

State Operations Manual
Appendix AA - Psychiatric Hospitals – Interpretive
Guidelines and Survey

(Rev. 149, 10-09-15)

Part II - Interpretive Guidelines - Psychiatric Hospitals

(Rev. 149, Issued: 10-09-15, Effective: 10-09-15, Implementation: 10-09-15)

NOTE: in the regulations or guidance which follow, in every instance where the following terms appear:

- *“spouse” means an individual who is married to another individual as a result of marriage lawful where entered into, including a lawful same-sex marriage, regardless of whether the jurisdiction where the psychiatric hospital is located, or in which the spouse lives, permits such marriages to occur or recognizes such marriages.*
- *“marriage” means a marriage lawful where entered into, including a lawful same-sex marriage, regardless of whether the jurisdiction where the psychiatric hospital is located, or in which the spouse lives, permits such marriages to occur or recognizes such marriages;*
- *“family” includes, but is not limited to, an individual’s “spouse” (see above); and*
- *“relative” when used as a noun, includes, but is not limited to, an individual’s “spouse” (see above).*

Furthermore, except where CMS regulations explicitly require an interpretation in accordance with State law, wherever the text of a regulation or associated guidance uses the above terms or includes a reference to a patient’s “representative,” “surrogate,” “support person,” “next-of-kin,” or similar term in such a manner as would normally implicitly or explicitly include a spouse, the terms are to be interpreted consistent with the guidance above.

A psychiatric hospital is expected to recognize all lawful marriages and spouses for purposes of compliance with the Conditions of Participation, regardless of any laws to the contrary of the state or locality or other jurisdiction where the psychiatric hospital is located or where the spouse lives.

B98

§482.60 Condition of Participation: Special Provisions Applying to Psychiatric Hospitals

Psychiatric hospitals must--

B99

§482.60(a) Be primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons.

Guidance §482.60(a)

The hospital will be deemed to meet standard (a) if it meets standards (c) and (d).

B100

§482.60(b) Meet the Conditions of Participation specified in §§482.1 through 482.23 and §§482.25 through 482.57;

Guidance §482.60(b)

The hospital is either accredited by JCAHO or AOA; or meets the Condition of Participation for Hospitals, §§482.1 through 482.23 and §§482.25 through 482.57.

B101

§482.60(c) Maintain clinical records on all patients, including records sufficient to permit CMS to determine the degree and intensity of treatment furnished to Medicare beneficiaries as specified in §482.61; and

B102

§482.60(d) Meet the staffing requirements specified in §482.62.

B103

§482.61 Condition of Participation: Special Medical Record Requirements for Psychiatric Hospitals

The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.

Guidance §482.61

The clinical record should provides information that indicates need for admission and treatment, treatment goals, changes in status of treatment and discharge planning, and follow-up and the outcomes experienced by patients.

The structure and content of the individual patient's record must be an accurate functional representation of the actual experience of the individual in the facility. It must contain

enough information to indicate that the facility knows the status of the patient, has adequate plans to intervene, and provides sufficient evidence of the effects of the intervention, and how their interventions served as a function of the outcomes experienced. You must be able to identify this through interviews with staff, and when possible with individuals being served, as well as through observations.

§482.61(a) Standard: Development of Assessment/Diagnostic Data

B104

§482.61(a) Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.

B105

§482.61(a)(1) The identification data must include the patient's legal status.

Guidance §482.61(a)(1)

Definition: Legal Status is defined in the State statutes and dictates the circumstances under which the patient was admitted and/or is being treated - i.e., voluntary, involuntary, committed by court, evaluation and recertification are in accordance with state requirements.

Determine through interview with hospital staff the terminology they use in defining "legal status." If evaluation and recertification is required by the State, determine that legal documentation supporting this status is present. Changes in legal status should also be recorded with the date of change.

B106

§482.61(a)(2) A provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnosis of intercurrent diseases as well as the psychiatric diagnosis.

Guidance §482.61(a)(2)

There is an admission or working psychiatric diagnosis (including rule-out diagnoses) written in the most current edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) or the approved International Classification of Diseases (ICD) nomenclature. This diagnosis is made and entered into the chart of each patient at the time of the admission examination. The final diagnosis may differ from the initial diagnosis if subsequent evaluation and observation support a change.

If a diagnosis is absent, there must be justification for its absence. For example, if a patient was psychotic on admission and was not accompanied by family or significant others.

Intercurrent (other than psychiatric) diagnoses must be documented when they are made. Attention should be paid to physical examination notes, including known medical conditions, even allergies and recent exposure to infections, illness, or substance abuse, and to available laboratory or test reports which identify abnormal findings to see that these are reflected by appropriate diagnosis.

These diagnoses may be found in a variety of locations in the medical record, e.g., the identification/face sheet, the finding of admission physical examination, the psychiatric evaluation the “admission work up “ or the physician’s progress notes. Diagnostic categories should include physical illness when present.

Probes §482.61(a)(2)

Are abnormal physical examination findings and/or laboratory findings justified by further diagnostic testing and/or development of an intercurrent diagnosis, and, if so, was such done?

If an identified physical illness requires immediate treatment, is the treatment being given?

How will an identified physical illness be likely to impact on the patient’s eventual outcome? To what extent has this potential impact been addressed by the team?

B107

§482.61(a)(3) The reasons for admission must be clearly documented as stated by the patient and/or others significantly involved.

Guidance §482.61(a)(3)

The purpose of this regulation is to provide an understanding of what caused the patient to come to the hospital, and the patient’s response to admission.

The hospital records the statements and reason for admission given by family and by others, as well as the patient (preferably verbatim), with informant identified, in a variety of locations, e.g., in transfer and admission notes from the physician, nurses and social workers.

Records should not contain vague, ill-defined reports from unknown sources. Records should record “who,” “what,” “where,” “when,” and “why.”

Probes §482.61(a)(3)

Can the patient describe problems, stresses, situations experienced prior to hospitalization or do they still exist?

Who is the informant?

Did the informant witness the patient's behavior? If not, on what basis has the informant come to know the patient's behavior?

Has staff elicited whether the patient has exhibited similar behavior previously? If so, what was different this time to make hospitalization necessary?

Were there other changes/events in the patient's environment (death, separations of significant others) which contributed to the need for hospitalization? If so, has staff explored how these will impact in the patient's treatment? Has this been addressed by the treatment team?

Has there been an interruption or change in the patient's medication which may have been a factor in the patient's hospitalization?

B108

§482.61(a)(4) The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.

Guidance §482.61(a)(4)

The purpose of the social work assessment is to determine the current baseline social functioning (strengths and deficits) of the patient, from which treatment interventions and discharge plans are to be formulated.

Patient length of stay is a key factor influencing hospital documentation policy, i.e., establishing timeframes for completion, documentation, and filing of the psychosocial assessment, and treatment planning in the medical record.

A psychosocial history/assessment must be completed on all patients. Three key components to be addressed:

A. Factual and Historical Information

1. Specific reasons for the patient's admission or readmission;
2. A description of the patient's past and present biopsychosocial functioning;

3. Family and marital history, dynamics, and patient's relationships with family and significant others;
4. Pertinent religious and cultural factors;
5. History of physical, sexual and emotional abuse;
6. Significant aspects of psychiatric, medical, and substance abuse history and treatment as presented by family members and significant others;
7. Educational, vocational, employment, and military service history;
8. Identification of community resources including previously used treatment sources;
9. Identification of present environmental and financial needs.

B. Social Evaluation

1. Patient strength and deficits;
2. High risk psychosocial issues requiring early treatment planning and intervention - i.e., unattended child(ren) in home; prior noncompliance to specific treatment and/or discharge interventions; and potential obstacles to present treatment and discharge planning.

C. Conclusions and Recommendations

Assessment of Sections A and B shall result in the development of (C) recommendations related to the following areas:

1. Anticipated necessary steps for discharge to occur;
2. High risk patient and/or family psychosocial issues requiring early treatment planning and immediate intervention regardless of the patient's length of stay;
3. Specific community resources/ support systems for utilization in discharge planning - i.e., housing, living arrangements, financial aid, and aftercare treatment sources;
4. Anticipated social work role(s) in treatment and discharge

planning. **Probes §482.61(a)(4)**

Does the psychosocial history/assessment indicate:

1. Clear identification of the informants(s) and sources of information?
2. Whether information is considered reliable?
3. Patient participation to the extent possible in provision of data relative to treatment and discharge planning?
4. Integration of significant data including identified high risk psychosocial issues (problems) into the treatment plan?
5. ~~How does the hospital insure the information is reliable?~~

