Revised Elements of Performance for Rehabilitation and Psychiatric Distinct Part Units in Critical Access Hospitals
Effective January 1, 2010
Critical Access Hospital Accreditation Program

Standard EC.02.02.01
The critical access hospital manages risks related to hazardous materials and waste.

Elements of Performance for EC.02.02.01

7. The critical access hospital minimizes risks associated with the selection and use of hazardous energy sources.
   Note: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs).

7. The critical access hospital minimizes risks associated with selecting and using hazardous energy sources.
   Note: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs).

Standard EC.02.06.01
The critical access hospital establishes and maintains a safe, functional environment.
Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

Elements of Performance for EC.02.06.01

20. Areas used by patients are clean, sanitary, and free of offensive odors.

20. Areas used by patients are clean and free of offensive odors.
Standard HR.01.02.01
The critical access hospital defines staff qualifications.

Elements of Performance for HR.01.02.01

1. The critical access hospital defines staff qualifications specific to their job responsibilities. (See also IC.01.01.01, EP 3)
   Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control).

1. The critical access hospital defines staff qualifications specific to their job responsibilities. (See also IC.01.01.01, EP 3)
   Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control).
   Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the critical access hospital.

Standard HR.01.02.05
The critical access hospital verifies staff qualifications.

Elements of Performance for HR.01.02.05

10. Physician assistants and advanced practice registered nurses who practice within the critical access hospital are credentialed, privileged, and reprivileged through the medical staff process or an equivalent process.
   Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: Physician assistants and advanced practice registered nurses are credentialed and privileged through the medical staff process required in the “Medical Staff” (MS) chapter.

10. Physician assistants and advanced practice registered nurses who practice within the critical access hospital are credentialed, privileged, and reprivileged through the medical staff process or an equivalent process.
   Note: Advanced practice registered nurses who are licensed independent practitioners are credentialed and privileged only through the medical staff credentialing and privileging process. (See also the "Medical Staff" (MS) chapter)

11. The equivalent process for credentialing and privileging physician assistants and advanced practice registered nurses who practice within the critical access hospital is approved by the governing body.
   Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: Physician assistants and advanced practice registered
11. The equivalent process for credentialing and privileging physician assistants and advanced practice registered nurses who practice within the critical access hospital is approved by the governing body.

12. The equivalent process for credentialing and privileging physician assistants and advanced practice registered nurses who practice within the critical access hospital includes the following: An evaluation of the applicant’s credentials. The evaluation is documented. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: Physician assistants and advanced practice registered nurses are credentialed and privileged through the medical staff process required in the “Medical Staff” (MS) chapter.

13. The equivalent process for credentialing and privileging physician assistants and advanced practice registered nurses who practice within the critical access hospital includes the following: An evaluation of the applicant’s current competence. The evaluation is documented.

14. The equivalent process for credentialing and privileging physician assistants and advanced practice registered nurses who practice within the critical access hospital includes the following: Peer recommendations. The peer recommendations are documented.

15. The equivalent process for credentialing and privileging physician assistants and advanced practice registered nurses who practice within the critical access hospital includes the following: Input from individuals and committees, including the medical staff, in order to make an informed decision regarding requests for privileges.

Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: Physician assistants and advanced practice registered nurses are credentialed and privileged through the medical staff process required in the “Medical Staff” (MS) chapter.
Standard IC.01.01.01
The critical access hospital identifies the individual(s) responsible for the infection prevention and control program.

Elements of Performance for IC.01.01.01

4. For rehabilitation and psychiatric distinct part units in critical access hospitals: The individual with clinical authority over the infection prevention and control program is responsible for the following:
   - Developing policies governing control of infections and communicable diseases
   - Implementing policies governing control of infections and communicable diseases
   - Developing a system for identifying, reporting, investigating, and controlling infections and communicable diseases
   - Maintaining a log of incidents related to infections and communicable diseases

Standard LD.01.02.01
The critical access hospital identifies the responsibilities of its leaders.

Elements of Performance for LD.01.02.01

1. Senior managers and leaders of the medical staff work with the governing body to define their shared and unique responsibilities and accountabilities. (See also NR.01.01.01, EP 3)

1. Senior managers and leaders of the organized medical staff work with the governing body to define their shared and unique responsibilities and accountabilities. (See also NR.01.01.01, EP 3)

4. For rehabilitation and psychiatric distinct part units in critical access hospitals: The chief executive officer, medical staff, and nurse executive make certain that the critical access hospital-wide performance improvement program and training programs identified by the individual responsible for infection control are implemented. (See also IC.03.01.01, EP 7)

4. For rehabilitation and psychiatric distinct part units in critical access hospitals: The chief executive officer, medical staff, and nurse executive make certain that the critical access hospital-wide performance improvement and training programs address problems identified by the individual responsible for infection prevention and control and that corrective action plans are successfully implemented. (See also IC.03.01.01, EP 7)
Standard LD.01.03.01
The governing body is ultimately accountable for the safety and quality of care, treatment, and services.

Elements of Performance for LD.01.03.01

3. The governing body approves the critical access hospital's written scope of services. (See also PC.01.01.01, EP 7)

3. The governing body approves the critical access hospital's written scope of services. (See also PC.01.01.01, EP 7)
   Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: For the provision of emergency services, the critical access hospital complies with the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer to the "Medicare Requirements for Critical Access Hospitals with Rehabilitation and/or Psychiatric Distinct Part Units" appendix.

6. The governing body works with the senior managers and leaders of the medical staff to annually evaluate the critical access hospital's performance in relation to its mission, vision, and goals.

6. The governing body works with the senior managers and leaders of the organized medical staff to annually evaluate the critical access hospital's performance in relation to its mission, vision, and goals.

8. The governing body provides the medical staff with the opportunity to participate in governance.

8. The governing body provides the organized medical staff with the opportunity to participate in governance.

9. The governing body provides the medical staff with the opportunity to be represented at governing body meetings (through attendance and voice) by one or more of its members, as selected by the medical staff.

9. The governing body provides the organized medical staff with the opportunity to be represented at governing body meetings (through attendance and voice) by one or more of its members, as selected by the organized medical staff.

10. Medical staff members are eligible for full membership in the critical access hospital’s governing body, unless legally prohibited.

10. Organized medical staff members are eligible for full membership in the critical access hospital’s governing body, unless legally prohibited.

Standard LD.01.05.01
The critical access hospital has a medical staff that is accountable to the governing body.

The critical access hospital has an organized medical staff that is accountable to the governing body.

Elements of Performance for LD.01.05.01

4. For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body approves the structure of the medical staff.

4. For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body approves the structure of the organized medical staff.

5. The medical staff oversees the quality of care, treatment and services provided by those individuals with clinical privileges.

5. The organized medical staff oversees the quality of care, treatment and services provided by those individuals with clinical
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privileges.

6. The medical staff is accountable to the governing body.
6. The organized medical staff is accountable to the governing body.

Standard LD.01.07.01
The governing body, senior managers, and leaders of the medical staff have the knowledge needed for their roles in the critical access hospital or they seek guidance to fulfill their roles.

The governing body, senior managers, and leaders of the organized medical staff have the knowledge needed for their roles in the critical access hospital or they seek guidance to fulfill their roles.

