

***CLINICAL DOCUMENTATION  
SYSTEM FOR HOSPICE***



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### **Attending Physician Initial Certification of Terminal Illness CL. 125a**

The *Attending Physician Initial Certification of Terminal Illness* is designed to document a verbal and/or written certification of terminal illness by the patient's attending physician.

The form includes:

- A place to record patient identifying information; the start of care date; the hospice diagnosis, secondary complications and co-morbid conditions; and whether the secondary complications and/or co-morbid conditions are needed to support limited prognosis.
- A section to document what the certification of terminal illness is based on, including any review of the LCD guidelines, if applicable.
- A place to record a verbal certification.
- A place to document the written certification.



### **Bereavement Plan of Care CL. 265**

The *Bereavement Plan of Care* is designed to document the post-death bereavement plan of care. The *Bereavement Plan of Care* is updated as frequently as necessary to meet bereavement needs. The level of risk for complicated bereavement, identified in the *Bereavement Risk Assessment*, is used to inform IDG decisions about the most appropriate interventions.

This form includes:

- A cover page with place to record patient identifying information, the attending MD and the date of the plan of care at the top of the page; the name and contact information for the primary bereaved and additional bereaved persons; signatures of the IDG members who participated in developing the plan of care; and a place to indicate that the plan was reviewed with the primary bereaved and/or others.
- A page for the plan with columns to indicate the problem/need; date problem/need identified or discontinued; IDG and survivor goals; interventions and the disciplines involved in the delivery of care.

#### Tips for completing certain elements of the form:

- **Problem/Need:** Describe the problem or need; if the issue concerns individuals other than the primary bereaved, these individuals should be identified in the plan.
- **Interventions:** Interventions may be based on the level of risk for negative bereavement outcomes, although any interventions can be used for any survivor. Add additional interventions as needed to meet individual survivor needs and/or to capitalize on individual survivor characteristics, preferences and support systems.
- **Disciplines (Disc.):** We recommend recording all disciplines involved in the interventions to emphasize the interdisciplinary nature of care. Note that different disciplines may be involved in different interventions. A WRI reference sheet (*Suggested Abbreviations for Disciplines Involved in Care*) suggests abbreviations for each discipline; the hospice may have other abbreviations they prefer to use.



### **Bereavement Risk Assessment CL.190**

This form is based on the Bereavement Assessment Form developed by the Colorado Center for Hospice and Palliative Care. The *Bereavement Risk Assessment* is designed to be completed as an element of the *Initial and Comprehensive Nursing Assessment*, the *Comprehensive Spiritual Assessment*, or as dictated by hospice policy. The *Bereavement Risk Assessment* focuses on the patient, family members and other individuals close to the patient; it captures the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death. This assessment can be completed by any member of the IDG.

Information gathered from the *Bereavement Risk Assessment* is incorporated into the *Hospice Plan of Care* and considered in the development of the post-death bereavement plan of care. The assessment is reviewed/updated whenever bereavement concerns are identified; it may also be updated following the patient's death.

The form includes:

- A place to record patient identifying information, date of form completion and assessment type at the top of each page.
- A place to document the name of the primary bereaved (pg. 1) and additional bereaved persons (pg. 2).
- An assessment of the risks and stressors affecting the patient and the primary bereaved person.
- A scale to score the level of risk for complicated bereavement and/or negative bereavement outcomes. This score may be transferred to the *Hospice Plan of Care* and/or the *Bereavement Plan of Care*.
- A place for narrative comments. If an additional narrative page is needed, a blank *Progress Note* or another form of the hospice's choice may be used.



### Care Coordination Sheet CL. 280

The *Care Coordination Sheet* is designed to facilitate communication among hospice and non-hospice providers when they collaborate to meet the needs, both related and unrelated to the terminal illness, of hospice patients. A new copy is used for each referral/provider.

This form includes:

- A place to record patient identifying information, hospice diagnosis, the date of form completion, the provider to whom the referral is made and the date of the referral.
- A place to record the reason for the consultation, the appointment date with the non-hospice provider, and the source of the referral.
- A pre-referral section to capture information about the relationship of the issue to the terminal diagnosis, and the information provided to practitioner being asked to provide consultation and/or care.
- A post-referral section to capture information about whether new orders were received and if so, whether they were approved by the attending physician, or by the hospice physician if related to the terminal illness.

#### Tips for completing certain elements of the *Care Coordination Sheet*:

- Relationship of issue to the terminal diagnosis: For issues related to the terminal illness and/or its related conditions, obtain hospice physician approval and note the date referral was approved by the hospice physician.
- Communication and Collaboration: Use the comments section to report information shared with the non-hospice provider and any other information pertinent to the referral.
- Outcome of consultation: Use the comments section to record the additional information about the non-hospice provider's findings and recommendations, as well as discussion and actions by the IDG. Note any plans for follow-up.



### **Comprehensive Hospice Assessment Cover Page CL.145**

This cover page is designed to help the team customize and track timely completion of the comprehensive hospice assessment. The information collected via the *Initial Nursing Assessment* determines the appropriate elements of the comprehensive hospice assessment for each individual patient. Each hospice will determine whether specific assessments (e.g., psychosocial, spiritual, fall risk, safety, and others) are required for all patients.

The individual hospice determines both the process to communicate with the other members of the IDG in order to assure that the required assessments are completed, and the process for tracking completion of assessments on the cover sheet.

The form includes:

- A place to record patient demographic and diagnosis information.
- A place to indicate who provided information for the assessment is gathered.
- Check boxes to indicate which elements of the comprehensive assessment are to be completed for the individual patient.
- Columns to record which discipline completed each element of the comprehensive assessment and the date of completion.
- A section to record the date of completion of the assessment, or the date of discharge if the assessment was not completed prior to discharge.  
NOTE: The date of completion of the assessment can be used to track compliance with the Medicare requirement for completion of the comprehensive hospice assessment no later than 5 calendar days after the election of hospice care (start of care date).
- A placed for additional information about the completion date, including any reason that the assessment was not completed within 5 days of admission. Note that the hospice must make every effort to complete the assessment on time.



The *Comprehensive Psychosocial Assessment* is designed to be completed by a psychosocial professional when the need for an in-depth assessment is identified, or as hospice policy dictates. The need may be identified as part of the *Initial Nursing Assessment*, the *Comprehensive Nursing Assessment*, the *Nursing Assessment Update*, or by another discipline providing patient/family care. Once completed, the assessment is updated as frequently as the patient's condition requires, but no less frequently than every 15 calendar days (along with other assessment updates.)

The form includes:

- A place to record patient identifying information and date of form completion at the top of each page.
- A place to document the inability to complete the assessment if the patient died or if the visit was declined by the patient/family.
- A place to record the type of visit and other visit information.
- A section to indicate whether the patient is experiencing pain.
- Shaded areas throughout the form to highlight data elements that may be used for outcome measure reporting; the data relate to patient anxiety, psychosocial distress rating, Primary Caregiver (PCG) anxiety, and planning/advance directives. (Note that these data elements are included in the QAPI Navigator from Hospice Quality Resources at [www.hospicequality.com](http://www.hospicequality.com).)
- Assessments of the patient's circumstances, response to illness, relationships, social interactions and living conditions; the Primary Caregiver's response to illness and ability/willingness to provide care; support systems available to the patient/family; financial and practical issues, advance care planning needs and documents; and other factors affecting care.
- A section to record possible crises/concerns and referrals.
- A place for narrative comments. If an additional narrative page is needed, a blank *Progress Note* or another form of the hospice's choice may be used.

### Tips for completing certain sections of the form

- **Timeliness:** Every effort should be made to complete the assessment as soon as possible after the need for assessment is identified. If the psychosocial assessment is part of the comprehensive hospice assessment, it should be completed within 5 days of the election of hospice care (start of care date). Hospice policy will dictate whether the assessment must be completed in person, and what to do if the patient/family declines a visit.





- Pain Assessment: Non-nursing disciplines are not asked to assess pain severity or location. Instead, they are asked to determine whether the patient is experiencing pain using one or more of the following three methods:
  1. Ask the patient if he/she is experiencing pain;
  2. Ask the PCG if the patient is experiencing pain; or
  3. Look for observable behaviors associated with pain such as low moaning or crying out, guarding or pulling away when touched, facial expressions of sadness or fear, labored breathing, or fidgeting.

If the patient or PCG report pain, or if pain behaviors are observed, notify the nurse unless the patient/PCG decline. If declined, check the box provided.

- Rating anxiety and psychosocial distress: Refer to the WRI *Symptom Assessment Reference Sheet: Concepts and Reminders*.
- Financial/Practical Needs: If the patient is private pay, indigent, or has insufficient financial reserves to meet needs, we recommend completion of a *Financial Assessment* form.



The *Comprehensive Spiritual Assessment* is designed to be completed by a Spiritual Care Counselor when the need for an in-depth assessment is identified, or as hospice policy dictates. The need for this assessment may be identified as part of the *Initial Nursing Assessment*, the *Comprehensive Nursing Assessment*, the *Nursing Assessment Update*, or by another discipline providing patient/family care. The assessment is updated as frequently as the patient's condition requires, but no less frequently than every 15 calendar days (along with other assessment updates.)

The form includes:

- A place to record patient identifying information and date of form completion at the top of each page.
- A place to document the inability to complete the assessment if the patient died or if the visit was declined by the patient/family.
- A place to record the type of visit and other visit information.
- A section to indicate whether the patient is experiencing pain.
- A shaded area on page 2 to highlight data elements for patient/family spiritual distress that may be used for outcome measure reporting. (Note that these data elements are included in the QAPI Navigator from Hospice Quality Resources at [www.hospicequality.com](http://www.hospicequality.com).)
- Sections to record spiritual history, contact information for the patient and PCG/family faith community, sources of spiritual distress and support for patient and PCG/family, and spiritual and/or cultural traditions that influence healthcare decisions.
- A section for narrative comments. If an additional narrative page is needed, a blank *Progress Note* or another form of the hospice's choice may be used.

#### Tips for completing specific elements of the form

- **Timeliness:** Document the inability to complete the assessment if the patient died or if the visit was declined by the patient/family. Every effort should be made to complete the assessment as soon as possible after the need for assessment is identified. If the spiritual assessment is part of the comprehensive hospice assessment, it should be completed within 5 days of the election of hospice care (start of care date). Hospice policy will dictate whether the assessment must be completed in person, and what to do if the patient/family declines a visit.
- **Delivery of Spiritual Care:** We recommend completion of this section even if the assessment cannot be completed in order to document how the patient/family spiritual needs will be met.



- Pain Assessment: Non-nursing disciplines are not asked to assess pain severity or location. Instead, they are asked to determine whether the patient is experiencing pain using one or more of the following three methods:
  1. Ask the patient if he/she is experiencing pain;
  2. Ask the PCG if the patient is experiencing pain; or
  3. Look for observable behaviors associated with pain such as low moaning to crying out, guarding or pulling away when touched, facial expressions of sadness or fear, labored breathing, or fidgeting.

