

Case Study Rationale – January 2017 Hospice Training

Section F: Preferences

F2000. CPR Preference

- **F2000A. Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)? = 1, Yes**
- **F2000B. Date the patient/responsible party was first asked about preference regarding the use of CPR: = 11/13/2016**
- **Rationale:** The November 13, 2016, note by the RN hospice liaison regarding the initial hospice consultation states that Mr. J was very clear regarding his wishes not to be resuscitated.

F2100. Other Life-Sustaining Treatment Preferences

- **F2100A. Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR? = 1, Yes**
- **F2100B. Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR: = 11/13/2016**
- **Rationale:** The November 13, 2016, note by the RN hospice liaison regarding the initial hospice consultation states that Mr. J wished not to have CPR or any other life supports, and he would like to be kept comfortable. The note also indicates that a Physician Orders for Life Sustaining Treatment (POLST) was completed.

F2200. Hospitalization Preference

- **F2200A. Was the patient/responsible party asked about preference regarding hospitalization? = 1, Yes**
- **F2200B. Date the patient/responsible party was first asked about preference regarding hospitalization: = 11/13/2016**
- **Rationale:** The November 13, 2016, note by the RN hospice liaison regarding the initial hospice consultation states that Mr. J prefers to remain home, but is clear that he does not want to become a burden to his family and would return to the hospital only if his symptoms cannot be controlled or it becomes too difficult for his wife and daughters at home.

Hospice Quality Reporting Program (QRP) Case Study Rationale

F3000. Spiritual/Existential Concerns

- **F3000A. Was the patient and/or caregiver asked about spiritual/existential concerns?** = 1, Yes
- **F3000B. Date the patient and/or caregiver was first asked about spiritual/existential concerns:** = 11/15/2016
- **Rationale:** In the note from November 15, 2016, the hospice RN noted that Mr. J stated he is not interested in seeking chaplain support and that he has a local priest who is a friend of the family who plans to visit during the week. This meets the requirements of F3000 because this statement provides evidence that the door was opened for a conversation regarding spiritual/existential concerns even though the patient declined a visit from the chaplain. The patient and/or caregiver was asked about chaplain support and given an opportunity to discuss spiritual/existential concerns.

Section J: Health Conditions

J0900. Pain Screening

- **J0900A. Was the patient screened for pain?** = 1, Yes
- **J0900B. Date of first screening for pain:** = 11/15/2016
- **J0900C. The patient's pain severity was:** = 2, Moderate
- **J0900D. Type of standardized pain tool used:** = 1, Numeric
- **Rationale:** The November 15, 2016, hospice RN note states that Mr. J was asked about his pain and that he explained that the right side of his abdomen (location) felt very tight (*character*); he described this as a bloating feeling and pressure from within (*character*) that was worse when he was lying flat (what worsens pain). He rated his pain as 6 on a scale of 0–10 (severity) at the time of the hospice RN visit. Pain rated as 6 on a 0–10 pain scale is documented as 2, Moderate for question J0900C on the Hospice Item Set. This answer indicates that the pain was rated as 4–6 on a 10-point numeric scale or the equivalent on a verbal, visual, other numeric, or staff observation scale. The documentation in this note meets the requirements for pain screening because it includes documentation that the patient was evaluated for presence of pain and that its severity was rated using a standardized tool.

J0905. Pain Active Problem

- **J0905. Pain Active Problem: Is pain an active problem for the patient?** = 1, Yes
- **Rationale:** The determination of whether or not pain is an active problem may be made by the assessing clinician, based on patient-specific findings. The November 15, 2016, hospice RN note states that Mr. J was asked about his pain and that he explained that the right side of his abdomen felt very tight; he described this as a bloating feeling and pressure from within. He rated his pain as 6 on a scale of 0–10 at the time of the hospice RN visit.

J0910. Comprehensive Pain Assessment

- **J0910A. Was a comprehensive pain assessment done? = 1, Yes**
- **J0910B. Date of comprehensive pain assessment: = 11/15/2016**
- **J0910C. Comprehensive pain assessment included:**
 - 1. **Location** = ✓
 - 2. **Severity** = ✓
 - 3. **Character** = ✓
 - 4. **Duration** = (not checked)
 - 5. **Frequency** = (not checked)
 - 6. **What relieves/worsens pain** = ✓
 - 7. **Effect on function or quality of life** = (not checked)
 - 9. **None of the above** = (not checked)
- **Rationale:** Although the hospice RN noted on November 18, 2016, that a more thorough pain assessment was possible, the nurse clearly documented on the day of admission (11/15/2016) four of the seven characteristics of a comprehensive pain assessment and can therefore answer “Yes” for item J0910A. The November 15, 2016, hospice RN note includes that Mr. J was asked about his pain and that he explained that the right side of his abdomen (location) felt very tight (character); he described this as a bloating feeling and pressure from within (character) that was worse when he was lying flat (what worsens pain). He rated his pain as 6 on a scale of 0–10 (severity) at the time of the hospice RN visit.
- **Note:** Since only four of seven characteristics were assessed within 1 day of the positive pain screening, this assessment would not be counted in the numerator for the Hospice and Palliative Care Composite Process Measure – Comprehensive Assessment at Admission.

