MINUTES OF THE MEETING OF THE HUMAN SERVICES COMMITTEE
March 21, 1983

The meeting of the Human Services Committee held on March 21, 1983, in Room 224 A of the Capitol Building, at 12:30 p.m., was called to order by Chairman Marjorie Hart. All members were present, except Reps. Farris, Menahan and Winslow, who were absent.

SENATE BILL 208

SEN. JACOBSON, sponsor. This is a bill to provide for licensure of hospice programs and was introduced at the request of the Hospice Exchange Council to further hospice development in the state of Montana. She read through the bill with the Committee.

PROPONENTS:

ROGER TIPPY, representing the Montana Hospice Exchange, urged support of SENATE BILL 208. He stated that Congress' recognition of hospice as a reimbursable service under medicare gives them reason to ask the Legislature to license hospice programs. Nothing in this bill calls for the licensing or certification of any individual or any profession (EXHIBIT 1).

SUE TWIDWELL, representing the Montana Hospice Exchange Council, spoke in support of the hospice legislation. This organization is a group of thirteen individual hospice units each developed to fit the situation within their own communities. This past year, the Montana Hospice Exchange has felt they need to license hospices in order to help protect consumers that might be using hospice services. With the impending reimbursement from the federal government, they could see some potential problems and they wanted to bypass those with a licensing procedure. The three models for licensing standards were presented to the Committee (EXHIBIT 2).

BONNIE ADDY, department head of Hospice of St. Peter's, Helena, urged support of this bill.

OPPONENTS: None

SEN. JACOBSON closed saying it is very important that our hospices are of very fine quality and she felt this licensing bill is very important.

QUESTIONS:

REP. SWIFT: Is it necessary to have this license in order to get reimbursement.
ROGER TIPPY: No.

CHAIRMAN HART: Would the people who are going to be licensed be reimbursed?
SEN. JACOBSON: The federal government has allowed that any hospice, if they go through certain procedures and meet certain requirements, can be reimbursed. Many of our organizations are still small and they are not certain whether they want to go through the reimbursement or stay on a voluntary basis. They would have that option available to them. Even if you don't license hospices, they can still go for federal reimbursement but they would have to be accredited through the Denver office. We would like to see Montana get in on the ground floor.

REP. SOLBERG: Do you have inspections?
SUE TWIDWELL: At the present, there is no survey or inspection of any kind. We would ask that the Department of Health send a survey team to look at the books and the way of operation to see if they are in line with those established by the department.
ROGER TIPPY: Under a law passed two years ago, if a hospital has accreditation from the Joint Commission on Accreditation of Hospitals, then the state health department is bound by that inspection. As long as the hospital maintains accreditation with JCAH, the state will not come in. Some would be inspected by being brought under licensure from the department. If they have JCAH accreditation, they would be inspected by JCAH but not by the state.

CHAIRMAN HART: Does it seem to work better if the hospice is related to the hospital?
SUE TWIDWELL: There are advantages and disadvantages to both types of programs and they are about evenly distributed throughout the state. The hospital based hospice is usually a department of the hospital and their survival and staff (salaries, etc.), are met as a department of ths hospital. An independent hospice is dependent upon the community for its monetary base through donations and memorials.

REP. HANSEN: How many different hospices do we have in Montana.
SUE TWIDWELL: Thirteen. Ten are performing and providing full service; the other three are in their formation stages.

REP. HANSEN: Is it mostly in the urban areas.
SUE TWIDWELL: In the past, it has been mostly in the larger communities but now the smaller communities are getting involved.

REP. BRAND: If you are under this legislation, will this mean you are going to be providing some health care facilities for medicaid and medicare?
SUE TWIDWELL: Not necessarily. This is simply to license every hospice in the state of Montana. The federal government has gotten into this act by amending the Medicare Act federally to make hospice service a reimbursable service.
REP. BRAND: What about the state of Montana? Would they participate in the reimbursement program?
SUE TWIDWELL: I don't know yet. We may have to in order to survive.

REP. BRAND: When you go into one of these homes, does that person help pay for the expenses or is it all voluntary money?
SUE TWIDWELL: It depends on the type of program that it is. A lot of hospital-based hospices and home-health based agency hospices are already medicare and medicaid certified. There are specific areas that they can be reimbursed for.
REP. BRAND: How many of those are there in the state?
SUE TWIDWELL: Probably two. Our independent community based--we do not charge anything at all. We ask for donations and memorials.

REP. HANSEN: In your licensing procedure, is this just for medically trained professionals or will this also license your volunteers who are not nurses?
SUE TWIDWELL: This would license the program--not individuals. I would anticipate some standards established that volunteers would meet a certain minimum criteria of education.
REP. HANSEN: You would still continue to use someone who was interested in the program trained by the hospice program.
SUE TWIDWELL: Yes. We have to have the volunteers. They are the backbone of the program.

CHAIRMAN HART closed the hearing on SENATE BILL 208.

REP. BROWN will carry SENATE BILL 208 on the House floor.

SENATE BILL 214

SEN. SMITH, sponsor. This bill was carried by CURT CHISHOLM, Department of Institutions, who said that SENATE BILL 214 is the companion bill to SENATE BILL 395 which gives rulemaking authority to the Department of Social and Rehabilitation Services to certify professionals in field of developmental disabled. SENATE BILL 214 gives the Department of Institutions new rulemaking authority as it relates to certifying mental health professionals. We are also eliminating references to

certain kinds of criteria in the law simply because it would be better if, through our rulemaking authority, we get more specific kinds of criteria developed to clarify the kinds of things we will be looking at in order to certify a mental health professional. What this mental health professional entity is--it is a unique kind of qualifications which contains both the Mental Health Act and the Developmental Disability Act. Mental health professionals are the only people who can testify in a court of law as to the seriousness of a mental disease or the only one that can testify as to what kind of treatment environment this person needs.

JUDITH CARLSON, Department of Social and Rehabilitation Services, urged support of this legislation.

OPPONENTS:

REP. BRAND stated that the reason he was opposing the rulemaking procedure was they are taking the law out of the hands of the Legislature and putting it into their own hands. He did not agree with rulemaking by departments.

JERRY LOENDORF, representing the Montana Medical Association, said he would like to go through the amendments. Page 2, lines 22-25 - definition of a professional person--the language that was stricken is how a person is now defined "trained in the field of mental health and certified by the department in accordance with standards of professional licensing boards, federal regulations, and the joint commission on accreditation of hospitals". The next phrase tells you "a person who has been certified as provided for in [section 3] by the department" only. In referring to section 3, page 4, lines 15-18, we start to go in a circle. Section 3 says, "The department shall certify professional persons as defined in 53-21-102(10)(b) which is the language we just read. A further amendment, page 4, line 19, simply eliminates the Department of SRS. What that says--the Department with reference to recognized national standards in the field of mental health shall certify standards or rules governing certification of professional persons as defined back in the section we just read. It seems we have substituted "recognized national standards". What are "recognized national standards"? Who recognizes them? Why aren't they presented with this bill? If we go back again to page 2, lines 22-25, we can see what we are substituting "recognized national standards" for. The standards now are the standards of the Professional Licensing Board of the state of Montana. How would these "national recognized standards" be different from that now required? We can't tell from reading this bill what is supposed to be done.

JAMES JOHNSON, representing Montana Legal Services, had the same concerns as JERRY LOENDORF. The Supreme Court was very much concerned because a person had been allowed to testify as a professional person that they did not feel was qualified. He thought these amendments were going to allow for better rules regarding certified professionals.

CURT CHISHOLM closed stating they eliminated reference to the national standards that were already in the Act because they are trying to amend the bill to get it back to what the author wanted in the first place. The Joint Commission on Accreditation of Hospitals (JCAH) accreditation standards do not recognize, nor are they aware of, the specific kinds of issues in the Mental Health Act and the Developmental Disability Act. National standards do not recognize that Montana has a unique provision in the law that allows, besides doctors, other kinds of practioners to be certified under the Mental Health Act and the Developmental Disability Act. We have to come up with very precise kinds of definitions. There are a lot of professional people who are professionally trained who do not want to apply to be professional people because they don't want to go into court to testify is a person is mentally ill or not. That is the purpose for these rules. We will develop special criteria for those people who want to be certified as mental health professionals. We have been doing it since 1975 and we simply want to clarify our rulemaking authority by the passage of this bill. We hope to be able, through training and working with various licensing boards,to come up with better criteria.

QUESTIONS:

REP. KEYSER: Because of the language the Senate cut out, we are running around in circles. If the language in the Statement of Intent were incorporated into the bill under the certification of professional persons, I wouldn't have a problem.
CURT CHISHOLM: We don't have any problem with that at all if it was incorporated into the body of the law.

REP. JONES: What are you going to do with REP. BRAND's bill and you don't have a Department of Institutions?
CURT CHISHOLM: Since we never anticipate what the Legislature will do, this could still be changed by the Code Commissioner.

REP. FABREGA: Regarding JERRY LOENDORF'S comments, if the opinion of the department is a fact then the opinion becomes a fact in Section 3. He realized in Section 3, rules are being adopted--but isn't that going around it?
CURT CHISHOLM: I guess that it is. The meat of the bill is subsection 2 of Section 3 that says we will develop these rules with reference to recognized national standards in the field of mental health and shall adopt standards and rules governing the certification of professional persons as defined in 53-21-102(10)(b). The reference is to say that a professional person is a person that is certified by the department; but it has to be a person that is certified against whatever standards we are able to come up with referencing other professional organizations.

REP. FABREGA: How much of an idea do you have at this time as to how much those rules are going to change. Could you, before the session adjourns, come up with the kinds of rules so we could go back to REP. KEYSER'S recommendation regarding the Statement of Intent?
CURT CHISHOLM: We could suggest that the statement that is in the Statement of Intent be incorporated into the body of the bill. I think we need a dual standard in certifying professional persons--one that relates to a certain level of expertise that will allow these people to testify in court and be recognized in court as someone who knows what they are talking about and another standard that would relate to perfunctory things a professional person needs to do.

CHAIRMAN HART closed the hearing on SENATE BILL 214.

SENATE BILL 324

SEN. TOWE, sponsor. This bill would establish a treatment center for mentally ill youth. The bill restricts admissions to the center and to Warm Springs state hospital, and addresses the disposition of mentally ill "youth in need of supervision". The Department of Institutions is required to adopt rules addressing the operation of the Montana Youth Treatment Center, including admission, treatment, and discharge provisions. He stated that people can be committed only by court commitment. Children cannot voluntarily commit themselves because they can't make those kinds of decisions.

PROPONENTS:

CURT CHISHOLM, Department of Institutions, said this bill was introduced in order to get an enabling section of law that recognizes the new children's units. We tried to precisely clarify what the omission of that program will be and the method by which they are admitted to the facility. He urged passage of this bill.

JERRY LOENDORF, Montana Medical Association, wanted to go on record as being in support of this bill.

OPPONENTS: None

SEN. TOWE closed.

QUESTIONS:

REP. FABREGA: How about the fiscal impact. Is the $1 million incorporated in the Governor's budget?
SEN. TOWE: Yes; that is just transfer of funds from one agency to another. The new program will cost more money to operate than previously, but that is already figured in.

REP. KEYSER: How many children do you have at the Reception Evaluation Center at Galen?
CURT CHISHOLM: We don't have any at all.

REP. BRAND: How many other states have separation and relocation for the mentally ill.
CURT CHISHOLM: I am not sure. Some states have a special unit for emotionally disturbed children. If states want to operate an inpatient psychiatric care hospital for children, it is operated distinctly and separately from the rest of the campus.
REP. BRAND: In surrounding states, that is the cost factor for the patients.
CURT CHISHOLM: I am not sure. I have no comparison.
REP. BRAND: When these children become 18-21 years of age, where will these children go?
CURT CHISHOLM: In Montana, they would go to the adult psychiatry ward of Warm Springs State Hospital.
REP. BRAND: Are you going to have to transport them from one facility to another? Which facility would be charged for those costs:
CURT CHISHOLM: It would be the reponsibility of the sending agency to the Youth Treatment Center to transport a patient to Warm Springs State Hospital and that would be part of their transportation budget costs.

REP. BRAND: How many mentally disturbed people do we have out of state that Montana taxpayers pay for.
CURT CHISHOLM: Approximately 30 are being served under the age of 18. Not all of those are mentally ill. Some of those are autistic children who are being sent to specialized programs.
REP. BRAND: Is it because of the thirty bed facility at Warm Springs and the 30 out-of-state that you are going to fill up right away.
CURT CHISHOLM: Some people don't feel that the program they operate at Warm Springs is adequate.
REP. BRAND: The facilities you send them to out-of-state, are they separated from the adult. Who is paying for those costs?
CURT CHISHOLM: We are not sending them out of state. Sometimes they are sent by the family; sometimes they are sent on the recommendation of the school district. We are just on the receiving end of those kinds of things. As far as who is paying for the costs--I am not sure.
REP. BRAND: That means that these children may not be back in the state of Montana.
CURT CHISHOLM: That is correct.

REP. HANSEN: How did you arrive at the age of 12 as your breaking point?
CURT CHISHOLM: That was a judgment decision that we made with a lot of input through the certificate of need process with a Justice Counsel and an interagency committee that helped us deal with children in an institutional setting. It was their opinion that up through the age of 12, just being able to physically deal with a youth that might be physically and emotionally disturbed, a youth might have a lot of psychotic problems. Up to the age of 12, children do not need the security measures they need up to the age of 18.

CHAIRMAN HART closed the hearing on SENATE BILL 324.

REP. DOZIER will carry SENATE BILL 324 on the House floor.

EXECUTIVE SESSION

SENATE BILL 324

REP. FABREGA: Moved that SENATE BILL 324 BE CONCURRED IN.

The motion was voted on and PASSED with REPS. BRAND and KEYSER voting no. REPS. DARKO and CONNELLY voted yes by proxy.

SENATE BILL 208

SEN. JACOBSON, sponsor. This bill would provide for the licensure of hospice programs.

REP. DOZIER: Moved that SENATE BILL 208 BE CONCURRED IN.

The vote was taken and PASSED UNANIMOUSLY. REPS. DARKO and CONNELLY voted yes by proxy.

REP. JAN BROWN will carry SENATE BILL 208 on the House floor.

SENATE BILL 446

SEN. THOMAS, sponsor. This bill is an act clarifying and further defining the services to be provided by personal-care facilities and establishing restrictions on eligibility for residency in such facilities.

REP. FABREGA; Moved that the Committee RECONSIDER its action on SENATE BILL 446.

The motion was voted on and PASSED with REP. BRAND voting no.

REP. FABREGA: Moved that "consistent with the provisions of this act" be added to the insertion, page 1, line 25, following "responsibility".

REP. FABREGA: Moved to strike two amendments:

Page 2, line 6.
Following: "(2)"
Insert: "(a)"
Following: "2]"
Insert: "and subsection (2)(b)"

Page 2.
Following: line 9.
Insert: "(b) Subsection (1)(a) applies only if the resident is a recipient of medical services, as provided under 53-6-111, and delivered by a home health agency, as defined in 50-5-101 or who is a recipient of medical assistance as provided under 53-6-111 (and HB 424]."

ROSE SKOOGS: What we have agreed to is eliminate page 2, subsection (2), lines 6-9 including the amendments that were added to that section. SRS's concern was they wanted to limit and consistent with part of it. If they limited it to section 1, would they have to be consistent with section 2. As we looked at the bill, we felt that what was in that position is reiterated down below describing rules that the Department of Health will promulgate. We felt that the concerns that subparagraph (2) were trying to address were already taken care of somewhere else.

REP. SWIFT: Is this in agreement with the Department of SRS?
JUDITH CARLSON: We agree.
JUDY OLSON, Nurses Association: We agree.

REP. FABREGA: Moved that the amendments be accepted.

The motion was voted on and PASSED UNANIMOUSLY.

REP. FABREGA: Moved that SENATE BILL 446 BE CONCURRED IN AS AMENDED.

The motion was voted on and PASSED UNANIMOUSLY.

SENATE BILL 150

SEN. STORY, sponsor. This bill would provide that for privately owned public swimming pools, no lifeguard is required if warning is given.

REP. DARKO: Moved to TABLE SENATE BILL 150.

The motion was voted on and PASSED with REPS. KEYSER, JONES, SOLBERG and SWIFT voting no.

SENATE BILL 193

SEN. CONOVER, sponsor. This bill provides that current medical practice must be referred to in determining standards for use of medication.

It was the consensus of the Committee to LEAVE SENATE BILL 193 ON THE TABLE.

The meeting was adjourned.

Marjorie Hart
CHAIRMAN MARJORIE HART

Gini Bussett
Secretary

Ex 1
SB 208

NAME: Roger Tippy DATE: March 21, 1983

ADDRESS: P. O. Box 514

PHONE: 442-8070

REPRESENTING WHOM? Montana Hospice Exchange

APPEARING ON WHICH PROPOSAL: Senate Bill 208

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENTS: Mr. Chairman and committee members, I am Roger Tippy, an attorney here in Helena, representing the Montana Hospice Exchange Council as its lobbyist. I urge your concurrence in SB208.

The hospice movement has been active in Montana for several years; Congress' recognition of hospice as a reimbursable service under medicare gives us reason to ask the legislature to license hospice programs.

Not people, programs. Nothing in this bill calls for the licensing or certification of any individual or any profession. We ask you to add one small duty to an existing agency: the Facilities Licensing and Certification Bureau within the Department of Health and Environmental Sciences. The duties involved -- promulgating a set of standards in the Administrative Rules of Montana and issuing licenses to hospice programs meeting those standards -- no fiscal impact attaches to this bill.

The Hospice Council has endeavored to discuss this bill with other concerned providers and to accommodate their views. Section 2, paragraph (2) is a statement inserted at the request of the Home Health Agencies association. Section 3 has been worked out with the Montana Hospital Association to alleviate their concerns about multiple inspections and multiple licenses.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Ex.2
S.B. 208

HOSPICE..... A COORDINATED PROGRAM OF HOME AND INPATIENT HEALTH CARE THAT PROVEDES OR COORDINATES PALLIATIVE AND SUPPORTIVE CARE TO MEET THE NEEDS OF A TERMINALLY ILL PERSON AND HIS FAMILY ARISING OUT OF PHYSICAL, PSYCHOLOGICAL, SPIRITUAL, SPCIAL, AND ECONOMIC STRESSES EXPERIENCED DURING THE FINAL STAGES OF ILLNESS AND DYING AND THAT INCLUDES FORMAL BEREAVEMENT PROGRAMS AS AN ESSENTIAL COMPONENT.

HISTORY OF HOSPICE

1967 Dr. Cicely Saunders, Medical Director of St. Christopher's Hospice, London admitted first hospice patient.

1974 New Haven Hospice, first in the United States, opened with state approval of their home care program.

1978 First Annual Hospice Meeting 75 hospice programs attended
1. Dr. Saunders stressed the need for standards and criteria to preserve the integrity of hospice
2. National Standards and Accreditation committee formed

1978 Dept. of Health, Education and Welfare funded 26 hospice demonstration projects to determine the efficacy of hospice care for terminally ill persons/families

1980 Specific Standards of Care were accepted at the annual meeting.

1981 Discussion of third-party reimbursement studied by NHO

1982 Admendment to the Medicare Act introduced and passed by Congress allows reimbursement for hospice care for Medicare recipients
Joint Commission on the Accrecidation of Hospitals (JCAH) presented standards to NHO meeting.
NHO membership endorsed JCAH standards of care
800 identified hospice programs nationwide.

SERVICES OF A HOSPICE PROGRAM

- 24 hours a day, 7 days a week on-call nurses for crisis intervention
- liaision between patient/family and physician
- coordination of appropriate community services
- control of distressing symptoms and pain
- respite for the person assuming the responsibility of care

PERSONS INVOLVED ON THE INTERDISCIPLINARY TEAM

patient and family members
patient's attending physician
hospice nurses, volunteers
others as needed such as:
social workers, counselors, clergy
physical therapist, dietician

LICENSING

April 1982... Nine states had some type of hospice-specific legislation
February 1983 Nine states had hospice-specific legislation pending

WHY LICENSING?