If the patient or PCG report pain, or if pain behaviors are observed, notify the nurse unless the patient/PCG decline. If declined, check the box provided.

- Rating Spiritual Distress: Refer to the *WRI Symptom Assessment Reference Sheet: Concepts and Reminders*.
- Spiritual care provided: Documentation of specific spiritual care provided during the assessment visit. Interventions that will be conducted regularly to address ongoing problems should be included in the *Hospice Plan of Care*.



## IDG Forms Instructions

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### Determining Terminal Status: Decline in Clinical Status Worksheet CL. 195

The *Determining Terminal Status: Decline in Clinical Status Worksheet* documents the patient's signs and symptoms of terminal illness based on the Local Coverage Determination (LCD) guidelines developed by fiscal intermediaries for Medicare. This worksheet is designed for use with patients who do not have a specific terminal diagnosis.

The worksheet includes places to document the following:

- Clinical status as evidenced by infections and/or history of weight changes over time.
  - Use check boxes to indicate frequent infections and/or progressive inanition (weakness).
  - For weight changes, use weight, mid-arm circumference (MAC), and/or body mass index (BMI).
- Signs and symptoms of terminal illness.
- Laboratory values indicating decline.
- Functional status and ADL dependence.
  - For functional status, use either the Karnofsky Performance Scale (KPS), or the Palliative Performance Scale (PPS). For both scales, lower scores indicate more decline.
  - An ADL dependence scoring chart is provided; higher scores indicate more dependence and therefore, more decline.
- Presence of stage III or IV pressure ulcers.
- Recent history of visits to the physician or ER, and/or hospitalizations.
  - Document dates of recent hospitalizations and/or physician or ER visits.
- Co-morbid conditions contributing to life expectancy
- Pattern of decline
  - Choose either rapid, saw-toothed or prolonged; and indicate whether expected or uncommon for patient's situation.
  - Provide specific details about the trajectory, such as history of decline and/or rebounding, if available
- Environmental factors and burden of illness.
- Patient's wishes for palliative care; and information on advance directives and DNR status.
- Summary statements about the patient's decline, life expectancy, and the extent to which LCD guidelines are met.
  - If LCD guidelines are only partially met, provide information on why patient is eligible for the hospice benefit.
- MD progress notes.



### Determining Terminal Status Worksheets

Page 1 of 4

<b>Adult Failure to Thrive Worksheet</b>	<b>CL. 200</b>	<b>Heart Disease Worksheet</b>	<b>CL. 230</b>
<b>Renal Disease Worksheet</b>	<b>CL. 205</b>	<b>HIV Worksheet</b>	<b>CL. 240</b>
<b>ALS Worksheet</b>	<b>CL. 215</b>	<b>Liver Disease Worksheet</b>	<b>CL. 245</b>
<b>Cancer Worksheet</b>	<b>CL. 220</b>	<b>Pulmonary Disease Worksheet</b>	<b>CL. 250</b>
<b>Dementia Worksheet</b>	<b>CL. 225</b>	<b>Stroke and Coma Worksheet</b>	<b>CL. 255</b>

The *Determining Terminal Status Worksheets* document the patient's signs and symptoms of terminal illness based on the Local Coverage Determination (LCD) guidelines developed by fiscal intermediaries for Medicare. These worksheets are designed for use with patients who have a specific terminal diagnosis.

The first page of each worksheet captures clinical status information applicable to patients with any diagnosis; the second page of each worksheet captures disease-specific information

#### **Use PAGE 1 of each worksheet to document the following:**

- Functional status and ADL dependence – should show decline over time and meet criteria in the LCD guidelines
  - For functional status, use either the Karnofsky Performance Scale (KPS), or the Palliative Performance Scale (PPS). For both scales, lower scores indicate more decline.
  - For patients with Alzheimer's or other dementia also use the Functional and Functional Assessment Staging (FAST) scale. Higher scores indicate more decline.
  - An ADL dependence scoring chart is provided; higher scores indicate more dependence and therefore, more decline.
- Co-morbid conditions that affect life expectancy and the pattern of disease trajectory – to support the terminal status.
  - For disease trajectory, choose either rapid, saw-toothed or prolonged; and indicate whether expected or uncommon for patient's diagnosis. Provide specific details about the trajectory, such as history of decline and/or rebounding, if available
- Environmental factors and burden of illness.
- Patient's wishes for palliative care; and information on advance directives and DNR status.
- Summary statements about the patient's decline, life expectancy, and the extent to which LCD guidelines are met.
  - If LCD guidelines are only partially met, provide information on why patient is eligible for the hospice benefit.



Use PAGE 2 of each worksheet to document disease-specific information as follows:

#### ***CL. 200 Adult Failure to Thrive***

- Nutritional impairment as evidenced by
  - height, weight/MAC (mid-arm circumference), and/or BMI (body mass index  $\leq 22$  kg per meter)
  - Patient declining enteral/parenteral feeding
  - Patient not responding to nutritional support despite adequate caloric intake
- Disability – as evidenced by KPS/PPS score or other evidence of debility
- Note – patients with nutritional impairment who do not meet medical criteria for Adult Failure to Thrive may meet criteria for another diagnosis or for Decline in Clinical Status

#### ***CL. 205 Renal Disease***

- Patient not seeking dialysis or transplant, or is planning to discontinue dialysis
- Lab values for creatinine clearance and serum creatinine
- Supporting factors – based on whether renal disease is acute or chronic

#### ***CL. 215 Amyotrophic Lateral Sclerosis (ALS)***

- Widespread muscle denervation as documented by history and presentation and/or report from a neurologist;
- Patient preference regarding tracheostomy and/or gastrostomy;
- Evidence of critically impaired respiratory function;
- Evidence of nutritional insufficiency.

#### ***CL. 220 Cancer***

- Criteria that should be met
  - Metastases present , and/or
  - Disease progression that is resistant to therapy or for which patient has declined therapy;
- Date, type and site of cancer;
- Treatment history and response to treatment.

#### ***CL. 225 Dementia due to Alzheimer's and Related Disorders***

- Criteria that should be met
  - FAST score of 7a or greater, and
  - Additional ADL dependence, plus loss of meaningful speech;
  - One or more specific markers of disease history/progression over the last 12 months;
- Clinical decline as evidenced by infections and/or history of weight loss over time,



- Use check boxes to indicate frequent infections and/or progressive inanition (weakness),
- For weight changes, use weight, mid-arm circumference (MAC), and/or body mass index (BMI);
- Presence of stage III or IV pressure ulcers.

#### **CL. 230 Heart Disease**

- Criteria that should be met
  - Evidence that the patient is being optimally treated for the disease,
  - Ejection fraction and New York Heart Association Classification;
- Supporting information about disease history and progression.

#### **CL. 235 HIV**

- Criteria that should be met
  - CD4 count or viral load – must have lab results,
  - At least one of several other indications of illness progression,
  - Decrease in performance status as measured by declining Karnofsky performance score over time;
- Supporting information about treatment history and response to treatment.

#### **CL. 240 Liver Disease**

- Criteria that should be met
  - Prothrombin time or INR and serum albumin – must have lab results,
  - At least one of several other indications of illness progression;
- Supporting information about disease history and progression;
- Clinical decline as evidenced by history of weight changes over time,
  - Use weight, mid-arm circumference (MAC), and/or body mass index (BMI).

#### **CL. 245 Pulmonary Disease**

- Criteria that should be met
  - Evidence of severe chronic lung disease including both disabling dyspnea and progression of end stage pulmonary disease (provide supporting evidence for both),
  - At least one of several indications of hypoxia.
- Supporting information about
  - Presence of RHF (cor pulmonale),
  - Resting tachycardia,
  - History of recent unintentional weight loss (use weight, mid-arm circumference (MAC), and/or body mass index),
- Current assessment of respiratory rate, oxygen saturation, lung sounds and infections.



#### ***CL. 250 Stroke and Coma***

- Stroke
  - Low performance status as evidenced by KPS or PPS score,
  - Inability to maintain hydration or caloric intake as evidenced by weight change (use weight, MAC, and/or BMI) serum albumin, calorie counts over time, dysphagia and/or recurrent aspiration,
  - Diagnostic imaging to show brain damage characteristic for either non-traumatic hemorrhagic or thrombolytic/embolic stroke.
- Coma
  - Clinical findings as of day 3 of stroke to support brain stem damage, loss of verbal ability, loss of pain response, and/or elevated serum creatinine,
  - Complications that support limited prognosis e.g., pneumonia, pyelonephritis, late stage pressure ulcers, and/or recurrent fever with antibiotic treatment.





### Drug Profile CL. 290

The *Drug Profile* is designed to record a comprehensive and up-to-date list of medications utilized by the patient at all times. It is meant to be used with the *Drug Profile Cover Page*. The form consists of two types of pages to record all patient medications: one to record routine/scheduled medications and one to record PRN medications.

The form includes:

- A place at the top of the page for the patient's name, medical record number, and the number of pages in use for the *Drug Profile*. Additional pages should be added to each section as needed, and then all pages may need to be renumbered.
- Recommendations for designating discontinued medications in an orderly fashion, included on the bottom of each page.
- The following information for each medication:
  - Whether the drug is Prescription (Rx), Over-the-Counter (OTC), Herbal (H), and Alternative (A).
  - Drug Classification\* (see below).
  - Start date/End date (discontinued).
  - Dosage, Route of Administration, Frequency.
  - Laboratory monitored – to indicate whether laboratory monitoring is required.
  - Duplicate drug therapy – to indicate whether the drug purpose and action duplicates another drug on the list.
  - Medications covered by hospice – to document whether or not the medication is paid for by the hospice (related to the terminal illness).
- We recommend that the drug profile be rewritten at each recertification and upon transfer to other care settings.

\* We recommend use of a drug classification list to document mechanisms of action, potential side effects, possible drug interactions, and contraindications. Weatherbee Resources Inc. recommends the Drug Classification Index available for purchase from Healthcare Concepts, which lists common classifications used in hospice care (<http://www.healthcareconcepts.com/publications/medication-profiles.php>). Hospices can find information to create their own classification list at the World Health Organization website (<http://www.whooc.no/atcddd/atcssystem.html>).



### **Drug Profile Cover Page CL. 295**

This form is designed as the cover page for the *Drug Profile*. The *Drug Profile* records a comprehensive and up-to-date list of medications utilized by the patient at all times. This cover page documents specific patient information relevant to all medications.

The form includes:

- A section to record patient name, medical record #, primary diagnosis, secondary complications, co-morbid conditions, and pharmacy contact information.
- A section to record medication allergies.
- A section to document safety of medication administration and disposal; education regarding medications and administration provided to patient/family; and understanding of education as verbalized or demonstrated.

