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## Hospice Clinical Record Review

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Purpose: Surveyors may use this worksheet when conducting clinical record reviews during a hospice survey.

Directions: Fill in appropriate data.

**Table 1. Patient Information**

Patient Information	
Residence	Provider Number
Open/Closed	Patient Claim Number
Patient's Birthdate	Admission Date
Patient Identifier	Survey Date
Diagnosis	

**Table 2. Clinical Record Review Tool—Hospice**

Item	Yes	No	N/A	Unknown
<b><i>Certification/Consent/Election</i></b>				
Certification—"6-month or less prognosis if terminal illness runs its normal course"				
Brief narrative explanation of the clinical findings that support the life expectancy written by certifying physician (either hospice physician or attending) is included.				
Written certification or verbal certification from attending physician (within two calendar days of election)				
Written certification or verbal certification from medical director (within two calendar days of election) is included.				

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Item	Yes	No	N/A	Unknown
Certification signed by medical director and attending physician prior to billing				
Recertification—Prior to subsequent certification periods, the medical director or physician designee reviews the patient’s clinical information.				
Is recertification—brief narrative by hospice physician—included?				
Election statement:				
<ul style="list-style-type: none"><li>• Identification of hospice that will provide care</li></ul>				
<ul style="list-style-type: none"><li>• Patient and/or representative acknowledgement of understanding of palliative nurture of hospice care</li></ul>				
<ul style="list-style-type: none"><li>• Acknowledgement that certain Medicare services are waived by the election</li></ul>				
<ul style="list-style-type: none"><li>• Effective date of election</li></ul>				
<ul style="list-style-type: none"><li>• Signature of patient or representative</li></ul>				
<b><i>Patient Rights/Advance Directives</i></b>				
Patient is given a written notice of rights.				
Signature from patient and/or representative confirming receipt of the notice of rights in included.				
Informed in writing of financial liability is included.				
Does patient have an advance directive?				
Copy of the advance directive in clinical record or documented attempt to obtain is included.				

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Item	Yes	No	N/A	Unknown
Legal representative exercises the patient's rights.				
<b><i>Initial Assessment/Comprehensive Assessment</i></b>				
Initial assessment completed by Registered Nurse (RN) within 48 hours of election of benefit.				
<ul style="list-style-type: none"><li>• RN must complete assessment in the location of the delivery of hospice services.</li></ul>				
Initial assessment includes physical, psychosocial, spiritual, and emotional status.				
The Interdisciplinary Group (IDG), in consultation with the patient's attending physician (if any), determines what disciplines visit patient to complete the comprehensive assessment.				
Comprehensive assessment completed within five calendar days after the election of hospice care (the effective date of the election statement)				
Comprehensive assessment must consider:				
<ul style="list-style-type: none"><li>• The nature and condition causing admission</li></ul>				
<ul style="list-style-type: none"><li>• Complications and risk factors that affect care planning</li></ul>				
<ul style="list-style-type: none"><li>• Functional status, including the patient's ability to understand and participate in his or her own care</li></ul>				
<ul style="list-style-type: none"><li>• Imminence of death</li></ul>				
<ul style="list-style-type: none"><li>• Severity of symptoms</li></ul>				
<ul style="list-style-type: none"><li>• Drug Profile</li></ul>				
<ul style="list-style-type: none"><li><ul style="list-style-type: none"><li>o Effectiveness of drug therapy</li></ul></li></ul>				

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Item	Yes	No	N/A	Unknown
<ul style="list-style-type: none"><li>o Drug side effects</li></ul>				
<ul style="list-style-type: none"><li>o Actual or potential drug interactions</li></ul>				
<ul style="list-style-type: none"><li>o Duplicate drug therapy</li></ul>				
<ul style="list-style-type: none"><li>o Drug therapy associated with laboratory monitoring</li></ul>				
<ul style="list-style-type: none"><li>• Bereavement</li></ul>				
<ul style="list-style-type: none"><li>• The need for referrals and further evaluation by appropriate health professionals</li></ul>				
Comprehensive assessment includes, but not limited to, screening for:				
<ul style="list-style-type: none"><li>• Pain</li></ul>				
<ul style="list-style-type: none"><li>• Dyspnea</li></ul>				
<ul style="list-style-type: none"><li>• Vomiting</li></ul>				
<ul style="list-style-type: none"><li>• Constipation</li></ul>				
<ul style="list-style-type: none"><li>• Restlessness</li></ul>				
<ul style="list-style-type: none"><li>• Anxiety</li></ul>				
<ul style="list-style-type: none"><li>• Sleep disorders</li></ul>				
<ul style="list-style-type: none"><li>• Skin integrity</li></ul>				
<ul style="list-style-type: none"><li>• Confusion</li></ul>				
<ul style="list-style-type: none"><li>• Emotional distress</li></ul>				
<ul style="list-style-type: none"><li>• Spiritual needs</li></ul>				

