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Hospice

Standards of Excellence

Hospice Standards
CHAP Inc.

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Introduction to the Hospice Standards of Excellence

Overview

The standards in this document pertain to the hospice conditions of participation (CoPs). These standards are approved by the Centers for Medicare and Medicaid Services (CMS) as meeting or exceeding the intent of the CoPs.

- All initial and renewing hospice providers that have a site visit and that are seeking or have been awarded CMS deemed status through the CHAP review process are evaluated using these standards.
- These standards also apply to Medicaid hospice providers seeking initial or renewed accreditation in states that require compliance with the Medicare hospice CoPs.

Regulatory Requirements

Federal regulations for hospice are cross-walked to standards when applicable.

Regulations are listed by the Code of Federal Regulations (CFR) number (e.g., §418.110). Each CFR corresponds to a Medicare Condition of Participation (CoP).

Revision Reference Table

In response to the *Medicare and Medicaid Programs; Policy and Regulatory Changes to the Omnibus COVID-19 Health Care Staff Vaccination Requirements Final Rule (CMS-3415-F),* the following revisions were approved by CMS.

Standard	Summary	Effective Date	Page
HIPC 11	Removed	8/5/2023	
HIPC 12	Removed	8/5/2023	
HIPC 13	Removed	8/5/2023	
HIPC 14	Removed	8/5/2023	
HIPC 15	Removed	8/5/2023	
HIPC 16	Removed	8/5/2023	
HIPC 17	Removed	8/5/2023	
HIPC 18	Removed	8/5/2023	

In response to *QSO-23-08-Hospice, Revisions to Hospice - Appendix M of the State Operations Manual and the Hospice Basic Surveyor Training,* the following revisions were approved by CMS.

Standard	Summary	Effective Date	Page
HPFC 1.D	Removed L501, Updated Evidence Guidelines	3/28/2023	1
HPFC 2.D	Updated Evidence Guidelines	3/28/2023	1-2
HPFC 4.I	Updated Evidence Guidelines	3/28/2023	3
HPFC 6.D	Updated Evidence Guidelines	3/28/2023	4-5
HPFC 7.D	Updated Evidence Guidelines	3/28/2023	5-6
HPFC 9.D	Updated Evidence Guidelines	3/28/2023	7-8
HCPC 7.I	Removed L521	3/28/2023	13
HCPC 9.I	Updated Evidence Guidelines	3/28/2023	14
HCPC 10.I	Updated Evidence Guidelines	3/28/2023	15
HCPC 11.I	Updated Evidence Guidelines	3/28/2023	16
HCPC 13.I	Updated Evidence Guidelines	3/28/2023	18
HCPC 14.I	Updated Evidence Guidelines	3/28/2023	19
HCPC 17.I	Updated Evidence Guidelines	3/28/2023	21
HCPC 18.I	Removed L537 and L538	3/28/2023	22
HCPC 21.I	Updated Evidence Guidelines	3/28/2023	24
HCPC 23.D	Updated Evidence Guidelines	3/28/2023	26
HCDT 1.I	Removed L687, Updated Evidence Guidelines	3/28/2023	27
HCDT 2.I	Removed L588, Updated Evidence Guidelines	3/28/2023	28
HCDT 3.I	Removed L589, Added L587	3/28/2023	29
HCDT 4.I	Updated Evidence Guidelines	3/28/2023	30
HCDT 5.I	Removed L665, Updated Evidence Guidelines	3/28/2023	31
HCDT 13.I	Removed L602, Added L603, Updated Standard Language	3/28/2023	36
HCDT 14.I	Removed L604, Updated Standard Language, Updated Evidence Guidelines	3/28/2023	37
HCDT 16.I	Updated Evidence Guidelines	3/28/2023	38
HCDT 19.I	Updated Evidence Guidelines	3/28/2023	40
HCDT 20.I	Updated Evidence Guidelines	3/28/2023	40
HCDT 21.I	Removed L642, Updated Evidence Guidelines	3/28/2023	41
HCDT 22.I	Updated Evidence Guidelines	3/28/2023	42
HCDT 26.I	Removed L687, Updated Evidence Guidelines	3/28/2023	45
HCDT 27.I	Removed L687, Updated Evidence Guidelines	3/28/2023	46
HCDT 28.I	Updated Evidence Guidelines	3/28/2023	47
HCDT 29.I	Removed L687	3/28/2023	48
HCDT 30.I	Updated Evidence Guidelines	3/28/2023	48

Standard	Summary	Effective Date	Page
HCDT 32.I	Updated Standard Language	3/28/2023	50
HCDT 33.I	Updated Evidence Guidelines	3/28/2023	51
HCDT 37.I	Updated Evidence Guidelines	3/28/2023	53
HCDT 41.I	Updated Evidence Guidelines	3/28/2023	56
HSRF 1.I	Removed L760	3/28/2023	57
HSRF 2.I	Updated Evidence Guidelines	3/28/2023	57
HSRF 3.I	Updated Evidence Guidelines	3/28/2023	58
HSRF 4.I	Updated Evidence Guidelines	3/28/2023	59
HSRF 6.I	Updated Evidence Guidelines	3/28/2023	63
HSRF 7.I	Updated Evidence Guidelines	3/28/2023	64
HSRF 8.I	Updated Evidence Guidelines	3/28/2023	65
HSRF 9.I	Updated Evidence Guidelines	3/28/2023	65
HSIC 1.I	Removed L705, Updated Evidence Guidelines	3/28/2023	67
HSIC 4.I	Updated Evidence Guidelines	3/28/2023	70
HSIC 6.I	Removed L719, L720 and L721, Added L820 and L821	3/28/2023	71
HSIC 7.I	Removed L722 and L725, Added L822 and L823, Updated Evidence Guidelines	3/28/2023	72
HSIC 8.I	Removed L724 and L723, Added L824 and L825, Updated Evidence Guidelines	3/28/2023	72
HSIC 13.D	Removed L727, Added L826	3/28/2023	77
HSIC 14.I	Removed L728, Added L827 and L828	3/28/2023	78
HSIC 16.I	Removed L728, Added L827	3/28/2023	79
HSIC 17.I	Removed L728, Added L827, Updated Evidence Guidelines	3/28/2023	79
HSIC 18.I	Removed L728, Added L827	3/28/2023	80
HSIC 19.I	Removed L728, Added L827	3/28/2023	80
HSIC 20.I	Removed L728, Added L827	3/28/2023	81
HSIC 21.I	Removed L728, Added L827	3/28/2023	81
HSIC 22.I	Removed L729 and L730, Added L829 and L830	3/28/2023	82
HSIC 23.I	Removed L730 and L731, Added L830 and L831	3/28/2023	82-83
HSIC 24.I	Removed L732, Added L832	3/28/2023	84
HSIC 25.I	Removed L734, Added L834	3/28/2023	84
HSIC 26.I	Removed L735, Added L835	3/28/2023	84
HSIC 27.I	Removed L733, Added L833, Updated Evidence Guidelines	3/28/2023	85
HSIC 28.I	Removed L736, Added L836, L837, L838 and L839	3/28/2023	86
HSIC 29.I	Updated Evidence Guidelines	3/28/2023	86
HSIC 30.D	Updated Standard Language	3/28/2023	87

Standard	Summary	Effective Date	Page
HSIC 34.I	Removed L737, Added L840	3/28/2023	89
HSIC 35.D	Removed L738 and L739, Added L841, L842 and L844	3/28/2023	89
HSIC 36.I	Removed L740, L741 and L742, Added L843, L844 and L845	3/28/2023	90
HSIC 37.I	Removed L743, Added L846	3/28/2023	90
HSIC 38.I	Removed L744 and L745, Added L847 and L848	3/28/2023	91
HSIC 39.D	Removed L746 and L747, Added L849 and L850	3/28/2023	92
HSIC 40.I	Removed L748, L749 and L750, Added L851, L852 and L853	3/28/2023	93
HSIC 41.I	Removed L751, Added L854	3/28/2023	94
HSIC 42.I	Removed L752, Added L855	3/28/2023	94
HSIC 43.I	Removed L753, L754 and L756, Added L856, L857 and L859	3/28/2023	95
HSIC 44.D	Removed L755, Added L858	3/28/2023	96
HSIC 45.I	Removed L757, Added L860	3/28/2023	97
HSIC 46.I	Removed L758, Added L861	3/28/2023	97
HSRM 9.I	Updated Evidence Guidelines	3/28/2023	108
HSRM 11.I	Updated Evidence Guidelines	3/28/2023	114
HSRM 13.I	Removed L608, Added L607	3/28/2023	116
HSRM 15.I	Updated Evidence Guidelines	3/28/2023	117
HSRM 16.I	Updated Evidence Guidelines	3/28/2023	118
HSRM 19.I	Updated Evidence Guidelines	3/28/2023	119
HSRM 20.I	Updated Evidence Guidelines	3/28/2023	120
HSRM 25.I	Updated Evidence Guidelines	3/28/2023	122
HSRM 27.D	Updated Evidence Guidelines	3/28/2023	123
HSRM 31.I	Removed L642, Added L641, Updated Evidence Guidelines	3/28/2023	125
HIPC 1.D	Removed L578, Updated Evidence Guidelines	3/28/2023	127
HIPC 2.I	Updated Evidence Guidelines	3/28/2023	128
HIPC 7.I	Updated Standard Language, Updated Evidence Guidelines	3/28/2023	131
HSIM 3.I	Removed L671	3/28/2023	136
HQPI 1.D	Removed L560, Updated Evidence Guidelines	3/28/2023	149
HSLG 1.I	Removed L798	3/28/2023	155
HSLG 5.I	Removed L649	3/28/2023	157
HSLG 11.I	Updated Evidence Guidelines	3/28/2023	160
HSLG 14.D	Updated Evidence Guidelines	3/28/2023	162
HSLG 18.I	Updated Evidence Guidelines	3/28/2023	165

In response to the *2021 Omnibus COVID-19 Health Care Staff Vaccination; Interim Final Rule (CMS-3415-IFC),* the following revisions were approved by CMS.

Standard	Summary	Effective Date	Page
HIPC 11	New COVID-19 Staff Vaccination Standard	1/27/2022	131
HIPC 12	New COVID-19 Staff Vaccination Standard	1/27/2022	132
HIPC 13	New COVID-19 Staff Vaccination Standard	1/27/2022	133
HIPC 14	New COVID-19 Staff Vaccination Standard	1/27/2022	134
HIPC 15	New COVID-19 Staff Vaccination Standard	1/27/2022	135
HIPC 16	New COVID-19 Staff Vaccination Standard	1/27/2022	136
HIPC 17	New COVID-19 Staff Vaccination Standard	1/27/2022	137
HIPC 18	New COVID-19 Staff Vaccination Standard	1/27/2022	138

In response to the *Medicare Program; Hospice Conditions of Participation Updates, Final Rule CMS-1754-F,* the following revisions were approved by CMS.

Standard	Summary	Effective Date	Page
HSRM 9.I	Added evaluation of aide's competency with pseudo-patient or pseudo-patient during a simulation.	10/1/2021	108-113
HSRM 26.I	Added specification to competency evaluation of the deficient skill and all related skill(s).	10/1/2021	122
Pseudo-patient	Added new key term	10/1/2021	172
Simulation	Added new key term	10/1/2021	173

In response to the *2019 Omnibus Burden Reduction (Conditions of Participation) Final Rule CMS-3346-F*, the following revisions were approved by CMS.

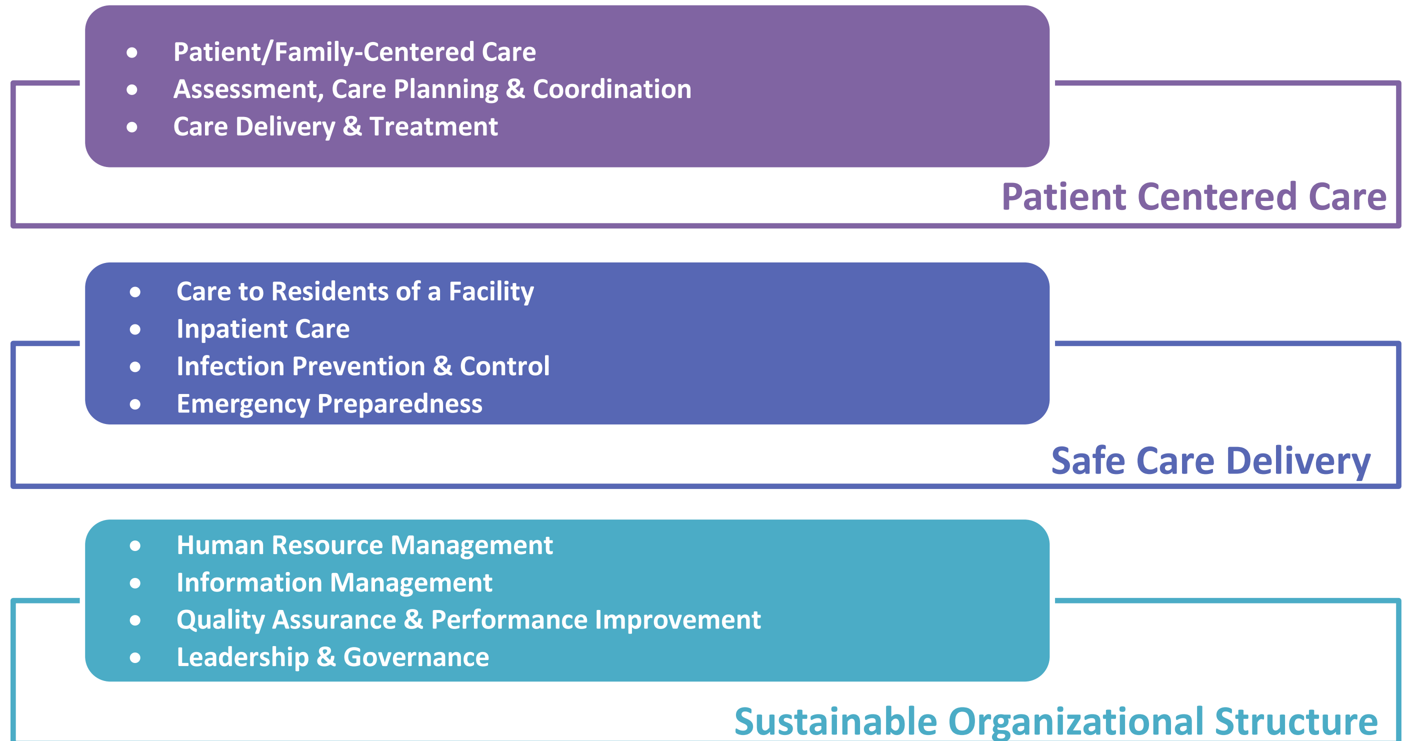
Standard	Summary	Effective Date	Page
HCDT 31.I	Previous HCDT 32.I	11/29/2019	49
HCDT 32.I	Previous HCDT 33.I	11/29/2019	50
HCDT 33.I	Previous HCDT 34.I	11/29/2019	51
HCDT 34.D	Previous HCDT 35.D	11/29/2019	51
HCDT 35.I	Previous HCDT 36.I	11/29/2019	52
HCDT 36.D	Previous HCDT 37.D	11/29/2019	53
HCDT 37.I	Previous HCDT 38.I	11/29/2019	53
HCDT 38.I	Previous HCDT 39.I	11/29/2019	54
HCDT 39.I	Previous HCDT 40.I	11/29/2019	54
HCDT 40.I	Previous HCDT 41.I	11/29/2019	55
HCDT 41.I	Previous HCDT 42.I	11/29/2019	56

Standard	Summary	Effective Date	Page
HSRF 10.I	Added hospice staff, in coordination with SNF/NF or ICF/IDF staff, ensures orientation and training of staff providing care to hospice patients.	11/29/2019	66
HSIC 11.I	New Standard - Hospice inpatient care provided directly by the hospice must conduct two tests annually.	11/29/2019	75-76
HSIC 12.I	Previous HSIC 11.I	11/29/2019	76
HSIC 13.D	Previous HSIC 12.D	11/29/2019	77
HSIC 14.I	Previous HSIC 13.I	11/29/2019	78
HSIC 15.I	Previous HSIC 14.I	11/29/2019	78
HSIC 16.I	Previous HSIC 15.I	11/29/2019	79
HSIC 17.I	Previous HSIC 16.I	11/29/2019	79
HSIC 18.I	Previous HSIC 17.I	11/29/2019	80
HSIC 19.I	Previous HSIC 18.I	11/29/2019	80
HSIC 20.I	Previous HSIC 19.I	11/29/2019	81
HSIC 21.I	Previous HSIC 20.I	11/29/2019	81
HSIC 22.I	Previous HSIC 21.I	11/29/2019	82
HSIC 23.I	Previous HSIC 22.I	11/29/2019	82-83
HSIC 24.I	Previous HSIC 23.I	11/29/2019	84
HSIC 25.I	Previous HSIC 24.I	11/29/2019	84
HSIC 26.I	Previous HSIC 25.I	11/29/2019	84
HSIC 27.I	Previous HSIC 26.I	11/29/2019	85
HSIC 28.I	Previous HSIC 27.I	11/29/2019	86
HSIC 29.I	Previous HSIC 28.I Added the hospice that provides inpatient care directly in its own facility provides pharmacy services under the direction of a qualified licensed pharmacist.	11/29/2019	86
HSIC 30.D	Previous HSIC 29.D	11/29/2019	87
HSIC 31.I	Previous HSIC 30.I	11/29/2019	87
HSIC 32.I	Previous HSIC 31.I	11/29/2019	88
HSIC 33.I	Previous HSIC 32.I	11/29/2019	88
HSIC 34.I	Previous HSIC 33.I	11/29/2019	89
HSIC 35.D	Previous HSIC 34.D	11/29/2019	89
HSIC 36.I	Previous HSIC 35.I	11/29/2019	90
HSIC 37.I	Previous HSIC 36.I	11/29/2019	90
HSIC 38.I	Previous HSIC 37.I	11/29/2019	91
HSIC 39.D	Previous HSIC 38.D	11/29/2019	92
HSIC 40.I	Previous HSIC 39.I	11/29/2019	93
HSIC 41.I	Previous HSIC 40.I	11/29/2019	94

Standard	Summary	Effective Date	Page
HSIC 42.I	Previous HSIC 41.I	11/29/2019	94
HSIC 43.I	Previous HSIC 42.I	11/29/2019	95
HSIC 44.D	Previous HSIC 43.D	11/29/2019	96
HSIC 45.I	Previous HSIC 44.I	11/29/2019	97
HSIC 46.I	Previous HSIC 45.I	11/29/2019	97
HSRM 9.I	Changed option 4 for hospice aide training and competency evaluation. If the state has hospice licensure requirements for hospice aide training and competency evaluation, the hospice aides only need to meet the state requirements.	11/29/2019	113
HSEP 2.D	Added EP plan is reviewed and updated at least every two (2) years.	11/29/2019	140-141
HSEP 3.D	Added EP policies and procedures are reviewed and updated at least every two (2) years.	11/29/2019	142-143
HSEP 4.D	Added EP communication plan, including all contact information, is reviewed and updated at least every two (2) years.	11/29/2019	144
HSEP 5.D	Added EP training program is reviewed and updated at least every two (2) years. EP training of all hospice employees and individuals providing services under arrangement at least every two (2) years with more frequent training if there is a significant update of EP policies and procedures.	11/29/2019	145
HSEP 6.I	Added EP annual testing includes participation in a full-scale exercise that is community-based every two (2) years. When a community-based exercise is not accessible, testing includes participation in an individual, facility-based functional exercise every two (2) years. The organization is exempt from its next required full-scale community-based exercise or individual, facility-based functional exercise following the onset of an actual natural or manmade emergency that requires activation of the emergency plan. An additional exercise is conducted every two years, opposite the year that a full-scale exercise or functional exercise is conducted.	11/29/2019	146
HSLG 7.I	Added hospice volunteers provide day-to-day administrative or direct patient care services in an amount that, at a minimum, equals five percent (5%) of the total patient care hours of all paid hospice employees and contract staff.	11/29/2019	158

Key Performance Areas

The Hospice Standards of Excellence are organized into one of the following Key Performance Areas.



A **Key Performance Area** is the central topic evaluated by the standards. Each Key Performance Area includes:

- **Standards** that identify the set of requirements CHAP uses to make accreditation determinations. CHAP evaluates compliance with each standard and bases the accreditation decision on the organization's total performance across all standards evaluated.
- **Evidence Guidelines** that provide additional detail about how each standard is assessed, as well as approaches organizations may consider in demonstrating compliance with the standard. More detail about Evidence Guidelines is provided below.

Within each Key Performance Area, two areas of performance are examined:

- **Design (D) standards**: The policies, procedures, qualifications, training and other resources the organization uses to support consistent implementation and quality outcomes in care and service delivery.
- **Implementation (I) Standards:** Evaluation of how effectively the organization implements its own defined parameters of organization structure and expectations, as well as those established nationally and at the state level.

Evidence Guidelines

Evidence guidelines provide organizations direction about how compliance with the standard is assessed. The following types of evidence guidelines are used:

1. **Guidance Statements:** Explain expectations, nuances or terms used in the standard. Guidance supports the organization in understanding the requirements of each standard. Examples are used for the purpose of explanation but are not meant to be statements of the only way to achieve compliance.
2. **Document Review:** Documentation from a variety of sources is used to demonstrate compliance (e.g., position descriptions, policies, complaint log).
3. **Interview:** One or more interviews with personnel and/or patients or caregivers are used to assess compliance with the standard.
4. **Record Review:** Personnel or patient records are an important source of assessing compliance.
5. **Observation:** One or more home visits or patient interviews are conducted to demonstrate compliance.
6. **Contract Review:** Contract language is the primary source reviewed as the demonstration of compliance.
7. **Tip:** These statements are also included in the Evidence Guidelines for particular standards. Tips provide resources to support organizational compliance with the standard, as well as evidence-informed practices. Information in a *Tip* is not used as part of a compliance determination.

Hospice Patient/Family-Centered Care (HPFC)

KEY PERFORMANCE AREA:

An Interdisciplinary Group (IDG) engages with patients and families at home and in their community to ensure that the care and services provided respect and respond to individual preferences and goals of terminally ill individuals and the needs of their families.

The patient defines "family" and "caregivers."

The hospice defines and protects patient and family rights in the delivery of care in the home and community.

Standards	Evidence Guidelines
HPFC 1.D The hospice has a written Patient Bill of Rights and Responsibilities (Bill of Rights). The patient has the right to be informed of their rights and responsibilities, and the hospice defines, protects, and promotes the exercise of these rights. *Applicable Regulations: L500-418.52.*	**Document Review:** Validate the agency has a Patient Bill of Rights prepared. **Clinical Record Review:** Confirm that there is a written statement of the Patient Bill of Rights provided to patients.
HPFC 2.D The written Patient Bill of Rights includes the right to: 1. Be involved in the development of their plan of care; 2. Be informed about the scope of services the hospice provides and any specific limitations on those services; 3. Refuse care or treatment; 4. Choose their attending physician; *(continued on following page)*	**Document Review:** Review a copy of the Bill of Rights that is distributed to patients and ensure patient information informs patients and family/caregivers of accurate information for filing a complaint. Verify that it contains the elements required by the standard. **Observation – Home Visit:** Verify the patient/family is knowledgeable of the complaint process. *(continued on following page)*

Standards	Evidence Guidelines
HPFC 2.D 5. Receive effective pain management and symptom control for conditions related to the terminal illness; 6. Be free from mistreatment, neglect, or verbal, mental, sexual, or physical abuse, including injuries of unknown source, and the misappropriation of patient property; 7. Have person and property treated with respect by anyone providing services on behalf of the hospice; 8. Voice grievances to the hospice, CHAP, or a state entity without fear of discrimination or reprisal; 9. Voice grievances regarding treatment or care that is—or fails to be—provided; 10. Be informed and receive written information concerning the hospice's policy on advance directives, including state law and regulation; 11. Have a confidential record per state and federal law and regulation; 12. Receive information about the services covered under the hospice benefit. Applicable Regulations: L503-418.52(a)(2); L505-418.52(b)(1)(i); L505-418.52(b)(1)(ii); L505-418.52(b)(1)(iii); L505-418.52(b)(1)(iv); L512-418.52(c)(1); L513-418.52(c)(2); L514-418.52(c)(3); L515-418.52(c)(4); L516-418.52(c)(5); L517-418.52(c)(6); L518-418.52(c)(7); L519-418.52(c)(8).	**Guidance:** Information about how to submit a complaint to CHAP via a 24 hour hotline (1-800-656-9656) is provided to each patient/family.

<table>
<tr><th>Standards</th><th>Evidence Guidelines</th></tr>
<tr><td>HPFC 3.I

During the initial assessment visit and in advance of providing care:
1. The hospice provides the patient—or their representative—with verbal and written notice of the patient's rights and responsibilities.
2. This information is provided in a language and manner that the patient understands.

The hospice obtains the patient's or representative's signature confirming that they received a copy of the Bill of Rights and Responsibilities statement.

Applicable Regulations: L502-418.52(a)(1); L504-418.52(a)(3).</td><td>Clinical Record Review: In reviewing the patient record, confirm there is evidence of the patient's signature indicating receipt of the Bill of Rights document.

Observation – Home Visit: During a home visit, ask the patient or family member if they received their statement of rights and responsibilities.</td></tr>
<tr><td>HPFC 4.I

The hospice patient has the right to exercise the rights as stated in the Bill of Rights without discrimination or reprisal.

Applicable Regulations: L505-418.52(b)(1)(i); L505-418.52(b)(1)(iv).</td><td>Interview: Interview IDG team members to verify through examples how patients and families can or have exercised their rights.

Observation – Home Visit: While conducting a home visit, and through interviews, confirm that the patient and family are informed of their rights and how to exercise them, if the patient is being treated with respect, and if the staff encourages the patient's feedback.</td></tr>
</table>

Standards	Evidence Guidelines
HPFC 5.I If a patient has been judged incompetent under state law by a court of jurisdiction, the rights of the patient are exercised by the person appointed pursuant to state law to act on the patient's behalf. OR If the state court has not judged a patient incompetent, any legal representative designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law. Applicable Regulations: L506-418.52(b)(2); L507-418.52(b)(3).	**Interview:** Ask an IDG member how they handle the process of identifying a patient with a guardian or a surrogate decision-maker for the patient.
HPFC 6.D Policies and procedures define the complaint/ grievance management process and include: 1. Designation of staff responsible for managing the complaint process; 2. Procedures and timeframes for documented intake and investigation; 3. Documented status of the complaint, including resolution (if any); 4. Corrective action taken (if necessary); 5. What information, if any, is shared with the complainant.	**Document Review:** Review policies, procedures and documentation of complaints made by patients or patients' families for the previous 12 months that describe the complaint process and address each of the requirements of the standard. Review the hospice election statement to validate the information includes the name and phone number of the appropriate Beneficiary and Family-Centered Care Quality Organization (BFCC-QIO) and is signed by the beneficiary and/or legal representative. **Interview:** Interview hospice staff to determine if they are aware of and follow the hospice's policy for *(continued on following page)*

Standards	Evidence Guidelines
HPFC 6.D	complaint investigation when a patient/family makes a complaint to a staff member. Interview hospice leadership to determine who in the hospice is ultimately accountable for receiving, investigating, and resolving any patient concerns or problems that cannot be resolved at the staff level. **Guidance:** Not every complaint can be resolved to the patient's, family's, or complainant's satisfaction; the expectation is evidence of response and investigation. **Guidance:** Complaints include, but are not limited to, issues of customer service, access to care and services, timeliness, quality of care, and respect for person, privacy, or property, etc. Information shared with the complainant can address complaint status and/or resolution (if applicable).
HPFC 7.D The hospice has a defined process to ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, or physical abuse, including injuries of unknown source or misappropriation of patient/family property by anyone furnishing services on behalf of the hospice, are reported immediately: 1. By the hospice employee to the hospice administrator; or 2. By the contracted hospice staff to the hospice administrator. *(continued on following page)*	**Document Review:** Review training records for hospice employees and contracted staff to ensure they have received training on how and when to report allegations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse by anyone furnishing services on behalf of the hospice. This includes reporting injuries of unknown origin, as well as misappropriation of patient property. *(continued on following page)*

Standards	Evidence Guidelines
HPFC 7.D Applicable Regulation: L508-418.52(b)(4)(i).	**Interview:** Ask the administrator how reported suspected events are handled. If one has occurred, ask him or her to walk you through the process. Clarify if the contracted staff are aware of this process. **Guidance:** Suspected instances may be reported by a patient, caregiver, family member, friend, or concerned other, as well as by any contracted or employed personnel, including volunteers. **Guidance:** Particular attention should be paid to potential misuse or abuse of patient medications. **Guidance:** States commonly have mandatory reporting requirements for providers, suppliers, and individuals making them legally responsible to report suspicions of abuse and neglect to appropriate State authorities. These facilities and individuals should follow existing mandatory reporting requirements in their State, in addition to any Federal requirements. Action or inaction on the part of a provider or supplier to follow mandatory reporting requirements does not preclude an employee from fulfilling their individual reporting obligations.

