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in this issue

The Role of the Hospice Nurse

The Journal

of the Louisiana-Mississippi Hospice & Palliative Care Organization

The Nurses' Point of View Regarding Changes in Hospice

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Nurses in hospice care are committed to quality care and compassionate concern for patients and families. They typically function independently and expect autonomy in their actions. These nurses have been attracted to the hospice philosophy, as well as being relatively unencumbered by the myriad of regulations that has plagued hospitals, nursing homes, and home health practice arenas in recent years.

The climate surrounding hospices have changed in light of the updated Conditions of Participation (CoPs), the anticipated Medicare and Medicaid rate changes, and other regulatory issues. To write this article, I emailed questions to a number of hospices across the state and to each of the nurses here. Questions asked were 1) How have nurses responded to the recent changes and issues in hospice care today? 2) How has it affected work? 3) Has the work become more time consuming? I also stated some of the changes that I thought may impact nurses' work, such as:

a. CMS Conditions of Participation update from May 2008
b. Competition and census issues
c. Medicare and Medicaid rate changes and potential changes
d. Quality Assessment and Performance Improvement issues
e. Issues related to medications and durable medical equipment
f. Electronic documentation – new or expanded
g. Nursing Home regulations and issues

The fact that I did not receive a single response may indicate that all are overwhelmed with additional responsibilities and attention to compliance (and the impact of recent hurricanes).

As the anticipated effective date of December 2 for the updated CoPs nears, hospices are gearing up to be in compliance while remaining in compliance with the current regulations. The significant focus on patient rights and quality assessment and performance improvement (QAPI) affects clinical staff. Areas of initial and comprehensive assessment, plan of care, and infection control also affects clinical staff. Those nurses with patients in nursing homes are increasingly becoming involved with present regulations and care planning as well as anticipating changes in regulations in the near future. It is also important to review State Regulations and to follow these if more stringent than CoPs. It is anticipated that these regulations will also change in the near future. Another factor is increased competition from having an increasing number of hospices within a region. Previously, nurses have had limited involvement in the economics of hospice. Now they are expected to be more fiscally responsible in their choices of medications and durable medical equipment and supplies. The mantra seems to be "Do more with less."

Nurses are striving to maintain the same quality of care in the face of increasing responsibility, accountability, and scrutiny. Increased documentation requirements and participation in organizational activities are taking time away from direct patient care, much to the distress of these conscientious professionals. For some hospices, electronic documentation has been instituted or expanded to capture the data for QAPI projects. This may also increase the time nurses need to learn new modes of documentation. The QAPI component of the CoPs emphasizes an organization wide assessment and development of projects to improve within each hospice. This will expand participation, committee activities, and attention to organizational issues for all staff, including the clinical staff, further increasing time constraints and will impact direct patient care time.

Although this article focuses on the impact of changes on the nurses, this issue also applies to all involved in direct hospice patient care: nurses, aides, social workers, pastoral care, volunteers, and bereavement. Nurses and other hospice staff continue to be committed to fulfilling their ministry of caring for hospice patients with competence and compassion in spite of the changing environment of hospice care.

LOUISIANA~MISSISSIPPI
HOSPICE AND PALLIATIVE CARE ORGANIZATION

The Louisiana-Mississippi Hospice and Palliative Care Organization is a 501(c)3 non-profit organization governed by a board of directors representing all member hospice programs. It is funded by membership dues, grants, tax-deductible donations and revenues generated by educational activities. LMHPCO exists to ensure the continued development of hospice and palliative care services in Louisiana and Mississippi. LMHPCO provides public awareness, education, research, and technical assistance regarding end-of-life care, as well as advocacy for terminally ill and bereaved persons, striving to continually improve the quality of end-of-life care in Louisiana and Mississippi.

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The Journal is produced monthly by Noya Design, Inc. Newsworthy submissions are encouraged. Please contact Glenn Noya with questions, comments and submissions at ph: 504-455-2585 • Em: noyadesign@cavtel.net

Calendar

www.LMHPCO.org

NHPCO September Audio Web Seminar Update

Leadership Topic, September 23, 2008
Enhancing Access for Eligible Patients: Successful Strategies
Advanced Registration Ends September 18th.
Register today!

All seminars take place from 2p - 3:30p ET. For presenter information, detailed seminar descriptions and a full listing of all 2008 seminar topics visit www.nhpco.org/aws2008.

Provided by the Meniscus Educational Institute

Management Strategies for Opioid-Induced Side Effects –
Available for CNE Credit

Registration Information
There is no fee for participating in these activities.

WEBINAR SCHEDULE
Tuesday, September 30, 2008: 8:00–9:00 PM EDT
Thursday, October 2, 2008: 9:30–10:30 AM EDT
Thursday, October 2, 2008: 2:30–3:30 PM EDT
Wednesday, October 8, 2008: 11:00 AM-12:00 PM EDT

GENERAL INFORMATION
Phone: 610-834-1810

REGISTRATION DEADLINE
Please register 1 to 2 days prior to the live webinar to download log-in and conference call instructions, and important program materials.

REGISTRATION OPTIONS
Phone 1-888-622-9927

INTERNET
www.meniscus.com/register/nursing-sideeffects08

Supported by an educational grant from Wyeth Pharmaceuticals

Area Code 601 Quarterly Luncheon
Tuesday September 30, 2008
(11:30AM -1:30PM)
To reserve your seat you must contact Belinda Patterson at *bpatterson@hospiceministries.org* or by phone at (800) 273-7724.

September 23-26, 2008
17th International Congress on Palliative Care
Palais des Congrès in Montréal, Canada
For more information go to: www.pal2008.com

October 16, 2008
662 Area Code Quarterly Luncheon
QAPI Presentation
To reserve your seat contact Nancy Dunn at nancy@LMHPCO.org or by phone at (662) 934-0860

October 23-25, 2008
NHPCO's 9th Clinical Team Conference
Hyatt Regency, Dallas, TX
For more information go to:
http://www.nhpco.org/i4a/pages/index.cfm?pageid=3259

March 25-28, 2009
AAHPM & HPNA Annual Assembly
Austin, TX
For more information go to:
http://www.hpna.org/DisplayPage.aspx?Title=Annual%20Conferences

April 23-25, 2009
NHPCO's 24th Management & Leadership Conference
Omni-Shoreham Hotel, Washington, DC
For more information go to:
http://www.nhpco.org/i4a/pages/index.cfm?pageid=3259

April 29, 2009
16th Annual National HFA Living with Grief Teleconference (12:30-3:00PM)
Diversity & End-of-Life Care
For more information, go to: www.hospicefoundation.org

The Leslie Lancon Memorial Education Nursing Scholarship was established in 2005 by LMHPCO. The annual scholarship will be awarded to support hospice nursing excellence and education throughout Lousisiana and Mississippi. The awards will focus not only on excellence for those seeking academic degrees in hospice nursing, but also those seeking advanced certification in hospice and palliative care nursing.

Hospice Nurses crosswalk

LA State Minimum Standards

Current as of December, 1999
Proposed Changes in Red

Subchapter A. General Provisions
§8201. Definitions

Continuous Home Care— care provided by the hospice during a period of crisis as necessary to maintain the terminally ill individual at home. A minimum of eight hours of care must be furnished on a particular day to be considered continuous home care. Nursing care must be provided for more than one half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Services may be provided by a homemaker or home health aide to supplement the nursing care. A registered nurse must complete an assessment of the patient and determine that the patient requires continuous home care prior to assigning a licensed practical nurse, homemaker, or a home health aide to a patient requiring continuous home care. This assignment must comply with accepted professional standards of practice.

Core Services— nursing services, physician services, medical social services, and counseling services, including bereavement counseling, dietary counseling, spiritual counseling, and any other counseling services provided to meet the needs of the individual and family. These services must be provided by employees of the hospice, except that physician services and counseling services may be provided through contract.

Interdisciplinary Group (IDG)— an interdisciplinary group or groups designated by the hospice, composed of representatives from all the core services. The IDG must include at least a doctor

Medicare Conditions of Participation (CoPs)

Revised June 5, 2008 with Effective Date of Revisions December 2, 2008

§ 418.3 Definitions.

Clinical note means a notation of a contact with the patient and/or the family that is written and dated by any person providing services and that describes signs and symptoms, treatments and medications administered, including the patient's reaction and/or response, and any changes in physical, emotional, psychosocial or spiritual condition during a given period of time.

Comprehensive assessment means a thorough evaluation of the patient's physical, psychosocial, emotional and spiritual status related to the terminal illness and related conditions. This includes a thorough evaluation of the caregiver's and family's willingness and capability to care for the patient.

Initial assessment means an evaluation of the patient's physical, psychosocial and
emotional status related to the terminal illness and related conditions to determine the patient's immediate care and support needs.

Licensed professional means a person licensed to provide patient care services by the
State in which services are delivered.

Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course.

Interdisciplinary Group (IDG)
(1) The hospice must designate an interdisciplinary group or groups composed of individuals who work together

MS State Minimum Standards

Current as of February 22, 2008

101 DEFINITIONS

101.54 Registered Nurse – An individual who is currently licensed in the State of Mississippi or in accordance with criteria established per the Nurse Compact Act and is performing nursing duties in accordance with the Mississippi Nurse Practice Act.

101.44 Nurse Practitioner – Shall mean an individual who is currently licensed as such in the State of Mississippi and is performing duties in accordance with the Mississippi Nurse Practice Act.

101.14 Continuous Home Care – Care provided by the hospice during a period of crisis as necessary to maintain the terminally ill individual at home. A minimum of eight hours of care must be furnished on a particular day to be considered continuous home care. Nursing care must be provided for more than one-half of the period of care and must be provided by either a registered nurse or licensed practical nurse. Services may be provided by a homemaker or hospice aide to supplement the nursing care. When determining the necessity for continuous home care, a registered nurse must complete/document a thorough assessment and plan of care that includes participation of all necessary disciplines to meet the patient's identified needs, prior to assigning a licensed practical nurse, homemaker, or a hospice aide to a patient requiring continuous home care. This assignment must comply with accepted professional standards of practice.

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of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor. The interdisciplinary group is responsible for participation in the establishment of the plan of care; provision or supervision of hospice care and services; periodic review and updating of the plan of care for each individual receiving hospice care, and establishment of policies governing the day-to-day provision of hospice care and services. If a hospice has more than one interdisciplinary group, it must designate in advance the group it chooses to execute the establishment of policies governing the day-to-day provision of hospice care and services.	to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services. 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. The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles: (i) A doctor of medicine or osteopathy (who is an employee or under contract with the hospice). (ii) A registered nurse. (iii) A social worker. (iv) A pastoral or other counselor. (2) If the hospice has more than one interdisciplinary group, it must identify a specifically designated interdisciplinary group to establish policies governing the day-to-day provision of hospice care and services.	**101.16 Core Services** – Nursing services, physician services, medical social services, and counseling services, including bereavement counseling, spiritual counseling, and any other counseling services provided to meet the needs of the individual and family. These services must be provided by employees of the hospice, except that physician services and counseling services may be provided through contract. **101.35 Interdisciplinary Team (IDT)** – An interdisciplinary team or group(s) designated by the hospice, composed of representatives from all the core services. The Interdisciplinary Team **must** include at least a doctor of medicine or osteopathy, a registered nurse, a social worker, and a pastoral or other counselor. The interdisciplinary team is responsible for participation in the establishment of the plan of care; provision or supervision of hospice care and services; periodic review and updating of the plan of care for each individual receiving hospice care, and establishment of policies governing the day-to-day provision of hospice care and services. If a hospice has more than one interdisciplinary team; it must designate, in advance, the team it chooses to execute the establishment of policies governing the day to-day provision of hospice care and services.
Subchapter B. Organization and Staffing **§8217. Personnel Qualifications/Responsibilities** **E. Director of Nurses (DON).** A person designated, in writing, by the Governing Body to supervise all aspects of patient care, all activities of professional staff and allied health personnel, and responsible for compliance with regulatory requirements. The DON, or alternate, shall be immediately available to be on site, or on site, at all	**§418.62 Condition of participation: Licensed professional services.** (a) Licensed professional services provided directly or under arrangement must be authorized, delivered, and supervised only by health care professionals who meet the appropriate qualifications specified under §418.114 and who practice under the hospice's policies and procedures. (b) Licensed professionals must actively participate in the coordination of all aspects of the patient's hospice care, in accordance with current professional	**PART V POLICIES AND PROCEDURES** **111 PERSONNEL POLICIES** 111.04 **Employee Health Screening** – Every employee of a hospice who comes in contact with patients shall receive a health screening by a licensed physician, nurse practitioner or employee health nurse who conduct exams prior to employment and annually thereafter. The employee health screening shall include, but not be limited to, tuberculosis screening.

LA State Minimum Standards

times during operating hours, and additionally as needed. If the DON is unavailable he/she shall designate a Registered Nurse to be responsible during his/her absence.

1. Qualifications. A registered nurse must be currently licensed to practice in the State of Louisiana:

a. with at least three years' experience as a registered nurse. One of these years shall consist of full-time experience in providing direct patient care in a hospice, home health, or oncology setting; and

b. be a full time, salaried employee of only the hospice agency. The Director of Nurses is prohibited from simultaneous/concurrent employment. While employed by the hospice, he or she may not be employed by any other licensed health care agency.

2. Responsibilities. The registered nurse shall supervise
all patient care activities to assure compliance with current standards of accepted nursing and medical practice including, but not limited to, the following:

a. the POC;

b. implement personnel and employment policies to assure that only qualified personnel are hired. Verify licensure and/or certification (as required by law) prior to employment and annually thereafter; maintain records to support competency of all allied health personnel;

c. implement hospice policies and procedures that establish and support quality patient care, cost control, and mechanisms for disciplinary action for infractions;

d. supervise employee health program;

e. assure compliance with local, state, and federal laws, and promote health and safety of employees, patients and the community, using the following non-exclusive methods:

i. resolve problems;

ii. perform complaint investigations;

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standards and practice, including participating in ongoing interdisciplinary comprehensive assessments, developing and evaluating the plan of care, and contributing to patient and family counseling and education; and

(c) Licensed professionals must participate in the hospice's quality assessment and performance improvement program and hospice sponsored in-service training.

§ 418.114 Condition of participation: Personnel qualifications for licensed professionals.

(a) *General qualification requirements.* Except as specified in paragraph (c) of this section, all professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally authorized (licensed, certified or registered) to practice by the State in which he or she performs such functions
or actions, and must act only within the scope of his or her State license, or State certification, or registration. All personnel qualifications must be kept current at all times.

(c) *Personnel qualifications when no State licensing, certification or regis tration requirements exist.*
If no State licensing laws, certification or registration requirements exist for the profession, the following requirements must be met:

(5) *Registered nurse.* A graduate of a school of professional nursing.

(6) *Licensed practical nurse.* A person who has completed a practical nursing program.

§ 418.116 Condition of participation: Compliance with Federal, State, and local laws and regulations related to health and safety of patients.

(a) *Standard: Licensure of staff.* Any persons who provide hospice services

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111.05 **Staffing Schedule** – Each hospice and alternate site shall maintain on site current staffing patterns for all health care personnel
including full-time, part-time, contract staff and staff under arrangement. The staffing pattern shall be developed at least one week in advance, updated daily as needed, and kept on file for a period of one year. The staffing pattern shall indicate the following for each working day:

1. Name and position of each staff member.
2. Patients to be visited.
3. Scheduled on call after office hours.

113 ORGANIZATION AND STAFFING PERSONNEL QUALIFICATIONS/RESPONSIBILITIES

113.05 Director of Nurses (DON)

A person designated, in writing, by the Governing Body to supervise all aspects of patient care, all activities of professional staff and allied health personnel, and responsible for compliance with regulatory requirements. The DON or alternate, shall be on site or immediately available to be on site, at all times during operating hours. If the DON is unavailable he/she shall designate a Registered Nurse to be responsible during his/her absence.

NOTE: The Director of Nurses is prohibited from simultaneous
concurrent employment with any entity or any other licensed health care entity, unless such licensed healthcare agency is occupying the same physical office space as the hospice.

1. Qualifications – A registered nurse who is currently licensed to practice in the State of Mississippi.

a. With at least three years experience as a registered nurse. One of these years shall consist of full-time experience in:

1. Providing direct patient care in a hospice, home health, or oncology setting; or

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iii. refer impaired personnel to proper authorities;
iv. provide for orientation and in-service training to employees to promote effective hospice services and safety of the patient, to familiarize staff with regulatory issues, and agency policy and procedures;
v. orient new direct health care personnel;
vi. perform timely annual evaluation of performance of health care personnel;
vii. assure participation in regularly scheduled appropriate continuing education for all health professionals and home health aides and homemakers;
viii. assure that the care provided by the health care personnel promotes effective hospice services and the safety of the patient; and
ix. assure that the hospice policies are enforced.

H. Licensed Practical Nurse. The L.P.N. must work under the direct supervision of a registered nurse and perform skilled nursing services as delegated by the registered nurse. The role of the L.P.N. in hospice is limited to stable hospice patients.
1. Qualifications. A licensed practical nurse must be currently licensed by the Louisiana State Board of Practical Nurse Examiners with no restrictions:
a. with at least three years' full time experience as an L.P.N.;
b. be an employee of the hospice agency; and
c. when employed by more than one agency the LPN must inform all employers and coordinate duties to assure quality provision of services.
2. Responsibilities. The L.P.N. shall perform skilled nursing services under the supervision of a registered nurse, in a manner consistent with standards of practice, including but not limited to, such duties as follows:
a. observe, record, and report to the registered nurse or director of nurses on

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must be licensed, certified, or registered in accordance with applicable Federal, State and local laws.

§ 418.76 Condition of participation: Hospice aide and homemaker services.
(g) *Standard: Hospice aide assignments and duties.*
(1) 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 who is responsible for the supervision of a hospice aide as specified under paragraph (h) of this section.
(h) *Standard: Supervision of hospice aides.*
(1) A registered nurse must make an onsite visit to the patient's home:
(i.) 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.
(ii.) If an area of concern is noted by the supervising nurse, then the hospice must make an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while he or she is performing care.
(iii.) If an area of concern is verified by the hospice during the on-site visit, then the hospice must conduct, and the hospice aide must complete a competency evaluation in accordance with §418.76(c).
(2) A registered nurse must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care.
(3) The supervising nurse must assess an aide's ability to demonstrate initial and continued satisfactory performance

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2. The management of patient care staff in an acute care setting, hospice or home health; and
b. Be a full time employee of only the hospice agency.
2. Responsibilities – The DON shall supervise all patient care activities to assure compliance with current standards of accepted nursing and medical practice including, but not limited to, the following:
a. The POC;
b. Implement personnel and employment policies to assure that only qualified personnel are hired.
verify licensure and/or certification (as required by law) prior to employment and annually thereafter;
maintain records to support competency of all allied health personnel;
c. Implement hospice policies and procedures that establish and support quality patient care, cost control, and mechanisms for disciplinary action for infractions;
d. Ensure clinical staff compliance with the employee health program; and
e. Ensure compliance with local, state, and federal laws to promote the health and safety of employees, patients and the community, using the following non-exclusive methods:
1. Resolve problems;
2. Perform complaint investigations;
3. Refer impaired personnel to proper authorities;
4. Ensure appropriate orientation and inservice training to employees;
5. Ensure the development and implementation of an orientation program for new direct health care personnel;
6. Ensure the completion of timely annual performance evaluations of health care personnel or designate other supervisory personnel to perform such evaluations;
7. Ensure participation in regularly scheduled appropriate continuing education for all health professionals, home health aides and homemakers;

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the general physical and mental conditions of the patient;
b. administer prescribed medications and treatments as permitted by State or Local regulations;
c. assist the physician and/or registered nurse in performing specialized procedures;
d. prepare equipment for treatments, including sterilization, and adherence to aseptic techniques;
e. assist the patient with activities of daily living;
f. prepare clinical and/or progress notes and incorporate them into the clinical record at least weekly;
g. perform complex wound care if in-service is documented for specific procedure;
h. perform routine venipuncture (phlebotomy) if written documentation of competency is in personnel record. Competency must be evaluated by an RN even if LPN has completed a certification course; and
i. receive orders from the physician and follow those that are within the realm of practice for an LPN and within the standards of hospice practice.
3. Restrictions. An LPN shall not:
a. access any intravenous appliance for any reason;
b. perform supervisory aide visit;
c. develop and/or alter the POC;
d. make an assessment visit;
e. evaluate recertification criteria;
f. make aide assignments; or
g. function as a supervisor of the nursing practice of any registered nurse.

O. Registered Nurse (RN). The hospice must designate a registered nurse to coordinate the implementation of the POC for each patient.
1. Qualifications. A licensed registered nurse must:
a. be currently licensed to practice in the State of Louisiana with no restrictions;
b. have at least two years' full time experience as a registered nurse (how-

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in meeting outcome criteria that include, but is not limited to–-
(i.) Following the patient's plan of care for completion of tasks assigned to the hospice aide by the registered nurse.
(ii.) Creating successful interpersonal relationships with the patient and family.
(iii.) Demonstrating competency with assigned tasks.
(iv.) Complying with infection control policies and procedures.
(v.) Reporting changes in the patient's condition

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8. Ensure that the care provided by the health care personnel promotes effective hospice services and the safety of the patient; and
9. Ensure that the hospice policies are enforced.

113.08 Licensed Practical Nurse (LPN)
The LPN must work under the direct supervision of a registered nurse and perform skilled services as delegated by the registered nurse.
1. Qualifications – A LPN must be currently licensed by the Mississippi State Board of Practical Nurse Examiners with no restrictions:
a. With at least one year full time experience as an LPN. Two years of full time experience is preferred;
b. Be an employee of the hospice agency.
2. Responsibilities – The LPN shall perform skilled nursing services under the supervision of a registered nurse, in a manner consistent with standards of practice, including but
not limited to, such duties as follows:
a. Observe, record, and report to the registered nurse or director of nurses on the general physical and mental conditions of the patient;
b. Administer prescribed medications and treatments as permitted by State regulations;
c. Assist the physician and/or registered nurse in performing procedures as per the patient's plan of care.
d. Prepare equipment for treatments, including sterilization, and adherence to aseptic techniques;
e. Assist the patient with activities of daily living;
f. Prepare clinical and/or progress notes and incorporate them into the clinical record at least weekly;
g. Perform wound care and treatments as specified per
nursing practice and if training competency is documented;

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ever, a person who was employed by a hospice as a registered nurse as of December 20, 1998 shall be exempt from this requirement as long as he/she remains employed by a hospice as a registered nurse); and

Proposed Changes:

However, two years of full time clinical experience in hospice care as a licensed practical nurse may be substituted for the required two years of experience as a registered nurse;

c. be an employee of the hospice. If the registered nurse is employed by more than one agency, he or she must inform all employers and coordinate duties to assure quality service provision.

Proposed Changes:

Obtain at least 2 hours of Continuing Education Units (CEU's) annually related to end of life care.

2. Responsibilities. The registered nurse shall identify the patient/family's physical, psychosocial, and environmental needs and reassess as needed but no less than every 14 days:

a. provide nursing services in accordance with the POC;

b. document problems, appropriate goals, interventions, and patient/family response to hospice care;

c. collaborate with the patient/family, physician and other members of the IDG in providing patient and family care;

Proposed Changes:

c. collaborate with the patient/family, attending physician and other members of the IDT in providing patient and family care;

d. instruct patient/family in self-care techniques when appropriate;

e. supervise ancillary personnel and delegates responsibilities when required;

f. complete and submit accurate and relevant clinical notes regarding the patient's condition into the clinical record within one week of the visit;

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h. Accepts verbal/written orders from the physician or nurse practitioner or physician's assistant in accordance with facility policies; and

i. Attend hospice IDT meetings

3. Restrictions – An LPN shall not:

a. Access any intravenous appliance for any reason;

b. Perform supervisory aide visit;

c. Develop and/or alter the POC;

d. Make an assessment visit;

e. Evaluate recertification criteria;

f. Make aide assignments; or

g. Function as a supervisor of the nursing practice of any registered nurse.

113.14 Registered Nurse (RN)

The hospice must designate a registered nurse to coordinate the implementation of the POC for each patient.

1. Qualifications – A licensed registered nurse must be currently licensed to practice in the State of Mississippi with no restrictions:

a. Have at least one year full-time experience as a registered nurse or have been a licensed LPN employed for three years full-time working in a healthcare setting; and

b. Be an employee of the hospice.

2. Responsibilities – The registered nurse shall identify the patient/family's physical, psychosocial, and environmental needs and reassess as needed but no less than every 14 days:

a. Provide nursing services in accordance with the POC;

b. Document problems, appropriate goals, interventions, and patient/family response to hospice care;

c. Collaborate with the patient/family, attending physician and other members of the IDT in providing patient and family care;

d. Instruct patient/family in self-care techniques when appropriate;

e. Supervise ancillary personnel and delegate responsibilities when required;

f. Complete and submit accurate and relevant clinical notes regarding the patient's condition into the clinical

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g. if a home health aide/homemaker is assigned to a patient by the RN, in accordance with the POC, specific written instructions for patient care are to be prepared by the RN. All personal care services are to be outlined for the patient, in writing, by the RN in charge of that patient;

Proposed Changes:

g. if a hospice aide/homemaker is assigned to a patient by the RN, in accordance with the POC, specific written instructions for patient care are to be prepared by the RN. All personal care services are to be outlined for the patient, in writing, by the RN in charge of that patient;

h. supervise and evaluate the home health aide/homemaker's ability to perform assigned duties, to relate to the patient and to work effectively as a member of the health care team;

Proposed Changes:

h. supervise and evaluate the hospice aide/homemaker's ability to perform assigned duties, to relate to the patient and to work effectively as a member of the health care team;

i. perform supervisory visits to the patient's residence at least every 14 days to assess relationships and determine whether goals are being met. A supervisory visit with the aide present must be made at least once every three (3) months;

Proposed Changes:

i. perform supervisory visits to the patient's residence at least every 14 days to assess relationships and determine whether goals are being met. A supervisory visit with the aide present must be made at least annually. Documentation of the aide present supervisory visit shall be placed in the hospice aide's personnel record;

j. document supervision, to include the aide/homemaker-patient relationships, services provided and instructions and comments given as well as other requirements of the clinical note; and

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record within one week of the visit;
g. Provide direct supervision of the Licensed Practical Nurse (LPN) in the home of each patient seen by the LPN at least once a month;
h. Make supervisory visits to the patient's residence at least every other week with the aide alternately present and absent, to provide direct supervision, to assess relationships and determine whether goals are being met. For the initial visit, the RN must accompany/assist the nurse aide;
i. If a hospice aide is assigned to a patient by the RN, in accordance with the POC, specific written instructions for patient care are to be prepared by the RN. All personal care services are to be outlined for the patient, in writing, by the RN;
j. Document supervision, to include the hospice aide relationships, services provided and instructions and comments given as well as other requirements of the clinical note;
k. Document annual performance reviews for the hospice aide. This performance review must be maintained in the individual's personnel record; and
l. Attend hospice IDT meetings.

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k. annual performance review for each aide/homemaker documented in the individual's personnel record. ***Proposed Changes:*** ***l. conduct an on-site supervisory visit with the LPN present annually.***		
Subchapter C. Patient Care Services **§8219. Patient Care Standard** C. Admission procedure. Patients are to be admitted only upon the order of the patient's attending physician. 1. An assessment visit shall be made by a Registered Nurse, who will assess the patient's needs with emphasis on pain and symptom control. This assessment shall occur within 48 hours of referral for admission, unless otherwise ordered by physician or unless a request for delay is made by patient/family. 2. Documentation at admission will be retained in the clinical record and shall include: a. signed consent forms; b. signed patient's rights statement; c. clinical data including physician order for care; d. patient Release of Information; e. orientation of the patient/care giver, which includes: i. advanced directives; ii. agency services; iii. patient's rights; and iv. agency contact procedures; f. for an individual who is terminally ill, certification of terminal illness signed by the medical director or the physician member of the IDG and the individual's attending physician. **§8229. Discharge/Revocation/Transfer** A. Hospice provides adequate and appropriate patient/family information at discharge, revocation, or transfer. **B. Discharge**. Patient shall be discharged only in the following circumstance: 1. change in terminal status; 2. patient relocates from the hospice's	**§ 418.25 Admission to hospice care.** **(a)** The hospice admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient's attending physician (if any). **§ 418.26 Discharge from hospice care.** **(a)** ***Reasons for discharge***. A hospice may discharge a patient if— (1) The patient moves out of the hospice's service area or transfers to another hospice; (2) The hospice determines that the patient is no longer terminally ill; or (3) The hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause that meets the requirements of paragraphs (a)(3)(i) through (a)(3)(iv) of this section, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. The hospice must do the following before it seeks to discharge a patient for cause: (i) Advise the patient that a discharge for cause is being considered; (ii) Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation; (iii) Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and (iv) Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records.	**114 PATIENT CARE SERVICES** **114.01 Patient Care Standard** 3. Admission Procedure – Patients are to be admitted only upon the order of the patient's attending physician. a. An assessment visit shall be made by a registered nurse, who will assess the patient's needs with emphasis on pain and symptom control. This assessment shall occur within 48 hours of referral for admission, unless otherwise ordered by physician or unless a request for delay is made by patient/family. b. Documentation at admission will be retained in the clinical record and shall include: 1. Signed consent forms; 2. Documented evidence that a patient's rights statement has been given or explained to the patient and/or family; 3. Clinical data including physician's order for care; 4. Patient Release of Information; 5. Orientation of the patient/care giver, which includes: a. Advanced directives; b. Agency services; c. Patient's rights; and d. agency contact procedures; e. Certification of terminal illness signed by the medical director and attending physician. **114.08** **Discharge/Revocation/Transfer** 1. The hospice must provide adequate and appropriate patient/family information at discharge, revocation or transfer. **2. Discharge** – The patient shall be discharged only in the following circumstance: a. The patient is determined to no

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geographically defined service area;
3. if the safety of the patient or of the hospice staff is compromised. The hospice shall make every effort to resolve these problems satisfactorily before discharge. All efforts by the hospice to resolve the problem must be documented in detail in the patient's clinical record; and
4. if the patient enters a non-contracted nursing home or hospital and all options have been exhausted (a contract is not attainable, the patient chooses not to transfer to a facility with which the hospice has a contract, or to a hospice with which the SNF has a contract), the hospice shall then discharge the patient. The hospice must notify the payor source to document that all options have been pursued and that the hospice is not "dumping" the patient;
5. the hospice must clearly document why the hospice found it necessary to discharge the patient.

C. Revocation. Occurs when the patient or representative makes a decision to discontinue receiving hospices services:
1. a recipient may revoke hospice care at any time. This is a right that belongs solely and exclusively to the patient or representative;
2. an effective date earlier than the actual date the revocation is made and signed can not be designated;
3. if a patient or representative chooses to revoke from hospice care, the patient must sign a statement that he or she is aware of the revocation and stating why revocation is chosen.

D. Non Compliance. When a patient is non-compliant, the hospice may counsel the patient/family on the option to revoke and any advantages or disadvantages of the decision that is made. A patient is considered non-compliant if:
1. the patient seeks or receives curative treatment for the illness; or
2. the patient seeks treatment related to the terminal illness in a facility that does not have a contract with the hospice;

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(b) ***Discharge order***. Prior to discharging a patient for any reason listed in paragraph
(a) of this section, the hospice must obtain a written physician's discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his or her review
and decision included in the discharge note.

(d) Discharge planning.
(1) The hospice must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.
(2) The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

§ 418.28 Revoking the election of hospice care.
(a) An individual or representative may revoke the individual's election of hospice care at any time during an election period.
(b) To revoke the election of hospice care, the individual or representative must file a statement with the hospice that includes the following information:
(1) A signed statement that the individual or representative revokes the individual's election for Medicare coverage of hospice care for the remainder of that election period.
(2) The date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that
the revocation is made).
(c) An individual, upon revocation of the election of Medicare coverage of hospice care for a particular election period--

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longer be terminally ill with a life expectancy of six months or less;
b. Patient relocates from the hospice's geographically defined service area;
c. If the safety of the patient or of the hospice staff is compromised. The hospice shall make every effort
to resolve these problems satisfactorily before discharge. All efforts by the hospice to resolve the
problem must be documented in detail in the patient's clinical record; and
d. If the patient enters a non-contracted nursing home
or hospital and all options have been exhausted (a contract is not attainable, the patient chooses not to
transfer to a facility with which the hospice has a contract, or to a hospice with which the SNF has a
contract), the hospice shall then discharge the patient.
e. The hospice must clearly document reasons for discharge.

3. Revocation – Occurs when the patient or representative makes a decision to discontinue receiving hospices services:
a. A recipient may revoke hospice care at any time;
b. If a patient or representative chooses to revoke from hospice care, the patient must sign a statement which states that he or she is aware of the revocation and stating why revocation is chosen.
The effective date of discharge cannot be earlier than the signed revocation date.

4. Non compliance – When a patient is non-compliant, the
hospice must counsel the patient/family on the option to
revoke and any advantages or disadvantages of the decision that is made. A patient is considered non-compliant if:
a. The patient seeks or receives curative treatment for the illness;
b. The patient seeks treatment related to the terminal illness in a facility that does not have a contract
with the hospice; or

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3. the patient seeks treatment related to the terminal illness that is not in the POC, or is not pre-approved by the hospice. **E. Transfer.** To change the designation of hospice programs, the individual must file with the hospice from which he/she has received care and with the newly designated hospice, a signed statement which includes the following information: 1. the name of the hospice from which the individual has received care; 2. the name of the hospice to which he/she plans to receive care; 3. the date of discharge from the first hospice and the date of admission to the second hospice; and 4. the reason for the transfer; 5. appropriate discharge plan/summary is to be written, and appropriate continuity of care is to be arranged.	(1) Is no longer covered under Medicare for hospice care; (2) Resumes Medicare coverage of the benefits waived under Sec. 418.24(e)(2); and (3) May at any time elect to receive hospice coverage for any other hospice election periods that he or she is eligible to receive. **§ 418.30 Change of the designated hospice.** (a) An individual or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received. (b) The change of the designated hospice is not a revocation of the election for the period in which it is made. (c) To change the designation of hospice programs, the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following information: (1) The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care. (2) The date the change is to be effective.	c. The patient seeks treatment related to the terminal illness that is not in the POC, or is not pre-approved by the hospice. **5. Transfer** – The hospice must document the reason for such transfer and an appropriate discharge plan/summary is to be written. Appropriate continuity of care is to be arranged prior to such transfer.
§8221. Plan of Care (POC) A. Prior to providing care, a written plan of care is developed for each patient/family by the attending physician, the Medical Director or physician designee and the IDG. The care provided to an individual must be in accordance with the POC. 1. The initial plan of care (IOPC) will be established on the same day as the assessment if the day of assessment is to be a covered day of hospice. 2. The IDG member who assesses the patient's needs must meet or call at least one other IDG member before writing the IPOC. At least one of the persons involved in developing the	**§ 418.54 Condition of participation: Initial and comprehensive assessment of the patient.** The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions **(a)** ***Standard: Initial assessment.*** The hospice registered nurse must complete an initial assessment within 48	**114.02 Plan of Care (POC)** 1. Within 48 hours of the admission, a written plan of care must be developed for each patient/family by a minimum of two IDT members and approved by the full IDT and the Medical Director at the next meeting. The care provided to an individual must be in accordance with the POC. a. The IDT member who assesses the patient's needs must meet or call at least one other IDT member before writing the IPOC. At least one of the persons involved in developing the IPOC must be a registered nurse or physician.

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IPOC must be a registered nurse or physician. Within 2 days of the assessment, the other members of the IDG must review the IPOC and provide their input. This input may be by telephone. The IPOC is signed by the attending physician and an appropriate member of the IDG. 3. At a minimum the POC will include the following:
a. an assessment of the individual's needs and identification of services, including the management of discomfort and symptom relief;
b. in detail, the scope and frequency of services needed to meet the patient's and family's needs;
c. identification of problems with realistic and achievable goals and objectives;
d. medical supplies and appliances including drugs and biologicals needed for the palliation and management of the terminal illness and related conditions;
e. patient/family understanding, agreement and involvement with the POC; and
f. recognition of the patient/family's physiological, social, religious and cultural variables and values.
4. The POC is incorporated into the individual clinical record.
5. The hospice will designate a Registered Nurse to coordinate the implementation of the POC for each patient.

B. Review and Update of the Plan of Care. The plan of care is reviewed and updated at intervals specified in the POC, when the patient's condition changes, and a minimum of every 14 days for home care and every 7 days for general inpatient care, collaboratively with the IDG and the attending physician.
1. Agency shall have policy and procedures for the following:
a. the attending physician's participation in the development, revision, and approval of the POC is documented.

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hours after the election of hospice care in accordance with § 418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.)
(b) ***Standard: 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.
(c) ***Standard: 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. The comprehensive assessment must take into consideration the following factors:
(1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints).
(2) Complications and risk factors that affect care planning.
(3) Functional status, including the patient's ability to understand and participate in his or her own care.
(4) Imminence of death.
(5) Severity of symptoms.
(6) 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:
(i) Effectiveness of drug therapy.
(ii) Drug side effects.
(iii) Actual or potential drug interactions.
(iv) Duplicate drug therapy.
(v) Drug therapy currently associated

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b. At a minimum the POC will include the following:
1. An assessment of the individual's needs and identification of services, including the management of discomfort and symptom relief;
2. In detail, the scope and frequency of services needed to meet the patient's and family's needs. The frequency of services established in the POC will be sufficient to
effectively manage the terminal diagnosis of the patient, provide appropriate amounts of counseling to the family, and meet or exceed
nationally accepted hospice standards of practice;
3. Identification of problems with realistic and achievable goals and objectives;
4. Medical supplies and appliances including drugs and biologicals needed for the palliation and management of the terminal illness and related conditions;
5. Patient/family understanding, agreement and involvement with the POC; and
6. Recognition of the patient/family's physiological, social, religious and cultural variables and values.
c. The POC must be maintained on file as part of the individual's clinical record. Documentation of
updates shall be maintained.
d. The hospice will designate a registered nurse to coordinate the implementation of the POC for each
patient.

114.03 Review and Update of the Plan of Care
The plan of care is reviewed and updated at intervals specified in the POC, when the patient's condition changes and a minimum of every 14 days for home care and every 7 days for general inpatient care, collaboratively with the IDT and the attending physician.
1. Agency shall have policy and procedures for the following:

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This is evidenced by change in patient orders and documented communication between Hospice Staff and the attending physician;
b. physician orders must be signed and dated in a timely manner, not to exceed 14 days, unless the hospice has documentation that verifies attempts to get orders signed; in this situation up to 30 days will be allowed.
2. The agency shall have documentation that the patient's condition and POC is reviewed and the POC updated, even when the patient's condition does not change.

C. Coordination and Continuity of Care. The hospice shall adhere to the following additional principles and responsibilities:
1. an assessment of the patient/family needs and desire for hospice services and a hospice program's specific admission, transfer, and discharge criteria determine any changes in services;
2. nursing services, physician services, and drugs and biologicals are routinely available to hospice patients on a 24-hour basis, seven days a week;
4. case-management is provided and an accurate and
complete documented record of services and activities describing care of patient/family is maintained;
16. each member of the IDG accepts a fiduciary relationship with the patient/family, maintaining professional boundaries and an understanding that it is the responsibility of the IDG to maintain appropriate
agency/patient/family relationships;

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with laboratory monitoring.
(7) 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.
(8) The need for referrals and further evaluation by appropriate health professionals.
(d) ***Standard: Update of the comprehensive assessment.***
The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.
(e) Standard: Patient outcome measures.
(1) The comprehensive assessment must include data elements that allow for measurement of outcomes. The hospice must measure and document data in the same way for all patients. The data elements must take into consideration aspects of care related to hospice and palliation.
(2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program.

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a. The attending physician's participation in the development, revision, and approval of the POC is documented. This is evidenced by change in patient orders and documented communication between Hospice Staff and the attending physician;
b. Physician orders must be signed and dated in a timely manner, but must be received before billing is submitted for each patient.
2. The agency shall have documentation that the patient's
condition and POC is reviewed and the POC updated, even when the patient's condition does not change.

114.04 **Coordination and Continuity of Care**
1. The hospice shall adhere to the following additional principles and responsibilities:
a. An assessment of the patient/family needs and desire for hospice services and a hospice program's specific admission, transfer, and discharge criteria determine any changes in services;
b. Nursing services, physician services, and drugs and biologicals are routinely available to hospice patients on a 24 hour basis, seven days a week;
d. Case-management is provided and an accurate and complete documented record of services and
activities describing care of patient/family is maintained;

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§8201 *Core Services*— nursing services, physician services, medical social services, and counseling services, including bereavement counseling, dietary counseling, spiritual counseling, and any other counseling services provided to meet the needs of the individual and family. These services must be provided by employees of the hospice, except that physician services and counseling services may be provided through contract.	**Core Services** **§ 418.64 Condition of participation: Core services.** A hospice must routinely provide substantially all core services directly by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice. These services include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in paragraph (a) of this section. ***(b) Standard: Nursing services.*** (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial assessment, comprehensive assessment, and updated assessments. (2) If State law permits registered nurses to see, treat, and write orders for patients, then registered nurses may provide services to beneficiaries receiving hospice care. (3) Highly specialized nursing services that are provided so infrequently that the provision of such services by direct hospice employees would be impracticable and prohibitively expensive, may be provided under contract.	**PART VI BASIC HOSPICE CARE** **116 CORE SERVICES** **116.01** Hospice care shall be provided by a hospice care team. Medical, nursing and counseling services are basic to hospice care and shall be provided directly (Medical Director only may be contract). Hospice care will be available twenty-four (24) hours a day, seven (7) days a week. 2. Nursing services shall be under the direction of a registered nurse and shall include, but not be limited to: assessment, planning and delivery of nursing care; carrying out physician's orders; documentation; evaluation of nursing care; and direction of patient care provided by nonprofessionals.
§8233. Clinical Records A. In accordance with accepted principles of practice the hospice shall establish and maintain a clinical record for every individual receiving care and services. The record shall be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval. The clinical record shall contain all pertinent past and current medical, nursing, social, and other therapeutic information, including the current POC under which services are being delivered.	**§ 418.104 Condition of participation: Clinical records.** A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically. **(a) *Standard: Content.*** Each patient's record must include the following: (1) The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes.	**114.10 Clinical Records** 1. In accordance with accepted principles of practice the hospice shall establish and maintain a clinical record for every individual receiving care and services. The record shall be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval. The clinical record shall contain all pertinent past and current medical, nursing, social and other therapeutic information, including the current POC under which services are being delivered.

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H. The clinical record shall contain a comprehensive compilation of information including, but not limited to, the following:
1. initial and subsequent Plans of Care and initial assessment;
2. certifications of terminal illness;
3. written physician's orders for admission and changes to the POC;
4. current clinical notes (at least the past sixty (60) days);
5. Plan of Care;
6. signed consent, authorization and election forms;
7. pertinent medical history; and
8. identifying data, including name, address, date of birth, sex, agency case number; and next of kin.
I. Entries are made for all services provided and are signed by the staff providing the service.
J. Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.) are recorded whether furnished directly by hospice staff or by arrangement.

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(2) Signed copies of the notice of patient rights in accordance with § 418.52 and election statement in accordance with § 418.24.
(3) Responses to medications, symptom management, treatments, and services.
(4) Outcome measure data elements, as described in § 418.54(e) of this subpart.
(5) 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.
(6) Any advance directives as described in § 418.52(a)(2).
(7) Physician orders.

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8. The clinical record shall contain a comprehensive compilation of information including, but not limited to, the following:
a. Initial and subsequent Plans of Care and initial assessment;
b. Certifications of terminal illness;
c. Written physician's orders for admission and changes to the POC;
d. Current clinical notes (at least the past sixty (60) days;
e. Plan of Care;
f. Signed consent, authorization and election forms;
g. Pertinent medical history; and
h. Identifying data, including name, address, date of birth, sex, agency case number and next of kin.
9. Entries for all provided services must be documented in the clinical record and must be signed by the staff providing the service.
10. Complete documentation of all services and event (including evaluations, treatments, progress notes, etc.) are recorded whether furnished directly by hospice staff or by arrangement.

122 **RECORDS**
122.02 **Content -** Each clinical record shall be comprehensive compilation of information. Entries shall be made for all services provided and shall be signed and dated within 7 days by the individual providing the services. The record shall include all services whether furnished directly or under arrangements made by the hospice. Each patient's record shall contain:
1. Identification data;
2. The initial and subsequent assessments;
3. The plan of care;
4. Consent and authorization forms;
5. Pertinent medical and psychosocial history;
6. Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.)

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§8223. Pharmaceutical Services
A. Hospice provides for the pharmaceutical needs of the patient, consistent with the Board of Pharmacy regulations.
1. Agency shall institute procedures which protect the patient from medication errors.
2. Agency shall provide verbal and written instruction to patient and family as indicated.
3. Drugs and treatments are administered by agency staff only as ordered by the physician.
B. Hospice ensures the appropriate monitoring and supervision of pharmaceutical services and has written policies and procedures governing prescribing, dispensing, administering, controlling, storing and disposing of all biologicals and drugs in compliance with applicable laws and regulations.
C. Hospice ensures timely pharmaceutical services on a 24 hour a day/seven day a week basis that include provision of drugs, biologicals and infusion services which are consistent with patient's individual drug profile.
D. Hospice provides the IDG and the patient/family with coordinated information and instructions about individual drug profiles.

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§ 418.106 Condition of participation: Drugs and biologicals, medical supplies, and durable medical equipment.
(b) ***Standard: Ordering of drugs.***
(1) Only a physician as defined by section 1861(r)(1) of the Act, or a nurse practitioner in accordance with the plan of care and State law, may order drugs for the patient.
(2) If the drug order is verbal or given by or through electronic transmission—
(i) It must be given only to a licensed nurse, nurse practitioner (where appropriate), pharmacist, or physician; and
(ii) 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.
(e) ***Standard: Labeling, disposing, and storing of drugs and biologicals.***
(2) **Disposing.**
(i) Safe use and disposal of controlled drugs in the patient's home. The hospice must have written policies and procedures for the management and disposal of controlled drugs in the patient's home. At the time when controlled drugs are first ordered the hospice must:
(A) Provide a copy of the hospice written policies and procedures on the management and disposal of controlled drugs to the patient or patient representative and family;
(B) Discuss the hospice policies and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs; and
(C) Document in the patient's clinical record that the written policies and procedures for managing controlled drugs was provided and discussed.

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114.05 Pharmaceutical Services
1. Hospices must provide for the pharmaceutical needs of the patient as related to the terminal diagnosis.
2. The agency shall institute procedures which protect the patient from medication errors.
3. The Agency shall provide verbal and written instruction to patient and family regarding the administration of their medications, as indicated.
4. Drugs and treatments are administered by agency staff as ordered by the physician.
5. The hospice must ensure appropriate monitoring and supervision of pharmaceutical services and have written policies and procedures governing prescribing, dispensing, administering, controlling, storing and disposing of all biologicals and drugs in compliance with applicable laws and regulations.
6. The hospice must ensure timely pharmaceutical services on a 24 hour a day/seven day a week basis that include provision of drugs, biologicals and infusion services which are consistent with patient's individual drug profile.
7. The hospice must provide the IDT and the patient/family with coordinated information and instructions about individual drug profiles.

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Subchapter D. Administration **§8235. Agency Operations** 1. Hospice services are available 24 hours per day, seven days a week, which include, at a minimum: a. professional Registered Nurse services; b. palliative medications; c. other services, equipment or supplies necessary to meet the patient's immediate needs. 2. Hospice provides on-call medical and nursing services to assess and meet changing patient/family needs, provide instruction and support, and conduct additional on-site assessment or treatment, 24 hours a day, seven days per week. D. Operational Requirements g. provide all services needed in a timely manner, at least within 24 hours, unless physicians orders indicate otherwise. However, admission time-frames shall be followed as indicated in the Admission Procedures subsection;	**§ 418.100 Condition of Participation: Organization and administration of services.** (2) Nursing services, physician services, and drugs and biologicals (as specified in § 418.106) must be made routinely available on a 24-hour basis 7 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.	**115 ADMINISTRATION** **115.02 Hours of Operation** 1. Hospice services shall be available 24 hours per day, seven days a week, which include, at a minimum: a. Professional registered nurse services; b. Palliative medications; c. Other services, equipment or supplies necessary to meet the patient's immediate needs. 2. Hospice provides on-call medical and nursing services to assess and meet changing patient/family needs, provide instruction and support, and conduct additional on-site assessment or treatment, 24 hours a day, seven days per week.
§8239. Quality Assurance A. Agency shall have an on-going, comprehensive, integrated, self-assessment quality improvement process which provides assurance that patient care, including inpatient care, home care, and care provided by arrangement, is provided at all times in compliance with accepted standards of professional practice. D. Hospice follows a written plan for continually assessing and improving all aspects of operations which include: 2. the identity of the person responsible for the program; 4. the method for evaluating the quality and the appropriateness of care; E. The plan is reviewed at least annually and revised as appropriate. G. Quality assessment and improvement activities are based on the systematic collection, review, and evaluation of data which, at a minimum, includes: 1. services provided by professional	**§ 418.58 Condition of participation: Quality assessment and performance improvement.** The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: Reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS. ***(c) Standard: Program activities.*** (1) The hospice's performance	**115.05 Quality Assurance** 115.05 **Quality Assurance** 1. The hospice shall conduct an ongoing, comprehensive integrated self-assessment quality improvement process (inclusive of inpatient care, home care and respite care) which evaluates not only the quality of care provided, but also the appropriateness care/services provided and evaluations of such services. Findings shall be documented and used by the hospice to correct identified problems and to revise hospice policies. 3. The hospice shall designate, in writing, an individual responsible for the coordination of the quality improvement program. 5. The Hospice's written plan for continually assessing and improving all aspects of operations must include: b. A system to ensure systematic, objective quarterly reports. Documentation must be maintained to reflect that such

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and volunteer staff; 2. outcome audits of patient charts; 3. reports from staff, volunteers, and clients about services; 4. concerns or suggestions for improvement in services; 5. organizational review of the hospice program; 6. patient/family evaluations of care; and 7. high-risk, high-volume and problem-prone activities.	improvement activities must: (i) Focus on high risk, high volume, or problem-prone areas. (ii) Consider incidence, prevalence, and severity of problems in those areas. (iii) Affect palliative outcomes, patient safety, and quality of care. (2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice. (3) The hospice must take actions aimed at performance improvement and, after implementing those actions, the hospice must measure its success and track performance to ensure that improvements are sustained. **(d)** ***Standard: Performance improvement projects.*** Beginning February 2, 2009 hospices must develop, implement, and evaluate performance improvement projects.	reports were reviewed with the IDT, the Medical Director, the Governing Body and distributed to appropriate areas; 6. Quality assessment and improvement activities are based on the systematic collection, review, and evaluation of data which, at a minimum, includes: a. Services provided by professional and volunteer staff; b. Outcome audits of patient charts; c. Reports from staff, volunteers, and clients about services; d. Concerns or suggestion for improvement in services; e. Organizational review of the hospice program; f. Patient/family evaluations of care; and g. High-risk, high-volume and problem-prone activities. 7. The quality improvement plan must be reviewed at least annually and revised as appropriate.
§8241. Branch Offices D. Each branch office must have a registered nurse immediately available to be on site, or on site in the branch office at all times during operating hours.		121 **IN-SERVICE TRAINING** 121.01 The hospice shall provide ongoing, relevant in-service training for all members of the hospice care team. (For hospice aide training, refer to section titled Personnel Qualification/Responsibility.) 121.02 For each direct-care employee, the hospice shall require training of twelve (12) hours inservice education, at a minimum annually. Documentation of such training shall be maintained.
Subchapter E. Hospice Inpatient Facility **§8253. Nursing Services** A. There shall be an organized nursing service that provides 24-hour nursing services. The nursing services shall be under the direction of a Director of Nursing, who is a registered nurse licensed to practice in Louisiana, employed full-time by only one licensed agency. There shall be a simi-	**§ 418.110 Condition of participation: Hospices that provide inpatient care directly.** A hospice that provides inpatient care directly in its own facility must demonstrate compliance with all of the following standards: **(a) Standard: Staffing**. The hospice is responsible for ensuring that staffing for all services reflects its volume of patients, their acuity, and the level of	**PART VIII INPATIENT FACILITY** **130 INPATIENT FACILITY** **130.01 Inpatient hospice staffing** – An inpatient hospice must maintain the coverage of a registered nurse twenty-four (24) hours a day. Other medical/nursing personnel must be available to meet the needs of the patients.

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larly qualified registered nurse available to act in the absence of the Director of Nursing.
B. The inpatient facility has staff on the premises on a twenty-four (24) hour a day, seven (7) day a week basis. There shall be a registered nurse on duty at all times when there are patients in the facility and the facility shall provide nursing services which are sufficient to meet the total nursing needs of the patients in the facility. When there are no patients in the hospice inpatient facility, the hospice shall have a registered nurse on-call to be immediately available to the hospice inpatient facility. The services provided must be in accordance with the patient's plan of care. Each shift shall include two direct patient care staff, one of which must be a registered nurse who provides direct patient care. The nurse to patient ratio shall be at least one nurse to every 8 patients. In addition there shall be sufficient number of direct patient care staff on duty to meet the patient care needs.
C. Written nursing policies and procedures shall define and describe the patient care provided. There shall be a written procedure to ensure that all licensed nurses providing care in the inpatient hospice facility have a valid and current license to practice prior to providing any care.
D. Nursing services are either furnished and/or supervised by a registered nurse and all nursing services shall be evaluated by a registered nurse.
E. A registered nurse shall assign the nursing service staff for each patient in the inpatient hospice facility. The facility shall provide 24-hour nursing services which are sufficient to meet the total nursing needs of the patient and which are in accordance with the patient's plan of care. Staffing shall be planned so that each patient receives treatments, medication, and diet as prescribed , and is kept clean, well-groomed, and protected from accident, injury, and infection. Nursing services staff shall be

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intensity of services needed to ensure that plan of care outcomes are achieved and negative outcomes are avoided.
(b) Standard: Twenty-four hour nursing services.
(1) The hospice facility must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well groomed, and protected from accident, injury, and infection.
(2) If at least one patient in the hospice facility is receiving general inpatient care, then each shift must include a registered nurse who provides direct patient care.
(m) Standard: Restraint or seclusion.
All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.
(5) Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).
(4) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.
(7) When restraint or seclusion is used for the management of violent or self destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention—
(i) By a—
(A) Physician; or
(B) Registered nurse who has been

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130.03 Nursing Services-Inpatient Services- The inpatient hospice facility shall provide an organized 24-hour nursing service.

130.04 The nursing service shall be under the direction of a Director of Nursing Services who is a registered nurse licensed to practice in Mississippi. The Director of Nurses is prohibited from simultaneous employment with more than one agency. Each facility shall provide a similarly qualified registered nurse available to act in the absence of the Director of Nursing Services. A registered nurse shall be responsible to assure the accurate assessment, development of a plan of care, implementation and evaluation of each patient's plan of care. Nursing care is administered and delegated in accordance with acceptable standards of nursing practice and the Mississippi Nurse Practice Act.
a) Nursing staff must be available on the premises twenty four hours a day, seven days a week. There shall be a registered nurse on duty at all times when there are patients in the facility. When there are no patients in the facility, the hospice shall have a registered nurse on call to be immediately available. The facility shall provide sufficient nursing personnel to meet each patient's needs in accordance with the patient's plan of care.

145 NURSING UNIT
145.01 Nursing Unit – Medical, nursing, and personal services shall be provided in a specifically designated area which shall include
bedrooms, special care room(s), nurses' station, utility room toilet
and bathing facilities, linen and storage closets and wheelchair
space.

145.02 The maximum nursing unit shall be twenty-five (25) beds.

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assigned clinical and/or management responsibilities in accordance with education, experience and the current Louisiana Nurse Practice Act.

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trained in accordance with the requirements specified in paragraph (n) of this section.
(ii) To evaluate—
(A) The patient's immediate situation;
(B) The patient's reaction to the intervention;
(C) The patient's medical and behavioral condition; and
(D) The need to continue or terminate the restraint or seclusion.
(9) If the face-to-face evaluation specified in § 418.110(m)(11) is conducted by a trained registered nurse, the trained registered nurse must consult the medical director or physician designee as soon as possible after the completion of the 1-hour face-to-face evaluation.
(n) Standard: Restraint or seclusion staff training requirements. The patient has
the right to safe implementation of restraint or seclusion by trained staff.
(1) *Training intervals.* All patient care staff working in the hospice inpatient facility must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion—
(i) Before performing any of the actions specified in this paragraph;
(ii) As part of orientation; and
(iii) Subsequently on a periodic basis consistent with hospice policy.
(4) *Training documentation.* The hospice must document in the staff personnel records that the training and demonstration of competency were successfully completed.

§ 418.114 Condition of participation: Personnel qualifications.
(a) *General qualification requirements.* Except as specified in paragraph (c) of this section, all professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally

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	authorized (licensed, certified or registered) in accordance with applicable Federal, State and local laws, and must act only within the scope of his or her State license, or State certification, or registration. All personnel qualifications must be kept current at all times.	
§8257. Pharmaceutical Services of Inpatient Hospice E. Orders for medications. A physician must order all medication for the patient. 1. If the medication order is verbal, the physician must give it only to a licensed nurse, pharmacist, or another physician; and the individual receiving the order must record and sign it immediately. 2. All orders (to include telephone and/or verbal) are to be signed by the prescribing physician in a timely manner, not to exceed 30 days. F. Administering Medications. 1. Medications are administered only by a physician, a licensed nurse; or the patient, if his or her attending physician has approved. 2. Physicians' orders are checked at least daily to assure that changes are noted. 3. Drugs and biologicals are administered as soon as possible after dose is prepared for distribution, not to exceed two (2) hours. 4. Each patient has an individual medication administration record (MAR) on which the dose of each drug administered shall be properly recorded by the person administering the drug to include: a. name, strength, and dosage of the medication; b. method of administration to include site, if applicable; c. times of administration; d. the initials of persons administering the medication, except that the initials shall be identified on the MAR to identify the individual by name;	**§ 418.106 Condition of participation: Drugs and biologicals, medical supplies, and durable medical equipment**. (d) *Standard: Administration of drugs and biologicals.* (2) Patients receiving care in a hospice that provides inpatient care directly in its own facility may only be administered medications by the following individuals: (i) A licensed nurse, physician, or other health care professional in accordance with their scope of practice and State law; (ii) An employee who has completed a State-approved training program in medication administration; and (iii) The patient, upon approval by the interdisciplinary group.	**130.05 Pharmaceutical Services of Inpatient Hospice**- The hospice shall provide pharmaceutical services in accordance with acceptable professional standards of nursing and pharmaceutical practice and State law. The hospice shall have policies and procedures that address receipt, storage, dispensing, labeling, medication administration, all aspects of controlled substance storage, usage, and disposal of controlled substances, the handling of medication errors and components for incorporating pharmacy practices into the facility's overall quality improvement plan.

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e. medications administered on a "PRN" or as needed basis shall be recorded in a manner as to explain the reason for administration and the results obtained. The Hospice shall have a procedure to define its methods of recording these medications; h. medication errors and drug reactions are immediately reported to the Director of Nurses, Pharmacist and Physician and an entry made in the patients' medical record and/or an incident report. G. Conformance with Physicians' Drug Orders. Each hospice inpatient facility shall have a procedure for at least quarterly monitoring of medication administration. This monitoring may be accomplished by a registered nurse or a pharmacist, to assure accurate administration and recording of all medications.		

This Crosswalk for Hospice Nurses is designed as an educational tool to assist hospice providers. It is not all inclusive of all standards and providers are urged to make certain they have a copy of the CoPs as well as their State Minimum Standards.
The newly revised CoPs are effective December 2, 2008. Hospice Providers are responsible to be compliant with the current regulations and its requirements until December 2, 2008.

Reminder: Hospice providers are held to the most stringent guidelines, whether it is state or federal.

NOTE

Now Available to Members:
Medicare Hospice Conditions Of Participation Crosswalk: 1983 to 2008
(316k PDF)
http://www.lmhpco.org/login/cms/Crosswalk_of_COPs_Current_to_New.pdf

NOTE

Medicare Conditions of Participation for Hospice Care 42 CFR418 -
June 2008
(241k PDF)
http://www.lmhpco.org/login/cms/COPS_BCFG_0608.pdf

Members make the work of LMHPCO possible!

(as of 9/19/2008):

PROVIDER MEMBERS:

A& E Hospice, Olive Branch, MS
Agape Hospice Care of Shreveport, LA
Agape Northeast Hospice, West Monroe, LA
Agape Northwest Hospice, Minden, LA
Baptist Memorial Hospice-Golden Triangle, Columbus, MS
Bayou Region Hospice, Houma, LA
Brighton Bridge Hospice, Oberlin, LA
Camellia Home Health & Hospice, Bogalusa, LA
Camellia Home Health & Hospice, Columbia, MS
Camellia Home Health & Hospice, Hattiesburg, MS
Camellia Home Health & Hospice, Jackson, MS
Christus Schumpert, Shreveport, LA
Circle of Life Hospice, Inc, Shreveport, LA
Comfort Care Hospice, Laurel, MS
Community Hospice, LLC, New Orleans, LA
Community Hospice, Inc, Sherman, MS
Community Hospices of America – McComb, MS
Community Hospices of America – Meridian, MS
Community Hospices of America – Minden, LA
Community Hospices of America – Natchez, MS
Community Hospices of America – Shreveport, LA
Continue Care Hospice & Home Health, Hollandale, MS
Delta Regional Medical Center Hospice, Greenville, MS
Destiny Hospice, Palliative Care & Specialty Services, Inc, Tutwiler, MS
Elayn Hunt Correctional Center Hospice, St Gabriel, LA
Eternity Hospice, Inc, Gulfport, MS
Eternity Hospice, Inc, Indianola, MS
Eternity Hospice, Inc, Laurel, MS
Faith Foundation, Alexandria, LA
First Choice Hospice, Inc, Olla, LA
Forrest General Hospice, Hattiesburg, MS
Generations Hospice Service Corporation, Denham Springs, LA
Genesis Hospice Care, Inc. Cleveland, MS
Gilbert's Hospice Care – Flowood, MS
Gilbert's Hospice Care – Tupelo, MS
Guardian Hospice Care, LLC, Alexandria, LA
Harbor Hospice of Lake Charles LP, LA
Heart to Heart Hospice, Inc – Amory, MS
Heart to Heart Hospice, Inc – Belmont, MS
Heart to Heart Hospice, Inc – Booneville, MS
Helping Hands Hospice dba: Hospice in His Hands-In-Patient, Kosciusko, MS
Helping Hands Hospice dba: Hospice in His Hands-In-Patient, Magee, MS
Helping Hands Hospice dba: Hospice in His Hands-In-Patient, Walnut Grove, MS
Heritage Hospice, Amory, MS
Heritage Hospice, Corinth, MS
Hospice Associates, Metairie, LA
Hospice Care of Louisiana, Alexandria, LA
Hospice Care of Avoyelles, Alexandria, LA
Hospice Care of Avoyelles, Marksville, LA
Hospice Care of Louisiana, Baton Rouge, LA
Hospice Care of Louisiana, Lafayette, LA
Hospice Care of Louisiana/Mississippi, Slidell, LA
Hospice Care of Louisiana, Monroe, LA
Hospice Care of Louisiana, New Orleans, LA
Hospice Care of Mississippi, Waveland, LA
Hospice Ministries, Brookhaven, MS
Hospice Ministries, Forest, MS
Hospice Ministries, Natchez, MS
Hospice Ministries, McComb, MS
Hospice Ministries, Ridgeland, MS
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Hospice of Baton Rouge, Baton Rouge, LA
Hospice of Caring Hearts, LLC, Dubach, LA
Hospice of Leesville, Leesville, LA
Hospice of Light, Gautier, MS
Hospice of Light, Lucedale, MS
Hospice of Many, Many, LA
Hospice of Natchitoches, Natchitoches, LA
Hospice of St Tammany, Mandeville, LA
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Louisiana Hospice & Pallaitive Care, Jennings, LA
Louisiana Hospice & Palliative Care, Opelousas, LA
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North Oaks Hospice, Hammond, LA
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Odyssey Healthcare, Jackson, MS
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Odyssey Healthcare of New Orleans, Metairie, LA
Odyssey Healthcare, Shreveport, LA
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Patient's Choice Hospice, Vicksburg,
Pax Hospice, Madison, MS
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Southeast Louisiana Hospice, Bogalusa, LA
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Willis Knighton Hospice of Louisiana, Shreveport, LA

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The Hospice Pharmacy Group, Grapevine, TX
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