

DEATH in NEW HAMPSHIRE:
A Review of Medical Charts

New Hampshire Partnership for End-of-Life Care

June 1999



FOUNDATION FOR
HEALTHY COMMUNITIES

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WHAT IS THE FOUNDATION?

The Foundation for Healthy Communities is a non-profit corporation that exists to improve health and health care. It was formed in 1968 by the New Hampshire Hospital Association as an educational and research organization for hospitals. In 1996, it was re-organized with a new and broader mission--to be an incubator that has the potential to affect people's health beyond the hospital and beyond New Hampshire.

Today, the Foundation is a partnership involving northern New England acute care hospitals, health plans, clinicians and home care agencies. It is guided by a broad-based Council representing the organizations involved.

The Foundation's primary objectives are;

- a.) to collect and analyze data about health, and the delivery, financing, management and organization of health services,
- b.) to promote, sponsor and conduct research and scientific investigation relative to health delivery process improvement and health policy, and
- c.) to publish information, sponsor education and training, and facilitate innovation for the improvement of health and the creation of healthy communities.

DEATH in NEW HAMPSHIRE: A Review of Medical Charts

EXECUTIVE SUMMARY

Hospitals, nursing homes, home care agencies and hospice programs in New Hampshire were invited to participate in a statewide, voluntary, medical chart review project to document end-of-life care issues. The information, based on 786 adult deaths (age 18 years or older) in October and November 1998, was compiled to provide baseline data on end-of-life care issues and assess interest among health provider organizations in end-of-life care concerns. Some key findings include:

- The average age of decedents in the study was 76 years. For nursing home decedents, the average age was 84 years.
- More than half (55%) of the decedents in the study were female.
- Forty-five percent of decedents in the study were married. Most nursing home decedents (62%) were widowed.
- Lung cancer was the most frequently identified primary diagnosis representing 10% of decedents in the study. It was followed by congestive heart failure (7%), Alzheimer's disease (2%) and strokes (2%).
- While one third of cases in the study were known to be in hospice programs, 28% of those cases entered hospice care in the week before they died.
- The average length of stay among hospital decedents was 8 days and for nursing home decedents it was 712 days, almost 2 years.
- Seventeen percent of the total number of decedents or 40% of the hospital cases were in a hospital intensive care unit (ICU) at the time of death or within the last 48 hours before death.
- Pain/Discomfort was the problem or symptom assessed most often by all health providers in the last 48 hours before death (88%). This assessment of symptoms was followed in frequency by shortness of breath (75%), anxiety/confusion/agitation (74%), lack of appetite (60%), fever (58%) and difficulty swallowing (48%).
- The family's emotional needs were noted in 74% of charts and 29% of the charts recorded a chaplaincy or spiritual care consult in the last 48 hours before death.
- Treatments provided in the last 48 hours before death: narcotics (75%), foley catheter (43%), IV fluids (42%), antibiotics (23%), intubation/ventilator (12%) and enteral tube (10%).
- One half of the decedents had a living will and 57% had a durable power of attorney for health care (DPAHC). There were do not resuscitate (DNR) orders for 87% of all the deaths.
- Only about a third of persons under age 55 years had a DPAHC or living will while nearly half of persons 55-84 years had these two directives.
- Medicare was the primary insurance (64%), followed by Medicaid (12%), managed care (7%) and private commercial insurance (7%) for all organizations. Managed care was higher among home care/hospice cases (12%).

The chart audit identified variations among the individual organizations that submitted data. The findings are being used to inform health professionals and the public and initiate statewide efforts to improve the delivery of end-of-life care in New Hampshire.

PROJECT OBJECTIVES:

Assess the level of interest in end-of-life care services among health providers and collect new information to better understand end-of-life care issues in a cross-section of health care provider organizations in New Hampshire.

METHOD:

A volunteer committee of health professionals, the NH Partnership for End-of-Life Care, was organized by the Foundation for Healthy Communities to create a chart review instrument for health care organizations statewide to conduct an end-of-life care chart review. The committee adapted a chart review instrument based on the toolkit instrument by the Center for Care of the Dying at George Washington University in Washington, DC. The instrument was pilot tested at a home care and hospice program and revised. It was estimated to take 20-24 minutes for a nurse to complete one chart review. The chart review had 19 questions and was designed to minimize interpretation by the reviewer. General demographic information, diagnoses, problem/symptoms and treatments administered in the last two days of life and directives were the major topics included in the chart audit. Appendix A. contains copies of the chart review instrument and instructions for the project.

A letter of invitation to participate in the project with chart review instructions and the instrument was sent on November 13, 1998 to:

- the senior administrator responsible for quality management at the 26 acute care hospitals in NH;
- executive directors of 40 hospice/home care agencies; and
- administrators at 88 nursing homes.

The health care organization lists were compiled with the cooperation of the Home Care Association of New Hampshire, NH Health Care Association, NH Hospice Organization, the ten county nursing homes and the NH Hospital Association. The 154 organizations surveyed represent all of the major licensed health care provider agencies in New Hampshire. A reminder notice to submit chart reviews was faxed on December 1, 1998. The deadline for completed chart review instruments was January 7, 1999.

