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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-62236 (01/2024) | | | | | | | | | | | | | | **STATE OF WISCONSIN**  Chapter DHS 131, Wis. Admin. Code  Page 1 of 2 | |
| **HOSPICE CLINICAL RECORD REVIEW** | | | | | | | | | | | | | | | |
| Name – HOSPICE AGENCY | | | | | | | | | | | | | | | CCN/License no. |
| Review Date | | Name – Patient | | | | | | | | | | | | | Name – Surveyor |
| Birth Date | | Date of Death | | | | | Record Number (Open/Closed) | | | | | | | | MB Election Date/SOC |
| **Service Agreement** *DHS 131.17(4)(b)*  **Patient Rights**  *DHS 131.19/L502*  **Advance Directive** *L503* | | | | | | | | | | | | | | | |
| Certification Period Reviewed | | | | | | | | **Certification of Terminal Illness** | | | | | | | | | |
|  | | | | | | | | Initial 90 days (both)  Subsequent 90 – 60 (either)  Medical Director  Medical Director  Attending MD  Narrative  Attending MD | | | | | | | | | |
| **Diagnosis** | | | | | | | |
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| **Patient Resides In** | | | | | | | | | | | | | | | | | |
| Home  ALF  SNF  Currently Inpatient  Other: | | | | | | | | | | | | | | | | | |
| **Initial Plan of Care** – Initial Assessment Completed within 48 hours from election of hospice care  Yes  No *DHS 131.21(2)* | | | | | | | | | | | | | | | | | |
| A nurse and one other core team person develop the POC*. [DHS 131.21(2)(c)]*  Attending MD  RN  Medical Director / Physician  Social Worker  Counselor | | | | | | | | | | | | | | | | | |
| **Revised Plan of Care/IDGs** – Disciplines must attend IDG:  RN  Med. Dir. / Phys.  SW  Counselor  *CFR 418.56(d)* *(at least every 15 days)* *DHS 131.21(3)(c)* | | | | | | | | | | | | | | | | | |
| **Date** | **IDG Discussion / Comments** | | | | | | | | | | | | | | | | |
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| Content of Plan of Care *CFR 418.56(c) / DHS 131.21(3)(b)* | | | | | | | | | | | Nursing Assessment *CFR 418.54(c) & DHS 131.20(3)* | | | | | | | |
| ***PLAN OF CARE*** | | | | | | **YES** | | | **NO** | | | **Comments** | | | | | | |
| Scope and Frequency of Services on POC | | | | | |  | | |  | | |  | | | | | | |
| Individualized to Patient | | | | | |  | | |  | | |  | | | | | | |
| Individualized interventions to manage pain/symptoms | | | | | |  | | |  | | |  | | | | | | |
| Include Patient/Caregiver Goals of Care/Measurable | | | | | |  | | |  | | |  | | | | | | |
| IDG maintains responsibility for directing/coordinating, and supervising the care/service provided | | | | | |  | | |  | | |  | | | | | | |
| Facility Patients have delineated services on the POC | | | | | |  | | |  | | |  | | | | | | |
| ***NURSING ASSESSMENT*** | | | | | | **YES** | | | **NO** | | | **Comments** | | | | | | |
| Assessments Complete, Consistent person centered/Individualized to patient | | | | | |  | | |  | | |  | | | | | | |
| 1st Comprehensive Assessment completed in 5 calendar Days after election of hospice care | | | | | |  | | |  | | |  | | | | | | |
| Care/Service in accordance with POC | | | | | |  | | |  | | |  | | | | | | |
| Medication Reconciliation Assessed | | | | | |  | | |  | | |  | | | | | | |
| Regular Pain/Symptom Management | | | | | |  | | |  | | |  | | | | | | |
| ***ADDITIONAL COMMENTS*** | | |  | | | | | | | | | | | | | | | |
| **Home Health Aide** | | | | | | | | | | | | | | | | | | |
| **Assignment Date** *418.76(g) & 131.26(2)(a)* | | | | **Documentation** *CFR 418.104 & DHS 131.33*  Yes  No | | | | | | | | | **Supervision Every 2 Weeks** *418.76(h) & 131.26(2)(c)*  Yes  No | | | | | |
| **Volunteers/Companions** | | | | | | | | | | | | | | | | | | |
| **Assignment Date** *DHS 131.26(1)(b)* | | | | | | | | | | **Documentation** *CFR 418.104 & DHS 131.33*  Yes  No | | | | | | | | |
| **Physician Orders** (Orders Signed Within 20 Business Days)  Yes  No *DHS 131.21(2)(d)* | | | | | | | | | | | | | | | | | | |
| **Bereavement Care Plan and Services Documentation** *CFR 418.64(d) & DHS 131.21(3)(d)* | | | | | | | | | | | | | | | | | | |
| Compatible with Core Team Direction Within the Plan of Care (POC).  Yes  No | | | | | | | | | | | | | | | | | | |
| **Social Services** – Provided by a Qualified Person in Accordance with the POC  Yes  No  N/A *CFR 418.64 & DHS 131.25(5)* | | | | | | | | | | | | | | | | |
| **Closed Record Reviews** *CFR 418.104* | | | | | | | | | | | | | | | | |
| Review care provided in the final days of life, post-death bereavement counseling and services for the family and caregivers.  Yes  No  Live discharges, explore the circumstances leading to the cessation of hospice services.  Yes  No  **Revoked/Discharged/Transfer Patients to have record of:**  Discharge Summary/Patient’s clinical record sent to Primary Attending MD if requested (L683/682)  Yes  No  **Discharge of Summary required information:**  Summary of Care, POC, Current/new orders; and other information for continuity of care (L684)  Yes  No | | | | | | | | | | | | | | | | |
| **Controlled Drug Disposal** *CFR 418.106 & DHS 131.32(2)(G)* | | | | | | | | | | | | | | | | |
| Has the RN participated?  Yes  No | | | | | Has the RN educated the family on how to dispose of drugs?  Yes  No | | | | | | | | | | | |
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| **TAG** | | **COMMENTS** | | | | | | | | | | | | | | |
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