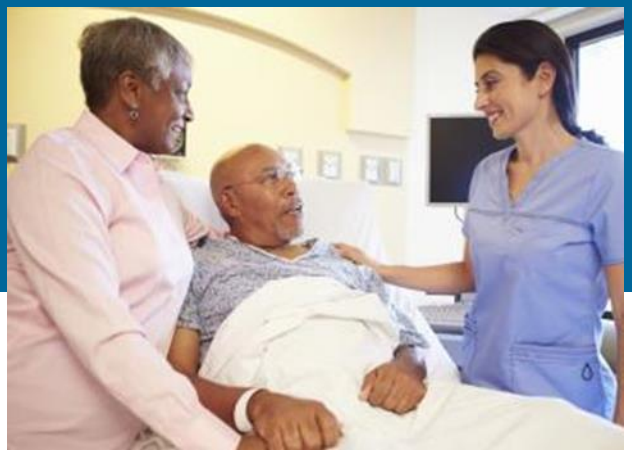
CMS HOSPITAL CONDITIONS OF PARTICIPATION 2022
Part 5 of 5



Infection Prevention, Discharge Planning, Organ, Surgery, PACU, Anesthesia, Emergency Services, Outpatient, Rehab, and Respiratory

Speaker

- Lena Browning
- MHA, BSN, RNC-NIC, CSHA
- Consultant, Nash Healthcare Consulting
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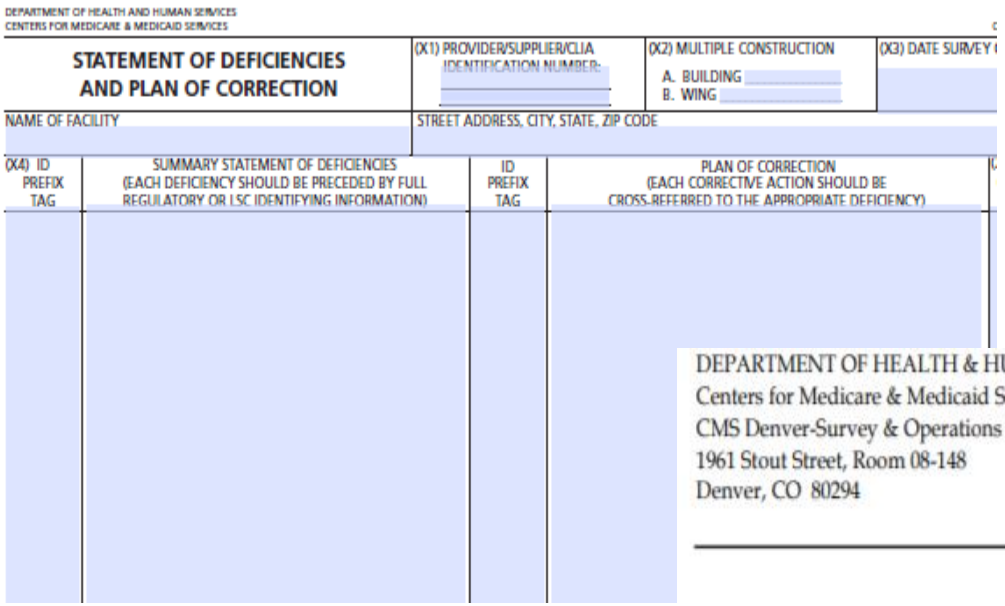
- LBrowning@Nashhc.com

- Email questions to CMS:
  Critical Access Hospitals: qsog_CAH@cms.hhs.gov.
  Acute hospitals: **qsog_hospital@cms.hhs.gov.**

NASH HEALTHCARE CONSULTING

Why We are Here Today



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

A. BUILDING _____ B. WING _____

NAME OF FACILITY

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
CMS Denver-Survey & Operations Group
1961 Stout Street, Room 08-148
Denver, CO 80294

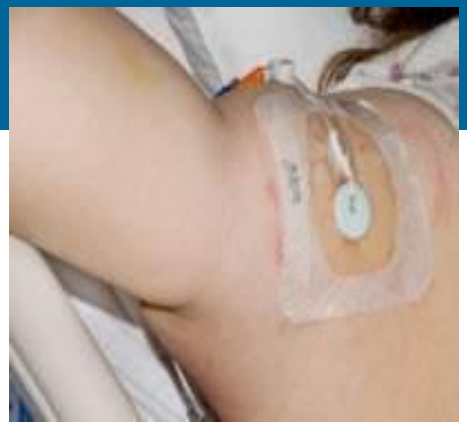
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

PUBLIC NOTICE FOR INVOLUNTARY TERMINATION OF MEDICARE/MEDICAID PROVIDER AGREEMENT

Notice is hereby given that the agreement between Clear View Behavioral Health, 4770 Larimer Parkway, Johnstown, Colorado 80534, and the Secretary of Health and Human Services, as a provider o services in the Health Insurance for the Aged and Disable Program (Medicare) is to be terminated at the close of October 28, 2020.

The Medicare program will not make payment for inpatient hospital services furnished to patients who are admitted after the close of October 28, 2020. For patients admitted on October 28, 2020, or earlier, payment may continue for up to 30 calendar days of inpatient hospital services furnished after October 28, 2020.

Introduction



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Email Address *

SUBMIT CANCEL

Your contact information is used to deliver requested updates or to access your subscriber preferences.

How to Keep Up with Changes

- Confirm current CoP [1].
- If new manual – check CMS transmittal page [2].
- Check the survey and certification website monthly [3].
- Have one person in your facility who has this responsibility

- [1] http://www.cms.hhs.gov/manuals/downloads/som107_Appendicestoc.pdf
- 2 http://www.cms.gov/Transmittals
- 3 http://www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

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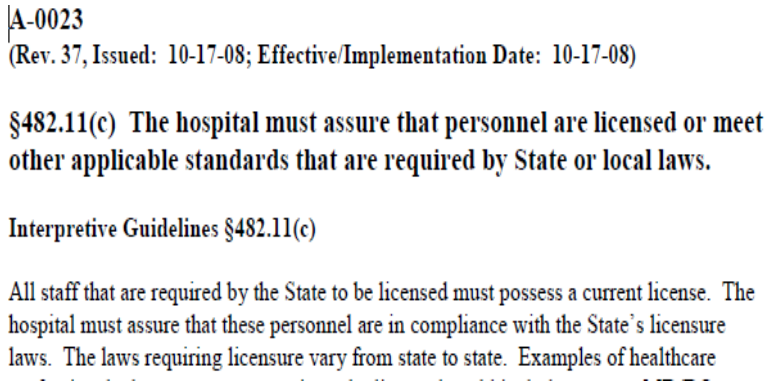
The Conditions of Participation (CoPs)

- Manual first out 1986
  - Multiple updates
- Section numbers – “Tag” numbers
- Start in the Federal Register
  - Interpretive Guidelines
  - Survey procedures
  - Hospitals should check this website once a month for changes



A-0023
(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

§482.11(c) The hospital must assure that personnel are licensed or meet other applicable standards that are required by State or local laws.

Interpretive Guidelines §482.11(c)

All staff that are required by the State to be licensed must possess a current license. The hospital must assure that these personnel are in compliance with the State's licensure laws. The laws requiring licensure vary from state to state. Examples of healthcare

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CMS Hospital CoP Manual

- https://www.cms.gov/files/document/som107appendicestoc.pdf.

Medicare State Operations Manual

Appendix

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. **Click on the corresponding letter in the "Appendix Letter" column to see any available file in PDF.**
- To return to this page after opening a PDF file on your desktop. Use the browser "back" button. This is because closing the file usually will also close most browsers

Appendix Letter	Description
A	Hospitals
AA	Psychiatric Hospitals- *Deleted (See Appendix A)*
B	Home Health Agencies

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CMS CoP Manual

Appendix Letter	Description
	Guidance
P	Survey Protocol for Long-Term Care Facilities
PP	Interpretive Guidelines for Long-Term Care Facilities
Q	Determining Immediate Jeopardy
R	Resident Assessment Instrument for Long-Term Care Facilities
S	Mammography Suppliers - **Deleted**
T	Swing-Beds – **Deleted (See Appendix A and Appendix W)**
U	Responsibilities of Medicare Participating Religious Nonmedical Healthcare Institutions
V	Responsibilities of Medicare Participating Hospitals In Emergency Cases
W	Critical Access Hospitals (CAHs)
Y	Organ Procurement Organization (OPO)
Z	Emergency Preparedness for All Provider and Certified Supplier Types

State Operation Manual – Acute/PPS

State Operations Manual
Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

Table of Contents
(Rev. 200, 02-21-20)

CMS Survey Memos

Policy & Memos to States and Regions

CMS Quality Safety & Oversight memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices. www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions

Show entries: 5 per page | Filter On | Apply

Showing 1-10 of 521 entries

Title	Memo #	Posting Date	Fiscal Year
Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes	QSO-20-14-NH	2020-03-04	2020
Suspension of Survey Activities	QSO-20-12-All	2020-03-04	2020
Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge	QSO-20-13-Hospitals	2020-03-04	2020
Release of Additional Toolkits to Ensure Safety and Quality in Nursing Homes	20-11-NH	2020-02-14	2020
Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness (2019-nCoV)	20-09-ALL	2020-02-06	2020
Notification to Surveyors of the Authorization for Emergency Use of the CDC		2020-02-	

Example of Survey Memo CRE and ERCP's

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C-15-32 Hospitals/CAHs/ASCs

DATE: **April 3, 2015**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Alert Related to Outbreaks of Carbapenem-Resistant *Enterobacteriaceae* (CRE) during gastrointestinal endoscopy, particularly Endoscopic Retrograde Cholangiopancreatography (ERCP)

Memorandum Summary

- *Situation:* Recent newspaper articles, medical publications, and adverse event reports associate multidrug-resistant bacterial infections caused by CRE with patients who have undergone ERCP. Duodenoscopes used to perform ERCP are difficult to clean and disinfect, even when manufacturer reprocessing instructions are followed correctly, and have been implicated in these outbreaks. The U.S. Food and Drug Administration (FDA) has issued a Safety Communication warning, with related updates, that the design of duodenoscopes may impede effective cleaning.

- *Expectations for Reprocessing Duodenoscopes:* Hospitals, critical access hospitals (CAHs), and ambulatory surgical centers (ASCs) are expected to meticulously follow the manufacturer's instructions for reprocessing duodenoscopes, as well as adhere to the nationally recognized Multisociety consensus guidelines developed by multiple expert organizations and issued in 2011.

Can Access Hospital Deficiency Data

- Includes acute care and CAH hospitals
  - List tag numbers
  - Does not include the plan of correction but can request
  - Questions to bettercare@cms.hhs.com
- Updated quarterly

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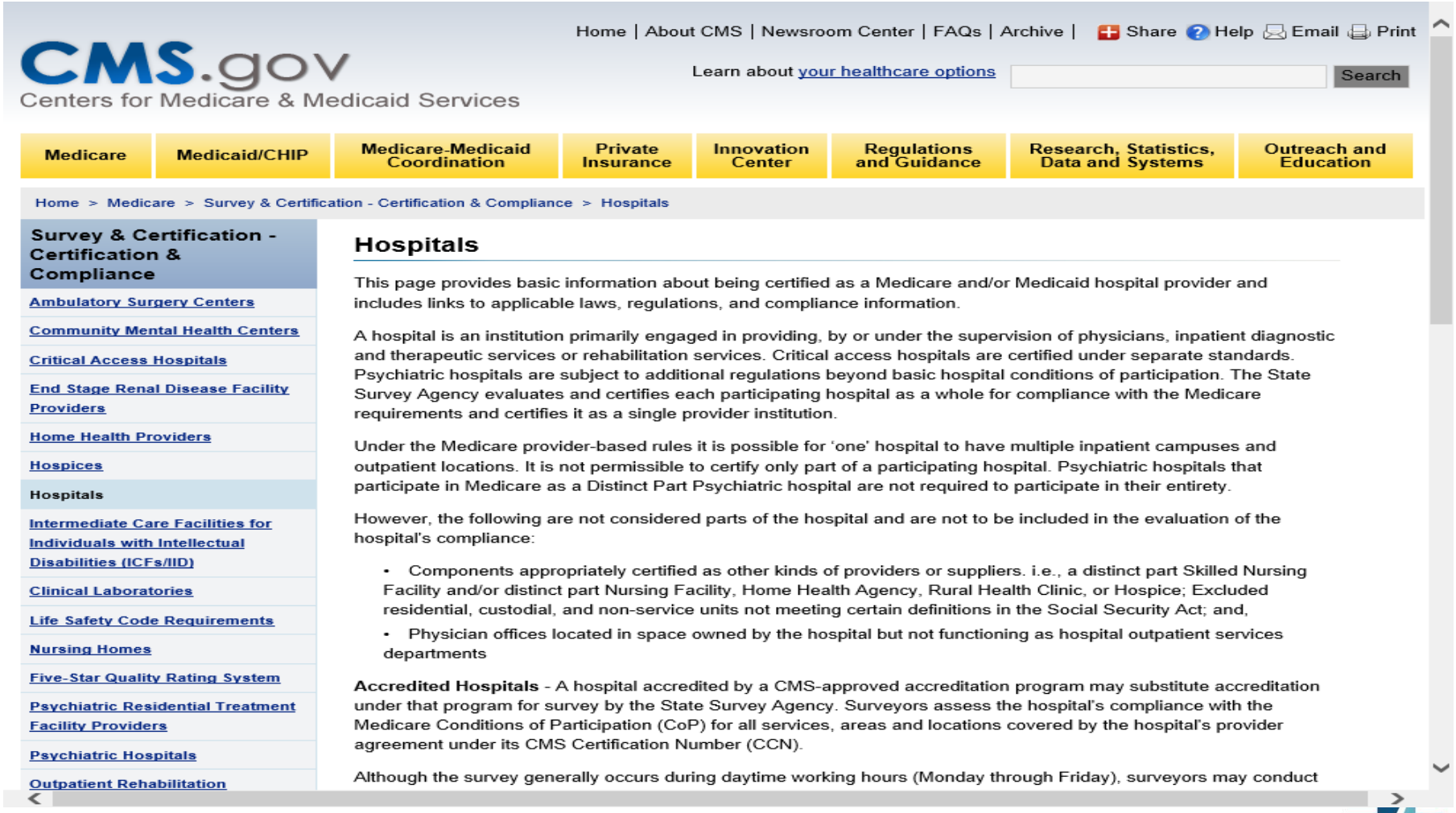
Updated Deficiency Data Reports



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Home > Medicare > Survey & Certification - Certification & Compliance > Hospitals

Survey & Certification - Certification & Compliance

- Ambulatory Surgery Centers
- Community Mental Health Centers
- Critical Access Hospitals
- End Stage Renal Disease Facility Providers
- Home Health Providers
- Hospices
- Hospitals
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)
- Clinical Laboratories
- Life Safety Code Requirements
- Nursing Homes
- Five-Star Quality Rating System
- Psychiatric Residential Treatment Facility Providers
- Psychiatric Hospitals
- Outpatient Rehabilitation

Hospitals

This page provides basic information about being certified as a Medicare and/or Medicaid hospital provider and includes links to applicable laws, regulations, and compliance information.

A hospital is an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services. Critical access hospitals are certified under separate standards. Psychiatric hospitals are subject to additional regulations beyond basic hospital conditions of participation. The State Survey Agency evaluates and certifies each participating hospital as a whole for compliance with the Medicare requirements and certifies it as a single provider institution.

Under the Medicare provider-based rules it is possible for 'one' hospital to have multiple inpatient campuses and outpatient locations. It is not permissible to certify only part of a participating hospital. Psychiatric hospitals that participate in Medicare as a Distinct Part Psychiatric hospital are not required to participate in their entirety.

However, the following are not considered parts of the hospital and are not to be included in the evaluation of the hospital's compliance:

- Components appropriately certified as other kinds of providers or suppliers. i.e., a distinct part Skilled Nursing Facility and/or distinct part Nursing Facility, Home Health Agency, Rural Health Clinic, or Hospice; Excluded residential, custodial, and non-service units not meeting certain definitions in the Social Security Act; and,
- Physician offices located in space owned by the hospital but not functioning as hospital outpatient services departments

Accredited Hospitals - A hospital accredited by a CMS-approved accreditation program may substitute accreditation under that program for survey by the State Survey Agency. Surveyors assess the hospital's compliance with the Medicare Conditions of Participation (CoP) for all services, areas and locations covered by the hospital's provider agreement under its CMS Certification Number (CCN).

Although the survey generally occurs during daytime working hours (Monday through Friday), surveyors may conduct

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals.html

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“Full Text Statements”

- Life Safety Code & Health Care Facilities Code Requirements
- Nursing Homes
- Five-Star Quality Rating System
- Psychiatric Residential Treatment Facility Providers
- Psychiatric Hospitals
- Outpatient Rehabilitation Providers
- Inpatient Rehabilitation Facilities
- Comprehensive Outpatient Rehabilitation Facilities
- Rural Health Clinics
- Religious Nonmedical Health Care Institutions
- Transplant

- Physician offices located in space owned by the hospital but not functioning as hospital outpatient services departments

Accredited Hospitals - A hospital accredited by a CMS-approved accreditation program may substitute accreditation under that program for survey by the State Survey Agency. Surveyors assess the hospital's compliance with the Medicare Conditions of Participation (CoP) for all services, areas and locations covered by the hospital's provider agreement under its CMS Certification Number (CCN).

Although the survey generally occurs during daytime working hours (Monday through Friday), surveyors may conduct the survey at other times. This may include weekends and times outside of normal daytime (Monday through Friday) working hours. When the survey begins at times outside of normal work times, the survey team modifies the survey, if needed, in recognition of patients' activities and the staff available.

All hospital surveys are unannounced.

- Should an individual or entity (hospital) refuse to allow immediate access upon reasonable request to either a State Agency , CMS surveyor, a CMS-approved accreditation organization, or CMS contract surveyors, the hospital's Medicare provider agreement may be terminated.
- The CMS State Operations Manual (SOM) provides CMS policy regarding survey and certification activities.

See the **downloads** section below for the Patient's Rights Final Rule that includes more information on the hospital death reporting requirements related to restraint and seclusion.

Downloads

Patient's Rights Regulation published 12/8/2006 (PDF, 335 KB) (PDF)
EMTALA (PDF)
Chapter 2 - The Certification Process (PDF)
Full Text Statements of Deficiencies Hospital Surveys - 2020Q2 (ZIP)
Full Text Statements of Deficiencies Transplant Surveys - 2020Q2 (ZIP)

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospitals.html

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Deficiencies by Tag Number

	A	B	C	D	E	F	G	H	I	J	
240	DOCTORS' HOSPITAL OF MICHIGAN	23(	461	MI	48341	Short Term	A	0364	AUTOPSIES	7/18/2012	Based on record review and interview, the facility failed to ensure that 1
241	MARTHA JEFFERSON HOSPITAL	49(	500	VA	22911	Short Term	A	0364	AUTOPSIES	9/8/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
242	SAINT LOUISE REGIONAL HOSPITAL	05(	940(	CA	95020	Short Term	A	0364	AUTOPSIES	1/18/2012	Based on interview and record review, the hospital failed to have a syste
243	EDGERTON HOSPITAL AND HEALTH SERVICES	521	111(	WI	53534	Critical Access H	C	0201	AVAILABILITY	10/2/2012	Based on review of MR, review of staffing guidelines, review of P&P, and
244	HOLZER MEDICAL CENTER JACKSON	361	500	OH	45640	Critical Access H	C	0205	BLOOD AND BLOOD PRODUCTS	1/20/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
245	BRANDON REGIONAL HOSPITAL	10(	119	FL	33511	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	4/8/2011	Based on clinical record review, staff interview and review of policy and
246	CHRISTUS ST PATRICK HOSPITAL	19(	524	LA	70601	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	3/9/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
247	COLUMBUS REGIONAL HEALTHCARE SYSTEM	34(	500	NC	28472	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	4/13/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
248	DANA-FARBER CANCER INSTITUTE	22(	450	MA	02115	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	9/7/2011	Based on review of documentation and confirmed by staff interviews, tw
249	GOOD SAMARITAN MEDICAL CENTER	10(	130	FL	33401	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	2/12/2013	Based on clinical record review and staff interview the facility failed to e
250	LONG BEACH MEDICAL CENTER	33(	455	NY	11561	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	12/22/2011	Based on record review, the facility failed to ensure that the patient ' s te
251	MANATEE MEMORIAL HOSPITAL	10(	206	FL	34208	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	4/16/2012	Based on record review, policy review and staff interview it was determi
252	MISSOURI BAPTIST MEDICAL CENTER	26(	301	MO	63131	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	4/11/2012	Based on observation, interview, and record review, the facility failed to
253	NORTHWEST MEDICAL CENTER	10(	280	FL	33063	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	8/2/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
254	RESTON HOSPITAL CENTER	49(	185(	VA	20190	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	11/2/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
255	SAINT AGNES HOSPITAL	21(	900	MD	21229	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	2/22/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
256	SAINT CATHERINE REGIONAL HOSPITAL	15(	220(	IN	47111	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	12/13/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
257	SOUTHEASTERN REGIONAL MEDICAL CENTER	34(	300	NC	28359	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	12/14/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
258	STANFORD HOSPITAL	05(	300	CA	94305	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	3/15/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
259	WAKEMED, CARY HOSPITAL	34(	190(	NC	27518	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	3/14/2013	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
260	WILKES-BARRE GENERAL HOSPITAL	39(	575	PA	18764	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	1/14/2013	Based on review of facility policy, facility documents, medical records (M
261	WILSON MEDICAL CENTER	34(	170	NC	27893	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	2/10/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
262	RIVERSIDE GENERAL HOSPITAL	45(	320	TX	77004	Short Term	A	0063	CARE OF PATIENTS	11/9/2012	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
263	CIVISTA MEDICAL CENTER	21(	5 GA	MD	20646	Short Term	A	0067	CARE OF PATIENTS - MD/DO ON CALL	8/4/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
264	MILFORD HOSPITAL, INC	07(	300	CT	06460	Short Term	A	0067	CARE OF PATIENTS - MD/DO ON CALL	9/22/2011	Based on review of hospital documentation and interviews with facility
265	PLAZA MEDICAL CENTER OF FORT WORTH	45(	900	TX	76104	Short Term	A	0067	CARE OF PATIENTS - MD/DO ON CALL	7/1/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
266	CLARA MAASS MEDICAL CENTER	31(	ONE	NJ	07109	Short Term	A	0068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE	6/2/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
267	GEISINGER - COMMUNITY MEDICAL CENTER	39(	182	PA	18510	Short Term	A	0068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE	6/14/2011	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
268	SENTARA NORTHERN VIRGINIA MEDICAL CEN	49(	230(	VA	22191	Short Term	A	0068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE	12/6/2012	Based on a complaint investigation, document review and interview, the

Sheet1

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Search for Hospital Survey Reports

LUTHERAN MEDICAL CENTER

8300 W 38TH AVE WHEAT RIDGE, CO 80033 | Voluntary non-profit - Private

View hospital's federal Hospital Compare record

Read complete reports

Report date	Number of violations	
Nov. 7, 2019	2 (click for details)	Read full report
July 29, 2019	2 (click for details)	Read full report
May 8, 2019	4 (click for details)	Read full report
Oct. 19, 2016	1 (click for details)	Read full report
June 29, 2016	2 (click for details)	Read full report
March 24, 2016	2 (click for details)	Read full report
Nov. 4, 2015	1 (click for details)	Read full report
Aug. 7, 2015	2 (click for details)	Read full report
Nov. 15, 2012	3 (click for details)	Read full report

Read the Report

LUTHERAN MEDICAL CENTER	8300 W 38TH AVE WHEAT RIDGE, CO 80033	Nov. 7, 2019
VIOLATION: *PATIENT RIGHTS*		**Tag No:** A0115

Based on the manner and degree of the standard level deficiency referenced to the Condition, it was determined the Condition of Participation 482.13, PATIENT RIGHTS, was out of compliance.

A-0144 The patient has the right to receive care in a safe setting. Based on interviews and document review, the facility failed to ensure all staff who were assigned to work on the orthopedic surgical floor were trained in order to care for patients with specific post-operative precautions for safety with transfers and bed mobility. This failure was identified in 1 of 3 medical records of patients who underwent total hip replacement surgeries (Patient # 2).

VIOLATION: *PATIENT RIGHTS: CARE IN SAFE SETTING*	**Tag No:** A0144

Based on interviews and document review, the facility failed to ensure all staff who were assigned to work on the orthopedic surgical floor were trained in order to care for patients with specific post-operative precautions for safety with transfers and bed mobility. This failure was identified in 1 of 3 medical records of patients who underwent total hip replacement surgeries (Patient # 2).

Findings include:

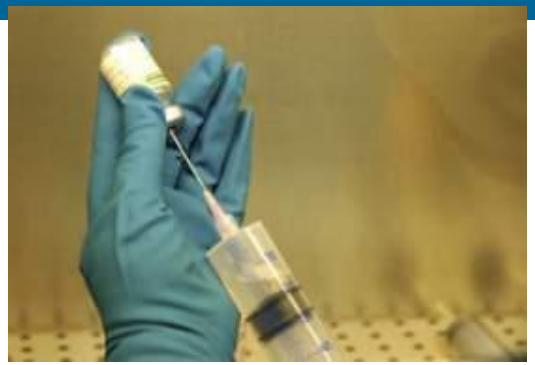
Facility policy:

The Nursing Service Staffing policy purpose was to give direction to nursing units regarding the use of staffing resources. The policy read it was the Staffing Coordinator, Shift Specialty Coordinator, and House Supervisors responsibility to serve as a liaison in floating staff to other units. Additionally, all associates were required to float to other units based on documented clinical competence, skill and patient care needs. The policy read staffing assignments were to be adjusted based on the judgement of the registered nurse (RN) in charge to provide special patient care needs depending on the patient's condition and to ensure the patient care needs were met.

1. The facility failed to ensure nursing staff had been educated on posterior hip precautions when caring for Patient #2. Subsequently, during Patient #2's transfer from the bed the patient suffered further injury after being moved by untrained staff.

a. A medical record review was conducted for Patient #2 who was admitted to the orthopedic surgical floor following a total hip arthroplasty (hip joint replacement) (THA) on

Hospital Improvement Rule Infection Control Standards



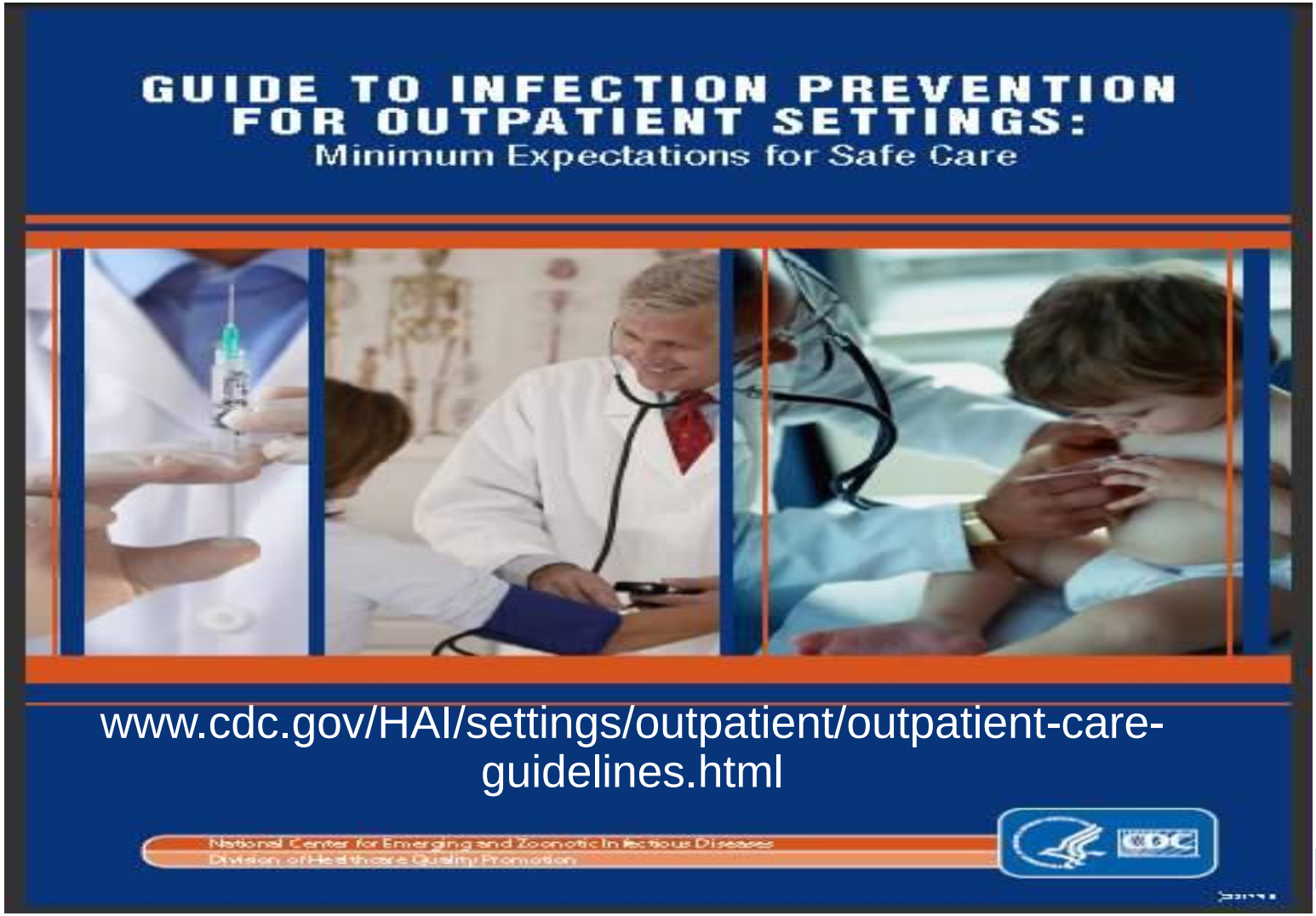
Introduction

- CMS published the final regulations September 2019
  - Became effective November 2019
  - Interpretive guidelines and survey procedures are pending
  - Hopefully by early 2022
  - Monitor the survey memo website
- 22 new Tag numbers

Hospital Improvement Rule

- Made many changes to infection control
- Basics:
  - Must follow evidenced based guidelines
  - Need to update P&P as guidelines change
  - Prevent and control infection between the hospital and other healthcare settings in which patients come from
- Want hospitals to look at the CDC documents on Guide to Prevention for Outpatient Centers

CDC Guide Infection Control Outpatients



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Antibiotic Stewardship Program

- Hospitals must have an active hospital-wide program for
  - Surveillance, prevention, and control
  - HAI and other infectious diseases
  - Infection prevention and control problems
  - Antibiotic use issues identified
    - Must be addressed in the QAPI program

Infection Preventionist

- The infection preventionist or IP
  - Must be qualified through education, training, experience
  - Or certification in infection prevention and control
  - Lists the responsibilities of the IP

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Responsibilities of the IP

- Has a direct role in the competency-based training of all staff
  - Including MS and LPs
- Must communicate and collaborate with the QAPI program in all IC issues
- Must develop and implement the P&P
  - Must be evidenced based – cite the authority in the reference section
  - Policy need to address hospital wide infection surveillance, prevention, and control

System-Wide Infection Control and ASP

- Hospital in a system can have system wide IC and ASP
  - Called unified and integrated infection prevention and control and ASP
  - Not for CAHs
- Board of 2 or more hospitals can elect to do
  - Must make sure is consistent with state law
  - Board is responsible and accountable for ensuring that **each** of its separately certified hospitals meets all of the requirements of this section

Preventionist and Leader of ASP

- Infection preventionist (IP) must be approved by the board, nursing leadership and MEC
- Leader of the ASP must be appointed by the board
  - Recommended by the Medical Staff
  - Qualified by training and education
    - The training should be in infectious diseases
    - Such as an infectious disease physician

Active Antibiotic Stewardship Program

- An active ASP must include the following:
  - Coordination with others such as the
    - IP – Medical staff – Nursing – Pharmacy – QAPI program
  - Documentation of evidence-based antibiotics in all departments and services
  - Documentation of sustained improvements in proper antibiotic use, reduction in C-diff and antibiotic resistance
  - Must follow evidenced-based guidelines and best practices
    - An example would be the CDC core elements of an ASP

CDC Core Elements of an ASP*

- Updated the core elements in November 2019
- Provides examples of leadership commitment to the ASP
- Highlights the priority interventions and process measures
- Emphasizes the key role of the pharmacists and nurses in improving antibiotic use

Introduction

Antibiotics have transformed the practice of medicine, making once lethal infections readily treatable and making other medical advances, like cancer chemotherapy and organ transplants, possible. Prompt initiation of antibiotics to treat infections reduces morbidity and save lives, for example, in cases of sepsis (1). However, about 30% of all antibiotics prescribed in U.S. acute care hospitals are either unnecessary or suboptimal (2, 3).

www.cdc.gov/antibiotic-use/core-elements/hospital.html

The Core Elements of Hospital Antibiotic Stewardship Programs, 2019 [PDF – 40 pages]

Antibiotic Stewardship Program Assessment Tool (Print Only) [PDF – 8 pages]

What's New in the *Core Elements of Hospital Antibiotic Stewardship Programs, 2019* [Video – 5:24]

Core Elements Small and CAHs

- CDC, AHA, Office of Rural Health and Pew Charitable Trusts came out with practical strategies to implement ASP
  - For small and critical access hospitals
- Implementation strategies include:
  - Leadership commitment and accountability
  - Pharmacist leader with drug expertise
  - Evidenced-based actions
  - Tracking such as days of therapy and use the CDC Net
  - Reporting and education

The Core Elements of Hospital Antibiotic Stewardship Programs

www.cdc.gov/getsmart/healthcare/pdfs/core-elements.pdf

National Center for Emerging and Zoonotic Infectious Diseases
Division of Healthcare Quality Promotion

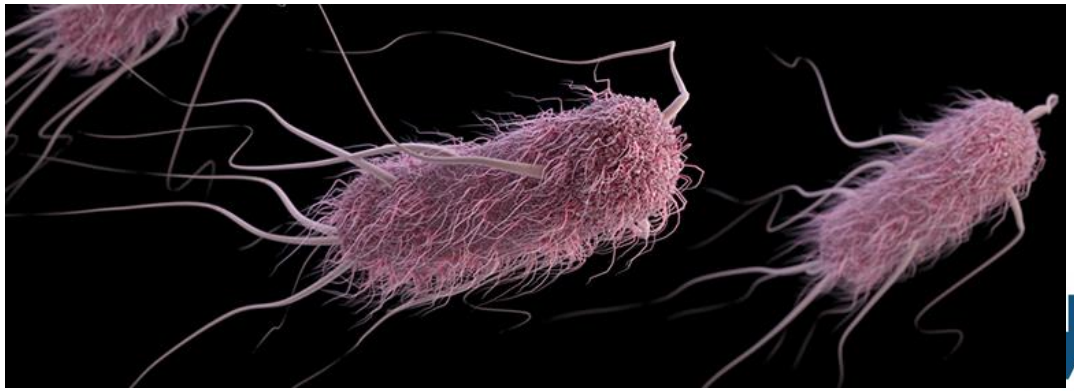
Infection Prevention and Control and ASP

Question

- Our infection control program covers every aspect of care provided within our facility.
  - Yes
  - No
  - Not sure

Infection *Prevention* and Control

- Called “Infection Prevention & Control and ASP”
- Updated to reflect changing infectious and communicable disease threats
  - Including current knowledge and best practices
- CDC estimates there are 1.7 million HAI in hospitals every year and 75,000 deaths



Hospital Wide Programs 747 New

- **Standard**: Hospital must have an active hospital wide program for surveillance, prevention, and control of HAIs and other infectious diseases
  - Must optimize the use of antibiotics through an antibiotic stewardship program (ASP)
- Programs must follow nationally recognized infection prevention and control guidelines
  - Must follow best practices for improving antibiotic use and reduce HAIs

Infection Control

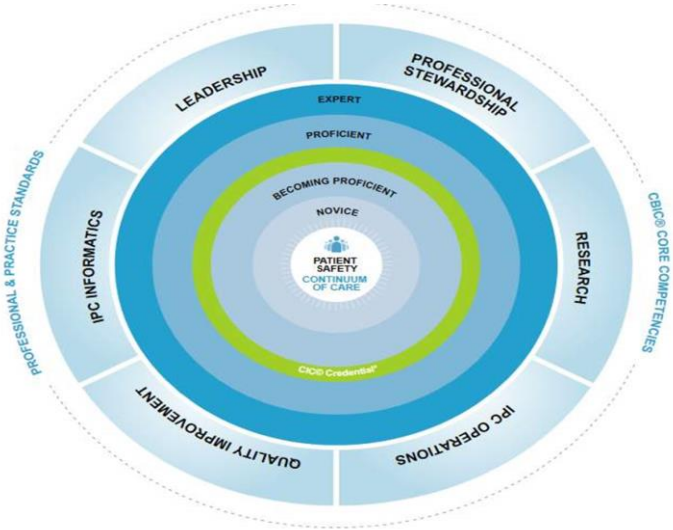
- Problems and antibiotic issues must be addressed with QAPI program
  - Interpretive guidelines are pending
- Previous guidelines* address:
  - Environmental Service – food storage
  - Communicable diseases - monitoring
  - Helpful to understand what CMS is looking for until the new ones come out

IC Organization & P&Ps 748 New

- **Standard**: Hospital must demonstrate that the IP (individual or individuals) is qualified
  - Through education, training, experience, or certification
  - Board must appoint
  - After approval of Medical Staff and nursing leadership
- The new interpretive guidelines are pending
  - The remaining are the current ones in effect

Infection Control

- APIC and CMS now calls person Infection Preventionist (IP)
  - APIC has a competency model*



  - TJC has chapter on Infection Prevention and Control

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Prevention & Control Program 749 2020

- **Standard**: The hospital infection prevention and control program must prevent and control the transmission of infections
  - Includes preventing infections within and between the hospital and other institutions and settings
- Must document this in the P&P
- Guidelines are pending
  - Current interpretive guidelines in appendix
  - Resources in appendix re: devices cleaning/reprocessing*

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Infection Control Program 750 2020

- **Standard**: The infection prevention and control program includes surveillance, prevention, and control of HAIs
  - Includes maintaining a clean and sanitary environment to avoid sources and transmission of infection
    - No blood on the walls or floor
    - Proper hand hygiene
- Must address any infection control issues identified by public health
  - Such as the Department of Health

Scope and Complexity 751

- IC program reflects the scope and complexity of the hospital service provided
  - Must ensure program looks at all departments and services
    - Transplant service
    - Surgical services
    - Labor and delivery
    - Chemo unit, etc.

