HealthTech

SWING BED AUDIT TOOL

DO NOT DISTRIBUTE BEYOND YOUR FACILITY

If you have any questions, please contact:

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SWING BED

Admission	
For patients in the same facility being admitted to Swing Bed, documentation that Quality and Resource information was provided, and the patient was given a choice of Swing Bed, Swing Bed programs in other CAHs, and SNFs. *Note: Can be limited to a geographic area as determined in hospital policy.*	C-1425
Discharge Order Provider discharge order from inpatient acute care if in the same facility.	C-1600

Admission: Provider Documentation	
1. Admission Order to Swing Bed.	C-1600
2. Orders for Swing Bed including orders for PT, OT, Speech if applicable.	C-1600
3. Attestation for Swing Bed Stay: by physician • Patient requires daily skilled care for an ongoing condition for which he/she was receiving inpatient hospital services (or for a new condition that arose while in the SNF for treatment of that ongoing condition); and • Will require skilled care on a daily basis which, as a practical matter, can only be provided in a SNF on an inpatient basis. ***Note:*** • *CMS does not require a specific form, although most organizations use a form that is included in the EMR to ensure the certification is not missed.* • *Recertification is required at admission, 14 days and then every 30 days thereafter.*	Medicare Benefits Manual Chapter 8, 40.0 Medicare General Information, Eligibility, and Entitlement Chapter 4, 40.3 and 40.4
4. History and Physical completed within the time frame specified in hospital bylaws. *Note: A new H&P is required for Swing Bed admissions.*	

Admission: Patient Required Disclosures	
5. Signature / attestation that patient received required disclosures.	C-1608, C-1612
6. Choice of attending physician (must be documented in the EMR).	C-1608
7. Contact Information for primary care providers, including primary care consultants provided to patient	C-1608
8. Swing Bed Rights and Responsibilities provided verbally and in a manner the patient can understand, and patient provided the opportunity to ask questions. *Notes:* • *This must be specific Swing Bed rights. Not hospital rights or long-term care rights.* • *If there are any patient rights in state regulations that are not included in the CMS rights, they must be included.*	C-1612
9. Freedom from abuse, neglect, exploitation, and misappropriation of property. *Note: This is usually included in patient rights, but a separate disclosure about the hospital's responsibility for preventing abuse is recommended.*	C-1612
10. Advance Directives • Patient was asked if they had an advance directive and if not if they wanted information • If the patient has an advance directive it is on the medical record? • If the patient a DNR there a physician order • Hospital staff and practitioners who provide care in the hospital comply with these directives	C-0812, §485.614 87 FR 72307, 72309, Nov. 23, 2022
11. Financial obligations for Medicare and Medicaid including what is covered and not covered under state plan. Include Medicare co-pay at day twenty-one.	C-1608

Transfer and Discharge Rights	
12. Hospital responsibility for preventing abuse. *Note: Freedom from abuse is required as part of patient rights. However, it is recommended that a statement or page be included in the admission packet regarding the hospital responsibilities for preventing abuse.*	C-1612
13. Information on how to file a grievance / complaint both internally and externally, including state licensing agencies and ombudsman).	C-1612

Admission: Assessment	
14. Assessment of patient's needs, strengths, goals, life history and preferences completed within 72 hours of admission. 1. Identification and demographic information 2. Customary routine 3. Cognitive patterns 4. Communication 5. Vision 6. Mood and behavior patterns 7. History of trauma 8. Psychosocial well-being 9. Physical functioning and structural problems 10. Continence 11. Disease diagnoses and health conditions 12. Dental 13. Nutritional status 14. Skin condition 15. Activity pursuit 16. Medications 17. Special treatments and procedures 18. Discharge planning *Note: CMS requirement of 14 days to complete the comprehensive assessment, does not apply to Swing Bed patients. 72 hours is recommended, if necessary to span a weekend.*	C-1620
15. Assessment by PT, OT, or Speech, if ordered by provider, within 72 hours of admission.	C-1620

Note: 72 hours is recommended if necessary to span a weekend. *Note: there is no regulation requiring 72 hours, but the time frame should be appropriate for the length of stay.*	
16. Assessment by dietician within 72 hours of admission. *Note: A dietician assessment should be completed even if patient is determined to not be at nutritional risk based on nursing risk assessment.* *Note: there is no regulation requiring 72 hours, but the time frame should be appropriate for the length of stay.*	C-1046, C-1048, C-1050
17. Assessment of Trauma.	C-1620
18. Review of PASRR (if a PASRR has been completed prior to admission). *Note: Will usually have been completed if patient has been a LTC patient)*	C-1620

Admission: Plan of Care	
19. Initial Plan of Care developed within 24 hours of admission (baseline plan of care). "*The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission, which would address resident-specific health and safety concerns to prevent decline or injury, such as elopement or fall risk, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary.* *Baseline care plans are required to address, at a minimum, the following: Initial goals based on admission orders, Physician orders, Dietary orders, Therapy services, Social Services, PASRR recommendation, if applicable.*"	Appendix PP F-655

