

STANDARDS OF PRACTICE FOR HOSPICE PROGRAMS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES



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STANDARDS OF PRACTICE FOR HOSPICE PROGRAMS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

1 / NHPCO'S Standards of Practice

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The National Hospice and Palliative Care Organization's (NHPCO) Standards of Practice encompass key components of quality that offers hospice providers a clear framework for a 360-degree surveillance of their entire operation, focusing on both clinical and non-clinical areas. The Standards of Practice assist hospice providers in meeting requirements in the Medicare Hospice Conditions of Participation which require Medicare-certified providers to implement and maintain a Quality Assessment Performance Improvement (QAPI) process for their organization. Hospice providers who choose to adopt standards of practice beyond compliance regulations will measurably demonstrate organizational excellence and improvement efforts across all areas of hospice operations.

The significant value of this document lies in the effect it can have on the evolution and improvement of each organization's hospice services. It is not intended to be filed away or sit on a shelf. Rather, it should be used as an active, viable tool for reference, self-evaluation, and improvement activities. We invite you to apply the principles and standards for evaluation and continuous improvement in your organization.

The *Standards of Practice for Hospice Programs (2018)* are organized around the following core components, which provide a framework for developing and implementing QAPI, thus reflecting NHPCO's commitment to ensuring that members have the tools and resources that ultimately result in improving care of patients and their families.

Patient and Family/caregiver-Centered Care: Providing care and services that are responsive to the needs and exceed the expectations of those we serve.

Ethical Behavior and Consumer Rights: Upholding high standards of ethical conduct and advocating for the rights of patients and their family/caregivers.

Clinical Excellence and Safety: Ensuring clinical excellence and promoting safety through standards of practice.

Inclusion and Access: Promoting inclusiveness in our community by ensuring that all people — regardless of race, ethnicity, color, religion, gender, disability, sexual orientation, age, disease or other characteristics — have access to our programs and services.

Organizational Excellence: Building a culture of quality and accountability within our organization that values collaboration and communication and ensures ethical business practices.

Workforce Excellence: Fostering a collaborative, interdisciplinary environment that promotes inclusion, individual accountability, and workforce excellence through professional development, training, and support to all staff and volunteers.

Compliance with Laws and Regulations: Ensuring compliance with applicable laws, regulations, and professional standards of practice, implementing systems and processes that prevent fraud and abuse.

Stewardship and Accountability: Developing a qualified and diverse governance structure and senior leadership who share the responsibilities of fiscal and managerial oversight.

Performance Measurement: Collecting, analyzing, and actively using performance measurement data to foster quality assessment and performance improvement in all areas of care and services.

STANDARDS OF PRACTICE FOR HOSPICE PROGRAMS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

2 / How to Use the Standards

2 / How to Use the Standards

The National Hospice and Palliative Care Organization's (NHPCO) Standards of Practice for Hospice Programs (2018) ("Standards") is organized into ten (10) chapters. None of the chapters are meant to stand alone. Each chapter begins with one or more principles of hospice care supporting that component of quality. Following the principle(s), the defined standards are divided into numerical group designations. The primary standard is designated by a whole number (e.g., 1, 2, 3) and is followed by related standards designated by the same whole number, a decimal, and a second number (e.g., 2.1, 2.2, 2.3). The numeric designations are solely for reference and are not intended to reflect priority or importance.

Following each group of standards is a set of "Practice Examples." Practice Examples are meant to be examples of various ways to implement the standards. The Practice Examples are not intended to be requirements or descriptions of the best or only way to meet the standards. They are only intended as examples from practice that can be imitated or used to spur ideas and creativity.

At the end of the standards text are appendices. Since the principles and standards in all chapters apply to the provision of hospice care in all settings, the appendices contain only additional principles and standards relevant to a particular practice area. Standards Change Tables follow the appendices to facilitate easy identification of key changes in the 2018 standards.

Please note: The Pediatric Standards are not included as an appendix in this document. They will be issued as a separate appendix in 2018, but will be included as an appendix in subsequent versions of NHPCO's Standards of Practice.

STANDARDS OF PRACTICE FOR HOSPICE PROGRAMS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

3 / Patient and Family/caregiver-Centered Care (PFC)

3 / Patient and Family/ caregiver-Centered Care (PFC)

PRINCIPLES

- Providing care and services that are focused on the dying person and the grieving family's unique experience.
- The patient, family, caregiver, and other individuals identified by the patient are the unit of care.
- The hospice interdisciplinary team, in partnership with the patient, family, caregiver, and other individuals identified by the patient, develops, coordinates, and implements a care-directed, individualized, and safe plan of palliative care.
- Addressing grief and bereavement needs begins at the time of admission to hospice with the initial comprehensive assessment and continues through 13 months after the patient's death, and beyond if necessary.
- Anticipatory grief services are provided to help patients, families, caregivers, and other individuals identified by the patient cope with the losses that occur during the illness and eventual death. Bereavement services are provided prior to and after death based on a plan of care that is created from a thorough bereavement assessment, including risk factors for complicated grief, social support, concurrent life stressors, relationship with the deceased, and other relevant factors.

Standard:

PFC 1: Hospice services are available twenty-four (24) hours a day, seven (7) days a week.

PFC 1.1 The hospice assures a timely response to patient and family/caregiver/caregiver telephone calls twenty-four (24) hours a day, seven (7) days a week.

PFC 1.2 Professional staff is available to make visits to address patient and family/caregiver/caregiver needs twenty-four (24) hours a day, seven (7) days a week.

PFC 1.3 Hospice interdisciplinary team support is accessible and available twenty-four (24) hours a day, seven (7) days a week.

PFC 1.4 Professional staff consultation and visits provide assessment, instruction, support, and interventions, as needed.

PFC 1.5 The hospice has reporting mechanisms and procedures to ensure that staff and volunteers are regularly informed and updated on the patient's current status after regular business hours.

Practice Examples:

- A system is in place to respond to contacts and meet patient and family/caregiver needs after regular business hours.
- Patients and families receive written information at the time of admission regarding how and when to access care after regular business hours. All team members regularly reinforce this information throughout the course of care.
- An established means of staff communication (e.g., written, electronic, voicemail) exists to assure the accurate and timely transmission of information on a daily basis.
- The hospice has an established method to relay documentation of actions taken after regular business hours (e.g. protected/encrypted emails and texts, faxes, documentation in the patient (electronic) medical record). On-call logs are used to document the response to all contacts and requests made after regular business hours.
- The hospice interdisciplinary team creates recommendations, parameters for interventions, and updates for staff providing care to patients and families/caregivers after regular business hours to ensure continuity of care. The updates include new or changed medications, changes in the patient's condition, a summary of current issues, individualized approaches, special concerns, and information on uncommon diagnoses.
- Policies and procedures have been established to ensure all levels of care are provided as needed and can be initiated twenty-four (24) hours a day.

Standard:

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

PFC 2.1 The hospice has criteria and a written process for receiving referrals and verification of eligibility which is used to make admission decisions for both adult and pediatric patients.

PFC 2.2 Procedures are established and utilized for initial and ongoing assessment of patients and families by all disciplines, including processes to evaluate special needs of children and Veterans, based on regulatory and hospice-defined time frames.

PFC 2.3 The hospice has criteria for determining appropriate levels of care, supports the decision of level of care with documentation, and utilizes all levels of care based on patient and family/caregiver needs.

PFC 2.4 The clinical record contains documentation of care coordination through documentation of all hospice interdisciplinary team contact including conference meetings, telephone communication, after-hours contacts and actions, and the visits by hospice interdisciplinary team members.

PFC 2.5 The hospice team delineates a process to transition family members and caregivers from patient care to bereavement care.

PFC 2.6 Documentation supports the patient's continuing terminal prognosis and eligibility.

PFC 2.7 The hospice team coordinates care with non-hospice healthcare providers, resource providers, and vendors involved in the patient's care (e.g., community health programs, healthcare facilities, nursing homes, pharmacists, health insurance programs, physical therapists, specialist physicians, nurse practitioners and physician assistants (effective 1-1-2019)).

Practice Examples:

- The attending physician is informed of pertinent and significant changes related to the patient's condition and the plan of care.
- Hospice interdisciplinary team meetings include contracted service providers, spiritual counselors, attending physicians (if any), volunteers, bereavement counselors, and family/caregivers or representative when needed to address issues related to the coordination of care.
- The registered nurse who performs the initial nursing assessment will discuss and review the medical history, terminal and related diagnoses, unrelated diagnoses, medication review, and the plan of care with the hospice physician.
- Grief and bereavement needs are identified and addressed at the time of admission and throughout the episode of care. A plan for bereavement care following the death is created and addresses any survivor risk factors identified at the time of the bereavement assessment.
- Processes are established to determine which medications are related and unrelated to the terminal prognosis and contributing conditions and diagnoses. Responsibility for payment is considered by the hospice for medications related to the terminal prognosis. Provision of medications is coordinated with health plans and pharmacies to ensure timely decision making and pharmacy service delivery.
- Processes are established in nursing facilities for the coordination of hospice care and services provided to hospice-enrolled nursing facility residents, with facility staff, the facility health care team, and the hospice interdisciplinary team.
 - The nursing facility plan of care is integrated with the hospice plan of care and reflects collaborative efforts to address the care needs of the nursing facility resident enrolled in hospice and family/caregivers or representative.
 - The hospice and the nursing facility develop a plan for communication about patient needs and changes.

Standard:

PFC 3: The hospice designates a hospice interdisciplinary team that assesses need and plans, directs, coordinates, and evaluates effectiveness of care and services provided to the patient, family/caregiver, and other family members.

PFC 3.1 The hospice interdisciplinary team must include:

1. Hospice physician;
2. Registered nurse;
3. Social worker; and
4. Pastoral or spiritual counselor.

Additional hospice interdisciplinary team members may include:

1. Patient's attending physician (if any);
2. Other physicians involved in the patient's care;
3. Nurse practitioner;
4. Physician assistant;
5. Pharmacist;
4. Volunteer;
5. Bereavement counselor;
6. Hospice aide;
7. Physical therapist, occupational therapist, speech-language pathologist and/or dietary counselor; and
8. Other clinicians, counselors, or healthcare practitioners involved in the patient's care.

Practice Examples:

- Attending physicians (if any) are invited to attend hospice interdisciplinary team meetings when their patients' care plans are scheduled for review and updating.
- Volunteers, bereavement counselors, physical therapists, occupational therapists, speech-language pathologists, dietary counselors, and volunteer managers/coordinators who provide patient support/care are invited to provide input, attend the hospice interdisciplinary team meetings, and participate in discussions regarding their assigned patients.
- Staff members who serve in more than one capacity (e.g., spiritual care and bereavement) will maintain awareness of their respective professional roles to ensure healthy boundaries and clear communication in patient and family/caregiver/caregiver relationships.
- Nursing facility staff members are invited to attend the hospice interdisciplinary team meetings when care plans for residents who are hospice patients at their facilities are scheduled for review and updating.

Standard:

PFC 4: A written individualized plan of care is developed by the hospice registered nurse in collaboration with the other members of the hospice interdisciplinary team. The care plan is based on information gathered from clinical information about the patient as well as the initial nursing assessment, and reflects the needs of the patient and family/caregiver, and addresses care and services to be provided.

PFC 4.1 Comprehensive assessments are completed to accurately reflect the patient's physical, psychosocial, emotional, and spiritual needs. The plan of care is based on comprehensive interdisciplinary assessments that include evaluation of physical, psychological, emotional, spiritual, medication, and equipment needs, including but not limited to:

1. Patient and family/caregiver goals for care;
2. Principal and secondary diagnoses and any co-morbid conditions;
3. Current medical findings, including clinical features and complications, that support the terminal prognosis;
4. Patient's health status, including changes related to their terminal prognosis, symptoms, functional status, coping ability, and spiritual/existential concerns;
5. Family caregiver's functional and cognitive capacity, coping ability, anticipatory grieving, preparation for the death, and spiritual needs;
6. Patient's and family's social support, cultural, and resource needs; and
7. Special population needs of patient and family/caregiver, such as Veteran, children, disability, etc.

PFC 4.2 The plan of care includes strategies and planned interventions for addressing needs identified through assessment (e.g., the management of pain, symptoms, and psychosocial or spiritual concerns) as well as frequency of contact by the hospice interdisciplinary team. The plan of care consists of but is not limited to:

1. Patient and family/caregiver preferences and desired outcomes;
2. Patient's and family caregiver's needs;
3. Interventions directed to achievement of desired outcomes and meeting the needs of the patient and family/caregiver as identified by the hospice interdisciplinary team;
4. Scope, frequency, and type of services to be provided, including hospice interdisciplinary team interventions;
5. Medications, medical equipment, and supplies necessary to meet the needs of the patient; and
6. Agencies or organizations, healthcare providers, or services that may be involved in the care.

PFC 4.3 The patient and family/caregiver are routinely engaged in developing the plan of care in a language and manner that they can understand. They are informed about options for care and may participate in planning, care, and treatment.

PFC 4.4 The hospice documents patient and family/caregiver participation, understanding, and level of agreement with the plan of care.

Practice Examples:

- The initial assessment visit is completed by the hospice registered nurse. Other hospice interdisciplinary team members, such as the social worker, may accompany the nurse.
- The plan of care is developed, based on assessments by the hospice interdisciplinary team members, with the patient, family/caregiver, hospice medical director, and attending physician (if any). The plan of care is reviewed and updated at least every 15 days or more frequently as indicated by changes in the patient's condition or family circumstances.
- The hospice uses a military history checklist to evaluate the impact of military experience on care needs and to determine if there are benefits to which the Veteran and surviving dependents may be entitled. Needs identified through use of the checklist are reflected in the plan of care.
- The plan of care is documented and communicated to all hospice interdisciplinary team members involved in providing care and services to the patient and family/caregiver.
- If the patient or family/caregiver has limited English speaking proficiency or other special communication needs, an approach to communication is developed and is indicated in the plan of care (e.g., use of a language line translation service, TTY for the deaf). Note that translation by a family member should be used as a last resort, or at the patient's specific request.

Standard:

PFC 5: The hospice interdisciplinary team members implement the interventions identified in the plan of care.

PFC 5.1 The hospice interdisciplinary team members provide services according to the scope and frequency specified in the plan of care.

PFC 5.2 The hospice interdisciplinary team members' interventions are directed toward achieving the desired goals or outcomes in the plan of care.

PFC 5.3 Each hospice interdisciplinary team member documents and communicates the interventions performed with the patient and family/caregiver, their response to care and services provided, and the goals or outcomes achieved.

Practice Examples:

- The clinical record reflects that the frequency of visits by the hospice interdisciplinary team members is in accordance with the visit frequency stated in the plan of care.
- Documentation in the patient record by each hospice interdisciplinary team member reflects and is consistent with the interventions related to the specific goals of care identified in the plan of care.

- During interdisciplinary meetings, team members discuss the interventions and plan for the patient's care.

Standard:

PFC 6: The hospice interdisciplinary team reviews, revises, and documents the plan of care to reflect the specific and changing needs of the patient and family/caregiver.

PFC 6.1 The plan of care is reviewed, revised, and documented in the patient's clinical record by the hospice interdisciplinary team at least every 15 calendar days.

PFC 6.2 Reassessment is performed during any contact by hospice interdisciplinary team members with the patient and/or family/caregiver.

PFC 6.3 The hospice interdisciplinary team revises the plan of care on an ongoing basis in response to changes in the status and care needs of the patient and the family/caregiver.

PFC 6.4 Hospice interdisciplinary team meeting documentation reflects the ongoing assessment of the patient's and family's needs and their participation in and agreement with the development and revision of the plan of care.

Practice Examples:

- The patient's and family's needs are reassessed during each visit by hospice interdisciplinary team members and documented in the patient record.
- Significant information obtained during patient and family/caregiver reassessment that is relevant to the plan of care is immediately communicated with other hospice interdisciplinary team members, documented in the clinical record, and the plan of care is collaboratively revised accordingly.
- For facility residents who are enrolled in hospice, documentation in the patient record demonstrates collaboration and communication by hospice team members and facility staff, and the plan of care is revised in response to the patient and family/caregiver reassessment.
- The nursing facility plan of care is integrated with the hospice plan of care and reflects collaborative efforts to address the care needs of the hospice enrolled nursing facility resident, the family representative, and facility staff.

Standard:

PFC 7: A registered nurse coordinates the delivery of care provided by the hospice interdisciplinary team of professionals and volunteers to assure that the patient's and family's needs are continuously assessed, planned for, and addressed.

PFC 7.1 The hospice registered nurse coordinates care while taking into consideration the patient's and family's needs and strengths and the health professionals involved in the care.

PFC 7.2 The hospice registered nurse's responsibilities include:

1. Coordinating the hospice interdisciplinary team to ensure adequate assessment, planning, and implementation of each patient's and family's plan of care; and
2. Ensuring effective hospice interdisciplinary team practice, coordination, and communication among team members.

Practice Examples:

- The hospice has a written job description for the registered nurse that outline qualifications and responsibilities as case manager.
- Care coordination by the nurse case manager among hospice interdisciplinary team members and across care settings is observable through a review of hospice interdisciplinary team conference notes, telephone communication, and clinical visit notes in the clinical record.

Standard:

PFC 8: The hospice interdisciplinary team identifies a patient's values, spiritual beliefs, and/or philosophies and honors these perspectives in all care coordination and planning.

PFC 8.1 A spiritual assessment is completed as part of the comprehensive assessment and spiritual support is provided according to the patient and family/caregiver's preferences and needs.

PFC 8.2 The hospice interdisciplinary team recognizes feelings and concerns such as loneliness, guilt, fear, and anger which may be shared by the patient and family/caregiver and addresses these according to patient and family/caregiver preferences.

PFC 8.3 The hospice interdisciplinary team assesses individual and family culture, history, and dynamics and utilizes the assessment as the basis for understanding and supporting patient's and family's wishes and developing appropriate interventions.

Practice Examples:

- Procedures and protocols are in place for including the patient's spiritual support system, as defined by the patient, in the care planning process.
- A spiritual assessment that addresses spiritual issues and concerns is completed within five days of electing hospice care.
- Documentation in the patient record indicates that the patient's spiritual beliefs and traditions are communicated to and supported by the hospice interdisciplinary team.

- All staff receives training to ensure an understanding of the ethical boundaries prohibiting the imposition of one's own beliefs on the patient or family.

Standard:

PFC 9: The hospice interdisciplinary team promotes opportunities for integration, reconciliation, and closure according to the preference of the patient.

PFC 9.1 The hospice interdisciplinary team helps the patient to identify areas of importance in achieving integration, reconciliation, and end-of-life closure including self, family, friends, and community.

PFC 9.2 The patient's strengths and unique qualities are supported by hospice interdisciplinary team members.

PFC 9.3 Additional support is offered and provided according to the patient's preferences as the patient approaches death.

PFC 9.4 Cultural perspectives and beliefs on death are recognized, honored, and supported in ways that are meaningful to the patient and family/caregiver.

Practice Examples:

- The hospice has written materials that explain what to expect during the dying process for the patient and family/caregiver (e.g., *signs and symptoms of approaching death*) in a manner and language that each understands.
- The hospice develops specially trained volunteer programs to provide patient and family/caregiver support, such as a vigil program, as death approaches.
- At the patient's request, the hospice chaplain or designated spiritual care coordinator facilitates patient contact with a faith community when the patient has been inactive for some time due to the progression of the patient's illness.
- At the patient's request, hospice staff may seek to facilitate visits for special needs, such as immigration problems or incarceration issues.
- Following the death, the hospice interdisciplinary team provides care of the body, honors cultural rituals when possible, and assists the family with funeral arrangements as needed.

Standard:

PFC 10: The patient's ability for self-care is regularly assessed and interventions are implemented in accordance with patient and family/caregiver wishes when the patient is no longer able to adequately provide self-care.

PFC 10.1 Medical equipment and supplies are provided to assist in the care of the patient as indicated.

PFC 10.2 Policies and procedures are developed to plan for patient care when there is no primary caregiver in the patient's residence.

PFC 10.3 Communication strengths and barriers (e.g., cognitive deficits, lack of proficiency in English) are routinely assessed and appropriate actions are taken to ensure patient understanding of care.

PFC 10.4 When indicated, a coordinated transition to another setting is facilitated by the hospice interdisciplinary team in order to meet the patient's care needs.

Practice Examples:

- The hospice ensures that non-English speaking patients and their families have access to information in an understandable form by offering literature written in languages for non-English speaking communities common in the hospice's service area and access to translators twenty-four (24) hours a day, seven (7) days a week.
- Assisted devices are available to the deaf and hearing impaired through local community TTY service providers.
- The hospice has appropriate procedures in place to support education and communication with those who have a limited ability to read and/or write and, when creating written materials, is mindful that much of the general population reads on a fifth grade level.
- Hospice staff proactively works with patients and families in planning for a higher level or increased intensity of care as needed as the patient's condition changes.
- The hospice helps the patient who lives alone to explore possible options for care when the patient can no longer care for himself/herself, such as a nursing facility, a hospice residence, a family member's home, or paid or unpaid assistants in the home.

Standard:

PFC 11: The family's ability to emotionally and/or spiritually adjust to changing conditions is assessed as a part of the ongoing comprehensive psychosocial and spiritual assessment.

PFC 11.1 The care planning process includes interventions that address the needs and goals of the family related to end-of-life care, loss, and grief.

PFC 11.2 Family members' spiritual beliefs, traditions, and rituals are respected during the care planning process.

PFC 11.3 Family members' feelings of loss, despair, loneliness, unresolved guilt, fear, and anger are recognized and addressed by the hospice interdisciplinary team.

PFC 11.4 Appropriate and timely communication and education are provided to the patient and family/caregiver from admission to discharge or death, and through bereavement.

Practice Examples:

- Psychosocial assessment tools include assessment of family history and coping skills.
- Family discord is identified and addressed in the plan of care as it relates to or impacts patient wellbeing and care needs.
- Bereavement staff routinely attends hospice interdisciplinary team meetings and participates in the care planning process.
- The hospice interdisciplinary team counsels patients and families who cannot take leave from work after the patient is diagnosed with a terminal illness.
- A hospice counselor meets with the caregiver to assist with unresolved grief issues from the past and anticipatory grief.
- The hospice interdisciplinary team respects and normalizes feelings of anger experienced by a young patient's parents as they live with the reality of their child's illness.
- The hospice interdisciplinary team counsels a patient and family/caregiver in dealing with issues of post-traumatic stress disorder or other disorders due to the patient's military history and combat duty experience.
- The hospice bereavement counselor assists a patient's spouse with coping with multiple recent family losses occurring over a short time span.
- The hospice interdisciplinary team educates the family on what to expect at the time of death and bereavement by using appropriate teaching tools.
- The hospice interdisciplinary team assists the patient's same-sex partner in navigating legal and financial challenges related to decision-making for the patient.

Standard:

PFC 12: The hospice interdisciplinary team promotes opportunities for reconciliation and end-of-life conversations according to patient and family/caregiver preference.

PFC 12.1 The hospice interdisciplinary team helps the patient and family/caregiver members identify important subject areas for reconciliation and end-of-life conversations.

PFC 12.2 The hospice interdisciplinary team facilitates communication between the family members and the patient by encouraging expression of emotions related to grief and loss (love, concern, regret, gratitude, and forgiveness) as appropriate to the needs and desires of the patient and family/caregiver.

PFC 12.3 Family members are educated about the physical, psychological, emotional, and spiritual aspects of the dying process.

PFC 12.4 The hospice interdisciplinary team nurtures and supports a sense of meaning for family members related to their relationships with each other and the family's identity within the community.

Practice Examples:

- Family members are encouraged to meet individually with the patient and express their feelings, facilitated by the hospice social worker and spiritual care coordinator or chaplain, if desired.
- Family members are educated about the patient's possible withdrawal from others as death approaches and are supported as they continue to care for the patient.
- The hospice uses a reminiscence tool to help the patient and family/caregiver remember and appreciate their lives together (e.g., journals, CDs, photos), with possible utilization of expressive therapy.
- Family meetings are offered as needed and facilitated by the hospice interdisciplinary team to help resolve issues and make decisions related to the patient's plan of care.

Standard:

PFC 13: The hospice interdisciplinary team evaluates and supports the family's physical, cognitive, and social capacity to communicate, learn, and carry out caregiving responsibilities.

PFC 13.1 Patient care and physical safety are regularly evaluated and interventions to ensure safety are incorporated into the care planning process as needed.

PFC 13.2 The capability and willingness of caregivers to participate in the care of the patient are regularly evaluated and interventions for change or improvement are incorporated into the care planning process, as needed.

PFC 13.3 Cultural language barriers, disabilities, caregiver burden, and other factors that impact communication are recognized and interventions are developed to support learning and effective caregiving.

PFC 13.4 The hospice takes a proactive approach to medication safety with particular attention to opioid safety to ensure that all medications are used and stored safely. Examples of proactive approaches:

1. Conduct opioid risk assessment
2. Identify who will control medication administration
3. Provide opioid safety education

Practice Examples:

- At the patient's request, the hospice nurse or other hospice interdisciplinary team members regularly communicate with family members/caregivers, including those residing outside the immediate community, to update them on the patient's condition.
- Volunteers are assigned to provide support services to patients when a family member/caregiver needs coverage for a special circumstance.

- The hospice offers respite care to family members/caregivers to support patients in staying in their own homes as long as possible by easing caregiver burden.
- Interpreter services or other language and communication strategies are available and utilized as appropriate.
- The hospice plan of care reflects specific arrangements for reconciliation of opioids on every RN visit, safe medication storage and administration, and review of the safety plan with the patient and family/caregiver if risk of diversion is identified.
- The hospice interdisciplinary team engages in contractual agreements with the patient and family/caregiver regarding unresolved safety issues to ensure staff and patient safety (e.g., smoking with oxygen, multiple falls, lack of patient supervision, weapons, abusive/violent behavior).

Standard:

PFC 14: The hospice interdisciplinary team assesses the patient's and family's environmental and financial resources as they relate to the provision of patient care.

PFC 14.1 Housing, welfare, caregiver burden, and safety issues (e.g., problems with shelter or inadequate financial resources) are identified. Interventions are initiated according to patient and family/caregiver preferences.

PFC 14.2 Personal business and family welfare issues, such as funeral and memorial service arrangements or financial, legal, and other services, are identified and interventions are initiated according to patient and family/caregiver preferences.

Practice Examples:

- The hospice interdisciplinary team educates the family on the importance of self-care, provides or suggests opportunities for additional support, and arranges for respite care to reduce caregiver burden.
- The hospice interdisciplinary team assists family members with additional care options, including placement for the patient as needed, appropriate to their financial capability.
- The hospice interdisciplinary team assists the patient and family/caregiver in completing advance directives, POLST, Five Wishes and/or another advance care planning tool and educates the patient and family/caregiver on the meanings of these documents on an ongoing basis.
- The hospice interdisciplinary team assists families with funeral or memorial service arrangements, and the hospice spiritual care coordinator or chaplain helps plan and conduct services as requested.
- For patients without third party payer coverage who are unable to pay for medically necessary hospice care, the hospice interdisciplinary team offers the option to complete a financial needs assessment for agency or community-sponsored financial assistance and facilitates the completion of the assessment, if necessary.

Standard:

PFC 15: Assessment of patient and family/caregiver feelings, strengths, goals, and needs related to loss, grief, and bereavement is performed. Interventions are developed based on the assessment and are incorporated into the interdisciplinary plan of care.

PFC 15.1 The hospice interdisciplinary team works in partnership with the patient and family/caregiver to identify issues that may complicate life closure.

PFC 15.2 The hospice interdisciplinary team encourages, facilitates, and validates the patient's and family's expressions of grief related to losses identified by the patient and family/caregiver.

PFC 15.3 The hospice interdisciplinary team supports patients and families/caregivers in their grief process through direct services and by referrals to appropriate community resources for additional assistance if needed.

PFC 15.4 Survivor risk and bereavement assessment tools are utilized by the hospice from admission throughout the course of care and through thirteen (13) months after the death.

PFC 15.5 The hospice interdisciplinary team identifies, documents, and addresses the patient's and family/caregiver's needs and goals related to anticipatory grief (before death) and bereavement (following death).

PFC 15.6 The hospice interdisciplinary team documents the evaluation of bereavement needs, the hospice's response to assessed needs, and the bereaved person's response to services provided.

Practice Examples:

- A bereavement risk assessment is completed at start of care to identify risk factors for complicated grief.
- Bereavement staff makes visits to the patient and family/caregiver prior to the patient's death in accordance with the plan of care.
- The hospice interdisciplinary team utilizes complementary therapies to assist in facilitation of a patient's expressions of feelings.
- Children who are impacted by the patient's death are identified and a plan is developed to respond to their needs.
- The patient and family/caregiver receive education regarding grief and loss.

Standard:

PFC 16: Preparation for the family prior to the patient's death and support for the family at the time of the patient's death are provided.

PFC 16.1 The hospice interdisciplinary team will, through written materials and verbal instructions, support families in understanding the signs and symptoms related to the final stages of illness and the dying process.

PFC 16.2 The hospice interdisciplinary team will ensure that families have opportunities to discuss their thoughts and feelings related to the final stages of illness, and to receive support in the ways that are meaningful to them.

PFC 16.3 Hospice interdisciplinary team members are available twenty-four (24) hours a day, seven (7) days a week to attend a patient death.

PFC 16.4 Hospice staff attending a death respect the cultural, religious, and spiritual traditions and beliefs of the patient and family/caregiver.

PFC 16.5 Each patient death is confirmed, documented, and communicated according to state law, regulation, and the hospice's policy.

PFC 16.6 The patient's body is handled with respect and dignity and in accordance with the requests of the patient and family/caregiver.

Practice Examples:

- Family members and caregivers are informed of standard notification procedures before death occurs.
- On-call services support the capability of staff attendance at all deaths in all settings.
- The appropriate hospice interdisciplinary team member attends and verifies a patient's death per state regulations. The hospice has specific procedures related to documentation for patient death, including care of the body, disposal of medications per federal and state regulations, and other required notifications.
- Family members are afforded time with the patient's body as desired and per cultural customs.
- On-call spiritual care staff is provided appropriate contact information for the family and other information to support the plan of care regarding cultural, religious, or spiritual traditions and beliefs of the patient and family/caregiver at the time of death.

Standard:

PFC 17: The hospice has a well-defined bereavement program that begins at start of care and provides services for a minimum of 13 months following the death of the patient.

PFC 17.1 The hospice has bereavement policies and procedures that delineate the scope of bereavement care provided and incorporate confidentiality procedures and mechanisms to assure that family preferences regarding bereavement contact are honored.

PFC 17.2 The hospice bereavement policies and procedures specify the services to be consistently provided within specific time frames during the course of bereavement care.

PFC 17.3 Guidelines for the hospice bereavement program clearly describe the nature of counseling services to be provided within specific time frames and the nature and constraints of such services.

PFC 17.4 The hospice has a systematic and ongoing method of evaluating the outcomes and effectiveness of the bereavement services provided.

PFC 17.5 The hospice defines eligibility criteria for bereavement services including consideration of the needs of bereaved members of the community.

Practice Examples:

- Bereavement services may include, but are not limited to:
 - Individual and family counseling;
 - Grief support groups, general and specialized, for all age groups;
 - Family support visits;
 - Telephone support;
 - Written materials about grief and coping that are appropriate for the age, language, average reading level, and special needs of the bereaved individuals served;
 - Scheduled mailings (e.g., personal, educational, and informational);
 - Memorial services and funerals;
 - Camps and retreats;
 - Spiritual and pastoral counseling;
 - Internal in-service programs;
 - External educational offerings; and
 - Referral to community resources.
- Bereavement counseling services are based on the understanding that grief is a normal part of life and can be navigated successfully with adequate support.
- Bereavement counseling for manifestations of non-complicated grief includes empathy and compassion, active listening, normalizing the grief experience, education, recognition of the bereaved person's natural resilience, encouragement, problem-solving, and the reinforcement of adaptive coping strategies.
- Bereavement outcomes are identified and data are collected and analyzed on an ongoing basis to measure the effectiveness of services provided and develop strategies for improvement.
- A means of communicating with out-of-area family members is developed to provide bereavement information and to identify supportive resources in their area, if desired.
- Childhood loss and grief counseling and other programs are designed and provided consistent with bereaved children's developmental phases and special needs.

Standard:

PFC 18: A plan of care that includes bereavement needs, interventions, goals, and outcomes is developed and documented for families served by the bereavement program.

PFC 18.1 Goals and outcomes related to bereavement care are part of the ongoing care planning process and are determined by family members in collaboration with the hospice interdisciplinary team/ bereavement staff.

PFC 18.2 The plan of care for bereavement services should reflect family needs and delineate the specific services provided, including the means for service provision and frequency of contact.

PFC 18.3 Bereavement needs, services, and interventions are documented in the patient clinical record during care of the patient, and in a separate record for the bereaved after the patient's death.

PFC 18.4 Routine bereavement services are available and offered to the family regardless of risk factors.

PFC 18.5 Family members/caregivers whose needs are assessed to be beyond the scope of the hospice bereavement program are referred to appropriate community agencies or practitioners.

Practice Examples:

- The plan of care identifies the interventions to meet family needs and preferences, including frequency of contact.
- Bereavement goals and outcomes are regularly reviewed with the individuals who are receiving bereavement services.
- A plan is developed to address the needs of bereaved individuals who are identified as at risk for complicated grief reactions.
- A list of community resources or practitioners is maintained for referral of family members whose needs are assessed to be beyond the scope of the hospice bereavement program counseling services.
- A bereaved child's record includes consent for care from the parent/guardian and ongoing communication of progress, needs, and therapies with the parent/guardian.

Standard:

PFC 19: The hospice utilizes qualified staff and volunteers to provide bereavement services.

PFC 19.1 Bereavement services are managed and coordinated by qualified professional hospice staff with education and training appropriate to the position's responsibilities.

PFC 19.2 Bereavement services are provided by appropriate hospice staff and volunteers who receive routine clinical supervision by qualified bereavement professionals.

