

Hospitalization Critical Element Pathway

Use this pathway for a sampled resident who was hospitalized for a reason other than a planned elective surgery to determine if facility practices are in place to identify, evaluate, and intervene to prevent hospitalizations.

Review the following to guide your observations and interviews:

- Review the most current comprehensive (i.e., admission, annual, significant change, or a significant correction to a prior comprehensive) and most recent quarterly (if the comprehensive isn't the most recent assessment) MDS/CAAS for B - communication, C - cognitive status, E - behaviors, J - pain or other health conditions, N - meds, O - special treatments or procedures,
- Care plan (e.g., measures to prevent initial hospitalization and reoccurrence of hospitalization),
- Physician's orders (e.g., d/c orders to the hospital, readmission orders, current orders), nursing notes, EMT records, hospital and discharge summaries, and progress notes, and
- Pertinent diagnosis.

Observation

Make observations as appropriate, over various shifts to corroborate the information obtained during the record review. You may also find it important to observe for information obtained from staff interviews. Potential pertinent observations are listed below.

- Observe the resident's overall physical and mental status (i.e., to ensure the resident isn't exhibiting the same s/s that sent the resident to the hospital).
 - Is the resident in physical distress?
 - Is the resident experiencing mental status changes?
 - Is the resident experiencing a change in condition?
 - Is the resident in pain? If so, where and what does staff do?
- Are care-planned interventions in place to prevent a re-hospitalization?
- Are MD-ordered interventions implemented to prevent re-hospitalization (e.g., respiratory treatments, blood pressure monitoring)?

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Interview

*As part of the investigation, surveyors should attempt to initially interview **the most appropriate direct care staff member**. Your interview question should be specific to the investigation at hand and based on findings from the record review and observations. Consider interviewing the DON, MD, CNP or PA to complete the investigation.*

Resident and/or representative:

- Why were you sent to the hospital? Has your condition improved? If not, do you know why it's not getting better?
- 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?
- Has your health declined since you were in the hospital? If so, what did staff do?
- What things are they doing to prevent another hospitalization? (Ask about specific interventions, e.g., monitoring BS).
- If you know the resident refused care, did the staff provide you with other options to treatment or did staff provide you with education on what might happen if you do not follow the treatment plan?
- 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?

Nurse:

- Are you familiar with the resident's care?
- Does the resident have pain? If so, how is it being treated?
- Since hospitalized, has the resident had a change or decline in condition? If so, what interventions are in place to address the problem(s)? What were the contributing factors for the hospitalization?
- Is the resident at risk for additional hospitalizations?
- Prior to the hospitalization, did the resident have a change or decline in condition? How often are you supposed to assess a resident who is experiencing a change in condition? Where is it documented?
- When did the hospitalization occur? What was the cause?
- Does the resident refuse any treatment? What do you do if the resident refuses?
- How do you monitor staff to ensure they are implementing care-planned interventions?
- How did you involve the resident in decisions regarding treatments?
- Ask about any concerns based on your investigation.

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Record Review

You may need to return to the record to corroborate information from the observations and interviews. Potential pertinent items in the record are listed below.

- Were vital signs taken at baseline prior to the hospitalization?
- Does the resident have a medical condition or receive medications that would require monitoring? If so, did the monitoring take place and was it documented (e.g., blood glucose monitored and treated appropriately)?
- Review laboratory results pertinent to the hospitalization.
- Has the care plan been revised to reflect any changes in the resident condition?
- The cause of the hospitalization was assessed, monitored, and documented.
- Was pain related to the hospitalization assessed and effective treatment measures documented?
- Were changes in the resident's status or other risks associated with the hospitalization correctly identified and communicated with staff and MD?
- Review facility policies and procedures with regard to factors contributing to the resident's hospitalization.

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Make compliance decisions below by answering the five Critical Elements.

Note: Remember if the facility failed to complete a comprehensive assessment resulting in a citation at F272, surveyors should not cite F279 and F280 as the facility could not have developed or revised a plan of care based on a comprehensive assessment they did not complete. If further guidance is needed, surveyors should refer to the regulation, IG, and investigative protocol as they conduct the investigation.

Critical Element

1. If the conditions or risks were present at the time of the required 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) of the resident's condition relevant to the care issues associated with the resident's hospitalization, and the impact upon the resident's function, mood, and cognition?
If No, cite F272
NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR a comprehensive assessment is not required yet.
2. Did the facility develop a plan of care with interventions and measurable goals, in accordance with the assessment, resident's wishes, and current standards of practice, to address the care and treatment related to the care issues associated with the hospitalization?
If No, cite F279
NA, the comprehensive assessment was not completed OR a comprehensive care plan was not required yet.
3. Did the facility provide or arrange services to be provided by qualified persons in accordance with the resident's written plan of care?
If No, cite F282
NA, no provision in the written plan of care for the concern being evaluated.
4. Did the facility reassess the effectiveness of the interventions and review and revise the plan of care (with input from the resident or representative, to the extent possible), if necessary, to meet the needs of the resident?
If No, cite F280
NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised.
5. Based on observation, interviews, and record review, did the facility provide care and services necessary to meet the needs of the resident in order to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care?
If No, cite F309

Other Tags and Care Areas to consider: F155, Notification of Change (F157), Dignity (F241), Choices (F155, F242, F246), F271, F274, F278, F281, Behavioral/Emotional Status (F309, F319, F320), Nutrition (F325), Hydration (F327), Sufficient Staffing (F353, F354), F385, F501, Infection Control (F441), F514, QA&A (F520).

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Notes: