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**APPLICABLE LAW**

This agreement is governed by the laws of the state of Florida. If any provision(s) of this agreement are found to be legally invalid, the other provisions shall remain in effect.

**RECOMMENDED HARDWARE/SOFTWARE**

CORRIDOR MEDIA, LLC's Recommended Hardware/Software Configuration for the PALLIATIVE CARE POLICIES:

Microsoft® Office 2007 or higher

Microsoft® Word 2007

Pentium III processor 1 GHz or faster

2 GB RAM or higher

Windows 7 or higher operating system (recommended, but not required)

To save the PALLIATIVE CARE POLICIES, CUSTOMER must accept this agreement.

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**MISSION STATEMENT**

**Policy No. 1-001.1**

**PURPOSE**

To outline the mission of the Palliative Care program.

**POLICY**

***Mission***

The organization provides an individualized program of care for people with Palliative Care needs, with an emphasis on control of pain and other symptoms. Palliative Care is centered on both the patient and family/caregiver. Palliative Care personnel respect and respond to the unique differences in family/caregiver, lifestyle, values, and wishes.

Utilizing an interdisciplinary approach to care, the organization provides palliative care services in the patient’s residence and mobilization and coordination of services, and other support services. Palliative Care services will be equitably distributed to a medically and financially diversified group of patients in a cost-effective manner which ensures adherence to the goals of the organization and the maintenance of the financial solvency of the organization.

Palliative Care exists to provide support and care for persons with a serious, life-limiting (i.e. debilitating chronic or life-threatening illness, condition or injury) so that they may live as fully and comfortably as possible.

Palliative Care exists in the belief that through appropriate care and the promotion of a caring and supportive community, patients and family/caregivers experience an improved quality of life.

***Values***

The organization recognizes these values and their roles in fulfilling this mission.

***Committed to Patients***

The organization recognizes the unique physical, emotional, psychological, and spiritual needs of each person receiving Palliative Care services. The organization strives to extend the highest level of courtesy, safety and service to patients and family/caregivers, visitors, and each other.

***Committed to Leadership***

The Governing Body and senior leadership ensure that the program delivers state-of-the-art Palliative Care services with identified standards of practice in Palliative Care. The program leaders communicate with and educate the organization in order to gain recognition of and support for the program and to make staff throughout the organization aware of the program’s objectives and the process for referring patients to the program. The organization engages in Palliative Care education for palliative care professionals, personnel and volunteers, as well as other educational programs for the public. The organization provides program leaders with opportunities for sharing best practices with other palliative care programs.

**Policy No. 1-001.2**

***Committed to Excellence***

The organization strives to create an environment of teamwork and participation, where, through continuous performance improvement and open communication, health care professionals pursue excellence and take pride in their work, the organization, and their personal development. The organization believes that the quality and expertise of our human resources—Palliative Care personnel, professionals and volunteers—is the key to continued success in the care of chronically and terminally ill patients.

Program leaders create opportunities for staff to participate in the design of the care, treatment, and services provided. The palliative care program leaders secure the resources it requires from the organization in order to meet the scope of care, treatment and services it provides. The program maintains financial viability through cost-effective operations to meet our long-term commitment to the community served.

***Committed to a Culture of Safety and Quality***

The organization strives to create a culture of safety and quality by developing a code of conduct, providing education, encouraging open communication, encouraging leaders to provide a team approach to safety and quality initiatives, providing leadership that defines how patients, family/caregivers, visitors, and other members of the community can help identify and manage issues of safety and quality, and implementing in order to maintain the culture of safety and quality.

The program evaluates whether its activities for identifying and minimizing risks to patients meets its objectives. The program leaders annually evaluate contract service providers to ensure safe and quality care is provided per organization policies.

***Goals***

Program and organization leaders work together to formulate the program’s goals for providing care, treatment and services to patients:

* 1. To provide a program of care that supports and addresses quality of life.
  2. To provide palliative care that adheres to standards of palliative practice through the development of partnerships, programs and initiatives that educate healthcare personnel, patients and families regarding quality palliative care services.
  3. To provide direct patient care, and family/caregiver support in a coordinated manner with an interdisciplinary program using existing resources and avoiding duplication of services.
  4. To offer additional care and services when the patient’s pain and symptoms must be closely monitored in order to be controlled, or when the family/caregiver needs assistance in caring for the patient.
  5. To maintain a commitment to realistic, cost-effective management, utilizing all available mechanisms for payment, to retain management responsibility for the patient’s care in the utilization of direct and indirect services.

**Policy No. 1-001.3**

* 1. To make Palliative Care services and the Palliative Care philosophy an accepted part of the health care system and to increase awareness concerning the needs of chronically ill patients.
  2. To provide a continuum of care which recognizes and responds to the physical, social, spiritual, emotional, and other needs of the patient and family/caregiver.

**REGULATORY COMPLIANCE**

**Policy No. 1-002.1**

**PURPOSE**

To ensure compliance with local, state, federal, and other regulatory bodies.

**POLICY**

1. The organization will maintain evidence of regulatory compliance, including but not limited to:
   1. Current state license
   2. Medicare and Medicaid provider numbers, as applicable
   3. Business license, as applicable
   4. CLIA certification, as applicable
   5. Reports of reviewing bodies (CHAP, FDA, state licensure surveys, OSHA, etc.)
   6. D/B/A state registration, as applicable
   7. HIPAA regulations, as applicable
   8. Civil Rights Act of 1964, Equal Employment Opportunity Acts, Americans with Disabilities Act, Fair Labor Standards Act, Section 1557 of the Affordable Care Act (ACA) of 2010
   9. Public Health regulations relating to infectious disease.
   10. Any state reporting requirements
   11. Professional standards and principles
       1. Federal regulations
       2. State practice acts
       3. Commonly accepted health standards established by national organizations, boards and councils.

**Executive Director/Administrator**

**Policy No. 1-003.1**

**PURPOSE**

To define the qualifications and selection process of the Executive Director/Administrator of the organization.

**POLICY**

The Governing Body will appoint the Executive Director/Administrator through a procedure established by the Governing Body.  The Executive Director/Administrator will:

1. Be responsible for the day-to-day operations of the organization.
2. Have the necessary authority to implement his/her responsibilities for the operations, as conferred by the Governing Body.
3. Have at least two (2) years health related experience and the education, knowledge, and ability to fulfill his/her responsibilities.  A master’s degree is preferred.
4. Be knowledgeable of applicable law and regulation including Medicare Conditions of Participation as applicable, state regulations, licensure requirements, and any other applicable local/state/ or federal regulations.
5. Ensure that the organization employs qualified personnel.
6. Ensure the development of personnel qualifications and policies.
7. Take reasonable steps to assure that:
   1. The organization complies with applicable law and regulation.
   2. Action is taken on reports and recommendations of any authorized planning or regulatory inspection organization.
8. Maintain organizational charts to be used to define relationships and lines of authority within the palliative care program.
   1. Organizational charts will be distributed as part of orientation.

**PROCEDURE**

1. The Governing Body will appoint the Executive Director/Administrator through the standard recruitment and selection process including, but not limited to:
   1. Interviews with human resource personnel, various members of the Governing Body, senior management, etc.
   2. Verification of educational preparation

**Policy No. 1-003.2**

* 1. Verification of references
  2. Verification of experience and previous work history

1. Candidates will be narrowed to the two (2) or three (3) best candidates meeting the selection criteria and the job description qualifications.  The President of the Board will make the final decision.
2. In the event that the Executive Director/Administrator is absent, the Clinical Director will assume the operational duties and responsibilities at Organization’s Name
3. In the event both are absent, an appropriately qualified nurse will assume the responsibilities.
4. These individuals have been identified as qualified to act on behalf of the Executive Director/Administrator in his/her absence.

Clinical Director:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Qualified Nurse:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Annual Operating Budget**

**Policy No. 1-004.1**

**PURPOSE**

To provide a written financial plan to assure sufficient allocation of resources and finances for organization operations.

**POLICY**

On an annual basis, senior management, including at least the Chief Executive Officer, Chief Financial Officer, and program directors, will prepare a budget and operating plan to assure that adequate monies are available to carry out the programs and services designed to meet the needs of the patient population being served.  These documents will be reviewed and approved by the Governing Body.

Factors used to develop the annual budget may include:

1. Strategic and operational plans, both short- and long-term
2. Assumptions upon which the budget is built include:
   1. Information from revenue and expense centers
   2. Budgetary variances
   3. Documented trends regarding availability of adequate funds
   4. Availability of external funding
   5. Funds restricted by granting institutions
   6. Reserves for unanticipated expenses
3. Applicable data from:
   1. Program evaluation findings
   2. Governing Body initiatives
   3. Other sources that address adequacy of fiscal and other resource allocations, including revenue, capital, and expenses
4. Information that indicates a need to refine fiscal allocations for the provision of care/service
5. Processes used for measuring and improving performance of each office, department, or service relative to the approved budget.
6. Survey of the marketplace serving key patient populations

**Policy No. 1-004.2**

**PROCEDURE**

1. Senior management will collaborate with representatives from all departments and programs to develop, implement, and monitor the annual operating budget.
2. The Chief Financial Officer will prepare a budget process outline and time frame.
3. The Chief Financial Officer or designee will prepare a draft schedule of revenues and expenses for the coming year and proposed capital expenditures, based on statistical data from current and prior periods.
4. The draft budget and capital expenditure plan will be reviewed by senior management and other designated personnel.  Consideration will be given to:
   1. Appropriateness of the plan for providing care/service to meet the patient’s needs
   2. Strategic plans that affect, involve, or influence the provision of care and service
   3. Revenue, capital, and expense budgets that directly/indirectly relate to organization personnel’s ability to provide care and service
   4. Operational plans that directly/indirectly affect the organization personnel’s ability to provide appropriate, effective, efficient, safe, timely, and continuous patient care and service with respect and caring
   5. Policies that directly/indirectly affect organization personnel and the care/service they provide
5. Changes will be proposed to the Chief Financial Officer, based on the review by senior management and other designated personnel.
6. The Executive Director/Administrator will present the budget and capital expenditure plan to the appropriate review committees.
7. Final approval will be by the Governing Body.
8. The Governing Body will review, revise as necessary, and approve the annual budget.
9. These actions will be documented in the Governing Body meeting minutes.

**scope of Services**

**Policy No. 1-005.1**

**PURPOSE**

To define the scope of palliative care services provided by the organization.

**POLICY**

Palliative Care includes comprehensive care and management of the physical, psychological, emotional and spiritual needs of patients of all ages and their families with serious, life-limiting illness, condition or injury. Palliative Care Services will be provided by the organization in accordance with the Palliative Care Program’s scope of services. Services will be provided in the patient’s place of residence twenty-four (24) hours a day, seven (7) days per week as needed. All services provided will be guided by the organization’s policies and procedures.

**PROCEDURE**

1. Palliative Care Services strive to:
   1. Optimize pain and symptom control, through prevention and early identification and impeccable assessment and treatment
   2. Optimize functional status
   3. Promote the highest quality of life for patient and family
   4. Integrate the psychological and spiritual aspects of patient care
   5. Serve as an educator and mentor for patients, families, peers and other healthcare personnel
   6. Educate patients and family regarding disease processes and expected course of the illness.
   7. Provides information and education about advance care planning to the patient and family as appropriate to the patient’s clinical status based on the patient’s expressed values, religious or spiritual beliefs, cultural practices, and preferences of care.
   8. Facilitate timely access to palliative care services and establish a comforting and healing environment
   9. Assist actively dying patients and their families in preparing for and managing life closure
2. The process of providing Palliative Care Services includes:
   1. Initial and ongoing assessment through patient and family interviews, review of medical records, discussion with other providers, physical examination and review of laboratory, diagnostic tests and procedures.

**Policy No.1-005.2**

* 1. Assessment includes evaluation of disease status and treatment history; functional status; prognosis; comorbid conditions; physical, psychological and spiritual symptoms; and advanced care planning.
  2. Assessment findings provide the basis for the interdisciplinary care planning process
  3. Reassessment is performed according to need and dictated by the patient’s clinical condition.

1. Services shall be provided by Organizations Name and any additional services may be requested and recruited by the Palliative Care Program leadership in collaboration with referral sources and health care practitioners as necessary.
2. The Palliative Care Program shall determine, in accordance with its policies and procedures, whether services listed will be provided directly or under contract.
3. Palliative Care Services will be provided by a core interdisciplinary team consisting of, but are not limited to:
   1. Registered nurse
   2. Nurse Practitioner
   3. Medical social worker
   4. Chaplain(s)/Spiritual care counselor
   5. Physician services
4. Other Palliative Care Services may include, but are not limited to:
   1. LPN
   2. PT, OT, SLP
   3. Registered Dietitian
   4. Nurse Aide
   5. Homemaker
   6. Volunteers
   7. Bereavement services

**STANDARDS OF PRACTICE**

**Policy No. 1-006.1**

**purpose**

To establish the standards of care and practice that provide the basis for the provision of quality palliative care services.

**policy**

Palliative care standards of practice will reflect the 8 core domains of care detailed in the Clinical Practice Guidelines for Quality Palliative Care which include:

1. Domain 1: Structure and Processes of Care
2. Domain 2: Physical Aspects of Care
3. Domain 3: Psychological and Psychiatric Aspects of Care
4. Domain 4: Social Aspects of Care
5. Domain 5: Spiritual, Religious and Existential Aspects of Care
6. Domain 6: Cultural Aspects of Care
7. Domain 7: Care of the Patient at the End of Life
8. Domain 8: Ethical and Legal Aspects of Care

***Domains of Care***

1. The Structure and Processes of Care will reflect the interdisciplinary mode of care designed to enhance patient and family inclusion in the decision-making process related to palliative care services and encompasses physical, psychological, emotional and spiritual care and processes.
2. The Physical Aspects of Care will focus on assessment and treatment of pain and symptoms using standardized assessment tools and treatment protocols that are safe and effective.
3. The Psychological and Psychiatric Aspects of Care will reflect the collaborative nature of holistic care with a focus on assessment and management of psychological and psychiatric care needs.
4. The Social Aspects of Care emphasizes the interdisciplinary care and collaboration with patients, families and caregivers with the goal of supporting the patient and family and identifying strengths and areas of need.

**Policy No. 1-006.2**

1. Spiritual, Religious and Existential Aspects of Care will address assessment and management of spiritual care needs with the goal of providing spiritual comfort and religious services to the patient and family/caregivers.
2. The Cultural Aspects of Care will focus on cultural strengths and support for the patient and family and may include practices and rituals that reflect cultural influences important to the patient and family/caregiver.
3. Care of the Patient at the End of Life ensures the palliative care team demonstrates skills and abilities to provide quality care to patients at end of life.
4. Ethical and Legal Aspects of care ensure the patient and family are knowledgeable about ethical and legal aspects of care.

***Personnel***

1. Palliative care personnel shall meet the education, experience, training and/or certification and regulatory requirements to fulfill the roles they perform on behalf of the Palliative Care Program.
2. When providing palliative care for pediatric patients, members of the interdisciplinary team have experience in providing care for children.
3. Healthcare professionals with experience in the developmental stages and needs of infants, children, and adolescents will perform and document the psychosocial and developmental assessment.
4. Program leaders, or designees, determine and evaluate the qualifications, training, and experience of individuals who are considered for membership on the program interdisciplinary team and staff.
5. Interdisciplinary group members shall provide care in compliance with state requirements as follows:
6. Physicians:
7. Physicians (MD) will maintain an unencumbered license to practice medicine within the state where palliative care services are provided.
8. Nurse Practitioners:
9. Nurse Practitioners (NP) will maintain an unencumbered license to provide nurse practitioner services in compliance with the state Nurse Practice Act.
10. Registered Nurses:
11. Registered Nurses (RN) will maintain an unencumbered license to provide care and services in compliance with the scope of practice in compliance with the state Nurse Practice Act.

**Policy No. 1-006.3**

1. Licensed Practical Nurses:
2. Licensed Practical Nurses (LPN) will maintain an unencumbered license to provide care and services under the supervision of a registered nurse in compliance with the state Nurse Practice Act.
3. Nurse Aides:
4. Nurse Aides will complete educational requirements and certification as required to provide care and services under the supervision of a registered nurse in compliance with regulatory requirements.
5. Social Workers:
6. Social Workers will maintain an unencumbered license to provide care and services in compliance with their education level and state regulations.
7. Spiritual Counselors:
8. Spiritual counselors will complete educational requirements and certification as required for the role and functions that they are assigned to perform on behalf of the palliative care program.
9. Other Counselors:
10. Other counselor members of the Palliative Care interdisciplinary group will provide evidence of education, training, certification and/or licensure for the role and functions that they are assigned to perform on behalf of the palliative care program.
11. Other Personnel:
12. Other members of the Palliative Care interdisciplinary group will provide evidence of education, training, certification and/or licensure for the role and functions that they are assigned to perform on behalf of the palliative care program.
13. Palliative care personnel will manage health conditions and terminal illnesses by developing an individualized plan of care, collaborating with an interdisciplinary group of healthcare practitioners, coordinate care and services and implementing care, treatment and services as prescribed in accordance with standards of palliative care.
14. Palliative care personnel will make recommendations to the palliative care interdisciplinary group regarding patient care and services in compliance with practice standards.
15. The palliative care leadership team shall develop and implement policies and procedures that align with standards of care in palliative care services.

**Policy No. 1-006.4**

***Skills***

1. Palliative Care program personnel shall demonstrate competency in knowledge and skills in the functions and activities that they will perform in their role.
2. These skills will be addresses in palliative care orientation and ongoing staff education.
3. This includes the performance of specific duties detailed in the palliative care program policies and procedures.
4. Skills and competencies required for the palliative care program shall include:
5. The Palliative Care Philosophy and the domains of palliative care
6. Participation in the Interdisciplinary Group
7. Pain and symptom assessment and management
8. Assessment and management of psychological symptoms and psychiatric diagnoses
9. Communication skills
10. Cross-cultural knowledge and skills
11. Information on specific populations served (adult and pediatric as appropriate)
12. Grief and bereavement
13. Ethical principles that guide the provision of palliative care
14. Documentation in the clinical record
15. Duties associated with their role
16. Administration of care and treatment as defined by their role
17. Infection control practices
18. Knowledge of equipment use
19. Safe delivery of care
20. Patient and family education and community resources available
21. Hospice care
22. Ongoing education topics and hours needed will be determined by an education needs assessment of staff.

**Policy No. 1-006.5**

1. The Program leaders will use the assessment results to determine education topics and the number of hours needed to provide or arrange for continuing education.
2. The organization provides pediatric-specific orientation and ongoing education to all staff and volunteers if pediatric care is being provided.

***Standards of Care***

1. The palliative care standards of care use current clinical practice guidelines and will be reflected in the policies, processes and procedures implemented by the palliative care program in managing patient care.
2. Palliative care practice shall represent evidence-based practice as demonstrated in research studies in palliative care.
3. The program reviews and revises its clinical practices in response to changes in evidence-based national guidelines or expert consensus, or results of its performance improvement activities.
4. Standards of care will reflect:
   1. The patient’s values, goals and preferences provided by the interdisciplinary group.
   2. A patient centered approach to the provision of care with the delivery of care in a structured, comprehensive and timely manner.
   3. That the interdisciplinary team provides compassionate care consistent with the patient’s quality of life needs, while preserving the patient’s comfort and dignity.
   4. A multidimensional approach to the management of pain and symptoms.
   5. Ongoing performance improvement initiatives that are data driven and focused on palliative outcomes.
   6. Collaboration with community resources to serve the patient and family effectively.
   7. Support for the patient and family in managing serious (i.e. chronic) and life-limiting illness.
   8. Ensure compliance with the Medicare conditions of participation and other state regulations that govern the provision of healthcare.
   9. Comply with all Health Insurance Portability and Accountability Act (HIPAA) requirements in accordance with federal, state and organizational policies.
   10. Participate in organizational monitoring of the quality of medical services and quality improvement initiatives.

**Policy No. 1-006.6**

* 1. Assume responsibility for personal growth.
  2. Develops, maintains and upgrades professional knowledge and practice skills through attendance at seminars, conferences and participation in continuing education and in-service classes.
  3. Fulfill the obligation of requested and/or accepted assignments.
  4. Demonstrate knowledge in communication and counseling patient/family in dealing with end-of-life issues.

**COMPLAINT and GRIEVANCE PROCESS**

**Policy No. 1-007.1**

**PURPOSE**

To set forth guidelines for the resolution of patient concerns, dissatisfaction, or complaints and to protect patient and family rights.

**POLICY**

Any difference of opinion, dispute, or controversy between a patient or family/caregiver or patient representative and Organization’s Name concerning any aspect of services or the application of policies or procedures will be considered a grievance.

The Executive Director/Administrator will be informed of situations that may become detrimental to good patient relations, and will be committed to maintaining a consistently high level of patient relations.  This grievance procedure will be included in the Bill of Rights document given to each patient upon admission.

The organization will investigate complaints regarding treatment or care, mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the organization. The organization shall be responsible for asking the necessary questions to determine cause of injuries.

**PROCEDURE**

1. The organization staff member receiving the complaint will discuss, verbally and in writing, the grievance with a supervisor within five (5) days of the alleged grievance.
2. The supervisor will investigate the grievance within five (5) days after receipt of such grievance and will make every effort to resolve the grievance to the patient’s satisfaction.
3. Response to the patient regarding the complaint will occur within ten (10) days of receipt.
4. If the grievance cannot be resolved to the patient’s satisfaction, the patient or his/her representative is to notify, verbally or in writing, the Executive Director/Administrator.
5. The grievance must state the problem or action alleged and the date the supervisor was notified.
6. The Executive Director/Administrator or designee will then investigate the grievance and contact the patient or his/her representative regarding the grievance in an attempt to resolve the differences.
7. The Executive Director/Administrator will respond to the patient within ten (10) days of notification of failure to resolve the complaint.

**Policy No. 1-007.2**

1. If the patient feels his/her grievance has not been resolved after working with Organization’s Name personnel, he/she will be informed of his/her right to notify the state or CHAP via the respective toll-free telephone numbers.
2. Complaints and any action taken will be documented on a complaint form.
3. Corrective action will be specific and related to the complaint.
4. Resolution information will be communicated in writing to the patient or his/her representative filing the complaint.
5. Risk management personnel will be notified of any complaints which may involve litigation by the clinician/technician involved completing an organization incident report or unusual occurrence form and forwarding a copy to the Risk Management Department.
6. Complaints received on patient satisfaction surveys (mail) will be documented on a complaint form and addressed as outlined above.
7. All complaints from patients who believe their privacy rights have been violated will be forwarded for review to the designated organization personnel or office specified in the organization’s Notice of Privacy Practices.
8. All complaints will be logged, tracked, trended, and filed in the performance improvement office.
9. The Performance Improvement Coordinator will prepare a quarterly report summarizing all complaints received that quarter.
10. Reports may include:
    1. Number of complaints received
    2. Type of complaints received
    3. Action and resolution of complaints
11. The Performance Improvement Committee will review patient grievance trends on a quarterly basis.
12. Identified trends will be followed through the established performance improvement process.
13. All organization personnel (clinical and non-clinical) will be informed of this process during a formal orientation process.

ASSESSMENT OF POSSIBLE ABUSE/NEGLECT

**Policy No. 1-008.1**

PURPOSE

To provide guidelines for identification of suspected abuse victims for care and referral to community resources.

POLICY

The organization will report all suspected cases of abuse, neglect, or exploitation in compliance with appropriate state statutes to appropriate protection organizations. The organization will investigate complaints regarding treatment or care, mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the organization. The organization shall be responsible for asking the necessary questions to determine cause of injuries.

Note: Any individual who is legally mandated to report suspected abuse and/or neglect and who intentionally fails to report such suspected abuse/neglect is guilty of a misdemeanor and liable for damages caused by failure.

An individual who willingly makes a false abuse and/or neglect report is liable for civil action for any damages suffered by individuals who were reported as suspects in such abuse and/or neglect.

PROCEDURE

1. Any clinician who discovers, within the course of rendering care, any suspected abuse or neglect will immediately report such occurrences to his/her immediate supervisor. This includes:
   1. Any knowledge of abuse or neglect
   2. Any knowledge of patient self‑abuse or self‑neglect
   3. Reasonable cause to suspect abuse or neglect
   4. Reasonable cause to suspect self‑abuse or self-neglect
   5. Any knowledge that a patient has sustained an injury that is not reasonably explained by the patient’s history of injuries
2. The clinician will submit a verbal report of the suspected abuse/neglect to the proper authorities in accordance with state law and complete a suspected abuse and/or neglect investigation report within twenty-four (24) hours of the incident, with the addition of the following information:
   1. Name of alleged perpetrator
3. **Policy No. 1-008.2**
   1. Relationship to patient, if any
   2. Information regarding suspected abuse/neglect:
      1. Date of occurrence
      2. Witness to occurrence, if any
      3. Nature of occurrence (as indicated above)
      4. Description of the abuse/neglect
4. If patient is in immediate jeopardy, the proper authorities will be contacted by the clinician immediately as required by state or local law.
5. The suspected abuse/neglect investigation report with specific information relating to the occurrence is forwarded to the Clinical Supervisor, who will:
   1. Notify the physician and referral source (as appropriate) or direct the clinician to do so
   2. Review the documentation for completeness and objectivity
   3. Forward the information to the Executive Director/Administrator
6. The Executive Director/Administrator will:
   1. Review all reports (incident report and follow‑up investigation)
   2. Conduct any further review if necessary
   3. Document additional information
   4. Submit reports to the proper authorities
7. Reports, reviews, and investigations of suspected abuse/neglect will be held in strictest confidence.
8. The organization will maintain a list of private and public community agencies that provide or arrange for assessment of suspected or alleged abuse/neglect victims.
9. The clinician will make a referral to a community organization whenever necessary.

**Advance Directives**

**Policy No. 1-009.1**

**PURPOSE**

To support the implementation of the Patient Self-Determination Act within the framework of state and federal law and organization policies.

**POLICY**

Organization’s Name recognizes that all adult persons have a fundamental right to make decisions relating to their own medical treatment, including the right to accept or refuse medical care.  It is the policy of Organization’s Name to encourage individuals and their family/caregivers to participate in decisions regarding care, treatment, and services.

Valid Advance Directives, such as living wills, Durable Powers of Attorney, and DNR (Do Not Resuscitate) or DNI (Do Not Intubate) orders will be followed to the extent permitted and required by law.  In the absence of Advance Directives, Organization’s Name will provide appropriate care according to the plan of care/service or as authorized by the attending physician.  Organization’s Name will not determine the provision of care/service or otherwise discriminate against an individual based on whether or not the individual has executed an Advance Directive.

**PROCEDURE**

1. Upon admission, the clinician/technician will provide information regarding a patient's right to make decisions concerning health care, which include the right to accept or refuse medical or surgical treatment, even if that treatment is life-sustaining, the right to execute Advance Directives, and applicable organization policies.
2. Written information designed for this purpose will be provided to the adult patient.
3. The clinician/technician will document in the clinical/service record that the information was provided and document all discussions concerning Advance Directives.
4. If the patient lacks a decision-making capacity, the admitting clinician/technician will provide information and direct inquiry about Advance Directives to the patient's representative.
5. The clinician/technician will document that the patient representative received information and his/her name and responses will be noted in the clinical record.
6. If conditions are such that it is not practical to provide information to the patient or his/her representative at the time of admission, such information will be provided as soon as feasible after admission.
7. During the admission/evaluation visit, the admitting clinician/technician will ask the patient or his/her representative whether or not he/she has completed an Advance Directive, Durable Power of Attorney (DPOA), living will, or DNR/DNI order.

**Policy No. 1-009.2**

1. If an Advance Directive has been completed, the clinician/technician will ask for a copy of the Advance Directive so it will be placed in the clinical/service record.
2. If a copy is not immediately available, the patient will be informed that it is his/her responsibility to provide a copy of the Advance Directive to the organization as soon as possible.
   1. Verify that the photocopy is an exact copy of the original and mark the top of the copy (“Copy From Original”).
      1. Document in the clinical/service record the date of the request and to whom the request was given.
   2. On the last page of the document, indicate “Provided By” and record the name of the person who is presenting the document to you.
      1. Document in the clinical/service record the date of the request and to whom the request was given.
   3. Indicate “Received By” and sign and date the document.
      1. Document in the clinical/service record the date of the request and to whom the request was given.
3. If a copy of the patient’s Advance Directive is not available to the organization, the clinician/technician will discuss the contents of the Advance Directive with the patient and/or patient representative and document the contents of the Advance Directive in the clinical/service record and communicate the contents to other home care providers.
4. When applicable, the admitting clinician/technician will document on the clinical/service record and notify the attending physician verbally if the patient has executed an Advance Directive.
5. The patient will be encouraged to participate in all aspects of decision-making regarding home care and treatment.
6. Statements by a competent patient of his/her desire to accept or refuse treatment will be documented in the patient's clinical record.
7. All clinicians/technicians providing care/service for the patient will:
   1. Review the Advance Directive and report any discrepancies between the Directive and current treatment/service plan to the attending physician, Program Director, and the patient.
   2. Utilize available educational materials to answer the patient's questions about Advance Directives, durable power of attorney, or living wills.
   3. Encourage the patient to discuss questions and concerns with appropriate individuals such as the physician, family/caregiver, and his/her selected advocate.

**Policy No. 1-009.3**

* 1. Assist the patient who wants to develop an Advance Directive by obtaining a form and providing access to the outside individuals as necessary to execute the directive.

1. An Advance Directive will be implemented as follows:
   1. The Durable Power of Attorney for an Advance Directive is effective *only* when the patient is unable to participate in his/her own medical treatment decisions.
   2. The attending physician and another physician or a licensed psychologist must document in the patient’s clinical record that the patient is unable to participate in medical treatment decisions.
   3. The patient’s designated advocate can then make medical treatment choices based on the Advance Directive.
      1. The patient advocate may make a decision to withhold or withdraw treatment that allows the patient to die.
      2. This is done only if the patient expressed, in a clear and convincing manner, that the advocate is authorized to make such a decision and acknowledges that such a decision would or could allow the patient’s death.
   4. Executing and implementing an Advance Directive is a process, not a one (1) time event.
      1. On an ongoing basis, personnel will keep the patient, family/caregiver, and patient’s representative up to date concerning the patient’s medical condition.
      2. They will discuss the patient’s preferred course of treatment as his/her condition changes.
      3. The discussions will be documented in the clinical/service record.
2. Educational information about Advance Directives and Organization’s Name’s policies and procedures regarding Advance Directives will be provided to the medical, nursing, and allied health professionals, as well as home care personnel and volunteers during the orientation period.
3. In order to educate the community about Advance Directives, Organization’s Name will participate in community forums, as appropriate, and make written materials available regarding Advance Directives.
4. If the state and/or region has endorsed the use of POLST/MOLST, the organization will utilize the state and regional specific forms and guidelines.  (For more information: <https://polst.org/programs-in-your-state/>)
5. The organization will update and disseminate changes to state law on advance directives no later than ninety (90) days from the effective date.

**Policy No. 1-009.4**

1. If the palliative care program cannot implement an advance directive based on conscience, it has a clear statement of any limitations. The statement includes:
   1. Clarification of any differences between organization-wide conscience objections and those raised by an individual physician;
   2. Identification of the state legal authority permitting such objection;
   3. A description of the range of medical conditions or procedures affected by conscience objection.

**Do Not Resuscitate/Do Not Intubate Orders**

**Policy No. 1-010.1**

**PURPOSE**

To facilitate a patient’s choice regarding the extent to which emergency medical care will be instituted.

**POLICY**

The organization will follow the patient’s Advance Directives completed according to the Advance Directives requirements of the jurisdiction of the state in which the patient resides.

The organization supports the patient’s right of autonomy to make choices regarding his/her care and encourages the patient to discuss this issue with his/her significant others.  In the event that the patient is without the capacity to make treatment decisions for himself/herself, this decision shall be made by an appropriate surrogate.

A written Do Not Resuscitate (DNR) order, signed by the patient’s physician (or other authorized independent practitioner), must be on file in the patient’s clinical record and admission folder in the patient’s home.  If there is no DNR order or valid Advance Directives and the patient expires in the presence of a CPR-trained staff person, CPR will be initiated according to the American Heart Association’s Basic Life Support (BLS).

**PROCEDURE**

1. A DNR/DNI decision will be made by the attending physician in consultation with the patient or other legally responsible person when, in the judgment of the physician, the patient suffers from an incurable medical condition, death is reasonably imminent in all medical probability, and a life threatening condition exists in which resuscitation would not be expected to render substantial improvement in the ultimate outcome.
2. The order will be written only by the attending physician (or other authorized independent practitioner).
3. Upon receipt of a DNR/DNI order, the following documentation will occur in the clinical record:
   1. A summary of the medical situation, including the Case Manager’s discussion with the attending physician and a statement of the therapeutic plan for comfort care.
   2. An account of the discussion with the patient and/or surrogate decision maker, preferably by the attending physician, or an explanation as to why a discussion has not occurred.
   3. The DNR/DNI order will be clearly identified in the clinical record.
   4. A copy of the DNR/DNI order will be kept in the patient’s home.

**Policy No. 1-010.2**

1. DNR/DNI status will be communicated as follows:
   1. The Case Manager will immediately advise the Clinical Supervisor.
   2. The Case Manager will notify other personnel involved in the case within twenty-four (24) hours and document this notification in the clinical record.
   3. The Case Manager will immediately notify the aides’ office:
      1. If the patient is new to aide service, “Do Not Resuscitate” will be written in the special instruction section of the aide assignment sheet.
      2. If the patient has ongoing aide service, a new aide assignment sheet will be created with “Do Not Resuscitate” written in the special instruction section.
      3. On the aides' weekly schedules, the letters “DNR” will be written next to the names of the patients with Do Not Resuscitate orders.
      4. When aides receive revised assignments via telephone, they will be told which patients have DNR status.
2. The order will be recertified every sixty (60) days or upon request of concerned parties.
3. The DNR/DNI order will be re-evaluated under the following conditions:
   1. When there is a significant change in patient condition, it will be the responsibility of the clinician, within the standard of practice, to communicate to the attending physician any change in the patient's condition that impacts the DNR/DNI order.
   2. At the request of the patient or his/her representative.
4. The DNR/DNI orders may be revoked at any time verbally or in writing by:
   1. The competent patient
   2. The incompetent patient's legal representative
   3. The attending physician in consultation with a competent patient or an appropriate surrogate decision maker
5. Organization personnel informed of or provided with a revocation of DNR/DNI by the patient or patient’s representative will immediately record the revocation request in the patient's clinical record, cancel the order, and notify the physician (or other authorized independent practitioner) responsible for the patient's care.
6. If the patient is not capable of making his/her decisions regarding medical care, a decision will be reached after consultation between the physician and one (1) of the following, according to the hierarchy of decision makers:

**Policy No. 1-010.3**

* 1. A court-appointed guardian
  2. A proxy designated by a durable power of attorney for health care authorized according to law
  3. A spouse
  4. An adult child
  5. A parent
  6. An adult sibling
  7. A nearest relative

1. All communication between organization personnel and the patient and family/caregiver regarding resuscitation of the patient will be documented in the clinical record.

**Record Retention**

**Policy No. 1-011.1**

**PURPOSE**

To define the process and timeframes for retention of clinical, administrative, financial and personnel records and to ensure that records are retained by the organization according to law and regulation.

**POLICY**

The clinical record will be retained for six (6) years from the month in which the organization’s cost report to which the record(s) applies is filed with the intermediary, or six (6) years after the end of the fiscal year to which the record(s) applies, unless state law stipulates longer. For Medicare managed care, patient records will be retained for ten (10) years. For minors, the six (6) year retention requirement begins upon reaching the age of 18, unless state law stipulates longer. The organization shall retain the emergency management plan for at least four (4) years.

Administrative, financial and personnel records will be retained in a manner that allows each to be easily retrievable and in keeping with timeframes of applicable local, state and federal law. All billing records will be retained for a minimum of five (5) years past the month of filing the applicable cost report or until the cost report is settled unless state law stipulates a longer period of time. Governing Body meeting minutes will be retained for a minimum of five (5) years. HIPAA Security audits/logs and compliance reports/investigations will be retained for a minimum of six (6) years.

**PROCEDURE**

***Clinical Records***

1. All active (open) paper records will be filed alphabetically and stored in a secure area with access by approved personnel only.
2. Electronic medical records will be stored in a secure manner that is easily retrievable if records are requested.
3. The Department shall be informed immediately, in writing, whenever patient health records are defaced or destroyed before termination of required retention period.
4. When a patient is discharged/expires:
   1. Paper records
      1. Original documents will be submitted to the appropriate department
      2. The Program Director or designee will review the clinical service record for completeness, including the discharge summary.

