

Hospice, End of Life and/or Palliative Care Critical Element Pathway

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 sampled resident:

- Identified by the facility as receiving end of life care, hospice, palliative care, comfort care, or terminal care; or
- Diagnoses, assessment, and/or care plan indicate that he/she may be approaching the end of life.
- *Palliative care means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.*
 - **“Hospice”** refers to a public agency or private organization or subdivision of either of these that is primarily engaged in providing an array of care and services necessary for the palliation and management of the terminal illness and related conditions.

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 comfortable 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, orders, and related documentation to identify facility interventions and to guide observations to be made.
- Verify observations by gathering additional information from record review, interviews with the resident or his or her legal representative, relevant staff and practitioners, and/or additional observations.

NOTE: Determine whether the resident is also receiving care from another entity such as a Medicare-certified hospice.

Hospice, End of Life and/or Palliative Care Critical Element Pathway

Observations

Observe the resident during various activities, shifts, and interactions with staff. Use the observations to determine:

- Whether staff accommodated the resident's needs and goals (such as comfort, independence and level of functioning during end of life), including, but not limited to:
 - Interventions used if the resident exhibited or verbalized pain or other symptoms of distress such as apprehension, restlessness, withdrawal, or lashing out at others. (If pain is identified, complete the Pain pathway);
 - Interventions used if the resident exhibits other symptoms, such as constipation, nausea, vomiting, that are not controlled;
 - Supportive and assistive devices/equipment used such as commodes and/or positioning devices;
 - Privacy, dignity, calming reassurance used; and
 - Preferences and choices acknowledged and respected, such as a resident's preferences for bathing, toileting, sleep schedules, activities, food and drink, environment, etc. (If a concern with choices is identified, complete the Choices pathway.)
- Whether staff consistently implemented the care plan according to the resident's goals.

Notes:

Hospice, End of Life and/or Palliative Care Critical Element Pathway

Resident/Representative Interview	
<p>Interview the resident, family, or responsible party, to the degree possible, to identify:</p> <ul style="list-style-type: none"><input type="checkbox"/> Whether the facility discussed advance directives, the right to make treatment choices (including refusing treatment), available resources and state-required documents related to end of life care or substitute decision making.<input type="checkbox"/> Whether the resident is currently having or has been having symptoms (e.g., pain, anxiety, depression, breathing difficulties), and whether the symptoms and extent of relief have been addressed to his/her satisfaction and consistent with his/her preferences and choices.<input type="checkbox"/> Whether the resident or his/ her legal representative was involved in the development of the care plan.<input type="checkbox"/> Whether the care plan accommodates the resident's needs and goals.<input type="checkbox"/> If interventions were declined, whether information about alternatives and consequences of such refusal were offered and documented.	<p>Notes:</p>

Hospice, End of Life and/or Palliative Care Critical Element Pathway

Staff Interviews	
<p>Direct care staff. Interview direct care staff on various shifts to determine:</p> <ul style="list-style-type: none"><input type="checkbox"/> Whether staff are aware of the resident's goals for care and treatment at the end of life.<input type="checkbox"/> How staff determine when and how to offer each intervention as necessary.<input type="checkbox"/> How staff monitor and document for effectiveness of the intervention. <p><i>If a resident is receiving hospice care:</i></p> <p>Determine how and when facility staff communicates with staff from the hospice service, how services are coordinated with the hospice in caring for the resident, who is responsible for coordinating care between the facility and hospice, and how contact with hospice staff occurs.</p>	<p>Notes:</p>

Hospice, End of Life and/or Palliative Care Critical Element Pathway

Health Care Practitioners and Professionals Interviews

If the defined interventions or care provided appear to be inconsistent with the resident's preferences or applicable recognized standards of practice; the interventions were not implemented as defined; or the resident's symptoms were not adequately controlled, interview one or more health care practitioners and professionals as necessary (e.g., physician, hospice nurse, facility charge nurse, certified nursing assistant, social worker, or director of nursing). These individuals, by virtue of training and knowledge of the resident, should be able to provide information about the evaluation and management of a resident's physical/psychosocial symptoms and needs related to end of life and palliative care. Depending on the issue, ask about:

- The basis for a determination that a resident is approaching the end of life.
- Whether there has been a discussion with the resident and/or the legal representative regarding a determination that the resident is approaching the end of life and about the resident's options for developing instructions regarding his or her choices for care and treatment (please refer to advance directives guidance at F155).
- When and how the resident's preferences regarding care at the end of life (including advance directives, if applicable) are communicated to the facility care team as well as emergency department, hospital or home care teams if the resident is transferred for any reason.
- How interventions are monitored for continued appropriateness and adjusted as necessary.
- Whether and how the staff communicates with the physician/practitioner regarding the resident's condition and response to interventions.

Notes:

Hospice, End of Life and/or Palliative Care Critical Element Pathway

Record Review	
<p>Review of Facility Practices</p> <p><i>Any concerns identified by the survey team related to End of Life care should trigger a review of the facility's policies and procedures on End of Life care and/or related policies (e.g., advance directives). Additional activities may include a review of policies, staffing, staff training and/or functional responsibilities related to care and services to be provided to a resident approaching the end of life.</i></p>	<p>Notes:</p>
Assessment	
<p>Review the resident's records for assessments related to end of life care including RAI/MDS, physician orders, hospice orders as appropriate, other available consultant and other progress notes to determine whether they:</p> <ul style="list-style-type: none"><input type="checkbox"/> Provided the basis for the determination that the resident is approaching the end of life;<input type="checkbox"/> Identified the resident's overall physical, mental and psychosocial needs including but not limited to:<ul style="list-style-type: none">▪ Bowel and bladder functioning (constipation, impactions, diarrhea, involuntary bowel movements, incontinence of urine);▪ Nutritional changes (alteration in taste and smell) and fluids (food and beverage choices, nausea, vomiting, refusal to eat/drink);▪ 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;▪ Symptom control which may produce sedation or excessive sleep and choices in when to sleep and awaken, lethargy;▪ Loss of function, mobility or positioning, ADL status;▪ Skin integrity;	<p>Notes:</p>

Hospice, End of Life and/or Palliative Care Critical Element Pathway

Assessment

- Spiritual needs; and
 - Lifestyles, ethnicity, cultural orientation.
- Identified the underlying factors affecting the resident's comfort, cognition, pain, and functional status;
- Identified the resident's values, wishes, choices, and goals (e.g., advance directives or other directions for interventions regarding hospitalization, acute care in the event of an illness or injury, artificial nutrition or hydration approaches, and respiratory and cardiac status);
- Indicated that staff implemented interventions, in conjunction with the practitioner, to try to prevent, minimize or manage symptoms; and whether the interventions addressed the pain and/or potential pain, distress, and/or other symptoms (such as constipation, nausea, and vomiting) consistent with the resident's goals and the facility and practitioner's identification and assessment of factors causing or influencing those symptoms; and
- Indicated that the facility monitored the resident's subsequent condition including any changes in status.

A change from a more aggressive treatment plan to a palliative care plan represents a significant change as defined by the MDS. If the facility did not conduct a significant change comprehensive assessment within 14 days, initiate F274, Resident Assessment When Required.

1. 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? Yes No F272

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 just admitted and the comprehensive assessment is not required yet

Hospice, End of Life and/or Palliative Care Critical Element Pathway

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.