- The Federal govermnemt will begin reimbursing hospices for Medicare recipients Nov. 1083
- Montana Hospice providers anticipate that Federal standards for reimbursement will not allow the flexability which may be necessary to deliver care in a rural state.
- State licensing will assure quality of care in Montana by reviewing programs which may choose not to seek Medicare reimbursement.
- State licensing process includes a review of the need for service in a given area.

POSSIBLE STANDARDS MODELS

- National Hospice Organization Standards
- Joint Commission on the Accreditation of Hospitals Standards

GOAL NINE

There is an active inpatient facilitywide or unitwide infection control plan.

RATIONALE

Patients/families, team members, and personnel are entitled to a sanitary and comfortable environment in which measures are taken for the prevention of the development and transmission of infection.

CHARACTERISTICS

1. There is a written plan for the prevention and control of infection and the maintenance of a sanitary environment. The plan pertains to at least the following:

   A. The designation of interdisciplinary personnel responsible for implementing and monitoring the program;
   B. The review of procedures for handling food, processing laundry, disposing of environmental and human wastes, controlling pests;
   C. The review of patient/family care practices, visiting rules for high-risk areas, and access to potential sources of infection;
   D. The monitoring of the health status of employees; and
   E. The monitoring of staff performance to assure that policies and procedures are being followed.

2. There are written policies and procedures for aseptic and isolation techniques, the policies and procedures are

   A. made known to and followed by all staff; and
   B. reviewed annually and revised as necessary.

3. An adequate amount of linen is available at all times for the proper care and comfort of patients.

   A. The linen is handled, processed, stored, and transported in a manner that prevents the transmission of infection.

4. The facility or unit is free of insects and rodents.

GOAL TEN

The inpatient facility or unit provides for the nutritional and special dietary needs of patients/families.

RATIONALE

Hospice care recognizes not only the nutritional and dietetic needs of patients/families, but also the psychological importance of food. The elements of alienation and isolation that may be experienced in an inpatient setting can be reduced with the provision of facilities that increase socialization for patients/families, while meeting patients' nutritional needs.

CHARACTERISTICS

1. Safe, sanitary, and adequately equipped facilities for food preparation by patients/families are provided.

2. Dietetic services are provided directly by the facility or unit or under arrangement with an outside foodservice or management company.

3. Dietetic services are directed by an individual who, by education or specialized training and experience, is knowledgeable in foodservice management.

4. The nutritional aspects of patient care are supervised by a dietitian who is registered by the Commission on Dietetic Registration of the American Dietetic Association or has the documented equivalent in education, training, and experience, as well as evidence of continuing education.

5. The duties of the supervisor of dietetic services include, but are not limited to, the following:

   A. Patient/family consultation;
   B. Participation in patient/family case conferences, as requested;
   C. Approval of menus, including special diets; and
   D. Nutritional assessments of patients.

6. If dietetic services are provided by the facility, the following applies:

   A. The department or service is organized, directed, and staffed to assure the provision of optimal nutritional care and foodservice.
   B. Dietetic personnel are appropriately trained and educated; and
   C. The dietetic department or service area is designed and equipped to provide safe, sanitary, and timely foodservice and to meet the nutritional needs of patients

7. Dietetic services are guided by written policies and procedures.

8. Dietetic services are provided to the patient in accordance with a written order by the attending physician. Appropriate dietetic information is recorded in the patient's/family's medical record.

9. The quality and appropriateness of the nutritional care in meeting the nutritional needs of patients/families are regularly reviewed and evaluated.

GOAL ELEVEN

The pharmaceutical needs of patients are met by the hospice program.

RATIONALE

An integral part of hospice home care and inpatient services is pain and symptom management, and essential to this element of care is meeting the pharmaceutical needs of the patients. Patients/families are entitled to pharmaceutical services that are conducted in accordance with accepted ethical and professional practices and all legal requirements.

CHARACTERISTICS

Home Care and Inpatient Services

1. Only health care practitioners who are authorized by law to write medication orders may do so.

2. Medication orders that contain abbreviations and chemical symbols are filled only if the abbreviations and symbols are on a standard list approved by the medical director and/or medical staff.

3. An individual other than a physician, registered nurse, or licensed practical nurse may administer medications under the supervision of a registered nurse or licensed practical nurse if in accordance with applicable laws and regulations and hospice program policy, and if approved by the attending physician.

4. Self-administered medication is permitted when specifically ordered for the patient by an approved prescriber in accordance with applicable laws and regulations.

5. Before discharge from inpatient services, the patient/family is instructed as to which medications, if any, are to be administered at home and by whom. The patient/family is also instructed as to the preparation, administration, dosages, and precautions to be taken.

6. The medications administered and any adverse drug reactions are documented in the medical record and are periodically reviewed by the attending physician.

7. There is a written policy and procedure regarding medication error follow-up and documentation of any corrective action taken.

8. There are up-to-date resources available to interdisciplinary team members to identify drug side effects and toxic reactions.

9. There is a reporting system for advising the Food and Drug Administration and the drug manufacturer of any unexpected or significant adverse reactions to a drug

10. Investigational drugs are used only under the direct supervision of an authorized investigator and with the approval of the medical director and the Institutional Review Board. (When hospice inpatient services are provided in a hospital, the hospital's procedures regarding investigational drugs supercedes this standard.)

11. All medication orders are reviewed in accordance with applicable regulations.

12. The pharmacist is experienced in or receives orientation in the specialized functions of the hospice program.

13. The pharmacist is licensed in the jurisdiction of the hospice program.

14. The pharmacist participates in the development of inservice education programs for the hospice program staff.

Inpatient Services

15. Pharmaceutical services for the inpatient facility or unit are provided directly by the facility or the unit or under arrangement.

16. A licensed pharmacist experienced in institutional pharmacy practice is responsible for the development of written policies and procedures to govern the storage, preparation, distribution, and administration of drugs in accordance with applicable federal, state, and local laws and regulations, regardless of the arrangement made for services.

17. A pharmacist makes at least weekly inspections of all drug-storage units, including the emergency cart.

18. In inpatient facilities or units where pharmaceuticals are provided through a community pharmacy, medications are obtained by written prescription from an authorized prescriber only.

19. Any drug brought into the inpatient facility or unit is not administered unless it can be identified, unless a written order to administer it is given by the attending physician, and unless it is judged physically and chemically stable by the pharmacist.

20. The inpatient facility or unit utilizes a drug profile, and a pharmacist regularly reviews the medication records of patients.

21. The inpatient facility or unit has specific policies and procedures for controlling and accounting for drug products. The procedures account for drugs ordered and drugs on hand, as well as their effectiveness dates.

22. Adequate precautions are taken to store medications under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security.

23. Drug preparation and storage areas are secure and well lighted.

GOAL TWELVE

The inpatient facility or unit provides, or has delineated access to, radiology services for patients.

RATIONALE

Diagnostic and therapeutic radiology services are necessary for effective pain and symptom management. Radiology services should be conveniently available to meet these needs, as determined by the medical staff, and provided in accordance with accepted professional practices and all legal requirements.

CHARACTERISTICS

1. When radiology services are provided by a facility or unit the type of radiology service available and the arrangements for referring and transferring patients is delineated in a written plan.

2. When radiology services are provided by the hospice inpatient facility or unit, the following apply:

   A. Written policies and procedures govern the operation and inspection of the services, as stated in applicable regulation;
   B. The services are directed by a physician member of the facility staff who is qualified through education and/or experience to assume this function;
   C. Provision is made for appropriate facilities for radiographic and flouroscopic diagnostic services; and
   D. An acceptable method of quality control is used.

GOAL THIRTEEN

The hospice inpatient facility or unit provides, or has delineated access to, pathology and laboratory services in accordance with the needs of patients, the size of the facility or unit, the services offered, and the resources available in the community.

RATIONALE

Pathology and laboratory services are necessary for pain and symptom management. These services should be conveniently available to meet the needs of patients as determined by the medical staff and provided in accordance with accepted professional practices and all legal requirements.

CHARACTERISTICS

1. The means of providing pathology and laboratory services are delineated in a written plan.

2. When pathology and laboratory services are provided by the hospice inpatient facility or unit, the following apply:

   A. Written policies and procedures govern the operation and inspection of the services, as stated in applicable regulations;
   B. The services are directed by a physician member of the facility or hospital staff who is qualified through education and/or experience to assume this function; and
   C. An acceptable method of quality control is used.

GOAL FOURTEEN

The hospice inpatient facility or unit has a written plan delineating the manner in which emergency services are provided.

RATIONALE

Patients/families, staff, and visitors are entitled, at the least, to lifesaving first aide, as deemed appropriate, and referral and ready access to the nearest facility that has the capability of providing emergency services.

CHARACTERISTICS

1. When emergency services are provided by a facility or unit other than the hospice inpatient facility or unit, the type of emergency services available and the arrangements for referring and transferring patients/families, staff, and visitors are delineated in a written plan.

2. When emergency services are provided by the hospice inpatient facility or unit, the type of emergency services available are delineated, and the services provided are organized and properly directed.

Chapter Five

Continuity of Care

GOAL ONE

The hospice program provides a continuum of home care and inpatient care through the direct provision of the services or under arrangement.

RATIONALE

Continuity of care in a hospice program is the capacity to respond to patients'/families' needs, whenever and wherever they arise. Hospice patients/families may experience fragmentation and alienation in seeking physical and psychosocial care, but continuity of care in regard to hospice program personnel and services, in both home care and inpatient care settings, can reduce the sense of fragmentation and alienation. Effective administrative and staff integration can assure the continuation of high-quality care for patients/families in both settings.

CHARACTERISTICS

1. Hospice program home care and inpatient services may be provided through various methods, depending on the scope of services offered by the program itself, local hospitals and health care agencies, and other resources in the community.

   A. Home care services may be provided through the following:
      (1) A hospice home care agency; or
      (2) A unit or designated service of a hospital-based, community-based, or public health home care program.
   B. Inpatient services may be provided through the following:
      (1) A hospice inpatient facility; or
      (2) An inpatient unit in a hospital, skilled nursing facility, or intermediate care facility; or
      (3) A scattered-bed or consultation team approach in an acute care hospital.

2. When the hospice program does not directly provide both home care and inpatient care services, there is a written agreement between the hospice program and the provider(s) governing the nature and scope of services and assuring continuity of care. The written agreement addresses at least the following:

   A. What services are provided by each party to the contract;
   B. The qualifications of the personnel providing services;

C. The role and responsibility of the hospice program in the selection, evaluation, orientation, and continuing education of the personnel who provide hospice care;
D. The manner in which services are initiated and coordinated;
E. The respective roles of hospice program interdisciplinary team members, provider(s), and attending physicians in the establishment, regular review, and implementation of interdisciplinary team care plans;
F. The requirements for providing documentation of services rendered in accordance with hospice program policy;
G. A requirement that all contracted services must comply with the standards contained in this Manual;
H. Compliance of the provider(s) with all applicable federal, state, and local regulations;
I. Liability and responsibility of the program and the provider(s);
J. The term of the agreement and the basis for its termination or renewal;
K. Provisions for reimbursement for services, if any; and
L. The individual(s) responsible for the implementation of the agreement's provisions.

3. If the hospice program, at the time of survey, is unable to provide a written agreement for the provision of home care and inpatient care services, there is evidence of at least the following:

A. A written plan to secure a written agreement for hospice services not currently provided directly, with supporting documentation of action taken on the plan;
B. The provision of interdisciplinary team care plans to the provider(s);
C. Provision for orientation and continuing education to identified personnel regarding pain and symptom management, psychosocial assessment and intervention, and the hospice philosophy of care;
D. Coordination of discharge and transfer planning;
E. Regular communication between the care providers and a designated hospice liaison, in accordance with hospice program policy, regarding the implementation and review of care plans; and
G. Twenty-four hour availability of hospice program consultation by interdisciplinary team members to the provider(s).

4. There is a written plan regarding the transfer or discharge of patients/families. The plan is applicable to program services whether or not provided directly and addresses at least the following:

A. The involvement of interdisciplinary team members who provide care;
B. The involvement of the patients/families in transfer or discharge decisions;
C. The instruction f the patients/families members, as appropriate, before discharge or transfer;
D. The delineation of the appropriate medical, clinical, and administrative information to be exchanged in a transfer as well as the method of exchange; and

E. Evidence of the attending physician's concurrence with the transfer or discharge plan, as indicated by his or her signature.

5. There is a policy in regard to communication between home care service and inpatient care service interdisciplinary team members regarding program issues, whether or not the services are provided by the program directly or under arrangement.

Chapter Six

Medical Records

GOAL ONE

An accurate, medical record that provides documentation of hospice program services and is readily accessible to permit prompt retrieval of information is maintained for each patient/family.

RATIONALE

Significant patient-specific clinical information is found only in the medical record, and during the ongoing evaluation, diagnosis, and treatment of the patient, the patient/family medical record is depended on for the following:

.Providing continuity of care between inpatient and home care services and evidence of communication among a number and variety of health care professionals involved in the care of the patient/family;

.Providing a record of the patient's course to guide appropriate evaluation and treatment in response to the patient's condition and progress or lack of progress;

.Providing information pertinent to the concurrent monitoring activities of the medical staff, interdisciplinary team members, and other hospice personnel; and

.Providing information for use in continuing education activities, clinical research, clinical review activities of the medical staff, interdisciplinary team members and home care and inpatient services personnel, as outlined in the hospice quality assurance plan.

Upon termination of hospice care, the patient/family medical record becomes a historical document depended on for the following:

.Providing information for use in the postdischarge care of the patient/family (if applicable);

.Providing information to assist in protecting the legal interests of the patient/family, the hospice program, and the practitioner responsible for the patient's/family's care; and

Providing information to validate charges for patient care services.

CHARACTERISTICS

1. There is a medical record for each patient/family served.

2. The medical record is sufficiently detailed and accurate to enable the assumption of care by any interdisciplinary team member.

3. There is a standardized medical record format designed according to the requirements of the hospice program. The format

   A. is used in both inpatient and home care services; and
   B. is used to document interdisciplinary team services.

4. The medical record of each patient/family provided hospice care includes, but is not necessarily limited to, the following:

   A. Data that identify the patient/family or an explanation for any missing items of identification;
   B. All pertinent diagnoses;
   C. The patient's prognosis;
   D. Designation of the attending physician(s);
   E. Designation of the family member or other primary caregiver to be contacted in the event of emergency or death;
   F. The patient's medical history, which may be a copy obtained from the hospital or physician's office, with an update added by the attending physician or hospice nurse;
   G. The findings of a physical examination by the attending physician performed within 24 hours upon admission to the inpatient care service;
   H. A current interdisciplinary plan of care that includes
      (1) a problem list,
      (2) a statement of goals and types and frequency of services to be provided, and
      (3) a statement of current medications, diet, treatment procedures, and equipment required;
   I. A description of the patient's functional limitations;
   J. A listing of the activities permitted;
   K. A listing of the safety measures required to protect the patient from injury;
   L. A physical assessment of the patient;
   M. A psychosocial assessment of the patient/family;
   N. For each home visit or inpatient service rendered, signed and dated progress notes that include
      (1) a description of signs and symptoms,
      (2) notations regarding treatment, service, or medication rendered and patient reaction,
      (3) notations regarding any change in the patient's condition, and
      (4) notations regarding any patient/family instruction as well as compliance with treatment;
   O. Legible and complete diagnostic and therapeutic orders authenticated by the attending physician;
   P. Relevant test determinations and procedure findings;
   Q. A record of interdisciplinary team conferences;

R. Copies of all transfer and summary reports;
S. A bereavement assessment and plan for intervention;
T. Instructions to the patient/family concerning care at discharge; and
U. Conclusions or evaluation at the termination of hospice care, including a copy of the referral to another resource, if applicable.

5. The medical record of each patient/family provided home care services includes, but is not necessarily limited to, the following information:

   A. The name of the person who will assume primary responsibility for the care of the patient at home; and
   B. The suitability or adaptability of the patient's/family's residence for the provision of required medical services.

6. There is a written program policy that delineates authority to make entries in or review the medical record.

7. Physician's verbal orders are recorded and later authenticated by the attending physician within the time period specified in hospice program policy and/or in the bylaws and the rules and regulations of the medical staff.

8. Any person who makes entries in the medical record dates and signs the entry, giving his or her title. Hospice program policy determines when initials may be used to authenticate an entry.

9. The medical record for each patient/family is maintained in such a manner that all information, including pertinent medical information obtained from outside sources, can be assembled routinely when the patient/family is admitted to inpatient, home care services, or bereavement service.

10. The record of a discharged patient/family is completed within a reasonable period of time, as specified in hospice program policy. A medical record is complete only when its contents include a listing of final diagnosis, complications, death or discharge, a clinical summary of the patient's course, and the patient's/family's psychosocial status, including bereavement follow-up.

11. The length of time for retaining medical records is recorded in the policies and procedures of the hospice program and is dependent on the use of the records in continuing patient/family care or for legal research or educational purposes.

12. A coding system and an indexing system are used to facilitate retrievability of medical records information for reporting, evaluation, and monitoring activities.

13. Reasonable security measures safeguard both the medical record and its informational content--whether in hand copy, on film, or in computerized form--against loss, defacement, tampering, unauthorized disclosure, and use by unauthorized persons.

GOAL TWO

There is adequate supervision and staffing for maintaining medical records.

RATIONALE

The qualifications and commitment of the individuals who provide medical record services, and the effectiveness and efficiency of the systems used for collecting, storing, and retrieving pertinent clinical information, are major factors affecting the maintenance of high standards of patient/family care.

CHARACTERISTICS

1. The hospice program director appoints an individual to maintain medical records in accordance with hospice program policy.

   A. There are written requirements stating the minimum education and experience required for maintaining medical records.

2. Medical record services and personnel are directed, or at least reviewed twice annually on a consultative basis, by a medical record professional who has successfully completed the examination requirements of the American Medical Record Association or the equivalent.

3. The role of the medical record services in supporting the overall hospice program quality assurance program, the evaluation and monitoring activities of hospice services personnel, and the evaluation and monitoring activities of the medical staff (if there is a medical staff) is defined by the hospice program administration.

Chapter Seven

Governing Body

GOAL ONE

An organized governing body is responsible for establishing hospice program policies, and for maintaining high standards of patient care and program management.

RATIONALE

In any organization, there must be a group that accepts ultimate responsibility and exerts ultimate authority.

CHARACTERISTICS

1. A private, independently owned, or community-agency-owned hospice program has a charter and/or constitution and bylaws and, where required, a state license.

2. The governing body is the individual, group, corporation, or government agency in which the ultimate responsibility and authority for the operation of the hospice program is vested.

3. A hospice program that is a component of another facility, institution, or government agency has a written description stating at least the following:

   A. The governing body responsible for the hospice program;
   B. The relationship of the governing body of the facility, institution, or agency to the director of the hospice program; and
   C. The authority given to the hospice program specific to

      (1) planning and organization,
      (2) program operation,
      (3) the hiring, termination, and assigning of hospice program personnel, and
      (4) policy and procedure adoption and review.

4. The governing body adopts bylaws in accordance with its legal accountability.

5. The bylaws include, but are not limited to, the following:

   A. The role and purpose of the hospice program;
   B. The duties and responsibilities of the governing body;

C. The method of selecting members of the governing body and the permissible length of members' service;
D. The method of selecting officers of the governing body and the permissible number of terms officers can serve;
E. The responsibilities of officers;
F. Meeting procedures, regularity of meetings, definition of "quorum" to conduct business, and attendance policy;
G. A list of the committees of the governing body and how they relate to the governing body;
H. The composition and responsibilities of the committees;
I. The mechanism by which bylaws are adopted and revised;
J. Provision for the regular review and revision of the bylaws and documentation of such action.

6. There is a defined and effective mechanism for communication between the governing body, the hospice program, the hospice administration, and the medical staff of the inpatient service.

7. The governing body provides for the establishment of auxiliary organizations, and approves the bylaws that delineate the purpose and function of such organizations.

8. Written records of the governing body's proceedings and the proceedings of each governing body committee is maintained and signed by a designated member of the governing body or committee, or by the secretary of the governing body.

9. Advisory-group committees or board membership reflect the involvement of members of the community served by the hospice program.

10. The capital budget and annual operating budget are adopted by the governing body, and implementation of these budgets is monitored.

11. The governing body appoints the hospice program director or designates that authority to the appropriate administrative representative in accordance with written institution or agency policy.

12. There is a defined mechanism for self-review and evaluation of the governing body's performance. The mechanism includes a statement of the regularity of the review and how it is initiated and analyzed.

13. The governing body reviews and approves the bylaws and the rules and regulations of the medical staff of the inpatient care service.

14. The responsibilities of the governing body are written, formally adopted, dated and available to all members of the governing body. The responsibilities include, but are not necessarily limited to, the following:

A. Approving of the hospice program's goals and objectives;
B. Evaluation of the program's performance with regard to its stated purpose, goals, and objectives;
C. Determining and approving of policies to govern the program;
D. Assuring fiscal solvency and adequacy of financial resources;

E. Planning for long-term development and maintenance;
F. Supporting a comprehensive quality assurance program; and
G. Providing the necessary support for implementing, and reporting the activities of, interrelated mechanisms of the home care and inpatient services for monitoring patient care and for identifying and resolving problems.

GOAL TWO

The governing body avoids conflict of interest.

RATIONALE

A governing body member whose decisions may be influenced by direct or indirect personal benefit may not be serving in the best interests of the hospice program and the community.

CHARACTERISTICS

1. There is full written disclosure of hospice program ownership and control.

2. The governing body develops and implements a written conflict of interest policy that includes the following:

   A. A description of the method and content of disclosure by governing body members;
   B. Guidelines for the resolution within a specific time frame, of any existing conflict of interest; and
   C. A defined ongoing mechanism for monitoring the conflict of interest policy and a specified time period for regular review of the policy.

GOAL THREE

The governing body provides for the orientation of its members.

RATIONALE

Orientation provides the means by which new governing body members can relate their expertise to hospice program functions and responsibilities and thereby participate in governing body discussions and decisions.

CHARACTERISTICS

1. An orientation is provided for each new governing body member and addresses at least the functions and responsibilities of the governing body and the history, services, and purpose of the hospice program.

Chapter Eight

Management and Administration

GOAL ONE

The hospice program is managed in a manner consistent with the authority and responsibility conferred by the governing body to accomplish program goals and objectives.

RATIONALE

The hospice program is a complex organization, and its management is responsible for using limited resources efficiently while maintaining high standards of patient/family care commensurate with currently available clinical knowledge and skills. The qualifications and commitment of individuals in management positions, as well as the effectiveness and efficiency of systems for supporting patient/family care, are essential to fulfilling these responsibilities.

CHARACTERISTICS

1. A qualified hospice program director, selected in accordance with hospice program or institution or agency policy, is responsible for operating the hospice program in a manner consistent with the authority conferred by the governing body.

   A. There are written requirements stating the minimum education and experience required for the position of hospice program director.

2. The hospice program director designates an individual to act in his or her absence.

3. The responsibilities of the hospice program director include, but are not necessarily limited to, the following:

   A. Implementation of the policies approved by the governing body;
   B. Effective utilization of personnel and resources to achieve program goals;
   C. Administration and evaluation of the program and interdisciplinary team services; and
   D. Participation with organizations that work to improve the care of the dying.

4. There are written policies and procedures to guide the hospice program director and the administrative staff in at least the following areas:

   A. The organization of programwide administrative functions, with clear delegation of duties, responsibilities, and lines of authority and accountability;

B. The establishment of the services needed for the efficient and effective functioning of the hospice;
C. Communication between program administration, the home care and inpatient care coordinator(s), interdisciplinary team members, and the governing body;
D. Compliance with applicable federal and state laws and regulations.
E. The establishment of internal controls to monitor the accuracy and reliability of data, and promote administrative efficiency;
F. The control of inventories, purchasing procedures, product selection and evaluation, and supply distribution;
G. The establishment of a administrative reporting system that provides understandable and standardized reports;
H. Protection and judicious use of the hospice program's physical resources;
I. The ongoing assessment of the community's hospice care needs;
J. Efforts to obtain community input and support of the hospice program;
K. The development of long-term and short-term program plans that reflect community hospice care needs; and
L. The development of evaluative reports on the efficiency and effectiveness and costs of hospice program service activities.

5. The hospice program director provides written plans to guide, and can confirm implementation of the personnel policies and procedures as stated in Chapter Nine of this Manual.

6. The hospice program director provides a written plan that states the method and frequency of reviewing all program and interdisciplinary team service policies and procedures at least annually. The plan addresses the following:

A. The appointment of a review committee by the hospice program director;
B. The composition and qualifications of the review committee;
C. The initiation of revisions of policies and procedures; and
E. Evidence of the annual review of the committee chairperson.

7. The hospice program director provides written fiscal policies and practices that address the implementation of at least the following:

A. An annual revenue and expense budget, with line items paralleling the hospice program's plan of organization;
B. A budgetary process in which at least the hospice program director, the home care and inpatient care coordinator(s), and the governing body participate;
C. An annual certified financial audit conducted by an outside accountant;
D. The control of accounts receivable and payable, the handling of cash, and the establishment of credit arrangements;
E. The preparation, in accordance with program policy, of comparative financial statements of budget versus actual revenue and expenses on an accrual basis; and
F. Reports on the nature and extent of available financial resources.

8. The hospice program director provides written plans to guide the collection and analysis of statistical data relevant to program evaluation, service utilization review, and problem-solving activities.

Chapter Nine

Personnel Policies and Procedures

GOAL ONE

Hospice program personnel policies and procedures are developed, adopted, and maintained. These policies and procedures promote the objectives of hospice services and provide for an adequate number of qualified personnel, during all hours of operation, to support the hospice services and provide high quality care.

RATIONALE

The qualifications of the individuals providing hospice program services, and the effectiveness and efficiency of the systems for collecting, storing, and reviewing pertinent personnel information, greatly affect the maintenance of a supportive, effective working environment and high standards of patient/family care.

CHARACTERISTICS

1. The hospice program director appoints an individual to be responsible for implementing and coordinating personnel policies and procedures and for maintaining personnel records.

2. There is a written organization plan for personnel services. The plan addresses at least the supervision of the processing of employment-related forms.

3. Personnel records are maintained in a manner that assures confidentiality and hospice program policy specifies who has access to various types of personnel information.

4. There are written policies and procedures that pertain to at least the following:

   A. Employee benefits.
   B. The recruitment and selection of employees. Hiring practices, which are written and are consistent with the needs of the hospice program, include at least
      (1) job-related criteria for selecting employees, and
      (2) a policy concerning the availability of bilingual personnel when people who speak languages other than English make substantial use of the program.
   C. Termination of employment.

D. Employee grievances and appeals procedures.
E. Safety.
F. Employee injuries and incident reports.
G. Wages, hours, and salary administration.
H. Rules of conduct.
I. Disciplinary systems.
J. Equal employment opportunities and affirmative action policies;
K. Liability insurance.
L. The acceptance of gratuities.
M. The determination that all personnel are medically capable of performing assigned tasks.

5. There are written policies and procedures that state the lines of authority and reporting of all hospice employees, including volunteers.

6. Personnel procedures are implemented to assure compliance with federal, state, and local laws related to employment practices.

7. There is written documentation to verify that the personnel policies and procedures apply to all hospice program employees and are explained and made available to each employee.

A. The policies and procedures are available to nonemployees upon request.
B. There is a mechanism for notifying employees of changes in policies and procedures.

8. There is written documentation of staff orientation initiated for each new employee before or during the first week of employment.

9. A personnel record is maintained for each hospice program employee and contains the following information:

A. The application for employment;
B. Documentation of both written and verbal references;
C. Verification of licensure, certification, and/or renewals;
D. Wage and salary information, including all adjustments;
E. Performance appraisals;
F. Initial and subsequent health clearances;
G. Counseling actions;
H. Disciplinary actions;
I. Commendations; and
J. Incident reports.

10. For each position in the program, there is a written job description that includes the following information:

A. The position title;
B. The department, service, or unit;
C. The direct supervisor's title;
D. If a supervisory position, the personnel supervised and degree of supervision;
E. The tasks and responsibilities of the job;

F. The minimum level of education, training, and/or related work experience required; and
G. Documentation of changes in qualifications, duties, and other major job-related factors.

11. There are written performance appraisals for each position in the program. An appraisal

A. is maintained in the employee's personnel record;
B. is related to the job description;
C. is conducted during the initial employment period;
D. is conducted at least annually after the initial employment period; and
E. contains documentation that the employee has reviewed the appraisal and has had an opportunity to comment on it.

12. The personnel service prepares an annual written report concerning its services and functions.

Chapter Ten

Utilization Review

GOAL ONE

The appropriate allocation of hospice resources is demonstrated through a utilization review program that includes the home care, inpatient care, and interdisciplinary team services.

RATIONALE

In striving to provide high-quality patient care in the most cost-effective manner, the administration of the hospice program needs information regarding the utilization of resources.

CHARACTERISTICS

1. A written plan that describes the utilization review program and governs its operations is implemented. The written plan is approved by the governing body and the hospice program director.

2. The written plan addresses at least the following:

   A. The appointment and composition of the utilization review committee which includes at least one representative each from the interdisciplinary team, home care, and inpatient services;
   B. The responsibility and authority of committee members;
   C. How the findings of the committee are interrelated with the quality assurance program;
   D. The frequency of committee meetings;
   E. The composition and dissemination of a report of the committee's findings at least annually;
   F. Procedures for conducting concurrent and retrospective reviews;
   G. A conflict-of-interest policy applicable to all review activities and, as determined by hospice program policy, to resultant findings and recommendations;
   H. A confidentiality policy applicable to all utilization review activities and to resultant findings and recommendations; and
   I. The mechanisms used to identify utilization-related problems.

3. At least annually, the utilization review committee reviews a defined number of medical records, selected randomly through a specific mechanism, to assess the appropriateness and adequacy of the services provided.

4. The mechanisms for identifying utilization-related problems include the following:

   A. Analysis of the appropriateness of admissions, continued stays longer than six months, home care versus inpatient services, and delays in provision of interdisciplinary team services; and
   B. Examination of the findings of related quality assurance activities and other relevant information.

5. The documentation of problem identification may include, but is not necessarily limited to, the following

   A. Profile analysis;
   B. Patient/family evaluation studies;
   C. Medication usage reviews; and
   D. Reimbursement-agency utilization reports that are service-specific.

6. There is ongoing retrospective and concurrent monitoring of the utilization of home care, inpatient, and interdisciplinary team services.

7. The procedures for conducting concurrent review of hospice program services have the following characteristics:

   A. Specific time periods following a patient's admission to home care or inpatient services within which the review is initiated;
   B. Length-of-stay norms and percentiles used in assigning continued-stay review dates that are specific to home care or inpatient care;
   C. The utilization of factors other than, or in addition to, payment sources as the basis for determining which patients receive concurrent review; and
   D. Written measurable criteria and length-of-stay norms that are approved by the utilization review committee and the hospice program administration.

8. There is a written plan for initiating transfer from one hospice service to another or discharge from the hospice program when care is no longer needed or appropriate. The plan includes delineation of the responsibility for initiation and follow-through.

9. There is evidence that the findings and recommendations of the utilization review committee are the basis of action in the preceding twelve months in any one or more of the following areas:

   A. Patient services;
   B. Administration or supervision;
   C. Inservice or continuing education; and
   D. Compliance with regulatory or legal requirements.

10. There is evidence that the utilization review program, including the written plan, discharge criteria, and length-of-stay norms, is reviewed at least annually and revised as appropriate.

Chapter Eleven

Quality Assurance

GOAL ONE

The hospice program has a well-defined, organized quality assurance program designed to enhance patient/family care through the ongoing objective assessment of important aspects of care and the correction of identified problems.

RATIONALE

Hospice programs are complex organizations in which the results of patient/family care depend on the interrelated contributions of a variety of health care services and personnel. A major component of the interdisciplinary team's endeavors to deliver patient/family care that is optimal within available resources and consistent with achievable goals is the operation of a quality assurance program.

CHARACTERISTICS

1. The hospice program director designates a committee to implement and maintain the overall hospice program quality assurance program.

2. The quality assurance committee includes a representative from the hospice program administration, interdisciplinary team services, home care and inpatient services, and the medical staff of the inpatient service.

3. The type and frequency of all quality assurance activities in the hospice program are defined in a written plan which addresses at least the following:

   A. The development, adoption, and implementation of an individual quality assurance plan for <u>each</u> type of service--
      (1). bereavement services,
      (2). nursing services,
      (3). physician services,
      (4). psychological and social work services,
      (5). volunteer services,
      (6). home care services, and
      (7). inpatient services;
   B. The integration of findings from the monitoring, evaluation, and problem-solving activities of each quality assurance plan into the overall hospice program quality assurance program; and
   C. Delegation of responsibility for the implementation of and reporting for each quality assurance plan and the overall hospice program quality assurance program.

4. The findings of the individual quality assurance plans are reported, as defined in hospice program policy, to the governing body, the hospice program administration, and the coordinator(s) of the interdisciplinary team, home care, and inpatient services.

5. The individual quality assurance plans and the overall hospice program quality assurance program include at least the following components:

   A. Problem identification;
   B. Problem assessment;
   C. Problem correction;
   D. Problem monitoring; and
   E. Evaluation, documentation, and follow-up.

6. The quality assurance program includes identification of actual and/or potential problems or related concerns in the care of patients/families through at least the following sources of data:

   A. Findings of the quality assurance activities of each service;
   B. Utilization review findings; and
   C. Incident reports.

7. The quality assurance program includes objective assessment of the cause and scope of the problems and concerns identified. Problem assessment has the following characteristics:

   A. Prospective, concurrent, and retrospective assessment of the actual or potential problems identified;
   B. Adequate sampling of the services, disciplines, and individuals involved in the problems identified; and
   C. The use of written criteria that, when applied to actual practice, can result in measurable improvement in regard to patient/family care and clinical performance.

8. The quality assurance program incorporates methods for the implementation of decisions or actions designed to eliminate or reduce identified problems.

9. There is evidence that the recommendations of the quality assurance committee are the basis of action in the preceding twelve months in any one or more of the following areas:

   A. Administration or supervision;
   B. Inservice or continuing education; and
   C. Patient/family services.

10. The results of corrective actions taken are monitored periodically to assure that the identified problems have been eliminated or satisfactorily reduced. Finding suitable solutions to problems is a function and responsibility, as appropriate, of the governing body, the hospice program administration, the medical director, and/or interdisciplinary team members.

11. There is evidence that the individual quality assurance plans and the overall hospice program quality assurance plan are reviewed at least annually and revised as appropriate.

GLOSSARY

active treatment - The receipt of therapies, specifically radiation or chemotherapy, primarily for palliation of pain and symptoms, but with acknowledgement of possible curative reaction.

administration - The fiscal and general management of a hospice program, rather than the direct provision of services.

advanced irreversible disease - The point in the disease process at which the retardation or cessation of the disease's progress can no longer be expected.

appropriate - Descriptive of an action or policy that is suitable or compatible with the individual hospice program's objectives and philosophy.

approved - Acceptable to the authority having jurisdiction.

assessment - Those procedures by which the strengths, weaknesses, problems, and needs are addressed.

attending physician - The primary physician, selected by the patient who is responsible for the medical care of the patient.

audit financial - An independent review by a public accountant certifying that the hospice program's financial reports reflects its financial status.

authentication - Proof of authority and responsibility by written signature, identifiable initials, computer key, or other method. The use of a rubber-stamp signature is acceptable only under the following conditions: The person whose signature the rubber stamp represents is the only one who has possession of the stamp and is the only one who uses it, and this person provides the hospice program director with a signed statement that he or she is the only one who has the stamp and the only one who will use it.

basic communication skills - The fundamental skills relating to effective listening and sensitive, productive response in communication.

bereavement - The period of time following the death of a significant other in which an individual experiences, responds physically and emotionally to, and adjusts to the loss.

bylaws - The laws, rules, or regulations adopted for the governance of the hospice program. Also used for the laws, rules or, regulations of the medical staff.

care plan, interdisciplinary team - A written statement that describes the major physical and psychosocial problems of the patient/family to be addressed in the provision of care; the plan for intervention, stating the interdisciplinary team members to be involved and the planned frequency of intervention; and the goals of the planned intervention

case conference - The formal or informal review, by interdisciplinary team members, of one or more patient/family care plans with regard to updating patient/family physical and/or psychosocial status and initiating any changes in the interdisciplinary team care plan.

case mix - The variety of physical and psychosocial problems presented by the patients/families served by a hospice program.

casework - A treatment method used by social workers to help individuals or families improve their functioning by changing attitudes, feelings, and social circumstances that directly affect them. Casework relies on a relationship between the social worker and client as the primary means of effecting change.

clergy - A body of persons ordained to perform religious functions and services; the official or sacerdotal class of any religious denomination or group.

clinical degree - A degree which has involved the direct observation or participation of the individual who has earned the degree in counseling individuals or families and the analysis of such intervention.

community - The individuals, groups, agencies, and facilities or other institutions within the locality served by a hospice program.

consultant - An individual who provides professional advice or services on request.

continuing education - All the education that is relevant to the type of patient care delivered in the hospice program and that provides current knowledge relevant to the interdisciplinary team members' fields of practice.

continuum - The availability of services appropriate to the needs of the patient/family, uninterrupted by time or place.

coordinator, home care or inpatient services - The individual responsible for the organization, management, and delivery of multiple services in home care or inpatient settings to effectively meet the needs of patient/families.

death - The permanent cessation of all vital functions.

dietetic services - The provision of services to meet the nutritional needs of patients, with emphasis on patients who have special dietary needs.

dietitian - An individual who is registered by the Commission on Dietetic Registration of the American Dietetic Association or has the documented equivalent in education, training, and/or experience, with evidence of relevant continuing education.

direction - Authoritative policy or procedural guidance for the accomplishment of a function or activity.

discharge - The point at which the patient's/family's active involvement with the hospice program is ended and the program no longer maintains active responsibility for the care of the patient/family or survivors, in the instance of bereavement care. The actual point of discharge is determined by each hospice program in regard to the continuum of home care and inpatient services provided and legal jurisdiction.

drug history - A delineation of the drugs used by a patient, including prescribed and unprescribed drugs and alcohol. A drug history includes, but is not necessarily limited to, the following: drugs used in the past; drugs used recently, especially in the preceding 48 hours; dosages used; previous occurrences of adverse drug reactions; and history of previous treatment for pain management.

dying - The progressive failure of body systems to retain normal functioning, thereby limiting the remaining life span.

facility - A designated freestanding building necessary for the implementation of inpatient services.

family - A group of individuals living under one household; a group of persons of common ancestry; or a group of individuals having a common commitment to one another.

fiscal management - Procedures used to control a hospice program's overall financial and general operations.

goal - An expected result or condition that takes time to achieve, is specified in a statement of relatively broad scope, and provides guidance in establishing intermediate objectives directed toward attainment of the goal.

governing body - The person or persons having ultimate authority and responsibility for the overall operation of the hospice program.

grief - A deep and poignant response caused by, or as if by, the loss of a person, an item, or a position of significance.

guardian - A parent, trustee, committee, conservator, or other person or agency empowered by law to act on behalf of, or have responsibility for a patient.

hazardous area - Any area in which any of the following are used: products that are highly combustible, highly flammable, or explosive; or materials that are likely to burn with extreme rapidity or produce poisonous fumes or gases. Consult the 1981 edition of the Life Safety Code (R) of the National Fire Protection Association (NFPA) for further clarification.

home care services - Formally structured organized services designed to render and coordinate the effective provision of hospice interdisciplinary team services to patients/families in the home.

homemaker or home health aide - An individual who may or may not have received specific training to perform services ranging from housekeeping, preparing meals, and assisting with dressing and bathing to rendering assistance with prescribed exercises, special mechanical aids, and the giving of medications under the supervision of a registered nurse or a social worker.

hospice program policy - The administration and procedures for action based on individual program philosophy and objectives.

incident report - A written report by either a patient/family or a interdisciplinary team member that documents any unusual problems, incident, or situation for which the patient/family or team member wishes to have follow-up action taken by appropriate administrative personnel.

