Northwell Health
Hospice Care Network

Policies and Procedures

TITLE: Incidents		**Policy Number: EC-08**
Chapter: Environment of Care		
Effective: 04/96	**Revised: 07/17**	**Reviewed: 05/21**

POLICY STATEMENT: Any event that deviates from accepted practice or is potentially harmful and/or has resulted in harm to a hospice patient, family member, employee, volunteer, visitor, or the property of any of those stated, is reported and investigated to determine the appropriate corrective action and response. Any event includes instances of inappropriate behavior and workplace violence.

PRACTICE/PROCEDURES/IMPLEMENTATION:

1. Hospice Care Network (HCN) implements a system for the confidential reporting, tracking and documentation of unanticipated, unintended or undesirable incidents involving staff and patients/caregivers that result in injury or death and/or that jeopardize safety within the environment of care.

2. Any staff member who is involved in, witnesses or discovers any event that is not consistent with routine operations and/or has resulted in or has the potential to result in injury or harm is required to complete a written incident report. (See Appendix A: Patient Incident Report and Appendix B: Staff Incident Report). The staff member is to immediately submit the completed document to their manager.

3. Reportable incidents may be characterized as follows:
    - Incidents/events/accidents that are unanticipated, unintended or undesirable that result in harm, injury or death;
    - Incidents/events/accidents that are inconsistent with routine agency operations;
    - Incidents/events/accidents that are inconsistent with standards of professional practice and/or HCN policy in the provision of care, treatment and services, and
    - Verbal or written complaints received by HCN. (See Appendix C: HCN Complaint Form.")

4. Examples of reportable incidents include, but are not limited to:
    a. Adverse outcomes;
    b. Damage to patient, family or hospice property;
    c. Employee, volunteer, patient or family injury or endangerment including falls;
    d. Equipment malfunction or failure;
    e. Suicide attempts or ideation;
    f. Automobile accidents;
    g. Alleged thefts;

h. Fires;
i. Problems related to the safe use and handling of narcotics;
j. Care provided outside the scope of a staff member's practice;
k. Violations of privacy and/or security policies and procedures;
l. Theft of property (grand larceny);
m. Theft of service (fraud);
n. Breaches of confidentiality;
o. Breaches of civil rights;
p. Acceptance of monetary incentives (bribes/kickbacks);
q. Medication issues;
r. Patient/Family/Caregiver report of missing medications;
s. Falls resulting in life-threatening injury or death;
t. Physical abuse;
u. Sexual harassment;
v. Inappropriate, hostile, intimidating and disruptive behaviors and language*; and
w. Workplace violence*. (*see Policy HR- 03: Workplace Violence).

*Anyone reporting instances of violence in the workplace and/or inappropriate behaviors is free from discrimination or reprisal.

Professional judgment is used when making decisions to report any incident beyond those listed in this policy.

Patient Falls – Upon receipt of information that a patient has fallen, ascertain if the patient has any sign or symptoms of injury and a nursing visit will be made by the nurse within 24 hours for an assessment. Notification of physician regarding fall and instruction on falls prevention will be documented in the patient's EMR.

5. The reporting employee's manager/designee is responsible for immediate follow-up and corrective action as appropriate to the incident.

6. If the incident involves a HCN employee/volunteer, within 24 hrs, a verbal and/or written incident report is submitted to the Human Resources Department/Volunteer Department for appropriate follow-up.

7. The incident report must be accurately completed as soon as feasible and submitted to the Quality Assessment/Performance Improvement (QAPI) Department for patient incidents and to the Human Resources/Volunteer Department for employees/volunteer incidents; a copy of which is provided to the QAPI Dept.

8. Documentation of all follow-up and corrective action is completed, submitted, and maintained by the QAPI Department.

9. Patient incidents are appropriately documented in the EMR.

10. All reportable incidents will be submitted to the appropriate agencies.

11. Documentation of privacy or security incidents is maintained by the HIPAA Privacy/Security Officer and maintained for six years from the date of the incident.

12. The QAPI Department tracks and trends all reports of incidents/accidents in order to analyze their causes, implement preventative actions and mechanisms that include feedback and learning throughout HCN.

13. Incident report/accident analysis considers the following:

    a. **Type of Accident**: the manner of contact with object or substance resulting in injury. Examples: striking against, struck by, caught in, caught on, caught between, fall (on same level), fall (to different level), slip (not a fall), exposure to temperature extremes, inhalation/ingestion of harmful substances, contact with electrical current, etc.
    b. **Agency**: objects or substances most closely associated with injury. Examples: Hoyer lifts, wheelchairs, walkers, stairs, floors, beds, oxygen tanks/tubing, medications, etc.
    c. **Injury**: result of the accident Examples: fractures, strains, lacerations, etc.
    d. **Cause or Unsafe Act**: violation of standards of practice or safe procedures resulting in the type of accident identified. Examples: failure to use bed side rails, failure to secure/safely store and position tubing and equipment, failure to properly instruct/supervise in safe use of equipment, failure to lock wheelchair prior to transfers, failure to perform medication reconciliation, failure to accurately pre-pour medications, etc.
    e. **Unsafe Mechanical/Physical Condition:** a condition in the work environment of the agency that could have been corrected or modified to prevent the accident. Examples: broken/non-functioning bedside rails, broken/non-functioning locks on wheelchairs, cluttered/obstructed walkways, etc.

14. The QAPI Department prepares a quarterly summary of the analysis of incidents and reports the findings at the QAPI Committee quarterly meetings.

Northwell Health
Hospice Care Network

Policies and Procedures

TITLE: Management of Patient Complaints and Grievances **Policy Number: RC-01**

Chapter: Record of Care, Treatment and Services

Effective: 03/08 **Revised: 05/2020** **Reviewed: 06/19**

GENERAL STATEMENT of PURPOSE:

The purpose of this policy is to provide guidelines for a timely and effective review and response process for addressing patient complaints and grievances.

POLICY:

Northwell Health is committed to the principle that all patients have the right to express complaints/grievances about the care and services they have received or are currently receiving and to have those complaints/grievances fully investigated and responded to in a timely manner without discrimination based on race, color, religion, sex, national origin, disability, sexual orientation, age, gender identity, gender expression, or source of payment. Individuals acting on behalf of patients may also express complaints for patients.

SCOPE:

This policy applies to all Northwell Health employees, as well as medical staff, volunteers, students, trainees, physician office staff, contractors, trustees and other persons performing work for or at Northwell Health; faculty and students of the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell conducting research on behalf of the Zucker School of Medicine on or at any Northwell Health facility and the faculty and students of the Hofstra Northwell School of Graduate Nursing and Physician Assistant Studies.

DEFINITIONS:

Patient grievance is a written (including email or facsimile) or verbal complaint (when the verbal complain about patient care is not resolved at the time of the complaint by staff present) by a patient or patient representative regarding the patient's care, patient harm, abuse or neglect, issues related to compliance with CMS Hospital conditions of participation, or a Medicare beneficiary complaint related to rights and limitations provided by 42 CFR § 489.

