# Hospice Documentation for Supportive Care

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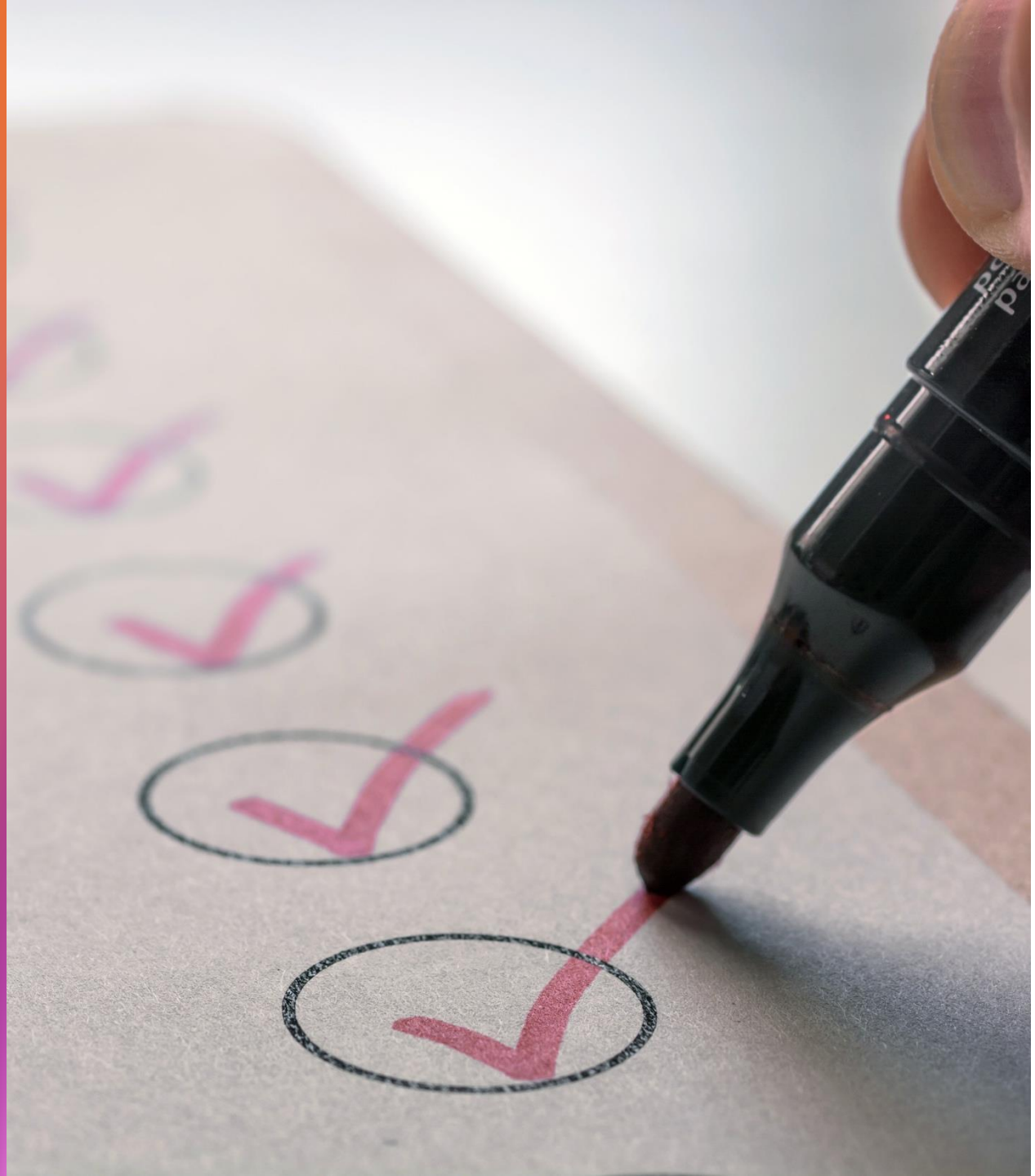
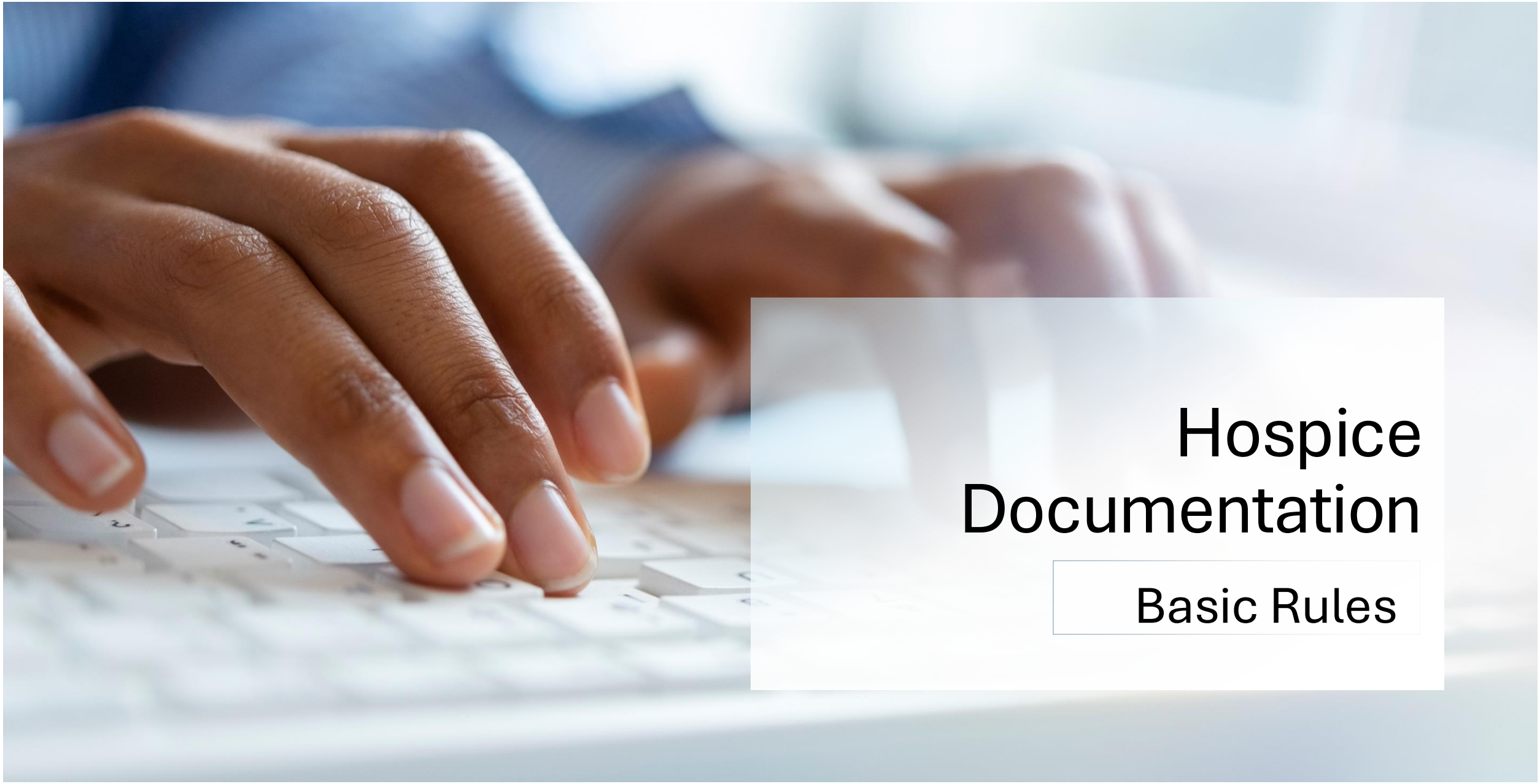