**Policy No. 1-011.2**

* + 1. The paper record will be closed and filed alphabetically with other discharged records within thirty (30) days of discharge and be stored in a secure area with access by approved personnel only.
    2. Closed (discharged) records will be stored on premises for two (2) years.
    3. After two (2) years, the records will be properly labeled, boxed and stored off site in a secure storage facility.
  1. Electronic records
     1. Discharged records will be closed, reviewed and stored in accordance with the software workflow within thirty (30) days of discharge.

1. The clinical record will remain the property of the organization.
2. The organization will keep all records of cases involved in litigation until the case is concluded, even if it goes beyond the retention time period prescribed by law.
3. In the event the organization should cease operation, all clinical records, administrative and financial files will be sent to and stored at another designated location and the appropriate legal authorities will be notified of the record disposition.

***Administrative, Financial and Personnel Records***

1. Applicable local, state and federal regulations regarding record retention will be reviewed on an ongoing basis.
2. A review of administrative, financial and personnel records produced by Organization’s Name will be completed to determine which records meet criteria for inclusion in local, state and federal regulations.
3. A directory of organization-specific reports and their respective retention times may be maintained by Organization’s Name
4. Records may be retained in paper form or as a part of the organization’s computer back-up system so long as they are easily retrievable.
5. Paper records will be stored by type of record first and record date second in a secure area with access by authorized personnel only.
6. Those records identified to meet regulatory criteria will be maintained at the organization’s primary site for three (3) years and after three (3) years the records will be properly labeled, boxed and stored off site in a secure storage facility.

**Policy No. 1-011.3**

***If ownership changes:***

1. Both the licensee and the applicant for the new license shall, prior to the change of ownership, provide the appropriate regulatory bodies with written documentation that:
   1. The new licensee will have custody of the patient’s health records upon transfer of the agency and the health records are available to both the new and former licensee and other authorized persons; or
   2. If the agency stores records in an off-site location, the following requirements shall apply:
      1. Timely accessibility of stored records on a 24 hour basis, seven (7) days a week.
      2. Records are organized and systematically maintained
      3. Protection of the clinical records from, destruction or unauthorized use
      4. A current written agreement with the storage facility
      5. Policies and procedures which address the retention, retrieval and security for off-site centralized storage of inactive patient records.

***Destruction of Records (Intentional)***

1. In the absence of an Investigation, Litigation, Cost Report or Legal Hold, records may be destroyed upon the termination of the applicable mandatory retention period.
2. The appropriate method of destruction depends on the record’s physical form or medium and subject matter or content.
3. Records that include Protected Health Information (PHI) or patient-specific identifiers will be destroyed or disposed of so that the personal data cannot practically be read or reconstructed.
4. Paper records will be redacted, burned, pulverized or shredded and electronic records will be destroyed or erased.
5. Absent any special instructions or unique circumstances, records generally will be destroyed at the end of their retention period; retaining any record past its mandatory retention period should be on an exceptions-only basis after weighing the potential usefulness of the record against cost or space limitations.

***Destruction of Records (Unintentional)***

1. Records destroyed unintentionally due to fire, natural disaster or human error, etc. will be recovered by means appropriate to the medium that they were stored.
2. Electronic records will be recovered by accessing the back-up system.
3. Paper records will be recreated to the extent possible by using available source and organization documents.

**Safeguarding/Retrieval of Clinical Record**

**Policy No. 1-012.1**

**PURPOSE**

To establish a procedure for the protection of patient clinical/service record information from loss or unauthorized use.

**POLICY**

The organization will safeguard the clinical/service record against loss, destruction, tampering, or unauthorized use through the development of processes, policies and procedures.  The clinical/service record will be safeguarded in compliance with Health Insurance Portability and Accountability Act (HIPAA) requirements.

**PROCEDURE**

1. All physical patient clinical/service records will be maintained in locked, waterproof file cabinets in a record room:
   1. The files will be locked at night.
   2. The clinical/service record room will be locked at night.
   3. The clinical/service record room will not be left unattended during working hours.
   4. If the room is left unattended during business hours, the door will be locked.
   5. Only authorized personnel will have access.
2. All clinical/service records will be returned to the clinical/service record room prior to the office closing.
3. Clinical/service information and documents such as intake information, field charts, minutes of patient care meetings, clinical/service notes, unsigned plans of treatment being reviewed, verbal orders, and data being retrieved from records for performance improvement will be secured after business hours.
4. The original clinical/service record for active patients will remain in the office at all times unless required under subpoena.
5. Any copies made of patient information will include measures to secure the confidentiality of the material and be in compliance with the HIPAA privacy rule.
6. Clinicians/technicians providing intermittent care may maintain copies of the clinical/service documents for continuity of care, use in care coordination and/or supervision of ancillary personnel.
7. Copies of parts of the record, if taken out of the office, must be secured.

**Policy No. 1-012.2**

* 1. Records will be transported in a covered, opaque, waterproof container.
  2. Once placed in a vehicle, they will be in an inconspicuous location, such as the trunk.
  3. The vehicle will be locked at all times.

1. Selected documents may be kept in the patient’s home in a home clinical/service record while the case is active.
   1. Elements of the clinical/service record necessary to provide continuity of care include the plan of care/service, aide assignment sheet, medication profile, clinical/service notes, etc.
   2. All home clinical/service record documents and supplies will be picked up by the organization personnel and returned to the office when care ends.
2. Organization personnel will return any and all clinical/service record contents or copies of such to the office for destruction no later than one business day after the time of discharge.  All exceptions must be approved by the clinical supervisor.
3. Patients have the right to access their clinical/service records and are informed of the process for requesting access at the time of admission.
4. Records will be retained according to organizational policy, local, state, and federal regulations.
   1. Records of adult patients will be retained for a minimum of six (6) years after discharge.
   2. Records of minors will be retained for a minimum of six (6) years after reaching the age of majority.
   3. Records involved in litigation will be retained until after settlement.
   4. Records of patients who received Medicare services will be retained for a minimum of six (6) years past the month of filing of the applicable cost report or until the cost report is settled.
5. If electronic medical record computers/devices are utilized, access to information procedures should be followed.  Safeguard procedures followed but not limited to:
   1. Minimum necessary information should be on the device.
   2. Passwords will not be taped to computer.
   3. Passwords will not be shared with other persons.
   4. Device should be programmed with a time-out feature.
6. When using the device outside the office, face screen away from other individuals.

**Policy No. 1-012.3**

1. Security of information will be ensured for electronic and manual systems and include issues such as:
   1. Disaster recovery plan and continuity of business
      1. Plans for scheduled and unscheduled interruptions
      2. Contingency procedures for operations interruptions
      3. Plans for minimal interruptions due to scheduled downtime
      4. An emergency service plan
      5. A backup system plan, either computerized or manual
      6. Data retrieval processes, including retrieval from storage and information presently in the system, retrieval of data in the event of system interruption and backup of data
   2. Theft
   3. Vandalism
   4. Fire and flood recovery
2. Any confirmed, suspected, or potential violation of security or confidentiality will be reported to the CEO/Executive Director/Administrator.
3. Violations will be considered a serious incident requiring immediate investigation and response.
4. Violations of security will be reported and monitored through the organization’s performance improvement plan.
   1. A thorough analysis will be conducted, assessing the need for process improvements or increasing security or confidentiality measures.
   2. As a result of this review, action will be taken as necessary to improve care.
   3. The Program Director or designee will identify issues with documentation and based on the review, if the issue:
      1. Is applicable to an individual, the individual will be counseled
      2. Is applicable to the organization as a whole, refer the issue to the senior management team for review
   4. Any areas demonstrating a pattern or trend will be analyzed by the Performance Improvement Committee for development of recommendations and actions.
5. Breach notification requirements as outlined in the Health Information Technology for Economic and Clinical Health (HITECH) Act will be followed.

**Uses and Disclosures of PHI**

**Policy No. 1-013.1**

**PURPOSE**

To safeguard protected health information (PHI) against unauthorized use.

**POLICY**

Protected health information will be used and disclosed according to the guidelines set forth in the organization’s Notice of Privacy Practices.

**PROCEDURE**

1. Organization’s Name may:
   1. Use or disclose protected health information to the patient.
   2. Use or disclose protected health information to carry out its own treatment, payment or health care operations.
      1. Patients will not be discussed by clinical or non-clinical personnel outside of the context of professional conversation regarding patient's condition and care.
      2. Comments and conversations relating to patients made by physicians, nurses or other organization personnel will be made in confidential settings.
      3. It will be standard, acceptable and necessary practice to share information with other members of the care team.
      4. The decision to share information can be aided by considering the intent of the discussion.
      5. Patient information and clinical record documents will not be left in open, public areas during business hours and will be secured after business hours.
   3. Disclose protected health information for treatment activities of a patient’s health care provider.
   4. Disclose protected health information to another covered entity or health care provider for its payment activities.
   5. Disclose protected health information to another covered entity for health care operations activities of the entity or for the purpose of health care fraud and abuse detection or compliance.
   6. Each entity must either have or had a relationship with the patient who is the subject of the protected health information being requested and the protected health information pertains to such relationship.
2. **Policy No. 1-013.2**
   1. A patient may request a restriction of uses and disclosures of his/her protected health information.
3. Organization’s Name will obtain a valid authorization from the patient to use or disclose protected health information:
   1. In psychotherapy notes
   2. For marketing activities
   3. For other uses and disclosures as required by law
4. Law enforcement inquiries
   1. Police or investigative agencies' requests for information will not be complied with unless the patient or his/her legal representative has given specific authorization for release of information or a court order or subpoena is presented.
   2. Exception: If Organization’s Name is acting as an organization of the police department to assist them in gathering data or treating a patient they have referred.
5. Request for original record by the court under subpoena
   1. The Clinical Records Supervisor will designate a staff member to carry the original record to the court designated location.
   2. The staff member will stay with the record at all times.
   3. The court will copy the record and the staff member will return to organization with the original record.

**Authorization for Use or Disclosure of PHI**

1. **Policy No. 1-014.1**

**PURPOSE**

To delineate the process for obtaining patient authorizations to use or disclose protected health information (PHI).  To ensure that Organization’s Name use or disclosure of protected health information is consistent with the authorization obtained.

**POLICY**

The organization will obtain a valid authorization from the patient or his/her legal representative prior to using or disclosing protected health information, as required by federal and state laws.  Authorizations will be obtained to use or disclose protected health information in psychotherapy notes and for marketing activities.  Organization’s Name will not condition the provision of treatment on obtaining an authorization, except as allowed by law.

**PROCEDURE**

1. The designated organization personnel will prepare the Authorization For Use or Disclosure of Information Form.
2. A valid authorization will contain the following elements and will be written in plain language:
   1. A description of information to be used or disclosed that identifies information in a specific and meaningful way
   2. Name or other specific identification of the person(s) or class of person(s), authorized to make the requested use or disclosure
   3. Name or other specific identification of the person(s) or class of person(s), to whom the organization may make the requested use or disclosure
   4. A description of each purpose of the requested use or disclosure
   5. An expiration date or expiration event that relates to the patient or the purpose of the use or disclosure
   6. Signature of the patient and date.  If the authorization is signed by a personal representative of the patient, a description of the representative’s authority to act for the patient must also be provided
   7. A statement of the ability or inability of the organization to condition treatment, payment, admission or eligibility for benefits on the authorization
3. The clinician will explain the authorization form to the patient and family/caregiver, or legal representative.

**Policy No. 1-014.2**

1. The patient and family/caregiver, or his/her legal representative will be asked to sign and date the authorization.
2. The authorization form will be filed in the patient's clinical record and a copy will be given to the patient.
3. The patient has the right to refuse to sign the authorization form.
4. If the authorization form is not signed, the clinician will document his or her efforts to obtain the signature and the reason why it was not obtained in the clinical note.
5. The clinician will notify the Clinical Supervisor whenever the patient refuses to sign the authorization form.
6. The designated organization personnel will carefully review the signed authorization form prior to each use or disclosure of protected health information to ensure that planned use or disclosure is consistent with the authorization.
7. The patient may revoke in writing an authorization at any time.
8. The revocation will be effective for uses or disclosures on or after the date of the revocation.

**SECTION TWO**

|  |  |
| --- | --- |
| **POLICY/PROCEDURE** | **CHAP STANDARDS** |
| 1. Referral Process | PCAC.5  PCTT.3 |
| 1. [Admission Process](#AdmissionCriteriaandProcess) | PCAC.1  PCAC.3  PCAC.4  PCAC.6  PCTT.15 |
| 1. Rights & Responsibilities | PPFC.1  PPFC.2 |
| 1. [Initial Assessment](#InitialAssessment) | PCAC.1  PCAC.6  PCAC.7  PCAC.8  PCAC.9  PCAC.10  PCTT.14 |
| 1. [Pediatric Assessment](#InitialAssessment) | PCAC.1  PCAC.6  PCAC.9  PCAC.10  PCTT.14 |
| 1. Comprehensive Assessment | PCAC.7  PCAC.11  PCTT.8  PCTT.11  PCTT.14 |
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| 1. [Plan of Care](#ThePalliativePlanofCare) | PCAC.1  PCAC.12  PCAC.13  PCTT.8  PCTT.12 |
| 1. [Interdisciplinary Palliative Care](#InterdisciplinaryCare) | PCAC.1  PCAC.2  PCTT.1  PCTT.8  PCTT.16  PCTT.17 |
| 1. [Physician Services](#PalliativeCarePhysicianServices) | PCTT.4 |
| 1. [Nurse Practitioner Services](#NursePractitionerServices) | PCTT.4  PCTT.5 |
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**SECTION TWO**

|  |  |
| --- | --- |
| **POLICY/PROCEDURE** | **CHAP STANDARDS** |
| 1. [Psychosocial Care](#PalliativeCarePsychosocialCare) | PCTT.6 |
| 1. [Pastoral Care](#PalliativeCarePastoralCare) | PCTT.7 |
| 1. [Pain and Symptom Management](#PainandSymptomManagement) | PCTT.8  PCTT.11  PCTT.12 |
| 1. [Patient Education](#PalliativeCarePatientEducation) | PCAC.15  PCIC.1  PCIC.4  PCTT.15  PCTT.19 |
| 1. [Case Management](#PalliativeCareCaseManagement) | PCTT.18 |
| 1. [Coordination and Continuity of Care](#CoordinationandContinuityofCare) | PCAC.1  PCAC.14  PCAC.15  PCTT.3  PCTT.18 |
| 1. Clinical Record | PCMG.7 |
| 1. Clinical/Service Data Collection | PCMG.7 |
| 1. Care of the Dying Patient | PCTT.19 |
| 1. Death at Home | PCTT.19 |
| 1. [Discharge](#DischargefromthePalliativeCareProgram) | PCTT.18 |

**REFERRAL PROCESS**

**Policy No. 2-001.1**

**PURPOSE**

To establish the process for acceptance and entry of patients into palliative care.

**POLICY**

Referrals will be accepted twenty-four (24) hours a day, seven (7) days per week.  Personnel will be available twenty-four (24) hours a day to accept patients into palliative care. Organization’s Name will accept only those patients whose needs can be met by the services it provides and who meet the palliative care admission criteria.

**PROCEDURE**

1. Palliative care referrals will be documented on a referral form.
2. Referrals for palliative care services may be accepted by members of the interdisciplinary team, including the Executive Director/Administrator, Clinical Supervisor, nurses, social worker or others, as deemed appropriate by the Executive Director/Administrator.
3. Referral information may be accepted by any of the following methods:
   1. Telephone
   2. Facsimile
   3. Written order
4. During scheduled working hours calls will first be received by the receptionist.
   1. The receptionist will receive information regarding patient demographics, diagnosis, services needed, medications, attending physician (or other authorized independent practitioner), hospitalization, etc., in order to make the initial determination of whether the patient’s needs can be met by palliative care and if he/she meets eligibility criteria. The information will be reviewed for completeness.
   2. When payer source is private insurance, the insurance coverage will be verified and an insurance information form completed.
   3. Referral information will be given to the Clinical Supervisor to accept the referral information and complete the referral form.
   4. If the referral call is not from a physician, the physician (or other authorized independent practitioner) will be contacted to confirm service needs, as well as patient’s medical prognosis and supporting documentation, and to obtain verbal orders.
   5. The Clinical Supervisor will assign personnel and schedule an initial assessment visit.

**Policy No. 2-001.2**

* 1. If palliative care services cannot be provided due to a patient not meeting palliative care admission criteria, personnel will give the referral source the names of other agencies that can provide the required services and will notify the attending physician.
  2. A log will be maintained on all patients that cannot be serviced.

1. After scheduled hours (weekends and evenings), a referral source will have access to palliative care through the answering service.
   1. The answering service will contact the on-call nurse via telephone or beeper.
   2. The on-call nurse will complete the initial referral information from the referral source and relay the information.
      1. If the referral is on the weekend, the on-call nurse will determine if the patient needs to be seen.
      2. If the patient must be seen, the on-call nurse will schedule an initial visit on the weekend to determine palliative care appropriateness.
      3. If the patient can wait until Monday, the on-call nurse will bring the referral information into the office on Monday morning or the next business day for scheduling by the Clinical Supervisor.
2. Upon receipt of a referral to palliative care services the organization will contact the attending physician to notify them of the referral and request permission to provide consultation services.
3. Referral information provided by family/caregiver, health care clinicians from acute care facilities, skilled or intermediate nursing facilities, other agencies, and physician offices will assist in the determination of eligibility for admission to the palliative care program.
4. If the request for service is not made by the patient’s physician, he/she will be consulted prior to the evaluation visit/initiation of palliative care services.
5. In the event that the time frame for assessment cannot be met, the patient’s physician and the referral source, as well as the patient, will be notified for approval of the delay. Such notification and approval will be documented.
6. If approval is not obtained for the delay, the patient will be notified and referred to another palliative care program for services.
7. The patient’s physician and the referral source will be notified of the referral to another program.
8. The organization palliative care personnel will attempt to make a first contact prior to the patient’s hospital discharge where needed, if possible.
9. The initial visit will be made within the time frame requested by the referral source, or as ordered by the physician (or other authorized licensed independent nurse practitioner).

**Policy No. 2-001.3**

1. Palliative Care program referral criteria shall include:
   1. Presence of a serious (i.e. debilitating chronic) and/or life-limiting illness, condition or injury
   2. New diagnosis of life-limiting illness for symptom control, patient/family support
   3. Declining ability to complete activities of daily living
   4. Progressive metastatic cancer
   5. Two or more hospitalizations for the same illness within three months
   6. Difficult-to-control physical or emotional symptoms
   7. Patient, family or physician uncertainty regarding prognosis
   8. Patient, family or physician uncertainty regarding treatment options
   9. Patient or family requests for futile care and require assistance with decision making
   10. DNR order uncertainty or conflicts
   11. Uncertainty or conflicts regarding the use of non-oral feeding/hydration in cognitively impaired, seriously ill or dying patients
   12. Limited social support in setting of a serious illness
   13. Patient, family or physician request for information regarding palliative care appropriateness
   14. Patient or family psychological or spiritual distress
2. If a patient does not meet the admission criteria or cannot be cared for by the organization, referrals to other care providers, if applicable, will be made on behalf of the patient within forty-eight (48) hours.
3. The following individuals will be notified if the patient is not admitted:
   1. Patient/Family/Caregiver
   2. Physician
   3. Referral source (if not physician)
4. A record of patients referred for palliative care services who were not admitted will be maintained for statistical purposes, with date of referral, date of assessment, patient name, services required, physician, reason for non-admit, referral to other palliative care facilities.

**ADMISSION PROCESS**

**Policy No. 2-002.1**

**PURPOSE**

To establish standards and procedures for referring and initiating palliative care services.

**POLICY**

The organization will admit patients with palliative care needs that meet the admission criteria for palliative care services. Patients will be accepted for care without discrimination on the basis of race, color, religion, age, gender, sexual orientation/identity, disability (mental or physical), communicable disease, or national origin. Patients will be accepted for care based on adequacy and suitability of personnel, resources to provide required palliative care services, and a reasonable expectation that the patient’s palliative care needs can be adequately met.

While patients are accepted for services based on their palliative care needs, a patient’s ability to pay for such services, whether through state or federal assistance programs, private insurance, or personal assets will be considered.

The patient’s palliative care needs with be determined in collaboration with the patient and family, his/her attending physician, and the interdisciplinary team. The organization reserves the right not to accept any patient who does not meet the admission criteria for palliative care services. The patient will be referred to other resources if the organization cannot meet his/her needs.

Once a patient is admitted to service, the organization will be responsible for providing palliative care services within its financial and service capabilities, mission, and applicable law and regulations.

***General Criteria***

1. The patient must identify a family member/caregiver or representative who agrees to be a primary support caregiver if and when needed and/or identify care alternatives as needed.
2. The patient must have palliative care needs, as determined by the attending or referring physician and the palliative care physician or nurse practitioner, utilizing standard clinical criteria along with the patient’s medical history and clinical status.
3. The patient must desire palliative care services, and be aware of the diagnosis and plan of care.
4. The focus of care desired must be palliative in nature, focused on quality of life, pain and symptom management, and related interventions.
5. The patient and family/caregiver desire palliative care, agree to participate in the plan of care, and sign the consent form for palliative care services.
6. The patient and family/caregiver agree that patient care will be provided primarily in the patient’s residence, which could be his/her private home, a family member’s home, or other living arrangements.

**Policy No. 2-002.2**

1. The physical facilities and equipment in the patient’s home must be adequate for safe and effective care.
2. The patient must reside within the geographical area that the organization serves.
3. If applicable, the patient must meet the eligibility criteria for Medicare, Medicaid, or private insurance reimbursement for palliative care services.
4. In the event continued care to a patient contradicts the recommendations of an external or internal entity performing a utilization review, the program director will be notified.
5. All care, service, and discharge decisions must be made in response to the care required by the patient, regardless of the external or internal organization’s recommendation.
6. The patient, family/caregiver (as appropriate), and physician will be involved in deliberations about the care decisions.
7. A record of conflict of care issues and outcomes will be kept for statistical purposes, referencing the date of the conflict of care issue, the patient’s name, the external or internal organization recommendations and reasons, and complete documentation of organization decision and patient care needs.

***Palliative Care Consultation Services***

1. Palliative care consultations will be prioritized according to:
   * 1. Emergent need, such as intractable pain, where a palliative care response and interventions are needed immediately.
     2. Urgent need, such as escalating symptoms, where a palliative care response and interventions are needed within two (2) to four (4) hours.
     3. Non-urgent need, such as the recent diagnosis of a chronic condition, where a palliative care response and interventions are needed within twenty-four (24) hours.
2. The role of palliative care consultation services will be to:
3. Provide advice and counseling to patients, families and healthcare personnel.
4. Provide recommendations regarding the care and management of the patient’s palliative care needs.
5. Identify care and services that will benefit and support the patient and families.
6. Discuss goals of care, planning and advance directives with patients, families and healthcare personnel.
7. Refer to the palliative care program for admission as needed.

**Policy No. 2-002.3**

**PROCEDURE**

1. The organization will admit a patient only on recommendation of the palliative care physician in consultation with, or input from, the patient’s referring or attending physician.
2. The patient’s physician (or other authorized licensed independent nurse practitioner) may provide the initial referral for palliative care consultation and services and be willing to provide patient information related to the need for palliative care services.
3. Palliative care personnel will conduct an assessment as requested by the referral source, based on the information regarding the patient’s condition or as ordered by the physician (or other authorized licensed independent nurse practitioner).
4. Assignment of appropriate palliative care personnel to conduct the initial assessment will be based on:
   1. Patient’s geographical location
   2. Complexity of patient’s palliative care needs/level of care required
   3. Palliative care personnel’s education and experience
   4. Palliative care personnel’s special training and/or competence to meet patient’s needs
   5. Urgency of identified need for assessment
5. The purpose of the initial visit will be to:
   * 1. Explain the palliative care philosophy and program of care with the patient and family/caregiver
     2. Explain the patient’s rights and responsibilities and grievance procedure
     3. Provide the patient with a copy of the organization Notice of Privacy Practices
     4. Conduct a clinical assessment
     5. Assess the family/caregiver’s ability to provide care as needed
     6. Evaluate physical facilities and equipment in the patient’s home to determine if they are safe and effective for care in the home if indicated
     7. Allow the patient and family/caregiver to ask questions and facilitate a decision for admission to the palliative care program
     8. Review appropriate forms and subsequently sign forms by patient and family/caregiver once agreement for the palliative care program has been decided

**Policy No. 2-002.4**

* + 1. Provide services, as needed and ordered by physician (or other authorized licensed independent practitioner), and incorporate additional needs into the palliative care plan of care.
    2. Give patient information about Advance Directives, Durable Power of Attorney for health care, and other advance care planning information if the patient has not already done so.

1. During the initial visit, the admitting palliative care clinician will review the patient’s need for palliative care services, according to the admission criteria and to determine/confirm further:
   1. Services required and frequency of service provision
   2. Eligibility for palliative care services (according to organization admission criteria)
   3. Source of payment
2. The Interdisciplinary Team Physician, APRN, or PA shall review the clinical information for each patient being evaluated for the palliative care program and consider the following when determining admission:
3. The patient’s serious illness(es)
4. Any related diagnosis(es)
5. Prognosis as it relates to the organization’s admission criteria
6. Current subjective and objective medical findings
7. The presence and severity of symptoms
8. Information about the medical management of any of the patient’s conditions unrelated to the serious illness
9. If admission criteria are met, the patient and family/caregiver will be provided with palliative care program information and educational materials providing sufficient information in a language or communication method that the patient and family can reasonably be expected to understand. The materials may include but are not limited to:
   1. Nature and goals of care and/or services provided by the palliative care program
   2. Hours during which care or service are provided and after hours (on-call) care as applicable
   3. How to access care, treatment, and services during business hours
   4. How to contact staff in case of an emergent situation during and after business hours
   5. Care costs, if any, to be paid by the patient

**Policy No. 2-002.5**

* 1. Palliative care mission, objectives, and scope of care
  2. Safety information
  3. Infection control information including hand and respiratory hygiene practices
  4. Emergency management plans
  5. Available community resources
  6. Rights and responsibilities including complaint/grievance process and encourage patients to express any concerns or complaints about their care to staff.
  7. inform patients, and families about the organization’s process to address concerns and resolve ethical concerns that may occur in the provision of community-based palliative care.
  8. Advance Directives and advance care planning
  9. Availability of additional care and services
  10. Other palliative care personnel involved in care.
  11. Mechanism for notifying the patient and family/caregiver of changes in care and any related liability for payment as a result of those changes.

**Note:** The organization will facilitate communication through the use of special devices, auxiliary aids, interpreters or other methods.

1. Palliative care personnel will document that the above information has been furnished to the patient and/or family/caregiver, and he/she will document any information not understood by the patient and/or family/caregiver.
2. The patient and family/caregiver, after review, will be given the opportunity to either accept or decline services.
3. The patient or his/her representative will sign the required forms indicating consent for palliative care services and receipt of patient rights and privacy information.
4. Palliative care personnel will:
5. Educate the family in techniques for providing care
6. Educate and assist the patient and family in understanding changes in the patient’s clinical status and the trajectory of disease progression, prognosis, pain and symptom management needs and/or additional palliative care interventions that may be provided so they are able to make informed care decisions.

**Policy No. 2-002.6**

1. Provide information and education about advance care planning to the patient and family as appropriate to the patient’s clinical status, based on the patient’s expressed values, religious or spiritual beliefs, cultural practices, and preferences for care. Document in the medical record and share with the interdisciplinary team.
2. Contact the physician or practitioner to establish an initial plan of care.
3. Discuss with patients how they want to receive information, including the type of information, the method in which it is provided, which family members are to receive this information, and whether a surrogate decision-maker is involved in care, treatment, and service.
   1. When there is a surrogate decision maker, the name and contact information is documented in the medical record.
4. Complete initial assessment documentation and include a detailed account of palliative care needs, services, goals of care, plan of care, patient preferences for treatment as the disease progresses, and additional relevant information as needed.
5. Assist the patient in collecting, organizing and communicating important health information that is needed by staff to provide safe quality care.
6. If patient has an advance directive, a copy will be included in the medical record.
7. Contact members of the interdisciplinary group as needed to initiate and coordinate the palliative plan of care.
8. Inform patients and families of their responsibility to provide information that is important to care, treatment, and services.
9. A clinical record will be initiated for each patient admitted for palliative care services.
10. In the event a patient does not meet the stated criteria for admission to the palliative care program, exceptions will be decided upon by the program director in consultation with the physician, upon request of the referring party and/or the patient.

**Rights and Responsibilities**

**Policy No. 2-003.1**

**PURPOSE**

To encourage awareness of patient rights and provide guidelines to assist palliative care patients in making decisions regarding care and for active participation in care planning.

**POLICY**

Each patient will be an active, informed participant in his/her plan of care. To ensure this process, the patient will be empowered with certain rights and responsibilities as described. If a patient has been judged incompetent under state law by a court of jurisdiction, the rights of the patient are exercised by the person appointed to act on the patient’s behalf, pursuant to state law. If the state court has not judged a patient incompetent, any legal representative designated by the patient may exercise the patient’s rights to the extent allowed by state law and regulation. The representative, if any, is documented in the patient record.

**PROCEDURE**

1. The patient will be informed verbally and in writing upon admission to the organization’s palliative care program.
2. The Patient Bill of Rights statement defines the right of the patient to:
   1. Be involved in care planning, including incorporating goals for intervention and decisions about treatment.
   2. Be informed in advance of the type and frequency of services to be provided, any changes or service limitations.
   3. Decline any offered care, service, or treatment.
   4. Receive effective pain management and symptom control.
   5. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and the misappropriation of patient property by anyone furnishing services on behalf of the organization.
   6. Have their person and property treated with respect.
   7. Privacy of person and information.
   8. A confidential record per federal and state law and regulation.
   9. Be informed how to voice complaints to the palliative care service and/or CHAP without fear of reprisal or discrimination.
   10. Be informed about advance care planning, including advance directives.
3. **Policy No. 2-003.2**
   1. Be informed about payment sources and any expected or known patient financial liability prior to the start of care, and any subsequent changes in payment liability.
4. The admitting clinician will provide each patient or his/her representative with a written copy of the Patient Rights and Responsibilities on admission.
5. The Patient Rights and Responsibilities statement will be explained (verbal) and distributed to the patient prior to the initiation of organization services.
   1. This verbal explanation will be in a conversational language and tone and/or communication method he/she can reasonably be expected to understand.
6. The patient or legal representative will be requested to sign the Patient Rights and Responsibilities form.
   1. The original form will be kept in the patient’s clinical record.
   2. A copy will be maintained by the patient.
   3. The patient’s refusal to sign will be documented in the clinical record, including the reason for refusal.
7. The admitting clinician will document that the patient has received a copy of the Patient Rights and Responsibilities.
   1. If the patient is unable to understand his/her rights and responsibilities, documentation in the clinical note will be made.
   2. In the event a communication barrier exists, if possible, special devices or interpreters will be made available.
   3. Written information will be provided to patients in English and predominant non-English languages of the population served.
8. When the patient’s representative signs the Patient Rights and Responsibilities form, an explanation of that relationship must be documented and kept on file in the clinical record.
9. The family or guardian may exercise the patient’s rights when a patient is incompetent or a minor.

**INITIAL ASSESSMENT**

## Policy No. 2-004.1

### PURPOSE

To provide guidelines for the initial assessments of patients admitted to service and for completing plans of care.

### POLICY

An initial patient assessment will be performed and documented in the patient’s clinical record by a member of the interdisciplinary team. The interdisciplinary team completes the initial assessment within three (3) business days of referral or as specified by the referral source.

The assessment will be patient-specific and comprehensive to include the patient’s need for home health care, rehabilitative care including but not limited to, physical, occupational and speech-language therapies, social services, and discharge planning.

### PROCEDURE

1. During the initial patient assessments, all baseline data to be used in measuring the patient’s progress toward goals and other relevant information will be documented in the patient’s clinical record, including at least the following information, if applicable:
   1. The patient’s current health status and need for palliative care, including an assessment of the presenting signs and symptoms and the nature of the condition resulting in admission for palliative care.
   2. The patient’s diagnosis and prognosis
   3. Co‐morbid medical and behavioral health disorders
   4. Specific physical symptoms and their severity, including but not limited to:
      1. Pain, dyspnea, nausea/vomiting, constipation
      2. Fatigue, anorexia, sleep disorder, restlessness
      3. Skin integrity
      4. Confusion, delirium, or cognitive impairment, including the patient’s ability to understand and participate in their care.
   5. The patient’s functional status including their ability to independently evacuate in an emergency
      1. When appropriate, a member of the interdisciplinary team shall recommend the patient to rehabilitation therapies including, but not limited to, physical, occupational, and speech-language therapies.

## Policy No. 2-004.2

* 1. Existing patient medical equipment and/or prosthetics and any related needs
  2. Allergies, including drug, food or other
  3. Current patient medications and biologicals, including over‐the‐counter medication
  4. The ability of the patient and/or family to safely administer medications and biologicals
  5. Complications or risk factors that affect care planning

1. The psychosocial assessment will include identification of patient and family:
   1. Distress, anxiety, depression, and stress
   2. Mental health crises, including suicidal ideation or evidence of substance abuse
   3. Mental status and how it may impact care or treatment
   4. Support systems
   5. Presence of able and willing caregivers
   6. Living arrangements and suitability for the delivery of care
   7. Coping mechanisms
   8. Anticipatory grief regarding the patient’s illness
   9. Changes in employment or finances that affect financial security and related access to treatment
   10. Cultural factors that may impact care or treatment
   11. The need for:
       1. Counseling and/or education
       2. Referrals and further evaluation by other appropriate health professionals
       3. Access to other community resources
2. Health care professionals with experience in the developmental stages and needs of infants, children, and adolescents perform and document the psychosocial and developmental assessment.
3. The initial assessment shall also include identification of patient’s and family’s
   1. Religious or spiritual preferences
   2. Satisfaction with current spiritual support

## Policy No. 2-004.3

* 1. Identification of their faith community or spiritual counselor, as appropriate
  2. If spiritual support is requested or declined.

1. The initial assessment also includes a determination if the patient has an advance directive.
   1. Documentation of an advance directive shall be made in the patient’s chart.
   2. If the patient does not have an advance directive, the interdisciplinary team shall provide information regarding advance care planning.

**PEDIATRIC ASSESSMENT**

**Policy No. 2-005.1**

**PURPOSE**

To provide assessment guidelines for pediatric patients and families receiving palliative care services.

**POLICY**

All patients admitted for pediatric palliative care services will have a specific pediatric assessment performed by a qualified clinician who has experience in providing care for children. Healthcare professionals with experience in the developmental stages and needs of infants, children, and adolescents will perform and document the psychosocial and developmental assessment. Assessment of infants, children, and adolescents will consider both the age and cognitive development of the patient.

**PROCEDURE**

1. The clinician providing pediatric palliative care services will follow a plan of care that applies to the pediatric patient’s needs.
2. Assessments of pediatric patients may include, as appropriate, but will not be limited to:
   1. Developmental age
   2. Length/height
   3. Head circumference (if applicable)
   4. Weight
   5. Level of function related to growth and development
   6. Emotional/Psychosocial needs
   7. Cognitive needs
   8. Educational needs
   9. Social needs
   10. Daily activity needs
   11. Pain status, when applicable including:
       1. Behavioral factors that indicate pain and symptoms, and include this information in assessment documentation.

**Policy No. 2-005.2**

* + 1. The parent/caregiver’s interpretation of his/her child’s behavioral changes that may indicate pain and symptoms.
  1. Rehabilitation needs
  2. Support needs
  3. Comprehension
  4. Effect of patient’s condition on family/caregiver/guardian
  5. Immunization status
  6. The family and/or guardian’s expectations for and involvement in the assessment, initial treatment, and continuous care of the patient.
  7. When developmentally appropriate, the child’s opinions and preferences are considered when making decisions and providing care.

1. The pediatric patient’s educational needs and daily activities will be assessed on an ongoing basis.
2. Appropriate referrals to community and social services will be made when prolonged home care services are anticipated.
3. Verification of immunization status may be obtained from a third party, such as the family/caregiver, physician, school records, etc.
4. Documentation in the clinical record should note the source of the immunization status, including name, telephone number, date, etc.
5. Reassessment will occur regularly at each visit to determine:
6. The patient’s response to care
7. If there is a significant change in the patient’s condition
8. If there has been a significant change in the patient’s diagnoses
9. If there has been a significant change in the patient’s environment or support system
10. Changes in the assessments will be documented and communicated to the appropriate physician and to the palliative care interdisciplinary team.
    1. This communication will be documented in the clinical record.

