HOSPICE & HOMECARE
OF RENO COUNTY
A Member of the Hutchinson Regional Healthcare System

Hospice House

Your Care Team:

Nursing: Hospice House Staff available 24 hours a day

Home Health Aides: Hospice House Staff available as needed

Social Worker: _____

Chaplain: _____

Volunteers: Available as needed

Therapist: _____

Hutchinson	**McPherson**	**Hospice House**
620-665-2473	620-245-0116	620-669-3773
2020 N Waldron, Ste. 100	1318 N Main	1523 East 20th
Hutchinson, KS 67502	McPherson, KS 67460	Hutchinson, KS 67502

Toll-Free: 800-267-6891

We CARE how YOU live!

Hospice Medicare Benefit Admission Criteria

For the Medicare Hospice benefit, individuals must be entitled to Medicare Part A and be certified by the attending physician and the Hospice Medical Director as terminally ill. That is, a life expectancy of six months or less if the terminal illness runs its normal course.

Eligible patients must sign a statement choosing Hospice care instead of regular Medicare A benefit. Treatment not related to the terminal and related diagnoses will remain under regular Medicare coverage.

The Hospice Medicare benefit continues as long as there is a physician's certification of the terminal illness. The certification periods consist of two 90 day periods followed by an unlimited amount of 60 day periods.

Patients can withdraw from the Hospice Medicare benefit at any time and resume all regular Medicare benefits.

Guidelines for patients using their Hospice Medicare Benefit are clearly established. Call Hospice & HomeCare of Reno County before using any of the following services:

- Emergency Room visits
- Hospitalization
- Ambulance services
- All treatment and services should be coordinated by hospice and part of the Plan of Care.

You may continue to be assessed by your attending physician under the hospice benefit.

If you have any questions or concerns that are not covered in this material, please do not hesitate to contact Hospice & HomeCare of Reno County.

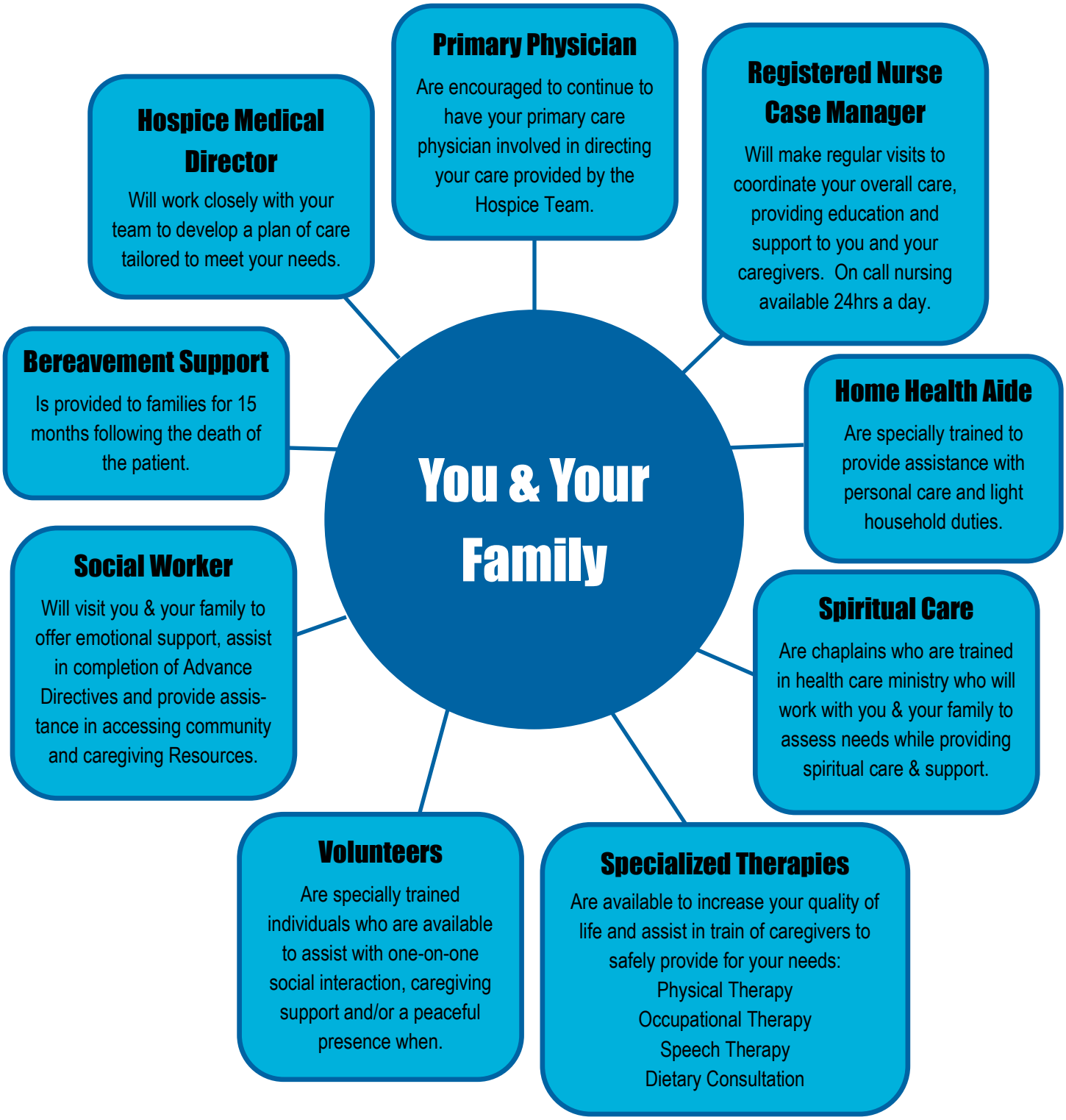
Other Insurance Providers

While most insurances follow the Medicare benefit, each individual insurance will be contacted and an explanation of benefits will be obtained. Your Social Worker/ Registered Nurse will provide you with specific information about your covered benefits.

Please contact our office for any further questions or concerns in regards to your insurance coverage.

Please notify Hospice & HomeCare of Reno County of all insurance changes while receiving services with our agency to ensure successful billing.

Your Care Team



Working together to honor the patient and family's wishes, while allowing the patient to live life as fully as possible.

Developing Your Plan of Care:

Identifying your goals for your Hospice Experience is our first priority.

