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History

Mission Statement

Friends of Caroline provides quality-of-life care that offers hope and encouragement to those nearing the end-of-life's journey and support for their family, friends and the community

Vision Statement

Friends of Caroline aspires to a world in which every life ends with compassion, dignity, and peace.

Values Statement

Friends of Caroline faithfully provides respect, integrity and empowerment by nurturing the community with dignity and sensitivity.

FRIENDS of Caroline
Palliative • Hospice • Grief Support

History of Friends of Caroline

"Hospice", originally a medieval term for a place where travelers could be sheltered, is used today by Friends of Caroline Hospice, a non-profit, tax-exempt organization providing for those who are suffering from a life-threatening illness. Hospice offers an alternative to hospital and nursing home care for those who are dying.

The purpose of hospice care is to comfort, not cure. Care is given in the home by family and friends, aided and guided by the Friends of Caroline team. This way, much of the physical, emotional and spiritual suffering caused by illness is reduced.

1977: Caroline Quann is Veronica Tovey's, RN, home health patient. Caroline became Veronica's inspiration to start the hospice movement in Beaufort.

1980: In January, founder Veronica Tovey coordinated with St. Helena Episcopal Church to sponsor a pilot hospice program. Later the same year, Caroline Hospice of Beaufort County was incorporated by the State of South Carolina.

1982: Vote taken by the Board of Caroline Hospice of Beaufort County to remain fully non profit, as government chooses to pay for hospice care, Medicare/Medicaid.

1984: Caroline Hospice of Beaufort County is recognized as a hospice model for the state and becomes 501 (c)(3) tax exempt.

1989: First Festival of Trees fundraiser held to solely benefit Caroline Hospice. A respite center and office are opened on Craven Street.

1990: Caroline Hospice of Beaufort County changes name and is reincorporated by the State of South Carolina as Friends of Caroline Hospice, Inc. of Beaufort County.

1994: Veronica Tovey, RN, founder and Executive Director of Friends, retires. Beverly Porter is named the new Executive Director. The first Friends newsletter goes out to the public.

1995: Friends of Caroline Hospice relocates the office and respite center to 810 King Street. Friends becomes computerized.

1996: The Red Door Thrift Store, benefitting Friends of Caroline Hospice, opens. A Store Manager position and Volunteer/Bereavement Coordinator position are created.

1998: Friends of Caroline Hospice is licensed as a hospice in South Carolina with the Department of Health and Environmental Control (DHEC).

1999: An Office Manager position is created. The Wardel Family Foundation helps purchase the new location for Friends of Caroline, and the respite center and office is relocated to 1110 13th Street in Port Royal.

2000: Director of Development position is created.

2006: Director of Clinical Care position is created.

2007: South Carolina State Service mark-registration of the Friends of Caroline Hospice name. A grant writer and Development Association position are created. A Memorial Garden is established.

2008: Executive Director Beverly Porter is awarded the "Palmetto Award" by The Carolinas Center for Hospice and End of Life Care for demonstrating vision and exemplary hospice leadership and thoughtful involvement.

2009: Friends of Caroline Hospice establishes an Endowment Fund.

2010: A succession plan is established. The policies and procedures are reevaluated, updated and approved by the Board of Directors.

2011: Beverly Porter retires. Heidi Owen is named the new Executive Director.

2013: Certified by Centers for Medicare/Medicaid Services as a provider.

2015: Lindsay Roberg named new Executive Director.

2018: Friends of Caroline is accredited by The Joint Commission in both their Hospice and Palliative Care Programs.

2019: Friends of Caroline is granted a Certificate of Need from SCDHEC to open the first hospice house in the area. Their first Capital Campaign is launched.

2022: Friends of Caroline opens Caroline's Cottage, the first inpatient hospice unit in Jasper SC.

Friends Of Caroline History

As a home health nurse, Veronica Tovey (our founder) advocated for her patient, Caroline Quann, to spend her final days at home with dignity and in comfort. This was the introduction of hospice care in our area and the beginning of FRIENDS of 'Caroline'. Veronica led the organization for 17 years and her legacy continues to impact our organization and the community.

After Veronica Tovey's retirement in 1994, Beverly Porter, a nurse, took over the reins for the next 17 years. During these years, we saw our organization grow with the addition of staff members, more fundraisers, and the organization became licensed through the South Carolina Department of Health and Environmental Control. More than 10 years after her retirement, Beverly still supports FRIENDS by encouraging people she meets to volunteer with us. Beverly's legacy lives on as the patient wing at Caroline's Cottage is named The Haven, in her honor.

After Beverly Porter's retirement in 2011, Heidi Owen came on board as our next Executive Director. A business woman, Heidi's objectives and accomplishments made a big impact. Under her watch, FRIENDS became a certified provider of the Centers for Medicare & Medicaid. This resulted in the receipt of payments for caring for Medicare/Medicaid patients while remaining a non-profit organization. Our non-profit status allows us to continue to accept donations and raise funds to provide quality end-of-life care to everyone, including under & uninsured patients, regardless of their ability to pay.

Our current President/CEO is Lindsay Roberg. A Nurse with a Masters in Business Administration, Lindsay is the perfect combination of her 3 predecessors. With Lindsay at the helm, FRIENDS has accomplished some impressive achievements. In 2018, FRIENDS became the only Hospice organization in Beaufort County to receive the Gold Seal of Approval from The Joint Commission for both our Hospice and Palliative Care programs. And after just 3 short years of receiving a Certificate of Need from SC DHEC, FRIENDS opened the area's first inpatient Hospice Facility, Caroline's Cottage, in 2022.

Friends of Caroline

Inpatient RN Orientation Checklist

Employee Name: _____Hire date: _____

Preceptor: Please initial and date next to each item to witness proficiency completed.

Admission

_ Calls potential admission within one hour of receiving referral to set up assessment that is convenient to patient, family situation.
_ Greets family and patient with name, title and "I'm from Friends of Caroline."
_ Uses hand hygiene prior to beginning assessment.
_ Utilizes PPE as indicated.
_ Explains and completes all admission paperwork, answers all questions regarding hospice benefit and care.
_ Obtains thorough health history, including dates of diagnosis, treatments, and any side effects.
_ Hospitalizations, falls, allergies, if veteran, family names and numbers, church/religion/spiritual affiliation. List of current medications.
_ Obtains prescriptions from Herold's or local pharmacy as needed for patient's comfort
_ Cleans all instruments using proper technique.
_ Completes head to toe assessment, including pain, constipation, swallowing, dyspnea, ability to perform own ADLs. Psychosocial assessment including mood and behavior.
_ Notifies physician/NP and IDT of admission. Leaves email report for all team members.
_ Informs Attending Physician if other than FOC Medical Director.
_ Gives all admission paperwork to Administrative Assistant for EMR and chart completion. All documentation is 100% complete.
_ Completes all charting within admission shift.
_ Refers to EMR Documentation sheet for reference.

Daily

_ Uses Universal Precautions and additional precautions as indicated. Follows infection control procedures and use proper hand hygiene.
_ Completes vital signs, head to toe assessment, reassesses for pain, constipation and medication effectiveness, side effects.
_ Consults physician/NP with any plan of care changes that require orders including medication changes
_ Teaching and documentation every visit including orienting family of facility amenities
_ Review CNA care plan and update as needed
_ CNA supervisory every shift
_ All documentation must be complete during scheduled shift
_ Complies with FOC Policies and Service Promises.

Death

_ Assessment of patient performed. Establishes absence of apical pulse, absence of respiration, etc.
_ Approach family compassionately and deliver news if in facility.
_ Notify Jasper County Coroner.
_ Call family if not onsite.
_ Notify Funeral Home when family is ready.
_ Call FOC Chaplain and ask family if they would like you to call their Minister.
_ Allows family time with patient and when ready bathes patient, remove any foley or IV catheters. Place fresh clothing on patient per family request, position patient and fold covers for family to view patient.
_ Give emotional support to the family.
_ Dispose of Narcotics at shift change per facility policy.
_ Inform FOC physician and attending physician of patient death.
_ Fax completed coroner report to Jasper County Coroner.
_ Complete discharge/death documentation in EMR. Break down chart and give to Administrative Assistant.

_ Leave email report to all team members.

Preceptor Printed Name: _____
Preceptor Signature: _____
Date Proficiency Completed :_____

RN Printed Name:_____
RN Signature:_____

Friends of Caroline Hospice RN

New Hire checklist

Employee Name: _____ Hire date: _____

Preceptor: Please initial and date next to each item to witness proficiency completed.

Admission

_____ Calls potential admission within one hour of receiving referral to set up appointment that is convenient to patient, family situation.

_____ Greets family and patient with name, title and "I'm from Friends of Caroline."

_____ Uses Sanitizer prior to entering home, washes hands Places nurses' bag on barrier on solid substance. Utilizes PPE specific to patient/family situation.

____ Explains hospice benefit and answers all questions regarding benefit and any concerns.

____ Explains all admission paperwork and obtains patient or POA signatures as appropriate.

____ Obtains thorough health history, including dates of diagnosis, treatments, and any side effects. Hospitalizations, falls, allergies, if veteran, family names and numbers, church/ religion/spiritual affiliation. Lists all current Medications.

____ Utilizes appropriate hand hygiene. Sanitizes all instruments and maintains a clean and dirty area on barrier with bag in the middle.

____ Completes head to toe assessment, including vital signs, pain, orientation, constipation, and dyspnea. Assesses for recent weight loss, falls, potential for aspiration and ability to perform ADL's. Psychosocial assessment including mood, behavior, and coping skills.

____ Notifies physician and all team members of admissions and if immediate interventions needed From MD, Chaplain and Social Worker, CNA. Leaves report for all team members.

____ Informs attending physician and medical director, gives Pharmacy billing information, Orders appropriate DME.

____ Obtains prescriptions for Morphine and/or other narcotics as needed for patient comfort.

____ Orders comfort kit from Herold's Pharmacy.

____ Completes all admission paperwork, leaving no blank spaces, gives completed paperwork to Director of Clinical Operations. Complete electronic charting, including comfort kit medications are entered into EMR within 24hrs.

____ EMR documentation includes Care plans, Initial Nursing Assessment form, Initial Plan of Care, and medications. Once all documentation completed – an Admit order is put into the computer and sent to FOCH physician or printed and given to Clinical Coordinator if patient using own PCP.

Supervisor signature: _____ Date: _____

RN signature: _____ Date: _____

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General

PALLIATIVE vs HOSPICE

Palliative Care is for patients with a life limiting illness who are continuing to receive curative/palliative treatments. Hospice care is for patients with a life expectancy of 6 months or less who have chosen to focus on receiving comfort treatments. Both Palliative Care and Hospice focus on relieving suffering related to the disease process and improving quality of life for people of any age.

	PALLIATIVE	HOSPICE
Definition	An interdisciplinary consult service which focuses on providing care for patients with serious illness. Services can be provided at the same time as curative/life-prolonging/Palliative care if desired.	An interdisciplinary approach to providing care for patients at the end of life that focuses on pain and symptom management. Comfort is the primary goal. Curative treatment is not part of hospice care.
Eligibility	• Physician order. • Diagnosis of a life-limiting illness during any stage of a disease, ideally early in the course of an illness.	• Physician order. • Diagnosis of a terminal illness. • Certification by a physician of prognosis likely to be 6 months or less.
Goals of Care	• Disease education and assistance with choosing treatment options. • Pain and other symptom management. • Assistance & Support in coping with the stressors of living with a life-limiting illness.	• Pain and other symptom management. • Improved quality of life. • Support throughout disease progression • Assistance & Support in coping with the stressors of living with a life-limiting illness.
Scope of Services	The interdisciplinary team includes a doctor, nurse, social worker, chaplain and care coordinator. All care is coordinated with a patient's medical team.	Interdisciplinary team including doctor, nurse, certified nursing assistant, social worker, chaplain, and volunteers. All care is coordinated with the patient's physician of choice and hospice physicians. Bereavement support is available to family for 13 months after the death.
Emergency After Hours	• 24/7 availability • Patient able to go to hospital, call 911 without first notifying Friends of Caroline	• 24/7 • Always call the Hospice Team before 911, they understand your hospice needs the best.
Location Services Provided	• Home • Skilled Nursing Facility • Assisted Living Facility • Hospital	• Home • Skilled Nursing Facility • Assisted Living Facility • In patient requires inpatient level of hospice care, needs to be in a contracted facility with 24-hour registered nurse coverage. • Hospital
Payer Source	Medicare Part B will pay these charges. We are committed to providing services regardless of insurance coverage or ability to pay.	Medicare Part A services pay 100%. Most Medicaid programs pay for Hospice 100% and most private insurance have a hospice benefit. We are committed to providing services regardless of insurance coverage or ability to pay.
Medications/ Supplies/ Equipment	Not Covered.	Covered. Related to comfort and the terminal illness.
Levels of Care	One Level of Care.	Routine, Respite, General Inpatient, and Continuous Care.
Restrictions	No restrictions, patients may continue to receive curative/life-prolonging/Palliative treatment.	• No longer seeking curative/life-prolonging treatment at the same time as hospice care. May still wish to go to some MD appts, dentist, eye appts, etc.

843-525-6257 (phone) www.fochospice.org 843-525-9418 (fax)

FRIENDS of Caroline
Palliative • Hospice • Grief Support

Ten Facts About Hospice Care You May Not Know

1. Hospice is not a place—it's high-quality care that focuses on comfort and quality of life.
2. Hospice is paid for by Medicare, Medicaid, and most insurance plans. Fear of costs should never prevent a person from accessing hospice care.
3. Hospice serves anyone with a life-limiting illness, regardless of age or type of illness.
4. Hospice provides expert medical care as well as spiritual and emotional support to patients and families.
5. Research has shown that the majority of Americans would prefer to be at home at the end of life—hospice makes this possible for most people.
6. Hospice serves people living in nursing homes and assisted living facilities.
7. Hospice patients and families can receive care for six months or longer.
8. A person may keep his or her referring physician involved while receiving hospice care.
9. Hospice offers grief and bereavement services to family members to help them adjust to the loss in their lives.
10. Research has shown people receiving hospice care can live longer than similar patients who do not opt for hospice.

Service Promises

RESPONSE TIME

Friends of Caroline promises to respond to your requests, needs and concerns within the following time frames:

- Referrals: When a request to admit a patient is received from a referral source, we promise that a staff member will be at the bedside of the patient within two hours of the initial contact.
- On Call: When a request to visit a patient is received after regular hours, holidays or weekends, our on-call staff will arrive at the bedside of the patient within one hour of the receipt of the initial request.
- Request for Information: When Friends of Caroline receives a request for information from a patient, family member, donor, or referral source, we promise to respond to that request within 30 minutes.
- Scheduled Patients Visits: The staff of Friends of Caroline will arrive at the scheduled visit time. If that is not possible for a reason that cannot be avoided, a phone call will be made to the patient to inform them of the reason and the expected new arrival time.

CAREGIVER SUPPORT

Friends of Caroline understands that families and friends providing primary care to terminally ill patients are under a great deal of physical and emotional stress. In order to alleviate some of that stress Friends of Caroline has several ways to provide caregiver support.

- Caregiver training that teaches the primary caregiver how to provide care to the patient is provided in the patient's place of residence by our nursing staff and certified nursing assistants.
- Specialized caregiver training is provided once per month at the Friends of Caroline offices. These training sessions are conducted by our nurses, physicians, certified nursing assistants and counselors.
- Support groups for caregivers are provided monthly at the Friends of Caroline offices. These groups are facilitated by our trained counselors and help friends and families cope with the emotional burden that comes with dealing with the illness and the anticipated loss of their loved one.
- Individual emotional, spiritual, and psychosocial support is also provided to caregivers at the patient's residence.
- Grief and bereavement support groups are offered once per month.

IN HOME PHYSICIAN VISITS

Friends of Caroline understands that there are times when patients need to be seen by a physician. Most hospice patients cannot leave their place of residence to travel to their physician's office for a visit because of their condition. In order to meet patient's need for physician assessment, Friends of Caroline provides in home visits to our patients.

- Initial physician visits are made within 7 days of admission to Friends of Caroline.
- Physician visits are made as identified in each patient's plan of care.
- Physician visits are available to patients who have a medical crisis that needs physician involvement.
- Physician visits are made to all patients who have been in the program for 180 days.

CUSTOMIZED COMMUNICATION

Friends of Caroline promises to address the communication needs of each patient, family, referral source, donor or community member in the manner that they request.

