HOME HEALTH SOLUTIONS GROUP – ORIENTATION, TRAINING & GENERAL GUIDELINES FOR CONTINUOUS CARE STAFFING

Included in this packet is everything a nurse needs to know about successfully working for HHSG as an agency Continuous Care (CC) Nurse. We have included an overall review of CC nursing duties and examples of all the paperwork required during each shift. Please thoroughly read the packet and let us know if you have any question regarding your role as a CC nurse for HHSG Staffing for Continuous Care.

This Orientation Package is property of Home Health Solutions Group and is designed for training of our employees for the Hospice — Continuous Care companies we staff personnel.

I (name of employee) _____ Disc _____

Understand that I have received the training from the staff at HHSG. Furthermore, I understand that failure to comply with the requirements will automatically terminate my employment at Home Health Solutions Group

Signature _____ Date _____

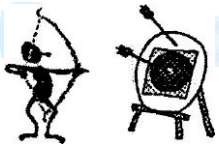
HHSG Values:

We ALWAYS take care of our PATIENTS and their FAMILIES

1. **We always take care of Patients and support their Families.**

2. **We take care of each other.**

3. **We will do our best today and even better tomorrow.**



4. **We are proud to make a difference.**

HOSPICE 101

What Hospice Is Not	What Hospice
Hospice is not a place to stay, like a hospital or a nursing home.	**Hospice is a way of providing care for a person who is terminally ill.**
Hospice is not a "death bed" service for people in the last 48 hours of life.	**Hospice is a program that focuses on quality of life.. It is most helpful during the final six months of life expectancy.**
Hospice is not a place to send dying people so they won't have to know what is happening to them.	**Hospice believes in the right of people to know accurately and honestly what is happening to them so they can choose how they want to spend the remaining amount of time in the most purposeful and meaningful way.**
Hospice is not just for cancer patients.	**Hospice is for people who have any terminal illness.**
Hospice is not a resignation to hopelessness and helplessness.	**Hospice is a way to deal realistically with a fatal disease. It offers the hope of dignity and comfort.**
Hospice is not a substitute for the family or the family's care.	**Hospice is a family-oriented program that helps families and/or friends to care for their loved one in their home.**
Hospice is not expensive.	**Hospice is covered by Medicare and many other insurance providers. No patient is ever denied care if he or she is unable to pay.**
Hospice is not euthanasia.	**Hospice neither hastens nor prolongs death.** **Hospice allows nature to take its course.**

FOUNDATIONS OF HOSPICE BACKGROUND, PHILOSOPHY AND CURRENT UTILIZATION PATTERNS

Hospice is a philosophy of care that addresses the physical, psychosocial, emotional, and spiritual needs of terminally ill patients, as well as their families, in whatever place the dying individual calls home.

Although caring for dying patients and their grieving loved ones is often difficult, the work hospice professionals do is also incredibly meaningful and can have a lasting effect on the community they serve. This is because hospice staff provide comprehensive care to patients during their final months, weeks, and days of life and at the same time offer emotional support to the loved ones of these individuals. In this way, hospice professionals have a profound impact on patients' physical, psychosocial, emotional, and spiritual states at the end of their life—and provide invaluable support to families as they cope and grieve.

To render the highest-quality care to patients and their loved ones, Home Health Solutions Group's hospice professionals must first be familiar with the unique expectations related to their service delivery.

Goals and approaches Hospice does not hasten death, but supports the natural dying process by focusing on many different aspects of care for patients and their families.

Goals of hospice are:

• Affirming life, promoting dignity, and helping patients fulfill their final wishes

• Providing care for the "whole person" by fostering physical, emotional, psychosocial, and spiritual well-being

• Managing pain and other physical symptoms for patients

• Conveying that dying is a natural part of life and that grief is a normal response to loss

• Supporting families and caregivers through the death of their loved one and into the grieving period that follows Hospice care is palliative in nature, which means it focuses on providing overall comfort and promoting the highest quality of life for patients and their families

rather than offering curative intervention. In fact, hospice is provided when a patient has decided to stop aggressive treatment for his or her terminal disease.