- If a verbal patient care complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further actions for resolution, the complaint is considered a grievance.

- Whenever the patient or the patient's representative requests a response/resolution, the complaint is considered a grievance.
- If an identified patient writes or attaches a written complaint on the patient satisfaction survey and requests a response/resolution, the complaint meets the definition of a grievance.

Patient complaint, for the purpose of this policy, is one that can generally be resolved by the staff present. Staff present includes any staff present at the time of the complaint or who can quickly be at the patient's location (i.e. nursing, administration, nursing managers, service excellence coordinator, patient advocates, administrator) to resolve the patient's complaint.

- Patient issues with environment, food services, amenities, TV etc. are generally considered to be complaints.
- Issues regarding billing, either written or verbal, are considered complaints.

NOTIFICATION:

Notification of Patient Rights is provided to each patient/patient's representative via the admission packet and/or signage indicating the phone numbers and addresses to lodge a complaint with the appropriate regulatory agency (NYS Department of Health, Quality Improvement Organization Island Peer Review Organization, The Joint Commission, New York State Office of Mental Health and New York State Office of the Aging).

PRACTICE/PROCEDURE/IMPLEMENTATION:

The Board of Trustees has delegated responsibility for the review of patient grievances to the Quality Assessment/Performance Improvement Committee (i.e. Grievance Committee) at each site in accordance with CMS COP Patient's Rights § 482/13(a)(2).

Staff will make every effort to resolve a patient complaint as defined above, at the time the complaint is presented. If a staff member is unable to provide resolution when the complaint is presented, staff will consider the complaint a grievance as defined above. Hospice Care Network (HCN) must inform the patient and/or the patient's representative of the internal grievance process, including whom to contact to file a grievance.

The response to these complaints/grievances will be in accordance with the privacy guidelines outlined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If a quality investigation is required, any reviews are privileged under the Confidentiality of Hospital Quality Assurance (and exemption from disclosure) as set forth in the New York Public Health Law 2808-m and New York Education Law 6527(3). Additionally, as a recipient of the Federal Financial Assistance ("FFA") under Title XVIII (Medicare) and XIX (Medicaid) of the Social Security Act of 1965, a prompt and equitable resolution of complaints will be provided alleging discrimination on

the protected bases covered by section 1557 of the Office of Civil Rights, Patient Protection and Affordable Care Act, 42 U.S.C. 18166, including complaints regarding discrimination on the basis of sex, including gender-based discrimination. No patient medical care will be compromised as a result of bringing a complaint/grievance to the attention of staff and/or a regulatory agency.

I. Patient Grievance Management:

1. A response will be provided within seven (7) calendar days of receipt of a grievance. A completed response to patient grievances will include:
   - The contact person at the site
   - The steps taken on behalf of the patient to investigate the grievance
   - The results of the grievance process
   - Date of the completion

   a. If the complexity of the grievance warrants further review, the seven (7) calendar day response will indicate that additional time is required to properly respond. The completed response will be provided within the timeframes set forth in this policy.

   b. The patient or patient's representative will be informed of the need for additional time via a documented phone call and/or written letter that the grievance is under review and a written response will be sent on or before 30 business days of receipt of the original grievance.

   c. If a response cannot be sent within 30 business days of receipt of the grievance due to the complexity of the grievance or extenuating circumstances in the resolution process, the patient or patient's representative will be informed of the need for additional time via a documented phone call and/or written letter, and a written response will be sent as soon as possible but not to exceed 60 business days from receipt of the original grievance.

2. Grievances addressed/directed to a member of Northwell Health Senior Administration at the Corporate Office or site will be initially responded to via documented phone call by the Senior Administrator or designee to the complainant.

3. Grievances that are clinical in nature, received at the Northwell Health Corporate Office/Office of the President/Office of the Chief Medical Officer/Office of the Chief Nurse Executive will be forwarded to the Institute for Clinical Excellence and Quality. The Institute for Clinical Excellence and Quality will forward the grievance to the appropriate site. The site is responsible for review of the grievance and will forward the findings to the Institute for Clinical Excellence and Quality for response to the complainant unless otherwise directed.

4. Grievances that are not clinical in nature, received at Northwell Health Corporate Office/Office of the President/Office of the Chief Medical Officer/Office of the Chief Nurse Executive will be forwarded to the appropriate site for review and response to the complainant.

5. Grievances received via facsimile or e-mail including e-mails from the Northwell Health public website can be acknowledged via e-mail. However, a written response letter will be sent as described above with the findings and resolution. It is the current practice of the Northwell Health that no resolution letters will be sent via e-mail.

6. All written and verbal grievances known to be related to participation in a research study that are received at a hospital/facility/healthcare entity (site) of the Northwell Health will be reported to the Northwell Health Institutional Review Board (IRB), as per the IRB's reporting requirements. If the IRB receives a grievance from a research subject, it should be reported to the Institute for Clinical Excellence and Quality.

7. Written and verbal grievances concerning improper disclosure, access, release or use of medical record information, and any privacy-related complaint will be referred to the Compliance and Privacy Officer of HCN for review, resolution, and response. Grievances related to HIPAA, fraud, waste, or abuse should also be referred to the Office of Corporate Compliance.

8. Written or verbal grievances made by an individual other than the patient/patient's representative will be informed that under state laws and regulations no patient information will be discussed and/or forwarded without consent from the patient/patient's representative and a signed Authorization for Release of Health Information Pursuant to HIPAA by patient or patient representative.

9. A complainant that expresses dissatisfaction with the initial response will have the grievance re-reviewed. A second response will be sent stating the findings from the re-review and a reminder of the complainant's right to contact a regulatory agency. Regulatory agency addresses and telephone numbers will be provided in the response. Also, a patient/family meeting may be offered for further clarification and response to the grievance. These scheduled meetings may include representatives from Senior Leadership or designees and other employees as deemed necessary.

10. In the situation where the site has taken appropriate and reasonable actions to resolve a grievance and the patient or patient's representative remain unsatisfied with the resolution, the site may consider the grievance closed for the purposes of these requirements.

11. All grievances will be entered and closed in the HCN Complaint and Tracking Database or other applicable database.

12. Reports on grievance investigations, resolutions, and corrective actions will be regularly reported at HCN's Quality Assessment/ Performance Improvement Committee. HCN will track and trend data to be utilized as a measure of performance and take actionable steps to improve quality patient care and patient experience. Periodic summary reports will be provided to the Committee on Quality by the Institute for Clinical Excellence & Quality and internal committees as appropriate.

II. Patient Complaint Management:

1. All complaints will be reviewed, responded to and resolved by the "staff present." Whenever possible, staff is empowered to immediately resolve complaints and to offer appropriate service recovery. If the staff member receiving the complaint cannot immediately resolve the issue, the staff member will escalate the complaint to the appropriate staff member for resolution.

