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IN THIS ISSUE

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It's 11 o'clock at night — Do you know where your medications are?

Take steps to prevent employee and family theft of drugs

A hospice nurse in Colorado was arrested in July for using a patient's name to obtain pain medication. The nurse also was charged in November for using a physician's name along with patient names to forge prescriptions for more than 4,000 pain pills.

In Louisiana, the staff members of Agape Hospice in Minden, reported a family member this year for stealing liquid morphine that belonged to her mother-in-law, the hospice patient.

Dealing with employees and family members or friends of the patient who might divert medication from patients is a critical issue for all hospices, says **Jane Garrett**, RN, MHSA, director of consulting services for Weatherbee Resources, a hospice consulting firm in Hyannis, MA. Although many hospice programs have policies in place to identify and handle drug diversion, it is critical to keep staff members aware of the policies and the agency's intent to enforce them, Garrett says.

"Hospice employees have open access to narcotics, they work without

EXECUTIVE SUMMARY

Most hospices have put protocols and policies into place to reduce the likelihood of drug theft by employees and by family members or friends of patients.

- Thorough background check, reference verification, and drug test prior to hiring a new employee is critical. Make sure all employees know that the agency will conduct random drug tests during employment.
- Educate staff members about indicators that someone might be using or stealing drugs.
- Deliver no more than two weeks of medication at one time or no more than one week at a time if there is a suspicion that a family member might steal drugs.
- Have nurses count pills, bottles, and patches at every visit.

direct supervision, and they experience a high level of work-related stress," she says. "The combination of all of these issues increases the risk of employees stealing drugs."

The first step to prevention of employee theft is thorough screening of all potential employees before they are hired, Garrett says. In addition to background checks and reference verifications, include drug testing as part of the pre-employment process, she says. "An agency should expect every potential employee to undergo a drug test before employment, and an agency should put in writing that employees can be required to take a drug test at any random point during employment," she explains. "Although most agencies won't request a drug test unless there are suspicions about an employee, every employee should understand that random tests are part of the condition of employment."

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In addition to being prepared to identify employees who might be stealing drugs from patients, all staff members need to recognize the threat of the patient's family or friends stealing medication, says **Debbie Williams**, RN, CHPC, administrator at Agape Hospice in Minden, LA.

"We have strict protocols in place to count medications at each visit and to count and dispose of medications at the time of the patient's death," explains Williams. In the case of the family member stealing liquid morphine, the nurse was accounting for the medications after the patient died. "The daughter-in-law offered to get the liquid morphine for the nurse, but when the nurse followed her to the other room, she saw the daughter-in-law trying to pour the morphine from the medication bottle into another container," she says. "We've had family members steal medication in the past, but never directly in front of us."

Agape staff members are trained on the signs that might indicate medication diversion by family members or other people in the home, Williams says. "If a patient is using more pain medication than usual or if the patient is experiencing pain even though the medication appears to be used, it might indicate that the patient is not getting the medication," she says. "We only deliver two weeks of medication at a time, and we monitor the patient closely to be sure that he or she is comfortable."

In some cases, when the patient is competent to handle medications, a lockbox will be placed in the home for the medications, Williams adds. "The patient and the nurse have a key to box, but other family members, guests, or friends can't open it," she says. **(For other tips on family members who steal, see p. 3.)**

Also, be sure that staff members know some of the techniques that can be used to steal medication so they can take steps to prevent family members from stealing, says Garrett. "Fentanyl patches are often used in hospice but most people don't realize that 28% to 44% of the medication is still in the patch after 72 hours, the typical amount of time that a patch is used before a new one is applied," she says. "Someone who wants to steal the medication can place the old patch on the patient, take the new patch and use a needle to withdraw the medication," Garrett says. Because there still is some medication left in the patch, the patient still may receive some benefit, making it hard for the nurse to recognize that an old patch is in place, she explains.

A simple way to ensure that fentanyl patches are not stolen, is to use a felt-tip marker to write the date and time of the patch's placement and

Need More Information?

For more information about medication diversion, contact:

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initial it, suggests Garrett. "Just as a nurse should count remaining pills at every visit, the nurse should also check the patches," she adds. "These are all best practices that should be used for all patients, not just those for whom you suspect a family member stealing drugs," she says.

