Thank you very much for purchasing this Policy Manual. This manual is designed so that implementation of the policies will result in compliance with the CHAP standards for accreditation and Medicare Conditions of Participation for Home Care. The manual is divided into two sections:

**CHAP Core Operational Policies and Procedures**

and

**CHAP Hospice Operational Policies and Procedures**

We know you will find it helpful as you prepare for CHAP accreditation, Medicare certification and continue to improve your operational practices.

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Microsoft Windows 98 or higher
Microsoft Word 97 with postscript fonts installed
Pentium II processor 350 MHz or higher

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Windows 95™ and above using Windows Explorer:

1. Insert the CD-ROM into your CD-ROM drive. On most computers, the CD-ROM should start automatically
2. If the install program does not start automatically, Open Windows Explorer.
3. Select your CD-ROM Drive.
5. Follow the prompts.

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2. Select File.
3. Select Open.
4. Under Drives, select C:
5. Open the path: Program files\Corridor Products\.
6. Select which file you would like to open.
7. Press Enter.

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NAVIGATION INSTRUCTIONS

Hypertext links are tools that facilitate navigation within a document. The user is able to go directly to a location within the document without manually scrolling through the pages. Hypertext links are located within this document. While the user always has the ability to navigate the document with the scroll bar, these tools allow easier movement within the document.

All items that are “linked” to another part of the document appear in color on the computer screen. Locate the section of the document that you want to find, click on the colored text and the hyperlink will take you directly to that section.
POLICY NUMBERING AND REFERENCES

Policies have been numbered to identify the manual name, section, policy number, and page.

Example:
H:2-043.1

- The H: represents the Hospice Manual
- The 2 represents Section Two
- The 043 represents policy 43 within the section
- .1 represents page 1 of that policy

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Policies in each manual have been “crosswalked” to the corresponding Community Health Accreditation Program (CHAP) standards and Medicare Conditions of Participation. The crosswalk also contains a legend identifying the evidence required by CHAP.
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WITH CHAP STANDARDS AND
MEDICARE CONDITIONS OF PARTICIPATION
## SECTION ONE
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Legend of Evidence for CHAP Accreditation:

- D = Documents
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- S = Survey
# Section Two

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PURPOSE

To define how the hospice program will consistently apply the organization’s philosophy, mission, and purpose.

POLICY

Visiting Nurse & Hospice Care provides an individualized program of physical, emotional, spiritual, and practical care for people in the last phases of a life-limiting illness, with an emphasis on control of pain and other symptoms. The program is reflective of a spirit and idea of caring that emphasizes comfort and dignity for the dying, making it possible for them to remain independent for as long as possible, and in familiar surroundings. Hospice care is centered on both the patient and family/caregiver. Hospice personnel respect and respond to the unique differences in family/caregiver, lifestyle, values, and wishes.

Utilizing an interdisciplinary team approach of physicians, nurses, social workers, homemakers, hospice aides, volunteers, spiritual counselors, bereavement counselors, and others, Visiting Nurse & Hospice Care provides palliative care in the home, short-term inpatient services, mobilization and coordination of ancillary services, and bereavement support. Services will be equitably distributed to a medically and financially diversified group of patients in a cost effective manner, which ensures adherence to the goals of Visiting Nurse & Hospice Care and the maintenance of the financial solvency of the organization.

Mission
The mission of Visiting Nurse & Hospice Care is to provide high-quality, comprehensive, home health, hospice and related services necessary to promote the health and well-being of all community residents, including those unable to pay.

Philosophy
Hospice affirms life. Hospice exists to provide support and care for persons in the last phases of a life-limiting illness so that they may live as fully and comfortably as possible. Hospice exists in the belief that through appropriate care and the promotion of a caring community, patients and families/caregivers will be free to attain a degree of mental preparation for death that is satisfying to them.

Committed to Patients
We recognize the unique physical, emotional, psychological, and spiritual needs of each person. We strive to extend the highest level of courtesy and service to patients and families/caregivers, visitors, and each other.
GOALS

1. The philosophy, mission, and purpose of the hospice program will be reflected in the referral, admission, and service policies and will demonstrate the ability to:

   A. Establish a commitment to the concept of hospice care

   B. Provide comprehensive, competent, quality care which optimizes comfort and dignity and is consistent with the patient and family needs and goals with the patients needs and goals as priorities.

   C. Deliver timely end-of-life care that is well coordinated, family-centered, and includes bereavement and counseling support

   D. Case manage and design services that are consumer-oriented and outcome-based

   E. Ensure continuity of care, consistent with the needs of the patient and family/caregiver, as it pertains to the terminal diagnosis, culture, environment, and appropriate level of care

   F. Acknowledge without discrimination the dignity, comfort, and choices determined by the patient and family/caregiver, including the election of the Medicare benefit or alternative health care options

   G. Design treatment protocols and interventions consistent with the philosophy, mission, and purpose of the organization

2. The philosophy, mission, and purpose of the hospice will be supported through the plan of care and the implementation and evaluation of services.

3. The philosophy, mission, and purpose of the hospice will be reflected at each level of care implemented in the care of patients.

4. The hospice mission statement is made available upon request to patient's referral sources and other interested parties
PURPOSE

To ensure compliance with local, state, federal, and other regulatory bodies.

POLICY

The organization will maintain evidence of regulatory compliance, including but not limited to:

1. Current state license
2. Medicare and Medicaid provider numbers
3. Business license
4. CLIA certification
5. Reports of reviewing bodies (CHAP, FDA, state licensure surveys, OSHA, etc.)
6. Nursing services waiver of requirement
7. Physical, occupational, speech therapy and dietary counseling waiver of requirement
8. Death report to CMS per requirement

The Medicare Conditions for Participation for hospice programs will apply to all patients of the hospice, including ownership and multiple location requirements.

Continuation of care requirements and the 80–20 inpatient care limitation will apply only to Medicare beneficiaries.
PURPOSE

To ensure that patient care and services are guided by current and relevant clinical policies and procedures.

POLICY

The organization will maintain current, up-to-date policies and procedures manuals for clinical personnel to utilize in the provision of patient care and service.

Clinical policies and procedures will be revised according to state/federal guidelines and current clinical practice.

PROCEDURE

1. Clinical policies and procedures manuals may be developed internally utilizing relevant and current professional practice guidelines or may be purchased commercially. Purchased manuals will be individualized to the organization’s practice.

2. Clinical policies and procedures will be reviewed and revised, as indicated, and approved and dated at least annually.

3. Approval of clinical policies and procedures may be completed by the Professional Advisory Committee, the Medical Director, or a clinician with recognized and documented expertise in a specific clinical arena. Final approval will be by the Governing Body.

4. Clinical policies and procedures, professional journals, and discipline-specific practice guidelines will be accessible to personnel at all times.
PURPOSE

To ensure the ongoing review of hospice operations in accordance with state and federal regulations.

POLICY

The Governing Body will appoint a multidisciplinary hospice Professional Advisory Committee (PAC). The committee will consist of at least one (1) practicing physician, a nurse with community health or hospice experience, and representatives of other professional services reflecting at least the scope of organization services (such as physical, speech, or occupational therapy, social work, and discharge planning). Members should be individuals who are aware of the needs of the community related to the population served.

This committee will meet quarterly, or more often, as needed, and minutes of each meeting must be recorded.

PROCEDURE

1. The Professional Advisory Committee will assist the Executive Director/Administrator in an annual and ongoing review of hospice's operations.

2. The committee will establish and review policies and procedures and oversee regulatory compliance, in the following areas:
   
   A. Admission and discharge policies and procedures
   B. Policies governing scope of services offered
   C. Medical supervision
   D. Development of plans of care
   E. Emergency procedures
   F. Clinical procedures
   G. Patient clinical records
   H. Personnel qualifications
I. Operating budget

J. Quality assessment performance improvement plan

3. The committee will refer to state or national association for the most recent Medicare regulations and trends in hospice care.

4. The committee will evaluate to what extent hospice has met the needs of the community for hospice care, has provided adequate and appropriate care to each patient, and is working towards a goal of financial self-sufficiency.

A list of the “Hospice Professional Advisory Committee Members” follows. (See Addendum H:1-004.A.)
ADDENDUM H:1-004.A

HOSPICE PROFESSIONAL ADVISORY COMMITTEE MEMBERS
## HOSPICE PROFESSIONAL ADVISORY COMMITTEE MEMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
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<td>RN, Hospice Director, VNHC</td>
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<tr>
<td>Cheryl Donkin</td>
<td>Spiritual Counselor</td>
<td></td>
</tr>
<tr>
<td>Holly Gendron</td>
<td>Director of Serenity House</td>
<td></td>
</tr>
<tr>
<td>Lisa Holden</td>
<td>Senior Director of Education &amp; Organizational Development, VNHC</td>
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<tr>
<td>Sam Leer</td>
<td>LCSW, VNHC, Hospice</td>
<td></td>
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<tr>
<td>Mary Beth Noggle</td>
<td>RN, Director Home Health, VNHC</td>
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<tr>
<td>Debbie Wright</td>
<td>Director Quality and Compliance, VNHC</td>
<td></td>
</tr>
<tr>
<td>Lynda Tanner</td>
<td>Executive Director and CEO, VNHC</td>
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</table>
PURPOSE

To define the overall responsibilities of the hospice director position.

POLICY

The hospice Director position will be responsible for the overall direction, coordination, and general supervision of all hospice services.

The full extent of the hospice Director’s responsibilities will be defined in the applicable job description.

The hospice Director will be qualified by education and experience including at least two (2) years of health related experience, and the knowledge and ability to effectively direct the program.

PROCEDURE

1. The hospice Director’s resume, diplomas/transcripts, and reference checks will be retained to validate the individual’s educational qualifications.

2. During the interview process, the individual’s knowledge regarding state regulations, Medicare Conditions of Participation, and other applicable regulations will be assessed. Only an individual with sufficient knowledge of these subjects will be considered for the position.

3. Responsibilities of the position will include but not be limited to:

   A. Operational planning and budgeting
   B. Ensuring organizational compliance with legal, regulatory, and accreditation requirements
   C. Monitoring business operations to ensure financial stability
   D. Evaluating hospice services and personnel using measurable outcomes and objectives
   E. Conflict and complaint management/resolution
   F. Establishing and maintaining effective channels of communication, including integrations of technology, as applicable
   G. Ensuring hospice personnel stay current with clinical information and practices
H. Ensuring adequate and appropriate staffing
I. Staff development including orientation, inservice, continuing education, competency testing, and performance improvement
J. Ensuring that interdisciplinary care is provided
K. Ensuring supportive services are available to staff
L. Ensuring coordination with other organization areas and senior management, as appropriate, according to structure and services
M. Ensuring staff and organization stay current on local and national issues and trends
N. Ensuring that appropriate service policies and procedures are developed and implemented to accomplish identified outcomes
O. Directing staff in performance of their duties, including admission, discharge, transfer, and revocation and provision of service to patients
P. Ensuring appropriate staff supervision during all service hours
Q. Monitoring service utilization to insure delivery of comprehensive care
R. Ensuring services provided by other agencies are authorized by hospice
S. Monitoring operational progress toward accomplishing operational and strategic goals
T. Insuring appropriate data collection and regular, complete reports are received by the Governing Body
U. Ensuring availability of adequate space, equipment, and supplies
V. Ensuring actionable objectives are derived from evaluation of hospice services and personnel
W. Ensuring that structure and systems promote interdisciplinary care
X. Ensuring collaboration with agencies and vendors for effective management of services
Y. Ensuring standards of ethical business and clinical practice are maintained
INFORMED CONSENT FOR PATIENT AND FAMILY/CAREGIVER
Policy No. H:1-006.1

PURPOSE

To delineate the process for informing patients and families/caregivers regarding hospice services and obtaining signed consent for hospice care.

POLICY

The patient or his/her legal representative (when the patient is not competent or of legal age) must sign a consent to participate in a hospice program prior to receiving care.

PROCEDURE

1. The admitting hospice social worker &/or hospice registered nurse will review the form with the patient and family/caregiver so that there is an understanding of the philosophy, goals, and services provided by the program. The explanation will include the palliative focus of hospice, the services of the interdisciplinary team with the registered nurse as the Case Manager, as well as any requirements to use services contracted by the hospice.

2. If possible, a member of the patient's family/caregiver will sign as a witness to the consent.

3. When the consent form is signed, the original copy will be kept on file in the patient's clinical record and a copy will be given to the patient.
PURPOSE

To establish the scope of services and requirements for patients eligible under the Medicare hospice benefit program.

POLICY

Visiting Nurse & Hospice Care will provide services as required for Medicare hospice benefit certification and applicable state licensing laws and regulations.

A Summary of the Medicare Hospice Benefit

Hospice care, which emphasizes comfort and palliative management of pain and other physical symptoms for patients who no longer have a realistic hope for a cure, has been provided by hundreds of hospice programs across the country in recent years. Hospice also specializes in a coordinated team approach that includes addressing psychosocial and spiritual needs of the individual patient and his/her family, however family is defined. Costs of providing some hospice services have been reimbursed by Medicare, Medicaid, and private insurance. However, the creation of the Medicare hospice benefit has made reimbursement possible for a broader range of the special services hospice provides, to permit terminally-ill persons to die in the comfortable surroundings of their own homes.

Visiting Nurse & Hospice Care is licensed by California Department of Health Services and is certified by Medicare to provide the Medicare hospice benefit to eligible patients. The benefit is available to patients who:

1. Are eligible for Medicare Part A
2. Are terminally ill and have a life expectancy of six (6) months or less confirmed by the attending physician and the hospice Medical Director
3. Meet criteria related to their terminal diagnosis
4. Are willing to sign an election statement that identifies services to be provided by hospice—services that are palliative not curative
5. Agree to give up traditional Medicare benefits after signing on to the hospice benefit, related to the terminal diagnosis
6. Have an available relative or friend willing and able to care for the patient (this may be waived under certain circumstances)
7. Are residents of Santa Barbara county
The Medicare hospice benefit is a total package of care for all medical needs associated with the patient's terminal illness. Therefore, the patient gives up the right to coverage for other Medicare benefits, such as hospital and hospice care from other agencies. The patient must also acknowledge an understanding that hospice is a program of care that emphasizes comfort, not cure.

The Medicare hospice benefit is elected for two (2) periods of 90 days and unlimited subsequent 60-day periods, the patient is certified as being terminally ill with a prognosis of six (6) months or less if the disease runs its normal course at the beginning of each benefit period. The patient may choose to revoke the benefit in writing, thereby forfeiting hospice coverage for the remaining days of any election period, and may re-elect the hospice Medicare benefit, for any subsequent period. The patient may elect a different hospice provider without losing benefit days. The patient may also revoke the benefit in order to pursue aggressive care options not offered under the hospice Medicare benefit, such as curative treatments.

The primary emphasis of the Medicare hospice benefit is on care in the patient's home, using family/caregiver as primary care clinician working with the hospice team to supply the patient's needs. The Medicare hospice benefit can be provided in a skilled nursing facility as the patient's place of residence if the hospice provider has a contract with the skilled nursing facility. The hospice organization must also make available inpatient services when needed to bring acute pain and symptom problems under control or to provide respite for exhausted family/caregiver. However, inpatient services are generally limited to short stays, which have as a goal stabilizing the patient and family/caregiver to permit the patient to return home. No more than 20% of total patient days in the hospice program should be inpatient days.

Hospice programs participating in the Medicare hospice benefit will be reimbursed for each patient day in the program, according to the level of care: routine home care, continuous care in times of crisis, inpatient respite care, and general inpatient care. Out of these daily rates, the hospice program must provide all of the hospice services required by the patient, with a few exceptions. The patient's attending physician may bill Medicare Part B for the services he/she provides. A hospice may not discontinue or diminish care due to a beneficiary's inability to pay for that care.

A patient in the hospice program remains under the care of his/her attending physician. Care is provided under an individualized written plan of care established by the attending physician and the interdisciplinary team of family/caregiver, which includes the physician, registered nurses, social workers, hospice aides, spiritual counselors, and volunteers.

The following services may also be provided by hospice personnel or through contract arrangements with other organizations: physical, occupational, and speech therapy; hospice aide and homemaker services; medical supplies including drugs and biologicals; and short-term inpatient care and respite care. The continuous care level of care can only be provided by contract private duty staff if the hospice provider shows extreme difficulty staffing the continuous care hours with core hospice staff. In addition, hospice provides a variety of volunteer services and programs designed to support grieving persons through the period of bereavement.
**Medicare Hospice Benefit Checklist**

**Eligibility Requirements**

The patient must:

1. Be eligible for Medicare Part A.

2. Be certified as being terminally ill, with a prognosis for a life expectancy of six (6) months or less if the disease runs its normal course.

3. Have an attending physician who will certify prognosis of terminal illness for first election period. The hospice Medical Director must also certify the first election and may alone certify terminal illness for the second 90-day period and subsequent 60-day benefit periods.

4. Consent to hospice care and be aware that hospice is palliative, not curative, in goals and interventions.

5. Have a primary care family member or friend willing and able to be available to provide services in the patient's home. (This requirement may be waived under certain circumstances.)

6. Be a resident of Santa Barbara county

**Time Period**

1. The patient is eligible for two (2) 90-day benefit periods and an unlimited number of subsequent 60-day periods, if the patient is certified and recertified as terminal.

2. Patient may revoke the benefit during any benefit period, losing the remaining days of the current election period, but can re-elect hospice care for subsequent election periods at a later date. At the time of re-election, the patient must meet certain criteria related to his/her end-stage disease process.

3. Once during each benefit period, the patient may elect another hospice organization certified to provide Medicare hospice benefit services for care, without losing days.

**Home Care Coverage**

To be provided by hospice as needed by patient:

1. Visits by registered nurses, licensed vocational nurses, social workers, rehabilitation therapists, spiritual counselors, physicians, and dietary counselors
2. Limited personal care assistance by homemaker/hospice aides/attendants

3. Private duty nursing (continuous care) during times of crisis as necessary to maintain an individual at home; must be predominantly nursing care (registered nurse or licensed vocational/practical nurse) but can include hospice aide service

4. Durable medical equipment (DME) from contracted vendors

5. Medical supplies by selected vendors

6. Medication related to the terminal diagnosis, from the contracted pharmacy with copayment waived

7. Emergency medications needed after hours from Visiting Nurse & Hospice Care

8. Medical Director available for consultation (supplementing the patient's attending physician)

9. Volunteers as requested

*General Inpatient Care*

Short-term general inpatient care for symptom management and/or pain control that cannot be managed in the home setting will be provided at contracted hospitals and/or skilled nursing facilities.

The following are not covered:

1. Long-term institutional care

2. Hospitalization for surgery

3. Evaluation unrelated to terminal diagnosis

4. Services not approved by the hospice interdisciplinary team

*Respite Care*

Respite care can be provided for up to five (5) days during any benefit period.
### Hospice Benefit—Regular Medicare Comparison

<table>
<thead>
<tr>
<th>Reimbursable Service</th>
<th>Regular Medicare</th>
<th>Hospice Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermittent Nursing…………………...</td>
<td>R…………………...</td>
<td>R…………………...</td>
</tr>
<tr>
<td>Extended Nursing *…………………...</td>
<td>No…………………...</td>
<td>R…………………...</td>
</tr>
<tr>
<td>Intermittent Hospice Aide……………</td>
<td>R…………………...</td>
<td>R…………………...</td>
</tr>
<tr>
<td>Extended Hospice Aide *……………...</td>
<td>No…………………...</td>
<td>R…………………...</td>
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<tr>
<td>Psychosocial Services………………...</td>
<td>R, Limited….....</td>
<td>R…………………...</td>
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<td>Intermittent or Extended…………….</td>
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<td>R…………………...</td>
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<td>Chaplain……………………………</td>
<td>P…………………...</td>
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<td>Bereavement………………………..</td>
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<td>Volunteers………………………..</td>
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<td>R…………………...</td>
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<td>Pharmacy……………………………</td>
<td>No…………………...</td>
<td>R…………………...</td>
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<td>80% (Part B)…..</td>
<td>R…………………...</td>
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<tr>
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<td>R (Part A)……...</td>
<td>R…………………...</td>
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<tr>
<td>Inpatient Respite……………………</td>
<td>No…………………...</td>
<td>R…………………...</td>
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* Extended = continuous care; minimum of up to eight (8) hours, 24 hours of care a day to provide skilled care for patient with acute changes

P = provided when needed but not reimbursed

R = required and provided

### Comparison of Requirements for Participation in Benefit

<table>
<thead>
<tr>
<th></th>
<th>Regular Medicare</th>
<th>Hospice Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility</td>
<td>A, A&amp;B, or 3</td>
<td>Part A, or A&amp;B</td>
</tr>
<tr>
<td>Treatment Goal</td>
<td>Curative, rehab</td>
<td>Palliation</td>
</tr>
<tr>
<td>Prognosis</td>
<td>Unlimited</td>
<td>6 months or less</td>
</tr>
<tr>
<td>Duration</td>
<td>Unlimited</td>
<td>2 90-day periods, unlimited 60-day periods</td>
</tr>
<tr>
<td>Home Care</td>
<td>Medical necessity must be justified, MSW limited rehab goals required</td>
<td>Extensive benefits for intermittent and extended (continuous) care</td>
</tr>
<tr>
<td>Bereavement</td>
<td>Not available</td>
<td>As needed, up to one (1) year after death</td>
</tr>
<tr>
<td>Homebound Status</td>
<td>Required</td>
<td>Not required</td>
</tr>
<tr>
<td>Requirement of Skilled Nursing</td>
<td>Required</td>
<td>Not required</td>
</tr>
</tbody>
</table>
PURPOSE

To establish the scope of services and requirements for patients eligible under the Medicaid hospice benefit program.

POLICY

Visiting Nurse & Hospice Care will provide services as required for Medicaid hospice benefit certification and applicable state licensing laws and regulations.

A Summary of the Medicaid Hospice Benefit

Hospice care, which emphasizes comfort, pain control and palliation, of physical symptoms for patients who no longer have a realistic hope for a cure, has been provided by several hundred hospice programs across the country in recent years. Costs of providing some hospice services have been reimbursed by Medicare, Medicaid, and private insurance. However, the creation of the Medicaid hospice benefit has made reimbursement possible for a broader range of the special services hospice provides, to permit terminally ill persons to die in the comfortable surroundings of their own homes.

Visiting Nurse & Hospice Care is certified by the California State Department of Health Services and Medicaid to provide the Medicaid hospice benefit to eligible patients. The benefit is available to patients who:

1. Are eligible for Medicaid who currently have a Medicaid number
2. Are terminally ill and have a life expectancy of six (6) months or less confirmed by the attending physician and the hospice Medical Director
3. Are willing to sign an election statement that identifies services to be provided by hospice
4. Agree to give up certain Medicaid benefits after signing on to the hospice benefit
5. Have an available relative or friend willing and able to care for the patient (this may be waived under certain circumstances)
6. Are residents of Santa Barbara county
The Medicaid hospice benefit is a total package of care for all medical needs associated with the patient's terminal illness. Therefore, the patient gives up the right to coverage for other Medicaid benefits, such as hospital and hospice care from other agencies. The patient must also acknowledge an understanding that hospice is a program of care that emphasizes comfort, not cure.

The Medicaid hospice benefit is elected for two (2) periods of 90 days and unlimited subsequent 60-day periods if the patient is certified/recertified as being terminally ill with a prognosis of six (6) months or less if the disease runs its normal course. The patient may choose to revoke the benefit in writing, thereby forfeiting hospice coverage for the remaining days of any election period, and may re-elect the Medicaid hospice benefit, for any subsequent period. The patient may elect a different hospice clinician without losing benefit days. The patient may also revoke the benefit in order to pursue care options not offered under the Medicaid hospice benefit, such as curative treatments.

The primary emphasis of the Medicaid hospice benefit is on care in the patient's home, using family/caregiver as primary care clinician working with the hospice team to supply the patient's needs. The Medicaid hospice benefit can be provided in a skilled nursing facility as the patient's place of residence if the hospice provider has a contract with the skilled nursing facility. The hospice organization must also make available inpatient services when needed to bring acute pain and symptom problems under control or to provide respite for exhausted family/caregiver. However, inpatient services are generally limited to short stays that have as a goal stabilizing the patient and family/caregiver to permit the patient to return home. No more than 20% of total patient days in the hospice program should be inpatient.

Hospice programs participating in the Medicaid hospice benefit will be reimbursed for each patient day in the program, according to the level of care: routine home care, continuous care in times of crisis, inpatient respite care, and general inpatient care. Out of these daily rates, the hospice program must provide all of the hospice services required by the patient, with a few exceptions. The patient's attending physician may bill Medicaid for the services he/she provides.

A patient in the hospice program remains under the care of his/her attending physician. Care is provided under an individualized written plan of care established by the attending physician and the interdisciplinary team of family/caregiver, which includes the physician, registered nurses, social workers, attendants, and spiritual counselors.

The following services may also be provided by hospice personnel of through contract arrangements with other organizations: physical, occupational, and speech therapy; hospice aide and homemaker services; private duty nurses for periods of crisis; medical supplies including drugs and biologicals; and short-term inpatient care and respite care within contracted hospitals and/or skilled nursing facilities.

In addition, hospice provides a variety of volunteer services and programs designed to support grieving persons through the period of bereavement.
Medicaid Hospice Benefit Checklist

Eligibility Requirements

The patient must:

1. Be eligible for Medicaid. A pending status is not acceptable as eligibility.

2. Be certified as being terminally ill, with a prognosis for life expectancy of six (6) months or less if the disease runs its normal course.

3. Have an attending physician who will certify prognosis of terminal illness for first election period. The hospice physician must also certify the first election and may alone certify terminal illness for the second 90-day period and subsequent 60-day benefit periods.

4. Consent to hospice care and be aware that hospice is palliative, not curative, in goals and interventions.

5. Have a primary care family member or friend willing and able to be available to provide services in the patient's home. (This requirement may be waived under certain circumstances.)

6. Be a resident of Santa Barbara county

Time Period

1. Two (2) 90-day benefit periods and an unlimited number of subsequent 60-day periods, if the patient is certified and recertified as being terminally ill at the beginning of each benefit period.

2. Patient may revoke the benefit during any benefit period, losing those remaining days of the current election period, but can re-elect hospice care for subsequent election periods at a later date. At time of re-election, the patient must meet certain criteria related to his/her end stage disease process.

3. Once during each benefit period, the patient may elect another hospice organization certified to provide Medicaid hospice benefit services for care, without losing days.

Home Care Coverage

To be provided by hospice as needed by patient:

1. Visits by registered nurses, licensed vocational nurses, social workers, rehabilitation therapists, spiritual counselors, physicians, and dietary counselors
2. Limited personal care assistance by homemakers/hospice aides/attendants

3. Private duty nursing (continuous care) during times of crisis as necessary to maintain an individual at home; must be predominantly nursing care (registered nurse or licensed vocational/practical nurse) but can include hospice aide service

4. Durable medical equipment (DME) from selected vendors with contracts

5. Medical supplies by selected vendors

6. Medications related to the terminal diagnosis, from the contracted pharmacy with copayment waived

7. Emergency medications needed after hours from organization

8. Medical Director available for consultation (supplementing the patient's attending physician)

9. Volunteers as requested

**General Inpatient Care**

Short-term general inpatient care for symptom management and/or pain control that cannot be managed in the home setting will be provided at contracted hospitals and/or skilled nursing facilities.

The following are not covered:

1. Long-term institutional care

2. Hospitalization for surgery

3. Evaluation unrelated to terminal diagnosis

4. Services not approved by hospice interdisciplinary team

**Respite Care**

Respite care can be provided for up to five (5) days during any benefit period.
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PURPOSE

To outline the process by which patients, families and caregivers will understand their financial responsibility for hospice services.

POLICY

Upon admission, the admitting hospice registered nurse will inform the patient and/or his/her representative of his/her payment responsibilities for hospice services. The patient will be informed of any subsequent changes in his/her financial responsibility.

PROCEDURE

1. Insurance coverage and patient's responsibility for copayment will be discussed, disclosed, and presented in writing to the patient and family/caregiver. The actual costs for care, if any, will be presented in writing to the patient and family/caregiver. If copay responsibilities are not known, the clinician will provide the patient and family/caregiver with total organization charges until more accurate information can be obtained.

2. If more information is needed for verification of coverage, the clinician will discuss this with the Clinical Supervisor and may alert social services if the patient's financial situation is unclear. The clinician will notify the billing department if a tailored payment plan is required.

3. Patients who incur financial liability must be notified in writing within 30 calendar days from the date the organization is notified of any changes from payers.

4. The ABN will be given less frequently for the hospice benefit than in other settings, for reasons including bundled per-diem payment and less advent of discharges for coverage reasons and non-covered care. (See “Advance Beneficiary Notice of Noncoverage” Addendum H:1-010.A.) There are three situations in which hospice services may be denied that could trigger liability protection under §1879.

   A. Ineligibility because the beneficiary is not “terminally ill” as defined in §1879(g)(2) of the Act;

   B. Specific item(s) and/or service(s) that are billed separately from the hospice payment, such as physician services, were not reasonable and necessary defined in either §1862(a)(1)(A) or §1862(a)(1)(C) and;

   C. The level of hospice care is determined not reasonable or medically necessary as defined in §1862(a)(1)(A) or §1862(a)(1)(C) specifically for the management of the terminal illness and related conditions.
5. A hospice **would issue** an ABN:

   A. To inform a hospice beneficiary, who has elected the hospice benefit and chooses to enter an inpatient setting that has not been arranged by the hospice provider, that he would be liable for payment

   B. To provide notice to a hospice beneficiary that he would be liable if the beneficiary decides to stay in the hospital after the hospice provider determines this level of care is no longer required, but chooses not to revoke the hospice benefit extend the stay

6. ABNs are **not required** for Hospice Services when:

   A. Hospice beneficiaries, or their representatives as defined by regulation, revokes the hospice benefit.

   B. Respite care exceeds five consecutive days and on the sixth consecutive day the patient wishes to remain in the facility, which is considered outside the definition of the hospice benefit. However, CMS encourages hospice providers to give the Notice of Exclusions from Medicare Benefits (NEMB) to alert the patient/family of potential financial liability

   C. Care is terminated for reasons unrelated to coverage

   D. A patient transfers to another hospice during a benefit period

   E. Care is terminated due to hospice staff safety issues in a beneficiary’s home. However, hospices must ensure the patient/family understands care will be discontinued and may choose to issue a NEMB.

   F. Hospice providers choose to give services like palliative care that Medicare does not cover to beneficiaries who have not elected hospice. However, CMS encourages hospice providers to give advance voluntary notice to beneficiaries of possible financial liability when it exists in these cases and The NEMB may be used for this purpose.

7. Refer to the instructions found in the manual revision 50.9 and 50.9.1 of Chapter 30 of the Medicare Claims Processing Manual- Financial Liability Protections for related information and additional requirements. (See “Additional CMS Resources for ABN and Expedited Notices” Addendum H:1-010.D.)

8. In the past, hospice providers would have only used the general ABN for all terminations where the beneficiary faced financial liability. Now hospice providers will be required to issue the Notice of Medicare Provider Noncoverage (generic notice) under the expedited review process for termination when covered care is ending for coverage reasons. (See “Advanced Beneficial Notice” Addendum H:1-010.A.) Hospice providers will also issue the ABN in addition to the expedited notice at terminations only when they continue to provide care to the beneficiary on a non-covered basis after the date Medicare coverage ends.
9. After reading the Notice of Provider Noncoverage (generic notice), the patient or his/her representative must sign and date the form indicating they have received the notice and understand they can appeal the decision by contacting a QIO.

10. A Detailed Notice is given to a patient or his/her representative when QIO review is requested in order to provide more explanation on why coverage is ending. (See “FFS Expedited Review Detailed Notice” Addendum H:1-010.C.)

11. CMS has provided explicit instructions including but not limited to when and how to fill out all required forms, the delivery of notices, time frames for delivery, and who pays for care while the QIO is reviewing the determination. (See “Additional CMS Resources for ABN and Expedited Notices” Addendum H:1-010.D.) Organization leadership is responsible for educating staff on current CMS requirements regarding the ABN, FSS ED Notices and FFS Detailed Notice.

12. All written and verbal notifications of the patient’s financial responsibility will be documented in the clinical and billing records. Original versions of the completed ABN, whether annotated or signed and copies of signed Notice of Provider Noncoverage (generic notice), will be kept on file at the organization.
ADDENDUM H:1-010.A

ADVANCE BENEFICIARY NOTICE (ABN) OF NONCOVERAGE

Form CMS-R-131

www.cms.hhs.gov/BNI/02_ABNGABNL.asp#TopofPage
ADDENDUM H:1-010.B

NOTICE OF MEDICARE PROVIDER NONCOVERAGE

Form CMS-10123 A

For the most current version of CMS required form, access the following website to print the form:

http://www.cms.hhs.gov/BNI/
ADDENDUM H:1-010.C

FFS EXPEDITED REVIEW DETAILED NOTICE

“Detailed Explanation of Noncoverage CMS 10124”

For the most current version of CMS required forms, access the following website to print the form:

http://www.cms.hhs.gov/BNI/
ADDENDUM H:1-010.D

ADDITIONAL CMS RESOURCES FOR ABN AND EXPEDITED NOTICES

For the most current information from CMS on the Expedited Review Process, access the following websites:

FFS Home Health Advanced Beneficiary Notice (HHABN)

www.cms.hhs.gov/BNI/03_HHABN.asp

Generic and Detailed Notices in English and Spanish, Word version of notices, Instructions on use of forms, Qs & As

http://www.cms.hhs.gov/BNI/

Medicare Claims Processing Manual, Chapter 30
Financial Liability Protections, Section 50.9 & 50.9.1


MLN Matters Article on New Expedited Review Process


CMS maintained Directory of QIOs

http://www.cms.hhs.gov/qio
PURPOSE

Visiting Nurse & Hospice Care is committed to prevention, detection, and to taking all appropriate action to assure compliance with all legal and regulatory statutes and to promote honest and ethical behavior in all work-related activities.

POLICY

An ongoing evaluation process will be established utilizing existing and new monitoring procedures to assure compliance. An annual evaluation of the compliance program’s intent and effectiveness will also be completed. Reports will be provided to Administration and the Governing Body. This policy includes key areas for monitoring, and is not intended to be all-inclusive of monitoring activities. Monitoring controls identified are categorized by functional areas and include, but are not limited to, those issues currently targeted by the Officer of the Inspector General. This list will be updated as necessary.

PROCEDURE

1. Administration/Financial

   A. All employees will be informed of the Standards of Conduct and report any suspected violations to their supervisor, or the Corporate Compliance Officer to reasonably ensure that all activities are in compliance with the Standards of Conduct. An annual audit of the Corporate Compliance Plan will be completed.

   B. The organization will have an annual financial audit conducted by its certified public accountants to examine, on a test-basis, evidence supporting the proper handling and reporting of amounts, and disclosures relating to, its financial activity.

   C. Visiting Nurse & Hospice Care will conduct an annual review of the Cost Report to assure proper allocation of costs to specific programs, assess the allowableness of G&A expenses, marketing and advertising expenses and proper recording of related expenses.

       1. Time sheets are reviewed to determine accuracy and completeness. Payroll staff will follow-up on any unusual program code or cost center allocations.

       2. The organization will perform periodic audits of expenditures to determine compliance with organization’s policies. All expenses are monitored to evaluate accuracy and validity.
D. Visiting Nurse & Hospice Care will conduct and document annual reviews with its third party contractors to reasonably ensure that activities are in compliance with the Standards of Conduct and related policies.
E. The organization will conduct an annual review of the Conflict of Interest policy with all employees and Governing Body

F. The organization will conduct an annual review of compliance with the terms, conditions and covenants contained in its financing loan agreements.

G. Visiting Nurse & Hospice Care will conduct and document an annual review of its billing practices to reasonably ensure that all activities are in compliance with the Standards of Conduct and organization policies, third party billing requirements, and that billing occurs for only those services provided, documented, and for which there are signed physician orders.

2. Human Resources (HR) Department

A. Visiting Nurse & Hospice Care will conduct an annual audit to assure that the Standards of Conduct and the agency personnel policies and procedures are being followed. The audit will include, but is not limited to:

1. Pre-employment interview sheets completed, reference checks completed and documented.

2. Criminal background completed on all new employees. Drivers’ license checks on field staff and driving positions.

3. Systems exist and are effective in tracking performance evaluations, professional licenses, inservice education (including mandatories).

4. Process exists and is effective for investigation/follow-up on work-related injuries.

5. OIG/GSA exclusion checks are completed and documented.

3. Clinical/Documentation Compliance

A. Patient's Eligibility and Appropriate Documentation

B. The six (6) month life-expectancy eligibility utilizing LCDs

The skilled care/hospice eligibility requirements for Medicare coverage are assessed utilizing several methods:

1. Interdisciplinary team conference

2. Supervisory visits with staff

3. Audits of Start of Care documentation

C. Patient Abandonment/Discriminatory Admission and Discharge Practices
1. Visiting Nurse & Hospice Care will ensure that patients will be admitted and discharged according to the organization policy.

D. Physician’s orders

Mechanisms are currently in place to assure timely signed physician orders prior to billing.

1. Order tracking on a daily basis by the Health Information Management/Department of Medical Records.

2. Staff will send regular follow-up notices to physicians that do not return signed orders in a timely manner.

3. Physician License Verification—A mechanism exists whereby Visiting Nurse & Hospice Care knows that a physician is licensed to practice and whether they have been precluded from the Medicare/Medicaid Program.

E. Payer Changes

A process is in place to assure that payer changes occur on a timely basis and that meets the requirement for patient notification (ABN-Advance Beneficiary Notice) within the required time frames.

F. Hospice Aide Services

This includes the following:

1. Appropriateness of level of worker for tasks needed to be completed

2. Personal care necessary, ordered and provided for payer coverage

3. Plan of Care matches orders, aide schedule matches orders and services provided match documentation, orders and bill generated.

G. Medical Records

A process is in place to assure that medical records are appropriately secure and that record retention meets the time frames required by regulation and accrediting bodies.

H. Denial Tracking

Denials for services rendered and bills are tracked and data compiled quarterly to determine any needed corrective action with respect to re-education, specific caregiver problems or any other trends.
## SECTION TWO

### Quality of Services and Products

**Hospice Services**

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*Requires state or organization-specific information.
HOSPICE II
Visiting Nurse & Hospice Care

Quality of Services and Products

Internal Referral Process

*Requires state or organization-specific information.

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HOSPICE II
Quality of Services and Products

HOSPICE PATIENT RIGHTS AND RESPONSIBILITIES
Policy No. H:2-000.1

PURPOSE

To encourage awareness of patient rights and provide guidelines to assist patients in making decisions regarding care and for active participation in care planning.

POLICY

Each patient will be an active, informed participant in his/her plan of care. To ensure this process, the patient will be empowered with certain rights as described. A patient may designate someone to act as his/her representative. This representative, on behalf of the patient, may exercise any of the rights provided by the policies and procedures established by the organization.

To assist with fully understanding patient rights, policies will be available to the organization personnel, patients, and his/her representatives as well as other organizations and the interested public.

This policy supplements the “Patient Bill of Rights” (see Policy No. C: 2-003.)

PROCEDURE

The Patient Rights statement defines the right of the patient to:

- Exercise his or her rights as a patient of the hospice;
- Have his or her property and person treated with respect;
- Voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice;
- Not be subjected to discrimination or reprisal for exercising his or her rights
- Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness;
- Be involved in developing his or her hospice plan of care;
- Refuse care or treatment;
- Choose his or her attending physician
- Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property;
- Receive information about the services covered under the hospice benefit;
• Receive information about the scope of services that the hospice will provide and specific limitations on those services.

• Be advised that the Hospice Organization complies with Subpart 1 of 42 CFR 489 and receive a copy of the organization's written policies and procedures regarding advance directives, including a description of an individual's right under applicable state law and how such rights are implemented by the organization.

• Receive written information describing the organization's grievance procedure which includes the contact information, contact phone number, hours of operation, and mechanisms for communicating problems.

• Receive an investigation by the organization of complaints made by the patient or patient's family or guardian regarding treatment or care or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the agency and that the organization will document the existence of the complaint and the resolution of the complaint.

• Receive information addressing any beneficial relationship between the organization and referring entities.

Patient and Families have the responsibility to:

• Remain under a doctor's care while receiving agency services.

• Inform the agency of any advance directives or any changes in advance directives and provide the agency with a copy.

• Cooperate with the primary doctor, agency staff and other caregivers.

• Advise the agency of any problems or dissatisfaction with patient care.

• Notify the agency if you do not understand information being given to you.

• Provide a safe home environment in which care can be given, and be involved in your care as a safety strategy. Patients and families need to be aware of that if the patient's or staff's welfare or safety is threatened, service may be terminated.

• Obtain medications, supplies and equipment ordered by the patient's physician if they cannot be obtained or supplied by the agency.

• Treat agency personnel with respect and consideration.

• Sign the required consents and releases for insurance billing and provide insurance and financial records as requested.

• Provide the agency with a complete and accurate health history.

• Accept the consequences for any refusal of treatment or choice of non-compliance.
HOSPICE II
Quality of Services and Products

SCOPE OF SERVICES
Policy No. H:2-001.1

PURPOSE
To describe Visiting Nurse & Hospice Care operations including the geographical service area.

POLICY
Visiting Nurse & Hospice Care provides hospice services that are intended to meet the physical, psychosocial, practical, and spiritual needs of hospice patients and families/caregiver.

Visiting Nurse & Hospice Care will operate an office that will provide a safe and adequate location related to space, facilities, and administrative services.

Visiting Nurse & Hospice Care will be open from 8:00 a.m. to 5:00 p.m., Monday through Friday, except designated holidays or other days decided by the CEO. Drugs, biologicals, and core hospice services provided by nurses, social workers, and physicians are available 24 hours a day, seven (7) days a week. Other covered services are available on a 24-hour basis to the extent necessary to meet the patient’s needs relating to palliation and treatment of the terminal illness and/or treatment of related conditions.

PROCEDURE
1. Refer to the Service Area policy C:2000 regarding Visiting Nurse & Hospice Care geographical service areas.

2. Hospice services will be provided to terminally ill patients in their place of residence, which could be in the patient’s own private residence, a skilled nursing facility, adult foster care, or other living arrangements.

3. An interdisciplinary team of professionals and volunteers will develop with each patient and family/caregiver a plan of care, which will include, as appropriate, the following services:

   A. Physician
   B. Registered nurse
   C. Psychosocial worker
   D. Counseling
   E. Spiritual support
F. Therapists (physical, occupational, and speech)

G. Dietary counseling

H. Hospice aide

I. Homemaker services

J. Hospice volunteers

K. Consultant pharmacist

L. Durable medical equipment related to the hospice patient's terminal diagnosis

M. Medications and medical supplies related to the hospice patient's terminal diagnosis

N. Inpatient care: short-term stay for symptom control and planned respite for family/caregiver

O. Bereavement follow-up for up to one (1) year after death

4. Routine home visits will be provided according to the plan of care including scope and frequency.

5. Continuous care will be provided for up to 24 hours per day during periods of crisis and may include nursing, hospice aide, social worker, or personal care of volunteer services. A minimum of eight (8) hours during a 24-hour period will be available during crisis. One-half of the total hours of care provided during each 24-hour period must be provided by nursing.

6. Inpatient respite care will be provided only in a Medicare/Medicaid facility, on a short-term basis to assist the family in their ability to provide continuing care to the patient.

7. General inpatient care will be arranged when the patient requires care for pain control and/or symptom management.

8. Transportation services required by the patient in the provision of hospice care will be coordinated by the organization.
PURPOSE

To assure that services, whether provided directly or under contractual agreement, adhere to hospice policies and procedures and professional management accountability.

POLICY

Services will be provided by personnel directly or under contractual agreements. All services provided, whether directly or under contractual agreement, will be guided by Visiting Nurse & Hospice Care policies and procedures and professional management accountability. All contractual agreements will clearly define roles and responsibilities for the hospice and the contractor.

PROCEDURE

1. Reimbursement of services provided will be reviewed annually by the Executive Director/Administrator and hospice Chief Financial Officer.

2. Services will be provided as listed below:

<table>
<thead>
<tr>
<th>Service</th>
<th>Directly</th>
<th>Under Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interdisciplinary Team</td>
<td></td>
<td>Each organization should indicate if provided under contract</td>
</tr>
<tr>
<td>• Registered nurse</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Licensed practical/vocational nurse</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Physical therapist</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Occupational therapist</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Speech therapist</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Psychosocial worker</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Registered dietary consultant services</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Hospice aide</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Homemaker</td>
<td>X</td>
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</tr>
<tr>
<td>• Volunteers</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Hospice Chaplain services</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Bereavement services</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Pharmacy consultant</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Physician services</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Policy No. H:2-002.2
### Table: Services Provided

<table>
<thead>
<tr>
<th>Service</th>
<th>Directly</th>
<th>Under Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Services</td>
<td></td>
<td>will be provided according to the hospice care plan and related to the terminal diagnosis</td>
</tr>
<tr>
<td>• DME/Supplies</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Medications</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>• Inpatient care</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

3. Nursing services are routinely provided by hospice employees. The hospice may enter into a written agreement for the provision of nursing services only under the following circumstances:

   A. unanticipated periods of high patient loads;

   B. staffing shortages due to illness or other short-term temporary situations that interrupt patient care;

   C. temporary travel of a patient outside of the hospice’s service area; and/or

   D. the need for highly specialized nursing services that are provided so infrequently that the provision of such services would be impracticable or prohibitively expensive.
INTERDISCIPLINARY TEAM MEMBERSHIP
AND RESPONSIBILITIES
Policy No. H:2-003.1

PURPOSE
To define the membership and responsibilities of the interdisciplinary team.

POLICY
The interdisciplinary team will collaborate with the patient’s attending physician to develop an individualized written plan of care.

When there is more than one (1) interdisciplinary team, the hospice will designate in advance the group responsible for program oversight and the establishment of policies that govern the day-to-day provision of hospice care and services.

PROCEDURE
1. The hospice interdisciplinary team membership includes at a minimum:
   A. Physician
   B. Registered nurse
   C. Social worker
   D. Pastoral or other counselor

2. Additional members may include:
   A. Physical therapist
   B. Occupational therapist
   C. Speech therapist
   D. Registered dietician
   E. Pharmacist
   F. Home care aide/homemaker
   G. Volunteer
3. The interdisciplinary team responsibilities include but are not limited to:

   A. Participation in the establishment of the plan of care for each patient admitted to the hospice service

   B. Participation in the periodic review and updating of the plan of care for each patient receiving hospice services

   C. Provision or supervision of hospice care and services

   D. Establishment of policies and procedures governing the day-to-day provision of hospice care and services

   E. Recognize and maintain professional boundaries in relationships with patients, family, and caregivers.

   F. Provide ongoing support for and techniques to avoid overstepping boundaries.

   G. Reviewing and resolving conflict of care and ethical issues

   H. Planning for community education regarding hospice services

   I. Participating in performance improvement activities
PURPOSE

To specify the role of the nurse in hospice care.

POLICY

Nursing services will be provided in accordance with accepted standards of practice by or under the supervision of a registered nurse. The hospice nurse (registered nurse or licensed vocational nurse) will be a member of the interdisciplinary team. The hospice nurse will play a key role in easing physical and psychosocial symptoms and initiating communication with the interdisciplinary team to establish the plan of care.

A hospice registered nurse will be assigned as the Case Manager for each patient and family/caregiver, and his/her duties will be enumerated in a job description. Duties will include the responsibility for coordination of care and fostering communication between the patient and the interdisciplinary team. The Case Manager will assure that components of the plan of care are established and implemented by the interdisciplinary team. The Case Manager will determine the scope and frequency of services needed based on acuity of the patient and family/caregiver needs.

(See “Interdisciplinary Team Coordination of Care” Policy No. H:2-035.)

PROCEDURE

1. The hospice registered nurse performs the initial assessment and participates in the comprehensive assessment and ongoing updates of the comprehensive assessments to assess the impact of the terminal diagnosis on the patient’s physical, functional, psychosocial and environmental needs and activities of daily living.

2. The hospice nurse will participate in developing and implementing the plan of care and will report the condition of patient and family/caregiver to the attending physician, Medical Director and interdisciplinary team on a regular basis, as well as changes in the plan of care.

3. The hospice nurse will:
   
   A. Implement the plan of care with a focus on palliative care.
   
   B. Manage discomfort and provide symptom relief.
   
   C. Incorporate specialized nursing skills related to palliative and end-of-life care into all clinical care provided.
D. Provide patient and family/caregiver education regarding the disease process, self-care techniques, end-of-life care, and processes for addressing ethical issues.

E. Provide emotional support to the patient and family.

F. Assess for risks of pathological grief, cultural and spiritual implications and verbal and nonverbal communication patterns exacerbated by the terminal diagnosis.

G. Initiate appropriate preventive and rehabilitative nursing procedures.

H. Prepare clinical and progress notes that demonstrate progress toward established goals.

I. Coordinate all patient and family/caregiver services and prioritization of needs with the interdisciplinary team.

J. Use a case management approach and make referrals to other services as needed.

K. Inform physicians and other team members of changes in patients’ needs and outcomes of interventions.

L. Provide specialized hospice training to other staff, family/caregivers to insure adequate care.

M. Provide an ongoing evaluation of the patient and family/caregiver response to care and recommend to IDT modifications of the plan of care based on their response.

N. Assess the ability of the caregiver to meet the patient’s immediate needs upon admission and throughout care.

O. Provide appropriate referral and follow-up.

P. Apply specific criteria for admission and recertification to hospice care to establish appropriate levels of care and the patient’s eligibility.

Q. Facilitate the implementation of another level of hospice care when necessary.

R. Assure communication between the hospice and other health care providers involved in the patient’s care.

S. Communicate information using EMR, email, and cell-phones per organizations processes and policies.

T. Participate in utilization review activities.
U. Participate in quality assessment performance improvement teams and activities.

Policy No. H:2-004.3

4. The hospice registered nurse will supervise licensed vocational nurses, hospice aides, homemakers and volunteers in the home, and follow the family/caregiver into the bereavement period, per organizational policy.

5. A hospice nurse will be available on a 24-hour basis to meet the physical, psychosocial, spiritual, and practical needs of patients and families/caregivers admitted to the hospice program.

6. Direct provision of nursing care will be based on hospice nursing standards and clearly defined treatment protocols.

7. Patient and family/caregiver education and training activities will be initiated and continued throughout the course of care.

8. The hospice nurse will:
   A. Participate in inservice programs
   B. Evaluate his/her own needs for support and utilize available systems to meet these needs

9. California Certified Nurse Practitioners may see, treat, and write orders for hospice patients as established by medical directors and IDT.

10. Licensed vocational nurses will supplement the nursing care needs of the patient as provided by the registered nurse; this may include:
    A. Providing services in accordance with organizational policies and procedures and regulations that define scope of practice.
    B. Preparing clinical and progress notes documenting outcomes of interventions
    C. Assisting the registered nurse or physician in performing specialized duties related to end-of-life care
    D. Assisting the registered nurse in carrying out the plan of care
    E. Preparing equipment and materials for treatment adhering to aseptic technique as required
    F. Assisting the patient in learning appropriate self-care techniques
    G. Assessing patient and family/caregiver response to care
H. Insuring communication of information to appropriate team members

Policy No. H:2-004.4

11. When nursing services are delegated to a licensed vocational nurse (LVN);

   A. The LVN is supervised by an RN who is available at least by phone during the hours
      the LVN is providing services or is on call; and
   
   B. The RN makes at least bi-monthly home visits (once every two weeks) and documents
      every 30 days that the LVN is routinely providing nursing services in accordance with
      the patient’s plan of care.

12. The hospice aide and/or homemaker function in a supportive relationship to professional
    disciplines and may function as an extension of these professional services with written
    instructions, appropriate supervision, and specialized hospice training. The hospice aide
    meets qualifications specified in 418.76.
PURPOSE

To specify the role of the hospice aide and/or homemaker in hospice care.

POLICY

Hospice aide services will include personal care services provided by trained hospice aides and non-skilled services provided by homemakers.

Hospice aide services may be included for routine care on an intermittent basis when personal care is needed. Services provided by an aide could include: bathing, shampoo, range of motion activities, dry dressing changes, assisting the patient to the bathroom, use of commode or bed pan, assisting with meal preparation, feeding the patient, light housekeeping and/or linen changes. These activities in accordance with the plan of care and physician's (or other authorized independent practitioner's) orders will be assigned and supervised by a hospice registered nurse.

Homemaker services may be included for routine care on an intermittent basis when non-hands-on care is required. These types of services could include: housekeeping, family/caregiver respite, and meal preparation. Specifically, these activities would not be related to personal care; however, they would assist the primary family/caregiver to keep the patient at home.

PROCEDURE

1. The need for hospice aide services will be identified by the RN Case Manager and included in the interdisciplinary plan of care.

2. Arrangements for hospice aide services will be made by either the Case Manager or Clinical Supervisor. When needed, this service could be referred to a contract organization.

3. Hospice aide assignments, plan of care, and interventions will be documented and included in the patient's clinical record.

4. Hospice aide duties include:
   A. Assisting with personal hygiene
   B. Assisting with ambulation and exercise
   C. Assisting with medications that are ordinarily self-administered (per state regulations)
D. Reporting changes in the patient’s condition and needs

E. Providing nutritional support

F. Other supportive tasks as assigned

5. Hospice aides will document care provided in accordance with the hospice aide assignment.

6. Homemaker/chore services personnel will provide the patient and family/caregiver with environmental support under professional supervision.
PURPOSE

To ensure that appropriate medical social services are provided to hospice patients and families/caregivers.

POLICY

Visiting Nurse & Hospice Care will provide medical social services by qualified social workers (MSW) under the direction of a physician and in accordance with the plan of care. Duties and responsibilities of social workers will be identified in appropriate job descriptions.

Medical social services will include:

1. Assessing emotional factors related to terminal illness and strengthening the patient/caregiver’s coping skills
2. Patient and family/caregiver counseling around issues of death, dying, and grief
3. Team and personnel support by assisting the physician and other interdisciplinary team members in recognizing and understanding the social/mental stress and/or disorder that exacerbates symptoms related to the terminal illness
4. Financial and community resource referrals
5. Maintaining the dignity of the dying patient.

A social worker will be assigned to each patient and family/caregiver based on the patient’s and family’s needs and acceptance of these services. The social worker will be a member of the interdisciplinary team and will participate in the development, implementation, and revision of the plan of care.

If the patient/caregiver declines social work services, no visits are required and the refusal is documented in the patient’s clinical records. The assigned Social Worker continues to offer support to the IDT in its care of the patient and to monitor the patient/caregiver’s evolving needs.

PROCEDURE

1. The social worker will perform the psychosocial assessment as described in the Psychosocial Assessment policy and will contribute to the interdisciplinary team’s updates at least every 15 days based on the needs of the patient. Services provided by the social worker will include but not be limited to:

   A. Assessing emotional factors related to terminal illness
B. Assisting the physician and other IDT/IDG members in recognizing and understanding the social/mental stress and/or disorder that exacerbates the symptoms related to terminal illness

C. Assessing the patient/family psychosocial status, potential risk of suicide and/or abuse or neglect

D. Assessing environmental resources and obstacles to maintaining safety

E. Participating in the development and revision of a plan of care

F. Providing social services including:
   1. Short-term individual counseling
   2. Crisis intervention
   3. Assistance in providing information and preparation of advance directives
   4. Funeral planning issues and transfers regarding fiscal, legal, and health care directions

G. Preparing clinical and progress notes

H. Identifying family dynamics, communication patterns

I. Involving the patient/family in the plan of care

J. Identifying and utilizing appropriate community resources and assessing patient/family ability to access them

K. Participating in in-service programs

L. Evaluating patient/family response to physical psychosocial interventions

M. Assessing caregiver’s ability to function adequately

N. Assessing need for counseling related to risk assessment for pathological grief

O. Assessing special needs related to cultural diversity including communication, space, role of family members, and special traditions

P. Identifying the developmental level of patient/family and obstacles to learning or ability to participate in care of patient
Q. Addressing patient/family questions and issues

R. Identifying obstacles to compliance and assisting in understanding the goals of interventions

S. Identifying support systems available to reduce stress and facilitate coping with end-of-life care

T. Evaluating for long-term care when appropriate and assessing ability to accept change in level of care

U. Communicating psychosocial information to inpatient facility when level of care is changed

V. Assisting patient/family in assessing financial resources when appropriate

W. Identifying patient family needs when discharged or when level of care changes

X. Evaluating patient/family response to intervention(s) when referred to community agency and satisfaction of the service(s) provided

Y. Assessing bereavement needs

2. Medical social services will be provided in whichever setting the patient may be at the time.

A. Psychosocial assessments will be performed on each new hospice admission and continue throughout the course of care. Interventions to assist the patient are based on assessment data.