**Comprehensive Assessment**

**Policy No. 2-006.1**

**PURPOSE**

To provide guidelines for the comprehensive assessment.

**POLICY**

A comprehensive patient assessment will be performed by the interdisciplinary group no later than five (5) calendar days after the election of palliative care in consultation with attending physician.

**PROCEDURE**

1. During the comprehensive patient assessment, all baseline data and other relevant information will be documented in the patient’s clinical record, including at least the following information, as relevant:
   1. An assessment of pain, including the origin, location, duration, severity, and relief measures
   2. An assessment of severity of secondary symptoms, such as:
      1. Dyspnea, nausea, vomiting, constipation, respiratory distress, and nutritional status
      2. Restlessness, anxiety, emotional distress
      3. Sleep Disorders
      4. Skin integrity
      5. Confusion
   3. An assessment of the need for a bowel regimen when the patient has been prescribed opioids.
   4. Nature and condition causing admission (including the presence or lack of objective data and subjective complaints)
   5. Alleviating and exacerbating factors for physical symptoms
   6. Current treatment and patient response to that treatment
   7. An assessment of the patient’s response to palliative treatment
   8. An assessment of the patient’s well-being, comfort and dignity throughout the dying process.
2. **Policy No. 2-006.2**
   1. A physical assessment, including blood pressure, temperature, pulse, respiration, skin, and other relevant data related to pertinent physical findings and the patient’s terminal illness
   2. Imminence of death
   3. Patient’s functional status including, but not limited to, the degree of self-care and the amount and level of assistance needed
   4. Patient’s cognitive status including the ability to understand and participate in his or her own care
   5. Complication and risk factors that affect care planning, including risk for drug diversion
   6. Patient’s past and present medical and psychiatric history including pertinent diagnosis and any co-morbid conditions
   7. Name and address of the patient’s attending physician
   8. Name of the hospital and other agencies or persons involved in the past and present care of the patient
   9. An evaluation of the home environment and assessment of emergency preparedness of the patient.
   10. Presence of any Advance Directives for care and/or discussions with patient and family/caregiver regarding the withholding of resuscitative services or the withdrawal of life-sustaining treatment
   11. Equipment presently in home and potentially needed by patient
   12. Review of current and related past medications, including prescription over-the-counter medications, supplements, herbal remedies, alternative treatments, allergy history and other medication information, including but not limited to identification of the following:
       1. Effectiveness drug therapy
       2. Unwanted side and toxic effects
       3. Drug interactions (actual or potential)
       4. Duplicate drug therapy
       5. Drug therapy currently associated with laboratory monitoring
       6. Whether the medication is unrelated to the terminal illness or related conditions (ensure that there is clinical documentation to support unrelatedness)
   13. Patient and family/caregiver support systems and the care the family/caregiver is available, capable, and willing to provide, including applicable strengths of patient, physical, psychosocial, and/or spiritual resources available

**Policy No. 2-006.3**

* 1. The patient’s psychosocial status, including emotional barriers to treatment, cognitive limitations, memory and orientation, family relationships, social history, source and adequacy of environmental and other resources, coping mechanisms, and the patient’s and family/caregiver’s reaction to illness.
  2. An assessment of the patient’s and family/caregiver’s spiritual orientation, including, as appropriate, any involvement in a religious group such as a church or synagogue or a support group such as Alcoholics Anonymous and spiritual concerns or needs such as despair, suffering, guilt, etc.
  3. Involvement of family/caregiver, neighbors, and/or other individuals/organizations, including involvement in any support groups
  4. An assessment of the need for volunteer services to offer support or respite to the patient and family/caregiver
  5. A bereavement assessment of the needs of the patient’s family and other individuals focusing on:
     1. The nature of the relationship to the patient
     2. Circumstances surrounding the illness/prognosis
     3. Behaviors prior to and after the illness/prognosis
     4. Survivor needs (social, spiritual and cultural) that may impact coping skills
     5. Potential for pathological grief reactions
  6. Laboratory results
  7. Medical, alcohol, and other drug history
  8. TB screening
  9. Specific, individualized patient needs/problems pertinent to the palliative care being provided
  10. Past medical and surgical care, including dates of onset/exacerbation
  11. The patient’s and family/caregiver’s educational needs, abilities, motivation, and readiness to learn
  12. The need for referrals and further evaluation by appropriate health professionals

1. When appropriate, a member of the interdisciplinary team shall recommend the patient to rehabilitation therapies including, but not limited to, physical, occupational, and speech-language therapies.
2. The assessment should determine:
   1. Probable prognosis of six (6) months or less
3. **Policy No. 2-006.4**
   1. Patient problems and needs related to the terminal illness
   2. Patient goals related to the terminal illness
   3. Type of services, frequency, and duration needed to meet patient care needs
   4. Anticipated discharge needs, including bereavement and funeral needs
   5. Survival risk factors, such as the nature of the relationship with the patient, circumstances surrounding the death, behaviors before and after the death, and availability of coping mechanisms and potential for pathological grief reactions
   6. The need for an alternative level of care
4. The organization must assure that the uniform data elements allow for measurement of outcomes and include palliative care aspects.
   1. Data elements should be documented in a systematic and retrievable way for each patient and used to individualize care planning and coordination of services for each patient.
   2. Data elements will be used in the aggregate for the Organization’s Name QAPI program
5. The Clinical Supervisor will be responsible for assuring that the documentation of clinical findings supports the terminal diagnosis.
6. The comprehensive assessment is updated by the interdisciplinary group as frequently as the patient’s condition requires but at a minimum every fifteen (15) days.
   1. The interdisciplinary group is required to only update those sections that require updating
   2. If no changes are needed, then that must be documented
   3. If there has been a change in the patient’s condition/status, then the comprehensive assessment must be updated

**Ongoing Assessment**

1. **Policy No. 2-007.1**

**PURPOSE**

To provide guidelines for assessments of patients during ongoing care.

**POLICY**

The scope and intensity of ongoing patient assessments will be determined by the patient's prognosis, diagnoses, condition, desire for care, response to previous care, and the care setting. The ongoing comprehensive assessment will be updated as frequently as the condition of the patient warrants or no less frequently than every fifteen (15) days.

**PROCEDURE**

1. During each home visit, the Case Manager or other discipline will evaluate the patient according to the problems identified during the initial assessment and thereafter the comprehensive assessment.
2. The nurse will assess each patient on each visit, for:
   1. Pain, including the origin, location, duration, severity, and relief measures
   2. Secondary symptoms related to the terminal illness such as, nausea, vomiting, and respiratory distress, and patient's response to medications and other interventions
   3. Factors that alleviate or exacerbate physical symptoms
   4. Current treatment related to the identified symptoms and the patient’s response
   5. Vital signs appropriate to the patient’s condition
   6. Breath sounds
   7. Skin integrity
   8. Bowel sounds, elimination (urinary and bowel)
   9. Mental status
   10. Appetite/diet, nutritional status
   11. Functional status
   12. Safety/home environment
   13. Patient and family/caregiver support
   14. Progress toward goals and patient needs and problems
3. **Policy No. 2-007.2**
   1. Compliance with treatments and medication regimen
   2. The need for an alternative setting or level of care
4. Ongoing comprehensive assessments should focus on:
   1. Patient's response to care
   2. Changes in patient condition, level of deterioration
   3. Changes in patient diagnoses/prognosis
   4. Changes in the patient's care environment or support systems
   5. Well-being
   6. Comfort
   7. Dignity throughout the dying process
5. Based on the assessments, the plan of care—including problems, needs, goals, and outcomes—will be reviewed and updated by the interdisciplinary group members responsible for the case.
6. When appropriate, a member of the interdisciplinary team shall recommend the patient to rehabilitation therapies including, but not limited to, physical, occupational, and speech-language therapies.
7. Based upon the findings of the assessment, change/verbal orders will be generated and forwarded to the physician (or other authorized independent practitioner) as needed.
8. The physician will be notified to verify any changes in medications, including over-the-counter medications, and treatment/interventions that require physician approval.

**PLAN OF CARE**

**Policy No. 2-008.1**

**PURPOSE**

To ensure that an individualized plan of care is established, reflects the patient and family’s palliative care needs and complies with accepted standards of care.

**POLICY**

A written individualized patient and family/caregiver plan of care will be established and maintained for each individual admitted to the palliative care program. The care provided to the patient must be in accordance with the plan of care. The plan of care will follow the physician or nurse practitioner directed medical orders and the care planning process. The plan of care will be based on assessments performed by members of the interdisciplinary team and will be reviewed and updated on a regular basis in accordance with the Palliative Care Program policies. This plan will focus on identified problems, goals, interventions and identification of measurable outcomes. The patient and family/caregiver will be encouraged to participate in the development of and continued revision of the plan of care. This plan of care must be initiated at start of care and revised as needed to meet the patient and family/caregiver needs.

**PROCEDURE**

1. The plan of care is based upon an ongoing assessment of the patient needs in conjunction with the patient’s strengths, limitations, values, and goals.
   1. Determination of goals of care is made with the patient and family and with consideration of the changing needs of the patient at various critical decision points during the course of the patient’s illness.
2. The plan of care is developed and updated by the interdisciplinary team in collaboration with the patient, family, caregivers and other healthcare providers involved in the care.
   1. Additional input may be requested from other specialists, caregivers and significant persons identified by the patient as needed.
3. The plan of care is communicated to staff across the care continuum who are involved in the patient’s care including the patient’s preferences about how he or she wants to receive information is communicated.
4. The process of plan of care development includes:
   1. Physical and psychological assessment of the current disease state, treatment options, functional status, expected prognosis, symptoms and coping mechanisms.
   2. Social and spiritual assessment of the social, practical, religious, spiritual, existential and legal needs of the patient and family/caregivers.

**Policy No. 2-008.2**

* 1. Cultural assessment of decision making, preferences, disclosure of information, communication, use of complementary and alternative medicine, perspective on dying, suffering and grieving and burial rituals.
  2. Assessment of the manner of how information should be tailored to the patient’s age, language, and ability to understand.
  3. When developmentally appropriate, the child’s opinions and preferences are considered when making decisions and providing care.
  4. When developmentally appropriate and proper for the clinical circumstance, the program provides age-appropriate information about the child’s illness, as well as potential treatments and outcomes, to the child as decided by the child’s family.

1. Care planning conferences with the patient and family will be arranged to determine goals of care and to coordinate care and services in collaboration with the attending physician and other healthcare personnel.
2. The admissions nurse, case manager or care coordinator will complete the initial assessment and will initiate the development of the palliative care plan of care after the consent forms are signed
3. The admissions nurse, case manager or care coordinator will then notify the attending physician and members of the interdisciplinary team as needed, of the initial assessment findings, the identification of patient care needs and the recommended services to meet patient care needs.
4. The plan of care will be initiated at the time of the initial assessment.
5. Orders for admission to the palliative care program will be provided by the attending physician (or other authorized practitioner) and documented on a physician’s order.
6. The plan of care will identify the patient’s needs and services to meet those needs, including the management of pain and symptoms.
   1. It must state, in detail, the scope and frequency of services needed to meet the patient’s and family/caregiver’s needs.
7. The individualized plan of care will be reviewed by the interdisciplinary team as needed.
8. The plan of care will be provided to both the attending physician and the palliative care physician for approval.
   1. The palliative care physician will review the patient’s history and physical, which is also provided, to ensure the plan of care meets the patient’s needs.
9. Each patient will be monitored for his/her response to care or services provided against established patient goals and patient outcomes, and progress toward goals will be closely monitored.

**Policy No. 2-008.3**

1. Care decisions and services to be provided will be made as a result of the care planning process, analysis of initial and ongoing comprehensive assessments, and analysis of patient response to care against goals and outcomes.
2. The plan of care will be reviewed, evaluated and revised as frequently as deemed necessary, by members of the interdisciplinary team, with input from the attending physician, the patient, and the family/caregiver.
   1. Review of the plan of care will be documented in the clinical record. Revision dates will be noted on the plan of care.
3. Any change in the patient’s condition may result in a change in the plan of care, and implementation of new services.
4. As needed, the patient and family/caregiver will receive written instructions regarding treatments or aspects of care that will be the responsibility of the patient and family/caregiver to provide or follow through with.
5. The palliative care team will provide support for decision making, developing and implementing the plan of care.
   1. All palliative care team members will communicate the plan of care to the patient, family and healthcare professional involved in the patient’s care.
6. The written plan of care will contain, but will not be limited to, the following:
7. Diagnoses
8. Identification of patient and family/caregiver needs, including physical, psychosocial, cognitive, cultural, spiritual, nutritional, functional, educational, and counseling
9. Functional limitations
10. Mental status
11. Safety measures to protect against abuse, injury, infection, or communicable disease, as appropriate
12. Nutritional requirements
13. DME and medical supplies necessary to meet patient needs
14. The scope and frequency of services and treatment to meet the patient and family’s needs and goals.
15. Referrals for:
    * 1. Counseling

**Policy No. 2-008.4**

* + 1. Spiritual care as needed by the patient and family through the program’s chaplain or spiritual care provider, through the patient’s own relationship with clergy or through community spiritual care resources.
    2. Bereavement services for the patient’s family prior to the patient’s death
    3. Additional disciplines, volunteers, and additional services as needed including for symptoms of psychiatric diagnoses such as depression, anxiety and suicidal ideation.

1. Individualized interventions to assist with the management of the patient’s physical and psychological symptoms
2. Patient and family/caregiver educational needs and assessment of their ability to learn and understand teaching, including physician-directed instruction to patients and family/caregivers.
3. Statement of the patient’s goals and values and treatment choices.
4. Interdisciplinary group assessment of needs as needed
5. Physician (or other authorized licensed independent practitioner) orders, including pharmacologic/non-pharmacologic treatments (including allergies), procedures and complementary therapy for pain and symptom management.
6. Measurable outcomes anticipated from implementing and coordinating the plan of care
7. Patient or representative’s level of understanding, involvement and agreement with the plan of care
8. As appropriate, the participation and updating of the family regarding the patient’s medical goals and treatment choices.
9. All appropriate palliative care staff will have access to the plan of care.
10. Care provided to the patient will be in accordance with the plan of care.

**INTERDISCIPLINARY Palliative CARE**

**Policy No. 2-009.1**

**PURPOSE**

To ensure the provision and coordination of interdisciplinary care and services for each patient enrolled in the Palliative Care Program.

**POLICY**

The organization will utilize a case management or care coordination model/process to guide the interdisciplinary team in the provision of comprehensive, coordinated palliative care services to patients and family/caregivers. It will be the responsibility of the Palliative Care Program clinical leader to designate and/or assign a Case Manager or Care Coordinator to each patient enrolled in the palliative care program. The Case Manager or Care Coordinator will be responsible for coordination of services with the interdisciplinary group from referral to discharge.

The CBPC program’s core interdisciplinary team is comprised of the following:

* Physician(s) (Doctor of Medicine or Osteopathy) who has specialized training in palliative care and/or hospice care; clinical experience in palliative medicine and/or hospice care; or is board-certified or eligible for board certification in Hospice and Palliative Medicine.
* Registered nurse(s) and/or advanced practice nurse(s) who has training in palliative care and/or hospice care; clinical experience in hospice or palliative care; or one who has, or is eligible for, palliative care certification.
* Chaplain(s) who has training in palliative care and/or hospice care; experience in hospice or palliative care; or one who has or is eligible for board certification; or a spiritual care professional(s)\* who has training in palliative care and/or hospice care or experience in hospice or palliative care.
* Social worker(s) who has training in palliative care and/or hospice care; experience in hospice or palliative care; or one who has, or is eligible for, palliative care certification.

Based on the care, treatment and services provided and population served and the patient’s and family’s needs, the interdisciplinary team may utilize additional individuals from other health care disciplines. The type and scope of services provided by the interdisciplinary group will be based upon the comprehensive and ongoing assessments and development of a plan of care that reflects the needs of the patient and family/caregiver. The interdisciplinary team provides family-centered care for the child and family. The comprehensive plan of care defines the patient and family/caregiver problems, goals, and interventions and defines the care and services to be provided. The types of care and services provided will be individualized to each patient and family/caregiver unit, and it will change as the needs of the patient and family/caregiver evolve over the course of their involvement with the Palliative Care Program.

The interdisciplinary group will maintain responsibility for the provision and coordination of care, in accordance with the Palliative Care Program services.

**Policy No. 2-009.2**

**PROCEDURE**

* 1. Each patient will be assigned a Case Manager or Care Coordinator by the Palliative Care Program clinical leader based on the patient’s care needs, geographic location, and type of services needed.
  2. The Case Manager or Care Coordinator will be qualified through education, training, and/or experience and will:

1. Understand the principles of care provided
2. Know required qualifications for palliative care personnel providing care and know which palliative care personnel possess these qualifications
3. Know the scope of care which can be provided by various interdisciplinary   
   group members
4. Understand the nature of the patient population served
   1. It will be the responsibility of the Case Manager or Care Coordinator to facilitate communication about changes in the patient’s status among interdisciplinary group members and the patient’s attending physician.
   2. The interdisciplinary team conducts regular patient care conferences with its members and other program staff members as needed to discuss patient-centered goals of care, disease prognosis, and advance care planning with input from the patient and family.
   3. The organization personnel will communicate changes in a timely manner according to the Palliative Care Programs policies and procedures.
   4. All communications, related to the care of the patient, will be included in the clinical record. Documentation will include the date and time of the communication, individuals involved with the communication, information discussed, and the outcome of the communication.
   5. Once assigned, the members of the interdisciplinary team initiate contact with the patient and family to assess their individual needs and build a rapport with the patient and family as needed.
   6. When the patient requires services from the interdisciplinary group, the Case Manager or Care Coordinator will be responsible for care planning to ensure goals, interventions, and outcomes are reflective of the palliative nature of the goals of care.
   7. Written evidence of care coordination will be found in the plan of care, visit notes and/or progress notes in the patient’s clinical record, and will be provided to the patient’s attending physician and other care providers as needed.
   8. Care will be provided by an interdisciplinary group made up of physicians, nurses, social workers, nurses’ aides, homemakers, clergy, counselors, volunteers, and therapists.
   9. These services will be provided according to the patient and family/caregiver’s needs and the scope of services provided by the Palliative Care Program.

**Policy No. 2-009.3**

* 1. The interdisciplinary group (in collaboration with the attending physician, if any) will conduct assessments and reassessments, develop and update the plan of care, and review the effectiveness of care routinely in accordance with the Palliative Care Program policies and procedures.

1. The attending physician will receive a copy of the plan of care and updates.
   1. The interdisciplinary group reassesses the patient on a regular basis, including the patient’s and family’s understanding of the patient’s serious illness and its trajectory, the patient’s goals of care and treatment, as well as preferences – making changes to the palliative care plan as appropriate.
   2. The interdisciplinary group shall provide the patient and family the opportunity to ask questions and request information.
   3. The reassessment is documented in the patient’s medical record.
   4. All interdisciplinary group members, including those providing services, will have access to the plan of care to facilitate coordination and continuity of care.
   5. Service providers will provide documentation of services provided to the case manager, or care coordinator, including clinical notes, schedule of visits, and patient evaluations; and communicate with the interdisciplinary group as needed.
   6. Continuity of care will be maintained throughout the patient’s enrollment with the Palliative Care program.
   7. Palliative care services will be available as defined in the Palliative Care Program policies and procedures.
   8. Exchange of information between palliative care staff and providers will be documented in the clinical record.

**PHYSICIAN SERVICES**

**Policy No. 2-010.1**

**PURPOSE**

To specify the role of the palliative care physician in the delivery of palliative care services.

**POLICY**

The medical care of each patient admitted to the organization’s Palliative Care Program will be the responsibility of the patient’s attending physician in collaboration with the Palliative Care physician and/or nurse practitioner. Communication between the attending physician and members of the Palliative Care Program interdisciplinary group will be ongoing and documented in the patient’s clinical record. When the attending physician is absent, the attending physician must designate another physician to oversee care for the patient, according to his/her medical group’s departmental procedure. The Palliative Care physician will provide care to the extent that care and services meet the criteria for palliative care services agreed upon with the patient and the attending physician.

**PROCEDURE**

1. The role of attending physician (or referring physician or provider) will include the following:
   1. The attending physician (or referring physician or provider) will:
      1. Approve the patient referral to the palliative care program, if indicated
      2. Provide clinical documentation to the palliative care program detailing the patient’s medical history and treatment plan if requested
      3. Inform the patient and family/caregiver about goals of care of the palliative care program
      4. Discuss advance directives with the patient and family/caregiver and provide documentation of the completed advance directive, where applicable
      5. Provide the following information to the Palliative Care Program:
         1. Patient name
         2. Diagnoses, recent history and physical, and physical exam
         3. Symptoms
         4. Current medications and treatment
         5. Advance directives
      6. Collaborate with the interdisciplinary group to coordinate Palliative Care and services to the patient

**Policy No. 2-010.2**

1. The role of the palliative care physician will include the following:
   1. The palliative care physician or designee will:
2. Collaborate with the attending physician to determine the palliative care needs of the patient
3. Determine goals of care with the patient and family/caregiver
4. Perform a clinical assessment and determine palliative needs related to:
5. Pain and symptom management
6. Functional status
7. Nutritional Status
8. Psychosocial needs
9. Spiritual needs
10. Other care needs
11. Discuss findings with the interdisciplinary group and create an individualized plan of care for the patient
12. Address the patients palliative care needs
13. Monitor the patients progress towards goals and effectiveness of treatment
14. Make referrals for care and services as needed
    1. Consultation services may be provided to patients and family/caregiver, physicians and other providers regarding recommendations for palliation of symptoms as needed.
15. The palliative care physician will:
    1. Work closely with the members of the interdisciplinary group and oversee the care provided to patients enrolled in the palliative care program
    2. Facilitate discussion and clarification of patient and family goals of care and communicate these goals to the interdisciplinary group and other healthcare personnel
    3. Facilitate access to appropriate supportive care services as needed
    4. Educate patients, family, peers, members of the interdisciplinary group and other healthcare personnel regarding Palliative Care services
    5. Participate in meetings to discuss and plan patient care

**Policy No. 2-010.3**

* 1. Assist in the development and implementation of standards of care
  2. Adhere to standard palliative care practices

1. The plan of care will be developed by the admissions registered nurse, case manager or care coordinator, in collaboration with the patient and family/caregiver, the attending physician, and the palliative care physician upon admission to the palliative care program.
   1. Once the initial assessment is completed, the interdisciplinary group determines the plan of care and updates according to patient care needs.
   2. The attending physician will be invited to participate in the interdisciplinary group and communicate with the team in person, via telephone or through written documentation mailed, faxed or emailed to the palliative care program.
   3. The palliative care physician will manage the palliative care needs of the patient in collaboration with the attending physician and offer recommendations for care and treatment as needed.
2. The palliative care program interdisciplinary group coordinate care and services with the patient and family/caregiver:
3. The attending physician will be invited to participate in care coordination activities.
4. The attending physician will make changes in the plan of care, in consultation with the interdisciplinary group.
5. Team members will communicate with the attending physician about any changes in the patient’s status, changes in the care or service being provided, changes in the patient’s physical or psychosocial condition, the patient’s response to care or service, the patient’s outcome related to care or service, and changes in diagnosis, treatment, or equipment.
6. If the patient dies, the attending physician will be promptly notified.
7. Withdrawal from the palliative care program (not due to death) will be mutually agreed upon by the attending physician, patient and family/caregiver, and the interdisciplinary group.
8. Hospitalization of palliative care patients will be arranged:
9. In collaboration with the attending physician or designee who will provide admitting orders to admit to the hospital as needed.
10. The attending physician will provide medical care and orders during the patient’s inpatient stay.
11. The palliative care physician may provide consultation services as needed in the hospital if requested at the hospital where the patient is admitted.

**Policy No. 2-010.4**

1. When the patient is ready for discharge from hospital, a discharge order and new palliative care orders will be written by attending physician (or other authorized licensed independent practitioner).
2. A discharge summary from the hospital will be sent to the palliative care program for inclusion in the clinical record along with the patient’s inpatient clinical record if requested.

**Nurse practitioner services**

**Policy No. 2011.1**

**PURPOSE**

To specify the role of the Palliative Care Nurse Practitioner in the delivery of palliative care services.

**POLICY**

The medical care for each patient admitted to the organization’s Palliative Care Program will be the responsibility of the patient’s attending physician in collaboration with the Palliative Care physician and/or Nurse Practitioner. The Palliative Care Nurse Practitioner works collaboratively with a physician and other members of the interdisciplinary group to deliver palliative care and related healthcare services to patients and their families.

Communication between the attending physician and members of the Palliative Care program interdisciplinary group will be ongoing and documented in the patient’s clinical record. When the attending physician is absent, the attending physician must designate another physician to oversee care for the patient, according to his/her medical group’s departmental procedure.

The Palliative Care Nurse Practitioner will provide care to the extent that care and services meet the criteria for palliative care services agreed upon with the patient and the attending physician.

**PROCEDURE**

1. The Palliative Care Nurse Practitioner:
   1. Performs palliative care visits with patients enrolled on the palliative care program.
   2. Completes history and physical examinations, by evaluating the patient’s medical condition and health history, ordering and interpreting results from laboratory and diagnostic tests or procedures, diagnosing health conditions and documents the findings in the patient’s medical record.
   3. Assists with diagnosis, treatment and management of acute and chronic health conditions.
   4. Manages chronic health conditions and terminal illnesses by developing an individualized plan of care, prescribing medications and/or treatments, obtaining consultations or making referrals and coordinating palliative care services.
   5. Makes recommendations to the palliative care physician and attending physician regarding patient eligibility for certification and recertification for palliative care.
   6. Reviews clinical information, coordinates and oversees patient care in consultation with the palliative care interdisciplinary group and other healthcare practitioners.
   7. Documents clinical findings in accordance with the palliative care program policies and procedures, signs and dates that they performed the visit where applicable.

**Policy No. 2011.2**

* 1. Prescribes medications including controlled substances to the extent permitted by licensure.
  2. Assures that patient receives appropriate measures to control symptoms through collaboration with interdisciplinary group members.
  3. Reviews and develops practice guidelines, standards and protocols for treatment and proposes options for interventions based on the current medical literature.
  4. Attends and participates in palliative care interdisciplinary group meetings.
  5. Consults the collaborating physician and/or organizational leadership when the patient's plan of care is outside standardized practice and protocols.
  6. Provides education and training in palliative care services to patients, families, peers, members of the interdisciplinary group and other healthcare personnel.
  7. Collaborates with hospital staff to coordinate care and services for the hospitalized patient as needed.
  8. Participates in discharge planning for managing patients enrolled in the palliative care program.
  9. Participates in the discussions related to and completion of Advance Directives and care planning.
  10. Provides consultation services with other care providers and referral sources.
  11. Adheres to standards of practice in palliative care.

1. Visits with the patient and family/caregiver are conducted with the purpose of:
   1. Performing a clinical assessment.
   2. Determining pain and symptom management needs in collaboration with the patient and family/caregiver and the attending physician.
   3. Managing and coordinating care and services.
   4. Meeting patient and family/caregiver care and educational needs as requested.
2. The Nurse Practitioner functions under the direction of the palliative care physician and in accordance with state regulations related to scope of practice.
3. The Nurse Practitioner is a member of the interdisciplinary group and participates in the case management, care coordination and determining the plan of care.
4. Members of the interdisciplinary group collaborate with the Nurse Practitioner to manage the patients care and services.

**NURSING CARE**

**Policy No. 2012.1**

**PURPOSE**

To ensure nursing services are provided to patients receiving palliative care services.

**POLICY**

Nursing services will be provided in accordance with accepted standards of practice by or under the supervision of a registered nurse. The palliative care nurse (registered nurse or licensed practical/vocational nurse) will be a member of the interdisciplinary group. The palliative care nurse will play a key role in managing the care and services provided to the palliative care patient and family/caregivers.

A palliative care registered nurse will be assigned as the Case Manager or care coordinator for each patient and family/caregiver. Duties will include coordination of care and fostering communication between the patient and the interdisciplinary group.

The Case Manager or Care Coordinator will ensure that components of the plan of care are established and implemented by the interdisciplinary group and ensure continuity of care.

**PROCEDURE**

1. The palliative care registered nurse performs comprehensive patient assessments that include the patient’s physical, psychosocial, emotional and environmental needs. The assessment will include functional status, activities of daily living and fall risk.
2. The palliative care registered nurse will:
3. Participate in developing and implementing the plan of care and will report the patient’s condition to the interdisciplinary group.
4. Manage discomfort and provide symptom relief.
5. Collaborate with the attending physician and other care providers involved in the patient’s care.
6. Coordinate care and services with the interdisciplinary group.
7. Incorporate specialized nursing skills related to palliative care into all clinical care provided to patients.
8. Provide patient and family/caregiver education regarding the disease process, self-care techniques, and processes for addressing ethical issues.
9. Assess for risks of pathological grief, cultural and spiritual implications and verbal and nonverbal communication patterns exacerbated by serious and/or life-limiting diagnosis.

**Policy No. 2012.2**

1. Initiate appropriate preventive and rehabilitative nursing procedures.
2. Prepare clinical and progress notes that demonstrate progress toward established goals.
3. Coordinate all patient and family/caregiver services, and prioritization of needs with the interdisciplinary group.
4. Use a case management approach, making referrals to other services as needed.
5. Provide specialized palliative care training to other staff, family/caregivers to ensure adequate care.
6. Provide an ongoing evaluation of the patient and family/caregiver response to care.
7. Assess the ability of the caregiver to meet the patient’s immediate needs upon admission and throughout care.
8. The palliative care registered nurse will supervise licensed practical/vocational nurses, nurse aides, homemakers and volunteers.
9. A palliative care nurse will be available on an ongoing basis, per program policy, to meet the physical, psychosocial, spiritual, and practical needs of patients and family/caregivers admitted to the palliative care program.
10. Direct provision of nursing care will be based on palliative care nursing standards and clearly defined treatment protocols.
11. Patient and family/caregiver education and training activities will be initiated and continued throughout the course of care.
12. Licensed practical/vocational nurses will supplement the nursing care needs of the patient as provided by the registered nurse by:
13. Providing services in accordance with organizational policies and procedures
14. Preparing clinical and progress notes documenting outcomes of interventions
15. Assisting the registered nurse or physician in performing specialized duties related to palliative care services
16. Assisting the registered nurse in carrying out the plan of care
17. Preparing equipment and materials for treatment adhering to aseptic technique, as required
18. Assisting the patient in learning appropriate self-care techniques
19. Assessing patient and family/caregiver response to care
20. Ensuring communication of information to appropriate team member

**Psychosocial Care**

**Policy No. 2-013.1**

**PURPOSE**

To ensure psychosocial counselors provide psychosocial services to patients and families receiving palliative care services.

**POLICY**

Psychosocial care of each patient admitted to the organization’s Palliative Care Program will be offered and provided to patients upon admission and communicated to the interdisciplinary group. Psychosocial care will be provided by the Palliative Care Medical Social Worker.

**PROCEDURE**

The role of the Palliative Care Psychosocial Counselor (Palliative Care Medical Social Worker) will include the following:

* 1. Availability to patients, family and healthcare personnel to offer support and counseling as needed.
  2. Assignment to patients and families will be determined in collaboration with the Palliative Care Case Manager or Care Coordinator.
  3. Prioritizing psychosocial care to patients who report psychosocial distress.
  4. Making initial contact with patients and families upon admission to the palliative care program and assessing their individual need for psychosocial support.
  5. Coordinating care and services in collaboration with the interdisciplinary group and other healthcare personnel.
  6. Developing a supportive rapport with the patient and family.
  7. Assess psychosocial issues that may either impede or facilitate the patient’s treatment and quality of life and provides intervention.
  8. Assess the psychosocial, mental and behavioral status of the patient and the family and intervenes to promote the maximum benefit of care.
  9. Facilitates access to community resources to meet patient and family needs.
  10. Contributes to and provides care per the palliative care plan.

**Palliative Care PASTORAL CARE**

**Policy No. 2-014.1**

**PURPOSE**

To ensure chaplaincy personnel provide pastoral/spiritual care services to patients and families receiving palliative care services.

**POLICY**

Pastoral/spiritual care of each patient admitted to the organization’s Palliative Care Program will be offered and provided to patients upon admission and communicated to the interdisciplinary group.

**PROCEDURE**

The role of the Palliative Care Chaplain or Spiritual Counselor will include the following:

1. Availability to patients, family and healthcare personnel to offer support and counseling as needed.
2. Assignment to patients and families will be determined in collaboration with the Palliative Care Case Manager or Care Coordinator.
3. Assess spiritual needs of the patient and the family.
4. Prioritizing spiritual care to patients who report spiritual and existential distress.
5. Making initial contact with patients and families upon admission to the palliative care program and assessing their individual need for spiritual and emotional support.
6. Coordinates with the patient’s or the family’s identified spiritual counselor and/or faith community or available spiritual counseling resources per the palliative care plan.
7. Developing a supportive rapport with the patient and family.
8. Building relationships and partnerships with multi-denominational clergy and spiritual leaders serving the palliative care patients and their families.
9. Conducting pastoral care rituals and ceremonies as requested, including memorial services and funerals as needed.

**palliative care PAIN AND Symptom ManagemENT**

**Policy No. 2-015.1**

**PURPOSE**

To ensure quality and consistent care is provided to patients experiencing pain and symptoms and to identify, assess and manage pain and symptoms effectively.

**POLICY**

All patients will have pain and symptom assessments completed routinely. When pain and symptoms are identified, a more comprehensive pain and symptom assessment will be completed. Assessments will be appropriate to the patient’s age and will be documented to facilitate regular reassessment and clinical follow-up. Assessment findings will be the basis from which pain and symptom management will be implemented.

The organization personnel shall utilize approved pain and symptom assessment tools to evaluate and document symptoms per the organization’s protocol. Fundamental principles of pain and symptom management will be followed.

**PROCEDURE**

1. During the initial assessment and on an ongoing basis, the patient will be asked general screening questions regarding current or recent pain and symptoms as part of the baseline evaluation.
2. Clinicians will consider the patient’s personal, cultural, spiritual, and ethnic beliefs when assessing pain and symptoms.
3. Assessment and treatment of pain and symptoms will be consistent with the patient’s cultural and age-specific needs.
4. During the initial assessment the patient will be screened for substance abuse and risk of diversion.
5. If the patient is unable to communicate pain and symptoms using approved rating scales, is cognitively impaired, or is a child, the clinician will assess behavioral factors that indicate pain and symptoms and include this information in assessment documentation.
6. For parent/caregiver of a child who exhibits or reports pain and symptoms, information will be provided regarding the parent/caregiver’s interpretation of his/her child’s behavioral changes that may indicate pain and symptoms.
7. Pain and symptom assessments will be routinely assessment, per palliative care program protocols, and will be updated if significant changes occur.

**Policy No. 2-015.2**

1. An individualized plan of care will be established to manage pain and symptoms that include pharmacological and non-pharmacological interventions which may include:
   1. Complimentary therapies,
   2. Herbal remedies,
   3. Touch therapy,
   4. Behavioral therapy and
   5. Other therapy (as appropriate)
2. Goals for pain and symptom management will be identified in collaboration with the patient and family.
3. Reassessment of pain and symptoms shall be implemented after each intervention to determine effectiveness.
4. Pain and symptoms that are not controlled with current regimens will be communicated to the physician or nurse practitioner to obtain orders for a more effective regimen.

**PATIENT EDUCATION**

**Policy No. 2-016.1**

**purpose**

To ensure palliative care patient education is provided to patients and their family enrolled in the palliative care program.

**policy**

Palliative care patient education is provided to patients and families/caregivers as it relates to their palliative care needs and their learning abilities. Palliative care education will be provided at the level of education that the patient and family understand and, in a manner, and language that is most effective and efficient.

**procedure**

1. Upon admission to the palliative care program the patient, family and caregivers are assessed for educational needs and cognitive/emotional capabilities.
2. Educational and counseling needs are routinely assessed and reassessed thought the course of care and treatment.
3. Educational initiatives will be tailored to the patient’s condition, disease process and comorbid condition, treatment and plan of care and educational needs.
4. Common educational needs include:
   1. Pain and symptom management.
   2. Advance care planning and advance directives
   3. Anticipated future medical needs
   4. Home or institutional support options (e.g., home hospice services)
   5. What to expect in the normal course of the disease
   6. Signs/symptoms of approaching death
   7. Community services (e.g., bereavement, counseling)
   8. Whom to call for routine and emergency/urgent needs
5. The interdisciplinary team shall instruction patients, families and visitors on infection prevention and exposure control practices.
6. The Palliative Care Program will prepare educational materials and offer educational resources to patients and families/caregivers as needed.