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Leadership's Responsibilities 770 & 771

- Board must ensure systems are in place and operational
  - Track all infection surveillance, prevention, and control, and antibiotic use activities (770)
  - Shows success and that activities are sustainable
- Board must ensure all HAI and infectious disease identified by the program and ASP
  - Are addressed with QAPI leadership (771)

Infection Preventionist 772 & 773

- Responsible to develop and implement hospital wide policies (772)
  - Surveillance, prevention, and control policies
  - Need to make sure follow national guidelines
- Responsible for documentation of the program
  - Including surveillance, prevention, and control activities (773)

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IP Responsibilities 774 – 777

- Communicate and collaborate with the QAPI program on IC issues (774)
- Provide competency-based training to the staff, the medical staff, and those providing contracted services (775)
  - Practical application of the IC guidelines and P&Ps
- Prevention and control of HAIs (776)
  - Includes auditing the IC policies
- Communicates and collaborates with ASP (777)

ASP Leader Responsibilities 778 & 779

- Developing and implementing the hospital wide ASP (778)
  - Based on nationally recognized guidelines
  - Must monitor and improve the use of antibiotics
- Documentation of all activities (779)
  - Written or electronic

Responsibilities cont'd 780

- Communicate and collaborate with
  - Medical staff
  - Nursing leadership
  - Pharmacy leadership
  - Infection prevention and control
  - QAPI program on antibiotic use issues

Responsibilities cont'd 781

- Ensure there is competency-based training and education
  - To hospital personnel
  - To staff
  - To medical staff and contract employees
  - On ASP guidelines and P&Ps (781)

Multi-Hospital System Program 785

- **Standard:** If part of a system of separately certified hospitals with a governing body over 2 or more hospitals
  - Can elect to have unified and integrated IPC and ASP for **all** hospitals
  - If complies with State and local laws
- Board responsible and accountable to ensure EACH hospital meets all the requirements of the section

Unified/Integrated Programs Must Ensure 786-788

- Considers each hospital's unique circumstances and differences in population (786)
- P&P meet the needs of each hospital regardless of practice or location (787)
- Programs have mechanisms to ensure issues localized to particular hospitals are considered and addressed (788)

Responsible Individual 789

- A qualified individual(s) with expertise in IC has been designated as:
  - Responsible to communicate with the unified IC and ASP programs
  - Responsible for implementing the P&Ps on infection control and ASP
  - Providing education and training on the practical applications of infection control
  - Guidance pending

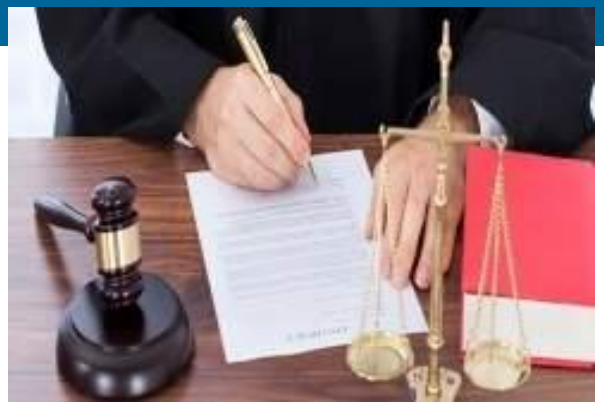
Infection Control Worksheets*

Module 1: Infection Prevention Program

Section 1.A. Infection Prevention Program and Resources

Elements to be assessed		
1.A.1 The hospital has designated one or more individual(s) as its Infection Control Officer(s).	◯ Yes ◯ No	
1.A.2 The hospital has evidence that demonstrates the Infection Control Officer(s) is qualified and maintain(s) qualifications through education, training, experience or certification related to infection control consistent with hospital policy.	◯ Yes ◯ No	
1.A.3 The Infection Control Officer(s) can provide evidence that the hospital has developed general infection control policies and procedures that are based on nationally recognized guidelines and applicable state and federal law.	◯ Yes ◯ No	
If no to any of 1.A.1 through 1.A.3, cite at 42 CFR 482.42(a) (Tag A-748)		
1.A.4 The Infection Control Officer can provide an updated list of diseases reportable to the local and/or state public health authorities.	◯ Yes ◯ No	

Discharge Planning Changes



Discharge Planning Changes

- Final discharge planning standards effective November 2019
  - Interpretive guidelines and survey procedures pending
  - Indicated in this program “2020”
- Includes hospitals, CAH, LTC hospitals, inpatient rehab, and home health agencies
  - Goal: better alignment with current practices and to reduce unnecessary readmissions
  - To implement the requirements of the IMPACT Act: Improving Medicare Post-Acute Care Transformation

Discharge Planning – Generally

- Final revised discharge planning requirements
  - The patient can request a copy of the discharge plan
  - Must include the caregiver or support person as an active partner in the discharge planning process for post-discharge care
  - The hospital must have an effective discharge planning process that focuses on:
    - Patient goals and treatment preferences

Discharge Plan

- Must be consistent with the patient's goals for care and treatment preference
- Must ensure an effective transition from the hospital to post-discharge
  - Process usually started when the patient is first admitted
  - The nurse will ask questions during the admission assessment
  - EX – ask patient if they are able to do activities of daily at home like shower or fix their meals

Discharge Planning

- The hospital must reduce the factors that lead to preventable hospital readmissions
- Predictive analysis can determine who is at risk for readmissions
  - Increased risk of admission for patient with cancer, takes multiple medications, history of depression
- Guidelines in appendix are reference only
- Worksheet – excellent self-assessment tool

Final Discharge Planning Worksheet

Section 2 Discharge Planning – Policies and Procedures		
Elements to be assessed		**Surveyor Notes**
2.1 Implementation of discharge planning policies and procedures for inpatients:		
2.1a For every inpatient unit surveyed is there evidence of applicable discharge planning activities?	○ Yes ○ No	
2.1b Are staff members responsible for discharge planning activities correctly following the hospital's discharge planning policies and procedures?	○ Yes ○ No	
If no for either 2.1a or 2.1b, cite the applicable standard for identification of patients needing discharge planning, 42 CFR 482.43(a) (Tag A-0800); discharge planning evaluation, 42 CFR 482.43(b) (Tag A-0806); and/or developing and implementing the discharge plan, 42 CFR 482.43(c) (Tag A-0818)		
2.2 Does the discharge planning process apply to certain categories of outpatients?	○ Yes ○ No	
If yes, check all that apply: ○ Same day surgery patients ○ Observation patients who are not subsequently admitted ○ ED patients who are not subsequently admitted ○ Other		
2.3 Is a discharge plan prepared for each inpatient?	○ Yes, skip to	

Discharge Planning Standards

Question

- Our facility has a dedicated/identified individual responsible for coordinating all discharge planning process.
  - Yes
  - No
  - Do not know

Discharge Planning 799 2020

- **Condition**: The hospital must have a discharge planning (DP) process that
  - Focuses on patient goals and treatment preferences
  - Includes patient and caregivers/support person
- Process and plan must:
  - Be consistent with patient goals and preferences
  - Ensure an effective transition of patient from hospital to post-discharge care
  - And reduce factors leading to preventable hospital readmissions

Patient Identification 800 2020

- **Standard**: Process must identify at an early stage those patients who are likely to suffer adverse consequences if no discharge planning is done
- Must provide discharge planning evaluation of patients identified as needing it
  - Also – patients or their representatives request it
  - Or the patient's physician can request

Discharge Planning 801 & 802 2020

- **Standard**: The hospital must develop and implement the discharge plan for the patient when requested by the doctor (801)
- **Standard**: Must regularly re-evaluate the patient's conditions to identify any changes that require the Plan be modified (802)

Evaluation of Hospital's Process 803 2020

- **Standard**: The hospital must assess the discharge planning process on a regular basis
  - Must be ongoing
  - Must do a periodic review of a sample of the discharge plans
  - Include patients admitted within 30 days
  - Ensure plans respond to the patient's post-discharge needs

Assist in Selection PAC 804 2020

- **Standard:** The hospital must assist patients, their families and representatives, in selecting a post-acute provider
  - Must provide data on
    - Quality measures
    - Resource use on measures
  - Information must be relevant and applicable to goals/preferences
  - Includes but not limited to data on HHA, SNF, IRF, LTCH

Evaluation 805 2020

- **Standard:** Must do a timely discharge planning evaluation to ensure appropriate arrangements for post-hospital care
  - Made before discharge
  - Must avoid unnecessary delays
- Surveyors will conduct discharge tracers on open and closed inpatient records

Need for Post Hospital Services 806

- **Standard:** Must provide a discharge planning evaluation to patients at risk, or requested by the patient or doctor
  - Must include the likelihood of needing post hospital services
    - Home health – hospice – RT – Rehab – nutritional consult – dialysis – supplies – transport – Meals-on-Wheels – housekeeping
    - Is the patient going to need any special equipment or modifications to the home
  - Must include an assessment if the patient can do self care or others can do the care

Return to Home or Other

- IGs provide information depending patient's need
  - Must evaluate if patient can return to their home
  - If from LTC, hospice or assisted living – is the patient able to return
    - Are expected to have knowledge of capabilities of the LTC, and Medical homes plus services provided
    - Discuss ability to pay out of pocket expenses
  - Expected to have know about community resources
    - Such as Aging and Disability Resources or Center for Independent Living
- Goal: return the patient to the setting from which they came

CMS DP Checklist for Patients

For Information– Not Required/Not to be Cited

Providing a discharge planning tool to patients and their family or other support persons may help to reinforce the discharge plan. Use of the tools may encourage patients' participation in developing the plan as well as provide them an easy-to-follow guide to prepare them for a successful transition from the hospital. The tool should be given to patients on admission, reviewed throughout their stay, and updated prior to discharge.

Examples of available tools include:

- *Medicare's "Your Discharge Planning Checklist," (available at http://www.medicare.gov/publications/pubs/pdf/11376.pdf)*
- *Agency for Healthcare, Research and Quality's (AHRQ) "Taking Care of Myself: A Guide For When I Leave the Hospital," (available at http://www.ahrq.gov/qual/goinghomeguide.pdf)*
- *Consumers Advancing Patient Safety (CAPS) "Taking Charge of Your Healthcare: Your Path to Being an Empowered Patient Toolkit" (available at http://www.patientsafety.org/page/transtoolkit/).*

Discharge Planning Evaluation 807 2020

- **Standard:** The discharge planning evaluations must include an evaluation of the patient likely need for post-hospital services
  - Such as hospice care, home health, post-hospital extended services, non-health care services and community-based providers
  - Are services available?
  - Can patient access such services?

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Evaluation Documentation & By Whom 2020

- **Standard:** The DP evaluation must be in the medical record (808)
  - To establish an appropriate discharge plan
  - And results of the evaluation have been discussed with the patient or representative
- **Standard:** DP evaluation or plan must be developed by or under the supervision of
  - An RN
  - Social Worker
  - Or other qualified person (809)

Discharge Planning Evaluation

- **Standard:** the evaluation must be completed timely to avoid unnecessary delays (810)
- **Standard:** Hospital must discuss the results of the DP evaluation with the patient (811)
- **Standard:** The evaluation must be in the medical record for use in establishing an appropriate discharge plan (812)

Discharge, Transfer Referral 813 2020

- **Standard:** Patient discharge and transmission of the patient's necessary medical information (813)
  - The hospital must discharge the patient
  - Or transfer or refer the patient
  - Must send along all necessary medical information

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What Must Be Sent

- Must send
  - Information pertaining to the patient's current course of illness and treatment
  - Post-discharge goals of care
  - Treatment preferences at the time of discharge
- Send to:
  - Appropriate post-acute care service providers, facilities and practitioners responsible for patient's follow-up or ancillary care
    - Includes suppliers, agencies, and other outpatient service providers

Home Health, SNF, IRF or LTCH 2020

- **Standard:** Requirements applicable to these post-acute care services (814)
- **Standard:** Must give the patient a list of the ones available to the patient, that participate in Medicare, and that serve the geographic area and document list given (815)
  - HH agencies must request to be on the list
  - Must give the list of the four if services are indicated
  - If managed care – verify are in network

Patient Rights and Disclosure 2020

- **Standard**: Must inform patient of their right to choose among Medicare providers and suppliers of their post-discharge services (816)
  - Must respect the patient or representative's goals of care and treatment preferences
  - Cannot limit qualified providers or suppliers
- **Standard:** Must disclose any financial interest in HHA or SNF (817)

Discharge *Plan*

- Tag 818 – RN, social worker or other appropriately qualified personnel develop or supervise discharge plan
  - Interpretive Guidelines provides what qualifications for "other personnel" should include
- Tag 819 – patient's physician can request a discharge plan
- Tag 820 – must arrange for initial implementation of the plan
  - Counsel patient/family to prepare for post-hospital care

Reassess Plan 821

- **Standard:** Must reassess plan if factors affect care needs or appropriateness of the discharge plan
  - Change in condition
- Survey procedures
  - Will review records
  - Will interview staff – when and how reassess

Plan: Include Home Health & SNFs 823

- **Standard:** Plan must include list of HHA or SNFs
  - Participate in Medicare
  - In geographic area
  - When services indicated and appropriate
  - If in managed care organization
  - Provide list of providers
  - Disclose if hospital has financial interest in HHA or SNF

Transfer or Referral 837

- **Standard:** Must transfer or refer
  - With necessary information
  - To appropriate facilities, agencies or outpatient services
  - As needed for follow-up or ancillary care
- Information to send:
  - Discharge summary >Condition at discharge
  - Medication list >Allergies
  - Pending diagnostic results >Advance directives
  - Follow up appointments or referrals

Reassess Discharge Planning Process 843

- **Standard:** Hospital must reassess discharge planning process on ongoing basis
  - Include review of discharge plans
  - Ensure responsive to patient's discharge needs
  - Must be part of QAPI program
- What to consider in review:
  - Was plan responsive to patient's needs
  - Was there a preventable readmission

Organ, Tissue, and Eye Procurement

Question

- We are experiencing more families who are refusing to allow organ/eye/tissue donations due to the pandemic.
  - Yes
  - No

Organ, Tissue, and Eye 884 – 893 & 899

- Must have:
  - Written P&P to address its organ procurement
  - Agreement with OPO
  - Timely notify OPO if death is imminent, or patient has died
    - OPO to determine medical suitability for organ donation
- Standard sets out what must be in your written agreement
  - Definitions, criteria for referral, access to your death record information
- TJC has similar standards in TS or transplant safety chapter

OPO Agreements with Hospitals

- OPO regulations in Appendix Y
- Hospitals must have a written agreement with the OPO
  - Interpretive guidelines for Tag 886 set out what must be in the written agreement
  - Includes definitions
- Must do the one call rule – notify the OPO if patient dies, or death is imminent

OPO Agreements – No OR/Ventilator*

- OPOs are not required to initiate an agreement if no OR nor ventilator
  - Are required to enter into an agreement with any hospital that requests an agreement
- Hospital without a ventilator and OR – the agreement may be limited to notification of imminent death and/or death which has occurred

Organ, Tissue, and Eye

- Board must approve your organ procurement policy
  - Must integrate into hospital's QAPI program
- Surveyor will review written agreement with the OPO
  - To ensure it has all the required information
- Make sure you call the OPO and notify them of all deaths

Tissue and Eye Bank

- Need an agreement with at least one tissue and eye bank
  - OPO can do all three
  - OPO is gatekeeper and notifies the tissue or eye bank chosen by the hospital
- OPO determines medical suitability
- Do not need separate agreement with tissue bank if agreement with OPO to provide tissue and eye procurement

Family Notification

- Once OPO has selected a potential donor
  - Family must be informed of the donor's family's option
- OPO and hospital will decide how and by whom the family will be approached
- Must work cooperatively with the OPO and in educating staff
- OPO can review death records

Initiation of Request

- Person to initiate request must be a designated requestor or organized representative of tissue or eye bank
  - Designated requestor must have completed course approved by OPO
- Encourage discretion and sensitivity to the circumstances, views and beliefs of the families
- Surveyor will review complaint file for relevant complaints

Training

- Staff must be trained on organ donation issues
  - Training program at a minimum should include:
  - Consent process
  - Importance of discretion
  - Role of designated requestor
  - Transplantation and donation
  - QI
  - Role of OPO
- Train all new employees, when change in P&P, and when problems identified in QAPI process

Organ Donation

- Hospital must cooperate with OPO to review death records to improve identification of potential donors
- Surveyor will verify P&P that hospital works with OPO
- Maintain potential donors while necessary testing and placement of donated organs take place
- Must have P&P to maintain viability of organs
- Ensure patient is declared dead within acceptable timeframe

Surgery and PACU

Surgical Services 940

- If provide surgical services must be well organized
- If outpatient surgery – must be consistent in quality with inpatient care
- Must follow acceptable standards of practice
  - AMA – ACOS – APIC – AORN – ASPAN
- Must be integrated into hospital wide QAPI
- Surveyors will inspect all OR rooms
- Access to OR and PACU must be limited to authorized personnel

Surgical Services – continued 940

- Conform to aseptic and sterile technique
- Appropriate cleaning between cases
- Room suitable for surgery performed
- Equipment available for rapid and routine sterilization (immediate use steam sterilization)
  - IUSS monitored, inspected and maintained by biomed
- Temperature and humidity controlled
  - ASA and AORN have P&Ps on many of these

Organization and Staffing

- Services must be appropriate to scope of services offered (941)
- OR must be supervised by experienced RN or MD/DO (942)
  - Must have specialized training in surgery and management of surgical service operation
  - Will review job description
- LPN's and OR techs can serve as scrub nurses under supervision of RN (943)
  - RN must be immediately available to physically intervene and provide care

Circulating Duties 944

- Qualified RN may perform circulating duties in OR (944)
  - LPN or surgery tech may assist in circulating duties if allowed by state law
  - RN must be immediately available to respond to emergencies

Surgical Privileges 945

- Surgical privileges must be delineated for all practitioners performing surgery
  - Per competence of each practitioner
- Surgery service must maintain roster specifying the surgical privilege
- Privileges must be reviewed every two years
- Current list of suspended surgeons must also be retained

Surgical Tasks

- Must specify for each practitioner that performs surgical tasks including
  - MD, DO, dentists, oral surgeon, podiatrists
  - RNFA, NP, surgical PA, surgical tech, et. al.
- Must be based on compliance with what can do under state law
- If task requires it to be under supervision of MD/DO
  - Supervising doctor must is present in the same room working with the patient

Surgery Policies 951

- Acceptable OR attire
  - See AORN standards
- Handling infectious and biomedical waste
- Outpatient surgery post op planning
- Aseptic and sterile surveillance and practice, including scrub technique
- Patient care requirements
  - Pre-op work area
  - Consents and releases
  - Safety practices
  - Patient identification process and clinical procedures
- Housekeeping requirements by procedures

Surgery Policies – continued

- Duties of scrub and circulating nurses
- Safety practices
- Surgical counts
- Surgery scheduling
- Personnel policies
- Resuscitative techniques
- DNR status
- Care of surgical specimens
- Malignant hyperthermia
  - Enough vials to treat
- Protocols for all surgical procedures
- Sterilization and disinfection procedures
- Identification of infected & non-infected cases

Preventing OR Fires

- Is a detailed section on use of alcohol-based skin prep and how to prevent an OR fire
  - Provides a fuel source
- Balance need for prevention of surgical site infections and preventing fires

A Patient Seriously Burned from an OR Fire

There'd been an accident, the doctors explained. An electrosurgical tool had ignited oxygen inside a mask under surgery drapes during the operation, sparking flames that left second- and third-degree burns from Talbert's chest to the top of her head.

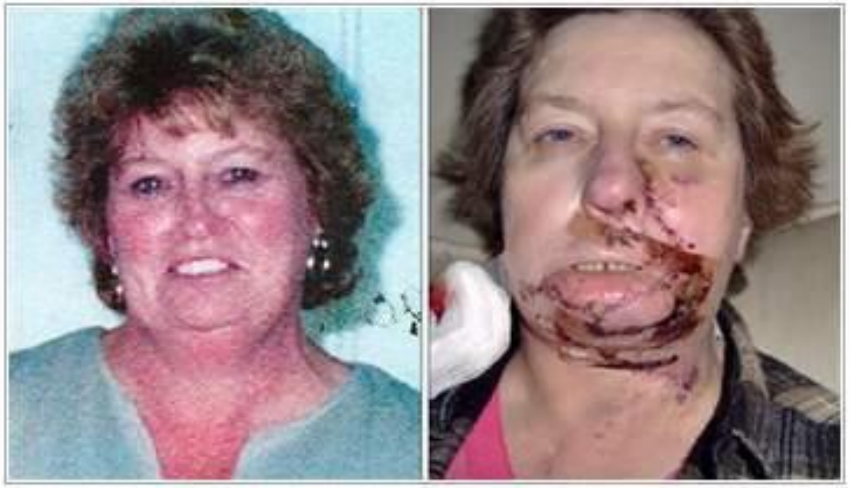
ECRI Institute

Growing use of electrosurgical devices and paper hospital drapes have contributed to fires in the operating room

"It just caught fire," she said, still incredulous at the idea. "They didn't even know it had caught on fire."

Back then, experts told her that the flash fire was a rare occurrence, a freak medical error that affected perhaps 100 people in the U.S. each year. It turns out, however, that surgical fires are at least five times as common as once thought, affecting between 550 and 650 patients a year, including 20 to 30 who suffer serious, disfiguring burns. Every year, one or two people die this way.

The first-ever specific figures, based on data collected from the Pennsylvania Patient Safety Reporting System, have helped quantify the problem, said Mark Bruley, vice president of accident and forensic investigations at the ECRI



Courtesy of Rita Talbert

Rita Talbert of Stafford, Va., suffered burns to her face, neck and chest during a routine
These photos show Talbert, now 62, before the fire and after a dozen reconstructive ope

Show tools

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H&P 952 & 953 2020

- Recap – prior sections on H&P
  - H&P no older than 30 days and updated prior to surgery
  - Healthy outpatients may not need a H&P but pre-surgery or procedure assessment
  - For procedures requiring anesthesia services
    - Discussed in MR chapter
- H&P must be on the chart before the patient goes to surgery
  - Except in emergencies
  - P&P specify what is an emergency

H&P – Exception 954 2020

- **Standard:** An assessment of the patient must be completed and documented after registration
  - Must be done prior to surgery or a procedure requiring anesthesia
  - Do not have to do a comprehensive H&P
  - If medical staff has chosen to develop a P&P
  - Are healthy outpatients
- Except in an emergency
- Guidance is pending

Consent 955

- Properly executed informed consent form for the operation
- Must be in the record before surgery
- Except – in emergencies
- Informed consent is in three sections
  - Surgery
  - Medical Records
  - Patient Rights
  - Each is different and not repeated
  - Look at all three

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Informed Consent 955

- Anesthesia consent is recommended
- Sets out elements for a well-designed process
  - Includes optional elements
- Mandatory elements were in MR section tag 466
  - Specifies what must be in the consent policy
  - Who can obtain
  - Which procedures need consent and required for all surgeries defined by the ACS

Informed Consent Policy

- Make sure consent is on chart before patient goes to surgery
  - Unless surgery is an emergency
- Content of consent form
- Process to obtain consent
- Who may obtain and which procedures require informed consent
- If consent obtained outside hospital – include how to get it into medical records

AORN

- AORN has PeriOperative Standards and Recommended Practices to help with many of the required P&P
  - Now called Guidelines for Perioperative Practices
  - Includes practices for high level disinfection, malignant hyperthermia, flash steam sterilization, appropriate attire, documentation, prevent OR fires, hand hygiene, electrosurgery, minimal invasive surgery etc.
  - Available at www.aorn.org

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Disclosure – Others Doing Tasks

- Must disclose if others are doing “important tasks”
- “Other” include
  - Residents
  - RNFA
  - Surgical PAs
  - Cardiovascular Techs

Important Surgical Tasks

- Includes:
  - Opening and closing
  - Dissecting tissue
  - Removing tissue
  - Harvesting grafts
  - Transplanting tissue
  - Administering anesthesia
  - Implanting devices and placing invasive lines
- Requirement to have this in writing under optional or well-designed list

Surgery Equipment 956

- Call-in system
- Cardiac monitor
- Defibrillator
- Aspirator (suction equipment)
- Trach set (cricothyroidotomy is not a substitute)
- TJC PC.03.01.01 includes this plus ventilator, and manual breathing bags

PACU 957

- **Standard:** Must be adequate provisions for immediate post-op care
- Must be in accordance with acceptable standards of care
  - For all patients including same day surgery patients
  - ASPAN standards of care and practice an example*
- Separate room with limited access
- P&P specify transfer requirements to and from PACU

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Assessment

- PACU assessment includes
  - Level of activity
  - Level of pain
  - Vital signs – respirations, BP
  - LOC
  - Patient color
  - Aldrete
- If not sent to PACU
  - Close observation until has gained consciousness by a qualified RN

Post-Operative Monitoring

- Hospitals are expected to have P&P on the minimum scope and frequency of monitoring in post-PACU setting
  - Must be consistent with the standard of care
- Concerned about post-op patients receiving opioids
  - Risk for over-sedation and respiratory depression
  - Once out of PACU not monitored as frequently
- Need appropriate assessment to prevent these complications (See Tag 405)

Survey Procedures

- Will observe care provided in the PACU
  - To determine patients are monitored and assessed prior to transfer or discharge
  - Will look to determine if hospital has system to monitor needs of post-op patient transferred from PACU to other areas of the hospital
  - Interview staff – how needs of post-op patients for vigilant monitoring addressed

Complete and Up-to-Date OR Register 958

- Patient's name & identification number
- Date of surgery
- Total time of surgery
- Name of surgeons, nursing personnel, anesthesiologist, and assistants
- Type of anesthesia
- Operative findings, pre-op and post-op diagnosis
- Age of patient
- TJC RC.02.01.03 – are the same

Operative Report 959

- Operative report must be written/dictated immediately following surgery
- Describe
  - Techniques
  - Findings
  - Tissues remove/altered
- Signed by the surgeon

Report Must Include

- Name & patient ID number
- Date & time of surgery
- Name of surgeons, assistants
- Pre-op & post-op diagnosis
- Name of procedure
- Type of anesthesia
- Complications & description of techniques & tissues removed
- Grafts, tissue, devises implanted
- Name & description of significant surgical tasks done by others
  - See list as includes activities such as opening, closing, harvesting grafts

Anesthesia

Question

- Our anesthesia providers include (check all that apply):
  - Anesthesiologist – MD/DO
  - CRNAs – supervised only
  - CRNAs – no supervision required
  - Anesthesiologist Assistants

Anesthesia 1000

- Must be provided in well organized manner under direction of qualified MD/DO
- Must be integrated into hospital QAPI
- MS establish criteria for director's qualifications
  - Will review job description of director - see elements
  - Wherever anesthesia provided
    - Radiology – OB – OR – Outpatient surgery – ECT – ED
- State exemption process of MD supervision for CRNA in 19 states

Anesthesia Standards Changes

- Hospitals are expected to have P&P on when medications that fall along the analgesia-anesthesia continuum are considered anesthesia
  - P&P must be based on nationally recognized guidelines
- Must specify the qualifications of practitioners who can administer analgesia

Anesthesia Definitions

- If hospital provides any degree of anesthesia service must comply with all CoPs and put definitions in P&P
- **Anesthesia:** administration of medication to produce a blunting or loss of:
  - Pain perception (analgesia)
  - Voluntary and involuntary movements
  - Memory and or consciousness
- **Analgesia:** use of medication to provide pain relief thru blocking pain receptor in peripheral and or CNS where patient does not lose consciousness
  - It is a continuum

Anesthesia Care

- **MAC** is anesthesia care that includes monitoring of patient by a qualified anesthesia provider – anesthesiologist or CRNA
  - Includes potential to convert to a general or regional anesthetic
- **Deep sedation** – drug induced depression of consciousness during which patient can not easily be aroused but responds purposefully following repeated or painful stimulus
  - Deep sedation/analgesia is included in a MAC

3 Things in Pain Bucket

- Services not subject to anesthesia administration and supervision requirements
- **Topical and local anesthesia:** application or injection of drug to stop a painful sensation
- **Minimal sedation:** drug induced state where patient can respond to verbal commands such as oral medication to decrease anxiety for MRI
- **Moderate or conscious sedation:** patients respond purposely to verbal commands, either alone or by light tactile stimulation

Anesthesia Services

- **Rescue capacity**
  - Sedation is a continuum and not always possible to predict how patient will respond so need intervention by one with expertise in airway management
  - Must have procedures in place to rescue patients whose sedation becomes deeper than initially intended
- Anesthesia services must be under one anesthesia services under direction of qualified physician regardless of where performed
  - Operating room, both inpatient and outpatient
  - OB, radiology, clinics, ED, psychiatry, endoscopy etc.

Anesthesia vs. Analgesia

- There is no bright line between anesthesia and analgesia
  - TJC has standards also on how to safely perform moderate or procedural sedation and anesthesia in the PC chapter
- Also references the need to follow nationally standards of practice
  - EX: ASA – ACEP – ASGE (American Society for GI Endoscopy)

Anesthesia Services

- Hospitals need to determine if sedation done in the ED or procedures rooms is anesthesia or analgesia
- This standard also sets forth the supervision requirements for staff who administer anesthesia
- P&Ps need to establish minimum qualifications and supervision requirements including moderate sedation
  - MS credentialing standards and the nursing standards exist to make sure staff are qualified and competent
  - Must have P&P to look at adverse events, medication errors and other safety and quality indicators

Organization and Staffing 1001

- Organization of anesthesia services must be appropriate to scope of service offered
- Administered only by
  - Qualified anesthesiologist
  - MD/DO – other than anesthesiologist
  - Qualified dentist, oral surgeon or podiatrist – per state law
  - CRNA
    - Under immediately available supervision unless exempt
  - Anesthesiologist's assistant under immediately available supervision

State Exemption

- Governor submits letter to CMS
- After consultation with State Medical and Nursing Boards
- Determined it is in the best interest of state's citizens to opt-out supervision
- Request for exemption and recognition and withdrawal of request effective upon submission
- List of 19 state (plus Guam) exemptions: Arizona, Iowa, Nebraska, Idaho, Minnesota, New Hampshire, New Mexico, Kansas, Kentucky, North Dakota, Washington, Alaska, Oregon, South Dakota, Wisconsin, Montana, Colorado, Oklahoma and California.
- https://www.aana.com

Anesthesia Services and Policies 1002

- Anesthesia must be consistent with needs of patients and resources
- P&P must include delineation of pre-anesthesia and post-anesthesia responsibilities
- Policies include:
  - Consent
  - Infection Control measures
  - Safety practices in all areas
  - How hospital anesthesia service needs are met

Required Policies – continued

- Policies required – cont'd
  - Protocols for life support function
    - Cardiac or respiratory emergencies
  - Reporting requirements
  - Documentation requirements
  - Equipment requirements
  - Monitoring, inspecting, testing and maintenance of anesthesia equipment
  - Pre and post anesthesia responsibilities

Question

- Our anesthesia providers are very good at spending time with patients/families to explain the sedation process.
- Yes
- No
- Prefer not to answer

Pre-Anesthesia Assessment 1003

- Pre-anesthesia evaluation must
  - Be done by some one qualified person to administer anesthetic (non-delegable)
  - Be performed with 48 hours prior to the surgery
    - Including inpatient and outpatient procedures
  - For regional, general, and MAC
- Not required for moderate
  - But still need to do pre-sedation assessment

Who Can Complete the Assessment

- Pre-anesthesia assessment done by someone who can administer anesthesia:
  - Qualified anesthesiologist or CRNA, Qualified doctor other than anesthesiologist
  - Anesthesiology assistant (AA) under the supervision of anesthesiologist who is immediately available if needed
  - Dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under state law

Pre-anesthesia Evaluation

- Cannot delegate the pre-anesthesia assessment to someone not qualified to administer anesthesia
- Delivery of first dose of medication for inducing anesthesia marks end of 48-hour time frame
- Some of the elements in the evaluation can be collected prior to the 48-hour time frame but it can never be more than 30 days
  - EX – if you saw a patient on Friday for Monday surgery would need to show that on Monday there were no changes

What Must Be Included

- Within 48 hours:
  - Review of medical history, including anesthesia, drug, and allergy history
  - Interview and exam the patient
- Remainder are updated but can be collected within 30 days
  - Notation of anesthesia risk – ASA level
  - Potential anesthesia problems identification – what could be complication or contraindication
    - Difficult airway – ongoing infection – limited intravascular access

What to be Included – cont'd

- Additional data or information in accordance with SOC
  - Such as stress test or additional consults
- Develop plan of care
  - Type of medication for induction
  - Maintenance
  - Post-operative care
- Risks and benefits of the anesthesia

Survey Procedure Pre-anesthesia Evaluation

- Will review sample of inpatient and outpatient records who had anesthesia
  - Ensure pre-anesthesia evaluation done and by one qualified to deliver anesthesia
  - Determine the 2-pre-anesthesia evaluations included all the required elements
  - Ensure completed within 48 hours before first does of medication given for purposes of inducing anesthesia for the surgery or procedure
- ASA and AANA has pre-anesthesia standards*

ASA Guideline Pre-Anesthesia Evaluation

- Pre-anesthesia Evaluation [1]
  - Patient interview to assess Medical history, Anesthetic history, Medication history
- Appropriate physical examination
- Review of objective diagnostic data (e.g., laboratory, ECG, X-ray)
- Assignment of ASA physical status
- Formulation of the anesthetic plan and discussion of the risks and benefits of the plan with the patient or the patient's legal representative

1 www.asahq.org/publicationsAndServices/standards/03.pdf

Standards for Nurse Anesthesia Practice*

- American Association of Nurse Anesthetists (AANA) has standards for nurse anesthesia practice
  - Has a section on standard for pre-anesthesia assessment and post-anesthesia assessment
- AANA website has many excellent resources
  - Includes practice documents
  - Standards, guidelines, joint position statements
  - Advisory opinions, forms, resources, practice considerations, position statements, quality of care in anesthesia, and more

Intra-Operative Anesthesia Record 1004

- Need policies related to the intra-operative anesthesia
- Need intra-operative anesthesia record for patients who have general, regional, or MAC
- Record must contain the following:
  - Hospital name and ID number
  - Name of practitioner who administer anesthesia
  - Techniques used and patient position, including insertion of any intravascular or airway devices

Intra-Operative Anesthesia Record

- Intra-operative record – cont'd:
  - Name, dosage, route and time of drugs
  - Name and amount of IV fluids
  - Blood/blood products
  - Oxygenation and ventilation parameters
  - Time based documentation of continuous vital signs
  - Complications, adverse reactions, problems during anesthesia with symptom, VS, treatment rendered and response to treatment

Post-anesthesia Evaluation 1005

- Must be done by individual qualified to give anesthesia
  - Completed no later than 48 hours after the surgery or procedure requiring anesthesia services
  - Completed as required by hospital policies and procedures
  - And as required by any state specific laws
- P&Ps must
  - Approved by the MS
  - Reflect current standards of care

Post Anesthesia Evaluation

- Document in chart within 48 hours for patients receiving anesthesia services (general, regional, MAC)
- For inpatients and outpatients
  - May need to call some outpatients if not seen before they left the hospital
- Does not have to be done by the same person who administered the anesthesia
  - Must be done by anesthesia person (CRNA, AA, anesthesiologist) or qualified doctor

Post Anesthesia Evaluation - Timing

- 48 hours starts at time patient moved into PACU or designated recovery area (SICU etc.)
- Evaluation cannot generally be done at point of movement to the recovery area since
  - Patient not recovered from anesthesia
  - Patient must be sufficiently recovered to participate in the evaluation
    - EX – answer questions, perform simple tasks etc.