B. Patient and family/caregiver counseling will be offered to every patient and family/caregiver and, as appropriate, will be provided to the patient and family/caregiver by a social worker or other interdisciplinary team member.

C. Crisis intervention services will be provided to patients and families/caregivers when required, 24 hours a day, seven (7) day a week, by a social worker or other interdisciplinary group member.

D. Information about and referrals to additional community support services will be made available to the patient and family/caregiver. The patient and family/caregiver’s ability to access these resources will be assessed

E. Psychosocial information will be communicated to an inpatient facility when level of care is changed.

F. Information regarding Advance Directives and Physical Orders for Life Sustaining Treatment (POLST) will be provided and assistance in preparation offered.
G.  Assistance with funeral planning will be provided including transfer of responsibilities regarding fiscal, legal, and health care decisions.

H.  Patient and family/caregiver questions and concerns will be promptly addressed and answered in a timely manner.

3.  Psychosocial assessments and interventions will be documented in the patient's clinical record as part of the comprehensive assessment and in interdisciplinary visit notes, as well as the plan of care.  Documentation will include:

   A.  Goals of care

   B.  Observations of the psychosocial needs or problems of the patient and family/caregiver, including counseling needs, assistance with planning for wills, funeral arrangements, financial planning, environmental needs, etc.

   C.  Interventions provided to address the psychosocial needs or problems of the patient and family/caregiver and the patient's response and progress towards goals

   D.  Plans and/or referrals made to address the psychosocial needs or problems of the patient and family/caregiver in accordance with the plan of care

4.  Social work personnel will participate in hospice inservice programs to maintain and improve their specialized skills.

5.  The social worker will provide staff support by:

   A.  Being available to staff for Bereavement Support

   B.  Participating in development of approaches to meet staff counseling needs.
PURPOSE

To provide guidelines for the appropriate assessment and provision of services to meet the spiritual needs of patients and families/caregivers.

POLICY

Patients will be advised of the availability of spiritual support. Hospice will provide spiritual care counseling in keeping with the patient's/family's/caregiver's belief system and practice, and in accordance with the plan of care.

The Hospice Spiritual Counselor (or designated spiritual care counselor) will provide direct support and coordinate services utilizing local clergy and other individuals, as appropriate.

A Spiritual Counselor will be assigned to each patient based on the patient’s needs and acceptance of these services. The Spiritual Counselor will be a member of the interdisciplinary team and will participate in the development, implementation and revision of the plan of care.

PROCEDURE

1. The hospice registered nurse or MSW will assess the patient's and family/caregiver's immediate spiritual support needs during the initial assessment.

2. When the patient/family request spiritual support at the time of admission, the Hospice Spiritual Counselor will contribute to the comprehensive assessment within 5 days of start of care and ongoing updates to the comprehensive assessment based on the needs of the patient and family.

3. If the patient and family/caregiver requests spiritual support from hospice, the Hospice Spiritual Counselor will provide services directly or coordinate a referral to appropriate resources.

4. The Hospice Spiritual Counselor will develop an individualized spiritual/pastoral plan of care, which will demonstrate an effort to work closely with local clergy as desired by the patient, and provision of spiritual support as defined and requested by the patient and family/caregiver.

5. The Hospice Spiritual Counselor will conduct religious services of prayer, worship, and rituals for patients/families as requested.

6. The Hospice Spiritual Counselor will offer patients and families/caregivers of different philosophies and religious beliefs opportunities to discuss and share their thoughts, feelings, beliefs, and values.
7. If the patient and family/caregiver identifies involvement with a church, synagogue, mosque, etc., and permission is given to contact them, the Hospice Spiritual Counselor will call to coordinate care. The identified spiritual support person will be encouraged to participate as an interdisciplinary team member in developing the plan of care.

8. Spiritual care assessments and counseling will be documented in the patient’s clinical record as part of the comprehensive assessment and in interdisciplinary visit notes, as well as the plan of care.

9. If the patient and family/caregiver refuses spiritual care services, the RN or the MSW involved in the case will document refusal. The interdisciplinary team members will make continued inquiries as appropriate. The Spiritual Counselor continues to offer support to the IDT in its care of the patient as well as monitoring the patient/caregiver’s evolving spiritual needs.

10. Ongoing comprehensive assessments will be made by the interdisciplinary team members to identify any developing spiritual needs of the patient and family/caregiver and to update the plan of care to meet those needs.

11. All referrals, assessments, clinical notes, interventions and significant phone calls will be documented in the patient’s clinical record.

12. The Hospice Spiritual Counselor will attend interdisciplinary team meetings, and will work in a team approach with members of the group and other qualified professionals to evaluate patient and family/caregiver response to care and resolution of ethical issues.

13. The Hospice Spiritual Counselor will provide staff support by:
   
   A. Meeting with individual staff members, upon request, regarding personal spiritual/pastoral issues that may affect their ability to function effectively
   
   B. Being available to staff for bereavement support
   
   C. Participating in development of approaches to meet staff spiritual needs
ADDENDUM H:2-007.A

HOSPICE SPIRITUAL CONCERNS
1. Need for a sense of integrity and self-worth:
   • Experiencing spiritual suffering of unspecified origin
   • Experiencing diminished spiritual capacity
   • Expressing need for spiritual support to maintain or increase existing resources for comfort, peace, hope, trust
   • Inability to cope
   • “Why me?” and related questions
   • Expressions of anxiety or insecurity
   • Expression of despair, hopelessness, apathy

2. Need for connection or reconciliation:
   • Expressions of guilt, shame, fear, regret, worthlessness, or unworthiness
   • Expressions of unfinished business with self, others, God, or institutions
   • Lack of trust
   • Fear of being alone or dying alone
   • Need to give and receive love
   • Experience of loneliness, isolation, rejection
   • Separation or alienation from community of faith or support network
   • Ambivalence or anger toward God

3. Need for sense of meaning, purpose, direction, and hope:
   • Crisis of meaning, purpose, values
   • Lack of objectives, goals, or hope
   • Openly questioning meaning of life, illness, suffering, or death
   • Need for symbolic expression—rituals, sacraments, etc.
PURPOSE

To ensure that appropriate and coordinated bereavement services are provided to families/caregivers.

POLICY

Visiting Nurse & Hospice Care will provide an organized bereavement program supervised by a qualified Bereavement Coordinator for up to one (1) year following the death of the patient. Services will be provided by personnel who have received training and have experience in dealing with grief. The duties and responsibilities of the Bereavement Coordinator and Bereavement Counselors will be specified in appropriate job descriptions.

The program will provide bereavement services to the families/caregivers of hospice patients both before and after the patient's death in accordance with the plan of care. The purpose of these services will be to facilitate a normal grieving process and to identify and appropriately refer those persons who may be experiencing pathological grief reactions that may interfere with the eventual resolution and integration of their losses. The purpose will also be to prepare the individual to function independently of hospice and to identify a support system with the individual.

Bereavement services will be coordinated, insofar as possible, with the individual's clergy, if any, as well as with other community resources judged to be useful and beneficial to the family/caregiver.

Bereavement counseling extends to residents of a SNF/INF or ICF/MR when appropriate and identified in the bereavement plan of care.

PROCEDURE

1. A bereavement risk assessment will be completed by the hospice social worker at the time of admission to hospice. (See “Bereavement Assessment” Policy No. H:2-053.) Information gathered will be incorporated into the plan of care and considered in the bereavement plan of care.

2. After the bereavement risk assessment is completed, a plan will be developed to address bereavement/grief issues and will be implemented as needed.

3. Depending on the patient and family/caregiver needs identified in the bereavement assessment, bereavement counselors may need to contact and/or visit the patient and family/caregiver prior to the death.
4. The bereavement counselors may provide supportive counseling to the patient and family/caregiver prior to the death.

5. After a death has occurred, the bereavement assessment will be updated and the family/caregiver needs will be discussed at the next interdisciplinary team meeting.

6. Bereavement interventions will be reflective of the family/caregiver’s choices to participate in the bereavement program.

7. Families/caregivers who choose to participate in the bereavement will be accorded the same confidentiality and privacy rights as a hospice patient.

8. Within two (2) weeks after the death of a patient, a sympathy card will be sent to the bereaved.

9. After three (3) weeks, a bereavement letter will be sent to the bereaved giving support and outlining the hospice bereavement services.

10. Within three (3) to five (5) weeks after the patient's death, a bereavement assessment (see "Bereavement Assessment" Policy No. H:2-053) will be completed by the bereavement counselor following the family/caregiver. This assessment will note and observe the bereaved for symptoms related to grief. The bereavement counselor will render a professional judgment as to whether the bereaved is experiencing normal grief, moderate grief, or a severe grief reaction.

11. If a person is noted as experiencing normal grief, the bereavement counselor will make contact with the bereaved person for ongoing assessment and support at three (3), six (6), and nine (9) months after the patient’s death and at the anniversary of the patient's death. The bereavement counselor will make information available to the bereaved person regarding bereavement support groups, other support groups available in the community, and the availability of individual counseling by the hospice personnel.

12. In addition to the services outlined above, persons deemed to be experiencing moderate or severe grief will be followed by the bereavement program with increased services and contact offered as noted in the plan of care. Persons identified will be referred to the Bereavement Coordinator and intervention will be provided as follows:

A. The Bereavement Coordinator will evaluate each bereaved on a case-by-case basis and evaluate the need for individual counseling. If necessary, the bereavement, spiritual care, or social work hospice personnel will provide individual counseling to the bereaved. Referrals to outside professionals may also be required.

B. A bereavement volunteer who has received additional training in bereavement support may be assigned to make regular contact with those bereaved people and work under supervision of the Bereavement Coordinator.

13. A bereavement file will be maintained on each family/caregiver unit of care. Each file will contain the following information:
A. Copy of the patient referral and initial bereavement assessment

B. Bereavement service report

C. All bereavement assessments made

D. A bereavement plan of care

E. All bereavement clinical notes that have been written and/or letters sent to the bereaved

14. Ongoing bereavement contact will be concluded at the end of up to one (1) year, if the bereaved is no longer in need of hospice bereavement services.

   A. A letter will be sent indicating completion of bereavement services.

   B. A copy of the letter will be placed in the bereavement file and the file retained.

15. If at up to one (1) year, grieving is still perceived as acute, the Bereavement Coordinator will attempt to reassess what additional professional services may be necessary and make appropriate referrals as indicated.

16. Bereavement assessment and clinical notes will be submitted to the patient's permanent clinical record.
PURPOSE

To ensure that qualified volunteers provide appropriate services in accordance with the plan of care and hospice program needs.

POLICY

Visiting Nurse & Hospice Care will provide volunteer services under the direction of a Volunteer Coordinator and with the assistance of trained hospice volunteers. The duties and responsibilities of the Volunteer Coordinator and volunteers will be identified in appropriate job descriptions. Volunteer professional services are provided by professionals who meet the State regulations for the discipline.

Volunteers may work in a variety of capacities, including:

1. **Patient care volunteers** provide personal care or emotional support and practical assistance, which enhance the comfort and quality of life for patients and families/caregivers. These services include being available for companionship, listening, simply “being there,” and preparing meals. Patient care volunteers may also provide relief for caregivers or assist them with household chores.

2. **Bereavement volunteers** provide anticipatory counseling and bereavement support to families/caregivers.

3. **Errands and transportation volunteers** offer a type of practical support often needed by hospice patients and families/caregivers. These duties may include picking up needed prescriptions or supplies, or grocery shopping.

4. **Office volunteers** lend their services working in hospice's administrative offices. These activities may include assembling information packets, filing, photocopying, and assisting with mailings.

Volunteers may attend interdisciplinary team meetings as appropriate.

Volunteers will report patient/family/caregiver response to volunteer services.

PROCEDURE

1. The Volunteer Coordinator will develop, implement, and evaluate the volunteer services program on an ongoing basis but at least annually.
2. The Volunteer Coordinator will arrange for volunteers to provide volunteer support to patient and family/caregiver in accordance with the plan of care.

3. Volunteers will document their activities on volunteer activity/clinical notes and submit this documentation for the patient's clinical records.

4. The Volunteer Coordinator will track the use of volunteers, the cost savings achieved, and that the hours of volunteer services will exceed 5% of the total patient care hours of paid and contracted hospice personnel.

5. The Volunteer Coordinator will document ongoing efforts to recruit, train, and retain volunteers of all ages and ethnic background.
PURPOSE

To specify the role of rehabilitation professionals in hospice care.

POLICY

Qualified rehabilitation professionals will develop and implement the rehabilitation plan with the patient and family/caregiver and interdisciplinary team. The provision of rehabilitation services will be appropriate to the patient’s and family’s end of life goals, care environment and comfort needs. Rehabilitation outcomes will promote patient safety, symptom management and an optimal level of functioning consistent with the patient’s prognosis.

All services will be provided in accordance with accepted standards of practice by or under the direction of a qualified physical, occupational, or speech therapist.

PROCEDURE

1. When rehabilitation needs are identified either at initial or during a comprehensive assessment, the patient’s physical status and functional abilities will be evaluated by a rehabilitation professional before instruction and treatments will be initiated.

2. Based on this functional assessment, the rehabilitation professional will develop, implement, and revise, in collaboration with the interdisciplinary team, the plan of care with the patient and family/caregiver. The patient is encouraged to make choices about his/her participation in rehabilitation. The rehabilitation professional will encourage patient and family/caregiver participation in implementing the rehabilitation plan by:

   A. Identifying problems and interventions to reach reasonable goals
   
   B. Coordinating and collaborating on rehabilitation interventions
   
   C. Timely documentation of the patient’s assessment and evaluation date, treatment choices, therapy interventions, response to interventions, progress toward goals and objectives, and changes in condition in the patient’s clinical record. (See “The Plan of Care” Policy No. H:2-031.)

3. Patient and family/caregiver will receive information regarding potential benefits and risks of rehabilitation services in order to make informed decisions. Their expectations will be considered and documented in the rehabilitation plan.
4. The RN Case Manager coordinates and supervises the services provided to the patient to ensure they are in accordance with the patient’s Plan of Care.

5. After the initial functional assessment and as treatment progresses, the patient will be reassessed as a part of the comprehensive assessment no less frequently than every 15 days or when changes occur. Patient goals and interventions will be revised on the plan of care as needed.

6. Rehabilitation goals and plans will be based on, but not limited to, the following:
   
   A. The patient’s personal goals and expectations
   
   B. Individualized needs for rehabilitation that are consistent with the patient’s diagnosis, age, severity of disease, prognosis, and disability

7. Rehabilitation goals and plans will be designed to help the patient achieve and maintain his/her optimal level of functioning, self-care, and independence by:
   
   A. Managing the patient’s specific health problems through the provision of an individualized treatment plan
   
   B. Providing patient and family/caregiver education
   
   C. Identifying and providing appropriate equipment required to increase the patient’s functional status and independence
   
   D. Maximizing the patient’s emotional well-being in accordance with the diagnosis, prognosis, and treatment program

8. Rehabilitative services personnel will attend interdisciplinary team meetings and participate in the comprehensive assessment and updating the plan of care as indicated.

9. Rehabilitation therapists will:
   
   A. Supervise therapy assistants and home health aides, as appropriate
   
   B. Participate in specialized hospice inservice programs
   
   C. Educate and consult with hospice staff
   
   D. Participates in discharge planning and evaluation

10. Licensed and/or certified assistants’ duties under the direction of a physical, occupational, or speech therapist will include:

    A. Performing services planned, delegated, and supervised by the therapist
B. Preparing clinical and progress notes
C. Participating in teaching the patient and family/caregiver
D. Assessing patient/family response to therapy
E. Participating in inservice programs
F. Communication of information to appropriate interdisciplinary team members
PURPOSE

To specify the role of the speech therapist in hospice care.

POLICY

Speech services will be provided in accordance with accepted standards of practice by or under the supervision of a speech therapist.

The speech therapist will be a member of the interdisciplinary team.

PROCEDURE

1. When speech therapy needs are identified during the initial or comprehensive assessment, the patient’s physical abilities in relation to speech and swallowing will be evaluated by a speech therapist before instruction and treatments will be initiated.

2. Based on this assessment, the speech therapist will develop, implement, and revise, in collaboration with the interdisciplinary team, the plan of care with the patient and family/caregiver. The patient will be encouraged to make choices about his/her participation in speech therapy. The therapist will encourage patient and family/caregiver participation in implementing the plan by:

   A. Identifying problems and interventions to reach reasonable goals

   B. Coordinating and collaborating on interventions

   C. Timely documenting of the patient’s assessment treatment choices, therapy interventions, response to interventions, progress toward goals and objectives, and changes in condition. (See “The Plan of Care” Policy No. H:2-030.1).

3. Patient and family/caregiver will receive information regarding potential benefits and risks of speech services in order to make informed decisions. Their expectations will be considered and documented in the plan.

4. After the speech therapy assessment and as treatment progresses, the patient will be reassessed as part of the comprehensive assessment no less frequently than every 15 days or when changes occur. Patient goals and interventions will be revised on the plan of care.

5. Speech/language pathology services will be provided by a qualified speech/language pathologist and/or audiologist and will include:
A. Testing and recommending mechanisms which focus on such interventions as alternative methods of communication/speech and swallowing exercises to help with nutrition

B. Ongoing comprehensive assessment, evaluation, and documentation of patient's level of functioning and hearing in response to therapy

C. Recommending appropriate inter- and intra-organization referrals

D. Will attend interdisciplinary team meetings and participate in updating the plan of care

E. Goal setting based on the needs of the hospice patient and family/caregiver

F. Education and consultation with the patient and family/caregiver and other organizational personnel

G. Discharge planning, as appropriate

H. Participating in inservice programs

I. Communicating information to the interdisciplinary team members
PURPOSE

To ensure that appropriate nutritional care and consultation is provided to hospice patients and families/caregivers.

POLICY

Terminally ill patients may experience a variety of nutritional problems that will require a nutritional assessment, intervention, or counseling. Families/caregivers may have questions or concerns about patients’ nutritional intake as it relates to the physiological changes in the dying process. Members of the IDT educate the patient/caregiver regarding the nutritional needs of the patient at end of life.

Dietary counseling, when identified in the plan of care, will be provided by, or under the direction of, a Registered Dietician, a nurse, or a qualified individual.

To assist hospice personnel in determining effective ways of managing the nutritional needs of hospice patients, a registered dietician will be available for consultations, inservice training, and patient/family care. The dietician may provide consultation over the phone, by mailing information, or on a home visit. Nutritional care and counseling will be provided on an intermittent basis as indicated in the plan of care.

PROCEDURE

1. Nutritional assessments will be made by the Case Manager and interdisciplinary team for each home hospice patient in order to identify the need for dietary counseling.

2. Based on the results of that assessment, if the nutritional needs or problems exceed the expertise of the RN Case Manager or other members of IDT, food and nutrition therapies will be ordered as part of the plan of care, as appropriate.

3. Criteria for referral for a nutritional consult may include, but not be limited to:
   A. Nutrition care planning is complex
   B. Nutrition related problems, i.e., taste changes, sore mouth, dysphasia, small stomach syndrome, nausea, weakness, enteral feedings
   C. Open, non-healing wounds
   D. Patient/family or caregiver request
E. There is need for a further nutrition assessment by a specially trained and educated clinician

4. The registered dietician or other qualified individual will provide consultation over the telephone to the patient and family/caregiver, by mailing information to the patient and family/caregiver, or by making a home visit.

5. Interventions by a registered dietician, nurse, or qualified individual may include but not be limited to:
   A. Assessing the nutritional needs of patients upon request
   B. Identifying factors that may cause variances in weight or size
   C. Educating patients and families/caregivers and personnel regarding special dietary supplements and nutritional requirements, as appropriate to diagnosis and individual preferences
   D. Providing counseling to adapt diet to the patient’s changing status
   E. Collaborating with nursing personnel and the interdisciplinary team in applying nutritional risk assessment to determine the need for a mechanically altered diet and/or the effect of end stage disease on hydration and nutrition.
   F. All consultation and interventions will be documented in the clinical record.

6. The registered dietician or other qualified individual will communicate his/her nutritional interventions and plan to the interdisciplinary team and attend interdisciplinary team meetings as indicated.

7. The registered dietician or other qualified individual will document his/her findings, interventions and plan on the clinical notes for the patient’s clinical record. Recommendations/interventions will be implemented as appropriate by the Case Manager or dietician and incorporated in the plan of care.

8. During routine hospice visits, clinicians will continually assess and educate the patient and family/caregiver, when appropriate, regarding:
   A. Proper conditions of sanitation to protect food and nutrition therapies from contamination and spoilage
   B. Proper temperatures of food storage, utilizing appropriate thermometers and maintaining temperature records, when appropriate
   C. The control of lighting, ventilation, and humidity to prevent condensation of moisture and growth of molds, when appropriate
D. Thorough cleaning and sanitizing of all work surfaces, supplies, and equipment after each use

E. Appropriate hand washing prior to and during preparation of food/nutrition solutions

9. Ongoing monitoring—to determine the extent to which goals are achieved and patient's nutrition needs/problems are met/resolved—will include the following activities, when appropriate:

A. Monitoring patient's response to food/nutrition therapy

B. Reviewing the appropriateness of choice of food/nutrition therapy, regimen, and route

C. Determining the effectiveness of medically prescribed diets

D. Communicating conclusions verbally and/or in writing to other hospice team members

E. Identifying/monitoring the patient who is not receiving adequate nutrition intake

F. Assessing patient and family/caregiver access to food/nutritional supplements, ability to prepare food and tools and space.

G. Identifying/monitoring the comfort levels of patient who chooses not to take food/nutrition therapy

10. Potential problems will be reported to the hospice interdisciplinary team and, when appropriate, the patient's physician.

11. When a patient has been prescribed a special diet, the Case Manager or registered dietician or other qualified individual will provide the patient and family/caregiver with written and verbal information regarding that diet as indicated or requested.

12. The effectiveness and appropriateness of nutrition therapies will be monitored on an ongoing basis through evaluation of goals, outcomes of therapies, and during interdisciplinary team meetings. This evaluation will be communicated to all disciplines involved in the care of the patient.
PURPOSE

To provide qualified medical direction and consultation for the delivery of hospice services and programs. To demonstrate that the Medical Director/hospice team physician has overall responsibility for patient care through documentation that demonstrates interaction/communication with the attending physician as necessary for appropriate medical care. To outline the responsibilities of the Medical Director.

POLICY

The hospice Medical Director will:
- have overall responsibility for the medical component of the hospice program
- provide oversight of physician services by complementing attending physician care, acting as a medical resource to the interdisciplinary team, assuring continuity of hospice medical services, and assuring appropriate measures to control patient symptoms
- serve as a hospice champion – promoting and representing the program to physicians, physician groups, discharge planners, other referral sources, community health organizations, and potential donors, as appropriate.
- be Board Certified in a related specialty and have expertise in the medical care of terminally ill individuals

The hospice Medical Director/hospice Team Physician will:
- be either a part- or full-time employee of the hospice, or have a contract with the hospice outlining his/her responsibilities
- be available whenever the hospice Medical Director is unable to perform his/her duties due to illness or vacation, or upon request.
- have a written service agreement with VNHC to provide medical direction and consultation for organizational programs and services.

ROLE AND RESPONSIBILITIES

The duties and responsibilities of the Medical Director will include, but not be limited to, the following:

1. Devoting his/her best ability to the proper management of the program
2. Providing overall medical direction to the program including supervision of all hospice physician employees and contract hospice physicians
3. Assuring that the established policies, bylaws, rules, and regulations of the organization are followed in the program
4. Providing medical oversight to the inpatient hospice facility
5. Establishing and continually reviewing policies and procedures related to patient care, medical education, and emergency procedures

6. Developing and continually reviewing, in cooperation with the Vice President Patient Care Services and/or Hospice Director, criteria to monitor the quality of the education programs provided to physicians, personnel, and volunteers

7. Evaluating quality assurance and performance improvement plans and monitoring to identify medical education needs in cooperation with the Executive Director/Administrator and/or Clinical Director

8. Proposing organizational programs to address the needs identified (with the assistance and input of consultants of the specialties where medical education needs were identified)

9. Working with the Vice President Patient Care Services and/or Hospice Director, after implementation of the programs, to determine the impact of said programs on the quality of care

10. Acting as a liaison to community physicians by providing consultation and education to colleagues and attending physicians related to admission criteria for hospice and palliative care

11. Acting as medical liaison with other physicians at Visiting Nurse & Hospice Care

12. Providing training regarding the medical aspects of caring for terminally ill patients to physicians, personnel, and volunteers

13. Providing hospice pre-election evaluation and counseling services

14. Certifying that the patient meets the medical criteria for hospice admission based upon available diagnostic and prognostic indicators, related diagnosis (as) if any, current subjective and objective medical findings, current medication and treatment orders, information about the medical management of any of the patient's conditions unrelated to the terminal illness.

15. Providing written certification of the terminal illness including a short clinical narrative for all initial and subsequent benefit periods. Will provide that a face-to-face encounter visit is performed with the patient prior to third and subsequent benefit periods.

16. Re-certifying patients, as appropriate, for continuation of Medicare Hospice Benefit at appropriate levels of care

17. Consulting with attending physicians regarding pain and symptoms management for hospice patients and assisting with Palliation and management of terminal illness and conditions related to the terminal illness. The hospice medical director will consult with attending physician, as needed regarding the medical care interventions targeting patient’s unmet general medical needs.
18. Managing oversight of the patient’s medications and treatments

19. Acting as medical resource to the interdisciplinary team

20. Attending interdisciplinary team meetings and working in a team approach with the team

21. Collaborating with the patient’s attending physician to develop and update the patient’s plan of care, at least every 15 days, to identify needs not met by the attending physician, and to ensure pain and symptom management and control. Documenting care provided in the patient’s clinical record, providing evidence of progression of the end-stage disease process

22. Acting as primary physician for patients whose referring/attending physicians desire to relinquish that care and/or if the referring/attending physicians are not available for further contact

23. Maintaining current knowledge of the latest research and trends in hospice care palliation management of terminal illness and conditions related to the terminal illness

24. Reviewing, developing and evaluating protocols for treatment, and proposing the most current options for interventions taking the quality and cost of outcomes into consideration.

25. Demonstrating knowledge in communications, and counseling patients and family/caregivers dealing with end-of-life issues

26. Participating in resolution of interpersonal conflict and issues of clinical and ethical concern

27. Ensuring that competent physician services are routinely available on a 24-hour basis to meet the general medical needs of the hospice patient to the extent the needs are not met by the attending physician
PHYSICIAN SERVICES—ATTENDING PHYSICIAN’S ROLE
Policy No. H:2-014.1

PURPOSE
To specify the attending physician’s role in the delivery of hospice services.

POLICY
The medical care of each patient admitted to Visiting Nurse & Hospice Care will be the responsibility of the patient’s attending physician. Communication between the attending physician and other members of the interdisciplinary team will be ongoing and documented in the hospice clinical record. When the attending physician is absent, the attending physician must designate another physician to oversee care for the hospice patient according to his/her medical group’s departmental procedure.

PROCEDURE
1. The role of the attending physician will include the following:
   A. The attending physician or designee will approve the referral of the patient and family/caregiver to the hospice program, and provide written initial certification of the terminal illness. Supportive documentation will be included.
   B. The attending physician will inform the patient and family/caregiver about the prognosis of six (6) months or less and about the hospice program. The physician will make known to the patient and family/caregiver that the goals of the hospice program are palliative, not curative, and that no care will be provided to artificially prolong life. The physician will explain DNR status to the patient and family/caregiver and document DNR status, if chosen, for the clinical record. It will also be explained that the focus of patient and family/caregiver care is in the home, and may include short-term inpatient stays or respite care as appropriate.
   C. Once the patient and family/caregiver chooses a hospice provider, the attending physician will notify the hospice program and make a referral. At a minimum, he/she will be asked to provide the following information:
      1. Patient name
      2. Diagnosis, recent history and physical, and physical exam
      3. Symptoms
4. Current medications and treatment

5. Written certification of terminal illness

6. When appropriate, a No Code/DNR order, written and signed after discussion with patient and family/caregiver

D. The plan of care will be developed by the hospice registered nurse, the patient and family/caregiver, attending physician, and the hospice Medical Director after the initial assessment is performed and prior to start of care.

E. Once the comprehensive assessment is completed and after each ongoing comprehensive assessment, the hospice interdisciplinary team, in collaboration with the attending physician, (or other authorized independent practitioner) will update the plan of care as often as needed, but no less often than every 15 days.

F. The attending physician will be invited to attend the interdisciplinary team meeting (patient care conferences). Plan of care updates will be communicated to the attending physician via telephone or written documentation mailed/faxed/emailed to the attending physician.

G. The attending physician will agree to comply with conditions for Medicare, Medicaid and private insurance hospice benefit requirements, as applicable to his/her patients.

2. Interdisciplinary team coordination of patient and family/caregiver care:

A. The attending physician will be invited to the initial presentation of the patient at the interdisciplinary team meeting.

B. The attending physician will make changes in the plan of care in consultation with the interdisciplinary team. Team members will communicate with the attending physician about any changes in the patient’s status, changes in the care or service being provided, changes in the patient’s physical or psychosocial condition, the patient’s response to care or service, the patient’s outcome related to care or services, and changes in diagnosis, treatment, or equipment.

C. Orientation will be provided to new physicians at the inpatient facility.

D. When the patient dies, the attending physician will be promptly notified.

E. Withdrawal from the hospice program (not due to death) will be mutually agreed upon by the attending physician, patient and family/caregiver, and interdisciplinary team.

3. Admission/discharge for hospice inpatient care:

A. The attending physician or designee will admit the patient for inpatient hospice care.
B. The attending physician (or other authorized independent practitioner) will write the admitting orders for inpatient care.

C. A written report of a physical examination within 5 days prior to admission or within 72 hours following admission will be completed.

D. Physician will share responsibilities with Serenity House staff to facilitate continuity of care, such as changes in the patient’s status or plan of care, referrals to additional physicians and/or agencies, and designation of alternative medical coverage.

E. The attending physician will provide medical care during the patient's inpatient stay and document in the health record at least every 30 days.

F. When the patient is ready for discharge from inpatient care, a discharge order and new hospice orders will be written.

G. A discharge summary from the inpatient unit will be sent to the hospice program for the clinical record.
PURPOSE

To establish the criteria and procedures for providing continuous care services to patients.

POLICY

Continuous care will be available to patients on the Medicare or Medicaid hospice benefits, or as other payers allow. Continuous care level of care must be provided a minimum of eight (8) hours or as much as 24 hours a day during periods in which an individual patient and family/caregiver require continuous nursing care to achieve palliation or to manage acute medical symptoms, in order to maintain the patient in his/her residence. The majority of care (50% of hours provided) needs to be licensed nursing care; other disciplines may be used to complete the time needed. Volunteers may be utilized, but their hours are not billable.

Definitions

1. Continuous Care: A short-term intervention for a medical crisis. The need for continuous care and the skill level of hospice personnel needed in the home will be evaluated daily by the hospice Case Manager or designee and clearly documented in the patient care notes and plan of care.

2. Crisis situations that may require continuous care include, but are not limited to, the following:

   A. Uncontrolled, severe symptoms, e.g., pain, dyspnea, nausea and vomiting, which require continuous skilled assessment, intervention, and evaluation

   B. When a function necessary for safe medical management must be performed and monitored continuously and/or closely, e.g., IV-related function

   C. If the patient meets criteria for an acute inpatient admission but cannot or will not agree to be moved

   D. Seizures

   E. Hemorrhaging

   F. Highly unstable vital signs, e.g., diabetic management

   G. Severe anxiety, agitation, or confusion that poses a safety threat

   H. Suicidal ideation or related action

   I. Delirium
PROCEDURE

1. This benefit is covered under Medicare/Medicaid and some private insurance programs. Verification of ability to pay must be made for all private pay and insurance patients prior to instituting continuous care services.

2. The hospice registered nurse or Case Manager will assess whether the patient and family/caregiver's condition requires continuous care.

   A. The hospice registered nurse confirms this assessment with the hospice Clinical Supervisor or designee.
   
   B. During non-business hours, the on-call nurse may initiate continuous care.
   
   C. The hospice personnel request and clinical eligibility will be reviewed immediately by the Clinical Supervisor when normal business operations resume.
   
   D. The Case Manager will inform all members of the interdisciplinary team of patient's change in level of care.

3. After the hospice registered nurse confirms the need and appropriateness of continuous care with the hospice Clinical Supervisor or designee, the hospice registered nurse will contact the attending physician and/or hospice Medical Director.

   A. The hospice registered nurse will report to the attending physician and/or Medical Director the patient's condition, nursing assessment, and any other relevant information.
   
   B. The hospice registered nurse will document the attending physician's (or other authorized independent practitioner's) or Medical Director's orders in the plan of care. The physician's (or other authorized independent practitioner's) orders will include the order for continuous care. This will be documented as a verbal order with specific time frame orders, i.e., “continuous care x 3 days.”

4. Continuous care will be provided by qualified personnel under the supervision of the hospice registered nurse. Contracted agencies may be used to supplement the services provided by hospice only in periods of staffing crisis when hospice has demonstrated a good faith attempt to staff continuous care hours with core nursing employees.

   A. Orientation sessions will be presented by the hospice Clinical Supervisor or designee to personnel providing continuous care services. Orientation will include discussion of hospice philosophy and goals, hospice expectations, and specific hospice nursing guidelines.
B. Continuous care personnel will be advised that they must work the entire shift for which they are scheduled and must fill in the continuous care log. If a need to leave earlier arises, they must call the hospice registered nurse or the on-call nurse for approval.

5. The hospice registered nurse, in conjunction with the hospice Clinical Supervisor or designee, will determine the level of skill needed for continuous care. Hospice registered nurses, licensed vocational nurses, and/or other disciplines may be utilized to provide this service.

A. The patient's predominant need must be for skilled nursing intervention. (50% of continuous care hours must be nursing.)

B. A minimum of eight (8) hours of care must be provided during a 24-hour day, which begins and ends at midnight. This care need not be continuous; that is, four (4) hours could be provided in the morning and another four (4) hours provided in the evening of that same day. Fifty percent (50%) of this skilled care must be provided by a nurse.

6. For a registered or licensed vocational nurse to be eligible to provide continuous care, that person must have a current license to practice nursing in California and must have completed the hospice orientation session. Hospice personal care aides and contract hospice aides must also have current certification from the state or equivalent and have completed the hospice orientation session. The responsible Clinical Supervisor or designee will determine the appropriateness of nurses and other professionals assigned to provide continuous care according to individual patient and family/caregiver requirements and will reassign correct level of personnel as necessary.

7. The initial report of the patient and family/caregiver condition will be given by the hospice registered nurse or hospice Clinical Supervisor or designee to the nurse or contract person providing continuous care. Shift-to-shift report will be the responsibility of the individuals providing continuous care.

8. A continuous care packet will be delivered to the home of the patient prior to or as soon as possible after continuous care is instituted. The packet will include information regarding:

A. “Responsibilities of Continuous Care Personnel” (see Addendum H:2-015.A)

B. “Charting Guidelines for Continuous Care” (see Addendum H:2-015.B)

C. Continuous Care Orders—The hospice registered nurse will specify all current physician’s (or other authorized independent practitioner’s) orders. The original copy will be taken to the hospice office to be signed by the attending physician and become part of the patient's clinical record. The hospice registered nurse will make a duplicate copy that will remain in the continuous care packet as a reference for the continuous care personnel. The following will be included in the physician’s (or other authorized independent practitioner’s) orders:
1. Initiate continuous care supervised by hospice registered nurse
2. Assess patient's physical condition and document results
3. Assess pain and titrate medication to affect maximum comfort level and document results
4. Provide counseling and emotional support to family/caregiver
5. Do not resuscitate, as appropriate
6. Specific medical orders
7. Physician to be notified of changes in condition by hospice registered nurse
8. Staff sign log—all staff must sign in (date, name, time in and out) for billing purposes

D. Continuous Care Plan—The hospice registered nurse will be responsible for initiating the continuous care plan prior to providing service. Any change in the continuous care plan must be approved by the hospice registered nurse to assure continuity of care.

E. Continuous Care Documentation Forms—Hospice and/or contract nursing personnel will document in the clinical record not less than hourly on continuous care notes. The documentation will include, but not be limited to:

1. The patient's and family/caregiver's physical or emotional status, counseling, teaching, skilled nursing care, and any medication given
2. Any acute change that necessitates notifying the hospice Case Manager
3. At a minimum, hourly entries of skilled nursing care
   a. The first entry must be made in the starting hour of the shift
   b. Continuous Care is reported and billed to Medicare in 15 minute “units”, although this does not constitute a need for 15 minute documentation
   c. The last entry must be made in the final hour of the shift.
   d. Direct patient care would end when patient expires. The time between expiration and pronouncement and/or funeral home arrival would not apply for continuous home care hours.
9. The Case Manager will make daily evaluations to determine if continuous care is warranted. The Case Manager will document supervisory visits in the continuous care notes. Supervision of continuous care includes:
A. A report from in-home nursing personnel

B. Assessment of the patient and family/caregiver by hospice Case Manager

C. Review of documentation by the hospice Case Manager with continuous care nursing personnel

D. Review of medications—administration and titration

E. Review of new or revised physician’s (or other authorized independent practitioner’s) orders

10. Continuous care personnel must notify the hospice Case Manager of any acute change in the patient and family/caregiver status necessitating nursing or medical intervention.

11. The hospice Case Manager will coordinate with the attending physician and hospice Medical Director any changes in medical treatment and the plan of care. The hospice Case Manager will document physician contacts in the patient's clinical record.

12. The hospice Case Manager will be responsible for contacting the attending physician to obtain changes in medical orders.

   A. The hospice Case Manager will notify the continuous care personnel of changes in medical and/or nursing orders.

   B. The orders will be documented with date and time by in-home nursing personnel on continuous care orders form.

   C. The hospice Case Manager will obtain any needed equipment or medications and for approving pharmacy charges according to hospice policies and procedures.

13. The hospice Case Manager will closely review the documentation of all personnel providing continuous care to assure that the level of skill is documented.

14. The hospice Case Manager will be responsible for ensuring that all forms completed by continuous care personnel become part of the patient's permanent clinical record. The hospice Case Manager will assure that all patient care clinical notes will be picked up and returned to the hospice office.

15. When the decision is made to institute continuous care, the Case Manager and social worker will begin assisting the family/caregiver in planning for care when continuous care is no longer needed or appropriate.

16. The hospice Case Manager or designee will determine, along with the attending physician and hospice Medical Director, when continuous care is no longer needed and notify interdisciplinary team members to resume routine home care plan of care.
ADDENDUM H:2-015.A

RESPONSIBILITIES OF CONTINUOUS CARE PERSONNEL
RESPONSIBILITIES OF CONTINUOUS CARE PERSONNEL

1. Perform as a member of the hospice interdisciplinary team.

2. All questions and/or suggestions regarding patient care should be addressed to the hospice Case Manager or Hospice Clinical Supervisor. DO NOT initiate any change of care without permission from the hospice Case Manager. Care for the hospice patient will be coordinated by an interdisciplinary team familiar with the patient's history and prognosis.

3. READ ALL CHARTING GUIDELINES and clinical record forms during each shift to ensure continuity of professional standards.

4. The hospice Case Manager or Hospice Clinical Supervisor must be contacted regarding any questions or changes in patient status. Do not contact the attending physician. The hospice Case Manager or designee will be available 24 hours a day at: 805-965-5555. The hospice Case Manager or designee will contact the physician if necessary.

5. Each shift is responsible for completing the following forms in a legible, professional manner:
   - Continuous care log
   - Continuous care notes in Allscripts (include appropriate time, date, assessment, and signature)
   - Medication administration record (both routine and titration)
   - Medicine inventory sheet, when necessary (at patient's death)
   - Staff sign log

6. All clinical notes/forms remain in the hospice packet in the patient's home. The hospice Case Manager designee will be responsible for reading these daily to ensure accurate skilled documentation and for returning them to the hospice office at the end of the continuous care.

7. Do not leave before your shift is completed. If no one arrives to relieve you, contact the hospice Case Manager or the hospice Clinical Supervisor at the hospice office at 805-965-5555.
ADDENDUM H:2-015.B

CHARTING GUIDELINES FOR CONTINUOUS CARE
CHARTING GUIDELINES FOR CONTINUOUS CARE

General Guidelines

1. All charting must be done Allscripts.

2. All e-charting must be done on the clinical note section.

3. Hourly entries of skilled nursing care are required.
   - The first entry must be made during the starting hour of the shift.
   - The last entry must be made during the final hour of the shift.

Note: The 24-hour day for hospice starts at 12:00 midnight; thus, the shifts run 8:00 am – 4:00 p.m., 4:00 p.m. – 12:00 am, 12:00 midnight – 8:00 am.

4. Each person will complete e-charting and synchronize at end of shift so information is available to next shift.

5. Any changes in medications or orders must be cleared with the hospice Case Manager or hospice Clinical Supervisor.

6. Only the hospice Case Manager (or designee) or hospice Clinical Supervisor may call the physician.

Specific Guidelines

1. Each shift must document:

   A. An initial physical assessment, using the following guidelines as appropriate:

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<tr>
<th>System</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sensory–Perceptual</td>
<td>• Vision and appearance of eyes</td>
</tr>
<tr>
<td></td>
<td>• Hearing, taste, and smell</td>
</tr>
<tr>
<td></td>
<td>• Taste and smell</td>
</tr>
<tr>
<td></td>
<td>• Touch</td>
</tr>
<tr>
<td>2. Skin</td>
<td>• Condition (color, turgor, character)</td>
</tr>
<tr>
<td></td>
<td>• Lesions</td>
</tr>
<tr>
<td></td>
<td>• Edema</td>
</tr>
<tr>
<td></td>
<td>• Hair distribution</td>
</tr>
<tr>
<td>3. Respiratory</td>
<td>• Rate, character, breath sounds, cough</td>
</tr>
<tr>
<td>4. Cardiovascular</td>
<td>• Pulses (rate, quality, rhythm)</td>
</tr>
<tr>
<td>System</td>
<td>Criteria</td>
</tr>
<tr>
<td>--------</td>
<td>----------</td>
</tr>
<tr>
<td>a. Pulses, Apical, Radial, Carotid, Dorsalis pedis, Brachial, Posterior, Tibial, Femoral</td>
<td></td>
</tr>
<tr>
<td>b. Blood pressure</td>
<td></td>
</tr>
<tr>
<td>c. Circulation (mucous membranes, nail beds)</td>
<td></td>
</tr>
<tr>
<td>5. Neurological</td>
<td>• Pupillary reactions</td>
</tr>
<tr>
<td>a. Orientation</td>
<td></td>
</tr>
<tr>
<td>b. Level of consciousness</td>
<td></td>
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<tr>
<td>c. Grasp strength</td>
<td></td>
</tr>
<tr>
<td>6. Gastrointestinal</td>
<td>• Mouth, gums, teeth, and tongue (color and condition)</td>
</tr>
<tr>
<td>a. Gag reflex</td>
<td></td>
</tr>
<tr>
<td>b. Bowel sounds</td>
<td></td>
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<tr>
<td>c. Presence of distention</td>
<td></td>
</tr>
<tr>
<td>d. Impaction, hemorrhoids</td>
<td></td>
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<tr>
<td>7. Genitourinary</td>
<td>• Presence of retention</td>
</tr>
<tr>
<td>a. Discharge (vaginal, urethra)</td>
<td></td>
</tr>
<tr>
<td>8. Musculoskeletal</td>
<td>• Muscle tone, strength, gait, stability, range of motion</td>
</tr>
</tbody>
</table>

B. A psychosocial assessment, including:

1. Patient and family/caregiver concerns or problems

2. Family/caregiver coping patterns (e.g., expressing feelings openly, tearful, expressing anger, distracted by housekeeping tasks, reminiscing, etc.)

3. Resources of support present (e.g., family/caregiver members, clergy)

C. Charting must be done no less than hourly.

D. Documentation should include:

1. Any change in the patient’s and family/caregiver's physical or psychosocial status

2. Any change necessitating contact with the hospice registered nurse

3. All medical and nursing interventions, including personal care, skilled nursing tasks, counseling, and teaching
4. Patient and family/caregiver response to all interventions

2. Modified Orders

A. Notify the hospice Case Manager or hospice Clinical Supervisor of any changes necessitating contact with the attending physician or hospice Medical Director.

B. The hospice Case Manager will contact the attending physician (or other authorized independent practitioner) and obtain any modified orders. The hospice Case Manager will write the verbal order Medical Records will obtain the attending physician's (or other authorized independent practitioner’s) signature.

C. The hospice Case Manager will call the continuous care nurse on duty in the home and give verbal notification of the order change.

D. The continuous care nurse must document receipt of the verbal order in Clinical Notes.

1. Write date and time of order.

2. If drug, write name of drug, dosage, route of administration, and times of administration. Order must be complete.

3. Write physician’s (or other authorized independent practitioner’s) name and hospice Case Manager who gave order. (This is for continuous care clinical record copy only.)

4. If treatment, write specific treatment and times to be done.

3. Medications

A. Medications must be charted on the medication profile record. Using clinical notes

   1. Chart all medicines given in sequential order.

   2. Chart date, time, medication, dosage route. (If subcutaneous or IM, chart site as well.)

4. Pain – use clinical monitoring

A. Assess intensity (0 – 10). Ask the patient if possible. If not, assess patient and confer with family/caregiver to obtain rating.

   0 = No pain; 1 = Mild pain; 3 = Discomfort; 5 = Distressing; 7 = Horrible pain; 10 = Excruciating pain
5. **Level of Consciousness**
   
   A. Patient may be confused and disoriented, but is awake.

   B. Patient is easily aroused and responds appropriately to minimal stimulation (call patient's name) but cannot maintain response; falls asleep at once.

   C. Patient responds inappropriately (grunts, moans) or without purpose to maximum stimulation. (NEVER USE PAINFUL STIMULATION.)

6. **Respiration**

   A. Count patient's respirations for a full 60 seconds.

7. **Nausea and vomiting**

   A. Mild – Intermittent nausea without vomiting

   B. Moderate – Continuous nausea with intermittent vomiting, responds to antiemetic

   C. Severe – Continuous nausea and vomiting, intractable to present antiemetic

8. **Bowel Movements**

   A. Note time. Chart in continuous care notes the color, consistency, amount, and continence

9. **Time of Death**

   A. At the time of death, the hospice Case Manager (or designee) or hospice social worker will come to the home

   B. For protection of hospice personnel, the medication inventory must be documented for legal proof of the disposition of all medications, especially narcotics.

10. **Plan of Care**

    A. The interdisciplinary team is responsible to initiate the continuous care plan and update it as needed.
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PURPOSE
To ensure that pharmacy services are available 24 hours per day.

POLICY
Pharmacy services needed by hospice patients and families/caregivers and hospice personnel will be available 24 hours a day. Medications will be available through contracts between specific pharmacies and Visiting Nurse & Hospice Care. Controlled substances and other medications will be available through these pharmacy contracts for patients on the Medicare, Medicaid, private insurance hospice benefits and for those unexpected situations requiring pain and symptom management after normal business hours.

Visiting Nurse and Hospice Care contracts with a licensed pharmacy to meet the needs of the patient.

PROCEDURE
1. The nurse will contact the patient's attending physician (or other authorized independent practitioner) for medication orders.
2. The attending physician (or other authorized independent practitioner) must submit a verbal or written order to the pharmacy for the medication.
3. The pharmacy will deliver the medication or notify the patient and family/caregiver when the medication will be available for pickup.
4. The pharmacy will dispense a quantity of medication consistent with the patient’s life expectancy as well as appropriate dosage and frequency of the medication.
5. The pharmacy will provide to the patient and family/caregiver education on drug use and adverse effects.
6. The contracted pharmacy will also:
   G.Oversee the drug control systems including receipt of prescriptions, storage of medications, preparations of drugs, labeling of prescriptions, preparing of drugs for distribution, and dispensing of medications prescribed by a physician
   H. Provide 24-hour availability of drugs and biologicals
   I. Provide information regarding the safe and appropriate use of drugs to other health professionals
J. Identify appropriate outcomes of drug therapy in consulting with hospice medical director.

K. Consult on drug therapy and coordinate with IDT as needed

L. Pharmacy services are provided in compliance with federal and state laws

M. Monitoring and documentation of ongoing drug therapy done through hospice software, attending physician, and pharmacy, and includes:
   1. Therapeutic appropriateness of the choice of drugs
   2. Therapeutic duplication in the patient’s drug regimen
   3. Appropriateness of the dose, frequency, and route of administration
   4. Adherence to the drug regimen
   5. Potential drug, food, or diagnostic test interactions or disease limitations to drug use
   6. Laboratory or clinical monitoring methods to detect drug effectiveness, side effects, toxicity, or adverse effects

7. Agency staff does not usually transport medications. An exception is made in the case of an emergency need for medications to control symptoms when no other means of transporting the medication is available.

8. An emergency is defined as any situation where the pharmacy is unable to deliver the medication and the family is unable to pick up the medication in a timely manner.

9. In this case, a staff member may transport the medication to the patient’s residence.

10. Under no circumstances may agency staff carry medications with them except to transport them from the pharmacy or Serenity House to the patient’s home in an emergency*.

11. Any staff member who is known to be carrying medications for any other purpose or who is found to be distributing medication other than that which was prepared by a licensed pharmacy for use by that patient will be subject to immediate termination and a report will be made to the state agency governing that person’s profession (e.g. The Board of Registered Nursing in the case of an RN).

12. Any staff member who knows of this practice but does not report it to management will be subject to disciplinary action.

13. Patient care staff member who may transport medication will sign a copy of the Policy Concerning Transporting Patient Medications (Addendum H:2-017.A) and it will be kept in the personnel file.
ADDENDUM H:2-017.A

POLICY CONCERNING TRANSPORTING PATIENT MEDICATIONS
POLICY CONCERNING TRANSPORTING PATIENT MEDICATIONS

Hospice staff does not usually transport medications requiring a triplicate physician order. An exception is made in the case of an emergency need for medications to control symptoms when other means of transporting the medication is not available. In this case, a hospice staff member may transport the triplicate medication to the patient’s residence.

Under no circumstances may Agency staff carry medications with them except to transport them from the pharmacy or Serenity House to the patient’s home in an emergency. Any Agency staff member who is known to be carrying medications for any other purpose or who is found to be distributing medication other than that which was prepared by a licensed pharmacy for use by that patient will be subject to immediate termination and a report will be made to the State agency governing that Individual’s profession (e.g., The Board of Registered Nursing in the case of an RN).

Any staff member who knows of this practice but does not report it to management, will be subject to disciplinary action.

No medications are kept in the Agency.

I have read and understand the above policy regarding transporting medications.

________________________________________________________________________
Employee Signature                        Date
________________________________________________________________________
Print Name
PURPOSE

To establish the guidelines for providing emergency room, pharmacy, radiology, and laboratory services to patients.

POLICY

Patients may require services that include the emergency room, pharmacy, radiology, and/or laboratory. These services are available 24 hours a day, seven (7) days a week as specified under the patient’s Medicare, Medicaid or private insurance hospice benefit. These services will be ordered by the attending physician (or other authorized independent practitioner), as needed, per the plan of care. Interdisciplinary team input will occur so that palliative focus of care is emphasized and maintained.

Services may be recommended for circumstances not related to the patient’s terminal illness but these will not be the financial responsibility of Visiting Nurse & Hospice Care.

PROCEDURE

Procedures will be developed to meet specific needs of selected vendor agreements.
DURABLE MEDICAL EQUIPMENT AND SUPPLIES
Policy No. H:2-019.1

PURPOSE

To provide guidelines for medical supplies and appliances as needed for the palliation and management of the terminal illness based on assessed health care needs.

POLICY

Equipment and supplies will be obtained through CMS-certified vendors holding contracts with Visiting Nurse & Hospice Care in order to meet the assessed health care needs for the palliation and management of the patient's terminal illness.

PROCEDURE

1. All durable medical equipment and supplies, as appropriate, will have an order from the physician (or other authorized independent practitioner).

2. Hospice will assess the needs of patients for appropriate HME and order from the contracted vendor.

3. The durable medical equipment needed for an individual's support to stay at home will be obtained from a hospice-approved company if the patient is on Medicare, Medicaid, or private insurance hospice benefit.

4. Those supplies required for optimal comfort, care, and management of the hospice patient will be obtained from the hospice stock supplies or approved company if the patient is on Medicare, Medicaid, or private insurance hospice benefit.

5. Hospice will have the option to order equipment from any contracted HME company in order to provide the necessary equipment to the patient.

6. The hospice Medicare, Medicaid, or private benefit patient will not be billed for equipment or supplies that are related to the terminal illness and necessary to carry out the plan of care. Hospice performs insurance checks to determine coverage for HME.

7. Hospice organizations educate patients, caregivers and families in safe and effective use of medical equipment and supplies. The HME company will also be responsible for teaching the patient about the equipment.

8. The patient, family, and/or caregiver must be able to demonstrate the appropriate use of durable medical equipment to the satisfaction of the hospice staff.

Note: Hospices may only contract for DME services with a durable medical supplier that meets the Medicare DMEPOS Supplier Quality and Accreditation Standards at 42CFR§424.57.
**PURPOSE**

To ensure that patients receive safe, operable home medical equipment.

**POLICY**

Visiting Nurse & Hospice Care will have procedures to assure that all equipment provided is safe, clean, working as intended, and processed prior to being delivered for a patient’s use.

**PROCEDURE**

*Soiled Equipment*

1. Soiled equipment and reusable accessories will be bagged and tagged before returning to the organization's facility for cleaning and disinfection in accordance with infection control policies. Large items may be disinfected “at the curbside” prior to transport in lieu of bagging.

2. Equipment or supplies designed for single customer use will be disposed of at the patient’s home, if possible, or bagged and tagged for disposal upon arrival at the organization’s facility.

3. Upon arrival at the Visiting Nurse & Hospice Care's cleaning facility, soiled equipment will be routed directly to a designated location. New or repaired equipment will also be treated as soiled. All equipment brought into the organization will be logged in by the individual bringing in the equipment.

4. Soiled equipment and accessories will not be stored or processed in any location where contamination of clean or sterile items could occur.

*Cleaning and Disinfection*

1. A written schedule will be maintained for cleaning equipment and work surfaces.

2. Soiled equipment will be disassembled to the appropriate level for that piece of equipment in accordance with the manufacturer’s instructions.

3. Each disassembled item will be thoroughly cleaned with cleaning agents appropriate for the equipment.

4. During the cleaning process, filters or other specific replaceable items will be changed if within the manufacturer’s recommended time frame or, in the case of inlet filters, between customers.
5. Equipment will be wiped dry, or moisture will be permitted to evaporate, before tagging and bagging or shelving to indicate readiness for further customer use.

6. Equipment will be disinfected before and after internal or external repairs. If repairs beyond routine maintenance need to be made, the equipment will be tagged with a note indicating the problem and will be removed to a designated repair area.

**Patient-Ready Equipment**

1. Equipment will be checked for proper operation and visual cleanliness before storage and before delivery.

2. An electrical check will be made to ascertain that power cords or other visible connections are not damaged and that grounded plugs have all three (3) prongs intact.

3. Physical integrity will be checked (e.g., wheelchair wheel locks, bearings, upholstery, bends or breaks in frames, hydraulics on customer lifts, etc.).

4. All equipment will be tested according to manufacturer's guidelines.

5. All equipment checked or tested will be documented by the manufacturer's serial number or Visiting Nurse & Hospice Care's ID number on the company's rental equipment log for that specific piece of equipment.

6. All patient-ready equipment, accessories, or supplies will be stored in a designated area removed from the dirty/contaminated segment of the cleaning area.

**Needle Safety Improvement**

1. Needle devices will be regularly examined when new products are introduced to determine if there is a safer device available.

1. A log will be maintained for any accidental sticks from contaminated sharps.

**Obsolete Equipment**

1. All equipment that has been designated “obsolete” for reasons of maintenance expense or hazards associated with continued use will be tagged indicating this status and stored in a designated area until such time as it is retired and removed according to management instructions.
PURPOSE

To delineate the guidelines for providing transportation for hospice patients.

POLICY

Hospice will make arrangements for non-emergency medical transportation services via ambulance or wheelchair van when the patient’s medical and physical condition is such that transport by means of public or private conveyance is medically contraindicated and transportation is required for the purpose of admission to a facility for respite or acute care, or for re-evaluation by the attending physician.

PROCEDURE

1. The Case Manager will assess the patient and determine that the patient must be transported.

2. The Case Manager will consult with the Clinical Director/Supervisor or the Medical Director to obtain authorization when appropriate.