B109

§482.61(a)(5) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

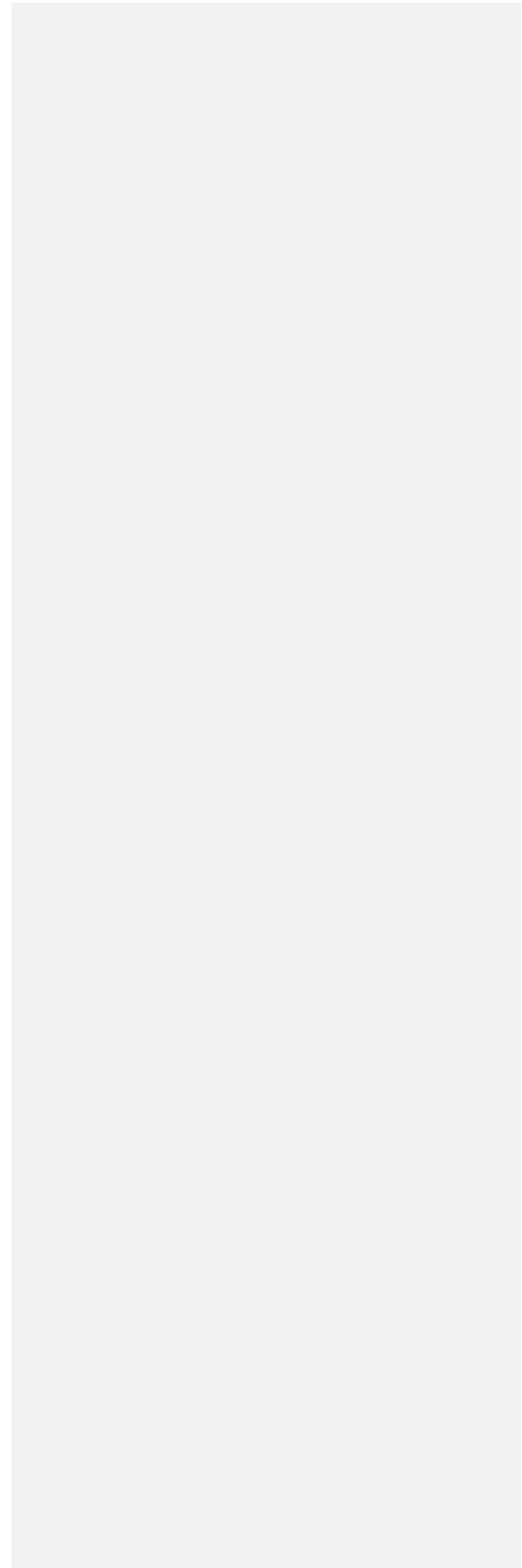
Guidance §482.61(a)(5)

Upon admission the patient should receive a thorough history and physical examination with all indicated laboratory examinations to determine if presenting psychiatric signs/symptoms may be due to a general medical condition or substance use disorder. ~~These investigations must be sufficient to discover all structural, functional, systemic and metabolic disorders. A thorough history of the patient's past physical disorders, head trauma, accidents, substance dependence/abuse, exposure to toxic agents, tumors, infections, seizures or temporary loss of consciousness, and headaches, will alert the physician to look for the presence of continuing pathology or possible sequelae any of which may turn out to be significant and pertinent to the present mental illness. Equally important is a thorough physical examination to look for signs of any current illness since psychotic symptoms may be due to a general medical condition or substance-related disorder.~~

The screening neurological examination

As part of the physical examination, the physician will perform a "screening" neurological examination. While there is no precise definition of a screening neurological examination in medical practice such examination is expected to assess gross function of the various divisions of the central nervous system as opposite to detailed, fine testing of each division. Gross testing of Cranial Nerves II through XII should be included. Statements such as "Cranial Nerves II to XII intact" are not acceptable. These areas may be found in various parts of the physical examination and not just grouped specifically

under the neurological.



In any case where a system review indicate positive neurological symptomatology, a more detailed examination would be necessary, with neurological work-up or consultation ordered as appropriate after the screening neurological examination was completed.

Complete neurological examination:

~~A complete, comprehensive neurological examination includes a review of the patient's history, physical examination and for psychiatric patients, a review of the psychiatric evaluation. The neurologist/psychiatrist himself/herself also takes a history to obtain the necessary information not already available in the medical record or referral form. The neurological examination is a detailed, orderly survey of the various sections of the nervous system. As an example, whereas a simple reading of a printed page will be sufficient to assess grossly the patient's sight (cranial nerve II) in a complete neurological examination, the neurologist may test visual acuity with a snellen chart, perform a fundoscopic examination of both eyes (sometimes after dilating the pupils) and he/she will examine the patient's visual fields. In the examination of the motor system, the power of muscle groups of the extremities, the neck and trunk are tested. Where an indication of diminished strength is noted, testing of smaller muscle groups and even individual muscles are tested. In a complete neurological examinations all the systems are examined, but the physician will emphasize even more the areas pertinent to the problem for which the examination was requested.~~

Probes §482.61(a)(5)

Did the presence of an abnormal physical finding or laboratory finding justify the need for further diagnostic testing, or for the development of an intercurrent diagnosis? If the finding justified further follow-up in either situation, was such follow-up done?

Is there evidence that a screening neurological examination was done and recorded at the time of the physical examination?

~~Was the screening neurological or history indicative of possible involvement (tremors, paralysis, motor weakness or muscle atrophy, severe headaches, seizures, head trauma)?~~

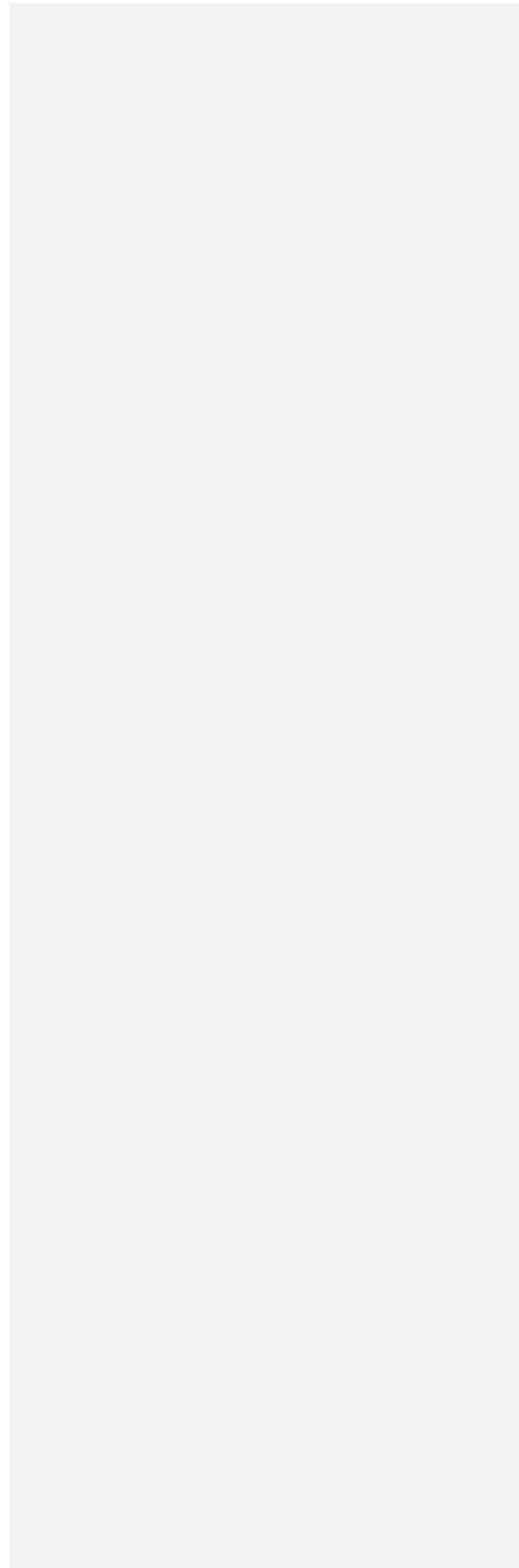
If indicated, was a complete, comprehensive neurological exam ordered, completed and recorded in the medical record in a timely manner?

§482.61(b) Standard: Psychiatric Evaluation

B110

Each patient must receive a psychiatric evaluation that must--

Guidance §482.61(b)



The psychiatric evaluation is done for the purpose of determining the patient's diagnosis and treatment and, therefore, it must contain the necessary information to justify the diagnosis and planned treatment.

The psychiatric evaluation is a total appraisal or assessment of the patient's illness. It is the physician's assessment of the contributing factors and forces in the evolution of the patient's illness including the patient's perception of his or her illness. Through the psychiatric evaluation the physician seeks to secure a biographical-historical perspective of the patient's personality, with a clear psychological picture of the patient as a specific human being with his or her individual problems. While performing the psychiatric evaluation, the physician reaches an understanding of the patient's basic personality structure, of the patient's developmental period, of his or her value systems, of his or her past medical history including surgical procedures and other treatments, his or her past psychological traumatic experiences, his or her defense mechanisms, his or her supporting systems, any precipitating factors and how all these may have impacted and interplayed with each other to result in the present illness. In the psychiatric evaluation the patient should emerge as a dynamic human being with a past, a present and a potential future with a thread of logical continuity.

The psychiatric evaluation includes all the requirements described in this standard and the information necessary to justify the diagnosis and treatment. A physician's signature is necessary. In those cases where the mental status portion of the psychiatric evaluation is performed by a non-physician, there should be evidence that the person is credentialed by the hospital, legally authorized by the State to perform that function, and a physician review and countersignature is present, where required by hospital policy or State law.

In order to satisfy the requirements §482.61(b) (1-7) of this standard, and to meet the standards of medical practice, the psychiatric evaluation should include the following component parts:

Probes §482.61(b)

1. The patient's chief complaints and/or reaction to hospitalization, recorded in patient's own words where possible.
Why is the patient in the hospital?
Was it his/her idea? (Does he/she feel ill/disturbed/frightened?)
Is the patient in the hospital against his/her will? Who decided to hospitalize/why?
2. Past history of any psychiatric problems and treatment, including prior precipitating factors, diagnosis, course and treatment.
Has the patient been chronically ill? Continuously/repeatedly?
How severely has the past illness/treatment interfered with the patient's development and/or adjustment?
Are there persistent symptoms/signs/behaviors that must be addressed and treated in order to favorably impact on the future psychiatric course?

