

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|----|--|---|--|---------------|----------------|
| 1. | <p>Is there a specific regulation or an interpretation of a regulation, in which soiled utility room doors must be locked?</p> | <p>No. There is not a specific regulation that states “the soiled linen door must be locked.”</p> <p>Notes: However soiled linen rooms may contain chemicals and other biohazards that need to be secured. Soiled linen rooms may also have air flow requirements that require the door to be closed (locking can assure the door stays closed). In addition, soiled linen stored to be picked up by contracted service may require doors to be locked if there is public access.</p> | <p>No.</p> <p>Notes: See notes in federal column.</p> | CAH | Laundry |
| 2. | <p>C-0320 Surgical Services</p> <p>This standard includes informed consent & states "a properly executed informed consent form contains at least the following: name/signature of person who explained the procedure to the patient or guardian". Does this mean name or signature?</p> <p>Our surgeons discuss & document informed consent in their clinic notes which are included in the surgical record. We have a section on the consent form that states: "Informed consent discussion is documented in the medical record" followed by a line for the provider to sign, date &</p> | <p>No. You must have a signature.</p> <p>No. The signature does not need to be on a form it can be part of the record.</p> <p>Notes: Usually there are multiple individuals who discuss consent with a patient. The person who witnesses the patient signing the consent form would be signing, dating and timing the witness. The surgeon/physician who is one person who discusses consent with the patient can document on a form or within medical record and sign, date and time. The regulations are not specific to where that documentation should be located. However, as a hospital a process must be in place that has been well defined and implemented so that you can readily know what the patient has been made aware of the care/surgical options and has consented. These</p> | <p>Notes: DHS 124 again is not specific in regulatory language as to contents of consent especially as it relates to signatures. However there can be subtypes of consents where there is language that identifies components of consent. You should be aware of DHS 94 if that pertains to your facility.</p> | CAH | Consent |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|----|--|---|--|---------------|--------------------|
| | time. Is it necessary for them to sign this form or can we leave the statement on the consent but not require a surgeon signature on the form? | procedures for consent should be part of Governing Body, Medical By-laws, surgery policy and procedures, Medical record procedures and Quality Assurance. | | | |
| 3. | If the PA who gives a telephone order comes in and signs the order within 48 hours, does the physician still need to co-sign that order also in 48 hours? | No. Notes: Co-signature and authentication are two different issues. Authentication has a 48 hour time requirement. Co-signature time requirements will vary. Hospital governing body and medical staff bylaws should address co-signatures and reflect the practices occurring in the hospital. Please see C-260 requirements that indicates a physician must periodically review and sign all orders for patients cared for by a physician assistant. | No. Notes: See Federal notes. Please see Med 8 for physician assistant requirements for issuing orders, the supervising physician and order review requirements. | CAH | Physician Extender |
| 4. | Must H&P be signed by the Surgeon prior to surgery if the H&P has been delegated to another MD with privileges to perform an H&P. | Yes. Notes: 485.639 Condition of Participation for Surgical Services reads: "Surgical procedures must be performed in a safe manner by qualified practitioners (this would be the surgeon performing the surgery who is ultimately responsible for the patient) who have been granted clinical privileges by the governing body of the CAH in accordance with the designation requirements under paragraph (a) of this section. -The interpretive guidelines (which the state agency does not cite to but refer to them in guiding the intent of the regulations) reads as follows: "All or part of the H & P may be delegated to other practitioners in accordance with State law | | CAH | H&P |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|----|--|--|-------------------------------|---------------|----------------|
| | | and CAH policy, but the surgeon must sign the H & P and assume full responsibility for the H & P". "This means that a nurse practitioner or a physician assistant, meeting these criteria, may perform the H & P". But it is clear in the guidance that the surgeon must sign the H & P. This is CMS guidance to providers and what the State agency would look for. | | | |
| 5. | Does the Surgeon need to sign the H&P if it has been delegated to a midlevel provider who also has privileges to do the H&P. | Yes. Notes: Seen notes at # 4 | | CAH | H&P |
