KINDFUL PROCESS

Excellence in Long-Term Care

Orders

Kindful will make sure that all hospice admission orders are written as below. This ensures compliance with State and Federal regulations that are required by the facility and will also keep Kindful Health in compliance.

Admit to Hospice under Kindful Health Services

Hospice for the primary diagnosis of:

Hospice RN Case Manager:

Hospice physician:

Diet:

Allergies:

Patient transfer status:

Patient code status:

Patient discharge plan:

The qualifying reason for respite: (if applicable)

Facility NP and MD may write orders for the patient while in GIP, but the facility must notify Kindful Health of new orders or changes.

Notify Kindful Health at (866) 730-4550 for any change of condition, new orders, or questions.

TIPS

- **Write each medication exactly as it is supplied and how it will be administered.**
- **Write an order for all specialty equipment.** (i.e. bed, wheelchair, mats, wound care, foleys, colostomies, etc.)

Actions required before leaving an admission visit

- **Review and determine every medication the patient has and will be taking.**
- **Ensure each medication is correctly profiled with the hospice pharmacy and is available, or a stat delivery time is communicated to the facility nurse.**
- **Determine what DME the patient will need and that it is in place or ordered.**
- **Document the education regarding medication, symptom management, and give them the Kindful Health 24/hr contact information for questions or issues that may arise.** Please be specific to document who you taught (patient, family, MPOA, staff, etc.)
- **How does the facility want their orders? Electronic?** Or, if the facility requests handwritten orders, all orders must be handwritten, and a copy must be left with the facility nurse. There will also be an order in-box at the nurse's station where the orders can be placed.
- **Please do not leave the facility until the DNR is in-house or a plan is in place for its arrival.** If the patient is not a DNR, please document the patient or MPOA's wishes for Full Code status.

Actions required before leaving routine visits

- **Review every medication before leaving.** For all scheduled visits, the medications must be reviewed, corrected as needed, and re-ordered if they are low in supply. Please be aware that this is a required practice.
- **For any new medications ordered, the POA must be notified, and the discussion documented in the chart.**
- **Complete a head-to-toe assessment on every scheduled visit.** If the patient refuses a skin assessment, document the reason why.
- **Complete a DME review on every scheduled visit and document "All DME was assessed and is in proper functional condition."** This must be done with each visit. If the DME has any noted problem, then notify the facility nurse and have a plan in place to get it replaced as soon as possible. If the equipment is in danger of harming the patient, it must be removed from the patient's access until the replacement DME arrives.
- **Assess the patient's Hospice Chart for completion.**
  - **Are the most recent orders in the chart?** (If not, alert the office specialist of the items needed, missing, or need to be updated.)
  - **Correct mistakes** and fill in anything missing in the chart before leaving the visit.

Assess that these required items are in the chart

- **Copies of hospice admission paperwork, including consents, and the Notification of Election (NOE)**
- **Certification of Terminal Illness (CTI)**
- **Re-Certification of Terminal Illness (If the patient has been on Hospice long enough)**
- **Most recent Hospice Plan of Care**
- **Most recent Hospice Orders**
- **Most recent Hospice Aide Care Plan**
- **Most recent Hospice Nurse's Notes**
- **Sign In/Sign Out sheet for all Hospice staff making visits**

Actions required before leaving a facility after all visits

- It is required that before leaving the facility, Kindful staff will **check in with management and give them a quick report** about the visit. The DON, ADON, or Charge Nurse are acceptable for this report.
- After each visit, please **call the POA and communicate what was done at the visit** and what changes, if any, were made.

QUICK TIPS IN A SNF/LTC COMMUNITY

- **Always knock before entering a room, then introduce yourself, and explain why you are there.**
- **Always provide care to a patient in privacy.** Close the door, pull the curtain, close the blinds.
- **Always assess or provide care for a patient in private**, never in the hallway or the dining room. The only exception is a medical emergency such as a fall or sudden illness, etc.
- **Always leave medications with the nursing staff to administer**, never leave with the patient to self administer.
- **Always report any new wound, injury, or s/sx of abuse or neglect to the facility administrator.**
- **Always remember that the facility administrator is the abuse and neglect coordinator for the facility.**
- **Always push a patient forward in a wheelchair**, never pull backward.
- **Always keep medical records secure and private**, never leave where anyone can read them.
- **Always remember your name tag.**
- **Always remember to smile and give everyone your love and compassion**—it will make a tremendous impact on all the facility patients and facility staff.