Practice Examples:

- The hospice utilizes staff with degrees in clinical social work, mental health counseling, or other related fields (e.g., pastoral counseling) to provide bereavement services.
- Volunteers receive additional bereavement-specific training including but not limited to supportive listening, communication skills, general concepts of grief and loss including risk factors for complications in bereavement, professional boundaries, spiritual and/or religious boundaries, stress management, self-care, and collaboration and communication with the team/bereavement staff.
- The hospice ensures that clinical staff is comprehensively trained in loss, grief, and bereavement and are regularly offered continuing education opportunities in grief and loss, such as identifying high risk survivors and those at risk for complicated grief reactions.
- The hospice has a plan for providing regular and ongoing supervision of bereavement staff and volunteers.
- The hospice documents bereavement services provided.
- The hospice defines bereavement staff roles and responsibilities for providing bereavement support to clinical staff and volunteers.

STANDARDS OF PRACTICE FOR HOSPICE PROGRAMS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

4 / Ethical Behavior and Consumer Rights (EBR)

4 / Ethical Behavior and Consumer Rights (EBR)

PRINCIPLE

Upholding high standards of ethical conduct and advocating for the rights of patients and their family caregivers. The hospice respects and honors the rights of each patient and family it serves. The hospice assumes responsibility for ethical decision-making and behavior related to the provision of hospice care.

For more detail on issues discussed in this chapter, please refer to NHPCO's [*Guide to Organizational Ethics in Hospice Care*](#) (2016).

Advance care planning information and state-specific advance directives are available through NHPCO's Caring Connections at www.caringinfo.org

Standard:

EBR 1: The hospice maintains the right of the patient, as well as the family/caregiver, to be involved in all decisions regarding care, treatment, and services.

EBR 1.1 Patients and families/caregivers are provided education and opportunities to review the hospice approach to care, treatment, and focus on palliative care services at the time of admission and throughout the course of care.

EBR 1.2 Informed consent for hospice care is obtained from the patient or designated representative and is documented in the clinical record.

EBR 1.3 The hospice obtains information related to the patient's advance care planning status, conditions, and specifications. The hospice documents the information in the clinical record.

EBR 1.4 The hospice educates the patient and family/caregiver on the importance and benefit of advance care planning and identifies additional resources for completing an advance directive, if requested.

EBR 1.5 The patient's wishes are respected and taken into consideration when planning for the patient's care. The hospice documents the patient's wishes in the clinical record.

EBR 1.6 The organization respects the patient's rights to choose and discontinue hospice services.

EBR 1.7 Decisions regarding care or services to be provided are based on the patient's and family/caregiver's goals for care, are communicated to the patient and family/caregiver, and are documented in the clinical record.

EBR 1.8 The hospice provides verbal explanation and written information about the organization's policies on advance directives, including a description of relevant state law.

EBR 1.9 Prior to provision of service or any change in service, the hospice informs patients and families of policies regarding discontinuing services and any potential costs to them. The hospice documents the patient's or the financially responsible party's understanding of that information.

Practice Examples:

- On admission, the hospice educates the patient and family/caregiver about hospice care and specific hospice services. In addition, the hospice explains insurance coverage and patient rights under that coverage.
- Families/caregivers are made aware of all services available to them, including psychosocial, spiritual, volunteer, and bereavement services.
- The hospice has a written policy that includes a clear and precise statement of limitation if a staff member or the hospice program cannot implement an advance directive, treatment, or procedure on the basis of conscience.
- On admission and prior to provision of care, the hospice educates each patient about his or her right to formulate an advance directive. The patient's decision is documented in the clinical record.
- The patient's status and desires related to end-of-life care decisions are documented in the psychosocial assessment.
- The hospice does not require specific provisions in advance directives, such as a Do Not Resuscitate (DNR) order, as a condition for admission.
- The hospice has a process in place to ensure that the patient's designated representative has the authority to make decisions on behalf of the patient in accordance with state laws and regulations.
- When the needs/goals of the patient differ from those of the family, the hospice ensures that the preferences of the patient are met and works with the family to gain acceptance of the patient's goals.
- The hospice provides translational services for patients who do not understand English. Written materials are developed in the patient's preferred language as needed. The hospice uses a family member/caregiver as translator only when (1) the patient's native language is uncommon and a translator is not available after effort to locate one, and (2) the patient consents or specifically requests a family member/caregiver as the translator.
- The hospice consults United States Census information or the Office of Civil Rights (OCR) list of the top 15 languages spoken by individuals with Limited English Proficiency (LEG) in each state, the District of Columbia, and each U.S. Territory - [PDF](#) to determine prevalence of various languages in the service area and makes written materials available in languages commonly found in the service area covered by the hospice.

Standard:

EBR 2: Hospice patients and families have the right to confidentiality.

EBR 2.1 The hospice has written policies and procedures regarding confidentiality and the protection of information from inappropriate and/or unlawful disclosure, which conform to federal regulations.

EBR 2.2 Individual patient confidentiality is protected by obtaining signed approval from the patient or designated representative for recordings, films, or other images and in data collection, aggregation, and submission to an outside entity.

EBR 2.3 All staff members, including volunteers, are educated about patient confidentiality and the hospice's policies and procedures related to confidentiality, privacy, and security.

EBR 2.4 During orientation and prior to any exposure to patient or family caregiver information, all staff members, including volunteers, agree to maintain patient confidentiality in writing.

EBR 2.5 The hospice maintains compliance with all components of the Health Insurance Portability and Accountability Act (HIPAA) and discloses health information only as authorized and in accordance with laws and regulations.

Practice Examples:

- Any patient information carried in staff vehicles is handled in a manner so that patient names, diagnoses, or clinical reports are not discernable.
- Hospice staff members know how to respond appropriately when asked by concerned individuals about patients.
- Staff ensures that patients' protected health information is not left exposed in work areas and uses security tools such as computer privacy screens.
- The hospice has defined procedures for the disposal of documents that contain protected health information, such as use of a paper shredder or shredding service.
- The hospice's electronic records and communications accessed through portable devices (laptops, cell phones, etc.) meet HIPAA/HITECH requirements and guidelines regarding passwords, locking, and secure networks.

Standard:

EBR 3: Patients and families have the right to have their complaints heard and addressed.

EBR 3.1 The hospice has a process in place that is initiated whenever a complaint is received to work toward resolution of the complaint. The hospice documents this process and resolution, including the follow-up performed with patient/family/caregiver.

EBR 3.2 At the time of admission, the hospice informs patients and families/caregivers of both the hospice's internal complaint resolution process and external processes, and provides a list of external bodies where complaints can be filed along with information on how to contact them.

EBR 3.3 Complaints are tracked and regularly reviewed to identify any patterns or trends.

EBR 3.4 Staff members are educated about the complaint resolution process and accept responsibility for helping to identify and address complaints.

EBR 3.2 The patient's and family/caregiver's views are respected and their expression of a grievance does not result in discrimination or reprisal.

Practice Examples:

- A complaint log is maintained and includes the complaint, source of the complaint, documentation of efforts toward resolution, and final resolution.
- A written summary of the types of complaints received is developed periodically (e.g., quarterly) and problem areas are identified and addressed.
- The hospice interdisciplinary team reviews any patient or family complaints about care provided and takes remedial action as appropriate.
- The hospice designates a staff member who is responsible for complaint follow-up, resolution, and documentation.
- Information on how to voice a complaint is provided in writing to the patient and family/caregiver, listing specific contact names and numbers of hospice leadership staff and the contact information for the state survey agency.
- The staff is educated in complaint resolution techniques that are constructive and do not place blame on others.
- Information gathered through the complaint process is regularly monitored as part of the hospice's QAPI program. Trends are identified as opportunities for improvement in care and outcomes.

Standard:

EBR 4: The hospice acknowledges and respects each patient's and family/caregiver's rights and responsibilities.

These include the right to:

1. Being treated with respect;
2. Quality end-of-life care;
3. Effective management of pain and symptoms;
4. Involvement in care plan development;

5. Refusal of care or treatment;
6. Choice of attending physician;
7. Confidentiality of information;
8. Freedom from abuse, mistreatment, and neglect;
9. Information about hospice insurance coverage;
10. Information on advance directives
11. Information about services and limitations of hospice service;
12. Freedom from discrimination or reprisal for exercising his or her rights; and
13. A medical record.

EBR 4.1 Upon admission, the hospice informs each patient and family/caregiver of the hospice patient's rights both verbally and through a written statement.

EBR 4.2 The hospice has written policies and procedures that address:

1. The purpose and scope of hospice services;
2. Informed consent by the patient/family for the provision of hospice services;
3. Designated representative consent according to state laws; and
4. Staff education related to patient and family/caregiver rights and responsibilities.

EBR 4.3 Signed documentation acknowledging that the patient and family/caregiver received an explanation of the patient's rights is included in the patient's medical record.

Practice Examples:

- The hospice has a clinical record review process to verify that each patient and family/caregiver received an explanation of the patient's rights and responsibilities.
- A statement of hospice patient rights is included in each admission packet or booklet.
- The hospice explains patient rights and responsibilities in a manner the patient and family/caregiver can understand during the admission visit.
- Family members/caregivers are informed at the time of admission of the consequences for certain decisions that may impact the care of the patient (e.g., calling 911, obtaining unauthorized services).

Standard:

EBR 5: Each member of the hospice interdisciplinary team recognizes and demonstrates a fiduciary relationship, maintains professional boundaries, and understands that it is his/her personal responsibility to maintain appropriate relationships with the patient, family, and caregivers.

EBR 5.1 The hospice provides orientation and training for staff, including volunteers, regarding the patient's rights and responsibilities.

EBR 5.2 The hospice provides orientation and training for staff, including volunteers, regarding the importance, principles, and maintenance of professional boundaries.

EBR 5.3 The hospice provides orientation and training for staff, including volunteers, regarding the fiduciary responsibility of the hospice to protect the interests of patients and families, including prohibited conflicts of interest.

Practice Examples:

- Hospice staff, board members, and volunteer personnel records include a signed conflict of interest statement on an annual basis that addresses both paid and unpaid staff.
- Hospice policy states staff may not communicate with the media without the administration's knowledge or permission.
- The hospice has a policy that addresses accepting of money or gifts from patients or family members.
- Hospice staff members, including volunteers, do not give patients or family members/caregivers their personal contact information (home phone numbers, cell phone numbers, email addresses).

Standard:

EBR 6: The hospice has a mechanism in place to assist the hospice interdisciplinary team when ethical conflicts or dilemmas arise during the provision of care to patients and families/caregivers.

EBR 6.1 The hospice establishes procedures to identify, review, and discuss ethical dilemmas that cannot be resolved by professional practice guidelines or hospice policies and procedures.

EBR 6.2 Hospice staff members are educated about ethics in hospice care and the hospice program's procedures for addressing ethical issues.

Practice Examples:

- The hospice staff has access to an ethics committee that meets to review ethical considerations related to patient care or end-of-life care issues (e.g., requests for physician assisted death, pediatric care, withdrawal of life-sustaining care or life support, caregiver safety).
- The hospice has a policy that addresses the withdrawal of life-sustaining interventions (e.g., enteral or parenteral nutrition, implanted cardiac defibrillator, ventilator).
- The hospice includes an ethics component in orientation for new staff and volunteers.
- The hospice has a Code of Ethics to guide ethical decision making.
- New hospice clinical staff members complete a competency-based educational module on ethics as part of orientation.

- Hospice team members are able to identify common ethical issues or dilemmas in hospice care and how they can be addressed.

Standard:

EBR 7: The hospice acknowledges and respects the rights and responsibilities of its volunteers and supports and empowers them in the fulfillment of their role.

EBR 7.1 The hospice has written guidelines that encourage surviving family members/caregivers to wait a minimum of one year following the patient's death before serving as a volunteer.

EBR 7.2 The hospice has a process to screen and evaluate individuals who wish to serve in a volunteer capacity to ensure compliance with established qualifications and regulations for hospice volunteers.

EBR 7.3 The hospice has written guidelines for employees related to working with volunteers.

EBR 7.4 The hospice fully orients volunteers to the role and expectations of the hospice volunteer, including the importance of maintaining boundaries with patients and caregivers.

EBR 7.5 The hospice provides clear role delineation guidelines for its volunteers and ensures that each individual volunteer assignment is within the scope of the accepted role and duties of hospice volunteers.

EBR 7.6 The hospice provides ongoing supervision and access to support for volunteers.

Practice Examples:

- Volunteer recruitment brochures clearly identify qualifications pertaining to volunteering after a death in the family.
- New volunteer orientation includes training related to maintaining boundaries with patients and families/caregivers.
- The volunteer coordinator maintains close contact with, and provides individualized support for, all volunteers who provide direct patient care. The volunteer coordinator pays particular attention to identifying potential conflicts of interest, ethics violations, and burnout.

Standard

EBR 8: The hospice ensures that all alleged violations of patient rights are reported immediately by the hospice staff, including contracted and arranged service providers, to the hospice administrator or a staff designee for appropriate action.

EBR 8.1 The hospice has written policies and procedures that guide the reporting of alleged violations and caregiver misconduct, and include required time frames for reporting.

EBR 8.2 The hospice administrator or staff designee investigates alleged violations and, if verified, the hospice reports the violation to state and federal authorities in the timeframe required by law.

EBR 8.3 The hospice administrator or staff designee assesses the current safety and comfort of the patient at the time of the reported allegation.

Practice Example:

The hospice observes a facility staff member mistreat a patient in a facility. They report what they saw to the hospice administrator and facility administrator for investigation according to their policy.

Standard

EBR 9: The hospice keeps the interests of the patient and family/caregiver, and provision of high quality care, a priority in all business practices.

EBR 9.1 The hospice has processes in place to ensure program integrity, accountability, and transparency in its business practices.

EBR 9.2 Business and marketing practices are carried out within the parameters of all relevant legal and regulatory frameworks.

EBR 9.3 Admission and discharge practices maximize access to care for all patients who meet eligibility requirements for receiving hospice care.

EBR 9.4 The hospice truthfully and accurately represents its capacity and services in all marketing, outreach, and education activities and media.

EBR 9.5 Involvement of patients and families in marketing and outreach are conducted so that their confidentiality, privacy, and physical and emotional wellbeing are maintained and respected.

Practice Examples:

- The hospice discloses any ownership interests or business relationships between the referral source and the hospice to every patient and family/caregiver.
- Before using patient/family/caregiver stories, testimonials and images in marketing materials, a valid signed patient/family agreement is obtained using a clearly stated consent form.
- When doing informational presentations, the hospice liaison nurse describes the full range of services available and the limitations of those services (e.g., the hospice does not provide hospice aides for round-the-clock custodial care).
- The hospice provides the option of opting out of receiving information related to the hospice's marketing and outreach activities to all patients and families/caregivers.

STANDARDS OF PRACTICE FOR HOSPICE PROGRAMS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

5 / Clinical Excellence and Safety (CES)

5 / Clinical Excellence and Safety (CES)

PRINCIPLES

- The hospice ensures clinical excellence and safety promotion through standards of practice.
- The desired outcomes of hospice interventions are for patients to feel safe and comfortable throughout the dying process; and for patients and families to feel supported and have adequate information appropriate to their needs throughout the trajectory of the illness, the dying experience, and for the first year or longer after the death. Hospice outcomes are individualized through a collaborative and reiterative process between the hospice interdisciplinary team and the patient/family/caregiver system. This process includes continuous assessment and identification of the goals, needs, strengths, and wishes of the patient and family/caregiver.
- The hospice provides for the safety of all staff while promoting the development and maintenance of a safe environment for patients and families/caregivers served.

Standard:

CES 1: The comprehensive assessment performed by the hospice interdisciplinary team and the patient's goals for care serve as the basis for the development of the patient's plan of care.

CES 1.1 Initial information documenting the patient's terminal prognosis and principle diagnosis, as well as contributory and secondary diagnoses, is obtained and reviewed prior to admission to hospice services.

CES 1.2 The hospice nurse makes an initial assessment within 48 hours of the effective date of the patient's hospice election statement.

CES 1.3 The hospice interdisciplinary team, in consultation with the patient's attending physician, completes the comprehensive assessment within five calendar days of the effective date of the hospice election statement.

CES 1.4 The comprehensive assessment identifies the physical, psychosocial, emotional, spiritual, bereavement, and educational needs of the patient and family/caregiver that must be addressed in order to promote the patient's definition of wellbeing, comfort, and dignity throughout the dying process.

CES 1.5 The comprehensive assessment includes:

1. The patient's immediate care needs on admission;
2. Physical, psychosocial, emotional, spiritual, bereavement, and educational needs related to the terminal prognosis and principle diagnosis, plus related conditions;
3. Patient and family/caregiver goals and preferences for care, learning styles, educational needs, and areas of concern;
4. Patient and family/caregiver preferences for life sustaining treatments and hospitalization;
5. Cognitive status evaluation;
6. Condition(s)/diagnoses causing and contributing to the terminal prognosis;
7. Current and previous palliation and management of the principle diagnosis and related condition(s);
8. Complications, non-related conditions, risk factors, allergies, and intolerances;
9. Functional status;
10. Kidney and liver function status (when/if available, to ensure safe medication dosing);
11. Imminence of death;
12. Chief complaint and prioritization of symptoms, including evaluation of symptom severity and burden;
13. Medication profile review and reconciliation (including indication, effectiveness/ineffectiveness, side effects, dosage, drug-drug and drug-disease interactions, therapeutic duplication, need for laboratory monitoring, overall appropriateness based upon patient status, patient prognosis, and patient/family goals of care, risk/benefit analysis, adverse effects). Documented medications include prescription and over the counter medications, herbal remedies, and other alternative treatments related and unrelated to the patient's principle diagnosis and condition(s) that contribute to the terminal prognosis;
14. Initial bereavement risk assessment of patient and family/caregiver, including social, spiritual, and cultural factors that may impact their ability to cope with the patient's death;
15. Referrals to community or ancillary services;
16. Military history checklist (for Veterans); and
17. Changes that have occurred since the initial assessment, progress towards goals, reassessment, and response to care.

CES 1.6 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 1.7 The comprehensive assessment includes data elements that allow for measurement of outcomes. These data elements are documented in a systematic and retrievable way for each patient and are used in individual care planning and documenting progress toward goals and outcomes, coordination of services and, in aggregate, for quality assessment/performance improvement.

Practice Examples:

- The hospice uses the military history checklist as part of the comprehensive assessment for Veterans to evaluate the impact of their military experience, identify related conditions (e.g., PTSD), and determine if there are benefits to which the Veteran and surviving dependents may be entitled.

- The hospice has a mechanism to obtain past medical records from referral sources.
- The hospice includes assessment of common co-morbid conditions as part of the initial nursing assessment and review of all prescription, over-the-counter, and herbal medications. The assessment includes documentation of which conditions and medications are related to the terminal prognosis.
- The initial assessment includes documentation on the stated goals and wishes of the patient and family/caregiver.
- The initial assessment includes evidence of the discussion or confirmation of patient and family/caregiver's preferences regarding life sustaining treatments, including CPR and hospitalization.

Standard:

CES 2: The patient's goals for pain management are achieved.

CES 2.1 An initial pain assessment is completed for every patient upon admission to hospice, including severity, location, character, duration, frequency, what relieves and worsens pain, and effect on function and quality of life.

CES 2.2 Ongoing pain assessments are performed and include the use of a self-report or observational pain rating scale appropriate to the patient's cognitive and functional status and general condition.

CES 2.3 Specialized pain assessment tools are available for various populations served (e.g., pediatric, nonverbal, non-English speaking, illiterate patients, and those unable to self-report).

CES 2.4 Procedures and protocols for pain assessment and management are developed and implemented with the involvement of a clinician(s) with pain assessment and management expertise.

CES 2.5 Patients and families/caregivers are educated about the importance of, barriers to, and methods of effective and safe pain management, including pain assessment and medication administration.

CES 2.6 Non-pharmacological interventions and adjuvant medications are included as pain management options as indicated.

CES 2.7 Common side effects of analgesics are anticipated and preventive measures are implemented.

CES 2.8 Regular assessment of the current pain medication regimen and supply is made in order to quickly optimize pain control and avoid interruption or delay in ordering or obtaining any required analgesics.

CES 2.9 Patients who have opioids prescribed for pain or other symptom management also have a bowel regimen or documentation why a bowel regimen is contraindicated.

Practice Examples:

- Pain assessment is a distinct, easily identifiable part of the initial and subsequent assessments.
- Patient/family/caregiver instruction about the use and side effects of analgesic and adjuvant medications, non-pharmacological techniques (e.g., guided imagery, breathing techniques, energy consolidation), and expected responses to therapy is consistently documented in the patient record.
- Patients and families/caregivers are educated about the relationship between pain and psychosocial/emotional/spiritual factors that contribute to stress and end-of-life challenges.
- Specific protocols/procedures are in place for reassessing patients who rate their pain greater than the identified level the patient desires.
- Non-pharmacologic therapies for pain management including, but not limited to, radiation therapy, complementary therapies, or surgical intervention are utilized as appropriate.
- The hospice has bowel regimen protocols for patients receiving opioids.

Standard:

CES 3: Symptoms other than pain are managed based on the patient's needs and response to treatments.

CES 3.1 Comprehensive assessments of all symptoms other than pain are routinely completed on every patient.

CES 3.2 Guidelines and/or protocols are developed for the assessment, screening, and management of common physical symptoms other than pain, including but not limited to:

1. Dyspnea and coughing;
2. Nausea and vomiting;
3. Anorexia and weight loss;
4. Dehydration and dry eyes/nose/mouth;
5. Anxiety;
6. Depression;
7. Confusion;
8. Delirium;
9. Skin conditions, lesions, and wounds
10. Constipation and diarrhea;
11. Restlessness and agitation;
12. Sleep disorders;
13. Mucositis;
14. Edema and lymphedema, including ascites;
15. Fever and infections;
16. Seizures;

17. Cachexia, weakness, and musculoskeletal disorders; and
18. Alterations in sensation and other neurological symptoms.

CES 3.3 The hospice nurse assesses the patient's nutritional status and implements appropriate nutritional interventions as desired by the patient and as deemed appropriate with regard to the patient's prognosis and medical history. If the patient's nutritional status needs are complex, a nutritionist or dietitian should assess the patient's needs.

CES 3.4 Education is provided to the patient and family/caregiver about the disease process and the palliation of the patient's symptoms.

Practice Examples:

- The hospice develops educational tools to utilize in teaching patients and families/caregivers about the nutritional needs of the terminally ill including concerns about the patient not eating or drinking and considerations related to the provision of artificial feeding.
- The hospice has resources available to educate and train staff and/or caregivers about Veteran-specific issues and symptoms related to their military service, such as post-traumatic stress disorder, and spiritual or moral distress.
- The hospice has textbooks and current evidence-based educational resources available to the staff related to the palliation of symptoms.
- Routine symptom assessment includes severity and alleviating and/or exacerbating factors including which therapies have been tried and whether those therapies have been effective.
- Specialized assessments are developed for various populations served (e.g., pediatric patients, developmentally disabled patients, homeless patients, incarcerated patients).
- The hospice has protocols for management of symptoms other than pain (e.g., dyspnea, delirium, vomiting).

Standard:

CES 4: The pharmacotherapeutic needs of patients are met while adhering to applicable state and federal laws and regulations and accepted standards of practice.

CES 4.1 The hospice interdisciplinary team confers with a professional or clinician who has education and training in medication management to ensure that medications and biologicals meet each patient's needs.

CES 4.2 A patient-specific medication profile is maintained and continuously reviewed to reconcile medications and to monitor for medication effectiveness, actual or potential medication-related adverse effects, drug-drug and drug-disease interactions, and medication duplication.

CES 4.3 A process is in place to review all prescribed medications for appropriate utilization. This process includes, at a minimum, an assessment of expected treatment outcomes, dosage, frequency and route of administration, duplicative therapy, potential adverse drug reactions and side effects, and potential drug-drug and drug-disease interactions.

CES 4.4 Written policies and procedures are developed in compliance with applicable state and federal laws and regulations governing the prescribing, dispensing, labeling, compounding, administering, transporting, delivering, tracking, controlling, and storing of all medications and biologicals.

CES 4.5 Written policies and procedures are developed to identify cost factors and guide formulary decisions for medications only after safety, efficacy, side effect profile, and therapeutic need have been established. Consideration of the use of equivalent alternative medications and therapies is incorporated into the evaluation process.

CES 4.6 Written policies and procedures are developed for the disposal of controlled medications when the patient no longer needs the medications or after the patient's death. Disposal methods follow federal and/or state guidelines.

CES 4.7 Patients and families are informed about policies for tracking and disposing of controlled substances when treatment with a controlled substance is initiated.

CES 4.8 Pharmacy services are available twenty-four (24) hours a day, seven (7) days a week.

CES 4.9 Quantities of medications dispensed to the patient are sufficient to maximize patient comfort while minimizing the potential for error, waste, and diversion.

CES 4.10 Written policies and procedures are developed for defining, identifying, reporting, and documenting medication errors and adverse drug reactions that ensure adequate follow-up in all settings where care is delivered.

CES 4.11 Written policies and procedures are developed to describe the use of experimental medications and protocols.

CES 4.12 Patients and families/caregivers are educated on safe and effective use of medications and safe medication administration as well as potential side effects and expected responses. The hospice interdisciplinary team assesses the ability of the patient and family/caregiver to safely administer medications.

CES 4.13 Written policies and procedures are developed to define the appropriate use of medications that may be considered "chemical restraints." The policies and procedures include stipulations that these medications may be used only if needed to improve the patient's wellbeing or to protect him/her or others from harm and only when less restrictive interventions have been determined ineffective.

CES 4.14 Written policies and procedures are developed for the identification of medications that are covered under the hospice benefit related to the principle diagnosis and co-morbid conditions that contribute to the terminal prognosis. The policies and procedures include provisions for coordination with pharmacies and medication plans regarding medication approvals when applicable.

Practice Examples:

- The pharmacist offers consultations regarding complex medication regimens and provides educational opportunities and updates for the hospice team members.
- A pharmacist or hospice physician reviews all medication profiles for potential medication-related effects, correct dosing, accurate and practical administration directions, drug-drug and drug-disease interactions, overall appropriateness based on patient status, patient prognosis and patient and family/caregiver goals of care, risk-benefit analysis, and duplication at the time the medication is ordered.
- The hospice nurse and/or hospice physician or hospice medical director counsels the patient and family/caregiver on the discontinuation of medications, as appropriate, based on the patient's terminal prognosis and changes in status on an ongoing basis.
- The hospice has a policy for disposal of controlled substances, communication about critical medication shortages, formulary maintenance, and how to handle substitution protocols and recalled or discontinued medications.
- The hospice nurse reviews and provides a copy of the hospice's medication disposal policy for controlled drugs with the patient and family/caregiver at the time the drug is prescribed.
- The hospice nurse reviews all written medication information with the patient and family/caregiver in a manner and language of their choice. The hospice nurse ensures and documents the patient and family/caregiver understands this information.
- The hospice nurse notifies the pharmacist regarding the patient's condition and estimates the quantity of medication needed to meet the patient's needs.
- Incident reports regarding medication errors are completed and monitored for trends or high risk.
- The hospice nurses have access to up-to-date medication information and resources to ensure timely and safe administration of medications.
- The hospice has a policy for handling patient requests for vaccine administration.
- Policies and procedures are in place for known and potential drug diversion.
- The hospice has a process to identify medications related to the principle illness and conditions that contribute to the terminal prognosis to coordinate medication approval with pharmacies and health plans.
- Hospice interdisciplinary team members are able to support and/or educate patients and families on the use of holistic or alternative products (e.g., vitamins, herbs, medical marijuana, homeopathy, ayurvedic, over-the-counter products, and other substances that can impact treatment and outcomes) as indicated.

Standard:

CES 5: Diagnostic services necessary for the management of symptoms and according to the patient's plan of care are provided.

CES 5.1 Lab specimens obtained by the hospice are taken only to laboratories that meet Clinical Laboratory Improvement Amendment (CLIA) and state law requirements.

CES 5.2 The hospice complies with applicable state law and secures a CLIA certificate of waiver for any waived testing performed by hospice staff.

CES 5.3 Policies and procedures address:

1. Personnel requirements for performing and supervising waived testing;
2. Training, orientation, and competency verification processes for staff performing waived testing;
3. Specific procedures related to the waived testing; and
4. Quality control checks and related recordkeeping requirements.

CES 5.4 Criteria are developed regarding the provision of laboratory, radiology, or other diagnostic assessments.

Practice Examples:

- Current competency evaluations related to instrument usage are documented on all hospice nurses performing blood glucose monitoring.
- Quality control checks are performed and documented for each PT-INR machine each day that the testing equipment is used.
- The hospice interdisciplinary team considers information from the attending physician, accepted standards of practice related to palliative care, and patient and family/caregiver preferences when determining whether to include a specific diagnostic assessment or therapy in the patient's plan of care.

Standard:

CES 6: Therapeutic treatments and interventions are provided for the management of symptoms according to the patient's plan of care.

CES 6.1 Services such as physical therapy, occupational therapy, speech therapy, psychosocial counseling, pharmacological counseling, and nutritional counseling are available and utilized to help the patient reach optimal functioning as permitted by patient status and goals for care.

CES 6.2 Criteria are developed regarding provision of radiation, chemotherapy, pharmacotherapy, and other therapies as indicated for palliation of symptoms.

CES 6.3 Indicated complementary and non-pharmacologic therapies are offered as an adjunct to promote quality of life depending on patient goals and preferences.

Practice Examples:

- The hospice provides complementary therapies such as expressive therapy (e.g., art therapy and music therapy), massage therapy, acupuncture, aromatherapy, reflexology, and healing touch.

- Palliative radiation therapy or other palliative therapies are considered for treatment of symptoms and to improve the patient's quality of life.

Standard:

CES 7: Interventions to assist the patient and family/caregiver in meeting preferences within a changing environment or life circumstances are based on the comprehensive assessment performed at the time of admission and repeated throughout the course of care.

CES 7.1 The comprehensive assessment includes an evaluation of social, practical, and legal needs of the patient and family/caregiver in home, work, and school settings, and, if applicable, the patient's military history.

CES 7.2 The comprehensive assessment includes an evaluation of the patient's cognitive ability, and preferred style of communicating feelings and expressing emotions, thoughts, and needs.

CES 7.3 The comprehensive assessment includes an evaluation of the patient's way of finding meaning in their experience within the context of their life and social environment (i.e., self, family, friends, groups and affiliations, and other supportive relationships including religious and spiritual beliefs).

CES 7.4 Policies and procedures address planning and intervention when the patient expresses suicidal ideation.

CES 7.5 Concerns related to patient coping are assessed and addressed by the hospice interdisciplinary team and include at a minimum:

1. Access to adequate and accurate information related to illness progression, care, and outcomes;
2. Access to adequate social and emotional support;
3. Access to spiritual or philosophical support, as desired;
4. Change in family roles or dynamics (i.e., related to the loss of physical abilities and function, employment, hobbies, lifestyle);
5. Changes in finances or resources;
6. Communication abilities and challenges;
7. Risk factors such as behavioral health or substance abuse;
8. Ability to fulfill desired sexual expression;
9. Suicidal ideation;
10. Signs of abuse or neglect; and
11. Care cost or other care-related financial concerns.

Practice Examples:

- The hospice documents patient conversations about suicidal thoughts and implements protocols for intervention.
- Psychosocial assessment tools allow for assessment related to end of life as well as issues identified by the patient as important and relevant.
- Patient and family/caregiver educational materials and support are delivered in a manner and language of choice. Materials may include information about the psychological aspects of a terminal illness, grief, and loss.
- The psychosocial evaluation includes issues related to military service, if applicable, for which the hospice provides support.
- Patient and family/caregiver concerns about cost of care are addressed and managed.

Standard:

CES 8: Services continue without interruption whenever there is a change in the patient's care setting.

CES 8.1 Care is provided in the setting designated by the patient and family/caregiver as the patient's place of residence.

CES 8.2 Access to all levels of care is provided. General inpatient care (GIP) and continuous home care (CHC) are available and utilized as necessary for pain control or management of acute symptoms that require a greater intensity of care than can be provided under routine home care. Respite care is available and utilized to relieve family members or other persons who are caring for the patient.

CES 8.3 The hospice collaborates with other organizations, service providers, and individuals involved in the provision of care.

CES 8.4 When services are not provided directly by the hospice, written contracts exist to define the services provided by both the hospice and the contracted provider. These contracts define care delivery to assure that contracted services are consistent with hospice standards and care is provided in accordance with the hospice plan of care. Written agreements assure that the hospice retains overall responsibility for managing the patient's plan of care.

CES 8.5 Care provided by the hospice in a contracted facility adheres to the same:

1. Standards of care;
2. Intensity; and
3. Core and other services to meet the plan of care as provided to patients in their place of residence.

CES 8.6 The hospice contracts for inpatient care specify that:

1. The hospice provides a copy of the patient's plan of care and specifies the inpatient services to be provided;
2. The inpatient provider has policies consistent with those of the hospice and agrees to abide by the hospice's patient care protocols;
3. The clinical record includes a record of all patient services and events;
4. A copy of the discharge summary and, if requested, a copy of the clinical record is provided to the hospice;
5. The party responsible for the implementation of the provisions in the agreement (the hospice or the inpatient facility) is identified;
6. The hospice provides appropriate training for facility staff that provides care under the agreement;
7. The hospice assumes overall management for the terminal illness in coordination with all other providers;
8. All inpatient care services must be authorized by the hospice and delivered in accordance with the plan of care; and
9. Timely communication must occur between the hospice and the facility, including clinical information and the plan of care, which will ensure continuity of care.

Practice Examples:

- Utilization review processes monitor care in all care settings to assure that the scope of services meet identified needs of patients and families including, but not limited to:
 - Patient services by discipline providing the services;
 - Levels of care;
 - After hours care and support (including attendance at the time of death); and
 - Bereavement care.
- The hospice has current written contracts in place with all contracted providers and both parties regularly review the contracts to assure compliance with the agreed upon requirements.
- The hospice has a formal relationship with the Department of Veterans Affairs (VA) for care provided to Veterans in the community if a VA facility is present within the hospice's service area. The formal relationship includes coordinating care with the appropriate VA facility across care settings, communicating with VA staff regarding the care plan, and notifying VA staff at the time of the Veteran's death or discharge.
- In coordinating services with a hospice Pharmacy Benefit Manager (PBM), the hospice ensures accurate communication regarding the patient's location and level of care to optimize medication dispensing, billing, and when applicable, delivery or shipping.
- If coordinating services with a Part D plan sponsor, the hospice coordinates the prior authorization process required by the Part D plan sponsor, by using the Part D A3 form, to ensure appropriate billing to the hospice for medications related to the terminal prognosis and billing to the Part D plan sponsor for those medications unrelated.
- Educational programs are regularly offered to contracted providers and to the professional staff of other organizations involved in the patient's care.

