CMS FY 2010 Top Ten Hospice Survey Deficiencies

Introduction

The Centers for Medicare and Medicaid Services (CMS) identifies the top ten most frequent survey deficiencies cited during Medicare hospice recertification surveys annually. This compliance tip sheet will:

- List the survey deficiency by Medicare hospice Condition of Participation* (CoP) and by Hospice Program Interpretive Guidance** L-Tag from federal Fiscal Year 2010.
- Provide an example of the deficiency based on actual CMS survey deficiency data.
- Provide suggestions from a clinical, documentation, and administrative perspective for 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) contain the federal regulations that govern all Medicare-certified hospice programs.

** The Hospice Program Appendix M: Interpretive Guidelines (2010) are guidance to personnel conducting surveys of hospices, and serve to clarify and/or explain the intent of the regulations. All surveyors are required to use them in assessing compliance with Federal requirements. The purpose of the protocols and guidelines is to direct the surveyor’s attention to avenues of investigation in preparation for the survey, conducting the survey and evaluating the survey findings.

CMS FY 2010 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(b) Standard: Plan of care.**
   
   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**

2. **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.

**Interpretive Guidelines L-Tag: L545**

3. **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**

4. **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**

5. **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**

6. **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**

7. **Medicare hospice CoP: §418.56(c)(2) Standard: Scope and frequency of services.**
   A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.

**Interpretive Guidelines L-Tag: L547**

8. **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**
9. **Medicare hospice CoP: §418.114(d) Standard: Criminal background checks.**
The hospice must obtain a criminal background check on all hospice employees who have direct patient contact or access to patient records. Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records.
*Interpretive Guidelines L-Tag: L548*

10. **Medicare hospice CoP: §418.64(d) Standard: Counseling services - Bereavement counseling.**
   (1) **Bereavement counseling. The hospice must:**
   (i) Have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling
   (ii) Make bereavement services available to the family and other individuals in the bereavement plan of care up to 1 year following the death of the patient. Bereavement counseling also extends to residents of a SNF/NF or ICF/MR when appropriate and identified in the bereavement plan of care
   (iii) Ensure that bereavement services reflect the needs of the bereaved.
   (iv) Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery.
*Interpretive Guidelines L-Tag: L596*

1. **Medicare hospice CoP: §418.56(b) Standard: Plan of care.**

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<thead>
<tr>
<th>Interpretive Guidelines L-Tag: L543</th>
<th>Examples of Deficiency:</th>
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<tbody>
<tr>
<td>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.</td>
<td>The plan of care listed the hospice aide visit frequency for 5 visits per week.</td>
</tr>
<tr>
<td>See the NHPCO <em>Standards of Practice for Hospice Programs (2010)</em> Patient and Family-Centered Care (PFC) for a complete list of standards and practice examples.</td>
<td>• The hospice aide visited 1x/week.</td>
</tr>
<tr>
<td>PFC 4: A written plan of care is developed for each patient, family and caregiver prior to providing care and services.</td>
<td>• There is no explanation for missed visits or the change in visit frequency in the clinical record.</td>
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<tr>
<td>PFC 4 Practice example:</td>
<td>Several patients are admitted with different terminal diagnoses.</td>
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<tr>
<td></td>
<td>• The plan of care for each patient showed 25 PRN visits for nurse, hospice aide and social worker.</td>
</tr>
</tbody>
</table>
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. Clinical compliance:**
   a. Ensure that all members of the interdisciplinary group (IDG) have access to the patient’s current plan of care.
   b. Ensure that the IDG provides care and visits per the visit frequency listed on the patient’s plan of care.
   c. Complete a review of the plan of care during the IDG meeting and change the plan of care visit frequency, interventions, etc., per the updates to the comprehensive assessment.
      i. A range of visits is acceptable as long as it continues to meet the identified needs of the patient and family.
      ii. Small intervals are acceptable (i.e. 1-3 visits/week; 2-4 visits/week) but ranges that include “0” as a frequency are not allowed.
      iii. If the patient requires frequent use of PRN visits, the plan of care should be updated to include the need for additional visits.