2. Resolution will be determined based on a mutually agreed upon decision or the complainant will be informed of the grievance resolution process in which all stated requirements would apply.

III. Record Maintenance:

1. The designated department of the site will maintain a grievance file including:
   a. A copy of the original grievance or, if verbal, a report of the original grievance that was conveyed to a staff member.
   b. A copy of the findings, recommendations, and actions taken.
   c. A copy of the written response letter to the complainant.

2. If a quality review was required based on the nature of the grievance, the quality review(s) will be maintained in a separate quality file by the designated Quality Department and would fall under the protection of the NY Public Health Law 2805-m and NY Education Law 6527(3).

3. HCN's Compliance and Privacy Officer will maintain a complete file of all grievances related to privacy issues including:
   a. A copy of the original grievance, if written or a report of the original grievance, if verbal, that was conveyed to a staff member
   b. A copy of HCN's report including findings, recommendations, and actions taken.
   c. A copy of the response, if written or a summary of the response given, if verbal.

Northwell Health
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Policies and Procedures

TITLE: SAFETY – PATIENT/CAREGIVER **Policy Number: PC-56**

Chapter: Provision of Care, Treatment and Services

Effective: 4/11 **Revised: 04/21** **Reviewed: 04/20**

POLICY STATEMENT: An evaluation of the safety of the patient/family member/caregiver's home environment is included in the comprehensive assessment of the patient.

PRACTICE/PROCEDURES/IMPLEMENTATION:

1. The RN assesses the patient/family member/caregiver's basic home safety during the initial assessment and addresses any immediate safety issues.

2. The RN conducts a home safety evaluation as part of the comprehensive assessment of the patient that addresses the following areas:
    a. fire safety (i.e., smoking, smoke detectors, fire escape routes, electric blankets, oxygen therapy (see Policy PC-40: "Oxygen Safety Assessment"), space heaters and cooking safety)
    b. electrical safety (extension cords, electrical cords, overloaded circuits, outlets)
    c. emergency preparedness (floods, hurricanes, natural disasters)
    d. bathroom safety (non-skid mats, grab bars, water temperature)
    e. infection control (handling, storage and disposal of infectious/hazardous materials);
    f. medication safety (proper labeling, handling, storage of medications and disposal)
    g. communication barriers (inability to use phone, seek help); and
    h. medical equipment and supplies (storage, handling and maintenance)
    i. weapons if present what type (ensure they are locked and secured)

3. Based on the results of the home safety evaluation, safety concerns are addressed and patient/family member/caregiver instruction and training is provided as needed and documented in the Electronic Medical Record (EMR).

4. Written materials are provided as needed to increase the safety/knowledge of the patient/family members/caregiver's in the home environment.

5. Safety issues are reassessed on an ongoing basis and safety problems should be documented as resolved or ongoing and remain part of the patient's plan of care.

Northwell Health
Hospice Care Network

Policies and Procedures

TITLE: ADMISSION TO HOSPICE -MEDICARE ELIGIBILITY **Policy Number: PC-06**

Chapter: Provision of Care, Treatment and Services

Effective: 01/03 **Revised: 11/16** **Reviewed: 11/2020**

POLICY STATEMENT:

Patients must meet Medicare eligibility requirements to be admitted to Hospice Care Network (HCN) for Medicare-covered services.

PRACTICE/PROCEDURE/IMPLEMENTATION:

1. To be eligible to elect the Medicare hospice benefit, the patient must:
    a. be entitled to Medicare Part A; and
    b. be certified as being terminally ill consistent with state and/or federal definitions. Certification by HCN's Medical Director or designee and his/her attending physician (if applicable) as being terminally ill (having a prognosis of six months or less if the illness follows its normal course) is required.

2. Hospice Care Network admits a patient only on the recommendation of HCN Medical Director or designee in consultation with, or with input from, the patient's attending physician when applicable .

3. Prior to admission, all patients are assessed for hospice appropriateness and eligibility using the LCD guidelines. Patients who meet the LCD guidelines are eligible for admission.

4. Failure to meet the LCD guidelines does not disqualify a patient for admission to Hospice Care Network. Patients who do not fully meet the LCD guidelines are discussed with HCN Medical Director or designee in order to determine hospice appropriateness and eligibility. Additional documentation is needed to support hospice eligibility.

5. Hospice staff may use the following assessment tools to measure and document functional status:

    a. Palliative Performance Scale (PPSv2) Version 2;
    b. New York Heart Association (NYHA) Functional Classification;
    c. Reisberg Functional Assessment Staging Tool(FAST Scale).

6. Complete and timely documentation of the specific clinical factors that qualify a patient for the Medicare Hospice Benefit is provided in the patient's clinical record.

7. Documentation regarding the patient's eligibility for the Medicare Hospice Benefit is maintained, appropriately organized in legible form, and available for audit and review.

8. The patient's clinical record contains complete documentation to support the initial and all subsequent recertifications of terminal illness made by HCN's Medical Director/Hospice Physician and attending physician.

9. HCN periodically evaluates its eligibility requirements and limitations with the goal of identifying and eliminating barriers to end of life palliative hospice care for eligible patients.

10. Hospice employs oversight mechanisms to ensure that the eligibility of every patient is verified and accurately documented.

Northwell Health
Hospice Care Network

Policies and Procedures

TITLE: ADMISSION CRITERIA **Policy Number: PC-03**

Chapter: Provision of Care, Treatment and Services

Effective: 10/09 **Revised: 11/16** **Reviewed: 11/20**

POLICY STATEMENT: Patients who meet the admission criteria are admitted to Hospice Care Network (HCN) regardless of race, color, national origin, age, sex, gender identity, gender expression, sexual orientation, religion, disability, or source of payment.

DEFINITION:

A hospice patient is a person certified as being terminally, who, alone or in conjunction with designated family member(s), has voluntarily requested admission and been accepted into a hospice for which the New York State Department of Health has issued a certificate of approval. The hospice clarifies that nothing shall be construed to require provision of services to a patient that are not covered by the patient's payment source.

Palliative care shall mean active, interdisciplinary care provided to a patient and/or a hospice patient with advanced, life-limiting illness, focusing on relief of distressing physical and psychological symptoms and meeting spiritual needs with the goal of achievement of the best quality of life for patients and families.

PRACTICE/PROCEDURE/IMPLEMENTATION:

1. During the referral process, hospice staff shall determine the patient's eligibility for hospice based on the following criteria:
    a. verbal or written certification by the patient's attending physician (if there is one) and hospice physician or designee that the patient has a prognosis of 6 months or less if the disease follows its normal course;
    b. the patient resides in the geographic area served by the hospice program;
    c. the patient understands and accepts the palliative and supportive care that is provided to a hospice patient for the reduction and abatement of pain and other symptoms and stresses associated with terminal illness and dying. In addition, the patient no longer seeks aggressive treatment;
    d. there is a capable primary caregiver living in the home or, if no caregiver is available, the patient agrees to assist HCN in developing a plan of care to meet his or her future needs;
    e. HCN has adequate resources and staffing to meet the needs of the patient; and
    f. the patient and/or caregiver wish to receive hospice services.