Data entry and assistance with data analysis was provided by students in the Health Management and Policy program at the University of New Hampshire under the direction of Lee Seidel, Ph.D.

RESULTS:

A total of 812 completed chart reviews were submitted from 64 health care organizations. The overall response rate was 42 percent. Nineteen hospitals out of 26 (73%) responded; 17 home care/hospice programs out of 39 home care/hospice programs and one independent hospice responded (42%) and 28 nursing homes out of 88 nursing homes responded (31%).

A check for duplicate chart reviews among the different health care organizations was done once the data entry was completed. This occurred because some hospice or home care patients died in a hospital or nursing home. For purposes of this analysis, when duplicate chart reviews were submitted from both a hospital and a home care/hospice program the hospital's chart review was used for this analysis. If a duplicate chart review came from a nursing home and a home care/hospice program then the home care/hospice chart review was used. There were no duplicate chart reviews between nursing homes and hospitals. There were 26 duplicate or incomplete (e.g, no date of death) records identified and omitted from the database providing a total of 786 cases for the study (333 / 42% cases from hospitals, 212 / 27% cases from nursing homes and 241 / 31% cases from home care/hospice programs).

A comparison of reported deaths to the NH Department of Health and Human Services Health Statistics section (Vital Records) identified a total of 1,677 deaths in October and November 1998. This indicates that results from this chart review project (786 cases) account for 47% of the deaths that occurred statewide during the study period.

The 64 health care organizations that responded represent all regions of the state. Almost a quarter (24%) of the charts from the North Country (Coos, Carroll & Grafton counties), 43% of charts from the Central Region (Belknap, Merrimack & Hillsborough counties), 27% of charts from the Seacoast (Strafford & Rockingham counties) and 6% of the charts from the Southwest Region (Sullivan & Cheshire counties).

FINDINGS:

General Characteristics:

A total of 786 charts or cases were used in the analysis. The average age of decedents in the study was 76 years. For nursing home decedents, the average age was 84 years. Analyzing age groups by the type of provider organization identified more than half (54%) of nursing home deaths were in the age group 85+ years old while among home care/hospice decedents nearly a quarter (23%) were under the age of 65 years. (See Figure 1.)

Figure 1	AGE PROFILE BY ORGANIZATION			
	Total Decedents (n = 786)	Hospitals (n = 333)	Nursing Homes (n = 212)	Home Care / Hospices (n = 241)
Age (Mean)	76 yrs.	73 yrs.	84 yrs.	74 yrs.
Age Groups				
18 - 44	4%	5%	1%	4%
45 - 54	3	4	0	4
55 - 64	10	10	6	15
65 - 74	20	26	10	21
75 - 84	33	34	29	34
85 +	30	21	54	22

More than half (55%) of the decedents in the study were female. Among hospital cases, males accounted for 56% of the deaths. In nursing homes, females accounted for 73% of the deaths. Forty-five percent of decedents in the study were married with slightly more than half of the hospital cases (54%) and home care/hospice cases (53%) were married while only 25% of the nursing home cases were married. Most nursing home decedents (62%) were widowed. The next of kin identified in the medical record was most often the spouse (41%) followed by a son or daughter (37%), a sibling (6%) and 16% were Other or Unknown. Among nursing home cases, more than half (52%) identified a son or daughter as next of kin. (See Figure 2.)

The predominant religion of decedents in the study was Roman Catholic (35%) followed by Protestant (30%) and None/Not Available (26%). The religious affiliation of a decedent was known most often among nursing home cases with only 9% None/Not Available while the religious affiliation of one third of hospital and home care/hospice cases was None/Not Available. Medicare was the primary insurer for most decedents (64%) in the study. Medicaid represented the next largest source of insurance coverage (12%) followed by managed care and private commercial insurance each at 7%. 'Other Insurance' were all cases from the Veterans Administration. The uninsured represented 2% of all cases in the study. Primary insurance varied by the type of provider organization with Medicare covering nearly three-fourths (74%) of hospital decedents while among nursing home deaths the major split was Medicare (39%) and Medicaid (38%). Among home care/hospice decedents, Medicare covered 73% with managed care providing coverage for 12%.