Elements of Performance for LD.01.07.01

1. The governing body, senior managers, and leaders of the medical staff work together to identify the skills required of individual leaders.
2. Individual members of the governing body, senior managers, and leaders of the medical staff are oriented to all of the following:
   - The critical access hospital’s mission and vision
   - The critical access hospital’s safety and quality goals
   - The critical access hospital’s structure and the decision-making process
   - The development of the budget as well as the interpretation of the critical access hospital’s financial statements
   - The population(s) served by the critical access hospital and any issues related to that population(s)
   - The individual and interdependent responsibilities and accountabilities of the governing body, senior managers, and leaders of the medical staff as they relate to supporting the mission of the critical access hospital and to providing safe and quality care
   - Applicable law and regulation

2. Individual members of the governing body, senior managers, and leaders of the organized medical staff are oriented to all of the following:
   - The critical access hospital’s mission and vision
   - The critical access hospital’s safety and quality goals
   - The critical access hospital’s structure and the decision-making process
   - The development of the budget as well as the interpretation of the critical access hospital’s financial statements
   - The population(s) served by the critical access hospital and any issues related to that population(s)
   - The individual and interdependent responsibilities and accountabilities of the governing body, senior managers, and leaders of the organized medical staff as they relate to supporting the mission of the critical access hospital and to providing safe and quality care
   - Applicable law and regulation
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Standard LD.02.01.01
The mission, vision, and goals of the critical access hospital support the safety and quality of care, treatment, and services.

Elements of Performance for LD.02.01.01

1. The governing body, senior managers, and leaders of the medical staff work together to create the critical access hospital’s mission, vision, and goals.

1. The governing body, senior managers, and leaders of the organized medical staff work together to create the critical access hospital’s mission, vision, and goals.

Standard LD.02.02.01
The governing body, senior managers and leaders of the medical staff address any conflict of interest involving leaders that affect or could affect the safety or quality of care, treatment and services.

Note: This standard addresses conflict of interest involving individual members of leadership groups. For conflicts of interest among staff and licensed independent practitioners who are not members of leadership groups, see Standard LD.04.02.01.

The governing body, senior managers and leaders of the organized medical staff address any conflict of interest involving leaders that affect or could affect the safety or quality of care, treatment and services.

Note: This standard addresses conflict of interest involving individual members of leadership groups. For conflicts of interest among staff and licensed independent practitioners who are not members of leadership groups, see Standard LD.04.02.01.

Elements of Performance for LD.02.02.01

1. The governing body, senior managers, and leaders of the medical staff work together to define in writing conflicts of interest involving leaders that could affect safety and quality of care, treatment, and services.

1. The governing body, senior managers, and leaders of the organized medical staff work together to define in writing conflicts of interest involving leaders that could affect safety and quality of care, treatment, and services.

2. The governing body, senior managers, and leaders of the medical staff work together to develop a written policy that defines how conflict of interest involving leaders will be addressed.

2. The governing body, senior managers, and leaders of the organized medical staff work together to develop a written policy that defines how conflict of interest involving leaders will be addressed.
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Standard LD.02.04.01
The critical access hospital manages conflict between leadership groups to protect the quality and safety of care.

**Elements of Performance for LD.02.04.01**

1. Senior managers and leaders of the medical staff work with the governing body to develop an ongoing process for managing conflict among leadership groups.

1. Senior managers and leaders of the organized medical staff work with the governing body to develop an ongoing process for managing conflict among leadership groups.

Standard LD.03.06.01
Those who work in the critical access hospital are focused on improving safety and quality.

**Elements of Performance for LD.03.06.01**

3. Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. (See also IC.01.01.01, EP 3; NR.02.03.01, EP 5)

3. Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. (See also IC.01.01.01, EP 3; NR.02.03.01, EP 5)
   Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered.

Standard LD.04.01.05
The critical access hospital effectively manages its programs, services, sites, or departments.

**Elements of Performance for LD.04.01.05**

3. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. (See also NR.01.01.01, EP 5)

[HR.01.01.01, EP 25 was consolidated with revised LD.04.01.05, EP 3]

25. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital designates an individual to direct dietary services and oversee its daily management, whether the services are provided by the critical access hospital or through a contracted service. This individual is a full-time employee who is qualified by experience and training.

3. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. (See also NR.01.01.01, EP 5)
   Note: This includes the full-time employee who directs and manages dietary services.
6. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital’s emergency services are as follows:
   - Integrated with other departments of the critical access hospital
   - Directed by a qualified member of the medical staff
   - Supervised by a qualified member of the medical staff

6. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital’s emergency services are directed and supervised by a qualified member of the medical staff.

Standard LD.04.01.07
The critical access hospital has policies and procedures that guide and support patient care, treatment, and services.

Elements of Performance for LD.04.01.07

1. Leaders review and approve policies and procedures that guide and support patient care, treatment, and services. (See also NR.02.03.01, EP 1)

1. Leaders review and approve policies and procedures that guide and support patient care, treatment, and services. (See also NR.02.03.01, EP 1; RI.01.07.01, EP 1)
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Standard LD.04.03.09
Care, treatment, and services provided through contractual agreement are provided safely and effectively.

**Elements of Performance for LD.04.03.09**

4. Leaders monitor contracted services by establishing expectations for the performance of the contracted services.
   Note: When the critical access hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following:
   - Verify that all licensed independent practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges.
   - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by licensed independent practitioners will be within the scope of their privileges.

4. Leaders monitor contracted services by establishing expectations for the performance of the contracted services.
   Note 1: When the critical access hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following:
   - Verify that all licensed independent practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges.
   - Specify in the written agreement that the contracted organization will ensure that all contracted services provided by licensed independent practitioners will be within the scope of their privileges.
   Note 2: For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders who monitor the contracted services are the governing body. All licensed independent practitioners who are responsible for the patient’s care, treatment, and services via a telemedicine link are credentialed and privileged to do so at the originating site (refer to LD.04.03.09, EP 9). (See also MS.13.01.01, EP 1)

9. When using the services of licensed independent practitioners from a Joint Commission–accredited ambulatory care organization through a telemedical link for interpretive services, the critical access hospital accepts the credentialing and privileging decisions of a Joint Commission–accredited ambulatory provider only after confirming that those decisions are made using the process described in Standards MS.06.01.03 through MS.06.01.07, excluding MS.06.01.03, EP 2. (See also MS.13.01.01, EP 1)

9. When using the services of licensed independent practitioners from a Joint Commission–accredited ambulatory care organization through a telemedical link for interpretive services, the critical access hospital accepts the credentialing and privileging decisions of a Joint Commission–accredited ambulatory provider only after confirming that those decisions are made using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding MS.06.01.03, EP 2). (See also MS.13.01.01, EP 1)
   Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: All licensed independent practitioners who are responsible for the patient’s care, treatment, and services via a telemedicine link are credentialed and privileged to do so at the originating site (refer to LD.04.03.09, EP 4).
Standard LD.04.04.05
The critical access hospital has an organization-wide, integrated patient safety program.

The critical access hospital has an organization-wide, integrated patient safety program within its performance improvement activities.

Elements of Performance for LD.04.04.05

13. At least once a year, the critical access hospital provides governance with written reports on the following:
   - All system or process failures
   - The number and type of sentinel events
   - Whether the patients and the families were informed of the event
   - All actions taken to improve safety, both proactively and in response to actual occurrences

13. At least once a year, the critical access hospital provides governance with written reports on the following:
   - All system or process failures
   - The number and type of sentinel events
   - Whether the patients and the families were informed of the event
   - All actions taken to improve safety, both proactively and in response to actual occurrences
   - For rehabilitation and psychiatric distinct part units in critical access hospitals: The determined number of distinct improvement projects to be conducted annually

Standard MM.01.01.03
The critical access hospital safely manages high-alert and hazardous medications.

Elements of Performance for MM.01.01.03

5. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital reports abuses and losses of controlled substances to the individual responsible for the pharmacy department or service and to the chief executive officer, in accordance with law and regulation.

5. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital reports abuses and losses of controlled substances, in accordance with law and regulation, to the individual responsible for the pharmacy department or service and, as appropriate, to the chief executive.
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Standard MM.04.01.01
Medication orders are clear and accurate.

Elements of Performance for MM.04.01.01

14. The critical access hospital requires a physician order or, as permitted by law and regulation, a physician-approved, critical access hospital-specific protocol(s) to administer influenza and pneumococcal polysaccharide vaccines.

14. **The critical access hospital requires an order from a doctor of medicine or osteopathy, or, as permitted by law and regulation, a critical access hospital-specific protocol(s) approved by a doctor of medicine or osteopathy, to administer influenza and pneumococcal polysaccharide vaccines.**

Standard MM.07.01.03
The critical access hospital responds to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.

Elements of Performance for MM.07.01.03

6. For rehabilitation and psychiatric distinct part units in critical access hospitals: Medication administration errors, adverse drug reactions, and medication incompatibilities are immediately reported to the attending physician, and, as determined by the critical access hospital, to the organization-wide performance improvement program.

6. **For rehabilitation and psychiatric distinct part units in critical access hospitals: Medication administration errors, adverse drug reactions, and medication incompatibilities as defined by the critical access hospital are reported to the attending physician or clinical psychologist, immediately when possible, and as appropriate to the organization-wide performance improvement program.**

   *Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).*

Standard MS.01.01.01
Medical staff bylaws address self-governance and accountability to the governing body.

Elements of Performance for MS.01.01.01

1. The medical staff develops medical staff bylaws.

1. **The organized medical staff develops medical staff bylaws.**

4. For rehabilitation and psychiatric distinct part units in critical access hospitals: The medical staff enforces and complies with the medical staff bylaws.

4. **For rehabilitation and psychiatric distinct part units in critical access hospitals: The organized medical staff enforces and complies with the medical staff bylaws.**
17. **For rehabilitation and psychiatric distinct part units in critical access hospitals:** The medical staff bylaws must also include the following: A description of the privileging process (including temporary and disaster privileging). (See also MS.06.01.07, EP 7)

17. **For rehabilitation and psychiatric distinct part units in critical access hospitals:** The medical staff bylaws must also include the following: A description of the privileging process (including temporary and disaster privileging) and criteria for determining the privileges to be granted to individual practitioners. (See also MS.06.01.07, EP 7)

20. **For rehabilitation and psychiatric distinct part units in critical access hospitals:** The medical staff bylaws include the following: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician (as defined in section 1861(r) of the Act), an oromaxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy.

20. **For rehabilitation and psychiatric distinct part units in critical access hospitals:** The medical staff bylaws include the following: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy.

Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

**Standard MS.03.01.01**

The medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.

The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.

**Elements of Performance for MS.03.01.01**

1. Licensed independent practitioner members of the medical staff are designated to perform the oversight activities of the medical staff.

2. Practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.

3. For rehabilitation and psychiatric distinct part units in critical access hospitals: Licensed independent practitioners are responsible for the oversight activities of the medical staff.

6. The medical staff specifies the minimal content of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services. (See also PC.01.02.03, EP 4)
6. The organized medical staff specifies the minimal content of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services. (See also PC.01.02.03, EP 4)

9. As permitted by state law and policy, the medical staff may choose to allow individuals who are not licensed independent practitioners to perform part or all of a patient’s medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified physician who is accountable for the patient’s medical history and physical examination.

9. As permitted by state law and policy, the organized medical staff may choose to allow individuals who are not licensed independent practitioners to perform part or all of a patient’s medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified doctor of medicine or osteopathy who is accountable for the patient’s medical history and physical examination.

10. The medical staff defines when a medical history and physical examination must be validated and countersigned by a licensed independent practitioner with appropriate privileges.

10. The organized medical staff defines when a medical history and physical examination must be validated and countersigned by a licensed independent practitioner with appropriate privileges.

Standard MS.03.01.03
The management and coordination of each patient’s care, treatment, and services is the responsibility of a practitioner with appropriate privileges.

Elements of Performance for MS.03.01.03

1. Licensed independent practitioners with appropriate privileges manage and coordinate the patient’s care, treatment, and services.

1. Licensed independent practitioners with appropriate privileges manage and coordinate the patient’s care, treatment, and services. For rehabilitation and psychiatric distinct part units in critical access hospitals: Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient’s care, treatment, and services. Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

3. For rehabilitation and psychiatric distinct part units in critical access hospitals: A patient’s general medical condition is managed and coordinated by a physician.

3. For rehabilitation and psychiatric distinct part units in critical access hospitals: A patient’s general medical condition is managed and coordinated by a doctor of medicine or osteopathy. A doctor of medicine or osteopathy manages and coordinates the care of any Medicare patient’s psychiatric problem that is not specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.

4. The medical staff, through its designated mechanism, determines the circumstances under which consultation or management by a physician or other licensed independent practitioner is required.

4. The organized medical staff, through its designated mechanism, determines the circumstances under which consultation or management by a doctor of medicine or osteopathy, or other licensed independent practitioner, is required.
5. Consultation is obtained for the circumstances defined by the medical staff.

5. Consultation is obtained for the circumstances defined by the organized medical staff.

**Standard MS.05.01.01**
The medical staff has a leadership role in organization performance improvement activities to improve quality of care, treatment, and services and patient safety.

The organized medical staff has a leadership role in organization performance improvement activities to improve quality of care, treatment, and services and patient safety.

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**Elements of Performance for MS.05.01.01**

17. For rehabilitation and psychiatric distinct part units in critical access hospitals: The medical staff attempts to secure autopsies in all cases of unusual deaths and cases of medical, legal, and educational interest.

18. For rehabilitation and psychiatric distinct part units in critical access hospitals: The medical staff, specifically the attending physician, is informed of autopsies that the critical access hospital intends to perform.

17. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital attempts to secure autopsies in all cases of unusual deaths and cases of medical, legal, and educational interest, and informs the medical staff (specifically the attending physician or clinical psychologist) of autopsies that the critical access hospital intends to perform.

Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

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**Standard MS.06.01.03**
The critical access hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege.

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**Elements of Performance for MS.06.01.03**

2. The credentialing process is based on recommendations by the medical staff.

2. The credentialing process is based on recommendations by the organized medical staff.
Standard MS.06.01.05
The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidenced-based process.

Elements of Performance for MS.06.01.05

2. The critical access hospital, based on recommendations by the medical staff and approval by the governing body, establishes criteria that determine a practitioner’s ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria:
   - Current licensure and/or certification, as appropriate, verified with the primary source
   - The applicant's specific relevant training, verified with the primary source
   - Evidence of physical ability to perform the requested privilege
   - Data from professional practice review by an organization(s) that currently privileges the applicant (if available)
   - Peer and/or faculty recommendation
   - When renewing privileges, review of the practitioner's performance within the critical access hospital

2. The critical access hospital, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a practitioner’s ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria:
   - Current licensure and/or certification, as appropriate, verified with the primary source
   - The applicant's specific relevant training, verified with the primary source
   - Evidence of physical ability to perform the requested privilege
   - Data from professional practice review by an organization(s) that currently privileges the applicant (if available)
   - Peer and/or faculty recommendation
   - When renewing privileges, review of the practitioner's performance within the critical access hospital

6. An applicant submits a statement that no health problems exist that could affect his or her ability to perform the privileges requested. Note: The applicant's ability to perform privileges requested must be evaluated. This evaluation is documented in the individual's credentials file. Such documentation may include the applicant's statement that no health problems exist that could affect his or her practice. Documentation regarding an applicant’s health status and his or her ability to practice should be confirmed. Initial applicants may have their health status confirmed by the director of a training program, the chief of services, or the chief of staff at another hospital or critical access hospital at which the applicant holds privileges, or by a currently licensed physician approved by the medical staff. In instances where there is doubt about an applicant’s ability to perform privileges requested, an evaluation by an external and internal source may be required. The request for an evaluation rests with the medical staff.

6. An applicant submits a statement that no health problems exist that could affect his or her ability to perform the privileges requested. Note: The applicant's ability to perform privileges requested must be evaluated. This evaluation is documented in the individual's credentials file. Such documentation may include the applicant's statement that no health problems exist that could affect his or her practice. Documentation regarding an applicant’s health status and his or her ability to practice should be confirmed. Initial applicants may have their health status confirmed by the director of a training program, the chief of services, or the chief of staff at another hospital or critical access hospital at which the applicant holds privileges, or by a currently licensed doctor of medicine or osteopathy approved by the medical staff. In instances where there is doubt about an applicant’s ability to perform privileges...
requested, an evaluation by an external and internal source may be required. The request for an evaluation rests with the organized medical staff.

9. Before recommending privileges, the medical staff also evaluates the following:
- Challenges to any licensure or registration
- Voluntary and involuntary relinquishment of any license or registration
- Voluntary and involuntary termination of medical staff membership
- Voluntary and involuntary limitation, reduction, or loss of clinical privileges
- Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
- Documentation as to the applicant’s health status
- Relevant practitioner-specific data as compared to aggregate data, when available
- Morbidity and mortality data, when available

9. Before recommending privileges, the organized medical staff also evaluates the following:
- Challenges to any licensure or registration
- Voluntary and involuntary relinquishment of any license or registration
- Voluntary and involuntary termination of medical staff membership
- Voluntary and involuntary limitation, reduction, or loss of clinical privileges
- Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
- Documentation as to the applicant’s health status
- Relevant practitioner-specific data as compared to aggregate data, when available
- Morbidity and mortality data, when available

Standard MS.06.01.07

The medical staff reviews and analyzes all relevant information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege.

The organized medical staff reviews and analyzes all relevant information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege.

Elements of Performance for MS.06.01.07

2. The critical access hospital, based on recommendations by the medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a requested privilege.

2. The critical access hospital, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a requested privilege.

Note: Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society.
Standard MS.06.01.09
The decision to grant, limit, or deny an initially requested privilege or an existing privilege petitioned for renewal is communicated to the requesting practitioner within the time frame specified in the medical staff bylaws.

**Elements of Performance for MS.06.01.09**

4. The process to disseminate all granting, modification, or restriction decisions is approved by the medical staff.

4. The process to disseminate all granting, modification, or restriction decisions is approved by the organized medical staff.

Standard MS.06.01.13
Under certain circumstances, temporary clinical privileges may be granted for a limited period of time.

**Elements of Performance for MS.06.01.13**

2. When temporary privileges are granted to meet an important care need, the medical staff verifies current licensure and current competence.

2. When temporary privileges are granted to meet an important care need, the organized medical staff verifies current licensure and current competence.

3. Temporary privileges for new applicants may be granted while awaiting review and approval by the medical staff upon verification of the following:
   - Current licensure
   - Relevant training or experience
   - Current competence
   - Ability to perform the privileges requested
   - Other criteria required by the medical staff bylaws
   - A query and evaluation of the National Practitioner Data Bank (NPDB) information
   - A complete application
   - No current or previously successful challenge to licensure or registration
   - No subjection to involuntary termination of medical staff membership at another organization
   - No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges

3. Temporary privileges for new applicants may be granted while awaiting review and approval by the organized medical staff upon verification of the following:
   - Current licensure
   - Relevant training or experience
   - Current competence
   - Ability to perform the privileges requested
   - Other criteria required by the organized medical staff bylaws
   - A query and evaluation of the National Practitioner Data Bank (NPDB) information
   - A complete application
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- No current or previously successful challenge to licensure or registration
- No subjection to involuntary termination of medical staff membership at another organization
- No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges

Standard MS.07.01.01
The medical staff provides oversight for the quality of care, treatment, and services by recommending members for appointment to the medical staff.

The organized medical staff provides oversight for the quality of care, treatment, and services by recommending members for appointment to the medical staff.

Elements of Performance for MS.07.01.01

1. The medical staff develops criteria for medical staff membership.
2. The organized medical staff develops criteria for medical staff membership.
   Note: Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society.
3. The medical staff uses the criteria in appointing members to the medical staff and appointment does not exceed a period of two years.
4. The organized medical staff uses the criteria in appointing members to the medical staff and appointment does not exceed a period of two years.

Standard MS.08.01.01
The medical staff defines the circumstances requiring monitoring and evaluation of a practitioner’s professional performance.

The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner’s professional performance.

Elements of Performance for MS.08.01.01

2. The medical staff develops criteria to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified.
3. The organized medical staff develops criteria to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified.
4. Focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the medical staff.
5. Focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff.
**Standard MS.08.01.03**
Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.

**Elements of Performance for MS.08.01.03**

1. The process for the ongoing professional practice evaluation includes the following: The type of data to be collected is determined by individual departments and approved by the medical staff.

2. The process for the ongoing professional practice evaluation includes the following: The type of data to be collected is determined by individual departments and approved by the organized medical staff.

**Standard MS.09.01.01**
The medical staff, pursuant to the medical staff bylaws, evaluates and acts on reported concerns regarding a privileged practitioner’s clinical practice and/or competence.

**The organized medical staff, pursuant to the medical staff bylaws, evaluates and acts on reported concerns regarding a privileged practitioner’s clinical practice and/or competence.**

**Elements of Performance for MS.09.01.01**

1. The critical access hospital, based on recommendations by the medical staff and approval by the governing body, has a clearly defined process for collecting, investigating, and addressing clinical practice concerns. (See also RI.01.07.01, EPs 1, 2, 4, 6, 7, and 10)

2. The critical access hospital, based on recommendations by the organized medical staff and approval by the governing body, has a clearly defined process for collecting, investigating, and addressing clinical practice concerns. (See also RI.01.07.01, EPs 1, 2, 4, 6, 7, and 10)
Standard MS.13.01.01

For originating sites only: Licensed independent practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.

Elements of Performance for MS.13.01.01

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: All licensed independent practitioners who are responsible for the patient's care, treatment, and services via a telemedicine link are credentialed and privileged to do so at the originating site according to standards MS.06.01.03 through MS.06.01.13.

   For critical access hospitals: All licensed independent practitioners who are responsible for the patient’s care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms:
   - The originating site fully privileges and credentials the practitioner according to Standards MS.06.01.03 through MS.06.01.13.
   - The originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited organization.
   - The originating site uses the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met:
     1. The distant site is a Joint Commission–accredited hospital or ambulatory care organization.
     2. The practitioner is privileged at the distant site for those services to be provided at the originating site.
     3. The originating site has evidence of an internal review of the practitioner’s performance of these privileges and sends to the distant site information that is useful to assess the practitioner’s quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the originating site. (See also LD.04.03.09, EP 9)

Note 1: This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law.

Note 2: In the case of an accredited ambulatory care organization, the critical access hospital verifies that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care.

Note 3: A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. See the "Sentinel Events" (SE) chapter for additional information.

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: All licensed independent practitioners who are responsible for the patient's care, treatment, and services via a telemedicine link are credentialed and privileged to do so at the originating site according to standards MS.06.01.03 through MS.06.01.13.

Note: If the distant site is a Medicare-participating critical access hospital, the originating site’s medical staff may use a copy of the distant site’s credentialing packet for privileging purposes. This packet includes a list of all privileges granted to the licensed independent practitioner by the distant site and an attestation signed by the distant site indicating that the packet is complete, accurate, and up-to-date.

