Hospice
in a
Skilled Nursing Facility
- a Model for Success

Developed by the Hospice in the Nursing Home Work Group, a subcommittee of the Long Term Care Advisory Committee of the Colorado Department of Public Health & Environment.

August 1999

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INTRODUCTION

Colorado and federal statutes entitle residents in long term care facilities to receive hospice services in the final stage of their lives. Regulations established that the nursing facility was to be the patient's home and the hospice interdisciplinary team would offer to that patient, the caregiver system, and the family the program of care defined in the Medicare and/or Medicaid Hospice Benefit. Hospice was designated to provide the professional management of the resident's plan of care. The nursing facility was to provide the resident with the same menu of room and board, skilled nursing, and other services available to any other resident.

In these years of experience in developing and refining the processes to maximize the breadth and depth of services available through this partnership, we have learned a great deal. In a health care environment which is undergoing consistent and significant change, two providers with two distinct cultures seek to provide compassionate and skilled care of the highest quality to individuals who are in the final weeks and months of life. Each provider simultaneously must be attentive to and in compliance with the regulations, conditions of participation, and licensure requirements which guide its respective services. This process of partnering has been challenging and arduous. Most believe, however, that the care provided has been enhanced because of the collaboration of nursing facilities and hospice.

Those giving care to residents of nursing facilities who have elected hospice care must find the commonalty of focus necessary to meet the needs of the dying patient. Research suggests that one of every three people over the age of 85 (the fastest growing segment of the American population) is likely to spend a portion of his or her remaining life in a nursing facility[1] and that nearly 20% (approximately 500,000 people) of annual deaths in this country will occur in nursing facilities.[2] Approximately one-third of all persons entering nursing facilities will die within 12 months of their admission,[3] yet the use of hospice services among nursing home residents is much lower than in other health care environments (less that 5% of those dying in nursing facilities versus approximately 18%

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[1] Kane, R.L., Ouslander, J.G., and Abrass, I.B., Essentials of Clinical Geriatrics, 3rd ed., New York, McGraw-Hill, 1994.

[2] Brock, D.B., and Foley, D.J., "Demography and Epidemiology of Dying in the U.S. Aging," in A Good Dying: Shaping Health Care for the Last Months of Life, George Washington Center to Improve Care of the Dying, 1996.

[3] Ouslander, J.G., Osterwell, D., and Morley, J., Medical Care in the Nursing Home, New York, McGraw-Hill, 1997.

of the total population dying in the United States each year).[4]

This Manual attempts to assist skilled nursing facility and hospice care providers in their partnership by setting forth the responsibilities of the two providers including the recognition that many of these responsibilities must be considered as "joint." For those caring for the nursing facility patients who have elected hospice care, the regulatory directive that "the hospice must maintain professional management and financial responsibility for the services provided under arrangements, regardless of the location or facility in which such services are furnished"[5] in itself raises questions and concerns. Perhaps a more practical description of the role that hospice is to play in the nursing facility setting is the fundamental understanding that hospice care is intended to supplement the care that is given routinely by the nursing facility while the hospice philosophy guides care decisions.

From the viewpoint of the hospice, the nursing facility should be considered no differently than would be the personal residence of the hospice patient cared for in a home setting. The nursing facility staff should not be asked by the hospice to perform functions that the hospice staff would not be asking of the patient's familial caregivers in the home setting, yet, at the same time, the nursing facility staff must satisfy all its requirements to provide room and board, skilled nursing, and other services to the resident. It is the hope of those from the hospice and long term care communities who have labored over this Manual that its pages will help to educate the community, lessen the cultural differences between the two providers, and promote a shared focus on the patient/family's ability to early access the full range of hospice services.

This Manual has been the effort of approximately two dozen professionals working under the aegis of the Long Term Care Advisory Committee of the Colorado Department of Public Health & Environment (CDPHE), and calling itself the Hospice in the Nursing Home Work Group. In addition to approximately equal membership in the Work Group from individuals representing the hospice and the nursing home communities, the Work Group has been assisted significantly by the active involvement of staff from the CDPHE and from Region VIII Health Care Finance Administration (HCFA).

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[4] Case Statement of the National Hospice Organization's "Nursing Home Task Force Report," Spring 1998.

[5] "State Operations Manual, Provider Certification," Dept of Health and Human Services, HCFA Transmittal No. 167, sec. 3176 3-113.51, Sept. 1994.

These guidelines are meant to serve as a source of information for facility staff and are not meant as a guarantee of compliance with the regulations for Medicare/Medicaid Certified Facilities and Colorado Licensure Regulations. Each facility that plans to implement these guidelines must develop written policies and procedures, specific to the facility, that provide instruction to staff for their use. It is recommended that the legal counsel for the facility review the policy and procedures prior to implementation.

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What Do Hospice Programs Do? (What is Hospice?)

The National Hospice Organization's Standards of Care identifies that the purpose of a hospice is to make available "palliative care to terminally ill patients and supportive service to patients, their families and significant others, 24 hours-a-day, 7 days-a-week in both home and facility based settings." Colorado's hospice licensure regulations define a hospice to be a centrally administered program of palliative, supportive and inter-disciplinary team services providing physical, psychological, spiritual and sociological care for terminally ill individuals and their families within a continuum of inpatient and home care available 24 hours, 7 days-a-week. Hospice services shall be provided in the home, residential facility, and/or licensed health care facility. Hospice services include but shall not necessarily be limited to the following: nursing, physician, home health aide, homemaker, physical therapy, pastoral counseling, trained volunteer and social services.

A terminally ill patient is one who has been identified by a physician as having an illness for which a cure is not possible. "Palliative care" is treatment that relieves discomfort and enhances quality of life. Often the patient, his or her family and physician will decide what might constitute palliative care. An interdisciplinary team, along with the patient and family, will collaborate to develop the palliative plan of care.

Medicare/Medicaid Guidelines

The Medicare Hospice Benefit is a component of Medicare Part A. When a patient accesses the Medicare Hospice Benefit, a different set of rules apply. Most noted are the levels of care. A hospice patient will have Routine Home Care, Continuous Home Care, Inpatient Respite Care, or General Inpatient Care status. In most respects, Colorado's Medicaid hospice benefit parallels Medicare provisions.

- **Routine Home Care** - the patient is under the care of the hospice and not receiving the care specified in the following levels of care, regardless of the volume and intensity of the services provided on any given day.

- **Continuous Care** - in order to maintain the terminally ill patient at home ("home" includes a nursing facility, if the facility is where the patient resides) in a period of crisis, predominantly skilled continuous care is necessary to achieve palliation of management of the patient's acute medical symptoms. Primarily, nursing care is to be used during continuous care. A RN or LPN must provide more than one half (51% or greater) of the care given in a 24-hour period.

- **Inpatient Respite Care -** an occasional period of time no longer than five consecutive days to provide relief as necessary to family members or other caregivers who are responsible for the patient's care in the home (not available to residents of a nursing facility).

- **General Inpatient Care** - available when the patient is in an inpatient setting to receive services reasonable and necessary for the palliation and management of acute and severe clinical problems related to the terminal condition that cannot be managed in other settings.

Reimbursement rates vary with each level. General Inpatient is similar to subacute reimbursement. Routine is the amount that the hospice receives for routine home care. Respite and Routine Home Care reimbursements are similar.

