QUINCY VALLEY MEDICAL CENTER	Ref.#	Tag#	Original Date: 10/03	Effective Date: 2/6/14	Supersede Date: 7/04
	Total Pages:		X Policy	:1!; Procedure	P
APPROVALS: ADMINISTRATOR; DEPARTMENT MANAGER			SUBJECT: Advance Directives		otocol
Manual Distribution: Acute, ED, NW, Registration	**Originating Department:** Administration		**Affected Department:** Acute, ED, NW, Regist		

GENERAL INFORMATION/POLICY

In accordance with federal and state laws and regulations on Patient's Rights, Free Choice, Quality of Life, Dignity, Self-Determination and Participation, and the Patient Self Determination Act (PSDA), this facility will respects a patient's right to make treatment decisions and to execute Advance Directives.

Advance Directives are a method by which patients may, voluntarily, provide written treatment direction regarding possible future medical care needs and/or appoint a person of persons to act as their health care decision-maker. Advance directives are relied on by the facility when; (1) The resident is no longer able to make medical treatment decisions and (2) The treatment direction is consistent with their current treatment need and their current conditions.

If the advance directive is a Durable Power of Attorney for Health Care, the facility will look to the person appointed for health care treatment direction either while the patient is capacitated or incapacitated, depending on the instructions in the durable power of attorney document.

Advance Directives are prepared while a patient is still competent and before there is a medical need for the treatment decision to be made. The most common types of Advanced Directives, in the nursing facility setting are: Health Care Directive's (Living Will), Durable Power of Attorney for Health Care (DPOAHC) and Do Not Resuscitate Instructions.

The facility will not provide the patient with legal advice regarding the execution of advanced directives.

DEFINITION/PURPOSE

1. NON DISCRIMINAION
   Under no circumstances will the facility require a patient to execute an advance Directive or othelWise discriminate against a patient on the basis of whether or not the patient has executed an advanced directive.

2. IDENTIFY1NG THE DECISION-MAKER AND PRIOR DECISIONS MADE
   The facility will determine:

   a. If the patient has executed an advance directive and if so, the facility will identity the type(s) of directive (s) executed. Depending on the type(s) of directives executed, the facility will also identifY the type of authority granted, when the authority granted takes effect and the treatment instructions provided. For example the facility will determined whether the patient has appointed another person to make heath care decision maker (DPOAHC), the facility will identifY whether the authority of the person appointed is effective while the patient is capacitated or incapacitated. The facility will also determine whether the patident has executed a Health Care direction (Living Will) or Do Not Resuscitate directive and, if so, will identifY the treatment decision(s) made.
   b. lfthe patient has not executed a Health Care Directive (Living Will), Do Not Resuscitate and/or DPOAHC advance directive, the facility will determine whether the patient has capacity to execute an advance directive. The patient's capacity will be determined during admission assessment period

(initially, annually, and significaut chauge iu condition) aud will review the capacity finding regularly (annually and upon a charge in condition which affects the patient's capacity.)

3. RIGHT TO EXECUTE ADVANCE DIRECTIVES

Upon admission, and periodically thereafter, and as the patient's condition chauges, the patient will be iuformed, iu writiug and orally, iu a language they understand, of their right to make health care decisions and of the facility's policies and procedures regardiug the implementation of advance directives. At a minimum, the facilities will review advanced directives annually and upon significant change in the **patient's medical condition.**

4. FACILITY ASSISTANCE

If a patient with capacity wishes to execute an advance directive, Social Services will assist the patient in obtaining needed outside assistance, including copies of forms, witnesses, and legal advice.

5. REVIEW OF EXETUED ADVANCE DIRECTIEVES.

Each completed advance directive wills be reviewed with the patient:

a. Upon admission
b. At the patient's request
c. When the patient's condition creates a higher or lower risk of physical or medical decline

d. \Vhenever there is a significant change in the patient's condition (a significant change in condition exists if the condition is not expected to resolve without staff intervention, impacts on more than one area of the patients health and requires iuterdiscipliuary review and /or revision to the care plan).

e. During annual review of the patient's care plan; at this time, a patient with capacity will be reminded of the right to execute and/or modify an advance directive.