For critical access hospitals: All licensed independent practitioners who are responsible for the patient's care, treatment, and
services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms:
- The originating site fully privileges and credentials the practitioner according to Standards MS.06.01.03 through MS.06.01.13.
- The originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited organization.
- The originating site uses the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met:
  1. The distant site is a Joint Commission–accredited hospital or ambulatory care organization.
  2. The practitioner is privileged at the distant site for those services to be provided at the originating site.
  3. The originating site has evidence of an internal review of the practitioner’s performance of these privileges and sends to the distant site information that is useful to assess the practitioner’s quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided; and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the originating site. (See also LD.04.03.09, EP 9)

Note 1: This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law.

Note 2: In the case of an accredited ambulatory care organization, the critical access hospital verifies that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care.

Note 3: A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. See the “Sentinel Events” (SE) chapter for additional information.

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**Standard PC.01.02.03**
The critical access hospital assesses and reassesses the patient and his or her condition according to defined time frames.

**Elements of Performance for PC.01.02.03**

4. The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, inpatient admission or registration, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 6; RC.02.01.03, EP 3)

4. The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 6; RC.02.01.03, EP 3)

5. For a medical history and physical examination that was completed within 30 days prior to inpatient admission or registration, an update documenting any changes in the patient's condition is completed within 24 hours after inpatient admission or registration, but prior to surgery or a procedure requiring anesthesia services, whichever comes first. (See also MS.03.01.01, EP 8; RC.02.01.03, EP 3)

5. For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an
update documenting any changes in the patient’s condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. (See also MS.03.01.01, EP 8; RC.02.01.03, EP 3)

**Standard PC.02.02.03**
The critical access hospital makes food and nutrition products available to its patients.

**Elements of Performance for PC.02.02.03**

22. For rehabilitation and psychiatric distinct part units in critical access hospitals: A current therapeutic diet manual approved by the dietitian and medical staff is readily available to all medical, nursing, and food service staff.

22. For rehabilitation and psychiatric distinct part units in critical access hospitals: A current therapeutic diet manual approved by the dietitian and medical staff is available to all medical, nursing, and food service staff.
Standard PC.03.01.01

The critical access hospital plans operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia.

**The critical access hospital plans operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia.**

*Note: Equipment identified in the elements of performance is available to the operating room suites.*

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**Elements of Performance for PC.03.01.01**

10. For rehabilitation and psychiatric distinct part units in critical access hospitals: In accordance with the critical access hospital’s policy and state scope-of-practice laws, anesthesia is administered only by the following individuals:
   - An anesthesiologist
   - A doctor of medicine or osteopathy other than an anesthesiologist
   - A doctor of dental surgery or dental medicine
   - A doctor of podiatric medicine
   - A certified registered nurse anesthetist (CRNA) supervised by the operating practitioner except as provided in 42 CFR 482.52(c) regarding the state exemption for this supervision
   - An anesthesiologist assistant supervised by an anesthesiologist
   - A supervised trainee in an approved educational program

*Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law or, if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission.*

*Note 2: An anesthesiologist assistant is defined in 42 CFR 410.69(b).*

*Note 3: 42 CFR 482.52(c) for state exemption states: A critical access hospital may be exempted from the requirement for doctor of medicine or osteopathy supervision of CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state’s boards of medicine and nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor attests that he or she has consulted with the state boards of medicine and nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state’s citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission.*

10. For rehabilitation and psychiatric distinct part units in critical access hospitals: In accordance with the critical access hospital’s policy and state scope-of-practice laws, anesthesia is administered only by the following individuals:
   - An anesthesiologist
   - A doctor of medicine or osteopathy other than an anesthesiologist
   - A doctor of dental surgery or dental medicine
   - A doctor of podiatric medicine
   - A certified registered nurse anesthetist (CRNA) supervised by the operating practitioner except as provided in 42 CFR 482.52(c) regarding the state exemption for this supervision
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- An anesthesiologist's assistant supervised by an anesthesiologist
- A supervised trainee in an approved educational program

Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law or, if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission.

Note 2: "Anesthesiologist assistant" is defined in 42 CFR 410.69(b).

Footnote: The CoP at 42 CFR 482.52(c) for state exemption states: A critical access hospital may be exempt from the requirement for doctors of medicine or osteopathy to supervise CRNAs if the state in which the critical access hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state’s Boards of Medicine and Nursing, requesting exemption for CRNAs. The letter from the governor attests that he or she has consulted with the state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state’s citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission.

Standard PC.03.05.05
For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital initiates restraint or seclusion based on an individual order.

Elements of Performance for PC.03.05.05

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: A physician or other authorized licensed independent practitioner primarily responsible for the patient’s ongoing care orders the use of restraint or seclusion in accordance with critical access hospital policy and law and regulation.
   Footnote: For law and regulation guidance pertaining to those responsible for the care of patients, refer to 42 CFR 482.12(c).

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: A physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient’s ongoing care orders the use of restraint or seclusion in accordance with critical access hospital policy and law and regulation.
   Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

3. For rehabilitation and psychiatric distinct part units in critical access hospitals: The attending physician is consulted as soon as possible, in accordance with critical access hospital policy, if he or she did not order the restraint or seclusion.

3. For rehabilitation and psychiatric distinct part units in critical access hospitals: The attending physician or clinical psychologist is consulted as soon as possible, in accordance with critical access hospital policy, if he or she did not order the restraint or seclusion.
   Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).
5. For rehabilitation and psychiatric distinct part units in critical access hospitals: Unless state law is more restrictive, every 24 hours, a physician or other authorized licensed independent practitioner primarily responsible for the patient’s ongoing care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others in accordance with critical access hospital policy and law and regulation. Footnote: For law and regulation guidance pertaining to those responsible for the care of patients, refer to 42 CFR 482.12(c).

5. For rehabilitation and psychiatric distinct part units in critical access hospitals: Unless state law is more restrictive, every 24 hours, a physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient’s ongoing care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others in accordance with critical access hospital policy and law and regulation.

Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

Standard PC.03.05.07
For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital monitors patients who are restrained or secluded.

Elements of Performance for PC.03.05.07

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: Physicians or other licensed independent practitioners or staff who have been trained in accordance with 42 CFR 482.13(f) monitor the condition of patients in restraint or seclusion. (See also PC.03.05.17, EP 3)

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: Physicians, clinical psychologists, or other licensed independent practitioners or staff who have been trained in accordance with 42 CFR 482.13(f) monitor the condition of patients in restraint or seclusion. (See also PC.03.05.17, EP 3)

Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).
Standard PC.03.05.09
For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has written policies and procedures that guide the use of restraint or seclusion.

Elements of Performance for PC.03.05.09

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital’s policies and procedures regarding restraint or seclusion include the following:
   - Physician and other authorized licensed independent practitioner training requirements
   - Staff training requirements
   - The determination of who has authority to order restraint and seclusion
   - The determination of who has authority to discontinue the use of restraint or seclusion
   - The determination of who can initiate the use of restraint or seclusion
   - The circumstances under which restraint or seclusion is discontinued
   - The requirement that restraint or seclusion is discontinued as soon as is safely possible
   - A definition of restraint in accordance with 42 CFR 482.13(e)(1)(i)(A–C)
   - A definition of seclusion in accordance with 42 CFR 482.13(e)(1)(ii)
   - A definition or description of what constitutes the use of medications as a restraint in accordance with 42 CFR 482.13(e)(1)(i)(B)
   - A determination of who can assess and monitor patients in restraint or seclusion
   - Time frames for assessing and monitoring patients in restraint or seclusion

Note 1: The definition of restraint per 42 CFR 482.13(e)(1)(i)(A–C) is as follows:
42 CFR 482.13(e)(1) Definitions. (i) A restraint is— (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or 42 CFR 482.13(e)(1)(i)(B) A restraint is— (B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
Note 2: The definition of seclusion per 42 CFR 482.13(e)(1)(ii) is as follows:
Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior.

