Crisis Management for Short-Stay Hospice Patients

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Objectives

- Define current status of hospice patients with short length of stay.
- Recognize the “red flags” indicating need for crisis management.
- Describe crisis interventions that will help ensure comfort and dignity in the final days of life.
Substantial increase in ALOS and gigantic jump in profit/patient over the past several years.
2012 Profits increased 5x per patient from what they were in 2002.
Patients who are “not dying” are admitted to hospice; with a large percentage discharged alive.
Didn’t address the other end of this spectrum—the increasing short lengths of stay and the implications for our patients and their families.
Hospice (ICU) Patients

Patients admitted to hospice with high symptom burdens, significantly conflicted emotions r/t their hospice admission, etc.
Medicare patients entering hospice
- 10% had a 2-3 day length of stay
- 25% had a length of stay 7 days or less regardless of diagnosis

(MedPac, 2013)
Reasons for Short Stay

- Physicians reluctant to have conversations with patients and their families on the “hard topics”
- Patients and families are often reluctant to ask the hard questions
- Hospices cannot afford to admit patients who, though clearly dying, are still receiving expensive treatments
- Increasing scrutiny from Medicare
Outcomes of short lengths of stay

- Timing of referral to hospice and quality of care
  - 631 hospices surveyed with over 100,000 family members responding
  - 11.4% believed they were referred “too late”
  - This was associated with
    - More unmet needs, higher reported concerns and lower satisfaction
  - Results were highly variable between hospices

(Teno, 2007)
Mr. G, a 68-year old man, was diagnosed with adenocarcinoma of the gall bladder and liver metastasis three months ago. He is now being referred to your hospice. Co-morbidities include acute liver failure, deep vein thrombosis and pulmonary emboli for which he has had multiple hospitalizations in the past few weeks.

During the admission visit, he and his wife express hope for more chemotherapy once he is “stronger”. They both desire CPR, if needed, but also express a desire for him to die at home. He is dependent in all ADLs with self-report of constant pain 7/10 and severe dyspnea with minimal exertion. He died six days after admission to hospice.
Is this patient “hospice appropriate?”
Would you admit him to your hospice?
Mr. G: “Red Flags” Requiring Crisis Management

- Conflicted emotional, psychological and spiritual issues r/t dying
- Severe pain and dyspnea
- Rapidly declining functional ability
- Recent hospitalization for DVT and pulmonary emboli
- Conflict between wanting CPR and wanting to die at home
- Unclear Advance Directives
Emergency Issues to be Addressed

- Note the conflicted emotional and psychological issues in this case study:
  - Recently diagnosed - rapid progression of Stage IV cancer
  - Multiple co-morbidities - recent hospitalizations
  - Still a full code but wants to die at home - conflicting message
  - Still hoping, if not for cure, then prolongation of life with more chemotherapy
- Significant symptoms that need to be quickly managed
- Rapidly becoming unable to care for himself
Other “Red Flags”

- Direct referral from acute care or a physician office
- No further cancer treatment options available
- Ineffective transitioning from aggressive to supportive hospice care
- Patient/family with lack of information r/t disease and/or prognosis
- No caregiver and/or few support systems
How do you handle the initial referral call? What information do you obtain?

Andrea Huertas’, nurse manager from a hospice in the New England area, “best practice” questions:

- Verify support systems available- is their family from out of town? Who will be present at initial visit? Etc.
- Does this warrant a social worker, nurse joint visit?
Extremely helpful in identifying how to handle patient’s admitted with high acuity needs.

Three or four timely questions to your referral source can greatly improve your team’s response in these situations.
Overall Goal: to bring comfort and dignity in the last days of life

- Excellent clinical assessment skills on an ongoing basis for maximum symptom management
- Artful communication conveying compassionate care
- Exceptional abilities to listen without judging and to “be present” as patients/families pursue their self-identified goals of care.
- Sensitivity to cultural, spiritual and psychosocial concerns.
Joint SW/RN admission visit?