Palliative Performance Scale (PPS)

%	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Level of Consciousness
100	Full	Normal activity, no evidence of disease	Full	Normal	Full
90	Full	Normal activity, some evidence of disease	Full	Normal	Full
80	Full	Normal activity with effort, some evidence of disease	Full	Normal or reduced	Full
70	Reduced	Unable to do normal work, some evidence of disease	Full	Normal or reduced	Full
60	Reduced	Unable to do hobby or some housework, significant disease	Occasional assist necessary	Normal or reduced	Full or confusion
50	Mainly sit/lie	Unable to do any work, extensive disease	Considerable assistance required	Normal or reduced	Full or confusion
40	Mainly in bed	Unable to do any work, extensive disease	Mainly assistance	Normal or reduced	Full, drowsy, or confusion
30	Totally bed bound	Unable to do any work, extensive disease	Total care	Reduced	Full, drowsy, or confusion
20	Totally bed bound	Unable to do any work, extensive disease	Total care	Minimal sips	Full, drowsy, or confusion
10	Totally bed bound	Unable to do any work, extensive disease	Total care	Mouth care only	Drowsy or coma
0	Death	—	—	—	—

Functional Assessment Scale (FAST)

1	No difficulty either subjectively or objectively.
2	Complains of forgetting location of objects. Subjective work difficulties.
3	Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. Decreased organizational capacity. *
4	Decreased ability to perform complex task, (e.g., planning dinner for guests, handling personal finances, such as forgetting to pay bills, etc.)
5	Requires assistance in choosing proper clothing to wear for the day, season or occasion, (e.g. pt may wear the same clothing repeatedly, unless supervised.*
6	Occasionally or more frequently over the past weeks. * for the following **A)** Improperly putting on clothes without assistance or cueing . **B)** Unable to bathe properly (not able to choose proper water temp) **C)** Inability to handle mechanics of toileting (e.g., forget to flush the toilet, does not wipe properly or properly dispose of toilet tissue) **D)** Urinary incontinence **E)** Fecal incontinence
7	**A)** Ability to speak limited to approximately ≤ 6 intelligible different words in the course of an average day or in the course of an intensive interview. **B)** Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview **C)** Ambulatory ability is lost (cannot walk without personal assistance.) **D)** Cannot sit up without assistance (e.g., the individual will fall over if there are not lateral rests [arms] on the chair.) **E)** Loss of ability to smile. **F)** Loss of ability to hold up head independently.

*Scored primarily on information obtained from a knowledgeable informant.
Psychopharmacology Bulletin, 1988 24:653-659.

Hospice Eligibility Criteria

Patient has a terminal illness with a life expectancy of 6 months or less

CANCER

Pt meets ALL of the following:
1. Clinical findings of malignancy with widespread, aggressive or progressive disease as evidenced by increasing sx, worsening lab values and/or evidence of metastatic disease
2. PPS <70%
3. Refuses further life-prolonging therapy
OR
Continues to decline in spite of definitive therapy

Supporting documentation includes:
Hypercalcemia >12
Cachexia or weight loss > 5% in past 3 months
Recurrent disease after surgery/radiation/chemo
Signs/sxs of advanced disease (e.g. nausea, requirement for transfusions, malignant ascites or pleural effusion, etc.)

RENAL FAILURE

Pt refuses dialysis or renal transplant (or requests to discontinue dialysis)
AND
Creatinine clearance is <10 (<15 for diabetics)
AND
Serum creatinine >8 (> 6 for diabetics)

Supporting documentation for CRF:
Uremia, oliguria (urine output <400cc/24hrs), intractable hyperkalemia (>7), uremic pericarditis, hepatorenal syndrome, intractable fluid overload

Supporting documentation for ARF:
Mechanical ventilation, malignancy (other organ system), chronic lung disease, advanced cardiac disease, advanced liver disease

DEMENTIA

Stage 7C or beyond according to FAST Scale
AND
One or more in the 12 months:
Aspiration pneumonia
Pyelonephritis
Septicemia
Multiple pressure ulcers (stage 3-4)
Recurrent Fever
Inability to maintain sufficient fluid and calorie intake in past 6 months (10% weight loss or albumin <2.5)
Other significant condition that suggests limited prognosis

HEART DISEASE

CHF NYHA Class IV --> Significant sxs at rest
AND
Inability to carry out minimal physical activity without dyspnea or angina
AND
Optimally treated: diuretics, vasodilators, ACEI, hydralazine, nitrates
OR
Angina at rest, resistant to standard nitrate tx, and either not a candidate for/or declined invasive procedures

Supporting documentation:
EF ‹20%, treatment resistant symptomatic dysrhythmias
h/o cardiac related syncope, CVA 2/2 cardiac embolism
H/o cardiac resuscitation, concomitant HIV disease

HIV/AIDS

CD4+ <25 **OR** Viral load >100,000
AND
At least 1: CNS lymphoma, untreated or refractory wasting (loss of >33% lean body mass), MAC bacteremia, PML, systemic lymphoma, visceral ICS, RF on no HD, cyptosporidium infection, refractory toxoplasmosis
AND
PPS <50%

LIVER DISEASE

ESLD as demonstrated by:
PT> 5 sec **OR** INR > 1.5
AND
Serum albumin <2.5
AND
One or more of the following:
Refractory ascites, h/o SBP, hepatorenal syndrome, refractory hepatic encephalopathy, h/o recurrent variceal bleeding

Supporting Documentation:
Progressive malnutrition, muscle wasting with dec. strength, ongoing alcoholism (>80 gm ethanol/day), hepatocellular CA HBsAg positive, Hep. C refractory to treatment

PULMONARY DISEASE

Patient has ALL of the following:
Disabling dyspnea at rest
Little/no response to bronchodilators
Decreased functional capacity --> bed to chair existence, fatigue, cough
AND
Progression of disease --> recent increasing office, home, ED visits and/or hospitalizations for pulmonary infection and/or respiratory failure
AND
Documentation within past 3 months:
RA hypoxemia at rest (p02 <55 by ABG)
or 02 sat <88%
or hypercapnia pC02 >50

Supporting documentation:
Cor pulmonale and right heart failure, unintentional progressive weight loss

NEUROLOGIC DISEASE:

Chronic degenerative conditions such as ALS, Parkinson's, Muscular Dystrophy, Myasthenia Gravis or Multiple Sclerosis)
Critically impaired breathing capacity, with all:
Dyspnea at rest, vital capacity <30%, needs O2 at rest, refuses artificial ventilation
OR
Rapid disease progression with progression from:
Independent ambulation to wheelchair or bed-bound status
Normal to barely intelligible or unintelligible speech
Normal to pureed diet
Independence in most ADLs to needing major assistance in all ADLs
AND
Critical nutritional impairment demonstrated by all of the following in the preceding 12 months:
Oral intake of nutrients/fluids insufficient to sustain life
Continuing weight loss
Dehydration or hypovolemia
Absence of artificial feeding methods
OR
Life-threatening complications in the past 12 months ›1:
Recurrent aspiration pneumonia, pyelonephritis, sepsis, recurrent fever, stage 3 or 4 pressure ulcers

STROKE OR COMA

PPS ‹40%
AND
Poor nutritional status with inability to maintain sufficient fluid and calorie intake with ›1 of the following:
›10% weight loss in past 6 months
›7.5% weight loss in past 3 months
Serum albumin <2.5
Current history of pulmonary aspiration without effective response to speech therapy interventions to improve dysphagia and decrease aspiration events

Supporting documentation includes:
Coma (any etiology) with 3 of the following on the 3rd day of coma:
Abnormal brain stem response
Absent verbal responses
Absent withdrawal response to pain
Post anoxic stroke
Serum creatinine > 1.5

***Other Terminal Illness

If pt does not meet any of the above guidelines, pt may still be eligible if documentation strongly supports a prognosis of less than 6 months
ie. Sepsis, Severe limb-threatening ischemia due to PVD

*Adult Failure to Thrive cannot be used as a principal dx

***Inpatient Unit (IPU) - Eligibility

Symptoms that cannot be managed in any other setting (i.e. pt requires IV pain medications/anti-emetics, uncontrolled dyspnea, frequent suctioning, intensive wound care)
Documentation of ongoing IPU eligibility required daily
Intended to be short-term
Imminent death - **only** if skilled nursing needs