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital’s policies and procedures regarding restraint or seclusion include the following:
   - Physician, clinical psychologist, and other authorized licensed independent practitioner training requirements
   - Staff training requirements
   - The determination of who has authority to order restraint and seclusion
   - The determination of who has authority to discontinue the use of restraint or seclusion
   - The determination of who can initiate the use of restraint or seclusion
   - The circumstances under which restraint or seclusion is discontinued
- The requirement that restraint or seclusion is discontinued as soon as is safely possible
- A definition of restraint in accordance with 42 CFR 482.13(e)(1)(i)(A–C)
- A definition of seclusion in accordance with 42 CFR 482.13(e)(1)(ii)
- A definition or description of what constitutes the use of medications as a restraint in accordance with 42 CFR 482.13(e)(1)(i)(B)
- A determination of who can assess and monitor patients in restraint or seclusion
- Time frames for assessing and monitoring patients in restraint or seclusion

Note 1: The definition of restraint per 42 CFR 482.13(e)(1)(i)(A–C) is as follows:

42 CFR 482.13(e)(1) Definitions. (i) A restraint is— (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or 42 CFR 482.13(e)(1)(i)(B) (A restraint is— ) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

Note 2: The definition of seclusion per 42 CFR 482.13(e)(1)(ii) is as follows:

Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior.

Note 3: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

2. For rehabilitation and psychiatric distinct part units in critical access hospitals: Physicians and other licensed independent practitioners authorized to order restraint or seclusion (through critical access hospital policy in accordance with law and regulation) have a working knowledge of the critical access hospital policy regarding the use of restraint and seclusion.

2. For rehabilitation and psychiatric distinct part units in critical access hospitals: Physicians, clinical psychologists, and other licensed independent practitioners authorized to order restraint or seclusion (through critical access hospital policy in accordance with law and regulation) have a working knowledge of the critical access hospital policy regarding the use of restraint and seclusion.

Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).
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For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital evaluates and reevaluates the patient who is restrained or secluded.

Elements of Performance for PC.03.05.11

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: A physician or other licensed independent practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse or a physician assistant may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3.

Note: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance.

2. For rehabilitation and psychiatric distinct part units in critical access hospitals: A physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse or a physician assistant may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3.

Note 1: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance.

Note 2: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

2. For rehabilitation and psychiatric distinct part units in critical access hospitals: When the in-person evaluation (performed within one hour of the initiation of restraint or seclusion) is done by a trained registered nurse or trained physician assistant, he or she consults with the attending physician or other licensed independent practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by hospital policy.

2. For rehabilitation and psychiatric distinct part units in critical access hospitals: When the in-person evaluation (performed within one hour of the initiation of restraint or seclusion) is done by a trained registered nurse or trained physician assistant, he or she consults with the attending physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by critical access hospital policy.

Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).
Standard PC.03.05.15
For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital documents the use of restraint or seclusion.

Elements of Performance for PC.03.05.15

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: Documentation of restraint and seclusion in the medical record includes the following:
   - Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior
   - A description of the patient’s behavior and the intervention used
   - Any alternatives or other less restrictive interventions attempted
   - The patient’s condition or symptom(s) that warranted the use of the restraint or seclusion
   - The patient’s response to the intervention(s) used, including the rationale for continued use of the intervention
   - Individual patient assessments and reassessments
   - The intervals for monitoring
   - Revisions to the plan of care
   - The patient’s behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion
   - Injuries to the patient
   - Death associated with the use of restraint or seclusion
   - The identity of the physician or other licensed independent practitioner who ordered the restraint or seclusion
   - Orders for restraint or seclusion
   - Notification of the use of restraint or seclusion to the attending physician
   - Consultations

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: Documentation of restraint and seclusion in the medical record includes the following:
   - Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior
   - A description of the patient’s behavior and the intervention used
   - Any alternatives or other less restrictive interventions attempted
   - The patient’s condition or symptom(s) that warranted the use of the restraint or seclusion
   - The patient’s response to the intervention(s) used, including the rationale for continued use of the intervention
   - Individual patient assessments and reassessments
   - The intervals for monitoring
   - Revisions to the plan of care
   - The patient’s behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion
   - Injuries to the patient
   - Death associated with the use of restraint or seclusion
   - The identity of the physician, clinical psychologist, or other licensed independent practitioner who ordered the restraint or seclusion
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- Orders for restraint or seclusion
- Notification of the use of restraint or seclusion to the attending physician
- Consultations

Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

Standard PC.03.05.17

For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital trains staff to safely implement the use of restraint or seclusion.

Elements of Performance for PC.03.05.17

2. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital trains staff on the use of restraint and seclusion and assesses their competence at the following intervals:
   - At orientation
   - Before participating in the use of restraint and seclusion
   - On a periodic basis thereafter

2. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital trains staff on the use of restraint and seclusion, and assesses their competence, at the following intervals:
   - At orientation
   - Before participating in the use of restraint and seclusion
   - On a periodic basis thereafter

3. For rehabilitation and psychiatric distinct part units in critical access hospitals: Based on the patient population served, staff education, training, and demonstrated knowledge focus on the following:
   - Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion
   - Use of nonphysical intervention skills
   - Methods for choosing the least restrictive intervention based on an assessment of the patient’s medical or behavioral status or condition
   - Safe application and use of all types of restraint or seclusion used in the critical access hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia)
   - Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary
   - Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by critical access hospital policy associated with the face-to-face evaluation conducted within one hour of initiation of restraint or seclusion
   - Use of first-aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification
    (See also PC.03.05.07, EP 1)

3. For rehabilitation and psychiatric distinct part units in critical access hospitals: Based on the population served, staff education, training, and demonstrated knowledge focus on the following:
   - Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the
use of restraint or seclusion
- Use of nonphysical intervention skills
- Methods for choosing the least restrictive intervention based on an assessment of the patient’s medical or behavioral status or condition
- Safe application and use of all types of restraint or seclusion used in the critical access hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia)
- Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary
- Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by critical access hospital policy associated with the in-person evaluation conducted within one hour of initiation of restraint or seclusion
- Use of first-aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification (See also PC.03.05.07, EP 1)

Standard PC.03.05.19
For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital reports deaths associated with the use of restraint and seclusion.

Elements of Performance for PC.03.05.19

2. For rehabilitation and psychiatric distinct part units in critical access hospitals: The deaths addressed in PC.03.05.19, EP 1 are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone no later than the close of the next business day following knowledge of the patient’s death.

3. For rehabilitation and psychiatric distinct part units in critical access hospitals: Staff document in the patient’s medical record the date and time that the patient death was reported to the Centers for Medicare & Medicaid Services (CMS).

2. For rehabilitation and psychiatric distinct part units in critical access hospitals: The deaths addressed in PC.03.05.19, EP 1 are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone no later than the close of the next business day following knowledge of the patient's death. The date and time that the patient’s death was reported is documented in the patient's medical record.
Critical Access Hospital Accreditation Program

Standard PC.04.01.01
The critical access hospital has a process that addresses the patient’s need for continuing care, treatment, and services after discharge or transfer.

