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# THE CLINICAL NURSING TRAINING MANUAL

*Hospice Reference Guide*

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## Welcome to Brighton Hospice

Welcome to the Brighton Hospice Team! We recognized the “Brighton Glow” in you, and we are so excited to have you join us, and that you are now a part of Brighton’s amazing culture.

This manual has been created as a reference guide to assist you as you navigate your clinical responsibilities. Please consult this guide as you begin your Brighton Hospice career, and throughout your nursing experience, to assist you in providing exemplary care to our patients and their families.

As you begin your experience as a Brighton Hospice team member, your Director of Clinical Services (DCS) will provide you with an onboarding schedule, the tools needed for your role, and will partner you with a specially trained Nursing Mentor who will provide you with your initial training and assist you with ongoing support. We realize that some of you may come to Brighton with hospice experience and some without however, it is critical that regardless of your experience level, that you complete our entire onboarding and Mentoring process. In this way you

## Welcome to Brighton Hospice

will best learn the Brighton standards and expectations that are unique to our culture.

Communication with your DCS leaders, Mentor, and Brighton Team members is key to our success. We want you to know that we welcome your questions, comments, and feedback, and that our DCS leaders and Mentors are always committed to open communication.

Again, we are so excited for you to be a part of the Brighton Team, to explore the Brighton Culture, and to learn and share what the Brighton Glow means to you.

Sincerely,

Shadd Preece RN, BSN  
Director of Clinical Education/Quality Assurance  
Brighton Home Team



## Communication

At Brighton Hospice we strive to provide the most professional and effective communication in the industry. This is key to providing exemplary care and support to our patients and their families.



Listed below are several important and required areas of communication

### **TigerConnect/TigerText**

TigerConnect is a texting application used by all Brighton team members to communicate HIPAA compliant information safely and securely. It can be used on any Android, iPhone, iPad, iPod Touch, tablet, Mac or PC. Brighton team members use this tool to communicate information such as patient care updates, questions, scheduling, supporting team members, adulations, team updates, etc.

### **Key Communication Points**

Communication should always be professional, regardless of how we may be feeling that day.

We may not have the answer to every question. It is okay to say something like “That is a great question, would you be okay if I discuss this with my direct leader and I will get right back with you...”, OR, “That is a great question, I do not have the answer right now, but I will find out and get right back with you.”

Negative Communication: Please always “Vent Up, Not Out” as this eliminates back biting and negativity which is detrimental to the Brighton Culture.

### **Communication Books**

Communication books are left with each patient (in the patient’s room) upon admission. These should have a Brighton Hospice sticker on the front cover showing our 24/7 phone number. Communication books are used for hospice team members to communicate with patients, families, and caregivers. Some patients, families, and caregivers read these daily, while others do not refer to them. In either case, it is important that

each team member documents in the communication book at the end of each visit.

**IMPORTANT:** The communication book does not take the place of direct communication preferences of the patient, family, and/or approved caregivers. Direct communication with these individuals is priority, especially with changes and urgent issues.

Communication books are also a way for RN Case Managers to communicate with the Hospice Aide's. In addition to adding key points of your visit in the communication book, it is helpful to add items such as medication changes or implementation of any new interventions such as new pain or anxiety management. Hospice Aides are also required to document in these communication books including all updates and/or changes. Many times, the Hospice Aide's see the patients more often than we do as RN Case Managers, and Aide observations help identify things that a Case Manager might not see or notice. This is very helpful for the RN Case Managers documentation purposes, especially for IDG meetings, reporting, and recertification documentation.

Be careful to not write too much, so that it is not overwhelming or difficult to understand.

Reminder: Patients, families and caregivers are not familiar with most medical terminology – “keep it simple.”

### **Facility/Agency Forms**

Each facility will have their own expectations in terms of communication and documentation. We are their guests and need to assist them to be in compliance by accommodating as they choose or instruct. Some facilities may ask us to document on their computers, while others will ask that you fill out a document sheet, such as an “outside agency form.” From the first time we enter a facility it is critical that we communicate with the appropriate facility members, to find out their expectations and communication preferences.

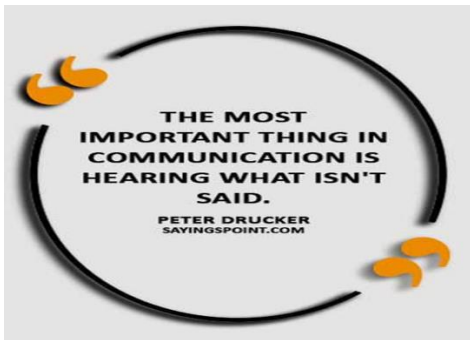
### **3 In 3 Out**

In addition to abiding by the facility expectations and communication preferences, Brighton team members should always practice the 3 In 3 Out rule. This is as follows: Brighton team members speak to at least 3 facility staff on the way into a facility and 3 on the way

out. This is a simple task that we all do mostly without even knowing it, however, be deliberate in your actions and communication so these individuals see the value in them personally. Learn names and 2 non-work-related things about them. This will help build a good report with the facility staff.

There have been countless times that Brighton has received Hospice referrals from the Dietitian, Janitor, and/or receptionist because we have taken the time to recognize them and get to know them.

**Remember – “We are ambassadors of the Brighton Mission Statement”**





## Hospice Interdisciplinary Team

### **Hospice Medical Director**

The Hospice Medical Director is responsible for developing a comprehensive medical care plan for each patient and ensuring that every member of the hospice team, caregivers, and the patient's family, are well informed of the care plan. Patients may maintain their existing primary care physician (PCP)/attending physician if they are willing/able to follow while on Hospice Services, or they may choose the Hospice Medical Director as their new primary care physician.

### **Nurse**

Registered Nurse Case Managers (RNCM) are responsible for the overall care of the patient. Whether administering medications, providing ongoing wound care, or carefully documenting assessment information, nurses play a first-hand role in ensuring their patients are as comfortable as possible. Hospice nurses require many of the same skills as nurses in other specializations. They need to be compassionate, sympathetic, patient, and calm under pressure. In addition, they need to be good listeners.

### **Hospice Aide**

The Hospice Aide assists patients with their day-to-day care/activities of daily living (ADLs). Their duties include such things as helping patients with hygiene assistance, getting dressed, repositioning, light meal preparation, light housekeeping, and tasks to ensure an overall clean and comfortable environment.

Observations of patient changes and communication with the RN Case Managers is a crucial aspect to this role.

### **Spiritual Care Coordinator/Chaplain**

During the end-of-life process, a hospice Spiritual Care Coordinator honors and nurtures a patient's spiritual needs. They are an important part of a hospice care team. Though their services may be spiritual in nature, they are a medical professional trained to work with patients in hospice care. The spiritual care coordinators' responsibilities include performing religious rites, conducting worship services, providing confidential counseling, and advising on religious, spiritual, and moral matters.



### **Medical Social Worker**

The Medical Social Worker provides care by conducting psychosocial assessments, coordinating care, providing counseling and psychotherapy, intervening in client crisis situations, and educating clients and families about their treatment plan and the resources and support systems available to them. Medical Social Workers provide advice, support, and resources to individuals and families to help them solve their problems. They also work with specific groups of clients, including children, the elderly, and families in crisis, and help them to solve the problems they are facing.

### **Hospice Volunteer**

Hospice Volunteers work directly with patients, caregivers, and families and are considered direct care volunteers by providing support. Volunteers also assist in light household chores, sitting with patients to provide companionship, and providing a comforting presence.



## Key Hospice Points

Death and dying is a part of life. During this time in life, hospice offers support for the physical, emotional, and spiritual needs of patients and their loved ones. Each patient will have a unique experience through end of life. The Brighton Team works to provide the best possible experience for both the patient and their loved ones by following our Mission Statement.

*“Our mission at Brighton Hospice is to provide the best physical, emotional, and spiritual care for our patients and their families. We achieve our mission by hiring the most compassionate and skilled people in the industry who deliver clinical expertise and exceed our patients' expectations. We cultivate an environment where our team members are valued, respected, and provided personal and professional growth opportunities. Our leaders focus on supporting the clinical team so they can concentrate on patient care. We are always guided by our commitment to excellence.”*

Hospice is a team approach, and there is no “I” in Team. The Brighton Hospice Team works together to provide a holistic approach to end-of-life care. Nurse Case Managers will collaborate with our Social Workers, Spiritual Care, Hospice Aides, Medical Director, Attending Physician, Volunteer Services, as well as Massage and Music Therapists to accomplish this objective.

Hospice care can take place wherever the patient lives. Hospice can take place at home, in an Assisted Living Facility, in a Skilled Facility, or in a hospital. The timing for hospice services can be a difficult decision for the patient, loved ones, care givers, and even the physician. The following can be used as a general guideline to determine when it is time for Hospice Care:

With the help of the Medical Director, (Attending/Primary Care Physician (PCP)), and Director of Clinical Services (DCS)

- Determining if the patient has 6 months or less to live.
- If the patient is declining rapidly despite medical treatment.

- If the patient/loved ones are ready for the patient to live their remaining days in comfort and forego any other life prolonging treatments or measures.

Some patients may pass away quickly, and others may remain on hospice for a longer period of time. As long as the patient continues to meet the hospice eligibility requirements, they may remain on hospice services.

### Notes

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## Coverage

For those who are of Medicare age, coverage includes a Hospice benefit under Medicare Part A. When a person elects to use this benefit, Medicare pays for Hospice services at 100% to provide and coordinate all cares and services relating to end of life cares.

Services included in the hospice benefit are as follows:

- All visits made by the Hospice Team (including bereavement after our patient passes away).
- Durable medical equipment (DME).
- Supplies for personal care.
- Wound care.
- Medications that are directly related to the hospice primary diagnosis.

Medicare coverage includes various levels of care for hospice services. (Additional information on levels of care is provided later in this manual).

Levels of care are as follows:

- Routine Care
- Continuous Care
- Acute Care (GIP)
- Respite Care

The Medicare hospice benefit consists of two 90-day benefit periods and then moves to 60-day benefit periods for the remainder of the patient's hospice services. The patient must continue to meet eligibility criteria for each benefit period and be certified as terminally ill, having 6 months or less to live if illness runs its normal course.

The patient and/or their family may choose to withdraw from the hospice program at any time. At time of discharge from hospice, the patient's Hospice Medicare benefit ends and regular Medicare benefits resume. The patient may return to Hospice at a later time if appropriate. A simple way to look at hospice care is that we become the patient's primary contact for all medical care and emergent needs. When communicating this to our patients and families, instruct them to NOT call 911 and to please call us with any emergent needs. Since we provide 24/7 care, hospice is called for all emergent needs and for any questions or concerns. We will then determine the nature of the emergency and recommend the best course of action.



## Local Coverage Determinations (LCDs)

*The following are the Local Coverage Determinations (LCDs) for hospice. It is crucial for you to familiarize yourself with these LCD guidelines to determine hospice eligibility initially, and then to support eligibility in your documentation throughout the care of our patients. Medicare requires our compliance with these guidelines. If you have any questions regarding LCD criteria and its proper usage, please discuss with your DCS.*

Coverage Indications, Limitations, and/or Medical Necessity



### GENERAL INDICATIONS:

Medicare coverage of hospice depends on a physician's certification that an individual's prognosis is a life expectancy of six months or less if the terminal illness runs its normal course. This policy describes guidelines to be used by Home Health & Hospice (HH&H) MAC in reviewing hospice claims and by hospice providers to determine eligibility of beneficiaries for hospice benefits. Although guidelines applicable to certain disease categories are included, this policy is applicable to all hospice patients. It is intended to be used to identify any Medicare beneficiary whose current clinical status and anticipated progression of disease is more likely than not to result in a life expectancy of six months or less.

Clinical variables with general applicability without regard to diagnosis, as well as clinical variables applicable to a limited number of specific diagnoses, are provided. Patients who meet the guidelines established herein are expected to have a life expectancy of six months or less if the terminal illness runs its normal course. Some patients may not meet these guidelines, yet still have a life expectancy of 6

months or less. Coverage for these patients may be approved if documentation of clinical factors supporting a less than 6-month life expectancy not included in these guidelines is provided.

