AHC Media

April 18, 2016

Records and Swinging: All the Requirements Your CAH Needs

Speaker

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Objectives

- Explain the informed consent elements required by CMS.
- List what must be contained in the operative report.
- Explain the patient rights that are afforded to patients in swing beds.
- Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate compliance requirements and penalties.

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Part 3 of 3

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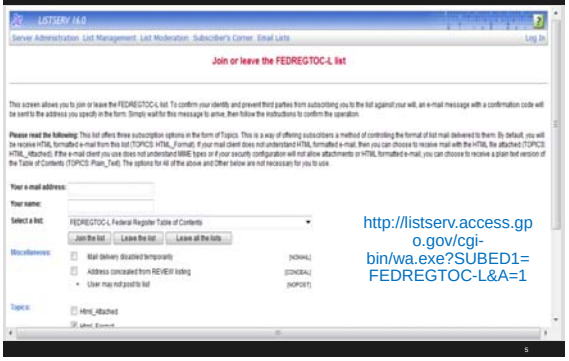

http://listserv.access.gpo.gov/cgi-bin/wa.exe?SUBED1=FEDREGTOC-L&A=1

Medicare State Operations Manual

Questions to DAPHNEG@cms.hhs.gov

Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers.

new website at
www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

App. No.	Description	PDF File
A	Hospitals	2,185 KB
AA	Psychiatric Hospitals	606 KB
B	Home Health Agencies	761 KB
C	Laboratories and Laboratory Services	

M	Hospice	720 KB
N	Pharmaceutical Service Requirements in Long-Term Care Facilities	Deleted
P	Survey Protocol for Long-Term Care Facilities	929 KB
PP	Interpretive Guidelines for Long-Term Care Facilities	1,440 KB
Q	Determining Immediate Jeopardy	326 KB
R	Resident Assessment Instrument for Long-Term Care Facilities	38 KB
S	Mammograpy Suppliers	Deleted
T	Swing-Beds	363 KB
U	Responsibilities of Medicare Participating Religious Nonmedical Healthcare Institutions	452 KB
V	Responsibilities of Medicare Participating Hospitals In Emergency Cases	393 KB
W	Critical Access Hospitals (CAHs)	1,597 KB

www.cms.gov/manuals/Downloads/som107ap_w_cah.pdf
and is critical access hospital CoP,

Radiology Services 283 2015

- Radiology services must be provided by qualified staff,
  - Can be provided as a direct service or through a contract,
- And do not expose patients or staff to radiation hazards,
- Must have services to meet the needs of its patients at all times,

Radiology Services 283

- Can offer minimal set or more complex, according to needs of the patients including nuclear medicine,
- Hospital has flexibility to decide the types and complexities of radiologic services offered
- Interpretation can be contracted out
- Diagnostic, therapeutic, and nuclear medicine, must be provided in accordance with acceptable standards of practice and must meet professionally approved standards for safety

Radiology Services 283

- Scope or what you do has to be in P&Ps approved by board or responsible party,
  - Must be consistent with state law
  - If telemedicine is used must comply with telemedicine standards
- And by standards recommended by nationally recognized professions such as the AMA, Radiology Society of North America, Alliance for Radiation Safety in Pediatric Imaging, ACC, American College of Neurology, ACP, and ACR,
  - Example would be the ACR 2013 MRI safety standards and 2015 contrast manual at www.acr.org

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Radiology Services 283

- P&P on adequate radiation shielding for patients, personnel and facilities which includes:
  - Shielding built into the physical plant
  - Types of personal protective shielding to use and under what circumstances
  - Types of containers to be used for radioactive materials
  - Clear signage identifying hazardous radiation area

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Radiology Policies Required

- Labeling of all radioactive materials, including waste with clear identification of the material
- Transportation of radioactive materials between locations within the CAH;
- Security of radioactive materials, including determining who may have access to radioactive materials and controlling access to radioactive materials;
- Periodic testing of equipment for radiation hazards;

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Radiology Policies

- Periodic checking of staff regularly exposed to radiation for the level of radiation exposure, via exposure meters or badge tests
- Storage of radio nuclides and radio pharmaceuticals as well as radioactive waste; and
- Disposal of radio nuclides, unused radio pharmaceuticals, and radioactive waste,
- To ensure periodic inspections of equipment,
  - Make sure problems are corrected in timely manner and have evidence of inspections and corrective actions

13

Radiology Policies 283

- There must be written policies developed and approved by the medical staff to designate which radiological tests must be interpreted by a radiologist,
- MR chapter standards apply
- Make sure patient shielding aprons are maintained properly and inspected
- Surveyor will review equipment maintenance reports (PM)
- Make sure staff know P&Ps

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Radiology Policies 283

- Supervision must include that all files, scans, and images are kept in a secure place and are retrievable,
- Written policy, consistent with state law on which personnel can operate radiology equipment and do procedures,
- Need copies of all reports and printouts,
- Written policy to ensure integrity of authentication,
- See tag 283 for required signage on hazardous radiation areas and more

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Tag 283 Blue Box Advisory

Information Only – Not Required/Not to be Cited

Well-designed radiologic services include a medical physicist, who, in conjunction with the person responsible for radiologic services, performs or supervises the pertinent procedures necessary to assure the safe and effective delivery of radiation to achieve a diagnostic or therapeutic result. The responsibilities of the medical physicist include: protection of the patient and others from potentially harmful or excessive radiation; establishment of adequate protocols to ensure accurate patient dosimetry; the measurement and characterization of radiation; the determination of delivered dose; advancement of procedures necessary to ensure image quality; development and direction of quality assurance programs; and assistance to other health care professionals in optimizing the balance between the beneficial and deleterious effects of radiation (www.aapm.org). CAHs are encouraged to involve a medical physicist in the calibration of the imaging equipment and monitoring of radiation dosage exposures.

16

Emergency Procedures 284 2015

- Must provide medical emergency services as a first response to common life threatening injuries and acute illness,
  - Emergency services can be done directly or through contracted services
  - Individuals providing the services must to be able to recognize a patient need for emergency care
  - Must provide medically appropriate initial interventions, treatment, and stabilization of any patient who requires emergency services

17

Agreements 285

- CAH has to have agreements with one or more providers or suppliers participating under Medicare to furnish services to patients
- CMS made an exception since distant-site telemedicine entity (DSTE) is not required to be a Medicare provider
- Agreements such as for obtaining outside lab tests

18

Contracted Services 287 2015

- Must have agreement or arrangement with one or more providers or supplies participating under Medicare to provide services to patients
- Arrangement or agreement with 1 or more doctors to provide care
- If referral agreement is not in writing then can show that doctors are accepting patients when referred (given appointments and seen)
- Need P&P for referring patients it discharges who need additional care

19

Lab & Diagnostic Services 288 2015

- Lab or diagnostic services that are not available at the CAH
  - Want to have an agreement with 1 or more other providers
  - Want to be sure referred patients are accepted and treated
- Need to make sure basic lab services are available to ensure an immediate diagnosis and treatment
  - Staff can provide services or can contract for services

20

Contracted Services 286-289

- Need to have agreement with a lab that can provide additional or specialized lab tests
  - CAH draws and sends tests out
  - Required to have P&P on this
  - If labs that provide additional diagnosis and clinical lab services must be in compliance with CLIA and lab will be surveyed separately for compliance,
- CAH needs evidence that the outside lab has a CLIA certificate or waiver
- Same is true of radiology services and if done outside make sure CAH gets copy of report

21

Contracted Services Food 289 2015

- CAH can provide food and other services to meet inpatient's nutritional needs
- Or CAH can contract out this service
  - If contracted out make sure they are aware of the CMS food service requirements and assess through QAPI process to ensure compliance with the contract also
- Must still make sure patient nutritional needs are met
- Dietary services must be provided as per the P&P

22

Contracted Services 291 2015

- **Need to keep list** of all services provided under contract or agreement
  - Try and keep contracts in one place
  - Must include service offered, individual or entity that is providing it, and whether on or off-site
  - Must include if any limit on the volume or frequency of the services provided
  - Must include when the services are available
  - Update list each time services added or removed

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Contracted Services 292 2015

- CEO is responsible for operation of all patient services furnished in the CAH
  - This includes those performed directly or by contract
  - Must take action to ensure this
- It includes not only care provided directly to patient but also services related to patient care
  - Housekeeping, instrument cleaning and sterilization, laundry, pharmacy services, lab, interpreters, security, dialysis, food service etc.

