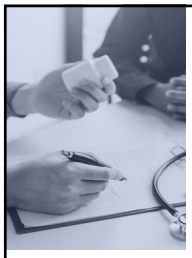
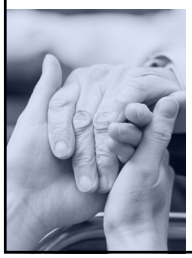


Hospice TOP 10 Deficiencies In 2021



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1

Objectives

The attendee will:

- Be provided an overview of chapters with the most citations
- Be introduced to the top 10 most cited standards for the Hospice program in 2021
- Identify the associated L tags for each top 10 standard
- Learn best practices to stay in compliance with commonly cited areas

2

Chapters

3

4 Of 11 Chapters Have The Top 10 Deficiencies:

HCPC- Hospice Assessment, Care Planning and Coordination
5 Standards, 12 L Tags, 384 Deficiencies

HCDT- Hospice Care Delivery and Treatment
3 Standards, 4 L Tags, 255 Deficiencies

HSIM- Hospice Information Management
1 Standard, 7 L Tags, 114 Deficiencies

HIPC – Hospice Infection Prevention and Control
1 Standard, 71 Deficiencies

Total 824 Deficiencies

4

HCPC- Assessment, Care Planning, Coordination
5 Standards, 12 L tags, Total 384 Deficiencies

HCPC.21.I - Individualized written plan of care
7 L tags total of 127 deficiencies cited

HCPC.19.I - Hospice designates a registered nurse member of the IDG to:...
2 L tags total of 78 deficiencies cited

HCPC.15.I - Comprehensive assessment includes a drug profile that contains the patient's current:...
1 L Tag total of 64 deficiencies cited

HCPC.13.I Initial Bereavement assessment
I L tag total of 53 deficiencies cited

HCPC.9.I - Completes an initial comprehensive assessment no later than 5 calendar days after the election of hospice care...
1 L tag total of 62 deficiencies cited

5

HCDT- Care Delivery & Treatment
3 Standards, 4 L Tags, Total 255 Deficiencies

HCDT.16.I - Hospice Aide provides services: ...
2 L tags Total of 125 deficiencies cited

HCDT.40.I – Discharge Summary
1 tag Total 53 deficiencies cited

HCDT.15.I - Written patient care instructions for a hospice aide are prepared by a RN responsible for the supervision of the hospice aide.
1 L tag Total 77 deficiencies cited

6

HSIM- Information Management
1 Standard, 7 L Tags, Total 114 Deficiencies

HSIM.3.I - Each patient's record includes, at a minimum: …

7 L tags

114 deficiencies cited

7

HIPC – Infection Prevention and Control
1 Standard, Total of 71 Deficiencies

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.

8

COUNTDOWN

9

HCDT.40.I L 684 53 Deficiencies

- It is required that 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: a summary…, treatments, symptoms, pain management; current plan of care; latest physician orders; other documentation that will assist in the post-discharge continuity of care or that is requested by the receiving facility or the attending physician.

10

HCDT.40.I L-684 - Examples

1. In 3 of 4 (75%) clinical records of live discharge patients, no documentation was present to support that a discharge summary was sent to the attending physician or facility receiving the hospice patient.

   The Administrator confirmed discharge summaries were not sent to the attending physician or facility receiving the hospice patient.

2. DPCS could not locate that a Discharge summary was sent to the attending physician or receiving facility.

3. Revocation was documented; No Discharge summary was done.

11

Tips for Compliance

- Review Discharge Summary process to identify if revisions necessary.
  - Address responsible party and location to document that DC summary was sent and to whom and on what date.
- Education to RN's and applicable Agency staff on Discharge Summary process.
- Education to RNs on Discharge Summary documentation.
- QAPI Quality Indicator if deficiency identified.

12

HCPC.13.I L-531 52 citations

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.