J2030. Screening for Shortness of Breath

- **J2030A. Was the patient screened for shortness of breath? = 1, Yes**
- **J2030B. Date of first screening for shortness of breath: = 11/15/2016**
- **J2030C. Did the screening indicate the patient had shortness of breath? = 0, No**
- **Rationale:** The hospice RN noted on November 15, 2016, that Mr. J was breathing easily during the assessment and denied shortness of breath.

J2040. Treatment for Shortness of Breath

- **J2040A. Was treatment for shortness of breath initiated? = (item skipped)**
- **J2040B. Date treatment for shortness of breath initiated: = (item skipped)**
- **J2040C. Type(s) of treatment for shortness of breath initiated: = (item skipped)**
- **Rationale:** Because Mr. J had no shortness of breath, completion of the items in J2040 is not required.

Section N: Medications

N0500. Scheduled Opioid

- **N0500A. Was a scheduled opioid initiated or continued?** = 1, Yes
- **N0500B. Date scheduled opioid initiated or continued:** = 11/15/2016
- **Rationale:** The hospice RN noted on November 15, 2016, that Mr. J was receiving BID long-acting oxycodone.

N0510. PRN Opioid

- **N0510A. Was a PRN opioid initiated or continued?** = 1, Yes
- **N0510B. Date PRN opioid initiated or continued:** = 11/15/2016
- **Rationale:** The hospice RN noted on November 15, 2016, that Mr. J was receiving oxycodone every 6 hours as needed; this dose was increased to every 4 hours as needed.

N0520. Bowel Regimen

- **N0520A. Was a bowel regimen initiated or continued?** = 2, Yes
- **N0520B. Date bowel regimen initiated or continued:** = 11/15/2016
- **Rationale:** The hospice RN noted on November 15, 2016, that Mr. J was receiving docusate sodium for his bowels. The medication was changed on November 15, 2016, to senna BID, due to the patient struggling to have a bowel movement.

Section O: Service Utilization

O5000. Level of care in the final 3 days

- **0 – No** is the correct answer.
- **Rationale:**
 - There is no evidence in the notes or on the visit calendar that the patient received Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 3 days of life.

O5010. Number of hospice visits in final 3 days

	Visits on day of death	Visits 1 day prior to death	Visits 2 days prior to death
A. Registered Nurse	0	1	0
B. Physician	0	0	0
C. Medical Social Worker	0	1	0
D. Chaplain or Spiritual Counselor	0	0	0
E. Licensed Practical Nurse	0	0	1
F. Aide	1	1	0

Hospice Quality Reporting Program (QRP) Case Study Rationale

- **Rationale:**

- On the day of Mr. J's death, the aide noted that Mr. J had markedly declined. She called the RN. The patient died before the RN arrived at his home. Because postmortem visits cannot be counted, only the aide visit is counted on the day of death.
- One day prior to the day of death, in addition to an aide visit and a joint visit by the RN and medical social worker (MSW), a volunteer visited. Even though the RN and the MSW visited together, both visits are counted. The aide visit is also counted. The volunteer visit cannot be counted in O5010 or O5030.
- Two days prior to the day of death, Mr. J was visited by an LPN and a volunteer. The LPN visit is counted; however, the volunteer visit cannot be counted in O5010 or O5030.

O5200. Level of care in final 7 days

- **0** – No is the correct answer.

- **Rationale:**

- There is no evidence in the notes or on the visit calendar that the patient received Continuous Home Care, General Inpatient Care, or Respite Care during any of the final 7 days of life.

O5030. Number of hospice visits in 3 to 6 days prior to death

	Visits 3 days prior to death	Visits 4 days prior to death	Visits 5 days prior to death	Visits 6 days prior to death
A. Registered Nurse	1	1	0	1
B. Physician	0	0	0	0
C. Medical Social Worker	0	0	0	1
D. Chaplain or Spiritual Counselor	0	0	0	0
E. Licensed Practical Nurse	0	1	0	0
F. Aide	0	1	1	1

- **Rationale:**

- Three days prior to death, Mr. J was visited by the Weekend RN.
- Four days prior to death, Mr. J was visited by the aide and the RN. Later in the day, his condition changed, necessitating a second nurse visit; this time an LPN visited Mr. J. All three of these visits are counted.
- Five days prior to death, Mr. J was visited by an aide. This visit is counted.
- Six days prior to death, Mr. J was visited by an RN, an MSW, and an aide. All three of these visits are counted.