Clinical Excellence and Safety (CES)

Principles:

Ensuring clinical excellence and promoting safety through standards of practice.

The desired outcomes of hospice intervention are safe and comfortable dying, self-determined life closure and effective grieving, all as determined by the patient and family/caregivers. The interdisciplinary team identifies, assists and respects the desires of the patient and family/caregivers in the facilitation of those outcomes through treatment, prevention and promotion of strategies based on continuous assessment.

The hospice provides for the safety of all staff and promotes the development and maintenance of a safe environment for patients and families served.
CLINICAL EXCELLENCE AND SAFETY (CES)

Standard:

CES 1 The basis for a patient’s plan of care is the comprehensive assessment by the interdisciplinary team.

CES 1.1 Initial information documenting the patient’s terminal illness and co-morbid conditions is obtained and reviewed at the time of the referral for hospice care. The hospice registered nurse makes an initial assessment within 48 hours of the effective date of the Notice of election.

CES 1.2 The interdisciplinary group, in consultation with the individual’s attending physician, completes the comprehensive assessment within five calendar days of the effective date of the Notice of election.

CES 1.3 The comprehensive assessment identifies the physical, psychosocial, emotional and spiritual needs of the patient and family 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.

CES 1.4 The comprehensive assessment includes:
1. Physical, psychosocial, emotional and spiritual needs related to the terminal illness and related conditions;
2. Nature and condition causing admission;
3. Complications and risk factors;
4. Functional status;
5. Imminence of death;
6. Symptom severity;
7. Medication profile (including effectiveness, side effects, interactions, duplication, requiring lab monitoring and identify ineffective medication therapies);
8. Initial bereavement assessment of patient’s family or caregiver;
9. Referrals; and
10. Military checklist (when indicated).

CES 1.5 The comprehensive assessment is updated as frequently as the condition of the patient requires but no less frequently than every 15 days and at the time of recertification.

CES 1.6 The comprehensive assessment includes data elements that allow for measurement of outcomes. These data elements are documented in a systematic and retrievable way for each patient and are used in individual care planning, coordination of services and, in the aggregate, for quality assessment performance improvement.

Practice Examples:

◆ The hospice includes assessment of common co-morbid conditions as part of the initial nursing assessment.
◆ There is an interdisciplinary assessment tool.
◆ The hospice uses the military history checklist to identify their veteran patients, evaluate the impact of the experience and determine if there are benefits to which the veteran and surviving dependents may be entitled.
◆ There is a mechanism to obtain past medical records from referral sources.
◆ The hospice includes the NHPCO End Results Outcomes Measures (EROM) as a part of their quality assessment and performance improvement program.
CLINICAL EXCELLENCE AND SAFETY (CES)

Standard:

**CES 2** The patient’s goals for pain management are achieved.

**CES 2.1** An initial pain assessment is completed on every patient on admission.

**CES 2.2** Ongoing pain assessments are performed including a defined rating scale appropriate to the patient's condition.

**CES 2.3** Separate specialized assessment is developed for various populations served (e.g., pediatric, nonverbal and non-English speaking and illiterate patients and those unable to self report).

**CES 2.4** Procedures and protocols for pain assessment and management are developed and implemented.

**CES 2.5** Patients and families are educated about the importance of, barriers to and methods of effective pain management, including pain assessment.

**CES 2.6** Non-pharmacological interventions and adjuvant medications are included as pain management options as indicated.

**CES 2.7** Common side effects of analgesics are anticipated and preventive measures are implemented.

**Practice Examples:**

- Pain assessment is a distinct, easily identifiable, part of initial assessment and other documentation tools.

- There is documentation of patient/family teaching about the use and side effects of analgesic and/or adjuvant medications, and expected responses to therapy.

- Specific protocols/procedures are in place for reassessing patients who rate their pain above 3 on a 0-10 scale, or who state that their pain is unacceptable.

- Non-pharmacologic therapies including radiation therapy, complementary therapies or surgical intervention are utilized as appropriate.
Standard:

**CES 3**  Routine, comprehensive assessments of other symptoms are completed on every patient based on the patient’s needs and response to treatments.