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Rehab Therapy 299 2015

- Standard: Rehab services are provided by qualified staff
  - Included PT, OT, and speech-language pathology
- Rehab is an optional service
  - Can be provided directly or through contracted services
- Must have an order, P&P, and be consistent with the SOC (American PT Association, American OT Association etc.)
- Must follow the rehab plan of care requirements and consistent with state law

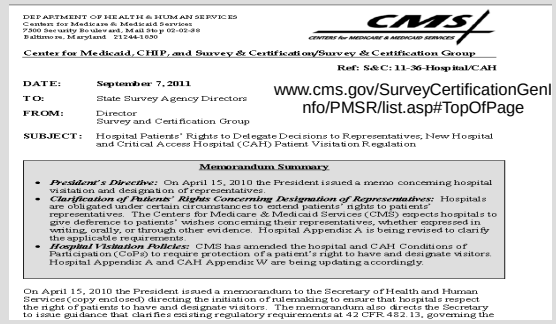
25

Rehab Plan of Care (POC) Requirements

- Must do POC before treatment is started
  - Can be done by MD/DO, PA, NP, CNS,
  - Can be done by PT, speech-language pathologist, or OT who is furnishing the service
- The POC must
  - Prescribe the type, amount, frequency, and duration
  - Must indicate the diagnosis and anticipated goal
- Any change in plan must be in accordance with provider's P&P

26

CMS Visitation



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-02-26
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP, and Survey & Certification/Survey & Certification Group

Ref: S&C: 11-36-Hospital/CAH

DATE: September 7, 2011

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Hospital Patients' Rights to Delegate Decisions to Representatives; New Hospital and Critical Access Hospital (CAH) Patient Visitation Regulation

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

Memorandum Summary

- ***President's Directive:*** On April 15, 2010 the President issued a memo concerning hospital visitation and designation of representatives.
- ***Clarification of Patients' Rights Concerning Designation of Representatives:*** Hospitals are obligated under certain circumstances to extend patients' rights to patients' representatives. The Centers for Medicare & Medicaid Services (CMS) expects hospitals to give deference to patients' wishes concerning their representatives, whether expressed in writing, orally, or through other evidence. Hospital Appendix A is being revised to clarify the applicable requirements.
- ***Hospital Visitation Policies:*** CMS has amended the hospital and CAH Conditions of Participation (CoPs) to require protection of a patient's right to have and designate visitors. Hospital Appendix A and CAH Appendix W are being updating accordingly.

On April 15, 2010 the President issued a memorandum to the Secretary of Health and Human Services (copy enclosed) directing the initiation of rulemaking to ensure that hospitals respect the right of patients to have and designate visitors. The memorandum also directs the Secretary to issue guidance that clarifies existing regulatory requirements at 42 CFR 482.13, governing the

27

Visitation 1000 (Starts after Tag 297)

- Must have P&P and process on visitation
  - Including any reasonable restrictions or limitations
- Discusses 2004 JAMA article encouraging open visitation in the ICU
- Includes inpatients and outpatients
  - Discusses role of support person for both
  - Patient may want support person present during pre-op preparation or post-op recovery

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Reasonable Restrictions 1000

- Infection control issues
- Can interfere with the care of other patients
- Court order restricting contact
- Disruptive or threatening behavior
- Room mate needs rest or privacy
- Substance abuse treatment plan
- Patient undergoing care interventions
- Restriction for children under certain age

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Visitation 1000

- Need to train staff on the P&P
- Need to determine role staff will play in controlling visitor access
- Surveyor will verify you have a P&P
- Will review policy to determine if restrictions
- Is there documentation staff is trained?
- Will make sure staff are aware of P&P on visitation and can describe the policy for the surveyor

30

Visitation 1001

- Must inform each patient or their support person, when appropriate, of their visitation rights
- Must include notifying patient of any restrictions
- Patient gets to decide who their visitors are
- Can not discriminate against same sex domestic partners, friend, family member etc.
- The patient gets to decide

31

Visitation 1001

- Support person does not have to be the same person as the DPOA
- Support person can be friend, family member or other individual who supports the patient during their stay
  - TJC calls it a patient advocate
- Support person can exercise patient's visitation rights on their behalf if patient unable to do so

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TJC Help Prevent Errors in Your Care

Ask a trusted family member or friend to be your advocate (advisor or supporter).

- Your advocate can ask questions that you may not think about when you are stressed. Your advocate can also help remember answers to questions you have asked or write down information being discussed.
- Ask this person to stay with you, even overnight, when you are hospitalized. You may be able to rest better. Your advocate can help make sure you get the correct medicines and treatments.
- Your advocate should be someone who can communicate well and work cooperatively with medical staff for your best care.
- Make sure this person understands the kind of care you want and respects your decisions.
- Your advocate should know who your health care proxy decision-maker is; a proxy is a person you choose to sign a legal document so he or she can make decisions about your health care when you are unable to make your own decisions. Your advocate may also be your proxy under these circumstances. They should know this ahead of time.
- Go over the consents for treatment with your advocate and health care proxy, if your proxy is available, before you sign them. Make sure you all understand exactly what you are about to agree to.
- Make sure your advocate understands the type of care you will need when you get home. Your advocate should know what to look for if your condition is getting worse. He or she should also know who to call for help.

www.jointcommission.org/speak_up_help_prevent_errors_in_your_care/

Visitation 1001

- Hospital must accept patient's designation of an individual as a support person
  - Either orally or in writing
  - Suggest you get it in writing from the patient
- When patient is incapacitated and no advance directives on file then must accept individual who tells you they are the support person
  - Must allow person to exercise and give them notice of patients rights and exercise visitation rights

34

Visitation 1001

- Hospital expected to accept this unless two individuals claim to be the support person then can ask for documentation
  - This includes same sex partners, friends, or family members
  - Need policy on how to resolve this issue
- Any refusal to be treated as the support person must be documented in the medical record along with specific reason for the refusal

35

Visitation 1001

- Patient can withdraw consent and change their mind
- Must document in the medical record that the notice was given
- Surveyor is to look at the standard notice of visitation rights
- Will review medical records to make sure documented
- Will ask staff what is a support person and what it means

36

Visitation 1002

- Must have written P&P
- Must not restrict visitors based on race, color, sex, gender identify, sexual orientation etc.
- In other words, if a unit is restricted to two visitors every hour the patient gets to pick their visitors not the hospital
- Suggest develop culturally competent training programs

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Medical Records 300

Must maintain clinical medical records system in accordance with P&Ps,

- Must have a system of patient records, ways to identify the author and protect security of MR,
- Must be sure MR are not lost, stolen, or altered or reproduced in authorized manner,
- Limit access to only those authorized persons,
- HIPPA is important and the OCR has been issuing heavy penalties for violation of privacy and security,

38

Medical Records 300

- Must have current list of authenticates signatures (like signature cards),
- And computer codes and signature stamps,
- Must be adequately protected and authorized by governing body,
- Must cross reference inpatients and outpatients,
- If transfer to swing bed can use one MR but need divider,

39

Medical Record

Both inpatient and swing bed must have MR;

- Admission, discharge orders, progress notes, nursing notes, graphics, laboratory support documents, any other pertinent documents, and discharge summaries,
- Must retain MR and file them,

40

Medical Records 300

- Must have system to be able to pull any old MR within past **6 years,**
- 24 hours a day and 7 days a week,
  - Inpatient or outpatient,
- Surveyor will verify there is a MR for every patient,
- Will look to be stored in place protected from damage, flood, fire, theft, etc.,
- Must protect confidentiality of MR,
- MR must be adequately staffed,

41

Medical Records 302

- Must be legible, complete, accurate, readily accessible and systematically organized,
- To ensure accurate and complete documentation of all orders, test results, evaluations, treatments, interventions, care provided and the patient's response to those treatments, interventions and care.
- Must have director of MR that has been appointed by governing board (303),

42

Medical Records 303

MR must contain:

- Identification and social data,
- Evidence of properly executed informed consent forms,
- Pertinent medical history,
- Assessment of the health status and health care needs of the patient,
- Brief summary of the episode, disposition, and instructions to the patient;

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Informed Consent 304

- Include evidence of properly executed informed consent forms for any procedures or surgical procedures,
- Specified by the medical staff,
- Or by Federal or State law, if applicable, that require written patient consent,
- Informed consent means the patient or patient representative is given the information, explanations, consequences, and options needed in order to consent to a procedure or treatment.
- See also tag 320,

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Consider List of Procedures

Procedure Name	Requires Consent
Ablations	Yes
Amniocentesis	Yes
Angiogram	Yes
Angiography	Yes
Angioplasties	Yes
Arthrogram	Yes
Arterial Line insertion (performed alone)	Yes
Aspiration Cyst (simple/minor)	No

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Consider List of Procedures

Aspiration Cyst (complex)	Yes
Blood Administration	Yes
Blood Patch	Yes
Bone Marrow Aspiration	Yes
Bone Marrow Biopsy	Yes
Bronchoscopy	Yes
Capsule Endoscopy	Yes
Catherizations, Cardiac & vascular	Yes
Cardioversion	Yes

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Informed Consent 304

- A properly executed consent form contains at least the following:
  - Name of patient, and when appropriate, patient's legal guardian;
  - Name of CAH;
  - Name of procedure(s);
  - Name of practitioner(s) performing the procedures(s);
  - Signature of patient or legal guardian;

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Consent Form Must Include

- Date and time consent is obtained;
- Statement that procedure was explained to patient or guardian;
- Signature of professional person witnessing the consent;
- Name/signature of person who explained the procedure to the patient or guardian.

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Medical Records 304

- MR must contain information such as progress and nursing notes, medical history, documentation, records, reports, recordings, test results, assessments etc. to:
  - Justify admission;
  - Describe the patient's progress and support the diagnosis;
  - Describe the patient's response to medications; and
  - Describe the patient's response to services such as interventions, care, treatments,

49

Medical Records

- Must maintain confidentiality of records,
- What precautions are taken to ensure confidentiality and prevent unauthorized persons from gaining access,
- MR retention period is 6 years and longer if required by state (311),
- When can records be removed ?
- AHIMA has practice briefs that can be helpful to hospitals at www.ahima.org,

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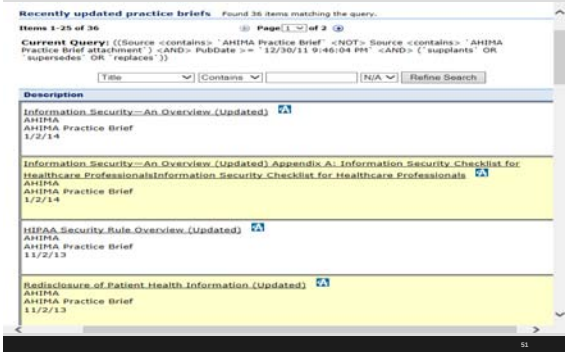
AHIMA Practice Briefs www.ahima.org



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Discharge Summary 304

A discharge summary discusses:

- The outcome of the CAH stay,
- The disposition of the patient,
- And provisions for follow-up care (any post appointments such as home health, hospice, assisted living, LTC, swing bed services,
- Is required for all hospitals stays and prior to and after swing bed admission.