2. If it is determined that the patient does not meet the criteria for admission, reasons for non-acceptance are documented in the referral log and communicated to the referrer and patient/caregiver as appropriate.

3. Efforts are made to refer non-accepted patients to appropriate community resources or other health care providers.

4. A plan for follow up contact with non-accepted patients is developed and recorded in the referral log.

5. Hospice Care Network collects data regarding the appropriateness and timeliness of admissions that is utilized in HCN's Quality Assessment/Performance Improvement (QAPI) program.

Northwell Health
Hospice Care Network

Policies and Procedures

TITLE: Admission to Hospice - Referrals **Policy Number PC-03A**

Chapter: Provision of Care, Treatment and Services

Effective: 10/08 **Revised: 04/17** **Reviewed: 03/21**

POLICY STATEMENT: Hospice Care Network (HCN) accepts referrals for hospice care 24 hours a day, 7 days a week for patients living in HCN's service area (Nassau, Suffolk and Queens Counties).

PRACTICE/PROCEDURES/IMPLEMENTATION:

1. During scheduled working hours of 9:00am to 5:00pm, seven (7) days a week, referrals are taken by the Referral Center. The Inquiry/Referral form in the Electronic Medical Record (EMR) is completed.

2. Outside of business hours stated above, referrals are taken by the Administrator On-Call or the Evening/Weekend Team and communicated to the Referral Center.

3. When a patient or family member makes the referral, the Referral Center, or other staff noted above, contacts the patient's attending physician to confirm his role as attending, to determine the physician's willingness to give Certification for Terminal Illness, eligibility for hospice care, and to request documentation supporting terminal diagnosis.

4. If the attending physician denies approval of the referral to HCN, HCN staff notifies the referral source of the attending physician's response. The staff member notifies the HCN Medical Director/Hospice Physician or designee to determine necessity of further discussion. If the Medical Director/Hospice Physician concurs with attending physician, the *Referral Form* is placed in the "Not Taken Under Care" file with documentation of why the patient was not admitted. If the HCN Medical Director/Hospice Physician feels that the patient may be appropriate, the HCN Medical Director/Hospice Physician may schedule an appointment with the patient to assess for eligibility. The HCN Medical Director/Hospice Physician then attempts to collaborate with the patient's attending physician.

5. When the referral is initiated or approved by a physician, the Referral Staff or designee will:

    a. contact the patient/family member/caregiver to schedule an appointment for the admitting RN to visit, unless the patient/family member/caregiver requests otherwise;
    b. notify the admitting RN of the date, time, and the location of the appointment; and
    c. provide a copy of the *Referral Form* to the admitting RN.

Northwell Health
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Policies and Procedures

TITLE: Admission – Referrals from Acute Care Facilities **Policy Number PC-03B**

Chapter: Provision of Care, Treatment and Services

Effective: 12/09 **Revised: 04/17** **Reviewed: 03/21**

POLICY STATEMENT: Hospice Care Network (HCN) responds to referrals from acute care facilities for patients with a life-threatening illness who meet HCN admission criteria.

PRACTICE/PROCEDURES/IMPLEMENTATION:

1. Referrals from acute care facilities must be accompanied by a physician's order.

2. HCN's nurse reviews the patient's hospital chart to determine the patient's eligibility for hospice services.

3. The nurse or social worker meets with the patient/family member/caregiver to explain the services provided by HCN, as well as its limitations. The nurse completes a pre-admission assessment.

4. If the patient is deemed eligible for hospice care, and the patient/family member/caregiver desire services, the nurse obtains approval from the HCN Medical Director/Hospice Physician as per Policy: PC-05: "Admission to Hospice- Eligibility Criteria" and Policy: PC-06: "Admission to Hospice- Medicare Eligibility." The nurse then:

    a. Documents the visit and outcome on the hospital chart according to hospital policy; and
    b. Documents collaboration with physician, patient/family/caregiver and referral source as applicable.

5. The hospice nurse or social worker continues to visit the patient in the acute care setting and contacts the hospital nurse, discharge planner, and/or attending physician during regular business hours to inquire about the condition of the patient and any noted changes.

6. Prior to the patient's discharge from the hospital, the hospice nurse:

    a. contacts the hospice billing department prior to ordering services or equipment if the patient has commercial insurance as primary coverage;

b. confirms all needed equipment and services, documents this information on the face sheet, and orders equipment through the appropriate vendor,
c. obtains orders for medications as needed;
d. confirms a meeting time with the patient at his or her place of residence after discharge from the hospital and
e. informs the admissions team and the appropriate team manager of the patient's discharge.

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Policies and Procedures

TITLE: LEVELS OF CARE **Policy Number: PC-69**

Chapter: Provision of Care, Treatment and Services

Effective: 04/04 **Revised: 04/21** **Reviewed: 04/20**

POLICY STATEMENT: Hospice Care Network (HCN) offers four levels of care, as provided for by the Medicare Hospice Benefit, to meet the needs of patients/caregivers. The levels of care include routine home care, continuous home care, inpatient respite care and general inpatient care.

PRACTICE/PROCEDURES/IMPLEMENTATION:

1. Routine home care, as the most frequently provided level of care, is provided in the patient's residence. A residence may be their own home, a family member's home, an assisted living facility, a skilled nursing facility, or another setting considered the patient's home.

2. Continuous home care is provided during a period of crisis to achieve palliation or management of acute medical symptoms in order to maintain the patient at home. Continuous home care is provided on a short-term basis during periods of crisis for at least 8 hours within a 24-hour period that begins and ends at midnight. Either homemaker or hospice aide services or both may be covered on a 24-hour continuous basis during periods of crisis, but the care must be predominantly nursing care.

3. Inpatient respite care is provided in a contracted facility when necessary to provide respite for family members or others caring for the patient. This level of care is limited to no more than five consecutive days for each respite stay.

4. The general inpatient level of care is provided in HCN's or a contracted facility when a patient's need for pain or acute/chronic symptom management cannot be managed in other settings.

5. HCN utilizes all levels of care and has criteria for determining appropriate levels of care for each patient based on his/her evolving needs.

6. Documentation in the clinical record supports the level of care received by each patient and clearly reflects the need for any changes in the patient's level of care.

7. When a patient's condition changes and requires a change in level of care, the, Primary RN/designee or Team Manager collaborates with members of the Interdisciplinary Team to receive an order for change in level of care. Revisions to the patient's plan of care must be made. The patient's attending physician should be notified for any change in the level of care.

8. Members of the interdisciplinary team providing care to the patient are advised of any changes to the patient's level of care and detailed information is provided in the clinical record to ensure continuity of care.

