**Local Hospital Capacity**

**Implementation Checklist**

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| **Regulation** | **Suggested Actions** |
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| **F843 Transfer Agreement**  **(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)**  **“§483.70(j) Transfer agreement.**  (1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that—  (i) Residents will be transferred from the facility to the hospital, and ***ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with State law;*** and  (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under  §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.  **GUIDANCE** §483.70(j)  A facility must demonstrate its good faith effort to secure a transfer agreement with a hospital. If a hospital that the facility reached out to refuses to accept a transfer agreement, determine if the facility reached out to any other hospitals.  A good faith effort is considered to have been made if the nursing home has exhausted all reasonable means and taken every necessary and appropriate step to enter into an agreement with a hospital sufficiently close to the facility to make the transfer of residents safe and orderly.  Also refer to §483.15 - Admission, transfer and discharge rights. Information in the transfer agreement should support the requirements in §483.15(c), F622 and the facility’s efforts to ensure safe and orderly transfers. In addition, the agreement should include the information in §483.15(c)(2)(iii), and consider other information that may be necessary for the safe and orderly transfer of the resident, and care and treatment of the resident at the receiving setting.”1 | * Review written Transfer agreement(s) with referral hospitals and update to ensure it remains current and includes all required elements. * Attempt good faith efforts to enter into an agreement with a hospital sufficiently close to the facility to make the transfer safely and orderly * Review and implement state specific guidelines for resident transfer to the acute care facility * Ensure transfer agreement(s) reasonably assures that residents will be transferred to the hospital as medically needed. * Maintain open communication with referral hospital(s) regarding hospital bed availability and ICU bed availability |
| **F578 Advance Directives**  §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.  **DEFINITIONS** §483.10(c)(6), (c)(8), (g)(12)  “**Advance care planning**” is a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions.  “**Advance directive”** is “a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.”1 | * Review advance directive policy and procedure * Social Services or designee, to review all resident records to audit status of current advance directives in place   + For residents with no advance directive, provide information and education on advance directives and offer assistance with formulation of an advance directive if they choose * Review resident care plans to identify inclusion of resident’s advance care planning directions. |
| **F726 Nursing Services**  “The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population in accordance with the facility assessment required at §483.70(e).  §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents’ needs, as identified through resident assessments, and described in the plan of care.  §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident’s needs.  §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents’ needs, as identified through resident assessments, and described in the plan of care.”1  **Staff Competencies in Identifying Changes in Condition**  “A key component of competency is a nurse’s (CNA, LPN, RN) ability to identify and address a resident’s change in condition. Facility staff should be aware of each resident’s current health status and regular activity, and be able to promptly identify changes that may indicate a change in health status. Once identified, staff should demonstrate effective actions to address a change in condition, which may vary depending on the staff who is involved.”  “These competencies are critical in order to identify potential issues early, so interventions can be applied to prevent a condition from worsening or becoming acute. Without these competencies, residents may experience a decline in health status, function, or need to be transferred to a hospital. Not all conditions, declines of health status, or hospitalizations are preventable. However, through the facility assessment (§483.70(e)), facilities are required to address the staff competencies that are necessary to provide the level and types of care needed for the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population. Furthermore, per §483.95, facilities must determine the amount and types of training based on the facility assessment. We also note that the curriculum of a nurse aide training program must include training on recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor (§483.152(b)(2)(iv)).Therefore, facility staff are expected to know how to identify residents’ changes in conditions, and what to do once one is identified.”1 | * The DON will review and revise facility protocol for resident change in condition * All nurses will be trained with competency verification:   + Assessment Process   + Change in Condition   + Communication/Reporting   + Resident Transfer Process   + COVID-19 and change in condition |
| **F880 Infection Control**  §483.80 Infection Control:  “The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection Prevention and Control Program  The facility must establish an infection prevention and control program that must include, at a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:  (i)A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;  (ii)When and to whom possible incidents of communicable disease or infections should be reported;  (iii)Standard and transmission-based precautions to be followed to prevent spread of infections;  (iv)When and how isolation should be used for a resident; including but not limited to:  (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and  (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.  (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and  (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.”1 | * Review for comprehensive and updated Infection Prevention and Control policies including COVID-19 guidelines and staff performance requirements * Educate staff regarding policies for infection prevention, hand hygiene and face mask use on an ongoing basis * Audit employee training and in-service records for IPCP education and competency of infection prevention practices * Monitor employee performance at varied times to observe proper infection control activities * Monitor the environment to ensure that social distancing guidelines are in place and followed * Monitor infection rates and trends. Follow national and state specific reporting guidelines * Evaluate staff adherence to universal source control measures and COVID-19 cases within the facility and community.   + Number of events   + Location and trends   + Outcomes   + Staff performance-based re-education   Present findings to QAPI Committee for discussion and follow up |
| **F882 Infection Preventionist**  “The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility’s IPCP. The IP must:  §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;  §483.80(b)(2) Be qualified by education, training, experience or certification;  §483.80(b)(3) Work at least part-time at the facility; and  §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility’s quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.”1 | * Ensure that the professional assigned responsibility as the Infection Preventionist meets all qualifications for the role and is a member of the QAPI/QAA committee * Is a member of the facility COVID-19 task force to plan and implement actions to prevent and mitigate spread * Review IPCP program at least annually and as needed and make revisions necessary * Update Infection Control policies with current COVID-19 recommendations by Federal, State, and Local Officials * Evaluate environment, infection control practices, and safety * Develop and implement COVID-19 Prevention Program and provide education to staff, residents, and others as required * Observe staff performance in proper application, removal and wearing a face mask at all times in the facility * Monitor staff performance of application, removal and disposal of PPE, proper and timely hand hygiene * Complete tracking of COVID-19 cases within the facility and collaborate with health officials in assessing and evaluating of community case levels for risk * Participate in monitoring and update of local hospital bed capacities * Complete reporting to local, state, and Federal officials as required * Maintain accurate and complete records of all infections within the facility and actions being taken to address potential issues * Present findings and improvement plans to QAPI/QAA Committee for discussion and follow up |

**References**

1Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17): <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf>

Centers for Disease Control and Prevention “Infection Control Guidance for Health Care Professionals about Coronavirus (COVID-19)”, June 3, 2020, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html>

Centers for Disease Control and Prevention “Preparing for COVID-19 in Nursing Homes” June 25, 2020**.** <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#core-practices>

Centers for Medicare & Medicaid Services. “Nursing Home Reopening Guidelines for States and Local Officials”; May 18, 2020, Revised 09/28/2020; QSO- 20-30-NH; <https://www.cms.gov/files/document/qso-20-30-nh.pdf-0>

Centers for Medicare & Medicaid Services. Toolkit on State Actions to Mitigate COVID-19 Prevalence in Nursing Homes. November 2020, Version 13: <https://www.cms.gov/files/document/covid-toolkit-states-mitigate-covid-19-nursing-homes.pdf>