In addition, the hospice philosophy treats the patient and family as a unit of care, and its overarching goals address both of these groups.

ORIGINS AND EARLY DEVELOPMENTS OF HOSPICE

Although the first inklings of the term "hospice" can be traced back as far as medieval times, today's understanding of the end-of-life philosophy grew out of the work of Dame Cicely Saunders, a British physician who cared for dying patients from the mid-1900s until her death in 2005.

Saunders was determined to provide care that was better than the traditional institutional end-of-life services offered to the terminally ill at the time.

To accomplish this goal, she opened St. Christopher's Hospice in 1967. Hospice eventually made its way to the United States in the early 1970s, carried by community grassroots efforts.

In 1982, Medicare created the hospice benefit. This introduction helped to position quality as a measurable and expected aspect of hospice care. Since then, emphasis on quality throughout the industry has only increased.

THE HOSPICE INTERDISCIPLINARY TEAM, SHARED GOALS AND RESPONSIBILITIES OF KEY CARE PROFESSIONALS

The interdisciplinary team is one of the most defining and important aspects of a hospice program.

To achieve the holistic aim of hospice, this diverse community of professionals must collaborate to provide individualized, integrated services that accomplish each patient's goals of care.

According to Medicare regulations, the hospice interdisciplinary team must include:

• A doctor of medicine or osteopathy (also called a physician)

• A registered nurse

• A social worker

• Certain types of counselors, namely a spiritual counselor, bereavement counselor, and dietary counselor

Beyond this core group, each hospice's interdisciplinary team can include virtually any other professional involved in a patient's palliative care who is employed directly by the hospice, or who has an arrangement with the hospice to provide services to patients. Pharmacists, hospice aides, and therapists belong to this camp.

PRACTICE THE SIX RIGHTS OF MEDICATION ADMINISTRATION

When preparing to administer any drug to a client, consider what is often referred to as the "Five Rights" of medication administration:

- **Right client**
- **Right route**
- **Right drug**
- **Right dose**
- **Right time**

A sixth right often mentioned, but not part of the original five, is the right documentation. Don't forget to administer the drug to the client first, and then document. Documenting beforehand is considered falsification of documentation and is a violation of the nurse practice act.

DOCUMENTATION RELATING TO THE DEATH OF THE PATIENT CONTINUOUS CARE DOCUMENTATION FORMAT

Initial Assessment Documentation

- **Report received ____ (HHA, LPN, LVN, RN) Reviewed Plan of Care including medication profile**
- **Assumed Care of (age) year old (black/white) (female/male) who was placed on Continuous Care because of (CHC reason)**
- **Describe how the patient was lying (for example, prone on right side). Appearance neat and clean**
- **Document any equipment in use: Oxygen at 2 liters per minute by nasal cannula, hospital bed with eggcrate or APP mattress, Foley catheter to gravity drainage**
- **Vital signs**
- **Responsive — verbal, tactile, or painful simulation**
- **Respiratory distress exhibited by: rales, rhonchi, wheezes, diminished breath sounds, pursed lip breathing, use of abdominal accessory muscles, gasping upon exhalation**

- **Bowel sounds positive x____ quadrants, active bowel sounds or hypoactive bowel sounds, abdomen tender or non-tender, distended or non-distended, rigid or soft**
- **Capillary refill — sluggish, good, pedal pulses present/absent, and weak or strong**
- **Pain as evidenced by facial grimacing, moaning, crying, grasping at gown or linen or bed rails, agitation, restlessness l l . Head of bed slightly elevated**
- **LPN held patients hand gently, skin cool/warm, dry/moist to touch**