CORE SERVICES

Core Services can be best described as people services. This includes nursing services, physician services, medical social services, spiritual counseling, bereavement counseling, dietary counseling, and any other counseling service delivered by an individual. Hospice Medicare Conditions of Participation (42 CFR 418.80) state that these services must be provided directly by hospice employees (or by staff contracted by the hospice during peak census to meet patient care demands). These services cannot be delegated to SNF staff.

Hospice provides core services through a 24-hour, 7 days-a-week on-call system. In the partnership of the hospice and the nursing facility, the resources of the hospice's interdisciplinary team are available not only to the patient and family, but to the staff of the nursing facility, as well.

Interaction of Hospice in a Skilled Nursing Facility

SERVICE	SKILLED NURSING FACILITY	HOSPICE	JOINT
Nursing Services	RNs, LPNs and CNAs in role of the daily caregivers. Continue provision of care as with all patients	RN coordinates & reviews care plan. Makes intermittent visits, based on patient need. Educates staff and families. Reviews record. Assigns and supervises hospice CNAs as needed	Maintain communication to fulfill plan of care and inform each other of changes in care plan
Physician Services	Attending physician and SNF medical director will continue to follow SNF state and federal regs for visitation schedules	Complements attending physician's care as a resource on palliation. Provides for unmet medical needs related to terminal diagnosis. Part of the interdisciplinary team	Each provider shall identify lines of communication for medical care
Medical Social Services, Spiritual Counseling, Dietary Counseling, Bereavement Counseling, and other Counseling	Performs these services as agreed upon in the plan of care and/or by contractual agreement with the facility in accordance with SNF state and federal regulations	Performs these services as indicated in the plan of care in accordance with Hospice Medicare Conditions of Participation. Medical social services, pastoral care, dietary are part of interdisciplinary team	Maintains open communication between hospice and facility for services performed and for status changes that affect the plan of care

I: Responsibilities Related to the Eligibility/Admission Process

Nursing Home Residents Considered for Hospice

Hospice inquiries may be made by anyone directly involved with the patient. The SNF staff will be most sensitive to the time that a patient may be ready to access hospice care.

SNF STAFF	HOSPICE STAFF	JOINT
Identify potential hospice patients. Approach physician for order for hospice care and for terminal diagnosis and DNR order	Respond to request to assist with initial evaluation. If referral generated from other than SNF staff, hospice contacts appropriate person in SNF	
Approach patient/representative. Educate regarding palliative care and hospice philosophy. Give hospice brochures, etc.	Provide hospice information for facility to give patients and families	
Contact hospice provider	Contract for care in the SNF must exist[6]	
	Assess patient using hospice and regulatory guidelines to confirm eligibility	
Identify payor status (Medicare, Medicaid, private, HMO, etc.)	Verify patient financial status (Medicare, Medicaid, HMO, etc.)	
Notify PT/OT/Speech, etc., Departments of hospice status		Assess need for therapies
	Contact family to set appointment for education/sign on	
	Conduct intake process including complete patient assessment	

[6]The number of contracts that a SNF or a hospice may enter to provide hospice care in a SNF is not limited.

SNF STAFF	HOSPICE STAFF	JOINT
	Notify County Coroner of hospice status, per county procedure	
	Submit Medicaid paperwork if indicated	
	Secure needed DME and hospice related medications and supplies (unless contract is for per diem rate for those items)	Assess patient's DME medication and treatment needs
Modify Care Plan and MDS for change of status. Notify hospice of scheduled care conference	Develop hospice plan of care	Hold joint care conference and develop integrated plan of care
Continue to provide daily care, give medications on schedule, assess for breakthrough pain and other symptoms, call hospice with any change in condition, family/caregiver needs, death, etc.	Hospice assumes case management of patient	

II: Responsibilities Related to the Eligibility/Admission Process

Hospice Home Care Patients Going into a Nursing Home for Respite Care

SNF STAFF	HOSPICE STAFF	JOINT
	Contact facility regarding bed availability (must have contract with facility for hospice care). Discuss respite care with family and suggest facility with bed availability	
Prepare room and staff for patient's admission		
	Provide transportation to facility	
	Provide sufficient medications for five day stay, medication and treatment schedule, and needed DME and supplies	Discuss medication and treatment schedules, plan of care and use of DME. Discuss integration of care
Provide chairs, etc., for patient's family's visits		
Provide daily care, give medications on schedule, assess for breakthrough pain and other symptoms, call hospice with any change in condition, family/care giver needs, death, etc.	Hospice maintains case management of patient and continues to provide hospice services	
Return unused medications and supplies and DME to patient	Provide transportation back home at end of respite period	
	Pay facility respite contract room and board rate	Post Case Review

III: Responsibilities Related to the Eligibility/Admission Process

Hospice Patients Going from Home to a Nursing Home to Live until Death

SNF STAFF	HOSPICE STAFF	JOINT
	Contact facilities regarding bed availability (must have contract with facility for hospice care). Discuss nursing home care with family and select facility with bed availability	
Prepare room (and roommate if appropriate) and staff for patient's admission		
	Provide transportation to facility	
	Submit Medicaid paperwork if needed	
	Notify County Coroner of hospice status, per county procedure	
Conduct intake process including complete physical assessment, MDS, and care plan according to regulatory guidelines. Notify hospice of scheduled care conference		
	Provide hospice related medications and present supply of non-hospice medications, treatment schedule, and needed DME and supplies (unless contract is for per diem rate for those items)	Discuss medication and treatment schedules, plan of care and use of DME. Integrate plan of care
Provide daily care, give medications on schedule, assess for breakthrough pain and other symptoms, call hospice with any change in condition, family/caregiver needs, death, etc.	Hospice maintains case management of patient, and continues to provide hospice services at SNF	

IV: Responsibilities Related to the Eligibility/Admission Process

Patients Entering Hospice and Nursing Home Simultaneously

SNF STAFF	HOSPICE STAFF	JOINT
	Assess patient using guidelines and regulations to confirm eligibility	
	Receive physician order for hospice care, terminal diagnosis and COR status	
	Hospice must have contract with SNF in order to provide hospice care	
Identify payor status (Medicare, Medicaid, private, HMO, etc.)	Verify payor source	
	Contact family to set appointment for education/sign on	Coordinate move to facility
Conduct intake process including complete patient assessment, MDS, and care plan according to regulatory guidelines. Notify hospice of scheduled care conference	Conduct intake process including complete patient/family assessment and plan of care	Assess patient's DME, medication, treatment, and therapy needs. Integrate plan of care
	Submit Medicaid paperwork if needed	
	Notify County Coroner of hospice status, per county procedure	
Order medications, DME, and supplies not related to terminal condition	Order DME, medications, and supplies related to terminal condition (unless contract specifies otherwise)	
Provide daily care, give medications on schedule, assess for breakthrough pain and other symptoms, call hospice with any change in condition, family/caregiver needs, death, etc.	Hospice assumes case management of patient	

THE INTEGRATED PLAN OF CARE

I. INTRODUCTION

Care planning in any setting is the cornerstone for the delivery of individualized care and treatment. The care plan provides for communication between caregivers and promotes continuity by establishing resident/patient goals and objectives. Care planning sets the stage for implementation and evaluation of care provided to the patient. In addition, care planning provides an opportunity for the patient and his or her significant other to be involved in and make decisions about care.

