Hospitalization Critical Element Pathway

Use this pathway for a resident hospitalized for a reason other than a planned elective procedure to determine if facility practices are in place to identify and assess a change in condition, intervene as appropriate to prevent hospitalizations, and evaluate compliance with requirements surrounding transfer and discharge.

Review the following in *a*dvance to *g*uide *o*bservations and *i*nterviews:

☐ *Offsite Preparation:*

- *Determine if the Ombudsman identified any resident-specific or general concerns related to a resident's hospitalization and/or transfer or discharge requirements.*
- *Review complaints and survey history for indications of noncompliance with concerns related to a resident's hospitalization and/or the requirements for transfer or discharge.*

☐ *Most current comprehensive MDS/CAAs. If the most recent MDS is a quarterly, then review both the most recent comprehensive and quarterly MDSs. Review sections* B, C, E, GG, I, J, N, and O.

☐ Physician's orders (e.g., treatment prior to being hospitalized, meds, labs and other diagnostics, transfer orders to hospital, readmission, and current orders).

☐ Pertinent diagnoses.

☐ Relevant progress notes (e.g., physician, non-physician practitioner, and/or nursing notes). Note: Surveyor may have to obtain/review records from the hospital, or request the previous medical record to review circumstances surrounding the resident's hospitalization.

☐ Care plan (e.g., symptom management and interventions to prevent re-hospitalization based on resident's needs, goals, preferences, and assessment).

Observations *(if resident is in the facility)*:

☐ Is the resident exhibiting the same symptoms that sent the resident to the hospital? Is the resident displaying:

- Physical distress;
- Mental status changes;
- A change in condition; and/or
- Pain?

☐ If symptoms are exhibited, *are they being addressed by staff*?

☐ Are care planned and ordered interventions in place to prevent a re-hospitalization (e.g., respiratory treatments, blood pressure monitoring)?

Resident, Representative Interview, or Family Interview:

☐ Why were you sent to the hospital?

☐ When did you start to feel sick, or have a change in condition?

☐ Do you feel staff responded as quickly as they could have when you had a change in condition?

☐ Has staff talked to you about your risk for additional hospitalizations and how they plan to reduce the risk?

☐ Do you have pain? If so, what does staff do for your pain?

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- ☐ Were you notified immediately about your change in condition and need for potential hospitalization?
- ☐ *Did staff take steps or revise your care plan in an effort to prevent your hospitalization.*
- ☐ *Were your choices and preferences honored and reflected in the steps staff took prior to and after your hospitalization?*
- ☐ Did you refuse care related to the symptoms which led to your hospitalization? If so, what was your reason for refusing care? Did the staff provide you with other options for treatment or provide you with education on what might happen if you did not follow the treatment plan?
- ☐ Has your health declined since you were in the hospital? If so, what has staff done?
- ☐ What things are staff doing to prevent another hospitalization? (Ask about specific interventions, e.g., monitoring blood sugars).
- ☐ Has your hospitalization caused you to be less involved in activities you enjoy?
- ☐ Since your hospitalization, have you had a change in your mood or ability to function? If so, what has staff done?
- ☐ Did you receive a notice of transfer or discharge from the facility?
- ☐ Did the facility give you information about holding your bed for you while you were at the hospital?
- ☐ Were you allowed to return to the facility and to your previous room? If not, do you know why not?

Staff Interviews (Nursing Aides, Nurses, DON, Practitioner):

- ☐ What was the *change in condition which* caused *the resident's hospitalization* (e.g., pain, infection, mental status change, or fall)?
- ☐ When *did you identify the change in condition or were you notified about it?*
- ☐ *Why couldn't the hospitalization have been avoided by either addressing the issue to prevent it from becoming acute, or treating the resident in-house?*

  How do you identify residents who are at risk for a hospitalization, and what do you do to reduce the risk?
- ☐ Prior to or after the hospitalization, did the resident refuse any treatment? What do you do if the resident refuses?
- ☐ *What has been implemented to prevent* additional hospitalizations?
- ☐ *Has the resident's condition declined since returning from the hospital?* If so, what interventions are in place to address the problem(s)?
- ☐ How did you involve the resident/representative in decisions regarding treatments?
- ☐ If care plan concerns are noted, interview staff responsible for care planning about the rationale for the current care plan.

