INTRODUCTION
The Centers for Medicare and Medicaid Services (CMS) identified the top ten most frequent survey
deficiencies cited during Medicare hospice recertification surveys for federal fiscal year 2009-2010. This compliance tip sheet will:

✓ List the survey deficiency by corresponding Medicare Hospice Condition of Participation* (CoP) and by Hospice Program Interpretive Guidance** L-Tag.
✓ Provide an example of the deficiency based on actual CMS survey deficiency data.
✓ Provide suggestions for regulatory compliance.
✓ List the standard and practice example from the NHPCO Standards of Practice for Hospice Programs (2010) related to the cited deficiency.

*The Medicare Hospice Conditions of Participation (2008) (CoPs) contain the federal regulations that govern all Medicare-certified hospice programs.

**The State Operations Manual, Appendix M – Guidance to Surveyors: Hospice (2010) contains guidance to personnel conducting surveys of hospices. It serves to explain the intent of the Medicare Hospice Conditions of Participation through “L-tags” that correspond to each CoP. Surveyors are required to use the Guidance to Surveyors – also referred to as Interpretive Guidelines – in assessing compliance with Federal requirements. The purpose of the Interpretive Guidelines Surveyor Procedures and Probes is to provide the surveyor with direction to prepare for the survey, conduct the survey and evaluate the results.

CMS TOP TEN HOSPICE SURVEY DEFICIENCIES

The top ten hospice survey deficiencies listed in order of the most frequently cited are:

1. Medicare Hospice CoP: §418.56(c) Standard: Content of the plan of care.
   The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:
   Interpretive Guidelines L-Tag: L545

   All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient’s needs if any of them so desire.
   Interpretive Guidelines L-Tag: L543
3. **Medicare Hospice CoP: 418.56(d) Standard: Review of the plan of care.**
   The hospice interdisciplinary group (in collaboration with the individual’s attending physician, if any) must review, revise and document the individualized plan as frequently as the patient’s condition requires, but no less frequently than every 15 calendar days.
   **Interpretive Guidelines L-Tag: L552**

4. **Medicare Hospice CoP: 418.64(b) Standard: Nursing services.**
   (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient’s initial assessment, comprehensive assessment, and updated assessments.
   **Interpretive Guidelines L-Tag: L591**

5. **Medicare Hospice CoP: 418.76(h) Standard: Supervision of hospice aides.**
   (1) A registered nurse must make an on-site visit to the patient’s home:
   (i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient’s needs. The hospice aide does not have to be present during this visit.
   **Interpretive Guidelines L-Tag: L629**

6. **Medicare Hospice CoP: 418.54(c)(6) – Drug profile.**
   A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:
   (i) Effectiveness of drug therapy
   (ii) Drug side effects
   (iii) Actual or potential drug interactions
   (iv) Duplicate drug therapy
   (v) Drug therapy currently associated with laboratory monitoring.
   **Interpretive Guidelines L-Tag: L530**

7. **Medicare Hospice CoP: 418.54(d) Standard: Update of the comprehensive assessment.**
   The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual’s attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient’s progress toward desired outcomes, as well as a reassessment of the patient’s response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.
   **Interpretive Guidelines L-Tag: L533**

8. **Medicare Hospice CoP: 418.54(c)(3) - Measurable outcomes anticipated from implementing and coordinating the plan of care.**
   **Interpretive Guidelines L-Tag: L548**

9. **Medicare Hospice CoP: 418.54(b) Standard: Timeframe for completion of the comprehensive assessment.**
   The hospice interdisciplinary group, in consultation with the individual’s attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24.
   **Interpretive Guidelines L-Tag: L523**

10. **Medicare Hospice CoP: 418.104(b) Standard: Authentication.**
    All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.
    **Interpretive Guidelines L-Tag: L679**
1. **Medicare Hospice CoP: §418.56(c) Standard: Content of the plan of care.*

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<td>Comprehensive assessment documentation shows that Patient A is allergic to medication X. However, review of the plan of care reveals that medication X is currently listed as medication for Patient A.</td>
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**Interpretive Guidelines Surveyor Procedures and Probes §418.56(c)**

Determine through interview/observation and record whether the plan of care identifies all of the services needed to address problems identified in the initial, comprehensive and updated assessments.

- Is there evidence of patients receiving the medication/treatments ordered?
- Are plans of care individualized and patient-specific?
- Does the plan of care integrate changes based on assessment findings?
- Is there documentation to support that the development of the plan of care was a collaborative effort involving all members of the IDG and the attending physician, if any? The attending physician and the IDG members do not have to sign the plan of care but there must be documentation of their involvement.

