National Hospice and Palliative Care Organization
Patient Outcome Measures

COMFORTABLE DYING GUIDELINES

MEASURE QUESTION:

“Was your pain brought to a comfortable level within 48 hours of your admission to the hospice program?”

RATING SCALE:
YES or NO or UNABLE TO COMMUNICATE

POPULATION AND SAMPLE SIZE

100% of the hospice’s patients will be given a thorough pain assessment (including physical, functional, emotional and spiritual components) upon admission.

Patients are eligible for this study question if they:
- Acknowledge they are uncomfortable because of pain at the time of admission. See #1 in Procedure, below.
- Communicate and understand the language of the person asking the question.
- Are able to self-report
- Are at least 18 years of age or older

PROCEDURE:

1. On admission, prior to any numerical 0-10 scoring (not part of the study) the nurse will ask the question “Are you uncomfortable because of pain?” If the patient says “yes,” and meets the other criteria above, the patient enters the study.

2. The nurse documents all responses on the Patient Core Measure Sheet, and then proceeds with the assessment that leads to an intervention, following the hospice’s customary practice for documentation.

3. The evaluation of the effectiveness of the pain management regimen will always be based on the intensity of each patient’s pain, but for this study the following will also occur: within 72 hours after the first 48 hours of admission the patient’s nurse or designee will, prior to any other form of scoring, ask the question: “Was your pain brought to a comfortable level within 48 hours of your admission to the program?” The yes or no response to that question is then documented. If the patient is unable to self-report, check unable to self-report or unable to communicate.

   Document the reason the person is unable to self-report – discharged due to death, unable to self-report due to disease process, discharged alive, unable to self-report for other reasons.

4. This follow-up assessment can be completed by a nurse or physician in person or by telephone, but the patient must self-report his/her own response to the question by answering “yes” or “no.” The hospice staff should not:

   - Interpret a patient’s nonverbal response based upon observation, or
   - Use the response of another person, such as a staff person or family member to substitute for the self-report.
Using language that is more natural or familiar to the patient is permissible, providing the question of achieving comfort within a prescribed time frame is kept intact. For example, it is permissible on Tuesday to ask a patient admitted on Saturday afternoon if they were “comfortable by Monday afternoon.”

Guiding the patients to a particular answer however is not permissible. For example, saying “You’re not in pain now are you?” or “You’re not comfortable are you?” is not permissible.

The study is not intended to supplant the usual procedures the hospice has for pain assessment, treatment, documentation or follow-up, including management of side effects.

**SCENARIOS YOU MIGHT ENCOUNTER:**

1. It is close to 72 hours and you are doing the follow-up by phone and the patient is unavailable to talk. Do you continue to try to reach the patient even if it would be past the 72 hours?
   
   *Yes. You want to visit or talk with the patient as close to the 48 hours as possible so the information is still fresh in the patient’s mind. The longer you go beyond the 72 hours, the greater the risk for inaccurate information.*

2. The patient recently transferred to your hospice from another hospice. Is the patient eligible to participate in the study?
   
   *Yes. The patient is a new admission to your hospice.*

3. The patient was discharged from the hospice and readmitted later. Is the patient eligible to participate?
   
   *Yes. The patient is a new admission to your hospice.*

4. You visit or phone the patient for the follow-up and find the patient unavailable. A family caregiver offers to respond on behalf of the patient. Is this acceptable?
   
   *No. The information must be reported by the patient only.*

5. You are doing your paperwork and realize you forgot to ask a patient the follow-up question. You know based on your visit with her how she would respond to the statement. Is it OK for you to write in the response you know the patient would have given you?
   
   *No. The information must be reported by the patient only.*

6. The patient responds to the statement by saying something like “almost,” ‘sorta,’ ‘I guess,’ ‘not really,’ ‘yes, but I’m still not real happy with it.” What do you document?
   
   *The appropriate documentation would be “No,” regardless of the amount of work, time and energy put forth on symptom relief already.*

7. Some patients may be admitted in severe pain. Asking them the questions as they are written may seem inappropriate. *For patients in severe pain, some leeway in asking the questions is acceptable. For example: “Your pain is making you very uncomfortable, is that right?” The second question regarding unacceptability may be waived in such extreme circumstances. Remember however that some people will find varying levels of pain acceptable, so asking the second question may be important. Try “I’m assuming your level of pain is unacceptable, is that right?”*