MobileWyse Hospice Admissions

Discussion for all admissions must include:

1. Explanation of benefits including medication coverage criteria.
2. Role of SN, MSW, Chaplain, HCA and volunteer.
3. Obtain patient History.
4. Goals of patient/family.
5. Explain meds for comfort.

Get signature on paper forms:

a) Notice of Election
b) MA Election for Mass Health/Medicaid insured.
c) Verification of Reimbursement (VOR) for SNF only.

Provide patient/ family with Hospice Handbook (available in Spanish also).

Provide Process of dying booklet if death is imminent or when appropriate.

For full Admission, start visit in MobileWyse, using MVH Integrated Assessment visit reason. The **Narrative** note and **NHPCO core measures** form will populate the visit as well as the Integrated Assessment. All 3 forms must be completed.

1. **MSP**- Patients must be assessed for need for MSP. Complete the MSP for all Medicare patients.
2. **Contacts**-Enter/ update contact list as needed.
3. **Diagnoses**-Accept SOC diagnoses from the referred list, indicate which Dx are/ are not hospice related and verify onset/exacerbation dates. Once Dx are accepted, go to the Current Dx list and move the primary Hospice DX to the top position. If you are not sure what the primary hospice DX should be, contact your manager or the Primary MD to verify.
4. **Medications**- Copy all meds from the referral, then add Comfort Kit and DC inappropriate meds as per MD. Be sure that all meds have a dose , rte and frequency as well as an indication/ PRN reason and payor.
5. **Enter Faith and religion**.
6. **Directive Attribute** -Enter DNR and /or MOLST.
7. **Veteran Status**-complete.
8. **Safety Assessment**- Complete the Environmental Safety Form- In Yes/No dropdown, just tap yes to those items that apply.
9. **Initial Assessment**- Complete .
10. **Comprehensive assessments**- Complete when death may occur prior to MSW and Clergy visits.
11. **Vitals**-complete.
12. **HT/WT** tab, enter weight and/or MAC (Mid Arm circumference).

13. **Pain assessment**- score pain when able, then complete the appropriate pain assessment including at least 5 of the 7 pain characteristics. For NonVerbal patients, use the non verbal pain assessment and document 1 characteristic of the pain. Use the FLACC for children and the PainAd for dementia patients.
14. **Review of systems**- complete and document head to toe assessment in the systems tabs.
15. **Respiratory Assessment**-Be sure to note non medication RX for dyspnea, if patient has dyspnea and is not taking meds to treat.
16. **GI Tab**- note non medication interventions for Bowel regime if patient taking narcotic pain meds and not taking meds to treat/prevent constipation. If no treatment necessary indicate reason 9ex- loose stools).
17. **Mental Status**- complete.
18. **ADL status**-completing required
19. **Mobility form**- complete status.
20. **MAHC 10 fall risk assessment**- must be completed. Be sure to include an Intervention on the POT to address fall risk for all patients with score > or= 4.
21. **Equip inventory**- identify any Equipment in the home and whether or not the patient/caregiver can use the equipment safely.
22. **Medication review**- complete review, teaching tabs.
23. **Rights**- Check all that apply.
24. **VFO**-
    a) Edit 1x/1day order for SN and enter appropriate visit frequency order for 1st week. Be sure to choose the day of the week that the assessment was completed as one of the days.
    b) Add the appropriate VFO for the remainder of the cert period (90 days for the initial cert period).
    c) Enter up to 3 SN PRN visit orders with appropriate reason.
    d) Enter 1x/wk for 1-2 weeks VFO for clergy and MSW.
    e) HCA- If patient accepts HCA services, enter appropriate HCA VFO.
25. **Unipolicy**- must complete 1st part and disease specific.
26. **Palliative**- (PPS) complete for all patients.
27. **Edmonton**- complete for all patients.
28. **Location and Level Of Care**- complete both. If Patient was admitted prior to the Integrated Assessment visit, be sure to go into the Attributes to back date the Location and level of care attributes to the sign on visit date.
29. **Primary MD**- verify the Primary MD is correct when you make the call to the physician to confirm terminal illness, meds and equip order. If the Primary MD is wrong in the chart, change it in the Prim MD tab.
30. **POT-**
    Complete all POT Items listed- ACTivities, Supply, M/S (mental status), Diet, Prognosis, Safety.
31. **Allergies**- in patient Profile/Facesheet, enter allergies. You can also access allergies via the POT Creation Wizard.
32. **Assessment**-complete initial assessment.
33. **Plan**-complete including disciplines referrals and whether or not patient accepted the referrals.

34. **Narrative Note**- Complete following template provided.

35. **Complete POT orders** – Go to the POT Creation Wizard to complete the POT orders.
    a) Be sure to address **allergies**.
    b) Interventions-
    Standing Orders –accept all standing orders **except** Foley Cath PRN Comfort Care Perform and instruct Venous Access Device per Agency Protocol, and Wound care pre agency protocol.
    Add- Interventions specific to the plan of care including:
    1. **Wound care Intervention**- when wound is present, include location of wound, frequency of dressing change, method to cleanse wound, and dressing material. (Integumentary status folder)
    2. **Pain Management/comfort**- for those with pain (Rest & Comfort/ Pain –R&C folders)
    3. **Medication –** Management and teaching Interventions (medication folders)
    4. **Foley Catheter Orders**- Include type, size, and frequency to change- (GU folder) family teaching (Hospice Urinary elimination folder)

Hospice Folder Interventions

1. **Bowel elimination**- for those with issues and/or on Narcotic pain meds.
2. **Fall risk intervention**- when fall risk is identified (Under mobility in Hospice folder or safety /General category)
3. **Skin integrity**- for those at risk for skin breakdown
4. **Dying process**- Interventions as appropriate.
5. **Respiratory**- address interventions for dyspnea, anxiety, 02 safety.
6. **Sleep /Rest Intervention**- as needed
7. **Spiritual**- as needed

c) Goals- enter appropriate goals
d) D/C plan- Requires Support until death.
e) Outcome Potential- for the stated goals (Do not enter Rehab Potential)

HCA- When needed, enter VFO, Goal and Interventions for HCA- See HCA order Entry Instruction!

Sign the POT- See Instructions for signing POT orders

Connect your Device as soon as you complete VFO's for Clergy, MSW and HCA.

Calls to make:

1. Primary MD
    a) Confirm terminal prognosis of less than 6 months.
    b) Obtain order for Meds- Comfort kit and Medications to be DC'd

c) Get order for any equipment required (Always confirm with Manager any special supplies that may be needed).
d) Comfort Kit- call Long Term Pharmacy to order.
e) Equipment- Call HCS
f) Care Team- Leave voicemail at 978-552-4050, X310. Inform of admission status , any special needs, and whether or not a visit is needed nest day.
g) Facility patients- communicate with MSW or case managers to inform of hospice Admission

Special Instructions for SNF Admission

1. Check for/obtain MD order for Hospice.
2. Make copies of DNR/MOLST, med sheets, HealthCare Proxy
   And Invocation of Proxy if one exists.
   Obtain Verification of Reimbursement (VOR) for SNF only.
3. Complete admit and print the following to leave in Chart:
   a) Med List
   b) Nursing Assessment.
   c) Yellow copy of Consent form.

SNF chart- Use green tab in front of printed forms and put info sheet for Hospice in front of chart.

HCA frequency usually 3-5x/wk in SNF.