Commented [NABH1]: There is need for clarification of the word "physician." We recommend the addition of "or other qualified mental health professional" when physician is used in order to include NPs and PAs as permitted by state licensure and scope of practice to perform evaluations. There are conflicts between the CoPs and the LCDs re: can the MSE be delegated to someone other than a physician. We recommend this be determined by the organization and not through guidance.

Commented [NABH2]: The components of a psychiatric evaluation should be determined by the organization and not prescribed through probes. There is also redundancy within elements required in other assessments, such as psychosocial evaluation).

What medications or supports helped him/her improve in the past? Are the same resources available to impact on the patient's treatment during this episode?

3. Past family, educational, vocational, occupational and social history.

To what extent, if any, is there a presence or absence of familial predisposition? What is the patient's educational level? Was he/she a good student? Is he/she still interested in learning?

What jobs has the patient held? For how long? Is he/she now employed/unemployed? For how long? Has he/she ever worked?

How does the patient get along with people? As a child, did he/she have friends? Does he/she have friends now?

Within the psychiatric evaluation does one find the specific signs and symptoms, and other factors, that justify the diagnosis?

B111

§482.61(b)(1) Be completed within 60 hours of admission;

B112

(Rev. 100, Issued: 02-14-14, Effective: 02-14-14, Implementation: 02-14-14)

§482.61(b)(2) Include a medical history;

Guidance §482.61(b)(2)

The psychiatric evaluation must include the non-psychiatric medical history including physical disabilities, intellectual disabilities and treatment.

Probes §482.61(b)(2)

Does the evaluation include:

Relevant past surgery? Past medical conditions and disabilities especially those of a chronic nature?

Have these contributed to the patient's psychiatric condition? How?

Are any of these conditions still present to any significant degree? Are they likely to impact on the patient's recovery/remission? Should they be addressed immediately?

Does the facility have the capability to intervene? If not, how is the need to be met?

B113

§482.61(b)(3) Contain a record of mental status;

Guidance §482.61(b)(3)

The mental status must describe the appearance and behavior, emotional response, verbalization, thought content, and cognition of the patient as reported by the patient and observed by the examiner at the time of the examination. This description is appropriate to the patient's condition.

~~Explore the mental status for descriptions of the patient's presentation during the examination that are relevant to the diagnosis and treatment of the patient. An example of a portion of the patient interview: The patient periodically states the examiner's name correctly during this examination after hearing it once, accurately describes his past history in great detail, precisely characterizes his present situation, can list events in logical sequence that have led to his present illness, but believes that his pre-admission insomnia, anorexia, and 35 pound weight loss over the past four months are totally the result of his sexual promiscuity of ten years ago and have nothing to do with his concurrent use of 50 to 60 mg. of Amphetamine daily." From this information one can conclude that the patient is oriented, his memory is intact, but that he has poor judgment and no insight. It is not acceptable just to write "oriented, memory intact, judgment poor, and insight nil," without any supportive information.~~

Commented [NABH3]: The standard requires that the record "Contain a record of mental status." There are many clinically appropriate definitions of a mental status exam and the degree of prescriptiveness in this guidance is not appropriate.

B114

§482.61(b)(4) Note the onset of illness and the circumstances leading to admission;

Guidance §482.61(b)(4)

In a hospitalized patient, the identified problem should be related to the patient's need for hospital admission. The psychiatric evaluation includes a history of present illness, including onset, precipitating factors and reason for the current admission, signs and symptoms, course, and the results of any treatment received.

Probes §482.61(b)(4)

How long has the patient been ill? Was it a gradual or sudden onset?

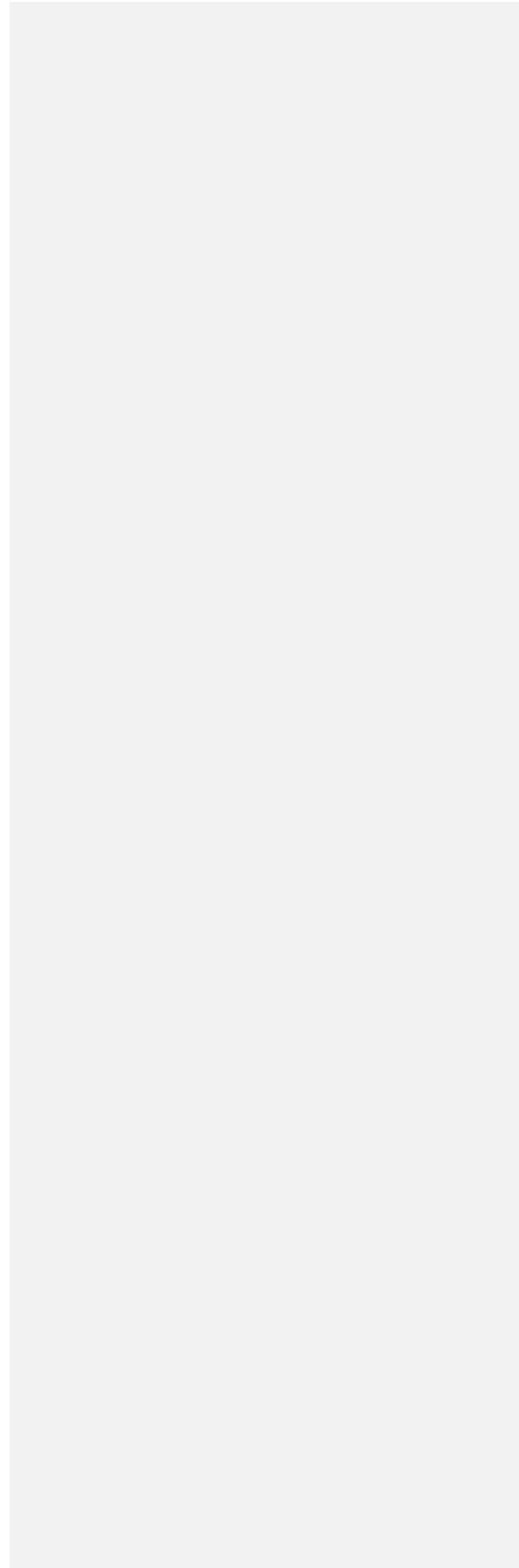
Is this a recurrence?

What were the precipitating factors? What happened?

What symptoms, signs, behaviors made this hospitalization necessary?

What treatment has the patient already received before coming to the hospital?

Is any medication he received listed?



B115

§482.61(b)(5) Describe attitudes and behavior;

Guidance §482.61(b)(5)

~~The problem statement should describe behavior(s) which require change in order for the patient to function in a less restrictive setting. The identified problems may also include behavioral or relationship difficulties with significant others which require active treatment in order to facilitate a successful discharge.~~

Commented [NABH4]: This is not the standard that should include problem statement.

B116

§482.61(b)(6) Estimate intellectual functioning, memory functioning and orientation; and

Guidance §482.61(b)(6)

Refer to [§482.61\(b\)\(3\)](#)

B117

(7) Include an inventory of the patient’s assets in descriptive, not interpretive fashion.

Guidance §482.61(b)(7):

Although the term strength is often used interchangeably with assets, only the assets that describe personal factors on which to base the treatment plan or which are useful in therapy represent personal strengths. Strengths are personal attributes i.e., knowledge, interests, skills, aptitudes, personal experiences, education, talents and employment status, which may be useful in developing a meaningful treatment plan. For purposes of the regulation, words such as “youth,” “pretty,” “Social Security income,” and “has a car” do not represent assets. (See also [§482.61\(c\)\(1\)](#).)

§482.61(c) Standard: Treatment Plan

B118

§482.61 (c)(1) Each patient must have an individual comprehensive treatment plan

Guidance §482.61 (c)(1)

The patient and treatment team collaboratively develop the patient’s treatment plan. The treatment plan is the outline of what the hospital has committed itself to do for the

patient, based on an assessment of the patient's needs. The facility selects its format for treatment plans and treatment plan updates.

Survey Procedure §482.61(c)(1)

Determination of compliance regarding treatment plans is accomplished by the surveyor using the following methods, and to the extent possible, the following order:

1. Observation of the patient and staff at planned therapies/meetings, in various settings both on and off the patient units, in formal and informal staff-patient interactions and in a variety of daily settings;
2. Interviews with patients, families, treatment staff and others involved directly or indirectly with active treatment;
3. Reviews of scheduled treatment programs (individual, group, family meetings, therapeutic activities, therapeutic procedures);
4. Attendance at multidisciplinary treatment planning meetings, if time permits; and
5. Medical record review.

Probe §482.61(c)(1)

Has the information gained from assessing/evaluating the patient been utilized to create an individualized treatment plan?

B119

§482.61(c)(1) The plan must be based on an inventory of the patient's strengths and disabilities.

Guidance §482.61(c)(1)

A disability is any psychiatric, biopsychosocial problem requiring treatment/intervention. The term disability and problem are used interchangeably. The treatment plan is derived from the information contained in the psychiatric evaluation and in the assessments/diagnostic data collected by the total treatment team. Based on the assessment summaries formulated by team members of various disciplines, the treatment team identifies which patient disabilities will be treated during hospitalization. Patient strengths that can be utilized in treatment must be identified. (See also §482.61(b)(7).)

Treatment planning depends on several variables; whether the admission is limited to crisis intervention, short-term treatment or long-term treatment. The briefer the hospital stay, the fewer disciplines may be involved in the patient's treatment.

Commented [NABH5]: This is very important guidance in light of the crisis stabilization goal of most hospitalizations yet is often not used by surveyors.

