TOP 10 **HOSPICE** DEFICIENCIES-2025

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CHAP Community Health Accreditation Partner

	Standard	L Tag	Standard Content
①	HCPC 21.I	L545	Patient's individualized written plan of care includes planned interventions based on problems identified in the initial and updated comprehensive assessments
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
③	HCDT 15.I	L625	Written patient care instructions for a hospice Aide are prepared by an RN who is responsible for the supervision of the hospice Aide
④	HSLG 7.I	L647	Hospice volunteers provide day-to-day administrative or direct patient care services in an amount that, at a minimum, equals five percent (5%) of the total patient care hours of all paid hospice employees and contract staff. The hospice documents the cost savings achieved through volunteers
⑤	HSRM.25.I	L629	Hospice Aides are supervised by a registered nurse who makes 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 hospice Aide
⑥	HCDT.16.I	L626	A hospice Aide provides services that are ordered by the Interdisciplinary Group, included in the plan of care; permitted to be performed under state law and regulation; and consistent with the hospice Aide training
⑦	HSIM.3.1	L672	A patient clinical record containing past and current findings is maintained for each hospice patient minimally including initial plan of care, updated plans of care, initial assessment, initial and updated comprehensive clinical notes, and physician orders
⑧	HIPC.2.1	L579	The hospice follows accepted standards of practice to prevent the transmission of infections and communicable disease, including the use of standard precautions
⑨	HCDT.39.1	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
⑩	HCDT.18.1	L628	Hospice Aides must report changes in the patient's medical, nursing, rehabilitative, and/or social needs to a registered nurse as the changes relate to the plan of care and any quality assessment and improvement activities, and complete appropriate records of service

Standard Domain Deficiency Analysis, Key Actions, and Performance Improvement Planning

The following is a structured analysis of the standards deficiencies organized into major domains. It identifies what each item is intended to accomplish and highlighted system-level issues these actions address. This gives you a clear, professional-quality evaluation suitable for Quality Assessment Performance Improvement (QAPI), compliance reviews, or internal performance improvement planning.

Interdisciplinary Assessment & Plan of Care (POC) Development

Analysis	Key Actions	Performance Improvement Planning

<u>Intended purpose of the standard</u>
The IDG must complete a comprehensive assessment and develops an individualized plan of care that reflects the patient's evolving needs. Deficiencies in assessment-driven care planning undermine quality, safety, regulatory compliance, and patient outcomes.
 	
<u>System-level issues for assessment</u>
• Lack of standardized IDG processes for translating assessments into actionable care plans.
• Insufficient interdisciplinary communication and accountability.
• Variability in documentation quality and care plan updates.
• Systemic gaps in staff competency related to care planning.
	• Educate IDG/all disciplines on:
	  ○ Incorporating problems, interventions, and goals based on initial and ongoing assessments.
	  ○ Ensuring goals are SMART.
	  ○ Individualizing the plan of care for each patient.
	• Ensure the care plan is updated promptly based on changes in condition, treatment, or services.
	• Develop a QAPI indicator/PIP focused on sustained compliance with individualized POCs.
		• Implement structured IDG training modules and competency validation.
		• Conduct routine audits of POCs for completeness, accuracy, and individualization.
		• Provide feedback loops for staff with trending data and targeted coaching.
		• Develop QAPI indicators for comprehensive assessment and develops an individualized plan of care.

Medication Management & Reconciliation

Analysis	Key Actions	Performance Improvement Planning
<u>Intended purpose of the standard</u> Medication reconciliation is a core safety requirement. Inaccurate medication profiles lead to adverse drug events, poor symptom control, and regulatory noncompliance. <u>System-level issues for assessment</u> • Fragmented communication between disciplines and care settings. • Inconsistent medication reconciliation practices. • Documentation gaps leading to inaccurate medication profiles. • Lack of monitoring systems to ensure reconciliation is completed.	• Conduct medication reconciliation during every home visit. • Ensure reconciliation includes medications administered in facilities (SNF/NF/ALF). • Educate IDG on communicating medication changes to the RN. • Perform record audits to verify medication profile accuracy. • Develop a QAPI indicator/PIP focused on medication regimen accuracy.	• Standardize medication reconciliation workflows and documentation tools. • Implement cross-setting communication protocols. • Use audit findings to identify training needs and process redesign. • Integrate medication accuracy metrics into QAPI dashboards.

Hospice Aide Care Plans, Supervision & Care Accuracy

Analysis	Key Actions	Performance Improvement Planning

Intended purpose of the standard
Hospice Aide services must follow a written care plan developed by an RN. Deficiencies in Aide care plans, supervision, and task execution pose compliance risks and compromise patient safety.
 	
System-level issues for assessment
• Inconsistent RN competency in developing Aide care plans.
• Lack of structured communication between RNs and Aides.
• Insufficient oversight and monitoring of Aide performance.
• Missing or inadequate documentation of supervisory visits.
	• Educate RNs on writing specific, clear Aide care plan tasks.
	• Educate Aides to:
	  ○ Notify RN if care plan lacks direction.
	  ○ Avoid varying tasks without RN approval.
	• Conduct home supervisory visits to ensure Aides follow the care plan.
	• Audit Aide care plans and assignment sheets for accuracy.
	• Develop QAPI indicators/PIPs if Aide care plan accuracy or supervision timeliness is an issue.
		• Implement standardized Aide care plan templates with required specificity.
		• Create a tracking system for 14-day supervisory visit compliance.
		• Conduct targeted training for RNs and Aides with competency checks.
		• Use audit data to drive corrective actions and monitor trends.
		• Develop QAPI indicators for Aide supervision every 14 days.