Standards	Evidence Guidelines
HPFC 8.D Per policy and procedure, the hospice responds to alleged violations involving anyone working on the hospice's behalf by: 1. Immediately investigating all alleged violations; 2. Taking immediate action to prevent further potential violations while the alleged violation is being verified; 3. Taking appropriate corrective action in accordance with state law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the state survey agency or local law enforcement agency; 4. Ensuring that verified violations are reported to the state and local bodies having jurisdiction (including the State Survey and Certification Agency) within five (5) working days of becoming aware of the violation. Applicable Regulations: L509-418.52(b)(4)(ii); L510-418.52(b)(4)(iii); L511-418.52(b)(4)(iv).	**Document Review:** Review logs, incident reports, or other documents that would record reports of suspected mistreatment, neglect, or verbal, mental, sexual, or physical abuse. Review records of the investigation, resolution, and response for any reported alleged violation in the most recent 12 months and confirm that the investigation, resolution, and reporting correlate to the policy and state law and regulation. **Guidance:** Most states clearly define actions required for identifying and reporting mistreatment, neglect, or verbal, mental, sexual, or physical abuse. It is expected that the hospice knows and follows state law and regulation.
HPFC 9.D The hospice informs and distributes to the patient written information about its policies on advance directives, including a description of applicable state law. 1. It is the patient's right to formulate an advance directive should she or he wish to do so. *(continued on following page)*	**Document Review**: Review the advance directives policy and procedure, as well as the information provided to the patient. **Clinical Record Review:** The hospice informs and distributes to the patient written information about its policies on advance directives, including a *(continued on following page)*

Standards	Evidence Guidelines
HPFC 9.D 2. The hospice maintains written policies and procedures concerning advance directives with respect to all adult individuals receiving care by or through the hospice. 3. The hospice provides written information to patients about their rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives at the individual's option. 4. The hospice updates and disseminates changes to state law on advance directives no later than 90 days from the effective date. If the hospice cannot implement an advance directive based on conscience, it has a clear statement of any limitations. The statement includes: 1. Clarification of any differences between organization-wide conscience objections and those raised by an individual physician; 2. Identification of the state legal authority permitting such objection; 3. A description of the range of medical conditions or procedures affected by conscience objection. Applicable Regulation: L503-418.52(a)(2).	description of applicable State law. The hospice provides written information to patients about their rights under State law to make decisions concerning medical care including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives at the individual's option. **Guidance:** Advance directives generally refer to written statements or instructions, completed in advance of serious illness, about how an individual wants medical decisions made. The two most common forms of advance directives are a living will and durable medical power of attorney. **Guidance:** If an adult is incapacitated at the time of admission or at the start of care and unable to receive the information or articulate if an advance directive has been executed, the hospice may give advance directive information to the family or surrogate. **Guidance:** If the hospice provides care in a state that has a "death with dignity" law, the hospice has a policy statement of any conscience objection regarding this advance directive. **Tip:** There may be state-specific requirements for advance directives that must be followed.

Standards	Evidence Guidelines
HPFC 10.I The hospice provides information on advance directives upon initiation of hospice care. Whether or not the patient has executed an advance directive is documented in a prominent part of the patient's record. Applicable Regulation: L503-418.52(a)(2).	**Document Review:** Confirm in the patient record whether an advance directive has been executed. **Interview:** Ask an IDG member to explain the process for providing information on advance directives and how they integrate providing the information at the time that hospice care is initiated.

Hospice Assessment, Care Planning and Coordination (HCPC)

KEY PERFORMANCE AREA:

Interdisciplinary Group (IDG) members use effective communication to:

- Facilitate ongoing assessment of patient and family needs;
- Develop and implement a care plan that represents the patient's goals and preferences;
- Support effective coordination of care.

Standards	Evidence Guidelines
HCPC 1.I The hospice designates an Interdisciplinary Group (IDG) composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the patient/family facing terminal illness and bereavement. 1. IDG members provide the care and services offered by the organization. 2. The IDG, in its entirety, supervises the care and services provided to the patient and family. **Applicable Regulations: L536-418.56; L539-418.56(a)(1).**	**Interview:** Ask members of the Interdisciplinary Group how they work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the patients/families. Ask members of the IDG how they supervise the care. **Guidance:** "Supervision" of care can be accomplished by face-to-face or telephonic conferences, evaluations, discussion, and general oversight, as well as by direct observation (per Centers for Medicare and Medicaid Services [CMS]).

Standards	Evidence Guidelines
HCPC 2.D The hospice Interdisciplinary Group includes, but is not limited to, individuals who are qualified and competent to practice in the following professional roles: 1. Doctor of Medicine or Osteopathy (who is an employee or under contract with the hospice); 2. Registered nurse; 3. Social worker; and, 4. Pastoral or other counselor(s). Applicable Regulation: L541-418.56(a)(1)(i); L541-418.56(a)(1)(ii); L541-418.56(a)(1)(iii); L541-418.56(a)(1)(iv).	**Document Review:** Review rosters, resumes, or other documentation reflecting the composition of the IDG. Confirm that members of the IDG represent the professional disciplines in the standard.
HCPC 3.I If the hospice has more than one Interdisciplinary Group, a designated IDG establishes policies governing the day-to-day provision of hospice care and services. Applicable Regulation: L542-418.56(a)(2).	**Interview:** If there is more than one IDG, interview IDG members to determine which IDG has responsibility to establish policies for day-to-operations. **Guidance:** The IDG responsible for policies must include all required disciplines.

Standards	Evidence Guidelines
HCPC 4.I The hospice medical director or physician designee reviews the clinical information for each patient being evaluated for admission and provides written certification that it is anticipated that the patient's life expectancy is six months or less if the illness runs its normal course. The physician considers the following when making this determination: 1. The primary terminal condition; 2. Related diagnosis(es), if any; 3. Current subjective and objective medical findings; 4. Current medication and treatment orders; 5. Information about the medical management of any of the patient's conditions unrelated to the terminal illness. Applicable Regulations: L667-418.102(b)(1); L667-418.102(b)(2); L667-418.102(b)(3); L667-418.102(b)(4); L667-418.102(b)(5); L669-418.102(d).	**Clinical Record Review:** Review patient records confirming that certification of the terminal illness for the Medicare/Medicaid hospice benefit is present. Confirm that the clinical information necessary for certification is in the record. **Interview:** Ask the medical director or physician-designee to describe his/her role in the initial certification and recertification of terminal illness. Also ask his/her understanding of being responsible for the medical component of the hospice patient's care. **Guidance:** Only physicians can certify the terminal condition. Nurse practitioners and physician assistants (PA), while they may take the role of attending physicians, cannot certify terminal illness.
HCPC 5.I The hospice notifies the referral source when hospice care cannot be provided.	**Interview:** Interview one or more individuals responsible for patient intake. Clarify the process of notifying the referral source (and/or ordering or referring physician) if a patient cannot be admitted.

Standards	Evidence Guidelines
HCPC 6.I The hospice medical director or physician-designee provides written and signed recertification of the terminal illness to meet the hospice care benefit requirement. 1. Recertification for the hospice care benefit is informed by the medical director or physician designee's review of the patient's clinical information. 2. Recertification is completed no later than two (2) calendar days after the first day of each benefit period, and no more than fifteen (15) days before the next benefit period begins. Applicable Regulations: L668-418.102(c); L676-418.104(a)(5).	**Clinical Record Review:** Review the patient record of a recertified patient. Validate that the medical director or physician-designee recertification of the terminal illness is present. Validate that the recertification(s) occurred within prescribed timelines. **Guidance:** Only physicians can certify the terminal condition. Nurse practitioners and physician assistants, while they take the role of attending physicians, cannot certify terminal illness.
HCPC 7.I The hospice conducts and documents 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. The assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions. Applicable Regulation: L520-418.54	**Clinical Record Review:** The comprehensive assessment is not mandated to be a specific format. The information must reflect the patient's current health status and include sufficient information to establish and monitor a plan of care.

Standards	Evidence Guidelines
HCPC 8.I The hospice registered nurse completes an initial assessment within 48 hours of the patient's election of hospice care, in accordance with CMS §418.24 (the elements of the hospice care election statement). 1. The physician, patient, or representative may request that the initial hospice assessment be completed in less than 48 hours. **Applicable Regulation: L522-418.54(a).**	**Clinical Record Review:** Verify that the initial assessment was within 48 hours of the patient's hospice election or within the requested or ordered timeframe if less than 48 hours. **Interview:** Interview administrator to verify initial assessment process is in place. **Guidance:** The initial assessment in the patient's home or other residential setting is meant to identify immediate care needs and begin a care plan. A physician order is not required to conduct the initial assessment. **Guidance:** Each organization can define which IDG members, if any, are also involved in the initial assessment with the registered nurse.
HCPC 9.I The hospice Interdisciplinary Group, in consultation with the individual's attending physician (if any), completes an initial comprehensive assessment no later than five (5) calendar days after the election of hospice care, in accordance with CMS §418.24–the elements of the hospice care election statement. **Applicable Regulation: L523-418.54(b).**	**Clinical Record Review:** Confirm that the initial comprehensive assessment was completed no later than five (5) days from the effective date on which the patient signs the hospice election statement. **Interview:** Interview the clinical manager. Verify there is a process for IDG, and physician (if any) to complete an initial assessment. **Guidance:** CMS expectation is that all members (disciplines) of the IDG are involved in completing the comprehensive assessment.

Standards	Evidence Guidelines
HCPC 10.I The comprehensive assessment identifies the physical, psychosocial, emotional, and spiritual needs related to the patient's terminal illness that are addressed to promote the patient's: 1. Well-being; 2. Comfort; 3. Dignity throughout the dying process. Applicable Regulation: L524-418.54(c).	**Clinical Record Review:** The comprehensive assessment identifies the physical (e.g., nausea), psychosocial (e.g., anxiety), emotional (e.g., anticipatory grief), and spiritual needs to be addressed to promote the patient's well-being, comfort, and dignity throughout the care process. **Document Review:** Document review includes a comprehensive assessment that addresses physical, psychosocial, emotional, and spiritual needs related to the patient's terminal illness. **Guidance:** If the patient refuses an assessment from one of the members of the IDG, the assessment is conducted by another qualified member of the IDG.

Standards	Evidence Guidelines
HCPC 11.I The comprehensive assessment includes consideration of the following factors: 1. The nature and condition causing admission, including the presence, or lack of, objective data and subjective complaints; 2. Co-morbid psychiatric diagnosis or history; 3. Complications and risk factors that affect care planning, including risk for drug diversion; 4. Functional status and cognitive status, including the patient's ability to understand and participate in her or his own care; 5. Imminence of death; 6. Symptoms and symptom severity, including: a) Dyspnea, nausea, vomiting, constipation; b) Restlessness, anxiety, emotional distress; c) Sleep disorders; d) Skin integrity; e) Confusion; 7. Bowel regimen when opioids are prescribed; 8. Patient and family support systems; 9. Patient and family need for counseling and education. **Applicable Regulations: L524-418.54(c); L525-418.54(c)(1); L526-418.54(c)(2); L527-418.54(c)(3); L528-418.54(c)(4); L529-418.54(c)(5).**	**Interview:** Ask the IDG how they ensure they have all the information necessary to complete the comprehensive assessment. **Clinical Record Review and Home Visit:** Are the reasons for admission, complications (if any), and risk factors and elements defined in the standard identified and being addressed? Review the comprehensive assessment to assure it is person-centered and individualized to meet the needs of the unique patient.

Standards	Evidence Guidelines
HCPC 12.I The patient's pain is assessed as part of a comprehensive assessment. 1. Assessment of pain in children and adolescents is conducted with consideration of age and neurocognitive development. The documented assessment of the patient's pain includes: 1. History of pain and its treatment, both pharmacological and non-pharmacological; 2. Use of a standardized pain assessment tool appropriate to the patient's developmental and cognitive status; 3. Characteristics of the pain, including: a) Location, frequency, and intensity; b) How pain impacts the patient's ability to engage in usual activities and function (e.g., appetite, sleeping); 4. The patient's/family's goals for pain management and their satisfaction with the current level of pain control. Applicable Regulation: L524-418.54(c).	**Clinical Record Review:** In review of patient records, verify that pain assessments are conducted and documented regularly. Critical to documentation is evidence of the assessment elements and the patient's and family's satisfaction with the pain management. If not satisfied, is there documentation of efforts to achieve the necessary level of pain management and/or to educate the patient and/or family on limitations of pain management?

Standards	Evidence Guidelines
HCPC 13.I The comprehensive assessment includes 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 is incorporated into the plan of care and considered in the bereavement plan of care. *Applicable Regulation: L531-418.54(c)(7).*	**Clinical Record Review:** Is there evidence of an initial bereavement assessment? Are issues identified that would be included in the care plan? Review documentation of other resources (e.g., organizations, group therapy, programs, etc.) provided to the patient family/caregiver. **Interview:** Ask IDG members how the need for referrals and further evaluation by appropriate health professionals is determined. **Guidance:** Prior to the patient's death, the hospice is assessing grief/loss issues of the patient's family. These are identified as risk issues in the initial care plan and are assessed in ongoing assessments. **Guidance:** Bereavement services may be offered prior to the death when a comprehensive assessment (initial or ongoing) identifies the need. **Tip:** Factors that may affect the ability to cope with the patient's death include family problems; communication issues; financial concerns; drug and alcohol abuse; mental health issues; feelings of despair, anger, guilt, or abandonment; or the presence or absence of a support system.

Standards	Evidence Guidelines
HCPC 14.I The comprehensive assessment includes the patient's or family's need for referrals and further evaluation by appropriate health professionals. *Applicable Regulation: L532-418.54(c)(8).*	**Interview:** Ask the IDG how they determine the need to refer a patient or family member(s) to appropriate health professionals for further evaluation (e.g., psychiatrist for mental health needs). **Clinical Record Review:** The comprehensive assessment includes the patient or family's need for referrals and further evaluation by appropriate health professionals.
HCPC 15.I The documented comprehensive assessment includes a drug profile that contains the patient's current: 1. Prescription and over-the-counter (OTC) drugs; Supplements; 2. Herbal remedies; 3. Other alternative treatments that could affect drug therapy. The medication review process includes the identification of the following: 1. The effectiveness of drug therapy; 2. Drug side effects; 3. Actual or potential drug interactions; 4. Duplicate drug therapy; 5. Drug therapy associated with laboratory monitoring. The assessment includes evidence that common side effects of medication in the hospice populations are anticipated, and as appropriate, preventive measurements are implemented to manage the side effects. *(continued on following page)*	**Clinical Record Review:** Evidence that common side effects of medication are anticipated (e.g., constipation with opioids) and preventive measures implemented (e.g., bowel regimen). Evidence that the drug profile is updated and elements #1-5 of the medication review are repeated and documented with each comprehensive assessment and/or when medications are added or changed. **Interview:** Ask the IDG to describe their process of medication review and drug profile update. **Observation - Home Visit:** Ask the patient or caregiver what prescriptions, OTC drugs, and/or herbal remedies are currently being taken and compare with the medication in the care plan. **Tip:** The hospice considers both the use of pharmacological and non- *(continued on following page)*

Standards	Evidence Guidelines
HCPC 15.I The drug profile is updated per the hospice policy and procedure, but, at minimum, at the time of each comprehensive assessment and/or when new medication is added or changes are made to existing medication. Applicable Regulations: L530-418.54(c)(6)(i); L530-418.54(c)(6)(ii); L530-418.54(c)(6)(iii); L530-418.54(c)(6)(iv); L530-418.54(c)(6)(v).	pharmacological intervention in promoting the patient's comfort level and sense of well-being, based on the assessment of patient needs and desires.
HCPC 16.I The comprehensive assessment includes data elements that allow for the measurement of outcomes. The hospice measures and documents data in the same way for all patients. The data elements: 1. Take into consideration aspects of the care related to hospice and palliation; 2. Are documented in a systematic and retrievable way for each patient; 3. Are used for each patient in individualized care planning and coordination of services; 4. Are used in the aggregate for the hospice's quality assurance and performance improvement (QAPI) program. Applicable Regulations: L534-418.54(e)(1); L535-418.54(e)(2).	**Interview:** Ask the IDG: a) which data elements are standardized in the assessments; b) how these are used in measuring outcomes related to palliation and hospice; and c) how they are used in care planning and coordination. **Document Review:** Ask to see a copy of the data elements in the comprehensive assessment. **Guidance:** Examples of data elements related to outcomes include pain level after treatment, dyspnea, nausea, depression screen, etc.

Standards	Evidence Guidelines
HCPC 17.I The update of the comprehensive assessment is completed by the hospice Interdisciplinary Group, who, in collaboration with the individual's attending physician, if any, consider the changes that have taken place since the initial assessment. The update of the comprehensive assessment includes: 1. Information on the patient's progress toward desired outcomes; 2. Reassessment of the patient's response to care. The assessment update is completed: 1. As frequently as the condition of the patient requires; 2. No less frequently than every 15 days. Applicable Regulation: L533-418.54(d).	**Clinical Record Review:** There is evidence of the patient's current response to care, treatment, and services provided as well as the patient's progress toward outcomes, to ensure the most current information is used to make care planning decisions. In reviewing the notes, is the most current information in the update? The clinical record reflects regular assessments for pain, symptom management to include spiritual and psychosocial needs. Confirm that each update is completed no later than 15 days from the previous one. **Interview:** Ask the IDG what constitutes a change in patient condition sufficient to support an update to the comprehensive assessment. **Guidance:** The hospice may select its own way to update a comprehensive assessment. Hospices are not required to update the assessment in full.

Standards	Evidence Guidelines
HCPC 18.I The hospice designates an Interdisciplinary Group or groups who, in consultation with the patient's attending physician, prepare a written plan of care (POC) for each patient. The plan of care specifies the hospice care and services necessary to meet the specific needs of the patient and family identified in the comprehensive assessment, relative to the terminal illness and associated conditions. *Applicable Regulations: L536-418.56*	**Clinical Record Review:** There is evidence of a link between the needs identified in the comprehensive assessment(s) and the plan of care. **Interview:** Ask the IDG how they ensure the POC is developed with the participation of all the IDG. How do they involve the attending physician, if there is one? **Guidance:** Hospices are responsible for including services and treatments in the POC that address the specific needs related to the terminal illness and associated conditions.
HCPC 19.I The hospice designates a registered nurse member of the IDG to: 1. Provide coordination of care; 2. Ensure continuous assessment of each patient's and family's needs; 3. Ensure the implementation of the interdisciplinary plan of care. Hospice care and services provided to patients and families follow the individualized plan of care established by: 1. The hospice IDG in collaboration with the attending physician (if any); 2. The patient or patient representative; 3. The primary caregiver in accordance with the patient's needs. *Applicable Regulations: L540-418.56(a)(1); L543-418.56(b).*	**Interview:** Ask the administrator to identify the designated RN(s) who acts as the coordinator. **Interview:** Ask one or more RN coordinators how they ensure coordination of care and continuous assessment of the patient/family needs among the members of the IDG. **Interview:** Ask an IDG member how they are kept informed of the patient/family status and the need for any further assessment. **Clinical Record Review:** Is there evidence that the POC was established with the patient, their representative as indicated, and the primary caregiver?

Standards	Evidence Guidelines
HCPC 20.I The hospice ensures that each patient and the primary caregiver(s) receive education and training, provided by the hospice, as appropriate to their responsibilities for care as stated in the plan of care. Applicable Regulation: L544-418.56(b).	**Clinical Record Review:** In the review of the patient's plan of care, is there reference to the patient's— and/or primary caregiver's— responsibilities for care? If so, is there evidence of education and training provided by the hospice to support their role (e.g., timely medication administration, etc.)?

Standards	Evidence Guidelines
HCPC 21.I Each patient's individualized written plan of care: 1. Reflects patient and family goals; 2. Identifies planned interventions based on problems identified in the initial and updated comprehensive assessments; 3. Includes all services necessary for the palliation and management of the terminal illness, including the following: a) Intervention to manage pain and symptoms; b) A detailed statement of the scope and frequency of services necessary to meet specific patient and family needs; c) Measureable outcomes anticipated from implementing and coordinating the plan of care; d) Drugs and treatment necessary to meet the needs of the patient; e) Medical supplies and appliances necessary to meet the needs of the patient; 4. Includes the Interdisciplinary Group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the POC; a) The documentation in the patient's record is in accordance with the hospice's policies and procedure. **Applicable Regulations: L545-418.56(c); L546-418.56(c)(1); L547-418.56(c)(2); L548-418.56(c)(3); L549-418.56(c)(4); L550-418.56(c)(5); L551-418.56(c)(6).**	**Clinical Record Review:** Upon review of the assessments, is the plan of care individualized and patient specific? **Document Review:** Review the policy delineating how, where, and when the IDG documents the patient's or representative's understanding, involvement, and agreement with the plan of care. Does the plan of care include all the elements of the standard? **Observation - Home Visit:** Verify if the current comprehensive assessment and plan of care accurately reflect the patient's status. Review the prescriptions and over-the-counter medications, herbal remedies, and other alternative treatments with the patient or caregiver and compare your findings with the drug profile in the patient's plan of care. **Interview - Patient/Caregiver:** Determine the patient's understanding of the purpose of the hospice services, and if they had input into setting the goals or objectives that were established for their care.

Standards	Evidence Guidelines
HCPC 22.I The Interdisciplinary Group, in collaboration with the individual's attending physician (if any), reviews, revises, and documents the individualized care plan: 1. As frequently as the patient's condition requires; but 2. No less frequently than every 15 calendar days. A revised plan of care includes: 1. Information from the patient's updated comprehensive assessment; 2. Record of the patient's progress toward the outcomes and goals specified in the plan of care. **Applicable Regulations: L552-418.56(d); L553-418.56(d).**	**Clinical Record Review:** Review plans of care. Confirm that the documentation includes: a) documentation of collaboration with the attending physician, if any; b) evidence of review if the patient's condition changes and revision is necessary; and c) review at least every 15 days. If a POC has been revised, ensure that it addresses the two elements required.

Standards	Evidence Guidelines
HCPC 23.D The hospice's policies and procedures define a system of communication and integration that sustains coordination of services and provides documentation of exchange of information. The policies and procedures ensure that: 1. The Interdisciplinary Group maintains responsibility for directing, coordinating, and supervising the care and services provided; 2. Care and services provided are in accordance with the plan of care; 3. Care and services provided are based on all assessments of the patient and family needs; 4. Sharing of information occurs between all disciplines providing care and services in all settings and is ongoing whether or not the care and services are provided directly or under arrangement; 5. Sharing of information occurs and is ongoing with other non-hospice healthcare providers providing services unrelated to the terminal illness and related conditions. Applicable Regulations: L554-418.56(e)(1); L555-418.56(e)(2); L556-418.56(e)(3); L557-418.56(e)(4); L558-418.56(e)(5).	**Document Review:** Review the system in place per policy and procedure to facilitate exchange of information and coordinate services among staff and with other non-hospice providers. **Interview:** Interview the hospice clinical manager to determine how the hospice ensures that coordination of services occurs between contracted staff and hospice employees. **Clinical Record Review:** Confirm that there is documentation in the patient record of sharing information between disciplines and with other healthcare providers providing services. Review documentation for missed visits communication with patient/family. if a pattern of missed visits by any discipline is identified, is there a mechanism in place to capture? Confirm that the patient receives the appropriate level of care, for example, does the hospice offer continuous home care for symptom management when indicated?

Hospice Care Delivery and Treatment (HCDT)

KEY PERFORMANCE AREA:

Care delivery and treatment are provided according to the patient's and family's needs and preferences, the hospice plan of care, and accepted standards of practice. The delivery of hospice care parallels the trajectory of the patient's illness and the changing needs of the patient and family.

Standards	Evidence Guidelines
HCDT 1.I The hospice is primarily engaged in providing the following care and services in a manner consistent with accepted standards of practice: 1. Nursing services; 2. Medical social services; 3. Physician services; 4. Hospice aide, volunteer, and homemaker services; 5. Physical therapy, occupational therapy, and speech-language pathology services; 6. Short-term inpatient care; 7. Counseling services, including spiritual counseling, bereavement counseling, and dietary counseling; 8. Medical supplies (including drugs and biologicals) and medical appliances related to the palliation and management of the terminal illness and related conditions as identified in the care plan. **Applicable Regulations: L652-418.100(c)(1); L686-418.106.**	**Document Review:** Review documents that describe the services that the hospice provides. Confirm that services are provided as required by the standard. **Interview:** How does the hospice introduce the availability of all hospice team members? **Guidance:** Drugs and supplies related to palliative management of the terminal illness and related conditions are provided while the patient is under hospice care.

Standards	Evidence Guidelines
HCDT 2.I Consistent with current professional standards of practice, licensed professionals actively participate in the coordination of all aspects of patient care including: 1. Conducting ongoing interdisciplinary comprehensive assessments; 2. Developing and evaluating the plan of care; 3. Contributing to patient and family counseling and education. Hospice "core" services are substantially provided directly by hospice employees in a manner consistent with acceptable standards of practice. 1. "Core" services include nursing services, medical social work, and counseling. 2. The hospice may contract for physician services per standard HCDT 5.I in this chapter. **Applicable Regulations: L585-418.62(b); L587-418.64.**	**Document Review:** Confirm that hospice "core" services (nursing services, medical social work, and counseling) are provided directly by hospice employees. **Interview:** Ask the administrator if there have been—or are—circumstances in which they contract for core services. If so, ask the reason why and does that reason fall within the provisions of the standard. **Clinical Record Review:** Does documentation reflect that licensed professionals coordinate all aspects of patient care including conducting ongoing interdisciplinary comprehensive assessments; developing and evaluating the plan of care; and contributing to patient and family counseling and education?

Standards	Evidence Guidelines
HCDT 3.I The hospice may use contracted staff, if necessary, to supplement hospice employees to meet the needs of patients under extraordinary or other non-routine circumstances that include: 1. Unanticipated periods of high patient loads; 2. Staffing shortages due to illness or other short-term temporary situations that interrupt patient care; 3. Temporary travel of a patient outside of the hospice's service area. The hospice may also supplement their hospice employees/staff by entering into a written agreement with another Medicare-certified hospice program for the provision of core services to meet the needs of patients. Applicable Regulation: L587-418.64.	**Interview:** Establish with the administrator and other Interdisciplinary Group members if they have contracted—or do contract—for "core" services in extraordinary circumstances. If "yes," ask for evidence of the reasons for the contract, what is the duration of the contract, and how did they know the staff were qualified. **Tip:** Review the definition of "employee" per Centers for Medicare & Medicaid Services (CMS) hospice regulation in the "Key Terms" section of this manual.

Standards	Evidence Guidelines
HCDT 4.I Hospice nursing services, physician services, drugs and biologicals are made routinely available on a 24-hour basis, seven (7) days per week. 1. All covered services are available on a 24-hour basis when reasonable and necessary to meet the needs of the patient and family. Applicable Regulation: L653-418.100(c)(2).	**Contract Review:** If these services are provided under contract, review any contracts. Validate that these services are made available on a 24-hour basis, seven (7) days a week, 365 days/year as well as the availability of the other IDG services on a 24/7 basis. **Interview:** Speak with the administrator and/or IDG members to verify that nursing services, physician services, and drugs and biologicals are made routinely available on a 24-hour basis, seven (7) days a week. **Clinical Record Review:** Verify that hospice nursing services, physician services, and drugs and biologicals are made routinely available on a 24-hour basis, 7 days a week. **Tip:** A biological is any medicinal preparation made from living organisms and their products, including serums, vaccines, antigens, and antitoxins.

Standards	Evidence Guidelines
HCDT 5.I The hospice medical director, physician employees, and contracted physician(s), in conjunction with the patient's attending physician, are responsible for the palliation and management of the terminal illness as well as conditions related to the terminal illness. 1. All physician employees, and those under contract, must function under the supervision of the hospice medical director. 2. Hospice physician employees, and those physicians under contract, meet the requirement by either providing the services directly or through coordinating patient care with the attending physician. 3. If the attending physician is unavailable, the medical director, contracted physician, and/or hospice physician employee is responsible for meeting the medical needs of the patient. **Applicable Regulations: L590-418.64(a); L590-418.64(a)(1); L590-418.64(a)(2); L590-418.64(a)(3); L664-418.102;**	**Clinical Record Review:** Is there evidence that the palliation and medical management needs of the patient are being met consistently? **Interview:** Interview the hospice medical director and ask how they coordinate with the patient's attending physician to meet the palliation and medical management needs of the patient. Confirm that the medical director is responsible for supervising and coordinating entities that comprise the medical component of the hospice's patient care program. **Interview:** Ask other members of the IDG (especially team members on-call) how the medical needs of the patient are met when the patient's attending or primary physician or hospice medical director is not available. **Guidance:** The medical director may also serve as the physician member of the Interdisciplinary Group.

Standards	Evidence Guidelines
HCDT 6.I Nursing care and services are provided by or under the supervision of a registered nurse and per the patient plan of care. 1. Nursing services ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and any updated assessments. Applicable Regulation: L591-418.64(b)(1).	**Clinical Record Review:** Ensure that identified nursing needs are met, with emphasis on assessment and management of pain and other physical symptoms.
HCDT 7.D Highly specialized nursing services that are provided so infrequently that the provision of such services by direct hospice employees would be impracticable and prohibitively expensive may be provided under contract. Applicable Regulation: L593-418.64(b)(3).	**Interview:** Ask the administrator if such contracts are used. If so, how do they monitor the quality of those services? The contract should meet the same requirements as other contracted services. **Guidance:** CMS considers highly specialized nursing services to include complex wound care and infusion specialties due to the level of nursing skill required or nursing services for specified patient populations such as a pediatric nurse when the hospice rarely cares for pediatric patients. **Guidance:** Continuous home care is not considered a highly specialized service.

Standards	Evidence Guidelines
HCDT 8.D **Nursing Services – Waiver of requirement that substantially all nursing services be routinely provided by a hospice.** CMS may waive the requirement that a hospice provide nursing services directly for one year if the hospice can provide the following evidence to CMS: 1. The location of the hospice's central office is in a non-urbanized area as determined by the Census Bureau; 2. The hospice has made and can provide evidence that a good faith effort has been made to hire a sufficient number of nurses to provide services. **Applicable Regulations: L599-418.66; L600-418.66(a); L600-418.66(a)(1); L600-418.66(a)(2); L600-418.66(a)(3); L600-418.66(b); L600-418.66(c); L600-418.66(d).**	**Interview:** If a waiver has been applied for, ask the administrator for evidence of the waiver. **Guidance:** Questions concerning a waiver should be directed to the CMS Regional Office.

Standards	Evidence Guidelines
HCDT 9.I Medical social services are provided: 1. Based on a psychosocial assessment; 2. According to the patient's and family's needs and acceptance of these services; 3. Per the plan of care; 4. Under the direction of a physician. The psychosocial assessment addresses: 1. The patient's and the family's adjustment to the terminal illness; 2. The social and emotional factors related to the terminal illness; 3. The presence or absence of adequate coping mechanisms; 4. Family dynamics and communication patterns; 5. Financial resources and any constraints; 6. The caregiver's ability to function effectively; 7. Obstacles and risk factors that may affect compliance with the plan of care; 8. Family support systems to facilitate coping with end-of-life issues. The psychosocial assessment is revised as new information is acquired and as progress toward goals is made. *Applicable Regulation: L594-418.64(c).*	**Clinical Record Review:** Is there evidence that each patient receives social work services unless specifically refused? Refusal is documented. **Interview:** How does the hospice introduce and offer medical social work services to the patient and family? **Interview:** Ask the social worker to describe the factors included in the psychosocial assessment and how the information is used in care planning to benefit the patient/family. **Guidance:** Hospice medical social services included in the physician-approved plan of care satisfy the Medicare requirement for physician direction. **Guidance:** The psychosocial assessment identifies issues that impede or facilitate the patient's treatment and what is needed to assist the patient and family in reaching the maximum benefit from hospice care. The psychosocial assessment can also include the bereavement risk assessment. **Guidance:** When the social worker is refused by the patient and/or family, do other IDG members address the elements of a psychosocial assessment? Is patient and family's openness to the social worker's intervention reassessed?

Standards	Evidence Guidelines
HCDT 10.I Counseling services are available to the patient and family to assist in minimizing the stress and problems that arise from the terminal illness, related conditions, and the dying process. Applicable Regulation: L595-418.64(d).	**Clinical Record Review:** Is there evidence that the hospice has offered spiritual counseling? If services are refused, it is documented.
HCDT 11.I Counseling services include spiritual counseling. The hospice provides an assessment of the patient's and family's spiritual needs. Spiritual counseling to meet spiritual needs is provided in accordance with the patient's and family's acceptance of the services and in a manner consistent with the patient and family beliefs and desires. The hospice advises the patient and family of spiritual counseling services and documents the acceptance or refusal of services. The hospice also makes all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or others who can support the patient's spiritual needs. Applicable Regulations: L598-418.64(d)(3)(i); L598-418.64(d)(3)(ii); L598-418.64(d)(3)(iii); L598-418.64(d)(3)(iv).	**Clinical Record Review:** Verify that the hospice has offered and/or provided spiritual counseling in accordance with the patient/family's desires. Refusal is documented. **Interviews and Home Visit:** Ask IDG members and patients how the hospice addresses the spiritual needs/concerns of the patient and family. How does the hospice introduce the availability of spiritual counseling? **Guidance:** Spiritual services under the Medicare hospice benefit are considered counseling services made available to reduce stress and problems that arise from terminal illness, related conditions, and the dying process. **Guidance:** If the patient and family refuse spiritual counseling, the other IDG team members assess spiritual needs as able and seek the spiritual counselor's assistance at IDG meetings.

Standards	Evidence Guidelines
HCDT 12.I Counseling services include dietary counseling, when identified in the plan of care. Dietary counseling is provided by a qualified individual, which includes dietitians as well as nurses and other individuals who can address and ensure that the dietary needs of the patient are met. Applicable Regulation: L597-418.64(d)(2).	**Clinical Record Review:** Verify evidence of addressing patient dietary needs. **Interview:** Ask how the IDG meets the dietary needs of patients, such as problematic enteral feedings or nutritional issues related to dying. **Guidance:** Dietary counseling may be provided by a registered nurse if she or he can meet the patient's needs. If the need exceeds the nurse's expertise, the organization has access to an appropriately qualified individual. **Guidance:** As dietary counseling is a "core" service, it must be provided by an employee.
HCDT 13.I A hospice ensures that "non-core" services are available and provided directly by the hospice or under arrangement. The following "non-core" services are provided in a manner consistent with current standards of practice: 1. Physical therapy; 2. Occupational therapy; 3. Speech-language pathology services; Applicable Regulations: L601-418.70; L603-418.70.	**Interview:** Ask how the hospice monitors the professional skills of non-core services that are made available to patients. How do they know that the rehabilitation therapists, for example, understand their role in hospice care? **Interview:** Ask hospice Interdisciplinary Group members how they know that staff providing non-core services follow professional standards of practice, hospice policies and procedures, and know whom on the IDG to contact if an issue arises.

Standards	Evidence Guidelines
HCDT 14.I A hospice located in a non-urbanized area may submit a written request for a waiver of the requirement for providing physical therapy, occupational therapy, speech-language pathology, and dietary counseling services. See CMS §418.74(a)(1-2)(a-c) for specifics regarding the waiver qualification and request process. **Applicable Regulations: L603-418.72; L605-418.74; L606-418.74(a).**	**Document Review:** Review documents that describe the services that the hospice provides and has access to. Validate that services are available as required by the standard. **Interview:** Ask the IDG members how they address home safety assessments, training in the use of adaptive equipment, or caregiver instruction in the use of good body mechanics for turning and lifting patients. Do they have access to and use PT, OT, and SLT when patient need is appropriate to these disciplines' skill sets? **Clinical Record Review:** Validate that therapy services were provided according to the plan of care.
HCDT 15.I Hospice aides are assigned to a specific patient by a registered nurse who is a member of the Interdisciplinary Group. 1. Written patient care instructions for a hospice aide are prepared by a RN who is responsible for the supervision of the hospice aide. **Applicable Regulation: L625-418.76(g)(1).**	**Clinical Record Review:** When hospice aide services are included in the plan of care, verify that aides are assigned by a registered nurse who is a member of the IDG. Confirm that hospice aide patient care instructions are written by the registered nurse who is responsible for the supervision of the aide.

Standards	Evidence Guidelines
HCDT 16.I A hospice aide provides services: 1. Ordered by the Interdisciplinary Group; 2. Included in the plan of care; 3. Permitted to be performed under state law and regulation; 4. Consistent with the hospice aide training. **Applicable Regulations: L607-418.76; L626-418.76(g)(2)(i); L626-418.76(g)(2)(ii); L626-418.76(g)(2)(iii); L626-418.76(g)(2)(iv).**	**Clinical Record Review:** When hospice aide services are provided, confirm that the services meet the elements of the standard: • The frequency and duration of the aide visits are the same as in the plan of care. • Aide services provided are consistent with the plan of care. **Observation – Home Visit:** During a home visit, ask the patient and/or family to verify that aide visits and tasks occur at the frequency in the plan of care; that the patient feels that the hospice aide is respectful of them and their property; and if the patient is aware of the aide's visit schedule, if the visits are made as scheduled, and if the hospice communicates any changes to that schedule in advance.

Standards	Evidence Guidelines
HCDT 17.I Hospice aide services include: 1. Providing hands-on personal care; 2. Performing simple procedures as an extension of therapy or nursing services; 3. Assisting in ambulation or exercises; 4. Assisting in administering medications that are ordinarily self-administered. *Applicable Regulation: L627-418.76(g)(3).*	**Clinical Record Review:** Do hospice aide services correspond to the standard? When reviewing the plan of care, does it include aide services? If so, does the hospice aide's documentation reflect services as on the POC? **Guidance:** If state or local law and regulation prohibit hospice aides from administering medications, they cannot do so. If it is within the scope of law and regulation, it is the hospice's choice to have aides perform this task. Also, the hospice must provide aide training in medication administration and ensure the aide is competent in this task before being assigned to a patient.
HCDT 18.I Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and/or social needs to a registered nurse as the changes relate to the plan of care and any quality assessment and improvement activities. The hospice aide must also complete appropriate records of service, including the report of changes in the patient's needs. Hospice aide documentation complies with hospice policies and procedures. *Applicable Regulation: L628–418.76(g)(4).*	**Interview:** Ask the Interdisciplinary Group nurses about the responsibility of the aides to report changes in the patient's medical condition, mental condition, and/or social needs to the RN. Does it occur regularly? **Observation - Home Visit:** If the patient is receiving aide services, ask the patient or staff accompanying you about any recent changes and if the aide reported these. **Clinical Record Review:** Does the documentation reflect reporting of any changes to an RN?

Standards	Evidence Guidelines
HCDT 19.I Homemakers provide environmental support that is coordinated by a member of the Interdisciplinary Group. Homemakers report all concerns about the patient or family to the IDG member coordinating homemaker services. *Applicable Regulations: L607-418.76; L638-418.76(k)(1); L639-418.76(k)(2); L640-418.76(k)(3).*	**Clinical Record Review:** If homemaker services are provided, confirm that there are written instructions for duties to be performed and any noted changes in the patient or family are reported to the coordinating IDG team member. **Interview:** Ask the IDG team coordinator how patients are selected to receive homemaker services and which member(s) of the IDG is responsible for the coordination and supervision of homemaker services. **Guidance:** Environmental support services can also be provided by a hospice aide.
HCDT 20.I Patients who are dually eligible for Medicare and Medicaid can receive personal care and homemaker services under the Medicaid benefit to the extent that the hospice would routinely use the services of a hospice patient's family in implementing a patient's plan of care. The hospice coordinates the hospice aide and homemaker services with the Medicaid personal care benefit to ensure the patient receives the hospice aide and homemaker services they need. *Applicable Regulations: L635-418.76(i)(2); L636-418.76(i)(3).*	**Interview:** Ask the IDG nurse coordinator if they utilize the patient's Medicaid eligibility to provide needed aide services. **Clinical Record Review:** Is there coordination of the hospice aide and homemaker services with the Medicaid personal care benefit to ensure the patient receives the hospice aide and homemaker services they need?

Standards	Evidence Guidelines
HCDT 21.I Volunteers are used in day-to-day administrative and/or direct patient care roles. Volunteer services provided to patients/families are in a defined role and under the supervision of a designated hospice employee. Volunteer services are: 1. Noted in the plan of care; 2. Documented in the patient record, including the time spent. *Applicable Regulations: L641-418.78; L644-418.78(b); L647-418.78(e).*	**Interview:** Ask the staff responsible for volunteers if they provide services to patients/families. If so, what type of services? **Interview:** Ask an IDG member how the patient and family's need for a volunteer is assessed. **Observation - Home Visit:** Verify the patient was offered and if desired, provided volunteer services. **Clinical Record Review:** Review patient records of patients/families receiving volunteer services. Confirm the volunteer services are documented, including time spent. **Guidance:** Volunteers may assist patients and families with household chores, such as shopping and transportation, and provide professional services if the individual meets the requirements associated with their discipline. **Guidance:** Volunteers are considered hospice employees for the purposes of complying with the core services requirement.

Standards	Evidence Guidelines
HCDT 22.I Counseling services include an organized program for providing bereavement services delivered by or under the supervision of a qualified professional with experience or education in grief or loss counseling. Bereavement services are available to the family and other individuals up to one (1) year following the death of the patient. Bereavement counseling extends to residents of a SNF/NF (skilled nursing facility/nursing facility) or ICF/IDF (intermediate care facility/intellectual disability facility) when appropriate and identified in the bereavement plan of care. The bereavement services reflect the needs of the bereaved per a bereavement plan of care that includes: 1. The types of bereavement services to be offered; 2. The frequency of service delivery. **Applicable Regulation: L596-418.64(d)(1)(i); L596-418.64(d)(1)(ii); L596-418.64(d)(1)(iii); L596-418.64(d)(1)(iv).**	**Clinical Record Review:** Select and review 2-4 bereavement plans of care from a list of patients who died in the past 12 months. Did they match the plan of care? Was each offered within the timeframe? Did the services reflect the needs of the bereaved based on the comprehensive assessment? **Interview:** Ask the IDG team how and when they incorporate the bereavement assessment into the comprehensive assessment. Ask the IDG what services the hospice provides to reflect the bereavement needs of the family. **Interview:** Interview the bereavement counselor to identify what grief assessments, surveys, questionnaires are utilized to screen bereavement needs of the patient and family/caregiver. **Guidance:** The bereavement services supervisor may be the IDG social worker or other professional with documented evidence/education in grief or loss counseling.

Standards	Evidence Guidelines
HCDT 23.D Complementary and alternative medicine (CAM) services are available per organizational policy and procedure that includes how preferred CAM providers are selected and how the Interdisciplinary Group provides oversight.	**Interview:** Does the hospice offer complementary or alternative medicine services? **Document Review:** If yes, ask to view the policies and procedures that describe available CAM services, how providers are selected to deliver services, who on the IDG provides oversight, and how these services are integrated into the plan of care. **Tip:** Complementary and alternative medicine (or complementary and integrative medicine) is used to manage pain and other symptoms and may include acupuncture, herbal treatments, movement therapy, massage, or aromatherapy. **Tip:** Consider medical marijuana as a CAM in states that do not require a prescription. The hospice is encouraged to have a policy about medical marijuana use.
HCDT 24.I CAM services—including the provider, type, frequency and duration of services—are noted in the plan of care. 1. Services are provided in accordance with the plan of care. 2. Services are documented in the patient record.	**Clinical Record Review:** If CAM services are provided, are they provided and documented per the plan of care? **Interview:** Ask the IDG about the use of CAM services and how these services are integrated into the plan of care.

Standards	Evidence Guidelines
HCDT 25.D When remote monitoring or telemonitoring equipment is provided to patients by the hospice, policies and procedures address: 1. Types of remote monitoring or telemonitoring available and equipment used; 2. Patient eligibility inclusion and exclusion criteria, including criteria for the discontinuation of services; 3. Patient and family education in the equipment's role in care delivery and its operation per manufacturer's guidelines; 4. How, and by whom, equipment is delivered, set-up, and tested upon initial use, as well as placement for privacy per patient preference; 5. Who provides equipment troubleshooting and replacement and how; 6. What data is collected and how it is integrated into care including: a) The scope and frequency of data collected; b) How and when findings are shared and with whom; 7. How, and who, transports used equipment from the home; 8. How storage of clean and dirty equipment is handled at the hospice's location.	**Interview:** Does the hospice provide remote monitoring or telemonitoring as part of patient care? **Document Review:** If "yes," review policies, procedures, and other documents related to remote monitoring equipment. Validate that the documents address the requirements of the standard. **Guidance:** Remote monitoring or telemonitoring refers to the use of technology to collect and transmit patient data for the purposes of monitoring and managing the patient's condition.

Standards	Evidence Guidelines
HCDT 26.I Medical supplies and appliances related to the palliation and management of the patient's terminal illness and related conditions are: 1. Identified in the plan of care; 2. Checked for expiration dates; 3. Provided to a patient while under the care of the hospice. **Applicable Regulations: L686-418.106.**	**Clinical Record Review:** Request a patient record in which medical supplies or appliances are provided. Confirm that these are noted in the plan of care and can be identified as provided. **Interview:** Ask members of the IDG how patients needing medical supplies are identified, how the type(s) is identified, how it is included in the plan of care, and how provision is verified. **Observation - Home Visit:** If the patient receives any supplies or appliances through the hospice, verify that equipment is provided timely and not expired. **Guidance:** Medicare medical supplies and appliances include dressings; splints, casts or other devices for reduction of fractures or dislocations; prosthetic devices, including colostomy bags and supplies; braces, etc., per §410.36.

Standards	Evidence Guidelines
HCDT 27.I Durable medical equipment (DME) related to the palliation and management of the patient's terminal illness and related conditions is: 1. Identified in the plan of care; 2. Provided to a patient while under the care of the hospice. *Applicable Regulations: L686-418.106.*	**Clinical Record Review:** Request a patient record in which durable medical equipment is provided. Confirm that these are noted in the plan of care and can be identified as provided. **Interview:** Ask members of the IDG how patients needing DME are identified, how the type(s) of medical equipment is identified, how it is included in the plan of care, and how provision and ongoing need is verified. **Observation - Home Visit:** Durable Medical Equipment is provided to the patient as needed and is in good working order. **Guidance:** DME medical supplies include hospital bed, wheelchairs, etc., per §410.38.

Standards	Evidence Guidelines
HCDT 28.I The Interdisciplinary Group ensures instruction of the patient, as appropriate, and the family and/or other caregivers on the proper handling, storage, and safe utilization of durable medical equipment and/or supplies. 1. Persons under contract with the hospice may instruct the patient and/or family. 2. Instruction is documented in the patient record. The patient, family and/or other caregiver must be able to demonstrate the appropriate use of the DME to the satisfaction of the IDG. 1. The IDG documents that the patient, family, and/or caregivers can demonstrate appropriate use. Applicable Regulation: L702-418.106(f)(2).	**Clinical Record Review:** Validate instruction on equipment and that a member of the IDG confirms that the patient, family, and/or caregivers can use it appropriately. **Interview:** Ask a member of the IDG who provides instruction on the appropriate use of DME and supplies. Also ask how it is documented, who on the IDG ensures that they know how to use it appropriately, and who documents that in the patient record. **Interview:** Ask if the patient/family had any problems with the equipment. Does the DME function as required and intended? Clinical record documentation should verify/support their responses. **Observation - Home Visit:** As applicable, is the patient/family/caregiver able to demonstrate appropriate use of DME?

Standards	Evidence Guidelines
HCDT 29.I Drugs and biologicals related to the palliation and management of the terminal illness and related conditions are: 1. Identified in the plan of care; 2. Provided to a patient while under the care of the hospice. *Applicable Regulations: L686-418.106.*	**Clinical Record Review:** Confirm drugs are noted in the plan of care and, if so, that there is evidence that drugs were provided. **Interview:** Ask members of the IDG how drugs and biologicals provided are ensured to be included in the plan of care, including refills or changes. **Guidance:** Biologics or biological products are medical products made from natural sources used to treat medical conditions, per the Food and Drug Administration (FDA).
HCDT 30.I Drugs and biologicals related to the palliation and management of the terminal illness and related conditions are routinely available on some 24-hour basis/7 days a week. *Applicable Regulation: L653-418.100(c)(2).*	**Interview:** Interview an IDG member who has oversight of the organization's medication and biologics availability. How does he/she ensure 24/7 access? **Document Review:** In review of complaint logs, is there any reference to lack of accessibility of needed drugs or biologicals? **Observation - Home Visit:** On a home visit, interview the patient. Verify that the patient receives drugs and biologicals in a timely manner.

Standards	Evidence Guidelines
HCDT 31.I Drugs and biologicals are labeled and stored in accordance with state law and regulation, as well as accepted standards of practice. At a minimum, labels include: 1. The patient's full name; 2. Generic, trade, or brand name of the medication, as well as amount dispensed; 3. Directions for use, including route, rate, frequency, and method of administration; 4. Prescriber's name; 5. Expiration date; 6. Cautionary instructions. Applicable Regulation: L693-418.106(e)(1).	**Observation – Home Visit:** Inspect prescription containers to verify that each container is labeled as per law and regulation and includes, at a minimum, the elements of the standard. **Guidance:** The intent of the standard is what system the hospice uses to ensure: • The right person has the right drug; • Drugs and biologicals in stock, or provided to patients, are not outdated, mislabeled or otherwise unusable; • Whether the items are provided directly or under contract with another organization.

Standards	Evidence Guidelines
HCDT 32.I Only a physician or a nurse practitioner, or a physician assistant (who is the patient's attending physician and not an employee of or under arrangement with the hospice) in accordance with the plan of care and state law, may order drugs for the patient. If the drug order is verbal or given by or through electronic transmission: 1. It is given only to a licensed nurse, nurse practitioner (where appropriate), pharmacist or physician. 2. The individual receiving the order records and signs it immediately and has the prescribing person sign it in accordance with state and federal law and regulation. Applicable Regulations: L592-418.64(b)(2); L690-418.106(b)(1)(i); L690-418.106(b)(1)(ii); L690-418.106(b)(1)(iii); L690-418.106(b)(2)(i); L690-418.106(b)(2)(ii).	**Clinical Record Review:** Verify that orders are appropriately taken, including through electronic transmission.

Standards	Evidence Guidelines
HCDT 33.I The Interdisciplinary Group determines the ability of the patient and/or family to safely self-administer drugs and biologicals to the patient in their home. The plan of care identifies the IDG's finding regarding safe self-administration and/or family administration of drugs and biologicals. 1. If the patient and/or family cannot administer drugs or biologicals, it is noted in the plan of care, as well as how it is addressed by the IDG. Applicable Regulation: L692-418.106(d)(1); L692-418.106(d)(2)(i); L692-418.106(d)(2)(ii); L692-418.106(d)(2)(iii).	**Clinical Record Review:** Identify if the patient and or family can administer drugs and biologicals. If not, does the POC note how the issue is dealt with? **Interview:** Ask an IDG team member how self-administration or family administration is evaluated and where it is noted in the record. **Observation – Home Visit:** Does observation in the home reveal that the individual identified to administer drugs and biologicals is capable?
HCDT 34.D The hospice has written policies and procedures for the management and disposal of controlled drugs in the patient's home. The policies and procedures address the circumstances under which controlled drugs are disposed of (e.g., the patient's death, a change in drug regimen, etc.) and the method to be used in accordance with the state and federal law and regulation. Applicable Regulation: L694-418.106(e)(2)(i).	**Document Review:** Review policies and procedures for the management and disposal of controlled substances in the patient's home.

Standards	Evidence Guidelines
HCDT 35.I When controlled medications are first ordered, a copy of the hospice's written policies and procedures for the management and disposal of controlled medications is provided to the patient or family or patient's legal representative(s). The Interdisciplinary Group: 1. Discusses the policies and procedures in a language and manner that the patient and family or patient's legal representative understand; 2. Ensures that the safe use and disposal of controlled drugs is understood; 3. Documents in the patient record that the policies and procedures for managing and disposing of controlled medications is provided and discussed. **Applicable Regulations: L694-418.106(e)(2)(i); L695-418.106(e)(2)(i)(A); L696-418.106(e)(2)(i)(B); L697-418.106(e)(2)(i)(C).**	**Clinical Record Review:** During patient record review, identify that: 1. The patient and/or family received a copy of the written management and disposal policies and procedures; 2. It was discussed, and, if a language issue has been identified, it was done in a manner that would be understood; 3. The provision of policies and procedures was done upon the first order of a controlled drug; 4. Receipt and discussion are documented. **Guidance:** It is expected that the hospice is aware of both federal and state law and regulations regarding controlled drugs.

Standards	Evidence Guidelines
HCDT 36.D The hospice has defined policy and procedures to promote continuity of care during the transfer of care or "live" discharge of a patient and family from the hospice to community providers. The policies and procedures address: 1. What information is provided to the organization or physician assuming responsibility for care as requested; 2. If the hospice is initiating the discharge to the community, how the patient and/or family is informed, and what is the related timeframe for discontinuing services; 3. Recommendations for resources, such as access to durable medical equipment, drugs and biologicals still needed in self-care post-discharge; 4. Documentation of the process in the patient record; 5. Other requirements per state law and regulation.	**Document Review:** Review the policies and procedures related to the "live" discharge process. **Guidance:** The intent of the standard is addressing the needs of patients who are discharged alive and have continuing care needs.
HCDT 37.I The hospice may not discontinue or reduce care to a Medicare or Medicaid beneficiary because of the beneficiary's inability to pay. *Applicable Regulation: L654-418.100(d).*	**Interview:** Interview the administrator. How are Medicare/Medicaid beneficiaries who are unable to pay addressed? **Guidance:** This condition applies to Medicare and Medicaid beneficiaries only.

Standards	Evidence Guidelines
HCDT 38.I If the care of a hospice patient is transferred to a Medicare/Medicaid-certified facility, the hospice forwards to the receiving facility a copy of: 1. The hospice discharge summary described in HCDT 40.I; and 2. The patient's record, if requested. Applicable Regulation: L682-418.104(e)(1)(i); L682-418.104(e)(1)(ii).	**Clinical Record Review:** Review the patient record of one or more patients transferred to a Medicare/Medicaid-certified facility. Confirm that the record contains documentation that a copy of the hospice discharge summary and, if requested, the patient's record or an abstract were sent to the receiving facility.
HCDT 39.I If a patient revokes the election of hospice care or is discharged from hospice per hospice regulation §418.26 (i.e., no longer terminally ill), the hospice forwards to the patient's attending physician: 1. A copy of the hospice discharge summary; 2. The patient's record, if requested. Applicable Regulations: L683-418.104(e)(2)(i); L683-418.104(e)(2)(ii).	**Clinical Record Review:** Review the patient record of one or more patients who revoked the hospice benefit. Confirm that the record contains documentation that a copy of the hospice discharge summary and the patient's clinical record or abstract were sent to the attending physician. **Interview:** Ask IDG members the process if patients revoke the benefit or the IDG decides that they should be discharged.

Standards	Evidence Guidelines
HCDT 40.I The hospice discharge summary provided to a facility receiving a hospice patient for care—or to the patient's community attending physician upon hospice discharge—includes at least the following: 1. A summary of the patient's hospice stay, including treatments, symptoms, and pain management; 2. The patient's current plan of care; 3. The patient's latest physician orders; 4. Any other documentation that will assist in the post-discharge continuity of care or that is requested by the receiving facility or the attending physician. Applicable Regulation: L684-418.104(e)(3)(i); L684-418.104(e)(3)(ii); L684-418.104(e)(3)(iii); L684-418.104(e)(3)(iv).	**Clinical Record Review:** Review the patient record of one or more patients who revoked the hospice benefit. Confirm that the record contains documentation that a copy of the hospice discharge summary and the patient's clinical record or abstract were sent to the attending physician. **Interview:** Ask IDG members the process if patients revoke the benefit or the IDG decides that they should be discharged. **Guidance:** When considering other documentation to be shared, ask how the hospice shares any relevant advance care planning and advance directives, as well unique types of care involving the family (e.g., counseling for patient's minor children, etc.).

Standards	Evidence Guidelines
HCDT 41.I When signs and symptoms indicate the imminent death of the patient, the Interdisciplinary Group: 1. Evaluates the best care setting considering the patient's and family's wishes and caregiver burden and willingness; 2. Ensures access to medication, supplies, and equipment that may be needed for symptom management; 3. Provides education and instruction to the family or other caregivers in preparation for the patient's death, including: a) Clarifying the IDG's presence as required or requested, including when to contact the hospice; b) What to expect regarding physical and/or symptom changes; c) Review of the patient's advance directives and wishes, including any related state or local requirements for availability of physician orders; d) What will happen after the patient dies, including the process for following the patient's wishes regarding organ or body donation. Following the death, if an IDG member is present, they act in accordance with local and state law and regulation regarding the declaration of death.	**Interview:** Ask IDG team members the process for preparing a family for the patient's anticipated death, including the elements of the standard. Ask the IDG team the process for declaration of death if present. **Clinical Record Review:** Verify that imminent death is addressed appropriately.

Hospice Care to Residents of a Facility (HSRF)

KEY PERFORMANCE AREA:

Medicare beneficiaries who are also residents of SNFs (skilled nursing facilities)/NFs (nursing facilities) as well as ICFs (intermediate care facilities)/IDFs (intellectual disability facilities) have access to hospice care. All of the same eligibility requirements and services are required. The main emphasis is an agreement and a process to coordinate the patient/resident's care with the facility staff, who assume a role similar to that of the family in the home. Home services are the same as if the resident lived in the community and services were provided by the hospice. The facility continues to provide room and board.