inpatient services - Formally structured organized services designed to render and coordinate the effective provision of hospice interdisciplinary team services to patients/families in an inpatient setting.

inservice education - All organized education for interdisciplinary team members and designed to enhance skills or teach new skills relevant to the team member's fields of practice.

interdisciplinary team - A group composed of individuals from various professions and disciplines, who interact on a regular basis and have a working knowledge of the assessment and care of the patient/family by each member of the team. The team is characterized by an ability by all members and disciplines to allow their roles to blur, while simultaneously providing emotional support to each other and maintaining a respect for each other's skills, training, and interventions.

interdisciplinary team services - The provision of, at the least, nursing, physician, psychological and social work, spiritual, volunteer, and bereavement services as an identified team.

licensed - Authorization to practice in the professional discipline for which an individual has been prepared, granted by the licensing authority having jurisdiction in the state where the individual practices.

licensed practical (vocational) nurse - A nurse who is a graduate of an approved school of practical (vocational) nursing and/or is licensed by waiver to practice as a practical (vocational) nurse.

limited prognosis - A projected life span of six months or less.

medical - Of, pertaining to, or dealing with the science of medicine.

medical director - A physician licensed who is primarily charged with the responsibility of acting as a consultant to the interdisciplinary team, and advocate for pain and symptom management with attending physicians, and a liaison with physicians in the community. In the instance of inpatient services, the medical director is primarily responsible for the medical care rendered to patients.

medical record - Documentation of an individual patient's/family's receipt of hospice services, including, but not necessarily limited to, interdisciplinary team services rendered in the home care and/or inpatient settings.

medication - Any substance, whether legend or over-the-counter drug, that is taken orally, injected, inserted, applied topically or otherwise administered to a patient.

minutes - A record of business introduced, transactions and reports made, conclusions reached, and recommendations made. Reports of officers and committees may be summarized briefly or mentioned as having been presented. In either case, a copy of the report is filed in the committee report book and the page number is included in the minutes.

nurse's aides - Auxiliary nursing personnel functioning as assistants to registered and practical nurses.

nursing services - Patient care services pertaining to curative, restorative, preventive, and palliative aspects of nursing that are performed and/or supervised by a registered nurse pursuant to interdisciplinary team care plans.

objective - An expected result or condition that takes less time to achieve than a goal, is stated in measurable terms, has a specified time for achievement, and is related to the attainment of a goal.

occupational therapist - An individual who is a graduate of an occupational therapy program approved by a nationally recognized accrediting body, or who currently holds certification by the American Occupational Therapy Association as an occupational therapist, registered, or who has the documented equivalent in education, training, and/or experience; who meets any current legal requirements of licensure or registration; and who is currently competent in the field.

organized - Administratively and functionally structured.

organized medical staff - A formal organization of physicians and dentists having the delegated authority and responsibility to maintain proper standards of medical care and to plan for continued betterment of that care.

palliative care - Intervention that focuses primarily on the reduction or abatement of the physical and psychosocial stress of terminal disease.

patient/family - The unit of individuals that hospice care focuses on. The individuals may be related by ancestry or by a common commitment to one another. The emphasis on the unit of care underscores the direction of hospice services in addressing the needs of both the patient and his or her family.

personal care - Assistance rendered to the patient in bathing, dressing, mobility, or any such activities of daily living and personal hygiene.

pharmacist - An individual who has a degree in pharmacy and is licensed and registered to prepare, preserve, compound, and dispense drugs and chemicals in the state in which he or she practices.

physical therapist - An individual who is a graduate of a physical therapy program approved by a nationally recognized accrediting body or who has the documented equivalent in training and/or experience; and who meets any current legal requirements of licensure or registration.

physician - An individual who has received a doctor of medicine or doctor of osteopathy degree and is currently fully licensed to practice medicine.

practice privileges - Permission to render care in the granting institution within well-defined limits, based on the individual's professional license and his or her training experience, competence, and judgment.

primary caregiver - The person designated by the patient and the hospice program to be responsible for the welfare of the patient, as defined by hospice program policy.

program director - The individual who has the authority and responsibility, as delegated by the governing body, to accomplish program-specific goals and objectives, implement program policy, and manage personnel and resources.

program services - The home care, inpatient, and/or interdisciplinary team services provided by a hospice program.

psychologist - An individual who meets current legal requirements of licensure, registration, or certification in the state in which he or she renders services and either has a doctorate in psychology and at least two years of clinical experience in a recognized health care setting or has the documented equivalent in education, training, and/or experience.

psychosocial - Psychological, social, and spiritual.

qualified - Having the experience and education deemed appropriate by the hospice program to meet the physical and/or psychosocial care needs of the patients/families served.

registered nurse - A nurse who is a graduate of an approved school of nursing and is licensed to practice as a registered nurse.

service - A functional division of a program of an interdisciplinary team. Also, the deliver of care.

significant other - An individual the patient identifies as having personal significance in the provision of care and/or support and who does not have a blood or legal relationship to the patient.

social history and assessment - The evaluation of a patient's/family's environment, religious background, financial status, and other pertinent psychosocial information that may contribute to the development of an individualized interdisciplinary team care plan.

social worker - An individual who has a master's degree from a school of social work accredited by the Council on Social Work Education or who has the documented equivalent in education, training, and/or experience.

spiritual services - Care given by a member of the interdisciplinary team, community clergy, or individual identified by the patient/family as supportive with regard to spiritual or religious matters.

staff - Paid or volunteer interdisciplinary team members who provide hospice services.

supervisor - The individual who directs the provision of services and by individuals, and reviews those services as stated in the individual's job description.

team members - These individuals responsible for the delivery of interdisciplinary team services.

terminal disease - An illness for which treatment directed toward cure or control of the disease process is no longer appropriate or effective.

transfer - The movement of the patient/family from one service or location to another (eg, from the home care to the inpatient service).

under arrangement - A formal agreement with any organization, agency, or individual, approved by the governing body, that specified the services, personnel, and/or space to be provided to, or on behalf of, the hospice program and the monies to be expended, if any, in the exchange.

unit - A functional division or a facility of an institution.

utilization review - The process of using predefined criteria to evaluate the necessity and appropriateness of allocated services and resources to assure that the facility's services are necessary, cost efficient, and effectively utilized.

Ex. 2
S.B. 208

HIGHLANDS
HOSPICE, Inc. P.O. Box 267, Butte, MT 59703

NATIONAL HOSPICE ORGANIZATION

STANDARDS OF CARE

NATIONAL HOSPICE ORGANIZATION

STANDARDS OF A HOSPICE PROGRAM OF C[illegible]

ADMINISTRATION

Principle:

The health care delivery system, of which a hospice program is an integral part, is regulated by local, State and Federal law. In order to provide care in this system, a hospice program must meet the fundamental requirements for operation and delivery of service.

Standard 1: The hospice program complies with applicable local, State and Federal law and regulation governing the organization and delivery of health care to patients and families.

CONTINUITY OF CARE

Principle:

Hospice patients and families may experience a considerable degree of fragmentation and alienation. Hospice maintains that continuity of care (including both services and personnel) reduces the sense of fragmentation and alienation. "Continuity" implies the capacity to respond to patient/family needs whenever they arise. It also implies enough administrative and staff integration to ensure continuation of the same high quality care when the patient moves from home to inpatient unit or vice versa.

Standard 2: The hospice program provides a continuum of inpatient and home care services through an integrated administrative structure.

Standard 3: The home care services are available 24 hours a day, seven days a week.

PATIENT/FAMILY AS THE UNIT OF CARE

Principle:

Inclusion of the family in the hospice care program is essential. The wishes and desires of the patient/family are of central importance in developing the care plan. The family members are seen both as primary caregivers and as needing care and support so that their own stresses may be attended to. Attention is also paid to developing a quasi-family support network when relatives are not available and a patient needs and wants that support.

Standard 4: The patient/family is the unit of care.

Standard 5: The hospice program has admission criteria and procedures that reflect:

A. The patient/family's desire and need for service

B. Physician participation

C. Diagnosis and prognosis

The hospice program encourages family participation in patient care and provides support for them.

Standard 6: The hospice program seeks to identify, teach, coordinate and supervise persons to give care to patients who do not have a family member available.

Standard 7: The hospice program acknowledges that each patient/family has its own beliefs and/or value system and is respectful of them.

PERSONNEL

Principle:

The amount and type of care is based on need, as established with the patient and family. Care is provided by an interdisciplinary staff which includes at least the following qualified personnel (core team): Patient and patient's family, physician, nurse, social worker, volunteer, clergy. The team is coordinated by a qualified health care professional. The team meets regularly to develop and maintain an appropriate plan of care and to determine which staff members will intervene and work together in a situation. Regular staff support, education and training are also provided, based on a recognized need.

Standard 8: Hospice care consists of a blending of a professional and nonprofessional services, provided by an interdisciplinary team, including a medical director.

Standard 9: Staff support is an integral part of the hospice program.

Standard 10: Inservice training and continuing education are offered on a regular basis.

SYMPTOM CONTROL

Principle:

Hospice programs recognize that when a patient and family are faced with terminal disease, stress and concerns may arise in many aspects of their lives. Optimum symptom control includes addressing those stresses and concerns, in addition to the use of appropriate therapies. This therapy may be a blend of curative and palliative treatments that produce the greatest degree of relief from stress caused by disease for the longest period of time, with the least undesired side effects.

Standard 11: The goal of hospice care is to provide symptom control through appropriate palliative therapies.

Standard 12: Symptom control includes assessing and responding to the physical, emotional, social and spiritual needs of the patient/family.

Principle:

Grief and bereavement are normal reactions to loss and death. Grief is the highly personal response to loss; bereavement is the extended period of deprivation following the loss of a loved one. Grieving may precede an anticipated death or may be delayed for a considerable time. Grief may manifest itself in emotional and/or physical distress and may affect different family members in different ways at different times. Death of a family member can result in a wide range of physical, emotional, social, familial, economic and spiritual disruptions. Some persons can resolve grief with time and their own available resources; others may require formal assistance and support over an extended period of time.

Hospice work includes attention to needs of the bereaved, to assessment of needs of the bereaved, both before and after a death, and to the development of programs and resources to meet the needs of the bereaved. Hospice encourages the expression of grief, recognizes social/religious and ethnic variables in bereavement and supports staff and family participation in meanful funeral services and rituals.

Standard 13: The hospice program provides bereavement services to survivors for a period of at least one year.

QUALITY ASSURANCE

Principle:

Hospice is committed to developing and utilizing methods to measure and assure quality of patient/family care.

Standard 14: There will be a quality assurance program that includes:

A. Evaluation of services

B. Regular chart audits

C. Organizational review

RECORDS

Principle:

Documentation of services is necessary and desirable in the delivery of quality care. Therefore, a hospice record of care will be maintained in order to insure compliance with regulatory and quality care standards. Of critical importance is the development of an integrated chart which records the assessments and proposed interventions by all interdisciplinary team members for the patient as well as for the family.

Standard 15: The hospice program maintains accurate and current integrated records on all patients/families.

PHYSICAL PLANT

Principle:

Not all patients can be maintained at home; some require inpatient services. The hospice inpatient unit reflects the unique nature of hospice care, and provides for special needs of the dying and their families.

Standard 16: The hospice complies with all applicable State and Federal regulations.

Standard 17: The hospice inpatient unit provides space for:

A. Patient/family privacy

B. Visitation and viewing

C. Food preparation by the family

December 1982 Ex 2
FINAL COPY S.B. 208
As developed through JCAH

HOSPICE PROJECT STANDARDS

Chapter One

Patient/Family as the Unit of Care

GOAL ONE

The patient and the patient's family is the unit of care.

RATIONALE

Inclusion of the patient's family or significant other(s) in the hospice program is essential, and family members should be encouraged to participate in developing the care plan and in caring for the patient according to their ability to do so. Family members are seen as both primary caregivers and as needing care and support.

CHARACTERISTICS

1. The hospice program has written admission criteria that reflect the following:

   A. An assessment of the patient's/family's desire and need for hospice services;
   B. The eligibility of a patient who does not have a designated primary caregiver; and
   C. Any factors with regard to the patient's diagnosis, prognosis, or receipt of active treatment that may affect eligibility.

2. A consent for care form is signed by the patient, and a family member or other primary caregiver.

3. The patient and the family or other primary caregiver participate in the development of the care plan according to their ability to do so, and such participation is documented in the medical record.

4. The interdisciplinary team care plan includes specific goals for involving family members or other primary caregiver.

GOAL TWO

Hospice program services and care reflect an acknowledgement that each patient-/family has basic rights, individual beliefs, and/or a value system and a life philosophy.

RATIONALE

Hospice care does not proffer a "right way to die." The terminally ill patient's and the family's own framework of values, preferences, and life outlook must be taken into account in planning and conducting treatment.

CHARACTERISTICS

1. The hospice program has a statement of patient/family rights that is written in simple and easy-to-understand terms and in a language understandable to patients/families and is available to them. The rights include, but are not necessarily limited to, the following:

   A. Support and protection of the fundamental human, civil, and legal rights of each patient/family;
   B. Impartial access to treatment, regardless of the patient's or family members' race, religion, sex, ethnicity, age, or handicap;
   C. Recognition of each patient's/family's personal dignity and autonomy and respect for each patient/family in the provision of all care and treatment; and
   D. Individualized treatment for each patient/family, which includes at least;

      (1) the provision of adequate and humane services, regardless of the source of financial support,

      (2) the provision of a care plan,

      (3) periodic review of the care plan,

      (4) the active participation in planning for treatment by all patients who are able to participate and by the responsible parents, relatives, or guardians of minors or legally incompetent patients,

      (5) a statement of charges for services provided, and

      (6) assurance and protection of each patient's/family's personal privacy and the confidentiality of patient-related information within the constraints of the care plan.

GOAL THREE

Program personnel seek to identify, teach, coordinate, and supervise persons other than interdisciplinary team members to give care to patients who do not have a family member of other primary caregiver available, if such patients are eligible for admission to the hospice program.

RATIONALE

Not every patient has a family or family members who are willing to give care.

The development of an alternative support network is needed when no relative or other primary caregiver is available and a patient needs and wants support.

CHARACTERISTICS

1. If the hospice program accepts patients who do not have primary caregivers, there are written policies and procedures that address at least the following:

   A. The responsibility of the program and the efforts program staff will make to identify a primary caregiver(s) for the patient;
   B. The definition of an "acceptable primary caregiver";
   C. What instruction will be given to the primary caregiver by interdisciplinary team members;
   D. The program's responsibility to the primary caregiver; and
   E. Under what circumstances the patient will no longer be eligible to receive hospice program services.

Chapter Two

Interdisciplinary Team Services

GOAL ONE

An interdisciplinary team consisting of qualified personnel, provides home care and inpatient hospice services. The team services include at lest the following:

Bereavement,
Nursing,
Physician,
Psychological,
Social Work,
Spiritual,
Volunteer,

and other services deemed necessary for patient/family care. Services are coordinated to assure the ongoing assessment of the patient's/family's needs and implementation of interdisciplinary team care plans.

RATIONALE

The patient/family facing terminal illness has a variety of physiological, psychological, legal, social, educational, spiritual, economic, and interpersonal problems. To meet the needs of the patient/family, representatives of many disciplines must work together as an integrated clinical team.

CHARACTERISTICS

1. Interdisciplinary team services may be provided by the following:

   A. Hospice program employees;

   B. Employees of agencies that provide care under arrangement with the hospice program; or

   C. Qualified and trained volunteers.

2. There are written policies and procedures pertaining to the scope and provision of interdisciplinary team services. The policies and procedures address at least the following:

   A. What services are offered;
   B. Who is responsible for the initial assessment of patient/family needs and for the preparation of the interdisciplinary team care plan;

C. Ongoing case management and assessment of the patient's/family's physical and psychosocial needs; and
D. Revision, as appropriate, of the interdisciplinary team care plan.

3. Interdisciplinary team services are coordinated by a qualified health care professional who is designated by the hospice program director and meets written entry-level requirements stating the minimum education and experience required for the coordinator position.

4. The responsibilities of the interdisciplinary team coordinator are stated in writing and include, but are not necessarily limited to, the following:

   A. Planning and implementing regular and interim patient/family conferences;
   B. Coordinating interdisciplinary team reports at team case conferences;
   C. Coordinating and implementing effective transfer of the care of patients/families between the home care and inpatient services of the hospice program;
   D. Coordinating the discharge of patients/families from the hospice program;
   E. Assuring consistency in the exchange of information and records upon transfer or discharge of patients/families, according to hospice program policies and procedures; and
   F. Coordinating, when applicable, the communication and interaction between interdisciplinary team members and personnel who provide services under arrangement.

5. Interdisciplinary team members conduct regularly scheduled team case conferences, which are documented in the medical record. The hospice program director or interdisciplinary team coordinator is responsible for implementing a consistent method for reviewing all current cases, and for determining which cases to discuss at team case conferences.

GOAL TWO

Interdisciplinary team members have access to emotional support, and to inservice and continuing education on a regular basis.

RATIONALE

Effective care of hospice patients/families by interdisciplinary team members presupposes a personal investment that can produce emotional exhaustion. Team members need time and encouragement to develop and maintain relationships with patients/families and should have effective support systems available to them.

An ever increasing body of knowledge about symptom control, patient/family centered care, psychosocial intervention, and other aspects of the care of terminally ill persons and their families is readily available. The director of the hospice program has the responsibility to assume the orientation, support, and education of staff about developments in the state of the art as they occur.

CHARACTERISTICS

1. The hospice program director or a designee appointed by the director is responsible for developing and maintaining a staff support program that

   A. provides individual counseling for staff members at their own request or on the recommendation of a supervisor, for job-related problems in accordance with hospice program policy;
   B. provides a means for group interaction among interdisciplinary team members regarding issues in caring for the dying and their families; and
   C. is directed by a qualified individual who

      (1) has an understanding of hospice care and of group dynamics and the professional and personal stress associated with the care of dying and bereaved persons, and
      (2) meets written entry-level requirements stating the minimum education and experience required for the position.

2. The hospice program director or a designee appointed by the director is responsible for the ongoing development and implementation of inservice and continuing education programs, which

   A. respond to the stated requests of interdisciplinary team members;
   B. provide opportinities for interdisciplinary team members to participate in educational activities (eg, workshops) outside the program;
   C. integrate the results of quality assurance activities; and
   D. include a mechanism for evaluating their effectiveness at least annually.

GOAL THREE

Physician services to a patient are provided by an attending physician who is primarily responsible for the patient's medical care and by the hospice medical director, in accordance with hospice program policy. A patient's attending physician is selected by the patient.

RATIONALE

Although the attending physician selected by the patient retains responsibility for the care of the patient, the medical director of the hospice program may also serve as the patient's attending physician. The medical director can complement attending physician care by providing a constant medical resource to interdisciplinary team members and attending physicians, as requested, as well as overall continuity in the provision of hospice program services. The medical director should also advocate for pain and symptom management.

CHARACTERISTICS

1. The medical care of every patient/family who receives hospice services is under the supervision of a licensed physician.

2. There is evidence of the attending physician's approval, by signature, of the interdisciplinary team care plan.

3. An attending physician who requests hospice services for a patient/family is responsible for abiding by the program's policies and procedures, which include, but are not necessarily limited to, the following:

   A. The admission of a patient/family only in accordance with established criteria;
   B. Prior to or upon admission of a patient/family, provision by the physician of information pertaining to at least
      (1) the admitting diagnosis and prognosis,
      (2) a summary of current medical findings, including specific reference to pain and symptom management,
      (3) diet or nutritional requirements,
      (4) medication and treatment orders,
      (5) pertinent orders regarding the patient's terminal condition, and
      (6) a history and physical examination; and
   C. The designation of an alternate physician to contact regarding emergency care of a patient when the attending physician is not available.

4. There is documentation of ongoing communication between the attending physician and the interdisciplinary team members.

5. The medical director of a hospice program may be

   (A) a full-time or part-time physician employee of the hospice program;

   (B) a private physician who is available to the team and offers direction on a contract basis;

   (C) a private physician who offers medical direction as a volunteer; or

   (D) the chairman of a medical staff committee who acts under that committee's guidance.