- Coordinated care planning occurs on a regular basis between the hospice staff and contracted providers.
- Procedures are jointly developed by the hospice and contracted providers that define each party's role and responsibilities in the provision of care.
- Contracted providers are invited to participate in performance improvement activities related to their provision of care and services.
- The hospice has a mechanism to record, address, and resolve complaints related to contracted providers.
- The hospice documents communication with contracted inpatient care providers regarding the plan of care for each patient who receives services from the contracted provider.
- The hospice evaluates patient satisfaction with services provided by contracted services (e.g., DME, pharmacy).

Standard:

CES 9: Transfers, discharges, revocations, and changes in setting of care are planned and managed in a manner that assures coordination and continuity of care for patients, families/caregivers, and service providers.

CES 9.1 The hospice has written policies and procedures pertaining to transfer, discharge, and revocation, which include criteria for referral or transfer when the hospice is no longer the appropriate provider of care.

CES 9.2 When provision of care in the patient's place of residence is no longer feasible; the hospice has standard procedures that assure a well-coordinated transition to another setting where hospice care can be provided.

CES 9.3 Education is provided by the hospice to the receiving care provider regarding the plan of care whenever there are changes in the patient's care setting.

CES 9.4 Transfer, discharge, revocation, and referral practices include:

1. A process for ongoing evaluation of the patient's status and eligibility for hospice care;
2. Interdisciplinary discharge planning that addresses the patient and family/caregiver's needs and goals;
3. A coordinated transition process across all involved providers;
4. Facilitation of a planned, well-coordinated, and effective transition for the patient and family/caregiver;
5. A mechanism for follow-up communications with the hospice as needed;
6. Copies of a discharge summary, including summary of treatments, allergies, symptoms, pain management, medication summary/profile, current plan of care, recent physician orders, and other relevant documentation, are sent to the attending physician and receiving care provider upon revocation or discharge; and

7. Compliance with regulatory requirements for issuing the correct notification form when a patient is discharged from hospice care because of ineligibility ([Notice of Medicare Provider Non-Coverage/ NOMNC](#)) or services are provided that Medicare is not expected to cover ([Advance Beneficiary Notice of Non-coverage/ABN](#)).

Practice Examples:

- The hospice provides written information whenever a patient moves to a different care setting. The information includes, but is not limited to:
 - Services and interventions being provided;
 - Specific medical, psychosocial, emotional, spiritual, or other problems requiring intervention or follow-up; and
 - Follow-up activities planned by the hospice interdisciplinary team.
- The hospice interdisciplinary team periodically evaluates the status of all patients for continuing eligibility for hospice services.
- A step-by-step plan for discharges and revocations is developed by the hospice team to assure that referrals to appropriate resources and care providers are made.
- The hospice ensures that required Medicare processes for discharge, including issuance of the Notice of Medicare Non-Coverage (NOMNC) and Advance Beneficiary Notice (ABN) documents, are provided to the appropriate parties and copies are in the medical record.

Standard:

CES 10: The hospice develops, implements, and evaluates a plan for environmental safety and security.

CES 10.1 The hospice develops, implements, and evaluates a plan that addresses:

1. Building safety and security;
2. Staff safety and security;
3. Equipment safety and security; and
4. Patient and family/caregiver safety and security.

CES 10.2 The hospice provides education on staff safety and security annually and during new employee and volunteer orientation based on need and changes in policies and procedures. Staff safety and security education includes:

1. Personal safety on route and during patient visits in any setting;
2. General safety and self-defense measures;
3. Policies and procedures related to unsafe situations;
4. Physical safety (e.g., body mechanics and back safety);

5. Occupational Safety and Health Administration (OSHA) and National Institute for Occupational Safety and Health (NIOSH) requirements as related to safety in the workplace; and
6. Center for Disease Control and Prevention (CDC), Americans with Disabilities Act (ADA), state, and local regulations.

CES 10.3 The hospice develops, implements, and evaluates a plan that addresses the safety of patients and families that includes:

1. A safety assessment of each home environment, which is adapted for the patient's age and risk for falls;
2. Appropriate teaching resources related to safety issues;
3. Implementation and documentation of interventions directed toward eliminating or minimizing safety concerns identified in the patient's environment; and
4. Ongoing assessment of patient functional capabilities and the adequacy of family caregivers as well as development of a plan for provision of care that ensures the patient's safety and addresses changing care needs.

Practice Examples:

- The hospice has a written policy that describes actions to be taken when employees or volunteers find themselves in unsafe situations.
- The hospice provides an annual safety education program for all staff and volunteers.
- The hospice makes teaching materials available to patients and families related to safety in the home.
- The assessment of each hospice patient includes an evaluation of the safety of the home environment with special attention paid to oxygen safety and storage.
- The initial assessment of each hospice patient includes evaluation of current need for caregivers, projected need as the patient's illness progresses and development of a plan for provision of care as the patient's care needs change.
- The hospice references Occupational Safety and Health Administration (OSHA) and National Institute for Occupational Safety and Health (NIOSH) standards regarding parameters for lifting.
- The hospice uses needleless systems and sharps disposal containers to prevent needle stick injury.
- The hospice uses safe medication disposal systems and/or reconciliation of wasted controlled substances in accordance with state and federal law.
- The hospice appoints a safety committee and safety officer.
- The hospice interdisciplinary team checks for weapons in the patient's home and develops a plan with the patient and family/caregiver for safety.

Standard:

CES 11: The hospice develops, implements, and evaluates a plan for emergency preparedness, which includes the development of policies and procedures, a communication plan, and training and testing programs. The plan is rehearsed annually.

CES 11.1 The hospice performs facility-based and community-based risk assessments, utilizing an all-hazards approach to determine areas of vulnerability for emergency response.

CES 11.2 The hospice has a written emergency preparedness plan that provides for the continuation of services in the event of an emergency. The emergency preparedness plan includes at a minimum:

1. Policies and procedures that address staffing, provision of patient services, evacuation, sheltering in place, safeguard of supplies, maintenance of clinical records, and collaboration with other community providers;
2. Strategies for addressing emergency events identified by the risk assessment;
3. A plan for the management of consequences from power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care;
4. The types of services the hospice has the ability to provide in an emergency;
5. Strategies for ensuring continuity of operations, including delegations of authority and succession plans;
6. Processes for cooperation and collaboration with local, tribal, regional, state, or federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation;
7. Documentation of collaboration and participation with local, tribal, regional, state, or federal emergency preparedness officials, when applicable, in planning efforts; and
8. The development of arrangements with other hospices and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to hospice patients.

CES 11.3 The hospice develops and maintains a communication plan that is updated annually. The communication plan includes at a minimum:

1. Contact information (primary and alternate) for hospice staff, contractors, and federal, state, tribal, regional, and local emergency preparedness staff;
2. A process for sharing hospice patient information and clinical documentation, as necessary, with other health care providers to maintain continuity of care;
3. A process to furnish and disclose information about the general condition and location of patients under a hospice's care as permitted under the Health Insurance Portability and Accountability Act (HIPAA) in the event of an evacuation; and
4. A process to provide information about a hospice's inpatient unit occupancy, needs, and its ability to provide assistance to emergency preparedness officials.

CES 11.4 Training and testing on the hospice's emergency preparedness plan, communication plan, and related policies and procedures are provided to all new and existing hospice employees and individuals providing services under a contractual arrangement with the hospice at least annually. The training and testing program includes at a minimum:

1. Staff knowledge of emergency procedures;
2. Documentation of all emergency preparedness training;
3. Exercises to test the emergency plan that include participation in a full-scale exercise that is community or facility based, as well as facilitation of an additional activity that may include a second full-scale exercise or a tabletop exercise; and
4. Documentation of testing and lessons learned.

CES 11.5 The hospice is integrated into the broader community network and is prepared to respond to broader community needs that result from a natural or civil disaster (e.g., relocation options for patients, requests for bereavement services, increased referrals).

Practice Examples:

- The hospice creates and regularly updates a telephone tree, using mobile telephones as necessary, to facilitate communication with the staff during an emergency.
- The hospice reviews the emergency preparedness plan with all new employees, volunteers, and contracted staff during initial orientation and annually thereafter.
- The hospice considers preparation for multiple emergency events (e.g., multiple storms or extended utility loss).
- The hospice has an internal plan related to its involvement in the greater community related to its role in response to a natural or civil disaster.
- The hospice completes a debriefing after any activation of the emergency preparedness plan to assess the need for revision to the plan for increased effectiveness in future events.
- The hospice has a crisis communication plan for communicating internally with staff and volunteers and externally with the media.
- The hospice participates annually in a state-wide or country-wide drill that includes triaging patient needs in an emergency.

Standard:

CES 12: The hospice develops, implements, and evaluates a plan for the management of infectious and hazardous materials and waste.

CES 12.1 The hospice develops and implements a written plan that addresses:

1. Identification of infectious and hazardous materials and waste, including hazardous medications;
2. Proper storage, transportation, and disposal of infectious and hazardous materials and waste;

3. Compliance with all applicable laws and regulations related to infectious and hazardous materials and waste;
4. Precautions, procedures, and personal protective equipment (PPE) to be utilized when handling infectious and hazardous materials and waste; and
5. Employees' right to know about infectious and hazardous materials and waste (e.g., availability of Safety Data Sheets (SDS)).

Practice Examples:

- Safety Data Sheets (SDS) are available for all hazardous materials used by staff in performing their duties and responsibilities.
- Hazardous materials and medications (e.g., finasteride, hydroxyurea) are appropriately labeled.
- Sharps containers are clearly labeled as "hazardous waste" or color-coded and are properly disposed of according to hospice policy.
- Specimens are safely and securely collected, handled, labeled, and transported to the diagnostic laboratory.
- All patient clinical records include documentation of known infections.
- All clinicians receive education related to management of infections and handling hazardous materials and waste annually. The hospice tracks and documents staff participation in the education program.

Standard:

CES 13: The hospice develops and implements an infection control program that is designed to identify and decrease the risks of infection for staff, patients, and families and to monitor trends, prioritization of infection control risks, and decrease the rates of infection.

CES 13.1 The hospice has an infection control program that reflects standard infection control policies and practice and includes the following components:

1. Educating patients, family members, and other caregivers regarding the prevention and control of infection in a manner and language that they can understand;
2. Developing, reviewing periodically, and updating of policies and procedures related to infection control;
3. Educating staff, volunteers, and contract staff related to infection control practices including routes of transmission of microorganisms and the importance of effective hand washing technique, potential for exposure to infection, and follow-up to an exposure;
4. Monitoring employee health and the provision of related services including vaccinations such as influenza and hepatitis B;

5. Designating a staff member responsible for implementation and oversight of the infection control program;
6. Establishing a system for communicating the components of the infection control program with employees and volunteers as well as referring and receiving organizations; and
7. Prioritizing infection control risks.

CES 13.2 The hospice staff reports patient, employee, and volunteer infections as identified in the hospice surveillance policies and in accordance with state reportable disease requirements.

CES 13.3 The hospice collects defined surveillance data as part of the infection control program and takes appropriate corrective actions based on analysis of the data. Infection control data collection may include:

1. Identification of targeted infections, unusual or undesirable trends, and factors contributing to such trends;
2. Results of monitoring staff for compliance with policies and procedures;
3. Reportable employee illnesses and infections including trends and correlation with patient infections; and
4. Unanticipated death related to healthcare associated infections and conforming to the hospice's definition of a sentinel or adverse event.

Practice Examples:

- Performance evaluations of staff who provide direct patient care include an assessment of their knowledge and practice of infection prevention and control.
- The hospice has a policy and procedure describing the follow-up actions to be taken in the event of an occupational exposure to blood borne or airborne pathogens.
- Employee illness and infections are reported and analyzed for relationship to patient infections.
- The parents of pediatric hospice patients receive education on childhood infections and diseases.
- When an infection is present, appropriate actions, including applicable isolation precautions, are taken to control its spread among staff and patients (e.g., providing written instructions via teaching sheets or safety booklets in addition to verbal instruction).
- Infection control education is provided to all hospice staff annually.
- The hospice provides instruction to patients and families regarding standard precautions and the prevention and control of infection in a manner and language they can understand.
- The hospice has written policies and procedures that establish and promote the communication and collaboration of infectious disease reporting and tracking with local, state, and federal agencies.

Standard:

CES 14: The hospice's infection control program conforms to the guidelines set by government agencies, professional associations, and applicable laws and regulations.

CES 14.1 The hospice has a written blood borne pathogen exposure control plan and a respiratory protection plan that are reviewed with all staff and volunteers during orientation and on an annual basis.

CES 14.2 The hospice has developed a policy and procedure for dealing with epidemics. The plan includes but is not limited to:

1. Patient management strategies:
 - a. Prolonged isolation;
 - b. Sanitation and hygiene;
 - c. Handling corpses; and
 - d. Coordination with other community agencies.
2. Staff protection and management strategies:
 - a. Personal protective equipment;
 - b. Prolonged work from home; and
 - c. Staff shortages.
3. Identification and transmission education.

Practice Examples:

- Infections are reported to the state's Department of Health as required.
- The hospice monitors Department of Health report of infection in the community.
- The hospice provides both fit testing and N-95 masks for staff that provide direct care to patients with tuberculosis (TB).
- The hospice has a blood borne pathogen exposure control plan, and staff participates in annual education on the plan.
- All clinical staff have personal protective equipment during patient visits.
- Hospice nurses provide wound care in accordance with the hospice's infection control protocols and physician's orders.
- All hospice staff and volunteers receive instruction and comply with hand hygiene according to the Centers for Disease Control and Prevention (CDC) and/or World Health Organization (WHO) guidelines.
- The hospice has a process for maintaining current knowledge of potential epidemics.

Standard:

CES 15: The hospice infection control program is monitored, reviewed, evaluated, and updated at least annually.

CES 15.1 A summary of all infection control activities performed, surveillance data collected, and actions taken related to the data aggregation and analysis is submitted to the hospice's administrative leadership and reviewed annually.

CES 15.2 The infection control program includes objective and systematic measurement, monitoring, and evaluation of services and implementation of quality improvement activities based upon the findings. The program uses quantifiable measures to establish and evaluate compliance with infection program standards.

Practice Examples:

- The hospice's performance improvement committee regularly reviews reports and data related to infection control activities.
- At least one aspect of care related to infection control is evaluated annually (e.g., Tuberculin skin test conversions, catheter-related infections, employee illnesses) with the goal of improvement.
- The hospice has established an influenza prevention program for patients and staff.

Standard:

CES 16: Seclusion and restraints may only be utilized if needed to improve the patient's wellbeing or protect the patient or others from harm, and only when less restrictive interventions have been determined to be ineffective.

CES 16.1 The hospice has written policies and procedures for implementation of seclusion and restraints including but not limited to:

1. Physician order;
2. Specification of purposes for restraint;
3. Definition of restrictive devices;
4. Education of patient and family/caregiver; and
5. Frequency of monitoring.

CES 16.2 If seclusion and restraints may be used in the hospice's inpatient facility, staff who provide direct patient care receives training and education in the proper use of seclusion and restraint application and techniques. Staff must also hold current certification in cardiopulmonary resuscitation (CPR). (Note: See Appendix 1, Hospice Inpatient Facility for additional standards for utilization of seclusion and restraints.)

CES 16.3 Hospice staff who provide direct patient care receives training and education in alternative methods for handling situations where seclusion and restraints customarily have been used.

CES 16.4 The hospice must report any serious injury and/or death related to the use of restraints to local, state, and federal regulatory agencies within the required timeframe.

Practice Examples:

- The hospice's seclusion and restraint policy and procedures specify what medications and restrictive devices are considered restraints within the hospice setting.
- Medications ordered for hospice patients that are considered chemical restraints in other settings (e.g., nursing homes) have clearly defined symptom management protocols that reflect the indications for use.
- The hospice informs the family/caregiver prior to initiating restraints.

Standard:

CES 17: The hospice has a written plan for fire safety and prevention within the hospice's environments and patient settings including:

1. Evacuation procedures and escape routes;
2. Management of fire extinguishers;
3. Protection of staff, visitors, and property from fire and smoke;
4. Policies for using smoking materials in all settings;
5. Policies for the management of highly combustible materials and/or equipment;
6. Fire equipment maintenance policies/procedures; and
7. Documented regularly scheduled fire drills.

CES 17.1 The hospice provides staff education related to fire safety, prevention, and response to a fire in all settings and conducts and documents quarterly fire drills.

CES 17.2 The hospice develops, implements, and evaluates a plan for fire prevention in the patient's environment that includes:

1. Assessment of fire hazards;
2. Implementation and documentation of actions taken related to fire prevention;
3. Patient and family/caregiver education related to fire prevention (e.g., use of smoke detectors, oxygen safety and risky behaviors); and
4. Patient and family/caregiver response to a fire in the home, including escape routes.

Practice Examples:

- Fire safety is included in new employee and volunteer orientation.
- Staff receives annual in-service education on fire safety.

- The hospice instructs patients and families/caregivers on fire prevention and developing an evacuation plan.
- The hospice ensures that parents of a pediatric hospice patient inform the local fire department that a disabled child resides in the home and stickers are placed on the patient's bedroom window to alert fire responders in the event of a fire.
- The hospice holds and documents regularly scheduled fire drills for hospice staff.
- The hospice regularly reviews oxygen safety with patients, families, and other caregivers when oxygen is in use in the home.

Standard:

CES 18: The hospice develops, implements, and periodically reviews a plan for continued operations in the event of interrupted communication and/or utility systems.

CES 18.1 The hospice develops, implements, and evaluates a plan for utility systems management within the hospice that provides for a safe and comfortable environment and communication system, including but not limited to:

1. Computer backup;
2. Telephone backup systems;
3. Utility systems failure (e.g., electrical system); and
4. Communication systems failure.

CES 18.2 The hospice addresses patient safety and continuation of hospice care in the patient's environment to include:

1. Assessing utility requirements for medical equipment used in patient care;
2. Assessing environmental requirements for medical equipment;
3. Assessing safety issues relating to electrical outlets, grounding, circuit overload, and other electrical system potential hazardous areas;
4. Providing education for all patients, family members, caregivers, and employees on the safe use of medical equipment;
5. Providing education on methods of contacting the hospice during communication systems failure; and
6. Identifying community resources to provide utility services needed for patient comfort as indicated.

Practice Examples:

- Patients and families/caregivers receive verbal instruction and related written instructional materials for any medical equipment used in the home in a format and language they can understand.
- Patients utilizing oxygen in the home have a backup source of oxygen in case of a system failure.
- The hospice ensures that patients are on a utility priority list in the event of a power outage.
- The hospice ensures that patients have adequate warmth or cooling, light, etc. to meet basic comfort needs.

Standard:

CES 19: The hospice assures that medications and nutritional products are properly transported, managed, handled, stored, prepared, and administered.

CES 19.1 The hospice has policies and procedures for proper storage and handling of medications and nutritional products in all patient settings including:

1. Securing all controlled medications in accordance with laws and regulations to prevent diversion;
2. Safe storage (e.g., proper temperature, attention to expiration dates, controlled ventilation, humidity) in accordance with manufacturers' recommendations;
3. Separate storage of medications for internal use and medications intended for external use; and
4. Proper labeling (e.g., medications are stored according to the label, package insert, or other written instructions).

CES 19.2 Hospice staff instructs patients and families/caregivers on the correct preparation and administration of medications and nutritional products in the patient's home.

Practice Examples:

- Expired medications and nutritional products are disposed of promptly and properly following applicable regulatory guidelines.
- All medications and nutritional products are adequately labeled and include an expiration date.
- The family is instructed to keep medication out of the reach of children and to track when medication is administered to prevent a medication error.
- The hospice has a tracking system to assure that medications are delivered safely and timely.
- The hospice incorporates methods to assure adherence to medication administration schedules based on the prescribed dosing frequency.
- The hospice educates patients and families/caregivers on proper medication dosing and routes of administration.
- The hospice contracts with pharmacies that comply with local, state, and federal laws related to the proper management, handling, storage, preparation, and transportation of medications and nutritional products.
- When there is a concern of possible drug diversion in the patient's home the hospice takes steps to safeguard medications including:
 - Initiating a controlled substance agreement;
 - Placing a lockbox in the home; limiting the quantity of medication dispensed;
 - Altering the route of medication administration; considering alternate locations for medication storage;
 - Increasing visit frequency; and
 - Implementing and documenting medication counts at each visit.

Standard:

CES 20: The hospice develops, implements, and evaluates a plan for reporting, monitoring, and following up on all incidents.

CES 20.1 The hospice has written policies and procedures that define reportable incidents and a mechanism for reporting, following up, and tracking incidents that includes but are not limited to:

1. Adverse outcomes including medication reactions and complications of treatment;
2. Staff endangerment or injury;
3. Patient or family/caregiver injury including falls;
4. Theft or damage to property;
5. Motor vehicle accidents incurred when conducting hospice business;
6. Equipment or mechanical device failure or user errors;
7. Problems related to the safe handling and use of controlled substances;
8. Unusual occurrences;
9. Patient-related suicide or homicide threats, attempts, or completion;
10. Unusual symptom clusters in a family or community;
11. Harassment or sexual abuse;
12. Patient abuse or neglect; or
13. Medication diversion.

CES 20.2 The hospice designates a person responsible for:

1. Investigating all incidents;
2. Taking follow-up actions as necessary;
3. Aggregating incident data to monitor for trends; and
4. Utilizing the data for risk management.

CES 20.3 The hospice assures adequate record keeping and reporting of incidents in compliance with state and federal law.

Practice Examples:

- The hospice has a form and process for reporting and documenting incidents.
- Incident reports are reviewed and summarized with patterns and trends analyzed on a regular basis.
- Incidents involving a premature death, unexpected or accidental death, or a suicide will receive an intensive evaluation to identify the root cause and prevent a similar event.
- Serious adverse events are reported to state and/or federal agencies according to abuse/neglect laws, HIPAA regulations, accrediting agency standards, or other laws and regulations.
- Staff members are free from reprisal for reporting incidents.

Standard:

CES 21: The hospice provides for the safe and effective use of medical equipment including delivery, setup, maintenance, and training of regular and contracted staff, patients, and families/caregivers.

CES 21.1 When the hospice provides medical equipment, directly or by contract, a system is in place to assure the quality, functionality, and cleanliness of the medical equipment.

CES 21.2 When the hospice provides medical equipment, directly or by contract, a system is in place to assure effective selection, delivery, setup, maintenance, and instruction in use of the equipment.

CES 21.3 The hospice assures that emergency maintenance, replacement, or backup for medical equipment is available twenty-four (24) hours a day, seven (7) days a week.

CES 21.4 The hospice assures that equipment hazards, defects, and recalls are appropriately addressed and reported as required by the Safe Medical Device Act.

CES 21.5 The hospice complies with manufacturer's instructions, as well as state and local laws, regarding the use of medical equipment.

CES 21.6 If the hospice contracts for durable medical equipment, the hospice must contract with a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) accredited company.

CES 21.7 Any equipment owned by the hospice for staff use is checked at least annually and recalibrated or replaced as necessary (e.g., blood pressure cuffs, glucose monitoring equipment).

Practice Examples:

- The hospice has a procedure for reporting and responding to defective medical equipment and equipment recalls.
- The hospice ensures that patients have an adequate backup source for oxygen in case of a power failure.
- When equipment is delivered to the patient's home, the patient and family/caregiver receive written and verbal information on how to operate and troubleshoot the medical equipment in a manner and language they can understand.
- When a contracted provider supplies medical equipment, the contracted provider's performance is monitored and evaluated.
- The hospice orders equipment consistent with state law (e.g., bedrails).

STANDARDS OF PRACTICE FOR HOSPICE PROGRAMS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

6 / Inclusion and Access (IA)

6 / Inclusion and Access (IA)

PRINCIPLE

Promoting inclusiveness in the community by ensuring that all people regardless of race, ethnicity, color, religion, gender, disability, sexual orientation, age, disease or other characteristics have access to the hospice's programs and services.

Standard:

IA 1: The hospice ensures that patient care and services provided are responsive to the needs of the population served.

IA 1.1 The organizational leaders periodically evaluate, review and revise the hospice's services to meet the community's needs.

IA 1.2 The hospice has established criteria that clearly identify the requirements for admission to and discharge from hospice care.

IA 1.3 Access to care, based on the needs of the patient and family/caregiver, is provided without regard to race, national origin, age, gender identity, religion, creed, diagnosis, disability, sexual orientation, place of residence within the hospice's service area, source of payment, or the ability to pay for services.

IA 1.4 The hospice's informational initiatives, including literature, website, and communication through social media, describe the organization's principles and approach to provision of care and includes detail on all services offered.

IA 1.5 The hospice uses community-specific communication methods to reach the intended population(s).

IA 1.6 The hospice considers utilizing multiple locations, if feasible, to ensure service provision is as timely and effective as possible.

IA 1.7 The hospice makes use of innovative technologies to address challenges related to care delivery such as provision of care in remote locations and unavailability of on-site caregivers.

Practice Examples:

- The hospice's strategic plan contains goals and strategies designed to meet community needs.
- The hospice implements performance improvement projects aimed at improving the hospice's performance in meeting the community's needs.

- Needs specific to the demographic characteristics of the family caregiver population (e.g., adult children, older spouses) served by the hospice are taken into consideration when developing informational materials.
- Brochures and other informational materials describing the services the hospice provides are available in the languages, in addition to English, that are prevalent in the community. The materials include culturally relevant visual and textural content, are written at appropriate literacy levels, and address specific cultural sensitivities related to death and dying and family caregiving.
- Photographs used in the hospice's brochures reflect the ethnic and racial diversity of the community it serves.
- Hospice informational brochures and educational materials are distributed throughout the service area to community and professional referral partners (e.g., churches, family caregiver support groups, adult day care centers).
- Information that specifies the procedures and criteria for admission to hospice care is distributed to referring and non-referring physicians.
- Contacts are made with specialty physicians (e.g., cardiovascular, pulmonary, neurology, nephrology, gerontology, family, pediatric) to facilitate the appropriate referral of patients with a non-cancer diagnosis.
- The hospice collaborates with disease-specific organizations to identify ways to facilitate timely access to care for eligible patients.
- The hospice explores Health Insurance Portability and Accountability Act (HIPAA) compliant telehealth options such as video conferencing, sensors to monitor falls and elopement, cardiopulmonary monitors, and robotic telepresence options.
- The hospice utilizes a system and appropriate technology to communicate with deaf and hard-of-hearing patients.
- The hospice uses a variety of marketing methods that reflect the preferences and habits of specific target audiences. Examples include: information directed toward parents of young children is disseminated through social media; radio is used to for information tailored to Hispanic communities; education for working family caregivers is offered at the workplace; an educational offering is recorded as a podcast to increase access.
- The hospice provides core services to all patients, regardless of ability to pay.

Standard:

IA 2: The hospice facilitates access to care by providing services as well as clinical and management staff that are sensitive to the culturally diverse needs of the community it serves.

IA 2.1 Hospice staff and volunteer orientation and in-service education programs include training that reflects the cultural diversity of the community served by the hospice.

IA 2.2 Information regarding the provision of services specific to the cultural diversity of the population served is included in the annual program evaluation.

IA 2.3 The hospice disseminates information to the community and referral sources about the services offered, who qualifies for services, how services may be obtained, and payment for services.

IA 2.4 The hospice arranges for interpreter services and culturally sensitive information in the preferred language of the patient/family/caregiver.

IA 2.5 Collection of cultural information is part of the comprehensive assessment, including but not limited to primary language, preferences for support services, and funeral/burial practices.

Practice Examples:

- The cultural, ethnic, and racial composition of the population in the hospice's service area is represented in the composition of the hospice staff and volunteer pool.
- The hospice annually assesses the cultural competency of clinical staff.
- The hospice intake staff receives training in cultural competence to enable them to respond appropriately when talking with individuals from various cultural backgrounds.

Standard:

IA 3: A periodic community needs assessment that examines both private and public resources, with special attention to securing access to care for underserved populations in the community, informs the development and implementation of hospice services.

IA 3.1 A periodic community-wide needs assessment is performed by or is available to the hospice.

IA 3.2 The hospice analyzes data from the needs assessment and develops a plan based on the results of the assessment. The hospice utilizes the results of the needs assessment to develop and implement outreach programs and services that are appropriate and responsive to the hospice and end-of-life care needs of the community it serves.

IA 3.3 Any limitations to provision of care are periodically evaluated with the goal of increasing access to hospice care in the community.

IA 3.4 The hospice provides education and training to all staff and volunteers related to community needs assessment, cultural sensitivity, and the population it serves.

Practice Examples:

- The community assessment includes key metrics, including but not limited to, average length of stay, median length of stay, market death/service ratio, analysis of referral source patterns, Centers for Disease Control (CDC) overall causes of death data and regional demographic statistics.

- When conducting the community needs assessment, the hospice considers the presence of diverse cultures, races, ethnicities, and vulnerable/special populations with particular attention to the potential limitations to access for these groups. Vulnerable and specific populations may include individuals with physical and cognitive disabilities, individuals with specific diseases/conditions, individuals residing in long term care facilities and correctional facilities, and Veterans.
- The hospice records and tracks the periodic evaluation and planned strategies to refashion the hospice's services to meet the community's needs.
- An annual community education seminar is conducted that addresses an important hospice topic identified by the needs assessment (e.g., pain management, advance care planning and advance directives, physician assisted suicide).
- The hospice convenes a task force/advisory group to develop ways to increase access to hospice care for diverse communities based on the ethnic and racial composition of the service area. The diverse composition of the community is reflected in the membership of the task force.
- Hospice staff and volunteers receive education related to the patient populations they may interact with during the course of care (e.g., infants; children; young parents; lesbian, gay, bisexual, and transgender patients and family members; Veterans and their families).
- Community education activities are marketed to all groups in the community.

Standard:

IA 4: Bereavement education and supportive services are offered to the community at large.

IA 4.1 The hospice provider is recognized as a resource for bereavement services and support.

IA 4.2 Bereavement services are accessible to anyone in need of support, regardless of whether they received hospice services.

IA 4.3 Bereavement expertise is available to any community member and organization impacted by loss.

IA 4.4 Education is provided on grief, loss, and other bereavement-related topics for target populations in the community.

Practice Examples:

- The hospice informs the community about its bereavement services, programs, and the availability of support groups through regular communication in its own publications and other means, and through community media resources that are appropriate to the target populations.
- Community bereavement needs are evaluated and programs are implemented to meet the community's identified needs.

- The hospice demonstrates its commitment to the community and the partners it serves by holding bereavement support groups for bereaved facility staff.
- The community at large is invited to participate in bereavement programs.
- The hospice actively promotes the community's understanding of grief and loss by sponsoring community educational programs in partnership with other community organizations (e.g., funeral homes, other healthcare providers, churches).
- The hospice collaborates with community crisis organizations and invites them to include hospice staff and services as part of their work.
- Programs (e.g., training, education, employee assistance programs and support) are developed to assist in meeting the bereavement needs of schools, businesses, law enforcement agencies, and emergency response teams.
- A systematic process is developed and implemented to respond to community inquiries and concerns related to general bereavement issues.

STANDARDS OF PRACTICE FOR HOSPICE PROGRAMS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

7 / Organizational Excellence (OE)

7 / Organizational Excellence (OE)

PRINCIPLE

Building a culture of quality, accountability, and service excellence within an organization that values collaboration and communication and ensures ethical business practices.

Standard:

OE 1: Operations of the hospice are in compliance with all applicable regulations and laws at the federal, state, and local levels.

Practice Examples:

- Durable Medical Equipment (DME) contracts are obtained with providers that meet the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier quality and accreditation standards.
- Medications are reviewed regularly for relatedness to the terminal prognosis and are billed to the appropriate payer.

Standard:

OE 2: The hospice accurately represents its services to the public.

OE 2.1 Marketing materials and individuals representing the hospice accurately describe the benefits, scope, capabilities, and cost of services.

Practice Examples:

- Speaker's bureau members are trained in the core services provided and the provisions of the Medicare and Medicaid hospice benefits or other insurance coverage.
- All marketing materials are reviewed annually to ensure that information is up to date and services are clearly defined and explained.
- The hospice provides orientation and training to partnering providers such as hospitals, nursing facilities, or assisted living facilities regarding hospice services.
- Patient information materials clearly explain the scope of the hospice's services, the palliative rather than curative goal of hospice care, waiver of Medicare/Medicaid benefits, and costs.

Standard:

OE 3: Processes are designed to collect and manage information to support the hospice's delivery of care and other operations.

OE 3.1 Data are routinely collected related to the allocation and utilization of services in all care settings, including but not limited to:

1. Average and median length of service;
2. Days of service by level of care (routine home care, continuous home care, respite care, inpatient care);
3. Length of time from referral to admission;
4. Services provided and visits made by all disciplines, including hospice aide visits, bereavement contacts, volunteer contacts, and number of volunteer hours;
5. Data required for the cost report submitted annually to the hospice's Medicare Administrative Contractor (MAC);
6. Data related to compliance with applicable laws and regulations; and
7. Data required for reports for aggregate and inpatient CAP liability.

OE 3.2 The hospice has a plan for systematically monitoring and evaluating the allocation and utilization of services provided to patients and families in all care settings, which includes but is not limited to:

1. Ensuring that all patients meet medical eligibility requirements for hospice care;
2. Evaluating timeliness of admissions;
3. Examining length of service (LOS) data for potential problems (e.g., short LOS, long LOS, patterns of live discharge) across all settings;
4. Evaluating the availability and appropriate utilization of all levels of care (routine home care, general inpatient care, respite care, and continuous home care);
5. Ensuring the provision of bereavement services to family members and facility staff;
6. Analyzing and evaluating patient and family/caregiver care outcome data;
7. Evaluating appropriateness of and reasons for live discharges;
8. Examining the rate and reasons for hospitalizations;
9. Examining staff productivity; and
10. Utilizing comparative statistical information in the evaluation process.

OE 3.3 Financial information is routinely reviewed, including but not limited to:

1. The annual operating budget in order to identify variances with planned expenses and income;
2. Accounts receivable and accounts payable to ensure that accounts are handled in a timely manner;
3. Accounting processes to ensure compliance with general accounting procedures;
4. Billing procedures to ensure compliance with regulations; and
5. Audits of patient clinical records to ensure compliance with regulatory requirements regarding:

- a. Dates of election of the Medicare and Medicaid hospice benefits;
- b. Completion of the face-to-face encounter requirement for compliance with the required timeframes;
- c. Physician narrative summary for certification of terminal status; and
- d. Level of care documentation requirements.

