PATIENT-RELATED CONSIDERATIONS

The following is a list of the most common patient-related considerations a clinician evaluates when formulating plans and beginning care. This alphabetical list is not all-inclusive; other considerations may apply, such as the hospice patient caseload and availability of services or other resources. Many of these factors are interrelated.

- Absence of caregiver
- Activities of daily living (ADL) limitations
- Adaptive or assistive devices
- Behavioral or mental disorders
- Belief systems
- Caregiver support/willingness/availability
- Chemical or drug problems (for example, alcoholism)
- Chronic illness(es)
- Clinician assessment and reassessment findings
- Clinician diagnoses
- Cognitive function
- Communication
- Compliance/noncompliance
- Coping skills
- Culture
- Directives
- Disabilities
- Discharge plan
- Educational level/barriers
- Emergency plan
- Environment of care
- Family
- Fatigue
- Functional limitations
- Goals/expected outcomes
- Health literacy (patient/family)
- History
- Home medical equipment (in place and needs)
- Independence
- Instrumental activities of daily living (IADLs)
- Knowledge of emergency procedures
- Language barriers
- Learning needs
- Loss of significant other
- Medications (number, type, interactions)
- Mobility
- Mood (for example, grief, depression, loneliness)
- Motivation
- Nutritional status
- Orthotic needs
- Pain
- Parenting
- Pathology
- Physical assessment findings
- Polypharmacy
- Potential for further complications

- Prognosis
- Psychopathology
- Psychosocial needs
- Reason for hospice referral
- Reason for prior hospitalizations
- Rehabilitative needs
- Resources (for example, financial, human)
- Rights
- Risk factors
- Safety
- Self-care status
- Skin integrity
- Social factors
- Social supports
- Socioeconomic condition
- Spiritual comfort/needs
- Stability
- Support system
- Swallowing
- Symptom management
- Values
- Voice

PATIENT DEATH

The patient's POC is individualized to provide interventions for comfort and quality of life with the goal of a peaceful death. The RN visits the patient and family at the time of death for the purposes of:

- Pronouncing death (nurses should check their state regulations for death pronouncement guidance)
- Contacting the hospice physician for a certification of death
- Comforting family members
- Providing education and assistance with drug disposal
- Contacting the funeral home for body pickup

A social worker or spiritual care counselor may be needed or requested on death visits depending on the family's needs and wishes. The hospice team should be aware of and honor any death rituals or ceremonies the family wants to commence at the time of the patient's death.

CARE PLANNING AND IDG CULTURAL COMPETENCY

The end-of-life process is a momentous experience for a patient and family, and it can be challenging for the IDG to individualize care related to the cultural and religious beliefs of today's diverse population. A hospice team member's challenges can be further influenced by the amount of training and experience in cultural diversity and his or her comfort level in discussing the topic.

Cultural competency can be characterized as continual active engagement through the process of cultural awareness, cultural knowledge, cultural skills, cultural collaboration, and cultural encounters. Cultural awareness and competency of the IDG ensures the provision of individualized hospice care within the cultural context of the patient (Coolen, 2012).

The IDG must have sufficient knowledge, understanding, and recognition of the specific influences that culture has on a patient's and family's behavior, attitudes, preferences, and decisions related to end-of-life care. One cannot make assumptions about a patient's/family's beliefs; it is important to determine through assessment and conversation what their beliefs are and how they will affect the POC. Cultural and religious beliefs could affect symptom management, communication, and the disposition of the patient's body at the time of death. Assessment of cultural and religious beliefs should be part of the comprehensive assessment for the IDG and guide the collaborative care planning process between the IDG, the patient, and the family (Coolen, 2012).

CASE STUDY: ELIGIBILITY AND THE PLAN OF CARE

Mr. Walsh is a 72-year old male who has the diagnosis of congestive heart failure, coronary artery disease, and ischemic cardiomyopathy. He is cared for at home by his wife, who is 70 years old and in fairly good

health. Mr. Walsh had five hospitalizations for symptom exacerbations in the past year, which has caused loss of independence in activities of daily living, episodes of syncope, decreased appetite and ambulation, increased shortness of breath, and generalized weakness and debilitation. He has gained 15–20 pounds in the past 2 months, which has limited his activity to going from the bed to the chair or the commode chair. Mr. Walsh is prescribed 2 liters of oxygen. He has shortness of breath, intermittent chest pain (5 out of 10 on a 0–10 pain measurement scale) upon moderate exertion that is relieved with rest and nitroglycerin, 2+ pitting edema in bilateral lower extremities, a cardiac ejection fraction score of 35%, and a Palliative Performance Scale (PPS) score of 30. Mr. Walsh is not medically eligible for any aggressive treatments or surgery, and his physician has been managing his symptoms through drug therapy.

Mrs. Walsh has taken excellent care of her husband, but they both believe they need additional help because Mr. Walsh's condition is deteriorating. Both Mr. and Mrs. Walsh want to keep him at home, comfortable, with the best quality of life possible, and to avoid further hospitalizations in the future. They are people of faith and receive support from their local church in the form of parish visitors, visits from their minister, and occasional potluck deliveries. Mr. Walsh appears downhearted and withdrawn and has verbalized his fear about dying and leaving his wife alone.

1. Is Mr. Walsh eligible for hospice care? Why?

   Although the hospice physician makes the determination of eligibility, Mr. Walsh has been referred at the right time in his disease trajectory for hospice evaluation. His frequent hospitalizations in the past year, his weight gain, and his PPS score of 30 indicate the progression of his disease and his decline and appropriateness for a hospice evaluation.

2. The hospice physician determined that Mr. Walsh is eligible for hospice services. The hospice interdisciplinary hospice team completed a comprehensive assessment, and Mr. Walsh's POC was developed. What considerations does the team need to address in the POC?

The following issues should be addressed in Mr. Walsh's initial POC and in updates to his POC as long as they remain problems:

- Pain management
- Other symptom management (SOB, syncope, edema, weakness, weight gain)
- Functionality (ability to perform ADLs, ambulation)
- Safety (Mr. Walsh is a fall risk related to his syncope, weakness, SOB, edema, and pain medication)

3. What do you identify as the main goals in Mr. Walsh's POC?

   The following would be important to address in the goals of care for Mr. Walsh. Goals should be measureable:

   - Management of the disease process in the patient's location of choice, his home.
   - Medication management. (The hospice physician recommends that Mr. Walsh discontinue taking his statin drugs because they are no longer medically necessary at this stage of his disease.)
   - Pain management. (The goal should be developed based on what Mr. Walsh wants his pain level to be.)
   - Shortness of breath management. (The goal should be developed based on what Mr. Walsh wants his comfort level to be.)
   - Measures for reduction of syncope and edema.
   - Fall safety measures and education for the patient and family.
   - Social work intervention for counseling related to Mr. Walsh's emotional state and planning for post death.
   - Spiritual care coordination with Mr. Walsh's minister directed toward life closure and support for the patient and family.