**Policy No. 2-016.2**

1. Educational material will be provided in a number of commonly spoken languages that reflect the demographic of the patient population served.
2. Educational needs that are identified are incorporated into the plan of care.
3. All members of the interdisciplinary group will provide education to patients as identified throughout the course of treatment.

**CASE MANAGEMENT**

**Policy No. 2-017.1**

**purpose**

To define and establish palliative care case management practices and procedures.

**policy**

Palliative care case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet a patient and family’s palliative care needs through communication and available resources to promote quality outcomes.

1. Case Managers maintain competency in palliative care case management by:
2. Meeting palliative care case management standards and practices
3. Adhering to the organization policies and procedures
4. Adhering to regulations and compliance expectations
5. Maintaining patient confidentiality
6. Meeting professional competency levels, licensure and certification as needed
7. Adhering to job description, role and responsibilities
8. Identifying case management goals

***Palliative Care Case Management Goals***

1. Case Management goals include:
2. Coordination, communication and collaboration with patients and families, providers, ancillary services, and other care providers to achieve patient care goals.
3. Implementing processes and procedures that support case management activities.
4. Utilizing a patient-centered approach and collaborative partnerships to achieve patient care goals.
5. Practicing cultural competence and awareness of the diverse needs of the patient and family.
6. Facilitating informed consent and decision making.
7. Educating patients and families regarding palliative care services and case management goals.

**Policy No. 2-017.2**

1. Utilizing evidence-based care, best practices and palliative care standards of care.
2. Ensuring patient safety and arranging resources to support patient safety.
3. Accessing community resources as needed to support patient care.
4. Identifying benchmarking indicators of excellence in palliative care case management and evaluating processes, outcomes and quality improvement mechanisms.

**procedure**

1. The case manager will:
   1. Be assigned upon patient admission to the palliative care program
   2. Establish criteria for case management services for palliative care patients
   3. Identify the purpose of case management
   4. Complete a patient assessment
   5. Identify problems that require case management and intervention
   6. Identify other comorbid conditions, if present
   7. Identify immediate care needs of the patient
   8. Assist patients and families with identifying and accessing community resources that are available to meet patients’ physical, psychosocial, and spiritual needs
   9. Develop an individualized plan of care for each patient
   10. Identify stakeholders involved in the care of the patient
   11. Employ assessment, documentation and communication practices in managing the patient’s care
   12. Establish caseloads and determine level of case management need:
2. Severity of Illness
3. Complexity of Care
4. Interdisciplinary needs
5. Role requirements
6. Other factors

**Policy No. 2-017.3**

1. Palliative care case managers coordinate care and services across:
   1. Healthcare settings
   2. Healthcare departments
   3. Healthcare personnel
   4. Multiple ancillary services and programs

**COORDINATION and Continuity OF CARE**

**Policy No. 2-018.1**

**PURPOSE**

To ensure that care coordination services and continuity of care are addressed by the Palliative Care Program.

**POLICY**

The organization and program leaders promote and support that a collaborative and trusting environment is maintained. Communication and teamwork among the interdisciplinary team members and other organizations will be facilitated by program leaders.

The Case Manager or Care Coordinator will coordinate palliative care services and ensure continuity of care across healthcare settings and the patient’s residence. The Palliative Care Program will maintain responsibility for services provided by the Palliative Care Program.

**PROCEDURE**

* 1. The Palliative Care Program will coordinate the provision of palliative care services which may include durable medical equipment, supplies, and professional services.
  2. The Palliative Care Program will retain responsibility for ensuring continuity of care in all settings by:
     1. Working collaboratively with other healthcare personnel and sharing information between disciplines and other providers
     2. Integrating the plan of care with facility and other service providers
     3. Assigning a care coordinator or case manager to coordinate care
     4. Assigning healthcare personnel who will provide the care consistently
     5. Utilizing discharge planners to arrange care and services
     6. Assigning a social worker who will assist in the coordinating care and ensuring continuity
  3. The Palliative Care Program will provide clinical information to healthcare personnel involved in the patients care throughout the patient’s enrollment in the palliative care program.
  4. The Palliative Care Program will provide education and training regarding Palliative Care to referral sources, practitioners and service providers involved in the patient’s care as needed.
  5. Palliative Care services and coordination of care will be provided by trained personnel.

**Policy No. 2-018.2**

* 1. Coordination of care with all providers involved in the patient’s care includes:

1. Making relevant information available to all providers
2. Clearly outlining each provider’s responsibilities in providing care
3. Managing patient co-occurring conditions, if present.
   1. When the patient’s co-occurring conditions are managed by the patient’s primary care physician, or staff from a setting(s) outside the program, the information necessary for its management is communicated to program staff and settings across the continuum of care.
4. Communicating changes in patient status and care in a timely manner
   1. Written evidence of care coordination with other providers will be documented in the clinical record.
   2. Routine processes of communication with other care providers will be arranged by the palliative care team and the provider.
   3. The Palliative Care Program shall ensure that information is communicated effectively to patients and families in a manner that they understand and that encourages questions and dialogue.
      1. Appropriate auxiliary aides and translation services shall be provided to ensure effective communication with the patient and family.
   4. The Interdisciplinary Team shall identify other healthcare professionals, providers, and community resources involved in the patient’s care and, as appropriate, consults, collaborates, and shares information relevant to the patient’s and family’s care.
   5. The Interdisciplinary Team shall make referrals to – or recommends referrals to – other health care providers or community resources to address patient and/or family needs.

**Contents of the Clinical Record**

**Policy No. 2-019.1**

**PURPOSE**

To outline the requirement and components of a clinical record.

**POLICY**

A clinical record will be maintained for each patient receiving care.  The clinical record will contain sufficient information to identify the patient, describe the patient’s problems and needs, justify care, accurately document care provided and results in detail, and facilitate continuity of care among interdisciplinary group members and contract personnel.

**PROCEDURE**

1. The following information will be available in the clinical record as applicable to care and services provided:
   1. Patient and family/caregiver demographic and identifying information
   2. Consent and authorization forms
   3. Election of the Medicare benefit, when applicable
   4. Patient’s Advance Directives, if executed, or documentation that such information has been received
   5. Name, address, and telephone number of:
      1. Contact person for emergencies and/or notification of death
      2. Legal representative for fiscal and health care decisions, when applicable
   6. Physician’s name including primary, secondary, and consulting physicians, as applicable
   7. Pertinent medical history
   8. Current medication profile including prescription and nonprescription medications, herbal products, and home remedies; dose, frequency, and route of administration; with ongoing updates to the patient’s medication regimen, including new, changed, and discontinued medications, adverse reactions, significant side effects, drug allergies, and contraindications.
   9. Legible, complete, and individualized diagnostic and therapeutic orders authenticated within the time frame defined by the organization or according to law and regulation.
   10. Identity of other individuals and organizations known to be involved in patient care.

**Policy No. 2-019.2**

1. Documentation will include:
   1. Substantiation of the terminal diagnosis and criteria for admission
   2. Signed copy of the notice of patient rights
   3. Patient and family/caregiver initial, comprehensive and ongoing comprehensive assessments
   4. Plan of care developed/revised by the interdisciplinary group based on comprehensive assessments and desired outcomes with time frames
   5. Relevant diet or dietary restrictions, allergies or sensitivities, and functional limitations related to care and services provided
   6. Suitability or adaptability of the home to planned services
   7. Safety measures to protect the patient from injury or harm
   8. Educational needs of patient and family/caregiver
   9. Patient and family education provided
   10. Documentation that drug therapy may be ineffective and a follow-up plan for correction of the ineffective drug therapy
   11. Change in interventions for ineffective drug therapy or other undesired outcomes
   12. Regular pain assessments, interventions, and outcomes
   13. Interdisciplinary group meetings and individual patient and family/caregiver case conferences
   14. Physician review of medications and plan of care oversight including justification for recertification
   15. Copies of summary reports sent to the physician, as appropriate
   16. Summary of care and coordination of care provided in other settings, when indicated
   17. Bereavement plan of care, including services being provided
   18. Assessment for volunteer needs, referral, and documentation when indicated
   19. Assessment for spiritual care needs
   20. Acceptance by the patient and family/caregiver of the diagnosis and prognosis
   21. Attitudes and response of the patient and family/caregiver to the plan of care
   22. Progress toward goals/outcomes of care

**Policy No. 2-019.3**

* 1. Certification and recertification(s) of terminal illness
  2. Outcome measure data elements
  3. Discharge summary, if applicable

1. Each entry will be dated and signed, including title and credentials, by the person providing the care/service.

**Clinical/Service Data Collection**

**Policy No. 2-020.1**

**PURPOSE**

To define who has authority to make entries into the clinical/service record and to provide guidelines for valid data collection.

**POLICY**

Home care personnel providing patient care and supervisory functions have authority to make entries into the clinical/service record.  Documentation in the clinical/service record will be timely, detailed, accurate, and reflect the care or services provided.  The record format will be reviewed and updated as necessary.

**Note:** *Time* means actual time that an event occurred, which is not necessarily the time when the documentation was entered into the record. The date and time requirement applies to all entries in the record and the medical record should accurately reflect a clear account of the patient’s entire course of care. The clinical record should tell a linear story of the course of the patient’s care that is managed and delivered by the organization.

**PROCEDURE**

1. A clinical/service record will be initiated and maintained for each patient receiving care or services according to organization policies found in this manual and will include at a minimum:
   1. Patient consent, authorization, and elections forms as applicable
   2. Advance Directives
   3. Copies of inpatient discharge summary, as applicable
   4. Pertinent medical history
   5. Physician (or other authorized licensed independent practitioner) orders, certification/recertification, face-to-face documentation, and evidence of physician oversight activities
   6. Changes to the plan of care/service
   7. Dates, times, and types of interventions, assessments, and coordination of care/service
   8. Patient response to medications, care and services in analyzed and documented as measurable goals
   9. Patient and family education
   10. Reasons for interruptions in the provision of care and services
2. **Policy No. 2-020.2**
   1. Current patient status and progress toward goals
   2. Outcomes of care/service
3. Entries to the clinical/service record will be made only by organization personnel and/or by contract personnel who have a written agreement with the organization.
4. Entries into the clinical/service record will be clear, concise, and specific statements of fact.
5. Entries into the clinical/service record will be legible.
6. Entries will be made using black ink only.
7. Entries into the clinical/service record will be made on the day care/service is provided to the patient.
   1. All documentation will be turned into the office at the end of the workday.
8. The clinical/service note will include:
   1. What care/service was provided
   2. Treatment and/or invasive procedures performed
   3. Patient response to treatment and/or procedures
   4. The date the service was provided (month, day, year)
   5. Signature of clinician/technician and his/her credentials
9. Signature authorization of clinical/service documentation will include the staff member’s name and credentials (as specified on professional licenses and/or certification documents).
10. Initials will be used on forms where authentication signature space is designated on the form.
11. All entries will reflect the date care was provided, including the month, day, and year.
12. Home health/hospice aides (HHA, HA) will only make entries on the aide visit form and the case conference form.
13. Late entries or amendments will be documented stating “late entry or amendment for visit of (date and time of visit)” and include:
    1. The date the entry is made (month, day, year)
    2. The date and documentation that was originally omitted or amended
    3. The signature and title of the staff member making the late entry or amendment

**Policy No. 2-020.3**

1. Errors in documentation will be corrected as follows:
   1. Draw a line through the entry, date and initial.
   2. Do not erase, use correction fluid, or deface a document.
2. Amendments, correction or late entries within an electronic health record must:
   1. Distinctly identify any amendment, correction or late entry
   2. Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each record modification
3. The information management system will be designed to assure that:
   1. Data is collected and entered into the record in a systematic manner.
   2. Organization personnel use consistent definition of data as specified in organization policies.
   3. Data is relevant, as determined through ongoing, as well as quarterly, clinical record reviews.
   4. Data is complete, as determined through ongoing, as well as quarterly, clinical record reviews.
4. Personnel authorized to use a computer to authenticate documentation will sign a computer confidentiality statement, verifying that no one else will be allowed to use their computer password.
5. Each staff member will be responsible for the security of his/her computer password.
6. The organization, at least annually, will verify the accuracy of coded data, through the review of records by a Registered Record Administrator or an Associate Record Technician.

**Care of the Dying Patient**

**Policy No. 2-021.1**

**PURPOSE**

To provide guidance for the care of the dying patient.

**POLICY**

Interdisciplinary group members recognize the importance of each patient and family/caregiver’s unique and individual needs.  Within this framework, responsive and respectful care for the dying patient will be planned, implemented, and monitored in order to:

1. Optimize the patient's comfort and dignity
2. Manage pain and symptoms through interventions that alleviate and/or control pain and assess the patient's level of pain control
3. Identify secondary symptoms, determine the patient's response to treatment, and take actions to limit them
4. Consider the psychosocial, emotional, and spiritual needs of the patient and family/caregiver
5. Implement bereavement care that supports the patient and family/caregiver unit's coping mechanisms throughout the grief process

**PROCEDURE**

1. At the start of care, and on an ongoing basis, personnel will assess the patient and family/caregiver unit (when appropriate) for:
   1. Comfort/pain level and response to pain management plan
   2. Coping mechanisms, strengths and unique qualities of the patient and family/caregiver unit, and participation in the grief process/bereavement
   3. Psychosocial, emotional, and spiritual needs
   4. Presence of secondary symptoms and response to treatment
   5. Knowledge of the physical and psychological aspects of the dying process
2. An individualized plan of care will be developed in cooperation with the patient and family/caregiver, attending physician, and interdisciplinary group members, which facilitates:
   1. Physical/psychological comfort measures.
3. **Policy No. 2-021.2**
   1. Pain management (control or alleviation) according to physician (or other authorized independent practitioner) orders, which may include analgesia and noninvasive or nonpharmacological interventions.
   2. Prevention of secondary symptoms, including, but not limited to, nausea, vomiting, diarrhea, stomatitis, alopecia, GI disturbances, blood dyscrasia, etc.
   3. Prompt identification and treatment—if possible and ordered by the physician (or other authorized independent practitioner)—of secondary symptoms if they should occur.
   4. Monitoring of the response of secondary symptoms to treatment.
   5. Support for development of the patient’s and family/caregiver’s coping mechanisms, including, but not limited to, verbalization of feelings, referral to community support services, etc.  Expressions of love, concern, regret, and forgiveness, as appropriate, will be encouraged.
   6. Recognition of the patient's needs related to dignity, self‑respect, and personal preferences.
   7. Support for the grieving process.  Levels of support will be increased or modified in consideration of patient preferences as death approaches.
4. With each patient visit, the registered nurse will follow the plan of care and assess the need for changes/updates, and will document accordingly.
5. Aspects of care that must be reflected in the clinical record, when applicable, include:
   1. The origin, location, severity (on a scale of 0 – 10: 0 = no pain, 10 = unbearable pain), alleviating, and exacerbating factors for pain/discomfort
   2. Preventative and treatment/measures provided for secondary symptoms and/or pain/discomfort, and the response to treatment
   3. Psychosocial interventions to facilitate development of coping mechanisms and the grieving process, and the patient and family/caregiver's response
   4. Referrals to community resources
6. The Chaplain will facilitate affirmations of faith or spiritual beliefs as appropriate to the patient’s wishes.
7. Interdisciplinary group case conferences will reflect coordination and communication between various team members relative to the patient's/families/caregiver's evolving physical, psychological, emotional, spiritual, and bereavement needs.
8. Personnel will adhere to:
   1. The desires made known by the patient through the use of an advance medical directive executed according to state regulations and policy.
   2. Do Not Resuscitate orders written by the patient's physician (or other authorized independent practitioner) in accordance with state regulations and policy.

**Death at Home**

**Policy No. 2-022.1**

**PURPOSE**

To establish the process to follow when a patient dies.

**POLICY**

It is anticipated that patients will die at home.  Nurses, social workers, and/or the Chaplain are available to attend a patient’s death 24 hours a day, seven (7) day a week.  The family/caregiver may require skilled nursing intervention, psychosocial support, and practical assistance during the time immediately surrounding the death.  Individual state and community regulations and practices will be followed.

Personnel attending a death event will respect the cultural and religious traditions and beliefs of the patient and family members.

**Note:** Organizations should check specific state law regarding death at home and adapt policy to meet state law/statute.

**PROCEDURE**

1. Following notification of a patient's approaching or actual death, the nurse or other interdisciplinary group member will assist the family/caregiver.
2. When desired by the surviving family members, the nurse will visit.
3. The nurse will assist the family/caregiver either via phone intervention or at the home with notification of the attending physician, coroner, and the selected funeral home.
4. The interdisciplinary group members will provide emotional support to the family/caregivers as necessary.
5. The nurse will notify the attending physician of the patient’s death.
6. It will be the attending physician's responsibility to pronounce death (depending on state regulations).
7. This will be done explicitly when the physician signs the death certificate.
8. The physician will routinely accept the organization’s description or report of the absence of vital signs when assuming this responsibility.
9. If the nurse is not at the patient's home when the death occurs, this will be communicated to the physician.
10. All deaths at home will be reported to the medical coroner or appropriate legal entity per state regulations.

**Policy No. 2-022.2**

1. The coroner’s office generally authorizes release of the body from its jurisdiction after the following information is provided by the mortuary, nurse, and/or attending physician:
   1. Name and address of the deceased
   2. Deceased date of birth
   3. Approximate time of death
   4. Name and telephone number of physician who will sign death certificate
   5. Date of last physician contact (if unknown or more than 20 days, encourage the physician to notify coroner)
   6. Medical diagnoses
   7. Next of kin (power of attorney) who have been notified
   8. Any unusual circumstances regarding death, e.g., suspicion of foul play
   9. Name of mortuary
2. If suicide is suspected, the nurse will report this to the physician and then ask the physician if he/she wants to notify the coroner of the death.
3. If the physician does not agree to notify the coroner of the death, then the organization will inform the coroner's office of its suspicions.
4. All of these observations/communications will be documented in the clinical record.
5. The nurse will offer to notify the mortician, funeral director, or cremation society as indicated and will give the name of the coroner who released the body as applicable.
6. The nurse will inform the family/caregiver that it is not necessary to remove the patient’s body right away if they wish to spend some time with the body.
7. The nurse will instruct/assist the family/caregiver to bathe and/or dress the patient’s body as specifically requested by the patient or as desired by the family/caregiver.
8. Any jewelry or valuables will be removed by family/caregiver members.
9. The nurse will encourage the family/caregiver to spend time alone with the patient's body if they wish.
10. The nurse will instruct the family/caregiver to dispose of all medications, including controlled substances, per federal, state, and local regulations and organization policy.
11. This instruction and the specific medications will be documented in clinical note.
12. The nurse will clamp but not remove all tubing entering the body, empty any drainage bags, discontinue oxygen, and remove its tubing.  All IV pumps will be turned off.
13. Any written patient information will be returned to the office.

**Policy No. 2-019.3**

1. The nurse will notify the home medical equipment (HME) company regarding pickup of equipment in home if death occurs during regular business hours.
2. If after regular business hours, the Case Manager will be notified to contact the HME company.
3. The nurse will document in the clinical record all of the above interventions and any other significant information regarding the death.
4. The nurse will also document any grief counseling initiated and/or if the bereavement program was explained to the family/caregiver.
5. The nurse will notify other interdisciplinary personnel about the patient’s death.

**DISCHARGE FROM THe Palliative Care PROGRAM**

**Policy No. 2-023.1**

**PURPOSE**

To establish standards and a process by which patients are discharged from the palliative care program.

**POLICY**

The organization will provide service to a patient and family/caregiver as long as the patient meets the criteria for palliative care services.

***Discharge Criteria***

1. The palliative care team, in collaboration with the physician determines that the patient no longer meets the criteria to receive palliative care services.
2. The patient leaves the palliative care service area, transfers to another palliative care program or transfers to hospice.
3. The patient’s environment is determined to be unsafe for the patient and/or staff.
4. The palliative care program determines that the patient’s (or other persons in the patient’s home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the palliative care program to operate is seriously impaired.
5. The patient and family/caregiver requests discharge.
6. The patient or family/caregiver refuses to allow palliative care program personnel to perform clinical assessment.

**PROCEDURE**

1. The palliative care interdisciplinary group will develop a discharge plan.
2. The discharge planning process will include any necessary family counseling, patient education or other services needed prior to discharge.
3. When the patient and family have made a decision to transfer to hospice care, a referral will be made for hospice services, providing the information listed below, to either the organization’s internal hospice program or to an external hospice program, based on the patient’s family’s choice.
4. Once the patient has been evaluated for hospice services and completed the election of benefits form, the patient will be discharged from the palliative care program.
5. The date of transfer will be coordinated with the hospice organization.

**Policy No. 2-023.2**

1. The palliative care case manager or care coordinator will ensure that discharge documents are completed at the time of discharge.
   1. This will include completion of a discharge summary.
2. When a patient is discharged, transferred, or referred to another organization, relevant information that is communicated to the staff in the new setting will include:
   1. Reason for transfer or discharge
   2. Clinical, physical and psychosocial status at time of transfer or discharge, including specific medical, psychosocial, or other problems requiring interventions or follow-up
   3. Summary of the care provided and progress toward achieving goals, including both positive and adverse patient responses to treatment or services
   4. Summary of the patient’s goals and preferences
   5. A copy of the current plan of care
   6. A copy of the medication profile, including discontinued medications
   7. The latest physician orders
   8. Continuing pain and symptom management needs
   9. Follow-up to be provided by an interdisciplinary group member from the service transferring the patient
   10. All pertinent laboratory data
   11. Summary of patient education provided to the patient and family/caregiver and their comprehension of that information
   12. Instruction and referrals provided to the patient
   13. Advanced care plan and Advance Directives, if applicable
   14. The date of discharge
3. Documentation will be filed in the clinical record.
   1. Information will be documented on a discharge/transfer form
4. If the environment is determined unsafe for the patient and/or staff, the following steps will be taken:
5. Provide written recommendations to the patient, family/caregiver, and physician to resolve unsafe situation
6. Refer to social worker for assistance with planning

**Policy No. 2-023.3**

1. Consult with and document referral to adult/child protective services as needed
2. Consider referrals to other agencies
3. A formal letter will be provided to the patient and/or his/her representative that includes the organization’s concern, recommendations, and consequences if concerns are not resolved, and potential discharge date
   1. A copy will be provided to the attending physician
4. Fourteen (14) day notice is recommended prior to discharge
5. Upon discharge:
6. Advise the patient and/or caregiver regarding the discharge date and discharge plan
7. Obtain a written discharge order from the palliative care physician or nurse practitioner
8. If the patient has an attending physician involved in the care, include the attending physician in the discharge planning and decision making
9. Document coordination of care in the clinical record
10. A copy of the discharge summary will be sent to the attending physician.
    1. If requested, the patient’s clinical record will be provided

**SECTION THREE**

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**SECTION THREE**

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**Medication Profile**

**Policy No. 3-001.1**

**PURPOSE**

To define the use of the medication profile in evaluating a patient’s medication regimen.

**POLICY**

Patients receiving medications administered by the organization will have a current, accurate medication profile in the clinical record.

The medication profiles will be updated for each change to reflect current medications, and new and/or discontinued medications.

**PROCEDURE**

1. Upon admission to the palliative care program, the admitting nurse will initiate a medication profile to document the current medication regimen, including name, dose, strength, route, frequency, date and time of administration.
2. If the patient is enrolled in Medicare Part D, the nurse will review the medications with the patient or their representative and determine the relationship of the medication to the patient’s terminal illness and related conditions that contribute to the terminal prognosis.
3. The nurse will designate medications as follows:
   1. Related to terminal illness or related conditions
   2. Related to terminal illness but no longer medically necessary
   3. Unrelated to the patient’s terminal illness
   4. Unrelated to terminal illness, in 4 categories of drugs (analgesics, antiemetics, laxatives and antianxiety drugs), and documented by a physician as unrelated.
   5. Unrelated but no longer medically necessary
4. A drug regimen review will be performed at the time of initial and comprehensive assessment, when updates to the comprehensive assessments are performed, when care is resumed after a patient has been placed on hold, and with the addition of a new medication.
5. The review will identify drug/food interactions, potential adverse effects and drug reactions, ineffective drug therapy, duplicative drug therapy, and noncompliance with drug therapy.
6. The interdisciplinary group will confer with an individual with education in drug management to ensure the drugs and biologicals meet the patient’s needs.

**Policy No. 3-001.2**

1. During subsequent home visits, the medication profile will be used as a care planning and teaching guide to ensure that the patient and family/caregiver, as well as other clinicians, understand the medication regimen.  This includes, but will not be limited to:
   1. Using the medication profile to evaluate the use of the drugs in the home setting
   2. Using the medication profile to teach purpose of medication, dosages, routes, administration times, side effects, and contraindications
   3. Using the medication profile as a communication tool for other clinicians involved in care
2. Each patient will receive appropriate written material for specific medications he/she is receiving.
3. The material will contain information on actions of the medication, potential side effects, contraindications the patient should be aware of, and any special instructions when taking the specific medication.
4. Based on review of the medication profile as well as the written material, changes in the plan of care may be required.
5. Any conclusions and findings of patient medication use or monitoring should be communicated to the pharmacist, when appropriate, and other clinicians.
6. Deviations from taking medications as ordered will be documented in clinical notes, and the physician (or other authorized independent practitioner) will be notified.

**Identification of Medication for Administration**

**Policy No. 3-002.1**

**PURPOSE**

To provide general guidelines for the safe administration of medications.

**POLICY**

Orders for the administration of medications must be given by a physician (or other authorized independent practitioner) and include patient name, patient identifier, the name of the medication, dosage, dilution, route, frequency of administration, and rate of infusion, if applicable, as well as orders for anaphylaxis and laboratory work, when appropriate.

**Note:** If the drug order is verbal or given by or through electronic transmission, it must be given only to a licensed nurse, nurse practitioner (where appropriate), pharmacist or physician.  The individual receiving the order must record it, sign it immediately and have the prescribing person sign it in accordance with state and federal regulations.

**PROCEDURE**

1. Prior to medication administration, the nurse will be familiar with the patient’s medical history and will review present medication regimen, including allergies to foods and drugs.
2. The nurse will review the written physician’s (or other authorized independent practitioner’s) orders prior to medication administration.
3. It will be the nurse's responsibility to be knowledgeable of the medication to be administered, including indications, normal dosage range, dilution, route of delivery, rate of delivery, precautions, side effects, expected therapeutic effect, proper antidote, and incompatibilities, as applicable.
4. Medications will be properly labeled with the patient’s name, an additional patient identifier, name of drug, dosage, diluent, date of preparation, expiration date, initials of preparer, and any special instructions, as applicable.
5. The nurse will review the medication label for name, additional patient identifier, drug, dosage, and prescription.
6. The nurse will validate patient name and listed patient identifier with the patient or family/caregiver, as appropriate.
7. All medications will be checked for stability by visualizing the medication and observing for, but not limited to, the following:
   1. Deterioration, as evidenced by particulate matter
   2. Discoloration, cloudiness
   3. Dampness
   4. Intactness, including seals
8. **Policy No. 3-002.2**
   1. Expiration date
   2. Storage facilities/containers
9. If the medication is not stable for administration, the nurse will hold the medication and contact the appropriate pharmacy for replacements.
10. Prior to administration, the nurse will verify and/or review information to determine that the medication is not contraindicated for the patient based on the following:
    1. Known medication allergies
    2. Known food allergies
    3. Medication incompatibility for potential interaction
    4. Patient’s physical or mental condition
    5. Relevant laboratory results
    6. Previous reactions to medications
11. If potential contraindications are identified, the nurse will contact the pharmacists and physician involved in the care of the patient for further instructions.
12. The nurse will document medication teaching, side effects, administration, and other related information in the clinical record.

**Note:** Except for very limited use related to research studies, the federal government prohibits the use or possession of marijuana for any purpose. Several states, however, have approved the use of marijuana for medical and, in some states, recreational use. Even in those states that permit the possession and use of marijuana, the federal government still prohibits it. Because of this tension between state and federal law, home health and hospice agencies should consult reputable legal counsel with familiarity of state and federal law to determine whether their employees may play a role in the self-administration of marijuana by the patient in the patient’s home.

**Administration and Documentation of Medications**

**Policy No. 3-003.1**

**PURPOSE**

To provide guidelines for the safe administration of medications by licensed personnel.

**POLICY**

Licensed nursing personnel will administer and document only those medications which have been ordered by the physician, as a part of the plan of care and have been approved for safe administration and monitoring during a palliative care visit.

Registered nurses may administer oral, subcutaneous, intramuscular, and intravenous medication. Licensed practical/vocational nurses will administer oral, subcutaneous, and intramuscular injections.  Intravenous medications administration will be per State Nurse Practice Act. Per practice act guidelines, certification and competency demonstrated for IV administration of identified drugs will be documented in the clinician’s personnel file.

Non-licensed personnel may, with instruction, supervise and assist the patient's self-administration of medication.  Non-licensed personnel may document assisting the patient in his/her self‑administration of medication where not prohibited by state law or regulation.

Organization’s Name will make available to palliative care personnel the current editions of drug reference materials or software such as but not limited to: USP, PDR, Nursing Drug Handbook, or Nursing Drug Guide to be used as drug information and patient education sources for consistency of referenced professional information.  These reference materials will provide information concerning drug indications, drug interactions, pharmacology/pharmacokinetics, side/adverse effects, and patient consultation guidance, dosing information, and dosing forms.

***Inpatient Unit Considerations***

When in a general inpatient unit, each patient must have a medication container that is labeled with the following: Patient name; physician prescribing; name and strength of drug; dose, method and frequency of administration; lot and/or control number; additional cautions or instructions; expiration date. Any medication stock containers in an inpatient unit must contain the following information: Name and strength of drug; lot and/or control number; expiration date.

**PROCEDURE**

1. As part of the assessment process, a drug history will be taken and a comparison made between the physician's (or other authorized independent practitioner’s) orders and the current medication the patient is taking.
2. Any discrepancies or contradictions should be reported to the physician for resolution.
3. The registered nurse will provide instruction to the patient on a continuing basis.
4. This instruction will include medication administration, route, how medication relates to disease process, contraindications, side effects, and adverse reactions.

**Policy No. 3-003.2**

1. Licensed nurses will administer medications ordered by the physician (or other authorized independent practitioner) that can be safely administered and monitored during a home visit.
   1. For those ordered medications that cannot be safely administered and monitored, the physician (or other authorized independent practitioner) will be contacted for discussion.
   2. Medication administration will occur upon successful completion of the competency skills checklist.
      1. This will include identification of precautions and requirements for treatments such as equipment required, assessments for adverse reactions, laboratory results to be reviewed prior to administration, guidelines for physician notification, and infection control practices.
2. Non-licensed personnel will not administer medications.
3. Where not prohibited by law, non-licensed personnel may assist the patient in the self‑administration of medication and complete the corresponding documentation.
4. Nurses who are providing intermittent home care visits will document only those medications that they administer, not medications the patient self‑administers during the absence of nursing personnel.
5. Medications will be administered within thirty (30) minutes before or after the prescribed times.
6. Deviance from this time frame will be noted on the medication profile with an explanation made in the clinical notes.
7. Medications refused, held, and/or omitted will be indicated on the medication profile with an explanation made in the clinical notes.
8. The Clinical Supervisor and attending physician will be notified.
9. An incident report will be filed as necessary.
10. If, in the judgment of the nurse, it would be beneficial to the patient to document his/her self‑administered medications, a patient self-medication checklist may be prepared and left in the home for the patient’s use.
11. This document will be used as a service only and will not be incorporated into the clinical record.
12. Chemotherapeutic agents will be administered as palliative therapy only.
13. Experimental drugs will be administered by Organization’s Name per organization policy.
14. Organization’s Name will not administer blood and blood products in the home.

**Patient Self-Administration of Medication**

**Policy No. 3-004.1**

**PURPOSE**

To promote correct administration of medication by patients and families/caregivers.

**POLICY**

Organization’s Name will encourage patient and family/caregiver participation in his/her own palliative care and will explain the correct administration of medications by patient and family/caregiver as ordered by the attending physician (or other authorized independent practitioner) or purchased over the counter.  Teaching will also include the safe storage of medications.

**PROCEDURE**

1. The Case Manager will provide an opportunity for the patient to administer his/her own medications.
2. The medications listed at the time of initial and comprehensive assessments and updates will be considered part of the plan of care.
3. The Case Manager will:
   1. Teach the patient the purpose and side effects of medications and the patient’s role in identifying and preventing medication errors.
   2. Assist the patient in setting up medications for the first time.
   3. Assess the patient's ability to self-administer medications correctly and document the patient’s response and understanding to teaching.
   4. Answer questions/concerns expressed by the patient and family/caregiver regarding patient's self-administration of medications.
   5. Document information given to the patient regarding the medication, date, and time medications are to be given; teaching of side effects; and any pertinent observations made during the information session, such as patient's needs, outcome, etc., in the patient's clinical record, as appropriate.
   6. Complete the medication profile form at initial and comprehensive assessment and updates.
   7. Assess the patient's use of over-the-counter (OTC) medications and document with start date.

**Policy No. 3-004.2**

1. Instruct the patient and family/caregiver regarding safe storage of medications. Considerations should be given to the following:
   1. Medications should be stored separately from other poisonous drugs and chemicals.
   2. Medication should be removed from storage during instruction and administration times.
   3. Medications should be kept out of the reach of children, pets, and confused or   
      disoriented patients.
   4. The nurse will plan with the patient and family/caregiver for the safe therapeutic storage of drugs during the assessment process.
   5. Drugs requiring refrigeration should be stored inside the refrigerator.
   6. Urine testing and other diagnostic materials should be stored away from all medications, heat, light, and moisture.

**Home Use and Disposal of Controlled Substances**

**Policy No. 3-005.1**

**PURPOSE**

To ensure the appropriate use and disposal of controlled substances in accordance with applicable state and federal regulations.

**POLICY**

Organization’s Name voluntarily adheres to a controlled drug reporting and disposal process.

**PROCEDURE**

1. Controlled substances will be distributed directly to the patient or his/her representative.
2. The dispensing pharmacist will be responsible for monitoring the amount of drug issued and the length of time between renewals.
3. The Admitting Nurse/Case Manager will provide a copy of the written policies and procedures on the management and disposal of controlled drugs to the patient/representative and family.
4. The Admitting Nurse/Case Manager will verbally discuss the policy in a language and manner that they understand to ensure the safe use and disposal of controlled drugs.
5. The Admitting Nurse/Case manager will document in the clinical record that the patient/representative and family have received a copy of the policies and procedures.
6. The Admitting Nurse/Case Manager will outline an informal disposal documentation procedure for the patient and family/caregiver when personnel are not present in the home.
7. In cases where personnel are in the home twenty-four (24) hours a day, a drug count will be made by the licensed personnel at the time of shift change.
   1. Controlled drugs will be accounted for on a narcotic count record, which will be maintained as a part of the clinical record.
8. The Admitting Nurse/Case Manager will document in a clinical note who is responsible for the disposal of the drugs.
9. Organizations will monitor for suspected drug diversion, including opioids, depressants, hallucinogens, stimulants, and anabolic steroids.
10. Identified discrepancies in the organization’s acquisition, storage, dispensing, administration, disposal or return of controlled medications are investigated immediately by the pharmacist and Executive Director/Administrator.
    1. Discrepancies are reported to the proper state authority.
11. **Policy No. 3-005.2**
    1. A written account of the investigation is made available to state and federal officials if required by law or regulation.

***Disposal of Controlled Substances - Family***

1. When a patient no longer has a need for a controlled substance, such as in the death of a patient, the drug regimen has changed or the controlled substance has expired, the Case Manager will instruct the patient and family/caregiver regarding proper disposal of the drugs in accordance with federal, state and local law/regulation.
2. The Case Manager will also provide information on the proper home disposal of drugs, take-back and mail-back programs.

**Note:** It is recommended to follow the United States Environmental Protection Agency (EPA) guidelines on the proper disposal of medication.

1. The Admitting Nurse/Case Manager will document in the clinical record that the patient and family/caregiver were given the written policies and procedures for managing controlled drugs and discussed the disposal of medications and took responsibility to do so.
2. The registered nurse, social worker, or chaplain attending the death of a patient will inform the family/caregiver of their responsibility to dispose of all the patient's prescribed medications and will document this instruction in a clinical note.
3. If the family/caregiver requests assistance with the disposal, the organization’s employee will observe and provide verbal assistance as the family/caregiver properly dispose of the prescribed medications.
4. The disposal will be documented in a clinical note.