#### Tips for completing certain sections of the *Drug Profile Cover Page*

- Secondary complications: These are complications related to the terminal diagnosis.
- Co-morbid conditions: These are medical conditions unrelated to the terminal illness.
- Education provided and understanding verbalized/demonstrated: Indicate the persons to whom education was provided and whether they verbalized/demonstrated understanding. If any persons identified as administering medications were not educated, or did not verbalize/demonstrate understanding, provide an explanation.



### Drug Profile Review CL. 285

The *Drug Profile Review* is designed to document the review of all of the patient's prescription and over the counter medications, as well as herbal and alternative remedies that could affect drug therapy. Medicare regulations require that a drug review be completed at the time of the comprehensive assessment. We recommend that a drug profile review also be completed whenever there are substantial changes to the medication profile, a medication issue or error is reported, and/or as dictated by hospice policy. Medicare regulations also require that the review be completed by an individual with education and training in drug management – as defined in hospice policies and procedures, and State law - who is an employee of or under contract with the hospice.

The form includes:

- A place to record patient identifying information at the top of each page.
- A place to record the reason for the review and the name and credentials of the person completing the review.
- A section to list all drugs reviewed.
- An area for the person reviewing the drug profile to record comments and recommendations on medication efficacy, side effects, actual and potential interactions, duplicate drug therapy and drug therapy associated with laboratory monitoring. Note that the person reviewing the profile may need to review relevant laboratory values when available.
- Areas for the IDG to document their discussion of the reviewer's comments and recommendations as well as their decisions related to each issue.
- A place for the IDG members involved in the discussion to sign the form.
- A section for narrative comments by the reviewer; and a place for the reviewer to sign the form.

Tips for completing the specific elements of the *Drug Profile Review*:

- The reviewer's comments and recommendations are advisory to the IDG; final decisions about medications are made by the IDG, in consultation with the attending physician and the patient/family.
- Any changes to the patient's medications as a result of the review must be accompanied by a physician's order and be documented on the drug profile.



## IDG Forms Instructions

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### Fall Risk Assessment CL. 155

The *Fall Risk Assessment* is designed to be completed as an element of the *Initial Nursing Assessment* and/or the *Comprehensive Nursing Assessment*. It is reviewed, and may be updated, whenever the patient has a fall and/or every 15 days when the interdisciplinary assessment is updated.

The form includes:

- A place to record patient identifying information, date of form completion and assessment type at the top of each page.
- Eight (8) items that are assessed and scored to calculate the relative risk that this patient may experience a fall.
- A section for narrative comments.



### Financial Assessment CL. 180

The *Financial Assessment* is designed to be completed as an element of the *Comprehensive Psychosocial Assessment* or the *Psychosocial Assessment Update* for patients who have significant financial issues as defined by the hospice. We recommend that a *Financial Assessment* be completed if the patient is private pay, indigent, or has insufficient financial reserves to meet needs.

The form includes:

- A place to record patient identifying information, date of form completion and assessment type at the top of each page.
- Sections for recording assets, debts (such as mortgage, loans, and credit card debt), income and expenses.
- Family size and sources of support other than those recorded in the income section.
- Actions taken and needed to cover hospice care expenses and to assist the patient/family with other financial needs.
- A section for narrative comments.



The *Hospice Aide Flow Sheet* is designed as the documentation form for the Hospice Aide. The Hospice Aide should refer to the *Hospice Aide Plan of Care* to determine which information and instructions apply for a specific patient. The *Hospice Aide Flow Sheet* can be used to document up to 7 visits over any period of time.

The form includes:

- A place to record patient identifying information at the top of each page.
- A place for the Hospice Aide to record the date and time of the visit in each of seven columns. Each column is used to document the activities completed on that visit.
- Sections to record activities for each of the six ADLs and one for additional care instructions. Rows that provide HA instructions have a check box in each column for indicating completion of the assigned task. Rows that provide information, rather than instructions to the Hospice Aide do not have check boxes.
- A section for the HA to record information on whether the patient is experiencing pain and, if necessary, time and date that the RN was contacted.
- A section to record supplies delivered and/or used on each visit.
- A section to indicate whether the RN was informed about changes in the patient's condition.
- A place for the HA to initial each visit column, indicating that the duties checked off were performed.
- A place for the PCG or facility staff to initial each visit column to indicate that the HA conducted the visit.
- A place for HA comments.
- A place for the HA to sign the form at the time designated by hospice policy.

Tips for completing certain elements of the *Hospice Aide Flow Sheet*:

- Patient information and instructions: In the first column of the flow sheet, fill in the information and instructions for the specific patient by referring to the *Hospice Aide Plan of Care*.
- Visit columns: Each visit is documented in one column that continues on all three pages of the flow sheet.
  - At the start of the visit complete the date and time information at the top of the page 1.
  - Also fill in the date at the top of pages 2 and 3.
  - At the end of the visit, fill in the time out information at the top of the form.
  - Put all documentation for one visit (except nurse contact information on page 2 and comments on page 3) in one column.



## IDG Forms Instruction

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Hospice Aide Flow Sheet CL. 110

Page 2 of 2

- Task completion: Document the tasks completed or information attended to by checking the box in the appropriate row. Refer to the first column and the *Hospice Aide Plan of Care*.
- Pain management: If the patient reports pain, contact the nurse and document the date and time contacted.
- Initials: Initial at the end of the visit column on page 3 to indicate that you visited and completed the tasks checked off in that column. Have the PCG or facility staff person initial to indicate that you conducted the visit.
- Comments: We suggest that you date and initial any comments written in this section.



## **IDG Forms Instructions**

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### **Hospice Aide Plan of Care CL. 260**

The *Hospice Aide Plan of Care* is designed to provide information about the patient and care instructions to the Hospice Aide. *The Hospice Aide Plan of Care* must be developed by the IDG and should be updated as frequently as the condition of the patient requires, but no less frequently than every 15 days.

The form includes:

- A place for patient identifying information, the names of the Hospice Aide and the Primary RN, and the date of that the plan of care is prepared at the top of the first page.
- A section to indicate safety concerns, patient limitations, general information and supplies needed.
- A section for each ADL that includes:
  - A scale for the RN to score the patient's ADL status (the level of assistance needed);
  - Check boxes to communicate patient information about the patient and provide instructions for the HA activities.
- A section to document other care information and instructions.
- A check box to direct the HA to routinely ask about the presence of pain.
- A section to identify members of the IDG who participated with the RN in developing the plan.
- A place for signatures by the RN, the Hospice Aide, and either facility staff or PCG.





### Hospice Longitudinal Data Assessment Tool and Quick Reference Guide CL.100 and CL.105

The *Longitudinal Data Assessment Tool (LDAT)* is designed to document clinical status data over time so that the patient's illness trajectory becomes apparent. The *Longitudinal Data Assessment Tool Quick Reference Guide* provides the scales and data element definitions for each of the clinical status markers on the *LDAT*. Not all *LDAT* scales are appropriate for all patients; some scales (FAST, NYHA and ECOG) are applicable to specific diseases.

The *LDAT (Form CL.100)* includes:

- Sections to record three different clinical status data assessments for all patients
  - For functional status, the Karnofsky Performance Scale or the Palliative Performance Scale;
  - For weight, weight in lbs, mid-arm circumference (MAC), and/or body mass index (BMI), and meal percentage for three meals;
  - For infection, type and site, antibiotics (ABX), number of days of antibiotic treatment, and outcome of treatment.
- Sections to record three different clinical status data elements for patients with specific diagnoses
  - For dementia diagnoses, the Functional Assessment Staging (FAST) scale;
  - For cardiac and pulmonary diagnoses, the New York Heart Association (NYHA) classification scale;
  - For cancer diagnoses, the Eastern Cooperative Oncology Group (ECOG) functional performance scale.
- Within each section, a grid to record the value on sequential dates.
- We recommend completion of the tool on admission, monthly, at recertification, and upon significant change in the patient's condition.

The *LDAT Quick Reference Tool* includes:

- Legends and instructions for using each of the scales on the *LDAT*.

#### Tips for completing specific elements of the *LDAT*:

- Section 1 – KPS/PPS
  - Circle the scale being used; if using the KPS, refer to the *LDAT Quick Reference Guide*, and if using the PPS, refer to a copy of the scale (not provided);
  - Write in the date that the assessment is conducted in the first row of the column;



### Hospice Longitudinal Data Assessment Tool and Quick Reference Guide CL.100 and CL.105

- Place a dot in the row showing the patient's performance score; connect the dots with a line to show the trajectory;
  - Initial the column;
  - Use a different column for each sequential assessment.
- Section 2 – Weight
    - Fill in the patient's height and indicate whether it is actual or estimated;
    - Write in the date that the assessment is conducted in the first row of the column;
    - Fill in the weight, MAC and/or BMI data on the designated row within the same column (refer to the *LDAT Quick Reference Guide* for instructions on MAC and BMI determination);
    - Fill in the meal percentages for breakfast (B), Lunch (L) and Dinner (D);
    - Initial the column;
    - Use a different column for each sequential assessment.
  - Section 3 – Infection
    - Write in the date that the assessment is conducted in the first row of the column
      - Record only those infection(s) active at the time of assessment (this form is not for comprehensive infection reporting),
      - Use the same date more than once if there is more than one infection;
    - Using the legend on the *LDAT Quick Reference Guide*, fill in infection type and site on the designated row within the same column;
    - Write "Yes" or "No" on the ABX row to indicate whether antibiotics are being administered;
    - Fill in the number of days that the antibiotic was ordered;
    - Indicate outcome per legend;
    - Initial the column;
    - Use a different column for each sequential assessment.
  - Section 4 – FAST scale
    - Write in the date that the assessment is conducted in the first row of the column;
    - Place a dot in the row showing the patient's FAST score; connect the dots with a line to show the trajectory;
    - FAST score;
    - Initial the column;
    - Use a different column for each sequential assessment.



## IDG Forms Instructions

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### Hospice Longitudinal Data Assessment Tool and Quick Reference Guide CL.100 and CL.105

Page 3 of 3

- Section 5 – NYHA classification
  - Write in the date that the assessment is conducted in the first row of the column;
  - Place an dot in the row showing the patient’s NYHA score; connect the dots with a line to show the trajectory;
  - Initial the column;
  - Use a different column for each sequential assessment.
  
- Section 6 – ECOG scale
  - Write in the date that the assessment is conducted in the first row of the column;
  - Place an dot in the row showing the patient’s ECOG score; connect the dots with a line to show the trajectory;
  - Initial the column;
  - Use a different column for each sequential assessment.



### **Hospice Physician Initial Certification of Terminal Illness CL. 125**

The *Hospice Physician Initial Certification of Terminal Illness* is designed to document a verbal and/or written certification of terminal illness by the hospice medical director or physician member of the IDG. The background of this form is lightly shaded to distinguish it from the *Attending Physician Initial Certification of Terminal Illness* which has a white background.

The form includes:

- A place to record patient identifying information; the start of care date; the hospice diagnosis, secondary complications and co-morbid conditions; and whether the secondary complications and/or co-morbid conditions are needed to support limited prognosis.
- A place to indicate the start and end dates of the initial benefit period and whether the patient has had prior hospice care.
- A section to document what the certification of terminal illness is based on, including any review of the LCD guidelines, if applicable.
- A place to record a verbal certification.
- A place to document the written certification.



