



All Care

Hospice & Palliative Care

CALL HOSPICE

A nurse is available 24 hours a day.

(208) 473-2717

All Care Hospice & Palliative Care
815 S Bridgeway Pl., Ste 122
Eagle, ID 83616

Fax: (208) 473-2451

STATEMENT OF CONFIDENTIALITY

This booklet may contain protected health information. Persons other than you and your health care provider must have your permission to view this booklet.



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Patient/Family Orientation

For

Hospice Care

(208) 473-2717 OFFICE

(208) 473-2451 FAX

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ALL CARE HOSPICE & PALLIATIVE CARE

815 S. Bridgeway Place, Suite 122
Eagle, ID 83616
(208) 473-2717

Section 1: Welcome, Mission, and Philosophy

The mission of All Care Hospice & Palliative Care is dedicated to promoting quality of life by addressing the medical, emotional, and spiritual needs of our patients and their families. We understand that each patient and family is unique. We are guided by the belief that providing the highest quality of patient care with dignity, compassion, and respect for each person is the most important activity of the organization.

We believe:

- Hospice affirms life.
- Hospice recognizes dying as a process and so our care provides comfort rather than cure.
- Hospice neither hastens nor postpones death.
- Hospice helps the terminally ill person maintain quality of life and helps family members through an extremely stressful time in their lives.

Hospice is primarily a home care program, but services may also be provided in a hospital or nursing home. A hospice team helps the patient and family make informed decisions about caregiving, teaches the necessary skills for “hands-on” care, and helps with the approaching and actual death. Hospice also offers help through the bereavement period.

All Care Hospice & Palliative Care is privately owned and operated by Idahoans. We are committed to ensuring your rights and privileges as a hospice patient. We have written this booklet to help you better understand hospice care. If you have additional questions, please do not hesitate to ask us.

Thank you for selecting us as your hospice and palliative care provider.

Sincerely,

The Management and Staff of All Care Hospice & Palliative Care

ACCREDITATION



A STATE LICENSED, MEDICARE-CERTIFIED HOSPICE AGENCY.
Community Health Accreditation Program as a deemed home health agency.

Section 2: Hospice Overview

POLICIES

This book contains general information regarding your rights and responsibilities as a patient. As state and federal regulations change, there may be additions or changes to this book as necessary. Our complete policy and procedure manual regarding your care and treatment is available upon request for your viewing at the agency office any time during normal business hours.

CRITERIA FOR ADMISSION

Admission to our hospice program is made upon the recommendation of your physician and is based upon your needs. Normally, appropriate candidates for hospice are patients:

- With a life expectancy of 6 months or less if the illness runs its normal course;
- Who desire palliative care;
- Who want to stay at home as long as possible; and
- Who have a primary care person.

On admission, our nurse will visit with you or your family to discuss hospice services, assess your immediate needs, and recommend a plan of care.

If we cannot meet your needs, either directly by our hospice or indirectly through service agreements with other providers, we will not admit you or will not continue to provide services to you.

HOSPICE CONCEPT

What is Hospice?

- Hospice care provides comfort and kindness to those persons nearing the end of life's journey.
- Hospice will help you make decisions about how and where you want to spend the rest of your life.
- Hospice is a special kind of caring.
- Every 14 days, an interdisciplinary team meets to review your plan of care. This team includes but is not limited to: a physician (Medical Director), a nurse (Case Manager), a chaplain; and a social worker.

Why Hospice?

- Hospice treats you, not the disease. The focus is on care, not cure. Your medical needs, along with you and your family's social, emotional, and spiritual needs, are addressed by a team of hospice professionals and volunteers.
- Hospice considers your entire family, not just you, as the "unit of care". You and your family are included in the decision making process. Hospice will help you and your family make choices about end-of-life issues and enable you to have greater control over these choices. Bereavement counseling is provided to your family for up to 13 months after your death.
- Hospice offers palliative/comfort, rather than curative treatment. Hospice will provide care and comfort when a cure is no longer an option. Through ever advancing technology, pain and symptom control will enable you to live as fully and comfortably as possible.
- Hospice emphasizes quality and comfort rather than curative measures. Hospice neither hastens nor postpones your death. It affirms life and regards dying as a normal process.

SERVICES

Hospice services include:

- Nursing
- Medical Social Services
- Physician Services
- Spiritual Counseling
- Volunteer Services
- Hospice Aide/Homemaker Services
- Dietary Counseling
- Bereavement Counseling

All services are provided under the direction of a physician and/or the Hospice Medical Director. Arrangements will be made for hospice approved medications, medical supplies, and equipment as appropriate.

LEVELS OF HOSPICE CARE

ROUTINE HOME CARE: Care is provided intermittently by hospice team members in the patient's or family's home or in a nursing care facility.

GENERAL INPATIENT CARE: Care is given at a contracted facility for patients who need pain control or acute/chronic symptom management or who have a breakdown in the family caregiving system. Paid length of stay for inpatient care and necessity of inpatient care will be determined by the hospice interdisciplinary group. If a hospice patient needs hospitalization for any reason unrelated to the terminal diagnosis, Medicare Part A will be utilized.



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INPATIENT RESPITE CARE: Under the direction of the hospice plan of care, up to five (5) days of respite care at a contracted nursing care facility will be paid by hospice. This benefit may be used to give the family/caregiver a rest and the patient does not need to meet acute care standards.

CONTINUOUS HOME CARE: Care to be provided only during periods of crisis to maintain the patient at home. Criteria for continuous home care are the same as general inpatient care. Hospice staff will provide a minimum of eight (8) hours of care per calendar day.

MEDICARE HOSPICE BENEFIT

Medicare will reimburse the cost of hospice care under your Medicare Hospital Insurance (Part A). When all requirements are met, Medicare will cover the following:

SERVICES COVERED UNDER THE MEDICARE HOSPICE BENEFIT (if included in the plan of care)	SERVICES NOT COVERED UNDER THE MEDICARE HOSPICE BENEFIT
<ul style="list-style-type: none"> • Physician services • Nursing care • Medical appliances and supplies • Medications for symptom management and pain relief of the terminal illness (must be pre-approved by hospice) • Short-term inpatient care for pain and symptom control • Hospice aide/homemaker • Spiritual counseling • Physical Therapy, Occupational Therapy, and Speech Therapy • Medical Social Services • Dietary Counseling • Volunteer Services • Short-Term Respite Care 	<ul style="list-style-type: none"> • Treatment for the terminal illness which is not for palliative symptom management and is not within the hospice plan of care • Care provided by another hospice that was not arranged by the patient's hospice • Ambulance transportation not included in the plan of care. • Medications that are not related to the terminal illness • Visits to the emergency department without the prior approval or arrangements by hospice • Inpatient care at non-contracted facilities • Sitter services/hired caregivers • Admission to the hospital without the prior approval or arrangements by hospice • Lab studies, medical testing and/or any treatments not indicated

If you are receiving care under the Medicare Hospice Benefit, Medicare requires that no more than 30 days prior to the beginning of the third benefit period (180 days) and prior to each subsequent benefit period, a hospice physician or nurse practitioner must conduct a face-to-face visit with you to determine



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continued eligibility for hospice care. If you refuse to allow the face-to-face visit, you will no longer be eligible to receive hospice care under the Medicare Hospice Benefit.

CHARGES

In most cases, your insurance company will pay hospice directly; however, not all insurance plans provide full coverage for hospice care and some hospice services may not be covered under your plan. We receive our reimbursement from Medicare, Medicaid and private health insurance for services. All third party payors are billed for hospice services as appropriate.

All patients, who meet the requirements, are accepted regardless of the ability to pay. Medicare or Medicaid patients will not be refused care or have their hospice care discontinued or reduced due to their inability to pay for that care. Our social worker will meet with the patient/family to determine concerns and needs.

Should any change be made in this policy regarding services or charges, you or your responsible party will be advised. Please call our office if you have questions about charges or insurance billing.

MAXIMUM RATES FOR SERVICES

SERVICE	COST	INS. PAYS	YOU PAY	SERVICE	COST	INS. PAYS	YOU PAY
SN				ST			
HHA				MSW			
PT				Spiritual counselor			
OT				Dietary counselor			

CO-PAYMENT: \$ _____ DEDUCTIBLE: \$ _____ DATE: _____

*Please see the Payment Responsibility portion of your legal documents for an actual cost breakdown

PLAN OF CARE, TREATMENTS, AND SERVICES

Our hospice involves key professionals and other staff members in developing your individual plan of care. Your plan of care is based upon identified problems, needs and goals, physician orders for medications, treatments and care, your environment, and your personal wishes whenever possible. Effective pain management is an important part of your treatment plan.



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This plan includes five basic areas:

- Physical Care
- Personal Care and Comfort
- Spiritual Needs
- Psychosocial Needs; and
- Bereavement Care

The plan is reviewed and updated as needed, based on your changing needs. We encourage your participation and will provide necessary medical information to assist you. You have the right to refuse any medication or treatment procedure. However, such refusal may require us to obtain a written statement releasing the agency from all responsibility resulting from such action. Should this happen, we would encourage you to discuss the matter with your physician for advice and guidance.

Upon admission, you and an agency representative will create a list of your current medications (including any over-the-counter medications, herbal remedies, and vitamins). We will compare this list to the medications ordered by your physician. Our staff will continue to compare the list to the medications that are ordered, administered, or dispensed to you while under our care. This will be done to resolve any discrepancies (such as omissions, duplications, contraindications, unclear information, potential interactions and changes).

We fully recognize your right to dignity and individuality, including privacy in treatment and in the care of your personal needs. We will always notify you if an additional individual needs to be present for your visit for reasons of safety, education, or supervision. Prior to anyone visiting your home, we will ask your permission. You have the right to refuse any visitors and this will not compromise your care in any way.

We do not participate in any experimental research connected with patient care except under the direction of your physician and with your written consent.

There must be a willing, able, and available caregiver to be responsible for your care between hospice visits. This person can be you, a family member, a friend, or a paid caregiver.

MEDICAL RECORDS

Your medical record is maintained by our staff to document physician orders, assessments, progress notes, and treatments. Your records are kept strictly confidential by our staff and are protected against loss, destruction, tampering, or unauthorized use. Our Notice of Privacy Practices describes how your protected health information may be used by us or disclosed to others, as well as how you may have access to this information.

DISCHARGE, TRANSFER, AND REFERRAL

Discharge, transfer, or referral from hospice may result from several types of situations including the following:

- The hospice determines that the patient is no longer terminally ill;
- The patient moves out of the hospice's service area;
- The patient transfers to another hospice;
- The patient's behavior (or situation) is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired;
- Issues of patient or staff safety cannot be resolved; and
- Patient/family requests to end (revoke) the services of the hospice.

You will be given a timely advance notice of a transfer to another agency or discharge, except in case of emergency. If you are referred, transferred, or discharged to another organization, we will provide them with a list of your current medications and information necessary for your continued care, including pain management.

If you are discharged because you are no longer considered to be terminally ill, we will provide any necessary family counseling, patient education, or other services as indicated.

All transfers or discharges will be documented in the medical record on a discharge summary. When a discharge occurs, an assessment will be completed and instructions will be provided for any needed ongoing care or treatment. We will coordinate your referral to available community resources as needed.

NOTICE OF MEDICARE NON-COVERAGE: You or your authorized representative will be asked to sign and date a Notice of Medicare Non-Coverage at least two days before your covered Medicare services will end. If you or your authorized representative are not available, we will make contact by phone, and then mail the notice. If you do not agree that your covered services should end, you must contact the Quality Improvement Organization (QIO) at the phone number listed on the form no later than noon of the day before your services are to end and ask for an immediate appeal.

PATIENT SATISFACTION

Our patients are very important to us. Please ask questions if something is unclear regarding our services or the care you receive or fail to receive.

PROBLEM SOLVING PROCEDURE

We are committed to ensuring that your rights are protected. If you feel that our staff has failed to follow our policies or has, in any way, denied you your rights, please follow these steps without fear of discrimination or reprisal.

1. Notify the Hospice Administrator by phone at **(208) 473-2717**, during normal business hours Monday-Friday. You may also submit your complaint in writing to 815 S. Bridgeway Pl., Ste. 122, Eagle, Idaho 83616. Most problems can be solved at this level.
2. You may contact the CHAP hotline 24 hours a day at **(800) 656-9656**.
3. You may also contact the state's toll-free Home Care/Hospice hotline at **(800) 345-1453** which operates from 8am-5pm Monday-Friday (except holidays). If voicemail answers, please leave a message and your call will be returned. The purpose of this hotline is to receive complaints or questions about local home health agencies and to lodge complaints concerning the implementation of advance directive requirements.

Section 3: The Role of Hospice Staff

PRIMARY CARE NURSE

You will be assigned a primary care nurse who will coordinate your care with other members of the interdisciplinary group and handle any nursing needs. The role of the nurse is to help prevent and relieve pain and other symptoms, as well as teach caregivers ways to provide for your care. The nurse will also make certain that necessary medical supplies and equipment are ordered, and will assist in monitoring medications. Regular communication with your physician will make certain he/she is aware of your status and that orders are being followed. Your hospice nurse will try to anticipate your needs and assist you to better understand the natural progression of your illness. With this information you will be encouraged to make decisions regarding your care.



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PHYSICIAN SERVICES

The hospice medical director, physician employees, and contracted physician(s) of the hospice, along with your attending physician are responsible for the palliation and management of your terminal illness and any conditions related to the terminal illness. If your attending physician is not available, the hospice medical director, contracted physician and/or the hospice physician employee is responsible for meeting your medical needs.

SOCIAL WORKER

Facing a serious illness can be a time of tremendous pain and confusion for you and your family. Because you must deal with emotions and challenges throughout the time in which the illness is occurring, a social worker may be assigned to help you and your family. Services that may be provided by the social worker include:

- Providing emotional support, counseling, and guidance to the patient and family in coping with stress related to the illness.
- Identify community resources which are available to help you.
- Assisting the patient and family with planning for funeral arrangements, nursing home placement, etc.
- Offering information about Advance Directives.

SPIRITUAL COUNSELOR

Hospice spiritual care is based on a high respect for the patients' and caregivers' personal faith and beliefs. The hospice spiritual counselor is available to assist patients and families cope with the significant spiritual issues that often arise during terminal illness. The services offered include regular pastoral care visits, on-call and available for crisis, conducting funerals and memorial services as requested, and contacting a patient's own clergy, pastoral counselor, or other individuals for additional support, if desired. The hospice spiritual counselor does not impose his/her own personal belief systems or seek to change the beliefs of others.

DIETARY COUNSELOR

Dietary counseling may be provided by a dietitian, nurse, or other qualified staff member to address and ensure that your dietary needs are met.



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HOSPICE AIDE/HOMEMAKER

Our hospice aide/homemaker services are provided under the supervision of a registered nurse to patients who have a need for personal care on a part-time basis. Our hospice aides have experience in caring for people in need and have been carefully chosen to provide care for the patients of the hospice. The hospice aide assists with the patient's personal care which may include bathing, hair care, shaving, skin care, linen changes, catheter care, and straightening the patient's immediate surroundings. Hospice aides are not allowed to dispense medication. They will report any changes in the condition of the patient to the appropriate team member. The nurse schedules their visits and days may vary to meet the patient's needs.

VOLUNTEERS

A vital part of hospice is the carefully selected and well-trained volunteers working alongside the professional staff. These special people provide many different types of support for the hospice program and those coping with terminal illness, grief, and loss. They are good listeners, nonjudgmental, adaptable, and have a strong desire to reach out with love and concern to others. Volunteers may be used on a regular schedule. You can call the office if volunteer services are desired.

BEREAVEMENT

Bereavement services are an integral part of the hospice program. Following a terminal diagnosis, patients, and families often struggle with anticipatory grief issues. The medical social worker and spiritual counselor are available to assist families during this emotionally difficult time, as well as provide information on common aspects of anticipatory grief. Following a hospice patient's death, hospice continues to provide bereavement support to grieving families. While one individual is identified as the primary contact with the family, generally the spouse or primary caregiver, all members of the family are eligible to receive bereavement services.

These services are available for a period of thirteen months following the patient's death. They include regular mailings to provide support and education regarding grief issues, a grief support group, phone contacts, and individual visits (as desired by the bereaved family) by the medical social worker or spiritual counselor to assess bereavement coping skills and provide emotional support. For needs that exceed the scope of hospice bereavement services, referrals to other organizations and professionals within the community are available. These services are also made available to anyone in the community in which hospice services are provided.

Section 4: Patient Rights and Responsibilities

As a hospice provider, we have an obligation to protect your rights. We will provide these rights to you or your representative verbally and in writing in a language and manner you can understand, during the initial assessment visit before care is provided and on an ongoing basis, as needed.

YOUR RIGHTS

YOU HAVE THE RIGHT TO:

- Exercise your rights as a hospice patient without discrimination or reprisal for doing so. Your court-appointed representative or the legal representative you have selected in accordance with state law may exercise these rights for you if you are not competent or able to exercise them for yourself.
- Receive information about organization ownership and control.
- Have a relationship with our staff that is based on honesty and ethical standards of conduct to have ethical issues addressed. You have the right to be informed of any financial benefit we receive if we refer you to another organization, service, individual, or other reciprocal relationship.
- Be free from mistreatment, neglect, verbal, mental, sexual, and physical abuse, injuries of unknown source, and misappropriation of your property. All mistreatment, abuse, neglect, injury, and exploitation complaints by anyone furnishing service on behalf of hospice are reported immediately by our staff to the hospice administrator. All reports will be promptly investigated, and immediate action taken to prevent potential violations during our investigation. Hospice will take appropriate corrective action in accordance with state law. All verified violations will be reported to the appropriate state/local authorities (e.g., state survey and certification agency) within five (5) working days of becoming aware of the violation.
- Be treated with respect and consideration; recognition of your individuality and dignity; to have cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected.
- The right to prevent organization personnel from discriminating against patients, or other organizations on the basis of social status, political belief, sexual preference, race, color, religion, national origin, age, sex, or handicap, gender identity, sex stereotyping, pregnancy, child birth and related condition, sexual orientation, disability (mental or physical), or communicable disease.
- To be free from discrimination, in accordance with the office of Civil Rights Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act (ACA) of 2010 and its implementing regulation, as amended (42 USC 2000d), prohibits discrimination on the basis of race, color, or national origin 45 CFR 80. Therefore, All Care Hospice & Palliative Care will, directly or through contractual or other arrangement, admit and treat all persons without regard to race, color, or place of national origin in its provision of services and benefits, including assignments or transfers within facilities.
- To be free from discrimination, in accordance with Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) of 2010 and its implementing regulations as amended (29 USC 794), prohibits



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discrimination against otherwise qualified individuals on the basis of disability in: Programs and activities receiving financial assistance from HHA 45 CFR 84; Notice of exercise of authority under regarding recipients with fewer than fifteen employees 45 CFR 84.52 (d) (2); Admissions or treatments against substance abusers suffering from medical conditions 45 CFR 84.53; and programs or activities conducted by HHS 45 CFR 85. Therefore, All Care Health Solutions will, directly or through contractual or other arrangement, admit and treat all persons accordingly to the Section 504 ruling.

