

§ 418.54

42 CFR Ch. IV (10–1–10 Edition)

information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.

(6) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property;

(7) Receive information about the services covered under the hospice benefit;

(8) Receive information about the scope of services that the hospice will provide and specific limitations on those services.

§ 418.54 Condition of participation: Initial and comprehensive assessment of the patient.

The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.

(a) *Standard: Initial assessment.* The hospice registered nurse must complete an initial assessment within 48 hours after the election of hospice care in accordance with § 418.24 is complete (unless the physician, patient, or representative requests that the initial assessment be completed in less than 48 hours.)

(b) *Standard: Timeframe for completion of the comprehensive assessment.* The hospice interdisciplinary group, in consultation with the individual's attending physician (if any), must complete the comprehensive assessment no later than 5 calendar days after the election of hospice care in accordance with § 418.24.

(c) *Standard: Content of the comprehensive assessment.* The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment must take into consideration the following factors:

(1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints).

(2) Complications and risk factors that affect care planning.

(3) Functional status, including the patient's ability to understand and participate in his or her own care.

(4) Imminence of death.

(5) Severity of symptoms.

(6) *Drug profile.* A review of all of the patient's prescription and over-the-counter drugs, herbal remedies and other alternative treatments that could affect drug therapy. This includes, but is not limited to, identification of the following:

(i) Effectiveness of drug therapy.

(ii) Drug side effects.

(iii) Actual or potential drug interactions.

(iv) Duplicate drug therapy.

(v) Drug therapy currently associated with laboratory monitoring.

(7) *Bereavement.* An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. Information gathered from the initial bereavement assessment must be incorporated into the plan of care and considered in the bereavement plan of care.

(8) The need for referrals and further evaluation by appropriate health professionals.

(d) *Standard: Update of the comprehensive assessment.* The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group (in collaboration with the individual's attending physician, if any) and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished as frequently as the condition of the patient requires, but no less frequently than every 15 days.

(e) *Standard: Patient outcome measures.* (1) The comprehensive assessment must include data elements that allow

for measurement of outcomes. The hospice must measure and document data in the same way for all patients. The data elements must take into consideration aspects of care related to hospice and palliation.

(2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program.

§ 418.56 Condition of participation: Interdisciplinary group, care planning, and coordination of services.

The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient. The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive assessment as such needs relate to the terminal illness and related conditions.

(a) *Standard: Approach to service delivery.* (1) The hospice must designate an interdisciplinary group or groups composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Interdisciplinary group members must provide the care and services offered by the hospice, and the group, in its entirety, must supervise the care and services. The hospice must designate a registered nurse that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care. The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles:

(i) A doctor of medicine or osteopathy (who is an employee or under contract with the hospice).

(ii) A registered nurse.

(iii) A social worker.

(iv) A pastoral or other counselor.

(2) If the hospice has more than one interdisciplinary group, it must identify a specifically designated interdisciplinary group to establish policies governing the day-to-day provision of hospice care and services.

(b) *Standard: Plan of care.* All hospice care and services furnished to patients and their families must follow an individualized written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician (if any), the patient or representative, and the primary caregiver in accordance with the patient's needs if any of them so desire. The hospice must ensure that each patient and the primary care giver(s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.

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

(1) Interventions to manage pain and symptoms.

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

(3) Measurable outcomes anticipated from implementing and coordinating the plan of care.

(4) Drugs and treatment necessary to meet the needs of the patient.

(5) Medical supplies and appliances necessary to meet the needs of the patient.

(6) The interdisciplinary group's documentation of the patient's or representative's level of understanding, involvement, and agreement with the