If a patient improves or stabilizes sufficiently over time while in hospice such that he/she no longer has a prognosis of six months or less from the most recent recertification evaluation or definitive interim evaluation, that patient should be considered for discharge from the Medicare hospice benefit. Such patients can be re-enrolled for a new benefit period when a decline in their clinical status is such that their life expectancy is again six months or less. On the other hand, patients in the terminal stage of their illness who originally qualify for the Medicare hospice benefit but stabilize or improve while receiving hospice care yet have a reasonable expectation of continued decline for a life expectancy of less than six months, remain eligible for hospice care.

### SPECIFIC INDICATIONS:

A patient will be considered to have a life expectancy of six months or less if he/she meets the non-disease



## **Part I. Decline in Clinical Status Guidelines**

Patients will be considered to have a life expectancy of six months or less if there is documented evidence of decline in clinical status based on the guidelines listed below. Since determination of decline presumes assessment of the patient's status over time, it is essential that both baseline and follow-up determinations be reported where appropriate. Baseline data may be established on admission to hospice or by using existing information from records. Other clinical variables not on this list may support a six-month or less life expectancy. These should be documented in the clinical record.

These changes in clinical variables apply to patients whose decline is not considered to be reversible. They are listed in order of their likelihood to predict poor survival, the most predictive first and the least predictive last. No specific number of variables must be met, but fewer of those listed first (more predictive) and more of those listed last (least predictive) would be expected to predict longevity of six months or less.

Local Coverage Determinations (LCDs)  
Part I. Decline in Clinical Status Guidelines

1. Progression of disease as documented by worsening clinical status, symptoms, signs, and laboratory results
  - a. Clinical Status
    - i. Recurrent or intractable infections such as pneumonia, sepsis, or upper urinary tract.
    - ii. Progressive inanition as documented by:
      1. Weight loss not due to reversible causes such as depression or use of diuretics
      2. Decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth), not due to reversible causes such as depression or use of diuretics
      3. Decreasing serum albumin or cholesterol

Local Coverage Determinations (LCDs)  
Part I. Decline in Clinical Status Guidelines

- iii. Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption.
- b. Symptoms
  - i. Dyspnea with increasing respiratory rate
  - ii. Cough, intractable
  - iii. Nausea/vomiting poorly responsive to treatment
  - iv. Diarrhea, intractable
  - v. Pain requiring increasing doses of major analgesics more than briefly.
- c. Signs
  - i. Decline in systolic blood pressure to below 90 or progressive postural hypotension
  - ii. Ascites
  - iii. Venous, arterial or lymphatic obstruction due to local progression or metastatic disease
  - iv. Edema
  - v. Pleural / pericardial effusion

Local Coverage Determinations (LCDs)  
Part I. Decline in Clinical Status Guidelines

- vi. Weakness
- vii. Change in level of consciousness
- d. Laboratory (When available. Lab testing is not required to establish hospice eligibility.)
  - i. Increasing pCO<sub>2</sub> or decreasing pO<sub>2</sub> or decreasing SaO<sub>2</sub>
  - ii. Increasing calcium, creatinine or liver function studies
  - iii. Increasing tumor markers (e.g. CEA, PSA)
  - iv. Progressively decreasing or increasing serum sodium or increasing serum potassium
- 2. Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) from <70% due to progression of disease.
- 3. Increasing emergency room visits, hospitalizations, or physician's visits related to hospice primary diagnosis
- 4. Progressive decline in Functional Assessment Staging (FAST) for dementia (from  $\geq 7A$  on the FAST)

Local Coverage Determinations (LCDs)  
Part II. Non-disease specific baseline guidelines

5. Progression to dependence on assistance with additional activities of daily living (See Part II, Section 2)
6. Progressive stage 3-4 pressure ulcers in spite of optimal care

**Part II. Non-disease specific baseline guidelines**

(both of these should be met)

1. Physiologic impairment of functional status as demonstrated by:
  - Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) <70%. Note that two of the disease-specific guidelines (HIV Disease, Stroke, and Coma) establish a lower qualifying KPS or PPS.
2. Dependence on assistance for two or more activities of daily living (ADLs)
  - a. Feeding
  - b. Ambulation
  - c. Continence
  - d. Transfer
  - e. Bathing
  - f. Dressing



Local Coverage Determinations (LCDs)  
Part II. Non-disease specific baseline guidelines

See appendix for disease specific guidelines to be used with these (Part II) baseline guidelines. The baseline guidelines do not independently qualify a patient for hospice coverage.

Note: The word “should” in the disease-specific guidelines means that on medical review the guideline so identified will be given great weight in making a coverage determination. It does not mean, however, that meeting the guideline is obligatory.

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### **Part III. Co-morbidities**

Although not the primary hospice diagnosis, the presence of disease such as the following, the severity of which is likely to contribute to a life expectancy of six months or less, should be considered in determining hospice eligibility.

- a. Chronic obstructive pulmonary disease
- b. Congestive heart failure
- c. Ischemic heart disease
- d. Diabetes mellitus
- e. Neurologic disease (CVA, ALS, MS, Parkinson's)
- f. Renal failure
- g. Liver Disease
- h. Neoplasia
- i. Acquired immune deficiency syndrome
- j. Dementia

#### **LIMITATIONS:**

Medical review of records of hospice patients that do not document that patient's meet the guidelines set forth herein may result in denial of coverage unless other clinical circumstances reasonably predictive of a life expectancy of six months or less are provided.

The condition of some patients receiving hospice care may stabilize or improve during or due to that care, with the expectation that the stabilization or improvement will not be brief and temporary. In such circumstances, if the patient's condition changes such that he or she no longer has a prognosis of life expectancy of six months or less, and that improvement can be expected to continue outside the hospice setting, then that patient should be discharged from hospice.

On the other hand, patients in the terminal stage of their illness who originally qualify for the Medicare hospice benefit but stabilize or improve while receiving hospice care, yet have a reasonable expectation of continued decline for a life expectancy of less than six months, remain eligible for hospice care.

### **General Information**

#### Associated Information

General Guidelines: Documentation certifying terminal status must contain enough information to support terminal status upon review. Documentation of the applicable criteria listed under the "Indications"

## Local Coverage Determinations (LCDs) Part III. Co-morbidities

section of this policy would meet this requirement. If other clinical indicators of decline are not listed in this policy such as psychological and spiritual factors form the basis for certifying terminal status, they should be documented as well. Recertification for hospice care requires the same clinical standards to be met as for initial certification, but they need not be reiterated. They may be incorporated by specific reference as part (or all) of the indication for recertification. Note, however, paragraph 3 of 'General Indications' under "Indications and Limitations of Coverage and/or Medical Necessity" regarding patients who improve or stabilize.

Documentation should “paint a picture” for the reviewer to clearly see why the patient is appropriate for hospice care and the level of care provided, i.e., routine home, continuous home, inpatient respite, or general inpatient. The records should include observations and data, not merely conclusions. However, documentation expectations should comport with normal clinical documentation practices. Unless elements in the record require explanation, such as a non-morbid diagnosis or indicators of likely

Local Coverage Determinations (LCDs)  
Part III. Co-morbidities

greater than 6-month survival, as stated below, no extra or additional record entries should be needed to show hospice benefit eligibility.

The amount and detail of documentation will differ in different situations. Thus, a patient with metastatic small cell CA may be demonstrated to be hospice eligible with less documentation than a chronic lung disease patient. These situations are obvious. Patients with chronic lung disease, long term survival in hospice, or apparent stability can still be eligible for hospice benefits, but sufficient justification for a less than six-month prognosis should appear in the record.

If the documentation includes any findings inconsistent with or tending to disprove a less than 6-month prognosis, they should be answered or refuted by other entries, or specifically addressed and explained. Most facts and observations tending to suggest a greater than 6-month prognosis are predictable and apparent, such as a prolonged stay in hospice or a low immediate mortality diagnosis, as stated above. But specific entries can also call for an answer, such as an opinion by one team member or recovery of ADLS

## Local Coverage Determinations (LCDs) Part III. Co-morbidities

when they were part of the basis for the initial declaration of eligibility. Also, the lack of certain documentation elements such as a tissue diagnosis for cancer will not create non-eligibility for the hospice benefit but does necessitate other supportive documentation.

Documentation submitted may include information from periods of time that fall outside the billing period currently under review. Include supporting events such as a change in the level of activities of daily living, recent hospitalizations, and the known date of death (if you are billing for a period prior to the billing period in which death occurred.)

Documentation should support the level of care being provided to the patient during the period under review, i.e., routine or continuous home or inpatient, respite, or general. The reviewer should be able to easily identify the dates and times of changes in levels of care and the reason for the change.

In addition, the documentation must comply with the requirements found in accordance with CMS IOM 100-02 Chapter 9 Section 20.

## **Disease Specific Guidelines<sup>1</sup>**

Note: These guidelines are to be used in conjunction with the “non-disease specific baseline guidelines” described in Part II of the basic policy.

### **Section I: Cancer Diagnoses**

- A. Disease with distant metastases at presentation  
OR
- B. Progression from an earlier stage of disease to metastatic disease with either:
  - 1. a continued decline in spite of therapy
  - 2. patient declines further disease directed therapy

Note: Certain cancers with poor prognoses (e.g. small cell lung cancer, brain cancer and pancreatic cancer) may be hospice eligible without fulfilling the other criteria in this section.

## Section II: Non-Cancer Diagnoses

### A. Amyotrophic Lateral Sclerosis (ALS)

#### General Considerations:

1. ALS tends to progress in a linear fashion over time. Thus, the overall rate of decline in each patient is fairly constant and predictable, unlike many other non-cancer diseases.
2. However, no single variable deteriorates at a uniform rate in all patients. Therefore, multiple clinical parameters are required to judge the progression of ALS.
3. Although ALS usually presents in a localized anatomical area, the location of initial presentation does not correlate with survival time. By the time patients become end-stage, muscle denervation has become widespread, affecting all areas of the body, and initial predominance patterns do not persist.
4. Progression of disease differs markedly from patient to patient. Some patients decline rapidly and die quickly; others progress more slowly. For this reason, the history of the rate of progression in



Disease Specific Guidelines  
A. Amyotrophic Lateral Sclerosis (ALS)

individual patients is important to obtain to predict prognosis.

5. In end-state ALS, two factors are critical in determining prognosis: ability to breathe, and to a lesser extent ability to swallow. The former can be managed by artificial ventilation, and the latter by gastrostomy or other artificial feeding, unless the patient has recurrent aspiration pneumonia. While not necessarily a contraindication to Hospice Care, the decision to institute either artificial ventilation or artificial feeding will significantly alter six-month prognosis.
6. Examination by a neurologist within three months of assessment for hospice is advised, both to confirm the diagnosis and to assist with prognosis.

Criteria:

Patients will be considered to be in the terminal stage of ALS (life expectancy of six months or less) if they meet the following criteria. (Should fulfill 1, 2, or 3).