II. PURPOSE

The purpose of the care plan is to provide a structure for the delivery of individualized care for the patient and family through the use of measureable objectives and timelines. The structure incorporates the identification of problems, goals, and interventions, and designates the role of each team member. While long term care plans generally focus on functional status, rehabilitation/restorative nursing, health maintenance, and daily care needs, hospice plans to a greater extent address pain and symptom management, preparation for death and bereavement, and end of life tasks. The challenge herein lies in incorporating the two modalities to enhance the quality of services provided to the patient. When successfully integrated the long term care team members come together in a synergistic way.

While there are no hard and fast rules for integrating the long term care and hospice care plans, several successful models have been identified. These models are based on early intervention for the hospice patient, enhanced communication between caregivers, and clear and consistent role clarification. Some teams choose to develop one care plan with long term care and hospice representatives formally coming together for care conferences. Others choose to develop separate plans that are incorporated into the medical record. Still others use a combination of short term active problem lists and separate comprehensive plans. Whatever the model, communication and role clarification is essential to integrated care and service delivery. Each long term care facility should develop a care planning system in conjunction with its hospice provider that incorporates these objectives.

In this Manual, when the term "integrated plan of care" is used, it refers to the one or more documents that the hospice and SNF have determined constitute the integrated plan of care.

The SNF team and hospice team both provide an invaluable service to patients and families faced with life limiting illness. Coming together in an integrated manner, caregivers assure optimum care and services, providing for the quality of life at the end of life that both entities so wholeheartedly embrace.

The SNF staff and the hospice team shall communicate, establish and agree upon a collaborative, interdisciplinary care plan for both providers which reflects measurable objectives and time lines to meet a resident's medical, nursing, physical, psychosocial and spiritual needs as well as the needs of the resident's family/caregivers, as identified in a comprehensive assessment.

A MODEL FOR THE INTEGRATED CARE PLANNING PROCESS:

STEP I: The SNF resident is determined appropriate for hospice care by the hospice and elects the hospice benefit.

STEP II: An initial plan of care is developed at the time of an admission to hospice care based on the limited information obtained, or the priorities identified during the initial assessment, which is consistent with the resident/family's immediate care needs and desires. The initial plan of care may be developed by the hospice nurse or hospice physician in consultation with the resident's attending physician and one other member of the hospice interdisciplinary team.

STEP III: Each of the hospice interdisciplinary team's core services (nursing, medical, social services and counseling) must review the initial plan of care and provide input into the process of establishing the plan of care within two calendar days following the assessment. The input may be provided through telephone consultation.

STEP IV: A copy of the initial hospice plan of care is placed in the SNF chart. Members of the hospice interdisciplinary team must include any plan of care changes which result from hospice interdisciplinary team care planning meetings. Any problems identified in the initial plan of care and unresolved must be included in the comprehensive integrated plan of care. Hospice team members are to review the initial plan of care regularly and ensure that problems identified by members of the long term care facility staff are addressed in the hospice plan of care.

STEP V: As soon as possible after the completion of their assessments of the resident/family, members of the SNF staff and members of the hospice interdisciplinary team shall meet to integrate a care plan which is driven by the hospice philosophy and goals. The integrated plan of care will replace the initial hospice plan of care and be placed in the SNF chart.

STEP VI: The integrated plan of care shall be revised at any time there is a change in the resident/family's assessed needs. Reassessments shall occur at least every two weeks. Progress notes reflecting reassessments by the hospice interdisciplinary team shall be placed in the SNF chart. Any change in the resident/family's needs (of significance to the integrated plan of care) assessed by the SNF staff must be communicated to the designated hospice interdisciplinary team members to be included in the integrated plan of care. The hospice interdisciplinary team shall assume full responsibility for the professional management of the resident/family's plan of care related to the terminal illness.

THE INTEGRATED PLAN OF CARE

The hospice retains overall professional management responsibility for implementing the plan of care related to the terminal illness.

SNF STAFF	HOSPICE STAFF	JOINT
Create initial plan of care or revise current plan of care at time of admission to hospice (no longer than 24 hours after admission) to assure that immediate patient needs are met	Determine that resident is hospice appropriate. Plan of care must be established within 2 days following assessment with input from physician, nurse, social worker, chaplain, and patient; must be consistent with hospice philosophy; and must be updated as necessary to reflect resident's changing status	Assure, via mutually agreed upon method, that care plans are integrated and congruent with one another and that responsibilities are clearly communicated
Assure that MDS is in place within 14 days of admission to facility or of significant change	An initial plan of care is developed at the time of an admission to hospice care based on the limited information obtained, or the priorities identified during the initial assessment, which is consistent with the resident/family's immediate care needs and desires. The initial plan of care may be developed by the hospice nurse or hospice physician in consultation with the resident's attending physician and one other member of the hospice interdisciplinary team. Each of the hospice interdisciplinary team's core services (nursing, medical, social services and counseling) must review the initial plan of care and provide input into the process of establishing the plan of care within two calendar days following the assessment. The input may be provided through telephone consultation	Create and maintain a mutually acceptable communication system, which includes the established conference, that maximizes the flow of information for enhanced care delivery

SNF STAFF	HOSPICE STAFF	JOINT
Assure plan of care is in place within 7 days of MDS	Update integrated plan of care at least every 2 weeks, or more frequently, as needed	Periodic assessment and review of care plans by both teams to ensure that the rapidly changing needs of the patient/family facing life limiting illness are met
Assure that hospice team always has available a current version of the SNF's interdisciplinary care plan and that changes to the care plan are communicated in a timely manner to the appropriate staff	Assure that SNF team always has available a current version of the hospice interdisciplinary care plan and that changes to the care plan are communicated in a timely manner to the appropriate SNF staff	
		There is an expectation that orientation and continuing education occur for both hospice and SNF staffs that ensure that the clinical caregivers are aware of and are guided by the integrated plan of care

See page XX of the appendix for a specific example of an integrated plan of care document

PHYSICIAN ORDERS

Protocols for communications between the SNF staff and the hospice staff shall be developed to address all medical orders. The primary physician (either the patient's attending physician and/or the hospice medical director) shall participate in the development of the plan of care with the hospice interdisciplinary team and the patient. The physician orders must be reviewed by the physician every 60 days.

SNF	HOSPICE	JOINT
		Both staffs will be knowledgeable of the hospice patient's medical plan of care. Predetermine plan for physician communication, as reflected in integrated plan of care. Timely inform each other of changes in physician orders. Establish and abide by protocol for provision and maintenance of supplies, drugs, and DME

UTILIZATION OF THERAPIES

Ancillary therapies including physical, occupational and speech therapies may be a part of the plan of care for a hospice patient if they are consistent with the patient's needs and pre-approved by the hospice interdisciplinary team and the primary physician.

All therapy services related to the terminal illness require approval and coordination by hospice.

