So What Went Wrong?
Top Hospice Survey Deficiencies & How to Avoid Them

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- Washington State Hospice and Palliative Care Organization
- Hospice Council of West Virginia
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Margherita Labson is Executive Director for the home care program at The Joint Commission where she coordinates the home care business development team in identifying new markets, familiarizes organizations with the accreditation process, and participates in new product development, strategic development, and tactical operations. Margherita is a veteran health care professional who has specialized in home care services since 1977 and has extensive knowledge of legal, regulatory, and accreditation requirements.

An experienced educator and published author, Margherita received a Bachelor’s in Nursing from Duquesne University in Pittsburgh and a Master’s in Health Care Administration from Nova Southeastern University in Davie, Florida. A Certified Professional of Healthcare Quality (CPHQ) and certified case manager, she was among the first wave of Green Belts certified by The Joint Commission in accordance with its enterprise-wide program of Robust Process Improvement.

Frances B. Petrella, BSN, RN,
Community Health Accreditation Partner

Fran Petrella is Vice President of Accreditation at Community Health Accreditation Partner (CHAP) in Washington, DC. CHAP was the first accrediting body for community-based health care organizations in the United States and was created in 1965 as a joint venture between the American Public Health Association (APHA) and the National League for Nursing (NLN).

Fran entered the home care arena in 1986, providing home health and hospice services in northwest Washington. In 2000, she began working as the home health expert resource for a home care benchmarking company. Fran returned to home care in 2010, working in management for a VNA and facilitating a merger with a hospital-based system providing home health, hospice, and home infusion pharmacy services. In 2012, she moved across the country to join the CHAP team. Fran strongly believes that quality, community-based care should be the core of health care.
Today’s Panelists & Moderator

Lisa Meadows, MSW
Accreditation Commission for Health Care, Inc.

Lisa Meadows has over 20 years’ experience in medical social work, including acute care hospitalization, home health care, and hospice and palliative care. She is currently the Clinical Compliance Educator for the Accreditation Commission for Health Care, Inc., where she is responsible for educating organizations on the ACHC accreditation process and assisting them with interpreting the ACHC Standards for Accreditation. In addition, Lisa teaches ACHC surveyors about standards, regulatory updates, and industry changes.

Prior to this role, Lisa was an ACHC hospice surveyor assisting organizations with ACHC Standards compliance and developing best practices. A speaker for state conferences and associations, Lisa conducts workshops on the accreditation process and other health care industry topics.

Katie Wehri, CHC, CHPC
Wehri & Associates, LLC

Katie is certified by the Health Care Compliance Association in health care compliance and health care privacy compliance. She has been working in the hospice, home health, private duty, and palliative care industries for 24 years and has held executive level positions in these arenas. Katie has worked for hospices in a variety of settings, including multiple locations in multiple states, a hospice inpatient unit, pediatric hospice, and adult and pediatric palliative care.

In addition, Katie has an extensive background in health care regulation and accreditation standards interpretation; compliance and quality assessment; performance improvement; and opening and expanding sites for both home health and hospice organizations. Katie is currently the Hospice Liaison for the Indiana Association for Home & Hospice Care (IAHHC) and the National Association for Home Care & Hospice (NAHC). She has been consulting in these areas since 2009.
Why?

IMPACT Act

- October 2014
- Hospices surveyed at least every three years
Top 10 Deficiencies

1. Supervision of Hospice Aides
2. Plan of Care 418.56(b)
3. Content of Comp. Assmt. - Drug Profile 418.54(c)(6)
4. Content Plan of Care 418.56(c)
5. Detailed Statement of Scope and Frequency 418.56(c)(2)
6. Timeframe for Completion Comp. Assmt. 418.54(b)
7. Level of Activity 418.78(e)
8. Coordination of Services - Ensure Services Provided According to Plan of Care 418.56(e)(2)
9. Review of POC 418.56(d)
10. Hospice Aide Assignment and Duties 418.76(g)
Focus Areas

Three areas encompass majority of top ten survey deficiencies

- Plan of care
- Aide services
- Comprehensive assessment
Plan of Care

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Some Realities to Keep Top of Mind:

- The most frequently cited tags tend to be the same year over year
- These issues frequently precipitate citations at other L tags
- They frequently involve activities required by more than 1 person

So, We Must Approach the Issues Differently:

- Let go of your assumptions and embrace the data
- Focus on all the steps in the process to understand the outcome
- Engage to sustain performance improvement
Root Causes of Repetitive Issues Tend to Fall into One of These Three Buckets

**Leadership**
- Accountability
- Culture & Relationships
- Mission
- Strategic Imperative
- Goals & Objectives

**Communication**
- Accountability
- Culture & Relationships
- Systems
- Processes
- Data

**Human Factors**
- Accountability
- Culture & Relationships
- Environment
- Resources
- Systems
- Process Capability
42 CFR §418.56 Plan of Care

5 Standards of Care that require:

(a) An interdisciplinary team composes plan: Doctor, RN, Social Worker, Chaplain

(b) Compliance to (follows) an individualized written plan of care (L543) (L544)

(c) Address patient and family needs and problems (L545) (L546)(L547)(L548) (L549) (550) (551)

(d) Review and revision of the plan at least every two weeks (L552) (L553)

(e) A system of communication and integration (L554) (L555) (L556) (L557) (L558)
L543 All care and services follow the plan of care
L544 Includes education/training provided to caregiver
L545 Content of Plan of Care is individualized to patient/family
L546 Includes interventions to manage pain and symptoms
L547 Plan details scope and frequency of care
L548 Plan includes measurable outcomes anticipated
L549 Plan includes necessary drugs and treatments
L550 Plan includes medical equipment and supplies used by patient
L551 Plan documents patient/caregiver understanding/involvement
L552 Plan is reviewed and revised no less frequently than every 15 days
L554 Develop/maintain coordination w/IDG responsibility
L555 Coordination ensures care/services delivered according to plan
L556 Care/services provided based on assessments
L557 Sharing of information between disciplines, services and settings
L558 Sharing information with non-hospice providers
POC indicates spiritual care ordered but no care delivered

POC indicates the use of Tylenol 650mg for a temp over 100° but notes indicate RN administered Tylenol when patient complained of headache

POC indicates wound care with ½ NS and ½ H₂O₂ but observation indicates wound cleansed with H₂O₂ and then rinsed with NS
Deficiencies Commonly Cited at: (L545) Develop an Individualized Plan of Care Based on Problems Identified in Assessment(s)

- Patient and family wish to manage incontinence with diaper but POC doesn’t include any plans for promoting skin integrity
- Patient’s assessment indicates patient is allergic to Morphine and patient’s POC directs the use of MSIR for breakthrough pain because that is what analgesic algorithm indicates for use
- Widespread: Plans of care for all hospice patients state, Spiritual Care Services. “Twice monthly and prn for distress or identified needs.” Interventions uniformly say, “Provide spiritually supportive activities” and goal is “Patient will experience spiritual support.”
Deficiencies Commonly Cited at

(L547) Plan Reflects Scope & Frequency to Address Problems Identified in Assessment(s)

- POC fails to address how patient will manage continuous use of oxygen considering the spouse smokes cigarettes in the home
- POC contains no indication of how often the patient’s colostomy must be irrigated, a routine activity noted on the assessment
- POC for bedbound patient, newly placed in nursing home does not address identified ‘sadness and depression’
Outcomes for all patients admitted to hospice indicate: “Patient will experience comfort” regardless of assessment data

Outcomes for patient with profound nausea and vomiting state: “Patient will receive post-emesis care”

Outcomes for patient with expressed anxiety over painful death stated as “Patient will remain calm”

Goals/outcomes are always

Deficiencies Commonly Cited at (L548) Plan Reflects Individualized Measurable Outcomes Anticipated
Deficiencies Commonly Cited at: (L552) Plan is Reviewed & Revised at Least Every Two Weeks

- Changes in wound care treatment or frequency
- Changes in the use of oxygen either liter flow or method of delivery
- Spiritual services provided documented, but no discussion of what type of services, outcome, or integration into POC
- Volunteer services reported as “four hours volunteer services” this month without indication of how this integrates into the plan
Deficiencies Commonly Cited at: (L557)

- Changes in type of bathing assistance is not provided to aide who is visiting patient on the weekend
- Transition orders do not include the revisions to all the medications that were made when patient was placed on continuous care for 48 hours
- IDT notes have no indication if and how the patient’s personal physician is involved in the plan of care planning process
Evaluating the Culture, System, Processes

- Compare written policy demands to observed cultural expectations
  - Policies need to articulate law, clearly guide process, and simply direct staff
  - Leaders embed culture by consistently role modeling 2-3 top-line imperatives

- Do resources expedite/facilitate work for staff or administration?
  - Resources provided to staff must be able to expedite their work to be valued
  - When not valued, work-arounds will result introducing more opportunity for error

- How effectively is the EMR system being used?
  - Frequently, EMR system use can be enhanced with minimal retraining.
  - The use of free text increases with ease of use

- Are algorithms and formularies being used?
  - Algorithms can be used to focus practice and promote appropriate team involvement
  - Formularies can develop standardize practice and promote appropriate care
You Can’t Solve the Issues Involving the POC Process by Only Auditing the Outcome...

- Ride along 1:1 with all disciplines observe and record. No judgment.
- Compare what was discussed to what was recorded.
- Interview staff to hear how he/she prepares for IDG.
- Observe what information they have ready to discuss.
- Compare what is discussed to what is ultimately documented.
- Do all team members approach the care of patient in similar fashion?
- Do all team members prepare for IDG in similar fashion?
- Does the coordinator of IDG lead or facilitate the discussion?
- Does the team parallel plan or plan in an interdisciplinary fashion?
**How Does the IDG Function?**

<table>
<thead>
<tr>
<th>Parallel Team Planning</th>
<th>Interdisciplinary Team Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Silos of discipline specific care</td>
<td>➢ Patient’s needs set priority</td>
</tr>
<tr>
<td>➢ Problems owned by discipline</td>
<td>➢ All team members attack problem</td>
</tr>
<tr>
<td>➢ Hospice centric focus</td>
<td>➢ Enables communication</td>
</tr>
<tr>
<td>➢ Staff work 1:1 with patient</td>
<td>➢ Team works collectively with patient</td>
</tr>
<tr>
<td>➢ Limited intervention opportunity</td>
<td>➢ Increases opportunity to intervene</td>
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**Example:**

- Pain and symptoms – RN and MD
- Financial needs – MSW
- Spiritual needs – Minister

**Example:**

- Depression over Dx – all team
- Pain – control, meaning, penance
Leading Practices to Promote Compliance:

- Policies clearly and simply define care planning and coordination activities
  - Policy and culture highlights importance of co-creating and implementing POC
  - Practice rewards full implementation of care planning process
  - Management supports staff with tools and resources to facilitate care planning
  - Practice expectations include criteria for team communication

- Tools and resources guide team through patient focus care planning:
  - Standardized data gathering tools for IDG meetings
  - Team rules emphasizing preparation, complete and concise reporting

- IDG includes:
  - Review and discussion of all active problems and those reasonably anticipated
  - All disciplines offer skills and talents have the ability to alleviate the problem
  - Patient and family/caregivers determine what services they will use to meet their needs
  - Documentation reflects a coordinated ‘all helpful hands on deck’ approach
  - Anticipated outcomes are measured, reported out, and managed
Questions?
Hospice Aides: Pitfalls & Strategies for Compliance

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We are what we repeatedly do. Excellence, then, is not an act, but a habit.

