HealthTech

Continuous Survey Readiness for CAHs Part 1

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Presenter

Carolyn St. Charles is the Chief Clinical Officer for HealthTech. Carolyn has extensive experience working with rural hospitals to develop and strengthen Swing Bed programs. St. Charles earned a master's degree in Business Administration from the Foster School of Business at the University of Washington and a bachelor's degree in Nursing from Northern Arizona University.

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Self-Paced Certificate Courses

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Self-Paced Certificate Courses

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Leadership Development

$499 - 20 Contact Hours
Leadership Development is a comprehensive course designed to address the critical need for cultivating leadership skills among middle managers who find themselves in leadership roles without formal training and staff members who aspire to grow into management and leadership roles.

Lean Practitioner

$499, 16 Contact Hours
A Lean culture empowers individuals closest to the work to drive meaningful improvements. This Lean course equips frontline staff with the essential tools, resources, and knowledge to master and apply Lean principles effectively.

At its core, Lean focuses on enhancing process efficiency through fundamental concepts and tools. The four key principles for designing, assessing, and refining processes include defining the ideal state, identifying waste (muda), applying the four rules, and harnessing the power of observation. Critical tools such as value stream mapping and A3 problem-solving drive this methodology. While some may view Lean as a fleeting trend, its evidence-based history proves it to be a reliable, results-oriented approach with a proven track record of success. Lean isn't just a set of processes—it's a transformative mindset and methodology that fosters a safe, efficient, and high-quality environment for both patients and healthcare workers.

01

Care Coordination

HealthTech acknowledges the crucial role Care Coordination plays in driving success and sustainability within primary care. To empower the growth and sustainability of your programs, we provide arange of self-paced, asynchronous courses designed to enhance and expand services under CMS Care Coordination:

- **Care Coordination Fundamentals** – $299, offering 12 contact hours
- **Behavioral Health Integration** – $219, offering 9 contact hours
- **Transitional Care Management** – $159, offering 8 contact hours
- **Annual Wellness Visits** – $199, offering 7.5 contact hours
- **Advance Care Planning** – $149, offering 6 contact hours

These courses are tailored to support the continued development of your care coordination services, ensuring your team stays at the forefront of primary care excellence. Each course is crafted to equip members of the professional primary care team—including nurses, health educators, health coaches, and other qualified health-care providers—with the essential knowledge, skills, and expertise to conduct comprehensive consultative visits and create personalized preventive care plans. Focusing on a team-based care model, the platform prioritizes coordinated care, harnessing the collective expertise
of diverse team members. This approach enhances care coordination for patients with chronic and behavioral health conditions while reinforcing the integration of health promotion and prevention into everyday practice.

Swing Bed Courses for Critical Access Hospitals

The Swing Bed concept allows a hospital to use its beds interchangeably for either acute care or post-acute care. The reimbursement "swings" from billing for acute care services to billing for post-acute skilled nursing services, even though the patient usually stays in the same bed . Swing Bed allows patients to receive care close to home. The two courses Basics and Beyond Basics provide the fundamentals to care for Swing Bed patients and meet regulatory requirements.

Swing Bed Basics for Critical Access Hospitals
$299 - 9 Contact Hours
The Swing Bed Basics course focuses on the elements of a successful Swing Bed program including understanding and implementing CMS regulatory requirements found in the State Operations Manual Appendix W, State Operations Manual Appendix PP, and the Medicare Benefit Policy Manuals.

Swing Bed Beyond Basics for Critical Access Hospitals
$299 – 9 Contact Hours
The Swing Bed Advanced Course is focused on strategies to grow and strengthen the Swing Bed program including understanding the requirements in Appendix PP that apply to Swing Bed strategies for increasing volume. The course is divided into six modules, with one bonus module discussing the MDS which is required for Swing Beds in a PPS hospital. Each module may take up to two-weeks, but the course is self-paced.

HealthTech | For more information, visit: www.health-tech.us

02

Feb – Jun 2026 webinars

All webinars are recorded for on-demand viewing.

Unlock the full potential of Care Coordination: What's new in 2026 for program growth and reimbursements?

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: February 13, 2026 | **Time:** 12pm CST
URL: https://bit.ly/4r6lvOt

Compassion fatigue – Building resilience

Presenter: Brian Merry, M.Ed., CEMSO, NRP - Director of EMS
Date: March 6, 2026 | **Time:** 12pm CST
URL: https://bit.ly/49KJOvp

Swing Beds: An important resource for CAH - Part 1

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: April 3, 2026 | **Time:** 12pm CST
URL: https://bit.ly/4qwYF3R

Swing Beds: An important resource for CAH - Part 2

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: April 17, 2026 | **Time:** 12pm CST
URL: https://bit.ly/45Pyq08

Continuous survey readiness for CAH - Part 1: Regulatory Requirements

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: May 15, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3Nx2nMa

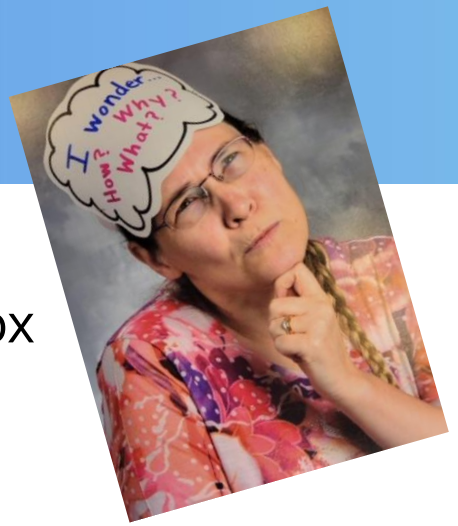
Continuous survey readiness for CAH - Part 2: Environment of care, life safety and emergency preparedness

Presenter: Michael Jones CHSP, CHCM, CSSGB, FAL, HACP-IC, HACP-CMS, HACP-PE
Date: June 5, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3YPJRkB

Continuous survey readiness for CAH - Part 3: Credentialing and privileging

Presenter: Carolyn St. Charles, RN, BSN, MBA – Chief Clinical Officer
Date: June 26, 2026 | **Time:** 12pm CST
URL: https://bit.ly/3NtJUA9

Instructions for Today



Please feel free to write questions in the Chat Box

The webinar is recorded and the recording will be sent out within 3 business days

Description

To receive Medicare and Medicaid reimbursement, critical access hospitals (CAHs) must be substantially compliant with regulatory requirements.

The presentation will discuss where to find the most recent regulatory requirements and discuss strategies for continuous survey readiness.

Regulatory requirements for nursing and non-nursing clinical departments, human resources, infection presentation, and quality assurance performance improvement will be discussed as well as requirements for policy and procedure review and approval.

Learning Objectives

Upon completion of the webinar, the participant will be able to:

1. Identify where to find CAH regulatory requirements
2. Describe at least three (3) ways to maintain continuous survey readiness
3. List at least five (5) regulatory requirement for nursing and quality assurance performance improvement
4. Review requirements for policy review and approval

PLEASE NOTE

INFECTION PREVENTION AND NON-NURSING CLINICAL DEPARTMENTS WILL BE MOVED TO THE THIRD SESSION ALONG WITH MEDICAL STAFF

Disclaimer

HealthTech hopes that the information contained herein will be informative and helpful on industry topics. However, please note that this information is not intended to be definitive.

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HealthTech does not and shall not have any authority to develop substantive billing or coding policies for any hospital, clinic or their respective personnel, and any such final responsibility remains exclusively with the hospital, clinic or their respective personnel.

HealthTech recommends that hospitals, clinics, their respective personnel, and all other third-party recipients of this information consult original source materials and qualified healthcare regulatory counsel for specific guidance in healthcare reimbursement and regulatory matters.

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CMS Manuals & Conditions of Participation

CMS Manuals

A	Hospitals	M	Hospice
AA	Psychiatric Hospitals	N	Psychiatric Residential Treatment Facilities (PRTF)
B	Home Health Agencies	P	Survey Protocol for LTC Facilities
C	Laboratories	PP	Interpretive Guidelines for LTC Facilities
D	Portable X-Ray Service	O	**Determining Immediate Jeopardy**
E	Outpatient PT or Speech Pathology	R	Resident Assessment Instrument for LTC Facilities
F	Community Mental Health Center (CMHC)	U	Responsibilities of Medicare Participating Religious Nonmedical Healthcare Institutions
G	Rural Health Clinics (RHCs)	V	**Responsibilities of Medicare Participating Hospitals in Emergency Cases (EMTALA)**
H	End-Stage Renal Disease Facilities	W	**Critical Access Hospitals (CAHs)**
I	**Life Safety Code**	X	Organ Transplant Programs
J	Intermediate Care Facilities for Individuals with Intellectual Disabilities	Y	Organ Procurement Organization (OPO)
K	Comprehensive Outpatient Rehabilitation Facilities	Z	**Emergency Preparedness for All Provider and Certified Supplier Types**
L	Ambulatory Surgical Services		

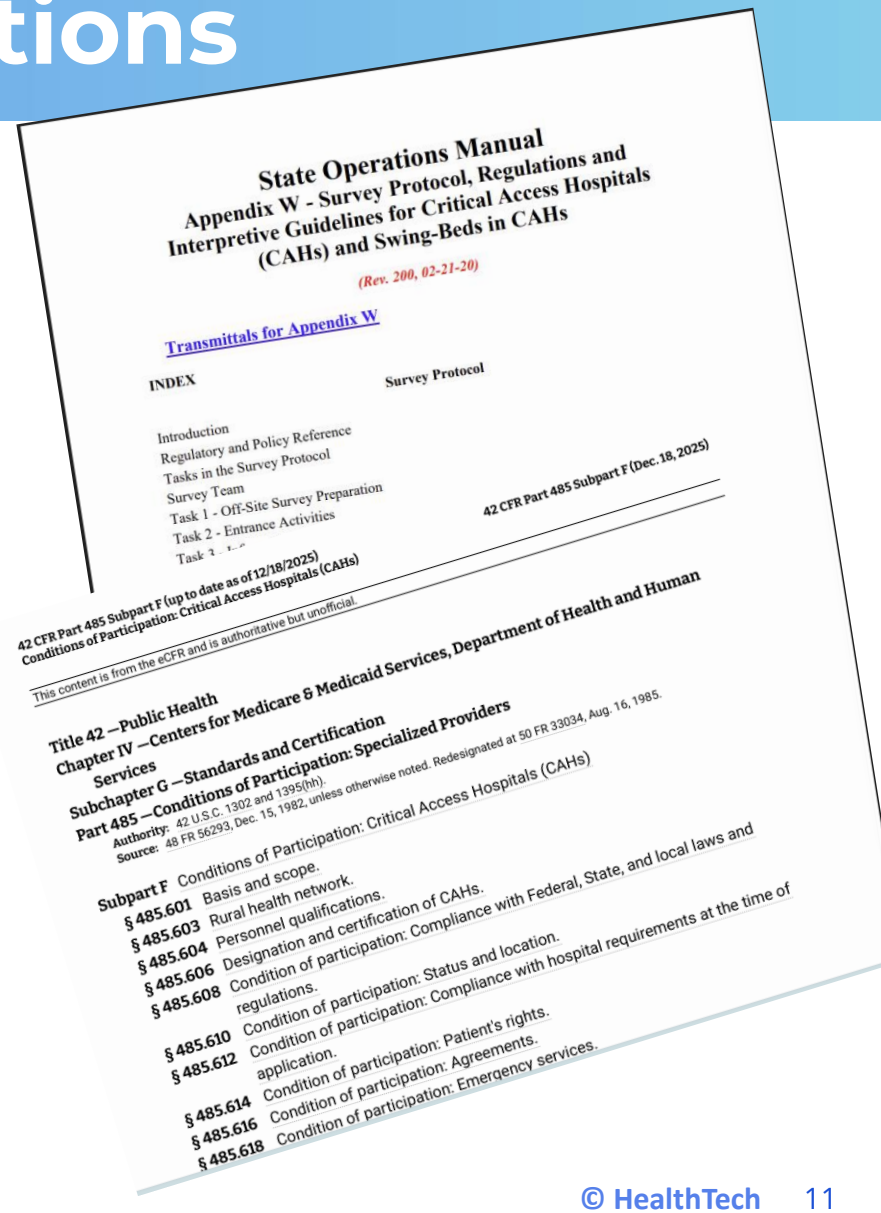
Appendix W – 2/1/2020
And - Code of Federal Regulations

A LITTLE CONFUSING

State Operations Manual - Appendix W was last published 2/2020.
Does not include all current CoPs

The most current CoPs are published in the CFR – However, the CFR does not have interpretive guidelines)
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-485/subpart-F

Recent Medicare publications (i.e., MLN Fact Sheet Swing Bed Services 5/2025) refers the reader back to the State Operations Manual Appendix W – even though the CFR is the most current



State Operations Manual
Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

(Rev. 200, 02-21-20)

Transmittals for Appendix W

INDEX Survey Protocol

Introduction
Regulatory and Policy Reference
Tasks in the Survey Protocol
Survey Team
Task 1 - Off-Site Survey Preparation
Task 2 - Entrance Activities

42 CFR Part 485 Subpart F (up to date as of 12/18/2025)
Conditions of Participation: Critical Access Hospitals (CAHs)

42 CFR Part 485 Subpart F (Dec. 18, 2025)

This content is from the eCFR and is authoritative but unofficial.

Title 42 —Public Health
Chapter IV —Centers for Medicare & Medicaid Services, Department of Health and Human Services
Subchapter G —Standards and Certification
Part 485 —Conditions of Participation: Specialized Providers
Authority: 42 U.S.C. 1302 and 1395(hh).
Source: 48 FR 56293, Dec. 15, 1982, unless otherwise noted. Redesignated at 50 FR 33034, Aug. 16, 1985.

