



Don't Just List Problems. Offer Solutions, Too.

In the article, Hospice and Assisted Living: Improving Care at the End of Life, *Assisted Living Consult*, July/August 2006, Ms. Cherry Meier offered a timely overview of what it would take to deliver an effective level of hospice-level palliative care in an assisted living environment. It would have been more rewarding had the list of barriers to delivering an acceptable, effective level of care been accompanied by some solutions.

Because I feel that your publication(s) are most helpful when they offer potential solutions/resolutions as well as describing the problems. I offer these comments:

What services does the facility offer residents? The article mentioned the painful practice of many facilities "moving out" their residents when independent living has been threatened or made impossible. What a fine PR thing it would be if facilities were to advertise where you can spend the rest of your life, offering hospice-level cooperative care as a positive and valuable "when-the-time comes" consideration.

What is the facility's position on the handling of narcotics?

Actually, the issues are:

- All facilities must use unit dosing.
- Many facilities do not have any protocol for Comfort kit pharmacologicals.
- Opioid therapy must be made in unit dosing (now available as gel "packets" sublingual disintegrating formulations, etc.)
- There is little place for as-needed (PRN) medications in facilities. (In one facility, our VITAS people found consensus after a them/us staff meeting by writing meds for a patient of mine up through 11PM, and starting at 6AM, the time the resident's licensed caregiver (RN/LPN) was accessible onsite)

Who is responsible for delivering meds? This is a matter of "what do we expect of hospice" from the facility staff, and "what do we expect of the facility staff" from hospice personnel?

Staffing, a key issue, if not *the* key issue, is often inadequate, even on 7-3 and 3-11 shifts because of economics. The expectations (although not in the Medicare guidelines) are for 24/7 staffing, respite, and custodial chores. But facility caregivers have been known to

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wait for the hospice team to dress, feed, change undergarments, clean the consequence of incontinence, and move from bed to chair, so other residents can be cared for.

It is not acceptable for me to visit a patient at 11AM and see the breakfast tray untouched and the resident still in bed because "it's a hospice case." Care for the resident on holidays and weekends; changing dressings and caring for wounds; and specifying which physician is going to be responsible for writing orders are important issues to be addressed, since some facilities view hospice as an alternative, rather than complementary, contribution. My hospice team early on welcomes the primary care physician (PCP), asks whether

he/she would remain the PCP, enlists his/her approval of the hospice physician as an advisor and contributor to care, and promises communication—all of which benefits the patient.

Facility protocol regarding writing orders (prescriptions faxed to facility, acceptability of verbal orders, and a mechanism for signing, identifying the contributing pharmacy, discovering that pharmacy's ability to provide comfort-level pharmacologicals, acceptability of the hospice pharmacy as a complementary source), are all done to make care more accessible and to forestall problems. One facility, in response to an end-of-life crisis, adopted a protocol that gives me, the hospice physician, "permission to contribute to care and write orders." This is now standard protocol.

Who should the hospice staff contact for a medical emergency? As with any patient, PCP should be the one to contact. More pertinent to the problem of unacceptable care is the facility night-staff, fearing legal repercussions, that treats change in status as a crisis, ignores advance directives, and calls 911 instead of the hospice on-call team. Everyone on the article's list of "who is, who does, who should" belongs on the "consensus table."

The articles in your publications are always productive and serve best when they highlight possible resolutions, where possible, for examples of clinical behaviors that have unacceptable consequences (such as illustrated above), equally important, by offering applause for the good things that happen, outcome-wise, from collaborative care. ALC

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