Tag	Conditions of Participation and Standards	Interpretive Guidelines	Procedures and Probes/Survey Protocol
L522	§418.54(a) Standard: Initial assessment The hospice registered nurse must complete an initial assessment within 48 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.)	The purpose of the initial assessment is to gather the critical information necessary to treat the patient/family's immediate care needs. The assessment needs to take place in the location where hospice services are being delivered. The initial assessment is not a "meet and greet" visit whereby the hospice introduces itself to the patient/family and begins to evaluate the patient's interest in and appropriateness for hospice care. It must assess the patient's immediate physical, psychosocial, emotional and spiritual status related to the terminal illness and related conditions. The initial assessment is necessary to gather the essential information necessary to begin the plan of care and provide the immediate necessary care and services. The registered nurse (RN) must conduct this initial assessment. Hospices may choose to send a social worker or other discipline along with the RN to complete the initial assessment. Hospices are free to choose their own method for documenting the initial assessment.	• Determine through interview, observation and record review if the hospice identified the patient/family's immediate needs. • Did the RN complete the initial assessment within the required time frames? Clinical record documentation should confirm/support that time frames are met. Pay particular attention to the effective date/time of the election and the date/time of the completion of the initial assessment.
L523	§418.54(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.	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 patient/family needs and desires and 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).	
L524	§418.54(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 assessment would include, but not be limited to, screening for the following: pain, dyspnea, nausea, vomiting, constipation, restlessness, anxiety, sleep disorders, skin integrity, confusion, emotional distress, spiritual needs, support systems, and family need for counseling and education. The hospice would then gather additional information, as necessary, to be able to meet the patient/family needs. For example, in addition to screening the patient for the presence of pain, a comprehensive assessment of the patient's pain based on accepted clinical standards of practice may necessitate gathering the following information, as applicable to the patient: • History of pain and its treatment (including non-pharmacological and pharmacological treatment); • Characteristics of pain, such as: – Intensity of pain (e.g., as measured on a standardized pain scale); – Descriptors of pain (e.g., burning, stabbing, tingling, aching); – Pattern of pain (e.g., constant or intermittent); – Location and radiation of pain; – Frequency, timing, and duration of pain; – Impact of pain on quality of life (e.g., sleeping, functioning, appetite, and mood);	

		– Factors such as activities, care, or treatment that precipitate or exacerbate pain; – Strategies and factors that reduce pain; and – Additional symptoms associated with pain (e.g., nausea, anxiety). • Physical examination (may include the pain site, the nervous system, mobility and function, and physical, psychological, and cognitive status); • Current medical conditions and medications; and • The patient/family's goals for pain management and their satisfaction with the current level of pain control.	
L530	§418.54(c)(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 with laboratory monitoring.	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.	Procedures and Probes §418.54(c)(6) Ask clinical staff to describe their process/policy of drug regimen/medication review including: • How potential adverse effects and drug reactions are identified? • What process is followed when a patient/family is found to be noncompliant? • What non-pharmacological methods are considered to relieve pain and other symptoms? • How patients and families are educated about effective pain and symptom management. • What process the hospice utilizes to assess and measure pain and other uncomfortable symptoms. • What procedures or protocols the hospice uses to reassess pain and symptom management. • How the hospice monitors a patient when they begin a new medication, increase/

		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.	decrease a dosage or discontinue a medication. During the home visit, ask the patient/caregiver what medications (prescription and over the-counter drugs, herbal remedies, etc.) the patient is currently taking and compare this information with the medications documented within the plan of care. Are the patient's preferences/goals for pain management and symptom control followed and achieved?