| 6. | Does the Surgeon also need to sign the H&P update of another MD or mid level provider | Yes. Notes: See notes at # 4. | | CAH | H&P |
| 7. | Do we need to obtain procedural consent or informed consent for vaccinations on children or newborns (in either the Clinic or hospital settings). | No. There is no specific requirement for a signed consent for vaccinations. Note: In hospitals patients have rights to be involved in care planning and to consent to care as a general rule. There are specific circumstances like for surgery, mental illness treatment, alcoholism treatment, drug treatment that have specific requirements for consent. For vaccines there is no specific hospital requirement for a consent. However there are federal requirements to make sure a current vaccination information sheet (VIS) is provided. Do to this requirement many providers institute a consent for this to show that they have provided the VIS. For more information please see: http://www.cdc.gov/vaccines/pubs/VIS/vis-facts.htm | No. See Federal Notes. | CAH | Consent |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|----|---|---|---|---------------|----------------|
| 8. | On OB patients, do we need a consent signed to perform toxicology on these patients (i.e. urine screening for drugs), or can we just do it without their consent? | <p>No. There is no specific requirement for a signed consent for vaccinations.</p> <p>Notes: In hospitals patients have rights to be involved in care planning and to consent to care as a general rule. There are specific circumstances like for surgery, mental illness treatment, alcoholism treatment, drug treatment etc. that have specific requirements for consent.</p> <p>For toxicology again there is not a specific hospital requirement for a specific consent for toxicology. However if the toxicology is being done for a specific reason and is not routine it would seem that consent would be in line to assure the patient is part of the decision</p> | <p>No.</p> <p>Notes: See Federal Notes.</p> | CAH | Consent |
| 9. | The surgeons want to be able to reference a full completed history and physical which has been completed within the last 365 days. The surgeon will see the pt within 90 days of the procedure and reference the previously completed h and p and document the reevaluation and do an update h and p the morning of the procedure. If the surgeon will not see the pt within 90 days, then the primary care MD will re do the H and P, referring to the previously completed H and P as long as it was done within 365 days of the scheduled procedure date and the surgeon will complete the update H and P the morning of the procedure. Is this | <p>No. Standard of practice is an H&P completed within 30 days.</p> <p>Notes: 485.639: C320: Surgical procedures must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body of the CAH.</p> <p>Interpretative Guidelines: A complete history and physical must be conducted in accordance with acceptable standards of practice, and the written document placed on the medical record, prior to surgery. All or part of the H & P may be delegated to other practitioners in accordance with State law and CAH policy, but the surgeon must sign the H & P and assume full responsibility for the H & P. This means that a nurse practitioner or a physician assistant,</p> | <p>No.</p> <p>DHS 124.14(3)(a)9: Except in an emergency, an appropriate H & P work-up recorded in the medical record of every patient before surgery.</p> <p>DHS 124.14 (3) (c) 2: If a patient is readmitted within 30 days for the same or a related condition, there shall be a reference to the previous history with an interval note, and any pertinent</p> | CAH | H&P |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|-----|--|--|---|---------------|----------------|
| | allowed? | meeting these criteria, may perform the H & P. In all circumstances, when an H & P has been conducted, but is not present on the chart prior to surgery, or in emergency situations where a complete H & P cannot be conducted prior to surgery, a brief admission note on the chart is necessary. The note should include at a minimum critical information about the patient's condition including pulmonary status, cardiovascular status, BP, vital signs, etc. | changes in physical findings shall be recorded. | | |
| 10. | Since labor epidurals are analgesia and not anesthesia, is it acceptable to not do the full post anesthesia evaluation including all the required elements? Would a post procedure note be sufficient? Also if the labor epidural is done by an OB physician and not anesthesia services, does that make any difference? | The type of note depends on the use of the epidural. Epidural evaluations are required prior to use, during use and after use. If an epidural is anesthesia e.g. a cesarean section then a full post anesthesia assessment and note is required. If the epidural is for analgesia e.g. for a normal vaginal deliver a full post anesthesia note may not be required however standards of practice and regulations do require assessments and documentation. Documentation for example should include removal of the catheter and return of sensation. This applies whether the anesthesiologist, CRNA or OB physician place the epidural. | | Acute | Anesthesia |