Hospice, End of Life and/or Palliative Care Critical Element Pathway

Care Planning

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

Review the care plan to determine:

- If it is consistent with the resident’s specific needs, condition, values, wishes and goals and progress as identified by periodic assessments including but not limited to:
 - ADLs – Interventions that emphasize support for activities of daily living to enhance the resident’s comfort and dignity (e.g., assistance with bowel and urinary function for the individual who can no longer toilet him or herself; appropriate adjustments in the frequency of turning, getting out of bed, and dressing).
 - Hygiene/Skin Integrity –
 - Ongoing, consistent oral care helps to maintain comfort and prevent complications associated with dry mucous membranes and compromised dentition.
 - Interventions related to skin integrity and personal hygiene to minimize pain and anxiety, and consider the resident’s underlying illnesses and progressive decline.
 - The resident receiving palliative care at the end of life may require adjustments in the frequency and intensity of measures such as turning and positioning, as well as the use of additional or alternative interventions to enhance comfort (e.g., pressure reducing mattress).
 - The facility addresses the risk of skin breakdown and manages existing wounds unless these prevention and treatment measures are not feasible or cause the resident a degree of discomfort that is greater than the benefit from the care.
 - Medical Treatment –
 - When the resident is approaching the end of life, it is appropriate to reevaluate the benefits and burdens of any

Notes:

Hospice, End of Life and/or Palliative Care Critical Element Pathway

Care Planning

medical treatment, and to consider discontinuing those treatments where the burdens outweigh the benefits.

- Diagnostic tests and monitoring. Although tests may help confirm an individual's prognosis or guide treatment decisions, decisions about diagnostic tests and medical procedures should be related to the resident's prognosis, values and goals, as well as comfort and dignity. It is often appropriate to discontinue or greatly reduce the frequency of routine tests and monitoring and to use the least intrusive tests possible.
- Treatments. Palliative care treatment at the end of life focuses on symptom management (e.g., controlling nausea, vomiting, uncomfortable breathing, agitation, and pain). Simple cause-specific interventions may sometimes provide effective palliation (e.g., resolving abdominal pain by reducing doses of medications with high anticholinergic properties that may lead to constipation or intestinal ileus).
- Medications/Drugs. It is important that use of medications be consistent with the goals for comfort and control of symptoms and for the individual's desired level of alertness. Review the continued need for any routine administration of medication and adjust or discontinue as may be appropriate. Routes of administration of medications may also need to be modified. Medication doses may need adjustment to attain desired symptom relief, while still considering whether side effects such as sedation and nausea are tolerable and consistent with the resident's wishes or that of his/her legal representative.
- Nutrition/Hydration –
 - A resident receiving palliative care at the end of life may experience a decline in appetite or have difficulty eating or swallowing. It is important to provide desired food and fluids in the form and frequency that best enable the resident to

Hospice, End of Life and/or Palliative Care Critical Element Pathway

Care Planning

consume them. Previous dietary restrictions may be unnecessary for the resident and may negatively impact quality of life or comfort.

- The determination of whether to use artificial nutrition and hydration, when a terminally ill resident's condition has progressed to the point where he or she may no longer chew or swallow his or her food, is made by the resident, or the resident's legal representative, consistent with applicable state law and regulation.
- Activities –
 - Consistent with the resident's interest, level of energy, and ethnic and cultural traditions associated with death and dying (e.g., visits from spiritual leaders and other individuals of the same religious/ethnic background; special spiritual ceremonies; reading or sharing information about the resident's culture).
 - As death approaches, activities that help provide comfort and symptom relief and those that require less conscious participation, rather than group or interactive activities, may be most appropriate. It is often helpful to involve the family or those with significant relationships with the resident in such activities, if possible.
- Psychosocial –
 - Identify psychosocial interventions that are pertinent to the needs of the dying resident (e.g., treatment for depression, , anxiety, loneliness, restlessness or bereavement) and approaches to providing support to the resident (e.g., visits by family and others expanding visiting hours and providing desired privacy).
- Environmental –
 - Promote resident comfort based on resident preferences (such as low level lighting and minimal background noise, etc.).

Hospice, End of Life and/or Palliative Care Critical Element Pathway

Care Planning

- If the resident refuses or resists staff interventions to manage symptoms and the needs identified in the assessment, determine if the record reflects efforts to seek alternatives.