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Item	Yes	No	N/A	Unknown
<ul style="list-style-type: none"><li>• Support systems</li></ul>				
<ul style="list-style-type: none"><li>• Family need for counseling and education</li></ul>				
<ul style="list-style-type: none"><li>• Need for referrals and further evaluation by appropriate health professionals</li></ul>				
<b><i>Update to the Comprehensive Assessment</i></b>				
Comprehensive assessment is updated as frequently as condition requires but no less frequently than every 15 days by the IDG in collaboration with the attending physician.				
Easily identifiable assessment updates are in the clinical record.				
<b><i>Patient Outcome Measures</i></b>				
Data elements for measurable outcomes are included in the comprehensive assessment.				
The same way should be used to measure and document data elements for all patients.				
A systematic a retrievable way is how documentation of data elements will happen. Individual planning and coordination of services uses the documentation.				
<b><i>Interdisciplinary Group (IDG)</i></b>				
All IDG in collaboration with the attending physician, the patient, or representative will establish the Plan of Care before providing care.				
A designated RN that is a member of the IDG provides coordinator of care. This RN will ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care.				

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Item	Yes	No	N/A	Unknown
IDG must include, but is not limited to, individuals qualified and competent to practice in the following professional roles:				
<ul style="list-style-type: none"><li>• Doctor of medicine or osteopathy (employee or under contact)</li></ul>				
<ul style="list-style-type: none"><li>• Registered nurse</li></ul>				
<ul style="list-style-type: none"><li>• Social worker</li></ul>				
<ul style="list-style-type: none"><li>• Pastoral or other counselor</li></ul>				
<b><i>Plan of Care (POC)</i></b>				
The POC is individualized and interventions reflect problems identified in the initial, comprehensive, and updated comprehensive assessment.				
Care is done in accordance with plan.				
Patient and primary care giver(s) receive education and training as appropriate to their responsibilities for the care and services identified in the POC.				
Plan of Care shall include:				
<ul style="list-style-type: none"><li>• Patient and/or family goals</li></ul>				
<ul style="list-style-type: none"><li>• Scope and frequency of services needed</li></ul>				
<ul style="list-style-type: none"><li>• Interventions to manage pain and symptoms to meet specific needs of patient and/or family</li></ul>				
<ul style="list-style-type: none"><li>• Measurable outcomes</li></ul>				
<ul style="list-style-type: none"><li>• Drugs and treatments necessary to meet needs of the patient</li></ul>				
<ul style="list-style-type: none"><li>• Medical supplies and appliances</li></ul>				

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Item	Yes	No	N/A	Unknown
<ul style="list-style-type: none"><li>Documentation of patient and/or caregiver involvement, understanding, and agreement with the plan of care</li></ul>				
Documentation that IDG, in collaboration with the attending physician, reviews and revises the plan of care at least every 15 days or as frequently as patient's condition requires.				
Revised plan of care includes information from the patient's updated comprehensive assessment.				
Revised plan of care includes information from the patient's updated comprehensive assessment.				
Revised plan of care includes patient's progress toward goals.				
POC reflects changings needs and required services.				
The plan of care incorporates initial bereavement assessment and any updates based on the comprehensive assessment and updates.				
<b><i>Coordination of Services</i></b>				
Evidence the IDG maintains responsibility for directing, coordinating, and supervising care and services.				
Ensure all care and services provided in accordance with POC.				
All assessments of patient and family needs have a basis in care and services provided.				
System of communication for information sharing with all disciplines in all care settings.				
Communication with other non-hospice healthcare providers furnishing services is included.				

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Item	Yes	No	N/A	Unknown
<b><i>Coordination with SNF/NF or ICF/IID</i></b>				
Hospice assumes responsibility for professional management of facility resident.				
Delineation of the responsibilities of the hospice and the SNF/NF or ICF/IID to provide bereavement services is included.				
Plan of care established and maintained in consultation with facility.				
Hospice plan of care identifies the care and services which each shall provide.				
Hospice, facility, patient, and family participate in developing a coordinated plan of care.				
Hospice plan of care updated to reflect changes.				
Changes to POC discussed with patient and/or representative and facility representative.				
Hospice designates RN to coordinate plan of care and communicate.				
Hospice IDG communicates with facility medical director, attending physicians, and other physicians.				
<b><i>Orders</i></b>				
All entries must be legible, clear, complete, and appropriately authenticated, and dated in accordance with hospice policy and currently accepted standards of practice.				
<b><i>CORE Services</i></b>				
Medical director meets needs when attending physician not available.				

