

Hospice and End of Life Care and Services Critical Element Pathway

Use this pathway for a resident identified as receiving end of life care (e.g., palliative care, comfort care, or terminal care) or receiving hospice care from a Medicare-certified hospice.

Review the Following in Advance to Guide Observations and Interviews:

- Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for areas pertinent to the resident's end of life care, services, and needs.
- Physician's orders (e.g., hospice or end of life services, advance directives, pain interventions, medications).
- Pertinent diagnoses.
- Care plan (e.g., advance directives; provision of ADLs; symptom management including controlling nausea, agitation, pain, uncomfortable breathing; pressure ulcer prevention interventions; nutrition and hydration needs; psychosocial interventions; coordination of care with hospice).

Observations:

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| <input type="checkbox"/> Are care planned and ordered interventions implemented and meeting the resident's needs? If not, describe the discrepancies. | <input type="checkbox"/> Whether the facility is meeting the resident's choices and preferences (e.g., bathing, toileting, sleep schedule, activities). |
| <input type="checkbox"/> Whether ADLs (including oral care) are provided to address the resident's comfort and dignity. | <input type="checkbox"/> Whether the resident appears to be agitated, apprehensive, withdrawn, or restless? If so, how are these symptoms being addressed? |
| <input type="checkbox"/> Whether skin integrity interventions are implemented (e.g., repositioning) to ensure the resident is comfortable. | <input type="checkbox"/> Whether the type, amount, consistency of food and fluids provided are based on resident's needs, choices and preferences. If not, describe. |
| <input type="checkbox"/> Whether the resident's symptoms (e.g., nausea, vomiting, uncomfortable breathing, agitation, or pain) are being managed. | <input type="checkbox"/> Whether the environment promotes comfort according to the resident's preferences (e.g., low lighting and minimal background noise)? If not, describe. |
| <input type="checkbox"/> Whether supportive/assistive devices are provided as needed. | |

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Resident, Representative, or Family Interview:

- Whether the resident/representative is aware of:
 - The name of the facility interdisciplinary team member/designee who is responsible for working and coordinating with the hospice team for communicating concerns regarding the provision of care; and
 - How to contact the facility's designated coordinator.
- If receiving hospice care, have you had any concerns with your hospice care? If so, what are your concerns and do you know who to talk to and how to contact that person?
- How did the facility involve you in the development of the care plan and goals regarding your care?
- Do you feel like the care you are receiving reflects your choices and preferences?
- Were you involved in making choices on the type of care and treatment you are receiving? Do you have an advance directive (according to State law) and is staff aware of your directives? If not, have you or your representative received information on advance directives?
- Has your care changed recently? If so, were you involved in revisions or changes for care and treatment?
- Are you experiencing any symptoms (e.g., pain, breathing difficulty, constipation)? How are your symptoms being managed?
- Have you experienced any anxiety, depression, or grief? How are these needs being addressed?
- Have you declined any treatments? Why? Did staff find out the reason for the refusal and try to offer alternatives?
- Do you think the coordination of care between the hospice and facility is meeting your needs? If not, why not? Have you notified staff? Who? What was the resolution?

Staff Interviews (Nursing Aides, Nurse, Hospice Staff, Designated Hospice Coordinator, DON):

- Can you describe the resident's goals for care and treatment at the end of life?
- What is the basis for the determination that a resident is approaching the end of life?
- How do you monitor and document symptoms, implement interventions, and document effectiveness of the interventions? Who do you report any changes to?
- If the resident is transferred to the ER or hospital, how are the resident's choices and preferences regarding care communicated, including advance directives, if applicable?
- If the resident is receiving hospice care, determine:
 - Whether nursing home staff understand the hospice philosophy and practices;
 - Who is the facility designated IDT member that communicates with hospice and whether he/she meets the qualifications; and
 - What and how often does the IDT member communicate with hospice.

NOTE: If concerns, see F849 for the hospice written agreement)

- Can you describe the ongoing (24/7) communication and coordination process between the facility and hospice?
- Can you describe your responsibilities compared to what hospice provides?
- How do you share concerns and responses and who coordinates the resident's care with the hospice?
- How do you communicate with the resident or resident representative, hospice, and the practitioner any change to the resident's condition that may reflect the need to modify or revise the coordinated care plan?
- If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current care plan.

NOTE: If concerns are identified related to the coordination of care, communication with the hospice, and responses to concerns, interview the facility-delegated coordinator. It may be necessary to interview the designated hospice coordinator regarding resident concerns.

Record Review:

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- Is the care plan comprehensive? Does it address identified needs, measurable goals, resident involvement, treatment preferences, and choices? Is the most recent hospice care plan included? Has the care plan been revised to reflect any changes?
- Does the care plan reflect the resident's diagnosis, palliative care and interventions, as appropriate, such as:
 - End of life or hospice status;
 - If on hospice:
 - Identification of the discipline and provider for care plan interventions;
 - How to contact the hospice 24 hours a day; and
 - Does the care plan reflect coordination between the hospice and the nursing home.
 - Identified resident choices, and goals including advance directives as allowed by State law (e.g., directions regarding hospitalization, acute care in the event of an illness or injury, artificial nutrition or hydration, respiratory and cardiac status).
 - Underlying factors affecting the resident's comfort, cognition, pain, and functional status;
- Does the record reflect assessment of concerns such as the following:
 - Lab/x-ray tests in agreement with the resident's advance directives, if any, including choices, preferences, goals, comfort, and dignity?
 - Does the record reflect a change in treatment to palliative care or hospice?. Was a significant change comprehensive assessment conducted within 14 days of the change?
 - Did the facility identify necessary changes in goals or care approaches to promote comfort and prevent the development or worsening of physical or psychosocial symptoms? Was this communicated with the resident, resident representative, hospice, and attending practitioner?
 - How does the facility monitor the resident's response to interventions for the management of physical and psychosocial needs?
 - Review the facility policy on end of life and hospice care or related policies (e.g., advance directives) if concerns are identified.
 - For a resident receiving hospice services: If the resident is receiving the hospice benefit, is care coordinated between hospice and the facility staff? If not, describe.
 - Does the facility have a current written agreement with the Medicare-certified hospice providing hospice services in the nursing home, and was the agreement developed prior to hospice services beginning. (Refer to F849 – hospice agreement.)
 - If the hospice was advised of resident concerns and failed to resolve issues related to the management of the resident's care, coordination of care, or implementation of appropriate services, review the appropriate portions of the written agreement.

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- Nutrition and hydration concerns (e.g., refusal to eat/drink; loss of appetite; alteration in taste and smell; dietary restrictions; food/beverage choices; the amount, type, texture, and frequency for food/fluids; or necessity for ongoing weight measurements)?
- Oral health status (e.g., ulcers in mouth; dryness of oral cavity/tongue; or diseases, such as candida or thrush) and how is it being addressed?
- Bowel and bladder concerns (constipation, impactions, diarrhea, incontinence)?
- Symptoms management (e.g., pain, nausea, vomiting, respiratory concerns, weakness, lethargy, vertigo, skin integrity issues including existing wounds, infections) and interventions?
- Level of activities desired including ethnic/cultural practices, choices regarding when to sleep and awaken?
- Functional/ADL status including mobility?
- Medications used for comfort, symptom control, and desired level of alertness?

Critical Element Decisions:

Referral of Hospice-Specific Concerns: If the resident is receiving Medicare-certified hospice services and 1) the hospice was advised of concerns by the facility and failed to address and resolve issues related to coordination of care or implementation of appropriate services; or 2) the hospice failed to provide services in accordance with the coordinated plan of care, regardless of notice from the facility; or 3) if there is no current written agreement between the nursing home and the hospice; the survey team must refer this as a complaint to the State agency responsible for oversight of hospice, identifying the specific resident involved and the concerns identified.

NOTE: Most noncompliance related to end of life or hospice care and services can be cited at other regulations (e.g., assessment, care planning, accommodation of needs, and physician supervision). Surveyors should evaluate compliance with these regulations and cite deficiencies at F675 only when other regulations do not address the noncompliance.

1. A. Did the facility provide appropriate treatment and services for end of life care?

B. For a resident receiving hospice services: Did the facility collaborate with the hospice for the development, implementation, and revision of the coordinated plan of care and/or communicate and collaborate with the hospice regarding changes in the resident's condition, including transfer to the emergency department and/or hospital, if applicable?

If No to A or B, cite F684

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2. Did the facility have an agreement to provide hospice services at the facility or with a Medicare-certified hospice, designate staff to the facility's interdisciplinary team who works with the hospice representative to coordinate care, and ensure each resident's care plan includes a description of the care and services provided by the hospice and facility?
If No, cite F849
3. For newly admitted residents and if applicable based on the concern under investigation, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.
4. 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 identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.
5. If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change in status.
6. Did staff who have the skills and qualifications to assess relevant care areas and who are knowledgeable about the resident's status, needs, strengths and areas of decline, accurately complete the resident assessment (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641
7. Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

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

If No, cite F657

NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised

Other Tags, Care Areas (CA) and Tasks (Task) to Consider: Right to be Informed Make Treatment Decisions F552, Advance Directives (CA), Choices (CA), Respiratory (CA), Pain (CA), Unnecessary Medications (CA), Behavioral-Emotional Status (CA), QOL F675, Facility Assessment F838, QAA/QAPI (Task).