Communicating your needs and desires with your Hospice Care Team is the first step in meeting your goals.

The Plan of Care is an essential part of your healthcare. It provides direction to your Hospice team on the goals, treatments and interventions you choose to meet your physical, emotional and spiritual needs. This plan is initiated at admission and evolves over time to address your changing healthcare needs.

To accomplish your goals it is important that you share your wants and desires at each visit. Please communicate with your Hospice Team any changes that you are experiencing.

Keep in mind the items listed below:

- When you are experiencing pain, anxiety, shortness of breath, constipation and other symptoms that aren't normal.
- When you are experiencing changes in your eating, walking, sleeping or the ability to do the things that you do on a daily basis.
- When you or your caregiver are unsure about how to provide care, medications, treatments or the natural disease process.
- When you are starting to run out of medications, incontinent supplies, or medical supplies.
- When you, your family or caregiver are scared, overwhelmed or fearful.

Our hope is to avoid crisis and work proactively to anticipate the needs of you, your family or caregivers.

Please feel free to call if any of the above issues arise.

Assistance is available 24 hour a day.

Time of Death at Hospice House:

Your Hospice Team and the Hospice House staff will provide you and your family with education about end-of-life signs and symptoms while your disease progresses. You also are provided the booklet "When Death is Near" which provides insight to the caregiver on signs your Hospice staff are watching for. Please don't hesitate to ask questions. Although hospice is unable to predict the exact time of death we can provide information on different timelines and normal disease processes.

What to do at Time of Death:

-Notify the Hospice House Staff if they aren't present.

-The body with be bathed, tubing will be removed and clothing will be changed. Family can assist with as much of the body preparation as desired.

-Staff will telephone physician to advise of death. The physician does not make a visit.

-Staff can assist in notification of family, friends, church or chaplain, simply request assistance if desired. People are welcome to view the body and say their goodbyes.

-Notify the staff when you are ready for the Funeral Home to be called. Family can choose to stay until their arrival however it isn't required.

Caregiving Support:

Being the caregiver can be emotionally and physically exhausting at times. Our hope as a Hospice agency is to provide the family and caregivers the support they need to be successful in caregiving. The Hospice Team will assist in educating the caregiver(s) on the disease process, medications, treatments, care needs and options available. It is always important to build a network of support. Creating a list of people available and willing to provide support, caregiver relief and assist in the care needs of the patient can elevate caregiver fatigue. Sometimes it is difficult to ask for help. When people reach out to offer assistance, make sure to have an idea of ways they can be helpful. Here are a few ideas:

- Friends to be present with patient so caregiver can run errands, rest or just get out of the house for a short time.
- Provide a small meal or snacks of patient's favorite foods.
- Helpful hand around the house with cleaning, laundry or dishes.
- Assistance with errands such as picking up medication or running to the grocery store.

Successful caregivers have to make sure to take care of themselves throughout this process. The following page includes some caregiving tips. Please reach out to your Hospice Team for additional support.

Helpful Hints for the Caregiver:

ROUTINES: Having a daily routine is helpful to patients and caregivers. Collecting all bath items before the bath is time saving and provides a sense of stability to the patient.

BELLS: A bell for the patient to call you can be helpful to both you and the patient. The patient can have ready access to you, and you can rest knowing the patient can call you when you are needed.

MEALS: The blender is useful when chewing and swallowing are difficult for the patient. Remember, even if the patient eats poorly, you (the caregiver) need to keep up your strength by eating, sleeping, and exercising regularly and in a healthy manner. You may consider having friends bring in meals or using Meals on Wheels.

BE KIND TO YOURSELF: Get enough rest and exercise. Eat a balanced diet. Make time for your favorite activities. Keep your sense of humor. Have someone to share your feelings and frustrations with. Avoid trying to do too much.

SHARING FEELINGS: Be ready to listen when others are ready to talk. The patient needs to set a timetable of when to talk. You may find yourself the target of anger or frustrations, but remember, you are not the cause of the hostility. Avoid expressing false cheer, saying “everything will be alright”. Remember touching, hugging, and caressing are ways to express acceptance and caring. Try to reach out gently and repeatedly to provide reassurance.

Leaving a Legacy

Be present by enjoying the small things each day. Reconnect with family members or friends that you haven’t seen and reminisce about past life events that have brought you joy. Spend this time that you have remembering your accomplishments, experiences and beloved memories of the past. Share those with the ones you love.

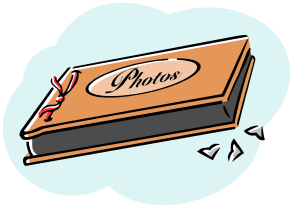
The next page, shares ideas and ways for you to Tell Your Story and leave your family and friends with your legacy...

Sharing Your Life Story

Telling your life story (life review) is one of the most valuable gifts you can give your loved ones. What may be a surprise to you is how valuable the telling of it will be to you. As our life comes to an end, we need to know that someone in this world has seen us and that our life had meaning and value. We need to put experiences into perspective, resolve past conflicts, forgive ourselves and others, feel a sense of completion, and celebrate our life successes.

This information is designed for families to assist their loved one to recall and record their life journey. Find a quiet, comfortable place and give yourself plenty of time for reflection. Make certain that you tell other family members what you are doing to gather their information and support.

Life review can be written, a video, or audio. Having the stories told by the loved one adds value to the story. Create a narrative on each item. Select a photo album large enough for documents and large pictures. If your loved one cannot participate, request information from other family members, especially his/her siblings. Music can help to trigger memories. Music from their era (big bands, rock and roll, jazz, etc.) can hold a million keys to the past.