*See the NHPCO Standards of Practice for Hospice Programs (2010) Clinical Excellence and Safety (CES) for a complete list of standards and practice examples.

**Standard: Clinical Excellence and Safety (CES) 4.2**

A patient-specific medication profile is maintained and periodically reviewed to monitor for medication effectiveness, actual or potential medication-related effects and untoward interactions.

**CES 4 Practice Examples**

- The hospice nurse reviews all written medication information with the family and/or caregivers.
- The pharmacist provides consultation regarding complex medication regimens and educational opportunities and updates for the hospice team members.
- Incident reports regarding medication errors are completed.

**Suggestions for Compliance**

1. Ensure organization policies and procedures describe:
   a. The process for individualization of the plan of care for each patient.
   b. Standards for collaborative care planning with the IDG and the attending physician; ensure that staff understand and can verbalize this process.
2. Audit for compliance.
   a. Perform an audit of admission and recertification records to assess and ensure consistency of interdisciplinary group (IDG) documentation.
   b. Evaluate physician orders, frequency of visits by discipline, and plans of care.
   c. Review 10% of the active records per month and 5% of the discharge records per month to assure compliance with individualized plans of care.
   d. Review records across the continuum of care; start with records from when a patient was newly admitted and review that patient’s records through the last 2-3 weeks of life to verify that the care plan is evolving as the patient needs change.
3. Audit medication orders and lists to assure documentation is consistent with current treatment.
   a. Examples of deficiency:
      - Wound care orders are not consistent with current treatment.
      - Failure to record the change in location of care order when moving a patient to general inpatient care.
b. Validate all items of the patient’s medications record on the plan as changes occur and minimally every 15 days during the update of the comprehensive assessment and plan of care.

4. Ensure that each plan of care is individualized when using electronic health records (EHR).
   a. Use the text field to add detail about the patient during a visit.
   b. Build in requirements for individualized comments into EHR care plans. Incorporate multiple interventions as blank areas where the IDG team member must type in specific information for each patient.
   c. Consider color coding the patient’s plan of care to highlight active problems, interventions and outcomes; when reviewing the plan of care, it should be clear which care plan pieces were updated during each visit.

5. Updates to comprehensive assessments should be reflected in care plans; avoid repetitive use of standard phrases or comments.

6. Suggestion for Managers: review a patient’s plan of care, and then accompany a staff member on a visit to that patient.
   a. Does the visit and patient interview reflect that the patient/family is receiving the services the team identified as appropriate?
   b. Are the services provided tailored to the needs of the patient/family or to the needs of the team?

7. Use the NHPCO Standards of Practice for Hospice Programs, referencing both the standard and the practice examples as models for survey preparedness.

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| All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient’s needs if any of them so desire. | • Clinical record review revealed that plans of care for most patients are identical, regardless of the diagnosis.  
• The IDG failed to establish an individualized written plan of care in collaboration with the attending physician, the patient and/or patient’s representative. |

*See the NHPCO Standards of Practice for Hospice Programs (2010) Patient and Family-Centered Care (PFC) and Workforce Excellence (WE) for a complete list of standards and practice examples.

Standard: Patient and Family-Centered Care (PFC) 4.3
The plan of care is based on the following data:
1. Patient/family goals for care;
2. Primary and secondary diagnosis and any co-morbidities;
3. Current medical findings, including clinical indicators and data to support the terminal prognosis; and
4. Interdisciplinary team assessments of the patient’s symptoms, patient, family and caregiver functional status, patient, family and caregiver coping status, cultural issues, special needs of veterans and their families, and family resource status.

PFC 4 Practice Examples
✓ The plan of care includes the patient’s and family’s problems, issues, opportunities, related interventions and desired outcomes, and the scope and frequency of services to be provided.
Assessment activities performed by the interdisciplinary team members are included in the plan of care and direct the determination of problems, opportunities, interventions and desired outcomes.

The plan of care is documented and communicated to all team members involved in providing care and services to the patient and family.

**Standard: Workforce Excellence (WE) 14.1**

Hospice nursing services include:

1. Development of an individualized plan of care based on the assessment;
2. Assessing all aspects of the patient’s pain and developing an individualized pain management plan;

**WE 14 Practice Examples**

- A complete physical assessment is performed and documented for each patient upon admission.
- Each nursing visit includes a reassessment of the patient’s physical status.
- The hospice nurse documents the patient’s pain assessment and related interventions on each visit note.