Practice Examples:

- Reports with statistical information on service utilization and hospice operations are generated and analyzed on a monthly or, at a minimum, quarterly schedule.
- The hospice conducts performance improvement projects to improve billing processes and ensures that each project includes an aim statement.
- Managers are accountable for adhering to the budget for their departments and reviewing all related invoices and payments.
- Inaccurate billing is identified, corrected, and resubmitted for payment.
- A system is in place to file the Notice of Election (NOE) and Notice of Termination/Revocation (NOTR) in the Fiscal Intermediary Standard System (FISS) within the required time frames, with a focus on timeliness and accuracy.
- A system is in place to determine the benefit period of a patient prior to admission using the Common Working File (CWF), as well as a process for scheduling face-to-face encounters to comply with the required timeframe for recertification.
- Utilization of services data are collected and compared to state, regional and national level results from the Program for Evaluating Payment Patterns Electronic Report (PEPPER).
- A system is in place that ensures that the physician narrative statement documenting the patient's eligibility and prognosis for hospice services is completed, signed and dated for each certification of terminal illness.
- A system is in place to ensure the accuracy of documentation of medications and refills listed on the bill.
- A system is in place to ensure accuracy of postmortem visit billing.

Standard:

OE 4: Operational information is collected and disseminated to appropriate individuals in a timely manner.

OE 4.1 Operational information is communicated to all hospice staff, the governing body, and volunteers on a regular basis.

OE 4.2 The hospice utilizes external industry data for comparison and participates, whenever possible, in external data collection initiatives.

OE 4.3 There is evidence that collected and reviewed data and information are the basis for decision making related to hospice operations.

Practice Examples:

- Clinical managers regularly review patient care costs and other financial data and share relevant information with staff on a regular basis.
- Medications are reviewed to ensure that hospice is paying for medications related to the principle diagnosis and other diagnoses and conditions contributing to the terminal prognosis.
- The Quality Assessment and Performance Improvement (QAPI) Program includes both clinical and operational performance improvement projects and utilizes reports and graphs with comparative data for benchmarking.
- The hospice participates in state and national comparative operational data collection and reporting initiatives.
- The governing body reviews financial data at each meeting and takes follow-up action as necessary.
- The governing body reviews QAPI program data at regular intervals and takes follow-up action as necessary.

STANDARDS OF PRACTICE FOR HOSPICE PROGRAMS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

8 / Workforce Excellence (WE)

8 / Workforce Excellence (WE)

PRINCIPLES

Fostering a collaborative, interdisciplinary environment that promotes inclusion, individual accountability, and workforce excellence through professional development, training, and support to all staff and volunteers.

Hospice organizational leaders ensure that the number and qualifications of staff and volunteers are appropriate to the scope of care and services provided by the hospice program.

Standard:

WE 1: The hospice identifies and maintains an appropriate number of qualified staff and volunteers to meet the unique needs of the patients, families/caregivers, and the organization and to ensure that core services are provided.

WE 1.1 The hospice's administrative leadership ensures that all individuals who provide patient and family/caregiver services are competent to provide such services.

WE 1.2 The hospice has written policies and procedures describing its method(s) for assessing competency of clinical staff and maintains a written description of staff development training.

WE 1.3 Hospice staff has current licensure, certifications, or other credentials appropriate to their practice and scope of responsibilities in accordance with applicable laws and regulations in the states where they practice.

WE 1.4 The hospice ensures that physician services are available through contract, direct employment with the hospice provider, or on a volunteer basis.

WE 1.5 The hospice establishes and utilizes appropriate staffing guidelines in planning for staff recruitment, retention, and assignments to ensure quality of patient care.

WE 1.6 The hospice ensures a patient's care or treatment is not negatively affected if the program grants a staff member's request not to participate in an aspect of a patient's care or treatment, such as for ethical, health, or personal reasons. The hospice does not penalize an employee for requesting not to participate in a modality of care or treatment for ethical or spiritual reasons.

WE 1.7 The hospice has identified a plan to respond to significant increases or decreases in census, based on strategic planning and staffing guidelines.

Practice Examples:

- Professional licenses are verified at least annually with the licensing body and documented in a personnel record.
- The hospice maintains accurate and current personnel records to support proof of current licensure, certification, or other required credentials.
- An employee whose license is expired or suspended is not allowed to work until the license is reinstated and verified.
- Documentation of hospice aide attendance at required monthly one-hour in-services is filed in each hospice aide employee record to reflect a total of twelve (12) in-service hours in a calendar year.
- Staffing coverage is secured when an employee is ill or requires a change in assignments.
- Education and organizational membership activities are documented in each staff member's personnel record.
- The hospice ensures that a social worker with a medical social work (MSW) degree supervises any social worker with a Bachelors in social work (BSW) degree hired after December 2, 2008 as well as staff with background in a related field who are functioning in a social work position.
- Additional staff is secured and/or contracted under non-routine circumstances, such as unanticipated periods of high patient census and case load, staffing shortages due to illness, or other short-term temporary situations that may interrupt patient care.

Standard:

WE 2: The hospice recruits staff and volunteers to reflect the diversity of the population in the community served.

WE 2.1 The hospice conducts an annual analysis to determine how the diversity of staff and volunteers correlates with the community served.

WE 2.2 The hospice recruitment plans and hiring activities demonstrate nondiscriminatory hiring and staffing practices.

Practice Examples:

- Recruitment efforts are aimed at hiring staff and volunteers that reflect the ethnicity and other characteristics of the population served.
- Community centers, places of worship, neighborhood associations, and local cable TV stations are utilized to recruit staff and volunteers from ethnic groups not well represented on the hospice's staff.

Standard:

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 substantiation as required by state or federal law and regulation.

WE 3.1 The hospice's administrative leadership defines the qualifications and performance standards for all staff positions.

WE 3.2 The hospice has a written job description that includes education, training and experience requirements, responsibilities, duties, and reporting lines for each position.

WE 3.3 Job descriptions are reviewed and updated on a regular basis.

WE 3.4 Personnel records are updated at least annually and include but are not limited to the following:

1. Verification of licensure;
2. Completed employment application;
3. Verification of experience;
4. Employee health screening records maintained in a separate secure file;
5. Pre-employment appraisals;
6. Annual performance evaluations;
7. Confidentiality Agreement;
8. Reference checks;
9. Criminal background checks for staff and volunteers;
10. The Office of the Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) (at hire and monthly);
11. Completed Form I-9 or Employment Eligibility Verification (excluding volunteers);
12. Conflict of interest form;
13. Child/adult abuse clearances per state requirement;
14. Competency assessments for clinical staff;
15. Verification of certifications; and
16. Other information as required by law, policy, or regulation.

WE 3.5 Each employee is provided copies of his/her job description upon hire and when revised.

Practice Examples:

- Potential employees receive a job description for the position for which they are applying.
- Supervisors evaluate the accuracy of a job description annually with input obtained from each employee in the position and make revisions as necessary.
- The hospice develops a personnel handbook and provides a copy to each employee on hire and when changes occur.

- Qualifications are defined in writing for all hospice team members and are included in position descriptions.
- Selection of hospice team members is made on the basis of the applicant's experience and education; communication and interpersonal skills; clinical or other specialty skills; experience related to loss, grief, and dealing with complex psychosocial issues; ability to work effectively within the demands of the hospice role/position and as a team member.
- The hospice utilizes a consistent process for recruiting and selecting staff with optimal qualifications including a competency validation and interviews with managers, peers, and others.
- Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) checks are completed on hire and monthly.
- The hospice maintains personnel records and credentialing information for the medical director and other physicians employed or contracted with the hospice, including Drug Enforcement Administration (DEA) registration.

Standard:

WE 4: The hospice has established personnel policies to direct employment practices that include:

1. Recruitment;
2. Hiring practices;
3. Benefits;
4. Grievance procedures;
5. Employee responsibilities;
6. Staff conflict of interest;
7. Performance expectations and evaluations;
8. Disciplinary actions;
9. Retention activities and efforts;
10. Termination;
11. Reporting of fraud, waste, and abuse; and
12. Emergency preparedness.

WE 4.1 Upon hire, every staff member is oriented to the hospice's personnel policies and procedures.

WE 4.2 Hospice personnel policies are regularly reviewed and updated.

WE 4.3 The hospice has a method for staff to express grievances related to their employment and a process for resolving such grievances and evaluating the grievance process.

WE 4.4 Hospice personnel policies and procedures meet all regulatory requirements and are in accordance with applicable laws.

WE 4.5 Educational programs are developed in accordance with the hospice's policies and individual competency development needs.

WE 4.6 Educational programs are evaluated by the participants, and the results are used to inform the development of future programs.

Practice Examples:

- The hospice has a written policy directing the regular review of all personnel policies and procedures.
- Expertise in the area of regulatory requirements related to human resources is utilized in the development of all hospice personnel policies and procedures.
- An evaluation form is utilized for participant evaluation of all educational offerings. Results are compiled and utilized in determining educational needs and staff development planning activities.
- Staff development and competency needs are evaluated annually and a plan for education and competency evaluation is developed based upon this assessment.

Standard:

WE 5: All staff receive orientation, training, continuing education, and opportunities for development appropriate to their responsibilities.

WE 5.1 All staff complete appropriate orientation, training, and competency evaluations before providing any care or assuming administrative responsibilities.

WE 5.2 The hospice provides orientation and continuing education programs in hospice care, pain and symptom management, infection control, compliance with regulations, and emergency preparedness to all direct care staff including facility-based and contracted staff.

WE 5.3 When changes in patient assignments occur, the hospice orients newly assigned staff members or volunteers to their responsibilities and to the individualized needs of the patient and family/caregiver.

WE 5.4 The hospice has established processes that support staff development and life-long learning.

WE 5.5 Hospice team members have access to emotional support to assist them in coping with work-related loss, grief, and change.

Practice Examples:

- A monthly calendar of available educational opportunities is published and distributed to staff.
- A structured orientation program is in place for all new employees which includes orientation to the hospice and hospice philosophy of care as well as education about death and dying.

- Hospice staff and volunteers are oriented to their job-specific duties.
- Staff members are surveyed annually to assess their learning needs.
- In-service educational offerings include competency evaluations as appropriate.
- The hospice maintains an agreement with a local employee assistance program to provide additional counseling services to staff.
- The hospice provides in-service educational offerings on topics of importance to patient care, including disease-specific information, post-traumatic stress disorder, and other issues faced by Veterans at the end of life.
- The hospice provides technology training for computer systems and electronic medical records.

Standard:

WE 6: The hospice's administrative leadership assures that continuous education is available for all staff in leadership positions.

WE 6.1 The hospice has a systematic process to identify the educational needs of staff in leadership positions on an ongoing basis.

WE 6.2 The hospice has an educational plan to continually enhance the skills and capabilities of staff in leadership positions.

WE 6.3 The hospice regularly provides instruction to staff in leadership positions related to regulatory compliance.

Practice Examples:

- For staff development, the hospice has designated staff members who have attended continuing education programs on topics specific to identified learning needs.
- The hospice provides educational sessions for members of the governing body.
- The hospice provides education related to human resource training [e.g., the Equal Employment Opportunity Commission (EEOC), hiring/firing practices, the Family and Medical Leave Act (FMLA), motivating employees, counseling low performers].
- The hospice facilitates participation in a hospice-specific education program designed to train new leaders in leadership competencies, such as change management, budgeting, conflict resolution, goal setting, and other managerial skills. The hospice facilitates participation in a hospice-specific compliance education program designed to train new leaders in rules and regulations, such as the Medicare hospice Conditions of Participation, Medicare regulations on eligibility, admission and discharge, other CMS regulations, False Claims Act, and billing requirements.

Standard:

WE 7: Hospice staff has access to current information relevant to hospice practice.

WE 7.1 Current books, websites, videos, and journals related to current relevant information and evidence-based literature are available for the staff's use.

WE 7.2 Staff members have access to up-to-date relevant information through attendance at internal and external education programs and seminars.

Practice Examples:

- The hospice makes current research and clinical information readily available by providing internet access for staff.
- A resource library is maintained and is accessible to all staff, volunteers, patients and family members.
- Current textbooks, journals, or online information related to hospice, palliative care, and bereavement care for all ages are available for the staff's use.

Standard:

WE 8: The hospice develops and implements a competency assessment program for all staff and volunteers responsible for providing direct patient care activities.

WE 8.1 The hospice has a competency assessment program and evaluates the data collected on the performance of staff and volunteers who provide hands-on patient care in order to identify their educational needs.

WE 8.2 The hospice assesses individual staff and volunteer ability to meet the performance expectations set in the job description.

WE 8.3 The hospice provides education and in-service programs, along with other activities, to maintain and improve staff and volunteers' knowledge, skills, and abilities.

WE 8.4 Appropriate actions are taken when adverse patient outcomes are directly related to an individual's performance.

Practice Examples:

- Supervisors regularly observe staff providing direct patient care and evaluate their competency.
- When staff performance results in an adverse outcome, the staff member is required to participate in a retraining program.

- Competency-based training is developed to address problematic performance areas.
- Documentation is maintained for all orientation, education, and competency testing carried out by the hospice.
- Clinical staff competencies are evaluated per accreditation standards, professional practice standards, and organizational policy.
- The hospice provides orientation and competency evaluation related to the Medicare Conditions of Participation (CoPs) for all staff.
- The hospice conducts a skills lab as part of competency evaluations and training.

Standard:

WE 9: The hospice utilizes and values specially trained caring volunteers capable of assisting the population served by the hospice.

WE 9.1 The hospice employs volunteer managers/coordinators to serve the entire hospice program through oversight of the volunteer program. Hospice volunteer manager/coordinator responsibilities include:

1. Recruiting, screening, and retaining volunteers to meet the needs of patients, families, and the hospice program (e.g., administration, fundraising);
2. Educating volunteers to meet hospice regulatory requirements and all applicable accreditation standards;
3. Identifying and responding to patient and family/caregiver volunteer needs by matching volunteers with skills needed;
4. Advocating for the utilization and integration of volunteers into the hospice interdisciplinary team and liaise among team members and volunteers as needed to ensure patient and family/caregiver needs are met;
5. Providing ongoing supervision and competency evaluation of volunteers in accordance with hospice regulatory requirements and all applicable accreditation standards;
6. Ensuring accurate documentation of volunteer visits and volunteer hours by following documentation standards and agency policies;
7. Promoting retention of volunteers through recognition, education, and support;
8. Developing strategies for evaluation of the volunteer program to ensure high quality volunteer services;
9. Supporting the hospice's community education efforts through the use of volunteers for presentations or other activities in the community;
10. Calculating and documenting the monetary value of volunteer hours and cost-savings based on information from the Independent Sector, United States Bureau of Labor Statistics, or a state resource;
11. Maintaining a sufficient number of volunteers to provide administrative or direct patient care in an amount that, at minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff;

12. Validating the augmentation of care and services achieved through the use of volunteers (e.g., addition of volunteer music therapist); and
13. Ensuring that volunteer personnel files are up to date.

WE 9.2 Hospice volunteer services are based on initial and ongoing assessments of patient and family/caregiver volunteer needs by members of the hospice interdisciplinary team. The scope and frequency of volunteer services are included in the interdisciplinary team (IDT) plan of care and are reviewed, revised, and documented regularly in accordance with regulatory requirements and patient and family/caregiver needs.

WE 9.3 Hospice volunteers receive appropriate orientation and training prior to providing services to the patient and family/caregiver. The orientation and training include but are not limited to the following:

1. The purpose and focus of hospice philosophy and hospice care;
2. Regulatory requirements for the use of volunteers in the provision of hospice care;
3. The value and contribution of the volunteer and the spectrum of volunteer duties and responsibilities;
4. The hospice interdisciplinary team's function and responsibility;
5. Role of various hospice team members;
6. Concepts of death and dying;
7. Communication skills;
8. Confidentiality and protection of patient and family/caregiver rights;
9. Care and comfort measures;
10. Diseases and conditions experienced by hospice patients;
11. Psychosocial and spiritual issues related to death and dying;
12. Concept of the patient and family/caregiver as the unit of care;
13. Stress management;
14. Infection control practices;
15. Professional boundaries and patient/family/caregiver boundaries;
16. Staff, patient, and family/caregiver safety issues;
17. Ethics and hospice care;
18. Family dynamics, coping mechanisms, and psychological issues surrounding terminal illness, death, and bereavement;
19. Reporting requirements related to changes in patient condition, pain, and other symptoms;
20. Other topics based on the hospice's unique mission, patient population served, and any specific state licensure requirements;
21. Specialized duties and responsibilities;
22. Specialized training for care and services in facility-based care settings or for patient populations with special needs or considerations; and
23. Information on whom to contact for assistance and instructions regarding the performance of duties and responsibilities including procedures to be followed in an emergency or the death of the patient.

WE 9.4 The hospice maintains personnel records for each volunteer that minimally include:

1. Job description or description of the type of activities carried out;
2. Orientation and training;
3. Competency assessments;
4. Annual performance evaluations;
5. Criminal background checks;
6. Conflict of Interest form;
7. Record of certifications and licensure, as appropriate;
8. Driver's license checks;
9. Mandated reporting of child/adult abuse responsibilities per state requirement;
10. Corporate compliance education;
11. Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) clearance checks if the volunteer is a participating Medicare provider or entity; and
12. Initial application and signed job description.

WE 9.5 Volunteers are evaluated at least annually using the performance criteria defined in the job description.

WE 9.6 Volunteers receive regular and ongoing supervision in accordance with policies and procedures established by the hospice.

WE 9.7 Volunteers are represented on the IDT either in person or through staff responsible for volunteer supervision.

Practice Examples:

- Recruiting activities are regularly scheduled and include various media such as print and electronic newspapers, newsletters, bulletins, and other broad-based community resources.
- The hospice has written criteria for recruiting, selecting, training, and assigning volunteers.
- Recruiting activities are planned and conducted with input obtained from staff and volunteers to meet volunteer recruitment goals.
- Volunteer retention activities include offering support groups, partnering with other volunteers, or making changes in assignments if necessary.
- Volunteer retention efforts include: support mechanisms; a mentoring or "buddying" program with experienced, competent peer volunteers; changing of assignments when the program's, patient's, or family/caregiver's needs are not met; providing ongoing feedback and informal and formal recognition; opportunities for communicating and camaraderie with other hospice team members (e.g., support groups, telephone calls, flyers, closure of care, meeting with volunteer coordinator).
- Volunteers demonstrate retention and understanding of information provided in orientation and training when, during the course of performing their regular activities, they have contact or communication with the hospice nurse, other team members, or the patient and family/caregiver.

- All patient care volunteers complete a comprehensive orientation prior to providing any patient, family, or caregiver care or services.
- All volunteers are invited to be active participants in support groups for volunteers.
- The hospice has a record keeping system for tracking ongoing supervision and evaluation of hospice volunteers as well as identification of their educational needs.
- Each volunteer's performance is assessed on hire and ongoing through observations made during orientation, evaluations made during care assignments, and the annual performance evaluation process.
- Performance evaluations incorporate the educational components of the hospice's orientation and ongoing educational initiatives. A review of these evaluations demonstrates a positive correlation between the educational material presented and the volunteer's demonstrated competence.
- There is a formalized process to elicit feedback from volunteers about the recruitment process, orientation and training, supervision, and their experiences with patients and families.
- Supplemental training is provided for hospice volunteers working in facility settings and/or with patients with special needs (e.g., nursing homes, facilities specializing in care for persons with AIDS, pediatric programs, Veterans, death vigils).
- Documentation of cost savings includes time spent and functions carried out by the volunteers and estimated dollar costs that would have been incurred if the functions had been performed by employees.

Standard:

WE 10: Adequate supervision and professional consultation by qualified personnel are available to staff and volunteers during all hours.

WE 10.1 The hospice provides twenty-four(24) hours per day, seven (7) days per week access to qualified consultation and supervision for team members, including volunteers.

WE 10.2 Supervisors and management staff have specialized training and experience, attend ongoing in-services and educational programs, and complete a competency evaluation.

Practice Examples:

- Consultation and guidance from knowledgeable senior staff or clinical professionals are available as needed to staff working after hours and on weekends.
- Supervision of baccalaureate-degreed (BSW, BA, BS) social workers by Master's prepared social workers includes documentation in the personnel files of regularly scheduled meetings and content of meetings, including reviews of documentation in the patient record.
- Pediatric consultation and specialty resources are available to staff and volunteers.
- When social workers or chaplains/spiritual counselors are supervised by a registered nurse, clinical consultations may be arranged with a qualified professional of the same discipline.

Standard:

WE 11: The hospice interdisciplinary team members provide quality, outcomes-oriented, coordinated care as defined by current regulatory, professional, competency, and credentialing standards that relate to the team member's practice specialty and principles of hospice interdisciplinary team practice.

WE 11.1 The care provided by the hospice interdisciplinary team reflects the scope of each specialty as defined by law and is provided in accordance with the code of ethics and practice standards for each discipline.

WE 11.2 Care is goal or outcome-directed, with the desired outcomes identified by the patient and family/caregiver on the initiation of hospice care and updated on an ongoing basis. Care is consistent with patient and family/caregiver input in the development of goals of care.

WE 11.3 The hospice demonstrates and documents congruency between team members' assessments and interventions and the patient's and family's plan of care.

WE 11.4 Hospice care is provided and documented in a timely manner and in ways that ensure accountability; reimbursement; support of patient rights; and patient, family, and caregiver confidentiality.

WE 11.5 The hospice interdisciplinary team members meet on a regular basis, and as needed, in compliance with the Medicare Conditions of Participation (CoPs) for collaboration and care coordination.

Practice Examples:

- Care coordination and effective communication among the hospice interdisciplinary team members are evidenced by documentation contained in the clinical record, which evaluates progress toward the achievement of goals or outcomes.
- The hospice interdisciplinary team interventions reflect cooperation and coordination among members.
- Frequent communication and collaboration among hospice interdisciplinary team members are documented throughout the patient's clinical record.
- Members of the patient's and family/caregiver's hospice interdisciplinary team communicate the anticipated bereavement needs and survivor risk assessment information to bereavement care staff using a consistent mechanism (e.g., survivor risk assessment tool, case summary for bereavement care).
- Hospice interdisciplinary team members maintain the confidentiality of the patient's and family/caregiver's care.
- A calendar is utilized in the patient's home, or a process of communication is established with the patient and family/caregiver, to inform them when hospice interdisciplinary team members anticipate making a home visit. The calendar or process of communication assists in care coordination.

Standard:

WE 12: The hospice medical director reviews, coordinates, and oversees the management of medical care for all patients in the hospice program.

WE 12.1 The hospice employs or contracts with a medical director who is a licensed doctor of medicine or osteopathy with experience and knowledge of hospice practice and palliative medicine.

WE 12.2 When the medical director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the medical director.

WE 12.3 Responsibilities of the hospice medical director include but are not limited to:

1. Collaborating with the patient's attending physician regarding the palliation and management of the principal illness and related conditions;
2. Assuming attending physician responsibilities if the patient has not named an attending physician or if the attending physician is unavailable;
3. Reviewing clinical information for each hospice patient, providing written certification of the patient's eligibility for hospice services upon admission and at recertification, and completing and signing initial certification and recertification of terminal illness;
4. Completing a brief narrative, in the physician's own words, related to hospice eligibility and patient prognosis to accompany both the initial certification of terminal illness and each recertification;
5. Reviewing the patient's clinical record and documenting evaluation of the patient's ongoing eligibility for hospice services, as well as needed treatment and care, prior to the start of each Medicare benefit period;
6. Providing oversight of medications and therapies and ensuring that documentation in the patient record specifies which medications are related and not related to the patient's terminal prognosis;
7. Providing a face-to-face encounter, or assuring it is done, prior to recertification for patients who are Medicare beneficiaries and are approaching their third or later benefit period;
8. Performing home and inpatient visits for patient assessment and intervention as needed and appropriate;
9. Overseeing the medical component of the hospice's patient care program and supervising other physicians who may be employed or under contract to the hospice. Reporting relationships and supervision should be shown in the hospice's organizational chart;
10. Acting as a medical resource for the hospice interdisciplinary team;
11. Assuring physician representation at and participation in hospice interdisciplinary team meetings;
12. Collaborating with the hospice interdisciplinary team in reviewing and documenting care, services, and medications that are related and not related to the terminal prognosis;
13. Participating in the hospice's quality assessment/performance improvement activities;
14. Providing coverage and support after normal business hours;
15. Assisting in the development and review of clinical protocols;
16. Acting as a liaison to physicians in the community;

17. Developing and coordinating procedures for the provision of emergency care;
18. Participating in continuing education for all hospice staff providing direct care;
19. Establishing guidelines and parameters for acceptable medical research;
20. Acting as a role model to peers;
21. Providing educational and consultative assistance related to hospice care;
22. Reporting abuse and neglect in accordance with state laws and regulations as well as the hospice's policy and procedures; and
23. Reporting communicable disease in accordance with state laws and regulations.

Practice Examples:

- The hospice medical director leads "grand rounds" at the local teaching hospital on a quarterly basis.
- The hospice medical director develops a quarterly hospice newsletter or email communication directed to all attending physicians who refer to the hospice.
- The hospice medical director attends hospice interdisciplinary team meetings or arranges for other hospice physicians to attend and participate.
- A hospice physician designee is available by telephone or other mechanism during non-business hours.
- The hospice has access to pediatric physicians to collaborate, consult, and provide recommendations on appropriate pediatric treatments.

Standard:

WE 13: The patient's attending physician provides initial and ongoing medical services to the patient.

WE 13.1 The attending physician (if any) provides the following information to the hospice before the patient is admitted:

1. Principal diagnosis, other diagnoses, and prognosis;
2. Current medical findings, including specific clinical indicators, history of changes in indicators, and evidence to support the terminal prognosis;
3. Orders for medications, treatments, and symptom management; and
4. Designation of an alternative physician to contact in the event that the attending physician is not available during a patient emergency or non-business hours.

WE 13.2 Physician's orders are obtained, as needed, prior to the provision of care and received within the time frame required by law and regulation.

WE 13.3 The hospice verifies the licensure of physicians, nurse practitioners, physician assistants (effective January 1, 2019), and other authorized individuals who provide orders or prescriptions for a hospice patient.

WE 13.4 The hospice defines the responsibilities of the patient's attending physician and clearly communicates the responsibilities to the physician.

WE 13.5 The attending physician's responsibilities for the hospice patient include but are not limited to:

1. Signing the certification of terminal illness (excluding nurse practitioners and physician assistants (effective January 1, 2019)) in addition to the hospice medical director;
2. Managing the patient's medical care;
3. Participating in the initial and ongoing care planning process;
4. Providing signed orders in a timely manner;
5. Respecting the patient's confidentiality and choices;
6. Staying available for medical consult to the hospice staff, the patient, and family members;
7. Sharing information as needed to facilitate continuity of care; and
8. Providing consultation on specialty patient populations (e.g., pediatric patients).

WE 13.6 The hospice interdisciplinary team communicates with the attending physician on an ongoing basis. Communication includes providing clinical updates, responding to questions regarding the patient's care and family/caregiver services, and conveying observations and pertinent information.

Practice examples:

- Patient status reports and a copy of the plan of care are sent to all attending physicians.
- Contacts and communication with the attending physician are documented in the clinical record.
- The attending physician is made aware of any changes in patient status and resulting changes in the plan of care.

Standard:

WE 14: Hospice nursing services are based on the initial, comprehensive, and ongoing assessments of the patient's needs by a registered nurse and are provided in accordance with the hospice interdisciplinary team's plan of care.

Services include:

1. Completion of initial, comprehensive, and updated assessment of patient and family/caregiver needs and provision of direct or supervised nursing services based on the plan of care;
2. Coordination of the patient's plan of care;
3. Provision of dietary counseling;
4. Medication review and update; and
5. Supervision of hospice aides.

WE 14.1 Responsibilities of the hospice nurse include:

1. Assessing the patient's and family/caregiver's physical, psychosocial, bereavement, environmental, safety and developmental needs;
2. Developing an individualized plan of care, in conjunction with the hospice interdisciplinary team, based on assessment, identification of needs, and patient and family/caregiver goals and preferences;
3. Providing care to patients and families through utilization of interventions and evaluation of outcomes of care;
4. Performing ongoing assessment and revision of the plan of care, with interdisciplinary collaboration, in response to the changing needs of the patient and family/caregiver;
5. Performing comprehensive assessment of the patient's pain and developing an individualized pain management plan;
6. Anticipating, preventing, and treating undesirable symptoms;
7. Providing support, instruction, and education of the patient, family, and other caregivers who participate in the care of the patient;
8. Documenting nursing assessments, identified problems, measurable goals of care, limitations to provision of care, care interventions, and response to care;
9. Coordinating all patient and family/caregiver services with the hospice interdisciplinary team and other healthcare providers, if any;
10. Consulting and collaborating with the hospice interdisciplinary team and others involved in the patient's care;
11. Developing the hospice aide plan of care and providing direct and indirect supervision of the aide at least every 14 days;
12. Maintaining the dignity of the patient;
13. Recognizing and supporting the patient's and family/caregiver's spiritual and cultural beliefs;
14. Providing holistic, family-centered care across treatment settings to ensure continuity of care and facilitate attainment of goals of care;
15. Participating in the hospice program's quality assessment performance improvement program;
16. Assessing the ability of patient and family/caregiver to safely administer medications and perform treatments; and
17. Reporting abuse and neglect in accordance with state laws and regulations as well as the hospice's policy and procedures.

Practice Examples:

- An appropriate physical assessment is performed and documented for each patient upon admission.
- Each nursing visit includes a reassessment of the patient's clinical status.
- The hospice nurse shares clinical observations of the patient and changes in treatment with all hospice interdisciplinary team members.

- The hospice nurse documents assessments of the patient's pain, related interventions, and outcomes for each visit.
- The hospice nurse, at admission and on an ongoing basis, reviews all of the patient's prescriptions and over-the-counter drugs, herbal remedies, and other alternative treatments that could affect drug therapy.
- The hospice nurse contacts the attending physician, as needed, for orders, updates, and changes in the plan of care.
- The hospice nurse consults with the pharmacist regarding medications, interactions, and side effects.
- The hospice nurse educates families about payment responsibilities for medications that are unrelated to the terminal prognosis and/or deemed ineffective at end of life.
- The hospice nurse educates families about medication disposal.
- The hospice nurse is available to perform, assist with, and/or coordinate post-death care.

Standard:

WE 15: Hospice social work services are based on initial and ongoing assessments of patient and family/caregiver needs by a social worker from an accredited school of social work and are provided in accordance with the hospice interdisciplinary team's plan of care.

WE 15.1 Social work responsibilities include:

1. Identifying the psychosocial needs of the patient and family/caregiver;
2. Assessing and strengthening the coping skills of the patient and family/caregiver;
3. Assessing and enhancing the appropriateness and safety of the environment and connecting the patient and family/caregiver with community resources, as needed;
4. Providing interventions for management of emotional symptoms (e.g., fear, grief, depression, anger);
5. Identifying needs of family members/caregivers and enhancing the strengths of the family system;
6. Assessing and referring family for bereavement services;
7. Documenting problems, psychosocial assessment, goals, care and interventions provided, and patient and family/caregiver response to each intervention;
8. Maintaining the dignity of the dying patient;
9. Supporting the patient's and family/caregiver's spiritual and cultural beliefs;
10. Providing holistic family-centered care across treatment settings;
11. Consulting and collaborating with the hospice interdisciplinary team;
12. Reporting abuse and neglect in accordance with state laws and regulations as well as the hospice's policy and procedures;
13. Assisting with funeral arrangements based on patient and family/caregiver need and preferences; and
14. Coordinating the discharge planning process.

Practice Examples:

- Initial and ongoing psychosocial assessments are completed for each patient and family/caregiver member involved in the care of the patient and the findings are shared with the hospice interdisciplinary team.
- The social worker evaluates the patient's and family's adaptation status, related needs, and opportunities for growth.
- The social worker identifies patients who are Veterans and, using the Military History Checklist, the social worker evaluates the Veteran's individual needs related to military service.
- The social worker identifies a spouse or other family members/caregivers at high risk for complicated grief and refers them to appropriate services.
- The social worker identifies the need for and plans a family conference with the patient, family members/caregivers, and other hospice team members as well as other persons involved in the care of the patient.
- The social worker coordinates the discharge process when the patient no longer needs hospice services through family counseling, patient and family/caregiver education, and arranging other services as needed.

Standard:

WE 16: The hospice interdisciplinary team identifies and involves auxiliary professionals and paraprofessionals with the knowledge, training, and skills to meet the specific needs of patients and families/caregivers as identified in the plan of care.

WE 16.1 The hospice ensures that auxiliary professionals are qualified to provide services and that they or their services are:

1. Authorized by the hospice with a properly executed contract, as applicable;
2. Provided in a safe and effective manner;
3. Delivered in accordance with the patient's plan of care;
4. Supervised by the hospice team; and
5. Provided with education/orientation to hospice services to ensure maintenance of standards of care.

WE 16.2 Auxiliary professionals may include:

1. Physical, occupational, speech, respiratory, and other therapists;
2. Dietitians or nutritionists;
3. Paraprofessional staff (e.g., homemaker or attendant);
4. Licensed practical nurses (LPNs) or licensed vocational nurses (LVNs);
5. Hospice volunteers with professional training;
6. Providers of complementary therapies such as massage, music, or aromatherapy; or
7. Other individuals based on the patient's, and family/caregiver's unique needs, as requested by the patient and family/caregiver or as ordered by the physician.

WE 16.3 The hospice exercises management of the services provided by auxiliary professionals and paraprofessionals regardless of whether the services are provided directly by hospice employees, volunteers, or contracted providers.

WE 16.4 Specialized services may assist the patient, family, and caregiver with:

1. Grief, loss, fear, and anxiety;
2. Nutritional concerns;
3. Activities of daily living including function, safety, and mobility;
4. Emotional and spiritual healing;
5. Expressive needs requiring intensive treatment;
6. Social issues;
7. Resource issues;
8. The dying process;
9. Physical and occupational therapy needs;
10. Speech/language pathology needs; and
11. Wound care.