There must be evidence of periodic review of the patient's response and progress toward meeting planned goals. If the patient has made progress toward meeting goals, or if there is a lack of progress, the review must justify: (1) continuing with the current goals and approaches; or (2) revising the treatment plan to increase the possibility of a successful treatment outcome.

Commented [NABH6]: In brief hospitalizations, it may be more appropriate to update the treatment plan through treatment and progress notes than formal revision of the treatment plan.

Consideration must be given to the type of psychiatric program(s) under review to determine the timeframe for treatment plan review. The interval within which treatment plan reviews are conducted is determined by the hospital, however, the hospital's review system must be sufficiently responsive to ensure the treatment plan is reviewed: whenever a goal(s) has been accomplished; when a patient is regressing; when a patient is failing to progress; or when a patient requires a new treatment goal. The facility is expected to pursue aggressively the attendance of all relevant participants at the team meetings. Question any routine and regular absences of individuals who would be expected to attend.

Commented [NABH7]: Technology such as phone, video conferencing, etc. should be allowed to be used to include members in the meeting in situations when face-to-face attendance is not possible.

Probes §482.61(c)(1)

Is the treatment plan individualized, i.e., patient-specific, or is there a predictable sameness from plan to plan?

When packaged plans or programs are used, do staff include needed individual adaptations in the plan?

~~Are the patient's observed behaviors consistent with the problems and strengths identified in the plan or update?~~

~~Have the views which the patient communicated to the surveyor regarding problems which require treatment during hospitalization and plans for discharge, been incorporated in the plan or update?~~

§482.61(c)(1) The written plan must include—

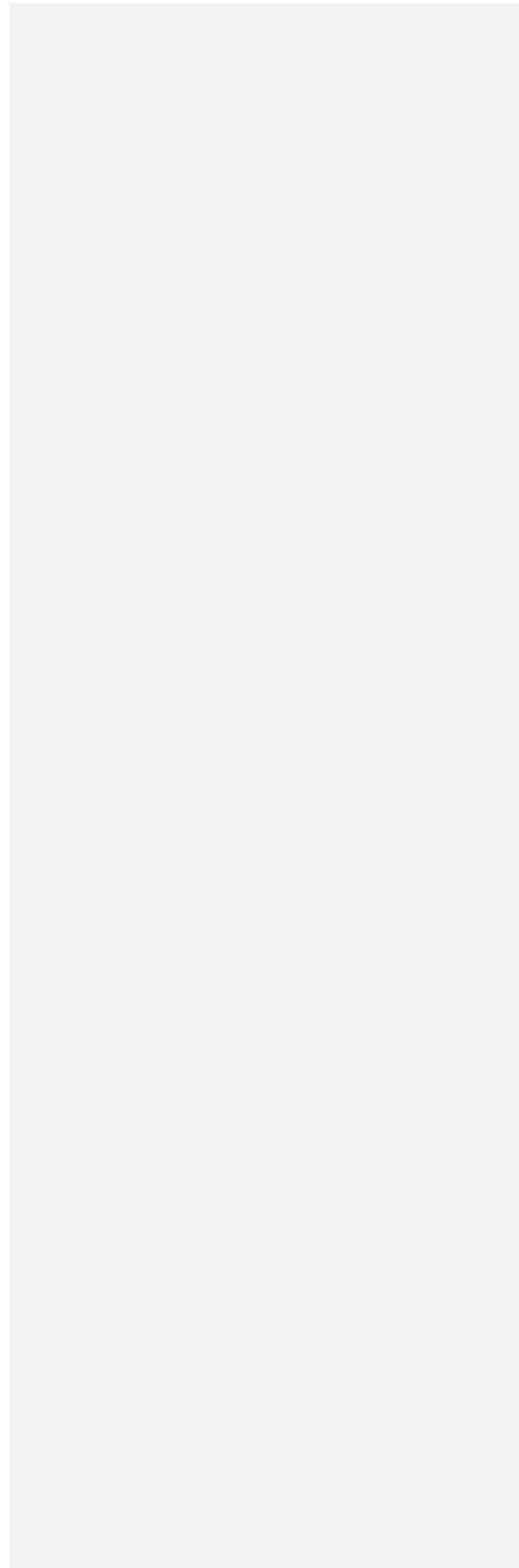
B120

§482.61(c)(1)(i) A substantiated diagnosis;

Guidance §482.61(c)(1)(i)

The substantiated diagnosis serves as the basis for treatment interventions. A substantiated diagnosis is the diagnosis identified by the treatment team to be the primary focus upon which treatment planning will be based. It evolves from the synthesis of data

from various disciplines.



At the time of admission, the patient may have been given an initial diagnosis or a rule-out diagnosis. At the time of treatment planning, a substantiated diagnosis must be recorded. It may be the same as the initial diagnosis, or, based on new information and assessment, it may differ.

Commented [NABH8]: The diagnosis may be found in other areas of the record—not necessarily on the treatment plan.

Rule-out diagnoses, by themselves are not acceptable as a substantiated diagnosis.

Data to substantiate the diagnosis may be found in, but is not limited to, the psychiatric evaluation, the medical history and physical examination, laboratory tests, medical and other psychological consults, assessments done by disciplines involved in patient evaluations and information supplied from other sources such as community agencies and significant others.

Probes §482.61(c)(1)(i)

What specific problems will be treated during the patient’s hospitalization?

Does the treatment plan identify and precisely describe problem behaviors rather than generalized statements i.e., “paranoid,” “aggressive,” “depressed?” or generic terminology i.e., “alteration in thought process,” “ineffective coping,” “alteration in mood?”

Are physical problems identified and included in the treatment plan if they require treatment, or interfere with treatment, during the patient’s hospitalization?

B121

§482.61(c)(1)(ii) Short-term and long range goals;

Guidance §482.61(c)(1)(ii)

Based on the problems identified for treatment, short-term and long-range goals are developed. Whether the use of short-term or a combination of short-term and long-range goals is appropriate is dependent on the length of hospital stay.

Short-term and long-range goals include specific dates for expected achievement. As goals are achieved, the treatment plan should be revised. When a goal is modified, changed or discontinued without achievement, the plan should be reviewed for relevancy, and updated as needed.

In crisis intervention and short-term treatment there may be only one timeframe for treatment goals. As the length of hospital stay increases (often because of the long-term chronic nature of the patient’s illness), both long-range and short-term goals are needed.

The long-range goal is achieved through the development of a series of short-term goals, i.e., smaller, logical sequential steps which will result in reaching the long-range goal. Both the short-term and long-range goals must be stated as expected behavioral outcomes for the patient. Goals must be related to the problems identified for treatment. Goals must be written as observable, measurable patient behaviors to be achieved. Discharge criteria may be included as long-range goals.

Probes §482.61(c)(1)(ii)

How do treatment plan goals relate to the problems being treated?

Do goals indicate the outcomes to be achieved by the patient?

~~Are the goals written in a way that allow changes in the patient's behavior to be measured?~~

If not apparent, what criteria do staff use to measure success?

How relevant are the treatment plan goals to the patient's condition?

B122

§482.61(c)(1)(iii) The specific treatment modalities utilized;

Guidance §482.61(c)(1)(iii)

This requirement refers to all of the planned treatment modalities used to treat the patient during hospitalization. Having identified the problems requiring treatment, and defining outcome goals to be achieved, appropriate treatment approaches must be identified.

Modalities include all of the active treatment measures provided to the patient. It describes the treatment that will be provided to the patient. It describes the treatment that will be provided by various staff.

A daily schedule of unit activities does not, in itself, constitute planned modalities of treatment. It is expected that when a patient attends various treatment modalities/activities, it is a part of individualized planning with a specific purpose and focus for that patient.

Simply "naming" modalities (i.e., individual therapy, group therapy, occupational therapy, medication education) is not acceptable. The focus of the treatment must be included.

Commented [NABH9]: The number, range (short or long term), time frames, observability, and measurability of goals has been a source of much debate and confusion since the development of the conditions. While the standard states long and short-term goals and the guidance allows for only short-term goals in brief hospitalization, surveyors tend to want to see multiple highly specified goals which distract from team focus on the reasons why a patient was admitted and how his readiness for discharge will be assessed. This leads to plans that focus on things such as "patient will focus on 3 new ways of coping with his boss" rather than more substantive movement toward discharge criteria.

Simply “stating” modality approaches (i.e., “set limits,” “encourage socialization,” “discharge planning as needed”) is not acceptable. Modality approaches must be specifically described in order to assure consistency of approach.

Observation of staff implementing treatment, both in structured and non-structured settings, is a major criterion to determine whether active treatment is being provided in accordance with planned treatment.

It must be clear to you that the active treatment received by the patient is internally consistent and not simply a series of disconnected specific modalities delivered within certain scheduled intervals.

Probes §482.61(c)(1)(iii)

Are qualified staff observed following the methods, approaches and staff intervention as stated?

Can staff explain the focus of the modality they have provided?

Are observed treatment methods, approaches and interventions from all disciplines included in the plan?

Do the pieces of the treatment plan work together to achieve the greatest possible gain for the patient?

Does the hospital integrate its activities, therapies, treatments, and patient routines to work for the patient’s therapeutic interest first, and its own convenience second?

Do the disciplines present at observed treatment planning meetings represent all of the patient’s needs?

If the patient attends treatment planning, how do the staff prepare the patient to participate?

If the patient does not attend, what reasons do staff give to explain the absence?

Is there a process to enable staff to reach a consensus regarding how treatment will be carried out?

Is the patient included in the decision-making, whenever possible?

Are the final decisions regarding treatment approaches defined clearly by the end of the discussion?