Rules For Life Review:

- Listen without criticism or judgment
- Encourage your loved one to tell his/her versions and tell old stories
- Be patient with repetition
- Encourage loved ones to cover various stages of life (from early life to present)
- If conversation dwells on sad/depressing topics, gently change the subject
- If he/she cannot remember, go to another topic and perhaps come back to previous topic another time
- Use dates if possible
- Ask "where were you when…." (i.e. Pearl Harbor, JFK was shot, the first spacecraft went up, dust bowl days)
- Ask, "Who was with you" on life events

Getting Started:

Make categories of life stages:

- Original family-what do you know about family coming to U.S.?
- Where did your family live when you were born?
- What do you remember about your early life?
- How old were you when you had your first TV, indoor plumbing, and electricity?
- Original family (parents, grandparents, etc.)
- What do you remember about your grandparents?
- What was your father's/mother's occupation?
- Where did your parents grow up?
- Were you closer to your mother or father?
- Did anyone live with your family when you were young?
- Work history (first job through retirement)
- Courting and marriage (first date, prom, proposal, marriage(s), etc.)
- Spouse(s); Children, children's weddings; Grandchildren; Siblings (brothers/sisters)
- Close friends (where you met, things in common)
- Recreation, hobbies; Travel, vacations
- Religion/faith/congregation
- Military Service
- School (grade, jr. high, high school, college)

Volunteer Services

In 1981 this agency was started by community volunteers. This group of individuals saw the need for hospice services to be provided to Reno County residents. To this day, our agency continues to function by the support of our volunteers. These volunteers have a passion to support patients and caregivers at end-of-life. Listed below are just a few way you and your caregivers can benefit greatly from our Volunteer Services:

"Do ordinary things with extraordinary love"
-Mother Teresa

As a hospice organization, our volunteers are treated just like staff members. Each volunteer goes through initial background checks, reference checks and training so you can feel confident in the people who come into your home. Please let your Hospice Team know how our Volunteer Services can assist you!

Medication & Supplies:

Typically hospice services are paid on a per diem basis. When this is the case, medication, medical supplies and durable medication equipment are provided by Hospice. Please notify your hospice team when you run low on:

Medications: Any medication related to your terminal diagnosis, related diagnoses or for your comfort will be covered by Hospice. Hospice will provide a 2 week refill on each medication.

Medical Supplies: Wound treatments/dressings, colostomy, drains that are related to your terminal diagnosis or related diagnoses will be provided by Hospice.

Durable Medical Equipment: Equipment might be needed for you to remain independent and lessen the amount of physical stress on your family and/or caregivers. Your hospice staff will work to anticipate your needs.

Please communicate with your Hospice Team when needs arise.

Safe Use & Disposal of Controlled Substances:

Safe use of all medications and any controlled substances is high priority for Hospice & HomeCare of Reno County. Our agency policy is for each medication to be prescribed by a licensed physician or a mid-level in accordance with State and Federal laws. It is important that each medication that you are using is reported to your nurse. Each medication will be included in your medication profile and administered as directed in your individualized plan of care.

The agency Policy and Procedure: Medication Administration and Safety at Hospice House is provided within the admissions information.

Hospice & HomeCare of Reno County completes the disposal of medications and controlled substances in accordance with accepted standards of practice within the State and Federal laws/regulations. Please speak with your nurse on specific directions for disposal of medication.

The agency Policy and Procedure: Medication Disposal at Hospice House is provided within the admission information.

At any time you would transfer to your home, nursing home or other care setting, specific policies and procedures for that location of care will be provided to you.

Patients who reside in facilities (hospital, nursing home, skilled nursing facilities, assisted livings) may have their medications disposed of, or returned to the pharmacy in accordance with the facilities procedures.

HOSPICE & HOMECARE OF RENO COUNTY A Member of the Hutchinson Regional Healthcare Family	Manual	Clinical
	Title	Medication Administration and Safety at Hospice House
	Policy Number	C142
	First Approved Date	04/2002
	Revision/Review Date	4/2/2013; 1/22/2016
	Approved Date	4/3/2013
		Page 1 of 3

I. POLICY:

a. Drugs and biologicals are administered to patients in the Hospice House by a licensed nurse or physician, or may be administered by the patient/family/caregiver with prior approval of the attending physician and/or Medical Director. Medications will be administered as directed in the patient's plan of care, as per physician order.

II. PROCEDURE:

a. The nurse will follow the physician's order when administering medications at the Hospice House.
   i. Home Health Aides and Volunteers do not administer medications.
   ii. Nursing staff will administer medications in accordance with accepted standards of practice.

b. Before administration the nurse administering the medication completes the following:
   i. Verifies that the medication selected matches the medication order and product label.
   ii. Visually inspects the medication for particulates, discoloration, or other loss of integrity.
   iii. Verifies that the medication has not expired.
   iv. Verifies that no contraindications exist.
   v. Verifies that the medication is being administered at the proper time, in the prescribed does and by the correct route.
   vi. Discusses any unresolved concerns about the medication with the patient's physician, prescriber, and/or staff involved with the patient's care, treatment or services.
   vii. Ensures that the patient and/or family is informed about any potential for clinically significant adverse drug reactions or concerns regarding administration of a new medication.
   viii. Identifies any high alert medication in the P&P A215 Medication: Management of High Alert Medications:
      1. Will perform lab draws as ordered related to ongoing monitoring of therapeutic blood levels of prescribed high alert medications.
      2. Collaboration with MD regarding dosage adjustments required for maintaining therapeutic blood levels of high alert medications.
      3. Educates patient/family about specifics safeguards to reduce risk related to prescribing of high alert medication.
      4. Reports s/s indicating risk of injury to patient taking prescribed high alert medication to MD.
   ix. Confirms the patient identification using the <u>two (2) identifier</u> system.

c. The administration of medications is documented on the patient's *Electronic Medication Record* and signed by the administering nurse.
    i. The documentation by the nurse includes: the name of the medication, strength, dose, amount, route, date and time.

d. Orders will be obtained for administration of medications by anyone other than the nurse or physician; patient or caregiver. Approval will also be received from the interdisciplinary team
    i. The nurse will assess the patient/caregiver's ability to safely administer medications prior to obtaining the order.
    ii. Instruction is provided to the patient/caregiver on the proper administration of medications if administration by such is approved. Instruction includes, but is not limited to:
        1. The potential side effects of medications included in the patient's plan of care
        2. Emergency responses to adverse reactions;
        3. How to safely store medications kept at the patient's bedside
        4. The proper disposal of used syringes or patches;
        5. When to administer medications included in the plan of care;
        6. Documenting self-administration of medication (if appropriate); and
        7. When to call the nurse if any difficulties or questions arise regarding self administration of medication
    iii. The nurse documents all instruction/interventions given regarding the safe administration of medication and/or high alert medication and includes the response of the patient/caregiver to the instruction as appropriate.
        1. Evidence of instruction on **High Alert Medications** will be via software data element: **Instructed/copy to: High Alert Medications.**
        2. Interventions on Care Plan as suggested under PROCEDURE b.viii of this policy.