13

HCPC.13.I L-531 Examples

- MSW visited 6 days after election of hospice care to do an assessment. There was no documentation to support the delay in performing the assessment. In addition, there was no documentation that an initial bereavement assessment was documented.
- Patient admitted 11/1. Chaplain visited on 11/15 to do an assessment which was past the 5 days required to complete the comprehensive assessment. The bereavement assessment was documented as completed on 11/15 as well, which was ten days after the election of hospice care. There was no documentation found to support the delay.
- The patient was admitted on 9/5. No initial bereavement assessment was done at the time of admission, up to and including the date of the survey on 10/1. No discipline addressed any bereavement area of concern at all during this patient's length of stay.
- No Bereavement Plan of Care initiated with the identified bereaved after the patient's death on 11/1. There was an identified problem titled Grief that indicated that the Bereavement Coordinator would contact the bereaved to offer condolences and to initiate the Bereavement plan of care, however, there was no documented attempt at communication or refusal of the program by the bereaved.

14

Tips for Compliance

- Review of policy/procedure for Bereavement Program, including the initial bereavement assessment.
- Educate the clinical staff that if the initial bereavement assessment is completed by the spiritual counselor, and there is no spiritual counselor visit within the timeframe, that the RN or MSW will complete it.
- Ensure scheduling process includes the initial bereavement assessment is completed within the timeframe.
- QAPI – quality indicator to audit compliance of the bereavement assessments / plan of care, etc.

15

HCPC.9.I L523 62 citations

It is required that the hospice Interdisciplinary Group, in consultation with the individual's attending physician (if any), completes an initial comprehensive assessment no later than 5 calendar days after the election of hospice care, in accordance with CMS §418.24–the elements of the hospice care election statement.

16

HCPC.9.I L523 Examples

This standard was not met as evidenced by clinical record review and interview. In 3 of 16 (19%) records reviewed, the agency failed to complete the initial comprehensive assessment in 5 days as required.

1. The initial Chaplain visit was performed on 11/29, 6 days post election of the hospice benefit. There was no documentation justifying the assessment being performed later than the required 5 days.

2. The initial MSW evaluation was performed on 12/24 - 6 days post election of the hospice benefit. There was no documentation in the record to justify the late assessment.

3. The initial Spiritual Care Assessment was performed on 8 days post-election. In addition, the initial Social Worker Assessment was performed 15 days post-election. There was no documentation regarding the late assessment

In an interview with the Administrator, it was confirmed that the assessments were not completed in the required 5 calendar days after the election of hospice care.

17

Tips for Compliance

- Review and/or implement process for ensuring completion of an initial comprehensive assessment no later than 5 calendar days after the election of hospice care.
- If there is patient refusal for MSW or Spiritual Counselor in that timeframe, educate the RN that they must include spiritual and psycho-social assessment in their initial assessment.

18

HCPC 15.I L530 64 citations

It is required that the documented comprehensive assessment includes a drug profile that contains the patient's current: prescription and over-the-counter (OTC) drugs.

The medication review process includes the identification of the following: the effectiveness of drug therapy; drug side effects; actual or potential drug interactions; duplicate drug therapy; and 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.

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.

19

HCPC 15.I L530 Example 1

- This standard was not met as evidenced by a review of clinical records, document review, and interview.
- In 1 of 8 (13%) records, the medication profile was not updated with accurate and current medications ordered, and consequently, a complete medication review was not conducted.

- 1. Nursing visit note 9/2 stated Dicyclomine 20 mg at night started for terminal symptom control and Oxygen 8 Liters per face mask.
- The medication profile:
  - Did not include Dicyclomine.
  - Had Oxygen at 3-5 liters continuous only.

- Interview with Clinical Manager on 11/15 stated that the medication profile was not updated with all medications and that the review of all medications was not documented.