**CES 3.1**  Guidelines and/or protocols are developed for the assessment and management of common physical symptoms other than pain including, but not limited to:

1. Dyspnea;
2. Nausea and vomiting;
3. Anorexia and weight loss;
4. Dehydration;
5. Anxiety and depression;
6. Confusion and delirium;
7. Skin lesions and wounds, including pressure ulcers;
8. Constipation;
9. Restlessness and agitation;
10. Sleep disorders; and

**CES 3.2**  The interdisciplinary team assesses the patient’s nutritional status and implements appropriate nutritional care as desired by the patient and family.

**CES 3.3**  Education is provided to the patient and family about the disease process and the palliation of the patient’s symptoms.

**Practice Examples:**

- The hospice develops educational tools to utilize in teaching patients and families about the nutritional needs of the terminally ill, including concerns about the patient not eating or drinking enough.

- The hospice has specific bowel protocols for patients on opiate analgesics.

- Veterans may experience other symptoms related to their military service, such as post traumatic stress disorder. The hospice has resources available to educate and train staff about veteran-specific issues.

- The hospice has textbooks and other resources available to the staff about palliation of symptoms.

- Routine symptom assessment includes severity and alleviating and/or exacerbating factors.

- Separate specialized assessment is developed for various populations served (*e.g.*, pediatric patients, homeless patients and incarcerated patients).
Standard:

**CES 4** The pharmaceutical needs of patients are met, consistent with applicable state and federal laws and regulations and accepted standards of practice.

**CES 4.1** The interdisciplinary group confers with an individual with education and training in medication management to ensure that medications and biologicals meet each patient's needs.

**CES 4.2** A patient-specific medication profile is maintained and periodically reviewed to monitor for medication effectiveness, actual or potential medication-related effects and untoward interactions.

**CES 4.3** The organization has a process to review all prescriptions for the appropriateness of the medication and the dose, frequency and route of administration.

**CES 4.4** Written policies and procedures are developed in compliance with applicable state and federal laws and regulations governing the prescribing, dispensing, labeling, compounding, administering, transporting, delivering, racking, controlling, storing and disposing of all medications and biologicals.

**CES 4.5** Written policies and procedures are developed for the disposal of controlled medications when the patient no longer needs the medications. Disposal methods follow appropriate guidelines to avoid use of public sewers.

**CES 4.6** Pharmaceutical services are available twenty-four (24) hours a day, seven (7) days a week.

**CES 4.7** The quantities of medications dispensed to the patient maximize patient comfort and minimize potential for error, waste or diversion.

**CES 4.8** Written policies and procedures are developed for defining, identifying, reporting and documenting medication errors and adverse drug reactions that ensure adequate follow-up in all settings where care is delivered.

**CES 4.9** Written policies and procedures are developed to define the use of atypical (i.e., experimental) medications or protocols.

**CES 4.10** Patients and families are educated on safe and effective use of medications, as well as potential side effects and expected responses.

**CES 4.11** Written policies and procedures are developed to define the appropriate use of centrally acting central nervous system depressants. Medications that can be considered “chemical restraints” may only be used if needed to improve the patient’s well-being or to protect him/her or others from harm, and only when less restrictive interventions have been determined ineffective.

**CES 4.12** Patients and families are informed about policies for tracking and disposing of controlled substances.

**Practice Examples:**

- The pharmacist provides consultation regarding complex medication regimens and educational opportunities and updates for the hospice team members.
- The hospice has a policy for disposal of narcotics.
- The hospice nurse reviews all written medication information with the family and/or caregivers.
- The hospice nurse notifies the pharmacist regarding the patient's condition and estimates the amount of refill appropriate to the patient's needs.
- Incident reports regarding medication errors are completed.
- The hospice nurses have access to up-to-date medication information and resources.
Clinical Excellence and Safety (CES)

Standard:

**CES 5** Diagnostic services are provided which are necessary for the management of symptoms according to the patient’s plan of care.