***Disposal of Controlled Substances***

1. In the event a patient no longer has a need for a controlled substance, a registered nurse (RN, LPN, LVN, NP), physician or physician assistant, employed by or under arrangements of a qualified program, acting within the scope of employment, may handle any controlled substance that was lawfully dispensed to the person receiving care for the purpose of disposal of the controlled substance in accordance with Federal, State, Tribal and local law/regulation.
   1. The disposal occurs after the death of the patient.
   2. The controlled substance is expired
   3. The patient no longer requires the controlled substance because the plan of care has been modified.

**Policy No. 3-005.3**

1. If the family requests the organization to dispose of the controlled substance, the registered nurse (RN, LPN, LVN, NP), physician or physician assistant, employed by or under arrangements of a qualified program, will dispose of the drug in the home and will document in a clinical note the following:
   1. The type of controlled substances
   2. Dosage
   3. Dosage form (i.e., tablet, patch, vial, etc.)
   4. Route of administration
   5. Quantity disposed of
   6. Time, date and manner of disposal
   7. Who witnessed the disposal.

**Note:** It is recommended to follow the United States Environmental Protection Agency (EPA) guidelines on the proper disposal of medication.

**Adverse Drug Reactions**

**Policy No. 3-006.1**

**PURPOSE**

To ensure patient, family/caregiver and organization personnel are instructed to identify adverse reactions to medications and to report them in a timely manner.  To ensure that the nurse, in coordination with the pharmacist and physician, implements actions when adverse drug reactions occur, including the reporting to appropriate outside agencies.

**POLICY**

All personnel will be prepared to identify and react to adverse drug reactions.  The process for defining, identifying, and reviewing significant adverse reactions will be collaborative in nature, among nursing, pharmacy, and others as appropriate.  All adverse drug reactions will be reported both internally and externally to appropriate agencies, as needed.

Patients and families/caregivers will receive instruction regarding medication side effects, signs and symptoms of adverse reactions, and any necessary emergency response measures.

**PROCEDURE**

1. Patient and family/caregiver will be verbally instructed and will receive written information regarding identification of potential adverse drug reactions on initiation of therapy.
2. Patient and family/caregiver will receive instructions to call the pharmacist and/or nurse immediately if signs and symptoms of adverse drug reactions develop.
3. This instruction will be documented in the clinical record and validated as part of the initial training session.
4. For patient receiving antibiotics (particularly IM or IV, antiarthritic and/or any drugs known to increase one’s risk for anaphylaxis or severe side effects), the physician (or other authorized independent practitioner) may be contacted prior to administration to obtain the orders for anaphylaxis protocol.
5. Whenever adverse drug reactions are observed by the clinician and/or reported by the patient, the clinician should advise the patient to hold the next dose until the physician can be consulted.
6. All adverse reactions will be promptly reported to the patient's physician in order to minimize patient’s health risks and discomfort.
7. If the patient is at risk for further complications of an emergency nature, the clinician will initiate appropriate emergency measures as per organization policy.
8. If the patient shows signs and symptoms of anaphylaxis, the clinician will follow the anaphylaxis protocol.
9. All adverse reactions will be reported through the incident reporting process.

**Policy No. 3-006.2**

1. Once reported, they will be reviewed and analyzed for any significant trends, patterns, or unusual occurrences that may impact patient care.
2. If the adverse drug reaction results in serious injury, illness, or death, risk management will be notified immediately.
   1. The FDA’s Med Watch Reporting Form will be completed by the pharmacist having knowledge of the ADR, and the form will be mailed/faxed to the FDA as appropriate in serious or unexpected adverse drug reactions.  The FDA Med Watch Reporting Form can be obtained from the FDA by calling 1-800-FDA-1088 or at the website [www.fda.gov](http://www.fda.gov/).
3. All adverse drug reactions will be reviewed as part of the performance improvement program.
4. Reports will be reviewed and analyzed for trending and pertinent actions that may be required.
5. Actions to improve performance will be determined based on the trends and/or analysis.
6. Any trends or patterns noted will be addressed through the performance improvement activities.
7. As part of the yearly organization evaluation, the adverse drug reporting process will be reviewed for its effectiveness in detecting reactions and the organization's ability to respond and improve the medication administration process.
8. In addition, the organization will assess the usefulness of the definitions used for adverse drug reactions.

**Medication Monitoring**

**Policy No. 3-007.1**

**PURPOSE**

To define the ongoing medication monitoring process for the patient.

**POLICY**

Ongoing patient medication monitoring will use a collaborative approach between the clinicians, physicians, pharmacists, patients, and families/caregivers.  The interdisciplinary group will confer with an individual (drug management consultant) with education and training in drug management who is an employee of or under contract with the organization to ensure that drugs and biologicals meet each patient’s needs.

The results of medication monitoring will be used to improve the patient’s medication regime. The ongoing monitoring will occur in accordance with the established goals of therapy and be used to:

1. Evaluate the continued use of a medication in the current regimen.
2. Evaluate patient adherence to the prescribed medication regimen.

**PROCEDURE**

1. The Case Manager will assess the effect of medications on the patient.
2. The assessment will identify drug interactions, duplicative drug therapy, and noncompliance with drug therapy.
3. The clinical effects of medications will be obtained through direct observation during assessments performed during home visits, review of assessment information, as well as clinical results of diagnostic studies.
4. Review of the information gathered from the above activities will be included in the comprehensive assessment and updates will be made if needed.
5. If there are questions, problems or issues with a patient’s medications the drug management consultant will be contacted to provide input to the interdisciplinary group.
6. The information obtained through patient medication monitoring will be documented in the patient’s clinical record and, if applicable, in the pharmacy record.

**Infection Control Plan**

**Policy No. 3-008.1**

**PURPOSE**

To delineate an infection control plan to meet the following goals:

1. Establish the mechanism by which the organization will address surveillance, prevention, identification, control and reporting of infections, utilizing current scientific methods and epidemiologic principles
2. Guide organization personnel in the care and services they provide in relation to infection control practices
3. Educate organization personnel, patients and family/caregivers, and others in the prevention and control of infections
4. Provide for surveillance systems to track the occurrence and transmission of infections
5. Comply with all applicable local, state, and federal regulations, including, but not limited to:
   1. State and federal OSHA mandates
   2. CDC recommendations and guidelines

**PolICY**

Organization’s Name is committed to reducing the risk of acquisition and transmission of health care associated infections (HAIs).  Recognized prevention and control mechanisms will be implemented for planning, surveillance, identification, prevention/controls, and reporting procedures.  To determine the effectiveness of the infection control plan, Organization’s Name will measure, assess, improve, and redesign (as appropriate) the surveillance, identification, prevention, and control function annually through its performance improvement program.  [Refer to Occupational Safety and Health Administration (OSHA) website for most recent standards on occupational exposure ([www.osha.gov](http://www.osha.gov/)).]

**PROCEDURE**

1. Organization’s Name will educate all personnel on infection control policies, procedures, and their responsibilities for implementation as contained throughout this section.
2. New personnel will receive a copy of the standard precautions in their orientation packets.
3. Personnel will be provided training on the basics of transmission of pathogens to patients and personnel, bloodborne diseases, the use of standard precautions, infectious waste management, and other infection control procedures when their work activities, as indicated below, may result in an exposure to blood, other potentially infectious materials, or under circumstances in which differentiation between body fluid types is difficult or impossible.

**Policy No. 3-008.2**

1. Infection control inservices will be scheduled no less than annually.
   1. Attendance will be mandatory and will be documented.
   2. Records of inservice attendance will be maintained in the personnel file.
2. The organization will utilize its safety and performance improvement process to identify risks for the acquisition and transmission of infectious agents on an ongoing basis.
3. The infection control plan will be monitored and evaluated in the annual program evaluation and in conjunction with the review of the organization’s safety and performance improvement activities.
   1. Success or failure of interventions for preventing and controlling infection will be addressed.
   2. Evolution of relevant infection control and prevention guidelines based on evidence and/or expert consensus will be considered.
4. The Performance Improvement Coordinator will be responsible for managing and coordinating infection control activities and reporting of infection control activities to the Performance Improvement Committee and other appropriate authorities.
5. The Performance Improvement Coordinator will maintain qualifications for infection control responsibility through ongoing education and training.

**Tuberculosis**

**Policy No. 3-009.1**

**PURPOSE**

To provide guidelines to reduce the risk of occupational exposure to mycobacterium tuberculosis (TB).

**POLICY**

Organization’s Name will minimize the occupational exposure to TB through the development of a TB exposure plan, organization personnel education, and implementation of this plan.  A risk assessment to evaluate the risk of transmission and prevalence rate, as recommended by CDC, of mycobacterium tuberculosis will be conducted indicating the geographic/community service area and company incidence rate.  Organization’s Name will reassess the risk of transmission of TB to evaluate the effectiveness of the TB exposure plan.  The risk assessment will include consideration of local and state regulations regarding Tuberculin Skin Tests (TSTs) for employees.

An occupational exposure to TB will be defined as face-to-face contact for more than ten (10) minutes or being in the same room with a patient having active pulmonary or laryngeal TB for more than 30 minutes without the use of a mask.  Any employee who may encounter these conditions during the performance of his/her assigned duties will be considered to be at risk.

**PROCEDURE**

1. Patients will be assessed on admission for high-risk categories or conditions, and signs and symptoms of TB.
2. Any patient who is considered high-risk and has exhibited a cough and at least one (1) other symptom will be identified as a potential TB patient.
3. The attending physician (or other authorized licensed independent practitioner) will be contacted for an order to perform a TST (with patient permission).
4. For patients with signs/symptoms suggestive of TB (persistent cough longer than two (2) weeks' duration, bloody sputum, night sweats, weight loss, anorexia, fever), respiratory precautions will be applied as part of the initial assessment and care/service planning process.
   1. If a patient is already diagnosed with TB, the patient will be accepted onto care/service after:
      1. A confirmed follow-up appointment with a licensed physician has been arranged
      2. Sufficient medication has been given to the patient until the outpatient appointment
      3. A registered nurse or respiratory therapist is assigned to coordinate the care/service

**Policy No. 3-009.2**

* 1. Patients should not be sent home if there are persons in the household who are at high-risk of active TB transmission (i.e., HIV, immunocompromised patients, or children younger than five (5) years old).

1. Personnel will:
   1. Attend an inservice on the use of a NIOSH-certified N95 mask and will undergo fit testing based on organization’s risk assessment or when a patient has been identified with known or suspected TB.
   2. Wear a NIOSH-certified N95 mask when entering the home of a patient with known or suspected TB.
   3. Place the patient on respiratory isolation only when there are children or immunocompromised individuals living in the home.
   4. Collect sputum for acid-fast bacilli (AFB) in a well-ventilated area of the home, away from other household members.
      1. Opening a window to improve ventilation or specimen collection outdoors should be considered, when feasible.
   5. Discontinue respiratory precautions when the patient has been on effective therapy, is improving clinically, and the sputum smear is negative for AFB on three (3) consecutive days.
   6. Monitor patients with active TB for relapse with sputum smears every two (2) weeks until discharged from care/services.
2. All personnel will receive training/education upon hire, and annually thereafter.  The education will include:
   1. Basic concepts of TB transmission, pathogenesis, diagnosis, the difference between the signs and symptoms of latent and active TB
   2. Potential for occupational exposure
   3. Principles of infection control to reduce risk of transmission
   4. Purpose of tuberculin skin testing
   5. Principles of preventative therapy for latent infection
   6. Principles of drug therapy
   7. Individual responsibility
   8. Responsibility of organization
3. All personnel will be tested for TB according to the risk assessment identification for which personnel have potential exposure to TB and in accordance with federal, state, and/or local regulations.

**Policy No. 3-009.3**

1. OSHA has determined that home care is not provided in one (1) of the workplaces where CDC has identified workers as having a higher incidence of TB infection than the general population.
   1. Risk Definitions
      1. Low-Risk—
         1. Personnel for whom the TST conversion rate is not greater than that for personnel for whom occupational exposure to TB is unlikely (i.e., office personnel) or than previous conversion rates for the same category of personnel.
         2. This includes personnel for whom there have been no clusters of TST conversions, no detection of TB transmission, and fewer than three (3) TB patients are cared for each year.
      2. Intermediate Risk—
         1. Personnel for whom the TST conversion rate is not greater than that for personnel for whom occupational exposure to TB is unlikely (i.e., office personnel) or than previous conversion rates for the same personnel.
         2. This includes personnel for whom no clusters of TST conversions have occurred, no detection of TB transmission, and three (3) or more TB patients are cared for each year.
      3. High-Risk—
         1. Personnel for whom the TST conversion rate is significantly higher than personnel for whom exposure to TB is unlikely (i.e., office personnel) or than previous conversion rates for the same personnel and epidemiologic evaluation suggests transmission of TB.
         2. This includes personnel for whom a cluster of TST conversions have occurred, and possible person-to-person transmission of TB has been detected.
   2. In the absence of known exposure or evidence of ongoing TB transmission, personnel without LTBI should not undergo routine serial TB screening or testing at any interval after baseline.
   3. The organization may consider using serial TB screening of certain groups who might be at increased risk for TB exposure or in certain settings if transmission has occurred in the past.
   4. Where required by state and/or local regulations, a two (2)-step TST will be given to all personnel upon hire, if no TST has been performed within 12 months of hire date, and thereafter, according to risk assessment.

**Policy No. 3-009.4**

* 1. If the new hire has documented prior history of either a negative result within twelve (12) months of hire, the organization may consider this as the first stage of testing and the additional TST represents the second stage of two-step testing.
  2. In addition to the TB screening test, all patient care personnel will be given an individual TB risk assessment to establish a baseline.
  3. The prior testing documentation, testing procedure, reading, documentation and record keeping of TSTs will be kept in compliance with applicable law and regulation.
  4. The person(s) conducting the testing procedures and reading the results of the TST will be competency tested in the appropriate procedures.
  5. Personnel with newly identified positive TB test result will be given a symptom evaluation and a chest radiograph to assess for TB disease.
  6. Follow-up with a physician will be mandatory for any employee identified through the use of the questionnaire to have signs or symptoms of active TB.
  7. When TB exposure is known or thought to have occurred, a TST will be administered to the individual as soon as possible.
     1. This test will serve as a baseline reading.
        1. Personnel known to be TST positive should not be retested.
        2. If negative, a second TST will be administered 8-10 weeks post-exposure to determine if infection has occurred.  If this TST is negative, no further testing is necessary.
  8. TST converters will be sent to an occupational health provider, the employee’s personal physician, or to the county health department for further interpretation and follow-up.
     1. Antimicrobial prophylaxis may be indicated.
  9. All TST converters must have a chest x-ray to determine possible presence of active pulmonary TB.
     1. To detect the existence of extrapulmonary TB, additional physical assessment and testing may be necessary.
  10. Work restriction will not be initiated if the employee is asymptomatic.
  11. When active disease is present, the individual will be restricted from work assignments until antimicrobial prophylaxis has been initiated and there are three (3) negative AFB smears obtained on different days.
  12. Organization’s Name will comply with reporting and record keeping requirements according to state and federal law.

**Policy No. 3-009.5**

**Note**: For further information regarding Tuberculosis please refer to the:

1. Morbidity and Mortality Weekly Report (MMWR) (Reference for this policy)

"Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005”

December 30, 2005/Vol. 54/No. RR-17

This may be obtained by contacting:

Superintendent of Documents

U.S. Government Printing Office

Washington, DC 20402-9325

(202) 512-1800

1. Visit <https://www.cdc.gov/tb/education/professionaltools.htm> for a list of resources by topic.

For more information, contact:

CDC

TB Surveillance Department

Atlanta, GA

(404) 639-1819

[www.cdc.gov](http://www.cdc.gov)

**Bloodborne Pathogens and Hepatitis B Exposure Control Plan**

**Policy No. 3-010.1**

**PURPOSE**

To provide guidelines to reduce the risk of occupational exposure to bloodborne pathogens, including Hepatitis B (HBV).

**POLICY**

Organization’s Name will minimize the occupational exposure to bloodborne pathogens, including Hepatitis B, through the development of an exposure plan, organization personnel education, and implementation of this plan.

**PROCEDURE**

1. Information will be provided to new employees upon hire regarding the risks of exposure to bloodborne pathogens, HBV vaccine, including information on its efficacy, safety, method of administration, and the benefits of being vaccinated.
2. Determination of the new employee’s current HBV vaccination will be completed in the pre-employment health assessment
3. The vaccine and vaccination will be offered free of charge within ten (10) days of employment.
4. An employee who reports having received the HBV vaccination previously will be required to provide Organization’s Name with a record of the vaccination and any antibody testing that may have been performed.
5. An employee who has not been previously vaccinated and who declines administration of the HBV vaccine is required to sign a declination statement.
   1. This statement will be kept as part of the individual’s health record.
6. An employee who wishes to receive the HBV vaccine will be administered three (3) doses over a six (6)-month period at the recommended intervals.
   1. Documentation of each dose will be maintained in the individual’s health record.
7. The use of standard precautions in the workplace is considered effective preventive methodology in the care of patients with suspected or diagnosed bloodborne pathogen infections.
   1. Standard precautions should be implemented.

**Management of Exposures in Personnel**

**Policy No. 3-011.1**

**PURPOSE**

To properly identify, manage, and report personnel exposures to infections.

**POLICY**

Organization’s Name will identify and report personnel exposures to bloodborne pathogens and infections on a routine basis through consistent enforcement of its procedures.

***General Considerations***

In all patient-care activities, personnel can decrease the risk of acquiring or transmitting infection by careful hand washing and by providing care to patients with potentially transmissible diseases according to standard precautions.

The following exposures by personnel should be immediately reported to the Program Director/Supervisor for appropriate follow-up.

1. Cuts, abrasions, needle sticks, wounds, etc., obtained during patient contact.\*
2. A splash by blood or body fluids on any mucous membranes, cuts, open lesions, or skin rashes.

\* Needle sticks are considered injuries and are to be reported in accordance with OSHA’s record keeping requirements effective January of 2002. OSHA 300 Log and 301 Incident Report will be used to maintain records of all sharps injuries.

Personnel can receive advice about health counseling from the organization infection control nurse, the Program Director/Supervisor, or the public health department.

**PROCEDURE**

***Post Bloodborne Pathogen Exposure Evaluation and Follow-up:***

***General Procedures***

1. After a report of an exposure incident to blood/body fluids, Organization’s Name will immediately make available to the exposed staff member a confidential medical evaluation and follow-up. This evaluation and follow-up will include:
   1. Documentation of the route(s) of exposure, and the circumstances under which the exposure incident occurred.
   2. Identification and documentation of the source individual, unless this identification is not feasible or prohibited by state or local law.

**Policy No. 3-011.2**

* 1. The source individual's blood will be tested by an accredited lab at no cost to the employee, as soon as feasible and after consent is obtained.
     1. If consent is not obtained, then it will be established that legally required consent cannot be obtained.
     2. When the source individual's consent is not required by law, the source individual's blood, if available, will be tested and the results documented.
  2. When the source individual is already known to be infected with HBV or HIV, testing for the source individual's HBV or HIV status need not be repeated.
  3. Results of the source individual's testing will be made available to the exposed organization personnel, and the exposed personnel will be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.
  4. Post-exposure, evaluation, follow-up, and prophylaxis will be provided at no cost to the exposed organization employee, and as recommended by the U.S. Public Health Service.
  5. Post-exposure counseling will be provided when medically indicated.

1. Organization’s Name will provide information for medical evaluation to the licensed physician who evaluates the exposed organization personnel after an exposure incident:
   1. A copy of the federal regulation #1910.1030 Bloodborne Pathogens, as necessary.
   2. A description of the exposed organization staff member’s duties as they relate to the exposure incident.
   3. Documentation of the route(s) of exposure and circumstances under which exposure occurred.
   4. Results of the source individual's blood testing, if available
   5. All clinical records relevant to the appropriate treatment of organization personnel, including vaccination status (HBV vaccination status). (Organization’s Name's is responsible to maintain these records)
2. Organization’s Name will obtain and provide the exposed staff member with a copy of the evaluation and the physician’s written opinion within fifteen (15) days of the completion of the evaluation.
   1. The physician’s written opinion for HBV exposure will be limited to whether HBV vaccination is indicated for the exposed staff member, and if the exposed organization staff member has received such vaccination.
   2. The physician’s written opinion for post-exposure evaluation and follow-up will be limited to the following information:

**Policy No. 3-011.3**

* + 1. That the exposed organization staff member has been informed of the results of the evaluation.
    2. That the exposed organization staff member has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.
    3. All other findings or diagnoses will remain confidential and will not be included in the written report.

***Personnel Restriction Due to Suspected or Known Infection***

1. Personnel providing patient care who have been exposed to or who exhibit signs and symptoms of potentially transmissible conditions should report this information to their Program Supervisor.
2. The Program Supervisor may exclude these individuals from direct patient contact.
3. These conditions might include, but are not limited to the following:
   1. Diarrhea:
      1. Personnel with diarrhea that is severe or accompanied by other symptoms (such as fever, abdominal cramps, or bloody stools), or lasts longer than twenty-four (24) hours should be excluded from direct patient contact pending evaluation by a physician.
   2. Herpes Infections:
      1. Personnel with primary, recurrent or facial herpes simplex infections should be excluded from direct patient contact with high-risk patients, (e.g., newborns, patients with burns or immunocompromised patients) until the lesions are healed.
      2. Personnel with herpes simplex infections of the fingers or hands (herpetic whitlow) should be excluded from direct patient contact until lesions are healed.
      3. Personnel with herpes zoster should be excluded from direct patient contact until lesions are healed.
   3. Respiratory Infections:
      1. Personnel with respiratory infections should be excluded from direct patient contact with high-risk patients, (e.g., neonates, patients with chronic obstructive lung disease, or immunocompromised patients.
   4. Streptococcal Disease:
      1. If a Group A streptococcal disease is suspected, appropriate cultures should be taken, and personnel should be excluded from direct patient contact until they have received adequate therapy for twenty-four (24) hours, or until streptococcal infection has been ruled out.

**Policy No. 3-011.4**

* 1. Other Diseases:
     1. Personnel exhibiting symptoms of other infectious diseases may be excluded from direct patient care pending examination by a physician; these include open, draining wounds, conjunctivitis, etc.

1. Management of personnel who are potential carriers—Increases in bacterial infections that can be traced to personnel who are potential carriers should be reported.
2. The identified personnel should be cultured (at no cost to the organization personnel).
3. If cultures are positive, personnel should be excluded from direct patient contact until the pathogen is eradicated or the risk of disease transmission is eliminated.
4. Management of personnel with Tuberculosis—The management of TB in the workplace will consist of the following areas: medical surveillance (at no cost to the organization personnel), evaluation and management of systematic organization personnel, exposure management, training and information, respiratory protection, and accurate record keeping.
   1. Medical surveillance:
      1. Where required by state and/or local regulations, all patient care personnel will be given a two (2) step TST and baseline screening at the time of employment if no previously documented TST had been performed in the last twelve (12) months.
         1. This will be conducted at no cost to the organization personnel.
      2. In addition to the TB screening test, all patient care personnel will be given an individual TB risk assessment to establish a baseline.
      3. All patient care personnel will be retested (TST) in accordance with risk determination and state/local regulations.
         1. Personnel working with intermediate to high-risk patients (e.g., HIV+, children, oncology, etc.) will be retested depending upon exposure risk.
      4. Personnel already known to have significant reactions should not have a chest X-ray unless they have pulmonary symptoms of TB.
   2. Evaluation and management of personnel who are symptomatic, who have a positive TST, or conversion with repeat testing:
      1. Personnel with current pulmonary or laryngeal TB whose sputum smear shows tuberculosis bacilli should be excluded from work until adequate treatment has begun or until sputum cultures show no growth.
      2. Personnel who have current TB at a site other than the lungs or larynx should be allowed to continue their usual activities.

**Policy No. 3-011.5**

* + 1. Personnel who discontinue medications for current pulmonary or laryngeal disease before their recommended course of therapy has been completed should not be allowed to work.
       1. All personnel with significant skin test reactions who do not have current tuberculosis and who have not had previous adequate therapy should be advised to have additional testing and physician follow-up. Return to work will be pending physician release with a written notice.
       2. Personnel who cannot take or do not accept or complete preventive treatment should have their work situations evaluated and may require reassignment. A change in assignment should be considered, if these persons work with high-risk patients.
       3. Personnel with a history of TB are at risk for recurring infections. These personnel should be instructed to report to their physician for evaluation if TB symptoms develop.
    2. Personnel with a newly positive test result (with confirmation from those persons at low risk) should undergo a symptom evaluation and chest radiograph to assess for TB disease.
  1. Post-exposure prophylaxis:
     1. After exposure to an active case of TB, all personnel, except those already known to have positive skin test reactions, should be skin tested eight (8) to ten (10) weeks after the exposure.
        1. Personnel whose skin tests convert should have a physical examination, appropriate laboratory and radiographic evaluations to determine whether they have infectious TB.
     2. Unless a skin test was given during the three (3) months prior to exposure, a baseline skin test should be done as soon as possible after the exposure to assist in interpreting the eight (8) to ten (10) week post-exposure skin test.
     3. Personnel already known to have significant reactions should not have a chest x-ray unless they have pulmonary symptoms of TB.
     4. Any incident involving exposure, including positive TB skin tests, will be recorded on the OSHA 300 form. The locations are:

|  |  |  |
| --- | --- | --- |
| Atlanta, GA  (404) 562-2300 | Boston, MA  (617) 565-9860 | Chicago, IL  (312) 353-2220 |
| Dallas, TX  (214) 767-4731 | Denver, CO  (303) 844-1600 | Kansas City, MO  (816) 426-5861 |
| New York, NY  (212) 337-2378 | Philadelphia, PA  (215) 596-1201 | San Francisco, CA  (415) 975-4310 |
| Seattle, WA  (206) 553-5930 |  |  |

**Policy No. 3-011.6**

* 1. Training and information:
     1. All personnel will be informed of the signs and symptoms of TB, the hazards of TB transmission, the risk of TB in Organization’s Name settings, current statistics about TB in health care workers, and the current CDC guidelines.
     2. Training will be conducted annually.
     3. Training will include the purpose of TB controls, proper use of protective equipment, medical surveillance procedures, and protocols specific to Organization’s Name
     4. Personnel should be counseled about the risk of developing the disease, risks they may pose to their contacts, and instructed to seek evaluation of any signs and symptoms that may be due to TB.
  2. Respiratory protection:
     1. In accordance with CDC guidelines, all patient care personnel will use a high efficiency particulate air (HEPA) respirator in the following situations:
        1. When appropriate ventilation is not available and the patient exhibits signs and symptoms that suggest a high potential for infectiousness, or
        2. The potentially infectious patient is undergoing a procedure that is likely to produce bursts of aerosolized infectious particles (e.g., aerosolized pentamidine administration, sputum induction, and suctioning)
     2. All personal protective equipment will be furnished to the appropriate personnel at no cost to the organization personnel.
     3. Training in proper usage, fit, and storage will be provided to appropriate personnel.
     4. Repeated failure to comply with established policies may result in disciplinary action.
  3. Accurate record keeping:
     1. Organization’s Name will maintain records on appropriate personnel.
     2. The files will contain, but will not be limited to, a record of TB skin testing, any personnel exposure incidents, medical evaluation, and treatment, as applicable.
     3. Organization’s Name will maintain a log of TB infections (positive TSTs) and any personnel exposure incidents. This information will be recorded on the OSHA Form 300.
     4. Each clinical/service record of potentially infectious patients will be tagged according to organization policy to alert all families/caregivers to follow protocols outlined by Organization’s Name

**Policy No. 3-011.7**

* 1. Management of personnel exposed to varicella or Herpes Zoster
     1. After exposure to varicella (chicken pox) or Herpes Zoster (shingles), personnel not known to be immune to varicella (by history or serology) should be excluded from work beginning on the twelfth (12th) day after exposure and remain away from work for the maximum incubation period of varicella (21 days).
     2. Personnel who have an onset of varicella should be excluded from work until all lesions have dried and crusted.
  2. Management of personnel with hepatitis infections
     1. Personnel who are suspected of being infected with Hepatitis A virus (HAV) should not take care of patients until seven (7) days after the onset of jaundice.
     2. Personnel at substantial risk of direct contact with body fluids will be offered HBV vaccinations free of charge.
     3. Personnel who are known carriers of HBV surface antigen (HBsAg) should be counseled about precautions to minimize their risk of infecting others and must strictly adhere to standard precautions at all times.
        1. Personnel who have no exudative lesions on the hands, who are acutely infected with HBV, are known to be carriers of HBsAg, or have hepatitis non-A/non B (NANB) should not be restricted from patient care responsibilities, unless there is evidence of disease transmission.
        2. Personnel who have no exudative lesions on the hands, who are acutely infected with HBV, are known to be carriers of HBsAg, or have hepatitis NANB should wear gloves for procedures that involve trauma to tissues or direct contact with mucous membranes or non-intact skin.
        3. Personnel with exudative lesions on the hands who are HBsAg positive should either wear gloves for all direct patient contact and when handling equipment that will touch mucous membranes or non-intact skin or abstain from all direct patient care.
     4. Personnel who initially decline the HBV vaccination may, at a later date while they are still covered under this requirement, decide to accept the vaccination.
     5. Organization’s Name will make the HBV vaccination available to them at that time.
     6. Personnel who decline to accept the HBV vaccination must sign the Hepatitis B Vaccine Declination Statement.
     7. Where a routine booster dose(s) of HBV vaccine is recommended by the U.S. Public Health Service at a future date, such booster dose(s) will be made available, in accordance with this policy.

**Policy No. 3-011.8**

* 1. Management of personnel with HIV
     1. Personnel with impaired immune system resulting from HIV infection should be counseled about the potential risk associated with taking care of patients with transmissible infections.
     2. Personnel with impaired immune systems from HIV infections are at an increased risk of acquiring or experiencing serious complications of infectious diseases (measles, varicella, hepatitis), and therefore, they should continue to strictly adhere to standard precautions.
     3. Personnel with impaired immune systems resulting from HIV infection should be informed of precautions to minimize their risk of infecting others and their risk of being infected while carrying out their job responsibilities.
     4. Personnel with exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient care equipment until the condition resolves.
     5. Whether personnel can adequately and safely perform patient care duties should be determined on an individual basis with the decision being made by the organization personnel's physician in conjunction with organization personnel health department and their Program Supervisor.
     6. Personnel may be excluded from direct patient contact for high-risk patients (e.g., newborns, patient with burns or immunocompromised patients).
  2. Management of personnel following possible exposure to HIV and/or HBV
     1. Serological testing should be done if any personnel are concerned that they may have been infected with HIV.
     2. Personnel infected with HIV usually develop the antibody against the virus within six (6) to twelve (12) weeks after infection.
        1. If organization personnel has a parenteral (e.g., needlestick or cut) or mucous membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids or has a cutaneous exposure involving large amounts of blood or prolonged contact with blood—especially when the exposed skin is chapped, abraded, or afflicted with dermatitis—the source patient should be informed of the incident and tested for serologic evidence of HIV and HBV infection after consent is obtained.
        2. If the source patient has AIDS/HBV, is positive for HIV/HBV antibody, or refuses to be tested, personnel should be counseled regarding the risk of infection and evaluated clinically and serologically for evidence of HIV/HBV infection as soon as possible after the exposure.
        3. Personnel will be advised to report and seek medical evaluation for any acute febrile illness (particularly one characterized by fever, rash, or lymphadenopathy) that occurs within twelve (12) weeks after exposure.

**Policy No. 3-011.9**

* + - 1. HIV seronegative personnel should be retested six (6) weeks post-exposure and on a periodic basis thereafter (e.g., twelve (12) weeks and six (6) months after exposure) to determine whether transmission has occurred.
      2. No further follow-up of persons exposed to infection described above is necessary if the source patient is seronegative, unless the source patient is at high-risk of HIV infection. In the latter case, a subsequent specimen (e.g., twelve (12) weeks following exposure) may be obtained from the exposed personnel for antibody testing.
      3. Follow-up procedures will be taken for personnel exposed, or potentially exposed, to HBV.
      4. The types of procedures depend on the immunization status of the worker and HBV serologic status of the source patient.

Occupational Exposure Information and Training

Policy No. 3-012.1

PURPOSE

To outline methods to inform and train personnel regarding occupational exposures.

POLICY

The organization will provide information and training for all personnel at risk for occupational exposure.

PROCEDURE

1. All personnel at risk for occupational exposure will participate in a training program.  
   This training will be:
   1. Provided at no cost to organization personnel and during working hours
   2. Provided during orientation, prior to the time of initial assignment to tasks where occupational exposure may take place
   3. Provided annually thereafter, within one (1) year of their previous training
   4. Provided within 90 days after the effective date of a bloodborne pathogen exposure
2. Organization’s Name will provide additional training when changes, such as modification of tasks or procedures or institution of new tasks or procedures, affect the organization personnel's occupational exposure.
   1. The additional training may be limited to addressing the new occupational exposures.
3. The training program will consist of material appropriate in content and vocabulary to educational level, literacy, and language ability of the organization personnel being trained.  It will contain, at a minimum, the following elements:
   1. Distribution of a copy of the regulatory text on the bloodborne pathogen standard, and an explanation of its content to each applicable employee
   2. A general explanation of the epidemiology and symptoms of bloodborne diseases, and the modes of transmission of bloodborne pathogens
   3. An explanation of the organization’s exposure control plan, and the means by which personnel can obtain a copy of the written plan
   4. An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials
   5. An explanation of the use and limitations of methods that will prevent or reduce exposure, including appropriate engineering controls, work practices, and personal protective equipment.
4. Policy No. 3-012.2
   1. Information on the types, basis for selection, proper use, location, removal, handling, decontamination and disposal of personal protective equipment
   2. Information on the HBV vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge
   3. Information on appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials
   4. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available
   5. Information on the post-exposure evaluation and follow-up that Organization’s Name is required to provide for personnel following an exposure incident
   6. An explanation of the signs, labels, and/or color-coding required by law and regulation
   7. An opportunity for interactive questions and answers with the person conducting the training session
   8. The person conducting the training will be knowledgeable in the subject matter as it relates to the special workplace that the training will address
5. The organization will maintain training records for three (3) years from the date training occurred for all personnel, including, but not limited to:
   1. Date, contents, and summary of training sessions
   2. Names and qualifications of persons conducting training
   3. Names and job titles of all persons attending training sessions

Standard Precautions

Policy No. 3-013.1

**PURPOSE**

To reduce the risk of exposure to and transmission of infections when caring for patients.

**POLICY**

Organization personnel will adhere to the following precautions and will instruct patients and family/caregivers in infection control precautions, as appropriate to the patient’s care needs.

**Note:** Patients may be given a copy of this procedure, if needed as a teaching tool.

**Note:** Organization’s Name has the right to limit the practice of organization personnel, if patient safety is in question.

***Definition***

Under standard precautions, blood and certain body fluids of all patients are considered potentially infectious for bloodborne pathogens, such as human immunodeficiency virus (HIV), and hepatitis B virus (HBV).  Standard precautions apply to blood and other body fluids potentially containing blood or bloodborne pathogens.  These body fluids include emesis, sputum, feces, urine, semen, vaginal secretions, cerebrospinal fluid (CSF), synovial fluid, pleural fluid, pericardial fluid, and amniotic fluid.  Standard precautions should be used with other fluids, such as nasal secretions, saliva, sweat, and tears when they contain visible blood or other potentially infectious materials and it is impossible to differentiate between body fluids.

**PROCEDURE**

***General Precautions***

***Hand Hygiene***

1. Hand hygiene will be performed to prevent cross-contamination between the patient and personnel.
2. When hands are visibly dirty, contaminated with proteinaceous material, or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial or antimicrobial soap and water.
3. When hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands.
4. An alternative to use of an alcohol-based hand rub is to wash hands with an antimicrobial soap and water.

