Learning Objectives

Upon completion, the learner will be able to:

■ 1. Describe the 3 terminal disease trajectories.
■ 2. Cite methods of documenting Activities of Daily Living (ADLs) to illustrate disease progression.
■ 3. Demonstrate correct application of the Palliative Performance Scale (PPS) and the Functional Assessment Staging (FAST) assessment tool.
■ 4. Identify key documentation elements pertaining to the New York Heart Association (NYHA) classification system.
TERMINAL TRAJECTORIES OF ILLNESS

RAPID DECLINE DISEASE TRAJECTORY

- Illnesses such as cancer have a progression that ends in a steady inevitable decline in function until death.
- The Hospice Benefit was predicated on this pattern of decline and death. Health Status Death Time Decline: short period of evident decline

TERMINAL TRAJECTORIES OF ILLNESS

SAW-TOOTHED DISEASE TRAJECTORY

- Cardiopulmonary and other organ system failures / conditions (HIV, Liver, Renal, etc.)
- A slow incremental decline punctuated by multiple episodes of acute exacerbations with failure to return to baseline
  - Hallmark sign: multiple exacerbations without return to baseline
TERMINAL TRAJECTORIES OF ILLNESS

- Documenting to saw-toothed trajectory during plateaus:
  - *Ask patient/family “What was your best day this week? What was your worst day this week?”*
  - Try to capture in documentation what’s happening when you’re not there

- Document retroactively:
  - Ex. Patient was hospitalized for 5 days 6 months ago in February for CHF exacerbation. In May he was hospitalized for 10 days for CHF exacerbation and was unresponsive to oral diuretics therefore requiring IV Lasix. 2 months ago he developed Pneumonia treated with oral antibiotics and remained at home while receiving ongoing hospice care.

- Talk about anticipatory planning:
  - Ex. Patient had acute CHF exacerbation 2 months ago with 3+ pitting edema in feet, ankles, and calves. Pt was SOB and required increased O2 from 2L to 4L around the clock. Pt’s edema responded to oral Lasix and patient remained at home with ongoing hospice care. Subsequent CHF exacerbations likely as disease trajectory worsens. Hospice team will continue to monitor and plan for further exacerbation; discussed with Hospice MD, and plan for subsequent exacerbation will include restarting oral Lasix, increasing O2, and family education to immediately report worsening symptoms (i.e., SOB, edema) to hospice team.

- Explain palliation of symptoms:
  - If pt is currently experiencing symptoms, explain why. Ex: Pt denies SOB during this visit, but reports using his PRN nebulizer treatment 1 hr prior to this RN’s arrival.
TERMINAL TRAJECTORIES OF ILLNESS

DWINDLING DISEASE TRAJECTORY

- Typical course of Dementia, Stroke and Coma, Parkinson’s, etc.
- Steady progressive disability leading to death
TERMINAL TRAJECTORIES OF ILLNESS

- Documenting to Dwindling Disease Trajectory:
  - Most Difficult to document
  - Remember small changes to us may be monumental changes to pt/family. Document ALL changes.
  - Best lens to see these changes is through the C.N.A.
    - Include C.N.A. information in documentation
      - Example: C.N.A. is requesting shower chair for patient as he is no longer able to safely stand in shower.
      - C.N.A. reported to this RN that patient had coughing episode lasting 5 minutes during lunch today, and per C.N.A. report, the patient appeared embarrassed and requested to leave the dining room and return to his room following coughing episode.
    - Comparative data (i.e., 2,3, 6 months ago vs. now) very important documentation for this population
TERMINAL DISEASE PROGRESSION

- Decline ≠ Dying
- Does the documentation evidence advancement along the expected terminal trajectory of illness?
- Comparative Data?
- Anticipatory planning?
- Medical necessity?
ACTIVITIES OF DAILY LIVING (ADLS)
The 6 ADLs include:

- Bathing
- Dressing
- Feeding
- Transfers
- Ambulation
- Toileting
DOCUMENTING ADLS

- Challenges:
  - Not capturing the broad range of level of dependence versus just the number of ADLs for which assistance is required.
  - Relying on “checkboxes” to tell the story of ADL dependence.
  - Absence of quantitative data (e.g., time to task completion) to support disease progression over time.
DOCUMENTING ADLS: DWINDLERS EXAMPLE

- 76 year old male, principal dx Alzheimer’s disease:
  - Bath in shower chair (able to hold sponge)
  - Requires assist with dressing (able to lift arms overhead)
  - Requires being fed by caregiver due to worsening ability to raise spoon; 1 hour to complete meal
  - Requires walker when ambulating
  - Requires assist x 1 for stand-pivot transfers
  - Incontinent bowel and bladder; wears briefs
ADL DOCUMENTATION EXAMPLES:

**BATHING**
- Able to tolerate sitting in shower chair for 20 minutes
- Able to wash torso with sponge/washcloth
- Unable to hold self upright; bed bath required

**DRESSING**
- Un/able to button shirt/put on pants/socks/tie shoes
- Requires pausing while dressing to catch breath
- Arms and legs contracted/requires full assistance
ADL DOCUMENTATION
EXAMPLES:

FEEDING
- Able to feed self finger foods only
- Increased difficulty managing utensils/food regularly found on floor
- Pocketing food every meal

TRANSFERS
- Standby assist required due to increased weakness
- Stand pivot transfer with assist x 1
- Requires multiple attempts to stand
- No longer able to bear weight/Hoyer lift required
ADL DOCUMENTATION EXAMPLES:

**AMBULATION**
- Requires guidance to dining hall
- Uses walls/furniture for support when ambulating
- Feet and walker often tangled in oxygen tubing increasing fall risk

**TOILETING**
- Requires bladder/bowel regimen due to urgency
- Bedside commode placed next to bed due to increased urination secondary to increased Lasix
- 2 episodes bowel incontinence past 5 days
PALLIATIVE PERFORMANCE SCALE (PPS)
PPS ADMINISTRATION

- PPS scores are determined by reading horizontally at each level to find a “best fit” for the patient which is then assigned a PPS% score
- PPS scores are in 10% increments only
- Begin at left column and read downwards until the appropriate ambulation level is reached, then read across to the next column and downwards again until the activity/evidence of disease is located
- Repeat until all 5 columns are covered before assigning the actual PPS for the patient
  - *Move left to right in a stepwise, downward fashion until you reach Conscious Level to find the appropriate PPS score*
<table>
<thead>
<tr>
<th>PPS Level</th>
<th>Ambulation</th>
<th>Activity &amp; Evidence of Disease</th>
<th>Self-Care</th>
<th>Intake</th>
<th>Conscious Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>Full</td>
<td>Normal activity &amp; work No evidence of disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>90%</td>
<td>Full</td>
<td>Normal activity &amp; work Some evidence of disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>80%</td>
<td>Full</td>
<td>Normal activity with Effort Some evidence of disease</td>
<td>Full</td>
<td>Normal or reduced</td>
<td>Full</td>
</tr>
<tr>
<td>70%</td>
<td>Reduced</td>
<td>Unable Normal Job/Work Significant disease</td>
<td>Full</td>
<td>Normal or reduced</td>
<td>Full</td>
</tr>
<tr>
<td>60%</td>
<td>Reduced</td>
<td>Unable hobby/house work Significant disease</td>
<td>Occasional assistance necessary</td>
<td>Normal or reduced</td>
<td>Full or Confusion</td>
</tr>
<tr>
<td>50%</td>
<td>Mainly Sit/Lie</td>
<td>Unable to do any work Extensive disease</td>
<td>Considerable assistance required</td>
<td>Normal or reduced</td>
<td>Full or Confusion</td>
</tr>
<tr>
<td>40%</td>
<td>Mainly in Bed</td>
<td>Unable to do most activity Extensive disease</td>
<td>Mainly assistance</td>
<td>Normal or reduced</td>
<td>Full or Drowsy +/- Confusion</td>
</tr>
<tr>
<td>30%</td>
<td>Totally Bed Bound</td>
<td>Unable to do any activity Extensive disease</td>
<td>Total Care</td>
<td>Normal or reduced</td>
<td>Full or Drowsy +/- Confusion</td>
</tr>
<tr>
<td>20%</td>
<td>Totally Bed Bound</td>
<td>Unable to do any activity Extensive disease</td>
<td>Total Care</td>
<td>Minimal to sips</td>
<td>Full or Drowsy +/- Confusion</td>
</tr>
<tr>
<td>10%</td>
<td>Totally Bed Bound</td>
<td>Unable to do any activity Extensive disease</td>
<td>Total Care</td>
<td>Mouth care only</td>
<td>Drowsy or Coma +/- Confusion</td>
</tr>
<tr>
<td>0%</td>
<td>Death</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Ambulation

■ a. Mainly sit/lie
■ b. Mainly in bed
■ c. Totally bed bound

Note: The difference in mainly “sit/lie” and “mainly in bed” is proportionate to the amount of time the patient is able to sit up versus need to lie down

