York Hospital Hospice

in partnership with Merrimack Valley Hospice

CARE COORDINATION WHEN A RESIDENT IS A HOSPICE PATIENT

Hospice/Facility must communicate, establish and agree upon a coordinated Plan of Care for both providers, which reflects the hospice philosophy and is based on an assessment of the individual's needs and unique living situation in the SNF/FF

COORDINATION OF CARE	
HOSPICE	**FACILITY**
Determine eligibility for hospice care	Complete/submit RAI/MDS data
Coordinates and supplies planned items not part of routine care at the facility related to the terminal diagnosis.	Provide services, supplies and DME ordinarily provided to Residents of the Facility
Assumes responsibility for the professional management of the patient's/resident's hospice care. Professional management involves the assessment, planning, monitoring, directing and evaluation of the patient's/resident's care.	Shall furnish to the individual all of those activities that the Facility normally would provide in the absence of the Hospice Program, as provided for in the Facility's policies, procedures, protocols and agreements with the resident and resident's family. Provide flexible visitation policy 24 hours/day regardless of age of visitor.
Coordinate Pharmaceutical services for medications related to the terminal diagnosis • Approve and arrange provision of related medications prescribed during stay	• Administer prescribed drugs, pharmaceuticals and treatments • Discuss observations related to medication management with hospice
Clarify physician orders related to the patient's terminal condition: • Diet • Medication/treatments • Code status • Activity • The extent which lab or x-ray services will be utilized (generally, "no lab or x-rays")	Assures that the care outlined in the care plan is performed by qualified staff and consistent with acceptable professional standards of practice. These services include: • Performing personal care services • Assisting w/activities of daily living • Socializing activities • Maintaining the cleanliness of the pts/residents room • Supervising and assisting in the use of DME and prescribed therapies
Communicate/coordinate observations and plans with NF personnel as well as with the patient's family.	Communicate/coordinate observations and plans with hospice personnel as well as with the patient's family.
Ensure that eligible residents are availed of all components of the Hospice program • Determine the need for inpatient or continuous (crisis) care	Notifies hospice when the resident experiences a change in condition or death. The NF must continue to meet the requirements for notifying the attending MD & family of significant changes in condition.
CARE PLANNING	
Professional management and coordination of hospice care through hospice Interdisciplinary group (IDG), to include collaboration with the Facility and the patient's physician to develop Coordinated Hospice Plan of Care (POC). The plan will be developed jointly upon admission to the Hospice program, and will detail scope & frequency of services provided by both the Hospice and Facility.	Collaborate with the Hospice IDG to develop the Coordinated Plan of Care. Provision and supervision of direct patient care in accordance with the Coordinated Hospice Interdisciplinary Plan of Care. The plan of care must be consistent with the hospice Philosophy of care.

Review hospice POC and participate in facility IDG meeting, as necessary	Participate in Hospice IDG meeting, as necessary.
Hospice must approve any changes to the hospice POC proposed by the Facility staff prior to implementation. This applies to therapies such as PT, OT, ST; any consults, x-rays, blood test, transfusions, and transfers to acute care facility, when related to the Hospice POC.	Emergency care unrelated to Hospice POC is the responsibility of the facility (i.e. injury secondary to fall). Notification to Hospice will be made as soon as possible.
ASSESSMENT/DOCUMENTATION	
HOSPICE	**FACILITY**
Initial and ongoing assessment per hospice protocols.	Initial & ongoing assessment per Facility Protocols.
Assess patient/family condition as per Hospice IDG Plan of Care	Observe, record, and report changes in condition to Hospice.
Document care per Hospice Policies. Provide copies of documentation to Facility necessary for coordination of patient care, including, but not limited to: • Initial and ongoing POC (485) • Initial assessment forms • Progress notes related to visits performed at facility during stay by all disciplines (RN, SW, & Chaplain, HHA flow sheets) • Signed election form & consent forms • IDG notes (bi-weekly) • List of approved medications • High-tech flow sheets and checklist	Prepare and maintain documentation per Facility protocols Provide copies to Hospice, when asked.
SCHEDULING	
HOSPICE	**FACILITY**
Furnish services and supplies related to the patient's terminal illness and specified in the hospice Interdisciplinary Plan of Care	Staff required to ensure that the Hospice patient is kept comfortable, clean, well groomed and protected from accident, injury and infection in accordance with Facility Policies and applicable Laws and Regulations
RN on call 24 hours/day for consultation regarding the Hospice POC	
Arrange appropriate Hospice training/orientation for Facility personnel	Will notify Hospice of needs for Hospice specific training
Will notify Facility of projected schedule for hospice HHA's at weeks end for following week (if applicable). Hospice will notify facility when there is a change in the schedule.	
COMPLIANCE	
HOSPICE	**FACILITY**
Comply with all applicable accreditation standards, policies and procedures, including confidentiality rules	Comply with all applicable accreditation standards, policies and procedures, including confidentiality rules

References: State Operation Manual 2082 (Rev 1, 05-21-04)