

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).