How does the patient get to know his/her treatment regime?

Commented [NABH10]: This is an example of where the guidance and probes have extended far beyond the standard of “the specific treatment modalities utilized.” There are many ways an organization can demonstrate compliance with the standard. Many of the probes are very subjective (such as: do the pieces of the treatment plan work together to achieve the greatest possible gain for the patient?). The probes tend to be used inappropriately as “checklists.”

How does the treatment team encourage the patient to accept responsibility for engaging in the treatment regime, rather than accepting it passively?

B123

§482.61(c)(1)(iv) The responsibilities of each member of the treatment team; and

Guidance §482.61(c)(1)(iv)

There are no “correct” number of staff who comprise the treatment team. The disciplines involved in the patient’s treatment depend upon the problems to be treated, the short-term and long-range goals and the treatment approaches and modalities used to achieve the goals.

The intent of the regulation is to insure that each individual on the treatment team who is primarily responsible for ensuring compliance with particular aspects of the patient’s individualized treatment program is identified. Identification of the staff should be recorded in a manner that includes the name and discipline of the individual. If other professionals or paraprofessionals provide care, the facility has the latitude to decide the manner with which it will identify them on the treatment plan.

The patient, as well as family/significant others, should be aware of the staff responsible for various aspects of treatment.

Probes §482.61(c)(1)(iv)

Are staff who are designated in the treatment plan observed carrying out treatment activities and therapies? Is the information in the plan consistent with surveyor observations?

Are the patients able to name the staff responsible for implementing their treatment? Is this information consistent with the treatment plan?

B124

§482.61(c)(1)(v) Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

Guidance §482.61(c)(1)(v)

Commented [NABH11]: There is nothing in the statement, “the responsibilities of each member of the treatment team” that requires the amount of specificity (e.g., by name) outlined in the guidance. Given the team approach of milieu treatment, implementation of the plan should not be dependent on named individuals. Individuals are identified in treatment and progress notes. Patients are not always to identify the staff/discipline responsible for implementing their treatment plan for many reasons.

When the progress and treatment notes are reviewed, the content of the notes must relate to the treatment plan. The notes must indicate what the hospital staff is doing to carry out the treatment plan and the patient's response to the interventions.

Probes §482.61(c)(1)(v)

Are the treatment notes relative to the identified problems?

Are the treatment notes indicative of the patient's response to treatment?

Do the progress notes relate to specific patient problems or progress?

B125

§482.61(c)(2) The treatment received by the patient must be documented in such a way to assure that all active therapeutic efforts are included.

Guidance §482.61(c)(2)

Active treatment is an essential requirement for inpatient psychiatric care. Active treatment is a clinical process involving ongoing assessment, diagnosis, intervention, evaluation of care and treatment, and planning for discharge and aftercare, under the direction of a psychiatrist. The patient is in the hospital because it has been determined that the patient requires intensive, 24 hour, specialized psychiatric intervention that cannot be provided outside the psychiatric hospital. The medical record must indicate that the hospital adheres to the patient's right to be counseled about medication, its intended effects, and the potential side effects. If the patient requires, because of danger to self or others, a more restrictive environment, the hospital must indicate that the staff attempted to care for the patient in the least restrictive setting before progressing to a more restrictive setting.

Through observation, look for evidence that each patient is receiving all the aspects of treatment to which the hospital has committed itself based upon his/her assessment, evaluation and plan of care. It is the hospital's responsibility to provide those treatment modalities with sufficient frequency and intensity to assure that the patient achieves his/her optimal level of functioning.

Through observation and interviews, look for evidence that each patient's rights are being addressed and protected. There should be policies and procedures in place to address the following areas: informed consent, confidentiality, privacy, and security. Expect to see detailed policies and procedures regarding the therapeutic use of restrictions, such as visitors, mail, and phone calls. Seclusion and restraint policies and procedures must address patient protection and safety while in a restricted setting.

Clarification of the types of notes found in the medical record.

Treatment notes are recordings in the medical record that indicate provision of, and a patient's response to, a specific modality. This modality may be drug therapy, individual, family, marital, or group therapy, art therapy, recreational therapy, and any specialized therapy ordered by the physician or anyone credentialed by the facility, in accordance with the State law, to write orders in the medical record.

A combined treatment and progress note may be written.

Progress notes are recordings in the medical record that are written by persons directly responsible for the care and active treatment of the patient. Progress notes give a chronological picture of how the patient is progressing toward the accomplishment of the individual goals in the treatment plan. These are frequently shift notes, weekly notes, or monthly notes.

Probes §482.61(c)(2)

Does the patient know his/her diagnosis?

What did the patient contribute to the formulation of the treatment plan? Goals of treatment?

If the patient receives medication, does the patient understand the reason for the medication? The name of the medication? The dose prescribed? The time of administration? The desired effects? The potential side effects?

If medication is changed, is there a rationale for the change?

Are staff members recording their observations relative to the patient's response to the treatment modalities, including medication?

Is there evidence that the patient was afforded the opportunity to participate in his/her plan of care?

What progress has the patient made? Has the patient achieved ~~his/her optimal level of functioning?~~ If not, why? a level of functioning that would allow him/her to be discharged safely from the hospital to a less restrictive level of care (at the time of discharge). Are these reasons/barriers reflected in the current treatment plan? Do treatment and progress notes support these insights?

Does the observed status of the patient in the various treatment modalities correspond to the progress note reports of status?

Do all treatment team members document their observations and interventions so that the

information is available to the entire team?

If a restrictive procedure is used (e.g., restraint and/or seclusion), is there evidence that attempts were made systematically to treat the patient in the least restrictive manner?

Is there evidence that the rights of the patient were protected while in the restrictive setting in accordance with Federal and State law and accepted standards of practice?

§482.61(d) Standard: Recording Progress

B126

§482.61(d) Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the patient as specified in §482.12(c),

Guidance §482.61(d)

Refer to §482.61(c)(2) Guidance for clarification between treatment notes and progress notes. The recording of progress is evidence of individual patient performance. Specifically, the progress notes recorded by the professional staff, or others responsible for the patient's treatment, must give a chronological picture of the patient's progress or lack of progress towards attaining short and long-range goals outlined in the individual treatment plan. Progress notes should relate to the goals of the treatment plan. Notes that state, "patient slept well" or "no complaints" constitute observations and do not indicate how the patient is responding to treatment and progressing towards set goals. Frequency alone does not determine the adequacy of progress notes. Expect to see greater frequency when patients are more acutely ill and/or in a crisis of some kind. Notes should be dated and signed (signature and title or discipline).

Commented [NABH12]: The distinction between treatment and progress notes is not as meaningful in a short-term hospitalization as it was in long term settings. Much energy is used on survey to make false distinctions.

Probes §482.61(d)

Are the physicians who are significantly involved in active treatment modalities/interventions actually documenting progress?

Do the progress notes relate to the goals of the treatment plan? Do they include precise statements of progress?

Is there a correlation between what is observed by the surveyor and what is described in the notes?

Do the notes give a clear picture of the patient's progress or lack thereof, during the course of hospitalization?

In reviewing the patient's progress, are aftercare/discharge plans being evaluated?

B127

§482.61(d) nurse

Probes §482.61(d)

Are the nurses who are significantly involved in active treatment modalities/interventions actually documenting progress?

B 128

§482.61(d) social worker

Probes §482.61(d)

Are the social workers that are significantly involved in active treatment modalities/interventions plan actually documenting progress?

B 129

§482.61(d) when appropriate, others significantly involved in active treatment modalities.

Probes §482.61(d)

Are staff from other disciplines, i.e., rehabilitative therapy and psychology, which are significantly involved in active treatment modalities/interventions actually documenting progress?

B 130

§482.61(d) The frequency of progress notes is determined by the condition of the patient but must be recorded at least weekly for the first 2 months and at least once a month thereafter,

Probes §482.61(d)

What is the frequency of progress notes in relation to the condition of the patient?

§482.61(d) and must contain

B 131

§482.61(d) recommendations for revisions in the treatment plan as indicated as well as

Probes §482.61(d)

Do the progress notes contain documentation substantiating changes/revisions in the treatment plan and subsequent assessment of the patient's responses and progress

B132

§482.61(d) a precise assessment of the patient's progress in accordance with the original or revised treatment plan.

Probes §482.61(d)

Do the notes give a clear picture of the patient's progress, or lack thereof, during the course of hospitalization?

Are the progress notes related to the goals of the treatment plan?

§482.61(e) Standard: Discharge Planning and Discharge Summary

B133

§482.61(e) The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization and

Guidance §482.61(e)

The record of each patient who has been discharged should indicate the extent to which goals established in the patient's treatment plan have been met.

As part of discharge planning, staff consider the discharge alternatives addressed in the psychosocial assessment and the extent to which the goals in the treatment plan have been met.

The surveyor should refer to hospital policy for discharge timeframes.

The discharge summary should contain a recapitulation of the patient's hospitalization, which is a summary of the circumstances and rationale for admission, and a synopsis of accomplishments achieved as reflected through the treatment plan. This summary includes the reasons for admission, treatment achieved during hospitalization, a baseline of the psychiatric, physical and social functioning of the patient at the time of discharge, and evidence of the patient/family response to the treatment interventions.

B134

Commented [NABH13]: The specificity of the guidance (including use of probes) in this area should take into account the many other requirements for discharge planning that psychiatric hospitals live with. There should not have to be separate documentation to meet hospital conditions, special conditions, accrediting, and IPFQR requirements, etc. These all have different requirements. This is a significant problem.

