POLICY

High Peaks Hospice (HPH) must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This will include all areas of hospice care related to the palliation and management of the terminal illness and related conditions.

PROCEDURE

1. A registered nurse (RN) will complete an initial assessment within 48 hours of an individual being admitted to the hospice program unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.

2. The Initial Assessment will evaluate the patient's physical, psychosocial and emotional status related to the terminal illness and related conditions to determine the patient's immediate care and support needs.

3. Comprehensive Assessment: The Interdisciplinary Team (IDT) in consultation with the individual's attending physician (if any) will complete the comprehensive assessment, no later than 5 calendar days after the election date of hospice care. Contents of the Comprehensive Assessment must:

   A. Identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.

   B. Take into consideration the following factors:
      1) Nature and condition causing admission (including the presence or lack of objective data and subjective complaints)
      2) Complications and risk factors that affect care planning
      3) Functional status, including the patient's ability to understand and participate in his or her own care
      4) Imminence of death
      5) Severity of symptoms
6) Drug Profile: A review of all of the patient’s prescription and over-the-counter
drugs, herbal remedies and other alternative treatments that could affect drug
therapy. This includes, but is not limited to, identification of the following:
   a) Effectiveness of drug therapy
   b) Drug side effects
   c) Actual or potential drug interactions
   d) Duplicate drug therapy
   e) Drug therapy currently associated with laboratory monitoring

C. Bereavement. An initial bereavement assessment of the needs of the patient’s
family and other individuals focusing on the social, spiritual, and cultural factors
that may impact their ability to cope with the patient’s death. Information gathered
from the initial bereavement assessment must be incorporated into the pan of
care and considered in the bereavement plan of care.

D. The need for referrals and further evaluation by appropriate health professionals

4. Update of Comprehensive Assessment:

A. The update of the comprehensive assessment must be accomplished by the IDT
   (in collaboration with the attending physician, if any) and must consider changes
   that have taken place since the initial assessment.

B. It must include information on the patient’s progress toward desired outcomes, as
   well as a reassessment of the patient’s response to care.

C. The assessment update must be accomplished as frequently as the condition of
   the patient requires, but no less frequently than every 15 days.

5. Patient Outcome Measures:

A. The comprehensive assessment must include data elements that allow for
   measurement of outcomes. HPH must measure and document data in the same
   way for all patients. The data elements must take into consideration aspects fo
care related to hospice and palliation.

B. The data elements must be an integral part of the comprehensive assessment
   and must be document in a systematic and retrievable way fo reach patient. The
data elements for each patient must be used in individual patient care planning
   and in the coordination of series, and must be used in the aggregate for HPH’s
   quality assessment and performance improvement program (QAPI)

6. The IDT will conduct and document the Initial/Comprehensive Assessment in
   collaboration with the attending physician and family to include:

A. Health history, including recent lab and test results
B. Vital signs/allergies, including height and weight (estimate if necessary)

C. Nutritional status-check descriptive terms appropriate to nutritional status, identify diet type, supplements and instructions given. Indicate status of mouth/teeth.

D. Functional status-check appropriate level of independence for each activity of daily living and degree of self care which can be performed. Include mobility status.  
(See Clinical Policy “Functional Status Assessment” CP227 for further information)

E. Describe appropriate areas of the following assessed systems:
   1) cardiovascular
   2) pulmonary
   3) musculoskeletal
   4) gastrointestinal
   5) genitourinary
   6) skin
   7) eyes
   8) ears
   9) mental status: orientation, cognitive level, communication skills, and memory

F. Age specific and gender specific findings

G. Statement of initial impressions/conclusions for initial assessment re: necessary services to be provided.

H. Discharge/bereavement plan: Must be noted on initial assessment.

I. Initial assessment of patient/family educational needs: Consider: language barriers, cultural and religious practices, emotional concerns, cognitive limitations, communication barriers

J. History of chemical dependency

K. Initial pain screening. If pain is a problem, or if the patient is taking pain medication, a comprehensive pain assessment shall be completed.

L. Describe significant psychosocial, environmental, and other findings

M. Emotional response to current health status

N. Home safety measure/deficits

O. Suitability or adaptability of the home for providing services.
7. Utilize the initial assessment to prioritize focus areas and formulate a plan of care in collaboration with the patient/family and attending physician. (See Clinical Policy "Patient/Family Care Plan CP247")

8. The assessment documentation shall include:

   A. Documentation that the Patient/Family Bill of Rights, informed consent, and information on advance directives were discussed and understood by the patient/family or representative

   B. Documentation of the patient’s previous level of care, previous care system, and other agencies/services that were previously involved in the patient care.

   C. The “Do Not Resuscitate (DNR)” status desires of the patient/family or representative

   D. Documentation for Health Care Proxy if patient is declared incapacitated by their attending physician

   E. Physician chosen by patient was notified of hospice admission and gave initial hospice orders.

   F. Detail of assessment findings

   G. Goals set by patient/family to show collaboration with plan of care

   H. Documentation of instruction given to patient/family/caregiver(s) and their comprehension.

   I. Documentation of nursing care performed during the initial visit and patients’/families’/caregiver(s) responses to this care.

   J. Identify nursing interventions, i.e.: skills observed, instructions provided, direct care given and physician contact made.

   K. Name and telephone number of family members or contact in case of emergency.

9. An RN Case Manager will be assigned to coordinate hospice services for the patient. The RN Case Manager or designee will conduct, and document within 24 hours of visit, an update to the comprehensive assessment prior to HPH’s IDT meeting in collaboration with the attending physician if any. (See Clinical Policies “Scope of Services-Nursing CP261”, “Interdisciplinary Team (IDT) CP286”).
10. A social worker and chaplain will conduct, and document within 24 hours of the visit, an update to the comprehensive assessment prior to the HPH’s IDT meeting scheduled not less frequently than every 15 days. (See Clinical Policies “Scope of Services-Bereavement CP260”, “Scope of Services-Spiritual Care CP263”, Scope of Services - Social Work CP262”.

11. Any other health professionals determined to be necessary by the IDT will conduct their services and document within 24 hours of their visits.

12. The Quality Assurance Coordinator will use data elements collected on each patient for aggregate reporting to the Board of Directors. (See Personal Policy “Quality Assessment and Performance Improvement (QAPI) HPH157

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