WE 16.5 The pharmacist is actively involved as a member of the hospice interdisciplinary team and provides the following services:

1. Reviews all patient prescriptions and over-the-counter drugs, herbal remedies, and other alternative treatments that could affect drug therapy; and
2. Identifies the following:
 - a. Effectiveness and outcomes of drug therapy;
 - b. Drug side effects or toxicity;
 - c. Actual or potential drug interactions;
 - d. Duplicate drug therapy; and
 - e. Drug therapy currently associated with laboratory monitoring.

Practice Examples:

- Nutritional assessment and counseling may be performed by a dietitian to meet patient needs as identified by the hospice interdisciplinary team if the patient's needs exceed the skills of the hospice nurse.
- The physical therapist providing treatment to a patient attends the hospice interdisciplinary team meetings and contributes to the plan of care.
- A massage therapist assigned to a patient utilizes massage to alleviate muscular pain and reduce anxiety.
- The hospice contracts with a sufficient number of therapists to meet the needs of the patient population served.
- The pharmacist reviews the medication profile for each patient to ensure that drugs and biologicals meet each patient's individual needs.
- The pharmacist serves as a clinical resource to physicians and nurses.

Standard:

WE 17: Hospice spiritual care and services are based on an initial and ongoing documented assessment of the patient's and family/caregiver's spiritual needs by qualified members of the hospice interdisciplinary team (clergy, spiritual counselor, or someone with equivalent education, training, and experience) and provided according to the hospice interdisciplinary team's plan of care.

WE 17.1 Spiritual care and services include:

1. Assessing the spiritual status of the patient, family, and caregiver;
2. Documenting the spiritual assessment, goals for spiritual care, services provided, and the patient's and family/caregiver's response to spiritual care;
3. Acknowledging and respecting the patient's and family/caregiver's beliefs, culture(s), and values related to life's meaning, including suffering and loss, and desire for services/support;
4. Meditation, counseling, prayer, sacred rituals or practices, active listening, and supportive presence;
5. Assisting with funerals and memorial services as requested by the family/caregiver;
6. Communicating with and supporting the involvement of local clergy and/or spiritual counselors as needed and as desired by the patient, family, and caregiver;
7. Consulting with and providing education to hospice interdisciplinary team members and patients and families/caregivers about spirituality and related care and services; and
8. Reporting abuse and neglect in accordance with state laws and regulations as well as the hospice's policy and procedures.

Practice Examples:

- The hospice chaplain/spiritual counselor prays with the patient who requests prayer.
- The hospice chaplain/spiritual counselor explains to the team the specific beliefs of a patient, and the team discusses the implications of those beliefs for that patient's care.
- The hospice chaplain/spiritual counselor counsels the patient who is a Veteran on spiritual issues related to military service.
- Other members of the hospice interdisciplinary team who have identified spiritual needs of the patient/family/caregiver consult with the hospice chaplain/spiritual counselor about how to best address those needs.
- The hospice chaplain/spiritual counselor provides education to community clergy on spiritual care at the end of life.
- The hospice chaplain/spiritual counselor coordinates the patient's and family/caregiver's spiritual care with community resources (local churches and affiliations) per patient/family/caregiver request.

Standard:

WE 18: Hospice volunteer services include the involvement of specially trained volunteers in the care of the patient, family, and caregiver and in other aspects of the hospice program.

WE 18.1 Hospice volunteer services include:

1. Providing emotional and practical support to patients and families/caregivers;
2. Providing respite for the patient's caregiver;
3. Assisting in bereavement education and support to survivors;
4. Assisting with program administration and development; and
5. Assisting with office duties.

WE 18.2 The total time spent in patient care by hospice employees and contract staff is matched by at least 5 percent in total volunteer direct patient service and/or administrative patient support service hours on an annual basis.

Practice Examples:

- The hospice recruits and trains an adequate number of volunteers to fill requests made by the hospice interdisciplinary team.
- The hospice realizes and documents the cost-savings of utilizing volunteers.
- The hospice volunteer provides individual attention to the siblings of a pediatric patient.

Standard:

WE 19: Hospice aide services are based on the registered nurse's initial and ongoing assessments of the patient's personal care needs, patient goals of care, ability to perform activities of daily living, and supervision of care.

WE 19.1 The hospice nurse communicates the findings from the assessment of the patient's personal care needs, plan of care, and any additional instructions related to the patient's care. This communication includes the:

1. Patient's cognitive status, current and changes in functional status related to feeding, personal hygiene, elimination, and mobility;
2. Family/caregiver's knowledge, ability, willingness, and confidence to provide care;
3. Duties to be performed by the hospice aide; and
4. Patient's preferences, wishes, and decisions regarding end-of-life care.

WE 19.2 The hospice nurse communicates in a timely manner to the hospice aide significant findings regarding the patient's status and changes in the personal care to be provided.

WE 19.3 The hospice aide's services and responsibilities include:

1. Assisting with personal hygiene, elimination, feeding, and mobility according to the patient's needs and the nursing instructions as identified in the plan of care;
2. Maintaining infection control and safety practices;
3. Providing support for and reinforcement of the team's instruction for the patient's caregivers;
4. Communicating with the hospice nurse regarding services provided and significant findings regarding the patient's functional status and change in care needs;
5. Documenting the care provided and the patient's response to care;
6. Participating with the hospice interdisciplinary team in the development and implementation of the patient's and family/caregiver's plan of care; and
7. Reporting abuse and neglect in accordance with aide scope of practice as well as the hospice's policy and procedures.

Practice Examples:

- The hospice nurse completes and regularly updates a form that outlines the patient's needs and duties to be performed by the hospice aide.
- The hospice aide attends the hospice interdisciplinary team meetings and provides input for the care planning process.

Standard:

WE 20: When the patient is receiving hospice aide services, the hospice nurse evaluates and supervises the aide services.

WE 20.1 The hospice nurse documents the supervision of the hospice aide's services in the patient's clinical record. The documentation includes an evaluation of the direct care provided, the patient's and family/caregiver's perception of the care provided, and the aide's adherence to the plan of care.

WE 20.2 The hospice RN 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 identified by the hospice interdisciplinary team meet the patient's needs. The hospice aide does not have to be present during this visit unless required by state law/regulation.

WE 20.3 When the hospice aide services are not satisfactory, the hospice nurse takes action to address and resolve the issues.

WE 20.4 Supervisory visits with the hospice aide are completed every 14 days related to specific patient care plan interventions and completed annually or more frequently for aide competency evaluation as warranted with state regulations or accreditation standards.

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/caregiver expresses dissatisfaction with a hospice aide's services.

STANDARDS OF PRACTICE FOR HOSPICE PROGRAMS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

9 / Compliance with Laws and Regulations (CLR)

9 / Compliance with Laws and Regulations (CLR)

PRINCIPLE

Ensuring compliance with applicable laws, regulations, and professional standards of practice and implementing systems and processes that prevent fraud, waste, and abuse.

Standard:

CLR 1: The organization maintains full compliance with legal and regulatory requirements.

Requirements include but are not limited to:

Medicare Hospice Regulations: The Medicare hospice regulations include the Conditions of Participation (CoPs – Subparts C and D), but also include Subpart A – General Provisions and Definitions, Subpart B – Election and Duration of Benefits, Subpart C – Patient Care, Subpart D – Organizational Environment, Subpart F – Covered Services, Subpart G - Payment for Hospice Services and Subpart H – Coinsurance. The CoPs are the health and safety requirements that all Medicare certified hospices are required to meet. They are the framework for patient care delivery, administrative and organizational processes, and quality improvement that hospices must comply with in order to receive payment for services under Medicare. Subpart B contains the regulations related to election of the hospice benefit, certifying and recertifying eligibility, and discharge, revocation and transfer regulations. Subpart F specifies the requirements for coverage, which specifies what must be done for Medicare reimbursement. The Medicare Hospice regulations can be accessed at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=45c00a9dd3d5dc55b66290b274c76054&mc=true&node=pt42.3.418&rgn=div5>

Medicare Hospice Interpretive Guidelines: The Interpretive Guidelines provide additional guidance, questions, and probes established by CMS to assist state survey agency and accrediting organization staff who are reviewing hospices for compliance with the Medicare Hospice Conditions of Participation. The guidelines offer explanation and amplification on the intent of the Medicare hospice regulations. The Interpretive Guidelines are a component of Appendix M of the State Operations Manual, which provides guidance for the entire survey process. They can be accessed at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_m_hospice.pdf The hospice emergency preparedness interpretive guidelines appear in Appendix Z and can be accessed at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Advanced-Copy-SOM-Appendix-Z-EP-IGs.pdf>

State Hospice Licensure Regulations: Most states have requirements that a hospice must meet in order to be licensed to provide hospice care and maintain hospice provider licensure in their respective state. State laws differ in regard to the licensure and certification process. The hospice must be in compliance with state laws and regulations regarding hospice licensure.

Health Insurance Portability and Accountability Act (HIPAA): Addresses the use and disclosure of “protected health information” (PHI including electronic protected health information (e-PHI)). The complete document can be accessed at: www.hhs.gov/hipaa/for-professionals/index.html

The Health Information Technology for Economic and Clinical Health (HITECH) Act: Subtitle D of the HITECH Act addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules. HITECH information can be access at: <http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/hitechblurb.html>

HIPAA Omnibus Final Rule: Clarifies the definition of a Business Associate (BA) and delineates what constitutes breaches of regulations and consumer rights including protections for decedents. Information can be accessed at: www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/combined-regulation-text/omnibus-hipaa-rulemaking/index.html

Clinical Laboratory Improvement Amendments (CLIA): CMS Conditions of Participation 418.116(b) require a hospice that performs clinical tests to have a certificate for the level of testing being performed. Details can be found at: <https://www.ecfr.gov/cgi-bin/text-idx?SID=45c00a9dd3d5dc55b66290b274c76054&mc=true&node=pt42.3.418&rgn=div5>

The Federal Occupational Safety & Health Administration (OSHA): Requires employers to provide their employees with working conditions that are free from known dangers and enforces protective workplace safety and health standards. More information about OSHA can be found at: www.osha.gov/

Benefit Policy Manual, Chapter 9 – Hospice Services: The Centers for Medicare and Medicaid Services (CMS) provides details on CMS policies for the Medicare Hospice Benefit. The hospice chapter can be accessed at: www.cms.gov/manuals/Downloads/bp102c09.pdf

The Centers for Medicare and Medicaid Services (CMS): CMS often issues “sub-regulatory guidance” through the issuance of Change Requests to communicate new or changed policies or procedures that they will incorporate into the CMS Online Manual System. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html>

Hospice Quality Reporting Program (HQRP) Regulations: CMS requires hospice providers to report Hospice Item Set (HIS) and CAHPS (Hospice Consumer Assessment of Healthcare Providers and Systems) data per designated timeframes. Failure to report data results shall result in a 2 percentage-point reduction to the market basket percentage increase for that fiscal year. More information about the HQRP programs can be found at: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Hospice-Quality-Reporting/ Information on the CAHPS can be accessed at: <http://www.hospicecahpsurvey.org/en/>

Brief Physician Narrative: CMS requires the physician writes a brief narrative as a component of the certification and recertification process. The regulation can be found in Section 20.1 “Timing and Content of Certification” in the Hospice Benefit Policy Manual, Chapter 9 at: www.cms.gov/manuals/Downloads/bp102c09.pdf

Face-to-Face Encounters: CMS requires that a hospice physician or nurse practitioner conduct a face-to-face encounter for every Medicare patient prior to the beginning of the third benefit period and for each subsequent period. The regulation can be found in Section 20.1 “Timing and Content of Certification in the Hospice Benefit Policy Manual, Chapter 9 at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c09.pdf>

Physician Certification and Recertification of Services: CMS provides details on CMS policies on physician certification and recertification of terminal illness. The regulation can be found in Section 60 – Certification and Recertification by Physicians for Hospice Care. The chapter can be accessed at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ge101c04.pdf>

Processing Hospice Claims: CMS provides details on CMS policies on billing for the hospice benefit in Medicare Claims Processing Manual Chapter 11. The chapter can be accessed at: www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c11.pdf

The Certification Process: CMS provides information on the certification process in the State Operations Manual (SOM) Chapter 2. The chapter can be found at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107c02.pdf>

Financial Liability Protections: The CMS State Operations Manual (SOM) Chapter 2 provides instructions regarding issuance of the Advance Beneficiary Notice (ABN) and the Notice of Medicare Non-coverage (NOMNC) to the Medicare beneficiary in advance of initiating, reducing, or terminating what they believe to be non-covered items or services. The CMS Beneficiaries Notifications Initiative page can be accessed at: <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html>

Hospice Cost Report: CMS provides forms and completion instructions for the hospice cost report. Hospice costs must be reported by level of care and submitted to the MAC within 5 months after the end of the fiscal year. The cost report forms and instructions are in Chapter 38 and can be accessed at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935.html>

The Office of the Inspector General’s (OIG): Is charged with protecting the integrity of Department of Health and Human Services (HHS) programs, including hospice. Both OIG work plans and reports provide information on OIG areas of focus related to hospice compliance. These can be accessed at: <https://www.oig.hhs.gov/>

CLR 1.1 The governing body adopts bylaws in accordance with the mission of the organization.

CLR 1.2 Mechanisms are in place to address the recommendations made in the reports received from authorized regulatory and accrediting bodies.

CLR 1.3 The hospice has a comprehensive compliance program that includes:

1. The development and distribution of written standards of conduct, as well as written policies and procedures, which promote the hospice's commitment to compliance and address specific areas of potential fraud such as Medicare hospice eligibility and admission, improper financial relationships with nursing facilities and other healthcare professionals and entities, and improper billing practices;
2. The designation of a Compliance Officer and other appropriate bodies (e.g., a Corporate Compliance Committee) charged with the responsibility for operating and monitoring the compliance program and who report directly to the CEO and the governing body;
3. The development and implementation of regular effective education and training programs in compliance for all affected employees;
4. The creation and maintenance of a process such as a hotline or other reporting system to receive complaints and ensure effective lines of communication between the Compliance Officer and all employees and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation;
5. The use of audits and/or other evaluation techniques to monitor compliance and identify problem areas to assist in the reduction of identified problem areas;
6. The development of appropriate disciplinary mechanisms to enforce standards and the development of policies to address:
 - a. Employees who have violated internal compliance policies, applicable statutes, regulations or federal healthcare program requirements; and
 - b. The employment of sanctioned, excluded, and other specified individuals.
7. The development of policies that direct prompt and proper responses to detected offenses including the initiation of appropriate corrective action and preventive measures.

Practice Examples:

- The hospice has a process in place to incorporate regulatory changes into the policies and procedures of the hospice and offers training for employees to ensure compliance.
- Results of surveys are documented in governing body meeting minutes.
- Ongoing mock surveys or self-assessments are conducted to identify areas for improvement and changes are made based on the findings.
- The hospice has a procedure for reporting and investigating compliance concerns.

Standard:

CLR 2: The hospice has a program to identify, prevent, and correct practices that are fraudulent or abusive.

CLR 2.1 Medicare-certified hospices provide care, treatment, and services as specified in Medicare hospice regulations.

CLR 2.2 The hospice uses specific guidelines to determine eligibility for hospice at admission and throughout the hospice service period.

CLR 2.3 The hospice regularly monitors its compliance with regulatory requirements and business practices.

CLR 2.4 Hospice organizations follow state licensure regulations and reporting requirements for fraud and abuse.

Practice Examples:

- The hospice uses resources available for regulatory questions and interpretive guidance. Resources include but are not limited to: NHPCO, Medicare Administrative Contractors (MACs), state hospice organizations, and accrediting bodies.
- The hospice seeks voluntary accreditation from an accrediting body with hospice deeming authority status from CMS.
- There is a process for review of patient eligibility for hospice services prior to admission as well as at the time of recertification. The recertification process includes a hospice physician or nurse practitioner conducting a face-to-face encounter.
- The hospice utilizes CMS regulations, Medicare Administrative Contractors' (MAC) Local Coverage Determinations (LCDs), and clinical assessments in keeping with professional standards of practice for admission to hospice services and recertification for continued provision of services.
- The hospice regularly audits compliance with regulatory requirements and business practices.
- The hospice monitors OIG risk areas and develops a compliance plan based on those risk areas.

Standard:

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

CLR 3.1 The hospice has 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.

CLR 3.2 A professional consistent format is used to document the services provided in all care settings.

CLR 3.3 Documentation in the hospice clinical record is descriptive, timely, and accurate and includes at a minimum:

1. A medical history including clinical evidence of the terminal prognosis on admission;
2. An age-appropriate physical assessment of the patient by the hospice nurse;
3. A comprehensive medication reconciliation;
4. A psychosocial assessment of the patient, family, and caregiver;
5. A spiritual assessment of the patient, family, and caregiver;
6. A bereavement assessment of the patient, family, and caregiver;
7. Physician certification and recertification of terminal illness form(s);
8. Physician certification and recertification of terminal illness and narrative statement(s);
9. Attestation and documentation of face-to-face encounters;

10. CMS quality measure data elements;
11. The hospice interdisciplinary team plan of care;
12. A record of the care provided by all disciplines from admission through bereavement;
13. Patient responses to medications, symptom management, treatments, and services;
14. Signed physician's orders for care;
15. Persons to contact in an emergency;
16. Hospice election statement form signed by patient or representative;
17. Informed consent and acknowledgment signed by patient or representative that a copy of the notice of rights and responsibilities, privacy practices, and information about advance directive were provided;
18. The patient's decisions regarding end-of-life care;
19. Advance care directive choices;
20. A record of military service for all patients;
21. Identification of other agencies involved in care;
22. Communication regarding care or services to be provided and care coordination;
23. Additional information as required by law and regulation;
24. Evidence that the patient or representative received written patient rights and information about how to voice a complaint; and
25. A record that drug disposal was carried out in accordance with federal, state, and local regulations.

CLR 3.4 When services are provided under a contractual agreement, clinical documentation or a summary of services provided by the contracted organization or individual is included in the hospice clinical record.

CLR 3.5 Clinical records of patients who transition between levels of care, or transfer to or from the hospice, contain detailed information to promote continuity of care and support care coordination across treatment settings.

CLR 3.6 Forms utilized in the clinical record are reviewed according to established policy and revised as appropriate.

CLR 3.7 The clinical record contains a physician order and discharge summary for every patient discharged alive.

CLR 3.8 The clinical record is completed within the time frame specified by the hospice for every discharged patient and per state regulations if any.

Practice Examples:

- Clinical records of discharged patients are reviewed to verify that a discharge physician order and summary was completed in a timely manner.
- All documentation for discharged patients is submitted in a timely manner in accordance with the hospice's policies and filed in the clinical record.
- The military history checklist is used to identify a patient who is a Veteran, evaluate the impact of the military experience, develop a care plan specific to the unique issues faced by the

Veteran, and determine benefits to which the Veteran and surviving dependents may be entitled.

- The following documents are provided to the nursing facility for each resident for whom the hospice is providing services:
 - An up-to-date hospice plan of care;
 - Hospice election form and any advance directives;
 - Physician certification and recertification of the terminal illness;
 - Names and contact information for hospice personnel involved in the patient's care;
 - Instructions on how to access the hospice's 24-hour on-call system;
 - Hospice medication information; and
 - Hospice physician and attending physician (if any) orders.
- Patients and caregivers are given a Notice of Privacy Practices informing them that protected health information is collected and maintained and may be shared with other providers as a part of their plan of treatment.
- When transferring to a different level of care, or a different service location, the patient's clinical record contains a transfer summary with the reason for transfer, a copy of the interdisciplinary plan of care, and other appropriate information for caregivers in the new level of care.
- When transferring to another hospice, the transferring hospice provides a transfer summary of all care provided, as well as a copy of the interdisciplinary plan of care, copies of signed consents for care, copies of certifications of terminal illness, and other information as requested by the receiving hospice.
- The hospice routinely evaluates the application of advancing technology including evaluating risks in the use of the technology, and addressing potential HIPAA privacy and security regulation violations.

STANDARDS OF PRACTICE FOR HOSPICE PROGRAMS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

10 / Stewardship and Accountability (SA)

10 / Stewardship and Accountability (SA)

PRINCIPLES

Developing a qualified and diverse governance structure and senior leadership that share the responsibilities of fiscal and managerial oversight. Hospice has an organizational leadership structure that permits and facilitates action and decision making by those individuals closest to any issue or process.

Standard:

SA 1: The hospice has an organized governing body that has complete and ultimate responsibility for the organization.

SA 1.1 The governing body meets regularly and is informed of ongoing and current issues affecting the hospice. The governing body receives reports of care, treatment, services, and quality improvement program activities and projects as required by the Medicare Conditions of Participation (CoPs), state licensure regulations, and/or accreditation standards.

SA 1.2 The governing body participates in an annual review of the hospice's policies and procedures and approves final modifications.

SA 1.3 Bylaws and/or policies and procedures specify the roles and responsibilities of the governing body members, staff, and, when appropriate, define the hospice's relationship to any parent organization governing body.

SA 1.4 The governing body develops and implements a written conflict of interest policy that includes guidelines for the resolution of any existing or apparent conflict of interest.

SA 1.5 The governing body members participate in an initial orientation and ongoing educational programs designed to enable them to fulfill their hospice responsibilities.

SA 1.6 All governing body members evaluate their initial orientation and continuing education programs.

SA 1.7 The hospice recruits governing body members who reflect a variety of expertise and the cultural diversity of the population and the communities served.

Practice Examples:

- Governing body meetings are documented and reflect the group's ultimate responsibility for the organization.
- Signed conflict of interest and confidentiality statements are obtained at the beginning of each term of service of governing body members and are kept on file in the hospice.

- Content of the governing body orientation and educational sessions are kept on file with dates of presentations and participants.
- The hospice maintains an organizational chart that clearly depicts the relationships between the governing body, management, and staff.
- Governing body members' names are included in minutes and rosters of staff, leadership, and committee meetings they attend.

Standard:

SA 2: The organizational leaders have processes to review and approve the hospice's mission, purpose, vision, and policies which include active participation and input by all stakeholders.

SA 2.1 The hospice develops and regularly reviews its mission and vision statements. This review is completed every three years at a minimum, or more often as necessary and appropriate.

SA 2.2 The hospice has written administrative and clinical policies and procedures which direct daily hospice operations.

SA 2.3 Policies and procedures are reviewed annually and revised as necessary. Revisions may be made prior to annual reviews in response to changes in regulations or practice.

Practice Examples:

- The management and staff can verbalize the mission and vision statements of the hospice.
- The hospice has a process for annual review and revision of policies and procedures, with documentation of the presentation to, and approval by, the governing body. Additional review and revision may be done as needed.
- The hospice involves members of the hospice interdisciplinary team in policy and procedure development, review, and editing.

Standard:

SA 3: The hospice administrator has full responsibility for the day-to-day operations of the hospice program.

SA 3.1 The governing body oversees the process of selection and evaluation of the hospice administrator and provides ongoing support.

SA 3.2 The governing body has a mechanism for evaluating the performance of the hospice administrator at least annually.

SA 3.3 The performance evaluation of the hospice administrator is documented and reviewed with that individual.

SA 3.4 The hospice administrator implements financial policies and practices that ensure the accuracy and reliability of the financial data.

SA 3.5 The hospice administrator is qualified by education and experience to operate the hospice in accordance with federal, state, and local laws and regulations, and hospice standards of practice.

SA 3.6 The hospice administrator is responsible to the governing body for:

1. Implementing, monitoring, and reporting on the hospice's services;
2. Ensuring quality in patient care;
3. Ensuring that the organization operates in a legal and ethical manner and in compliance with all local, state, and federal regulations;
4. Ensuring that performance improvement and safety activities are planned and implemented; and
5. Providing the governing body with up to date information on a regular ongoing basis.

SA 3.7 In the absence of the hospice administrator, a qualified individual is appointed to carry out day-to-day operational responsibilities.

SA 3.8 The hospice administrator promotes and directs a culture of quality and compliance in all aspects of operational conduct.

Practice Examples:

- The hospice administrator's position description is documented in writing and includes qualifications and role responsibilities.
- The hospice administrator develops and communicates specific organizational goals aligned with the hospice's mission, strategic plan, as well as professional development goals.
- The hospice administrator, administrative leaders, and staff sign confidentiality and conflict of interest statements upon employment.
- Leaders and staff know how to contact the hospice administrator or his/her designee at all times.
- The governing body conducts an annual written performance evaluation of the hospice administrator including a review of goal achievement.
- The hospice's board of directors utilizes a performance appraisal tool in evaluating the performance of the hospice administrator.
- The hospice administrator performs a self-evaluation as part of his/her annual performance evaluation.
- The hospice administrator's performance appraisal process allows for a comprehensive review with input obtained from peers, subordinates, and leaders.

Standard:

SA 4: Administrative leadership ensures effective strategic planning and resource management.

SA 4.1 Administrative leadership establishes a process for the ongoing monitoring of the organization's risks, threats, and opportunities.

SA 4.2 Administrative leadership monitors the adequacy and availability of its economic and human resources to ensure the organization's ongoing viability.

SA 4.3 Administrative leadership establishes a process for determining and responding to the needs of internal and external customers and the community at large.

SA 4.4 The hospice planning process addresses the:

1. Basic philosophy of hospice care;
2. Mission and vision of the hospice; and
3. Physical, psychosocial, spiritual, emotional, and bereavement needs of patients and families/caregivers.

SA 4.5 The hospice planning process includes:

1. Establishment and periodic review of the mission, vision, and short-term and long-range goals;
2. Monitoring of goal achievement to ensure that the mission is realized in practice and sustained over time;
3. Input from employees, contracted staff, and volunteers; and
4. Feedback from patients and families/caregivers served, contract facilities, vendors, and the community at large.

SA 4.6 Administrative leadership communicates the strategic plan to the hospice's staff and governing body, and periodically evaluates the status and results of the plan's execution based on the goals of the stated plan.

Practice Examples:

- A committee structure exists that permits internal and external customers to participate in the hospice's evaluation and planning.
- The hospice reviews and analyzes results of patient and family/caregiver satisfaction surveys, concern and service failure reports, employee engagement surveys, and community focus group input to assess the level of goal and mission achievement.
- Statements of the hospice's mission, vision, and strategic plans are clearly evident on its website.
- The hospice's administrative leadership and staff can verbalize the mission and vision statement of the hospice.
- Administrative leadership communicates strategic plans, goals, and outcomes to staff on a regular basis.

- Staff and/or team goals are aligned with the mission and strategic plan as well as individual professional development goals. Staff progress toward goals is reviewed periodically and is included in staff annual performance evaluation.

Standard:

SA 5: Administrative leadership practices fiscal and fiduciary responsibility in management of the hospice's finances.

SA 5.1 Administrative leadership and representatives from all professional disciplines collaboratively develop, implement, and monitor an annual operating budget and long term capital expenditure plan in compliance with laws and regulations.

SA 5.2 The budget is approved by the governing body and reflects the goals and operations of the hospice program.

SA 5.3 The hospice contracts with an independent certified public accounting firm to conduct a financial audit at least annually.

SA 5.4 Administrative leadership and the governing body regularly monitor and review financial statements, budget documents, and tax documents, as applicable.

SA 5.5 Administrative leadership implements the financial policies and practices that ensure the accuracy and reliability of the financial data.

SA 5.6 Mechanisms are in place to manage accounts payable, accounts receivable, handling of cash, and arrange credit and assistance if needed.

SA 5.7 Policies and procedures that guide ethical, timely, and accurate billing and payment practices are implemented and evaluated on an ongoing basis.

SA 5.8 The hospice prepares a volunteer cost savings report that demonstrates at least 5% of total patient care hours of all paid and contract direct care staff are provided by volunteers.

Practice Examples:

- Administrative leadership receives regular financial reports, can demonstrate knowledge of financial principles and tax reporting requirements, and can explain management and monitoring of the budget.
- Financial policies and procedures exist and include the requirement that investments are reviewed and approved by the governing body.
- An annual financial audit occurs and includes a management report.
- A written compliance plan for the hospice is developed and addresses the hospice risk areas identified by the Office of the Inspector General (OIG) and other areas of concern identified by CMS.

- A written policy exists that describes the process to determine whether patients meet criteria for financial assistance established by the hospice.
- The Director of Volunteer Services uses the dollar value defined by [The Independent Sector](#) or the Bureau of Labor Statistics each year to calculate the value of the volunteer services in the cost savings report.

Standard:

SA 6: Administrative leadership continually evaluates and assesses its performance.

SA 6.1 Administrative leadership periodically evaluates and assesses their job performance related to fulfillment of the hospice's mission and all other aspects of the organization's operations.

SA 6.2 Administrative leadership assesses their educational needs and regularly identifies and participates in educational opportunities based on the assessed needs.

Practice Examples:

- Administrative leadership establishes annual goals related to the accomplishment of the mission and the strategic plan.
- Administrative leadership conducts quarterly and annual reviews of goal achievement and educational activities, and implements improvement and/or corrective actions to address any failure to achieve goals.
- The hospice develops and implements a leadership training program.
- Administrative leadership facilitates, with staff involvement, a comprehensive evaluation of the hospice, including progress toward fulfillment of the strategic plan annually or more often. A summary of the evaluation is provided to the governing body and staff. Administrative leadership uses the results to inform the process of goal development, quality improvement, and action plans.

Standard:

SA 7: Administrative policies define the roles and responsibilities of the governing body, administration, and the hospice interdisciplinary team.

SA 7.1 The hospice has written administrative and clinical policies and procedures that direct daily hospice operations.

SA 7.2 The hospice maintains written policies and procedures that state the roles and responsibilities of the governing body, administrative staff, hospice interdisciplinary team members, and volunteers.

SA 7.3 Administrative policy and procedures include annual, and more often as needed, evaluation of the hospice program and review of all policies and procedures.

Practice Examples:

- The hospice's policies and procedures address areas including but not limited to: the compliance program; development, marketing, and fundraising; financial management of human resources (hiring, termination, benefits, safety, etc.); the QAPI program; health information management; patient care and safety; and volunteer services.
- The hospice has a written description of responsibilities for members of the governing body.
- The hospice has a written policy that details the annual program review procedure including review of the participation by the hospice interdisciplinary team in policy and procedure development, as well as the review of the policies and procedures.
- The hospice maintains written policies that define the composition, organization, and performance standards of the hospice interdisciplinary team.

Standard:

SA 8: Information is protected against loss, theft, destruction, and unauthorized disclosure.

SA 8.1 At a minimum, sensitive and confidential data including financial and patient records are stored in a manner that prevents both unauthorized physical and remote access and damage from fire, water, and electrical malfunction.

SA 8.2 The hospice has a plan for protecting its computerized information that includes:

1. Safeguards to prevent unauthorized access to computerized records;
2. Safeguards to prevent unauthorized access to computer equipment, servers, storage area networks, mobile devices, network-attached storage devices and backup systems;
3. Strategies for performing and testing routine back-up and storage of computerized records, including secure offsite storage;
4. Methods to replace information and the systems required to operate, if necessary;
5. A comprehensive annual review of the Health Insurance Portability and Accountability Act (HIPAA) risk assessment;
6. A comprehensive information security policy; and
7. A system for authentication of electronic device users and handwritten signatures.

SA 8.3 The hospice has a written policy for the retention of records.

Practice Examples:

- Hospice retains clinical records according to state law and for the federally-required period of six years.
- The hospice backs up computerized data daily. Backup discs and tapes are stored in a fireproof container off-site or in secure electronic off-site storage (e.g., data warehouse, cloud).

Standard:

SA 9: Confidentiality of information is maintained.

SA 9.1 Protected Health Information (PHI) may only be released for the provision of patient care, billing or operations, or as directed by federal and state laws and regulations.

SA 9.2 Hospice policy stipulates that patient information may only be released with the written consent of the patient or authorized patient representative unless authorized by appropriate legislative or judicial authority.

SA 9.3 The hospice has policies and procedures that address the secure transfer and transmission of confidential patient and family/caregiver information via the use of fax machines, computers, telephones, mobile devices, and other technological mechanisms and routes.

SA 9.4 All employees, contractors, and volunteers of the hospice are trained on the privacy and security of PHI and are in compliance with HIPAA Privacy and Security, HITECH, and Omnibus regulations.

SA 9.5 The hospice has a plan for reporting a breach of unsecured PHI according to state and federal regulations.

Practice Examples:

- All staff members sign a confidentiality agreement on hire prior to any exposure to patient or family information.
- Corrective action including appropriate coaching, training, and discipline, is in place and documented when confidentiality is compromised or placed at risk of compromise.
- Patients or legal representatives sign a HIPAA Notice of Privacy at admission and additional releases as needed prior to the release of information or sharing of any information.
- The hospice policies and procedures address staff access and use of the hospice's computers (e.g., password, logging off, and authentication process).
- The physical layout of the hospice office and other hospice facilities is conducive to maintaining patient privacy and is regularly assessed to assure patient privacy is being maintained.
- The hospice educates staff regarding correct handling of protected information on computers, the internet, cell phones and other mobile devices, and printed materials that contain patient information.

STANDARDS OF PRACTICE FOR HOSPICE PROGRAMS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

11 / Performance Measurement (PM)

11 / Performance Measurement (PM)

PRINCIPLES

Collecting, analyzing and actively using performance measurement data to foster quality assessment and performance improvement in all areas of the hospice organization's processes of care, palliative and hospice services, and operations (including those furnished under contract or arrangement).

The hospice defines a systematic planned approach to improving performance including indicators at both the patient and organizational level for which there is evidence that improvement in those indicators will improve palliative care outcomes and end-of-life support. This approach is authorized and supported by the governing body and leadership.

Standard:

PM 1: The hospice's leadership ensures that an organization-wide, integrated, data-driven, and outcome-oriented Quality Assessment and Performance Improvement (QAPI) program is implemented.

PM 1.1 The governing body is responsible for ensuring:

1. The presence of an ongoing data-driven QAPI program that is inclusive of all hospice operations, as evidenced in a written QAPI plan;
2. A focus on improved outcomes across all areas of the organization;
3. The appointment of one or more individuals to lead the QAPI program;
4. The QAPI activities address operational functions of the hospice and reflect the complexity of the organization as well as quality of care and service, including patient safety; and
5. An annual review of improvement efforts including evaluation for sustained effectiveness.

PM 1.2 The hospice's administrative leadership is responsible for allocating resources to improve the hospice's processes and systems, including resources for staff and management as well as information systems to facilitate data collection and reporting.

PM 1.3 The governing body, administrative leadership, employees, and volunteers are informed of quality assessment results and performance improvement activities.