**Suggestions for Compliance**

1. Ensure organization policies and procedures describe:
   a. Standards for documenting teamwork among physicians, the IDG and patients to create a plan of care based on the needs of the patient that honors the patient/family statements regarding goals.
   b. Standards for documenting communication between the attending physician and hospice physician in the clinical record and during the update of the plan of care process.

2. Audit for compliance.
   a. Perform monthly plan of care audits to ensure all components of the POC regulations are met.
   b. Ensure that documentation supports that care was delivered according to the plan of care. Could a hospice provider deliver care according to the plan of care if (s)he did not know the patient?
   c. Does the visit frequency made match the visit frequency on the plan of care? Do all patients get the same number of visits?
   d. Review records for documentation of patient/family involvement. Does documentation note staff response to requested, recommended or actual changes? How does the staff respond if recommendations are declined?

3. Review care plans to ensure that documented goals and interventions reflect collaboration with the interdisciplinary group (IDG), attending physician, patient/caregiver, and facility staff, if appropriate.
   a. Complete a review of the plan of care during the IDG meeting and change the plan of care interventions per the updates to the comprehensive assessment.
   b. Complete and document a review of the plan of care with the family after the IDG meeting.
   c. Does information on the plan of care align with outcomes of the comprehensive assessment?
   d. Is there documented evidence that the attending physician is notified when the patient’s care requires changes to the plan of care?

4. Document all care plan updates! Voicemails to IDG members of plan of care changes are usually not recorded in the clinical record.

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3. **Medicare Hospice CoP: §418.56(d) Standard: Review of the plan of care.**

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<tr>
<td>The hospice interdisciplinary group (in collaboration with the individual’s attending physician, if any) must review, revise and document the</td>
<td>• Inconsistent documentation of plan of care updates</td>
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<td></td>
<td>• Missing documentation of plan of care updates</td>
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individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days.

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<td>Communication with the attending physician may be through phone calls, electronic methods, orders received, or other means according to hospice policy and patient needs.</td>
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*See the NHPCO Standards of Practice for Hospice Programs (2010) Patient and Family-Centered Care (PFC) for a complete list of standards and practice examples.

Standard: Patient and Family-Centered Care (PFC) 6.1
The plan of care is reviewed by the interdisciplinary team no less than every 15 calendar days and documented on the patient’s clinical record.

Standard: Patient and Family-Centered Care (PFC) 6.2
The interdisciplinary team revises the plan of care as often as needed to reflect changes in the patient’s and family’s status and needs.

PFC 6 Practice Examples
✓ The patient, family and caregiver plan of care is reviewed regularly during the interdisciplinary team meeting.
✓ The plan of care is updated whenever there is a change in the patient’s and family’s condition that alters their status or needs (e.g., inpatient placement, new onset or increased severity of symptoms, caregiving crisis, inadequate financial resources, etc.).
✓ Significant information obtained during the patient and family’s reassessment that affects the plan of care is immediately shared with other interdisciplinary team members and the plan of care is revised accordingly.
✓ Documentation supports collaboration by team members as the plan of care is revised in response to the patient and family’s reassessment.

Suggestions for Compliance
1. Ensure organization policies and procedures describe:
   a. The process of plan of care collaboration with the attending physician and IDG staff. (Does your staff know the process and can they articulate it?)
   b. The process of updating the plan of care, including the use of updates to the comprehensive assessment to update the plan of care.
   c. That the review of the plan of care is completed as the patient’s status requires or minimally every 15 calendar days.
2. Audit for compliance.
   a. Review documentation of IDG meetings to update the patient’s plan of care against individual patient notes.
      • Were all changes captured?
      • Is the plan of care individualized?
   b. Ensure that care plan goals and interventions reflect collaboration with the IDG, attending physician, patient/caregiver, and facility staff.
   c. Ensure that goals for the plan of care are measurable and that clinical notes support progress towards goals.