Standards	Evidence Guidelines
HSRF 1.I A hospice providing hospice care to residents of a SNF/NF or an ICF/IDF follows the standards defined elsewhere in this Manual and those that follow. Applicable Regulations: L759-418.112.	**Interview:** Establish if hospice care is provided to residents of these types of facilities. **Guidance:** In the following standards, "patient" refers to an eligible resident of a facility receiving services from the hospice.
HSRF 2.I Patient eligibility, election, and duration of benefits for Medicare beneficiaries residing in a SNF, NF, or ICF/IDF are subject to the same Medicare eligibility criteria as that previously stated for patients residing in the community. Applicable Regulation: L761-418.112(a).	**Interview:** Interview the administrator. Are there any differences related to patient eligibility, election, and duration of benefits for Medicare beneficiaries residing in a SNF, NF, OR ICF/IDF? **Guidance**: Set the expectation that the eligibility criteria presented earlier in the standards is no different for a Medicare beneficiary living or residing in these facilities than for a beneficiary in the community.

Standards	Evidence Guidelines
HSRF 3.I The hospice assumes responsibility for the professional management of the SNF/NF or ICF/IDF resident's hospice services in accordance with the hospice plan of care (POC) and the hospice conditions of participation. 1. Any arrangements necessary for hospice-related inpatient care are made in a participating Medicare/Medicaid facility per the inpatient standards (HSIC chapter in this Manual). **Applicable Regulation: L762-418.112(b).**	**Contract Review**: Review contracts for the provision of care within a SNF/NF OR ICF/IDF. Ensure the contract reflects that the facility is a participating Medicare/Medicaid facility. **Guidance**: A resident of a facility who is in need of inpatient care must be admitted to a facility that meets the inpatient care standards. It is not assumed their facility of residence meets these requirements. **Guidance**: "Professional management" means assessing, planning, monitoring, directing, and evaluating the patient's/resident's hospice care across setting.

Standards	Evidence Guidelines
HSRF 4.I The hospice is responsible for providing all hospice services to the residents/hospice patients including: 1. Ongoing assessment, monitoring, care planning, coordination, and provision of care by the hospice Interdisciplinary Group (IDG); 2. Assessment, coordination, and provision of needed general inpatient or continuous care; 3. Consultation about the patient's/resident's care with the facility staff; 4. Coordination by the hospice RN for the implementation of the plan of care for the patient/resident; 5. Provision of hospice aide services, if these services are determined to be necessary by the IDG to supplement the nurse aide services provided by the facility; 6. Provision, in a timely manner, of all supplies, medications, and durable medical equipment (DME) needed for the palliation and management of the terminal illness and related conditions; 7. Financial management responsibilities for all supplies, appliances, medications, and biologicals related to the terminal illness and related conditions; 8. Determination of the appropriate level of care to be given to the patient/resident (i.e., routine homecare, inpatient or continuous care); 9. Arranging any necessary transfers from the facility of residence in consultation with the facility staff. **Applicable Regulation: L762-418.112(b).**	**Contract Review**: Review the contract between the hospice and facility. Does it meet the provisions noted? Does it adequately address what the facility staff should do in the event of a potential crisis or the need for temporary emergency measures? **Document Review:** Review and analyze documentation related to patient and staff incidents and accidents to identify any incidents/accidents or patterns of incidents/accidents concerning a safe environment. **Guidance**: The professional services offered by the hospice should be the same core services as offered in the community. These routine services cannot be delegated to the facility.

Standards	Evidence Guidelines
HSRF 5.I The hospice and SNF/NF or ICF/IDF have a written agreement that specifies the provision of hospice services in the facility. 1. The agreement is signed by an authorized representative of the SNF/NF or ICF/IDF before hospice services are provided. The agreement includes the following provisions: 1. The ways in which the SNF/NF or ICF/IDF and the hospice communicate with each other and document the communication to ensure that patient needs are addressed and met 24 hours a day. 2. The SNF/NF or ICF/IDF immediately notifies the hospice if: a) A significant change occurs in the patient's physical, mental, social, or emotional status; b) Clinical complications appear that suggest a need to alter the plan of care; c) A need arises to transfer a patient from the SNF/NF or ICF/IDF, in which case the hospice makes arrangements for—and remains responsible for—any necessary continuous care or inpatient care related to the terminal illness and related conditions; or d) A patient dies. 3. The hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. *(continued on following page)*	**Contract Review:** Review the agreement for the presence of elements #1-9.

Standards	Evidence Guidelines
HSRF 5.I 4. The SNF/NF or ICF/IDF is responsible for continuing to furnish 24-hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home, at the same level of care provided before hospice care was elected by the patient/resident. 5. The hospice is responsible for providing services at the same level and to the same extent as those services would be provided if the SNF/NF or ICF/IDF resident were a patient in their own home (SNF/NF and ICF/IDF contract provisions). 6. The hospice's responsibilities include, but are not limited to: a) Providing medical direction and management of the patient; b) Nursing; c) Counseling (including spiritual, dietary, and bereavement); d) Social work; e) Provision of medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; f) All other hospice services that are necessary for the care of the resident's terminal illness and related conditions *(continued on following page)*	

Standards	Evidence Guidelines
HSRF 5.I 7. The hospice may use the SNF/NF or ICF/IDF nursing staff, where permitted by state law and as specified by the SNF/NF or ICF/IDF, to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a hospice patient's family. 8. The hospice will report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice, to the SNF/NF or ICF/IDF administrator within 24 hours of the hospice becoming aware of the alleged violation. 9. The responsibilities of the hospice and the SNF/NF or ICF/IDF to provide bereavement services to SNF/NF or ICF/IDF staff. **Applicable Regulations: L763-418.112(c); L764-418.112(c)(1); L765-418.112(c)(2); L766-418.112(c)(3); L767-418.112(c)(4); L768-418.112(c)(5); L769-418.112(c)(6); L770-418.112(c)(7); L771-418.112(c)(8); L772-418.112(c)(9).**	

Standards	Evidence Guidelines
HSRF 6.I Hospice care of the patient/resident is stated in a written plan of care established and maintained in consultation with SNF/NF or ICF/IDF representatives. 1. The hospice plan of care identifies the care and services that are needed and specifies which provider is responsible for performing the functions that are agreed upon and included in the plan of care. 2. The plan of care reflects the participation of the hospice, the SNF/NF or ICF/IDF, and the patient and family to the extent possible. 3. All hospice care is provided in the facility in accordance with the hospice plan of care. 4. Any changes to the hospice plan of care are discussed with the patient or representative and SNF/NF or ICF/IDF representatives, and are approved by the hospice before implementation. Applicable Regulations: L773-418.112(d); L774-418.112(d)(1); L775-418.112(d)(2); L776-418.112(d)(3).	**Clinical Record Review**: In the patient plan of care, confirm there is a section governing and delineating the service portion and actions of the hospice and that it also describes the needs of the patient. The POC identifies which provider is responsible for which specific service. **Interview:** Interview a facility staff person who is knowledgeable about the needs and care of the patient and provides direct care to determine care coordination between the hospice and facility. **Guidance:** The plan of care that guides both providers is developed for each patient. The patient and family are involved to the extent possible. **Guidance**: The facility plan of care may be divided into two portions, one for the facility and one for the hospice. The hospice maintains the plan of care.

Standards	Evidence Guidelines
HSRF 7.I The hospice designates a member of each Interdisciplinary Group who is responsible for a patient/resident in a SNF/NF or ICF/IDF. The designated IDG member: 1. Provides overall coordination of care of the patient/resident, working with the facility representative staff; 2. Communicates with facility staff and others providing care for the terminal illness and related conditions; 3. Is responsible for ensuring the quality of care for the patient and family. Applicable Regulations: L777-418.112(e)(1); L778-418.112(e)(1)(i); L779-418.112(e)(1)(ii).	**Clinical Record Review**: Review records for patients in a SNF/NF or ICF/IDF. Verify designated IDG member is responsible for the patient in the facility. Verify IDG member coordinates care with the facility, communicates with facility, and ensures the quality of care for the patient and family. **Interview**: Ask the hospice IDG how they designate the IDG member responsible for coordinating each patient in a facility. Ask how they accomplish elements #1-3. Ask if the hospice provides education to the facility staff on the patient's pain and symptom management plan. Does the hospice system for ordering, renewing, delivery, and administration of medications work for the facility? What procedures are in place to ensure that the patient receives timely medication and treatments per the hospice POC? **Guidance**: The hospice member responsible may/may not be the hospice RN, but instead might be the physician or social worker, etc.

Standards	Evidence Guidelines
HSRF 8.I The Interdisciplinary Group member ensures that the IDG communicates with the SNF/NF or ICF/IDF medical director, the patient's attending physician, and other physicians participating in the patient's/resident's care to coordinate the hospice care with the medical care provided by other physicians. **Applicable Regulation: L780-418.112(e)(2).**	**Clinical Record Review**: Review records for patients in a SNF/NF or ICF/IDF. Verify the IDG coordinates all physician participation. **Interview:** Ask for evidence of how the IDG member or others sustain interface with the physicians involved in the patient's/resident's care, including the facility medical director.
HSRF 9.I The designated IDG member provides the SNF/NF or ICF/IDF with the following information for each patient/resident: 1. The most recent hospice plan of care; 2. Hospice election form and any advance directives; 3. Physician certification and recertification of the terminal illness; 4. Names and contact information for hospice staff involved in the patient's care; 5. Instructions on how to access the hospice's 24-hour on-call system; 6. Hospice medication information; 7. Hospice physician and attending physician (if any) orders. **Applicable Regulation: L781-418.112(e)(3)(i); L781-418.112(e)(3)(ii); L781-418.112(e)(3)(iii); L781-418.112(e)(3)(iv); L781-418.112(e)(3)(v); L781-418.112(e)(3)(vi); L781-418.112(e)(3)(vii).**	**Observation and Interview**: Assess the process to share information with the facility staff about the IDG's review of the plan of care in a timely manner. Ask for a walk-through of process to ensure timely communication with the SNF/NF or ICF/IDF staff. **Guidance**: The hospice and facility may communicate between patient visits, as appropriate, to share information about the patient's needs and response to the plan of care.

Standards	Evidence Guidelines
HSRF 10.I Hospice staff, in coordination with SNF/NF or ICF/IDF staff, ensures orientation and training of staff providing care to hospice patients. At a minimum, the orientation and training include: 1. An introduction to hospice philosophy; 2. Hospice policies and procedures regarding methods of comfort, pain control, symptom management; 3. Principles about death and dying and individual responses to death; 4. Patient rights; and, 5. Appropriate forms and record keeping requirements. Applicable Regulation: L782-418.112(f).	**Observation and Interview**: Ask facility representatives and assigned hospice staff how they ensure that staff, especially new staff, are oriented and trained in hospice care. **Document Review**: If concerns are identified in the interview, ask to see evidence that a facility employee assigned to a hospice patient has been oriented and trained. **Guidance**: The hospice shares the responsibility with the facility to ensure that facility staff that care for hospice patients receive orientation and training in the 5 hospice elements in the standard. No contract is required.

Hospice Inpatient Care (HSIC)

KEY PERFORMANCE AREA:

A hospice ensures that patients have access to inpatient care for the purposes of pain management, symptom management, and caregiver respite. The services may be provided by Medicare-certified facilities or a hospice-operated inpatient facility that meets the provisions of the following standards.

All facilities must ensure adequate nursing staff to meet the needs of the patient population, considering volume, acuity, and complexity of care being provided.

Standards	Evidence Guidelines
HSIC 1.I Short-term inpatient care is available for pain control, symptom management, and respite purposes. The hospice has criteria for general inpatient care and for respite admissions. Inpatient care is provided in a participating Medicare or Medicaid facility. *Applicable Regulations: L704-418.108.*	**Interview:** Ask the medical director and IDG member how the decision is made to admit a patient to an inpatient unit for pain and symptom management and for respite. **Patient/Family Interview:** Interview patients and/or their family to determine how the hospice is addressing the reason the patient is receiving inpatient hospice care, such as severe pain management and abating other symptoms such as shortness of breath, nausea and vomiting, constipation, pathological fractures, agitation/anxiety.

Standards	Evidence Guidelines
HSIC 2.I Hospice inpatient care for pain control and symptom management is provided in one of the following: 1. A Medicare-certified hospital or a skilled-nursing facility that also meets the standards specified in §418.110(b) (requiring 24-hour nursing care) and §418.110(e) (regarding home-like patient areas). or 2. A Medicare-certified hospice that meets the conditions of participation (CoP) for providing inpatient care directly as specified in §418.110 for a hospice-operated inpatient facility. Applicable Regulations: L706-418.108(a)(1); L707-418.108(a)(2).	**Document Review:** When the source(s) of short-term inpatient care are identified, validate how the hospice verifies the facility's Medicare-certification status, if contracted. **Guidance:** The primary purpose of the standard is the identification of an appropriate source of inpatient care.

Standards	Evidence Guidelines
HSIC 3.I Hospice inpatient care for respite purposes is provided by one of the following: 1. A Medicare-certified hospital or a skilled-nursing facility that also meets the standards specified in §418.110(b) (requiring 24-hour nursing care), and §418.110(e) (regarding home-like patient areas). or 2. A Medicare- or Medicaid-certified nursing facility that meets §418.110(e) (regarding home-like patient areas). or 3. A Medicare-certified hospice that meets the conditions of participation for providing inpatient care directly as specified in §418.110. Applicable Regulations: L708-418.108(b)(1)(i); L709-418.108(b)(1)(ii).	**Interview:** Ask how respite care is provided. **Document Review:** Ask to see documentation that the respite-care facility meets one of the qualifiers in the standard.

Standards	Evidence Guidelines
HSIC 4.I The facility offering respite care provides 24-hour nursing services that meet the needs of the patients and each patient's plan of care (POC). Each patient: 1. Receives all nursing services as prescribed in the plan of care; 2. Is kept comfortable, clean, well-groomed, and protected from accident, injury, and infection. **Applicable Regulation: L710-418.108(b)(2).**	**Interview:** Ask how the hospice ensures that sufficient nursing is provided 24/7 when patients receive hospice care. Ask who has oversight of the patients in respite care and ask how they ensure the POC is being met. **Clinical Record Review:** The facility providing respite care provides 24-hour nursing services that meet the needs of the patients and each patient's plan of care. Each patient receives all nursing services as prescribed in the plan of care, and is kept comfortable, clean, well-groomed and protected from accident, injury, and infection.
HSIC 5.D A hospice that provides short-term inpatient care under arrangement with a facility has a written agreement describing the arrangement and how the hospice coordinates the care; it includes at a minimum: 1. The hospice provides a copy of the patient's plan care to the inpatient provider and specifies the inpatient services to be provided. 2. The inpatient provider establishes patient care policies consistent with those of the hospice and agrees to abide by the palliative care protocols and plan of care established by the hospice for its patients. 3. The hospice patient's inpatient clinical record includes a record of all inpatient services provided and all events regarding care that occurred at the facility. *(continued on following page)*	**Contract Review**: If hospice inpatient services are provided under the arrangement, review the contract to ensure the elements are addressed. **Interview:** Ask the hospice clinical manager how they monitor care in the inpatient facilities. **Interview:** Ask how the hospice ensures that all staff providing inpatient care have been trained in the hospice philosophy and are able to provide the care per the patient's POC. Contact the facility for verification if indicated.

Standards	Evidence Guidelines
HSIC 5.D 4. A copy of the discharge summary is provided to the hospice at time of discharge, and a copy of the inpatient record is available upon request. 5. The inpatient facility designates an individual within the facility as responsible for implementing the provisions of the agreement. 6. The hospice retains responsibility for ensuring that training has been provided to personnel who will be providing the patient's care; a) A description of the training and names of personnel trained are documented. 7. The methods used by the hospice to ensure the preceding requirements are met. **Applicable Regulations: L711-418.108(c)(1); L712-418.108(c)(2); L713-418.108(c)(3); L714-418.108(c)(4); L715-418.108(c)(5); L716-418.108(c)(6).**	
HSIC 6.I A hospice that provides inpatient care directly in its own facility is responsible to ensure that staffing for all services reflects the: 1. Volume of patients; 2. Patient acuity; 3. The level of intensity of services needed to ensure that the patient's plan of care outcomes are achieved and negative outcomes avoided. **Applicable Regulations: L820-418.110; L821-418.110(a).**	**Interview:** Ask how the hospice determines that there is adequate staff on duty, especially during evening, nighttime, weekend, and holiday shifts. **Clinical Record Review**: Review at least one (1) record to evaluate if care is being provided per the POC. **Interview Patient/Family:** Ask patients/families if they are satisfied with the care and service. **Observation:** Are the staff responsive to patient needs, and are call bells answered promptly? Are patients or families frequently calling for service?

Standards	Evidence Guidelines
HSIC 7.I The hospice providing inpatient care directly provides 24-hour nursing services that meet the nursing needs of all patients and are provided per the patient's plan of care. 1. Each patient receives the care ordered and is kept comfortable, clean, well-groomed, and protected from accident, injury, and infection. 2. If at least one patient in the hospice facility is receiving general inpatient care, then each shift includes a registered nurse (RN) who provides patient care. Applicable Regulations: L822-418.110(b)(1); L823-418.110(b)(2).	**Document Review:** Review the past 30 days patient census and corresponding staff schedule to determine that the hospice meets this requirement. **Interview:** Ask the hospice for a schedule of RN staff for the past month and ask how the hospice ensures an RN provides direct patient care on each shift. **Clinical Record Review:** The hospice providing inpatient care directly provides 24-hour nursing services that meet the nursing needs of all patients and are provided per the patient's plan of care. Each patient receives the care ordered, and is kept comfortable, clean, well-groomed, and protected from accident, injury, and infection. **Guidance:** Assigning an RN to every shift to provide direct patient care is not automatically needed if the patients in the hospice facility are only receiving respite or routine levels of care.
HSIC 8.I The inpatient hospice facility addresses real or potential threats to the health and safety of patients, hospice staff, visitors, others, and property. 1. The hospice facility documents patient and staff incidents and accidents, evaluates these, and takes action as appropriate. Applicable Regulations: L824-418.110(c); L825-418.110(c)(1).	**Interview:** Ask staff what security measures are in place to protect patients, staff, and visitors. Ask if patients are checked frequently for safety, comfort, and positioning. **Document Review:** Ask to review documentation of patient or staff incidents, such as falls, etc., and evidence that the incident was investigated, and action taken.

Standards	Evidence Guidelines
HSIC 9.D A hospice operated inpatient care facility meets the following emergency preparedness requirements in addition to those stated in the Hospice Emergency Preparedness (HSEP) chapter of this Manual. Policies and procedures address the provision of subsistence needs for hospice staff and patients whether they evacuate or shelter in place, including the following: 1. Food, water, medical, and pharmaceutical supplies; 2. Alternate sources of energy, including emergency power, necessary to maintain: a) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions; b) Emergency lighting; and, c) Fire detection and extinguishing, as well as alarm systems; 3. Maintaining sewage and waste disposal; and, 4. Timely relocation or evacuation should the hospice facility be unable to sustain appropriate temperatures, utilize alternate sources of power, or maintain sewage and waste disposal. **Applicable Regulation: E15-418.113(b)(6)(iii).**	**Document Review:** Review policies and procedures for the elements in the standard. **Guidance:** A hospice operated inpatient care facility is not required to heat and cool the entire building evenly but must ensure safe temperatures are maintained in those areas deemed necessary to protect patients, hospice staff and other people in the facility, and for provisions stored in the facility during an emergency. **Guidance:** A hospice operated inpatient facility must address alternate energy sources that meet applicable law and regulation, manufacturer requirements, and applicable Life Safety Code (LSC) and National Fire Protection Agency (NFPA) guidelines. An alternate emergency power resource may include the use of a generator: • A portable and mobile generator that meets LSC NFPA 70 code; or • A permanent generator that meets current LSC and NFPA guidelines.

Standards	Evidence Guidelines
HSIC 10.D The inpatient hospice facility has emergency preparedness policies and procedures based on the hospice EP plan, including risk assessment and communication plans. The inpatient policies and procedures: 1. Are reviewed and updated at least annually; 2. Include a system to track the location of on-duty staff and sheltered patients in the facility's care during an emergency, including whether, if on-duty staff and sheltered patients are relocated during an emergency, the hospice facility documents the specific name and location of the receiving facility or other location; 3. Provide for safe evacuation from the hospice facility including consideration of care and treatment needs of evacuees, staff responsibilities, transportation, identification of evacuation location(s), and primary and alternate means of communication with external sources of assistance; 4. Provide for a means to shelter in place for patients and hospice employees who remain in the hospice facility. **Applicable Regulations: E18- 418.113(b)(6)(v); E20-418.113(b)(6)(ii); E22-418.113(b)(6)(i); E26-418.113(b)(6)(iv).**	**Document Review:** Review the policies and procedures for elements #1-4. • Verify if they address how the hospice will—or if it will—provide a means to shelter in place for those who remain in the facility. • Does the inpatient plan align with the hospice's EP plan, including communication plan and operations back-up? **Guidance:** The policies and procedures should also consider the evacuation of staff, their families (if any), and the patients' families and visitors who may have sheltered in place at the hospice. **Guidance:** The policies and procedures considers those patients most critically ill and whether they should be accompanied by staff in case of evacuation.

Standards	Evidence Guidelines
HSIC 11.I Testing for hospices providing inpatient care directly. When inpatient care is provided directly by the hospice, the facility conducts exercises to test the emergency preparedness plan twice a year. The inpatient hospice facility: 1. Participates in a full-scale community-based exercise. a) When a community-based exercise is not accessible, an annual individual, facility-based functional exercise is conducted; or b) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, it is exempt from engaging in its next required full-scale community-based exercise or facility-based functional exercise following the onset of the emergency event. 2. Conducts an additional exercise that may include, but is not limited to: a) A second full-scale exercise that is community-based or a facility-based functional exercise; or b) A mock disaster drill; or c) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically relevant emergency scenario and a set of problem statements, directed messages, or prepared questions designed to challenge the emergency plan. *(continued on following page)*	**Document Review:** Documented evidence of EP Plan testing twice each year. Acceptable tests include: 1st annual test: Full-scale community-based exercise • If community-based not accessible, an annual individual, facility-based functional exercise is acceptable. • If the hospice inpatient activates its emergency preparedness plan due to a disaster or other emergency, the next required full-scale community-based exercise or facility-based functional exercise AFTER the activation of the plan is waived. 2nd annual test: • A second full-scale community-based exercise or individual facility-based exercise (Note: If the hospice inpatient EP plan has been activated in the preceding 12 months, it may substitute for this second test), OR • A mock disaster drill, OR • A tabletop exercise or workshop. **Document Review:** Review documented evidence of all tests, results, and if the EP Plan needed to be and was revised.

Standards	Evidence Guidelines
HSIC 11.I 3. Analyzes the inpatient hospice's response to and maintains documentation of all drills, tabletop exercises, and emergency events, revising the hospice's emergency plan as needed. Applicable Regulation: E39-418.113(d)(3).	
HSIC 12.I In accordance with the hospice's emergency preparedness (EP) plan, the hospice has identified a means of providing information about the hospice inpatient occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the Incident Command, or designee. Applicable Regulation: E34-418.113(c)(7).	**Interview:** Ask the inpatient manager what the system is for providing information to the Incident Command Center. **Guidance:** Occupancy reporting includes not just the number of patients at the facility, but also if the facility can accept new patients. **Guidance:** The information to be reported on is any shortage of provisions, and the need for transportation or help with evacuation. **Tip**: The authority having jurisdiction varies by a geographic area and the type of disaster.

Standards	Evidence Guidelines
HSIC 13.D The inpatient hospice has procedures for controlling the reliability and quality of: 1. Routine storage and prompt disposal of trash and medical waste; 2. Lighting, temperature, and ventilation/air exchanges throughout the hospice; 3. Emergency gas and water supply; 4. The scheduled and emergency maintenance and repair of all equipment. Applicable Regulation: L826-418.110(c)(2)(i); L826-418.110(c)(2)(ii); L826-418.110(c)(2)(iii); L826-418.110(c)(2)(iv).	**Document Review:** Review the procedures addressing each of the elements of the standard. Ask to see records of scheduled and/or emergency maintenance of equipment. **Interview:** Ask how the hospice ensures the reliability of the lighting, temperature, and ventilation throughout the building.

Standards	Evidence Guidelines
HSIC 14.I A hospice-operated inpatient care facility complies with all applicable federal, state and local health and safety codes, including: 1. The applicable provisions of the Life Safety Code (LSC) of the National Fire Protection Association NFPA 101, Life Safety Code 2012 edition; and, a. Tentative Interim Amendments (TIA) 12-1, TIA 12–2, TIA 12–3, and TIA 12–4; and, 2. The Health Care Facilities Code NFPA 99, 2012 edition and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5, TIA 12–6 – except Chapters 7, 8, 12, and 13 that do not apply to hospice. Applicable Regulations: L827-418.110(d)(1)(i); L828-418.110(e); E15-418.113(b)(6)(iii).	**Document Review:** Evidence of compliance with State and/or Federal Building codes, such as those stated in the 2012 edition of the Life Safety Code (LSC). **NOTE:** The federal LSC is not applicable when a State has in effect a fire and safety code in State law that adequately protects patients in health care facilities. **NOTE:** A hospice may request a CMS waiver for a cited LSC deficiency. The hospice must demonstrate that if the code is rigidly applied it would result in an unreasonable hardship. CMS may waive the specific provision of the LSC for a specific time period, but only if the waiver would not adversely affect the health and safety of the patients and/or staff.
HSIC 15.I The hospice inpatient facility has documented and dated written reports of *Life Safety Code* fire drills at varied times on all shifts. The hospice inpatient facility has evacuation diagrams posted and visible to all staff, patients, and family members or visitors. Applicable Regulation: E39-418.113(d)(2).	**Document Review:** Review dated documentation of each fire drill and its evaluation. **Observation:** Look for the diagrams for evacuation. Are they visible for all staff, patients, and families? **Interview:** Ask random hospice staff about: 1) their knowledge of specific responsibilities during a disaster or a drill, and 2) what they do regarding fire in a specific situation, such as patient's room.

Standards	Evidence Guidelines
HSIC 16.I The inpatient hospice facility can use alcohol-based hand rub dispensers if there is no conflict with state or local codes restricting placement in a healthcare facility. If used, the dispensers are installed in a manner that: 1. Minimizes leaks and spills that could lead to falls; 2. Adequately protects against access by vulnerable populations; 3. Meets the provisions of Chapter 18.3.2.6 or 19.3.2.6 of 2012 edition of the Life Safety Code issued by the NFPA on August 11, 2011. Applicable Regulation: L827-418.110(d)(4).	**Document Review:** Evidence of compliance with a state fire and safety code that adequately protects patients in healthcare facilities. **Observation:** In a sample of patient rooms and/or facility open areas, observe for the placement of the dispenser and if it represents a fall risk or access by vulnerable populations (e.g., children).
HSIC 17.I Each patient room is equipped with a functional smoke detector. Applicable Regulation: L827-418.110(d)(1)(i).	**Observation:** Observe a sample of rooms and note the presence of a smoke detector in each. **Document Review:** Evidence of maintenance testing.

Standards	Evidence Guidelines
HSIC 18.I There is a program that includes inspection, testing, and maintenance for: 1. Fire extinguishers, sprinkler systems, and smoke detectors; 2. Preventive maintenance programs for electrical, HVAC (heat, ventilation, and air conditioner), sprinkler, and security systems. Maintenance, inspection, and testing activities are documented, and regular and emergency maintenance repair is conducted. 1. Identified deficiencies from the inspection, testing, or maintenance are addressed within specified timelines determined by the hospice and supplier. Applicable Regulation: L827-418.110(d)(1)(i).	**Document Review:** Ask to see evidence of the implementation of the inspection, testing, and maintenance of the equipment noted in the standard. **Interview:** Ask the hospice if there have been incidents of failure of the system noted; if so, review the documentation.
HSIC 19.I When a sprinkler system in the hospice inpatient facility is shut down for more than 10 hours in a 24-hour period: 1. The hospice evacuates the building, or the portion of the building, affected by the system outage until the system is back in service; or 2. Establishes a fire watch until the system is back in service. Applicable Regulations: L827-418.110(d)(5)(i); L827-418.110(d)(5)(ii).	**Interview:** Ask hospice staff what they are to do if a sprinkler system is shut down for more than 10 hours in any 24-hour period.

Standards	Evidence Guidelines
HSIC 20.I Corridor doors and doors to rooms containing flammable or combustible materials in a hospice inpatient facility are provided with positive latching hardware. Roller latches are prohibited on such doors. *Applicable Regulation: L827-418.110(d)(1)(ii).*	**Observation:** Note where flammable or combustible materials are kept and inspect the corridors, rooms, and doors to the rooms for positive latching hardware.
HSIC 21.I A hospice inpatient facility has an outside window or outside door in every sleeping room, and, for any building constructed after July 5, 2016, the sill height does not exceed 36 inches above the floor. *Applicable Regulation: L827-418.110(d)(6).*	**Observation:** While touring the facility, consider when it was built, the presence of doors and windows, and the 36-inch provision.