NH End-of-Life Care
 Medical Chart Review
 Adult Deaths - October & November 1998

Figure 2

GENERAL PROFILE BY ORGANIZATION

	Total Decedents (n=786)	Hospitals (n=333)	Nursing Homes (n=212)	Home Care/ Hospices (n=241)
Characteristics				
Sex				
Male	45%	56%	27%	45%
Female	55	44	73	54
Incomplete	0	0	0	1
Marital Status				
Married	45%	54%	25%	53%
Widowed	4	29	62	34
Single, Div./Sep.	14	17	12	12
Incomplete	1	0	1	1
Religion				
Jewish	1%	1%	1%	0%
Protestant	30	29	36	25
Roman Catholic	35	31	45	31
Other	8	7	9	10
Not Available/Incomplete	26	32	9	34
Next of Kin				
Spouse	41%	47%	21%	49%
Son/Daughter	37	28	52	36
Sibling	6	7	7	6
Other/Unknown	16	18	20	9
Primary Insurance				
Medicare	64%	74%	40%	73%
Medicaid	12	4	38	1
Managed Care	7	7	3	12
Private Commercial	7	5	8	8
Other Insurance	4	6	3	2
No Insurance	2	2	4	1
Incomplete	2	2	4	3

Diagnoses:

Lung cancer was the most frequently identified primary diagnosis (71 cases) representing 10% of decedents in the study. It was followed by congestive heart failure (48 cases, 7%), Alzheimer's disease (18 cases, 2%) and cerebrovascular accident or strokes (18 cases, 2%).

Using the same ICD9 Codes for causes of death as the NH Department of Health and Human Service's Health Statistics Section (Vital Records), the ten leading diagnostic groups for decedents in the study are shown in Figure 3. Malignant Neoplasm (Cancer) represented 30% of cases in the study. Other Internal (respiratory failure, food/vomit pneumonitis, urinary tract infections nos (not otherwise specified), post-traumatic pulmonary insufficiency, etc.) was the second largest group at 17% followed by Heart Disease at 16%.

Figure 3

TEN PRIMARY DIAGNOSTIC GROUPS

Diagnosis Group	ICD-9 Code ¹	All Cases ²
1. Malignant Neoplasm (Cancer)	140-208	30%
2. Other Internal ³	001-7998	17%
3. Heart Disease	390-398, 402, 404-429	16%
4. Cerebrovascular	430-439	9%
5. Mental Disorders	290-319	4%
6. Central Nervous System	329-349	4%
7. Unintentional Injuries	800-949	3%
8. Chronic Obst. Pulmonary Dis.	490-496	3%
9. Pneumonia & Influenza	480-487	3%
10. Nephritis, Nephrotic Syndrome & Nephrosis	580-589	2%

1. The Diagnostic Groups and ICD-9 Codes were selected to match those used by the NH Department of Health and Human Services, Office of Community and Public Health, Health Statistic Section (Vital Records).

2. N = 786 Decedents

3. Other Internal includes respiratory failure, food/vomit pneumonitis, urinary tract infections, post traumatic pulmonary insufficiency, gastrointestinal hemorrhage nos, hypertension nos, post inflammatory pulmonary fibrosis, etc.

Analyzing the top five diagnostic groups by type of provider organization identified Malignant Neoplasm accounting for nearly two-thirds (64%) of the cases among home care/hospice cases. Only for nursing home cases does Mental Disorders (13%) appear among the top five diagnostic groups. Other Internal (25%) and Heart (24%) represent nearly half of all hospital cases. (See Figure 4.)

Figure 4 **PRIMARY DIAGNOSIS GROUPS BY ORGANIZATION**

Organization Type	Diagnosis Group	% of Cases
Hospitals		
	Other Internal ¹	25%
	Heart Disease	24%
	Malignant Neoplasm	18%
	Cerebrovascular	10%
	Pneumonia & Influenza	5%
Nursing Homes		
	Other Internal	14%
	Heart Disease	14%
	Mental Disorders	13%
	Malignant Neoplasm (Cancer)	12%
	Cerebrovascular	11%
Home Care/Hospices		
	Malignant Neoplasm (Cancer)	64%
	Other Internal	10%
	Heart Disease	7%
	Central Nervous Systems	5%
	Nephritis, Nephrotic Syndrome	4%

1. Other Internal includes respiratory failure, food/vomit pneumonitis, urinary tract infections, post traumatic pulmonary insufficiency, gastrointestinal hemorrhage nos, hypertension nos, post inflammatory pulmonary fibrosis, etc.

Hospice Care:

Almost one third (32%) of decedents in the study received hospice care. There is a wide range among the three types of provider organizations with home care/hospice organizations reporting 90% of their cases receiving hospice care, nursing homes reported 10% and hospitals reported 5%. Some provider organizations did not know if the decedent was receiving hospice care. Over one-fifth (21%) of hospital cases and 10% of nursing home cases indicated that they did not know from the medical chart if the decedent was receiving hospice care. (See Figure 5.)

Figure 5

DECEDENTS IN HOSPICE CARE

	All (n=786)	Hospitals (n=333)	Nursing Homes (n=212)	Home Care / Hospices (n=241)
Yes	32%	5%	10%	90%
No	56%	74%	80%	10%
Don't Know	12%	21%	10%	0%

Length of Stay:

The average length of stay among the three types of provider organization ranged from 8 days for hospital cases to 712 days, almost 2 years, for nursing home cases. The home care/hospice organizations reported 59 days as the average length of stay. Examining length of stay for hospice cases (n=216) more closely reveals that 17% of decedents were admitted into hospice care within 3 days before death, more than a quarter (28%) within a week before death and over half (62%) in the month before death.

Place of Death:

Most home care/hospice decedents died at home (64%) with 20% dying in a nursing home and 3% dying in a hospital. Most nursing home cases died in the nursing home (94%) although 6% died in a hospital. All the hospital decedents died in the hospital. (See Figure 6.) For reference, the 1995 New Hampshire Department of Health and Human Services (vital records) identified 48% of all deaths in the state occurred in a hospital and 25% in a nursing home, 22% at home and 5% in other places.

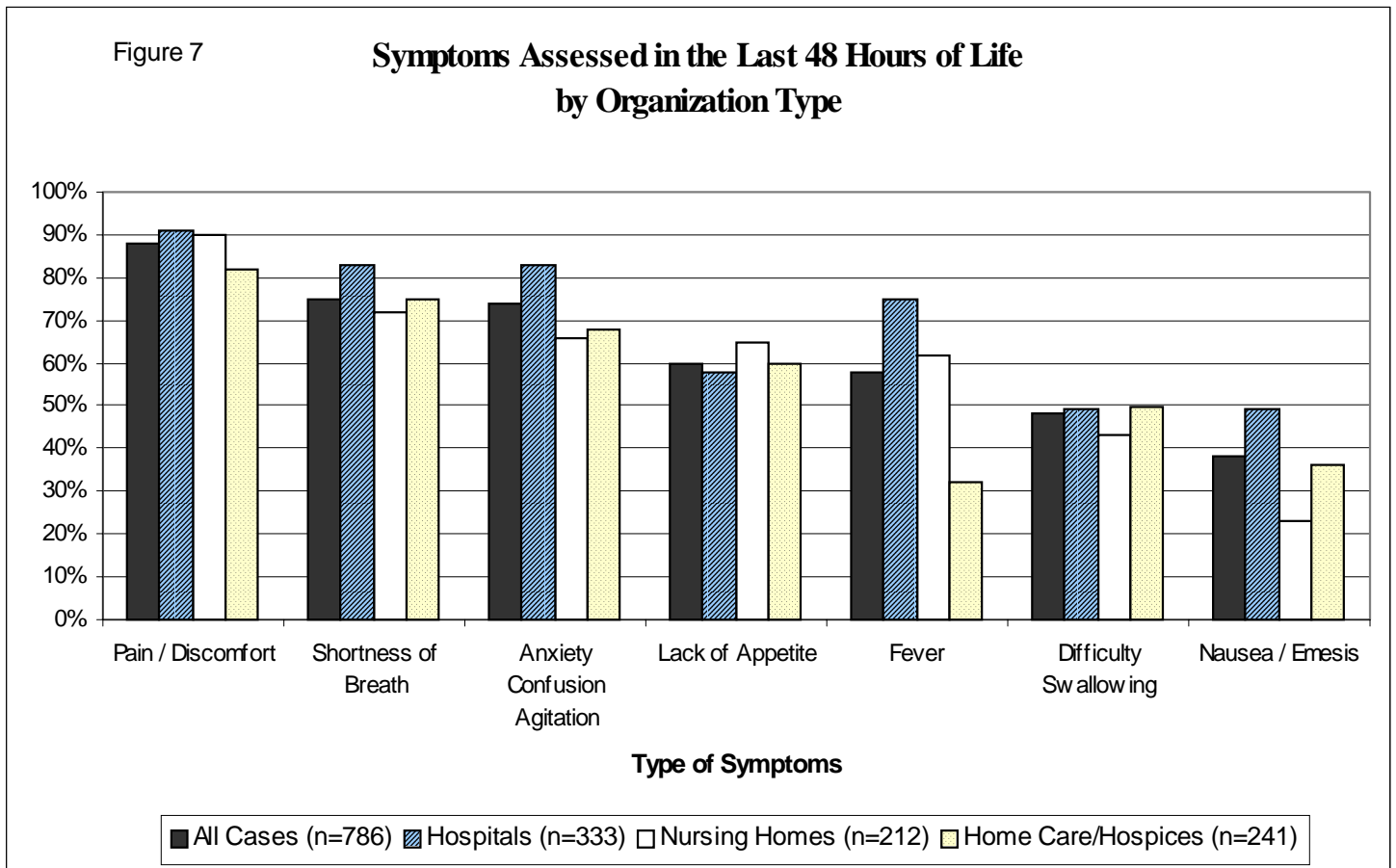
Figure 6	PLACE OF DEATH BY ORGANIZATION		
	Place of Death	Decedents	Percentage
Hospitals (n=333)	Hospital	333	100%
Nursing Homes (n=212)	Hospital	12	6%
	Nursing Home	200	94%
Home Care/Hospices (n=241)	Hospital	8	3%
	Nursing Home	47	20%
	Home	155	64%
	Other	30	13%
	Incomplete	1	0%

Intensive Care:

There were 133 decedents in a hospital intensive care unit (ICU) at the time of death or within the last 48 hours before death. This represents 17% of the total number of decedents in the study and 40% of the cases reported by hospitals. Of the 133 decedents, 57% were admitted to the ICU on the day of their hospital admission and 80% died in the ICU. Among decedents known to be in hospice care (n=252), only 1% were admitted to an ICU.