SNF	HOSPICE	JOINT
SNF staff may recommend therapies to the hospice nurse; the hospice team, including the physician, will evaluate the appropriateness of an ancillary therapy as a part of the plan of care	Hospice nurse will get the physician order and make arrangements for PT, OT, speech therapy, nutritional counseling if it is in the patient's plan of care. The therapy and its duration will be documented on the plan of care and in the hospice progress notes; if the services are purchased through the SNF, proper notifications will be made	Both staffs will monitor and evaluate the efficacy of a therapy included on the plan of care

EMERGENCY CARE

Emergency care should be consistent with the patient's stated wishes in advance directives and the physician's orders with regard to CPR status. SNF staff are to call the hospice in a timely manner for any change of condition and reassessment and revision of the plan of care. SNF staff should obtain approval of the hospice prior to transfer of the patient to another care setting when the circumstance is related to the terminal condition (when the transfer is unrelated to the terminal condition, communication with the hospice should occur as soon as practicable.)

All emergency care related to the terminal illness requires approval and coordination by hospice.

SNF	HOSPICE	JOINT
Staff member will call hospice in a timely manner for any change of condition, reassessment and revision of the plan of care. Staff will not transfer the hospice patient to another care setting without hospice consultation	Unless otherwise agreed upon, the hospice nurse or on-call nurse will call the ambulance or other transport in transferring the hospice patient to another care setting	Both staffs will know the resuscitation status of the resident. Both staffs will know the patient's advance directives, if applicable. Both staffs will be aware of and communicate to each other a transfer to the ER or other acute care setting

MEDICAL RECORD MANAGEMENT

In accordance with accepted principles of practice, the hospice and SNF must establish and maintain a clinical record for every individual receiving care services. Clinical records must be retained as required by state and federal law documenting all services furnished directly or by arrangement. The SNF and the hospice should decide what areas of the clinical records should be copied and which agency retains the original forms.

Confidentiality of the clinical record must be maintained.

SNF	HOSPICE	JOINT
SNF will establish and maintain a clinical record of the resident in accordance with long term care regulations	Hospice will maintain a clinical record of the resident receiving hospice services in accordance with hospice regulations	Decide where hospice documentation is located in the SNF chart. Decide which documents are part of both hospice and SNF clinical records. Decide who retains original forms, who the copies. Retain clinical records as required by state and federal law. Document all services furnished directly or by arrangement

DISPUTE RESOLUTION FOR CLINICAL DECISIONS

The hospice philosophy and concepts of care guide clinical decisions related to the terminal illness.

SNF	HOSPICE	JOINT
		Make commitment to problem-solving and resolution for the sake of excellent end-of-life care for the patient. LEVEL ONE: SNF and hospice staff will problem solve directly LEVEL TWO: SNF clinical supervisor will problem solve with hospice clinical supervisor LEVEL THREE: SNF administrator will problem solve with hospice administrator

NUTRITION

I. INTRODUCTION

It is well recognized that an individual's nutritional needs are dependent upon his or her stage in the life cycle. An individual in the latter stages of dying may have unique needs, but very few references focus on the dying process and nutrient needs. There is growing evidence and support for making modifications related to end-of-life nutrition for the terminally ill. Hospice references have provided a great deal of insight for the nutrition profession in this regard.

It is appropriate for the dietitian (RD) or a designated dietary manager in a nursing facility to join with the hospice care team in providing individualized care for the resident. The focus of this nutritional care is *palliative care* rather than *curative care* for the terminally ill resident and may differ from routine restorative nutrition care.

II. PURPOSE

Palliative care (not passive, uninvolved care) is an active, goal-oriented care that is designed to meet the individual's needs. It includes assessment, intervention, and periodic reevaluation of nutritional needs.

A. The **assessment process** for a hospice resident involves asking a different set of nutrition related questions which center around easing the symptoms the resident may be experiencing. The focus is to find a way to minimize discomfort with food/fluid intake. Adequate nutrition and hydration remain a goal, but are secondary to comfort measures. The focus is on minimizing discomfort associated with food or fluid intake. Some of the symptoms include:

nausea	constipation
vomiting	diarrhea
poor oral status	altered fluid status
dysphagia	depressed emotional state

1. Assessment should **identify the stage of denial/acceptance** of the resident/family/caregivers regarding the dying process

2. Assessment is **no longer centered around Ideal Body Weight** (IBW) and **dietary restrictions** rarely apply

3. **Labs** are only ordered if they are not considered intrusive and the information is

needed to justify or further direct the nutrition care

4. If obtaining **heights/weights** in traditional ways is too uncomfortable, use of alternative methods should be considered, e.g., monthly mid-arm circumference (*UMAC)* measurements, finger tip height measurements, use of knee-height caliper

5. Consider use of appetite stimulating **medications**, or medications that reduce pain to enhance nutritional status

6. Use of a resource such as Gallagher-Allred's *Nutritional Care of the Terminally Ill* can provide examples of nutritional assessment forms, questions to ask the resident, and what to do if the resident is not eating. These will aid in setting up a nutritional care plan. Traditional eating plans may need to be revised. Many considerations may need exploration before setting up the actual plan of care.

B. **Medically-delivered nutritional support** (tube feedings, TPN) or the use of **medically-delivered hydration** needs to be clearly defined by evaluating the **benefits/burdens** of each in light of the patient's desires and legal considerations. The RD is uniquely qualified to help in this decision-making process with the attending physician. The RD works with the hospice team to help the patient/family members resolve difficult decisions about the nutrition care the patient will receive.

Medically-delivered nutritional intervention is most successful in the early stages of illnesses. In the later stages decisions must be made as to the effectiveness of medically-delivered nutritional support in improving life versus merely prolonging death. The following are examples of some of the benefits/burdens that may exist when choosing medically-delivered nutritional intervention:

Benefits	**Burdens**
Decrease malnutrition discomfort	Feeding tube discomfort/irritant
Decrease nausea/vomiting	Nausea/vomiting
Emotional support	Diarrhea
Decrease weight loss	Aspiration (pneumonia)
Time to get other life concerns in order	IV discomfort
	Edema
	Fluid overload

C. **Hydration/Dehydration** concerns for the terminally ill have been the subject of much debate over the past two decades. The RD's role in this area is helping the hospice and SNF teams, patient, and family members make responsible, informed choices regarding medically-delivered hydration. In patients with reversible symptoms (like nausea related to hypercalcemia), medically-delivered hydration may be part of the palliative care. For an individual very close to death, the decision to start or continue medically-delivered hydration must be analyzed in light of the fact that it may offer no benefit. In fact, some evidence supports that its use can cause discomfort and increased pain, edema and pulmonary secretions, etc., and would be a burden. Refer to the references at the end of this section for further review of the view that there may be a natural dehydration as death approaches, which actually has palliative effects for the patient. It is important for the RD (and the attending physician) to answer questions about the use of IV's or oral hydration in an honest, caring way.

D. After the above items are considered, it is imperative that the RD/Dietary Manager from the nursing facility be involved with the hospice team to provide the nutrition care that will best accommodate the patient's situation. Without such involvement from a nutrition perspective it is difficult to provide two of the most important ingredients in anyone's life: food and fluid.

E. **Legal considerations** must always be kept in mind when evaluating for nutritional needs. These can be discussed with other members of the team for insight and direction.