Friends Of Caroline

329 Friends Lane Ridgeland, South Carolina 29936

Essential Phone Numbers

Friends of Caroline: Ph# 843-525-6257, Fax# 843-525-9418

Clementine answering service after hours can call Friends of Caroline #

Friends of Caroline Medical Providers

Dr. Poling 330-285-7349 Dr. Melissa APRN 614-937-1946

Pharmacies

Herold's Pharmacy – all billing information for patients goes here first

Ph# 843-637-3037 option #7; Fax# 843-203-0883

Beaufort Pharmacy – Ph# 843-379-3278; Fax# 843-379-3232

Coroners

Beaufort County Coroner – 843-255-5153

Jasper County Coroner – 843-726-4451

Hampton County Coroner – 803-914-2150

Funeral Homes

Anderson – 843-524-7144

Chisolm Funeral Home – 843-524-6634

Copeland – 843-525-1111

Marshel's Wright Donalson – 843-525-6625

Sauls 843-815-5535

Simplicity: Lowcountry Cremation and Burial- 843-353-4641

Concierge Physicians

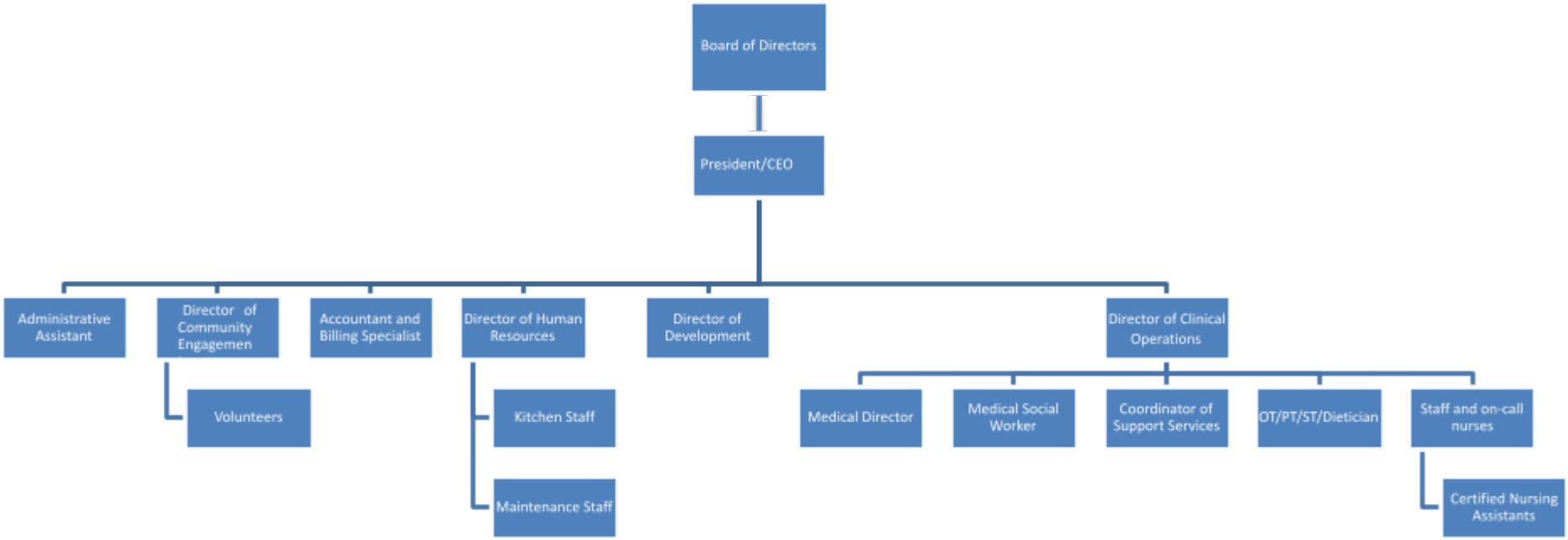
Dr. Laffitte – at patient's death call 24/7. Office # 843-322-8477; cell # 843-812-7438

Dr. Trask – 843-524-2001 - Call at patient's death

Dr. Ripley – 843-379-9025

Friends of Caroline Hospice of Beaufort, Inc.

Organization Chart



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Procedures

RN Shift Schedule Day Shift 6:45 AM - 7:15 PM

6:45 - 7:00 AM Change of Shift

SBAR Report

Narcotic Tracking and Wasting

Key Sign-In and Out

7:00 - 7:30 AM Opening Duties

Create RN Plan for Day - start with patients receiving frequent comfort

meds Coordinate CNA Plan for the Day

1. Personal Care Needs - those who will need baths this shift and what type (Bed Bath, Shower, Spa Bath) which ones will require two person assist
2. Patients who will require meal assistance/feeding
3. Anticipated Admissions and Discharges and expected time frames for those - room turnover and preparation needs
4. Any individual/family issues to be aware of

Check on Fridge Temps, Blanket Warmer, Linen Par, Laundry

7:30 - 8:00 AM Purposeful Rounding on Guest Suites

- **Introduce self and write name, CNA and Day/Date on Board**
- **Plan for the morning/day overview - What is their greatest need/desire?**
- **Point out paper and pen there for them to write questions and requests as they think of them for when RN/CNA return**
- **Five P's:**
    - **Pain scale**
    - **Personal belongings within reach - Call bell/phone instructions**
    - **Position**
    - **Potty**
    - **Pump (or other equipment needs: Accucheck, O2, Suction)**

8:00 - 9:00 AM Morning Medications and Meal Service

Any pre-meal AccuChecks/Insulin

Any patients requiring meal assistance - CNA to oversee tray set up and those requiring feeding

Prep Individual Patient Meds in Med Cups within Numbered trays

Chart on Paper Mar in Notebooks

Record all Narcotics in Narcotic Notebook, as well

10:00 AM - 12:00 PM Morning Duties

Charting
Teaching
Wound Care
Admissions/Discharges
Assist CNA with Personal Care
Laundry
Update SBAR form
Cleaning
Add any updates to Patient's Paper Charts

12:00 - 1:00 PM Meal Service

Any pre-meal AccuChecks/Insulin

Any patients requiring assistance - CNA to oversee tray set up and those requiring feeding

1:00 - 4:30 PM Afternoon Duties

Charting
Teaching
Wound Care
Admissions/Discharges
Assist CNA with Personal Care
Laundry

Update SBAR form
Cleaning
Add any updates to Patient's Paper Charts

4:30 - 6:00 PM Meal Service and Evening Duties

Any pre-meal AccuChecks/Insulin

Any patients requiring assistance - CNA to oversee tray set up and those requiring feeding

Review Individual MARs for missing charting

Add any updates to Patient's Paper Charts

6:00 - 6:45 PM End of Shift

Finalize Charting

Update SBAR sheet

Laundry

6:00 - 6:45 PM Change of Shift

SBAR Report

Narcotic Tracking and Wasting

Key Sign-In and Out

RN Shift Schedule Night Shift 6:45 PM - 7:15 AM

6:45 - 7:00 PM Change of Shift

SBAR Report

Narcotic Tracking and Wasting

Key Sign-In and Out

7:00 - 7:30 PM Opening Duties

Create RN Plan for Shift - start with patients receiving frequent comfort meds

Coordinate CNA Plan for the Shift

1. Personal Care Needs - those who will need baths this shift and what type (Bed Bath, Shower, Spa Bath) which ones will require two person assist
2. Anticipated Admissions and Discharges and expected time frames for those - room turnover and preparation needs
3. Any individual/family issues to be aware of

Check on Fridge Temps, Blanket Warmer, Linen Par, Laundry

7:30 - 7:45 PM Purposeful Rounding on Guest Suites

- **Introduce self and write name, and CNA on Board**
- **Plan for the evening/ overview - What is their greatest need/desire?**
- **Point out paper and pen there for them to write questions and requests as they think of them for when RN/CNA return**
- **Five P's:**
    - **Pain scale**
    - **Personal belongings within reach - Call bell/phone instructions**
    - **Position**
    - **Potty**

- Pump (or other equipment needs: Accucheck, O2, Suction)

7:45 - 8:45 PM Evening Medications

Prep Individual Patient Meds in Med Cups within Numbered trays

Chart on Paper MARs in Notebooks

Record all Narcotics in Narcotic Notebook, as well

8:45 PM - 6:00 AM Evening Duties

- **Charting**
- **Teaching**
- **Wound Care**
- **Admissions/Discharges**
- **Assist CNA with Personal Care**
- **Laundry**
- **Update SBAR form**
- **Cleaning**
- **Add any updates to Patient's Paper Charts**

6:00 - 6:45 AM End of Shift

Finalize Charting

Update SBAR sheet

Laundry

6:00 - 6:45 AM Change of Shift

SBAR Report

Narcotic Tracking and Wasting

Key Sign-In and Out

Friends of Caroline
Policies and Procedures

Category: Nursing Procedures	**Code: NP011**
Subject: Clinician Bag Technique	**Page: 1 of 1**
Policy Date: May 2022	**Revised: 5-16-2022**
Approved:	**Date:**

I. Policy

This policy is developed as a guideline to address general circumstances. There may be certain instances in which the exercise of professional judgement and/or discretion by the health care provider warrants taking other actions.

Purpose

To prevent, reduce, and control spread of microorganisms by clinicians utilizing proper clinician bag technique.

II. Use of Clinician Bag

A. Equipment

1. Multi-compartment bag with closure (a.k.a. clinician supply bag)
2. Water resistant barriers
3. Disinfect zip-top or closeable plastic bags, as needed
4. Alcohol-based hand-rub (gel, foam, or liquid)
5. Hand washing kit (antimicrobial hand soap and paper towels)
6. Approved disinfectant wipes

ALERT: Do NOT carry clinician bag in homes known with insect and/or rodent infestation and/or known resistant microorganisms such as COVID-19. Consider transporting only supplies needed for visit in a disposable zip-top or closeable disposable bag.