| 11. | Can you provide the CMS definition of "anesthesia services." The definition is most pertinent here for H&Ps and H&P updates. | Yes. Anesthesia services is defined by CMS within Appendix A of the State Operations Manual and updated with S&C memo 10-09 located at http://www.cms.hhs.gov/SurveyCertificationGenI | | Acute | Anesthesia |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|-----|---|---|--|---------------|--------------------|
| | | <p>nfo/downloads/SCLetter10_09.pdf</p> <p>Notes: For H & P's with regards to surgery/anesthesia requirements; as written in the regulations , "H & P's must be done prior to surgery or a procedures requiring anesthesia services". 482.22 (c) (5) 482.22 (c) (5) (ii)</p> | | | |
| 12. | <p>CAH swing bed patients are reimbursed differently by Medicare than CAH acute inpatients; therefore, do they need to comply with the same regulations and hospital policies?</p> | <p>Yes. Appendix W: CAH Swing-Bed Survey Module: Survey Procedures: Regulatory Authority and Requirements for CAH Providers of Extended Care Services (Swing beds) states:</p> <p>“CAH swing bed care is regulated by both the CAH requirements and the swing-bed requirements at 42 CFR Part 485. The requirements for acute-care CAHs also apply to swing bed patients.”</p> <p>485.645: C350 Interpretive Guidelines: Swing-bed patients receive a SNF level of care, and the CAH is reimbursed for providing SNF level of care; however, swing-bed patients are not SNF patients. Swing-bed patients in CAH’s are considered to be patients of the CAH.</p> | | CAH | Swing Bed |
| 13. | <p>Can a nurse practitioner do “rounding” on CAH patients?</p> | <p>Yes, with medical supervision.</p> <p>485.631(b): C257: The doctor of medicine or osteopathy (i) provides medical direction for the CAH’s health care activities and consultation for, and medical supervision of, the health care staff.</p> <p>Interpretive Guidelines: A CAH must have an MD/DO on its staff who must perform all of the</p> | <p>Yes, if under the direct supervision of the admitting MD/DO.</p> <p>DHS 124.05(2)(g): Patient care. The governing body shall establish a policy which requires that every</p> | CAH | Physician Extender |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|-----|---|--|---|----------------------|-----------------------|
| | | <p>medical oversight functions. The MD/DO provides medical direction for the CAH's health care activities and is available for consultation and supervision of the CAH health care staff.</p> | <p>patient be under the care of a physician, dentist, or podiatrist. The policy shall provide that:</p> <p>DHS 124.05 (2)(g)1. A person may be admitted to a hospital only on the recommendation of a physician, dentist or podiatrist, with a physician designated to be responsible for the medical aspects of care; and</p> <p>2. A member of the house staff or another physician shall be on duty or on call at all times.</p> | | |
| 14. | <p>Can Physician Extenders round for MDs in acute bed areas for Mental Health Certified Units?</p> | <p>Yes.</p> <p>485.631(a)(4): C254: A doctor of medicine or osteopathy, nurse practitioner, clinical nurse specialist, or physician assistant is available to furnish patient care services at all times the CAH operates.</p> | <p>Yes, if under the direct supervision of the admitting MD/DO.</p> <p>DHS 124.05(2)(g): Patient care. The governing body shall establish a policy which requires that every patient be under the care of a physician, dentist, or podiatrist. The policy shall provide that:</p> | CAH | Physician Extender |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|-----|---|---|---|---------------|--------------------|
| | | | <p>DHS 124.05 (2)(g)1. A person may be admitted to a hospital only on the recommendation of a physician, dentist or podiatrist, with a physician designated to be responsible for the medical aspects of care; and</p> <p>2. A member of the house staff or another physician shall be on duty or on call at all times.</p> <p>Further information regarding Mental Health certification can be directed to Mark Hale, Chief, Behavioral Health Certification Section, Division of Quality Assurance.</p> | | |
| 15. | <p>Does an MD need to sign-off for a person who presented to an ED and not admitted as an inpatient?</p> | <p>Yes.</p> <p>485.631(b)(1)(iv): C260: the doctor of medicine must periodically review and sign the records of all inpatients cared for by the nurse practitioners, clinical nurse specialists, or physician assistants.</p> <p>Interpretive guidelines: A MD/DO must review and sign all records for patients cared for by mid-</p> | <p>Yes.</p> <p>DHS 124.05(2)(g): Patient care. The governing body shall establish a policy which requires that every patient be under the care of a physician, dentist,</p> | CAH | Physician Extender |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|-----|--|---|---|---------------|----------------|