References

1. Billings, A., "Comfort Measures for the Terminally Ill: Is Dehydration Painful?" J Am Ger Soc 33 (11): 808-10, 1985.
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PAIN AND SYMPTOM MANAGEMENT

Hospice staff members and SNF staff members are a *COLLABORATIVE TEAM* working together to provide the best possible treatment of a resident's pain and symptoms, so that his or her days may be spent as comfortably as possible and allow for dying with peace and dignity. Therefore, communication regarding treatment for hospice resident's pain and symptoms needs to be open so that both staffs feel committed to the above goal. This is of utmost importance, particularly when the resident has been cared for by the SNF staff for many years. The transition from restorative treatment to palliative treatment can often be difficult, so the team needs to work together with compassion and sensitivity. Included in the appendix to this Manual are additional resources and tools concerning the management of pain and symptoms.

SNF STAFF	HOSPICE STAFF	JOINT STAFF
Collaborates with hospice nurse in development of plan of care including pain & symptom management	Coordinates admission and development of plan of care that addresses assessment and management of hospice resident's pain and symptoms	
Notifies hospice of time of care planning conference		Participate in joint care planning conference
Contacts hospice with changes in resident's level of pain or changes in symptoms	Trains SNF staff in pain assessment. Communicates pain assessments/observations to SNF staff	Utilize tools (shown on following pages) to assess pain on an ongoing basis and communicate observations via established channels
	Is available as resource to SNF staff 24 hours-a-day, 7 days-a-week	
Implements changes in resident's treatment as ordered by physician	Communicates with resident's physician or hospice physician for orders or changes in orders for pain and symptoms	
Notifies hospice of any changes made by physician, written and orally	Notifies SNF staff re: orders from physician or changes in orders from physician, orally and written	

SNF STAFF	HOSPICE STAFF	JOINT STAFF
Follows the agreed procedure for documenting and ordering medications. Makes available the medication record for review by hospice nurse	Provides or designates a system to be used to order medications related to pain and symptom management and communicates procedure to SNF staff. Assesses SNF staff's ability to manage hospice resident's pain and symptoms	
Participates in educational offerings	Provides education on pain and symptom management	Share knowledge gained by caring for terminally ill residents

PAIN ASSESSMENT GUIDE

Where is the pain?
Intensity (0-10)
Words to Describe Pain/Discomfort:

Aching	Throbbing	Shooting
Stabbing	Gnawing	Sharp
Tender	Burning	Exhausting
Tiring	Penetrating	Nagging
Numb	Miserable	Unbearable
Dull	Radiating	

Words to Describe Pain in Other Languages:

itami	Japanese
tong	Chinese
dau	Vietnamese
dolor	Spanish
duloeur	French
bolno	Russian

Duration (constant or intermittent)
What relieves the pain?
What increases the pain?
How long has the pain been a problem?
How does pain affect:

- Sleep
- Appetite
- Energy
- Mood
- Activity
- Relationships

Other symptoms:

- Nausea and vomiting
- Constipation
- Pruritis
- Urinary retention
- Sedation

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SYMPTOM MANAGEMENT

Hospice patients frequently experience distressing non-pain symptoms during the last days and months of their lives. Although assessment and management of pain has received more attention, non-pain symptoms can be just as, if not more, troubling for both the dying patients and their caregivers.

Steps to remember when treating non-pain symptoms are:

* Completion of thorough history and physical
* Careful assessment of each symptom
* Use of effective doses of medication
* Patient and family education
* Continual reassessment

To help with treatment of non-pain symptoms refer to:

Symptom Management Algorithms for Palliative Care by Linda Wrede-Seaman, M.D.

LOSS AND GRIEF SERVICES

Available to family and significant others from admission and for up to 1 year following the death of the patient.

	SNF	HOSPICE	JOINT
FAMILY	- Gives hospice input and info re: coping, support, anticipatory grieving by family and participates with hospice in providing support and services primarily prior to and at the time of death.	- Does ongoing risk assessment starting on admissions: coping, support, etc. - Explains and offers grief support, individual or group - Provides info, education and community resources	- Joint care planning addresses bereavement risk
OTHER RESIDENTS	- Provides grief support and services	- Provides grief education and support and identifies community resources as needed	- Assess need for hospice to provide grief support
SNF STAFF	- Provides grief support and services	- Provides grief education and support and identifies community resources as needed	- Assess need for hospice to provide grief support

DEATH

	SNF	HOSPICE	JOINT
IMMINENT DEATH	- Calls hospice to inform of imminent death	- Makes visit to dying patient as needed - Supports family as needed	- Determine who will call family - Determine care/support needs
DEATH	- Destroys medications as per facility protocol - Follows SNF post-death protocol - Notifies Accounting Dept.	- Makes death visit and assists with arrangements (calls to physician, mortuary, coroner) as determined - Follows hospice protocols re: documentation - Manages extreme psychosocial response by family by referring to MSW or chaplain - Refers family/caregivers to bereavement program - Notifies hospice and team members of death	- Determine who notifies physician, mortuary, and coroner, per county procedure - Support family members - Support staff - Follow SNF protocol for dealing with difficult behaviors

REVOCATION/DISENROLLMENT/TRANSFER

	SNF	HOSPICE	JOINT
REVOCATION			
Hospice Benefit patient elects curative treatment or no longer wants hospice	- Notifies patient/family of room change, if applicable - Notifies patient/family of any new financial responsibilities - Assesses and evaluates need for revised care plan	- Gets revoke form signed by patient/family and physician - Notifies SNF Accounting Department of revocation - Provides patient/family with info on community resources	- Discuss revocation and care implications - Write discharge plan and summary
DISENROLLMENT FROM HOSPICE BENEFIT			
Hospice Benefit patient no longer meets hospice criteria or hospice demonstrates other grounds for discharge	- Notifies patient/family of room change, if applicable - Notifies patient/family of any new financial responsibilities - Assesses and evaluates need for revised care plan	- Consults with physician regarding recertification - Notifies SNF Accounting Dept. of disenrollment - Provides patient/family with info on community resources	- Discuss discharge and care implications - Write discharge plan and summary
TRANSFER			
Patient moves out of service area, patient wants another hospice in same area, patient moves to new care setting		- Facilitates transfer to new hospice or care setting, per protocol - Arranges transportation, if needed	- Discuss discharge and care implications - Write discharge plan and summary
CHANGE IN SITE OF CARE			
	- Assist patient/family in transfer per protocol	- Facilitates transfer to facility per hospice protocol - Arrange transportation, if needed	- SNF and hospice discuss change - Reflect change in care plan or DC summary

APPENDICES

MANAGING PAIN IN NURSING HOME RESIDENTS

Developed by the Colorado Medical Directors Association, the Ad Hoc Task Force on Chronic Pain in Long Term Care Residents, and the Colorado Department of Public Health and Environment.

Purpose: To provide nursing facilities with some generally-accepted guidelines and tools for improving chronic pain management in nursing home residents.

All definitions of pain suggest that it is a complex phenomenon composed of sensory experiences that include time, space, intensity, emotion, cognition and motivation. Pain is an unpleasant phenomenon that is uniquely experienced by each individual; it cannot be adequately defined, identified or measured by the observer. (McCance & Huether, 1994; p. 439.)

Medicinal therapies can usually control 90-95% of physical pain symptoms, but do not necessarily always help with pain's impactual/residual feelings of suffering which include helplessness, lack of self-control and fear. These feelings are experienced to a magnified degree by residents in nursing homes, for whom pain is but one of many exacerbating factors present in this population.