- **CES 5.1** Lab specimens obtained in the patient’s home are taken only to laboratories that meet Clinical Laboratory Improvement Amendment (CLIA) and state law requirements.

- **CES 5.2** The hospice complies with applicable state law and secures a CLIA certificate of waiver for any waived testing performed by hospice staff.

- **CES 5.3** Policies and procedures address:
  1. Personnel requirements for performing and supervising waived testing;
  2. Training, orientation and competency verification processes for staff performing waived testing;
  3. Specific procedures related to the waived testing; and
  4. Quality control checks and related recordkeeping requirements.

- **CES 5.4** Criteria are developed regarding the provision of laboratory, radiology or other diagnostic assessments.

Practice Examples:

- Current competency evaluations related to instrument usage are documented on all hospice nurses performing blood glucose monitoring.

- Quality control checks are performed and documented for each glucometer for each day that the glucometer is used.

- The interdisciplinary team considers information from the attending physician, accepted standards of practice related to palliative care and patient/family preferences when determining whether to include a specific diagnostic assessment or therapy in the patient’s plan of care.
Standard:

**CES 6** Therapies are provided when necessary for the management of symptoms according to the patient’s plan of care.

**CES 6.1** Services such as physical, occupational and speech therapies and nutritional counseling are available and utilized to reach optimal functioning as permitted by the disease.

**CES 6.2** Criteria are developed regarding provision of radiation, chemo and other therapies as indicated for palliation of symptoms.

**CES 6.3** Indicated complementary therapies are offered as an adjunct to promote quality of life depending on patient wishes.

**Practice Examples:**

- Complementary therapies often utilized are expressive therapy, massage therapy, acupuncture, aromatherapy, reflexology and healing touch.

- Palliative radiation therapy or other palliative therapies are considered to treat symptoms, improve patient’s performance status and/or quality of life.
CLINICAL EXCELLENCE AND SAFETY (CES)

Standard:

CES 7 Interventions to assist the patient in meeting his/her preferences with a changing environment or life circumstances are based on a thorough psychosocial assessment initiated at the time of admission and continued throughout the course of care.

CES 7.1 The psychosocial assessment evaluates social, practical and legal needs of the patient and family in home, work and school settings. And, when applicable, the patient’s military history.

CES 7.2 The psychosocial assessment includes an evaluation of the patient’s preferred style of communicating feelings and expressing emotions, thoughts and needs.

CES 7.3 Policies and procedures address planning and intervention when suicidal ideations are present.

CES 7.4 Issues related to patient coping are assessed and addressed by the interdisciplinary team and include at least:
1. Access to adequate and accurate information;
2. Change in family roles;
3. Communication abilities;
4. Ability to fulfill desired sexual expression;
5. Suicide ideation; and
6. Signs of abuse or neglect.

Practice Examples:

◆ The hospice documents patient conversations about suicidal thoughts and implements protocols for intervention.

◆ Psychosocial assessment tools allow for assessment related to end of life as well as issues identified by the patient as important and relevant.

◆ Patient/family educational materials include information about the psychological aspects of a terminal illness.

◆ The psychosocial evaluation includes issues related to military service for which the hospice provides support.
Standard:

**CES 8** Services continue without interruption whenever there are changes in the patient care setting.

**CES 8.1** Care is provided in the setting defined by the patient and family as the patient’s place of residence.

**CES 8.2** Inpatient care and continuous care are available and utilized as necessary for intensive symptom management and caregiver breakdown. Inpatient respite care is available and utilized for caregiver respite.

**CES 8.3** Hospice collaborates with other organizations and individuals involved in the provision of care.

**CES 8.4** When services are not provided directly by the hospice, written agreements exist to define the services provided by both the hospice and the contracted provider. These agreements define care delivery to assure that contracted services are consistent with hospice standards and care is provided in accordance with the hospice plan of care. Written agreements assure that the hospice retains overall responsibility for managing the patient’s plan of care.

**CES 8.5** Care provided by the hospice in a contracted facility adheres to the same:
1. Standards of care;
2. Intensity; and
3. Mix of services as provided to patients in their own place of residence.