# Agenda

- Basic Rules
- What's Different About Hospice Documentation?
- Hospice Audits:  What We've Learned
- How Supportive Care Documentation Can Show Decline
- Resources



# Hospice Documentation

## Basic Rules

# Multiple Functions of Documentation

- Record of Care
  - Goals of care
  - Care plan
    - Assessment
    - Interventions
    - Response to treatment
- Communication
- Reimbursement
- Quality Assurance
- Process improvement

# Documentation 101 - Legally Speaking…

- Courts view the medical record as verification of patient care.
- If it isn’t documented, it isn’t done.
- Altered medical records have no credibility.

# Documentation 101
# Basic Requirements

- Write accurate documentation according to policy.
- Be accurate and truthful.
- Allow no omissions, blanks, or empty spaces.
- Note all communications with other providers.
- List all assessment findings and actions.
- Never refer to documents that are not part of the medical record (incident reports etc.).
- Sign, Date and Lock every entry at the time it is written.
    - Amendments to documentation are available.

# Documentation 101
# More Basic Requirements

- Write legibly when handwriting.
- Sign with name, credentials.
  - Signatures should be legible, or name printed underneath.
- Use only approved abbreviations.
- Spell words correctly.
- Complete documentation immediately following care.
  - Waiting until the end of the day leads to inaccuracies and has been proven to be more time consuming.
- In EMR, narrative notes to supplement check boxes better support hospice eligibility.

# Documentation 101

Illegally changing documentation -> legal risk

- Improperly adding to a colleague's note
- Copy/pasting notes from one event to the next
- Destroying any part of the record
- Omitting facts
- Deliberately documenting inaccurate information
- Falsifying entry date/time or late entry without indication late.

# Documentation 101
# Computer Corrections

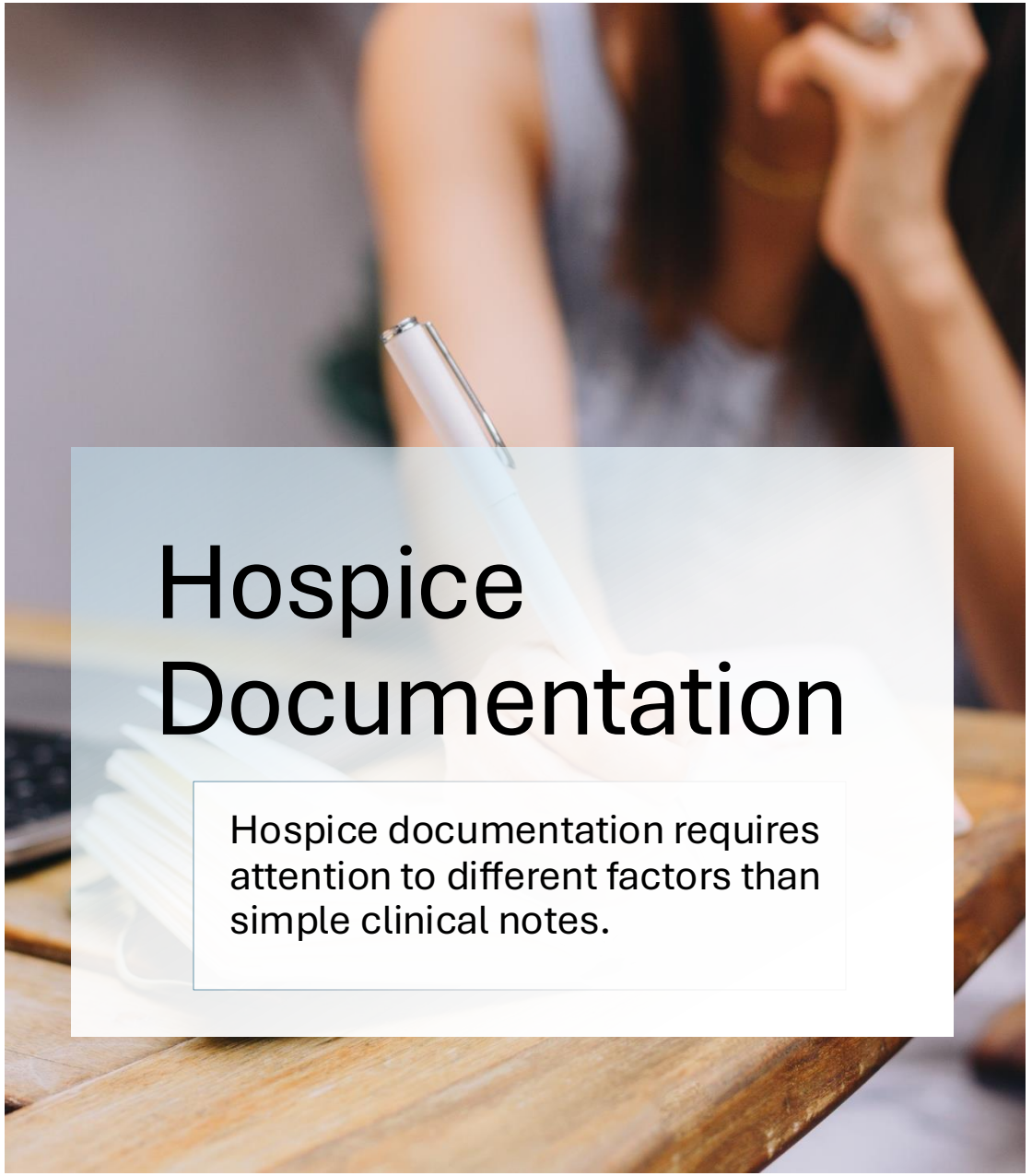
- Late entries are better than no entry at all.
- Start the late entry with the date and time of the entry.
- Label the documentation as “late” entry.
- Explain in narrative why the entry is late.
- Note the date and time that the entry should have been written.
- Always sign, date and lock documentation.

