Levels of Care – Inpatient Respite Care PC.L30

Regulatory Citation(s):	42 CFR 418.204(b); 418.302(b)(3); 418.108(b)(1); 418.108(b)(1)(ii); 418.108(b)(2)
L-Tag(s):	708, 709, 710

POLICY: Short-term inpatient respite care is available to patients and is provided in a contracted facility on an occasional basis for not more than 5 consecutive days at a time. The inpatient respite level of care is not available to patients who reside in facilities.

PROCEDURE:

1. Short term inpatient respite care is provided in Medicare-certified facilities that have enough nursing personnel available on all shifts to ensure that adequate safety measures are in place for the patients and that the routine, special, and emergency needs of all patients are met at all times.

2. The IDG identifies the patient's/family's need for respite care. Situations indicating a need for respite care may include, but are not limited to:
    a. injury or impairment of the caregiver; and/or
    b. the caregiver requires or requests an interval (5 days or less) of rest or relief from providing care to the patient.

3. The Social Worker or designee assesses the need for respite care and arranges the patient's admission for inpatient respite care with a contracted facility and transportation if needed.

4. The Social Worker or RN Case Manager completes a *Level of Care Change* form and forwards it to the hospice billing department.

5. The Social Worker or the RN Case Manager provide documentation of the patient's condition to the facility staff, including but not limited to:
    a. hospice diagnosis, current medications, and treatment orders;
    b. DNR and advance directives if any; and
    c. current plan of care.

6. The hospice educated the family on what to pack for the respite stay, including any and all prescribed medications as defined in the facility contract.

Created:	Reviewed:	Revised:	Effective:
6/18	2/19		4/2019
Reviewed:	**Reviewed:**	**Reviewed:**	**Reviewed:**

7. The IDG continues to provide services to the patient/family during the period of respite and re-evaluates and updates the comprehensive assessment, safety assessment, evacuation status, fall risk assessment and the plan of care at the time of admission to and discharge from inpatient respite care.

8. A summary of the care provided to the patient during the respite stay is filed in the patient's clinical record.

Created:	Reviewed:	Revised:	Effective:
6/18	2/19		4/2019
Reviewed:	**Reviewed:**	**Reviewed:**	**Reviewed:**