**CES 8.6** The hospice contracts for inpatient care specify:
1. That the hospice provides a copy of the patient’s plan of care and specifies the inpatient services to be provided;
2. That the inpatient provider has policies consistent with those of the hospice and agrees to abide by the hospice’s patient care protocols;
3. That the clinical record includes a record of all patient services and events;
4. That a copy of the discharge summary and, if requested, a copy of the medical record are provided to the hospice;
5. The party responsible for the implementation of the provisions in the agreement;
6. That the hospice provides appropriate training for personnel who provide care under the agreement; and
7. That the hospice assumes overall management for the terminal illness in coordination with all other providers.
Practice Examples:

- Utilization review processes monitor care in all care settings to assure that the scope of services meet identified needs of patients and families:
  1. Patient services by discipline;
  2. Levels of care;
  3. After hours care and support *(including attendance at the time of death)*; and

- Current written agreements are in place with all contracted providers and are regularly reviewed by both parties to assure compliance with the agreed upon contract requirements.

- Written information is provided to others involved in the provision of care that defines the hospice’s services.

- The hospice has a formal relationship with the Department of Veterans Affairs (VA) for care provided to enrolled veterans in the community, coordinates care with the appropriate VA facility across care settings, communicates with VA staff regarding the care plan and notifies VA staff at the time of the veteran’s death.

- In-service/educational programs are regularly offered to contracted providers and to the professional staff of other organizations involved in the patient’s care.

- Coordinated care planning occurs on a regular basis between the hospice staff and the contracted provider.

- Procedures are jointly developed by the hospice and contracted provider that define each party’s role and responsibilities in the provision of care.

- Contracted providers are invited to participate in performance improvement activities related to their care or service.

- A mechanism exists to record, address and resolve complaints related to contracted providers.

- The clinical record contains documentation of communication between the hospice and the inpatient care provider regarding the plan of care whenever a patient receives inpatient care.

- A method exists to evaluate satisfaction of contracted providers.
Standard:

CES 9 Transfers, discharges and revocations are planned and managed in a manner that assures coordination and continuity of care for patients, families and service providers.

CES 9.1 The hospice has written policies and procedures pertaining to transfer, discharge and revocation.

CES 9.2 When care provided in the patient’s place of residence is no longer possible, transfer procedures assure a well-coordinated transition to another setting where hospice care can be provided.

CES 9.3 Appropriate education is provided on the hospice’s plan of care and philosophy whenever there are changes in the patient’s care setting.

CES 9.4 Transfer, discharge and revocation practices include:

1. A process for ongoing evaluation of the patient’s status and eligibility for hospice care;
2. Interdisciplinary discharge planning which addresses the patient’s and family’s needs and goals;
3. A coordinated transfer among all involved providers;
4. Facilitation of a planned, well communicated and effective transition for the patient, family and caregiver;
5. A mechanism for follow-up communications with the hospice where appropriate; and
6. Copies of a discharge summary include summary of treatments, symptoms and pain management, current plan of care, recent physician orders and other relevant documentation which are sent to the attending physician and receiving agency upon revocation or discharge.

Practice Examples:

◆ Written transfer information is provided by the hospice whenever a patient transfers to another care setting. The recorded information includes, but is not limited to the:

1. Services being provided;
2. Specific medical, psychosocial, spiritual or other problems requiring intervention or follow-up; and
3. Follow-up activities planned by the hospice interdisciplinary team.

◆ A recertification committee periodically reviews all active patients’ care for the ongoing need for hospice services.

◆ A step-by-step plan for discharge and revocation is developed by the hospice team to assure that well coordinated transfers to other levels of care occur and that referrals to other appropriate resources are made when indicated.
Standard:

**CES 10** The hospice develops implements and evaluates a plan for environmental safety and security.

### CES 10.1
The hospice develops implements and evaluates a plan that addresses:
1. Building safety and security;
2. Staff safety and security;
3. Equipment safety; and
4. Patient and family safety and security.