Volunteer Services & 5% Cost Savings Compliance

Analysis	Key Actions	Performance Improvement Planning

Intended purpose of the standard
Hospice providers must demonstrate that volunteer hours equal at least 5% of total patient care costs. Failure to track and categorize volunteer hours accurately results in regulatory noncompliance.
 	
System-level issues for assessment
• Inadequate tracking systems for volunteer hours.
• Staff misunderstanding of qualifying volunteer activities.
• Lack of routine monitoring and trending.
	• Conduct quarterly audits of volunteer hours.
	• Educate volunteer program staff on:
	  ○ Activities that count toward the 5% requirement.
	  ○ Distinguishing patient care vs. administrative hours.
	• Include volunteer compliance in QAPI if the 5% threshold is a compliance issue.
		• Implement standardized volunteer hour tracking tools.
		• Provide ongoing training and competency validation for volunteer coordinators.
		• Trend volunteer hours quarterly and escalate deficits early.
		• Develop QAPI indicators for volunteer 5% cost savings tracking calculation.

Clinical Documentation & Physician Orders

Analysis	Key Actions	Performance Improvement Planning
Intended purpose of the standard Accurate, timely documentation and physician orders are essential for regulatory compliance, continuity of care, and patient safety. System-level issues for assessment • Documentation delays or omissions. • Lack of standardized review processes. • Inconsistent clinician understanding of documentation requirements.	• Educate clinicians on documenting all physician orders. • Conduct ongoing clinical record reviews to identify missing or late documentation. • Perform focused audits on high-risk areas (e.g., wound orders). • Include documentation compliance in QAPI if issues persist.	• Implement documentation checklists and order-tracking workflows. • Provide targeted training and real-time feedback. • Use audit results to identify systemic barriers and redesign processes. • Develop QAPI indicators for timely documentation and physician orders.

Infection Prevention & Standard Precautions

Analysis	Key Actions	Performance Improvement Planning

Intended purpose of the standard
Infection control is a foundational safety requirement. Field staff must consistently apply standard precautions to prevent transmission risks.
 	
System-level issues for assessment
• Inconsistent staff competency in infection control practices.
• Lack of direct observation and validation.
• Insufficient reinforcement of infection control expectations.
	• Provide ongoing education on standard precautions.
	• Conduct routine field observations to validate compliance with:
	  ○ Hand hygiene
	  ○ Bag technique
	  ○ Equipment management
	  ○ PPE use
	• Include infection control in QAPI if deficiencies are identified.
		• Develop structured field observation tools.
		• Provide immediate coaching during observations.
		• Trend compliance data and integrate into staff performance evaluations.
		• Develop QAPI indicators for hand hygiene, bag technique, equipment management, and PPE use.

Discharge Documentation

Analysis	Key Actions	Performance Improvement Planning
Intended purpose of the standard Hospice must provide attending physicians with discharge summaries and maintain complete documentation for revocations and discharges. Deficiencies create compliance risks and disrupt continuity of care. System-level issues for assessment • Lack of standardized discharge workflows. • Documentation gaps and inconsistent communication with attending physicians.	• Ensure a process exists for sending discharge summaries to attending physicians. • Audit discharged patient records for compliance. • Include discharge documentation in QAPI if issues persist.	• Implement discharge summary checklists and tracking logs. • Provide staff training on discharge requirements. • Monitor compliance through routine audits. • Develop QAPI indicators for discharge summary distribution to attending physician.

Hospice Aide Reporting & Interdisciplinary Communication

Analysis	Key Actions	Performance Improvement Planning
Intended purpose of the standard Aides often observe early changes in patient condition. Failure to report changes compromises safety and delays interventions. System-level issues for assessment • Communication gaps between Aides and RNs. • Lack of structured reporting expectations. • Inconsistent review of Aide documentation by RNs.	• Educate Aides on reporting changes to the RN. • Educate RNs about comparing Aide documentation with other IDG notes. • Include Aide reporting compliance in QAPI if needed.	• Implement standardized Aide-to-RN communication tools. • Train RNs on cross-checking documentation. • Audit Aide reporting patterns and provide targeted coaching. • Develop QAPI indicators for Aide reporting to RN.

Cross-Cutting Themes Across All Domains

1. **Documentation Accuracy & Timeliness**
   Nearly every deficiency involves incomplete, inaccurate, or delayed documentation. Strengthening documentation systems and staff competency is essential.

2. **Staff Education & Competency Validation**
   Multiple domains require enhanced training, ongoing reinforcement, and competency checks—not one-time education.

3. **Communication & Interdisciplinary Coordination**
   Breakdowns in communication appear across medication management, Aide reporting, IDG care planning, and discharge processes.

4. **Monitoring, Auditing & Feedback Loops**
   Sustained compliance requires:
   - Routine audits
   - Trending of data
   - Feedback to staff
   - Integration into QAPI

5. **Standardization of Processes**
   Variability in care planning, medication reconciliation, Aide supervision, and documentation indicates a need for:
   - Standard workflows
   - Templates
   - Checklists
   - Tracking systems

6. **Integration into QAPI**
   Each domain includes potential QAPI indicators or PIPs, reinforcing that performance improvement must be systematic and data-driven.