| | | <p>level practitioners.</p> <p>485.631(b)(2): C261: Periodically, but not less than every 2 weeks, reviews and signs a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants according to the policies of the CAH and according to current standards of practice where State law requires record review.</p> <p>EMTALA: 489.24(a): C-2406: In the case of a hospital that has an emergency department, if an individual comes to the emergency department the hospital must provide an appropriate medical screening examination. The examination must be conducted by an individual who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of 482.55 concerning emergency services personnel and direction.</p> | <p>or podiatrist.</p> <p>DHS 124.14(3)(a)2: Medical Record: A concise statement of complaints, including the chief complaint which led the patient to seek medical care and the date of onset and duration of each.</p> | | |
| 16. | Do patient consents need to be dated and timed? | <p>Yes.</p> <p>485.638(a)(4): C304: For each patient receiving health care services, the CAH maintains a record that includes, as applicable...</p> <p>Interpretative guidelines: A properly executed consent form contains at least the following...date and time consent is obtained.</p> | <p>Yes.</p> <p>DHS 124.05(3)(a)1.i.: Except in emergencies, the consent of the patient or the patient's legally authorized representative shall be obtained before treatment is administered;</p> | CAH | Consent |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|-----|--|---|--|---------------|-------------------|
| | | | DHS 124.14(5)(a)1: All entries in medical records by medical staff or other hospital staff shall be legible, permanently recorded, dated and authenticated with the name and title of the person making the entry. | | |
| 17. | Does every inpatient require a discharge summary? | <p>Yes.</p> <p>485.638(a)(4)(i): C304: For each patient receiving health care services, the CAH maintains a record that includes, as applicable-</p> <p>(i) identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;</p> <p>Interpretative guidelines: The medical record must contain complete information and documentation regarding medical history, assessment of the health status and health care needs of the patient, and a summary of the episode, disposition, and instructions to the patient. This information and documentation is contained in a discharge summary.</p> <p>A discharge summary discusses the outcome of the CAH stay, the disposition of the patient, and provisions for follow-up care. Follow-up care provisions include any post CAH appointment,</p> | <p>Yes.</p> <p>DHS 124.14(3)(a)14: A discharge summary including the final diagnosis, the reason for hospitalization, the significant findings, the procedures performed, the condition of the patient on discharge and any specific instructions given the patient or family or both the patient and the family;</p> <p>DHS 124.14(3)(b)4: The attending physician's signature on the face sheet and discharge summary.</p> | CAH | Discharge Summary |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|-----|---|--|---------------------------|---------------|-------------------|
| | | <p>how post CAH patient care needs are to be met, and any plans for post-CAH care by providers such as swing-bed services, home health, hospice, nursing homes, or assisted living. A discharge summary is required following any CAH acute care stay prior to and following a swing-bed admission and discharge.</p> <p>The MD/DO or other qualified practitioner with admitting privileges in accordance with State law and CAH policy, who admitted the patient, is responsible for the patient during the patient's stay in the CAH. This responsibility would include developing and entering the discharge summary.</p> <p>The MD/DO may delegate writing the discharge summary to other qualified health care personnel such as nurse practitioners and physician assistants to the extent recognized under State law or a State's regulatory mechanism. The MD/DO may also delegate writing the discharge summary to another MD/DO who is familiar with the patient.</p> <p>SWING BED PATIENTS: 483.12(a)(3): C376: When the facility transfers or discharges a resident under any of the circumstances specified in ... the resident's clinical record must be documented. The documentation must be made by the resident's physician when transfer or discharge is necessary ...</p> | | | |
| 18. | Is a discharge summary required for “observation”? | Yes. | Yes. | CAH | Discharge Summary |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|--|-----------------|---|--|----------------------|-----------------------|