6. The medical director is appointed by the hospice program director with the approval of the governing body.

7. There are written entry-level requirements stating the minimum education and experience required for the position of medical director. These requirements include, but are not necessarily limited to, the following: The medical director is

A. a licensed physician;
B. knowledgeable about hospice services and care;
C. knowledgeable about the psychosocial care of patients/families; and
D. knowledgeable about the care of advanced irreversible disease, especially in regard to pain and symptom management and the case mix of patients receiving services in the hospice program.

8. The duties and responsibilities of the medical director include, but are not necessarily limited to, the following:

A. Consulting with attending physicians, as requested, regarding pain and symptom management;
B. Determining patient medical eligibility for hospice services in accordance with hospice program policy;
C. Acting as a medical resource to the interdisciplinary team;
D. Coordinating efforts with each attending physician to provide care in the event the attending physician is unable to retain responsibility for patient care; and
E. Acting as a medical liaison with physicians in the community.

GOAL FOUR

Qualified individuals provide nursing services that are consistent with high standards of performance and conduct and with currently available knowledge and nursing skills; attention is given to the physical, psychosocial, and interpersonal needs of patientS/families.

RATIONALE

Because the hospice nurses function as an interdisciplinary team members and may be the most constant attendants of patients in any hospice setting, they should be responsible for the early recognition of changes in patient's condition and for relaying this information to attending physicians. In addition, nurses must possess sophisticated knowledge and skills in order to apply technology to pain ans symptom management and meet the psychosocial needs of dying patients and their families.

CHARACTERISTICS

1. The hospice program director designates a currently licensed registered nurse to supervise nursing services.

2. There are written entry-level requirements stating the minimum education and experience required for the position of nursing service supervisor. These requirements include, but are not necessarily limited to, the following:

A. A bachelor of nursing science degree and a demonstrated ability in nursing practice, including two years of clinical experience in home care and inpatient services, as deemed appropriate in hospice program policy; or

B. The documented equivalent in education, training, and/or experience.

3. A qualified registered nurse is designated by the nursing supervisor and authorized to act in the nurse supervisor's absence.

4. There are written entry-level requirements stating the minimum education and experience required of individuals who provide nursing services.

   A. The qualification relate directly to the skills necessary to provide the level of nursing care required by patients/families receiving hospice services.
   B. Each individual who provides nursing services has a currently valid license.

5. There are written policies and procedures stating the scope, provision, and documentation of nursing services. These policies and procedures are reviewed at least annually and revised as necessary, in accordance with hospice program policy, to reflect a level of nursing practice commensurate with currently available knowledge and skills.

6. The provision of nursing services is documented and is based on a nursing assessment of the patient's physical condition and the psychosocial needs of the patient/family. The documentation is

   A. goal-directed, reflecting observations, actions, and plans in accordance with the interdisciplinary team care plan; and
   B. submitted in a timely manner in accordance with hospice program policy.

7. The members of the interdisciplinary team, nurses have a role in instructing and counseling patients/families regarding discharge or transfer, which includes the documentation of discharge instructions.

8. There is evidence of a current valid license for each individual providing nursing services.

GOAL FIVE

Qualified personnel provide psychological and social work services to patients, and to their families and other persons significant to them.

RATIONALE

The patient/family facing terminal illness often experiences a profound crisis. Psychological and social work services can assist the patient/family in both minimizing stresses and problems that arise from social, economic, or psychological situations and maximizing the positive aspects and opportunities for growth. The expertise of the individuals providing hospice psychological and social work services should be utilized to assess and formulate goals on an ongoing basis, focusing on the enhancement of the coping capabilities of the patient/family.

It should be noted that, although psychological and social work services are in many ways similar, they are not the same.

CHARACTERISTICS

1. The hospice program director designates an individual to supervise psychological and social work services.

2. There are written entry-level requirements stating the minimum education and experience required for the position of supervisor of psychological and social work services. These requirements include but are not necessarily limited to, the following:

   A. A master's degree in social work or a doctorate in psychology and a demonstrated ability in casework and counseling, including two years of clinical experience, in accordance with hospice program policy; or
   B. The documented equivalent in education, training, and/or experience.

3. There are written entry-level requirements stating the minimum education and experience required of individuals who provide psychological and social work services.

   A. The qualifications relate directly to the skills necessary to provide the level of psychological and social work services required by the patients/families receiving hospice services.
   B. In accordance with state law, each individual who provides psychological and social work services has a currently valid license or certification.

4. There are written policies and procedures stating the scope, provision, and documentation of psychological and social work services. These policies and procedures are reviewed at least annually and revised as necessary, in accordance with hospice program policy, to reflect a level of psychological and social work practice commensurate with currently available knowledge and skills.

5. The provision of psychological and social work services is documented and is based on a history and an assessment of the patient's/family's psychosocial status and needs.

   A. The documentation indicates a plan for intervention that is

      (1) goal directed,
      (2) reflects observations, actions, and plans in accordance with the interdisciplinary team care plan, and
      (3) submitted in a timely manner, in accordance with hospice program policy.

   B. If there is no intervention indicated at the time of assessment, there is a documented plan for re-evaluation of patient/family needs on a regular basis.

6. As members of the interdisciplinary team, the individuals who provide psychological and social work services have a role in instructing and counseling patients/families regarding discharge or transfer, which includes the documentation of discharge instructions.

GOAL SIX

Spiritual services are available in accordance with the needs of patients/families.

RATIONALE

Patients/families in the crisis of terminal illness may face issues of life assessment in terms of religious and spiritual beliefs. Hospice spiritual services can entail a variety of resources and persons engaged in meeting patients'/families' needs, including members of the hospice interdisciplinary team and the religious and spiritual leadership and resources of the community.

CHARACTERISTICS

1. Hospice spiritual services may be provided

   A. by a hospice program employee;

   B. by a qualified and trained volunteer; and/or

   C. through a working relationship with local clergy and spiritual counselors.

2. There are written entry-level requirements stating the minimum education and experience of individuals who provide spiritual services.

3. The responsibilities of the spiritual services program include, but are not necessarily limited to, the following:

   A. Spiritual counseling to assure that patients/families are offered spiritual care in keeping with their belief systems;
   B. Advocacy in contacting appropriate clergy or spiritual counselors in the community and in supporting a patient's/family's spiritual counselor; and
   C. Consultation and education to patients/families and interdisciplinary team members, as requested.

4. There are written policies and procedures stating the scope, provision, and documentation of spiritual services. These policies and procedures are reviewed at least annually and revised as necessary, in accordance with hospice program policy.

5. The provision of spiritual services is documented and indicates a plan for intervention based on an assessment of the patient's/family's spiritual needs. The documentation

A. reflects observations, actions, and plans in accordance with the interdisciplinary team care plan; and
B. is submitted in a timely manner, in accordance with hospice program policy.

6. As a member of the interdisciplinary team, the individual who provides spiritual services has a role in counseling the patient/family regarding discharge or transfer.

GOAL SEVEN

Volunteers who have received training and orientation provide defined services under the supervision of a designated, qualified, and experienced staff member.

RATIONALE

One of the bases of hospice care, since its inception, has been the services and involvement of volunteers. Volunteers provide an important source of outreach and support to patients/families, as well as the necessary community input to assist in developing and maintaing the hospice program in accordance with community response, need, and resources.

CHARACTERISTICS:

1. The objectives, scope, and provision of volunteer services are clearly stated in writing. This statement is reviewed at least annually and revised as necessary, in accordance with hospice program policy.

2. The hospice program director designates an appropriate and qualified individual to coordinate volunteer services. There are written entry-level requirements stating the minimum education and experience required for the position of volunteer services coordinator.

3. The responsibilities of the volunteer services coordinator are stated in writing and include, but are not necessarily limited to, the following:

   A. Determining the need for volunteer services in accordance with interdisciplinary team care plans;
   B. Planning and implementing a program for volunteer recruitment;
   C. Coordinating efforts to recruit and select volunteers;
   D. Implementing a volunteer training program;
   E. Assigning volunteers to patients/families and to appropriate services;
   F. Instructing interdisciplinary team members on the proper, effective, and creative use of volunteers;
   G. Keeping team members and the community informed of volunteer services and activities;
   H. Providing regular programs of continuing education and training specific to the needs of volunteers; and
   I. Performing at least annual evaluations of individual volunteers.

4. An orientation and training program is conducted to familiarize volunteers with the hospice program's goals and services and provide appropriate clinical orientation regarding patients/families. The program includes, but is not necessarily limited to, orientation and/or training in regard to the following:

   A. The hospice program's goals and services;
   B. Confidentiality and the protection of patient's/family's rights;
   C. Procedures for responding to unplanned events, including untoward incidents, emergencies, and presence at death;
   D. The hospice program's method of communication between volunteers and other interdisciplinary team members;
   E. The distinction between administrative and clinical authority and responsibility;
   F. The physiological and psychological aspects of terminal disease;
   G. Family dynamics, coping mechanisms, and psychosocial issues surrounding terminal disease, death, and bereavement;
   H. General communication skills; and
   I. Personal issues relating to death and dying.

5. A support program for volunteers is developed, adopted, and maintained to provide volunteers with individual and group interchange, guidance, and emotional support.

6. Volunteers are supervised by an appropriate person designated by the volunteer services coordinator, in accordance with hospice program policy. The supervision of volunteers includes at least the following elements:

   A. The availability of interdisciplinary team members to assist volunteers in establishing relationships with patients/families; and
   B. Procedures for assuring that any observations of volunteers are recorded and reported to appropriate team members.

7. Volunteer activity records contain information that provide an account of services provided and can be used to evaluate the provision of volunteer services. At least the following records are maintained:

   A. A record for each volunteer that includes the volunteer's application, record of assignments, and performance evaluation;
   B. A master assignment schedule for all volunteers;
   C. A description of the services that can be provided by volunteers; and
   D. Entries in each record that provide, at the least,

      (1) the name of the volunteer providing services,
      (2) the date(s) of services provided,
      (3) the type of services provided, and
      (4) any patient/family reaction, incident, or change noted by the volunteer.

8. A volunteer can provide direct patient care only

   A. with the approval of the attending physician;

B. when care is consistent with the interdisciplinary team care plan;
C. with the approval of patient/family;
D. when the training and experience of the volunteer is appropriate to the service performed;
E. when the volunteer's services, activities, and qualifications are commensurate with the goals and characteristics for the appropriate discipline contained in this chapter of the Manual; and
F. when applicable, when there is documentation of the health status of the volunteer, are prescribed by state requirements.

GOAL EIGHT

A qualified individual provides bereavement services that are consistent with current knowledge and skills. Bereavement services are available to survivors for at least one year after the death of a patient.

RATIONALE

Grief and bereavement are normal reactions to loss and death. Grief is a highly personal response to loss; bereavement is the extended period of deprivation following the loss of a loved one. The hospice concept encourages the expression and resolution of grief, which may precede an anticipated death or be delayed for a considerable time. The death of a family member can result in a range of physical, emotional, social, familial, economic, and spiritual disruptions. Some persons can resolve grief with time and their own available resources; others may require formal assistance and support over an extended period of time. The provision of appropriate continuity of care in dealing with grief and bereavement is the responsibility of the hospice program.

CHARACTERISTICS

1. Bereavement services may be provided through various sources:

   A. A hospice program employee;
   B. An individual or agency that provides bereavement services under arrangement with the hospice program;
   C. A trained and qualified volunteer; or
   D. Interdisciplinary team members who provide direct patient care and have had appropriate bereavement training.

2. The hospice program director designates an individual to supervise bereavement services.

3. There are written entry-level requirements stating the minimum education and experience required for the position of supervisor of bereavement services. These requirements include, but are not necessarily limited to, the following:

   A. A graduate clinical degree in a field that addresses psychosocial needs (eg, a master's degree in social work or a doctorate in psychology) and a demonstrated ability in casework and counseling,

including two years of clinical experience, in accordance with hospice program policy; or

B. The documented equivalent in education, training, and/or experience.

4. A reasonable effort is made to match the qualifications of the individual who provides bereavement care with the level of knowledge and skills required to intervene effectively with survivors. The minimum education, training, and experience required of individuals who provide bereavement services are determined by the hospice program.

5. When bereavement services are provided by volunteers and/or interdisciplinary team members who also provide direct patient care, there is a bereavement training program, which is outlined in writing.

6. There are written policies and procedures stating the scope, provision, and documentation of bereavement services. The policies and procedures are reviewed annually and revised as necessary, according to hospice program policy, to reflect a level of bereavement care commensurate with available knowledge and skills.

7. Bereavement services include, but are not necessarily limited to, the following:

   A. Regular survivor contact in the 12 months following death;
   B. An interchange of information between the team members who provided care before the death of the patient and the individuals who provide bereavement services to the survivors;
   C. An assessment of family members' needs both before and after the death of the patient;
   D. The development and maintenance of programs and resources to meet the needs of the bereaved;
   E. A process for the assessment of grief reactions that indicate the need for prolonged intervention or appear to be pathological and indicate the need for referral of the individual; and
   F. Support to interdisciplinary team members regarding participation in meaningful formal services and/or rituals.

8. The provision of bereavement services is documented and based on an assessment of the needs of the survivors. The documentation

   A. is goal-directed;
   B. reflects follow-up based on a plan for intervention, as agreed upon with the survivors; and
   C. is submitted in a timely manner, in accordance to hospice program policy.

GOAL NINE

Special services deemed necessary in the interdisciplinary team care plan, are provided to patients/families by hospice program employees, or under arrangement.

RATIONALE

Advanced irreversible disease can create a variety of problems for the patient/family that need to be addressed. Special services with traditionally low utilization by terminally ill patients and their families can be contracted by a hospice program to facilitate efficient utilization of resources.

CHARACTERISTICS

1. There are written policies and procedures that describe the conditions under which referrals for special services are made and services are provided. These conditions provide for, at least for, examinations, assessments, or consultations that are not within the professional expertise of interdisciplinary team members.

2. At least the following services are provided as needed:

   A. Consultation by a registered dietician;
   B. Occupational therapy; and
   C. Physical therapy.

3. To assure continuity of care for the patient/family, there are written policies and procedures that pertain to at least the following:

   A. The exchange of treatment goals and the interdisciplinary team care plan between the coordinator and the individual providing care under arrangement;
   B. The exchange of patient/family psychosocial information;
   C. A method of communication with the interdisciplinary team members providing care; and
   D. Timely submission to the hospice coordinator of documentation of services provided.

4. There are written policies and procedures regarding referral for services. These policies and procedures

   A. describe the mechanisms by which a patient/family may request a referral for services the hospice program does not provide;
   B. describe the role of the interdisciplinary team members in assisting the patient/family in the referral process; and
   C. are reviewed annually and revised as necessary, in accordance with hospice program policy.

Chapter Three

Symptom Management

GOAL ONE

Physical pain and symptom management is provided through appropriate therapies.

RATIONALE

The pain and symptoms of terminal disease can usually be minimized through the use of appropriate palliative treatments that produce the greatest relief from disease-caused problems for the longest period of time and with the least side effects. In addition, curative treatments are utilized when indicated for physical problems secondary to the primary diagnosis.

CHARACTERISTICS

1. Pain and symptom management is documented in the interdisciplinary team care plan and in progress notes throughout the course of patient care and across disciplines. The following elements of pain and symptom management are documented:

   A. Physical assessment;
   B. Chronic or acute pain, or a change in pain;
   C. Symptoms associated with chronic pain;
   D. Adjustment of pain and symptom modalities as needed;
   E. Interdisciplinary team communication and consultation with attending physicians;
   F. Discussion with patients/families about the approach to pain relief as well as instruction regarding any therapies used; and
   G. Repeated assessments of pain and symptoms, including determinations of compliance with the interventions prescribed.

2. Education programs for the introduction and review of effective approaches to pain and symptom assessment and management are available at least twice annually to interdisciplinary team members. The content of education programs includes, but is not necessarily limited to, the following:

   A. Common terminology for use in describing pain and pain relief to patients/families;
   B. Discussion of approaches to analgesia, including noninvasive approaches, analgesic drugs and their side effects management, surgical approaches, and other treatment modalities; and
   C. Pain and symptom assessment.

GOAL TWO

Symptom management includes assessing and responding to the psychosocial needs of the patients/families.

RATIONALE

Hospice care recognizes that when a patients/families are faced with terminal disease, stress and concerns may arise in many areas of their lives. Successful symptom management frequently requires concurrent physical and psychosocial intervention to address those concerns and stresses.

CHARACTERISTICS

1. Psychosocial assessment of an intervention with a patient/family are documented in the interdisciplinary team care plan and in progress notes throughout the course of patient care and across disciplines. The following elements of psychosocial symptom assessment and management are documented.

   A. Such symptoms as anxiety or depression;
   B. Family dynamics;
   C. The patient's/family's understanding of the illness and prognosis and their reaction to the course of the illness; and
   D. Interdisciplinary team communication and consultation with the attending physician.

2. Education programs for the introduction and review of psychosocial assessment and intervention are available at least twice annually to interdisciplinary team members. The content of education programs includes, but is not necessarily limited to, the following:

   A. Basic aspects of psychosocial assessment;
   B. Basic communication skills;
   C. Patient/family response to terminal illness and death; and
   D. Family response to bereavement.

Chapter Four

Home Care and Inpatient Services

GOAL ONE

Hospice program services include home care and inpatient care. The home care and inpatient services are organized, managed, staffed with a sufficient number of personnel, and appropriately integrated with other services of the hospice program.

RATIONALE

Many of the physical and psychosocial needs of the dying patient can be met at home, and being cared for at home can enable the development and continuance of significant human relationships between the dying person and his or her family members. However, hospice care recognizes that the needs of patients/families cannot always be met at home. In those instances when the physical and psychosocial needs of hospice patients necessitate acute care hospitalization, hospice inpatient services must be available.

CHARACTERISTICS

1. There is a written statement of the philosophy and objectives of the home care service and of the inpatient service. The statement includes a description of the services offered in both care settings.

2. All applicable federal, state and local regulations and/or licensure and certification requirements are met by the home care service and the inpatient care service.

3. There are written policies and procedures for the home care services and inpatient services in regard to personnel and the services they provide. These policies and procedures address at least the following:

   A. The qualifications of the physicians who provide care to the patients/families admitted to the hospice program;
   B. The treatment modalities provided, including intravenous procedures, parenteral feedings, chemotheraphy, and the administration of injections; and
   C. The designation of tasks that are performed by home health technicians, home health aides, nurse's aides, and homemakers.

(1) These personnel have satisfactorily completed a structured or on-the-job training program, if such instruction is consistent with legal requirements applicable to the hospice program.

4. There are written policies and procedures for the home care and inpatient services in regard to the resuscitation of patients. These policies and procedures address the following:

   A. The involvement of the patient and the family in deciding whether to resuscitate; and
   B. The attending physician's involvement in, and approval of, the decision.

5. There are written policies and procedures for home care and inpatient services regarding student placement and training in the hospice program. These policies and procedures address at least the following:

   A. The placements and training available;
   B. The supervision, by appropriately qualified hospice personnel, of students when performing patient care; and
   C. The roles and responsibilities of the hospice program and the outside education program if the hospice program provides education and training for students from an outside education program.

6. The hospice program director designates a coordinator of home care and/or inpatient services. A coordinator is responsible for providing administrative direction to home care and/or inpatient services.

7. There is a written statement regarding a coordinator's authority, duties, and responsibilities, which includes, but are not necessarily limited to, the following:

   A. Implementing policies and procedures pertinent to the home care and/the inpatient setting;
   B. Acting as an adviser to the hospice program director;
   C. Directing and, as appropriate, supervising home care and inpatient interdisciplinary team members in their duties;
   D. Participating in the review and evaluation of the quality and appropriateness of patient/family care; and
   E. Preparing and submitting program service reports, which include
      (1) statistical records of the quantity and types of services rendered, and
      (2) records and reports reflecting the nature of the patient population.

8. The scope of services provided, the utilization of services, and the skills necessary to provide the level of care appropriate to the home care and inpatient services are considered when determining the following:

   A. The number, education, and training of qualified personnel necessary; and
   B. Patient-staff ratios for the home care and inpatient services.