If a resident is receiving hospice care:

- When hospice services are involved, the facility and hospice are jointly responsible for developing a coordinated plan of care for the resident that guides both providers and is based upon their assessments and the resident's needs and goals.
- The coordinated plan of care must identify which provider (hospice or facility) is responsible for various aspects of care.
- The hospice and the facility must have a process by which they can exchange information from their respective plan of care reviews, assessment updates, and patient and family (to the extent possible) conferences, when updating the plan of care and evaluating outcomes of care to assure that the resident receives the necessary care and services.
- The facility's services must be consistent with the plan of care developed in coordination with the hospice (i.e., the hospice patient residing in a facility should not experience any lack of services or personal care because of his/her status as a hospice patient).
- The facility must offer the same services to its residents who have elected the hospice benefit as it furnishes to its residents who have not elected the hospice benefit. As such, the facility continues to have responsibility for providing the resident's overall care and comfort, including, for example, providing general medical and nursing care, assisting with ADLs, administering medications, giving personal care, providing activities, if desired, and maintaining the cleanliness of the resident's room.
- The hospice program is also responsible for assessing the resident and identifying the physical, psychosocial, emotional, cultural, and spiritual needs related to the terminal illness that must be addressed in order to promote the resident's well-being, comfort, and dignity

Hospice, End of Life and/or Palliative Care Critical Element Pathway

Care Planning

throughout the dying process.

- The facility is responsible for notifying the hospice when the resident experiences a significant change in physical, mental, social, or emotional status, or needs to be transferred from the facility.
- In order to ensure that each provider meets its responsibilities, it is essential the facility and hospice have a means to communicate how all needed services, professionals, medical supplies, DME, drugs and biologicals will be made available to the resident 24 hours a day, 7 days a week, including who may receive and/or write orders for care, in accordance with State/Federal requirements.

***NOTE:** If the resident has elected the Medicare and/or Medicaid hospice benefit and concerns were identified with coordinated plan of care or management of the resident's care, verify that the hospice was advised of the concerns. After verifying that the hospice was advised of concerns by the facility and the hospice failed to resolve issues related to the management of a resident's care, coordination of care or implementation of appropriate services, file a complaint with the State Agency responsible for oversight of hospice programs, identifying the specific resident(s) involved and the concerns identified.*

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 or the resident was just admitted and the comprehensive care plan is not required yet**

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

Hospice, End of Life and/or Palliative Care Critical Element Pathway

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>3. Did the facility provide or arrange services to be provided by qualified persons in accordance with the resident’s written plan of care and did the facility implement the care plan adequately and/or correctly? <input type="checkbox"/> Yes <input type="checkbox"/> No F282</p> <p><input type="checkbox"/> NA, no provision in the written plan of care for the concern being evaluated</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 an actual or potential outcome.</i></p>	<p>Notes:</p>

Care Plan Revision	
<p><i>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”.</i></p> <p><input type="checkbox"/> When the resident is nearing the end of life, it is important that the physician/practitioner and interdisciplinary team review or update the prognosis with the resident and/or the resident’s legal representative and review and revise the care plan as necessary to address the resident’s situation, including expectations and management of specific symptoms and concerns.</p> <p><input type="checkbox"/> 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 preferences/choices, response and outcome.</p>	<p>Notes:</p>

Hospice, End of Life and/or Palliative Care Critical Element Pathway

Care Plan Revision	
<p><input type="checkbox"/> 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.</p> <p><i>If a resident is receiving hospice care:</i></p> <p><input type="checkbox"/> Evaluation and revision of the care plan is coordinated between hospice and the facility;</p> <ul style="list-style-type: none"> ▪ 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. <p>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?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No F280</p> <p><input type="checkbox"/> NA, the comprehensive assessment was not completed OR the care plan was not developed.</p>	

