TRU Nurse Tip Sheet - Documenting on a GIP Facility Patient

Facility contractual requirements: (normally PCC responsibilities)

- RN in facility 24/7
- Hospice provides plan of care to facility
- Hospice specifies the inpatient services to be provided
- Facility agrees to provide palliative care
- Facility agrees to provide services outlined in POC
- Facility agrees to provide Hospice with copy of discharge plan
- Facility agrees to provide Hospice with medical record of GIP stay
- Hospice to confirm with billing dept that this is a Hospice pt and our hospice is the payor while pt is on GIP

Nursing Documentation requirements:

- Obtain physician order: see standard orders for "change in level of care" orders
- Document discussion with physician regarding change in condition, precipitating events, and any order changes
- Update Plan of Care – clearly state goals and interventions
- Chart detailed description of change in condition and symptoms warranting GIP level of care
- **Daily Documentation must clearly state the reason for GIP and include:**
  - RN assessment daily.
    - *Assessments for new admission:*
      - *Initial assessment within 48 hours (use same SOC visit as for any pt)*
      - *Comprehensive assessment within 5 calendar days, and every 14 days thereafter.*
      - *Hospice inpatient encounter every day, including narrative note with GIP justification. On the ipad choose Revisit as the visit category. The visit note to use on the ipad is Inpatient Shift note. The Service Code to use is RN IPU visit.*
    - *Assessments for patients already on service:*
      - *Check if Hospice Comprehensive Assessment has been done:*
        -If done within past 24 hrs: *chart Hospice Inpatient Encounter (daily)*
        -If not done within past 24 hrs: *chart Hospice Comprehensive Assessment*
      - *Hospice inpatient encounter every day, including narrative note with GIP justification. On the ipad choose Revisit as the visit category. The visit note to use on the ipad is Inpatient Shift note. The Service Code to use is RN IPU visit.*
      - *Discontinue SN frequencies and add in daily SN frequency*

- *Daily documentation MUST include the following to justify GIP level of care:*

- Why the care cannot be provided in a different setting (*what was tried before GIP?)*
- What skilled nursing care is needed 24/7?
- Quantitative data: vitals, scales, pain ratings
- Daily collaboration with the facility staff (physician and/or RN) about the patient's plan of care
- What medications are being titrated? For what symptoms? (*keep med profile updated)*
- How much (dose), how often (frequency) and route of administration. How many prn doses did they need over the past 24 hrs? How many clinician boluses?
- Other interventions and responses to all interventions *(include suctioning, repositioning, wound care, spiritual support, etc).*
- Document all education and training to facility staff providing care as well as to family/PCG
- Discharge criteria: medical reasons for GIP have stabilized; teaching to family/PCG; update POC. Document discussion with physician and order for change in level of care.

SW and chaplain documentation:

- Team collaboration
- Discharge planning (starts upon admission to GIP) (have plan A and B) *(document daily)*
- Add collaborative interventions to the plan of care
- Response to all interventions (*spiritual care, family support)*
- Discharge criteria: re-establishment of family support system

- Remember, actively dying is not a reason for GIP. There must be a 24/7 skilled nursing need.

Chart set-up to include:

- Identify and provide MDPOA contact
- 60 day physician orders/care plan
- Current medication list
- Pharmacy fax cover sheet
- Hospice Benefit Election and informed consent
- DNR/advanced directives/MOST form
- Hospice team names listed in front of chart
- Nursing facility status form
- Hospice card and sticker to front of chart

Feel free to reach out to our care coordinator for the facility if you have questions regarding point of contact person or need help setting up the chart!