**Written Documentation Checklist**

This worksheet lists elements of performance (EPs) that require written documentation that a surveyor could ask to see during a survey to show compliance with a standard. *(Note: Documentation can be on paper or in an electronic format.)*

<table>
<thead>
<tr>
<th>✓</th>
<th>Standard</th>
<th>EP</th>
<th>Provision of Care, Treatment, and Services Standards</th>
<th>Home Care Service</th>
<th>Date last verified</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PC.01.01.01</td>
<td>1–3</td>
<td>EP 1—The organization has a written process for accepting a patient that is based on its ability to provide the care, treatment, or services required by the patient. EP 2—The organization has a written process for accepting a patient that includes the following: Criteria to determine the patient’s eligibility for care, treatment, or services. EP 3—The organization has a written process for accepting a patient that includes the following: Procedures for accepting referrals.</td>
<td>All services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PC.01.02.01</td>
<td>1, 2, 5–9, 12, 33–35</td>
<td>EP 1—The organization defines, in writing, the scope and content of screening, assessment, and reassessment information it collects. EP 2—The organization defines, in writing, criteria that identify when additional, specialized, or more in-depth assessments are performed.</td>
<td>EP 1—All services</td>
<td>EP 2—HH, PC&amp;S, Hosp (both), O&amp;P (both), CRS, RT (both)</td>
</tr>
</tbody>
</table>

Shading indicates a change effective July 1, 2015, unless otherwise noted in the What’s New.
EP 5—Based on the patient’s condition and the care, treatment, or services it provides, the organization defines, in writing, which of the following information it collects in the patient’s assessment and reassessment:
- Pertinent diagnoses
- Pertinent physical findings
- Pertinent medical history
- Functional status
- Psychosocial status
- Cultural or religious practices that may affect care
- Care the family or support system is capable of and willing to provide
- Educational needs, including the abilities, motivation, and readiness to learn
- Barriers and safety hazards in the home environment
- Any other relevant information that may affect the patient’s goals

EP 6—Based on the patient’s condition and the care, treatment, or services it provides, the organization defines, in writing, which of the following information it collects in the patient’s assessment and reassessment:
- Pertinent prognosis
- Laboratory values
- Medication history, including drug allergies, drug sensitivities, medication compliance and past adverse drug reactions
- Current medication use, including prescribed and over-the-counter medications
- Nutritional status
- Diet, including the therapeutic regimen, if any, reason for the therapeutic regimen, and its route of administration
- Medical equipment in the home

EP 7—The hospice’s written definition of information the organization collects during assessment and reassessment includes the following:

EP 5—All services

EP 6—HH, PC&S, Hosp (both)

EP 7—Hosp (both); some bullets specifically for deemed status

Shading indicates a change effective July 1, 2015, unless otherwise noted in the What’s New.

CAMHC Update 1, July 2015
<table>
<thead>
<tr>
<th>Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>The severity of symptoms</td>
</tr>
<tr>
<td>Factors that alleviate or exacerbate physical symptoms</td>
</tr>
<tr>
<td>The comfort level of a patient who chooses not to take nutrition therapy</td>
</tr>
<tr>
<td>Patient and family spiritual orientation, including their desire for the involvement of a religious group</td>
</tr>
<tr>
<td>Spiritual concerns or needs identified by the patient or family, such as despair, suffering, guilt, and forgiveness</td>
</tr>
<tr>
<td>Patient and family involvement in a support group, if any</td>
</tr>
<tr>
<td>Additional information about the patient’s psychosocial status, such as family relationships, social history, the source and adequacy of environmental and other resources, coping mechanisms, and the patient’s and family’s reactions to illness</td>
</tr>
<tr>
<td>The need for volunteer services to offer support or respite to the patient, family, or other caregivers</td>
</tr>
<tr>
<td>The need for an alternative setting or level of care - Anticipated discharge needs, including bereavement and funeral needs</td>
</tr>
<tr>
<td>Survivor risk factors, such as the nature of the relationship with the patient, circumstances surrounding the death, behaviors before and after the death, availability of coping mechanisms, and potential for pathological grief reactions</td>
</tr>
</tbody>
</table>

Shading indicates a change effective July 1, 2015, unless otherwise noted in the What's New.
| For hospices that elect to use The Joint Commission deemed status option: Cultural factors that may impact the patient’s and family’s ability to cope with the patient’s death |
| For hospices that elect to use The Joint Commission deemed status option: The need for referral to and evaluation by other health professionals |

EP 8—Based on the care, treatment, or services it provides, the pharmacy's written definition of data and information collected during assessment and reassessment includes the following:
- Pertinent prognosis (not applicable for pharmacy dispensing services or for clinical/consultant pharmacist services)
- Nutritional status
- Any equipment required for administering medication
- Dietary intake related to allergies or drug-food interactions
- Information contained in Standard MM.01.01.01

EP 9—The home medical equipment or rehabilitation technology service’s written definition of data and information collected during assessment and reassessment includes any medical equipment the patient uses.