Standards	Evidence Guidelines
HSIC 22.I The hospice inpatient facility provides a home-like atmosphere, and patient areas are designed to support the dignity, comfort, and privacy of patients. The hospice facility provides: 1. Physical space for private patient and family visiting; 2. Accommodations for family members to remain with the patient throughout the night; 3. Physical space for family privacy after a patient's death. The hospice provides opportunity for patients to receive visitors at any hour, including infants and small children. The hospice facility accommodates a patient and family request for a single room whenever possible. **Applicable Regulations: L829-418.110(f); L830-418.110(g)(2).**	**Observation**: Tour of the facility. **Interview:** Ask the hospice staff regarding visiting hours 24/7, ability to provide privacy after death, and access to a single room if requested.
HSIC 23.I The rooms of the hospice inpatient facility are designed and equipped for nursing care, as well as for the dignity, comfort, and privacy of the patient. Each patient room: 1. Is at or above grade/ground level; *(continued on following page)*	**Observation:** See a sample of patient rooms and determine that, in addition to a comfortable bed, each patient has a place to put personal effects, such as pictures, and there is furniture suitable for the comfort of the patient and visitors, as well as adequate lighting suitable to the tasks the patient chooses to perform or the inpatient staff need to perform. *(continued on following page)*

Standards	Evidence Guidelines
HSIC 23.I 2. Has a suitable bed with flame-retardant cubicle curtains, movable screens, or other acceptable means of providing full visual privacy, as well as other appropriate furniture for each patient; 3. Has—or is conveniently located near—toilet and bathing facilities; 4. Has closet space that provides security and privacy for clothing and personal belongings; 5. Accommodates no more than two patients and provides room for visiting family members; 6. Provides at least 80 square feet for each residing patient in a double room and at least 100 square feet for each patient residing in a single room; 7. Is equipped with a device used for calling for assistance that is easily activated, functioning, and accessible to the patient. CMS may waive the space and occupancy requirements of elements #4 and #5, above, if it determines that the requirements result in an unreasonable hardship for the hospice and that patient needs can be met without adversely affecting their health and safety. *Applicable Regulations: L830-418.110(g); L831-418.110(h).*	**Observation:** "Toilet facilities" means a space that at least contains a sink and a toilet. Each floor has at least one toilet facility and shower large enough to accommodate a wheelchair and patient transfer. **Guidance:** Waiver requests must be submitted in writing to the CMS regional office.

Standards	Evidence Guidelines
HSIC 24.I Each patient room in the hospice facility always has an adequate supply of hot water and has plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by patients. Applicable Regulations: L832-418.110(i)(1); L832-418.110(i)(2).	**Document Review:** Ask to see incident reports for the past 12 months. Ask to see the maintenance logs for the control valves and review the temperatures recorded. **Guidance:** 120 degrees can produce a 2nd degree burn in eight (8) minutes. 131 degrees produces a 2nd degree burn in less than 17 seconds.
HSIC 25.I Hospice inpatient facilities provide a sanitary environment by following current standards of practice, including nationally recognized infection control precautions, and avoiding sources and transmission of infections and communicable diseases. Applicable Regulation: L834-418.110(k).	**Interview:** Ask staff how they keep the facility clean and sanitary. **Observation:** Observe how items are kept clean and sanitary. **Guidance:** "Sanitary" includes keeping patient equipment clean and properly stored; this includes toothbrushes, dentures, denture cups, glasses, water pitchers, emesis basins, bed pans, etc.
HSIC 26.I Hospice inpatient facilities have a quantity of clean linen available in sufficient amounts for all patient uses at all times. 1. Linens are handled, stored, processed, and transported in such a manner to prevent the spread of contaminants. Applicable Regulation: L835-418.110(l).	**Interview:** Ask patients or families if linen was promptly changed if soiled. **Interview:** Ask staff what the policy on changing linen is. **Observation:** Request to see the linen storage area. Is it clean and dust free? Are soiled linens and clothing collected and enclosed in suitable bags or containers and separated from clean linen?

Standards	Evidence Guidelines
HSIC 27.I The hospice inpatient facility maintains an infection control program that protects patients, staff, and others by preventing and controlling infections and communicable disease. The inpatient infection control program includes policies and procedures that define: 1. Nosocomial infections and communicable disease; 2. Processes to identify, investigate, and report nosocomial infection and communicable disease; 3. How patients and healthcare workers are assessed and identified as at risk for infection and communicable disease; 4. Actions taken to prevent infection; 5. Measures for the prevention of communicable disease outbreaks such as airborne disease (e.g., SARS, etc.), food-borne disease (e.g., salmonella, etc.), bloodborne disease (e.g., Hepatitis B, etc.) and other infectious disease (e.g., MRSA); 6. Steps to provide for a safe environment consistent with nationally recognized infection control practices, such as that of the CDC (Centers for Disease Control); 7. Isolation precautions for immunosuppressed patients; 8. The required use of standard precautions; 9. Screening of staff—including hospice staff, contract workers, and volunteers—for communicable disease; evaluation of staff and volunteers exposed to patients with non-treated communicable disease; 10. Any work restrictions on employees rendering patient care or providing service, including whether to report to work when ill. **Applicable Regulation: L833-418.110(j).**	**Document Review:** Review the policies and procedures to ensure that all elements are included. **Document Review:** Ask to see the tracking of infections unrelated to the patients' diagnoses. Is there a trend? Has the hospice noted it and acted? **Interview:** Ask management and staff if they are aware of what to do if a patient, family member, or employee has an infectious or communicable disease. **Guidance:** The hospice inpatient population at risk for infection and communicable disease includes the patients, hospice staff, healthcare workers, contracted staff (e.g., agency staff, housekeeping staff) and volunteers.

Standards	Evidence Guidelines
HSIC 28.I The hospice inpatient facility provides meals to each patient that are: 1. Consistent with the patient's plan of care, nutritional needs, cultural preferences, and therapeutic diet; 2. Palatable, attractive, and served at the proper temperature; 3. Obtained, stored, prepared, distributed, and served under sanitary conditions. Food is available 24/7 to respond to patient's needs or requests. The Interdisciplinary Group (IDG) is kept informed of the patient's response to their prescribed diet. Applicable Regulations: L836-418.110(m); L837-418.110(m)(1); L838-418.110(m)(2); L839-418.110(m)(3).	**Observation:** If able, be present when meals are being served and ask if food is perceived as served at the right temperature. Is it palatable? **Document Review:** Does the food served correlate to the prescribed diet in the patient's plan of care? **Interview:** Ask the hospice staff how the IDG is made aware of the patient's response to their diet.
HSIC 29.I The hospice that provides inpatient care directly in its own facility provides pharmacy services under the direction of a qualified licensed pharmacist who is an employee of—or under contract with—the hospice. The pharmacist evaluates each patient's response to medication therapy, identifies potential adverse drug reactions, and recommends appropriate corrective action. Applicable Regulation: L688-418.106(a)(1).	**Document Review:** Ensure that the pharmacist is licensed and either an employee or under contract. **Interview:** Ask the pharmacist about the scope of their duties and how these are addressed 24/7. Ensure their comfort with recommending corrective action following medication reconciliation. **Observation – Home Visit:** Observe medication administration observation with a minimum of two patients.

Standards	Evidence Guidelines
HSIC 30.D The hospice that provides inpatient care directly in its own facility has a written policy in place for accurately dispensing medication and maintains current and accurate records of the receipt and disposition of all controlled drugs. Applicable Regulation: L691-418.106(c).	**Document Review:** Review inpatient policy for accurately dispensing medication. **Interview:** Ask the pharmacist to walk you through the process.
HSIC 31.I Patients receiving care in a hospice inpatient facility may only be administered medications by the following individuals: 1. A licensed nurse, physician, or other health care professional in accordance with the scope of practice and state law and regulation; 2. An employee who has completed a state-approved training program in medication administration; 3. The patient who can self-administer upon approval of the Interdisciplinary Group and as noted in the plan of care. Applicable Regulations: L692-418.106(d)(1); L692-418.106(d)(2)(i); L692-418.106(d)(2)(ii); L692-418.106(d)(2)(iii).	**Observation:** Observe medication administration in the facility. **Interview:** Ask the nursing staff to review the medication administration process. Are there non-nursing personnel administering medication? What are their qualifications to do so? **Clinical Record Review:** Ask to review the record of a patient who can self-administer and verify it is so noted in the plan of care.

Standards	Evidence Guidelines
HSIC 32.I Hospice inpatient facilities dispose of controlled medications in compliance with hospice policy and in accordance with state and federal law and regulation. 1. The hospice maintains current and accurate records of the receipt and disposition of all controlled medications. *Applicable Regulation: L698-418.106(e)(2)(ii).*	**Document Review:** Review hospice policy for disposal of controlled medications in accordance with state and federal law and regulation. Ask for the records of disposal of controlled medications. **Contract Review:** If there is a contract for disposal, review it for guaranteeing disposal per state and federal law.
HSIC 33.I Hospice inpatient facilities store medications and biologicals in secure areas. 1. All controlled drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1976 are stored in locked compartments within secure storage areas. 2. Only personnel authorized to administer controlled medications per HSIC 30.I have access to the locked compartments. *Applicable Regulation: L699-418.106(e)(3)(i).*	**Interview:** Ask the pharmacist and/or nurse on duty to walk you through the process for storing controlled drugs and access. **Observation:** View the storage system.

Standards	Evidence Guidelines
HSIC 34.I Patients in the hospice inpatient facility have the right to be free from: 1. Physical or mental abuse and corporal punishment; 2. Restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others, and must be discontinued at the earliest possible time. *Applicable Regulation: L840-418.110(n).*	**Interview:** Ask the hospice staff their policy on restraint and seclusion. Note that every hospice inpatient facility must have a policy.
HSIC 35.D Restraint or seclusion in a hospice inpatient facility is used when less restrictive interventions are determined to be ineffective to protect the patient, a staff member, or others from harm. The type of technique of restraint or seclusion used is the least restrictive intervention that is effective to protect the patient, staff, or others from harm. The hospice policy and procedure defines when restraint and seclusion is used and who may order such in the inpatient facility in accordance with state law and regulation. *Applicable Regulations: L841-418.110(n)(1); L842-418.110(n)(2); L844-418.110(n)(4).*	**NOTE:** A hospice can decide that the inpatient unit is restraint- and seclusion-free. All staff must be aware of the decision. A restraint- and seclusion-free hospice is not subject to standards HSIC 35.D–HSIC 46.I. **Document Review:** Hospice policy regarding restraint or seclusion ensures that it addresses the elements in the standard. Note who may order restraint or seclusion in the inpatient facility. **Interview:** Ask inpatient staff if restraint is used and under what circumstances. **Guidance:** It is the expectation that responsible hospice inpatient staff are aware of any inpatient state law or regulation that could dictate elements of the policy.

Standards	Evidence Guidelines
HSIC 36.I The use of restraint or seclusion in the hospice inpatient facility is in accordance with: 1. A written modification to the patient's plan of care; 2. Safe and appropriate restraint and seclusion techniques, as determined by hospice policy in accordance with state law; 3. The order of a physician authorized to order restraint and seclusion per hospice policy and state law and regulation. Orders for the use of restraint or seclusion must never be written as a standing order or an as-needed or PRN order. Applicable Regulations: L843-418.110(n)(3); L844-418.110(n)(4); L845-418.110(n)(5).	**Document Review:** Ask for a record of any patient on whom restraint or seclusion was initiated and review for the elements. If no such case, interview the staff on a theoretical case. **Interview:** Ask staff if restraint or seclusion can be a standing order.
HSIC 37.I The medical director or physician designee is consulted as soon as possible if the attending physician did not order the restraint or seclusion. Applicable Regulation: L846-418.110(n)(6).	**Clinical Record Review:** Review records of patients who underwent restraint and seclusion. Was the intent of the standard met? **Interview:** Ask an inpatient facility nursing staff member if they are aware of this provision.

Standards	Evidence Guidelines
HSIC 38.I Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed with the following limits for up to a total of 24 hours: 1. Four (4) hours for adults 18 years of age or older. 2. Two (2) hours for children and adolescents nine (9) to 17 years of age. 3. One (1) hour for children under nine (9) years of age. After 24 hours, before writing a new order for the use of restraint or seclusion, a physician authorized to order restraint or seclusion in accordance with state law must see and assess the patient. Restraint or seclusion is discontinued at the earliest possible time, regardless of the length of time identified in the order. **Applicable Regulations: L847-418.110(n)(7); L848-418.110(n)(8).**	**Document Review:** Ask for cases involving restraint or seclusion in the past 12 months and review against standard. **Interview:** If no cases, ask the staff if they understand the differences by age groups.

Standards	Evidence Guidelines
HSIC 39.D The hospice inpatient facility policy addresses: 1. The interval that the restrained or secluded patient is monitored by a physician or trained staff; 2. The training requirements for physicians, including attending physicians who may write restraint and seclusion orders; 3. The requirement that physicians and attending physicians must have a working knowledge of the inpatient policy of restraint or seclusion to write orders. The physician and trained hospice staff have completed the training criteria in standard HSIC 44.D. **Applicable Regulations: L849-418.110(n)(9); L850-418.110(n)(10).**	**Document Review:** Review policy for elements #1-3. Ask for evidence of physician training and note how long since last training.

Standards	Evidence Guidelines
HSIC 40.I When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others: 1. The patient is seen face-to-face within one (1) hour after the initiation of the intervention by a physician or a registered nurse who has been trained in accordance with standard HSIC 44.D. The physician or registered nurse evaluates: 1. The patient's immediate situation; 2. The patient's reaction to the intervention, medical, and behavioral condition; 3. The need to continue or terminate the restraint or seclusion. If the face-to-face evaluation is conducted by a trained registered nurse, the RN must consult the medical director or physician designee as soon as possible after the completion of the one-hour face-to-face evaluation. NOTE: States may have requirements by statute or regulation that are more restrictive for restraint or seclusion in a facility. More restrictive state provisions supersede federal regulation. **Applicable Regulations: L851-418.110(n)(11); L852-418.110(n)(12); L853-418.110(n)(13).**	**Document Review:** Ask to review a record of any patient within the past 12 months who was subject to restraint or seclusion to address violent or self-destructive behavior. **Interview:** Ask the hospice inpatient unit directing clinical staff about the process should a patient become violent or self-destructive. Can they articulate what to do, and does it follow the basic provisions of the standard? Ask the inpatient unit manager to identify the physician and/or RN who has been trained in accordance with HSIC 44.D. Is that staff member still active and accessible? Would the training be considered recent?

Standards	Evidence Guidelines
HSIC 41.I Simultaneous restraint and seclusion are used only if the patient is continually monitored face-to-face by: 1. An assigned, trained staff member; or 2. Trained staff using both video and audio equipment, and the staff is in close proximity to the patient. All provisions of standards HSIC 34.I through HSIC 40.I apply to simultaneous restraint and seclusion. *Applicable Regulation: L854-418.110(n)(14).*	**Observation and Interview:** Ask the hospice inpatient unit staff how a patient who is simultaneously restrained and secluded is monitored by staff, including the ability to see the patient.
HSIC 42.I When restraint or seclusion is used, documentation in the patient's clinical record includes: 1. The one-hour face-to-face medical and behavioral evaluation in cases of violent or self-destructive behavior; 2. A description of the patient's behavior and the intervention used; 3. Alternatives or other less restrictive interventions attempted (as applicable); 4. The patient's condition or symptom(s) that warranted its use; 5. The patient's response to the intervention(s), including the rationale for continued use of the restraint or seclusion. *Applicable Regulation: L855-418.110(n)(15).*	**Document Review:** Ask to review the documentation of any patient that has been restrained or secluded in the hospice inpatient unit in the past 12 months and compare content to the elements of the standards. **Interview:** Ask inpatient staff who would be involved in restraint or seclusion—RNs or medical director or physician—how they would know what to document if the need for restraint or seclusion occurred.

Standards	Evidence Guidelines
HSIC 43.I The hospice designates that inpatient staff who have direct patient care responsibility are trained and demonstrate competency in: 1. Applying restraints; 2. Implementing seclusion; 3. Monitoring, assessment, and care of a patient in restraint or seclusion. The training is provided by individuals whose qualifications are evidenced by their education, training, and experience in techniques used to address patient behaviors. The hospice inpatient staff training is documented and occurs: 1. Before performing any duties related to restraint or seclusion; 2. As part of the hospice inpatient facility orientation; 3. Subsequently, on a periodic basis consistent with hospice policy and in consideration of the competency of the staff and the needs of the patient population served. Applicable Regulations: L856-418.110(o); L857-418.110(o)(1)(i); L857-418.110(o)(1)(ii); L857-418.110(o)(1)(iii); L859-418.110(o)(3).	**Interview:** Ask the facility's clinical leader which of the direct care staff have been designated as requiring training and demonstration of competency in restraint and seclusion. Do those designated for training adequately cover all shifts? If not, how does the hospice inpatient facility address any gaps? Ask the inpatient manager how the instructor demonstrates appropriate qualifications for the course. **Clinical Record Review:** In review of inpatient facility personnel records, ensure that those designated for training completed training as part of orientation and before performing any duties related to restraint or seclusion. **Document Review:** Per hospice policy and procedure, what timeframe has the hospice selected for ongoing training? **Guidance:** The hospice may develop and implement their own training program or use an outside source. **Guidance:** The safe implementation of restraint and seclusion by trained and competent staff is a right extended to the patient in the hospice inpatient unit.

Standards	Evidence Guidelines
HSIC 44.D The required hospice education, training, and demonstrated knowledge in the management of patients who are restrained or secluded must include at least the following: 1. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances requiring the use of restraint or seclusion; 2. The use of nonphysical intervention skills; 3. Choice of the least restrictive intervention based on an individualized patient assessment of medical or behavioral status; 4. The safe application and use of the various types of restraint or seclusion, including training in how to recognize and respond to signs of physical and psychological distress (e.g., positional asphyxia); 5. Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary; 6. Monitoring the physical and psychological well-being of a restrained or secluded patient, including at least respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospice policy associated with the one-hour face-to-face evaluation; 7. The use of first-aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification. Applicable Regulation: L858-418.110(o)(2).	**Document Review:** Request a copy of the training. Does it contain all the required elements as stated in the standard? Ask for attendance sheets for training. Based on how often restraint and seclusion is used, do timeframes for training make sense? **Personnel Record Review:** Request a copy of 3 new-employee (hired within the past 12 months) personnel files to verify there is evidence of appropriate training in restraint and seclusion use if the employee is so designated.

Standards	Evidence Guidelines
HSIC 45.I The hospice inpatient facility documents the training and demonstration of competency in restraint or seclusion in each designated employee's personnel record. 1. The documentation provides evidence of competency. Applicable Regulation: L860-418.110(o)(4).	**Personnel Record Review:** Ask for the personnel records of three (3) new hires over the past 12 months who are in the designated categories to ensure their records indicate orientation training.
HSIC 46.I The hospice inpatient facility reports to CMS each known, unexpected patient death that occurs, per the hospice's policy and procedure. The deaths to be reported are those that occur: 1. While a patient is in seclusion or restraint; 2. Within 24 hours of the patient being removed from seclusion or restraint; or 3. Within one (1) week after restraint or seclusion was used, if it is reasonable to assume that the use of restraint or seclusion contributed directly or indirectly to a patient's death. Each death is reported by telephone no later than the close of business on the next business day following knowledge of the patient's death. 1. There is documentation of the date and time of the report to CMS in each patient's clinical record. Applicable Regulation: L861-418.110(p).	**Document Review:** Ask the manager or clinical leader to review the policy as stated in the standard. **Interview:** Ask the manager or clinical leader of the inpatient unit if any death as noted in the standard has been known to occur. If so, and within the past 12 months, ask to see the documentation for compliance with the timelines and minimum content. **Guidance:** The report of a death per the standards is to be made to the CMS Regional Office. **Guidance:** The expectation that the death would be "reasonable to assume" as related to restraint or seclusion includes deaths related to restriction of movement for prolonged time periods or death related to chest compression, restriction of breathing, or asphyxiation.

Hospice Human Resource Management (HSRM)

Key Performance Area:

Hospices ensure adequate staffing with personnel who have the knowledge, skills, and experience necessary to deliver safe, quality, patient-centered care to the population that the hospice serves. Resource allocation reflects the hospice's commitment to appropriate orientation, supervision, continuous knowledge enhancement, and retention of its workforce.

Standards	Evidence Guidelines
HSRM 1.D The hospice maintains documented human resources policies and procedures that support operations and care delivery, as well as comply with local, state, and federal law and regulation.	**Document Review:** Review personnel policies to confirm that they address the scope of services provided.
HSRM 2.D The hospice documents: 1. The duties, roles, and responsibilities for each position; 2. The qualifications and required experience, education, training, certifications, registrations, and licensure; 3. Applicable health screenings, criminal background checks, and verification of employment eligibility (I-9) in accordance with local, state, and federal law and regulation. A current organizational chart delineates the lines of authority and accountability for positions to the patient level, and across locations of care (e.g., inpatient unit (IPU), skilled nursing facility (SNF), etc.)	**Document Review:** Review documents that outline the duties, roles, and responsibilities of positions (e.g., job descriptions). Verify that content includes description of duties and all applicable qualification requirements. **Personnel Record Review:** Review a sample of personnel files to confirm content matches hospice policy and elements of the standard. **Guidance:** When personnel are supervisors, their position description includes this information.

Standards	Evidence Guidelines
HSRM 3.I All hospice professionals who provide services directly, under an individualized contract, or under arrangements with a hospice: 1. Are legally authorized (licensed, certified or registered) in accordance with local, state, and federal law and regulation; 2. Act only within the scope of their state license or state certification or registration; 3. Keep their qualifications current at all times. Applicable Regulations: L783-418.114; L784-418.114(a).	**Personnel Record Review:** Validate that personnel providing care or services are licensed, certified, or registered in accordance with applicable local, state, or federal law and regulation. **Guidance:** Copies of diplomas or transcripts are not required. Licensed healthcare professionals are graduates of approved programs; therefore, a primary source verification of licensure, such as a dated printout from a state practice board website verifying current licensure, also validates completion of education.
HSRM 4.I A physician is a Doctor of Medicine or Osteopathy legally authorized to practice medicine by the state in which they practice, and who is acting within the scope of their license. Applicable Regulation: L785-418.114(b)(1).	**Personnel Record Review:** Validate that primary source verification has been completed to verify that physicians are legally authorized to practice medicine by the state in which such function or action is performed. **Guidance:** For hospices, podiatrists are not included in the definition of a physician and may not serve as a hospice physician or a hospice medical director. **Tip:** State medical associations or an accredited Credentialing Verification Organization (CVO) can be a means to obtain primary source verification.

Standards	Evidence Guidelines
HSRM 5.I 1. A registered nurse (RN) is a graduate of a school of professional nursing and is currently licensed, certified, or registered in the state(s) in which he/she practices. 2. A licensed practical nurse has completed a practical nursing program and is currently licensed, certified or registered in the state(s) in which he/she practices. Applicable Regulations: L793-418.114(c)(1); L794-418.114(c)(2).	**Personnel Record Review:** Validate that registered nurses are currently licensed as registered professional nurses in the state(s) in which they practice.
HSRM 6.I Advanced practice registered nurses (APRNs) and physician's assistants are graduates of an accredited institution for their discipline and are licensed in accordance with state and federal law and regulation. A current DEA license is verified if the advanced practice registered nurse or physician's assistant has prescriptive authority.	**Personnel Record Review:** Validate that advanced practice registered nurses and physician assistants are graduates of an accredited institution for their discipline and are licensed in accordance with federal and state law for writing prescriptions and orders, as applicable to their job duties.

Standards	Evidence Guidelines
HSRM 7.D A social worker has: 1. A Master of Social Work (MSW) degree from a school of social work accredited by the Council on Social Work Education; OR 2. A baccalaureate degree in social work from an institution accredited by the Council on Social Work Education; OR 3. A baccalaureate degree in social work, psychology, sociology, or other field related to social work and is supervised by an MSW meeting the qualification as stated in No. 1 above; AND 4. At least one (1) year of social work experience in a health care setting. Applicable Regulation: L787-418.114(b)(3).	**Personnel Record Review:** Validate that personnel providing social work services are qualified professionals with the requisite education and experience in social work. Verify that license is current if such licensure is required by state law. **Guidance:** A social worker who has a baccalaureate degree from a school of social work accredited by the Council on Social Work Education and was employed by the hospice before December 2, 2008, is not required to be supervised by an MSW. **Guidance:** State law is, at times, more stringent and defines a social worker as only those with a Bachelor of Social Work (BSW) or an MSW. In these instances, the state requirement prevails.

Standards	Evidence Guidelines
HSRM 8.I An occupational therapist, speech language pathologist, physical therapist, or an occupational therapy assistant or physical therapy assistant: 1. Is licensed or otherwise regulated, if applicable, by the state in which they practice, unless licensure does not apply; 2. Has completed the education program and has the experience required for certification in accordance with the requirements of CMS on the following pages. Applicable Regulations: L788-418.114(b)(4); L789-418.114(b)(5); L790-418.114(b)(6); L791-418.114(b)(7); L792-418.114(b)(8).	**Personnel Record Review:** Validate that personnel providing therapy services are currently licensed, certified, or registered in accordance with applicable local, state, or federal law and regulation and meet the education and experience requirement of federal regulation.

HSRM 8.I — Applicable Regulation: L791-418.114(b)(7).

Physical Therapist (PT): A person who meets one of the following requirements:

1. **A person who graduated after successful completion of a physical therapist education program approved by one of the following:**
   a) The Commission on Accreditation in Physical Therapy Education (CAPTE);
   b) Successor organizations of CAPTE;
   c) An education program outside the United States determined to be substantially equivalent to physical therapist entry-level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or an organization identified in §CFR 212.15(e) as it relates to physical therapists; or
   d) Passed an examination for physical therapists approved by the state in which physical therapy services are provided.

2. **A person who on or before December 31, 2009**: graduated after successful completion of a physical therapy curriculum approved by the Commission on Accreditation in Physical Therapy Education (CAPTE) or meets both of the following:
   a) Graduated after successful completion of an education program determined to be substantially equivalent to physical therapist entry-level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or identified in §CFR 212.15(e) as it relates to physical therapists; and

(continued on following page)

b) Passed an examination for physical therapists approved by the state in which physical therapy services are provided.

3. **A person who before January 1, 2008:** graduated from a physical therapy curriculum approved by one of the following:
   a) The American Physical Therapy Association;
   b) The Committee on Allied Health Education and Accreditation of the American Medical Association; or
   c) The Council on Medical Education of the American Medical Association and the American Physical Therapy Association.

4. **A person who on or before December 31, 1977:** was licensed or qualified as a physical therapist and meets both of the following:
   a) Has two (2) years of appropriate experience as a physical therapist; and
   b) Has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

5. **A person who before January 1, 1966:**
   a) Was admitted to membership by the American Physical Therapy Association;
   b) Was admitted to registration by the American Registry of Physical Therapists; or
   c) Graduated from a physical therapy curriculum in a four-year college or university approved by a state department of education.

6. **A person who before January 1, 1966, was licensed or registered, and before January 1, 1970**: had 15 years of fulltime experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of an attending and referring Doctor of Medicine or Osteopathy.

7. **A person who if trained outside the United States before January 1, 2008**, and meets the following requirements:
   a) Was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy; and
   b) Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.

HSRM 8.I — **Applicable Regulation: L792-418.114(b)(8).**
Physical Therapy Assistant (PTA): A person who meets one of the two following requirements.

1. A person who graduated from a physical therapist assistant curriculum approved by the Commission on Accreditation in Physical Therapy Education of the American Physical Therapy Association, or, if educated outside the United States or trained in the United States military, graduated from an education program determined to be substantially equivalent to physical therapist assistant entry-level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or identified at §CFR 212.15(e);
   a) Passed a national examination for physical therapist assistants.
2. **A person who on or before December 31, 2009,** meets one of the following:
   a) Is licensed, or otherwise regulated in the state in which practicing; or
   b) In states where licensure or other regulations do not apply, graduated before December 31, 2009, from a two-year, college-level program approved by the American Physical Therapy Association and, after January 1, 2010, meets the requirements of being licensed, registered, or certified as a physical therapist assistant by the state in which practicing, unless licensure does not apply;
   c) Before January 1, 2008, where licensure or other regulation does not apply, graduated from a two-year college-level program approved by the American Physical Therapy Association; or
   d) **On or before December 31, 1977:** was licensed or qualified as a physical therapist assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

HSRM 8.I — **Applicable Regulation: L789-418.114(b)(5).**
Occupational Therapist (OT): A person who meets one of the following requirements:

1. **A person who:**
   a) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the state in which practicing, unless licensure does not apply;
   b) Graduated after successful completion of an occupational therapist education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or successor organizations of ACOTE; and
   c) Is eligible to take—or has successfully completed—the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

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2. **A person who on or before December 31, 2009:**
   a) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the state in which practicing, or
   b) When licensure or regulation does not apply:
      i. Graduated after successful completion of an occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or the successor organization of ACOTE; and
      ii. Is eligible to take—or has successfully completed—the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

3. **A person who on or before January 1, 2008:**
   a) Graduated after successful completion of an occupational therapy program accredited jointly by the Committee on Allied Health Education and Accreditation of the American Medical Association and the AOTA; and
   b) Is eligible for the National Registration Examination of the American Occupational Therapy Association or the National Board for Certification in Occupational Therapy.