PHRASES TO USE FOR ONGOING DOCUMENTATION

- **Family inquired as to the patient's current status. LPN reviewed the patients care with the family members including the frequency of administration of medication.**
- **Reassurance provided that patients symptoms would be closely monitored by hospice with the goal of providing optimal patient comfort.**
- **Caregiver appears drawn/exhausted. Encouraged caregiver rest to prevent breakdown of the family support system.**
- **Discussed disease process and signs and symptoms of impending death with patient's family.**
- **Cool, moist washcloth applied to patient's fòrehead to provide comfort and relieve temperature elevation.**
- **Patient incontinent of urine, peri care provided and adult diaper changed**
- **Patient noted to be sleeping and this time with no observed indications of pain**
- **Head of Bed elevated ___ degrees to facilitate ——— ease of breathing. No oral intake x hours/days. Pillows placed beneath lower extremities to prevent breakdown of heels.**

- **Explained to family common symptoms associated with actively declining status of patient and family verbalized understanding of teaching.**
- **Anticipatory grief noted with Caregiver/wifè/spouse reflecting on life with patient l l. Emotional support provided to reluctant family members who are hesitant to administer medication necessary to relieve pain.**
- **Patient appears weaker today**
- **Patients privacy and dignity maintained throughout care provided**
- **Infection control maintained during the provision of care**
- **Gentle skin care and oral care provided**
- **Lips parted, gasping for air**
- **Reassurance provided with TLC (tender loving care)**
- **Turning self with unlimited or limited bed mobility**
- **Adult diaper checked. Patient is incontinent of bowel &/or bladder**
- **Incontinent care with change of adult diaper. Perineal care provided**
- **Provided ongoing teaching to family members relating to signs and symptoms of death and dying.**
- **Personal care provided with bed bath, oral care, skin care, incontinent care, and linen change.**
- **Review signs and symptoms of final stages of life with family allowing family to ask questions as needed.**
- **This LPN remains at patient's bedside to monitor effectiveness of symptom management.**
- **Patient awake with eyes wide, fearful expression noted. Family tearful regarding patient's declining condition.**
- **LPN provided emotional support and further teaching regarding changes to be expected in patient's condition.**
- **Family still anxious with fear regarding the patient's death.**

SIGNS AND SYMPTOMS TO DOCUMENT

- **Patient is nauseated, vomited x in past hour**
- **Patient chokes easily, unable to swallow**
- **Voided or Foley catheter in place with: document color of urine, odor, appearance of sediment.**
- **Date of last Bowel Movement___ (document the color and amount of the stool, and document whether the stool was formed, soft, constipated, or diarrhea).**
- **Apnea increasing in frequency.**
- **Pulse strong/weak, regular/irregular, and/or bounding/thready.**
- **Breath sounds moist with rales, rhonchi, and/or wheezing noted**
- **Increased respiratory secretions with gurgling noted in upper airways**
- **Mottling noted to knees and lower extremities 10. Feet and lower legs cool/cold to touch l l . Patient is diaphoretic and skin is pale**
- **Breathing pattern is slower with apnea lastingseconds**
- **Eyes open, but not seeing**
- **Resistance noted to approaching death due to fear. Patient calmed and reassured. Read the Bible and prayed with the patient and family**
- **Patient has decreased food/fluid intake**
- **Patient complains of his/her body being "heavy"**
- **Patient talking with the unseen**
- **Patient remains confused, redirected by LPN**
- **Ineffective coughing noted**
- **Muscle jerking noted**
- **Expression serene**
- **Patient coping: Patient fearful, tearful, depressed, or anxious**
- **Caregiver coping: Fear of patient's death, tearful, in denial regarding patient's deteriorating condition.**