9. A change in the Level of Care is recorded in the patient's electronic medical record to ensure accurate billing.

10. For all levels of care, the patient has the right to an environment that preserves dignity and contributes to a positive self-image. The patient also has the right to have his or her property treated with respect.

Northwell Health
Hospice Care Network

Policies and Procedures

TITLE: LEVELS OF CARE – GENERAL INPATIENT **Policy Number: PC-70**

Chapter: Provision of Care, Treatment and Services

Effective: 4/11 **Revised: 04/21** **Reviewed: 04/20**

POLICY STATEMENT:

Hospice Care Network (HCN) provides the general inpatient level of care for pain control and symptom management in Medicare certified facilities with which HCN has written agreements.

PRACTICE/PROCEDURES/IMPLEMENTATION:

1) Short-term inpatient care for pain control and symptom management is only provided in a Medicare-certified hospital, nursing facility or hospice that has a registered nurse working on each shift, 24/7.

2) Short-term inpatient hospice care is provided when the patient's condition or disease progression must be closely monitored in order to manage pain and for management of symptoms related to the terminal illness that cannot safely be managed in the patient's own home.

3) The provision of inpatient services shall include, but is not limited to:

- 24 hour nursing services that meet the needs of all patients and are furnished in accordance with the patient's plan of care, including the services of a registered professional nurse if a hospice patient has been admitted to inpatient services for other than respite care;
- each patient must receive all nursing services as prescribed and must be comfortable, clean, well groomed, and protected from accident, injury and infection;
- provides environmental adaptations to help patients with dementia, cognitive impairment or temporary confusion;
- allows the patient to keep and use personal clothing and possessions, unless this infringes in other's rights or is medically contraindicated based on the setting or service;
- accommodations to enable families to store and prepare food brought in by the family;
- informs the patient in advance of room changes;
- accommodations to enable families to remain with the patient throughout the night;
- flexible visitation policies which include 24 hour a day visiting privileges regardless of age of visitor;

- provides space for the patient to receive visitors in comfort and privacy;
- provision of adequate and wholesome food and supplemental nourishments under the direction of a dietitian;
- flexibility in meal times and in selection of food based on individual needs of patients;
- accommodations for recreational and religious activities;
- adequate space for private small group interactions;
- retention and use of personal possessions as space and safety permits;
- a telephone accessible to the patient;
- oxygen is available to each patient as necessary; and
- makes accommodations for family privacy after a patient's death.

4) Patients and families are instructed to call HCN before making arrangements to go to a hospital and physicians are requested to call before admitting hospice patients to a hospital or nursing home for the inpatient level of care. If the patient is admitted to a non-contracted facility, HCN staff requests the patient be transferred to a facility with which HCN contracts.

5) The Primary RN/designee gives the attending physician or designee a report of the patient's medical status and obtains an order for the change in level of care and inpatient admission. If the attending physician or designee is unavailable, the Primary RN/designee collaborates with HCN physician regarding change in level of care and necessary orders.

6) HCN's physician or designee is consulted if necessary to determine if the need for the inpatient admission is related or unrelated to the terminal illness.

7) The Primary RN/designee calls the contracted inpatient facility and provides them with appropriate patient information and arranges transportation of the patient to the inpatient facility if needed.

8) The Primary RN/designee provides the inpatient facility with a snapshot summary per Electronic Medical Record (EMR) that includes, at a minimum, a copy of the patient's plan of care, current medications, allergies and DNR/advance directives status.

9) The Primary RN/designee ensures that the patient's comprehensive assessment, plan of care and medication profile are updated to reflect the patient's GIP admission.

10) The Interdisciplinary Team (IDT) is responsible for the coordination of services rendered to the patient and for the professional management of the patient's plan of care during the inpatient admission.

11) Ongoing assessments of the patient's condition by the Primary RN/designee and the attending physician or designated Hospice Physician determine the continued appropriateness of the general inpatient (GIP) level of care.

12) Patients receiving the general inpatient level of care at a contracted facility receive a documented visit by an HCN RN. The frequency of RN visits is determined by the patient's clinical needs and review of the plan of care.

13) At a minimum, a phone call to inpatient staff is documented daily. The nurse communicates any changes in the patient's status to the attending physician (if any) and the hospice physician and the other members of the IDT.

14) The Social Worker or the Primary RN/designee is responsible for coordinating discharge plans for the patient in anticipation of ending the general inpatient level of care and returning the patient to routine home care.

15) The discharge summary is provided by the inpatient facility and entered into the patient's hospice clinical record upon discharge of the patient. Hospital records are available to HCN upon request.

16) When the patient returns to routine home care, his/her comprehensive assessment and plan of care are updated to reflect current status, needs, interventions and goals.

17) Annual "Train the Trainer" inservice education is provided to hospital staff.

Northwell Health
Hospice Care Network

Policies and Procedures

TITLE: PAIN AND SYMPTOM MANAGEMENT **Policy Number: PC-55**

Chapter: Provision of Care, Treatment & Services

Effective: 9/11 **Revised: 12/16** **Reviewed: 12/20**

POLICY STATEMENT: The Interdisciplinary Team (IDT) ensures that patients receive effective pain management and symptom control from Hospice Care Network (HCN).

PRACTICE/PROCEDURES/IMPLEMENTATION:

1. The hospice nurse assesses the patient's pain and other symptoms as part of the initial assessment. Based on findings from the initial assessment, the HCN nurse ensures that the patient's immediate care and support needs are met. Patient involvement in pain management strategies includes discussing the objectives used to evaluate treatment progress and providing education on pain management, treatment options and safe use of pain medications.

2. The patient's pain and other symptoms related to the terminal condition are thoroughly assessed during the comprehensive assessment of the patient by the Primary RN or designee within four days of the patient's start of care. Pain identification/rating is performed by all disciplines. The comprehensive pain assessment is consistent with its scope of care, treatment or services and the patient's condition.

3. The comprehensive assessment includes a 0 –10 pain assessment scale so patients can rate their level of pain numerically. 0= no pain; 1-3= mild pain; 4-6= moderate pain and 7-10= severe pain. Patients are also asked to rate their acceptable threshold of pain. This rating is used to determine whether the pain-related interventions on the patient's plan of care are effective in bringing the patient's pain down to an acceptable level. Please note: As required, HCN uses methods to assess pain that are consistent with the patient's age, condition , ability to understand and whether the pain is acute or chronic.

4. Pain is re-assessed during every home visit, any time a patient states that his/her pain level has changed, and whenever pain medication or dosage is changed. This information is documented in the patient's clinical record. HCN responds to the patient's pain, based on its reassessment criteria. Reassessment and response to the patient's pain focuses on progress toward pain management goals and includes the following: evaluation and documentation of response (s) to pain interventions; progress toward pain management goals including functional ability; side effects of treatment and risk factors for adverse events caused by the treatment.