Post Anesthesia Evaluation

- For same day surgeries – may be done after discharge if allowed by P&P and state law
- If the patient is still intubated and in ICU – still need to do within the 48 hours
  - Document that the patient is unable to participate
- If patient requires long-acting anesthesia that would last beyond the 48 hours
  - Document such and note that full recovery from regional anesthesia has not occurred

Assessment Includes

- Respiratory function with respiratory rate, airway patency and oxygen saturation
- CV function including pulse rate and BP
- Mental status
- Temperature
- Pain
- Nausea and vomiting
- Post-operative hydration

Survey Procedure

- Review medical records for patients having anesthesia
  - Make sure post-anesthesia evaluation is in the chart
  - Determine done by practitioner qualified to give anesthesia
  - Determine all post-anesthesia evaluations are done within 48 hours
  - Determine all the required elements are documented for the post-anesthesia evaluation

Post Anesthesia ASA Guidelines

- Patient evaluation on admission and discharge from the post-anesthesia care unit
- A time-based record of vital signs LOC
- A time-based record of drugs administered, dosage and route of administration
- Type and amounts of intravenous fluids administered, including blood and blood products
- Any unusual events including post-anesthesia or post procedural complications
- Post-anesthesia visits

CMS Final Changes Hospital Improvement to Outpatient

Regarding Nursing Services

- CMS: some of requirements were confusing due to unnecessary distinctions between inpatient and outpatient services
  - Confusion on how hospitals met nursing staffing requirements
- Currently: must be supervisory and staff personnel for each nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient
  - Deleted bedside which implies that it applies to inpatients only

Patient Care and Staffing

- Patient must have ongoing assessments
- Must have sufficient numbers and types of supervisory and staff nursing personnel
  - Respond to the appropriate nursing needs and care of the patients
- Hospitals need a policy to state which outpatient departments would be required to have an RN present
  - Such as outpatient ambulatory surgery recovery unit
  - Maybe not needed at outpatient MRI

Policy re: Outpatient RN

- Which outpatients need a RN
- Must establish criteria the outpatient dept taking into account:
  - Acuity of the patient, services rendered – i.e., chemo, etc.
- Must consider standards of practice
- Must be reviewed every three years
- Must be approved by the CNO
- Must establish alternative staffing plans

Outpatient

Outpatient Services 1076

- **Standard:** Outpatient services must meet the needs of the patient
  - Be in accordance with standards of practice
    - ACR, AMA, ACS, etc.
- Optional service but must comply with all CoPs
  - Both on and off campus
- Services must be integrated into hospital QAPI

Outpatient Services 1077

- Must be integrated with inpatient services
  - Provide old medical records when indicated
  - Radiology and lab done timely
  - Anesthesia, including pain management
  - Diagnostic tests completed timely
- Hospital must coordinate the care of the patient
- Make sure pertinent information in medical record

Outpatient Services 1079

- Have appropriate professional and nonprofessional personnel
  - Based on scope and complexity of outpatient services
- Define in writing the qualifications & competencies necessary to direct the department
  - Include education, experience and training
  - Usually found in their job description
- Will review P&P to determine person's responsibility

Outpatient

- The outpatient services department must be accountable to one or more individuals responsible for the outpatient area
  - No longer says it must be single person responsible
- Must have appropriate personnel at each location where outpatient services are rendered
- Hospital has flexibility to determine how to organize their outpatient department
- Define in writing the qualifications and competencies of each of the outpatient directors

Survey Procedure

- Ask the hospital how it has organized its outpatient services
  - Identify the individual(s) responsible for providing direction for outpatient services
- Will review the organization's policies and procedures
  - Determine the person's responsibility
- Will review the position description of the individuals responsible for outpatient services

Outpatient Orders 1080

- Must be ordered by practitioner who is:
  - Responsible for the care of the patient
  - Licensed in state where he/she provides care to the patient
  - Within state scope of practice
  - Authorized by the MS, approved by the board, to order outpatient services under written P&P
  - Whether C&P by the hospital or not
  - Verify is licensed in state and within scope of practice
  - Consider checking license,
    - OIG excluded list of individuals*

Standards of Practice 1081

- **Standard:** Outpatient Services must meet the needs of the patients in accordance with standards of practice
  - Like AMA, ACR, ACS, etc.
- Optional service – but must comply with CoPs
- Services, equipment, staff, and facilities must be appropriate
- Orders for outpatients may be made by practitioner responsible for the care of the patient

Emergency Services

Emergency Services 1100 - 1102

- Hospital must meet needs of patients (1100)
- Hospital must ensure specific services organized and directed appropriately (1101)
- Must follow acceptable standards of practice
  - ACEP and ENA
- Must be integrated into hospital wide QAPI
- Need qualified MS director (MD or DO) (1102)
- Other section that affects ED at tag 91

Emergency Services 1103

- Services must be integrated with other departments in hospital
  - Surgery, lab, medical records, et al.
- Includes communications between departments
- Immediate availability of services, equipment, and resources of hospital
- Length of time to transport between departments is appropriate

Emergency Services & Other Departments

- Other departments must provide emergency patients the care within safe and appropriate times
- If offer urgent care on premises or in provider-based clinics
  - Must follow these regulations
- Is a separate CoP on EMTALA
  - Most common deficiency among hospitals
- Will review policies, including triage policy

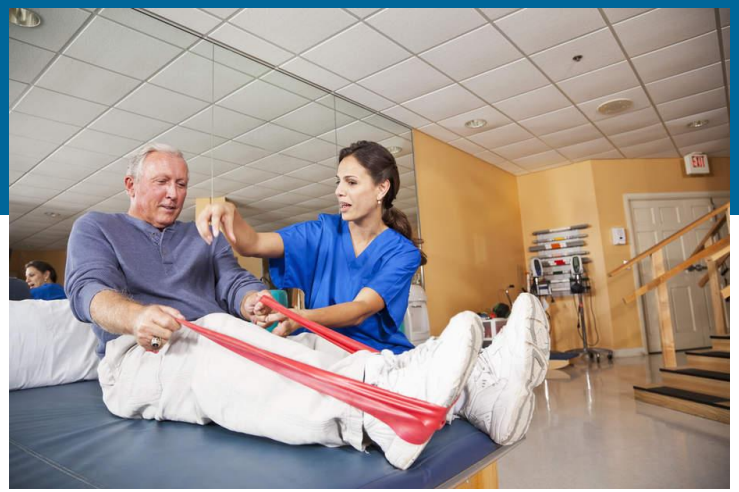
Emergency Services - Generally

- Must have appropriate equipment
- Periodic assessments of needs (ESI levels)
- Work with state and feds in emergency preparedness
- Surveyor will Interview staff to see if knowledgeable
  - Blood & IV fluid and administration of electrolytes
  - Injuries to extremities
  - CNS
  - Prevention of infection

Urgent Care Clinics

- May be on campus or in provider-based clinics
- Must comply with CoPs
- Evaluated here if:
  - Hospital holds out as providing only urgent care services and possibly other service
  - Clearly advises public that UC clinic NOT emergency services department
  - And does not meet EMTALA definition of dedicated emergency department

Rehab and Respiratory Services



Rehab Services 1123

- **Standard:** If provide rehab, PT, OT, speech language pathology, audiology
- Must be staffed and organized to ensure safety of patients
  - Staff must be qualified as specified by MS and state law
  - Meet standards - American Physical Therapy Association, American Speech and Hearing Association, American Occupational Therapy Association, American College of Physicians, AMA
- (Read what must be in the plan of care)

Rehab Services 1123 - 1126

- Must be integrated into hospital wide QAPI
- Must have proper equipment and personnel
- Scope of service should be defined in writing
- Surveyor will review medical records to verify each person documents
- Director must be knowledgeable and experience and capable
  - Will review job description
- Services must be furnished in accordance with written plan of care

Rehab Services 1132 - 1133

- Must be provided per order of practitioner including outpatient orders
  - No longer says physician only
- Orders must be incorporated in the medical record
  - By one authorized by the MS to order and by P&P
  - Could be PA, CNS, NP as allowed per hospital P&P
  - Document order (1133)
  - Must be consistent with state scope of practice
- Plan of care must meet criteria: based on assessment, measurable short- and long-term goals, updated as needed

Question

- Our respiratory department has been able to meet the needs of all our patients despite occasional COVID surges.
- Yes
- No
- Not sure

Respiratory Services 1151 - 1154

- Must meet needs of patients
- Follow acceptable standard of practice
- Appropriate equipment and number of qualified personnel
- Scope of service should be defined in writing
- Director who is doctor with experience to supervise service

- Section lists the written policies you must have

Required Policies

- Equipment assembly, operation, PM
- Safety practices
  - IC for sterile supplies, biohaz waste, posting of signs and gas line id
- CPR
- Pulmonary function testing
- Storage, access and control of medications
- ABG procedure for analyzing
- Procedures to follow with adverse reactions to treatments or interventions
- Therapeutic percussion and vibration
- Bronchopulmonary drainage
- Mechanical ventilation
- Aerosol, humidification, and therapeutic gas administration
- Need for an order - ?LP

Respiratory Services 1164 (Last CoP)

- If blood gases or other clinical lab tests are performed in unit then the applicable lab standards must be met
- Need order of practitioner (1163, 2015) including outpatient orders
  - One licensed and qualified and within scope of practice
  - Such as NP, PA, CNS
- Will review medical records
- Will review to make sure all required policies and procedures are written

Thank You

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  Acute hospitals: **qsog_hospital@cms.hhs.gov.**

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APPENDIX

Additional Resources and Internet Links

NASH HEALTHCARE CONSULTING

Websites

- Center for Disease Control CDC – www.cdc.gov
- Food and Drug Administration - www.fda.gov
- Association of periOperative Registered Nurses at AORN - www.aorn.org
- American Institute of Architects AIA - www.aia.org
- Occupational Safety and Health Administration OSHA – www.osha.gov
- National Institutes of Health NIH - www.nih.gov
- United States Dept of Agriculture USDA - www.usda.gov
- Emergency Nurses Association ENA - www.ena.org

Websites

- American College of Emergency Physicians ACEP - www.acep.org
- Joint Commission Joint Commission - www.JointCommission.org
- Centers for Medicare and Medicaid Services CMS - www.cms.hhs.gov
- American Association for Respiratory Care AARC - www.aarc.org
- American College of Surgeons ACS -www.facs.org
- American Nurses Association ANA - www.ana.org
- AHRQ is www.ahrq.gov
- American Hospital Association AHA - www.aha.org

Websites

- U.S. Pharmacopeia (USP) www.usp.org
- U.S. Food and Drug Administration MedWatch - www.fda.gov/medwatch
- Institute for Healthcare Improvement - www.ihi.org
- AHRQ at www.ahrq.gov
- Drug Enforcement Administration –www.dea.gov (copy of controlled substance act)
- US Pharmacopeia - www.usp.org, (USP 797 book for sale)
- National Patient Safety Foundation at the AMA -www.ama-assn.org/med-sci/npsf/htm
- The Institute for Safe Medication Practices - www.ismp.org

Websites

- CMS Life Safety Code page - http://new.cms.hhs.gov/CFCsAndCoPs/07_LSC.asp
- American College of Radiology- www.acr.org
- Federal Emergency Management Agency (FEMA)- www.fema.gov
- Sentinel event alerts at www.jointcommission.org
- American Pharmaceutical Association - www.aphanet.org
- American Society of Heath-System Pharmacists - www.ashp.org

Websites

- Enhancing Patient Safety and Errors in Healthcare - www.mederrors.com
- National Coordinating Council for Medication Error Reporting and Prevention - www.nccmerp.org,
- FDA's Recalls, Market Withdrawals and Safety Alerts Page: www.fda.gov/opacom/7alerts.html
- Association for Professionals in Infection Control and Epidemiology (APIC) infection control guidelines at www.apic.org
- Centers for Disease Control and Prevention - www.cdc.gov
- Occupational Health and Safety Administration (OSHA) at www.osha.gov

Infection Control Websites

- The National Institute for Occupational Safety and Health NIOSH at www.cdc.gov/niosh/homepage.html
- AORN at www.aorn.org
- Society for Healthcare Epidemiology of America (SHEA) at www.shea-online.org

CDC Outpatient Assessment Tool

Infection Prevention and Control Assessment Tool for Outpatient Settings

This tool is intended to assist in the assessment of infection control programs and practices in outpatient settings. In order to complete the assessment, direct observation of infection control practices will be necessary. To facilitate the assessment, health departments are encouraged to share this tool with facilities in advance of their visit.

Please note, Not Applicable should only be checked if the element or domain is not applicable to the types of services provided by the facility (e.g., the facility never performs point-of-care testing, controlled substances are never kept at the facility). If a particular service is provided by the facility but is unable to be observed during the visit (e.g., no injections were prepared or administered during the visit) that section should still be completed by interviewing relevant personnel about their practices.

www.cdc.gov/infectioncontrol/pdf/icar/outpatient.pdf

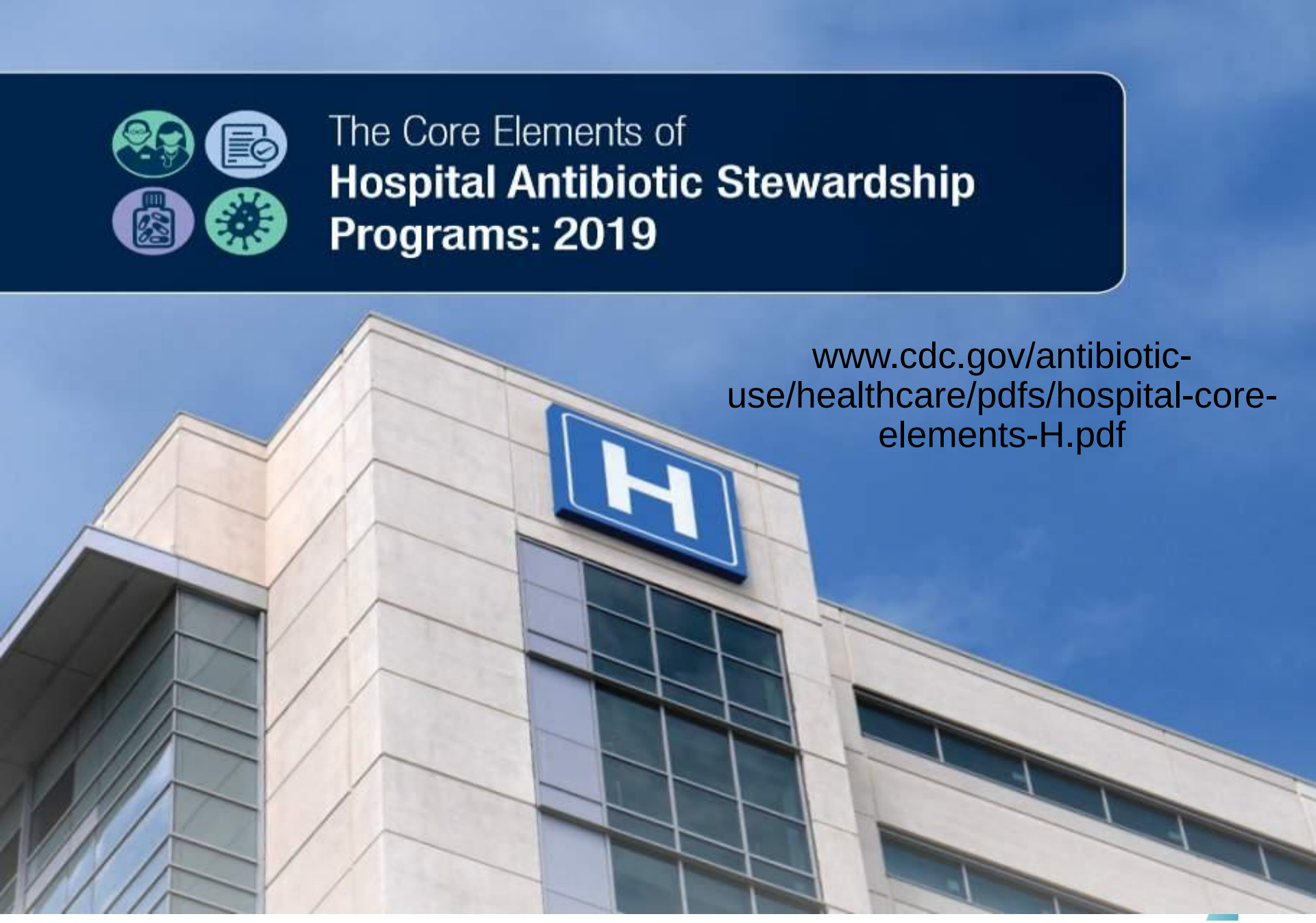
Overview

Section 1: Facility Demographics

Section 2: Infection Control Program and Infrastructure

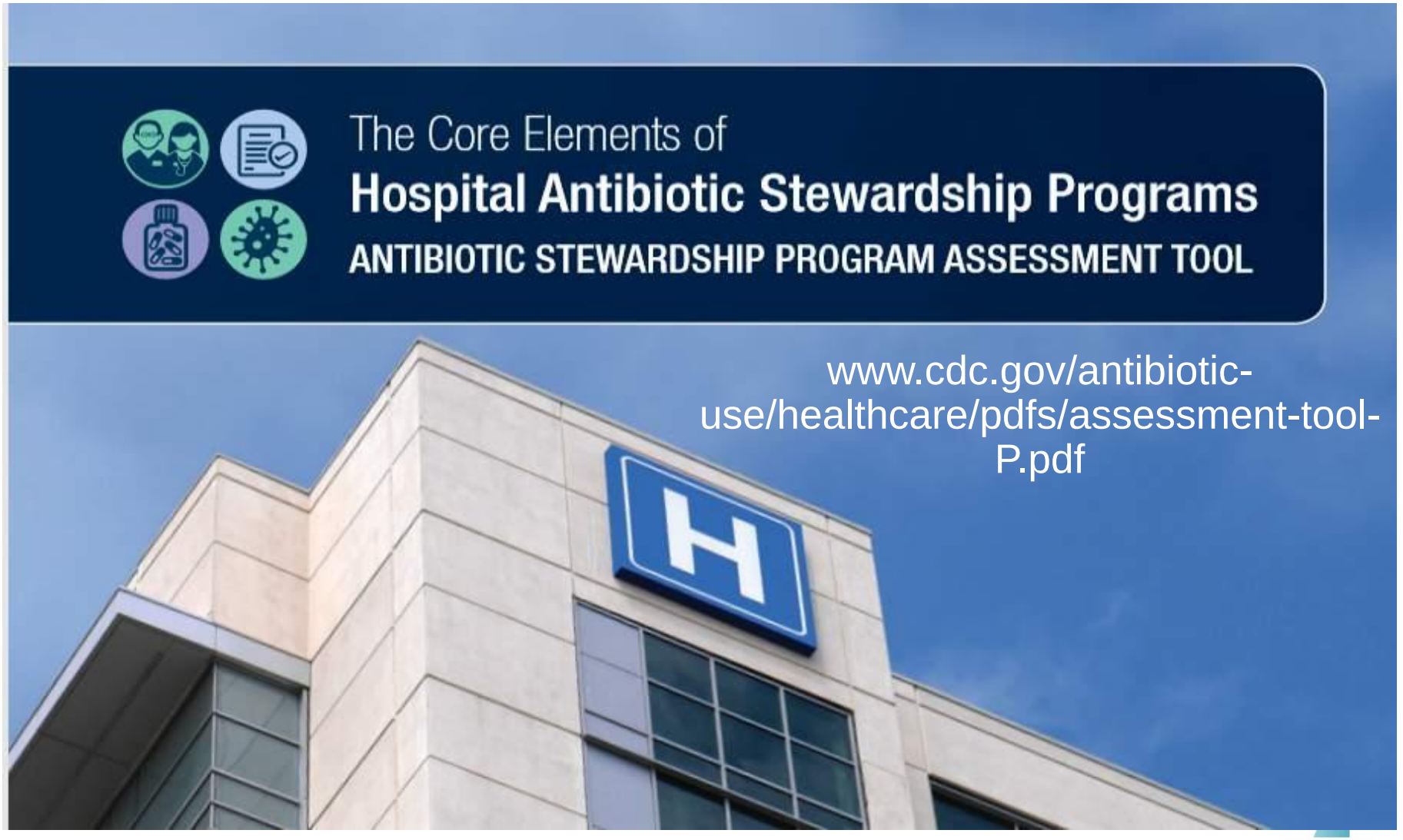
Section 3: Direct Observation of Facility Practices

Section 4: Infection Control Guidelines and Other Resources

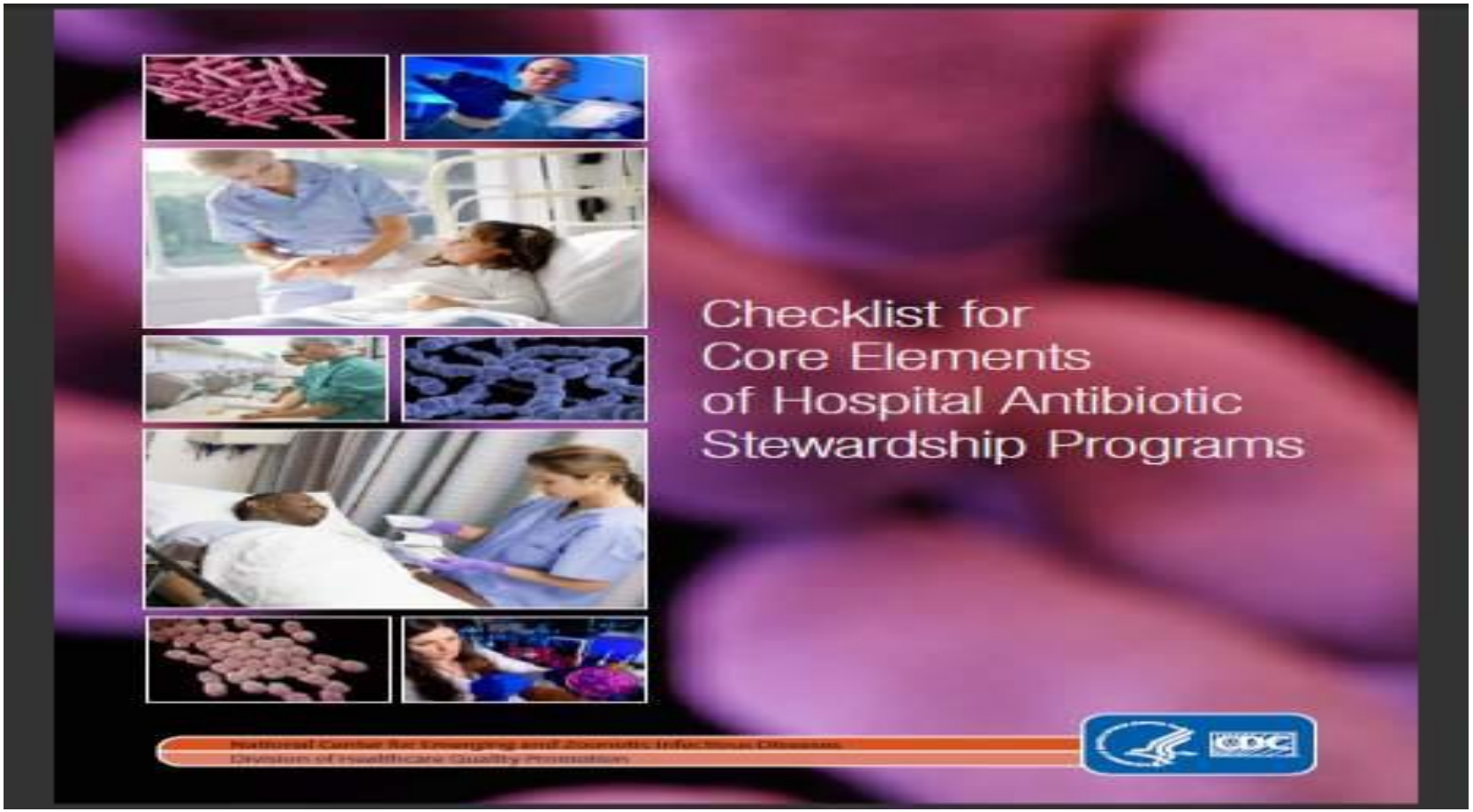


www.cdc.gov/antibiotic-use/healthcare/pdfs/hospital-core-elements-H.pdf

Has a Program Assessment Tool



CDC Toolkit Core Elements OLD



www.ahaphysicianforum.org/resources/appropriate-use/antimicrobial/content%20files%20pdf/CDC%20checklist.pdf

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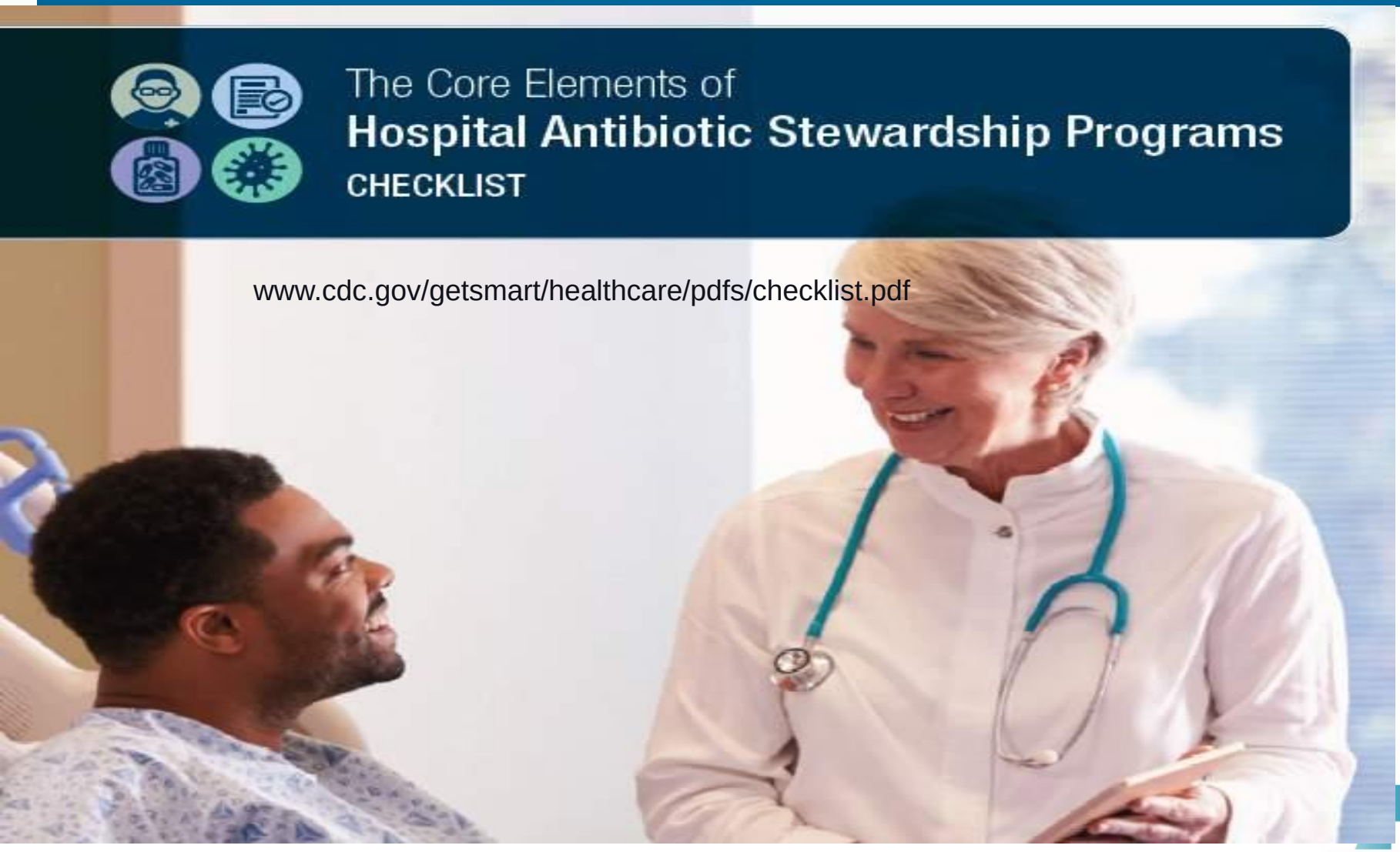
CDC Outpatient Core Elements

http://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6506.pdf

Core Elements of Outpatient Antibiotic Stewardship

Check List of Core Elements



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Worksheet Links

- Infection Control:
- https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/survey-and-cert-letter-15-12-attachment-1.pdf.
- Discharge Planning:
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-12-Attachment-3.pdf.
- QAPI:
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-12-Attachment-2.pdf.

Hospital Improvement Introduction

- CMS published a final rule effective November 29, 2019 that impacts the outpatient departments
- Called " Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care"
- It makes changes to the following CoP sections:
  - Nursing, Infection Control, Patient Rights, Medical Records, QAPI, Lab, Outpatient, and Dietary (CAH)
  - It addresses restraints, implementation of an antibiotic stewardship program, care plans, non-discrimination, LIP

Hospital Improvement Final Rule

This document is scheduled to be published in the Federal Register on 09/30/2019 and available online at **https://federalregister.gov/d/2019-20736**, and on **govinfo.gov**

[Billing Code: 4120-01-P]

https://federalregister.gov/d/2019-20736 and 393 Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 416, 418, 441, 460, 482, 483, 484, 485, 486, 488, 491, and 494

[CMS-3346-F; CMS-3334-F; CMS-3295-F]

RIN 0938-AT23

Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule reforms Medicare regulations that are identified as unnecessary, obsolete, or excessively burdensome on health care providers and suppliers. This final rule also

Copy of New Law 201 Pages

This document is scheduled to be published in the Federal Register on 09/30/2019 and available online at **https://federalregister.gov/d/2019-20732**, and on **govinfo.gov**

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 482, 484, and 485

[CMS-3317-F and CMS-3295-F]

RIN 0938-AS59

www.federalregister.gov/documents/2019/09/30/2019-20732/medicare-and-medicaid-programs-revisions-to-requirements-for-discharge-planning-for-hospitals

Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule empowers patients to be active participants in the discharge planning process and complements efforts around interoperability that focus on the seamless exchange of patient information between health care settings by revising the discharge planning requirements that Hospitals (including Short-Term Acute-Care Hospitals, Long-Term Care Hospitals (LTCHs), Rehabilitation Hospitals, Psychiatric Hospitals, Children's Hospitals, and Cancer Hospitals), Critical Access Hospitals

Section 2: Infection Control Program and Infrastructure

I: Infection Control Program and Infrastructure

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Written infection prevention policies and procedures are available, current, and based on evidence-based guidelines (e.g., CDC/ HICPAC), regulations, or standards. *Note: Policies and procedures should be appropriate for the services provided by the facility and should extend beyond OSHA bloodborne pathogens training* **Please paste the link to your policies & procedures below:**	◯ Yes ◯ No ◯ Other	
B. Infection prevention policies and procedures are reassessed at least annually or according to state or federal requirements, and updated if appropriate.	◯ Yes ◯ No ◯ Other	
C. At least one individual trained in infection prevention is employed by or regularly available (e.g., by contract) to manage the facility's infection control program. *Note: Examples of training may include: Successful completion of initial and/or recertification exams developed by the Certification Board for Infection Control & Epidemiology; participation in infection control courses organized by the state or recognized professional societies (e.g., APIC, SHEA).*	◯ Yes ◯ No ◯ Other	
D. Facility has system for early detection and management of potentially infectious persons at initial points of patient encounter. *Note: System may include taking a travel and occupational history, as appropriate, and elements described under respiratory hygiene/cough etiquette.*	◯ Yes ◯ No ◯ Other	

Insulin Pens CMS Memo

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Office of Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 12-30-ALL

DATE: **May 18, 2012**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

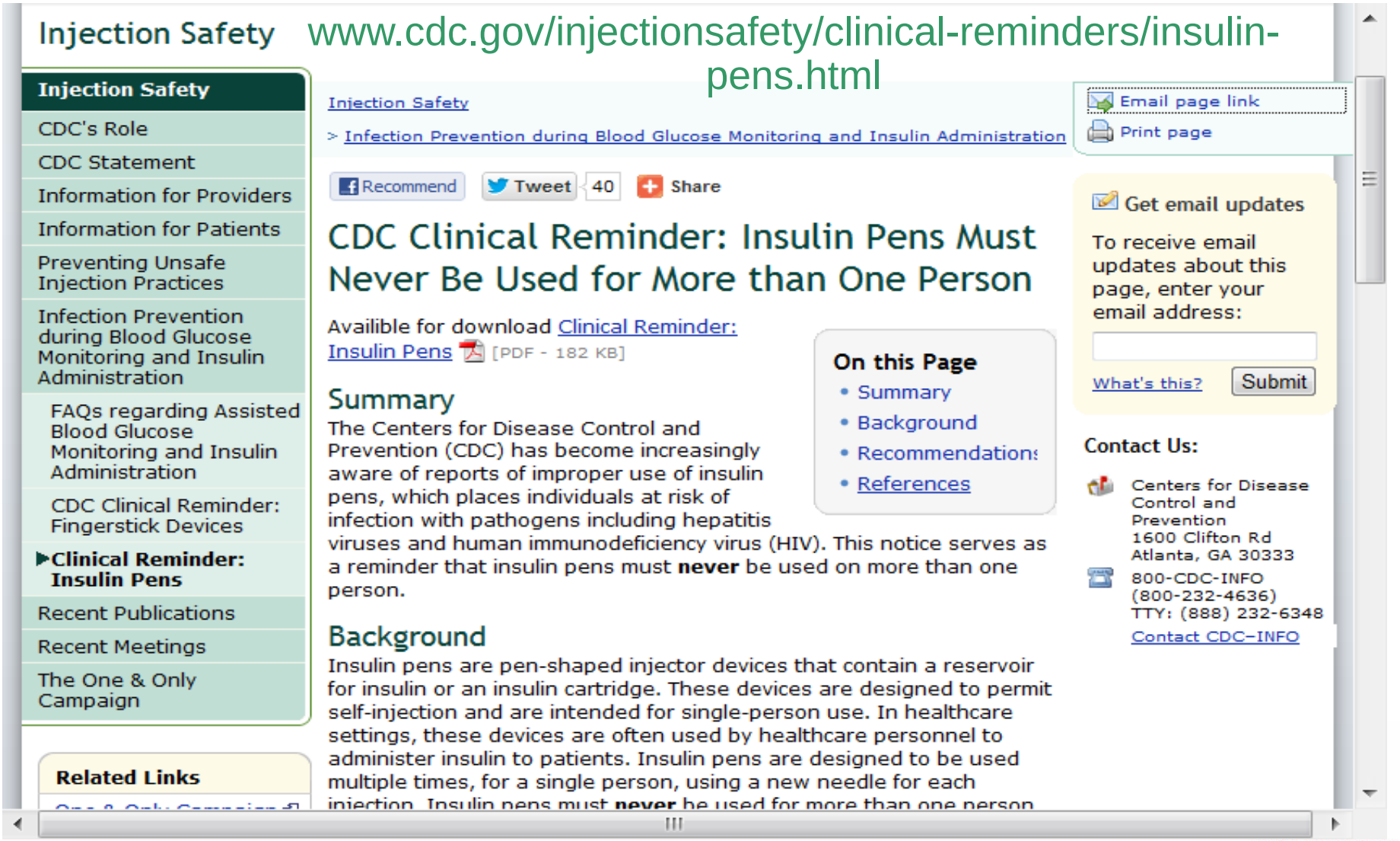
SUBJECT: Use of Insulin Pens in Health Care Facilities

Memorandum Summary

Insulin Pen devices: The Centers for Medicare & Medicaid Services (CMS) has recently received reports of use of insulin pens for more than one patient, with at least one 2011 episode resulting in the need for post-exposure patient notification. These reports indicate that some healthcare personnel do not adhere to safe practices and may be unaware of the risks these unsafe practices pose to patients. **Insulin pens are meant for use by a single patient only.** Each patient/resident must have his/her own. Sharing of insulin pens is essentially the same as sharing needles or syringes, and must be cited, consistent with the applicable provider/supplier specific survey guidance, in the same manner as re-use of needles or syringes.

Background
Insulin pens are pen-shaped injector devices that contain a reservoir for insulin or an insulin cartridge. These devices are designed to permit self-injection and are intended for single-person use. In healthcare settings, these devices are often used by healthcare personnel to administer insulin to patients. Insulin pens are designed to be used multiple times by a single patient/resident, using a new needle for each injection. Insulin pens must never be used for more than one patient/resident. Regurgitation of blood into the insulin cartridge after injection will create a risk of bloodborne pathogen transmission if the pen is used for more than one patient/resident, even when the needle is changed [1]. A previous memo (10-28-NH), dated

CDC Reminder on Insulin Pens



NASH HEALTHCARE CONSULTING

CDC Has Flier for Hospitals on Insulin Pens

CDC CLINICAL REMINDER

Insulin Pens
Must Never Be Used for More than One Person

Summary

The Centers for Disease Control and Prevention (CDC) has become increasingly aware of reports of improper use of insulin pens, which places individuals at risk of infection with pathogens including hepatitis viruses and human immunodeficiency virus (HIV). This notice serves as a reminder that insulin pens must **never** be used on more than one person.

Background

Insulin pens are pen-shaped injector devices that contain a reservoir for insulin or an insulin cartridge. These devices are designed to permit self-injection and are intended for single-person use. In healthcare settings, these devices are often used by healthcare personnel to administer insulin to patients. Insulin pens are designed to be used multiple times, for a single person, using a new needle for each injection. Insulin pens must **never** be used for more than one person. Regurgitation of blood into the insulin cartridge can occur after injection [1] creating a risk of bloodborne pathogen transmission if the pen is used for more than one person, even when the needle is changed.

In 2009, in response to reports of improper use of insulin pens in hospitals, the Food and Drug Administration (FDA) issued an alert for healthcare professionals reminding them that insulin pens are meant for use on a single patient only and are not to be shared between patients [2]. In spite of this alert, there have been continuing reports of patients placed at risk through inappropriate reuse and sharing of insulin pens, including an incident in 2011 that required notification of more than 2,000 potentially exposed patients [3]. These events indicate that some healthcare personnel do not adhere to safe practices and may be unaware of the risks these unsafe practices pose to patients.

Recommendations

BE AWARE
DON'T SHARE

Insulin pens that contain more than one dose of insulin are only meant for one person.

They ***should never be used for more than one person***, even when the needle is changed.

ONE INSULIN PEN, ONLY ONE PERSON

The One & Only Campaign is a public health campaign aimed at raising awareness among the general public and healthcare providers about safe injection practices.

For more information, please visit:
www.ONEandONLYcampaign.org

Infection Prevention and Control

Antibiotic Stewardship Program

NASH HEALTHCARE CONSULTING

A-0747

(Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§482.42 Condition of Participation: Infection *Prevention and* Control *and Antibiotic Stewardship Programs*

The hospital must *have active hospital-wide programs for the surveillance, prevention, and control of HAIs and other infectious diseases, and for the optimization of antibiotic use through stewardship. The programs must demonstrate adherence to nationally recognized infection prevention and control guidelines, as well as to best practices for improving antibiotic use where applicable, and for reducing the development and transmission of HAIs and antibiotic resistant organisms. Infection prevention and control problems and antibiotic use issues identified in the programs must be addressed in collaboration with the hospital-wide quality assessment and performance improvement (QAPI) program.*

Interpretive Guidelines §482.42

Guidance is pending and will be updated in future release.

A-0748

(Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§482.42(a) Standard: *Infection prevention and control program* **organization and** *p***olicies.** *The hospital must demonstrate that:*

(1) An individual (or individuals), who is qualified through education, training, experience, or certification in infection prevention and control, is appointed by the governing body as the infection preventionist(s)/infection control professional(s) responsible for the infection prevention and control program and that the appointment is based on the recommendations of medical staff leadership and nursing leadership;

Interpretive Guidelines §482.42(a)*(1)*

Guidance is pending and will be updated in future release.

A-0749

(Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§482.42(a)*(2)* The *hospital* infection *prevention and* control *program, as documented in its policies and procedures, employs methods for preventing* and controlling *the transmission of* infections *within the hospital and between the hospital and other institutions and settings;*

Interpretive Guidelines §482.42(a)*(2)*

Guidance is pending and will be updated in future release.

A-0751
(Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§482.42(a)(4) The infection prevention and control program reflects the scope and complexity of the hospital services provided.

Interpretive Guidelines §482.42(a)(4)

Guidance is pending and will be updated in future release.

A-0770
(Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§482.42(c)(1) Standard: Leadership responsibilities

(1) The governing body must ensure all of the following:

> ***(i) Systems are in place and operational for the tracking of all infection surveillance, prevention, and control, and antibiotic use activities, in order to demonstrate the implementation, success, and sustainability of such activities.***

Interpretive Guidelines §482.42(c)(1)(i)

Guidance is pending and will be updated in future release.