4. **A person who on or before December 31, 1977:**
   a) Had two (2) years of appropriate experience as an occupational therapist; and
   b) Had achieved a satisfactory grade on an occupational therapist proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

5. **A person who, if educated outside the United States, must meet both of the following:**
   a) Graduated after successful completion of an occupational therapist education program accredited as substantially equivalent to occupational therapist entry level education in the United States *by one of the following*:
      i. The Accreditation Council for Occupational Therapy Education (ACOTE);
      ii. Successor organizations of ACOTE;
      iii. The World Federation of Occupational Therapists;
      iv. A credentialing body approved by the American Occupational Therapy Association.
      v. Successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT); and
   b) On or before December 31, 2009, is licensed or otherwise regulated, if applicable, as an occupational therapist by the state in which practicing.

HSRM 8.I — **Applicable Regulation: L790-418.114(b)(6).**

Occupational Therapy Assistant/Certified Occupational Assistant (COTA): A person who meets one of the following:

1. **A person who:**
   a) Graduated after successful completion of an occupational therapy assistant education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or its successor organizations; and
   b) Is eligible to take—or successfully completed—the entry-level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

2. **A person who on or before December 31, 2009,** must meet *both* of the following:
   a) Completed certification requirements to practice as an occupational therapy assistant established by a credentialing organization approved by the AOTA; and
   b) After January 1, 2010, meets the requirements in 1.a) & 1.b) of this section.

3. **A person who after December 31, 1977 and on or before December 31, 2007:**
   a) Completed certification requirements to practice as an occupational therapy assistant established by a credentialing organization approved by the AOTA; or
   b) Completed the requirements to practice as an occupational therapy assistant applicable in the state in which practicing.

4. **A person who on or before December 31, 1977:**
   a) Had two (2) years of appropriate experience as an occupational therapy assistant; and
   b) Had achieved a satisfactory grade on an occupational therapy assistant proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

5. **If educated outside the United States, on or after January 1, 2008:**
   a) Graduated after successful completion of an occupational therapy assistant education program that is accredited as substantially equivalent to occupational therapist assistant entry-level education in the United States by:
      i. The Accreditation Council for Occupational Therapy Education (ACOTE);
      ii. Its successor organizations;
      iii. The World Federation of Occupational Therapists;
      iv. By a credentialing body approved by the American Occupational Therapy Association; and
   b) Successfully completed the entry-level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

HSRM 8.I — Applicable Regulation: L788-418.114(b)(4).

Speech Language Pathologist: A person who meets one of the two following requirements:

1. A person who meets one of the two following requirements:
   a) The education and experience requirements for a Certificate of Clinical Competence in speech-language pathology granted by the American Speech-Language-Hearing Association; or
   b) The educational requirement for certification and is in the process of accumulating the supervised experience required for certification.

Standards	Evidence Guidelines
HSRM 9.I All hospice aide services must be provided by an individual who has successfully completed **one (1) of the four (4)** training and competency evaluations programs described below**.** AND The individual furnishes hospice aide services on behalf of a hospice only after successfully completing a competency evaluation program also described below. AND The hospice maintains documentation that each hospice aide has met the requirements. Documentation of training includes: 1. A description of the training and competency evaluation program; 2. The qualifications of the instructor; 3. A statement that distinguishes skills taught in a laboratory using a real person (not a mannequin); 4. Indicators of which skills the aide was judged to be competent in; 5. How additional skills, if any, are taught and tested if the hospice's admission policies and case-mix of hospice patients requires aides to perform more complex procedures. *(See following pages)*	**Personnel Record Review:** Review a sample of 3-4 hospice aide training files to validate that aides are receiving the required number of training hours. **Guidance:** A hospice aide may receive training from different organizations that totals the 75 hours required if the content of the training covers all subjects listed in the following options, and the organization and documentation meet the requirements. **Guidance:** The hospice ensures that the skills learned or tested elsewhere are transferred successfully to the care of hospice patients in all settings the aide is assigned. Evaluation of aides employed and contracted is emphasized. **Guidance:** The evaluation of skills can be done by the nurse when introducing an aide into a new patient situation or during a supervisory visit. Mannequins cannot be used.

HSRM 9.I Applicable Regulations: L607-418.76; L608-418.76; L609-418.76(a)(1)(i); L609-418.76(a)(1)(ii); L609-418.76(a)(1)(iii); L609-418.76(a)(1)(iv); L611-418.76(b)(1); L612-418.76(b)(2); L613-418.76(b)(3)(i); L613-418.76(b)(3)(ii); L613-418.76(b)(3)(iii); L613-418.76(b)(3)(iv); L613-418.76(b)(3)(v); L613-418.76(b)(3)(vi); L613-418.76(b)(3)(vii); L613-418.76(b)(3)(viii); L613-418.76(b)(3)(ix)(A); L613-418.76(b)(3)(ix)(B); L613-418.76(b)(3)(ix)(C); L613-418.76(b)(3)(ix)(D); L613-418.76(b)(3)(ix)(E); L613-418.76(b)(3)(ix)(F); L613-418.76(b)(3)(x); L613-418.76(b)(3)(xi); L613-418.76(b)(3)(xii); L613-418.76(b)(3)(xiii); L614-418.76(b)(4); L615-418.76(c)(1); L616-418.76(c)(2); L617-418.76(c)(3); L618-418.76(c)(4); L619-418.76(c)(5); L786-418.114(b)(2).	

HSRM 9.1 — Applicable Regulation: L609-418.76(a)(1)(i).

Option 1 for Hospice Aide Training and Competency Evaluation

Option 1: A qualified hospice aide has successfully completed:

1. A training program and competency evaluation that includes classroom and supervised practical training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or licensed practical nurse who is under the supervision of a registered nurse:
   a) Classroom and supervised practical training that total at least 75 hours.
   Applicable Regulation: L611-418.76(b)(1).
   b) A minimum of 16 hours of classroom training that precedes a minimum of 16 hours of supervised practical training as part of the 75 hours.
   Applicable Regulation: L612-418.76(b)(2).

AND

2. A training program that addresses each of the following subject areas:
   a) Communication skills, including the ability to read, write, and verbally report clinical information to patients, caregivers, and other hospice staff;
   b) Observation, reporting, and documentation of patient status and the care or service provided;

(continued on following page)

c) Reading and recording temperature, pulse, and respiration;
d) Basic infection control procedures;
e) Basic elements of body function and changes in body function that must be reported to an aide's supervisor;
f) Maintenance of a clean, healthy, and safe environment;
g) Recognizing emergencies and the knowledge of emergency procedures and their application;
h) The physical, emotional, and developmental needs of—and ways to work with—the populations served by the hospice, including the need for respect for the patient, their privacy, and their property;
i) Appropriate and safe techniques in performing personal hygiene and grooming tasks, including items on the following basic checklist:
    i. Bed bath;
    ii. Sponge, tub, and shower bath;
    iii. Hair shampoo (sink, tub, and bed);
    iv. Nail and skin care;
    v. Oral hygiene;
    vi. Toileting and elimination;
j) Safe transfer techniques and ambulation;
k) Normal range of motion and positioning;
l) Adequate nutrition and fluid intake;
m) Any other task that the hospice may choose to have an aide perform not addressed item 2.i (a-f) above, the basic checklist. **Applicable Regulation: L613-418.76(b)(3).**

AND

3. The competency evaluation addresses each of the following subject areas from item 2, above; they are evaluated by observation of an aide's performance with a patient or pseudo-patient, including:
    a) Communication skills, including the ability to read, write, and verbally report clinical information to patients, caregivers, and other hospice staff;
    b) Reading and recording temperature, pulse, and respiration;
    c) Appropriate and safe techniques in performing personal hygiene and grooming tasks, including items on the following basic checklist:
        i. Bed bath;
        ii. Sponge, tub, and shower bath;
        iii. Hair shampoo (sink, tub, and bed);
        iv. Nail and skin care;
        v. Oral hygiene;
        vi. Toileting and elimination;
    d) Safe transfer techniques and ambulation;
    e) Normal range of motion and positioning.

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4. The remaining subject areas in item 2 above may be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient or a pseudo-patient during a simulation.
   Applicable Regulation: L615-418.76(c)(1).

AND

5. The competency evaluation is performed by a registered nurse in consultation with other skilled professionals, as appropriate. Applicable Regulation: L617-418.76(c)(3).

AND

6. A hospice aide is not considered competent in any task for which they are evaluated as "unsatisfactory."
   a) A hospice aide may not perform that task without direct supervision by a registered nurse until after they have received training in the task for which they were evaluated as "unsatisfactory" and has successfully completed a subsequent evaluation.
   b) A hospice aide is not considered to have successfully completed a competency evaluation if the aide has an "unsatisfactory" rating in more than one (1) of the required areas.
      Applicable Regulation: L618-418.76(c)(4).

AND

7. The hospice maintains documentation that demonstrates the requirements of competency evaluation are met (items 3-5 above). Applicable Regulation: L619-418.76(c)(5).

HSRM 9.1 — Applicable Regulation: L609-418.76(a)(1)(ii).

Option 2 for Hospice Aide Training and Competency Evaluation

Option 2: A qualified hospice aide has successfully completed a competency evaluation program that:

1. Evaluates the aide's competency in the following subject areas by observation of the aide's performance with a patient or pseudo-patient:
   a) Communication skills, including the ability to read, write, and verbally report clinical information to patients, caregivers, and other hospice staff;
   b) Reading and recording temperature, pulse, and respiration;
   c) Appropriate and safe techniques in performing personal hygiene and grooming tasks, including items on the following basic checklist:
      i. Bed bath;
      ii. Sponge, tub, and shower bath;
      iii. Hair shampoo (sink, tub, and bed);
      iv. Nail and skin care;
      v. Oral hygiene;
      vi. Toileting and elimination;

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   d) Safe transfer techniques and ambulation;
   e) Normal range of motion and positioning.

2. Evaluates the aide's competency in the following subject areas by written exam, oral examination, or after observation of a hospice aide with a patient or a pseudo-patient during a simulation:
   a) Observation, reporting, and documentation of patient status and the care or service provided;
   b) Basic infection control procedures;
   c) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor;
   d) Maintenance of a clean, safe, and healthy environment;
   e) Recognizing emergencies and the knowledge of emergency procedures and their application;
   f) The physical, emotional, and developmental needs of—and ways to work with—the populations served by the hospice, including the need for respect for the patient, their privacy, and their property;
   g) Adequate nutrition and fluid intake;
   h) Any remaining task(s) that the hospice chooses to have an aide perform.
   Applicable Regulation: L615-418.76(c)(1).

AND

3. The competency evaluation is performed by a registered nurse in consultation with other skilled professionals, as appropriate. **Applicable Regulation: L617-418.76(c)(3).**

AND

4. A hospice aide is not considered competent in any task for which they are evaluated as "unsatisfactory."
   a) A hospice aide may not perform that task without direct supervision by a registered nurse until after he/she has received training in the task for which he/she was evaluated as "unsatisfactory" and has successfully completed a subsequent evaluation.
   b) A hospice aide is not considered to have successfully completed a competency evaluation if the aide has an "unsatisfactory" rating in more than one (1) of the required areas.
   Applicable Regulation: L618-418.76(c)(4).

AND

5. The hospice maintains documentation that demonstrates the requirements of competency evaluation are met. **Applicable Regulation: L619-418.76(c)(5).**

HSRM 9.1 — Applicable Regulation: L609-418.76(a)(1)(iii). **Option 3 for Hospice Aide Training and Competency Evaluation**
Option 3: A qualified hospice aide: 1. Has completed a nurse aide training and competency evaluation program approved by the state as meeting the requirements of nurse aide training and competency evaluation per CMS CFR 483.151-154 (state approval of aide training and competency program per regulation); and 2. Is currently listed in good standing on the state nurse aide registry.

HSRM 9.1 — Applicable Regulation: L609-418.76(a)(1)(iv). **Option 4 for Hospice Aide Training and Competency Evaluation**
Option 4: A qualified hospice aide has completed a state licensure program.

Standards	Evidence Guidelines
HSRM 10.I A hospice aide is not considered to have completed a training and competency evaluation program, if, since the individual's most recent completion of the program(s), there has been a continuous period of 24 consecutive months during which none of the services described in §409.40 (home health aide services) were provided for compensation. 1. If there has been a 24-month lapse in providing services, the individual must complete another program, as described in HSRM 9.I, options 1-4. Applicable Regulation: L610-418.76(a)(2).	**Personnel Record Review:** If during reviewing the personnel records, such an individual is identified, ask how hospice subsequently ensured he/she met the qualifications of a hospice aide.
HSRM 11.I A hospice aide competency evaluation program may be offered by any organization except a home health agency that within the previous two (2) years: 1. Was out of compliance with home health agency aide training and competency evaluation; 2. Permitted an individual that does not meet the definition of a "qualified home health aide" to furnish home health aide services (with the exception of licensed health professionals and volunteers); 3. Was subjected to an extended (or partially extended) survey as a result of being found to have provided substandard care (or for other reasons as determined by CMS or the state); OR *(continued on following page)*	**Document Review:** If the organization provides a hospice aide competency evaluation program, validate that they have not met any of the conditions which prohibit the ability of the organization to offer this training. **Guidance:** CMS has been asked to give guidance on the inclusion of this standard in the hospice Conditions of Participation (CoPs).

Standards	Evidence Guidelines
HSRM 11.I 4. Was assessed a civil monetary penalty of $5,000 or more as an intermediate sanction; OR 5. Was found by CMS to have compliance deficiencies that endangered the health and safety of the home health agency's patients and had temporary management appointed to oversee the management of the home health agency; OR 6. Had all or part of its Medicare payments suspended; OR 7. Had been found by CMS or the State under any federal or state law to have: a) Had its participation in the Medicare program terminated; b) Been assessed a penalty of $5,000 or more for deficiencies in federal or state home health agency standards; c) Been subject to a suspension of Medicare payment to which it otherwise was entitled; d) Operated under temporary management that was appointed by a governmental authority to oversee the operation of the home health agency and to ensure the health and safety of the home health agency's patients; e) Has been closed by CMS or state, or had its patients transferred by the state. Applicable Regulation: L624-418.76(f).	

Standards	Evidence Guidelines
HSRM 12.I Individuals providing Medicaid personal care aide-only services under a Medicaid personal care benefit can provide personal care services on behalf of a hospice if the individual is found competent by the state (if regulated by the state) to provide those services. The individual personal care aide needs only to demonstrate competency in the services that he/she is required to furnish. **Applicable Regulation: L634-418.76(i)(1).**	**Interview and Personnel Record Review:** Ask a hospice staff member if the hospice is using Medicaid personal care aides for a Medicare/Medicaid dual-eligible patient. If so, ask to see the documented competencies correlating to their assignment.
HSRM 13.I Homemaker services are provided by qualified individuals who: 1. Can provide assistance in maintenance of a safe and healthy environment and services to support the plan of care; 2. Have successfully completed hospice orientation addressing the needs and concerns of patients and families coping with a terminal illness; OR 3. Are qualified hospice aides as described under HSRM 9.I, above. **Applicable Regulations: L607-418.76; L637-418.76(j).**	**Personnel Record Review:** Review the homemaker personnel records.

Standards	Evidence Guidelines
HSRM 14.I The hospice assesses the skills and competencies of all individuals providing care, including volunteers providing services and, as necessary, provides in-service training and education programs where required. The hospice has written policies and procedures describing the method(s) of assessing competency and: 1. Maintains a written description of the in-service training provided during the previous 12 months. Applicable Regulation: L663-418.100(g)(3).	**Document Review:** Review the policy and procedure regarding competency assessment. Clarify that these requirements apply to contracted personnel and volunteers. **Personnel Record Review:** In reviewing personnel records confirm the assessment of skills and competency. Ask to see evidence for volunteers providing services.
HSRM 15.I The hospice provides an initial orientation for each employee that addresses the employee's specific job duties, including infection control and organization procedures and policies and procedures on advance directives. Orientation on the hospice philosophy is also provided to all employees and contracted staff who have patient and family contact. Orientation includes the following, as appropriate to the employee's specific job duties: 1. The needs and concerns of patients and families coping with a terminal illness; 2. Education regarding the hospice's policies and procedures on advance directives. Applicable Regulations: L503-418.52(a)(2); L637-418.76(j); L661-418.100(g)(1); L662-418.100(g)(2).	**Personnel Record Review:** Review personnel records to verify orientation provided to staff and contracted employees. Verify that initial orientation, assessment of skills and competency, and in-service training was provided to all employees, contracted staff, and volunteers furnishing care/services to hospice patients and families. **Document Review:** Does the orientation provided to all employees and contracted staff who have patient and family contact address the needs and concerns of patients and families coping with a terminal illness and education regarding the hospice's policies and procedures on advance directives?

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HSRM 16.I

The hospice obtains a criminal background check on all hospice employees who have direct patient contact or access to patient records.

1. Hospice contracts require that all contracted employees who have direct patient contact or access to patient records obtain criminal background checks.
2. Criminal background checks are obtained in accordance with state requirements.
    a) In the absence of state requirements, criminal background checks are obtained within three (3) months of the date of employment for all states in which the individual has lived or worked during the past three (3) years.

Applicable Regulations: L795-418.114(d)(1); L796-418.114(d)(2).

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Personnel Record Review: Review personnel records to verify that employees and contracted staff who have direct patient contact or access to patient records have criminal background checks as required by the standard.

Contract Review: Does the hospice contract require that all contracted employees who have direct patient contact or access to patient records obtain criminal background checks?

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HSRM 17.I

Licensed professionals participate in hospice sponsored in-service training.

Applicable Regulation: L586-418.62(c).

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Personnel Record Review: Ask for evidence that licensed hospice professionals participate in hospice in-service training programs.

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Standards	Evidence Guidelines
HSRM 18.I A hospice aide receives at least 12 hours of in-service training during each 12-month period. 1. In-service training may occur while an aide is furnishing care to a patient. 2. In-service training may be offered by any organization and is supervised by registered nurse. 3. The hospice maintains documentation that demonstrates that requirements 1 and 2, above, have been met for each aide. Applicable Regulations: L620-418.76(d); L621-418.76(d)(1); L622-418.76(d)(2).	**Personnel Record Review:** Ask for evidence of in-service training for a sample of the hospice aides. **Interview:** Ask how the hospice ensures that every aide receives at least 12 hours in-service training in a 12-month period. **Guidance:** The annual 12 hours can be fulfilled on a calendar year basis, an employment anniversary, or a rolling 12-month basis for each aide. **Guidance:** Hospice aide in-service training that occurs with a patient in a place of residence with an RN as part of the every 14-day supervisory visit can count toward the in-service requirement with documentation of the new skill or theory.
HSRM 19.I Classroom and supervised practical training are performed by a registered nurse who possesses a minimum of two (2) years nursing experience, at least one (1) year of which is in home care. 1. Other individuals can provide practical training under the general supervision of an RN. Applicable Regulation: L623-418.76(e).	**Personnel Record Review:** Confirm the experience of the RN(s) providing classroom and supervised training. **Document Review:** If the organization provides aide training, was the classroom and supervised practical training performed by a registered nurse who possesses a minimum of two (2) years nursing experience, at least one (1) year of which is in home care? **Guidance:** The two (2) years “hands-on” experience can be in hospice or home health. **Guidance:** Other individuals who may help with training include physicians, PTs, social workers, pharmacists, etc.

Standards	Evidence Guidelines
HSRM 20.I Licensed professional services provided directly or under arrangement are supervised only by appropriately qualified health care professionals who meet the appropriate qualifications and who practice under the hospice's policies and procedures. Applicable Regulations: L583-418.62; L584-418.62(a).	**Interview:** Interview one or more licensed professionals who are providing care; ask who is directly supervising their care/services. Verify how the supervisor is qualified. **Clinical Record Review:** Confirm that licensed professional services are provided per the plan of care. **Personnel Record Review:** Confirm that licensed professionals, direct and contracted, are appropriately supervised. **Guidance:** For this standard, licensed professionals include physicians, skilled nursing, PT, SLT, OT and medical social services. **Guidance:** Professional practice acts may limit if one professional discipline is permitted to evaluate the clinical performance of another professional discipline. It is expected that hospices are aware of such requirements and structure the evaluation of clinical care as necessary.
HSRM 21.I Employed physicians and those under contract practice under the supervision of the hospice medical director. Applicable Regulations: L590-418.64(a); L590-418.64(a)(1); L590-418.64(a)(2); L590-418.64(a)(3).	**Interview:** Ask the medical director how they provide supervision to other physicians.

Standards	Evidence Guidelines
HSRM 22.I The hospice provides nursing care under the supervision of a registered nurse. Applicable Regulation: L591-418.64(b)(1).	**Document Review:** Review documents and/or processes that delineate supervision of nurses and the qualifications of those supervisors.
HSRM 23.I A social worker who holds a bachelor's degree is supervised by a CMS-qualified MSW who has a degree from a school of social work accredited by the Council on Social Work Education and has one (1) year of experience in a health care setting. Applicable Regulation: L787-418.114(b)(3).	**Personnel Record Review:** If the social worker has a bachelor's degree, confirm that the supervisor is a qualified MSW. **Guidance:** Supervision may occur in person, over the telephone, through electronic communication, or any combination thereof. The supervision occurs on a regular basis defined by the hospice.
HSRM 24.I Bereavement services are supervised by a qualified professional with experience or education in grief or loss counseling. Applicable Regulations: L596-418.64(d)(1)(i); L596-418.64(d)(1)(ii); L596-418.64(d)(1)(iii); L596-418.64(d)(1)(iv).	**Personnel Record Review:** Verify that there is documentation that bereavement services are supervised by a qualified professional with experience or education in grief or loss counseling.

Standards	Evidence Guidelines
HSRM 25.I Hospice aides are supervised by a registered nurse who makes an on-site visit to the patient's home no less frequently than every 14 days to: 1. Assess the quality of care and services provided by the hospice aide; 2. Ensure that services ordered by the hospice Interdisciplinary Group (IDG) meet the patient's need. The hospice aide does not need to be present. Applicable Regulation: L629-418.76(h)(1)(i).	**Clinical Record Review:** Evidence of supervision documented in the patient's record. **Guidance:** The elements of hospice aide supervision ensure that aides furnish care safely and effectively, including, but not limited to, the following: • Following the patient's plan of care for completion of tasks assigned to a hospice aide; • Creating a successful interpersonal relationship with the patient and family; • Demonstrating competency with assigned tasks; • Complying with infection prevention and control policies and procedures; • Reporting changes in the patient's condition; and • Honoring patients' rights.
HSRM 26.I If an area of concern regarding aide services is noted by the supervising nurse, the hospice arranges an on-site visit to the location where the patient is receiving care to observe and assess the aide while they are performing care. If the area of concern is verified during the on-site visit, the hospice conducts—and the hospice aide completes—a competency evaluation of the deficient skill and all related skill(s). Applicable Regulations: L630-418.76(h)(1)(ii); L631-418.76(h)(1)(iii).	**Personnel Record Review:** Ask if a situation as described has occurred through interview or in a patient record documentation. If so, review documentation that the aide completed competency evaluation again before being re-assigned.

Standards	Evidence Guidelines
HSRM 27.D A registered nurse makes an annual on-site visit to the location where a patient is receiving care in order to observe and assess each hospice aide while they are performing care per the hospice's policies and procedures. Applicable Regulation: L632-418.76(h)(2).	**Personnel Record Review:** Review a random sample of 2 hospice aide personnel records to confirm the supervisory direct observations are completed annually. **Interview:** Ask staff how the hospice assures that all aides are supervised annually. **Document Review:** Review the P&P as to how the setting in which the aide works is selected. **Guidance:** There is no requirement for the observation to be conducted for each patient for whom the aide is caring.
HSRM 28.I The supervising registered nurse assesses an aide's ability to demonstrate initial and continued satsifactory performance in meeting outcome criteria that include, but are not limited to: 1. Following the patient's plan of care for completion of tasks assigned by the RN; 2. Creating successful interpersonal relationships with the patient and family; 3. Demonstrating competency with assigned tasks; 4. Complying with infection control policies and procedures; 5. Reporting changes in the patient's condition. Applicable Regulation: L633-418.76(h)(3).	**Personnel Record Review:** In a sample of aide personnel files, look for the annual assessment addressing the five elements. **Guidance:** Supervisory visits can be made in conjunction with a visit to provide services. Registered nurse documentation includes if the aide is following the plan of care, is competent in performing a task, and is satisfactory to the patient and family.

Standards	Evidence Guidelines
HSRM 29.D Personnel performance is evaluated as defined by the hospice's policy and procedure, as well as in accordance with state and federal law and regulation.	**Personnel Record Review:** Validate that performance evaluations are completed in accordance with hospice policy. **Guidance:** Professional practice acts may limit if one professional discipline is permitted to evaluate the clinical performance of another professional discipline. It is expected that hospices are aware of any limitation and structure the performance evaluation as necessary. **Guidance:** The organization determines the frequency of the evaluation.
HSRM 30.I The hospice documents and demonstrates viable and ongoing efforts to recruit and retain volunteers. Applicable Regulations: L645-418.78(c).	**Interview:** Interview the volunteer coordinator to determine what recruitment and retention activities are planned and/or used.

Standards	Evidence Guidelines
HSRM 31.I The hospice maintains, documents, and provides hospice volunteer orientation and training that is consistent with hospice industry standards; it includes**:** 1. The volunteer's duties and responsibilities; 2. The person to whom they report; 3. The person to contact if they need assistance and instruction; 4. Hospice goals, services, and philosophy; 5. Confidentiality and protection of the patient's and family's rights; 6. Family dynamics and psychological issues surrounding terminal illness, death, and bereavement; 7. Procedures to be followed in an emergency and/or following the death of a patient; 8. Guidance specific to individual responsibilities. Volunteers are supervised by a designated hospice employee. **Applicable Regulations: L641-418.78; L643-418.78(a).**	**Personnel Record Review:** Ask to see evidence of the orientation and ongoing training of a sample of volunteers. Review to assess if content meets the intent of the standard and if the designated supervisor is identifiable. **Interview:** Ask a volunteer about the training and orientation they received.

Hospice Infection Prevention and Control (HIPC)

KEY PERFORMANCE AREA:

Providing hospice care requires effective infection prevention and control processes to reduce the risk of acquiring or transmitting infectious disease in any settings where hospice care is provided.

Effective communication with the Interdisciplinary Group (IDG), patients, families, and visitors about infection prevention and control is key to supporting their roles in reducing the risk of spreading infectious and communicable disease through daily activities and interaction.

The environment of care is also where the patient/family resides. The IDG must balance respect for a patient's self-care as well as patient and family autonomy with identified infection control risk. The IDG's role is to ensure that the patient and family understand the importance of minimizing those risks.

Standards	Evidence Guidelines
HIPC 1.D The hospice documents and maintains an effective infection control program that protects patients, families, visitors, and hospice staff by preventing and controlling infections and communicable diseases. The infection control program includes: 1. Identifying risk for acquiring and transmitting infectious agents where the patient resides; 2. Guidelines for addressing and preventing infection related to infusion therapy, urinary tract care, respiratory tract care, and wound care; 3. Guidelines for caring for patients with a multi-drug resistant organism; 4. Policies on protecting patients, staff, and families from bloodborne or airborne pathogens; 5. Education of employees, contracted providers, patients, families, and other caregivers in infection control; 6. How timely communication occurs with hospice staff, patients, families, and visitors about infection prevention and control issues, including their role in preventing the spread of infections and communicable diseases through daily activities. Applicable Regulations: L577-418.60; L582-418.60(c).	**Document Review:** Review the written infection prevention and control program and note how it correlates to the items in the standard. **Personnel Record Review:** Ask to see evidence of infection control training and how often the hospice repeats the training. **Interview:** Ask IDG members what steps they routinely take to ensure they are following the defined infection prevention and control program, and what their role is in educating the patient and family. Patient-specific examples can be used. Ask IDG members how they ensure that patient and family receive timely instruction about preventing and controlling infection when a risk is identified. Ask the staff what training they received in infection control and how often they receive the training. Training should include but not be limited to identification of infection signs and symptoms, routes of infection transmission, and the components of standard precautions.

Standards	Evidence Guidelines
HIPC 2.I The hospice follows accepted standards of practice to prevent the transmission of infections and communicable disease, including the use of standard precautions, such as: 1. Hand hygiene; 2. Use of gloves, mask, eye protection, or face shield depending on anticipated exposure; 3. Safe handling of equipment in the patient's care environment if it is likely to have been contaminated with body fluids; 4. Safe handling of soiled items in the patient's care environment; 5. Other requirements of applicable state and federal law and regulation. Applicable Regulation: L579-418.60(a).	**Observation:** During home visits, observe precautions to avoid risk of infection in addition to use of standard precautions. Observe hand hygiene and wound care to see how clean/ sterile wound supplies are stored/ protected in the home and during transport by staff, and how soiled/ contaminated dressings are handled by hospice staff. **Guidance:** Standard precautions are defined by the Centers for Disease Control (CDC) and based on the principle that all blood, body fluid, secretions, excretions (except sweat), non-intact skin, and mucous membranes may contact transmissible infectious agents. Standard precaution practices apply to all patients, regardless of suspected or confirmed infectious status, in any setting in which care is provided.
HIPC 3.I Hand hygiene products, personal protective equipment (PPE), and other equipment and supplies are available to the IDG members at risk of occupational exposure to bloodborne pathogens and other potentially infectious materials in accordance with state law and regulation.	**Observation:** During home visits, validate that the IDG has hand hygiene products and PPE available for use. **Interview:** Ask IDG members about their access to PPE and hand hygiene products. **Guidance:** Some local or state authorities may require specialized PPE. Some states, for example, may require that all personnel be fitted with an N95 respirator or similar device. It is expected that the hospice has knowledge of and complies with state law and regulation.