20. Interdisciplinary Plan of Care (POC) developed (first IDT meeting) within time frame appropriate for length of stay.	C-1620
21. Plan of Care developed by interdisciplinary team that includes at a minimum: 1. Attending physician 2. Registered nurse with responsibility for the patient 3. CNA with responsibility for the patient 4. Member of food and nutrition staff 5. To the extent practicable, the participation of the patient and the patient's representative(s) (If do not attend – signs that they are in concurrence with plan) 6. Other appropriate staff or professionals in disciplines as determined by the patient's needs or as requested by the patient. (If patient is being seen by rehab, then they should attend. If there are complex medication issues, pharmacist should attend) *Notes:* • *An explanation must be included in a patient's medical record if the participation of the patient and their patient representative is determined not practicable for the development of the plan of care.* • *There must be documentation that all required members of the interdisciplinary team attended the care conference to develop the plan of care. If attending physician cannot attend, there can be documentation that the physician agreed with the plan of care. However, this should be an isolated occurrence and not routine.* • *If there are no CNAs on duty, document in the care plan meeting minutes.* • *If the patient is receiving PT, OT, or Speech, they should be in attendance.* • *If the patient has complex medication regimen, the pharmacist should attend.*	C-1620

22. POC includes measurable objectives and timeframes to meet patient's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment. *Note: Goals MUST be measurable and must have timeframes for completion of each goal.*	C-1620
23. Plan of Care includes any specialized services or specialized rehabilitative services provided as a result of PASRR recommendations. If a facility disagrees with the findings of the PASRR, the rationale must be documented in the medical record.	C-1620
24. Plan of Care developed in consultation with the patient and the patient's representative(s), the patient's goals for admission and desired outcomes. Includes the patient's preference and potential for future discharge. *Note: Must include documentation of the patient's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities.*	C-1620
25. Plan of Care updated once or twice per week with input from the interdisciplinary team and the patient. *Note: There is not a specific regulatory requirement for weekly. However, with length of stay the POC should be updated at least weekly, and ideally twice per week.*	C-1620

Continued Care	
26. Dietician recommendations implemented and documented. *Note :If the dietician recommends weekly weights, check and see if they were done and recorded.* *Note: If the dietician recommends a snack at bedtime – check and make sure the snack was offered and documented.*	C-1046, C-1048, C-1050

27. Nutrition • Food in form to meet individual needs (F-805) • Drinks available to meet needs / preferences (F-807) • Assistive devices-eating equipment/utensils if needed (F-810) • Allergies, preferences & substitutes taken into consideration (F-804)	F-804, F-805, F-807, F-810
28. Weight at admission and at least weekly, or as required based on patient status. *Note: Maintaining weight and hydration are critical elements of Swing Bed care.*	F-692
29. Documentation of food intake. *Note: Maintaining weight and hydration are critical elements of Swing Bed care.*	F-692
30. Rehab, if ordered, is provided at least five days per week.	Medicare Benefit Policy Manual Chapter 8 -30.6
31. Rehab, if ordered, is provided at the frequency determined by the assessment and provider order.	C-1052
32. If the patient refuses rehab, documentation in the medical record as to why and what was done to ensure the patient will not refuse in the future (i.e., medication prior to therapy, etc.).	C-1052
33. Evidence that nursing is supporting therapy goals (i.e., assisting the patient to walk, dress, etc.) *Note: Nursing support of therapy goals is extremely important to maintaining functional status, especially on the weekends.*	C-1620
34. Therapeutic interventions, wound care, oxygen therapy, etc., provided as ordered and documented in the medical record.	C-1006

35. Activities are provided, as needed based on the patient assessment. *Note: CMS no longer requires a formal activities program. However, it is important to ensure that the patient is not just lying-in bed and does not have mental stimulation between therapy or other treatments. The assessment still includes activities.*	C-1620
36. Comprehensive reassessment completed with any significant change in condition.	C-1620

Discharge	
37. For patients being discharged to a post-acute provider (SNF, LTC, Home Health, IRF). Quality and Resource information for post-acute providers in the geographic area provided in writing, discussed with patient, and documented in the medical record.	C-1425
38. Patient provided with Notice of Medicare Non-Coverage 2 days before discharge.	Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections, Chapter 30 §260.2
39. Discharge notice including: • The reason for transfer or discharge • The effective date of transfer or discharge • The location to which the patient is transferred or discharged • A statement of the patient's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request • The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman • For nursing facility patients with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities	C-1610

42. Copy of the patient notice of transfer or discharge sent to the State Ombudsman.	C-1610
43. Provider discharge summary that includes a recapitulation of the patient's stay that includes, but is not limited to diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.	C-1620
44. Reconciliation of all pre-discharge medications with the patient's post-discharge medications (both prescribed and over the counter).	C-1620
45. A post-discharge plan of care that is developed with the participation of the patient and, with the patient's consent, the patient representative(s), which will assist the patient to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the patient's follow up care and any post-discharge medical and non-medical services.	C-1620
46. A final summary of the patient's status to include items in §483.20. *Note: This requires a reassessment of the same items in the original comprehensive assessment.*	C-1620
47. Other information to next provider of care: • Contact information of the practitioner responsible for the care of the patient • Patient representative information including contact information • Advance Directives • All special instructions or precautions for ongoing care, as appropriate	C-1620