**Hospice Integration**

**Competency**

General Information

**Hospice**

**General Information**

Planning for quality of care for resident’s at end of life is essential for long term care professionals. There is not a requirement that nursing homes offer hospice services. If the facility does not offer hospice services and the resident chooses to elect the hospice benefit, the facility will need to inform the resident both when admitted and during the stay, and if necessary, assist the resident to a setting where those services are provided. If hospice services are provided, the facility “there must be a written agreement between each hospice and the nursing home that describes their responsibilities prior to the hospice initiating care for the resident.”[[1]](#footnote-1) Care planning must be coordinated between each entity.

**F684 Quality of Care**

§ 483.25 Quality of care “Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents’ choices”[[2]](#footnote-2)

“**Hospice Care”** means a comprehensive set of services described in Section 1861(dd)(l) of the Act, identified and coordinated by an interdisciplinary group (IDG) to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.”[[3]](#footnote-3)

Competency in the comprehensive assessment process is essential in order to develop the plan of care for the resident, ensuring preferences and choices for end of life care. The Person-Centered Care Plan should include:

* Oral Care and ADL’s
* Skin Integrity
* Medical Treatment/Diagnostic Testing
* Symptom Management
* Nutrition and Hydration
* Activities/Psychosocial Needs[[4]](#footnote-4)

**F849 Hospice Services**

“§483.70(o) Hospice services.

(1) A long-term care (LTC) facility may do either of the following:

(i) Arrange for the provision of hospice services through an agreement with one or more

Medicare-certified hospices.

(ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:

(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.

(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:

(A) The services the hospice will provide.

(B) The hospice’s responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.

(C) The services the LTC facility will continue to provide based on each resident’s plan of care. (

D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.

(E) A provision that the LTC facility immediately notifies the hospice about the following:

(1) A significant change in the resident’s physical, mental, social, or emotional status. (

2) Clinical complications that suggest a need to alter the plan of care.

(3) A need to transfer the resident from the facility for any condition. (

4) The resident’s death.

(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.

(G) An agreement that it is the LTC facility’s responsibility to furnish 24-hour room and board care, meet the resident’s personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident’s needs.

(H) A delineation of the hospice’s responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident’s terminal illness and related conditions.

(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.

(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (

K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility’s interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following:

(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.

(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.

(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient’s attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.

(iv) Obtaining the following information from the hospice:

(A) The most recent hospice plan of care specific to each patient.

(B) Hospice election form.

(C) Physician certification and recertification of the terminal illness specific to each patient.

(D) Names and contact information for hospice personnel involved in hospice care of each patient.

(E) Instructions on how to access the hospice’s 24-hour on-call system.

(F) Hospice medication information specific to each patient.

(G) Hospice physician and attending physician (if any) orders specific to each patient.

(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.”[[5]](#footnote-5)

**Description**

The nursing home and Hospice Services will enter into an agreement which will be signed by and authorized representative of the facility and Hospice. This agreement will specify services provided by hospice and by the facility. The written agreement must be in accordance with State and Federal law. It is a requirement that residents receive treatment and care in accordance with professional standards of practice.

**Hospice Responsibilities**

* Regular visits by a hospice Registered Nurse to the nursing home as well as aide services as indicated in the plan of care
* Resident Assessment
* Coordination of Care Plan with Nursing Home
* Medical Social Services
* Volunteer Services
* Counseling Services
* Consultations by a specialized hospice physician as needed.
* Expert management of pain and other symptoms, such as problems breathing or swallowing.
* Education for nursing home staff, patients and families about patients’ condition, symptoms, medications, and how-to best care for patients’ medical needs during this phase of their illness.
* Emotional and spiritual support for both the patient and their family during this phase of life. This includes help for the family before and after the patient dies.
* Provides medications and supplies related to the patient’s terminal illness
* Coordinating the patient’s care and medications across all of the patient’s medical providers, including the patient’s own doctors, hospice doctors, hospice nurses, hospice aides and all nursing home staff.
* Provides bereavement services to the nursing home staff
* Provides Medical Supplies and medications related to the resident’s terminal illness
* Determines the Hospice Level of Care
* Meets all Hospice CoPs (Condition of Participation)

**Nursing Home Responsibilities**

* Room and Board
* Nursing Services including, but not limited to:
  + Assess Resident
  + Maintain MDS/RAI
  + Provide Personal Cares
  + Medication Administration
  + Care in Accordance with the Coordinated Plan of Care
* Dietary Services
* Lab Services
* Formal Therapy if indicated
* Communicating and coordinating patient’s care with the hospice.
* Provide Activities
* Monitoring the patient’s condition and reporting any changes to the hospice.
* Report to hospice immediately if clinical complication would suggest a need to alter plan of care
* Normally scheduled medical care and examinations by the attending physician and medical director.
* Providing medications and supplies for care not related to the patient’s terminal illness.
* Designate facility IDT member responsible for working with hospice representative to coordinate care
* Provide bereavement services to the nursing home staff
* Report alleged violations by hospice personnel to the hospice administrator immediately
* Ensure the plan of care includes both the most recent facility and hospice plan of care as well as a description of services each will provide
* The facility must ensure the hospice services meet professional standards and timeliness

**Suggestions for Resources/Data to Support the Competency**

A resource for expectations for providers for Hospice includes the CMS State Operations Manual, Appendix PP, Guidance to Surveyors for Long Term Care Facilities.

Suggested competencies for staff will include:

* Licensed Nurse(s):
  + Comprehensive Assessment Process
  + Person-Centered Care Plan-the hospice and the nursing home must collaborate in the development of a coordinated plan of care for each resident receiving hospice services.
  + Oversee Implementation
  + Demonstration/Evaluation
  + Documentation
  + Communication between Hospice and facility.
* CNA’s:
  + Implementation of Person-Centered care plan interventions
  + Communication
  + Documentation and reporting of weight/vital signs
  + Identification and Reporting of Change of Condition
* Interdepartmental Employees

**F-Tag Reference General Information**

Examples of (Federal) F tags that could be cited during a survey inspection that are related to hospice consider:

* F552 Right to be Informed/Participate in Treatment
* F578 Advance Directives
* F636 Resident Assessment
* F637 Significant Change in Condition Assessment
* F641 Accuracy of Assessments
* F655 Comprehensive Person-Centered Care Planning
* F656, Comprehensive Care Plans
* F657 Comprehensive Care Plan Revision
* F658 Professional Standards
* F659 Be provided by Qualified Persons
* F684 Quality of Care
* F685 Quality of Care
* F686 Pressure ulcer
* F692 Nutrition and Hydration
* F697 Pain Management
* F710 Physician Supervision
* F725 Sufficient and Competent Staffing
* F745 Medically Related Social Services
* F757 Unnecessary Medications
* F838 Facility Assessment
* F841 Medical Director
* F842 Resident Records
* F849 Hospices Services
* F867 Quality Assessment and Assurance.

**Link to Critical Element Pathway**

Use the Hospice End of Life Critical Element (CE) Pathway, along with the interpretive guidelines when determining if the facility meets the requirements for providing care and services for a resident receiving hospice services, in accordance with professional standards of practice, and the comprehensive person-centered hospice/facility care plan.

**Resources**

* Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf>
* Centers for Medicare and Medicaid Services, Hospice end of Life Critical Element Pathway. CMS 20073 (5/2017): <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes.html>
* American Hospice Foundation (www.americanhospice.org} <https://americanhospice.org/learning-about-hospice/hospice-care-while-living-in-a-nursing-home/>

1. 1,2,3,4 Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-1)
2. [↑](#footnote-ref-2)
3. [↑](#footnote-ref-3)
4. [↑](#footnote-ref-4)
5. Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf> [↑](#footnote-ref-5)