20

HCPC 15.I L530 Examples

- 2. Patient had physician orders written on 9/2 that included the use of Santyl and Zinc Oxide for wound care to the left foot. These medications were not present on the medication profile.
- 3. RN's initial comprehensive assessment dated 3/1 stated the patient "now requires continuous O2 2L to keep saturations above 90%". There was no evidence that the drug profile contained Oxygen.
- 4. Home Visit- Medication list in the home had 4 medication updates- with varying dosage changes and 2 discontinued medications. These were not in the clinical record in the Hospice Agency.

21

Tips for Compliance

- PIP- Recommend Medication Management PIP if deficiencies are found on Hospice audits or on site visits / surveys as:
  - Medication management is complex and involves not only IDG, patient/ caregiver, but pharmacy, nursing home as applicable, records in home/facility and Hospice Clinical record.
  - Medications are High volume, High Risk and Problem Prone
- Education on audit findings – in group or one on one recommended quarterly at minimum.
- Educate IDG that all disciplines in home should communicate to case manager RN if any medication changes.

22

HIPC 9.1 standard - 71 required actions

It is required that 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 occurs per the current CDC guidelines.

There is appropriate follow-up when TB risk is identified.

Examples: Primary reason was that agency wasn't following agency policy.

23

Tips for Compliance

- Identify state or local laws and regulations.
- Ensure agency is identifying TB exposure risk based on the population and/or the community served.
- Review policy at minimum of yearly to ensure is accurate.
- If policy is more strict than laws/regulations, ensure Agency follows it.

24

HCDT.15.I L625 77 CITATIONS

It is required that hospice aides are assigned to a specific patient by an RN who is a member of the IDG.

Written patient care instructions for a hospice aide are prepared by an RN who is responsible for the supervision of the hospice aide.

25

HCDT.15.I L625 Example

This standard was not met as evidenced by interviews and review of clinical records. In 2 of 18 (11%) applicable clinical records of patients who received Hospice Aide services, there was no documented evidence that the RN prepared clear written patient care instructions for the Hospice Aide.

1. Hospice Aide care plan stated complete "bed bath" and "transfer to or from tub or shower" every visit, which was also populated onto the Hospice Aide visit notes. Hospice Aide care plan did not provide clear instructions on the type of bath to be performed.

2. Patient lived at a facility. Hospice Aide care plan stated, "complete seated shower" and "OK for bed bath, for now, patient in isolation," which was assigned in the "special instructions" section of the Hospice Aide care plan.

Aide care plan did not provide clear instructions on the type of bath to be performed and if the patient was in isolation. During the dates of service reviewed, the DPCS and the RN confirmed that the patient was not in isolation; pt had been in isolation months before. RN stated patient should only be receiving a shower now. Aide stated that the patient was no longer on isolation and that the patient was only getting a shower now.

26

HCDT.15.I L625 Examples

Hospice Aide care plans revealed a lack of clear and specific written instruction for the aide assignment, thus leaving the aide to make decisions outside of the aide's scope of practice.

- The Aide care plan assigned the aide to provide a complete bath each visit and if the patient was having a "good day", the aide could give a shower.
- Hospice Aide plan of care did not include direction for the gauze dressing on the right foot and management of the dressing during the shower.
  - Interview with the aide- stated the dressing was removed, and the foot was held outside the shower to avoid getting wet. After the shower, the foot is patted dry, and the facility staff dress the wound.
  - Interview with Clinical Manager stated that the specific direction for the dressing should be on the aide plan of care.

27

Tips for Compliance

- Education to RNs on writing Aide Care Plans with specific and clear direction for all tasks assigned to the Aides.
- Audit of Aide Care Plans to identify if compliance issues
  - If noncompliance, recommend Quality Indicator.
- Inservice to Aides to have them notify the RN Case Manager if the Aide Care Plan lacks specific directions for them to follow.

  Also, remind them that they must contact the RN prior to varying any tasks not on the Assignment sheet.
- Home Visits to ensure Aides are following the Assignment Sheet.