(1) An identified methodology that reflects the objectives of the home care and inpatient services is utilized to determine patient-staff ratios.

Home Care Services

GOAL TWO

Home care services are available 24 hours a day, seven days a week.

RATIONALE

The varied physical and psychosocial problems and anxieties associated with terminal illness can occur at any time of the day or night. Hospice care must be available for patients/families whenever it is needed.

CHARACTERISTICS

1. There are written policies and procedures describing the scope of home care services. These policies and procedures pertain to at least the following:
   A. What services are available on a 24-hour basis seven days a week, including access to pharmacy services;
   B. Any limitations regarding care provided after normal working hours or on weekends; and
   C. The method of information exchange between on-call and day-to-day interdisciplinary team members.

2. Unless otherwise provided by law, at least nursing services are available on a 24 hour basis seven days a week.

GOAL THREE

Interdisciplinary team members are prepared to provide care to the patient/-family at the time of the patient's death at home.

RATIONALE

A unique aspect of hospice care is the need to prepare interdisciplinary team members for presence before, during, or immediately after the death of a patient at home. To provide supportive continuity of hospice care at the time of death, members must be aware of state and local regulations, laws, and procedures regarding death in the home, as well as the patient's/family's wishes.

CHARACTERISTICS

1. There is a written plan of orientation and inservice training for team members that addresses, but is not necessarily limited to, the following:

A. State and local laws, regulations, and procedures regarding death in the home and the role of the attending physician;
B. A procedure for working with the coroner's office and, as applicable, law officials; and
C. A procedure for the disposal of drugs in the home at the time of death.

Inpatient Services

GOAL FOUR

The inpatient facility or unit has an organized medical staff.

RATIONALE

An organized medical staff is a single identified body that accepts overall responsibility for the quality of medical care provided to patients and the responsibility unless otherwise provided by law, for the qualifications of those individuals licensed to practice medicine and dentistry who care for patients in the inpatient service.

CHARACTERISTICS

1. The medical staff is accountable to patients/families and the hospice program governing body for the quality of medical care provided and for the ethical and professional practice of medical staff members.

2. The medical staff, with the assistance of the medical director, formulates bylaws and rules and regulations necessary for self-governance and for the discharge of the medical staff's responsibilities. The bylaws and the rules and regulations include, but are not limited to, the following:

   A. A descriptive outline of the organization of the medical staff;
   B. A statement of the qualifications a physician must have to be privileged to attend patients in the inpatient facility or unit;
   C. A procedure for granting and withdrawing physician's practice privileges;
   D. Provisions for regular meetings of the medical staff;
   E. Provisions for keeping accurate and complete medical records, which include signed progress notes at the time of each visit and all orders given since the last visit;
   F. Provisions for securing emergency medical care if the attending physician is not available;
   G. Provisions that require a physician's written orders to be recorded and signed;
   H. Provisions that require a physician's verbal and telephone orders to be recorded and signed by the accepting physician, nurse, or pharmacist (in the case of medication orders) and countersigned by the attending physician;
   I. A statement of the necessary qualifications, staff appointments, and rights of dentists, podiatrists, psychologists, nurse practitioners, physician assistants, and other health professions;

J. Provisions for establishing effective controls throughout the medical staff to assure the achievement and maintenance of maximum standards of ethical and professional practices;
K. Provisions for a fair hearing in the event of denial of staff appointment or reappointment or the curtailment, suspension, or revocation of privileges;
L. Provisions for review and evaluation of the quality of services rendered, including the appropriateness of attending physician visit schedules; and
M. A procedure for physician contact and care when neither the attending physician nor the designated alternative are available to examine and treat a patient needing immediate attention.

3. The duties and responsibilities of the medical director of inpatient services include direction of the medical care in the facility or unit.

GOAL FIVE

Provision is made in the inpatient setting for the privacy of patients/families.

RATIONALE

Hospice care recognizes that dying patients and their families continue to have special needs with regard to privacy that need to be respected and accepted within the confines of an inpatient unit or facility.

CHARACTERISTICS

1. Physical space is provided for private patient/family visiting.

2. There are accommodations for family members to remain throughout the night with the patient.

3. Space is provided for family viewing and privacy after a patient's death.

GOAL SIX

The inpatient facility or unit is designed, constructed, equipped, and furnished in a manner that assures the physical safety of patients/families, personnel, and visitors.

RATIONALE

Patients/families, team members, and personnel are entitled to receive and provide care in a building that meets appropriate national standards for construction safety and fire protection.

CHARACTERISTICS

1. The building complies with the 1981 edition of the Life Safety Code (R) of the National Fire Protection Association. The following is required:

   A. Submission of a statement of construction and fire protection. This document is completed by the facility or unit. The information entered in the document is verified and authenticated by an individual who is knowledgeable about institutional construction and fire safety, particularly in regard to health care facilities. Individuals qualified to verify and authenticate the information include registered professional engineers, registered architects, members of the Society of Fire Protection Engineers, or qualified employees of either a fire insurance rating organization or the office of the state fire marshal. It is strongly recommended that such verification or authentification be made following an on-site visit.

   B. A plan of correction for all physical plan deficiencies identified by authorized inspecting agencies and/or indicated in the statement of construction and fire protection. This plan of correction is approved by the authority having jurisdiction and specifies the anticipated time of completion.

   C. A document which certifies that the facility's physical plant is in compliance with the requirements of the 1981 Life Safety Code (R). This documentation may include copies of the state fire marshal's report, state licensure survey reports, or reports of other authorized agencies. Consideration is also given to equivalency when an element of safety is provided at a level equal to or greater than that described in the codes, provided that no other safety element or system is compromised or adversely altered in any way. When alternate protection has been installed and has been accepted by the local authority having jurisdiction, appropriate documentation is required. Copies of all such documentation are available.

   D. If the building is constructed prior to 1973 and the requirements of the standards or their equivalency are not met, the facility institutes and documents--on a sustained basis--extraordinary fire prevention measures in the form of effective housekeeping and maintenance practices, adequate fire-fighting equipment, adequate staffing, and frequent fire drills on all shifts.

GOAL SEVEN

The environment of the inpatient facility or unit is adequate, comfortable, accessible and has sufficient space and equipment for the clinical and personal care of patients.

RATIONALE

Patients/families are entitled to receive clinical and personal care in a comfortable environment that has adequate space and equipment for meeting their needs.

CHARACTERISTICS

1. Adequate, comfortable lighting levels and adequate ventilation through windows, mechanical means, or a combination of both are provided.

2. Sounds are contained at comfort levels.

3. Comfortable room temperatures are maintained.

4. In the event of loss of normal water supply, provision is made to assure that water is available to all essential areas.

5. The facility is accessible to and functional for the physically handicapped. Reasonable accommodations are made in accordance with Standard A1117.1, Specifications for Making Buildings and Facilities Accessible to, and Usable by, the Physically Handicapped, of the American National Standards Institute.

6. Each patient/family care area has at least the following:

   A. A nurses' station;
   B. Drug storage and preparation areas; and
   C. Utility and storage rooms.

7. The nurses' station is equipped to register patients'/families' calls through a communication system from patient/family areas, including patient/family rooms and toilet and bathing facilities.

8. Patient/family rooms are designed, equipped, and furnished to comply with all applicable federal, state, and local laws, rules, and regulations, as well as facilitate effective patient/family care and comfort.

9. Each patient/family room is equipped with, or located near, toilet and bathing facilities.

10. Each patient/family room has direct access to a corridor and outside exposure, with the floor at or above ground level.

GOAL EIGHT

The environment of the inpatient facility or unit is functionally safe and sanitary.

RATIONALE

Patients/families, team members, and personnel are entitled to receive and provide care in a facility or unit that is safe and sanitary and in which appropriate measures can be taken in the event of fire, disaster, or other emergency.

CHARACTERISTICS

1. The hospice program director or designee implements and monitors a comprehensive facilitywide or unitwide safety program that is appropriate to the size of the facility or unit.

2. The inpatient team and other personnel as appropriate, are utilized in the development, implementation, and monitoring of safety characteristics and practices to eliminate or reduce hazards to patients/families through the formation of a safety committee.

3. The safety program has written policy and procedures pertaining to at least the following:

   A. The enhancement of safety within the facility or unit and on the facility's grounds;
   B. Coordination of the development of safety rules and practices;
   C. The establishment of an incident-reporting system that includes mechanisms for investigating and evaluating all incidents reported and mechanisms for documenting the review of all reports and actions taken;
   D. The establishment of liaison between the safety committee and the infection control committee;
   E. The provision of safety-related information to be used in the orientation of all staff and volunteers;
   F. The conducting of hazard surveillance programs at specifically defined intervals;
   G. The establishment of methods for measuring results of the safety program;
   H. The establishment of methods, including the review of all pertinent records and reports, to periodically analyze the effectiveness of the safety program; and
   I. The familiarization of facility or unit personnel with applicable federal, state, and local safety regulations.

4. The facility or unit has an available emergency power source that provides essential service when the normal electrical supply is interrupted.

5. Comprehensive safety devices are installed, and safety practices, policies, and procedures are instituted to minimize hazards to patients/families, staff, and visitors.

6. The facility or unit has a written internal disaster and fire plan, as well as fire drills.

7. Sanitation practices, policies, and procedures are implemented to minimize health hazards to all patients/families, staff, and visitors.

GOAL NINE

There is an active inpatient facilitywide or unitwide infection control plan.

RATIONALE

Patients/families, team members, and personnel are entitled to a sanitary and comfortable environment in which measures are taken for the prevention of the development and transmission of infection.

CHARACTERISTICS

1. There is a written plan for the prevention and control of infection and the maintenance of a sanitary environment. The plan pertains to at least the following:

   A. The designation of interdisciplinary personnel responsible for implementing and monitoring the program;
   B. The review of procedures for handling food, processing laundry, disposing of environmental and human wastes, controlling pests;
   C. The review of patient/family care practices, visiting rules for high-risk areas, and access to potential sources of infection;
   D. The monitoring of the health status of employees; and
   E. The monitoring of staff performance to assure that policies and procedures are being followed.

2. There are written policies and procedures for aseptic and isolation techniques, the policies and procedures are

   A. made known to and followed by all staff; and
   B. reviewed annually and revised as necessary.

3. An adequate amount of linen is available at all times for the proper care and comfort of patients.

   A. The linen is handled, processed, stored, and transported in a manner that prevents the transmission of infection.

4. The facility or unit is free of insects and rodents.

GOAL TEN

The inpatient facility or unit provides for the nutritional and special dietary needs of patients/families.

RATIONALE

Hospice care recognizes not only the nutritional and dietetic needs of patients/families, but also the psychological importance of food. The elements of alienation and isolation that may be experienced in an inpatient setting can be reduced with the provision of facilities that increase socialization for patients/families, while meeting patients' nutritional needs.

CHARACTERISTICS

1. Safe, sanitary, and adequately equipped facilities for food preparation by patients/families are provided.

2. Dietetic services are provided directly by the facility or unit or under arrangement with an outside foodservice or management company.

3. Dietetic services are directed by an individual who, by education or specialized training and experience, is knowledgeable in foodservice management.

4. The nutritional aspects of patient care are supervised by a dietitian who is registered by the Commission on Dietetic Registration of the American Dietetic Association or has the documented equivalent in education, training, and experience, as well as evidence of continuing education.

5. The duties of the supervisor of dietetic services include, but are not limited to, the following:

   A. Patient/family consultation;
   B. Participation in patient/family case conferences, as requested;
   C. Approval of menus, including special diets; and
   D. Nutritional assessments of patients.

6. If dietetic services are provided by the facility, the following applies:

   A. The department or service is organized, directed, and staffed to assure the provision of optimal nutritional care and foodservice.
   B. Dietetic personnel are appropriately trained and educated; and
   C. The dietetic department or service area is designed and equipped to provide safe, sanitary, and timely foodservice and to meet the nutritional needs of patients

7. Dietetic services are guided by written policies and procedures.

8. Dietetic services are provided to the patient in accordance with a written order by the attending physician. Appropriate dietetic information is recorded in the patient's/family's medical record.

9. The quality and appropriateness of the nutritional care in meeting the nutritional needs of patients/families are regularly reviewed and evaluated.

GOAL ELEVEN

The pharmaceutical needs of patients are met by the hospice program.

RATIONALE

An integral part of hospice home care and inpatient services is pain and symptom management, and essential to this element of care is meeting the pharmaceutical needs of the patients. Patients/families are entitled to pharmaceutical services that are conducted in accordance with accepted ethical and professional practices and all legal requirements.

CHARACTERISTICS

Home Care and Inpatient Services

1. Only health care practitioners who are authorized by law to write medication orders may do so.

2. Medication orders that contain abbreviations and chemical symbols are filled only if the abbreviations and symbols are on a standard list approved by the medical director and/or medical staff.

3. An individual other than a physician, registered nurse, or licensed practical nurse may administer medications under the supervision of a registered nurse or licensed practical nurse if in accordance with applicable laws and regulations and hospice program policy, and if approved by the attending physician.

4. Self-administered medication is permitted when specifically ordered for the patient by an approved prescriber in accordance with applicable laws and regulations.

5. Before discharge from inpatient services, the patient/family is instructed as to which medications, if any, are to be administered at home and by whom. The patient/family is also instructed as to the preparation, administration, dosages, and precautions to be taken.

6. The medications administered and any adverse drug reactions are documented in the medical record and are periodically reviewed by the attending physician.

7. There is a written policy and procedure regarding medication error follow-up and documentation of any corrective action taken.

8. There are up-to-date resources available to interdisciplinary team members to identify drug side effects and toxic reactions.

9. There is a reporting system for advising the Food and Drug Administration and the drug manufacturer of any unexpected or significant adverse reactions to a drug

10. Investigational drugs are used only under the direct supervision of an authorized investigator and with the approval of the medical director and the Institutional Review Board. (When hospice inpatient services are provided in a hospital, the hospital's procedures regarding investigational drugs supercedes this standard.)

11. All medication orders are reviewed in accordance with applicable regulations.

12. The pharmacist is experienced in or receives orientation in the specialized functions of the hospice program.

13. The pharmacist is licensed in the jurisdiction of the hospice program.

14. The pharmacist participates in the development of inservice education programs for the hospice program staff.

Inpatient Services

15. Pharmaceutical services for the inpatient facility or unit are provided directly by the facility or the unit or under arrangement.

16. A licensed pharmacist experienced in institutional pharmacy practice is responsible for the development of written policies and procedures to govern the storage, preparation, distribution, and administration of drugs in accordance with applicable federal, state, and local laws and regulations, regardless of the arrangement made for services.

17. A pharmacist makes at least weekly inspections of all drug-storage units, including the emergency cart.

18. In inpatient facilities or units where pharmaceuticals are provided through a community pharmacy, medications are obtained by written prescription from an authorized prescriber only.

19. Any drug brought into the inpatient facility or unit is not administered unless it can be identified, unless a written order to administer it is given by the attending physician, and unless it is judged physically and chemically stable by the pharmacist.

20. The inpatient facility or unit utilizes a drug profile, and a pharmacist regularly reviews the medication records of patients.

21. The inpatient facility or unit has specific policies and procedures for controlling and accounting for drug products. The procedures account for drugs ordered and drugs on hand, as well as their effectiveness dates.

22. Adequate precautions are taken to store medications under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security.

23. Drug preparation and storage areas are secure and well lighted.

GOAL TWELVE

The inpatient facility or unit provides, or has delineated access to, radiology services for patients.

RATIONALE

Diagnostic and therapeutic radiology services are necessary for effective pain and symptom management. Radiology services should be conveniently available to meet these needs, as determined by the medical staff, and provided in accordance with accepted professional practices and all legal requirements.

CHARACTERISTICS

1. When radiology services are provided by a facility or unit the type of radiology service available and the arrangements for referring and transferring patients is delineated in a written plan.

2. When radiology services are provided by the hospice inpatient facility or unit, the following apply:

   A. Written policies and procedures govern the operation and inspection of the services, as stated in applicable regulation;
   B. The services are directed by a physician member of the facility staff who is qualified through education and/or experience to assume this function;
   C. Provision is made for appropriate facilities for radiographic and flouroscopic diagnostic services; and
   D. An acceptable method of quality control is used.

GOAL THIRTEEN

The hospice inpatient facility or unit provides, or has delineated access to, pathology and laboratory services in accordance with the needs of patients, the size of the facility or unit, the services offered, and the resources available in the community.

RATIONALE

Pathology and laboratory services are necessary for pain and symptom management. These services should be conveniently available to meet the needs of patients as determined by the medical staff and provided in accordance with accepted professional practices and all legal requirements.

CHARACTERISTICS

1. The means of providing pathology and laboratory services are delineated in a written plan.

2. When pathology and laboratory services are provided by the hospice inpatient facility or unit, the following apply:

   A. Written policies and procedures govern the operation and inspection of the services, as stated in applicable regulations;
   B. The services are directed by a physician member of the facility or hospital staff who is qualified through education and/or experience to assume this function; and
   C. An acceptable method of quality control is used.

GOAL FOURTEEN

The hospice inpatient facility or unit has a written plan delineating the manner in which emergency services are provided.

RATIONALE

Patients/families, staff, and visitors are entitled, at the least, to lifesaving first aide, as deemed appropriate, and referral and ready access to the nearest facility that has the capability of providing emergency services.

CHARACTERISTICS

1. When emergency services are provided by a facility or unit other than the hospice inpatient facility or unit, the type of emergency services available and the arrangements for referring and transferring patients/families, staff, and visitors are delineated in a written plan.

2. When emergency services are provided by the hospice inpatient facility or unit, the type of emergency services available are delineated, and the services provided are organized and properly directed.

Chapter Five

Continuity of Care

GOAL ONE

The hospice program provides a continuum of home care and inpatient care through the direct provision of the services or under arrangement.

RATIONALE

Continuity of care in a hospice program is the capacity to respond to patients'/families' needs, whenever and wherever they arise. Hospice patients/families may experience fragmentation and alienation in seeking physical and psychosocial care, but continuity of care in regard to hospice program personnel and services, in both home care and inpatient care settings, can reduce the sense of fragmentation and alienation. Effective administrative and staff integration can assure the continuation of high-quality care for patients/families in both settings.

CHARACTERISTICS

1. Hospice program home care and inpatient services may be provided through various methods, depending on the scope of services offered by the program itself, local hospitals and health care agencies, and other resources in the community.

    A. Home care services may be provided through the following:
        (1) A hospice home care agency; or
        (2) A unit or designated service of a hospital-based, community-based, or public health home care program.
    B. Inpatient services may be provided through the following:
        (1) A hospice inpatient facility; or
        (2) An inpatient unit in a hospital, skilled nursing facility, or intermediate care facility; or
        (3) A scattered-bed or consultation team approach in an acute care hospital.

2. When the hospice program does not directly provide both home care and inpatient care services, there is a written agreement between the hospice program and the provider(s) governing the nature and scope of services and assuring continuity of care. The written agreement addresses at least the following:

    A. What services are provided by each party to the contract;
    B. The qualifications of the personnel providing services;

C. The role and responsibility of the hospice program in the selection, evaluation, orientation, and continuing education of the personnel who provide hospice care;
D. The manner in which services are initiated and coordinated;
E. The respective roles of hospice program interdisciplinary team members, provider(s), and attending physicians in the establishment, regular review, and implementation of interdisciplinary team care plans;
F. The requirements for providing documentation of services rendered in accordance with hospice program policy;
G. A requirement that all contracted services must comply with the standards contained in this Manual;
H. Compliance of the provider(s) with all applicable federal, state, and local regulations;
I. Liability and responsibility of the program and the provider(s);
J. The term of the agreement and the basis for its termination or renewal;
K. Provisions for reimbursement for services, if any; and
L. The individual(s) responsible for the implementation of the agreement's provisions.

3. If the hospice program, at the time of survey, is unable to provide a written agreement for the provision of home care and inpatient care services, there is evidence of at least the following:

A. A written plan to secure a written agreement for hospice services not currently provided directly, with supporting documentation of action taken on the plan;
B. The provision of interdisciplinary team care plans to the provider(s);
C. Provision for orientation and continuing education to identified personnel regarding pain and symptom management, psychosocial assessment and intervention, and the hospice philosophy of care;
D. Coordination of discharge and transfer planning;
E. Regular communication between the care providers and a designated hospice liaison, in accordance with hospice program policy, regarding the implementation and review of care plans; and
G. Twenty-four hour availability of hospice program consultation by interdisciplinary team members to the provider(s).

