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| Change in Patient Condition (Hospice) | **Last Revision**: | May 2018 |
| **Last Reviewed:** | June 2020 |
| **Applies to the following THA Group of Companies:** | Island Hospice |
| **Included in the following THA Manuals:** | Administrative Policy & Procedure Manual  Provision of Care, Treatment, & Service |

**POLICY**

Knowing and responding to changes in a patient’s condition are critical to providing quality health care. Such changes may be reported by the patient, the patient’s family member or other caregiver(s), a physician or other health care professional. A change in the patient’s condition is immediately communicated to proper personnel.

**PROCEDURE**

1. Any change in a patient’s condition observed by a hospice team member during a home visit is documented in the electronic medical record (EMR) and communicated to the RN Case Manager (CM); in the event the CM is unavailable report the change to the Hospice Clinical Supervisor
2. The RN CM or Care Coordinator is to notify the attending physician and/or as appropriate, the Hospice Clinical Supervisor , and the Hospice Medical Director.
3. If a change in condition is noted in a phone call from the patient, the family and/ or the physician, the RN CM is notified and the call is documented in the EMR.
4. A nursing assessment is made if the change in condition is reported by a hospice team member other than a RN.
5. The Plan of Care is updated as needed to reflect the change in condition and any interventions initiated to address issues related to the change.