### **Hospice Physician Recertification of Terminal Illness CL. 120**

The *Hospice Physician Recertification of Terminal Illness* is designed to document a verbal and/or written recertification of terminal illness by the hospice medical director or physician member of the IDG. The background of this form is darkly shaded to distinguish it from the *Hospice Physician Initial Certification of Terminal Illness* which has a lightly shaded background and the *Attending Physician Initial Certification of Terminal Illness* which has a white background.

The form includes:

- A place to record patient identifying information; the start of care date; the hospice diagnosis, secondary complications and co-morbid conditions; and whether the secondary complications and/or co-morbid conditions are needed to support limited prognosis.
- A place to identify the benefit period for which the patient is being certified, and to indicate the start and end dates of the benefit period.
- A section to document what the recertification of terminal illness is based on, including any review of the LCD guidelines, if applicable.
- A place to record a verbal certification.
- A place to document the written certification.



This form records the Hospice Interdisciplinary Plan of Care. It is designed to capture the individualized problems, interventions and goals (desired outcomes) of care for each patient and family. It must be reviewed and updated as frequently as the patient's condition requires, but no less frequently than every 15 calendar days.

The form includes:

- A cover page to document specific patient information including diagnosis, level of care, location of care, disaster triage level, scope and frequency of services, DME, supplies, activity level, any referenced addenda (such as *Drug Profile*, *Drug Profile Review*, *HA Plan of Care*), signatures of the participating IDG members, information on review of the plan with the patient/family, and the next anticipated review date.
- A place for signatures of the IDG members who participated in developing the plan of care.
- A place to indicate that the plan was reviewed with the patient, patient's representative, and/or others.
- A place to record patient identifying information at the top of each page.
- Sections for each of nine problem areas within which the IDG can define the specific needs and individualized goals and interventions for the patient/family. The form provides a column to capture the following for each specific problem/need: Date identified, Date discontinued, Description of the problem/need, IDG and pt/family goals, Interventions, and Discipline(s) responsible for the intervention(s).
- A section to identify other problems and interventions to address them.
- Suggested needs/problems for each area appear at the top of each section.
- Note that suggested goals and interventions are provided for the IDG on the WRI reference sheet *Suggested Goals and Interventions for the Hospice Plan of Care*.

#### Tips for completing specific elements of the form:

- Scope and frequency of services: indicate the projected number of visits for the next 15 days. Consult state regulations concerning the use of visit frequency ranges. Do not use "zero" as a frequency; if there is no plan for a specific discipline to visit, document per hospice policy.
- Problems: Address the actual problems identified in the comprehensive hospice assessment as well as the potential problems that can be reasonably anticipated based on diagnosis, disease trajectory, and burden of care. Refer to the suggested problems for each area as a guide only; define the problem very specifically for each patient/family.
- Goals: Provide both IDG goals and patient/family goals, with the latter preferably as stated in their own words. The goals are the desired outcomes of care. Refer to the suggested goals and interventions (on the *Suggested Goals and Interventions for the Hospice Plan of Care* reference sheet provided), but focus on creating an individualized plan for each patient/family.



- Disciplines (Disc.): We recommend recording all disciplines involved in the interventions to emphasize the interdisciplinary nature of care.
  - Different disciplines may be involved in different interventions. A WRI reference sheet (*Suggested Abbreviations for Disciplines Involved in Care*) suggests abbreviations for each discipline; the hospice may have other abbreviations they prefer to use.
  - For patients receiving care in nursing facilities, record the involvement of facility staff in the delivery of interventions. This may be recorded either in the intervention column or in the column for disciplines responsible.
- It is recommended that the *Hospice Plan of Care* be rewritten/copied, with the current problems, goals, interventions, and disciplines responsible, at the time of recertification of terminal illness or as dictated by Hospice policy.



### Hospice Plan of Care Change CL. 255a

The *Hospice Plan of Care Change* is designed to document changes to the *Hospice Plan of Care* that take place between the full IDG discussion and update to the plan of care (at least every 15 days.) Any member of the IDG can initiate a change to the plan of care, based a change in the patient's condition, and in consultation with other members of the IDG.

The form includes:

- A place to record patient identifying information and date of form completion at the top of the page.
- A place to document the discipline of the individual completing the form.
- A place to indicate the problem areas (from the *Hospice Plan of Care*) and specific problems being addressed; the new goals and interventions; and the disciplines involved in delivering the interventions.
- A place for additional information and comments. If an additional narrative page is needed, a blank *Progress Note* or another form of the hospice's choice may be used.
- A place to indicate the names and disciplines of the other IDG members who collaborated on the changes.
- A place to indicate that the changes were discussed with the patient/PCG.

#### Tips for completing specific elements of the *Hospice Plan of Care Change*:

- Indicate which problem area is being addressed – refer to the *Hospice Plan of Care*.
- Consider combining intervention and goals into one statement.  
For example: (*Intervention*) Educate PCG to reposition the patient, (*Goal*) in order to prevent pressure ulcers.
- Use the additional comments section if needed to provide more information on changes in patient condition that prompted the change to the plan of care.





The *IDG Review and Update to the Hospice Plan of Care* is designed to document IDG discussion and care planning based on information gathered via assessment updates and other patient visits. The form captures progress toward achieving desired palliative outcomes and goals as well as plans for maintaining or improving these outcomes. We recommend attaching the update to the front of the *Hospice Plan of Care* so that the top page always shows the most recent information. *The Hospice Plan of Care* must be reviewed as frequently as the patient's condition requires, but no less frequently than every 15 calendar days.

The form includes:

- A cover page for updating the first page of the *Hospice Plan of Care*, indicating the reason for the review/update, the scope and frequency of services planned, and DME/supplies in place until the next update. The cover page also includes a section for signatures/dates.
- A place to record patient identifying information at the top of each page.
- A place for signatures of the IDG members who participated in the review and update of the plan of care.
- A place to indicate that the plan was reviewed with the patient, patient's representative, and/or others.
- A section to review each problem area on the plan of care and indicate which remain "open".
- For each open area, columns are set up to record whether it is a new problem (or one that has been closed and is being reopened), whether goals are being met, what action if any is to be taken, and the IDG discussion leading to the action decision. (Note that actual changes to problems or interventions are documented on the *Hospice Plan of Care*.)

#### Tips for completing specific elements of the *IDG Review and Update to the Hospice Plan of Care*:

- Scope and frequency of services: indicate the projected number of visits for the next 15 days. Consult state regulations concerning the use of visit frequency ranges. Do not use "zero" as a frequency; if there is no plan for a specific discipline to visit, document per hospice policy.
- Note the reason for the review: scheduled update, change in condition, or recertification.
- First column of page 2: Identify any problem areas open at the time of the update by checking the "open" checkbox in the first column.
- The "problem" column: This is the general category of problem; details appear on the *Hospice Plan of Care*.
- Problem status: Note the current problem status as previously identified, still open; closed; opened as of this update.



- Outcomes: Indicate whether goals are being met with current interventions.
- Action: Indicate whether any changes are made to the plan of care based on this update.
- Discussions and Decisions: Document discussion of assessment updates, interventions, and outcomes along with decisions related to each problem area.
- Upon completion of the *Review and Update to the Hospice Plan of Care*, it is recommended that it be placed in the medical record on top of the previous review/updates and the *Hospice Plan of Care*.



This 8-page nursing assessment is designed as one form with 2 distinct halves: the *Initial Nursing Assessment*, in the first 4 pages, and the *Comprehensive Nursing Assessment*, in the last 4 pages. The design allows for the completion of both assessments by one or two clinicians, without duplication of effort or documentation.

The *Initial Nursing Assessment* (pages 1-4) is an overall assessment of the patient/family immediate care needs, including physical, psychosocial/emotional, and spiritual care needs, and gathers information that determines which other elements of the comprehensive hospice assessment are needed to assure that all patient/family needs are identified. This initial portion of the assessment must be completed by an RN within 48 hours after the election of hospice care (start of care date).

The *Comprehensive Nursing Assessment* (pages 5-8) gathers more in depth medical information about all body systems. Depending on the patient's diagnosis, severity of symptoms, and other specific concerns, portions of the more in-depth assessment on pages 5 through 8, may be completed at the time of the initial assessment, along with specific assessment addenda. The *Comprehensive Nursing Assessment* (pages 5-8) must be completed by an RN within 5 days of the start of care date.

The form includes:

- A place to record patient identifying information and date of completion at the top of each page.
- A place to record the type of visit and other visit information.
- Shaded areas throughout the form to highlight data elements that may be used for outcome measure reporting. (Note that these data elements are included in the QAPI Navigator from Hospice Quality Resources at [www.hospicequality.com](http://www.hospicequality.com).)
- Information on the nature and condition of the terminal illness, patient/family goals of care, communication, environment, ADLs, safety issues, other factors affecting care, vital signs, IVs, pain and other symptoms, imminence of death, psychosocial/emotional concerns, spiritual concerns, structural and functional impairments for all body systems, personal care needs, patient/family teaching needs, and referrals to other IDG members or other providers.
- Room for narrative comments related to both the initial and the comprehensive nursing assessments.

Tips for completing specific elements of the *Initial Nursing Assessment* (pages 1-4):

- **Nature and Condition of Terminal Illness:** As a result of conversation and observation with patient/family, and identified others, summarize the history and course of illness, reason for hospice admission, and the limitations imposed by the disease. Use performance scales as



designated by your individual hospice to track decline over time. Record the primary complaints/concerns and desired outcomes as identified by the patient/family.

- Factors Affecting Care: Identify both patient and PCG/Family complications and risk factors that affect care planning.
- Environment/Safety: If any factors are checked, we recommend completion of the *Safety Assessment* as part of the initial assessment; if the patient has a history of falls, we recommend completion of the *Fall Risk Assessment* as part of the initial assessment.
- ADLs/Activity/Function and Use of Assistive Devices: This section gathers information that can be used for scoring the International Classification of Functioning, Disability, and Health (ICF) ([www.who.int/bookorders](http://www.who.int/bookorders)) if desired.
- Symptom Screening: We recommend completion of the *Pain Assessment* for all patients as part of the initial assessment. For all other symptoms:
  - Complete column 2 first and indicate whether each body system is associated with the hospice diagnosis. If it is, then complete the in-depth assessment for that body system on page 5, 6, or 7; there is a check box provided to identify any body system assessments completed on the initial assessment.
  - Complete the rating (how much the symptom has bothered in the last three days) for every symptom on the list. (Refer to the *WRI Symptom Assessment Reference Sheet: Concepts and Reminders*.) The PCG may rate the symptoms if the patient is unwilling or unable to do so. The hospice will identify the rating scales to use. If using a 0 to 10 scale for any symptom, translate the values to None, Mild, Moderate or Severe as shown. For any symptoms rated above None (0), ask about and record a Self Identified Threshold (SIT score) to indicate what the patient wants his or her pain level to be. If the patient cannot provide a SIT score, document that fact in this column; or follow hospice policy.
  - If any symptoms are rated Moderate or Severe, we recommend completing the in-depth assessment for the related body system on page 5, 6, or 7 as part of the initial assessment; there is a check box provided to identify any body system assessments completed on the initial assessment.
- Imminence of Death: Use the information in this section, and those that precede it, to ensure that imminently dying patients receive appropriate and timely assessments and care despite an anticipated short length of stay.
- Psychosocial/Emotional and Spiritual: These factors can be used to determine the need for inclusion of psychosocial or spiritual assessments as part of the comprehensive hospice assessment. The information may also signal the need for an immediate visit by the Social Worker or Spiritual Care Counselor. The Psychosocial and/or Spiritual Distress rating can be completed (for outcome assessment) whether or not there is a SW or spiritual counselor referral. This section also asks the RN to indicate which discipline will complete the



*Bereavement Risk Assessment* addendum, which we recommend be included as part of the comprehensive hospice assessment for all patients.