- To be free from being excluded or denied services. In accordance with Title II of the Americans with Disabilities act of 1990, All Care Health Solutions will not, on the basis of disability, exclude or deny a qualified individual with a disability from participation in, or benefits of, the services, programs or activities of the organization.
- Have access to interpreters as indicated and necessary to ensure accurate communication.
- Voice grievances/complaints or recommend changes in policy, staff, or service/care regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice without fear of coercion, discrimination, restraint, interference, reprisal, or an unreasonable interruption in care, treatment, or services for doing so. The organization must document both the existence of a complaint and the resolution of the complaint. Our complaint resolution process is explained in our problem solving procedure.
- Be advised when you are accepted for treatment or care, of the availability of the state's toll-free home care/hospice hotline number, its purpose, and hours of operation. The hotline receives complaints or questions about local home care/hospice agencies and is also used to lodge complaints concerning the implementation of the advance directives requirements. Hotline hours are 8am-5pm Monday-Friday. The hotline may be reached at **(800) 345-1453**. You may also call the CHAP hotline 24 hours a day at **(800) 656-9656**.
- Be free from discrimination based on age. In accordance with the Age Discrimination Act of 1975, Section 1557 of the Affordable Care Act (ACA) of 2010 as amended 42 USC 6101, prohibits discrimination on the basis of age in: programs or activities receiving federal financial assistance 45 CFR 90; and programs or services receiving HHS financial assistance 45 CFR 91, and its implementing regulation, Therefore, All Care Health Solutions will not, directly or through contractual or other arrangements, discriminate on the basis of age in the provision of services unless age is a factor necessary to the normal operation or the achievement of any statutory objective.

DECISION MAKING- YOU HAVE THE RIGHT TO:

- Choose your attending physician and other health care providers and communicate with those providers.
- Be fully informed in advance about the services/care covered under the Medicare or other hospice benefit, the scope of services hospice will provide, service limitations, name(s),



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disciplines, and responsibilities of staff members who are providing and responsible for your care, treatment or services, the planned frequency of visits proposed to be furnished, expected and unexpected outcomes, potential risks or problems, and barriers to treatment.

- Be fully informed of your responsibilities.
- Receive quality hospice care, regardless of your ability to pay.
- Be involved in developing your hospice plan of care; and to participate in changing the plan whenever possible and to the extent that you are competent to do so.
- Be advised of any change in your services or plan of care before the change is made. Have family involved in decision making as appropriate concerning your care, treatment, and services when approved by you or your surrogate decision maker and when allowed by law.
- Participate or refuse to participate in research, investigational, or experimental studies, or clinical trials. Your access to care, treatment, and services will not be affected if you refuse or discontinue participation in research.
- Formulate advance directives and receive written information about the agency's policies and procedures on advance directives, including a description of applicable state law before care is provided. You will be informed if we cannot implement an advance directive on the basis of conscience.
- Have your wishes concerning end of life decisions addressed and to have health care providers comply with your advance directives in accordance with state laws. You have the right to receive care without conditions or discrimination based on the execution of advance directives.
- Accept, refuse, or discontinue care, treatment, and/or services without fear of reprisal or discrimination after being informed of the consequences for doing so. You may refuse part or all of care/services to the extent permitted by law. However, should you refused to comply with the plan of care and your refusal threatens to compromise our commitment to quality care, then we or your physician may be forced to discharge you from our services and refer you to another source of care.

PRIVACY AND SECURITY- YOU HAVE THE RIGHT TO:

- Personal privacy and security during home care visits and to have your property and person treated with respect. Our visiting staff will wear proper identification so you can identify them.
- Confidentiality of written, verbal, and electronic protected health information including your medical records, information about your health, social, and financial circumstances or about what takes place in your home.
- Refuse filming or recording or revoke consent for filming or recording of care, treatment and services for purpose other than identification, diagnosis, or treatment.
- Access, request changes to and receive an accounting of disclosures regarding your own protected health information as permitted by law.
- Request us to release information written about you only as required by law or with your written authorization and to be advised of our policies and procedures regarding accessing and/or disclosing of clinical records. Our Notice of Privacy Practices describes your rights in detail.

FINANCIAL INFORMATION- YOU HAVE THE RIGHT TO:

- Be advised orally and in writing, before care is initiated, of our billing policies and payment procedures and the extent to which payment may be expected from Medicare, Medicaid, any other federally funded or aided program or other third party sources known to us; charges for services that will not be covered by Medicare; and the charges that you may have to pay.
- Be advised orally, and in writing, of any changes in payment, charges, and patient payment liability as soon as possible when they occur, but no later than 30 calendar days from the date that we become aware of a change.
- Have access to all bills, upon request, for the services you have received regardless of whether the bills are paid out-of-pocket or by another party.

QUALITY OF CARE- YOU HAVE THE RIGHT TO:

- Receive high quality, appropriate care without discrimination, in accordance with physician orders.
- Receive effective pain management and symptom control from the hospice for conditions related to your terminal illness(es); and to receive education about your role and your family's role in managing pain when appropriate, as well as potential limitations and side effects of pain treatments.
- Receive pastoral and other spiritual services.
- Be admitted only if we can provide the care you need. A qualified staff member will assess your needs. If you require care or services that we do not have the resources to provide, we will inform you, and refer you to alternative services, if available; or admit you, but only after explaining our care/service limitations and the lack of a suitable alternative.
- Receive emergency instructions and be told what to do in case of an emergency.

YOUR RESPONSIBILITIES

YOU HAVE THE RESPONSIBILITY TO:

- Provide complete and accurate information to the best of your knowledge about your present complaints and past illness(es), hospitalizations, medications, allergies, and other matters relating to your health.
- Remain under a doctor's care while receiving hospice services.
- Notify us of perceived risks or unexpected changes in your condition (e.g., hospitalization, changes in the plan of care, symptoms to be reported, pain, homebound status, or change of physician).
- Follow the plan of care and instructions and accept responsibility for the outcomes if you do not follow the care, treatment or service plan.

- Ask questions when you do not understand your care, treatment and service, or other instruction about what you are expected to do. If you have concerns about your care or cannot comply with the plan, let us know.
- Report and discuss pain, pain relief options and your questions, worries, and concerns about pain medication with staff or appropriate medical personnel.
- Tell us if your visit schedule needs to be changed due to medical appointment, family emergencies, etc.
- Tell us if your Medicare or other insurance coverage changes or if you decide to enroll in a Medicare or private HMO (Health Maintenance Organization).
- Promptly meet your financial obligations and responsibilities agreed upon with the agency.
- Follow the organization's rules and regulations.
- Tell us if you have an advance directive or if you change your advance directive.
- Tell us of any problems or dissatisfaction with the services provided.
- Provide a safe and cooperative environment for care to be provided (such as keeping pets confined, putting away weapons or not smoking during your care).
- Show respect and consideration for agency staff and equipment.
- Carry out mutually agreed upon responsibilities.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION PROVIDED IN THIS DISCLOSURE CAREFULLY.

PRIVACY PROMISE:

All Care Hospice & Palliative Care understands that your medical and health information is personal. Protecting your health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information.

OUR PRIVACY RESPONSIBILITIES:

All Care Hospice & Palliative Care is required by law to:

- Maintain the privacy of your health information;
- Maintain this notice that describes the way we may use and share your health information; and
- Follow the terms of the notice currently in effect.

We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain. You may request a copy of any notice from our office (see the "Contact Us" section following).



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HOW WE USE YOUR HEALTH INFORMATION:

When you receive care from All Care Hospice & Palliative Care, we may use your health information during your treatment, billing for services, and conducting our normal business (known as “health care operations”). Examples of how we use your information include:

- **TREATMENT** – We keep records of the care and services provided to you. Health care providers use these records to deliver quality care to meet your needs. For example, your doctor may share your health information with a specialist who will assist in your treatment. Some health records, including some confidential communications with a mental health care professional, some substance abuse treatment records, some genetic test results, and some health information of minors may have additional restrictions for use and disclosure under state and federal laws.
- **PAYMENT** – Your information may be used to obtain payment from Medicare, your secondary insurance company or other third party. We may also contact your insurance company to verify coverage for your care or to notify them of upcoming services that may need prior notice or approval. For example, we may disclose information about the services provided to you to claim and obtain payment from Medicare or your insurance company.
- **HEALTH CARE QUESTIONS** – We use health information to improve the quality of care, train staff and students, provide customer service, manage costs, conduct required business duties, and make plans to better serve our communities. For example, we may use your health information to evaluate the quality of treatment and services provided by our physicians, nurses, and other health care workers.

OTHER SERVICES WE PROVIDE AND/OR OTHER WAYS WE MAY USE YOUR HEALTH INFORMATION:

- In recommending treatment alternatives;
- To inform you about health services and/or products that may benefit you;
- To share information with family or a friend involved in your care or payment for your care, when appropriate;
- To share information with third parties that assists us with treatment, payment, and health care operations. Our business associates must protect your information by following our privacy practices;
- To include you in our patient directory for callers, visitors, and clergy;
- To contact you for fund-raising purposes; and
- To provide appointment reminders.

IF YOU DO NOT WISH TO PARTICIPATE, NOTIFY THE ALL CARE HOSPICE & PALLIATIVE CARE ADMINISTRATIVE OFFICES. FOR MORE INFORMATION ABOUT THE PRACTICES AND RIGHTS DESCRIBED IN THIS NOTICE, NOTIFY THE ALL CARE HOSPICE & PALLIATIVE CARE ADMINISTRATOR AT (208) 473-2717.



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SHARING YOUR HEALTH INFORMATION:

There are limited situations when we are permitted or required to disclose health information without your signed authorization. These situations are:

- For public health purposes, such as reporting communicable diseases, work-related illnesses, or other diseases and injuries that are permitted to be disclosed by law; reporting deaths; reactions to drugs; and problems with medical devices;
- To protect victims of abuse, neglect, or domestic violence;
- For health oversight activities such as investigations, audits, and inspections;
- For lawsuits and similar proceedings;
- When otherwise required by law;
- When requested by law enforcement as required by law or court order;
- To coroners, medical examiners, and funeral directors;
- For organ and tissue donation;
- To reduce or prevent a serious threat to public health and safety; and
- For specialized government function such as intelligence and national security.

All other uses and disclosures, not described in this notice, require your signed authorization. You may revoke your authorization at any time with a written statement.

YOUR INDIVIDUAL RIGHTS:

- Request restriction on how we use and share your information. We will consider all requests for restriction carefully, but are not required to agree to any restriction;
- Request that we use a specific telephone number or address to communicate with you;
- Inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information, and you may request a review of the denial;
- Review corrections or additions to your health information (must be a written request);
- Request an accounting or certain disclosures of your health information made by us. The accounting does not include disclosures made for treatment, payment, health care operations, and some disclosures required by law;
- Your request must state the period of time desired for the accounting, which must be within the six years prior to your request and exclude dates prior to April 14, 2003. The first accounting is free, but a fee will apply if more than one request is made in a 12-month period (must be a written request); and
- Request a paper copy of this notice even if you agree to receive it electronically.

This notice describes the privacy of All Care Hospice & Palliative Care. All Care Hospice & Palliative Care services include affiliations with hospitals, clinics, doctor's offices, long-term care facilities, and assisted living facilities. This notice also describes the privacy practices of affiliated providers while they are performing services with All Care Hospice & Palliative Care, unless they provide you with a notice of their specific privacy practices.



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Affiliated providers may have different privacy practices from those described in this Notice. For more information about the privacy practices of affiliated providers, please contact them directly.

CONTACT US:

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that was made about access to your health information, please contact the Administrator. We will investigate all complaints and will not penalize or treat you differently for filing a complaint. The State of Idaho Department of Health and Welfare has a state hotline for complaints or questions about local agencies: **(800) 345-1453**. You may also file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. If you have any questions or concerns about All Care Hospice & Palliative Care, you may contact the Community Health Accreditation Program (CHAP) hotline at **(800) 656-9656**.

IMPORTANT PHONE NUMBERS

Welcome to All Care Hospice & Palliative Care, we are pleased you will be receiving service from us. Below we have listed information about the staff that will be attending to your care. We have also included a care calendar and the key to this calendar can be found with your signature pages. As in all things, if you have any questions please contact our office at **(208) 473-2717**. We thank you for using us for your hospice and palliative care needs. We can be reached 24 hours a day/7 day a week at **(208) 473-2717**.

Warm Regards,

The Staff at All Care Hospice & Palliative Care

Your Administrator is: Angela Hilleshiem, RN

Your Assistant Administrator is: Lance Robinson, RN

Your Director of Nursing is: Allison Ashford, RN

Your Primary Nurse is: _____

Your Home Health Aide is: _____

Your Spiritual Counselor is: _____

Your Social Worker is: _____

***Other Important Phone Numbers on the following page.**

Important Phone Numbers Continued:

Idaho Centers for Independent Living

380 South 4th St., Suite 102
Boise, ID 83720
(208) 334-3800
Open M-F 8:00 am - 5:00 pm

National Adult Protective Services

(208) 334-3833
Open 24 hours per day / 7 days per week

Idaho Aging & Disability Resource Center

1447 South Tyrell Lane
Boise, ID 83706
(208) 345-0106
Open M-F 8:00 am - 5:00 pm

Southwest Idaho Interim Area Agency on Aging

701 S Allen, Suite 100
Meridian, ID 83642
(208) 332-1745
Open M-F 8:00 am - 5:00 pm

Home Health / Hospice Hotline

1 (800) 345-1453
Open 24 hours per day / 7 days per week

AT&T USADirect Language Assistance

1 (831) 648-7582
Email: Relay@HamiltonRelay.com
Open 24 hours per day / 7 days per week

Idaho Commission on Aging

341 W Washington St
Boise, ID 83702
(208) 334-3833
Open M-F 8:00 am - 5:00 pm

Pinnacle Quality Insight

7440 S. Creek Road
Sandy, UT 84093
(801) 293-0700
Open M-F 8:00 am - 5:00 pm

Qualis Health - Quality Improvement Organization (QIO)

720 Park Boulevard
Boise, ID 83712
(208) 343-4617

Idaho Relay TTY/TDD

TTY: 1-800-377-3529
Voice: 1-800-377-1363
Spanish: 1-866-252-0684
Speech-to-Speech: 1-888-791-3004
Customer Care Information:
1 (800) 368-6185 V/TTY
PO Box 285
Aurora, NE 68818
Open 24 hours per day / 7 days per week

Section 5: Advance Directives

It is your right to decide about the medical care you will receive. You have the right to be informed of treatment options available before giving consent for medical treatment. You also have the right to accept, refuse, or discontinue any treatment at any time.

The team that provides you with health care services is responsible for following your wishes. However, there may be times when you may not be able to decide, or make your wishes known.



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Many people want to decide ahead of time what kinds of treatment they want to use. Advance Directives let you make your wishes for treatment known in advance.

Idaho recognizes three types of advance directives: Living Will, a Durable Power of Attorney for Health Care (DPAHC) and a Physician Orders for Scope of Treatment (POST) form.

A **Living Will** is a legal document that lets you state your wishes about medical care in the event that you are terminally ill or in a persistent vegetative state and can no longer make your own medical decisions. Your Living Will becomes effective when a medical doctor certifies that you are terminally ill and that your death will occur with or without the use of life-sustaining procedures or that you are in a persistent vegetative state. If you do not want to receive artificial nutrition or hydration and you are terminally ill or in a persistent vegetative state, you must check this on the living will document or your attending physician will not be able to withhold or withdraw artificial nutrition and hydration from you. If you are pregnant, your Living Will may not be honored due to restrictions in state law.

A **Durable Power of Attorney for Health Care (DPAHC)** is a legal document which allows you to designate a particular person (agent) to make decisions regarding your medical care when you are not able to do so. This person should be someone you trust to carry out your wishes and should be reasonably available. This person cannot be your doctor or other treating health care provider; an employee of a treating health care provider unless he/she is related to you; an operator of a community care facility; or an employee of an operator of a community care facility unless he/she is related to you. You can also name alternate agent(s). Your agent has the same rights as you do regarding the use and disclosure of your individually identifiable health information or other medical records. If you designate your spouse as your agent or alternate agent and your marriage dissolves, your agent designation will be revoked. You can limit your agent's authority to make health care decisions for you, by writing limitations on the DPHAC form.

The **Physician Orders for Scope of Treatment (POST)** form is completed and signed by your physician and contains orders such as "Do-Not-Resuscitate" in the event that your heart stops or you stop breathing and your treatment wishes that you have discussed with your physician. The POST form becomes effective when you develop an incurable or irreversible injury, disease, illness, or condition or are in a persistent vegetative state and cannot make your wishes known.

Your physician will work with your Durable Power of Attorney for Health Care (If you have one), to carry out your wishes. If your Living Will and POST form have conflicting instructions, your physician will follow the POST form or amend the POST form to better care for your needs at the time, if it is in your best interest.

