The Carolinas Center for Hospice and End of Life Care
General Inpatient (GIP) Documentation Tool

PREAMBLE

The Carolinas Center for Hospice and End of Life Care Facility-Based Work Group raised questions, faced challenges, discussed, and researched the issue of documentation for the General Inpatient (GIP) level of care. The group produced the attached tool and offers it to hospice agencies as a guide for documentation.

Use of the tool should help those providing GIP in any setting (free-standing facility, long-term care facility, or hospital) to define their own policies and processes. It is not intended to define criteria for GIP. Rather, the tool is intended to guide the Interdisciplinary Team's critical thinking process in assessment, goal identification, establishment of an effective plan of care, and communication of that plan to all involved in the care.

The sample documentation pieces demonstrate how visits can be documented to reflect the family as the unit of care, IDT communication, and implementation of the plan of care in the context of GIP level of care. **Sample documentation is for illustrative purposes only and is not offered as specific phrases or formats to satisfy criteria for GIP.**

Use of this tool does not guarantee payment. This tool is not endorsed by any professional agency, governmental agency, or fudicial intermediary.

The Carolinas Center for Hospice and End of Life Care
Facility Based Hospice Work Group
General Inpatient Level of Care:
Recommendations, Action and Supporting Rationale

Recommendations	Actions	Supporting Rationale
A change in patient condition or circumstance requires a change in the interdisciplinary plan of care.	Changes in level of care are supported by comprehensive documentation that addresses the reason(s) for the change and the communications with other members of the IDG, including the attending physician. Any changes in the plan of care reflect the goals of the patient and families. The hospice agency requests a discharge summary from a contracted facility providing GIP upon return to RHC Use words such as "change" instead of "transfer," "inpatient" or "GIP" instead of "acute", "routine" instead of "residential", "continuous care" instead of "crisis care".	The medical record is a comprehensive compilation of information and should contain complete documentation of all services and events. If changes in level of care are not supported by thorough documentation, payment may be denied. Continuity of care provided among providers & settings. Promotes language consistent with regulation. Hospice is charged with professional management of patient care.
Utilize consistent language when discussing levels of care. A patient is either at general inpatient (GIP), routine home care, continuous care, or inpatient respite care.	Daily visits by hospice team member(s) to provide oversight of plan of care and current medical orders. If extenuating circumstances prevent a daily visit, a telephone contact is acceptable. In the non-hospice facility setting, document communications with facility staff and ancillary providers.	Promotes continuity of care.
A hospice IDG team member makes a daily visit to each patient/family at GIP level of care.	Documentation includes interactions with family members.	Supports communication between all entities. Demonstrates accountability to payers, accrediting bodies, and surveyors. The family is the unit of care in hospice

