

Case Study Part 1

This is the story of Mr. Joseph (Mr. J), a 75-year-old patient who was admitted in November 2016 to Community Hospice. Excerpts from the narrative section of his electronic medical record are below.

November 13, 2016: RN Hospice Liaison (Initial Hospice Consultation)

Called in to see this patient hospitalized at Mount Faith Hospital for the last week with a diagnosis of late-stage adenocarcinoma of the colon with extensive local and distant metastasis and a new partial bowel obstruction. Upon admission, Mr. J was unable to hold down any food and was treated with antiemetics and intravenous (IV) fluids, and he was ordered to receive nothing by mouth for 3 days. By day 4, Mr. J was able to tolerate clear liquids and had slowly progressed to soft foods, which he is tolerating fairly well now. He underwent a series of tests to determine the extent of his disease. It was found that the disease in his abdomen had progressed significantly since his last CT scan, and his primary oncologist discussed these findings with both him and his wife last Friday. The physician's note states that the patient and family were informed that no further treatment options were possible and that he recommended comfort care options. They were told that the prognosis was approximately 2–3 months. Mr. J and his wife of 42 years, Mary, were presented with discharge options that included a short stay in a skilled nursing facility for some rehabilitation and strengthening or going directly home with hospice. The family chose to speak with a hospice representative due to some experience with it in the past when hospice cared for Mrs. J's mother.

At the visit today, the patient, his wife, and one of their two daughters were present for the discussion. His other daughter from out of state is a licensed practical nurse and is to arrive on Monday evening; she plans to stay indefinitely to assist with his care. The hospital discharge planner was also present in the room and is hoping to discharge the patient within 1 to 2 days.

After much tearful discussion, the patient and family agreed to hospice services and requested discharge to home on November 15th to give them time to prepare the house and get the necessary equipment in place. Mr. J was very clear regarding his wishes not to be resuscitated or to have any other life supports, and he wanted to be kept comfortable. He realized that the IV fluids would be stopped and was looking forward to having more freedom from the equipment to walk around his house when he returned home. He preferred to remain home but was clear that he did not want to become a burden to his family and would return to the hospital only if his symptoms could not be controlled or it became too difficult for his wife and daughters at home. He agreed to sign a Physician Orders for Life Sustaining Treatment (POLST), and the discharge planner, together with the hospitalist, helped the family complete that process. A copy was provided for the hospice chart.

November 14, 2016: Hospice RN (Telephone Calls)

Confirmation calls made today. Equipment delivery by XYZ Medical Supply Company confirmed for today. Hospital discharge planner to confirm tomorrow morning's discharge.

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Comfort pack ordered per hospice medical director and scheduled for delivery once patient arrives home tomorrow.

November 15, 2016: Hospice RN (Admission Note)

Arrived at the home of Mr. J to conduct hospice admission post-discharge from Mount Faith Hospital at 3 p.m. During today's visit, this hospice nurse conducted a full physical assessment. The family of Mr. J was in the home and helping to settle him in. Both daughters tearful today, but were trying to be upbeat for their dad. Support was given to all.

Noticed Mr. J wincing as he repositioned from bed to chair. When asked if he had pain, Mr. J explained that the right side of his abdomen felt very tight; he described this as a bloated feeling and pressure from within. He stated that his pain was worse when lying flat. He also explained that getting in and out of bed was difficult because he was so weak. When asked to rate the pain on a scale of 0–10, he hesitated, but then reported it at a level 6 today and stated, “the medicine doesn't seem to last long enough.” He had not been medicated since leaving the hospital and was overdue for his breakthrough medication. This nurse attempted to conduct more comprehensive questioning regarding the pain, but Mr. J was distracted by his grandchildren and promptly changed the subject. It was noted during medication reconciliation that the hospice orders indicated that Mr. J was currently on BID long-acting oxycodone, but had insufficient breakthrough medication ordered per pain standards and hospice protocol. The patient was also noted to be on docusate sodium for his bowels, and he reported that he has been having more success moving his bowels but still struggling at times. Mr. J was breathing easy during the assessment and denied shortness of breath.

Teaching was conducted regarding diet, repositioning, fluids, and medications, and the schedule of all medications was reviewed with particular attention to use of pain meds with emphasis on staying on schedule and not letting pain get ahead of him. Call placed to medical director regarding pain and requested an increase in the frequency of the breakthrough oxycodone to every 4 hours as needed instead of every 6 hours as needed. The hospice medical director confirmed the new orders for breakthrough oxycodone and also, in response to the report of Mr. J's bowel status, ordered senna tablets BID. Reviewed comfort pack medications with the patient and family and called the pharmacy to confirm receipt of new orders. Delivery scheduled for later today.

Mr. J declined all other services by the hospice team at this time, yet he did agree to a social worker visit so that his wife and daughters could get to meet her. He was not interested in seeking chaplain support and stated that he has a local priest who is a friend of the family and plans to see him this week as well. He seemed to be looking forward to this visit.

November 16, 2016: Hospice Social Worker Visit

I visited today with Mr. J and his family. Most of the visit was spent with the patient's wife and daughters who are still grappling with the prognosis and want to keep Mr. J home if at all possible. They reminisced about their family life and talked of how to discuss this with their

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grandchildren. They are working on a schedule with friends and family to give them some time to rest.

Before leaving I spoke briefly with Mr. J, and he emphasized that his concern is for his wife. He denied any need for additional support or a hospice chaplain visit for himself, stating that he is not afraid to die and he has made peace with this. He feels that his strong belief system will see him through, and he confirmed that his friend, the priest, is coming over later today. He would like me to continue to visit to provide support to his wife for now.

November 17, 2016: Brief RN Telephone Call

Called Mr. J today and offered visit. He declined, stating that there were many visitors coming. He reported that his pain was under control and that he was eating small amounts and tolerating well. Plan to visit tomorrow.

November 18, 2016: Hospice RN Visit

Upon arrival at Mr. J's home today he was noted to be more relaxed and said that he was tired from all his recent company. One daughter was present during today's visit; the other daughter and Mrs. J were out to the grocery store. Mr. J's daughter joined us and held her dad's hand as we discussed his pain. A more thorough pain assessment was possible today, and findings include that there has been a change in the character of Mr. J's pain. He says that it now is a burning pain that radiates towards his back and is worse in the morning after his morning activities of bathing and dressing. Other than this time of more constant pain, which he rates as a 5–7, he describes his pain at a level 2–3 and as coming and going 3–4 times per day. Teaching was provided to Mr. J and his daughter regarding use of the breakthrough pain medication, and he was encouraged to take rest breaks during his morning activities. Call placed to the physician to request an increase in the dose of Mr. J's long-acting opioids. Receipt of orders by pharmacy confirmed, and delivery scheduled for later today.