L533
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§418.54(d) Standard: Update of the comprehensive assessment

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

Interpretive Guidelines §418.54(d)

Hospices are free to choose their own method for documenting updates to the assessment. The hospice should evaluate and document the patient's response to the care, treatment and services provided, and progress toward desired outcomes. The purpose of updating the assessment is to ensure that the hospice IDG has the most recent accurate information about the patient/family in order to make accurate care planning decisions. Assessment updates should be easily identified in the clinical record.

Hospices are required to update the comprehensive assessment as frequently as the condition of the patient requires, which may be more frequently than every 15 days. The hospice must ensure that each update is completed no later than 15 days from the previous one. Hospices are not required to complete, in full, those documents that they identified as comprising their comprehensive assessment every 15 days, although hospices are free to do so if they so choose. They are required to identify and document if there were no changes in the patient/family condition or needs.