Be sure to train staff members, especially supervisory staff, on the signs and symptoms that an employee might be using drugs, says Garrett. "Inconsistent quality of work; absences without notice, especially after a weekend or other days off; and excessive number of mistakes are just a few of the signs of a problem," she says. **(For other tips on dealing with employees with drug problems, see story, p. 4.)**

There are many reasons to make sure your hospice policies adequately address medication diversion, says Williams. Not only is it important from a liability standpoint, but also patient care is affected when patients don't get their medications, she points out. "Our priority is to make sure patients are comfortable and if they are not receiving their pain medications, we are not meeting our goal," Williams says. ■

Pay attention to behavior of family members, friends

Lockboxes, limited drug supply discourage theft

A family member's statement that "Dad's pain is really helped by methadone rather than hydrocodone," should serve as a red flag for any hospice nurse, says **Debbie Williams**, RN, CHPC, administrator of Agape Hospice in Minden, LA. Any time a family member or friend of the patient is naming specific drugs to bring into the house, you should be suspicious of drug diversion, she says.

This suspicion doesn't mean a nurse should report the family member immediately, but it does mean the nurse should pay careful attention to what is happening in the home, says Williams. "Give them the benefit of the doubt, but ask questions about medication, be sure to count pills and patches in view of the family member, and talk to the patient about effectiveness of pain control," she says. "Make it obvious that medication is carefully monitored, especially if there are always a lot of family members and friends hanging around."

Jane Garrett, RN, MHSA, director of consulting services for Weatherbee Resources, a hospice consulting firm in Hyannis, MA, says, "It is usually not the primary caregiver who steals medication but other family members or friends who are at the house are more likely to be the suspects if medications are missing."

If the nurse suspects that medication is being diverted from the patient because the number of pills is decreasing but the patient is in pain, a drug test of the patient can be ordered, says Garrett. "You can get a physician's order to test the patient to see if the proper level of medication is in the bloodstream," she explains. "This will give you more proof that the patient isn't receiving the medication."

Williams says, "In one case, the patient was using a lot of narcotics between visits but was still complaining of pain. The nurse suspected theft by a family member but knew the patient would not say anything about the theft." The nurse explained to the patient that because he was using such a high dose of narcotic with no relief, the best way to keep him comfortable would be to admit him to an inpatient unit for intravenous medication. "If possible, we move the patient to a nursing home or inpatient unit if we see signs that the patient is not getting medication, proper food, or appropriate care, and sometimes that is the only way to help," Williams says.

Although her agency only delivers two weeks of medication at a time, there are some patients who receive only one week at a time, Williams says. "If there are fewer pills or patches, it is much easier to monitor and control diversion," she says.

Nurses should know what different medications look like, says Williams. "I've seen family members take a narcotic and substitute with a

different pill," she explains. "Nurses should know what color, consistency, size, and smell different medications have." A pharmacist can be helpful in staff education and identification of medications that nurses don't recognize, Williams says.

At the time of death, it is important that nurses count and document all remaining medications and dispose of them according to guidelines from the Food and Drug Administration (FDA), says Garrett. Narcotics can be mixed with kitty litter or coffee grounds and put into the garbage, or medication can be flushed down the toilet if the label allows, she says. The nurse should have another person witness the disposal and sign the documentation, Garrett says. "This ensures that the hospice accounts for all medication," she says. ■

Use checkpoints to ID employee medication theft

Pharmacy alerts, logbooks are effective tools

There are two ways that the staff at Agape Hospice have identified cases of medication diversion by employees. One involved patients reporting less medication in the bottle than listed on the label. Another involved a nursing home hospice patient who was receiving pain medication on an as-needed basis but was running out of pills before the nurse's next visit.

The most incredible story an employee used to explain missing hydrocodone involved a clean car, says **Debbie Williams**, RN, CHPC, administrator at Agape Hospice in Minden, LA. "The nurse told us she needed another supply of hydrocodone because her husband cleaned out her car and threw out the medication she had left in the car for delivery to a patient the next day," she says.

The medication was reordered and delivered to the patient by another nurse, and Williams began monitoring the nurse that reported the medication thrown out by her husband. "We could not prove anything from the first incident but after seeing some trends that indicated a problem, we terminated her employment," she says.

Agape has several checkpoints in place to discourage employee theft of medication. "Our contract pharmacy notifies us if there is any unusual activity such as nurses who call in frequently to order more medication because the patient ran out," she says. "I will investigate the case to see if there is suspicious activity on the employee's part or if we need to have a physician re-evaluate the patient's medications."

Because the pharmacy delivers medications to the hospice office for the nurses to deliver to patients, the pharmacy employee signs the logbook identifying the medication and patient's name, says Williams. "The nurse signs the logbook verifying the amount of medication when she takes the medication to deliver to the patient, and the patient signs a sheet indicating that the proper amount of medication was delivered," she says.

This same procedure is followed when the medication is delivered directly to a nursing home in which hospice patients are located, says Williams. "Although I prefer that our nurses deliver the medication, some nursing homes require the pharmacy to deliver to them," she says. The logbook has improved medication record keeping and reduced the opportunity for nursing home employees to divert medication, Williams adds. ■

Improve risk assessment for pressure ulcers

Educate aides to ensure success

An Indiana initiative to reduce pressure ulcers throughout all areas of health care has resulted in a reduction of bedsores at more than 160 organizations participating in the project.

With pressure ulcers representing the most commonly reported medical error since Indiana started mandatory reporting in 2006, it made sense to look for ways to increase the identification of the risk of pressure ulcers and improve methods of preventing pressure ulcers, say project participants. A key component of the Indiana Pressure Ulcer Initiative's collaboration between health care providers, which was launched in June 2008 and concluded in August 2009, was the focus on a pressure ulcer risk assessment at admission. At the project's start, only 42.1% of participating agencies indicated that they always performed a pressure ulcer risk assessment within 24 hours of admission. After education and training regarding the use of assessment tools, the percentage of agencies performing a risk assessment within 24 hours of admission grew to 71.4%. **(See p. 6 for other project results.)**

"We joined the initiative because we were seeing

EXECUTIVE SUMMARY

The Indiana Pressure Ulcer Initiative reduced the number of pressure ulcers at more than 160 organizations in a 15-month period. The initiative included a collaborative effort among the providers to share best practices and develop educational materials related to pressure ulcers.

- Aides play a key role in the monitoring of skin condition and early identification of potential problems.
- Standardized tools, such as the Braden Scale, can be used to accurately identify risk levels.
- Intervention guidelines must be available to all staff members to ensure timely prevention or treatment of pressure ulcers.

more patients with wounds," says **Paula J. Long**, RN, CHCE, administrator of Sullivan County Community Hospital Home Health and Hospice in Sullivan, IN. Not all of the wounds her nurses see are pressure ulcers, but she and her staff recognized the need to incorporate some best practices into their protocols to improve care of wounds.

Although her nurses were conducting skin assessments of all patients, they were not assessing the risk of pressure ulcer development in patients, Long says. "One of the first steps we took was to implement the use of the Braden Scale to assess the risk of each patient," she explains. **(For more information on Braden Scale, see resource box, p. 6.)**

In her staff education, Long emphasized the need to base interventions on the scores for each individual category of risk included in the Braden Scale as opposed to the total risk factor score. "A patient may have an overall score that represents a mild risk of developing a pressure ulcer, but the patient's score in the shear and friction category might be severe," she says. "In this case, the nurse needs to focus on reducing the risk in that category."

Interventions include lifting the bed-bound patient, as opposed to sliding the patient, and having the patients wear protective clothing such as socks to minimize friction on heels and feet. "If you only look at the overall score, you will miss opportunities to prevent pressure ulcers," Long adds.

To make it easy for her nurses to have all of the tools such as the Braden Scale, documentation forms, intervention guidelines, and patient education material required for the risk assessment, Long developed a Pressure Ulcer Risk Assessment Packet. "I'm a believer in packaging everything you need in one packet so all the nurse has to do is pick up one envelope," she explains. The prepackaging saves the nurse time and ensures that she can complete the assessment accurately, Long says. **(See p. 6 for description of packet.)**

Because the state-sponsored initiative included different types of health care providers, communication between providers improved, says Long. "By standardizing transfer reports and other information, we are aware of the patient's pressure ulcer risk as they are coming to us for care."

In addition to coordinating communication between providers, the initiative also created online educational programs that staff can access in addition to training provided through their own agencies. "We provided educational courses to all of our nurses and our home health aides," says **Terri Edmiston**, RN, MSN, clinical manager for Parkview Hospital Home Health and Hospice in Huntington, IN. One of the benefits of the pressure ulcer project was the development of tips and training suggestions to make pressure ulcer education more interesting, especially to the aides, she says. **(For educational tips, see p. 7.)** "Our aides are an important component of our pressure ulcer program because they are with the patients more often than the nurses and because they bathe the patients, they have an opportunity to assess the patients' skin for changes," she explains. "We stress the important role they play in the detection of pressure ulcers since they are our 'eyes' on the patient on a day-to-day basis."

A key part of pressure ulcer education is the focus on communicating with other members of the patient care team, points out Edmiston. Not only do nurses talk with patients and their families about how to prevent pressure ulcers and how to monitor skin changes, but also the aides reinforce the teaching. "If an aide notices a change in the skin that a nurse should evaluate, the aide documents the change and calls the nurse," she says. "We are fortunate to have a good relationship with the hospital's wound care nurses, so we always have experts we can call with questions. Not all agencies have this expertise in house."

Tonya L. Gudell, RN, WCC, performance improvement coordinator for St. Elizabeth Regional Health and Hospice in Lafayette, IN, says, "I am receiving a lot more questions from nurses." As the wound care specialist for the agency, Gudell develops and presents the educational session and serves as a consultant to nurses and aides. "I am also seeing a great improvement in documentation," she adds. Not only are nurses regularly using the Braden Scale to assess pressure ulcer risk, but they also are routinely measuring and properly staging wounds, Gudell says. "We

RESOURCES

- **For information on the Indiana State Pressure Ulcer Initiative**, go to the Pressure Ulcer Resource Center at www.in.gov/isdh/24558.htm. The site contains free resources such as the educational program developed by the initiative, links to related organizations and associations, data from the project, and a library of articles and presentations that can be used as resources.
- **For a copy of the Braden Scale**, go to any of the educational modules listed in the Pressure Ulcer Resource Center and click on the "tools" button in the upper right hand corner once you start the module. Course 2: "Preventing Pressure Ulcers: Assessment Process" contains the description of how to use the scale.

really didn't have patients who developed pressure ulcers in our care, but we tell employees that our focus on assessment and proper intervention help us do a better job of keeping patients comfortable and reduce their pain," she explains.

The biggest challenge faced by her agency was data collection, says Gudell. "We needed a better way to monitor pressure ulcers, especially in our hospice since those nurses don't use OASIS [Outcome and Assessment Information Set] like the home health nurses," she explains. Gudell worked with their information technology department to develop a data collection tool that became part of their online documentation system. The tool added text to the nurses' notes to prompt the nurse to include a description of the wound, measurement, and staging. "The new format did require some training, and the data collection is still a work in progress, but we are now able to monitor our progress throughout the agency," Gudell says.

She is happy that her agency participated in the initiative as a way to identify best practices that could be implemented at St. Elizabeth. "Everyone in other agencies has great ideas, and this initiative gave us an opportunity to share with others in order to better care for all patients," Gudell says. ■

Best practices bring reduction of ulcers

The Indiana Pressure Ulcer Initiative's collaborative effort to share education and tools to improve the risk identification, prevention, and treatment of pressure ulcers included more than 160 home health agencies, hospitals, and nursing homes. With the focus on education and sharing best practices among the providers, members of the 15-month first phase of the initiative posted some impressive results that contributed to a drop in reported pressure ulcers throughout the state.

• Always performs risk assessment within 24 hours of admission:
— Prior to participation in initiative, 42.8%;
— After participation in initiative, 71.4%.

• Always performs risk assessment during length of care, at change of condition:
— Prior to participation in initiative, 14.3%;
— After participation in initiative, 57.1%.

• Always communicates results of risk and skin assessments to appropriate staff:
— Prior to participation in initiative, 14.3%;
— After participation in initiative, 28.6%.

• Always includes pressure ulcer training in orientation:
— Prior to participation in initiative, 28.6%;
— After participation in initiative, 71.4%.

• Always includes pressure ulcer training on an ongoing basis:
— Prior to participation in initiative, 0%;
— After participation in initiative, 42.9%.

• Always involves nurses' aides in care planning:
— Prior to participation in initiative, 0%;
— After participation in initiative, 42.9%.

• Always tracks nosocomial ulcers and patients admitted with pressure ulcers:
— Prior to participation in initiative, 14.3%;
— After participation in initiative, 51.1%.

• Uses a multidisciplinary team approach to pressure ulcers:
— Prior to participation in initiative, 57.1%;
— After participation in initiative, 85.7%. ■

Packets make assessments easy for nurses to perform

Nurses at Sullivan County Community Hospital Home Health and Hospice in Sullivan, IN, don't spend time looking for a copy of the Braden Scale, documentation checklists, pressure ulcer intervention guidelines, or teaching tools. They just pick up a pre-packaged envelope and go.

"The best way to make sure a nurse has everything necessary for a pressure ulcer assessment is to

put it together ahead of time," says **Paula J. Long,** RN, CHCE, administrator of the agency. They have two pressure ulcer-related packets. One packet contains tools and information to use for patients who require a risk assessment for pressure ulcers, and the other packet is for patients who already have a pressure ulcer that requires treatment.

