient and family.

COMFORT CARE MEASURES

- Promote a quiet, private environment for residents and families that supports the intimate process of dying.
- Support personal rituals used to honor the dying resident.
- Provide emotional, spiritual and bereavement care.
- Offer food and fluids only as the dying person desires and is able to take.
- Reposition at frequent intervals to ensure comfort.
- Offer frequent oral care.
- Instill artificial tears or eye lubricant for increased comfort.
- Limit vital signs to respirations and pulse when appropriate.
- Stop medications that are not essential to promoting comfort.
- Stop needle sticks for blood draws, including finger sticks for blood sugars.
- Remove nonessential equipment that may distract care providers and family from focusing on their loved one who is dying.

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BREAK

SIGNS OF APPROACHING DEATH

Emotional & Spiritual signs of approaching death:

- Withdrawal
- Vision-like Experiences
- Restlessness
- Decreased Socialization
- Needing permission from loved ones to go
- Saying Good-bye

SIGNS OF APPROACHING DEATH

- Physical signs of approaching death:
  - Increased amount of time sleeping
  - Coolness of arms & legs
  - Skin color changes
  - Bowel and/or bladder incontinence
  - Decreased urinary output
  - Decreased appetite & thirst, may want little or no food or fluid
  - Breathing pattern changes
  - Congestion, gurgling sounds with respirations

WHEN TO CALL YOUR HOSPICE PARTNER

- Imminent death
  - As patient shows increased signs of imminent death, call your hospice team

- When patient dies,
  - Call your hospice team at time of death
  - Notify physician and family/resp party

INDIVIDUAL REACTIONS TO DEATH/LOSS

FIVE STAGES OF GRIEF as identified by Elizabeth Kubler-Ross:

1 - Denial and Isolation Overwhelmed, in shock, trying to manage day-to-day, denying reality as it's too painful

2 - Anger about reality Expressing anger when the reality is recognized and can't avoided; posing the questions: 'Why me? Blaming others for the illness or death. "Why weren't you there with me during my greatest time of need?"

3 - Bargaining Making promises in exchange for a cure or a longer life, focus on "What if's", "Maybe Dad would still be alive if only I…"

4 - Depression Becoming too weakened by the illness/death, feeling a deep sadness, unable to perform simple tasks or function. Keen awareness of the approaching end of life/the actual death.

5 - Acceptance Often associated with the notion that it's now OK; whereas, it's just recognizing reality is finally sinking in.

** Dying patients and their family members may follow these stages in sequence or, more frequently, may revert back and forth between stages.*

BEREAVEMENT SERVICES

- Every hospice program offers bereavement services to family and loved ones for a minimum of 12 months following the death of a patient.
- Services can include:
  - **Phone contact**
  - **Short-term counseling**
  - **Assessment of need and referrals to community resources**
  - **Support groups**
  - **Educational forums**
  - **Written information on the grief process**
  - **Memorial services**

BEREAVEMENT SERVICES CAN BE AVAILABLE TO:

- Resident's roommate
- Family members
- Staff caregiver who experiences grief from the loss of the patient
- Example— "Journal and A Rose"

THE HOSPICE/SNF RELATIONSHIP

- The nursing facility staff become part of the interdisciplinary team when a facility resident elects hospice care.
- Important for each provider to recognize each other's knowledge and remain open to two-way learning. Nursing facility staff are generally skilled in meeting the clinical and psychosocial, and spiritual needs of their residents.
- Hospice staff are skilled at meeting the special clinical, psychosocial, and spiritual needs at end of life.
- Combined expertise allows the nursing facility and hospice to deliver the most comprehensive care to the patient/ family as possible.

THE HOSPICE/SNF RELATIONSHIP

- Successful partnerships between a hospice provider and a nursing facility include:
  - Acknowledgement and respect for each other's regulations
  - Developing an excellent communication process
  - Consistent coordination of care by the hospice and the nursing facility
  - Identification of care plan in both the nursing facility and the hospice medical record
  - Consistent communication, coordination, and documentation are keys for success!

DOCUMENTATION PROVIDED BY HOSPICE

When a Hospice patient is admitted to a facility, the hospice will provide the facility with the following information:

- Patient's most recent Plan of Care
- Copy of patient's Hospice election form
- Patient's advanced directives
- Physician certification/recertification of terminal illness
- Names and contact information for hospice personnel
- Instructions on how to access the hospice's 24-hour on call system
- Hospice medication information
- Hospice physician/attending physician orders

SNF DOCUMENTATION AND RESPONSIBILITIES

SNF Record Keeping Requirements

- The hospice patient's facility clinical record will include a record of all inpatient services furnished and all events regarding care that occurred at the facility.
- A copy of the facility's discharge summary will be provided to the hospice at the time of discharge.
- A copy of the patient's inpatient clinical record is available for review upon request of the hospice at the time of discharge.

SUMMARY

- Standardized Training developed for all SNF providers in CT who offer Hospice Care to their residents
- Training does not need to be duplicated across providers. This is a one and done process at orientation.
- Ongoing hospice in-service topics can be offered by the individual hospice based on service needs
- Incorporate the recorded webinar and post-test into orientation of all new direct care staff
- SNF Designee (usually Staff Development) will track training and documentation of completed training to ensure compliance.
- Notify the hospice team or the CT Association for Healthcare at Home with questions.

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THANK YOU!

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