Studies and experience have identified these general barriers to effective pain management: lack of identification of pain relief as a priority in patient care; insufficient knowledge of pain relief among health care professionals; a system which fails to hold health care professionals accountable for pain relief; lack of institutional policies to deal with poor pain treatment outcomes; beliefs and myths about addiction, tolerance, dependence and narcotic side effects.

Other barriers in pain management unique to the long term care environment have been identified as nurses' fear of placing too many calls to the physician; fear among staff that their assessments of resident pain may be inadequate to merit taking action; nurses' fear of the possibility of regulatory reprisal, fear of doing harm by over-sedation and, in particular, the threat of respiratory depression; concern about conflict between rehabilitative therapies and sedative effect of pain medication; and delays in receiving medication from contract pharmacies.

OBRA Requirements:

The Omnibus Budget Reconciliation Act (OBRA'87) requires nursing homes to individualize care in ways that assist each resident to attain or maintain his or her highest practicable physical, mental and psychosocial well-being. A corollary of this requirement

is that long term care residents have the right to appropriate and effective pain management since pain can be a major limiting factor in the quality of their lives.

This protocol provides a basis for providing improved pain management in nursing home facilities throughout Colorado by providing a description of the types of conditions/illnesses and attendant pain that nursing home residents experience; behaviors which may be manifestations of that pain; some tools for providing better assessment of pain; suggested medications and adjunctive therapies for pain treatment.

"**Concerns about regulatory scrutiny should not make physicians who follow appropriate guidelines reluctant to prescribe or administer substances for patients with a legitimate medical need for them."- Colorado Board of Medical Examiners--Guidelines for Prescribing Controlled Substances for Intractable Pain (Adopted 05/16/96)**

Protocol for Managing Pain in Residents of Long Term Care Facilities

1. **Profile of the Nursing Home Resident:** Residents most often have multiple medical problems, many of which are accompanied by chronic and/or intractable pain. More often than not, the pain accompanying these conditions is neither diagnosed nor treated effectively. Some of the more common ailments nursing home residents suffer from are:

    Arthritis, osteoarthritis, rheumatoid arthritis
    Osteoporosis and associated fractures
    Pressure sores
    Neuropathic pain
    Cancers
    Pain associated with contractures
    Headache pain
    Ischemic pain
    Pain from other medical causes including ulcer disease, urinary tract infection, angina

    Residents may have difficulty verbalizing their pain due to secondary cognitive or neurological conditions and/or cultural factors. Residents may have "learned to live with their pain". In many residents, untreated pain is exhibited as behaviors which may include:

Depression
Anxiety
Withdrawal
Decrease in appetite
Decrease in activities
Insomnia
Agitation such as yelling, pacing, striking out
Refusal to participate in Activities of Daily Living

Unfortunately, these behaviors are often seen as arising from mental disorders including generalized anxiety disorder, organic mental syndromes (delirium, dementia) and other cognitive disorders. In such cases, residents may receive psychoactive drugs for treatment, rather than treatment for the underlying pain, which causes or exacerbates certain of these behaviors. The underlying causes of pain must first be identified and then treated appropriately.

2. **Federal Guidelines on the Use of Psychoactive Medications:** Federal guidelines require that the use of psychoactive medications be carefully monitored and that physicians provide a continuing rationale for their use as clinically appropriate. **(See Guidance to Surveyors--Long Term Care Facilities, tag number F329)**. Failure to follow recommended steps may result in a facility's being cited for non-compliance with the regulations. Regulations for use of psychoactive drugs prohibit excessive dose, excessive duration, inadequate monitoring, inadequate indications for use or use which creates adverse consequences. **(See F483.25 (1) (1) regarding "unnecessary" drug therapies in the Guidance to Surveyors.)** Treatment for pain may be a factor which can reduce or eliminate use of psychoactive medications and pain must be ruled out prior to using psychoactive agents.

3. **Assessment and Care Planning:** The long term care setting offers an appropriate environment in which to manage pain more effectively. Assessment and care planning are linked with input from the resident, family members and his/her team of caregivers on a regular basis during care planning meetings. These meetings represent an opportunity to explore what the resident is experiencing in regard to pain, either through discussion with the resident and/or family members. It is important for the long term care team to discuss issues, including pain management, with the resident and the family, with participation by the physician.

4. **The Four Components of Pain:**

P Physical problems, often multiple, must be specifically diagnosed and treated.

A Anxiety, anger and depression are critical components of real pain that must be addressed by the whole team.

I Interpersonal problems--social problems, financial stress, family tensions.

N Non-acceptance or spiritual distress can cause severe suffering that opioids won't help.

5. **Mapping/Assessing for Pain:** The following areas should be covered in a thorough assessment of pain:

Location: Using a drawing or having the patient point to body areas, try to pinpoint pain locations.

Intensity: A variety of measures, from numbers to faces that express pain, can be used. This helps objectify the pain and adds consistency to ongoing assessment. Whatever scale is used, be sure it makes sense to the patient.

Quality: Ask the patient to describe the pain **in his/her own words.** Expressions that utilize "burning" or "shooting" probably indicate neuropathic pain, whereas "aching" or "cramping" may indicate visceral pain, and somatic pain may be described as "throbbing", "aching", or "pressure."

Onset, duration, variations, rhythms: Ask how long the patient has had this pain, has its intensity increased, decreased? When does pain occur?

Manner of expressing pain: In patients who cannot communicate pain verbally, these expressions are very important and family members can help interpret expressions and gestures.

What relieves pain? Individuals troubled with pain prior to admission should be asked what remedies worked successfully at home. Something simple like heat or listening to music may be added to the care plan.

What causes or increases pain? This information can be valuable in anticipating and managing pain proactively.

Effects of pain: Many of the behaviors seen in nursing home residents may be the result of pain, rather than generalized dysfunction. Cover such areas as: accompanying symptoms, sleep, appetite, physical activity, relationship/involvement with others, emotion, concentration.

Based on the resident's (or family members') answers to these questions, a care plan for pain may be developed. (Section 4 and 5 above, were adapted from materials developed by the American Academy of Hospice and Palliative Medicine, AAHPM.)
Continual assessment and reassessment should be the primary factor in effective pain management!

6. **A Comprehensive Approach to Pain Management:** Although there is no single approach to effective pain management, one should take into account the stage of the disease, concurrent medical conditions, characteristics of pain, and psychological and cultural characteristics of the patient. Effective management of pain also requires ongoing reassessment of the pain and treatment effectiveness. (From the Clinical Practice Guideline, Number 9, "Management of Cancer Pain", U.S. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research.)

7. **Opioid Analgesics May Be Added to Non-Opioids to Manage Acute and Chronic Pain:** For pain that does not respond to non-opioids alone, opioid analgesics may be added to non-opioids to manage acute and chronic pain. Many of these opioids are marketed with a non-opioid and it is the latter component that limits the dose. Caution must be used with acetaminophen and aspirin in these combination medications to prevent toxicity.