All healthcare providers and Emergency Medical Service personnel should follow your wishes if you have a valid POST form, or you are wearing POST identification, such as a necklace, wrist or ankle bracelet that has been approved by the Department of Health and Welfare. This document can travel with you from one health care setting to another, making sure all healthcare personnel recognize your wishes.

The law only requires that you sign your Living Will and Durable Power of Attorney for Health Care to make it legal. If you think there is a possibility that your document may be disputed at any time, you



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may consider having your signature witnessed and/or notarized. The POST form must be signed by your physician to make it legal.

You should give a copy of your Living Will and/or DPAHC to your doctor, family or friends, and health care providers. Keep the originals with other important documents in a safe place that is easy to find. **PLEASE INFORM US IF YOU EXECUTE OR CHANGE EITHER OF THESE DOCUMENTS DURING THE COURSE OF YOUR CARE.**

You can revoke any Advance Directive at any time by canceling, defacing, obliterating (burn/tear) or otherwise destroying the document or directing another to do so in your presence; signing a written revocation; or telling someone of your intent to revoke your document.

If you have a valid Living Will, Durable Power of Attorney for Health Care or other instrument that was signed before the new law went into effect July 1, 2005, it is still effective and will be interpreted according to previous law. If you executed an advance directive when you lived in another state, it is still effective if it substantially complies with Idaho law.

AGENCY POLICY ON ADVANCE DIRECTIVES

PURPOSE – To support the implementation of the Patient Self-Determination Act within the framework of state and federal law and organization policies.

POLICY – All Care Hospice & Palliative Care recognizes that all adult persons have a fundamental right to make decisions relating to their own medical treatment, including the right to accept or refuse medical care. It is the policy of All Care Hospice & Palliative Care to encourage individuals and their families/caregivers to participate in decisions regarding care, treatment and services. Valid Advance Directives, such as Living Wills, Durable Powers of Attorney and DNR (Do Not Resuscitate) or DNI (Do Not Intubate) orders will be followed to the extent permitted and required by law. In the absence of Advance Directives, All Care Hospice & Palliative Care will provide appropriate care according to the plan of care/service or as authorized by the attending physician. All Care Hospice & Palliative Care will not determine the provision of care/service or otherwise discriminate against an individual based on whether or not the individual has executed an Advance Directive.

Section 6: Safety

All patients need to take special precautions to ensure a safe living environment. Most accidents in the home can be prevented by eliminating hazards. This list will help you find potential hazards in your home. Take note of each statement that you need to work on to make your home a safer place. Please speak with your nurse/therapist or call the agency at any time if you have any concerns or questions about patient safety.

PREVENTING FALLS

At least half of all falls happen at home. Each year, thousands of Americans experience falls that result in serious injuries, disability, and even death. Falls are often due to hazards that are easily overlooked but easy to fix. Use the following **SELF ASSESSMENT** to see your fall risk. Check all of the risk factors below that apply to you and your home. The more factors checked, the higher your risk for falling.

- HISTORY OF FALLING** – 2 or more falls in the last 6 months.
- VISION LOSS** – Changes in ability to detect and discriminate objects; decline in depth perception; decreased ability to recover from sudden exposure to bright light or glare.
- HEARING LOSS** – May not be as quickly aware of a potentially hazardous situation.
- FOOT PAIN/SHOE PROBLEMS** – Foot pain; decreased sensation/feeling; skin breakdown; ill-fitting or badly worn footwear.
- MEDICATIONS** – Taking 4 or more medications; single or multiple medications that may cause drowsiness, dizziness, or low blood pressure.
- BALANCE AND GAIT PROBLEMS** – Decline in balance; decline in speed of walking; weakness of lower extremities.
- HIGH OR LOW BLOOD PRESSURE**- That causes unsteadiness.
- HAZARDS INSIDE YOUR HOME** – Tripping and slipping hazards; poor lighting; bathroom safety; spills; stairs; reaching; pets that get under feet.
- HAZARDS OUTSIDE YOUR HOME** – Uneven walkways; poor lighting; gravel or debris on sidewalks; no handrails; pets that get under feet; hazardous materials (snow, water, ice, oil) that need periodic removal and clean up.

REVIEW EACH OF THE FOLLOWING SAFETY TIPS AND NOTE THE ONES THAT YOU NEED TO WORK ON:

- Keep emergency numbers in large print near each phone.
- Put a phone near the floor in case you fall and can't get up.
- Wear shoes that give good support and have thin, non-slip soles. Avoid wearing slippers, avoid athletic shoes with deep treads.
- Remove things you can trip over (such as paper, books, clothes, and shoes) from stairs and places where you walk.
- Keep outside walkways and steps clear of snow and ice in the winter.
- Remove small throw rugs or use double sided tape to keep them from slipping.
- Ask someone to move any furniture so your path around the house is clear.
- Clean up spills immediately.
- Be aware of where your pets are at all times.
- Do not walk over or around cords or wires, i.e., cords from lamps, extension cords, or telephone cords. Coil or tape cords and wires next to the wall so you can't trip over them. Have an electrician add more outlets if needed.
- Keep items used often within easy reach (about waist high).



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- Use a steady step stool with a hand bar. Never use a chair as a step stool.
- Improve the lighting in your home. Replace burned out bulbs. Lamp shades or frosted bulbs can reduce glare.
- Make sure stairways, halls, entrances, and outside steps are well lit. Have a light switch at the top and bottom of the stairs.
- Place a lamp, flashlight, and extra batteries within easy reach of your bed.
- Place night-lights in bathrooms, halls, and passageways so you can see where you're walking at night.
- Make sure the carpet is firmly attached to every step. If not, remove the carpet and attach non-slip rubber treads on the stairs. Paint a contrasting color on the top front edge of all steps so you can see the stairs better.
- Fix loose handrails or put in new ones. Make sure handrails are on both sides of the stairs and are as long as the stairs. Fix loose or uneven steps.
- Install grab bars next to your toilet and in the tub or shower.
- Use non-slip mats in the bathtub and on shower floors.
- Use an elevated toilet seat and/or shower stool, if needed.
- Exercise regularly. Exercise makes you stronger and improves your balance and coordination. Talk to our doctor about what exercise is right for you.
- Have your nurse, doctor, or pharmacist look at all the medicines you take, even over-the-counter medicines. Some medicines can make you sleepy or dizzy.
- Have your vision checked at least once a year by an eye doctor. Poor vision can increase your risk of falling.
- Get up slowly after you sit or lie down.
- Use a cane or assistive device for extra stability, if needed.
- Consider wearing an alarm device that will bring help in case you fall and can't get up.

FIRE SAFETY/BURN PRECAUTIONS

- Post the fire department number on every telephone. All family members and caregivers should be familiar with emergency 911 procedures.
- Notify the fire department if a disabled person is in the home.
- Do not smoke in bed or where oxygen is being used. Never leave burning cigarettes unattended. Do not empty smoldering ashes in a trash can. Keep ashtrays away from upholstered furniture and curtains.
- Install smoke alarms on every floor of your home, including the basement. Place smoke alarms near rooms where people sleep. Test smoke alarms every month to make sure they are working properly.
- Install new smoke alarm batteries twice a year or when you change your clocks for daylight savings time in the spring and fall.
- Fire extinguishers should be checked frequently for stability.



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- Make a family fire escape plan and practice it every six months. At least two different escape routes should be planned from each room for each family member. If your exit is through a ground floor window, make sure it opens easily.
- If you live in an apartment building, know where the exit stairs are located. Do not use an elevator during a fire emergency.
- Designate a safe place in front of the house or apartment building for family members to meet after escaping a fire.
- If your fire escape is cut off, remain calm, close the door, and seal cracks to hold back smoke. Signal for help at the window.
- Evacuate a bedbound patient to a safe area by placing him/her on a sturdy blanket and pulling/dragging the patient out of the home.
- Remember, life safety is first, but if the fire is contained and small, you may be able to use your fire extinguisher until the fire department arrives.
- Have your heating system checked and cleaned regularly by someone qualified to do maintenance.
- Wood burning stoves should be properly installed, chimney should be inspected and cleaned by a professional chimney sweep and trash should not be burned in the stove because this could overheat the stove. Gasoline or other flammable liquids should never be used to start wood stove fires.
- Keep portable electric or kerosene heaters out of high-traffic areas. Operate them on the floor at least three feet from upholstered furniture, drapes, bedding, and other combustible materials, and turn them off when family members leave the house or go to sleep. Use kerosene heaters only in well-ventilated rooms. Store kerosene outside in a tightly sealed, labeled container.
- Make sure electrical appliances and cords are clean, in good condition and not exposed to liquid.
- Electrical outlets should be grounded and outlets with several plugs should not be used.
- Keep cooking areas free of flammable objects (potholders, towels, etc.).
- Keep storage area above the stove free of flammable/combustible items.
- Wear short or tight sleeves while cooking; don't reach over stove burner.
- Do not leave the stove unattended when cooking, especially when the burner is turned to a high setting. Turn the pan handles away from burners and the edge of the stove.
- Avoid cooking on high heat with oils and fat.
- Puncture plastic wrap before heating foods in the microwave.
- Never place hot liquids/solids at the edge of a counter.
- Place layered protection between skin and heating pad.
- Keep electrical appliances away from the bathtub/shower area.
- Never leave patient alone in the shower/tub.
- Set water thermostat below 120°F to prevent accidental scalding.
- Store flammable liquids in properly labeled, tightly closed, non-glass containers. Store away from heaters, furnaces, water heaters, ranges, and other gas appliances. Make sure the garage is adequately ventilated.



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MEDICATION SAFETY

- Do not take medications that are prescribed for someone else.
- Create a complete list of current medications (including prescription and over-the-counter medications, herbal remedies, and vitamins), and keep this list with you at all times in the event of emergency situations. Review the list for discrepancies and make changes immediately as they occur. Show the list to your doctor or pharmacist to keep from combining drugs inappropriately.
- Know the name of each of your medicines; why you take it; how to take it; potential side effects; and what foods or other things to avoid while taking it.
- Report medication allergies or side effects to your health care provider.
- Take medications exactly as instructed. If the medications looks different that you expected, ask your health care provider or pharmacist about it.
- Drug names can look alike or sound alike. To avoid errors, check with your health care provider if you have questions.
- Do NOT use alcohol when you are taking medication.
- Do NOT stop or change medicines without your doctor's approval, even if you are feeling better. If you miss a dose, do NOT double the next dose later.
- Use a chart or container system (washed egg carton or med-planner) to help you remember what kind, how much and when to take medicine.
- Take your medicine with a light on so you can read the label.
- Read medicine labels (including warnings) carefully and keep medicines in their original containers.
- Store medications safely in a cool, dry place according to instructions on the label of the medication.
- Keep medicines away from children and confused adults.

FEDERAL DISPOSAL GUIDELINES FOR MEDICATIONS

Remove drugs from their original containers. Conceal or remove personal information and prescription number using the black marker, duct tape, or by scratching it off. Mix drugs with an undesirable substance like coffee grounds, soap, or kitty litter. Put the mix in an empty margarine tub or sealable bag. Throw it and the empty containers in the trash. If your community has a pharmaceutical take-back program, take your unused drugs to them for proper disposal.

SAFE USE AND DISPOSAL OF CONTROLLED DRUGS

PURPOSE – To ensure the appropriate use and disposal of controlled substances in accordance with applicable state and federal regulations.

POLICY – All Care Hospice & Palliative Care voluntarily adheres to a controlled drug reporting process.

PROCEDURE –

1. Controlled substances will be distributed directly to the patient or his/her representative. The dispensing pharmacist will be responsible for monitoring the amount of drugs issued and the length of time between renewals.
2. The Case Manager will provide a copy of the written policies and procedures on the management and disposal of controlled drugs to the patient/representative and family. The Case Manager will verbally discuss the policy in a language and manner that they understand to ensure the safe use and disposal of controlled drugs.
3. The Case Manager will outline an informal documentation procedure for the patient and family/caregiver when hospice personnel are not present in the home.
4. In cases where hospice personnel are in the home 24 hours a day, a drug count will be made by the licensed personnel at the time of shift change.
5. Controlled drugs will be accounted for on a narcotic count record.
6. When a hospice patient no longer has a need for a controlled substance, the Case Manager will instruct the patient or family/caregiver to dispose of them.
7. The Case Manager will document in the clinical record that the patient and family/caregiver were given the written policies and procedures for managing controlled drugs and disposal of medications.
8. The hospice nurse, social worker, or chaplain attending the death of a hospice patient will inform the family/caregiver of their responsibility to dispose of all the patient's prescribed medications and will document this instruction in a clinical note.

HAZARDOUS ITEMS AND POISONS

- Know how to contact your poison control team.
- Carefully store hazardous items in their original containers.
- Do not mix products that contain chlorine or bleach with other chemicals.
- Purchase insecticides for immediate need only and store excess properly.
- Keep hazardous items, cleaners, and chemicals out of reach of children and confused or impaired adults.
- Dispose of hazardous items and poisons only as directed.

MEDICAL EQUIPMENT SAFETY

- Keep manufacturer's instructions with or near specialized medical equipment.
- Perform routine and preventative maintenance according to the instructions.
- Keep phone numbers available in the home to obtain service in case of equipment problems or equipment failure.
- Have backup equipment available, if indicated.
- Provide adequate electrical power for medical equipment.

- Test equipment alarms periodically to make sure that you can hear them.
- Have equipment batteries checked regularly by a qualified service person.
- Have bed side rails properly installed and use only when necessary. Do not use bed rails as a substitute for a physical protective restraint.
- If bed rails are split, remove or leave the foot-end down so that patient is not trapped between the rails.
- Mattress must fit the bed. Add stuffers in gaps between the rail and mattress or between the head and foot board and mattress to reduce gaps.
- Register with your local utility company if you have electrically powered equipment such as oxygen or ventilator.

OXYGEN SAFETY

- Use oxygen only as directed.
- **DO NOT SMOKE AROUND OXYGEN.** Post “No Smoking” signs in the home.
- Store oxygen cylinders away from heat and direct sunlight. Do not allow oxygen to freeze or overheat.
- Keep oil/petroleum products (such as Vaseline[®], oily lotions, face creams or hair dressings), grease and flammable material away from your oxygen system. Avoid using aerosols near oxygen.
- Dust the oxygen cylinder with a cotton cloth and avoid draping or covering the system with any material.
- Keep open flames (such as gas stoves and lit candles) at least 10 feet away from the oxygen source.
- Have electrical equipment properly grounded and avoid operating electrical appliances such as razors and hairdryers while using oxygen. Keep any electrical equipment that may spark at least 10 feet away from the oxygen system.
- Use 100% cotton bed linens and clothing to prevent sparks from static electricity.
- Place oxygen cylinders in appropriate stand to prevent tipping, or secured to the wall or placed on their side on the floor. Store in a well-ventilated area and not under porches, decks or cars.
- Have a back-up portable oxygen cylinder in case of a power or oxygen concentrator failure.



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EMERGENCY PREPAREDNESS PLAN

In the event of a natural or man-made disaster, inclement weather, or emergency, we have some emergency operations plan to continue necessary patient services. We will make every effort to continue home care visits; however, the safety of our staff must be considered. When roads are too dangerous to travel, our staff will contact you by phone, if possible, to let you know that they are unable to make your visit that day. Every possible effort will be made to support that your medical needs are met.

All patients are assigned a priority category code that is updated as needed. The category assignment determines agency response priority, in case of a disaster or emergency these codes are maintained in the agency office, along with information which may be helpful to Emergency Management Services in case of an area disaster or emergency. You will be contacted for medical attention:

Category 1 - Within 24 hours: Patients who cannot safely forgo care and require health care intervention regardless of other conditions. Patients in this category may include: highly unstable patients with a high probability of inpatient admission if home care is not provided; IV therapy patients; highly skilled wound care patients with no family/caregiver or other outside support.

Category 2 - Within 24-48 hours: Patients with recent exacerbation of disease process; patients requiring moderate level of skilled care that should be provided that day; patients with essential untrained families/caregivers not prepared to provide needed care.

Category 3 - Within 48-72 hours: Patients who can safely forego care or a scheduled visit without a high probability of harm or deleterious effects; this category may include homemaker patients, routine supervisory visits, evaluation visits, patients with frequencies of one or two times a week if health status permits, or if a competent family/caregiver is present.

In case of bad weather or other situations that might prevent our staff from reaching you, turn to your local radio and/or television station(s) or check local news websites. Listen/watch for official information and follow the instructions provided by emergency response personnel. Based on what is known about the threat, you may be asked to take shelter, go to a specific location or evacuate the area. Please notify our office if you evacuate to another location or emergency shelter.

POWER OUTAGE

If you need help in a power outage and our phone lines are down:

- Call 911 or go to the emergency room if you have a crisis or an emergency.
- Call your closest relative, friend, or neighbor if it is not an emergency.

LIGHTNING

IF YOU ARE INSIDE:

- Avoid tubs, faucets, and sinks because metal pipes conduct electricity.
- Stay away from windows.
- Avoid using the phone except for emergencies.

IF YOU ARE OUTSIDE:

- Avoid natural lightning rods such as tall trees in open areas.
- Get away from anything metal.

FLOOD

Be aware of flood hazards, especially if you live in a low-lying area, near water, or downstream from a dam. Flooding can take days to happen, but flash floods produce raging waters in minutes. Six inches of moving water can knock you off your feet. Avoid moving water if you must walk in a flooded area. Use a stick to test if the ground is firm enough to walk on.

Be ready to evacuate if a flood watch is issued. Move important items upstairs. Fill a clean bathtub with water in case water becomes contaminated or is shut off. Turn off your utilities at the main valves if you are instructed to do so. Do not touch electrical equipment if you are wet or standing in water

TORNADO

As soon as a tornado is sighted, go to the lowest floor and find an interior room. Good shelters are basements, rooms and halls with no outside walls, bathtubs, and spaces under the stairs. Many public buildings have designated shelter areas. Stay away from windows, doors, and outside walls. Get under a sturdy item, such as a table, and protect your head. Stay until the danger passes.

