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EXPERIENCE THE ACHC DIFFERENCE

Avoiding the Top Survey Deficiencies

TOP SURVEY DEFICIENCIES

- The deficiencies focus on the top four Condition Level Deficiencies :
 - §418.54 Condition of Participation: Initial and Comprehensive Assessment of the Patient
 - §418.56 Condition of Participation: Interdisciplinary Group, Care Planning, and Coordination of Services
 - §418.76 Condition of participation: Hospice Aide and Homemaker Services
 - §418.104 Condition of Participation: Clinical Records

INITIAL AND COMPREHENSIVE ASSESSMENT

- §418.54 Initial and Comprehensive Assessment of the Patient
 - L523 Timeframe for completion of the comprehensive assessment
 - The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with §418.24

INITIAL AND COMPREHENSIVE ASSESSMENT

- Comprehensive assessment completed with the required time frame
 - The patient was admitted on 5/26/xx. The spiritual care assessment was completed on 6/2/xx.
 - The patient was admitted on 7/28/xx. The social work assessment was completed on 8/7/xx.

INITIAL AND COMPREHENSIVE ASSESSMENT

- §418.54 Initial and Comprehensive Assessment of the Patient
 - L524 Content of the comprehensive assessment
 - The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process

INITIAL AND COMPREHENSIVE ASSESSMENT

- Content of the comprehensive assessment
 - There was no evidence of a spiritual care assessment of the patient or family. Chaplain services were declined. There is no evidence the RN or the SW completed this part of the assessment
 - Upon review of 8 of 16 records, there was no evidence of a spiritual assessment of the family

INITIAL AND COMPREHENSIVE ASSESSMENT

- §418.54 Initial and Comprehensive Assessment of the Patient
 - L528 Content of the comprehensive assessment
 - Imminence of death

INITIAL AND COMPREHENSIVE ASSESSMENT

- Imminence of death
 - Upon medical review, 11 of 11 do not assess the imminence of death. The paper comprehensive assessment used by the agency does not have the ability to assess for imminence of death

INITIAL AND COMPREHENSIVE ASSESSMENT

- §418.54 Initial and Comprehensive Assessment of the Patient
 - L530 Drug profile
 - A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:
 - Effectiveness of drug therapy
 - Drug side effects
 - Actual or potential drug interactions
 - Duplicate drug therapy
 - Drug therapy currently associated with laboratory monitoring

INITIAL AND COMPREHENSIVE ASSESSMENT

- Drug profile
 - The RN note on admission dated 5/2/18 indicated that "for the patient's doctor with orders for insulin with a sliding scale per husband request." There was no evidence of this on the medication profile
 - The record indicated that the patient was on oxygen at 2L/min via nasal cannula. There was no evidence that this was added to the medication profile

INITIAL AND COMPREHENSIVE ASSESSMENT

- §418.54 Initial and Comprehensive Assessment of the Patient
 - L531 Bereavement
 - An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care

INITIAL AND COMPREHENSIVE ASSESSMENT

- Bereavement assessment
 - The patient was admitted on 5/4/xx; bereavement risk assessment completed 7/5/xx
 - The patient was admitted on 4/14/xx. There was no evidence of a bereavement risk assessment at the time of survey (July)
 - 4 of 11 did not contain evidence of a bereavement risk assessment completed

IDG, CARE PLANNING AND COORDINATION

- §418.56 Interdisciplinary group, care planning, and coordination of services
 - L540 Continuous assessment
 - The hospice must designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care

IDG, CARE PLANNING AND COORDINATION

- RN continuous assessment of the patient
 - The record indicated a coordination note on 7/21/XX at 5:05 am indicating a caller who stated that "the patient has been up since midnight with complaints of dyspnea, pain throughout her body, shaking and vomiting. There was no effect from the pain medication given at 4:30 am. Reach out to the on-call nurse for follow-up and to set up visit for the am. Patient and caller in agreement." There was no evidence of follow -up until 7/23/XX at 4:19 PRN when a visit was conducted

IDG, CARE PLANNING AND COORDINATION

- §418.56 Interdisciplinary group, care planning, and coordination of services
 - L545 Content of the plan of care
 - The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions

IDG, CARE PLANNING AND COORDINATION

- Identified goals and interventions
 - There was no evidence of problem statements related to the spiritual problems and concerns of the patient with identified goals and interventions and progress towards outcomes developed from the Spiritual Care assessment. The care plan problem list included only chaplain spiritual assessment performed, additional visits required

IDG, CARE PLANNING AND COORDINATION

- §418.56 Interdisciplinary group, care planning, and coordination of services
 - L547 Content of the plan of care
 - A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs
 - The plan of care may include a range of visits and PRN
 - Visit ranges with small intervals are acceptable
 - There should be documentation in the record to support the need for the extra visit

IDG, CARE PLANNING AND COORDINATION

- Discipline visit orders
 - The SW and Chaplain visit orders included PRN visits without a frequency for those visits
 - SW and Chaplain visits were ordered as 2x a month plus 3 prn visits. There is documentation of 3 SW visits and 3 Chaplain visits in June. There was no evidence that any of these visits were PRN visits
 - Documentation in the medical record demonstrates that patient is receiving volunteer services, on an average of 2 visits a month. There is no order for volunteer services

IDG, CARE PLANNING AND COORDINATION

- §418.56 Interdisciplinary group, care planning, and coordination of services
 - L549 Content of the plan of care
 - Drugs and treatment necessary to meet the needs of the patient

IDG, CARE PLANNING AND COORDINATION

- Medication and treatment orders are complete
 - There were also notes dated 3/28/XX and 5/6/XX that indicated that the nurse drained a PleurX catheter that the patient had in his right chest wall. There was no evidence of an order care of the PleurX catheter
 - Nurse note dated 3/14/18 indicated, the patient had pitting edema. Instructed the patient to take an extra Lasix pill for 3 days. There was no evidence of an order to increase Lasix
 - The initial nurse assessment indicated that the patient was on C-PAP. There was no evidence of an order with settings
 - There is documentation of a stage III ulcer on the buttocks that RN is dressing. The order for the wound did not identify the location of the wound

IDG, CARE PLANNING AND COORDINATION

- §418.56 Interdisciplinary group, care planning, and coordination of services
 - L553 Review of the plan of care
 - A revised plan of care must include information from the patient's updated comprehensive assessment and must note the patient's progress toward outcomes and goals specified in the plan of care

IDG, CARE PLANNING AND COORDINATION

- Updated plan of care based on identified needs
 - On recent skilled nurse visit note, patient stated, "I just wonder what is going to happen to my soul after I'm gone." Patient had declined Spiritual Care provider upon admission. No evidence in the medical record that Spiritual Care services were offered again
 - Since admission, the patient has developed wounds, infections (UTI) and increased lethargy. There was no update to the care plan problems with goals, interventions, and progress towards outcome since 6/20/XX, including the additional problems

IDG, CARE PLANNING AND COORDINATION

- §418.56 Interdisciplinary group, care planning, and coordination of services
 - L555 Review of the plan of care
 - Ensure that the care and services are provided in accordance with the plan of care

IDG, CARE PLANNING AND COORDINATION

- Care is provided in accordance with the plan of care
 - SN visits were ordered as 2x/week. There is no documentation of any visits the week of 4/9/17. There were 3 missed visit notes for that week stating the nurse was on PTO
 - Upon medical record review, 3 of 11 Chaplain visits were ordered as 1/month. There was no evidence of a visit for the month of July, 2017 and 1 patient had no visit for the month of August
 - A physician's order dated 8/1/xx indicated to remove Foley catheter. The nurse notes from 8/8/xx through 8/28/xx indicate that the patient continues to have a Foley catheter (inserted 7/24, 10cc balloon). No evidence in medical record that Foley catheter was removed

HOSPICE AIDE AND HOMEMAKER SERVICES

- §418.76 Hospice Aide and Homemaker Services
 - L625 Hospice aide assignments and duties
 - Hospice aides are assigned to a specific patient by a registered nurse that is a member of the interdisciplinary group. Written patient care instructions for a hospice aide must be prepared by a registered nurse.

HOSPICE AIDE AND HOMEMAKER SERVICES

- Hospice aide written instructions
 - The aide plan of care indicated the tasks of bed bath, ear care, nail care, hair care, shampoo, change linen PRN and shave every visit/PRN
 - The aide plan of care indicated the tasks of bath; bed/tub/shower were circled on the aide plan of care
 - The visit frequency on the aide plan of care was indicated at 2x/week and 1 PRN q 14 days
 - The aide plan of care indicated for bed bath, hair care, nail care, oral care, skin care. There was no evidence of a frequency

HOSPICE AIDE AND HOMEMAKER SERVICES

- §418.76 Hospice Aide and Homemaker Services
 - 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 by such hospice aide
 - Consistent with the hospice aide training

HOSPICE AIDE AND HOMEMAKER SERVICES

- Hospice aide provided care in accordance with the written instructions
 - The aide plan of care included a shower q visit. On several visits, the aide documented the shower was not needed per frequency
 - The aide plan of care indicated all tasks to be completed on Tuesday and Thursday. On Wednesday and Monday, the aide documented completing all tasks, including a bath, hair care, skin care, perineal care, oral care and assist with dressing
 - During the visit with the aide, the aide was observed shampooing patient's hair which was not an identified task on the aide plan of care

HOSPICE AIDE AND HOMEMAKER SERVICES

- §418.76 Hospice Aide and Homemaker Services
 - L629 Supervision of hospice aides
 - A registered nurse must make 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 and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs. The hospice aide does not have to be present during this visit

HOSPICE AIDE AND HOMEMAKER SERVICES

- Supervision of the aide
 - 14-day supervision
 - There was no evidence of aide supervisory visits from 1/2/18 to 2/26/18
 - There was no evidence of aide supervisory visits from 3/12/18 to 4/20/18

CLINICAL RECORDS

- §418.104 Clinical records
 - L673 Content
 - Signed copies of the notice of patient rights in accordance with §418.52 and election statement in accordance with §418.24

CLINICAL RECORDS

- Hospice Medicare election statement
 - Election statement for XX does not have evidence the patient chose their attending physician or indicated they chose to have the hospice physician as their attending physician. The line on the election statement for the identification of the attending physician is blank. The initial certification does identify an attending physician in addition of the hospice physician

CLINICAL RECORDS

- §418.104 Clinical records
 - L676 Content
 - Physician certification and recertification of terminal illness as required in §418.22 and §418.25 and described in §418.102(b) and §418.102(c) respectively, if appropriate

CLINICAL RECORDS

- Physician initial certification and re-certification
 - The record indicated the patient had chosen an attending medical director but the medical director signed the initial certification of terminal illness as both the attending physician and the medical director
 - The hospice physician provided verbal certification on 2/4/XX, which is greater than the 15 days prior that is allowable as patient was admitted to hospice on 3/2/XX
 - The medical record does not contain the initial certification of terminal illness; there is no verbal certification of terminal illness either

CLINICAL RECORDS

- §418.104 Clinical records
 - L679 Authentication
 - All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice

CLINICAL RECORDS

- Entries in the medical record
 - Aide visits notes do not include the signature of the individual completing the tasks on 10 out of 12 visits from 5/18/xx to 6/4/xx
 - Clinical note by RN on 4/12/xx indicates that facility staff provided wound dressing during visit. The patient lives at home with wife

EVIDENCE FOR COMPLIANCE

- Documented evidence that is readily available
- If it's not documented, it's not done!

AFTER ACCREDITATION

- Once your Account Advisor emails you with the survey decision, there will be a link to the After Accreditation webinar which will tell you how to complete a Plan of Correction as well as review resources to help you maintain compliance



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THANK YOU

Accreditation Commission for Health Care

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