| | | <p>485.620(a): C211: Except as permitted for CAHs having distinct part units under §485.647, the CAH maintains no more than 25 inpatient beds after January 1, 2004, that can be used for either inpatient or swing-bed services.</p> <p>Interpretative Guidelines: Observation Patient Services. Observation services BEGIN and END with an order by a physician or other qualified licensed practitioner of the CAH.</p> <p>485.638(a)(4)(i): C304: For each patient receiving health care services, the CAH maintains a record that includes, as applicable- (i) identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient.</p> <p>Interpretative guidelines: The medical record must contain complete information and documentation regarding medical history, assessment of the health status and health care needs of the patient, and a summary of the episode, disposition, and instructions to the patient. This information and documentation is contained in a discharge summary.</p> <p>A discharge summary discusses the outcome of the CAH stay, the disposition of the patient, and provisions for follow-up care. Follow-up care provisions include any post CAH appointment, how post CAH patient care needs are to be met, and any plans for post-CAH care by providers</p> | <p>DHS 124.14(3)(a)14: A discharge summary including the final diagnosis, the reason for hospitalization, the significant findings, the procedures performed, the condition of the patient on discharge and any specific instructions given the patient or family or both the patient and the family.</p> <p>DHS 124.14(3)(b)4: The attending physician’s signature on the face sheet and discharge summary.</p> | | |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|-----|---|---|--|----------------------|-----------------------|
| | | <p>such as swing-bed services, home health, hospice, nursing homes, or assisted living. A discharge summary is required following any CAH acute care stay prior to and following a swing-bed admission and discharge.</p> <p>The MD/DO or other qualified practitioner with admitting privileges in accordance with State law and CAH policy, who admitted the patient is responsible for the patient during the patient's stay in the CAH. This responsibility would include developing and entering the discharge summary.</p> <p>The MD/DO may delegate writing the discharge summary to other qualified health care personnel such as nurse practitioners and physician assistants to the extent recognized under State law or a State's regulatory mechanism. The MD/DO may also delegate writing the discharge summary to another MD/DO who is familiar with the patient.</p> | | | |
| 19. | <p>Is a discharge summary required for hospice respite patient?</p> <p>If yes, can the hospice RN write the d/charge summary?</p> | <p>Yes; see response to question #17 above.</p> <p>485.638(a)(4)(i): C304: For each patient receiving health care services, the CAH maintains a record that includes, as applicable-</p> <p>(i) identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient.</p> | <p>Yes.</p> <p>DHS 124.14(3)(a)14: A discharge summary including the final diagnosis, the reason for hospitalization, the significant findings, the procedures performed, the condition of the patient on discharge and any specific instructions given the patient or</p> | CAH | Discharge Summary |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|-----|--|---|--|---------------|-------------------|
| | | <p>Interpretative guidelines: The medical record must contain complete information and documentation regarding medical history, assessment of the health status and health care needs of the patient, and a summary of the episode, disposition, and instructions to the patient. This information and documentation is contained in a discharge summary.</p> <p>The MD/DO may delegate writing the discharge summary to other qualified health care personnel such as nurse practitioners and physician assistants to the extent recognized under State law or a State's regulatory mechanism. The MD/DO may also delegate writing the discharge summary to another MD/DO who is familiar with the patient.</p> <p>The MD may delegate this task to a Hospice nurse if she is under the direct supervision of the admitting physician.</p> | <p>family or both the patient and the family.</p> <p>DHS 124.14(3)(b)4: The attending physician's signature on the face sheet and discharge summary.</p> | | |
| 20. | <p>Is a discharge summary required for patients less than 48 hour stay?</p> | <p>Yes; see responses to #17 and #18 above.</p> <p>485.638(a)(4)i: C304: For each patient receiving health care services, the CAH maintains a record that includes, as applicable- (i) identification and social data, evidence of properly executed informed consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;</p> <p>Interpretive guidelines: A discharge summary is required following any CAH acute care stay prior</p> | <p>Yes.</p> <p>All the information you would expect to see in a discharge summary must be found in the medical record. It does not however need to be a formal dictated note. See below</p> <p>Per BQC-93-046 July 21, 1993 Clarification of HSS</p> | CAH | Discharge Summary |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|-----|---|--|--|---------------|----------------|
| | | to and following a swing-bed admission and discharge. | 124.14(3)(a)14 Discharge Summary Requirements:on short-term stays ...as being less than 48 hours: Division of Quality Assurance will accept a medical record which includes the final diagnosis, the reason for hospitalization, the significant findings, the procedures performed, the condition of the patient on discharge and any specific instructions given the patient and/or family as meeting the intent of a discharge summary for those patients with short-term stays of under 48 hours. | | |