4. Medicare Hospice CoP: §418.64(b) Standard: Nursing services.*

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<td>(1) The hospice must provide nursing care and services by or under the supervision of a registered RN.</td>
<td>• Nursing services provided without consistent supervision by a RN.</td>
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CMS Top Ten Survey Deficiencies
Compliance Recommendations

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<th>Nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient’s initial assessment, comprehensive assessment, and updated assessments.</th>
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<td>• LPN placed in the position of independently assessing patient’s changing status, modifying treatments and assessing for the need of increased levels of care for symptom management.</td>
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<tr>
<td>• No documentation in the clinical record indicating that an RN assessed and directed changes to the patient’s symptom management and plan of care orders, nor documentation to show how a RN was supervising and directing the LPN.</td>
</tr>
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*See the NHPCO Standards of Practice for Hospice Programs (2010) Workforce Excellence (WE) for a complete list of standards and practice examples.

**Standard: Workforce Excellence (WE) 14.1**

Hospice nursing services include:

1. Assessing the patient’s and family’s physical, psychosocial, environmental, safety and developmental needs;
2. Assessing all aspects of the patient’s pain and developing an individualized pain management plan;
3. Anticipating, preventing and treating undesirable symptoms or secondary symptoms;
4. Documenting problems, nursing assessments, appropriate goals, care provided, care interventions and patient and family outcomes;
5. Coordinating all patient and family services with the team;

**WE 14 Practice Examples**

- A complete physical assessment is performed and documented for each patient upon admission.
- Each nursing visit includes a reassessment of the patient’s physical status.
- The hospice nurse documents the patient’s pain assessment and related interventions on each visit note.

**Suggestions for Compliance**

1. Ensure organization policies and procedures describe:
   a. Required frequency of Registered Nurse (RN) visits to supervise Licensed Practical Nurse (LPN) and Licensed Vocational Nurse (LVN) care.
      - Ensure that RN supervision of LPN/ LVN activity occurs per the appropriate state nurse practice act, if applicable*.
2. Audit for compliance.
   a. RN and LPN/LVN visit frequency and interventions should be defined in the patient’s plan of care, including RN supervisory visits of the LPN/LVN. Be specific about what care has been delegated by the RN to the LPN/LVN.
   b. Review the records to verify that the frequency of nursing visits and updates to the comprehensive assessment are consistent with identified patient needs; if this is not the case, documentation must reflect that the patient/family declined nurse recommendations.
   c. If the hospice utilizes LPN/LVN staff, review the records to assure:
      - There is evidence of communication between the LPN/ LVN and the RN regarding changes in the patient status and orders.
      - There are RN visits to the patient for assessment and identification of patient nursing needs.
      - Make certain that RNs demonstrate competency in conducting initial and comprehensive assessments and ongoing care.
   d. Ensure that all nurses provide care in accordance with the patient’s plan of care.

* Allowable practice, practice limitations, and supervisory requirements for LPN’s/LVN’s are outlined in a state’s nurse practice act.

View state nurse practice acts at: [http://www.nhpco.org/custom/iMAP1123/index.htm](http://www.nhpco.org/custom/iMAP1123/index.htm)

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<td>(1) A registered nurse must make an on-site visit to the patient’s home:</td>
<td>Clinical documentation revealed missing or late documentation of hospice aide supervision visits by the RN every 14 days.</td>
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<td>(i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient’s needs. The hospice aide does not have to be present during this visit.</td>
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Interpretive Guidelines Surveyor Procedures and Probes §418.76(h)(1)(i)

If the RN makes a supervisory visit on a Tuesday, the next supervisory visit is due by the Tuesday which occurs 14 days later.

In addition to ensuring that hospice aides furnish the care identified in the plan of care, RN supervisors must assess the adequacy of the aide services in relationship to the needs of the patient and family. In-person visits by the supervising nurse to the patient’s home allow the nurse to directly observe the patient and the results of the aide’s care. The supervisory visits must be documented in the patient’s clinical record.

*See the NHPCO Standards of Practice for Hospice Programs (2010) Workforce Excellence (WE) for a complete list of standards and practice examples.

Standard: Workforce Excellence (WE) 19
Hospice aide services are based on the registered nurse’s initial and ongoing assessments of the patient’s personal care needs, ability to perform activities of daily living and supervision of care.

WE 19 Practice Example
✓ The hospice nurse completes a form that communicates the patient’s needs and duties to be performed by the hospice aide.

Standard: Workforce Excellence (WE) 20.2
The hospice nurse visits the home at least every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient’s needs. The hospice aide does not have to be present during this visit unless required by state law.

WE 20 Practice Examples
✓ The nursing visit note form includes a checklist to document an evaluation of the hospice aide’s services during each nursing visit.
✓ The nurse investigates and addresses the stated concerns when the patient or family expresses dissatisfaction with hospice aide’s services.