Practice Examples:

- Details on performance improvement projects (PIPs) are regularly reported to the governing body.

- An annual comprehensive QAPI program plan is submitted to and approved by the governing body, including quality indicators to be measured and tracked.
- An annual review of the QAPI program, including a summary of the quality indicator outcomes and improvement activities, is approved by the governing body.
- Resources for and leadership of the QAPI program are outlined in the QAPI program plan.
- Performance Improvement Projects (PIPs) are conducted organization-wide and reflect the organization's complexity and scope of services.
- The hospice maintains documentation of the governing body's oversight of the QAPI program and of the reports provided to them.

Standard:

PM 2: The Quality Assessment and Performance Improvement (QAPI) program is informed by the hospice's strategic plan and supports its mission, vision, and values.

PM 2.1 The hospice's administrative leadership ensures that QAPI program activities are focused on:

1. High risk, high volume, and problem-prone areas with consideration of incidence, prevalence, and severity of problems in those areas; and
2. The impact on palliative outcomes, patient safety, the patient's and family/caregiver's experience of care, and other quality of care concerns including but not limited to patient-centered care and changes in setting of care.

PM 2.2 QAPI activities, processes, and outcomes enable the hospice to assess all aspects of care, services, and operations, including contracted services.

PM 2.3 The hospice's performance related to the needs, expectations, and experiences of key consumers and stakeholders (e.g., patients, family members/caregivers, physicians, referral sources, contracted vendors) is evaluated as part of the QAPI program.

Practice Examples:

- The hospice has a written performance improvement plan that describes the areas targeted for data collection, analysis, and improvement and reviews the plan on a regular schedule.
- The hospice has a mechanism, such as a satisfaction survey, to periodically obtain feedback from key stakeholders as defined by the hospice (e.g., physicians, nursing home staff, hospital administrators).
- The annual budgeting process includes targeted areas for improvement as well as the necessary funding resources to carry out the performance improvement program.
- The hospice's staff is involved in identifying quality indicators included in the QAPI program.
- The management team facilitates the identification of high priority targets for performance improvement.

Standard:

PM 3: The hospice collects, analyzes, and utilizes multiple types of performance and outcome data, including patient, financial, volunteer, human resources, key operations, and care delivery services data.

PM 3.1 The hospice's administrative leadership and QAPI staff identify the frequency and scope of the data collection activities.

PM 3.2 The hospice's administrative leadership understands performance improvement principles and methods and employs them, utilizing data, to facilitate management decisions.

PM 3.3 Data are collected related to patient and family/caregiver needs, expectations, and outcomes.

PM 3.4 Data sources utilized by the hospice for QAPI may include, but are not limited to:

1. Utilization, staffing, and allocation of services;
2. Evaluation of care and services surveys from patients, families, pre and post-death bereavement services, contracted entities, referral sources, physician, volunteers, and community partners;
3. Staff satisfaction surveys;
4. Clinical records;
5. Complaints and reports of service failures from patients, families, referral sources, physicians, contracted vendors, care partners, among others;
6. State or federal compliance surveys and/or accreditation surveys;
7. Incident, adverse event, and sentinel event reports;
8. Infection surveillance;
9. Medical and service review from the MAC, Recovery Audit Contractors (RAC), Unified Program Integrity Contractors (UPICs), or other government entities or contractors;
10. Financial reports; and
11. Other data sources, such as administrative and operational records, as determined by the hospice.

PM 3.5 A process is in place to review collected data to determine if patterns or trends exist that negatively impact care and/or place the patient or staff at risk. When these trends and their root causes are identified, corrective actions are taken to improve performance and sustain improvements.

Practice Examples:

- The hospice creates and posts a quarterly QAPI dashboard containing key quality indicators.
- Quality indicator data related to the results of each performance improvement activity are presented to staff on a regular basis via the organization's internal communication process (e.g., newsletter, bulletin board or intranet).
- The hospice utilizes an annual self-evaluation tool to identify processes and systems that need improvement.

- Patient-level data are collected to reflect processes of care (e.g., ongoing assessment, plan of care updates) and patient outcomes.
- The hospice regularly reviews results from the CMS Hospice Quality Reporting Program (HQR) measures and creates performance improvement projects to improve measure scores based on comparison to national level results.
- Financial reports are reviewed and used by administrative leadership to evaluate progress toward goals on a routine basis.
- State and federal government contractor reviews are recorded, addressed in a timely manner, and integrated in the QAPI program.
- The hospice collects data on Veteran's services and evaluates the components and outcomes of the care provided specific to Veteran needs.
- Employee and volunteer satisfaction or engagement surveys are part of the evaluation process for internal improvement.
- Bereavement evaluation of services surveys are sent to caregivers who have participated in bereavement care.
- Data pertinent to inpatient processes are collected and monitored (e.g., responsiveness to patient call lights) for the hospice's inpatient facility.

Standard:

PM 4: The planning, development, implementation, and evaluation of performance improvement activities are comprehensive and collaborative.

PM 4.1 Performance improvement activities are based on objective data and involve collaboration among departments, disciplines, and programs, as well as input from individuals involved in the process targeted for improvement.

PM 4.2 Performance improvement activity results are communicated to employees, volunteers, and administrative leadership and the governing body.

PM 4.3 A process is in place to conduct a root cause analysis when an undesirable outcome or adverse patient event occurs, as well as a mechanism for reporting specific serious adverse events to regulatory agencies as required. The hospice has a policy defining what constitutes an adverse patient event and a serious adverse patient event. Adverse events may include but are not limited to:

1. Patient falls with injury;
2. Patient injuries unrelated to a fall;
3. Medication errors;
4. Adverse drug reactions;
5. DME or medical equipment problems;
6. Unsafe handling or misuse of narcotics;

7. Uncontrolled symptoms;
8. Threatened or actual suicide attempts;
9. Patient abuse, neglect, or exploitation;
10. Patient death not related to the principle diagnosis; and
11. Other problematic events and serious service failures as defined by the hospice.

PM 4.4 Following a serious adverse event, a systematic root cause analysis of the event is conducted in order to generate preventive and corrective actions and mechanisms.

Practice Examples:

- The hospice has a quality committee or council, with representation from all disciplines and departments, to oversee performance improvement activities.
- The hospice regularly and systematically reviews records and documentation related to DME to identify areas for improvement (e.g., complaint, malfunction, or failure; patient injury resulting from malfunction or failure).
- The hospice provides education and training regarding the QAPI program and activities to employees and volunteers during orientation, when assigned to a performance improvement project team, and throughout their employment/association with the hospice.
- The hospice routinely communicates the activities and results of QAPI process improvement teams.
- The hospice maintains documentation that demonstrates that a root cause analysis is conducted when trends appear in adverse patient events. There is also evidence that the analysis leads to staff training and process improvements to minimize reoccurrences.
- The hospice identifies external barriers to optimal delivery of care (e.g., restrictive drug prescribing policies, inadequate insurance coverage) and acts as an advocate for their removal.

Standard:

PM 5: Components of the hospice's QAPI program include a well-defined methodology for improving performance that demonstrates and documents the results of changes in processes and the development of a plan to ensure sustainability of improvements.

PM 5.1 An identifiable and specified methodology is utilized for measurement, goal setting, implementation, evaluation, learning, and change management related to performance improvement activities.

PM 5.2 The hospice adopts an approach to improving performance that includes:

1. A systematic process for ongoing assessment of quality of care and services provided;
2. An established process for identifying and prioritizing performance improvement activities;
3. A defined process for problem solving and performance improvement work;

4. A defined process for conducting and documenting performance improvement projects;
5. A means to ensure ongoing, systematic, collaborative performance improvement activities;
6. Mechanisms for communicating performance improvement activities and results throughout the organization;
7. Methods for ongoing data collection and measurement to detect significant trends in performance and to compare performance over time;
8. Methods for ensuring sustainability of improvements; and
9. A mechanism for determining resource requirements for performance improvement.

PM 5.3 Performance improvement planning activities and the selection of areas for improvement are determined based on data collected and input by employees, volunteers, leadership, and third party survey administrators.

PM 5.4 A desired performance outcome is established and quantified for each performance improvement activity to enable measurable results.

PM 5.5 Plans are established in writing detailing the actions to be taken to achieve the desired performance outcomes.

PM 5.6 Changes in the organization's programs and processes are planned, piloted, implemented, and evaluated.

PM 5.7 Process changes are evaluated for performance and achievement over time with results communicated throughout the hospice.

PM 5.8 The hospice maintains documented evidence of each performance improvement project in its portfolio along with the reasons for conducting the projects, measurable progress achieved, and the results of monitoring for sustained improvement.

Practice Examples:

- Performance improvement project teams include staff directly involved in the processes targeted for improvement.
- The hospice utilizes an established performance improvement model for improving processes within the hospice program (e.g. The Institute for Healthcare Improvement (IHI) Model for Improvement [Plan Do Study Act or PDSA], FOCUS-PDCA, FADE, IDEAS, Joint Commission's Framework for Improving Performance design, LEAN, Six Sigma, Adaptive Design).
- The hospice's selection of performance improvement projects is based on current measurable quality indicator trends.
- The hospice uses "story boards," bulletin boards, and other communication methods to display the results of data collected and improvements achieved.
- The hospice can demonstrate measurable sustained improvements for patient care outcomes and processes based on performance improvement activities.
- A summary report from each improvement team is submitted to the hospice's quality committee or council and includes evidence of realized improvements.

- The hospice maintains a record of all performance improvement projects. The record includes the desired performance outcomes, an activity summary, data driven outcomes of implemented changes, and plans to sustain improvements.
- Improvement efforts are monitored for six months following the implementation of a successful action plan to assure that the results achieved are maintained over time.
- The hospice's step-wise approach to quality improvement:
 - Identify the areas targeted for improvement;
 - Determine the goals for improvement;
 - Develop an implementation plan;
 - Educate staff regarding the changes in processes made based on the initial data collected;
 - Pilot test changes;
 - Implement changes;
 - Evaluate results at a specified timeframe (ex: in three months); and
 - Plan to sustain improvement.

Standard:

PM 6: The hospice participates in government mandated quality reporting programs and voluntary quality reporting initiatives sponsored by the state and other organizations.

PM 6.1 The hospice submits accurate and timely data to federal, state, and other entities for the purpose of contributing to the development of quality databases and ensuring the availability of hospice provider quality comparison data.

PM 6.2 Staff is trained in accurate and timely generation, documentation, and extraction of quality data elements. Completeness and accuracy of data processes are systematically monitored.

PM 6.3 The hospice has a mechanism in place for periodic aggregation and reporting of quality data internally and to federal, state, and other entities on an ongoing basis. This includes allocation of sufficient resources and personnel to ensure that reporting is timely, relevant, and accurate.

PM 6.4 The hospice incorporates data and results from mandatory and voluntary quality initiatives into its QAPI program activities.

Practice Examples:

- The hospice routinely responds to NHPCO's requests to submit quality data (e.g. STAR (Survey of Team of Attitudes and Relationships) staff satisfaction survey, evaluation of care surveys).
- The hospice participates in federal, state, or local efforts to collect and analyze data across hospice organizations.

- The hospice routinely monitors quality measure results derived from quality data submitted to CMS and carries out performance improvement projects based on those data as indicated.
- The hospice utilizes available performance measure comparison results to identify improvement opportunities. The results are also reviewed for potential best practices that should be promoted, implemented, and maintained.

STANDARDS OF PRACTICE FOR HOSPICE PROGRAMS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

12 / NHPCO Performance Measures

12 / NHPCO Performance Measures

Overview

A system of performance measurement is essential to quality improvement and needs to be a component of every hospice organization's quality strategy. For optimal effectiveness, performance measurement results should include internal comparisons over time and as well as external comparisons with peers.

NHPCO offers performance measures that yield useful, meaningful, and actionable data. NHPCO provides on-demand provider level results for these performance measures and some comparative reporting of results as a member benefit. In addition, NHPCO is engaged in the development of new performance measures, plus ongoing refinement and enhancement of the current measures.

NHPCO provides online data submission, provider-level reporting, and comparative reporting for the following tools: Evaluation of Grief Support Services (EGSS) (formerly FEBS, the Family Evaluation of Bereavement Services), Survey of Team Attitudes and Relationships (STAR), and the National Data Set (NDS). STAR is the only job satisfaction tool specific to the hospice field. The NDS is an annual data collection effort. The National Summary of Hospice Care is a report of the results of the National Data Set (NDS). Both STAR and the NDS are valuable organization and program evaluation tools.

For the following tools, we provide data workbooks for automatic visual analysis and results a hospice's data: Family Evaluation of Hospice Care (FEHC), Family Evaluation of Palliative Care (FEPC), and the Comfortable Dying Measure.

Below are detailed descriptions of all our performance measures and tools:

- Patient Outcomes and Measures (POM) – The POM includes two measures, 1) Comfortable Dying Measure (how well hospices achieve the goal of managing pain within 48 hours of admission) and 2) the Self-Determined Life Closure Measure (SDLC) (avoiding unwanted hospitalizations and avoiding unwanted CPR). For more information on NHPCO's about POM, please visit www.nhpc.org/pom.
- Evaluation of Grief Support Services (EGSS) – The EGSS survey is designed to evaluate bereavement services from the perspective of the recipients of the services. The survey takes a comprehensive approach by including questions on a wide range of services, many of them optional so that hospices may tailor the EGSS survey to reflect the specific services they offer. For more information on EGSS, please visit www.nhpc.org/egss.
- Family Evaluation of Hospice Care (FEHC) – FEHC is a post-death survey that asks questions about the family's perception of the care provided to the patient, as well as their own hospice experience. Hospices that utilize FEHC must be exempt from CMS-required CAHPS Hospice Survey. For more information on FEHC, please visit www.nhpc.org/fehcc.

- Family Evaluation of Palliative Care (FEPC) – FEPC is a post-death survey that captures family members’ perceptions about the quality of the palliative care their loved ones received — whether that care was provided by a hospital-based consult service or by a hospice program offering palliative care. The questions on the FEPC survey are based on those in the Family Evaluation of Hospice Care (FEHC) survey, with wording modifications appropriate to palliative care service delivery. For more information on FEPC, please visit www.nhpco.org/fepc.

Organization and Program Evaluation Tools

- National Data Set (NDS) – The NDS is comprised of program level descriptive statistical information that provides a comprehensive picture of hospice operations and care delivery. NDS data are used to answer such key questions as who is providing hospice care, who are the patients receiving that care, and how much and what kind of services were provided. For more information on the National Data Set (NDS), please visit www.nhpco.org/nds.
- Survey of Team Attitudes and Relationships (STAR) – STAR is the only job satisfaction tool designed specifically for the hospice field. In addition to providing agency level reports, NHPCO creates an annual national level report available through NHPCO Marketplace. For more information on STAR, please visit www.nhpco.org/star.

Support

NHPCO offers support for implementation, data collection and submission, and report interpretation for all of the performance measures. Each performance measure’s web page includes detailed information and guidelines for all aspects of the data collection and reporting process. In addition, NHPCO maintains a separate dedicated email address for each performance measure to answer any questions that hospices may have:

EGSS: egss@nhpco.org

FEHC: fehc@nhpco.org

FEPC: fepc@nhpco.org

NDS: nds@nhpco.org

POM: pom@nhpco.org

STAR: star@nhpco.org

Research: research@nhpco.org (for general research inquiries)

STANDARDS OF PRACTICE FOR HOSPICE PROGRAMS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

13 / Appendix I: Hospice Inpatient Facility (HIF)

Patient and family/caregiver-Centered Care (HIF PFC)

Ethical Behavior and Consumer Rights (HIF EBR)

Clinical Excellence and Safety (HIF CES)

Inclusion and Access (HIF IA)

Organization Excellence (HIF OE)

Workforce Excellence (HIF WE)

Compliance with Laws and Regulations (HIF CLR)

Stewardship and Accountability (HIF SA)

Performance Measurement (HIF PM)

13 / Appendix I: Hospice Inpatient Facility (HIF)

Introduction

The principles and standards in all chapters of the Standards of Practice for Hospice Programs apply to hospice care in all care environments. The Hospice Inpatient Facility Appendix contains additional principles and standards that apply only to hospices that operate an owned or leased inpatient facility intended to provide hospice patients with the general inpatient (GIP) level of care.

This appendix applies to General Inpatient (GIP) level of care. For patients on routine level of care please refer to the Hospice Residential Care Facility (HRCF) appendix. Hospices that operate an owned or leased inpatient facility must comply with applicable federal, state and local health and safety laws, regulations and codes unless specific waivers have been granted by the appropriate regulatory authorities. The inpatient facility and its staff must be appropriately licensed and, as applicable, certified to provide inpatient care.

PATIENT AND FAMILY/CAREGIVER-CENTERED CARE (HIF PFC)

Standard:

HIF PFC 1: Nursing services are available on-site twenty-four (24) hours a day, seven (7) days a week to meet the patient's nursing needs in accordance with the hospice general inpatient level of care and the patient's individualized plan of care.

HIF PFC 1.1 A registered nurse, knowledgeable and competent in providing direct care to hospice patients, is available on-site twenty-four (24) hours a day, seven (7) days a week. Each patient must receive all nursing services as prescribed in the plan of care and must be kept comfortable, clean, well groomed, and protected from injury.

HIF PFC 1.2 Other nursing staff including registered nurses (RN), advanced practice nurses (APRN/NP), licensed practical nurses (LPN) or licensed vocational nurses (LVN), or hospice aides (titles as defined by applicable law) are available to ensure that each patient's medical needs are met in a timely, compassionate, and professional manner.

HIF PFC 1.3 The hospice has established policies regarding physician services to meet the patient's medical needs in accordance with the hospice general inpatient level of care and the patient's individualized plan of care.

Practice Example:

- The hospice ensures that staffing schedules demonstrate that a registered nurse is always present to provide direct patient care and supervise other nursing staff providing patient care).

Standard:

HIF PFC 2: The hospice must designate a hospice interdisciplinary team composed of individuals who work together to meet the physical, psychosocial, emotional, and spiritual needs of the patients and families/caregivers facing terminal illness and bereavement.

HIF PFC 2.1 Psychosocial and spiritual care are provided by members of the hospice interdisciplinary team and/or counselors or social workers directly assigned to the hospice inpatient facility.

Practice Examples:

- A specific social worker is assigned to the hospice inpatient facility to address the psychosocial needs of each patient and family/caregiver.
- A specific social worker is assigned to the hospice inpatient facility to address the discharge planning and continuity of care needs of each patient and family/caregiver.
- Chaplains/spiritual caregivers trained in hospice care make rounds at the hospice inpatient facility to attend to the spiritual needs of each patient and family/caregiver.
- A written schedule for after hours and weekend availability demonstrates that social worker and chaplain/spiritual caregiver services are available to address patient and family/caregiver needs.
- A bereavement counselor is available to provide services to family members/caregivers in need of additional support to cope with anticipatory grief and to prepare for the patient's death.

Standard:

HIF PFC 3: The hospice inpatient facility provides services designed to meet the unique nutritional needs of each hospice patient.

HIF PFC 3.1 Dietary counseling, when identified as a necessity in the plan of care, includes education and interventions provided to the patient and family/caregiver regarding appropriate nutritional intake as the patient's condition changes.

HIF PFC 3.2 Meal planning and the timing of meals are discussed with each patient and adjusted, as reasonable and appropriate, according to each patient's preference, selection, and nutritional needs.

HIF PFC 3.3 Food and nutritional supplements are provided in accordance with the special dietary restrictions noted on the patient's plan of care.

HIF PFC 3.4 The hospice inpatient facility assures that food is procured, stored, prepared, distributed, and served under sanitary conditions and in a manner that is appealing to each patient.

HIF PFC 3.5 Any patient requiring assistance with meal planning and/or feeding receives such assistance by staff, volunteers, family members, or caregivers.

HIF PFC 3.6 Dietary counseling, when identified as a necessity in the patient's plan of care, is provided by qualified individuals, which may include a registered nurse, dietician, or nutritionist.

Practice Examples:

- Meals are individually scheduled allowing for frequent small meals if desired by the patient.
- Trained volunteers or staff members are available during meal times to assist patients with feeding as needed.
- Special dietary requirements are noted on the patient's plan of care and food is ordered and provided accordingly.
- Food, including between meal snacks or nourishment is available twenty-four (24) hours a day, seven (7) days a week to address the patient's reasonable requests and needs, unless limited by dietary restrictions prescribed by a physician.
- If the dietary counseling needs of the patient exceed the expertise of the nurse, then the hospice must have available an appropriately trained and qualified individual such as a registered dietitian or nutritionist to meet the patient's dietary needs. The dietitian or nutritionist must be a hospice employee.

Standard:

HIF PFC 4: The hospice inpatient facility assures that all medications and treatments are available as ordered to meet each patient's needs and are dispensed and administered in accordance with all applicable federal and state laws and regulations.

HIF PFC 4.1 A licensed physician (or legal designee) orders all medication and treatment for each patient receiving hospice general inpatient care, in accordance with the plan of care and applicable state and federal laws.

HIF PFC 4.2 Verbal/telephone physician orders are received, immediately recorded, and read back by the licensed individual. The prescribing physician signs and dates the order in accordance with applicable laws and regulations.

HIF PFC 4.3 Medications are administered in accordance with applicable laws and regulations and in accordance with each patient's individual medication record developed as part of the hospice plan of care.

HIF PFC 4.4 A hospice that provides inpatient care directly in its own facility must provide pharmacy services under the direction of a qualified licensed pharmacist who is an employee of or under contract with the hospice. The pharmacist's services must include evaluation of a patient's response to medication

therapy, identification of a potential adverse drug reaction, duplicative or ineffective therapy, and recommendation of appropriate corrective actions.

HIF PCF 4.5 Patients receiving care in a hospice that provides inpatient care directly in its own facility may only be administered medications by the following individuals:

1. Licensed nurse, physician, or other health care professionals in accordance with their scope of practice and state laws;
2. An employee that has completed a state approved training program in medication administration; and
3. The patient who may self-administer medications upon approval by the hospice interdisciplinary team.

Practice Examples:

- The hospice inpatient facility has a process to ensure timely signing and receipt of verbal orders.
- Medications are administered in accordance with physician orders and at the scheduled frequency.
- The hospice inpatient facility has a process for obtaining required medications in a timely manner twenty-four (24) hours a day, seven (7) days a week.
- A medication administration record is maintained for each patient and each medication given is documented.
- Infusion pumps have free flow protection and audible alarms.
- A medication reconciliation process is in place.
- The facility has a process for reporting medication events, such as errors or missing medications, and implements corrective actions accordingly.
- The facility has a process for safe disposal of discontinued/unused medications and controlled substances in compliance with the hospice policy and in accordance with local, state and federal requirements. The hospice maintains current and accurate records of the receipt and disposition of all controlled substances.

Standard:

HIF PFC 5: Death that occurs in the hospice inpatient facility is handled with respect and compassion toward the patient and family/caregiver.

HIF PFC 5.1 Post mortem policies and procedures are in place and minimally include:

1. Compassionate care and preparation of the body in accordance with the desires of the patient and family/caregiver;
2. Respect for any cultural or religious ritual or practice, spiritual traditions, beliefs relating to the death, and subsequent handling of the body and mourning of the family/caregiver;
3. Allowance for family presence with the body as desired and for a reasonable amount of time subsequent to the death;

4. Provision of spiritual, psychosocial, or bereavement care or services as needed or desired by the family; and
5. Provision for dignified removal of the body.

Practice Examples:

- Specific training is provided to the hospice inpatient facility staff on how to handle a patient death including information regarding respect for cultural and religious beliefs.
- Family members are afforded privacy with the patient's body as desired.
- Private meditation space is available for family members/caregivers' use.
- Private exits are available for removal of bodies from the hospice inpatient facility.
- Policies and procedures permit families to remain for reasonable periods of time in patients' rooms following death.
- Private areas are available for the family/caregiver's use following the death of a patient.
- Policies and procedures exist to ensure return of personal possessions to the appropriate individual, notify attending physician and family members/caregivers of the patient's death, and verify death in accordance with state and local requirements.

ETHICAL BEHAVIOR AND CONSUMER RIGHTS (HIF EBR)

Standard:

HIF EBR 1: Patients and families/caregivers are informed of eligibility requirements for the level of care being provided and the decisions, actions, and responsibilities to occur if a change in level of care is indicated.

HIF EBR 1.1 When a change in the patient's level of care is indicated, the patient and family/caregiver are informed of their choices and obligations, including financial responsibilities if the patient remains in the hospice inpatient facility (HIF) and/or needs to move to another setting.

Practice Examples:

- Patients and responsible parties are informed of the purpose and short-term nature of General Inpatient (GIP) or Respite level of care upon admission to that level of care.
- An Advance Beneficiary Notice (ABN), with explanations, is provided to the patient and family/caregiver when the patient no longer meets GIP criteria but wishes to remain at the HIF.
- Discussion with patient/responsible party of the change in levels of care and any relocation of the patient or charges incurred, such as room and board, is documented.
- Patients and responsible parties are informed of rights to appeal during the admission to services process.

HIF CES 1: CLINICAL EXCELLENCE AND SAFETY (HIF CES)

Standard:

HIF CES 1: The hospice inpatient facility is designed to provide a homelike environment and offer patient areas designed to preserve the dignity, comfort, and privacy of patients.

HIF CES 1.1 The hospice inpatient facility decor is homelike in design and function.

HIF CES 1.2 The hospice inpatient facility has physical space and policies and procedures that assure:

1. Patient and family/caregiver privacy;
2. Accommodations for family members/caregivers to remain with the patient as desired;
3. Unrestricted visitation privileges including children;
4. Appropriate accommodations that provide for privacy;
5. Appropriate safety measures to minimize patient falls; and
6. If smoking is permitted it is limited only to designated areas away from patient care.

HIF CES 1.3 The hospice inpatient facility has physical space and equipment that addresses and supports:

1. The patient's plan of care;
2. Close proximity of the patient to toileting and bathing areas;
3. Patient care space at or above grade level;
4. Closet space for security and privacy;
5. No more than two (2) beds in any single patient room;
6. Space adequate to provide medical treatments and personal care, facilitate patient mobility, and comfortably accommodate visitors regardless of single or double occupancy of the room (room accommodations must meet applicable state regulations for room size);
7. An adequate supply of hot water with plumbing control valves that automatically regulate temperature;
8. Ability to support flexibility related to individual patient room temperatures; and
9. An accessible, easily activated, consistently functioning device that is used for calling for assistance.

HIF CES 1.4 The hospice inpatient facility has linens available for appropriate care and comfort of patients. Linens are handled, stored, processed, and transported in compliance with applicable infection control standards, policies, and procedures.

HIF CES 1.5 The hospice inpatient facility has policies and procedures addressing the isolation of patients with infectious diseases and complies with applicable infection control standards, policies, and procedures.

Practice Examples:

- The hospice inpatient facility provides for semi-private accommodations that include curtain separations, partitions, or screens to create privacy and contain a private bathroom and shower.

- Patient accessible electronic media players and telephones are available.
- Furnishings, lighting, wall coverings, window treatments, and floor coverings are residential in appearance and design.
- Convertible patient furniture or portable “beds” are available for family members/caregivers.
- A bathroom and shower are available for family members/caregivers.
- Kitchen area is available that allows for family food preparation.
- A sufficient number of private gathering spaces are available to create an intimate environment for various purposes and numbers of people.
- Spaces exist that are designed to accommodate visiting children and their needs.
- Patient isolation policies and procedures exist which encourage as much normal patient functionality as possible and preserve patient dignity.
- The hospice inpatient facility has physical space and a plan which permits appropriate patient access to the outdoors.

Standard:

HIF CES 2: The hospice develops, implements, and evaluates a plan for emergency preparedness. A written emergency preparedness plan exists and is regularly communicated to staff through orientation and ongoing measures and includes:

1. A definition of an emergency event for the hospice inpatient facility’s given location and circumstances;
2. Arrangements for prompt identification and transfer of patients and records to another facility if necessary;
3. Arrangements for coordination of community resources; and
4. Compliance with applicable Life Safety Code of the National Fire Protection Association (NFPA) and other regulations.

HIF CES 2.1 The hospice inpatient facility staff is oriented to life safety code features and equipment.

HIF CES 2.2 The hospice inpatient facility staff demonstrates and evaluates their proficiency in understanding the emergency preparedness plan by routine rehearsal.

HIF CES 2.3 The emergency preparedness plan is regularly evaluated for appropriateness and revised as necessary.

Practice Examples:

- The facility’s electronic clinical record system or database is backed up to an off-site data storage facility for retrieval if onsite records are lost or corrupted.
- The facility conducts and documents an annual review of written fire safety and emergency preparedness plans.
- Transfer arrangements with other facilities are written and reviewed.
- Evacuation diagrams are posted and visible to all staff, patients, and family members/caregivers.

- Rehearsals and critiques are conducted semi-annually for the emergency preparedness plan.
- Reasons to shelter in place versus evacuate are defined and the procedures for both are practiced.
- The facility has a back-up generator for short-term electrical generation.
- There is enough food onsite to provide sufficient nutrition for patients and staff for prolonged periods as applicable to state and federal laws or accrediting bodies.

Standard:

HIF CES 3: The hospice inpatient facility meets all federal, state, and local laws, and regulations and codes pertaining to health and safety, especially the applicable edition of the Life Safety Code of the National Fire Protection Association.

HIF CES 3.1 The hospice inpatient facility has been constructed and/or renovated to comply with applicable federal, state, and local laws, regulations, and codes.

HIF CES 3.2 The hospice inpatient facility is sufficiently equipped, maintained, and sanitized to care for admitted patients and to comply with applicable federal, state, and local laws, regulations, and codes.

HIF CES 3.3 The hospice inpatient facility has received any appropriate CMS waivers related to the Life Safety Code.

HIF CES 3.4 The hospice inpatient facility has a contract and appropriate policies and procedures related to disposal of biohazardous waste.

Practice Examples:

- A mechanism exists for staff to report equipment maintenance needs.
- A preventive maintenance program exists for electrical, Heating, ventilation, and air conditioning (HVAC), sprinkler, and security systems.
- Announced and unannounced fire drills are regularly carried out. Fire alarm tests are scheduled on a regular basis.
- Fire extinguishing equipment, sprinkler systems, grease traps, and elevator testing and maintenance is regularly documented.
- A capital equipment replacement schedule is in place and included in budgeting process.

Standard:

HIF CES 4: The hospice inpatient facility provides for the appropriate storage and disposal of drugs and medications.

HIF CES 4.1 The hospice inpatient facility has separately locked compartments for Schedule II drugs.

HIF CES 4.2 The hospice inpatient facility has appropriate policies and practices for the review of discontinued, expired, or deteriorated drugs.

Practice Examples:

- Policies and procedures exist and are evaluated for the appropriate access to medication storage areas.
- A process is outlined for staff members and they are educated on the proper counting and tracking of all drugs, especially controlled substances.
- A pharmacist regularly inspects drug ordering, storage, administration, disposal, and record keeping procedures.
- There is a Pharmacy and Therapeutics Committee with responsibility for facility medication management functions.
- Discrepancies in drug supply are reported and addressed promptly and in a consistent manner.
- A policy and procedure is in place for the disposal of all drugs including compliance with disposal requirements for controlled substances, in compliance with federal law.

Standard:

HIF CES 5: The hospice inpatient facility environment is safe, clean, and secure for patients, families/caregivers, volunteers, and staff.

HIF CES 5.1 The hospice inpatient facility has written policies and procedures that are communicated to staff and appropriate for the facility's location that address:

1. Housekeeping procedures;
2. Security measures;
3. Visitor entrance procedures;
4. Access to security and emergency personnel (e.g., police, security staff, sheriff, fire department, EMT, emergency psychiatric team);
5. Inappropriate behavior which could harm others; and
6. Monitoring of public areas.

HIF CES 5.2 The hospice inpatient facility has written policies and procedures to address the cleanliness and safety of the facility.

HIF CES 5.3 The hospice inpatient facility has a process to report, document, and evaluate safety and security incidents for corrective actions.

Practice Examples:

- Security staff ensures appropriate access to the facility and that entry areas are staffed.
- Electronic alarm, voice, or video systems exist to monitor the grounds and entrances.
- Visitor identification requirements exist and are enforced.
- Electronic devices exist to summon authorities.
- Incidents are regularly reported and reviewed and systems are regularly assessed for needed change.
- Staff awareness programs exist to enforce and highlight security issues.
- Policies and procedures are available for dealing with family/caregiver or visitor behavior that is unacceptable and/or impedes patient care.
- Housekeeping of patient areas follows a defined process to ensure adequate infection control measures throughout the facility.
- Housekeeping staff are regularly available and a twenty-four (24) hour per day plan exists for meeting patients' housekeeping needs.
- Resource agreements are written and reviewed for ongoing and emergency service for major cleaning needs.
- Records are kept to demonstrate that any draperies have been treated to be flame retardant.

Standard:

HIF CES 6: All patients have the right to be free from physical and mental abuse and corporal punishment.

HIF CES 6.1 Seclusion and restraints may only be used when ordered by a physician and needed to ensure the immediate physical safety of the patient, a staff member, or others, and must be discontinued at the earliest possible time. Seclusion and restraints may only be used in accordance with state law and only when less restrictive interventions have been deemed ineffective.

HIF CES 6.2 All patient care staff working in the inpatient facility must have training and demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and care provision for a patient in seclusion or restraints per physician order specifications, organizational policy, and procedure; staff must also be certified in Cardiopulmonary resuscitation (CPR).

HIF CES 6.3 Hospices must report deaths associated with the use of seclusion or restraints in accordance with state and federal regulations.

HIF CES 6.4 An inpatient facility may be restraint and seclusion free. If the inpatient facility is restraint and seclusion free, the facility must have an applicable policy which includes care provisions for a patient requiring restraint or seclusion.

Practice Examples:

- The hospice provides staff orientation and ongoing training related to physical and chemical restraints and patient seclusion.
- The hospice has a policy addressing alternative treatments or settings to manage patients that are violent or have self-destructive behavior.

HIF IA 1: INCLUSION AND ACCESS (HIF IA)**Standard:**

HIF IA 1: Access to hospice general inpatient care is made available to all hospice patients who are in need of acute inpatient pain control or symptom management which cannot be provided in other settings and who meet the general admission criteria to a hospice program.

HIF IA 1.1 The hospice patient has a right to participate in the decision making process regarding available locations for the delivery of inpatient level of care and to choose their attending physician.