4. There is a written plan regarding the transfer or discharge of patients/families. The plan is applicable to program services whether or not provided directly and addresses at least the following:

A. The involvement of interdisciplinary team members who provide care;
B. The involvement of the patients/families in transfer or discharge decisions;
C. The instruction f the patients/families members, as appropriate, before discharge or transfer;
D. The delineation of the appropriate medical, clinical, and administrative information to be exchanged in a transfer as well as the method of exchange; and

E. Evidence of the attending physician's concurrence with the transfer or discharge plan, as indicated by his or her signature.

5. There is a policy in regard to communication between home care service and inpatient care service interdisciplinary team members regarding program issues, whether or not the services are provided by the program directly or under arrangement.

Chapter Six

Medical Records

GOAL ONE

An accurate, medical record that provides documentation of hospice program services and is readily accessible to permit prompt retrieval of information is maintained for each patient/family.

RATIONALE

Significant patient-specific clinical information is found only in the medical record, and during the ongoing evaluation, diagnosis, and treatment of the patient, the patient/family medical record is depended on for the following:

.Providing continuity of care between inpatient and home care services and evidence of communication among a number and variety of health care professionals involved in the care of the patient/family;

.Providing a record of the patient's course to guide appropriate evaluation and treatment in response to the patient's condition and progress or lack of progress;

.Providing information pertinent to the concurrent monitoring activities of the medical staff, interdisciplinary team members, and other hospice personnel; and

.Providing information for use in continuing education activities, clinical research, clinical review activities of the medical staff, interdisciplinary team members and home care and inpatient services personnel, as outlined in the hospice quality assurance plan.

Upon termination of hospice care, the patient/family medical record becomes a historical document depended on for the following:

.Providing information for use in the postdischarge care of the patient/family (if applicable);

.Providing information to assist in protecting the legal interests of the patient/family, the hospice program, and the practitioner responsible for the patient's/family's care; and

Providing information to validate charges for patient care services.

CHARACTERISTICS

1. There is a medical record for each patient/family served.

2. The medical record is sufficiently detailed and accurate to enable the assumption of care by any interdisciplinary team member.

3. There is a standardized medical record format designed according to the requirements of the hospice program. The format

   A. is used in both inpatient and home care services; and
   B. is used to document interdisciplinary team services.

4. The medical record of each patient/family provided hospice care includes, but is not necessarily limited to, the following:

   A. Data that identify the patient/family or an explanation for any missing items of identification;
   B. All pertinent diagnoses;
   C. The patient's prognosis;
   D. Designation of the attending physician(s);
   E. Designation of the family member or other primary caregiver to be contacted in the event of emergency or death;
   F. The patient's medical history, which may be a copy obtained from the hospital or physician's office, with an update added by the attending physician or hospice nurse;
   G. The findings of a physical examination by the attending physician performed within 24 hours upon admission to the inpatient care service;
   H. A current interdisciplinary plan of care that includes
      (1) a problem list,
      (2) a statement of goals and types and frequency of services to be provided, and
      (3) a statement of current medications, diet, treatment procedures, and equipment required;
   I. A description of the patient's functional limitations;
   J. A listing of the activities permitted;
   K. A listing of the safety measures required to protect the patient from injury;
   L. A physical assessment of the patient;
   M. A psychosocial assessment of the patient/family;
   N. For each home visit or inpatient service rendered, signed and dated progress notes that include
      (1) a description of signs and symptoms,
      (2) notations regarding treatment, service, or medication rendered and patient reaction,
      (3) notations regarding any change in the patient's condition, and
      (4) notations regarding any patient/family instruction as well as compliance with treatment;
   O. Legible and complete diagnostic and therapeutic orders authenticated by the attending physician;
   P. Relevant test determinations and procedure findings;
   Q. A record of interdisciplinary team conferences;

R. Copies of all transfer and summary reports;
S. A bereavement assessment and plan for intervention;
T. Instructions to the patient/family concerning care at discharge; and
U. Conclusions or evaluation at the termination of hospice care, including a copy of the referral to another resource, if applicable.

5. The medical record of each patient/family provided home care services includes, but is not necessarily limited to, the following information:

   A. The name of the person who will assume primary responsibility for the care of the patient at home; and
   B. The suitability or adaptability of the patient's/family's residence for the provision of required medical services.

6. There is a written program policy that delineates authority to make entries in or review the medical record.

7. Physician's verbal orders are recorded and later authenticated by the attending physician within the time period specified in hospice program policy and/or in the bylaws and the rules and regulations of the medical staff.

8. Any person who makes entries in the medical record dates and signs the entry, giving his or her title. Hospice program policy determines when initials may be used to authenticate an entry.

9. The medical record for each patient/family is maintained in such a manner that all information, including pertinent medical information obtained from outside sources, can be assembled routinely when the patient/family is admitted to inpatient, home care services, or bereavement service.

10. The record of a discharged patient/family is completed within a reasonable period of time, as specified in hospice program policy. A medical record is complete only when its contents include a listing of final diagnosis, complications, death or discharge, a clinical summary of the patient's course, and the patient's/family's psychosocial status, including bereavement follow-up.

11. The length of time for retaining medical records is recorded in the policies and procedures of the hospice program and is dependent on the use of the records in continuing patient/family care or for legal research or educational purposes.

12. A coding system and an indexing system are used to facilitate retrievability of medical records information for reporting, evaluation, and monitoring activities.

13. Reasonable security measures safeguard both the medical record and its informational content--whether in hand copy, on film, or in computerized form--against loss, defacement, tampering, unauthorized disclosure, and use by unauthorized persons.

GOAL TWO

There is adequate supervision and staffing for maintaining medical records.

RATIONALE

The qualifications and commitment of the individuals who provide medical record services, and the effectiveness and efficiency of the systems used for collecting, storing, and retrieving pertinent clinical information, are major factors affecting the maintenance of high standards of patient/family care.

CHARACTERISTICS

1. The hospice program director appoints an individual to maintain medical records in accordance with hospice program policy.

   A. There are written requirements stating the minimum education and experience required for maintaining medical records.

2. Medical record services and personnel are directed, or at least reviewed twice annually on a consultative basis, by a medical record professional who has successfully completed the examination requirements of the American Medical Record Association or the equivalent.

3. The role of the medical record services in supporting the overall hospice program quality assurance program, the evaluation and monitoring activities of hospice services personnel, and the evaluation and monitoring activities of the medical staff (if there is a medical staff) is defined by the hospice program administration.

Chapter Seven

Governing Body

GOAL ONE

An organized governing body is responsible for establishing hospice program policies, and for maintaining high standards of patient care and program management.

RATIONALE

In any organization, there must be a group that accepts ultimate responsibility and exerts ultimate authority.

CHARACTERISTICS

1. A private, independently owned, or community-agency-owned hospice program has a charter and/or constitution and bylaws and, where required, a state license.

2. The governing body is the individual, group, corporation, or government agency in which the ultimate responsibility and authority for the operation of the hospice program is vested.

3. A hospice program that is a component of another facility, institution, or government agency has a written description stating at least the following:

   A. The governing body responsible for the hospice program;
   B. The relationship of the governing body of the facility, institution, or agency to the director of the hospice program; and
   C. The authority given to the hospice program specific to

      (1) planning and organization,
      (2) program operation,
      (3) the hiring, termination, and assigning of hospice program personnel, and
      (4) policy and procedure adoption and review.

4. The governing body adopts bylaws in accordance with its legal accountability.

5. The bylaws include, but are not limited to, the following:

   A. The role and purpose of the hospice program;
   B. The duties and responsibilities of the governing body;

C. The method of selecting members of the governing body and the permissible length of members' service;
D. The method of selecting officers of the governing body and the permissible number of terms officers can serve;
E. The responsibilities of officers;
F. Meeting procedures, regularity of meetings, definition of "quorum" to conduct business, and attendance policy;
G. A list of the committees of the governing body and how they relate to the governing body;
H. The composition and responsibilities of the committees;
I. The mechanism by which bylaws are adopted and revised;
J. Provision for the regular review and revision of the bylaws and documentation of such action.

6. There is a defined and effective mechanism for communication between the governing body, the hospice program, the hospice administration, and the medical staff of the inpatient service.

7. The governing body provides for the establishment of auxiliary organizations, and approves the bylaws that delineate the purpose and function of such organizations.

8. Written records of the governing body's proceedings and the proceedings of each governing body committee is maintained and signed by a designated member of the governing body or committee, or by the secretary of the governing body.

9. Advisory-group committees or board membership reflect the involvement of members of the community served by the hospice program.

10. The capital budget and annual operating budget are adopted by the governing body, and implementation of these budgets is monitored.

11. The governing body appoints the hospice program director or designates that authority to the appropriate administrative representative in accordance with written institution or agency policy.

12. There is a defined mechanism for self-review and evaluation of the governing body's performance. The mechanism includes a statement of the regularity of the review and how it is initiated and analyzed.

13. The governing body reviews and approves the bylaws and the rules and regulations of the medical staff of the inpatient care service.

14. The responsibilities of the governing body are written, formally adopted, dated and available to all members of the governing body. The responsibilities include, but are not necessarily limited to, the following:

A. Approving of the hospice program's goals and objectives;
B. Evaluation of the program's performance with regard to its stated purpose, goals, and objectives;
C. Determining and approving of policies to govern the program;
D. Assuring fiscal solvency and adequacy of financial resources;

E. Planning for long-term development and maintenance;
F. Supporting a comprehensive quality assurance program; and
G. Providing the necessary support for implementing, and reporting the activities of, interrelated mechanisms of the home care and inpatient services for monitoring patient care and for identifying and resolving problems.

GOAL TWO

The governing body avoids conflict of interest.

RATIONALE

A governing body member whose decisions may be influenced by direct or indirect personal benefit may not be serving in the best interests of the hospice program and the community.

CHARACTERISTICS

1. There is full written disclosure of hospice program ownership and control.

2. The governing body develops and implements a written conflict of interest policy that includes the following:

   A. A description of the method and content of disclosure by governing body members;
   B. Guidelines for the resolution within a specific time frame, of any existing conflict of interest; and
   C. A defined ongoing mechanism for monitoring the conflict of interest policy and a specified time period for regular review of the policy.

GOAL THREE

The governing body provides for the orientation of its members.

RATIONALE

Orientation provides the means by which new governing body members can relate their expertise to hospice program functions and responsibilities and thereby participate in governing body discussions and decisions.

CHARACTERISTICS

1. An orientation is provided for each new governing body member and addresses at least the functions and responsibilities of the governing body and the history, services, and purpose of the hospice program.

Chapter Eight

Management and Administration

GOAL ONE

The hospice program is managed in a manner consistent with the authority and responsibility conferred by the governing body to accomplish program goals and objectives.

RATIONALE

The hospice program is a complex organization, and its management is responsible for using limited resources efficiently while maintaining high standards of patient/family care commensurate with currently available clinical knowledge and skills. The qualifications and commitment of individuals in management positions, as well as the effectiveness and efficiency of systems for supporting patient/family care, are essential to fulfilling these responsibilities.

CHARACTERISTICS

1. A qualified hospice program director, selected in accordance with hospice program or institution or agency policy, is responsible for operating the hospice program in a manner consistent with the authority conferred by the governing body.

   A. There are written requirements stating the minimum education and experience required for the position of hospice program director.

2. The hospice program director designates an individual to act in his or her absence.

3. The responsibilities of the hospice program director include, but are not necessarily limited to, the following:

   A. Implementation of the policies approved by the governing body;
   B. Effective utilization of personnel and resources to achieve program goals;
   C. Administration and evaluation of the program and interdisciplinary team services; and
   D. Participation with organizations that work to improve the care of the dying.

4. There are written policies and procedures to guide the hospice program director and the administrative staff in at least the following areas:

   A. The organization of programwide administrative functions, with clear delegation of duties, responsibilities, and lines of authority and accountability;

B. The establishment of the services needed for the efficient and effective functioning of the hospice;
C. Communication between program administration, the home care and inpatient care coordinator(s), interdisciplinary team members, and the governing body;
D. Compliance with applicable federal and state laws and regulations.
E. The establishment of internal controls to monitor the accuracy and reliability of data, and promote administrative efficiency;
F. The control of inventories, purchasing procedures, product selection and evaluation, and supply distribution;
G. The establishment of a administrative reporting system that provides understandable and standardized reports;
H. Protection and judicious use of the hospice program's physical resources;
I. The ongoing assessment of the community's hospice care needs;
J. Efforts to obtain community input and support of the hospice program;
K. The development of long-term and short-term program plans that reflect community hospice care needs; and
L. The development of evaluative reports on the efficiency and effectiveness and costs of hospice program service activities.

5. The hospice program director provides written plans to guide, and can confirm implementation of the personnel policies and procedures as stated in Chapter Nine of this Manual.

6. The hospice program director provides a written plan that states the method and frequency of reviewing all program and interdisciplinary team service policies and procedures at least annually. The plan addresses the following:

A. The appointment of a review committee by the hospice program director;
B. The composition and qualifications of the review committee;
C. The initiation of revisions of policies and procedures; and
E. Evidence of the annual review of the committee chairperson.

7. The hospice program director provides written fiscal policies and practices that address the implementation of at least the following:

A. An annual revenue and expense budget, with line items paralleling the hospice program's plan of organization;
B. A budgetary process in which at least the hospice program director, the home care and inpatient care coordinator(s), and the governing body participate;
C. An annual certified financial audit conducted by an outside accountant;
D. The control of accounts receivable and payable, the handling of cash, and the establishment of credit arrangements;
E. The preparation, in accordance with program policy, of comparative financial statements of budget versus actual revenue and expenses on an accrual basis; and
F. Reports on the nature and extent of available financial resources.

8. The hospice program director provides written plans to guide the collection and analysis of statistical data relevant to program evaluation, service utilization review, and problem-solving activities.

Chapter Nine

Personnel Policies and Procedures

GOAL ONE

Hospice program personnel policies and procedures are developed, adopted, and maintained. These policies and procedures promote the objectives of hospice services and provide for an adequate number of qualified personnel, during all hours of operation, to support the hospice services and provide high quality care.

RATIONALE

The qualifications of the individuals providing hospice program services, and the effectiveness and efficiency of the systems for collecting, storing, and reviewing pertinent personnel information, greatly affect the maintenance of a supportive, effective working environment and high standards of patient/family care.

CHARACTERISTICS

1. The hospice program director appoints an individual to be responsible for implementing and coordinating personnel policies and procedures and for maintaining personnel records.

2. There is a written organization plan for personnel services. The plan addresses at least the supervision of the processing of employment-related forms.

3. Personnel records are maintained in a manner that assures confidentiality and hospice program policy specifies who has access to various types of personnel information.

4. There are written policies and procedures that pertain to at least the following:

   A. Employee benefits.
   B. The recruitment and selection of employees. Hiring practices, which are written and are consistent with the needs of the hospice program, include at least
      (1) job-related criteria for selecting employees, and
      (2) a policy concerning the availability of bilingual personnel when people who speak languages other than English make substantial use of the program.
   C. Termination of employment.

D. Employee grievances and appeals procedures.
E. Safety.
F. Employee injuries and incident reports.
G. Wages, hours, and salary administration.
H. Rules of conduct.
I. Disciplinary systems.
J. Equal employment opportunities and affirmative action policies;
K. Liability insurance.
L. The acceptance of gratuities.
M. The determination that all personnel are medically capable of performing assigned tasks.

5. There are written policies and procedures that state the lines of authority and reporting of all hospice employees, including volunteers.

6. Personnel procedures are implemented to assure compliance with federal, state, and local laws related to employment practices.

7. There is written documentation to verify that the personnel policies and procedures apply to all hospice program employees and are explained and made available to each employee.

A. The policies and procedures are available to nonemployees upon request.
B. There is a mechanism for notifying employees of changes in policies and procedures.

8. There is written documentation of staff orientation initiated for each new employee before or during the first week of employment.

9. A personnel record is maintained for each hospice program employee and contains the following information:

A. The application for employment;
B. Documentation of both written and verbal references;
C. Verification of licensure, certification, and/or renewals;
D. Wage and salary information, including all adjustments;
E. Performance appraisals;
F. Initial and subsequent health clearances;
G. Counseling actions;
H. Disciplinary actions;
I. Commendations; and
J. Incident reports.

10. For each position in the program, there is a written job description that includes the following information:

A. The position title;
B. The department, service, or unit;
C. The direct supervisor's title;
D. If a supervisory position, the personnel supervised and degree of supervision;
E. The tasks and responsibilities of the job;

F. The minimum level of education, training, and/or related work experience required; and
G. Documentation of changes in qualifications, duties, and other major job-related factors.

11. There are written performance appraisals for each position in the program. An appraisal

A. is maintained in the employee's personnel record;
B. is related to the job description;
C. is conducted during the initial employment period;
D. is conducted at least annually after the initial employment period; and
E. contains documentation that the employee has reviewed the appraisal and has had an opportunity to comment on it.

12. The personnel service prepares an annual written report concerning its services and functions.

Chapter Ten

Utilization Review

GOAL ONE

The appropriate allocation of hospice resources is demonstrated through a utilization review program that includes the home care, inpatient care, and interdisciplinary team services.

RATIONALE

In striving to provide high-quality patient care in the most cost-effective manner, the administration of the hospice program needs information regarding the utilization of resources.

CHARACTERISTICS

1. A written plan that describes the utilization review program and governs its operations is implemented. The written plan is approved by the governing body and the hospice program director.

2. The written plan addresses at least the following:

   A. The appointment and composition of the utilization review committee which includes at least one representative each from the interdisciplinary team, home care, and inpatient services;
   B. The responsibility and authority of committee members;
   C. How the findings of the committee are interrelated with the quality assurance program;
   D. The frequency of committee meetings;
   E. The composition and dissemination of a report of the committee's findings at least annually;
   F. Procedures for conducting concurrent and retrospective reviews;
   G. A conflict-of-interest policy applicable to all review activities and, as determined by hospice program policy, to resultant findings and recommendations;
   H. A confidentiality policy applicable to all utilization review activities and to resultant findings and recommendations; and
   I. The mechanisms used to identify utilization-related problems.

3. At least annually, the utilization review committee reviews a defined number of medical records, selected randomly through a specific mechanism, to assess the appropriateness and adequacy of the services provided.

4. The mechanisms for identifying utilization-related problems include the following:

   A. Analysis of the appropriateness of admissions, continued stays longer than six months, home care versus inpatient services, and delays in provision of interdisciplinary team services; and
   B. Examination of the findings of related quality assurance activities and other relevant information.

5. The documentation of problem identification may include, but is not necessarily limited to, the following

   A. Profile analysis;
   B. Patient/family evaluation studies;
   C. Medication usage reviews; and
   D. Reimbursement-agency utilization reports that are service-specific.

6. There is ongoing retrospective and concurrent monitoring of the utilization of home care, inpatient, and interdisciplinary team services.

7. The procedures for conducting concurrent review of hospice program services have the following characteristics:

   A. Specific time periods following a patient's admission to home care or inpatient services within which the review is initiated;
   B. Length-of-stay norms and percentiles used in assigning continued-stay review dates that are specific to home care or inpatient care;
   C. The utilization of factors other than, or in addition to, payment sources as the basis for determining which patients receive concurrent review; and
   D. Written measurable criteria and length-of-stay norms that are approved by the utilization review committee and the hospice program administration.

8. There is a written plan for initiating transfer from one hospice service to another or discharge from the hospice program when care is no longer needed or appropriate. The plan includes delineation of the responsibility for initiation and follow-through.

9. There is evidence that the findings and recommendations of the utilization review committee are the basis of action in the preceding twelve months in any one or more of the following areas:

   A. Patient services;
   B. Administration or supervision;
   C. Inservice or continuing education; and
   D. Compliance with regulatory or legal requirements.

10. There is evidence that the utilization review program, including the written plan, discharge criteria, and length-of-stay norms, is reviewed at least annually and revised as appropriate.

