TOP 10 **HOSPICE** DEFICIENCIES

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CHAP Community Health Accreditation Partner

	Standard	L Tag	Standard Content	Tips for Compliance
1	HCPC 21.I	L545, L548, L549	Patient's individualized written plan of care includes planned interventions based on problems identified in the initial and updated comprehensive assessments, measurable outcomes, and all drugs and treatments	• Educate IDG / all disciplines on including problems, interventions and goals based on the completed initial comprehensive assessment and on-going clinical assessments • Ensure goals are SMART (Specific, Measurable, Achievable, Realistic, Timely) • Focus on individualization of the plan of care specific to each patient's unique needs • QAPI indicator or PIP to achieve and sustain compliance with problems, interventions, goals, and accurate medications
2	HCPC 15.I	L530	The comprehensive assessment includes a drug profile that contains the patient's current prescription and over-the-counter (OTC) drugs with medication regimen review process	• Conduct medication reconciliation during home visits • Educate IDG to communicate any medication changes found on visits to RN • Perform record audits to verify all medications are present on medication profile
3	HCDT 15.I	L625	Written patient care instructions for a hospice aide are prepared by a RN who is responsible for the supervision of the hospice aide	• Educate RNs on writing specific tasks with clear direction on Aide Care Plans • Educate Aides to notify the RN if Aide Care Plan lacks specific directions to follow, and to contact RN prior to varying any tasks on the assignment sheet • Perform home supervisory visits to ensure Aides are following the assignment sheet • Audit Aide Care Plans to identify noncompliance
4	HSIM 3.I	L678	Patient clinical record containing past and current findings is maintained for each hospice patient including Physician Orders	• Educate clinicians on documenting all physician orders in the clinical record • Perform ongoing clinical record review using criteria to capture noncompliance in physician orders • Perform focused audits on non-compliant areas, such as wound orders
5	HCDT 16.I	L626	Hospice aides provide services ordered by the IDG and included in the plan of care	• Educate Aides on following the Aide Care Plan and communicating with the RN if changes needed • Educate RNs on collaboration with Aide and to revise Aide Care Plan as needed • Perform home supervisory visits to observe Aide and identify if following Aide Care Plan • Educate RNs to compare Aide documentation to the Aide Care Plan during the supervisory process to ensure compliance
6	HCDT 39.I	L683	If a patient revokes the election of hospice care or is discharged from hospice per hospice regulation, the hospice forwards a copy of the discharge summary to the attending physician	• Ensure a process is in place for providing the attending physician a copy of the discharge summary for patient who revoke the benefit or are discharged from service • Audit records of discharged patients to validate compliance
7	HCPC 9.I	L523	The Hospice IDG completes an initial comprehensive assessment no later than 5 calendar days after the election of hospice care	• Develop tracking process to ensure initial comprehensive assessment is completed in required timeframe • Ensure RN includes spiritual, psychosocial, and/or bereavement assessment in the initial comprehensive assessment if other disciplines are refused
8	HCPC 19.I	L540, L543	The hospice designates a Registered Nurse to ensure implementation of the plan of care. Hospice care and services are provided to patients and families follow the individualized plan of care.	• Ensure a Registered Nurse is designated and provides coordination of care, ensuring ongoing assessment, and implementation of the patient's individualized plan of care • Ensure a process is in place to audit visit frequencies against actual visits completed • Ensure a process is in place to audit clinical documentation against the plan of care to ensure all disciplines are following the plan care as established by the IDG
9	HCDT 18.I	L628	Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and/or social needs to a registered nurse. The hospice aide must also complete appropriate records of service, including the report of changes in the patient's needs. Hospice aide documentation complies with hospice policies and procedures.	• Conduct ongoing education and training for hospice aides regarding reporting requirements and required documentation. • Conduct routine chart audits to review aide documentation for completeness and accuracy. • Educate RNs to review aide documentation during supervisory visits.
10	HCDT 40.I	L684	The hospice discharge summary provided to a facility receiving a hospice patient for care—or to the patient's community attending physician upon hospice discharge—includes at least the following: 1. A summary of the patient's hospice stay, including treatments, symptoms, and pain management; 2. The patient's current plan of care; 3. The patient's latest physician orders; 4. Any other documentation that will assist in the post-discharge continuity of care or that is requested by the receiving facility or the attending physician.	• Provide education to RNs regarding the required contents of a completed discharge summary. • Conduct routine chart audits with a focus on discharge summary documentation to ensure a completed discharge summary is present and contains all of the required elements listed in the standard.