

2025 Nursing Competency Fair



1801 Westchester Drive • High Point, NC 27262-7009 • 336.889.8446 • www.hospiceofthepiedmont.org
416 Vision Drive • Asheboro, NC 27203-3855 • 336.672.9300 • www.hospiceofrandolph.org

HOPE Documentation

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How many HOPE Assessments?

How many HOPE-related visits COULD be required within the first 30 days of care?

Initial HOPE + SFV

HUV-1 + SFV

HUV-2 + SFV

= 6 Visits

Site of Service at Admission – Most Common

(A0215) Site of Service at Admission

- 01. Patient's Home/Residence
- 02. Assisted Living Facility
- 03. Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF)
- 04. Skilled Nursing Facility (SNF)
- 05. Inpatient Hospital
- 06. Inpatient Hospice Facility (General Inpatient (GIP))
- 07. Long Term Care Hospital (LTCH)
- 08. Inpatient Psychiatric Facility
- 09. Hospice Home Care (Routine Home Care (RHC)) Provided in a Hospice Facility
- 99. Not listed



Availability of Assistance – Most Common

(A1910) Availability of Assistance

Code the level of in-person assistance from available and willing caregiver(s), **excluding hospice and facility staff**, at the time of this admission.

- 1. Around-the-clock (24 hours a day with few exceptions)
- 2. Regular daytime (all day every day with few exceptions)
- 3. Regular nighttime (all night every night with few exceptions)
- 4. Occasional (intermittent)
- 5. No assistance available

- ❖ At the time of admission does not mean while you are conducting the assessment. This section documents how much help is available for the patient currently.
- ❖ “Help” does not necessarily mean physical care. It may mean emotional support, advocacy, and decision-making.
- ❖ Are family members/caregivers staying with the patient nearly all the time? Only during the day? Only at night?
- ❖ Are family members/caregivers in and out at different times of the day or night?
- ❖ Is no one ever visiting at all?

Comorbidities

Please review the Referral, Liaison, and Intake notes for comorbidities.



Section F: Preferences

- **No is never the answer.**
- Provide evidence that discussion occurred, not just the result.
- Facility staff may not answer these questions. The Pt/Family must be asked.
- If the family is not available and the patient is unable to respond, option 2 - Yes, but the patient/responsible party refused to discuss may be used, since their unavailability is a type of refusal to participate in the admissions process.
- **HOWEVER**, always **ATTEMPT** to discuss these important goals of care and support needs with the patient/family. If you did not attempt, then could not refuse.

Section F: Preferences

Some acceptable examples:

- ❖ Pt/Family confirm desire to avoid CPR/Hospitalization/Aggressive Treatment, etc.
- ❖ Pt/Family desire comfort measures only
- ❖ Discussed with Pt/Family and confirmed wishes (which should be documented somewhere in the patient's chart).
- ❖ No spiritual concerns reported by Pt/Family.
- ❖ Family reports they feel patient is at peace.
- ❖ Hospital Liaison discussed – **Do not default to this answer. Check the Liaison notes to confirm discussion occurred.**

Pain Screening

C. Comprehensive pain assessment included:

↓ Check all that apply

- 1. Location
- 2. Severity
- 3. Character
- 4. Duration
- 5. Frequency
- 6. What relieves/worsens pain
- 7. Effect on function or quality of life
- 9. None of the above

- ❖ Every Patient must be screened for pain
- ❖ If pain is an active problem, all 7 domains must be assessed and the boxes checked.
- ❖ If you ATTEMPT to assess but cannot determine how to answer because the patient is unable to communicate, your ATTEMPT to assess is sufficient to check the box.



Symptom Impact Screening

- 0. Not at all - symptom does not affect the patient, including symptoms well-controlled with current treatment
 - 1. Slight
 - 2. Moderate
 - 3. Severe
- 9. Not applicable (the patient is not experiencing the symptom)

0 = The symptom is not impacting the Patient's quality of life at all.

9 = This does not apply because the Patient does not have this symptom.



Symptom Impact Screening

- ❖ If **pain** is an **active** problem, but it is not impacting the Patient's quality of life **at all**, then the symptom impact is 0 – Not at all.
- ❖ If the **dyspnea** screening indicates **shortness of breath**, but it is not impacting the Patient's quality of life **at all**, then the symptom impact is 0 – Not at all.
- ❖ If pain and/or dyspnea are **not active problems**, then the symptom impact **does not apply** to this Patient, so the answer is 9 – Not applicable.
- ❖ Make sure the assessment details match the answers in the Symptom Impact Screening.

Section N: Opioids and Bowel Regimen

(N0500) Scheduled Opioid

A. Was a scheduled opioid initiated or continued?

0. No → Skip to N0510, PRN Opioid
 1. Yes

B. Date scheduled opioid initiated or continued:

(N0510) PRN Opioid

A. Was a PRN opioid initiated or continued?

0. No → Skip to N0520, Bowel Regimen
 1. Yes

B. Date PRN opioid initiated or continued:

(N0520. Bowel Regimen) Bowel Regimen - Complete only if N0500A or N0510A = 1

A. Was a bowel regimen initiated or continued? - Select the most accurate response

0. No → Skip N0520B
 1. No, but there is documentation of why a bowel regimen was not initiated or continued → Skip N0520B
 2. Yes (specify details):

B. Date bowel regimen initiated or continued:

- ❖ Enter the date of your assessment every time.
- ❖ If you did not initiate this treatment order, this is the date you are **CONTINUING** the treatment.
- ❖ Initiated = Treatment is ordered and is intended to begin.