Contents of each packet are:

• **Pressure ulcer risk assessment packet:**

— Braden Scale;

— guideline for assessment of skin, lower extremities, medical conditions, medications, and other risk factors associated with pressure ulcers;

— guidelines for interventions based on risk factors, patients goals, and patient input;

— teaching protocol tool to use with patient, family member, or other caregiver;

— care plan with clinical goals.

• **Pressure ulcer packet:**

— process checklist that goes to pressure ulcer team manager and outlines actions and time frame;

— a fax physician communication form specifically for pressure ulcers that the nurse completes to include a description of the ulcer, treatment recommendations, nutritional status, and other information the physician will need to order treatment;

— weekly pressure ulcer record on which the nurse documents details of the wound and the treatment;

— intervention guidelines;

— care plan with clinical goals. ■

Keep education fun for aides

Tips for successful pressure ulcer program

Pressure ulcer education is pretty straightforward for nurses who want up-to-date clinical information that will help them select the best interventions to prevent pressure ulcers and the best treatments to help their patients with ulcers, says **Terri Edmiston**, RN, MSN, clinical manager for Parkview Hospital Home Health and Hospice in Huntington, IN. Finding creative ways to teach aides is a little more of a challenge because you have to make them see how it applies to their patient care responsibilities, Edmiston adds. The more visual and participatory the activity, the more effective it is, she says.

"I have found three demonstrations that make learning fun but reinforce the teaching," says Edmiston. The demonstrations that she incorporates into her aides' pressure ulcer classes are:

• Use colored water to demonstrate the different properties of different barrier creams, suggests Edmiston. "Have an aide apply a cream to her hand, then place the hand in a bowl of colored water," she says. As the aides observe which creams repel water and which absorb water, discuss the specific situations to use each cream and why, she adds.

• Because poor nutrition is an indicator of high risk for pressure ulcers, be sure to discuss reasons for poor eating habits, says Edmiston. Poor vision can affect how attractive a meal might appear to the patient, which will diminish the patient's interest in eating, she says. To demonstrate the situation, she smears petroleum jelly on glasses and then has the aides wear them while she serves them food on colored plates. "I will put blue M&Ms on a blue plate to show how hard it might be to see the food," she says. "I will also have aides wear gloves that are too big to simulate arthritis and have them try to get the food off the plates." These activities help aides understand how they might make food more appealing to their patients, she adds.

• The importance of keeping skin moisturized is demonstrated by placing the dry outer skin of an onion in the bottom of a tube sock and asking the aide to remove it without tearing it, says Edmiston. "This is a very visual demonstration of how important moisturizing the skin is," she points out. ■

Music therapy taken to hospice patients

Add guitars and other musical instruments to the tools caregivers can use to help patients in hospice care. That's what University of Alabama (UA) senior **Sarah Pitts** found when she brought her music therapy skills to patients in Hospice of West Alabama in Tuscaloosa.

"We've gotten a lot of encouraging comments from families," says Pitts, a music therapy major from Memphis, TN. "Sometimes families who hear us say, 'Can you come and play a song or two?' Even one session with a music therapist can reduce pain and anxiety in this setting."

Pitts' experiences in hospice care inspired her to research how students doing clinical practice in

hospices react to the experience. She won the E. Thayer Gaston Award for outstanding student paper, and she continues her survey research with her mentor, **Andrea Cevasco**, MMEd, MT, PhD, assistant professor of music at UA. The resulting article is titled "A survey of music therapy students' practical experiences in hospice and palliative care." Part of Pitts' motivation for pursuing this research was the lack of resources she could draw on when working with hospice patients.

"In this particular area, there's not a lot of research to go to as a student," Pitts says. "The emotional component and goals are a little bit different from other clinical settings. You're improving the quality of life or helping with the changing needs of the patient, and you're also helping to provide closure and support for families. For students, It's a very difficult thing to handle."

Music therapy, taught in a four-year program with a six-month internship following coursework, combines work in music, psychology, and other disciplines. It has many applications in a wide variety of environments and a broad range of clients, from premature babies to people needing physical or psychological therapy. The key is to get a patient moving or involved with the music, perhaps singing along or playing an instrument as the therapist plays on the guitar.

"It might be that we have kids playing drums," Cevasco says. "They reach and extend their arms out, which might help a child who has cerebral palsy whose muscles may be tense. Reaching out and playing the drum is fun and enjoyable, but the therapy also is important, because the child is using specific muscles that might normally be painful to use during physical therapy and daily exercises."