1. Patient should demonstrate critically impaired breathing capacity.

Disease Specific Guidelines  
A. Amyotrophic Lateral Sclerosis (ALS)

- a. Critically impaired breathing capacity as demonstrated by all the following characteristics occurring within the 12 months preceding initial hospice certification:
  - i. Vital capacity (VC) less than 30% of normal (if available)
  - ii. Dyspnea at rest
  - iii. Patient declines mechanical ventilation; external ventilation used for comfort measures only
2. Patient should demonstrate both rapid progression of ALS and critical nutritional impairment.
  - a. Rapid progression of ALS as demonstrated by all the following characteristics occurring within the 12 months preceding initial hospice certification:
    - i. Progression from independent ambulation to wheelchair to bed bound status
    - ii. Progression from normal to barely intelligible or unintelligible speech

## Disease Specific Guidelines

### A. Amyotrophic Lateral Sclerosis (ALS)

- iii. Progression from normal to pureed diet
    - iv. Progression from independence in most or all activities of daily living (ADLs) to needing major assistance by caretaker in all ADLs.
  - b. Critical nutritional impairment as demonstrated by all the following characteristics occurring within the 12 months preceding initial hospice certification:
    - i. Oral intake of nutrients and fluids insufficient to sustain life
    - ii. Continuing weight loss
    - iii. Dehydration or hypovolemia
    - iv. Absence of artificial feeding methods, sufficient to sustain life, but not for relieving hunger.
- 3. Patient should demonstrate both rapid progression of ALS and life-threatening complications.
  - a. Rapid progression of ALS, see 2.a above.
  - b. Life-threatening complications as demonstrated by one of the following

Disease Specific Guidelines  
A. Amyotrophic Lateral Sclerosis (ALS)

characteristics occurring within the 12 months preceding initial hospice certification:

- i. Recurrent aspiration pneumonia (with or without tube feedings)
- ii. Upper urinary tract infection, e.g., pyelonephritis
- iii. Sepsis
- iv. Recurrent fever after antibiotic therapy
- v. Stage 3 or 4 decubitus ulcer(s)

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## **B. Dementia due to Alzheimer's Disease and Related Disorders**

Patients will be considered to be in the terminal stage of dementia (life expectancy of six months or less) if they meet the following criteria. Patients with dementia should show all the following characteristics:

1. Stage seven or beyond according to the Functional Assessment Staging Scale
2. Unable to ambulate without assistance
3. Unable to dress without assistance
4. Unable to bathe without assistance
5. Urinary and fecal incontinence, intermittent or constant
6. No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words

Patients should have had one of the following within the past 12 months:

1. Aspiration pneumonia

## Disease Specific Guidelines

### B. Dementia due to Alzheimer's Disease and Related Disorders

2. Pyelonephritis or other upper urinary tract infection
3. Septicemia
4. Decubitus ulcers, multiple, stage 3-4
5. Fever, recurrent after antibiotics
6. Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin  $<2.5$  gm/dl

Note: This section is specific for Alzheimer's Disease and related disorders, and is not appropriate for other types of dementia, such as multi-infarct dementia.



## C. Heart Disease

Patients will be considered to be in the terminal stage of heart disease (life expectancy of six months or less) if they meet the following criteria. (1 and 2 should be present. Factors from 3 will add supporting documentation.):

1. At the time of initial certification or recertification for hospice, the patient is or has been already optimally treated for heart disease or is not a candidate for a surgical procedure or has declined a procedure. (Optimally treated means that patients who are not on vasodilators have a medical reason for refusing these drugs, e.g., hypotension or renal disease.)
2. The patient is classified as New York Heart Association (NYHA) Class IV and may have significant symptoms of heart failure or angina at rest. (Class IV patients with heart disease have an inability to carry on any physical activity without discomfort. Symptoms of heart failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is

- increased.) Significant congestive heart failure may be documented by an ejection fraction of  $\leq 20\%$ , but is not required if not already available.
3. Documentation of the following factors will support but is not required to establish eligibility for hospice care:
    - a. Treatment resistant symptomatic supraventricular or ventricular arrhythmias
    - b. History of cardiac arrest or resuscitation
    - c. History of unexplained syncope
    - d. Brain embolism of cardiac origin
    - e. Concomitant HIV disease

### Notes

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## D. HIV Disease

Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet the following criteria. (1 and 2 should be present; factors from 3 will add supporting documentation):

1. CD4+ Count 100,000 copies/ml, plus one of the following:
  - a. CNS lymphoma
  - b. Untreated, or persistent despite treatment, wasting (loss of at least 10% lean body mass)
  - c. Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment, or treatment refused
  - d. Progressive multifocal leukoencephalopathy
  - e. Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy
  - f. Visceral Kaposi's sarcoma unresponsive to therapy
  - g. Renal failure in the absence of dialysis

- h. Cryptosporidium infection
      - i. Toxoplasmosis, unresponsive to therapy.
- 2. Decreased performance status, as measured by the Karnofsky Performance Status (KPS) scale, of  $\leq 50\%$ .
- 3. Documentation of the following factors will support eligibility for hospice care:
  - a. Chronic persistent diarrhea for one year
  - b. Persistent serum albumin  $< 2.5$  gm/dl
  - c. Concomitant, active substance abuse
  - d. Age  $> 50$  years
  - e. Absence of, or resistance to effective antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease
  - f. Advanced AIDS dementia complex
  - g. Toxoplasmosis
  - h. Congestive heart failure, symptomatic at rest
  - i. Advanced liver disease

## E. Liver Disease

Patients will be considered to be in the terminal stage of liver disease (life expectancy of six months or less) if they meet the following criteria. (1 and 2 should be present; factors from 3 will lend supporting documentation.):

1. The patient should show both a and b:
  - a. Prothrombin time prolonged more than 5 seconds over control, or International Normalized Ratio (INR)  $>1.5$ ;
  - b. Serum albumin  $<2.5$  gm/dl
2. End stage liver disease is present and the patient shows at least one of the following:
  - a. Ascites, refractory to treatment or patient non-compliant
  - b. Spontaneous bacterial peritonitis
  - c. Hepatorenal syndrome (elevated creatinine and BUN with oliguria)
  - d. Hepatic encephalopathy, refractory to treatment, or patient non-compliant
  - e. Recurrent variceal bleeding, despite intensive therapy

3. Documentation of the following factors will support eligibility for hospice care:
  - a. Progressive malnutrition
  - b. Muscle wasting with reduced strength and endurance
  - c. Continued active alcoholism (>80 gm ethanol/day)
  - d. Hepatocellular carcinoma
  - e. HBsAg (Hepatitis B) positivity
  - f. Hepatitis C refractory to interferon treatment

Patients awaiting liver transplant who otherwise fit the above criteria may be certified for the Medicare hospice benefit, but if a donor organ is procured, the patient should be discharged from hospice.

## **F. Pulmonary Disease**

Patients will be considered to be in the terminal stage of pulmonary disease (life expectancy of six months or less) if they meet the following criteria. The criteria refer to patients with various forms of advanced pulmonary disease who eventually follow a final common pathway for end stage pulmonary disease. (1 and 2 should be present. Documentation of 3, 4, and 5, will lend supporting documentation.):

1. Severe chronic lung disease as documented by both a and b:
  - a. Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough: (Documentation of Forced Expiratory Volume in One Second (FEV1), after bronchodilator, less than 30% of predicted is objective evidence for disabling dyspnea, but is not necessary to obtain.)
  - b. Progression of end stage pulmonary disease, as evidenced by increasing

Disease Specific Guidelines  
F. Pulmonary Disease

visits to the emergency department or hospitalizations for pulmonary infections and/or respiratory failure or increasing physician home visits prior to initial certification.  
(Documentation of serial decrease of FEV1 > 40 ml/year is objective evidence for disease progression, but is not necessary to obtain.)

2. Hypoxemia at rest on room air, as evidenced by  $pO_2 \leq 55$  mmHg; or oxygen saturation  $\leq 88\%$ , determined either by arterial blood gases or oxygen saturation monitors; (These values may be obtained from recent hospital records.) OR Hypercapnia, as evidenced by  $pCO_2 \geq 50$  mmHg. (This value may be obtained from recent [within 3 months] hospital records.)
3. Right heart failure (RHF) secondary to pulmonary disease (Cor pulmonale) (e.g., not secondary to left heart disease or valvulopathy).
4. Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.
5. Resting tachycardia  $> 100$ /min.



## G. Renal Disease

Patients will be considered to be in the terminal stage of renal disease (life expectancy of six months or less) if they meet the following criteria.

### **Acute renal failure:**

(1 and either 2 or 3 should be present. Factors from 4 will lend supporting documentation.)

1. The patient is not seeking dialysis or renal transplant or is discontinuing dialysis
2. Creatinine clearance GFR <15 ml/min
3. Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetics)
4. Comorbid conditions:
  - a. Mechanical ventilation
  - b. Malignancy (other organ system)
  - c. Chronic lung disease
  - d. Advanced cardiac disease
  - e. Advanced liver disease
  - f. Sepsis
  - g. Immunosuppression/AIDS
  - h. Albumin
  - i. Cachexia
  - j. Platelet count <25,000



- k. Disseminated intravascular coagulation
- l. Gastrointestinal bleeding

**Chronic renal failure:**

(1 and either 2 or 3 should be present. Factors from 4 will lend supporting documentation.)

- 1. The patient is not seeking dialysis or renal transplant or is discontinuing dialysis
- 2. Creatinine clearance GFR <15ml/min
- 3. Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetics)
- 4. Signs and symptoms of renal failure:
  - a. Uremia
  - b. Oliguria
  - c. Intractable hyperkalemia (>7.0) not responsive to treatment
  - d. Uremic pericarditis
  - e. Hepatorenal syndrome
  - f. Intractable fluid overload, not responsive to treatment



## H. Stroke & Coma

**(A patient cannot be admitted with a primary diagnosis of Stroke. (Exception: Hemorrhagic if still active) We can admit a patient with the Late Effects of the stroke for example: Dysphagia due to cerebral infarction, psychomotor deficit due to cerebral infarction.**

Patients will be considered to be in the terminal stage of stroke or coma (life expectancy of six months or less) if they meet the following criteria.

### **Stroke:**

1. Karnofsky Performance Status (KPS) or Palliative Performance Scale (PPS) of 40% or less
2. Inability to maintain hydration and caloric intake with one of the following:
  - a. Weight loss >10% in the last 6 months or >7.5% in the last 3 months;
  - b. Serum albumin <2.5 gm/dl
  - c. Current history of pulmonary aspiration not responsive to speech language pathology intervention
  - d. Sequential calorie counts documenting inadequate caloric/fluid intake

- e. Dysphagia severe enough to prevent the patient from receiving food and fluids necessary to sustain life, in a patient who declines or does not receive artificial nutrition and hydration.

Documentation of diagnostic imaging factors which support poor prognosis after stroke include:

**For non-traumatic hemorrhagic stroke:**

1. Large-volume hemorrhage on CT:
  - a. Infratentorial:  $\geq 20$  ml.
  - b. Supratentorial:  $\geq 50$  ml.
2. Ventricular extension of hemorrhage
3. Surface area of involvement of hemorrhage  $\geq 30\%$  of cerebrum
4. Midline shift  $\geq 1.5$  cm
5. Obstructive hydrocephalus in patient who declines, or is not a candidate for, ventriculoperitoneal shunt

**For thrombotic/embolic stroke**

1. Large anterior infarcts with both cortical and subcortical involvement
2. Large bihemispheric infarcts

3. Basilar artery occlusion
4. Bilateral vertebral artery occlusion

### **Coma (any etiology)**

Comatose patients with any 3 of the following on day three of coma:

1. Abnormal brain stem response
2. Absent verbal response
3. Absent withdrawal response to pain
4. Serum creatinine >1.5 mg/dl

Documentation of the following factors will support eligibility for hospice care:

Documentation of medical complications, in the context of progressive clinical decline, within the previous 12 months, which support a terminal prognosis:

1. Aspiration pneumonia
2. Upper urinary tract infection (pyelonephritis)
3. Sepsis
4. Refractory stage 3-4 decubitus ulcers
5. Fever recurrent after antibiotics



## Palmetto LCDs <sup>ii</sup>

### Palmetto Government Benefit Administrators (GBA) LCD Guidelines

<https://www.palmettogba.com/HHH/LCD>

For areas using Palmetto LCDs: Access the Palmetto website from the address shown above, (you may need to then accept terms), scroll down to the Hospice LCDs, and click on the LCD ID# link next to the specific disease process for your patient. This will open the LCDs for that disease process for your review.

**Note:** Palmetto LCDs places emphasis on secondary and co-morbid conditions. Ultimately, in order to support a hospice plan of care, the combined effects of the primary condition **and** any identified secondary condition(s) and /or comorbid conditions(s) should be such that the beneficiaries with the identified impairments would have a prognosis of six months or less.