Elements of Performance for PC.04.01.01

24. For rehabilitation and psychiatric distinct part units in critical access hospitals: When the discharge planning evaluation indicates a need for posthospital extended care services, the critical access hospital includes in the discharge plan a list of skilled nursing facilities that are available, in the geographic area requested by the patient, and participate in the Medicare program. For patients enrolled in managed care organizations, the critical access hospital lists skilled nursing facilities that have a contract with the managed care organization.

24. For rehabilitation and psychiatric distinct part units in critical access hospitals: When the discharge planning evaluation indicates a need for posthospital extended care services, the critical access hospital includes in the discharge plan a list of participating Medicare skilled nursing facilities that are available and in the geographic area requested by the patient. For patients enrolled in managed care organizations, the critical access hospital lists skilled nursing facilities that have a contract with the managed care organization.

Standard PC.04.01.03
The critical access hospital discharges or transfers the patient based on his or her assessed needs and the organization’s ability to meet those needs.

Elements of Performance for PC.04.01.03

3. The patient, the patient’s family, licensed independent practitioners, and staff involved in the patient’s care, treatment, and services participate in planning the patient’s discharge or transfer.
For psychiatric distinct part units in critical access hospitals: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the critical access hospital.

3. The patient, the patient’s family, licensed independent practitioners, physicians, clinical psychologists, and staff involved in the patient’s care, treatment, and services participate in planning the patient’s discharge or transfer.
Note 1: For rehabilitation and psychiatric distinct part units in critical access hospitals: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).
Note 2: For psychiatric distinct part units in critical access hospitals: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the critical access hospital.
Critical Access Hospital Accreditation Program

Standard PC.05.01.09
For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital safely provides blood and blood components.

Elements of Performance for PC.05.01.09

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27.
   Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Critical Access Hospitals with Rehabilitation and/or Psychiatric Distinct Part Units" appendix.

2. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27.
   Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the "Medicare Requirements for Critical Access Hospitals with Rehabilitation and/or Psychiatric Distinct Part Units" appendix.

* These EPs appear in bold text because they are new EPs for critical access hospitals with rehabilitation and psychiatric distinct part units (DPUs). However, these are not new requirements because the current EPs (PC.05.01.01 through PC.05.01.09) were deleted in order to match the hospital requirements.

Standard PI.01.01
The critical access hospital collects data to monitor its performance.

Elements of Performance for PI.01.01

2. The critical access hospital identifies the frequency for data collection.

2. The critical access hospital identifies the frequency for data collection. For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders identify the frequency for data collection.
   Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The leaders that specify the frequency and detail of data collection is the governing body.

8. The critical access hospital collects data on the following: All confirmed transfusion reactions. (See also LD.04.04.01, EP 2)
8. The critical access hospital collects data on the following: All reported and confirmed transfusion reactions. (See also LD.04.04.01, EP 2; LD.04.04.05, EP 6)
Critical Access Hospital Accreditation Program

Standard RC.01.01.01
The critical access hospital maintains complete and accurate medical records.

The critical access hospital maintains complete and accurate medical records for each individual patient.

Elements of Performance for RC.01.01.01

11. All entries in the medical record, including all orders, are dated.
11. All entries in the medical record are dated.

Standard RC.01.02.01
Entries in the medical record are authenticated.

Elements of Performance for RC.01.02.01

4. Entries in the medical record, including all orders, are authenticated by the author. Information introduced into the medical record through transcription or dictation is authenticated by the author.
   Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key.
   Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or critical access hospital policy. For electronic records, electronic signatures will be date-stamped.
   Note 3: For rehabilitation and psychiatric distinct part units in critical access hospitals: For a five-year period following January 26, 2007, all orders, including verbal orders, are dated and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient (as specified at 42 CFR 482.12(c)), and who, in accordance with critical access hospital policy and law and regulation, is authorized to write orders.

See RC.02.03.07, EP 4, Note 2 on page 39 of this report for the origin of Note 3 in this EP.
Standard RC.01.03.01
Documentation in the medical record is entered in a timely manner.

Elements of Performance for RC.01.03.01

4. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital records the patient's medical history and physical examination, including updates, in the medical record within 24 hours after inpatient admission or registration but prior to surgery or a procedure requiring anesthesia.

4. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital records the patient's medical history and physical examination, including updates, in the medical record within 24 hours after registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services.
Standard RC.02.01.01
The medical record contains information that reflects the patient's care, treatment, and services.

Elements of Performance for RC.02.01.01

2. The medical record contains the following clinical information:
   - The reason(s) for admission for care, treatment, and services
   - The patient’s initial diagnosis, diagnostic impression(s), or condition(s)
   - Any findings of assessments and reassessments (See also PC.01.02.01, EPs 1 and 4; PC.03.01.03, EPs 1 and 8)
     - Any allergies to food
     - Any allergies to medications
     - Any conclusions or impressions drawn from the patient’s medical history and physical examination
   - Any diagnoses or conditions established during the patient’s course of care, treatment, and services
   - Any consultation reports
   - Any observations relevant to care, treatment, and services
   - The patient’s response to care, treatment, and services
   - Any emergency care, treatment, and services provided to the patient before his or her arrival
   - Any progress notes
   - All orders
   - Any medications ordered or prescribed
   - Any medications administered, including the strength, dose, and route
   - Any access site for medication, administration devices used, and rate of administration
   - Any adverse drug reactions
   - Treatment goals, plan of care, and revisions to the plan of care (See also PC.01.03.01, EPs 1 and 23)
   - Results of diagnostic and therapeutic tests and procedures
   - Any medications dispensed or prescribed on discharge
   - Any health care–associated infections
   - Any complications
   - Discharge diagnosis
   - Nursing notes
   - Vital signs
   - Discharge plan and evaluation results
   (See also PC.01.02.03, EPs 6-8)

2. The medical record contains the following clinical information:
   - The reason(s) for admission for care, treatment, and services
   - The patient’s initial diagnosis, diagnostic impression(s), or condition(s)
   - Any findings of assessments and reassessments (See also PC.01.02.01, EPs 1 and 4; PC.03.01.03, EPs 1 and 8)
     - Any allergies to food
     - Any allergies to medications
     - Any conclusions or impressions drawn from the patient’s medical history and physical examination
- Any diagnoses or conditions established during the patient’s course of care, treatment, and services
- Any consultation reports
- Any observations relevant to care, treatment, and services
- The patient’s response to care, treatment, and services
- Any emergency care, treatment, and services provided to the patient before his or her arrival
- Any progress notes
- All orders
- Any medications ordered or prescribed
- Any medications administered, including the strength, dose, and route
- Any access site for medication, administration devices used, and rate of administration
- Any adverse drug reactions
- Treatment goals, plan of care, and revisions to the plan of care (See also PC.01.03.01, EPs 1 and 23)
- Results of diagnostic and therapeutic tests and procedures
- Any medications dispensed or prescribed on discharge
- Discharge diagnosis
- Discharge plan and discharge planning evaluation
   (See also PC.01.02.03, EPs 6-8)

4. As needed to provide care, treatment, and services, the medical record contains the following additional information:
   - Any advance directives (See also RI.01.05.01, EP 11)
   - Any informed consent, when required by critical access hospital policy (See also RI.01.03.01, EP 13)
   - Any records of communication with the patient, such as telephone calls or e-mail
   - Any patient-generated information

4. As needed to provide care, treatment, and services, the medical record contains the following additional information:
   - Any advance directives (See also RI.01.05.01, EP 11)
   - Any informed consent, when required by critical access hospital policy (See also RI.01.03.01, EP 13)
   Note: The properly executed informed consent is placed in the patient’s medical record prior to surgery, except in emergencies.
   - Any records of communication with the patient, such as telephone calls or e-mail
   - Any patient-generated information

Standard RC.02.03.07
Qualified staff receive and record verbal orders.