Suggestions for Compliance
1. Ensure organization policies and procedures describe:
   a. That RN supervision of hospice aide activity occurs per state hospice regulations. Some states require that the aide be present during supervision.
   b. A process for tracking the due date of the aide supervision visit for each patient.
2. Provide a space on the Nursing Assessment to verify that the patient and family were consulted regarding their satisfaction with the patient care. Visual inspections and onsite observations should be placed on the nursing assessment on a weekly basis.
3. Audit for compliance.
a. Review records of patients receiving hospice aide services; verify that aide supervision is occurring no less frequently than every 14 days. **NOTE:** Supervision must be consistent with federal or state regulations - whichever is more stringent.

4. Both the hospice aide and the supervising RN should track aide supervision visits.
   a. Consider documenting whether aide supervision occurred for each weekly visit.

6. **Medicare Hospice CoP:** §418.54(c)(6) – Drug profile.*

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<td>• Incomplete drug profiles. • Lack of documentation regarding drug side effects, along with actual or potential drug interactions. • Lack of a complete review of all of the elements required for an appropriate drug profile review.</td>
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**Interpretive Guidelines §418.54(c)(6)**

In reviewing the patient’s prescribed and over-the-counter medications and any additional substance that could affect drug therapy, the hospice must consider drug effectiveness, side effects, interactions of drugs, duplicate drugs and drugs associated with laboratory testing which could affect the patient. In addition, the hospice should consider both the use of pharmacological and non-pharmacological interventions to promote the patient’s comfort level and sense of well being based on the assessment of patient needs and desires.

**Medication interaction** is the impact of another substance (such as another medication, nutritional supplement (including herbal products), food, or substances used in diagnostic studies) upon a medication’s action. The interactions may alter absorption, distribution, metabolism, or elimination. These interactions may decrease the effectiveness of the medication or increase the potential for adverse consequences.

**Duplicate therapy** refers to multiple medications of the same pharmacological class/category or any medication therapy that substantially duplicates a particular effect of another medication that the individual is taking.

**Non-pharmacological interventions** refers to approaches to care that do not involve medications, generally directed towards stabilizing or improving a person’s mental, physical or psychosocial well being.

There should be evidence in the clinical record that common side effects of medications are anticipated and preventive measures are implemented. The hospice should review each patient’s medications and monitor for medication effectiveness, actual or potential medication-related effects, duplicate drug therapy and untoward interactions during each update to the comprehensive assessment, and as needed as new medications are added or changed, or the patient’s condition changes.

**Interpretive Guidelines Surveyor Procedures and Probes §418.54(c)(6)**

Ask clinical staff to describe their process/policy of drug regimen/medication review including:

- How potential adverse effects and drug reactions are identified?
- What process is followed when a patient/family is found to be noncompliant?
- What non-pharmacological methods are considered to relieve pain and other symptoms?
- How patients and families are educated about effective pain and symptom management.
- What process the hospice utilizes to assess and measure pain and other uncomfortable symptoms.
- What procedures or protocols the hospice uses to reassess pain and symptom management.
- How the hospice monitors a patient when they begin a new medication, increase/ decrease a
dosage or discontinue a medication.

During the home visit, ask the patient/caregiver what medications (prescription and over-the-counter drugs, herbal remedies, etc.) the patient is currently taking and compare this information with the medications documented within the plan of care. Are the patient’s preferences/goals for pain management and symptom control followed and achieved?

*See the NHPCO Standards of Practice for Hospice Programs (2010) Clinical Excellence and Safety (CES) for a complete list of standards and practice examples.

**Standard: Clinical Excellence and Safety (CES) 4.2**
A patient-specific medication profile is maintained and periodically reviewed to monitor for medication effectiveness, actual or potential medication-related effects and untoward interactions.

**CES 4 Practice Examples**
- The pharmacist provides consultation regarding complex medication regimens and educational opportunities and updates for the hospice team members.
- The hospice nurse reviews all written medication information with the family and/or caregivers.
- The hospice nurse notifies the pharmacist regarding the patient’s condition and estimates the amount of refill appropriate to the patient’s needs.
- Incident reports regarding medication errors are completed.