## Determining Hospice Eligibility and Primary Diagnosis

When determining if a patient is eligible for hospice and what primary hospice diagnosis is most appropriate for a potential patient, please follow these important guidelines:

Gather the past medical history (PMH) and status/changes of the patient. This can be found in the history and physical (H&P), intake information, communication with the Attending/Primary Care Physician (PCP), discussion with the patient and family/caregiver, facility staff, facility documents, etc. This should include all patient information and/or changes over the **last 6 months**.

Once you have this information and have initially assessed the patient, take ALL of these findings to your Medical Director and DCS for discussion. This is **very important** because the patient may not meet outlined criteria however may still be eligible to enroll in their hospice benefit. Also, we may not have a clear primary diagnosis that meets all LCD criteria and discussing overall status/decline over the last 6 month is a key indicator of eligibility and prognosis. Again, the Medical Director and DCS will need this history, and your



## Determining Hospice Eligibility and Primary Diagnosis

assessment information, including clinical status, to determine eligibility, and decide on the most prevalent or critical diagnosis which will most likely cause the demise of the patient in 6 months or less.

It is the responsibility of the Attending/PCP and/or Medical Director to determine the primary hospice diagnosis of our patients. They have the responsibility to be involved in the completion of the comprehensive assessment, development of the POC, delivery of the patient's medical care, and to certify the patient's terminal prognosis.

### **Diagnoses that CANNOT be used as primary diagnoses in hospice & helpful diagnoses tips:**

- Failure to Thrive – cannot be used as a primary hospice diagnosis
- Dementia (alone) cannot be used as a primary hospice diagnosis. It must be the specific type – Alzheimer's, Frontotemporal, Lewy Body, or Alcohol Induced.
- Vascular Dementia cannot be used as a primary hospice diagnosis
- Acute CVA cannot be used as a primary hospice diagnosis. If the CVA itself does not cause the

## Determining Hospice Eligibility and Primary Diagnosis

demise of the patient, it will most likely be the late effects of the CVA that does i.e., Dysphagia, or psychomotor deficit. The only exception to this is if the patient has had a hemorrhagic stroke and the current bleed is still active at the time of the hospice admit - This is rare

- A fracture cannot be used as a primary hospice diagnosis. Again, it is typically the effects of the fracture that will cause the demise of the patient i.e., malnutrition, dysphagia.
- Unofficial Cancer Diagnosis Procedure: if a patient does not have an official diagnosis of cancer and it is only “suspected,” you must discuss the patient history and all findings with the Attending PCP/Medical Director. If the Attending PCP/Medical Director does feel comfortable diagnosing the patient with a specific type of cancer, we can proceed with this as the diagnosis for the patient. If the Attending PCP/Medical Director does not feel comfortable diagnosing without further testing, we can use what we do have in the patient records as a primary diagnosis for example: if the patient has a lung mass, and has declined further testing, yet is exhibiting



## Hospice Levels of Care

### **Routine Care**

The Routine level of care is the most common level of care for hospice patients. This level of care takes place wherever a patient calls home for example: private home, group home, Assisted Living or Skilled facilities. It includes Skilled Nursing visits, Hospice Aide visits, Social Work and Spiritual Care visits, Volunteer services, Massage and Music therapy visits. Once this level of care is elected, the patient is electing to receive their hospice benefit, thus we become their provider for medical needs.

### **GIP (General Inpatient Care) <sup>iii</sup>**

The GIP level of care is utilized when the patient has uncontrolled symptoms that cannot be feasibly managed in any other setting. This is generally implemented in situations such as unmanaged pain, nausea or vomiting, or behavioral issues when other efforts to manage these symptoms have been ineffective. GIP *cannot* take place in a private residence, Assisted Living Facility (ALF), or a hospice residential facility. GIP *can* be provided in a Medicare

## Hospice Levels of Care GIP (General Inpatient Care)

certified hospital, a Skilled Nursing Facility (SNF) where an RN is available 24 hours a day, or a hospice inpatient facility. We will always need to verify that Brighton is contracted with a hospital and/or SNF before making the decision to transfer and initiate the GIP level of care.

If you are taking care of a patient that has uncontrolled symptoms and you have made several medication changes/interventions to further manage that issue, yet the symptoms remain unresolved, contact your DCS to discuss the case and determine if transitioning to GIP level of care is needed. Each case is unique and must be discussed with your DCS and agreed upon by the IDG team. Discussion should include the reason GIP may now be needed, and how GIP interventions would differ from interventions being implemented on the current level of care.

The following are tips to assist you if the GIP level of care change is appropriate:

- Coordinate with the contracted facility the need for GIP level of care and determine their ability to accommodate this need.

## Hospice Levels of Care GIP (General Inpatient Care)

- Discuss transfer plans with the facility and send all necessary documentation.
- TigerText to the IDG team (including medical director, Attending/PCP) with the change in level of care and new location of the patient.
- Physicians Order – this should include the change from the current level of care to GIP level of care. It should also include the detailed reason(s) for GIP level of care change and provide a clear understanding of the GIP need, specifically what symptom(s) is no longer manageable, and what interventions were implemented and were not effective in managing the uncontrolled symptom(s) in the current setting. The physicians order should also include facility name, date GIP begins, equipment needs, medications, mobility (i.e., bed bound), diet order (i.e., pureed), frequency change, etc.
- Patient-Billing Level of Care form (This form is found in the Hospice Consent Forms area of Devero).

## Hospice Levels of Care GIP (General Inpatient Care)

- Update the patients plan of care, including appropriate goal(s) and intervention(s), in the applicable area(s).
- The GIP patient must receive daily skilled nursing visits for symptom management, and we must document the continued need for the GIP level of care, identifying the specific symptoms being managed. It is important to note that the documentation should always reflect working towards a lower level of care with discharge planning evident, from the first day of the GIP admission.

Daily documentation should include:

- a. What specific interventions were implemented?
- b. What was the patient's response?
- c. How many PRN medications were required in the last 24 hours to meet symptom control goals.
- d. Updating Status towards goal(s).
- e. All education provided to the patient/family and coordination with facility staff.
- f. Documentation supporting discharge planning.

Once a patient's symptoms become managed, they must return to a lower level of care/routine level of

## Hospice Levels of Care GIP (General Inpatient Care)

care. Once the symptoms are managed, coordinate with the patient/family/facility and IDG team. This may include transfer arrangements back to the patient's previous place of residence. In addition to this coordination, please document the following:

- a. The reason GIP level of care has resolved and the discharge plan.
- b. Physician Order showing GIP level of care to Routine level of care.
- c. Update the patients plan of care.
- d. Completion of a new Patient-Billing Level of Care form.
- e. Tigertext to the IDG team (including the medical director, Attending/PCP) with the change in level of care and the new location of the patient.

***ATTENTION:*** GIP cannot be continued for more than 7 days and anything over 5 days will likely flag an Additional Development Request (ADR) requested from Medicare, for need.

*Side note:* The general decline of the patient, end-of-life care, or a patient who is actively dying, are not appropriate reasons for GIP care.



## **Respite Care**

The Respite level of care is available to provide temporary relief to the patient's primary caregiver if they require a break from caregiving. This level of care is reserved for caregiver(s) who are the primary caregiver(s) of hospice patients who reside in a private residence. The Respite level of care is then provided in a contracted skilled facility so that nursing staff can ensure the patient needs are being met.

Reasons for utilizing the Respite level of Care:

- Caregiver burnout
- Short-term caregiver illness
- Caregiver is going out of town overnight

This service can only take place for a maximum of 5 consecutive days at a time and may be provided on an occasional basis. When a patient utilizes their Respite care benefit the patient is transferred to a licensed skilled nursing facility which Brighton has contracted with.

If you recognize a caregiver burnout situation where the Respite level of care could be utilized, please

contact your DCS to discuss. This should also be agreed upon by the IDG team. Once we have decided to initiate the Respite level of care, please complete the following:

*Note:* collaborate with support services with regards to coordination of tasks. Utilize your entire team.

- Tigertext to the IDG team (including PCP) with the change in level of care and new location of the patient.
- Physician's Order - containing the change of level of care, the facility providing the respite care, the reason for respite, the dates of the respite stay from day 1 of entry to last full day of respite care, any medications, diet order, and activity level.
- Patient-Billing Level of Care form with facility signature. (This form is found in the Hospice Consent Forms area of Devero).
- Update the plan of care.
- Standard visit documentation showing the support of the patient during Respite care.

At the completion of the Respite stay please complete the following:

## Hospice Levels of Care Respite Care

- Tigertext to the IDG team (including PCP) with the change in level of care and new location of the patient.
- Physicians Order – containing the change back to the lower level of care (Routine level of care).
- Patient-Billing Level of Care form
- Update the plan of care.



## Continuous Home Care (CHC) <sup>iv</sup>

Continuous home care is to be provided only during periods of crisis to maintain the beneficiary at home and has *very specific documentation requirements*.

Continuous care cannot be provided in a skilled nursing facility (SNF), inpatient hospital, inpatient hospice facility, a long-term care hospital (LTCH), or an inpatient psychiatric facility. A period of crisis is a period of time when the beneficiary requires the higher level of “continuous care” for at least 8 hours in a 24-hour period (midnight to midnight) to achieve palliation or management of acute medical symptoms. The care does not need to be “continuous” but must total eight hours or more of care within the 24-hour period. The care must be predominantly nursing care provided by an RN, LPN, or LVN. Homemaker or hospice aide services may be provided to supplement the nursing care. This means that at least 50 percent of the total care provided must be provided by a nurse. All nursing, aide and homemaker services must be counted into the continuous home care time. Hospices cannot choose to count fewer aide hours than were actually provided to increase the percentage of nursing

## Hospice Levels of Care Continuous Home Care (CHC)

hours. When aide hours exceed the nursing hours, routine home care must be billed.

### **Forms needed for Continuous Care**

1. Physician order and other supportive documentation on the need for continuous care.
2. Updated plan of care
3. Continuous Care Form documentation completed every hour

***ATTENTION:*** If you find yourself in a situation where you have given over 4 hours of care in a given day, please contact your DCS to further discuss the need for continuous care. Please refer to the Brighton protocol for CHC. The patient's plan of care must be modified to take CHC into account and documentation must clearly establish the delivery of skilled services to the patient throughout each 24-hour period for the time(s) that the nurse is present.

***Reminder.*** Please communicate via TigerText to the IDG team (including the medical director, Attending/PCP) when starting and concluding the CHC level of care.



## Advanced Directives and POLST Forms Overview

An advance directive is a legal document in which an individual appoints a person or persons to make health care decisions in their stead, in the event that individual loses the capacity to make health care decisions. Advance directives may be called by different names i.e., living will, health care power of attorney. An advance directive is direction from the patient, not a medical order.

The POLST form is a portable medical order for specific medical treatments the patient wants, based on his/her diagnosis, prognosis, and goals of care. POLST forms are appropriate for individuals with a serious illness or frailty near the end-of-life. POLST forms may also be called by different names and may Not be applicable in certain states.

Although both Advanced Directives and POLST forms provide information about treatment wishes, they give different information. A POLST form complements the advance directive, but it does not replace it.

## Advanced Directives and POLST Forms Overview

*Please discuss Advance Directives and POLST form guidelines for your area with our DCS.*

Health care professionals should discuss advanced directives (and POLST form if appropriate for your area) on admission to hospice. Please ensure to utilize the support of the IDG team in facilitating any information and support needed by the patient, and family/caregiver.

### Notes

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## **Patient Notification of Hospice Non-Covered Items, Services, and Drugs/Addendum <sup>v</sup>**

The Patient Notification of Hospice Non-Covered Items, Services, and Drugs/Addendum became a Medicare requirement and condition of payment on October 1, 2020. “The purpose of the addendum is to notify the individual (or representative), in writing, of those conditions, items, services, and drugs the hospice will not be covering because the hospice has determined they are unrelated to the individual's terminal illness and related conditions.” If “the hospice determines there are conditions, items, services, or drugs that are unrelated to the individual's terminal illness and related conditions, the individual (or representative), non-hospice providers furnishing such items, services or drugs, or Medicare contractors, may request a written list as an addendum to the hospice election statement.”

