HospiceTools™
How Hospice Happens

Nurses' eDocs EMR Forms Patient Ongoing Care Checklist

This checklist details the most common and regulatorily required forms a nurse will use during ongoing patient care.

Title	Notes
NURSING VISIT NOTE	Completed at each scheduled visit, minimally once every 14 days. Serves to document a full patient visit as well as update to comprehensive assessment, aide supervision, and prompts nurse to update care plan.
NURSE PROGRESS NOTE	The Nurse Progress Note can be used for a variety of situations including PRN visits, phone calls, care plan meetings, care coordination, etc.
NURSING TELEHEALTH NOTE (FACILITY)	Same as traditional Nurse Visit Note but for telehealth with patient in facility
NURSING TELEHEALTH NOTE (HOME)	Same as traditional Nurse Visit Note but for telehealth with patient at home
CARE PLAN & UPDATE	Create/update as needed during care. The plan of care needs to be updated with any changes in problems, goals, & interventions every 15 days min.
IDG UPDATE	Completed at each IDG meeting. Documentation of changes to DME, medications, and patient status over the past two weeks. Also, collaboration with patient/family, attending physician, facility (if applicable) and hospice team. Planned frequencies for next IDG period.
HOSPICE AIDE CARE PLAN & UPDATE	Assigns specific tasks for hospice aide to perform, if applicable. Updated as needed during care with changes.
HOMEMAKER ASSIGNMENT AND PLAN OF CARE & UPDATE	Assigns specific tasks for homemaker to perform, if applicable. Updated as needed during care with changes.
MEDICATION / MULTIPLE MEDICATIONS FORM	Complete Medication order(s) and select physician for dashboard eSigning.
TREATMENT ORDERS	Complete treatment order(s) (e.g. wound care, tube feeding, etc.) and select physician for dashboard eSigning.
NURSE RECERTIFICATION	"To be completed by the nurse 21-30 days prior to the end of the certification period. Helps substantiate continued hospice appropriateness."
CHANGE IN LEVEL OF CARE	As needed. Physician order to change patient's level of care
DISCONTINUE MEDICATION FORM	Use form or medication grid in patient chart (medication tab in chart) to discontinue medication(s)
DISCONTINUE TREATMENT ORDERS	Use form or physician order grid (physician order tab in chart) in patient chart grid to discontinue order(s)
TRIAGE NOTE	Use this form to document after-hours calls from patients/caregivers, facilities, physicians, pharmacies, etc. and actions taken
SUPERVISORY NOTE	Use when the Nurse Visit Note was not completed but still need to document Supervisory Note

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DEATH VISIT REPORT	Complete upon patient death
DISCHARGE SUMMARY	Complete when patient discharges alive
CHANGE OF FREQUENCY ORDER	As needed. Physician order to update team member(s) frequencies between IDG periods
INFECTION INCIDENT REPORT	As needed to document patient infections more thoroughly than in a visit note.
VOLUNTEER REQUEST FORM	As needed when patient/caregiver requests a volunteer (if request is made of nurse). Sent to volunteer coordinator for review and volunteer assignment
WOUND ASSESSMENT	As needed to document wounds more thoroughly than in a visit note
COVID-19 ASSESSMENT	As needed
PATIENT INCIDENT REPORT	As needed to document incidents that occur such as falls, suspected abuse/neglect etc.
CONTINUOUS CARE FLOW SHEET	As needed to document vital signs, respirations, bowel movements, urine output etc. during a continuous care shift
CONTINUOUS CARE HOURLY DOCUMENTATION	As needed to document hour-by-hour changes in patient condition, nursing assessments and symptom management provided
CONTINUOUS CARE INITIATION SHEET	As needed. When continuous care starts. Documentation of symptom-specific crisis necessitating continuous care need. Identifies hospice team and initial orders for continuous care staff to manage symptoms
CONTINUOUS CARE SPECIFIC INSTRUCTIONS	When continuous care starts. Detailed specific instructions for patient care to be provided by continuous care staff
DOCUMENTATION TO SUPPORT ADMISSION TO GIPLC	As needed. When GIP care is initiated. Documentation of symptom-specific crisis necessitating GIP need.
GIP EVALUATION/ASSESSMENT	As needed to document frequent changes in patient condition, nursing assessments and symptom management provided
STICKY NOTES TAB	As needed: eDocs Sticky Notes Tab is often used for planning, note taking and sharing relevant data with team that will not hit the chart.

Notes