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Discharge Summary 304

- Admitting practitioner must do,
- MD/DO may delegate writing the discharge summary to other qualified health care personnel such as nurse practitioners and physician assistants if state allows,
- Surveyor will verify MS have specified which procedures or treatments need informed consent,
- Surveyor will verify consent forms contain all the elements,
- Will do review of closed and open MR-at least 10% of average daily census.

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Discharge Summary 304

- Recommendations to avoid unnecessary readmissions;
  - Make the appointment for the patient with the PCP before discharge
  - Dictate the discharge summary as soon as patient is discharge
  - Hospital has the responsibility to get the discharge summary or medical record information into the hands of the PCP before the first visit
  - Make appointment within 4 days after discharge

54

History and Physicals 305

- All or part of H&P may be delegated to other practitioners if allowed by state law and CAH (see also tag **320),**
- However MD/DO assume full responsibility,
- MD/DO must sign also,
- Surveyor will look at bylaws to determine when H&P must be done,
- Make sure H&P on chart before patient goes to surgery unless an emergency
  - Important issue with CMS and TJC

55

Response to Treatment 306

- **The following must describe the patient's response to treatment;**
  - All orders,
  - Reports of treatment and medications,
  - Nursing notes,
  - Documentation of complications,
  - Other information used to monitor the patients such as progress notes, lab tests, graphics,

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Medical Records 306

- Must make sure MR get filed promptly,
- All MR must contain all lab reports,
- Radiology reports,
- All vital signs,
- All reports of treatment include complications and hospital acquired infections,
  - Now called healthcare associated infections
- All unfavorable reaction to drugs,

57

Entries in the MR 307

- Only those specified in the MS P&P can write in the MR,
- All entries must be DATED, TIMED, and authenticated (must sign off each order),
- If rubber stamps used-person must sign they will be the only one who uses it,
  - Just DON'T use rubber stamps
- Must have sanctions for improper use of stamp, computer key or code signature,
- Must date and time when a verbal order is signed off,

58

Confidentiality of MR 308

- Must maintain confidentiality of information,
- Access to information limited to those who need to know,
- Safeguard MR, videos, audio,
- Will verify only authorized people can access MR contained in MR department
  - Which many call Health Information Management (HIM)
- Need to release only with written authorization of patient or authorized representative,

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MR Policies 309

- Need written P&P that govern the use and removal of MR,
- To include the conditions of release of information,
- Remember the federal HIPAA law on MR confidentiality and privacy and ARRA, HITECH, and breach notification law,
- Written consent of patient required to release (310),

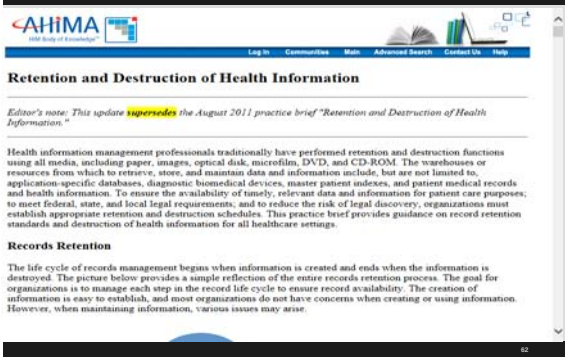
60

Retention of MR 311

- Records are retained for at least **6** years from date of last entry,
- And longer if required by State or federal law (OSHA, FDA, EPA),
  - Or if the records may be needed in any pending proceeding,
- Can be in hard copy, microfilm or computer memory banks,
- AHIMA has practice brief on retention periods,

61

Retention & Destruction Updated 10/15/2013



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Retention and Destruction of Health Information

Editor's note: This update supersedes the August 2011 practice brief "Retention and Destruction of Health Information."

Health information management professionals traditionally have performed retention and destruction functions using all media, including paper, images, optical disk, microfilm, DVD, and CD-ROM. The warehouses or resources from which to retrieve, store, and maintain data and information include, but are not limited to, application-specific databases, diagnostic biomedical devices, master patient indexes, and patient medical records and health information. To ensure the availability of timely, relevant data and information for patient care purposes; to meet federal, state, and local legal requirements; and to reduce the risk of legal discovery, organizations must establish appropriate retention and destruction schedules. This practice brief provides guidance on record retention standards and destruction of health information for all healthcare settings.

Records Retention

The life cycle of records management begins when information is created and ends when the information is destroyed. The picture below provides a simple reflection of the entire records retention process. The goal for organizations is to manage each step in the record life cycle to ensure record availability. The creation of information is easy to establish, and most organizations do not have concerns when creating or using information. However, when maintaining information, various issues may arise.

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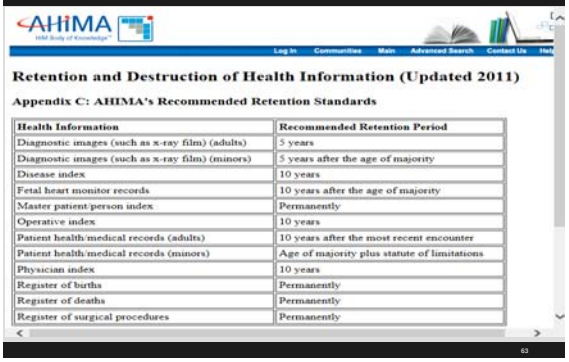
Retention & Destruction



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Retention and Destruction of Health Information (Updated 2011)

Appendix C: AHIMA's Recommended Retention Standards

Health Information	Recommended Retention Period
Diagnostic images (such as x-ray film) (adults)	5 years
Diagnostic images (such as x-ray film) (minors)	5 years after the age of majority
Disease index	10 years
Fetal heart monitor records	10 years after the age of majority
Master patient/person index	Permanently
Operative index	10 years
Patient health/medical records (adults)	10 years after the most recent encounter
Patient health/medical records (minors)	Age of majority plus statute of limitations
Physician index	10 years
Register of births	Permanently
Register of deaths	Permanently
Register of surgical procedures	Permanently

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Federal and State Retention Periods

Practice Brief—Retention of Health Information (updated)

Table 3: Federal Record Retention Requirements

Type of Documentation	Retention Period	Citation/Reference
Abortions and related medical services documentation	Maintained for three years.	42 CFR 36.56 42 CFR 50.309
Ambulatory surgical services	Retention periods are not specified.	42 CFR 416.47
Clinics, rehabilitation agencies, and public health agencies as providers of outpatient physical therapy and speech-language pathology services	As determined by the respective state statute, or the statute of limitations in the state. In the absence of a state statute, five years after the date of discharge, or in the case of a minor, three years after the patient becomes of age under state law or five years after the date of discharge, whichever is longer.	42 CFR 485.721(d) 42 CFR 486.161(d)
Clinics, rural health	Six years from date of last entry and longer if required by state statute.	42 CFR 491.10(c)
Competitive medical plans (see HMOs, competitive medical plans, healthcare prepayment plans)		
Comprehensive outpatient rehabilitation facilities (CORFs)	Five years after patient discharge.	42 CFR 485.60(c)
Critical access hospitals (CAHs)	Six years from date of last entry, and longer if required by state statute, or if the records may be needed in any pending proceeding.	42 CFR 485.638(c)
Department of Veterans Affairs—Diagnostic and	Destroy monthly listing after receipt of consolidated biannual listing.	Records Control Schedule (RCS)10-1, Section XXII—

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Surgical Procedures 320

- Standard: If a CAH provides surgical services it must be performed in a safe manner,
  - By qualified practitioner with clinical privileges,
- What does safe manner mean?
- The equipment and supplies are sufficient so the type of surgery can be performed safely,
- Surgery dept must be organized and staffed if you have one,

65

Surgical Services 320

- Must follow state and federal laws,
- Must follow standards of practice and recommendations by national recognized organizations (AMA, ACOS, APIC, AORN),
- Quality of outpatient surgical services must be consistent with inpatient,
- Scope of surgical services must be writing and approved by MS,
- OR must be supervised by experienced staff member, address qualifications of supervisor of OR rooms in P&P.

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Surgical Procedures 320

- If LPN or OR tech used as scrub nurses then must be under RN who is immediately available to physically intervene,
- There are also a number of policies and procedures that need to be in place.
- AORN have many resources to help meet CMS and TJC requirements
  - Now called Guidelines for Perioperative Practice
- Must wear clean surgical attire that covers hair

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Surgery Policies 320

- Aseptic surveillance and practice, including scrub techniques
- Identification of infected and non-infected cases
- Housekeeping requirements/procedures
- Patient care requirements
  - Preoperative work-up
  - Patient consents and releases
  - Clinical procedures
  - Safety practices
  - Patient identification procedures

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Surgery Policies 320

- Duties of scrub and circulating nurse,
- Safety practices,
- The requirement to conduct surgical counts in accordance with accepted standards of practice,
- Scheduling of patients for surgery,
- Personnel policies unique to the OR,
- Resuscitative techniques,
- DNR status,
- Care of surgical specimens,
- Malignant hyperthermia,

69

Surgery Policies 320

- Appropriate protocols for all surgical procedures performed.
  - These may be procedure-specific or general in nature and will include a list of equipment, materials, and supplies necessary to properly carry out job assignments.
- Sterilization and disinfection procedures
- Acceptable operating room attire
- Handling infections and biomedical/medical waste

70

H&P 320

- Complete H&P must be done in accordance with acceptable standards of practice,
- All or part may be delegated to other practitioners (like PA or NP) if allowed by your state law and CAH,
- Surgeon must sign and assumes full responsibility,

71

H&P 320

- Need to have H&P on the chart PRIOR to surgery,
- An exception is an emergency and then need brief admission note on chart,
- Note should include at a minimum critical information about the patient's condition including pulmonary status, cardiovascular status, BP, vital signs, etc.

72

Informed Consent 320

- This includes all inpatient and outpatient,
- Is informed of who will actually perform the surgery (no ghost surgery),
- Must inform patient if practitioner other than the primary surgeon will perform important parts of the surgical procedure,
  - EVEN if it is under the primary surgeon's supervision,

73

Informed Consent 320

Consent must include:

- Name of patient or their legal guardian,
- Name of hospital (CAH),
- Name of specific procedure,
- Name of person doing the procedure or important parts of the procedure other than primary surgeon,
- Significant surgical tasks include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices and altering tissue,

74

Informed Consent 320

- Nature and purpose of proposed treatment, Risks, consequences if no treatment is rendered, alternative procedures or treatments, probability that proposed procedure would be successful
- Signature of patient or guardian,
- Date and time consent obtained,
- Statement that procedure explained to the patient or guardian,
- Signature of professional person witnessing the consent (proposal to change to only witness and they are witness to signature only),
- Name of person who explained procedure,

75

Informed Consent 320

- Must disclose information to patient necessary to make a decision,
- It is a process and not a form,
- Authorization form signed by a patient who does not understand what he is signing is not informed consent,
- Given in language patient can understand (interpreter and issue of health care literacy).

76

PACU 320

- Must be adequate provisions for immediate post-op care,
- Must be in accordance with acceptable standards of care (ASPAN),
- Separate room with limited access,
- P&P specify transfer requirements to and from PACU,
- PACU assessment includes level of activity, respiration, BP, LOC, patient color (Aldrete),
- If no PACU close observation by RN in patient's room,

77

OR Register 320

- **Register will include;**
  - Patient's name, id number,
  - Date of surgery,
  - Total time of surgery,
  - Name of surgeons, nursing personnel, anesthesiologist,
  - Type of anesthesia,
  - Operative findings, pre-op and post-op diagnosis, age of patient,

78

Operative Report Must Include 320

- Name and id of patient,
- Date and time of surgery,
- Name of surgeons, assistants,
- Pre-op and post-op dx,
- Name of procedure,
- Type of anesthesia,
- Complications and description of techniques and tissue removed,
- Grafts, tissue, devises implanted,
- Name and description of significant surgical tasks done by others (see list-opening, closing, harvesting grafts,

79

Surveyor in OR 320

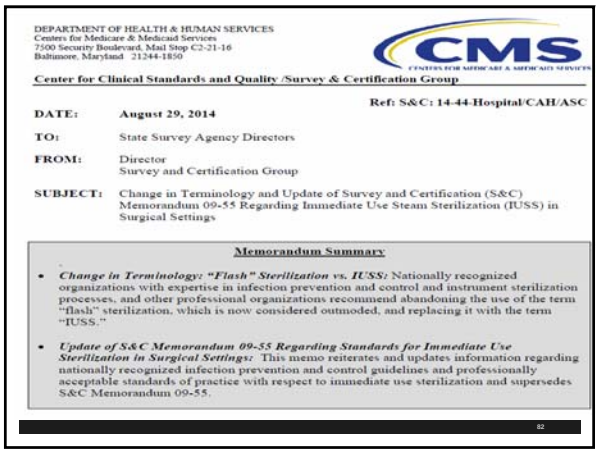
- Will verify access to OR and PACU is limited,
- That there is appropriate cleaning between surgical cases and appropriate terminal cleaning applied;
- That operating room attire is suitable for the kind of surgical case performed,
- That persons working in the operating suite must wear only clean surgical costumes,
  - AORN has a position statement on this

80

Surveyor in OR 320

- That equipment is available for rapid and routine sterilization of OR materials,
  - Called Immediate Use Steam Sterilization
- Equipment is monitored, inspected, tested, and maintained by the CAH'S biomedical equipment program,
- Sterilized materials are packaged, handled, labeled, and stored in a manner that ensures sterility e.g., in a moisture and dust controlled environment,
- **P&P on expiration dates** is followed,

81



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality /Survey & Certification Group

Ref: S&C: 14-44-Hospital/CAH/ASC

DATE: August 29, 2014

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Change in Terminology and Update of Survey and Certification (S&C) Memorandum 09-55 Regarding Immediate Use Steam Sterilization (IUSS) in Surgical Settings

Memorandum Summary

- ***Change in Terminology: "Flash" Sterilization vs. IUSS:*** Nationally recognized organizations with expertise in infection prevention and control and instrument sterilization processes, and other professional organizations recommend abandoning the use of the term "flash" sterilization, which is now considered outmoded, and replacing it with the term "IUSS."
- ***Update of S&C Memorandum 09-55 Regarding Standards for Immediate Use Sterilization in Surgical Settings:*** This memo reiterates and updates information regarding nationally recognized infection prevention and control guidelines and professionally acceptable standards of practice with respect to immediate use sterilization and supersedes S&C Memorandum 09-55.

82

Surveyor in OR 320

- OR organizational chart show lines of authority and delegation within the dept,
- Make sure have the following:
- On-call system (intercom),
- Cardiac monitor,
- Resuscitator, Defibrillator, Aspirator (suction equipment),
- **Tracheotomy** set (a cricothyroidotomy set is not a substitute),

83

Surgical Privileges 321

- Must designate who are allowed to perform surgery,
- Must conform to P&Ps,
- Must be within scope of practice laws,
- Review the list of physician privileges to determine if current,
- Surgical privileges updated every 2 years,
- Are procedures performed by appropriate physicians,

84

Surgical Privileges 321

- Surgery service must maintain roster specifying the surgical privilege,
- Current list of surgeons suspended must also be retained,
- MS bylaws must have criteria for determining privileges,
- Surveyor will review written assessment of the practitioner's training, experience, health status, and performance.

85

Surgical Privileges 321

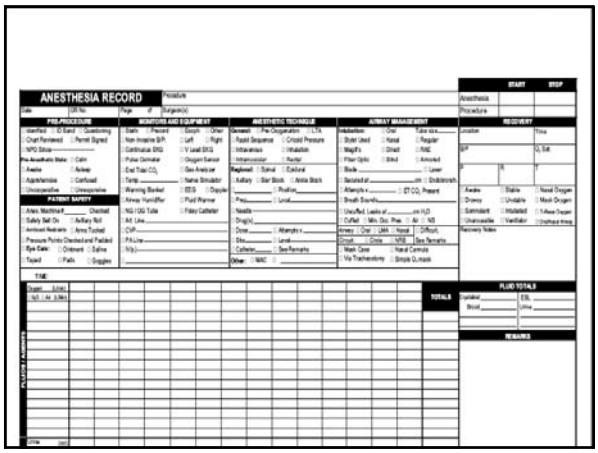
- Surgical privileges are granted in accordance with the competence of each,
- MS appraisal procedure must evaluate each practitioner's training, education, experience, and competence,
- As established by the QAPI program, credentialing, adherence to hospital P&P, and laws,

86

Surgical Privileges 321

- Must specify for each practitioner that performs surgical tasks including MD, DO, dentists, oral surgeon, podiatrists,
- RNFA, NP, surgical PA, surgical tech et. al.,
- Must be based on compliance with what they are allowed to do under state law,
- If task requires it to be under supervision of MD/DO this means supervising doctor is present in the same room working with the patient,

87



Pre-Anesthesia Assessment 322

- Pre-anesthesia evaluation must be performed immediately prior to the surgery,
- By qualified person to administer anesthetic to evaluate risk of anesthesia,
- Must include; notation of risk of anesthesia, anesthesia, drug, and allergy history,
- Potential anesthesia problems identified,
- Patient's condition prior to induction,

89

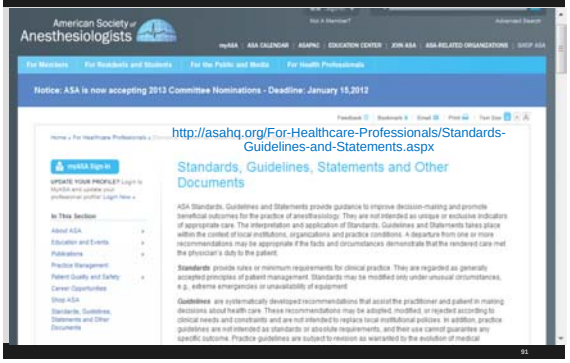
Pre-anesthesia ASA Guideline

- Preanesthesia Evaluation [1]
  - Patient interview to assess Medical history, Anesthetic history, Medication history
- Appropriate physical examination
- Review of objective diagnostic data (e.g., laboratory, ECG, X-ray)
- Assignment of ASA physical status
- Formulation of the anesthetic plan and discussion of the risks and benefits of the plan with the patient or the patient's legal representative

[1] www.asahq.org/publicationsAndServices/standards/03.pdf

90

ASA Guidelines and Standards



http://asahq.org/For-Healthcare-Professionals/Standards-Guidelines-and-Statements.aspx

STANDARDS FOR BASIC ANESTHETIC MONITORING

Committee of Origin: Standards and Practice Parameters

(Approved by the ASA House of Delegates on October 21, 1986, and last amended on October 20, 2010 with an effective date of July 1, 2011)

These standards apply to all anesthesia care although, in emergency circumstances, appropriate life support measures take precedence. These standards may be exceeded at any time based on the judgment of the responsible anesthesiologist. They are intended to encourage quality patient care, but observing them cannot guarantee any specific patient outcome. They are subject to revision from time to time, as warranted by the evolution of technology and practice. They apply to all general anesthetics, regional anesthetics and monitored anesthesia care. This set of standards addresses only the issue of basic anesthetic monitoring, which is one component of anesthesia care. In certain rare or unusual circumstances, 1) some of these methods of monitoring may be clinically impractical, and 2) appropriate use of the described monitoring methods may fail to detect untoward clinical developments. Brief interruptions of continual† monitoring may be unavoidable. These standards are not intended for application to the care of the obstetrical patient in labor or in the conduct of pain management.