- Example:
  - If patient is able to sit up ≥ 50% of time per day = “Mainly sit/lie”
  - If patient lies in bed ≥ 50% of time per day (but still gets up for meals, few hours per day, etc.) = “Mainly in Bed”
  - “Totally bed bound” = total care patient
PPS ADMINISTRATION

Ambulation

- The subtle differences in ambulation scores are related to items in the self-care column.
- “Totally bed bound” is due to either profound weakness or paralysis such that the patient not only cannot get out of bed, but is also unable to do any self-care.
PPS ADMINISTRATION

PPS: Self-Care

- **Full** – No assistance needed [PPS 70 – 100%]

- **Occasional Assistance** – Patient is able to transfer, walk, wash, toilet, and eat by their own means; however, on occasion (perhaps once daily or a few times weekly), the patient requires minor assistance [PPS 60%]

- **Considerable assistance** – Means regularly (every day), the patient needs help (usually by one person), to do some activities
  - Example: The patient needs help to the bathroom, but is then able to brush his/her teeth or wash hands and face; food may need to be cut up, but the patient can eat independently [PPS 50%]
PPS ADMINISTRATION

■ Mainly assistance – A further extension of “considerable”
  – Example: The patient now needs help getting up, but also needs assistance washing face and shaving; however, s/he can usually eat with minimal or no help [PPS 40%]

■ Total assistance – The patient is completely unable to eat without help, toilet, or do any self care. Depending on the clinical situation, the patient may or may not be able to chew and swallow food once prepared and fed to him/her [PPS 10 – 30%]
FUNCTIONAL ASSESSMENT STAGING (FAST)
# FAST SCALE

The Functional Assessment Scale (FAST) is a tool used to assess the functional status of individuals. It includes items that gauge various levels of difficulty, such as difficulty in social settings, health status, and daily living skills. The scale ranges from 0 to 28, with higher scores indicating more functional impairment. The FAST is scored primarily on information obtained from a knowledgeable informant. The fullscale item (FAST-5) consists of 13 items, and the subset FAST-3 uses a smaller number of items. The scale was developed and validated by R. E. Costa and M. J. Souza in 2001. Scoring and interpretation guides are available in the referenced literature.

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

Alzheimer’s disease is a progressive condition. Patients progress **through** the stages listed in the FAST scale (i.e., stages are not “skipped”)

The appropriate FAST value is the **highest consecutive level** of disability

- *Example: In order for the patient to be a FAST stage of 7d, (s)he has to meet stages 7a, 7b, and 7c first.*
- *Example: Patient needs wheelchair for ambulation but still speaks less than or equal to six (6) intelligible words throughout day or interview, then patient is a 7a (not 7c).*
FAST CHALLENGES

- Inappropriate application of the FAST scale
- Differentiating between FAST 7a and 7b
  - “How many words is the patient able to reliably, consistently, and meaningfully communicate?” (i.e., “word salad” is not meaningful communication)
- Inconsistent scoring among IDG members
- Narrative documentation contradictory to assigned FAST
- Use on non-Alzheimer’s or non-dementia patients
- Assigning a FAST value due to a condition other than Alzheimer’s disease*
  - The FAST scale is truly meant for Alzheimer’s only. If using the FAST for a non-Alzheimer’s form of dementia, documentation should include the specific elements of the FAST score that the patient meets.
  - Example: Patient with Lewy Body Dementia; “Pt unable to sit up in wheelchair without lateral supports to maintain upright truncal position and therefore meets elements of FAST 7d.”
NEW YORK HEART ASSOCIATION (NYHA) CLASSIFICATION SYSTEM
NYHA CLASSIFICATION SYSTEM

- Originally published in 1928 as a means of classifying heart failure
- Includes 4 categories based on the limitations of physical abilities in relation to cardiac disease
- Higher class is indicative of increased severity of symptoms, limitation in physical activity, and worse health
# New York Heart Association (NYHA) Classification of Heart Failure

<table>
<thead>
<tr>
<th>Class</th>
<th>Patient Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I (Mild)</td>
<td>No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, rapid/irregular heartbeat (palpitation) or shortness of breath (dyspnea).</td>
</tr>
<tr>
<td>Class II (Mild)</td>
<td>Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, rapid/irregular heartbeat (palpitation) or shortness of breath (dyspnea).</td>
</tr>
<tr>
<td>Class III (Moderate)</td>
<td>Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, rapid/irregular heartbeat (palpitation) or shortness of breath (dyspnea).</td>
</tr>
<tr>
<td>Class IV (Severe)</td>
<td>Unable to carry out any physical activity without discomfort. Symptoms of fatigue, rapid/irregular heartbeat (palpitation) or shortness of breath (dyspnea) are present at rest. If any physical activity is undertaken, discomfort increases.</td>
</tr>
</tbody>
</table>
NYHA CLASSIFICATION: CHALLENGES

- Inconsistent/Incorrect documentation of NYHA Classification
  - Example: Documenting patient as NYHA Class IV one month and then classifying as Class III following month because symptoms are palliated. If symptoms are palliated, patient is still Class IV with managed symptoms (documentation should reflect interventions provided to palliate symptoms).