**Suggestions for Compliance**

1. Ensure organization policies and procedures describe:
   a. Review of drug profiles by an individual with education and training in drug management; drug profiles must include documentation of:
      - Medication Interaction
      - Duplicate therapies
      - Non-pharmacological interventions
   b. Required documentation of a drug review and reconciliation of all medications in the home at each clinical visit.
   d. Pain assessment and re-assessment.
2. Provide updated staff training on completing drug profiles and ensure forms and documentation support requirements.
3. Audit for compliance.
   a. Ensure that the patient’s drug profile is current at all times in the clinical record and in the home.
   b. Ensure that an updated drug profile is part of the update to the plan of care.
   c. Conduct an audit of medical records to make certain that each patient’s comprehensive assessment includes an accurate drug profile.
   d. Review records of patients on Opioid therapy – are there appropriate bowel regime medications also on the patient medication list?
   e. Use pharmacy benefit manager medication lists to compare with current patient medication lists for accuracy of medications.
   f. Randomly audit patient records to determine if staff is adhering to organizational policies and procedures regarding pain assessment and reassessment. Emphasize to staff that this is a risk management issue as well as a care planning issue.

**Interpretive Guidelines L-Tag: L533**

Example of Deficiency:

Inconsistent or missing documentation that the comprehensive assessment was updated as the patient's status required and/or at least every 15 days.

The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.

**Interpretive Guidelines §418.54(d)**

Hospices are free to choose their own method for documenting updates to the assessment. The hospice should evaluate and document the patient's response to the care, treatment and services provided, and progress toward desired outcomes. The purpose of updating the assessment is to ensure that the hospice IDG has the most recent accurate information about the patient/family in order to make accurate care planning decisions. Assessment updates should be easily identified in the clinical record.

Hospices are required to update the comprehensive assessment as frequently as the condition of the patient requires, which may be more frequently than every 15 days. The hospice must ensure that each update is completed no later than 15 days from the previous one. Hospices are not required to complete, in full, those documents that they identified as comprising their comprehensive assessment every 15 days, although hospices are free to do so if they so choose.

They are required to identify and document if there were no changes in the patient/family condition or needs. There should be evidence that the IDG identifies through its ongoing assessments when a change is needed to the plan of care and evidence that the patient/family receives the care and services necessitated by the change.

**Interpretive Guidelines Surveyor Procedures and Probes §418.54(d)**

Determine through interview, observation and record review if there is evidence that all members of the IDG are actively involved in evaluating the patient's care, so that the patient receives the benefit of the full IDG’s assessment.

*See the NHPCO Standards of Practice for Hospice Programs (2010) Patient and Family-Centered Care (PFC) and Clinical Excellence and Safety (CES) for a complete list of standards and practice examples.

**Standard: Patient and Family-Centered Care (PFC) 2.5**

Ongoing, patient-specific comprehensive assessments are completed to accurately reflect the patient’s current health status and needs and the interdisciplinary team’s services are adjusted as required by the patient and family’s needs.

**PFC 2 Practice Example**

- The patient/family/caregiver’s needs are assessed utilizing available tools (e.g., NHPCO’s A Pathway for Patients and Families Facing Terminal Illness) throughout the course of care and the plan of care.

**Standard: Clinical Excellence and Safety (CES) 1.5**

The comprehensive assessment is updated as frequently as the condition of the patient requires but no less frequently than every 15 days and at the time of recertification.

**Suggestions for Compliance**

1. Ensure organizational policies and procedures describe:
a. How the patient's comprehensive assessment is updated.
b. How the update is documented and identified in the clinical record.
c. That the update is completed as the patient's status requires and at least every 15 days.

2. Ensure there is evidence that the comprehensive assessment documents progress or lack of progress toward goals listed in the plan of care.

3. Audit for compliance.
   a. Conduct a review of medical records to ensure that the comprehensive assessment of each patient is updated every 15 days or more frequently if needed.
   b. Audit services provided by various disciplines of IDG staff.
   c. Review records of short length of stay patients to assess who was involved in providing services.
   d. Review records of hospital discharge patients or other patient types known to have been dealing with high stress situations; is there evidence in the record that the patient and family are benefitting from the full IDG?

8. Medicare Hospice CoP: §418.56(c)(3) - Measurable outcomes anticipated from implementing and coordinating the plan of care.*

<table>
<thead>
<tr>
<th>Interpretive Guidelines L-Tag: L548</th>
<th>Example of Deficiency</th>
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<tbody>
<tr>
<td>The outcomes should be a measurable result of the implementation of the plan of care. The hospice should be using data elements as a part of the plan of care to see if they are meeting the goals of care.</td>
<td>Inconsistent documentation or missing documentation of measurable outcomes on the plan of care.</td>
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<tr>
<th>Interpretive Guidelines Surveyor Procedures and Probes §418.56(c)(3)</th>
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<tbody>
<tr>
<td>Are the outcomes documented and measurable? Look for movement towards the expected outcome(s) and revisions to the plan of care that have been made to achieve the outcomes.</td>
</tr>
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</table>

*See the NHPCO Standards of Practice for Hospice Programs (2010) Patient and Family-Centered Care (PFC) for a complete list of standards and practice examples.

