

### Stage 2 Critical Elements for Hospice and/or Palliative Care

Facility Name: \_\_\_\_\_ Facility ID: \_\_\_\_\_ Date: \_\_\_\_\_  
Surveyor Name: \_\_\_\_\_  
Resident Name: \_\_\_\_\_ Resident ID: \_\_\_\_\_  
Initial Admission Date: \_\_\_\_\_ Interviewable:  Yes  No Resident Room: \_\_\_\_\_  
Care Area(s): \_\_\_\_\_

#### Use

Use this protocol for a resident who is receiving hospice and/or palliative care as noted below:

- Palliative care (comfort/end of life care, terminal care) is a lessening and relief of physical, psychosocial, and spiritual suffering so that the resident can accomplish his/her goals and life closure tasks; and/or
- Hospice: The resident is identified as being in a hospice program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions. This program may or may not be covered by the Medicare benefit. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.

NOTE: Hospice is a service that:

- Provides support and care for a resident who is terminally ill so that he/she may live as fully and as comfortably as possible;
- Views death as a natural part of life;
- Neither hastens death nor prolongs life; and
- Provides palliative care.

#### Procedure

- Briefly review the assessment, care plan, and orders to identify facility interventions and to guide observations to be made.
- Corroborate observations by interview and record review.

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Observations	
<p>Observe whether staff consistently implement the care plan over time and across various shifts. For residents receiving hospice and/or palliative care services, staff are expected to assess and provide appropriate care from the day of admission. During observations of the interventions, note and/or follow up on deviations from the care plan as well as potential negative outcomes, including but not limited to the following:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Exhibited signs or symptoms of pain; (If pain is identified, complete the Pain CE)</li><li><input type="checkbox"/> Other symptoms, such as constipation, nausea, vomiting, that are not controlled;</li><li><input type="checkbox"/> Any special interventions carried out by staff including use of supportive and assistive devices/equipment; and</li><li><input type="checkbox"/> Interventions specific to preferences such as bathing, toileting and sleep schedules, visiting hours and access, activities, and food and drinks.</li></ul>	<p><b>Notes:</b></p>

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### Resident/Representative Interview

Interview the resident, family, or responsible party to the degree possible to identify:

- The resident's/representative's involvement in the development of the care plan, defining the approaches and goals, and if interventions reflect choices and preferences;
- The resident's/representative's awareness of pain management and other symptom management programs in use and if care is provided according to the care plan;
- Presence of current symptoms experienced (e.g., pain, anxiety, depression, breathing) degree of relief from interventions, and if the symptoms are controlled to satisfaction;
- If interventions are refused, whether counseling on alternatives, consequences, and/or other alternative approaches was offered; and
- Staff responsiveness to privacy/dignity needs, and preferences and choices.

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### Staff Interviews

Interview staff on various shifts to determine:

- Knowledge of clinical and psychosocial end of life issues the resident/family is experiencing;
- Whether staff identified and implemented in a timely manner appropriate measures related to the resident's level of comfort;
- Whether the nurse monitors for the implementation of the care plan, effectiveness of symptom management, and any changes in symptoms experienced by the resident; and
- How and when facility staff communicate with staff from the hospice service, how services are coordinated with the hospice in caring for this resident, who is responsible for coordinating care between the facility and hospice, and how contact with hospice staff occurs.

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Assessment	
<p>Review assessments from the hospice (if available) and the facility. Review hospice orders, physician orders, consultations, and other progress notes that may have information regarding the assessment of comfort, cognition, pain, and psychosocial needs.</p> <p>NOTE: Services between the certified Medicare hospice and the facility should be coordinated.</p> <p>Determine whether the assessment information accurately and comprehensively reflects:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> The causal, contributing, and risk factors which may affect the resident's physical or psychological comfort;</li><li><input type="checkbox"/> Bowel and bladder functioning (constipation, impactions, diarrhea, involuntary bowel movements, incontinence of urine);</li><li><input type="checkbox"/> Nutritional changes (alteration in taste and smell) and fluids (food and beverage choices, nausea, vomiting, refusal to eat/drink, requests only cereal, soup, ice cream, frozen ices, etc.);</li><li><input type="checkbox"/> Oral health status, such as dentures, ulcers in mouth, dryness of oral cavity/tongue, and other oral health issues, such as broken, painful teeth, or diseases, such as candida or thrush;</li><li><input type="checkbox"/> Symptom control which may produce sedation or excessive sleep and choices in when to sleep and awaken, lethargy;</li><li><input type="checkbox"/> Advance directives (if present), directions for interventions regarding respiratory and cardiac status;</li><li><input type="checkbox"/> Psychosocial and/or emotional issues, such as fear of isolation, death and/or the dying process, fear of pain, loss of independence, control, familiar environment, access to family/friends, and grieving;</li><li><input type="checkbox"/> Loss of function, mobility or positioning, ADL status;</li><li><input type="checkbox"/> Skin integrity;</li><li><input type="checkbox"/> Spiritual needs;</li></ul>	<p><b>Notes:</b></p>

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Assessment	
<p><input type="checkbox"/> Relationship issues such as social choices, sexual preferences, family structures;</p> <p><input type="checkbox"/> Values, wishes, choices, goals;</p> <p><input type="checkbox"/> Lifestyles, ethnicity, cultural orientation; or</p> <p><input type="checkbox"/> Symptom control for pain, need for, and/or response to, pain medications.</p> <p><input type="checkbox"/> Determine whether there was a "significant change" in the resident's condition and whether the facility conducted a significant change comprehensive assessment within 14 days. A "significant change" is a decline or improvement in a resident's status that:</p> <ol style="list-style-type: none"><li>1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting;"</li><li>2. Impacts more than one area of the resident's health status; and</li><li>3. Requires interdisciplinary review and/or revision of the care plan.</li></ol> <p>If there was a "significant change" in the resident's condition and the facility did not conduct a significant change comprehensive assessment within 14 days, initiate <b>F274, Resident Assessment When Required</b>. If a comprehensive assessment was not conducted, also cite F272.</p>	
<p><b>1. If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to determine the resident's specific palliative and end-of-life needs and the impact upon the resident's function, mood, and cognition?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>F272</b></p>	
<p><input type="checkbox"/> <b>NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS</b></p>	

## Stage 2 Critical Elements for Hospice and/or Palliative Care

### Assessment

*NOTE: Although Federal requirements dictate the completion of RAI assessments according to certain time frames, standards of good clinical practice dictate that the assessment process is more fluid and should be ongoing.*

*The comprehensive assessment is not required to be completed until 14 days after admission. For newly admitted residents, before the 14-day assessment is complete, the lack of sufficient assessment and care planning to meet the resident's needs should be addressed under **F281, Professional Standards of Quality**.*

## Stage 2 Critical Elements for Hospice and/or Palliative Care

### Care Planning

*If the comprehensive assessment was not completed (CE#1 = No), mark CE#2 “NA, the comprehensive assessment was not completed”.*

- Determine whether the facility developed a care plan that was consistent with the resident’s specific conditions, risks, needs, behaviors, and preferences and current standards of practice, and included measurable objectives and timetables, with specific interventions/services to meet hospice and/or palliative care needs.
- If the care plan refers to a specific facility treatment protocol that contains details of the treatment regimen, the care plan should refer to that protocol and should clarify any deviations from or revisions to the protocol for this resident. The treatment protocol must be available to the caregivers and staff should be familiar with the protocol requirements. If care plan interventions that address aspects of pain management are integrated within the overall care plan, the interventions do not need to be repeated.
- Review the care plan to determine whether the plan is based upon the goals, needs, and strengths specific to the resident and reflects the comprehensive assessment. Determine whether the care plan addresses, as appropriate:
  - The coordination of care between the facility and the involved Medicare-certified hospice;
  - Who is responsible for delivery and implementation of the plan;
  - Interventions, including identification of those conditions which would require transfer for treatment such as acute illnesses (for example, respiratory or urinary tract infections), and that the choices reflect the resident’s medical/health condition and resident/representative preferences and opinions;
  - Information from the assessment process that addresses relevant factors affecting physical comfort such as bowel and bladder status, mobility and positioning, oral health status, respiratory and cardiac status, nausea, sedation/sleep, lethargy, anxiety, ADL

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### Care Planning

status, skin integrity, activities, and food and beverage choices;

- Environmental factors to promote resident comfort based on resident preferences (such as low level lighting and minimal background noise, etc.);
- The need for psychosocial support, spiritual support, and family interventions;
- The need for supportive and assistive devices/equipment to meet comfort needs (special mattresses, etc.);
- Provision of special nutritional needs based on resident choice; and
- Advance directives according to state law.

If the resident refuses or resists staff interventions to manage symptoms, determine whether the care plan reflects efforts to seek alternatives to address the needs identified in the assessment.

If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current plan of care.

**2. Did the facility develop a plan of care with measurable goals and interventions to address the care and treatment related to the resident's palliative and end-of-life needs, in accordance with the assessment, resident's wishes, and current standards of practice?**

Yes  No **F279**

**NA, the comprehensive assessment was not completed**

*The comprehensive care plan does not need to be completed until 7 days after the comprehensive assessment (the assessment completed with the RAPS). Lack of sufficient care planning to meet the needs of a newly admitted resident should be addressed under **F281, Professional Standards of Quality**.*

### Stage 2 Critical Elements for Hospice and/or Palliative Care

Care Plan Implementation by Qualified Persons	
<p>Observe care and interview staff over several shifts and determine whether:</p> <p><input type="checkbox"/> Care is being provided by qualified staff, and/or</p> <p><input type="checkbox"/> The care plan is adequately and/or correctly implemented.</p> <p><b>3. Did the facility provide or arrange services to be provided by qualified persons in accordance with the resident's written plan of care?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>F282</b></p> <p><input type="checkbox"/> <b>NA, no provision in the written plan of care for the concern being evaluated</b></p> <p><i>NOTE: If there is a failure to provide necessary care and services, the related care issue should also be cited when there is actual or potential outcome.</i></p>	<p><b>Notes:</b></p>

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### Care Plan Revision

*If the comprehensive assessment was not completed (CE#1 = No), OR, if the care plan was not developed (CE#2 = No), mark CE#4 "NA, the comprehensive assessment was not completed OR the care plan was not developed".*

- Determine whether the staff have been monitoring the resident's response to interventions for the management of physical and psychosocial needs and have evaluated and revised the care plan based on the resident's response and outcomes. Review the record and interview staff for information and/or evidence that:
- Evaluation and revision of the care plan is coordinated between the hospice and the facility;
  - Staff evaluate outcomes of the plan (the effect of care plan goals and interventions) on a timely basis;
  - Staff identify changes in the resident's condition that require revised goals and care approaches; and
  - The resident and/or the responsible person is involved in the review and revision of the plan.
- Determine whether the care plan was reviewed and revised as necessary to promote comfort and prevent the development or worsening of physical and/or psychosocial symptoms.

**4. Did the facility reassess the effectiveness of the interventions and review and revise the plan of care (with input from the resident or representative, to the extent possible), if necessary, to meet the needs of the resident?**

Yes  No F280

**NA, the comprehensive assessment was not completed OR the care plan was not developed**

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Provision of Care and Services	
<p>Determine whether staff have:</p> <ul style="list-style-type: none"><li><input type="checkbox"/> Recognized and assessed factors affecting the resident's level of comfort and physical and psychosocial well-being;</li><li><input type="checkbox"/> Defined and implemented pertinent interventions consistent with resident conditions, goals, and recognized standards of practice to manage/relieve physical and psychosocial symptoms;</li><li><input type="checkbox"/> Monitored and evaluated the resident's response to interventions and treatment; and</li><li><input type="checkbox"/> Revised the approaches as appropriate.</li></ul> <p><b>5. Based on observation, interviews, and record review, did the facility provide care and services necessary to promote comfort, pain relief, and provide support to meet the needs of the special care hospice resident in order to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care?</b></p> <p style="text-align: right;"><input type="checkbox"/> Yes   <input type="checkbox"/> No   <b>F309</b></p>	<p><b>Notes:</b></p>

## Stage 2 Critical Elements for Hospice and/or Palliative Care

### Concerns with Independent but Associated Structure, Process, and/or Outcome Requirements

During the investigation of care and services provided to meet the needs of the resident receiving hospice or palliative care, the surveyor may have identified concerns with related structure, process and/or outcome requirements, such as the examples listed below. If an additional concern has been identified, the surveyor should initiate the appropriate care area or F tag and investigate the identified concern. Do not cite any related or associated requirements before first conducting an investigation to determine compliance.

- Privacy** \_\_ Determine whether the facility has accommodated the resident's need for privacy for visiting with family, friends, and others, as desired by the resident.
- F172, Access and Visitation Rights** \_\_ Determine whether the facility has accommodated the resident's family and/or other visitors (as approved by the resident) to be present with the resident as much as desired, even round-the-clock.
- Choices (Self-Determination and Participation)** \_\_ Determine whether the facility has provided the resident with choices about aspects of his or her life in the facility that are significant to the resident.
- F246, Accommodation of Needs** \_\_ Determine whether the facility has adapted the resident's physical environment (room, bathroom, furniture, etc.) to accommodate the resident's individual needs.
- Social Services** \_\_ Determine whether the facility is providing medically-related social services, including
  - Meeting the needs of residents who are grieving;
  - Maintaining contact with family;
  - Providing or arranging for provision of needed counseling services;
  - Supporting preferences, customary routines, concerns and choices;

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### Concerns with Independent but Associated Structure, Process, and/or Outcome Requirements

- Assisting residents/families in decision-making; and
- Promoting actions by staff that maintain or enhance dignity.

NOTE: If there are issues related to care provided by the certified hospice, a complaint identifying the resident and the concerns must be brought to the attention of the state agency responsible for regulating hospice services.

- F271, Admission Orders** — Determine whether the facility received physician orders for provision of immediate care before conducting the comprehensive assessment and developing an interdisciplinary care plan.
- F278, Accuracy of Assessments** — Determine whether staff that are qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline conducted an accurate assessment.
- F281, Professional Standards** — Conduct observations and interviews throughout Stage 2 using the observation and interview probes.
  - Observe care and interview staff over several shifts to ensure consistent application of interventions that reflect current standards of practice such as:
    - Care implementation is coordinated between the hospice and the facility;
    - Staff address psychosocial issues with the resident/representative and resident's family; and
    - Interventions provided reflect current standards of practice in accordance with resident/family preference and advance directives.
  - Interviews **with Health Care Practitioners and Professionals:**  
If the interventions defined or care provided appear not to be

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consistent with recognized standards of practice, interview one or more health care practitioners and professionals as necessary (e.g., physician, hospice nurse, facility charge nurse, director of nursing) who, by virtue of training and knowledge of the resident, should be able to provide information about the management and evaluation of the resident's physical and psychosocial symptoms and needs. If there is a medical question, contact the physician if he/she is the most appropriate person to interview. If the attending physician is unavailable, interview the medical director, as appropriate. Depending on the issue, ask about:

- How it was determined that chosen interventions were appropriate;
- Changes in condition that may justify additional or different interventions; or
- How staff validated the effectiveness of current interventions.

**F514, Clinical Records** — Determine whether the clinical records:

- Accurately and completely document the resident's status, the care and services provided (e.g., to prevent, to the extent possible, or manage the resident's pain) in accordance with current professional standards and practices and the resident's goals; and
- Provide a basis for determining and managing the resident's progress including response to treatment, change in condition, and changes in treatment.