Recommendations	Actions	Supporting Rationale
Each discipline is responsible for documenting to the current plan of care in a manner that supports the current level of care.	Each discipline's documentation should demonstrate the continuum of care. Chart to the structural, functional and activity impairment. Document what issues need to be addressed that cannot be efficiently attended to at RHC. In the freestanding hospice facility, RNs will complete a full physical assessment every 24 hours and a summary progress note that relates to the plan of care and supports the level of care. Reassessments may be completed by LPNs in accordance with the applicable state scope of practice for LPNs In other inpatient settings, the hospice RN will conduct assessments at the frequency defined in agency policy. Documentation will include a progress note that relates to the plan of care and supports the level of care. In all settings, use the language of the plan of care: Prompting question leading to documentation: • What were you expecting to find when you entered the room? • What has been happening with symptoms/treatments you need to re-assess? • What caregiver needs should be assessed & addressed? • How has the patient changed since you last observed patient? Hospice social workers, chaplain, and counselor documentation of each contact / visit contains the assessment, the interventions and the plan, including the intended follow-up contact. Documentation of assessments and interventions should reflect the impact of increased symptoms &/or care issues that necessitated the change to GIP level of care. Prompting questions leading to documentation • "What does this mean to you?" • "How do you feel about this?" • What caregiver issues need to be addressed? Hospice physicians will document to the plan of care, the goals of care and supporting the level of care. No charting by exception.	Today's documentation should both tie into what has gone before and what is planned for the future. State scope of practice regarding patient assessment must prevail. Agency policy defines a standard charting format, (i.e. PIE, SOAP, or narrative charting), to be used by each discipline The disciplined use of standard charting formats facilitates comprehensive and logically organized documentation. All hospice staff documentation is reflective of the plan of care and consistent with the level of care. Documentation must include specifics, not generalities, to support the level of care. Documentation should be reflective of what has happened (eg, what event necessitated GIP level) and what is planned for the future (eg, what is implemented to achieve pt/family goals and attempt return to RHC level). Documentation must demonstrate that the IDG is following the plan of care. Charting by exception does not reflect holistic patient and family oriented plan of care.
Care options available within each hospice agency are discussed at the time of initial explanation of hospice services and on an ongoing basis.	At the point the level of care changes, all ongoing care options need to be re-emphasized with patient and family. All disciplines are knowledgeable about the level of care, understand the implications, and are consistent in their documentation and communications with the patient and family.	Care options must specifically include anticipated transitions in level and/or location of care and the implications to the patient and family.

General Inpatient Level of Care: Documentation Examples

Patient Scenario: Renal carcinoma resident in hospice facility at routine level of care has experienced increase in pain as evidenced by wakefulnees during the night, decreased appetite, decreased verbal communication and has developed a Stage II decubitus. Patient reports pain increased when measured on Pain Tool. He has requested breakthrough pain medication 5 times over the past 24 hours.

NURSING DOCUMENTATION

LESS THAN ADEQUATE CHARTING

0730: First rounds. Pt. awake. Asked for cold H2O & drank w/o dysphagia. Denies pain. Daughter present. Poor appetite.

0900: Pt. outside in W/C smoking. Dtr present. Given 20 mg Oxyfast per request.

1100: Back in room. Denies pain. CNA assisting with personal care.

1200: Coccyx with small Stage II decub, Mepilex applied. Oxyfast 20mg given for pain.

1330: Seen by MD. Changed to Inpatient.

1500: Resting quietly with eyes closed, in bed. NAD.

1700: On porch in W/C with family. No c/o pain/distress.

1900: In room with wife. No change from earlier assessment.

CHARTING SYSTEM (PIE)

P: Report from prior shift & review of MAR demonstrates increased pain (6-7/10) and administration of BTP med 5X past 24 hours. Limited sleep last night. Relief to a reported 3/10 with Oxyfast 20 mg past 3 episodes, last dose 1 hour ago. Pt currently reports 2/10 & declines pain medication. Exhibits restless movements, guarding of L thorax, & grimacing with pain >3/10. .Took 4 oz OJ & 1 piece toast with AM meds, spent most of AM visiting with family in room or on front porch. Stage II dime-size shallow exfoliation w/o exudates & w/ surrounding 2" mild erythema on coccyx.

I: Advised MD of pain assessment & management past 24 hours & early Stage II. Orders received to increase OxyContin & change to Inpatient LOC for continued assessment & management of pain & decubitus. Coccyx wound cleaned & dressed per protocol.
POC updated re: pain & skin integrity. Educated patient & spouse re: med dose change & value of reporting early discomfort for effective management.

E: Informed pt., spouse, SW & chaplain of Inpatient LOC to evaluate symptoms & POC effectiveness . Medicated X2 this shift for BTP with relief from 5/10 to 0-2/10. Dressing on coccyx remains clean & intact. See flow sheet for complete assessment & activity.

