### PURPOSE

To ensure that an individualized plan of care that is developed, reviewed and revised, complies with accepted standards of care and regulatory issues.

### Policy

A written individualized patient and family/caregiver plan of care is be established and maintained for everyone admitted to the hospice program. The care provided to the patient must be in accordance with the plan of care. The plan of care will meet the documentation requirements of the physician-directed medical orders and the care planning process. The plan of care will be based on the initial, comprehensive and ongoing comprehensive assessments performed by members of the interdisciplinary group. This plan will focus on identified problems, measurable goals and outcomes for planned interventions. The patient and family/caregiver will be encouraged to participate in the development of and continued updating of the plan of care. This plan of care will be initiated at start of care.

The patient’s plan is established by the attending physician, the medical director or physician designee and the interdisciplinary group (IDG) in collaboration with the patient and family/caregiver.

### PRocEDURE

### The admitting registered nurse will complete the initial assessment and will initiate the development of the plan of care after the consent forms are signed.

1. The admitting registered nurse will then communicate to the attending physician, medical director and IDG the initial assessment findings and the identification of patient needs and the recommended services to meet those needs. The plan of care will be reviewed prior to care delivery.
2. Orders for the start of care will be received by the admitting hospice registered nurse from the attending physician and documented on the plan of care.
3. The plan of care will identify the patient’s needs and other services to meet those need.
4. The registered nurse coordinates the implementation of the plan of care and ensures the following:
   1. Initial assessment of the patient/family with identification of risks and interventions
   2. Implementation of the plan of care with a focus on palliative care
   3. Referrals and follow-up
   4. Care coordination and case management
   5. Recommends modifications to the plan of care to the IDG based on patient/family/caregiver response and ability to respond to hospice care and services
   6. Facilitates implementation of another level of hospice care if/when necessary
   7. Utilization review
   8. Assessment of risks associated with grieving/loss
   9. Coordinates communication between hospice and other care professionals
   10. Identifying obstacles and solutions for access of care issues.
   11. A level care for services is required
   12. Developing, reviewing and modifying plans of care, considering
       1. Changes in patient’s condition
       2. Social, cultural and physical environments that may present obstacles to effective interventions
       3. Any special needs of the patient
       4. Evaluating current services for effectiveness
       5. Evaluating the appropriateness of re-certification based on identified criteria and progression of end-stage disease
       6. Planning for transfer, based on review of clinical data and patient/family choice, if change in level of care becomes necessary
       7. Evaluating patient/family progress toward achievement of expected outcomes, and revising goals and objectives as needed
       8. Evaluating pharmacotherapeutic effectiveness of symptom management outcomes including pharmacodynamics, pharmacokinetics and pharmacotherapies
       9. Integration of alternative therapies into medical regime to assist in effectiveness
       10. Determining need for, and coordinating bereavement services for family members
       11. Monitoring changes that may contribute to risk for pathological grief
       12. Reviewing discharge of the patient/family to ensure appropriateness of care
       13. Reviewing deaths to retrieve information required to address bereavement needs
       14. Assessing grievances and issues of ethical concern
       15. Assistance with transfer and/or revocation of benefit.
5. The individualized plan of care will be reviewed by the interdisciplinary group within two (2) days of start of care. The plan of care will be provided to both the attending physician and the Hospice Medical Director for approval of orders and certification of the terminal illness signatures. The Hospice Medical Director will review the patient’s history and physical and sign the certification of terminal illness section of the plan of care. The Hospice Medical Director will prepare a narrative summarizing of the patient’s terminal illness and eligibility.
6. Each patient will be monitored for his/her response to care or services provided against established patient goals and patient outcomes to evaluate progress toward goals.
7. Care decisions and services to be provided will be made based on the care planning process, analysis of initial and ongoing comprehensive assessments, and analysis of patient response to care against goals and outcomes.
8. The plan of care will be reviewed and revised as frequently as deemed necessary, but not less often than every 15 days, by the interdisciplinary group, medical director, with input from the attending physician, the patient, and the family/caregiver and based on ongoing

comprehensive assessments of the patient and family/caregiver. Review of the plan of care will be documented in the clinical record. Revision dates will be noted on the plan of care.

1. The clinical record or minutes of the IDG document that the plan of care was reviewed and updated and that effective discussion, reporting and coordination of patient/family care occurred.
2. The patient and family/caregiver will receive instructions regarding treatments or aspects of care that will be the responsibility of the patient and family/caregiver to provide or follow through with.
   1. The nurse will assist the family with understanding changes in the patient’s status related to the progression of end-stage disease and will evaluate caregiver routines
3. The written plan of care will contain, but will not be limited to, the following:
   1. Diagnosis
   2. Identification of patient and family/caregiver needs, including physical, psychosocial, cognitive, cultural, spiritual, nutritional, functional, educational, and counseling.
   3. Reduction in risk factors
   4. Functional limitations
   5. Mental status
   6. Safety measures to protect against abuse, injury, infection, or communicable disease, as appropriate
   7. Nutritional requirements
   8. Prognosis
   9. Symptom management and pain control/relief
   10. DME and medical supplies necessary to meet patient needs
   11. Frequency of services
   12. Placement at the appropriate level of care and referrals as needed for counseling, additional disciplines, volunteers, adjunctive services, victims of abuse/neglect/exploitation
   13. Individualized interventions to assist with end-of-life care
   14. Patient and family/caregiver educational needs and assessment of their ability to learn and understand teaching, their ability to safely self-administer drugs and biologicals and their ability to provide care
   15. Statement of treatment goals
   16. Interdisciplinary group assessment of needs
   17. Pain and symptom management interventions
   18. Drugs and treatments
   19. Allergies
   20. Physician-directed instruction to patient and family/caregiver
   21. Physician orders
   22. Measurable outcomes anticipated from implementing and coordinating the plan of care.
   23. Patient or representative’s level of understanding, involvement and agreement with the plan of care
4. All appropriate hospice staff will have access to the plan of care.