**2. Documentation compliance:**
   a. If the visit frequency on the patient’s plan of care was not followed, be sure that the IDG documents the reason.
   b. The IDG may change the visit frequency or exceed the number of visits in the visit range to address patient and family needs.
      i. Ensure that there is documentation to support the adjusted visit frequency and that the entire IDG was informed about the adjustment.
   c. Document all care plan updates! Voicemails that alert IDG members of plan of care updates, for example, are usually not recorded in the clinical record.

**3. Audit compliance:**
   a. Audit for accuracy and consistency:
      i. Does the staff visit frequency match the visit frequency on the plan of care?
   b. Ensure that documentation supports that care was delivered according to the plan of care.
   c. Audit clinical records for documentation of all care plan updates!
2. Medicare hospice CoP: §418.56(c) Standard: Content of the plan of care.

**Interpretive Guidelines L-Tag: L545**

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<th>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.</th>
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<td><strong>Example of Deficiency</strong></td>
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Patient resided in an ALF and was assessed with multiple skin tears.
- Specific orders for wound care were included in the plan of care, but no frequency for the wound care was indicated.
- IDG notes and documentation showed no information regarding wound care, skin care or the fact that the patient resided in an ALF.

**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) Patient and Family-Centered Care (PFC) and Workforce Excellence (WE) for a complete list of standards and practice examples.

**PFC 4: A written plan of care is developed for each patient, family and caregiver prior to providing care and services.**

**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.

**Suggestions for Compliance**

1. **Clinical compliance:**
   a. Ensure that all problems identified during assessment are included on the patient’s plan of care and that they are updated during each visit and minimally every 15 days in the update to the comprehensive assessment.
   b. Be consistent in assessment, provision of care, and follow-up.
      - Example: If a skin assessment was completed at admission and a problem was identified, then there should be follow up skin assessment.

2. **Documentation compliance:**
   a. Consistency is crucial!
      i. Review previous visit notes when composing your current visit note to ensure that there is documentation addressing previously identified problems.
      ii. Determine whether documented problems are ongoing, resolved, etc.
   b. Updates to comprehensive assessments should be reflected in care plans; avoid repetitive use of standard phrases or comments.
   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.
   d. Bring the clinical record to IDG meetings and ensure that everyone has the same information and that it is documented the same way in the clinical record.

3. **Audit compliance:**
   a. Through interview, observation and record review, determine whether the plan of care identifies all of the services needed to address problems identified in the initial, comprehensive and updated assessments.
   b. Ensure that there is evidence of patients receiving the medication and treatments ordered.
   c. Ensure that the plan of care integrates changes based on assessment findings.
   d. Accompany IDG members on home visits to ensure consistency in the plan of care, the care delivered and visit notes.

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3. **Medicare hospice CoP: §418.76(h) Standard:**
   **Supervision of hospice aides.**

   **Interpretive Guidelines L-Tag: L629**

   **Example of Deficiency:**

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<td>(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</td>
<td>Supervision of hospice aides varied from 16 days to more than 30 days.</td>
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</table>
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 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. Clinical compliance:
a. 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.

b. 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.

2. **Documentation compliance:**
   a. Ensure organization policies and procedures describe RN supervision of hospice aide activity per state hospice regulations. Some states **require** that the aide be present during supervision.
   b. Provide a space on the Nursing Assessment to verify that the patient and family were consulted regarding their satisfaction with patient care. Visual inspections and onsite observations should be placed on the nursing assessment on a weekly basis.
   c. **Consider documenting supervision of the hospice aide at every visit to ensure timely compliance.**

3. **Audit compliance:**
   a. Initiate a central tracking process for due dates of hospice aide supervision.
   b. Review records of patients receiving hospice aide services; verify that aide supervision is occurring no less frequently then every 14 days. **NOTE:** Supervision must be consistent with federal or state regulations - whichever is more stringent.
   c. Both the hospice aide and the supervising RN should track aide supervision visits.

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| 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. | A patient was admitted with debility on 10/28/10.  
- The plan of care was updated 12/09/10 and then again on 12/29/10. |

**Interpretive Guidelines Surveyor Procedures and Probes §418.56(d)**

Communication with the attending physician may be through phone calls, electronic methods, orders received, or other means according to hospice policy and patient needs.

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. **Clinical compliance:**
   a. Ensure that the IDG is communicating and collaborating continuously regarding the patient’s care both internally and externally. Communication should include:
      i. the attending physician
      ii. community resources
      iii. the patient, caregiver and family
   b. Ensure that the patient, caregiver and family are included in the process to update the plan of care.