Provision of Care and Services	
<p>Determine whether staff have:</p> <p><input type="checkbox"/> Assessed the resident’s clinical condition, risk factors, and preferences and identified the resident’s prognosis and the basis for it.</p> <p><input type="checkbox"/> Initiated discussions regarding advance care planning and resident choices to clarify resident goals and preferences regarding treatment at the end of life.</p> <p><input type="checkbox"/> Recognized and advised the resident and/or the resident’s legal representative that the resident was approaching the end of life and, if the resident was not already receiving palliative care, advised that</p>	<p>Notes:</p> <p>Written agreement describing the responsibilities between hospice and the NH. (does not need to be resident-specific).</p>

Hospice, End of Life and/or Palliative Care Critical Element Pathway

Provision of Care and Services

care appropriately be shifted to a palliative focus.

- Defined and implemented resident-directed care, treatment interventions, services, and support, consistent with the resident's choices, rights, goals, and the recognized standards of practice, in the attempt to manage pain and other physical and psychosocial symptoms and meet the resident's psychosocial and spiritual needs.
- Communicated the resident's goals and preferences to the facility interdisciplinary team, as well as the hospice, emergency department, hospital or home health team in the event of a transfer.
- Monitored and evaluated the impact of the interventions provided to address the resident's end of life condition and revised the approaches as appropriate.

***NOTE:** Most deficiencies related to end of life 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 F309 only when other regulations do not address the noncompliance.*

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 resident at the end of life 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?

Yes No **F309**

Hospice, End of Life and/or Palliative Care Critical Element Pathway

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.

- F154, Notice of Rights and Services** – Determine if the resident was fully informed in language he/she understands of his/her total health status.
- F155, Rights Regarding Treatment, Experimental Research and Advance Directives** – For concerns regarding the resident’s right to refuse treatment, to participate in experimental research, and to formulate an advanced directive.
- Notification of Change** – Determine if the facility immediately informed the resident/legal representative, physician, and agency contracted to provide end of life care (if applicable) regarding a resident’s change of condition.
- F172, Access and Visitation Rights** – Determine if the facility limited visitation rights, which did not infringe upon the rights of other residents, of the end of life resident.
- Admission, Transfer and Discharge Requirements** – Determine if the end of life resident was allowed to remain in the facility unless his/her needs could not be met.
- Choices** – Determine if the facility honors the resident’s specific values, wishes and goals regarding end of life treatment and services.
- F246, Accommodation of Needs** – Determine if the resident received appropriate treatment and services, including assistive devices, to enhance the resident’s comfort and dignity.
- Activities** – Determine if activities are consistent with the resident’s interest, level of energy, and ethnic and cultural traditions associated

Notes:

Hospice, End of Life and/or Palliative Care Critical Element Pathway

Provision of Care and Services

with death and dying.

- Social Services** – Determine if the facility provided the needed social services, for example, to identify a substitute decision making method in accordance with state law; to give the resident or the resident’s legal representative information on available services such as support groups and bereavement services or to assist in settling the resident’s affairs (e.g., disposition of the resident’s belongings, organ donations, or funeral arrangements).
- Activities of Daily Living** – Determine where the facility is providing support for activities of daily living to enhance the resident’s comfort and dignity.
- Respiratory Care** – Determine if the resident received proper care and services for respiratory care.
- Unnecessary Medications** – Determine if the medication regimen consistent with the goals for comfort and control of symptoms and for the individual’s desired level of alertness.
- Sufficient Staff** – Determine whether the facility has employed qualified nursing staff in sufficient numbers to fulfill their assistive role in transportation, ADL assistance, etc., to facilitate the resident's choices (staff are not giving baths at a specific time/day because of short staffing).
- F385, Physician Supervision** – Determine if the resident’s care is supervised by a physician and another physician supervises medical care when the attending physician is unavailable.
- F501, Medical Director** – Determine if the medical director , develops, implements, and modifies (as needed) policies and procedures to identify, assess and manage potential palliative care conditions, including pertinent interventions that are consistent with current standards of practice.