- Referrals: Note referrals to other disciplines and record the other needed elements of the comprehensive hospice assessment on the *Comprehensive Hospice Assessment Cover Page*; communicate to the IDG as per individual hospice policy and procedure.
- Narrative (Initial Assessment): This narrative is for the initial portion of the assessment. If both parts are completed at the same time by the same RN, the entire narrative may be documented at the end of the form and you may write “See narrative on page 8” in this space. If an additional narrative page is needed, a blank *Progress Note* or another form of the hospice’s choice may be used.

#### Tips for completing certain elements of the *Comprehensive Nursing Assessment (pages 5-8)*

- Pain Assessment: Reassess within 72 hours of admission for any patients who were uncomfortable on admission; if the *Physical Pain Assessment* was not completed as part of the initial assessment, it should be completed now. If it was completed on the initial assessment, and the patient is in pain, we recommend a review/update to the *Physical Pain Assessment*.
- Body Systems: Assess every body system. Any sections completed as part of the *Initial Nursing Assessment* should have a checkmark in the left column. For each body system to be assessed, identify any type of structural impairment and the effect of the impairment on care needs. Body structures are anatomical parts of the body such as organs, limbs, and their components. Impairments are problems in structure such as a significant deviation or loss. (Note: Additional information is available at <http://www.who.int/classifications/icf/training/icfchecklist.pdf>.) If there is no impairment, check “None.” In the Integumentary/Skin section, if any kind of skin impairment is identified, we recommend completion of the *Skin Impairment Assessment*.
- Environmental Factors/Safety: Complete the disaster triage section; the patient’s triage priority is also recorded on the *Hospice Plan of Care*. We recommend completion of the *Safety Assessment* and *Fall Risk Assessment*, if not completed as part of the initial nursing assessment.
- Personal Care and Support Needs: Assess the need for a Hospice Aide, volunteers, and other community supports. In most cases, this information, with other assessment data, will be used to develop the *Hospice Aide Plan of Care*.
- Narrative: This narrative applies to the second portion of the assessment. If the same nurse completes both portions (initial and comprehensive), the entire narrative may be completed here. If an additional narrative space is needed, a blank *Progress Note* indicating or another form of the hospice’s choice may be used.



### **Hospice Benefit Revocation Form CL. 130**

The *Hospice Benefit Revocation Form* is designed to document the patient's desire to dis-enroll from the Medicare hospice benefit. The form can be signed by the patient or the patient's representative.

The form includes:

- A place to record patient identifying information; the start of care date; and Medicare number.
- A place to document the reasons for revocation.
- A section that informs the patient/representative of the results of revocation.
- A place for additional information and comments.
- A place for signatures by the patient or authorized representative, and the hospice staff.



### Medicare/Medicaid Statement of Consent and Election CL. 140

The *Medicare/Medicaid Statement of Consent and Election* is designed to document the patient's election of the hospice benefit. The form can be signed by the patient or the patient's representative.

The form includes:

- A place to record patient identifying information; the start of care date and time; whether the patient is covered by Medicare, Medicaid or both; and the name of the hospice.
- A place to document that the patient has been informed about hospice services and understands the palliative nature of hospice care.
- A statement of consent to receive visits from hospice staff, other professionals working with the hospice, and accrediting or regulatory surveyors.
- Information on the Medicare/Medicaid hospice benefit and the requirement to waive certain Medicare coverage.
- A statement that the patient has received notice of the hospice privacy practices (HIPAA.)
- A statement of assignment of insurance payments to the hospice.
- A place for a signature by the patient or authorized representative.



The *Nursing Assessment Update* is designed to capture information that may change as the patient's illness progresses. This form is part of the required update to the comprehensive hospice assessment that must occur as frequently as the condition of the patient requires (per hospice policy), but no less than every 15 days.

This form includes:

- A place to record patient identifying information, diagnosis and date of completion at the top of each page.
- A place to record the type of visit and other visit information.
- A place to record the reason for the update.
- Shaded areas throughout the form to highlight data elements that may be used for outcome measure reporting. (Note that these data elements are included in the QAPI Navigator from Hospice Quality Resources at [www.hospicequality.com](http://www.hospicequality.com).)
- Areas to update information on prognosis and progression of illness, changes in goals of care, functional status, psychosocial/emotional needs, spiritual needs, factors affecting care, safety concerns, symptom severity, structural and functional impairments by body system, personal care needs, and teaching needs.
- A section for Hospice Aide Supervision. The supervision ensures that services ordered by the hospice IDG are provided in accordance with the plan of care and meet the patient's needs.
- A section for narrative comments.

#### Tips for completing certain elements of the form:

- Complete this form per hospice policy. We recommend that each section of the assessment be reviewed carefully; if there are no changes since the last assessment, document per hospice policy.
- Imminence of death: Use the information in this section to ensure that imminently dying patients receive appropriate and timely care.
- Progression of illness: Note any changes since the last assessment including hospitalizations, ER visits, lab values, or signs of disease progression.
- Psychosocial/emotional and Spiritual: Indicate whether adequate interventions are in place. Refer to the *Symptom Assessment Reference Sheet: Concepts and Reminders* to rate psychosocial and spiritual distress. Distress ratings may indicate a need for further referral/intervention and/or changes to the care plan.
- Communication, environment and other factors affecting care: Note any changes since the last assessment.





- Hospice Aide Supervision: We recommend that the RN who is the case manager for the patient complete the supervision. The hospice aide does not have to be present during the visit, but if any area of concern is noted, the RN should follow-up with the aide and/or make a joint visit with the aide to observe the care being provided.
- Symptom Screening:
  - Complete column 2 first and indicate whether the body system is associated with the hospice diagnosis.
  - Complete the rating for every symptom on the list. (Refer to the WRI *Symptom Assessment Reference Sheet: Concepts and Reminders*.) The PCG may rate the symptoms if the patient is unwilling or unable to do so. If using a 0 to 10 scale for any symptom, translate the values to None, Mild, Moderate or Severe as shown. For any symptoms rated above None (0), ask about and record a Self Identified Threshold (SIT score) to indicate what the patient wants his or her pain level to be. If the patient cannot provide a SIT score, document that fact in this column; or follow hospice policy.
- Body systems: We recommend reviewing all body systems to determine whether new problems are present. Refer to hospice policy for specific instructions.
- Personal care and support needs: Update based on current patient needs.
- Teaching needs and referrals: Update based on current patient needs.
- Patient response to interventions, and new complaints /concerns: Use these sections to summarize findings during the visit. Comment on how well current interventions are working to help achieve desired goals. Also note any new concerns identified by the patient/family or from your own observations.
- Narrative: If an additional narrative page is needed, a blank *Progress Note* or another form of the hospice's choice may be used.



### Nursing Clinical Note CL. 315

The *Nursing Clinical Note* is designed to collect information relative to patient status during nursing visits when a full assessment update is not indicated.

This form includes:

- A place to record patient identifying information, diagnosis and date of completion at the top of each page.
- A place to record the type of visit and other visit information.
- A place to record the reason for the update.
- Shaded areas throughout the form to highlight data elements that may be used for outcome measure reporting. (Note that these data elements are included in the QAPI Navigator from Hospice Quality Resources at [www.hospicequality.com](http://www.hospicequality.com).)
- Sections for recording vital signs and symptom severity.
- A section to record patient changes in condition relative to the areas of the nursing comprehensive assessment.
- A section to document problems addressed and narrative comments.

#### Tips for completing certain elements of the *Nursing Clinical Note*:

- Imminence of death: Use the information in this section to ensure that imminently dying patients receive appropriate and timely care.
- Pain Assessment: If the patient's pain is not well controlled, review/update the *Pain Assessment* as needed and per hospice policy.
- Symptom screening: Complete as described for the *Nursing Assessment Update*. (Refer to the *WRI Symptom Assessment Reference Sheet: Concepts and Reminders*.)
- Changes in condition: Observe and assess the patient's condition in each area listed. If there are no changes, check the box provided. If there are changes, describe them.
- Hospice Aide Supervision: Complete as described for the *Nursing Assessment Update*.
- Narrative Comments/Problems Addressed: Use the check boxes to identify specific problem areas from the *Hospice Plan of Care* that were addressed on this visit. Document any information pertinent to the problems identified in the narrative section.



### Physical Pain Assessment CL.160

The *Physical Pain Assessment* is designed to be completed at the following intervals as patient needs dictate, and based on hospice policy:

- At the time of the *Initial Nursing Assessment* or the *Comprehensive Nursing Assessment*, or both if indicated;
- Whenever the nursing assessment is updated (no less than every 15 days);
- Whenever there is a change in the patient's pain - either a new location, or a significant increase in severity.

The form includes:

- A place to record patient identifying information, date of form completion and assessment type at the top of each page.
- Two scales for patients who can self-report verbally. \* One is a 0 to 10 scale, where 0 = No pain and 10 = the worst pain possible. The other is a 4-point scale: None, Mild, Moderate or Severe. The relationship between the two scales is shown on the form.
- One scale for patients who are non-verbal. The clinician assigns a pain value (None, Mild, Moderate, or Severe) based on observational descriptors. The hospice may also choose to implement a different validated scale for patients who are cognitively impaired or otherwise cannot self-report.
- A place to record the patient's Self Identified Threshold (SIT). If the patient cannot self-report, the Primary Caregiver (PCG) may be asked to select the threshold, based on what the PCG wants the pain to be.
- Additional signs and symptoms of pain.
- Body diagrams for designating the location of specific pains.
  - Circle the area in pain, assign a number (use another sheet if needed for additional pain sites);
  - For each pain, indicate the intensity, whether at rest or with activity, frequency, description, and anything that makes the pain better (medication, distraction, etc.) or worse (activity, etc.)
- A report on the effectiveness of current therapy for different pains from the perspective of the patient or, if the patient is unable to report, the perspective of the PCG.
- Additional comments/narrative. If an additional narrative page is needed, a blank Progress Note indicating the writer's discipline or another form of the hospice's choice may be used.