1. STANDARD I

Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care.

1.1 Objective –

ETCO2 for Moderate and Deep Sedation ASA

3.2.4 During regional anesthesia (with no sedation) or local anesthesia (with no sedation), the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs. During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment.

http://asahq.org/For-Healthcare-Professionals/Standards-Guidelines-and-Statements.aspx

ASA Practice Advisory Preanesthesia Evaluation

http://asahq.org/For-Members/Practice-Management/Practice-Parameters.aspx

■ SPECIAL ARTICLE

Practice Advisory for Preanesthesia Evaluation

A Report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation

PRACTICE advisories are systematically developed reports that are intended to assist decision-making in areas of patient care where scientific evidence is insufficient to develop an evidence-based model. Practice advisories provide a synthesis of opinion from experts, open forums, and other public sources. Practice advisories report the current state of scientific literature, but are not supported by literature to the same degree as standards or guidelines due to the lack of sufficient numbers of adequately controlled studies.

Advisories are not intended as guidelines, standards, or absolute requirements. The use of practice advisories cannot guarantee any specific outcome. They may be adopted, modified, or rejected according to clinical needs and constraints. Practice advisories are subject to periodic revision as warranted by the evolution of medical knowledge, technology, and practice.

Definition of Preanesthesia Evaluation

the patient's medical records, interview, physical examination, and findings from medical tests and evaluations. As part of the preanesthesia evaluation process, the anesthesiologist may choose to consult with other healthcare professionals to obtain information or services that are relevant to perioperative anesthetic care. Preoperative tests, as a component of the preanesthesia evaluation, may be indicated for various purposes, including but not limited to (1) discovery or identification of a disease or disorder that may affect perioperative anesthetic care, (2) verification or assessment of an already known disease, disorder, medical or alternative therapy that may affect perioperative anesthetic care, and (3) formulation of specific plans and alternatives for perioperative anesthetic care. For this Advisory, *perioperative* refers to the care surrounding operations and procedures.

The assessments made in the process of a preanesthesia evaluation may be used to educate the patient, organize resources for perioperative care, and formulate

94

ASA Standard on Preanesthesia Care

BASIC STANDARDS FOR PREANESTHESIA CARE

Committee of Origin: Standards and Practice Parameters

(Approved by the ASA House of Delegates on October 14, 1987, and last affirmed on October 20, 2010)

These standards apply to all patients who receive anesthesia care. Under exceptional circumstances, these standards may be modified. When this is the case, the circumstances shall be documented in the patient's record.

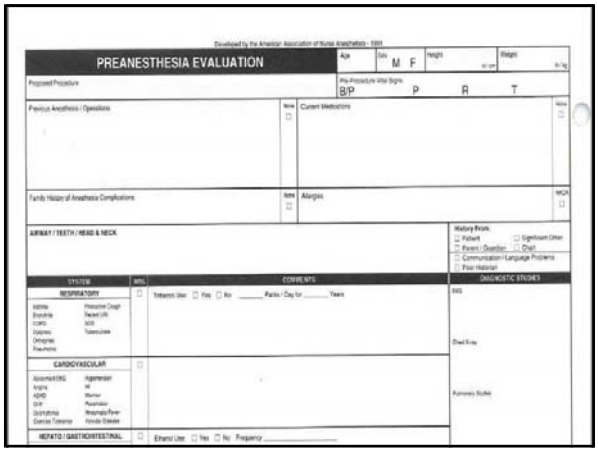
An anesthesiologist shall be responsible for determining the medical status of the patient and developing a plan of anesthesia care.

The anesthesiologist, before the delivery of anesthesia care, is responsible for:

1. Reviewing the available medical record.
2. Interviewing and performing a focused examination of the patient to:
   - 2.1 Discuss the medical history, including previous anesthetic experiences and medical therapy.
   - 2.2 Assess those aspects of the patient's physical condition that might affect decisions regarding perioperative risk and management.
3. Ordering and reviewing pertinent available tests and consultations as necessary for the delivery of anesthesia care.
4. Ordering appropriate preoperative medications.
5. Ensuring that consent has been obtained for the anesthesia care.
6. Documenting in the chart that the above has been performed.

http://asahq.org/For-Healthcare-Professionals/Standards-Guidelines-and-Statements.aspx

95


PREANESTHESIA EVALUATION

Age | Sex M F | Height | Weight

Proposed Procedure

Pre-Procedure Vital Signs: B/P P R T

Previous Anesthesia / Operations | Current Medications

Family History of Anesthesia Complications | Allergies

AIRWAY / TEETH / HEAD & NECK

History From: Patient | Significant Other | Parent / Guardian | Chart | Communication / Language Problems | Poor Historian

SYSTEM	WNL	COMMENTS	DIAGNOSTIC STUDIES
RESPIRATORY		Tobacco Use: Yes No ____ Packs / Day for ____ Years	EKG
CARDIOVASCULAR			Chest X-ray
HEPATIC / GASTROINTESTINAL		Ethanol Use: Yes No Frequency ____	Pulmonary Studies

Post Anesthesia Evaluation 321

- Post-anesthesia follow-up report must be written on all inpatients and outpatients **prior to discharge**,
- Written by the individual who is qualified to administer the anesthesia.
- Must include at a minimum: Cardiopulmonary status, LOC, follow-up care and/or observations; and,
- Any complications occurring during PACU.

97

Post Anesthesia ASA Guidelines

- Patient evaluation on admission and discharge from the postanesthesia care unit
- A time-based record of vital signs and level of consciousness
- A time-based record of drugs administered, their dosage and route of administration
- Type and amounts of intravenous fluids administered, including blood and blood products
- Any unusual events including post-anesthesia or post procedural complications
- Post-anesthesia visits

98

STANDARDS FOR POSTANESTHESIA CARE

Committee of Origin: Standards and Practice Parameters

(Approved by the ASA House of Delegates on October 27, 2004, and last amended on October 21, 2009)

These standards apply to postanesthesia care in all locations. These standards may be exceeded based on the judgment of the responsible anesthesiologist. They are intended to encourage quality patient care, but cannot guarantee any specific patient outcome. They are subject to revision from time to time as warranted by the evolution of technology and practice.

STANDARD I

ALL PATIENTS WHO HAVE RECEIVED GENERAL ANESTHESIA, REGIONAL ANESTHESIA OR MONITORED ANESTHESIA CARE SHALL RECEIVE APPROPRIATE POSTANESTHESIA MANAGEMENT.[1]

1. A Postanesthesia Care Unit (PACU) or an area which provides equivalent postanesthesia care (for example, a Surgical Intensive Care Unit) shall be available to receive patients after anesthesia care. All patients who receive anesthesia care shall be admitted to the PACU or its equivalent **except** by specific order of the anesthesiologist responsible for the patient's care.
2. The medical aspects of care in the PACU (or equivalent area) shall be governed by policies and procedures which have been reviewed and approved by the Department of Anesthesiology.
3. The design, equipment and staffing of the PACU shall meet requirements of the facility's accrediting and licensing bodies.

STANDARD II

A PATIENT TRANSPORTED TO THE PACU SHALL BE ACCOMPANIED BY A MEMBER OF THE ANESTHESIA CARE TEAM WHO IS KNOWLEDGEABLE ABOUT THE PATIENT'S CONDITION. THE PATIENT SHALL BE CONTINUALLY EVALUATED AND TREATED DURING TRANSPORT WITH MONITORING AND SUPPORT APPROPRIATE TO THE PATIENT'S CONDITION.

STANDARD III

UPON ARRIVAL IN THE PACU, THE PATIENT SHALL BE RE-EVALUATED AND A VERBAL REPORT PROVIDED TO THE RESPONSIBLE PACU NURSE BY THE MEMBER

99

Anesthesia 323

- CAH must designate who can administer anesthesia,
- MS include criteria for determining privileges, In accordance with P&P and scope of practice and state law,
- Only by anesthesiologist, MD/DO, CRNA, anesthesiology assistant, supervised trainee in education program, dentist, podiatrist,
- State exemption process of MD supervision for CRNA,

100

Anesthesia 323

- A CRNA may administer anesthesia when under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed,
- An anesthesiologist's assistant (AA) may administer anesthesia when under the supervision of an anesthesiologist who is **immediately available** if needed.

101

Immediately Available Means

- Physically located within the OR or in the L&D unit;
- And Is prepared to immediately conduct hands-on intervention if needed;
- And Is not engaged in activities that could prevent the supervising practitioner from being able to immediately intervene and conduct hands-on interventions if needed

102

Discharge 325

- All patients are discharged in the company of a responsible adult,
- Any exceptions to this requirement must be made by the attending practitioner and documented in the medical record,
- Surveyor will verify that the CAH has P&Ps in place to govern discharge procedures and instructions,

103

Quality Assessment 331

- Must periodically review total program
  - Will look at who is to do this such as the QAPI Director
- At least once per year,
- Include services provided and number of patients served,
- Look at volume of service (332),
- Include at least 10% of charts- active and closed charts (333),

104

Quality Assessment 335

- Review all P&Ps also
  - Show evidence of how these are evaluated and reviewed
- Purpose of the evaluation is to determine whether the utilization of services was appropriate,
- And whether the P&P were revised if needed,

105

Quality Assessment 336

An effective program includes;

- Ongoing monitoring and data collection,
- Problem prevention, identification and analysis,
- Identification of corrective actions,
- Implementation of corrective actions,
- Evaluation of corrective actions,
- Measures to improve quality on a continuous basis,

106

Quality Assessment 336

- QA program to evaluate appropriateness of diagnosis and treatment and in treatment outcomes,
- Facility wide QAPI program (QI),
- Can have QAPI by arrangement,
- Surveyor will look at your QI PLAN, QI minutes,

107

Healthcare Associated Infections 337

- Must evaluate infections,
  - Now called HAI or healthcare association infections
  - Remember the CMS infection control worksheet
- Must look at medication therapies,
- Must evaluate the quality of care of LIPs (NP, PA, CNS) by doctor on MS or under contract,
- Will look at how their performance is evaluated (339),
- Quality of care and appropriateness of diagnosis and treatment by doctors must be reviewed by QIO, hospital that is member of network, or as identified in state rural health plan (340),

108

Quality Assessment 341

- Staff consider the findings and evaluations and recommendations of the evaluations and take corrective actions,
- Take steps to remedial action to address deficiencies found through QAPI process,
- Will look to see who is responsible for implementing actions,
- Document the outcomes of all remedial actions (343)

109

Quality Assessment 340

- CAH have an arrangement for outside entity to review the appropriateness of the diagnosis and treatment provided by each MD/DO providing services
  - This includes doctors providing telemedicine services
- Some CAHs may also prefer to conduct their own internal review in addition to the outside review but not required
  - Outside review may be done by hospital that is a member of the same rural health network as the CAH; a Medicare QIO

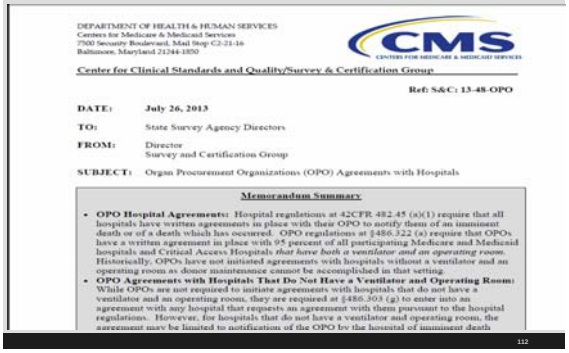
110

Organ, Tissue, and Eye 344

- Hospital must have written P&P to address its organ procurement,
- Must have agreement with OPO,
  - If OR and hospital has a ventilaor
- Must timely notify OPO if death is imminent or has patient has died,
- OPO to determine medical suitability for organ donation,
- Defines what must be in your written agreement
  - Definitions, criteria for referral, access to your death record information

111

OPO Agreements



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-48-OPO

DATE: July 26, 2013

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

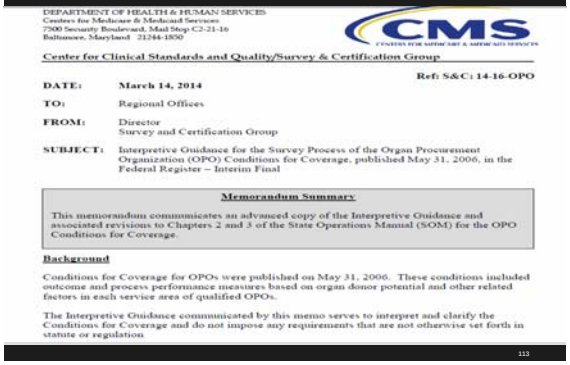
SUBJECT: Organ Procurement Organizations (OPO) Agreements with Hospitals

Memorandum Summary

- **OPO Hospital Agreements:** Hospital regulations at 42CFR 482.45 (a)(1) require that all hospitals have written agreements in place with their OPO to notify them of an imminent death or of a death which has occurred. OPO regulations at §486.322 (a) require that OPOs have a written agreement in place with 95 percent of all participating Medicare and Medicaid hospitals and Critical Access Hospitals *that have both a ventilator and an operating room.* Historically, OPOs have not initiated agreements with hospitals without a ventilator and an operating room as donor maintenance cannot be accomplished in that setting.
- **OPO Agreements with Hospitals That Do Not Have a Ventilator and Operating Room:** While OPOs are not required to initiate agreements with hospitals that do not have a ventilator and an operating room, they are required at §486.303 (g) to enter into an agreement with any hospital that requests an agreement with them pursuant to the hospital regulations. However, for hospitals that do not have a ventilator and operating room, the agreement may be limited to notifications of the OPO by the hospital of imminent death

112

OPO Memo March 14, 2014



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 14-16-OPO

DATE: March 14, 2014

TO: Regional Offices

FROM: Director
Survey and Certification Group

SUBJECT: Interpretive Guidance for the Survey Process of the Organ Procurement Organization (OPO) Conditions for Coverage, published May 31, 2006, in the Federal Register – Interim Final

Memorandum Summary

This memorandum communicates an advanced copy of the Interpretive Guidance and associated revisions to Chapters 2 and 3 of the State Operations Manual (SOM) for the OPO Conditions for Coverage.

Background

Conditions for Coverage for OPOs were published on May 31, 2006. These conditions included outcome and process performance measures based on organ donor potential and other related factors in each service area of qualified OPOs.

The Interpretive Guidance communicated by this memo serves to interpret and clarify the Conditions for Coverage and do not impose any requirements that are not otherwise set forth in statute or regulation

113

Organ, Tissue, and Eye 345

- Board must approve your organ procurement policy,
- Must integrate into hospital's QAPI program,
- Surveyor will review written agreement with the OPO to make sure it has all the required information,
- Check off the long list to ensure all elements are present
  - Such as definition of imminent death, what is timely notification, allows them access to your death records etc.,

114

Imminent Death 345

Definition of imminent death might include a patient with severe, acute brain injury who:

- Requires mechanical ventilation (due to brain injury);
- Is in an ICU or ED; and
- Has clinical findings consistent with a Glasgow Coma Score

that is less than or equal to a mutually-agreed-upon threshold; or

- MD/DOs are evaluating a diagnosis of brain death (within 1 hour) ; or
- An MD/DO has ordered that life sustaining therapies be withdrawn, pursuant to the family's decision (notify them before withdrawing life sustaining therapies),
- Make sure your staff is aware of the P&P,

115

Tissue and Eye Bank 346

- Need an agreement with at least one tissue and eye bank,
- OPO is gatekeeper and notifies the tissue or eye bank chosen by the hospital,
- OPO determines medical suitability,
- Don't need separate agreement with tissue bank if agreement with OPO to provide tissue and eye procurement,

116

Family Notification 347

- Once OPO has selected a potential donor, person's family must be informed of the donor's family's option,
- OPO and hospital will decide how and by whom the family will be approached,

117

Organ Donation 347

- Person to initiate request must be a designated requestor or organized representative of tissue or eye bank,
- Designated requestor must have completed course approved by OPO,
- Encourage discretion and sensitivity to the circumstances, views and beliefs of the families (348),
- Surveyor will review complaint file for relevant complaints,

118

Organ Donation Training 349

- Patient care staff must be trained on organ donation issues,
- Training program at a minimum should include: consent process, importance of discretion, role of designated requestor, transplantation and donation, QI, and role of OPO,
- Train all new employees, when change in P&P, and when problems identified in QAPI process,

119

Organ Donation 349

- Hospital must cooperate with OPO to review death records to improve identification of potential donors,
- Surveyor will verify P&P that hospital works with OPO,
- Maintain potential donors while necessary testing and placement of donated organs take place,
- Must have P&P to maintain viability of organs,

120

Swing Beds LTC Services 350-408

- Must meet following to provide post-hospital SNF care (350),
- Must be certified by CMS,
- SNF services must be in compliance with Subpart B of part 483,
- Allows CAH to use beds interchangeable for either acute care or SNF level,
- Swings from acute care reimbursement to SNF services and reimbursement,

121

Swing Beds

- Must be discharge orders from acute care, progress notes and discharge summary and subsequent admission orders,
- If patient does not change facilities can use same MR with chart separator,
- Medicare requires 3 day qualifying stay in CAH prior to admission to swing bed,
- 3 day rule only applies to Medicare patients,

122

Swing Beds

- No LOS restriction for swing bed,
- No transfer agreement needed between CAH and nursing home,
- CAH does not have to use the MDS form for recording patient assessment,
- Swing bed patients receive SNF level of care and CAH is reimbursed for SNF level.

123

Swing Beds Requirements

- Resident rights,
- Admission, transfer, and discharge rights,
- Resident behavior and family practices (restraints),
- Patient activities,
- Social services, comprehensive assessment, dental services, and nutrition,

124

Eligibility 351

- Must be certified as CAH,
- Have no more than 25 beds,
- Section on facilities participating as rural health care hospital (see 352),
- Have to be in compliance with SNF requirements in subpart B of part 483,
  - Residents rights, nutrition, dental, admission and discharge rights, patient activities, social services, comprehensive assessment etc.,

125

Resident Rights 361

- Right to dignified existence,
- Self determination,
- Communicate and access to persons and services outside the facility,
- Right to a copy of a notice of their rights,
- In language they can understand,
- Right to refuse treatment,

126

Resident Rights 361

- Right to get access to their records within 24 hours (excluding weekends/holidays),
- A right to buy a copy of their medical records with 2 working days notice,
- Rights in writing about their conduct and responsibilities during their stay,
- Facility must assure patient's rights are followed,
- Right to know what their rights are,

127

Resident Rights 361

- Right to choose attending MD,
- Right to share room with their spouse,
- Participate in their plan of care,
- Right to privacy and confidentiality,
- Right to get mail and send mail unopened,
- Right to personal property and visitors,
- Work or not work,
- Provide interpreters, sign language when needed,

128

Resident Rights 362

- Right to refuse treatment,
- Right to refuse to participate in experimental research,
- A resident being considered for participation in experimental research must be fully informed of the nature of the experiment and understand the possible consequences of participating,
- Will look to see if IRB has approved experimental treatment,
- Right to make an advance directive,
- If M/M does not make payment for service, must notify the resident of what is not covered,

129

Resident Rights 363

- Inform each Medicaid patient that items and services that will be included and for which the resident will be charged and amount,
- May charge for phone, TV, radio, personal clothing, confections, flowers, plants, private room unless isolation, social events, books etc.,
- Must have P&P for advance directives, educate your staff on advance directives,
- Must document in the MR if they have one,
- Provide for community education on advance directives (can use videotapes and audiotapes),

130

Free Choice 364

- Right to choose an attending MD/DO,
- But doctor must fulfill given requirements such as the frequency of visits,
- Facility has right to inform resident to seek another doctor,
- Facility must help patient to find another physician,

131

Consent 365

- Right to be fully informed in advance about care and treatment,
- Including any changes,
- They have right to receive information in order to make healthcare decisions,
- Information should include medical condition, changes in condition, the benefits, reasonable risks of the recommended treatment, and reasonable alternatives,
- Financial costs to treatment options must be disclosed in advance and in writing,

132

Privacy/Confidentiality 367

- Right to personal privacy,
- Right to confidentiality,
- Privacy to written and telephone calls,
- Right to privacy for visits in office, dining room, vacant chapel,
- Privacy when using bathroom,
- Staff should pull curtains, close doors,

133

Work 368

- Resident has right to refuse to perform services for the facility,
- Perform services if she wants
  - Housekeeping, laundry, meal preparation
- Document need or desire to work in the plan of care,
- Specify if services performed are paid or voluntary,
- Rate must be at prevailing rate, laundry

134

Mail 369

- Right to send and promptly receive mail that is unopened
- Have access to stationery, postage, and writing implements at the resident's own expense
- Deliver mail within 24 hours of delivery by US post office

135

Access and Visitation 370

- The resident has the right and the facility must provide immediate access to any resident by the following,
- Immediate family or other relatives of the resident,
- Others who are visiting with the consent of the resident.
- Resident can withdrawal consent at any time,

136

Personal Property 371

- Right to retain and use personal possessions,
- Including some furnishings, and appropriate clothing, as space permits,
- Unless to do so would infringe upon the rights or health and safety of other residents,
- Surveyor will look to see if residents are encouraged to have and use personal items,

137

Married Couples 372

- Resident has the right to share a room with his or her spouse,
- When married residents live in the same facility,
- And both spouses consent to the arrangement.
- If there is a room available,

138

Admission, Transfers, Discharge

- Transfer means outside of the facility,
- Purpose to restrict transfer by facility-to prevent dumping of high care or difficult residents (373),
- Only when initiated by the facility not the patient,
- May not transfer or discharge a resident unless necessary to meet their welfare,
- Appropriate because no longer needs the services provided (374),

139

Admission, Transfers, Discharge

- Safety or health of individuals in facility is endangered,
- Must document these in the medical record,
- Must notify resident and family members and document reasons,
- 30 days notice with exceptions, endangerment to others, condition improved, urgent medical needs to be transferred,
- Not a resident for 30 days,

140

Payment of Care 375

- Resident has failed to pay for care after reasonable notice,
- If eligible for Medicare after admission, may only charge allowable rate,
- Must provide notice to the patient and document reason in MR (377),
- Must be made within 30 days before resident is transferred, unless safety or health of individuals would be in danger,
- Need to document accurate assessments to address resident's needs,

141

Resident Behavior-Restraints

- Right to be free from restraints (381),
- Both physical and chemical,
- Must do assessment and care planning,
- Never used for discipline or convenience,
- Need to have process of assessment and evaluation before restraints used,
- Include in the plan of care,

142

Abuse 382

- Right to be free from verbal, sexual, physical, and mental abuse,
- Free from involuntary seclusion,
- Defines each of these,
- Must have written policies that prohibit neglect, and abuse and mistreatment,
  - Include the definitions of each in your policy,
- Will review any records of abuse,
- Need P&P that prohibit mistreatment, neglect, and abuse and misappropriation of resident property,

143

Hiring of Employees 384

- Do not hire if found guilty of abusing, neglecting, or mistreating residents by a court of law,
  - Or entered into state NA registry for this,
- Report any alleged violation involving neglect or abuse, or misappropriation of property to administrator and to other officials as required by state law,
- Must investigate,
- Should check all references,

144

Quality of Life

- Must care for residents in way that promotes quality of life,
- Have activities directed by qualified person,
- Qualified occupational therapist,
- Must provide social services to attain physical, mental and psychosocial well being,

145

Activities 385

- Facility must provide for an ongoing program of activities designed the interests and the physical, mental, and psychosocial well-being of each resident.
- Activities program by a qualified therapeutic recreation specialist or activity professional who is licensed or registered by state,
- Or 2 yr experience on social or recreational program within the last 5 years, or
- Is qualified OT or OT assistant,
- Or had completed training by the state,

146

Activities 385

- Surveyor will observe individual and group activity,
- Long list of things under the survey procedures on this one,
- What activities are planned,
  - Be sure to post list of activities
- Outcomes and responses,
- Included in care plans based on resident's assessment,
- Adequate supplies,

147

Social Services 386

- Facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident,
- Need bachelor's degree in social work or human services field (psychology, rehab counseling, etc.) and 1 year supervised social work experience in health care setting,

148

Social Services 386

Making arrangements for obtaining needed adaptive equipment, clothing, and personal items;

Maintaining contact with family (with resident's permission) to report on changes in health, current goals, discharge planning, and encouragement to participate in care planning;

Assisting staff to inform residents and those they designate about the resident's health status and health care choices;

Making referrals and obtaining services from outside entities (e.g., talking books, absentee ballots, community wheelchair transportation);

149

Social Services 386

Assisting residents with financial and legal matters (e.g., applying for pensions, referrals to lawyers, referrals to funeral homes for preplanning arrangements);

Discharge planning services (e.g., helping to place a resident on a waiting list for community congregate living, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities);

Providing or arranging provision of needed counseling services;

150

Resident Assessments 388

Conduct initial and periodic and reproducible assessments of each resident's functional capacity, and includes;

- Identification and demographic information.
- Customary routine.
- Cognitive patterns.
- Communication and vision.
- Mood and behavior patterns.
- Psychosocial well-being.

151

Resident Assessments 388

- Physical functioning and structural problems.
- Continence.
- Disease diagnoses and health conditions.
- Dental and nutritional status.
- Skin condition.
- Activity pursuit.
- Medications

152

Resident Assessments 388

- Special treatments and procedures.
- Discharge potential.
- Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.
- Documentation of participation in assessment.
- Must do direct observation and communicate with resident and licensed members on all shifts,
- Intent to do this to develop care plan,

153

Assessments

- Assessment within **14 days after admission**,
- Assessment if significant change (390),
- Excludes **readmissions** if no significant change in condition (389),
- Very detailed information on what constitutes a significant change (394),
- Must have a comprehensive care plan (395),
- Care plan must include measurable objectives to met patient's needs,

154

Care Plans 395

- Interdisciplinary team should develop objectives to attain highest level of functioning,
- Document if patient refuses something staff feel would help,
- Care plan must be developed within 7 days after comprehensive assessment done,
- Prepared by interdisciplinary team that includes doctor, RN with responsibility for resident, resident and family,
- Review and revise as necessary,

155

Care Plan 395

- Did an occupational therapist design needed adaptive equipment or a speech therapist provide techniques to improve swallowing ability?
- Do the dietitian and the speech therapist determine, for example, the optimum textures and consistency for the resident's food that provide both a nutritionally adequate diet and effectively use oropharyngeal capabilities of the resident,
- Does staff make an effort to schedule care plan meetings at the best time of the day for residents and their families?

156

Service Provided 397

- Services provided must meet the standard of care,
- Make sure person providing care are qualified,
- Are residents with acute conditions promptly hospitalized, as appropriate?
- Are there errors in medication administration?
- Make sure they follow the care plan (399),

157

Discharge Summary 399

Resident must have a discharge summary that includes;

- Recapitulation of the resident's stay,
- Final summary of the resident's status,
- A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

158

Nutrition 400

The facility must ensure that a resident;

- Maintains acceptable parameters of nutritional status, such as body weight and protein levels,
- Unless the resident's clinical condition demonstrates that this is not possible,
- Unacceptable parameters include unplanned weight loss, peripheral edema, cachexia and laboratory tests indicating malnourishment (e.g., serum albumin levels).

