GIP section/question	What documentation should be present in the chart? Where will documentation be located?
Was the POC updated and do the goals and/or interventions reflect the GIP symptom management?	• Care plans should be updated as needs for the patient change. Care plan interventions and goals should reflect relevant assessments and present symptoms. • Medication orders should be updated once SNF/hospital accept and obtain the order from their MD/NP. We should not enter orders only upon making recommendation unless order is obtained by facility. We must review medications at each visit. • Clinicians see current care plan/goal/intervention orders under "care plan" in the patient's chart. If the "history" box is checked, they are able to see discontinued orders. • Clinicians will also be entering their GIP order via the care plan section.
Is there documentation on the collaborative planning and communication with the staff?	• Community GIP visit collaboration with our staff and hospital/SNF staff should be documented in the narrative note. We should be documenting exactly who we spoke to during our visits.
Is d/c planning evident at the initiation of GIP and ongoing?	• Discharge planning should be initiated at admission. Admitting RN should discuss varying levels of care as well as a plan B should the patient become routine LOC. This documentation should be present in narrative note. • Ongoing discussion and planning should occur with the primary care team at subsequent visits.
Is there evidence of discussion with the NP/MD/interdisciplinary team regarding GIP?	• At each GIP visit the RN should be calling MD/NP to discuss ongoing GIP status. Documentation should be located in the narrative note stating "Per MD/NP (name) patient remains GIP LOC for management of...." If the patient remains GIP.
Is there supporting documentation of previous interventions/treatments without adequate results?	• Medication lists and care plans must be up to date to reflect changes to the POC. • If a patient in the community becomes GIP LOC and is transferring to the HPH or becoming GIP in hospital/SNF, documentation in visits should be clear as to what interventions have been in place, medications given/frequency/dose in use, and symptoms requiring in-patient management.
Once GIP, in the hospital or community, were daily visits related to the qualifying symptoms? Is there daily documentation related to the admitting reason for GIP, describing the patient's responses to treatment and the ongoing need for GIP?	• Daily RN visits occur for all GIP patients in hospital and SNF settings. • Documentation should support why patient is GIP. RN should document at each daily visit symptom being managed, medications in use, frequency/dose changes, response to changes, etc. to support ongoing need for GIP. • As stated above, discussion with MD/NP occurs with each daily visit as well.
Was there a precipitating event?	• Documentation in narrative note/quick note is required. • Detailed report to team leader when transferring to the HPH also required as well as order from MD/NP. • For routine to GIP in community SNF or hospital, a visit note narrative should detail the LOC of care change and GIP order from MD. I • **If change in LOC in SNF, business office must be given VOR changing LOC from routine to GIP and vice versa.**
Was there an MD order in the POC for GIP?	• In IPad, the LOC orders are found in the care plan tab under "Hospice Level of Care". Community nurses should add this order when transferring to the HPH or changing LOC to GIP at SNF/hospital. • If changing a patient from routine to GIP in the community, level of care attribute must also be changed with the date of the change.