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Record Review:

- ☐ Was the cause of the hospitalization *identified,* assessed, monitored, and documented timely (e.g., nursing notes, EMT records, hospital discharge summaries, H&P, progress notes/vital signs*), with proper notifications to resident/representative, staff and practitioners*?
- ☐ If the transfer to the hospital is necessary for the resident's welfare and the resident's needs cannot be met in the facility, did the facility document the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s)?
- ☐ Could the transfer to the hospital have been avoided (e.g., had the change in condition been identified and addressed earlier, the condition would not have declined to the point where the resident required a transfer)?
- ☐ Did the facility send all necessary clinical information to the hospital (i.e., practitioner and representative's contact info, advance directive, special instructions or precautions for ongoing care, care plan goals, and all other information needed to care for the resident). Refer to 483.15(c)(2)(iii) for additional guidance on what must be conveyed.
- ☐ Did the appropriate practitioner document the basis for the transfer [*F627*, 483.15(c)(2)(ii)]*?*
- ☐ Was the resident/representative provided with a written Notice of Transfer (and/or discharge as appropriate) in a manner they could understand*, and which meets all the notice requirements at 483.15(c)(3)? (F628)*
- ☐ Did the resident/representative receive the notice of Bed Hold per *F628,* 483.15(d)?
- ☐ Did the facility implement interventions to prevent further hospitalizations*, such as a change in medications, or increase in monitoring of high risk medications and laboratory results*?
- ☐ Review the facility's admission information provided during the Entrance Conference regarding bed holds and transfers.
- ☐ Ensure the resident was provided the policy on returning to the facility in the same room, if possible, and bed holds.
- ☐ *Was the resident adequately prepared for his or her transfer to the hospital? [Refer to F627]*

- ☐ **Residents not permitted to return to facility after hospitalization (Discharge):** When a resident is initially transferred to an acute care facility, and the facility does not permit the resident to return, this situation is a discharge – ensure the facility is in compliance with all discharge requirements at *F627 and F628/Discharge pathway*.

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☐ For any resident whose **transfer to the hospital resulted in a discharge**, review documentation in the medical record and facility policies related to bed hold and permitting residents to return after hospitalization/therapeutic leave: [Refer to 483.15(c), (d), and (e) for additional guidance.]

- Was the resident permitted to return to his or her bed, or the first available bed following his or her hospitalization? If not, review documentation in the medical record related to facility efforts to allow the resident to return to his or her bed. Also review facility admissions since the date of the resident's discharge (not date of transfer to the ER) for admission of residents with conditions similar to the discharged resident. [Refer to *F627/Discharge pathway*]
- When the transfer became a discharge, what was the basis for the discharge?
- For residents discharged after a transfer to the hospital because the health or safety of individuals would be endangered, *was there onset of a new symptom or condition, or was the resident's condition present throughout their entire stay*? [Refer to *F627/Discharge pathway*]
- When the transfer became a discharge, what was the basis for the discharge?
- For residents discharged after a transfer to the hospital because the health or safety of individuals would be endangered, *was there onset of a new symptom or condition, or was the resident's condition present throughout their entire stay*? [Refer to *F627/Discharge pathway*]
- *Was the decision to discharge the resident after hospitalization based on the inability to meet the resident's needs? If so, is there evidence the facility made this decision* based on the resident's care needs at the time of transfer to the hospital/acute care setting or at the time the resident sought return to the facility? Do the resident's records from the nursing home and the acute care facility support this decision (Surveyors may need to review hospital records in this situation)? [Refer to *F627/Discharge pathway*]
- Did the resident appeal the transfer/discharge? If so, was the resident permitted to return to the facility while the appeal was pending? If not allowed to return while the appeal was pending, is there evidence that no bed was available, or that the health or safety of individuals in the facility would have been endangered if the resident returned? [Refer to *F627/Discharge pathway*]
- *Did* the facility issue another notice of discharge? Was a copy of the Notice of Discharge sent to the ombudsman? [Refer to *F628/Discharge pathway]*