This is a condition of payment for Medicare, so if the chart is pulled and it is indicated that this has been

requested and the signed addendum is not in the record, we will not get paid.

**Please refer to our policy on the Patient Notification of Hospice Non-Covered Items, Services, and Drugs/Addendum for any further information.**

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## Medications

**For overall medication management, please always utilize the Hospice Formulary as reference, and discuss all medication interventions with your patients PCP/Attending and/or Medical Director prior to initiating. Please discuss site specific e-kits and formularies with your DCS.**

The following was written by our Brighton Hospice Medical Director, Dr. Richard Allen. This information can be used as reference for medication conversations with patients, families, caregivers, and facilities.

Discussing drugs on Hospice patients

by Richard Allen, MD, MPH

*Published in NHPCO Monthly Newsletter, 2014*

By definition, when patients enroll in hospice, they are no longer seeking life-sustaining treatments. Yet many may still be taking medications that are no longer helpful to them — neither beneficial for sustaining life nor effective at providing comfort.

In this article, I review 10 commonly-prescribed medications that may provide little benefit — and possibly cause harm — to patients in a terminal state. Helping patients and caregivers understand the negligible effect and potential danger of these medications is also part of this review.

While I also provide the evidence to support the disuse of these medications, please note that my recommendations are meant only as a guide. Each hospice medical director must take an individualized approach, weighing the risks and benefits for each patient as well as the patient and family's goals of care.

1. **Warfarin and other anti-coagulants:** 2% risk of stroke, 8% risk of major bleed (GI or intracranial) in debilitated patients. Stroke might be a welcome exit to poor quality of life, but bleed is an undignified and messy exit.
2. **Statins:** NCEP: “patients with a limited life span from a concomitant illness are probably not candidates for drug therapy.” Studies show an *increase* in early death in elderly patients on statins. Cholesterol levels plateau after age 65,

- and cholesterol is necessary for cell stabilization (i.e. wounds).
3. **Clopidogrel and aspirin:** A trial of 15,000 patients showed no coronary benefit, and double the risk of gastrointestinal bleeding on clopidogrel and aspirin. The drug is only indicated for patients who've recently (1-6 months) had a stent.
  4. **Furosemide and diuretics:** Increases norepinephrine, renin, and vasopressin, causing the circulatory system to feel that it's in a constant state of stress. Decreased renal blood flow, elevated creatinine, and relative dehydration. Orthostasis, falls, and electrolyte abnormalities are common. Use only for *symptomatic* edema or heart failure.
  5. **Bisphosphonates:** Long-term studies show excellent benefit in the first 3 years, then plateau--patients who've taken for 3-5 years can stop and maintain benefit of strong bones. Not recommended for patients with any level of kidney disease, or who are unable to remain upright for thirty minutes after ingesting the medicine with 8 ounces of water: risk of painful esophagitis and osteodystrophy.

6. **Donepezil and other dementia drugs:** Indicated for mild to moderate Alzheimer's dementia, specifically patients with a FAST score less than seven. No long-term difference in ADLs, debility, or cognition. Common side effects: hypotension, syncope, nausea, and anorexia
7. **Sulfonylureas and insulin:** Studies show that most elderly patients are *over-treated* for diabetes. A1c goals are much higher, i.e. 8% for frail elderly. Occult hypoglycemia (i.e. nighttime) is associated with short- and long-term cognitive impairment, delirium, weakness, and dizziness.
8. **Vitamins:** Too many LARGE pills with no evidence of benefit, even for wound care, anemia, fatigue, malnutrition (protein much more important)
9. **Anti-hypertensives:** BP goals are *higher* for elderly, i.e. 150/85. Frequent adverse effects: orthostasis, falls, fatigue. Studies show that elderly people do better with higher pressures.
10. **Antidepressants:** Increased confusion and falls (SSRI and benzos). Increase in early mortality (anti-psychotics). Always weigh risk and benefit, and avoid "layering" polypharmacy.



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## Hospice Plan of Care

### Overview

A documented Plan of Care (POC) must be established and maintained for each patient admitted to hospice services. The hospice POC is an ongoing document that describes both the palliative and supportive care that will be provided by the hospice Interdisciplinary Group (IDG) to the patient and the patient's family/caregiver, as well as the manner in which the IDG will provide that care.

The POC is established upon admission to hospice services following the initial comprehensive assessment. The POC must be specific to the patient and the patient's family/caregiver needs, and *goals* of care. It is therefore imperative that members of the IDG collaborate with the patient/family/caregiver in development of the POC to determine the specific interventions and specific goals needed to meet these needs.

The POC is then reviewed and discussed by the IDG at least every fifteen days in IDG meeting. The IDG

## Hospice Plan of Care Principles of Quality Care Planning

consists of the Attending/Primary Care Physician (PCP), the Hospice Medical Director or Team Physician, Registered Nurse, Social worker, Spiritual Care, Volunteer Coordinator, Hospice Aide Coordinator, and any others as appropriate (this includes the patient/family/CG as they may attend IDG meetings to discuss the plan of care, if they choose). At each IDG meeting, the IDG discusses the POC and makes any revisions/updates that are necessary to manage discomfort, provide symptom relief, and utilize specialized nursing and support services skills related to palliative and end-of-life care.

### **Principles of Quality Care Planning**

The POC is one of the most important aspects to the overall care of our patients and their families and is therefore *critical* to our documentation. All services provided in the care of our patients and their families should correspond accurately with the POC. Documentation should follow and reflect what is occurring daily with relation to the POC and must be

## Hospice Plan of Care Principles of Quality Care Planning

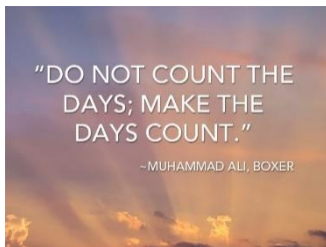
updated timely to include any changes and/or updates that are needed.

Medicare requires the following to be included in each care plan:

- Interventions to manage pain and symptoms
- A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs
- Measurable outcomes anticipated from implementing and coordinating the POC
- Drugs and treatments necessary to meet patient needs
- Medical supplies and appliances necessary to meet patient needs
- IDG documentation of the patient's or representative's level of understanding, involvement, and agreement with the POC

**Common Deficiencies Related to POC  
Implementation as per Centers for Medicare and  
Medicaid Services (CMS) <sup>vi</sup>**

- POCs were not individualized
- Hospice staff missed direct-care visits
- Documentation of visits did not meet requirements (for example, wound care)
- POCs were incomplete (for example, not inclusive of all needed services)
- IDG meetings were inconsistent, with POCs not being updated
- The HHA Assignment (Aide Care Plan) does not match what tasks the aide is actually performing.



## Building a “*Patient Centered*” Plan of Care (POC)

A necessary and key aspect of care planning is to first understand that you must build a **Patient Centered** plan of care, **not a clinician centered** plan of care. In order to effectively build a patient centered care plan, it is imperative that you start by discussing the plan of care for the patient, with our patient, and/or their family/caregiver(s). They will need to take part in creating their plan of care based on their desires and goals of hospice care.

When developing a patient centered plan of care, the use of **S.M.A.R.T.** goals will greatly enhance the creation of, and the continuation of, a successful patient centered plan of care.

### **S.M.A.R.T. Goals** <sup>vii</sup>

***Specific:*** Goals should be clear and specific. If they are not clear and specific your patient and their family/caregiver(s) may not be able to focus efforts or feel motivated to achieve it. Setting broad and/or

generalized nursing goals allows them to be open for interpretation.

**Measurable:** It's important to have measurable goals so that you and your patient and their family/caregiver(s) are better able to track progress and stay motivated. Assessing progress, or “Status” towards goals and discussing these during our visits, helps everyone stay focused, meet achieve by dates, and may give our patients and their family/caregiver(s) a feeling the excitement of getting closer to achieving patient specific goals.

**Achievable:** When discussing goals with our patients and their family/caregiver(s) please **remember and that goals must be realistic and attainable to be successful.** This may take education on our part to explain realist expectations with regards to end-of-life (EOL) preparation.

**Relevant:** This step is about ensuring that goals matter to your patient and their family/caregiver(s), and that it also aligns with other relevant goals of comfort.

Hospice Plan of Care  
Patient Centered Plan of Care

***Time-Bound:*** Every goal in our patient’s plan of care must have an “achieve by” date. This should be realistic to your patient’s needs and wishes and should be determined on a patient specific basis. This will require your education and guidance as the RN Case Manager. This will also give you a focus to document towards in your daily visit notes and when updating the “Status” towards goals area in the plan of care.

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Hospice Plan of Care  
Patient Centered Plan of Care Examples Table

## Patient Centered Plan of Care Examples Table

Question to patient and/or family/caregiver	Goal	Intervention
Q: What is your favorite dessert? A: Chocolate ice cream	I would like a cup of chocolate ice cream each night before bed	Notify the facility dietician to add 1 cup of chocolate ice cream to the patient's meal plan each night at 8:00pm.
Q: What is/was the patient's favorite book? A: Where the Red Fern Grows	Read Where the Red Fern Grows to the patient for 15 minutes at each visit.	Obtain the book Where the Red Fern Grows and place in the patient's room. Read to the patient at each visit. (Consider coordinating with IDG team to assist)



Hospice Plan of Care  
Patient Centered Plan of Care Examples Table

<p>Q: Is there a friend or someone in your family that you would like to communicate with? A: Niece Jane in Texas</p>	<p>Visit with niece Jane who lives out of state by: (add date within 2 weeks)</p>	<p>Contact niece Jane and arrange to visit with patient via facetime.</p>
<p>Q: What makes you/the patient smile? A: The patient loved to watch the Carol Burnett show</p>	<p>Watch a segment of the Carol Burnett show with the patient 3 times each week</p>	<p>Assist the family/caregiver with how to watch the Carol Burnett show on TV, iPad, etc. (times, channels or obtaining DVDs from library) etc.</p>
<p>Q: What would you like to happen over the next month of your hospice care?</p>	<p>Set a measurable goal with relation to their answer</p>	<p>Set an appropriate intervention(s) to assist them in accomplishing their goal.</p>

Hospice Plan of Care  
Patient Centered Plan of Care Examples Table

<p><b><i>Primary diagnosis of cardiac disease:</i></b>  Q: How do you want to manage your shortness of breath? What techniques would you like to know about?  A: Ways to help with shortness of breath other than taking medicine</p>	<p>Patient/ caregiver will demonstrate proper technique for pursed lip breathing, energy conservation, repositioning, and elevating the head of bed 30 degrees while relaxing or sleeping by: (Set an appropriate date based off the patient/ caregivers desired timeframe)</p>	<p>Provide teaching on pursed lip breathing, energy conservation, and repositioning to improve shortness of breath discomfort, and elevating the head of bed 30 degrees while relaxing or sleeping</p>
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Hospice Plan of Care  
Patient Centered Plan of Care Examples Table

<p><b><i>Pain</i></b> Q: How would you rate your pain today _/10? Where is your pain? A: My pain is 8/10 in my left hip today</p>	<p>Patient's pain will be managed as evidence by pain rating of &lt;3/10 (desired level) as evidenced by no more than 3 PRN pain medications received in 24 hours (or whatever their specific goal is)</p>	<p>Patient will be provided with education and medication management with an increase in (add specific medication/ intervention) to mitigate left hip pain.</p>
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Hospice Plan of Care  
Patient Centered Plan of Care Examples Table

<p><b><i>Pain</i></b> Patient has a history of knee pain and has been unable to go outside and view his/her flower garden as a result.</p>	<p>Patient/ Caregiver goal to maintain a pain rating of equal to or less than <u>2</u> /10 so that the patient is comfortable enough to go for a stroll through their flower garden 3 times each week. (set appropriate achieve by date).</p>	<p>Provide education and medication management (add specific medication/ intervention) to maintain patient's desired pain goal.</p>
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Hospice Plan of Care  
Patient Centered Plan of Care Examples Table