Policy No. 3-013.2

***Personal Protective Equipment***

1. Gloves:
   1. The use of gloves (intact latex or vinyl of appropriate size and quality) is important when personnel have cuts, abraded skin, chapped hands, dermatitis, etc.  Gloves are to be worn when:
      1. There is actual or potential contact with blood or other potentially infectious materials
      2. Contact with non-intact or abraded skin is anticipated
      3. Touching contaminated items or surfaces
      4. Performing invasive procedures
      5. Handling any drainage appliance
      6. Taking a rectal temperature
      7. Shaving a patient with a safety razor
      8. Obtaining laboratory specimens
      9. Patients have active bleeding
      10. Cleaning of body fluids and decontamination procedures
      11. Performing wound care
      12. Entering the room of, or providing care for, patients who are colonized or infected with vancomycin-resistant enterococci or multidrug-resistant Staphylococcus aureus (MRSA)
      13. Handling soiled linen
   2. Sterile gloves are to be worn for sterile procedures.
   3. Gloves are to be changed:
      1. Between tasks and procedures on the same patient
      2. During changing or cleaning an incontinent patient
      3. After removing an old dressing
      4. When the integrity of the glove is in doubt
   4. Gloves should never be washed or disinfected for reuse.
   5. General purpose utility gloves (e.g., rubber household gloves) will be used for housekeeping chores involving potential blood contact and for instrument cleaning and decontamination procedures.
2. Policy No. 3-013.3
   1. Utility gloves may be decontaminated and reused, but should be discarded if they are peeling, cracked, or discolored, or if they have punctures, tears, or other evidence of deterioration.
   2. Gloves are not necessarily needed for general care or during casual contact, such as bathing of intact skin or assisting with ambulation.
   3. Gloves are to be worn by the family/caregiver when direct contact with any bodily substance is anticipated (blood, urine, pus, feces, saliva, drainage of any kind.)
3. Gowns:
   1. The use of gowns is required when splashes to the skin and/or clothing are likely or when caring for patients with epidemiologically important microorganisms, such as multi-drug resistant organisms.
   2. The gowns will be made of or lined with fluid-proof or fluid-resistant material and will protect all areas of exposed skin.
   3. The type and characteristics will depend on the task and degree of exposure anticipated.
4. Mask/Protective Eyewear:
   1. Masks, protective eye wear, or face shields are required when contamination of mucosal membranes, eyes, mouth, or nose is possible, such as splashes or aerosolization of material.
   2. They are not required for routine care.
   3. A NIOSH-certified N95 respiratory mask must be worn when caring for patients with suspected or confirmed Mycobacterium Tuberculosis.
5. Resuscitation Equipment:
   1. One (1)-way valve pocket masks, resuscitation bags, or other ventilation devices will be provided to personnel where the need for emergency mouth-to-mouth resuscitation would be required.

***Sharps***

1. After use, needles and other sharps will be placed directly into a puncture-proof container located in the immediate patient care area.
2. Needles must not be recapped, bent, broken, or clipped.
3. Whenever possible, needleless protective devices will be utilized in the provision of patient care.
4. Appropriate personnel will be involved in the selection of these products.

Policy No. 3-013.4

***Laboratory Specimens***

1. Laboratory specimens should be transported in a Ziploc bag or other leak-proof container.
2. The leak-proof container should be transported to the office or alternate lab site in a puncture-resistant container that is properly labeled.
3. Specimens transported to the office will be placed in a designated storage container located in the dirty supply area.

***Labels***

1. Biohazard labels will be used to prevent accidental injury or illness to personnel exposed to hazardous or potentially hazardous conditions that are out of the ordinary, unexpected, or not readily apparent.
2. Labels will state—BIOHAZARD—or the hazard symbol, readable at the minimum distance of five (5) feet.
3. Personnel will be informed as to the meaning of the labels.
4. Labels will be affixed as close as possible to respective hazards.
5. Labels will be used to identify equipment, containers, refrigerators, and rooms containing hazardous agents.
6. If labels are not used, other effective means will be used, such as RED bagging.

***Housekeeping and Hygiene***

1. Housekeeping procedures at Organization’s Name’s location will be implemented to ensure that the worksite is maintained in a clean and sanitary condition.
2. The following guidelines will be implemented at Organization’s Name’s office.
3. These same guidelines will be implemented and taught to the patients and family or caregivers.
4. Organization’s Name recognizes that patients have a right to refuse to follow these guidelines.
   1. Organization’s Name will ensure that the worksite is maintained in a clean and sanitary condition.
   2. The organization will determine and implement an appropriate written schedule for cleaning and decontamination based upon the location within the facility; type of surface to be cleaned; and tasks or procedures to be performed in the area.
   3. All equipment, environmental and working surfaces shall be cleaned and decontaminated after contact with blood or other potentially infectious materials.

Policy No. 3-013.5

* 1. An appropriate disinfectant (e.g., household bleach 5.25% mixed 1:10 with water) should be used to clean floors, toilet bowl, tub, shower, sink, countertops, and soiled furniture.
     1. This solution will be discarded after each use, or at least every twenty-four (24) hours.
  2. Sponge and mops used to clean up body fluid spills should not be rinsed out in the kitchen sink or used where food is prepared.
  3. Dirty mop water should be poured down the toilet, rather than the sink.
  4. Rooms will be kept well aired to decrease the risk of colds, flu and other airborne communicable disease.
  5. Infectious organisms may be found in animal wastes, birdcages, cat litter boxes, and fish tanks.
     1. They should be maintained by someone other than a person with HIV disease or other causes of immunosuppression.
  6. Humidifiers and air conditioners can harbor infectious organisms, and should be cleaned and serviced regularly.
  7. All bins, pails, cans (e.g., waste cans) intended for reuse which have a reasonable likelihood for becoming contaminated with blood and other potentially infectious materials, will be inspected and decontaminated weekly.
     1. They will also be cleaned and decontaminated immediately, or as soon as feasible, upon visible contamination.

1. Blood/Body Fluid Spills
   1. Blood/body fluid spills should be mopped or wiped up using disposable towels or wipes with hot soapy water, then disinfected with bleach.
   2. If the cleanup is done by hand, disposable gloves must be worn.
   3. Disposable towels or wipes used in the cleanup should be bagged to prevent leaking and exposure to others.
   4. A heavy-duty plastic bag should be used for bagging this type of waste with double bagging.
   5. The bag should be disposed in accordance with local and state regulations.
2. Hygiene
   1. Personal items, such as toothbrushes, razors, and enema equipment, should never be shared.

Policy No. 3-013.6

* 1. Maintaining a state of personal cleanliness is the key to reducing infection transmission from person to person.
     1. This includes bathing regularly, washing hands after use of bathroom facilities, after contact with one’s own body fluids, and before preparing food.

***Waste Disposal***

1. General Waste:
   1. Materials not contaminated or visible soiled with blood or other infectious waste, such as diapers, incontinence pads, non-soiled PPE, dressing wrappers, or IV tubing not used for blood administration.
   2. General waste should be disposed of in a securely fastened plastic bag and can be placed into the patient’s trash receptacle.
2. Regulated Medical Waste:
   1. According to OSHA guidelines, these may include:
      1. Liquid or semi-liquid blood or other potentially infectious material
      2. Contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed
      3. Items that are caked with blood or other potentially infectious materials and are capable of releasing these materials during handling
      4. Pathological and microbiological wastes containing blood or other potentially infectious material
   2. Place regulated medical waste into a leak-proof, heavy duty, securely fastened plastic bag.
      1. Items should be double bagged when the potential for contamination of the outside of the first bag is present.
      2. Items should also be double bagged when the first bag may be at risk for tearing.
      3. They should be disposed of according to local and/or state regulation.
3. Syringe/Sharps Disposal:
   1. In the home setting, a sharps disposal container will be available for use by the clinician or patient and family/caregiver.
   2. The uncapped needle will be placed directly into the disposal container.
   3. When 3/4 full, the disposal container will be sealed and transported to the dirty supply area located in the office.
4. Policy No. 3-013.7
   1. A new container should be provided to the patient for any future use.
   2. If the patient is self-administering medications and generating one (1) or more syringes per day, the patient should notify the garbage collection service, or the local Department of Public Health, to obtain information on local and/or state regulations for proper disposal.

***Laundry***

1. Handling and Changing of Linens:
   1. Contaminated laundry should be handled as little as possible with minimal agitation.
   2. Towels and washcloths should not be shared by different users.
   3. Gloves and other appropriate personal protective equipment are to be worn when handling soiled linen.
   4. Soiled clothing and linens should be soaked as promptly as possible.
      1. Ideally, they should be machine washed in hot (160° F) soapy water.
      2. If appropriate, (e.g., colorfast material), a cup of bleach may be added to the water.
      3. If low temperature (less than 150° F) laundry cycles are used, chemicals suitable for low-temperature washing at proper use concentration should be used.
   5. When contaminated laundry is wet and likely to soak through or leak from the bag to the container, the laundry should be transported in containers or bags that prevent leakage to the exterior.
   6. Laundry and linens should be carried away from the body.

***Equipment/Nondisposable Instruments***

1. Bedpans/Urinals/Commodes:
   1. Bedpans and urinals should be used by only one (1) patient and should be cleaned on a regular basis with household detergent.
   2. Shared commodes do not require special precautions unless blood, contaminated body substance, or fluid is present.
      1. If soiled, the commode should be cleaned with a 1:10 dilution of bleach.
2. Thermometers:
   1. Thermometers are not supplied by Organization’s Name, but may be owned by patients.

Policy No. 3-013.8

* 1. Electronic thermometers with disposable sheaths need no special precautions unless they become visibly soiled.
  2. When thermometers are soiled, they should be wiped with a disinfectant solution.
  3. Glass thermometers used in the home should be rinsed with soap and water before and after use.
  4. If the thermometer will be used by more than one (1) family/caregiver member, it should be soaked in 70–90% ethyl alcohol for thirty (30) minutes followed by a rinse under a stream of water in between users.

1. Medical Equipment/Supplies:
   1. Any nondisposable equipment returned to organization stock will be placed in the dirty supply area and then thoroughly wiped down with an organization-approved disinfectant.
   2. After proper cleaning, the equipment may be returned to stock for patient use.
   3. In the event a nondisposable piece of equipment comes in contact with blood or body fluids, a 1:10 dilution of bleach or other organization-approved disinfectant is used to clean it.
   4. Soiled blood pressure cuffs will be washed in hot, soapy water.
   5. Dressing supplies contaminated with the patient’s blood or body fluids should be double bagged in plastic bags, tied securely, and labeled “contaminated” then placed with household trash for garbage pickup (according to local and state regulations).

***Kitchen/Food Preparation***

1. Hand washing:
   1. Proper hand washing techniques should be observed prior to touching food.
2. General hygiene:
   1. “Tasting” of food during cooking should be done with a new, clean spoon each time.  Wash the spoon with soap and water immediately after “tasting.”
3. Cleaning of kitchen:
   1. Counters, sinks, and floors in the kitchen should be free from food particles and cleaned with a disinfectant regularly.
4. Refrigerator:
   1. The interior of the refrigerator should be cleaned with soap and warm water regularly to control molds.

Policy No. 3-013.9

1. Food freshness:
   1. Observe expiration dates and general freshness of food.
   2. Do not use cracked eggs due to the likelihood of Salmonella contamination.
2. Food storage:
   1. Store open packages of food (e.g., sugar) in covered containers to discourage infestation.
3. Food preparation:
   1. Pork, poultry, and eggs should be thoroughly cooked before eating.
   2. Porous (e.g., wood) cutting boards used for poultry should not also be used for fruits and vegetables.
4. Dishes/utensils:
   1. Wash dishes and utensils in hot soapy water.
   2. The water should be hot enough to require the use of lined gloves.
   3. Allow dishes to air dry.
   4. Known infected persons do not need separate dishes or utensils provided they are washed as described.
5. Sponges:
   1. Sponges used to clean in the kitchen should not be the same sponges used to clean bathrooms and body fluid spills.
   2. Sponges used to clean bathrooms and body fluid spills should be disinfected with bleach and changed periodically.

***Special Considerations for a Person with HIV Disease***

1. Unpasteurized milk, raw eggs, or products containing raw eggs or cracked or non-intact eggs should be avoided.
2. They have been associated with Salmonella infections and may be problematic, especially for the person with HIV disease or other immune-suppressed diseases.
3. All fresh produce should be washed thoroughly.

***Other Considerations***

1. Eating, drinking, smoking, applying makeup or lip balm, or handling contact lenses should be avoided in work areas where there is a reasonable chance of exposure.

Policy No. 3-013.10

1. Sterile technique will be employed for sterile dressing changes, IV insertion, IV site care, phlebotomy, tracheal suctioning, insertion of a urinary catheter, and whenever appropriate to prevent infection.
2. Disinfectants:
   1. HIV is inactivated rapidly after being exposed to chemical germicides.
   2. HIV can be inactivated after exposure for ten (10) minutes to any of the following:
      1. Chlorine bleach (1:10 dilution)
      2. Alcohol (70–95%)
      3. Quaternary Ammonium (TRI-GUAT)
      4. Phenolic (Vesphene II)

**Personal Protective Equipment**

**Policy No. 3-014.1**

**PURPOSE**

To define personal protective equipment requirements and indications for use in patient care.

**POLICY**

Organization’s Name will supply and make accessible appropriate personal protective equipment consistent with the tasks being performed.  Organization’s Name will provide guidelines to assist organization personnel in selecting appropriate personal protective equipment.

**Note:** Personal protective equipment for eyes, face, head, and extremities, protective shields and barriers reduce the incidence of contamination but cannot prevent penetrating injuries due to needles and other sharp instruments.

**PROCEDURE**

1. On assignments where personnel have a risk of occupational exposure, the organization will furnish, repair, clean, and launder, at no cost to personnel, appropriate personal protective equipment so that barrier precautions can be observed and compliance with this policy can be maintained.
2. Personal protective equipment includes, but is not limited to:
   1. Powderless gloves,
   2. Gowns,
   3. Laboratory coats,
   4. Face shields or masks,
   5. Eye protection,
   6. Mouthpieces,
   7. Resuscitation masks/devices,
   8. Pocket masks, or
   9. Other ventilation devices.
3. Personal protective equipment will be considered appropriate only if it does not permit blood or other potentially infectious materials to pass through to or reach the organization personnel's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

Policy No. 3-014.2

1. All personnel must use appropriate personal protective equipment when exposed to blood or other potentially infectious materials.
2. This equipment will be readily accessible at the work site or will be issued to personnel prior to assignments where personal protective equipment is needed.
3. If, in rare and under extraordinary circumstances, organization personnel decline to use personal protective equipment for brief and temporary periods, they must do so only when in their professional judgment, in that specific instance, its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of themselves or a coworker.
4. When this occurs, Organization’s Name will investigate the circumstances involved in order to determine whether changes can be instituted to prevent such occurrences.
5. Garments penetrated by blood or other potentially infectious materials, will be removed immediately, or as soon as feasible.
6. All personal protective equipment will be removed prior to leaving the work area.
7. When removed, it will be placed in an appropriately designated container or area for storage, washing, decontamination, or disposal.
8. Powderless gloves will be worn when it can be reasonably anticipated that personnel may have contact with blood or other potentially infectious materials; when performing vascular access procedures; and when handling or touching contaminated items or surfaces.
   1. Any variety of powderless latex or vinyl glove is acceptable as long as they are impervious to liquids and strong enough to withstand the rigors of the tasks to be performed.
   2. Personnel who are allergic to latex or vinyl gloves should notify their Program Supervisor so that hypoallergenic gloves, glove liners, or other similar alternatives may be provided to them.
9. Gloves must not be so large and loose fitting as to easily slip off during use.
10. Disposable gloves will be removed and discarded after contact with each person, fluid item, surface, if torn or punctured, or when their ability to function as a barrier is compromised.
11. Hands must be decontaminated immediately, or as soon as feasible, after removal of gloves or any other personal protective equipment.
12. A new set of gloves will be used for contact with each patient.
13. Gloves may not be washed or disinfected for reuse.
14. When utility gloves are used, they may be decontaminated for reuse as long as the integrity of the glove is not compromised.
    1. However, they must be discarded if they are cracked, peeling, torn, punctured, or exhibit other signs of deterioration or when their ability to function as a barrier is compromised.
15. Policy No. 3-014.3
16. Masks, in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin length face shields, and gowns or aprons must be worn for all tasks or procedures which are likely to generate droplets, sprays, spatters or splashes of blood, or other potentially infectious materials and where eye, nose, or mouth contamination can be reasonably anticipated.
17. Appropriate protective clothing, such as gowns, aprons, lab coats, clinic jackets, or similar outer garments, will be worn in occupational exposure situations.
18. The type and characteristics will depend upon the task and degree of exposure anticipated.
19. Appropriate protective clothing, such as gowns, aprons, lab coats, clinic jackets, or similar outer garments, will be worn when administering hazardous medications.
20. Personnel whose tasks include participation in CPR must use a one (1)-way valve mask when performing mouth-to-mouth resuscitation.
    1. The masks will be provided by Organization’s Name.
21. Linen, clothing, or other materials that are visibly contaminated with blood, body fluids, or other infectious materials must be placed in bags or containers that are impervious to moisture before transport for cleaning.
    1. Gloves must be worn while bagging these materials.

**Hand Hygiene**

**Policy No. 3-015.1**

**PURPOSE**

To prevent cross-contamination and home care-acquired infections.

**POLICY**

Personnel providing care in the home setting will regularly wash their hands, per the most recently published CDC regulations and guidelines for hand hygiene in healthcare settings.

When hands are visibly dirty, contaminated with proteinaceous material, or are visibly soiled with blood or other body fluids, they should be washed with either a non-antimicrobial or antimicrobial soap and water.

When hands are not visibly soiled, they should be washed using an alcohol-based hand rub for routinely decontaminating hands.  An alternative to use of an alcohol-based hand rub is to wash hands with an antimicrobial soap and water.

**PROCEDURE**

***Hand decontamination with an alcohol-based hand rub:***

Equipment: Organization-approved, alcohol-based hand rub which conforms to CDC Guideline for Hand Hygiene.

1. Apply alcohol-based hand rub product to palm of one (1) hand and rub hands together, covering all surfaces of hands and fingers (including under nails) until hands are dry.
2. The volume of product needed to reduce the number of bacteria on hands will vary by product, so product directions must be followed.
3. Hand decontamination using an alcohol-based hand rub should be performed:
   1. Before having direct contact with patients
   2. Before donning sterile gloves when performing sterile procedures; before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices
   3. After contact with a patient’s intact skin (when taking a pulse, blood pressure or lifting a patient)
   4. After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings, if hands are not visibly contaminated.
   5. When moving from a contaminated body site to a clean body site during patient care.
   6. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.
4. Policy No. 3-015.2
   1. After removing gloves.
5. At any time, personnel may choose to wash their hands with soap and running water in addition to using the alcohol-based hand rub, especially if personnel feel there is a “build-up” on the hands after repeated used of the alcohol-based hand rub.

***Hand Washing with Soap and Water***

Equipment: Paper towels and liquid soap; if water and liquid soap are not available, waterless hand washing products will be used.

1. Wet hands and apply the soap, and rub hands together vigorously; avoid use of hot water because repeated exposure to hot water may increase risk of dermatitis.
2. Wash hands for at least twenty (20) seconds covering all surfaces of the hands and fingers.
3. Rinse with warm water and dry the hands with a disposable towel from the fingers toward the forearm.
4. Use a dry disposable towel to turn off faucet.
5. Hand washing using soap and water should be performed:
   1. Before eating
   2. After using the restroom
   3. When hands are visibly dirty or contaminated
   4. If exposure to Bacillus anthracis is suspected or proven

**Bag Technique**

1. Policy No. 3-016.1

**PURPOSE**

To describe the procedure for maintaining a clean nursing bag/computer bag and preventing cross-contamination.

**POLICY**

As part of the infection/exposure control plan, Organization’s Name personnel will consistently implement principles to maximize efficient use of the patient’s care supply bag when used in caring for patients.

**PROCEDURE**

1. The bag may have the following contents:
   1. Hand washing equipment:
      1. Alcohol based hand rub
      2. Skin cleanser,
      3. Soap, and
      4. Paper towels
   2. Assessment equipment (as appropriate to the level of care being provided):
      1. Thermometers,
      2. Stethoscopes,
      3. A hem gauge to measure wounds,
      4. Sphygmomanometer, and
      5. Urine testing equipment
   3. Disposable supplies (as appropriate to the level of care being provided):
      1. Plastic Thermometer Covers (if applicable),
      2. Sterile and Non-sterile Gloves,
      3. Plastic Aprons,
      4. Dressings,
      5. Adhesive Tape,
2. Policy No. 3-016.2
   * 1. Alcohol Swabs,
     2. Tongue Blades,
     3. Applicators,
     4. Lubricant Jelly,
     5. Scissors,
     6. Bandages,
     7. Syringes and Needles,
     8. Vacutainer Equipment for Venipuncture,
     9. Skin cleanser,
     10. Paper towels, and
     11. A CPR mask
   1. Paper supplies (if applicable):
      1. Printed forms and
      2. Materials necessary to teach patients and family/caregivers and document patient care
   2. Laptop, computer, or other documentation device

***Bag Technique***

1. The bag will be placed on a clean surface (i.e., a surface that can be easily disinfected) in the car and in the home.
2. Prior to administering care, alcohol-based hand rub or soap and paper towels will be removed, and hands will be washed.
3. These supplies will be left at the sink for hand washing at the end of the visit.
4. Hand washing will always be completed before opening the bag.
5. After hand washing, the supplies and/or equipment needed for the visit will be removed from the bag.
6. The bag will contain a designated clean and dirty area.
7. The clean area contains unused or cleaned supplies/equipment, and the dirty area is designated for contaminated materials (i.e., used equipment, etc.).
8. Policy No. 3-016.3
9. When the visit is completed, reusable equipment will be cleaned using alcohol, soap and water, or other appropriate solution, hands will be washed, and equipment and supplies will be returned to the bag.
10. Hands will be decontaminated prior to returning clean equipment to bag.
11. If paper towels/newspapers have been used as protective barrier for bag placement in the patient’s home, they will be discarded.

**IMPROVING OPERATIONAL PERFORMANCE**

## Policy No. 3-017.1

### PURPOSE

To establish a performance improvement framework for the palliative care program which integrates with the organization-wide performance improvement plan and allows program specific data collection, improvement priorities and action plans to be monitored and reported upon.

To improve organizational performance by focusing on high risk, high volume, and problem-prone areas.

**POLICY**

Senior management and program leadership, as designated and approved by the Governing Body, will carry the responsibility to guide the organization's efforts in improving the program’s performance in governance, management, clinical and support activities; to define expectations and priorities of the program’s performance improvement activities; to generate the written plan and processes the program will utilize to assess, improve and maintain quality of care and service; and to evaluate whether its activities for identifying and minimizing risks to patients meets its objectives.

All personnel will be active participants in the evaluation of the provision of care, treatment and services and in the organization's performance improvement activities.

### PROCEDURE

1. Senior management will:
   1. Participate in educational activities to increase their level of understanding of palliative care and ability to implement performance improvement activities.
   2. The educational activities may include seminars, consultations, readings, periodicals, benchmarking, and review of available information from other organizations regarding the occurrence of sentinel events to reduce the risk of similar sentinel events within the organization.
   3. Set expectations for performance improvement, set priorities and manage processes to improve organization performance.
      1. Plan process and performance improvement activities to encompass multiple disciplines and/or settings.
      2. Select valid, reliable performance measures based on evidence-based national guidelines or, in the absence of such guidelines, expert consensus, and in the absence of both, a review of the health care literature.
         1. The program collects data related to processes and outcomes at the level of the individual patient and the data it needs to improve processes and outcomes.

**Policy No. 3-017.2**

* + - 1. Uses consistent data sets, definitions, codes, classifications, and terminology
      2. Collects data that is timely, accurate, complete and relevant to the program
      3. Monitors the quality of the data
      4. Collects and uses patient satisfaction data that is specific to the care, treatment, and services it provides in order to improve care of patients and families
      5. Sets priorities for improvement and adjusts priorities in response to unusual or urgent events
  1. The program uses its data analysis to improve and sustain its performance:
     1. Utilizes appropriate statistical techniques to analyze and display data
     2. Identifies and evaluates variables that affect outcomes
     3. Evaluates care, treatment, and services provided through contractual arrangement to ascertain whether the scope and level of care, treatment, and services are consistently provided
     4. Continues to use a measure if the data suggests an unstable pattern of performance or identifies an opportunity for improvement
     5. Changes to a new measure if data reflects continuing stable and satisfactory performance

1. Senior management will ensure that the program performance improvement plan is implemented.
   1. The program’s performance improvement plan, including its data analysis, is communicated at least annually to the organization’s leaders.
   2. Upon request, the program provides the public with information about its performance improvement activities.
      1. This information will both be general in nature and consist of patient satisfaction data or general information about how the program improves its performance.
2. The patient’s defined role in the evaluation of the provision of care, treatment, and services includes:
   1. Patient Outcomes
   2. Participation on Patient Satisfaction Surveys

## Policy No. 3-017.3

* 1. Through the Complaint and Grievance process of which patients are informed and encouraged to provide feedback and information regarding the care, treatment and services provided.
  2. Participation in the process to address and resolve ethical concerns
  3. Incidence of Adverse Events

1. All other organization personnel will:
2. Be involved in performance improvement activities
3. Promote communication and coordination of performance improvement activities, as well as contribute to those activities
4. Forward relevant information regarding performance improvement activities to senior management and to the Performance Improvement Coordinator

**SUPERVISION OF SERVICES**

## Policy No. 3-018.1

### PURPOSE

To ensure the palliative care program has dedicated leadership and staff necessary to meet the scope of care, treatment and services it provides.

### POLICY

A Palliative Care Program Director will be named to oversee the Palliative Care Program. Dedicated staff will be named to provide the care, treatment and services the program provides. Supervision of clinical care and services will be available 24 hours a day, seven (7) days a week. Supervisor-to-patient-care personnel ratios will depend on the acuity level of the patients and case-mix, and will be in compliance with applicable law or regulation.

***Palliative Care Program Director***

1. The Palliative Care Program Director will be responsible for the clinical direction of the organization and will take reasonable steps to ensure that:
   1. Services are continuously available
   2. Care and services provided by program personnel and contracted organization personnel are coordinated and integrated
   3. Care treatment and services provided by program are integrated with those of the organization
   4. Policies and procedures, which guide and support the provision of care and services, are developed and implemented
   5. Recommendations for required resources are made in a timely and effective manner
2. The Palliative Care Program Director will be qualified and possess appropriate clinical training and experience, as verified by:
   1. Education, training, and previous work experience
   2. Current professional licensure
   3. Interview assessing understanding of care and service being provided as well as population being served
   4. Management experience and clinical knowledge

**Policy No. 3-018.2**

### PROCEDURE

1. The Palliative Care Program Director will oversee the day-to‑day clinical operations.
2. The Program leaders will coach and mentor staff to improve their ability to provide care, treatment and services in a manner that builds mutual trust with the patient and family.
3. The Program leaders will provide clinical support and guidance to promote staff’s confidence in their ability to provide palliative care for patients.
4. The Program leaders will provide for emotional support for leaders, members of the interdisciplinary team, staff and volunteers.
5. On a daily basis, staffing will be reviewed in combination with the patient census, acuity, etc.
   1. If staffing is problematic, the Palliative Care Program Director, in coordination with the Clinical Supervisors, will review options, such as:
      1. Use of outside contracted personnel
      2. Use of overtime by organization personnel
      3. Use of office nursing personnel (i.e., Clinical Supervisor, QA/I nurses, etc.)
   2. Any issue not resolved will be brought to the attention of the Executive Director/Administrator.
6. The Palliative Care Program Director will monitor the care and service provided by organization personnel and contract personnel.
7. Monitoring includes the review of performance improvement results, incident reports, infection reports, clinical record review results, etc.
8. Any noted trends of individual performance will be used during the evaluation process.
9. Recommendations regarding resources (personnel and other) and services will be made to the Executive Director/Administrator, as well as to the appropriate committee.
10. The Clinical Director will have access to qualified clinical consultation for services outside his/her expertise, through the use of the Medical Director and other resources, as appropriate.
11. The Clinical Director will ensure that the supervision and supervisory visits are maintained within the organization per organization policy.

**Written Agreement**

1. Policy No. 3-019.1

**PURPOSE**

To specify the contents of a written agreement by defining the nature and scope of services provided by clinicians/technicians and others not directly employed by the organization.

**POLICY**

Senior management will be responsible for the availability of qualified care and services to meet the needs of the patients served.  When the organization provides care and services through another source, the patients are entitled to the same level of performance from that source as from the organization itself.  These contracted services will be defined by a written agreement before individuals from that source will be permitted to provide services on behalf of the organization. Written agreements are signed and dated by authorized individuals of each organization. Written agreements are reviewed annually.

**PROCEDURE**

1. The written agreement between the organization and the contract service/individual will define the nature and scope of services.
2. The organization shall ensure that all services furnished under arrangement provided by other entities or individuals meet the requirements of the Medicare Conditions of Participation and accreditation standards.
3. The agency, organization, or individual providing services under arrangement may not have been:
   1. Denied Medicare or Medicaid enrollment
   2. Been excluded or terminated from any federal health care program of Medicaid
   3. Had its Medicare or Medicaid billing privileges revoked
   4. Been debarred from participating in any government program
4. The written agreement will stipulate the following:
   1. Service to be provided
   2. Contractor is required to perform work in accordance with the primary organization’s applicable policies and procedures
   3. The Interdisciplinary Group will maintain oversight and coordination of care
   4. Care will be provided upon authorization of the organization and will be provided in a safe and effective manner by qualified personnel.
5. Policy No. 3-019.2
   1. Contractor assures that all personnel providing care have the education, training, and qualifications specified by Organization’s Name
   2. Mechanisms for the contractor to participate in performance improvement activities
   3. Procedures for scheduling visits, and periodic patient evaluation
   4. Procedures for submission of required patient related documentation that verifies the provision of services in accordance with the written service contract
   5. Contractor does not hold the patient financially liable for services furnished
   6. Procedures for the submission of invoices and related information and reimbursement for care provided
   7. Effective dates of the contract including terms of renewal or termination
   8. The above elements of the written agreements will be used for all contracted services.  Any deviation from the approved format must be approved by the Executive Director/ Administrator.
6. The organization will retain responsibility for evaluating services, maintaining professional management responsibility, and ensuring continuity of care through its performance improvement program and/or corporate compliance program. If during the annual vendor evaluation of services it is found that services are not being provided per the written agreement, those services will not be billed to avoid improper billing.
7. As part of the organization’s annual evaluation process, the Executive Director/ Administrator, with the assistance of other organization personnel will monitor, evaluate, and audit the contracted services to ensure that they are being provided according to the contract, and CHAP standards.  In addition, the review will:
   1. Formally assess the quality of services provided by the contracted provider
   2. Determine pertinence of agreement to current practice
   3. Extend or modify the terms of the agreement
   4. Negotiate new terms as necessary
   5. Terminate the contract, if necessary
8. Validation of the annual contract evaluation will be documented and includes
   1. Date of review
   2. Participating parties
   3. Continuing relevance of the contract to the provision of care
9. Contractual agreements for provision of services by Organization’s Name to another entity will delineate the responsibilities of all parties.

**Emergency Management Plan**

1. Policy No. 3-020.1

**PURPOSE**

To establish a plan which will allows for the continuation of services in the event of a disaster affecting the organization or the community.

**POLICY**

The organization will comply with all applicable, Federal, State, and local emergency preparedness requirements and will establish and maintain an emergency preparedness program that meets those regulations. The organization will establish an all-hazards approach to emergency preparedness that focuses on identifying hazards and developing emergency preparedness capabilities. The organization will comply with all Federal, State and local emergency preparedness requirements, including maintaining a written comprehensive emergency plan and will establish and maintain an emergency program that meets those regulations. The organization shall review and update the emergency preparedness plan every two (2) years.

The organization shall maintain written documentation of the emergency management plan for at least four (4) years.

**Note:** An all-hazards approach includes emergency preparedness for natural, man-made or facility emergencies including, but not limited to, care-related emergencies, weather related emergencies (e.g., extreme heat or cold), equipment/power failures, communication interruptions (e.g. cyber attacks), loss of facility or facility supplies (i.e., food and water) and emerging infectious disease threats (i.e. hazardous waste, bioterrorism, Influenza, highly communicable disease (such as Ebola, Zika, SARS, COVID-19, etc.)) or pandemics.

**Procedure**

***Planning Process - Before an Emergency***

Organization leadership will conduct a hazard vulnerability analysis (HVA), that is both facility-based and community-based, to identify potential emergencies (risks) that could impact the need for services or the ability to provide care to patients.

1. The HVA is documented and evaluated at least every two (2) years to reflect changes in organization, risk conditions, patient information and changes in staff.
2. The HVA should evaluate the organizations risk and potential for hazards and should include all risks that could disrupt the organization’s operations and necessitate emergency response planning to address the risk mitigation requirements and ensure continuity of care.
3. Strategies should be developed based on events identified during the development of the HVA such as a staffing strategy for staff shortages and a surge capacity strategy in the event the organization accepts additional patients during an emergency.

Policy No. 3-020.2

1. Staff will work with regional or county emergency management planning agencies, where available, in:
   1. Establishing priorities among the potential emergencies identified in the hazard vulnerability analysis
   2. Defining organization's role in relation to the community-wide emergency management program, use of volunteers, other emergency staff, including state or federally-designated health care professionals to address the organization's surge needs.
   3. Developing an "all-hazards" command structure within the organization that links with the community command structure.
2. Specific procedures that describe mitigation, preparedness, response and recovery strategies, actions, and responsibilities will be developed for each priority emergency.
3. The organization shall develop contingencies for managing the consequence of power failures, natural disasters and other emergencies that would affect the organization’s ability to provide care.
4. The organization shall develop policies, such as:
   1. Ways to address the use of employees in an emergency (e.g., staffing strategies)
   2. Potential surge needs in patients requiring care
   3. Maintaining the continuity of services to patients
   4. Staff ability to provide safe care, including any potential needs such as PPE
   5. Potential equipment needs
   6. Ways to decontaminate equipment or limit equipment taken into homes
   7. Screening phone calls prior to arrival and screening questions prior to entry into a home.
5. Based on the hazard vulnerability analysis and community planning activities, the organization’s general emergency plan may be enhanced or revised according to identified potential emergencies and planning activities.

**Note:** If the organization has identified emerging infectious diseases on the HVA, the organization will need to consider the following: facility modifications (i.e., isolation, social distancing, or capacity/surge limitations), screening patients and visitors (e.g., testing procedures for staff, visitors and patients), transfer/discharge of patients and personal protective equipment (PPE) measures.

1. The Executive Director/Administrator or designee has been designated as key leadership who is responsible for all emergency activities and makes the decision to implement the emergency plan upon becoming aware of an emergency situation.
2. Policy No. 3-020.3
3. The Executive Director/Administrator and key leadership will determine the leadership command structure to ensure continuity of operations.
4. The decision to discontinue or terminate the emergency management plan (operations) will be made by the Executive Director/Administrator or designee.
5. The Executive Director/Administrator or designee will assign recovery responsibilities by functional areas (e.g. the IT department will access off-site back-ups of the electronic medical records).
6. An alternate site will be designated in the event the office must be evacuated or is not accessible due to the emergency.
7. Any clinical and financial records or blank documentation forms necessary for care during the emergency will be maintained off-site in the event they cannot be retrieved from the office.
8. Electronic health care records and other vital assets will be protected against loss from unexpected natural or man-made disasters
   1. All vital information will be backed up regularly
   2. A backup must be in place and tested regularly for the ability to restore properly.
   3. The backup must be stored at a non-local offsite facility or in a cloud-based environment so that it cannot be affected by the same disaster that befalls the main computer system.
9. Individualized plans for patients during a natural or man-made disaster will be included as part of the comprehensive patient assessment.
10. The comprehensive assessment will be updated as frequently as the patient’s condition warrants due to a major decline or improvement in the patient’s health status and a revised risk categorization may be assigned.
11. The organization educates patients and their families on emergency preparedness at the time of admission including where they can go to shelter and what is required by the shelter.
12. During the comprehensive assessment, the patient will be placed in one of three (3) categories for triaging patient care in the event the emergency management plan (operations) is implemented. The categories included:
    1. *Category I:* Patients who cannot safely forego care and require intervention regardless of other conditions. Patients in this category may include highly unstable patients with a high probability of inpatient admission if palliative care is not provided; IV therapy patients; highly skilled wound care patients with no family/caregiver or other outside support; patients in need of critical supplies or medications.
    2. *Category II:* Patients with recent exacerbation of disease process; patients requiring moderate level of skilled care that should be provided that day; patients with essential untrained family/caregivers not prepared to provide needed care.
13. Policy No. 3-020.4
    1. *Category III:* Patients who can safely forego care or a scheduled visit without a high probability of harm or deleterious effects; this category may include homemaker patients, routine supervisory visits, evaluation visits, patients with frequencies of one (1) or two (2) times a week, if health status permits, or if a competent family member/caregiver is present.
14. The agency maintains hard-copy of a current patient list including contact information and categories identified for each patient in the event there is a power failure.
15. Sufficient medical supplies and non-medical supplies will be maintained in a patient’s home in the event of an emergency.
16. The agency will contact suppliers prior to an emergency and develop a plan to receive additional supplies as needed.
17. Sufficient medical supplies and non-medical supplies (including food, bedding, and other provisions) will be maintained in the organization’s office in the event of an emergency and the need to shelter in-place.
18. The agency will contact suppliers prior to an emergency and develop a plan to receive additional supplies as needed.
19. Sufficient medical supplies such as personal protective equipment and critical care equipment will be maintained in the organization’s office.
20. The organization shall include in their emergency management plan the available transportation needs or options available in preparation for surge events.
21. All staff will be identified by use of company badges. If volunteers are utilized, other forms of identification are utilized (i.e. wrist bands, badges, vests).