§482.61(e) recommendations from appropriate services concerning follow-up or aftercare

Guidance §482.61(e)

The patient's discharge summary should describe the services and supports that are appropriate to the patient's needs and that will be effective on the day of discharge.

Examples include:

- A complete description of arrangements with treatment and other community resources for the provision of follow-up services. Reference should be made to prior verbal and written communication and exchange of information;
- A plan outlining psychiatric, medical/physical treatment and the medication regimen as applicable;
- Specific appointment date(s) and names and addresses of the service provider(s);
- Description of community housing/living arrangement;
- Economic/financial status or plan, i.e., supplemental security income benefits;
- Recreational and leisure resources; and
- A complete description of the involvement of family and significant others with the patient after discharge.

Probes §482.61(e)

How does the discharge planning process verify appointment source(s), dates and addresses?

How was the patient involved in the discharge and aftercare planning process?

Were discharge related documents made available to the patient, family, community treatment source and/or any other appropriate sources?

Is there indication that the discharge planning process included the participation of multidisciplinary staff and the patient? Have the results been communicated to the post-hospital treatment entity?

Is there evidence that contact with the post-hospital treatment entity included communication of treatment recommendations (including information regarding the patient's medications)?

Is a contact person named, and does the patient have a specific appointment date and time for the initial follow-up visit?

B135

§482.61(e) a brief summary of the patient's condition on discharge.

Guidance §482.61(e)

The patient's discharge planning process should address anticipated problems after discharge and suggested means for intervention, i.e., accessibility and availability of community resources and support systems including transportation, special problems related to the patient's functional ability to participate in aftercare planning.

The discharge summary and/or plan should contain information about the status of the patient on the day of discharge, including psychiatric, physical and functional condition.

B136

§482.62 Condition of Participation: Special Staff Requirements for Psychiatric Hospitals

The hospital must have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures and engage in discharge planning.

Guidance §482.62

The purpose of this Condition of Participation is to ensure that the psychiatric hospital is adequately staffed with qualified mental health professionals and supportive staff to carry out an intensive and comprehensive active treatment program and to protect and promote the physical and mental health of the patients.

Through observation, interview and record review determine if numbers and/or deployment of qualified staff is a concern. Review incident reports, medication error reports, patient and staff injury reports, for indications that staffing is an issue.

Adequate numbers are defined to mean the numbers, and deployment, of staff with qualifications to evaluate, plan, implement and document active treatment.

Do not look at numbers alone. The hospital is responsible for organizing its available staff and administrative duties along with patient appointments, treatment plan meetings,

treatment sessions, activities, materials, equipment and patient assignments to wards and groups in such a way that results in patients achieving the maximum therapeutic benefit.

Survey Procedure §482.62

Assess the adequacy of the Special Staffing Condition by:

1. Observing sampled patients and others during structured sessions and in unstructured settings. You should be able to observe behavioral evidence of a rational organization of resources.
2. Next, interview patients and staff to determine whether or not necessary treatment modalities and other services are being provided in a timely manner.
3. Next review the medical records of patients in the sample to ascertain if necessary active treatment assessments, treatments, evaluations and activities have been conducted and documented.
4. Also, review other records such as restraint and seclusion records, incident reports, medication error reports, reports of patient/staff injuries, etc., to determine the extent to which staffing levels or deployment contributed to negative patient outcomes.
5. Evaluate all outcome data in light of the success or failure observed during the survey relevant to each patient receiving active treatment, and achieving desired outcomes of care. This is the primary basis for evaluating the adequacy of the hospital's staffing under this Special Condition.

Commented [NABH14]: This is difficult guidance to understand. What outcome data is being evaluated? How does outcome data directly correlate with observations of patients achieving desired outcomes of care during survey?

§482.62(a) Standard: Personnel

§482.62(a) The hospital must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to:

B137

§482.62(a)(1) Evaluate Patients

Probes §482.62(a)(1)

Is there adequate staff to assure that the admission work-ups (assessment, diagnostic data gathering) are completed in a timely manner?

Is there evidence that there is continuing evaluation of the patient's progress and response to treatment?

Are evaluations delayed or absent?

B138

§482.62(a)(2) Formulate written individualized, comprehensive treatment plans;

Guidance §482.62(a)(2)

Staffing must be sufficient so that members of the patient's treatment team and others responsible for evaluation and assessment can contribute their respective data for consideration in the formulation of the treatment plan.

Probes §482.62(a)(2)

Was there sufficient discipline participation at the treatment team meeting to assure formulation of a treatment plan that meets the patient's individualized needs?

What problems prevent staff members from attending treatment meetings? Do they relate to staffing?

Are the assessments/evaluations absent or delayed to the extent that they are not useful to the treatment team for the purpose of planning individualized treatment?

B139

§482.62(a)(3) Provide active treatment measures;

Guidance §482.62(a)(3)

Active treatment occurs when the patient receives treatment interventions that are delivered under the direction of a physician, and which are specific to patient strengths, disabilities, and problems identified in the treatment plan. Treatment interventions and other services are furnished in accordance with accepted standards of professional practice. Although the active treatment process must be identifiable in documentation, it must be first and foremost observable and evident in daily practice.

Treatment interventions need to be individualized, in that the patient receives assistance with resolving or ameliorating the problems/circumstances that led to hospitalization. Expect to see treatment focused on the unique needs of individual patients. For example, several patients may be referred to "Anger Management Group," but the focus of discussion and therapeutic intervention may differ depending on the individual patient's particular issue regarding managing anger.

Whether structure must be imposed by staff or whether the patient can direct his or her own activities for periods of time (without staff supervision), is based on the patient's

ability to engage in constructive, appropriate behavior (without engaging in harm to self or others). Be certain that the patient's time on the unit is maximized toward the further development of appropriate desired outcomes, including but not limited to leisure and recreation.

Probes §482.62(a)(3)

Through observation, interviews and record reviews, can you determine that patients receive active treatment?

Is the distribution of staff consistent with particular patient needs? Is appropriate staffing sufficient to carry out treatment plans?

Does the patient attend therapies that are relevant to the identified problems that brought the patient to the hospital?

Are staff absences and/or vacancies preventing the patient from receiving active treatment? Are patients not attending therapeutic activities off the unit because there is no staff to escort them? Are therapeutic groups not available on the unit for patients who are not able to go off the unit?

Are patients observed not engaged in activities while staff attend to administrative tasks?

Are active treatment sessions or activities carried out at discrete time intervals exclusively? Or is active treatment implemented as the patient's needs emerge during the course of the day, as well?

Does a review of quality assurance data reveal a pattern of serious incidents occurring on particular shifts and/or days of the week?

What do patients report to the surveyor are their treatment modalities?

Do patient interviews indicate that patients believe the treatment being provided is helpful?

Does the scheduling of activities and their content relate directly to the patient's treatment objectives or are the activities/content generalized, non-therapeutic "time-fillers"?

Can staff describe how their activities relate to the patient's treatment objectives?

At any point in time, in any of the patient's experiences in the hospital is the thrust of the patient's treatment plan observable during the staff and/or patient interactions?

Is there a consistent, observable pattern of evidence that hospital staff provide, reinforce and otherwise implement measures to achieve active treatment objectives?

Commented [NABH15]: Observation of active treatment is not always easy. Patients may not be engaged in groups, etc. because of the level of their psychiatric distress. Close staff monitoring and interaction is often the type of active treatment appropriate to their needs. Focus on all sources of data described in the probe is important.

B140

§482.62(a)(4) Engage in discharge planning;

Guidance §482.62(a)(4)

The patient together with all relevant professionals caring for the patient should be expected to participate in the discharge planning process. Staffing should be sufficient to facilitate this outcome, to the maximum extent possible.

Probes §482.62(a)(4)

Do patients participate in their discharge planning process? If not, why?

Do staff interviews elicit information that staff working with patients are aware of the discharge plans for those patients?

Do record review and interviews indicate that all relevant staff have participated in discharge planning?

§482.62(b) Standard: Director of Inpatient Psychiatric Services; Medical Staff

B141

§482.62(b) Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program.

Guidance §482.62(b)

Inpatient psychiatric services include the following functions: admission interviews, assessments and evaluations; psychiatric and medical work-ups; treatment team leadership; medication management; on-call provision of emergency psychiatric and medical treatment; provision of individual, group and family therapies; provision of clinical supervision to other professionals and paraprofessionals; provision of medical and psychiatric educational workshops and conferences for all staff; and provision of consultation to staff for clinical and/or administrative matters.

The clinical director is ultimately responsible for the medical and psychiatric care that is provided to patients. The clinical director should ascertain that quality improvement programs are in place to monitor all areas of patient care, and should implement educational programs for all levels of staff.

Survey Procedure §482.62(b)

Just prior to the end of the survey, schedule a meeting with the clinical director. By the time of this meeting, you should already have conducted required observation, interviews and record reviews for at least a majority of the patients in the sample. Collect any additional information that is necessary to consider in light of outcomes observed for patients, including: the qualifications of the clinical director; the leadership exhibited for the scope of psychiatric/medical treatment programs needed by patients; and the rationale for medical staffing coverage. If necessary, follow-up on letters of complaint previously reported serious problems, discrepancies with Data Collection Medical Staff Coverage (CMS-729).

B142

§482.62(b) The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services.