### CES 10.2
The hospice addresses staff safety and security during new employee and volunteer orientation and annually based on need and changes in policies and procedures. Staff safety and security education include:
1. Personal safety during home visits;
2. General safety and self-defense measures;
3. The hospice's policies and procedures related to unsafe situations;
4. Physical safety (*e.g.*, body mechanics and back safety); and
5. OSHA requirements as related to safety in the workplace.

### CES 10.3
The hospice develops implements and evaluates a plan that addresses the safety of patients and families that includes:
1. A safety assessment of each home environment that is adapted for the patient’s age and risk for fall;
2. Appropriate teaching resources related to safety issues; and
3. Implementation and documentation of interventions directed toward eliminating or minimizing safety concerns identified in the patient’s environment.

### Practice Examples:

- There is a written policy that describes actions to be taken when employees or volunteers find themselves in unsafe situations.
- There is an annual safety in-service provided to all staff and volunteers.
- There are teaching materials related to safety in the home available for patients and families.
- The assessment of each hospice patient includes an evaluation of the safety of the home environment.
- The parents of pediatric hospice patients are informed that safety locks should be placed on kitchen and medicine cabinets and safety covers placed on unused electrical outlets.
- The hospice references OSHA and NIOSH standards regarding parameters for lifting.
- The hospice uses needleless systems and a sharp disposal container to prevent needle stick injury.
- The hospice requests a voluntary survey from OSHA on-site consultants in their state to assure compliance with applicable OSHA regulations.
Standard:

**CES 11** The hospice develops implements and evaluates a plan for emergency preparedness.

**CES 11.1** The hospice performs a hazardous vulnerability analysis, an assessment of events that would require the initiation of an emergency preparedness plan.

**CES 11.2** The hospice has a written emergency preparedness plan that provides for the continuation of services in the event of an emergency. The emergency preparedness plan minimally addresses:
1. Chain of command for implementation of the plan;
2. Notification and assignment of staff responsibilities;
3. Communication among staff and volunteers;
4. Communication with community emergency services;
5. Alternative resources and travel routes;
6. Means of prioritizing, identifying and responding to patient care needs with the goal of preventing or diminishing the effects of the disaster;
7. Types of anticipated natural and civil disasters (e.g., hurricanes, tornadoes, floods, earthquakes, chemical spills and inclement weather as appropriate to the geographical area where the hospice resides);
8. Time frames for the initiation of the plan;
9. Education of the patient/family to the emergency preparedness plan; and
10. Recovery and re-establishment of normal operation.

**CES 11.3** The hospice orients all employees to the emergency preparedness plan and provides annual reviews.

**CES 11.4** The hospice is integrated into the broader community network and is poised for responding to broader community needs as a result of a natural or civil disaster (e.g., bereavement, increased referrals).

**Practice Examples:**

- A telephone tree, using mobile telephones as necessary, is set up to facilitate communication with the staff during an emergency.
- The emergency preparedness plan is reviewed with all new employees and volunteers during orientation.
- There is an annual safety day held to keep staff and volunteers updated regarding the emergency preparedness plan.
- The hospice considers preparation for multiple disasters (e.g., multiple storms or extended utility loss).
- The hospice has an internal plan related to their involvement in the greater community as to their role in response to a natural or civil disaster.
- The hospice completes a debriefing after any activation of the emergency preparedness plan to assess the need for revision to the plan for increased effectiveness in future events.
CLINICAL EXCELLENCE AND SAFETY (CES)

Standard:

**CES 12** The hospice develops implements and evaluates a plan for the management of infectious and hazardous materials and waste.

**CES 12.1** The hospice develops and implements a written plan that addresses:

1. Identification of infectious and hazardous materials and waste;
2. Proper storage, transportation and disposal of infectious hazardous materials and waste;
3. Compliance with all applicable law and regulation related to infectious and hazardous materials and waste;
4. Precautions, procedures and personal protective equipment (PPE) to be utilized when handling infectious and hazardous materials and waste; and
5. Employees right to know about infectious and hazardous materials and waste (*i.e.*, availability of Material Safety Data Sheets (MSDS)).