B. Procedure

1. Inside of clinician bag regarded and maintained as a clean area.
2. Transport clinician bag in a clean area of car.
3. When inside patient's home
    a. Select a location to place clinician bag on a barrier close to work area.
    b. Do not place clinician bag on floor.
4. Perform hand hygiene according to Friends Of Caroline hand hygiene policy.
5. Remove ALL necessary items for visit from clinician bag and place items on a clean water-resistant barrier. If needed, perform hand hygiene per Friends Of Caroline policy and apply personal protective equipment, as needed.
6. Close clinician bag compartments and clinician bag opening after removing equipment.
7. Prior to patient use, disinfect all equipment removed from clinician bag with Friends Of Caroline approved disinfectant.
8. Clinician must perform hand hygiene prior to retrieving items, additional equipment/supplies needed from clinician bag.
9. After providing care and before returning items to clinician bag, disinfect all equipment with Friends Of Caroline approved disinfectant. Do not place used sharps, soiled/dirty equipment, or soiled dressings in clinician bag.
10. Perform hand hygiene, following manufacturer's guidelines.
11. Dispose of barriers in client's trash; perform hand hygiene.
12. For immunocompromised patients, consider only bringing necessary supplies into home in a disposable zip-top or closeable clean plastic bag.

Hand Hygiene for Healthcare Workers

- Use warm water to wet the hands
- Apply antiseptic soap (containing chlorhexidine)
- Work up a good lather
- Apply with vigorous contact on all surfaces of the hands
- Wash hands for 15-20 seconds
- Be sure to clean under nails
- Rinse, avoid splashing
- Keep hands down so that run off will go into the sink and not down the arm
- Dry well with paper towels and use the paper towel to turn off the faucet
- Discard the paper towels into the appropriate trash container

Hand Sanitizer

- When using hand sanitizer, the following technique should be used:
- If hands are visibly soiled, wash hands with soap prior to application of hand sanitizer.
- Apply enough hand sanitizer to cover the entire surface of hands and fingers.
- Rub solution vigorously into hands until dry.
- Multiple times using hand sanitizer may result in a sticky residue on the hands.
- Wash with soap and water periodically to remove the hand rub residue.
- Hand washing and or sanitizer should be used in between changing gloves and there are many other opportunities for sanitizing and hand washing.
- Employee states when appropriate to wash hands, and when to use hand sanitizer.

Healthcare workers with direct patient contact shall adhere to CDC and UTMB epidemiology guidelines. They must maintain fingernails so that nail enhancements are not to be worn. This includes, but is not limited to, artificial nails, tips, wraps, appliques, acrylics, gel, shellac, glue, and any additional items applied to the nail surface. Nail polish is permitted but anything applied to natural nails other than nail polish is considered an enhancement. Chipped nail polish supports the growth of the organisms on fingernails and is strictly prohibited. Individual departments can institute measures, in addition to those above, to comply with established standards of care in specialty areas.

I have read this and have received a copy of this policy.

_____ has been observed and has demonstrated correct hand washing technique.

_____

Employee Signature

_____ _____

Director of Clinical Operations Signature Date

CLEAN HANDS COUNT

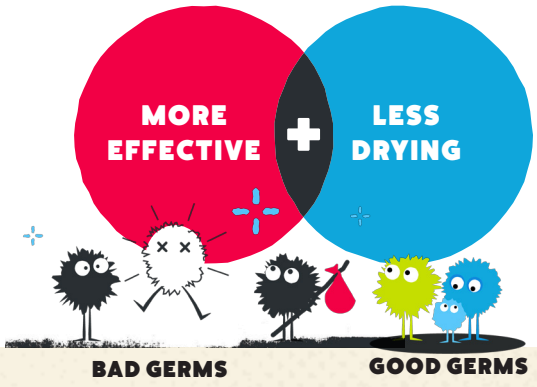
FOR HEALTHCARE PROVIDERS

KNOW THE TRUTH TO PROTECT YOURSELF AND PROTECT YOUR PATIENTS

TRUTH:

Alcohol-based hand sanitizer is more effective and less drying than using soap and water.

THE NITTY GRITTY:
Compared to soap and water, alcohol-based hand sanitizers are better at reducing bacterial counts on hands and are effective against multidrug-resistant organisms (e.g., MRSA). Additionally, alcohol-based hand sanitizers cause less skin irritation than frequent use of soap and water.



TRUTH:

Using alcohol-based hand sanitizer does NOT cause antibiotic resistance.

THE NITTY GRITTY:
Alcohol-based hand sanitizers kill germs quickly and in a different way than antibiotics. There is no chance for the germs to adapt or develop resistance.

TRUTH:

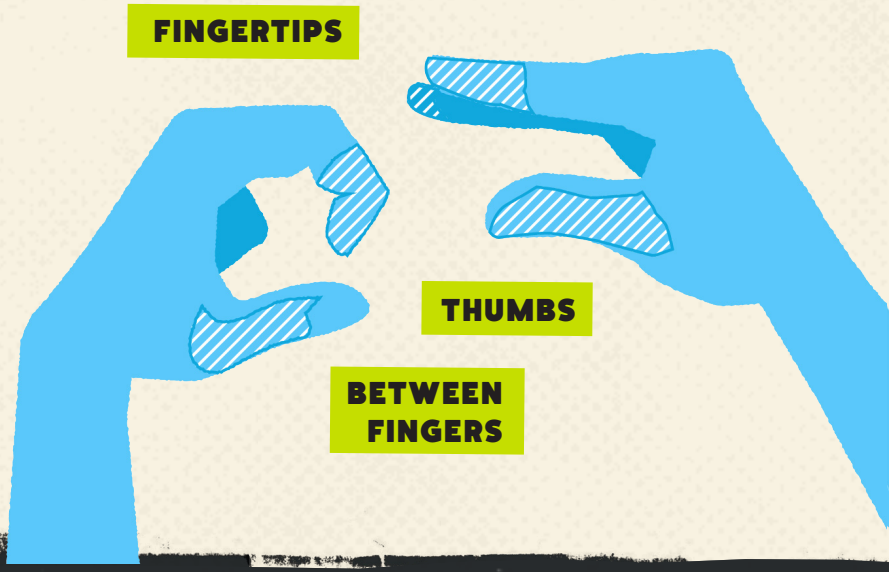
Alcohol-based hand sanitizer does not kill *C. difficile*, but it is still the overall recommended method for hand hygiene practice.

THE NITTY GRITTY:
Always use gloves when caring for patients with *C. difficile*. In addition, when there is an outbreak of *C. difficile* in your facility, wash your hands with soap and water after removing your gloves.

TRUTH:

Some healthcare providers miss certain areas when cleaning their hands.

THE NITTY GRITTY:
Using alcohol-based hand sanitizer becomes a habit and sometimes healthcare providers miss certain areas:



Clean Hands Count 100% of the Time

PROTECT YOURSELF AND PROTECT YOUR PATIENTS FROM POTENTIALLY DEADLY GERMS

TRUTH:

The amount of product you use matters.

THE NITTY GRITTY:
Use enough alcohol-based hand sanitizer to cover all surfaces of your hands. Rub your hands together until they are dry. Your hands should stay wet for around 20 seconds if you used the right amount.

TRUTH:

Glove use is not a substitute for cleaning your hands. Dirty gloves can soil your hands.

THE NITTY GRITTY:
Clean your hands after removing gloves to protect yourself and your patients from infection.

TRUTH:

On average, healthcare providers perform hand hygiene less than half of the times they should.

THE NITTY GRITTY:
When healthcare providers do not perform hand hygiene 100% of the times they should, they put themselves and their patients at risk for serious infections.

CLEAN HANDS COUNT

www.cdc.gov/HandHygiene

This material was developed by CDC. The Clean Hands Count Campaign is made possible by a partnership between the CDC Foundation and GOJO.

Facts About Falls

Each year, millions of older people—those 65 and older—fall. In fact, more than one out of four older people falls each year, [1] but less than half tell their doctor. Falling once doubles your chances of falling again.

Falls Are Serious and Costly

- One out of five falls causes a serious injury such as broken bones or a head injury.[4,5]
- Each year, 3 million older people are treated in emergency departments for fall injuries.[6]
- Over 800,000 patients a year are hospitalized because of a fall injury, most often because of a head injury or hip fracture.[6]
- Each year at least 300,000 older people are hospitalized for hip fractures.[7] • More than 95% of hip fractures are caused by falling,[8] usually by falling sideways.[9]
- Falls are the most common cause of traumatic brain injuries (T.B.I.).[10] • In 2015, the total medical costs for falls totaled more than $50 billion.[11] Medicare and Medicaid shouldered 75% of these costs.

What Can Happen After a Fall?

Many falls do not cause injuries. But one out of five falls does cause a serious injury such as a broken bone or a head injury.[4,5] These injuries can make it hard for a person to get around, do everyday activities, or live on their own.

- Falls can cause broken bones, like wrist, arm, ankle, and hip fractures. • Falls can cause head injuries. These can be very serious, especially if the person is taking certain medicines (like blood thinners). An older person who falls and hits their head should see their doctor right away to make sure they don't have a brain injury.
- Many people who fall, even if they're not injured, become afraid of falling. This fear may cause a person to cut down on their everyday activities. When a person is • less

active, they become weaker and this increases their chances of falling.[12]

What Conditions Make You More Likely to Fall?