Guidance §482.62(b)

The number of full-time, part-time and consulting staff, who are board certified within each category and their availability to the hospital must be adequate to provide psychiatric services, as described above. Adequacy is considered in light of the following:

1. Number of admissions, discharges and current patients by treatment units;
2. Size of the hospital;
3. Geographic proximity of the wards and units;
4. Organization and kinds of treatment services rendered to the patients;
5. Availability of the physician coverage on evening, nights and weekends;
6. Availability of physicians to participate in treatment planning;
7. Availability of psychiatrists to consult with non-psychiatric physicians about psychotropic medication regimens; and
8. Availability of physicians to consult with multi-disciplinary staff about treatment issues.

Probes §482.62(b)

How many staff are board certified? Fully trained? How many full-time/part-time specialties are represented?

How are medical staff deployed? To what programs/units are they assigned? Why?

How much time do physicians spend on the units? Based on observations, interviews, and medical record reviews is coverage adequate to meet the needs of sampled patients? To meet the needs of other patients observed during the survey?

B143

§482.62(b)(1) The clinical director, service chief or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology, or the American Osteopathic Board of Neurology and Psychiatry.

Guidance §482.62(b)(1)

A physician is qualified to take the examinations for board certification upon successful completion of a psychiatric residency program approved by the American Board of Psychiatry and Neurology and/or the American Osteopathic Board of Psychiatry and Neurology.

Survey Procedures §482.62(b)(1)

Review the clinical director's personnel folder or ask the clinical director if he/she has one of the following:

- a. Certification of the American Board of Psychiatry and Neurology and/or certification of the American Osteopathic Board of Neurology and Psychiatry.
- b. If no certification, evidence that the person took the Boards would satisfy that the person had the training and equivalency to be admitted to the board examination.
- c. If indicated, medical school and residency training
- d. Length of time he has been employed at the facility; length of time he has been at his position

To be admitted to the American Board Examinations the following conditions must be met:

1. License without restrictions
2. Graduation from a medical school approved by either the Medical Osteopathic Association or the American Medical Association.

3. A successful completion of an approved residency-training program for at least 3 years before 1988 that the American Council on Graduate Medical Education (ACGME) approves. After 1988, it has to be a four year accredited program.

B144

§482.62(b)(2) The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.

Guidance §482.62(b)(2)

Services and treatment prescribed to patients must be in accordance with appropriate and acceptable standards of practice.

In states that allow psychologists to have admitting privileges, it is still the responsibility of the clinical director to oversee the quality of the patient's treatment.

Probes §482.62 (b)(2)

What mechanisms does the director use to monitor and evaluate the work of the medical staff (personal interviews? Quality Improvement reports? incident reports?)?

When problems are discovered by the clinical director, how are they corrected?

Are services, notes, and reports timely?

Are medications used appropriately for the patient's diagnosis?

§482.62(c) Standard Availability of Medical Personnel

B145

§482.62(c) Doctors of medicine or osteopathy and other appropriate professional personnel must be available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical diagnostic services and treatment are not available within the institution, the institution must have an agreement with an outside source of these services to ensure that they are immediately available or a satisfactory agreement must be established for transferring patients to a general hospital that participates in the Medicare program.

Guidance §482.62(c)

Contracts or other arrangements with individuals and/or providers assure that medical and surgical services are available to meet the needs of the patients. Review the medical and surgical services provided by the hospital during the interview with the clinical director.

Discuss contract or arrangements with the clinical director for services provided off grounds.

Probes §482.62(c)

How did the hospital meet the medical/surgical/diagnostic needs represented by each patient in the sample? Were these done timely? Appropriately?

If contracts are not current or available, how are these services provided for the patient, if needed? Is there evidence of negative outcomes as a result of these arrangements?

Are reports from other services such as pharmacy, radiology, and clinical laboratory timely? Appropriate?

§482.62(d) Standard: Nursing Services

B146

§482.62(d) The hospital or unit must have a qualified director of psychiatric nursing services. In addition to the director of nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each patient's active treatment program and to maintain progress notes on each patient.

Guidance §482.62(d)

Psychiatric nursing functions may include the following: supervision of paraprofessional staff; assessment, planning, provision, and evaluation of psychiatric nursing care to patients; medication teaching; management of the therapeutic milieu; provision of mandatory and voluntary in-service training to all staff; and provision of specialized treatments and therapies, such as individual, group and family therapies, that require the clinical expertise of a professional psychiatric nurse.

Expect to see evidence of orientation programs as well as ongoing continuing education programs for Licensed Practical Nurses and mental health workers that stress individualized treatment interventions.

Determine that there is a qualified Director of Nursing (DON) providing the required leadership and supervision for the psychiatric nursing department.

B147

§482.62(d)(1) The director of psychiatric nursing services must be a registered nurse who has a master's degree in psychiatric or mental health nursing or its equivalent

from a school of nursing accredited by the National League for Nursing, or be qualified by education and experience in the care of the mentally ill.

Guidance §482.62(d)(1)

During the interview with the DON, assess his/her educational background and psychiatric nursing and leadership skills. If the DON has less than a Master's Degree in Psychiatric Nursing, expect to see evidence of experience and on-going training in psychiatric nursing. Documented consultation from a nurse with a Master's in Psychiatric Nursing constitutes on-going training.

Commented [NABH16]: The requirement that the DON have a master's degree from a school accredited by the NLN is outmoded. Master's programs are typically accredited by AACN. Master's degrees in psychiatric nursing are also not the only advanced degrees available in nursing. Advanced practice nurses do not necessarily have degrees in psychiatric nursing, even if their focus is psychiatric nursing. Educational requirements for the DON (and consultants) should be consistent with that in medical/surgical settings and focused on competencies rather than strictly on academic preparation.

Probes §482.62(d)(1)

Are nursing assessments completed on all patients?

Do the multidisciplinary treatment plans reflect nursing input which include specific nursing interventions for nursing problems (e.g. violence toward self/others, physical/medical crises)?

Is nursing care evaluated by an R.N., with changes in the care based on the patient's progress or lack thereof?

Are intrusive techniques (e.g. seclusion, restraint, electroconvulsive therapy (ECT), and/or medical procedures) and patient incidents (e.g. medication errors, patient falls, patient-to-patient and patient-to-staff injuries) monitored in accordance with hospital policy, State statutes and safe nursing practice?

Are nursing personnel observed relating to patients in a therapeutic manner?

B148

§482.62(d)(1) The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished

Guidance §482.62(d)(1)

Based on structured observations of the patients in the sample and other patients in the hospital, patient and staff interviews and medical record review, ascertain that nursing services are provided in accordance with safe, acceptable standards of nursing practice

Information obtained from the DON should include: implementation of continuous quality improvement programs; provision of orientation, in-service and continuing education programs for nursing personnel especially in the areas of psychiatric nursing,

nursing process, prevention and management of violence, CPR and Universal Precautions.

B149

§482.62(d)(2) The staffing pattern must ensure the availability of a registered nurse 24 hours each day.

B150

§482.62(d)(2) There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient's active treatment program.

Guidance §482.62(d)(2)

The evaluation of sufficient numbers and level of RNs, LPNs and mental health workers is based on the patient characteristics as seen in structured observations of patients in the sample and other patients in the hospital, patient interviews, and as evidenced in medical records and other data related to patients (e.g. incident reports, seclusion/restraint reports). Patient care assignments should be appropriate to the skills and qualifications of the nursing personnel providing patient care.

There should be evidence that all nursing personnel have education, experience and/or training in psychiatric care. Mental health workers spend the majority of their workday interacting with patients. Expect to see evidence that they are receiving on-going supervision and training. Mental health workers should be assigned patient care duties and therapeutic modalities that reflect their educational level, psychiatric training, and experience.

Survey Procedure §482.62(d)(2)

The nursing staffing patterns should be reviewed on a sample of approximately 25% of the certified wards. The staffing, including levels of nursing personnel, should be reviewed for the day(s) of the survey and evaluated based on the level of needs presented by the patients. Additional staffing patterns shall be reviewed if a problem or concern is evidenced. Decisions regarding extent of additional data (number of wards and dates) to be reviewed shall be based on the degree of problem/concern. Patient need assessment/patient acuity shall be reviewed for any wards as deemed necessary based on problems/concerns found in the sampling review.

If your observations and/or interviews indicate a staffing problem, you may want to consider the following variables in assessing adequacy of nursing personnel coverage:

1. Organization and types of services provided to patients by the nursing department;4
2. Number and levels of nursing care needs of patients, including average length of stay, acuity of patients and nursing care requirements;
3. Number and levels of nursing personnel based on the roles and functions required of nursing;
4. Number of suicidal/assaultive patients;
5. Seclusion/restraint incidents;
6. Number of admissions and discharges;
7. Number and type of accidents and/or injuries;
8. Amount and complexity of medication regimens;
9. Medication errors;
10. Use of P.R.N. (as needed) medications;
11. Medical (physical) procedures;
12. Assignment and utilization of “pool” nursing personnel (those staff who are hired through a contract service and are not employees of the hospital). Contractual staff should receive orientation and training necessary for assigned functions, and should be supervised by employees of the hospital;
13. Availability of RNs to supervise/consult with nursing/non-nursing personnel about patient care;
14. Availability of RNs to assess and implement care in crisis situations;
15. Availability of RNs to interact with patients in structured activities; and
16. Involvement of patients with personnel.

Probes §482.62(d)(2)

Are personnel interacting with patients? Are patients involved in structured activities?
Are patients lying in beds/on floors, sitting alone, fighting and arguing?

When interviewing/observing staff, do they interact therapeutically with patients? If unclear, request rationale from staff.

Why have nursing staff been deployed in the manner that they have?

§482.62(e) Standard Psychological Services

B151

§482.62(e) The hospital must provide or have available psychological services to meet the needs of the patients.