**Practice Examples:**

- MSDS are available on all hazardous materials used by staff in performing their duties and responsibilities.
- Hazardous materials are appropriately labeled.
- Sharps containers are clearly labeled as “hazardous waste” or color-coded and are properly disposed of according to hospice policy.
The hospice develops and implements an infection-control program that is designed to identify and decrease the risks of infection for staff, patients and families and to monitor trends and decrease the rates of infection.

**CES 13.1**
The hospice has an infection-control program that is supported by leaders and includes the following components:
1. Education of patients, family members and caregivers in the prevention and control of infection;
2. Development, periodic review and update of related policies and procedures;
3. Staff and volunteer education in orientation is related to infection-control practices, including routes of transmission of microorganisms and the importance of hand washing, potential for exposure to infection and follow-up to an exposure;
4. Monitoring of employee health and the provision of related services;
5. Designation of a person responsible for implementation and oversight of the program; and
6. System of communication with employees and volunteers as well as referring and receiving organizations.

**CES 13.2**
The hospice staff report patient, employee and volunteer infections as identified in the hospice surveillance policies and as reportable diseases according to law and regulation.

**CES 13.3**
The hospice collects defined surveillance data related to the infection control program and takes appropriate corrective actions based on the data analysis. Infection control data collected may include:
1. Identification of targeted infections, unusual or undesirable trends and factors contributing to such trends;
2. Results of monitoring for staff compliance with policies and procedures; and
3. Reportable employee illnesses and infections including trends and correlation with patient infections.

**Practice Examples:**
- Employees and volunteers can describe the infections that must be reported and understand the procedure for reporting infections.
- Performance appraisals of direct care providers include an evaluation of their knowledge and practice of infection prevention and control.
- There is a policy and procedure describing the follow-up actions to be taken in the event of an occupational exposure to a blood borne or airborne pathogen.
- Employee illness and infections are reported and analyzed in relation to patient infections.
- The parents of pediatric hospice patients receive education on childhood infections and diseases.
- When an infection is present, appropriate action (including appropriate isolation precautions) is taken to control its spread between staff and patients (e.g., providing written instructions on teaching sheets or safety booklets and verbal instruction).
- Patients and families receive instruction regarding standard precautions and the prevention and control of infection on admission.
Standard:

CES 14  The hospice’s infection control program conforms to the guidelines set by government agencies, professional associations and applicable laws and regulations.

CES 14.1  The hospice has a written blood borne pathogen exposure control plan and a respiratory protection plan that are reviewed with all staff and volunteers during orientation and on an annual basis.

CES 14.2  The hospice has developed a policy and procedure for dealing with epidemics. The plan will include:
1. Patient management strategies
   a. Prolonged isolation
   b. Sanitation and hygiene
   c. Handling corpses
   d. Coordination with other community agencies
2. Staff protection and management strategies
   a. Personal protective equipment
   b. Prolonged work from home
   c. Staff shortages
3. Identification and transmission education

Practice Examples:

◆ Infections are reported to the state’s Department of Health when required.
◆ The hospice provides both fit testing and N-95 masks for direct care providers assigned to patients with tuberculosis (TB).
◆ The hospice has a blood borne pathogen exposure control plan and staff participates in an annual in-service on the plan.
◆ All clinical staff are in possession of personal protective equipment and practice standard precautions during home visits.
◆ Hospice nurses provide wound care in accordance with the hospice’s infection control protocols and physician’s orders.
◆ All hospice staff and volunteers receive instruction and comply with hand hygiene according to CDC and WHO guidelines.
◆ The hospice maintains current knowledge of potential epidemics.
Standard:

**CES 15** The hospice infection control program is monitored, reviewed, evaluated and updated.

**CES 15.1** A summary of all infection-control activities performed, surveillance data collected and actions taken related to the data aggregation and analysis is submitted to leaders and reviewed on a regular basis.

**Practice Examples:**

- The hospice’s Performance Improvement Committee regularly reviews reports and other data related to infection control activities.