5. If the patient is not receiving relief from the current pain medication or dosage, the nurse collaborates with the attending physician, if applicable, to obtain an order for effective symptom management, including non-pharmacologic, pharmacologic or a combination of

approaches interventions. Pain management strategies consider the patient's current presentation, type of pain, past medical history and pain management goals. If the patient's attending physician is unavailable, the nurse will collaborate with HCN's Medical Director/Hospice Physician/Nurse Practitioner.

6. Guidelines and/or protocols are developed for the assessment and management of common physical symptoms that are addressed by the interdisciplinary team in the patient's plan of care, including, but not limited to:

a. dyspnea;
b. nausea and vomiting;
c. anorexia and weight loss;
d. anxiety and confusion;
e. pressure injuries;
f. constipation;
g. fatigue;
h. restlessness and agitation; and
i. sleep disorders.

7. All members of the IDT should assess for the patient's level of pain within the parameters of their visit. Any significant new findings should be shared promptly with the RN. Pain assessment and management are included in the IDT discussions.

8. HCN provides staff and licensed independent practitioners with educational resources to utilize in patient education to improve pain assessment, pain management, safe use of non-opioid medications and the safe and responsible use, storage and disposal of opioid medications when prescribed based on the identified needs of its patient population.

Northwell Health
Hospice Care Network

Policies and Procedures

TITLE: Interdisciplinary Team **Policy Number: PC-27**

Chapter: Provision of Care, Treatment and Services

Effective: 4/11 **Revised: 11/16** **Reviewed: 11/20**

POLICY STATEMENT: Hospice Care Network (HCN) designates an Interdisciplinary Team (IDT) composed of qualified individuals who work together to meet the physical, medical, psychosocial, emotional and spiritual needs of HCN's patients and families facing terminal illness and bereavement.

PRACTICE/PROCEDURES/IMPLEMENTATION:

1. The IDT at HCN includes, at a minimum, the following individuals:
    a. a doctor of medicine or osteopathy (who is an employee or under contract with HCN)
    b. a registered nurse
    c. a social worker
    d. a pastoral or other counselor

2. In addition, the IDT may include:
    a. the patient's attending physician (if any);
    b. trained volunteers under the supervision of the Volunteer Coordinator;
    c. hospice aides;
    d. bereavement counselors;
    e. dietician; and
    f. others with appropriate clinical and educational experience who meet specific needs of HCN's patients as identified in the plan of care.

3. The IDT is responsible for:
    a. establishing, implementing, reviewing and revising the patient's plan of care;
    b. providing and coordinating care, treatment and services in accordance with the patient's plan of care in its entirety, and collectively supervising HCN's care, treatment and services;
    c. documenting all care, treatment and services provided in a timely manner in accordance with HCN's documentation requirements;
    d. promoting the patient's acceptance of his/her own strengths and unique qualities;
    e. communicating with the patient's attending physician, if any, on a regular basis;
    f. recognizing and addressing the patient/caregiver/family's feelings of loss, despair, loneliness, unresolved guilt, fear and anger;
    g. conferring with an individual educated and trained in drug management to ensure that drugs and biologicals meet each patient's needs;

h. ensuring that each patient and primary care giver(s) receives education and training regarding responsibilities for the care, treatment and services identified in the plan of care followed by an assessment of their ability to provide care including their ability to self-administer drugs and biologicals;
i. ensuring discussion and written instructions are provided to the patient/family regarding the management and disposal of controlled drugs in the home when controlled drugs are initially ordered and documentation of such in the clinical record;
j. promoting opportunities for the patient/caregiver/family's personal growth including identifying areas for reconciliation, facilitating expressions of love, concern, regret and forgiveness, and supporting a sense of meaning; and
k. recommending and establishing policies governing the day-to-day provision of hospice care and services to HCN's Operations IDT.

4. A registered nurse member of the IDT is designated as the RN Coordinator of Care for each patient/caregiver/family. The RN Coordinator of Care is responsible for coordinating the care, treatment and services provided by the IDT, ensuring continuous assessment of patient/caregiver/family needs, and implementing the interdisciplinary plan of care.

5. HCN provides the patient/caregiver with information about the identity and role of the staff member(s) who will provide care, treatment or services.

Northwell Health
Hospice Care Network

Policies and Procedures

TITLE: Interdisciplinary Team Meeting **Policy Number: PC- 28**

Chapter: Provision of Care, Treatment and Services

Effective: 04/11 **Revised:** **Reviewed: 03/21**

POLICY STATEMENT: The members of the Interdisciplinary Team (IDT) meet in person weekly to plan and coordinate the care and services provided to Hospice Care Network's patients, families and their caregivers.

PRACTICE/PROCEDURES/IMPLEMENTATION:

1. The interdisciplinary team reviews each patient's plan of care every two weeks, or more frequently if needed, in order to continually monitor the care and services provided to the patient and his or her continued eligibility for hospice care.

2. During the interdisciplinary team meeting, the patient's plan of care is reviewed, updated and changes are communicated to the hospice physician with requests for new orders when needed. In addition, patient emergency preparedness information, i.e. Priority Code, Transportation Assistance Level, emergency contact information etc., is reviewed to ensure that all information is up-to-date.

3. The interdisciplinary team meeting follows a consistent agenda to ensure that all patients are reviewed and that appropriate care planning occurs. The agenda follows the D-A-R-E format of patient review:
    a. D – discharges (including transfers and revocations) and deaths;
    b. A – admissions (and readmissions);
    c. R - recertifications (all patients scheduled to be recertified into a new benefit period within the following two weeks;
    d. E – existing patients (each patient is reviewed, at a minimum every two weeks and patients receiving continuous care or the general in-patient level of care is reviewed at every meeting).

4. The review of existing patients is guided by the appropriate LCD guidelines to monitor the patient's status and continued eligibility for hospice care.

5. The focus of the interdisciplinary team meeting is on reviewing the patient's plan of care and revising it as needed, based on updated reassessment information.

Northwell Health
Hospice Care Network

Policies and Procedures

TITLE: HOSPICE CARE FOR NURSING FACILITY RESIDENTS **Policy Number: PC-73**

Chapter: Provision of Care, Treatment & Services

Effective: 04/03 **Revised: 11/16** **Reviewed: 11/20**

POLICY STATEMENT: Hospice Care Network (HCN) ensures that all care, treatment and services routinely offered to hospice patients are available to individuals, including those individuals with intellectual disabilities, eligible for hospice care who reside in a SNF/NF or ICF/IID.

PRACTICE/PROCEDURES/IMPLEMENTATION:

1. HCN provides services to patients who reside in facilities when a written agreement for the provision of hospice services between the two entities has been duly signed by an authorized representative of HCN and the facility. The written agreement specifies the responsibilities of HCN and the facility.

2. HCN does not offer or provide gifts, free services, or other incentives to patients, relatives of patients, or physicians of the nursing facility for the purpose of inducing referrals of nursing facility residents.