# Hospice Documentation

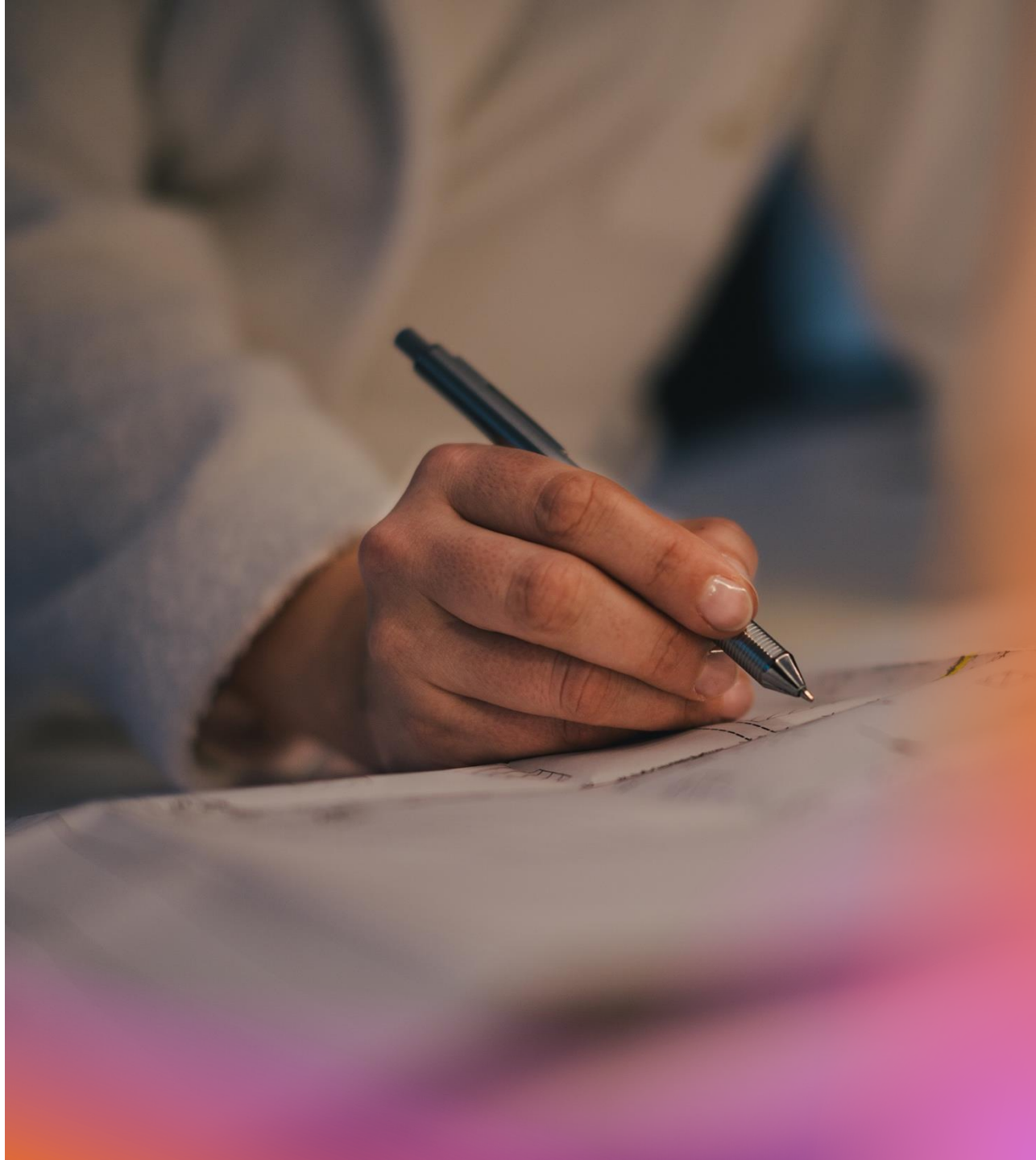
What's Different  About Hospice?

# What’s the Purpose?

- Proof of patient eligibility.
- Documentation of decline is hospice industry specific.
- Proof of care and services rendered to patient.
- Support for the level of care provided.
- Advocacy to preserve the HMB.
- Basis for the ADR response.
- Response to any other audits (RAC, MIC, ZPIC/UPIC).



- All Notes Should be Driven by the Interdisciplinary Plan of Care
- All Notes should stand alone
- All Notes should paint a picture



# Hospice Documentation: General Tips

- Document to problems identified in the POC.
- Read the last clinical notes from each discipline prior to this visit
- Quote what others report
- Use events for recollection (holidays, seasons).
- Avoid vague terms (bed bound, WNL, limited).
- Paint the picture – can someone “See” the person?
- Specific documentation – not cookie cutter notes.
- Document objectively (see, smell, hear, touch, measure).
- POC should snapshot recent 2 weeks.
- Education and teaching. Think of CAHPS questions – these are your responsibility.

# Hospice Documentation Checklist

- ☑ Are all pieces of the note complete?
- ☑ Are all areas addressed completely? Is the information clear and understandable to third party?
- ☑ Does the note include the plan of care components?
- ☑ Could another person read this note and continue the plan of care effectively?
- ☑ Does the record paint a clear picture of the hospice patient and family, interventions and responses/outcomes?
- ☑ Are you using “negative charting?”
- ☑ Does the documentation show active and ongoing assessment?
- ☑ Are psychosocial and spiritual concerns on the care plan and documentation that they are being addressed?
- ☑ Does the documentation indicate communication and training with patient, family and caregivers?
- ☑ If a surveyor were to read your documentation, would the documentation reflect the care being provided, interdisciplinary coordination and care?

