

Terminal Illness Certification Case

Objective	Given a scenario, the surveyor will identify areas of concern, potential citations, and related regulatory requirements.
Prior to Class	Print copies of the scenario. Have the hospice regulations available. Have flip charts and markers available.
Total Time for Activity	60 minutes* (The time given is approximate.)
Set-up	Set class up for small groups if appropriate.*

Step	Preceptor Instructions	Activity Time
1.	Divide the class into groups.*	5 min.
2.	Each group should select someone to take notes on the flip charts and be prepared to report to class. Groups must answer the questions provided.	5 min.
3.	Give the teams time to read and discuss the scenario. As the groups are completing this task, walk around the room and listen to the conversations. Provide direction where appropriate. Warn the class when the time available is down to the last five minutes.	35 min.
4.	Debrief each scenario by discussing key points contained in the Preceptor Answer Sheet.	15 min.

*For individual assignment, provide the worksheet and support where appropriate during the completion of the activity. Once completed, review answers against the answer sheet, and discuss the key points together from the scenario.

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Directions: Read the scenario and document your answers on the flip chart. Work as a team, if able.

Residents of Skilled Nursing Facility (SNF)/Nursing Facility (NF) or Intermediate Care Facilities/Individuals with Intellectual Disabilities (ICF/IID) Scenario

The patient, Joe Smith, had cancer with metastasis to the bone. Mr. Smith was discharged from a hospital on 02/21/12. The patient was admitted to Professional Hospice on 02/22/12. On 03/04/12, a complaint against Professional Hospice alleged hospice nursing staff failed to assess for the presence of pressure ulcers during the admission of a new patient who resided in a Skilled Nursing Facility (SNF). The complainant said the patient had a large open sore that developed on the ankle, and the hospice did not detect the sore or include treatment in their care, but the nursing home staff found the sore and treated it.

Survey Findings: Review of the clinical record for the patient (Joe Smith) showed:

The patient had a recent fall and had a non-healing fracture of the left lower leg. The hospital discharge doctor's orders said to keep an immobilizer on the left leg that would only be removed for skin checks and bathing.

The patient was re-admitted to the nursing home on 02/21/12, and had the initial nursing assessment by a hospice admissions nurse on 02/22/12, which did not show if the nurse took off the left leg immobilizer to assess the skin.

- The hospice nursing case manager performed a comprehensive assessment on 02/25/12, but did not indicate if she removed the left lower leg immobilizer to assess the skin.
- The hospice Plan of Care (POC), developed by the nursing case manager, showed nurses visited twice a week. Nursing documentation showed the Registered Nurses visited on 02/22/12, 02/25/12, 02/26/12 (AM), and 03/02/12.
- The hospice POC included a bath aide, who would bathe the nursing home resident twice a week, starting 02/25/12.
- The aide assignment sheet, completed by the hospice nursing case manager, failed to show the aide what to do with the left leg immobilizer.
- Hospice aide documentation showed the aide performed bed baths on 02/23/12, 02/26/12 (AM), and 03/01/12, but did not document any skin problems.
- On 02/26/12, hospice nursing documentation showed the nursing home charge nurse contacted hospice (4:00 PM) to advise them the charge nurse found an open sore on the resident's lower left ankle under the leg immobilizer which measured 2.4 by 3.4 centimeters (cm) and had a 1.0 cm depth.
- On 03/05/12, the coordinated POC, found in the hospice chart and at the nursing home, contained no plan for the care of the patient's left lower leg, or who would be responsible to remove the left leg immobilizer to give skin care and assess for pressure areas.

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- As of 03/05/12, the hospice interdisciplinary POC failed to include skin breakdown or interventions to treat the left ankle wound.

On 03/06/13, interviews showed:

The hospice admission nurse agreed she did not remove the left leg immobilizer to check the skin condition on 02/22/12. The hospice nursing case manager said she failed to remove the left leg immobilizer to check the skin condition during her assessments on 02/25/12 and 03/02/12. The hospice nursing case manager also verified she knew the nursing home charge nurse reported a wound on the lower left ankle 02/26/12, but the hospice nurse thought the nursing home took care of the wound care. The hospice aide verified she never removed the left leg immobilizer during the baths because her assignment did not tell her to remove it.

The nursing home charge nurse verified she found the ankle wound when she removed the left leg immobilizer on 02/26/12, after the patient complained of pain in the left ankle. The charge nurse said she also noticed serous drainage was oozing from under the immobilizer. The charge nurse said she called the doctor and obtained orders for wound care and notified the hospice nursing case manager.

The patient said when the hospice case manager came to see him in the days after hospice admission, hospice nurses did not observe the wound or remove the leg immobilizer. The patient said the only treatment to the wound so far was treatment provided by the nursing home staff.

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Survey Team Questions:

1. What records and other agency documents would the surveyor want to request during the hospice complaint survey?
2. Are there any interviews you would want to conduct?
3. What would be the likely deficiencies you would cite? Defend your answer.

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Preceptor Answer Sheet

1. What records and other agency documents would the surveyor want to request during the hospice complaint survey? Are there any interviews you would want to conduct?
 - New surveyors should be able to articulate the infection control breaches as the major concern.
 - Request a list of all current patients, with names, Start of Care (SOC) dates, diagnoses, and disciplines that serve the patients. Request several clinical records, including the patient named in the complaint. Request a list of all hospice staff, with names and positions, who serve hospice patients. If Mr. Joe Smith was no longer on the current list of patients, request a list of discharged patients for the past two months. Ask for access to hospice agency policies and/or procedures for admissions, accepting and/or implementing physician orders, and comprehensive assessments. Try to visit the patient at the nursing home to evaluate the coordination of care with the nursing home staff, and interview the patient and/or family and/or nursing home staff.
2. What would be the likely deficiencies you would cite? Defend your answer.
 - The hospice Condition of Participation (CoP) (4418.112) Residents of SNF/NF or ICF/IID would have multiple deficiencies, probably at the condition level (L759), due to:
 - a. Lack of professional management of the hospice patient's care needs (L762), when hospice nurses failed to include a full skin assessment or plan to provide skin ulcer care after the left lower ankle wound was discovered by the nursing home staff
 - b. Hospice staff failing to include care needs of the patient by the hospice aide, when the aide assignment failed to show the need to remove the left leg immobilizer during each bath to assess the skin and provide skin care (L774); the interdisciplinary group failing to assure the coordinated plan of care between the hospice and nursing home would include all care needs (L779)
 - Since this was a complaint, the focus was on the professional management of the nursing home resident's care by hospice and the coordination of care between hospice and nursing home. However, when a complaint includes at least one CoP out of compliance, the focused complaint survey needs to be followed with a complete survey looking at ALL CoP, and would likely include more deficiencies in areas such as acceptance of patient's plan of care, aide assignments and/or supervision, comprehensive assessments, and skilled nursing services.

(State Operations Manual Appendix M - Guidance to Surveyors: Hospice 2015)