3. The contract transporter will be contacted by the RN Case Manager or MSW and provided with needed information including, but not limited to:
   A. Patient identification information
   B. Type of transport required: wheelchair, gurney, van, or ambulance
   C. Pickup location and destination

4. If hospice assumes financial responsibility for transport under the Medicare, Medicaid, private insurance hospice benefit programs, the transporter will be instructed to bill hospice directly for services.
PURPOSE

To ensure that the community served by the hospice organization is continually aware of the services provided and available.

POLICY

Visiting Nurse & Hospice Care will provide community education reflective of the organization’s philosophy, mission, and purpose, with the goal of making the community aware of hospice services for end-of-life care.

PROCEDURE

1. A hospice community education program is established and will be revised as necessary. The program will include planning, establishing goals and objectives, and evaluation of educational activities.

2. Community Outreach education is accomplished through the dissemination of written materials, participation in health fairs, presentations to groups or associations, etc.

3. Examples of educational content may include:
   A. Access to hospice services
   B. The Medicare Hospice Benefit
   C. Advance Directives
   D. Admission criteria and scope of services
   E. Caregiver support and education
   F. Bereavement services
   G. Planning for end-of-life care

4. Documentation of educational activities will be maintained by the organization.
PURPOSE

To establish the process for acceptance and entry of patients into hospice.

POLICY

Referrals will be accepted 24 hours a day, seven (7) days per week. Personnel will be available 24 hours a day to accept patients into hospice.

Visiting Nurse & Hospice Care will accept only those patients whose needs can be met by the services it provides and who meet the hospice admission criteria.

PROCEDURE

1. Hospice referrals will be documented in the electronic medical record.

2. Referrals for hospice services may be accepted by clinicians, including the Hospice Director, Clinical Supervisor, nurses, social worker or others, as deemed appropriate by the VP Patient Care Services.

3. Referral information may be accepted by any of the following methods:
   A. Telephone
   B. Facsimile
   C. Written order

4. Referrals may be accepted from any of the following individuals:
   A. Doctors of Medicine, Osteopathy, Podiatry, Psychiatry, Dentistry, or Dental Surgery
   B. Discharge planners from inpatient and/or outpatient services
   C. Social service agencies
   D. Individual patients and/or families/caregivers
   E. Case Managers and/or insurance company representative
   F. Home health agencies
G. Other hospice organizations

5. During scheduled working hours (office hours are from 8:00 a.m. to 5:00 p.m., Monday through Friday) calls will first be received by the receptionist. Patient referral calls will be transferred to the intake department.

A. Intake personnel will receive information regarding patient demographics, diagnosis, services needed, medications, attending physician (or other authorized independent practitioner), hospitalization, etc., in order to make the initial determination of whether the patient's needs can be met by hospice and if he/she meets eligibility criteria. (See “Admission Criteria and Process” Policy No. H:2-024.) The information will be reviewed for completeness.

B. When payer source is private insurance, the insurance coverage will be verified and an insurance information completed in electronic medical record.

C. Intake information will be reviewed by the Clinical Supervisor to accept the referral information and intake will complete the entry in e-chart.

D. If the referral call is not from a physician, the physician (or other authorized independent practitioner) will be contacted to confirm service needs, as well as patient's medical prognosis and supporting documentation, and to obtain verbal orders.

E. The Intake Coordinator will assign personnel and schedule an initial assessment visit.

F. If hospice service cannot be provided due to a patient not meeting hospice admission criteria, the intake personnel will give the referral source the names of other agencies that can provide the required services and will notify the attending physician. A log will be maintained on all patients that cannot be serviced.

6. After scheduled hours (weekends and evenings), a referral source will have access to hospice through the answering service.

A. The answering service will contact the on-call nurse via telephone.

B. The on-call nurse will complete the initial intake information from the referral source and relay the information.

1. If the referral is on the weekend, the week end nurse or on-call nurse will determine if the patient needs to be admitted for services.

2. If the patient must be seen, the on-call nurse will schedule an initial visit on the weekend to determine hospice appropriateness and admit as appropriate.

3. If the patient can wait until Monday, the on-call nurse will alert intake personnel on Monday morning or the next business day for scheduling by the Intake Coordinator.
PURPOSE

To establish standards and a process by which a patient can be evaluated and accepted for admission.

POLICY

Visiting Nurse & Hospice Care will admit any patient with a life-limiting illness that meets the admission criteria.

Patients will be accepted for care without discrimination on the race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin.

Patients will be accepted for care based on need for hospice services. Consideration will be given to the adequacy and suitability of hospice personnel, resources to provide the required services, and a reasonable expectation that the patient's hospice care needs can be adequately met in the patient's place of residence.

While patients are accepted for services based on their hospice care needs, the patient's ability to pay for such services, whether through state or federal assistance programs, private insurance, or personal assets is a factor that will be considered.

The patient's life-limiting illness and prognosis of six (6) months or less will be determined by utilizing standard clinical prognosis criteria developed by the fiscal intermediary’s Local Coverage Determinations (LCDs).

Visiting Nurse & Hospice Care reserves the right not to accept any patient who does not meet the admission criteria.

A patient will be referred to other resources if Visiting Nurse & Hospice Care cannot meet his/her needs.

Once a patient is admitted to service, the organization will be responsible for providing care and services within its financial and service capabilities, mission, and applicable law and regulations.

Admission Criteria

1. The patient must be under the care of a physician. The patient's physician (or other authorized independent practitioner) must order and approve the provision of hospice care, be willing to sign or have a representative who is willing to sign the death certificate, and be willing to discuss the patient's resuscitation status with the patient and family/caregiver.
2. The patient must identify a family member/caregiver or legal representative who agrees to be a primary support care person if and when needed. Persons without such an identified individual and who are independent in their activities of daily living (ADLs) will require a specific plan to be developed at time of admission with the social worker.

3. The patient must have a life-limiting illness with a life expectancy of six (6) months or less, as determined by the attending physician and hospice Medical Director, utilizing standard clinical prognosis criteria developed by LCD.

4. The patient must desire hospice services, and be aware of the diagnosis and prognosis.

5. The focus of care desired must be palliative versus curative.

6. The patient and family/caregiver desire hospice care, agree to participate in the plan of care, and sign the consent form for hospice care.

7. The patient and family/caregiver agree that patient care will be provided primarily in the patient’s residence, which could be his/her private home, a family member’s home, a skilled nursing facility, or other living arrangements.

8. Patients requiring higher acuity of care that cannot be delivered in another setting will be considered for the inpatient unit if beds are available.

9. The physical facilities and equipment in the patient's home must be adequate for safe and effective care.

10. The patient must reside within the geographical area that the Visiting Nurse & Hospice Care services.

11. Eligibility for participation will not be based on the patient's race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin.

12. If applicable, the patient must meet the eligibility criteria for Medicare, Medicaid, or private insurance hospice benefit reimbursement.

13. Eligibility criteria will be continually reviewed on an ongoing basis by the interdisciplinary team to assure appropriateness of hospice care.

**PROCEDURE**

1. The organization will utilize referral information provided by family/caregiver, health care clinicians from acute care facilities, skilled or intermediate nursing facilities, other agencies, and physician offices in the determination of eligibility for admission to the program. If the request for service is not made by the patient's physician, he/she will be consulted prior to the evaluation visit/initiation of services.
2. The Admission Coordinator will assign hospice personnel to conduct initial assessments of eligibility for services within the time frame requested by the referral source, or based on the information regarding the patient’s condition or as ordered by the physician (or other authorized independent practitioner).

3. Assignment of appropriate hospice personnel to conduct the initial assessments of patient's eligibility for admission will be based on:
   
   A. Patient's geographical location
   B. Complexity of patient's hospice care needs/level of care required
   C. Hospice personnel's education and experience
   D. Hospice personnel's special training and/or competence to meet patient's needs
   E. Urgency of identified need for assessment

4. In the event that the time frame for assessment cannot be met, the patient's physician and the referral source, as well as the patient, will be notified for approval of the delay.

   A. Such notification and approval will be documented.
   B. If approval is not obtained for the delay, the patient will be referred to another hospice for services.

5. A hospice registered nurse will make an initial contact prior to the patient's hospital discharge, if possible or appropriate. The initial home visit will be made within the time frame requested by the referral source and according to organization policy, or as ordered by the physician (or other authorized independent practitioner). The purpose of the initial visit will be to:

   A. Explain the hospice philosophy of palliative care with the patient and family/caregiver as unit of care.
   B. Explain the patient's rights and responsibilities and grievance procedure. (See Patient Bill of Rights Policy No. C:2-003.)
   C. Provide the patient with a copy of Visiting Nurse & Hospice Care notice of privacy practices.
   D. Assess the family/caregiver’s ability to provide care.
   E. Evaluate physical facilities and equipment in the patient's home to determine if they are safe and effective for care in the home.
   F. Allow the patient and family/caregiver to ask questions and facilitate a decision for hospice services especially provided under the Medicare/Medicaid hospice benefit.
G. Review appropriate forms and subsequently sign forms by patient and family/caregiver once agreement for the hospice program has been decided.

H. Provide services as needed and ordered by physician (or other authorized independent practitioner), and incorporate additional needs into the hospice plan of care.

I. Give patient information about durable power of attorney for health care, if the patient has not already done so.

6. During the initial assessment visit, the admitting clinician will assess the patient's eligibility for hospice services according to the admission criteria and standard prognosis criteria to determine/confirm further:

   A. Level of services required and frequency criteria
   B. Eligibility (according to organization admission criteria)
   C. Source of payment

7. If eligibility criteria is met the patient and family/caregiver will be provided with a hospice brochure and various educational materials providing sufficient information on:

   A. Nature and goals of care and/or service
   B. Hours during which care or service are available (physician, nursing, drugs and biological are available 24 hours/day. All other services are available to meet individual patient care needs)
   C. Access to care after hours
   D. Costs to be borne by the patient, if any, for care
   E. Hospice mission, objectives, and scope of care provided directly and those provided through contractual agreement
   F. Safety information
   G. Infection control information
   H. Emergency preparedness plans
   I. Available community resources
   J. Complaint/grievance process
K. Advance Directives

L. Availability of spiritual counseling in accordance with religious preference

M. Hospice personnel to be involved in care

N. Mechanism for notifying the patient and family/caregiver of changes in care and any related liability for payment as a result of those changes

8. The hospice registered nurse or MSW will document that the above information has been furnished to the patient and family/caregiver and any information not understood by the patient and family/caregiver.

9. The patient and family/caregiver, after review, will be given the opportunity to either accept or refuse services.

10. The patient or his/her representative will sign the required forms indicating election of hospice care and receipt of patient rights and privacy information.

11. Refusal of services will be documented in the clinical record. Notification of the Clinical Supervisor, attending physician, and referral source will be completed and documented in the clinical record.

12. The hospice registered nurse will assist the family in understanding changes in the patient’s status related to the progression of an end-stage disease.

13. The hospice registered nurse will educate the family in techniques for providing care.

14. The hospice registered nurse will contact the physician for clinical information in writing to certify patient for hospice care.

15. The hospice registered nurse will complete an initial assessment during this visit within 48 hours after the election of the hospice care (unless the physician, patient or representative requests that the initial assessment be completed in less than 48 hours.) (See “Initial Assessment” Policy No. H:2-045.)

16. The hospice registered nurse will contact at least one (1) other member of the interdisciplinary team for input into the plan of care, prior to the delivery of care. The two (2) remaining core services must be contacted and provide input into the plan of care within two (2) days of start of care; this may be in person or by phone.

17. If the patient is accepted for hospice care, a comprehensive assessment of the patient will be performed no later than 5 calendar days after the election of hospice care. A plan of care will be developed by the attending hospice physician, the Medical Director or physician designee, and the hospice team. It will then be submitted to the attending physician for signature. The patient’s wishes/desires will be considered and respected in the development of the plan of care. (See “Comprehensive Assessment” Policy No. H:2-046.)
18. The time frames will apply for weekends and holidays, as well as weekday admissions.

19. A clinical record will be initiated for each patient admitted for hospice services.

20. Patients admitted to the inpatient unit will be provided an additional orientation as well as 24 hour visiting hours. Other inpatient guidelines include

   A. Patient must be at least 18 years of age.

   B. Patient must have tuberculosis test upon admission or proof of testing within last 90 days.

   C. Room and Board fees are arranged between billing department and patient/patient family/DPOA.

21. If a patient does not meet the admission criteria or cannot be cared for by Visiting Nurse & Hospice Care, the Clinical Supervisor should be notified and appropriate referrals to other sources of care made on behalf of the patient.

22. The following individuals should be notified of non-admits:

   A. Patient

   B. Physician

   C. Referral source (if not physician)

23. A record of non-admits will be kept for statistical purposes, with date of referral, date of assessment, patient name, services required, physician, reason for non-admit, referral to other hospice care facilities, etc.

24. In instances where patient does not meet the stated criteria for admission to the program, exceptions will be decided upon by the Hospice Director in consultation with the Medical Director, upon request of the referring party and/or the patient.
HOSPICE II
Quality of Services and Products

CERTIFICATION OF TERMINAL ILLNESS
Policy No. H:2-025.1

PURPOSE
To ensure physician certification of terminal illness and authorization for hospice services, in accordance with applicable state and federal regulations and payer requirements.

POLICY
At the time a patient and family/caregiver chooses hospice care, the hospice Medical Director and the patient’s attending physician, if any, will certify the patient’s terminal illness.

When certifying the patient as terminally ill, the hospice Medical Director must consider at least the diagnosis of the terminal condition of the patient, other health conditions, whether related or not to the terminal condition, and current relevant information supporting the diagnosis.

Patients who elect the hospice Medicare or Medicaid benefit will be certified as terminally ill, with a prognosis of six (6) months or less life expectancy if the disease runs its normal course, by the attending physician and the hospice Medical Director. Hospice services will be provided in two (2) 90-day periods and an unlimited number of 60-day periods if the patient is recertified at the beginning of each benefit period.

For patients on service greater than 180 days, a face-to-face visit will be done by physician or nurse practitioner and documented within 30 days prior to patient recertification. (See Face-To_Face Encounter, Policy No. H:2-025.A)

PROCEDURE
1. At the time of admission to hospice, the hospice Medical Director or the patient’s attending physician will complete a certification narrative that reflects the patient’s individual circumstances based on: his/her review of the patient’s medical record or, if applicable, examination of the patient. (The hospice Medical Director and the patient’s attending physician will sign the certification of terminal illness and authorization for hospice services forms.)

2. If written certification cannot be obtained within two (2) calendar days following the start of care, verbal certification must be obtained and documented in the clinical record within two (2) days following initiation of care.

3. Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the clinical record with the written certification. Initially, the clinical information may be provided verbally, and must be documented in the clinical record and included as part of the hospice’s eligibility assessment.

4. Both the attending physician’s and Medical Director’s signed and dated initial certification forms must be on file prior to billing the first claim.
5. Nurse practitioners cannot certify a terminal diagnosis or the prognosis of six months or less, if the illness or disease runs its normal course, or re-certify terminal diagnosis or prognosis. In the event that a beneficiary’s attending physician is a nurse practitioner, the hospice medical director and/or physician designee may certify or re-certify the terminal illness.

6. A subsequent recertification, at the beginning of each new benefit period, may be signed by the attending physician or the hospice Medical Director. At recertification, the hospice Medical Director must compose and sign the narrative based on a review of the patient’s medical record or, if applicable, examination of the patient. A verbal or written certification statement must be obtained from the Medical Director or the attending physician no more than two (2) weeks prior or two (2) calendar days after the first day of each period. The signed and dated certification must be present prior to billing for each recertification period.

7. The hospice physician or nurse practitioner must have a face-to-face encounter with the patient within the 30 days prior to the third benefit period recertification and within 30 days prior to each subsequent recertification period.

8. All physician certification and authorization for hospice services and the certification of terminal illness forms will be filed in the patient's permanent clinical record.

9. A patient who is not eligible for the Medicare/Medicaid hospice benefits will be certified for services according his/her specific payer requirements.

10. Tools such as the fiscal intermediary's Local Coverage Determinations, along with other supporting documentation, can be used to provide guidance in determining and documenting terminal prognosis.
PURPOSE
To establish a process to comply with the Face-to-Face Encounter requirement.

POLICY
A face-to-face encounter will be performed for patients entering the third and all subsequent benefit periods.

PROCEDURE
1. The hospice director (employed, volunteer, or under contract) or a hospice employed nurse practitioner (NP) will perform a face-to-face encounter within 30 days of a hospice recertification for the third and all subsequent benefit periods.

2. Face-to-Face must gather and document clinical findings to determine continued hospice eligibility.

3. The physician/NP who performs the face-to-face encounter will attest in writing that he/she had the face-to-face encounter, including the date of the visit. The NP must also attest that the clinical findings were provided to the certifying physician.

4. The face-to-face attestation must be signed and dated by the individual who performed the visit.

5. If a patient is admitted and is in the third or later benefit period, exceptional circumstances may prevent a face-to-face encounter prior to the start of the benefit period. Exceptional circumstance is defined as 11th hour admissions (actively dying), weekend admissions, and other exceptional circumstances.

6. To qualify for face-to-face exemption “prior to” third and subsequent benefit periods, the following would apply:
   
   A. Requirements
      1. New hospice admission
      2. Third or later benefit period
   
   B. Timing
      1. ONLY if the above requirements are met and documented:
A. Face-to-Face which occurs within two (2) days after admission will be considered timely.

B. If the patient dies within two (2) days of admission without a face-to-face encounter, the encounter will be deemed complete.

C. Documentation

1. Documentation is required for the exceptional circumstances that prevented the face-to-face encounter from being conducted in a timely way.
HOSPICE ELECTION STATEMENT
Policy No. H:2-026.1

PURPOSE

To ensure that patients and/or legal guardians/caregivers understand the Medicare Part A or Medicaid coverage for hospice care and agree to this program.

POLICY

Patients who are eligible for hospice services under Medicare Part A or Medicaid and have met all other criteria will be required to sign a hospice election statement. The date on the hospice election statement will be the official service start date.

PROCEDURE

1. On admission, the admitting registered nurse or MSW will discuss the patient's eligibility for the Medicare or Medicaid hospice benefit.

2. The admitting registered nurse or MSW will explain the hospice election statement to the patient and family/caregiver or legal representative.

3. The patient and family/caregiver, or his/her legal representative will be asked to sign the hospice election statement.

4. The hospice election statement will be filed in the patient's clinical record and a copy will be given to the patient.

5. Election Statement must include:
   A. Identification of the particular hospice that will provide care to the individual.
   B. The individual’s or representative’s acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care as it relates to the individual’s terminal illness.
   C. Acknowledgment that certain Medicare services are waived by this election.
   D. The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement.
   E. The signature of the individual or representative.
PURPOSE
To establish the criteria for admitting a patient for general inpatient care.

POLICY
General inpatient care will be provided as specified under the Medicare, Medicaid, and specific private insurance hospice benefits. Inpatient care may be recommended in other circumstances not related to the terminal illness, but will not be the financial responsibility of Visiting Nurse & Hospice Care.

Hospice personnel will be available 24 hours a day for clinical consultation to the inpatient personnel.

Note: Home management will always be the preferred method over hospitalization.

Note: General inpatient care level of care is a short-term level of care for care that cannot feasibly be provided at home. The key is the patient's medical condition. It is not intended as a solution to a negligent or absent caregiver.

GENERAL GUIDELINES

1. One or more of the following clinical criteria must be present in order for the patient to be considered appropriate for admission for general inpatient care. Admission decisions are made on an individual case-by-case basis after evaluation by the hospice interdisciplinary team and in consultation with the patient's attending physician.

A. Pain control that is unable to be managed appropriately in the home setting

B. Other Symptoms

1. Rapid decline related to varied factors, such as bleeding, that are inconsistent with home management.

2. Fluctuating/deteriorating mental status, psychosis, severe confusion and/or combativeness necessitating titration of medications, change in environment, or consultation and intervention by psychologist or psychiatrist.

3. Severe shortness of breath or respiratory distress that creates an unmanageable situation for patient and family/caregiver in home care setting.

4. Intractable nausea or vomiting.
5. Open lesions requiring frequent professional care (decubiti, malignant ulcerations, burns, severe abrasions or fistulas—at least b.i.d. dressing changes).

6. Other complicated care—frequent nasotracheal suctioning or GI suctioning, frequent parenteral injections, management of draining fistulas.

7. Need for continued close monitoring of unstable recurring medical conditions, e.g., hemorrhage, severe anemia, severe hypertension, unstable diabetes, recurrent severe electrolyte disturbance, recurrent seizures, rapidly reaccumulating ascites or pleural effusion requiring recurrent tapping, recurrent aspiration.

8. Family/caregiver relief from the demands of interventions required for end-of-life care

9. Death is imminent and family is unable to cope

10. Other presenting problems may be identified and evaluated on an individual basis.

C. Psychosocial Pathology

1. Evaluation of disturbed mental status, e.g., hallucinations, delusions, paranoia, excessive agitation, combativeness, requiring intensive monitoring

2. Depression, anxiety in the extreme—suicidal ideation, euthanasia, assisted suicide ideation, extreme withdrawal, including inadequate P.O. intake

D. Clinical indications for continued stay at the general inpatient level of care:

One or more of the clinical criteria identified above must be present in order for the patient to be considered appropriate for continued general inpatient care. Decisions for continued inpatient stay will be made on an individual case-by-case basis after evaluation by the interdisciplinary team including the hospice Medical Director or designated hospice physician and in consultation with the patient's attending physician.
PURPOSE
To establish the criteria for admitting a patient for inpatient respite care.

POLICY
Inpatient respite care will be provided by arrangement to patients whose care is covered under the Medicare or Medicaid hospice benefit and specific private insurance hospice benefits. Inpatient respite care will be provided at times when the patient and/or family/caregiver need a short period of relief. This is offered on an “as needed” basis for a maximum of five (5) days per respite admission.

Hospice personnel will be available 24 hours a day for clinical consultation to the inpatient personnel.

GENERAL GUIDELINES
Respite care is indicated when:

1. The family/caregiver is unable to continue managing the patient's physical, emotional, or psychological needs and requires a break for one (1) to five (5) days.

2. Injury or impairment to the family/caregiver creates a need for respite to provide the family/caregiver and the interdisciplinary team an opportunity to problem solve.

3. The primary family/caregiver must be out of the home for a period of time greater than 24 hours to attend to urgent affairs but no longer than five (5) days.

4. Rest or relief is required by the family/caregiver in order to maintain this individual at home.

PROCEDURE
1. The interdisciplinary team identifies the patient's need for respite care.

2. The Social Worker assesses the need for respite care and arranges inpatient respite care with a contracted facility.

3. The RN Case Manager obtains orders for inpatient respite care from the patient's attending physician.

4. The Social Worker makes arrangements with the facility for the patient's admission and for transportation, if needed.
5. The Social Worker or RN Case Manager completes a *Level of Care Change* in admissions and EMR status screen.

6. The Social Worker or the RN Case Manager provide documentation of the patient’s condition to the facility staff, including but not limited to:
   
   A. Hospice diagnosis, current medications, and treatment orders;
   
   B. DNR status and advance directives if available; and
   
   C. Current plan of care.

7. The interdisciplinary team continues to provide services to the patient/caregiver during the period of respite and re-evaluates and updates the comprehensive assessment and the plan of care at the time of discharge from inpatient care.
PURPOSE

To define the patient and family/caregiver as the unit of care receiving hospice services.

POLICY

The unit of care in hospice services is the patient and family/caregiver. Hospice recognizes that care and support of the patient affects the family/caregiver and vice versa. Hospice will strive to help the patient and family/caregiver not only with physical symptoms and problems of terminal illness, but also with emotional and psychosocial stresses so that their time together may be lived to the fullest according to the patient's own choices.

To this end, hospice will offer medical care and psychosocial, spiritual, and financial guidance and support, and follow both patient and family/caregiver. If the patient and family/caregiver are separated because the patient is hospitalized (or goes to a nursing home or other facility), both patient and family/caregiver are still seen by the hospice team. Bereavement support will be available for family/caregiver members for up to one (1) year after the patient's death, as needed or requested.
INTERDISCIPLINARY TEAM PLAN OF CARE
Policy No. H:2-030.1

PURPOSE

To ensure that an individualized plan of care is completed that complies with accepted standards of care and regulatory issues.

POLICY

A written individualized patient and family/caregiver plan of care will be established and maintained for each individual admitted to the hospice program. The care provided to the patient must be in accordance with the plan of care. The plan of care will meet the documentation requirements of the physician-directed medical orders and the care planning process. The plan of care will be based on the initial, comprehensive and ongoing comprehensive assessments performed by members of the interdisciplinary team and will be reviewed on a regular basis but no less than every fifteen (15) days. This plan will focus on identified problems, goals, and interventions. The patient and family/caregiver will be encouraged to participate in the development of and continued updating of the plan of care. This plan of care must be initiated at start of care. (See “Initial Assessment” Policy No. H:2-045, “Comprehensive Assessment” Policy No. H:2-046 and “Ongoing Comprehensive Assessments” Policy No. H:2-047.)

PROCEDURE

1. The Case Manager (or admitting registered nurse) will complete the initial assessment and will initiate the development of the plan of care after the consent forms are signed. (See “Initial Assessment” Policy No. H:2-045.)

2. The Case Manager (or admitting registered nurse) will then notify the attending physician and a core member of the interdisciplinary team of the initial assessment findings, the identification of patient needs and the recommended services to meet those needs. The plan of care will be reviewed prior to care being delivered.

3. Orders for the start of care will be verbally received by the Case Manager (or hospice registered nurse) from the attending physician (or other authorized independent practitioner) and documented on the plan of care/physician order form.

4. The plan of care will identify the patient’s needs and services to meet those needs, including the management of pain and discomfort and symptom relief. It must state, in detail, the scope and frequency of services needed to meet the patient’s and family/caregiver’s needs.
5. The plan of care will be provided to both the attending physician and the hospice Medical Director for approval of verbal orders and certification of the terminal illness signatures. The hospice Medical Director will need to review the patient’s history and physical, which is also provided, to be able to sign the certification of terminal illness section of the plan of care.

6. Each patient will be monitored for his/her response to care or services provided against established patient goals and patient outcomes to evaluate progress toward goals.

7. Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing comprehensive assessments, and analysis of patient response to care against goals and outcomes.

8. The plan of care will be reviewed and revised as frequently as deemed necessary, but not less often than every 15 days, by the interdisciplinary team, with input from the attending physician, the patient, and the family/caregiver, based on ongoing comprehensive assessments of the patient and family/caregiver. Review of the plan of care will be documented in the clinical record. Revision dates will be noted on the plan of care.

9. Any change in the patient’s condition must result in a change in the plan of care, prior to implementation of the new service.

10. As needed, the patient and family/caregiver will receive written instructions regarding treatments or aspects of care that will be the responsibility of the patient and family/caregiver to provide or follow through with.

11. The written plan of care will contain, but will not be limited to, the following:

   A. Diagnosis

   B. Identification of patient and family/caregiver needs, including physical, psychosocial, cognitive, cultural, spiritual, nutritional, functional, educational, and counseling.

   C. Reduction in risk factors

   D. Functional limitations

   E. Mental status

   F. Safety measures to protect against abuse, injury, infection, or communicable disease, as appropriate

   G. Nutritional requirements

   H. Prognosis

   I. DME and medical supplies necessary to meet patient needs
J. Frequency of services

K. Placement at the appropriate level of care and referrals as needed for counseling, additional disciplines, volunteers, and adjunctive services

L. Individualized interventions to assist with end-of-life care

M. Patient and family/caregiver educational needs and assessment of their ability to learn and understand teaching

N. Statement of treatment goals

O. Interdisciplinary team assessment of needs

P. Pain and symptom management interventions

Q. Drugs and treatments (including allergies) Refer to H: 2-058 Patient Self-Administration Of Medication for self administration policy and procedure

R. Physician-directed instruction to patient and family/caregiver

S. Physician (or other authorized licensed independent practitioner) orders

T. Measureable outcomes anticipated from implementing and coordinating the plan of care.

U. Patient or representative’s level of understanding, involvement and agreement with the plan of care

12. All appropriate hospice staff will have access to the plan of care.

13. Care provided to the patient will be in accordance with the plan of care.
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VERIFICATION OF PHYSICIAN ORDERS
Policy No. H:2-032.1

PURPOSE

To ensure that accurate physician (or other authorized independent practitioner) orders are obtained in accordance with applicable law and regulation.

POLICY

Orders will be obtained from a licensed physician (or other authorized independent practitioner) for care and services to be provided to hospice patients. (See “Physician Licensure Verification” Policy No. H:3-017.)

Orders will be taken only by professional, licensed hospice personnel.

A qualified individual will review each order or prescription before care is provided. The sole exception for verification will be with emergency orders or prescriptions where a delay for verification would likely result in an adverse result for the patient.

PROCEDURE

1. An order or prescription will be verified when there is a question or discrepancy in the order/prescription and when the order is communicated by someone other than the physician (or other authorized independent practitioner) or his/her agent. The order or prescription reviewed may be the original order, a facsimile copy if permitted by law, or the direct transcription of a verbal order.

2. All telephone orders or verbal orders will be “read back” to the physician (or other authorized independent practitioner) or designee to assure accuracy.

3. Orders will be documented in patient’s electronic medical record (EMR) dated and electronically signed by the professional receiving the order.

4. A copy of the physician's or licensed independent practitioner’s order will be kept in the clinical record.

5. The original of the order form will be faxed to the physician (or other authorized independent practitioner) for signature.

6. When the signed order form is returned to Visiting Nurse & Hospice Care, the original is scanned into the EMR and filed in the clinical record.

7. Signed orders will be in the clinical record within 30 days of initiation of care or interim order, unless otherwise specified by applicable state law and regulation.
PURPOSE

To ensure that patients have adequate resources/plans to provide for up to 24-hour care in the home should their condition warrant.

POLICY

Visiting Nurse & Hospice Care does not provide primary family/caregiver or 24-hour coverage for the patient through its hospice program of services. A patient who does not have a primary family/caregiver member will develop a plan with the hospice social worker to provide for his/her care in the event his/her condition dictates the need for additional care. Such care may be arranged through friends, volunteers, and/or private pay attendant services.

At the time of admission, if the patient is able to independently manage his/her activities of daily living (ADLs), a plan for future needs will be developed with the assistance of the hospice social worker.

PROCEDURE

1. The Case Manager (or admitting registered nurse) will identify the patient's functional capabilities on the initial assessment visit.

2. If the patient is unable to manage independently and/or does not have an adequate family/caregiver, the Case Manager will determine what the patient has planned for care, if anything. The Case Manager will explain that Visiting Nurse & Hospice Care does not provide 24-hour family/caregiver or take 24-hour responsibility for the patient.

3. If the patient needs assistance in planning for a family/caregiver, a hospice social worker will visit the patient to address this problem.

4. If a problem or potential problem is identified, the hospice social worker will present the patient and family/caregiver with information regarding possible solutions.

5. The social worker will assist the patient and family/caregiver in planning and arranging for additional assistance.

6. If patient and family/caregiver refuse or are unable (due to financial considerations) to accept the plan for necessary caregiving assistance, the situation will be discussed by the interdisciplinary team, and termination from hospice services may occur.
PURPOSE

To provide clinical direction to clinicians providing direct patient care.

POLICY

A written, individualized plan of care will be established within 48 hours of hospice benefit election to assist with identification and prioritization of patient immediate problems/needs.

PROCEDURE


2. All hospice interdisciplinary team members involved in the patient's care will contribute to the written plan of care.

3. Using the data obtained during the initial, comprehensive and ongoing hospice assessments, the hospice interdisciplinary team members will develop a list of patient problems and needs, with corresponding goals and anticipated target dates for reaching those goals.

4. The analysis of data obtained during assessments should facilitate the ongoing identification and prioritization of patient problems, needs, goals, and care.

5. The plan of care should include:
   A. Patient and family/caregiver needs (prioritized)
   B. Goals
   C. Dates problems identified/onset
   D. Resolution dates

6. The plan of care will be updated by the interdisciplinary team as often as the condition of the patient indicates or no less than every 15 days.

7. As goals are achieved, additional interventions may be added to the plan of care to direct patient care.
INTERDISCIPLINARY TEAM COORDINATION OF CARE

Policy No. H:2-035.1

PURPOSE

To ensure the coordination of services for each patient.

POLICY

The hospice interdisciplinary team will retain professional management responsibilities for the provision of services, including inpatient care, and will insure that services are furnished in a safe and effective manner.

Visiting Nurse & Hospice Care will utilize a case management system to guide an interdisciplinary team to provide comprehensive, coordinated health care to patients and families/caregivers serviced by the hospice. It will be the responsibility of the Clinical Supervisor to assign a Case Manager who is a registered nurse. The Case Manager will be responsible for coordination of services with the interdisciplinary team from referral to discharge.

The type and scope of services provided by the interdisciplinary team will be based upon comprehensive and ongoing assessments regarding the needs of the patient and family/caregiver and the comprehensive plan of care that defines patient and family/caregiver problems, goals, and interventions. The exact combination of services and the level of care will be unique to each patient and family/caregiver unit and will change as the needs of the patient and family/caregiver evolve over the course of their involvement with hospice.

PROCEDURE

1. Each patient will be assigned a Case Manager by the Admissions Coordinator upon admission, based on patient’s needs and level of care required, geographic area, and qualifications of personnel needed.

2. The Case Manager will be qualified through education, training, and/or experience and will:
   
   A. Understand the principles of care provided
   B. Know required qualifications for hospice personnel providing care and know which hospice personnel possess these qualifications
   C. Know the scope of care, which can be provided by various interdisciplinary group members
   D. Understand the nature of patient population served
3. It will be the responsibility of the Case Manager to facilitate communication about changes in the patient's status between interdisciplinary team members and the patient's attending physician.

4. Visiting Nurse & Hospice Care personnel will communicate changes in a timely manner via email, telephone, one-to-one meetings, interdisciplinary team meetings, and home visits. Documentation of all communications will be included in the clinical record on a communication note, interdisciplinary team meeting form, and/or clinical note. Documentation will include the date and time of the communication, individuals involved with the communication, information discussed, and the outcome of the communication.

5. When the patient requires services from the interdisciplinary team, the Case Manager will be responsible for cooperative care planning to assure goals, interventions, and outcomes are palliative in nature.

6. Written evidence of care coordination will be found in the plan of care and/or interdisciplinary team meeting forms in the patient's clinical record, and will involve the hospice patient's attending physician.

7. Care will be provided by an interdisciplinary team made up of physicians, nurses, social workers, certified hospice aides, homemakers, clergy, counselors, volunteers, and therapists. These services will be provided in both residence and inpatient settings.

8. The interdisciplinary team (in collaboration with the attending physician, if any) will conduct assessments, develop and update the plan of care, and review the effectiveness of care a minimum of every 15 calendar days. The attending physician will receive a copy of the care plan updates.

9. All interdisciplinary team members, including those providing contracted services, will have access to the plan of care to ensure coordination and continuity.

10. Contract personnel will participate in preparation of the plan of care; submit documentation of services provided, including clinical notes, schedule of visits, and participate in interdisciplinary team meetings as appropriate. Care provided by contracted services will be monitored by the interdisciplinary team to insure compliance with the plan of care.

11. Continuity of care will be maintained throughout the patient's course with hospice. Exchange of information between hospice staff and contracted providers will be documented in the clinical record.

12. The interdisciplinary team will provide ongoing support for patient and family/caregivers.
PURPOSE

To define the process for interdisciplinary team meetings and documenting patient status in the clinical record.

POLICY

The interdisciplinary team will meet on a regular basis to discuss patient and family/caregiver changes and progress and updates to the plan of care, deaths and changes in patient and family/caregiver circumstances, referrals, and admission/certification and recertification of patients on the hospice program. Each patient’s plan of care will be updated utilizing the results from the ongoing comprehensive assessment no less frequently than every 15 days or more frequently if the patient's condition requires.

The meeting will be facilitated by the hospice Clinical Supervisor or designee. The hospice Medical Director will provide oversight of the plan of care and all hospice interdisciplinary team members will be present, including volunteers and attending physicians, as available. The patient and family/caregiver will be informed of the schedule for this meeting, its purpose, and that the discussion is confidential.

PROCEDURE

1. Members at the interdisciplinary team meeting will sign an attendance form that will be kept by the hospice Clinical Supervisor.

2. Referrals and admissions will be reviewed to establish appropriateness for hospice care. Obstacles to access of care issues will be identified and resolved. Admissions will be reviewed to insure compliance with hospice policies and procedures.

3. Level of services will be reviewed for new and ongoing patients based on hospice team assessments. The group will approve recommendation for a change in the level of care.

4. The patient’s plan of care will be updated no less frequently than every 15 days or more frequently if the patient’s condition requires; social, cultural, and physical environments presenting obstacles to effective intervention; integration of alternative therapies into medical regime to assist in effectiveness; and any special needs of the patient.

5. A plan of care update will be completed for each patient and family/caregiver no less frequently than every 15 days utilizing the ongoing comprehensive assessment. Patient/family progress toward achievement of expected outcome will be evaluated, and goals and objectives will be revised as needed.
6. Issues related to patient coping are assessed and addressed by the interdisciplinary team and include at a minimum:
   A. Access to adequate and accurate information
   B. Changes in family roles
   C. Communication abilities
   D. Ability to fulfill desired sexual expression

7. An interdisciplinary team meeting plan of care update form will be used for update of the patient and family/caregiver and the attending physician. It will note changes, response to treatment and progress toward targeted outcomes, which may include:
   A. Pharmacotherapeutic effectiveness of symptom management outcomes
   B. An increase or decrease in symptoms or acuity and evaluation of current services for effectiveness.
      1. Nutritional status
      2. Pain management
      3. Condition of skin/presence/status of pressure ulcers
   C. Increases or decreases in frequency of visits by team members and reason for the change
   D. Changes in the location of care
   E. Psychosocial and other consultations/conferences with patient and family/caregiver
   F. Changes that may contribute to risk for pathological grief
   G. Ongoing spiritual support
   H. Plan for changes in treatments or procedures

8. Patient approaching recertification will be reviewed for the appropriateness of continuation of care based on identifiable criteria and progression of the terminal illness.

9. Patient requesting or requiring a transfer due to a change in the level of care necessary to meet his/her needs or a wish to utilize the services of another hospice will be reviewed and planning initiated for the transfer.
10. Patient being discharged from hospice will be reviewed to ensure appropriateness of ongoing care.

11. Problem solving for optimal care of the patient and family/caregiver will occur, and changes will be documented on the interdisciplinary team meeting form.

12. For patient residing in a skilled nursing facility, any changes in plan of care or patient education that has occurred during the visit will be communicated to the nursing staff of the skilled facility.

13. Grievances and issues of ethical concern will be discussed.

14. Patient requesting transfer to another hospice or revocation of the hospice benefit will be reviewed to determine any assistance he/she may need to complete these processes.
PURPOSE

To specify the physician’s responsibilities in managing patients requiring hospice services.

POLICY

Upon referral and admission of his/her first patient to services, VNHC staff will assist the physician in understanding his/her role in the medical management of the terminal illness, as needed.

PROCEDURE

1. Information provided to the physician may include the following:

   The physician has the right to:

   A. Be an active participant in the development of the plan of care in the provision of hospice orders.

   B. Be provided with timely information regarding his/her patient. Notification and contact will occur with, but will not be limited to, the following:

      1. Changes in the patient’s condition

      2. Changes in the patient’s psychosocial status

      3. Changes in the patient’s home environment

      4. Lack of achievement of goals within the defined time frame

      5. Changes and/or lack of patient response to hospice care

      6. Changes needed regarding diagnoses, treatments, medications, precautions, and limitations

   C. Have hospice personnel available to respond to questions regarding patients. When the Case Manager is not available, another clinician familiar with the patient will answer questions.

   D. Information to assist in continuity of care, including ongoing updates, written summaries at a minimum every 15 days.
E. Confidentiality of information and communication to the physician by hospice personnel.

F. Legible, complete, and accurate information regarding the patient.

G. Participate in the consideration and resolution of ethical issues related to hospice patients.

The physician has a responsibility to:

A. Be an active participant in the development of the plan of care and in the provision of hospice orders.

B. Provide hospice with timely information regarding his/her patient. Notification and contact will occur when there are changes that the hospice may not be aware of, including, but not limited to:
   1. Changes in the patient's condition
   2. Changes in the patient's psychosocial status
   3. Changes in the patient's home environment
   4. Changes and/or lack of patient response to hospice care
   5. Changes needed regarding diagnoses, treatments, medications, precautions, and limitations

C. Be available to respond to questions regarding patients. When the attending physician is not available, another physician who is familiar with the patient will be designated as the alternate coverage.

D. Provide legible, complete, and accurate information, including treatment orders for his/her patient.

E. Sign and return hospice orders and other required documentation within the time frame specified in organization policy and in accordance with applicable law and regulation.

F. Participate in the consideration and resolution of ethical issues related to hospice patients.
PURPOSE

To provide guidelines for monitoring the patient's response to hospice care, and for reporting to the patient's physician.

POLICY

Clinicians will monitor, document, and report the patient’s response to care and treatment provided on each hospice visit. Progress of goals will be measured at regular intervals.

Clinicians will establish and maintain ongoing communication with the patient’s physician and the hospice Medical Director to ensure safe and appropriate care for the patient.

PROCEDURE

1. During each hospice visit, the clinician will monitor the patient's response to care against established goals including, but not limited to:
   A. Care interventions for pain and symptom management
   B. Medications
   C. Teaching

2. During interdisciplinary team meetings, as well as during the recertification process, the care will be evaluated to determine achievement of hospice goals.

3. The patient's physician and/or the hospice Medical Director will be contacted on the same day when any of the following occur:
   A. Changes in the patient's condition
   B. Changes in the patient's psychosocial status
   C. Changes in family/caregiver support or home environment
   D. Inability to achieve goals within the specified time frame
   E. Changes in the patient's expected response to hospice care or medications
   F. Changes occur regarding diagnosis, prognosis, or treatment (including procedures, medications, precautions, and limitations)
G. Results are received for relevant laboratory tests ordered

H. There is any problem implementing the plan of care

I. With interdisciplinary team recommendations for changes in the plan of care and care plan updates

J. Patient is to be discharged from hospice or a specific service is to be discontinued

K. Death occurs

4. All conferences or attempts to communicate with the attending physician and/or hospice Medical Director will be documented in the clinical record.

A. Documentation of the physician notification will include:
   1. Date and time contacted
   2. Patient name
   3. Name of physician notified or his/her representative
   4. Reason for notification
   5. Physician’s response
   6. Action taken or orders obtained

B. Documentation of attempted physician notification will include:
   1. Date and time
   2. Patient name
   3. Name of physician attempting to notify
   4. Reason for notification
   5. Name of person taking message
   6. Professional’s signature and title

5. When unable to contact the patient’s physician for medical consultation warranted by change in patient’s condition, the nurse will contact the Hospice Medical Director on-call.
6. Based on the communication with the physician, a verbal order will be obtained for any change in the plan of care and communicated to all interdisciplinary team members to ensure that care is provided according to the revised plan of care.

7. The plan of care will be updated according to hospice policies and procedures.
PURPOSE

To define the requirements for patient notification of changes in care.

POLICY

The patient will be notified within 24 hours of any significant changes in the agreed-upon schedule or plan of care.

PROCEDURE

Visit Schedule

1. Hospice interdisciplinary team members will contact the patient the night prior to a visit to verify the approximate time of the visit (within a two (2)-hour time span). Personnel assigned to continuous care shifts need not communicate with the patient regarding the shift schedule.

2. Any significant changes will be called into the office, e.g., moving a visit from morning to afternoon.

3. When a significant variation of tentative time for visit is anticipated (i.e., greater than one (1) hour), hospice personnel will notify the patient of the change and verify acceptance.

4. When it is anticipated that a visit cannot be made because of unforeseen problems, hospice personnel will immediately notify the office.

Plan of Care

1. Whenever the plan of care is changed including services, frequencies, treatments, etc., the patient will be notified at the time of the visit.

2. Documentation of the notification will include:

   A. Date/time of notification
   
   B. Specific changes in the plan of care
   
   C. Patient response and/or acceptance
Changes in Liability for Payment

1. The patient or his/her representative will be advised verbally and in writing of any changes in the initial information regarding his/her liability for payment within 30 days from the date the organization becomes aware of the changes.

2. Documentation of the notification will be made in the clinical and billing records.
PURPOSE

To establish the process by which patients have access to hospice services 24 hours per day.

POLICY

Patient care needs are the highest priority; therefore, weekend and evening staffing will be scheduled accordingly. Clinical personnel are expected to perform visits on an as-needed basis, including weekends.

There will be on-call staff available after office hours, Monday through Friday, and 24 hours a day on weekends. Staff on-call will be:

1. Administrative call by a senior management staff member
2. Clinical call by a registered nurse
3. Other interdisciplinary team members, as needed (e.g., social worker, Hospice Chaplain)

PROCEDURE

1. On admission, the patient will be made aware of the organization’s 24-hour availability.

2. The on-call schedule will be developed on a monthly basis by the Clinical Supervisor or designee. The schedule will be forwarded to the answering service and on-call staff. Supplies will be available to the on-call staff, through direct access to the office. Patient records are available through electronic medical records (EMR).

3. The on-call nurse will be issued a cellular phone to allow for mobility.

4. The on-call staff can be reached by calling the Visiting Nurse and Hospice Care number. After hours this number will be forwarded to the answering service. The answering service will pass every patient related call to the on-call nurse.

5. The on-call nurse will provide follow-up appropriate to the call:
   
   A. Call the patient/family/caregiver
   
   B. Visit the patient, if necessary
   
   C. Obtain physician (or other authorized independent practitioner) orders, as needed
D. Arrange for other hospice services, as needed

6. The on-call nurse will document each patient/family interaction in a clinical note.

7. On-call staff will respond to a call within 15 minutes and must be able to reach a patient within one (1) hour. (There may be rare exceptions, depending on how far away the patient lives and if the staff member is with another patient at the time of the call.)

8. Reports will be given to the on-call nurse daily Monday through Friday.

9. The on-call nurse will report his/her evening and/or weekend patient care activities to the appropriate case manager and/or clinical supervisor.

GUIDELINES

The following list is meant to guide the on-call nurse. It is not an exhaustive list, but includes many problems that may require a visit from the hospice nurse.

- Death, suspected death**†
- Unusual, severe or uncontrolled pain†
- Nausea/vomiting not resolved with present medications†
- New onset seizures or suspected seizures†
- IV problems
- Occluded intravenous lines†
- Suspected bleeding
- Respiratory difficulty
- Report of patient falling
- No BM for four (4) days or more (if taking nourishment)
- No urine for 8 to 12 hours (if taking fluids and having discomfort) †
- Increased anxiety and/or confusion*
- Duplicate calls regarding the same problem†
- Patient/family/caregiver perceives a problem and requests a visit†

* May be appropriate for a social worker/chaplain depending on state and community requirements.

† Visit required.
PURPOSE

To ensure the coordination of care provided by hospice and by outside providers.

POLICY

Core services including physician, nursing, social work, counselors are provided directly by hospice. Other services may be provided under written agreement. The Case Manager will coordinate services provided under contractual agreement. Hospice will maintain professional responsibility for all services provided.

PROCEDURE

1. Hospice program will have written agreements to provide general and respite inpatient services, drugs and biologicals, durable medical equipment and supplies, and routine hospice home care for patients in facilities.

2. The hospice program will retain responsibility for evaluating services, maintaining professional management responsibility, and ensuring continuity of care in all settings through its performance improvement program and/or corporate compliance program.

3. Hospice will provide education and training regarding hospice care to inpatient personnel at contracted facilities at least once annually.

4. Hospice will evaluate contract facility personnel needs for education and training at least once annually through its performance improvement program and/or corporate compliance program.

5. Hospice inpatient care will be delivered by designated, hospice-oriented, and trained registered nurses and other personnel.

6. All care provided will be in accordance with the hospice plan of care and documented in the clinical record.

7. When services are provided by an organization other than the hospice organization, the hospice organization will receive a summary of care provided by the outside organization every two (2) weeks or as warranted by changes in care/services provided.
PURPOSE
To establish the process to ensure continuity and communication in the delivery of hospice care between home and inpatient settings.

POLICY
Continuity of care and communication will be provided for patients transferring between the home and inpatient setting.

PROCEDURE
1. The interdisciplinary team will assess the need for inpatient care utilizing the comprehensive assessment.

2. The Case Manager will contact attending physician (or other authorized independent practitioner) to discuss need for patient to be admitted to an inpatient setting and to obtain inpatient orders.

3. The Case Manager or designee will make arrangements with a contracted facility for respite or general inpatient admission.

4. The Case Manager/MSW will arrange for transportation. General inpatient and respite admission transportation is covered under the Medicare or Medicaid hospice insurance benefit and is the responsibility of hospice.

5. The Case Manager will enter a transfer/change in level of care and inform the Clinical Supervisor.

6. The Case Manager or patient's attending physician will call designated inpatient personnel with a verbal report. The Case Manager will provide the inpatient unit with the current plan of care, which specifies inpatient services to be furnished by faxing to facility (history and physical if available). Additionally, information regarding any follow-up to be provided by an interdisciplinary team member will be communicated.

7. If admission occurs after hours, the on-call nurse will follow the same steps as the Case Manager and will inform the Case Manager of the changes on the next day during business hours.

8. The hospice social worker will contact the inpatient social worker on admission day or the next working day to communicate the plan of care.
9. The Case Manager or Clinical Supervisor will continue to participate, as do all hospice interdisciplinary team members, with the plan of care during the inpatient stay.
   
   A. Visits will be made as necessary, at least daily if patient admitted to hospital.
   
   B. Documentation will be recorded in the hospice clinical record by hospice personnel. All telephone contacts will be documented in the hospice clinical record.
   
   C. Consultation will be available 24 hours per day to inpatient personnel.

10. The hospice interdisciplinary team, through the Case Manager and with input from the inpatient personnel, will determine the day of discharge. Other than death, the patient will be discharged after a maximum five (5)-day respite stay, or when his/her symptoms are stabilized during a general inpatient stay and can be managed at home.

11. The Case Manager/MSW will coordinate the transfer of the patient to his/her home.

12. If the family/caregiver is unwilling to accept the patient at home or the patient prefers long-term placement, assistance will be given to help identify long-term placement options.

13. One copy of the inpatient clinical record, including a discharge summary, will be sent to the hospice immediately following discharge or as soon as it is reasonably available.
PURPOSE

To ensure the coordination of care provided to residents of SNF/NF.

POLICY

Core services including physician, nursing, social work, counselors, medical supplies, durable medical equipment and drugs will be directly provided by hospice. Other services may be provided. A designated interdisciplinary team member is responsible for the coordination of services. Hospice will assume responsibility for professional management of the SNF resident’s hospice services provided, in accordance with the hospice plan of care and the hospice CoPs, and make any arrangements for hospice-related inpatient care in a participating Medicare/Medicaid facility.

PROCEDURE

The organization provides hospice care to residents of a SNF and will abide by the following standards:

1. Medicare patients receiving hospice services are subject to the Medicare hospice eligibility criteria set out at §418.20 through §418.30.

2. The organization will assume responsibility for professional management of the resident’s hospice services provided.

3. The organization and SNF will have a written agreement that specifies the provision of hospice services in the facility. The agreement must be signed by the authorized representatives of the hospice and facility before the provision of services. The written agreement must include at least the following:

   A. The manner in which the parties will communicate with each other and document such communications to ensure the needs of patients are addressed and met 24 hours a day.

   B. A provision that the hospice is notified if:

      1. A significant change in a patient’s physical, mental, social, or emotional status occurs

      2. Clinical complications appear that suggest a need to alter the plan of care
3. A need to transfer the patient from the SNF/NF or ICF/MR, and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care related to the terminal illness and related conditions

4. Patient dies

C. A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.

D. An agreement that it is the SNF/NF or ICF/MR responsibility to continue to furnish 24 hour room and board care, meeting the personal care and nursing needs at the same level of care before hospice care was elected.

E. An agreement that it is hospice’s responsibility to provide services at the same level and to the same extent as those services would be provided if the resident were in his or her own home.

F. A delineation of the hospice’s responsibilities, which include, but are not limited to the following:

1. Providing medical direction and management

2. Providing nursing, counseling (including spiritual, dietary and bereavement), social work

3. Providing medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with terminal illness

4. Provision of other hospice services that are necessary for care related to the terminal status and related conditions

G. A provision that the hospice may use SNF/NF or ICF/MR nursing personnel where permitted by State law and as specified by the SNF/NF or ICF/MR to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a patient’s family in implementing the plan of care.

H. A provision that the hospice must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the SNF/NF or ICF/MR administrator within 24 hours of the hospice becoming aware of the alleged violation.

I. A delineation of the responsibilities of the hospice and the SNF/NF or ICF/MR to provide bereavement services to SNF/NF or ICF/MR staff.
4. A written plan of care must be established and maintained in consultation with SNF/NF or ICF/MR representatives. All hospice care provided must be in accordance with this plan of care. The plan of care must:

   A. Identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions

   B. Reflect the participation of the hospice, the SNF/NF or ICF/MR, and the patient and family to the extent possible

   C. Any changes in the hospice plan of care must be discussed with the patient or representative, and SNF/NF or ICF/MR representatives, and must be approved by the hospice before implementation.

5. The organization will designate a member of each interdisciplinary team that is responsible for a patient who is a resident of the SNF/NF or ICF/MR. The designated member is responsible for:

   A. Providing overall coordination of hospice care of the resident with the facility representatives

   B. Communicating with the facility representatives and other health care providers participating in the provision of care for the terminal illness and related conditions and other conditions to ensure quality of care for the patient and family

6. The organization will ensure that the interdisciplinary team communicates with the SNF/NF or ICF/MR Medical Director, the patient’s attending physician, and other physicians participating in the provision of care as needed to coordinate the hospice care with the medical care provided by other physicians.

7. The organization will provide the SNF/NF or ICF/MR the following information specific to each patient:

   A. The most recent plan of care

   B. Hospice election form and Advance Directives

   C. Physician certification and recertification of the terminal illness

   D. Names and contact information for hospice personnel involved in hospice care

   E. Instructions on how to access the hospice’s 24-hour on-call system

   F. Hospice medication information

   G. Hospice physician and attending physician (if any) orders
8. The organization must assure orientation of SNF/NF or ICF/MR staff furnishing care to hospice patients in the following:

A. Hospice philosophy

B. Hospice policies and procedures regarding methods of comfort, pain control and symptom management

C. Principles about death and dying and individual responses to death

D. Patient rights

E. Appropriate forms and record keeping requirements
PURPOSE

To outline the process to make a referral for additional services.

POLICY

Referrals to other disciplines will be processed as any other referral.

PROCEDURE

1. All internal referrals to other disciplines will be documented within the clinical record.

2. When an interdisciplinary team member identifies that an additional service is needed, he/she will notify the Case Manager.

3. The referral will be completed in e-chart and the supervisor will be notified and will assign the appropriate clinician for free.

4. The clinician assigned to provide additional service will contact the physician (or other authorized independent practitioner) for orders for evaluation and treatment.

5. For admissions to Serenity House, see the Serenity House Policy and Procedure: “Admission of Current Home Hospice Patient.”
PURPOSE
To provide guidelines for the initial assessment to evaluate the patient’s physical, psychosocial and emotional needs and determine immediate care and support needs.

POLICY
An initial assessment will be performed by a registered nurse within 48 hours after election of hospice care unless otherwise specified by the physician, patient or representative to be completed in less than 48 hours.

PROCEDURE
1. Admitting registered nurse uses an assessment scale/rating tool to assess for problems and to establish a baseline status of each symptom rated. Items assessed may include, but are not limited to, the following:
   A. Pain assessment
   B. Vital signs
   C. Current symptoms such as fatigue, shortness of breath, anxiety, nausea, and vomiting
   D. Skin assessment
   E. Home safety assessment
   F. Identify the qualifying criteria for Hospice admission
   G. Functional limitation
   H. Patient/family caregiver support services
2. Admitting registered nurse will determine the patient’s and caregiver’s primary concern, goals and immediate care needs.
3. Admitting registered nurse will document interventions and teaching performed.
4. Admitting registered nurse will determine the other disciplines to complete the appropriate sections of the comprehensive assessment based on identified problems and needs during this initial assessment.
A. Nursing and bereavement sections will always be identified
5. Based on the initial assessment, the plan of care will be initiated on the day of admission.

6. If the comprehensive assessment is completed during the admission visit, the initial assessment will be included as a part of the comprehensive assessment.
PURPOSE

To provide guidelines for the comprehensive assessment.

POLICY

A comprehensive patient assessment will be performed by the interdisciplinary team no later than 5 calendar days after the election of hospice care in consultation with attending physician.

PROCEDURE

1. During the comprehensive patient assessment, all baseline data and other relevant information will be documented in the patient's clinical record, including at least the following information, as relevant:

A. An assessment of pain, including the origin, location, duration, severity, and relief measures (See “Pain Assessment” Policy No. H:2-050.)

B. An assessment of severity of secondary symptoms, such as nausea, vomiting, constipation, respiratory distress, and nutritional status (See “Nutritional Assessment” Policy No. H:2-049.)

C. Nature and condition causing admission (including the presence or lack of objective data and subjective complaints)

D. Alleviating and exacerbating factors for physical symptoms

E. Current treatment and patient response to that treatment

F. An assessment of the patient's response to palliative treatment

G. A physical assessment, including blood pressure, temperature, pulse, respiration, skin, and other relevant data related to pertinent physical findings and the patient's terminal illness

H. Imminence of death

I. Patient's functional status including, but not limited to, the degree of self-care and the amount and level of assistance needed (See “Functional Assessment” Policy No. H:2-048.)

J. Complication and risk factors that affect care planning
K. Patient's past and present medical and psychosocial history including pertinent diagnosis and any co-morbid conditions

L. Name and address of the patient's attending physician

M. Name of the hospital and other agencies or persons involved in the past and present care of the patient

N. An evaluation of the home environment and assessment of emergency preparedness of the patient.

O. Presence of any Advance Directives for care and/or discussions with patient and family/caregiver regarding the withholding of resuscitative services or the withdrawal of life-sustaining treatment

P. Equipment presently in home and potentially needed by patient

Q. Review of current and related past medications, including prescription and over-the-counter medications, allergy history and other medication information, including but not limited to identification of the following:
   1. Effectiveness drug therapy
   2. Unwanted side and toxic effects
   3. Drug interactions (actual or potential)
   4. Duplicate drug therapy
   5. Drug therapy currently associated with laboratory monitoring
   6. Ability of patient/family to self-administer drugs and biologicals in the home.

R. Patient and family/caregiver support systems and the care the family/caregiver is available, capable, and willing to provide, including applicable strengths of patient, physical, psychosocial, and/or spiritual resources available

S. The patient’s psychosocial status, including emotional barriers to treatment, cognitive limitations, memory and orientation, family relationships, social history, source and adequacy of environmental and other resources, coping mechanisms, and the patient’s and family/caregiver’s reaction to illness.

T. An assessment of the patient's and family/caregiver's spiritual orientation, including, as appropriate, any involvement in a religious group such as a church or synagogue or a support group such as Alcoholics Anonymous and spiritual concerns or needs such as despair, suffering, guilt, etc.
U. Involvement of family/caregiver, neighbors, and/or other individuals/organizations, including involvement in any support groups

V. An assessment of the need for volunteer services to offer support or respite to the patient and family/caregiver

W. A bereavement assessment of the needs of the patient’s family and other individuals focusing on:
   1. The nature of the relationship to the patient
   2. Circumstances surrounding the illness/prognosis
   3. Behaviors prior to and after the illness/prognosis
   4. Survivor needs (social, spiritual and cultural) that may impact coping skills
   5. Potential for pathological grief reactions

X. Laboratory results

Y. Medical, alcohol, and other drug history

Z. Specific, individualized patient needs/problems pertinent to the hospice care being provided

AA. Past medical and surgical care, including dates of onset/exacerbation

BB. The patient’s and family/caregiver’s educational needs, abilities, motivation, and readiness to learn

CC. The need for referrals and further evaluation by appropriate health professionals

2. The assessment should determine:
   A. Probable prognosis of six (6) months or less
   B. Patient problems and needs related to the terminal illness
   C. Patient goals related to the terminal illness
   D. Type of services, frequency, and duration needed to meet patient care needs
   E. Anticipated discharge needs, including bereavement and funeral needs
F. Survival risk factors, such as the nature of the relationship with the patient, circumstances surrounding the death, behaviors before and after the death, and availability of coping mechanisms and potential for pathological grief reactions

G. The need for an alternative level of care

3. The organization must assure that the data elements allow for measurement of outcomes.

4. The Clinical Supervisor will be responsible for assuring that the documentation of clinical findings supports the terminal diagnosis.

5. The comprehensive assessment is updated by the interdisciplinary team as frequently as the patient’s condition requires but at a minimum every 15 days.
   
   A. The interdisciplinary team is required to only update those sections that require updating

   B. If no changes are needed, then that must be documented

   C. If there has been a change in the patient’s condition/status, then the comprehensive assessment must be updated
PURPOSE
To provide guidelines for assessments of patients during ongoing care.

POLICY
The scope and intensity of ongoing hospice patient assessments will be determined by the patient's prognosis, diagnoses, condition, desire for care, response to previous care, and the care setting.

PROCEDURE
1. During each home visit, the Case Manager or other discipline will evaluate the patient according to the problems identified during the initial assessment and thereafter the comprehensive assessment.

2. The nurse will assess each patient on each visit, for:  
   (See “Comprehensive Assessment” Policy No. H:2-046.)
   
   A. Pain, including the origin, location, duration, severity, and relief measures
   B. Secondary symptoms related to the terminal illness such as, nausea, vomiting, and respiratory distress, and patient's response to medications and other interventions
   C. Factors that alleviate or exacerbate physical symptoms
   D. Current treatment related to the identified symptoms and the patient’s response
   E. Vital signs appropriate to the patient’s condition
   F. Breath sounds
   G. Skin integrity
   H. Bowel sounds, elimination (urinary and bowel)
   I. Mental status
   J. Appetite/diet, nutritional status
   K. Functional status
   L. Safety/home environment
M. Patient and family/caregiver support

N. Progress toward hospice goals and patient needs and problems

O. Compliance with treatments and medication regimen

P. The need for an alternative setting or level of care

3. Ongoing comprehensive assessments should focus on:
   A. Patient's response to care
   B. Changes in patient condition, level of deterioration
   C. Changes in patient diagnoses/prognosis
   D. Changes in the patient's care environment or support systems

4. Based on the assessments, the plan of care—including problems, needs, goals, and outcomes—will be reviewed and updated by the interdisciplinary team members responsible for the case.

5. Based upon the findings of the assessment, change/verbal orders will be generated and forwarded to the physician (or other authorized independent practitioner) as needed.

6. The physician will be notified to verify any changes in medications, including over-the-counter medications, and treatment/interventions that require physician approval.

(See “Verification of Physician Orders” Policy No. H:2-032.)
PURPOSE

To provide guidelines for the appropriate assessment of patients who may have functional limitations requiring assistance and services from hospice.

POLICY

During the initial and comprehensive assessment, patients will have their functional status assessed for provision of appropriate services. When rehabilitation needs are identified, a qualified rehabilitation professional will perform an in-depth, functional assessment prior to the initiation of treatment.

PROCEDURE

1. During the initial assessment, the hospice nurse performing the admission visit will assess the patient's functional status, including, but not limited to the following:

   A. Level of independence in the home environment for:
      1. Eating
      2. Toileting
      3. Transfers
      4. Walking
      5. Shopping
      6. Cleaning
      7. Laundry
      8. Bathing
      9. Dressing
   B. Mobility status
   C. Pain status
   D. Problems with continence
E. Ability to operate and maintain equipment
F. Communication level and skills
G. Memory
H. Cognitive level
I. Orientation
J. Emotional response to current health status
K. Dental/oral hygiene

2. Based on the above assessment criteria, the functional level classification should be made:
   A. 0 – completely independent
   B. 1 – requires use of equipment or device
   C. 2 – requires help from another person for assistance, supervision, or teaching
   D. 3 – requires help from another person in activity
   E. 4 – dependent, does not participate in activity

3. Once the level of functioning is determined, the Case Manager will determine which additional hospice interdisciplinary team services or further functional assessment the patient may benefit from, including hospice aide, therapies, (physical, occupational and/or speech), psychosocial worker services, spiritual counselors, and volunteers.

4. This information will be included and implemented in the plan of care.

5. When rehabilitation needs are identified and an order has been received from a physician (or other authorized independent practitioner), the patient’s physical status and functional abilities will be evaluated by a qualified rehabilitation professional and incorporated into the comprehensive assessment and the plan of care.

6. The patient’s functional rehabilitation status will be assessed, including, but not limited to the following:
   A. Current level of functioning
   B. Self-care responsibilities
   C. Independence level
D. Quality of life

7. Based on this functional assessment, a rehabilitation professional may be consulted to develop and implement a rehabilitation plan with the patient and family/caregiver (see “Rehabilitative Services” Policy No. H:2-010.)
PURPOSE

To provide guidelines for the appropriate assessment of patients who may require a nutritional assessment by a qualified clinician.

POLICY

When the comprehensive assessment indicates an alteration in nutritional status, the hospice Case Manager will have a qualified clinician perform a nutritional assessment. (See “Nutritional Services” Policy No. H:2-012.) All Serenity House inpatients will have a nutritional assessment performed within 7 days of admission.

PROCEDURE

1. During the comprehensive assessment, the following information will be obtained as part of the baseline data:
   A. Diet/appetite
   B. Height/weight (estimated)
   C. Digestive disorders
   D. Dysphasia/swallowing difficulties
   E. Factors affecting nutritional status including, but not limited to:
      1. Nausea/vomiting
      2. Diarrhea/constipation
      3. Emotional issues
      4. Oral hygiene/dental care
      5. Environment for meals
   F. Hydration/fluid intake

2. Based on the above, the Case Manager will be notified if the patient is determined to have any of the following:
A. Nutrition, altered, less than body requirements weight loss of 10%

B. Patient desires to eat but is unable to

C. Gastric tube in place with complications

D. TPN infusion

3. Documentation in the clinical record will reflect the physician (or other authorized independent practitioner) contacted and the nutritional assessment findings and any follow-up orders needed.

4. The qualified clinician will make entries into the clinical record regarding plans, discussions, and interventions related to the nutrition assessment.

5. Based on the comprehensive assessment the plan of care will be updated.
PAIN ASSESSMENT
Policy No. H:2-050.1

PURPOSE
To provide guidelines for the appropriate identification and assessment of patients who may experience pain.

POLICY
All patients will receive pain assessments at every nursing visit. When pain is identified, a more comprehensive pain assessment will be completed when warranted by the patient’s condition. Pain assessments will be appropriate to the patient’s age and will be documented to facilitate regular reassessment and follow-up by clinicians. For patients experiencing a pain level greater than or equal to 4, intervention(s) to relieve pain will be performed and pain level will be reassessed by the end of the visit and at 24 and 48 hours.

PROCEDURE
1. During the initial assessment and on an ongoing basis, the patient will be asked a general screening question regarding current or recent pain as part of the initial assessment. Clinicians will consider the patient’s personal, cultural, spiritual, and ethnic beliefs when assessing pain or discomfort.

2. When the patient or the clinician identifies pain, the following in-depth pain assessment information will be obtained whenever possible:

   A. Pain intensity using a rating scale (on a scale of 0 – 10: 0 = no pain, 10 = unbearable pain). Pain intensity should include current pain, worst pain, and least pain using the scale. The patient will be reassessed every visit for the existence and intensity of pain and the effectiveness of interventions to relieve pain. A separate pain scale may be used for children.

   B. Pain location.

   C. Pain quality, patterns of radiation, and character. Use the patient’s own words whenever possible.

   D. Pain onset, duration, variations, and patterns.

   E. Alleviating and aggravating factors.

   F. Present pain management regimen and effectiveness.
G. Pain management history, to include a medication history, presence of common barriers to reporting pain and using analgesics, past interventions and response, and manner of expressing pain.

H. Effects of pain. These include impact on daily life, function, sleep, appetite, relationships with others, emotions, concentration, etc.

I. The patient’s pain goal, including pain intensity and goals related to function, activities, and quality of life.

J. Physical exam including observation of the site of pain.

K. Secondary symptoms related to pain such as nausea, vomiting, respiratory distress, or nutritional compromise.

3. If patient is unable to communicate pain using the rating scale, is cognitively impaired, or is a child, the clinician will assess behavioral factors that signal pain or discomfort and include this information in the assessment.

4. For parent/caregiver of a child who exhibits or reports pain, information will be provided regarding the parent/caregiver’s role in interpreting the child’s behavioral changes that may indicate pain or discomfort.

5. The nurse will assist the patient in determining pain management goals and these will be reviewed and revised as needed.

6. The Plan of care will reflect the patient and family’s goal for interventions for pain management. This will be included in the initial, comprehensive and updated assessments.

**Documentation**

1. Pain assessments will be part of the initial, comprehensive and updated assessments.

2. Pain levels will be documented at every patient visit and every phone call related to pain in the Clinical Monitoring section of Allscripts.

**Pain Management**

1. If a patient’s pain level is $\geq 4$ on the initial visit or at any other time, intervention(s) to relieve pain will be performed until $< 4$ or at another acceptable level per the patient; pain will be reassessed at the end of the visit. If the pain level is not less than 4 by the end of the visit, it will be reassessed at 24 and 48 hours and appropriate interventions will be performed.

2. The patient’s preferences for pain management will be reflected in the pain control measures selected.

3. Non-pharmacological interventions will be considered for the treatment of pain.
4. Common side effects of analgesic medications will be anticipated, and preventive measures will be implemented.

5. Patient and family/caregiver education will focus on the use and side effects of analgesic and/or adjuvant medications, expected responses to therapy, and the importance of administering medications according to prescribed dosage and frequency.
PURPOSE
To provide guidance for the assessment and reassessment of the psychosocial needs of patients and families/caregivers.

POLICY
A comprehensive psychosocial assessment will be initiated at the time of admission and continued throughout the course of care.

Psychosocial assessment will be completed by a qualified hospice social worker or hospice registered nurse. The assessment includes, but is not limited to:

1. Coping with and adjusting to the patient’s terminal illness
2. Making final arrangements
3. Reaction to the terminal illness and bereavement needs
4. Patient/Family spiritual needs.

PROCEDURE
1. A social work contact will be made either by a home visit or by telephone based on the patient’s and family’s needs and acceptance of these services.

2. A psychosocial assessment will be performed at the initial meeting of patient and family/caregiver:
   A. In whatever setting they may be.

3. The psychosocial assessment will include, but not be limited to:
   A. An evaluation of the patient’s preferred style of communication, including expressing emotions, feelings, thoughts, and needs
   B. Patient’s and family/caregiver's attitude and emotional response to the terminal illness and treatment interventions
   C. An evaluation of the patient's mental health needs.
   D. The patient and family/caregiver identification of substance abuse history and symptoms when appropriate or indicated.
E. A scale of psychosocial support

F. A scale of coping styles and impact of illness on certain physical functions

G. Need for volunteer services to offer support or respite to the patient and family/caregiver

H. Financial assessment

I. An initial bereavement risk assessment is documented in Allscripts at the time of admission for any family/friends that are entered. A bereavement risk score is provided at the time of death for the family/friends during the IDT time of remembrance. The Bereavement Coordinator/Bereavement Counselor will consider this information for follow-up when the patient dies (see “Bereavement Assessment” Policy No. H:2-053.)

4. The assessment will be completed in the patient's clinical record.

5. After the assessment is performed, ongoing contact will be maintained by phone and/or home visits by the hospice social worker:

   A. If requested by the patient and family/caregiver

   B. If requested by another hospice interdisciplinary team member

   C. Identified as necessary by the hospice social worker

6. Issues identified related to patient coping will be included in the comprehensive assessment and addressed in the plan of care and will include at least:

   A. Access to adequate and accurate information

   B. Change in family roles

   C. Communication abilities

   D. Ability to fulfill desired sexual expression when appropriate.

7. A finding of suicidal ideation will be immediately reported to the interdisciplinary team and appropriate interventions will be implemented.

8. If the patient and/or family/caregiver refuse psychosocial visits or contacts, patient and family/caregiver needs will continue to be assessed on an ongoing basis at the IDT meeting. Social work services will be re-initiated when requested by the patient and/or family/caregiver.
PURPOSE

To provide guidance for the assessment and reassessment of the spiritual needs of patients and families/caregivers.

POLICY

A spiritual assessment will be completed for each patient/family that accepts this service by the Hospice Spiritual Counselor. The assessment will include, but not be limited to, evaluation of the following:

1. Coping with and adjusting to the patient’s terminal illness
2. Assessing bereavement needs
3. Religious and/or spiritual reactions to terminal illness (see “Spiritual Care Counseling Services” Policy No. H:2-007)

PROCEDURE

1. On admission, the hospice registered nurse or medical social worker will conduct an initial spiritual assessment.

2. The Hospice Spiritual Counselor will contact the patient/family by a home visit or by telephone based on the patient’s and family’s needs and acceptance of these services.

3. If the patient and/or family/caregiver refuse these services, the refusal will be documented. The interdisciplinary team members will continue to assess for spiritual needs at the IDT and offer appropriate services to the patient and/or family/caregiver.

4. The in-depth spiritual assessment will be performed by the Hospice Chaplain in whatever setting the patient decides.

5. The spiritual assessment will include, but not be limited to:

   A. Patient's spiritual response to the terminal illness and treatment interventions
B. Survivor risk factors, such as availability of coping mechanisms and the potential for pathological grief reactions

C. Available religious spiritual support

D. Coping styles and impact of illness on spirituality

E. Anticipatory grief assessment

6. The assessment will be documented in the patient’s clinical record.

7. After the spiritual assessment is performed, ongoing contact will be maintained by phone and/or home visits by the Hospice Spiritual Counselor if requested by the patient and family/caregiver and will be included in the comprehensive assessment and the plan of care.
Bereavement Assessment Policy

Policy No. H:2-053.1

Purpose

To provide guidance for the assessment and reassessment of the bereavement needs of families/caregivers.

Policy

Visiting Nurse & Hospice Care will provide bereavement services for up to one (1) year after the patient’s death to surviving family/friends.

The hospice bereavement plan of care will be developed based on an initial assessment of the patient and family/friend needs, during the course of care, and at the time of the patient’s death as part of the comprehensive assessment. (See “Bereavement Services” Policy No. H:2-008.)

Procedure

1. On admission, the social worker or hospice registered nurse will complete a bereavement risk assessment that is given to the Bereavement Coordinator/Bereavement Counselor at the first IDT meeting at which it is discussed. At a minimum, it will include:

   A. Patient and family/caregiver loss issues
   
   B. Survivor needs
   
   C. Social, spiritual, and cultural factors
   
   D. Services to be provided including individual counseling, support groups, and letters and cards
   
   E. Referrals to be made
   
   F. Grief risk factors and potential for pathological grief reactions

2. The Bereavement Counselor will review the bereavement risk assessment to determine potential needs of the survivors.

3. After the death occurs, the assigned Bereavement Counselor will complete the bereavement follow-up assessment.

4. The assigned Bereavement Counselor will develop a plan for intervention based on the findings of the bereavement follow-up assessment.
5. The assigned Bereavement Counselor will document the family bereavement interventions.

6. Upon completion of the period for bereavement follow-up, all bereavement documentation will be merged with the corresponding patient’s medical record.
PurpOe

To provide guidelines for identification of suspected abuse victim for care and referral to community resources. These guidelines stipulate when and how to report suspected Dependent Adult/Elder Abuse and Child Abuse.

Policy

The organization will report all suspected cases of abuse, neglect, or exploitation in compliance with appropriate state statutes to appropriate protection organizations.

Dependent adult/elder abuse

"Elder," means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). "Dependent Adult," means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3).

Reporting responsibilities

Mandated reporters (see definition below under "Reporting Party Definitions") shall complete form SOC 341 for each report of a known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect, (self-neglect), isolation, and abandonment (see definitions in WIC Section 15610) involving an elder or a dependent adult.

Copies of the most current REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE form as well as instructions for completing, it can be found at the State of California website by using the following link: http://www.dss.ahw.net/Forms/English/SOC341.pdf. (COPY THIS LINK INTO THE INTERNET EXPLORER SEARCH BAR.)

The original SOC 341 report shall be submitted within two (2) working days of making the telephone report to the responsible agency as identified below:

- The county Adult Protective Services (APS) agency or the local law enforcement agency (if abuse occurred in a private residence, apartment, hotel or motel, or homeless shelter).
- Long-Term Care Ombudsman (LTCO) program or the local law enforcement agency (if abuse occurred in a nursing home, adult residential facility, adult day program, residential care facility for the elderly, or adult day health care center).
REPORTING PARTY DEFINITIONS
Mandated Reporters (WIC) "15630 (a) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter."

Health Practitioner (WIC) "15610.37 ‘Health practitioner’ means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner."

WHAT TO REPORT
Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment has observed, suspects, or has knowledge of an incident that reasonably appears to be physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect), or is told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, abduction, or neglect, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days to the appropriate agency.

MULTIPLE REPORTERS
When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

FAILURE TO REPORT
Failure to report by mandated reporters (as defined under “Reporting Party Definitions”) any suspected incidents of physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than $1,000, or by both imprisonment and fine. Any mandated reporter who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to $5,000, or by both imprisonment and fine.
EXCEPTIONS TO REPORTING
Per WIC Section 15630(b)(3)(A), a mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report a suspected incident of abuse where all of the following conditions exist:

1. The mandated reporter has been told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect).

2. The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.

3. The elder or the dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.

4. In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

DISTRIBUTION OF SOC 341 COPIES
Mandated reporter: After making the telephone report to the appropriate agency, the reporter shall send the original and one copy to the agency; keep one copy for the reporter's file.

Suspected Child Abuse
California Penal Code Section 11164-11174.3, known as the Child Abuse and Neglect Reporting Act (CANRA), defines a "child" as a person under the age of 18 years.

MANDATED CHILD ABUSE REPORTERS
Mandated child abuse reporters include all those individuals and entities listed in Penal Code Section 11165.7. A "mandated reporter", as pertains to VNHC employees, is defined as any of the following:

- A physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage, family and child counselor, clinical social worker, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

- A clergy member, as specified in the California Penal Code means a priest, minister, rabbi, religious practitioner, or similar functionary of a church, temple, or recognized denomination or organization.

TO WHOM REPORTS ARE TO BE MADE
Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department, or the county welfare department. (PC Section 11165.9.)
REPORTING RESPONSIBILITIES

- Any mandated reporter who has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof **within 36 hours** of receiving the information concerning the incident. (PC Section 11166(a).)

- No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA. Any other person reporting a known or suspected incident of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by CANRA unless it can be proven the report was false and the person knew it was false or made the report with reckless disregard of its truth or falsity. (PC Section 11172(a).)

- A mandated reporter must complete and submit the Suspected Child Abuse Report form (SS 8572) even if some of the requested information is not known. (PC Section 11167(a).)

DEFINITIONS OF CHILD ABUSE

Examples of child abuse listed in the penal code (PC Sections 11165.1 to 11165.6) include:

- sexual abuse meaning sexual assault or sexual exploitation
- neglect meaning the negligent treatment or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person.
- the willful harming or injuring of a child or endangering of the person or health of a child unlawful corporal punishment or injury meaning a situation where any person willfully inflicts upon any child any cruel or inhuman corporal punishment or injury resulting in a traumatic condition.
- child abuse or neglect including physical injury or death inflicted by other than accidental means upon a child by another person

INSTRUCTIONS FOR COMPLETION OF FORM SS 8572

Copies of the most current Suspected Child Abuse Report form (SS 8572), as well as instructions for completing, it can be found at the State of California website by using the following link: [http://ag.ca.gov/childabuse/pdf/ss_8572.pdf](http://ag.ca.gov/childabuse/pdf/ss_8572.pdf) (COPY THIS LINK INTO THE INTERNET EXPLORER SEARCH BAR.)

DISTRIBUTION

**Reporting Party:** After completing Form SS 8572, retain the yellow copy for your records and submit the top three copies to the designated agency.
PURPOSE

To define the use of the medication profile in evaluating a patient’s medication regimen.

POLICY

Patients receiving medications administered by the organization will have a current, accurate medication profile in the clinical record, updated for each change to reflect current medications, and new and/or discontinued medications.

PROCEDURE

1. Upon admission to hospice, the admitting nurse will initiate a medication profile to document the current medication regimen.

2. A drug regimen review will be performed at the time of initial and comprehensive assessment, when updates to the comprehensive assessments are performed, when care is resumed after a patient has been placed on hold, and with the addition of a new medication. The review will identify drug/food interactions, potential adverse effects and drug reactions, ineffective drug therapy, duplicative drug therapy, and noncompliance with drug therapy. The interdisciplinary team will confer with an individual with education in drug management to ensure the drugs and biologicals meet the patient’s needs.

3. During subsequent home visits, the medication profile will be used as a care planning and teaching guide to ensure that the patient and family/caregiver, as well as other clinicians, understand the medication regimen. This includes, but will not be limited to:

   A. Using the medication profile to evaluate the use of the drugs in the home setting

   B. Using the medication profile to teach purpose of medication, dosages, routes, administration times, side effects, contraindications, and appropriate outcomes.

   C. Using the medication profile as a communication tool for other clinicians involved in care

   D. Therapeutic appropriateness of the choice of drug, dose, frequency, and route of administration.

4. Based on review of the medication profile, changes in the plan of care may be required.

5. Any conclusions and findings of patient medication use or monitoring should be communicated to the pharmacist, when appropriate, and other clinicians.

6. Deviations from taking medications as ordered will be documented in clinical notes, and the physician (or other authorized independent practitioner) will be notified.
IDENTIFICATION OF MEDICATION FOR ADMINISTRATION
Policy No. H:2-056.1

PURPOSE

To provide general guidelines for the safe administration of medications.

POLICY

Orders for the administration of medications must be given by a physician (or other authorized independent practitioner) and include patient name, the name of the medication, dosage, dilution, route, frequency of administration, and rate of infusion, if applicable, as well as orders for anaphylaxis and laboratory work, when appropriate.

Note: If the drug order is verbal or given by or through electronic transmission, it must be given only to a licensed nurse, nurse practitioner (where appropriate), pharmacist or physician. The individual receiving the order must ‘read back’ the order, record it, sign it immediately and have the prescribing person sign it in accordance with state and federal regulations.

PROCEDURE

1. Prior to medication administration, the nurse will be familiar with the patient’s medical history and will review present medication regimen, including allergies to foods and drugs.

2. The nurse will review the written physician’s (or other authorized independent practitioner’s) orders prior to medication administration.

3. It will be the nurse’s responsibility to be knowledgeable of the medication to be administered, including indications, normal dosage range, dilution, route of delivery, rate of delivery, precautions, side effects, expected therapeutic effect, proper antidote, and incompatibilities, as applicable.

4. Medications will be properly labeled with the patient’s name, an additional patient identifier, name of drug, dosage, diluent, date of preparation, expiration date, initials of preparer, and any special instructions, as applicable.

5. The nurse will review the medication label for name, additional patient identifier, drug, dosage, and prescription.

6. The nurse will validate patient name and listed patient identifier with the patient or family/caregiver, as appropriate.

7. All medications will be checked for stability by visualizing the medication and observing for, but not limited to, the following:
A. Deterioration, as evidenced by particulate matter
B. Discoloration, cloudiness
C. Dampness
D. Intactness, including seals
E.Expiration date
F. Storage facilities/containers

8. If the medication is not stable for administration, the nurse will hold the medication and contact the appropriate pharmacy for replacements.

9. Prior to administration, the nurse will verify and/or review information to determine that the medication is not contraindicated for the patient based on the following:
   A. Known medication allergies
   B. Known food allergies
   C. Medication incompatibility for potential interaction
   D. Patient’s physical or mental condition
   E. Relevant laboratory results
   F. Previous reactions to medications

10. If potential contraindications are identified, the nurse will contact the pharmacists and physician involved in the care of the patient for further instructions.

11. The nurse will document medication teaching, side effects, administration, and other related information in the clinical record.
PURPOSE

To provide guidelines for the safe administration of medications by licensed personnel.

POLICY

Licensed nursing personnel will administer and document only those medications which have been ordered by the physician, as a part of the plan of care.

Registered nurses may administer oral, subcutaneous, intramuscular, and intravenous medication. (See “Intravenous Administration of Medications/Solutions” Policy No. H:2-060 and “Intravenous Administration of Chemotherapy” Policy No. H:2-061.)

Licensed vocational nurses will administer oral, subcutaneous, intramuscular injections and IV fluid per California Nurse Practice Act. Certification and competency demonstrated for peripheral IV fluid administration will be documented in the clinician’s personnel file.

Non-licensed personnel may, with instruction, supervise and assist the patient's self-administration of medication. Non-licensed personnel may document assisting the patient in his/her self-administration of medication.

Visiting Nurse & Hospice Care will make available to hospice personnel the current editions of drug reference materials or software such as but not limited to: Medispan, PDR, Nursing Drug Handbook, or Nursing Drug Guide to be used as drug information and patient education sources for consistency of referenced professional information. These reference materials will provide information concerning drug indications, drug interactions, pharmacology/pharmacokinetics, side/adverse effects, and patient consultation guidance, dosing information, and dosing forms. The pharmacies dispensing patient medications also independently checks for drug interactions, pharmacology/pharmacokinetics, and potential side/adverse effects.

Inpatient Unit Considerations

When in a general inpatient unit, each patient must have a medication container that is labeled with the following: Patient name; physician prescribing; name and strength of drug; dose, method and frequency of administration; lot and/or control number; additional cautions or instructions; expiration date.

Any medication stock containers in an inpatient unit must contain the following information: Name and strength of drug; lot and/or control number; expiration date.
PROCEDURE

1. As part of the assessment process, a drug history will be taken and a comparison made between the physician's (or other authorized independent practitioner's) orders and the current medication the patient is taking. Any discrepancies or contradictions should be reported to the physician for resolution.

2. The nurse will provide instruction to the patient which includes medication administration, route, how medication relates to disease process, contraindications, side effects, and adverse reactions.

3. Licensed nurses will administer medications ordered by the physician (or other authorized independent practitioner) which are not listed in the Medications Not Approved for Safe Home or Serenity House Administration list (See "Addendum H:2-057.B.")
   
   A. For those ordered medications that cannot be safely administered and monitored, the physician (or other authorized independent practitioner) will be contacted for discussion.
   
   B. Medication administration will occur upon successful completion of the competency skills checklist. This will include identification of precautions and requirements for treatments such as equipment required, assessments for adverse reactions, laboratory results to be reviewed prior to administration, guidelines for physician notification, and infection control practices.

4. Nurses who are providing intermittent home care visits will document only those medications that they administer, not medications the patient self-administers during the absence of nursing personnel.

5. Patients in the inpatient unit who wish to self-administer medications will need:
   
   A. A physician or Independent Nurse Practitioner's order
   
   B. Will follow the guidelines prescribed by the inpatient unit for self-administration of medications.

6. Medications will be administered within 60 minutes before or after the prescribed times. Deviance from this time frame will be noted on the medication profile with an explanation made in the clinical notes.

7. Medications refused, held, and/or omitted will be indicated on the medication profile with an explanation made in the clinical notes. The attending physician will be notified in compliance with inpatient unit regulations. An incident report will be filed for medication errors.

8. If, in the judgment of the nurse, it would be beneficial to the patient to document his/her self-administered medications, a patient self-medication checklist may be prepared and left
in the home for the patient’s use. This document will be used as a service only and will not be incorporated into the clinical record.
## DRUG/CLASSIFICATIONS AND THEIR ROUTES

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<th>Classification</th>
<th>Route</th>
<th>By Whom</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gastrointestinal Tract Drugs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Antacids, Antiflatulants</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Digestive Enzymes</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Antidiarrheals</td>
<td>PO, SC</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Laxatives</td>
<td>PO, Suppository, Enema</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Antiemetics</td>
<td>PO, IM</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Antiulcer Agents</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td><strong>Hormonal Agents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Antiepileptics</td>
<td>PO, IM</td>
<td>RN, LVN</td>
</tr>
<tr>
<td><strong>Agents for Fluid &amp; Electrolyte Balance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Antiepileptics</td>
<td>PO, IM</td>
<td>RN, LVN</td>
</tr>
<tr>
<td><strong>Hematologic Agents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hematinics</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Anticoagulants</td>
<td>PO, SC</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Hemostatics</td>
<td>In wound/ulcer</td>
<td>RN, LVN</td>
</tr>
<tr>
<td><strong>Antineoplastic Agents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Antiepileptics</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td><strong>Immunomodulation Agents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Immunosuppressants</td>
<td>PO</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Vaccines and Toxoids</td>
<td>PO, SC, IM, Intradermal</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Immune Serums</td>
<td>IM</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Biological Response Modifiers</td>
<td>SC, IM</td>
<td>RN, LVN</td>
</tr>
<tr>
<td>• Biological Response Modifiers</td>
<td>IV</td>
<td>RN</td>
</tr>
<tr>
<td><strong>Ophthalmic, Otic, Nasal Drugs</strong></td>
<td>Eye, Ear, Nose</td>
<td>RN, LVN</td>
</tr>
<tr>
<td><strong>Topical Agents</strong></td>
<td>Topical</td>
<td>RN, LVN</td>
</tr>
<tr>
<td><strong>Nutritional Agents</strong></td>
<td>PO, IM</td>
<td>RN, LVN</td>
</tr>
</tbody>
</table>
ADDENDUM H:2-057.B

MEDICATIONS NOT APPROVED FOR
SAFE HOME ADMINISTRATION
## MEDICATIONS NOT APPROVED FOR SAFE HOME OR SERENITY HOUSE ADMINISTRATION

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Route</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood and Blood products</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Adrenergic agonists</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Antiarrhythmics, ie. Diltiazem</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>IV infusion/push</td>
<td>IV Valium and Ativan are acceptable to give</td>
</tr>
<tr>
<td>Antihypertensives, ie: Enalapril, Methylldopate HCl, Metoprolol Tartrate, Labetalol HCl, Atenolol</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Chemotherapeutic IV drugs</td>
<td>IV infusion/push</td>
<td>May be given for HH by IV chemo certified nurse</td>
</tr>
<tr>
<td>General anesthetic agents</td>
<td>IV infusion/push</td>
<td>Ketamine may be administered per protocol for Palliative Sedation</td>
</tr>
<tr>
<td>Insulin drip</td>
<td>IV infusion/push</td>
<td>Insulin may be added to TPN</td>
</tr>
<tr>
<td>IV medications requiring Cardiac monitoring, ie: Atropine, Cogentin, EDTA, Hydralazine, Interleukin - 2</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Digoxin</td>
<td>IV infusion/push</td>
<td>requires case by case approval</td>
</tr>
<tr>
<td>Dilantin</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Desferol (Test dose must be given)</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Fentanyl</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>L-Aspariginase</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Neuromuscular blocking agents</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Pentobarbital</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Potassium aliquots (or runs, or riders)</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Phenergan (Promethazine)</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Sufentanil Citrate</td>
<td>IV infusion/push</td>
<td></td>
</tr>
<tr>
<td>Thrombolytics (unless for catheter clearance) ie: Streptokinase</td>
<td>IV infusion/push</td>
<td></td>
</tr>
</tbody>
</table>
PATIENT SELF-ADMINISTRATION OF MEDICATION
Policy No. H:2-058.1

PURPOSE
To promote the correct administration of medication by patients and families/caregivers, or licensed nursing staff.

POLICY
Visiting Nurse & Hospice Care will encourage patient and family/caregiver participation in his/her own hospice care. The Interdisciplinary Team as part of the review of the plan of care will determine the ability of the patient or family to safely self-administer drugs and biologicals in the home. In the inpatient unit the Interdisciplinary Team will grant approval for self-administration or administration of medications by an authorized individual specified in the patient's plan of care. Education will include correct administration of authorized drugs and biologicals as ordered by the attending physician (or other authorized independent practitioner) or purchased over the counter. Teaching will also include the safe storage of medications. IPU licensed nursing staff will follow guidelines for safe patient self-administration, after MD order is received.

(See “Safe/Effective Use of Medications” Policy No. H:5-002.)

PROCEDURE
1. The Case Manager or licensed nurse will:
   A. Teach the patient or any other individual in accordance with applicable state and local laws and as specified in patient’s plan of care the purpose and side effects of medications and the patient’s role in identifying and preventing medication errors.
   B. Assist the patient or other authorized person in setting up medications for the first time.
   C. Assess the patient's ability to self-administer medications correctly and document the patient’s response and understanding to teaching.
   D. Answer questions/concerns expressed by the patient and family/caregiver regarding patient's self-administration of medications.
   E. Document education regarding medications and biological which may include safe use and possible side effects.
Policy No. H:2-058.2

F. Complete the medication profile form at initial and comprehensive assessment and updates.

G. Assess the patient's use of over-the-counter (OTC) medications and document with start date.

H. Instruct the patient and other authorized person regarding safe storage of medications. Consideration should be given to the following:

1. Medications should be stored separately from other poisonous drugs and chemicals.

2. Medication should be removed from storage during instruction and administration times.

3. Medications should be kept out of the reach of children, pets, and confused or disoriented patients.

4. The nurse will plan with the patient and family/caregiver for the safe therapeutic storage of drugs during the assessment process.

5. Drugs requiring refrigeration should be stored inside the refrigerator.

6. Urine testing and other diagnostic materials should be stored away from all medications, heat, light, and moisture.

7. Patients in the inpatient unit who wish to self-administer medications will need:

   a. A physician or Independent Nurse Practitioner’s order

   b. Will follow the guidelines prescribed by the inpatient unit for self-administration of medications.
**PURPOSE**

To ensure the appropriate use and disposal of controlled substances in accordance with applicable state and federal regulations.

**POLICY**

Visiting Nurse & Hospice Care voluntarily adheres to a controlled drug reporting process.

**PROCEDURE**

1. Controlled substances will be distributed directly to the patient or his/her representative. The dispensing pharmacist will be responsible for monitoring the amount of drug issued and the length of time between renewals. In the Inpatient Unit, the licensed nurse is responsible for accepting the delivery of controlled substances, as well as all medications.

2. The Case Manager will educate the patient and/or family in the practices of safe use and disposal of controlled drugs.

3. In cases where hospice personnel are in the home 24 hours a day, a drug count will be made by the licensed personnel at the time of shift change.

4. Controlled drugs will be accounted for on a narcotic count record, which will be maintained as a part of the clinical record; in the IPU.

5. When a patient no longer has a need for a controlled substance, the nurse will instruct the patient and family/caregiver to dispose of them. In the Inpatient Unit, the licensed nurse will remove from the medication cart and lock up all controlled substances that are no longer needed by the patient. At a minimum of once per month, all controlled substances that are no longer needed will be destroyed by a Pharmacist and Licensed RN together. All destroyed medication logs will be kept on file for 7 years.

6. The Licensed Hospice Nurse will document in the clinical record that the patient and family/caregiver were instructed on managing controlled drugs and disposal of medications.

7. The hospice nurse, social worker, or chaplain attending the death of a hospice patient will inform the family/caregiver of their responsibility to dispose of all the patient's prescribed medications and will document this instruction in a clinical note.

8. Home Hospice personnel will not dispose of any patient medications.
ADDENDUM H:2-059.A

DRUG DISPOSAL INSTRUCTIONS

Drug Disposal

PURPOSE
To establish the conditions for administration of intravenous medications/solutions in the home.

POLICY
Registered nurses with documented competency may establish peripheral intravenous (IV) lines and administer IV medications and solutions under the orders of a physician (or other authorized independent practitioner). (See Medications Not Approved for Safe Home or Serenity House Administration list, Addendum H:2-057.B for IV medications which are NOT approved for administration.)

PROCEDURE
1. A physician’s (or other authorized independent practitioner) order will be obtained for approved IV medications and solutions.

2. All orders for IV medications and solutions will specify dilution, route, frequency of administration, and rate of infusion.

3. The patient receiving IV medications and solutions should have received his/her first dose of prescribed medicine in a hospital setting, in a physician's office, or under the supervision of a physician or his/her representative prior to admission to Visiting Nurse & Hospice Care, without evidence of allergic reaction. Otherwise, prior approval of dispensing pharmacist will be obtained with consultation regarding any special considerations for administration.

   In the case that the first dosages of medication or solution is given in the home without prior administration, the nurse will remain in the home for at least 30 minutes after discontinuing the IV infusion. (See first Dose Policy).

4. IV medications and solutions will only be administered through a peripheral or central venous line.

5. Laboratory work, as indicated for each medication or solution, will be ordered by the physician (or other authorized independent practitioner).

6. Only medications and solutions that are prepared by a pharmacy, and are properly labeled with the patient’s name, name of drugs, dosage, dilution, date of preparation, expiration date, initials of preparer, and any special instructions will be administered, except in the case of emergency kit usage.

7. Patient-specific anaphylaxis kits will be supplied by the home infusion company in the following instances (see “Anaphylaxis Protocol” Policy No. H:2-068):
A. Patient is receiving an approved first time dose of medication

B. Patient has numerous medication allergies

C. At physician's (or other authorized independent practitioner's) request/order

8. A physician must be notified if any of the following circumstances occur:

A. If clinical findings are abnormal

B. If laboratory findings are abnormal

C. If any allergic or toxic symptoms are exhibited by the patient

D. If drug regimen review shows an alternative pharmacotherapeutic plan that could achieve safer, more effective, and more economical patient care

E. If anaphylaxis occurs and/or different medication is required to treat

F. When proper placement of a central venous catheter is questioned

G. If repeated difficulty occurs in establishing a peripheral line

H.

9. If a physician orders an IV Medication listed on the Medications Not Approved for Safe Home or Serenity House Administration list (Addendum H:2-057.B.) or the IV use of the medication is questionable, the following process must be followed if an exception is to be made:

A. Determine the medication and patient need.

B. Program Director or supervisor consults with Pharmacist consultant to establish that medication is safe for Intravenous Administration in the Home Health, Hospice or Inpatient Hospice setting.

C. Approval of Administration of that medication will be made in writing and a signed copy of the approval will be filed in the patient’s chart.

D. In order for a medication to be removed from the Medications Not Approved for Safe Home or Serenity House Administration list, there must be approval by the Directors of Home Health, Hospice, Serenity House and Medical Director. The approval to remove will be placed in the policy manual until the policy is reviewed and updated.
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FIRST DOSE POLICY
Policy No. H:2-062.1

PURPOSE

To define the process for the safe administration of a first dose medication in the home setting.

POLICY

Whenever possible, the first dose of any IV medication or therapy should be administered under the direct supervision of a physician (or other authorized independent practitioner) in order to assess the safety and appropriateness of the drug and administration techniques.

FIRST DOSING IN THE HOME IS ALWAYS CONSIDERED AN EXCEPTION AND ALL OTHER OPTIONS SHOULD BE EXPLORED.

Criteria for First Dosing

1. An appropriate and complete physician’s (or other authorized independent practitioner’s) order must be obtained that specifies the drug, dose, route, frequency, infusion time (if appropriate), and allergic or anaphylactic precautions.

2. All attempts to obtain information regarding the patient’s past medication allergies or anaphylactic reaction will be made.

3. The patient must be assessed as clinically stable at the time the decision is made to administer the first dose of medication at home and prior to the actual administration of the first dose.

4. The patient must be at least three (3) years old and weigh at least 15 Kg.

5. The patient will be alert, cooperative, and able to respond in such a way as to report symptoms.

6. The patient must reside in an area where there is access to emergency medical service.

7. The drug will be administered by an IV-qualified registered nurse.

8. The nurse will remain in the home to observe the patient for at least 30 minutes after discontinuing the infusion, or for at least one (1) hour after initiating a continuous infusion.
Some examples of IV therapies that may be suitable for first dose in the home are:

- Antibiotics
- SQ/IV pain management (not anesthetics)
- Hydration
- Parenteral and enteral nutrition
- Specific Drugs such as: Epogen

Therapies NOT suitable for first time dosing are:

- Intraspinal pain management and anesthetic pain management
- IgG
- Investigational drugs
- Specific drugs such as: Terbutaline, Aminophylline, Amphotericin, Dextron
- Innovar
PURPOSE

To provide guidelines for crushing medications.

PROCEDURE

1. The nurse will determine whether or not a medication may be crushed based on the following considerations:
   
   A. Medication may not be placed in applesauce prior to 20 minutes before administration.

   B. Certain drugs may not be crushed. As a matter of policy, the organization will adhere to the following list of medications as noncrushable medications. (See “Oral Dosage Forms That Should Not Be Crushed” Addendum H:2-063.A.)

   C. Should a question arise as to the “crushability” of any medication, the situation will be referred to the consultant pharmacist immediately.

   Note: If solid form is unsuitable for patient, contact consultant pharmacist for alternatives.

2. The nurse will instruct patient and family/caregiver regarding the safe crushing of medication.
ADDENDUM H:2-063.A

ORAL DOSAGE FORMS THAT SHOULD NOT BE CRUSHED
Visiting Nurse and Hospice Care’s Do Not Crush Code:

1. **Enteric Coated Tablets** – An enteric coating resists the action of stomach fluids and disintegrates or dissolves in the intestines.

2. **Time Release Capsules** – Medication is released over a period of usually 8 to 12 hours. The beads or contents within the capsule dissolve at different times. The capsules may be emptied to facilitate administration, but the contents should be crushed or chewed.

3. **Time Release Tablets** – Medication is released over a period of 6 to 12 hours. Different types include:
   a. **Slow Release Core** – The outer coating dissolves first for an initial dose of medication; then the core dissolves slowly for a prolonged release.
   b. **Mixed Release Granules** – Regular and slow release granules dissolve immediately and prolonged release of medication.
   c. **Multilayer Tablets** – The first layer dissolves quickly for a loading dose, and the remaining layers dissolve at a slower rate to obtain constant blood levels of the medication.
   d. **Porous Inert Carriers** – A small plastic pellet containing many small passages filled with the medication slowly releases medication into the gastric fluids
   e. **Soluble Matrix** – A wax matrix slowly releases medication into the gastric fluids to prevent gastric upset.

4. **Phenothiazine Drugs** – There is the possibility of irritation, a bitter taste, and temporary local anesthesia if crushed. Syrups and liquid concentrates are available and recommended.

5. **Sublingual, Chewable, and Buccal Tablets** – Swallowing, chewing, or crushing may prevent complete absorption, as these tablets rapidly dissolve in the oral fluids in the mouth.

6. **Miscellaneous** – Crushing should be avoided with some other medication for various reasons (i.e. bitter taste, caustic, Liquid-filled, etc.). If a liquid form is available, it is recommended. If there is no other alternative and the medication must be crushed, obtain order from physician to crush, crush well and add to a vehicle such as applesauce, jelly, or peanut butter and immediately after administration flush well with juice or another liquid.

*Note: Medications not to crush are listed on the following pages*
### COMMON MEDICATIONS NOT TO CRUSH

<table>
<thead>
<tr>
<th>CODE</th>
<th>DRUG</th>
<th>CODE</th>
<th>DRUG</th>
<th>CODE</th>
<th>DRUG</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>ACCUTANE</td>
<td>3</td>
<td>CONCERTA</td>
<td>3</td>
<td>EFICAC-24</td>
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<td>3</td>
<td>ACIPHEX</td>
<td>3</td>
<td>CONSTANT-T</td>
<td>2</td>
<td>ELIXOPHILLIN-SR</td>
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<tr>
<td>3</td>
<td>ACUTRIM</td>
<td>2/3</td>
<td>CONTACT 12-HR</td>
<td>1</td>
<td>E-MYCIN</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>capsule/caplet</td>
<td></td>
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</tr>
<tr>
<td>6</td>
<td>ADALAT</td>
<td>1</td>
<td>COTAZYM-S</td>
<td>3</td>
<td>ENTEX-LA</td>
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<tr>
<td>3</td>
<td>ADALAT-CC</td>
<td>1</td>
<td>COVERA-HS</td>
<td>3</td>
<td>ENTEX-PSA</td>
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<td>2</td>
<td>AEROLATE-III/JR/SR Caps</td>
<td>1</td>
<td>CREON</td>
<td>3a</td>
<td>ENTOZYME</td>
</tr>
<tr>
<td>2</td>
<td>AGGRENOX</td>
<td>2</td>
<td>CREON-10 &amp; 20</td>
<td>5</td>
<td>ERGOMAR</td>
</tr>
<tr>
<td>3</td>
<td>ALLEVE Cold &amp; Sinus</td>
<td>2</td>
<td>DECONAMINE –SR Capsule</td>
<td>1</td>
<td>ERYC</td>
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<tr>
<td>3</td>
<td>ALLEREST 12-hr caplet</td>
<td>3</td>
<td>DEMAZIN Tab</td>
<td>1</td>
<td>ERY-TAB</td>
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<tr>
<td>1</td>
<td>AMMONIUM CHLORIDE</td>
<td>6</td>
<td>DEPAKENE</td>
<td>1</td>
<td>ERYTHROMYCIN BASE (film coated)</td>
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<tr>
<td>2</td>
<td>ARTANE Sequel</td>
<td>3</td>
<td>DEPAKOTE</td>
<td>3</td>
<td>ASKALITH –CR Tablet</td>
</tr>
<tr>
<td>1</td>
<td>ARTHROTEC</td>
<td>1</td>
<td>DESOXYN Gradument</td>
<td>2</td>
<td>FEDAHIST Gyrocap/ Timecap</td>
</tr>
<tr>
<td>3</td>
<td>ASACOL</td>
<td>6</td>
<td>DESYREL</td>
<td>6</td>
<td>FELDENE</td>
</tr>
<tr>
<td>1</td>
<td>ASPIRIN Enteric-Coated</td>
<td>2</td>
<td>DEXATRIM</td>
<td>1</td>
<td>FEOSOL</td>
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<tr>
<td>3</td>
<td>ASBRON-G Inlay Tablet</td>
<td>2</td>
<td>DEXADRINE S spansule</td>
<td>3</td>
<td>FEROFOLIC-500</td>
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<tr>
<td>1</td>
<td>AZULFIDINE Entab</td>
<td>2</td>
<td>DIAMOX Sequel</td>
<td>3</td>
<td>FERO-GRAD-500</td>
</tr>
<tr>
<td>3</td>
<td>BAYER 8-hr Caplet</td>
<td>2</td>
<td>DILACOR-XR</td>
<td>3</td>
<td>FERRO-SEQUEL</td>
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<tr>
<td>3</td>
<td>BAYER Low Adult Strength 81 mg</td>
<td>6</td>
<td>DILANTIN Kapsel</td>
<td>1/6</td>
<td>FERROUS SULFATE</td>
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<tr>
<td>3</td>
<td>BELLERGAL-S</td>
<td>2</td>
<td>DILATRATE-SR</td>
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<tr>
<td>2</td>
<td>BETACHRON-ER</td>
<td>2</td>
<td>DILATIAZEM-SR</td>
<td>5</td>
<td>GAS-X</td>
</tr>
<tr>
<td>10</td>
<td>BIAxin granular sus. Will clog tube</td>
<td>3</td>
<td>DIMETAPP Extentab</td>
<td>3</td>
<td>GLUCOTROL-XL</td>
</tr>
<tr>
<td>1</td>
<td>BISACODYL</td>
<td>3</td>
<td>DISOBROM</td>
<td>3</td>
<td>GLYNASE Micronized Pres-Tab</td>
</tr>
<tr>
<td>3</td>
<td>CALAN-SR</td>
<td>3</td>
<td>DISOPHROL Chronotab</td>
<td>3</td>
<td>GRIESEOFULV impatient</td>
</tr>
<tr>
<td>6</td>
<td>CARAFATE (dissolve in 15 cc warm water)</td>
<td>3</td>
<td>DITROPA-N-XL</td>
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<td>HALPRIN</td>
</tr>
<tr>
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<td>CARDENE-SR</td>
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<td>DONNATAL Extentab</td>
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<td>HEMASPAN</td>
</tr>
<tr>
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<td>CARDIZEM-CD/SR</td>
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<td>DONNAYME</td>
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<td>HIMIBID-DM</td>
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<td>DORYZ</td>
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<td>CECLOR-CD</td>
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<td>DOXIDAN</td>
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<td>HUMIBID SPRINKLE</td>
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<td></td>
<td>CHARCOAL PLUS</td>
<td>6</td>
<td>DRISDOL</td>
<td>2</td>
<td>HUMIBID-DM SPRINKLE</td>
</tr>
<tr>
<td>3</td>
<td>CHLOR-TRIMETON ALLERGY 8 hr &amp; 12 hr Tabs</td>
<td>3</td>
<td>DRIXORAL</td>
<td>6</td>
<td>HYDERGINE-LC</td>
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<td>6</td>
<td>CHLORAL HYDRATE</td>
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<td>DYNABAC</td>
<td>5</td>
<td>HYDERGINE Sublingual</td>
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<td>10</td>
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<td>1</td>
<td>DULCOLAX</td>
<td>3</td>
<td>IBERET/IBERET-500</td>
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<tr>
<td>3</td>
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<td>EASPRIN</td>
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<td>E-BASE</td>
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<td>INDERAL-LA Capsule</td>
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<td>MAXALT-MLT (dissolve on tongue w/out water)</td>
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<td>PROCAN-SR</td>
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<td>RU-TUSS Tablet</td>
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<td>NORFLEX</td>
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<td>NORPACE-CR</td>
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<td>3</td>
<td>SLO-PHYLLIN-GG</td>
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<td>3</td>
<td>ORAMORPH-SR</td>
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<td>SLOW-K</td>
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<td>2</td>
<td>ORNADE Spansule</td>
<td>3</td>
<td>SLOW-FE Tablet</td>
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<td>VALRELEASE</td>
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<td>2</td>
<td>ORUVAIL</td>
<td>3</td>
<td>SODIUM FLORIDE</td>
<td>3</td>
<td>VERAPAMIL-SR</td>
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</table>
Some medications and dosage forms should not be crushed. If there are any questions regarding the crushing of medications, call the pharmacy.

DO NOT CRUSH CODE:

1. **Enteric-Coated Tablets/Preps**: An enteric coating resists the action of stomach acid and dissolves in the intestines.
2. **Time Release Capsules**: Medication is released over a period of usually 8 to 12 hours. The beads or contents within the capsules often dissolve at different times. The capsules may be emptied to facilitate administration, but the contents should not be crushed or chewed.
3. **Time-Release Tablets**: Medication is released over a period of 6 to 12 hours. Different types include: slow-release core, mixed-release granules, multilayer tablets, porous inert carriers, and soluble matrix.
4. **Phenothiazine Drugs**: There is the possibility of irritation, a bitter taste, and temporal local anesthesia if crushed. Phenothiazines are available as syrups or liquid concentrates – equivalent liquid doses are recommended.
5. **Lingual, Sublingual, Chewable, and Buccal Tablets**: Swallowing, chewing, or crushing may prevent complete absorption, as these tablets rapidly dissolve in the fluids in the mouth.
6. **Miscellaneous**: Crushing should be avoided for various reasons: bitter taste, caustic, liquid-filled, etc. – a liquid form of the drug is recommended. If there is no other alternative and the medication must be crushed, obtain order from physician to crush, add to a vehicle such as applesauce, and flush well with juice or another liquid immediately after administration.
7. **Effervescent**: Dissolve in water.
8. **Pregnant women or women attempting to become pregnant**: Should avoid handling these crushed medications.
9. **Contents should NOT be crushed**: Open cap, sprinkle uncrushed contents on applesauce or administer in juice via enteral-tube.
10. Suspension should NOT be chewed OR administered via enteral tube, due to granular/microcapsular formulation which will clog the tube.
PURPOSE

To ensure that medications and nutritional therapy solutions are properly handled and stored.

POLICY

Medications and nutritional therapy solutions will be properly stored in the organization and patient’s environment.

The hospice Case Manager will be responsible for instructing the patient and family/caregiver regarding the safe storage of medications. “Safety” is defined both in terms of patient's safety and protection of the drug against damage from heat, sun, etc.

PROCEDURE

1. Storage of medication in the organization will be consistent with applicable law and regulation.

2. Investigational medications and cytotoxic medications will be stored in a secure location and appropriately identified.

3. Medications used for external use and disinfectants will be stored separately from internal and injectable medications.

4. All medications, chemicals and biologicals will be labeled for contents, with expiration dates clearly identified.

5. Medications and nutritional therapy solutions will be stored under conditions that enhance stability. Elements to be considered include:
   
   A. Appropriate storage temperatures utilizing appropriate thermometers and temperature logs

   B. Protecting solutions from contamination and spoilage

   C. Controlling lighting, ventilation, and humidity

   D. Prevention of moisture, condensation, and mold growth

   E. Thorough cleaning and sanitizing of all surfaces, supplies, and equipment after each use
6. The environment where medications or nutritional therapies are prepared will be appropriate to the therapy preparations, whether in the office or in the patient’s home. As appropriate to the setting, areas to consider include:

   A. Functionally separate areas for sterile product preparation
   B. An environment suitable to preparation of sterile products
   C. Safety equipment to protect personnel preparing cytotoxic or hazardous medications
   D. Clutter free, clean work surface for medication preparation or nutritional therapy solutions

7. Medication and nutrition therapy preparation will only be done by personnel with documented competencies regarding medication and nutrition therapy preparation.

8. The hospice Case Manager will plan with the patient and family/caregiver for the safe therapeutic storage of drugs in the home. Consideration will be given to the following:

   A. Medications should be stored separately from other poisonous drugs and chemicals.
   B. Medication should be removed from storage during instruction and administration times.
   C. Medications should be kept out of the reach of children, pets, and confused or disoriented patients.
   D. Drugs requiring refrigeration are to be stored inside the refrigerator.
   E. Urine testing and other diagnostic materials are to be stored away from all medications, heat, light, and moisture.
PURPOSE

To promote safe medication administration through appropriate labeling.

POLICY

Medications will be administered only from properly labeled containers. No self-prescribed (patient) medications will be given by Visiting Nurse & Hospice Care personnel.

PROCEDURE

1. All prescriptions will be labeled by the pharmacist with the following: pharmacy name and number, prescription number, patient’s name, date of filling, physician's name, name and strength of medication, directions for administration, and expiration date.

2. Medications will not be borrowed from one patient to administer to another.

3. If necessary, the clinician will obtain additional medication information.

4. Medications will not be administered from non-labeled containers.

5. If there is any reason to suspect the drug found in a container is not the drug labeled, the medication will not be given.

6. Labels will be carefully checked for expiration date, and the medication should be checked for stability (i.e., without indication of deterioration, dampness, cloudiness, discoloration, etc.).

2.
ADVERSE DRUG REACTIONS
Policy No. H:2-067.1

PURPOSE

To provide guidance for instructing patient, family/caregiver and staff in identification of adverse reactions to medications and in reporting them in a timely manner. To provide guidelines for the nurse, to implement actions when adverse drug reactions occur, in coordination with the pharmacist and physician,

POLICY

All hospice personnel will be prepared to identify and react to adverse drug reactions. The process for defining, identifying, and reviewing significant adverse reactions will be collaborative in nature, among nursing, pharmacy, and others as appropriate. All adverse drug reactions will be reported both internally and externally to appropriate agencies, as needed.

Patients and families/caregivers will receive instruction regarding medication side effects, signs and symptoms of adverse reactions, and any necessary emergency response measures.

Definition

1. **Adverse Drug Reaction:** An undesirable or unexpected event that occurs due to administration of a medication, which results in:
   
   A. Discontinuation of a drug
   
   B. Modification of a dose of medication
   
   C. Supportive treatment or additional treatment with prescription medication
   
   D. A condition which is life-threatening
   
   E. Prolonging or requiring hospitalization
   
   F. A disability
   
   G. Death

The World Health Organization defines an adverse drug reaction as, “Any response to a drug which is noxious and unintended, and which occurs at doses normally used in man for prophylaxis, diagnosis, or therapy of disease, or for the modification of physiological function.”
PROEDURE

1. Patient and family/caregiver will be verbally instructed and will receive written information regarding identification of potential adverse drug reactions on initiation of therapy. Patient and family/caregiver will receive instructions to call the pharmacist and/or nurse immediately if signs and symptoms of adverse drug reactions develop. This instruction will be documented in the clinical record and validated as part of the initial hospice training session.

2. For patient receiving antibiotics (particularly IM or IV, antiarthritic and/or any drugs known to increase one’s risk for anaphylaxis or severe side effects), the physician (or other authorized independent practitioner) may be contacted prior to administration to obtain the orders for anaphylaxis protocol.

3. Whenever adverse drug reactions are observed by the clinician and/or reported by the patient, the clinician should advise the patient to hold the next dose until the physician can be consulted.

4. All adverse reactions will be promptly reported to the patient’s physician in order to minimize patient’s health risks and discomfort.

5. If the patient is at risk for further complications of an emergent nature, the clinician will initiate appropriate emergency measures as per organization policy.

6. If the patient shows signs and symptoms of anaphylaxis, the clinician will follow the anaphylaxis protocol. (See “Anaphylaxis Protocol” Policy No. H:2-068.)

7. All adverse reactions will be reported through the incident reporting process. (See “Incident Reporting” Policy No. C:2-070.) Once reported, they will be reviewed and analyzed for any significant trends, patterns, or unusual occurrences that may impact patient care.

8. If the adverse drug reaction results in serious injury, illness, or death, risk management will be notified immediately.

   A. The FDA’s Med Watch Reporting Form will be completed by the pharmacist having knowledge of the ADR, and the form will be mailed/faxed to the FDA as appropriate in serious or unexpected adverse drug reactions. The FDA Med Watch Reporting Form can be obtained from the FDA by calling 1-800-FDA-1088 or at the website www.fda.gov.

9. All adverse drug reactions will be reviewed as part of the performance improvement program.

10. As part of the yearly organization evaluation, the adverse drug reporting process will be reviewed for its effectiveness in detecting reactions and the organization’s ability to respond and improve the medication administration process. In addition, the organization will assess the usefulness of the definitions used for adverse drug reactions.
ADDENDUM H:2-067.A

ADVICE ABOUT VOLUNTARY REPORTING
ADVICE ABOUT VOLUNTARY REPORTING

Report experiences with:
— medications (drugs or biologics)
— medical devices (including in vitro diagnostics)
— special nutritional products (dietary supplements, medical foods, infant formulas)
— other products regulated by FDA

Report SERIOUS adverse events. An event is serious when the patient outcome is:
— death
— life-threatening (real risk of dying)
— hospitalization (initial or prolonged)
— disability (significant, persistent, or permanent)
— congenital anomaly
— required intervention to prevent permanent impairment or damage

Report even if:
— you’re not certain the product caused the event
— you don’t have all the details

Report product problems — quality, performance, or safety concerns such as:
— suspected contamination
— questionable stability
— defective components
— poor packaging or labeling

How to report:
— only fill in the sections that apply to your report
— use section C for all products except medical devices
— attach additional blank pages if needed
— use a separate form for each patient
— report either to FDA or the manufacturer (or both)

Important numbers:
— 800-FDA-0178 to FAX report
— 800-FDA-7737 to report by modem
— 800-FDA-1088 for more information or to report quality problems
— 800-822-7967 for a VAERS form for vaccines

If your report involves a serious adverse event with a device and it occurred in a facility outside a doctor’s office, that facility may be legally required to report to FDA and/or the manufacturer. Please notify the person in that facility who would handle such reporting.

Confidentiality: The patient’s identity is held in strict confidence by FDA and is protected to the fullest extent of the law. The reporter’s identity may be shared with the manufacturer unless requested otherwise. However, FDA will not disclose the reporter’s identity in response to a request from the public, pursuant to the Freedom of Information Act.
PURPOSE
To provide guidelines for the clinician to follow in the event of anaphylactic reaction.

POLICY
Visiting Nurse & Hospice Care’s nurse will implement the anaphylaxis protocol for emergency use in the event of anaphylactic reaction during administration of IV medications. Emergency medications will be given according to a physician’s (or other authorized independent practitioner’s) order.

Signs and Symptoms of Anaphylaxis
1. Respiratory distress: dyspnea, wheezing, choking, cyanosis
2. Dermatologic changes: urticaria, erythema, angioedema, pruritus
3. Gastrointestinal complaints: nausea, vomiting, abdominal cramps, diarrhea
4. Vascular response: rapidly falling blood pressure, chills, sweating

PROCEDURE
Prior to IV Medication Administration
1. Obtain baseline nursing assessment and vital signs.
2. Review patient’s prior response to medication. Specifically inquire about allergies.
3. Instruct patient as to signs and symptoms to report at once.
4. Be prepared to call 911 if necessary.
5. Have anaphylaxis kit within reach.

If symptoms of anaphylaxis occur during IV medication administration:
1. Stop flow of drug.
2. Continue to evaluate signs and symptoms rapidly.
3. Administer medications from an anaphylaxis kit according to physician described directions.

4. Notify physician (or other authorized independent practitioner) and follow orders received.

5. Monitor patient’s vital signs. If patient is hypotensive, keep him/her supine and elevate his/her legs.

6. Remain with patient until paramedics arrive.

7. If cardiopulmonary arrest occurs, begin resuscitation unless patient has current DNR order.
PURPOSE

To provide a process for identifying, reporting, and reviewing medication errors.

POLICY

Any medication error will be reported to the Clinical Director or Clinical Supervisor and the attending physician. The process for defining, identifying, and reviewing significant medication errors will be collaborative among nursing, pharmacy and others, as appropriate. The medication error rate will be monitored and reported per the performance improvement program.

Definition

3. *Medication Error:* Any error, which includes, but is not limited to the following:

   A. Patient and/or family/caregiver titrates IV opiates outside of the physician's (or other authorized independent practitioner's) ordered titration parameters or has an untoward outcome as a result of not following physician’s (or other authorized independent practitioner’s) orders or nurse instructions in administering medications.

   B. Wrong medication, wrong time, wrong dose, wrong route of administration, extra dose, or omission of ordered drug by the nurse.

PROCEDURE

1. If an error is made in medication administration, the personnel making or discovering the error will notify the attending physician.

2. The Clinical Supervisor will be notified of the physician’s, or other authorized independent practitioner’s), comments and correction to orders, if applicable.

3. The patient will be observed for any untoward effects of the medication error and will report such effects to the attending physician.

4. If appropriate, the pharmacist will be notified for any further actions that may be required.

5. For wrong time errors or omissions, the nurse will correct the medication schedule.

6. Events and actions resulting from the error are objectively outlined in the clinical notes and incident report.
7. The error will be noted on the patient’s medication profile.

8. All medication errors will be reviewed as part of the performance improvement program.
PURPOSE

To define the ongoing medication monitoring process for the patient.

POLICY

Ongoing patient medication monitoring will use a collaborative approach between the clinicians, physicians, pharmacists, patients, and families/caregivers.

The results of medication monitoring will be used to improve the patient’s medication regime. The ongoing monitoring will occur in accordance with the established goals of therapy and be used to:

1. Evaluate the continued use of a medication in the current regimen.
2. Evaluate patient adherence to the prescribed medication regimen.

PROCEDURE

1. The Case Manager will assess the effect of medications on the patient. The assessment will identify drug interactions, duplicative drug therapy, and noncompliance with drug therapy.

2. The clinical effects of medications will be obtained through direct observation during assessments performed during home visits, review of assessment information, as well as clinical results of diagnostic studies.

3. Review of the information gathered from the above activities will be included in the comprehensive assessment and updates will be made if needed.

4. The information obtained through patient medication monitoring will be documented in the patient's clinical record and, if applicable, in the pharmacy record.
IDENTIFICATION, PREVENTION, AND TREATMENT OF SECONDARY SYMPTOMS
Policy No. H:2-072.1

PURPOSE

To provide direction for symptom control.

POLICY

Symptom control is the foundation of good hospice care. Symptom control is best achieved in the context of the interdisciplinary team care. Supporting and educating the patient and family/caregiver is an essential part of symptom control. Care will be directed to optimize the patient's comfort and dignity through appropriate treatment of secondary symptoms as well as aggressively managing these symptoms.

The hospice interdisciplinary team will use published standards of care in the treatment of patient symptoms.

PROCEDURE

1. Interdisciplinary team members will report to the Case Manager symptoms they may observe that are changes or are new from the patient's comprehensive assessments.

2. The Case Manager will receive any and all information and will notify the attending physician.

3. Orders will be obtained as necessary.

4. The plan of care will be updated.
PURPOSE

To provide guidance for the care of the dying patient.

POLICY

Hospice interdisciplinary team members recognize the importance of each patient and family/caregiver's unique and individual needs within the hospice setting. Within this framework, responsive and respectful care for the dying patient will be planned, implemented, and monitored in order to:

1. Optimize the patient's comfort and dignity
2. Manage pain and symptoms through interventions that alleviate and/or control pain and assess the patient's level of pain control
3. Identify secondary symptoms, determine the patient's response to treatment, and take actions to limit them
4. Consider the psychosocial, emotional, and spiritual needs of the patient and family/caregiver
5. Implement bereavement care that supports the patient and family/caregiver unit's coping mechanisms throughout the grief process

PROCEDURE

1. At the start of care, and on an ongoing basis, hospice personnel will assess the patient and family/caregiver unit (when appropriate) for:
   A. Comfort/pain level and response to pain management plan
   B. Coping mechanisms, strengths and unique qualities of the patient and family/caregiver unit, and participation in the grief process/bereavement
   C. Psychosocial, emotional, and spiritual needs
   D. Presence of secondary symptoms and response to treatment
   E. Knowledge of the physical and psychological aspects of the dying process
2. An individualized plan of care will be developed in cooperation with the patient and family/caregiver, attending physician, and interdisciplinary team members, which facilitates:

A. Physical/psychological comfort measures.

B. Pain management (control or alleviation) according to physician (or other authorized independent practitioner) orders, which may include analgesia and noninvasive or nonpharmacological interventions.

C. Prevention of secondary symptoms, including, but not limited to, nausea, vomiting, diarrhea, stomatitis, alopecia, GI disturbances, blood dyscrasia, etc.

D. Prompt identification and treatment—if possible and ordered by the physician (or other authorized independent practitioner)—of secondary symptoms if they should occur.


F. Support for development of the patient’s and family/caregiver’s coping mechanisms, including, but not limited to, verbalization of feelings, referral to community support services, etc. Expressions of love, concern, regret, and forgiveness, as appropriate, will be encouraged.

G. Recognition of the patient's needs related to dignity, self-respect, and personal preferences.

H. Support for the grieving process. Levels of support will be increased or modified in consideration of patient preferences as death approaches.

3. With each patient visit, the hospice nurse will follow the plan of care and assess the need for changes/updates, and will document accordingly. Aspects of care that must be reflected in the clinical record, when applicable, include:

A. The origin, location, severity (on a scale of 0 – 10: 0 = no pain, 10 = unbearable pain), alleviating, and exacerbating factors for pain/discomfort

B. Preventative and treatment/measures provided for secondary symptoms and/or pain/discomfort, and the response to treatment

C. Psychosocial interventions to facilitate development of coping mechanisms and the grieving process, and the patient and family/caregiver’s response

D. Referrals to community resources

4. The Hospice Chaplain will facilitate affirmations of faith or spiritual beliefs as appropriate to the patient’s wishes.
5. Interdisciplinary team case conferences will reflect coordination and communication between various team members relative to the patient's/families/caregiver's evolving physical, psychological, emotional, spiritual, and bereavement needs. (See “Interdisciplinary Team Meeting” Policy No. H:2-036.)

6. Hospice personnel will adhere to:

   A. The desires made known by the patient through the use of an advance medical directive executed according to state regulations and policy. (See “Advance Directives” Policy No. C:2-006.)

   B. Do Not Resuscitate orders written by the patient's physician (or other authorized independent practitioner) in accordance with state regulations and policy. (See “Do Not Resuscitate/Do Not Intubate Orders” Policy No. H:2-075.)
PURPOSE

To establish the process to follow when a patient dies.

POLICY

It is anticipated that hospice patients will die at home. Nurses, social workers, and/or the Hospice Chaplain are available to attend a patient's death 24 hours a day, seven (7) day a week. The family/caregiver may require skilled nursing intervention, psychosocial support, and practical assistance during the time immediately surrounding the death. Individual state and community regulations and practices will be followed.

Personnel attending a death event will respect the cultural and religious traditions and beliefs of the patient and family members.

PROCEDURE

1. Following notification of a patient's approaching or actual death, the nurse or other hospice interdisciplinary team member will assist the family/caregiver. When desired by the surviving family members, the nurse will visit.

2. The nurse will assist the family/caregiver either via phone intervention or at the home with notification of the attending physician and the selected funeral home.

3. The interdisciplinary team members will provide emotional support to the family/caregivers as necessary.

4. The nurse will notify the attending physician of the patient’s death. It will be the attending physician's responsibility to sign the death certificate. The physician will routinely accept hospice's description or report of the absence of vital signs when assuming this responsibility. If the nurse is not at the patient's home when the death occurs, this will be communicated to the physician.

5. All deaths at home will be reported to the attending physician and medical director. The coroner's office generally authorizes release of the body from its jurisdiction after the following information is provided by the mortuary and/or attending physician:
A. Name and address of the deceased
B. Deceased date of birth
C. Approximate time of death
D. Name and telephone number of physician who will sign death certificate
E. Date of last physician contact (if unknown or more than 20 days, encourage the physician to notify coroner)
F. Medical diagnoses
G. Next of kin (power of attorney) who have been notified
H. Any unusual circumstances regarding death, e.g., suspicion of foul play
I. Name of mortuary

6. If suicide is suspected, the nurse will report this to the physician and then ask the physician if he/she wants to notify the coroner of the death. If the physician does not agree to notify the coroner of the death, then hospice will inform the coroner's office of its suspicions. All of these observations/communications will be documented in the clinical record.

7. The nurse will offer to notify the mortician, funeral director, or cremation society as indicated. The nurse will inform the family/caregiver that it is not necessary to remove the patient's body right away if they wish to spend some time with the body.

8. The nurse will instruct/assist the family/caregiver to bathe and/or dress the patient's body as specifically requested by the patient or as desired by the family/caregiver. Any jewelry or valuables will be removed by family/caregiver members. The nurse will encourage the family/caregiver to spend time alone with the patient's body if they wish.

9. The nurse will instruct the family/caregiver to dispose of all medications, including controlled substances, per federal, state, and local regulations and organization policy. (See "Home Use and Disposal of Controlled Substances" Policy No. H:2-059.)

10. The nurse will remove all tubing entering the body, empty any drainage bags, discontinue oxygen, and remove its tubing. All IV pumps will be turned off and removed.

11. Any written patient information will be returned to the office.

12. The nurse will notify the home medical equipment (HME) company regarding pickup of equipment in home if death occurs during regular business hours. If after regular business hours, and the family is insistent to have equipment removed, the RN will notify the HME on-call to remove equipment. Otherwise the hospice assistant will be notified to have HME remove next business day by email.
13. The nurse will document in the clinical record all of the above interventions and any other significant information regarding the death.

14. The nurse will also document any grief counseling initiated and/or if the bereavement program was explained to the family/caregiver.

15. The nurse will notify other interdisciplinary hospice personnel about the patient's death.

(See "Privacy of Health Information of Deceased Individuals” Policy No. C:2-021.)
DO NOT RESUSCITATE/DO NOT INTUBATE ORDERS
Policy No. H:2-075.1

PURPOSE

To facilitate a patient’s choice regarding the extent to which emergency medical care will be instituted.

POLICY

The organization will follow the patient’s Advance Directives completed according to the Advance Directives requirements of the jurisdiction of the state in which the patient resides. (See “Advance Directives” Policy No. C:2-006.)

The organization supports the patient’s right of autonomy to make choices regarding his/her care and encourages the patient to discuss this issue with his/her significant others. In the event that the patient is without the capacity to make treatment decisions for himself/herself, this decision shall be made by an appropriate surrogate.

A written Do Not Resuscitate (DNR) order, signed by the patient’s physician (or other authorized independent practitioner), must be on file in the patient’s clinical record and admission folder in the patient’s home. If there is no DNR order or valid Advance Directives and the patient expires in the presence of a CPR-trained staff person, CPR will be initiated according to the American Heart Association’s Basic Life Support (BLS).

PROCEDURE

1. A DNR/DNI decision will be made by the attending physician in consultation with the patient or other legally responsible person when, in the judgment of the physician, the patient suffers from an incurable medical condition, death is reasonably imminent in all medical probability, and a life threatening condition exists in which resuscitation would not be expected to render substantial improvement in the ultimate outcome.

2. The order will be written only by the attending physician (or other authorized independent practitioner).

3. Upon receipt of a DNR/DNI order, the following documentation will occur in the clinical record:

   A. A summary of the medical situation, including the Case Manager’s discussion with the attending physician and a statement of the therapeutic plan for comfort care.

   B. An account of the discussion with the patient and/or surrogate decision maker, preferably by the attending physician, or an explanation as to why a discussion has not occurred.
C. The DNR/DNI order will be clearly identified in the clinical record.

D. A copy of the DNR/DNI order will be kept in the patient’s home.

4. DNR/DNI status will be communicated as follows:

   A. The Case Manager will immediately advise the Clinical Supervisor.

   B. The Case Manager will notify other personnel involved in the case within 24 hours and document this notification in the clinical record.

   C. The Case Manager will immediately notify the hospice aides’ office:

      1. If the patient is new to hospice aide service, “Do Not Resuscitate” will be written in the special instruction section of home health aide assignment sheet.

      2. If the patient has ongoing hospice aide service, a new home health aide assignment sheet will be created with “Do Not Resuscitate” written in the special instruction section.

      3. On the hospice aides' weekly schedules, the letters “DNR” will be written next to the names of the patients with Do Not Resuscitate orders.

      4. When hospice aides receive revised assignments via telephone, they will be told which patients have DNR status.

5. The order will be recertified every 60 days or upon request of concerned parties.

6. The DNR/DNI order will be re-evaluated under the following conditions:

   A. When there is a significant change in patient condition, it will be the responsibility of the clinician, within the standard of practice, to communicate to the attending physician any change in the patient's condition that impacts the DNR/DNI order.

   B. At the request of the patient or his/her representative.

7. The DNR/DNI orders may be revoked at any time verbally or in writing by:

   A. The competent patient

   B. The incompetent patient’s legal representative

   C. The attending physician in consultation with a competent patient or an appropriate surrogate decision maker
8. Organization personnel informed of or provided with a revocation of DNR/DNI by the patient or patient’s representative will immediately record the revocation request in the patient's clinical record, cancel the order, and notify the physician (or other authorized independent practitioner) responsible for the patient's care.

9. If the patient is not capable of making his/her decisions regarding medical care, a decision will be reached after consultation between the physician and one (1) of the following, according to the hierarchy of decision makers:

   A. A court-appointed guardian
   B. A proxy designated by a durable power of attorney for health care authorized according to law
   C. A spouse
   D. An adult child
   E. A parent
   F. An adult sibling
   G. A nearest relative

10. All communication between organization personnel and the patient and family/caregiver regarding resuscitation of the patient will be documented in the clinical record.
PURPOSE

To outline the responsibilities of organization personnel in initiating cardiopulmonary resuscitation.

POLICY

All LVNs and RNs will be CPR certified in accordance with the American Heart Association’s (AHA) guidelines for Basic Life Support (BLS) upon hire and as directed thereafter by the AHA.

In the event of an arrest, witnessed or not, and in the absence of Advance Directives, 911 (or emergency rescue squad) will be called and BLS initiated and followed per AHA guidelines. (See “Advance Directives” Policy No. C:2-006 and “Do Not Resuscitate/Do Not Intubate Orders” Policy No. H:2-075.)
WITHDRAWAL OF LIFE-SUSTAINING CARE  
Policy No. H:2-077.1

PURPOSE

To outline the responsibilities of organization personnel in withdrawing life-sustaining care.

POLICY

The decision to withdraw life-sustaining care will be made by the patient and family/caregiver (or his/her legal representative) and the physician in consideration of any Advance Directives. Visiting Nurse & Hospice Care will comply with a written order from the attending physician (or other authorized independent practitioner) to withdraw life-sustaining care.


PROCEDURE

1. Upon admission, the patient receiving life-sustaining care and his/her family/caregiver will be informed of the organization policy regarding the withdrawal of this care.

2. All communication between organization personnel and the patient and family/caregiver or the physician regarding withdrawal of life-sustaining care will be documented in the clinical record.

3. If a decision to withdraw life-sustaining care is made, organization personnel will comply with a written order from the attending physician (or other authorized independent practitioner).
PURPOSE

To delineate the appropriate use of emergency services for hospice patients.

POLICY

In emergency situations, Visiting Nurse & Hospice Care personnel will assess the patient's condition and initiate the use of emergency services to assist the patient for those instances that are not related to the terminal illness. Hospice personnel will administer any appropriate techniques they are qualified to perform and notify the patient's attending physician, family/caregiver, and their Clinical Supervisor as soon as possible.

PROCEDURE

1. Specific actions of hospice personnel will be determined using the following triage concept:

   A. In the absence of a DNR/DNI order, maintain an open airway and provide cardiopulmonary resuscitation (CPR). CPR will be performed only by those personnel who are CPR certified. If the patient has elected to rescind his/her DNR order or has not yet obtained an order, certified hospice personnel will initiate CPR, call 911, inform the patient's attending physician (or other authorized independent practitioner), and inform their Clinical Supervisor.

   B. Control bleeding

   C. Prevent and treat shock

   D. Protect any wounds from contamination

   E. Keep injured or ill person lying down and warm

   F. Allay anxiety and keep the patient as comfortable as possible

   G. Make an effort to determine the extent of injury or cause of emergency situation

   H. Observe, evaluate, and comfort patient at all times when not directly involved in obtaining appropriate emergency assistance

2. An ambulance or rescue squad will be contacted for assistance and/or transport to the nearest emergency facility.
3. The patient will not be left unattended for longer than the duration of an emergency assistance phone call.

4. Once assistance is available, hospice personnel will notify the physician, the supervisor, and family/caregiver. Non-licensed personnel will notify the Clinical Supervisor as soon as possible to assist in notifying the attending physician and family/caregiver.

5. The decision to transport the patient to a hospital will be made in order of priority by the physician, the ambulance attendants, the Clinical Supervisor, Visiting Nurse & Hospice Care nursing personnel, the patient's family/caregiver, or Visiting Nurse & Hospice Care non-nursing personnel.

6. Hospice personnel will not attempt to transport the patient alone in a private vehicle.

7. If the decision is made to transport the patient to a hospital, hospice personnel will accompany the patient unless instructed otherwise by the supervisor, the physician, and/or the family/caregiver.

8. Documentation of the situation will be made in the patient's clinical record.
PURPOSE

To provide guidelines for the appropriate assessment of suicide risk and response to prevent suicide.

POLICY

Hospice affirms life. This is done through assisting persons experiencing an advanced life-threatening illness, with the goal of improving the quality of his/her life. Hospice will provide care aimed at preventing suicide for patients who express suicidal ideation or intentions.

PROCEDURE

1. Any interdisciplinary team member (including contract personnel) who is in contact with a patient who:
   A. Talks of suicide
   B. Attempts suicide
   C. Commits suicide
   must report this information to his/her immediate supervisor or designee as soon as possible.

2. The interdisciplinary team member will document the incident in the patient's clinical record.

3. The Case Manager or designee will report this information to the attending physician.

4. All hospice personnel must be familiar with the symptoms often associated with suicide:
   A. Loss of communication – which results in feelings of hopelessness, helplessness often related to the separation or loss of a significant or valued thing or relationship (death; divorce; separation; loss of a job, income, prestige, status, health, understanding family/caregiver support, friends or neighbors; and sudden change in life).
   B. Ambivalence about life and death – The individual is filled with contradictory feelings about living or dying. Often associated with a self-view—rejected, worthless, hopeless, and helpless. References, especially if repeated, to such ideas as, “I’d be better off dead,” or “If I had the nerve, I’d kill myself,” or a seeming preoccupation with death or the hereafter. Delusions of guilt or wrongdoing.
C. Lack of coping skills or inappropriate coping skills, often associated with sudden withdrawal, quiet and uncommunicative behavior, a depressed appearance, saying little or nothing, sometimes moving through the day as if in a trance, an inability to function, and the person suddenly or gradually losing the ability to get through the day.

D. Anxiety/depression, demonstrated by loss of appetite, weight loss, inability to sleep, loss of interest, withdrawal, apathy, despondency, exhaustion, agitation, tension, rage, etc.

5. The social worker will routinely assess the potential for suicide. In assessing that potential, the following criteria for high-risk should also be considered:

A. Suicide increases proportionately with age in white males. Suicide peaks around age 50 in females. More males commit suicide. More females attempt suicide.

B. Has the patient or family/caregiver suffered an early childhood loss?

C. Is the patient or family/caregiver an alcoholic or abuser of drugs? Alcoholics/drug abusers are at a high-risk of suicide.

D. Is there a recent irreversible loss? Suicide is associated with an accumulation of losses throughout life.

E. Does the patient or family/caregiver have a suicide plan? If you suspect suicide, gently confront and ask about how he/she plans to do it. Is it a lethal method, e.g., firearm, jumping from a high place, hanging, or any use of an irrevocable method?

F. Does the individual have the means available? Is he/she physically able to carry it out? Does he/she have a gun, etc.?

G. Is the plan specific? That is, can the person tell you exactly how and when?

6. Any of these potential risk factors will require immediate investigation, evaluation, and possible intervention. The more factors present and the more specific the plan, the more intensive intervention will be needed.

A. All members of the hospice interdisciplinary team including the attending physician will be informed of the risk as soon as it is known. All team members will be informed of the plan of care and follow through with the plan.

B. If a patient talks of suicide with any team member, then the team member notified must:

1. Document the discussion in the clinical note.

2. Identify the follow-up plan.
3. Identify in the plan who will contact the attending physician and make appropriate referrals.

C. Patients will be informed that any suicide plan will be reported to the team, supervisors, and/or attending physician.

D. In case of death, the hospice nurse will inform the coroner’s office of potential suicide.

7. If the team member is convinced there is a real potential for suicide and the patient or family/caregiver is showing that he/she is potentially unable to control the suicidal urge, the team member should not allow the person out of his/her sight or the sight of a responsible person until a plan of care is implemented. If the patient makes an attempt at suicide, the team member will call the patient’s attending physician immediately.
NOT IN USE
PURPOSE

To establish standards and a process by which patients are transferred to another hospice provider.

POLICY

Situations occur that dictate Visiting Nurse & Hospice Care will no longer be able to provide continued hospice care and will require the patient to be transferred to another hospice provider. They may include the following:

1. Patient and family/caregiver choose to leave service area of Visiting Nurse & Hospice Care.

2. Patient and family/caregiver desire another provider of hospice care.

3. Visiting Nurse & Hospice Care's services are no longer sufficient to provide the necessary care.

A patient receiving hospice services under the Medicare or Medicaid hospice benefit may change the designation of the particular hospice from which he/she receives care. This may be done once during each election period. This is not a revocation and therefore there is no loss of benefit days for that election period. A signed statement with specific information is required at the time this occurs. This form will be filed in the patient's clinical record and a copy sent to the receiving hospice.

PROCEDURE

1. The Case Manager will notify the attending physician of the need to change hospice providers.

2. The attending physician will complete and sign the transfer form. The original will stay in the patient's clinical record; the copy will be sent to the receiving hospice program/health care setting.

3. The Case Manager or the Clinical Supervisor will provide relevant information to the organization to which the patient is being transferred. (See "Discharge From Hospice Program" Policy No. H:2-085 for relevant information.)

4. The Case Manager will explain to the patient under the Medicare or Medicaid hospice benefit that he/she may transfer from one hospice program to another one time each benefit period and not lose any Medicare or Medicaid hospice benefit days.
5. The Case Manager or the Clinical Supervisor will contact the receiving hospice to provide a full report on patient and family/caregiver care needs and to facilitate a smooth transition for the patient.
PURPOSE

To define the requirements for documentation of patients transferred to another organization and/or internally within the organization.

POLICY

All patients transferred from hospice will have a transfer summary complete and filed in the clinical record.

PROCEDURE

1. The physician will be notified of any transfers of patients from hospice to another organization, another level of care, service, or location.

2. The transferred clinician will provide a verbal report to the receiving organization with a preliminary report on the patient. This communication will be documented in the clinical record.

3. Within 48 hours of transfer, the transferring clinician will complete a transfer summary that includes as appropriate:

   A. The reason for transfer
   B. The physical and psychological status at the time of transfer
   C. A summary of the care provided at the time of transfer
   D. The current plan of care
   E. Latest physician orders
   F. Continuing symptom management needs
   G. Any instructions and/or referrals provided to the patient
   H. The existence of any Advance Directives known to hospice
   I. If appropriate, date and documentation of the face-to-face encounter

2. Completed transfer summaries will be given to a clinical records clerk who will send a copy to the receiving organizations within 72 hours of transfer and file the original in the clinical record.
PURPOSE

To ensure that the patient’s right to revoke the Medicare or Medicaid hospice benefit is understood and properly applied.

POLICY

A patient and family/caregiver may revoke the election of hospice care at any time. In order to revoke this care, a revocation of election of hospice care statement must be signed and filed in the patient’s clinical record. Revoking the Medicare or Medicaid hospice benefit is the patient’s and family/caregiver’s choice. In revoking these benefits, the individual forfeits coverage for any remaining days in that election period. Any individual can in the future sign onto remaining election periods as long as he/she meets admission criteria. An individual may not designate an effective date earlier than the date the revocation of election of hospice care statement was signed.

PROCEDURE

1. The patient will choose to revoke his/her election of hospice benefit when he/she:
   
   A. Elects active treatment, inconsistent with role of palliative hospice care
   
   B. Moves beyond the geographical service area of the hospice and cannot be transferred to another hospice provider
   
   C. Chooses to withdraw from the program with or without cause.

2. The Case Manager will facilitate the patient’s revocation and assist with a smooth transition to another setting or independent care.

3. The Case Manager will notify the attending physician and interdisciplinary team about the revocation and reason. A discharge summary will be sent to the attending physician and a copy of the hospice clinical record (if requested).

4. A revocation of election of hospice care statement will be signed by the patient and will document the date, time, and reason for revocation. A copy will be sent to billing and will be retained in the clinical record.

5. Relevant information will be documented in the clinical record by the Case Manager and/or Clinical Supervisor. (See “Discharge From Hospice Program” Policy No. H:2-085.)
PURPOSE

To establish standards and a process by which patients are discharged or recommended for discharge from the hospice program.

POLICY

Visiting Nurse & Hospice Care will provide service to a patient and family/caregiver as long as the patient remains terminally ill and lives in the designated service area. The organization will not discontinue or reduce care provided to a Medicare or Medicaid beneficiary because of the inability to pay.

Discharge Criteria

1. The Medical Director and/or attending physician will determine the patient is not hospice-appropriate according to standard clinical criteria for determining disease prognosis of six (6) months or less.

2. Patient leaves service area of Visiting Nurse & Hospice Care or transfers to another hospice.

3. Environment is determined to be unsafe for the patient and/or staff.

4. The patient and family/caregiver request discharge.

5. The patient or family/caregiver refuses to allow the hospice physician or nurse practitioner to have the required face-to-face encounter (prior to third and subsequent benefit periods).

PROCEDURE

1. The hospice interdisciplinary team will develop a discharge plan.

2. The Hospice Case Manager will ensure that necessary paperwork is completed at the time of discharge. This will include a signed revocation form, if necessary, and a written physician order to discharge, if appropriate. An expedited appeal notice will be provided and signed by patient or power of attorney at least 48 hours prior to discharge.

3. In instances where continued care to a patient contradicts the recommendations of an external or internal entity performing a utilization review, the Director will be notified. All care, service, and discharge decisions must be made in response to the care required by the patient, regardless of the external or internal organization’s recommendation. The patient and family/caregiver, as appropriate, and physician will be involved in deliberations about the denial of care or conflict about care decisions.
4. A record of conflict of care issues and outcomes will be kept for statistical purposes, referencing the date of the conflict of care issue, the patient name, the external or internal organization recommendations and reasons, and complete documentation of organization decision and patient care needs.

6. When a patient is discharged, transferred, or referred to another organization, relevant information will include:

A. Reason for transfer or discharge
B. Physical and psychosocial status at time of transfer or discharge, including specific medical, psychosocial, or other problems requiring interventions or follow-up
C. Summary of the care provided and progress toward achieving goals, including both positive and adverse patient responses to treatment or services.
D. A copy of the current plan of care
E. A copy of the medication profile, including discontinued medications
F. The latest physician orders
G. Continuing symptom management needs, e.g., pain, nausea, dyspnea
H. Follow-up to be provided by an interdisciplinary team member from the service transferring the patient
I. All pertinent laboratory data
J. Summary of patient education provided to the patient and his/her comprehension of that information.
K. Instruction and referrals provided to the patient
L. Existence of any Advance Directives, if applicable
M. The date of discharge, which is the date of the last visit made

7. Documentation will be filed in the clinical record. Information will be documented on a discharge/transfer form, which is to be completed within 72 hours.

8. If the environment is determined unsafe for the patient and/or staff, the following steps will be taken:

A. Provide written recommendations to patient and family/caregiver and physician to resolve unsafe situation.
B. Refer to social worker for assistance with placement planning.

Policy No. H:2-085.3

C. Consult with adult/child protective services and document.

D. Consider referrals to other agencies.

E. A formal letter will be provided to the patient and/or his/her representative that includes the organization’s concern, recommendations, consequences if concerns are not resolved, and potential discharge date. A copy will be provided to the attending physician.

9. If the hospice determines the patient should be discharged for the cause of face-to-face encounter refusal, the following steps will be taken:

A. Advise the patient and/or caregiver that a discharge for cause is being considered.

B. Make serious effort to resolve the problem and document efforts and document efforts in the clinical record.

C. Obtain a written discharge order from the hospice medical director.

10. A copy of the discharge summary will be sent to the attending physician. If requested, the patient’s clinical record will be provided.
PURPOSE

To define the requirements for documentation of a discontinuation of a service and when patients are discharged from hospice.

POLICY

All patients discharged from a service and from hospice will have a discharge summary completed and filed in the clinical record.

PROCEDURE

1. Hospice personnel who provide care will complete a discharge summary at the time the discipline is discontinued, which may include, as appropriate:
   
   A. The date of discharge, the date the physician and patient informed of discharge
   
   B. The reason for discharge, including the name of the organization to which the patient is being transferred, if applicable
   
   C. The status of problems identified at admission and during the provision of care
   
   D. The resolution of identified problems
   
   E. Continuing symptom management needs
   
   F. The overall status of the patient
   
   G. A summary of care or services provided including treatments, symptoms, and pain management.
   
   H. Other documentation facilitating continuity of care and/or requested by the attending physician or receiving facility

2. The discharge summary and other relevant clinical record documents will be completed and submitted within 72 hours of discharge from service.

3. A copy of the discharge summary will be provided to the patient's attending.

4. Hospice will complete all necessary audits to determine the completeness of the patient's clinical record within 30 days of the last hospice visit and discharge date. The discharge record will be organized according to policy for clinical records contents and removed from the active files.
CONTENTS OF CLINICAL RECORD
Policy No. H:2-087.1

PURPOSE
To outline the requirement and components of a clinical record.

POLICY
A clinical record will be maintained for each patient receiving care. The clinical record will contain sufficient information to identify the patient, describe the patient's problems and needs, justify care, accurately and timely documentation of care provided and results in detail, and facilitate continuity of care among hospice interdisciplinary team members and contract personnel.

(See “Clinical/Service Data Collection” Policy No. C:2-033.)

PROCEDURE
1. The following information will be available in the clinical record as applicable to care and services provided:

   A. Patient and family/caregiver demographic and identifying information

   B. Consent and authorization forms

   C. Election of the Medicare hospice benefit, when applicable

   D. Patient's Advance Directives, if executed, or documentation that such information has been received

   E. Name, address, and telephone number of:

      1. Contact person for emergencies and/or notification of death

      2. Legal representative for fiscal and health care decisions, when applicable

   F. Physician’s name including primary, secondary, and consulting physicians, as applicable

   G. Pertinent medical history

   H. Current medication profile including: prescription and nonprescription medications, herbal products, and home remedies; dose, frequency, and route of administration; with ongoing updates to the patient's medication regimen, including new, changed, and
discontinued medications, adverse reactions, significant side effects, drug allergies, and contraindications

I. Legible, complete, and individualized diagnostic and therapeutic orders authenticated within 30 days of the telephone order. (See “Verification of Physician Orders” Policy No. H:2-032.)

J. Identity of other individuals and organizations known to be involved in patient care

2. Documentation will include:

A. Substantiation of the terminal diagnosis and criteria for admission

B. Signed copy of the notice of patient rights

C. Patient and family/caregiver initial, comprehensive and ongoing comprehensive assessments, interventions, care and services provided

D. Plan of care developed/revised by the interdisciplinary team based on comprehensive assessments and desired outcomes with time frames

E. Relevant diet or dietary restrictions, allergies or sensitivities, and functional limitations related to care and services provided

F. Suitability or adaptability of the home to planned services

G. Safety measures to protect the patient from injury or harm

H. Educational needs of patient and family/caregiver

I. Patient and family education provided

J. Documentation that drug therapy may be ineffective and a follow-up plan for correction of the ineffective drug therapy

K. Change in interventions for ineffective drug therapy or other undesired outcomes

L. Regular pain assessments, interventions, and outcomes

M. Interdisciplinary team meetings and individual patient and family/caregiver case conferences

N. Physician review of medications and plan of care oversight including justification for recertification

O. Copies of summary reports sent to the physician, as appropriate

P. Summary of care and coordination of care provided in other settings, when indicated
Q. Bereavement plan of care, including services being provided

R. Assessment for volunteer needs, referral, and documentation when indicated

S. Assessment for spiritual care needs

T. Acceptance by the patient and family/caregiver of the diagnosis and prognosis

U. Attitudes and response of the patient and family/caregiver to the plan of care

V. Progress toward goals/outcomes of care

W. Certification and recertification(s) of terminal illness

X. Outcome measure data elements

Y. Discharge summary, if applicable

Z. Verification of need for changing level of care, transfer to another hospice, or revocation of services

3. Each entry will be dated and signed, including title and credentials, by the person providing the care/service.
PURPOSE

To establish a consistent, organized structure for the hospice clinical record.

POLICY

All clinical records will be assembled and maintained according to hospice policy and applicable state and federal law. The structure will be defined and approved by the Management of Information Committee. Any changes must be approved by that committee.

PROCEDURE

1. The contents of the record will be assembled as follows:

   (If utilizing electronic clinical records, the following information would need to be retrievable.)

   **Section I: Patient Data**

   A. Referral and intake forms
   B. Insurance verification forms
   C. Family/caregiver resource data form
   D. Transfer forms from other organization
   E. Signed notice of patient rights
   F. Consent for treatment
   G. Hospice election statement
   H. Hospice revocation statement
   I. Discharge/transfer forms (upon discharge)

   **Section II: Physician Orders**

   A. Physician authorization for hospice services
   B. Certification and recertification of terminal illness
C. Non-certification form
D. Plan of care/treatment
E. Verbal orders
F. Pharmaceutical orders

Section III: Clinical Notes
A. Interdisciplinary team meeting forms
B. Communication notes

Section IV: Plan of Care
A. Plan of care
B. Medication profile
C. Hospice aide assignment

Section V: Nurses Clinical Notes
A. Initial, comprehensive and ongoing comprehensive assessments
B. Clinical notes

Section VI: Hospice Aide Notes
A. Hospice aide clinical notes
B. Supervisory clinical notes

Section VII: Social Service Notes
A. Comprehensive assessment and ongoing comprehensive assessments
B. Social service notes
Section VIII: Therapy/Rehabilitation Notes
A. Comprehensive assessment and ongoing comprehensive assessments
B. PT, OT, ST, nutrition notes

Section IX: Lab and Special Reports
A. Lab results

Section X: Advance Directives
A. Living will
B. Durable Power of Attorney for health care
C. DNR/DNI

Section XI: Miscellaneous
A. Spiritual care assessment and notes
B. Volunteer notes
C. Bereavement assessments and notes
D. Communication with insurers, other clinicians, etc.
E. DME and supply documentation

2. Documentation will be assembled in chronological order, most recent first.
3. Documentation will include that which is provided directly by hospice and by contracted personnel.
4. Hospice personnel, including contracted personnel, will only use hospice-approved forms.
PURPOSE

To define the process for periodic and ongoing review of the patient's clinical record.

POLICY

Clinical records will be reviewed at least quarterly by qualified organization personnel to assure that documentation entered is reliable, timely, valid, and accurate.

PROCEDURE

Ongoing Review

1. Each clinical record will be reviewed on an ongoing basis by the Clinical Supervisor, Quality Assessment Performance Improvement (QAPI) Coordinator, Clinical Director, or designees for:
   
   A. The timeliness of entries into the clinical record
   B. Compliance with organizational policy
   C. Compliance with the established plan of care
   D. The completeness of clinical records
   E. The accuracy of clinical records
   F. The appropriateness of services rendered
   G. The need for continued care

2. As a result of this review, action will be taken as necessary to improve care. The Clinical Supervisor, QAPI Coordinator, Clinical Director, or designees will identify issues with documentation and, based on the review, if the issue:
   
   A. Is applicable to an individual, the individual will be counseled
   B. Is applicable to the organization as a whole, will refer the issue to the management team for review
Quarterly Review

1. The clinical record review will consist of a process based on the following guidelines:
   
   A. The review will consist of a random sample selection of both active and inactive cases.
      
      1. The sample will represent 10% of the organization's census.
      2. Of the 10% sample, 5% will be active patient clinical records and 5% will be discharged patients.
      3. The sample will be proportionate to the area census.
      4. The sample will be representative of each Case Manager’s caseload.
   
   B. The review will encompass a representation of all professional disciplines defined in the scope of services.
   
   C. Each professional discipline will participate in review of clinical records for their service.
   
   D. No person involved in the care of a patient may participate in the review of that patient’s record.
   
   E. All records reviewed will be secured for confidentiality.
   
   F. All records will be reviewed in the designated area.
   
   G. All records will be reviewed using a clinical record review tool to:
      
      1. Determine the adequacy of the plan of care and to determine if further service is necessary and appropriate
      2. Determine that data is reliable, valid, and accurate
   
   2. All record reviews will be documented and the data collated and analyzed.
   
   3. Results will be utilized for improvements in patient care and incorporated into performance improvement plans and activities.

   4. A summary of the results and corresponding analysis will be presented to the following:
      
      A. QAPI Committee
B. Professional Advisory Committee
PURPOSE

To ensure access to external information to assist hospice personnel in performing their functions, and for comparative purposes.

POLICY

Hospice and its personnel may access external databases and bodies of expert knowledge, when available, in the performance of their functions. These functions include the evaluation of hospice performance and the identification of deviations from expected trends.

External databases, when available, will be used for comparative analysis for improving organizational performance.

Hospice will contribute to external databases when required by law or regulation and accrediting bodies as appropriate to the hospice’s mission and scope of service. Hospice will maintain confidentiality and security of information when contributing or using an external database for comparative purposes.

Benchmarking software products or resources may be used for quarterly reports of selected benchmarks.
ICD/PACEMAKER DEACTIVATION POLICY
Policy No. H:2-091.1

PURPOSE
To provide education regarding the ethical rationale and physical consequences of deactivating or not deactivating Implantable Cardioverter Defibrillators (ICDs) in hospice patients. To establish a process for informed consent and deactivation of an ICD.

POLICY
The Visiting Nurse & Hospice Care hospice nurse will discuss the potential benefits and burdens of the ICD with the patient and/or family/caregiver so that an informed decision can be made regarding deactivation. The ICD may be deactivated according to the procedure outlined in this policy.

Ethical Rationale for Deactivation:
Implantable Cardioverter Defibrillators (ICDs) are often multi-functional devices that are programmed to meet an individual patient's cardiac needs. These devices are designed to terminate potentially life-threatening arrhythmias in patients, and one way that they do this is to deliver electrical shocks to the heart. Unlike other treatments these devices may deliver to correct arrhythmias, the patient may experience pain or discomfort when the ICD discharges. That an ICD is present does not automatically mean that it will fire as death approaches. Deactivation of the shocking function is not a requirement for admission to hospice, but may be in line with the goals of hospice care to preserve quality of life during the dying process. Defibrillators are medical treatments subject to the same ethical and clinical considerations as any other treatment. ICDs are subject to an analysis of potential benefits and burdens and patients/surrogates have the right to accept or refuse its interventions just like any other treatment. These should not be isolated decisions but instead made in the context of the patient's larger goals of care.

Identification of Device
At the time of evaluation and admission to hospice (regardless of setting in which care is delivered), all patients/families will be queried about the presence of a pacemaker and/or ICD. On physical examination, the chest wall of each patient should be checked for the presence of a cardiac device. (Devices are usually placed underneath the clavicle and may be visible and/or palpable.) If a device is identified, the patient/family should be asked if they have the card that was provided at the time of implantation to aid in determining the nature of the device. If the card cannot be located, the hospice nurse should contact the patient's primary care physician or cardiologist to determine the nature of the device.

Informed Consent Discussion about Device Deactivation
If an ICD has been identified, the hospice nurse should engage in an informed consent discussion with the patient/family/surrogate about the potential benefits and burdens of the device at this point in the patient's illness. In order to make a truly informed choice about whether or not to deactivate the shocking function, the following points should be emphasized during the discussion:

- **Implanted Cardiac Defibrillators (ICD)**
  - *Patients (or their surrogate decision makers) have a right to have devices turned off.*
• **People with terminal illnesses can/will still die even if their ICD is left on.** They may however experience repeated shocks and be at risk of more discomfort as they go through the dying process.

• **Turning off an Implanted Cardiac Defibrillator (ICD) is painless and does not create uncomfortable symptoms.**

• **Turning off an ICD does not cause death directly.** However, once the ICD is turned off it will no longer deliver a shock if the patient has a life threatening arrhythmia. (If one is having trouble understanding or making this distinction, one can think of the act of turning off an ICD as being similar to writing a DNR order - writing the order does not cause death; however it will result in allowing a natural death when the patient has a terminal event.)

• **ICD are less likely to successfully restore a normal heart rhythm as a person’s general health deteriorates and their body begins the normal dying process.**

• **If one is touching a person with an ICD when a shock is given one will not receive a shock himself.** The shocks from ICDs are much less intense than those given with paddles on the outside of the chest. At most, one might feel a buzz or tingle.

• **In a patient with a combination ICD/Pacemaker, use of a magnet will deactivate the shocking function but will not deactivate the Pacemaker.**

• **When a patient or surrogate decision maker wants an ICD deactivated on an emergent basis a magnet can be placed and kept (with tape) over the ICD to prevent shocks.** Two common scenarios might require a magnet deactivation:
  - An imminently dying patient who has been shocked repeatedly in whom further shocks are not desired
  - An imminently dying patient who wants to avoid the possibility of being shocked

If a pacemaker but not an ICD as been identified, the hospice nurse is not required to engage in an informed consent discussion with the patient/family/surrogate about the device but should be prepared to answer questions about the pacemaker using the following information:

**Pacemakers**

**Turning off a pacemaker may result in a number of different results and it may be difficult or even impossible to predict which of these situations is most likely:**

- No change in clinical status at all
- Rapid death if a patient is pacemaker dependent
- Worsening symptoms of heart failure
- Fainting episodes
- Increased fatigue
Pacemaker discontinuation is generally discouraged as the outcome is often uncertain and may result in uncomfortable symptoms or a decline in functional status. It remains a patient’s right however to have a pacemaker turned off and a few individuals may decide to do so if they believe ongoing pacemaker function may be prolonging their dying process. If a patient does decide to have a pacemaker discontinued it should be done in a setting where the patient will not fall (in bed) and with a physician or hospice nurse present and emergency medications available to treat symptoms such as shortness of breath and anxiety.

**Process for De-activating an ICD**

If a decision has been made to deactivate the shocking function of the ICD, the hospice nurse will inform the medical director to let him/her know the decision has been made to re-program the device so it will no longer deliver shocks. Note: Re-programming an ICD in this manner will stop it from ever delivering shocks. Placing a magnet over the ICD will stop it from sensing the rhythm and delivering a shock, but only while the magnet is physically present over the device. If the patient is ambulatory, the nurse will contact the patient's cardiologist or electrophysiologist to arrange for the patient to come to the office to have the device re-programmed so the shocking function can be deactivated.

If the patient is not able to leave his/her place of residence, then the hospice nurse will develop a plan with the attending physician for the re-programming of the patient's ICD, which may include one of the following processes:

1. The patient's cardiologist/electrophysiologist or a member of the team will be contacted to come to the patient's place of residence to re-program the device.

2. A representative from the device manufacturing company, after appropriate consultation with the hospice medical director and/or the patient's cardiologist/electrophysiologist will come to the patient's place of residence to re-program the ICD.

**Process for Deactivation of an ICD in an Emergent Scenario**

If there is a decision for the shocking function of the ICD to remain active, a magnet designed for cardiac devices should be left in the patient's place of residence in the event of an emergent scenario where the patient is being repeatedly shocked. It should be explained to the family that if a patient is receiving repeated shocks from the ICD, then placing the magnet over the device will stop it from sensing the cardiac arrhythmia. The magnet will need to be taped in place, as it only stops the ICD from sensing. (An ICD which does not sense will not deliver treatments.) Once the magnet is removed the ICD will begin sensing again and may again deliver shocks.

The magnet is heavy and may not be comfortable if left in place for an extended period of time. If the family is not comfortable performing this procedure themselves, the magnet should still be left in the place of residence so in an emergent situation a hospice nurse who arrives will have the tools necessary to suspend the shocking function of the device.

**Post-Mortem Care**

After a patient has died, the ICD will not deliver a shock. If a magnet has been taped to the chest, it can be removed as soon as a nurse has verified the patient no longer has cardiac function. If the body is to be cremated, the funeral director should be notified of the presence of an ICD, as incinerating the battery can lead to its explosion.
PURPOSE

To establish the guidelines for providing inpatient services.

POLICY

The total number of inpatient days used by Medicare beneficiaries who elect hospice coverage in any 12-month period will not exceed 20% of the total number of hospice days for this group of beneficiaries.

General inpatient care and inpatient respite care will be provided by arrangement to patients whose care is covered under the Medicare or Medicaid hospice benefit and specific private insurance hospice benefits (see “Admission for General Inpatient Services” Policy No. H:2-027 and “Admission for Respite Care” Policy No. H:2-028.)

1. Any inpatient facility will meet the following criteria:
   
   A. Is a contracted Medicare and/or Medicaid-certified hospital, skilled facility, or congregate living facility.
   
   B. Provide 24-hour nursing services including:
      
      1. Sufficient staffing to meet the patient’s total nursing needs
      2. Provision of care in accordance with the patient’s plan of care established by hospice for treatments, medications, and diet as prescribed
      3. A focus on insuring that the patient is kept comfortable, clean, well groomed, and protected from accident, injury, and infection
      4. Each shift at the facility being staffed with a registered nurse who provides direct patient care (24-hour RN not required for respite care)
   
2. Admission and discharge from inpatient services will be the responsibility of the hospice Case Manager.
   
   A. A Physician (or other authorized independent practitioner) order will be obtained to change the level of care.
   
   B. All interdisciplinary team members will be notified of the change.
   
   C. Hospice will be responsible for coordination of the patient’s transfer into and out of the inpatient level of care.
PURPOSE

To establish standards and a process by which a patient can be evaluated for inpatient care and accepted for admission.

POLICY

Visiting Nurse & Hospice Care (VNHC) home hospice patients may be transferred to Serenity House by physician order and according to admission criteria.

PROCEDURE

1. VNHC home hospice staff will notify the admission team of patient / family requesting transfer to Serenity House.

2. VNHC Case Manager will provide a status report to the Medical Director.

3. The Medical Director will determine if the patient meets admission criteria.

4. Serenity House will accept the patient based on patient status and bed availability.

5. Transfer information is completed in Electronic Medical Record (EMR) including physicians order for transfer and level of care.

6. Finance Office is notified of Serenity House admission and Fee Agreement arrangements are made with responsible party.

7. Appropriate records will accompany patient to include: H&P, consults, current medication list, funeral plans, recent progress notes or other documentation to support hospice diagnosis and prognosis. If the patient has a DNR order, it should accompany patient to Serenity House.

8. The home hospice nurse calls report to the Serenity House nurse; and with the support of VNHC Social Services, arranges for transportation.

9. Prior to the arrival of the patient, equipment and supplies needed for the admission (e.g., oxygen, suction equipment, etc.) are set up.

10. Upon admission to Serenity House, the inpatient Aide:

   A. Identifies the patient and provides an identification bracelet.

   B. Orients patient and family/caregiver to surroundings.
C. Assesses the patient, including obtaining vital signs, and weight and height.

D. Inventories patient items brought to the facility, returning all personal valuables to family or designated person for safe keeping.

11. The inpatient nurse:

A. Completes the comprehensive nursing assessment and medicates the patient, as needed.

B. Acts on urgent orders.

C. Communicates medication orders to the pharmacy, indicating whether the patient has own medications from home and which medications require delivery.

D. Confirms the Code Status.

E. Enters appropriate information (location and status) in the electronic medical record (EMR) Admission and Status.

12. The Social Worker:

A. Provides emotional support to patient/family.

B. Completes psych-social assessment.

C. Collaborates with the nursing staff to determine required interventions.

D. Obtains the patient/legal representative signature on fee agreement paperwork

E. Assesses status of funeral arrangement.

F. Notifies the spiritual care team as appropriate.
PURPOSE
To establish standards and a process by which a patient can be evaluated and accepted for admission.