Standards	Evidence Guidelines
HIPC 4.I Bags used to carry medical equipment (e.g., BP cuff) or supplies into or out of the care environment are transported and used in a manner consistent with organizational policy to prevent the spread of infections and communicable diseases.	**Observation:** Observe the transport and use of bags in the care environment. Verify that policy is followed and that bags are managed in a manner that avoids cross-contamination.
HIPC 5.I The hospice maintains a coordinated, agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases. The infection control program includes: 1. A method for identifying infectious and communicable disease problems; 2. A plan for implementing appropriate actions that are expected to result in improvement and disease prevention. Applicable Regulations: L580-418.60(b)(1); L581-418.60(b)(2)(i); L581-418.60(b)(2)(ii).	**Interview:** Ask the hospice staff member who has oversight of the infection control program to explain the methods used to identify infectious and communicable disease. **Document Review:** Ask to see how the hospice is identifying risk and what is monitored. **Guidance:** Infection control practices can include monitoring employee illness and infection and analyzing these in relation to patient infections. Take appropriate actions (e.g., appropriate cough technique) when an infection or communicable disease is present to prevent its spread among patients, family, visitors, and the IDG.

Standards	Evidence Guidelines
HIPC 6.I The hospice properly stores and disposes of medical waste products and contaminated syringes generated in the performance of care and services. 1. All used needles are placed in a non-permeable, tamper-proof, puncture-resistant container that is not recapped or broken. 2. The puncture-proof container is disposed of appropriately. 3. Storage and disposal of medical waste products is in accordance with local, state, and federal law and regulation.	**Observation:** Conduct home visits or other observations of the care environment. If medical waste is generated, observe that it is disposed of and transported safely. **Guidance:** When medical waste is not produced in the provision of care and services, the standard does not apply. **Guidance:** It is expected that the hospice has knowledge of and complies with state and local law and regulation. **Guidance:** In offices or other administrative spaces, it is expected that medical waste is stored in a separate and clearly labeled space prior to disposal. The space chosen does not need to be a separate location that is locked or otherwise secured. **Tip:** Specific guidelines on infectious waste can be found on the Centers for Disease Control and Prevention (CDC) website.

Standards	Evidence Guidelines
HIPC 7.I The hospice provides infection control education to employees, contracted providers, patients, family members, and other caregivers that is individualized to the needs of each patient. Applicable Regulation: L582-418.60(c).	**Clinical Record Review:** Validate the types of education provided to patients and families for minimizing the spread of infections and communicable disease, including safe handling and disposal of waste products and syringes. **Patient/family Interview:** Interview patient to determine: • If hospice staff perform hand hygiene, use personal protective equipment, clean reusable equipment, and handle/dispose of needles and sharps safely. • If infection control education has been provided prior to treatments. Inquire with the patient regarding the information to assess their knowledge and recall of the information. **Tip:** Information on the safe disposal of sharps generated by patients can be found on the Food and Drug Administration (FDA) website.
HIPC 8.D Work surfaces in the patient's environment are cleaned as defined in the hospice's infection prevention and control policies and procedures.	**Document Review:** Review the policy and procedure for work surface cleaning. **Observation:** During a home visit, confirm that work surfaces are cleaned as defined in policy. **Guidance:** "Care environment" is where the patient is receiving care. **Guidance:** It is recognized that in a patient's home, there may be limitations beyond the control of the hospice.

Standards	Evidence Guidelines
HIPC 9.I Hospice staff at risk for occupational exposure to TB, are screened and tested as defined in state or local law and regulation or per the organization's assessment of TB exposure risk based on the population and/or the community served. In the absence of state or local law and regulation or organization identified risk, screening and testing of staff occurs per the current Centers for Disease Control and Prevention (CDC) guidelines. There is appropriate follow-up when TB risk is identified.	**Document Review:** Review documents describing the hospice's TB testing and screening program. Confirm that it identifies when, and which, hospice staff are screened for TB. Confirm it is consistent with CDC guidelines and complies with local and state TB testing and screening guidelines/laws and regulations, such as requirements for documentation of chest x-rays for staff with previous history of a positive TB test. **Personnel Record Review:** Review documents recording TB testing and screening for individual personnel. Confirm that testing and screening occur as described in the Infection Prevention and Control Program. **Guidance:** TB testing is administered by reading the results of a TB test. Testing can be done by the organization or an outside entity. It is expected that new personnel at risk for TB exposure are tested in accordance with policy and procedure (P&P) and as required by state or local law or guidelines. Ongoing TB testing of staff should be based on the risk assessment of the communities being served and state and local law or guidelines that apply to the risk assessment results. **TIP:** Organizations may want to contact their local or state health department for guidance on TB risk assessment, follow up, testing, treatment, and chest x-ray requirements.

Standards	Evidence Guidelines
HIPC 10.D The hospice has policies and procedures for the management of reported work-related exposure and post-exposure follow-up. Follow-up notifications, testing, and treatment policy comply with local, state, and federal law and regulation.	**Document Review:** Ask to review the policies and procedures that define the reporting and response to occupational exposure, including employee follow-up and intervention. **Document Review:** Ask to review any reports that have been made in the last year and confirm if the process was followed per P&P and applicable law and regulation. **Tip:** Additional guidance can be found in Occupational Safety and Health Administration (OSHA) directives.

Hospice Information Management (HSIM)

KEY PERFORMANCE AREA:

The hospice's effective use of information supports clinical improvement and business intelligence. Whether paper or electronic, the system for using the data requires defined processes to collect, store, retrieve, transmit, and protect data.

Standards	Evidence Guidelines
HSIM 1.D Information management policies and procedures (P&P) address how the hospice documents, collects, retrieves, protects, shares, and retains information in accordance with state and federal law and regulation. Patient clinical records are retained for six (6) years after the death or discharge of the patient unless state law stipulates a longer time period. **Applicable Regulation: L681-418.104(d).**	**Document Review:** Review policies and procedures or other documentation related to information management. Validate that P&P describes how the organization collects, protects, shares, and retains information in accordance with state and federal law and regulation.

<table>
<tr><th>Standards</th><th>Evidence Guidelines</th></tr>
<tr><td>HSIM 2.I

The hospice uses standardized formats, data elements, and a system for documenting information and storing it for easy access. The system is used for:
1. Operational information (e.g., financial, staffing, etc.);
2. Personnel information;
3. A record of the delivery of care and services.

The format is consistent with hospice policies and procedures.

The hospice has a list of abbreviations, acronyms, or symbols that cannot be used by staff.</td><td>Clinical Record Review: Confirm that entries in the patient record use a standardized format for documenting the delivery of care.

Document Review: Ask to see the list of abbreviations, acronyms, and symbols that the hospice is prohibited from using in documentation.

Guidance: The format for recording required information is determined by the hospice. Records may be in paper or electronic form, and the method(s) for recording data may vary depending on the electronic record and hospice policy.</td></tr>
</table>

Standards	Evidence Guidelines
HSIM 3.I A patient clinical record containing past and current findings is maintained for each hospice patient. The record contains correct clinical information that is available to the patient's attending physician and hospice staff. The record may be maintained electronically or on paper. Each patient's record includes, at a minimum: 1. The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes including the care and services provided; 2. Signed copies of the notice of patient rights and the hospice election statement; 3. Responses to medications, symptom management, treatments, and services; 4. Outcome measure data elements per regulation; 5. Physician certification and recertification of terminal illness as required; 6. Any advance directives; 7. Copies of inpatient discharge summary, as applicable; 8. Physician orders. **Applicable Regulations: L670-418.104; L672-418.104(a)(1); L673-418.104(a)(2); L674-418.104(a)(3); L675-418.104(a)(4); L676-418.104(a)(5); L677-418.104(a)(6); L678-418.104(a)(7).**	**Clinical Record Review:** Review a sample of patient records against the standard criteria. If inpatient care is provided, it is the hospice's choice whether or not a copy of the inpatient record is provided. **Guidance:** Hospices follow state laws regarding authentication of clinical records. **Guidance:** Hospices are expected to alter their documentation practices to adapt to changing technologies used in their organization. **Exception:** Facsimiles of original written or electronic signatures are acceptable for the certification of terminal illness for hospice.

Standards	Evidence Guidelines
HSIM 4.I All entries in the patient record are legible, complete, and appropriately authenticated and dated by the person performing the care/service in accordance with hospice policy and with currently acceptable standards of practice. The hospice has a means to authenticate entries or to identify the author of each entry. 1. If the hospice uses electronic records, electronic authentication utilizes a user ID and password protection. **Applicable Regulation: L679-418.104(b).**	**Clinical Record Review:** In reviewing the sample of patient records, consider the authentication. **Interview:** Ask the hospice administrator how they authenticate entries or identify the author of each entry. **Guidance:** Medicare requires a legible identifier for services provided/ordered. Authentication must be a handwritten (not stamped) or electronic signature for all orders or other clinical documentation. If the state law is more restrictive than Medicare, the hospice needs to apply the state law.
HSIM 5.I The clinical patient record, its content, and the information it contains is safeguarded against loss or unauthorized use. The hospice addresses: 1. Leaving and protecting patient record information in the home; 2. Prevention of physical or electronic altering of the patient record. The hospice complies with state and federal law and regulation addressing privacy, including the Health Insurance and Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). **Applicable Regulation: L680-418.104(c).**	**Interview:** Ask the staff responsible for patient records how the hospice protects their confidentiality, including access by unauthorized staff and by hospice staff needing access during non-business hours. **Interview:** If the hospice uses electronic records, what security is in place to protect the electronic system against loss, damage, disruption in operations (e.g., EP), or system failure? **Observation:** Note the security practices during home visit, transit to the visit, and in the office.

Standards	Evidence Guidelines
HSIM 6.I The patient clinical record, whether in hard copy or in electronic form, is made readily available on request by an appropriate authority. *Applicable Regulation: L685-418.104(f).*	**Document Review:** Review policy related to release of information. Verify that it defines authorization processes and timeframes, and that it states that patient records are available to authorized persons and entities. **Interview:** Interview person(s) responsible for releasing patient records. Discuss the process to request patient records, the authorization process, and the timeframes for release of records.
HSIM 7.I In the event the hospice discontinues operations, policies stipulate procedures for: 1. Retention of records; 2. Storage of records; 3. Access to those records; 4. Notification to the State Survey Agency and its CMS Location as to where such records are stored and how they may be accessed. *Applicable Regulation: L681-418.104(d).*	**Document Review:** Review policies regarding record retention. Validate that the policy specifies how records will be retained and stored if the hospice discontinues operations.

Hospice Emergency Preparedness (HSEP)

KEY PERFORMANCE AREA:

Hospices prepare for emergency events through planning, organizing, training, evaluating, and taking necessary corrective actions to ensure an effective, coordinated response when such events occur.

The goal of emergency preparedness (EP) is to prioritize the safety of patients, caregivers, families, and hospice staff to minimize interruptions to the delivery of care and services.

Standards	Evidence Guidelines
HSEP 1.I The hospice maintains a written comprehensive emergency preparedness program that: 1. Demonstrates compliance with applicable federal, state, and local emergency preparedness requirements; 2. Uses an "all hazards" approach; 3. Describes the hospice's approach to meeting the health, safety, and security of: a) The staff; b) The patient population, with attention to their mobility; 4. Describes how the hospice coordinates with other healthcare facilities, as well as the community, during an emergency or disaster situation. Applicable Regulation: E1-418.113.	**Document Review:** Review the written EP plan; confirm that it considers the mobility of the patient population and how that is addressed within changing patient needs such as GIP (general inpatient care), continuous care, and routine home care. **Interview:** Interview the hospice's clinical and administrative leaders and ask them to describe the basics of the EP plan. **Guidance:** "Comprehensive" incorporates the "all hazards" definition (i.e., threats or hazards classified as probable and that could cause injury, property damage, business disruption or environmental impact) and is specific to the hospice's location and geographic area, covering consideration of a multitude of events (e.g., not solely seasonal weather events).

Standards	Evidence Guidelines
HSEP 2.D The hospice develops and maintains an emergency preparedness (EP) plan that is reviewed and updated at least every two(2) years. The plan: 1. Is based on and includes a documented hospice-based and community-based risk assessment, using an "all-hazards" approach specific to the geography and population served; 2. Includes strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of: a) Power failures; b) Natural or man-made disasters; c) Emerging infectious diseases (EIDS) that place the health and safety of patients and employees at risk; and d) Other anticipated emergencies that could affect the hospice's ability to provide care; 3. Addresses the patient population served, specifically: a) the care and safety of patients with limited mobility; and b) those requiring evacuation due to a medical or psychiatric condition, or their home environment; 4. Addresses when emergency preparedness officials are contacted regarding evacuation of patients; 5. Defines the type of care and services the hospice can provide in an emergency; *(continued on following page)*	**Document Review**: Review the EP plan and ensure that it is reviewed and updated every two years. Review documentation of the risk assessment. Does the plan include: • Strategies for responding to events identified in the risk assessment, including EIDS? • A means to identify patients with limited mobility, and likely need assistance with evacuation and a strategy to respond? • When EP officials are advised of the need to evacuate? • Definition of how the hospice will continue operations during the emergency, and delegation of authority? **Interview:** Interview the hospice staff member responsible for the EP Plan. Ask about the hazards that were identified in the community-based assessment and how they were incorporated into the EP plan. Ask the staff identified as the leader for EP: • What are the most common emergency event(s) identified and their strategies for response? • Their experience in working with EP official at the local, State and Federal levels? **Guidance:** Regarding Emerging Infectious Diseases (EIDs) (e.g. zika, ebola, measles, and others), the plan *(continued on following page)*

Standards	Evidence Guidelines
HSEP 2.D 6. Addresses continuity of business functions essential to operations, including identification of staff or positions that can assume key organization roles if current staff and leadership are not available; and, 7. Includes a process 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. **Applicable Regulations: E4-418.113(a); E6-418.113(a)(1); E6-418.113(a)(2); E7-418.113(a)(3); E9-418.113(a)(4).**	should include anticipating needed changes to the hospice's protocols to protect the health and safety of patients such as availability of isolation as well as protect the health of staff including additional personal protective equipment (PPE) and/or other measures.

Standards	Evidence Guidelines
HSEP 3.D The hospice implements emergency preparedness (EP) policies and procedures, based on the emergency plan, the risk assessment, and the communication plan. The policies and procedures address: 1. Development and inclusion of a plan for each hospice patient during a natural or man-made disaster as part of a patient/family comprehensive assessment; 2. The documented discussion of the plan provided to the patient/family, and maintained by the hospice; 3. Follow up with patients/families to determine needs in the event that care is interrupted during or due to an emergency; 4. Arrangements with facilities and other providers to receive patients to maintain the continuity of care to patients; 5. Informing local and state emergency officials about patients in need of evacuation from their residence at any time due to the emergency based on the patient's medical or psychiatric condition, or home environment; 6. The minimum information provided to facilitate patient evacuation and transportation including: a) If the patient is mobile or not; b) If the patient has life-dependent equipment, and if so, is it able to be transported (e.g. battery operated, size, condition, etc.); and, c) Any patient special needs including cognitive disorders, intellectual disabilities, or communication issues (e.g. deaf, non-English speaking, etc.). *(continued on following page)*	**Document Review:** Review EP policies and procedures that should align with identified hazards in the risk assessment. Verify the policies and procedures address the following: • Identification of the patients who should be evacuated by reason of need for medical or psychiatric condition, home environment or continuity of care; • How and when EP officials are told of the need to evacuate patients; • Identification of the information to accompany the patient including if the patient is mobile, has life-dependent equipment and ability to transport it, and any special needs identified; and, • Plans for emergency staffing to meet patient needs, including volunteers, contacting off-duty staff, or integrating state or federal designated staff to address surge patient needs during an emergency. Confirm EP policies and procedures are updated at least every two (2) years. **Clinical Record Review:** Verify that each patient has an individualized emergency plan documented as part of the comprehensive assessment and there is evidence of the discussion. **Observation – Home Visit:** Ask the patient or family member during the home visit about their emergency plan. *(continued on following page)*

Standards	Evidence Guidelines
HSEP 3.D 7. A system of medical documentation that preserves patient information, protects the confidentiality of patient information, and secures and maintains the availability of records; 8. Informing local and state emergency officials of any on-duty employees that the hospice is unable to contact; 9. The role of hospice employees in providing care at alternate care sites during emergencies; and, 10. The use of volunteers, off-duty hospice employees and other emergency staffing strategies, including the process and role for the integration of State and Federally designated health care professionals to address surge patient care needs during an emergency. Policies and procedures are reviewed and updated at least every two (2) years. **Applicable Regulations: E13-418.113(b); E16-418.113(b)(1); E19-418.113(b)(2); E23-418.113(b)(3); E24-418.113(b)(4); E25-418.113(b)(5); E26-418.113(b)(6)(iv).**	**Interview:** Interview a member management and ask them to describe the process in place if they cannot contact all on-duty employees or patients during an emergency or disaster. At a minimum they know where to reference the process policies and procedures, and who has the lead for the situation.

Standards	Evidence Guidelines
HSEP 4.D The hospice maintains an emergency preparedness communication plan that complies with federal, state and local laws. The communication plan includes: 1. Names and contact information for hospice employees, patients' physicians, entities providing services under arrangement, and other hospices; 2. Contact information for the federal, state, tribal, regional, local emergency preparedness staff, and other sources of assistance; 3. Primary and alternate means for communicating with hospice staff, federal, state, tribal, regional, and local emergency management agencies; 4. How information and medical documentation for patients under the hospice's care is shared, as necessary, with other healthcare providers to maintain the continuity of care; 5. Information in the event of an evacuation concerning how to release patient information, including their general condition and location, as permitted by the Health Insurance Portability and Accountability Act (HIPAA). The communication plan, including all contact information, is reviewed and updated at least every two (2) years. **Applicable Regulations: E29-418.113(c); E30-418.113(c)(1); E31-418.113(c)(2); E32-418.113(c)(3); E33-418.113(c)(4-6).**	**Document Review:** Verify that the communication plan includes the elements noted, and that there is a means of updating information based on staff changes and/or changes in arrangements with other providers. Confirm it is reviewed and updated every two (2) years.

Standards	Evidence Guidelines
HSEP 5.D The hospice maintains an emergency preparedness training program that is based on the emergency preparedness plan, risk assessment, policies and procedures, and the communication plan. The training program is reviewed and updated at least every two (2) years. The hospice EP training program includes the following: 1. For all new hospice employees and those providing services under arrangement, initial training in EP policies and procedures consistent with their expected roles; 2. Demonstration of staff knowledge of emergency procedures; 3. EP training of all hospice employees and individuals providing services under arrangement at least every two (2) years; a) More frequent training occurs if there is a significant update of EP policies and procedures; 4. A periodic review and rehearsal of the hospice's EP plan with hospice employees (including non-employee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others; and, 5. Documentation of each training including the date(s), participants, and content. Applicable Regulations: E36-418.113(d); E37-418.113(d)(1).	**Document Review:** Review training documentation to ensure all elements of the standard have been met. • Evidence that the training program is reviewed every two (2) years and updated as needed. • EP staff training occurs at least every two (2) years, or more frequently if policies and procedures change in the interim period. • All new hospice employees, and those providing care under arrangement receive initial training in EP policies and procedures appropriate to their role. • There is a periodic review and rehearsal of the hospice EP plan with staff with emphasis on carrying out operations necessary to protect patients and others; and • Evidence of each training with dates, participants and content. **Interview:** Interview hospice staff to ensure clinical staff can state basic knowledge of the organization's EP plan relevant to their role (e.g. hospice nurse can advise how patients are identified as being able to remain at home in the event of a disaster and who needs to be admitted to a hospital.) **Guidance:** Hospices have the flexibility to determine the focus of the training and how it aligns with the EP plan and risk assessment. **Guidance:** Hospices with multiple locations provide training that reflects the risks identified for each specific location.

Standards	Evidence Guidelines
HSEP 6.I Testing: The hospice providing care in the patient's home conducts exercises to test the emergency preparedness plan annually, including: 1. Participation in a full-scale exercise that is community-based every two (2) years. a) When a community-based exercise is not accessible, testing includes participation in an individual, facility-based functional exercise every two (2) years. b) If the organization experiences a natural or man-made emergency that requires activation of the emergency plan, the organization is exempt from engaging in its next required full-scale community-based exercise or individual, facility-based functional exercise following the onset of the emergency event. 2. Conducting an additional exercise every two (2) years – opposite the year that a full-scale exercise or functional exercise is conducted. This exercise may include, but is not limited to: a) A second full-scale exercise that is community-based or a facility-based functional exercise; or b) A mock disaster drill; or c) A tabletop exercise or workshop that is led by a facilitator that includes a group discussion using a narrated, clinically relevant emergency scenario and a set of problem statements, directed messages, or prepared questions designed to challenge the emergency plan. **Applicable Regulation: E39-418.113(d)(2).**	**Document Review:** Review documentation evidencing organizational testing of the EP plan once annually. Acceptable tests include: 1st test in a 12-month period: Full-scale community-based exercise • If a community-based test is not accessible, an annual individual, facility-based functional exercise is acceptable. • If the hospice activates its emergency preparedness plan due to a disaster or other emergency, the next required full-scale community-based exercise or facility-based functional exercise AFTER the activation of the plan is waived. Subsequent test in next 12 twelve-month period: • A second full-scale community-based exercise or individual facility-based exercise (Note: If the hospice EP plan has been activated in the preceding 12 months it may substitute for this test), OR • A mock disaster drill, OR • A tabletop exercise or workshop. **Document Review:** Review documented evidence of all tests, results, and if the EP Plan needed to be and was revised.

Standards	Evidence Guidelines
HSEP 7.I Hospices that are part of a healthcare system consisting of multiple separately certified healthcare facilities that elect to have a unified and integrated emergency preparedness program may choose to participate in the healthcare system's coordinated EP program. If selected, the unified and integrated EP program: 1. Demonstrates that the hospice actively participated in the development of the unified and integrated emergency preparedness program; 2. Is maintained in a manner that considers the hospice's unique circumstances, patient populations, and services offered; 3. Demonstrates that the hospice is capable of actively using the unified and integrated EP program and is in compliance with it; 4. Meets the requirements of HSEP 2.D above; 5. Is based on a documented community-based risk assessment for the hospice, utilizing an all-hazards approach; 6. Includes integrated policies and procedures, a coordinated communication plan, and training and testing programs. **Applicable Regulation: E42-418.113(e).**	**Document Review:** Verify if the hospice has elected to participate in the healthcare system's program. Ask to see and review the documentation of the hospice's inclusion in the program. Ask to see the documentation verifying that the hospice was actively involved in the development of the EP plan. Ask to see documentation that the hospice was actively involved in the annual review of the program requirements and any updates. **Interview:** Ask the designated hospice staff to describe how the hospice is involved in the integrated systems exercises, review of gaps, and any changes made.

Hospice Quality Assurance and Performance Improvement (HQPI)

KEY PERFORMANCE AREA:

A hospice maintains a Quality Assurance and Performance Improvement (QAPI) program.
The QAPI program is a proactive, data-driven process to improve organizational performance and patient/family care.

Quality Assurance (QA): Quality assurance is the hospice statement of standards for quality care and outcomes. It sets the threshold throughout the organization for ensuring that care is maintained at acceptable levels in relation to those standards. QA is both anticipatory and retrospective in its efforts to identify how the hospice is performing, including where and why performance is at risk or has failed to meet standards.

Performance Improvement (PI): Performance improvement (also called Quality Improvement or QI) is the continuous evaluation and improvement of processes with the intent to improve care or outcomes, as well as prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches to fix the underlying causes of persistent problems or barriers to improvement.

QAPI represents an ongoing, organized data-driven method of improving care delivery.

Standards	Evidence Guidelines
HQPI 1.D The hospice develops, implements, and maintains an effective, ongoing, hospice-wide, data-driven quality assurance and performance improvement program (QAPI). The hospice governing body is responsible for ensuring that the program: 1. Reflects the complexity of the hospice and services; 2. Involves all hospice services, including those provided under contract; 3. Addresses efforts and sets priorities for improved quality of care and patient safety, and ensures all improvement actions are evaluated for effectiveness; 4. Focuses on indicators related to improved palliative outcomes; 5. Includes investigation and analysis of sentinel and adverse events; 6. Includes defined data detail and frequency of collection, and approves such; 7. Has evidence of action taken that results in improvement in hospice performance; 8. Is evaluated annually. Applicable Regulations: L559-418.58; L565-418.58(b)(3); L574-418.58(e)(1); L575-418.58(e)(2).	**Document Review:** Review the documented QAPI plan. Validate that it addresses the elements noted. **Guidance:** The following elements are recommended by CMS (the Centers for Medicare & Medicaid Services) to be considered in the QAPI plan: • Program objectives; • All patient care disciplines; • How the program will be administered and coordinated; • Methodology for monitoring and evaluating quality of care; • Priorities for resolving problems; • Monitoring to determine the effectiveness of action; • Responsibility for reports to governance; • Documentation of the evaluation of the QAPI program. This information will allow alignment of the data provided by the hospice with the actual experiences of hospice employees and patients to ensure that the QAPI program is prevalent throughout the hospice's operations and services, and that it is positively influencing patient care. **Guidance:** "Ongoing" means there is a continuous and periodic collection and assessment of data.

Standards	Evidence Guidelines
HQPI 2.I One or more individual(s) is appointed by the governance as responsible for operating the QAPI program. Applicable Regulation: L576-418.58(e)(3).	**Document Review:** Is there evidence of the governing body appointment of the individual(s) responsible for operating the QAPI program?
HQPI 3.I The QAPI program demonstrates measurable improvement among indicators related to improved palliative outcomes and hospice services. Applicable Regulation: L561-418.58(a)(1).	**Document Review:** In review of hospice PI projects, ascertain which ones relate to palliative care outcomes (e.g., improved pain management) and hospice services (e.g., timely social work evaluation). Is there evidence of improvement, and, if not, are there ongoing efforts to achieve improvement?
HQPI 4.I The hospice measures, analyzes, and tracks quality indicators of performance that enable the assessment of: 1. Processes of care; 2. Hospice services; 3. Operations; 4. Adverse events. Applicable Regulation: L562-418.58(a)(2).	**Document Review:** Review the QAPI program activity documentation. Validate that the hospice meets the components of the standard. **Guidance:** Hospice Medicare regulation mandates tracking of adverse events. Each hospice may develop its own definition of an "adverse health event." **Tip:** In some states, an "adverse health event" is defined. **Interview:** Interview the person responsible for the QAPI program. Verify the measurement, analysis, and tracking in the four (4) areas noted.

Standards	Evidence Guidelines
HQPI 5.I The hospice uses quality indicator data, including patient care data and other relevant data, in the QAPI program. 1. Data elements abstracted and aggregated from comprehensive patient assessments are used in quality assessment and improvement. Data collected is used to: 1. Monitor the effectiveness and safety of services and quality of care; 2. Identify opportunities and priorities for improvement. The frequency and detail of the data collection is approved by the hospice's governance. **Applicable Regulations: L535–418.54(e)(2); L563-418.58(b)(1); L564-418.58(b)(2)(i); L564-418.58(b)(2)(ii); L565-418.58(b)(3).**	**Document Review:** In the review of PI projects, review the data used. Is there evidence that the hospice identified opportunities or priorities for PI projects? Is the data working for the hospice? Is data included on analysis from sources other than assessments? Identify other sources, such as pharmaceutical data, operations related to durable medical equipment (DME) timely delivery and working order, etc. Review evidence that the frequency and detail of data collection was approved by governing body.

Standards	Evidence Guidelines
HQPI 6.1 Hospice performance improvement (PI) activities: 1. Focus on high-risk, high-volume, or problem-prone areas; 2. Consider the incidence, prevalence, and severity of problems in high-risk, high-volume, or problem-prone areas; 3. Affect palliative outcomes, patient safety, and quality of patient/family care; 4. Include the surveillance, identification, prevention, control, and investigation of infectious and communicable disease as included in the infection control program; 5. Involve licensed professionals as participants. Applicable Regulations: L566-418.58(c)(1)(i); L567-418.58(c)(1)(ii); L568-418.58(c)(1)(iii); L580-418.60(b)(1); L586-418.62(c).	**Document Review:** Review the PI activities and determine if they represent the five (5) areas required. **Interview:** Interview an individual involved in the QAPI program and ask him/her to clarify, through examples, the types of high-risk, high-volume, and problem-prone areas that are assessed—how they select priority projects and develop indicators could improve care. In review of PI projects, confirm the participation of professionals. **Guidance:** PI activities are the processes implemented by the organization to measure, analyze, and track its quality indicator and outcome data. **Guidance:** Indicators from infection control could include employee incidence of flu, patient incidence of flu, employee flu vaccination, patient incidence of pneumonia or shingles, etc.