Critical Element Decisions:

1) Did the facility *provide appropriate care that could have* prevent*ed* the hospitalization*(e.g., by following* professional standards of practice, comprehensive, person-centered care plan*ning*, and the resident's choice*)*?
If No, cite the relevant outcome tag in Quality of Life, Quality of Care, or if no specific outcome tag, cite F684

2) Was the basis for the resident's transfer/discharge consistent with the requirements at 483.15(c)(1)? Does evidence in the medical record support the basis for transfer/discharge and meet the documentation requirements at 483.15(c)(2)(i)-(ii)? Was a resident who appealed their discharge permitted to return to the nursing home while their appeal was pending, unless there was evidence that the resident's return would pose a health or safety risk to individuals in the facility, or there was no bed?
If No to any of these questions, cite *F627*
N/A, resident was permitted to return and not discharged.

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3) Was the resident sufficiently prepared and oriented for their transfer to the hospital?
If No, cite *F627*

4) Was the resident allowed to return to the facility, to the first available bed, or to their previous room if available, after being hospitalized?
If No, cite *F627*
N/A, resident was permitted to return and not discharged.

5) *Is there evidence that the required information at 483.15(c)(2)(iii) was conveyed to the hospital at the time of transfer ?*
If no, cite F628

6) Did the facility notify the resident and resident's representative in writing of the reason for the transfer/discharge to the hospital in a language they understand and send a copy of the notice to the ombudsman?
If No, cite *F628*

7) For residents who were not permitted to return following hospitalization (who were discharged), did the facility also provide a notice of discharge to the resident, resident representative and send a copy of the notice to the representative of the Office of the Long-Term Care Ombudsman?
If No, cite *F628*
N/A, resident was permitted to return and not discharged.

8) Did the facility notify the resident and/or resident's representative of the facility policy for bed hold, including reserve bed payment?
If No, cite *F628*

9) For newly admitted residents, did the facility develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the immediate needs of the resident? Did the resident and resident representative receive a written summary of the baseline care plan that he/she was able to understand?
If No, cite F655
NA, the resident did not have an admission since the previous survey OR the care or service was not necessary to be included in a baseline care plan.

10) If the condition or risks were present at the time of the required comprehensive assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or to determine underlying causes, to the extent possible, and the impact upon the resident's function, mood, and cognition?
If No, cite F636
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR the resident was recently admitted and the comprehensive assessment was not yet required.

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11) If there was a significant change in the resident's status, did the facility complete a significant change assessment within 14 days of determining the status change was significant?
If No, cite F637
NA, the initial comprehensive assessment had not yet been completed; therefore, a significant change in status assessment is not required OR the resident did not have a significant change status.

12) *Does the most recent resident assessment accurately reflect the resident's status* (i.e., comprehensive, quarterly, significant change in status)?
If No, cite F641

13) Did the facility develop and implement a comprehensive person-centered care plan that includes measureable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs and includes the resident's goals, desired outcomes, and preferences?
If No, cite F656
NA, the comprehensive assessment was not completed.

14) Did the facility reassess the effectiveness of the interventions and review and revise the resident's care plan (with input from the resident or resident representative, to the extent possible), if necessary to meet the resident's needs?
If No, cite F657
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.

Other Tags, Care Areas (CA), and Tasks (Task) to Consider: Advance Directives (CA), Notification of Change F580, Dignity (CA), Informed Treatment Decisions F552, Choices (CA), Accommodation of Needs (Environment Task), Admission Orders F635, Professional Standards F658, QOL F675, Behavioral-Emotional Status (CA), Nutrition (CA), Hydration (CA), Sufficient and Competent Staffing (Task), Physician Services F710, Medical Director F841, Infection Control (Task), Facility Assessment F838, Resident Records F842, QAPI/QAA (Task).

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