The music therapy program has had a relationship with Hospice of West Alabama since 2007. Cevasco says one of her students came to her asking if she could work in hospice for her clinical experience, so Cevasco set it up. She notes that it takes a student with a particular interest in working with patients at the end of life to follow this path.

"I don't force the students, but if they're interested in it, we move in that direction," Cevasco says. "As an undergrad myself, I never pictured myself doing any kind of hospice work. Personally, I wasn't ready to deal with death and dying as an 18- to 22-year-old."

Pitts chose to work with hospice patients because of a personal experience that brought her face to face with mortality. "I've also faced death in someone my own age," she says. "Last year, my brother dealt with a potentially fatal health condition. I understand you need someone to support you at that time. As a therapist, I can be there for people when they face very difficult times in their lives."

Her work with the hospice patients varied. Two clients became well enough that they could leave hospice. In one case, Pitts, at the request of a family who had heard her play, did perform music while a patient died.

"The family requested a few songs, and I played straight through," Pitts says. "I added a couple of songs of my own that I felt were appropriate. I felt like what she [the patient] needed was slowing-down music as her breathing slowed. I got to be there as she was dying, and we all got a chance to be a part of that."

Music still matters

Patients in hospice care, depending on their illnesses, might not be able to participate in the playing of music for therapy, Pitts says. However, music still matters. In her clinical experience, Pitts says she found a wide range of music to be helpful in working with hospice patients and families. Hymns, including "Amazing Grace," are often requested, but patients frequently want to hear other styles of music as well.

"Typically, when we go in, I have a list of songs I know," she says. "I prepare songs from different genres: hymns, show tunes, or sometimes songs from the '30s, '40s and '50s, which may be from the patients' young adult years. If the patient isn't responsive and awake, I find out what the family wants me to play. If I'm in a situation where the patient is actively dying, I just play a few songs, and I'll be a very passive member of the room. The family is just there saying goodbye, and I'm providing an atmosphere for that."

For Pitts, this kind of therapy represents a way she can use her deep background in music to help people. She ended up choosing to pursue music therapy in college, particularly once she became involved in the clinical part of the degree program. "I grew up in a very musical family," Pitts says. "I had piano lessons, and I started singing in middle school and high school choir. . . . I found music therapy to be a nice mix of psychology and music."

Cevasco says she admires the work Pitts has done with the research article and the therapy she provided the hospice clients. "I was really surprised when she chose hospice," Cevasco says. "I realized, and she realized, how great she was working with patients with mental health

needs in the previous semesters of her clinical work. I was very surprised, and I was so pleased with her and her work that she did with those hospice patients. It was beautiful the way she was able to work with the hospice families and the beauty of her being able to play the guitar and sing and provide these families with what they needed, and the patients what they needed, at this critical moment of their life." ■

Palliative care programs help challenging groups

Homeless, poor, and chronic conditions addressed

(Editor's note: This is the second of two-part series about best practices in palliative care programs. Last month we looked at an overview of three palliative care programs that were awarded the Circle of Life Award: Celebrating Innovation in End-of-Life Care by the American Hospital Association. We also examined the use of research to develop best practice and establish benchmarks. This month, we look at special programs to address challenging populations, including patients with chronic disease.)

Home health and hospice employees are accustomed to seeing patients in a variety of settings, but the staff of the palliative care program at Wishard Health Services in Indianapolis provide care for some of the poorest patients in their geographical area.

"We may initially see the patient in a hospital clinic, but when we visit them in the community, we may find out that they have no home," says **Gregory Gramelspacher**, MD, professor of medicine at Indiana University and director of Wishard Health Services Palliative Care Program. "Even if they have a place to stay, it may not be clean, have utilities, or even have furnishings," he says.

Because Wishard's management has made a commitment to serve the community, Gramelspacher's staff looks for ways to provide the best care for patients while respecting their wishes at the same time. "We do have agreements with local inpatient hospices to take patients who may not have a home," he says. "But, not all patients want to go into an inpatient facility." When a patient doesn't want to leave the place he or she calls home, social workers and chaplains will work to find services that can support the patient in the community.

Although the palliative care team doesn't force a patient into hospice care, all members of the team make sure patients understand the benefits of hospice care, says Gramelspacher. "We do make sure they have the opportunity to complete advanced directives and when they do decide to enter hospice, our patients tend to be admitted earlier in the process so they receive the best care possible," he adds.