- At least one aspect of care related to infection control is evaluated annually (e.g., *TB skin test conversions, catheter-related infections, employee illnesses*) with the goal of improvement.
CLINICAL EXCELLENCE AND SAFETY (CES)

Standard:

CES 16  Seclusion and restraint may only be imposed if needed to improve the patient’s well-being or protect him/her or others from harm, and only when less restrictive interventions have been determined ineffective.

CES 16.1  The hospice has written policies and procedures on defined seclusion and restraints and their proper usage including:
   a) Physician order;
   b) Specification;
   c) Definition of restrictive devices;
   d) Education of patient and primary caregiver; and
   e) Frequency of monitoring.

CES 16.2  If seclusion and restraints are used in the hospice’s own inpatient unit, hospice direct care personnel receive training and education in the proper use of seclusion and restraint application and techniques, and they must also hold current certification in cardiopulmonary resuscitation (CPR). This is not a requirement if a hospice declares their inpatient unit as “restraint free” and follows the guidelines for that designation. (Note: For seclusion and restraint requirements in hospice inpatient facility settings, see Appendix 1, Hospice Inpatient Facility.)

CES 16.3  Hospice direct care personnel receive training and education in alternative methods for handling situations that historically indicated the need for seclusion and restraint.

CES 16.4  The hospice must report any restraint related serious injury and/or death to local, state and federal regulatory agencies.

Practice Examples

◆ The seclusion and restraint policy identifies specifically what medications and restrictive devices are considered restraints within the hospice setting.

◆ Medications considered as chemical restraints in other settings have clearly defined symptom management protocols which reflect the indication for use.

◆ The hospice obtains informed consent prior to initiating restraints.
Standard:

**CES 17**  
The hospice has a written plan for fire safety and prevention within the hospice's environments including:
1. Evacuation procedures and escape routes;
2. Management of fire extinguishers;
3. Protection of staff, visitors and property from fire and smoke;
4. Policies for using smoking materials in all settings; and
5. Other applicable fire equipment.

**CES 17.1**  
The hospice provides staff education related to fire safety, prevention and response to a fire in all settings.

**CES 17.2**  
The hospice develops implements and evaluates a plan for fire prevention in the patient's environment that includes:
1. Assessment of fire hazards;
2. Implementation and documentation related to actions taken related to fire prevention;
3. Patient and family teaching related to fire prevention (e.g., use of smoke detectors, oxygen safety and risky behaviors); and
4. Patient and family response to a fire in the home including escape routes.

**Practice Examples:**

- Fire safety is included in new employee and volunteer orientation.
- Staff receives annual in-service education on fire safety.
- Patients and families receive instruction regarding fire prevention and developing an evacuation plan.
- The parents of a pediatric hospice patient inform the local fire department that a disabled child resides in the home and stickers are placed on the patient's bedroom window to alert fire responders in the event of a fire.
- The hospice holds regularly scheduled fire drills for hospice staff.
The hospice develops implements and periodically reviews a plan for continued operations in the event of interrupted communication and/or utility systems.

**CES 18.1**
The hospice develops implements and evaluates a plan for utility systems management within the hospice that provides for a safe and comfortable environment and communication system including, but not limited to:

1. Computer backup;
2. Telephone backup systems;
3. Utility systems’ failure (e.g., electrical system); and
4. Communication systems’ failure.

**CES 18.2**
The hospice addresses patient safety and continuation of hospice care in the patient’s environment to include:

1. Assessing utility requirements for medical equipment used in patient care;
2. Assessing environmental requirements for medical equipment;
3. Assessing safety issues relating to electrical outlets, grounding, circuit overload, etc.;
4. Providing education for all patients, family members, caregivers and employees on the safe use of medical equipment;
5. Providing education on methods of contacting the hospice during communication systems’ failure; and
6. Exploration of community resources as indicated to provide for adequate utilities for patient comfort.