Subpart F Conditions of Participation: Critical Access Hospitals (CAHs)
§ 485.601 Basis and scope.
§ 485.603 Rural health network.
§ 485.604 Personnel qualifications.
§ 485.606 Designation and certification of CAHs.
§ 485.608 Condition of participation: Compliance with Federal, State, and local laws and regulations.
§ 485.610 Condition of participation: Status and location.
§ 485.612 Condition of participation: Compliance with hospital requirements at the time of application.
§ 485.614 Condition of participation: Patient's rights.
§ 485.616 Condition of participation: Agreements.
§ 485.618 Condition of participation: Emergency services.

CoPs in CFR but NOT in Appendix W (example)

CFR CAH § 485.649
(a) Standard: Organization and staffing.
Effective January 1, 2026, the organization of the obstetrical services must be appropriate to the scope of the services offered. As applicable, the services must be integrated with other departments of the CAH.
(Not All Text Included)
No Interpretive Guidelines

Appendix W

Not Included

§ 485.614 Condition of participation: Patient's rights.
A CAH must protect and promote each patient's rights.
(a) Standard: Notice of rights. (1) A hospital must inform each patient, or when appropriate, the patient's representative (as allowed under state law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible.
(Not All Text Included)
No Interpretive Guidelines

Appendix W

Not Included

CoP Description MAY be the Same -- But No Interpretive Guidelines in CFR

CFR CAH § 485.635

(d)(4) A nursing care plan must be developed and kept current for each inpatient.

No Interpretive Guidelines

Appendix W

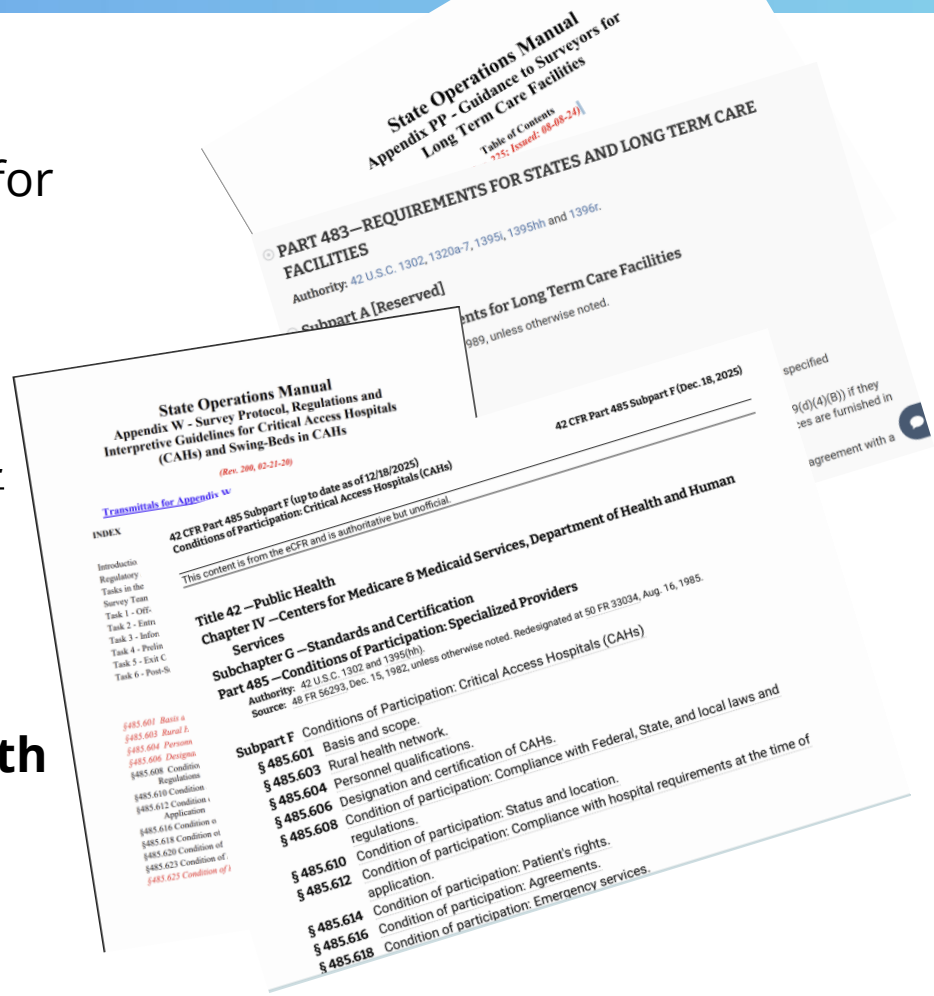
C-1050 (Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)
§485.635(d)(4)
A nursing care plan must be developed and kept current for each inpatient.

Interpretive Guidelines §485.635(d)(4)
There must be a nursing care plan for every CAH inpatient. Nursing care planning starts upon admission. It includes planning the patient's care while in the CAH as well as planning for transfer to a hospital, to a post-acute care facility or for discharge.

Swing Bed: Use CAH eCFR & Appendix W & Appendix PP & LTC eCFR

State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities was last published 08-08-24

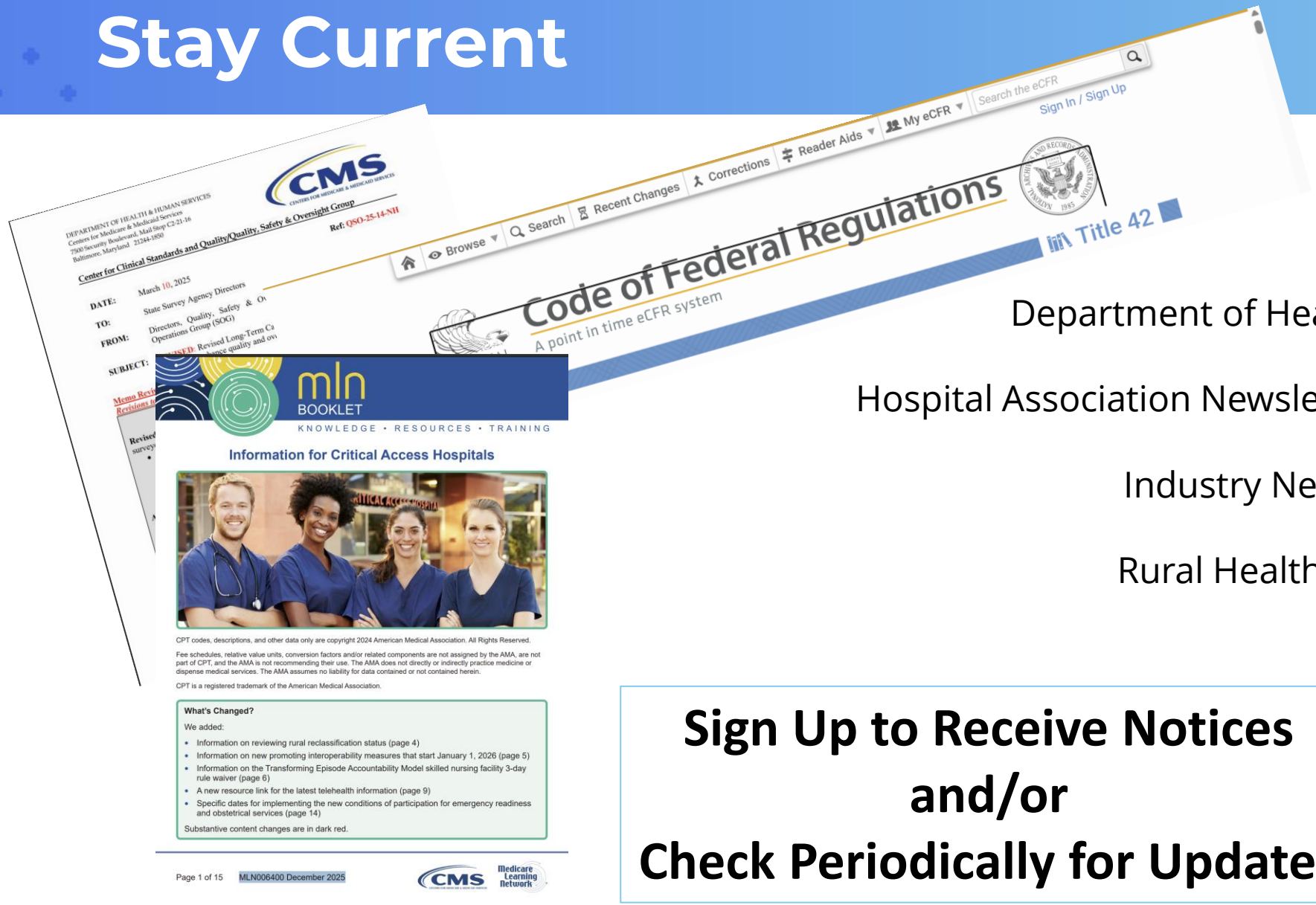
The most current CoPs are published in the CFR – *(CFR does not have interpretive guidelines)* *https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483*



So…… you will need to use the State Operations Manual Appendix PP -- AND -- eCFRs to ensure you are compliant with the most current regulatory requirements!

The good news is that Appendix PP is updated more frequently than Appendix W

Stay Current



Department of Health Newsletters

Hospital Association Newsletters (State and National)

Industry Newsletters

Rural Health Network

Sign Up to Receive Notices
and/or
Check Periodically for Updates

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Continuous Survey Readiness

1. Leadership

- Leader Rounding
- Resource Allocation (including time)
- Understand importance of survey readiness
- Feedback and Support
- Rewards for success

2. Multi- Disciplinary Survey Readiness Team

3. Assign Specific Individuals Responsibility to Monitor and Report on Changes in Regulations

Standard Changes / Updates	Designated Person
Medication Management	Pharmacist
Antibiotic Stewardship	Pharmacist
Infection Prevention	Infection Preventionist
Restraints and Ligature Risk	Quality Leader
Emergency Management	Emergency Management Coordinator
Obstetrics	Nursing Leader

4. Take Action (Quickly) When Regulations Change

1. Update or Revise P&Ps. Take the opportunity to:
    - Review current policies and take the opportunity to reduce redundancy
    - Search and identify other policies that cover the same topic or are similar
    - Determine if policies can be combined
    - Read carefully to see if similar policies conflict

2. Educate all involved staff and **providers** on new P&Ps and change in regulatory requirement(s)

3. Develop and implement competencies

4. Monitor for compliance

Strategy 5: So Many Opportunities So Little Time --- Prioritize

Potential Priority	New Regulatory Requirement Weight 4	Findings on most recent survey Weight 4	Frequent Survey Findings Weight 4	High Volume % of Patients Impacted Weight: 4	Multiple Depts Involved Weight 4
Restraint documentation					
Pain assessment / reassessment					
Safe obstetrical care (ED)					
Safe obstetrical Care (OB)					

6. Use Department Scorecards

	Focused Improvement	What did we miss?	What can we do today?	What can we do tomorrow?
Mon				
Tues				
Wed		**Post in Department**		
Th				
Fri				
Sat				
Sun				

7. Leverage Multi-Disciplinary Teams

EXAMPLE	Provider	Lab	Imaging	ICU	Med-Surg	Regis.	ER	Mother-Baby	Pharmacy	Case Mang.	IC	Quality	Plant Security	Wound Care	Surg. Services	Cancer Center	Clinics
Goal: Restraint Documentation	✓ P	✓	✓ P	✓ P	✓ P	✓ P	✓ L					✓ S					
Goal: Implement antibiotic stewardship	✓ P	✓							✓ L		✓	✓ S					
Goal: Implement Post-Partum Hemorrhage Initiative	✓ P							✓ L				✓ S					
Goal: Implement Patient Safety Ligature Risk							✓ L					✓ S	✓ P				