Home health agencies have implemented chronic care programs to better care for patients with chronic diseases, but a chronic care program also can be beneficial for hospice patients, says **John Morris**, MD, medical director of palliative care and vice president of clinical outreach for Four Seasons, a hospice and palliative care agency in Flat Rock, NC.

Although a hospice patient might be dying from a disease other than a chronic condition, it still is important to understand the chronic disease and how to treat symptoms that might exacerbate pain or discomfort, says Morris. His agency implemented a chronic care program to provide specialized care to patients with cardiac conditions and chronic obstructive pulmonary disease.

"Staff members are trained in the use of diuretics, evaluation of chest pain, and protocols that best manage symptoms of patients with chronic conditions," says Morris. Because a patient with a cardiac problem might have symptoms not related to the reason for hospice admission, it is important to continue to manage those symptoms, he explains. "This program gives cardiologists confidence that their patients will receive the best care for all of their symptoms," he adds.

Because hospice's goal is to provide the best quality of life at the end of life, no one can ignore

Need More Information?

For more information about palliative care programs, contact:

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the symptoms of a chronic condition and treat the patient as if there were only one diagnosis, says Morris. "We need to get away from treating all hospice patients the same," he says. ■

Nursing home patients have hospice potential

Study shows patients don't elect hospice benefit

Nursing home residents can benefit from hospice services provided in the nursing home, according to Harvard Medical School researchers.[1]

Key findings reported in an article published in the *Journal of Pain and Symptom Management* found:

• Hospice in nursing homes can provide high quality end-of-life care and offers benefits such as reduced hospitalizations and improved pain management.

• The provision of hospice care in nursing homes has been shown to have positive effects on nonhospice residents, which suggests indirect benefits on nursing home clinical practices.

• Hospice is relatively underutilized among nursing home residents at the end of life.

While most hospice care in the United States is provided in the home, the use of hospice in nursing homes has risen in recent years. This growth has coincided with increased use of hospice care more generally.

The National Hospice and Palliative Care Organization reports that more than 1.4 million Americans receive care from the nation's hospice providers annually, with 22.8% residing in a nursing home. However, only 6% of nursing home residents in the United States elect the hospice benefit, even though nearly one in four deaths in the United States occur in a nursing home.

Authors of the study found that nursing home hospice patients received the same high-quality care as those hospice patients living in their own homes.

Compared to similar residents not enrolled in hospice, previous studies reviewed by the researchers found nursing home hospice patients were more likely to be assessed for pain, twice as likely to receive daily treatment for pain, and more likely to receive pain management in accordance with clinical guidelines. They also were less likely to require hospitalization in the final 30 days of life.

The importance of communication and coordination between the hospice provider and the nursing home staff as well as the need for more education on end-of-life care among professionals was another point clearly shown in the literature reviewed. **(For more information about hospice and nursing home collaborations, see "Hospice and long-term partnerships work well with attention to details," *Hospice Management Advisor*, March 2008, p. 25.)**

Reference

1. Stevenson DG, Bramson JS. Hospice care in the nursing home setting: A review of the literature. *J Pain Symptom Manage* 2009; 38:440-451. ▼

Chronic pain increases risk of falls in older adults

Chronic pain is experienced by as many as two out of three older adults. Now, a new study finds that pain may be more hazardous than previously thought, contributing to an increased risk of falls in adults over age 70. The findings appear in the Nov. 25 issue of *The Journal of the American Medical Association (JAMA).*

"It's clear that pain is not just a normal part of aging and that pain is often undertreated in older adults," explains lead author **Suzanne Leveille**, PhD, RN, who conducted the research while a member of the Division of Primary Care at Beth Israel Deaconess Medical Center (BIDMC) and is currently on the faculty at the University of Massachusetts Boston. "Our findings showed that older adults who reported chronic musculoskeletal pain in two or more locations — mainly in the joints of the arms and legs — as well as individuals who reported more severe pain or pain that interfered with daily activities were more likely to experience a fall than other individuals."

Leveille used data gathered as part of MOBILIZE Boston (Maintenance of Balance, Independent Living, Intellect and Zest in the Elderly), a cohort study with headquarters at the Institute for Aging Research at Hebrew SeniorLife and led by principal investigator **Lewis Lipsitz**, MD. One of the goals of

the study is to gain a better understanding of what causes falls in older adults in order to develop new ways to prevent falls from occurring.

Between September 2005 and January 2008, 749 adults over age 70 enrolled in the MOBILIZE study were interviewed about their health, including questions about pain. They also underwent a physical assessment by a nurse. Over the next 18 months, the participants recorded any falls they had on monthly calendar postcards that were then mailed to the Institute for Aging Research.