8. **World Health Organization's Three-Step Analgesic Ladder (1990):**
Pain
STEP ONE - FOR MILD TO MODERATE PAIN

Nonopioid	Examples:	Salicylate
		Acetaminophen
		NSAID
		Others
+Adjuvant medica	Examples:	Antispasmodics
		Anticonvulsants
		Muscle Relaxants
		Anxiolytics
		Tricyclic Antidepressants
		Steroids
		Others

STEP TWO - PAIN PERSISTS OR INCREASES

SECOND STEP - FOR MILD TO MODERATE PAIN

Opioid	Examples:	Codeine Hydrocodone Oxycodone Others

+Nonopioid - (See Examples in step one above)

+Adjuvant - (See Examples in step one above)

STEP THREE - PAIN PERSISTS OR INCREASES

THIRD STEP - FOR MODERATE TO SEVERE PAIN

Opioid	Examples:	Oxycodone (controlled and instant release) Morphine (controlled and instant release) Hydromorphone Fentanyl Transdermal Others

+Nonopioid - (See examples in step one above)

+Adjuvant - See examples in step one above)

Note: An adjuvant is an agent (or another medication) added to a drug to increase or aid its effect. The "±" symbols indicate that the use of an adjuvant may or may not be added depending on the type of pain being treated. When this non-invasive approach is ineffective, alternative modalities include other routes of drug administration (besides oral), such as topical applications, nerve blocks and ablative neurosurgery.

9. **Dosing:** When pain medications are not effective, it is recommended that individual doses be administered routinely rather than PRN, to avoid "chasing the pain".

10. **Side Effects:** If the step-ladder approach is used, side effects are generally minimal, self limiting and easily treated. The most common side effect of opioid analgesics is constipation and this can be treated with appropriate laxative intervention.

11. **Break-through Pain:** In addition to routine dosing, it is recommended that a PRN order for a supplementary opioid between regular doses be available for break-through pain.

12. **Overcoming Barriers to Pain Management:** Techniques which may be tried include teaching pain assessment skills to staff, correlating knowledge with pain management strategies and using appropriate clinical scenarios, including health care professionals at all levels in the facility.

13. **Non-Pharmacological, Natural Approaches to Pain Management:** These are not substitutes for pharmacological treatment--they are used to enhance the use of pain medications. Here are some options:

- **Relaxation**-eliminates or decreases stress, which is often an important component of severe pain. Pain produces stress which can lead to more production of pain. Examples of relaxation techniques include:

    - Progressive muscle relaxation where one tenses/relaxes large muscle groups
    - Deep abdominal breathing
    - Jaw stretching and relaxing
    - Yawning

- **Biofeedback**-relaxation used in conjunction with a machine that allows one to be more aware of one's physiological responses such as pulse, temperature, and blood pressure. Biofeedback can also be learned without a machine by simply learning how to self-monitor and alter certain autonomic responses.
- **Guided Visual Imagery**-create and experience positive, peaceful mental pictures in one's own mind which produce relaxation and lessen pain.
- **Hypnosis**-used a great deal with cancer pain.
- **Distraction**-tv, taking walks, talking & visiting, journaling about such topics as health, pain, joy, family.
- **Music**-increases circulation to the brain; increases respirations and muscle strength. Studies find it allows for decreased medication usage.
- **Laughter**-deepens breathing, lowers blood pressure and releases endorphins. Changes mood, reduces anxiety, anger, fear, depression and resentment, all of which are components of chronic pain.
- **Massage**-and similar techniques such as reflexology, therapeutic touch, acupuncture, acupressure are helpful in providing pain relief.
- **Aromatherapy** adds pleasant scents to the environment which positively affect mood and behavior. Derived from natural sources, aromatic substances may be used to calm, sooth, warm, comfort and relax individuals.
- **Vibration, bathing, Cold/Heat treatments**-help relieve chronic pain. Use based on individual preferences for heat or cold.
    - Heat--includes hot packs, moist air, radiant heat
    - Cold--reduces muscle spasm, skin sensitivity, inflammation & joint stiffness. Usually more effective than heat, but a little more uncomfortable to adjust to. Two types of cold therapies: cold pack; ice massage. Note: cold is not to be used where tissue is necrotic or there is poor circulation or malignancy.

ABCs of Pain Management

AHCPR (Agency for Health Care Policy and Research) Guidelines:

A. Ask about pain regularly - assess pain systematically

B .Believe the patient and family in their reports of pain and what relieves it

C. Choose pain control options appropriate for the patient, family, and setting

D. Deliver interventions in a timely, logical, and coordinated fashion

E. Empower patients and their families. Enable patients to control their course to the greatest extent possible.

Opiate Analgesics

"The cornerstone of treatment for pain," Colorado Board of Medical Examiners, 1996

Weak

1. Codeine up to 360 mg Q 24 Hrs

2. Hydrocodone with Acetaminophen (various combinations)
   Vicodin (5 mg Hydrocodone with Acetaminophen 500 mg) 8 Tabs Q 24 Hrs
   Vicodin ES (7.5 mg Hydrocodone with 750 mg Acetaminophen) 5 Tabs Q 24 Hrs
   Lortabs (7.5/500) 8 Tabs Q 24 Hrs
   Lorcet Plus (7.5/650) 6 Tabs Q 24 Hrs

Note:

1. Fixed combination drugs i.e. Tylenol with codeine, Vicodin, Lortabs, Percocet, Percodan, etc. All have ceiling doses due to either (1) Acetaminophen (Tylenol) 4,000 mg Q day, or (2) ASA 3200 mg Q day.

2. Propoxyphene (Darvocet) & Meperidene (Demerol) are contraindiscated in the elderly due to active metabolites, GI & CNS side effects.

Opiate Analgesics

Strong

1. Oxycodone with Acetaminophen

   Percocet/Roxicet (5/325) 12 Q day
   Tylox/Roxilox (5/500) 8 Q day
   Oxycodone with ASA (4.5/325 mg) 10 Q day
   Percodan-Roxiprin (4.5/325 mg) 10 Q day

2. Oxycodone - Oxy IR/Roxidodone Tabs/Oral soln (5 mg)
   Roxicodone Intensol 20 mg/ml
   Oxycontin Tabs (controlled release) 10, 20, 40, & 80 mg
   NO CEILING DOSE

3. Morphine - Tabs, 10, 15, 30 mg
Controlled release, 15, 30, 60, 100, 200 mg, MS Contin
Oramorph
Oral solution, 20 mg/ml, MSIR, Rosanol
Supp 5, 10, 20, 30 mg
Parenteral 15 mg/ml
NO CEILING DOSE

4. Hydromorphone (Diluadid) - Tabs, 1, 2, 3, 4, & 8 mg
Supp 3 mg
Parenteral 2, 10 mg/ml

5. Duragesic (Fentanyl) Transdermal 25, 50, 75, 100 mcg Q 48-72 Hrs, Max Dose 600 mcg

Give analgesics in doses high enough and frequent enough to control the pain.

Treat the pain before it returns. This involves maintaining constant blood levels of the analgesic at all times and is achieved by giving the medication around the clock rather than "PRN."

TYPES OF PAIN AND TREATMENT MODALITIES

1. **Bone Pain**

Usually found in arthritis, degenerative joint disease, osteoporosis and associated fractures, contractures, bony metastasis from cancer of prostate, kidney, rectum, lung, and breast.

Suggested Drug Regimen:

NSAIDS are treatment of choice with the understanding that in the elderly the incidence of adverse effects including gastrointestinal bleeding, edema, confusion, exacerbation of CHF, and renal failure are more frequent. NSAIDS such as ibuprofen are protein bound, in the frail elderly protein stores are frequently depleted and hence lower doses should be used.