Elements of Performance for RC.02.03.07

1. The critical access hospital has policies and procedures that identify the staff who are authorized to receive and record verbal orders, in accordance with law and regulation.

1. The critical access hospital identifies, in writing, the staff who are authorized to receive and record verbal orders, in accordance with law and regulation.
4. Verbal orders are authenticated within the time frame specified by law and regulation. For rehabilitation and psychiatric distinct part units in critical access hospitals: If there is no state law that designates a specific time frame for authentication of verbal orders, the verbal orders are authenticated within 48 hours.

Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: In some instances, the ordering practitioner may not be able to authenticate his or her verbal order (for example, the ordering practitioner gives a verbal order that is written and transcribed, and then he or she is “off duty” for the weekend or an extended period of time). In such cases, for a temporary period expiring on January 26, 2012, it is acceptable for another practitioner who is responsible for the patient’s care to authenticate the verbal order of the ordering practitioner.

4. **Verbal orders are authenticated within the time frame specified by law and regulation.**
   
   **Note 1:** For rehabilitation and psychiatric distinct part units in critical access hospitals: If there is no state law that designates a specific time frame for authentication of verbal orders, the verbal orders are authenticated within 48 hours.
   
   **Note 2:** For rehabilitation and psychiatric distinct part units in critical access hospitals: In some instances, the ordering practitioner may not be able to authenticate his or her verbal order (for example, the ordering practitioner gives a verbal order that is written and transcribed, and then he or she is “off duty” for the weekend or an extended period of time). In such cases, for a temporary period expiring on January 26, 2012, it is acceptable for another practitioner who is responsible for the patient’s care to authenticate the verbal order of the ordering practitioner.
Standard RC.02.04.01
The critical access hospital documents the patient’s discharge information.

Elements of Performance for RC.02.04.01

3. In order to provide information to other caregivers and facilitate the patient’s continuity of care, the medical record contains a concise discharge summary that includes the following:
   - The reason for hospitalization
   - The procedures performed
   - The care, treatment, and services provided
   - The patient’s condition at discharge
   - Information provided to the patient and family
   - For rehabilitation and psychiatric distinct part units in critical access hospitals: The patient's disposition at discharge
   - For rehabilitation and psychiatric distinct part units in critical access hospitals: Provisions for follow-up care

3. In order to provide information to other caregivers and facilitate the patient’s continuity of care, the medical record contains a concise discharge summary that includes the following:
   - The reason for hospitalization
   - The procedures performed
   - The care, treatment, and services provided
   - The patient’s condition and disposition at discharge
   - Information provided to the patient and family
   - Provisions for follow-up care

Note 1: A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care.

Note 2: When a patient is transferred to a different level of care within the critical access hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used.
Critical Access Hospital Accreditation Program

Standard RI.01.02.01
The critical access hospital respects the patient's right to participate in decisions about his or her care, treatment, and services.

Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

Elements of Performance for RI.01.02.01

1. The critical access hospital involves the patient in making decisions about his or her care, treatment, and services.

27. For rehabilitation and psychiatric distinct part units in critical access hospitals: The patient has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the critical access hospital.

1. The critical access hospital involves the patient in making decisions about his or her care, treatment, and services, including the right to have his or her own physician promptly notified of his or her admission to the critical access hospital.

Standard RI.01.03.01
The critical access hospital honors the patient's right to give or withhold informed consent.

Elements of Performance for RI.01.03.01

13. Informed consent is obtained in accordance with the critical access hospital’s policy and processes. (See also RC.02.01.01, EP 4)

13. Informed consent is obtained in accordance with the critical access hospital’s policy and processes and, except in emergencies, prior to surgery. (See also RC.02.01.01, EP 4)

Standard RI.01.04.01
For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital respects the patient's right to receive information about the individual(s) responsible for, as well as those providing, his or her care, treatment, and services.

Elements of Performance for RI.01.04.01

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital informs the patient of the name of the physician or other practitioner who has primary responsibility for his or her care, treatment, and services.

1. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital informs the patient of the name of the physician, clinical psychologist, or other practitioner who has primary responsibility for his or her care, treatment, or services.

Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).
2. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital informs the patient of the name of the physician(s) or other practitioner(s) who will provide his or her care, treatment, and services.

2. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital informs the patient of the name of the physician(s), clinical psychologist(s), or other practitioner(s) who will provide his or her care, treatment, and services.

Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

Standard RI.01.07.01

The patient and his or her family have the right to have complaints and grievances reviewed by the critical access hospital.

The patient and his or her family have the right to have complaints reviewed by the critical access hospital.

Elements of Performance for RI.01.07.01

1. The critical access hospital establishes a complaints and grievances resolution process. (See also MS.09.01.01, EP 1)

17. The critical access hospital establishes a complaint resolution process. (See also LD.04.01.07, EP 1; MS.09.01.01, EP 1)

Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body is responsible for the effective operation of the complaint resolution process unless it delegates this responsibility in writing to a grievance committee.

1. The critical access hospital establishes a complaint resolution process. (See also LD.04.01.07, EP 1; MS.09.01.01, EP 1)

Note: For rehabilitation and psychiatric distinct part units in critical access hospitals: The governing body is responsible for the effective operation of the complaint resolution process unless it delegates this responsibility in writing to a complaint resolution committee.

2. The critical access hospital informs the patient and his or her family about the complaint and grievance resolution process. (See also MS.09.01.01, EP 1)

2. The critical access hospital informs the patient and his or her family about the complaint resolution process. (See also MS.09.01.01, EP 1)

4. The critical access hospital reviews and, when possible, resolves complaints and grievances from the patient and his or her family. (See also MS.09.01.01, EP 1)

4. The critical access hospital reviews and, when possible, resolves complaints from the patient and his or her family. (See also MS.09.01.01, EP 1)

6. The critical access hospital acknowledges receipt of a complaint or grievance that the critical access hospital recognizes as significant and notifies the patient of follow-up to the complaint or grievance.

6. The critical access hospital acknowledges receipt of a complaint that the critical access hospital cannot resolve immediately and notifies the patient of follow-up to the complaint.

6. The critical access hospital acknowledges receipt of a complaint that the critical access hospital cannot resolve immediately and notifies the patient of follow-up to the complaint.

7. The critical access hospital provides the patient with the phone number and address needed to file a complaint or grievance with the relevant state authority. (See also MS.09.01.01, EP 1)

7. The critical access hospital provides the patient with the phone number and address needed to file a complaint with the relevant state authority.
Critical Access Hospital Accreditation Program

10. The critical access hospital allows the patient to voice complaints or grievances and recommend changes freely without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care. (See also MS.09.01.01, EP 1)

18. For rehabilitation and psychiatric distinct part units in critical access hospitals: In its resolution of grievances, the critical access hospital provides the individual with a written notice of its decision, which contains the following:
   - The name of the hospital contact person
   - The steps taken on behalf of the individual to investigate the grievance
   - The results of the process
   - The date of completion of the grievance process

18. For rehabilitation and psychiatric distinct part units in critical access hospitals: In its resolution of complaints, the critical access hospital provides the individual with a written notice of its decision, which contains the following:
   - The name of the critical access hospital contact person
   - The steps taken on behalf of the individual to investigate the complaint
   - The results of the process
   - The date of completion of the complaint process

19. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital determines time frames for grievance review and response.

19. For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital determines time frames for complaint review and response.

20. For rehabilitation and psychiatric distinct part units in critical access hospitals: The process for resolving grievances includes a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the quality improvement organization (QIO).

20. For rehabilitation and psychiatric distinct part units in critical access hospitals: The process for resolving complaints includes a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the quality improvement organization (QIO).