POLICY
A patient may be admitted to Serenity House directly or from any setting if appropriate for hospice inpatient care.

PROCEDURE
1. Serenity House will accept the patient based on patient status and pending bed availability.
2. Admission documentation is faxed/delivered to Serenity House by VNHC Hospice Intake Team or liaison.
3. Transportation arrangements are made as needed.
4. Finance Office is notified of Serenity House admission and fee agreement arrangements are made with the responsible party.
5. Appropriate admission records include, but are not limited to: H&P, consults, current medications list, recent progress notes or other documentation to support hospice diagnosis, written evidence of a TB screening if done within the last ninety (90) days, transfer form if from other facility. When patient has been examined by physician in the past five (5) days, the physician note shall be provided to Serenity House.
6. Upon transfer of a patient to Serenity House, the nurse:
   A. The nurse coordinates with social worker and admission team to be sure consents are signed before care is provided.
   B. Assesses the patient, completes initial assessment and comprehensive assessment as indicated (due within 24 hours).
   C. Verifies the admission order and calls the attending physician for additional orders as needed.
   D. Acts on urgent orders.
   E. Medicates the patient if necessary.
F. Communicates the medication orders to the pharmacy, indicating if the patient has their own medications and which medications require delivery.

G. Completes the comprehensive nursing assessment; documents the all findings in the electronic medical record.

H. Develops the Problems according to what was identified in the assessment, Interventions, and Goals specific for each patient.

I. Completes tuberculosis screening form – and process.

J. Confirms the Code status.

K. Develops initial plan of care with IDT members.

7. The inpatient Aide:

A. Identifies the patient and applies ID band.

B. Orients patient and family/caregiver to surroundings

C. Inventories patient items brought to the facility, returns valuables to family for safekeeping away from Serenity House.

8. The Social Worker or Designee:

A. Reviews the appropriate admission documents including election statement with the patient or family/caregiver and obtains signatures as needed.

B. Reviews the patient’s rights and responsibilities with the patient/family/caregiver.

C. Inquires as to status of funeral arrangements.

D. Completes the psychosocial assessment and documents in the electronic medical record.

E. Contributes to the initial plan of care, completes comprehensive plan of care as indicated.

F. Obtains patient/legal representative signature on fee agreement paperwork.

G. Notifies the Spiritual Care Team as appropriate.

9. If the admission occurs after hours or on the weekend, the nurse or designee:

A. Notifies the Social Worker on-call to complete the psychosocial portion of the admission.

B. Informs admissions team of admission.
C. Completes admission process as outlined in item #6 above.
PURPOSE

To establish a process to follow when all inpatient beds are at full capacity.

POLICY

The Serenity House Director and Medical Director will be notified by the RN in charge when all beds are at full capacity.

PROCEDURE

1. When Serenity House is at full capacity, the appropriate notifications as stated above will occur in a timely manner.

2. All referrals received when Serenity House is at full capacity will be evaluated by the Serenity House Director, Medical Director, and designated care staff to determine patient needs.

3. The following options should be discussed with the patient/caregiver:
   
   A. Staff should advise the patient, attending physician and caregiver of hospice services at home.
   
   B. Patients currently in the hospital may remain there until a bed at Serenity House becomes available; or transferred to another appropriate facility.
   
   C. Home care hospice patients will be evaluated on a case by case basis until Serenity House beds become available.

4. A patient waiting list will be initiated to prioritize future admissions.

5. As discharges occur and beds become available, patients will be admitted by priority consideration:

   A. Symptoms such as unmanaged pain, intractable nausea, respiratory distress, a bleeding crisis, or family crisis; which are unmanageable in another setting.
   
   B. Actively dying and family unable to cope.
   
   C. Psychosis or severe confusion secondary to end stage disease processes.

6. The Serenity House Director, the Medical Director, and care team will continue to monitor the patients to:
A. Facilitate transfer of patients for whom orders for Serenity House have been written.

B. Prioritize cleaning of patient rooms and patient care equipment

C. Facilitate admissions to the Serenity House as beds become available.
PURPOSE

To provide dignity and comfort to all patients and families referred to Serenity House.

POLICY

Any patient who dies en route to or upon arrival at Serenity House will receive appropriate services as delineated.

PROCEDURE

1. Place patient in assigned room.

2. RN or MD conducts a brief assessment to determine that patient has died and notes the time. (See Hospice of the Foothills operational Policy and Procedure Manual, “Pronouncement of Death”).

   A. RN notifies the attending physician.

3. Patient is not admitted.


5. Complete the Post Death Checklist.

6. RN and/or Social Worker provides supportive counseling, encourages use of bereavement follow-up and contacts Spiritual Care/community clergy if appropriate.

7. MD documents brief discharge summary.
CONDITIONS REQUIRING NOTIFICATION OF PHYSICIAN
Policy No. H: 2-105.1

PURPOSE

To communicate any change in patient status to primary physician.

POLICY

The Serenity House Nursing Staff will notify the attending physician or designee when there is a change in a patient’s condition.

PROCEDURE

1. The following conditions require notification of the attending physician:
   
   A. Admission of the resident.
   
   B. Any unexpected sudden or marked adverse change in the resident.
   
   C. Any unusual occurrence.
   
   D. An unexpected weight change of 5 lbs. or more in a 30-day period. Note: The physician may make another stipulation in the health record.
   
   E. Any untoward reaction to a medication or treatment.
   
   F. Any error in the administration of a medication or treatment that presents a risk to the patient.
   
   G. The inability of the facility to obtain or administer on a prompt and timely basis, drugs, equipment supplies or services as prescribed under conditions which present a risk to the health, safety or security of the patient.

2. When a significant and/or unexpected change is noted in the patient’s condition which could result in a safety issue or threat, the following may be notified:

   A. Serenity House Director, if change is unexpected
   
   B. Physician, if change is unexpected
   
   C. Family or responsible party

3. Document all persons that were notified in the Nursing Clinical Notes.
HOSPICE II
Quality of Services and Products
MEDICATION ADMINISTRATION
Policy No. H: 2-106.1

PURPOSE
To provide guidelines for the safe administration of medications by licensed nursing personnel.

POLICY
Medications are administered to patients in the Serenity House by a licensed nurse or physician.

PROCEDURE
1. A licensed physician/designee orders all medications.

2. All orders for medications are written on each patient’s Physician Order Sheet and transcribed on the Medication Administration Record (MAR). Orders shall include:
   A. Date medication was ordered;
   B. Name of medication;
   C. Dose of medication;
   D. Frequency of administration
   E. Route of administration.

3. A licensed nurse or pharmacist takes all verbal orders for new medications or changes in medication dose, frequency, or route directly from the physician. The licensed nurse reads back and verifies the order and it is then written on a Physician Order Sheet. The order is faxed to the pharmacy and the original placed in the patient’s medical records. Physicians are required to co-sign all verbal orders within five (5) days. Faxing signatures will be accepted.

4. Medications and treatments shall be administered as follows:
   A. Preparation of only one (1) dose per medication at a time is permitted;
   B. All medications and treatments shall be administered only by licensed physicians or licensed nursing personnel with the following exceptions:
      1. Unlicensed persons may, under the direct supervision of licensed nursing or licensed medical personnel, after demonstrating evidence of competence, administer the following:
a. Medical shampoos and baths;

b. Over the counter (OTC) topical ointments, creams, lotions, and solutions when applied to intact skin surfaces.

C. Unlicensed personnel will not administer any medication associated with treatment of eyes, ears, nose, mouth, or genitourinary tract.

5. The licensed nurse is responsible to ensure that the correct patient receives the correct medication and dose by the proper route of administration at the proper time.

6. Medication and treatment records will contain:

A. Name of medication, dosage and time of administration;

B. The route of administration and the site of injections;

C. If the scheduled time is indicated on the record, the initial of the person administering the dose shall be recorded, provided that the drug is given within one hour of the scheduled time;

D. If the scheduled time is not recorded, the person administering the dose will record both initials and the time of administration;

E. The record will contain the name and professional title of the staff signing by signature.

F. Justification for the results of all PRN medications and the withholding of scheduled medications.

7. Untoward drug reactions and/or medication errors are handled as an unusual occurrence (Incident Report), the attending physician is notified and the proper documentation is completed.

8. Oxygen will be administered via oxygen concentrators:

A. Follow oxygen administration procedures;

B. Humidifier bottles on oxygen equipment shall be cleaned every twenty-four (24) hours and refilled as necessary;

C. Only sterile, distilled, demineralized or deionized water will be used in humidifier bottle.

9. Psychotropic medications will be monitored every shift and on a monthly basis as follows:

A. The specific behavior or manifestations of disordered thought process to be treated with the drug is identified in the patient’s medical record
B. The plan of care for each patient specifies data to be collected for use in evaluating the effectiveness of the drugs and the occurrence of adverse reactions.

C. The data collected shall be made available to the prescriber in a consolidated manner at least quarterly.

10. Emergency drug kit process.

A. Pharmacy provides emergency drug kits in accordance with pharmacy law.

B. Emergency drug kits are sealed and all medications removed are documented on pharmacy records.

C. Medications ordered by the physician required for administration within 2 hours can be procured from the emergency drug kit. Emergency drug kits are replaced by pharmacy within 24 hours of the seal being broken.
NARCOTIC COUNT
Policy No. H: 2-107.1

PURPOSE
To ensure appropriate dispensing of controlled substances in accordance with applicable State and Federal regulations.

POLICY
In order to comply with State and Federal regulations, narcotics are counted each shift by two (2) licensed nurses.

PROCEDURE
1. The in-coming licensed nurse counts all doses present for each narcotic, for each patient; either visually or manually.

2. The off-going licensed nurse verifies the number of doses remaining with the narcotic sign-out; present for individual patients.

3. The on-coming licensed nurse unlocks refrigerator to visualize drugs and verify count received from off-going licensed nurse.

4. The on-coming licensed nurse who has control of the narcotic key is then responsible for accuracy of the count during his/her shift.

5. The narcotic key can only be surrendered to another licensed nurse upon completion of the narcotic count of all patients within the locked container.

6. Any discrepancies are to be resolved prior to end of shift.

7. When there is any discrepancy that cannot be resolved:
   A. The Serenity House Director is notified immediately.
   B. An Incident Report is completed
   C. The pharmacy is notified.
   D. Data is forwarded to Quality Department.
PURPOSE

To ensure that supplies are provided for hospice patients based on assessed health care needs.

POLICY

To meet patients' hygiene and physical needs, the Serenity House will have equipment and supplies necessary for the routine personal care and maintenance of adequate hygiene for all patients.

PROCEDURE

1. Serenity House supplies will be ordered through Visiting Nurse & Hospice Care vendors based on quality, service and competitive pricing.

2. The supply room will be kept neat and orderly.

3. The Administrative Coordinator or designee will be responsible for maintaining the inventory and ordering supplies to assure availability as needed.

4. Disposable sterile supplies will be kept in quantities necessary to meet patient needs.

5. Glass thermometers, oral or rectal, will not be used at Serenity House.
PURPOSE

To establish the process to follow when a patient dies.

POLICY

The family/caregiver is supported in dealing with the death of a loved one and appropriate healthcare staff is notified in a timely manner. Notification of the patient’s death is made to the patient’s family/caregiver, appropriate staff members, clergy, and others as required and/or directed by the family/caregiver.

PROCEDURE

1. The nurse or physician assesses the patient for absence of pulse and respiration and pronounces the death of the patient.

2. The staff provides emotional support to the family/caregiver as necessary.

3. The family/caregiver is allowed to view and stay with the body. Serenity House staff may contact a spiritual care provider or other team/community members as requested by the family.

4. When the family/caregiver is ready, the nurse or designee notifies the selected funeral home of the patient’s death. If funeral arrangements have not been made, the staff assists the family/caregiver in this process.

5. The inpatient staff places clean clothes or a gown on the body, and arranges the body in as natural a position as possible. The nurse will remove appropriate tubing unless the patient’s death is to be reviewed by the Coroner’s Office.

6. The nurse or designee notifies both the attending physician and Medical Director of the date and time of death.

7. Jewelry and valuables are removed by the family/caregiver, and the family/caregiver is allowed private time with their loved one.

   A. If the family/caregiver is not available, the inpatient staff will gather and inventory any possessions in the room. A second staff member will witness the inventory and document.

   B. Jewelry/valuables will be stored in a secure place.
8. Bodies with an infectious disease, or bodies with recent chemotherapy or radiation implants, must be appropriately labeled for the mortuary. The mortuary is also notified of pace makers.

9. The funeral home may pick up the body from the patient’s room. The mortuary representative transporting the deceased patient from Serenity House must sign a release form.

10. All medical equipment and waste is removed from the room.

11. The nurse or designee notifies the hospice team and appropriate department and contractors including:
   A. Pharmacy
   B. Housekeeping
   C. Dietary
   D. DME company

12. The nurse on duty places all unused medications in a locked container in the medication room for monthly destruction. Narcotic medications will be logged in the Destruction Log and co-signed by two (2) nurses.
PURPOSE

To establish standards and a process by which patients are discharged or transferred from the inpatient unit.

POLICY

After collaboration with the Interdisciplinary or Care Team, a patient may be transferred or discharged from Serenity House under the following circumstances:

1. Services required are beyond those for which Serenity House is licensed or has the functional ability to provide or in an emergency situation.

2. Patient and caregiver request discharge.

3. Criteria is no longer met.

4. The patient or his/her visitors fail to follow Serenity House policies.

PROCEDURE

1. A physician’s order for transfer or discharge is obtained.

2. When it is deemed appropriate to transfer a patient home or to another facility, Serenity House staff arranges for the transfer, including safe transportation, of the patient and his/her personal belongings/valuables.

3. Except for an emergency, the family/caregiver is notified prior to the patient transfer.

4. A transfer summary note, including current medications, is completed by the nurse prior to transfer and faxed to the receiving agent.

5. A patient report is communicated to the receiving agent (home care team, nursing home, etc.). A copy of the plan of care is sent to the receiving agent.

6. Medications will be sent with patients when appropriate.

7. New prescriptions for medications may be written by the discharging physician or Hospice Medical Director.

8. Billing Department is notified of the pending discharge/transfer.

9. The IDT summary is completed within seven (7) days of transfer/discharge and is signed by the physician as the discharge summary.
PREVENTION OF DECUBITI, CONTRACTURES, AND DEFORMITIES
Policy No. H: 2-111.1

PURPOSE
To provide guidance for the prevention of decubiti, contractures, and / or deformities.

POLICY
To maintain mobility and prevention of skin breakdown for patients at the Serenity House, each patient will be given care to prevent formation and progression of decubiti, contractures and deformities.

PROCEDURE
1. Care will include changing position of bed-fast and chair-fast patients with preventive skin care in accordance with needs.

2. Encouraging, assisting and training in self-care and activities of daily living.

3. Maintaining proper body alignment and joint movement to prevent contractures and deformities.


5. Providing care to maintain clean, dry skin free from feces and urine.

6. Changing of linens and other items in contact with the patient as necessary to maintain a clean, dry skin free from feces and urine.

7. Carrying out the physician’s orders for treatment of decubitus ulcers.
   A. Serenity House shall notify the physician when a decubitus ulcer first occurs as well as when treatment is not effective.
   B. A physician’s order will be obtained for the treatment of any wound or ulcer.
   C. Such notification will be documented in the patient’s medical record.
PATIENTS LEAVING ON PASS OR AGAINST MEDICAL ADVICE
Policy No. H: 2-112.1

PURPOSE
To allow patients who are assessed to be well enough, to leave on trips and vacation

POLICY
Serenity House patients will be granted a pass to leave if ordered by the Medical Director.

PROCEDURE
1. A pass to leave may be granted if the patient’s condition allows for no more than 72 hours.
2. For patients receiving hospice services, the Medical Director will assess the patient’s condition and recommend appropriateness.
3. The patient will be accompanied by a responsible family member or other designated responsible party.
4. Medications will be sent with the patient/responsible party which will be in accordance with pharmacy policies. The nurse on duty will prepare enough medications for the duration of the patient’s pass.
5. Patients choosing to leave the Serenity House without a physician’s order or against medical advice will be discharged from the Serenity House. The RN on duty will report the occurrence on an Incident Report and notify the Director.
6. The primary physician and Medical Director will be notified immediately if a patient leaves without an order or against medical advice.
7. Billing Department will be notified of a patient leaving without order or against medical advice.
USE OF POSTURAL SUPPORTS
Policy No. H: 2-113.1

PURPOSE
To provide guidelines for staff in the use of postural supports to assist patients in proper body position, balance, and prevention of falls.

POLICY
Postural supports are for the purpose of assisting patients to achieve proper body position and balance. They will be used only with an order from the physician.

PROCEDURE
1. Postural support means a method other than orthopedic braces used to assist patients to achieve proper body position and balance and shall only be used to improve a patient’s mobility and independent functioning, to prevent the patient from falling out of a bed or chair, or for positioning, rather than to restrict movement.
2. Postural supports may only include soft ties, seat belts, spring release trays or cloth vests.
3. The use of postural support and the method of application shall be specified in the patient’s care plan and approved in writing by the physician or other person lawfully authorized to prescribe care.
4. Postural supports shall be applied under the supervision of a licensed nurse.
5. The supports shall be used in accordance with principles of good body alignment and with concern for circulation and allowance for change of position.

RESTRAINT USE AT SERENITY HOUSE
1. When deciding whether or not to restrain, assess patient for causes of confusion or disorientation, which can be corrected:
   - Effects of Medications, especially narcotics/sedatives.
   - Environment – too much or too little stimulation
   - Unmet needs – toileting, personal items out of reach
   - Pain
   - Abnormal lab values:
     O2 Sat, Na, Calcium

2. Correct causes of confusion/disorientation; Call MD for orders if necessary or discuss medication issues with the MD or pharmacist.
3. Patients who are known to be dying should not be restrained. Involve the family and MD in providing comfort measures without restraints.

4. Alternatives to restraints must be attempted before initiation of restraint. Alternative measures may include:
   - Family/friends or volunteer to stay with patient for frequent re-orientation and reality links.
   - Bed and/or tab alarms
   - Frequent re-orientation, toileting and hydration rounds (q 1 hour)
   - Conceal lines or contact M.D. to have them discontinued if not necessary

**Restrain only as a last resort.** Seek advice from other staff members to prevent initiation of restraint. If patient is restrained, procedure and care includes:
   - Use the least restrictive restraint possible (i.e., don’t use wrist restraints and a posey vest if a patient is trying to get out of bed unsafely).
   - Restraints must be tied with a quick release knot to allow quick release in an emergency and must be attached to a non-moveable part of the bed or wheelchair to prevent injury to the patient.
   - Maintain privacy and dignity. Inform patient and family the reason why restraints are needed in the language they understand.
   - Place the call within the patient’s reach. Give the patient a hand held call light if wrist restraints are used.
   - Check patient every 2 hours for toileting and other needs, to re-orient patient and to release restraints and check skin.
   - Assess patient every shift for need for continued use of restraints.
   - Obtain a complete Physician order for initiation of restraint and for every calendar day the patient is restrained. The MD must evaluate the patient after initiation.
   - Q2 hour checks, initiation, validation and discontinuation of restraint MUST be documented in Allscripts.
PURPOSE
To outline the requirements and components of a patient's clinical record.

POLICY
Serenity House will maintain a medical record for each individual receiving care and services. The record shall be current and kept in detail, consistent with good medical and professional practices based on the services provided to each patient, confidential and disclosed only to authorized persons.

PROCEDURE
1. The medical record shall contain:
   A. The admission record will include the following:
      1. Name, current address, age, date of birth, sex, admission and discharge date;
      2. Name, address, and telephone number of the next of kin, guardian or authorized representative;
      3. Name, address, and telephone number of the attending physician, and his/her designated alternative;
      4. Admission diagnosis, allergies, final diagnosis;
      5. Medicare, MediCal and other insurance numbers when appropriate;
      6. An inventory list of the patient’s valuables brought with him/her and signed by a staff member and the patient or his/her authorized representative at the time of admission and discharge. Each will retain a copy. The list will be updated as needed. The inventory will include, but is not limited to, items of jewelry, items of furniture, radios, television and other appliances, prosthetic and orthopedic devices, other valuable items as identified by the patient, family or authorized representative.
   B. The current history and physical dated within five (5) days prior to admission or within seventy-two (72) hours following admission.
   C. Current diagnosis.
   D. Evidence of TB screening.
E. Physician orders to include drug, treatment, and diet orders. Orders shall be correctly transcribed.

F. Nurses notes dated and signed which include:
   1. Meaningful and informed nurses progress notes written by licensed nurses as often as the patient’s condition warrants, as well as a weekly summary and shall include:
      a. Patient needs, the plan of care, all interventions provided, and patient’s response to treatments, including response to prn medication;
      b. Changes in patient condition and documentation of notification of attending physician.

G. Medication administration:
   1. Name, dosage and time of administration of drugs, the route of administration or site of injection, if other than oral. If the scheduled time is indicated on the record, the initial of the person administering the dose shall be recorded, provided that the drug is given within one (1) hour of the scheduled time. If the scheduled time is not recorded, the person administering the dose shall record both initials and the time of administration. Medication and treatment records shall contain the name and professional title of staff signing by initials.
   2. Justification for the results of the administration of all prn medications and the withholding of scheduled medications.

H. Medications and treatments administered and recorded as prescribed.

I. Documentation of oxygen administration.

J. Temperature, pulse, respirations, and blood pressure when indicated.

K. Lab, x-ray reports prescribed and completed, all tests prescribed and completed.

L. Progress notes:
   1. Physician – dated and signed on each visit;
   2. Activity leader – written and dated at least quarterly;
   3. Observations and information pertinent to the patient's diet;
   4. Discharge planning – notes where applicable.
M. All applicable consent forms not included in the general consent form.

N. Condition and diagnoses at time of discharge or final disposition.

O. A copy of a transfer form, including name, complete address and telephone number when the patient is transferred to another health facility.

2. Confidentiality/Release of Information

A. Medical record information is safeguarded against loss, destruction or unauthorized use. Patients and/or patient’s legal representative’s written consent is required for release of information not authorized by law.

   1. Any and all requested information will be provided except documentation which was not originated by the Serenity House personnel.

B. Medical records shall be made available only to the facility’s clerical and professional staff who are either employees or persons who have an employment agreement with Serenity House.

3. Record Entries

A. Record entries may be made by any member of the staff. All entries should:

   1. Be legibly written and made in permanent black ink.

   2. Be signed by the person making the entry utilizing their first initial, last name and title.

B. Errors must be corrected by drawing a single line through the error and initialing above the line. Correction fluid (white out) must not be used to correct an error.

C. Abbreviations listed on the “DO NOT USE” List (See Attachment 1) will not be used.

D. Only those abbreviations or symbols that appear on the Serenity House “ABBREVIATION LIST – Approved for Use” will be used (See Attachment 2).
CONSENT FOR MEDICAL PROCEDURES
Policy No. H: 2-115.1

PURPOSE
To ensure that the patient or Dual Power Of Attorney (DPOA) provides informed consent for medical procedures.

POLICY
Prior to undergoing any medical procedure, Serenity House patients receive an explanation of the procedure by the performing physician and sign a Consent for Medical Procedures specific to said procedure.

PROCEDURE
1. The physician explains, in detail, the potential benefits, risks, and complications of a proposed procedure, and documents it in the medical record.

2. The patient must be capable of making a decision. If the patient is incapable of making a decision, the patient’s DPOA may make the decision.

3. The consent form is completed, signed, witnessed and dated prior to beginning the procedure.

4. The consent form will comply with the American Hospital Association (AHA) guidelines.
HOSPICE II
Quality of Services and Products

PHYSICIAN AND FACILITY RESPONSIBILITIES
IN THE PROVISION OF CARE
Policy No. H:2-116.1

PURPOSE

To ensure qualified medical direction and consultation for the delivery of hospice services at inpatient unit. To outline the responsibilities of the physician at Serenity House.

POLICY

Physician and facility responsibilities in the provision of care in the Serenity House (SH) shall be clearly delineated. The inpatient facility shall have a process to inform physician of his/her responsibilities in the provision of care to patients upon referral and admission of his/her first patient to services and when changes to the policy occur. The licensed staff at the inpatient unit are responsible for insuring that, should the attending physician and the designated alternate physician not be available, a designated alternate is available.

DEFINITIONS

Attending or Primary Physician: The attending or primary physician is a doctor of medicine or osteopathy, currently licensed by the State of California and is identified by the patient, at the time he or she is admitted as having the most significant role in the determination and delivery of the patient’s medical care.

Alternate Physician: The physician designated by the attending physician to provide coverage in the event he/she is not available for services; required by the patient or as mandated by licensure/regulatory requirements.

PROCEDURE

1. Physician Responsibilities:

   A. Share information with inpatient staff to facilitate continuity of care, such as changes in the patient’s status or plan of care, referrals to additional physicians and/or agencies, and designation of alternate medical coverage when not available, to insure twenty-four (24) hour physician coverage for the patient.

   B. Patient evaluation including a written report of a physical examination within five (5) days prior to admission or within seventy-two (72) hours following admission.

   C. Provide continuing supervision by evaluating the patient as needed but at least every thirty (30) days and document the visit in the health record.

   D. Written documentation and summary of the patient’s terminal illness.
E. Availability for collaboration/participation with inpatient staff regarding patient care needs, treatment and interventions, and orders.

F. Responding in a timely manner to inpatient staff regarding patient care needs, treatment and interventions, and orders.

G. Notification to the facility as soon as possible if there are concerns regarding the plan of care.

H. Maintain confidentiality of all verbal, telephonic, faxed, and written communications relating to the patient’s care and services.

I. Sign and date all verbal orders within thirty (30) days of patient discharge. Fax signature will be accepted as original.

2. Inpatient Responsibilities:

A. Inpatient unit does not use or accept standing orders.

B. Provide treatment and instruction as ordered by the physician within the scope of services offered by the facility, and within regulatory parameters. If unable to provide services, assist the physician with alternate suggestions.

C. Communicate with the physician in a timely manner about patient condition, changes, family and psychosocial dynamics impacting patient’s health, and place for care.

D. Ensure confidentiality of all verbal, telephonic, faxed, and written communications relating to the patient’s care and services.

E. Send, via facsimile, verbal orders to the physician for signature in a timely manner. Fax signature will be accepted as original.

F. Respond to physician questions/concerns about a patient in a timely manner.

G. Provide periodic clinical updates to the physician as requested and not less than every 15 days.

H. Provide information to physicians regarding admission and eligibility criteria and other regulations related to the provision of services.

I. Provide patient care services twenty-four (24) hours per day, seven (7) days per week.

J. Utilize resources and personnel effectively.

K. Provide orientation of new physicians to the facility and changes in facility policies, as appropriate.
PURPOSE

To offer activities that promote physical, emotional, and social well being for individuals in Serenity House.

POLICY

To promote patient/family quality of life at the Serenity House, patients will be offered the opportunity to participate in activities to meet their individual needs. The activities will be designed to make life more meaningful, to stimulate and support physical and mental capabilities to the fullest extent as long as possible, and also to enable the patient to maintain the highest attainable social, physical, and emotional functioning.

PROCEDURE

1. The activities program shall have a written, planned schedule of social and other purposeful independent or group activities.

2. The activities program shall consist of individual, small and large group activities which are designed to meet the needs and interests of each patient. They shall include, but not be limited to:
   
   A. Social activities.
   B. Indoor and out-of-doors activities, which may include supervised daily walks.
   C. Activities away from the facility if patients are able.
   D. Opportunity for patient involvement for planning and implementation of the activity.
   E. Creative activities.
   F. Educational activities.
   G. Religious programs.

3. Activities shall be available on a daily basis.

4. The activity leader shall:
   
   A. Develop, implement, and supervise the program.
   B. Plan and conduct in-service training of the staff of the Serenity House at least annually.
C. Coordinate the activity schedule with other patient services.

D. Maintain a current list of patients from the nursing staff who are not physically able to participate in activities.

E. Post the activity schedule conspicuously, in large visible print, for the information of patients and staff.

F. Request and maintain equipment and supplies.

G. Develop and maintain contacts with community agencies and organizations.

H. Develop and implement activities for patients unable to leave their rooms.

I. Maintain progress notes specific to the patient’s activity plan which is recorded at least quarterly in the patient’s health record.

J. Maintain a current record of the type and frequency of activities provided and the names of patients participating in each activity.

5. An activity plan shall be developed and implemented for each patient as part of the individual interdisciplinary patient care plan.

   A. Be reviewed and approved by the attending physician at least quarterly.

6. Activity program personnel with appropriate training and experience shall be available to meet the needs and interests of the patient.

   A. An activities program coordinator shall be designated by and be responsible to the administration.

   B. An activities program coordinator shall meet one of the following requirements:

      1. Have two (2) years experience in a social or recreational program within the past five (5) years, one (1) year of which was full-time in the patient activities program in a healthcare setting; or

      2. Be an occupational therapist, art therapist, music therapist, dance therapist, recreation therapist, or occupational therapy assistant; or

      3. Have satisfactorily completed at least thirty-six (36) hours of training in a course designed specifically for this position and approved by the Department of Public Health, and shall receive regular consultation from an occupational therapist, occupational therapy assistant or recreation therapist who has at least one (1) year of experience in a healthcare setting.

6. The designated activity area will meet the independent and group activity needs of patients.
A. The activity area will be accessible to wheelchair and ambulatory patients.

B. Per patient need or request, individual activities may be carried out in patient rooms or common areas.

8. Serenity House will provide equipment and supplies for both independent and group activities and for patients having special needs.

A. Equipment and supplies will be stored and maintained in a clean and orderly manner.
PATIENT VISITORS
Policy No. H: 2-118.1

PURPOSE
To establish a process for family and friends who visit Serenity House patients.

POLICY
To meet patient and family/caregiver needs for quality time spent together at Serenity House, Serenity House does not restrict visitors at any time unless so requested by the patient or ordered by the Serenity House physician.

PROCEDURE
1. Visitation is allowed twenty-four (24) hours a day, seven (7) days a week.
2. Visitors will check in at the reception desk and sign the Visitors log prior to entering a patient's room.
3. Staff assists in guiding restriction of visitors as requested/required for patient comfort and privacy.
4. Children must be closely supervised.
5. Staff’s access to and care of the patient is of primary importance and cannot be restricted by visitors.
6. Visitors exhibiting inappropriate behavior may be asked to leave and may be prohibited from visiting.
PERSONAL EFFECTS OF THE PATIENT
Policy No. H: 2-119.1

PURPOSE
To provide guidelines for staff to assist patients and families in caring for their personal effects upon admission to Serenity House.

POLICY
The Serenity House is not responsible for the patient's personal effects. The patient's valuables are inventoried and secured in the patient's room.

PROCEDURE
1. At admission, the family/caregiver is encouraged to take the patient's valuables home.

2. Any valuables not removed are inventoried and secured. Locked drawers are provided in each patient room.

3. Upon discharge, if belongings are found in the room, the patient's family/caregiver is notified.

4. Items will be held for up to two (2) weeks unless directed otherwise by the family/caregiver.

5. Items that are not picked up will be considered donations.
PURPOSE

To provide suitable accommodations for patient families/caregivers to remain with the patient throughout the night.

POLICY

Serenity House will make overnight accommodations available to the patient’s family/caregiver upon request.

PROCEDURE

1. Family/caregiver will make the request for overnight accommodations.

2. Sleeping accommodations will be provided in the patient’s room, along with a clean set of linens.

3. Overnight guests are expected to care for their own needs and must not restrict the staff’s access to the patient.
PURPOSE

To provide guidelines to inpatient staff on proper storage of clean linens and how often they should be changed.

POLICY

Serenity House shall store, handle and transport clean linen in a way that precludes cross-contamination.

PROCEDURE

1. Clean linens shall be stored in clean, ventilated closets, rooms or alcoves out of the flow of traffic.
   
   A. Clean linen not in covered storage shall be covered.

2. Linens shall not be threadbare and shall be maintained in good repair.

3. A quantity of essential clean linen shall be provided and available to meet the care needs and comfort of each patient.
PURPOSE

To establish a method to routinely keep all patient care and visitor areas clean and free of infection.

POLICY

The Serenity House housekeeper or designated staff will follow an established cleaning schedule to meet regulatory requirements and to maintain a sanitary environment. Schedules and procedures shall be posted which indicate the areas of the facility which shall be cleaned, daily, weekly or monthly. These schedules shall be implemented.

PROCEDURE

1. **Patient Rooms (Daily):**
   A. Wipe over bed table
   B. Empty waste can/replace liner
   C. Vacuum/dry mop

2. **Patient Rooms (Weekly):**
   A. Dust light fixtures
   B. Wipe night stands
   C. Dust furniture tops
   D. Dust television
   E. Clean window as needed
   F. Vacuum/mop (moving things to get into tight corners)
   G. Wipe, or vacuum reclining chair/furniture
   H. Thorough cleaning and disinfecting of patient rooms will be done at time of patient discharge
   I. Straighten patient patio area

3. **Patient Bathrooms (Daily):**
A. Clean mirrors
B. Clean sink, toilet bowl, and wipe down exterior
C. Refill Towels, toilet paper and soap
D. Empty waste basket/replace liner
E. Sweep floor – wet mop floor
F. Thorough cleaning and disinfecting of patient bathrooms will be done at time of patient discharge

4. Patient Bathrooms (Weekly):
A. Dust light fixtures – towel dispensers
B. Spot wash walls
C. Clean shower area after each use

5. Open Patient and Family Areas, Living Room (Daily):
A. Empty trash/replace liner
B. Men and Women’s (family) bathrooms will be thoroughly cleaned
C. Keep patio area and tables wiped down and clean

6. Open Patient and Family Areas, Living Room (Bi-weekly):
A. Vacuum carpet
B. Dust furniture
C. Spot wash walls and doors, tables
D. Wipe Windowsills

7. Kitchen and Dietary Storage Areas (Daily):
A. Floor sweeping and mopping
B. Clean sinks
C. Serenity House staff will inspect and document the refrigerator daily for temperature and expiration dates of food stored
D. Wipe down dining room tables daily
E. Sweep dining room floor daily

8. Kitchen and Dietary Storage Areas (Bi-weekly)
   A. Clean all equipment, large and small
   B. Wipe down all refrigerators, freezers, and ice machines

9. Kitchen and Dietary Storage Areas (6 months)
   A. Vents, hoods, and filters are thoroughly cleaned every six (6) months or more frequently as needed

10. Off Areas and Team Station (Daily)
    A. Empty waste basket/replace liner

11. Off Areas and Team Station (Weekly or as needed):
    A. Clean break room kitchen areas
    B. Sweep and mop floor, except for the Medication Room floor, which will be cleaned only during presence of licensed staff
    C. Medication Room counters will be cleaned by licensed staff

12. Off Areas and Team Station (Bi-weekly):
    A. Dust furniture
    B. Clean bathrooms

*Note: See Infection Control Policy for thorough cleaning instructions of patient areas.*
PURPOSE

To maintain a sufficient quantity of clean linen to meet the day to day needs and comfort of patients.

POLICY

Serenity House will contract with an outside laundry service to meet the Serenity House patients and staff needs. Small amounts of linen will be done by the Serenity House staff as needed to meet patient and facility needs. The laundry service shall meet the required standards of Federal, State and County agencies.

PROCEDURE

1. The contracted laundry will be maintained to:
   A. Have separate rooms for the storage of clean linen and soiled linen
   B. Have posted procedures for handling, storage, transportation and processing of linens in the laundry and shall be followed.

2. For laundry done in house
   A. The laundry room will be adequate in size, well light and ventilated.
   B. The laundry room will be located in relationship to other areas so that steam, odors, lint and objectionable noises do not disturb patients and staff.
   C. Laundry equipment will be suitable capacity, kept in good repair, and maintained in clean and sanitary condition.

3. Separate carts for soiled and clean linen constructed of washable materials shall be laundered or suitably cleansed as needed to maintain sanitation.
HANDLING OF DIRTY/SOILED LINEN
Policy No. H: 2-124.1

PURPOSE
To establish a method of properly handle dirty and soiled linen.

POLICY
Serenity House housekeeping and designated staff will handle, store, process, and transport soiled linen in such a manner as to prevent the spread of infection.

PROCEDURE
1. Standard and Transmission-Based Precautions will be followed in handling all soiled linen.
2. The assigned staff will change linen as often as necessary to maintain patient’s comfort.
3. Linen soiled with blood or body fluids shall be placed in a plastic bag to prevent leakage before being transported to the soiled linen room. (Note: Double bag is required if the outside of the bag is contaminated with blood or body fluids or if there is a possibility the bag will leak.)
4. Soiled linen shall be stored and transported in a closed container which does not permit airborne contamination of corridors and areas occupied by patients and precludes cross contamination of clean linen.
5. Soiled linen should be handled as little as possible. Always remove linen away from you to prevent contamination of your garment. Avoid shaking soiled linen to prevent contamination of the air.
6. All soiled linen must be bagged in the patient room. Bags must be securely sealed before being removed from the patient’s room and taken to the soiled linen room.
PURPOSE
To establish guidelines by which the inpatient facility will be routinely cleaned to prevent the spread of infection.

POLICY
To provide a safe and sanitary environment for patients, visitors, and personnel, Serenity House employees and contracted services will follow established cleaning policies and frequencies. Cleaning supplies and equipment shall be available to designated staff.

PROCEDURE
1. Cleaning supplies and equipment shall meet the following requirements:
   A. Supplies and equipment shall be stored in the janitor or housekeeping closets for appropriate staff.
      1. The closets, service sinks, and storage areas shall be clean and maintained to meet the needs of the facility.
   B. A commercial approved detergent germicide shall be used for all cleaning. Selected detergent germicides will be approved by the Serenity House Supervisor.
   C. Mop heads shall be removed and changed at least daily.
2. Cleaning Housekeeping Surfaces:
   A. Housekeeping surfaces require regular cleaning and removal of soil and dust. Housekeeping services will provide daily, weekly, bi-weekly and monthly cleaning services per established schedules and as needed
   B. Most non-patient area housekeeping surfaces need to be cleaned only with soap and water or a detergent-disinfectant, depending on the nature of the surface and the type and degree of contamination.
   C. Cleaning and disinfection schedules and methods vary according to the area of Serenity House, type of surface to be cleaned, and the amount and type of soil present.
      1. Established schedules for each area and type of cleaning will be maintained.
      2. Cleaning of surfaces with wiping or scrubbing for removal of microorganisms and soil is important in combination with the disinfectant/detergent.
3. Disinfectant/detergent formulations registered by the EPA will be used for environmental surface cleaning.
   
a. Manufacturers’ instructions will be followed.

4. Selection of registered cleaning agents will be made by the Serenity House supervisor based on OSHA requirements and EPA lists, cost, safety, product-surface compatibility, and acceptability by housekeeping. These will be approved by the Administrator or designee.

5. Material safety data sheets (MSDS) will be available to determine appropriate precautions to prevent hazardous conditions during product applications.

6. Personal protective equipment (PPE) will be used when appropriate during cleaning and housekeeping procedures (See Infection Control Policy).

3. Cleaning schedules will be established based on:
   
   A. Surfaces with minimal hand-contact (e.g. carpeted floors and ceilings).
   
   B. Surfaces with infrequent hand-contact (e.g. window sills and hard-surface flooring).
   
   C. Surfaces with frequent hand-contact (high-touch surfaces, e.g. doorknobs, bedrails, light switches, wall areas around the toilet).
   
   D. All areas will additionally be cleaned as needed.

4. Cleaning strategies are followed to minimize contamination of cleaning solutions and cleaning tools:
   
   A. Cleaning solutions in buckets will be replaced every three (3) rooms.
   
   B. Cleaning cloths and mop heads shall be changed or replaced at least daily.
   
   C. If laundered they will be allowed to dry before re-use.

   (See Infection Control Policies)

5. Cleaning Strategies for Spills of Blood and Body Substances:
   
   A. All spills of blood or body substances will be promptly removed and disinfected.
   
   B. EPA registered chemical germicide, that is ‘disinfectant’ and tuberculosical’ when used at recommended dilutions to decontaminate blood or body fluid spills will be used for all blood and body substance spills.
   
   C. Staff will utilize gloves and other personal protective equipment as appropriate (see Infection Control Policy).
D. Staff will clean small spills and then disinfect.

E. For large amounts of blood or bodily substances staff will first remove visible organic matter with absorbent material (e.g. disposable paper towels discarded to leak-proof, properly labeled containers) and then clean and decontaminate the area.

6. Carpeting and Cloth Furnishings:

A. Carpet cleaning equipment will be kept in good repair and allowed to dry between uses.

B. Vacuum cleaners shall be maintained to minimize dust dispersal in general, and be equipped with HEPA filters. Filters will be changed per manufacturers’ instructions.

C. Equipment that utilizes wet cleaning and extraction may serve as a reservoir for waterborne organisms and properly cleaning procedures will be used per manufacturers’ instructions.

D. Cleaning will be scheduled on a regular basis and documented.

E. Upholstered furniture will be vacuumed regularly per schedule to keep dust and allergens to a minimum.

F. If upholstered furniture in a patient’s room requires cleaning to remove visible soil, or body substance contamination, it will be moved to a maintenance area where it can be adequately cleaned with a process appropriate for the type of upholstery, and nature of the soil.

G. Spills of blood or bodily fluids will be cleaned immediately and dried completely within 72 hours (See Infection Control Policy).
PURPOSE

To provide guidelines for staff to ensure each patient is provided a clean, comfortable, and suitable bed.

POLICY

Fresh, clean linens will be available to each patient daily as needed at the Serenity House (SH).

PROCEDURE

1. Linen Service:
   A. Linen service will be provided by the staff at SH.
   B. Clean linen must be covered when transporting to a patient room.

2. Linen Storage:
   A. Clean linen is stored in the clean, dry and dust free areas.
   B. Clean linens are stored on a cart, in the clean linen closet, out of the flow of traffic.

3. Bed Make-up:
   A. General bed make-up shall consist of: a bottom sheet, draw sheet and pad as needed, pillow, pillow case, top sheet, and blanket.

4. Linen Change:
   A. Linens shall be changed as needed upon soiling and per patient/family request.
   B. Blankets and bedspreads will be changed when soiled, or upon patient/family request, and upon discharge.
   C. Dirty linens are placed in a covered container and/or bag until they can be brought to the soiled linen/utility area.

5. Pillows and Positioning:
   A. One pillow will be used for each patient bed.
   B. Additional pillows needed for positioning, patient request or for use by family/caregivers staying with the patient, may be obtained.
6. Blankets:
   A. Blankets will be supplied to patients who require additional warmth.
   B. Blankets will be provided upon request to family/caregivers who are staying with patient.

7. Bath Towels and Wash Cloths:
   A. A bath towel and wash cloth will be supplied to each patient.
   B. Additional bath towels and wash cloths will be supplied as needed for patient use.
   C. Soiled towels and washcloths are replaced in the patient’s bathroom daily and as needed.

8. Patient Discharge:
   A. When a patient is discharged, the linens will be stripped from the bed, placed in a plastic bag and placed in the dirty linen container.
   B. Removable/washable plastic pillow covers will be placed in the dirty linen container and replaced with a clean cover. Pillows not covered with plastic will be placed in a plastic bag and placed in the dirty linen container.
   C. SH staff will be notified of patient discharge and the room will be terminally cleaned before the next admission.
PURPOSE

To prevent the spread of infection or disease to other residents, personnel and visitors.

POLICY

Patient rooms will be cleaned and disinfected based on the principles of infection control.

PROCEDURE

1. Isolation categories are identified to caution the medical staff, nursing staff, housekeeping staff, other personnel and visitors that special care must be taken before entering the room.

2. Before entering an isolation room to clean, the housekeeper takes the following steps in order:
   
   A. Washes hands thoroughly
   B. Puts on a protective gown
   C. Puts on a protective facemask covering mouth and nose if necessary
   D. Puts on disposable gloves.
   E. Leaves the cleaning cart outside the doorway and takes only the supplies and equipment needed into the room.

3. After cleaning an isolation room:
   
   A. Discards any cleaning cloths into the trash in the room in appropriate bag
   B. Bags the mop head and send to the laundry in appropriate bag
   C. Washes the mop handle and other housekeeping equipment with cleanser-disinfectant solution
   D. Discards the gown in patient’s isolation laundry bag
   E. Places the mask in trash bag
   F. Removes gloves and discard in trash
   G. Washes hands thoroughly
4. Patient Rooms - terminal cleaning of an isolation room
   A. Follows above procedure.
   B. In addition, cleans and removes all medical equipment.
   C. Remove any unused linen and disposes of same in soiled linen cart.
   D. Nurse will dispose of any unused medical supplies.
SOLID AND INFEKTIOUS WASTE
Policy No. H: 2-128.1

PURPOSE

To reduce the risk of exposure to, and transmission of, infections while handling solid and infectious waste.

POLICY

In order to prevent transmission of communicable diseases at Serenity House, all solid and infectious waste materials will be handled and disposed of in accordance with the Hazardous Waste Control Law, Chapter 6.5, Division 20, Health & Safety Code, Section 25100, and any regulations adopted.

PROCEDURE


2. Employees and contracted staff will be trained in appropriate handling and disposal methods.
TEMPERATURE MONITORING AND REFRIGERATOR CLEANING

Policy No. H: 2-129.1

PURPOSE

To establish guidelines on the maintenance and cleanliness of medication and dietary refrigerators.

POLICY

Serenity House staff will monitor the temperature of the medication and dietary refrigerators to ensure proper storage temperature. The Serenity House staff will also monitor the temperature of the medication room to ensure proper storage temperature. The Serenity House staff will monitor the cleanliness of the refrigerators and clean refrigerators on a routine and PRN basis.

PROCEDURE

1. For drug storage, temperatures will remain within the following temperature guidelines:
   A. Refrigerator, 36 – 41 degrees F, Freezer < 0 degrees F
   B. Medication Room 59-86 degrees F
   C. Medication refrigerator temperature is checked daily and recorded on the temperature log.

2. Drugs shall be stored at appropriate temperatures. Drugs requiring refrigeration shall be stored in a separate refrigerator than food and stored between 36-41 degrees Fahrenheit.

3. Daily, Serenity House staff will check the food and medication refrigerators and write the results on the monitor sheet, indicate if any corrective actions were indicated and what actions taken, and sign his/her initials.

4. If temperature cannot be regulated with the temperature control device, the Serenity House Administrator will be notified.

5. The refrigerators will be emptied and cleaned as needed.

6. In the event of power failure, a generator automatically keeps refrigerated items at appropriate temperature.
Hospice Manual/revised February 2011

MEDICAL EQUIPMENT
Policy No. H: 2-130.1

PURPOSE

To establish a mechanism by which medical equipment is safely maintained and the spread of infection is prevented.

POLICY

To assure all medical equipment used for patient care is clean and safe, it will be inspected, cleaned and disinfected prior to patient contact, and routinely, and as needed during use.

PROCEDURE

1. Patients will be provided with durable medical equipment (DME) as needed.

2. DME will be clean and ready to use by patients or staff. Manufacturers care and maintenance instructions specific to their equipment will be followed.
   - Serenity House staff will inspect, clean and disinfect DME equipment stored at the house routinely and after each use.
   - Clean equipment will be tagged and dated as cleaned, and initialed by the person who cleaned it.
   - The DME vendors will be responsible for maintaining and decontaminating their equipment when needed. Dirty equipment that will be picked up by the vendor will be covered with a plastic bag and not stored near any clean items.
   - Equipment will be labeled with a current service inspection date.

3. The selection, delivery, set-up and maintenance of DME and oxygen is the responsibility of the Serenity House if the DME is supplied internally, and the responsibility of the contracted DME company if supplied from a contracted source.

4. Medical gas cylinders will be handled and stored safely. Oxygen H and E-cylinders will be delivered and maintained by DME contractor. Oxygen cylinders will be stored upright and the safely to prevent trajectory, or risk of spark fire.

5. The Serenity House Director, or designee assumes the responsibility for overseeing the instruction of staff on safe and appropriate use of DME, supplies, and oxygen. This process is achieved through orientation, annual safety and risk management in-services, and ongoing programs as needs are identified.
6. Non-critical, small medical equipment (stethoscopes, blood pressure cuffs, and equipment knobs and controls, etc.) in the absence of manufacturers’ instructions usually require cleansing followed by disinfection with alcohol.

   A. Alcohol evaporates quickly and should only be used on small surfaces

   B. CAUTION: Alcohol may cause discoloration, swelling, hardening, and cracking of rubber, certain plastics, and equipment lenses with repeated use.

7. Serenity House DME will be cleaned per manufacturers’ recommendations on a scheduled basis routinely by designated staff and as needed.

8. Barrier protection of surfaces and equipment should be used if these surfaces are touched frequently by gloved hands during the delivery of patient care, or likely to become contaminated with body substances, or are difficult to clean.

   A. Potential barriers: plastic wrap, aluminum foil or fluid resistant barriers or covers.

   B. Coverings should be removed and discarded while the health-care worker is still gloved.

   C. These areas will be cleaned before the next patient encounter.
MEDICAL EQUIPMENT MALFUNCTION
Policy No. H: 2-131.1

PURPOSE

To provide a mechanism by which faulty equipment is identified and handled.

POLICY

It is the policy of Serenity House to report and document any medical equipment malfunction and serious injury, illness, or death associated with any medical equipment (whether the equipment has malfunctioned or not).

PROCEDURE

1. Faulty equipment will be immediately removed from the patient care area and marked for repair or permanent removal as appropriate.

2. Personnel should report any medical equipment malfunction to the Serenity House Director.

3. The Serenity House Director and/or licensed nurse will be responsible for reporting the malfunction to the contracted DME equipment company, completing an Incident Report, and completing a ‘Safe Medical Device Act’ report.

4. The Medical Device Report will be forwarded to the appropriate agency and a copy will be provided to Performance Improvement Director.

5. The patient’s physician will be notified of any adverse effect upon the patient.

6. If the medical equipment malfunction or misuse results in serious injury, illness, or death (i.e., unusual occurrence, see Unusual Occurrence policy), the Serenity House Director, and Quality Director should be notified immediately. The Quality Director must report the illness, injury, or death in association with any medical device to the FDA within ten (10) working days of the event in order to be in compliance with the Safe Medical Devices Act of 1990 and the 1995 Final Rule requiring home health care compliance effective 7/31/96. The Quality Director will notify the CEO/President of VNHC.
CONSENT FOR USE OF PSYCHOTROPIC MEDICATIONS
Policy No. H: 2-132.1

PURPOSE

To establish guidelines, in the inpatient unit, for informed consent for the use of psychotropic medications.

POLICY

Psychotropic medication administration requires informed consent from the patient or DPOA. Informed consent is a process whereby the responsible physician provides information to the patient/DPOA in regard to the intended effects, potential side effects, risks, benefits and alternatives to psychotropic medications.

PROCEDURE

1. Patients have the right to informed consent and to refuse to use antipsychotic drugs, unless there is a judicial determination of their incapacity to make treatment decisions.

2. Prior to taking psychotropic medication, all patients or their DPOA are informed by their physician, about the actions and side effects of psychotropic medications.

3. Written materials regarding specific medications may be provided to the patient by nursing staff as part of the informed consent process.

4. At the time of admission, patients, already taking a familiar prescribed psychotropic medication and are willing to continue taking may continue to receive the medication with which he/she is familiar.

5. Informed consent may also be accomplished by telephone conversation between patient/DPOA and the responsible physician followed by the patient's/DPOA signature on the consent form.

6. NOTE: In an emergency situation, a patient may be given medications without prior consent.
PURPOSE

To meet workload demands, provide comfortable safe patient care, by meeting adequate staffing guidelines and delegation of assignments.

POLICY

Serenity House will provide 24-hour nursing services including sufficient staffing to meet the patient’s total nursing needs in accordance with the patient’s plan of care established by hospice, for treatments, medications, and diet as prescribed. A minimum of one (1) licensed registered nurse (RN), and one HHA who provides direct patient care, will be available during each shift; and the RN will be responsible for the supervision of nursing activities for patients under her/his care in the Serenity House.

PROCEDURE

1. RN will complete a comprehensive assessment of the patient and develop a plan of care, according to the Hospice Plan of Care Policy.

2. Assigning nursing personnel to patients based on needs and acuity:
   A. Nursing personnel shall be responsible for providing patient treatments, medications, and diet as prescribed;
   B. Nursing personnel shall be responsible for keeping each patient comfortable, clean, well-groomed and free of offensive odors, protected from accident, injury and infection;
   C. Nursing personnel will support the patient and family when they are in the dying process.

3. A licensed nurse will be responsible for:
   A. Make a patient assessment every shift to observe and evaluate the patient’s physical and emotional status; Clinical monitoring will be done once per shift;
   B. Notifying the physician if symptoms are not controlled and obtaining new orders;
   C. Reviewing medication orders for completeness of information, accuracy in the transcription of physician orders, and adherence to stop order policies;
   D. Ordering any new medications from the pharmacy;
   E. Administration of medications, including documenting reason for and effectiveness of PRN medications, and psychotropic monitoring;
F. Delegating responsibilities for the direct care of specific patients based on the physical arrangement of the facility, and the capability of staff;

G. Providing direct patient care as needed;

H. Complete and timely documentation of patient care;

I. Arranging time to allow for supervision and evaluation of performance of all nursing personnel on his/her team;

J. Recording intake and output for each patient as follows:
   1. If ordered by the physician
   2. For each patient with an indwelling catheter, unless otherwise ordered by the MD
   3. Intake and output records shall be evaluated at least weekly and each evaluation shall be included in the weekly note;
   4. After thirty (30) days, the patient shall be reevaluated by the licensed nurse to determine further need for the recording of intake and output.

K. Keeping the Serenity House Director informed of the status of patients and related matters through written and verbal communication.

4. All clinical staff will be responsible for answering patient calls promptly.

5. Each patient shall be provided visual privacy during treatments and personal care.
PATIENT BATHING WITH PACIFIC SPA TUB
Policy No. H:2-134.1

PURPOSE
To insure proper use and safety of the Pacific Spa Tub; by following manufacturer's guidelines.

POLICY
Serenity House staff will be properly trained and signed off before using the Pacific Spa Tub for patients. Staff will follow the procedures and guidelines to ensure that patient safety is maintained. The Spa tub is for patient use only.

PROCEDURE

System Preparation (Before Bath)
Prior to the bath, perform the following preparation steps:

Note: Check the level of bath oil, shampoo, and disinfectant concentrate in the supply bottles daily to ensure that adequate amounts are available for the day’s bathing requirements. These bottles are located inside the top lid on the Pacific Bath Tub Panel. Replace a bottle before it runs out to avoid re-priming the system.

1. Press the tub height “DOWN” - button # 7 - and lower the Pacific Tub to its lowest position.
2. Place the drain plug in the drain.
3. Press the tub fill “ON” -button # 4 -to begin filling the tub.
4. Monitor the water temperature by watching the Fill/Shower WaterTemperature - Readout #2. Adjust the water temperature by turning the Temperature Control Knob # 1 to a normal bathing temperature, 95 to 105 degrees Fahrenheit. (Also available in Centigrade.)

WARNING
In addition to monitoring the temperature readout, always check the water temperature by allowing it to run over your wrist. Failure to do this could result in a hot-water burn to the resident.

5. Fill the tub to approximately 5 inches below the overflow plate. This will normally result in the water rising to an appropriate level as the resident is lowered into the bath. Less water may be used pending evaluation of the candidate being bathed to achieve less submersion.

Note: The Pacific Bath System is a large capacity tub. Fill only to the level required to obtain the desired submersion determined by the type of resident you are bathing.

6. (Still Bath Systems) Will not have the controls related to any water action.
WARNING
Do not overfill, splash, or spill water on the floor. Water on the floor could result in injury to the operator or resident.

7. When filled, press the Fill Button again to stop the water flow. DO NOT start the water action until the resident is transferred into the tub.

8. Make sure you have all of your bathing supplies ready, such as a washcloth and towels.

You are now ready to transfer the resident from the bed to the bath. To do so:

9. Push the Stretcher/Transfer Lift to the resident’s bed and position it for a normal bed-to-stretcher-transfer position.

10. Lock the brakes by stepping down on the lock-arm tab located on the back of the rear casters as shown.

WARNING
Failure to lock the caster brakes before the resident is transferred into the Stretcher/Transfer Lift could result in injury to the operator or resident.

Transfer from Bath to Bed

11. Transfer the resident into the Stretcher/Transfer Lift using the proper nursing transfer techniques. Place the three safety belts, one across the upper body, one across the midsection, and one across the lower body. Secure all belts to the proper attaching points on the stretcher as shown below. Adjust the incline of the Stretcher/Transfer based on the resident’s size and level of water in the tub.