Opiate analgesics can be effective. Topical analgesic balms and ointments have had some efficacy.

Non-pharmacologic management should be considered concomitant with pharmacologic treatment. Restorative programs to maintain strength and flexibility are important. Massage therapy can promote relaxation and relieve muscle spasm associated with the pain. Body positioning and seating should be reviewed.

- NSAIDS (Table 2 Acetaminophen and nonsteroidal anti-inflammatory drugs, AGS Clinical Practice Guidelines) Chronic use of ibuprophen dosing of 400 mg tid recommended (Unipac 3)
- Opiate analgesia (See opiate analgesic section of this document)
- Calcitonin nasal spray 200 IU daily or subcutaneous 100 IU daily
- Steroids - Prednisone 2.5 - 5.0 mg daily
  Decadron 4 mg - 16 mg daily (devided dosing qid)

2. **Smooth Muscle Spasm Pain**

Occurs where smooth muscle is found in large quantities. This type of pain is found in MS, and cancers of the:
Colon
Rectum
Bladder
Pancreas
Biliary tract
Stomach

Use of anticholinergic agents in the elderly are associated with dry mouth interfering with oral intake, constipation, urinary retention, confusion, falls.

Usually this pain is episodic

- Opiate analgesics
- Belladona and opium (B&O) suppositories q 6 hour (opium 30mg or 60mg either with 16.5 mg belladona)
- Tincture of opium 10-20 drops q 4 hours
- Oxybutinin 5 mg tid
- Hycosamine (Levsin) 0.125 mg po or sl q4-6 hours
- Scopalamine (Transderm scop) 1-2 patches q 3d

1. **Neuropathic pain**

Quality described as “numbness, burning, pins and needles, or horrible”.

The involved extremity shows a marked hypersensitivity to even the slightest touch.

Usually found in trigeminal neuralgias, post herpetic neuralgia, diabetic neuropathy, peripheral neuropathy, and cancer involving brachial plexus, lumbar or sacral plexus and brain tumors, post chemotherapy neuropathy.

Suggested drug regimen:

Adjuvants

- Antidepressent
  - Tricyclics — Nortriptyline 10-50 mg daily; Desipramine 25-50 mg daily; Amitriptyline 10mg-25mg not first line due to anticholinergic side effects; Doxepin 10-100mg po qhs, anticholinergic, useful in those individuals with complaints of puritis
  - SSRI — not generally effective; Paroxitene 10-20 mg daily only SSRI shown to have any efficacy
  - Misc — Trazadone 25-150mg qhs

– Anticonvulsants

Carbamezepine (Tegretol) 100-200 mg bid-tid

Valproic acid (Depakote) 200 mg tid

Gabapentin 100mg bid-tid
Clonazepam 0.25-0.5 mg daily

- Miscellaneous — Lioresal 5-20 mg tid-qid
  Prednisone 5-40 mg daily

2. **Somatic and visceral pain**
   Quality described as overall body or organ pain

   Suggested Drug Regimen:

   Opiate analgesia most effective

3. Voluntary Muscle Spasm with Associated Rigidity or Spasticity:
   Pain is usually episodic and very severe. Demonstrated signs are arching of the back and crying out by the patient.

   This pain syndrome is found: Multiple sclerosis, pain associated with cord injury or stenosis, intracranial neoplasms, and tumors that invade the cervical spine with cord compression.

   Suggested Drug Regimen:

   Opiate analgesia
   - Lorazapam .5-1mg qid
   - Diazepam 2-5mg qid
   - Lioresal 5-10mg tid-qid

RESOURCES FOR PAIN AND SYMPTOM MANAGEMENT

AHCPR Guidelines: *Management of Cancer Pain Adults*, Quick Reference Guide for Clinicians

AHCPR Guidelines: *Pressure Ulcer Treatment*, Quick Reference Guide for Clinicians

Colorado Department of Public Health and Environment: *Managing Pain in Nursing Home Residents:* Developed by the Colorado Medical Directors Association, the Ad Hoc Task Force on Intractable Pain in Long Term Care Residents and the Colorado Department of Public Health and Environment.

Symptom Management Algorithms for Palliative Care: First Edition, Linda Wrede-Seaman, M.D.

STATUTORY AND REGULATORY REQUIREMENTS

SUBJECT	MEDICARE HOSPICE BENEFIT	STATE LICENSE	LTC
Statutory Basis	42 CFR 418.1	Chapter XXI	
Definitions	42 CFR 418.3	Chapter 1	
Eligibility	42 CFR 418.20	Chapter 6	
Election	42 CFR 418.21/418.24		
Certification	42 CFR 418.22		
Revoking or changing the designated hospice	42 CFR 418.28/418.24	Chapter 6.2/ 5.1.2	42 CFR 483.12
Core Services	42 CFR 418.50/418.80 SOM 2080	Chapter 1.6	
Coverage Regulations	42 CFR 418.200 Requirements for coverage 42 CFR 418.202 Covered Services	Chapter 1.1	42 CFR 483.11 (c) (b) (1)
Levels of Care	42 CFR 418.204 Special coverage requirements. 42 CFR 418.302 Payment Procedures (1) routine home care (2) continuous home care (3) inpatient respite care (4) general inpatient care	Chapter 4/7/8/9/14	42 CFR 483.30
Emergency Care	42 CR 418.50 General provisions. 42 CFR 418.204 Periods of Crises	Chapter 14.3/ 14.11	
Medications, DME, Supplies	42 CFR 418.50 (b)(1)(2) General Provisions. 42 CFR 418.96 Medical Supplies. 42 CFR 418.202 (f) Covered services	Chapter 11	42 CFR 483.11 (c) (8) (i)
Discharge	42 CFR 418.28 Revoking. 42 CFR 418.60 Continuation of care	Chapter 1.10/ 4.1.2 (3)	
Death			42 CFR 483.10 (b)(11)6

SUBJECT	MEDICARE	STATE LICENSE	LTC
Bereavement	42 CFR 418.50 General Provision. 42 CFR 418.88 Bereavement Counseling	Chapter 7.7	
Care Planning	42 CFR 418.58	Chapter 4.1.2(6)/ 5.1.2 (2)	42 CFR 483.20 (d)/ 483.25
Joint Care Planning	42 CFR 418.56 Professional Management. 42 CFR 418.58 Plan of Care	Chapter 7	42 CFR 483.20 (b) (7)/ 483.20 (c) (i)
Medical Record Management	42 CFR 418.74	Chapter 12	42 CFR 483.20 (e) (i)
Pain and Symptom Management	42 CFR 418.58 (c) Plan of Care	Chapter 6.12 (12)	42 CFR 483.25
Dispute Resolution	42 CFR 418.66 QA. 418.62 Informal Consent	Chapter 5.1.2 (6)/ 4.1.2 (4)	42 CFR 483.10 (f)
Advance Directives	SOM 2087		42 CFR 483.10 (b) (4)
Professional Management	42 CFR 418.56 SOM 2082	Chapter 2.3	
Report Occurrences		Chapter II-Licensure 25-1-124 (2) C.R.S.	42 CFR 483.10 (b)(11) (B)