POLICY

High Peaks Hospice (HPH) will provide nursing care for all patients admitted to HPH for hospice services. Nursing care will be provided by hospice registered nurses (RNs) and licensed practical nurses (LPNs) under the supervision of the Patient Care Coordinator (PCC) or designee.

PROCEDURES

1. A HPH nurse will maintain contact with the patient/family as appropriate across all care settings. Hospice nursing services will be provided in the following settings:
   A. Private homes (including adult homes and senior residences)
   B. Contracted Skilled Nursing Facilities
   C. Contracted hospitals

2. The PCC will assign an RN Case Manager to the patient/family to provide nursing care and to coordinate other services designated on the care plan across all settings after they have been approved for admission to HPH Services.

3. The RN Case Manager, in addition to participation in the development of the care plan, will see that the physical, psychosocial, emotional, spiritual and family member assessments for each patient/family are completed by the appropriate disciplines.
   A. An initial assessment will be completed within 48 hours of the admission.
   B. A comprehensive assessment will be completed within 5 days of the admission.
   C. An updated comprehensive assessment will be completed at a minimum every 14 days and collaborated with the Interdisciplinary Team (IDT).
   D. Will be responsible for coordinating the discharge or transfer of patients. (See separate policies for procedures)

4. The RN Case Manager will provide case management as follows:
   A. Visit a minimum of once every 14 days to perform physical assessments of the patient.
   B. Be a liaison between all disciplines providing care, as well as with other organizations providing care.
C. Facilitate communications between IDT members, the family and the patient’s attending physician, via personal or telephone contact, and document in the patient medical record and wherever else is appropriate.

D. Provide nursing care in accordance with the acceptable standards of nursing practice and HPH policies.

E. Assess patients and families responses to care and services provided by other individuals and organizations. Coordinate subsequent care and services as appropriate (including transfers of patients between levels of care within the hospice system of care), based on the assessment and the patient and family responses.

F. Document coordination of all services provided to the patient, referrals to appropriate disciplines, and cooperation with other health, social and community organizations.

G. Ensure, when possible, that each patient consistently receives care from the same IDT members.

2. The nursing staff will:
   A. Document within 24 hours all care and services provided in manual or electronic form as required by HPH.
   B. Establish and maintain a current medication profile.
   C. Obtain signed physician orders for initial admission, modifications to initial orders or medications, and renewal of orders for recertification to the hospice services as needed.
   D. Attend IDT conferences to review the IDT plan of care.

3. In the home and nursing home setting the RN Case Manager will:
   A. Incorporate hospice aides (HAs) and volunteers into the plan of care as appropriate.
   B. Provide on-site introduction and orientation of such individuals to the family and review services to be provided.
   C. Supervise these individuals every 14 days and reassess continued need.
   D. Document all supervisory visits of LPN and HA services in the patient/family record.
   E. Notify the patient in a timely manner of significant changes in these persons’ schedules.
   F. Notify the LPN, HA, and volunteer if visits should be stopped such as when the patient’s level of care changes or in case of discharge.

4. In the inpatient setting, the RN Case Manager will:
   A. Include the patient, family members and facility staff in the planning of care and proposed outcomes.
   B. Instruct facility staff regarding hospice philosophy, appropriate symptom management, and anticipatory guidance as it relates to the management of the disease process.
C. Incorporate IDT members, LPNs, HAs, and volunteers into the plan of care as appropriate. These individuals will be introduced to the patient, family and facility staff, and oriented by or designee.
D. Document all supervisory visits of LPN and HA services in the patient/family record.
E. Notify the patient and facility staff in a timely manner of significant changes in the person’s schedule.

5. All nurses shall be provided with orientation and in-service programs as needed in order to maintain clinical skills.

More detailed procedures can be found in other Clinical Policies by Topic.

Practice Guidelines:
Hospice Nursing Practice Guidelines. 1997 (attached to Clinical Policy: Professional Nursing Practice CP254)
Scope and Standards of Hospice & Palliative Nursing Practice, (www.hpna.org/pub)
New York State Nurse Practice Act (www.ncsbn.org/regulation)
Scope and Standards of Home Health Nursing Practice and Nursing: Scope and Standards of Nursing Practice (www.nursingworld.org/publications
Hospice Code of Ethics: National Hospice Association (www.hpna.org)

LAST REVIEW DATE:  IDT 02/08/17, Clinical Comm 04/25/17

LAST UPDATED:  Comp Coord 10/21/16, 04/05/17, 05/10/17, 05/24/17, 09/01/18

BOARD APPROVAL:  May 23, 2017