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Item	Yes	No	N/A	Unknown
Nursing services must meet identified nursing needs of the patient.				
Nursing care and services by or under the supervision of an RN are included.				
Social work services have a basis in the patient's psychosocial assessment and the patient's and/or family's needs and acceptance of those services.				
A qualified social worker, under the direction of a physician, must provide social work services.				
The needs identified in the Bereavement POC have services provided to meet them.				
Select and review a sample of two–three Bereavement POC from a list of patients who have died within the past 12 months:				
<ul style="list-style-type: none"><li>Was bereavement follow-up appropriate and provided within identified timeframes?</li></ul>				
<ul style="list-style-type: none"><li>Did bereavement services provided reflect the needs of the bereaved?</li></ul>				
There should be evidence that a qualified individual (dietitians, nurses, or other individuals able to address dietary needs of the patient) provided dietary counseling when identified within the POC.				
There should be evidence in the record that spiritual needs assessment and counseling was provided in a manner consistent with the patient's and family's acceptance of this service and their beliefs and desires.				
<b>Non-Core Services</b>				
Physical therapy, occupational therapy, and speech-language pathology services must follow accepted standards of practice.				

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Item	Yes	No	N/A	Unknown
Hospice aides must complete appropriate records in compliance with the hospice's policies and procedures.				
Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and social needs to an RN as those changes relate to the POC and QAPI activities.				
An RN must make an on-site visit to the patient's home every 14 days to assess the quality of care and services provided by a hospice aide and ensure IDG group meets the patient's needs.				
Qualified homemakers written instructions for performed duties. Homemaker services coordinator receives reports of any patient family concerns.				
Documented in the record are the duties of the qualified homemaker.				
Is there documentation that any volunteers assigned to a patient and/or family have received training and orientation?				
Is there evidence that volunteers are aware of:				
Their duties and responsibilities:				
<ul style="list-style-type: none"><li>The person to whom they report</li></ul>				
<ul style="list-style-type: none"><li>The person to contact if they need assistance and instructions regarding the performance of their duties and responsibilities.</li></ul>				
<ul style="list-style-type: none"><li>Hospice goals, services, and philosophy</li></ul>				
<ul style="list-style-type: none"><li>Confidentiality and protection of the patient's and family's rights</li></ul>				
<ul style="list-style-type: none"><li>Family dynamics, coping mechanisms, and psychological issues surrounding terminal illness, death, and bereavement</li></ul>				

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Item	Yes	No	N/A	Unknown
<ul style="list-style-type: none"><li>Procedures to be followed in an emergency or following the death of the patient</li></ul>				
<ul style="list-style-type: none"><li>Guidance related specifically to individual responsibilities</li></ul>				
<b><i>Provision of Services</i></b>				
Nursing services, physician services, and drugs and biologicals are routinely available on a 24-hour basis, seven days a week. Other covered services must be available on a 24-hour basis when reasonable and necessary to meet the needs of the patient and family.				
<b><i>Protection of Information</i></b>				
The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use.				
<b><i>Discharge or Transfer of Care</i></b>				
The hospice must forward the hospice discharge summary and the patient's clinical record, if requested.				
Discharge summary must include:				
<ul style="list-style-type: none"><li>A summary of the patient's stay including treatments, symptoms, and pain management</li></ul>				
<ul style="list-style-type: none"><li>The patient's current plan of care</li></ul>				
<ul style="list-style-type: none"><li>The patient's latest physician orders</li></ul>				
<ul style="list-style-type: none"><li>Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility</li></ul>				
<b><i>Appropriate Provision and Use of Medications</i></b>				

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Item	Yes	No	N/A	Unknown
Medication orders obtained only from physician or nurse practitioner				
Drug orders received only by licensed nurse, nurse practitioner, pharmacist, or physician are included.				
The individual receiving the order must record and sign it immediately and have the prescribing person sign it in accordance with state and Federal regulations.				
Medications administered by appropriate persons				
Medication use reviewed and education completed with patient and/or family.				
Patient and/or family administration capability evaluated and documented.				
Documentation that patient/family received agency's policies and/or procedures for management of controlled drugs are included.				
Disposal of controlled substance medications per agency policy are included.				
The hospice must maintain current and accurate records of receipt and disposition of all controlled drugs.				
<b><i>Appropriate Provision of Medical Supplies and Equipment</i></b>				
Medical supplies and appliances are provided as needed.				
Education of patient/family/employees/volunteers on safe use of equipment happens.				
Hospice assures maintenance and repair of durable medical equipment.				
<b><i>Clinical Record</i></b>				

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Item	Yes	No	N/A	Unknown
Record is complete, legible, accessible, organized, and appropriately authenticated (no stamped signatures).				
Entries made for all services provided.				
Entries signed by the person providing services.				
Review at least one clinical record to evaluate if staff provided the treatments, medications, personal care, and diet in compliance with the patient's POC.				
<b><i>Inpatient Acute/Respite</i></b>				
IDG involvement is included.				
Patient and/or family needs met.				
Periodic contact with staff, patient, and family is included.				
Hospice arranged for admission.				
Patient's current plan of care is included.				
Hospice plan of care includes inpatient services to be furnished.				
Hospice plan of care updated in facility is included.				

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