

HOSPICE

COMPARISONS OF STATE (DHS 131) AND FEDERAL CONDITIONS OF PARTICIPATION

Name – Agency	License Number	Survey Dates	Surveyor Number
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NOTE: Not Included in this Document: DHS 131, Subchapter 5: Physical Environment and 42 CFR 418.110(d): Standard: Fire Protection

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P615	DHS 131.17 Admission. (1) PROGRAM DESCRIPTION. A hospice shall have a written description of its program that clearly describes the general patient and family needs that can be met by the hospice, and that includes written admission policies that includes all of the following:	G: Hospice shall have a clear, written program description. Included in this description will be Patient Rights/Family Rights (DHS 131.19; and define the prognostic criteria for admission as limited to those individuals with a life expectancy of 12 months or less [DHS 131.13(10)]. Such a written program description needs to be provided to the prospective patient and acknowledged in writing prior to initiating services to the patient and family. P: Survey staff to review program description and information provided to the patient.		
P616	(a) Clearly define the philosophy of the program.			
P617	(b) Limit admission to individuals with terminal illness as defined under s. DHS 131.13(24).			
P618	(c) Clearly define the hospice's limits in providing services and the settings for service provision.			
P619	(d) Ensure protection of patient rights.			
P620	(e) Provide clear information about services available for the prospective patient and his or her representatives, if any.			
P621	(f) Allow an individual to receive hospice services whether or not the individual has executed an advance directive.			
P622	(2) PROGRAM EXPLANATION. (a) A hospice employee shall inform the person and his or her representative, if any, of admission policies under sub. (1).	G: The hospice employee designated by the care coordinator shall explain the program to the prospective patient and family prior to the initiation of clinical assessment to determine physiological and emotional need.		

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		P: Survey staff to conduct home visits and review a sample of patient records to determine whether the information defined in 131.17(1) was provided to the relevant individuals at the time of assessment. (Outcome)		
P623	(3) INITIAL DETERMINATION. (a) The hospice employee shall, based on the needs described by the person seeking admission or that person's representative, if any, or both, make an initial determination as to whether or not the hospice is generally able to meet those needs.	G: Hospice must assure that employees have been oriented and trained on the program's policies and procedures related to admissions, including program description, explanation, initial determination procedures, and all facets of clinical assessment related to the expertise of specific professional disciplines and palliative standards of practice. P: Survey staff to interview selected employees regarding the process of making an initial determination. (Outcome)		
P624	(b) If the hospice employee determines that the hospice does not have the general capability to provide the needed services, the hospice may not admit the person but rather shall suggest to the referring source alternative programs that may meet the described needs.	P: Through interviews determine how hospice employees refer if the prospective patient's needed services cannot be provided by the hospice program. (Outcome)		
	(4) PATIENT ACKNOWLEDGEMENT AND HOSPICE ACCEPTANCE. The person seeking admission to the hospice shall be recognized as being admitted after:			
P625	(a) Completion of the assessment under sub. (3).			
	(b) Completion of a service agreement in which			
P626	1. The person or the person's representative, if any, acknowledges, in writing, that he or she has been informed about admission policies and services.			
P627	2. The hospice agrees to provide care for the person.			
P628	3. The person or the person's representative, if any, authorizes services in writing.			
P629	(5) PROHIBITION. Any person determined not to have a terminal illness as defined under s. DHS 131.13(24) may not be admitted to the hospice.			

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P630	DHS 131.18 Discharge. (1) OBLIGATION. Once a hospice has admitted a patient to the program, and the patient or the patient's representative, if any, has signed the acknowledgement and authorization for services under s. DHS 131.17(4)(b), the hospice is obligated to provide care to that patient.	G: Refer to DHS 131.19, Rights of Patients, and DHS 131.17(4), Patient Acknowledgment and hospice acceptance. P: Interview administrator to ascertain agency discharge criteria and number of patients discharged during a recent time period.		
P631	(2) WRITTEN POLICY. The hospice shall have a written policy that details the manner in which the hospice is able to end its obligation to a patient. This policy shall be provided to the patient or patient's representative, if any as part of the acknowledgement and authorization process at the time of the patient's admission. The policy shall include all of the following as a basis for discharging a patient:	G: Self explanatory. P: Review written policy and verify that it has been provided to the patient or patient's representative. See DHS 131.19, Rights of Patients.		
	(a) The hospice may discharge a patient:			
P632	1. Upon the request or with the informed consent of the patient or the patient's representative.			
P633	2. If the patient elects care other than hospice care at any time.	G: Hospice shall discharge a patient from the program if the patient chooses to seek care for their terminal illness from a program not related to the hospice program. If the hospice does not have the functional capability to manage the patient's care because of choices that the patient has made, then the hospice shall discharge the patient. P: Survey staff to review selected voluntary discharge files.		
P634	3. If the patient elects active treatment, inconsistent with the role of palliative hospice care.			
P635	4. If the patient moves beyond the geographical area served by the hospice.			

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P636	5. If the patient requests services in a setting that exceeds the limitations of the hospice's authority.	G: Hospice discharge policy shall detail within written procedures the manner in which the patient is to be discharged from the hospice program. This procedure shall include the serving of written notice to the patient/patient or family representative at least 14 days prior to the date of discharge, along with a proposed date for a pre-discharge planning meeting. P: Survey staff to review a sample of discharge patient records.		
P637	6. For non payment of charges, following reasonable opportunity to pay any deficiency.			
P638	7. For the patient's safety and welfare or the safety and welfare of others.	G: This specific cause does NOT require a 14-day notice.		
P639	8. If the hospice determines that the patient is no longer terminally ill.			
	(b) The hospice shall do all of the following before it seeks to discharge a patient whose behavior or the behavior of other persons in the patient's home, is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.			
P640	1. Advise the patient that a discharge for cause is being considered.			
P641	2. Make a serious effort to resolve the problem or problems presented by the patient's behavior or situation.			
P642	3. Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services.			
P643	4. Document the matter and enter this documentation into the patient's clinical record.			
P644	(3) PROCEDURE. When a patient is being discharged pursuant to sub. (2)(a) 2., 3., 4., 5., or 6., the hospice shall give written notice to the patient or patient's representative, if any, family representative and attending physician at least 14 days prior to the date of discharge, with a proposed date for a pre-discharge planning conference.			

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P645	(4) PLANNING CONFERENCE. The hospice shall conduct the pre-discharge planning conference with the patient or the patient's representative and review the need for discharge, assess the effect of discharge on the patient, discuss alternative placements and develop a comprehensive discharge plan.			
P646	DHS 131.19 Patient rights. (1) GENERAL INFORMATION. A hospice shall provide each patient and patient's representative, if any, with a written statement of the rights of patients before services are provided and shall fully inform each patient and patient's representative, if any, of all of the following:	G: Hospice shall have developed a procedure to provide patient rights and information in written form to the prospective patient/representative. P: Survey staff to ascertain whether all rights under DHS 131.19 were provided in written form to the relevant individuals prior to the initiation of services by the hospice program. Method: Review statement of patient rights. (Outcome)	L502	(1) During the initial assessment visit in advance of furnishing care the hospice must provide the patient or representative with verbal (meaning spoken) and written notice of the patient's rights and responsibilities in a language and manner that the patient understands.
P647	(a) Those patient rights and all hospice rules and regulations governing patient responsibilities, which shall be evidenced by written acknowledgement provided by the patient, if possible, or the patient's representative, if any, prior to receipt of services.	G: Self explanatory. P: Survey staff to review selected patient records for written acknowledgment by relevant individual, prior to initiation of services by the hospice program. (Outcome)	L504	(3) The hospice must obtain the patient's or representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities.
P648	(b) The right to prepare an advance directive.		L503	(2) The hospice must comply with the requirements of subpart I of part 489 of this chapter regarding advance directives. The hospice must inform and distribute written information to the patient concerning its policies on advance directives, including a description of applicable State law.
P649	(c) The right to be informed of any significant change in the patient's needs or status.			
P650	(d) The hospice's criteria for discharging the individual from the program.	G: Hospice to provide patients with written statement of criteria for discharge from the program. P: Survey staff to review selected sample of patient records. Sample should include both active and discharged records. Relate findings to DHS 131.18 Discharge.		
	(2) RIGHTS OF PATIENTS. In addition to rights to the information under sub. (1), each patient shall have all of the following rights:			