DOCUMENT REASONS FOR CONTINOUS CARE

- **Patient having increased pain, anxiety, and restlessness**
- **Patient having increased weakness, changes in level of consciousness**
- **Elderly primary caregiver is (name) who is overwhelmed with recent rapid decline in the patient's condition.**
- **Patient's condition is imminent as evidenced by sudden deterioration requiring intensive nursing interventions for assessment and evaluation of pain &/or symptom management.**
- **Document the progressive decline in status using words such as now bed bound, requires total care, nonresponsive, non-verbal, moaning with pain, easily agitated with movement, jaw now slack, eyes glazed with upward stare.**
- **Medication effective/not effective after 30 minutes as evidenced by: patient now sleeping, patient continues to be very restless, moaning, clutching clothing, etc.**
- **Medication effective/noneffective as evidenced by vital signs (did the pulse rate decrease or remain the same, has the blood pressure decreased, what is the respiratory rate?)**
- **Patient appears comfortable/ less agitated at this time following administration of medication.**
- **IV PICC line dressed with Tegaderm. Site appears clean and dry with no signs of infection.**
- **Reviewed medication regimen with family. Explained the expected side effects of medication (Morphine, Ativan, Atropine) including the fact that sedation, constipation, dry mouth, and nausea and vomiting are potential side effects of symptom management. Family appears receptive to instructions.**

INTERVENTIONS FOR ANXIETY

- **Reduce stimulus**
- **Allow patient to talk freely about concerns**
- **Assess spiritual needs and intervene as necessary. Consult with Chaplain if needed**
- **Relaxation/visualization distractions**
- **Massage and medications**
- **Assess for hallucinations, confusion, restlessness, muscle twitching, jerking &/ or sweating**

INTERVENTIONS FOR RESPIRATORY DISTRESS

l. Educate patient/family on positioning techniques to facilitate chest expansion

2. **Elevate the head of the bed**
3. **Cool room with a fan to increase the circulation of the air**
4. **Cool moist compress to face**
5. **Minimize patient's exertion**
6. **Relaxation exercises**
7. **Emotional support and reassurance**
8. **Administer medication (i.e. Atropine) for excessive secretions**
9. **Document the color of the secretions 10. Administer oxygen as ordered l l . Administer medications to relive respiratory distress and document effectiveness of intervention**

STAGING OF DECUBITUS ULCERS AND DOCUMENTION OF SKIN CARE

- **Skin intact**
- **Pressure Ulcers: How to stage a pressure ulcer**
    - **Stage I : Erythema of site that does not resolve within 30 minutes of pressure relief. Epidermis intact.**
    - **Patient positioned to relive pressure to site. Discoloration of skin of hardness may also be indicators. Stage II: Partial-thickness skin loss noted involving epidermis, dermis, or both. Area is superficial and presents clinically as a blister, abrasion, or shallow crater.**
    - **Stage III: Full-thickness skin loss involving damage or necrosis or subcutaneous tissue, which may also extend down to but not through underlying fascia. Presents clinically as a deep crater with or without undermining of adjacent tissue.**
    - **Stage IV: Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures.**
- **Moisturizing lotion applied to all bony prominences**
- **Turn every two hours**
- **Turned and repositioned to side with skin care provided. Lift sheet utilized to reduce friction shear and pillows placed beneath lower extremities to support heels off the bed.**
- **Medication effective/not effective after 30 minutes as evidenced by: patient now sleeping, patient continues to be very restless, moaning, clutching clothing, etc.**

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ON DUTY MEAL / REST PERIODS FOR CONTINUOUS CARE STAFF

- **Considerations:**
- **Continuous Care is a higher level of care that requires more intense nursing care for the patient. Therefore, hourly employees who provide Continuous Care to patients should not leave the patient unattended.**
- **Employees can take a break and are allowed the opportunity to eat while working but they must remain available to the patient and family should a need arise.**
- **The Continuous Care employee should not leave the premises but may step away from the bedside to use the restroom or eat a meal if the patient's needs are being met and thë staff member has obtained permission from the family in the home or the nursing staff in a facility. Employees are expected to bring their own food and drink.**
- **General Instructions:**
- **All Continuous Care Staff are to be informed of this standard at time of hire. At HHSG, all employees who provide Continuous Care are required to sign an AGREEMENT FOR "ON-DUTY" MEAL PERIOD as a condition of employment.**

WHEN TO CALL HOME HEALTH SOLUTIONS

At the first inkling of a thought that you would like or need someone with you, any questions, concerns, roadblocks.

CALL US AT 786-991-2300
24 HOURS / EVERY DAY