Guidance §482.62(e)

Psychology services may include the following: diagnostic testing and diagnostic formulations on request from physicians; provision of individual, group and family therapies; participation in multi-disciplinary treatment conferences; and program development and evaluation.

The number of full-time, part-time and consulting psychologists must be adequate to provide necessary services to patients. Arrangements with outside resources must assure that necessary patient services will be provided.

Probes §482.62(e)

Did the patients in the sample have a need for psychological services or testing? Were they provided in a timely manner and with sufficient intensity?

Did any of the patients in the sample indicate a need for psychological services, but none were requested?

What types of psychological services are offered? (e.g., assessments, therapy)

Do certain groups of patients receive testing routinely? Dementia?, Children?, Adolescents? Why?

Once tests are performed, are results reported in sufficient time to be integrated in the patient's active treatment and treatment plan?

How does the hospital or Psychological Service Department determine whether or not: it meets the needs of patients? Its services are underutilized or over-utilized?

Why have psychological services staff been deployed in the manner that they have?

§482.62(f) Standard: Social Services

B152

§482.62(f) There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished.

Guidance §482.62(f)

Social work functions may include the following functions: Intake or admission screening, psychosocial assessment of a newly admitted patient; developing an update or detailed re-assessment of the patient; high-social risk case finding; contact with family and others significant in the patient's life. Such functions may include patient and family education, support, and advocacy; providing coordination/liaison with community-based social and mental health agency(ies) regarding the pre-admission status of the patient; participating as a member of the treatment team in development of treatment planning and subsequent planned interventions (modalities). Such modalities may include supportive, individual, couple, family, or group therapy, aimed at meeting specified goals identified in the treatment plan.

Continuity of care is an important social work principle and may be demonstrated through case management and a major role in discharge planning. Activities, in conjunction with the patient wishes, may include contact with patient's family, identifying and assisting in referral of the patient to community-based agency(ies) at the time of discharge. Finally, post-discharge follow-up may be done to assure that linkage of the patient with community resources has occurred to reduce re-hospitalization.

Determine who completed the assessment required by §482.61(a)(4) and initiated preliminary discharge planning. When staff other than a Social Worker perform these duties, the Director of Social Work or a Master's level social worker (MSW) qualified supervisory staff member should be involved to oversee the quality and appropriateness of service provided.

Patient and staff interviews, structured observations and review of selected medical records yield the information necessary to determine how well social work has met the needs of the patients. The surveyor should evaluate these data to determine adequacy of qualified and support staff deployed to patient areas and their duties.

The social work policies for service provision to the patient should describe: the organizational structure of the department (program) and the range of services performed by the department.

Survey Procedure §482.62(f)

Just prior to the end of the survey, schedule a meeting with the Director of Social Work. By the time of the meeting, you should already have conducted required observations,

interviews and record reviews for at least a majority of the patients in the sample. Collect any additional information that is necessary to consider in light of outcomes observed for patients, including: the qualifications of the director; the leadership exhibited for the scope of services needed by the patient; and the rationale for social work staffing coverage.

Probes §482.62(f)

How does the director periodically audit the quality of social work services furnished?

What are the outcomes of audits conducted? What percentage of psychosocial assessments was completed and available in written form at the time of the interdisciplinary treatment plan? How does the patient's social needs as addressed by the social worker in the psychosocial assessment compare against the goals developed in the interdisciplinary treatment plan?

Has social work staff provided active treatment in accordance with the patient's treatment plan?

B153

§482.62(f) The services must be furnished in accordance with accepted standards of practice and established policies and procedures.

Guidance §482.62(f)

Accepted standards of practice are based on policy statements adopted by the National Association of Social Workers and a definition of social work practice in health care adapted by the Consortium of Health Care Social Work Organizations. Staff should adhere to the facility's personnel requirements.

B154

§482.62(f)(1) The director of the social work department or service must have a master's degree from an accredited school of social work or must be qualified by education and experience in the social services needs of the mentally ill. If the director does not hold a master's degree in social work, at least one staff member must have this qualification.

Guidance §482.62(f)(1)

The duties, functions, and responsibilities of the director of social services/social work should be clearly delineated and documented in the facility's policies and procedures. If the director is not MSW qualified and at least one staff member is MSW qualified, verify the duties, functions, and responsibilities of the MSW.

Commented [NABH17]: Difficult to understand why quality audit functions are identified specifically for social services and not included under the overall requirements for the organization's quality program.

Commented [NABH18]: Other examples of accepted standards of practice should be included.

Probes §482.62(f)(1)

What are the director's qualifications, experience and scope of duties within this position?

If a MSW staff member, other than the director, is performing any of these duties, what are this staff member's experience and scope of duties performed? Why were these duties delegated?

To what extent is the director's knowledge of the social work needs of the various wards?

Why has the social work staff and services provided throughout the hospital been deployed in the manner it has?

B155

§482.62(f)(2) Social service staff responsibilities must include, but are not limited to, participating in discharge, planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital.

Guidance §482.62(f)(2)

Social work contact with the patient, family, and significant others should occur during, or as soon as possible, after the admission. High-risk case finding should result in significant data being available for early integration into the treatment plan and subsequent social work action as indicated. The treatment team should consider, for possible inclusion into the patient's treatment plan, the anticipated social work role and expected interventions as recommended in the psychosocial assessment . Treatment and discharge planning activities, liaison/follow-up efforts should be based upon the goals, including discharge goals, and staff responsibilities specified in the treatment plan.

Probes §482.62(f)(2)

Are social work staff routinely involved in providing services to the patient that are identified in the treatment plan?

To what extent do social work staff provide discharge planning services to the patient in the way of: supportive individual, couple, family, or group therapy focused on discharge goals of the patient? Carrying out a liaison role with community resource providers?

Have social work staff assured that adequate information is provided to post-hospital patient service providers?

§482.62(g) Standard: Therapeutic Activities

B156

§482.62(g) The hospital must provide a therapeutic activities program.

Guidance §482.62(g)

A variety of therapeutic and rehabilitative activities are selectively used as therapeutic tools in providing active treatment to the psychiatric patients. Therapeutic activities focus upon the development and maintenance of adaptive skills that will improve the patient's functioning. In contrast, leisure activities provide the patient with individualized opportunities to acquire knowledge, skills and attitudes about meaningful leisure involvement and experiences. A patient may need treatment and/or remediation of functional behavior(s) prior to leisure involvement. However, for some psychiatric patients the priority need may be for leisure education and activities.

B157

§482.62(g)(1) The program must be appropriate to the needs and interests of patients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

Guidance §482.62(g)(1)

The hospital is responsible for ensuring consistent availability and provision of individualized therapeutic activities and rehabilitative services based on patient needs.

The selection of individualized therapeutic and rehabilitative staff modalities should be based on patient need and goals set in the patient's treatment plan. Rehabilitative services may include educational, occupational, recreational, physical, art, dance, music, and speech therapies and vocational rehabilitation evaluation and counseling. There are other disciplines that also serve patients. Consultants include but are not limited to the following: educational instructors, registered occupational therapist/certified occupational therapy assistant, certified therapeutic recreation specialist, certified therapeutic recreation assistant, speech-language pathologist has certificate of clinical competence, registered and certified music therapist, registered art therapist, and registered physical therapist. The qualified vocational specialist may perform duties of a rehabilitation counselor, vocational evaluator, or the work adjustment specialist.

B158

§482.62(g)(2) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each patient's active treatment program.

Guidance §482.62(g)(2)

Qualified staff should complete their respective discipline assessments for use in multidisciplinary treatment planning. Specific role(s) and modalities to be implemented by rehabilitative staff must be determined by goals set in the patient's treatment plan.

Qualified therapists who provide clinical services and administrative staff should utilize established monitoring and evaluation mechanisms to conduct consistent timely review of the quality and appropriateness of therapeutic and rehabilitative services delivered to patients.

Probes §482.62(g)(2)

Is there evidence that sampled patients and staff are familiar with the goals and staff interventions described in the patient's treatment plan? Are these observed interventions being carried out? What is the patient's response? Are these interventions and activities of sufficient frequency and intensity to achieve maximum therapeutic benefit?

What are the qualifications, experience, duties and responsibilities of the Therapeutic Activities Director and discipline supervisor(s)?

How is the program organized?

Did the patients in the sample have a need for any therapeutic activities? Were their needs met?

Did any of the patients in the sample indicate a need for therapeutic activities, but none were considered?

What kinds of services are provided to the patient population?

Are activity areas/sites accessible and available to meet the patient's individual needs?
Are the facilities and resources adequate to enable implementation of goals set in the patient's treatment plan?

Does the program utilize available community resources to provide opportunities for socialization, leisure, and therapeutic and/or rehabilitation activities for patients who can participate outside the hospital setting?

Are current activity schedules clearly posted for patient and staff reference and use? Are the scheduled activities related to the particular patient area and specific treatment needs of patients?

Are patient needs met consistently at all times including evenings and weekends?

If a large number of patients are assigned to the same therapeutic activity, do patients have individualized goals within their treatment plans?

Why have therapeutic activities staff been deployed in the manner they have?

Transmittals Issued for this Appendix

Rev #	Issue Date	Subject	Impl Date	CR#
R149SOM	10/09/2015	State Operations Manual (SOM) for All Types of Providers and Suppliers Subject to Certification	10/09/2015	N/A
R100SOM	02/14/2014	State Operations Manual (SOM) Appendix AA revisions for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	02/14/2014	N/A
R01SOM	05/21/2004	Initial Release of Pub 100-07	N/A	N/A