\* Refer to the *WRI Symptom Assessment Reference Sheet: Concepts and Reminders* for more information on pain and other symptom assessment.



### Physician's Orders and Medication Administration Record CL. 135

The *Physician's Orders and Medication Administration Record* was created for use in the hospice inpatient setting. This convenient tool combines physician's orders with the Medication Administration Record (MAR) in a practical and time-saving form.

This form includes:

- A place to record patient identifying information at the top of the page, including:
  - Patient name;
  - Level of care;
  - Date of birth;
  - Gender;
  - Current month and year; and
  - The patient's medical record (MR) number.
- The first column on the left is intended to record each medication the patient will receive while in the inpatient setting, along with a check box to indicate whether the medication is covered (C) or non-covered (N) in the hospice plan of care. As you write the ordered medications here, you are also creating the MAR. Therefore, it is important to document medications clearly and legibly – we recommend printing – and to bear down firmly with your pen.
- In the next column, indicate the time or times each medication is due; write "PRN" if the medication is to be administered as needed or when requested.
- The final column, "Additional Physician Orders", is intended to capture all non-medication orders (e.g., diet, activity, treatments, medical equipment, etc.). There is a space for the physician to sign and date this form, indicating that he or she provided the orders as written.
- Below these columns, there is a space for the nurse to document the name of the physician who provided the orders as well as a space for the nurse's signature and a line to indicate the date the orders were received and verified.
- A place to indicate the patient's hospice diagnosis. Note: It is important to consider the diagnosis when making determinations about what is and is not covered in the plan of care.
- A place to record the patient's allergies.
- Places to record the physician's name, telephone number, and DEA number (if required per hospice policy).
- A small check box in the lower left corner of the form alerts the reader as to whether the medications are continued on additional pages.
- Page 2 of this form, a mirror image of much of page 1, becomes the MAR once all the medications are listed. This page contains a place to record the hour and date that each medication was administered. For example, a nurse administering Tylenol 650mg PO q 4 hrs



## IDG Forms Instructions

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PRN for pain at 8:00 in the morning would document 8A and his or her initials in the "Hour" column and the date of administration in the date column.

- The back of page 2 provides a place to document the PRN medication administered to the patient as well as a place to record the reason and results. For example, 30 minutes after administering the Tylenol, the nurse would reassess the patient and document whether or not the medication provided the expected relief.
- The back of page 2 also provides a place to document the nurse's initials alongside his or her signature. Remember to document your credentials in the signature block (e.g., RN, LPN, or LVN).
- If space for additional narrative documentation is needed, the use of a "Progress Note" is recommended.



## IDG Forms Instructions

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### **Progress Note CL. 330**

The *Progress Note* is a generic narrative note that may be used by any discipline to record information relative to patient care. It may be used to document discussions and collaborations with other IDG members. Although visits should be documented on clinical notes, this form may also be used to continue the narrative section of any clinical note.

This form includes:

- A place to record patient identifying information and the date of completion at the top of the page.
- A section to indicate the discipline of the writer.
- A section for narrative comments.



### Psychosocial Assessment Update CL. 305

The *Psychosocial Assessment Update* is designed to capture information that may change as the patient's illness progresses. This form is part of the required update to the comprehensive hospice assessment that must occur as frequently as the condition of the patient requires (per hospice policy), but no less than every 15 days.

This form includes:

- A place to record patient identifying information, diagnosis and date of completion at the top of each page.
- A place to record the type of visit and other visit information.
- A place to record the reason for the update.
- Shaded areas throughout the form to highlight data elements that may be used for outcome measure reporting. (Note that these data elements are included in the QAPI Navigator from Hospice Quality Resources at [www.hospicequality.com](http://www.hospicequality.com).)
- Many of the same assessment topics found on the *Comprehensive Psychosocial Assessment*, along with checkboxes to select if there have not been any changes since the prior assessment.
- A section for comments and narrative.

#### Tips for completing certain elements of the *Psychosocial Assessment Update*:

- Document the inability to complete the update if the patient has died or the visit was declined by the patient/family. If a visit cannot be completed, a telephone call may substitute for a visit if permitted by hospice policy.
- Pain Assessment: Non-nursing disciplines are not asked to assess pain severity or location. Instead, they are asked to determine whether the patient is experiencing pain using one or more of the following three methods:
  1. Ask the patient if he/she is experiencing pain;
  2. Ask the PCG if the patient is experiencing pain;
  3. Look for observable behaviors associated with pain such as low moaning to crying out, guarding or pulling away when touched, facial expressions of sadness or fear, labored breathing, or fidgeting.If the patient or PCG report pain, or if pain behaviors are observed, notify the nurse unless the patient/PCG decline. If declined, check the box provided.
- Complete other sections as described for the *Comprehensive Psychosocial Assessment*.



### Psychosocial/Spiritual Clinical Note CL. 320

The *Psychosocial/Spiritual Clinical Note* is designed to document encounters by clinicians providing psychosocial care and/or spiritual care. It is utilized for visits, phone calls, and bereavement contacts whenever an assessment update is not indicated.

The form includes:

- A place to record patient identifying information, diagnosis and date of completion at the top of each page.
- A place to record the type of visit and other visit information.
- Shaded areas to highlight data elements that may be used for outcome measure reporting. (Note that these data elements are included in the QAPI Navigator from Hospice Quality Resources at [www.hospicequality.com](http://www.hospicequality.com).)
- A section to document problems addressed and narrative comments.

#### Tips for completing certain elements of the *Psychosocial/Spiritual Clinical Note*:

- Indicate the type and reason for the note.
- Pain Assessment: Non-nursing disciplines are not asked to assess pain severity or location. Instead, they are asked to determine whether the patient is experiencing pain using one or more of the following three methods:
  1. Ask the patient if he/she is experiencing pain;
  2. Ask the PCG if the patient is experiencing pain; or
  3. Look for observable behaviors associated with pain such as low moaning to crying out, guarding or pulling away when touched, facial expressions of sadness or fear, labored breathing, or fidgeting.

If the patient or PCG report pain, or if pain behaviors are observed, notify the nurse unless the patient/PCG decline. If declined, check the box provided.

- Distress and anxiety ratings: *Refer to the Symptom Assessment Reference Sheet: Concepts and Reminders*. The ratings may indicate the need for further intervention and an update to the Psychosocial or Spiritual assessment, or to the *Bereavement Plan of Care*.
- Narrative Comments/Problems Addressed: Use the check boxes to identify specific problem areas from the *Hospice Plan of Care* that were addressed on this visit. Document any information pertinent to the problems identified in the narrative section.





## IDG Forms Instructions

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### Safety Assessment CL. 170

The *Safety Assessment* is designed to be completed as an element of the *Initial Nursing Assessment* and/or the *Comprehensive Nursing Assessment*. It is reviewed/updated as the patient's condition changes, at least every 15 days when the interdisciplinary assessment is updated.

The form includes:

- A place to record patient identifying information, date of form completion and assessment type at the top of each page.
- An assessment of safety concerns related to the patient, primary caregiver (PCG), and care processes. If there are no concerns, check the box provided in each section to indicate that none are identified.
- An assessment of safety concerns related to the environment. If the patient is in a facility (nursing facility, assisted living, hospital, or other) use the last column to indicate safety issues that are managed by the facility.
- A section for narrative comments. If an additional narrative page is needed, a blank *Progress Note* or another form of the hospice's choice may be used.



### Skin Impairment Assessment CL. 165

The *Skin Impairment Assessment* is designed to be completed and updated whenever an impairment to skin integrity is identified. Typically, it will be completed as part of the *Initial Nursing Assessment*, the *Comprehensive Nursing Assessment*, and/or the *Nursing Assessment Update*.

The form includes:

- A place to record patient identifying information, date of form completion and assessment type at the top of each page.
- A body diagram and table for documenting pressure ulcer location, staging and characteristics.
- An area to document treatments for each pressure ulcer.
- A body diagram and table for documenting the location and treatment of other skin impairments that impact comfort and care of the patient.
- A section for comments and narrative.

#### Tips for completing certain elements of the form

- Pressure ulcer staging and characteristics: Use the legend provided and the WRI reference sheet (*Pressure Ulcer Stages*) for staging pressure ulcers to document the stage and characteristics of each pressure ulcer.
- Pressure ulcer treatments: Use the treatment legend to document the treatments ordered for each pressure ulcer. If treatments other than those listed are to be used, write the treatment type in appropriate column for each specific pressure ulcer.
- Treatments for other skin impairments: Describe treatments for other skin impairments in as much detail as needed so that another clinician could complete the care.
- Photos: If photos are taken for any of the pressure ulcers or other skin impairments, check the box provided to indicate a photo was taken and write the following on each picture: patient identifying information, the number of the pressure ulcer or the type of other impairment, and the date of the photo. Attach photos to the skin impairment assessment form.
- Narrative/comments: Use this section to comment on treatment effectiveness, changes in the skin impairments over time, impact on the patient/PCG, and other factors affecting the care of these impairments.



### Spiritual Assessment Update CL. 310

The *Spiritual Assessment Update* is part of the required update to the comprehensive assessment that must occur as frequently as the condition of the patient requires (per hospice policy), but no less than every 15 days.

This form includes:

- A place to record patient identifying information, diagnosis and date of completion at the top of each page.
- A place to record the type of visit and other visit information.
- A place to record the reason for the update.
- A shaded area on page 2 to highlight data elements that may be used for outcome measure reporting. (Note that these data elements are included in the QAPI Navigator from Hospice Quality Resources at [www.hospicequality.com](http://www.hospicequality.com).)
- Many of the same assessment topics found on the *Comprehensive Spiritual Assessment*, along with checkboxes to indicate that there have not been any changes since the prior assessment.
- A section for comments and narratives.

#### Tips for completing certain elements of the *Spiritual Assessment Update*:

- Document the inability to complete the update if the patient has died or the visit was declined by the patient/family. If a visit cannot be completed, a telephone call may substitute for a visit if permitted by hospice policy.
- Pain Assessment: Non-nursing disciplines are not asked to assess pain severity or location. Instead, they are asked to determine whether the patient is experiencing pain using one or more of the following three methods:
  1. Ask the patient if he/she is experiencing pain;
  2. Ask the PCG if the patient is experiencing pain; or
  3. Look for observable behaviors associated with pain such as low moaning to crying out, guarding or pulling away when touched, facial expressions of sadness or fear, labored breathing, or fidgeting.If the patient or PCG report pain, or if pain behaviors are observed, notify the nurse unless the patient/PCG decline. If declined, check the box provided.
- Spiritual distress rating: Refer to the *Symptom Assessment Reference Sheet: Concepts and Reminders*.
- Faith Community Information: Review the Faith Community Information for any changes.
- Complete other sections as described for the *Comprehensive Spiritual Assessment*.