2. **Documentation compliance:**
   a. Document the review of the plan of care as the patient’s status requires or minimally every 15 calendar days.
   b. Any change in the patient’s condition which requires an update to the plan of care should be documented at the time of the change per the provider’s policy.
   c. The clinical record should include documentation that members of the IDG were informed regarding updates to the plan of care.
   d. Review documentation of IDG meetings to update the patient’s plan of care against individual notes. Were all changes captured? Is the plan of care individualized?
   e. Ensure that care plan goals and interventions reflect collaboration with the IDG, attending physician, patient and caregiver, and facility staff.
   f. Ensure that goals for the plan of care are measurable and that clinical notes support progress towards goals.

3. **Audit compliance:**
   a. Ensure organization policies and procedures describe:
      i. 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?)
ii. The process of updating the plan of care, including the use of updates to the comprehensive assessment to update the plan of care.

iii. That the review of the plan of care is completed as the patient’s status requires or minimally every 15 calendar days.

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

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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. | A patient was admitted to hospice on 12/6/10.  
- The psychosocial assessment was completed by a MSW on 12/23/10.  
- The initial assessment was completed by a chaplain on 1/20/11. |

**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.

**Standard: Clinical Excellence and Safety (CES) 1.2**
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. **Clinical compliance:**
   a. Ensure that IDG staff understand:
      i. The process for completion of the comprehensive assessment
      ii. That the timeframe for the completion of the comprehensive assessment by the IDG is 5
calendar days from the effective date of the notice of hospice election
      iii. The process to address urgent needs of the patient/ family
      iv. The process for assessment if a member of the IDG is refused

   **NOTE:** The comprehensive assessment is a process... not just a form. The comprehensive
assessment identifies the patient’s need for hospice care and services, and the patient’s need
for physical, psychosocial, emotional, and spiritual care. CMS allows a provider to develop the
process and the documentation of the outcomes of the comprehensive assessment.

2. **Documentation compliance:**
   a. The comprehensive assessment process should be documented in the clinical record within
      5 calendar days of the effective date of the notice of hospice election
   b. If the comprehensive assessment is in parts (i.e.: multiple forms), develop a tracking
      mechanism to ensure completion/ documentation within the specified timeframe
   c. Comprehensive assessment must be readily identifiable in the clinical record

3. **Audit compliance:**
   a. Ensure organization policies and procedures describe:
      i. The process for completion of the comprehensive assessment.
      ii. The timeframe for the completion of the comprehensive assessment by the IDG.
      iii. The process to address urgent needs of the patient/ family.
      iv. The process for assessment if a member of the IDG is refused.
   b. 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.
   c. 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).
d. Are the disciplines visiting or working on behalf of the patient/family in the first 5 days consistent with issues identified at admission?

e. 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.)

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

6. Medicare hospice CoP: §418.54(d) Standard: Update of the comprehensive assessment

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<td>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.</td>
<td>No evidence in clinical record that:</td>
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<td></td>
<td>– Hospice nurses performed complete and accurate pain assessments and were not communicating and updating changes in pain status to the IDG</td>
</tr>
<tr>
<td></td>
<td>– The IDG, when assessing the patient’s pain status consistently considered the most recent pain assessment documentation by the RN</td>
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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
Interpretive Guidelines Surveyor Procedures and Probes §418.54(d)

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<tr>
<td>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.</td>
</tr>
</tbody>
</table>

See the NHPCO *Standards of Practice for Hospice Programs (2010)* Patient and Family-Centered Care (PFC), Clinical Excellence and Safety (CES), and Workforce Excellence (WE) 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) 2**
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.

**CES 2 Practice Examples**
- ✓ An initial pain assessment is completed on every patient on admission.
- ✓ Ongoing pain assessments are performed including a defined rating scale appropriate to the patient’s condition.

**Standard: Workforce Excellence (WE) 11.3**

**WE 11 Practice Example**
- ✓ The hospice demonstrates and documents congruency between team members assessments and interventions and the patient’s and family’s plan of care.