- Assess the most urgent and distressing symptoms
- Evaluate caregiver’s ability to administer medications
- Explore available support systems
- Assess home safety issues
- Begin to explore goals of care related to resuscitation and rehospitalization
1. Assess most **urgent symptoms**.
   - Utilize **pain and dyspnea** assessment tools; encourage self-report; For pts with other symptoms, use appropriate tools.
   - What medication is the patient currently taking?
   - Utilize “comfort kit or emergency kit” if available.
     - Make sure liquid morphine and lorazepam are in home for every patient admitted with potential for acute pain and/or dyspnea. Based on diagnosis- patients with end stage cardiac or pulmonary disease, advanced cancer, ALS, need these drugs in home at time of admission.

2. Assess the caregiver’s readiness to learn and ability to administer medications.
Explore available **support systems**
- Physical and emotional state of spouse
- Other family members?
- Hospice volunteer needed?

**Safety Issues**
- Does the patient need someone with him full time?
- Is he a fall risk?

Is patient still a **full code**
- May not be fully addressed on initial visit
Best Practice Guidelines

Interventions

- Establish rapport/trust with patient and caregivers
  - Create a list of phone numbers caregiver can call
- Intervene aggressively to relieve pain and dyspnea
  - Simplify interventions based on caregiver need
- Address safety issues r/t oxygen, potential falls, etc
- Alert all team members to intensity of need
  - Ensure adequate response time if/when an emergent after-hour call is made

Clarify when a hospice team member will return
Aggressive Symptom Management Intervention

- Be persistent on this initial visit to alleviate severe symptoms.
- Mr. G- problem was the severe pain and dyspnea.
  - Orders for oral IR opioids (morphine) q 1 or 2 hours prn- I like q 2 hours best in the home, just for safety sake
  - American Cancer Society guidelines indicate q 1 hour morphine prn is acceptable
  - If I don’t know the capability of the caregivers, I’m usually more conservative in a home situation; orders for lorazepam q 4 hrs prn are often a part of this initial acute symptom management plan.
Assess Caregiver Knowledge and Skill

- You may need to draw these up into syringes with labels clearly marking which is which.
- Place morphine syringes in clear blue plastic cup that is clearly labeled morphine- often dispensed 20 mg/cc blue liquid.
- Liquid lorazepam is usually clear- place in a clear plastic cup (label this clearly).
- Safety Issues:
  - These are individual- is the patient on oxygen?
  - Smoking issues by patient or others
  - Fall risk- do whatever you can to decrease risk. May take 24 hours to get a hospital bed, bedside commode, or walker in the home
Support Systems

- Build trust and confidence in patient and family - “safety net”
  - Inform them of response time to an emergent call. *Remember when someone is in severe pain or cannot breathe, a minute feels like an hour.
  - Have back-up plan (i.e. a neighbor, friend, family member)
- Every team member (especially after-hours team) needs to be alerted when there is a patient on service who is still desiring resuscitation.
  - List of phone numbers for the wife to call IF Mr. G should have a significant need before another team member can return.
- Review with caregiver - when and how to call the after hour triage team.
- Does a visit need to be made during the evening?
  - Dependent on symptoms that need to be controlled and pt/caregiver comfort.
Artful Conversation

- Agenda-free—the “art” of being present
- Suspend judgment
- Open-ended vs. closed-ended questions
- Clarification and reflection
- Appropriate use of silence
Care for the Hospice Caregivers

- Cumulative loss
- Compassion fatigue
  - Symptoms
    - Work-related—reduced ability to feel empathy towards patients/families, dread of working with certain patients/families
    - Physical—headaches, sleep disturbances, fatigue, chest pain
    - Emotional—mood swings, anxiety, anger, loss of objectivity
- Support systems
  - Creating balance
  - Strong professional boundaries
  - Self care
  - Creative outlets
Tools for Self-Care

- Rituals
- Physical fitness
- Debriefing support
- Fun and playful friends
- Fun activities
- Meditation
- Prayer
- “Learning to let go”
Hospice Short-stay Take-aways

1. Crisis Management is here to stay
2. Hospice expertise is mandatory
3. Patient/caregiver trust in the hospice team is critical
4. Symptom management protocols are needed
5. Expert communication skills are essential
6. Hospice response time must be timely and decisive
7. There must be support for the hospice interdisciplinary team
Bringing Comfort and Dignity as Life Nears Its End
Questions/Comments?

Thank You!