**Practice Examples:**

- Patients receive verbal instruction and related teaching materials for any medical equipment used in the home.
- Patients utilizing oxygen in the home have a backup source of oxygen in case of a system failure.
- Patients are on a utility priority list in the event of a power outage.
- Patients have adequate warmth, light, etc., to meet basic comfort needs.
- Hospice workers explore community resources as necessary to assist families when patients have inadequate resources of light, temperature control or water to meet their basic comfort needs.
Standard:

CES 19 The hospice assures that medications and nutritional products are properly transported, handled, stored and prepared.

CES 19.1 The hospice has policies and procedures for proper storage and handling of medications and nutritional products in all patient settings to include:
1. Securing medications in accordance with law and regulation;
2. Safe storage (e.g., proper temperature, attention to expiration dates, controlled ventilation, humidity, etc.);
3. Separate storage of internal medications and medications intended for external use; and
4. Proper labeling (i.e., medications are stored according to the label, package insert or other written instructions).

CES 19.2 Hospice staff teach patients and caregivers to assure that medications and nutritional products are properly prepared in the patient’s home.

Practice Examples:

◆ Expired medications and nutritional products are disposed of promptly and properly following applicable regulatory guidelines.

◆ All medications and nutritional products are adequately labeled.

◆ The family is instructed to keep medication out of the reach of children and to use a form to record when medication is administered to prevent a medication error.

◆ The hospice has a tracking system to assure that medications are delivered safely and timely.
**Standard:**

**CES 20** The hospice develops, implements and evaluates a plan for reporting, monitoring and following up on all incidents.

**CES 20.1** The hospice has written policies and procedures that define reportable incidents, a reporting mechanism, follow up and tracking clearly identified by the hospice and include, but are not limited to:

1. Adverse outcomes, including medication reactions and complications of treatment;
2. Staff endangerment or injury;
3. Patient or family injury, including falls;
4. Damage to patient or family property;
5. Motor vehicle accidents incurred when conducting hospice business;
6. Equipment or mechanical device failure or user errors;
7. Problems related to the safe handling and use of narcotics;
8. Unusual occurrences;
9. Patient related suicide or homicide threats, attempts, or completion; or
10. Unusual symptom clusters in a family or community.

**CES 20.2** The hospice designates a person responsible for:

1. Investigating all incidents;
2. Taking follow-up actions as necessary;
3. Aggregating incident data to monitor for trends; and
4. Utilizing the data for risk management.

**CES 20.3** The hospice assures adequate record keeping and reporting of incidents in compliance with state and federal law.

**Practice Examples:**

- The hospice has a form for documenting incidents.
- Incident reports are reviewed and summarized with patterns and trends analyzed on a regular basis.
- Incidents involving a premature death, unexpected or accidental death or a suicide will receive an intensive evaluation to identify the root cause and prevent a similar event.
**Standard:**

**CES 21** The hospice provides for the safe and effective use of medical equipment including delivery, setup, maintenance and training of staff, patients, family members and caregivers.

- **CES 21.1** When the hospice provides medical equipment directly or by contract, a system is in place to assure the quality of the medical equipment and related services.
- **CES 21.2** When the hospice provides medical equipment directly or by contract, a system is in place to assure effective selection, delivery, setup, maintenance and related instruction.
- **CES 21.3** The hospice assures that emergency maintenance, replacement or backup for medical equipment is available twenty-four (24) hours a day, seven (7) days a week.
- **CES 21.4** The hospice assures that equipment hazards, defects and recalls are appropriately addressed and reported as required by the Safe Medical Devices Act.
- **CES 21.5** The hospice complies with manufacturer’s instructions, state and local laws regarding the use of medical equipment.
- **CES 21.6** The hospice contracts with a DMEPOS accredited company.

**Practice Examples:**

- There is a procedure for reporting and responding to defective medical equipment.
- Patients and families receive adequate instruction and related printed resources for all medical equipment used by the patient.
- There is an adequate back up source for oxygen in case of a power failure.
- When equipment is delivered to the patient’s home, the patient, family and caregiver receive written and verbal information on how to operate and troubleshoot the medical equipment.
- When contracted providers are used to supply medical equipment to the hospice’s patients, the contracted provider’s performance is monitored and evaluated.
- The hospice orders equipment consistent with state law (e.g., bedrails).