e. Medications are dispensed in sufficient quantities to meet the needs of the hospice patient and to minimize the potential for waste.

f. Medications that are no longer needed are disposed of in accordance with the agency medication disposal policy and procedure. Refer to this policy for more information.

g. Orders for medications are received in accordance with professional guidelines by licensed nurses, pharmacist or another physician. Refer to agency Medication Orders P/P for further information.

h. Orders received will be integrated into the patient's plan of care. Refer to agency P/P Physician Orders / Obtaining Signatures for more information.

i. The nurse receiving the order is responsible for updating the patients MAR, scheduling the medication in the Electronic Medical Record, and ordering the medications if necessary.

i. Physician orders will be reviewed by a nurse every 24 hours to ensure all orders have been completed as directed by the physician.

j. All medications are labeled in accordance with state and federal laws. Refer to Receipt of Medications at Hospice House P/P A218.

k. Caution is utilized on the High Alert Medication, Concentrated Morphine Sulfate.

i. When a concentration is ordered other than the most commonly used morphine sulfate 20mg/ml, the bottle label is highlighted and the concentration is circled in black.

l. The use of experimental drugs, or any FDA-approved drug in a non-approved manner, is not permitted.

m. As appropriate, nurses instruct patients/caregivers on the use, dose, frequency, interactions, and side effects of all medications and document this instruction.

n. The nurse reviews all medication for duplication, ineffective drug therapy adverse effects and drug reactions, drug interactions, and noncompliance with drug therapy. Refer to agency Medication Regimen Review P/P C149 for more information.

o. Untoward drug reactions and/or medication errors are handled as an occurrence; the attending physician is notified and the proper documentation is completed. Refer to agency Occurrence Reporting P/P A144.

HOSPICE & HOMECARE OF RENO COUNTY A Member of the Hutchinson Regional Healthcare Family	Manual	Clinical
	Title	Medication Disposal at Hospice House
	Policy Number	C144
	First Approved Date	04/2006
	Revision/Review Date	1/2013; 1/2016
	Approved Date	1/30/2013
		Page 1 of 1

I. POLICY:

a. Medications will be disposed of in compliance with the agency policy and in accordance with State and Federal requirements. In addition controlled drugs will be disposed of with the oversight pharmacist to ensure that controlled drugs are accurately accounted for and destroyed or returned to the pharmacy.

II. PROCEDURE:

a. The Hospice House nurse will complete the Disposal of Non-Controlled Drugs Form and Disposal of Controlled Drugs Form and accurately account for the medications and number of each medication that remained that were prescribed for a specific patient.
b. Each patient's individual controlled drugs will be placed in a zip-lock bag along with the completed Disposal of Controlled Drugs Form and be locked in the cabinet in the locked medication room.
c. Two professional nurses will verify the counts of individual non-controlled medications and following verification of accuracy they will destroy all non-controlled medications in accordance with the agency disposal policy and procedure.
d. Following verification of accuracy and disposal of non-controlled medications, the nurses will confirm their actions by signing the Disposal of Non-Controlled Drug Form.
e. The Pharmacist and the Hospice House Director, or designee, will verify the counts of patient specific controlled medications on a regular basis (at least monthly, depending on volume) and confirm accuracy by signature on the Controlled Drug Disposal Form.
f. The Pharmacist will properly destroy the medications in accordance with the agency disposal policy or return the medication to the pharmacy.
g. Documentation of controlled drug destruction or pharmacy return will be completed on the Disposal of Controlled Drug Form by the pharmacist.
h. The Disposal Forms will be forwarded to Medical Records to be placed in the patient's medical record.
i. Refer to agency P/P Disposal of Medications C143 for further information regarding process for disposal of medications.

III. ADDENDUM

a. Disposal of Non-Controlled Drugs form F129
b. Disposal of Controlled Drugs form F130

Dismissal Criteria

At times it is necessary for patients to be discharged from Hospice services. These discharges are typically planned due to no longer meeting the eligibility requirements for hospice. When Medicare is the primary pay source, the agency will notify you of a planned discharge at least two days prior to the discontinuation of Hospice services. This notification allows you time to appeal the agency's decision for discharge. Appeal information is provided to you on the following page.

You or your legal representative have the right to discontinue Hospice services at your discretion:

- If you no longer desire hospice services
- If you desire aggressive treatment for your terminal illness which is inconsistent with the hospice philosophy and/or your plan of care
- If you choose to receive treatment from an inpatient facility which the agency does not have and/or cannot obtain a written agreement with
- If you move outside the agency's service area

Please notify your Hospice team or our office if you choose to be discharged from Hospice services. Completion of a Revocation form is necessary for further insurance coverage.

There are circumstances that do not fall within the requirements set by Medicare for notification. If the agency determines that you, your family member(s) and/or caregivers' behavior is disruptive, abusive, or uncooperative to the extent that the delivery of care is ineffective or the agency determines there to be a safety concern for staff, a discharge for cause can be considered. You and your physician will be made aware immediately.

Should you be dismissed from Hospice services due to no longer meeting the insurance eligibility requirements, you could be eligible for services in the future.

If you ever experience changes in your overall health status, don't hesitate to inquire about eligibility.

Your Right To Appeal Discharge:

You have the right to an immediate, independent medical review (appeal), while your services continue, of the decision to end Medicare coverage of these services.

If you choose to appeal, the independent reviewer will ask for your opinion and you should be available to answer questions or supply information. The reviewer will also look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.

If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.

If you choose to appeal, and the independent reviewer agrees that services should no longer be covered after the effective date indicated above, Medicare will not pay for these services after that date.

If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to ask for an immediate appeal:

You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.

Your request for an immediate appeal should be made as soon as possible, but *no later than noon of the day before the effective date indicated above.*

The QIO will notify you of its decision as soon as possible, generally by no later than two days after the effective date of this notice. To appeal your discharge or ask questions:

KEPRO QIO
5201 W. Kennedy Blvd, Suite 900
Tampa, FL 33609
(855) 408-8557
TTY: (855) 843-4776
Fax: (844) 834-7130

Other Appeal Rights:

If you miss the deadline for filing an immediate appeal, you may still be able to file an appeal with a QIO, but the QIO will take more time to make its decision.