**Standard: Patient and Family-Centered Care (PFC) 4.4**
The plan of care includes the:
1. Desired goals or outcomes;
2. Patient's and family's problems/issues/needs and opportunities for growth;
3. Interventions directed to achieve the desired goals or outcomes of the patient, family and interdisciplinary team;
4. Scope, frequency and type of services to be provided, including the interdisciplinary team interventions, pharmaceuticals and medical equipment to be provided; and
5. Other agencies or organizations which may be involved in the care.

**PFC 4 Practice Example**
✓ The plan of care includes the patient's and family's problems, issues, opportunities, related interventions and desired outcomes, and the scope and frequency of services to be provided.

**Suggestions for Compliance**
1. Ensure organizational policies and procedures describe:
   a. Defined measurable outcomes.
      - Ensure that the IDG members understand what a measurable outcome is and how it relates to assessment, service provision and coordination of care.
      - Develop good examples and practice cases for new staff training and current staff practice review.
      - Include measurable outcomes in your QAPI program.
b. That outcome measures are established at the time of admission and that progress toward goals is to be evaluated/updated at every patient contact.

2. Develop plans of care templates with measurable outcomes as a requirement.

3. Audit for compliance.
   a. Prior to or at IDG meetings, the clinical leader should review a random sample of care plans to validate that outcomes are documented and measurable.
   b. Conduct a monthly review of clinical records to ensure that plans of care include measurable outcomes and that each clinical note includes documentation of progress toward specific goals/outcomes indicated on the plan of care, e.g. documented use of symptom measurement scales in clinical notes.

9. Medicare Hospice CoP: §418.54(b) Standard: Timeframe for completion of the comprehensive assessment.*

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<th>Interpretive Guidelines L-Tag: L523</th>
<th>Examples of Deficiency</th>
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| The hospice interdisciplinary group, in consultation with the individual’s attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24. | • Inconsistent or missing documentation of all components of the comprehensive assessment, including physical, psychosocial, emotional, and spiritual needs within 5 calendar days after the election of hospice care.  
• Lack of documentation indicating that the RN consulted the IDG members to complete the comprehensive assessment within 5 calendar days after the election of hospice care. |

Interpretive Guidelines §418.54(b)

All members of the IDG must be involved with completing the comprehensive assessment in order to identify the patient/family’s physical, psychosocial, emotional and spiritual needs and contribute to the development of the plan of care to address those needs. The individuals/disciplines that complete the assessment should be consistent with the hospice’s own policies and procedures and the discipline’s scope of practice. The RN, in consultation with the other members of the IDG, considers the information gathered from the initial assessment as they develop the plan of care and the group determines who should visit the patient/family during the first 5 days of hospice care in accordance with patient/family needs and desires and the hospice’s own policies and procedures.

The patient may or may not have an attending physician. If the attending physician is unavailable or unresponsive, the hospice physician must assume this role. If the patient does have an attending physician, one or more members of the IDG should consult with this physician in completing the comprehensive assessment. This consultation can occur through phone calls or other means of communication (Fax, e-mails, text messages, etc.,) and will help to acquire a better understanding of the patient and family. Attending physicians can often provide a history of the patient’s disease process and family dynamics that can help the hospice make better care planning decisions that address all areas of need related to the terminal illness and related conditions, resulting in improved patient outcomes.

The “election of hospice care” is the effective date of the election statement. The patient may sign the hospice election statement with a later (not earlier) effective date. Hospices may choose to complete the comprehensive assessment earlier than 5 days after the effective date of the election (e.g., it may complete the comprehensive assessment at the same time the initial assessment is completed).

* See the NHPCO Standards of Practice for Hospice Programs (2010) Clinical Excellence and Safety (CES) for a complete list of standards and practice examples.
The interdisciplinary group, in consultation with the individual’s attending physician, completes the comprehensive assessment within five calendar days of the effective date of the Notice of election.

**CES 1 Practice Examples**
- The hospice includes assessment of common co-morbid conditions as part of the initial nursing assessment.
- There is an interdisciplinary assessment tool.