| 21. | Is there a requirement for a medical record committee? | No. There is no requirement for a “committee.” Notes: However, Clinical Records System shall: 485.638(a)3: C303: A designated member of the professional staff is responsible for maintaining the records and for ensuring that they are completely and accurately documented, readily accessible, and systematically organized. | No requirement for a “committee.” Notes: However, Medical Record Services shall: DHS 124.14(2)(d): Adequate numbers of personnel who are qualified to supervise and operate the service shall be provided. | CAH | Med Rec |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|-----|---|---|--|---------------|--------------------|
| | | | DHS 124.14(2)(d)1 DHS 124.14(2)(d)2a and 2b. | | |
| 22. | Can a midwife medical student write progress notes in the clinical record and sign standing orders if the C.N.M. co-signs? | <p>Yes.</p> <p>485.638(a)(4)(iv): C307: For each patient receiving health care services, the CAH maintains a record that includes, as applicable</p> <p>(iv) dated signatures of the doctor of medicine or osteopathy or other health care professional.</p> <p>Interpretative guidelines: The parts of the medical record that are the responsibility of the MD/DO must be authenticated by this individual. When non-MD/DOs have been approved for such duties as taking medical histories or documenting aspects of physical examination, such information shall be appropriately authenticated by the responsible MD/DO. Any entries in the medical record by house staff or non-MD/DOs that require counter signing by supervisory or attending medical staff members shall be defined in the medical staff rules and regulations.</p> | <p>Yes.</p> <p>DHS 124.14(3)((c)3: All records of discharged patients shall be completed within a reasonable period of time specified in the medical staff by-laws, but not to exceed 30 days.</p> <p>Hospital policy/procedure can set a timeline, as long as it falls within the 30 days for a complete record.</p> <p>Orders cannot be given by students; only by privileged staff.</p> <p>If students are granted privileges similar to a MD resident, they could write orders, but those orders must be co-signed within 48 hours by a CNM or MD.</p> | CAH | Physician Extender |
| 23. | Do hospital personnel need to be | Yes. | Yes. | CAH | Cleaning |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|--|--|---|--|---------------|---------------------|
| | <p>present when cleaning staff are in medication rooms, medical record rooms, and MD offices?</p> | <p>485.638(b): C308: The CAH maintains the confidentiality of record information and provides safeguards against loss, destruction, or unauthorized use.</p> <p>Interpretive Guidelines: The CAH has sufficient safeguards to ensure that access to all information regarding patients is limited to those individuals designated by law, regulation, policy; or duly authorized as having a need to know. No unauthorized access or dissemination of clinical records is permitted. Clinical records are kept secure and are only viewed when necessary by those persons having a part in the patient’s care.</p> <p>485.635(a)(3)(iv): C276: Rules for the storage, handling, dispensation, and administration of drugs and biologicals....</p> <p>Interpretive Guidelines: Drug Storage: All drugs and biologicals must be kept in a locked room or container. If the container is mobile or readily portable, when not in use, it must be stored in a locked room, monitored location, or secured location that will ensure that security of the drugs or biologicals. All drugs and biologicals must be stored in a manner to prevent access by unauthorized individuals. Persons without legal access to drugs and biologicals cannot have unmonitored access to drugs or biologicals.</p> | <p>DHS 124.14 Medical record services. (1) Medical Record. A medical record shall be maintained for every patient admitted for care in the hospital. The record shall be kept confidential and released only in accordance with ss. 51.30, 146.81 to 146.83, or 252.15, Stats., and ch. DHS 92, as appropriate.</p> <p>DHS 124.14(2)(b)1: Confidentiality. Written consent of the patient or the patient’s legally authorized representative shall be presented as authority for release of medical information to persons not otherwise authorized to receive this information.</p> <p>DHS 124.15(2) Pharmaceutical services: The hospital shall have a pharmacy directed by a pharmacist or a drug room under competent supervision. The</p> | | <p>Staff Access</p> |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|-----|---|---|---|---------------|----------------|
| | | | <p>pharmacy or drug room shall be administered in accordance with accepted professional practices.</p> <p>DHS 124.15(4)(a): Facilities: Storage and equipment. Drugs shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation and security.</p> <p>DHS 124.15(4)(b)2: Drug stocks and all medication areas shall be routinely reviewed by the pharmacist. All floor stocks shall be properly controlled.</p> | | |