Professional Practice

- Overview
- Developmental path of the infection preventionist
- Infection preventionist (IP) competency model
- APIC Fellows Program
- Implementation guides
- Practice resources
- Scientific guidelines
- Research
- Emergency preparedness
- AJIC
- International Infection Prevention Week
- MegaSurvey 2020
- Practice Guidance Committee Activities

Home > Professional Practice > Infection Preventionist (IP) Competency Model

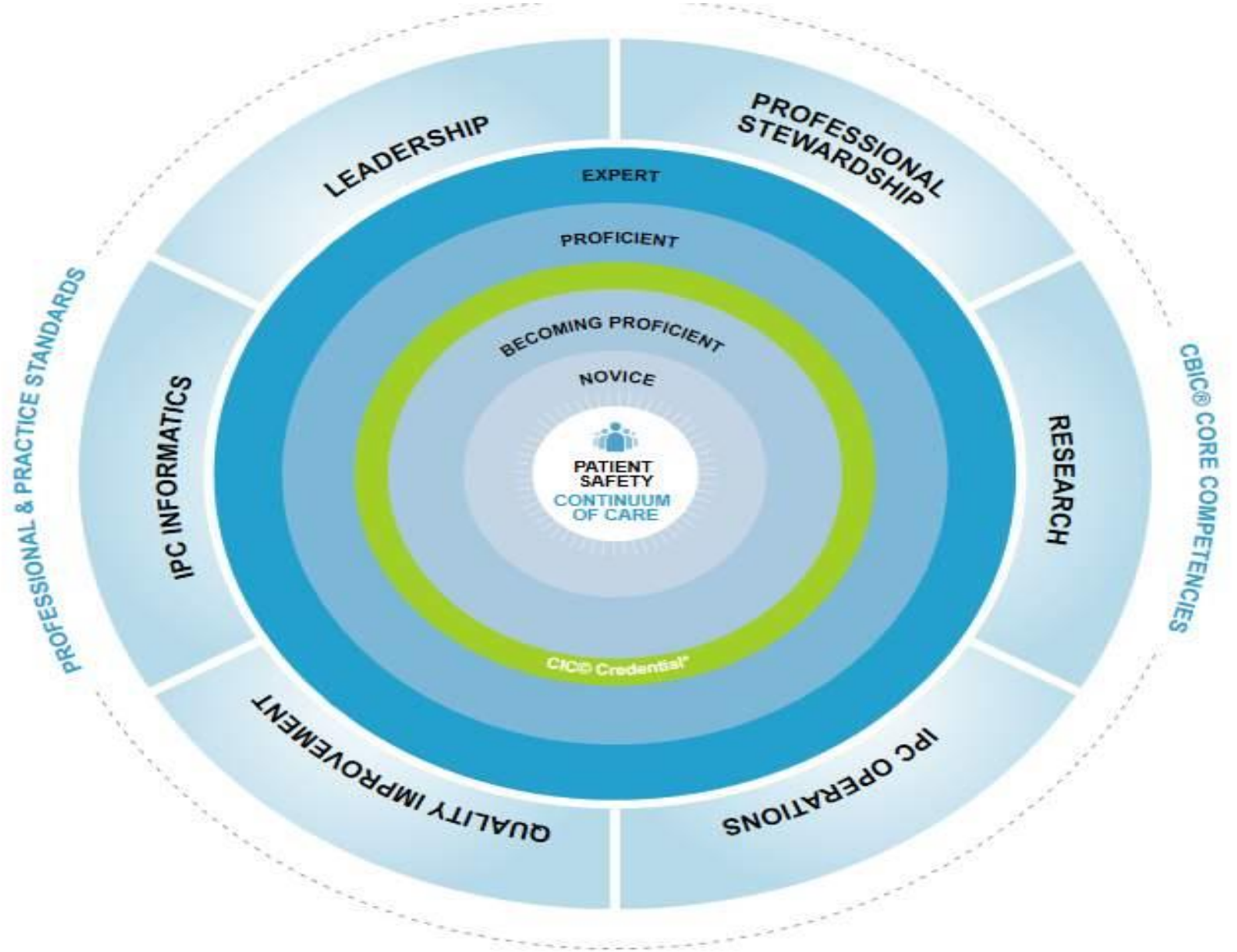
Infection preventionist (IP) competency model

To meet the demands of the rapidly expanding field of infection prevention, and equip professionals for the challenges of the future, APIC created the first model for infection preventionist (IP) competency in 2012. Learn more about the May 2012 white paper in the American Journal of Infection Control (AJIC).

The updated **APIC Competency Model for the IP** (enclosed below) also reflects the dynamic nature of the IPC field. Patient safety remains the core of IPC practice. New to the updated model is a focus on the continuum of care. The updated model has four career stages (Novice, Becoming Proficient, Proficient, and Expert) and six future-oriented competency domains (each with subdomains) to guide IPs in progressing through the career stages and pursuing leadership roles.

- Access the **June 2019 *AJIC* white paper** introducing the updated model. It includes guidance on application and examples of competency statements across career stages.
- Access the **Summer 2019 *Prevention Strategist*** article featuring an interview with members of the Competency Model Revision Task Force.
- **Novice or Becoming Proficient IP self-assessment tool for the** CBIC core competencies and APIC Competency Model.
- **Sample job description** for an IP developed by the Professional Development Committee.
- **Explore the updated, interactive competency model below.** To see a definition for each element in the model, including for each future-oriented competency domain and subdomain, click on the screen.

https://apic.org/professional-practice/infection-preventionist-ip-competency-model/



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APIC Self Assessment

Name: _____

Date: _____

Competency Self-Assessment Activity for Novice or Becoming Proficient IPs

CBIC Core Competencies – APIC Competency Model Future-Oriented Competency Domains

Self-Assessed Rating Scale and Comfort Level (Knowledge/Skills/Experience/Confidence):
1. No idea 2. Unsure 3. Some knowledge 4. Know it

Competency categories, CBIC domains	IP practice areas as identified in CBIC practice analysis	Assessment of personal competency in each practice area	For each category list one specific question you have and/or learning goal (something you would like to learn more about!)
For more details on the CBIC exam content categories visit https://www.cbic.org/CBIC/Exam-Prep-Resources.htm			
Identification of infectious disease processes (CBIC) *22 exam items	a. Interpret the relevance of diagnostic and laboratory reports	1 2 3 4	• Specific IPC question you have (could be related to your own facility) and/or learning goal (area you want to learn more about).
	b. Identify appropriate practices for specimen collection, transportation, handling, and storage	1 2 3 4	
	c. Correlate clinical signs and symptoms with infectious disease process	1 2 3 4	
	d. Differentiate between colonization, infection and contamination	1 2 3 4	
	e. Differentiate between prophylactic, empiric and therapeutic uses of antimicrobials	1 2 3 4	
Surveillance and epidemiologic	a. Design of surveillance systems	1 2 3 4	• Specific IPC question you have (could be related to your own facility) and/or learning goal (area you want to learn more about).
	b. Collection and compilation of surveillance data	1 2 3 4	

Medical Equipment and Supplies Resources

- Multi-Society Guidelines for Reprocessing Flexible Gastrointestinal Endoscopes by APIC at www.apic.org/AM/Template.cfm?Section=Guidelines_and_Standards&template=/CM/ContentDisplay.cfm&section=Topics1&ContentID=6381
- Cleaning of scopes is hit hard
- Disinfection of Healthcare Equipment Chapter in Guidelines for Disinfection and Sterilization in Healthcare Facilities Nov 2008 at www.cdc.gov/ncidod/dhqp/pdf/guidelines/Disinfection_Nov_2008.pdf
- Single Use Device Reprocessing at http://cms.h2e-online.org/ee/waste-reduction/waste-minimization/

Immediate Use Steam Sterilization IUSS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality /Survey & Certification Group

Ref: S&C: 14-44-Hospital/CAH/ASC

DATE: **August 29, 2014**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Change in Terminology and Update of Survey and Certification (S&C) Memorandum 09-55 Regarding Immediate Use Steam Sterilization (IUSS) in Surgical Settings

Memorandum Summary

- ***Change in Terminology: "Flash" Sterilization vs. IUSS:*** Nationally recognized organizations with expertise in infection prevention and control and instrument sterilization processes, and other professional organizations recommend abandoning the use of the term "flash" sterilization, which is now considered outmoded, and replacing it with the term "IUSS."

- ***Update of S&C Memorandum 09-55 Regarding Standards for Immediate Use Sterilization in Surgical Settings:*** This memo reiterates and updates information regarding nationally recognized infection prevention and control guidelines and professionally acceptable standards of practice with respect to immediate use sterilization and supersedes S&C Memorandum 09-55.

CMS Memo on Insulin Pens

- Regurgitation of blood into the insulin cartridge after injection can occur
  - Creates a risk if used on more than one patient
  - Hospital needs to have a policy and procedure
- Staff should be educated regarding the safe use of insulin pens
  - More than 2,000 patients were notified in 2011 because an insulin pen was used on more than one patient
  - CDC issues reminder on same and has free flier*

Insulin Pen Posters and Brochures Available

www.oneandonlycampaign.org/content/insulin-pen-safety

Blue Box Use Automated Surveillance

- *Patients or staff with identified communicable diseases that local, State, or Federal health agencies require be reported;*
- *Patients identified by laboratory culture as colonized or infected with multi-drug-resistant organisms (MDROs), as defined by the hospital's Infection Prevention and Control Program;*
- *Patients who meet CDC criteria for requiring isolation precautions (other than "Standard Precautions" or a protective environment) during their hospitalization;*
- *Patients or staff with signs and symptoms that have been requested be reported or recorded by local, State, or Federal health agencies; and*
- *Staff or patients who are known or suspected to be infected with epidemiologically-significant pathogens that are identified by the hospital or local, State, or Federal health agencies.*

For Information – Not Required/Not to be Cited

Many hospitals are using automated surveillance technology (AST) or "data mining" for identification and control of hospital-acquired infections (HAI) and implementation of evidence-based infection control practices. Use of AST or similar technology is encouraged in hospitals, but is not required.

Discharge Planning

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A-0799

(Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§482.43 Condition of Participation: Discharge Planning

The hospital must have in effect a discharge planning process that focuses on the patient goals and treatment preferences and includes the patient and his or her caregivers support person(s) in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to a preventable hospital readmissions.

Interpretive Guidelines §482.43

Guidance is pending and will be updated in future release.

A-0800

(Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§482.43(a) Standard: Discharge Planning *Process*

(a) The hospital's discharge planning process must identify at an early stage of hospitalization those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and must provide a discharge planning evaluation for those patients so identified as well as for other patients upon the request of the patient, patient's representative, or patient's physician.

Interpretive Guidelines §482.43(a)

Guidance is pending and will be updated in future release.

A-0801
(Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§482.43(a)(4) Standard: Discharge Planning Process

(4) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

Interpretive Guidelines §482.43(a)(4)

Guidance is pending and will be updated in future release.

A-0802
(Rev. 200, Issued: 02-21-20; Effective: 02-21-20, Implementation: 02-21-20)

§482.43(a)(6) Standard: Discharge Planning Process

(6) The hospital's discharge planning process must require regular re-evaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.

Interpretive Guidelines §482.43(a)(6)

Organ Procurement

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OPO Agreements with Hospitals

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-48-OPO

DATE: **July 26, 2013**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Organ Procurement Organizations (OPO) Agreements with Hospitals

Memorandum Summary

- **OPO Hospital Agreements:** Hospital regulations at 42CFR 482.45 (a)(1) require that all hospitals have written agreements in place with their OPO to notify them of an imminent death or of a death which has occurred. OPO regulations at §486.322 (a) require that OPOs have a written agreement in place with 95 percent of all participating Medicare and Medicaid hospitals and Critical Access Hospitals *that have both a ventilator and an operating room.* Historically, OPOs have not initiated agreements with hospitals without a ventilator and an operating room as donor maintenance cannot be accomplished in that setting.
- **OPO Agreements with Hospitals That Do Not Have a Ventilator and Operating Room:** While OPOs are not required to initiate agreements with hospitals that do not have a ventilator and an operating room, they are required at §486.303 (g) to enter into an agreement with any hospital that requests an agreement with them pursuant to the hospital regulations. However, for hospitals that do not have a ventilator and operating room, the agreement may be limited to notification of the OPO by the hospital of imminent death and/or death which has occurred in the facility.

Overview

Conditions of Participation for Hospitals at 42CFR 482.45 (a)(1) state that, "the hospital must have and implement written protocols that: Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital."

Conditions for Coverage for Organ Procurement Organizations (OPO) at §486.322 (a) state, "An

Resource on Organ Donors Research

Opportunities for Organ Donor Intervention Research

SAVING LIVES BY IMPROVING THE QUALITY AND QUANTITY OF ORGANS FOR TRANSPLANTATION

www.nap.edu/read/24884/chapter/1

Committee on Issues in Organ Donor Intervention Research

James F. Childress, Sarah Domnitz, and Catharyn T. Liverman, *Editors*

Board on Health Sciences Policy

Health and Medicine Division

A Consensus Study Report of

The National Academies of
SCIENCES • ENGINEERING • MEDICINE

Surgery

Immediate Use Steam Sterilization IUSS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality /Survey & Certification Group

Ref: S&C: 14-44-Hospital/CAH/ASC

DATE: **August 29, 2014**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Change in Terminology and Update of Survey and Certification (S&C) Memorandum 09-55 Regarding Immediate Use Steam Sterilization (IUSS) in Surgical Settings

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- ***Update of S&C Memorandum 09-55 Regarding Standards for Immediate Use Sterilization in Surgical Settings:*** This memo reiterates and updates information regarding nationally recognized infection prevention and control guidelines and professionally acceptable standards of practice with respect to immediate use sterilization and supersedes S&C Memorandum 09-55.

Preventing OR Fires

- AORN has very detailed policy on flammable prep in the OR and how to prevent fires
- Special precautions developed by NFPA and incorporated into NPSG by TJC
- ASA (American Society of Anesthesiologists) has a document on preventing fires in the OR
- PA Patient Safety Authority has great recommendations and a resource

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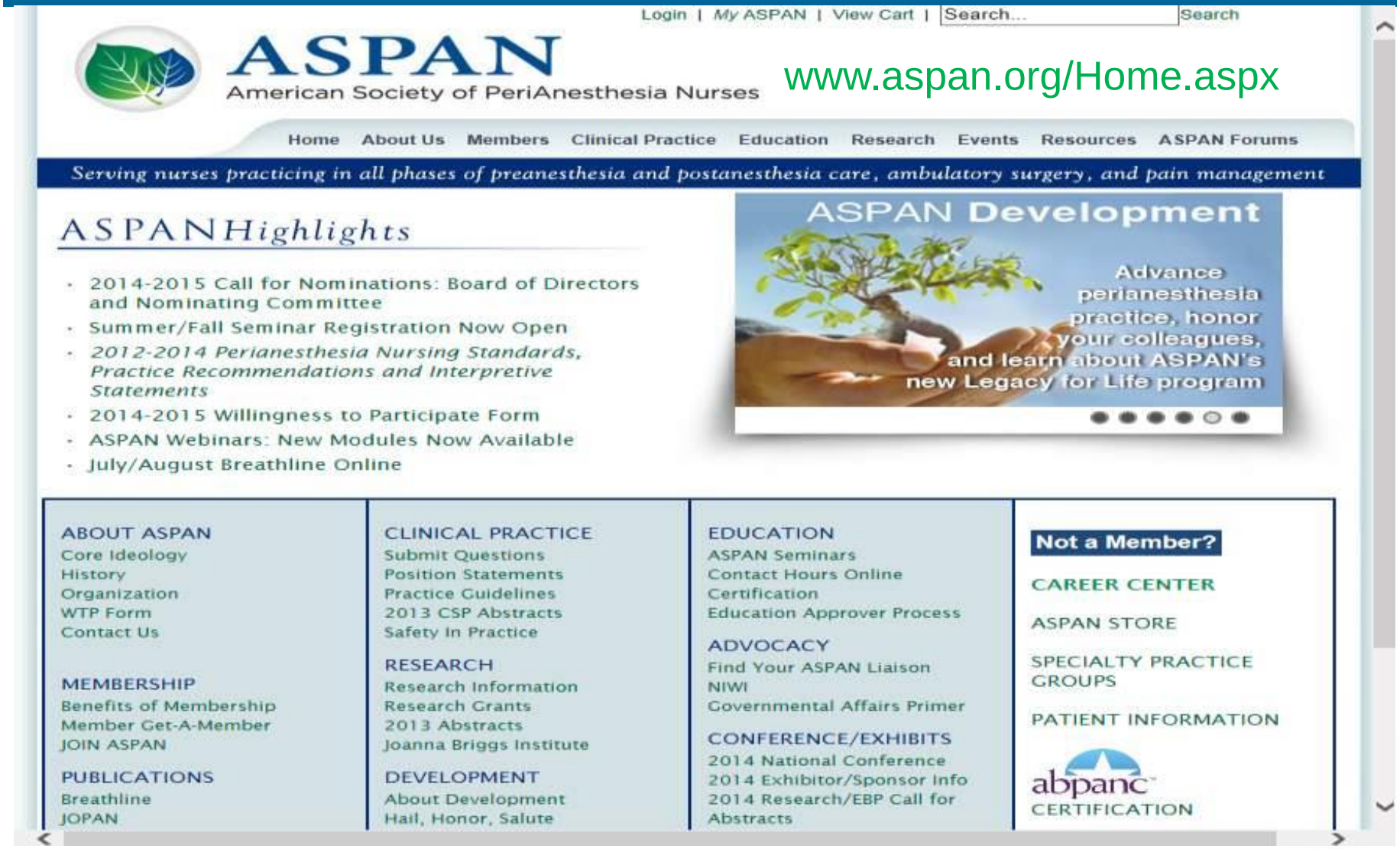
ASPAN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American Society of PeriAnesthesia Nurses
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Home About Us Members Clinical Practice Education Research Events Resources ASPAN Forums
Serving nurses practicing in all phases of preanesthesia and postanesthesia care, ambulatory surgery, and pain management
ASPAN Highlights
2014-2015 Call for Nominations: Board of Directors and Nominating Committee
Summer/Fall Seminar Registration Now Open
2012-2014 Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements
2014-2015 Willingness to Participate Form
ASPAN Webinars: New Modules Now Available
July/August Breathline Online
ASPAN Development
Advance perianesthesia practice, honor your colleagues, and learn about ASPAN's new Legacy for Life program
ABOUT ASPAN
Core Ideology
History
Organization
WTP Form
Contact Us
MEMBERSHIP
Benefits of Membership
Member Get-A-Member
JOIN ASPAN
PUBLICATIONS
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2013 CSP Abstracts
Safety In Practice
RESEARCH
Research Information
Research Grants
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Joanna Briggs Institute
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ASPAN Seminars
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abpanc
CERTIFICATION

BASIC STANDARDS FOR PREANESTHESIA CARE

Committee of Origin: Standards and Practice Parameters

(Approved by the ASA House of Delegates on October 14, 1987, and amended on October 25, 2005)

These standards apply to all patients who receive anesthesia care. Under exceptional circumstances, these standards may be modified. When this is the case, the circumstances shall be documented in the patient's record.

An anesthesiologist shall be responsible for determining the medical status of the patient and developing a plan of anesthesia care.