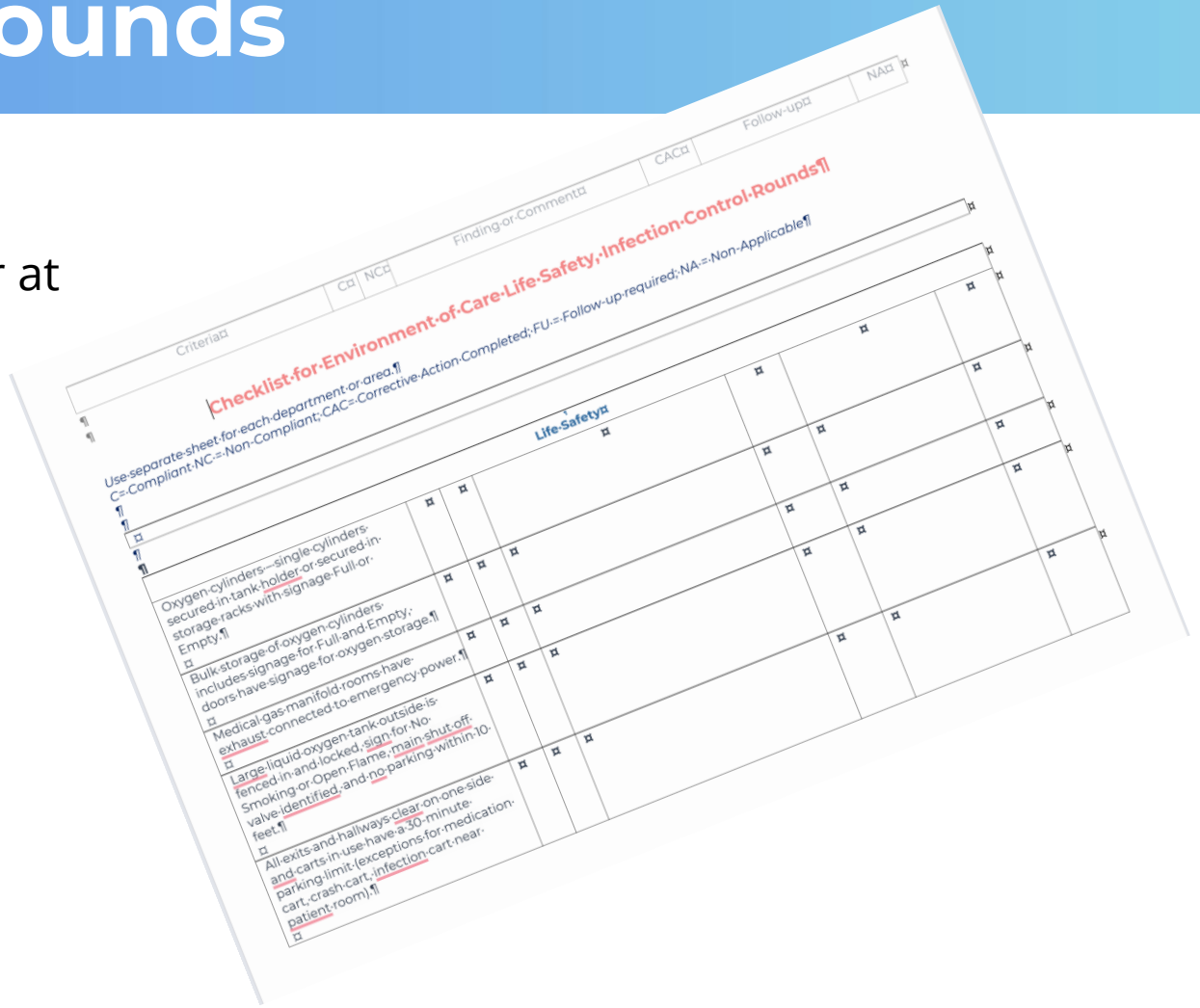
8. Take Time to Educate – Explain WHY

9. EOC / Life Safety Rounds

1. Rounds in every department every month (or at a minimum of quarterly)

2. Compile results

3. **Important:** Follow-up and take corrective actions


Checklist for Environment of Care Life Safety, Infection Control Rounds

Use separate sheet for each department or area.
C=Compliant; NC=Non-Compliant; CAC=Corrective Action Completed; FU=Follow-up required; NA=Non-Applicable

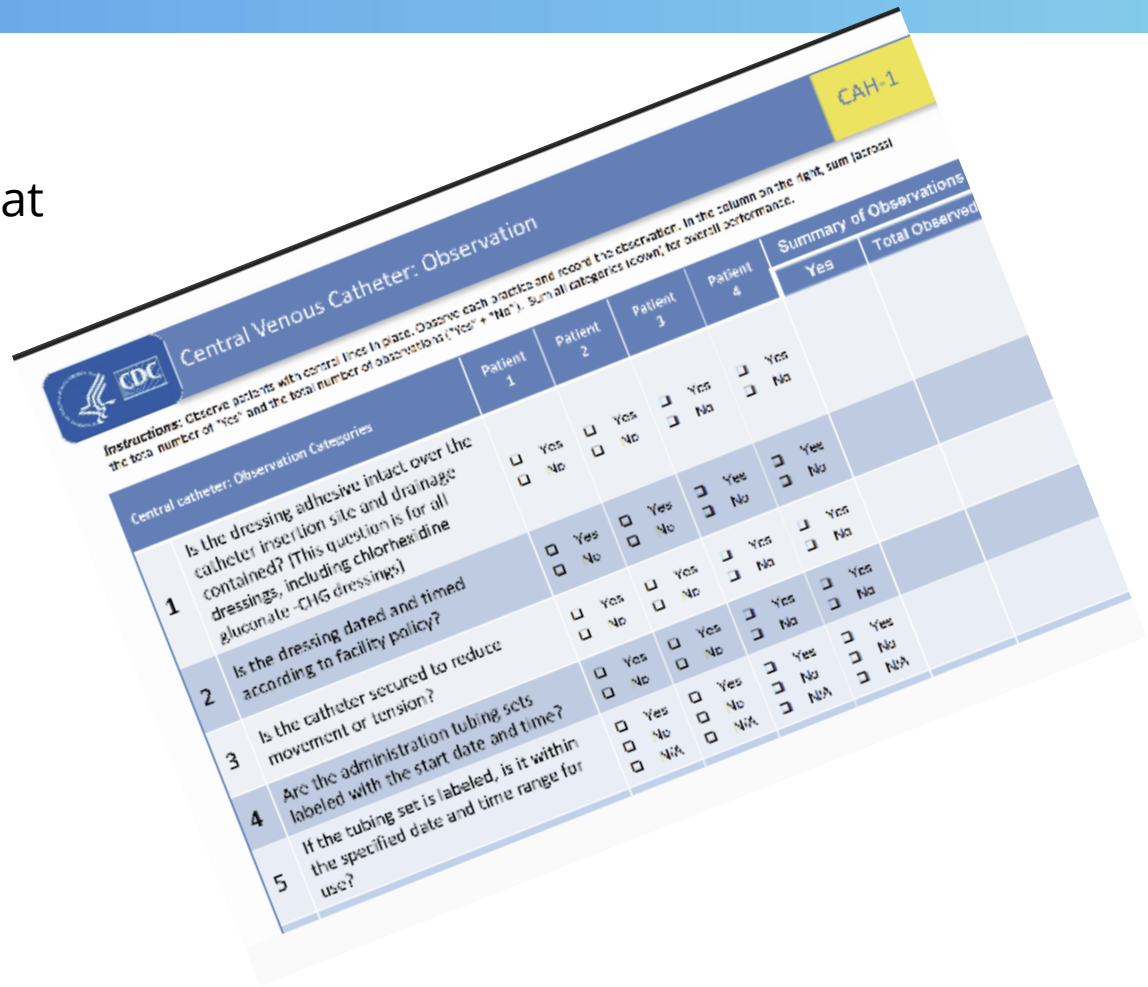
Criteria	C	NC	Finding or Comment	CAC	Follow-up	NA
Life Safety						
Oxygen cylinders—single cylinders secured in tank holder or secured in storage racks with signage Full or Empty.						
Bulk storage of oxygen cylinders includes signage for Full and Empty; doors have signage for oxygen storage.						
Medical gas manifold rooms have exhaust connected to emergency power.						
Large liquid oxygen tank outside is fenced in and locked, sign for No Smoking or Open Flame, main shut off valve identified, and no parking within 10 feet.						
All exits and hallways clear on one side and carts in use have a 30 minute parking limit (exceptions for medication cart, crash cart, infection cart near patient room).						

10. Infection Prevention Rounds

1. Rounds in every department every month (or at a minimum of quarterly)

2. Compile results

3. **Important:** Follow-up and take corrective actions



11. Use Tracers (Concurrent) Rather than Chart Audits (Retrospective)

Tracers can include the **whole** medical record – or – focus on one aspect such as:

- Assessment before and after pain medication
- Consent
- Restraint
- Advance Directive
- Blood transfusion

It is usually best to start with the whole medical record, and then if needed --- review additional charts for a specific element to see if the findings are consistent.

For example, if you review two records and both do **NOT** have complete documentation for consents, you may want to review 2 – 3 more records, but **only** look at the consent documentation

Choose a patient who has been in the hospital at least two days Ask to speak to the nurse taking care of the patient.
Tell me about the patient • How old are they? • Why were they admitted to the hospital? • How long have they been in the hospital? • What is nursing doing for the patient?
Tell me about the nursing care plan. Does it include all of the problems that the patient was admitted to the hospital for – or – any chronic medical conditions you need to monitor? Why or why not?
Do the interventions on the nursing care plan match what you are doing for the patient? Why or why not?
Can you show me the P&P for developing and updating nursing care plans. Do you think it was followed for this patient?

12. Celebrate Achievements Even Small Ones

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Policies & Procedures

Policies and Procedures

C-1006 §485.635(a) Patient Care Policies
The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law. Interpretive Guidelines §485.635(a)(1) The CAH must have written policies governing the health care services the CAH furnishes and these policies must be consistent with applicable State law.

C-1008 §485.635(a)(2)
The policies are developed with the **advice of members of the CAH's professional healthcare staff, including one or more doctors of medicine or osteopathy and one or more physician assistants, nurse practitioners, or clinical nurse specialists, if they are on staff**

These policies are reviewed at least **biennially** by the group of professional personnel required under paragraph (a)(2) of this section ……

…… the final decision on the content of the written policies is made by the CAH's governing body or individual responsible for the CAH, consistent with the requirement at §485.627(a).

Consider

Rather than providing every policy in it's original form for review and approval - have the policies available –

and provide a summary of each policy and if anything has changed since the last review or approval.

You can use this for both physician and APP review as well as governing board review.

Policy Name/Number	Applies to	Last review and approval	Changes
Restraints Policy #101	All Clinical Staff Providers	2026	Added requirement for all staff who may interact with a patient in restrains to have trauma-informed training and education

Compliance with P&Ps

C-0962 §485.627(a)
The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH'S total operation and for ensuring that those policies are administered so as to provide quality health care in a safe manner.

C-1006 §485.635(a)
The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law

YOU ARE HELD ACCOUNTABLE TO YOUR POLICIES

Human Resources

License – Qualifications - Certification

§485.608(d)
Staff of the CAH are licensed, certified, or registered in accordance with applicable Federal, State, and local laws and regulations.

Interpretive Guidelines §485.608(d)
All CAH staff must meet all applicable standards required by State or local law for CAH personnel. This would include at a minimum:

- Certification requirements
- Minimum qualifications; and
- Training/education requirements

Contract Staff & Travelers TOO
Don’t forget mobile imaging

Background Checks

C-1612 §483.12(a)(3) **Applies to everyone in the organization, including providers**

Not employ or otherwise engage individuals who—

(i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;

(ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property.

Contract Staff & Travelers TOO
Don’t forget mobile imaging

Orientation

Three types of Orientation:

1. House-wide or General Orientation
2. Department-specific Orientation
3. Job-specific Orientation

100% of ALL staff including contract staff and travelers

Don’t forget Mobile Imaging (General Safety, IP)

Examples of Education and Competency References in CoPs

- C-0880 Cardiopulmonary & Emergency Services
- C-0914 Biomedical
- C-0950 Emergency Preparedness & Fire Safety
- C-1016 Pharmacy staff
- C-1018 Reporting ADRs and Medication Errors
- C-1016 Access to Pharmacy After-Hours
- C-1030 Medical Imaging
- C-1046 Nursing
- §485.618 (e)(2): ED OB Safety (annually)
- §485.649(c): OB staff
- C-1049 Medication Administration
- C-1052 Rehabilitation
- C-1140 Surgical Services
- C-1204 Infection Control Preventionist
- C-1239 Infection Control (competency-based training and education including medical staff)
- C-1250 Antibiotic Stewardship (competency-based training and education including medical staff)
- C-1511 Organ Procurement
- C-1612 & F-943 Swing Bed Patient abuse, neglect, exploitation, and misappropriation of property
- C-1620 & F-741 Culturally Competent Trauma-Informed Care
- F-726 Swing Bed (Appendix PP)
- §485.614 Restraint patient-centered, trauma-informed competency-based training

Example

C-1046 §485.635(d)
A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH.

Interpretive Guidelines §485.635(d) & (d)(1)
For both inpatient and outpatient services there must be sufficient numbers of supervisory and non-supervisory nursing personnel with the

- appropriate education,
- experience, licensure (as applicable),
- **competence,**
- and **specialized qualifications** to respond to the nursing needs of the patient population of each CAH department or nursing unit.

Strategies for Compliance: Develop a Grid for Each Department

	Orientation At-Hire	Orientation Dept.	Competency At-Hire	Education Annual	Competency Annual
ALL staff and providers	• IP • Fire/Safety • ETC.				
ALL RNs & LPNs / LVNs		Code Carts	• Medication Mang. • Restraints • Trauma-Informed Care		• Restraints
RN OB			• MSE • OB emergencies • Protocols • Titration • Infant Security • Fetal Monitoring • MH		• OB Emergencies
RN ICU			• Drug Titration • Telemetry • Protocols		

EXAMPLE ONLY

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Quality Assurance Performance Improvement

QAPI Program

§ 485.641

(c) Standard: Governance and leadership. The CAH's governing body or responsible individual is ultimately responsible for the CAH's QAPI program and is responsible and accountable for ensuring that the QAPI program meets the requirements of paragraph (b) of this section.

§ 485.641

(b) The CAH's QAPI program must:

(1) Be appropriate for the complexity of the CAH's organization and services provided

- Cancer Center
- Cardiopulmonary / Sleep Studies
- Cardiology / Catheterization Lab
- Diagnostic Imaging & Radiology
- Emergency Department
- Family Birth Center
- General Surgery
- Infusion / Hematology
- Laboratory
- Laser Vein Center
- OB/GYN – Women's Wellness
- Orthopedics
- Outpatient Surgery
- Pain Management
- Pediatrics (0-18 years)
- Pharmacy
- Physical Therapy
- Podiatry
- Primary Care
- Radiation Oncology
- Telemedicine
- Weight Loss Center
- Wound & Hyperbarics
- Urology

(2) Be ongoing and comprehensive

(3) Involve all departments of the CAH and services (including those services furnished under contract or arrangement)

Think Synergy

EXAMPLE	Provider	Lab	Imaging	ICU	Med-Surg	Regis.	ER	OB	Pharmacy	Case Mang.	IC	Quality	Plant	Surgery	Cancer Center	Clinics
Goal: Reduce ER Wait Times	P	P	P	P	P	P	L					S				
Goal: Implement antibiotic stewardship	P	P							L			S				
Goal: Implement Post-Partum Hemorrhage Initiative	P							L				S		S		
Goal: Reduce Readmissions	S				P					P					P	P
Goal: Reduce Ligature Risk							L					S	P			

L = Lead
P – Primary Team
S = Support

Performance Indicators

§ 485.641

(b) The CAH's QAPI program must:

(4) Use objective measures to evaluate its organizational processes, functions and services.

(5) Address outcome indicators related to improved health outcomes and the prevention and reduction of medical errors, adverse events, CAH-acquired conditions, and transitions of care, including readmissions.

(d) For each area listed in paragraph (b):

(1) Focus on measures related to improved health outcomes that are shown to be predictive of desired patient outcomes

(2) Use the measures to analyze and track its performance.

Performance Measures

Required	Potential Indicators	
Relevant data including patient care data submitted externally	• Medicare QIP • Medicaid QIP • Hospital Compare	• State required measures • Patient Satisfaction
§ 485.641(b)(5) Improve Health Outcomes	• Stroke • Sepsis • STEMI • Post-Partum hemorrhage	• Healthcare Disparities • Social Determinants of Health • Opioid overdose reversal in ED
§ 485.641(b)(5) Transitions of Care including readmissions	• Readmission IP < 30 days • Readmissions Swing Bed < 30 days • Swing Bed discharge to prior residence • Return to ED < 72 hours	• ED Transfer Communication (8 measures) • Median time form ED arrival to ED departure for discharged pts. • Patients left E.D. without being seen
§ 485.641(b)(5) Hospital / CAH Acquired Conditions	• Blood incompatibility • Stage III and IV pressure ulcers • Falls with injury	• Poor glycemic Control • Catheter associated UTI

Performance Measures

Required	Potential Indicators	
§ 485.641(b)(4) Use objective measures to evaluate organizational processes, functions and services **Pretty Broad…… Think High Risk, High Volume, Problem Prone**	• Restraint events including time in restraints • Seclusion events including time in seclusion • Restraint / Seclusion documentation per policy	• Fall Prevention Assessment • Fall Prevention Interventions implemented • Pain assessment / reassessment • **Outcome indicators for each service line……..**
§ 485.641(b)(5) Negative health outcomes Adverse Events Reportable Events	• Adverse events • Restraint death (reportable) • Unexpected death • Unexpected cardiac/respiratory arrest • Falls with injury	• Adverse drug reactions with harm • Instances of workplace violence • Abuse, neglect, exploitation, misappropriation of property (Swing Bed)
§ 485.635(3)(iv) Medication Errors & ADRs	• Medication Errors with harm • Adverse rug reactions with harm	

Performance Measures

Required	Potential Indicators
485.618 (e)(2)(iv) **Safe Obstetrical Care – ED** Identify staff training needs and any additions, revisions, or updates to training topics on an ongoing basis	• Percent staff completion of training for OB emergencies • Audit of all OB emergencies in the ED and if protocols were followed
§ 485.649 (b) **Obstetrical Care - OB** Performance measures to identify protocols for obstetrical emergencies, complications, immediate post-delivery care, and other patient health and safety events as identified	• Percent staff completion of training modules • Completion of OB protocols approved by OB Committee or MEC • Audit of all OB emergencies to determine if protocols were followed • Compliance with post-partum hemorrhage protocol • Time from identified need for a C-Section (emergency) to C-Section started

Performance Measures

Required	Required
§ 485.641 by 1/1/2027 Safe Obstetrical Care The CAH's QAPI program must: assess and improve health outcomes and disparities among obstetrical patients on an ongoing basis .	At a minimum, the CAH must: (i)Analyze data and quality indicators collected for the QAPI program by diverse subpopulations as identified by the CAH among obstetrical patients. (ii) Measure, analyze, and track health equity data, measures, and quality indicators on patient outcomes and disparities in processes of care, services and operations, and outcomes among obstetrical patients (iii) Analyze and prioritize identified patient health outcomes and disparities, develop and implement actions to improve patient health outcomes and disparities, measure results, and track performance to ensure improvements are sustained when disparities exist among obstetrical patients. (iv) Conduct at least one measurable performance improvement project focused on improving health outcomes and disparities among the CAH's population(s) of obstetrical patients annually.

Priorities

§ 485.641

(d) The CAH must

(3) Set priorities for performance improvement, considering either high volume, high-risk services, or problem-prone areas

Organizational Priority	***Problem Prone** **Potential of non-compliance** **Weight 4**	***High Volume** **% of Patients Impacted** **Weight: 4**	***High-Risk** **Potential Harm** **Weight 4**	**State, Federal or Accreditation Requirement** **Weight 4**	**Community Priority (i.e., CHNA)** **Weight 3**
Patient Satisfaction					
Post Partum Hemorrhage					
Swing Bed (Documentation)					
STEMI					
Sepsis					

Infection Prevention & Antibiotic Stewardship -- Collaboration with QAPI

C-1150 §485.639(e): Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in **coordination with the facility-wide quality assessment and performance improvement (QAPI) program.**

C-1150 §485.640: Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in coordination with the **facility-wide quality assessment and performance improvement (QAPI) program.**

C-1229 §485.640(c)(1)(ii) All HAIs and other infectious diseases identified by the infection prevention and control program as well as antibiotic use issues identified by the antibiotic stewardship program are addressed in **collaboration with the CAH's QAPI leadership.**

C-1237 §485.640(c)(2) The infection prevention and control professional(s) is responsible for:
(iii) Communication and collaboration with the CAH's QAPI program on infection prevention and control issues.

C-1242 §485.640(c)(2) The infection prevention and control professional(s) is responsible for:
(vi) Communication and collaboration with the antibiotic stewardship program.

C-1248 §485.640(c)(3) The leader(s) of the antibiotic stewardship program is responsible for:
(iii) Communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as the CAH's infection prevention and control and QAPI programs, on antibiotic use issues.

Nursing

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Advance Directives Survey Focus

Advance Directives

§ 485.614 (b)(3)
The patient has the right to formulate advance directives and to have hospital staff and practitioners who provide care in the hospital comply with these directives, in accordance with §§ 489.100, 489.102, and 489.104 of this chapter

§ 489.100 Definition.
For purposes of this part, *advance directive* means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Advance Directives

§ 489.1002 *(not all text included)*
Hospitals, critical access hospitals, ... must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care, ...and are required to:

- Maintain written policies and procedures concerning advance directives
- Provide written information to such individuals concerning an individual's rights under State law (whether statutory or recognized by the courts of the State) to make decisions concerning such medical care
- The written policies of the provider or organization respecting the implementation of such rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience.
- **Document in a prominent part of the individual's current medical record, whether or not the individual has executed an advance directive**
- Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
- Provide for staff and community education

Advance Directives

Many times the nurse is responsible for asking patients if they have an Advance Directive

IF the patient HAS an Advance Directive

1) If the patient has an advance directive, ensure that there is a copy in the medical record and displayed in a prominent place
2) If the patient or family says "*we will bring it in*" --- make sure there is follow-up and documentation that the family was reminded if necessary

IF the patient DOES NOT have an Advance Directive

1) Ask the patient if they would like information about executing an advance directive
2) If they say yes, provide information
3) If they say no, document that the patient said "no"

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Nursing Assessment

Admission Assessment

Each EMR has different elements of an admission assessment. Elements usually include:

1) History of prior illnesses, chronic conditions, etc. (some facilities include this in the nursing assessment)

2) Physical Assessment
   - Systems Review
   - Vital signs
   - Pain
   - Allergies
   - Medications (medications)
   - Psychosocial
   - Nutrition
   - Depression / Suicidal Ideation
   - Social Determinants of health (per hospital policy)

3) Risk / Safety assessments
   - Skin (Braden)
   - Falls
   - Nutrition

4) Preferred learning style (verbal, oral, writing)

5) Support system/family

6) Advance Directives

Follow-Up Assessments

For any risk/safety concerns there must be documented follow-up:

1) **Nutrition Risk:** Request a dietitian assessment. Follow dietitian recommendations.
Ensure that the nutrition risk assessment that is being used by nursing is approved by the dietitian

1) **Fall Risk**: Implement fall risk reduction per policy, and document that interventions are implemented

2) **Risk of Skin Breakdown (Braden):** Implement strategies to prevent skin breakdown or prevent further skin breakdown, and document that interventions are implemented

3) **Depression / Suicide Risk:** Social work or provider assessment. (If immediate danger implement safety precautions

4) **Wound Care / Wound Staging**

5) **ETC……**

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Nursing Care Plans

Survey Focus Area

Nursing Care Plans

§485.635(d)(4)
A nursing care plan must be developed and kept current for each inpatient.

Interpretive Guidelines §485.635(d)(4)

The nursing care plan is kept current by ongoing assessments of the patient's needs and of the patient's response to interventions, and updating or revising the patient's nursing care plan in response to assessments.

The nursing care plan is part of the patient's clinical record and must comply with the clinical records requirements at §485.638.

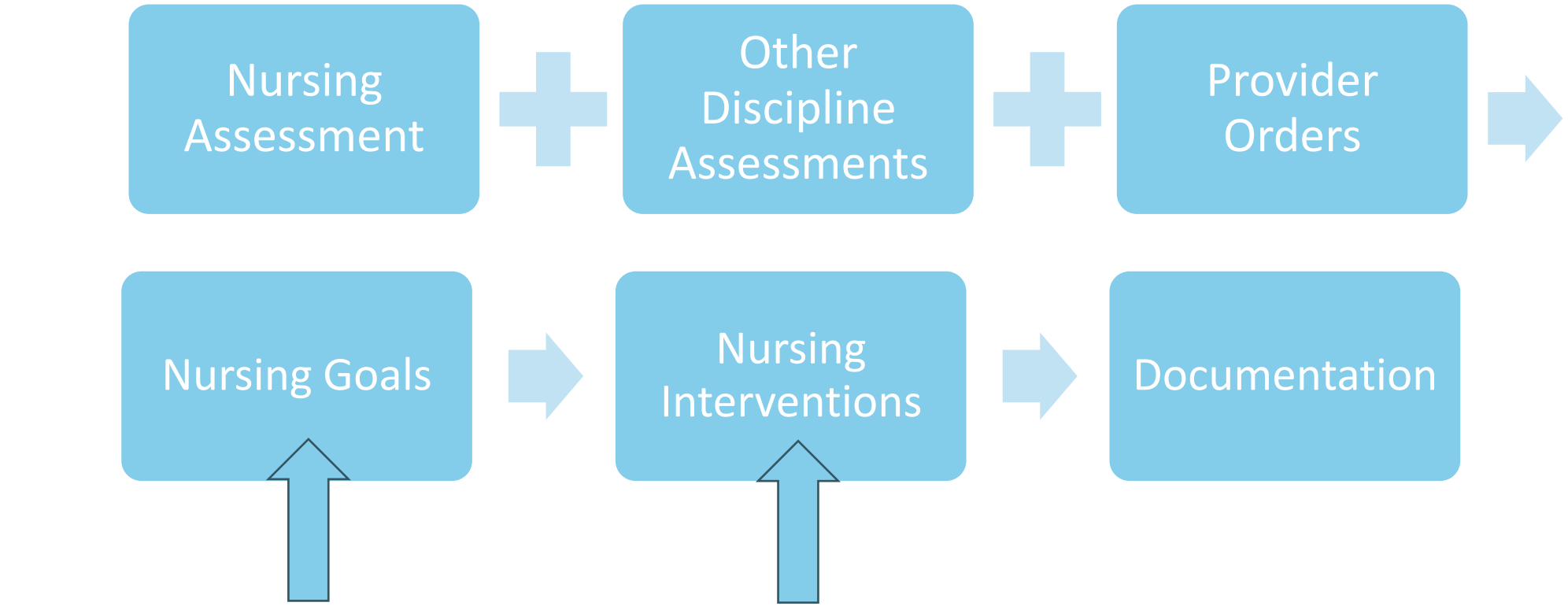
Care Plans: What Goes Wrong (or) Right

Most EMRs have a standardized care plan template for nurses to choose from for nurses to use

Saves time
Relatively Easy

However,… Many times the care plan **does not** reflect patient needs or interventions – patients are not the same. Care plans **MUST be individualized**!

Care Plan Process



Select Goals and Interventions Appropriate for the Patient Care Plan MUST be Individualized

Pain Management

Survey Focus Area

Pain Management Policy

C-1006 §485.635(a) Standard: Patient Care Policies

(1) The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

You will be held accountable to your policy including methods of assessing pain, frequency of assessing pain, and documentation before and after pain medication is administered

Infant and Pediatric Pain Scales (Have a Policy Even if Only Used in the ED)

1. **Neonatal Infant Pain Scale (NIPS)**

Less than 12 months)

2. **CRIES Pain Scale**

Infant younger than six months

3. **Faces Legs Activity Cry Consolability Revised Scale (FLACC-R)**

Older than one year but can't report pain

4. **Faces Pain Scale Revised (FPS-R)**

Older children that can not use numbers

5. **Numeric Rating Scale (NRS) 0-10**

Older children

Type of pain scale MUST be appropriate to the patient

Other Pain Scales (As Appropriate for Your Population)

1. **Numbers 1 – 10**
   - 0 no pain
   - 1 to 3 mild pain
   - 4 to 6 moderate pain
   - 7 to 10 severe pain

2. **Defense and Veterans Pain Rating Scale**
https://www.va.gov/WHOLEHEALTHLIBRARY/docs/Defense-and-Veterans-Pain-Rating-Scale.pdf

3. **Critical-Care Pain Observation Tool (CPOT)**

4. **COMFORT Pain Scale**

For patients who can't describe or rate pain

- Children
- Adults with cognitive impairments
- Adults who are temporarily impaired by medication or illness
- People who are sedated in intensive care or surgery

5. **Pain Assessment in Advanced Dementia (PAINAD) Scale**

Pain Medications Orders

Provider Order Must Be Specific

- Hydrocodone 5 mg. p.o. prn every four (4) hours for pain of 5-7
- Hydrocodone 10 mg. p.o. prn every four (4) hours for pain of 8 – 10

✓ If patient requests pain medication for pain scale of 2 AND there isn't an order, the provider must be notified

✓ If the patient reports their pain as a 6, but requests 10 mg. (higher dose than ordered), it cannot be administered. The provider must be notified for a new order.