28

HCPC.19.I - 78 Required Actions; L543 - 67 citations

It is required that the hospice designates a Registered Nurse member of the IDG to 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 the IDG in collaboration with the attending physician (if any); the patient or patient representative; the primary caregiver in accordance with the patient's needs.

29

HCPC.19.I - 78 Required Actions L543 - 67 citations

Examples: Following the ordered visit frequencies:

1. Initial POC stated, "SN 4wk1". Week 1, 2 SN visits were performed. There were no documented reasons for the missed visits.

2. Order dated 10/20 stated, "order clarification 1x/weekly SNV per hospice POC". The week of 12/28, 2 SN visits were performed. There was no order for the second visit.

3. Order dated 12/1 stated SW 1x/month and 2 prn and CH 1x/month and 2 prn. There were no documented Social Work or Chaplain visits in December 2021 and no documented reasons for the missed visits.

30

Tips for Compliance

- Ensure process to proactively schedule visits to current orders.
- Audit random to assess compliance
  - If Audit indicates challenges, QAPI quality indicator to review ongoing.
- Educate clinicians on the need to follow current orders and to update orders if revisions.
- Ensure missed visits documented if applicable and approved by Medical Director or Attending physician.

31

HSIM.3.I – 144 RA; L 678 – 48; L673 – 30 citations

HSIM.3.I Patient clinical record containing past and current findings is maintained for each hospice patient…
Each patient's record includes, at a minimum:

1. 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. Physician orders.

L673, 678 - It is required that a patient clinical record containing past and current findings is maintained for each hospice patient. Each patient's record includes, at a minimum, …Physician orders, Election Statement… .

32

HSIM.3.I L673 Examples

- **Ex 1:** Election of Benefits form- regarding changes from 10/01/2020, Agency's Hospice Election Statement does contain a section for the patient or legal representative to request or decline the "Patient Notification of Hospice Non-Covered Items, Services, and Drugs".
- However, at admission Notification of Patient non-covered checkmark by "decline the addendum" was marked, but there were no initials or date indicating that was patient/POA's choice.

- **Ex 2:** The content of the election statement must identify the Hospice that will provide care to the individual. In 5 of 5 Records reviewed, the hospice was not identified in the Election Statement.

- **Ex 3:** Each patient's record includes, at a minimum signed copies of the notice of patient rights and the hospice election statement. 2 of 5 (40%) records reviewed were missing evidence of documentation of the patient's name on the signed copies of the notice of patient's rights/hospice election statement.

33

HSIM.3.I L 678 Examples

- **Examples of Wound Care Orders missing:**

1. 1 of 2 (50%) clinical records of patients with wounds contained incomplete physician's order. Record #3- Physician's order stated, "wound care- cleanse with NS, pat dry, apply ointment, cover with clean gauze, change daily and PRN". There was no order for the type of ointment that was to be applied to the wound.

2. RN Visit Documentation: "Pt has small stage 1 to coccyx area 1x1- no infection noted." Documentation of education provided to clean area, apply barrier cream and cover with 4x4 optifoam. There was no evidence of physician's order for wound care found in the clinical record.

3: 1 of 15 (6%) records reviewed. Documentation of 4 separate stage 1 pressure injuries -did not include any documented evidence of wound care orders.

34

HSIM.3.I L 678 Examples

- **Examples of intervention orders missing:**

- **Ex 1:** On home visit, the nurse performed BGM on the patient. Review of the record revealed that there are no orders for blood sugar testing. The DCS stated they were not aware that blood sugar tests require physician orders.

- **Ex 2:** The patient was admitted with orders from the referring physician to draw PT/INR once a week; 2 weeks later, the lab draws increased to 2 times a week for PT/INR.

- There was no documented evidence of physician orders for PT/INR's in the Hospice record. The Administrator stated they have never completed a physician order for PT/INR.

