POLICY STATEMENT:
Hospice care and services provided to patients and their families are in accordance with an individualized, written plan of care established by the hospice interdisciplinary team (IDT) in collaboration with the patient’s attending physician (if any), and, if appropriate, the patient or representative and the primary caregiver.

The plan of care reflects patient and family goals and interventions that are based on the problems identified in the initial, comprehensive and updated assessments.

PROCEDURE:
1. The patient’s plan of care specifies the care and services necessary to meet the needs of the patient/caregiver as identified in the initial, comprehensive, and updated assessments of the patient.
2. The patient’s plan of care includes all services necessary for the palliation and management of the terminal illness and related conditions.
3. The plan of care includes, but is not limited to:
   a. Interventions to manage pain and symptoms.
   b. A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.
   c. Measurable outcomes anticipated from implementing and coordinating the plan of care.
   d. Drugs and treatment necessary to meet the needs of the patient.
   e. Medical supplies and appliances necessary to meet the needs of the patient.
   f. Documentation from the IDT of the patient or representative’s level of understanding, involvement and agreement with the plan of care.
4. The services provided are explicitly linked to the assessed needs of the patient/family related to the patient’s terminal illness and related conditions.
5. Efforts to involve the patient’s attending physician (if there is one) in the development and updating of the hospice plan of care and the results of those efforts are documented in the patient’s clinical record.
6. Each patient and his or her primary caregiver(s) receive education and training from the hospice as appropriate to their responsibilities for the care and services provided in the plan of care.
7. When the patient/representative evidence impediments to participating in care planning and understanding the plan of care, those impediments are documented in the patient’s clinical record and the level of understanding or lack of understanding are recorded.
8. When the patient, representative or primary caregivers decline to be involved in actively developing the plan of care, this is documented in the patient’s clinical record.
9. The plan of care is reviewed and updated by the IDT every 15 days, or more frequently, if needed.
10. Revisions to the plan of care are based on information from the patient’s updated comprehensive assessment and the patient’s progress toward outcomes specified in the plan.
11. Reviews of, and changes to, the plan of care are documented and communicated to members of the IDT.

REFERENCES: