### L523: Interpretive Guidelines §418.54(b)

All members of the IDG must be involved with completing the comprehensive assessment in order to identify the patient/family’s physical, psychosocial, emotional and spiritual needs and contribute to the development of the plan of care to address those needs. The individuals/disciplines that complete the assessment should be consistent with the hospice’s own policies and procedures and the discipline’s scope of practice. The RN, in consultation with the other members of the IDG, considers the information gathered from the initial assessment as they develop the plan of care and the group determines who should visit the patient/family during the first 5 days of hospice care in accordance with the hospice’s own policies and procedures.

The patient may or may not have an attending physician. If the attending physician is unavailable or unresponsive, the hospice physician must assume this role. If the patient does have an attending physician, one or more members of the IDG should consult with this physician in completing the comprehensive assessment. This consultation can occur through phone calls or other means of communication (Fax, e-mails, text messages, etc.,) and will help to acquire a better understanding of the patient and family. Attending physicians can often provide a history of the patient’s disease process and family dynamics that can help the hospice make better care planning decisions that address all areas of need related to the terminal illness and related conditions, resulting in improved patient outcomes.

The “election of hospice care” is the effective date of the election statement. The patient may sign the hospice election statement with a later (not earlier) effective date. Hospices may choose to complete the comprehensive assessment earlier than 5 days after the effective date of the election (e.g., it may complete the comprehensive assessment at the same time the initial assessment is completed.)

### L530: Interpretive Guidelines §418.54(c)(6)

In reviewing the patient’s prescribed and over-the-counter medications and any additional substance that could affect drug therapy, the hospice must consider drug effectiveness, side effects, interactions of drugs, duplicate drugs and drugs associated with laboratory testing which could affect the patient. In addition, the hospice should consider both the use of pharmacological and non-pharmacological interventions to promote the patient’s comfort level and sense of well being based on the assessment of patient needs and desires.

“Medication Interaction” is the impact of another substance (such as another medication, nutritional supplement (including herbal products), food, or substances used in diagnostic studies) upon a medication’s action. The interactions may alter absorption, distribution, metabolism, or elimination. These interactions may decrease the effectiveness of the medication or increase the potential for adverse consequences.

Duplicate therapy” refers to multiple medications of the same pharmacological class/category or any medication therapy that substantially duplicates a particular effect of another medication that the individual is taking.

“Non-pharmacological interventions” refers to approaches to care that do not involve medications, generally directed towards stabilizing or improving a person’s mental, physical or psychosocial well being.

There should be evidence in the clinical record that common side effects of medications are anticipated and preventive measures are implemented. The hospice should review each patient’s medications and monitor for medication effectiveness, actual or potential medication-related effects, duplicate drug therapy and untoward interactions during each update to the comprehensive assessment, and as needed as new medications are added or changed, or the patient’s condition changes.
### TAG  L545

**§418.56(c) Standard: Content of the plan of care**

The hospice must develop an individualized written plan of care for each patient. The plan of care must reflect patient and family goals and interventions based on the problems identified in the initial, comprehensive, and updated comprehensive assessments. The plan of care must include all services necessary for the palliation and management of the terminal illness and related conditions, including the following:

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<th>Procedures and Probes §418.56(c)</th>
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<td>• Determine through interview/observation and record review if the plan of care identifies all the services needed to address problems identified in the initial, comprehensive and updated assessments.</td>
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<td>• Is there evidence of patients receiving the medication/treatments ordered?</td>
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<td>• Are plans of care individualized and patient-specific?</td>
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<td>• Does the plan of care integrate changes based on assessment findings?</td>
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<td>• Is there documentation to support that the development of the plan of care was a collaborative effort involving all members of the IDG and the attending physician, if any? The attending physician and the IDG members do not have to sign the plan of care but there must be documentation of their involvement.</td>
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### TAG  L547

(1) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs.

**Interpretive Guidelines §418.56(c)(2)**

*The use of visit ranges in the patient plan of care should follow these parameters:*

- The plan of care may include a range of visits and PRN orders for visit frequencies to ensure the most appropriate level of service is provided to the patient.
- A range of visits is acceptable as long as it continues to meet the identified needs of the patient/family.
- Visit ranges with small intervals are acceptable (i.e. 1-3 visits/week; 2-4 visits/week) but ranges that include “0” as a frequency are not allowed.
- The IDG may exceed the number of visits in the range to address patient/family’s needs. There should be documentation in the record to support the need for the extra visit(s).

If the patient requires frequent use of PRN visits, the plan of care should be updated to include the need for additional visits.

Standing orders or routine orders must be individualized to address the specific patient’s needs and signed by the patient’s physician.

The IDG should be proactive in developing each patient’s plan of care by planning ahead for anticipated patient changes and needs. Decisions should reflect the patient/family preferences rather than be solely a response to a crisis.

**Procedures and Probes §418.56(c)(2)**

*Ask the clinical manager and other IDG members to describe:*

- What criteria are used to assess the needs of the patient and family?
- Who is involved in this process?
- How the IDG decides what services the patient will receive?
- How the hospice evaluates if the services provided are continuing to meet the patients’ and families’ needs?
- How the hospice monitors the delivery of services, including those provided under arrangement or contract, to ensure compliance with the hospice philosophy?

During the home visit, ask the patient/family if they are aware of all the services included in the hospice benefit. If they are not able to describe them, ask to see any information/documentation the hospice may have left with them describing these services. Ask the patient/family who comes to see them from the hospice, how often they come, what services they provide and if they are provided in a timely manner. Are they satisfied with the level of services they are receiving?

During your clinical record review and home visit, determine if there is any indication the patient needs hospice services that he/she is not receiving.
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| L552 | §418.56(d) Standard: Review of the plan of care | Interpretive Guidelines §418.56(d)  
Communication with the attending physician may be through phone calls, electronic methods, orders received, or other means according to hospice policy and patient needs. |
| L555 | §418.56(e) Standard: Coordination of Services |  
(1) Ensure that the care and services are provided in accordance with the plan of care. |
| L625 | §418.76(g) Standard: Hospice aide assignments and duties | Interpretive Guidelines §418.76(g)(1)  
Hospice aide written instructions for patient care prepared by the R.N. responsible for the supervision of the aide must be patient specific and not generic. |
|      |           | Interview key staff to determine the following:  
• Are aides direct employees of the hospice or provided by arrangement?  
• If services are provided under arrangement, how does the hospice ensure that the aides providing patient care have the appropriate competency skills?  
• How the hospice ensures that aides are proficient to carry out their assignments in a safe, efficient and effective manner.  
• How the hospice monitors the assignments of aides to match the skills needed for individual patients.  
If you have questions that arise as a result of home visits or record reviews, ask the clinical managers to respond to specific issues. |
| L629 | §418.76(h) Standard: Supervision of hospice aides | Interpretive Guidelines §418.76(h)(1)(i)  
If the RN makes a supervisory visit on a Tuesday, the next supervisory visit is due by the Tuesday, which occurs 14 days later.  
In addition to ensuring that hospice aides furnish the care identified in the plan of care, RN supervisors must assess the adequacy of the aide services in relationship to the needs of the patient and family. In-person visits by the supervising nurse to the patient’s home allow the nurse to directly observe the patient and the results of the aide’s care. The supervisory visits must be documented in the patient’s clinical record.  
(1) A registered nurse must make an on-site 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. |
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<td>L647</td>
<td>§418.78(e) Standard: Level of activity</td>
<td>Interpretive Guidelines §418.78(e)</td>
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Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked.

In computing this level of activity, the hospice divides the number of hours that hospice volunteers spent providing administrative and/or direct patient care services by the total number of patient care hours of all paid hospice employees and contract staff. For example, if the hospice provides 10,000 hours of paid direct patient care during a one-year period the hospice must provide 500 volunteer hours in direct patient care or administrative activities to meet the required 5 percent total.

A hospice may fluctuate the volume of care provided by volunteers after the hospice meets the required 5 percent minimum.