### Volunteer Note CL. 325

This form is designed for use by volunteers to record visits of any kind with patients and/or family members.

The form includes:

- A place to record patient identifying information, diagnosis and date of completion at the top of each page.
- A place to record the type of visit and other visit information.
- Designated sections for recording observations, services provided and response, and a comments section.

#### Tips for completing certain elements of the *Volunteer Note*:

- Pain Assessment: Non-nursing disciplines are not asked to assess pain severity or location. Instead, they are asked to determine whether the patient is experiencing pain using one or more of the following three methods:
  1. Ask the patient if he/she is experiencing pain;
  2. Ask the PCG if the patient is experiencing pain; or
  3. Look for observable behaviors associated with pain such as low moaning to crying out, guarding or pulling away when touched, facial expressions of sadness or fear, labored breathing, or fidgeting.If the patient or PCG report pain, or if pain behaviors are observed, notify the nurse unless the patient/PCG decline. If declined, check the box provided.
- Observations of patient/family: Record observations of overall demeanor (e.g., relaxed, anxious, confused, quiet, withdrawn, interactive, or other) Also use this section to make observations about the environment.
- Services provided: Use the check boxes to indicate what service you provided on this visit. Add others as needed, especially for phone interactions.
- Patient/family response to services provided: See examples on the forms; include both positive and negative responses, if applicable.
- Other information/comments: Summarize observations, conversations and impressions. In your notes, you may want to refer to previous visits and/or plans for future visits.

# ***APPENDIX A***

## ***CLINICAL DOCUMENTATION SYSTEM FOR HOSPICE***

### ***REFERENCE GUIDES***



### Pressure Ulcer Stages Revised by NPUAP (National Pressure Ulcer Advisory Panel)

#### **Stage I:**

Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

#### **Further description:**

The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons (a heralding sign of risk)

#### **Stage II:**

Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

#### **Further description:**

Presents as a shiny or dry shallow ulcer without slough or bruising.\* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.

\*Bruising indicates suspected deep tissue injury

#### **Stage III:**

Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

#### **Further description:**

The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

#### **Stage IV:**

Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

#### **Further description:**

The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

#### **Unstageable:**

Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

#### **Further description:**

Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.

For more information, contact [www.npuap.org](http://www.npuap.org) or 202-521-6789

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### Suggested Abbreviations for Disciplines Involved in Care

AMD – Attending Physician

Ber – Bereavement counselor

D – Dietician

Fac – Facility staff

Fam – Family member(s)

HMD – Hospice Physician

IDG – Interdisciplinary Group

LPN / LVN – Licensed Practical/Vocational Nurse

OT – Occupational Therapist

PCG – Primary caregiver

Pt – Patient

PT – Physical Therapist

RN – Registered Nurse

SC – Spiritual Care provider

ST – Speech / Language Pathologist or Therapist

SW – Social Worker

Vol – Volunteer

RECOMMENDED FREQUENCY QUICK REFERENCE GUIDE



**CLINICAL DOCUMENTATION SYSTEM FOR HOSPICE**

#	Form Name	Complete on Admission	Complete on Each Visit	Complete Q 15 Days	Complete on Recert	Change in Pt Condition	Other	Comments
CL.125a	Attending Physician Initial Certification of Terminal Illness	√						
CL.265	Bereavement Plan of Care						√	Upon death of patient.
CL.190	Bereavement Risk Assessment	√					PRN	Update post death and PRN per Hospice Policies & Procedures.
CL.280	Care Coordination Sheet						PRN	PRN to be completed prior to seeing a referral from a non-hospice provider.
CL.145	Comprehensive Hospice Assessment Cover Page	√						
CL.175	Comprehensive Psychosocial Assessment	√					PRN	Complete upon request if deferred at admission.
CL.185	Comprehensive Spiritual Assessment	√					PRN	Complete upon request if deferred at admission.
CL.290	Drug Profile	√					PRN	PRN update/rewrite as needed.
CL.295	Drug Profile Cover Page	√						
CL.285	Drug Profile Review	√					PRN	Review at first 15-day IDG meeting and PRN thereafter.
CL.200	DTS: Adult Failure to Thrive	PRN			PRN			To be completed for patient with this terminal diagnosis.
CL.225	DTS: Alzheimer's and Related Disorders Worksheet	PRN			PRN			To be completed for patient with this terminal diagnosis.
CL.215	DTS: Amyotrophic Lateral Sclerosis (ALS) Worksheet	PRN			PRN			To be completed for patient with this terminal diagnosis.
CL.220	DTS: Cancer Worksheet	PRN			PRN			To be completed for patient with this terminal diagnosis.
CL.195	DTS: Decline in Clinical Status Worksheet	PRN			PRN			To be completed for patients with general decline in health status, debility unspecified, etc.
CL.230	DTS: Heart Disease Worksheet	PRN			PRN			To be completed for patient with this terminal diagnosis.
CL.235	DTS: HIV Worksheet	PRN			PRN			To be completed for patient with this terminal diagnosis.
CL.240	DTS: Liver Disease Worksheet	PRN			PRN			To be completed for patient with this terminal diagnosis.
CL.245	DTS: Pulmonary Disease Worksheet	PRN			PRN			To be completed for patient with this terminal diagnosis.
CL.205	DTS: Renal Disease Worksheet	PRN			PRN			To be completed for patient with this terminal diagnosis.
CL.250	DTS: Stroke and Coma Worksheet	PRN			PRN			To be completed for patient with this terminal diagnosis.
CL.155	Fall Risk Assessment						PRN	Weatherbee recommends completing this assessment on admission and PRN thereafter per hospice P&Ps.
CL.180	Financial Assessment						PRN	PRN per Hospice Policies & Procedures.
CL.110	Hospice Aide Flow Sheet		√					
CL.260	Hospice Aide Plan of Care						PRN	PRN if aide services are ordered.
CL.100	Hospice Longitudinal Data Assessment Tool (LDAT)	√	PRN	√	√	√	PRN	
CL.105	Hospice Longitudinal Data Assessment Tool (LDAT) Quick Reference Guide							Refer to this reference guide as needed.
CL.125	Hospice Physician Initial Certification of Terminal Illness	√						
CL.120	Hospice Physician Recertification of Terminal Illness				√			
CL.255	Hospice Plan of Care	√			PRN			PRN per Hospice Policies & Procedures. Weatherbee recommends re-writing the POC at each recertification.
CL.255a	Hospice Plan of Care Change					PRN		PRN per Hospice Policies & Procedures.
CL.275	IDG Review and Update to the Hospice Plan of Care			√		PRN		PRN per Hospice Policies & Procedures.
CL.150	Initial & Comprehensive Nursing Assessment	√						
CL.130	Medicare Hospice Revocation Form						√	Complete upon revocation.
CL.140	Medicare/Medicaid Statement of Consent and Election	√						
CL.300	Nursing Assessment Update			√		PRN		PRN per Hospice Policies & Procedures.
CL.315	Nursing Clinical Note		√					Skip this note when completing an assessment update.
CL.160	Physical Pain Assessment						PRN	Weatherbee recommends completing this assessment on admission and PRN thereafter per hospice P&Ps.
CL.135	Physicians Orders and Medication Record (inpatient only)	√						For use in hospice-owned inpatient settings only. Update/rewrite as needed.
CL.330	Progress Note						PRN	
CL.305	Psychosocial Assessment Update			√		PRN	PRN	PRN per Hospice Policies & Procedures.
CL.320	Psychosocial/Spiritual Clinical Note		√					Skip this note when completing an assessment update.
CL.170	Safety Assessment						PRN	Weatherbee recommends completing this assessment on admission and PRN thereafter per hospice P&Ps.
CL.165	Skin Impairment Assessment						PRN	Weatherbee recommends completing this assessment on admission and PRN thereafter per hospice P&Ps.
CL.310	Spiritual Assessment Update			√		PRN	PRN	PRN per Hospice Policies & Procedures.
CL.325	Volunteer Note		√				PRN	Use this form to document telephone calls.





### Suggested Goals and Interventions for the Hospice Plan of Care

#### IDG and Pt/Fam goals may include (examples):

##### **IDG Goals:**

- ❖ Patient will verbalize / exhibit relief of pain / symptoms.
- ❖ Pt/PCG will verbalize / demonstrate understanding of treatments.
- ❖ Maximize / balance patient comfort and level of consciousness, based on patient preference.
- ❖ Pt/PCG/Fam will use available strengths and support to aid in coping.

##### **Pt/Fam Goals:**

- ❖ Feel as comfortable as possible
- ❖ Make sure my family will be OK
- ❖ Sleep through the night
- ❖ Say my "good-byes"
- ❖ Other Pt/PCG/Fam goals (specify)

#### Interventions may include:

##### **Medication-related**

- ❖ Implement medications as prescribed and instruct Pt/PCG/Fam in safe administration, possible side effects, and when to contact nurse.
- ❖ Collaborate with attending MD to adjust medication regimen as needed to maximize pain / symptom control.
- ❖ Specific medication regimens
- ❖ Oxygen therapy @ \_\_\_\_\_L/min via
  - Nasal cannula
  - Mask
- ❖ Other (specify)

##### **Educational**

- ❖ Instruct Pt/PCG/Fam or facility staff regarding:
  - Disease process
  - Safety
  - Effective communication techniques
  - Budgeting / planning strategies
  - Infection control and standard precautions
  - Pursed-lip breathing
  - Energy conservation techniques
  - Safe use of oxygen
  - Bowel regimen
  - Other (specify)

##### **Non-pharmacological**

- ❖ Wound care
- ❖ Encourage expression of feelings
- ❖ Facilitate life review
- ❖ Encourage / support expressions of grief
- ❖ Explore religious identity / spirituality
- ❖ Offer / support religious / spiritual rituals
- ❖ Encourage prayer / meditation
- ❖ Help build and encourage use of coping mechanisms and support system
- ❖ Referrals and/or collaboration
- ❖ Volunteer services when indicated for (specify):
  - Companionship
  - Reading to pt
  - Writing letters/e-mail messages for pt
  - Errands
  - Simple food preparation
  - Light housekeeping
  - Other (specify)
- ❖ Instruct Pt/PCG/Fam regarding non-pharmacological techniques, such as:
  - Heat applications
  - Cold applications
  - Position for comfort
  - Relaxation techniques/imagery
  - Distraction/diversion
  - Fan to circulate air
  - Loose/comfortable clothing and bed covers
  - Other (specify)



## Symptom Assessment Reference Sheet Concepts and Reminders

### Pain Assessment

- Patient should rate pain severity whenever possible, using a scale designated by hospice policy.
  - WRI forms use a 0 to 10 linear scale where 0 is “no pain” and 10 is “the worst possible pain.”
  - The Faces Scale (Wong-Baker), which also rates pain on a 0 to 10 scale, is often used in hospice setting.
- When the patient cannot report, nurses may rate pain using the following observational scale, or another scale designated by the hospice.
  - None – Resting quietly
  - Mild – Occasional labored breathing; occasional soft moan
  - Moderate - Face looks sad or scared; tense; low-level vocalization
  - Severe – Pulls away; distressed; fidgeting; loud moaning; crying; clenched fists
- PCG may indicate whether the patient is in pain by describing their observations, but should not provide a severity rating.
- Self-identified threshold (SIT)
  - Should be provided by the patient whenever possible.
  - PCG may identify their preferred threshold if patient cannot report. This is what the PCG wants, though it may be informed by what the patient has said. (Example: *My sister always said she wanted to be a comfortable as possible, even it meant that she might be somewhat sedated.*)
- Non-nursing disciplines are not asked to assess pain severity or location. Instead, they are asked to determine whether the patient is experiencing pain using one or more of the following three methods:
  - Ask the patient if he/she is experiencing pain;
  - Ask the PCG if the patient is experiencing pain; or
  - Look for observable behaviors associated with pain such as low moaning or crying out, guarding or pulling away when touched, facial expressions of sadness or fear, labored breathing, or fidgeting.
- If the patient or PCG report pain, or if pain behaviors are observed, notify the nurse unless the patient/PCG decline. If declined, check the box provided.