# What We've Learned

Hospice Audits

# Types of Hospice Audits

- **TPE**
  - Targeted Probe & Educate
- **ADR**
  - Additional Document Request
- **UPIC**
  - Unified Program Integrity Contractors

# The Cost....

- $ that can be used for patient care.
- Time that can be used for staff/patient care.
- Anxiety that can be spared.

# Audits: What we learned

- It’s a reality for hospices across the nation.
- Critical for preventing claim denials and/or ensuring successful audits.
- Document in a specific way to pass audits.
  - Document negatively.
  - Document showing decline.
- Auditors are known to look back three years at cases – start now.

# What does that have to do with me?

- Consents – Details matter
- Assessments
  - Initial
  - Comprehensive
  - Updates to comprehensive – at least every 15 days
- Visit notes
- IDG notes/summaries
- Levels of Care
  - Understand the regulations
  - Document appropriately for the level of care

# THE WHY

Because we are professionals & we care

# Assessments

## Initial

- Must be completed by Hospice RN
- Within 48 hours after the election of hospice care is complete
- UNLESS the physician, patient or representative requests that it be completed in less than 48 hours
- Must address physical, psychosocial, emotional and spiritual status related to the terminal illness and related conditions

## Comprehensive

- Must be completed by hospice IDG, in consultation with attending physician (if any)
- No later than 5 calendar days after the election of hospice care
- Definition states "… this includes a thorough evaluation of the caregiver's and family's willingness and capability to care for the patient."
- Must identify physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the patient's well-being, comfort, and dignity throughout the dying process.
- Must be on-going – at least every 15 days

# Comprehensive Assessment (cont'd)

- ~~Pain~~
- ~~Dyspnea~~
- ~~Nausea~~
- ~~Vomiting~~
- ~~Constipation~~
- ~~Restlessness~~
- Anxiety
- ~~Sleep disorders~~
- ~~Skin integrity~~
- ~~Confusion~~
- Emotional distress
- Spiritual needs
- Support systems
- Family need for counseling and education
- Additional information, as necessary

# Updating the Comprehensive Assessment

- Must be accomplished by the IDG, in collaboration with the attending physician (if any)
- Must consider changes that have taken place since the initial assessment
- Must include information on:
  - Patient's progress toward desired outcomes
  - Reassessment of the patient's response to care
- Must be accomplished:
  - As frequently as the condition of the patient requires
  - BUT no less frequently than every 15 days

# IDG & Care Planning

- 418.56 The IDG, in consultation with the attending physician (if any), must prepare a written plan of care for each patient.

- The plan of care must:
  - Specify the hospice care and services necessary to meet the patient and family-specific needs *identified in the comprehensive assessment* as such needs relate to the terminal illness and related conditions

# 518.56 (c)Plan of Care includes

- Patient and family goals and interventions
- Based on problems identified in the
  - Initial assessment
  - Comprehensive assessment
  - Updates to the comprehensive assessment

# 518.56 (e)Coordination of Services

**The Hospice must develop and maintain a system of communication and integration .**

# How WE Can Show Decline

Supportive Care Documentation

# Medicare Hospice Eligibility

- Nurses and Physicians – document against the local coverage determination (LCD) and level of care criteria
- Social Workers, Chaplains, Music Therapists – can provide reiteration and supportive documentation

# Supportive Care Documentation

What can we do?

While we have a different scope of practice and cannot document the same as nurses or doctors, our documentation can be used to support terminal decline.

**Here’s what nurses are taught...**

How can we support within our scope of practice?

# Transfers

- How does the patient transfer?
  - Independent, assist x1, 2 – full assist or partial, Max assist?
  - Stand-pivot? Sit to Stand lift? Full body lift?

- Has their transfer ability declined?

- Do they require more help?

# Locomotion

- Do they ambulate?
- How far? How often?
- Do they need stop and take breaks?
- What happens when they ambulated? (i.e. fatigue, weakness, dyspnea)
- With how much assistance?
- Do they require supportive equipment?
    - Walker (type), O2, gait belt, cane (type), etc.
- How was ambulation 6 months prior?
- Non-ambulatory? Wheelchair? Self-propel or pushed (totally dependent).