WARNING
The Stretcher/Transfer is pictured below in the first incline position. You may need to raise the level of the stretcher/Transfer to the second or third incline position based on the resident’s size and level of water in the tub. Adjust the incline BEFORE the resident has been transferred into the Pacific Bath. Failure to ensure the resident’s head is above water level, could result in injury to the resident or patient.

WARNING
Failure to ensure that the resident is properly secured in the Stretcher/Transfer Lift before being transferred, could result in injury to the operator or resident.

Transferring the resident at the Bath Station

12. Lower the Stretcher/Transfer Lift to the lowest position, unlock the casters, and carefully push the Stretcher/Transfer Lift to the bathing area, being careful to avoid uneven floors and objects in hallways.
13. At the bathing area, position the Stretcher/Transfer Lift on the side of the Bathing System near the side of the tub, with the resident’s feet towards the control panel.

14. Lock the casters once again on the Stretcher/Transfer Lift. Push the UP button, on the hand control of the Stretcher/Transfer Lift, and slowly raise the resident to a height that will clear the top edge of the tub when it is in its lowest position. Always watch for objects that may interfere or obstruct the Stretcher/Transfer Lift operation.

**WARNING**
Do not allow the resident to interfere with the operation of the Stretcher/Transfer Lift while operating the equipment. Do not allow garments, towels, and other foreign objects to interfere with its operation. Ensure the resident is belted properly at all times with all limbs kept inside the Stretcher area near the resident’s body. Failure to take these precautions could result in injury to the resident or operator.

15. Once at the correct height to clear the tub, unlock the casters and carefully push the Stretcher/Transfer Lift towards the tub until the Stretcher is located over the Bathing system. Ensure the legs of the Stretcher/Transfer Lift clear the tub legs underneath the tub while pushing the unit in.

16. Lock the casters once again and you are now ready to lower the resident into the Bath or raise the Pacific Bathing system up to the Stretcher/Transfer Lift whichever is safest for the resident and operator.

**Transferring the resident into the Pacific Bath**

**WARNING**
When using the Pacific Height Adjustable Bath System, in conjunction with the Stretcher/Transfer Lift, caution must be used when raising or lowering the units. Do not raise or lower the Stretcher/Transfer Lift without consideration of the height of the bathing system. Always ensure that all limbs are inside the Stretcher area near the body and all objects clear. Failure to take these precautions could result in injury to the resident or operator. Failure to take these precautions could also result in damage to either the Bathing system and/or the Stretcher/Transfer Lift.

17. Before raising the Pacific Bath, ensure that all limbs are inside the Stretcher so that the limbs don’t get pinched between the tub rim and the bottom of the Stretcher frame. Raise the Pacific Bath button #6 to height that is ergonomically correct for you to bathe the resident. Always be aware of the height of the Stretcher/Transfer Lift to ensure they do not hit each other or that objects get caught between the tub rim and the bottom of the Stretcher frame.

18. Lower the Stretcher/Transfer Lift into the tub until the resident is submersed to a safe and correct depth into the water. ENSURE THAT THE RESIDENT’S HEAD REMAINS ABOVE WATER AT ALL TIMES. Always be aware of the resident’s limbs and anything that may obstruct the lowering of the Stretcher/Transfer Lift and/or raising of the Pacific Bath.
**NOTE:** The Stretcher/Transfer Lift is equipped with a RED EMERGENCY STOP button which can be pushed at any time to stop the Stretcher/Transfer Lift from raising and/or lowering.

**Bathing Procedure**

1. You are now ready to begin washing the resident. The suggested bathing time is 5 to 10 minutes. Bathing a resident more than 10 minutes is not recommended.

2. To bathe the resident, use the following procedures:

3. Start the Aqua-Aire (Aqua-Aire tubs) by pressing the on/off Button #8. Procedures applying to any water action do not apply to the (Still Bath System).

4. Push the Bath Oil Pump Plunger #13 to add Penner’s Bath Oil to the water. The amount of bath oil will vary according to the resident’s skin condition. (One push of the Bath oil pump plunger will dispense approximately 1 oz of bath oil.)

**Note.** Penner Bath Oil is a non-aqueous, liquid bathing oil containing refined lanolin similar to natural skin oil. When combined with water, Penner Bath Oil can penetrate the skin. This combination of water and oil restores moisture to the resident’s skin and benefits the nursing attendant, whose hands are frequently in water as well. Additionally, the use of Penner Shampoo & Body Wash eliminates the risk of cross-contamination, which can result from sharing a single bar of soap. Penner Shampoo & Body Wash works with the bubble aeration of the system to clean and condition the skin.

5. Bathe the resident’s upper body as follows:

   A. Push the Shampoo Pump Plunger #14 and dispense (from shampoo dispensing spout) into your hand or into a washcloth. Then apply the Penner Shampoo & Body Wash directly to the resident’s body.

   B. Begin gently washing the resident’s upper body. Pay special attention to folds or creases in the skin and under the arms. If the scalp is flaky, apply a small amount of Penner Bath Oil to the problem area and let it soak in until time for shampoo.

6. Rinse the upper body with the shower sprayer as follows:

   A. Pick up the hand-held shower sprayer located on the right side of the control panel.

   B. Ensure that the shower sprayer trigger is NOT engaged when you activate the shower sprayer. Press the Shower Button #12 to activate the shower sprayer.

**WARNING**

Never place the shower sprayer submerged in the bath water. Always replace it on the side of the control panel in it’s holder. Failure to do so could result in contamination of the facility water system, which may result in a health hazard.
Note. Once the shower sprayer is activated, it will stay activated for a period of time and then automatically shut off. This time period (up to 10 minutes) is adjustable by maintenance personnel only. The shower sprayer will shut off when releasing the trigger.

C. While pointing the sprayer into the tub, not onto the resident, press the shower sprayer trigger.

D. Adjust the water temperature by turning the Temperature Control Knob #1 to the normal bathing range of 95 to 105 degrees Fahrenheit (or Centigrade) as shown below. Monitor the temperature by viewing the Fill/Shower Temperature Readout #2. As a further precaution, always test the water on the inside of your wrist before turning the sprayer toward the resident.

E. Repeat the washing and rinsing steps for the upper body a second time.

7. Bathe the resident’s perineal area as follows:
   Lift the resident’s right leg and let the Aqua-Aire bubbling action; wash the perineal area. This technique protects the resident’s dignity and removes any residual waste or fecal matter.

8. The resident’s feet will be cleaned by the Aqua-Aire bubbling action) at the bottom of the tub. For Still Baths and extremely soiled feet, use the following procedure:
   A. Raise the Stretcher/Transfer Lift seat until the resident’s feet are at the same level as the outlet.
   B. Hold the feet in the stream for 30 to 60 seconds.

9. To shampoo the resident’s hair, use the following procedure:
   A. Wet the resident’s hair with the shower sprayer.
   B. Push the Shampoo Pump Plunger #11 and apply a small amount of Penner Shampoo to the wet hair.

Note. Penner Shampoo & Body Wash is a special formula with lanolin for use with residents who have dry scalp and/or skin conditions. Penner Shampoo special conditioning formula assures that all residues will be removed quickly and easily, leaving hair clean, conditioned, and shining.

C. Massage the resident’s head to create a lather. Continue the massage to fully clean the hair and scalp.
D. Rinse with the shower sprayer.
E. Shampoo and rinse a second time if required.

Transferring from Bath to Bed
Transfer the resident back to the bed as follows:
WARNING
When raising the resident out of the water with the Stretcher/Transfer Lift, or lowering the Pacific Bath, ensure that all limbs are inside the Stretcher area near the body and all objects clear. Ensure the feet clear the control panel area at all times. Push the “EMERGENCY STOP” button at any time to stop the Stretcher/Transfer Lift from raising and/or lowering. Failure to take these precautions could result in injury to the resident or operator. Failure to take these precautions could also result in damage to either the Pacific Tub and/or the Stretcher/Transfer Lift.

1. Turn off the Aqua-Aire button # 8, and remove the drain plug.

2. Push the “Down” Button #14 on the Pacific Bath lowering it to its lowest position. Ensure the resident’s feet clear the control panel area.

3. If the bottom of the Stretcher/Transfer Lift will not clear the rim of the Pacific Bath, raise or adjust the height of the Stretcher/Transfer Lift to clear the rail two inches.

4. Rinse the resident’s body with the shower sprayer.

5. Pat the resident dry with a soft towel. No rubbing is necessary.

6. Use the towel to dry and clean the underside of the chair. This will prevent water from dripping on the floor and residue buildup under the seat.

7. Before you move the resident out of the tub, make sure the lower extremities have been towel dried so the bathroom floor stays dry. Unlock the casters of the Stretcher/Transfer Lift and slowly move it away from the Pacific Tub then lock the casters again

   Note. This is an excellent time to give the resident a pedicure, if needed. The resident is at a convenient working level and the nails are now soft and easily trimmed and cleaned.

8. Unlock the casters and position the Stretcher/Transfer Lift in a clear area then push the “DOWN” Button until it is at its lowest position.

9. Ensure all three belts are properly secured on the Stretcher/Transfer Lift. You may now push the resident back to the bed being careful to avoid uneven floors and objects in hallways.

10. Position the Stretcher/Transfer Lift beside the bed and lock the casters once again.

11. Release all three belts from the resident and transfer the resident to the bed using proper nursing techniques.

12. With the Stretcher/Transfer Lift now empty, unlock the casters and return it to the bathing area for cleaning.
13. Raise the Stretcher/Transfer Lift to clear the edge of the Pacific Tub which is still in its lowest position. Move the Stretcher/Transfer Lift over the Pacific Tub, then lower into the Pacific Tub for cleaning and disinfecting.

System Cleaning (After Every Bath)
Clean and disinfect the Pacific Tub and Stretcher/Transfer Lift after every bath with Penner Cleaner/Disinfectant as follows:

Note. Penner Cleaner/Disinfectant is a special non-abrasive cleaning and disinfecting solution that will not harm the tub’s fiberglass surface. Penner Cleaner/Disinfectant is the only cleaning solution designed and recommended for use with your Pacific Tub.

CAUTION
Some cleaners, disinfectants, and floor strippers contain ingredients that are corrosive or abrasive. These solutions or compounds may contain chlorine, acid, basic ingredients or abrasives. DO NOT allow such solutions or compounds to come in contact with your Penner equipment. Failure to heed this caution could result in damage to the equipment and void the warranty.

1. Drain the water from the tub.

2. Remove visible tissue residue or fluids before disinfection

3. Press the Shower Button and rinse the inside surfaces with the shower sprayer

   Note: Penner Cleaner/Disinfectant is a special non-abrasive cleaning disinfecting solution that will not harm the tub’s fiberglass surface. Penner Cleaner/Disinfectant is the only cleaning solution designed and recommended for use with your Pacific Bathing System.

WARNING
Housekeeping personnel should wear protective glasses and gloves to prevent disinfectant from damaging their eyes or skin. If disinfectant gets on the skin or in the eyes, rinse thoroughly with plenty of water. Seek medical advice if irritation occurs.

4. (For Aqua-Aire Tubs) Press and hold the Disinfect Button #2 located on the left side of the tub. As the button is held down, the properly mixed cleaning solution is running through the air injection system and out all of the air jets. Release the button after you see solution coming out of all the air jets and you have 1 to 1 1/2 gallons of disinfectant solution in the foot well of the tub.

5. (For all Systems and Still Bath) Using a long-handled brush (available from your Penner distributor) to thoroughly scrub all interior surfaces of the tub with the solution that remains in the foot well of the tub.

6. Push the “DISINFECT SPRAY BUTTON” #1. Using the disinfect hand sprayer and spray the entire stretcher portion of the Stretcher/Transfer Lift.
7. Using a long-handled brush (available from your Penner distributor) to thoroughly scrub all surfaces of the Stretcher/Transfer Lift with the solution from the hand sprayer.

8. Allow for proper disinfectant contact time (usually 10 minutes or as recommended by the disinfectant's manufacturer).

9. Remove the plug from the drain.

10. **(For Aqua-Aire tubs)** Spray water from the shower sprayer to rinse out most of the disinfecting solution. Then press and hold the rinse button (#9) until you see clear water (not soapy) coming out of the air jets. Release the rinse button.

11. Finish rinsing the interior surfaces of the Pacific Bath and all surfaces of the Stretcher/Transfer Lift with the shower sprayer.

12. Start the air blower by pushing the Aqua-Aire Button #8. Allow it to run for 30 seconds. This pushes the rinse water out of the air injection system. If this was the last bath of the day, allow the blower to run for 2 minutes to dry out the system.

13. Stop the air blower by again pushing the Aqua-Aire button #8.

**Daily Maintenance**

To properly maintain the Pacific Recumbent Height Adjustable Bath System, perform the following daily maintenance procedures.

1. Check that there is an adequate supply of system liquids such as shampoo, bath oil, and disinfectant concentrate in the supply bottles located behind the small access door on the left side of the tub (right-hand side on Aqua-Aire tubs). Replace the bottles before they are empty to avoid re-priming the system. Be sure each bottle label matches the label found on the hose to which the bottle is attached.

**WARNING**

While replacing system liquids, housekeeping personnel should wear protective glasses and gloves to prevent disinfectant concentrate from damaging their eyes or skin. If disinfectant gets on the skin or in the eyes, rinse thoroughly with plenty of water. Seek medical advice if irritation occurs.

2. Perform the Daily Safety Checklist described in the following section before using the Pacific Bathing System.

**WARNING**

Failure to perform the daily safety checks and take corrective action, when required, prior to the operation of the equipment each day could result in injury to the resident or operator.
WARNING
If any part of the system is not functioning properly, cease all bathing activities until the problem is corrected by maintenance. The system must be maintained on a scheduled basis to ensure it is functioning properly. Failure to heed these precautions could result in injury to the resident or operator.

Daily Safety Checklist
CHECK THE FOLLOWING ITEMS EACH DAY BEFORE USING YOUR PACIFIC RECUMBENT HEIGHT ADJUSTABLE BATH 9700. DOCUMENT YOUR FINDINGS DAILY.

Perform the following safety checks for the Pacific Bath:

1. High temperature limit – Press the Fill Button #5 and turn the Temperature Control Knob #7 all the way to the left to the highest setting. Test the fill and shower water temperature to ensure that it reaches no more than 115 degrees Fahrenheit (lower if required by local regulations).

2. Temperature Read-Out Accuracy – Press the Fill Button #5 and adjust the temperature of the water to the normal bathing range of 95 to 105 degrees Fahrenheit. Test the temperature of the water with a thermometer and by letting the water flow over your wrist. The water temperature should be consistent with the thermometer reading and should not feel too hot or too cold.

3. Check the Actuator operation by raising and lowering the Pacific Tub insuring a smooth motion with no grinding, binding, or rubbing anywhere.

Penner Stretcher/Transfer Lift
Perform the following safety check on the Stretcher/Transfer Lift.

1. Batteries – Check that the batteries are fully charged (Lift operates normally).

2. Emergency Stop Button – Check that while the Stretcher/Transfer Lift is being raised or lowered, pushing the Red Emergency Stop Button stops the Stretcher/Transfer Lift from raising or lowering.

3. Overload Cut-off – Check that while the Stretcher/Transfer is being lowered, you can lift the stretcher from the bottom of the stretcher frame and stop the downward motion.

4. Seat Belts (Three) – Check the condition of the seat belt(s) for signs of excessive wear. Also, check the fastening holes on the belts for tearing or excessive enlargement.

5. Casters – Check the casters for tightness and lint build up.

6. Welds – Inspect all welds for cracks, rusting, and damage.
WARNING
If during the safety checks you find parts are missing, are excessively worn, do not function properly, or do not meet the recommended safe operating levels, do not operate the equipment until the maintenance department has taken the appropriate corrective action.

Your Penner Distributor and his personnel are trained to provide in-service instruction and maintenance on your Pacific Recumbent Height Adjustable Bath System 9700. If you have any questions about the operation or maintenance of your Pacific Bath System, please contact your Penner Distributor. For your nearest Penner distributor, contact resident Care, Inc. at:

1-866-736-6377 OR 1-800-732-0717
HANDLING AND DELIVERY OF MEDICATIONS
Policy No. H: 2-135.1

PURPOSE

To ensure the proper handling of all medications that are delivered to the Inpatient Unit.

POLICY

Only licensed nurses will accept delivery of medications from the pharmacy; and have access to medications in the inpatient unit.

PROCEDURE

1. All medications that are delivered from the pharmacy will be received by licensed nurses only.

2. Medications that are brought to the inpatient unit by patient / family when being transferred into the inpatient unit will also be handled by licensed nurses only.

3. The licensed nurse will review all incoming medications from either the pharmacy or the patient and determine that the correct medications have been delivered & or accepted from patient; and that there are current orders for each medication.

4. All medications will be placed in the medication cart immediately or in the medication room; and the room will remain locked at all times.

5. Only licensed nurses will have to have access to the medication room and medication carts.
PURPOSE

To provide staffing and hygiene guidelines to dietary staff and volunteers.

POLICY

Serenity House Dietary department shall maintain adequate staffing and follow established standards of personal hygiene and cleanliness.

“Dietetic Service” means a service organized, staffed, and equipped to assure that food service to patients is safe, appetizing, and provides for their nutritional needs.

PROCEDURE

1. A dietician shall be employed part-time or on a consulting basis. The part-time or consultant dietician shall be on the premises on a regularly scheduled basis. A written record of the dietician's visits shall be maintained in the patient's record.

2. Sufficient staff/volunteers shall be employed, orientated trained and their working hours scheduled to provide for the nutritional needs of the patients and to maintain the dietetic service area.

3. Dietetic personnel shall be trained in basic food sanitation techniques.

4. Proper hand washing is observed by all employees and volunteers before starting work, after utilizing rest rooms, after handling garbage and at other times when hands have been soiled.

5. A sign explaining proper hand washing technique will be displayed above the hand washing sink in the kitchen.

6. Gloves must be worn:
   A. When handling articles that may be contaminated with secretions.
   B. When stripping a meal tray.
   C. When preparing food that hasn't been previously cooked (including fruits and vegetables).
   D. While preparing sandwiches.
7. Dietary staff shall wear clean clothing, with hair pulled back tightly or a hair net or cap such that all loose hair is secured. Beards and mustaches which are not closely cropped and neatly trimmed shall be covered.

8. Any Dietary Department staff/volunteer who is infected with a communicable disease, or who is a carrier of organisms that cause such a disease or has boils, infected wounds and cuts will not work in the dietary department until they are free of that disease or condition.

9. Dietary cleaning supplies and equipment are maintained for exclusive use in the kitchen and dining areas.
### Section Three

**Human, Financial, and Physical Resources**

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**Note:**

Job Descriptions can be found in Section 6 of this manual.

Clinical Competency Assessment Skills Checklists can be found as Appendices at the end of Section 6 of this manual.

*Requires state or organization-specific information.
PURPOSE
To ensure that the hospice program maintains adequate human resources to meet caseload demands.

POLICY
The hospice program will recruit and retain qualified personnel. Documentation of these efforts will be evidenced in the hospice personnel and health record for each employee hired by the organization.

Personnel will be selected based on qualifications, education, experience, specialized training, communication and interpersonal skills, sensitivity to issues of loss and grief, and ability to deal effectively with the demand of the job, in accordance with job description requirements.

PROCEDURE
1. Professional personnel recruited and hired by Visiting Nurse & Hospice Care will be graduates of schools approved or accredited by their respective professional organizations.

2. Pre-employment interviews will be conducted and documented with a copy retained in the personnel file.

3. Prior to hire, the organization will secure multiple reference checks, health reports as required by the state or policy, criminal record checks when required by law, and proof of citizenship or documentation of resident status.

4. Professional personnel will submit copies of their diplomas or transcripts showing successful completion of the approved/accredited programs. The copies will be retained in the individual’s personnel file.

5. Clinical personnel will maintain active licensure or certification. Verification of current licensure or certification will be filed in the personnel record.

6. All new employees will complete an orientation program including but not limited to:
   A. Review of policies and procedures
   B. Position responsibilities and limitations
C. Ethics and confidentiality

D. Communication techniques

E. Supervision process

F. Safety

G. Infection control

H. Patient rights

I. Responding to emergencies

J. Documentation

K. Role of the health team

(See “Orientation” Policy No. C:3-020.)

7. Completion of the orientation process will be documented in the personnel record.

8. Clinical competencies will be assessed during the orientation process and annually thereafter for professional and paraprofessional personnel providing direct patient care. Competency assessments will be documented and retained in the personnel file. (See “Competency Program” Policy No. C:3-023 and the “Initial Competency Assessment Skills Checklists” in Hospice Section Six.)

9. All staff will receive an annual performance evaluation. (See “Performance Evaluations” Policy No. C:3-019.)
PURPOSE
To ensure that staffing guidelines adequately meet workload demands.

POLICY
Staffing guidelines will be developed and implemented to adequately meet caseload demands on a 24-hour basis.

PROCEDURE
1. Hospice employees will substantially provide all core services.
2. Volunteers will be defined as employees.
3. Supervisors and staff will comply with the current organizational staffing guidelines.
4. Staffing assignments will be determined and documented by the Clinical Supervisor or designee.
5. Visit schedules will be written and available to Case Managers.
6. A mechanism will be developed and maintained to supplement staff during peak caseloads or unanticipated or extraordinary circumstances.
7. Hospice paraprofessional personnel will be selected based on the requirements of the job descriptions and will include at least:
   A. Experience
   B. Training
   C. Communication and interpersonal skills
   D. Ability to deal effectively with the demands of the job and the population service
   E. Ability to work without constant direct supervision
   F. Ability to read written communication
   G. Satisfactory criminal record check when mandated by state regulation
PURPOSE

To ensure that there is a process for the selection of a qualified individual for overseeing all clinical care and services.

POLICY

Nursing and hospice aide services will be under the supervision of a registered nurse who has at least two (2) years of hospice or community based health care experience.

Supervision of clinical care and services will be available 24 hours a day, seven (7) days a week.

Supervisor-to-patient care personnel ratios will depend on the acuity level of the patients and case-mix, and will be in compliance with applicable law or regulation.

The Clinical Director will be responsible for the clinical direction of the organization and take reasonable steps to assure that:

1. Services are available.
2. Care and services provided by organization personnel and contracted organization personnel are coordinated and integrated.
3. Policies and procedures, which guide and support the provision of care and services, are developed and implemented.
4. Recommendations for required resources are made.

The Clinical Director will be qualified and possess appropriate clinical training and experience, as verified by:

1. Education, training, and previous work experience
2. Current professional licensure
3. Interview for understanding of care and service being provided as well as population being served
4. Management experience and clinical knowledge
PROCEDURE

1. The Clinical Director will oversee the day-to-day clinical operations.

2. On a daily basis, staffing will be reviewed in combination with the patient census, acuity, etc.
   
   A. If staffing is problematic, the Clinical Director, in coordination with the Clinical Supervisors, will review options, which include but will not be limited to:
      
      1. Use of outside contracted organization personnel
      2. Use of overtime by organization personnel
      3. Use of office nursing personnel (i.e., Clinical Supervisor, intake, QAPI nurses, etc.)
   
   B. Any issue not resolved will be brought to the attention of the Executive Director/Administrator.

3. The Clinical Director will monitor the care and service provided by organization personnel and contract personnel. Monitoring includes the review of quality assurance performance improvement results, incident reports, infection reports, clinical record review results, etc. Any noted trends of individual performance will be used during the evaluation process.

4. The Clinical Director will participate as a member of the following:
   
   A. Senior Management Team
   B. Professional Advisory Committee
   C. Clinical Operations Committee
   D. Quality Assessment Performance Improvement Committee

5. Recommendations regarding resources (personnel and other) and services will be made to the Executive Director/Administrator as well as at the appropriate committee.

6. The Clinical Director will have access to qualified clinical consultation for services outside his/her expertise, through the use of the Medical Director and other resources as appropriate.
7. The Clinical Director will assure that the following supervision is maintained within the organization:

A. Hospice aides, personal care and environmental support/chore service workers:
   1. Hospice aide supervisory visits will be conducted on site at least every two (2) weeks by a hospice registered nurse. Supervisory visits can be made in conjunction with the hospice aide or in his/her absence. A direct observation supervisory visit will be made at least every six (6) months.
   2. Patients receiving personal care services will be contacted monthly, and a direct observation supervisory visit will be completed on site every 60 days.
   3. Patients receiving environmental support/chore services will be contacted every 60 days, and a direct observation supervisory visit will be completed on site annually.

B. A monthly patient visit will be completed by a registered nurse to supervise licensed practical/vocational nursing services. More frequent supervision may be required per state regulations.

C. Physical therapy and occupational assistants:
   1. Physical therapy assistant services will be supervised by a physical therapist, and certified occupational therapy assistant services will be supervised by an occupational therapist via a patient visit at least monthly. At the discretion of the physical/occupational therapist, supervisory visits may be made in conjunction with the therapy assistant. A direct observation supervisory visit will be made at least every six (6) months or as directed by the state practice act, whichever is more frequent.

D. Supervisory visits will be made more often if indicated by patient's and/or organization personnel's need.

E. Supervisory contacts and visits will be documented, dated, and signed by the supervising professional.

F. Clinical personnel that report to a supervisor of a different discipline will have the opportunity for consultation and review with a professional manager in their discipline to ensure adherence to and accountability for professional standards of clinical practice.
PURPOSE
To ensure that qualified personnel direct patient care.

POLICY
All skilled nursing and other therapeutic services will be provided under the supervision or direction of a qualified Clinical Supervisor or designee.

Clinical supervisors will possess professional education, a current professional license, and a minimum of two (2) years of hospice experience (preferred).

PROCEDURE
1. A registered nurse will be available on the premises or by telephone/electronic paging 24 hours a day.

2. The Clinical Supervisor or designee will be available for consultation 24 hours a day via an electronic paging system. The process for contacting the designated Clinical Supervisor will be reviewed during personnel orientation.

3. A registered nurse (or therapist, when appropriate) will be available whenever hospice aide services are provided. Hospice aide services will be supervised every fourteen (14) days.

4. All clinicians will be observed in the home by a Clinical Supervisor at least once per year.

5. A summary of the field supervisory visits will be documented utilizing an observation tool. The results will be shared with the clinician, and a copy will be retained in the personnel file.

6. If services are contracted from another organization, that organization will be expected to comply with Visiting Nurse & Hospice Care’s personnel supervision policies.

7. Supervision of patients who are not patients of the organization and whose services are provided through a contract with another organization will be in accordance with the contracting organization’s plan of care and contract.

8. When a Clinical Supervisor does not have experience related to the clinical specialty area, he/she will consult with the Clinical Director, Executive Director/Administrator, or an appropriate supervisory consultant. (See “Access to Qualified Consultation” Policy No. H:3-006.)
Purpose

To define the expectation of orienting hospice personnel to assigned responsibilities.

Policy

All hospice personnel will be oriented to the physical, psychosocial, and environmental aspects of care, including patient needs, Visiting Nurse & Hospice Care personnel's specific responsibilities, and specific care they are to provide. This orientation may include verbal or written instruction and/or demonstration. The orientation to assigned responsibilities will occur on site, when appropriate, but minimally, on the telephone prior to caring for the patient.

Procedure

Hospice Aides

1. The personal care and support services provided will be based on the initial, comprehensive and ongoing comprehensive assessments of patient needs as conducted by the interdisciplinary team.
   
   A. The Case Manager will be responsible for the initial assessment and assignment of the hospice aide.
   
   B. The functional status, psychological status, and availability of able and willing support are considered in determining the frequency of visits and plan of care.

2. The hospice aide will understand the duties to be performed and the arrangements for providing services as stated in the plan of care.
   
   A. An orientation or placement visit will be scheduled in the patient's home by the Case Manager, whenever feasible.
   
   B. A hospice aide assignment sheet will be completed, reviewed with the hospice aide, and signed by both the clinician and hospice aide. Return demonstration will be requested as appropriate.

3. Each patient will receive care in accordance with the plan of care and related instructions.
A. The hospice aide assignment sheet will correlate with the orders on the plan of care.

B. The hospice aide will complete a hospice aide clinical note on each patient. This will be returned to the hospice office and incorporated in the clinical record.

C. When a health problem is identified or a significant change in a patient's physical condition is noted, the hospice aide will report such to the Case Manager and/or a Clinical Supervisor in the office.

4. When a change in hospice aide or substitution of hospice aide is required:

A. Orientation will occur on site unless hospice personnel are already familiar with the patient.

B. The Clinical Supervisor will document the change of hospice aide in the clinical record on a clinical note.

Professional Hospice Personnel

1. Professional hospice personnel (RN, LVN/LVN, PT, OT, ST, SW, and Medical Director) will receive initial information of patients from the referral and intake form.

2. Any questions regarding care will be communicated and clarified with the Clinical Supervisor or designee.

3. Individuals possessing appropriate clinical training, experience, and evaluation in a clinical specialty area (e.g., oncology, neurology, etc.), in identified clinical settings (e.g., university medical centers, teaching institutions, etc.), will be consulted when a question concerning clinical specialty and/or practice arises. If appropriate, these individuals will provide an orientation, in the home, to the professional hospice personnel.

4. Orientation in the patient's home may be necessary when the newly assigned hospice personnel has not had previous hospice experience or experience with a particular procedure, treatment, or equipment.
PURPOSE
To ensure for the provision of a qualified consultant when a question related to a clinical specialty area arises.

POLICY
Individuals possessing appropriate clinical training, experience, and evaluation in a clinical specialty area (e.g., pharmacy, psychiatry, or oncology), in identified clinical settings (e.g., university medical centers, teaching institutions, hospitals, etc.), will be consulted when a question concerning clinical specialty and/or practice arises.

The organization will maintain a system for accessing consultation with a qualified individual whenever a Clinical Supervisor does not have the appropriate clinical training and/or experience for a clinical specialty area.

PROCEDURE
1. The Case Manager will notify the Clinical Supervisor of the need for clinical consultation.
2. Whenever a Clinical Supervisor is confronted with a patient situation out of his/her area of expertise, the Clinical Supervisor may:
   A. Contact the Medical Director
   B. Contact organization personnel who have the clinical experience/expertise
   C. Contact another organization whose Clinical Supervisors have the clinical experience/expertise
   D. Contact specialists in the clinical specialty area (e.g., pharmacy, respiratory therapy, psychiatry, oncology) at an affiliated hospital
   E. Contact specialists in the clinical specialty area at a local area medical center and/or medical school
   F. Contact any appropriate trade organization specializing in the clinical area
3. Documentation of the contact, including name of individual, discussions, recommendations, and actions taken will be kept within a file in the Clinical Supervisor's office.
4. The Case Manager may also contact the clinical consultant and coordinate a consultation.

5. The Case Manager will obtain orders as appropriate from the patient’s physician (or other authorized independent practitioner).

6. The Case Manager will document appropriate instructions in the clinical record.
PURPOSE

To define the organization’s expectation for communication between clinicians and the office.

POLICY

Clinicians will contact the office daily to confirm their schedules and caseload, and receive reports on patients.

PROCEDURE

1. Clinicians will contact the office daily to:
   
   A. Confirm their schedules for the day.
   
   B. Receive any necessary reports on patients to be visited
   
   C. Confirm caseloads with Clinical Supervisor or designee

2. Clinicians will communicate with the office to verify that all planned visits for the day were made, report availability for visits the next day, and receive reports on admission or changes for the next day's schedule.

3. Clinicians cannot alter the schedule for assignment of cases without the prior approval of Clinical Supervisor or designee. The clinician will alert the Clinical Supervisor of any requests.

4. If an emergency arises or if any organization staff member is ill and it is impossible to fulfill his/her obligations, it is mandatory that the staff member contact the organization as soon as possible to report the absence. It is essential that all organization personnel contact the office as soon as the workday begins if advance notice could not be given.
PURPOSE

To ensure that contracted services are provided by trained and qualified professionals and paraprofessionals.

POLICY

Visiting Nurse & Hospice Care will verify and document the training and qualifications for professionals and paraprofessionals who provide services to the organization’s patients via contractual agreement. (See “Written Agreements for Contracted Services” Policy No. C:3-027.)

PROCEDURE

1. Documentation of training and professional qualifications may be maintained by Visiting Nurse & Hospice Care or by the contracted organization. If maintained by the contracted organization, verification by Visiting Nurse & Hospice Care will occur at least annually.

2. Documentation will be maintained for at least the following items:
   
   A. Successful completion of an approved training course
   B. Demonstration of skills competency
   C. Completion of organization’s orientation
   D. Current personnel records containing the documentation required by Visiting Nurse & Hospice Care
HOSPICE III
Human, Financial, and Physical Resources

HOSPICE AIDE TRAINING
Policy No. H 3-009.1

PURPOSE
To outline a hospice aide training program to ensure the competence and skills of hospice aides.

POLICY
Visiting Nurse & Hospice Care will only hire individuals as hospice aides (on a full-time, temporary, per diem or other basis) who have completed a training program or a competency evaluation program that meets the organization's criteria described below:

1. If the individual has not been employed as a hospice or home health aide for a continuous period of 24 months since completing a program, then the individual will not be considered to have completed either a training and competency program or a competency evaluation program.

2. There will be a three (3)-month probationary period for all new paraprofessional personnel. Successful completion of the probationary period will be documented, dated, and signed by the employee and supervisor.

3. Bi-weekly on-site supervisory visits will be conducted during the initial eight (8) weeks of employment for all newly trained or probationary hospice aides.

4. The organization will provide performance reviews (at least annually) and inservice education to ensure competence of hospice aides. The performance review will address each of the areas of the competency evaluation. The inservices will be provided by a qualified instructor and may occur while an aide is providing care to patients.

Criteria

1. A hospice aide training program must include at least 75 hours of a combination of classroom and supervised practical training. The training program must contain at least 16 hours devoted to supervised practical training preceded by a minimum of 16 hours of classroom instruction. Supervised practical training could occur in the course of providing care to patients as long as the trainee is accompanied by a registered nurse who retains responsibility for the care being provided.

2. The hospice aide training program must include each of the following subject areas:
   A. Introduction to hospice services, organization and health status
   B. Overall responsibilities and limitations
C. Communication skills, including the ability to read, write and verbally report clinical information to patient, caregivers and other hospice staff

D. Patient’s rights including ethics, confidentiality of care, and respect for property

E. Observation, reporting, and documentation of patient status and care or service furnished

F. Taking and recording temperature, pulse, and respiration

G. Basic infection control procedures

H. Basic elements of body function and changes in body function that must be reported to an aide’s Clinical Supervisor

I. Procedures for maintaining a clean, safe, and healthy environment

J. Recognizing emergencies and knowledge of emergency procedures

K. The physical and developmental characteristics of the populations served by the organization

L. Bathing and personal care techniques including bedbath; sponge, tub, or shower bath; shampoo in sink, tub, or bed; nail and skin care; oral hygiene; toileting and elimination

M. Transfers, ambulation, positioning, and passive exercise

N. Normal range of motion and positioning

O. Nutrition, fluid intake, and meal preparation

P. Assistance with medications that are ordinarily self-administered as allowed per state regulations

Q. Assisting patients to achieve maximum self-reliance

R. Emotional problems associated with the illness

S. Care of children, the aged, chronically ill, disabled and acutely ill patients

T. Reporting changes in the patient’s condition

U. Working as a member of the interdisciplinary team

V. Procedures that support/extend skilled nursing or therapy services
W. Care of patients receiving high technology interventions or complex patients

X. Any other tasks that Visiting Nurse & Hospice Care may choose to have the hospice aide perform

3. The competency evaluation program will be conducted annually and will include observation of performance of the following skills:

A. Taking and recording temperature, pulse, and respiration

B. Appropriate and safe techniques in personal hygiene and grooming that include:
   - bedbath; sponge, tub, or shower bath; shampoo in sink, tub, or bed; nail and skin care;
   - oral hygiene; toileting and elimination

C. Safe transfer techniques and ambulation

D. Normal range of motion and positioning

4. Instructors for hospice aide training and competency evaluation programs must be registered nurses with two (2) years of nursing experience and at least one (1) year in hospice care. Other individuals may supplement the instruction as long as they function under the supervision of a qualified instructor.

5. Documentation that the requirement relating to the training program and competency evaluation program has been met should include:

A. Description of the training/competency program, including qualifications of the instructor

B. A record that distinguishes between skills taught at a patient bedside (with supervision) and those taught in a laboratory using a “pseudo patient” (not a mannequin)

6. A hospice aide will not be considered competent in any task in which he/she is evaluated “Unsatisfactory.” The aide must not perform that task without direct supervision. The aide may perform the task that was evaluated as unsatisfactory after retesting in that area and receiving a satisfactory evaluation. There will be no limit on the number of times that an individual may be retested.

A hospice aide will not be considered to have successfully passed a competency evaluation if he/she has an “Unsatisfactory” rating in more than one of the required areas.
7. Visiting Nurse & Hospice Care may offer a competency preparation program in lieu of the formal training program. This program, designed to prepare hospice aides to pass the competency evaluation, will not be subject to the 75-hour requirement. Visiting Nurse & Hospice Care may also offer a remedial program in areas where hospice aides have been evaluated as “Unsatisfactory”. After this program and retesting, if the hospice aide is evaluated “Satisfactory”, he/she will be competent to perform the task. Documentation of all preparation and evaluation will be kept in the personnel file.

8. Additional training will be provided and documented when patients are receiving high technology or complex services.

PROCEDURE

1. All hospice aide applicants will complete a written/verbal basic knowledge/skills test. The test consists of five (5) questions in each of the following areas:

   A. Observing and reporting
   B. Infection control
   C. Basic elements in body function and abnormalities
   D. Maintenance of a clean, safe environment
   E. Recognizing emergencies and emergency procedures
   F. Physical, emotional, and developmental needs
   G. Adequate nutrition and fluid intake

2. Applicants must correctly answer three (3) of the five (5) questions within each category.

3. When an employment offer is extended to the applicant, the organization will:

   A. Review written/verbal test with applicant
   B. Obtain copy of competency testing, if done previously
   C. Review skills checklist
   D. If competency testing is required, determine training needs before competency testing is scheduled
   E. Schedule orientation
F. Schedule training/competency testing time

1. Competencies and skills will be assessed prior to delivery of services and updated every 12 months.

2. The appropriate Clinical Supervisor will assure completion of the manual skills evaluation on all hospice aide personnel.

3. Areas evaluated as “Unsatisfactory” will be reviewed.

4. Practical training will be provided with supervision.

5. Competency skill will be re-evaluated.

6. Competency evaluations will be signed and dated by the registered nurse and will be maintained in the personnel file.

7. For the purpose of the skills evaluation, a patient will be defined as a live volunteer in a lab setting or an actual patient in a home.

4. The hospice aide competency evaluation program will be under the direction of a registered nurse and will include direct observation of all tasks that the paraprofessional will be required to perform.

A. Hospice aide personnel files will be reviewed quarterly.

B. All files must contain:

1. Copy of competency training and/or evaluation

2. Skills and experience inventory (See “Competency Program” Policy No. C:3-023 and the “Initial Competency Assessment Skills Checklists” in Hospice Section Six.)

3. Inservice records

4. Annual performance reviews, which will include:

   a. On-site skills assessments for supervisory visits done annually

   b. Updating of skills checklist

   c. Compliance with inservice requirements

5. Visiting Nurse & Hospice Care will complete a performance and competency evaluation for each hospice aide at least once annually.
6. **The organization will offer 12 hours of inservice training annually. Topics may include, but not be limited to:**

- **Nutrition**
  - NLN 1 hour
- **Personal Care and Hygiene**
  - NLN 1 hour
- **Coping with Feelings**
  - NLN 1 hour
- **Safe Mobility and Patient Transfer**
  - 1 hour
- **How to Monitor, Evaluate, and Report on Patient Condition**
  - 1 hour
- **Standard Precautions**
  - 1 hour
- **I Make the Difference**
  - 4 hours
- **OSHA Bloodborne Pathogens**
  - 2 hours

**Note:** Many elements of this hospice aide training program are appropriate for other paraprofessional personnel and other hospice volunteers.
PURPOSE

To outline a hospice homemaker training program to ensure the competence and skills of hospice homemakers.

POLICY

Visiting Nurse & Hospice Care will only hire individuals as hospice homemakers (on a full-time, temporary, per diem, or other basis) who are able to successfully complete an eight (8)-hour training program and demonstrate competency in required skills.

1. There will be a three (3)-month probationary period for all new paraprofessional personnel. Successful completion of the probationary period will be documented, dated, and signed by the employee and supervisor.

2. The organization will provide performance reviews (at least annually) and inservice education to ensure competence of hospice homemakers. The performance review will address each of the areas of the competency evaluation. The inservices will be provided by a qualified instructor and may occur while an aide is providing care to patients.

PROCEDURE

1. A hospice homemaker training program must include a minimum of eight (8) hours of training related to environmental support services. Instruction will include, but not be limited to:

   A. Overall responsibilities and limitations

   B. Communication techniques

   C. Standards of supervision

   D. Ethics, confidentiality of patient care, and patient rights

   E. Safety in the home and how to respond to emergencies

   F. Incidental household functions

   G. Procedures for maintaining a clean and healthful environment
H. Infection control procedures related to food preparation and storage, laundry, and handling waste

I. Shopping

J. Participating as a member of the interdisciplinary team

K. Documentation in the clinical record of care and services provided
PURPOSE

To establish guidelines for the responsibilities and the frequency of supervisory visits for hospice aide personnel in the home.

POLICY

Nursing personnel (or therapists, as appropriate) must be available to the hospice aide for consultation at all times during the aide's working hours. The hospice Case Manager will conduct supervisory visits to the patient's residence at regular intervals and the aide may or may not be present.

PROCEDURE

1. The frequency of supervisory visits will be based upon the needs of the patient after the plan of care is established. They must be conducted no less frequently than every 14 days.

2. The visit must assess quality of care and services provided by the hospice aide, and whether the IDT services ordered meet the patient's needs and to assess whether the aide is:
   • Following patient's plan of care for completion of tasks assigned to the hospice aide by the registered nurse.
   • creating successful interpersonal relationship with the patient and family
   • demonstrating competency with assigned tasks

3. If an area of concern is noted by the supervising nurse during the onsite visit, the supervisory nurse is to make a follow-up on-site supervisory visit with the aide present to observe the delivery of care

4. If the supervising nurse verifies the area of concern during the follow-up on-site visit with the hospice aide present, that hospice aide will complete a competency evaluation prior to providing further care.

5. The overall performance of the aide will be evaluated at least annually for competency by the Case Manager making an on-site visit.

6. The Case Manager will be responsible for:
   A. Supervision of all services and written instructions for compliance with the plan of care
   B. Specific training in personal care skills and other procedures related to the care of the patient with annual skill competency evaluations and supervisory reports.
C. Regular consultations (i.e., case conferences) with the aide

Policy No. H:3-011.1

D. Documentation of all pertinent clinical notes, which may include observations made by the aide

7. Supervisory encounters are documented in the patient’s medical record, dated and authenticated by the supervising professional.

A. Ongoing supervision will be documented within the plan of care, and clinical notes.
PURPOSE

To ensure that qualified volunteers are available to assist with the provision of hospice services.

POLICY

Volunteers will be utilized in defined roles to support ancillary, administrative, and/or patient care services.

Volunteers are considered to be employees of the organization.

Surviving family members wishing to join the volunteer staff in the capacity of direct care or public relations will be strongly encouraged to wait a minimum of one (1) year following the death of their loved one.

PROCEDURE

1. There will be active and ongoing efforts to recruit, train, and retain volunteers. All efforts will be documented. Written information will be available to the community outlining the involvement of the family member or caregiver serving as a volunteer in public relations or in other non-therapeutic activities.

2. Volunteer staff will be chosen based upon their communication and interpersonal skills and availability.

3. Volunteer staff will meet all organizational requirements for hire, including criminal record checks as required. Personnel and health records will be maintained for volunteers.

4. Health requirements (HBV, PPD, etc.) will be per organizational policy.

5. Volunteers attend an orientation program specific to hospice services and the jobs/tasks to be performed. The orientation will be consistent with accepted standards of hospice practice and include:

   A. Duties to be performed
   B. Associated responsibilities related to the tasks
   C. Identification of the person the volunteer reports to
   D. Persons to contact for assistance and instruction
E. Hospice goals, service, and philosophy

F. Confidentiality and the protection of patient and family/caregiver rights

G. Family dynamics, coping mechanisms, and psychological issues surrounding terminal illness, death, and bereavement

H. Procedures to be followed in the event of an emergency or following the death of a patient

I. Individual volunteer guidance.

6. Volunteer activities will be documented and include type of services provided and time worked.

7. Assignments will be made based on the volunteer’s request for type of work desired (e.g., patient contact, bereavement, office work) and the needs of the organization.

8. The Volunteer Services Manager or other professional member of the interdisciplinary team will supervise each patient care volunteer at least every six (6) months. The supervisory visit will be documented in the clinical record for the patient(s) receiving volunteer services.

9. Volunteers will receive an annual performance evaluation.
HOSPICE III
Visiting Nurse & Hospice Care
Human, Financial, and Physical Resources

HOSPICE VOLUNTEER DOCUMENTATION
Policy No. H:3-013.1

PURPOSE
To delineate the requirement for hospice volunteers to document their activities.

POLICY
The volunteer is an integral member of the interdisciplinary team. All volunteer patient/family support will be documented in the patient’s clinical record.

All non-patient-related volunteer activities will be documented and filed in the volunteer department.

PROCEDURE
1. Each volunteer will complete a separate clinical note for each patient and family/caregiver visited. Successive activities and dates may be recorded on the same form as long as they are for the same patient.

2. Volunteer clinical notes will be filed in the patient’s clinical record.

3. A separate form will be filled out for non-patient-related activities that support hospice.

4. Documents will be due monthly and must be turned in to the Volunteer Coordinator no later than the first of each month following the date of services provided.
PURPOSE

To delineate the process by which the hospice will document the utilization of volunteers and the cost savings achieved.

POLICY

Visiting Nurse & Hospice Care will document the cost savings achieved. The hours of volunteer services will exceed 5% of the total patient care hours of paid and contracted hospice personnel.

PROCEDURE

1. Volunteers will submit their documentation for services and time to the Volunteer Coordinator on a monthly basis.

2. The Volunteer Coordinator will compile and analyze the data monthly.

3. The Volunteer Coordinator will document the following:

4. The continuing level of volunteer activity and the expansion of care and services achieved through the use of volunteers

   A. Volunteer service hours to show that volunteer hours equal at least 5% of the total patient care hours of all paid hospice and contract staff

   B. Cost savings achieved through the use of volunteers, including:

      1. Identification of necessary positions that are occupied by volunteers

      2. The time worked by volunteers occupying these positions

      3. Estimate of the dollar costs that the hospice would have incurred if paid personnel had occupied those positions

5. Monthly and annual statistical reports will determine the percentage of services given by volunteers in relationship to the other disciplines.

6. The Volunteer Coordinator will estimate the dollar costs that hospice would have incurred if paid hospice personnel occupied the identified positions.

7. The Volunteer Coordinator will also maintain records to demonstrate the organization’s ongoing effort to recruit, train, and retain volunteers.
PURPOSE

To delineate organization policies for inservice education programs designed to increase competence in a specific area and improve overall organization performance of major functions and processes.

POLICY

1. Visiting Nurse & Hospice Care will provide training and education to give personnel opportunities to learn new skills and improve/expand existing knowledge. Training topics may include information regarding the organization’s professional standards of care/practice, performance improvement monitoring results, updates in patient care techniques/resources, and safety/infection control requirements.

2. Mandatory inservices will be attended by all disciplines.

3. Attendance at education programs may be required relative to job classification.

4. Professional personnel will receive at least the number of continuing education units to maintain their licenses.

5. Paraprofessional personnel will receive education as follows:
   A. Aides (CNAs/HHAs) must receive at least 12 hours of inservice training per calendar year. This may be provided while the aide is furnishing care to patients.

PROCEDURE

1. Annual inservices may include, but not be limited to:
   A. Hospice philosophy, goals, and services
   B. Protection of patient and family/caregiver rights, including confidentiality (HIPAA)
   C. Knowledge of Advance Directives and power of attorney
   D. Communication and documentation skills
   E. Interdisciplinary team approach to care with the registered nurse as care coordinator
   F. Physiological, psychosocial, and spiritual aspects of terminal care
   G. Protocols to deal with grievances and issues of ethical concern
H. Respect for cultural diversity and special communication needs

I. Bereavement care

J. Family dynamics and crisis management

K. Concepts of palliative versus curative care

L. Procedures for responding to medical emergencies

M. Processes for communicating with the hospice staff

N. On-call protocols

O. Safety policies and procedures

P. Infection control

Q. Establishing and maintaining professional boundaries with patient and family/caregiver

R. Areas of potential conflict of interest

S. Skills updates

T. Medical device act

U. Quality assessment performance improvement process

2. Personnel will receive notification of organization-sponsored programs at least one (1) week in advance.

3. A record will be maintained for each session, including:

   A. Topic

   B. Course objectives

   C. Speaker (and his/her qualifications)

   D. List of attendees

4. An inservice log will be kept to track the number of inservice hours the aides (CNAs/HHAs) have obtained on a cumulative basis.

5. During ongoing supervision and competency reviews, the supervisors will evaluate if the training and education has improved the competence of the organization personnel.
TEAM ACCESS TO EMOTIONAL SUPPORT
Policy No. H:3-016.1

PURPOSE
To outline the mechanisms for emotional support to ensure continuity, stability, and health of hospice personnel.

POLICY
The provision of quality hospice services to terminally ill patients and families/caregivers is dependent on the highest levels of skills, knowledge, and sensitivity of members of the interdisciplinary team in the areas of physical, emotional, social, and spiritual care. It is also recognized that the emotional demands on those providing care to hospice patients and families/caregivers are high, and that consistent mechanisms for feedback and support are necessary in order to ensure hospice personnel continuity, stability, and health. Visiting Nurse & Hospice Care is committed to providing mechanisms to the interdisciplinary team to receive emotional support regarding hospice caregiving.

PROCEDURE
1. Interdisciplinary team meetings, which provide an opportunity for hospice personnel support, will be held on a regular basis. Although the interdisciplinary team meetings will primarily focus on patient and family/caregiver review, it will also be an opportunity to provide group support to team members.

2. One-to-one support will be available and provided to interdisciplinary team members as needed by the hospice Clinical Supervisor, the hospice social worker, or the Hospice Chaplain.

3. Regularly scheduled hospice personnel meetings will include opportunities for interdisciplinary team members to share problems and concerns regarding overall program direction, program policies, and current and future program development.

4. Hospice support groups, facilitated by a social worker or other professional counselor, will be held to discuss teamwork and emotional issues related to providing care to the dying.

5. Individual and/or group support will be available through the employee assistance program (EAP).

6. Other mechanisms to ensure adequate support to hospice team members will be developed based on identified needs and interests.
PHYSICIAN LICENSURE VERIFICATION
Policy No. H:3-017.1

PURPOSE

To ensure that all physicians or licensed independent practitioners are properly licensed to practice medicine in the organization’s service areas.

POLICY

Orders will only be received from physicians (or other authorized independent practitioner) licensed to provide care in the state(s) served by the organization.

PROCEDURE

1. The organization will verify that all referring physicians or licensed independent practitioners are licensed to practice in the state(s).

2. The physician (or other authorized independent practitioner) license will be verified when the individual provides orders to the organization for the first time and annually thereafter.

3. Physician or licensed independent practitioner licensure will be verified by:
   A. Ascertaining that the individual is a practitioner “in good standing” with the appropriate State Board of Licensure
   B. Contacting the local Medical Society or State Board of Licensure
   C. Accessing Medical Society or State Board of Licensure information on the Internet
   D. Receiving updated notices from the Board of Licensure listing probationed, suspended, or revoked licenses

4. The organization will maintain documentation that verification was done.

5. Verification will be reviewed at least annually or upon expiration of license.
PURPOSE

To provide guidelines for the acceptance and use of donated funds.

POLICY

Visiting Nurse & Hospice Care will accept donations from individuals who wish to support the hospice program and services. Most donations are in memory of patients who have been served by the program. Funds will be utilized to promote the hospice program and hospice philosophy. Funds will be utilized in a constructive and consistent manner.

PROCEDURE

1. When a surviving family/caregiver inquires as to the procedure regarding donation funds to the hospice program, the following information can be given:
   A. The donor forwards a check with a note or card identifying in whose name the donation is being made. The check is made out to Visiting Nurse & Hospice Care.

2. All donated funds received will be forwarded to the development department. This department will keep a record of all donations, make a copy of the check and correspondence for its files, and send an acknowledgment to the family/caregiver and a thank-you letter to the donor. The Executive Director/Administrator will sign a card expressing appreciation, which will be included in the card sent to the donor. The donated check will be forwarded to the business office.

3. Request for use of donated funds can be made by any hospice team member.

4. All expenditures of the donated funds will be approved by the hospice Executive Director/Administrator. Criteria for use or request:
   A. To purchase items that increase comfort of hospice patients and families/caregivers
   B. To pay for personal care services that are needed but not covered under the hospice Medicare/Medicaid benefit
   C. To provide for special supplies or equipment that hospice patients cannot afford and which will allow the patients to stay at home or return home
   D. To pay for expenses associated with the bereavement program
5. A report on the amount of donations and their usage will be submitted biannually to the hospice Professional Advisory Committee by the Executive Director/Administrator. At any time, information about monies will be available from the Executive Director/Administrator.
PURPOSE

To specify the contents of a Medicare Certified Hospice written agreement by defining the nature and scope of services provided by clinicians and others not directly employed by the organization.

POLICY

Senior management will be responsible for the availability of care and services to meet the needs of the patients served. When the organization provides care and services through another source, the patients will be entitled to the same level of performance from that source as from the organization itself. These contracted services will be defined by a written agreement, before individuals from that source will be permitted to provide services on behalf of the organization.

PROCEDURE

1. The written agreement between the organization and the contract service/individual will define the nature and scope of services.

2. The following Medicare COP requirements for written agreements will be included in all hospice contracts in addition to those requirements as listed in “Annual Organization Evaluation” (see Policy C:4-007):

   A. Patients will be accepted for care only by Visiting Nurse & Hospice Care.

   B. Primary organization maintains control of, supervises, coordinates, and evaluates care provided. Methods to ensure Primary organization control are described within the contract.

   C. Procedures for scheduling visits and periodic patient evaluation.

   D. Mechanism to ensure that contracted clinicians possess current professional licensure and/or certification, as applicable.

   E. Mechanism for orienting contracted personnel to the primary organization’s policies, procedures and processes.

   F. Mechanism for contracting parties to participate in the development of patient’s individualized plan of care.
G. Timeframes for placement of contracted staff and contingency staffing plans.

H. Confidentiality of all protected health information.

3. When hospice aide services are provided under contract, Visiting Nurse & Hospice Care retains the following responsibilities:

A. To ensure the quality of care provided by the hospice aide.

B. Perform hospice aide supervision as per regulation.

C. To ensure that the hospice aides have successfully completed mandated training and competency requirements.

4. The above elements of the written agreements will be used for all contracted services. Any deviation from the approved format must be approved by the Executive Director/Administrator.

5. The organization’s annual evaluation process as defined in “Annual Organization Evaluation” (see Policy C:4-007) will additionally, monitor, evaluate, and audit the contracted services to ensure compliance with the Medicare Condition of Participation.
ADDENDUM 3-019.A

HOSPICE CONTRACTED SERVICES REVIEW
## HOSPICE CONTRACTED SERVICES REVIEW

The following components must be included in all hospice contracts.

<table>
<thead>
<tr>
<th>Contract Requirements</th>
<th>CHAP Standard</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>1. Specific services or products to be provided by the contracted organization</td>
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<td>2. Contractor adheres to organization’s policies and procedures</td>
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<td>3. Education, training, and qualifications required of contracted employees</td>
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<td>4. Mechanism for contractor to participate in QAPI activities, as applicable</td>
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<td>5. Procedures for documenting and submitting notes that verify provision of contracted services</td>
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<td>6. Procedures for submission of invoices and methods for reimbursement for contracted services provided</td>
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<td>7. Effective date of the contract</td>
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<td>8. Terms for renewal and/or termination</td>
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<td>9. Patients are accepted for care only by Visiting Nurse &amp; Hospice Care</td>
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<td>10. Methods for Visiting Nurse &amp; Hospice Care to control, coordinate and evaluate contracted services</td>
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<td>11. Procedures for scheduling visits</td>
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<td>12. Procedures for periodic evaluation of patient care</td>
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<td>13. Mechanism to ensure contracted personnel maintain current licensure and/or certification, as applicable</td>
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<td>14. Responsibility for development of the patient’s individualized plan of care</td>
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<td>15. Timeframes for placement of contracted staff</td>
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<td>16. Contingency staffing plans</td>
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<td>17. Maintenance of confidentiality for protected health information</td>
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<td>18. Contract signed and dated by authorized principles of each party</td>
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Review of contract completed by: ________________________________
SECTION FOUR

Long Term Viability

Policy No.