**SUGGESTIONS FOR COMPLIANCE**

1. Ensure organization policies and procedures describe:
   a. The process for completion of the comprehensive assessment.
   b. The timeframe for the completion of the comprehensive assessment by the IDG.
   c. The process to address urgent needs of the patient/family.
   d. The process for assessment if a member of the IDG is refused.

2. Audit for compliance.
   a. Conduct a monthly review of clinical records to ensure that the comprehensive assessment is completed within 5 days after the effective date of the notice of election.
   b. Review records for patients admitted in the last 7-14 days; start with the initial nursing assessment and care plan (or similar documents as defined by organization policies and procedures).
   c. Are the disciplines visiting or working on behalf of the patient/family in the first 5 days consistent with issues identified at admission?
   d. Does every record look the same? (Example: nursing visits occur during the first week, but there is no contact by the social worker or spiritual counselor.)

3. Establish clinical oversight to track compliance during patient care delivery.

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**10. Medicare Hospice CoP: §418.104(b) Standard: Authentication.***

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<tr>
<th>Interpretive Guidelines L-Tag: L679</th>
<th>Examples of Deficiency</th>
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<td>All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.</td>
<td>• Inconsistent entries by IDG staff in the clinical record.</td>
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<td>• IDG staff use of abbreviations not on the agency’s approved abbreviation list.</td>
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**Interpretive Guidelines §418.104(b)**

A hospice may create its own policy on authentication of clinical records based on accepted standards of practice. Hospices must follow State laws regarding authentication of clinical records, and within this context, alter their policies as often as necessary to adapt to changing technologies and practices.

Medicare requires a legible identifier for services provided/ordered. This method must be handwritten (not stamped) or an electronic signature to sign an order or other clinical record documentation. The noted exception is that facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice. Stamped signatures are not acceptable.

Providers and physicians using electronic signatures should recognize that there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and software products that are protected against modification, etc., and should apply administrative procedures that are adequate and correspond to recognized standards and laws. The individual whose name is on the alternate signature method as well as the provider bear the responsibility for the authenticity of the information to which they have attested. Physicians should check with their attorneys and malpractice insurers in regard to the use of alternative signature methods.
Hospices may not accept stamped physician signatures on orders, treatments, or other documents that are a part of the patient's clinical record.

Surveyors must have access to clinical records. If the record is maintained electronically, the hospice must provide all equipment necessary to read the record in its entirety. The hospice must also produce a paper copy of the record, if requested by the surveyor.

All State licensure and State practice regulations continue to apply to Medicare-approved hospices. Where State law is more restrictive than Medicare, the hospice needs to apply the State law standard.

Interpretive Guidelines Procedures and Probes §418.104(b)

Ask the hospice to explain their system of authentication. Verify that at a minimum it includes the following safeguards:

- The hospice has a method to identify the author of each entry. This would include verification of the author of faxed orders/entries or computer entries.
- If the hospice is using electronic medical records, electronic authentication must have a user ID and password protections in place.
- Every entry, both written and electronic, must be signed and dated by the person performing the service.

See the NHPCO Standards of Practice for Hospice Programs (2010) ‘Compliance with Laws and Regulations (CLR)’ for a complete list of standards and practice examples.

Standard: Compliance with Laws and Regulations (CLR) 3.1
There are written policies and procedures that address the content, maintenance, security, storage, retention and access to hospice clinical records. These policies and procedures conform to all state and federal laws.

Standard: Compliance with Laws and Regulations (CLR) 3.2
A standardized format is used to document the services provided in all care settings.

Standard: Compliance with Laws and Regulations (CLR) 3.3
Documentation in the hospice clinical record is descriptive, timely, and accurate.

CLR 3 Practice Example
- The hospice maintains a comprehensive, timely, and accurate clinical record of services provided in all care settings for each patient and family.

Suggestions for Compliance
1. Ensure organization policies and procedures describe:
   a. Standards for documentation accuracy, consistency, legibility.
   b. Standards for contracted staff documentation.
   c. Standards for authentication of technical documents, such as consent forms/elections and certification narratives.
   d. The process and standards for correcting errors on documentation.
2. Audit for compliance.
   a. Conduct a monthly review of clinical records to ensure that clinical documentation has appropriate, legible signatures.
   b. Review for entries and legibility should be incorporated into the IDG meetings.
WORKS CITED


Special thanks to the NHPCO Regulatory Committee for the development and review of this resource.