### Other Physical/Mental Symptoms – Nursing Assessment [Anxiety , Depression , Dizziness , Dyspnea (Shortness of breath) , Cardiac-related pain , Nausea , Vomiting , Appetite (weight loss or swallowing), Constipation , Diarrhea , Urinary problems , Level of sexual interest or activity, Weakness or stiffness , Pruritis (Itching or rash), Wounds, Pressure ulcer (Bed sores), Insomnia , Somnolence Drowsy/Excess sleep)]

- Rating by the patient is always preferred.
- Only the PCG or patient will rate these; if neither can rate, record Unwilling/Unable or some other indication as dictated by hospice policy.
- These symptoms are rated on “bothersomeness.” The goal is to relieve the distress or suffering associated with these symptoms, regardless of their objective severity.
- Ask patient or PCG “How much did this distress or bother you over the last 3 days?”
- Based on hospice policy, use any one of the following scales (Note that all scales are recorded on the WRI documentation as None, Mild, Moderate or Severe):



- 0 to 10 linear scale
- 0 to 10 Faces scale
- Any other validated 0 to 10 scale
- 4 point scale – None, Mild, Moderate, Severe

### **Patient Emotional/Psychological/Spiritual Distress [Anxiety, Psychosocial distress, Spiritual distress]**

- The patient should rate his or her own distress whenever possible; You might ask the patient
  - For anxiety: *How would you rate your level of anxiety? Or You seem very anxious to me. Is that right? Would you say your anxiety level is mild, moderate or severe?*
  - For psychosocial distress: *How would you rate your level of emotional distress? Or You seem to be OK with your situation; is that right? Would you say your emotional distress is None or Mild?*
  - For spiritual distress: *How would you rate your level of spiritual distress? Or You seem to be struggling with your faith; is that right? Would you say your level of distress is Mild, Moderate or Severe?*
- If the patient is unable or unwilling to rate, the clinician will rate after considering all of the following:
  - Information gathered in the other parts of the assessment (observation and what others have said)
  - Patient's demeanor and specific statements
  - For psychosocial and spiritual distress, the influence and concerns of other family members
  - Clinical experience and judgment
- Examples: Patient statements that evidence anxiety
  - "I am so worried about ....." OR "I am afraid that ....." OR "Everything seems out of control."
- Examples: Patient statement that evidence psychosocial distress
  - "How will my family manage ....." OR "I feel so alone....." OR "I don't know how to help....." or "I don't know where to turn..."
- Examples: Patient statements that evidence spiritual distress
  - "Why is this happening to me?" OR "Why is God punishing me?" OR "I think I am being punished for..." OR "I am losing (have lost) my faith..."

### **PCG Anxiety**

- The PCG should rate his or her own anxiety whenever possible; You might ask the PCG
  - *How would you rate your level of anxiety? Or You seem very anxious to me. Is that right? Would you say your anxiety level is mild, moderate or severe?*
- If the PCG is unable or unwilling to rate, the clinician will rate after considering all of the following:
  - Information gathered in the other parts of the assessment
  - PCG's demeanor and specific statements
  - Clinical experience and judgment
- Examples: PCG statements that evidence anxiety
  - "I am so worried about ....." OR "I am afraid that ....." OR "Everything seems out of control."

# ***APPENDIX B***

## ***CLINICAL DOCUMENTATION SYSTEM FOR HOSPICE***

### ***ORDERING INFORMATION***

# ORDER FORM



DATE: \_\_\_\_\_

## CLINICAL DOCUMENTATION SYSTEM FOR HOSPICE

The forms included in Weatherbee's *Clinical Documentation System for Hospice*:

- Meet the requirements of the new Medicare CoPs
- Reduce the redundancy found in most hospice clinical documentation systems
- Include quality outcome measures needed for the hospice's QAPI program

The *Clinical Documentation System for Hospice* represents not only tools to use, but a process designed to improve patient care planning and the quality of care provided. To help hospices most fully benefit from the system, comprehensive instructions are provided free of charge on the Hospice Education Network (HEN) with streaming videos describing how each form is used.



If you have any questions, call us at 866-969-7124.

### DELIVERY INFORMATION

#### SHIP TO ADDRESS

Contact Name \_\_\_\_\_ Title \_\_\_\_\_

Organization \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

#### ORDER METHODS

**Call** 866-969-7124 Mon-Fri 9 to 5 EST

**Fax** 508-778-8899

**Mail** Weatherbee Resources  
259 North St Hyannis, Ma 02601

**Online** [www.weatherbeeresources.com](http://www.weatherbeeresources.com)

**ALL ORDERS ARE PREPAID**

**SHIPPING & HANDLING:** Orders will ship FedEx Ground unless otherwise indicated:  Next Day delivery  2-day delivery.

**NOTE:** S & H is not included in price and will be added at time of processing. Once processed, you will receive an order confirmation with total amount charged, including S&H.

**DELIVERY:** Forms will be shipped same day order is received if received before 11 AM EST.

### PAYMENT INFORMATION

Charge my Credit Card:  Visa  MC  Discover  AmExp

Account No.: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

Billing ZIP Code: \_\_\_\_\_

Name on Card: \_\_\_\_\_

*Office use only*

Date Proc'd: \_\_\_\_\_ By: \_\_\_\_\_

Auth #: \_\_\_\_\_ Amount Charged: \_\_\_\_\_



# CLINICAL DOCUMENTATION SYSTEM FOR HOSPICE

## ORDER FORM

Please complete the order form below with your payment info before submitting an order.

NOTE: The Prices Listed below are for (1) 100-pack.

Qty (100's):	Document Title	Form#	Pgs	1-Part (no NCR)	2-part NCR	3-part	Price
	60-90 Day Benefit Calculator Wheel	CL.335	1	8.99			
	60-90 Day Benefit Calculator Sheet	CL.340	1	8.99			
	Attending Physician Initial Certification of Terminal Illness	CL.125a	1	8.25	25.50	38.25	
	Bereavement Plan of Care	CL.265	2	13.75	42.50	63.75	
	Bereavement Risk Assessment	CL.190	2	13.75	42.50	63.75	
	Care Coordination Sheet	CL.280	1	8.25	25.50	38.25	
	Comprehensive Hospice Assessment Cover Page	CL.145	1	8.25	25.50	38.25	
	Comprehensive Psychosocial Assessment	CL.175	3	20.63	70.63	95.63	
	Comprehensive Spiritual Assessment	CL.185	3	20.63	70.63	95.63	
	Determining Terminal Status: Adult Failure to Thrive Worksheet	CL.200	2	16.50			
	Determining Terminal Status: ALS Worksheet	CL.215	2	16.50			
	Determining Terminal Status: Alzheimer's and Related Disorders Worksheet	CL.225	2	16.50			
	Determining Terminal Status: Cancer Worksheet	CL.220	2	16.50			
	Determining Terminal Status: Decline in Clinical Status Worksheet	CL.195	2	16.50			
	Determining Terminal Status: Heart Disease Worksheet	CL.230	2	16.50			
	Determining Terminal Status: HIV Worksheet	CL.235	2	16.50			
	Determining Terminal Status: Liver Disease Worksheet	CL.240	2	16.50			
	Determining Terminal Status: Pulmonary Disease Worksheet	CL.245	2	16.50			
	Determining Terminal Status: Renal Disease Worksheet	CL.205	2	16.50			
	Determining Terminal Status: Stroke - Coma Worksheet	CL.250	2	16.50			
	Drug Profile	CL.290	2	13.75	42.50	63.75	
	Drug Profile Cover Page	CL.295	1	7.00	21.25	31.88	
	Drug Profile Review	CL.285	2	13.75	42.50	63.75	
	Fall Risk Assessment	CL.155	1	8.25	25.50	38.25	
	Financial Assessment	CL.180	2	16.50	51.00	76.50	
	Hospice Aide Flow Sheet	CL.110	3	26.75	70.75	95.63	
	Hospice Aide Plan of Care	CL.260	2	13.75	42.50	63.75	
	Hospice Longitudinal Data Assessment Tool (LDAT)	CL.100	4	37.50			
	Hospice Longitudinal Data Assessment Tool (LDAT) Quick Reference Guide	CL.105	2	37.50			
	Hospice Physician Initial Certification of Terminal Illness	CL.125	1	8.25	25.50	38.25	
	Hospice Physician Recertification of Terminal Illness	CL.120	1	8.25	25.50	38.25	
	Hospice Plan of Care	CL.255	6	41.25	127.50	191.25	
	Hospice Plan of Care Change	CL.255a	1	13.75	21.25	31.88	
	IDG Review and Update to the Hospice Plan of Care	CL.275	3	20.63	70.63	95.63	
	Initial & Comprehensive Nursing Assessment	CL.150	8	55.00	170.00	255.00	
	Medicare Hospice Revocation Form	CL.130	1	8.25	25.50	38.25	
	Medicare/Medicaid Statement of Consent and Election	CL.140	1	8.25	25.50	38.25	
	Nursing Assessment Update	CL.300	7	55.00	157.50	223.13	
	Nursing Clinical Note	CL.315	3	20.63	70.63	95.63	
	Physical Pain Assessment	CL.160	2	16.50	51.00	76.50	
	Physicians Orders and Medication Record	CL.135	3		82.50		
	Progress Note	CL.330	1	7.00	21.25	31.88	
	Psychosocial Assessment Update	CL.305	3	20.63	70.63	95.63	
	Psychosocial/Spiritual Clinical Note	CL.320	1	7.00	21.25	31.88	
	Safety Assessment	CL.170	2	16.50	51.00	76.50	
	Skin Impairment Assessment	CL.165	2	16.50	51.00	76.50	
	Spiritual Assessment Update	CL.310	3	20.63	70.63	95.63	
	Volunteer Note	CL.325	1	7.00	21.25	31.88	

1/15/08: Prices are subject to change

**TOTAL:**