HIF IA 1.2 The hospice has additional option(s) available for general inpatient care other than the hospice inpatient facility.

Practice Examples:

- The hospice utilizes written criteria that meet regulatory guidance for admission to and continued stay in the hospice inpatient facility.
- The hospice offers options for GIP stays for each patient, which includes, but is not limited to, an inpatient stay in the hospice's owned inpatient facility or at a contracted hospital or skilled nursing facility.

ORGANIZATIONAL EXCELLENCE (HIF OE)**Standard:**

HIF OE 1: The HIF is included in agency-wide strategic planning and participates in activities to meet these goals.

WORKFORCE EXCELLENCE (HIF WE)

Standard:

HIF WE 1: The hospice that provides inpatient care directly in its own facility must provide pharmacy services under the direction of a qualified licensed pharmacist who is an employee of or under contract with the hospice.

The pharmacist services include:

1. Evaluation of the patient's response to medication therapy;
2. Identification of potential adverse drug reactions, duplicative, or ineffective therapy; and
3. Recommended appropriate corrective action.

COMPLIANCE WITH LAWS AND REGULATIONS (HIF CLR)

Standard:

HIF CLR 1: The hospice identifies and ensures compliance with all federal, state, and local regulations that apply to the operation of an inpatient facility and/or the licensure of the facility itself.

STEWARDSHIP AND ACCOUNTABILITY (HIF SA)

Standard:

HIF SA 1: Funds donated specifically for use at the inpatient facility are acknowledged and procedures are in place to ensure use meets donor wishes.

PERFORMANCE MEASUREMENT (HIF PM)

Standard:

HIF PM 1: The HIF is included in the agency-wide QAPI program.

HIF PM 2: The HIF identifies performance improvement opportunities and demonstrates participation in performance improvement projects (PIPs).

STANDARDS OF PRACTICE FOR HOSPICE PROGRAMS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

14 / Appendix II: Nursing Facility Hospice Care (NF)

NF PFC 1: Patient and Family/caregiver-Centered Care (NF PFC)

NF EBR 1: Ethical Behavior and Consumer Rights (NF EBR)

NF CES 1: Clinical Excellence and Safety (NF CES)

NF IA 1: Inclusion and Access (NF IA)

NF OE 1: Organizational Excellence (NF OE)

NF WE 1: Workforce Excellence (NF WE)

NF CLR 1: Compliance with Laws and Regulations (NF CLR)

NF SA 1: Stewardship and Accountability (NF SA)

NF PM 1: Performance Measurement (NF PM)

14 / Appendix II: Nursing Facility Hospice Care (NF)

Introduction

The principles and standards in all chapters of the Standards of Practice for Hospice Programs apply to hospice care provided in all care environments. The Nursing Facility Hospice Care Appendix outlines additional principles and standards that apply only to hospices providing care to individuals residing in a nursing facility that provides primary caregiver services predominantly hired by the facility. The Nursing Facility Hospice Care Appendix does not apply to individuals receiving skilled nursing care in a facility. The term “nursing facility” includes skilled nursing facilities (SNF), nursing facilities (NF), and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

The hospice will comply with all applicable federal, state, and local health and safety laws, regulations and codes, unless the appropriate regulatory authorities have granted specific waivers. The nursing facility and its staff will be appropriately licensed and, as applicable, certified to provide this level of service.

NF PFC 1: PATIENT AND FAMILY/CAREGIVER-CENTERED CARE (NF PFC)

Standard:

NF PFC 1: The hospice assumes professional management responsibility of hospice services provided to residents of nursing facilities in accordance with the hospice plan of care.

NF PFC 1.1 The hospice ensures that all care and services routinely offered to home patients are also offered and available to patients whose residence is a nursing facility.

NF PFC 1.2 The hospice demonstrates collaboration with the facility partner to ensure a coordinated plan of care.

Standard:

NF PFC 2: The hospice develops a hospice plan of care in consultation with the nursing facility staff and the patient and family/caregiver.

NF PFC 2.1 The hospice and the facility collaboratively develop and document a coordinated plan of care for each patient that guides both providers and is in accordance with any federal, state, or local laws and regulations for the facility and the hospice.

NF PFC 2.2 When the hospice and facility have their individual care plans, both plans should contain the same problems and goals when laid side by side. Interventions are complementary and reflect palliative rather than curative care.

NF PFC 2.3 The plan of care should reflect patient and family/caregiver goals and include interventions based on the problems identified in the initial comprehensive and updated assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions.

NF PFC 2.4 The plan of care should specify appropriate delegation of responsibilities for provision of hospice care and non-hospice services by delineating which provider and discipline is responsible for performing each function related to the patient's care. The hospice staff routinely reviews the nursing facility's plan of care and communicates and coordinates with the nursing professional who completes the minimum data set (MDS), and other nursing facility nursing leadership as designated.

NF PFC 2.5 The hospice works with the nursing facility staff and the patient and family/caregiver to ensure that all changes to the plan of care are discussed and mutually agreed upon prior to implementation.

NF PFC 2.6 The hospice nurse case manager is responsible for the coordination of the hospice services for each hospice patient residing in a nursing facility. The plan of care shall be communicated by the nurse case manager or other hospice staff to the facility staff and other health care providers.

NF PFC 2.7 The hospice communicates with the patient's attending physician, the nursing home medical director, and other physicians actively participating in the care of the patient to ensure coordination of the patient's hospice care with all other aspects of the patient's medical care.

NF PFC 2.8 Representatives from the hospice interdisciplinary team will participate in nursing facility/hospice care plan meetings whenever possible.

Standard:

NF PFC 3: The hospice provides the nursing facility at a minimum with copies of the following:

1. Most recent hospice plan of care;
2. Hospice election form;
3. Advance directive, as appropriate, including the Health Care Power of Attorney and/or medical surrogacy information;
4. Physician certification and recertification of the terminal illness which includes the brief physician narrative;
5. Name and contact information for hospice personnel involved in hospice care for each patient;
6. Instructions for accessing the hospice's 24-hour on-call system;
7. Hospice medication information specific to each patient; and
8. Hospice physician and attending physician orders.

PFC 3.1 Information already on file regarding advance directives, medical surrogacy, and/or funeral arrangements shall be provided to the hospice by the nursing facility.

Standard:

NF PFC 4: Caregivers in a nursing facility will have access to hospice staff 24 hours a day, seven days a week and hospice staff will have access to the nursing facility's staff 24 hours a day, seven days a week.

NF PFC 4.1 Hospice demonstrates evidence there is communication and collaboration with the nursing facility staff, as appropriate, and documents communication.

NF PFC 4.2 Spiritual/psychosocial issues after hours and on weekends may be addressed by after hours and weekend staff and relayed to the hospice interdisciplinary team for further follow-up.

NF PFC 4.3 Hospice provides the nursing home with information regarding the date and time to expect visits from members of the hospice interdisciplinary team.

Standard:

NF PFC 5: The hospice has a plan for providing bereavement care to identified nursing facility staff and residents as appropriate.

Standard:

NF PFC 6: The hospice interdisciplinary team assures that the nursing facility patient receives the appropriate level of care and services.

NF PFC 6.1 A well-coordinated transition to another level of care or setting is facilitated by the hospice interdisciplinary team when a change in the patient's condition requires an adjustment in hospice level of care and services.

NF PFC 6.2 The hospice interdisciplinary team is responsible for coordination of appropriate end-of-life care in cooperation with the nursing facility and in accordance with state regulations.

Practice Examples:

- Specific training is provided to the nursing facility staff to manage a patient death, including information regarding respect for cultural and religious beliefs.
- Family members are afforded privacy with the patient's body as desired.
- Private meditation space is available for family members/caregivers' use.
- Policies and procedures permit families to remain for reasonable periods of time in patients' rooms following death.
- An area that affords privacy is available for the family's use following the death of a patient.
- The nursing facility and hospice collaborate to develop and update the patient's coordinated plan of care.

- The hospice and nursing facility have a process by which information from updated hospice assessments and nursing facility patient/family/caregiver information is exchanged.
- The hospice establishes a policy for provision of complementary services (as available) to patients in collaboration with the nursing home staff.
- The hospice social worker partners with the nursing facility social worker to educate the patient and family/caregiver regarding advance directive information, treatment decisions, and funeral arrangements.
- The hospice social worker partners with the nursing facility social worker in completing applications for Medicaid eligibility as needed.
- The hospice interdisciplinary team assesses family members/caregivers' reactions/concerns regarding a patient's transition to a location of care other than his/her personal residence and facilitates discussion of those concerns.
- The hospice interdisciplinary team assists the patient and family/caregiver in identifying nursing facility placement options and financial planning for payment of nursing facility care.
- Nursing facility staff is invited to attend and participate in hospice interdisciplinary team meetings when the needs of a patient residing in the nursing facility will be discussed.
- The hospice medical director discusses coordination of hospice care services with the nursing facility medical director as needed.
- Hospice staff members communicate with nursing facility staff and pharmacy about Medicare Part D payment for medications that are not related to the terminal prognosis and ensures that the hospice will be billed for any medications related to the terminal prognosis.
- The hospice volunteer program includes a component for volunteer assignments for patients residing in a nursing facility, especially for those with no family members nearby.
- Volunteer orientation and training includes appropriate components for assignment to patients residing in nursing facilities.
- Hospice staff members attend the nursing facility's care planning meetings for hospice patients.
- The record of each hospice patient in a nursing facility has the hospice's name and telephone number prominently displayed. Instructions related to on-call availability and when to contact the hospice is contained in the record in an easily accessible place.
- Nursing facility staff members on all shifts receive training regarding the availability of after-hours and/or on-call services for hospice patients.
- The hospice offers to facilitate annual memorial services for nursing facility patients who have died as the need is identified.
- Hospice bereavement services are offered to nursing facility staff and residents on an ongoing basis.
- All communication with the nursing facility is documented in the patient's facility medical records and the hospice clinical record.
- After-hours/weekend call logs document communication to and from nursing facilities.
- The hospice and nursing facility have a process by which information from the hospice interdisciplinary team plan of care is reviewed and updated and can be found in both the hospice and nursing facility clinical records.

NF EBR 1: ETHICAL BEHAVIOR AND CONSUMER RIGHTS (NF EBR)

Standard:

NF EBR 1: The hospice fully complies with the federal anti-kickback statute that prohibits personnel and representatives from knowingly and willfully offering, paying, requesting, or receiving money or other benefits directly or indirectly from third parties in connection with items or services billed to federal programs.

NF EBR 1.1 The hospice does not submit or cause to be submitted to federal healthcare programs claims for patients who were referred pursuant to contracts or financial arrangements that were designed to induce such referrals in violation of the anti-kickback statute or similar federal or state statutes or regulations.

NF EBR 1.2 The hospice does not engage in activity in violation of the state or federal regulations in which gifts or services are provided in return for referrals or future consideration.

NF EBR 1.3 The hospice will develop internal policies and procedures in accordance with applicable laws and regulations as evidenced by the compliance program.

Practice Examples:

- Hospice staff members ensure items provided to nursing facility staff are within established dollar limits (e.g., provides pens or other items to the nursing facility staff for promotional reasons).
- Hospice staff members present in-service education on hospice related topics for nursing facilities without additional incentives (e.g., extravagant meals, staff gifts, facility gifts).
- Continuing education credit is provided only for a reasonable cost (i.e., not provided for free).
- Education is provided by the hospice for nursing facility staff only as it relates to the care of hospice patients.
- Services purchased through a nursing facility are at fair market value.
- Hospice aide services in nursing facilities are offered at the same frequency and duration as such services are provided in patients' homes. The hospice aide supplements the services of the facility certified nursing assistant.

NF CES 1: CLINICAL EXCELLENCE AND SAFETY (NF CES)

Standard:

NF CES 1: The hospice and nursing facility collaborate to ensure safety and clinical excellence of care for hospice patients residing in the facility.

NF CES 1.1 The hospice and nursing facility collaborate on identifying safety risks and develop a plan to address identified risks.

NF CES 1.2 Hospice and nursing facility staff collaborate to improve operational processes and deliver coordinated clinical care.

Practice Examples:

- The hospice staff members maintain an awareness of and participate as appropriate in the nursing facility safety program as it relates to:
 - fall prevention;
 - infection control;
 - hazardous material and waste;
 - fire and evacuation plans;
 - emergency/disaster preparedness plans; and
 - communication contingency plans.
- Incidents and accidents are reported and monitored by both the hospice and the nursing facility, and joint plans of correction are developed, when indicated.
- Hospice staff members report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the SNF/NF or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) administrator within 24 hours of the hospice becoming aware of the alleged violation, or as defined by state regulations which may require more stringent reporting timelines according to the type of violation.
- The process for hospice provision of durable medical equipment in the nursing facility is clearly communicated and coordinated with the facility.
- The hospice durable medical equipment provider instructs the nursing facility and hospice staff in the proper use of any delivered equipment.
- The hospice and nursing facility utilize risk assessment tools to determine the patient's level of risk for falls and wounds.
- The hospice staff members are educated on infection control measures in the nursing facility, (e.g., hand washing, infection reporting, and isolation procedures).
- The hospice participates in the nursing facility infection control and safety review evaluation and includes the information in the hospice quality program.
- Hospice staff reports potential patient safety hazards and collaborates with the nursing facility to improve patient safety, including strategies for falls reduction.

NF IA 1: INCLUSION AND ACCESS (NF IA)

Standard:

NF IA 1: The hospice patient or the patient's representative has a right to participate in the decision making process regarding care and treatment.

Practice Examples:

- A routine procedure for communication with the patient's representative is implemented when the patient does not have decision making capacity.
- The patient or patient's representative is contacted before there is a change in the plan of care unless delay in implementing the change would have a negative impact on the patient's condition.

NF OE 1: ORGANIZATIONAL EXCELLENCE (NF OE)

Standard:

NF OE 1: The hospice demonstrates professional management of the patient's hospice care services in accordance with the hospice/nursing facility coordinated plan of care.

Practice Examples:

- The hospice nurse case manager manages the plan of care with input from the patient, family/ caregiver and nursing facility and coordinates the implementation of the plan with the nursing facility staff.
- Hospice identifies a specific member of the hospice core team to communicate with the nursing facility staff on a regular basis to evaluate:
 - the needs of the hospice patient and the nursing facility staff; and
 - the implementation/updating of the plan of care.
- The hospice nurse case manager reviews the nursing home and hospice care plans and documents communication, coordination, and collaboration of the hospice and nursing home care plans on a regular ongoing basis.

NF WE 1: WORKFORCE EXCELLENCE (NF WE)

Standard:

NF WE 1: The hospice provides orientation and training to nursing facility staff.

NF WE 1.1 The hospice demonstrates that nursing facility staff on all shifts are offered education in the hospice philosophy, hospice policies and procedures, symptom management, death and dying, patient rights and record keeping requirements.

NF WE 1.2 The hospice staff are trained in the principles of long term care including the assessment and management of frail elders, collaborative care planning and nursing home systems, rules and regulations.

Practice Examples:

- The hospice attempts to hire staff with nursing facility experience.
- Hospice staff orientation includes education related to nursing facility requirements and environment.
- The hospice provides in-service training to nursing facility staff about the reasons to contact the hospice immediately.
- The hospice provides in-service training to nursing facility staff on the topics of work-related grief and loss and end-of-life care.
- The hospice responds to questions concerning hospice patients during the nursing home survey process and provides nursing home surveyors with documentation from the hospice patient records as well as answering questions regarding hospice services.
- Orientation to hospice care is included in the nursing facility's orientation program.
- The hospice collaborates and coordinates educational offerings related to hospice and end-of-life care with the nursing facility's education coordinator.

NF CLR 1: COMPLIANCE WITH LAWS AND REGULATIONS (NF CLR)

Standard:

NF CLR 1: The hospice and nursing facility have a written agreement specifying each party's responsibilities for hospice patients residing in the nursing facility.

NF CLR 1.1 The written agreement includes:

1. A delineation of the hospice's responsibilities and nursing facility responsibilities;
2. Method of communication between hospice and nursing facility staff to ensure that the needs of the patients are met 24 hours/day;
3. A provision that the nursing facility immediately notifies the hospice if:

- a. there is a significant change in the patient's status;
 - b. the plan of care needs to be altered;
 - c. the patient needs to be transferred to an alternate care setting or needs a level of care change, or
 - d. the patient dies.
4. Hospice responsibility for determining the appropriate course of hospice care including determining the level of care and changes to the level of care;
 5. A provision that the nursing facility continues to provide the same level of care to the patient as before hospice was provided;
 6. A provision that the hospice will provide the same level of services as if the patient was in his own home;
 7. A provision that the hospice must report to the nursing facility administrator all alleged mistreatment, neglect, or abuse by anyone unrelated to the hospice within 24 hours of becoming aware of the alleged violation, or as defined by state regulations which may require more stringent reporting timelines according to the type of injury; and
 8. A delineation of the hospice's responsibility to provide bereavement services to the nursing facility staff.

NF SA 1: STEWARDSHIP AND ACCOUNTABILITY (NF SA)

Standard:

NF SA 1: The hospice staff members follow an established code of conduct, act in a professional manner, and observe the regulations governing both the hospice and the nursing facility.

Practice Example:

- The hospice has an effective compliance program that includes a code of conduct acknowledged by all hospice staff.

NF PM 1: PERFORMANCE MEASUREMENT (NF PM)

Standard:

NF PM 1: Hospice quality assessment and performance improvement efforts are inclusive and reflective of services provided in all settings.

Practice Examples:

- The nursing facility and hospice share information on their performance improvement programs and current performance improvement initiatives as appropriate.
- The nursing facility and hospice collaborate on performance improvement projects for hospice patients residing in the facility as appropriate.

STANDARDS OF PRACTICE FOR HOSPICE PROGRAMS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

15 / Appendix III: Hospice Residential Care Facility (HRCF)

Patient and Family/caregiver-Centered Care (HRCF PFC)

Ethical Behavior and Consumer Rights (HRCF EBR)

Clinical Excellence and Safety (HRCF CES)

Inclusion and Access (HRCF IA)

Organizational Excellence (HRCF OE)

Workforce Excellence (HRCF WE)

Workforce Excellence (NF WE)

Compliance with Laws and Regulations (HRCF CLR)

Stewardship and Accountability (HRCF SA)

Performance Measurement (HRCF PM)

15 / Appendix III: Hospice Residential Care Facility (HRCF)

Introduction

The principles and standards in all chapters of the Standards of Practice for Hospice Programs apply to hospice care provided in a hospice residential care facility. The Hospice Residential Care Facility Appendix contains additional principles and standards that apply only to hospices that operate an owned or leased residential care facility intended to provide hospice patients with the routine or continuous levels of care. The facility offers discrete private living arrangements for hospice-appropriate patients for whom the hospice takes on primary caregiving responsibility. The standards contained in this Appendix are intended to apply to facilities operated as an owned or leased facility by a hospice.

Patients in such a facility will be encouraged to maintain and develop their fullest potential for independent living through participation in planned activities for as long as they are able or desire to do so. The activities made available may include: socialization achieved through activities such as discussion and conversation, recreation, arts and crafts; daily living skills/activities which foster and maintain independent functioning; leisure time activities cultivating personal interests and pursuits; physical activities and free time so residents may engage in activities of their own choosing.

Recognizing that regulations and licensure rules vary from state to state, hospices that operate an owned or leased hospice residential care facility will comply with applicable federal, state, and local health and safety laws, regulations and codes unless specific waivers have been granted by the appropriate regulatory authorities. The hospice residential care facility and its staff will be appropriately licensed and, as applicable, certified to provide hospice care.

HRCF PFC 1: PATIENT AND FAMILY/CAREGIVER-CENTERED CARE (HRCF PFC)

Standard:

HRCF PFC 1: Nursing services are available to meet the patient's nursing needs in accordance with the hospice plan of care.

HRCF PFC 1.1 A registered nurse experienced in providing direct care to hospice patients is available on site or on-call twenty-four (24) hours a day, seven (7) days a week.

HRCF PFC 1.2 A hospice aide is on site twenty-four (24) hours a day with increased levels of staffing consistent with the acuity of the patients and their plans of care.

HRCF PFC 1.3 Prior to admission and throughout the patient stay, patients are evaluated against written criteria to assess the program's capability of providing the appropriate level of care.

Practice Examples:

- Staff assigned to the hospice residential care facility has received training in hospice care including pain and symptom management.
- Staffing schedules demonstrate availability of a registered nurse twenty-four (24) hours a day, seven (7) days a week.
- Documentation provides evidence of registered nurse supervision of other nursing staff providing care (e.g., LPN/ LVN, hospice aide) no less often than every 14 days.
- Policies and procedures are in place for the assessment, documentation, and communication of the reasons for admission to the residence.
- There is clinical documentation that supports each patient accepted for admission has a life expectancy of six months or less (if the terminal condition follows its normal course) and the plan of care can safely be managed at the level of care provided at the residence.
- Assessment and transfer policies and procedures direct when a patient's needs and plan of care cannot be met at the level of care at the facility.
- A transfer summary is generated with detailed information when a patient transfers to or from the hospice residential care facility.
- Policies and procedures are in place to determine the amount of supervision necessary for patients who wander, patients who are confused or forgetful, for social activities, or for patients who choose to manage their own financial resources.
- A program is implemented to provide training and supervision for volunteer sitters who may be assigned, as needed, to provide reassurance and companionship to the patient or to maintain safety.
- A procedure is followed for transfer of patients to an inpatient setting when required.
- The hospice residential care facility has a plan for transfer of patients to an appropriate facility when discharged from hospice care but unable to live independently.
- The hospice IDT conducts case conferences at the hospice residential care facility with the patient and family/caregiver invited to explore care plan options as appropriate.
- The hospice physician assumes primary care for the hospice residential care facility patient, if chosen by the patient or patient representative.
- The hospice residential care facility hospice interdisciplinary team members (including hospice aides and volunteers) participate in hospice interdisciplinary team meetings and provide input for the care planning process on an ongoing basis.
- The environment is maintained in a manner that promotes safety, infection control, visitors, and rest and night time sleep for the residents.

Standard:

HRCF PFC 2: Psychosocial and spiritual care is available twenty-four (24) hours a day, seven (7) days a week to meet the needs of each patient and family/caregiver receiving hospice residential care.

HRCF PFC 2.1 Psychosocial and spiritual care is provided by qualified members of the hospice interdisciplinary team and/or counselors or social workers who are directly assigned to the hospice residential care facility.

HRCF PFC 2.2 Non-core services such as physical therapy, occupational therapy, and speech-language pathology are arranged for and provided by the hospice as indicated by patient needs.

Practice Examples:

- A specific social worker is assigned to provide services at the hospice residential care facility to address the psychosocial needs of the patient and family/caregiver.
- Chaplains/spiritual caregivers trained in hospice care attend to the spiritual needs of patients and families at the hospice residential care facility.
- Patients and families/caregivers are assessed for adjustment to the new environment within a few days following admission to the hospice residential care facility.
- A written schedule of after normal business hours availability demonstrates that social worker and chaplain/spiritual caregiver services are available twenty-four (24) hours a day, seven (7) days a week.
- Patient and family/caregiver requests for visits by clergy of all religions is accommodated and welcomed.
- The celebration of all religious holidays is respected and recognized as appropriate.
- Art, music, and pet therapies are available to the hospice residential care facility patient.
- A process exists to provide spiritual/psychosocial/bereavement support to the hospice residential care facility staff as needed in promoting self-care.
- Specific volunteers are assigned to the hospice residential care facility to address administrative and patient support needs (e.g., receptionist services, passing meal trays, coordinating activities).

Standard:

HRCF PFC 3: The hospice residential care facility assures that all medications and treatments are available as ordered to meet each patient's needs and are dispensed and administered in accordance with all applicable laws, regulations, and codes.

HRCF PFC 3.1 All medications for each patient receiving hospice residential care must be prescribed in accordance with all applicable laws, regulations and codes.

HRCF PFC 3.2 Verbal orders are received in accordance with all applicable laws, regulations, and codes and immediately recorded, signed, and dated by the prescribing individual in accordance with all applicable laws, regulations, and codes. A procedure for verbal order read-back is implemented to ensure accuracy of verbal orders.

HRCF PFC 3.3 Medications are administered in accordance with all applicable laws, regulations, and codes and in accordance with each patients' individual medication record developed as part of the hospice plan of care.

HRCF PFC 3.4 The hospice residential care facility arranges for a licensed pharmacist to monitor ordering, safe storage, dispensing, disposal, and record keeping related to pharmaceutical services and to provide review and consultation regarding each patient's medications. (Safe storage, e.g., proper temperature, attention to expiration dates, controlled ventilation, humidity) in accordance with manufacturers' recommendations.

Practice Examples:

- The hospice residential care facility arranges with the patients to self-administer their own medications when policy allows and it is safe for them to do so.
- The hospice residential care facility has a process for securing needed medications twenty-four (24) hours a day, seven (7) days a week.
- Physicians sign, date, and time all verbal orders within the time frame designated by state standards of practice (no stamped physician signatures are permitted).
- A medication administration record is maintained for each patient and each medication administered by a staff member is documented.
- The hospice residential care facility has emergency medications available to manage pain and other symptoms, and qualified staff has access to these medications twenty-four (24) hours a day.

Standard:

HRCF PFC 4: Death that occurs in the hospice residential facility is handled with respect and compassion toward the patient and family/caregiver.

HRCF PFC 4.1 Post mortem policies and procedures are in place and include:

1. Compassionate care and preparation of the body in accordance with the desires of the patient and family/caregiver;
2. Respect for any cultural or religious ritual or practice, spiritual traditions, and beliefs relating to the death and subsequent handling of the body and mourning of the family/caregiver;
3. Allowance for family presence with the body as desired and for a reasonable amount of time subsequent to the death;
4. Provision of spiritual, psychosocial, or bereavement care or services as needed or desired by the family;

5. Provision for dignified removal of the body; and
6. Disposal of all medications in accordance with applicable state and federal laws.

Practice Examples:

- Specific training including information regarding respect for cultural and religious beliefs is provided to the hospice residential facility staff to provide care at the time of a patient death.
- Family members/caregivers are afforded privacy with the patient's body as desired.
- Private meditation space is available for family members/caregivers' use.
- Removal of bodies from the hospice residential facility is handled with privacy, dignity, and respect.
- Policies and procedures permit family members to remain for reasonable periods of time in the patient's room following death.
- The hospice allows time for facility staff and volunteers to participate in memorial observance of deaths that occurred in the residential facility.

HRCF EBR 1: ETHICAL BEHAVIOR AND CONSUMER RIGHTS (HRCF EBR)

Standard:

EBR 1: Upon admission to the residential care facility, the patient/representative is provided with patient rights as a resident and facility rules and behavior expectations (e.g., smoking policy, privacy for self and other residents, visitor rules, supervision of children visiting, process to leave the facility for short periods).

Practice Examples:

- The hospice has policies and procedures for approval of icons, shrines, etc. that patients and families may wish to use within the hospice residential care facility.
- The hospice residential care facility briefs new family members on confidentiality expectations for all patients and families residing within the facility.

HRCF CES 1: CLINICAL EXCELLENCE AND SAFETY (HRCF CES)

Standard:

HRCF CES 1: The hospice residential care facility is designed to provide a homelike environment.

HRCF CES 1.1 The hospice residential care facility decor is homelike in design and function.

HRCF CES 1.2 The hospice residential care facility has physical space and policies and procedures that assure:

1. Patient and family/caregiver privacy;
2. Visitation privileges that include young children are supervised by persons other than staff;
3. Appropriate gathering space provided for privacy; and
4. Individual practices of faith are respected.

HRCF CES 1.3 The hospice residential care facility has physical space and equipment that addresses and supports:

1. The patient's plan of care and its coordination and continuity;
2. Appropriate proximity of the patient to toileting and bathing areas;
3. Closet space for security and privacy;
4. No more than two (2) beds in any single patient room;
5. At least 120 square feet for a single patient room and at least 100 square feet for each patient residing in a double room, or in compliance with state law;
6. Devices for summoning staff that can be adapted, as needed, for patient/family/caregiver use;
7. A comfortable room temperature for residents throughout the entire year;
8. An adequate supply of hot water with plumbing control valves that automatically regulate temperature to avoid the risk of scalds and burns;
9. Routine storage and prompt disposal of trash and medical waste; and
10. Emergency gas, electric, and water supply.

HRCF CES 1.4 The hospice residential care facility has physical space and a plan that permits appropriate patient access to the outdoors.

HRCF CES 1.5 Telephone access is made available to residents that permit private communication.

HRCF CES 1.6 The hospice residential care facility has a quality and quantity of linens available for appropriate care and comfort of patients. Linens are handled, stored, processed, and transported in compliance with applicable infection control standards, policies, and procedures.

HRCF CES 1.7 The hospice residential care facility has policies and procedures addressing the isolation of patients with infectious diseases and complies with applicable infection control standards, policies, and procedures.

HRCF CES 1.8 The hospice residential care facility has a plan that permits dignified private removal of bodies.

HRCF CES 1.9 The hospice residential care facility provides an area for patients and family to practice their own spiritual beliefs and practices.

Practice Examples:

- Patient accessible televisions, DVD or videotape players, computers/internet access, and radios/CD players are available.
- Private areas are available for the family/caregiver's use following the death of a patient.
- Spaces exist that are designed to accommodate visiting children and their needs.
- Patient isolation policies and procedures which encourage as much patient flexibility as possible and preserve patient dignity are in place.
- Housekeeping services maintain a safe clean environment on a daily and as needed basis and are compliant with health and safety rules and regulations.

Standard:

HRCF CES 2: The hospice residential care facility provides services designed to meet the unique nutritional needs of each patient.

HRCF CES 2.1 Meal planning and timing of meals is discussed with patients.

HRCF CES 2.2 Food served is palatable, attractive, and served at the proper temperature.

HRCF CES 2.3 Special dietary restrictions and patient wishes are noted in the patient's plan of care and food and nutritional supplements are provided accordingly.

HRCF CES 2.4 The facility assures that food is procured, stored, prepared, distributed, and served under sanitary conditions in accordance with applicable laws, rules, and regulations, and in a manner that is appealing to the patient's wishes.

HRCF CES 2.5 Any patient requiring assistance with meal planning and/or feeding receives such assistance by staff, volunteers, family members, or caregivers.

HRCF CES 2.6 A registered dietitian oversees meal planning in accordance with applicable federal, state and local health and safety laws and any medically prescribed special diets.

HRCF CES 2.7 Food brought in by family members or friends is stored and prepared for the patient in accordance with all applicable laws, rules, and regulations.

Practice Examples:

- Trained volunteers are available during meal times to assist patients with feedings as needed and directed.
- Special diets are noted on the patient's plan of care and food is ordered and provided accordingly.
- Food, including between meal snacks or nourishment, is available twenty-four (24) hours a day, seven (7) days a week to respond to the patient's reasonable requests and needs, unless limited by dietary restrictions prescribed by a physician.

- Meals are planned with consideration for cultural and religious background and food habits of patients.
- All equipment, fixed and mobile, and dishes are kept clean and maintained in good repair and free of breaks, open seams, cracks, or chips.
- Kitchen areas are available that allow for family/caregiver food preparation for the patient.

Standard:

HRCF CES 3: The hospice residential care facility makes reasonable accommodation for family members/caregivers and friends to remain with the patient twenty-four (24) hours, seven (7) days a week.

Practice Examples:

- A bathroom and shower is available for family members/caregivers and friends.
- Convertible patient furniture or portable “beds” are available for family members/caregivers and friends.
- A family kitchen area is available for family/caregivers to store and prepare food for a reasonable and safe number of visitors, or family may arrange with facility to pre-order and purchase meals from patient meal suppliers.

Standard:

HRCF CES 4: The hospice residential care facility staff is prepared for the demands of a emergency event that impacts or severely limits the facility’s operations.

HRCF CES 4.1 The hospice has a written emergency preparedness plan that is reviewed and updated at least annually and is regularly communicated to staff through orientation and ongoing education. The plan includes:

1. A definition of and emergency event and anticipated emergency situations for the facility’s location and circumstances;
2. A facility-based and community-based risk assessment is developed and conducted utilizing an all-hazards approach;
3. A plan and practice for “sheltering in place” when advisable instead of evacuation;
4. Arrangements for prompt identification and transfer of patients and records to another facility if necessary;
5. Arrangements for coordination of community resources;
6. Collaboration and coordination with the hospice for receiving other hospice patients during an emergency event, as well as with federal, state, tribal, regional, and local emergency management agencies; and
7. Compliance with all applicable codes, laws, and other regulations.

HRCF CES 4.2 The facility staff demonstrates and evaluates their proficiency in understanding the emergency preparedness plan by routine rehearsal on all shifts. Facility staff must:

1. Participate in a community-based mock emergency drill at least annually.
2. Conduct a paper-based tabletop exercise at least annually.

HRCF CES 4.3 The emergency preparedness plan is regularly evaluated for appropriateness and revised as necessary.

Practice Examples:

- The facility demonstrates annual review and collaboration with the hospice agency of a written emergency plan.
- Transfer arrangements with other facilities are written and reviewed.
- Evacuation diagrams are posted and visible to all staff, patients, and family members/caregivers.
- Supervision of patients during evacuation or relocation and contact after relocation to ensure that relocation has been completed as planned is provided in the emergency preparedness plan.
- Rehearsals and critiques are conducted semi-annually for the emergency preparedness plan on all shifts.
- The facility has a back-up generator for short-term electrical generation.
- During an imminent or actual emergency event there is a means of contacting the hospice agency administration and local safety agencies such as the fire department, law enforcement, civil defense, and other emergency management authorities. Telephone numbers or other contact methods are accessible to staff and tested at least annually to ensure they are valid and working.

Standard:

HRCF CES 5: The hospice residential care facility meets all federal, state, and local laws, regulations, and codes pertaining to health and safety, especially the applicable edition of the Life Safety Code of the National Fire Protection Association.

HRCF CES 5.1 The hospice residential care facility has been constructed and/or renovated to comply with applicable laws, regulations, and codes.

HRCF CES 5.2 The hospice residential care facility is sufficiently equipped, maintained, and sanitized to care for admitted patients and to comply with applicable state and federal laws, regulations, and codes.

HRCF CES 5.3 The hospice residential care facility has received any appropriate CMS and/or state written waivers related to the Life Safety Code or other safety codes, rules, and regulations.

