POLICY

High Peaks Hospice (HPH) will provide predominately skilled nursing care, in compliance with an established plan of care, for 8 to 24 hours per day to a patient in the home during periods of crisis, in order to achieve palliation or management of acute medical symptoms.

DEFINITIONS:

- **Predominantly** refers to the majority of hours, 50% needing to be filled by a Nurse (RN) or Licensed Practical Nurse (LPN) under the supervision of a RN. Hospice Aide (HA) or Homemaker services may augment but not exceed nursing services as determined by the patient’s condition.

- **Skilled nursing** is that set of activities defined by the New York Nurse Practice Act.

- **In the home** refers to a patient already receiving home care services at the time of needing continuous services.

- **8 hours** is a minimum and must be counted from midnight to midnight.

- **A crisis** is the sudden onset of a problem that interrupts palliation and requires at least 8 hours of nursing (RN or LPN) intervention to assess and control.

- **Palliation and management of acute medical symptoms** includes skilled nursing assessment of patient’s status, administration and evaluation of specific treatments, and instruction to the caregivers to provide the needed care if they are able and willing to learn.

CRITERIA

One or more of the following criteria must be present in order for the patient to be considered appropriate, and therefore admitted to hospice continuous care. Decisions are made on a case-by-case basis after evaluation by the appropriate HPH staff. The need for continuous care must be assessed, deemed reasonable and necessary, clearly documented by the RN and approved by the HPH Medical...
Director. Acute medical symptoms shall be defined as acute exacerbation and/or decompensation of the following signs/symptoms:

1. Seizures: onset/status epilepticus
2. Severe pain
3. Severe respiratory distress
4. Severe nausea and vomiting
5. Hemorrhaging
6. Suicidal gesture/attempt
7. Severe agitation/confused state
8. Imminent death
9. Other – to be determined/authorized by the Patient Care Coordinator (PCC) or designee

PROCEDURE

1. The primary nurse (RN) is responsible for the initial identification of the patient’s need for continuous care.

2. The RN confers with the attending physician, Patient Care Coordinator (PCC) and all other interdisciplinary team (IDT) members to determine the need for continuous care.

3. If appropriate, the fiscal intermediary is contacted to verify justification.

4. The RN will prepare the patient/family for the presence of nurses in the home on a continuous basis.

5. The RN will inform the patient/family that continuous care is only for the period of crisis and the patient/family will return to routine home care when the patient’s medical condition has stabilized.

6. The PCC or designee is responsible for scheduling continuous care nurses to meet patient care needs.

7. The RN will instruct the family to provide specific treatments regarding the care of the patient, if willing and able.

8. Each continuous care RN and LPN will receive an orientation by a HPH RN to the hospice program and continuous care services.

9. Each Hospice Aide (HA) will be oriented and supervised following HPH regulations.
10. Each continuous care nurse will receive a copy of the Continuous Care Guidelines for Hospice Patients.

11. All documentation forms (physician orders, interdisciplinary care plan, medication schedule, pain assessment flow sheets, narratives, continuous care schedule, narcotic and syringe count, controlled substance disposition record, note at time of death, and time sheets) will be provided in the home to the continuous care nurse in order to assure continuity.

12. Continuous care nurses are responsible for reporting off at the end of shift, documenting all patient care services and keeping HPH informed of patient’s status.

13. The patient’s RN, in conjunction with the PCC will determine when the crisis period is ended.

14. When determination is made to end continuous care, due to patient stabilizing, the family and attending physician will be informed by the RN and a routine home care plan will be updated and resumed to meet current needs.

15. The PCC or designee will notify continuous care nurses already scheduled of termination time of continuous.

16. All documents must be filed in the patient’s chart in the HPH office and the electronic clinical record updated.

**DOCUMENTATION**

1. The **Physician’s Orders** are to be transcribed as soon as they are received.

2. The **Interdisciplinary Care Plan** must document, in detail, the acute medical symptoms that constitute the crises and the plans (goals) to alleviate/palliate symptom(s).

3. **Narratives** are to be done hourly and must document the need for nursing skills.

4. The **Pain Flow Sheet** is to record assessment of pain hourly.

5. The **Medication Record** is to record the administration of all medications.

6. The **Narcotic and Syringe** count is for recording the number of syringes and the amount of narcotics which are in the home at the change of shift.
7. The **Continuous Care Schedule** will note the name, time, discipline and agency of all RNs, LPNs and HAs. The schedule will be submitted to the Business Office after verification by the PCC or designee to ensure accuracy.

**CONTINUOUS CARE PROCESS**

1. Each office will maintain two (2) Continuous Care Books. If both books are to be in patients homes simultaneously, provisions will be made to have a backup copy of the Continuous Care Book ready in the office in case of need.

2. The *entire* Continuous Care Book will be taken into the patient’s home.

3. Once Continuous Care is initiated, the following steps will be followed:
   A. An order for Continuous Care will be obtained and processed
   B. An adequate number of necessary forms are available:
      1) Interdisciplinary Progress Notes
      2) Initial Pain Assessment sheets (one is done every time a different type of pain, place of pain is identified)
      3) Pain Assessment Flow Sheets
      4) Interim Physician Orders
      5) Medication Administration Sheets
      6) Narcotic and Syringe count forms
      7) Continuous Care Scheduling Sheets.
   C. The following will be copied: *(originals go into binder, copies stay in clinical record in office):*
      1) Interdisciplinary Care Plan
      2) Pain Flow sheets
   D. The following will be copied: *(originals stay in clinical record maintained in office):*
      1) the initial and any current interim orders
      2) medication profile sheets
   E. A minimum of one page of patient identification labels *(Patient’s name and MR#)* will be made for Continuous Care Book.
   F. The Continuous Care Book will be returned to the HPH office as soon as continuous care is discontinued. At that time, information will be entered into the electronic medical record.

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