159

Nutrition 401

- Suggested parameters for evaluating significance of unplanned and undesired weight loss are:
- See detailed information under 401,

Interval	Significant Loss	Severe Loss
1 month	5%	Greater than 5%
3 months	7.5%	Greater than 7.5%
6 months	10%	Greater than 10%

160

Suggested Laboratory Values

- Albumin >60 yr.: 3.4 - 4.8 g/dl (good for examining marginal protein depletion),
- Plasma Transferrin >60 yr.:180 - 380 g/dl. (Rises with iron deficiency anemia. More persistent indicator of protein status.),
- Hemoglobin 14-17 males and 12-15 females,
- Hemocrit males 41-53, females 36-46,
- K+ 3.5-5.0 and Mg+ 1.3-2.0,

161

Rehab Services 402

- If specialized rehabilitative services such as, but not limited to,
- Physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's **comprehensive plan of care**,
- Facility must provide the required service,

162

Rehab Services 402

- Need physician order (403)
- May get from outside source,
- No fee can be charged a Medicaid recipient for specialized rehabilitative services because they are covered facility services.

163

Occupational Therapy 402

- What did the facility do to decrease the amount of assistance needed to perform a task?
- What did the facility do to decrease behavioral symptoms?
- What did the facility do to improve gross and fine motor coordination?
- What did the facility do to improve sensory awareness, visual-spatial awareness, and body integration?
- What did the facility do to improve memory, problem solving, attention span, and the ability to recognize safety hazards?

164

Speech, Language Pathology

- What did the facility do to improve auditory comprehension?
- What did the facility do to improve speech production and expressive behavior?
- What did the facility do to improve the functional abilities of residents with moderate to severe hearing loss who have received an audiology evaluation?
- For the resident who cannot speak, did the facility assess for a communication board or an alternate means of communication?

165

Dental Services 404

- The facility must assist residents in obtaining routine and 24-hour emergency dental care.
- This requirement makes the facility directly responsible for the dental care needs of its residents.
- The facility must ensure that a dentist is available for residents,
- Make appt and arrange transportation (408),
- Can't charge Medicaid patients,
- For Medicare and private pay can impose additional charge,

166

AHA Website on CAH

- Provides updates,
- Directory of resources,
- Federal legislation, OIG report on CAH
- Growth of the program,
- Grants, Newsletters,
- State hospital association links, and supervision of hospital outpatient therapeutic services
  - http://www.aha.org/advocacy-issues/cah/index.shtml

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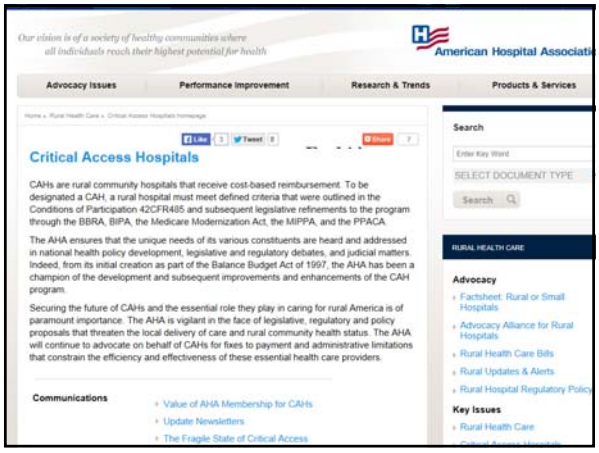
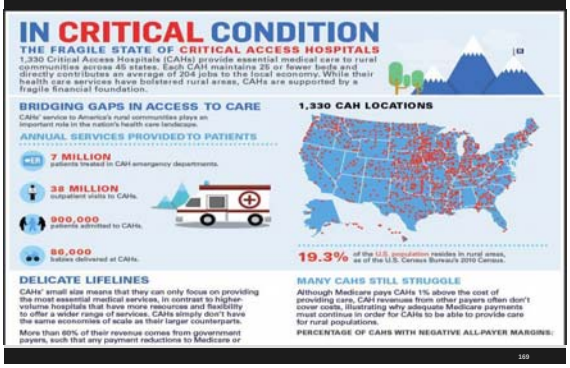


AHA Poster on CAH



IN CRITICAL CONDITION

THE FRAGILE STATE OF CRITICAL ACCESS HOSPITALS

1,330 Critical Access Hospitals (CAHs) provide essential medical care to rural communities across 45 states. Each CAH maintains 25 or fewer beds and directly contributes an average of 204 jobs to the local economy. While their health care services have bolstered rural areas, CAHs are supported by a fragile financial foundation.

BRIDGING GAPS IN ACCESS TO CARE

CAHs' service to America's rural communities plays an important role in the nation's health care landscape.

ANNUAL SERVICES PROVIDED TO PATIENTS

7 MILLION patients treated in CAH emergency departments.

38 MILLION outpatient visits to CAHs.

900,000 patients admitted to CAHs.

80,000 babies delivered at CAHs.

1,330 CAH LOCATIONS

19.3% of the U.S. population resides in rural areas, as of the U.S. Census Bureau's 2010 Census.

DELICATE LIFELINES

CAHs' small size means that they can only focus on providing the most essential medical services. In contrast to higher-volume hospitals that have more resources and flexibility to offer a wider range of services, CAHs simply don't have the same economies of scale as their larger counterparts.

More than 60% of their revenue comes from government payers, such that any payment reductions to Medicare or

MANY CAHS STILL STRUGGLE

Although Medicare pays CAHs 1% above the cost of providing care, CAH revenues from other payers often don't cover costs, illustrating why adequate Medicare payments must continue in order for CAHs to be able to provide care for rural populations.

PERCENTAGE OF CAHS WITH NEGATIVE ALL-PAYER MARGINS:

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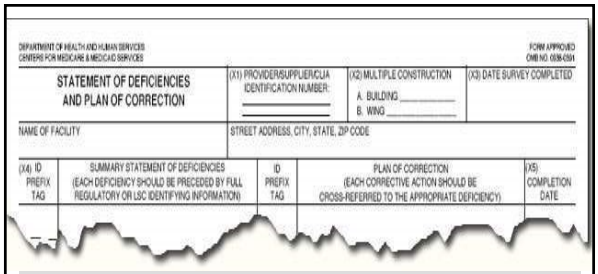

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

A. BUILDING _____

B. WING _____

NAME OF FACILITY

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

- Statement of Deficiencies and Plan of corrections,
- Based on documentation of surveyor worksheet or notes and form CMS-2567,

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The End! Questions??

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The End

- Are you up to the challenge??
- See additional resources including patient safety resources,

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Websites

- Tools and Resources Rural Health Resource Center at http://www.ruralcenter.org/tasc/
- American Association for Respiratory Care AARC- www.aarc.org,
- American College of Surgeons ACS-www.facs.org,
- American Nurses Association ANA-www.ana.org

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Websites

- Center for Disease Control CDC – www.cdc.gov,
- Food and Drug Administration- www.fda.gov,
- Association of periOperative Registered Nurses at AORN- www.aorn.org,
- American Institute of Architects AIA- www.aia.org,
- Occupational Safety and Health Administration OSHA – www.osha.gov,
- National Institutes of Health NIH-www.nih.gov,

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Websites

- United States Dept of Agriculture USDA- www.usda.gov,
- Emergency Nurses Association ENA- www.ena.org,
- American College of Emergency Physicians ACEP- www.acep.org,
- Joint Commission Joint Commission- www.JointCommission.org,
- Centers for Medicare and Medicaid Services CMS- www.cms.hhs.gov,

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Websites

- American Association for Respiratory Care AARC- www.aarc.org,
- American College of Surgeons ACS- www.facs.org,
- American Nurses Association ANA- www.ana.org,
- AHRQ is www.ahrq.gov,

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Websites

- American Hospital Association AHA- www.aha.org,
- CMS Life Safety Code page - http://new.cms.hhs.gov/CFCsAndCoPs/07_LSC.asp,
- COPs available in word and PDR at http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr485_04.html,
- American College of Radiology- www.acr.org,

178

Websites

- Federal Emergency Management Agency (FEMA)- www.fema.gov,
- Drug Enforcement Administration –www.dea.gov (copy of controlled substance act),
- US Pharmacopeia- www.usp.org, (USP 797 book for sale),
- Rural Assistance Center or RAC at http://www.raconline.org/
- CAH seminar Oct 2007 handouts at http://www.nrharural.org/conferences/sub/CAH.html

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Websites

- National Patient Safety Foundation at the AMA- www.ama-assn.org/med-sci/npsf/htm,
- The Institute for Safe Medication Practices- www.ismp.org
- U.S. Pharmacopeia (USP) Convention, Inc.- www.usp.org
- U.S. Food and Drug Administration MedWatch- www.fda.gov/medwatch
- Institute for Healthcare Improvement- www.ihi.org,
- AHRQ at www.ahrq.gov,
- Sentinel event alerts at www.jointcommission.org,

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Websites

- American Pharmaceutical Association-www.aphanet.org
- American Society of Heath-System Pharmacists-www.ashp.org
- Enhancing Patient Safety and Errors in Healthcare-www.mederrors.com
- National Coordinating Council for Medication Error Reporting and Prevention-www.nccmerp.org,
- FDA's Recalls, Market Withdrawals and Safety Alerts Page: http://www.fda.gov/opacom/7alerts.html

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Pa Patient Safety Authority

www.psa.state.pa.us/psa/site/default.asp

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Thanks for attending!

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