35

Tips for Compliance

- The clinical record content contains multiple items. Therefore, QAPI is an effective way to ensure compliance and sustaining it.
  - The Clinical record review audit tool can capture the criteria on HSIM.3.I.
  - If there is noncompliance in any of the criteria, such as missing wound orders, then a focused audit can be done quarterly on that criteria.
  - In addition, education is necessary as noncompliant areas are found- such as, missing elements of the Election Statement, or not understanding that all interventions require physician orders, etc.

36

HCDT.16.I – 125 RA L 626 -123 citations

- A hospice aide provides services: 1. Ordered by the IDG 2. Included in the plan of care…

Examples: Hospice Aide was not compliant with following the assigned Hospice Aide Care Plan:

1. 4 of 4 (100%) records of patients receiving Aide services were not compliant with following the assigned Hospice Aide Care Plan for the specific patient being reviewed. All 4 related to assigned task to shampoo hair weekly, stated on which day. However, aides shampooed hair every visit (3 -4 times a week).

2. During home visit observation, interview with the aide with the patient's daughter revealed that "for several weeks" the aide had been providing a partial bed bath with peri care, on every visit (5 days per week) as per the daughter's request. Aide is doing No hair shampooing (the daughter is performing), and No denture care (the patient is no longer wearing dentures).

The current plan of care effective SOC and continuing, includes a full bed bath, hair shampoo, and denture care to be performed on every visit.

37

HCDT.16.I L626 (123) Examples

Visit Frequencies:

1. Hospice aide was noncompliant with the ordered visit frequencies in the Plan of Care.

The Plan of Care included an order for an aide visit frequency of 3w8 and 1w1. In Week 5, one aide visit was performed, rather than the three visits ordered. There were no documented missed visits.

2. The plan of care stated the patient was to receive hospice aide services 3 times a week starting 12/15. There was no evidence of a hospice aide visit between 12/15-12/21. The first hospice aide visit was on 12/22.

The DPCS confirmed this finding and stated there should have been 3 visits that week according to the plan of care.

38

Tips for Compliance

- Aide re-education - that *Everything* on the Aide Care Plan must be followed exactly. If there is going to be *Any* variance, the RN must be notified and approve prior to a change being made.
- RN re-education to revise Aide Care Plan as necessary.
- Aide Supervisory Visits need to include communication between the RN and Aide to review Aide Care Plan.
- Supervisory visits made with the Aide to observe staff in Home to identify if following aide care plan.
- Visit frequencies need to be confirmed with the Aides, and reinforced that the Aide may not change the days without notifying the RN.
- QAPI audit can include criteria for following the Aide Care Plan and following visit frequencies / documenting missed visits if variation.

39

HCPC.21.I – 127 Ras; **L545** – 62, **L548** – 25, **L549** – 18 citations

HCPC.21.I - Each patient's individualized written plan of care- includes:

Identification of planned interventions based on problems identified in the initial and updated comprehensive assessments;

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) Measurable outcomes anticipated from implementing and coordinating the plan of care;

d) Drugs and treatment necessary to meet the needs of the patient;

40

HCPC.21.I L545 Examples

It is required that each patient's individualized written plan of care: Identifies planned interventions based on problems identified in the initial and updated comprehensive assessments.

Ex 1: Comprehensive assessment identified a patient with underlying Dementia and problem with social relations. POC documented a problem for need for volunteer services. No documented evidence of volunteer provided as of review date in any updated plans of care during hospice.

Ex 2: 6 of 11 (55%) records reviewed revealed there was no documented evidence of any problems, interventions and/or goals identified by the Chaplain and/or Medical Social Worker (MSW) based on the completed initial comprehensive assessment and on-going clinical assessments. Chaplain and Medical Social Worker Problems, Interventions, and Goals failed to be included in the POC.