IF the order is not specific it must be clarified prior to administration of the pain medication

Hydrocodone 5 mg. p.o. prn for pain
- No pain scale
- No frequency

Do not accept dual range pain orders

Give hydrocodone 5 – 10 mg. every 4 – 6 hours for pain

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Drug Titration

Survey Focus Area

Drug Titration

§**485.635(d)(3)**

All drugs, biologicals, and intravenous medications must be administered by or under the supervision of a registered nurse, a doctor of medicine or osteopathy, or, where permitted by State law, a physician assistant, in accordance with written and signed orders, accepted standards of practice, and Federal and State laws.

Titration allows the adjustment of medications in a patient with a rapidly changing clinical status.

- Analgesics
- Antihypertensives
- Neuromuscular blockers
- Vasoactive Medications
- Oxygen (**Yes oxygen is considered a medication!)**

Provider Orders Must be Followed

Titration MUST be implemented and documented as required by the provider order

The nurse cannot use "*judgement*" to titrate the drug

Documentation MUST follow provider order including frequency of titration

- Start at 1 mcg/min
- May increase/decrease rate by minimum of 1 mcg/min
- Increase or decrease at intervals of not less than every 15 minutes
- Goal BP greater than ___or MAP greater than ___
- Notify provider if BP greater than ___ or lower than ___

Oxygen Too!

Oxygen per Nasal Cannula at 1 – 6 l/min. to maintain O2 saturation between 88-92%

Check vital signs and SpO2 q4h

Notify provider if oxygen saturation less than 88% on 6 L of oxygen

Oxygen cannot be increased or decreased except specified in the order

An order for "Use Oxygen Protocol" is not acceptable unless there really is an oxygen protocol that has been approved by the medical staff

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Emergency Department

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EMTALA

EMTALA Signage

§489.20(q) (1) To post conspicuously in any emergency department or in a place or places likely to be noticed by all individuals entering the emergency department, as well as those individuals waiting for examination and treatment in areas other than traditional emergency department (that is, entrance, admitting area, waiting room, treatment area)

Recommended But Not Required (YET)

Updated Model Signage for the Emergency Medical Treatment and Labor Act (EMTALA)

QSO-24-17-EMTALA 2024-08-13

https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/policy-memos-states-and-cms-locations/updated-model-signage-emergency-medical-treatment-and-labor-act-emtala

EMTALA Policy

VERY IMPORTANT to ensure your EMTALA policy is current, including a provision for infant-born alive

ALL staff and providers **MUST** be knowledgeable about EMTALA regulations – and – penalties if regulations are not met

State Operations Manual Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases (Rev. 191, 07-19-19)
https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_v_emerg.pdf

Center for Clinical Standards and Quality Ref: QSO-24-02-Hospitals/CAHs/REH/EMTALA DATE: December 08, 2023: Surge Capacity
https://www.cms.gov/files/document/qso-24-02-hospitals-cahs-reh-emtala.pdf

Caution – Aggressive / Combative Patients

Holy Cross Hospital Agreed to Pay $85,000 for Allegedly Violating Patient Dumping Statute by Failing to Provide an Appropriate Medical Screening Examination

On October 5, 2023, Holy Cross Hospital (Holy Cross), Chicago, Illinois, entered into a $85,000 settlement agreement with OIG. The settlement agreement resolves allegations that, based on OIG's investigation, Holy Cross violated the Emergency Medical Treatment and Labor Act (EMTALA) when it failed to provide an appropriate medical screening examination to patient M.N. on October 16, 2022. **Specifically, Holy Cross failed to register M.N. upon arrival to the triage area in the emergency department (ED) accompanied by paramedics and, when M.N. began exhibiting aggressive behaviors, security officers escorted M.N. out of the emergency department and prevented M.N.'s re-entry.** Nursing staff spoke to M.N. while M.N. was outside the ED but the ED physician was not alerted of M.N.'s arrival and no assessment of M.N. was performed by ED personnel prior to law enforcement personnel removing M.N. from the premises. M.N. was brought back to the Holy Cross ED approximately five hours later on October 16, 2022, after suffering cardiac arrest at M.N.'s home. Efforts to resuscitate M.N. were unsuccessful and M.N. expired. Deputy Branch Chief Nicole Caucci represented OIG.

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Obstetric Emergencies

Protocols for OB Emergencies 7/1/2025

§ 485.618 (e)
Standard: Emergency services readiness. Effective July 1, 2025, in accordance with the complexity and scope of services offered, there must be adequate provisions (as required under paragraphs (b) and (c) of this section) and protocols to meet the emergency needs of patients. (

1) Protocols. Protocols must be consistent with nationally recognized and evidence-based guidelines for the care of patients with emergency conditions, **including but not limited to patients with obstetrical emergencies, complications, and immediate post-delivery care.**

Training for OB Emergencies 7/1/2025

§ 485.618 (e)
Standard: Emergency services readiness. Effective July 1, 2025, in accordance with the complexity and scope of services offered, there must be adequate provisions (as required under paragraphs (b) and (c) of this section) and protocols to meet the emergency needs of patients. (

(2) Staff training. Applicable staff, as identified by the CAH, must be trained annually on the protocols and provisions implemented pursuant to this section.

(i)The governing body must identify and document which staff must complete such training.

(ii) The CAH must document in the staff personnel records that the training was successfully completed.

(iii) The CAH must be able to demonstrate staff knowledge on such training.

QAPI 7/1/2025

§ 485.618 (e)
Standard: Emergency services readiness. Effective July 1, 2025, in accordance with the complexity and scope of services offered, there must be adequate provisions (as required under paragraphs (b) and (c) of this section) and protocols to meet the emergency needs of patients.

(2) Staff training. Applicable staff, as identified by the CAH, must be trained annually on the protocols and provisions implemented pursuant to this section.

(iv) The CAH must use findings from its QAPI program, as required at § 485.641, to inform staff training needs and any additions, revisions, or updates to training topics on an ongoing basis

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Nursing Care in the ED

Assessment: Vital Signs

Most EDs have a policy for frequency of vital signs

Frequency of vital signs is often based on the triage level

SOMETIMES ---- vital signs may not be taken at the frequency required in the ED policy – or not all elements of vital signs are taken (i.e. BP and pulse, but not oxygen saturation)

Most hospitals also have a policy for when vital signs need to be taken prior to discharge (i.e., vital signs within 30 mins – 1 hour of discharge)

Vital Signs by ESI Level - Example

- ESI Level 1: Every 5-15 minutes as needed and no less frequently than every hour for the first four hours, then every 2 hours if clinically stable
- ESI Level 2: Vital signs no less frequently than every hour for the first four hours, then every 2 hours if clinically stable
- ESI Level 3: Vital signs no less frequently than every two hours for the first four hours, then every four hours if clinically stable
- ESI Level 4: Vital signs per acuity and clinical assessment, but no less than every four hours
- ESI Level 5: Vital signs per acuity and clinical assessment, but no less than every four hours

You may have a different policy

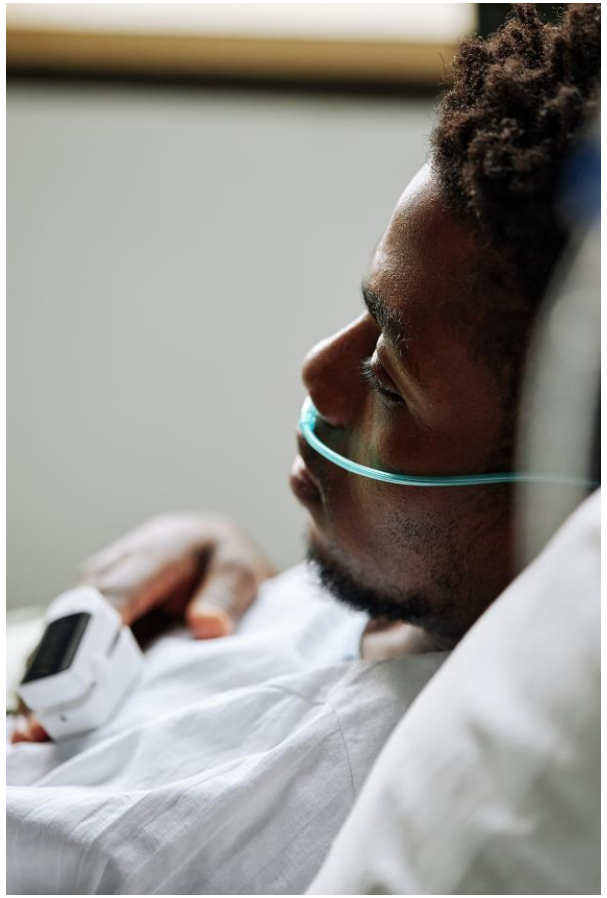
Long Stay Patients

For long-stay patients – (usually because you are not able to transfer or there is not an inpatient bed)

You must follow your ED policy for frequency of assessments

or

Have a separate policy for long-stay patients



Discharge

1. If you use pre-printed discharge instructions, review at least every two years in conjunction with providers to ensure that discharge instructions are:
    - Available in the most common languages in your community
    - Sixth-grade reading level
    - Includes the most frequent diagnosis for your patient population

2. If providers frequently add individualized discharge instructions, consider developing additional pre-printed instructions or instructions that can be filled in as needed (i.e., frequency of Tylenol)

3. Don’t provide instructions that don’t apply to why the patient was in the ED

Transfer

1. The individual (or person acting on his or her behalf) after being **informed of the risks** and the hospital's obligations requests a transfer

2. **A physician has signed the certification that the benefits of the transfer of the patient to another facility outweigh the risks**

3. **Provide treatment** to minimize the risks of transfer

4. **Send all pertinent records to the receiving hospital**

5. **Obtain the consent of the receiving hospital to accept the transfer**

6. Ensure that the **transfer** of an unstabilized individual is effected through **qualified personnel and transportation equipment**, including the use of medically appropriate life support measures;

State Operations Manual Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases

Obstetrics

HealthTech

Safe OB Care
Effective January 1, 2026

Safe OB Care 1/1/2026

§ 485.649

Obstetrical services. If the CAH offers obstetrical services, the services must **be well organized and provided in accordance with nationally recognized acceptable standards of practice** for the health care (including physical and behavioral health) of pregnant, birthing, postpartum patients.

If **outpatient obstetrical services** are offered, the services must be **consistent in quality with inpatient care** in accordance with the complexity of services offered

Safe OB Care 1/1/2026

§ 485.649(a) Standard: Organization and staffing.

Effective January 1, 2026, the organization of the obstetrical services must be appropriate to the scope of the services offered. As applicable, the services must be integrated with other departments of the CAH.

(1) Labor and delivery rooms/suites (including labor rooms, delivery rooms (including rooms for operative delivery), and post-partum/recovery rooms whether combined or separate) must be **supervised by an experienced** registered nurse, certified nurse midwife, nurse practitioner, physician assistant, or a Doctor of Medicine or a Doctor of Osteopathy (MD/DO).

(2) **Obstetrical privileges must be delineated** for all practitioners providing obstetrical care in accordance with the competencies of each practitioner, and consistent with credentialing agreements established under § 485.616(b).

Safe OB Care 1/1/2026

§ 485.649(b) Standard: Delivery of service

Effective January 1, 2026, obstetrical services must be consistent with needs and resources of the CAH. Policies governing obstetrical care must be designed to assure the achievement and maintenance of high standards of medical practice and patient care and safety.

(1) The **following equipment must be kept at the CAH and be readily available** for treating obstetrical cases to meet the needs of patients in accordance with the scope, volume, and complexity of services offered: call-in-system, cardiac monitor, and fetal doppler or monitor.

(2) **There must be adequate provisions and protocols, consistent with nationally recognized and evidence-based guidelines, for obstetrical emergencies, complications, immediate post-delivery care, and other patient health and safety events as identified as part of the QAPI program** (§ 485.641). Provisions include equipment (in addition to the equipment required under paragraph (b)(1) of this section), supplies, and medication used in treating emergency cases. Such provisions must be kept in the CAH and be readily available for treating emergency cases.

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Safe OB Care
Effective January 1, 2027

Safe OB Care 1/1/2027

§485.649(c) Standard: Staff training.

Effective January 1, 2027, the CAH must develop policies and procedures to ensure that relevant staff are trained on select topics for improving the delivery of maternal care.

(1) Training concepts must reflect the scope and complexity of services offered within the facility, including but not limited to:

(i) facility-identified **evidence-based best practices and protocols** to improve the delivery of maternal care within the facility; and

(ii) The CAH must use **findings from its quality assessment and performance improvement** (QAPI) program, as required at § 485.641, **to inform staff training needs** and any additions, revisions, or updates to training topics on an ongoing basis.

Safe OB Care 1/1/2027

§485.649(c) Standard: Staff training.

(2) The CAH must provide relevant new staff with initial training.

(3) The **governing body must identify and document which staff must complete initial training and subsequent biennial training** on the topics identified at paragraph (c)(1) of this section.

(4) The CAH must **document in the staff personnel records t**hat the training was successfully completed. (5) The CAH must be able to demonstrate staff knowledge on the topics identified at paragraph (c)(1) of this section

(5) The CAH must be able to **demonstrate staff knowledge** on the topics identified at paragraph (c)(1) of this section.

Safe OB Care 1/1/2027

§ 485.641(d) Program activities

(4) Effective January 1, 2027, for CAHs that offer obstetrical services, the following additional QAPI requirements apply:

(i) Obstetrical services leadership must engage in **QAPI as specified in this section for obstetrical services, including but not limited to participating in data collection and monitoring** as specified in this paragraph (d) and paragraph (e) of this section.

(ii) If a maternal mortality review committee (MMRC) is available at the State, Tribal, or local jurisdiction in which the CAH is located, the facility leadership, obstetrical services leadership, or their designate(s) must further have a process for incorporating publicly available MMRC(s) data and recommendations into the CAH QAPI program as specified in this section

Safe OB Care 1/1/2027

§ 485.641(e) Program data collection and analysis.

(1) The program must **incorporate quality indicator data** including patient care data, in order to achieve the goals of the QAPI program.

(2) Effective January 1, 2027, CAHs that offer obstetrical services, the CAH must **utilize its QAPI program to assess and improve health outcomes and disparities among obstetrical patients on an ongoing basis.**

Safe OB Care 1/1/2027

§ 485.641(e) Program data collection and analysis.

(2) At a minimum, the CAH must:

(i) Analyze data and quality indicators collected for the QAPI program by diverse subpopulations as identified by the CAH among obstetrical patients.

(ii) Measure, analyze, and track health equity data, measures, and quality indicators on patient outcomes and disparities in processes of care, services and operations, and outcomes among obstetrical patients.

(iii) Analyze and prioritize identified patient health outcomes and disparities, develop and implement actions to improve patient health outcomes and disparities, measure results, and track performance to ensure improvements are sustained when disparities exist among obstetrical patients.

(iv) Conduct at least one measurable performance improvement project focused on improving health outcomes and disparities among the CAH's population(s) of obstetrical patients annually

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Assessment & Plan of Care

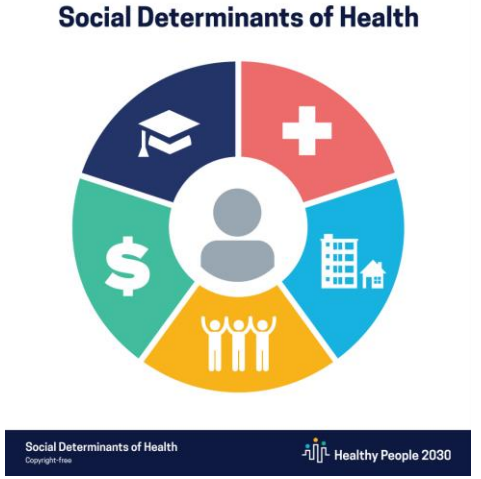
Assessment
Identify Social Determinants of Health

Social Determinants of Health

1) Economic Stability
2) Education Access and Quality
3) HealthCare Access and Quality
4) Neighborhood and Built Environment
5) Social and Community Context

Examples

- Safe housing, transportation, and neighborhoods
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Discrimination and violence
- Polluted air and water
- Language and literacy skills



Assessment
Identify High-Risk Patients

In addition to routine assessment, assess for high-risk factors

1) Extremes of Age
2) More than 4 pregnancies
3) Minimal weight gain during pregnancy
4) Previous premature deliveries
5) Previous birth to a large infant
6) Poverty
7) Limited education
8) Single – no support systems
9) Unplanned pregnancy
10) Minimal or no antenatal care
11) History of drug use/cigarette use
12) Other social determinants of health

Nursing Care Plans

§485.635(d)(4)
A nursing care plan must be developed and kept current for each inpatient.

Interpretive Guidelines §485.635(d)(4)

The nursing care plan is kept current by ongoing assessments of the patient's needs and of the patient's response to interventions, and updating or revising the patient's nursing care plan in response to assessments.

The nursing care plan is part of the patient's clinical record and must comply with the clinical records requirements at §485.638.

HealthTech

Surgical Services

Surgical Policies and Procedures

§**485.639 Interpretive Guidelines**

- ❑ 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
- ❑ 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
- ❑ 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

Medical Record Documentation

IP and OP Surgical Procedure

- Consent dated and signed
- Pre-anesthesia assessment including ASA class
- Surgeon H&P within 30 days
- Surgeon H&P update day of the procedure
- Nursing admission assessment
- Site marked prior to procedure if laterality by physician
- Time-out before procedure, including confirmation of laterality if appropriate
- PACU documentation at the frequency required in policy
- Physician or anesthesia order for discharge from PACU
- If discharged home, the patient meets the criteria per policy

Endoscopy

- Consent dated and signed
- Pre-anesthesia assessment, including ASA class completed by the physician performing endoscopy if NO anesthesia provider is available
- Surgeon H&P within 30 days
- Surgeon H&P update day of the procedure
- Nursing admission assessment
- Time-out before procedure
- Number of scope documented in medical record
- PACU documentation at the frequency required in policy
- Physician or anesthesia order for discharge from PACU
- If discharged home, the patient meets the criteria per policy

Informed Consent

§485.639 Interpretive Guidelines

A properly executed informed 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 procedure(s) or important aspects of the procedure(s), as well as the name(s) and specific significant surgical tasks that will be conducted by practitioners other than the primary surgeon/practitioner. (Significant surgical tasks include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues)
- Signature of patient or legal guardian
- 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

Informed Consent, cont.

§485.639 Interpretive Guidelines

The responsible practitioner must provide as much **information about treatment options** as is necessary based on a patient's personal understanding of the practitioner's explanation of the risks of treatment and the probable consequences of the treatment. Informed consent means the patient or patient representative is **given (in a language or means of communication he/she understands)** the information needed in order to consent to a procedure or treatment.

An informed consent would include at least:

- an explanation of the nature and purpose of the proposed procedures,
- risks and consequences of the procedures,
- risks and prognosis if no treatment is rendered,
- the probability that the proposed procedure will be successful,
- and alternative methods of treatment (if any) and their associated risks and benefits.

Universal Protocol
Time Out & Site Marking

§485.639 Surgical Services.
Interpretive Guidelines §485.639
Surgical services that are performed in a safe manner would be performed in accordance with acceptable standards of practice. In accordance with acceptable standards of practice includes maintaining compliance with applicable Federal and State laws, regulations and guidelines governing surgical services or surgical service locations, as well as, any standards and recommendations promoted by or established by nationally recognized professional organizations (e.g., the American Medical Association, American College of Surgeons, Association of periOperative Registered Nurses, Association for Professionals in Infection Control and Epidemiology, etc.)

Who Can Mark the Site

LIP

Where and When Should the Site Be Marked?

At or near procedure site

What about the Marker?

Use those that do not promote bacterial growth

Which Procedures Require It?

More than one possible location

Get the Patient's Attention

Involve the patient

Post-Op Recovery

§**485.639 Interpretive Guidelines**

Adequate provisions for immediate post-operative care means:

- Post operative care must be in accordance with acceptable standards of practice
- The post-operative care area or recovery room is a separate area of the CAH. Access is limited to authorized personnel
- **Policies and procedures specify transfer requirements to and from the recovery room**

- Depending on the type of anesthesia and length of surgery, the post- operative assessment before transferring the patient from the recovery room should include the following:
  - Level of activity, Respirations, Blood Pressure, Level of Consciousness, Patient Color

- If the patients are not transferred to the recovery room, determine that provisions are made for close observation until they have regained consciousness, e.g., **direct observation** by an RN in the patient's room.

Malignant Hyperthermia (MH)

§485.618(b)
Equipment, Supplies, and Medication Equipment, supplies, and medication used in treating emergency cases are kept at the CAH and are readily available for treating emergency cases. The items available must include the following:

(1) Drugs and biologicals commonly used in life-saving procedures, including analgesics, local anesthetics, antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids, antiarrythmics, cardiac glycosides, antihypertensives, diuretics, and electrolytes and replacement solutions

(2) Equipment and supplies commonly used in life-saving procedures, including airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, chest tubes, and indwelling urinary catheters

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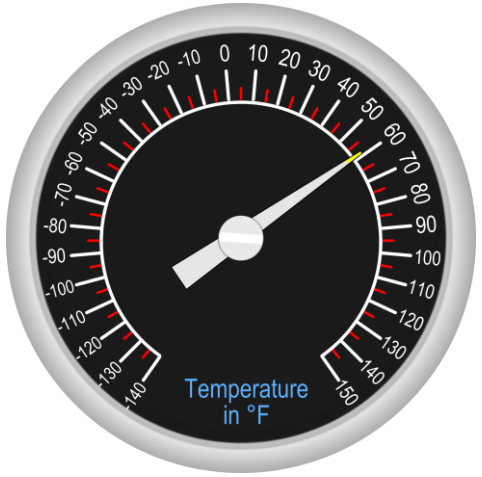
Temperature in Surgical Suites

§**485.623(b)(5)**
There is proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas.
AORN 68 – 75 degrees
APIC 68 – 75 degrees
CDC 68 – 73 degrees



TJC Standards FAQ
The Joint Commission references NFPA 99-2012 Chapter 9, that requires the use of ASHRAE 170-2008, Ventilation Table 7-1. This document provides allowances to exceed minimum temperature ranges.

To use this exception, it must be done by following the established organizational policy.

In accordance with the allowances, the policy or formal process must be limited to cases based on either surgeon, patient, or procedure. It is not acceptable to consistently maintain temperatures outside of the required ranges.

Humidity in Surgical Suites

§485.623(b)(5)
There is proper ventilation, lighting, and temperature control in all pharmaceutical, patient care, and food preparation areas. *(2000 edition of NFPA 101: Life Safety Code®. That edition references the 1999 edition of NFPA 99: Health Care Facilities Code, which requires operating room humidity to be at least 35 percent.)*

Center for Clinical Standards and Quality /Survey & Certification Group Ref: S&C: 13-25-LSC & ASC
The Centers for Medicare & Medicaid Services (CMS) is issuing a categorical LSC waiver permitting new and existing ventilation systems supplying hospital and critical access hospital (CAH) anesthetizing locations to operate with a RH of **≥20 percent, instead of ≥35 percent**. We are also recommending that RH not exceed 60 percent in these locations.

This Waiver Does Not Apply
- When more stringent RH control levels are required by State or local laws and regulations; or
- Where reduction in RH would negatively affect ventilation system performance

Hospitals & CAHs Must Elect to Use the Categorical Waiver
- Individual waiver applications are not required, but facilities are expected to have written documentation that they have elected to use the waiver

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-25.pdf

However.....

- Relative humidity can affect the shelf life and product integrity of some sterile supplies. Some products, such as EKG electrodes used for patient monitoring, are especially sensitive to humidity
- Some electro-medical equipment, particularly older model equipment, may be affected by electrostatic discharge commonly occurring at low humidity levels
- FUs from the manufacturer should be followed
- Supplies and equipment have manufacturer's instructions for use (IFUs) that explain any required environmental parameters, which may or may not include relative humidity requirements
- Health care facilities should consider the effects on equipment and/or supplies before reducing operating room relative humidity below 30 percent
- Many supplies can be used outside of the minimum humidity requirements but should not be stored for long periods in low-humidity conditions

American Society for Healthcare Engineering (ASHE) and the Association for Healthcare Resource & Materials Management (AHRMM

Reprocessing Semi-Critical and Critical Equipment, Instruments & Devices

1. Sterile processing
    - Biological indicator, intended specifically for the type and cycle parameters of the sterilizer, used at least weekly for each sterilizer and with every load containing implantable items.
    - For dynamic air removal-type sterilizers (e.g., prevacuum steam sterilizer), air removal test (Bowie-Dick test) performed in an empty dynamic-air removal sterilizer each day the sterilizer is used.
    - Sterile packs labeled with a load number that indicates the sterilizer used, the cycle or load number, the date of sterilization, and, if applicable, the expiration date.
    - Sterilization logs current and complete (include results from each load).

2. Immediate-use steam sterilization
    - Only done in circumstances in which routine sterilization procedures cannot be performed.
    - Immediate use log reviewed at Infection Control or QAPI quarterly
    - Corrective actions taken to limit immediate use sterilization
    - Instruments that undergo immediate-use steam sterilization used immediately and not stored

Reprocessing Semi-Critical and Critical Equipment, Instruments & Devices

3. NO reprocessing of disposable instruments including those made in Pakistan
4. Hinged instruments have spreaders – processed in open position
5. Devices stored in a manner to protect from damage or contamination
6. Plumbed eye wash in areas where high-level disinfection performed or cleaning instruments

Storing Endoscopes

The 2021 AAMI standard recommends two types of cabinets for storing flexible endoscopes after they have undergone high-level disinfection or liquid chemical sterilization.

Each circulates HEPA-filtered or instrument air through the cabinet at continuous positive pressure.

One type is referred to as “conventional cabinets,” because they don’t include a method of circulating forced air through the long, narrow channels of the scopes.

