TOP ACHC SURVEY DEFICIENCIES

HOSPICE

§418.54: Condition of Participation: Initial and Comprehensive Assessment of the Patient

ACHC STANDARD: HSP5-3C

The Hospice Interdisciplinary Group (IDG), in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than five calendar days after the election of hospice care.

- **L-523 – Time Frame for Completion of the Comprehensive Assessment:** The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than five calendar days after the election of hospice care in accordance with §418.24.
- **L-524 – Content of the Comprehensive Assessment:** The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.
- **L-531 – Bereavement:** An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.

TIPS FOR COMPLIANCE:

- Ensure each patient admitted to hospice has a comprehensive assessment completed that identifies the physical, psychosocial, emotional, and spiritual needs of the patient and family, related to the terminal illness.
- Ensure the comprehensive assessment must be completed no later than five calendar days after the election of the hospice care.
- If all members of the IDG are not requested by the patient at time of admission, the Registered Nurse (RN) should identify and document the presence or absence of any psychosocial, emotional, and spiritual needs as identified by the patient and family, and coordinate with the other members of the IDG to develop an individualized plan of care.
- Ensure the bereavement risk assessment is completed and identifies any issues that may impact the family member's or caregiver's ability to cope, and that such issues are incorporated into the plan of care.

ACHC STANDARD: HSP5-3D

A medication profile is part of the patient-specific comprehensive assessment. A Registered Nurse (RN) creates and maintains a current medication profile and reviews all patient medications, both prescription and nonprescription, on an ongoing basis in collaboration with other interdisciplinary group (IDG) members.

- **L-530 – Drug Profile:** A review of all of the patient's prescription and over-the-counter drugs, herbal remedies, and other alternative treatments that could affect drug therapy. This

includes, but is not limited to, identification of the following:

- Effectiveness of drug therapy
- Drug side effects
- Actual or potential drug interactions
- Duplicate drug therapy
- Drug therapy currently associated with laboratory monitoring.

TIPS FOR COMPLIANCE:

- Ensure an ongoing medication review is completed for all patients in order for the medical record to reflect the most current medication profile.
- Ensure all PRN medications identify an indicator as to when the PRN medication should be administered.
- Ensure oxygen (0_2) is listed on the medication profile.
- Ensure the physician is notified of any medication discrepancies, side effects, problems, or reactions.

§418.56: Condition of Participation: Interdisciplinary Group, Care Planning, and Coordination

ACHC STANDARD: HSP5-4A

The hospice develops an individualized written plan of care for each patient in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs, if any of them so desire. The plan of care must reflect patient/family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions.

- **L-545 – Content of the Plan of Care:** The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions.
- **L-547 – Content of the Plan of Care:** A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.
- **L550 – Medical supplies and appliances necessary to meet the needs of the patient.**
- **L549 – Drugs and treatment necessary to meet the needs of the patient.**

TIPS FOR COMPLIANCE:

- Ensure an individualized plan of care is established for each patient and family based on the identified needs in the assessments.
- Ensure the plan of care includes all services necessary for the palliation and management of the terminal illness to include medications, treatments, disciplines providing care, equipment, and supplies.
- Ensure all medication and treatment orders are complete.
- Ensure all DME utilized by the patient is included on the plan of care.

ACHC STANDARD: HSP5-4B

Hospice services are delivered in accordance with the written plan of care.

- **L-555 – Coordination of Services:** Ensure that the care and services are provided in accordance with the plan of care.

TIPS FOR COMPLIANCE:

- Ensure documentation in the medical record supports that care was provided based on physician orders.

ACHC STANDARD: HSP5-4F

There is evidence that the plan of care is reviewed and changes are made to the plan of care based on reassessment data.

- **L-553 – Review of the Plan of Care:** A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care.

TIPS FOR COMPLIANCE:

- Ensure the medical record contains documentation to support progress or the lack of progress toward the patient's goals as specified in the plan of care.
- Ensure the plan of care integrates changes based on re-assessment data of the patient and family as well as changes based on the progress made toward the patient's goals.

§418.76: Condition of Participation: Hospice Aide and Homemaker

ACHC STANDARD: HSP5-13A

Hospice aides are assigned to a specific patient by a Registered Nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a Registered Nurse who is responsible for the supervision of a hospice aide.

- **L-625 – Hospice Aide Assignments and Duties:** Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section.
- **L-626 – Hospice Aide Assignments and Duties:** A hospice aide provides services that are:
  - Ordered by the interdisciplinary group.
  - Included in the plan of care.
  - Permitted to be performed under State law by such hospice aide.
  - Consistent with the hospice aide training.
- **L-628 –** Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment and improvement activities. Hospice aides must also complete appropriate records in compliance with the hospice's policies and procedures.

TIPS FOR COMPLIANCE:

- Ensure the written instructions provided to the hospice aide are specific to the task provided and frequency in which to provide it. "Per patient request" and PRN orders should not be

used for any tasks, as the hospice aide lacks the decision-making ability to interpret information/data needed to revise the plan of care.

- Ensure all revisions to the aide plan of care are discussed, approved, and documented by the RN.
- Ensure documentation in the patient record supports that hospice aide provided care in accordance with the plan of care and that if the patient refuses care, the refusal is properly documented.
- Ensure documentation in the patient record supports the hospice aide notified the RN when there was a change in the patient's status such as a fall or skin breakdown.

ACHC STANDARD: HSP5-13B

Hospice aides are supervised by a Registered Nurse to ensure the quality of care the patient is receiving.

- **L-629 – Supervision of Hospice Aides:** A registered nurse must make an on-site visit to the patient's home: (i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit.

TIPS FOR COMPLIANCE:

- Ensure all patients receiving hospice aide services are properly supervised by the RN at least every 14 days.