Hospice Operational Planning.........................................................................................H:4-001
Hospice Innovation........................................................................................................H:4-002

*Requires state or organization-specific information.
HOSPICE OPERATIONAL PLANNING
Policy No. H:4-001.1

PURPOSE

To define a process for the development and monitoring of a hospice operational plan that is consistent with the organization’s mission and patient needs.

POLICY

The hospice operational plan will be developed or revised at least every three (3) years.

The hospice plan will be consistent with the organizational plan when the hospice is part of a larger organization. (See “Organizational Planning” Policy No. C:4-001.)

1. The leaders will be responsible for developing and implementing an effective organization-wide planning process, which will include:

   A. Establishing the organization’s mission, vision, and goals/objectives

      1. Determination of realistic and measurable outcomes
      2. Clearly defining long range, strategic, and operational plans
      3. Determination of time frames for implementation of action plans and expected results
      4. Allocation of necessary resources
      5. Assignment of staff to specific activities
      6. Ongoing monitoring to ensure that the organization’s mission is maintained over time

2. The leaders will plan and monitor the organization’s care and services to be consistent with its mission and patient needs. The planning process will include:

   A. Promoting the philosophical basis of hospice care

   B. The physical, psychosocial, spiritual, and social needs, as applicable, of individuals served and staff

   C. Clinical practice guidelines and relevant literature

   D. Sound business practices
E. Resources needed to provide and support care and services
F. Recruitment, retention, development, and continuing education needs for all staff
G. Appropriate hospice and inpatient services staff, other interdisciplinary team services, and appropriate advisors
H. The data needed to measure the performance of the processes and outcomes of care and services
I. Results of organization quality assessment and performance improvement activities

3. Visiting Nurse & Hospice Care will notify applicable regulatory and accrediting bodies, in writing, of any changes in key management personnel or changes in ownership.

4. Organization leadership will communicate the organization's plans to personnel on an ongoing basis. All hospice personnel will have an opportunity to communicate with leadership regarding operational and clinical issues on a routine, scheduled basis.

PROCEDURE

1. Annually, the organization's leadership will plan for hospice service delivery by:
   A. Allocating resources through the budgeting process
   B. Directing planning activities through an annual review and evaluation of the strategic plan
   C. Developing policies and procedures to effectively meet the needs of the patient, physicians, staff, and other identified customers

2. The planning process will involve:
   A. Assessing the needs of the organization's patients, physicians, and other identified customers through routine collection of information from surveys
   B. Recruitment, retention, development, and continuing education needs for all staff including inpatient services staff, interdisciplinary team services, and appropriate advisors
   C. Development of long range, strategic, and operational plans which include all care and services to be provided, based on the organization's mission and philosophy
D. Development of policies and procedures, both administrative and clinical, which direct the activities of all organization personnel in the provision of care and service.
3. The planning process will be monitored by leadership through a quarterly review of:
   
   A. Meeting organization goals and objectives
   B. Organization strategic plan and evaluation of the need for adjustments
   C. Organization perception of care surveys and complaint forms
   D. Organization quality assessment and performance improvement results
   E. Organization policies and procedures (annually)

4. Minutes of the management meetings and other committees as well as minutes from the Governing Body and Professional Advisory Committee will reflect the planning process.

5. The Governing Body and senior management will communicate the organization’s plan to personnel on an ongoing basis. All hospice personnel will have an opportunity to communicate with senior management regarding operational and clinical issues on a routine, scheduled basis.
PURPOSE

To ensure that the corporate philosophy for innovation is incorporated throughout hospice services.

POLICY

In addition to the corporate focus on innovation, hospice management staff will ensure that:

1. The program identifies and reaches market segments or populations in need of its services using innovative approaches to meet community needs.

2. There is a continuous evaluation and update of services delivered, based on community needs and changes in the industry.

3. Specialty programs are developed, maintained, or changed to increase market share

4. Personnel are updated on the newest technology or products to ensure up-to-date service delivery.

5. Community education and awareness of hospice services is promoted by all personnel.
Section Five

Patient and Family/Caregiver Education

Policy No.

Patient Education Process........................................................................................................H:5-001
Safe/Effective Use of Medications............................................................................................H:5-002
Pain Management Education....................................................................................................H:5-003
Safe/Effective Use of Equipment and Supplies.........................................................................H:5-004
Basic Home Safety....................................................................................................................H:5-005

Addendum: Fall Reduction Program*....................................................................................H:5-005.A

Rehabilitation Techniques.........................................................................................................H:5-006
Storage, Handling, and Access to Supplies and Gases.............................................................H:5-007
Identification, Handling, and Disposal of Hazardous Waste....................................................H:5-008
Infection Control Precaution Education....................................................................................H:5-009
Natural Disasters/Emergencies.................................................................................................H:5-010

Addendum: Guidelines for Emergency Management*............................................................H:5-010.A

Appropriate Use of Restraints and Supplies............................................................................H:5-011
Signs and Symptoms of Approaching Death............................................................................H:5-012
Community Resources.............................................................................................................H:5-013
Educational Resources..............................................................................................................H:5-014

*Requires state or organization-specific information.

PATIENT EDUCATION PROCESS
Policy No. H:5-001.1

PURPOSE

To provide guidelines for giving specific instruction and information to patients and family/caregivers regarding hospice services.

POLICY

Patients and family/caregivers will receive education in verbal, visual, and written format, as appropriate. The scope of teaching will be determined by the assessed needs, abilities, learning preferences, and readiness to learn of the patient and family/caregiver, as well as by the plan of care. Education will be the responsibility of each interdisciplinary team member and will focus on, as appropriate:

1. Facilitating the patient’s and family/caregiver’s understanding of his/her health status, health care options, and consequences of options
2. Encouraging patient participation in decision-making about health care options
3. Increasing patient and family/caregiver potential to follow the plan of care
4. Maximizing care skills of the patient and family/caregiver
5. Increasing the patient’s and family/caregiver’s ability to cope with the health status, prognosis, and outcomes
6. Enhancing the patient’s and family/caregiver’s role in continuing care
7. Promoting a healthy lifestyle
8. Maintaining the patient’s and family/caregiver’s health status
9. Assisting the patient’s and family/caregiver’s ability to cope with hospice care and the patient's impending death
10. Pain and symptom management

PROCEDURE

1. As part of the comprehensive assessment, the following will be assessed and included in the plan of care, as appropriate:
   A. The atmosphere for conducive learning
B. The pertinent information needed by the patient and family/caregiver in relation to the care being rendered

C. The level of knowledge of the patient and family/caregiver in relation to the diagnoses, plan of care, required activities by patient and family/caregiver, lifestyle changes, etc.

D. The ability and readiness of the patient and family/caregiver to learn

E. Cultural and religious practices that might affect learning

F. Emotional barriers that might affect learning

G. Desire and motivation to learn

H. Physical and/or cognitive limitations, as well as communication and language barriers to learning

2. Based on the above, the comprehensive assessment will be used as the basis for planning patient and family/caregiver education. In the event that any barriers to learning exist, these barriers, as appropriate, will be discussed with the patient and family/caregiver as well as the Clinical Supervisor. If they cannot be overcome, the patient's physician will be contacted.

3. When appropriate, the clinician will use preprinted, hospice-approved patient teaching handouts. When not available, the clinician will, if needed, identify available written or visual materials to aid in the education process.

4. If a patient's condition prevents him/her from participating in instruction, family/caregivers will receive the information/instruction.

5. If a patient lives alone and there is no one able or willing to receive the instruction, the physician will be informed, and this information will be documented in the clinical record.

6. Unless otherwise ordered by the physician (or other authorized licensed independent practitioner), the patient and family/caregiver will receive verbal, and as appropriate, written instructions on:

A. Hospice philosophy and the nature of palliative care

B. The patient's disease process and prognosis

C. The medical regimen

D. Medication management and administration

E. Food and drug interactions
SAFE/EFFECTIVE USE OF MEDICATIONS

Policy No. H:5-002.1

PURPOSE

To provide guidelines for the instruction of patients and family/caregivers regarding the safe, effective use of medication.

To promote correct administration of medication by patients and family/caregivers.

POLICY

Patients and family/caregivers will receive information regarding the safe and effective use of medications, in accordance with applicable hospice policies.

Visiting Nurse & Hospice Care will encourage patient and family/caregiver participation in his/her own hospice care and will explain the correct administration of medications by the patient or family/caregiver, as ordered by the attending physician (or other authorized licensed independent practitioner) or purchased over the counter. Teaching will also include the safe storage of medications.

PROCEDURE

1. As part of the comprehensive assessment, the patient and family/caregiver will be assessed as to their knowledge and skill required for safe and effective use of medications.

2. The components of the medication assessment used to determine patient and family/caregiver knowledge and skill related to medication administration will include, but not be limited to:
   A. Name, dosage, route, duration, time, and usage of medication, intended use as well as expected actions of drug therapy
   B. Preparation, self-administration, and use of medication, including over-the-counter products
   C. Safeguards against contamination
   D. Compounding and administration techniques (if applicable)
   E. Significant side effects, adverse reactions/interactions (including drug-to-drug and drug–food interactions) as well as contraindications and how to avoid and respond to such factors
F. Self-monitoring of drug therapy

G. Proper storage and expiration dating of medications

H. Refill information

I. Actions to take in the event of a missed dose

J. Proper disposal of unused or expired medications, especially controlled substances/Schedule II drugs

K. Other information, as applicable

3. Based on the assessment(s), the clinician will review written hospice information available for patient and family/caregiver instruction.

4. Using the written information, the clinician will review the key points required, based on patient knowledge and skills, as well as identified needs. This may include:

A. Teaching the patient the purpose and side effects of medications, and the patient’s role in identifying and preventing medication errors.

B. Assisting the patient in setting up medications for the first time.

C. Assessing the patient’s ability to self-administer medications correctly, and document the patient’s response and comprehension.

D. Answering questions/concerns expressed by the patient and family/caregiver regarding patient’s self-administration of medications.

E. Instructing the patient and family/caregiver regarding safe storage of medications:

   1. Medications should be stored separately from other poisonous drugs and chemicals.
   2. Medication should be removed from storage during instruction and administration times.
   3. Medications should be kept out of the reach of children, pets, and confused or disoriented patients.
   4. The nurse will plan with the patient and family/caregiver for the safe, therapeutic storage of drugs during the assessment process.
   5. Drugs requiring refrigeration should be stored inside the refrigerator.
6. Urine testing and other diagnostic materials should be stored away from all medications, heat, light, and moisture.

5. The clinician will include information, when appropriate, regarding poison control center numbers, allergies, pharmacy numbers, and emergency actions.

6. Documentation of patient and family/caregiver instruction in the clinical record will include:
   A. Information taught
   B. Patient and family/caregiver understanding
   C. Return demonstrations
   D. Response to teaching
   E. Updating medication profile
PURPOSE

To provide guidelines for the instruction of patients and family/caregivers regarding identification and management of pain.

POLICY

Patients and family/caregivers will receive information regarding pain and the management of pain as an integral part of hospice care. (See “Pain Assessment” Policy No. H:2-050.)

PROCEDURE

1. The clinician will identify patients with pain or who are at risk for pain during each patient assessment.

2. The patient and family/caregiver will receive verbal or written instructions, as appropriate, regarding:
   A. The pain process
   B. The risk for pain
   C. The pain assessment process
   D. The importance of effective pain management
   E. Methods for pain management, when identified as part of treatment
   F. Potential limitations of pain management modalities
   G. Side effects of pain treatment

3. Documentation of patient and family/caregiver instruction and understanding in the clinical record will include:
   A. Information taught
   B. Patient and family/caregiver understanding
   C. Response to teaching
   D. Additional learning needs
B. Humidifiers
C. Oxygen concentrators
D. Oxygen cylinders
E. Suction machines
F. Mechanical lifts
G. Trapeze bars
H. Pressure pads/pumps
I. TENS units
J. Canes, walkers, wheelchairs
K. Hospital beds
L. Lift chairs
M. Bathroom aids

6. Specific operational information related to these items will be obtained from the company providing the equipment. This will include such information as:

A. Basic purpose and description of the equipment
B. Basic operating instructions
C. Troubleshooting
D. Safety precautions and warnings
E. Cleaning and/or disinfecting
F. Infection control precautions as applicable
G. Backup equipment and accessories, if applicable
H. Emergency plans, when applicable
I. Correct use of the equipment
J. Checklists, when appropriate
K. Maintenance to be performed by patient
L. Storage and/or transport of equipment

7. If equipment operation has not been explained to the patient by the HME company the hospice clinician will provide or arrange education or contact the company to provide further information and/or instruction, as needed.

8. Documentation of patient and family/caregiver instruction in the clinical record will include:
   A. Information taught
   B. Patient and family/caregiver understanding
   C. Return demonstrations
   D. Response to teaching
HOSPICE V
Patient and Family/Caregiver Education

BASIC HOME SAFETY
Policy No. H:5-005.1

PURPOSE
To provide guidelines for the instruction of patients and family/caregivers regarding basic home safety.

POLICY
Patients will receive information regarding basic home safety in accordance with applicable hospice policies including, but not limited to, “Environmental Safety—Patient” (see Policy No. C:2-065) including:

1. Fire response
2. Electrical safety
3. Environmental and mobility safety
4. Bathroom safety

PROCEDURE
1. As part of the comprehensive assessment, the patient's home will be assessed for potential hazards.
2. Based on the results of that assessment, the patient and family/caregiver learning needs will be identified.
3. Using the assessment, written and verbal information appropriate to the patient's environment will be used as a basis for patient instruction.
4. The information that will be reviewed with every patient will include, as indicated:
   A. **Fire safety**—Smoking, smoke detectors, fire escape route, burns, electric blankets, heating pads, oxygen therapy precautions, space heaters, cooking safety, and flammable liquids.
   B. **Electrical safety**—Extension cords, electrical cords, overloaded circuits, outlets, light bulbs, grounding, and electrical appliances.
C.  *Environmental and mobility safety* – Fall prevention techniques, wheelchair safety, walker safety, exits/passageways, use of handrails, loose carpets, stairway safety, adequate lighting, emergency medical plan, disaster plan. (See “Fall Reduction Program” Policy No. H:5-005.A.)

D.  *Bathroom safety* – Nonskid mats, slippery surfaces, grab bars, water temperature

5. During subsequent home visits, clinicians will continually assess the patient and family/caregiver compliance to home safety and re-instruct when safety issues surface.

6. Documentation of patient and family/caregiver instruction in the clinical record will include:

   A. Information taught
   
   B. Adaptations made to the environment
   
   C. Patient and family/caregiver understanding
   
   D. Return demonstrations in use of equipment, if appropriate
   
   E. Response to teaching
   
   F. Additional learning needs
ADDENDUM H:5-005.A

FALL REDUCTION PROGRAM

(Insert Organization’s Fall Reduction Program here. Note: Guidelines for developing your organization’s program included.)
**VNHC Hospice Falls Risk Reduction Program**

1. Leadership promotes an agency culture of safety  
   a. Presentations at agency meetings  
   b. Fall Risk Reduction and Fall Prevention Awareness Events  
   c. Approval and provision of patient education materials

2. Staff Education  
   a. Definition of a “fall” and how it will be reported. 
   b. Fall risk assessment using Morse Fall Scale [Assessment> Environment> Safety> Morse Fall Scale]  
      i. Prior fall/ History of falls  
      ii. Medical issues/ Secondary diagnosis  
      iii. Ambulatory aids  
      iv. Medications/ IVs  
      v. Musculoskeletal issues/ Gait  
      vi. Mental issues  
      vii. Comments such as additional information on mental status or medications (but will not be included in numerical Risk Score)  
      viii. A numerical score will be used to determine the appropriate falls prevention intervention. Using the Morse Fall Scale in Allscripts, these scores can be calculated as Low <45; Moderate >45 to <80; and High >80.  
   c. Plan and implement the correct interventions based on the assessment results  
      i. Environmental Interventions  
      1. Home, structural, equipment, lighting and management assessment  
      ii. General interventions for all patients  
      1. appropriate clothing  
      2. educate on assistive devices (walker, wheelchair, commode)  
      3. medication education  
      4. monitor changes in risk factors  
      5. patient, family and caregiver education and contract for safety  
      iii. Individualized interventions for high risk patients  
      1. Allscripts modifications  
         a. Re-assess for fall risk at every visit  
         b. Add or update Morse Fall Scale and Problems in Allscripts  
      2. IDT review for falls interventions  
      3. consider altering room set-up, bed location, room location  
      4. medication review with physicians and pharmacist  
      5. consider referral for PT, OT, vision,  
      6. bed monitor  
      7. scheduled toileting assistance  
      iv. Interventions are based on Risk score

Morse Fall Scale in Allscripts
3. Fall Risk Reduction Interventions

All patients will have Morse Fall Scale completed. All Interventions will be documented in Problems [Mobility/safety; falls; add optional modifier] and detailed in Clinical Notes. Interventions are based on fall history and contributing causes [a contributing cause is any factor that has potential to increase fall risk]

[Transition to the Morse Fall Scale in Allscripts in planning so we can use the numbers listed below]

1. Low risk <45

   a. At each visit ask if patient has fallen (HHA, MSW, SC will notify CM)
   b. Provide verbal fall risk reduction information to patient/family/caregiver
   d. If no additional falls, re-assess risk at re-certification
2. Moderate risk >45 to <80
   a. Include all Low Risk interventions
   b. Review fall history and interventions at each IDT; document on IDT notes
   c. Medication review with PCP/medical director; determine if any medication modification to reduce fall risk can be made
   d. Consider for referral to OT, PT or vision care based on individual risk when there is potential for improvement in the patient's own ability to prevent falls by improving balance skills, improving proprioception, improving strength, improving range of motion, and as appropriate.
   e. Review written and verbal information with patient/family/caregiver
   f. MSW intervention regarding community resources (CG, sitter)
   g. MSW and SC to reinforce risk reduction strategies
   h. If no additional falls, re-assess on re-certification

3. High risk >80
   a. Include prior interventions, document on IDT notes
   b. Clinical consultation with PCP/medical director/nursing supervisor for additional fall risk reduction strategies
   c. Medication review primarily routine meds with Hospiscripts pharmacist and PCP/medical director
   d. Review for possible appropriate referral to decrease fall risk
   e. Provide instruction on fall prevention to patient/family/caregiver
   f. Consider recommending/providing risk reduction equipment such as side rails, bed alarm, personal audio monitor
   g. Evaluate effectiveness of interventions at next IDT

4. Fall reporting
   a. Allscripts has a fall report to be completed.
   b. Allscripts fall report allows for the following information to be reported: date of fall, injury or no injury, witnessed by clinician or not, who notified clinician of fall, the name of the physician notified, by whom and date and time notified and comments/narrative about the fall.
   c. Injuries may be recorded as: admitted to hospital, bleeding, bruise/abrasion, burn/scald, ED visit, fracture, laceration requiring stitches, and wound
   d. The time of the fall must be entered manually in the area for comments.
   e. The nurse who reports the fall must also report the fall to the physician on a VNHC standardized fax form. (attached)
   f. If the fall results in an ER visit or hospitalization, notify Quality with-in 24 hours by e-mail during business hours (Debbie.wright@vnhcsb.org)
   g. A copy of the fall report is to be printed out by nurse, signed and provided to Manager. The Manager signs the report and submits it to Quality.

5. Patient contacts
   a) Assessments
      i. Morse Fall Scale risk assessment will be completed on admission by the admitting nurse
      ii. As soon as a fall is reported to the nurse an assessment will be made if a visit is indicated based on the circumstances of the fall, and resultant injury and the patient/CG request.
      iii. After hours falls policy indicates a visit will be made by on-call nursing staff within 2 hours of specific falls. See after hours policy.
iv. The fall report will be completed by the nurse receiving the report unless a visit is to be made in which case the nurse seeing the patient will complete the report.

b) Interventions (see Interventions above)

c) Patient education

i. Determine the patient education information you will utilize.

ii. Materials need to be written at an appropriate education level and culturally appropriate as determined by your patient demographics

iii. Handouts should include information on the risks and causes of falls, home safety and modifications for fall prevention (e.g. stair railings, proper lighting, proper footwear) and ways to reduce risk

6. Quality

a) Fall incidents should be tabulated, trended and shared with appropriate committees (e.g. PI, QAPI, Safety committees) and staff. The data can be used for PI or QAPI projects.)

i. Falls data is tabulated by Allscripts by “injury” or “no injury”.

ii. This data is reviewed by nursing supervisors and provided to the Quality Director for further analysis and benchmarking.

iii. The analyzed data is provided to the PAC quarterly.

iv. Benchmarking will be internal.

b) For all falls resulting in an ER visit or hospitalization a post-fall review will be done by Quality with-in 5 days of fall.

References:


PURPOSE

To provide guidelines for the instruction of patients and family/caregivers in habilitation or rehabilitation techniques to facilitate adaptation and/or functional independence.

Definitions

1. Habilitation: Educational, medical, social, and other measures undertaken for individuals born with limited functional abilities.

2. Rehabilitation: The combined and coordinated use of educational, medical, social, and vocational measures for training or retraining individuals disabled by disease or injury. The goal is to enable individuals to achieve their highest possible level of functional ability.

POLICY

Patients will receive, when appropriate, information and instructions regarding habilitation or rehabilitative techniques in accordance with applicable Visiting Nurse & Hospice Care policies. (See “Functional Assessment” Policy No. H:2-048 and “Rehabilitative Services” Policy No. H:2-010.)

PROCEDURE

1. As part of the comprehensive assessment, the patient will be assessed regarding functional limitations that need to be addressed to ensure adaptation to the home environment.

2. The functional assessment will include, but not be limited to, activities of daily living:
   A. Dressing
   B. Feeding
   C. Hygiene
   D. Activity/exercise
   E. Homemaking/housekeeping
   F. Toileting/elimination
3. Based on the assessment, a physician's (or other authorized licensed independent practitioner's) order will be obtained, and a referral will be made to physical, speech, and/or occupational therapy, as needed and if appropriate.

4. The patient’s physical status and functional abilities will be evaluated by a rehabilitation professional before instruction and treatment is initiated.

5. The therapists, when involved in the care of the patient, will be responsible for instructing the patient in habilitation or rehabilitation techniques in response to identified needs. When a therapist is not involved in the care, the Case Manager will be responsible.

6. Verbal and/or written information regarding habilitation or rehabilitation techniques will be provided to the patient and family/caregiver, based on their ability to adapt to their environment.

7. Information regarding potential benefits and risks of habilitation or rehabilitation services will be provided to the patient in order to make an informed decision regarding services and treatment.

8. Documentation of patient and family/caregiver instruction in the clinical record will include:
   
   A. Information taught
   B. Adaptations made to the environment
   C. Patient and family/caregiver understanding
   D. Return demonstrations in use of rehabilitation equipment, if appropriate
   E. Response to teaching
   F. Additional learning needs
PURPOSE

To provide guidelines for the instruction of patients and family/caregivers in storage, handling, and access to supplies and medical gases.

POLICY

Patients will receive, when appropriate, information and instruction regarding storage, handling, and access to supplies and medical gases, in accordance with applicable Visiting Nurse & Hospice Care policies.

Definitions

1. **Medical Equipment**: An assistive device or piece of equipment used by hospice personnel and patient and family/caregiver to meet the patient's needs, such as wheelchairs, walkers, canes, lifts, and monitors.

2. **Home Care Supplies**: Those disposable items used by hospice personnel and patients and family/caregivers to meet the patient's needs, such as sterile dressings, syringes, catheters, tubing, and gloves.

3. **Oxygen and Related Equipment**: Any equipment used to deliver the gas to the patient, such as oxygen tank and tubing.

PROCEDURE

1. As part of the comprehensive assessment, the patient will be assessed as to any medical gases and/or sterile supplies to be used in the home setting, as well as the name of the home medical equipment company providing such service/equipment.

2. The selection, delivery, setup, initial instruction, and maintenance of home medical equipment are the responsibility of the equipment company.

3. The initial home assessment will include, but not be limited to:
   
   A. medical gas cylinders  
      Use of oxygen and oxygen-related equipment, including stored
   
   B.  
      The areas where medical gases are stored
   
   C.  
      The environment, including temperature where gases are stored
D. Use of sterile supplies related to care being provided by hospice

4. At the start of care or whenever supplies are initially utilized, the patient and family/caregiver using supplies (sterile and non-sterile) will designate an appropriate area in the home for storage.

5. The patient and family/caregiver will be instructed, as applicable, on:
   
   A. Storage of medical gases in a stable, ventilated, protected area
   
   B. Protection from heat extremes
   
   C. Safe filling of portable oxygen units
   
   D. Proper handling of sterile supplies
   
   E. Response to emergency situations and/or accidents in the home
   
   F. Delivery of and access to supplies

6. Documentation of patient and family/caregiver instruction in the clinical record will include:
   
   A. Information taught
   
   B. Adaptations made to the environment
   
   C. Patient and family/caregiver understanding
   
   D. Return demonstrations in use of medical equipment and/or supplies, if appropriate
   
   E. Response to teaching
   
   F. Additional learning needs
IDENTIFICATION, HANDLING, AND DISPOSAL OF HAZARDOUS WASTE
Policy No. H:5-008.1

PURPOSE

To provide guidelines for the instruction of patients and family/caregivers in the identification, handling, and disposal of hazardous materials and wastes.

POLICY

The patient and family/caregiver will receive, when appropriate, information and instruction regarding the identification, handling, and disposal of hazardous materials and wastes, in accordance with applicable Visiting Nurse & Hospice Care policies including, but not limited to, “Hazardous Waste Handling” (see Policy No. C:2-053), “Contaminated Materials Disposition” (see Policy No. C:2-051), “Contaminated Waste Disposal” (see Policy No. C:2-052), and “Communication of Hazards to Personnel” (see Policy No. C:2-059).

PROCEDURE

1. As part of the comprehensive assessment, the patient will be assessed for educational needs related to the identification, handling, and disposal of hazardous materials and wastes.

2. The assessment will include, but not be limited to:
   A. The potential need for and use of puncture-resistant needle containers
   B. The potential need for and use of bags for soiled dressing/linens
   C. The potential need for and use of gloves and protective clothing

3. The assessment will include the appropriate actions for both hospice personnel and the patient and family/caregiver while receiving hospice services.

4. The patient who has the potential for handling and disposing of hazardous materials will receive information on OSHA's bloodborne pathogens standards, as well as hospice home safety information that addresses hazardous waste in the home setting.

5. The materials will be reviewed initially with the patient and family/caregiver to assess their understanding of the actions to be taken to protect themselves. Completion of this instruction and full understanding are necessary prior to the patient and family/caregiver assuming care and performing interventions, which may put them at risk.
6. On subsequent visits, the Case Manager will observe the patient and family/caregiver performing appropriate care activities using information learned. Failure to perform activities according to accepted standards will result in re-instruction.

7. Documentation of patient and family/caregiver instruction in the clinical record will include:

   A. Information taught
   B. Adaptations made to the environment
   C. Patient and family/caregiver understanding
   D. Return demonstrations in use of equipment/procedures, if appropriate
   E. Response to teaching
   F. Additional learning needs
PURPOSE
To provide guidelines for the instruction of patients and family/caregivers in infection control precautions.

POLICY
The patient and family/caregiver will receive, when appropriate, information and instruction regarding infection control precautions, in accordance with applicable Visiting Nurse & Hospice Care policies including, but not limited to “Standard Precautions” (see Policy No. C:2-046) and “Hand Hygiene” (see Policy No. C:2-048).

PROCEDURE
1. As part of the comprehensive assessment, the patient and family/caregiver will be assessed for knowledge regarding infection control.

2. Based on the assessment and patient needs, the patient and family/caregiver will receive information and instruction on standard precautions, including such information as:
   A. Hand washing
   B. Protecting skin membranes
   C. Use of antiseptic cleaners
   D. Disposing of sharps in puncture-resistant containers
   E. Breaking of needles
   F. Food and drink in the patient care area
   G. Transmission of infections
   H. Personal protective equipment
   I. Cleaning and decontamination schedules, if appropriate
   J. Handling of soiled laundry and linen
   K. Emergency responses
3. When appropriate, the patient and family/caregiver will receive verbal and written information on standard precautions.

4. The use of standard precautions must be demonstrated by the patient and family/caregiver prior to them assuming responsibility for care.

5. Ongoing assessments will continually address the use of standard precautions.

6. Documentation of patient and family/caregiver instruction in the clinical record will include:
   
   A. Information taught
   B. Adaptations made to the environment
   C. Patient and family/caregiver understanding
   D. Return demonstrations in use of equipment, if appropriate
   E. Response to teaching
   F. Additional learning needs
PURPOSE

To provide guidelines for specific instruction and information for patients and family/caregivers in relation to emergency preparedness and actions to take in the event of a natural disaster and/or emergency.

POLICY

Patients and family/caregivers will receive information on an emergency management plan during the initial visit. (See “Guidelines for Emergency Management” Addendum H:5-010.A.)

PROCEDURE

1. As part of the comprehensive assessment, the patient and family/caregiver will be assessed regarding their emergency management plan for the home, and any special needs will be noted.

2. The patient’s and family/caregiver’s understanding will be assessed on an ongoing basis. Instruction will be in accordance with applicable organization policies, including, but not limited to, “Emergency Management Plan” (see Policy No. C:2-010.)

3. The patient and family/caregiver will be assessed and instructed regarding the components of an emergency preparedness/natural disaster plan that will include, but not be limited to:

   A. Emergency phone access, including ambulance, police, fire, gas, electric, water

   B. Emergency supplies, including food, water, heat, light, day-to-day necessities, and needed medical supplies

   C. Disaster follow-up, including battery-powered access to local radio stations

   D. Procedures to follow if care is disrupted by a natural disaster

   E. Actions to take in preparation and during natural disasters, such as flood, storms or earthquakes

   F. Actions to take in case of fire

   G. Evacuation plans for the home
4. Written information will be presented and reviewed, based on patient and family/caregiver knowledge, skills, and identified needs.

5. The Case Manager will document all patient and family/caregiver education information in the clinical notes. Noncompliance and/or lack of understanding will be documented, and a plan for instruction will be developed as part of the plan of care.
ADDENDUM H:5-010.A

GUIDELINES FOR EMERGENCY MANAGEMENT
SEVERE WEATHER/ EARTHQUAKES

1. Have emergency equipment and medical supplies readily available.

2. Close all drapes.

3. Move away from windows.

4. CLOSE exit doors.

5. Go to inside room of building with no windows, if available.

6. Do not enter damaged portions of the building until instructed.

7. Monitor weather bulletins/radio announcements.

8. Do not exit building until instructed.

REMAIN CALM. DO NOT PANIC.
FLOODS
(Flood warnings, alerts, or an actual flood)

Precautions before the flood:
1. Make sure emergency supplies and equipment are readily available.
2. Do not touch any electrical equipment unless it is dry.

Precautions if evacuation of building is ordered:
1. Travel only routes designated.
2. Do not try to cross a stream or other water areas unless you are sure it is safe.
3. Monitor local radio broadcast.
   A. Watch for fallen trees, live wires, etc.
   B. Watch for washed-out roads, earth slides, broken water lines, etc.
   C. Watch for areas where rivers, lakes, or streams may flood suddenly.

After the flood:
1. Do not enter the building until an all-clear has been given.
2. Do not use any open flame devices until the building has been inspected for possible gas leaks.
3. Do not turn on any electrical equipment that may have gotten wet.
4. Shovel out mud while it is still moist.

Flash floods:
1. Remember, flash floods can happen without warning.
2. When a flash flood warning is issued, take immediate action.

FOLLOW ALL INSTRUCTIONS ISSUED WITHOUT DELAY
SNOW EMERGENCY
(Snow emergency or winter storms)

1. Keep a one (1) to two (2) week supply of heating fuel, food, and water on hand in case of isolation at home.

2. Keep your car properly serviced, with snow tires and filled with gas.

3. Keep emergency supplies in the car: container of sand, shovel, windshield scraper, tow chain or rope, flares, blanket and flashlight.

4. Dress appropriately – wear several layers of loose, lightweight, warm clothing, mittens, and winter headgear to cover head and face.

5. Carry a cellular phone (if available).

6. Drive with all possible caution. If caught in a blizzard, seek refuge immediately. Keep car radio on for weather information.

7. If your car breaks down—turn flashers on or hang a cloth from the radio aerial; stay in your car. If your car is stuck in snow or traffic jam and car is running, crack windows to prevent carbon monoxide poisoning and keep exhaust pipe free of snow. If engine is not running, you do not need to crack windows.
Additional or alternate guidelines should be included by the organization based on its hazard vulnerability analysis and subsequent plan.

(See “Emergency Management Plan” Policy No. C:2-010.)
APPROPRIATE USE OF RESTRAINTS AND SUPPLIES
Policy No. H:5-011.1

PURPOSE

To provide guidelines for the instruction of family/caregivers regarding the appropriate, safe, and effective use of patient restraints.

POLICY

Patients and family/caregivers will receive information regarding the appropriate, safe, and effective use of restraints, alternatives to the use of restraints, and attention to the needs of the patient in restraint. Every effort will be used to avoid restraining patients. A physician’s (or other authorized licensed independent practitioner’s) order is required for the application of any restraint.

Definitions

1. Restrained: Any method (chemical or physical) of restricting a patient's freedom of movement, physical activity, or normal access to the body.

2. Physical Restraints: Specially designed devices including: an arm board, side rails on a bed, a wrist or hand restraints, or lap belts. Household materials intended for other purposes can also be used as a restraint, such as a sheet tied around the waist and chair, or a sheet tucked over a person and under the mattress to keep a person in bed.

3. Chemical Restraints: Any drugs that are used to control behavioral symptoms. Behavioral symptoms are actions used when a patient is unable to communicate verbally due to a medical condition, which expresses distress. Some examples of behavioral symptoms include: anger, agitation, screaming, continuous wandering, pacing, repetitive actions, or paranoia.

4. Psychoactive Drugs: The most common drugs that are used as chemical restraints. Psychoactive drugs include major tranquilizers or antipsychotics, sedatives/hypnotics, antidepressants, and minor tranquilizers or anxiolytics, and other drugs used to treat a physical illness that has psychoactive effects.

PROCEDURE

1. As part of the comprehensive assessment, each patient will be assessed regarding devices or medications being used within the home as restraints.

2. The clinician will, through interview and observation, determine the patient and family/caregiver level of understanding in the appropriate use of the restraint.
3. If the patient and family/caregiver have identified knowledge and skill deficits, the Case Manager will provide additional instructions to the patient and family/caregiver, including:

   A. How the device or medication acts as a restraint
   B. Correct and appropriate application of the device or the use of the medication
   C. Attention to the needs of the patient while the device or medication is being used
   D. Any alternatives to the use of the device or medication purely as a restraint

4. Hospice will maintain generic written and pictorial teaching tools for common devices used as physical restraints. These tools will be used whenever the family/caregiver chooses to restrain the patient. The teaching tools will include:

   A. Definition of the restraint
   B. Why family/caregivers choose to use the restraint
   C. The dangers associated with the use of the restraint
   D. Alternatives to using the restraint

5. Teaching materials will be provided for patients and family/caregivers that address the potential for psychoactive medications to be used as chemical restraints. The material may be provided by the pharmacist directly to the family/caregivers or to the hospice nursing personnel to discuss with them during home visits. The materials will include:

   A. The definition of a chemical restraint
   B. The actions and uses for a psychoactive drug
   C. At what point this type of drug is considered a chemical restraint

6. The clinician will assess on an ongoing basis the appropriate use of devices or medications used as restraints. Any suspected abuse/neglect will be reported according to “Assessment of Possible Abuse/Neglect” (see Policy No. H:2-052).

7. Documentation of instruction in the clinical record will include:

   A. Information taught
   B. Patient and family/caregiver understanding
   C. Return demonstrations
   D. Response to teaching
SIGN AND SYMPTOMS OF APPROACHING DEATH
Policy No. H:5-012.1

PURPOSE

To provide guidelines for recognizing the signs and symptoms of approaching death and taking appropriate action.

POLICY

A family/caregiver instruction sheet will be provided to hospice patients and family/caregivers describing signs and symptoms of approaching death and appropriate actions to take.

PROCEDURE

<table>
<thead>
<tr>
<th>Symptoms to Observe</th>
<th>Action to Take</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The arms and legs may become cool to the touch and you may notice underside of</td>
<td>1. Keep warm blankets on the family member's body to prevent him/her from</td>
</tr>
<tr>
<td>the body becoming much darker in color.</td>
<td>feeling overly cold. Do not use electric blankets.</td>
</tr>
<tr>
<td>2. The patient will gradually spend more and more time sleeping during the day</td>
<td>2. Plan your time with your family member for those occasions when he/she</td>
</tr>
<tr>
<td>and at times will be difficult to arouse.</td>
<td>seems more alert.</td>
</tr>
<tr>
<td>3. The patient may become increasingly confused about time, place, and identity</td>
<td>3. Remind your family member frequently what day it is, what time it is, and</td>
</tr>
<tr>
<td>of close and familiar people.</td>
<td>who is in the room and talking to him/her.</td>
</tr>
<tr>
<td>4. Incontinence (loss of control) of urine and bowel movements is often not a</td>
<td>4. Consult your nurse/aide about buying pads to place under the incontinent</td>
</tr>
<tr>
<td>problem until death becomes imminent.</td>
<td>patient.</td>
</tr>
<tr>
<td>5. Oral secretions may become more profuse and collect in the back of the throat.</td>
<td>5. Provide a cool mist humidifier to increase the humidity in the room.</td>
</tr>
<tr>
<td>You may have heard friends refer to a “death rattle.”</td>
<td>Elevating the head of the bed with pillows will make breathing easier.</td>
</tr>
<tr>
<td></td>
<td>Turn the patient often to either side, keeping off of the back. Ice chips,</td>
</tr>
<tr>
<td></td>
<td>a straw, and cool, moist washcloths will relieve feelings of dehydration.</td>
</tr>
<tr>
<td></td>
<td>Let the nurse know if this is a significant change.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Symptoms to Observe</th>
<th>Action to Take</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Clarity of hearing and vision decrease slightly.</td>
<td>6. Keep lights on in the room when vision decreases and never assume that the patient cannot hear you. Hearing is the last of the five (5) senses to be lost.</td>
</tr>
<tr>
<td>7. You may notice your loved one becoming restless, pulling at bed linen, and having visions of people or things which do not exist.</td>
<td>7. Talk calmly and assuredly with the confused person so as not to startle or frighten him/her further.</td>
</tr>
<tr>
<td>8. Your family member will have decreased need for food and drink.</td>
<td>8. Ask the nurse for a nutrition sheet for information about supplements.</td>
</tr>
<tr>
<td>9. During sleep, you may notice breathing patterns change to an irregular pace.</td>
<td>9. Elevating the head of the bed often relieves the person who has irregular breathing patterns.</td>
</tr>
</tbody>
</table>

_How You Would Know Death Has Occurred_

1. No breathing
2. No heartbeat
3. Loss of control of bowel and bladder
4. No response to shaking or shouting
5. Eyes fixed on a certain spot or eyelids slightly open
6. Jaw relaxed and mouth slightly open
PURPOSE

To provide guidelines for the use of community resources for patient and family/caregiver education.

POLICY

Hospice personnel, as well as the patient and family/caregiver, will have access to community resources in the provision of patient education appropriate to patient and family/caregiver needs.

PROCEDURE

1. Hospice will maintain a list of community resources and appropriate contacts that have patient education materials available for use in the hospice setting.

2. Resources available may include, but not be limited to:
   
   A. American Diabetic Association
   B. American Heart Association
   C. American Lung Association
   D. Cancer Society
   E. Drug and pharmaceutical companies
   F. National groups supporting diseases, such as ALS, MS, etc.
   G. Support groups, such as Ostomy, Y-Me, etc.

3. Hospice will use this information in conjunction with other materials developed by hospice.

4. Use of community and outside resources should be documented in the clinical record.
PURPOSE

To provide guidelines for identifying and providing educational resources required to achieve learning objectives for patients and family/caregivers.

POLICY

Visiting Nurse & Hospice Care will select and provide educational resources for the patient, based on patient and family/caregiver educational needs.

PROCEDURE

1. Hospice will provide educational resources that include, but will not be limited to:
   
   A. Members of the hospice interdisciplinary team
   
   B. Written instructions developed by hospice pertinent to services, pain and symptom management, treatments, medications, etc.
   
   C. Written information provided by the community, regional and national companies, and associations
   
   D. Written information provided by the patient's hospital
   
   E. The patient's physician
   
   F. Community resources

2. Educational methods will be based on the patient’s and family/caregiver’s ability to comprehend information and may include, but will not be limited to, any of the following methods:
   
   A. Verbal instruction
   
   B. Written instruction
   
   C. Demonstration and return demonstration
   
   D. Verbal demonstration
   
   E. Role playing
F. Videos/DVDs

G. Computer CDs/websites

3. When appropriate, hospice will arrange for additional education to be provided by community resources.

4. Patient and family/caregiver education will be provided in a language and at a level the patient and family/caregiver can be expected to understand, including the use of special devices, interpreters, and other aids needed to meet the patient's specialized needs.
SECTION SIX

Job Descriptions

Policy Statement ............................................................................................................................................ H:6-001
Professional Services Agreement For Medical Director ............................................................................ H:6-002
Scope of the Program/Process Methodology ......................................................................................... H:6-003
Competency Based Orientation .............................................................................................................. H:6-004
Core Competency Skills ......................................................................................................................... H:6-005
Annual Core Competence ....................................................................................................................... H:6-006
Specialized Services ................................................................................................................................. H:6-007
Requirements for Supervisors/Preceptors ............................................................................................. H:6-008

*Requires state or organization-specific information.

POLICY

Visiting Nurse & Hospice Care defines job responsibilities unique to the specific services provide or operations of the office. Job descriptions are provided to each employee who is hired. Job descriptions are available through Human Resources.
PROFESSIONAL SERVICES AGREEMENT FOR MEDICAL DIRECTOR
Policy No. H:6-002.1

PURPOSE

To ensure qualified medical direction and consultation for the delivery of hospice services and programs. To demonstrate that the Medical Director/hospice team physician has overall responsibility for patient care through documentation that demonstrates interaction/communication with the attending physician as necessary for appropriate care.

To outline the responsibilities of the Medical Director.

POLICY

The hospice Medical Director will have overall responsibility for the medical component of the hospice program.

The hospice Medical Director will provide oversight of physician services by complementing attending physician care, acting as a medical resource to the interdisciplinary team, assuring continuity of hospice medical services, and assuring appropriate measure to control patient symptoms. The Medical Director will serve as a hospice champion – promoting and representing the program to physicians, physician groups, discharge planners, other referral sources, community health organizations, and potential donors, as appropriate.

The hospice Medical Director/hospice Team Physician will be either a part-or full-time employee of the hospice, or have a contract with the hospice outlining his/her responsibilities.

The hospice Team Physician will be available whenever the hospice Medical Director is unable to perform his/her duties due to illness or vacation, or upon request.

Visiting Nurse & Hospice Care will have a written service agreement with a qualified physician to provide medical direction and consultation for organization programs and services. (See “Professional Services Agreement for Medical Director Sample” Addendum H:6-002.A.)

ROLE AND RESPONSIBILITIES

The duties and responsibilities of the Medical Director will include, but not be limited to, the following:

1. Devote his/her best ability to the proper management of the program.

2. Providing overall medical direction to the program including supervision of all hospice physician employees and contract hospice physicians.

3. Assuring that the established policies, bylaws, rules, and regulations of the organization are followed in the program.
4. Adhering to requirements, terms, and conditions required by Medicare Conditions of Participation, CHAP, and federal and state statutes governing the provision of services.

5. Establishing and continually reviewing policies and procedures related to patient care, medical education, and emergency procedures.

6. Developing and continually reviewing, in cooperation with the Executive Director/Administrator and/or, Clinical Supervisor, criteria to monitor the quality of the educational programs provided to physicians, personnel, and volunteer.

7. Evaluating quality assessment performance improvement (QAPI) plans and monitoring to identify medical education needs in cooperation with the Executive Administrator/Director and/or Clinical Director. Participates in QAPI teams and activities, as needed.

8. Proposing organizational programs to address the needs identified (with the assistance and input of consultants of the specialties where medical education needs were identified).

9. Working with the Executive Director/Administrator and/or Clinical Supervisor, after implementation of the programs, to determine the impact of said programs on the quality of care.

10. Serving as a hospice champion in the community

11. Acting as a liaison to community physicians by providing consultation and education to colleagues and attending physicians related to admission criteria for hospice and palliative care.

12. Acting as a medical liaison with other physicians at Visiting Nurse & Hospice Care.

13. Providing training regarding the medical aspects of caring for terminally ill patients to physicians, personnel, and volunteers.

14. Reviewing patient’s medical eligibility for hospice services, in accordance with hospice program policies and procedures, and establishing the plan of care in conjunctions with attending physician and interdisciplinary team prior to providing care including written certification of terminal illness.

15. Providing written certification of the terminal illness for all subsequent benefit periods.

16. Perform face-to-face encounters within thirty (30) days of the third and subsequent hospice benefit certification periods and attest to the encounter. (NP may complete the encounter and report findings to hospice physician.)

17. Consulting with attending physicians regarding pain and symptoms for management for hospice patients.

18. Managing oversight of the patient’s medications and treatments.
19. Acting as a medical resource to the hospice interdisciplinary group

20. Attending interdisciplinary group meetings and working in a team approach with the group

21. In conjunction with the attending physician and interdisciplinary group, reviewing and updating the plan of care every 15 days, or more frequently as needed.

22. Documenting care provided in the patient’s clinical record, providing evidence of progression of the end-stage disease process.

23. Acting as primary physician for patients who referring/attending physicians desire to relinquish that care and/or if the referring/attending physicians are not available for further contact.

24. Maintaining current knowledge of the latest research and trends in the hospice care and pain/symptom management.

25. Reviewing and developing protocols for treatment, and proposing the most current option for interventions.

26. Demonstrating knowledge in communications, and counseling patients and family/caregivers dealing with end-of-life issues.

27. Participating in resolution of interpersonal conflict and issues of clinical and ethical concern.

28. Ensuring that competent physician services are routinely available on a 24-hour basis to meet the general medical needs of the hospice patient to the extent the needs are not met by the attending physician.

29. Assisting with evaluation of protocols and procedures with respect to quality and cost outcomes.
SCOPE OF THE PROGRAM/PROCESS METHODOLOGY
Policy No. H:6-003.1

PURPOSE
To ensure that the recruitment and retention of personnel whose competence is assessed, maintained and improved on a continuing basis.

POLICY
Hospice defines and implements an objective, measurable assessment system to evaluate the competency of all clinical personnel.

Hospice personnel will demonstrate knowledge and proficiency of skills appropriate to their assigned responsibilities, including an ability to perform specified duties determined by the hospice. Skills will be maintained and improved through continuing education programs, based on the analysis of trends and outcomes identified through the Clinical Competency Program, on-site supervision and established reviews.

Skill proficiency can be determined by: verbal or written examination; skill demonstration in a lab setting or patient’s home; or by completion of a specialized training course specific to a clinical procedure (i.e., PICC Certification).

PROCEDURE
1. Hospice establishes and annually re-evaluates its job specific “Competency Based Orientation Checklist” which reflects duties commonly required in the performance of clinical positions.

2. Hospice will establish and annually evaluate a group of specific skills related to patient care responsibilities and complexity of care provided by staff. Competencies must be successfully demonstrated before hospice personnel complete orientation.

3. Hospice will clearly identify and define the skills which are essential to observe for the determination of competence, for each job category. In the identification of core competence, the essential skills will be demonstrated upon hire and annually thereafter. 100% of the designated core competencies must be met for the determination of competence.

4. Special attention is provided to communication, interpersonal skills and issues of loss and grief.

5. Specific competencies will be developed for high-risk, high volume, problem prone, and specialty service care areas. (See “Specialized Services” Policy No. H:6-007.) Personnel providing service in the defined target areas will receive specialty training and provide demonstrated competence prior to the provision of specialty service.
6. A preceptor will be assigned to each new staff member as part of the orientation process. The preceptor/supervisor will observe and deem proficient the indicated skills and core competencies. If necessary, additional training, or inservice education will be provided to the staff member. Hospice personnel will not provide the care or service independently until satisfactory completion of required skills competency.

7. After the completion of orientation, competency will be monitored at least annually as part of the annual performance evaluation process. Competency will also be monitored when:

   A. Personnel are performing a new procedure, or using a piece of equipment for the first time.

   B. The Orientation Skills Checklist indicates a trend for retraining. The trend can be identified by a demonstrated knowledge deficit when the skill is an invasive procedure, or when the hospice expects the skill to be performed routinely in the scope of patient care.

   C. Care is provided in a specialized area for the first time. (See “Specialized Services” Policy No. H:6-007.)

   D. Reporting systems indicate that hospice personnel require additional training or supervision.

   E. Whenever hospice personnel request it.

8. Qualified evaluators will conduct the proficiency demonstration component of the Clinical Competency Program. (See “Requirements for Supervisors/Preceptors” Policy No. H:6-008.)

9. Clinical competency of qualified evaluators (preceptors, supervisors, peers, clinical specialists) is also defined and regularly evaluated. (See “Requirements for Supervisors/Preceptors” Policy No. H:6-008.)
PURPOSE
To evaluate skills and experience upon hire using a standard tool.

POLICY
Hospice ensures that the competency of all personnel is assessed on hire, prior to providing care to hospice patients.

GUIDELINES
Orientation is intended to prepare the employee to perform the duties of a new role with a competent level of skill. Competency Based Orientation (CBO) is a method of learning which stresses performance of competencies that relate directly to the employee’s job description. There is flexibility in the time and sequence of the orientation activities.

A preceptor(s) will be assigned to each orientee. The primary role of the preceptor(s) is to facilitate the learning and socialization of the new employee during the orientation program.

PRECEPTOR OBJECTIVES
1. Present information needed to function in the hospice.
2. Observe specific tasks to assure satisfactory performance of essential duties and procedures.
3. Identify problems and additional learning needs as early as possible in the orientation process.

ORIENTEE OBJECTIVES
1. Assess the Physical and Functional characteristics, Psychosocial characteristics, past and current medical history, current medication and treatments, patient/family educational needs, discharge planning needs, and environmental and/or equipment needs of each patient assigned.

4. Evaluate the effect of discipline specific interventions.

5. Exhibit professional behavior.

6. Provide high quality of service in all aspects of job performance.

**COMPETENCY ORIENTATION SKILLS CHECKLIST GUIDELINES**

1. Hospice personnel are given the appropriate job category Orientation Checklist during the orientation process.

2. Hospice personnel rate their knowledge and abilities in the various procedures routinely performed in the course of their jobs on the self-assessment position of the checklist.

3. If hospice personnel work in a specialized area (i.e., Infusion Therapy) they must complete the Basic Inventory plus the specialty Orientation Skills Checklist. (Example: registered nurse who does IV Therapy completes the Basic Registered Nurse and Infusion Nurse.)

4. The method to evaluate each indicator will be documented on the checklist.

5. When the Competency Orientation Skills Checklist is completed, it is reviewed by the preceptor and the Clinical Supervisor. Additional training and education is performed as indicated until competence is demonstrated.
CORE COMPETENCY SKILLS
Policy No. H:6-005.1

PURPOSE
To identify and define the specific core competency skills for clinical personnel.

POLICY
Hospice personnel will be provided with core competency statements relative to the skills required for their particular positions.

PROCEDURE
1. Hospice will define the mandatory core competency skills for each discipline based upon the nature of their job responsibilities and complexity of care required.

2. Core competency skills will be reviewed with new personnel during their orientation.

3. Each core competency skill has a corresponding set of performance criteria. (See “Annual Core Competence” Policy No. H:6-003.)

4. Core competency skill areas may be changed based upon data trends, regulatory requirements, services provided, or hospice personnel needs.
PURPOSE

To ensure that all hospice personnel are able to display competence in skills specific to the hospice’s needs on an annual basis.

POLICY

Hospice will implement an objective, measurable system to evaluate competency. The performance criteria lists the required behavior hospice personnel must demonstrate to be deemed proficient in the skills required.

PROCEDURE

1. Hospice personnel will demonstrate proficiency in the performance criteria/skills during the orientation period, and at least annually thereafter as part of the annual performance evaluation process.

2. If hospice personnel are not required to perform a specific aspect of care or task as a routine part of their job responsibilities, the performance criteria is simply labeled “Not Applicable” or “N/A” by a qualified evaluator.

3. Hospice personnel are deemed proficient only when 100% of the applicable performance criteria are demonstrated.
PURPOSE

To define the specialized services and related staff qualifications to provide safe, effective care.

POLICY

In the case that specialized services would be provided, Visiting Nurse & Hospice Care will ensure that any clinical personnel providing any of the following services will have special training and demonstrated skills competence. The following services are defined as high-risk, low volume and problem prone:

1. Care of ventilator dependent patients
2. Vesicant chemotherapy
3. PICC line insertions
4. Midline catheter insertions
5. Accessing implanted ports
6. Epidural catheter management
7. Intrathecal catheter management
8. Other (invasive, high-risk) procedures or services as determined by the Director.

PROCEDURE

Prior to providing any of the defined services, hospice personnel must possess specific training and experience with the required associated skill. Specialty training/experience includes:

1. A certificate of completion from a training program sponsored by a professional organization (Intravenous Nurses Society, Oncology Nurses Society, and Hospice Nursing Association). The training course includes a didactic and skill demonstration component.
2. A certificate of completion from a training program sponsored by a hospice, organization, or hospital that meets the criteria for continuing education by the State Board of Nursing, Professional Standards of Practice and is approved by the American Nurses Association. The course includes both didactic and skills demonstration.
3. In addition to meeting the above requirements for education and training, hospice personnel must also demonstrate proficiency to a qualified individual through direct observation prior to performing this service independently.
PURPOSE

To define level of clinical knowledge and expertise required for clinical supervision.

POLICY

Hospice supervisory personnel will have demonstrated clinical knowledge/experience appropriate to their assigned responsibilities, and complete a clinical skills competency on a defined, regular basis.

PROCEDURE

1. Personnel who may supervise include the following:
   A. Personnel who supervise direct care hospice personnel.
   B. Evaluators/preceptors that perform proficiency determinations.
   C. Consultants/contracted personnel that assume those duties.

2. Personnel who supervise will demonstrate clinical competency by:
   A. Completion of appropriate Orientation Skills Checklist for discipline.
   B. Demonstration of competencies annually.
   C. Appropriate education and experience required in the job description, and required by regulatory requirements.
   D. Meeting hospice requirement for inservice programs intended to maintain and improve skill competency.

3. If the Supervisor does not have appropriate clinical training or experience in a specialty area, they will seek qualified consultation.

4. Supervisors will monitor staff skills through direct observation at regular, defined intervals.

5. Documentation of the observed skills, along with the purpose for the joint visit, will be maintained and filed with personnel files.
ATTACHMENTS

Attachment I: Medicare Conditions of Participation
Attachment II: Hospice Interpretive Guidelines
Attachment III: Hospice Manual
Attachment IV: Additional Resources
ATTACHMENT I

MEDICARE CONDITIONS OF PARTICIPATION

We recommend accessing www.access.gpo.gov/nara/cfr/waisidx_01/42cfr418_01.html to download the most recent Federal/Medicare Conditions of Participation.
ATTACHMENT II

HOSPICE INTERPRETIVE GUIDELINES

We recommend accessing www.cms.hhs.gov/manuals/Downloads/som107ap_m_hospice.pdf to download the Hospice Interpretive Guidelines.
ATTACHMENT III

HOSPICE MANUAL

We recommend accessing www.cms.hhs.gov/Manuals/OM/list.asp to download the most current Medicare Hospice Benefit Policy Manual, CMS Publication 100-2, Chapter 9, and the Medicare Hospice Claims Processing Manual, CMS Publication 100-4, Chapter 11.
ATTACHMENT IV

ADDITIONAL RESOURCES

We recommend accessing the following websites to download the most current information. Please print and insert applicable documents here.

State Operations Manual, CMS Publication 100-8: [www.cms.hhs.gov/Manuals/IOM/list.asp](http://www.cms.hhs.gov/Manuals/IOM/list.asp)
Centers for Disease Control: [www.cdc.gov](http://www.cdc.gov)
Occupational Safety and Health Administration (OSHA): [www.osha.gov](http://www.osha.gov)

**State-specific Websites:**

State Hospice Association website
State Professional Practice Acts
Other

The following website can be used to access all federal forms for provider use:

[http://www.cms.hhs.gov/forms](http://www.cms.hhs.gov/forms)