Research has identified many conditions that contribute to falling. These are called risk factors. Many risk factors can be changed or modified to help prevent falls. They include:

- Lower body weakness
- Vitamin D deficiency (that is, not enough vitamin D in your system) •
  Difficulties with walking and balance
- Use of medicines, such as tranquilizers, sedatives, or antidepressants. Even some over-the-counter medicines can affect balance and how steady you are on your feet.
- Vision problems
- Foot pain or poor footwear
- Home hazards or dangers such as
  - broken or uneven steps, and
  - throw rugs or clutter that can be tripped over.

Most falls are caused by a combination of risk factors. The more risk factors a person has, the greater their chances of falling.

Healthcare providers can help cut down a person's risk by reducing the fall risk factors listed above.

What You Can Do to Prevent Falls
Falls can be prevented. These are some simple things you can do to keep yourself from falling.

- Ask your doctor or healthcare provider to **evaluate your risk** for falling and talk with them about specific things you can do.
- Ask your doctor or pharmacist to **review your medicines** to see if any might make you dizzy or sleepy. This should include prescription medicines and over-the counter medicines.
- Ask your doctor or healthcare provider about taking **vitamin D** supplements. Do exercises that make your legs stronger and improve your balance. Tai Chi is a good example of this kind of exercise.

Have your eyes checked by an eye doctor at least once a year, and be sure to update your eyeglasses if needed.

If you have bifocal or progressive lenses, you may want to get a pair of glasses with only your distance prescription for outdoor activities, such as walking. Sometimes these lenses can make things seem closer or farther away than they are.

- Get rid of things you could trip over.
- Add grab bars inside and outside your tub or shower and next to the toilet. •

Put railings on both sides of stairs.

· Make sure your home has lots of light by adding more or brighter light bulbs. · Keep items you use often in cabinets you can reach easily without using a step stool. · Use non-slip mats in the bathtub and on shower floors.

Friends of Caroline
Caroline's Cottage
Policies and Procedures

Category:	**Nursing**	**Code: N008**
Subject:	**Death Pronouncement /Post Mortem Care**	**Page: 1 of 2**
Policy Date:	**May 2013**	**Rev: 04/2018**
Approved:	_____	**Date:**

I. Policy

Friends of Caroline shall be committed to providing a continuum of care for the patient and family members through the transition of the dying process to the time of death and into bereavement care. The Friends of Caroline nurse will perform the death pronouncement according to physicians' orders and in accordance with the South Carolina Board of Nursing Nurse Practice Act. In the event of a questionable death, suicide, medication overdose, etc., the Friends of Caroline nurse shall consult the patient's physician and contact the medical examiner and/or county coroner. The nurse will perform post-mortem care according to the following procedures.

II. Procedure

A. Prepare the patient and family for impending death when anticipated and possible. Discuss referrals related to ongoing bereavement needs.

B. Insure that a physician's order for death pronouncement is in the patient's medical record.

C. At time of death:

1. Assess the body for cessation of all life signs.
2. Call Coroner to pronounce the patient dead if no heartbeat is heard after one full minute of auscultation apically.
3. Notify the physician of death (if death occurs after hours notify the physician the next working day). If patient does not have a DNR order contact MD for orders to pronounce.
4. Notify other team members of the death and any anticipated grief issues.
5. Notify the funeral home.
6. Contact other persons as requested by family.
7. Consult with family immediately after the death regarding religious customs and viewing the body.
8. Using standard infection control precautions remove all tubes and drains if possible, (unless a questionable death), close mouth and eyes and maintain the body in proper alignment as much as possible
9. Do not cover the patient's head unless requested by family.
10. Comfort the family and allow them time alone with the body.
11. Remain at the home until the body is released to the funeral home. Document the name of the funeral home and name of person the body is released to.
12. Arrange for pick up of equipment and removal of supplies.

13. Inform family regarding disposal of all patient drugs, completing necessary paperwork. Upon the death of a patient receiving outpatient services from a hospice, ownership of unused medications related to the care of the patient constituting Schedule II, III, IV, or V controlled substances under 21 C.F.R. Part 1308 shall transfer to the hospice for immediate disposal. Each hospice providing outpatient services shall establish a written procedure to ensure safe disposal of unused controlled substances at the time of a patient's death. Upon the death of a patient receiving outpatient services, in the presence of a witness, the hospice nurse shall record in the medical record the name and quantity of each unused controlled substance. The hospice nurse then shall conduct immediate disposal at the site of care by complying with Environmental Protection Agency and Drug Enforcement Administration guidelines for safe disposal or immediate mail-back to a collector registered pursuant to 21 C.F.R. Section 1317.40. If conducting immediate disposal at the site of care, the nurse should perform the disposal in the presence of a witness, who shall sign a document indicating their witnessing of the disposal. If participating in immediate mail-back to a registered collector, the hospice nurse shall deposit the unused medications into a mail-back envelope and seal the envelope at the site of outpatient services. Hospice employees must not remove any medications from the site of outpatient services other than to conduct immediate mail-back to a registered collector. The hospice nurse shall record the method of disposal in the medical record.

D. Document the following information:
   1. Date and time of death, (date and time of actual pronouncement by nurse)
   2. Disposition of the body and time funeral home was notified.
   3. Destroy medications in accordance under 21.C.F.R Part 1308. Each medication must be written on the Medication Disposal Form. Include Medication, Strength, Dosage Form, Quantity Disposed and Disposition Method. RN and Witness must sign and date.
   4. Date and time physician notified.
   5. Date and time equipment pickup arrangements made.
   6. Removal of jewelry and personal effects and whom given to.
   7. Notification of family members.
   8. Any other pertinent information.

Friends of Caroline Hospice Medication Disposal Form

Patient Name:_____ ID# _____

Reason for Medication Disposal _____

MEDICATION	STRENGTH	DOSAGE FORM	QTY DISPOSED	DISPOSITION METHOD

RN Signature _____ Date_____

Witness Signature _____ Date_____

Witness Printed Name_____

Friends of Caroline Hospice Medication Disposal Refusal Form

Patient Name:_____ ID# _____

Reason for Refusal (RN initial in box):

Family/Caregiver Refusal (section 1) ☐

Facility Policy (section 2) ☐

Other ☐

_____
_____
_____
_____

Comments:

_____
_____
_____
_____

1. **I, _____, understand that under 21 C.F.R Part 1308, medication prescribed to patient, upon discharge/death, become the property of the hospice. Hospice is to destroy these medications in accordance of 21 C.F.R Part 1308. Should I refuse to comply, I have been informed of the procedures required by Hospice. I have also been advised of the proper methods of disposal as outlined by 21 C.F.R. Part 1308.**

2. **If refusal is based on facility policy, I, _____, hereby sign that all prescribed medications of patient will become property of Facility and disposed off in accordance of Facility policy as well as in accordance of 21 C.F.R. Part 1308.**

RN Signature _____ Date_____

Refusing Party Signature _____ Date_____

Refusing Party Printed Name_____

Friends of Caroline Clinical Coordinator Signature _____ Date _____

Training Manual Cover Page

Medication

Friends of Caroline

High Alert and Hazardous Medications List

Clonazepam – Benzodiazepine

Colchicine – Antigout

Divalproex – Anticonvulsant, Miscellaneous

Fentanyl – Opioid

Haldol – Antipsychotic

Hydrocodone - Opioid

Hydromorphone – Opiate

Lorazepam – Benzodiazepine

Megestrol – Antineoplastic Agent

Morphine – Opioid

Oxycodone – Opioid

Prochlorperazine – Antipsychotic

Promethazine – Phenothiazine

Spironolactone – Mineralocorticoid receptor antagonists

Temazepam – Benzodiazepine

Valproic Acid – Anticonvulsant, Miscellaneous

Warfarin – Coumarin derivative

Purpose

To provide guidelines for safe storage, handling, administration, secure disposition and wasting of high alert and hazardous medications.

A. The Hospice Nurse will assess the need for and account for all high alert/hazardous medications.

1. On admission
2. At each visit

B. The assessment shall include:

Safe storage

1. Keep medications out of sight of children.
2. Keep medications in lock box if there is a concern for theft from others in home or visitors to home.
3. Refrigerate, if necessary, per medication instructions.
4. Keep at temperature as stated on medication packaging.

C. Safe handling

1. Teaching on infection control
2. Hand washing before and after administration of medications
3. Use of gloves for removing transdermal medications
4. Wear new gloves to place on new transdermal patch.

D. Administration

1. Eight medication
2. Right route
3. Right dose
4. Right time

E. Safe disposal

1. Follow specific label instructions for disposal.
2. Do not flush in toilet unless label specifically instructs to do so.
3. Remove all identifying labels from prescription bottles and discard in garbage.
4. Do not give unused medications to others.