Will Durant: *The Story of Philosophy: The Lives and Opinions of the World’s Greatest Philosophers*
Objectives

• Identify the most commonly cited deficiencies related to Hospice Aide services
• Understand competency evaluation requirements for Hospice Aides
• Consider effective development of Hospice Aide Plans of Care
• Define Hospice Aide documentation with respect to following the Aide Care Plan
• Ascertain the relevance and requirements of Hospice Aide supervision
• Apply strategies to minimize citations of deficiencies
Skills Competency Evaluation

• The paraprofessional competency evaluation program must meet all of the standards established by the Secretary of Health and Human Services and including state requirements.

• The competency evaluations are performed by a Registered Nurse (L-617).

• Skills competencies are assessed prior to independent delivery of care (L-615).

• A lab setting and “pseudo-patients” may be utilized for assessment of competencies.
  • No mannequins or other simulation.

• For all the tasks that the agency chooses to have the aide perform, competency must be evaluated as described by the standards.
  • Tasks cannot be assigned until the aide’s competency has been validated as satisfactory.
  • If an aide’s performance is unsatisfactory in more than one skill, the aide is considered not to be competent to perform as an aide and would be precluded from performing as an aide in any subject area until the aide is reevaluated and deemed competent.
Skills Competency Evaluation

• Minimum required competencies to be assessed by direct observation with a patient or pseudo-patient:
  • Reading and recording temperature, pulse, and respiration
  • Bed bath
  • Sponge, tub, and shower bath; all three must be observed
  • Hair shampoo (sink, tub, and bed); all three must be observed
  • Nail and skin care
  • Oral hygiene
  • Toileting and elimination
  • Safe transfer techniques and ambulation
  • Normal range of motion and positioning
  • Communication skills, including the ability to read, write, and verbally report clinical information to patients, caregivers, and other hospice staff
Skills Competency Evaluation

- Other required competencies to be assessed (may be by written/oral examination, or observation):
  - Observation, reporting and documentation of patient status and the care or services furnished
  - Basic infection control procedures
  - Basic elements of body functioning and changes in body function that must be reported to the aide’s supervisor
  - Maintenance of a clean, safe, and healthy environment
  - Recognizing emergencies and knowledge of emergency procedures
  - The ability to care for the physical, emotional, and developmental needs of the populations served by the hospice/home health agencies
  - Respect for the patient, his/her privacy, and his/her property
  - Adequate nutrition and fluid intake
  - Any other task that the agency may choose to have the aide perform
Common Competency Evaluation Pitfalls

• The Competency Evaluation Tool
  • The tool is not clear: skills not delineated as observed during patient care or lab setting (with a pseudo-patient or simulation)
  • Required tasks are grouped together into generic categories
  • The tool does not “cue” the evaluating RN to correctly document all tasks which must be observed

• A couple of misperceptions:
  • The RN can complete a full initial competency evaluation by observing the aide with one patient (at one visit)
  • A self-evaluation can be used in lieu of observed skills evaluation or testing
  • LPN/LVNs cannot conduct the observed skills competencies

• The “met” column has a line drawn from top to bottom which indicates that all the tasks were performed on one patient at one time (shave, incontinence care, catheter, walker, cane, prosthetic, positioning, etc.)

• No identifying information on the competency evaluation tool (patient name and/or medical record number, pseudo-patient, dates, signature/credential line, etc.)

• “Unsatisfactory” evaluations are not followed up with documented training and re-evaluation
Competency Evaluation Strategies

- There is no specific format required for a skills competency evaluation tool
  - Review and revise as necessary to ensure elements are present and clear (observation, testing, dates, patient ID, etc.)
- Include observation of required skills during the probationary period
- Review competency evaluation with the aide prior to independent assignment to identify gaps in knowledge or skill
- Include skills labs with pseudo-patients (staff volunteers, for example)
  - Annual skills fair
- Make note of unsatisfactory performance and formally schedule training and re-evaluation
  - Document, document, document
Competency Evaluation Strategies

• Audit the personnel record (or the vehicle utilized to track competency evaluations)
  • On completion of the probationary period
  • Documentation of observed skills vs. skills by testing and skills lab
  • Documentation of who conducted the competency evaluation (signature/credentials field, date field)
• Consider joint home visit with aide at a short period of time after independent assignment for performance
Development of the Aide Plan of Care (L625)