CHRONOLOGICAL CHARTING

0700: Report received from prior shift re: increase in PRN pain meds (X5 past 24 hrs). 1st rounds resident awake, A&O. See flow sheets re: V/S, activity & assessment this shift. Pain 2/10 @ present & declined pain med. Educated re: management of pain early when reaching level unacceptable to patient.
0900: Reports little appetite, only 4oz juice & 1 toast for AM. Aching pain in lower L rib area, 5/10, no known physical injury. No sign edema or redness but does have tenderness to firm pressure on lowest rib @ midclavicular line. Restless movements, furrowed brow. Given 20mg Oxyfast.

0920: Relief to 3/10 & requesting to go outside to smoke. Assisted transfer to w/c & dtr took resident to porch & stayed with him.

1000: On porch still with dtr. Pain 1/10 & pt satisfied.

1200: C.N.A. has completed shower assist & reports red area on coccyx. Stage II decub on coccyx assessed by RN, dime-size shallow excoriation with 2" surrounding erythema, no exudates. Cleaned & dressed per protocol. Teaching re: pressure relief to coccyx to pt/fam/ CNA. Pt. reports mild discomfort @ coccyx & pain in L thorax returned @ 4/10. Guarding L side with movement & deep breaths. Offered & accepted 20mg Oxyfast.

1230: Pain @ 1/10 & acceptable. Eating some lunch, wife present.

1330: Seen by MD & RN reported pain & management past 24 hrs & Stage II decubitus. Received orders to increase OxyContin & change to Inpatient LOC. POC & MAR updated, SW & Chaplain notified of changes. Advised pt & wife of med change, educated re: principles of pain management with long-acting vs. immediate release & informed of change to Inpatient LOC to observe sx management for next 2-3 days at least. No questions @ this time.

1500: Pt. resting in bed quietly, eyes closed, respirations even & shallow, no signs of distress. Wife visiting with SW.

1700: Resident on porch in w/c with family. Denies pain or any needs @ present.

1830: In room with wife. Pain 1-2/10@ present & acceptable to patient. No questions re: meds. Encouraged to let nurse know when pain begins to increase so sx can be managed quickly. Dressing remains clean & intact. Report to next shift.

SOCIAL WORK DOCUMENTATION

LESS THAN ADEQUATE CHARTING	CHARTING SYSTEM (PIE)	CHRONOLOGICAL CHARTING
Patient level of care status changed from Routine to Inpatient as of this date. Pt & wife notified of change. Frequency & Cost of Services form explained by SW. Wife signed form. Provided Hospice support & presence.	P: Advised by RN of order to change to Inpatient LOC due to increased pain. Met with patient & spouse re: change in LOC & possibility of return to Routine based on clinical observation & management. I: Completed Cost of Services with pt/spouse. Offered time for questions, both express understanding. Later SW observed spouse alone in sitting room, sat with her & asked how she is. Appeared mildly anxious, expressed fear of increase pain. When asked what she feared she stated fear that disease is progressing. Offered emotional support & validation concerns, encouraged her to ask clinical questions to MD/RN. Encouraged self-care, access of own support system, discussed anticipatory grief & coping. She expressed gratitude re: life with her husband. Encouraged her to express that to him. E: Appropriate tearfulness, able to identify support structure, though some common hesitancy to access them. Discussed benefits to her & to support people of expressing her concerns & receiving support. SW also informed IDT of spouse's fear. POC updated re: family support needed with patient decline and visit frequency adjusted per crisis intervention. Pt. & family aware of agency SW availability PRN.	1300: Patient changed to Inpatient LOC due to increased symptoms. Met with patient & wife re: LOC change, Frequency & Cost of Services form completed. Reviewed possibility of return to Routine LOC if clinical status indicates. Allowed for questions. Both expressed understanding. Asked how they felt/are affected by this change. Both expressed some concern re: increased pain, but aware MD is changing drug dose to control pain. Patient stated he is aware this may mean he "is getting worse". Appropriate tearfulness & anticipatory grief. Emotional support provided. 1530: Observed wife alone in sitting room, sad affect. Offered support & asked about concerns. Expressed sadness re: disease progression, increased pain. Life review and gratitude for relationship with spouse. Validated mixture of joy, grief, fear. Encouraged continued use of effective support systems & coping mechanisms & self-care. POC updated & visit frequency adjusted for PRN crisis intervention, IDT advised of anticipatory grief & increased support.