EP 8—Pharm (all)
EP 12—For home health agencies that elect to use The Joint Commission deemed status option: The home health agency’s written definition of data and information collected during assessment and reassessment includes the Outcome and Assessment Information Set (OASIS) as follows:
- Patient record items
- Demographic patient history
- Living arrangements
- Supportive assistance
- Sensory status
- Integumentary status
- Respiratory status
- Elimination status
- Neuro/emotional/behavioral status
- Activities of daily living - Medications
- Equipment management
- Emergent care
- Data items collected at inpatient facility admission
- Data items collected at inpatient facility discharge

EP 33—For hospices that elect to use The Joint Commission deemed status option: The hospice’s written definition of data and information to be collected during the initial assessment includes the patient’s need for hospice care and services. This assessment includes all areas of hospice care related to the palliation and management of terminal illness and related conditions.

EPs 33–35—Deemed Hosp (both)

Shading indicates a change effective July 1, 2015, unless otherwise noted in the What's New.
EP 34—For hospices that elect to use The Joint Commission deemed status option: The hospice’s written definition of data and information to be collected during the comprehensive assessment includes the following:

- The patient’s 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
- The nature of the condition causing the patient’s admission to the hospice program, including the presence or absence of objective data and subjective complaints
- Complications and risk factors that affect care planning
- Functional status, including the patient’s ability to understand and participate in his or her care
- Imminence of death

EP 35—For hospices that elect to use The Joint Commission deemed status option: The hospice’s written definition of data and information to be collected during the comprehensive assessment includes data elements that measure outcomes and that can be documented in the same way for all patients.

| PC.01.02.03 | 1 | EP 1—The organization defines, in writing, the time frame(s) within which it conducts the patient’s initial assessment, in accordance with law and regulation. | All services |
| PC.01.02.09 | 1–2 | EP 1—The organization has written criteria to identify those patients who may be victims of physical assault, sexual assault, sexual molestation, domestic abuse, or elder or child abuse, neglect, and exploitation. EP 2—To assist with referrals of possible victims of abuse, neglect, and exploitation, the organization maintains a list of private and public community agencies that can provide or arrange for assessment and care. | All services |
| PC.01.03.01 | 30, 33, 34 | EP 30—For home health agencies that elect to use The Joint Commission deemed status option: The registered nurse, or other professional who is responsible for supervision of the home health aide, prepares written patient care instructions that specify the duties of the home health aide or homemaker. EP 33—For hospices that elect to use The Joint Commission deemed status option: A registered nurse who is a member of the interdisciplinary group prepares written patient care instructions for the hospice aide. EP 34—For hospices that elect to use The Joint Commission deemed status option: A member of the interdisciplinary group prepares written instructions for the homemaker. | EP 30—Deemed HH EP 33–34—Deemed Hosp (both) |
| PC.02.01.07 | EP 1, 3 | EP 1—The organization identifies in writing the source of the blood or blood component(s), the types of blood or blood component(s) that staff can administer, and the laboratory results that require review. EP 3—The organization has a process, defined in writing, to respond to adverse blood transfusion reactions that includes notifying the physician and others involved in the patient's care. | HH, Hosp (both), FSAI |
| PC.02.03.01 | 11 | EP 11—The organization provides written and verbal instructions to the patient and/or caregiver about the equipment, supplies, and services provided. The instructions cover the following topics, as appropriate to the equipment, supplies, or services: ■ Use of the equipment or supplies ■ Maintenance of the equipment ■ Potential hazards and safety considerations related to the equipment, supplies, or services | DME (all), Resp, Supp (both), O&P (both), CRS, RT (both) |
| PC.03.05.17 | 5–6 | EP 5—For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The organization documents in staff records that restraint and seclusion training and demonstration of competence were completed. | Deemed Hosp Inpt |

Shading indicates a change effective July 1, 2015, unless otherwise noted in the What's New.
| | EP 6—For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: Hospice policy specifies the training requirements for physicians, including attending physicians. | |