Contact (800)-MEDICARE (1-800-633-4227), or TTY: (877) 486-2048 for more information about the appeals process.

HOSPICE & HOMECARE OF RENO COUNTY

2020 N Waldron ST, Suite 100
Hutchinson, KS 67502
Phone: 620-665-2473
Fax: 620-669-5959

Application for Reduced Rates

This application provides us with the information we need to determine your eligibility for reduced rates. Please complete this application to the best of your ability and return it as soon as possible.

Name:_____ **Date of Birth**:_____

Please Tell Us About Your Resources

Does anyone in your house hold own or have their name on any resources?

☐ No ☐ Yes If yes, complete the following. Mark no or yes on each item below.

Type of Resource		Name(s) On Resources	Amount or Value	Where is Resource Held? (Name of Bank, Credit Union or Company)	Account No.
Cash	☐ No ☐ Yes				
Checking Account	☐ No ☐ Yes				
Savings/CD	☐ No ☐ Yes				
IRA/Retirement Account	☐ No ☐ Yes				
Nursing Facility Accounts	☐ No ☐ Yes				
Stocks and Bonds	☐ No ☐ Yes				
Funeral or Burial Plans	☐ No ☐ Yes				
Other: _____	☐ No ☐ Yes				
Do you have a vehicle? ☐ No ☐ Yes	Year:____ Make:_____Model:_____Value:_____Amount Owed:_____ Year:____ Make:_____Model:_____Value:_____Amount Owed:_____				

1. Does anyone in your home have life insurance? ☐ No ☐ Yes If yes, complete the following:

Policy Owner	Insurance Co.	Policy Number	Face Value	Cash Value

2. Does anyone in your household own a home? ☐ No ☐ Yes If yes, fill out the following:

Owners:_____ Locations:_____
Date Purchased:_____Value:_____Amount Owed:_____
Who lives in this home?_____
If the owner does not live there, explain why:_____

3. Does anyone in your household own other land (including buildings, lots, farm ground, second homes, and rental property)? ☐ No ☐ Yes If yes, complete the following:

Describe property:_____
Location:_____
Owner(s):_____Value:_____Amount Owed:_____

4. Does anyone in your household have a life estate or life interest in any property? ☐ No ☐ Yes
If yes, complete the following:
Describe property:_____
Location:_____Owner(s):_____
List date life estate created:_____Value of property:_____

5. Does anyone in your household have or is a beneficiary of a trust? ☐ No ☐ Yes
If yes, list type, owners, purpose and amount below:

_____
_____
_____

6. Does anyone in your household have an annuity or other similar investment, including those issued as part of a retirement package? ☐ No ☐ Yes If yes, complete the following:

Owner(s):_____Value or Monthly Income_____
Company:_____

7. Does anyone owe you money through a promissory note or other loans? ☐ No ☐ Yes
If yes, explain:

_____
_____

8. Does anyone in your household have other assets (such as an R.V., trailers, boats, livestock, oil rights, machinery, etc.)? ☐ No ☐ Yes If yes, complete the following:

   a. Describe
      Assets:_____
   Owner(s):_____Value:_____
   b. Describe
      Assets:_____
   Owner(s):_____Value:_____

9. Do you have any other liabilities you wish to share? ☐ No ☐ Yes If yes, please explain:

_____
_____
_____
_____
_____

Please Tell Us About Your Earned Income

Is anyone in your household self-employed or working at a job? ☐ No ☐ Yes

If yes, complete the information below for all jobs. Self-employment includes earnings from odd jobs, child care, lawn mowing, snow removal, cosmetic sales, etc.

Name	Employers Name, Phone & Address (if self-employed, list type of business)	Salary or Hourly Wage	Tips or Commission	Weekly Hours Worked	How often do you get paid?	Day of the week paid

Has anyone in your household lost or quit a job in the last 60 days? ☐ No ☐ Yes
If yes, complete the following:

Name:_____Employer:_____
Last work day:_____Reason:_____
_____
_____

Please Tell Us About Your Other Income

Complete the following chart. Mark no or yes on each item below.

Type/Source of Income		Name of Person Who Receives This	Amount Received (before deductions)	How Often Received	Claim No.
Social Security Benefits	☐ No ☐ Yes	1			
	☐ No ☐ Yes	2			
	☐ No ☐ Yes	3			
Supplemental Security Income (SSI)	☐ No ☐ Yes	1			
	☐ No ☐ Yes	2			
Veteran's Benefits	☐ No ☐ Yes				
Railroad Retirement	☐ No ☐ Yes				
Trust Payments	☐ No ☐ Yes				
Annuity Payments	☐ No ☐ Yes				
Other Retirement or Pension. Source_____	☐ No ☐ Yes				
Workers Compensation/ Unemployment	☐ No ☐ Yes				
Oil Royalties / Mineral Rights / Tribal Payments	☐ No ☐ Yes				
Contract Sale / Rental Income	☐ No ☐ Yes				
Other Income Source 1:_____	☐ No ☐ Yes				
Source 2:_____	☐ No ☐ Yes				

Do you have any monthly expenses you wish to share? ☐ No ☐ Yes If yes, please explain:_____

_____

_____

_____

I/we acknowledge that Hospice of Reno County, Inc. is relying on the representations made herein, and I/we do hereby certify that to the best of my/our knowledge, this information is complete and accurate.

_____
Client Signature/Date

_____
Legal Representative/Responsible Party/Date

_____
Witness Signature/Date

OFFICE OF RENO COUNTY CORONER

Dr. Scott Kipper MD

206 W. 1st, Hutchinson KS 67501

HOSPICE REPORT OF DEATH

Patient: _____ **DOB:** _____ **Age:**_____ **Sex:** ☐ male ☐ female

Race: _____ **Social Security #:** ___-___-_____.

Home **Address: (include city/state, zip):** _____

Date and Time of death: _____ **Mortuary Service:** _____

Who *Confirmed* Death? _____ **Physician Contacted** _____

Recent Attending Physician: _____ **Will Sign Death Certificate:** ☐ **Yes** ☐ **No**

Next of Kin? _____ **Phone:** _____

Contacted? ☐ **Yes** ☐ **No** ☐ **Present at time of death.**

Address where Death Occurred: _____

CIRCUMSTANCES OF DEATH (MEDICAL HISTORY IF AVAILABLE)

Diagnosis as to Cause of Death: _____

_____

Date enrolled in Hospice Care? _____**Name of Hospice:** _____

****Name Physician signing Death Certificate?** _____

** *If case is determined to be a Coroner Case, The Coroner will sign the Death Certificate.*

See Page 2 for Determination as to Coroner Case. Call Investigator when Patient admitted to Hospice to discuss if the person could be considered a Coroner Case.