| 24. | <p>Do H&Ps need updating prior to surgery?</p> | <p>Yes.</p> <p>485.639: C320: Surgical procedures must be performed in a safe manner by qualified practitioners who have been granted clinical privileges by the governing body of the CAH.</p> <p>Interpretative Guidelines: A complete history and physical must be conducted in accordance with acceptable standards of practice, and the written document placed on the medical record, prior to surgery. All or part of the H & P may be delegated to other practitioners in accordance with State law and CAH policy, but the surgeon</p> | <p>Yes.</p> <p>DHS 124.14(3)(a)9: Except in an emergency, an appropriate H & P work-up recorded in the medical record of every patient before surgery.</p> <p>DHS 124.14 (3) (c) 2: Updating an H & P within 30 days of readmission....a surgery is a readmission if day</p> | CAH | H&P |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|-----|--|---|---|---------------|----------------|
| | | <p>must sign the H & P and assume full responsibility for the H & P. This means that a nurse practitioner or a physician assistant, meeting these criteria, may perform the H & P.</p> <p>In all circumstances, when an H & P has been conducted, but is not present on the chart prior to surgery, or in emergency situations where a complete H & P cannot be conducted prior to surgery, a brief admission note on the chart is necessary. The note should include at a minimum critical information about the patient's condition including pulmonary status, cardiovascular status, BP, vital signs, etc.</p> | <p>surgery.</p> <p>DHS 124.20(5)(d)1: For an infant delivered enroute to a hospital, admission may be made directly to the newborn nursery if an admission history and physical assessment does not reveal the likelihood of communicable disease or infection.</p> | | |
| 25. | <p>Who can admit a patient to a CAH?</p> <p>‘To a swing bed within a CAH?’</p> | <p>485.631(c)(3): C268: Whenever a patient is admitted to the CAH by a nurse practitioner, physician assistant, or clinical nurse specialist, a doctor of medicine or osteopathy on the staff of the CAH is notified of the admission.</p> <p>Interpretive Guideline: The CAH regulations do permit licensed mid-level practitioners, as allowed by the State, to admit patients to a CAH. However, CMS regulations do require that Medicare and Medicaid patients be under the care of an MD/DO if admitted by a mid-level practitioner and the patient has any medical or psychiatric problem that is present on admission or develops during hospitalization that is outside the scope of practice of the admitting practitioner. Evidence of being under the care of an MD/DO must be in the patient's medical record. If a CAH allows a mid-level practitioner to admit and care for patients, as allowed by State law, the governing body (or responsible individual) and</p> | <p>DHS 124.05(2)(g) Patient care. The governing body shall establish a policy which requires that every patient be under the care of a physician, dentist, or podiatrist. The policy shall provide that:</p> <p>DHS 124.05 (2)(g)1. A person may be admitted to a hospital only on the recommendation of a physician, dentist or podiatrist, with a physician designated to be responsible for the medical aspects of care; and</p> | CAH | Admissions |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|--|-----------------|--|--|----------------------|-----------------------|
| | | <p>medical staff would have to establish policies and bylaws to ensure patient safety. As applicable, the patient's medical record must demonstrate MD/DO responsibility/care.</p> <p>C350 485.645: C350: Special Requirements for CAH Providers of Long Term Care Services (Swing Beds).</p> <p>Interpretative Guidelines: A "swing-bed" is a change in reimbursement status. The patient swings from receiving acute-care services and reimbursement to receiving skilled nursing (SNF) services and reimbursement.</p> <p>There must be discharge orders changing status from acute care services, appropriate progress notes, discharge summary, and subsequent admission orders to swing-bed status regardless of whether the patient stays in the same facility or transfers to another facility. If the patient does not change facilities, the same chart can be utilized but the swing-bed section of the chart must be separate with appropriate admission orders, progress notes, and supporting documents.</p> <p>Swing-bed patients receive a SNF level of care, and the CAH is reimbursed for providing a SNF level of care, however swing-bed patients are not SNF patients. Swing-bed patients in CAHs are considered to be patients of the CAH.</p> <p>485.627(a): C241: Interpretive Guidelines: All CAH patients must be under the care of a member of the medical staff or under the care of a</p> | <p>2. A member of the house staff or another physician shall be on duty or on call at all times.</p> | | |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|-----|--|---|--|---------------|----------------|
| | | <p>practitioner who is under the supervision of a member of the medical staff. All patient care is provided by or in accordance with the orders of a practitioner granted privileges to provide or order that care and is in accordance with State Law.</p> | | | |