IF THE PATIENT IS BEDBOUND, move the bed as far from windows as you can. Use heavy blankets or pillows to protect the head and face.

IF YOU ARE IN A VEHICLE, TRAILER, OR MOBILE HOME, get out immediately and go to a sturdy structure. If there is not one close by, lie flat in the nearest ditch and cover your head. Do not try to out-drive a tornado. They are erratic and move swiftly.

LANDSLIDE

If you live in a low-lying area or near a stream or channel, be alert for any sudden increase or decrease in water flow and notice whether the water changes from clear to muddy. Move away from the path of a landslide or debris flow as quickly as possible. Mudflows can move faster than you can walk or run. Look upstream before crossing a bridge and do not cross the bridge if a mudflow is approaching.

HOT WEATHER

There is a higher risk for heat-related illness in the summer. When it is hot outside:

- Never leave anyone sitting in a closed, parked care
- Drink adequate water even if you are not thirsty. Avoid alcohol and caffeine.
- Eat small, frequent meals.
- Stay inside and out of the sun. Stay on the lowest floor, pull shades over the windows and use fans if you do not have air conditioning.
- Mist or sponge yourself frequently with cool water.
- Use sunscreen.
- Wear hats and clothes that are loose and lightweight. Clothes with light colors will reflect away the sun's energy.
- Talk to your doctor about how sun and heat exposure will affect you if you take drugs such as diuretics or antihistamines.
- Move to a cool place at the first sign of heat illness (dizziness, nausea, headache, cramps). Rest and slowly drink a cool beverage. Seek medical attention immediately if you do not feel better.

WINTER STORM

Heavy snowfall and extreme cold can immobilize a region, resulting in isolation. Icy and/or blocked roads and downed power lines can happen any time it is cold or snowy. Wear layers of loose, lightweight, warm clothes, rather than one heavy layer. Wear hats and outer layers that are tightly woven and water repellent. Mittens will keep your hands warmer than gloves.

EARTHQUAKE

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If you are inside

- Get under a sturdy table and protect your head.
- If you are in a wheelchair, move to a doorway, lock the wheels and cover your head with your arms
- If you are in bed, stay there. Cover your head with a pillow to protect it from falling objects and debris

If you are outside, stay there. Stay away from the outside of buildings.

If you are in a car, stop, park away from dangerous items and stay there until the quaking stops.

After the earthquake, wait a few minutes before moving. Make any noise you can if you are trapped or shine a flashlight. Be prepared for aftershocks.



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WILDFIRE

Wildfires often begin unnoticed and can spread quickly. If a wildfire threatens your area, follow these simple steps to protect yourself:

Evacuate immediately when asked by firefighters and law enforcement officials.

- Wear only cotton or wool clothes.
- Proper attire includes long pants, long sleeved shirt or jacket and boots.
- Carry gloves, a handkerchief to cover your face, water to drink and goggles.
- Keep a flashlight, mobile phone and portable radio with you at all times.
- Take important documents with you (bank, IRS, trust, investment, insurance policy, birth certificates, passports, medical records).
- Make sure to designate a safe meeting place and contact person.
- Close all interior doors of your home.
- Remove lightweight, non-fire resistant curtains and other combustible materials from around windows.
- Turn off all pilot lights.
- Move overstuffed furniture, such as couches and easy chairs, to the center of the room.
- Place vehicles in the garage, pointing out with keys in the ignition.

CIVIL DISTURBANCE

- Consider installing an electronic security system.
- Unless instructed to evacuate, the safest place to stay is your home.
- Do not go to observe the disturbance or unrest.
- Close all window blinds and curtains.
- Lock all doors and windows and secure your valuables and important records.
- Stay away from doors and windows.
- If you are confronted, remain calm and try to peacefully remove yourself from the situation.
- Call 911 if there is threat to life or safety.

BIOLOGICAL THREAT

The first evidence of an attack may be when you notice symptoms of the disease caused by exposure to an agent. It may take time for public health officials to determine exactly what the illness is, how it should be treated and who is in danger. Watch TV, listen to the radio, or check local news websites for official news and information including signs and symptoms of the disease, and areas in danger, if medications or vaccinations are being distributed and where you should seek medical attention if you become ill. In the event of a biological threat or attack, follow these safety guidelines:

BIOLOGICAL THREAT (Continued)

- If you become aware of an unusual or suspicious substance, quickly get away.
- Protect yourself, cover your mouth, and hold nose with layers of fabric that can filter the air, but still allow breathing. Examples include two to three layers of cotton, such as a t-shirt, handkerchief, or towel.
- There may be times when you would want to consider wearing a face mask: to reduce spreading germs if you are sick; or to avoid coming in contact with contagious germs if others around you are sick.
- If you have been exposed to a biological agent, remove and bag your clothes and personal items. Follow official instructions on disposal of contaminated items. Wash yourself with soap and water and put on clean clothes.
- If a family member becomes sick, it is important to be suspicious; however, do not assume that you should go to the emergency department or that any illness is a result of the biological attack. Symptoms of many common illnesses may overlap; however, if your or your family member's symptoms match those described, and you and your family members are in the group considered to be at risk, immediately seek emergency medical attention.
- Be prepared for public health officials and medical professionals to issue mandatory quarantine if the illness caused by the biological agent is believed to be contagious.
- Otherwise expect to receive a medical evaluation and follow instructions of the doctor and other public health officials.
- Implement the health and hygiene practices listed in the Infection Prevention and Control section of this booklet.

CHEMICAL EXPOSURE

In the event of an exposure to a hazardous chemical, item, or poison follow these safety steps:

- Seek medical attention for screening and professional treatment.
- Drink only stored water.

If you are outdoors, get as far away as possible from the contamination by moving upwind (and uphill if possible) from it.

If you are indoors, close doors and windows tightly, shut off heating and air conditioning, and close fireplace dampers. Tape plastic over windows in the room and use duct tape around the windows and doors to make an unbroken seal. Also, tape over any vents in the room and seal any electrical outlets or other openings. Sink and toilet drain traps should have water in them, so you can use the sink and toilet as usual.

CHEMICAL EXPOSURE (continued)

Remove possible contamination from your person by:

- Removing any exposed clothing (avoid touching any contaminated areas) as quickly as possible. Clothing that must be pulled over your head should be cut off instead of pulled over your head.
- Wash contaminants from your skin with large amounts of soap and water as quickly as possible. If your eyes are burning or your vision is blurred, rinse your eyes with plain water for 10 to 15 minutes. If you wear contacts, remove them and put them with the contaminated clothing. Do not put the contacts back in your eyes. If you wear eyeglasses, decontaminate them with household bleach, then rinse and dry.
- To dispose of contaminated clothing, avoid touching contaminated areas of clothing by wearing gloves or using tongs, tool handles, etc., and place anything that has touched the contaminated clothing inside a plastic bag. Seal the bag and then seal that bag inside another plastic bag.
- Dress in clothing that is not contaminated. Clothing stored in a drawer or closet is unlikely to be contaminated, therefore, that will be your safest choice.
- When you leave your shelter-in-place location, follow instructions from local emergency coordinators to make your home safe again and to avoid any contaminants outside.

EXPLOSION

- Get under a sturdy table or desk if things are falling around you. When they stop falling, leave quickly, and watch for falling debris.
- Stay low if there is smoke and check for hazards such as damaged floors and stairs.
- Do not stop to retrieve personal possessions or make phone calls.
- Do not use elevators.
- Check for fire and other hazards.
- Once you are out, do not stand in front of windows, glass doors, or other potentially hazardous areas.
- Move away from sidewalks or streets to be used by emergency officials or others still exiting the building.
- Make any noise you can or shine a flashlight if you are trapped. Shout only as a last resort. Shouting can cause you to inhale dangerous amounts of dust.
- Avoid unnecessary movement so you do not kick up dust.
- Cover your nose and mouth with anything you have on hand.



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NUCLEAR EXPLOSION

Remember the three protective factors: distance, shielding, and time. Radioactive fallout can be carried by the wind for hundreds of miles. Radiation levels are extremely dangerous after a nuclear detonation, but the levels reduce rapidly. During the period with the highest radiation levels, it is safest to stay inside.

If a nuclear attack warning is issued:

- Take cover as quickly as you can, below ground if possible, and stay there until instructed to do otherwise. Go as far below ground as possible or in the center of a tall building.
- Find the nearest building, preferably built of brick or concrete, and go inside to avoid any radioactive material outside. If other shelter, such as a multi-story building or basement can be reached within a few minutes, go there immediately.
- Expect to stay inside for at least 24 hours, unless told otherwise by authorities.
- If you are downwind from the detonation, you may also be asked to take protective measures.

If you are caught outside and unable to get inside immediately:

- Do not look at the flash or fireball as it can blind you.
- Take cover behind anything that might offer protection.
- Lie flat on the ground and cover your head. If the explosion is some distance away, it could take 30 seconds or more for the blast wave to hit.
- Get clean as soon as possible, to remove radioactive material that may have settled on your body.
- Remove your clothing to keep radioactive material from spreading. Removing the outer layer of clothing can remove up to 90% of radioactive material.
- If practical, place your contaminated clothing in a plastic bag and seal or tie the bag. Place the bag as far away as possible from humans and animals so that the radiation it gives off does not affect others.
- When possible, take a shower with lots of soap and water to help remove radioactive contamination. Do not scrape or scratch the skin. If you cannot shower, use a wipe or clean wet cloth to wipe your skin that was not covered by clothing.
- Wash your hair with shampoo or soap and water. Do not use conditioner in your hair because it will bind radioactive material to your hair, keeping it from rinsing out easily.
- Gently blow your nose and wipe your eyelids, eyelashes and ears with a clean wet cloth.

NUCLEAR POWER PLANT EMERGENCY

Follow Emergency Alert System (EAS) instructions carefully.

- Minimize your exposure by increasing the distance between you and the source of the radiation.
- If you are told to evacuate, keep car windows and vents closed; use recirculating air.
- If you are advised to remain indoors, turn off the air conditioner, ventilation fans, furnace and other air intakes; shield yourself by placing heavy, dense material between you and the radiation source; and go to a basement or other underground area, if possible.
- Do not use the telephone unless necessary.
- Stay out of the incident zone. Most radiation loses its strength quickly.

INFECTIOUS DISEASE

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The best defense is prevention. The following everyday preventative actions can help prevent the spread of illnesses.

Clean your hands often:

- **Wash hands:** Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food.
- **Hand sanitizer:** If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry.
- **Soap and water:** Soap and water are the best option if hands are visibly dirty.
- **Avoid touching:** Avoid touching your eyes, nose, and mouth with unwashed hands.

Clean all “high-touch” surfaces everyday:

- **Clean and disinfect:** Practice routine cleaning of high touch surfaces. High touch surfaces include counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables.
- **Disinfect areas with bodily fluids:** Also, clean any surfaces that may have blood, stool, or body fluids on them.
- **Household cleaners:** Use a household cleaning spray or wipe, according to the label instructions. Labels contain instructions for safe and effective use of the cleaning product including precautions you should take when applying the product, such as wearing gloves and making sure you have good ventilation during use of the product.

Avoid close contact: These infectious diseases are spread mainly from person-to person.

- Avoid close contact with people who are sick
- Put distance between yourself and other people if COVID-19 is spreading in your community. This is especially important for people who are at higher risk of getting very sick.

INFECTIOUS DISEASE (CONTINUED)

If you are sick or suspect you may be infected with a virus that causes any infectious disease, you should call your healthcare provider immediately.

You can help prevent the spread of the virus by taking the following steps:

Stay home except to get medical care:

- **Stay home:** You should restrict activities outside your home, except for getting medical care.
- **Avoid public areas:** Do not go to work, school, or public areas.
- **Avoid public transportation:** Avoid using public transportation, ride-sharing, or taxis.

Separate yourself from other people and animals in your home:

- **Stay away from others:** As much as possible, you should stay in a specific room and away from other people in your home. Also, you should use a separate bathroom, if available.
- When possible, have another member of your household care for your animals while you are sick. Avoid contact with your pet, including petting, snuggling, being kissed or licked, and sharing food. If you must care for your pet or be around animals while you are sick, wash your hands before and after you interact with pets and wear a face mask.

Call ahead before visiting your doctor:

- If you have a medical appointment, call the healthcare provider and tell them you suspect you may have an infectious disease. This will help the healthcare provider's office take steps to keep other people from getting infected or exposed.

Wear a face mask if you are sick:

- **If you are sick:** You should wear a face mask when you are around other people (e.g., sharing a room or vehicle) or pets and before you enter a healthcare provider's office.
- **If you are caring for others:** If the person who is sick is not able to wear a face mask (for example, because it causes trouble breathing), then people who live with the person who is sick should not stay in the same room with them, or they should wear a face mask if they enter a room with the person who is sick.

Cover your coughs and sneezes:

- **Cover:** Cover your mouth and nose with a tissue when you cough or sneeze.
- **Dispose:** Throw used tissues in a lined trash can.
- **Wash hands:** Immediately wash your hands with soap and water for at least 20 seconds or, if soap and water are not available, clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol.

INFECTIOUS DISEASE (CONTINUED)

Avoid sharing personal household items:

- **Do not share:** You should not share dishes, drinking glasses, cups, eating utensils, towels, or bedding with other people or pets in your home.
- **Wash thoroughly after use:** After using these items, they should be washed thoroughly with soap and water.

Monitor your symptoms:

- **Seek medical attention:** Seek prompt medical attention if your illness is worsening (e.g., difficulty breathing).
- **Call your doctor:** Before seeking care, call your healthcare provider and tell them that you have, or are being evaluated for, COVID-19.
- **Wear a face mask when sick:** Put on a face mask before you enter the facility. These steps will help the healthcare provider's office to keep other people in the office or waiting room from getting infected or exposed.
- **Alert health department:** Ask your healthcare provider to call the local or state health department. Persons who are placed under active monitoring or facilitated self-monitoring should follow instructions provided by their local health department or occupational health professionals, as appropriate.

Household members, intimate partners, and caregivers in a non-healthcare setting may have close contact with a symptomatic person with. Close contacts should monitor their health; they should call their healthcare provider right away if they develop symptoms (e.g., fever, cough, shortness of breath)

Close contacts should also follow these recommendations:

- Make sure that you understand and can help the patient follow their healthcare provider's instructions for medication(s) and care. You should help the patient with basic needs in the home and provide support for getting groceries, prescriptions, and other personal needs.
- Monitor the patient's symptoms. If the patient is getting sicker, call his or her healthcare provider. This will help the healthcare provider's office take steps to keep other people in the office or waiting room from getting infected. Ask the healthcare provider to call the local or state health department for additional guidance.
- Household members should stay in another room or be separated from the patient as much as possible. Household members should use a separate bedroom and bathroom, if available.
- Prohibit visitors who do not have an essential need to be in the home.
- Household members should care for any pets in the home. Do not handle pets or other animals while sick.
- Make sure that shared spaces in the home have good air flow, such as by an air conditioner or an opened window, weather permitting.

INFECTIOUS DISEASE (CONTINUED)

- Perform hand hygiene frequently. Wash your hands often with soap and water for at least 20 seconds or use an alcohol-based hand sanitizer that contains 60 to 95% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry. Soap and water should be used preferentially if hands are visibly dirty.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- You and the patient should wear a face mask if you are in the same room.
- Wear a disposable face mask and gloves when you touch or have contact with the patient's blood, stool, or body fluids, such as saliva, sputum, nasal mucus, vomit, urine.
- Throw out disposable face masks and gloves after using them. Do not reuse.
- When removing personal protective equipment, first remove and dispose of gloves. Then, immediately clean your hands with soap and water or alcohol-based hand sanitizer. Next, remove and dispose of face mask, and immediately clean your hands again with soap and water or alcohol-based hand sanitizer.
- Avoid sharing household items with the patient. You should not share dishes, drinking glasses, cups, eating utensils, towels, bedding, or other items. After the patient uses these items, you should wash them thoroughly (see below "Wash laundry thoroughly").
- Clean all "high-touch" surfaces, such as counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables, every day. Also, clean any surfaces that may have blood, stool, or body fluids on them.
- Use a household cleaning spray or wipe, according to the label instructions. Labels contain instructions for safe and effective use of the cleaning product including precautions you should take when applying the product, such as wearing gloves and making sure you have good ventilation during use of the product.
- Wash laundry thoroughly.
- Immediately remove and wash clothes or bedding that have blood, stool, or body fluids on them.
- Wear disposable gloves while handling soiled items and keep soiled items away from your body. Clean your hands (with soap and water or an alcohol-based hand sanitizer) immediately after removing your gloves.
- Read and follow directions on labels of laundry or clothing items and detergent. In general, using a normal laundry detergent according to washing machine instructions and dry thoroughly using the warmest temperatures recommended on the clothing label.
- Place all used disposable gloves, face masks, and other contaminated items in a lined container before disposing of them with other household waste. Clean your hands (with soap and water or an alcohol-based hand sanitizer) immediately after handling these items. Soap and water should be used preferentially if hands are visibly dirty.
- Discuss any additional questions with your state or local health department or healthcare provider.

HOME EMERGENCY KIT

If there is an emergency situation, it could be several days (or weeks) without power, internet or running water. But in the event of an emergency, anything can happen. You should have an emergency plan and supplies ready for any type of disaster.

Depending on where you live, a disaster could mean heavy snow, flooding, a tornado or a hurricane. So make your plan personal – no matter what the weather is like in your area, a little preparedness can go a long way.