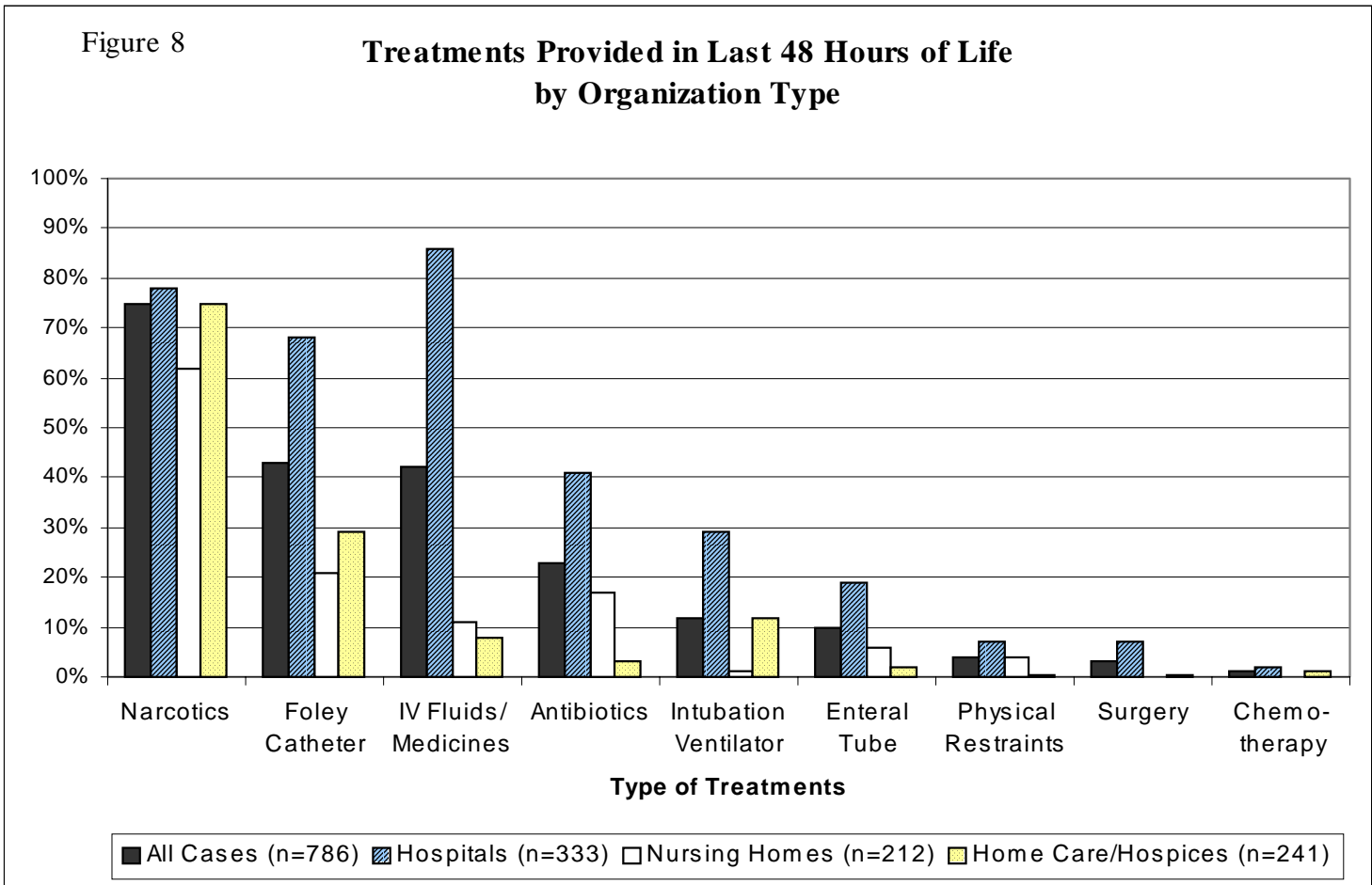
Symptoms Assessed:

Pain/Discomfort was the problem or symptom assessed most often by all health providers in the last 48 hours before death (88%). This assessment of symptoms was followed in frequency by shortness of breath (75%), anxiety/confusion/agitation (74%), lack of appetite (60%), fever (58%), difficulty swallowing (48%) and nausea/vomiting (38%). (See Figure 7.)



Treatments:

Narcotics was the treatment most frequently provided by all health providers in the last 48 hours before death. This treatment was followed in frequency by indwelling catheter for on-going urine drainage (43%), intravenous fluids and/or medications (42%), antibiotics (23%), intubation/ventilation (12%), enteral tube for nutrition (10%), physical restraints (4%), surgery (3%) and chemotherapy (1%). Hospital cases were much more likely than nursing home or home care/hospice cases to receive these treatments in the last 48 hours before death. (See Figure 8.)



Emotional and Spiritual Care:

The emotional needs of the decedent's family were noted in the medical chart in almost three-quarters (74%) of all cases in the study. Among different types of provider organizations the range was 80% for home care/hospice cases and 62% for nursing home cases. A chaplaincy or spiritual care consult in the last 48 hours before death was noted in 29% of all medical charts in the study. The range for a chaplaincy or spiritual care consult among the three different types of provider organizations was 37% for home care/hospice cases and 25% for hospital cases. (See Figure 9.)

Figure 9	CARE IN THE LAST 48 HOURS BEFORE DEATH	
	Family's Emotional Needs Noted in Chart	Chaplaincy / Spiritual Consult
All Cases (n=786)	74%	29%
Hospitals (n=333)	76%	25%
Nursing Homes (n=212)	62%	27%
Home Care/Hospices (n=241)	80%	37%

Directives:

The most frequent directive among all decedents in the study was a do not resuscitate (DNR) order (87%). This was followed in frequency by a durable power of attorney for health care (DPAHC) directive (57%), a living will (50%), comfort measures only (50%), do not intubate (DNI) directive (30%) and a do not hospitalize (DNH) directive (8%). Physician notes in the record as to how the directive(s) apply were identified for 42% of all decedents. A values history was identified for 21% of all decedents. A DPAHC was much more prevalent among nursing home cases (74%) and home care/hospice cases (66%) than among hospital cases (39%). (See Figure 10.)

Figure 10

DIRECTIVES BY ORGANIZATION

	DNR ¹ Order	DPA ²	Living Will	DNI ³ Order	DNH ⁴ Order	Comfort Measures Only	Values History	Physician Notes
All Cases (n=786)	87%	57%	50%	30%	8%	50%	21%	42%
Hospitals (n=333)	82%	39%	43%	47%	1%	50%	2%	58%
Nursing Homes (n=212)	88%	74%	51%	26%	19%	47%	10%	33%
Home Care/Hospices (n=241)	92%	66%	60%	9%	7%	53%	12%	28%

1. DNR - Do Not Resuscitate Order
2. DPA - Durable Power of Attorney for Health Care
3. DNI - Do Not Intubate Order
4. DNH - Do Not Hospitalize Order

Analyzing more closely the characteristics of the decedents with a DPAHC or living will identifies the greatest number as widowed, more than half are 75 years or older, a son or daughter is their next of kin, and Medicare was their primary insurer. (See Figure 11).

Nearly half of DNR directives (46%) were done after the admission date into the facility or program while only 15% of the living wills and 23% of the durable power of attorney for health care were done after the admission date (See Figure 12.).

Figure 11

NH End-of-Life Care
 Medical Chart Review
 Adult Deaths - October & November 1998

**DECEDENTS WITH KEY DIRECTIVES BY
 GENERAL CHARACTERISTICS**

	Decedents with Key Directives	
	DPA ¹ (n=448)	Living Will (n=396)
Marital Status		
Married	37%	42%
Widowed	48	44
Never Married/Divorced	13	12
Incomplete	2	2
Age Group		
Less than 54	4%	4%
Ages 55-64	10	10
Ages 65-74	16	19
Ages 75-84	31	33
Ages 85+	39	34
Next of Kin		
Spouse	33%	38%
Sibling	7	6
Son or Daughter	44	41
Other/Unknown	16	15
Primary Insurance		
Medicare	65%	66%
Medicaid	15	12
Managed Care	6	7
Private Commercial	7	7
Other (VA)	3	3
No Insurance	3	2
Incomplete	3	3

1. Durable Power of Attorney for Health Care

Figure 12

NH End-of-Life Care
 Medical Chart Review
 Adult Deaths - October & November 1998

TIMING OF DIRECTIVES NOTED IN CHART

	DNR Order (n=629)	DPA (n=411)	Living Will (n=362)	DNI Order (n=215)	DNH Order (n=57)
Cases Where Directive Date Was Noted in the Chart After Date of Admission	46%	23%	15%	58%	56%
	(n=622)	(n=407)	(n=359)	(n=213)	(n=54)
Cases Where Directive Date is Noted in the Chart in the Last Week of Life	54%	33%	35%	72%	52%

LIMITATIONS:

There are limitations in the process employed in collecting this information that must be considered in reviewing this data. The health provider organizations that responded to the data request may represent those health care organizations in New Hampshire that are more active and concerned about end-of-life care. This could bias the overall study to show more favorable results. Similarly, the individual health care staff persons who completed the chart audits may have been inclined to complete the survey to show the most desirable findings. The chart review instrument was modified to minimize interpretative questions and Foundation for Healthy Communities staff were available to answer questions by telephone from staff completing the chart reviews but there no resources for specific organizational reliability checking. This process is always limited by the available documentation in the medical chart and it may not identify events that occurred but were not recorded in the medical chart. The focus on the last 48 hours of life may also limit understanding the full range care during final stages of end-of-life.

CONCLUSION:

This represents the first effort to collect statewide, baseline information for health providers and the public to better understand end-of-life care in New Hampshire. The data suggest areas for further study such as what does the late referral to hospice care mean and what can be done about it or do the relatively high rates of symptom assessment mean that corresponding care plans are in place and appropriate services provided? The project also identified much variation among the health care organizations that submitted data. While three-fourths of all decedents received narcotics in the last 48 hours before death, this treatment ranged from 100% in many organizations to 40% in one hospital. Similarly, while more than half the decedents had a durable power of attorney for health care, the range for this directive was from 100% to zero among health care organizations reporting their data. The organizations that submitted data for this study received more detailed results to compare their organization to the other health care organizations.

This project is intended to stimulate further study and work on improving different elements of care. The NH Partnership for End-of-Life Care has identified advance care planning as one priority issue in which to organize community efforts to change policy and practices. Also, there is an effort underway to reduce barriers to hospice care among different providers and some health plans in the state. The ability to make improvements in the delivery of care depends upon understanding the issues and being able to measure change. The great level of participation in this project indicates a strong desire to understand end-of-life care issues. The Foundation for Healthy Communities welcomes an opportunity to continue work to improve policies and practices related to end-of-life care.

New Hampshire
End-of-Life Care Chart Review
Instructions

Introduction

Hospitals, nursing homes, home care agencies and hospice programs are being invited to participate in a voluntary chart review project. The information will be compiled on a statewide basis to provide a 'snapshot' of how end-of-life care is delivered. Your participation in the chart review project is important in helping to improve end-of-life care for patients and their families.

Study participants will be identified as those NH residents age 18 years or older that occurred in your facility or program in October and November 1998. We estimate that it takes about 20 minutes for a nurse or medical records person to complete a chart review and we recommend that you keep a copy of the completed chart reviews. **Please return your completed chart review forms as soon as possible in December but no later than January 8, 1999.** Summary data will be reported back to participants in March. If you want to call with any questions about the project please contact Shawn LaFrance or Kathy Bizarro at 225-0900.

These data will be collected after death from a review of the medical charts. These instructions have been prepared for the chart abstractor. Typically, the chart abstractor is an experienced nurse clinician or other health care professional who is familiar with medical terminology, medical technology, and the clinical environment. Also, the chart abstractor is detail-oriented and well organized. The data instrument used by the chart abstractor should be completed while reviewing the patient's chart.

Confidentiality

The chart abstractor must not discuss the contents of a patient's chart or medical record other than for necessary discussions with other personnel involved in this project. It is important that all data collection instruments which have a patient's name, medical record number, or other identifiers never be left unattended or in such a manner that they would be seen or read by other people. All data will be handled with strict confidentiality and the reporting of aggregate data will not attribute specific data to any patient, facility or organization.

Completing the Chart Review

General Information

1. Date - Date of chart audit
2. Organization Name and City/Town
3. Chart Abstractor Name and Telephone
4. Patient ID # - *Record the patient's medical record number or other ID number. (This number is requested in the event that we need to contact you with a question about a specific chart.)*
5. Gender - Check the appropriate box.
6. Religion - Record the patient's religion as indicated by the medical record. Check the appropriate box.
7. Primary Insurance - Check one box for the primary insurance carrier for the patient.
8. Marital Status - Check the box for the marital status at time of death.
9. Relationship of next of kin - Check the box of the relation to the patient of the next of kin listed in the record.

10. Date of Admission - Record the date the patient was admitted to the hospital, nursing home, home care or hospice program.
11. Date of Death - Record the date the patient died.
12. Date of Birth - Record the patient's date of birth.
13. Place of Death - Check the box where the patient died.

(Note: Not all questions may apply. Write N/A if not applicable.)

14 & 15. **Primary Diagnosis & Secondary Diagnoses** - Record the ICD-9 code listed for the primary diagnosis and secondary diagnosis.

16. Problems/Symptoms - For the day of death and the day before.

Assessed: For all of the symptoms and problems, enter Yes or No if the symptom is documented in the chart as having been assessed by a physician or nurse.

Plan of treatment documented?: If the symptom was assessed, enter Yes or No if a plan of treatment was documented for the control/amelioration of that symptom.

For example:

A. Patient M has severe back pain. His physician assesses the pain and describes a plan of treatment where M is given intravenous morphine and turned regularly.

For this example, the form would be completed as follows:

Symptom/Problem	Assessed?	Is a plan of treatment documented?	
Pain/Discomfort	Yes	Yes	

B. Patient R. suffers from constipation, as noted by his nurse. The constipation is never noted again.

For this example, the form would be completed as follows:

Symptom/Problem	Assessed?	Is a plan of treatment documented?	
Constipation	Yes	No	

Symptoms: Mostly, these symptoms are straightforward. Common synonyms have been listed that may appear in the chart.

Pain/Discomfort: Patient expressed pain and/or discomfort of any kind, or was noted to be in pain or discomfort.

Anxiety/ Confusion: Patient was noted to be anxious, agitated, restless or generally fearful. Patient was noted to be confused, delirious, or express inappropriate verbalizations.

