

CMS Conditions of Participation Update

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Objectives

- Introduction to COPs
- Discuss Recent Changes
 - Patient Rights
 - History and Physicals
 - Verbal Orders
 - Completion of Post-Anesthesia Evaluations
 - Infection Control

Mandatory Compliance

- Hospitals that participate in Medicare or Medicaid must meet the Conditions of Participation (COPs) for all patients in the facilities, and not just those patients who are Medicare or Medicaid
- Does not matter who the accrediting agency is
- COPs (for hospitals) are located at 42 CFR 482

Interpretive Guidelines

- Located in the Appendices of the State Operations Manual
- www.cms.hhs.gov/manuals/downloads/som107_Appendicestoc.pdf
- Recent Changes October 17, 2008

Interpretive Guidelines

App. No.	Description	PDF File
A	Hospitals	2,185_KB
AA	Psychiatric Hospitals	606_KB
B	Home Health Agencies	761_KB
C	Laboratories and Laboratory Services	3,868_KB
D	Portable X-Ray Service	82_KB
E	Outpatient Physical Therapy or Speech Pathology Services-Interpretive Guidelines	234_KB
F	Physical Therapists in Independent Practice	Deleted
G	Rural Health Clinics (RHCs)	382_KB
H	End-Stage Renal Disease Facilities	1,669_KB

Interpretive Guidelines

App. No.	Description	PDF File
I	Life Safety Code	140_KB
J	Intermediate Care Facilities for Persons With Mental Retardation	1,810_KB
K	Comprehensive Outpatient Rehabilitation Facilities	202_KB
L	Ambulatory Surgical Services Interpretive Guidelines and Survey Procedures	263_KB
M	Hospice	720_KB
N	Pharmaceutical Service Requirements in Long-Term Care Facilities	Deleted
P	Survey Protocol for Long-Term Care Facilities	229_KB
PP	Interpretive Guidelines for Long-Term Care Facilities	1,440_KB
Q	Determining Immediate Jeopardy	326_KB
R	Resident Assessment Instrument for Long-Term Care Facilities	38_KB
S	Mammography Suppliers	Deleted

Interpretive Guidelines

- Surveyors use the information contained in the interpretive guidelines
- Do not replace the law, but provide valuable information about what surveyors might look for during the survey process

Patient Rights

- Rights include:
 - Right to notification of rights,
 - Exercise of rights,
 - Privacy and safety
 - Confidentiality of medical records,
 - Freedom from physical or mental abuse, and corporal punishment, including restraints and seclusion when used as discipline, convenience, etc.

Hospital Discharge Appeal Rights

- Effective July 2, 2007
- Hospitals must have a Medicare patient sign and date a form called the Important Message from Medicare on admission or within 48 hours of admission.
- The hospital must deliver to the patient a copy of this signed form within 48 hours of discharge.
- If the patient voices a concern about being discharged prematurely, they must be given a more detailed notice and they can request the QIO review their case.

Informed Consent

- Interpretive Guidelines Issued April 13, 2007
- Mentioned in three sections of the COPs
- Patient Rights 42 CFR 482.13(b)(2)
- Medical Record Services 42 CFR 482.24(c)(2)(v)
- Surgical Services 42 CFR 482.51(b)(2)

Patient Rights

- There have been recent changes to many standards related to restraints and seclusion
 - COPs Effective January 8, 2007
 - Note: Recent TJC standards on restraints and seclusion – Effective July 2009

Patient Rights

- Standard: Restraint or seclusion
 - 42 CFR 482.13(e) or Tag A-0154
 - CMS no longer distinguishes between clinical and behavioral restraints
 - CMS now refers to patients as violent or self-destructive or non V/SD
 - RS must be discontinued at the earliest possible time
 - May be imposed only to ensure immediate physical safety of patient, staff, or others

Definition of Restraint

- Any physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely
- A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom or movement and is NOT a standard treatment or dosage for the patient's condition

Restraint DOES NOT include:

- Orthopedically prescribed devices, dressings, or bandages
- Protective helmets
- Methods used to hold a patient during a procedure
- Devices used to prevent the patient from falling out of bed (e.g. 2 rails)
- Methods used to permit the patient to participate in activities without the risk of harm

Bed Rails

- If rails are raised and restrict the patient's freedom to exit the bed, and the patient cannot remove/release the side rail, bed rails are considered a restraint.
- Four bed rails are considered a restraint according to CMS.

Weapons Used as Restraints

- CMS does not consider the use of weapons in the application of restraint or seclusion as a safe, appropriate health care intervention
 - Weapon includes:
 - Pepper Spray
 - Mace
 - Nightsticks
 - Stun guns
- The use of handcuffs, shackles, etc, by non-hospital employed or law enforcement officials is not governed by this rule.

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 that jeopardizes the immediate physical safety of the patient, a staff member, or others.

Seclusion

- Is not being on a locked unit with others
- Not for time out
- Is when the patient is alone in a room and is physically prevented from leaving.

Reason for Restraint

- Surveyor will look to see if there is evidence that staff determined the reason for the R & S.
- Must be documented.
- Restraints can only be used when least restrictive interventions have been determined to be ineffective to protect the patient or others from harm. (Request from family is not sufficient).

Restraint Orders

- Must be based on a written modification of the plan of care
- Must be implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by policy
- Restraints must be ordered by MD/DO or other LIP responsible for the care of the patient and authorized to order restraint.

Restraint Orders

- PRN or standing orders are not allowed
 - If restraint is released and reapplied except for care, a new order must be obtained.
- Attending physician must be consulted as soon as possible if he/she did not order the restraint.

Monitoring

- Condition must be monitored by a physician or LIP who has completed training on:
 - Techniques to identify factors that may trigger behavior that requires the use of restraint or seclusion
 - The use of nonphysical interventions
 - Choosing the least restrictive intervention based on assessment
 - Safe application of all types of restraints used in the hospital
 - Monitoring

Documentation

- One hour face-to-face evaluation if restraint or seclusion used to manage violent or self-destructive behavior
- Intervention used
- Alternatives attempted
- Patient's condition or symptoms warranting the use of restraints
- Patient's response to the intervention, including the rationale for continued use of the intervention.

Reporting

- Must report deaths associated with the use of restraint or seclusion
 - Each death that occurs while the patient is in restraint or seclusion
 - Each death that occurs within 24 hours after the patient has been removed from the restraint or seclusion
 - Each death known to the hospital that occurs within one week after restraint or seclusion where it is reasonable to assume that the use of restraint or seclusion contributed to the patient's death.

Reporting

- Must be reported to CMS Regional Office by telephone no later than close of business the next business day following the patient's death.
- Staff must document the date and time the death was reported to CMS
- CMS Form

History and Physical

- Effective January 26, 2007
- Medical history and physical must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia.
- If completed within 30 days, update must be done within 24 hrs.
- All medical record entries must be authenticated, dated, and TIMED.

Verbal Orders

- Patient Safety Issue (JC and CMS)
- To be used infrequently
- Verbal orders must be authenticated within 48 hours (or state law if more stringent)
- All medical record entries must be authenticated, dated, and TIMED

Anesthesia Services

- Pre-anesthesia evaluation must be performed within 48 hours prior to any inpatient or outpatient surgery requiring anesthesia services by an individual qualified to administer
- Should include:
 - Notation of anesthesia risk
 - Anesthesia, drug and allergy history
 - Any potential anesthesia problems identified
 - Patient's condition prior to induction of anesthesia

Anesthesia Services

- Post-anesthesia evaluation must be completed and documented by an individual qualified to administer, no later than 48 hours after surgery.
- Must be in accordance with policies and procedures
- Recommend consulting ASA's recognized guidelines for P & P's

Infection Control

- Updated to include "Special Challenges in Infection Control"
 - Multi-Drug Resistant Organisms
 - Ambulatory Care
 - Communicable Disease Outbreaks
 - Bioterrorism
- Log of incidents related to infections and communicable diseases

Other Updates

- Governing Body
- Grievance Process
- Medical Staff
- Medication Storage
- Life Safety
- Discharge Plan

Questions?

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