**Suggestions for Compliance**

1. **Clinical Compliance:**
   - Ensure IDG understand provider policy/procedure for:
     - That the update is completed as the patient’s status requires and at least every 15 days.  
     - How the patient’s comprehensive assessment is updated...what is the process? 
     - That there communication and coordination between the IDG as the patient’s status requires and at least every 15 days.

2. **Documentation compliance:**
   - Define what the “update to the comprehensive assessment” means in your hospice and how is it documented
     - Is every visit note an update?  
     - Is there a summary of care and problems status that serves as an update?  
   - There should be documentation every 15 days minimally to evidence the update to the comprehensive assessment or as often as the patient’s status changes. It should be evident in the clinical record.
   - Document communication among IDG members when an update to the comprehensive assessment initiates an update to the patient’s plan of care.
3. **Audit compliance:**  
   a. Ensure organizational policies and procedures describe:  
      i. How the patient’s comprehensive assessment is updated.  
      ii. How the update is documented and identified in the clinical record.  
      iii. That the update is completed as the patient’s status requires and at least every 15 days.  
   b. Conduct a review of clinical records to ensure that the comprehensive assessment of each patient is updated every 15 days or more frequently if needed.  
   c. Audit for update in the patient status which updated the patient’s plan of care.  
      Was there accompanying IDG communication documented in the clinical record?

7. **Medicare hospice CoP: §418.56(c)(2) Standard: Scope and frequency of services.**  
   *This is a first-time citation since implementation of the final Medicare hospice CoPs.*

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<tr>
<td>A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.</td>
<td>Plan of care contained services missing the frequency of the care to be provided</td>
</tr>
</tbody>
</table>

**Interpretive Guidelines §418.54(d)**

The use of visit ranges in the patient plan of care should follow these parameters:  
- The plan of care may include a range of visits and PRN (Latin abbreviation for pro re nata - as needed; as circumstances require) orders for visit frequencies to ensure the most appropriate level of service is provided to the patient.  
- A range of visits is acceptable as long as it continues to meet the identified needs of the patient/family.  
- Visit ranges with small intervals are acceptable (i.e., 1-3 visits/week; 2-4 visits/week) but ranges that include “0” as a frequency are not allowed.  
- The IDG may exceed the number of visits in the range to address patient/family’s needs. There should be documentation in the record to support the need for the extra visit(s).  
- If the patient requires frequent use of PRN visits, the plan of care should be updated to include the need for additional visits.  
- Standing orders or routine orders must be individualized to address the specific patient’s needs and signed by the patient’s physician.  
- The IDG should be proactive in developing each patient’s plan of care by planning ahead for anticipated patient changes and needs. Decisions should reflect the patient/family preferences rather than be solely a response to a crisis.  

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

Ask the clinical manager and other IDG members to describe:  
- What criteria are used to assess the needs of the patient and family?
Who is involved in this process?
How the IDG decides what services the patient will receive?
How the hospice evaluates if the services provided are continuing to meet the patients’ and families’ needs?
How the hospice monitors the delivery of services, including those provided under arrangement or contract, to ensure compliance with the hospice philosophy?

During the home visit, ask the patient/family if they are aware of all the services included in the hospice benefit. If they are not able to describe them, ask to see any information/documentation the hospice may have left with them describing these services. Ask the patient/family who comes to see them from the hospice, how often they come, what services they provide and if they are provided in a timely manner. Are they satisfied with the level of services they are receiving?

During your clinical record review and home visit, determine if there is any indication the patient needs hospice services that he/she is not receiving.

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.

**PFC 4:** A written plan of care is developed for each patient, family and caregiver prior to providing care and services.

**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. **Clinical Compliance:**
   a. Ensure that all members of the interdisciplinary group (IDG) have access to the patient’s current plan of care.
   b. Ensure IDG provides care/visits per the frequency listed on the patient’s plan of care.
   c. Complete a review of the plan of care during the IDG meeting and change the plan of care visit frequency, interventions, etc...per the updates to the comprehensive assessment.

2. **Documentation compliance:**
   a. Ensure consistency and accuracy in documentation as the documenter
      i. Review all documentation to ensure accuracy and completeness
      ii. Review clinical records of patients in your caseload to identify trends and inaccuracies in documentation

3. **Audit compliance:**
   a. Ensure that contents of the plan of care are complete per the CoPs at §418.56(c) Standard: Content of the plan of care.
   b. Ensure that documentation supports that care was delivered according to the plan of care.
   c. Consider implementing IDG peer review of clinical records for educational and compliance experience.
8. Medicare hospice CoP: §418.54(c)(6) - Drug profile.