# ADLs

- To what degree does the patient participate in ADLS?
- Independent? Can they wash upper body, hands? Needed cueing?
- Why is their participation limited? (SOB, confusion, pain, etc.)
- How do they bathe? (whirlpool, tub, shower, bed, on a liter or trolly?)
- If a patient does not participate in bathing, they are “totally dependent.”

# Mobility in Bed

- Are they able to reposition themselves?
- How much help do they need for repositioning?
- How many staff to pull them up in bed?
- Can they hold onto the side rail?
- Can they roll side to side?
- Hold their position? Require propping? Wedges?
- What mattress is required (floor, perimeter, APM, LAL, etc.)
- Are they at high risk for skin breakdown related to repositioning?

# Seating

- Impaired structure and function leads to seating changes:
  - Wheelchair
  - Wheelchair with footrests
  - High-backed wheelchair – cannot sit independently
  - High-back wheelchair with head or foot supports – cannot control head or feet
  - Geri chair – no longer comfortable in the sitting position
  - Geri chair with positioning devices – cannot maintain body alignment
  - Any props, pads, wedges, cushions, rolled blankets, etc. that assist.

# Communication

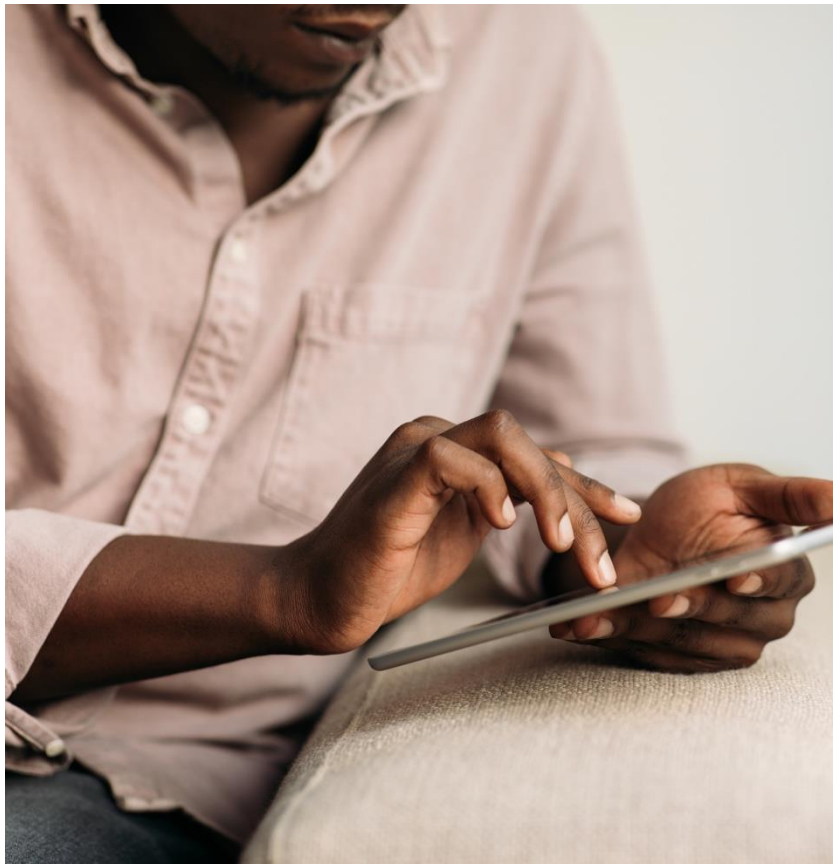
- Can the patient communicate in a meaningful way?
- Can they be understood?
- Any assistive devices? (board, sign, etc.)
- Can they complete sentences? Why not?
- Do they exhibit frustration or behaviors r/t inability to communicate?
- Can they make their needs clearly known? Use the call bell?
- What is their speech pattern? (repetitive, non-sensical, limited, etc.)
- Can they answer yes/no questions? With any degree of meaning?