“Drying cabinets,” meanwhile, have that feature, which attaches a forced-air delivery system onto each endoscopic channel

Outpatient Surgery, A Division of AORN Flexible Endoscope Storage Solutions
https://www.aorn.org/outpatient-surgery/article/flexible-endoscope-storage-solutions

Restraints Survey Focus

Patient Rights

§ 485.614 Patient's rights

(e) Standard: Restraint or seclusion.

All patients have the right to be free from physical or mental abuse, and corporal punishment.

All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.

Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

§ 485.614(e)

(1) (i) A restraint is—

(A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move their arms, legs, body, or head freely

Policies and Procedures

§ 485.614(e)
(4) The CAH must have **written policies and procedures** regarding the use of restraint and seclusion that are consistent with **current standards of practice**

You are held accountable to your policy!

Most CAHs who are not surveyed by a deemed status organization (i.e., ACHC, CIHQ, DNV, TJC) use the standards for hospitals in Appendix A

Policy and Procedure Elements

1) Definitions of types of restraints including chemical restraints and seclusion
2) Alternatives to restraints
3) Restraints used only when less restrictive methods have been used and are ineffective
4) Type of restraints that are authorized for use in the organization
5) Type of restraint based on a patient assessment
6) Clinical justification
7) Plan of care for restraints
6) Content of restraint order
7) Assessment and monitoring by providers and clinical staff
8) Frequency of documentation by providers and clinical staff
9) Discontinued as soon as there is no further clinical justification
10) Restraint use reviewed (ideally concurrently)
11) Staff and Provider training
12) Forensic restraints

Restraint for Non-Violent or Non-Self-Destructive Behavior

Generally used in the acute care patient population

Primary reason for use is to support medical healing when patient pulling out IV lines or tubes

Not a restraint
A restraint does NOT include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical exams or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities with the risk of physical harm (not a physical escort)

Restraint for Violent or Self-Destructive Behavior

Violent or self-destructive behavior includes.....

danger to self or
danger to others

that poses an imminent danger to the physical safety of the patient, staff, or others, regardless of patient location

CMS no longer uses the term “behavioral restraint”

A patient, regardless of mental health history or diagnosis, may require a restraint for violent or self-destructive behavior

Chemical Restraint: Almost always used for violent / self-destructive behavior

§ 485.614(e)
(1) (i) A restraint is—
(B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

NOT A Chemical Restraint
Therapeutic doses of psychotropic medications for patients who are suffering from serious mental illness to improve their level of functioning so that they can participate in their treatment. (i.e. Haldol)

1. Therapeutic doses of anti-anxiety medication
2. Appropriate doses of sleeping medication for insomnia. (i.e. benzodiazepines)
3. Appropriate doses of analgesic medications ordered for pain management. (i.e. narcotics)

Reasons for Chemical Restraint

1) Attempted Self-Harm
2) Violent posturing
3) Destruction of Property
4) Violence towards staff or others
5) Threats of violence towards staff or others

Seclusion

Involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.

Seclusion may only be used for the management of violent or self-destructive behavior.

Forensic Restraint

Typically, a patient in handcuffs or a patient that is prevented from leaving – and – is under the control / observation of law enforcement is NOT considered a restraint

However, if you are using law enforcement as observer / sitter then it is a restraint (patient not in law enforcement custody

Preventing Patient From Leaving

IF the patient would be prohibited from leaving the organization --- then it is considered a RESTRAINT!

HealthTech

Assessment, Orders & Documentation

CAH CoPs

There are no specific requirements regarding restraints in CAH Conditions of Participation – except:

1) Right of patients to be free from restraints
2) Training to include trauma-informed care

§ 485.614

(f) Standard: Restraint or seclusion: **Staff training requirements**. The patient has the right to safe implementation of restraint or seclusion by trained staff .

(1) The CAH must provide **patient-centered, trauma informed competency-based training** and education of CAH personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the CAH, on the use of restraint and seclusion.

(2) The training must include alternatives to the use of restraint/seclusion.

You will be held accountable to your policy

Comprehensive Assessment

Appendix A: §482.13(e)

The decision to use a restraint or seclusion is not driven by diagnosis, but by a comprehensive individual patient assessment.

For a given patient at a particular point in time, this comprehensive individualized patient assessment is used to determine whether the use of less restrictive measures poses a greater risk than the risk of using a restraint or seclusion.

The comprehensive assessment should include a physical assessment to **identify medical problems that may be causing behavior changes in the patient**. For example, temperature elevations, hypoxia, hypoglycemia, electrolyte imbalances, drug interactions, and drug side effects may cause confusion, agitation, and combative behaviors. Addressing these medical issues may eliminate or minimize the need for the use of restraints or seclusion.

CMS 2023 QSO-23-19-Hospitals
https://www.cms.gov/files/document/qso-23-19-hospitals.pdf

Face-to-Face Assessment

Appendix A: §482.13(e)(12)
When restraint or seclusion is used for the management of **violent or self-destructive behavior** that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient **must be seen face-to-face within 1 hour after the initiation of the intervention** –

(i) By a – (A) Physician or other licensed practitioner; or (B) Registered nurse who has been trained in accordance with the requirements specified in paragraph (f) of this section.

Appendix A: §482.13(e)(12)(ii)To evaluate – (A) The patient's immediate situation; (B) The patient's reaction to the intervention; (C) The patient's medical and behavioral condition; and (D) The need to continue or terminate the restraint or seclusion.

Physician Order

Appendix A: §482.13(e)(5)

The use of restraint or seclusion must be in accordance with the order of a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law.

A protocol cannot serve as a substitute for obtaining a physician's or other LP's order prior to initiating each episode of restraint or seclusion use. If a hospital uses protocols that include the use of restraint or seclusion, a specific physician or LP order is still required for each episode of restraint or seclusion use.

Appendix A: 482.13(e)(7)

The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.

Restraint Orders

Appendix A: §482.13(e)

(6) - Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).

Provider Order

- Date and Time
- Alternatives Attempted
- Reason for restraint
- Type of restraint
- Extremities to be restrained
- Duration of restraint - maximum time
- Other safety considerations as appropriate
- Criteria for discontinuing restraint

Restraint Order
Violent or Self-Destructive Behavior

Appendix A: §482.13(e)(8)

Unless superseded by State law that is more restrictive –

(i) Each order for restraint or seclusion used for the management of violent or self destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours

A) 4 hours for adults 18 years of age or older

B) 2 hours for children and adolescents 9 to 17 years of age

C) 1 hour for children under 9 years of age

Appendix A: §482.13(e)(8)(ii)

After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior,

a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law

must see and assess the patient.

Least Restrictive

Appendix A: §482.13(e)

Patient care staff must demonstrate through their documentation in the patient's medical record that the restraint intervention used is the **least restrictive intervention that protects the patient's safety, and that the use of restraint is based on individual assessments of the patient.**

The assessments and documentation of those assessments must be **ongoing** in order to demonstrate a continued need for restraint.

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CMS 2023 QSO-23-19-Hospitals
https://www.cms.gov/files/document/qso-23-19-hospitals.pdf

Discontinue Restraint

Appendix A: §482.13(e)

Staff must assess and monitor a patient's condition on an ongoing basis to ensure that the **patient is released from restraint or seclusion at the earliest possible time.**

Restraint or seclusion may only be employed while the unsafe situation continues.

Once the unsafe situation ends, the use of restraint or seclusion should be discontinued.

However, the decision to discontinue the intervention should be based on the determination that the need for restraint or seclusion is no longer present, or that the patient's needs can be addressed using less restrictive methods.

CMS 2023 QSO-23-19-Hospitals
https://www.cms.gov/files/document/qso-23-19-hospitals.pdf

Reassessment - Restraint for Non-Violent / Non-Self-Destructive Behavior

Every 2 hours

- Mental status
- Neurological and physical assessments and comfort
- Education reinforcement Visualization and repositioning of the patient
- Skin
- Circulation checks
- Toileting / Hydration needs
- ROM to the restrained extremity
- Attempts to release
- Alternatives / medications tried or behavior to justify continued restraint use

Reassessment - Restraint for Violent / Self-Destructive Behavior

Every 15 minutes

- Assessment and documentation of Behavior, Circulation, & Skin Condition

Every 2 hours and PRN

- Toilet and nutrition / fluid needs
- ROM and exercise for 10 minutes every 2 hours
- Evaluation for earliest possible release. Behavior criteria for release may include:
  - Patient's ability to contract for safety
  - Patient oriented to environment
  - Cessation of verbal threats
  - Cessation of violent behavior

Restraint and Seclusion

§482.13(e)(15)

Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored – (i) Face-to-face by an assigned, trained staff member; or (ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.

Appendix W - Staff Training

§ 485.614

(f) Standard: Restraint or seclusion: **Staff training requirements**. The patient has the right to safe implementation of restraint or seclusion by trained staff .

(1) The CAH must provide **patient-centered, trauma informed competency-based training** and education of CAH personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the CAH, on the use of restraint and seclusion.

(2) The training must include alternatives to the use of restraint/seclusion.

Appendix A - Training

Appendix A: §482.13(e)(10)

The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy.

Appendix A: §482.13(e)(11)

Physician and other licensed practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.

Appendix A - Training

Appendix A: §482.13(f)(1) Training Intervals - Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion – (i) (ii) (iii) **Before performing any of the actions specified in this paragraph; As part of orientation; and Subsequently on a periodic basis consistent with hospital policy**

Appendix A: §482.13(f)(2) Training Content. - The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:

(i) Techniques to identify staff and patient behaviors, events, and environmental factor that may trigger circumstances that require the use of a restraint or seclusion.

(ii) The use of nonphysical intervention skills

(iii) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition

Appendix A – Training

(iv) - The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia).

(v) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.

(vi) - Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation.

(vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

Hospitals should also provide the appropriate level of education and training to staff regarding the **identification of patients at risk of harm to themselves or others, the identification of environmental patient safety risk factors, and mitigation strategies.**

Appendix A – Training

Staff would include direct employees, volunteers, contractors, per diem staff, and any other individuals providing clinical care under arrangement.

CMS expects hospitals to provide education and training to all new staff initially upon orientation and whenever policies and procedures change.

Additionally, CMS recommends ongoing training at least **every two years** after initial training

CMS 2023 QSO-23-19-Hospitals
https://www.cms.gov/files/document/qso-23-19-hospitals.pdf

Trainer Requirements

Appendix A: §482.13(f)(3) Trainer Requirements

Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.

Appendix A: §482.13(f)(4) Training Documentation

The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.

Death Reporting

§ 485.614(g) Death reporting requirements

Hospitals must report deaths associated with the use of seclusion or restraint.

(1) With the exception of deaths described under paragraph (g)(2) of this section, the hospital must report the following information to CMS by telephone, facsimile, or electronically, as determined by CMS, no later than the close of business on the next business day following knowledge of the patient's death:

(i) Each death that occurs while a patient is in restraint or seclusion.

(ii) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.

(iii) Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time. “Reasonable to assume” in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation

Death Reporting Exception

§ 485.614(g)

(2) **When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff must record in an internal log or other system, the following information:**

(i) Any death that occurs while a patient is in such restraints.

(ii) Any death that occurs within 24 hours after a patient has been removed from such restraints.

(3) The staff must document in the patient's medical record the date and time the death was:

(i) Reported to CMS for deaths described in paragraph (g)(1) of this section; or

(ii) Recorded in the internal log or other system for deaths described in paragraph (g)(2) of this section.

Documentation

§ 485.614(g)

(3) The staff must document in the patient's medical record the date and time the death was:

(i) Reported to CMS for deaths described in paragraph (g)(1) of this section; or

(ii) Recorded in the internal log or other system for deaths described in paragraph (g)(2) of this section.

Suicide Risk Survey Focus

Environmental Risk

§ 485.623 Physical plant and environment.
(a) Standard: Construction. The CAH is constructed, arranged, and maintained to ensure access to and safety of patients, and provides adequate space for the provision of services.

Appendix A

Although all risks cannot be eliminated, hospitals should be able to demonstrate how they identify patients at risk of self-harm or harm to others and the steps they are taking to minimize those risks in accordance with nationally recognized standards and guidelines.

Ligature Risks

- Handrails, doorknobs, door hinges, shower curtains, exposed plumbing/pipes, soap and paper towel dispensers on walls, power cords on medical equipment or call bell cords, and light fixtures or projections from ceilings, etc.
- Unattended items such as utility or housekeeping carts that contain hazardous items (mops, brooms, cleaning agents, hand sanitizer, etc.)
- Unsafe items brought to patients by visitors
- Windows that can be opened or broken
- Unprotected lighting fixtures
- Staffing levels inadequate for appropriate patient observation and monitoring

Develop mitigation strategies --- If this requires removing items from the room – ensure it is done and documented!

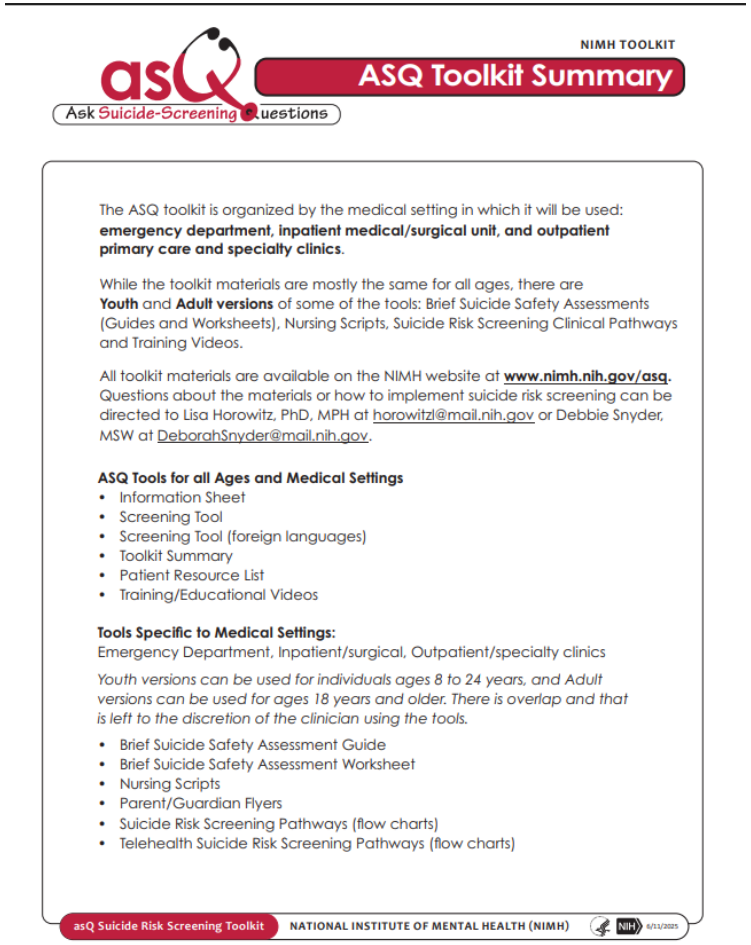
Patient Assessment

There are numerous models and versions of patient screening and assessment tools to identify the risk of harm to self or others.

The type of patient screening or assessment tool used to determine the risk of harm to self or others should be appropriate to the patient population served, care setting, and staff competency.

CMS Center for Clinical Standards and Quality: Ligature Risk and Assessment in Hospitals
https://www.cms.gov/files/document/qso-23-19-hospitals.pdf

ASQ Toolkit



NIMH TOOLKIT

asQ Ask Suicide-Screening Questions

ASQ Toolkit Summary

The ASQ toolkit is organized by the medical setting in which it will be used: **emergency department, inpatient medical/surgical unit, and outpatient primary care and specialty clinics**.

While the toolkit materials are mostly the same for all ages, there are **Youth** and **Adult versions** of some of the tools: Brief Suicide Safety Assessments (Guides and Worksheets), Nursing Scripts, Suicide Risk Screening Clinical Pathways and Training Videos.

All toolkit materials are available on the NIMH website at **www.nimh.nih.gov/asq**. Questions about the materials or how to implement suicide risk screening can be directed to Lisa Horowitz, PhD, MPH at horowitzl@mail.nih.gov or Debbie Snyder, MSW at DeborahSnyder@mail.nih.gov.

ASQ Tools for all Ages and Medical Settings

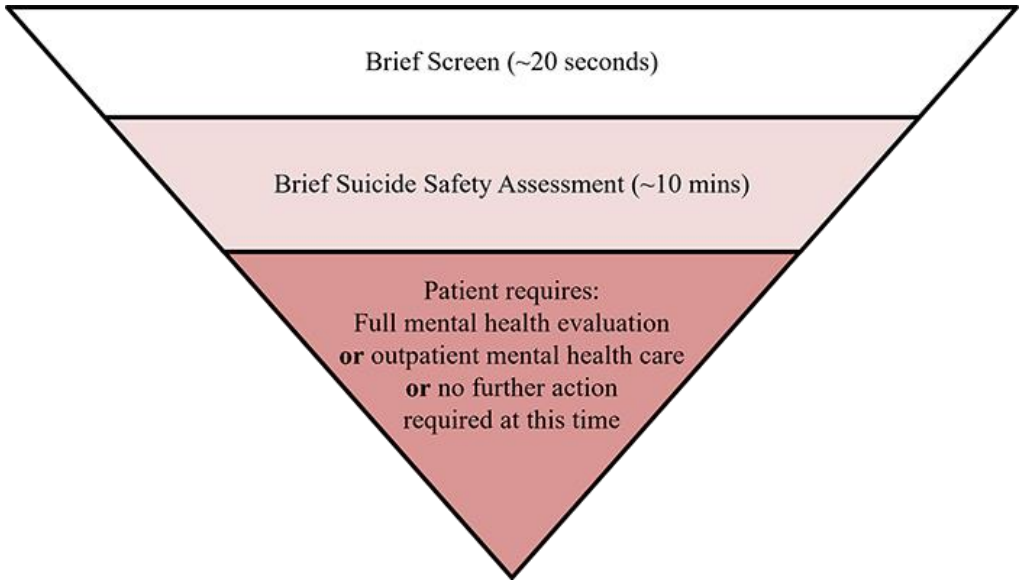
- Information Sheet
- Screening Tool
- Screening Tool (foreign languages)
- Toolkit Summary
- Patient Resource List
- Training/Educational Videos

Tools Specific to Medical Settings:
Emergency Department, Inpatient/surgical, Outpatient/specialty clinics

Youth versions can be used for individuals ages 8 to 24 years, and Adult versions can be used for ages 18 years and older. There is overlap and that is left to the discretion of the clinician using the tools.

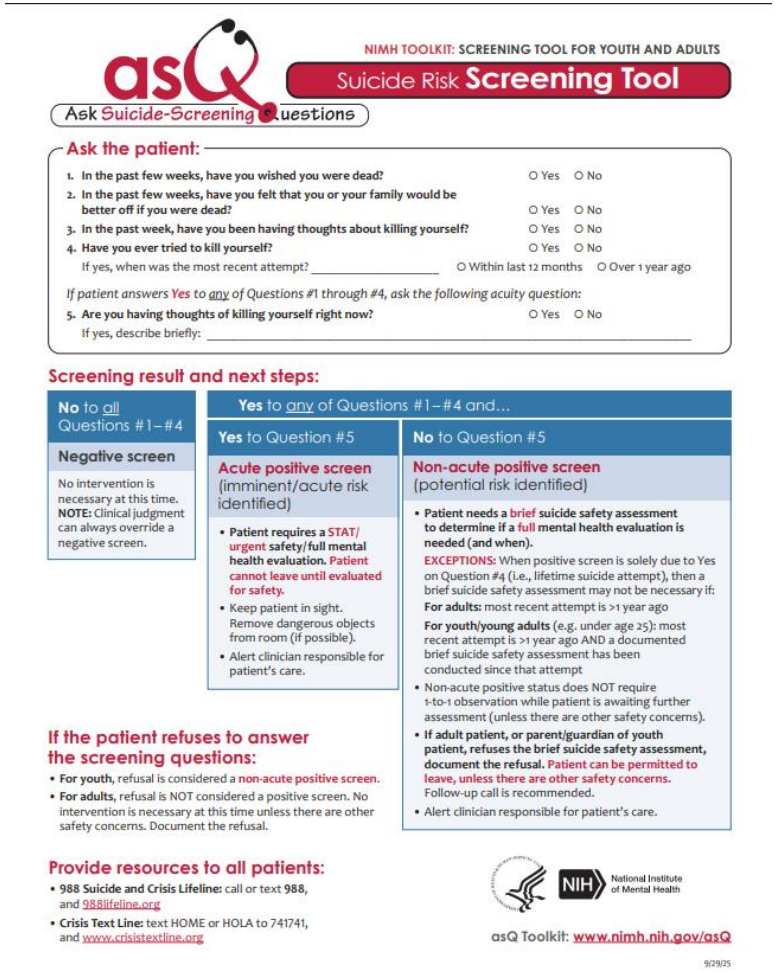
- Brief Suicide Safety Assessment Guide
- Brief Suicide Safety Assessment Worksheet
- Nursing Scripts
- Parent/Guardian Flyers
- Suicide Risk Screening Pathways (flow charts)
- Telehealth Suicide Risk Screening Pathways (flow charts)

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)



Ask Suicide-Screening Questions (ASQ) Toolkit
https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

ASQ Screening Tool



asQ Ask Suicide-Screening Questions

NIMH TOOLKIT: SCREENING TOOL FOR YOUTH AND ADULTS

Suicide Risk Screening Tool

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ○ Yes ○ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ○ Yes ○ No
3. **In the past week, have you been having thoughts about killing yourself?** ○ Yes ○ No
4. **Have you ever tried to kill yourself?** ○ Yes ○ No
   If yes, when was the most recent attempt? _____ ○ Within last 12 months ○ Over 1 year ago

If patient answers Yes to any of Questions #1 through #4, ask the following acuity question:

5. **Are you having thoughts of killing yourself right now?** ○ Yes ○ No
   If yes, describe briefly: _____

Screening result and next steps:

No to all Questions #1–#4

Negative screen

No intervention is necessary at this time. **NOTE:** Clinical judgment can always override a negative screen.

Yes to any of Questions #1–#4 and...

Yes to Question #5

Acute positive screen (imminent/acute risk identified)

- **Patient requires a STAT/urgent safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
- Keep patient in sight. Remove dangerous objects from room (if possible).
- Alert clinician responsible for patient's care.

No to Question #5

Non-acute positive screen (potential risk identified)

- **Patient needs a brief suicide safety assessment to determine if a full mental health evaluation is needed (and when).**
  EXCEPTIONS: When positive screen is solely due to Yes on Question #4 (i.e., lifetime suicide attempt), then a brief suicide safety assessment may not be necessary if:
  For adults: most recent attempt is >1 year ago
  For youth/young adults (e.g. under age 25): most recent attempt is >1 year ago AND a documented brief suicide safety assessment has been conducted since that attempt
- Non-acute positive status does NOT require 1-to-1 observation while patient is awaiting further assessment (unless there are other safety concerns).
- **If adult patient, or parent/guardian of youth patient, refuses the brief suicide safety assessment, document the refusal. Patient can be permitted to leave, unless there are other safety concerns.** Follow-up call is recommended.
- Alert clinician responsible for patient's care.

If the patient refuses to answer the screening questions:

- **For youth,** refusal is considered a **non-acute positive screen.**
- **For adults,** refusal is NOT considered a positive screen. No intervention is necessary at this time unless there are other safety concerns. Document the refusal.

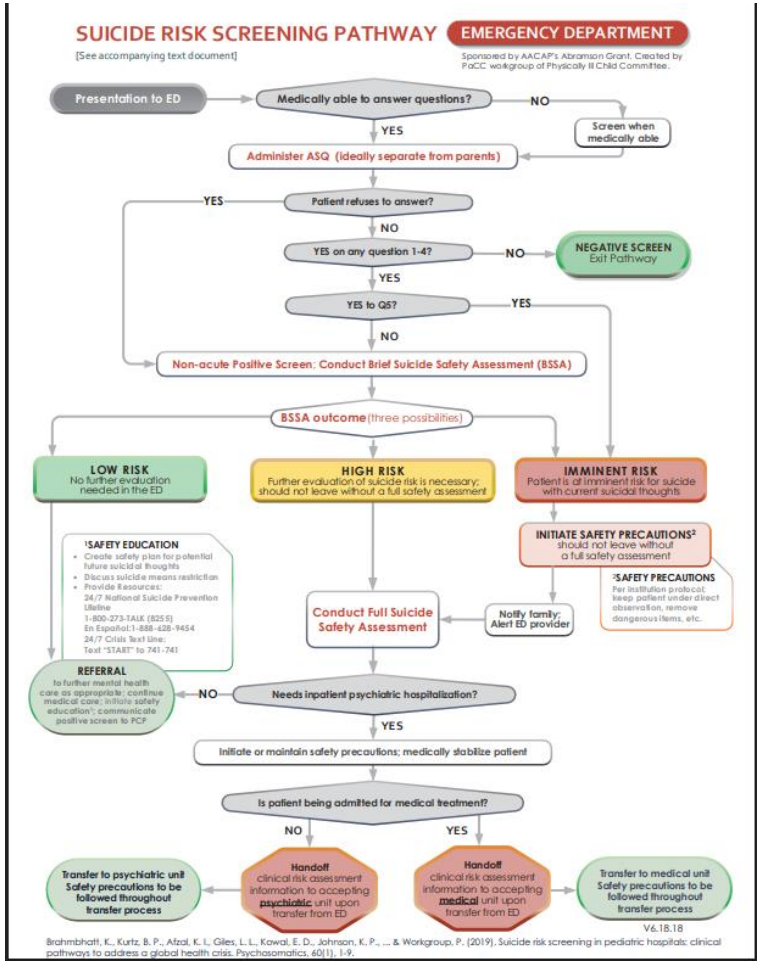
Provide resources to all patients:

- **988 Suicide and Crisis Lifeline:** call or text **988**, and 988lifeline.org
- **Crisis Text Line:** text HOME or HOLA to 741741, and www.crisistextline.org

NIH National Institute of Mental Health

asQ Toolkit: www.nimh.nih.gov/asQ

9/29/25



Ask Suicide-Screening Questions (ASQ) Toolkit
https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

Critical Considerations

1) Use a validated tool specific to age of patient and department to assess suicide risk

2) If the patient scores at risk on the initial screen – complete a more in-depth assessment

3) If the in-depth assessment is completed by an external entity, assume suicide risk and implement appropriate interventions until the additional assessment is completed

4) If your strategies to reduce risk includes removing items from a room or other strategies such as removing patient clothes, paper plates, etc. --- **make sure this occurs and that there is documentation**

5) If the patient requires 1 to 1 observation – make sure the individual monitoring the patient is qualified to do so

6) Don't allow family / friend to be the observer – this is a hospital responsibility

7) Document the 1 to 1 observation

8) If observation is thru camera / video ---- ensure observation 100% of the time

9) Document nurse observation at the frequency in your policy (usually every 15 minutes)

Critical Considerations, cont.

Beware Frequent Flyers -----

DON'T ASSUME THEY WON'T FOLLOW THRU THIS TIME!

Questions

THANK YOU

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