Documenting Instruction/Education

- Family has been instructed to begin treatment/medication.
- PCG instructed on Senna.
- Discussed Bowel Regimen.
- Bowel POC initiated.
- List the medication (e.g., Senna, Bisacodyl, laxative)

What is your favorite way to document this?

Documenting Instruction/Education

- As you are discussing medications, treatments, s/s of disease progression, care options, etc. with the Pt/Caregiver(s), document somewhere in your note(s) that you provided this support.
- Give yourself credit for the work you are doing, which demonstrates compliance with expectations.

Section Z: Signing your assessment

(Z0400. Signature(s) of Person(s) Completing the Record)

I certify that the accompanying information accurately reflects patient a:
and Medicaid requirements. I understand that reporting this informatio
submit this information by this provider on its behalf.

Name / Signature	
A. YOUR NAME	/ See electronic signature below
B.	/ See electronic signature below
C.	/ See electronic signature below

Title
RN

Sections
All but SFV
or ALL

Date Section Completed

10/31/2025	Clear
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← Enter the date of your assessment here.

Section Z: The Bottom Line

The very last signature in the HOPE and HUVs is for QA (Quality Assurance) only, with the date that QA verifies the record is correct and complete.



(Z0500. Signature of Person Verifying Record Completion)

A. Name / Signature

NOT YOU

/ See electronic signature below

Who is QA?

Section Z: The Bottom Line

Section Z

Record Administration

(Z0400. Signature(s) of Person(s) Completing the Record)

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable M and Medicaid requirements. I understand that reporting this information is used as a basis for payment from federal funds. I further understand that failure to report such information may lead to a payment reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this provider on its behalf.

Name / Signature	Title	Sections	Date Section Completed
A. <input type="text" value="Nurse's NAME"/> / See electronic signature below	<input type="text" value="RN"/>	<input type="text" value="All but SFV"/>	<input type="text" value="10/31/2025"/> <input type="button" value="Clear"/>
B. <input type="text" value="Kelly A. Olmeda, M"/> / See electronic signature below	<input type="text" value="QA"/>	<input type="text" value="SFV transcribed"/>	<input type="text" value="11/02/2025"/> <input type="button" value="Clear"/>
C. <input type="text"/> / See electronic signature below	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="button" value="Clear"/>
D. <input type="text"/> / See electronic signature below	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="button" value="Clear"/>
E. <input type="text"/> / See electronic signature below	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="button" value="Clear"/>
F. <input type="text"/> / See electronic signature below	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="button" value="Clear"/>
G. <input type="text"/> / See electronic signature below	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="button" value="Clear"/>
H. <input type="text"/> / See electronic signature below	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="button" value="Clear"/>
I. <input type="text"/> / See electronic signature below	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="button" value="Clear"/>
J. <input type="text"/> / See electronic signature below	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="button" value="Clear"/>
K. <input type="text"/> / See electronic signature below	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="button" value="Clear"/>
L. <input type="text"/> / See electronic signature below	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="button" value="Clear"/>

(Z0500. Signature of Person Verifying Record Completion)

A. Name / Signature

/ See electronic signature below

B. Date:

DEATH/DISCHARGE

Section Z: A DIFFERENT Bottom Line

Section Z Record Administration

(Z0400. Signature(s) of Person(s) Completing the Record)

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that reporting this information is used as a basis for payment from federal funds. I further understand that failure to report such information may lead to a payment reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this provider on its behalf.

Name / Signature	Title	Sections	Date Section Completed
A. Arianne Wright / See electronic signature below	RNCM	ALL	10/29/2025 <input type="button" value="Clear"/>
B. / See electronic signature below			<input type="button" value="Clear"/>

The very last signature in Z0500 is **YOU**. There is no need to QA the Death/Discharge HOPE. You will be able to Complete this assessment yourself.

(Z0500. Signature of Person Verifying Record Completion)

A. Name / Signature

Arianne Wright / See electronic signature below

PATIENT NAME - (Last, First, Middle Initial)

B. Date:

10/29/2025

Skills Lab



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Clinical Procedures Resource Guide

Education Portal - Employee Intranet



 | MACY
CATHETER

PleurX™ Pleural Catheter System

Aspira®
DRAINAGE SYSTEM

MOOG | MEDICAL

CURLIN 6000



Self Assessment

A = I could teach someone else how to do this.

B = I have done this before, but it has been a while.

C = I have no experience with this skill.

Pair Up and Practice

- Procedures are available at each station.
- Talk through the procedure with your partner(s).
- Use the supplies and equipment to practice the skill.
- Teach each other!
- Initial and date each item on your partner(s) form.