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P651	(a) To receive effective pain management and symptom control from the hospice for conditions related to the terminal illness.		L512	The patient has a right to the following: (1) Receive effective pain management and symptom control from the hospice for conditions related to the terminal illness.
P652	(b) To participate in planning care and in planning changes in care.	G: Hospice shall develop a procedure to promote the Rights of Patients to prospective patients. Those rights conform with DHS 131.21(2). P: Survey staff will review selected sample of patient records and conduct home visits for outcome of process. In addition, selected patients or spokespersons may be interviewed (with permission granted) as a means of ascertaining whether rights have been protected.	L513	(2) Be involved in developing his or her hospice plan of care.
P653	(c) To select or refuse care or treatment.		L514	(3) Refuse care or treatment
P654	(d) To choose his or her attending physician.		L515	(4) Choose his or her attending physician
P655	(e) To confidential treatment of personal and clinical record information and to approve or refuse release of information to any individual outside the hospice, except in the case of transfer to another health care facility, or as required by law or third party payment contract.		L516	(5) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.
P656	(f) To request and receive an exact copy of one's clinical record.			
P657	(g) To be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property.		L517	(6) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property.

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P658	(h) To be free from restraints and seclusion except as authorized in writing by the attending physician to provide palliative care for a specified and limited period of time and documented in the plan of care.	<p>G: With respect to DHS 131.19(2)(h), the hospice needs to assure the relevant individuals that the use of chemical and physical restraints shall not occur, except as authorized by the attending physician and as an accepted palliative intervention in the plan of care.</p> <p>The patient has the right to refuse services. [See DHS 131.19(2)(c).]</p> <p>P: Survey staff will review a sample of patient records and conduct home visits to ensure that, if chemical or physical restraints are used, the physician has authorized this intervention and that such an intervention is included in the plan of care.</p>	L737	All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from 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.
P659	(i) To be treated with courtesy, respect and full recognition of the patient's dignity and individuality and to choose physical and emotional privacy in treatment, living arrangements and the care of personal needs.	<p>P: Survey staff will review a sample of patient records and conduct home visits to ensure intent of DHS 131.19(2)(i)(j)(k).</p>	L505	<p>(1) The patient has the right:</p> <p>(i) To exercise his or her rights as a patient of the hospice;</p> <p>(ii) To have his or her property and person treated with respect;</p> <p>(iii) To voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice; and</p> <p>(iv) To not be subjected to discrimination or reprisal for exercising his or her rights.</p>
P660	(j) To privately communicate with others without restrictions			
P661	(k) To receive visitors at any hour, including small children, and to refuse visitors.			
P662	(L) To be informed prior to admission of the types of services available from hospice, including contracted services and specialized services for unique patient groups such as children.	<p>G: Hospice assures that the procedure developed informs the relevant individuals in writing about the types of services available, including the fact that contracted services may be provided through the hospice program.</p> <p>P: Same as above. Survey staff to review selected patient records for evidence that relevant individuals were informed of the types of services available from the hospice. (Outcome)</p>	L519	(8) Receive information about the scope of services that the hospice will provide and specific limitations on those services.

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P663	(m) To be informed of those items and services that the hospice offers and for which the resident may be charged, and the amount of charges for those services.	G: Hospice to provide service agreement that informs patient of services and charges signed by the patient.		
	(3) PATIENT COMPLAINT PROCEDURE. Each patient shall have the right, on his or her own behalf or through others, to do all of the following:			
P664	(a) Express a complaint to hospice employees, without fear of reprisal, about the care and services provided and to have the hospice investigate the complaint in accordance with an established complaint procedure. The hospice shall document both the existence of the complaint and the resolution of the complaint.	G: Hospice shall develop a procedure for patient complaints. The patient needs to be informed of the right to express a complaint. Hospice needs to have a complaint procedure and investigate complaints according to that procedure. Hospice shall document both the complaint and the resolution of that complaint. P: Survey staff shall review the hospice complaint procedure and review individual investigations, documentation, and the resolutions of complaints.	L505	(1) The patient has the rights: (i) To exercise his or her rights as a patient of the hospice; (ii) To have his or her property and person treated with respect; (iii) To voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice; and (iv) To not be subjected to discrimination or reprisal for exercising his or her rights.
P665	(b) Express complaints to the department, and to receive a statement provided by the department setting forth the right to and procedure for filing verbal or written complaints with the department.	G: Hospice to disseminate the Department's statement on complaint procedure to patients. The statement to include the toll-free hospice hotline telephone number and Ombudsman information. P: Survey staff to conduct home visit and/or interview selected patients or representative to assure that complaint procedure has been explained.		
P666	(c) Be advised of the availability of a toll-free hotline, including its telephone number, to receive complaints or questions about local hospices, and be advised of the availability of the long term care ombudsman to provide patient advocacy and other services under s. 16.009, Wis. Stats.			

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P667	131.20 Assessment. (1) INITIAL ASSESSMENT. (a) If the hospice determines that it has the general capability to meet the prospective patient's described needs, then before services are provided, a registered nurse shall perform an initial assessment of the person's condition and needs and shall describe in writing the person's current status, including physical condition, present pain status, emotional status, pertinent psychosocial and spiritual concerns and coping ability of the prospective patient and family support system, and shall determine the appropriateness or inappropriateness of admission to the hospice based on the assessment.	G: Hospice is expected to provide a determination as to whether the prospective patient is appropriate for hospice palliative care. Once that decision has been made, the purpose of the clinical assessment is to identify palliative needs as the first step in organizing a method of intervention through the development of a plan of care. This assessment is to be done by a core team member whose skill, qualifications, and training are commensurate with clinical procedures. It is expected that the employee doing the assessment will confer with at least <u>one other</u> member of the core team prior to the development of the Initial Plan of Care. Documentation of this interaction should be recorded in the health record. P: Survey staff to review a sample of patient records to determine whether significant palliative problems noted at the time of the assessments were addressed and/ or noted in the ensuing initial plan of care.	L522	The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with s. 418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.)
P668	(b) The designated hospice employee shall confer with at least one other core team member and receive that person's views in order to start the initial plan of care.	As above.		
P669	(2) TIME FRAME FOR COMPLETION OF THE COMPREHENSIVE ASSESSMENT. The hospice interdisciplinary group, in consultation with the individual's attending physician, if any, shall complete the comprehensive assessment no later than 5 calendar days after the election of hospice.		L523	The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with s. 418.24.
P670	(3) CONTENT OF THE COMPREHENSIVE ASSESSMENT. The comprehensive assessment shall identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that shall be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment shall take into consideration all of the following factors:		L524	The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process.

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P671	(a) The nature and condition causing admission including the presence or lack of objective data and subjective complaints.		L525	The comprehensive assessment must take into consideration the following factors: (1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints).
P672	(b) Complications and risk factors that affect care planning		L526	(2) Complications and risk factors that affect care planning
P673	(c) Functional status, including the patient's ability to understand and participate in his or her own care.		L527	(3) Functional status, including the patient's ability to understand and participate in his or her own care.
P674	(d) Imminence of death.		L528	(4) Imminence of death.
P675	(e) Severity of symptoms.		L529	(5) Severity of symptoms.
P676	(f) Drug profile. A review of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:		L530	(6) Drug profile. A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following: (i) Effectiveness of drug therapy (ii) Drug side effects (iii) Actual or potential drug interactions (iv) Duplicate drug therapy (v) Drug therapy currently associated with laboratory monitoring.
P677	1. Effectiveness of drug therapy.		L530	“
P678	2. Drug side effects.		L530	“
P679	3. Actual or potential drug interactions.		L530	“
P680	4. Duplicate drug therapy.		L530	“
P681	5. Drug therapy currently associated with laboratory monitoring.		L530	“

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P682	(g) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment shall be incorporated into the plan of care and considered in the bereavement plan of care.		L531	(7) Bereavement. An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.
P683	(h) The need for referrals and further evaluation by appropriate health professionals.		L532	(8) The need for referrals and further evaluation by appropriate health professionals.
P684	(4) UPDATE OF THE COMPREHENSIVE ASSESSMENT. The update of the comprehensive assessment shall be accomplished by the hospice interdisciplinary group in collaboration with the individual's attending physician, if any, and shall consider changes that have taken place since the initial assessment. The comprehensive assessment shall include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update shall be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days. The hospice interdisciplinary group shall primarily meet in person to conduct the update of the comprehensive assessment.		L533	The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.
P685	(5) PATIENT OUTCOME MEASURES. (a) The comprehensive assessment shall include data elements that allow for measurement of outcomes. The hospice shall measure and document data in the same way for all patients.		L534	(1) The comprehensive assessment must include data elements that allow for measurement of outcomes. The hospice must measure and document data in the same way for all patients. The data elements must take into consideration aspects of care related to hospice and palliation.
	(b) The data elements shall do all of the following:		L534	“
P686	1. Take into consideration aspects of care related to hospice and palliation.		L534	“

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P687	2. Be an integral part of the comprehensive assessment.		L535	(2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program.
P688	3. Be documented in a systematic and retrievable way for each patient.		L535	“
P689	(c) The data elements for each patient shall be used in individual patient care planning and in the coordination of services, and shall be used in the aggregate for the hospice's quality assessment and performance improvement program.		L535	“
P690	DHS 131.21 Plan of care. (1) GENERAL REQUIREMENTS. A written plan of care shall be established and maintained for each patient admitted to the hospice program and the patient's family. The hospice plan of care is a document that describes both the palliative and supportive care to be provided by the hospice to the patient and the patient's family, as well as the manner by which the hospice will provide that care. The care provided to the patient and the patient's family shall be in accordance with the plan of care.	G: Hospice shall develop an individualized plan of care for each person admitted to the program. The plan is to describe the care being provided by the hospice. Such a plan of care is to define the problem(s), the goal of care, the approaches defined to provide that care, the employee(s) identified to deliver that care, and the effect of those interventions in meeting the defined goal. In order for the plan of care to be maintained as current on each patient admitted to the program, the plan needs to be updated. P: Survey staff will conduct home visits and review a sample of active and discharged patient records. Interviews may be conducted to clarify/substantiate issues.	L537 L538 L543	The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient. The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions. All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire.
	(2) INITIAL PLAN OF CARE. (a) The hospice shall develop an initial plan of care that does all of the following:			

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P691	1. Defines the services to be provided to the patient and the patient's family.	G: Hospice shall develop an initial plan of care based on the needs identified as a result of the assessment and conference between the two members of the core team. Identification of services to be provided shall be based on patient/family problem(s) defined and determination of goals. P: Survey staff to review a sample of active and discharged patient records. Initial surveys, review prototype of initial and integrated plans of care agency will utilize.		
P692	2. Incorporates physician orders and medical procedures.			
P693	(b) The initial plan of care shall be developed upon conclusion of the assessment under s. DHS 131.20(1)(a).			
P694	(c) The initial plan of care shall be developed jointly by the employee who performed the initial assessment and at least one other member of the core team.			
P695	(d) The registered nurse shall immediately record and sign a physician's oral orders and shall obtain the physician's counter-signature within 20 days.			
P696	(3) PLAN OF CARE. (a) <i>Integrated plan of care.</i> The hospice core team shall develop an integrated plan of care for the new patient within 5 days after the admission. The core team shall use the initial plan of care as a basis for team decision-making and shall update intervention strategies as a result of core team assessment and planning collaboration.	G: Hospice shall update the initial plan of care developed by at least two members of the core team. The integrated plan of care shall modify and upgrade the initial plan of care as result of further assessment and greater knowledge and experience with the patient and family. The care coordinator is the facilitator of this function, and responsible for the ensuing actions taken by the hospice as a result of the documentation within this plan. P: Survey staff to conduct home visits and review a sample of active and discharged patient records.		

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P697	(b) <i>Content of the plan of care.</i> The hospice shall develop an individualized written plan of care for each patient. The plan of care shall reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care shall include all services necessary for the palliation and management of the terminal illness and related conditions, including all of the following:		L545	The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:
P698	1. Interventions to manage pain and symptoms		L546	(1) Interventions to manage pain and symptoms.
P699	2. A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.		L547	(2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.
P700	3. Measurable outcomes anticipated from implementing and coordinating the plan of care.		L548	(3) Measurable outcomes anticipated from implementing and coordinating the plan of care.
P701	4. Drugs and treatment necessary to meet the needs of the patient.		L549	(4) Drugs and treatment necessary to meet the needs of the patient.
P702	5. Medical supplies and appliances necessary to meet the needs of the patient.		L550	(5) Medical supplies and appliances necessary to meet the needs of the patient.
P703	6. The interdisciplinary group's documentation of the patient's or representative's, if any, level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.		L551	(6) The interdisciplinary group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.

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P704	(c) <i>Review of the plan of care.</i> The hospice interdisciplinary group in collaboration with the individual's attending physician, if any, shall review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days. A revised plan of care shall include information from the patient's updated comprehensive assessment and shall note the patient's progress toward outcomes and goals specified in the plan of care. The hospice interdisciplinary group shall primarily meet in person to review and revise the individualized plan of care.	G: Hospice shall hold formal meetings to review and update current plans of care. Such meetings shall be held at least every 15 days or more frequently if identified in the plan and in response to a significant change of condition. Death is considered a significant change of condition; therefore, the POC must be reviewed/updated by IDG group. P: Survey staff to: <ul style="list-style-type: none"> • Review agency policy. • Ascertain that a schedule has been established to review each patient's plan of care at least at 15-day intervals. • Verify through documentation that core team employees have attended this review meeting. • Review a sample of patient records to determine if changes have occurred in patient's condition, and review the hospice's formal response in this review of patients' plans of care. • Survey staff may observe an interdisciplinary group review meeting. (Outcome)	L552	The hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) must review, revise and document the individualized plan as frequently as the patient's condition requires, but no less frequently than every 15 calendar days.
P705	(d) <i>Bereavement plan of care.</i> The hospice core team shall review and update the bereavement plan of care, at minimum:		L553	A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care.
P706	1. Fifteen calendar days following a patient's death.			
P707	2. Within 60 calendar days following the patient's death.			
P708	3. As often as necessary based on identified family needs.			
P709	4. At the termination of bereavement services.			
	(e) <i>Contents of the bereavement plan of care.</i> The bereavement plan of care shall include all of the following:		L596	(iv) Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery. A special coverage provision for bereavement counseling is specified in 418.64(d).

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P710	1. The family and caregiver's specific needs or concerns.			
P711	2. Intervention strategies to meet the identified needs.		L596	(iii) Ensure that bereavement services reflect the needs of the bereaved.
P712	3. Employees responsible for delivering the care.		L596	"
P713	4. Established timeframes for evaluating and updating the interventions.			
P714	5. The effect of the intervention in meeting established goals.			
P715	(f) <i>Record of notes.</i> The core team shall develop a system for recording and maintaining a record of notes within the plan of care.	G: Hospice shall develop a procedure to record a summary of the topics discussed and IDG decisions on each patient/family as related to the plan of care review. P: Survey staff will review updated plans and/or summary meeting notes related to the review function of the plan of care. (outcome)		
P716	DHS 131.22 Quality assessment and performance improvement. (1) PROGRAM STANDARDS. (a) The hospice shall develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program.	G: Hospice shall establish a system to evaluate the care/services provided to its patients. The Quality Assessment and Performance Improvement (QAPI) program should monitor both the program and patient outcome. Hospice should have in place written standards of practice from which to measure its performance. P: Survey staff to verify that the hospice has developed and initiated a QAPI program.	L560	The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.
P717	(b) The hospice's governing body shall ensure that the program reflects the complexity of its organization and services, involves all hospice services including those services furnished under contract or arrangement, focuses on indicators related to improved palliative outcomes, and takes actions to demonstrate improvement in hospice performance.		L560	"

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P718	(c) The hospice shall maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to the department.		L560	“
P719	(2) PROGRAM SCOPE. (a) The program shall at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.		L561	(1) The program must at least be capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services.
P720	(b) The hospice shall measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.		L562	(2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.
P721	(3) PROGRAM DATA. (a) The program shall use quality indicator data, including patient care, and other relevant data, in the design of its program.		L563	(1) The program must use quality indicator data, including patient care, and other relevant data, in the design of its program.
	(b) The hospice shall use the data collected to do all of the following:		L564	(2) The hospice must use the data collected to do the following:
P722	1. Monitor the effectiveness and safety of services and quality of care.		L564	(i) Monitor the effectiveness and safety of services and quality of care.
P723	2. Identify opportunities and priorities for improvement.		L564	(ii) Identify opportunities and priorities for improvement.
P724	(c) The frequency and detail of the data collection shall be approved by the hospice's governing body.		L565	(3) The frequency and detail of the data collection must be approved by the hospice's governing body.
	(4) PROGRAM ACTIVITIES. (a) The hospice's performance improvement activities shall include all of the following:			(1) The hospice's performance improvement activities must:
P725	1. Focus on high risk, high volume, or problem-prone areas.		L566	(i) Focus on high risk, high volume, or problem-prone areas.
P726	2. Consider incidence, prevalence, and severity of problems in those areas.		L567	(ii) Consider incidence, prevalence, and severity of problems in those areas.
P727	3. Affect palliative outcomes, patient safety, and quality of care.		L568	(iii) Affect palliative outcomes, patient safety, and quality of care.

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P728	(b) Performance improvement activities track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.		L569	(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.
P729	(c) The hospice shall take actions aimed at performance improvement and after implementing those actions. The hospice shall measure its success and track performance to ensure that improvements are sustained.		L570	(3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained.
P730	(5) PERFORMANCE IMPROVEMENT PROJECTS. The hospice shall develop, implement, and evaluate performance improvement projects.		L571	Beginning February 2, 2009, hospices must develop, implement and evaluate performance improvement projects.
P731	(a) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, and shall reflect the scope, complexity, and past performance of the hospice's services and operations.		L572	(1) The number and scope of distinct performance improvement projects conducted annually, based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity, and past performance of the hospice's services and operations.
P732	(b) The hospice shall document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.		L573	(2) The hospice must document what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.
	(6) EXECUTIVE RESPONSIBILITIES. The hospice's governing body is responsible for ensuring all of the following:			The hospice's governing body is responsible for ensuring the following:
P733	(a) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually		L574	(1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained, and is evaluated annually.
P734	(b) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.		L575	(2) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness.

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P735	(c) That one or more individuals who are responsible for operating the quality assessment and performance improvement program are designated.		L576	(3) That one or more individual(s) who are responsible for operating the quality assessment and performance improvement program are designated.
P736	DHS 131.23 Infection control. (1) INFECTION CONTROL PROGRAM. The hospice shall maintain and document an effective infection control program that protects patients, families, visitors, and hospice employees by preventing and controlling infections and communicable diseases.		L578	The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.
P737	(2) PREVENTION. The hospice shall follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.		L579	The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.
P738	(3) CONTROL. The hospice shall maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that:		L580	The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that ...
P739	(a) Is an integral part of the hospice's quality assessment and performance improvement program and		L580	(1) Is an integral part of the hospice's quality assessment and performance improvement program; and
P740	(b) Includes all of the following:		L581	(2) Includes the following:
P741	1. A method of identifying infectious and communicable disease problems.		L581	(i) A method of identifying infectious and communicable disease problems; and
P742	2. A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.		L581	(ii) A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.
P743	(4) EDUCATION. (a) The hospice shall provide infection control education to employees, contracted providers, patients, and family members and other caregivers.		L582	The hospice must provide infection control education to employees, contracted providers, patients, and family members and other caregivers.

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P744	(b) The hospice shall develop and implement initial orientation and ongoing education and training for all hospice workers having direct patient contact, including students, trainees and volunteers, in the epidemiology, modes of transmission, prevention of infection and the need for routine use of current infection control measures as recommended by the U.S. centers for disease control and prevention.	G: The administration ensures orientation and training. P: Survey staff to review a sample of personnel records on orientation, training and prevention. (Outcome)		
P745	DHS 131.24 Employee health. * (1) DISEASE SURVEILLANCE. Agencies shall develop and implement written policies for control of communicable diseases which take into consideration control procedures incorporated by reference in ch. DHS 145 and which ensure that employees with symptoms or signs of communicable disease or infected skin lesions are not permitted to work unless authorized to do so by a physician, physician assistant or advanced practice nurse.	G: Hospice shall establish and maintain written policies for control of communicable disease; and shall establish a system for employees to use to report communicable disease. P: Survey staff shall review policies and procedures of the system, and the actions of the administration and governing body. (Outcome)		
P746	(2) PHYSICAL HEALTH OF NEW EMPLOYEES. Each new employee, prior to having direct patient contact, shall be certified in writing by a physician, physician assistant or registered nurse as having been screened for tuberculosis, and clinically apparent communicable disease that may be transmitted to a patient during the normal employee's duties. The screening shall occur within 90 days prior to the employee having direct patient contact.			
P747	(3) CONTINUING EMPLOYEES. Each employee having direct patient contact shall be screened for clinically apparent communicable disease by a physician, physician assistant, or registered nurse based on the likelihood of their exposure to a communicable disease, including tuberculosis. The exposure to a communicable disease may have occurred in the community or in another location.			

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P752	2. Promptly notify the registered nurse of any change in patient status that suggests a need to update the plan of care.			
P753	3. Provide services consistent with the patient plan of care.			
P754	4. Provide education and counseling to the patient and, as necessary, to the patient's family, consistent with the plan of care.			
P755	5. Participate in developing and revising written patient care policies.		L542	(2) If the hospice has more than one interdisciplinary group, it must identify a specifically designated interdisciplinary group to establish policies governing the day-to-day provision of hospice care and services.
P756	(c) The hospice may contract for physician services as specified in sub. DHS 131.25(2)(a) of this section. A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. A hospice may also enter into a written arrangement with another Medicare certified hospice program for the provision of core services to supplement hospice staff to meet the needs of patients. Circumstances under which a hospice may enter into a written arrangement for the provision of core services include unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care and temporary travel of a patient outside of the hospice's service area.		L588 L589	A hospice must routinely provide substantially all core services directly by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice. These services include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in paragraph (a) of this section. A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. A hospice may also enter into a written arrangement with another Medicare certified hospice program for the provision of core services to supplement hospice employee/staff to meet the needs of patients. Circumstances under which a hospice may enter into a written arrangement for the provision of core services include: unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care; and temporary travel of a patient outside of the hospice's service area.

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P757	(3) PHYSICIAN SERVICES. The hospice medical director, physician employees, and contracted physicians of the hospice, in conjunction with the patient's attending physician are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness.		L590	The hospice medical director, physician employees, and contracted physician(s) of the hospice, in conjunction with the patient's attending physician, are responsible for the palliation and management of the terminal illness and conditions related to the terminal illness.
P758	(a) All physician employees and those under contract must function under the supervision of the hospice medical director.		L590	(1) All physician employees and those under contract, must function under the supervision of the hospice medical director.
P759	(b) All physician employees and those under contract shall meet this requirement by either providing the services directly or through coordinating patient care with the attending physician. 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.		L590	(2) All physician employees and those under contract shall meet this 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.
P760	(4) NURSING SERVICES. (a) Nursing services shall be provided by or under the supervision of a registered nurse and shall consist of all of the following:	G: Hospice shall assure that nursing services are provided by qualified individuals and that procedures have been developed delineating the responsibilities for each job category of nursing personnel, as well as for all aspects of the delivery of nursing services. P: Survey staff to review licensure status of nurse employees. In addition, survey staff will review defined nursing functions, including clinical, teaching, supervising, and evaluative aspects of this service. Method will be through a sample of patient records, home visits, use of selected interviews and review of selected personnel records. (Outcome)	L591	(1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments.
P761	1. Regularly assessing the patient's nursing needs, implementing the plan of care provisions to meet those needs and reevaluating the patient's nursing needs.			
P762	2. Supervising and teaching other nursing personnel, including licensed practical nurses, nurse aides.			

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P763	3. Evaluating the effectiveness of delegated acts performed under the registered nurse's supervision.			
P764	(b) 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.		L593	(3) 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.
P765	(c) <i>Licensed practical nursing services.</i> If licensed practical nursing services are provided, the licensed practical nurse shall function under the supervision of a registered nurse with duties specified in writing and updated by a registered nurse.	G: If hospice decides to use Licensed Practical Nursing services, the position description must define that duties assigned must be under the supervision of a Registered Nurse. P: Survey staff to review position descriptions, and through a sample of patient records, review RN assignment of duties for the LPN's performance. Home visits may be conducted.		
P766	(5) SOCIAL SERVICES. (a) Social services shall be provided by a qualified social worker and shall consist of all of the following:	G: Hospice shall assure that the individual identified to provide social services holds a social worker certificate or clinical social worker license under s. 457.08, Wis. Stats. Hospice shall assure that social services are available for the patient and family. P: Survey staff to review personnel record of the assigned individual(s).	L594	Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient's psychosocial assessment and the patient's and family's needs and acceptance of these services.
P767	1. Regularly assessing the patient's social service needs, implementing the plan of care to meet those needs and reevaluating the patient's needs and providing ongoing psychosocial assessment of the family's coping capacity relative to the patient's terminal condition.	G: Hospice is responsible for the quality of care provided by the individual designated to deliver social services, including the psychosocial assessment and ensuing interventions to the patient and family. P: Survey staff to review a sample of patient records, conduct home visits and interview selected staff to verify patient and family psychosocial needs are met. (Outcome)	L594	“
P768	2. Linking patient and family with needed community resources to meet ongoing social, emotional and economic needs.			

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P769	(6) COUNSELING SERVICES. Counseling services shall be available to the patient and family to assist the patient and family in minimizing the stress and problems that arise from the terminal illness, related conditions, and the dying process.		L595	Counseling services must be available to the patient and family to assist the patient and family in minimizing the stress and problems that arise from the terminal illness, related conditions, and dying process.
P770	(a) <i>Bereavement services.</i> Bereavement services shall be provided to families of hospice patients. Each hospice shall have its own bereavement program. Bereavement services shall be:	G: Hospice must establish an organized bereavement program for the purpose of providing direct bereavement care. Such care must be provided under the direction of the core team through approaches and outcomes (goals) established in the plan of care. The bereavement program must provide for regular ongoing planned contact with families for at least one year after the death, which at a minimum includes offers of: <ul style="list-style-type: none"> • individual support contact; • access/referral to support groups; • written materials (letter, card, educational information, etc.); and • a mechanism for handling complex grief referral for counseling), etc. The hospice program services are available to the bereaved family that includes, at a minimum, the family spokesperson, immediate family, and primary caregiver(s) as identified by the patient. The hospice bereavement plan of care shall be established upon assessment of loss after death and shall: <ul style="list-style-type: none"> • be directed by the hospice plan of care and prior assessments; • be compatible with core team directions; • reflect death related grief and loss issues/needs for family members; • include approaches and outcomes related to grief/loss issues; • specify the bereavement services to be provided and frequency of said services as defined by the hospice program; and, be updated as indicated by needs identified through hospice assessment of family needs and responses to the plan of care 		

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		<p>While the bereavement plan is not established and implemented until death has occurred, any grief/loss issues or needs identified by hospice staff prior to death must be documented and addressed in the care plan. Neither federal nor state regulations specify a time frame for implementation of the bereavement plan following death (i.e., the next day, the following week). Implementation time frame is based on identified patient/family needs and agency policy.</p> <p>P: Survey staff may interview the bereavement coordinator, select staff and review a sample of bereavement records to ascertain that:</p> <ul style="list-style-type: none"> • identified needs have been recognized; • approaches are compatible with bereavement needs; • actual interventions are directed by the plan of care; and • updates to the bereavement plan follow the procedures outlined for review of the plan of care. <p>Survey staff may contact family and/or caregivers six months after their loss.</p>		
<p>P771</p>	<p>1. Coordinated by an individual recognized by the governing body to possess the capacity by training and experience to provide for the bereavement needs of families, including the ability to organize a program of directed care services provided to family members.</p>		<p>L596</p>	<p>(1) Bereavement counseling. The hospice must:</p> <p>(i) Have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling.</p> <p>(iii) Ensure that bereavement services reflect the needs of the bereaved.</p> <p>(iv) Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery. A special coverage provision for bereavement counseling is specified in 418.64(d).</p>
<p>P772</p>	<p>2. Compatible with the core team's direction within the plan of care for the patient.</p>			

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P773	3. Available for one year following the patient's death as part of an organized program and provide all of the following:		L596	(ii) Make bereavement services available to the family and other individuals in the bereavement plan of care up to 1 year following the death of the patient. Bereavement counseling also extends to residents of a SNF/NF or ICF/MR when appropriate and identified in the bereavement plan of care.
P774	a. Orientation and training to individuals providing bereavement services to ensure that there is continuity of care.	G: Hospice shall develop procedures for orientation and training, assignment, supervision, and evaluation of direct employees or contract employees performing bereavement care. Hospice shall develop procedures to anticipate individuals that have complex grief issues and may need additional grief counseling at other community agencies (referrals). P: Survey staff may interview the bereavement coordinator and other select staff and review bereavement service procedures, in addition to review of a sample of patient records.		
P775	b. Service intervention either directly or through trained bereavement counselors			
P776	c. Assignment, supervision and evaluation of individuals performing bereavement services.			
P777	d. Referrals of family members to non-hospice community programs where appropriate.			
P778	(b) <i>Dietary counseling.</i> Dietary counseling services shall be provided only as authorized by the hospice and in conjunction with the plan of care. The services shall be provided by a registered dietician or an individual who has documented equivalency in education or training. Dietary services shall be supervised and evaluated by a registered dietician or other individual qualified under this paragraph who may delegate acts to other employees. Dietary counseling services shall consist of all of the following:		L597	(2) Dietary counseling. Dietary counseling, when identified in the plan of care, must be performed by a qualified individual, which include dietitians as well as nurses and other individuals who are able to address and assure that the dietary needs of the patient are met.
P779	1. Assessment of nutritional needs and food patterns;			
P780	2. Planning diets appropriate for meeting patient needs and preferences; and			

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P781	3. Providing nutrition education and counseling to meet patient needs, as well as necessary consultation to hospice employees.			
	(c) <i>Spiritual counseling</i> . The hospice shall do all of the following:	G: Should hospice develop this optional service, the individual providing spiritual counseling services must demonstrate the capability to perform this function as recognized by the governing body. P: Survey staff will review the personnel record of the spiritual counselor, and then review a sample of patient/family assessments performed by this individual to ascertain that the spiritual needs of patients and families are noted and acted upon. Home visits may be conducted.	L598	(1) Spiritual counseling. The hospice must:
P782	1. Provide an assessment of the patient's and family's spiritual needs.		L598	(i) Provide an assessment of the patient's and family's spiritual needs.
P783	2. Provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires.		L598	(ii) Provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires.
P784	3. Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability.		L598	(iii) Make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability.
P785	4. Advise the patient and family of this service.		L598	(iv) Advise the patient and family of this service.
P786	DHS 131.26 Non-core services. (1) GENERAL REQUIREMENTS. A hospice is responsible for providing care and services to a patient and, as necessary, the patient's family, based on the plan of care developed by the core team. Volunteers shall participate in the delivery of program services. The hospice may provide other services as follows:		L644	Volunteers must be used in day-to-day administrative and/or direct patient care roles.

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P787	(a) <i>Therapy services.</i> Therapy services are provided in accordance with the plan of care for the patient and by individuals who meet qualification requirements for therapy service delivery such as evidence of current licensure or registration and academic training. Therapy services shall consist of all of the following:	G: Should hospice decide to provide therapy services, the position descriptions shall contain duties and responsibilities, including direction of therapy assessments and interventions as directed by the patient's plan of care, and supervision by the care coordinator. P: Survey staff to review these position descriptions to review personnel qualifications, and verify that direct patient interventions are compatible with the position descriptions, meet patient needs and congruent with the plan of care as determined through a review of a sample of patient records. Home visits may be conducted.	L604	Physical therapy services, occupational therapy services, and speech-language pathology services must be available and, when provided, offered in a manner consistent with accepted standards of practice.
P788	1. Physical, occupational, speech and language pathology or respiratory therapy.			
P789	2. The provision of a patient assessment as directed by the plan of care.			
P790	3. The development of a therapy plan of care.			
P791	(b) <i>Homemaker services.</i> If homemaker services are provided, they shall be provided in accordance with the patient's plan of care and shall consist of:	G: Should hospice provide Homemaker services, the position description for such services must state that all services performed will be provided under the plan of care, and that assignment of these services will be done by the care coordinator. P: Survey staff will review sample of records that contain Homemaker assignments.	L638 L639	(1) Homemaker services must be coordinated and supervised by a member of the interdisciplinary group. (2) Instructions for homemaker duties must be prepared by a member of the interdisciplinary group.
P792	1. Housekeeping activities			
P793	2. Performing errands and shopping.			
P794	3. Providing transportation.			
P795	4. Preparing meals.			
P796	5. Other assigned tasks intended to maintain the capacity of the household.			

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P797	(2) NURSE AIDE SERVICES. The hospice may provide nurse aide services as follows:	<p>G: If hospice decides to provide Hospice aide services, the position descriptions shall contain defined duties and include the procedures for written assignments, and direction by an RN. Supervision by an RN to be provided every 14 days.</p> <p>P: Survey staff to conduct home visits and select sample of patient records that contain Hospice aide assignments. A review of those assignment and RN supervision will be conducted. (Outcome)</p>		
P798	(a) <i>Assignment.</i> Nurse aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a nurse aide shall be prepared by a registered nurse who is responsible for the supervision of a nurse aide as specified under paragraph (c) of this section.		L625	Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section.
P799	(b) <i>Plan of Care.</i> The nurse aide shall provide care in accordance with the patient's plan of care. Nurse aide services consist of, but are not to be limited to, all of the following:		L626	(2) A hospice aide provides services that are: (i) Ordered by the interdisciplinary group. (ii) Included in the plan of care. (iii) Permitted to be performed under State law by such hospice aide. (iv) Consistent with the hospice aide training.
P800	1. Assisting patients with personal hygiene.		L627	(3) The duties of a hospice aide include the following: (i) The provision of hands-on personal care. (ii) The performance of simple procedures as an extension of therapy or nursing services.
P801	2. Assisting patients into and out of bed and with ambulation.		L627	(iii) Assistance in ambulation or exercises.
P802	3. Assisting with prescribed exercises which patients and hospice aides have been taught by appropriate health care personnel.		L627	“
P803	4. Assisting patients to the bathroom or in using a bedpan.			

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P804	5. Assisting patients with self-administration of medications.		L627	(iv) Assistance in administering medications that are ordinarily self-administered.
P805	6. Administering medications to patients if the aide has completed a state-approved medications administration course and has been delegated this responsibility in writing for the specific patient by a registered nurse.			
P806	7. Reporting changes in the patient's condition and needs.		L628	(2) Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment and improvement activities.
P807	8. Completing appropriate records.		L628	Hospice aides must also complete appropriate records in compliance with the hospice's policies and procedures.
P808	(c) <i>Supervision of nurse aides.</i> 1. A registered nurse shall make an on-site visit to the patient's home no less frequently than every 14 days to assess the quality of care and services provided by the nurse aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The nurse aide does not have to be present during this visit.		L629	(1) A registered nurse must make an on-site visit to the patient's home: (i) No less frequently than every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit.
P809	2. If an area of concern is noted by the supervising nurse, then the hospice shall make an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while the aide is performing care.		L630	(ii) If an area of concern is noted by the supervising nurse, then the hospice must make an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while he or she is performing care.
P810	3. If an area of concern is verified by the hospice during the on-site visit, then the hospice shall conduct, and the nurse aide shall complete a competency evaluation.		L631	(iii) If an area of concern is verified by the hospice during the on-site visit, then the hospice must conduct, and the hospice aide must complete, a competency evaluation in accordance with 418.76(c).

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P811	4. A registered nurse shall make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while the aide is performing care.		L632	(2) A registered nurse must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care.
P812	(d) <i>Assessment of aide.</i> The supervising nurse shall assess an aide's ability to demonstrate initial and continued satisfactory performance in meeting outcome criteria that include all of the following, but is not limited to:		L633	(3) The supervising nurse must assess an aide's ability to demonstrate initial and continued satisfactory performance in meeting outcome criteria that include, but is not limited to ...
P813	1. Following the patient's plan of care for completion of tasks assigned to the nurse aide by the registered nurse.		L633	(i) Following the patient's plan of care for completion of tasks assigned to the hospice aide by the registered nurse.
P814	2. Creating successful interpersonal relationships with the patient and family.		L633	(ii) Creating successful interpersonal relationships with the patient and family.
P815	3. Demonstrating competency with assigned tasks.		L633	(iii) Demonstrating competency with assigned tasks.
P816	4. Complying with infection control policies and procedures.		L633	(iv) Complying with infection control policies and procedures.
P817	5. Reporting changes in the patient's condition.		L633	(v) Reporting changes in the patient's condition.
P818	DHS 131.27 Volunteers. Prior to beginning patient care, a volunteer shall be oriented to the hospice program and shall have the training for the duties to which he or she is assigned.	G: Hospice shall establish procedures for volunteer orientation to both the hospice program, as well as specific training for any individual duties that the volunteer may be assigned. Volunteers may be used in direct patient functions, as well as non-patient activities within the hospice program. P: Survey staff to review volunteer orientation as well as volunteer assignments. Select interviews may be conducted.	L643	The hospice must maintain, document and provide volunteer orientation and training that is consistent with hospice industry standards.

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P819	DHS 131.28 Governing body. + * (1) Each hospice shall have a governing body that assumes full legal responsibility for determining, implementing and monitoring the overall conduct and operation of the program, including the quality of the care and services.	G: Hospice must demonstrate that there is a designated individual, group or corporation with the responsibility and authority in writing for the day-to-day operation of the hospice. The governing body must establish policies that encompass the full operation and evaluation of the hospice program. P: Survey staff to: <ul style="list-style-type: none"> • review charter, by-laws or other documents to determine the legal responsibility for hospice care; • establish that the governing body has developed policies regarding the hospice's full operation, including evaluation of those policies and program effectiveness. (Outcome) 	L651	A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator appointed by and reporting to the governing body is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body.
	(2) The governing body shall do all of the following:			
P820	* (a) Be responsible for the establishment and maintenance of policies and for the management, operating and evaluation of the hospice.			
P821	(b) Adopt a statement that designates the services the hospice will provide and the setting or settings in which the hospice will provide care.			
P822	+ (c) Ensure that all services are provided consistent with accepted standards of professional practice.			
P823	* (d) Appoint an administrator and delegate to the administrator the authority to operate the hospice in accordance with policies established by the governing body.		L651	“
P824	+ (e) Ensure that nursing and physician services and drugs and biologicals are routinely available on a 24 hour basis 7 days a week.	P: Review on-call system developed by the hospice.		
P825	+ (f) Ensure that other covered services are available on a 24 hour basis when reasonable and necessary to meet the needs of the patient and family.			

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P826	DHS 131.29 Administration. (1) ADMINISTRATOR. The administrator shall be responsible for day-to-day operation of the hospice.	G: The Administrator shall play an active role in implementing policies, evaluating hospice performance, and establishing a functional organizational structure. P: Survey staff to interview the administrator in order to determine the role of the administrator in organizing, implementing and evaluating policies of the program. (Outcome)	L651	“
	(2) DUTIES OF THE ADMINISTRATOR. The administrator shall do all of the following:			
P827	(a) Implement and regularly evaluate policies for the management and operation of the hospice and evaluation of the overall program performance of the hospice, and implement and regularly evaluate procedures consistent with those policies.			
P828	(b) Establish an organizational structure appropriate for directing the work of the hospice's employees in accordance with the program's policies and procedures.			
P829	(c) Maintain a continuous liaison between the governing body and the hospice employees.			
P830	(d) Ensure that employees are oriented to the program and their responsibilities, that they are continuously trained and that their performance is evaluated.	G: Hospice administrator to ensure that the system developed provides for adequate orientation, training and performance evaluation of hospice employees. The administrator is to set up a procedure for a alternate administrator to act in the administrator's absence. P: Survey staff to review personnel records of selected employees for evidence of orientation, training, and evaluation.		
P831	+ (e) Designate in writing, with the knowledge of the governing body, a qualified person to act in his or her absence.	P: Survey staff to check on alternate administrator designation by governing body.		
P832	DHS 131.30 Professional management responsibility. (1) RESPONSIBILITY. The hospice is responsible for providing services to the patient or family, or both, based on assessed need and as established by the plan of care.	G: Self explanatory P: Survey staff will assure that hospice has assumed responsibility to manage services provided to the patient or family as defined in the plan of care.	L655	A hospice that has a written agreement with another agency, individual, or organization to furnish any services under arrangement must retain administrative and financial management, and oversight of staff and services for all arranged services, to ensure the provision of

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				quality care. Arranged services must be supported by written agreements that require that all services be ...
P833	+ (2) CONTRACT SERVICES. The hospice may contract with other providers for the provision of services to a patient or the patient's family, or both, in which case the hospice shall retain responsibility for the quality, availability, safety, effectiveness, documentation and overall coordination of the care provided to the patient or the patient's family, or both, as directed by the hospice plan of care. The hospice shall:	<p>G: If hospice shall provide services under contract, these services shall be described by a legally binding written agreement between the hospice and the source of the service.</p> <p>P: Survey staff to review this process through a sample of patient records, as well as reviewing a sample of contract language for hospice's retaining responsibility for contracted services provided. Request a listing of contractees for sample selection. For initial survey request a contract prototype for review.</p>	L655	<p>(1) Authorized by the hospice; (2) Furnished in a safe and effective manner by qualified personnel; and (3) Delivered in accordance with the patient's plan of care.</p> <p>The hospice must assume responsibility for professional management of the resident's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to 418.110 and 418.108.</p>
P834	(a) Ensure that there is continuity of care for the patient or the patient's family, or both, in the relevant care setting.	<p>G: Hospice shall provide smooth provision of services within a defined care setting, or from one location (setting) to another.</p> <p>P: Survey staff shall review a sample of patient records and conduct home visits to assure that continuity of care has occurred in the relevant care setting. (Outcome)</p>	L762	The hospice must assume responsibility for professional management of the resident's hospice services provided, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility according to 418.110 and 418.108.
P835	(b) Be responsible for all services delivered to the patient or the patient's family, or both, through the contract. The written contract shall include all of the following:	<p>G: The hospice shall retain the program and clinical responsibility for services provided to the patient/family under the terms of this agreement. The hospice plans for the patient's care, assures management for, and retains responsibility of that care. The hospice must assure that services offered are consistent with the hospice philosophy of palliative and supportive care. The contract specifies the services to be provided, personnel qualifications, the role and responsibility of each party, and a stipulation that all services provided will be in accordance with the direction defined in the hospice's plan of care.</p> <p>P: Survey staff to review contract for language compliance. Selected interviews with contractees may be conducted, if warranted. (Outcome)</p>	L763	The hospice and SNF/NF or ICF/MR must have a written agreement that specifies the provision of hospice services in the facility. The agreement must be signed by authorized representatives of the hospice and the SNF/NF or ICF/MR before the provision of hospice services.

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P836	1. Identification of the services to be provided.		L767	An agreement that it is the SNF/NF or ICF/MR responsibility to continue 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.
P837	2. Stipulation that services are to be provided only with the authorization of the hospice and as directed by the hospice plan of care for the patient.		L776	Any changes in the hospice plan of care must be discussed with the patient or representative, and SNF/NF or ICF/MR representatives, and must be approved by the hospice before implementation.
P838	3. The manner in which the contracted services are coordinated and supervised by the hospice.		L776	A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
P839	4. The delineation of the roles of the hospice and service provider in the admission process, assessment, interdisciplinary group meetings and ongoing provision of palliative and supportive care.		L769	A delineation of the hospice's responsibilities, which include, but are not limited to the following providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary and bereavement); social work; 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; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
P840	5. A method of evaluation of the effectiveness of those contracted services through the quality assurance program under s. DHS 131.22.		L560	POSSIBLE: The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate

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				improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.
P841	6. The qualifications of the personnel providing the services.		L784	Except as specified in paragraph (c) of this section, all professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally authorized (licensed, certified or registered) in accordance with applicable federal, state and local laws, and must act only within the scope of his or her state license, or state certification, or registration. All personnel qualifications must be kept current at all times.
P842	(c) Evaluate the services provided under a contractual arrangement on an annual basis.	G: The hospice must annually evaluate services provided under contractual arrangements to ensure contract compliance and outcomes of patient care. P: Survey staff will review a sample of contract evaluations. (Outcome)		
				NOTE: There may be alternate requirements at 418.100 more appropriate in specific situations than those referenced above as related to DHS 131.30.
P843	DHS 131.31 Employees. (1) CAREGIVER BACKGROUND CHECKS. Each hospice shall comply with the caregiver background check and misconduct reporting requirements in s. 50.065, Wis. Stats., and ch. DHS 12, and the caregiver misconduct reporting and investigation requirements in ch. DHS 13.			

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P844	(2) GENERAL REQUIREMENTS. Prior to beginning patient care, every employee or contracted staff shall be oriented to the hospice program and the job to which he or she is assigned.	G: Hospice shall establish both general orientation as well as specific job-focused training. Orientation and training shall be established by policy. Hospice shall, based on orientation and training, assign only those duties for which the employee demonstrates competency. (Outcome) P: Survey staff to review hospice orientation and training through review of selected personnel records to affirm that employees received an orientation and demonstrated competency in specific duties prior to assignment. Selected staff may be interviewed.	L661 L662	(1) A hospice must provide orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact. (2) A hospice must provide an initial orientation for each employee that addresses the employee's specific job duties.
	(3) ORIENTATION PROGRAM. A hospice's orientation program shall include all of the following:			
P845	* (a) An overview of the hospice's goal in providing palliative care.			
P846	* (b) Policies and services of the program.			
P847	* (c) Information concerning specific job duties.		L622	(2) A hospice must provide an initial orientation for each employee that addresses the employee's specific job duties.
P848	* (d) The role of the plan of care in determining the services to be provided.			
P849	* (e) Ethics, confidentiality of patient information, patient rights and grievance procedures.			
P850	* (4) DUTIES. Hospice employees or contracted staff may be assigned only those duties for which they are capable, as evidenced by documented training or possession of a license or certificate.			
P851	* (5) CONTINUOUS TRAINING. A program of continuing training directed at maintenance of appropriate skill levels shall be provided for all hospice employees providing services to patients and their families.	G: Hospice shall provide a program of continuing training to all hospice employees to ensure maintenance of appropriate skill levels.	L663	(3) A hospice must assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training

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				provided during the previous 12 months.
P852	(6) EVALUATION. A hospice shall evaluate every employee annually for quality of performance and adherence to the hospice's policies. Evaluations shall be followed up with appropriate action.	G: Hospice shall establish procedures for the annual evaluation of employees. P: Survey staff shall review selected employee performance evaluations. The sample may include the administrator, core team members and contracted staff.	L633	"
P583	(7) PERSONNEL PRACTICES. (a) Hospice personnel practices shall be supported by appropriate written personnel policies.			
P854	(b) Personnel records shall include evidence of qualifications, licensure, performance evaluations and continuing training, and shall be kept up-to-date.	P: Survey staff shall review a selected sample of personnel records for evidence of qualifications and/or licensure.		
P855	131.32 Medical Director. (1) The hospice shall have a medical director who shall be a medical doctor or a doctor of osteopathy.	G: Hospice shall assure that the medical director has assumed the overall responsibility for direction for the medical components of the program, and that s/he ensures the terminal status of each individual admitted to the program. P: Survey staff to: <ul style="list-style-type: none"> review personnel folder of medical director to verify qualifications, and review sample of patient records to verify that the medical director has concurred with the prognostic status of the patient at the time of admission. 	L665	The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is an employee, or is under contract with, the hospice. When the medical director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the medical director.
	(2) The medical director shall do all of the following:			
P856	(a) Direct the medical components of the program.		L669	The medical director or physician designee has responsibility for the medical component of the hospice's patient care program.

