POLICY

High Peaks Hospice & Palliative Care (HPHPC) provides hospice services twenty-four (24) hours per day, seven (7) days a week by utilizing on-call services. On-call services demonstrate ease of access to services, prompt response, and appropriate assessment and interventions.

PROCEDURES:

1. ON-CALL STAFFING:

   A. Patient Care Coordinators (PCC) are responsible for assuring that sufficient triage and on-call team members are scheduled to meet hospice care requirements outside of regular business hours. These schedules are coordinated and communicated to assure agency-wide coverage.

   B. Supervision of on-call staff and activities is provided by the designated Supervisor On-Call.

   C. After orientation, all Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) will complete on-call training and share in on-call responsibilities as needed to meet hospice service requirements.

   D. All Triage RNs and emergent on-call visit responsibilities are covered by team members with appropriate credentials, training and judgment to provide the needed care. Since emergent nursing visits require the ability to complete assessment and make judgments, such visits will be provided by qualified nursing staff with appropriate supervision.

   E. LPNs who have been scheduled for on-call may make visits when the need for such visits has been identified by on-call Triage staff. These visits might include ongoing wound care, personal care and reinforcement of the existing plan of care.

2. ON-CALL PROCESS

   A. On-call team members are responsible for responding to all contacts concerning HPHPC patients and their families, according to agency standards, in a timely
manner utilizing problem solving skills and interviewing techniques to determine the plan of action to respond to the needs of the patient and family.

B. Patients and caregivers receive verbal and written information at the time of admission regarding how and when to access care after normal business hours.

C. The patient or caregiver can call the hospice for care or other needs at any hour. Outside of business hours, calls are received by the hospice’s answering service. The answering service forwards all patient/family related calls to the Triage RN.

D. The Triage RN determines whether the patient/family needs can be met by phone intervention or require a visit. If a visit is required, the Triage RN arranges for a visit by the appropriate on-call team member and informs the patient/family to expect the visit. Psychosocial and/or spiritual needs may be referred to the Social Worker or Chaplain.

E. The Triage RN provides follow-up appropriate to each call. Activities may include, but are not limited to:
   1) Calling the patient, family or caregiver;
   2) Providing needed information, education or instructions;
   3) Arranging a visit if necessary;
   4) Obtaining physician orders as needed;
   5) Arranging for other services as needed;
   6) Arranging for changes in the level of care as needed (RN visit and consultation with Supervisor On-Call required);
   7) Obtaining medications, equipment, and/or supplies as needed;
   8) Attending to the death of a patient if a visit is declined;
   9) Making status check or intro to on-call phone calls as requested;
   10) Taking referrals for service; and/or accepting and communicating messages for agency personnel.
   11) Will review and sign off on all LPN documentation for on-call visits

F. If a visit is made, responsibility for such activities is shared appropriately between the visiting staff member and the Triage RN.

G. All on-call care and activities are documented in a timely manner according to agency standards. On-call report is completed at the end of each day or shift.

H. The Triage RN communicates information (e.g., changes in the plan of care, status updates, deaths, referrals, admissions, etc.) to the Supervisor On-Call according to agency standards in a timely manner.

I. Interdisciplinary team members update on-call staff members, before the end of each business day, of status changes and plan of care revisions in order to ensure continuity of care.
J. Each clinical office provides an update to on-call staff members, census changes and requested calls or visits at the end of each business day.

3. EMERGENT VISITS:

A. Problems that may require an emergent hospice visit include, but are not limited to:
   1) death or suspected death;
   2) new, unusual, severe, or uncontrolled pain;
   3) respiratory difficulty;
   4) nausea/vomiting not resolved with present medications;
   5) new onset seizures or suspected seizures;
   6) IV or parenteral access issues;
   7) occluded tubes or drains;
   8) bleeding or suspected bleeding;
   9) report of patient fall or accident;
   10) no bowel movement for four days or more (if taking food);
   11) no urine for 8 – 12 hours (if taking fluids and having discomfort);
   12) increased anxiety and/or confusion change in mental status;
   13) psychosocial crisis (i.e. caregiver dysfunction, profound grief or depression);
   14) repeat calls regarding the same problem;
   15) if the patient, family or caregiver perceives an emergent problem and requests an immediate visit.

B. Emergent visits are made without delay, with the shortest reasonable travel time

C. All on-call team members will notify the supervisor on-call of any issues/concerns out of the ordinary.

D. All on-call team members will notify the supervisor on-call in the event of an accident, incident or inability to complete an on-call shift.

LAST REVIEW DATE: 6/14/12

LAST UPDATED: ED, CFO with DOH 08/04/16, Comp Coord 08/15/16

BOARD APPROVAL: 7/31/12