Any obvious trauma or surgery that could have contributed to Death? ☐ **Yes** ☐ **No. If Yes Describe:**

_____

Was patient ☐ **ambulatory or** ☐ **bed bound?**

What was the decedent's condition over the last 2-3 days? _____

_____

Current Medications: _____

Who Administered Medications? _____

DNR present? ☐ **Yes** ☐ **No**

Nurses Signature: _____ **Date:** _____

Reviewed by Medical Investigator: _____ **Date:**_____

Coroner: _____ **Date:** _____

Fax Form Immediately to: John Tracy, Medical Investigator at (620) 694-2762
Office Phone Number: (620) 694-2765 during normal business hours
Cell (620) 664-3991 after hours or cannot reach in Office
THIS FORM NEEDS TO BE FAXED TO INVESTIGATOR THE SAME DAY OF DEATH!
3/2010

Cases to be Considered Coroner Cases

1. Admitted to Emergency Room and dies. (No previously known or diagnosed medical condition, or was in apparent good physical condition prior to admission or death.)

2. EMS case and dies with no previously known medical condition.

3. Dies within 24 hours of admission. (No previously known or diagnosed medical condition)

4. Dies within a surgical procedure itself or while under anesthesia, or patients who do not regain consciousness following a procedure. Patients who die later of complications arising from an intraoperative event.

5. Dies from injuries that would be considered a criminal case. "With or Without a Report having been made to law enforcement".

6. Any case of suspected Child Abuse.

7. Any case of suspected Elder Abuse.

8. Any case of a child (under the age of 18) that dies, even with a known diagnosis.

9. Newborns that have a respiration or heart beat even in the umbilical cord. Children born that weigh 250gm stillborn require a stillborn certificate signed by the physician(If no respiration or heart beat Investigator does not need to be contacted).

10. Any case of suspected poisoning or drug overdose, or when an illegal drug was detected (Methamphetamine, Heroin, Alcohol Overdose).

11. Allergic reaction to any medications administered prior to Admission, or in the Hospital.

12. No diagnosis made prior to death.

13. Death that was caused by any accidental injury, or the injury that contributed to the death of the person. Hip Fractures, Skull Fractures, and Subdural Hematoma from a fall. Fracture that possibly caused a Pulmonary Embolism. Anything considered an accident that hastens the death of a person (Frequently occurs with an elderly person). Motor Vehicle Accidents, Boating Accident, Hunting accidents, choking, etc. The time of the accident does not matter. A Motor Vehicle Accident or fall even 20 + years ago could be a Coroner Case if Complications caused from the injury(s) from the accident contributed to the death.(Paralysis or traumatic brain injury, even from a Criminal Offense years ago causing these conditions) . ***In cases considered accidents, only the Coroner can sign the death certificate.***

14. Any death that was caused by a self-inflicted injury, or by an overdose in an apparent suicide.

15. Physician will not sign the Death Certificate.

8/20/2015

HOSPICE & HOMECARE
OF RENO COUNTY
A Member of the Hutchinson Regional Healthcare Family

Disposal of Controlled Drugs

Disposal of medications is verified and documented by completion of this form by the nurse and caregiver/witness/pharmacist at the time of disposal.

Client:_____Number:_____Date of Death:_____

Medications	Amount	Disposal Method

_____ _____

Signature of Ultimate User Signature of RN

Date of Disposal:_____

❑ Family Declined Disposal of Controlled Drugs
❑ Prescribing Physician Notified of Declination

HOSPICE & HOMECARE OF RENO COUNTY

A Member of the Hutchinson Regional Healthcare Family

Disposal of Non-Controlled Drugs

Disposal of non-controlled medications is verified and documented by completion of this from by the nurse and caregiver/witness at the time of disposal.

Client:_____ Number:_____ Date of Discharge:_____

Medications	Amount	Disposal Method

_____ _____

Signature of Witness Signature of RN

❑ Family Declined Disposal of Non-Controlled Drugs Date of Disposal:_____

HOSPICE & HOMECARE
OF RENO COUNTY

NURSING ADMISSION FORM

Date _____ Time _____

Vital Signs: T_____P_____BP_____/_____
Standing BP _____/_____ Lying BP_____/_____
Height _____ Weight _____

HEALTH HISTORY	CLIENT		COMMENTS
	YES	NO	
Heart Disease			
Hypertension			
Stroke			
Lung Disease			
Rheumatic Fever			
Faint/Seizures			
Diabetes			
Thyroid Disease			
Hepatitis			
Kidney Disease			
Cancer			
Arthritis			
Bleeding Disorders			
Other Diseases			
Smoke/smokeless tobacco			Amount/day:
Alcohol			Amount/day:

Subjective complaint: _____

HEENT-Head-Normal hair distribution. Head is symmetrically round without evidence of physical trauma. No nodules or masses visually observed.
Eyes-without redness, discharge, blurred vision or foreign body.
Ears-Without discharge, foreign body and/or pain.
Nose-Symmetrical, without discharge, air passes freely through nares-no foreign body.
Throat-Without redness, edema or pain. Able to swallow without difficulty. Oral cavity is pink, moist and intact. No obvious dental abnormalities.
___WNL ___Other

Describe _____

NEUROLOGICAL-Alert and oriented to person, place and time. Pupils equal and reactive to light. Active ROM of all extremities normal for the patient. No parasthesia. Verbalization clear and understandable. Swallowing without coughing or choking on liquids and solids.

___WNL ___Other

Describe _____

RESPIRATORY- Describe
Respirations 10-20 per minute at rest. Respirations quiet and regular. Breath sounds audible through both lung fields with no adventitious sounds. Sputum clear, mucous membranes pink.

___WNL ___Other

CARDIOVASCULAR- Describe
Regular apical pulse. Neck veins flat with patient at forty-five degrees. Capillary refill time <3 seconds. Peripheral pulses palpable. No edema, no calf tenderness.

