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| **DEPARTMENT OF HEALTH SERVICES** Division of Quality AssuranceF-62322 (03/2024) | **STATE OF WISCONSIN**Page 1 of 2 |
| **HOSPICE INPATIENT CLINICAL RECORD REVIEW – INTERVIEWS**  |
| Name – HOSPICE AGENCY/Inpatient Location      | CCN/License No.       | Name and No. – Surveyor      |
| Name – Patient      | Date of Birth      | Record No. (Open/Closed)      | Date – Review      |
| Diagnosis      | Reason For Admission[ ]  Pain/Symptom Management [ ]  Respite | Date – Inpatient Admission      |
| Reimbursement Source: [ ]  Medicare [ ]  Medicaid [ ]  Insurance [ ]  Private Pay |
| **Evidence that Hospice Provided Inpatient Provider with Required Information (L781)**  [ ]  Yes [ ]  No [ ]  N/A  |
| [ ]  Most recent hospice plan of care [ ]  Advanced Directive[ ]  Name/contact info hospice personnel involved in care[ ]  Medication information  | [ ]  Hospice election forms and Patient Rights[ ]  Certification of Terminal Illness[ ]  Instruction on how to access 24-hour on-call system[ ]  Hospice physician/Attending physician orders specific to patient |
| **HOSPICE PLAN OF CARE** Date – Hospice Provided POC:       | **YES** | **NO** | **Comments** |
| Established and maintained in consultation and participation of facility representative and patient/family (***L773, L775)*** | **[ ]**  | **[ ]**  |       |
| Identifies care and services with responsible party (***L774)*** | **[ ]**  | **[ ]**  |       |
| Changes in POC discussed with facility representative and pt/family, addresses physical and psychosocial needs *(****L776)*** | **[ ]**  | **[ ]**  |       |
| Coordination of Services: Evidence of IDG care coordination and POC communication between Inpatient Care Staff/ hospice/ physicians **(*L777 - L780, P3170)*** | **[ ]**  | **[ ]**  |       |
| ***NURSING ASSESSMENT/INTERVENTION*** | **YES** | **NO** | **Comments** |
| Initial, Comprehensive, and reassessments conducted as needed to meet patient needs ***(L591, L672, P4075)*** | **[ ]**  | **[ ]**  |       |
| Evaluate effectiveness and response to medication, symptom management, & treatment documented ***(L512/ P2170 or L674/ P4600)*** | **[ ]**  | **[ ]**  |       |
| Provides 24-hour nursing care in accordance with patient’s POC ***(L822-IPU, L710-respite)*** | **[ ]**  | **[ ]**  |       |
| ***OTHER CORE/NON-CORE SERVICES:*** *Provided based on patient needs in accordance with the Plan of Care* ***(L-652)*** | **YES** | **NO** | **N/A** | **Comments** |
| Social Services | **[ ]**  | **[ ]**  | **[ ]**  |       |
| Aide Services | **[ ]**  | **[ ]**  | **[ ]**  |       |
| Counseling – Spiritual/Dietary/Bereavement | **[ ]**  | **[ ]**  | **[ ]**  |       |
| Aide, Volunteer, Homemaker  | **[ ]**  | **[ ]**  | **[ ]**  |       |
| Interview – Patient or Family Member/ Pt. Spokesperson *(To be used in conjunction with a Patient Care Observation if possible, with the patient/ family member, or pt spokesperson. If Unable, mark this section ‘N/A’)* |
| Date – Interview       | Services Being Provided      | Are needs met?[ ]  Yes [ ]  No *(Explain.)* |
| Patient Response to Intervention - *(Ask if Hospice addressing the patient reason for inpatient hospice care? Pain, symptom management?)*      |
| Facility’s Response to Requests and Patient and/or Family Needs - *(Ask that Hospice is not restricting visiting hours, accommodations made for family spending night, respect of privacy, take time to listen, and patient preferences are taken into consideration, including food and hydration needs?)*      |
| Facility Staffing Meets Patient and/or Family Needs- *(Ask whether staff respond timely to calls for assistance and if enough staff available in evenings or weekends to meet care needs?)*      |
| Identification of Unmet Patient and/or Family Needs      |
| Respite Specific Needs -if applicable *(Ask if patient is receiving care that they would expect to receive at home. Is there an awareness of respite length of stay and discharge plan?)*      |

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| **TAG** | **COMMENTS** |
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