6. ACTIVATION OF ADVANCE DIRECTIVES

A patient's advance directive(s) will be activated (effective) when properly executed and as follows:

a. For medical treatment decisions, a patient's Health Care Directive (Liviug Will) or Do Not Resuscitate directive will be honored:
   I. While the patient has capacity; and
   2. Upon the occurrence ofthe medical condition and related factors or circumstances specified in the **directive.**

b. The authority of a DPOAHC is activated as indicated in the document either:
   1. While the patient has capacity; (If able to make own decisions the patient will always be consulted first. See iuformed consent policy.)
   2. Only after certaiu criteria, specified within the DPOAHC document, have been satisfied. If the advance directive appoiutiug a DPOAHC is silent as the when it is to go into effect, it will become effective when the facility determiues the patient lacks decisional capacity.

c. Any medical treatment direction included iu the DPOAHC document will not be relied on by the facility since this facility considers any such treatment direction to be guidance or iustruction to the patient's legally appointed representative. The facility will, however, consult with the person appointed; using the informed consent process, to obtaiu needed treatment.

7. RELIANCE ON ADVNACE DIRECTIVES

The facility will honor the advance directive of a patient, unless the facility has reason to question the legal validity of the advance directive. Absent a reason or basis for questioning the legal validity of au advance directive, this facility will presume tbat the directive is valid. The facility will, however, honor the right of a capacitated patient to change their advance directive.

The facility will also honor the right of an incapacitated patient, wbo strongly and persistently object to the facility's implementation of the directive, to either refuse or request treatment which would otherwise be provided or withheld pursuant to the patient's directive. The facility may question off the DPOAHC if the facility does not believe that the DPOACH's decision has been made in accordance with the known wishes or, if not know, in the best iuterest of the patient. Ifthe facility has a reasonable basis for questioning the decision of the DPOAHC, the facility will immediately notifY the DPOAHC and explain to the DPOACH the basis for our concern. The facility will attempt to resolve with the DPOAHC any possible

misunderstanding. In the even the facility continues to have concerns regarding the DPOAHC's decisions, believing that it is not made based on the known wished or best interests of the patient, emergency conrt intervention may be sought by either the facility or the DPOAHC. Pending the court's determination, the facility will provide medically appropriate treatment to the patient, with notice to the DPOAHC, and consistent with the patient's known wishes if the facility has determined that he patient has decisional capacity. See policy on Informed Consent, Section VII, identifying the facility's process for resolving **capacity determination conflicts.**

To determine whether the patient has decisional capacity, the facility will rely on the criteria, if any, specified in the DPOAHC document, or if the DPOAHC document is silent, then is accordance with WAC 388-97-066 (4) (a).

The facility reserves right not to honor an advance directive pending advice of counsel or a judicial

determination.

In a staff member objects to carrying out a patient's advance directive, then another staff member wiii be assigned to provide for the patient consistent with their wishes. If a physician objects to carrying out a patient's treatment in accordance with their advance directive the facility will assist in finding a physician who will provide care consistent with the patient wishes.

If a terminally ill patient wishes to die at home, in accordance with state law, the facility will use the informed consent process to explain the risk associated with discharge. Thereafter, the facility will arrange for the patient to be discharges as soon as reasonably possible, if this continues to be the patient's choice.

8. FACILITY ACTION IN THE ABSENCE OF AN ADVANCE DIRECTIVE

For patients who have not executed an advance directive or whose advance directive does not address the treatment which is currently needed, medical decisions will be made consistent with facility policies on Decisional Capacity and Informed Consent.

9. PATIENTRIGHTS

The existence of an advance directive, directing the facility to provide or not provide certain treatments, or appointing a surrogate decision-maker, does not diminish the patient's right to participate, to the extent possible, in decisions affecting care, treatment, and day-to-day life in the facility. Patients will be encouraged to participate in all aspects of decision-making, to the extent possible, even when the patient appears to be unable to make a particular decision.

Patient's expressed choices and preferences wi11 be considered and accommodated whenever possible.

Patient, with or without capacity, have the right to override their advance directive, however, it the patient is incapacitated their right to override their advance directive will be honored when the patient's wishes are strongly and persistently expressed. Patients may execute a new advance directive if the patient has the **necessary capacity.**

Capacitated patients have the right to refuse treatment and to refuse continued stay in the facility. The facility will notify the patient's surrogate when the facility bas determined that be patient has regained capacity. The facility will explain to the surrogate the basis for its capacity fmding. The facility and

surrogate will attempt to resolve any disagreements they may have regarding the capacity fmding, however, **emergency court intervention maybe necessary.**

Pending review by the court, if necessary, the facility will provide medically appropriate treatment consistent with tbe patient expressed, wishes when the facility has reasonably determined that the patient has capacity. The informed consent process will follow in determining the patient's treatment wishes.

Incapacitate patients have the right to reuse treatment and to refuses continued stay in the facility when the

patient's refuses is strongly and persistently expressed.

MAKING YOUR WISHES KNOWN THROUGH ADVANCE DIRECTIVES

Federal law, state law and hospital policy require us to advise you of your right to make decisions conceming your medical care, including your right to accept or refused medical and surgical treatment. Quincy Valley Medical Center is committed to helping you facilitate your specific wishes.

You can make your wishes known about you future medical treatment through ADVANCE DIRECTIVES such as:

LIVING WILL- a document stating your personal directions about life-prolonging treatment.

DURABLE POWER OF ATTORNEY FOR HELATH CARE- a document selecting someone to make health care decisions for you if you become unable.

Whatever your decision conceming ADVACNE DIRECTIVES may be, YOU WILL RECEIVE THE SAME QUALITY MEDICAL TREATMENT.

Please check the following statements that apply:

_____I have NOT executed an advance directive

--'HAVE executed an advanced directive.

Living Will: Location of form----,-,----------'
Durable Power of Attorney for Health Care

Location of Form:_____.

Designee's Name:_____

_____I have received the Advanced Directs Packet. (Optional)

I have read the above statement concerning my right to accept or refuse medical treatment and my right to formulate Advance Directives.

Signed:----------

Witness:	Signature of Patient:	Date:
Witness:	Signature of Patient:	Date:

908 10 Ave SW Quincy, Wa 98848 509-787-3531

LIVING WILLS

Current state law requires that health care facilities provide information to assist patients in making decisions related to medical care, including the right to accept or refuse surgical treatment and the right to fonnulate a "Living Will."

This information is provided to help you understand the subject, to provide for your wishes and protect your rights.

WHAT IS A LIVING WILL?

fu Washington State, a Living Will is also known as a "Directive to Physicians." It is a legal document directing your attending physician to withhold or withdraw artificial life-sustaining treatment if you have any incurable illness, irreversible brain damage, or terminal coma. Current law requires that resuscitation be attempted and life support initiated if death is discovered in a reasonable length of time, unless medical staff are directed otherwise by a "Directive to Physicians."

SIGNING A LIVING WILL

If you decide to use a living will, sign the Directive to Physician in the presence of two witnesses. Neither witness may be related to you by blood or marriage, be an heir of your estate or have a claim against your estate, nor be your attending physician or employee of same or of a health facility in which you are a patient. These witnesses may be clergymen, a lawyer, or close family friends, etc.

WHAT DO I DO WITH IT?

Read it, think about it. Discuss your directive with your family and encourage them to understand your wishes. Discuss you concerns with your physician or clergy men if you desire. If you decide to sign a Living Will or Directive to Physicians, give a copy to your physician for your medical record, and provide a copy to a friend or relative who may be notified in case of an emergency.

IT IS EASY TO REVOKE YOUR LIVING WILL

Periodically review your Living Will. lfyou wish to make changes or revoke it, notify your physicians and family.

READ THE ENTIRE ATTACHED LIVING WILL FORM CAREFULLY

Be sure to read the two paragraphs under "Other Specific Directions" carefully. If either or both of these statements do not represent your wishes, delete the part before you sign the directive. (Just strike it out, put your initials in the margin and date the change.)

We have provided a manual for further reading and a copy of a Living Will. IF you have further questions, concerns or needs, please feel free to contact your physician.

HEALTH CARE DIRECTIVE (RCW 70.122)

Directive made this -day of -(month), 20 .

I, having the capacity to make health care decisions, willfully, and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

I. If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, 1 direct that such treatment be withheld or withdrawn, and that 1be permitted to die naturally. l understand by using this fonn that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness that would within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

2. In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person is guided by this directive and any other clear expressions of my desires.

3. If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (check one for each item below):

A. ____Withhold CPR (cardia pulmonary resuscitation) in case of cardiac arrest.

——CPR (cardiopulmonary resuscitation) to be done.

B. — -Do not use antibiotic therapy for acute infection.

- -Antibiotic therapy may be used for acute infection.

C. - -Nutrition by maintained by oral means only and no nasogastric tubes.

- _Nasogastric tube feedings may be utilized to maintain nutritional status.

D. Hydration be maintained by oral means only and on intravenous fluids be given

— -Intravenous fluids may be utilized to maintain hydration

4. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.

5. I understand the full import of this directive and I am emotionally and mentally capable to make the health care decisions contained in this directive.

6. I understand that before I sign this directive, I can add to or delete from, or otherwise change the working of this directive and I may add to or delete form this directive at any time and that any changes shall be consistent with Washington State Law or Federal Constitutional Law to be legally valid.

7. It is my wish that every part of this directive by fully implemented. If for any reason is held invalid this is my wish that the remainder of my directive be implemented.

Signed:_____

_____
City, County, and State of Residence

I have personally known the declarer and I believe him or her capable of making health care decisions.

Witness:_____

Witness:_____

** You will also need the Bright Green, **Physicians Orders for Life-Sustaining Treatment (POLST)** completed.

7"HIPAA PERMITS DISCJ;;OSURE OE POILSTF CEO :OIHER HEAliiH CARE PROVIDERS AS NECESSARY

Physician Orders

for Life-Sustaining Treatment (POLST)

'IRST follow these orders, THEN contact physician, nurse practitioner or PA-C. fhis is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.

Last Name

rst/Middle Initial

Date of Birth

A Check One

B Check One

CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and is not breathing.

O CPR/Attempt Resuscitation 0 DNR/Do Not Attempt Resuscitation (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B, C and D.

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

O COMFORT MEASURES ONLY Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer: *EMS contact medical control to determine if transport indicated.*

O LIMITED ADDITIONAL INTERVENTIONS Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer *to hospital if indicated. Avoid intensive care if possible.*

C Check One **ANTIBIOTICS:**

O FULL TREATMENT Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. Transfer *to hospital if indicated. Includes intensive care.*

Additional Orders: (e.g. dialysis, etc.) _____

D Check One

O No antibiotics. Use other measures to relieve symptoms.
O Determine use or limitation of antibiotics when infection occurs, with comfort as goal.
O Use antibiotics if life can be prolonged.

Additional Orders:

E

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and liquids by mouth iffeasible.

O No artificial nutrition by tube.
O Trial period of artificial nutrition by tube. (Goal: _____
O Long-term artificial nutrition by tube.

Additional Orders:

SuMMARY OF GoALS AND SIGNATURES

Discussed with:
O Patient O Parent of Minor
0 Health Care Representative
O Durable Power of Attorney for Health Care
0 Court-Appointed Guardian

Patient Goals/Medical Condition:

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Print Physician/ARNP/PA-C Name	Phone Number	Patient/Resident or Legal Surrogate for Health Care Signature (mandatory)	Date

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Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid

MAKING YOUR WISHES KNOWN THROUGH ADVANCE DIRECTIVES

Federal law, state law and hospital policy require us to advise you of your right to make decisions "Jncerning your medical care, including your right to accept or refuse medical and surgical treatment. -"uincy Valley Medical Center is committed to helping you facilitate your specific wishes.

You can make your wishes known about you future medical treatment through ADVANCE DIRECTIVES such as:

LIVING WILL- a document stating your personal directions about life-prolonging treatment.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE- a document selecting someone to make health care decisions for you if you become unable.

Whatever your decision concerning ADVANCE DIRECTIVES may be, YOU WILL RECEIVE THE SAME QUALITY MEDICAL TREATMENT.

Please check the following statements that apply:

_____I have NOT executed an advance directive.

_____I HAVE executed an advanced directive.

Living Will: location of form_____
Durable Power of Attorney for Health Care

Location of Form_____

Designee's Name,_____

_____I have received the Advanced Directs Packet. (Optional)

I have read the above statement concerning my right to accept or refuse medical treatment and my right to formulate Advance Directives.

Signed:

Witness	Signature of Patient	Date
Witness	Substitute Judgment Maker (If patient is unable to sign)	Date

LIVING WILLS

,urrent state law requires that health care facilities provide information to assist patients in making decisions related to medical care, including the right to accept or refuse surgical treatment and the right to formulate a "Living Will."

This information is provided to help you understand the subject, to provide for your wishes and protect your rights.

WHAT IS A LIVING WILL?

In Washington State, a Living Will is also known as a "Directive to Physicians." It is a legal document directing your attending physician to withhold or withdraw artificial life-sustaining treatment if you have any incurable illness, irreversible brain damage, or terminal coma. Current law requires that resuscitation be attempted and life support initiated if death is discovered in a reasonable length of time, unless medical staff are directed otherwise by a "Directive to Physicians."

SIGNING A LIVING WILL

If you decide to use a living will, sign the Directive to Physicians in the presence of two witnesses. Neither witness may be related to you by blood or marriage, be an heir of your estate or have a claim against your estate, nor be your attending physician or employee of same or of a health facility in which you are a patient. These witnesses may be clergymen, a lawyer, or close family friends, etc.

WHAT DO I DO WITH IT?

Read it, think about it. Discuss your directive with your family and encourage them to understand

Jur wishes. Discuss your concerns with your physician or clergymen if you desire. If you decide to sign a Living Will or Directive to Physicians, give a copy to your physician for your medical record, and provide a copy to a friend or relative who may be notified in case of an emergency.

IT IS EASY TO REVOKE YOUR LIVING WILL

Periodically review your Living Will. If you wish to make changes or revoke it, notify your physicians and family.

READ THE ENTIRE ATTACHED LIVING WILL FORM CAREFULLY

Be sure to read the two paragraphs under "Other Specific Directions" carefully. If either or both of these statements does not represent your wishes, delete that part before you sign the directive. (Just strike it out, put your initials in the margin and date the change.)

We have provided a manual for further reading and a copy of a Living Will. If you have further questions, concerns or needs, please feel free to contact your physician.

HEALTH CARE DIRECTIVE (RCW70.122)

'irective made this_____day of_____(month), 200_.

I, , having the capacity to make health care decisions, willfully, and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

1. If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand by using this form that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness that would within reasonable medical judgment as having no reasonable probability of recovery from an irreversible coma or a persistent vegetative state.

2. In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a durable power of attorney or otherwise, I request that the person be guided by this directive and any other clear expressions of rny desires.