<p><b><i>Respiratory</i></b> Patient has a productive cough and elevated temperature. (Patient/ Caregiver would like to treat for comfort)</p>	<p>Patient/ caregiver(s) will report completion of antibiotics and management of related symptoms within 10 days. (Patient/ caregiver(s) will report any signs/symptoms of adverse reactions to antibiotics within 48 hours)</p>	<p>Provide patient/caregiver(s) teaching on antibiotic therapy to mitigate suspected respiratory infection. Physician Order obtained for ....</p>
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Hospice Plan of Care  
Patient Centered Plan of Care Examples Table

<p><b><i>COPD</i></b> COPD patients may be at a higher risk for revocation to go to the hospital due to end stage shortness of breath (SOB) fears.</p>	<p>Patient will remain on hospice services and will not go to the hospital due to SOB (set appropriate achieve by date) Patient/ caregiver(s) will verbalize understanding of calling Hospice rather than 911 for SOB concerns (set appropriate achieve by date)</p>	<p>Provide education to patient and caregiver(s) on SOB management (include specific medication and non-medication interventions for your patient/caregiver(s).</p>
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Hospice Plan of Care  
Patient Centered Plan of Care Examples Table

<p><i>Covid or Other Isolation Situations</i></p>	<p>Patient/ caregiver(s) will verbalize understanding of appropriate type and length of isolation (set appropriate achieve by date). Patient/ caregiver(s) will demonstrate proper use of PPE, as per CDC recommendation (set appropriate achieve by date).</p>	<p>Educate patient/caregiver(s) on appropriate type and length (add type and length here) of isolation as per policy. Educate patient/caregiver(s) on prevention of the spread of infection with proper use of PPE as per CDC recommendations.</p>
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Hospice Plan of Care  
Patient Centered Plan of Care Examples Table

<p><b><i>Dysphagia</i></b> (Difficulty Swallowing) Patient/caregiver report: I/we are noticing that there are increased choking episodes</p>	<p>Patient and/or caregiver will demonstrate understanding of aspiration precautions with nectar thick liquids within 1 week (set appropriate achieve by goal date)</p>	<p>Patient and caregiver(s) provided with education on aspiration precautions. Order for nectar thick liquids obtained.</p>
<p><b><i>Nausea/Vomiting</i></b> Patient/caregiver report: I/we are noticing that there is nausea and sometimes vomiting after meals</p>	<p>Patient and/or will report management of symptoms as evidenced by a decrease in nausea and vomiting within 1 week (set appropriate achieve by goal date)</p>	<p>Patient/caregiver(s) will be provided with education and medication management to mitigate symptoms of nausea and vomiting after meals.</p>



Hospice Plan of Care  
Patient Centered Plan of Care Examples Table

<p><b>Anxiety</b> Q: How are you feeling today? A: I am feeling anxious. (Or if caregiver reports signs of anxiety, or if you observe signs of anxiety)</p>	<p>Patient/caregiver(s) will report anxiety level at or below mild within 1 week.</p>	<p>Patient/caregiver(s) will be provided with education on medication management to mitigate symptoms of anxiety. Physician Order obtained for ....</p>
<p><b>Skin</b> Patient is now bedbound, and skin is more reddened on bony prominence of coccyx.</p>	<p>Patient/caregiver(s) will demonstrate understanding and proper technique of frequent repositioning and pressure relief within 1 week.</p>	<p>Provide frequent repositioning education and technique to patient/caregiver(s) on pressure ulcer prevention.</p>

Hospice Plan of Care  
Patient Centered Plan of Care Examples Table

<b><i>Transitioning</i></b> Patient is transitioning to actively dying stage.	Patient/caregiver(s) will verbalize understanding of signs and symptoms of end of life within 48 hours.	Patient/caregiver(s) will be provided with support and education on signs and symptoms of end of life.
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## Additional Question Ideas When Developing a Patient Centered Care Plan

The first question we should be asking our patients/caregivers at start of care is: “what are your top 3 goals for the next 3 months?” This can also be asked at any time throughout the patient's care.

For patients that are unable to respond to your questions, here are some ideas for questions to ask your patients caregiver(s) when developing patient centered goals and interventions:

- What makes them smile?
- What does the patient love to eat?
- What is/was their favorite dessert?
- What is/was their favorite book?
- What are their favorite clothes to wear?
- What is/was their favorite movie?
- Who would they like to communicate with (maybe a family member who does not live close)?
- How do they like their hair done?
- What is their favorite color (fingernail polish)?
- Do they like art and who was a favorite artist?

- Do they like to spend time outside?

***Important:*** Structure and document each visit in relation to the patient's primary diagnosis, disease process, LCDs, and with relation to the goals and interventions you have set for your patient and family/caregiver(s)

It is very important to create a care plan that is patient/caregiver driven and that the care plan and the goals and interventions reflect only what you are currently working towards with your patient/caregiver(s) This will be beneficial in your documentation as you are required to update the "Status" of goals, at each visit.

You may need to have conversations with patient and family/caregiver(s) on realistic goals and interventions and to keep in mind that even though certain goals may not be in line with family thinking, we should advocate for our patients wishes and end of life goals through education to family/caregiver(s).



## Interdisciplinary Group (IDG) Meetings

### Key Points in Preparing for IDG Meeting

- During standard patient visits, the patient's POC must be updated and kept current from the Hospice Nursing Clinical Note. Certain POC areas may also be updated from the Physician Orders i.e., medication, DME/Supplies, advanced directives, and diet changes. The POC may also be accessed outside of standard patient visits, through the IDG Module link in the patient's chart. Ensure that you are updating the "Status" towards the goal(s) you are addressing at that visit, as you document that visit. If you are focusing on a new issue during your visit, please make sure that appropriate intervention(s) and goal(s) are added to the POC during that visit. It is imperative that the POC is updated and current prior to each IDG meeting so that you can accurately report during the IDG meeting.
- Communicate regularly with each member of our IDG team to be best prepared to report pertinent information during IDG meeting. *Reminder:* Coordination of care is also a requirement in the

## Hospice Plan of Care Key Points in Preparing for IDG Meeting

overall care of our patients therefore it is crucial that you discuss and coordinate the care of your patients with each IDG member on a regular basis.

- Ensure that you have reviewed the care plan prior to IDG meeting and adjusted any “Achieve by” dates for each goal as needed, and update any “Status” towards goals that are not up to date. This will ensure that the care plans are kept current, and you will be prepared to report on Status towards goals at IDG meeting.
- Come prepared to each IDG meeting by knowing the POC for each of your patients. *Reminder:* You are the Case Manager for each of your patients.
- Come prepared to each IDG meeting prepared to discuss the interventions that were implemented since last IDG meeting, and whether they were effective or need to be revised.
- Come prepared to report on the Status/progress towards goals since last IDG meeting.
- *Recap:* The IDG reporting should summarize the effectiveness of interventions that were implemented since the last IDG meeting, Status towards goals, and the IDG’s plan until the next

## Hospice Plan of Care Key Points in Preparing for IDG Meeting

IDG meeting i.e., what has been going on over the past 2 weeks in relation to our current interventions and goals, and what will we be working on for the next 2 weeks.

*Recap:* The IDG reporting should summarize the effectiveness of interventions that were implemented since the last IDG meeting, Status towards goals, and the IDG's plan until the next IDG meeting i.e., what has been going on over the past 2 weeks in relation to our current interventions and goals, and what will we be working on for the next 2 weeks.

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**Reporting in IDG Meeting: *IDG Meeting is for Review and Revision***

- Report on each patient starting with the primary diagnosis.
- Report on the effectiveness of interventions that were implemented since the last IDG meeting and discuss if any revisions to those interventions are needed.
- Report on Status toward goals, completion of goals, and any new goals that have implemented over the past 2 weeks. *Reminder:* All changes to the POC should have been discussed and agreed upon by the patient, and the patient's family/caregiver.
- *Recap:* When reporting, please do not use terms such as "status quo" "continue with POC" "No changes" "ongoing" etc. The IDG reporting should summarize the effectiveness of interventions that were implemented since the last IDG meeting, Status towards goals, and the IDG's plan until the next IDG meeting i.e., what has been going on over the past 2 weeks in relation to our current

interventions and goals, and what will we be working on for the next 2 weeks.

*Side note:* If new interventions and/or goals are initiated during IDG meeting, update these in the appropriate care plan area immediately.



## **Recertification**

Communicate with all IDG members before presenting for recertification. Then come to IDG meeting prepared to discuss pertinent information about your patient to support your belief that the patient should or should not be recertified.

*Side note:* In many instances the CNA sees the patient more than any other clinician and can offer key

observations and insights to the patient's status, as well as any changes they are noticing i.e., time to task changes.

Use the last benefit period to frame your presentation i.e., what has changed over the last benefit period. Use comparative data from the previous benefit period, to support your decision. This comparative data should be in accordance with the *LDC guidelines* for the primary diagnosis of your patient, their disease process, and how they are progressing towards death.

Examples of comparative data:

- The patient's PPS was 50% at the beginning of last benefit period and is now a PPS of 30% as evidenced by ....
- The patient was able to don a pull up type brief on own last benefit period and now requires full assistance in bed to don a tab type brief.
- Patient was able to ambulate with walker to the bathroom (approximately 20 feet) without stopping 2 weeks ago, and now must stop and catch breath after ambulating approximately 5 feet.

Hospice Plan of Care  
Recertification

- Patient became short of breath (SOB) with minimal exertion last benefit period and now becomes SOB with conversation.
- Patient was able to feed self this last benefit period however now the patient requires full assistance with feeding as evidence by not being able to understand the mechanics of using utensils.
- FAST was 7a last benefit period and is now a 7c as evidenced by patient now only able to speak a single intelligible word and independent ambulatory ability is now lost.

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## When To Discharge a Patient from Hospice Who is No Longer Appropriate

To continue hospice services, we must be able to document continued decline of a patient. This is important because our Medical Director must certify that our patient is terminally ill, meaning they have a life expectancy of six months or less if their illness runs its normal course.

If the patient's condition improves and they are no longer considered terminally ill, we will be unable to recertify the patient.

It is not uncommon for a patient's condition to improve during their time receiving hospice services.

Questions to ask when determining a patient's continued appropriateness for hospice services:

- Has the patient had significant improvements since start of care (SOC)?
- Has the patient had little to no significant changes in the last 6 months or since the previous benefit period?

If you as the RNCM feel that there have been improvements and/or no significant changes over the past 6 months, or since the previous benefit period, please discuss these findings with the entire IDG team during your IDG meeting. This is crucial as other members of the IDG team may have different assessment findings and input that may help to support continued eligibility.

Following this discussion, if the IDG team decide to move forward with discharge, please consult with your DCS and follow your site discharge protocol.