Keep a kit with at least the following items:

- Battery powered radio
- Medications
- Lamps and flashlights
- Extra batteries
- Non-perishable food
- Manual can opener
- Utensils, cups, and plates
- Extra blankets
- Water in clean milk or soda bottles
- Rock salt or sand for walkways
- Extra fuel
- Water (one gallon per person, per day)
- First aid kit

SHELTER SUPPLIES

The following is a list of what to bring to a shelter during an evacuation:

- Two-week supply of medications
- Medical supplies and oxygen
- Wheelchair, walker, cane, etc.
- Special dietary foods/can opener
- Bedding
- Air mattress, sleeping bag, or cot
- Lightweight folding chair
- Extra clothing, hygiene items, glasses
- Important papers
- Valid ID with current name and address
- Hospice Folder

Section 7: Infection Control at Home

Stay clean and use good hygiene to help stop the spread of infection. Items used in health care, such as bandages or gloves, can spread infection and harm the environment. They can harm trash handlers, family members, and others who touch them if they are not disposed of properly. Be careful when you handle them.

Some illnesses and treatments (such as chemotherapy, dialysis, AIDS, diabetes, and burns) can make people more at risk for infection. Your nurse will tell you how to use protective clothing (such as gowns or gloves) if you need it.

Please tell your doctor or a home care staff member if you notice any of the following signs or symptoms of infection:

- Pain, tenderness, redness, or swelling
- Inflamed skin, rash, sores, or ulcers
- Pain when urinating
- Confusion
- Nausea, vomiting, or diarrhea
- Fever or chills
- Sore throat or cough
- Increased tiredness or weakness
- Green or yellow pus

WASH YOUR HANDS

WASH YOUR HANDS FREQUENTLY AND CORRECTLY, EVEN IF YOU WEAR GLOVES. IT IS THE SINGLE MOST IMPORTANT STEP IN CONTROLLING THE SPREAD OF INFECTION.

ALWAYS WASH HANDS BEFORE:

- Tending to a sick person
- Treating a cut or wound
- Touching or eating food

ALWAYS WASH HANDS AFTER:

- Tending to a sick person
- Treating a cut or wound
- Using the bathroom
- Touching animals or their waste
- Touching soiled linens
- Touching garbage
- Changing diapers
- Coughing, sneezing, or blowing your nose

IF YOU HAVE VISIBLY DIRTY HANDS, or they are contaminated or soiled in any way, wash them with soap (liquid soap is best) and warm running water. Remove jewelry, apply soap, wet your hands, and rub them together for at least 20 seconds. Wash all surfaces, including wrists, palms, back of hands, between fingers, and under nails. Rinse off the soap and dry your hands with a clean towel that has not been shared. If one is not available, air-dry your hands. Use a towel to turn off the faucet. If you used paper towels, throw them in the trash.

IF YOU DO NOT HAVE VISIBLY DIRTY HANDS, use an alcohol based hand rub to clean them. Use a rub with 60-90% ethyl or isopropyl alcohol. Open the cap or spout and apply a dime-sized amount in one palm, then rub hands vigorously, covering all surfaces of hands and fingers, until they are dry.

COVER YOUR COUGH

Cover your mouth and nose with a tissue when you cough or sneeze. If you do not have a tissue, cover your mouth with your upper sleeve, not your hands. Throw your used tissue in the trash. You may be asked to wear a mask to protect others.

DISPOSABLE ITEMS AND EQUIPMENT

SOME ITEMS THAT ARE NOT SHARP: paper cups, tissues, dressings, bandages, plastic equipment, catheters, depends, Chux, plastic tubing, gloves, etc.

Store these in a clean, dry area. Throw away used items in waterproof (plastic) bags. Fasten the bags securely and throw them in the trash.

NON-DISPOSABLE ITEMS AND EQUIPMENT

SOME ITEMS THAT ARE NOT THROWN AWAY: dirty laundry, dishes, thermometers, toilets, walkers, wheelchairs, bath seats, suction machines, oxygen equipment, mattresses, etc.

WASH DIRTY LAUNDRY SEPARATELY in hot, soapy water. Handle it as little as possible so you don't spread germs. If the patient has a virus, add a mix of 1 part bleach and 10 parts water to the load.

CLEAN EQUIPMENT AS SOON AS YOU USE IT. Wash small items (not thermometers) in hot, soapy water, then rinse and dry them with clean towels. Wipe thermometers with alcohol before and after each use. Store them in a clean, dry place. Wipe off equipment with a normal disinfectant or bleach mix. Follow the cleaning instructions that came with the item and ask your nurse or therapist if you have any questions.

POUR LIQUIDS IN THE TOILET. Clean their containers with hot, soapy water, then rinse them with boiling water and let them dry.

SHARP OBJECTS

SOME SHARP ITEMS: needles, syringes, lancets, scissors, knives, staples, glass tubes, glass bottles, IV catheters, razors, etc.

Put used sharps in a clean, hard plastic or metal container with a screw on or tight lid. Seal it with heavy duty tape and dispose of it in the trash or according to area regulations. Do not overfill sharps containers or re-cap used needles. DO NOT use glass or clear plastic containers. NEVER put sharps in containers that will be recycled or returned to a store.

BODY FLUID SPILLS

Put on gloves and wipe the fluid with paper towels. Use a solution of 1 part bleach and 10 parts water to wipe the area again. Double bag used paper towels and throw them in the trash.

Section 8: Pain Management

Discuss with your physician or your hospice nurse any concerns or questions you have about your pain management. Following are a few of the common concerns or questions of hospice patients:

IF I HAVE LOTS OF PAIN, DOES THAT MEAN I'M IN BAD SHAPE?

Pain is not a measurement of disease advancement. Some people have severe pain early in the disease process, others have no pain. Pain depends solely on the location and involvement of the disease, not on how far along it is.

HOW WILL MY PAIN BE CONTROLLED?

Your physician and nurse will work with you so that you are as pain free and alert as possible. The nurse will ask you at each visit how your pain and comfort have been and will need honest answers from you about your pain.

SHOULD I ONLY TAKE MY PAIN MEDICATION IF THE PAIN GETS REALLY BAD?

It is proven that the best way to control pain is to prevent pain. Your physician and nurse will encourage you to take your pain medication regularly, rather than only when needed. For example: every 4, 6, 8, or 12 hours. You'll sleep better and generally feel better if you keep your pain under control.

WHAT IS THE CORRECT DOSE I SHOULD BE TAKING?

The correct dose of pain medication is the dose that relieves your pain and is within the orders prescribed by your doctor.

IF I TAKE PAIN MEDICATIONS, SUCH AS NARCOTICS, WILL I SLEEP ALL THE TIME?

It is normal to experience mild drowsiness the first two to three days when narcotics are prescribed. This is due to your body getting much needed rest. Fighting pain is exhausting. After the first few days, you will feel and sleep better as your pain will be under control. Narcotic medication is often in a long-acting form, so you can have longer pain relief.

IF I TAKE PAIN MEDICATION TOO OFTEN, WILL I GET ADDICTED?

People fear addiction needlessly. You will not become addicted because there is a real need for the medication – pain relief. If you take medication to relieve pain, you are not an addict.

WHAT IF I CAN'T SWALLOW?

There are many ways to deliver pain medication. If you have difficulty swallowing, other ways will be suggested. Other options are equally effective as oral, such as rectal, under the tongue, under the skin, patches, or intravenous.

WHAT IF I DON'T WANT TO TAKE MORPHINE BECAUSE IT IS SO STRONG AND IS USED AS A LAST RESORT?

Morphine is no longer viewed as a last resort for pain control. It is easy to use, easy to change, offers the best relief for people who have pain and has a very wide window of safety. Studies have shown that many ideas about morphine are fiction and not fact.

I'VE HEARD THERE ARE SIDE EFFECTS FROM TAKING NARCOTICS. WHAT IF I DON'T WANT TO TAKE THEM?

To prevent the common side effects from narcotics, your physician and nurse will suggest such medications as laxatives, anti-nausea medications, and anti-histamines.



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PAIN SCALES

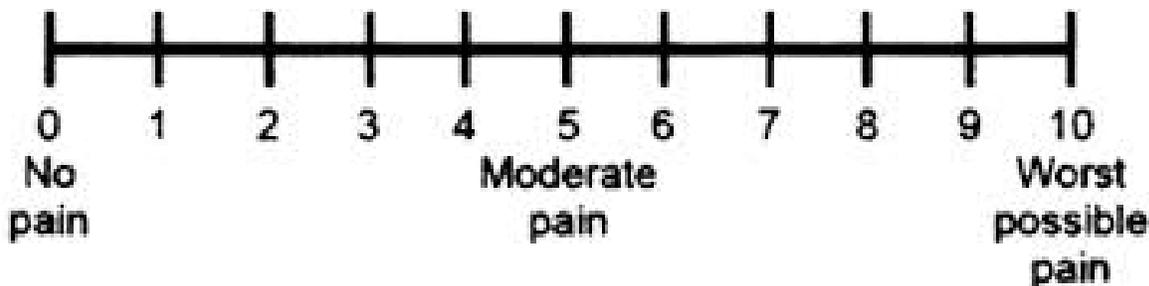
NON VERBAL:

Wong-Baker FACES™ Pain Rating Scale

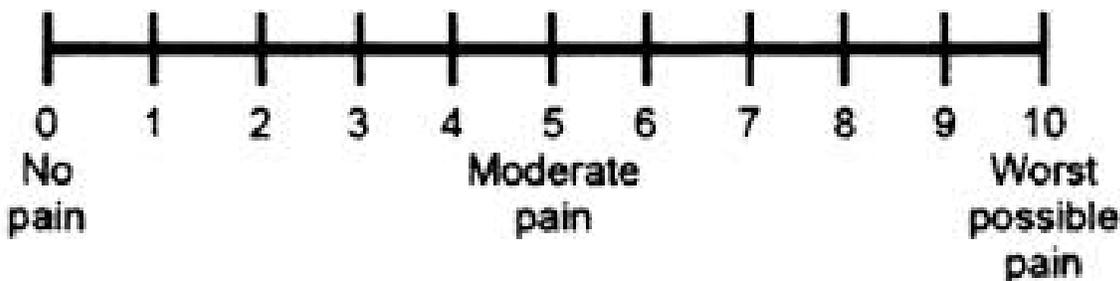


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VERBAL:



NON-COMMUNICATIVE:



0-2: Resting

5-6: Grimacing on Movement

9-10: Thrashing/Moaning

3-4: Restlessness

7-8: Thrashing on Movement

Section 9: Nutrition

GENERAL INFORMATION:

Nutrition is an important part of our lives, from the time we take our first breath as an infant. Our culture places great importance on meal planning and social interactions centered on food. Often feeding and preparing meals for a loved one is a non-verbal way of communicating love, concern, and caring.

Whenever anyone is ill, it is common for his or her appetite to decrease, whether the illness is the flu or a cancer-related process. The body's need for calories and other nutrients is altered because of the change in activity and the change in metabolic rate, due to the disease process.

Many hospice patients experience one or more of the following problems that interfere with nutrient intake: decrease or loss in appetite, nausea, vomiting, chronic pain, diarrhea, and constipation. This makes it difficult to find the right kind of foods that are well tolerated and accepted by the patient. Too often this challenge can turn into friction between the patient and the caregiver and interfere with open communication. To keep communication open, it is best to allow the patient to eat what and when he/she desires. When a person is facing the end of their life, their priorities change and eating is often not important to them. Furthermore, the disease process and medication can cause taste aversions and specific foods may taste bland, salty, sour, or too sweet.

The following are some frequent eating problems and suggestions for overcoming them. Remember that these are just suggestions. Each person has individual needs and preferences. For increased nutritional needs such as calories, protein, fluids, vitamins, and/or minerals, contact the hospice nurse.

WHEN IT IS DIFFICULT TO SWALLOW LIQUIDS OR SOLIDS

1. Thin liquids are usually the most difficult to swallow, softer blended foods are easier to swallow. There is also commercial thickener available.
2. If mucous is a problem, then cranberry, pineapple, or citrus juice may be helpful in cutting or thinning the mucous. If milk is a problem and increases intolerance to mucous production, a milk free nutritional supplement can be used. (For further information swallowing difficulties or for special products, contact the hospice nurse)

WHEN YOU'RE JUST NOT HUNGRY

1. Keep snacks handy and in sight for "nibbling."
2. Drinks made with ice cream or frozen yogurt (such as milk shakes and smoothies) provide a large number of calories within a small volume. Also, supplemental drinks such as Carnation® Breakfast Essentials™ provide nutrients.
3. Breakfast foods are often well tolerated. Do not feel that a particular food should be eaten at a particular time. Eat whatever you like, whenever you like.
4. Try eating small meals with snacks in between. (Small meals may even be just one item.)

WHEN YOU ARE NAUSEATED

1. Eat frequent small meals.
2. Dry foods such as toast and crackers are usually well tolerated.
3. Choose bland foods that are not greasy or too sweet, such as chicken noodle soup with saltine crackers, gelatin with fruit and apple juice.
4. Drink liquids between meals rather than at meal times. Clear, cool beverages are usually better tolerated. Popsicles® and flavored ice cubes are good choices.
5. Do not lie down for at least two (2) hours after eating. Sit up or recline with your head at least four inches above your feet.

WHEN YOUR MOUTH OR THROAT IS SORE OR DRY

1. Take small bites of food and take a swallow of beverage with each bite.
2. Try cold foods such as Popsicles®, sherbet, ice cream, fruit ices, milk shakes, and ice chips. (Sometimes eating ice-cold foods first may make eating other foods more tolerable.)
3. Sometimes using a straw can make swallowing more comfortable.
4. Smooth foods such as whipped cream, pudding cream pies, canned fruits, or gelatins are usually less irritating to the mouth or throat.
5. Creamed soups and other creamed foods are often well tolerated. Keep temperatures warm rather than piping hot.
6. Drink soothing beverages such as apple juice, peach or pear nectar, and milk (if tolerated). Carbonated beverages, salty liquids (such as broth or vegetable juices), citrus juices (containing acid), and spicy foods may irritate a sore mouth or throat.

Section 10: Bowel Management Instructions

Most hospice patients have some difficulty with their bowel movements. There are several reasons why you may be constipated. Changes in your diet, decreased fluid intake, or decreased activity may contribute to constipation. However, the use of pain medications (narcotic analgesics) is usually the major cause of constipation.

Untreated constipation can lead to a more serious condition (impaction or bowel obstruction), and a daily bowel program can help to prevent such problems. The overall goal is to have a bowel movement approximately every three (3) days. The following guidelines should help you maintain normal bowel function.

1. Drink plenty of liquids, especially in combination with high-fiber foods. Tea, hot lemon water and juices, such as prune juice, may be effective.
2. Try to have a bowel movement at the same time each day. Be sure to allow adequate time on the toilet or bedpan.
3. Keep a record of your bowel movements and note whether they are hard or soft.

4. Take your stool softener/laxative pill as prescribed. The dose can range from two to eight (2-8) pills per day or more if needed. Examples of such preparations are Peri-Colace[®], Senokot S[®], or Doxidan[®].
5. Other laxative preparations can be added if the stool softener/laxative pill alone does not work. Examples of these are Dulcolax[®], milk of magnesia, Phillips' M-O, or lactulose.
6. Call the nurse if you do not have a bowel movement in three (3) days. It might be necessary for you to have a rectal suppository, an enema, or be checked for stool impaction.
7. Call the nurse if you have any of the following symptoms:
 - Abdominal distention or bloating,
 - Rectal pain with your bowel movement,
 - The urge, but inability to pass stool,
 - Oozing of liquid stool after no bowel movement for several days, or
 - Rectal fullness and pressure.

Section 11: Primary Caregiver Guidelines

We at **ALL CARE HOSPICE & PALLIATIVE CARE** thank you for the privilege of assisting you with the care of your loved one. We salute you for all you have done to surround your loved one with understanding care, to provide your loved one with comfort and calm, and to enable your loved one to leave this world with a sense of peace and love. You have given your loved one the most wonderful, beautiful, and sensitive gifts we as humans are capable of, and, in giving that gift, have given yourself a wonderful gift as well.

Caring in the home for a loved one who has a limited life expectancy and who is undergoing many physical, emotional, mental, and spiritual changes, can be a challenging and fulfilling experience. It can also be confusing and tiring.

Our hospice supports your willingness to undertake the role of primary caregiver for your loved one. In this way, you permit him or her to be maintained in comfortable and familiar surroundings at this vulnerable time in his or her life's journey.

We will do everything possible to help you do this effectively and appropriately. We see ourselves as a team, with each of us having differing roles and responsibilities which, taken together, achieve maximum benefit for your loved one and for you.

Primary care refers to the basic physical and emotional activities involved in meeting the regular ongoing daily living needs of your loved one at home.



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This may involve doing such things as maintaining the person's hygiene, nourishment, and use of medications. It may involve such comfort measures as preventing constipation, nausea, or other symptoms, turning, skin care, oral care, bathing, and grooming. It may include learning such skills as ostomy care and utilizing special equipment. It may include filling prescriptions, communicating with the physician, communicating with community resources, utilizing printed materials, and making final arrangements. Generally, it means being available to your loved one to listen, to touch, to share, to be present, and to care.

Your individual hospice team is pledged to support you in every possible way as you undertake this role. It will help you deal with your limitations and frustrations. It will help you arrange for all supportive services that are needed in the home. It will help facilitate utilization of respite care and inpatient care as needed. It will help you deal with your own feelings and how this situation is affecting your life, your needs, and your hopes. It will help you clarify your choices, your available alternatives and resources, and your values, priorities and beliefs, and to implement them in the most helpful manner.

The team will explain the progression of the illness, how the needs of your loved one will change and how to respond as these changes take place. It will seek to help you anticipate these changes and implement procedures so that they do not become big problems or out-of-control situations.

In all that the team says, does, and offers you, it is the team's deepest commitment to enable you to maximize your involvement of time, energy and love with your loved one.

TO BE ABLE TO TAKE CARE OF ANOTHER, YOU MUST FIRST TAKE CARE OF YOURSELF.

TIPS ON TAKING CARE OF YOURSELF:

- If you don't care for yourself, you can't care for the one you love.
- Get enough rest, perhaps naps during the day. Conserve your energy.
- Exercise. Even a short walk helps sleep and gives energy.
- Eat well. Choose a variety of foods from the five basic food groups. Drink plenty of water.
- Reduce stress. Think about what has helped in the past.
- Take breaks. Relax and think of other things.
- Pay attention to what your body is telling you. Is it tired, stressed, tense?
- Nurture your spiritual side. Pursue those things that are uplifting to you.
- Pamper yourself, especially on difficult days. Be patient and considerate of yourself.
- Avoid unrealistic expectations of yourself.
- Allow others to help you.
- Set limits. It's okay to say "no" sometimes.
- Recognize your needs and limitations.