| 26. | <p>Can facility staff (nursing, technicians, therapists) review the risks and benefits of a procedure/treatment for a consent instead of a MD/DO?</p> | <p>No.</p> <p>485.638(a)(4): C-304: Interpretive Guideline: Informed consent means the patient or patient representative is given the information, explanations, consequences, and options needed in order to consent to a procedure or treatment. The consent must contain: A statement the procedures was explained to the patient or guardian, and the name/signature of the person who explained the procedure to the patient or guardian.</p> <p>Nursing staff, technicians, and therapists are not qualified to give the information, explanations, consequences, and options needed in order for a patient to consent to a procedure or treatment.</p> | <p>No.</p> <p>Per Wisconsin Statute Section 448.30 “Information on alternate modes of treatment. Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments.”</p> <p>DHS 124.05(3)(a)f. every patient, the patient’s legally authorized representative, or any person authorized in writing by the patient shall receive, from the appropriate person within the facility, information about the patient’s illness, course of treatment and prognosis for recovery</p> | CAH | Consent |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|--|-----------------|----------------------------|---|----------------------|-----------------------|
| | | | <p>in terms the patient can understand.”</p> <p>Per the American College of Radiology (revised 2006(Res.32) Informed Consent for Image-Guided Procedures: “Because of the documented low incidence of adverse events resulting from intravenous injection of contrast media, it may be exempted from the need for the informed consent, but this decision should be based on state law, and institutional policy, departmental policy and local community practice.” “A consent form given to the patient by personnel unfamiliar with the procedure is not a substitute for a face-to-face discussion of the procedure between the physician or other qualified person and the patient, especially if the patient has unanswered questions about the procedure.”</p> | | |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|-----|---|---|--|----------------------|-----------------------|
| 27. | <p>Can a CAH do emergency detentions for 72 hours?</p> <p>If yes, does it require another certification/license from the State?</p> | <p>Yes, as long as the CAH has additional certification for Psychiatric Distinct Part per 412.25 and meets:</p> <p>485.635(d)(1): C295: A registered nurse must provide the nursing care of each patient... The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available.</p> | <p>Yes.</p> <p>DFS 124.13(3)(a)1. Individuals selected for the nursing staff shall be qualified by education, experience, and demonstrated ability for the positions to which they are appointed.</p> <p>If a hospital is interested in obtaining separate certification for AODA/Mental Health Treatment, contact Mark Hale, Chief, Behavioral Health Certification Section, DQA.</p> | CAH | Emergency Detention |
| 28. | <p>Are all CAH patients (acute, swing bed, respite, hospice) required to have a daily MD/DO visit.</p> | <p>Not required; however, note:</p> <p>485.631(b)(2): C261: A doctor of medicine or osteopathy is present for sufficient periods of time, at least once in every 2 week period...to provide medical direction, medical care services, consultation and supervision...Interpretative guidelines suggest an MD/DO visit often enough to provide medical oversight for all patient services.</p> | Not required. | CAH | MD Visit |
| 29. | <p>How long does a hospital need to retain the DHS 124.07(3) health</p> | | The hospital administrative code is | Acute/CAH | Employee Records |

| | Question | Federal Requirement | State DHS 124 Requirement | Facility Type | Question Topic |
|-----|--|--|--|---------------|----------------|
| | records of their volunteers? | | not specific. A hospital establishes a timeframe per internal policy. | | Volunteer |
| 30. | There are some provisions of HFS 124 that require a physician to order a service (e.g. DHS 124.16, which provides that therapeutic diets shall be prescribed by a physician). In these cases I assume that a non-physician practitioner (NPP) may write the order and then obtain a physician co-signature. Assuming my assumption is correct, must the physician co-sign the actual order or could the physician somehow indicate elsewhere in the medical record that s/he has reviewed and approved the order (e.g., in a note)? | | Yes. Other people may write orders and obtain co-signatures. No. Physician must authenticate each actual order or sheets of orders. | Acute/CAH | Co-signature |
| 31. | Is it safe to say that all medical record entries and orders by first-year residents must be co-signed? | Yes, generally. Notes: Governing body, By-laws, privileging and physician licensure all have a role. If the resident is a physician who meets all the criteria as other physicians within the hospital then a co-signature would not be required. | Yes, generally. Notes: See federal notes. | Acute/CAH | Co-signature |
| 32. | Is there any rule against having a post-op note and an order sheet all on one piece of paper? | No. | No. | Acute/CAH | Records |