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## Common End of Life (EOL) S/S

### Disease Progression and Transition Signs and Symptoms

*The following end of life (EOL) signs and symptoms may increase in prevalence and severity as the patient transitions to the actively dying process. Decreasing PPS%, ADL requirements, and FAST scale (if Alzheimer') will also occur.*

Common Hospice Principal Diagnosis	Common Related EOL Symptoms
Cardiac: Congestive Heart Failure or Heart Failure - CHF, Hypertensive Heart Disease with Heart Failure, Cardiomyopathies, Coronary Artery Disease - CAD, Coagulopathy, Arrhythmias	Cardiac: Dyspnea/Orthopnea, weakness, fatigue, shortness of breath/dyspnea (SOB), cough, wheezing, fluid buildup/crackles in lung sounds, pain, anxiety, sleep disturbance, edema, confusion, delirium, increased heart rate, decreased appetite, and intake

## Common End of Life (EOL) S/S

<p>Pulmonary: Chronic Obstructive Pulmonary Disease - COPD, Lung Cancer, Emphysema, Pulmonary Fibrosis, Pleural Effusion, Interstitial Lung Disease, Pneumonia, Covid-19</p>	<p>Pulmonary: dyspnea, weakness, fatigue, shortness of breath/dyspnea (SOB), xerostomia, coughing, anxiety, depression, delirium, pain, increased secretions, dysphagia, decreased appetite and intake, confusion, immobility, decreased consciousness</p>
<p>Dementia: Alzheimer's, Lewy Body (associated with Parkinson's), Frontotemporal Dementia, Cerebral Atherosclerosis (See Neurological also)</p>	<p>Dementia: Amnesia, depression, anxiety, pain neuromotor defects, behavioral disturbances, skin breakdown, dysphagia - difficulty swallowing, dysphasia – impairment of speech (Symptoms are progressive and irreversible), decreased appetite and intake</p>

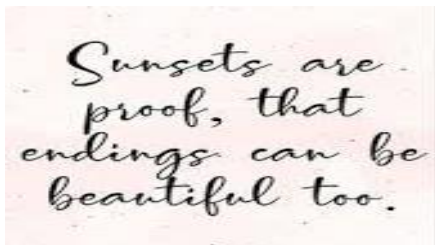


## Common End of Life (EOL) S/S

<p>Cancer</p>	<p>Cancer: Pain, weakness, fatigue, loss of interest in activities and inability to concentrate, loss of appetite, anxiety, anorexia, Shortness of Breath/dyspnea (SOB), spinal compression, depression, delirium, obstructions</p>
<p>End Stage Renal Disease - ESRD</p>	<p>ESRD: Fatigue, anemia, ascites, edema, sleep disturbances, skin issues and pruritis, anxiety, pain, constipation, xerostomia (dry mouth), shortness of breath/dyspnea (SOB), confusion, decreased appetite and intake, muscle cramps, decreased urine output</p>

## Common End of Life (EOL) S/S

Chronic Liver Disease: Cirrhosis, Hepatitis, Cancer	Chronic Liver Disease: Malaise, pain, GI bleed, encephalopathy, pruritis, ascites, jaundice, infection, nausea/vomiting decreased appetite and intake
Neurologic: Amyotrophic Lateral Sclerosis - ALS, Parkinson's, Multiple Sclerosis – MS, Cerebrovascular Accident/Stroke – CVA, Brain Tumors, Epilepsy – Seizures, Head Trauma, Dementias	Neurologic: Pain, tremors, depression, constipation, behavioral issues, hallucinations, skin breakdown, sensory deficits, dysphagia, secretions, dysphasia, decreased appetite, and intake



## End of Life (EOL) Stages

### **Transitioning Stage** <sup>viii</sup>

While the transitioning stage is different for everyone, it can typically last for a few days up to approximately 3 weeks until the patient enters the actively dying process.

Absence of solid food and fluid for at least 48 hours is typically a good indicator that the patient is transitioning to the actively dying stage.

Terminal Restlessness is another sign or symptom that may be present as a patient approaches the actively dying stage. This is characterized by sudden agitation, anxiety, anger, or confusion as death approaches. This change may be sudden and dramatic, causing loved ones/caregivers to feel helpless and overwhelmed. Terminal restlessness is also called terminal agitation, excited delirium, terminal delirium, or end-stage restlessness.

At this time, it is important to assess and coordinate daily visits with the IDG team.

### **Actively Dying Stage** <sup>ix</sup>

Actively dying is the final phase of the dying process. Although this is different for everyone, the active stage of dying lasts approximately three days.

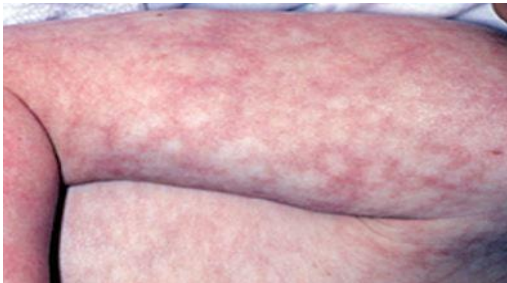
Listed below are some typical signs of active dying. While a patient may not experience all of these signs, this list will help you provide education to the patient's loved ones and caregivers in recognizing and defining actively dying.

If you have any questions about signs and symptoms of transitioning and/or actively dying, please reach out to your Mentor and/or DCS for additional support. Signs and symptoms of actively dying may include the following:

- Terminal Restlessness/Agitation:
- Drop in blood pressure
- Pulse and heartbeat are irregular or hard to feel or hear
- Patient is unresponsive, or semi-unresponsive
- Depression of lower jaw and open mouth breathing
- Unable to swallow

## End of Life (EOL) Stages Actively Dying Stage

- Cold hands, feet, and legs
- Skin on lower extremities, hands, and backside, turns a mottled red, or bluish-purple (often in the last 24 hours)<sup>x</sup>



- Eyes tear or glaze over, may not close eye lids, eyes do not follow movement
- Fever – temperature may increase  $>100$
- Urinary and bowel incontinence and/or decrease in urine; urine may also be discolored
- Build-up of fluid in the lungs, which may cause unusual gurgling sounds
- Cheyne-Stokes Respirations: Long pauses in breathing; patient's breathing patterns may also be very irregular



## Death

### Preparing for Death

It is important to begin planning for death from admit. Hospice patients can pass at any time, even if they are not showing current end of life signs and symptoms.

Preparing the patient and family/caregiver(s) and assisting them to plan for death as early as possible is of the utmost importance as a hospice team. You as the RN Case Manager (RNCM) are responsible to oversee this plan of care by coordinating with all IDG Team members. Particular focus should be on preparing the patient and family/caregiver(s) for end-of-life signs and symptoms, plan for comfort management, mortuary and funeral arrangements, end of life desires and wishes, and step-by-step what to do when the patient expires i.e., call Brighton Hospice 24/7. It is also important to explain to the patient and family/caregiver(s) that Brighton Hospice offers 13 months of grief support after the patient's death, as part of the hospice benefit. With the assistance of your IDG Team, offer resources to assist in end-of-life

education and comfort such as the booklets “When the Time Comes” and “Gone From My Sight.” Remember to utilize your entire team in the overall end of life preparation and care of our patients and their families/caregivers.

Note: Check with your site DCS/ADCS prior to your patient’s death to verify any specialized information and instruction such as Medical Examiner protocol, Coroner’s case’s, need for autopsy, organ and/or tissue donation, etc. Make sure that the entire IDG team, including the on-call team, are aware of any specialized information.

### **Attending a Death <sup>xi</sup>**

In the post-mortem period, the nurse will prepare the body in accordance with family preferences and/or facility protocols. Be sure to follow standard precautions when providing postmortem care. Remember to gather any needed supplies prior to starting. The nurse should always treat the body with dignity and respect.



***Important! With a coroner's case: There should be NO physical contact after pronouncing such as post-mortem cares, foley removal, etc. until they are cleared by the coroner in case an autopsy is wanted/warranted. The patient should remain untouched at time of death.***

When receiving a call that the patient has expired, offer support, and give an estimated time of arrival to attend the death.

Key points when attending a death: <sup>xiii</sup>

1. Be respectful of cultural and religious beliefs, and facility protocols
2. Notification of appropriate family/caregiver(s)
3. Verify correct patient
4. Pronounce death. Verify vital signs have ceased as per site and/or State protocol.
5. Follow protocol for any Medical Examiner protocol, Coroner's case's, need for autopsy, organ and/or tissue donation, etc.
6. Follow specific protocol for removal or clamping of venous lines, catheters, or other tubing.
  - If it is a medical examiner's case, do not remove indwelling tubes and lines (e.g.,

feeding tubes, urinary catheters, IV catheters). Clamp tubes and send them with the body. The medical examiner may also want to examine devices and IV solutions.

- If it is not a medical examiner's case, disconnect and cap IV lines, if present. Rationale: Removing IV catheters allows fluids to leak out. Funeral home personnel remove lines after embalming.
7. If family/caregiver(s) are present, explain the procedure to the family and caregivers and ensure that they agree to postmortem care. Ask family members if they have requests for the preparation or viewing of the body (example: position of the body, special clothing, shaving). Determine whether the family or caregivers wishes to take the lead, assist with, or be present for the care of the body. Discuss the planned cultural, spiritual, or personal rituals or practices with the family or caregivers. If family members are participating in washing the body and providing postmortem care, assist them with donning PPE, as available, for protection from bodily fluids.

8. Elevate the head of the patient's bed and place a clean pillow under the patient's head. (This will help to prevent discoloration of the face following death)
9. Position the body in supine position with anatomical alignment. Close eyes and mouth if open. (a rolled cloth placed under the chin can help to keep the mouth closed if needed)
10. Discuss jewelry and/or personal item preferences with family prior to removal. Identify which of the patient's belongings are to stay with his or her body and which are to be left with the family. (Always document actions taken with these items at time of death)
11. Using a basin pan with water and soap, give a bed bath to the body. Fix hair to family/caregiver preferences.
12. Change bed linens and cover the patient with a sheet (only to the shoulders) if the family will be visiting.
13. A brief or absorbent under pad may be applied for possible fluid leakage.
14. Dress the body in a clean gown or clothing preferences of the family.

15. Gauze or a rolled washcloth may be used to put in patient's hands to support contractures.
16. If the patient has dentures and they are not in his or her mouth, place them there. If the dentures do not stay securely in the mouth, place them in a labeled denture cup and ensure that they are transported with the patient's body to the funeral home.
17. Allow the family ample time alone with the patient's body. Encourage the family to say goodbye with chosen religious, cultural, or personal rituals and in their preferred manner.
18. Notify funeral home when patient is ready to be released.
19. IDG Team notification – via secure Tigertext/per site protocol
20. Attending/PCP physician notification – this is common courtesy and may be required to authorize release of the body in some sites/States.
21. Medication disposal – as per facility and/or site protocol
22. Notification to pharmacy
23. Notification to DME/equipment/supplies for pick-up



## Palliative Performance Scale (PPS)

### Key Points

- The PPS % must be changed in your documentation as the patient declines. Once a patient has a PPS of 20% it may be time to start daily visits. Once the patient transitions to “actively dying” PPS should be 10%.
- When determining PPS, start on the left column, then work across the scale until you have the best fit. Do not move back up the scale once you start. Examples: if a patient is totally bedbound, requires assistance with 6/6 ADLs, but is eating well and sleeping only 15 hours a day, they would be a PPS of 30%. If a patient that is up for meals/in recliner, but only eating 25-50% of meals and sleeping 20+ hours a day, they would have a PPS of 40% because they are still getting up for meals/activities. If a patient is getting out of bed even once a day for a meal or activity, they would fall under a PPS of 40%.

### Further Breakdown

- A patient with a PPS of 60% would likely not be eligible for hospice unless they have a cancer diagnosis. They would need minimal assistance with ambulation and transfers (possible use of an assistive device), are unable to perform housework, but can perform most ADL's with minimal help/cueing (handing them their shirt to put on). Keeping in mind safety with these tasks. Intake is normal or may be reduced. Has full level of consciousness, maybe some forgetfulness (forgetting what they had for lunch yesterday) but able to make decisions and understands them.
- A patient with a PPS of 50% would need assistance or a device for ambulation and transfers. Is unable to ambulate without significant assistance. Cannot do any housework or hobbies and needs more hands-on assistance with most ADL's. Intake is normal or may be reduced. Confusion may be more frequent but is still able to make basic decisions.