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P857	(b) Ensure that the terminal status of each individual admitted to the program has been established.		L667	The medical director or physician designee reviews the clinical information for each hospice patient and provides written certification that it is anticipated that the patient's life expectancy is 6 months or less if the illness runs its normal course. The physician must consider 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; and (5) Information about the medical management of any of the patient's conditions unrelated to the terminal illness.
P858	(c) Ensure that medications are used within accepted standards of practice.	G: Hospice shall assure that the medical director through the role of directing the medical component of the program ensures that medications are used within accepted standards, that a system has been developed to document the disposal of controlled substances, and ensures that the medical needs of the patients are being met. P: Survey staff to review medication usage and disposal through sample selection of patient records, as well as review policy for the disposal of controlled substances. Review patient records to determine how medical director was involved in situations where the medical needs of the patients were not being met - e.g., patient either had no attending physician, or the attending physician's efforts proved insufficient to meet the patient's needs.		
P859	(d) Ensure that a system is established and maintained to document the disposal of controlled drugs.		L694	(2) Disposing. (i) Safe use and disposal of controlled drugs in the patient's home. The hospice must have written policies and procedures for the management and disposal of controlled drugs in the patient's home. At the time when controlled drugs are first ordered, the hospice must:

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P860	(e) Ensure that the medical needs of the patients are being met.			
P861	(f) Provide liaison as necessary between the core team and the attending physician.			
P862	(g) Ensure that a system is established for the disposal of controlled drugs.		L694	(3) Disposing. (i) Safe use and disposal of controlled drugs in the patient's home. The hospice must have written policies and procedures for the management and disposal of controlled drugs in the patient's home.
P863	DHS 131.33 Clinical record. (1) GENERAL. A hospice shall establish a single and complete clinical record for every patient. Clinical record information shall remain confidential except as required by law or a third-party payment contract.	G: The hospice must maintain a single, complete clinical record for each individual admitted to the hospice. The record reflects the course and effects of services/events with respect to the patient's illness. P: The survey staff to review a sample of patient records.	L671 L680	A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically. The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use.
P864	* (2) DOCUMENTATION AND ACCESSIBILITY. The clinical record shall be completely accurate and up-to-date, readily accessible to all individuals providing services to the patient or the patient's family, or both, and shall be systematically organized to facilitate prompt retrieval of information.	G: Hospice shall assure that all information pertinent to patient/family care is documented in such a manner to assure accuracy. Such information needs to be retrievable by all employees in a timely manner so that patient/family needs can be determined and acted on by the hospice employees. Hospice shall develop health care policies that ensure record information is safeguarded. P: Survey staff to verify, through record review, that all services (direct or under contract) are documented and that this documentation system allows for accessibility to all employees. Survey staff may verify that the storage area for records affords protection from fire, water, and environmental threats. (Outcome)	L671 L685	A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically. The clinical record, whether hard copy or in electronic form, must be made readily available on request by an appropriate authority.

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	(3) CONTENT. A patient's clinical record shall contain all of the following:	G: Hospice shall assure every patient record contains all information outlined in 131.33(3)(a) through (m). With respect to (3)(e), the language, "a current medication list", refers to both prescribed medication as well as over-the-counter medications that the patient is taking. P: To review a select sample of health care records to survey staff, verify the content. (Outcome)		
P865	(a) The initial, integrated and updated plans of care prepared under s. DHS 131.21		L672	(1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes.
P866	(b) The initial, comprehensive and updated comprehensive assessments.		L672	"
P867	(c) Complete documentation of all services provided to the patient or the patient's family or both, including:			
P868	1. Assessments.		L672	"
P869	2. Interventions.			
P870	3. Instructions given to the patient or family, or both.			
P871	4. Coordination of activities.			
P872	(d) Signed copies of the notice of patient rights under s. DHS 131.19(1)(a) and service authorization statement under s. DHS 131.17(4)(b).		L673	(2) Signed copies of the notice of patient rights in accordance with 418.52 and election statement in accordance with 418.24.
P873	(e) A current medications list.			
P874	(f) Responses to medications, symptom management, treatments, and services.		L674	(3) Responses to medications, symptom management, treatments, and services.
P875	(g) Outcome measure data elements, as described in s. DHS 131.20(5).		L675	(4) Outcome measure data elements, as described in 418.54(e) of this subpart.
P876	(h) Physician certification and recertification of terminal illness.		L676	(5) Physician certification and recertification of terminal illness as required in 418.22 and 418.25 and described in 418.102(b) and 418.102(c) respectively, if appropriate.

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P877	(i) A statement of whether or not the patient, if an adult, has prepared an advance directive; and a copy of the advance directive, if prepared.		L677	(6) Any advance directives as described in 418.52(a)(2).
P878	(j) Physician orders.		L678	(7) Physician orders.
P879	(k) Patient and family identification information.			
P880	(L) Referral information, medical history and pertinent hospital discharge summaries.			
P881	(m) Transfer and discharge summaries.			
P882	(4) AUTHENTICATION. (a) All entries shall be legible, permanently recorded, dated and authenticated by the person making the entry, and shall include that person's name and title.		L679	All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.
P883	(b) A written record shall be made for every service provided on the date the service is provided. This written record shall be incorporated into the clinical record no later than 7 calendar days after the date of service.	G: Hospice shall assure that employees document patient and family information in such a manner that the document developed by the employees can be available to all employees within the hospice program. All entries need to be signed by the person making the entry. The use of initials is acceptable provided there is an indication the record identifies the initials with the signer's signature and title. Photocopies are considered a legal document. P: Survey staff to verify through record review that entries are made in the Health Care Record on a timely basis. The procedure to verify will be through review of a sample of patient records.		
P884	(c) Medical symbols and abbreviations may be used in the clinical records if approved by a written program policy which defines the symbols and abbreviations and controls their use.	G: The hospice must have an approved policy outlining symbols and abbreviations that may be used by employees. P: Surveyors will verify through record review, that staff adheres to agency policy.		
P885	(d) <i>Protection of information.</i> Written record policies shall ensure that all record information is safeguarded against loss, destruction and unauthorized usage.		L680	The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use.

P Tag	DHS 131 STATE RULE * = Agency Policy Required + = Additional Documentation Required	STATE G = Interpretive Guideline P = Surveyor Procedures	L Tag	FEDERAL Condition of Participation Requirement
P886	(e) <i>Retention and destruction.</i> 1. An original clinical record and legible copy or copies of court orders or other documents, if any, authorizing another person to speak or act on behalf of the patient shall be retained for a period of at least 5 years following a patient's discharge or death when there is no requirement in state law. All other records required by this chapter shall be retained for a period of at least 2 years.		L681	Patient clinical records must be retained for 6 years after the death or discharge of the patient, unless state law stipulates a longer period of time. If the hospice discontinues operation, hospice policies must provide for retention and storage of clinical records. The hospice must inform its state agency and its CMS Regional Office where such clinical records will be stored and how they may be accessed.
P887	2. A hospice shall arrange for the storage and safekeeping of records for the periods and under the conditions required by this paragraph in the event the hospice closes.		L681	“
P888	3. If the ownership of a hospice changes, the clinical records and indexes shall remain with the hospice.			
P889	DHS 131.34 Personnel Qualifications. (1) PERSONNEL QUALIFICATIONS. All professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, shall be legally authorized, licensed, certified or registered in accordance with applicable federal, state and local laws, and shall act only within the scope of his or her state licensure, or state certification, or registration. Personnel qualifications shall be kept current at all times.		L784	Except as specified in paragraph © of this section, all professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally authorized (licensed, certified or registered) in accordance with applicable federal, state and local laws, and must act only within the scope of his or her state license, or state certification, or registration. All personnel qualifications must be kept current at all times.