Shortness of Breath: Patient was noted to be short of breath or have dyspnea.

Lack of Appetite: Patient was noted to have a lack of appetite, anorexia.

Difficulty Swallowing: Patient was noted to have difficulty swallowing or dysphagia.

Nausea/Emesis: Patient was noted to be nauseous and/or vomiting.

Fever: Patient was noted to have a fever, or be febrile.

17. Treatments Administered - For the day of death and the day before.

Antibiotics: *Patient administered any antibiotic in any dose or frequency.*

Chemotherapy: *The patient received continuous or intermittent parental chemotherapy.*

Narcotics: *The patient received any narcotic drug by any route.*

Intravenous (IV) fluid +/- medication: *The patient received any fluids via IV or received any dosage of scheduled or bolus IV medication (this may include prn medications if administered intravenously).*

Enteral tube (NG/peg G): *The patient received a form of nutrition via a tube that enters the patient's stomach or intestine. i.e. nasogastric tube, ileostomy tube, etc.*

Foley catheter: *A foley catheter was inserted for ongoing urine drainage.*

Intubation/Ventilation: *The patient was nasotracheally or orotracheally intubated in the day of death or the day before. The patient required controlled ventilation for breathing assistance and may or may not require PEEP.*

Restraints to prevent harm: *Patient required physical restraints to protect him/herself and/or others, i.e. posey vests, soft wrist or leather restraints, etc.*

Surgery in the OR: *The patient received any surgery performed in the operating room.*

Family Emotional Needs: *The emotional needs of the patient's family were noted and attended to.*

Chaplaincy Consult: *A minister, rabbi, priest, chaplain, or other religious figure was provided for the patient.*

18. **ICU** - (*Note: Not all questions may apply. Write N/A if not applicable.*)

Record whether the patient was in an intensive care unit **for the day of death or the day before**. If the patient did receive care in the ICU near death, record the admission and discharge dates spent in the ICU.

19. DIRECTIVES -

The chart abstractor should note the existence of any advance planning documents or orders in the chart that bears the signature of the patient. The document may be a standardized form such as a living will, a durable power of attorney, or a written note to health care providers from the patient regarding health care preferences. **Record the first date that any directive is documented in the chart** (not necessarily the date the directive was signed, but the date it was put in the chart or was noted in the progress notes or orders).

Org. # _____
Type: _____
Hospice: Yes No
Region: No Se Ce Sw

New Hampshire
End of Life Care Chart Review Form
(Please read the instructions before completing this form.)

1. Date: _____
2. Organization Name: _____
3. Chart Abstractor Name: _____ Telephone: _____
4. Patient ID# _____
5. Gender: Male Female
6. Religion:
- Jewish
 - Protestant
 - Roman Catholic
 - Other
 - None/Not Available
7. Primary Insurance:
- Medicare
 - Medicaid
 - Private/Commercial
 - Managed Care/HMO
 - Managed Care/Medicare
 - No Insurance/Self Pay
 - Other Insurance
8. Marital Status: Never Married Married Widowed Divorced/Separated
9. Next of Kin: Spouse Sibling Son/Daughter Other Unknown
10. ____/____/____ 11. ____/____/____ 12. ____/____/____
Date of Admission Date of Death Date of Birth
13. Place of Death: Hospital * Nursing Home * Home Other
* Enrolled in a Hospice Program: Yes No Don't Know

14. Primary **Diagnosis**, ICD-9 Code:

15. Secondary **Diagnoses**, ICD-9 Codes:

For FHC Use Only: _____ Org. Code _____ Org. Type

Organization Name _____

Patient ID # _____

16. PROBLEMS/SYMPTOMS

Refer to any notes in the chart **for the day of death and the day before**. Please fill in Yes or No.

Symptom/Problem	Assessed?	Plan of treatment documented?
Pain/Discomfort		
Anxiety/Confusion/Agitation		
Shortness of Breath		
Lack of Appetite		
Difficulty Swallowing		
Nausea/Emesis		
Fever		

17. TREATMENTS ADMINISTERED

Refer to any notes in the chart **for the day of death and the day before**. Please fill in Yes or No.

Treatments	Yes	No
Antibiotics		
Chemotherapy		
Narcotics (patch/oral/IV)		
Intravenous fluid/medications		
Enteral tube (NG/peg/G)		
Foley catheter		
Intubation/Ventilator		
Physical restraints		
Surgery in the OR		
Family emotional needs are noted		
Chaplaincy/Spiritual consult		

18. ICU

Was patient in an ICU at the time of death or within their last 2 calendar days? Yes No

If yes, dates in the ICU - ICU Admission Date ICU Discharge Date

19. DIRECTIVES

All information should be obtained from notes or orders in the medical chart.

Description	Yes	No	First date noted in chart
Living Will			
Values History			
Durable Powers of Attorney for Health Care			
Do Not Hospitalize (DNH) order			
Do Not Resuscitate (DNR) order			
Do Not Intubate (DNI) order			
Comfort Measures Only order			
Any physician notes as to how the directives apply?			

Thank you