CHAPLAIN DOCUMENTATION

LESS THAN ADEQUATE CHARTING	CHARTING SYSTEM (PIE)	CHRONOLOGICAL CHARTING
Use of active listening skills. Offered reassurance of a Divine presence. Encouraged illness review & facilitate connections with sources of faith/hope.	P: Chaplain visit with patient who was alone and resting quietly in his room. Pt. expresses some emotional distress and welcomed opportunity to process his feelings. Discussion of pt's emotional well being and pain status revealed self-reported anxiety about perceived disease progression. I: Chap offered reassurance of emotional support and used active listening to process pt's feelings of anxiety. Chap reminded pt of formerly identified sources of strength and comfort and assisted pt in articulating same. Pt voiced regret regarding life choices and Chap listened empathetically and encouraged continue spiritual life review to fully embrace faith-based beliefs. Chap validated pt's beliefs and facilitated further exploration of concepts of divine grace/forgiveness. At pt request, Chap provided scripture reading and prayer. E: Pt was appreciative of Chap support visit and with assistance was able to reframe his thoughts/concepts about his life decisions and current health status. Pt expressed an increased sense of peace and agreed to further explore his faith perspective with his PCG. Pt was reassured of Chap's continued availability and agreed to increased visit frequency for spiritual/emotional support per updated POC.	10:00AM: RN informed Chaplain of pt's increased pain and change to Inpatient Status. Chap provided support visit during which pt expressed increased emotional distress and anxiety regarding fear of disease progression. Chap provided active listening as pt processed his anxiety and feelings of regret regarding life decisions and consequences of same. Chap helped pt identify personal coping skills, former sources of strength and comfort and Chap encouraged pt's continued spiritual life review to full embrace faith-based beliefs. Pt and Chap discussed concepts of divine grace, reconciliation and forgiveness at length. Pt has no history of faith-based community support and Chap provided reassurance of continued spiritual/emotional support. At pt request, Chap provided scripture reading and prayer as visit concluded. POC and visit frequency updated to reflect pt need for increased support.

HOSPICE MD DOCUMENTATION

LESS THAN ADEQUATE CHARTING	CHARTING SYSTEM (PIE)	CHRONOLOGICAL CHARTING
Feels better, meds effective, will follow up next 2-3 days	P- Pain I- Patient appears visibly uncomfortable, moving about in bed in a restless manner. Rates back pain at 7/10. Pulse rate 96 regular, respirations increased 16-18. Lungs clear. Abd soft non- tender; bowel sounds present, voiding without difficulty Family at bedside and distressed with level of discomfort. Reassured that medication would be increased and patient would be monitored closely. E. Increase in oxycontin today- orders written Continue current dose oxyfast for breakthrough pain but increase prn dose frequency- orders written Continue to monitor use of any breakthrough medications to assure continued adequate pain control. Will revisit in 24 hours to reassess. Remains at GIP level of care P. Decubitus I. Staff report minimal change in decubitus. Patient states awareness of "that spot" but dressing is "soothing" E. No need to change treatment plan at this time but would watch for any indication of infection or increase in drainage. Total time spent in counseling 15 minutes; total time spent 50 minutes	Date/Time MD visit Patient appears uncomfortable, less mobile that when seen initially, family also state that pain has increased. Staff report increased pain. Based on prn use of oxyfast will increase oxycontin dose and increase frequency of prn dosing. Decubitus wound unchanged, will continue current treatment plan. If any indication of infection will consider a change in treatment. Will reassess in 24 hours . Family aware of plan. Total Time Spent 50 minutes