TIPS ON HELPING LOVED ONES:

- Allow them to talk. Listen without judgment and with only occasional comment.
- Acknowledge and validate their feelings and let them express their feelings in many ways.
- Avoid taking any negative feelings personally.
- Let them have control over their situation as much as possible.
- Include them in decision making and discussions.
- Let them do as much as they want to and have energy for, no matter how slow, painful, or difficult it seems to you.
- Don't underestimate their pains, symptoms, and fear. They are valid and real.
- Avoid judging.
- Talk about subjects you used to discuss together, the times you shared. Laugh together.

Experience has shown that often times, the best patient care provided is given by family and friends. Regardless of how capable and efficient a professional's care may be, the presence and touch of a person who has a close relationship with the patient will provide the greatest gift.

Section 12: Preparing for the Dying Process

When a person enters the final stage of the dying process, two different, but interrelated, dynamics are at work. On the physical plane, the body begins the final process that ends when all physical activities cease to function. Usually, this is an orderly and progressive series of physical changes that, rather than invasive intervention, are best responded to through comfort enhancing measures.

The second dynamic of the dying process occurs on the emotional/spiritual/mental plane. This dynamic may appear as a withdrawal from one's present surroundings and relationships or a letting go of all that keeps one attached to this life. This process also tends to follow its own path and schedule but it often includes activity or conversations to resolve whatever is unfinished in one's life. Examples of this work may be attempts to resolve misunderstandings or broken relationships, or to make preparations for the well-being of a loved one following one's own death. There is sometimes the need to receive family permission to die or "to let go". For patient and for family, it is helpful to offer words of forgiveness, if needed, as well as words of appreciation and love. Acceptance and compassionate support/assist both patient and family through this time of transition.

When a person's body is ready to stop but he/she still has important matters that are not resolved or a significant individual with whom he/she has not made peace, the patient may linger even though very debilitated. On the other hand, when a person is emotionally, spiritually, mentally ready to let go, but his or her body has not completed its final physical process, he/she will continue to live. The person dying appears to have some control over the process, and sometimes staff, reading the signs, can offer estimates of when death is approaching. Ultimately, however, one's own death is not under human control or prediction.

The goal of hospice care, at this point, is to help you and your family to prepare for dying, death, and for their continued living. Working with hospice staff to control symptoms that cause pain and discomfort, taking responsibility to complete unfinished business and understanding what the dying process looks like will give you active ways to interact with loved ones as caregivers.

The physical, emotional, spiritual, and mental changes which indicate impending death are offered to you below to help you understand the natural circumstances which may happen and how you can respond appropriately. Not all of these changes will occur with every person, nor will they occur in this particular sequence. Each person is unique. What has been most characteristic of the way your loved one has lived consistently, may affect the way this final death phase and release occurs. This is not the time to try to change your loved one, but the time to give full acceptance, support and comfort.

PHYSICAL CHANGES WITH SUGGESTED RESPONSES

COOLNESS: The person's hands and feet, then arms and legs become increasingly cool to the touch and at the same time the color of the skin may change. This is a normal indication the circulation of blood is decreasing to the body's extremities and being reserved for the most vital organs. Keep the person warm with a blanket. Do NOT use an electric blanket.

SLEEPING: The person may spend an increasing amount of time sleeping and appear to be non-communicative and unresponsive. This normal change is partly due to changes in body chemistry. Sit with your loved one, hold hands and speak softly and naturally. Do not talk about the person in the person's presence as the sense of hearing remains intact during the dying process. Speak to him or her directly as you normally would, even though there may be no response.

DISORIENTATION: The person may seem confused about the time, place, and identity of family and friends. This is also due in part to the body's chemistry changes. Sometimes a paper or white board reminder of the day and time is helpful. Identify yourself by name before you speak rather than asking the person to guess who you are. For the patient's comfort, speak softly, clearly, and truthfully when you have to communicate, such as, "It is time to take your medication..." and explain the reason for the communication, such as "....so you won't begin to hurt."

INCONTINENCE: The person may lose control of urine and/or bowel matter as the muscles in those areas begin to relax. Discuss with the hospice nurse what can be done to keep your loved one clean and comfortable as well as how to protect the bed.

CONGESTION: The person may have sounds of congestion coming from his/her throat or chest, as small amounts of fluids accumulate and cause a vibration noise. This normal change is due to the decrease of fluid intake and inability to cough up normal secretions. Suctioning usually only increases the secretions and causes much discomfort. Gently turn the person's head to the side and allow gravity to drain the secretions. You may also gently wipe the mouth with a moist cloth. The sound of the congestion does not indicate the onset of severe or new pain and is normal for the physical decline.

INTAKE DECREASE: The person may begin to want little or no food or liquid. This means the body is conserving energy for other functions and getting ready for the end phase. Do not try to force food or drink or use guilt to manipulate them into eating or drinking. To do this only makes the person uncomfortable. Small chips of ice, frozen juice, or sports drink may be refreshing in the mouth. Glycerin swabs may help keep the mouth and lips moist. A cool, moist washcloth on the forehead may increase physical comfort.

URINE DECREASE: The person's urine output normally decreases due to the decreased fluid intake as well as decrease in circulation through the kidneys. Consult with your hospice nurse to determine whether there may be a need to insert or irrigate a catheter.

BREATHING PATTERN CHANGE: The person's regular characteristic breathing pattern may change with the onset of a different breathing pace which alternates with periods of no breathing. This pattern is called the "Cheyne-Stokes" syndrome. It is very common and indicates a decrease in circulation in the internal organs. Elevating the head, holding hands, and speaking gently may help bring comfort.

EMOTIONAL/SPIRITUAL/MENTAL CHANGES WITH SUGGESTED RESPONSES

DECREASED SOCIALIZATION: The person may only want to be with a very few or even just one person. This is a sign of preparation for release and affirms from whom the support is most needed in order to make the approaching transition. If you are not a part of this inner circle at the end, it does not mean you are not cared about, or are unimportant. It means you have already fulfilled your task with him/her and it is the time for you to say goodbye. If you are part of the final inner circle of support, the person needs your affirmation, support, and permission.

WITHDRAWAL: The person may seem unresponsive, withdrawn, or in a comatose-like state. This indicates preparation for release, a detaching from surroundings and relationships and a beginning of "letting go." Hearing is believed to remain until the end, so speak to your loved one in your normal tone of voice, identify yourself by name when you speak, hold his/her hand and say whatever you need to say that will help the person let go.

SENSORY EXPERIENCES: The person may speak or claim to have spoken to those who have already died, or to see or have seen places not presently accessible or visible to you. This does not indicate a drug reaction or hallucination. The person is beginning to detach from this life and is being prepared for the transition so it will not be frightening. Do not contradict, explain away, belittle, or argue about what the person claims to have seen or heard. Just because you cannot see or hear it does not mean it's not real to your loved one. Affirm the experiences. They are normal and common. If they frighten your loved one, explain to him or her that they are normal.

RESTLESSNESS: The person may perform repetitive and restless tasks. This may be caused by decreased oxygen circulation to the brain and body chemistry changes. The restlessness may, in part, indicate that something is unresolved or unfinished that is disturbing, and prevents him or her from letting go. Do not interfere or try to restrain such motions. Your hospice team member will assist you in identifying what may be happening and help you find ways to help the person find and release from the tension or fear. Other things which may be helpful in calming the person are to speak in a quiet natural way, recall a favorite place, lightly massage the forehead, reading to the person, and/or playing music. Give assurances that it is okay to let go.

UNUSUAL COMMUNICATION: The person may make statements, gestures, or requests that are seemingly out of character. This may indicate the time is ready for the person to say goodbye and is testing to see if you are ready to let him/her go. Accept this moment as a beautiful gift when it is offered. Kiss, hug, hold, cry, and say whatever you need to say.

GIVING PERMISSION: Giving permission to your loved one to let go without making him or her feel guilty for leaving, or trying to keep him or her with you to meet your own needs can be difficult. A dying person will normally try to hold on, even though it brings prolonged discomfort, in order to be sure that those who are going to be left behind will be all right. Therefore, your ability to release the dying person from this concern and give him or her assurance that it's all right to let go whenever he or she is ready is one of the greatest gifts you have to give your loved one at this time.

SAYING GOODBYE: When the person is ready to die and you are able to let go, then is the time to say goodbye. Saying goodbye is your final gift of love to the loved one, for it achieves closure and makes the final release possible. It may be helpful to lie in bed with the person and hold him/her. It may also be helpful to take their hand and say everything that you need to say so that afterward you do not have regrets for not saying certain things to your loved one. It may be as simple as saying, "I love you." It may include recounting favorite memories, places, and activities you shared. It may include saying, "I'm sorry for whatever I contributed to add tensions or difficulties in our relationship." It may also include saying "thank you for..."

Tears are normal and a natural part of saying goodbye. Tears do not need to be hidden from your loved one and you do not need to apologize for them. Tears express your love and help you to let go.

HOW WILL YOU KNOW WHEN DEATH HAS OCCURRED?

The death of a hospice patient is not a medical emergency. Nothing must be done immediately. The signs of death include such things as:

- No breathing
- No heartbeat
- Loss of control of bowel and bladder
- No response



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- Eyelids slightly open
- Eyes fixed on a certain spot
- No blinking
- Jaw relaxed and mouth slightly open

FAMILY GUIDELINES WHEN DEATH OCCURS

We have a hospice nurse on call 24 hours a day, 7 days a week.

1. **DO NOT CALL 911.**
2. Call the hospice nurse at (208) 473-2717.
3. The hospice nurse will call the funeral home when he/she arrives.

Section 13: Consents

As part of the admission process, we ask for your consent to treat you, release information relative to your care and allow us to collect payments directly from your insurer. You or your legal representative must sign this consent before we can admit you.

CONSENT FOR TREATMENT – We require your permission before we can treat you. The treatments that we provide will be prescribed by your doctor and carried out by professional health care staff. Without your consent or your representative's consent, we cannot treat you.

You may refuse treatment at any time. If you decide to refuse treatment, we will ask you for a written statement releasing us from all responsibility resulting from such action.

In the event an employee inadvertently comes in contact with your blood or body fluids, we must test your blood for Hepatitis B, C, and HIV (The virus that causes AIDS). We will pay for these tests.

RELEASE OF INFORMATION – Your medical record is strictly confidential and protected by federal law. We may release protected health information as explained in our Notice of Privacy Practices in order to carry out treatment, payment, and/or health care operations. Protected health information may be received or released by various means including telephone, mail, fax, etc.

AUTHORIZATION FOR PAYMENT – We will directly bill your insurer for the services which we provide to you. You authorize us to collect payments on your behalf.

SPECIAL SERVICES – We will coordinate all of your medical needs and supplies while under the hospice plan of care. Should you obtain services or supplies on your own, you will be responsible for their cost.

CONSENT TO PHOTOGRAPH/FILM/RECORD – You consent for us to record or film your care, treatment, and services and allow us to use the photographs/recordings for internal use (e.g., performance improvement, education), for documenting your medical condition or for insurers to document your condition for payment purposes.



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ADVANCE DIRECTIVES – You must tell us if you have an advance directive so that we may obtain a copy to allow us to follow your directives. We will provide you care whether or not you have executed an advance directive, but having an advance directive may have an impact on the type of care provided during emergency situations.

ELECTION OF HOSPICE BENEFIT – You and your family are electing the hospice benefit and acknowledge, consent, and agree to the election requirements.



Public Disclosure Statement: All Care Hospice & Palliative Care, LLC.

Names and addresses of individuals, corporations, or subcontractors having a combined direct or indirect ownership or 5% or more in the organization:

Angela Hilleshiem
Phil Gisi

Names and addresses of those persons directly related (spouse, sibling, parent, child) to individuals named in "A": None at this time

Names and addresses of individuals in "A" or "B" with an ownership or controlling interest in a Medicare or Medicaid facility: Edgewood OpCo: None

When the organization is a corporation, the names and addresses of officers, directors, or partners:

Edgewood OpCo
Phil Gisi, President/CEO
322 DeMers Ave, Ste 500
PO Box 13238
Grand Forks, ND 58208-3238

Description of any criminal offense conviction involving titles XVIII, XIX, or XX brought against any persons listed in "A", "B", or "C": None

Names and addresses of any individual currently employed in a managerial, accounting, auditing, or similar capacity who were employed by the organization's fiscal intermediary within the previous 12 months: None

Changes in the Administrator, Program Director, or Medical Director during the previous 12 months: None

Actual or anticipated change in ownership or control in the previous or next 12 months: None

Anticipated bankruptcy filings: None

Operational changes by a management company: None

Leasing agreements by another organization: None

Address changes for the parent, subunits, or branches: None



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The annual disclosure statement will be signed by the Executive Director/Administrator of All Care Hospice & Palliative Care, LLC.

Mission statement: All Care Hospice & Palliative Care is dedicated to promoting quality of life by addressing the medical, emotional, and spiritual needs of our patients and their families. We understand that each patient and family is unique. We are guided by the belief that providing the highest quality of patient care with dignity, compassion, and respect for each person is the most important activity of the organization. We feel that we should help every patient facing end of life decisions to be free of pain and in a safe compassionate environment. These choices allow patients to spend their final days with dignity, comfort, and surrounded by their loved ones.

Licensure and accreditation status, as applicable: Currently Deemed Status through Community Health Accreditation Program.

Angela Hilleshiem, RN
Administrator and CEO
All Care Health Solutions
angieh@myallcare.net
(208)473-2717



All Care

Hospice & Palliative Care

Your Professional Hospice Staff

NURSE: _____

NURSE: _____

MEDICAL DIRECTOR: _____

HOSPICE AIDE: _____

SOCIAL WORKER: _____

SPIRITUAL COUNSELOR: _____

VOLUNTEER(S): _____

MISSION STATEMENT

The mission of All Care Hospice & Palliative care is to provide physical, emotional, social, and spiritual support to terminally ill patients, as well as their families and loved ones, while assisting patients and families to live with dignity and comfort as they cope with end of life issues.

(208) 473-2717

Hospice & Palliative Care

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday



Hospice & Palliative Care

Patient Name: _____

DOB: _____

Today's Date: _____

ALF Coordinated Plan of Care

Resident Name:	Room #:	Daytime Phone:
Diagnosis:	Bed #:	After Hours Phone:
RN Case Manager:	Hospice Social Worker:	
Hospice Aide:	Hospice Volunteer:	
Hospice Chaplain:	Other:	

Date		Nurse Visits	Date		Hospice Aide Visits
Start	End		Start	End	
		Frequency:			Frequency:
		Frequency Change:			Frequency Change:
		Hospice Social Worker Visits			Hospice Volunteer Visits
		Frequency:			Frequency:
		Frequency Change:			Frequency Change:
		Hospice Chaplain Visits			Wound Care Visits
		Frequency:			Frequency:
		Frequency Change:			Frequency Change:

Date		Treatments	Party Responsible & Frequency	
Start	End		Hospice	ALF
		Foley Catheter Change		
		Other Tx: (therapy, labs, trach care, ostomy care, etc.)		

Medications

--	--	--

Medical Supplies Provided by Hospice:

<input type="checkbox"/> Incontinence	<input type="checkbox"/> Dressings	<input type="checkbox"/> Foley Catheter
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other

DME Provided by Hospice:

<input type="checkbox"/> Oxygen	<input type="checkbox"/> Commode	<input type="checkbox"/> Walker
<input type="checkbox"/> Bed	<input type="checkbox"/> Nebulizer	<input type="checkbox"/> Wheelchair
<input type="checkbox"/> Walker	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Other

All Care Representative **All Care Representative Signature** Date

Facility Representative Facility Representative Signature Date



Patient Name: _____

DOB: _____

Today's Date: _____

SNF Coordinated Plan of Care

Resident Name:	Room #:	Daytime Phone:
Diagnosis:	Bed #:	After Hours Phone:
RN Case Manager:	Hospice Social Worker:	
Hospice Aide:	Hospice Volunteer:	
Hospice Chaplain:	Other:	

Date		Nurse Visits	Date		Hospice Aide Visits
Start	End		Start	End	
		Frequency:			Frequency:
		Frequency Change:			Frequency Change:
		Hospice Social Worker Visits			Hospice Volunteer Visits
		Frequency:			Frequency:
		Frequency Change:			Frequency Change:
		Hospice Chaplain Visits			Wound Care Visits
		Frequency:			Frequency:
		Frequency Change:			Frequency Change:

Date		Treatments	Party Responsible & Frequency	
Start	End		Hospice	SNF
		Foley Catheter Change		
		Other Tx: (therapy, labs, trach care, ostomy care, etc.)		