3. HCN does not engage in the referral-inducing practice of "patient charting."

4. HCN assumes full responsibility for the professional management of the hospice services provided to the resident, in accordance with the hospice plan of care, including assessing, planning, monitoring, directing and evaluating the patient's/resident's hospice care across all settings.

5. HCN may use the facility's nursing personnel to assist in the administration of prescribed therapies included in the patient's plan of care only to the extent that HCN would routinely utilize the services of a hospice patient's family in implementing the plan of care.

6. Hospice staff assures that facility staff furnishing care to hospice patients including patients with intellectual disabilities are oriented and trained to all to the hospice philosophy of care, including policies and procedures regarding methods of comfort, pain control, symptom management, principles about death and dying, individual responses to death, patient's rights, appropriate forms and record keeping requirements.

7. It is a shared responsibility of the hospice in conjunction with the SNF/NF or ICF/IID to assess the need for staff training and coordinate staff training with representatives of the facility, and to determine how frequently training needs to be offered in order to ensure that the facility staff

furnishing care to hospice patients are oriented to the philosophy of hospice care. Facility staff turnover rates should be a consideration in determining training frequency.

Northwell Health
Hospice Care Network

Policies and Procedures

TITLE: HOSPICE CARE FOR NURSING FACILITY RESIDENTS **Policy Number: PC-73**

Chapter: Provision of Care, Treatment & Services

Effective: 04/03 **Revised: 11/16** **Reviewed: 11/20**

POLICY STATEMENT: Hospice Care Network (HCN) ensures that all care, treatment and services routinely offered to hospice patients are available to individuals, including those individuals with intellectual disabilities, eligible for hospice care who reside in a SNF/NF or ICF/IID.

PRACTICE/PROCEDURES/IMPLEMENTATION:

1. HCN provides services to patients who reside in facilities when a written agreement for the provision of hospice services between the two entities has been duly signed by an authorized representative of HCN and the facility. The written agreement specifies the responsibilities of HCN and the facility.

2. HCN does not offer or provide gifts, free services, or other incentives to patients, relatives of patients, or physicians of the nursing facility for the purpose of inducing referrals of nursing facility residents.

3. HCN does not engage in the referral-inducing practice of "patient charting."

4. HCN assumes full responsibility for the professional management of the hospice services provided to the resident, in accordance with the hospice plan of care, including assessing, planning, monitoring, directing and evaluating the patient's/resident's hospice care across all settings.

5. HCN may use the facility's nursing personnel to assist in the administration of prescribed therapies included in the patient's plan of care only to the extent that HCN would routinely utilize the services of a hospice patient's family in implementing the plan of care.

6. Hospice staff assures that facility staff furnishing care to hospice patients including patients with intellectual disabilities are oriented and trained to all to the hospice philosophy of care, including policies and procedures regarding methods of comfort, pain control, symptom management, principles about death and dying, individual responses to death, patient's rights, appropriate forms and record keeping requirements.

7. It is a shared responsibility of the hospice in conjunction with the SNF/NF or ICF/IID to assess the need for staff training and coordinate staff training with representatives of the facility, and to determine how frequently training needs to be offered in order to ensure that the facility staff

furnishing care to hospice patients are oriented to the philosophy of hospice care. Facility staff turnover rates should be a consideration in determining training frequency.

Northwell Health
Hospice Care Network

Policies and Procedures

TITLE: HOSPICE CARE FOR NURSING FACILITY RESIDENTS- Hospice Plan of Care **Policy Number: PC-74**

Chapter: Provision of Care, Treatment & Services

Effective: 04/03 **Revised: 11/15** **Reviewed: 11/20**

POLICY STATEMENT: A written plan of care is established and maintained for each facility patient and is developed and coordinated with Hospice Care Network's (HCN) Interdisciplinary Team (IDT) in consultation with facility representatives and the patient's attending physician.

PRACTICE/PROCEDURES/IMPLEMENTATION:

1. The HCN Primary RN/designee, assigned to the facility patient, is the Coordinator of Care and is responsible for:
    - providing overall coordination of the hospice care of the resident with the facility representatives;
    - establishing, maintaining and implementing the patient's plan of care in collaboration with members of the HCN's IDT and with facility representatives;
    - Ensuring that the patient's plan of care:
        - identifies the care and services that are needed and specifically identifies which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care; and
        - reflects the participation of HCN, the facility staff and patient/family/caregiver to the extent possible.

2. All care provided to the facility patient must be in accordance with the written plan of care that includes the patient's current medical, physical, social, emotional and spiritual needs.

3. Based on collaboration between HCN and the facility, the hospice plan of care should reflect:
    - a common problem list;
    - palliative interventions;
    - palliative outcomes;
    - responsible discipline;
    - responsible provider; and
    - patient goals.

4. In conjunction with a representative from the facility, the plan of care is reviewed, at a minimum, every fifteen days.

5. HCN must approve any changes in the hospice plan of care before implementation and discuss such changes with the patient or representative and facility representatives.

Northwell Health
Hospice Care Network

Policies and Procedures

TITLE: Hospice Care For Nursing Facility Residents-Coordination of Care **Policy Number: PC-75**

Chapter: Provision of Care, Treatment and Services

Effective: 04/03 **Revised: 03/16** **Reviewed: 02/21**

POLICY STATEMENT: Hospice Care Network (HCN) ensures that mechanisms are in place to provide for coordination of all hospice services provided to patients residing in nursing facilities.

PRACTICE/PROCEDURES/IMPLEMENATION:

1. HCN designates a member of each interdisciplinary team that is responsible for a patient who is a resident of a facility. The Registered Nurse (RN) is the designated Coordinator of Care. The RN is responsible for:
    a) Providing overall coordination of the hospice care of the resident with facility representatives; and
    b) Communicating with facility representatives and other health care providers participating in the provision of care for the terminal illness and related conditions and other conditions to ensure quality of care for the patient/ family/caregiver.

2. HCN ensures that HCN's IDT communicates with the facility medical director, the patient's attending physician, and other physicians participating in the provision of care to the patient as needed, to coordinate the care of the hospice patient with the medical care provided by other physicians.

3. The following information is provided to the facility:

    a) The most recent hospice plan of care specific to each patient;
    b) Hospice election form and any advance directives specific to each patient;
    c) Physician certification and recertification for the terminal illness specific to each patient;
    d) Names and contact information for hospice personnel involved in the hospice care of each patient;
    e) Instructions on how to access HCN's 24-hour on-call system;
    f) Hospice medication information specific to each patient; and
    g) Hospice physician and attending physician (if any) orders specific to each patient.

Northwell Health
Hospice Care Network

Policies and Procedures

TITLE: Coordination of Services **Policy Number: PC-49**

Chapter: Provision of Care, Services and Treatment

Effective: 04/04 **Revised: 03/18** **Reviewed: 02/21**

POLICY STATEMENT: The Interdisciplinary Team (IDT) ensures that the patient's care, treatment or services is coordinated and that there is effective ongoing sharing of information amongst and between all disciplines, with all contracted service providers and in all settings.

PRACTICE/PROCEDURES/IMPLEMENTATION:

1. The Associate Executive Director of Clinical Operations assumes overall responsibility for ensuring there are effective methods of communication that allow for the coordination of the care and services provided by the IDT.

2. The Primary RN coordinates the patient's plan of care and facilitates the ongoing sharing of information with the attending physician, contracted facilities, vendors, other members of the IDT and non-hospice healthcare providers furnishing services unrelated to the terminal illness.

3. The complexity of providing care, treatment or services requires a collaborative, interdisciplinary approach and a mutual effort among those who work at HCN to coordinate care in a manner that is conducive to optimal patient outcomes, quality and safety. The IDT meets every week to provide care planning for Hospice Care Network (HCN's) patients/family members/caregivers. Each patient/family member/caregiver is discussed, at a minimum, every 15 days.

4. All members of the IDT participate in assessing patient needs, planning care, treatment and services, providing care, treatment and services, coordinating care, treatment and services, documenting problems, interventions, goals, observations, and outcomes based on the assessed and reassessed needs of the patient/caregiver.

5. All members of the IDT, volunteers and contracted personnel have access to the patient's plan of care and are expected to provide care in accordance with the plan of care.

6. Coordination of services and continuity of care, including the way HCN shares and receives patient information, is facilitated by established formal and informal communication mechanisms between/among all disciplines providing care (whether directly or under contract). These communication mechanisms include, but are not limited to:
    a. IDT meetings;
    b. review of documentation in the electronic medical record;
    c. ad hoc case conferences when needed;
    d. family meetings as appropriate;

e. discharge and/or transfer summaries as needed;
f. telephone communications and voice mail; and
g. report from and to on-call staff.

7. HCN's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information.

8. When HCN cannot provide equipment, items or services that have been ordered for a patient, it notifies the prescribing practitioner within five calendar days.

9. HCN integrates the services provided directly or under arrangement so that it can identify patient needs and factors that could affect patient safety and treatment effectiveness and coordinate patient care provided by all disciplines.

Northwell Health
Hospice Care Network

Policies and Procedures

TITLE: Hospice Aide Services **Policy Number: PC-32**

Chapter: Provision of Care, Treatment and Services

Effective: 04/03 **Revised: 04/19** **Reviewed: 06/20**

POLICY STATEMENT: Hospice aide services (home health aide services) are provided under the supervision of a registered nurse by individuals who meet home health aide training requirements and who have successfully completed a competency evaluation program as required by regulation. In addition, the home health aide must be currently listed in good standing on the New York State Home Care Registry.

PRACTICE/PROCEDURES/IMPLEMENTATION:

1. Hospice Care Network (HCN) makes every effort to ensure that there are enough hospice aides (home health aides) employed by the hospice to meet the needs of its patients. If necessary HCN contracts with other entities to provide hospice aides and ensures that the overall quality of services provided and the qualifications of the contract aides meet regulatory requirements.

2. Hospice aide services are assigned based on the Registered Nurse's (RN), who is a member of the interdisciplinary team, comprehensive assessment and reassessment of the patient's personal care needs and ability to perform activities of daily living.

3. The Hospice RN develops a written hospice aide plan of care that provides instructions to the hospice aide of the care to be provided. The expectation is that all assigned activities on the hospice aide plan of care will be performed at each patient/hospice aide interaction. The Hospice RN will document only frequency exceptions in the special instructions section of the activity on the hospice aide plan of care, if it is to differ from the above.

4. The hospice aide's services are ordered by a member of the interdisciplinary team, included and ordered by the physician in the patient's plan of care and are consistent with the hospice aide's training and tasks permitted under state law to be performed by the hospice aide, including but not limited to personal care and simple procedures as an extension of nursing or therapies.

5. Hospice aides receive twelve hours of in-service training every twelve months.

6. The hospice aide must be currently listed in good standing on the Home Care Registry in New York State.

Northwell Health
Hospice Care Network

Policies and Procedures

TITLE: Hospice Aide Assignments and Duties **Policy Number: PC-33**

Chapter: Provision of Care, Treatment and Services

Effective: 04/03 **Revised: 09/16** **Reviewed: 06/20**

POLICY STATEMENT: Hospice aides are assigned to specific patients by a member of Hospice Care Network's (HCN) Hospice Aide Department. The Hospice Aide is a member of the Interdisciplinary Team and follows written patient care instructions prepared by HCN's RN when providing care to assigned patients.

PRACTICE/PROCEDURE/IMPLEMENTATION:

1. A hospice aide provides services that are:
    a. Ordered by the interdisciplinary team.
    b. Included in the plan of care.
    c. Permitted to be performed under State law by hospice aides.
    d. Consistent with the hospice aide's training.

2. The duties of the hospice aide include the following:
    a. The provision of hands-on personal care.
    b. The performance of simple procedures as an extension of therapy or nursing services.
    c. Assistance in ambulation or exercise.
    d. Medication reminding, as appropriate, for those medications that are ordinarily self-administered.

3. Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and any quality assessment and performance and improvement activities.

4. Hospice aides must complete accurate, appropriate and legible documentation of services provided to the patient in compliance with HCN's policies and procedures.

Northwell Health
Hospice Care Network

Policies and Procedures

TITLE: Hospice Aide Supervision		**Policy Number: PC-34**
Chapter: Provision of Care, Treatment and Services		
Effective: 04/03	**Revised: 09/16**	**Reviewed: 06/20**

POLICY STATEMENT: Hospice aides are supervised by a registered nurse (RN) in a manner and frequency that assures the safety of patients and the quality of aide services provided.

PRACTICE/PROCEDURES/IMPLEMENTATION:

1. A registered nurse makes an on-site visit to the patient's home no less frequently than every 14 days to ensure that the quality of care, treatment and services ordered by the Interdisciplinary Team and provided by the aide are meeting the patient's need.

2. The aide should be present during the RN's on-site visit periodically, but no less frequently than every ninety days, or more frequently if an area of concern is noted by the supervising nurse.

3. If an area of concern is noted by the supervising nurse during the onsite visit, then HCN must conduct, and the aide must successfully complete a competency evaluation. Follow-up to any area of concern is conducted as appropriate.

4. The supervising nurse assesses an aide's ability to demonstrate initial and continued satisfactory performance in meeting outcome criteria that include, but is not limited to:
    a. following the patient's plan of care for completion of tasks assigned to the hospice aide by the registered nurse;
    b. creating successful interpersonal relationships with the patient and family;
    c. demonstrating competency with assigned tasks;
    d. complying with infection control policies and procedures;
    e. reporting changes in the patient's condition; and
    f. completing appropriate records and documentation of care provided.