Chapter Eleven

Quality Assurance

GOAL ONE

The hospice program has a well-defined, organized quality assurance program designed to enhance patient/family care through the ongoing objective assessment of important aspects of care and the correction of identified problems.

RATIONALE

Hospice programs are complex organizations in which the results of patient/family care depend on the interrelated contributions of a variety of health care services and personnel. A major component of the interdisciplinary team's endeavors to deliver patient/family care that is optimal within available resources and consistent with achievable goals is the operation of a quality assurance program.

CHARACTERISTICS

1. The hospice program director designates a committee to implement and maintain the overall hospice program quality assurance program.

2. The quality assurance committee includes a representative from the hospice program administration, interdisciplinary team services, home care and inpatient services, and the medical staff of the inpatient service.

3. The type and frequency of all quality assurance activities in the hospice program are defined in a written plan which addresses at least the following:

   A. The development, adoption, and implementation of an individual quality assurance plan for <u>each</u> type of service--
      (1). bereavement services,
      (2). nursing services,
      (3). physician services,
      (4). psychological and social work services,
      (5). volunteer services,
      (6). home care services, and
      (7). inpatient services;
   B. The integration of findings from the monitoring, evaluation, and problem-solving activities of each quality assurance plan into the overall hospice program quality assurance program; and
   C. Delegation of responsibility for the implementation of and reporting for each quality assurance plan and the overall hospice program quality assurance program.

4. The findings of the individual quality assurance plans are reported, as defined in hospice program policy, to the governing body, the hospice program administration, and the coordinator(s) of the interdisciplinary team, home care, and inpatient services.

5. The individual quality assurance plans and the overall hospice program quality assurance program include at least the following components:

   A. Problem identification;
   B. Problem assessment;
   C. Problem correction;
   D. Problem monitoring; and
   E. Evaluation, documentation, and follow-up.

6. The quality assurance program includes identification of actual and/or potential problems or related concerns in the care of patients/families through at least the following sources of data:

   A. Findings of the quality assurance activities of each service;
   B. Utilization review findings; and
   C. Incident reports.

7. The quality assurance program includes objective assessment of the cause and scope of the problems and concerns identified. Problem assessment has the following characteristics:

   A. Prospective, concurrent, and retrospective assessment of the actual or potential problems identified;
   B. Adequate sampling of the services, disciplines, and individuals involved in the problems identified; and
   C. The use of written criteria that, when applied to actual practice, can result in measurable improvement in regard to patient/family care and clinical performance.

8. The quality assurance program incorporates methods for the implementation of decisions or actions designed to eliminate or reduce identified problems.

9. There is evidence that the recommendations of the quality assurance committee are the basis of action in the preceding twelve months in any one or more of the following areas:

   A. Administration or supervision;
   B. Inservice or continuing education; and
   C. Patient/family services.

10. The results of corrective actions taken are monitored periodically to assure that the identified problems have been eliminated or satisfactorily reduced. Finding suitable solutions to problems is a function and responsibility, as appropriate, of the governing body, the hospice program administration, the medical director, and/or interdisciplinary team members.

11. There is evidence that the individual quality assurance plans and the overall hospice program quality assurance plan are reviewed at least annually and revised as appropriate.

GLOSSARY

active treatment - The receipt of therapies, specifically radiation or chemotherapy, primarily for palliation of pain and symptoms, but with acknowledgement of possible curative reaction.

administration - The fiscal and general management of a hospice program, rather than the direct provision of services.

advanced irreversible disease - The point in the disease process at which the retardation or cessation of the disease's progress can no longer be expected.

appropriate - Descriptive of an action or policy that is suitable or compatible with the individual hospice program's objectives and philosophy.

approved - Acceptable to the authority having jurisdiction.

assessment - Those procedures by which the strengths, weaknesses, problems, and needs are addressed.

attending physician - The primary physician, selected by the patient who is responsible for the medical care of the patient.

audit financial - An independent review by a public accountant certifying that the hospice program's financial reports reflects its financial status.

authentication - Proof of authority and responsibility by written signature, identifiable initials, computer key, or other method. The use of a rubber-stamp signature is acceptable only under the following conditions: The person whose signature the rubber stamp represents is the only one who has possession of the stamp and is the only one who uses it, and this person provides the hospice program director with a signed statement that he or she is the only one who has the stamp and the only one who will use it.

basic communication skills - The fundamental skills relating to effective listening and sensitive, productive response in communication.

bereavement - The period of time following the death of a significant other in which an individual experiences, responds physically and emotionally to, and adjusts to the loss.

bylaws - The laws, rules, or regulations adopted for the governance of the hospice program. Also used for the laws, rules or, regulations of the medical staff.

care plan, interdisciplinary team - A written statement that describes the major physical and psychosocial problems of the patient/family to be addressed in the provision of care; the plan for intervention, stating the interdisciplinary team members to be involved and the planned frequency of intervention; and the goals of the planned intervention

case conference - The formal or informal review, by interdisciplinary team members, of one or more patient/family care plans with regard to updating patient/family physical and/or psychosocial status and initiating any changes in the interdisciplinary team care plan.

case mix - The variety of physical and psychosocial problems presented by the patients/families served by a hospice program.

casework - A treatment method used by social workers to help individuals or families improve their functioning by changing attitudes, feelings, and social circumstances that directly affect them. Casework relies on a relationship between the social worker and client as the primary means of effecting change.

clergy - A body of persons ordained to perform religious functions and services; the official or sacerdotal class of any religious denomination or group.

clinical degree - A degree which has involved the direct observation or participation of the individual who has earned the degree in counseling individuals or families and the analysis of such intervention.

community - The individuals, groups, agencies, and facilities or other institutions within the locality served by a hospice program.

consultant - An individual who provides professional advice or services on request.

continuing education - All the education that is relevant to the type of patient care delivered in the hospice program and that provides current knowledge relevant to the interdisciplinary team members' fields of practice.

continuum - The availability of services appropriate to the needs of the patient/family, uninterrupted by time or place.

coordinator, home care or inpatient services - The individual responsible for the organization, management, and delivery of multiple services in home care or inpatient settings to effectively meet the needs of patient/families.

death - The permanent cessation of all vital functions.

dietetic services - The provision of services to meet the nutritional needs of patients, with emphasis on patients who have special dietary needs.

dietitian - An individual who is registered by the Commission on Dietetic Registration of the American Dietetic Association or has the documented equivalent in education, training, and/or experience, with evidence of relevant continuing education.

direction - Authoritative policy or procedural guidance for the accomplishment of a function or activity.

discharge - The point at which the patient's/family's active involvement with the hospice program is ended and the program no longer maintains active responsibility for the care of the patient/family or survivors, in the instance of bereavement care. The actual point of discharge is determined by each hospice program in regard to the continuum of home care and inpatient services provided and legal jurisdiction.

drug history - A delineation of the drugs used by a patient, including prescribed and unprescribed drugs and alcohol. A drug history includes, but is not necessarily limited to, the following: drugs used in the past; drugs used recently, especially in the preceding 48 hours; dosages used; previous occurrences of adverse drug reactions; and history of previous treatment for pain management.

dying - The progressive failure of body systems to retain normal functioning, thereby limiting the remaining life span.

facility - A designated freestanding building necessary for the implementation of inpatient services.

family - A group of individuals living under one household; a group of persons of common ancestry; or a group of individuals having a common commitment to one another.

fiscal management - Procedures used to control a hospice program's overall financial and general operations.

goal - An expected result or condition that takes time to achieve, is specified in a statement of relatively broad scope, and provides guidance in establishing intermediate objectives directed toward attainment of the goal.

governing body - The person or persons having ultimate authority and responsibility for the overall operation of the hospice program.

grief - A deep and poignant response caused by, or as if by, the loss of a person, an item, or a position of significance.

guardian - A parent, trustee, committee, conservator, or other person or agency empowered by law to act on behalf of, or have responsibility for a patient.

hazardous area - Any area in which any of the following are used: products that are highly combustible, highly flammable, or explosive; or materials that are likely to burn with extreme rapidity or produce poisonous fumes or gases. Consult the 1981 edition of the Life Safety Code (R) of the National Fire Protection Association (NFPA) for further clarification.

home care services - Formally structured organized services designed to render and coordinate the effective provision of hospice interdisciplinary team services to patients/families in the home.

homemaker or home health aide - An individual who may or may not have received specific training to perform services ranging from housekeeping, preparing meals, and assisting with dressing and bathing to rendering assistance with prescribed exercises, special mechanical aids, and the giving of medications under the supervision of a registered nurse or a social worker.

hospice program policy - The administration and procedures for action based on individual program philosophy and objectives.

incident report - A written report by either a patient/family or a interdisciplinary team member that documents any unusual problems, incident, or situation for which the patient/family or team member wishes to have follow-up action taken by appropriate administrative personnel.

inpatient services - Formally structured organized services designed to render and coordinate the effective provision of hospice interdisciplinary team services to patients/families in an inpatient setting.

inservice education - All organized education for interdisciplinary team members and designed to enhance skills or teach new skills relevant to the team member's fields of practice.

interdisciplinary team - A group composed of individuals from various professions and disciplines, who interact on a regular basis and have a working knowledge of the assessment and care of the patient/family by each member of the team. The team is characterized by an ability by all members and disciplines to allow their roles to blur, while simultaneously providing emotional support to each other and maintaining a respect for each other's skills, training, and interventions.

interdisciplinary team services - The provision of, at the least, nursing, physician, psychological and social work, spiritual, volunteer, and bereavement services as an identified team.

licensed - Authorization to practice in the professional discipline for which an individual has been prepared, granted by the licensing authority having jurisdiction in the state where the individual practices.

licensed practical (vocational) nurse - A nurse who is a graduate of an approved school of practical (vocational) nursing and/or is licensed by waiver to practice as a practical (vocational) nurse.

limited prognosis - A projected life span of six months or less.

medical - Of, pertaining to, or dealing with the science of medicine.

medical director - A physician licensed who is primarily charged with the responsibility of acting as a consultant to the interdisciplinary team, and advocate for pain and symptom management with attending physicians, and a liaison with physicians in the community. In the instance of inpatient services, the medical director is primarily responsible for the medical care rendered to patients.

medical record - Documentation of an individual patient's/family's receipt of hospice services, including, but not necessarily limited to, interdisciplinary team services rendered in the home care and/or inpatient settings.

medication - Any substance, whether legend or over-the-counter drug, that is taken orally, injected, inserted, applied topically or otherwise administered to a patient.

minutes - A record of business introduced, transactions and reports made, conclusions reached, and recommendations made. Reports of officers and committees may be summarized briefly or mentioned as having been presented. In either case, a copy of the report is filed in the committee report book and the page number is included in the minutes.

nurse's aides - Auxiliary nursing personnel functioning as assistants to registered and practical nurses.

nursing services - Patient care services pertaining to curative, restorative, preventive, and palliative aspects of nursing that are performed and/or supervised by a registered nurse pursuant to interdisciplinary team care plans.

objective - An expected result or condition that takes less time to achieve than a goal, is stated in measurable terms, has a specified time for achievement, and is related to the attainment of a goal.

occupational therapist - An individual who is a graduate of an occupational therapy program approved by a nationally recognized accrediting body, or who currently holds certification by the American Occupational Therapy Association as an occupational therapist, registered, or who has the documented equivalent in education, training, and/or experience; who meets any current legal requirements of licensure or registration; and who is currently competent in the field.

organized - Administratively and functionally structured.

organized medical staff - A formal organization of physicians and dentists having the delegated authority and responsibility to maintain proper standards of medical care and to plan for continued betterment of that care.

palliative care - Intervention that focuses primarily on the reduction or abatement of the physical and psychosocial stress of terminal disease.

patient/family - The unit of individuals that hospice care focuses on. The individuals may be related by ancestry or by a common commitment to one another. The emphasis on the unit of care underscores the direction of hospice services in addressing the needs of both the patient and his or her family.

personal care - Assistance rendered to the patient in bathing, dressing, mobility, or any such activities of daily living and personal hygiene.

pharmacist - An individual who has a degree in pharmacy and is licensed and registered to prepare, preserve, compound, and dispense drugs and chemicals in the state in which he or she practices.

physical therapist - An individual who is a graduate of a physical therapy program approved by a nationally recognized accrediting body or who has the documented equivalent in training and/or experience; and who meets any current legal requirements of licensure or registration.

physician - An individual who has received a doctor of medicine or doctor of osteopathy degree and is currently fully licensed to practice medicine.

practice privileges - Permission to render care in the granting institution within well-defined limits, based on the individual's professional license and his or her training experience, competence, and judgment.

primary caregiver - The person designated by the patient and the hospice program to be responsible for the welfare of the patient, as defined by hospice program policy.

program director - The individual who has the authority and responsibility, as delegated by the governing body, to accomplish program-specific goals and objectives, implement program policy, and manage personnel and resources.

program services - The home care, inpatient, and/or interdisciplinary team services provided by a hospice program.

psychologist - An individual who meets current legal requirements of licensure, registration, or certification in the state in which he or she renders services and either has a doctorate in psychology and at least two years of clinical experience in a recognized health care setting or has the documented equivalent in education, training, and/or experience.

psychosocial - Psychological, social, and spiritual.

qualified - Having the experience and education deemed appropriate by the hospice program to meet the physical and/or psychosocial care needs of the patients/families served.

registered nurse - A nurse who is a graduate of an approved school of nursing and is licensed to practice as a registered nurse.

service - A functional division of a program of an interdisciplinary team. Also, the deliver of care.

significant other - An individual the patient identifies as having personal significance in the provision of care and/or support and who does not have a blood or legal relationship to the patient.

social history and assessment - The evaluation of a patient's/family's environment, religious background, financial status, and other pertinent psychosocial information that may contribute to the development of an individualized interdisciplinary team care plan.

social worker - An individual who has a master's degree from a school of social work accredited by the Council on Social Work Education or who has the documented equivalent in education, training, and/or experience.

spiritual services - Care given by a member of the interdisciplinary team, community clergy, or individual identified by the patient/family as supportive with regard to spiritual or religious matters.

staff - Paid or volunteer interdisciplinary team members who provide hospice services.

supervisor - The individual who directs the provision of services and by individuals, and reviews those services as stated in the individual's job description.

team members - These individuals responsible for the delivery of interdisciplinary team services.

terminal disease - An illness for which treatment directed toward cure or control of the disease process is no longer appropriate or effective.

transfer - The movement of the patient/family from one service or location to another (eg, from the home care to the inpatient service).

under arrangement - A formal agreement with any organization, agency, or individual, approved by the governing body, that specified the services, personnel, and/or space to be provided to, or on behalf of, the hospice program and the monies to be expended, if any, in the exchange.

unit - A functional division or a facility of an institution.

utilization review - The process of using predefined criteria to evaluate the necessity and appropriateness of allocated services and resources to assure that the facility's services are necessary, cost efficient, and effectively utilized.

VISITOR'S REGISTER

HOUSE HUMAN SERVIC ES COMMITTEE

BILL SENATE BILL 208 DATE 3-21-83

SPONSOR SENATOR JACOBSON

NAME	RESIDENCE	REPRESENTING	SUP-PORT	OP-POSE
Sue Tyndwell	54 apple Orchard Rd Butte	Montana Hospice Exchange Council	✓	
Sr. Kathleen O'Sullivan	821 E. First, Butte	Highlands Hospice, Butte	✓	
June Stohr	Anaconda, Mt.	Pintlar Hospice Assoc	✓	
Jim [illegible]	~~[illegible]~~ Helena, Mt	Mt. [illegible]	324	214
Roger Tippy	Helena	Hospice Exchan Council	✓	
Bonnie [illegible]	Helena	Self	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

WHEN TESTIFYING PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

FORM CS-33

VISITOR'S REGISTER

HOUSE HUMAN SERVICES COMMITTEE

BILL SENATE BILL 214 DATE 3-21-83

SPONSOR SENATOR SMITH

NAME	RESIDENCE	REPRESENTING	SUP-PORT	OP-POSE
Joey McGrath	Helena	Mental Health Assn	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

WHEN TESTIFYING PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

FORM CS-33

VISITOR'S REGISTER

HOUSE HUMAN SERVICES COMMITTEE

BILL SENATE BILL 324 DATE 3-21-83

SPONSOR SENATOR TOWE

NAME	RESIDENCE	REPRESENTING	SUP-PORT	OP-POSE
Jay McGrath	Helena	Mental Health Assn	✓	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR LONGER FORM.

WHEN TESTIFYING PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

FORM CS-33
1-83

STANDING COMMITTEE REPORT

March 21, 19 93

MR. SPEAKER

We, your committee on HUMAN SERVICES

having had under consideration SENATE Bill No. 208

third reading copy (blue color)

A BILL FOR AN ACT ENTITLED: "AN ACT DEFINING A HOSPICE FOR LICENSING PURPOSES; REQUIRING THE DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES TO ADOPT RULES SETTING STANDARDS FOR LICENSING A HOSPICE; REQUIRING THE DEPARTMENT TO LICENSE A HOSPICE APPROVED BY THE COMMISSION ON ACCREDITATION OF HOSPITALS; AMENDING SECTION 50-5-101, MCA."

Respectfully report as follows: That SENATE Bill No. 208

BE CONCURRED IN
~~DO PASS~~

MARJORIE HART Chairman.

STATE PUB. CO.
Helena, Mont.

STANDING COMMITTEE REPORT

March 23, 1983

MR. SPEAKER

We, your committee on HUMAN SERVICES

having had under consideration SENATE Bill No. 214

third reading copy (blue)
color

A BILL FOR AN ACT ENTITLED: "AN ACT AUTHORIZING THE DEPARTMENT OF INSTITUTIONS AND THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES TO CERTIFY MENTAL HEALTH PROFESSIONAL PERSONS AND GRANTING THE DEPARTMENTS RULEMAKING AUTHORITY; AMENDING SECTION 53-21-102, MCA."

Respectfully report as follows: That SENATE Bill No. 214

BE AMENDED AS FOLLOWS:

1. Page 4, line 23 of SB 214.
Following: "53-21-102(10)(b)."
Insert: "(3) The rules for certification must address, but are not limited to:
(a) the type of education that an individual has received, including degrees;
(b) the type of experience or training received by the individual;
(c) continuing education, training, instruction, and work experience necessary to maintain certification;
(d) an examination instrument to be used to determine an individual's proficiency and understanding of mental health laws, diagnosis and treatment procedures;
(e) the procedure for categorical certification qualifying the level of professional authority and responsibility of an individual; and
(f) specific procedures for certification, recertification, and revocation of certification."

AND AS AMENDED BE CONCURRED IN

MARJORIE HART Chairman.

COMMITTEE SECRETARY

STATE PUB. CO.
Helena, Mont.

March 23, 19 83

AMENDMENT TO STATEMENT OF INTENT

BE AMENDED AS FOLLOWS:

1. Statement of Intent
Page 1, lines 11 through 25.
Following: "address" on line 11
Strike: the remainder of line 11 through line 25
Insert: "the provisions of [section 3] of SB 214."

Chairman.

STATE PUB. CO.
Helena, Mont.

STANDING COMMITTEE REPORT

March 21, 19 83

MR. SPEAKER

We, your committee on HUMAN SERVICES

having had under consideration SENATE Bill No. 324

~~third~~ reading copy (blue color)

A BILL FOR AN ACT ENTITLED: "AN ACT TO CREATE A MONTANA YOUTH TREATMENT CENTER FOR THE CARE AND TREATMENT OF MENTALLY ILL YOUTHS BETWEEN THE AGES OF 12 AND 18 YEARS; AMENDING SECTIONS 41-5-207, 41-5-403, 41-5-523, 53-1-104, 53-1-202, 53-1-402, 53-21-112, 53-21-130, 53-21-164, AND 53-30-211, MCA; REPEALING SECTION 53-30-201, MCA; AND PROVIDING AN APPLICABILITY SECTION."

Respectfully report as follows: That SENATE Bill No. 324

BE CONCURRED IN

~~BE XXXXX~~

MARJORIE HART Chairman.

STATE PUB. CO.
Helena, Mont.

COMMITTEE SECRETARY