***Communication Plan***

The organization will maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and is reviewed and updated at least every two (2) years. The plan includes the following:

1. Names and contact information for the following:
   1. Staff
   2. Entities providing services under arrangement
   3. Patients’ physician
   4. Other Hospices
   5. Volunteers, if applicable
2. Contact information for the following:
   1. Federal, state, tribal, regional and/or local emergency preparedness staff
3. Policy No. 3-020.5
   1. Other sources of assistance
4. Primary and alternate means for communicating with the staff, federal, State, tribal, regional and local emergency management agencies.
5. A timeframe requirement for on-duty and off-duty staff to check in with the organization’s designated individual (e.g. every two (2) to four (4) hours for on-duty staff and every eight (8) hours for off-duty staff).
6. A method for sharing information and medical documentation for patients under the organization’s care as necessary.
7. A means of providing information about the general condition and location of patients under the organization's care as permitted.
8. A means of informing state and local emergency preparedness officials before, during and after and emergency on the following:
   1. Patients that the organization has been unable to contact to determine service needs
   2. Patients in need of evacuation due to their medical or behavioral health, or conditions of their home environment
9. A means of providing information about the organization's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

***Training and Testing***

The training and testing program is reviewed and updated at least every two (2) years.

***Training***

1. The training includes initial training in emergency preparedness policies and procedures and their assigned emergency response roles to all new and existing staff, individuals providing service under arrangement, and volunteers if applicable.
2. The training is provided at least every two (2) years, unless more frequent training is necessary due to a significant update of the organization’s policies and procedures.
   1. Staff will be able to demonstrate knowledge of emergency procedures after receiving training.
3. Organization leadership will provide for orientation to all personnel regarding participation in the emergency management plan. Education to include:
   1. Specifics of organization's emergency management plan
   2. Specific assigned emergency response plan
   3. Information on developing their family's emergency response plan
   4. Information regarding accessing housing and transportation for staff if necessary
4. Policy No. 3-020.6
5. All training will be documented, including the dates, participants and content, in the personnel record of staff, individuals under arrangement and volunteers, if applicable

***Testing:***

1. Organization’s Name will test the emergency management plan, at each site included in the plan, at least annually, either in response to an actual emergency or in a planned exercise.
2. The agency participates in a full-scale exercise that is community-based every two (2) years or when a community-based exercise is not accessible, conduct an individual, facility-based functional exercise every two (2) years.
   * 1. In the event an actual natural or man-made emergency occurred, the agency will be exempt from engaging in its next required full-scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.
3. The agency conducts an additional exercise every two (2) years, on the year opposite of the full-scale community-based or individual facility-based functional exercise. The additional exercise may include, but is not limited to:
   1. A second full-scale exercise that is community–based or facility-based, or
   2. A mock disaster drill, or
   3. A table top exercise or workshop that is led by a facilitator and includes group discussion using a narrated, clinically-relevant emergency scenarios, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
      1. Planned exercises are realistic scenarios and related to the priority emergencies defined by leadership and will focus on the organization’s response to an emergency that is likely to affect continuation of care, treatment or services. Exercise scenarios will allow the organization to evaluate its handling of communication, resources and assets, staff and patients.
4. All actual responses and exercises will be documented and critiqued through a multidisciplinary process that includes administrative, clinical and support staff.
   1. Documentation will be used to identify deficiencies and opportunities for improvement based on all monitoring activities and observations during the exercise or actual emergency.
   2. The documentation will identify the effectiveness of the preparedness, mitigation, response and recovery activities of the emergency operations plan.
5. Organization’s Name will modify the emergency management plan in response to the critiques of the actual emergency event response and will prioritize processes identified for improvement, develop and institute plans for improvement.
6. Organization’s Name will modify the emergency management plan in response to the critiques of the exercise.

Policy No. 3-020.7

1. The next scheduled planned exercise will evaluate the effectiveness of the improvements that were made in response to the critiques of the previous exercise.
2. If improvements require substantive resources that can’t be accomplished by next planned exercise, interim improvements must be put in place until final resolution.
3. The evaluation results and proposed improvements of any exercise or actual emergency will be presented to all staff, individuals under agreement, volunteers as applicable and the Governing Body.
4. The evaluation may be incorporated into the organization’s QAPI program.

***When an Emergency is Declared***

1. Once the decision has been made to implement the emergency management plan, the Executive Director/Administrator or designee will initiate the Pyramid Phone Communication Plan (PPCP) to notify personnel and community authorities, as appropriate.
2. Personnel must listen to the organization-identified Emergency Broadcasting System for organization instructions and updates, if the telephone system is not functioning, and leadership staff is unable to initiate the PPCP.
3. Additionally, as able, personnel are to report to the office or alternate site if the office building is not accessible and normal communication systems are not working.
4. The Executive Director/Administrator and supervisory personnel will be responsible for identifying and assigning staff to cover all essential functions.
5. Following the initiation of the PPCP, all available and qualified personnel will be mobilized to perform identified services.
6. Alternate communication systems will be implemented (e.g., call forwarding, cell phones, email, walkie-talkie, etc.) as needed.
7. The Clinical Supervisors or designee(s) will review the assigned category classifications for all current patients.
8. The agency will notify the patient/caregiver to obtain needed medications and supplies immediately upon implementation of the plan.
9. The agency will communicate, when possible, any information received about changes in patients’ location to durable medical equipment (DME)/infusion suppliers in the event additional supplies need to be delivered.
10. If feasible, the Clinical Supervisors or designee(s) will assign all available, qualified personnel to care for Category I patients first and Category II patients second.
11. Category III patients and any other patients who do not receive scheduled care will be contacted as soon as possible.
12. Policy No. 3-020.8
13. If transportation is needed to safely get personnel to patient homes, it will be arranged via county support services, such as the police, fire, or sheriff’s office.
14. If care cannot be provided to Category I patients, emergency transport to alternate care delivery sites will be arranged with community support agencies.
15. New patients will not be accepted for care until the emergency situation is controlled or staffing levels permit. Patients accepted, but not yet admitted, will be triaged as noted above.
16. If the community experiences an epidemic or infection, Organization Name will not continue to accept or treat infected patients unless a plan for managing an ongoing influx of potentially infectious patients over an extended time period has been implemented.
17. In the event of a prolonged emergency situation, the Executive Director/Administrator or designee will:
    1. Determine staffing availability and limitations, including assistance available from external staffing agencies
    2. Identify those patients who could be discharged from the organization earlier than anticipated
    3. Determine course of action based on above information
    4. Identify patients with continuing care needs
    5. Contact other area organizations to determine the degree to which they may be able to accept new patients, if the decision is made to transfer
    6. Notify attending physicians regarding ability to continue caring for patients
    7. Make transfer or discharge arrangements as necessary, notifying patients and family/caregivers as appropriate
    8. In prolonged emergency situations, the organization will retain only those patients for whom it can safely and adequately provide care
18. Safety of patients and organization personnel will take priority in all emergency situations.
    1. Weather and road conditions will be monitored via local weather reports and state patrol reports.
    2. Natural or community disasters will be monitored via the Emergency Broadcasting System, reports from local authorities, reports from other local health care facilities in the event there is no telephone communication.
    3. Strike conditions will be monitored via liaison with local representatives.
    4. In the event the office building is determined to be unsafe, the Executive Director/Administrator or designee will communicate the location to which all personnel are to report for work.
19. Policy No. 3-020.9
20. In all emergency situations, the Executive Director/Administrator or designee will maintain communications and act as the spokesperson among other facilities, media, and community and safety authorities.

***After the Emergency***

1. Staff will contact the agency administrator (or designee) to report in and receive instructions.
2. The agency administrator (or designee) and staff will make a survey of patients to find out their location and condition, enquire about possible injuries or deterioration of health status and will initiate corrective action.
3. The actual response will be documented and critiqued through a multidisciplinary process that includes administrative, clinical and support staff.
4. Documentation will be used to identify deficiencies and opportunities for improvement based on all monitoring activities and observations during the emergency.
5. The documentation will identify the effectiveness of the preparedness, mitigation, response and recovery activities of the emergency operations plan.
6. Organization’s Name will modify the emergency management plan in response to the critiques of the emergency event response and will prioritize processes identified for improvement, develop and institute plans for improvement.

**TELEMEDICINE PROGRAM**

**Policy No. 3-021.1**

**PURPOSE**

To define the organization’s telemedicine program.

**POLICY**

Patient encounters provided via telemedicine applications will be strictly monitored for compliance with the organization’s policies and procedures.

The telemedicine program will be monitored by senior management for compliance with operating guidelines.

**Note:** These policies are only applicable if the organization has a telemedicine program.

***Definitions***

* 1. *Home Telehealth*: A method of remote monitoring or care delivery provided to a patient in his/her place of residence by a health care provider.
  2. *Interactive Home Telehealth:*A method of remote care delivery that utilizes two-way interactive audio video between the patient and health care provider. This type of application may collect clinical data from the patient, which is then delivered to the health care provider.
  3. *Telemonitoring*: A method of collecting clinical data and transmitting such data from the patient’s place of residence to the health care provider’s location through a remote interface. This may include the use of automated laboratory or other monitoring equipment.
  4. *Self-monitoring*:A method of collecting clinical data through the periodic and scheduled use of a device by a patient. Examples may include blood pressure, blood glucose, weight, and temperature.
  5. *Patient Encounters*:A patient encounter is the communication of information between the patient and the health care provider that establishes, changes, or implements a plan of care.

**PROCEDURE**

1. Prior to acceptance into the telemedicine program, the patient must be determined to meet the established admission criteria.
2. The organization will determine the type of remote monitoring, telemonitoring and equipment to be used.

**Policy No. 3-021.2**

1. The patient will sign an informed consent allowing for the interactions and any recording/pictures that may be taken as parts of the telehealth interaction prior to being admitted to the program.
2. A face-to-face assessment will be completed at the patient’s place of residence to determine if telemedicine applications will be appropriate for the patient.
3. Physician approval will be obtained prior to admission into the program.
4. A specific telemedicine plan of care will be developed in association with the attending physician.
5. Patient education will be completed prior to initiation of in-home monitoring.
6. Patient satisfaction feedback specific to the telemedicine program will be collected and utilized in the organization’s performance improvement efforts.
7. Patient privacy rights will be protected during all telemedicine transmissions and patient encounters.
8. The organization will determine how and who will deliver, set-up, test and remove telemonitoring equipment.
9. Staff eligible to participate in the telemedicine program may include:
   1. Registered nurses
   2. Licensed practical/vocational nurses
   3. Nurse practitioners
   4. Pharmacists
   5. Physical, occupational, and speech therapists
   6. Social workers
   7. Nutritionists
   8. Physicians
10. Personnel working in the telemedicine program will complete an orientation program prior to providing services.
11. Personnel orientation and continuing education will focus on equipment set-up, use, maintenance, troubleshooting, transportation, cleaning and storage, and the evolving principles of home telemedicine.
12. Personnel participating in the program must successfully complete a specific telemedicine skills competency assessment prior to delivering services and annually thereafter.

**Policy No. 3-021.3**

1. Documentation of telehealth encounters will be made in the clinical record according to organization policy for clinical documentation.
2. Telehealth interactions will be clearly differentiated from a home visit.
3. Information obtained during each telehealth encounter will be determined by the equipment employed and the patient’s health monitoring needs.
4. Specifics will be outlined in the patient’s plan of care.
5. Cleaning, maintenance, and repair of telemedicine equipment will be completed per organizational policy for equipment safety and will include at a minimum:
   1. Equipment maintenance logs for each piece of equipment
   2. Cleaning logs for each piece of equipment
   3. Patient ready tag identification on each piece of equipment indicating the date equipment was tested and cleaned and the initials of the person cleaning the equipment
   4. A tracking system to ensure proper placement and location of each piece of equipment
6. Telemedicine equipment failures will be reported and documented using the organization’s incident reporting system.
7. Equipment failures that have potentially or actually caused serious injury or patient death will be reported per the Safe Medical Device Act reporting requirements.
8. Backup equipment may be maintained at the organization’s site or in the patient’s home, depending in the distance and time for replacement.
9. The organization will determine what data is collected and integrated into the palliative plan of care including the scope and frequency of data collection and sharing of findings.

**TELEMEDICINE—PATIENT PRIVACY**

**Policy No. 3-022.1**

**PURPOSE**

To ensure that the patient’s rights to privacy and confidentiality are protected.

**POLICY**

Patient privacy will be maintained at all times. This includes the patient’s place of residence as well as the locations receiving the patient’s information. The telemedicine program will continuously monitor its policy, procedure, practice, and equipment to ensure the patient’s privacy rights are not violated. Any data collected that is made available outside the organization will be presented in the aggregate.

**PROCEDURE**

1. Prior to admission into the telemedicine program, the patient will be asked to sign an informed consent that will include language regarding the use of private health information collected and safeguards for the confidential transmission of clinical data.
2. Interactive home telehealth patients will be assured of the following:
   1. Patient will not be viewed through video or heard through audio without his/her knowledge and prior written consent.
   2. When other staff members enter the telehealth viewing area, the patient will be immediately informed and his/her verbal consent obtained in order for the additional staff member to participate or view the interactive home telehealth encounter.
   3. In the event that an additional remote site is participating in the interactive telehealth encounter, the patient will be made aware of and approve the participation of the additional site.
   4. Patient photographs will not be utilized without the patient’s specific permission. Patient will sign a consent to photograph.

**TELEMEDICINE—ADMISSION CRITERIA**

**Policy No. 3-023.1**

**PURPOSE**

To ensure appropriate admission of patient into the telemedicine program.

**POLICY**

Patients will be assessed on a face-to-face basis to determine eligibility for the telemedicine program.

**PROCEDURE**

1. Each patient, upon admission, will be assessed for eligibility into the telemedicine program.
2. A patient determined at admission to not be eligible may be reassessed for admission into the program at any time while receiving home health services.
3. Eligibility for admission into the program will include at least the following criteria:
   1. Patient’s diagnosis and associated ongoing clinical monitoring needs can be adequately met through the use of telemedicine monitoring equipment.
   2. Patient understands and desires to participate in the program.
   3. Patient has the cognitive capacity to learn and correctly use the telemedicine monitoring equipment.
   4. Patient has the physical ability to use the telemedicine equipment.
   5. Patient’s place of residence has the electrical capacity or other operating requirements to support use of the equipment.
   6. Telemedicine monitoring equipment can be safely maintained in the home.
   7. The patient’s primary physician approves the use of telemedicine.
4. The patient will continue to be served through the program as long as the above criteria are met.

**TELEMEDICINE—PLAN OF CARE**

**Policy No. 3-024.1**

**PURPOSE**

To define the criteria for development of the patient’s telemedicine plan of care.

**POLICY**

A specific telemedicine plan of care will be initiated and maintained for each patient in the program.

Patient care will be provided in compliance with the telemedicine plan of care.

**PROCEDURE**

1. A plan of care will be developed for the specific telemedicine intervention being provided. This may include but not be limited to:
   1. Disease management
   2. Rehabilitation
   3. Remote vital sign collection
   4. Interactive home care
2. The plan of care will be developed in collaboration with the patient and appropriate caregivers.
3. The plan of care will include the home telehealth encounter frequency.
4. The plan of care will be sent to the primary physician for signature.
5. Home telehealth may be incorporated into critical pathways.
6. Changes in the plan of care will be documented and signed by the physician.
7. Changes in the plan of care will be communicated to the patient and appropriate caregivers.
8. The plan of care will include how the patient will be monitored after the discontinuation of the telehealth program.

**TELEMEDICINE—PATIENT EDUCATION**

**Policy No. 3-025.1**

**PURPOSE**

To promote effective utilization of the telemedicine program.

**POLICY**

Patient and family/caregiver will receive training on home telehealth equipment prior to use and on an ongoing basis as necessary. Patient and family/caregiver will have a functional knowledge and thorough understanding of the capabilities and limitations of the equipment and telemedicine program.

**PROCEDURE**

1. Education will include proper handling, storage, operation, electrical connection, phone requirement, if any, and cleaning.
   1. Manufacturer’s recommendations will be followed.
2. Use of peripherals, the purpose of each peripheral, frequency of monitoring and/or visit schedule will also be reviewed at time of admission and before any change in the plan of care.
3. Written information provided to the patient may include:
   1. Procedures to operate and maintain the equipment
   2. Diagrams or pictures indicating the proper placement and use of peripherals
   3. Contact information and procedures in case technical problems occur
   4. Safety instructions including electrical safety
   5. How to access after-hours care
   6. Instruction on the difference between using telehealth and the need to call 911 to ensure a delay in emergency care does not occur
4. Clear instruction will be provided regarding emergency procedures in the event of a natural disaster or severe weather conditions, which may interrupt services.
5. Return demonstration showing correct use of equipment by the patient and/or caregiver will be required prior to initiation of home telehealth.
6. Patient/caregiver education, training, and understanding and ability to assume designated responsibilities will be documented in the clinical record.

**TELEMEDICINE—DISCHARGE CRITERIA**

**Policy No. 3-026.1**

**PURPOSE**

To define the events that may trigger discharge of a patient from the telemedicine program.

**POLICY**

When the patient’s plan of care changes and this change results in discontinuation of telemedicine services, the patient and/or caregiver, as well as his/her primary physician, will be notified and involved in discharge planning. The patient may be discharged from the telemedicine program but continue to receive home health services.

**PROCEDURE**

1. Telemedicine services will be terminated when the patient meets one (1) or more of the discharge criteria:
   1. A change in the patient's medical or treatment program.
   2. A change in the patient’s condition requires care or services other than that provided by the organization.
   3. If appropriate, the goals of the telemedicine program have been attained or are no longer attainable.
   4. There is no longer anyone to provide support for use of equipment in the home.
   5. The patient or family/caregiver refuses or discontinues care.
   6. The patient or family/caregiver refuses to cooperate in attaining the objectives of the telemedicine program.
   7. Conditions in the home are no longer safe for the patient or organization personnel.
   8. An alternative means of monitoring the patient’s health has been judged to be preferable to the telemedicine program.
   9. The patient moves from the geographic area served by the organization.
   10. The patient’s physician (or other authorized independent practitioner) has failed to renew orders or the patient has changed physicians and orders cannot be obtained from the new physician to support patient's needs.
   11. The physician (or other authorized independent practitioner) gives orders that are not consistent with the stated diagnosis as required by law and fails to give the needed orders when requested by the organization.

**Policy No. 3-026.2**

* 1. The organization is closing out a particular service or all of its services.
  2. The patient expires.

1. Relevant policies and procedures for discharge/reduction of service will be followed.

**SECTION FOUR**

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| **POLICY/PROCEDURE** | **CHAP STANDARDS** |
| 1. Equal Opportunity Employer | PCMG.8 |
| 1. Categories/Qualifications of Personnel | PCMG.8 |
| 1. Selection/Hiring of Personnel | PCMG.8 |
| 1. Licensure/Certification/Registration | PCMG.8 |
| 1. Personnel Record Contents | PCMG.8 |
| 1. On-Call/Weekend Services | PCTT.2  PCTT.10 |
| 1. Orientation and Ongoing Education | PCMG.8 |
| 1. Palliative Care Competencies | PCMG.8 |
| 1. Job Descriptions | PCMG.9 |

**Equal Opportunity Employer**

**Policy No. 4-001.1**

**PURPOSE**

To assure that all persons have equal employment opportunity.

**POLICY**

In accordance with Title VI of the Civil Rights Act of 1964 and its implementing regulation, Organization’s Name is an EQUAL OPPORTUNITY EMPLOYER and WILL NOT DISCRIMINATE AGAINST RACE, COLOR, RELIGION, AGE, GENDER, SEXUAL ORIENTATION, DISABILITY (MENTAL OR PHYSICAL), COMMUNICABLE DISEASE, OR PLACE OF NATIONAL ORIGIN AS DEFINED IN SECTION 504 OF TITLE VI.

In accordance with Section 504 of the Rehabilitation Act of 1973 and its implementing regulation, Organization’s Name *WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF DISABILITY.*

In accordance with the Age Discrimination Act of 1975 and its implementing regulation, Organization’s Name *WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF AGE* in the provision of services, unless age is a factor necessary to the normal operation or the achievement of any statutory objective.

In accordance with the Americans with Disabilities Act of 1992 (42 USC §12101) and its implementing regulations, (private employers with more than 25 organization personnel), Organization’s Name *WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL* *OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF DISABILITY*.  A disability is a physical or mental impairment that substantially limits a major life activity, or for which there is a record of impairment or which causes the individual to be regarded as impaired.

In accordance with the Genetic Information Nondiscrimination Act (GINA), the organization *WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF GENETIC INFORMATION*.

In accordance with the Vietnam Era Veterans’ Readjustment Assistance Act (VEVRAA), the organization *WILL NOT, DIRECTLY OR THROUGH CONTRACTUAL OR OTHER ARRANGEMENTS, DISCRIMINATE ON THE BASIS OF VETERAN STATUS*.

**Note:** All statutes include provisions regarding retaliation.

**Note:** The current federal EEO laws do not prevent an employer from requiring all employees to be vaccinated for COVID-19, subject to the reasonable accommodation provisions of Title VII and the ADA.

**Categories/Qualifications of Personnel**

**Policy No. 4-002.1**

**PURPOSE**

To define personnel/staffing categories and classifications.

**POLICY**

1. The organization defines the qualifications, competencies, health status, and type of staffing needed to fulfill its mission.
2. All personnel are employed for an indefinite term.  Therefore, either the personnel or the organization may terminate the employment relationship at any time, with or without cause or notice.  This status can only be altered by a written contract or an employment contract that is specific to all material terms and is signed by the employee and the Executive Director/ Administrator.
3. The organization will employ or contract only those individuals who have valid credentials as stipulated by state and federal requirements.
4. Personnel qualifications include appropriate professional licensure, certification, and absence of a criminal background for those positions designated by law and regulation.

**CATEGORIES OF PERSONNEL**

***Definitions***

1. *Regular Full-Time Personnel*: Individuals whose employment is without defined term, and are scheduled to work a minimum of 35 hours per week on a regularly scheduled basis.  Full-time personnel qualify for employment benefits.
2. *Regular Part-Time Personnel*: Individuals scheduled to work less than 35 hours per week on a regularly scheduled basis.  Regular part-time personnel qualify for some benefits.
3. *Temporary Personnel*: Individuals with a limited duration work assignment.  Temporary personnel are not, however, guaranteed employment for the duration of work assignments; employment is for an indefinite term, not to exceed the duration of the work assignment(s).  If temporary personnel become either full-time or part-time, without break in service, the date of employment will be “rolled back” to the date employment began at the organization.  If personnel are in a “temporary acting” position for 90 days, the status of the position and the personnel will be reviewed.
4. *PRN or Per Diem Personnel*: Individuals whose employment is without defined term, and are scheduled to work on an “as needed” basis.  Any time worked by personnel in a PRN or Per Diem status MAY NOT COUNT for the purposes of longevity, personnel benefits, etc.
5. *Non-Exempt Personnel*: Individuals who are not exempt from the overtime and minimum wage provisions of the Fair Labor Standards Act of 1939, as amended.  Non-exempt personnel will receive overtime pay for hours worked in excess of 40 hours per week, in accordance with applicable organization policy and federal and state labor regulations.

**Policy No. 4-002.2**

1. *Exempt Personnel*: Individuals who are exempt from the overtime and minimum wage provisions of the Fair Labor Standards Act of 1939, as amended.  Exempt personnel (i.e., executive, administrative and professional) are not eligible to receive overtime pay.
2. *Contract Personnel*: Individuals or groups of individuals who perform services as directed in a written agreement.  Contract personnel are not considered employees for purposes of overtime, longevity, benefits, etc.  However, contract personnel are subject to all position qualifications and competency requirements.
3. Exemption status and classifications are defined by the Fair Labor Standards Act.

**QUALIFICATIONS OF ORGANIZATION PERSONNEL**

The organization seeks to provide quality patient care through recruiting and maintaining qualified, competent personnel.  In addition to professional licensure requirements and specific position certifications, additional factors will be utilized in selecting personnel.  Some of these factors include case-mix of patient population served, acuity of care required by the target patient population, services provided by Organization’s Name and any technology used in providing care/service.

***Minimum Qualifications***

*Professional Personnel*: Individuals must present evidence of required licensure and experience as appropriate.  This includes registered nurses, licensed practical nurses, speech-language pathologists, occupational therapists, physical therapists, medical social workers, pharmacists, and respiratory therapists.  Further qualifications are found within the specific job descriptions.

1. Registered Nurse
   1. A graduate of an approved school of professional nursing as determined by the Board of Registration in Nursing
   2. Licensed in the state as a registered nurse by the Board of Registration in Nursing
2. Practical or Vocational Nurse
   1. Licensed as a practical or vocational nurse by the Board of Registration in Nursing
3. Occupational Therapist
   1. A graduate of an occupational therapy curriculum accredited jointly by the Council on Medical Education of the American Medical Association and the American Occupational Therapy Association
   2. Registered by the American Occupational Therapy Certification Board
   3. Refer to the Conditions of Participations
   4. Licensed by the state, if applicable

**Policy No. 4-002.3**

1. Certified Occupational Therapy Assistant
   1. Successfully completed an Occupation Therapy Assistant Education Program accredited by the Accreditation Council for Occupation Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) and licensed by the state
   2. Refer to the Conditions of Participations
2. Social Worker
   1. Holds a master's degree from a school of social work accredited by the Council on Social Work Education OR
   2. Holds a baccalaureate degree in social work from an institution accredited by the Council on Social Work Education OR
   3. Holds a baccalaureate degree in social work, psychology, sociology, or other field related to social work and is supervised by an MSW meeting the above qualifications AND has at least one (1) year of social work experience in a health care setting.
   4. Refer to the Conditions of Participations
   5. Has one (1) year of social work experience in a health care setting
3. Marriage and Family Therapist
   1. Holds a master’s degree or doctoral degree which qualifies for licensure or certification as a marriage and family therapist.
   2. After obtaining a degree has performed at least two (2) years or 3,000 hours of post master’s degree clinical supervised experience in marriage and family therapy in an appropriate setting such as a hospital, SNF, private practice or clinic; and
   3. Is licensed or certified as a marriage and family therapist by the State in which the services are performed.
4. Mental Health Counselor
   1. Holds a master’s or doctor’s degree which qualifies for licensure or certification as a mental health counselor, clinical professional counselor, or professional counselor.
   2. After obtaining a degree has performed at least two (2) years or 3,000 hours of post master’s degree supervised clinical experience in mental health counseling in an appropriate setting such as a hospital, SNF, private practice or clinic; and
   3. Is licensed or certified as a mental health counselor, clinical professional counselor, or professional counselor by the state in which the services are performed.

**Policy No. 4-002.4**

1. Speech Pathologist or Audiologist
   1. Registered as a speech pathologist
   2. Graduated from an accredited school of Speech Pathology or Audiology approved by the American Speech and Hearing Association
   3. Licensed by the state, if applicable
   4. Refer to the Conditions of Participations
2. Physical Therapist
   1. Registered as a physical therapist with the Board of Registration and Discipline in Medicine and the Board of Allied Health
   2. Graduated from an accredited school of physical therapy approved by the American Physical Therapy Association
   3. Refer to the Conditions of Participations
   4. Licensed by the state, if applicable
3. Physical Therapist Assistant
   1. Graduated from a two (2)-year, college-level program approved by the American Physical Therapy Association and licensed by the state
   2. Refer to the Conditions of Participations
4. Pharmacist
   1. Licensed as a pharmacist by the applicable state Board of Pharmacy
   2. Graduated from an accredited school of pharmacy
5. Respiratory Therapist
   1. Credentialed as a certified or registered therapist
   2. Graduated from an approved respiratory therapy program
   3. Licensed by the state, if applicable

***Para-Professional and Support Personnel:***

1. Home Care Aide
   1. Trained in a homemaker, home health aide, or nurse assistant training program approved by the Executive Director/Administrator and in accordance with state requirements. Refer to CHAP standard, HSRM 9.I for a list of acceptable training and competency evaluation programs.

**Policy No. 4-002.5**

1. Other Personal Care Providers
   1. Competent to perform the duties of a companion, nanny, housekeeper, or live-in
2. Clerical/Non-Clinical Personnel
   1. Documented evidence of appropriate education and/or experience commensurate with required job responsibilities

***Competency***

1. *Professional Personnel*: Individuals must demonstrate their competency, within their orientation and probationary period, according to the orientation checklists developed for each position.  In addition, ongoing competency assessments will be performed through joint visits, based on the degree and complexity of care being performed and by monitoring information regarding performance.  Failure to meet the organization's competency expectations may result in termination.
2. *Home Care Aide (if applicable)*: Individuals must demonstrate their competency, within orientation, according to the orientation checklist and the activities delineated in the CMS (for Medicare Certified organizations) competency testing.  In addition, ongoing competency assessments are performed through observation and supervisory visits every two (2) weeks as well as monitoring information regarding performance.  The ongoing competency review is part of the annual performance evaluation.  Failure to meet the organization's competency expectations may result in termination.
3. *Clerical /Non-Clinical Personnel*: Individuals must demonstrate their competency, within their orientation and probationary period, according to the orientation checklist.  The competency of clerical and non-clinical organization personnel is periodically monitored through observation of performance.  This review is part of the annual performance evaluation.  Failure to meet the organization's expectations may result in termination.

***Health Requirements***

1. *Personnel With Patient Contact:* All new personnel who will be in contact with patients and rehires who have not been employed by the organization for over six (6) months, must undergo a physical screening before they are employed or re-employed.  In addition, personnel must have TST or show evidence that there is no active Tuberculosis in the past 12 months (by providing a copy of a negative TST taken within the past 12 months) prior to providing care.  Documentation of these tests will be maintained in the personnel health file.
2. *Clerical /Non-Clinical Personnel:* All new personnel not providing direct patient care as well as rehires who have not been employed by the organization for over six (6) months, must undergo a physical screening. An offer of employment for both new hires and re-hires will be contingent upon the completion of the physical screening.
3. The organization retains the option to require annual physical screening of all personnel as required by state or local law or as deemed appropriate by the organization.
4. The organization also retains the option to require medical examination (including drug and alcohol screening procedures) of personnel as allowed by state or local law or as deemed appropriate by the organization policy.

**Selection/Hiring of Personnel**

**Policy No. 4-003.1**

**PURPOSE**

To specify the criteria for the recruitment and hiring of personnel to meet the care/service needs of patients.

**POLICY**

The organization will use a consistent, nondiscriminatory process for the selection of all personnel.  The most qualified individuals will be employed without regard to race, color, religion, age, gender, sexual orientation, marital status, disability (mental or physical), communicable disease, or place of national origin as required by state and federal law.

The organization will provide promotion and advancement opportunities in a nondiscriminatory fashion.

**PROCEDURE**

***Selection and Screening***

1. A notice of position opening will be posted in-house and published in local newspapers and/or other instruments appropriate for recruiting personnel.
2. Candidates will be screened by phone or in person to assure that the candidate meets the job requirements and qualifications, such as:
   1. Valid state license or certification, as applicable
   2. At least one (1) year of experience and/or as defined in the job description

***Hiring***

1. An individual seeking employment will complete an application, including information and verification about education, work experience, job history, and references, and have a personal interview.
2. A criminal background check will be obtained for positions as required by law and regulations.
3. If the decision not to hire a candidate is made due to unsatisfactory background check results, the results of the background check will be provided to the candidate to ensure compliance with the Fair Credit Reporting Act.
4. In the absence of state requirements, criminal background checks are obtained within three (3) months of the date of employment for all states in which the individual has lived or worked during the past three (3) years.
5. Applicants for non-supervisory positions will be interviewed by the Executive Director, Clinical Director, Department Supervisor, or designee.

**Policy No. 4-003.2**

1. Applicants for supervisory positions will be interviewed by the Executive Director/Administrator.
2. The Executive Director/Administrator will confirm the applicants understanding of all care and services appropriate to the job the individual is applying for.
3. The interviewer will utilize a standardized interviewer's report form as well as the job description during the interview process.
4. Two (2) references, either telephone and/or written, will be obtained prior to an offer of employment.
5. Education will be verified, as appropriate, through viewing and copying the certificate, diploma or transcripts, or by institution contact.
6. Professional licensure/certification will be confirmed through viewing or copying the actual license and/or certificate.
7. In addition, current licensure will be verified through the internet sites of official licensing bodies when they are available.
8. Other information obtained during the application process will include, but not be limited to, social security number and driver's license.
9. Upon completion of the selection process, a candidate meeting all the organization requirements will be offered a position within the organization.
10. An offer of employment will be contingent upon a current physical and TB test/chest X-Ray.
11. All new personnel (clinical and non-clinical) must attend an orientation program prior to assuming job responsibilities.
12. Depending on the personnel classification, a specific orientation program will be conducted which addresses job responsibilities and a further review of organization policies.
13. All new personnel will be on a probationary status for ninety (90) days from the date of hire unless otherwise specified.
14. New employee not on the OIG exclusion list.
15. Verification of the above will be documented.

***Promotion***

1. When possible, supervisory and management positions will be filled by internal candidates.
2. All supervisory and management position openings will be posted internally for at least two (2) weeks.
3. Interested personnel can apply for promotion verbally or in writing.
4. All interested applicants will be interviewed for the promotion.

**Policy No. 2-021.3**

1. In the event there is not a qualified internal applicant, the position will be filled with an outside applicant following the organization’s policy.

**Licensure/Certification/Registration**

**Policy No. 4-004.1**

**PURPOSE**

To ensure that all personnel meet license/certification/registration requirements per applicable laws and/or organization policy.

**POLICY**

All organization personnel will be properly licensed, certified, and/or trained to meet specific job requirements.

**PROCEDURE**

1. Personnel must maintain and show proof of licensure, certification, and/or registration as appropriate.
2. Personnel must comply with requirements to maintain such licensure, certification, and/or registration in accordance with applicable state law and regulation.
3. A current copy or other proof of licensure, certification, and/or registration will be kept in the personnel file.
4. Personnel not requiring specific licensure, certification, and/or registration will demonstrate competency through the organization's competency evaluation process.
5. Any employees who fail to maintain a required license, certification or registration will be subject to suspension or termination.

**Personnel Record Contents**

**Policy No. 4-005.1**

**PURPOSE**

To specify the content of the personnel files for direct employees and independent contractors.

**POLICY**

Organization’s Name will maintain current and complete personnel files on all direct personnel and independent contractors.  Personnel files are confidential files of the organization.  All health-related information on personnel will be kept in a separate file to maintain confidentiality according to the provisions set forth regarding personal health information (PHI) under HIPAA and the Americans with Disabilities Act.

Upon request, the organization will provide personnel with a copy of all confidential information being placed in the file.  If personnel make a written request to the Executive Director/Administrator, the personnel may review and make notes regarding information contained within their file under supervision by an authorized employee (i.e. Administrator, Director of Human Resources, etc.).

**PROCEDURE**

1. The content of the personnel files and contracted personnel files shall include:

|  |  |  |
| --- | --- | --- |
| **Documents** | **Organization Personnel** | **Contract Personnel** |
| **Benefit Documents** | | |
| 1. Insurance Entitlement/Declination | X |  |
| 1. Insurance change forms | X |  |
| 1. Beneficiary information | X |  |
| 1. Flexible benefit plan election form | X |  |
| 1. Insurance correspondence | X |  |
| 1. Requests for leaves of absences | X |  |
| 1. Leave of absences correspondence | X |  |
| 1. Paid days off documentation | X |  |
| 1. 401k enrollment/documentation | X |  |
| **General Documents** | | |
| 1. Skills & Experience Inventory | X | X |
| 1. Signed Standards of Conduct | X | X |
| 1. Verified professional licensure or certification | X | X |
| 1. CPR certification (professional personnel) | X | X |
| 1. Continuing education documentation | X | X |

**Policy No. 4-005.2**

|  |  |  |
| --- | --- | --- |
| **Documents** | **Organization Personnel** | **Contract Personnel** |
| **New Hire Documents** | | |
| 1. Evidence of pre-employment interview | X |  |
| 1. Individual job qualifications | X |  |
| 1. Employment application | X | X |
| 1. Resume | X |  |
| 1. References (2) | X | X |
| 1. Acknowledgement of temporary employment (if applicable) |  | X |
| 1. Diploma (copy) or educational transcripts | X |  |
| 1. Specialty practice certification certificates | X |  |
| 1. Verification of education/training | X |  |
| 1. Statement of formal training for non-professionals | X |  |
| 1. Orientation checklist (completed) | X | X |
| 1. Employee Handbook acknowledgement (signed) | X |  |
| 1. Initial competency assessments | X |  |
| 1. Signed Job Description | X | X |
| 1. Conditions of Employment | X |  |
| 1. Signed and dated confidentiality statement | X | X |
| 1. Criminal background check (if applicable – keep in separate file) | X | X |
| 1. National sex offender registry check (if applicable – keep in separate file) | X | X |
| 1. Driver’s license and proof of auto insurance (if applicable) | X | X |
| 1. Completed I-9 form which has been verified by the employer and two (2) forms of acceptable identification (kept in a separate folder) | X | X |
| 1. Malpractice coverage for independent contractors | X | X |
| 1. OIG exclusion list verification (if applicable) | X | X |
| **Compensation Documents** | | |
| 1. State and Federal W-4 | X | X |
| 1. Salary increase profiles | X | X |
| 1. Salary documentation | X | X |
| **Performance Evaluations/Counseling Documents** | | |
| 1. Performance Evaluations (probationary and annual) | X | X |
| 1. Organization personnel performance observation reports (clinical only) | X | X |
| 1. Ongoing competency assessments | X | X |
| 1. Personnel counseling/disciplinary documentation | X | X |
| 1. Personnel performance plans | X | X |
| 1. EEOC/legal claims or correspondence | X | X |
| 1. Training/award certificates | X | X |

**Policy No. 4-005.3**

|  |  |  |
| --- | --- | --- |
| **Documents** | **Organization Personnel** | **Contract Personnel** |
| **Personnel Termination Documents** | | |
| 1. Termination profile | X | X |
| 1. Exit interview summary | X | X |
| 1. Request for transfer | X |  |
| 1. Unemployment separation records | X | X |
| 1. Unemployment claims | X | X |
| **Health Information Documents (Keep in Separate File)** | | |
| 1. Short and long-term disability forms | X |  |
| 1. Workers’ compensation reports and correspondence | X | X |
| 1. TB test documentation | X | X |
| 1. Physician’s statement of health | X | X |
| 1. HBV vaccination/HBV refusal documentation | X | X |
| 1. Results of pre-employment physical |  | X |

**PALLIATIVE CARE On-Call/Weekend Services**

**Policy No. 4-006.1**

**PURPOSE**

To establish the process by which patients have access to palliative care services twenty-four (24) hours per day, seven (7) days a week.

**POLICY**

Patient care needs are the highest priority; therefore, weekend and evening staffing will be scheduled accordingly.  Clinical personnel are expected to perform visits on an as-needed basis, including weekends.

There will be on-call staff available after office hours, Monday through Friday, and twenty-four (24) hours a day on weekends.  Staff on-call will be:

1. Administrative call by a senior management staff member
2. Clinical call by a registered nurse
3. Other interdisciplinary team members, as needed (e.g., social worker, Chaplain)

**PROCEDURE**

1. On admission, the patient will be made aware of the organization’s twenty-four (24) hour availability.
2. The on-call schedule will be developed on a monthly basis by the Clinical Director or designee.
3. The schedule will be forwarded to the answering service and on-call staff.
4. Supplies and records will be available to the on-call staff, through direct access to the office.
5. The on-call nurse will be issued a pager and/or a cellular phone to allow for mobility.
6. The on-call staff can be reached by calling the organization’s number.
7. After hours this number will be forwarded to the answering service.
8. The answering service will pass every patient related call to the on-call nurse.
9. The on-call nurse will provide follow-up appropriate to the call:
   1. Call the patient/family/caregiver
   2. Visit the patient, if necessary
   3. Obtain physician (or other authorized independent practitioner) orders, as needed

**Policy No. 4-006.2**

* 1. Arrange for other services, as needed

1. The on-call nurse will document each patient/family interaction in a clinical note.
2. The on-call nurse will maintain an on-call log of all patient contacts during on-call hours.
3. On-call staff will respond to a page within fifteen(15) minutes and must be able to reach a patient within one (1) hour.  (There may be rare exceptions, depending on how far away the patient lives and if the staff member is with another patient at the time of the page.)
4. Reports will be given to the on-call nurse daily Monday through Friday.
5. The on-call nurse will report his/her evening and/or weekend patient care activities to the Clinical Director.

**ORIENTATION AND ONGOING EDUCATION**

**Policy No. 4-007.1**

**purpose**

To provide guidelines for the orientation and education process to the palliative care program.

**policy**

In addition to the organization orientation, all staff assigned to provide services in the palliative care program will be required to attend a palliative care program specific orientation. Orientation may be provided over a period of time and in a variety of methods, including live and video presentations; electronic or written materials; clinical experience with a preceptor or mentor; or education at a seminar or other organization.

All staff will demonstrate knowledge and proficiency in skills appropriate to their assigned roles and responsibilities during the orientation period. As appropriate, staff can describe or demonstrate their roles and responsibilities relative to patient safety in the home.

**procedure**

1. The orientation plan includes the following areas:
2. The domains of palliative care
3. Assessment and management of pain and other physical symptoms
4. Assessment and management of psychological symptoms and psychiatric diagnoses
5. Communication skills
6. Cross-cultural knowledge and skills
7. Information on specific population(s) served
8. Grief and bereavement
9. Ethical principles that guide provision of palliative care
10. The organization’s process to address concerns and resolve ethical concerns that may occur in the provision of community-based palliative care.
11. Process for handling patients’ or families’ concerns or complaints about the program or their care
12. Community resources for patients and families

**Policy No. 4-007.2**

1. Hospice Care
2. Staff roles and responsibilities relative to patient safety
3. In addition, pediatric specific orientation is provided to interdisciplinary team members, staff and volunteers who provide care to pediatric patients.
4. All staff will be expected to participate in the organization’s annual mandatory training (12 hours).
5. The palliative care team will participate in three (3) additional hours of education determined by a staff needs assessment and/or the patient population needs.
6. Leaders will support participation in ongoing education by scheduling programs at times and places that facilitate access by the staff.

**PALLIATIVE CARE COMPETENCIES**

**Policy No. 4-008.1**

**purpose**

To ensure palliative care services are provided by competent, educated and trained palliative care personnel who have achieved standards of practice consistent with palliative care standards of care.

**policy**

1. Palliative care personnel will be knowledgeable regarding common palliative care clinical activities and demonstrate competence in the standards of palliative care practices. Core competencies in palliative care include:
2. General medicine
3. Pain and symptom management
4. Emotional, psychosocial, spiritual and cultural support
5. Family and community support
6. Honoring patient wishes
7. Death and dying
8. After death interventions
9. Bereavement
10. Communication
11. Education of patient and family/caregiver
12. Interdisciplinary group collaboration

**procedure**

1. Program leaders assess and document each program staff member’s competence to perform job responsibilities **through observation** during orientation and annually thereafter.
2. Competency evaluation will include, but are not limited to:
3. Conducting a family conference and setting goals for the meeting
4. Giving bad news to patients and families

**Policy No. 4-008.2**

1. Discussing DNR and advance directives
2. Discussing hospice referral
3. Discussing a shift in treatment approach from curative to comfort care
4. Discussing treatment withdrawal (e.g., antibiotics, hydration, ventilator)
5. Managing requests for futile treatments
6. Performing a basic pain assessment
7. Using oral and parenteral opioid analgesics
8. Using adjuvant analgesics (e.g., tricyclics, steroids, anticonvulsants)
9. Converting from one opioid to another
10. Assessing and managing delirium, dyspnea, nausea/vomiting, constipation
11. Assessing patient decision–making capacity
12. Managing common opioid side effects (sedation confusion, nausea, constipation)
13. An educational needs assessment is conducted to evaluate palliative care personnel learning needs.
14. The educational needs assessment will reflect the role and responsibilities of each member of the palliative care team.
15. Program leaders identify and respond to the specific learning needs of the interdisciplinary team and program staff including determining education topics and number of hours of continuing education and providing or arranging for needed education.
16. Palliative Care education will align with palliative care standards of care and practice.
17. Educational initiatives will be tailored to the palliative care personnel’s needs, role and responsibilities and are assessed annually or more frequently as needed.
18. Pediatric specific ongoing education is provided to interdisciplinary team members, staff and volunteers who provide care to pediatric patients.
19. Palliative Care personnel will be encouraged to obtain palliative care certification specific to their role and education level.
20. The Palliative Care Program will provide education and training for palliative care personnel and other healthcare personnel.

**Policy No. 4-008.3**

1. The Palliative Care Program will assist staff in obtaining references that are necessary for the patient’s care and self-management and information on community resources that are available to the patient and family.
2. Educational needs that are identified are incorporated into each palliative care team member’s professional development goals.

**ADDENDUM 4-008.A**

**COMPETENCY ASSESSMENT SKILLS CHECKLIST**

***(Sample for the Palliative Care Program)***

*(In addition to the discipline specific organization competency assessment skills checklist, this form is to be utilized for staff who begin providing services in the palliative care program)*

**Key for Evaluation Method**

*(to be determined by organization)***:**

Verbal Test = **V**

Written Test = **W**

Observation = **O**

Demonstration = **D**

Special Training = **ST**

**Competency Assessment Skills Checklist—Palliative Care Program**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Employment/Assignment

to Palliative Care Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

| **Self-Assessment** | | | | **Competency for Palliative Care Personnel** | **Proficiency Required** | **Evaluation**  **Method** | **Competency Validation Indicated by**  **Preceptors Initials and Date** |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Do you have experience with this skill?** | | **Are you competent performing the following:** | |
| **YES** | **NO** | **YES** | **NO** |
|  |  |  |  | **For all Palliative Care Staff (in addition to specific job competency)** |  |  |  |
|  |  |  |  | 1. Demonstrates knowledge of the philosophy and mission of Palliative care |  |  |  |
|  |  |  |  | * + - 1. Mission of Palliative care program |  |  |  |
|  |  |  |  | * + - 1. Domains of Palliative care |  |  |  |
|  |  |  |  | * + - 1. Standards of Palliative care |  |  |  |
|  |  |  |  | 1. Demonstrates knowledge of the Palliative Care Program Processes |  |  |  |
|  |  |  |  | * + - 1. Patient rights |  |  |  |
|  |  |  |  | * + - 1. Services available |  |  |  |
|  |  |  |  | * + - 1. Participation requirements |  |  |  |
|  |  |  |  | * + - 1. Reimbursement |  |  |  |
|  |  |  |  | * + - 1. Participation in the interdisciplinary group |  |  |  |
|  |  |  |  | 1. Exhibits ability to conduct/support patient family communication including |  |  |  |
|  |  |  |  | * + - 1. Conducting a family conference & setting goals for the meeting |  |  |  |
|  |  |  |  | * + - 1. Giving bad news to patients and families |  |  |  |
|  |  |  |  | * + - 1. Discussing DNR and advance directives |  |  |  |
|  |  |  |  | * + - 1. Discussing home/hospice referral |  |  |  |
|  |  |  |  | * + - 1. Discussing a shift in treatment approach from curative to comfort care |  |  |  |
|  |  |  |  | * + - 1. Discussing treatment withdrawal (e.g., antibiotics, hydration, ventilator) |  |  |  |
|  |  |  |  | * + - 1. Managing requests for futile treatments |  |  |  |
|  |  |  |  | 1. Demonstrates ability to perform a basic pain assessment | \* |  |  |
|  |  |  |  | 1. Adheres to Documentation Requirements |  |  |  |
|  |  |  |  | * + - 1. Medicare guidelines for documentation |  |  |  |
|  |  |  |  | * + - 1. Corrections to the medical record |  |  |  |
|  |  |  |  | * + - 1. Accident/incident reports |  |  |  |
|  |  |  |  | * + - 1. Clinical notes, flow charts |  |  |  |
|  |  |  |  | **For Palliative Care Clinical Staff (in addition to specific clinical competency)** |  |  |  |
|  |  |  |  | * 1. Demonstrates ability to process paperwork and associated functions necessary to facilitate: |  |  |  |
|  |  |  |  | * + - 1. Admission to organization |  |  |  |
|  |  |  |  | * + - * 1. Initiates palliative care assessment form |  |  |  |
|  |  |  |  | * + - * 1. Initiates palliative care plan based on assessment |  |  |  |
|  |  |  |  | * + - * 1. Knowledge of nursing process |  |  |  |
|  |  |  |  | * + - * 1. Health history/physical exam |  |  |  |
|  |  |  |  | * + - * 1. Development of problem list and care planning |  |  |  |
|  |  |  |  | * + - * 1. Conducts complete initial evaluation |  |  |  |
|  |  |  |  | * + - * 1. Assessing patient decision–making capacity |  |  |  |
|  |  |  |  | 1. Using oral and parenteral opioid analgesics |  |  |  |
|  |  |  |  | * + - 1. Using adjuvant analgesics (e.g., tricyclics, steroids, anticonvulsants) |  |  |  |
|  |  |  |  | * + - 1. Converting from one opioid to another |  |  |  |
|  |  |  |  | * + - 1. Assessing and managing delirium, dyspnea, nausea/vomiting, constipation |  |  |  |
|  |  |  |  | * + - 1. Assessing patient decision–making capacity |  |  |  |
|  |  |  |  | * + - 1. Managing common opioid side effects (sedation confusion, nausea, constipation) |  |  |  |
|  |  |  |  | 1. Demonstrates knowledge of concepts of death and dying |  |  |  |
|  |  |  |  | * + - 1. Normal vs. abnormal |  |  |  |
|  |  |  |  | * + - 1. Cultural attitudes toward death |  |  |  |
|  |  |  |  | * + - 1. Values of patient/family |  |  |  |
|  |  |  |  | * + - 1. Denial and coping mechanisms |  |  |  |
|  |  |  |  | * + - 1. Grief and family, children and others |  |  |  |
|  |  |  |  | * + - 1. Anticipatory grief |  |  |  |
|  |  |  |  | 1. Demonstrates knowledge of hospice services and appropriate referrals |  |  |  |
|  |  |  |  | * 1. Completes discipline specific competency assessment for technical skills | \* |  |  |

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Preceptor(s) Date

**JOB DESCRIPTIONS**

**Job Title/Position:** *Palliative Care Nurse Practitioner*

**Reports To:** *Clinical Director*

**Job Description Summary**

The Palliative Care Nurse Practitioner is a registered professional nurse with advanced graduate education and clinical training who provides comprehensive home care services in compliance with the state Nurse Practice Act. He/She provides palliative care through the evaluation and assessment of the health history, health promotion, diagnosing medical conditions, management of health problems by directing and developing the plan of care, prescribing medications or treatments, coordinating and collaborating with patients, families and other healthcare practitioners. Under the supervision of a physician, the nurse practitioner visits patients, completes physical assessments, performs face to face assessments, as appropriate, and begins the development of the palliative care plan of care in consultation with the palliative care interdisciplinary team. The nurse practitioner builds from the resources of the community to plan and direct services to meet the need of individuals and families within their homes and communities.

**Essential Job Functions/Responsibilities**

***Patient Care***

1. Provides medical care, palliates and manages terminal illness in compliance with the state Nurse Practice Act.
2. Completes history and physical examinations, by evaluating the patient's medical condition and health history, ordering and interpreting results from laboratory and diagnostic tests or procedures, diagnosing health conditions and documents the findings in the patient's medical record.
3. Manages acute and chronic health conditions and terminal illnesses by developing an individualized plan of care, prescribing medications (to the extent permitted by licensure) and or treatments, obtaining consultations or making referrals and coordinating hospice care services.
4. Reviews clinical information, coordinates and oversees patient care in consultation with the palliative care interdisciplinary team and other healthcare practitioners.
5. Assures that patient receives appropriate measures to control symptoms through collaboration with interdisciplinary team members.
6. Reviews and develops protocols for treatment and proposes options for interventions based on the current medical literature.
7. Consults the collaborating physician or organizational leadership when the patient's plan of care is outside standardized practice and protocols.

**Job Title/Position:** *Palliative Care Nurse Practitioner*

***Communication***

1. Communicates and collaborates with the interdisciplinary group to create, review and revise the patient's plan of care.
2. Consults with the patient's attending physician, the palliative care Physician and other healthcare practitioners regarding the ongoing care needs and medical management related to the patient's life-limiting illness, condition or injury.
3. Communicates with other community health practitioners to coordinate the plan of care.
4. Attends and participates in palliative care interdisciplinary group meetings.
5. Completes, maintains and submits accurate and relevant clinical notes, physical examination notes, assessment visit notes, medical orders, collaboration notes and other documentation in the medical record.
6. Educates/counsels patients, families, and/or caregivers as to preventative care, medical problems, psychological problems, and spiritual problems in conjunction with the interdisciplinary team to meet the total needs of patients.
7. Provides and maintains a safe environment for the patient.
8. Assists the patient and family/caregiver and other team members in providing continuity of care.
9. Provides information and education about advance care planning to the patient and family as appropriate.
10. Works in cooperation with the family/caregiver and palliative interdisciplinary group to identify the goals of care and meet the care needs of the patient and family/caregiver.
11. Serves as a nursing resource for consultation and educations to members of the interdisciplinary team and other healthcare practitioners in the community.
12. Establishes, builds and nurtures relationships with staff and community referral sources to facilitate program growth.

***Additional Duties***

1. Maintains knowledge of and compliance with current Medicare/Medicaid, state/federal rules and regulations for palliative care services.
2. Ensures compliance with the Medicare conditions of participation and other state regulations govern the provision of healthcare.
3. Complies with all Health Insurance Portability and Accountability Act (HIPAA) requirements in accordance with federal, state and organizational policies.

**Job Title/Position:** *Palliative Care Nurse Practitioner*

1. Participates in organizational monitoring of the quality of medical services and quality improvement initiatives.
2. Assumes responsibility for personal growth. Develops, maintains and upgrades professional knowledge and practice skills through attendance at seminars, conferences and participation in continuing education and in-service classes.
3. Fulfills the obligation of requested and/or accepted assignments.
4. Demonstrate knowledge in communication and counseling patient/family in dealing with end-of-life issues.

**Position Qualifications**

1. Graduation from an accredited School of Nursing and accredited Nurse Practitioner Program.
2. Current nursing licensure in State and CPR certification, as required by organizational policy.
3. Master's degree with a minimum of one (1) year Nurse Practitioner experience who has training in palliative care and/or hospice care; clinical experience in hospice or palliative care; or one who has, or is eligible for, palliative care certification.
4. Pediatrics: Must have experience and/or training in the developmental stages and needs of infants, children and adolescents.
5. Accreditation from an approved certifying body for advanced practice nursing as required by State.
6. Certification in a specialist area preferred; (e.g. Hospice and Palliative Nursing (CHPN), Pediatrics or Geriatrics).
7. Excellent observation, verbal and written communication skill, problem solving skills, mathematical skills; nursing skills per competency checklist.
8. Prolonged or considerable walking or standing. Able to lift, position and/or transfer patients. Able to lift supplies and equipment. Considerable reaching, stooping, bending, kneeling and/or crouching. Visual acuity and hearing to perform required nursing skills.
9. Must be a licensed driver with an automobile that is insured in accordance with state/or organization requirements and is in good working order.

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**Job Title/Position:** *Palliative Care Registered Nurse*

**Reports To:** *Clinical Supervisor*

**Job Description Summary**

The registered nurse plans, organizes and directs palliative care and is experienced in nursing, with emphasis on community health education/experience. The professional nurse builds from the resources of the community to plan and direct services to meet the needs of individual and families within their homes and communities. The registered nurse will act as Case Manager/Care Coordinator for palliative care patients.

**Essential Job Functions/Responsibilities**

***Patient Care***

1. Completes a comprehensive initial and ongoing assessments of patient and family to determine palliative care needs. Provides a complete physical assessment and history of current and previous illness(es).
2. Provides professional nursing care by utilizing all elements of nursing process.
3. Assesses and evaluates patient’s status by:
   1. Writing and initiating plan of care
   2. Regularly re-evaluating patient and family/caregiver needs
   3. Participating in revising the plan of care in collaboration with the interdisciplinary team as necessary
4. Uses health assessment data to determine nursing diagnosis.
5. Develops a care plan that establishes goals, based on nursing diagnosis and incorporates palliative nursing actions. Includes the patient and the family in the planning process.
6. Initiates appropriate preventive and rehabilitative nursing procedures. Administers medications and treatments as prescribed by the ordering physician or Palliative Nurse Practitioner.
7. Counsels the patient and family in meeting nursing and related needs.
8. Provides information and education about advance care planning to the patient and family as appropriate.
9. Provides health care instructions to the patient as appropriate per assessment and plan.
10. Assists the patient with the activities of daily living and facilitates the patient’s efforts toward self-sufficiency and optional comfort care.

**Job Title/Position:** *Palliative Care Registered Nurse*

1. Acts as Case Manager/Care Coordinator as assigned by Clinical Supervisor and assumes responsibility to coordinate patient care for assigned caseload.

***Communication***

1. Completes, maintains and submits accurate and relevant clinical notes regarding patient’s condition and care given. Records pain/symptom management changes/outcomes as appropriate.
2. Communicates with the physician and interdisciplinary team regarding the patient’s needs and reports changes in the patient’s condition; obtains/receives orders as required.
3. Communicates with community health related persons to coordinate the care plan.
4. Teaches the patient and family/caregiver regarding disease process(es), self-care techniques and processes for addressing ethical issues, as appropriate. Provides medication, diet and other instructions and recognizes and utilizes opportunities for health counseling with patients and families/caregivers. Works in concert with the interdisciplinary group.
5. Provides and maintains a safe environment for the patient.
6. Assists the patient and family/caregiver and other team members in providing continuity of care.
7. Works in cooperation with the family/caregiver and Palliative Interdisciplinary Group Members to meet the emotional and spiritual needs of the patient and family/caregiver.
8. Attends interdisciplinary group meetings.

***Additional Duties***

1. Participates in on-call duties as defined by the on-call policy.
2. Ensures that arrangements for equipment and other necessary items and services   
   are available.
3. Supervises ancillary personnel and delegates responsibilities when required.
4. Assumes responsibility for personal growth and development and maintains and upgrades professional knowledge and practice skills through attendance and participation in continuing education and inservice classes.
5. Fulfills the obligation of requested and/or accepted case assignments.
6. Actively participates in quality assessment performance improvement teams and activities.

**Job Title/Position**:*Palliative Care Registered Nurse*

**Position Qualifications**

1. Registered nurse with current licensure to practice professional nursing in the state.
2. Graduate of National League for Nursing accredited school of nursing.
3. Maintains a current CPR certification as required by organizational policy.
4. Must be a licensed driver with an automobile that is insured in accordance with state or organization requirements and is in good working order.
5. Minimum of two years’ experience, at least one of which is in the area of public health, home care, palliative care or hospice nursing; has training in palliative care and/or hospice care or has, or is eligible for, palliative care certification.
6. Pediatrics: Must have experience and/or training in the developmental stages and needs of infants, children and adolescents.
7. Self-directed and able to work with minimal supervision.
8. Management experience not required. Responsible for supervising home care aides.
9. Demonstrates excellent observation, problem solving, verbal and written communications; nursing skills per competency checklist.
10. Shows ability to organize and prioritize workload independently.
11. Prolonged or considerable walking or standing. Able to lift, position, and/or transfer patients. Able to lift supplies and equipment. Considerable reaching, stooping, bending, kneeling, and/or crouching. Visual acuity and hearing to perform required nursing skills.

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**Job Title/Position****:** *Palliative Care Licensed Practical/Vocational Nurse*

**Reports To:** *Clinical Supervisor*

**Supervised By:** *Palliative Care Registered Nurse*

**Job Description Summary**

The Licensed Practical/Vocational Nurse is responsible for providing direct patient care under the supervision of the palliative care registered nurse. Responsibilities include following the interdisciplinary plan of care, providing treatments, and working collaboratively with the members of the team to help meet patient palliative care outcomes.

**Essential Job Functions/Responsibilities**

1. Provides direct patient care as defined in State Nurse Practice Act.
2. Implements current nursing practice following a comprehensive assessment and the plan of care.
3. Provide accurate and timely documentation of patient services to reflect the plan of care.
4. Assess and provide patient and family/caregiver education and information pertinent to diagnosis and self-plan of care.
5. Participates in coordination of palliative care services, appropriately reporting the identified needs to the interdisciplinary group.
6. Uses equipment and supplies effectively and efficiently.
7. Provides appropriate pain/symptom management. Evaluates patient’s response to treatments/medications.
8. Participates in personal, professional growth and development. Also participates in quality assessment performance improvement teams and activities.
9. Performs other duties as assigned by the palliative care registered nurse.

The above statements are intended to be a representative summary of the major duties and responsibilities performed by incumbents of this job. The incumbents may be requested to perform job-related tasks other than those stated in this description.

**Job Title/Position:** *Licensed Practical/Vocational Nurse*

**Position Qualifications**

1. Graduate of an accredited practical nurse or vocational nursing program.
2. Three years nursing experience. Community health/hospice or medical/surgical and palliative care experience is preferred. Pediatrics: Must have experience and/or training in the developmental stages and needs of infants, children and adolescents.
3. Currently licensed as an LPN/LVN in the State.
4. Complies with accepted professional standards and practice.
5. Demonstrates good verbal and written communication, and organization skills.
6. Must be a licensed driver with an automobile that is insured in accordance with state and/or organization requirements and is in good working order.
7. Excellent observation, verbal and written communication skill, problem solving skills, mathematical skills; nursing skills per competency checklist.
8. Prolonged or considerable walking or standing. Able to lift, position and/or transfer patients. Able to lift supplies and equipment. Considerable reaching, stooping, bending, kneeling and/or crouching. Visual acuity and hearing to perform required nursing skills.
9. Possesses and maintains current CPR certification as required by organizational policy.
10. Understands philosophy of palliative. Also understands needs of the terminally ill.

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**Job Title/Position:** *Palliative Care Medical Social Worker*

**Reports To:** *Clinical Supervisor or Masters of Social Work*

**Job Description Summary**

The palliative care medical social worker contracted or employed through the organization is responsible for the implementation of standards of care for medical social work services.

**Essential Job Functions/Responsibilities**

1. Assesses the psychosocial status of patients and families/caregivers related to the patient's life-limiting illness and environment and communicates findings to the palliative care registered nurse and other members of the interdisciplinary group. Provides an assessment in the patient's identified residence and assistance when this is not safe and another plan is required.
2. Carries out social evaluations and plans intervention based on evaluation findings. Counsels patient and family/caregivers as needed in relationship to stress, and other identified coping difficulties.
3. Provides information and education about advance care planning to the patient and family as appropriate.
4. Maintains clinical records on all patients referred to social work.
5. Provides information and referral services for organization patients and families/caregivers regarding practical and environmental needs.
6. Provides information to patients and families/caregivers and community agencies.
7. Serves as liaison between patients and families/caregivers and community agencies.
8. Maintains collaborative relationships with organization personnel to support palliative patient care.
9. Maintains and develops contacts with public and private agencies as resources for patient and personnel.
10. Participates in the development of the individualized plan of care and attends regularly scheduled interdisciplinary group meetings.
11. Assists physician and other team members in understanding significant social and emotion­al factors related to chronic health problems and death/dying issues.
12. Actively participates in quality assessment performance improvement teams and activities.
13. Other duties as delegated by the Clinical Supervisor.

**Job Title/Position:** *Palliative Care Medical Social Worker*

The above statements are only meant to be a representative summary of the major duties and responsibilities performed by incumbents of this job. The incumbents may be requested to perform job related tasks other than those stated in this description.

**Position Qualifications**

1. A graduate of a bachelor’s program in social work accredited by the Council on   
   Social Work Education.
2. Minimum of one year's experience in health care, home care, hospice or palliative care experience preferred. Understands palliative care philosophy, and issues of chronic illness and death/dying.
3. Pediatrics: Must have experience and/or training in the developmental stages and needs of pediatric patients. Understands the unique psychosocial needs of pediatric patients and their caregivers.
4. Has training in palliative care and/or hospice care; experience in hospice or palliative care; or has, or is eligible for, palliative care certification.
5. Experience in palliative care or hospice preferred.
6. Demonstrates good verbal and written communication, and organization skills.
7. Possesses and maintains current CPR Certification as required by organizational policy.
8. Must be a licensed driver with an automobile that is insured in accordance with state or organization requirements and is in good working order.

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**Job Title/Position:** *Palliative Care Chaplain/Spiritual Counselor*

**Reports To:** *Clinical Director*

**Job Description Summary**

The Chaplain/Spiritual Counselor is responsible for the provision of pastoral care services to patients and families/caregivers of Organization’s Name, either directly or through coordination of care with other spiritual counselors.

**Essential Job Functions/Responsibilities**

1. Assures spiritual assessment of patients and families/caregivers in the palliative care program and appropriate services are rendered in a timely manner.
2. Participates in the development of the individualized plan of care by participating in the comprehensive assessment to meet identified spiritual needs.
3. Provides direct spiritual care to patients and families/caregivers.
4. Serves as liaison and support to community chaplains and spiritual counselors.
5. Maintains records of spiritual care services utilization and related activities for quality assurance, program development, and policies and procedures review and revision.
6. Documents direct services and ongoing communication with community chaplains and spiritual counselors.
7. Attends patient care conference and interdisciplinary group meetings as a member of the interdisciplinary group.
8. Recruits community chaplains, spiritual counselors, and spiritual care volunteers adequate to meet patient and family/caregiver needs by developing community contacts and offering education through congregations about palliative care.
9. Actively participates in quality assessment performance improvement teams and activities.
10. Provides for funeral or memorial services for patients as requested.
11. Plans periodic memorial services to meet the needs of personnel, volunteers, and community clergy/spiritual counselors working with the palliative care team.
12. Accepts and performs other related duties and responsibilities as required.

**Job Title/Position:** *Palliative Care Chaplain/Spiritual Counselor*

**Position Qualifications**

1. Graduate of accredited seminary or school of theology (BD, M.Div. or equivalent theological degree) who has training in palliative care and/or hospice care OR has experience in hospice or palliative care OR has or is eligible for board certification

OR

1. A spiritual care professional who has training in palliative care and/or hospice care or experience in hospice or palliative care including a parish nurse.
2. Pediatrics: Must have experience and/or training regarding the unique spiritual needs of pediatric patients and parents
3. Ability to work as member of interdisciplinary group.
4. Comfort in an interfaith setting.
5. Ability to accept different lifestyles, cultures, beliefs, and values.
6. Ability to network with community clergy and congregations.
7. Knowledge of and commitment to the palliative care philosophy.
8. Must be a licensed driver with an automobile that is insured in accordance with state or organization requirements and is in good working order.
9. Hospice experience preferred.

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**Job Title/Position:***Palliative Care Physician*

**Reports To:** *CEO/Executive Director/Administrator or Chief Clinical Officer (CCO)*

**Job Description Summary**

The Palliative Care Physician will have overall responsibility for the medical component of the palliative care program in collaboration of the patient’s attending physician and the Palliative Care Nurse Practitioner.

The Palliative Care Physician will provide oversight of physician services by complementing the attending physician care, acting as a medical resource to the interdisciplinary group, assuring continuity of medical services, and assuring appropriate measures to control patient symptoms. The Palliative Care Physician will promote and represent the program to physicians, physician groups, discharge planners, other referral sources, community health organizations, and potential donors, as appropriate.

**Essential Job Functions/Responsibilities**

The duties and responsibilities of the Palliative Care Physician will include, but not be limited to, the following:

1. Collaborate with the attending physician to determine the palliative care needs of the patient
2. Determine goals of care with the patient and family/caregiver
3. Perform a clinical assessment and determine palliative needs related to:
   1. Pain and symptom management
   2. Functional status
   3. Nutritional Status
   4. Psychosocial needs
   5. Spiritual needs
   6. Other care needs
4. Discuss findings with the interdisciplinary group and create an individualized plan of care for the patient
5. Address the patients palliative care needs
6. Monitor the patients progress towards goals and effectiveness of treatment
7. Make referrals for care and services as needed

**Job Title/Position:***Palliative Care Physician*

1. Consultation services may be provided to patients and family/caregiver, physicians and other providers regarding recommendations for palliation of symptoms as needed.
2. Work closely with the members of the interdisciplinary group and oversee the care provided to patients enrolled in the palliative care program
3. Facilitate discussion and clarification of patient and family goals of care and communicate these goals to the interdisciplinary group and other healthcare personnel
4. Facilitate access to appropriate supportive care services as needed
5. Educate patients, family, peers, members of the interdisciplinary group and other healthcare personnel regarding Palliative Care services
6. Participate in meetings to discuss and plan patient care
7. Assist in the development and implementation of standards of care
8. Adhere to standard palliative care practices

The above statements are intended to be a representative summary of the major duties and responsibilities performed by incumbents of this job. The incumbents may be requested to perform job-related tasks other than those stated in this description.

**Position Qualifications**

1. Licensed as a Doctor of Medicine or Osteopathy in the state without restriction or subject to any disciplinary or corrective action.
2. Has specialized training in palliative care and/or hospice care; clinical experience in palliative medicine and/or hospice care; or is board-certified or board eligible for certification in Hospice and Palliative Medicine.
3. Maintains controlled substances registration with state and federal authorities.
4. Pediatrics: Has experience and/or training in the developmental stages of pediatric patients.
5. Participates in ongoing medical education activities related to the medical care of home health/hospice and palliative care patients.
6. Not excluded from participating in the Medicare program.

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| **CHAP**  **STANDARD** | **POLICY/PROCEDURE** | **POLICY #** |
| PCAC.1 | Admission Process | 2-002 |
| PCAC.1 | Initial Assessment | 2-004 |
| PCAC.1 | Pediatric Assessment | 2-005 |
| PCAC.1 | Plan of Care | 2-008 |
| PCAC.1 | Interdisciplinary Palliative Care | 2-009 |
| PCAC.1 | Coordination and Continuity of Care | 2-018 |
| PCAC.2 | Interdisciplinary Palliative Care | 2-009 |
| PCAC.3 | Admission Process | 2-002 |
| PCAC.4 | Admission Process | 2-002 |
| PCAC.5 | Referral Process | 2-001 |
| PCAC.6 | Admission Process | 2-002 |
| PCAC.6 | Initial Assessment | 2-004 |
| PCAC.6 | Pediatric Assessment | 2-005 |
| PCAC.7 | Initial Assessment | 2-004 |
| PCAC.7 | Comprehensive Assessment | 2-006 |
| PCAC.8 | Initial Assessment | 2-004 |
| PCAC.9 | Initial Assessment | 2-004 |
| PCAC.9 | Pediatric Assessment | 2-005 |
| PCAC.10 | Initial Assessment | 2-004 |
| PCAC.10 | Pediatric Assessment | 2-005 |
| PCAC.11 | Comprehensive Assessment | 2-006 |
| PCAC.12 | Plan of Care | 2-008 |
| PCAC.13 | Plan of Care | 2-008 |
| PCAC.14 | Coordination and Continuity of Care | 2-018 |
| PCAC.15 | Patient Education | 2-016 |
| PCAC.15 | Coordination and Continuity of Care | 2-018 |
| PCIC.1 | Patient Education | 2-016 |
| PCIC.1 | Infection Control Plan | 3-008 |
| PCIC.1 | Tuberculosis | 3-009 |
| PCIC.1 | Bloodborne Pathogens and Hepatitis B Exposure Control Plan | 3-010 |
| PCIC.1 | Management of Exposures in Personnel | 3-011 |
| PCIC.1 | Occupational Exposure Information and Training | 3-012 |
| PCIC.1 | Standard Precautions | 3-013 |
| PCIC.1 | Personal Protective Equipment | 3-014 |
| PCIC.1 | Hand Hygiene | 3-015 |
| PCIC.1 | Bag Technique | 3-016 |
| PCIC.1 | Improving Operational Performance | 3-017 |
| PCIC.2 | Standard Precautions | 3-013 |
| PCIC.2 | Personal Protective Equipment | 3-014 |
| PCIC.2 | Hand Hygiene | 3-015 |
| PCIC.2 | Bag Technique | 3-016 |
| PCIC.2 | Improving Operational Performance | 3-017 |
| PCIC.3 | Bag Technique | 3-016 |
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**CROSSWALK**

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