Standards	Evidence Guidelines
HQPI 7.I Performance improvement activities: 1. Track adverse patient events; 2. Analyze the causes; 3. Implement preventive action and mechanisms that include feedback and learning throughout the hospice. *Applicable Regulation: L569-418.58(c)(2).*	**Document Review:** Review PI activities involving adverse patient events. Confirm evidence of analysis of cause and preventive action implemented. **Interview:** Ask staff involved in QAPI for the definition of adverse event used, and how feedback and learning throughout the hospice is facilitated after the adverse event.
HQPI 8.I The hospice: 1. Takes action to improve performance; 2. Assesses the success of the action after implementing it; 3. Tracks ongoing results to ensure improvement is sustained. *Applicable Regulation: L570-418.58(c)(3).*	**Document Review:** Review PI activities and assess if appropriate action is taken to correct the problems identified. Is there evidence that performance continues to be monitored to ensure improvement is sustained?

Standards	Evidence Guidelines
HQPI 9.I The documented number and scope of performance improvement projects conducted annually: 1. Represent the needs of the hospice population served; 2. Represent the internal needs of the organization; 3. Reflect the scope, complexity, and past performance of the hospice's services and operations. Documentation of selected PI projects include: 1. The reason for conducting the projects; 2. Measurable progress achieved. **Applicable Regulations: L571-418.58(d); L572-418.58(d)(1); L573-418.58(d)(2).**	**Guidance:** There is no requirement to implement a minimum number of PI activities. The number and scope should be based on the results of quality monitoring and other quality information, such as results of accreditation or state surveys. **Document Review:** PI projects are documented and address the elements of the standard.

Hospice Leadership and Governance (HSLG)

Key Performance Area:

Leadership, as governance and management, actively participates in the organization, including the effective oversight and efficient management of legal requirements, fiscal viability, and day-to-day operations of the hospice.

Governance has the overall accountability for the sustainability of the hospice.

Standards	Evidence Guidelines
HSLG 1.I The hospice and its staff operate and provide care and services: 1. In compliance with local, state, and federal law and regulation related to the health and safety of patients; 2. As a licensed entity if state or local law provides for hospice licensing. *Applicable Regulation: L797-418.116.*	**Document Review:** Review documentation related to organizational compliance. **Interview:** Ask the administrator or governing body member or owner how they ensure that the hospice is in compliance with local, state, and federal law and regulation. **Guidance:** This standard is designed to assess the organization's compliance with, and knowledge of, applicable law and regulation.

Standards	Evidence Guidelines
HSLG 2.I The hospice's governance (or designated person(s) so functioning) assumes full legal authority and responsibility for the organization's: 1. Overall management and operation; 2. Provision of care and services; 3. Fiscal operations; 4. Ongoing performance improvement and patient safety program that is defined, implemented, maintained, and evaluated annually. Applicable Regulations: L574-418.58(e)(1); L651-418.100(b).	**Document Review:** Identify evidence that the governance is involved in the four (4) elements of the standard, particularly the sustainment and annual evaluation of the hospice's quality assurance and performance improvement (QAPI) program. **Interview:** Ask a member of governance how they are informed of the organization's ongoing operations, including issues of patient/family care delivery, as well as QAPI. **Interview:** Ask the person responsible for QAPI how governance is involved and if it meets the standard.
HSLG 3.I A qualified administrator is appointed by and reports to the governing body and is responsible for day-to-day hospice operation. The hospice administrator: 1. Is an employee of the organization; 2. Informs the governing body about ongoing operations, including patient care delivery issues and QAPI activities; 3. Has the education and experience as required by the governing body. If the administrator is not available, another individual is assigned the administrator's duties and responsibilities as defined in policy and procedure. Applicable Regulation: L651-418.100(b).	**Document Review:** There is evidence that the administrator: a) has been appointed by the governing body; and b) is an employee of the hospice. **Interview:** Ask the administrator: a) who is responsible when the administrator is not available; and b) to describe the process of how she/he keeps the governing body informed.

Standards	Evidence Guidelines
HSLG 4.I The management and governance of the hospice is responsible to provide care that: 1. Optimizes comfort and dignity; 2. Is consistent with patient and family needs and goals, with the patient's needs and goals as priority. Applicable Regulation: L650-418.100(a).	**Interview:** Ask a member of the governing body or the owner, as well as the hospice administrator, about the elements of the standard and how they are translated into their accountability and responsibility.
HSLG 5.I The hospice organizes, manages, and administers its resources to provide the hospice care and services to patients, families, and caregivers necessary for the palliation and management of the terminal illness and related conditions. Applicable Regulation: L648-418.100.	**Interview:** Ask the hospice administrator how he/she meets the intent of the standard, considering the scope of services provided.
HSLG 6.I The hospice develops an annual operating budget that reflects the scope and complexity of the care and services provided and includes projected revenue and expenses.	**Document Review:** Review the most recent annual budget. Verify that it includes projected revenues and expenses consistent with the organization's size and scope of services.

Standards	Evidence Guidelines
HSLG 7.I Hospice volunteers provide day-to-day administrative or direct patient care services in an amount that, at a minimum, equals five percent (5%) of the total patient care hours of all paid hospice employees and contract staff. The hospice documents the cost savings achieved through volunteers. Documentation includes: 1. The identification of each position that is occupied by a volunteer; 2. The work time spent by volunteers occupying those positions; 3. Estimates of the dollar costs that the hospice would have incurred if paid employees occupied the positions noted in item 1 and for the durations noted in item 2. **Applicable Regulations: L646-418.78(d); L647-418.78(e).**	**Document Review:** Review documents related to cost savings achieved through volunteers. Confirm that documentation includes required components listed in the standard. **Guidance:** It is expected that the hospice realizes cost savings by utilizing volunteers to provide day-to-day administrative services and/or direct patient care.

Standards	Evidence Guidelines
HSLG 8.I The total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in a 12-month period may not exceed 20 percent of the total number of hospice days consumed in total by Medicare beneficiaries. Note: A hospice that began operations before January 1, 1975, is not subject to the above limitation. Applicable Regulations: L717-418.108(d); L718-418.108(e).	**Interview:** Interview the administrator and clarify how the organization tracks the number of hospice inpatient days used by Medicare beneficiaries. **Document Review:** Confirm the percentage of inpatient days that the organization has provided in the last 12-month period. **Guidance:** The calculation applies to Medicare beneficiaries only. It does not include patients with other payer sources.
HSLG 9.I The hospice ensures that the durable medical equipment (DME) is safe and in working order as intended for use in the patient's environment. 1. The hospice ensures that the manufacturer's guidelines for performing routine maintenance and preventive maintenance are followed. 2. The hospice ensures that repair and maintenance policies are developed when manufacturer's guidelines for a piece of equipment do not exist. 3. The hospice may use persons under contract to ensure maintenance and repair of durable medical equipment. Applicable Regulation: L701-418.106(f)(1).	**Interview:** Ask the responsible hospice staff how the organization provides for the three (3) elements of the standard. **Document Review:** Review documentation that indicates that the hospice ensures that routine and preventive maintenance of DME is completed. Complaint logs may be a source for identifying equipment not in working order.

Standards	Evidence Guidelines
HSLG 10.I A hospice may contract for durable medical equipment services with a Medicare-certified DME point-of-service (POS) supplier that: 1. Meets the CMS DMEPOS Supplier Quality and Accreditation standards; 2. Has a letter verifying that the DMEPOS supplier is accredited by a recognized accreditation organization. Applicable Regulation: L703-418.106(f)(3).	**Contract Review**: Review a DME contract to confirm the items in the standard. **Document Review:** Confirm that the hospice has the letter confirming current DMEPOS accreditation by a recognized accrediting organization. **Tip:** CHAP is a recognized accrediting organization for DMEPOS.
HSLG 11.I If laboratory testing is performed by hospice staff—and it is other than assisting an individual in self-administering a test with an appliance that has been approved for that purpose by the FDA—such testing complies with all applicable state and federal law and regulation. If the hospice refers specimens for laboratory testing to a reference laboratory, the reference laboratory is currently certified in the appropriate specialties and subspecialties of services in accordance with the applicable requirement of Clinical Laboratory Improvement Amendments (CLIA) certification and state law requirements. Applicable Regulations: L800-418.116(b)(1); L801-418.116(b)(2).	**Guidance:** Assisting individuals in their own testing is not considered testing subject to a CLIA waiver. **Document Review:** If the hospice staff are responsible for testing and use of the hospice's equipment to conduct the test, a current CLIA certificate of waiver is needed. In some states, a state specific CLIA waiver is required. **Interview:** If the organization refers specimens for laboratory testing, verify that the referral laboratory is currently CLIA-certified in the appropriate specialties and subspecialties of services. **Tip:** For a complete listing of waived tests, refer to CMS' website at: http://www.cms.hhs.gov/CLIA/10CategorizationofTests.asp#TopOfPage

Standards	Evidence Guidelines
HSLG 12.I The hospice obtains drugs and biologicals from community or institutional pharmacists or stocks drugs and biologicals itself. Applicable Regulation: L691-418.106(c).	**Interview:** Ask the hospice administrator how drugs and biologicals are obtained or if the hospice stocks these. **Guidance:** Drugs and biologicals are the two dispensing options in the regulation.
HSLG 13.I Identified discrepancies in the hospice's acquisition, storage, dispensing, administration, disposal, or return of controlled medications are investigated immediately by the pharmacist and hospice administrator. 1. As required, discrepancies are reported to the appropriate state authority. A written account of the investigation is made available to state and federal officials if required by law or regulation. Applicable Regulation: L700-418.106(e)(3)(ii).	**Interview:** Interview the hospice administrator or the pharmacist who oversees the management of medications. Ask her/him to describe the actions taken to identify discrepancies in any of the areas in the standard. Ask what would happen if a discrepancy was found and who else in the organization would be involved. **Document Review:** For any identified discrepancy, review investigation reports and reports submitted to state or federal authorities. Verify that there is documented record of the investigation and, as appropriate, the action taken.

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HSLG 14.D

A written agreement with another organization or individual to furnish hospice care or services includes:

The scope of services to be provided;
How Interdisciplinary Group (IDG) management oversight and coordination is provided;
How communication with the IDG and hospice administration occurs;
Care provided only upon authorization of the hospice;
Care provided in a safe and effective manner and by qualified personnel that meet the human resources requirements of the hospice;
Care delivered in accordance with patient’s plan of care.

The hospice retains administrative and financial management responsibility, as well as the oversight of staff and the quality of care and services provided under arrangement.

Applicable Regulations: L655-418.100(e)(1); L655-418.100(e)(2); L655-418.100(e)(3).
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Contract Review: Review a sample of contracts for arranged services to confirm the requirements of the standard are included, including the provision of training programs for contracted personnel.

Interview: Ask the administrator or RN coordinator how they ensure that:

Care follows the plan of care;
Care and services are provided when authorized by the hospice;
Communication occurs;
Services are provided by qualified staff.

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Standards	Evidence Guidelines
HSLG 15.D A hospice may contract for medical director services with either: 1. A self-employed physician; or 2. A physician employed by a professional entity or physician group. The contract specifies the physician who assumes the medical director responsibilities and obligations. Applicable Regulation: L666-418.102(a).	**Contract Review:** Review a contract for the medical director. Verify that the contract specifies the name of the physician who assumes the medical director responsibilities. **Guidance:** The medical director may also be a volunteer physician under the control of the hospice if the individual meets all federal and state requirements for a hospice physician.
HSLG 16.D A hospice may contract for highly specialized nursing services that are provided so infrequently that the provision of such services by direct hospice employees would be impracticable and prohibitively expensive. Applicable Regulation: L593-418.64(b)(3).	**Guidance:** CMS considers highly specialized nursing services to include complex wound care and infusion specialties, due to the level of nursing skill required or the specified patient population (e.g., such as a pediatric nurse when the hospice rarely cares for pediatric patients). **Interview:** Ask the administrator or nursing leader to determine if such contracts are used. If so, how do they monitor the quality of those services? The contract should meet the same requirements as previously noted.

Standards	Evidence Guidelines
HSLG 17.I A hospice operating multiple locations, also known as alternative delivery sites (ADS): 1. Complies with federal regulation regarding disclosure of ownership and control information; 2. Ensures hospice multiple locations are approved by Medicare and licensed in accordance with state licensure laws; 3. Ensures that each location is: a) Approved by Medicare as a multiple location before providing hospice care and services to Medicare patients; 4. Clearly delineates lines of authority and professional and administrative control in the hospice's organizational structure and in practice that can be traced to the location issued the certification number (CCN); 5. Shares administration, supervision, and services with the hospice issued the certification number. The determination that a multiple location does or does not meet the definition of multiple location is an initial determination per §498.3. Applicable Regulations: L656-418.100(f)(1)(i); L657-418.100(f)(1)(ii); L658-418.100(f)(1)(iii); L659-418.100(f)(1)(iv); L799-418.116(a).	**Document Review:** Each hospice alternate delivery site (ADS) meets elements #2-4 in the standard. **Interview:** Ask the administrator about any ADS and how it complies with state and federal law and regulation. **Interview:** Interview key leaders of the hospice to confirm the process for sharing administration and supervision of services for one or more ADS.

Standards	Evidence Guidelines
HSLG 18.I A hospice continually monitors and manages all services provided at each of its multiple locations to ensure: 1. Services are delivered in a safe and effective manner; 2. Each patient and family receives the necessary care and services outlined in the plan of care; 3. The scope of care and services is the same as offered directly or under contract at the location with the certification number. *Applicable Regulation: L660-418.100(f)(2).*	**Guidance:** Reviews may be conducted—the entire review or part of the review—at alternative delivery sites when the hospice has multiple locations or documentation can be brought to the location of the site review. Each location is responsible to the same governing body and central administration that governs the hospice that was issued the certification number, and the governing body and central administration must be able to adequately manage the location and assure quality of care. It is allowable for an ADS to have a hospice physician functioning under the supervision of the hospice medical director. **Document Review:** 1. Care at each alternate delivery site is responsive to identified patient/family needs. 2. Full range of services provided is the same as at the hospice CCN location. 3. Each patient has a specific IDG. 4. Care is provided per the plan of care. 5. There is evidence of management and oversight of care.

Hospice Key Terms

Advance Directives: Written statements of instructions about how an individual wants medical decisions made if they are unable to speak for themselves. Two most common types are a "living will" or a "durable medical power of attorney" for health care decisions. There are often state-specific requirements for advance directives that must be followed.

Adverse Event (ADE): Injury or unintended harm to a patient resulting by an act of commission or omission, rather than by the underlying disease or condition of the patient.

Aide: A paraprofessional worker with specified training and/or certification to provide non-clinical care, such as assistance with personal hygiene or nutritional support, as assigned by his or her supervisor.

> **Hospice Aide:** A qualified hospice aide is a person who has successfully completed one of the following, as defined in Appendix M of the *Hospice State Operations Manual*: (i) A training program and competency evaluation; (ii) A competency evaluation; (iii) A nurse aide training and competency evaluation program approved by the State and currently listed in good standing on the State nurse aide registry; or (iv) a State licensure program.

All-Hazards Approach: An integrated approach for prevention, mitigation, preparedness, response, continuity, and recovery that addresses a full range of threats and hazards, including natural, human-caused, emerging infectious disease, and technology-caused. This approach is specific to the location of the provider and the particular types of hazards which most likely occur in their geographic area.

Alternate Delivery Site (ADS): A Medicare-approved location from which the hospice provides the same full range of hospice care and services that is required of the hospice issued the certification number. An ADS meets the hospice Conditions of Participation.

Bereavement Counselor: A person who evaluates and provides emotional, psychosocial, and spiritual support and services before and after the death of the patient to assist with issues related to grief, loss, and adjustment.

Biologicals: Any medicinal preparation made from living organisms and their products including, but not limited to, serums, vaccines, antigens, and antitoxins.

Bloodborne Pathogens: As described by the Occupational Safety and Health Administration (OSHA), bloodborne pathogens are pathogenic microorganisms present in human blood that

can cause disease in humans. These pathogens include hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV).

CAM or Complementary and Alternative Medicine: CAM includes products and services that are not considered part of standard medical care.

Caregiver: A caregiver is defined by the patient and may be a family member, partner, neighbor, private-pay individual, or other individual external to the hospice.

Care Planning: The necessary steps followed by all members of the care team to achieve the identified goals of the care plan. Care planning is an interactive and evolving interdisciplinary process that occurs across the duration of patient/family care and includes strategies and planned interventions to meet patient goals and manage physical and psychosocial symptoms.

Care Transitions: A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different settings or different levels of care within the same setting.

Centers for Medicare and Medicaid Services (CMS): A federal agency within the Department of Health and Human Services. CMS administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program, and health insurance portability standards.

Centers for Disease Control and Prevention (CDC): A federal agency under the Department of Health and Human Services. The CDC's goal is to protect the public's health and safety through prevention and control of disease, injury, and disability. The CDC focuses its attention on infectious diseases, foodborne pathogens, environmental health, occupational safety, health promotion, injury prevention, and educational activities.

Clinical Record: Documentation of a contact with the patient and/or the family that is written and dated by any person providing services and that describes signs and symptoms, treatments and medications administered, including the patient's reaction and/or response, and any changes in physical, emotional, psychosocial, or spiritual condition during a given period of time.

Competency: Having sufficient ability to administer safe and reliable care on a consistent basis. To achieve competency, one must possess the proper knowledge, skills, training, and professionalism.

Complaint: A statement that a situation is unsatisfactory or unacceptable.

Conscience Objections: Statements that permit pharmacists, physicians, and/or other providers of health care not to provide certain medical services for reasons of religion or conscience.

Dietary Counseling: Education and interventions provided to the patient and family regarding appropriate nutritional intake as the patient's condition progresses. Dietary counseling is provided by qualified individuals, which may include a registered nurse, dietitian, or nutritionist, when identified in the patient's plan of care.

Drug Dispensing: The preparation, packaging, labeling, record keeping, and transfer of a prescription to a patient or intermediary who is responsible for administration of the drug.

Drug Review Regimen: A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

Durable Medical Equipment: Nonexpendable articles used for medical purposes in cases of illness or injury; this includes hospital beds, respirators, walkers, and apnea monitors.

Emergent Event: An unforeseen set of circumstances that results in the need for immediate action or an urgent need for assistance. Larger-scale emergent events are usually considered disasters. An emergency can be a temporary (e.g., short-term power outage due to a snow storm), or a longer-term set of events that lead to relocation or, on a larger scale, a community-wide or regional emergency.

Emerging Infectious Diseases (EIDs): Infections that have recently appeared within a population or those whose incidence or geographic range is rapidly increasing or threatens to increase in the near future.

Employee: Employee means a person who**:** (1) works for the hospice and for whom the hospice is required to issue a W-2 form on his or her behalf; or (2) if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice; or (3) is a volunteer under the jurisdiction of the hospice. (CMS definition *State Operations Manual*, Appendix M.)

Evidence-Informed Practices: Evidence-informed practices use the best available research and practice knowledge to guide program design and implementation within context. This informed practice allows for innovation and incorporates the lessons learned from the existing research literature.

Exploitation: Controlling or taking advantage of by artful, unfair, or insidious means. This may include taking financial advantage of a disabled or elderly person. State law for preventing abuse, neglect, and exploitation, and rules and protections vary from state to state.

Facility: A building, storage site, warehouse, inpatient care setting, or administrative space (not the patient home) owned, operated, or leased by an organization.

Goal, Measure, Outcome: Goals are the broad and general aims the organization is trying to achieve and are often tied to its mission or business objectives. Measures (also called indicators) are used to track progress toward achieving outcomes. Outcomes define the specific measurable results related to the actions taken to achieve a goal.

Grievance: A real or imagined wrong or other cause for complaint or protest, especially unfair treatment.

Home: A patient's place of residence in a private home, an assisted living facility, an extended care or skilled nursing facility, a group home, etc.

Incompetent: A person who is not able to manage their affairs due to mental deficiency or physical disability. Being incompetent can be the basis for the appointment of a guardian or conservator after a hearing in which the individual is interviewed by a court investigator and is present or represented by an attorney. The court ruling results in the judgement that the person is unable to handle their person or affairs.

Information Management System: A systematic approach that provides the tools to organize, evaluate, and efficiently manage all data and information necessary to make informed decisions about the provision of care and services. Information management systems define processes that govern the quality, ownership, use, and security of information. This includes the physical infrastructure, software, and/or hardware that facilitate organization, storage, protection, retrieval, and analysis of information. In this context, "information" refers to all types of information, regardless of origin (i.e., collected by the organization or provided to the organization) or type (e.g., paper, electronic, audio, video, verbal).

Licensed Practical (Vocational) Nurse (LPN/LVN): A person who has completed a practical (vocational) nursing program, is licensed in the state where he or she practices, and who furnishes services under the supervision of a qualified registered nurse.

Management: The qualified persons that plan, organize, direct, and supervise the clinical and business operations within an organization.

Medical Appliance: Any of various devices used to provide a functional or therapeutic effect.

Medical Supplies: Non-durable disposable health care materials ordered or prescribed by a physician**,** that are primarily and customarily used to serve a medical purpose and include ostomy supplies, catheters, oxygen, and diabetic supplies.

Medication: A drug or other substance (e.g., oxygen) used to treat disease or injury. A medication may be commonly referred to as a drug, medicament, medicine, or pharmaceutical.

Mental Abuse: Includes, but is not limited to humiliation, harassment, and threats of punishment or deprivation.

Misappropriation of Patient Property: The deliberate misplacement, exploitation, or wrongful temporary or permanent use of a patient's belongings or money without the patient's consent.

Mistreatment: To treat or handle badly, cruelly, or roughly; abuse: to maltreat a patient.

Neglect: A failure to provide goods and services necessary to avoid physical harm or mental anguish.

Occupational Therapist (OT): An occupational therapist is a person who is licensed or otherwise regulated, if applicable, as an occupational therapist by the state in which he or she practices, unless licensure does not apply, and who has met the educational requirements established in §42 CFR 484.115(f)**:** Occupational Therapist.

Occupational Therapy Assistant/Certified Occupational Assistant(COTA): A person who is licensed—unless licensure does not apply, or is otherwise regulated, if applicable—as an occupational therapy assistant by the state in which practicing, and who meets the educational requirements established in §42 CFR 484.115(g)**:** Occupational Therapy Assistant.

Occupational Exposure: As defined by the Occupational Safety and Health Administration, occupational exposure refers to the reasonable anticipation of skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials (e.g., pleural fluid or any body fluid that is visibly contaminated with blood) that may result from the performance of personnel duties.

Occupational Safety and Health Administration (OSHA): A federal agency that is part of the Department of Labor. OSHA's Bloodborne Pathogen Standards prescribe safeguards to protect healthcare workers and patients against health hazards caused by bloodborne pathogens, imposing federal requirements on employers whose personnel can reasonably anticipate contact with blood or other potentially infectious materials. The requirements address items such as exposure control plans, universal precautions, engineering and work practice controls, personal protective equipment, housekeeping, laboratories, hepatitis B vaccination, post-exposure follow-up, hazard communication and training, and record-keeping.

"On-duty": Currently working during the staff member's assigned hours or per their schedule of visits.

Other Potentially Infectious Material (OPIM): According to the Occupational Safety and Health Administration, OPIM includes the following**:** "(1) semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; (2) any unfixed tissue or organ (other than intact skin) from a human (living or dead); and (3) HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV."

Patient: An individual who receives care or services provided by an organization, its employees, volunteers, and/or contracted staff, toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain. For the purposes of the CHAP standards, the use of the word "patient" may also indicate client, customer, the family and caregivers.

Patient-Centered Care: A patient-centered care delivery model is one that provides care that is respectful of and responsive to individual patient preferences, needs, goals, and values, and ensures that the patient guides all decisions. Patient-centered care also accommodates the degree to which patients wish to be involved in decisions about their care. This approach also applies to family members, caregivers, or patient representatives when they are involved in supporting care planning/delivery decisions.

Patient Record/Clinical Record: The patient record may also be referred to as the clinical record, medical record, health record, or medical chart. The terms are used somewhat interchangeably to describe the systematic documentation of a single patient's medical history, care, and service delivery across time. For the purposes of the CHAP standards, this documentation is referred to as the patient record.

Patient Representative/Patient-Selected Representative: A representative, designated by the patient, who could be a family member or friend. A patient-selected representative may accompany the patient; act as a liaison between the patient and the organization to help the patient communicate, understand, remember, and cope with the interactions that take place; and explain any instructions to the patient that are delivered by the organization's personnel. The representative does not need to be the patient's legal representative. The patient determines the role of the representative, to the extent possible, as described in *Federal Register* Vol. 82, No. 9, January 13, 2017. The extent of such representation may vary from one patient to another. A professional interpreter is not considered to be a patient's representative.

Performance Improvement (PI): Activities undertaken, based on findings from the Continuous Quality Improvement Program, to improve the quality of services provided to patients and their families.

Personal Protective Equipment (PPE): PPE refers to protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection. The hazards addressed by protective equipment include physical hazards, electrical hazards, heat, chemicals, biohazards, and airborne particulate matter. Examples of *PPE* include such items as gloves, foot and eye protection, respirators, masks, and gowns.

Pharmacy: The practice and profession of preparing and selling medications by a pharmacist licensed in the state in which they practice. Pharmacy practice may take place in a variety of community settings, such as retail, infusion, long-term care, or specialty.

Physical Therapist (PT): A person who is licensed, if applicable, by the state in which he or she practices, unless licensure does not apply, and who meets the educational requirements established in §42 CFR 484.115(h)**:** Physical Therapist.

Physical Therapy Assistant (PTA): A person who is licensed, registered, or certified as a physical therapist assistant, as required, by the state in which he or she practices, and who meets the educational requirements established in §42 CFR 484.115(i)**:** Physical Therapist Assistant.

Physical Abuse: Includes, but is not limited to, hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.

Physician Designee: A Doctor of Medicine or Osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available.

PPE: Personal Protective Equipment. PPE refers to protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection. The hazards addressed by protective equipment include physical, electrical, heat, chemicals, biohazards, and airborne particulate matter. Examples of PPE include such items as gloves, foot and eye protection, respirators, masks, gowns, etc.

Pseudo-patient: A person trained to participate in a role-play situation, or a computer-based mannequin device. A pseudo-patient must be capable of responding to and interacting with the hospice aide trainee, and must demonstrate the general characteristics of the primary patient population served by the hospice in key areas such as age, frailty, functional status, cognitive status and care goals.

Restraint: Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort); or a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Seclusion: The involuntary confinement of a patient alone in a room or an area from which the patient is physically prevented from leaving.

Sexual Abuse: Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion, and sexual assault.

Shelter-in-Place: According to the CDC, shelter-in-place refers to taking immediate shelter where you are: at home, work, school, or in between. It may also mean "seal the room"; in other words, take steps to prevent outside air from coming in, in the case of chemical or radiological contaminants released into the environment.

Simulation: A training and assessment technique that mimics the reality of the homecare environment, including environmental distractions and constraints that evoke or replicate substantial aspects of the real world in a fully interactive fashion, in order to teach and assess proficiency in performing skills, and to promote decision making and critical thinking.

SNF/NF or ICF/IDF: Acronyms refer to Skilled Nursing Facility/Nursing Facility, or an Intermediate Care Facility or Intellectual Disability Facility.

Speech-Language Pathologist (SLP): A person who: (1) meets the education and experience requirements for a Certificate of Clinical Competence in speech-language pathology granted by the American Speech-Language-Hearing Association; or (2) meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

Spiritual Counselor: A spiritual counselor uses counseling techniques and practices targeted to help patients cope with grief, pain, and difficult life decisions by focusing on the patient's spiritual characteristics and environment. A spiritual counselor may or may not be affiliated with specific religious tenets.

Surveillance: Surveillance in public health is defined by the Centers for Disease Control and Prevention as "the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve [the public's] health." Surveillance, as part of an infection prevention and control program, is a comprehensive method of measuring outcomes such as healthcare-acquired infections and related processes of care to provide information to organizations to improve the safety and quality of patient care or services.

Telehealth: The direct interface between the physician or other provider and the patient via technology, such as telephone, video, email or other electronic means for the purpose of assessment, diagnosis and/or treatment. Telehealth may be as simple as a phone call to remind patients to take their medication or as complex as a physician examination and treatment via videoconferencing.

Telemonitoring or Remote Monitoring: The use of technology to collect and transmit patient data for the purposes of monitoring and managing the patient's condition. These technologies might include the collection and transmission of cardiac or fetal monitoring, weight, or blood sugar readings or other pertinent data.

Verbal Abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to patients or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.

Volunteer: A person who donates their time and resources to support the hospice, patients, caregivers, or staff. Volunteers may do a number of important tasks that range from assisting in office work to attending a dying patient's bedside.