• The aide is assigned to a specific patient by an RN

• Written patient care instructions (plan of care) for the aide are prepared by the RN

• The plan of care is individualized based on assessment of patient needs and the patient/family/caregiver desires and goals
  • Specific to the patient

• Patient safety and cognitive status are considered
Development of the Aide Plan of Care

• The tasks assigned are ordered by the Interdisciplinary Group/Team; as permitted by state law. These duties may include (L-627):
  • Hands-on personal care
  • Performance of simple procedures as an extension of nursing or therapy services
  • Assistance in ambulation or exercises,
  • Assistance in administering medications ordinarily self-administered (as permitted under state law)
• Tasks are clear and specific
  • Leave little to no room for the aide to have to make decisions that are out of the aide’s scope of practice
• Frequency of visits are clear
  • Consideration – using a range for visit frequencies
The Aide Plan of Care

• The aide assignment: consider
  • The skills of the aide
  • Specific needs of the patient
  • The capabilities and needs of the patient’s family/caregivers
• Orientation of the hospice aide to the plan of care prior to or during the initial aide visit
• Documentation verifies reassessment of the patient as well as review and update of the plan of care by the RN and the IDG/T
Common Pitfalls in Developing the Plan of Care

- Conflicting understanding/definition of terms on the plan of care
- Reassessment of the status and needs of the patient in consultation with the patient/family/caregiver is not conducted
- The RN and/or the aide are not clear on the aide’s scope of practice
- Range of options (i.e., multiple kinds of baths without specific direction), PRNs and “per request” could compel the aide to make decisions outside their scope of practice
- The plan of care is not updated as patient needs change
Strategies for Effective Plan of Care Development

• Develop a glossary of approved definition of terms and abbreviations and train staff to that glossary

• Review the Aide Plan of Care at every IDG/IDT meeting, discuss and update the Plan of Care as applicable based on supervisory visit findings and assessment

• Familiarize the RNs to the aides’ scope of practice for your state (training)

• Determine whether or not to use ranges for visit and/or task frequencies
  • If allowed, define documented parameters for aides to decrease (or increase) the visits or tasks assigned within the range
Strategies for Effective Plan of Care Development

• Consider revising the Plan of Care to include cognitive status
• Be specific when assigning a task as PRN (orient the aide, provide documented parameters)
• Implement a Performance Improvement Project
  • Audits:
    • Plan of Care is specific and individualized to the patient
    • Plan of Care is reviewed and updated as applicable
      • Documented review and/or update date and signature per agency policy
      • Plan of Care includes safety precautions, environmental challenges
    • Display trends of improvement; celebrate!
    • If trends are not improving, investigate potential issues and implement additional actions
Compliance with the Established Aide Plan of Care

• The aide performs tasks that are within the aide’s scope of practice under state law
• The aide performs tasks only if he/she has undergone validated competencies
• Aides are required to follow the plan of care “as written” (L-626)
  • Tasks assigned
  • Frequency of visits
• The visit note documents the plan of care was followed
  • If not followed, rationale is documented
• There is documentation that the aide communicated with the RN (L-628):
  • When the plan of care was not followed
  • If the patient wants a change in the plan of care, and/or
  • There is a change in the patient condition
Common Pitfalls With Aide Compliance With the Plan of Care

• Lack of systematic orientation to the plan of care
• Lack of understanding how to document accurately
• Missed visits without documentation of reason
• The missed visit note reflects the visit wasn’t made due to agency/personnel issues (aide not available, car broke down, holiday, personal reasons)
• The plan of care and the Aide visit notes are not congruent (formatting and design)
  • Missing fields to assign particular tasks on the plan of care document
  • Missing fields for the aide to document that the tasks assigned were completed on the visit note
Strategies for Facilitating Compliance with the Plan of Care

• Aide participation in IDT/IDG – devote time to orienting the aide(s) to the Plan of Care (including revisions)