Medications

--	--	--	--

Medical Supplies Provided by Hospice:

<input type="checkbox"/> Incontinence	<input type="checkbox"/> Dressings	<input type="checkbox"/> Foley Catheter
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other

All Care Representative **All Care Representative Signature** Date

Facility Representative Facility Representative Signature Date

Patient Name: _____

DOB: _____

Today's Date: _____

**SNF Coordinated Plan of Care –
Delineation of Services/Responsibilities**

Resident Name: _____

Hospice Name: All Care Hospice & Palliative Care

SOC:

Item #	Duties & Responsibilities	Hospice	SNF	Comments
1	Arrange for the provision of Hospice Services by written agreement with Medicare Certified hospice	X	X	
2	Ensure that hospice services meet professional standards and principles that apply to individuals providing the services and to the timeliness of services	X		
3	Have written agreement with hospice, signed by authorized representatives that sets out at least the following	X	X	
3a	The hospice service to be provided	X	X	
3b	Hospice responsibilities for determining the appropriate hospice plan of care	X	X	
3c	Services facility will continue to provide based on each hospice patient's plan of care	X	X	
3d	A communication process including how the communication will be documented between the facility and hospice to ensure the needs of the hospice patient are met 24-hours per day	X	X	Hospice 24-hour # 208-473-2717
4	Facility immediately notifies hospice of the following		X	
4a	A significant change in hospice patient's physical, mental, social or emotional status	X	X	Collaboration: facility notify family and hospice assess and provide updates
4b	Clinical complications that suggest a need to alter the plan of care	X	X	Collaboration: Change care plan as needed
4c	A need to transfer hospice patient from facility for any condition	X	X	Joint decision
4d	The hospice patient's death	X	X	Hospice to respond to call and provide facility support if not already present.
5	Designate interdisciplinary team member to be responsible for working with hospice representative to coordinate care of the hospice patient provided by facility and hospice staff. The individual must meet the following requirements and responsibilities.		X	
5a	Have a clinical background function within their state scope of practice act and have the ability to assess the hospice patient or have access to someone who has the skills and capabilities to assess hospice patient		X	

Patient Name: _____

DOB: _____

Today's Date: _____

**SNF Coordinated Plan of Care –
Delineation of Services/Responsibilities**

Resident Name: _____

Hospice Name: All Care Hospice & Palliative Care

SOC:

Item #	Duties & Responsibilities		Hospice	SNF	Comments
5b		Be responsible for collaborating with hospice representatives and coordinating facility staff for those hospice patient receiving hospice services		X	
5c		Communicate with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness related conditions and other conditions to ensure quality of care for the patient and family		X	
5d		Ensure the facility communicates with Hospice Medical Director, patients attending physician and other practitioners participating in the care		X	
5e		Obtain the following information from hospice:		X	
	5e1	Most recent hospice plan of care for each patient	X		
	5e2	Hospice election form	X		
	5e3	Physician certification and recertification of the terminal illness specific to each patient	X		
	5e4	Names and contact information for hospice personnel involved in hospice care of each patient	X		
	5e5	Instructions on how to access the hospice 24-hour on call system	X		
	5e6	Hospice medication information specific to each patient	X		
	5e7	Hospice physician and attending physician (if any) orders specific to each patient	X		
5f		Ensure facility staff provides orientation in facility policies/procedures, including patient rights and appropriate forms and record keeping to hospice staff	X	X	
6		Responsible for all care decisions related to the terminal diagnosis of hospice patients			
7		Determines hospice services to be provided			
8		Provide bereavement counseling to facility staff upon request			
9	Start	End	Personal Cares Frequency: Hospice to Provide		
			Skilled Nurse		
			MSW		
			Volunteer		
			Bath Aide		
			Chaplain		

Patient Name: _____

DOB: _____

Today's Date: _____

SNF Coordinated Plan of Care – Delineation of Services/Responsibilities

Resident Name: _____

Hospice Name: **All Care Hospice & Palliative Care**

SOC:

10	Start	End	Treatments: Frequency and party responsible			
			Example: Foley Catheter Change			
11	Start	End	Medications:			
12	Check if yes		Medical Supplies: Provided by hospice			
			Incontinence			
			Dressings			
			Foley Catheter			
			Other:			
			Other:			
			Other:			
			Other:			

Facility Representative Name & Signature

Date

All Care Hospice & Palliative Care Representative Name & Signature

Date



Hospice & Palliative Care

815 S Bridgeway Place, Suite 122
Eagle, ID 83616
P-208.473.2717 / F 208.473.2451

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Hospice Election of Benefits

Hospice Philosophy

I acknowledge that I have been given a full explanation and have an understanding of the purpose of hospice care. Hospice care is to relieve pain and other symptoms related to my terminal illness and related conditions and such care will not be directed toward cure. The focus of hospice care is to provide comfort and support to both me and my family/caregivers.

Effects of a Medicare Hospice Election

I understand that by electing hospice care under the Medicare Hospice Benefit, I am acknowledging that I understand the palliative rather than curative nature of hospice care, as it relates to my terminal illness and related conditions. I understand that by electing hospice care under the Medicare Hospice Benefit, I am waiving (give up) all rights to Medicare payments for services related to my terminal illness and related conditions and I understand that while this election is in force, Medicare will make payments for care related to my terminal illness and related conditions only to the designated hospice and attending physician that I have selected. I understand that services not related to my terminal illness or related conditions will continue to be eligible for coverage by Medicare; however, I also understand that services unrelated to my terminal illness and related conditions are exceptional and unusual and hospice should cover all care related to my terminal illness and related conditions needed under the hospice election.

Hospice Coverage and Right to Request "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" I acknowledge that I have been provided with information about my financial responsibility for certain hospice services (drug copayment and inpatient respite care). I understand that I have the right to request at any time, in writing, the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs" addendum that lists the items, services, and drugs that the hospice has determined to be unrelated to my terminal illness and related conditions that would not be covered by the hospice. I acknowledge that I have been provided information regarding the provision of Immediate Advocacy through the Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) if I disagree with any of the hospice's determinations and I have been provided with the contact information for the BFCC-QIO that services my area.

Beneficiary and Family Centered Care Quality Improvement Organization Contact Information

Idaho: Kepro 888-317-0891

Beneficiary and Family Centered Care Quality Improvement Organizations help file quality of care complaints as well as immediate advocacy services to quickly resolve medical concerns. For information about the availability of auxiliary aids and services please visit: http://www.medicare.gov/about-us/nondiscrimination/nondiscrimination-notice.html. This website has been designed to comply with Section 508 of the U.S. Rehabilitation Act.

[] I elect to receive the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

(Hospice: Please provide the beneficiary with the addendum. Must be signed and dated accompanying the election statement.)

[] I decline to receive the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

Signature: _____ Date: _____



Hospice & Palliative Care

815 S Bridgeway Place, Suite 122
Eagle, ID 83616
P-208.473.2717 / F 208.473.2451

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Patient Notification of Hospice Non-Covered Items, Services, and Drugs

Elected to receive the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

Declined to receive the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs"

Date of Request: _____

(Hospice must furnish this addendum within 5 days if requested at the time of hospice election and within 72 hours if requested during the course of hospice care.)

Diagnoses Related to Terminal Illness and Related Conditions (hospice is responsible to cover all items, services, and drugs):

Table with 2 columns and 3 rows for diagnosis entries.

Diagnosis Unrelated to Terminal Illness and Related Conditions:

Table with 2 columns and 3 rows for diagnosis entries.

Non-covered items, services, and drugs determined by hospice as not related to my terminal illness and related conditions:

Table with 2 columns: Items/Services/Drugs and Reason for Non-coverage.



Hospice & Palliative Care

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Note: The hospice makes the decision as to whether or not conditions, items, services, and drugs are related for each beneficiary. This addendum should be shared with other health care providers from which you seek item, services, or drugs, unrelated to your terminal illness and related conditions to assist in making treatment decisions.

Right to Immediate Advocacy

As a Medicare beneficiary you have the right to appeal the decision of the hospice agency on items not being covered because the hospice has determined they are unrelated to the individual’s terminal illness and related conditions. You have the right to contact the Medicare Beneficiary and Family Centered-Quality Improvement Organization (BFCC-QIO) for immediate assistance. Visit this website to find the BFCC-QIO for your area. <https://quiprogram.org/contact-zones> or call 1-800-MEIDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Acknowledgement of non-covered items, services, and drugs not related to my terminal illness and related conditions

The purpose of this addendum is to notify beneficiary (or representative), in writing, of those conditions, items, services, and drugs the hospice will not be covering because the hospice has determined they are unrelated to the individual’s terminal illness and related conditions. I acknowledge that I have been given a full explanation and have an understanding of the list of items, services and drugs not related to my terminal illness and related conditions not being covered by hospice. Signing this addendum (or its updates) is only acknowledgement of receipt of the addendum (or its updates) and not necessarily agreement with the hospice’s determinations.

Signature of Beneficiary/Representative

Date

Signature of All Care Representative

Date



Hospice & Palliative Care

815 S Bridgeway Place, Suite 122
Eagle, ID 83616
P-208.473.2717 / F 208.473.2451

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Authorization for Release of Medical Information

Patient: _____

Date of Birth: _____

To: _____

You are hereby authorized and requested to furnish to All Care Hospice & Palliative Care, or their representative, all of my medical and drug records including:

- History and Physical Exam
Progress Notes
Clinical Summary
Physician's Notes
Consultation Reports
Laboratory Reports
Operative Reports
Nurse's Notes
Pathology Reports
Outpatient Information
X-Ray Reports
Other (Specify):

I also hereby give consent to All Care Hospice & Palliative Care to make copies of said records for the purpose of coordinating and providing my medical care.

This authorization will remain in effect a maximum of six months from the date of signature and may be canceled by me in writing at any time. I understand that such cancellation may be harmful to proceedings requiring these records. I do not authorize re-release of this information to anyone. A photocopy of this authorization will be treated in the same manner as the original.

The following email address can be used to inform, update or coordinate care with myself, family, or care providers.

Email address: _____

Patient/Representative Signature

Date



Hospice & Palliative Care

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Eagle, ID 83616
P-208.473.2717 / F 208.473.2451

Patient Name: _____

Date of Birth: _____

Today's Date: _____

911/Emergency Services Notice to Protect You

It is an honor to care for you, or your loved one during this difficult time. We would like to take a moment to explain the Medicare/Medicaid hospice benefit and what it covers in terms of emergency/urgent care services.

Once a person chooses to receive hospice care, they enable the hospice benefit election. Part of that benefit is that a patient chooses not to receive curative treatment for their terminal diagnosis. A patient can still call 911 or go to the emergency room for injuries/illnesses that are not related to their terminal diagnosis. However, the hospice agency must be aware of all treatments and services the patient is going to receive prior to receiving care. Hospice can provide most services and treatments, so contact hospice prior to calling 911.

If you or your loved one wish to enable 911 or emergency services, the hospice agency must first obtain a revocation notice from you.

By signing below, you acknowledge that you must sign a revocation notice prior to obtaining any other medical interventions such as emergency services or calling 911. This will enable you to use those services and they will get billed to your insurance instead of you. In the event that you don't sign the revocation form before seeking treatment, the hospital and/or emergency services can bill you for the services instead of your insurance.

Your signature on the affirmations page acknowledges you have received and fully understand All Care Hospice & Palliative Care's explanation of the Medicare/Medicaid Hospice Benefit as it applies to emergency and urgent care services.



Hospice & Palliative Care

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Patient Name: _____

Date of Birth: _____

Today's Date: _____

Right to choose an attending physician

I understand that I have a right to choose my attending physician to oversee my care. My attending physician will work in collaboration with the hospice agency to provide care related to my terminal illness and related conditions.

[] I do not wish to choose an attending physician

[] I acknowledge that my choice for an attending physician is:

Physician Full name: _____ NPI: _____

Office Address: _____

I acknowledge and understand the above, and authorize Medicare hospice coverage to be provided by _____ (Hospice Agency)

to begin on _____ (Effective Date of Election)

Note: The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement. An individual may not designate an effective date that is retroactive.

Signature of Beneficiary/Representative

(Date Signed)

[] Beneficiary is unable to sign -Reason: _____

Signature of All Care Representative

(Date Signed)



Hospice & Palliative Care

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Patient Name: _____

Date of Birth: _____

Today's Date: _____

Consent for Primary Caregiver

I, _____ agree to accept the role of primary caregiver(s)
caregiver(s) for _____ who is requesting admission into All
Care Hospice & Palliative Care program of care. The commitment and responsibilities of this role and of hospice
care/services are described below:

- 1. I understand the goal of hospice is not to cure the terminal illness but to provide symptom relief and
supportive care in this final phase of life.
2. I understand the hospice interdisciplinary team will provide education, training, and support in the
management of the patient's physical, emotional, psychosocial, and spiritual needs.
3. I understand the hospice staff will provide emotional, psychosocial, and spiritual support to help me
cope with my caregiver responsibilities, the eventual patient's death, and my bereavement.
4. I understand that in my role as a primary caregiver, I will be responsible for meeting or arranging for the
patient's 24 hours a day care needs. I will arrange for care in my absence.
5. I understand the hospice medical record will contain information about me. Every effort will be made
to keep this information confidential. I authorize this information to be released to the attending physician
and other appropriate healthcare providers for the patient's care. I also authorize the release of this
information, as needed, to process insurance claims.
6. I understand hospice services are primarily provided on a prearranged, appointment basis, but crisis or
consultation assistance with hospice is available 24 hours a day, 7 days a week. I will consult hospice in case
of any emergency.
7. I understand to receive full benefits of hospice care it is important for me and the patient to make our needs
and concerns known to the hospice interdisciplinary team and to participate in the planning for care.
8. I understand I may choose to change my mind about this method of care and withdraw from this
primary caregiver agreement. However, I agree not to do so without giving advance notice to the patient
and hospice, so another primary caregiver can be arranged for.
9. I have received the Patient/Family Orientation for Hospice Care Packet. At this time, I believe I understand
the responsibility of being primary caregiver, the nature of the patient's illness, and the goal of hospice care.
My questions about the hospice program have been answered to my satisfaction by the hospice staff.

Your signature on this page acknowledges you have received and fully
understand All Care Hospice & Palliative Care's Consent for Primary Caregiver
as well as the role and responsibilities of the primary caregiver.

Printed Caregiver Name(s): _____

Signature: _____ Date: _____



Hospice & Palliative Care

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Patient Name: _____

Date of Birth: _____

Today's Date: _____

To :

All Care Hospice & Palliative Care is participating in a national survey to provide the United States Department of Health and Human Services with information about the quality of health care delivered to people in their homes. You may be selected to take part in this important telephone interview. We have partnered with **Pinnacle Quality Insight** to contact you **via telephone** to complete this interview. Phone calls from Pinnacle Quality Insight will appear on your caller ID as being from a toll-free area code.

The number that will appear on your caller ID is 1-888-444-9961

This will help you know when Pinnacle might be calling, so that you will feel safe to answer. Please keep this in mind so that you do not miss this survey opportunity.

The interviewer will ask for your opinions about the hospice care your loved one received. We hope that you will take a few minutes to go through this important call. The survey is designed to measure caregiver's perspectives on hospice care for public reporting. The data collected from the survey will be provided to consumers to help them make informed choices when selecting a hospice. It will also be used to help improve the quality of care provided by hospices. *Your participation is important.*

It is important that your answers reflect your own opinions about the Hospice care your loved one received, so please do **not** ask anyone from this Hospice Agency for help completing the survey.

All information you give in this survey will be held in confidence and is protected by the Privacy Act. Your name will not be attached to the publicized results.

If you have any questions about the survey, please contact Pinnacle Quality Insight at 1-888-444-9961.

Thank you in advance for your participation.

Sincerely,

Angela Hilleshiem
All Care Hospice & Palliative Care
Administrator



10/10

GIVE US A 10!

HOSPICE CUSTOMER SATISFACTION SURVEY

Communication with family

Family caregivers reported how often the hospice team:

- Kept them informed about when they would arrive to care for their family member
- Explained things in a way that was easy to understand
- Listened carefully to them when they talked about problems with their family member's hospice care
- Kept them informed about the family member's condition
- Listened carefully to them
- Gave them confusing or contradictory information about their family member's condition or care

Getting timely help

Family caregivers reported how often:

- They got help as soon as they needed it, when they asked the hospice team for help
- They got the help they needed from the hospice team during evenings, weekends, or holidays

Treating patient with respect

Family caregivers reported how often:

- The hospice team treated their family member with dignity and respect
- They felt the hospice team really cared about their family member

Emotional and spiritual support

Family caregivers reported about how much:

- Emotional support they got from the hospice team while their family member was in hospice care
- Emotional support they got from the hospice team in the weeks after their family member died
- Support they got for their religious or spiritual beliefs

Help for pain and symptoms

Family caregivers reported whether their family member got as much help with pain as needed, and how often their family member got needed help for:

- Pain
 - Trouble breathing
 - Trouble with constipation
 - Feelings of anxiety or sadness
-

Training family to care for patient

Family caregivers reported whether the hospice team gave them the training they needed about:

- Side effects to watch for from pain medicine
 - If and when to give more pain medicine
 - How to help if their family member had trouble breathing
 - How to help if their family member became restless or agitated
-

Rating of this hospice

Family caregivers rated this agency on a scale of 0 (worst possible) to 10 (best possible)

Willing to recommend this hospice

Family caregivers reported how likely they would be to recommend this agency to other friends or family





Hospice & Palliative Care

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Patient Name: _____

Date of Birth: _____

Today's Date: _____

Insurance and Billing

Check all insurance sources the patient currently has:

- Medicare, Medicaid, Private Insurance checkboxes

Information listed below should be copied directly from the patients Medicare card. Name of Beneficiary: Medicare Claim #:

To be completed by admission discipline:

YES NO

- Is the patient now or ever been a participant in the Hospice program?
Was illness/injury due to a work related accident covered by Workers Comp or Black Lung?
Was illness/injury due to a Non-Work related accident?
Is the patient on kidney dialysis for End Stage Renal Disease?
Is the patient covered under a Group Health Plan by their employer or spouse's employer?
Is the patient currently working full or part-time?
Is the patient a disabled Medicare Beneficiary under the age of 65?
Is the patient's spouse employed and under the age of 70?

Patient's Medicaid ID Number: Number unknown follow up needed
Patient has applied for Medicaid and is pending
Contact All Care Hospice & Palliative Care billing office prior to admitting HMO patient

Medicaid HMO:
Name of Insurance: Customer Service Phone #:
Insured's Name: Relationship to Patient:
Insured's DOB: Insured's Social Security Number:
Insured's Employer: Employer's phone:

Skilled Nursing Facility Only N/A

Effective Date: Admission Change Facility:

Facility billing office informed of hospice admission/change. Notified:

Room and Board will be paid by:

Level of Hospice Care:

- Patient/family will be responsible (facility to bill patient)
Patient is on skilled days under a diagnosis other than the hospice admission diagnosis.
All Care Hospice & Palliative Care will be responsible while the patient is on in-patient level of care
Medicaid (facility to bill hospice)
Routine
Inpatient
Respite
Continuous Care

Your signature on the affirmations page acknowledges you have received, answered correctly, and fully understand All Care Hospice & Palliative Care's Hospice Insurance Benefit Form.