# Behaviors

- What behaviors does the patient exhibit?
- Anxious? Repetitive? Depressed? Agitated? Sundowning?
- Rocking? Hand-wringing? Grinding teeth? Yelling?
- Scratching or picking? Inappropriately sexual or social behavior?
- Combative with any particular situation or experience?
- Wandering?
- Crying?
- Visual or auditory hallucinations? Delusions?

# What we can do….

- Be observant
- Compare patient over time
- Use descriptions not generalizations
  - What you see
  - What you hear
- Quote caregiver, patient, etc.

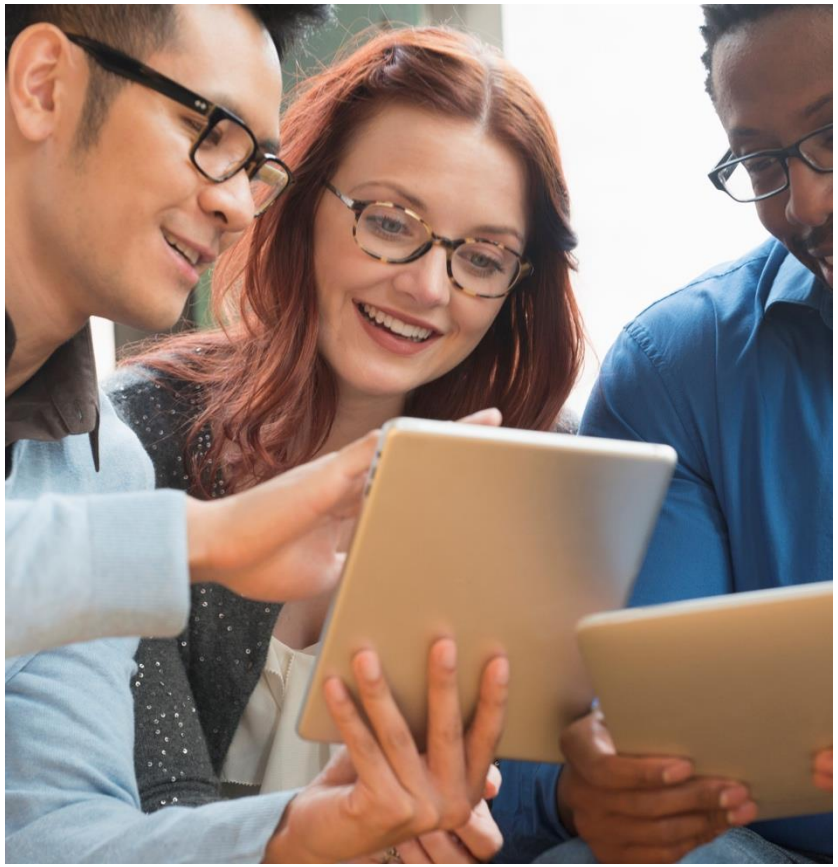


# What we can do....

- Document to the Care Plan and YOUR interventions
- Do not document out of your scope of practice. We are not nurses.
- Read all previous notes - consistency
- What do you see, hear, experience.....
- Be succinct – do not be wordy. Stay focused.
- Document during the visit, in your car. Same day.

# YOU make a difference

- **Most importantly with patients and families….**
- **AND because you understand how you document makes a difference.**



# Resources

- Federal Register : Medicare and Medicaid Programs: Hospice Conditions of Participation
- Understand Hospice Audit Types, Processes to Boost Compliance - Hospice News
- Compliance for Hospice Social Workers & Chaplains (hhvna.com)
- Five Steps to proper Hospice Chaplain Documentation- For Routine Visits – Hospice Chaplaincy
- Initial Chaplain Visit Assessment and Documentation Examples – Hospice Chaplaincy

# Thank you

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