NARCOTIC Safety

- Narcotics for all patients must be ordered/prescribed every two weeks, not for an entire month. This includes both Hospice and Palliative patients. The maximum number of tables prescribed in a 2 week period is not to exceed 90 – and this should be only after careful consideration of the patient pain/home environment and mental status. If they need 90 within a 2 week period the case manager should be evaluating and discussing with IDT if the current regime is effective and provide a rationale.
- If a patient is actively dying narcotics need to be written weekly to prevent waste. We do have an opiod crisis and at times we have had difficulty getting them.
- Physicians – if a nurse asks for you to write 90 tablets or more it must go to Clinical Coordinator for approval. Unless it's a cancer patient in severe pain they should not need 90 tablets, (6 prns a day).
- RN's are to count all narcotics every visit to know what the patient is taking, if it's working and that they are following directions.
- If a patient lives alone and/or has any confusion, or if family is suspect the medications need to be locked up and planners filled 2-3 times per week for patient, family and organizational safety.

- Narcotics are not to be picked up by staff and are not to be sent/delivered to the office. The case manager as part of the assessment is asking who can sit or pick up medications for them. This is why you should be asking if they have a church and be asking about friends and family during your assessment. The case manager is also assessing where the patient lives. If in an area where not easy to get mail – send Roxanol rx to Beaufort Pharmacy or another local pharmacy. If a patient is in pain or close to dying – narcotics should be gotten locally. When in doubt, send rx to Beaufort Pharmacy to prevent them from being delayed.
- The name of the pharmacy must be written on the top of the rx by the RN case manager not the physician – this prevents double dipping.
- After a narcotic rx is faxed the nurse must call to confirm that it has been received and that it will be filled that day. Then the rx is to have void written largely across it so there is no doubt that it is void.

How to identify an opioid overdose:

Look for these common signs:

- The person won't wake up even if you shake them or say their name
- Breathing slows or even stops
- Lips and fingernails turn blue or gray
- Skin gets pale, clammy

In case of overdose:

1 Call 911 and give naloxone
If no reaction in 3 minutes, give second naloxone dose

2 Do rescue breathing or chest compressions
Follow 911 dispatcher instructions

3 After naloxone
Stay with person for at least 3 hours or until help arrives

NARCAN® (naloxone HCl) NASAL SPRAY

QUICK START GUIDE

Opioid Overdose Response Instructions

Use NARCAN Nasal Spray (naloxone hydrochloride) for known or suspected opioid overdose in adults and children.
Important: For use in the nose only.
Do not remove or test the NARCAN Nasal Spray until ready to use.

1 Identify Opioid Overdose and Check for Response

Ask person if he or she is okay and shout name.

Shake shoulders and firmly rub the middle of their chest.

Check for signs of opioid overdose:
- Will not wake up or respond to your voice or touch
- Breathing is very slow, irregular, or has stopped
- Center part of their eye is very small, sometimes called "pinpoint pupils"

Lay the person on their back to receive a dose of NARCAN Nasal Spray.

2 Give NARCAN Nasal Spray

Remove NARCAN Nasal Spray from the box.
Peel back the tab with the circle to open the NARCAN Nasal Spray.

Hold the NARCAN nasal spray with your thumb on the bottom of the plunger and your first and middle fingers on either side of the nozzle.

Gently insert the tip of the nozzle into either nostril.
- Tilt the person's head back and provide support under the neck with your hand. Gently insert the tip of the nozzle into **one nostril**, until your fingers on either side of the nozzle are against the bottom of the person's nose.

Press the plunger firmly to give the dose of NARCAN Nasal Spray.
- Remove the NARCAN Nasal Spray from the nostril after giving the dose.

3 Call for emergency medical help, Evaluate, and Support

Get emergency medical help right away.

Move the person on their side (recovery position) after giving NARCAN Nasal Spray.

Watch the person closely.

If the person does not respond by waking up, to voice or touch, or breathing normally another dose may be given. NARCAN Nasal Spray may be dosed every 2 to 3 minutes, if available.

Repeat Step 2 using a new NARCAN Nasal Spray to give another dose in the other nostril. If additional NARCAN Nasal Sprays are available, repeat step 2 every 2 to 3 minutes until the person responds or emergency medical help is received.

Training Manual Cover Page

Documentation

Hospice Documentation – Why effective charting is important

- What are the essentials in charting in hospice?
- Does charting need to be individualized or are general statements acceptable?
- What needs to be included when charting for a patient with Alzheimers? COPD? CHF? Parkinsons? Protein Calorie Malnutrition? Cancer?
- When is it appropriate to chart a patient is improving?
- What specific language should be used to document decline?
- What are "ADL's" and when should they be documented?
- What needs to be documented when a patient is dying?
- When is it time to increase patient visits for SN, SW, Chap, Vol?
- Are vital signs necessary at all visits for hospice patients?
- How specific should pain documentation be?
- Upon admission how do I answer the pain question and the 72hour f/u?
- Does it need to be documented when medications are ordered?
- What medications does Hospice cover? Is there a formulary?
- How often do care plans need to be updated?
- Should RN give and document emotional support?
- Does it need to be documented that the Chaplain or Social Worker were contacted to reach out to patient/family.
- Should my charting and my visits improve the longer I work in hospice, or do I think I don't need to grow and improve?

Skilled nursing visits

- Head to toe assessment with focus on decline – especially related to diagnosis. Anything new going on – not related to diagnosis?
- Ask to see all medications every visit. Do you need any medications? Are you running out of anything?
- Hospice patients only receive 2 weeks worth of medications – so you should already have an idea of what routine medications they'll need.
- Ask how is it working out with the CNA?
- Ask questions. Lots of questions. Pain? Fall? Appetite? Pocketing food? ADL's – Can they do on their own or need assist? What kind of assist? Last bowel movement? What color? Hard, soft, loose? Urine color, smell, any other problems.

- Am I asking to many questions? Never! Be the detective, get your information, it's amazing what you'll find out! "Did I tell you mom had a fall last week?" Aha – that's why she has a pain, a new bruise, a limp! You can never ask to many questions.

- Does my documentation accurately reflect the patient scenario?
- Am I giving emotional support and reaching out to Chaplain/Social Worker as needed for my patient and am I documenting that I have given emotional support and offered and/or reached out to CH/SW
- Am I documenting my teaching on the end of life process?
- Am I documenting on admission that I have educated the patient, family, caregivers on the Hospice benefit.
- If another case manager sees my patient can they read my last note and know what is going on with the patient, how a patient's pain is being managed? What pain medications they are taking and how often?

Patient Plan of Care

Disciplines of Nursing, Social Work and Chaplain shall each document a Plan of Care for all Patients.

Plans of Care are to be reevaluated and updated every two weeks during IDT and as per changing needs of patient and family.

A. All Plans of Care are to have specific and measurable goals.

    1. Goals are to meet needs of patient and family.
    2. Plans of Care are to be individualized
    3. Goals will be discussed with patient and family
    4. What are the symptoms that you are most worried about?
    5. What are the problems that you are most concerned about?

B. Interventions are to be specific to each patient and for effectiveness of goal.
    1. Discuss with patient, family interventions helpful to achieving goals.
    2. Provide interventions focused on effective management of symptoms
    3. Teaching with patient and family on doable interventions

C. All Plans of Care to be reevaluated every two weeks in IDT and with patient and family as disease progression permits.

    1. Discuss in IDT if current Plan of Care working and if continues applicable to patient and family
    2. During each visit assess, observe and teach patient and family if goals of current Plan of Care have been met
    3. Teaching and update goals, interventions per changing needs and disease progression.
    4. Evaluate Plan of Care every 2 weeks for effectiveness of patient and family needs.