Palliative Performance Scale (PPS)  
Further Breakdown

- A patient with a PPS of 40% is mainly in bed (think of only up for meals). Unable to ambulate. Requires assistance with most ADL's, (possibly able to feed self). Intake is normal or may be reduced. Someone that is sleeping 15+ hours per day with more confusion.
- A patient with a PPS of 30% is **bedbound**. Unable to ambulate or sit. Is either in bed, and/or requires reclining wheelchair or high back wheelchair. Unable to support trunk. Total assistance with 6/6 ADL's. Total care. Intake should be reduced as well, eating only up to 75%. Not oriented to time or place. Sleeping or in bed 18+ hours per day.
- A patient with a PPS of 20% is bedbound, unable to do any tasks. Total assistance with 6/6 ADL's. Intake should be minimal to sips only, instead of reduced, should ideally be less than 25% of meals. Possible orientation x 1. Sleeping 20+ hours a day.
- A patient with a PPS of 10% is bedbound, intake is mouth care only, responds to tactile stimuli only, and actively dying





## Palliative Performance Scale (PPS)

%	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Level of Conscious
100	Full	Normal activity, no evidence of disease	Full	Normal	Full
90	Full	Normal activity, some evidence of disease	Full	Normal	Full
80	Full	Normal activity with effort, some evidence of disease	Full	Normal or reduced	Full
70	Reduced	Unable to do normal work, some evidence of disease	Full	Normal or reduced	Full
60	Reduced	Unable to do hobby or some housework, significant disease	Occasional assist necessary	Normal or reduced	Full or confusion
50	Mainly sit/lie	Unable to do any work, extensive disease	Considerable assistance required	Normal or reduced	Full or confusion
40	Mainly in bed	Unable to do any work, extensive disease	Mainly assistance	Normal or reduced	Full, drowsy, or confusion
30	Totally bed bound	Unable to do any work, extensive disease	Total care	Reduced	Full, drowsy, or confusion
20	Totally bed bound	Unable to do any work, extensive disease	Total care	Minimal sips	Full, drowsy, or confusion
10	Totally bed bound	Unable to do any work, extensive disease	Total care	Mouth care only	Drowsy or coma
0	Death	—	—	—	—

## Functional Assessment Scale (FAST)

- The FAST score is used **only for Alzheimer's** type dementia patients as Alzheimer's disease follows a clear progression through the FAST scale with all steps typically occurring in order.
- Lewy Body dementia, Frontotemporal dementia, and other types of dementia typically do not follow this clear progression. For these other types of dementia, document the patients decline in relation to the FAST score symptoms of progression, however, do not use the actual FAST scores in our documentation i.e., document that the patient has lost the ability to smile without adding 7E to your documentation.
- We cannot skip steps when scoring FAST i.e., Let's say we have a patient that has fecal incontinence (6E) and independent ambulatory is lost (7C) however, the patient is able to speak more than 6 intelligible words in an average day (7A); then the patients FAST is a 6E, until they meet each subsequent step.

- When testing the FAST score of a patient, ask questions that are open ended and not yes or no questions i.e., “I heard your daughter was here yesterday what did you talk about?” “What did you have for breakfast/lunch?” “Tell me about your family?” Please remember to take into account the cognitive understanding of the patient. Is the answer consistent and does it make sense with what was asked?
- Do not use patient quotes when documenting on Alzheimer’s dementia patients as this can be contradictory to the FAST score.
- Alzheimer’s patients may have better days than others and communication ability may vary. In this case, there is no need to change the FAST score based on only one or two days of increased clarity or functioning for the patient. Rather, assess a few times and make certain that the change seems to be more permanent before making a change to their FAST score. On these days, document that the patient seemed to be having a clearer day however, this is not the norm for the patient.

## Functional Assessment Scale (FAST)

### Functional Assessment Scale (FAST)

1	No difficulty either subjectively or objectively.
2	Complains of forgetting location of objects. Subjective work difficulties.
3	Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. Decreased organizational capacity. *
4	Decreased ability to perform complex task, (e.g., planning dinner for guests, handling personal finances, such as forgetting to pay bills, etc.)
5	Requires assistance in choosing proper clothing to wear for the day, season or occasion, (e.g. pt may wear the same clothing repeatedly, unless supervised.*
6	Occasionally or more frequently over the past weeks. * for the following <b>A)</b> Improperly putting on clothes without assistance or cueing . <b>B)</b> Unable to bathe properly ( not able to choose proper water temp) <b>C)</b> Inability to handle mechanics of toileting (e.g., forget to flush the toilet, does not wipe properly or properly dispose of toilet tissue) <b>D)</b> Urinary incontinence <b>E)</b> Fecal incontinence
7	<b>A)</b> Ability to speak limited to approximately $\leq 6$ intelligible different words in the course of an average day or in the course of an intensive interview. <b>B)</b> Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview <b>C)</b> Ambulatory ability is lost (cannot walk without personal assistance.) <b>D)</b> Cannot sit up without assistance (e.g., the individual will fall over if there are not lateral rests [arms] on the chair.) <b>E)</b> Loss of ability to smile. <b>F)</b> Loss of ability to hold up head independently.

\*Scored primarily on information obtained from a knowledgeable informant.  
 Psychopharmacology Bulletin, 1988 24:653-659.

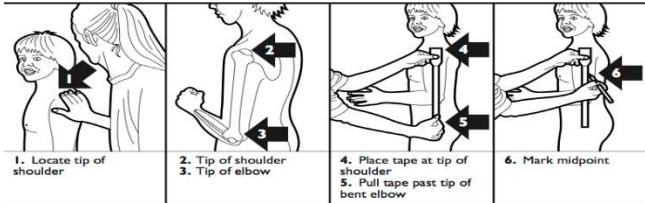
## New York Heart Association (NYHA) Classification

<i>Class I</i>	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnea.
<i>Class II</i>	Slight limitation of physical activity. Comfortable at rest but ordinary physical activity results in fatigue, palpitation, or dyspnea.
<i>Class III</i>	Marked limitation of physical activity. Comfortable at rest but less than ordinary activity results in fatigue, palpitation, or dyspnea.
<i>Class IV</i>	Unable to carry out any physical activity without discomfort. Symptoms at rest. If any physical activity is undertaken, discomfort is increased.

# Mid-upper Arm Circumference (MUAC)

## Mid-upper Arm Circumference (MUAC)

Arm circumference "insertion" tape



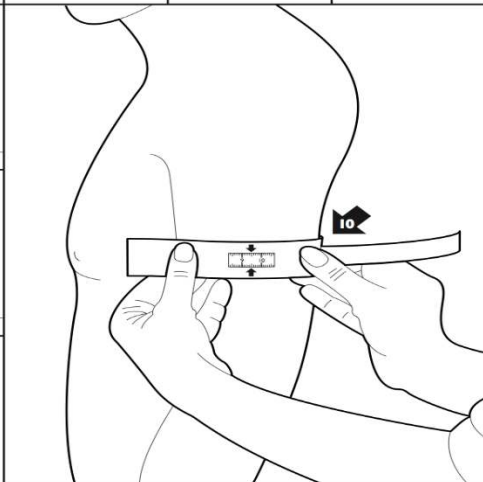
**7.** Correct tape tension



**8.** Tape too tight



**9.** Tape too loose



**10.** Correct tape position for arm circumference

## Documentation Tips

***Brighton expectations are that daily documentation is completed within 24 hours, and admissions are completed within 48 hours.***

- Know your patients care plan. This will help you document towards the interventions we have in the care plan, and in documenting status/progress toward our patients' goals, in your visit notes.
- Document toward the disease process of the patient at each visit.
- Daily documentation should paint the picture of how the patient is progressing towards death/passing. It should also contain what you did at the visit that day, observations made, changes noted, interventions implemented, education provided and why, and updates of status/progress toward goals.
- Do not copy and paste – this is the law and will lead to denial of payment for our hospice services.
- Every visit note should be different from the previous note and should stand alone in painting the picture of that specific visit.



- We must document necessity for each visit – justify each visit by documenting interventions, cares and comfort provided, education, etc.
- Every visit matters.
- Use the phrase “as evidenced by” to help your documentation to be more descriptive.
- Document your visual assessments i.e., the patient appears cachectic in appearance. Pallor is noted today. Patient has temporal wasting noted at today's visit. Lips appear cyanotic at today's visit.
- Take credit for what you do at each visit, in each visit note.
- Do not add “fluff” in your documentation i.e., patient continues to be weak and remains in bed. Continues to lose weight. Continues to decline. Remains appropriate for hospice. PPS 30%, FAST 7C. This does not paint a specific and accurate picture and will lead to denial of payment for our hospice services.
- Do not use the words “continues to decline.” Instead use “advancing or progressing towards death or passing.”

- Ask yourself “How is this patient progressing towards death?”
- Document in relation to the patient’s principal diagnosis and that specific disease process.
- Learn the disease trajectories for hospice diagnoses to assist you in what to observe and verbiage to add in your documentation.
- Know the LCD criteria for your patients’ primary diagnoses. If the patient has disease specific LCD guidelines, start with those when documenting towards the disease process. If not, use part 1 observations in your documentation.
- If you are seeing the same things at your visits: Ask the Patient/CG what the patient’s day has been like before your arrival. We may not be seeing what is actually happening. Ask about the in-between times. If you ask how they are right at that time, you will not be getting the full picture of what truly has been happening.
- Ask “what was the patient’s best day this week and why,” and “what was their worst day this week, and why.”

- If you are struggling to document towards a patient's disease process, ask the MD at IDG meeting why they feel they are still appropriate.
- Do your visits at different times of the day as this will help you see the patient at different stages in their day.
- Cardiac patients follow a “Sawtooth” trajectory, meaning their decline pattern moves up and down. When documenting on Cardiac Disease patients, note if the patient returns to baseline following any exacerbations. This paints a picture that the “Sawtooth” pattern moves up and down however the patient does not quite return to their baseline and is therefore progressing towards passing. It is important to paint a very good picture of a cardiac patient's baseline at time of admission in order to reference their changes from baseline throughout their care.
- A chronically ill patient – returns to baseline – may not be appropriate for hospice.
- A terminally ill patient – Does not return to baseline – appropriate for hospice.

- Cardiac patient documentation: what happens to their RR during mealtime? What happens to their RR during conversation? Example: patients RR was \_\_\_\_ when I first arrived and after 5 minutes of conversation, RR increased to \_\_\_\_; Or O2 sats and RR on arrival were \_\_\_\_ following ambulation with my assistance approximately 10 feet, the patient had to stop and rest and O2 sats were \_\_\_\_ and RR increased to \_\_\_\_.
- COPD patients are at higher risk for revocation due to shortness of breath/air fears.
- Are we preventing hospitalization through our interventions and education? Add how in your visit note(s).
- If a patient is a high risk to go to the hospital, add why you are needed i.e., “without hospice, this patient is most likely going to the hospital; Or would have most likely gone to the hospital today.”
- Communicate frequently with the CNA and assist them in monitoring for, and reporting time to task changes with the patient.

- Time to task examples that the CNA can assist with: Changed from a pull up type brief to a tab type brief this week as evidence by patient no longer being able to assist with donning a brief due to increased weakness. It took 5 minutes to brush teeth 2 weeks ago, and now it takes about 15 minutes as evidenced by decreasing strength in hands and arms. Patient was able to assist with donning clothing 2 weeks ago, and today the patient is unable as evidenced by no longer able to button their shirt or pants as they are now unable to understand the mechanics of buttoning their clothing. It was taking approximately 30 minutes for the patient to eat lunch last week and is now taking approximately 1 hour as evidenced by food having to manually be removed because the patient is now pocketing food; Or it takes 10 minutes for the patient to chew each bite whereas last week it was only taking a couple of minutes to chew and swallow each bite of food. Changed from Medium to Small briefs as it appears the patient is losing weight. We now need an extra hole in belt because clothes are fitting looser.

- Time to task changes should be documented in minutes or hours.
- You can use comparative time frames for admissions and recertification eligibility criteria such as over the past 3, 6, 9, and/or 12 months.
- Assess functional status at visits and be descriptive when documenting this i.e., patient is sitting in broda chair at my arrival because he/she cannot sit upright and must be in a reclined position for comfort and safety.
- Elaborate on ADLs in visit notes by adding specific examples and comparisons, *especially* for long length of stay patients.
- Document why the patient has the PPS you have assessed. Also, if Alzheimer's, why they have the FAST you have assessed. Spelling this out is a great way to paint an accurate picture.
- Adding comparative data will give context to your visit notes.
- It is very important to remember that at some point, all documentation will be read by family, facility staff, attorneys, auditors, team members, etc.















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# OUR MISSION

*Our mission at Brighton Hospice is to provide the best physical, emotional, and spiritual care for our patients and their families.*

*We achieve our mission by hiring the most compassionate and skilled people in the industry who deliver clinical expertise and exceed our patients' expectations.*

*We cultivate an environment where our team members are valued, respected, and provided personal and professional growth opportunities. Our leaders focus on supporting the clinical team so they can concentrate on patient care.*

*We are always guided by our commitment to excellence.*

Bright n  
HOSPICE