___WNL ___Other

GASTROINTESTINAL- Describe
Abdomen is soft. Bowel sounds active 5-34 per minute. No pain with palpation. Tolerates prescribed diet without nausea and vomiting. Having BM's within own normal pattern and consistency. No change in diet/appetite. No weight gain/loss of 10lbs. or more in 3-6 months.

___WNL ___Other

MUSCULOSKELETAL- Describe
Absence of joint swelling and tenderness. Appropriate ROM for patient. No muscle weakness. No evidence of joint inflammation or deformity.

___WNL ___Other

GENITOURINARY-Able to void without dysuria. Bladder not distended after voiding. Urine clear, yellow to amber in color with no foul odor. Describe

___WNL ___Other

NEUROVASCULAR- Describe
Extremities within patient's normal coloring. Peripheral pulses palpable. No edema. Sensation intact without numbness or parasthesia.

___WNL ___Other

INTEGUMENTARY-Skin color within patient's norm. Skin warm, dry and intact. Mucous membranes moist. No masses, nodules or rashes seen. Describe

___WNL ___Other

PSYCHOSOCIAL-Interacts and communicates in an appropriate manner with others. Describe

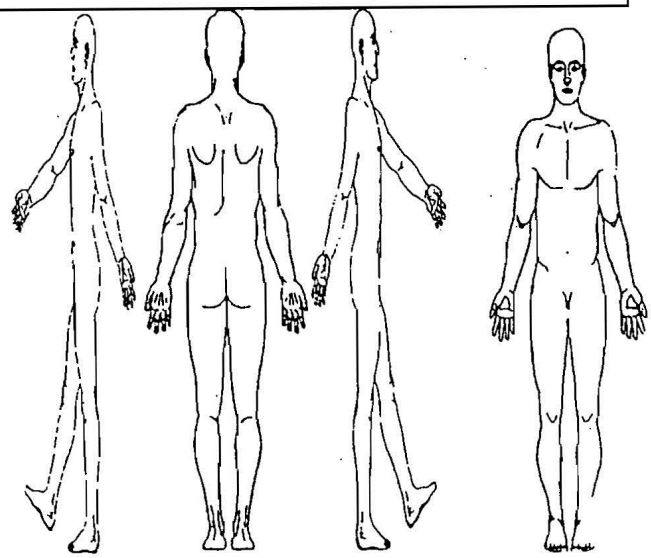
___WNL ___Other

PAIN - Sharp Dull Throbbing Burning Stabbing
Frequent Seldom Intermittent Constant Pain Scale 0-10

VENOUS ACCESS DEVICE:

PATIENT RIGHTS:
Authorization for treatment signed: Y N
Explanation of services provided: Y N
Plan of Care/return visit:

HOMEBOUND DUE TO:



CLINICAL NOTE:

Signature of RN

HOSPICE & HOMECARE OF RENO COUNTY
A Member of the Hutchinson Regional Healthcare Family

INITIAL PSYCHOSOCIAL ASSESSMENT

PATIENT INFORMATION

Name _____ Date_____

Address _____ Phone _____

Members of Household

Name _____ Rel _____

Name _____ Rel _____

Name _____ Rel _____

How long married/together? _____

If widowed/divorced, how long? _____

Anniversary date? _____

Age of Significant Other? _____

CAREGIVER INFORMATION

(Place * beside identified bereaved client)

Primary Caregiver Name _____

Relationship _____

Address _____

_____

Telephone:
H_____W_____C_____

Health Status _____

Emotional Status _____

Availability _____

Limitations _____

OTHER SIGNIFICANT OTHERS

Name _____

Address _____

_____

Phone: H: _____W: _____C:_____
Relationship_____
Comment: _____

Name _____

Address _____

_____

Phone: H: _____W: _____C:_____
Relationship_____
Comment: _____

Name _____

Address _____

_____

Phone: H: _____W: _____C:_____
Relationship_____
Comment: _____

Name _____

Address _____

_____

Phone: H: _____W: _____C:_____
Relationship_____
Comment: _____

Social Summary:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Hospice House Discharge Plans :

_____

_____

_____

_____

_____

Materials Provided: Midwife for the Souls____
Kids Kits____ Final Seasons____ Other____

_____

_____

_____

_____

Patient Name _____

Patient Employment/Occupational History

_____

_____

_____

Financial/Educational Assessment

Highest grade attained (if known)?

_____

Financial Information

_____

_____

_____

Veteran Status – Client and Spouse

Client: Yes No If Yes, branch and dates of service:

_____

Spouse: Yes No If Yes, branch and dates of service:

_____

Client's Hobbies/Interests

_____

_____

Client's Goals

_____

_____

_____

Coping Concerns/Strengths

_____

_____

_____

Environmental Safety Assessment

Environmental Concerns:

__Heating __Plumbing __Infestations
__Clutter __Odor __Repair needed
__Other: _____

Safety Concerns:

__Pets __Smoker __Weapons
__Other: _____

Self Care Ability

	Self	Family	Hired	Facility	Needs
Help					
Meals	___	___	___	___	___
Cleaning	___	___	___	___	___
Laundry	___	___	___	___	___
Shopping	___	___	___	___	___
Transport	___	___	___	___	___

Funeral Home:

_____

Additional Comments:

_____

_____

_____

_____

_____

Community Resource Referrals

Key **C**-Currently Utilizing **N**-Needed

Home Services:

__ Lifeline __Meals on Wheels __Friendship Meals

Transportation:

__RCat __Other: _____

Homemaker Services:

__ Dept. of Aging __SRS __HCBS
__ County Referral: _____

Financial Services:

__SSDI __SSI __Medicaid __The Salvation Army
__LEAP __Drug Indigent Prgm __Faith in Action
__ Other: _____
__ Mental Health Counseling

Volunteer Assessment

Would a volunteer be accepted? Yes No Undecided

Copy of psycosocial assess to Volunteer. Coor. Date____

Needed immediately? Yes No

If No, then when? _____

Preference: Male Female Either

Time of day volunteer is needed:

Day Evening Weekend No preference

Type of assistance needed:

Caregiver relief Beautician/Masseuse
Transportation Friendly Visitor

Comments:

_____

_____

_____

Advance Directive Information Copy

Has the Client Signed:	Yes	No	requestd
A Living Will?	__	__	___
DPOA-HC**?**	__	__	___
DNR/DNI?	__	__	___
Was information given to the clt on Living Will and DPOA-HC?	__	__	

Spiritual Assessment

Name of church that client or PCG is affiliated with:

_____(City)_____

Minister:

_____

Does Clergy visit? Yes No How often? _____

Send Minister Admission Letter? Yes No Date_____

Role of faith: _____

Hospice chaplain referral needed? Yes No N/A

Copy of psycosocial assess to Chaplain Date_____

Hospice chaplain letter sent to patient/family Date_____

Comments: _____

Social Worker _____**Date**_____ **Data Entered by**_____**Date**_____

HOSPICE HOUSE NURSING ADMIT CHECKLIST	PATIENT NAME:
	MR#:
PAGE 1 OF 1	Date of Admit: Time of Admit:

	Yes	No	N/A	Date	Time
Admission Orders Received					
Attending MD identified (box checked if attending will continue to follow)					
Emergency Kit orders received					
Comfort Protocol orders received					
Initial comprehensive assessment completed					
Hospice Clinical Summary tool completed					
Braden Assessment completed – Wound Consult if indicated					
Fall assessment completed					
Plan of Care initiated					
HHA POC completed					
Medication Profile completed with covered medications identified					
PPOC completed					
Palliative Drug Card Co. notified, enrollment form completed and faxed					
Medications received from family					
Medications ordered					
MAR Initiated					
Level of Care Updated in computer					
Admission reported on communicator					
Kardex initiated					
Patient valuables form completed					
When death is near booklet to DPOA					
Hospice House info booklet reviewed					
Patient labels made					
Face sheet faxed to Dr Yackley and coder Susan Funk on patient's he is to follow and Dr. Crater and coder Amy Kling on patient's he is to follow					
Notify nursing home of admission if applicable					
Census book update					
In social workers absence:					
Hospice consent to treat form reviewed and signed					
Hospice Benefit Election form signed					
Complete friends and family section in computer					
Identify funeral home					

SIGNATURE: _____

HOSPICE & HOMECARE OF RENO COUNTY

A Member of the Hutchinson Regional Healthcare Family

PERSONAL EFFECTS

PATIENT NAME:
MR#:
Admission Date:

ITEM	COLOR	DESCRIPTION
NECKLACE		
RING		
BRACELET		
WATCH		
GLASSES		
DENTURES		
HEARING AID		
WALLET		CONTENTS:
PURSE		CONTENTS:

MONEY:	1's	5's	10's	20's	Other Bills/Change
TOTAL AMOUNT: $					

MISCELLANEOUS ITEMS:
MEDICATIONS:
Were valuables returned to the family? o Yes o No (If "Yes" please complete bottom section.)
Are valuables locked up? o Yes o No
Are valuables retained by patient? o Yes o No

I HAVE REVIEWED THE ABOVE INFORMATION AND FIND IT TO BE ACCURATE.

_____

(Signature) (Date) (Relationship to Patient)

I ATTEST THAT ALL OF THE ITEMS SHOWN ABOVE WERE RETURNED TO ME:

_____

(Signature) (Date) (Relationship to Patient)

_____

(Address if not on file in patient's record)

HOSPICE OF RENO COUNTY, INC. PHYSICIAN'S ORDERS	PATIENT NAME:
	MR#:
	Date:

ALLERGIES:_____

Date & Time	Another brand of drug identical in form and content may be dispensed unless checked ☐	RN Initials

PLEASE USE BALL POINT PEN ONLY

HOSPICE OF RENO COUNTY, INC. HOSPICE HOUSE PROGRESS NOTE	PATIENT NAME:
	MR#:

DATE	

HOSPICE HOUSE SUPPLY SHEET

PATIENT NAME:_____ NUMBER:_____

HOSPICE OF RENO COUNTY, INC. ***1523 EAST 20TH*** ***HUTCHINSON, KANSAS 67502*** ***620-669-3773*** *FAX# 620-669-5134*	PATIENT NAME:
	MR#:
	Date:

Attending Physician: _____Admission Date: _____

PEOPLE TO CALL			
NAME	**RELATIONSHIP**	**PHONE**	**COMMENTS**

Funeral Home		
Spiritual Faith		
Congregation		
Special Needs		
Sacrament of the Sick	Needed: o Y o N	Received: o Y o N

Date/Initial	**DISCHARGE CHECKLIST**
	Discharge discussion / teaching family and patient
	Referral to Social Worker for discharge planning
	Transportation Company: Type: Date/Time:
	Care Plan Update for Transfer complete:
	Medication Discharge Sheet complete.
	Medications given to patient
	Medication sheet faxed to pharmacy
	Paperwork faxed to facility and/or Home Care Team
	RN report given
DISCHARGE/DEATH NEEDS:	
DISPOSITION OF VALUABLES, BELONGINGS and DME:	
SPECIAL INSTRUCTIONS:	

HOSPICE OF RENO COUNTY, INC. ***1523 EAST 20TH*** ***HUTCHINSON, KANSAS 67502*** ***620-669-3773*** FAX # 620-669-5134	PATIENT NAME: MR#: ROOM#: Date:

Age:	DOB:
Diagnosis:	
Allergies (list all):	
Attending Physician:	
Consulting Physicians (list all):	
Patient's Address:	Phone #:

Level of Care: Routine_____ Respite_____ InPatient_____

PERSONAL CARE	**ACTIVITY**	**ELIMINATION**
Bath: o Bed o Shower o Shower Chair o Self o Assist o Complete Mouth Care: o Own Teeth o Dentures o Upper o Lower	Ability: Safety Issues: Mattress Type: Diet:	Urine o BRP o BSC o Urinal o Incontinent o Foley Bowels: Regimen: o Continent o Incontinent Last BM:

Venous Access: o Y o N If Yes, type & site:
Oxygen/Nebulizer Therapy: o Y o N If Yes, list:
Diabetic: o Y o N If Yes, o Insulin o Oral Hypoglycemic o Finger sticks
Dressings: oY o N If Yes, type & site:
Infection Control Issues: oY o N If Yes, list:

Lab Work		
Order/Date:		
Order/Date		
Order/Date:		

REFERRALS:

o Arts o Spiritual Care o Social Work o Volunteer o Bereavement o Other_____