The Joint Commission

Official 'Do Not Use List' [1]

Do Not Use	Potential Problem	Use Instead
U (Unit)	Mistaken for "0" (zero).the number "4" (four) or "cc"	Write "Unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D,, QD, q.d., qd (Daily) Q.O.D., QOD, q.o.d, qod (Every Other Day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0) mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO_4 and $MgSO_4$	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

[1] Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

*** Exception: A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.**

CONTINUOUS CARE DOCUMENTATION INSTRUCTIONS

1.) All documentation will follow Friends of Caroline documentation guidelines. An order to change the level of care from "Routine" to "Continuous care" is obtained from MD and entered into the EMR when Continuous care started.
2.) All staff will document the exact start time of their visit/shift on the continuous care log in the home and in the EMR.
3.) Each day will have a separate continuous care log for documentation of staff hours (the 24 hours for Hospice continuous care starts at 12:00 am through 11:59 pm).
4.) Documentation will be done hourly by all staff and reflect the crisis. The PLAN OF CARE and NOTES MUST SAY, "Continuous care required due to_____, as evidenced by_____." "Dying process or "end of life care" is not acceptable without specifying the distressing symptoms that require constant care and /or monitoring.
5.) CNA will follow Hospice RN's instructions and Plan of Care. The CNA will also document every hour – and cannot administer any medications.
6.) RN will document all medications administered per MD orders.
7.) Documentation is to include (but not limited to):
    - Patient condition and status, addressing the symptoms necessitating continuous care.
    - Interventions/treatments of care given, client response to care, and effectiveness of treatments/care and how tolerated.
    - The reason to continue Continuous care.
    - Collaboration with any team members, physician, family, or facility staff.
    - Instructions of all teaching, who was taught, and response to instruction.
8.) "Paint the Picture of what you see. An example of a note:
    9/2/2021 9:30 pm
    79-year-old male with end stage liver cancer on continuous care for active pain management. Increased MS Contin to 60mg by mouth to every 12 hours with Roxanol (20mg/ml) to 1ml every hour as needed for breakthrough pain. Teaching done with wife on medication administration, dosage to keep patient comfortable to manage pain/dyspnea. Wife states or demonstrates understanding.
    Nancy Nurse RN.

9.) Once the symptoms that required Continuous care are managed, the continuous care will be discontinued, the MD and team will be notified and a level of care order is obtained and changed back to "Routine" in the EMR.

Admission /Routine Checklist-

On-Call RN

EMR-Smartchart

Under "Orders & Notes"

- Select drop down and "record verbal order->patient admission
- Then enter information example: **phone** conversation on **08/23/23** with **Jeff Poling, MD** admission to **routine** care taking effect on **08/23/23**. Admitted into **Patient's Home.**
- Click check mark to complete. Standing orders then will come up. Select check boxes for Nurse, Social Worker and Spiritual. Remove or add any standing orders needed ie. If full code remove DO NOT RESISTATE, etc. Click check mark to complete.
- Click check mark at top right of top to get out of "orders & notes."

Open Visit by clicking 

Change date and time if needed, select "Start New Visit"-you do not have to select a check box, just select "Start New Visit" again.

Then select the paper icon above open visit icon. Fill out the following forms:

Home Hospice-First Visit

- € Covid-19
- € Initial Nursing Assessment

Home Hospice-Second Visit, etc

- € Nursing Visit Record

Measures

- € This is where you enter vitals, MACs and PPS

Medications

Enter current medications and any orders here. Include stock meds even if there is a standing order if you have started one. Don't forget to add Oxygen

Care Plan Problems-on admission

- € Advanced Directives

- € Primary Plan of Care

Orders and Notes

Admission:

In Smartchart->click top Left widget “order & notes”->click four arrows to expand widget->

Select drop down arrow and select->record verbal order->patient admission.

General Order:

In Smartchart->click top Left widget “order & notes”->click four arrows to expand widget->

Select drop down arrow and select->record verbal order->general order.

In This is where you enter orders for wounds etc. Notes are very short-i.e. Patient daughter called to give access code to gate etc. This is not for progress notes.

Once completed, click pin again to close visit.

Admission /Routine Checklist-

Field RN/On-Call RN

EMR-Smartchart

Under "Orders & Notes"

- Select drop down and "record verbal order->patient admission
- Then enter information example: **phone** conversation on **08/23/23** with **Jeff Poling, MD** admission to **routine** care taking effect on **08/23/23**. Admitted into **Patient's Home.**
- Click check mark to complete. Standing orders then will come up. Select check boxes for Nurse, Social Worker and Spiritual. Remove or add any standing orders needed ie. If full code remove DO NOT RESISTATE, etc. Click check mark to complete.
- Click check mark at top right of top to get out of "orders & notes."

Open Visit by clicking 

Change date and time if needed, select "Start New Visit"-you do not have to select a check box, just select "Start New Visit" again.

Then select the paper icon above open visit icon. Fill out the following forms:

Home Hospice-First Visit

- € Covid-19
- € Initial Nursing Assessment

Home Hospice-Second Visit, etc

- € Nursing Visit Record

Measures

- € This is where you enter vitals, MACs and PPS

Medications

Enter current medications and any orders here. Include stock meds even if there is a standing order if you have started one. Don't forget to add Oxygen

Care Plan Problems-on admission

- € Advanced Directives

- € Primary Plan of Care
- € And 1 additional nursing specific

Care Plan-Visit Frequency

Enter Nurse and Aide. For Field whatever you are doing and PRN check. For Aide frequency change date to actual start date of visits. Example: I admit a patient on Wednesday (5/31). They will have one visit the first week which I enter into the system. The next week (6/5) they are going to have 3x/week. I go into the system and update to 3x week with a date of 6/5.

Orders and Notes

This is where you enter orders for wounds etc. Notes are very short-i.e. Patient daughter called to give access code to gate etc. This is not for progress notes.

Once completed, click pin again to close visit.

EMR-Patient CII

CNA ASSIGNMENTS AND HIS ARE STILL IN OLD SYSTEM. You have to login to the patient portal to complete these. This will be changing…not sure when.

- CNA Assignment (if they have one)
- HIS Admission-within 7 days

Admission Visit and Daily Visits Checklist-Cottage

EMR-Smartchart

Under "Orders & Notes"

- Select drop down and "record verbal order->patient admission
- Then enter information example: **phone** conversation on **08/23/23** with **Jeff Poling, MD** admission to **respite** care taking effect on **08/23/23**. Admitted into **Caroline's Cottage**.
- Click check mark to complete. Standing orders then will come up. Select check boxes for Nurse, Social Worker and Spiritual. Remove or add any standing orders needed ie. If full code remove DO NOT RESISTATE, etc. Click check mark to complete.
- Click check mark at top right of top to get out of "orders & notes."

Open Visit by clicking 

Change date and time if needed, select "Start New Visit"-you do not have to select a check box, just select "Start New Visit" again.

Then select the paper icon above open visit icon. Fill out the following forms:

New Patient GIP or Respite

€ Initial Nursing Assessment

€ Covid-19

GIP Documentation after first contact:

€ Nursing Visit Record (daily after initial nursing assessment complete)

€ IPU Contact-every 4 hours thereafter

Respite Patient (from home)

€ Nursing Visit Record (one time per shift minimum)

Measures

- This is where you enter vitals, MACs and PPS

Medications

Enter current medications and any orders here. Include stock meds even if there is a standing order if you have started one. Don't forget to add Oxygen

Care Plan Problems-on admission

- € Advanced Directives
- € Primary Plan of Care
- € And 1 additional nursing specific

Care Plan-Visit Frequency

Enter Nurse and Aide. For Cottage (Daily).

Orders and Notes

This is where you enter orders for wounds etc. Notes are very short-i.e. Patient daughter called to give access code to gate etc. This is not for progress notes.

Once completed, click pin again to close visit.

EMR-Patient CII

CNA ASSIGNMENTS AND HIS ARE STILL IN OLD SYSTEM. You have to login to the patient portal to complete these. This will be changing…not sure when.

Discharge Checklist-

Field RN/On-Call RN/Cottage

EMR-Smartchart

Under “Orders & Notes”

- Select drop down and “discharge patient->select discharge type.
- Then enter information date and time.
- Click check mark at top right of top to get out of “orders & notes.”

Care Plan Problems-

- € Discharge Summary
- € Resolve all open care plans aside from discharge summary

EMR-Patient Portal (old system)

- € Enter HIS DISCHARGE

As Friends Of Caroline strives to provide compassionate and comprehensive care to our guests, it is important to receive feedback in a timely manner. The feedback that is gathered will help us to better serve our guests, their family and the community, in the future, as well as, recognize a good job by our team members.

Copies of the attached survey are placed in each guest's room and at various locations throughout the Cottage so they can be easily accessed at any time.

Please complete this short survey so that we may be able to better serve you, your family and the community in the future.

Rate the professionalism of the staff that provided your care-

Nurse:	Excellent	Good	Poor
CNA:	Excellent	Good	Poor
Social Worker:	Excellent	Good	Poor

Comments:_____

Rate your suite at Caroline's Cottage-

Bedroom/Gathering Area Cleanliness:	Excellent	Good	Poor
Bathroom Cleanliness:	Excellent	Good	Poor
Patio Accessibility & Cleanliness:	Excellent	Good	Poor
Bed/TV Controls Assessiblity:	Excellent	Good	Poor

Comments:_____

Rate the meals that were provided-

Meal Delivery Times:	Excellent	Good	Poor
Serving Portions:	Excellent	Good	Poor
Serving Temperatures:	Excellent	Good	Poor
Finished Tray Removal:	Excellent	Good	Poor

Comments:_____

Did you have a superior experience with a team member and want to tell us about it? If so, please share their name and how they made your day. We love to recognize the good.

_____

_____

_____

Please return this survey to the drop box at the main entrance. Thank you.