41

HCPC.21.I L545 Examples

Ex 3: Chaplain did not complete a Spiritual initial comprehensive assessment. There was no documented evidence that Chaplain services were declined or a reason why an initial assessment was not completed. However, Chaplain conducted routine Chaplain visits with the patient without an initial comprehensive assessment, without establishing problems, interventions, and goals on the plan of care.

Ex 4: Chaplain completed initial comprehensive assessment. Chaplain documented, "They welcomed the spiritual support and agreed to have at least a couple of visits a month plus prn as (reasonably) needed." Ordered frequency for Chaplain documented in the record was 1x month, and as needed. The chaplain completed the initial comprehensive assessment, however, did not establish any problems, interventions, and/or goals on the plan of care.

Ex 5: MSW initial comprehensive assessment not completed until 10 days after SOC. There was no documented evidence of the establishment of MSW problems, interventions, and goals to plan of care.

42

HCPC.21.I L548 Examples

Measurable Outcomes Anticipated From Implementing And Coordinating The Plan Of Care.

Ex: Goals described are not measurable.

- Chaplain goals example:
  - "Patient / family achieves feelings of spiritual comfort."
  - "Patient will feel comfort after visits"
- MSW goals example:
  - "Patient/caregiver will have a healthy adjustment to the loss."
  - "Family/Caregiver will minimize effects of abnormal grief."

43

HCPC.21.I L548- SN Goals Examples:

- "Patients cardiovascular status is stable."
- "Patient/caregiver can maintain adequate nutrition/hydration."
- Pt diagnosis of Acute Respiratory Failure with Hypoxia. SN goal stated, "Optimal activity level achieved and maintained within baseline respiratory and energy parameters."
- Pt diagnosis of CHF. CP Goal stated, "patient will exhibit reduction/relief of cardio pulmonary symptoms."
- Pt has a stage 3 pressure ulcer. Skin Integrity Goal stated, "skin integrity will be maintained."
- Pt -Port in the right chest and pain control infusion. The goals for pain control state to "use PCA pump". There are no specific goals or outcomes to include the goals for the port care, safety, infection control and patency.
- Pt with a PICC- no include goals for patency, safety and infection control for the PICC line.

44

HCPC.21.I L549 Example

- It is required that each patient's individualized written plan of care: Drugs and treatment necessary to meet the needs of the patient.
- This standard was not met as evidenced by 3 of 13 (23%) records reviewed revealed that all medications and treatments were not documented on the plan of care.

1: Nurse documents in the nursing visit note that the Tylenol 500mg, two tablets control the patient's pain. POC does not include Tylenol as of discharge of patient.

2: Social Work clinical note states, "compression wrap on the left hand." Patient resides in an ALF, and the plan of care was not updated to reflect this treatment.

3: Nurse documents in nursing visit notes from 10/11 through 12/28, "wound on right heel cleaned with cleanser and Vaseline gauze dressing,". POC was not updated to reflect this treatment.

45

Tips for Compliance

- Education to all IDG that each patient's individualized written plan of care must be specific and customized for the patients.
- Examples:
- All disciplines, including volunteers and spiritual counselors must have specific visit frequencies.
- Planned interventions are based on problems identified in the initial and updated comprehensive assessments.
  - Ensure all disciplines understand the requirements for initial assessments re: interventions.
  - All interventions must be specific in the plan of care.

46

Tips for Compliance

- Educate and give examples to field staff/ IDG on Goal writing to include measurable outcomes.
  - Specific for each problem with timeframes
- Drugs and treatment necessary to meet the needs of the patient.
  - Ensure any medications in visit notes are in orders
  - All treatments such as wound care must be in orders.
- QAPI indicator or PIP to achieve and sustain compliance in all noncompliant areas.

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Conclusion

- Top 10 CHAP Standards and the associated L Tags do not vary significantly from year to year.
- Therefore, ensure that your Agency has methods such as QAPI monitoring, education, review of processes, home supervisory visits, etc., in place on an on-going basis to achieve and sustain compliance.

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thank you!
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