Practice Examples:

- A mechanism exists for staff to report equipment maintenance needs.
- A preventive maintenance program exists for all building systems such as HVAC, sprinkler, and security systems.
- A Safety Committee routinely reviews safety checks, fire drill performance, and emergency preparedness drills, and debriefs after safety/emergency events to identify and plan areas of improvement.
- Announced and unannounced fire/emergency drills are regularly conducted at local and state minimum guidelines. Fire bell tests are scheduled on required regular basis.
- Fire extinguishing equipment and sprinkler systems are tested according to local and state guidelines.
- All outdoor and indoor passageways and stairways are kept free of obstruction, including wheelchairs and walkers.
- Nightlights are maintained in hallways and passages to non-private bathrooms.
- Emergency exits are clearly marked, well lit, and barrier free.

Standard:

HRCF CES 6: The hospice residential care facility is safe, clean, and secure for patients, families/caregivers, volunteers, and employees.

HRCF CES 6.1 The hospice residential care facility has written policies and procedures that are communicated to staff and appropriate for the facility's location that address:

1. Security measures;
2. Visitor entrance procedures;
3. Access to authority figures (e.g., hospice administration, security staff, police/sheriff, fire);
4. Inappropriate behavior which could harm others;
5. Monitoring of public areas;
6. Smoking in the facility and on the grounds of the facility;
7. Residents and visitors are informed of safety measures and expected behaviors; and
8. Infection surveillance and control.

HRCF CES 6.2 Patient care areas in the hospice residential care facility meet Life Safety Codes and local fire and safety standards and are located at or above grade level.

HRCF CES 6.3 The hospice residential care facility will maintain a sanitary environment and will have general preventative infection control practices in place, as well as the use of isolation when needed.

HRCF CES 6.4 The hospice residential care facility has written policies and procedures to address the cleanliness and safety of the facility.

HRCF CES 6.5 The hospice residential care facility has a process to report, document, and evaluate safety and security incidents for corrective action.

HRCF CES 6.6 The hospice must determine the appropriate licensure category for the hospice residential care facility and obtain a license from the appropriate local or state authority. The license shall be posted in a prominent location in the facility accessible to public view.

Practice Examples:

- Safety behavior expectations of residents and visitors are provided, in writing, upon admission to the facility and are appropriately posted (e.g., smoking, cooking, weapons, access when doors are locked, hand washing signs in restrooms).
- Electronic alarm and voice or video systems exist to monitor the grounds and entrances.
- Visitor identification requirements exist and are enforced.
- Electronic devices exist to summon authorities.
- Criminal background clearance checks are performed at minimum according to state guidelines prior to employees and volunteers having contact with patients. Incidents are regularly reported and reviewed and systems are regularly assessed for needed change.
- Staff awareness programs exist to enforce and highlight security and safety issues.
- Policies and procedures are available for dealing with patient, family/caregiver, or visitor behavior that is unacceptable and/or impaired.
- Grab bars are maintained for each toilet, bathtub, and shower used by patients.
- Non-skid mats or strips are used in all bathtubs and showers.
- Disinfectants, cleaning solutions, poisons, firearms, and other items that could pose a danger if readily available to residents are stored where inaccessible to patients.
- Material Safety Data Sheets (MSDS) online or hard copy reports are accessible to staff.
- All staff members receive and are compliant with wearing identification badges at all times while working at the facility.
- Infection control methods are used including personal protective equipment (PPE), disinfecting supplies and protocols, alerts for specific precautions for staff and visitors, and isolation techniques.

Standard:

HRCF CES 7: The hospice has policies and procedures regarding the use of physical and chemical restraints. All patients have the right to be free from seclusion or restraint, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Seclusion or restraint may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

HRCF CES 7.1 All patients have the right to be free from seclusion or restraint, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

HRCF CES 7.2 Seclusion or restraint may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

HRCF CES 7.3 All patient care staff working in the hospice residential care facility must have training and demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in seclusion or restraints.

HRCF CES 7.4 Hospices must report deaths associated with the use of seclusion or restraints in accordance with CMS, state, and federal regulations.

HRCF CES 7.5 Hospice residential facility staff members are trained in the use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

HRCF CES 7.6 If the residential facility is restraint and seclusion free, the facility must have a policy which includes alternative care provisions to maintain patient, staff, and other's safety.

Practice Examples:

- Hospice has an orientation and ongoing training program related to physical and chemical restraints including assessments, frequency of re-assessments, medical orders, and discontinuation. Hospice has a policy addressing alternative treatments or settings to manage patients that are violent or have self-destructive behavior.
- Hospice has a policy for utilizing sitters or companions when safe and appropriate as a first line alternative to restraints.

HRCF IA 1: INCLUSION AND ACCESS (HRCF IA)

Standard:

HRCF IA 1: Access to hospice residential care is made available to all hospice patients who are in need of residential care that cannot be provided in another setting and who meet the general admission criteria for admission to a hospice program.

HRCF IA 1.1 The hospice patient/representative has a right to participate in the decision making process regarding where care is to be delivered and to choose their attending physician.

HRCF IA 1.2 Access to residential care allows for options other than the hospice residential care facility.

Practice Examples:

- The hospice utilizes written criteria for admission to and continued stay in its hospice residential care facility that does not distinguish between patients based on criteria other than clinical or social necessity.
- The hospice demonstrates consideration of the patient's desire to remain in their choice of home in lieu of admission to the hospice residential facility.
- The hospice does not limit residential options for hospice care to its own hospice residential care facility and does not discharge from hospice services patients requesting the use of other residential facilities within the service area.
- The hospice allows patient choice in attending physician when admitted to the hospice residential care facility.
- The hospice admission criteria and plan of care for the patient consider the individual needs of the patient including socialization and recreational needs and the most appropriate setting for meeting those needs.
- The hospice residential care facility updates new family members/caregivers about confidentiality expectations and behaviors for all patients and families to assist in the best care for their loved ones.
- The hospice has written criteria for selection of patients for admission to the hospice residential care facility when it experiences a waiting list, and adheres to the defined process.
- The hospice has clear criteria and clearly explains those criteria to the patient and family/caregiver related to a patient's ability to pay any applicable self-pay portions of a hospice residential facility stay.
- The hospice is able to demonstrate an ability to provide financial assistance to patients unable to pay self-pay portions of a hospice residential care facility stay.
- A needs assessment is conducted as part of the initial licensure process to identify support for a hospice residential care facility and the appropriate numbers of beds to be allocated to a facility.

- The hospice offers written information and community education regarding admission policies and criteria for the hospice residential care facility.
- Patient information materials available for the hospice residential care facility specifically address payment expectations for self-pay portions of charges and the qualifications for financial assistance.

ORGANIZATIONAL EXCELLENCE (HRCF OE)

Standard:

No additional standards apply to organizational excellence in a hospice residential care facility.

WORKFORCE EXCELLENCE (HRCF WE)

Standard:

No additional standards apply to workforce excellence in a hospice residential care facility.

Practice Examples:

- Policies and procedures exist and are adhered to when hospice staff members elect to not participate in a patient's or family/caregiver's request for withdrawal or continuation of life sustaining procedures.
- Prospective staff members of the hospice residential care facility are offered an opportunity to speak with a staff member from their discipline to discuss job role, responsibilities, day-to-day activity, and expectations before hire.
- An orientation program for hospice residential care facility staff and volunteers includes safety procedures such as patient and visitor behaviors, building security, infection control, inclement weather reactions, and evacuation decisions.
- Staff members with responsibilities in multiple work site locations are specifically oriented to similarities and differences in care of patients residing in the hospice residential care facility.
- Hospice aides assigned to the hospice residential care facility receive specific primary caregiver education such as patient repositioning, transfers, feeding, and reporting patient needs and changes to the RN or medical provider.
- Hospice aides are fully oriented to all required skills and are observed providing specific tasks or skills with patients prior to independent practice in the hospice residential care facility.
- Hospice residential care facility volunteers are fully oriented to the hospice residential care facility in addition to standard volunteer training activities.

COMPLIANCE WITH LAWS AND REGULATIONS (HRCF CLR)

Standard:

No additional standards apply to compliance with laws and regulations in a hospice residential care facility.

Practice Example:

- A greeter for visitors (employee or volunteer) complies with HIPAA rules and is informed of appropriate and limited patient information.

STEWARDSHIP AND ACCOUNTABILITY (HRCF SA)

Standard:

No additional standards apply to stewardship and accountability in a hospice residential care facility.

Practice Examples:

- An organizational chart exists that clearly designates responsibility and accountability for care and maintenance of the hospice residential care facility and the facility's accountability relationship with the hospice agency as a whole.
- The governing body's minutes of the organization indicate regular routine reporting and evaluation of the operation of the hospice residential care facility.
- The hospice has appropriately reviewed and approved policies guiding admission, continued stay, transfers, discharges from service, and care provided in the hospice residential care facility.
- Minutes of appropriate planning groups consider the number of hospice residential care facility beds that may be appropriate for a particular community as part of the licensure process.

PERFORMANCE MEASUREMENT (HRCF PM)

Standard:

No additional standards apply to performance measurement in a hospice residential care facility.

Practice Examples:

- The hospice's annual performance improvement plan includes specific activities that address the improvement needs of the hospice residential care facility.
- The hospice residential care facility staff participates in the hospice's overall QAPI program.
- The hospice plans opportunities for residential care facility patients and families to give feedback for improving the facility's care.

STANDARDS OF PRACTICE FOR HOSPICE PROGRAMS

PROFESSIONAL DEVELOPMENT AND RESOURCE SERIES

16 / Change Tables - Standards of Practice 2018

Patient and Family/Caregiver-Centered Care (PFC)

STANDARD	2018 UPDATES
Principles	Revised
PFC 1	No change
PFC 1.1	No change
PFC 1.2	No change
PFC 1.3	No change
PFC 1.4	No change
PFC 1.5	No change
PFC 2	No change
PFC 2.1	No change
PFC 2.2	Revised
PFC 2.3	No change
PFC 2.4	Revised
PFC 2.5	Previously PFC 2.7
PFC 2.6	Previously PFC 2.8
PFC 2.7	New Sub-standard
PFC 2.8	No longer exists
PFC 3	Previously PFC 5; Revised
PFC 3.1	Previously PFC 5.1; Revised
PFC 3.2	No longer exists
PFC 4	Revised
PFC 4.1	Previously PFC 4.3; Revised
PFC 4.2	Previously PFC 4.4; Revised
PFC 4.3	Previously PFC 4.1; Revised
PFC 4.4	New Sub-standard
PFC 5	Previously PFC 7
PFC 5.1	Previously PFC 7.1
PFC 5.2	Previously PFC 7.2
PFC 5.3	Previously PFC 7.3
PFC 6	No change
PFC 6.1	No change
PFC 6.2	Previously PFC 6.4
PFC 6.3	Previously PFC 6.2

Patient and Family/Caregiver-Centered Care (PFC) *(Continued)*

STANDARD	2018 UPDATES
PFC 6.4	Previously PFC 6.5
PFC 6.5	No longer exists
PFC 7	Previously PFC 3
PFC 7.1	Previously PFC 3.1
PFC 7.2	Previously PFC 3.2
PFC 7.3	No longer exists
PFC 8	Previously PFC 9
PFC 8.1	Previously PFC 9.1
PFC 8.2	Previously PFC 9.2
PFC 8.3	New Sub-standard
PFC 9	Previously PFC 10
PFC 9.1	Previously PFC 10.1
PFC 9.2	Previously PFC 10.2; Revised
PFC 9.3	Previously PFC 10.3
PFC 9.4	Previously PFC 10.4; Revised
PFC 10	Previously PFC 11
PFC 10.1	Previously PFC 11.1
PFC 10.2	Previously PFC 11.2
PFC 10.3	Previously PFC 11.3
PFC 10.4	New Sub-standard
PFC 11	Previously PFC 12
PFC 11.1	Previously PFC 12.1
PFC 11.2	Previously PFC 12.2
PFC 11.3	Previously PFC 12.3
PFC 11.4	Previously PFC 12.4; Revised
PFC 12	Previously PFC 13
PFC 12.1	Previously PFC 13.1
PFC 12.2	Previously PFC 13.2; Revised
PFC 12.3	Previously PFC 13.3; Revised
PFC 12.4	Previously PFC 13.4

Patient and Family/Caregiver-Centered Care (PFC) *(Continued)*

STANDARD	2018 UPDATES
PFC 13	Previously PFC 14
PFC 13.1	Previously PFC 14.1
PFC 13.2	Previously PFC 14.2
PFC 13.3	New Sub-standard
PFC 13.4	New Sub-standard
PFC 14	Previously PFC 15; Revised
PFC 14.1	Previously PFC 15.1; Revised
PFC 14.2	Previously PFC 15.2
PFC 15	Previously PFC 8; Revised
PFC 15.1	Previously PFC 8.1
PFC 15.2	Previously PFC 8.2
PFC 15.3	New Sub-standard
PFC 15.4	New Sub-standard
PFC 15.5	New Sub-standard
PFC 15.6	New Sub-standard
PFC 16	No change
PFC 16.1	New Sub-standard
PFC 16.2	New Sub-standard
PFC 16.3	Previously PFC 16.1
PFC 16.4	Previously PFC 16.2
PFC 16.5	Previously PFC 16.3
PFC 16.6	Previously PFC 16.4
PFC 17	No change
PFC 17.1	No change
PFC 17.2	No change
PFC 17.3	No change
PFC 17.4	No change
PFC 17.5	New Sub-standard

Patient and Family/Caregiver-Centered Care (PFC) *(Continued)*

STANDARD	2018 UPDATES
PFC 18	Previously PFC 19
PFC 18.1	Previously PFC 19.1
PFC 18.2	New Sub-standard
PFC 18.3	Previously PFC 19.2; Revised
PFC 18.4	Previously PFC 19.3
PFC 18.5	Previously PFC 19.4
PFC 19	Previously PFC 20
PFC 19.1	Previously PFC 20.1
PFC 19.2	Previously PFC 20.2
PFC 19.3	No longer exists
PFC 19.4	No longer exists
PFC 20	No longer exists
PFC 20.1	No longer exists
PFC 20.2	No longer exists

Ethical Behavior and Consumer Rights (EBR)

STANDARD	2018 UPDATES
EBR 1	No change
EBR 1.1	Revised
EBR 1.2	No change
EBR 1.3	No change
EBR 1.4	No change
EBR 1.5	No change
EBR 1.6	New Sub-standard
EBR 1.7	Previously EBR 1.6; Revised
EBR 1.8	New Sub-standard
EBR 1.9	Previously EBR 1.8; Revised
EBR 2	No change
EBR 2.1	Revised
EBR 2.2	Revised
EBR 2.3	Revised
EBR 2.4	No change
EBR 2.5	Revised
EBR 3	No change
EBR 3.1	Revised
EBR 3.2	Revised
EBR 3.3	No change
EBR 3.4	No change
EBR 3.5	New Sub-standard
EBR 4	Revised
EBR 4.1	Revised
EBR 4.2	No change
EBR 4.3	No change
EBR 5	No change
EBR 5.1	No change
EBR 5.2	New Sub-standard
EBR 5.3	New Sub-standard

Ethical Behavior and Consumer Rights (EBR) *(Continued)*

STANDARD	2018 UPDATES
EBR 6	No change
EBR 6.1	No change
EBR 6.2	No change
EBR 7	New Standard
EBR 7.1	Previously EBR 7 Standard
EBR 7.2	New Sub-standard
EBR 7.3	Previously EBR 7.2; Revised
EBR 7.4	New Sub-standard
EBR 7.5	New Sub-standard
EBR 7.6	New Sub-standard
EBR 8	No change
EBR 8.1	Revised
EBR 8.2	Revised
EBR 8.3	Revised
EBR 9	New Standard
EBR 9.1	New Sub-standard
EBR 9.2	New Sub-standard
EBR 9.3	New Sub-standard
EBR 9.4	New Sub-standard
EBR 9.5	New Sub-standard

Clinical Excellence and Safety (CES)

STANDARD	2018 UPDATES
CES 1	Revised
CES 1.1	Revised
CES 1.2	New Sub-standard
CES 1.3	Previously CES 1.2
CES 1.4	Previously CES 1.3; Revised
CES 1.5	Previously CES 1.4; Revised
CES 1.6	Previously CES 1.5
CES 1.7	Previously CES 1.6; Revised
CES 2	No change
CES 2.1	Revised
CES 2.2	Revised
CES 2.3	No change
CES 2.4	Revised
CES 2.5	Revised
CES 2.6	No change
CES 2.7	No change
CES 2.8	New Sub-standard
CES 2.9	New Sub-standard
CES 3	No change
CES 3.1	New Sub-standard
CES 3.2	Previously CES 3.1; Revised
CES 3.3	Previously CES 3.2
CES 3.4	Previously CES 3.3
CES 4	No change
CES 4.1	No change
CES 4.2	Revised
CES 4.3	Revised
CES 4.4	Revised
CES 4.5	New Sub-standard
CES 4.6	Previously CES 4.5
CES 4.7	Previously CES 4.12
CES 4.8	Previously CES 4.6

Clinical Excellence and Safety (CES) *(Continued)*

STANDARD	2018 UPDATES
CES 4.9	Previously CES 4.7
CES 4.10	Previously CES 4.8
CES 4.11	Previously CES 4.9
CES 4.12	Previously CES 4.10; Revised
CES 4.13	Previously CES 4.11
CES 4.14	New Sub-standard
CES 5	No change
CES 5.1	No change
CES 5.2	No change
CES 5.3	No change
CES 5.4	No change
CES 6	No change
CES 6.1	Revised
CES 6.2	Revised
CES 6.3	Revised
CES 7	No change
CES 7.1	No change
CES 7.2	Revised
CES 7.3	New Sub-standard
CES 7.4	Previously CES 7.3
CES 7.5	Previously CES 7.4; Revised
CES 8	No change
CES 8.1	No change
CES 8.2	Revised
CES 8.3	No change
CES 8.4	No change
CES 8.5	No change
CES 8.6	Revised
CES 9	No change
CES 9.1	Revised
CES 9.2	No change
CES 9.3	No change

Clinical Excellence and Safety (CES) *(Continued)*

STANDARD	2018 UPDATES
CES 9.4	Revised
CES 10	No change
CES 10.1	No change
CES 10.2	Revised
CES 10.3	Revised
CES 11	Revised
CES 11.1	Revised
CES 11.2	Revised
CES 11.3	New Sub-standard
CES 11.4	Previously CES 11.3; Revised
CES 11.5	Previously CES 11.4
CES 12	No change
CES 12.1	Revised
CES 13	Revised
CES 13.1	Revised
CES 13.2	No change
CES 13.3	Revised
CES 14	No change
CES 14.1	No change
CES 14.2	No change
CES 15	Revised
CES 15.1	Revised
CES 15.2	New Sub-standard
CES 16	No change
CES 16.1	No change
CES 16.2	Revised
CES 16.3	No change
CES 16.4	Revised
CES 17	Revised
CES 17.1	Revised
CES 17.2	No change
CES 18	No change

Clinical Excellence and Safety (CES) *(Continued)*

STANDARD	2018 UPDATES
CES 18.1	No change
CES 18.2	No change
CES 19	Revised
CES 19.1	Revised
CES 19.2	No change
CES 20	No change
CES 20.1	Revised
CES 20.2	No change
CES 20.3	No change
CES 21	Revised
CES 21.1	Revised
CES 21.2	No change
CES 21.3	No change
CES 21.4	No change
CES 21.5	No change
CES 21.6	Revised
CES 21.7	New Sub-standard

Inclusion and Access (IA)

STANDARD	2018 UPDATES
IA 1	Previously IA 4; Revised
IA 1.1	Previously IA 4.2
IA 1.2	No change
IA 1.3	New Sub-standard
IA 1.4	Previously IA 1.6; Revised
IA 1.5	New Sub-standard
IA 1.6	Previously IA 4.4
IA 1.7	New Sub-standard
IA 2	No change
IA 2.1	No change
IA 2.2	No change
IA 2.3	Previously IA 1.4; Revised
IA 2.4	Previously IA 2.3
IA 2.5	Previously IA 2.4; Revised
IA 3	Previously IA 1
IA 3.1	Previously IA 4.1
IA 3.2	Previously IA 1.1; Revised
IA 3.3	Previously IA 1.3; Revised
IA 3.4	Previously IA 4.3; Revised
IA 4	Previously IA 3
IA 4.1	Previously IA 3.1; Revised
IA 4.2	Previously IA 3.2
IA 4.3	Previously IA 3.3
IA 4.4	Previously IA 3.4; Revised

Organizational Effectiveness (OE)

STANDARD	2018 UPDATES
OE 1	New Standard
OE 1.1	No longer exists
OE 2	Previously OE 1
OE 2.1	Previously OE 1.1
OE 2.2	No longer exists
OE 2.3	No longer exists
OE 3	Previously OE 2
OE 3.1	Previously OE 2.2; Revised
OE 3.2	Previously OE 2.1; Revised
OE 3.3	Previously OE 2.3; Revised
OE 4	Previously OE 3
OE 4.1	Previously OE 3.1; Revised
OE 4.2	Previously OE 3.2
OE 4.3	Previously OE 3.3

Workforce Excellence (WE)

STANDARD	2018 UPDATES
WE 1	Revised
WE 1.1	No change
WE 1.2	Previously WE 1.7; Revised
WE 1.3	Previously WE 1.2; Revised
WE 1.4	Previously WE 1.3
WE 1.5	Previously WE 1.4
WE 1.6	Previously WE 1.5; Revised
WE 1.7	Previously WE 1.6; Revised
WE 2	No change
WE 2.1	No change
WE 2.2	No change
WE 3	No change
WE 3.1	No change
WE 3.2	Revised
WE 3.3	Revised
WE 3.4	#12-15 added
WE 3.5	No change
WE 4	#11 & 12 added
WE 4.1	No change
WE 4.2	No change
WE 4.3	No change
WE 4.4	No change
WE 4.5	No change
WE 4.6	No change
WE 5	No change
WE 5.1	No change
WE 5.2	Revised
WE 5.3	Revised
WE 5.4	No change
WE 5.5	No change
WE 6	No change
WE 6.1	No change

Workforce Excellence (WE) *(Continued)*

STANDARD	2018 UPDATES
WE 6.2	Revised
WE 6.3	New Sub-standard
WE 7	No change
WE 7.1	Revised
WE 7.2	No change
WE 8	No change
WE 8.1	Revised
WE 8.2	No change
WE 8.3	No change
WE 8.4	No change
WE 9	No change
WE 9.1	#4, 6, 10 & 12 revised; #13 added
WE 9.2	Revised
WE 9.3	#3, 20, 22 & 23 revised; #2 added
WE 9.4	#1 revised; #7-12 added
WE 9.5	No change
WE 9.6	Revised
WE 9.7	No change
WE 10	No change
WE 10.1	Revised
WE 10.2	No change
WE 11	No change
WE 11.1	No change
WE 11.2	Revised
WE 11.3	No change
WE 11.4	Revised
WE 11.5	No change
WE 12	Revised
WE 12.1	Revised
WE 12.2	New Sub-standard
WE 12.3	Previously WE 12.2; #1, 3, & 9 revised; #2, 5-7, 12, 22, & 23 added

Workforce Excellence (WE) *(Continued)*

STANDARD	2018 UPDATES
WE 13	No change
WE 13.1	#1 revised
WE 13.2	No change
WE 13.3	No change
WE 13.4	No change
WE 13.5	#1 & 6 revised
WE 13.6	No change
WE 14	#1 revised
WE 14.1	#1, 2, 6, 8, 9, & 12-15 revised; #3, 4, 11, 16 & 17 added
WE 15	No change
WE 15.1	#3, 5, 7, & 12 revised; #13 added
WE 16	Revised
WE 16.1	#1 revised; #5 added
WE 16.2	#1, 3, & 6 revised
WE 16.3	Revised
WE 16.4	#9-11 added
WE 16.5	#2a & 2b revised
WE 17	No change
WE 17.1	#8 added
WE 18	No change
WE 18.1	No change
WE 18.2	No change
WE 19	Revised
WE 19.1	#1, 2 & 4 revised
WE 19.2	No change
WE 19.3	#1 revised; #2 & 7 added
WE 20	No change
WE 20.1	No change
WE 20.2	No change
WE 20.3	No change
WE 20.4	New-Sub-standard

Compliance with Laws and Regulations (CLR)

STANDARD	2018 UPDATES
CLR 1	Revised
CLR 1.1	No change
CLR 1.2	No change
CLR 1.3	No change
CLR 2	No change
CLR 2.1	No change
CLR 2.2	No change
CLR 2.3	No change
CLR 2.4	New Sub-standard
CLR 3	No change
CLR 3.1	No change
CLR 3.2	Revised
CLR 3.3	Revised
CLR 3.4	No change
CLR 3.5	No change
CLR 3.6	No change
CLR 3.7	Revised
CLR 3.8	Revised

Stewardship and Accountability (SA)

STANDARD	2018 UPDATES
SA 1	No change
SA 1.1	Revised
SA 1.2	New Sub-standard
SA 1.3	Previously SA 1.2
SA 1.4	Previously SA 1.3
SA 1.5	Previously SA 1.4; Revised
SA 1.6	New Sub-standard
SA 1.7	New Sub-standard
SA 2	No change
SA 2.1	Revised
SA 2.2	Revised
SA 2.3	New Sub-standard
SA 3	Previously SA 7
SA 3.1	New Sub-standard
SA 3.2	New Sub-standard
SA 3.3	New Sub-standard
SA 3.4	Previously SA 7.1
SA 3.5	Previously SA 7.2
SA 3.6	Previously SA 7.3; Revised
SA 3.7	Previously SA 7.4
SA 3.8	New Sub-standard
SA 4	No change
SA 4.1	Revised
SA 4.2	New Sub-standard
SA 4.3	Previously SA 4.2
SA 4.4	Previously SA 4.3; Revised
SA 4.5	Previously SA 4.4; Revised
SA 4.6	Previously SA 4.5; Revised
SA 5	No change
SA 5.1	No change
SA 5.2	No change
SA 5.3	No change

Stewardship and Accountability (SA) *(Continued)*

STANDARD	2018 UPDATES
SA 5.4	Revised
SA 5.5	No change
SA 5.6	No change
SA 5.7	Revised
SA 5.8	No change
SA 6	No change
SA 6.1	Revised
SA 6.2	Previously SA 6.3; Revised
SA 6.3	No longer exists
SA 7	Previously SA 8
SA 7.1	Previously SA 8.1
SA 7.2	New Sub-standard
SA 7.3	Previously SA 8.2; Revised
SA 7.4	No longer exists
SA 8	Previously SA 9; Revised
SA 8.1	Previously SA 9.1; Revised
SA 8.2	Previously SA 9.2; Revised
SA 8.3	Previously SA 9.3
SA 9	Previously SA 10
SA 9.1	Previously SA 10.1
SA 9.2	Previously SA 10.2
SA 9.3	Previously SA 10.3
SA 9.4	Previously SA 10.5; Revised
SA 9.5	New Sub-standard
SA 10	No longer exists
SA 10.1	No longer exists
SA 10.2	No longer exists
SA 10.3	No longer exists
SA 10.4	No longer exists
SA 10.5	No longer exists

Performance Measurement (PM)

STANDARD	2018 UPDATES
PM 1	Revised
PM 1.1	Revised
PM 1.2	Revised
PM 1.3	No change
PM 2	No change
PM 2.1	Revised
PM 2.2	Revised
PM 2.3	No change
PM 3	Revised
PM 3.1	No change
PM 3.2	No change
PM 3.3	Revised
PM 3.4	Revised
PM 3.5	No change
PM 4	No change
PM 4.1	No change
PM 4.2	No change
PM 4.3	Revised
PM 4.4	No change
PM 5	No change
PM 5.1	New Sub-standard
PM 5.2	Revised
PM 5.3	Previously PM 5.2
PM 5.4	Previously PM 5.3
PM 5.5	Previously PM 5.4
PM 5.6	Previously PM 5.5
PM 5.7	Previously PM 5.6
PM 5.8	Previously PM 5.7; Revised
PM 6	Revised
PM 6.1	No change
PM 6.2	New Sub-standard
PM 6.3	New Sub-standard
PM 6.4	New Sub-standard

APPENDIX I: Hospice Inpatient Facility (HIF)

STANDARD	2018 UPDATES
HIF PFC 1	No change
HIF PFC 1.1	No change
HIF PFC 1.2	No change
HIF PFC 1.3	New Sub-standard
HIF PFC 2	No change
HIF PFC 2.1	No change
HIF PFC 3	No change
HIF PFC 3.1	Revised
HIF PFC 3.2	Revised
HIF PFC 3.3	No change
HIF PFC 3.4	No change
HIF PFC 3.5	No change
HIF PFC 3.6	No change
HIF PFC 4	No change
HIF PFC 4.1	No change
HIF PFC 4.2	No change
HIF PFC 4.3	No change
HIF PFC 4.4	Revised
HIF PFC 4.5	No change
HIF PFC 5	No change
HIF PFC 5.1	No change
HIF EBR 1	New Standard
HIF EBR 1.1	New Sub-Standard
HIF CES 1	Revised
HIF CES 1.1	No change
HIF CES 1.2	Revised
HIF CES 1.3	No change
HIF CES 1.4	No change
HIF CES 1.5	No change
HIF CES 2	No change
HIF CES 2.1	New Sub-standard
HIF CES 2.2	No change

APPENDIX I: Hospice Inpatient Facility (HIF) (Continued)

STANDARD	2018 UPDATES
HIF CES 2.3	No change
HIF CES 3	No change
HIF CES 3.1	No change
HIF CES 3.2	No change
HIF CES 3.3	No change
HIF CES 3.4	New Sub-standard
HIF CES 4	Revised
HIF CES 4.1	No change
HIF CES 4.2	No change
HIF CES 5	Revised
HIF CES 5.1	Revised
HIF CES 5.2	No change
HIF CES 5.3	No change
HIF CES 6	No change
HIF CES 6.1	Revised
HIF CES 6.2	Revised
HIF CES 6.3	No change
HIF CES 6.4	New Sub-standard
HIF IA 1	No change
HIF IA 1.1	Revised
HIF IA 1.2	No change
HIF OE 1	New Standard
HIF WE 1	Revised
HIF CLR 1	New Standard
HIF SA 1	New Standard
HIF PM 1	New Standard
HIF PM 2	New Standard

APPENDIX II: Nursing Facility Hospice Care (NF)

STANDARD	2018 UPDATES
NF PFC 1	No change
NF PFC 1.1	No change
NF PFC 1.2	New Sub-standard
NF PFC 2	No change
NF PFC 2.1	New Sub-standard
NF PFC 2.2	New Sub-standard
NF PFC 2.3	New Sub-standard
NF PFC 2.4	New Sub-standard
NF PFC 2.5	Previously NF PFC 2.3
NF PFC 2.6	New Sub-standard
NF PFC 2.7	Previously NF PFC 2.5; Revised
NF PFC 2.8	New Sub-standard
NF PFC 3	Revised
NF PFC 3.1	New Sub-standard
NF PFC 4	No change
NF PFC 4.1	New Sub-standard
NF PFC 4.2	New Sub-standard
NF PFC 4.3	New Sub-standard
NF PFC 5	No change
NF PFC 6	No change
NF PFC 6.1	Revised
NF PFC 6.2	New Sub-standard
NF EBR 1	New Standard
NF EBR 1.1	New Sub-standard
NF EBR 1.2	New Sub-standard
NF EBR 1.3	New Sub-standard
NF CES 1	Revised
NF CES 1.1	No change
NF CES 1.2	New Sub-standard
NF IA 1	New Standard
NF OE 1	No change
NF WE 1	No change

APPENDIX II: Nursing Facility Hospice Care (NF) *(Continued)*

STANDARD	2018 UPDATES
NF WE 1.1	Revised
NF WE 1.2	No change
NF CLR 1	No change
NF CLR 1.1	Revised
NF SA 1	New Standard
NF PM 1	No change

APPENDIX III: Hospice Residential Care Facility (HRCF)

STANDARD	2018 UPDATES
HRCF PFC 1	No change
HRCF PFC 1.1	No change
HRCF PFC 1.2	No change
HRCF PFC 1.3	No change
HRCF PFC 2	No change
HRCF PFC 2.1	No change
HRCF PFC 2.2	New Sub-standard
HRCF PFC 3	No change
HRCF PFC 3.1	No change
HRCF PFC 3.2	No change
HRCF PFC 3.3	No change
HRCF PFC 3.4	No change
HRCF PFC 4	No change
HRCF PFC 4.1	Revised
HRCF EBR 1	New Standard
HRCF CES 1	No change
HRCF CES 1.1	No change
HRCF CES 1.2	Revised
HRCF CES 1.3	Revised
HRCF CES 1.4	No change
HRCF CES 1.5	No change
HRCF CES 1.6	No change
HRCF CES 1.7	No change
HRCF CES 1.8	No change
HRCF CES 1.9	No change
HRCF CES 2	No change
HRCF CES 2.1	No change
HRCF CES 2.2	No change
HRCF CES 2.3	No change
HRCF CES 2.4	Revised
HRCF CES 2.5	No change
HRCF CES 2.6	No change

APPENDIX III: Hospice Residential Care Facility (HRCF) *(Continued)*

STANDARD	2018 UPDATES
HRCF CES 2.7	Revised
HRCF CES 3	No change
HRCF CES 4	No change
HRCF CES 4.1	Revised
HRCF CES 4.2	Revised
HRCF CES 4.3	No change
HRCF CES 5	No change
HRCF CES 5.1	No change
HRCF CES 5.2	No change
HRCF CES 5.3	Revised
HRCF CES 6	No change
HRCF CES 6.1	Revised
HRCF CES 6.2	New Sub-standard
HRCF CES 6.3	New Sub-standard
HRCF CES 6.4	Previously HRCF CES 6.2
HRCF CES 6.5	Previously HRCF CES 6.3
HRCF CES 6.6	Previously HRCF CES 6.4; Revised
HRCF CES 7	No change
HRCF CES 7.1	Revised
HRCF CES 7.2	No change
HRCF CES 7.3	No change
HRCF CES 7.4	No change
HRCF CES 7.5	New Sub-standard
HRCF CES 7.6	New Sub-standard
HRCF IA	Revised
HRCF IA 1.1	Revised
HRCF IA 1.2	No change
HRCF OE	No change
HRCF WE	No change
HRCF CLR	No change
HRCF SA	No change
HRCF PM	No change

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