<table>
<thead>
<tr>
<th>Interpretive Guidelines L-Tag: L530</th>
<th>Examples of Deficiency:</th>
</tr>
</thead>
</table>
| (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: | • Incomplete drug profiles  
• Medication changes were not documented  
• Duplicate medications were not monitored |
| (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 §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. **Clinical compliance:**
   a. Review of drug profiles by an individual with education and training in drug management
   b. Ensure nurse continuously updates the medication profile and provides a copy to the patient/ family
   c. Ensure consistent assessment of medication at every patient visit
   d. Ensure that changes to medication from physician orders are reflected on medication profile

2. **Documentation compliance:**
a. Require documentation of a drug review and reconciliation of all medications in the home at each clinical visit.
b. Ensure documentation of a drug review and reconciliation of all medications in the home at each clinical visit
c. Implement provisions for documenting and updating the patient’s drug profile in the comprehensive assessment tool
d. Make sure that there is a documented review of drug profiles by an individual with education and training in drug management

3. Audit compliance:

   a. Ensure organization policies and procedures describe:
      i. Review of drug profiles by an individual with education and training in drug management; drug profiles must include documentation of:
         1. Medication Interaction
         2. Duplicate therapies
         3. Non-pharmacological interventions
      ii. Provisions for documenting and updating the patient's drug profile in the comprehensive assessment tool.
      iii. Pain assessment and re-assessment.
   b. Provide updated staff training on completing drug profiles and ensure forms and documentation support requirements.
   c. Ensure that the patient’s drug profile is current at all times in the clinical record and in the home.
   d. Ensure that an updated drug profile is part of the update to the plan of care.
   e. Conduct an audit of medical records to make certain that each patient’s comprehensive assessment includes an accurate drug profile.
   f. Review records of patients on Opioid therapy – are there appropriate bowel regime medications also on the patient medication list?
   g. Use pharmacy benefit manager medication lists to compare with current patient medication lists for accuracy of medications.
   h. 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.

9. **Medicare hospice CoP: §418.114 (d)(2) Standard: Criminal Background Checks**

   This is a first-time citation since implementation of the final Medicare hospice CoPs.

<table>
<thead>
<tr>
<th>Interpretive Guidelines L-Tag: L795</th>
<th>Example of Deficiency:</th>
</tr>
</thead>
</table>

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The hospice must obtain a criminal background check on all hospice employees who have direct patient contact or access to patient records. Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records.

- Directly employed hospice staff—no evidence of criminal background checks completed
- Contractual agreements reviewed did not require criminal background checks, specifically inpatient and respite services, pharmacy services and DME

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

WE 3 The hospice maintains a consistent, nondiscriminatory process for recruiting and selecting staff with optimal qualifications which includes competence and license validation, a personal interview, criminal background checks and other checks as required by law and regulation.

WE 3 Practice example: The hospice maintains a consistent process for recruiting and selecting staff with optimal qualifications that includes competency validation and interviews with managers and others.

**SUGGESTIONS FOR COMPLIANCE**

1. **Clinical Compliance:**
   a. The hospice must obtain and document a criminal background check on all hospice employees who have direct patient contact or access to patient records prior to patient contact
   b. This also includes volunteers and contracted staff such as physicians, hospice aides, etc...

2. **Documentation compliance:**
   a. Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records and that the criminal background checks be documented and accessible to the hospice upon request

3. **Audit compliance:**
   a. Review hospice personnel files to ensure that all staff have a criminal background check completed.
   b. Review hospice volunteer files to ensure that all volunteers who have direct patient contact or access to patient records have a criminal background check completed.
   c. Review contractual agreements to ensure they require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records.
   d. Consider implementing IDG peer review of clinical records for educational and compliance experience.
   e. Review compliance of contracted entities with the criminal background check requirement periodically.
   f. Ask a contracted entity for documentation of criminal background checks for staff that have direct patient contact or access to patient records.
10. **Medicare hospice CoP: §418.64 (d)(2) Standard:**

Counseling services must include, but are not limited to Bereavement counseling

This is a first-time citation since implementation of the final Medicare hospice CoPs.