"At the beginning of the study, 40% of the participants reported experiencing chronic pain in more than one joint area, and 24% reported chronic pain in a single joint," explains Leveille. "During the 18-month study period, the 749 participants reported a total of 1,029 falls, with more than half the participants falling at least once during this period." Data analysis revealed that compared with study participants who reported no pain, the participants who experienced chronic pain in two or more joints had a 50% greater risk of falling.

"Our results suggest that pain should be added to the list of risk factors for falls, as persons who have chronic pain in two or more joints, and those who have moderate to severe pain or disabling pain, are at significantly higher risk," says Leveille. "Assessment and management of chronic pain is a key part of health care for many older adults." ■

Hospice LOS shortens — Stats released by NHPCO

More than 35% (35.4%) of patients served by hospices in 2008 died or were discharged in seven days or less, reports the National Hospice and Palliative Care Organization (NHPCO). This reflects a 4.6% increase from 2007, when 30.8% of patients had what is considered a short hospice experience.[1]

Patients and families receiving care for seven days or less are often unable to take full advantage of the range of benefits that the hospice interdisciplinary team provides. These benefits include psychosocial support and spiritual care for patients and their families, as well as pain management and symptom control,

While the average length of service increased from 67.4 days in 2007 to 69.5 days in 2008, the jump in patients receiving care for a short time is of concern to hospice providers and NHPCO.

Only 12.1% of those served died or were discharged with service of 180 days or more.

Reference

1. National Hospice and Palliative Care Organization. *NHPCO Facts and Figures: Hospice Care in America*. Alexandria, VA; 2009. ■

Health care reform bills: Side by side

While the details of health care reform, and the outcome of debates and votes, were uncertain at press time, a review of the two health care reform bills under debate do point out two areas that home health and hospice agencies can look ahead to implement.

A summary of the House bill (Affordable Health Care for America Act) and the Senate bill (Patient Protection and Affordable Care Act) refer to two opportunities for hospice to partner with other entities to provide care. The House bill calls for insurance plans to provide information related to end-of-life planning to individuals and provide the opportunity to establish advance planning directives and physician's orders for life-sustaining treatment. Because hospices and palliative care program employees are already providing these services, the potential to expand services might develop with insurance plans.

Both bills call for the creation of an Independence at Home demonstration program to provide health care services to high-need Medicare beneficiaries in their homes. The team of health professionals will share in any savings if preventable hospitalizations are reduced, hospital readmissions are prevented, health outcomes are

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improved, and the cost of health care services is reduced.

To see the summary and comparison of both bills by Kaiser Family Foundation, go to tinyurl.com/yeshhgv. ■

Psychotropic meds linked to risk of falls in seniors

Older adults who take several types of psychotropic medications, such as antidepressants or sedatives, appear more likely to experience falls, according to an analysis of previous studies reported in the Nov. 23 issue of *Archives of Internal Medicine.*

More than 30% of individuals older than 65 will fall at least once a year, and falls and their complications are the fifth-leading cause of death in the developed world, according to background information in the article. Each year, 85% of all injury-related hospital admissions and more than 40% of nursing home admissions are related to falls, and the annual costs related to falls and their complications are estimated to be in the billions of dollars worldwide. Internal and external risk factors contribute to falls, and medications previously have been implicated in the probability of falling and in the risk of sustaining a fracture.

John C. Woolcott, MA, of University of British Columbia and Centre for Health Evaluation and Outcomes Sciences, Vancouver, Canada, and colleagues conducted a meta-analysis of 22 previously published studies conducted between 1996 and 2007. The studies involved 79,081 participants older than 60 years and evaluated nine drug classes: antihypertensive agents; diuretics; beta-blockers; sedatives and hypnotics; neuroleptics and antipsychotics; antidepressants; benzodiazepines; narcotics; and nonsteroidal anti-inflammatory drugs (NSAIDS).

When the data were pooled and results adjusted for other factors, the use of sedatives and hypnotics, antidepressants, and benzodiazepines were significantly associated with the risk of falling in older adults. "Given the divergent results shown by some observational assessments within specific medication classes, the results of our meta-analysis reiterate the need for caution when prescribing these medications to seniors," the authors wrote. ■

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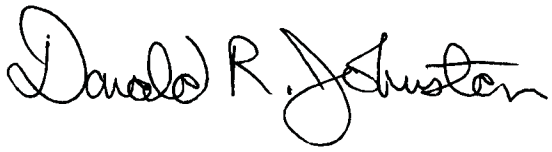

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