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Hospice Services Disclosure Form

Required Services Covered by the Medicare Hospice Benefit

All of the following services are required and covered *if they are needed to palliate the symptoms of a terminal diagnosis* and are included in the patient's Plan of Care.

- Medicines, medical supplies, and durable medical equipment (hospital bed, walker, etc.)
- Laboratory services
- X-ray and radiation therapy
- Emergency services
- Ambulance and transport services
- Short-term inpatient stays in a hospice facility, hospital, or skilled care facility for management of acute symptoms
- Short-term continuous nursing care in the home for crisis care of acute symptoms that can be managed at home with extra support from the hospice team.
- Five-day inpatient respite periods when caretakers require a break from care giving responsibilities
- Bereavement support and counseling services
- Use of an interdisciplinary team
 - ▶ Medical supervision and physician services
 - ▶ Individual case management and coordination of care by a registered nurse
 - ▶ Intermittent nursing visits
 - ▶ Social work services
 - ▶ Pastoral counseling and spiritual support provided or coordinated by a hospice chaplain
 - ▶ Home health aide and homemaker services
 - ▶ Volunteer services
 - ▶ Dietary counseling and physical, occupational, speech, and respiratory therapy services as appropriate

Medicare Hospice Levels of Care

- Routine Home Care** is provided in a patient's residence or a nursing facility if they reside there.
- Continuous Care** is used to provide intensive care for short periods of time to manage a crisis situation. At least 8 hours of direct one on-one care must be required during a 24-hour period, and at least half of that care must be provided by a licensed nurse.
- Inpatient Care:** For the control of acute pain or symptoms that cannot be adequately managed in the home, short-term care is provided in a hospital or skilled nursing facility.
- Respite Care** is provided in a hospital or skilled nursing home to allow the patient's primary care giver a rest. Up to 5 days of respite care are allowed at a time.

Special Services

I understand that if I need hospitalization or special services not provided by hospice, I or my legal representative must make arrangements for these services. The hospice shall in no way be responsible for failure to provide the same and is hereby released from any liability arising from the fact that I am not provided with such additional care.

I have read and understood the services provided by All Care Hospice & Palliative Care and the four levels of care as outlined above. I have also received a copy of this form.

Your signature on the affirmations page acknowledges you have received and fully understand All Care Hospice & Palliative Care's Hospice Services Disclosure Form.



Hospice & Palliative Care

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Patient Name: _____

Date of Birth: _____

Today's Date: _____

Medicare Benefit Recipients: The patient understands that application for payment under Title XVIII of the Social Security Act may be made and that information must be provided by the patient in order to receive such payment. The patient hereby certifies that the information given in applying for payment under Title XVIII of the Social Security Act is correct. The patient hereby requests payment of authorized Medicare benefits are to be made on the patient's behalf.

Initials

- 1. All Care Hospice & Palliative Care will receive payment for my care, relating to my terminal illness. Medicare will continue to make payment to my attending physician for services if my physician is neither a hospice employee nor receiving payments from All Care Hospice & Palliative Care.
2. I accept Medicare benefits related to my terminal illness while enrolled in the Medicare Hospice program. I understand that I must have prior approval from hospice before ordering or receiving treatments, supplies, equipment, or any other service related to my terminal illness.
3. The Medicare hospice program is divided into benefit periods consisting of two 90-day periods and unlimited 60-day periods. I must use the benefits periods in the above order.
4. I acknowledge that I have been given a copy of the Patient's Rights and Responsibilities and Notice of Hospice Privacy Practices.
5. As a Medicare recipient, I understand the above and authorize hospice Medicare services from All Care Hospice & Palliative Care by signing below.

Certification: The undersigned hereby certifies that he or she has read the foregoing, received a copy thereof, and is the patient or is the duly authorized patient's agent/representative authorized by the patient to execute the above and accept its terms.

I consent for hospice care to begin on: _____ Benefit Period Elected: [] 1 [] 2 [] 3 [] 4
I designate Dr. _____ as my attending physician.

Your signature on the affirmations page acknowledges you have received and fully understand All Care Hospice & Palliative Care's Hospice Benefit Authorization.

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Medicare Secondary Payer Worksheet

Section A

- Are you receiving Black Lung (BL) Benefits?
 - Yes. Date benefits began: _____
 - No. Go to 2.
 BL is Primary Only for Claims Related to BL.
- Are the services to be paid by a government program such as a research grant?
 - Yes. Government program will be primary.
 - No. Go to 3.
- Has the Department of Veterans Affairs (DVA) authorized to pay for care at this facility?
 - Yes. DVA is primary.
 - No. Go to 4.
- Was the illness/injury due to a work related accident or condition?
 - Yes. Date of injury/illness: _____
Complete Payer Info. Workers Comp. is primary payer only for claims related to the injury/illness that is work related.
 - No. Go to Section B.

Section B

- Was the illness/injury due to non-work related accident?
 - Yes. Date of accident: _____
 - No. Go to Section C.
- What type of accident caused the illness/injury?
 - Automobile
 - Non-Automobile**Complete Payer Info.** No Fault-Insurer is Primary Payer. Only for those claims related to the accident. Go to Section C.
- Was another party responsible for this accident?
 - Yes. **Complete payer info.** Liability Insurer is primary only for those claims related to the accident.
 - No. Go Section C.

Section C

- Are you entitled to Medicare based on:
 - Age. Go to Section D.
 - ESRD. Go to Section F.
 - Disability. Go to Section E.

Section D - Age

- Are you currently employed?
 - Yes. **Complete Payer Info.**
 - No. Never employed.
 - No. Date of Retirement: _____
- Is your spouse currently employed?
 - Yes. **Complete Payer Info.**
 - No. Never employed.
 - No. Date of Retirement: _____
 If the patient answered "No" to both questions 1 and 2, Medicare is primary. Do not proceed any further.
- Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment?
 - Yes.
 - No. Stop
 Medicare is primary unless the patient answered "Yes" to the questions in Sections A or B.
- Does the employer that sponsors your GHP employ 20 or more employees?
 - Yes. Stop. GHP is primary. **Complete payer info.**
 - No. Stop
 Medicare is primary unless the patient answered "Yes" to the questions in Sections A or B.

Section E - Disability

- Are you currently employed?
 - Yes. **Complete Payer Info.**
 - No. Never employed.
 - No. Date of Retirement: _____

Section E - Disability (cont.)

- Is your spouse currently employed?
 - Yes. **Complete Payer Info.**
 - No. Never employed.
 - No. Date of Retirement: _____
 If the patient answered "No" to both questions 1 and 2, Medicare is primary. Do not proceed any further.
- Do you have group health plan (GHP) coverage based on your own, or a family member's current employment?
 - Yes.
 - No. Stop, Medicare is primary.
- Are you covered under the GHP of a family member other than your spouse?
 - Yes. **Complete payer info.**
 - No.
- Does the employer that sponsors the GHP employ 100 or more employees?
 - Yes. Stop, GHP is primary. **Complete payer info.**
 - No. Stop, Medicare is primary.

Section F - ESRD

- Do you have GHP coverage?
 - Yes. **Complete Payer Info.**
 - No. Stop, Medicare is primary.
- Have you received a kidney transplant?
 - Yes. Date of Transplant: _____
 - No.
- Have you received maintenance dialysis treatments?
 - Yes. Date Began: _____
If you participated in a self-dialysis training program, provide date training started: _____
 - No.
- Are you within the 30-month coordination period that starts _____ ? (The coordination period-CP - starts the first day of the month an individual is eligible for Medicare, even if not yet enrolled. If the individual is participating in a self-dialysis training program or has a kidney transplant during the 3-month waiting period, the coordination period starts with the first day of the month of dialysis or kidney transplant.)
 - Yes.
 - No. Stop, Medicare is primary.
- Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?
 - Yes.
 - No.
- Was your entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?
 - Yes. Stop, GHP is primary through 30M CP.
 - No. Initial entitlement based on age or disability.
- Does the working age or disability MSP provision apply? (Is the GHP primarily based on age or disability entitlement)
 - Yes. GHP is primary through 30M CP.
 - No. Medicare is primary.

Primary Payer Information

Employer (Patient): _____
 Address: _____
 Employer (Spouse): _____
 Address: _____
 Insurer/GHP: _____
 Address: _____
 Policy ID Number: _____
 Group ID Number: _____
 Membership Number: _____
 Name of Policy Holder: _____
 Relationship to Patient: _____



Hospice & Palliative Care

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Patient Name: _____

Date of Birth: _____

Today's Date: _____

Payment Responsibility: The patient and/or the patient's authorized agent have full responsibility for the payment of all fees and charges in accordance with All Care Hospice & Palliative Care's fee schedule. It is understood that for hospice patients, All Care Hospice & Palliative Care assumes financial responsibility for medications and/or durable medical equipment and medical supplies related to the terminal illness. The patient and/or patient's agent assumes financial responsibility for all other unauthorized charges. All Care Hospice & Palliative Care, in accordance with this agreement, shall assist the patient in obtaining financial assistance from third-party payers, such as Medicare, Medicaid and private insurers.

Rates: Should a patient choose to receive care from All Care Hospice & Palliative Care without having Medicare, Medicaid, other private insurance, or third party payer source, the following rates will apply:

Routine Home Care: \$166/Day

Inpatient Care: \$704/Day

Continuous Care: \$48/Hour

Respite Care: \$171/Day

If your ability to pay changes after you are on hospice, you will not be removed from hospice care due to inability to pay.

Agency Choice: Medicare/Medicaid hospice care is a Medicare or Medicaid benefit. As such, patients can choose what hospice agency provides their hospice care. By signing below, I confirm that I am aware that I have a choice over which agency provides my hospice care and I have chosen All Care Hospice & Palliative Care of my own free will. If at any time I wish to discontinue care with All Care Hospice & Palliative Care, I or my legal representative must contact All Care Hospice & Palliative Care at (208) 473-2717 to cancel.

Advance Directives: I have been made aware of my right to make health care decisions for myself. I am also aware that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself. I have a:

[] Living Will

[] Durable Power of Attorney for Health Care

[] POST Form

[] N/A

Consent to Film/Record: I hereby consent for the agency to record or film my care, treatment, and services and allow the agency to use the photographs/recordings for their internal use, for documenting my medical condition, or for insurance providers to document my condition for payment purposes.

Frequencies: You are receiving the following care at the following daily/weekly/monthly frequencies. If there is a change in any of these services or frequencies, they will be communicated to you:

Skilled Nursing: _____

Aide: _____

Social Worker: _____

Spiritual Care: _____

Volunteer: _____

Non-Discrimination: All Care Hospice & Palliative Care does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, publication in its programs, services, activities, or in employment. For further information about this policy, contact the All Care Hospice & Palliative Care Administrator at (208) 473-2717.

Administrator: Angela Hilleshiem, RN

Assistant Administrator: Lance, Robinson, RN

Director of Nursing: Allison Ashford, RN



Hospice & Palliative Care

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P-208.473.2717 / F 208.473.2451

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Family/Friend Contact List

Patient: _____

Date of Birth: _____

Contact: _____ Phone: _____ Relationship: _____

EmailAddress: _____

Address: _____

Contact: _____ Phone: _____ Relationship: _____

EmailAddress: _____

Address: _____

Contact: _____ Phone: _____ Relationship: _____

EmailAddress: _____

Address: _____

Contact: _____ Phone: _____ Relationship: _____

EmailAddress: _____

Address: _____

Contact: _____ Phone: _____ Relationship: _____

EmailAddress: _____

Address: _____



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Patient Name: _____

Date of Birth: _____

Today's Date: _____

Are you on life support equipment? [] Yes [] No

Do you require special transportation or equipment to leave the [] Yes [] No

If yes: what is needed: [] Wheelchair [] Van [] Ambulance [] Hoyer Lift [] Other:
Please mark all that apply to your patient.

Medical Suppliers:

- [] Norco 208-344-0299 [] Procare 208-322-5055 [] Bennett 208-327-8888 [] Adderson 208-895-0033 [] Medeco 208-429-1138 [] Other: _____

Utilities:

- [] Idaho Power 800-488-6151 [] Utah Electric 801-998-2527 Intermountain Gas 208-377-6840

Police/Fire/EMS-911

Physician Name: Phone:
Pharmacy Name: Phone:
Neighbor Name: Phone:

American Red Cross
208-947-4357

Emergency Management Offices: Contact emergency officials in the event of an emergency requiring assistance such as:

- [] Ada County 208-577-3000 [] Canyon County 208-454-7271 Payette County 208-642-6000

Listen to local radio stations (WXK68 162.5 Ada/Canyon WXK88 162.4 Payette) for emergency broadcast announcements.

Creating a disaster plan and practicing it are your responsibility, keep it simple but be sure it will meet your needs.



Hospice & Palliative Care

815 S Bridgeway Place, Suite 122
Eagle, ID 83616
P-208.473.2717 / F 208.473.2451

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Oxygen Use Waiver

To : _____

Date : _____

As our patient, we want to make sure that you get the education, tools, and training you need to remain safely in your home. If you use oxygen, the following conditions can put you at risk. Please ask questions or state your concerns should you have any at any time.

- Being a smoker and having oxygen in your home
- Smoking while using oxygen
- Others around you smoke while you are using oxygen
- The presence of candles, fireplace, wood burning stove, oven, and/or barbeque
- N/A

This is a very serious concern as your personal well-being and safety are of the utmost importance to us. The purpose of this letter is to stress how important it is to follow All Care Hospice & Palliative Care's well-defined safety precautions.

The All Care Hospice & Palliative Care Patient/Family Orientation for Hospice Care binder refers to fire safety and oxygen use precautions. Oxygen greatly enhances combustion and is therefore a primary safety concern while you are on oxygen. Please see Section 6: Safety in the Patient/Family Orientation for Hospice Care binder for further information. Fire *Safety/Burn Precautions* starts on page 24 and continues through page 25. Specific Oxygen Safety is on page 28.

Your signature on the affirmations page acknowledges you have received and fully understand All Care Hospice & Palliative Care's Oxygen Safety and Fire Precaution Recommendations. Your signature also indicates you will follow the recommendations as set forth in the Patient/Family Orientation Binder for Hospice Care. Failure to do so may lead to serious injury, up to and including death. The patient assumes responsibility for any injury incurred by failure to follow this policy.

Patient Name: _____

Date of Birth: _____

Today's Date: _____

TB SCREENING UPON ADMISSION

- | | | |
|---|-----|----|
| 1. Have you had a cough for two or more weeks duration? | Yes | No |
| 2. Has your cough been productive of sputum | Yes | No |
| Is it blood stained? | Yes | No |
| 3. Have you had: | | |
| Fever | Yes | No |
| Night sweats | Yes | No |
| Unintentional weight loss | Yes | No |
| Lethargy | Yes | No |
| Weakness | Yes | No |
| 4. Do you or your family have TB now, or a history of TB? | Yes | No |

Comments:

*Any patient who is considered high risk AND has exhibited a cough and at least one other symptom will be identified as a potential TB patient, refer to exposure control plan.

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Statement Affirmations

Initials

- _____ 1. I have read the Name of Beneficiary of Health Insurance form and its contents, and furthermore acknowledge that if I have a Medicare HMO or Advantage Plan, I am responsible for any co-pays and/or co-insurance costs.
- _____ 2. I have read the Consent for Care, Patient Rights and Responsibilities, to include, the State Home Health Hotline phone number, Release of Information, Liability for Payment, Consent to Photograph, Statement of Patient Privacy Rights/Notice About Privacy, Privacy Act Statement – Health Care Records, Notice of Privacy Practices, Your Rights as a Patient to Make Medical Treatment Decisions, Advance Directives, and the Complaint and Grievance Process.
- _____ 3. I have read Advance Directive for Health Care, Patient Bill of Rights and HIPAA Information.
- _____ 4. I have read Authorization to Release Information for Payment and Reimbursement Purposes.
- _____ 5. I have read Authorization for Release of Medical Information.
- _____ 6. I have read Medicare Secondary Payer Worksheet.
- _____ 7. I have read the Pinnacle Quality Insight survey notice and its contents.
- _____ 8. I have received the Quality Improvement Organization (QIO) contact information (Kepro: 888-317-0891)
- _____ 9. I have read and understand the Oxygen Use Waiver.
- _____ 10. I have read and understand the explanation of the Medicare/Medicaid hospice benefit as it applies to emergency/urgent care services.
- _____ 11. I have read and understand the Consent for Primary Caregiver.
- _____ 12. I have read and understand the Hospice Insurance Benefit form.
- _____ 13. I have read and understand the Hospice Services Disclosure form.
- _____ 14. I have read and understand the Hospice Benefit Authorization.
- _____ 15. I have read the Emergency Preparedness Plan and its contents.
- _____ 16. I have read TB Screening upon Admission

Category 1 - Within 24 hours: Patients who cannot safely forgo care and require health care intervention regardless of other conditions. Patients in this category may include: highly unstable patients with a high probability of inpatient admission if home care is not provided; IV therapy patients; highly skilled wound care patients with no family/caregiver or other outside support.

Category 2 - Within 24-48 hours: Patients with recent exacerbation of disease process; patients requiring moderate level of skilled care that should be provided that day; patients with essential untrained families/caregivers not prepared to provide needed care.

Category 3 - Within 48-72 hours: Patients who can safely forgo care or a scheduled visit without a high probability of harm or deleterious effects; this category may include homemaker patients, routine supervisory visits, evaluation visits, patients with frequencies of one or two times a week if health status permits, or if a competent family/caregiver is present.

BY SIGNING BELOW YOU AGREE TO THE ABOVE STATEMENTS OF AFFIRMATION

Patient or Representative Signature

Date

Relationship to Patient (If unable to sign)

Reason Patient Unable to Sign

Signature of All Care Representative

Date