<table>
<thead>
<tr>
<th>Interpretive Guidelines L-Tag: L596</th>
<th>Example of Deficiency:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) - Bereavement counseling. The hospice must:</td>
<td>• Bereavement files in the survey sample failed to contain a bereavement reassessment or bereavement plan of care for the deceased patients’ family</td>
</tr>
<tr>
<td>(i) Have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling</td>
<td>o Hospice agency policy required bereavement assessment/intervention within 10 days of the death</td>
</tr>
<tr>
<td>(ii) Make bereavement services available to the family and other individuals in the bereavement plan of care up to 1 year following the death of the patient. Bereavement counseling also extends to residents of a SNF/NF or ICF/MR when appropriate and identified in the bereavement plan of care</td>
<td></td>
</tr>
<tr>
<td>(iii) Ensure that bereavement services reflect the needs of the bereaved.</td>
<td></td>
</tr>
<tr>
<td>(iv) Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery.</td>
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</tbody>
</table>

**Interpretive Guidelines Surveyor Procedures and Probes §418.64(d)**

The supervisor of bereavement services may be the IDG social worker or other professional with documented evidence of experience or education in grief or loss counseling.

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

Ask the hospice to explain how and when they incorporate the bereavement assessment into the comprehensive assessment.

- What services does the hospice provide to reflect the needs of the family and other individuals in the bereavement plan of care?
- How does the hospice evaluate the outcomes and effectiveness of the bereavement services they provide?
- Select and review a sample of 2-3 bereavement plans of care from a list of the patients who have died within the past 12 months. Determine if the bereavement follow up was appropriate and provided within identified time frames? Did the bereavement services provided reflect the needs of the
bereaved?

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.

PFC 2 Care is fully coordinated to assure ongoing continuity for the patient, family and caregiver.

**PFC 2 Practice example:**
Bereavement services are addressed at the time of admission and reinforced ongoing through written materials, direct contact and a plan for bereavement following the patient’s death.

**PFC 12** The family’s unique ability to emotionally or spiritually adjust to changing environmental conditions is assessed as a part of the ongoing, total psychosocial and spiritual patient and family assessment.

**PFC 2 Practice example:**
The hospice bereavement counselor counsels a patient’s husband on how to cope with the loss of multiple family members, and now his wife within a short period of time.

**PFC 18** Hospice patients and all significant family members and caregivers are assessed for grief and bereavement needs.

**PFC 18 example**
The assessment process is ongoing (i.e., initially upon admission, periodically during the patient’s hospice care and following the patient’s death).
Assessment includes:
1. Patient, family and caregiver needs;
2. Physical and emotional well being;
3. Past history and life adaptation/adjustments;
4. Current and anticipated support systems;
5. Age and developmental level;
6. Social, spiritual and cultural variables;
7. Manifestations of grief;
8. Suicidal ideation/intention and related concerns (e.g., homicide);
9. Potential for complicated grief (i.e., evidence of risk factors);
10. Military experience, service-connected trauma and effects of war;
11. Desire for bereavement care;
12. A plan for ongoing evaluation of status and needs;
13. Survivor risk factors;
14. Caregiver strain index; and
15. Grief Measurement Scale.

**Suggestions for Compliance**

1. **Clinical Compliance:**
   a. Ensure that an initial bereavement assessment is completed and documented as a component of the comprehensive assessment.
   b. Ensure that the bereavement professional participates in the update to the comprehensive assessment and plan of care process as an IDG member.
   c. Make certain that the bereavement professional is alerted immediately when a patient dies.
2. **Documentation compliance:**
   a. Make certain there is documentation in the clinical record of initial bereavement assessment and ongoing assessment as appropriate.
   b. Ensure bereavement professional provides input and documentation to update the patient’s plan of care as needed.
   c. Make sure bereavement professional follows policy/procedures regarding contact and assessment post patient death and document all contact & assessment outcomes.

3. **Audit compliance:**
   a. Review patient records for initial bereavement assessment documentation
   b. Review patient plan of care for bereavement care planning
   c. Review bereavement records to assess:
      i. Initial and ongoing contact after patient death
      ii. Development of a bereavement care plan for caregiver or family

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**Works Cited**