• Train hospice aides in accurate documentation to the Plan of Care
  • Use skits and teach-back methods in the training
  • Emphasize requirement to notify the RN

• Set up “chats” with the aides (if feasible); case scenarios and how the aide might approach particular situations

• Train to agency expectations for documentation of missed visits

• Develop contingency plans for provision of aide services in the event that an aide is not available for a scheduled visit
Strategies for Facilitating Compliance with the Plan of Care

• Review and revise documentation formats as necessary to ensure all elements are present and congruent
• Implement a Performance Improvement Project
  • Audits:
    • Visits conducted at the frequency ordered
    • Tasks performed as assigned on the Plan of Care
    • Documentation of RN notification as applicable
    • Aides are performing tasks within their scope
  • Display trends of improvement; celebrate!
  • If trends are not improving, investigate potential issues and implement additional actions
Hospice Aide Supervision

True supervision = an assessment of multiple factors in the provision of care which can identify issues early on, thus facilitating a path to correction and enhanced compliance.
Hospice Aide Supervision

• The RN must perform the supervisory visit
• Supervisory visits may be made in conjunction with a visit to provide care
• The supervisory visit is made every 14 days in the patient’s to assess whether the aide is (L-629):
  • Compliant with the patient’s plan of care
  • Creating successful interpersonal relationships with the patient and family
  • Demonstrating competency with assigned tasks
• The RN assesses the quality of care and services provided by the aide, and whether the ordered services are meeting the patient’s needs
• The aide may or may not be present during the 14-day supervisory visits
  • Annually, a supervisory visit is conducted with the aide present to assess performance (L-632)
Common Pitfalls of Aide Supervision

• Checking a box for supervisory visit vs documenting the elements of supervision
  • Limitations of the electronic medical record (EMR)
• The RN does not connect the dots during a supervisory visit and note a discrepancy of what was assigned vs what the aide actually performed, the plan of care may not be updated appropriately to reflect patient needs
• The visit schedule and the 14-day challenge
  • Once-a-week visit frequencies assigned to LPN/LVN (rigid scheduling)
  • The patient/caregiver refuses a visit (or many supervisory visits)
  • 15+-day visit instead of 14-day visit
Strategies for Compliance with Hospice Aide Supervision

• Implement a Performance Improvement Project with the QAPI team
  • Audits:
    • Every 14-day supervision
    • Annual supervision
  • Develop a checklist for auditing specifics inclusive of complete documentation
  • Display trends of improvement; celebrate!
  • If trends are not improving, investigate potential issues and implement additional actions
Strategies for Compliance with Hospice Aide Supervision

- Schedule supervisory visits by the RN minimum every 14 days
  - Weekly visits or at every visit?
- Document specifically to the required components
  - Tasks assigned and compliance with visit frequencies
  - Interpersonal relationships
- If on EMR, work with your vendor to modify the application as necessary to meet your needs
- Train/refresh RNs on the specific requirements
Questions?
Comprehensive Assessment

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The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient’s need for hospice care and services, and the patient’s need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.
Comprehensive Assessment

- §418.54(a) Standard: Initial assessment
- §418.54(b) Standard: Timeframe for completion of the comprehensive assessment
- §418.54(c) Standard: Content of the comprehensive assessment
- §418.54(d) Standard: Update of the comprehensive assessment
- §418.54(e) Standard: Patient outcome measures
§148.54(a) Standard: Initial Assessment

- RN completes an initial assessment with 48 hours after the election of hospice care
The hospice IDG, in consultation with the individual’s attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care.
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.
§148.54(c) Standard: Content of the Comprehensive Assessment

• Nature and condition causing admission
• Complications and risk factors that affect care planning
• Functional status, including the patient’s ability to understand and participate in his or her own care
• Imminence of death
• Severity of symptoms
• Drug profile
• Bereavement
• Need for referrals and further evaluation by appropriate health professionals
§148.54(d) Standard: Update of the Comprehensive Assessment

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

- The comprehensive assessment must include data elements that allow for measurement of outcomes.
- Data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient.
Questions?

Thank You for Attending!

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