- Failure to explain justification of NYHA classification

- Failure to explain the palliation of symptoms (e.g., angina, shortness of breath, fatigue, etc.) as it relates to the clinical presentation of the patient
NYHA CLASSIFICATION SYSTEM: EXAMPLE

- Patient has a comorbid condition of CHF. She has an ejection fraction of 20%, occasional chest pain while at rest, approximately 1-2 times weekly, and becomes short of breath after speaking 2-3 words.

Which NYHA Class is her presentation consistent with?
NYHA CLASSIFICATION SYSTEM: EXAMPLE

- Patient has a comorbid condition of CHF. She has an ejection fraction of 20%, occasional chest pain while at rest, approximately 1-2 times weekly, and becomes short of breath after speaking 2-3 words.

Which NYHA Class is her presentation consistent with?

- Answer: Class IV
NYHA CLASSIFICATION SYSTEM: EXAMPLE

Follow-up 1 Month Later:

- The IDG implements multiple interventions (e.g., nitroglycerin, short-acting morphine, oxygen, daily diuretic, energy conservation techniques, etc.). Prior to visits, she takes a preventative dose of short-acting Roxanol. During subsequent visits, she does not present with shortness of breath while at rest, although she still reports dyspnea with any exertion.

Which NYHA Class is her condition consistent with now?
NYHA CLASSIFICATION SYSTEM: EXAMPLE

- The IDG implements multiple interventions (e.g., nitroglycerin, short-acting morphine, oxygen, daily diuretic, energy conservation techniques, etc.). Prior to visits, she takes a preventative dose of short-acting Roxanol. During subsequent visits, she does not present with shortness of breath while at rest, although she still reports dyspnea with any exertion.

Which NYHA Class is her condition consistent with now?

- Answer: Still Class IV.
  - Documentation should include all of the above interventions to explain that patient is Class IV with symptoms well palliated as a result of hospice interventions.
Auditors don’t air in our favor. It’s our job to fill in the gaps. Be as specific as possible with all documentation.

Ask patient “What did your best day this week look like?” “What did your worst day this week look like?” Try to capture the whole picture and not just what you’re seeing at the time of visit.

Document to palliation. If presenting well, explain why. (“Pt didn’t have SOB during time of visit because pt had taken 5mg Roxanol 30 minutes prior to the RN’s arrival to alleviate SOB symptoms”).

Infections: Be specific. (“Pt was hospitalized 4 months ago for 5 days for PNA and received IV antibiotics.” “Pt received oral antibiotics for PNA for 7 days and was able to remain at home with hospice supportive care.”)

Observable signs of weight loss: “temporal wasting,” “loose-fitting clothing,” etc. loses its value when it’s repeated week after week. Document these observable signs but don’t let it become repetitive.
DOCUMENTATION GOLDEN NUGGETS

- Intake: Be as specific as possible. Ex. “Pt ate 1 cup of pureed diet during lunch. Pt was able to feed himself, but it took him 1 hour to finish his meal due to episodes of frequent coughing.” or “For breakfast, pt consumed half a piece of toast and 6 oz of orange juice.”

- Edema: Must be graded (1-4+)(pitting or non-pitting). Avoid stating “3+ edema in BLE.” Instead write, “3+ pitting edema in feet, ankles, and calves” (Be specific!)

- O2 sats: Document what patient was doing just prior to taking O2 sats and ALWAYS include whether patient was on RA or O2 (Ex. Pt’s O2 sat 89% on RA immediately following pt sitting up from lying in bed).

- Wounds: Spell it out. Document full wound assessment (size, drainage, tunneling, stage, etc.) (Be sure your measurements are congruent with facility’s if they’re also providing wound care).

- High Risk ER patients: For those patients who we know are at high risk of returning to the ER before calling hospice, document what hospice interventions are put in place to minimize risk of pt returning to ER. (Ex. CHF patient - What’s being done to prepare for subsequent CHF exacerbation? Medications? O2? Education?)
Questions?
Reference

Weatherbee Resources. Webinar from June 5, 2019 presented by Colleen O’Keefe, RN, CHPN and Senior Consultant and Project Specialist with Weatherbee Resources.