   If I arn diagnosed to be in a terminal condition or in a permanent unconscious condition (check one for each itern below):

   A. ____Withhold CPR (cardiopulmonary resuscitation) in case of cardiac arrest.

   ____ CPR (cardiopulmonary resuscitation) to be done.

   B. ____Do not use antibiotic therapy for acute infection.

   ____Antibiotic therapy may be used for acute infection.

   C. ____Nutrition be maintained by oral means only and no nasogastric tubes.

   ____Nasogastric tube feedings rnay be utilized to maintain nutritional status.

D. ____Hydration be maintained by oral means only and on intravenous fluids be given.

____Intravenous fluids may be utilized to maintain hydration.

4. If I have been diagnosed as pregnant and that diagnosis is know to my physician, this directive shall have no force or effect during the course of my pregnancy.

" I understand the full import of this directive and I am emotionally and mentally capable to make

1 the health care decisions contained in this directive.

6. I understand that before I sign this directive, I can add to or delete from, or otherwise change the wording of this directive and that I may add to or delete from this directive at any time and that any changes shall be consistent with Washington State law or federal constitutional law to be legally valid.

7. It is my wish that every part of this directive be fully implemented. If for any reason is held invalid it is my wish that the remainder of my directive be implemented.

Signed_____ __

_____

City, County, and State of Residence

I have personally known the declarer and I believe him or her capable of making health care decisions.

Witness_____ __

Witness_____ __

)

Effective Date: 7/30/13	Supet'sede Date:

Hospice Respite Care

QUINCY VALLEY MEDICAL CENTER	Ref. #:	Original Date: 7.30.13
	Total Pages: 1	
APPROVALS:		SUBJECT:
Department Manager		
	[redacted] Policy	_x Procedure
Manual Distribution ED, NW,Acute	Originating De[redacted]nts: Nursing Departm	Affected Departr Acute, NW, ED

DEFINITION / PURPOSE

Respite care is short term inpatient care provided to the individual only when necessary to .relieve the family members or other persons caring for the indi·vidual at home. Respite care may not be reimbursed for more than five consecutive days at a time, including the date of admission but not including the date of discharge.

The goal of respite care is to give family caregivers and other informal social support systems temporary relief from the demands of daily care.

PERSONNEL

Nursing on Acute and NW

Admission Criteria

Any request for Respite admit must go through the Social Worker, Utilization Review Nurse and or designee.

Administrative Chain of Command

GENERAL INFORMATION POI.Icy

1. A patient's plan of care during an inpatient respite stay would be the same as if the patient were receiving care in their home.
2. Care in the facility will be custodul only and the hospice plan of care will be followed by the facility staff.
3. A hospice registered nurse will be a liaison between hospice and the care facility
4. If the hospice care plan is not followed, and/or treatments are initiated without the approval of the interdisciplinary group, hospice will not be financially .responsible for any treatment procedures or facility charges.
5. Hospice must be notified of any and .all patient changes. Hospice must a.llprove of any changes in patient care.
6. \Ve will accept orders form the hospice nurses'
7. Hospice will supply the facility with:
    a. Provision of a copy of the patient's care plan and specifies the inpatient respite services to be furnished.
    b. *A* copy of the hospice v-.isit schedule
    c. How to contact the hospice provider
    d. How to contact the patient's caregiver
    e. Report from hospice nurse re above.
    £ c\11 medications for the patient
    g. .All supplies needed for the patient.

8. Documentation in the clinical record should include the following:
    a. Reason for respite care
    b. Dates of respite care provision
    c. Visits by any hospice discipline to the patient during the respite stay
    d. We received report from hospice nurse re: plan of care, and contact numbers.
9. All documentation will occur in a paper chart form.
    a. Paper 11ar for medications
    b. Nursing documentation will be in summary charting on the nursing progress notes.
    c. Pt medications will be put in the non-formulary portion of the pyxis
    d. Paper form for I and O and vitals will be utilized if necessary.
    e. Paper provider order form for any orders from hospice.

REFERENCES

Level of Care Tip Sheet, National Hospice and Pallative Care Organ.ization, 2012

LHC Group, INC, policy, Inpatient Respite Care, Policy number 3.010