The anesthesiologist, before the delivery of anesthesia care, is responsible for:

1. Reviewing the available medical record.
2. Interviewing and performing a focused examination of the patient to:
    a. Discuss the medical history, including previous anesthetic experiences and medical therapy.
    b. Assess those aspects of the patient's physical condition that might affect decisions regarding perioperative risk and management.
3. Ordering and reviewing pertinent available tests and consultations as necessary for the delivery of anesthesia care.
4. Ordering appropriate preoperative medications.
5. Ensuring that consent has been obtained for the anesthesia care.
6. Documenting in the chart that the above has been performed.

Developed by the American Association of Nurse Anesthetists - 1991

PREANESTHESIA EVALUATION

Age	Sex M F	Height in / cm	Weight lb / kg

Proposed Procedure

Pre-Procedure Vital Signs
B/P P R T

Previous Anesthesia / Operations — None ☐

Current Medications — None ☐

Family History of Anesthesia Complications — None ☐

Allergies — NKDA ☐

AIRWAY / TEETH / HEAD & NECK

History From:
☐ Patient ☐ Significant Other
☐ Parent / Guardian ☐ Chart
☐ Communication / Language Problems
☐ Poor Historian

SYSTEM	WNL	COMMENTS
RESPIRATORY Asthma, Bronchitis, COPD, Dyspnea, Orthopnea, Pneumonia, Productive Cough, Recent URI, SOB, Tuberculosis	☐	Tobacco Use: ☐ Yes ☐ No _____ Packs / Day for _____ Years
CARDIOVASCULAR Abnormal EKG, Angina, ASHD, CHF, Dysrhythmia, Exercise Tolerance, Hypertension, MI, Murmur, Pacemaker, Rheumatic Fever, Valvular Disease	☐	
HEPATO / GASTROINTESTINAL	☐	Ethanol Use: ☐ Yes ☐ No Frequency _____

DIAGNOSTIC STUDIES

EKG

Chest X-ray

Pulmonary Studies

AANA Standards for Nurse Anesthesia

Standard I
Perform and document a thorough preanesthesia assessment and evaluation.

Standard II
Obtain and document informed consent for the planned anesthetic intervention from the patient or legal guardian, or verify that informed consent has been obtained and documented by a qualified professional.

Standard III
Formulate a patient-specific plan for anesthesia care.

www.aana.com/resources2/professionalpractice/Pages/Standards-for-Nurse-Anesthesia-Practice.aspx

Standard IV
Implement and adjust the anesthesia care plan based on the patient's physiologic status. Continuously assess the patient's response to the anesthetic, surgical intervention, or procedure. Intervene as required to maintain the patient in optimal physiologic condition.

Standard V
Monitor, evaluate, and document the patient's physiologic condition as appropriate for the type of anesthesia and specific patient needs. When any physiological monitoring device is used, variable pitch and threshold alarms shall be turned on and audible. The CRNA should attend to the patient continuously until the responsibility of care has been accepted by another anesthesia professional.

a. **Oxygenation**
   Continuously monitor oxygenation by clinical observation and pulse oximetry. If indicated, continually monitor oxygenation by arterial blood gas analysis.
b. **Ventilation**
   Continuously monitor ventilation. Verify intubation of the trachea or placement of other artificial airway devices by auscultation, chest excursion, and confirmation of expired carbon dioxide. Use ventilatory pressure monitors as indicated. Continuously monitor end-tidal carbon dioxide during controlled or assisted ventilation and any anesthesia or sedation technique requiring artificial airway support. During moderate or deep sedation, continuously monitor for the presence of expired carbon dioxide.
c. **Cardiovascular**
   Continuously monitor cardiovascular status via electrocardiogram. Perform auscultation of heart sounds as

STANDARDS FOR POSTANESTHESIA CARE

Committee of Origin: Standards and Practice Parameters

(Approved by the ASA House of Delegates on October 27, 2004, and last amended on October 21, 2009)

These standards apply to postanesthesia care in all locations. These standards may be exceeded based on the judgment of the responsible anesthesiologist. They are intended to encourage quality patient care, but cannot guarantee any specific patient outcome. They are subject to revision from time to time as warranted by the evolution of technology and practice.

STANDARD I

ALL PATIENTS WHO HAVE RECEIVED GENERAL ANESTHESIA, REGIONAL ANESTHESIA OR MONITORED ANESTHESIA CARE SHALL RECEIVE APPROPRIATE POSTANESTHESIA MANAGEMENT.[1]

1. A Postanesthesia Care Unit (PACU) or an area which provides equivalent postanesthesia care (for example, a Surgical Intensive Care Unit) shall be available to receive patients after anesthesia care. All patients who receive anesthesia care shall be admitted to the PACU or its equivalent **except** by specific order of the anesthesiologist responsible for the patient's care.
2. The medical aspects of care in the PACU (or equivalent area) shall be governed by policies and procedures which have been reviewed and approved by the Department of Anesthesiology.
3. The design, equipment and staffing of the PACU shall meet requirements of the facility's accrediting and licensing bodies.

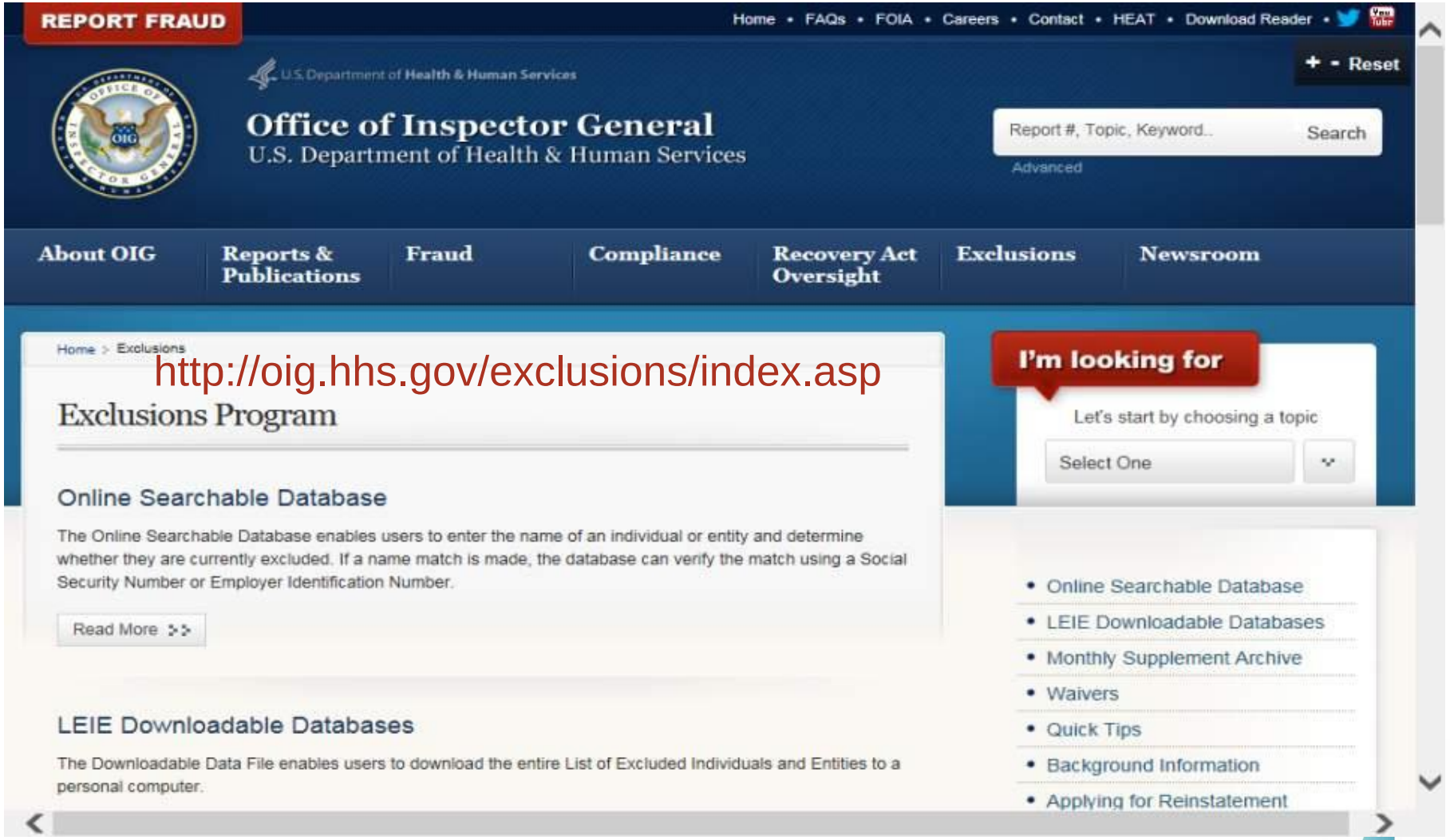
STANDARD II

A PATIENT TRANSPORTED TO THE PACU SHALL BE ACCOMPANIED BY A MEMBER OF THE ANESTHESIA CARE TEAM WHO IS KNOWLEDGEABLE ABOUT THE PATIENT'S CONDITION. THE PATIENT SHALL BE CONTINUALLY EVALUATED AND TREATED DURING TRANSPORT WITH MONITORING AND SUPPORT APPROPRIATE TO THE PATIENT'S CONDITION.

STANDARD III

UPON ARRIVAL IN THE PACU, THE PATIENT SHALL BE RE-EVALUATED AND A VERBAL REPORT PROVIDED TO THE RESPONSIBLE PACU NURSE BY THE MEMBER

OIG List of Excluded Individuals



Nuclear Medicine 1025

- Services must meet needs of patients
- Optional service
- Radioactive material must be prepared, labeled, uses, transported, stored and disposed of in accordance with acceptable standards of practice
- Will **not** discuss but be sure to provide to your director if you do nuclear medicine the revised standards in 2015

Nuclear Medicine 1026

- Need to follow standards of practice (1026)
- Must follow state or federal laws
- Must follow recommendations by national professional organizations such as:
  - ACR, Radiologic Society of North America, America, the Society of Nuclear Medicine and Molecular Imaging, the American Society of Nuclear Cardiology, and the American Association of Physicists in Medicine
- Hospital can run or have a contracted service
- Same risks such as patient can develop cancer

Nuclear Medicine 1026

- Use as low as reasonably achievable (ALARA)
- Must be integrated into QAPI program
- Lists indicators of potential quality and safety problems
  - Wrong radiopharmaceutical is used
  - Lack of premedication or no IV access so procedure is cancelled
- Need a qualified NM medical director (1027) approved by the Medical Staff
- Had written scope to show what services are offered

Nuclear Medicine

- Radioactive material must be prepared, labeled, used, transported, stored, and disposed of in accordance with acceptable standards of practice (1035)
  - Must have a policy addressing the use of radioactive materials in the hospital
  - Must have clear signage
  - Must protect high risk patients; pregnant, children, multiple NM studies
  - Monitor staff monitoring devices such as dosimeters

Nuclear Medicine

- If lab tests done in NM service must meet CLIA (1038)
- Equipment and supplies must be appropriate (1044)
  - Must be maintain for safe and efficient performance
  - Must be in good operating condition
- Must have signed and dated reports of interpretations, consultations, and procedures (1051)
  - Must be signed by MS who interpreted it
  - Must keep copies for 5 years

Nuclear Medicine

- Must keep records of the receipt and distribution of radiopharmaceuticals (1054)
- Need order of person who licensure and privileges allow to order or board and MS allow to order (1055)

Nuclear Med 1036

- Must be maintained in safe operating condition
  - Inspected, tested, and calibrated annually by qualified person
- Sign and date reports of nuclear interpretation, consults, and procedures
  - Keep copies for five years of records
- Radiopharmaceuticals can be prepared on off hours without radiologist or pharmacist present
  - Need P&P and follow guidelines like Society of NM and Molecular Imaging

SNMMI Website

In This Section

- Legislative Issues & Priorities
- Regulatory Issues & Priorities
- + Grassroots Issues
- Position Statements
- Coalition for PET Drug Approval
- HPRA Newsletter
- Government Relations News

Conditions of Participation

Background

Previously, section § 482.53(b)(1) required that the in-house preparation of radiopharmaceuticals be performed by, or under the direct supervision of, an appropriately trained registered pharmacist or a doctor of medicine or osteopathy. Direct supervision means that one of these professionals must be physically present in the hospital and immediately available during the preparation of all radiopharmaceuticals.

In the past, hospitals had reported to CMS that the direct supervision requirement is extremely burdensome when the presence of a pharmacist or physician is required for the provision of off-hour nuclear medicine tests that require only minimal in-house preparation of radiopharmaceuticals.

On February 4, 2013, the Centers for Medicare and Medicaid Services (CMS) released the Proposed Rule for Part II Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction. This long awaited proposed rule was important to nuclear medicine and addressed the issue of direct supervision in the preparation of radiopharmaceuticals.

Following SNMMI's suggestions, CMS proposed removing the word "direct."

We propose to revise the current requirement at § 482.53(b)(1) by removing the term "direct." The revised requirement would then require that in-house preparation of radiopharmaceuticals be performed by, or under the supervision of, an appropriately trained registered pharmacist or doctor of medicine or osteopathy. The revision to "supervision" from "direct supervision" would allow for other appropriately trained hospital staff to prepare in-house radiopharmaceuticals under the oversight of a registered pharmacist or doctor of medicine or osteopathy, but it would not require that such oversight be exercised by the physical presence in the hospital at all times of one of these professionals, particularly during off-hours when such a professional would not be routinely present.

Current Status

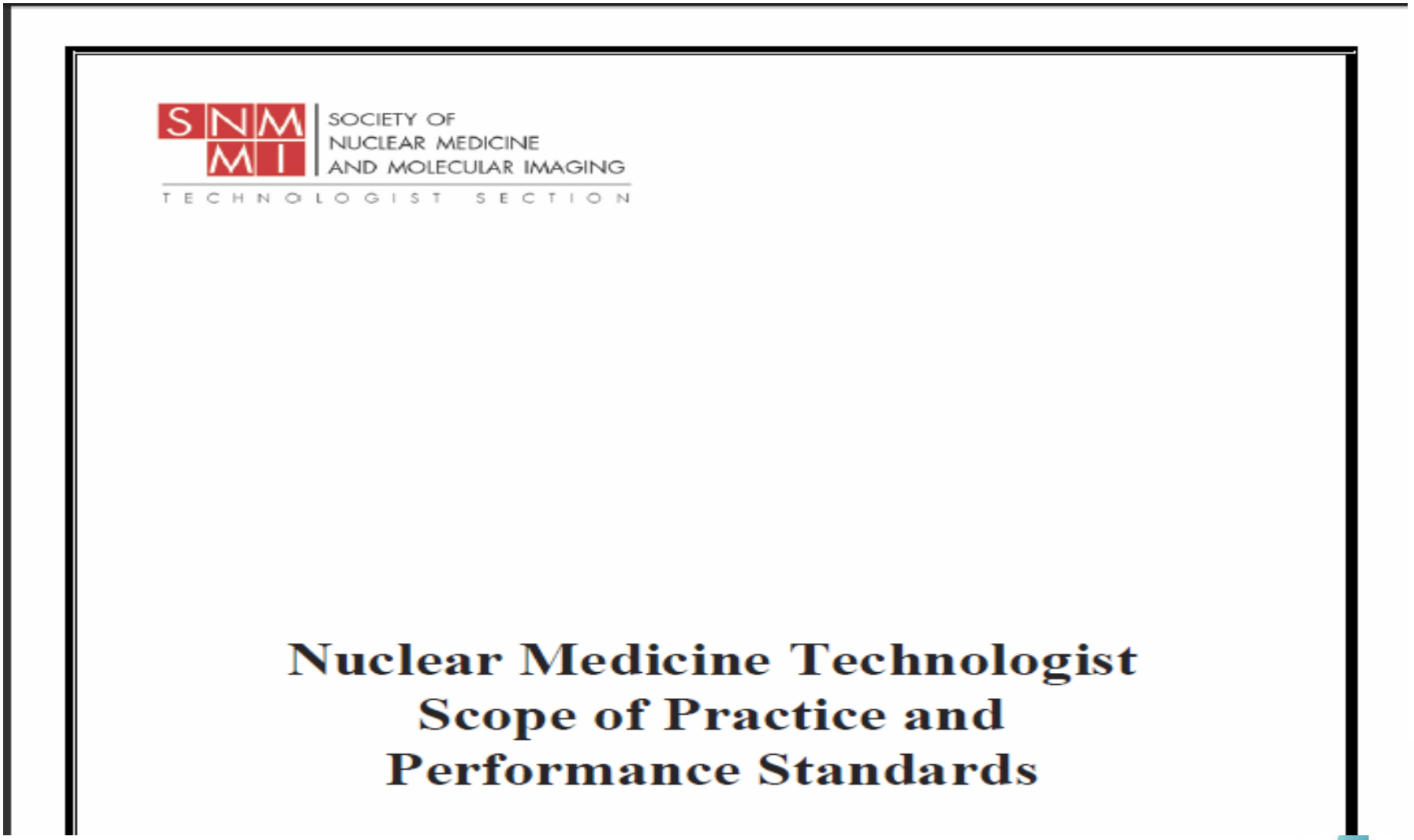
On May 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule for Part II Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction. This new rule finalized the previously proposed change of removing the term "direct" from the current requirement at § 482.53(b)(1).

CMS stated: *We received several comments on our proposed change to §*

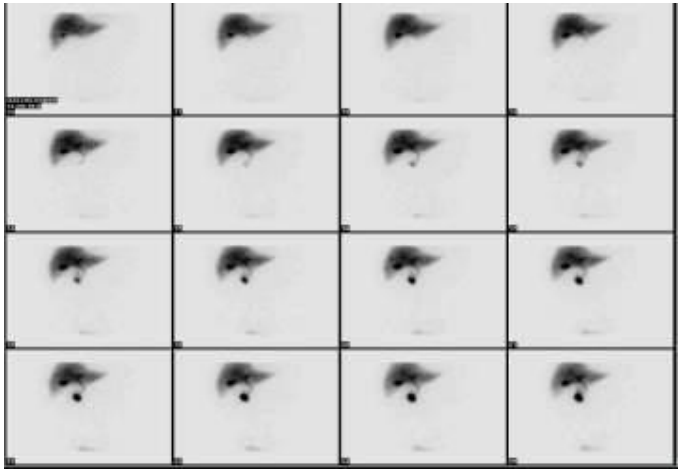
RELATED CONTENT

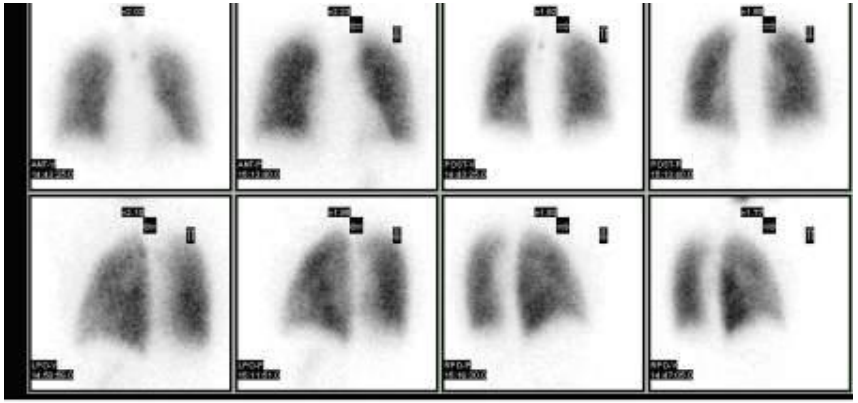
- 2013 Proposed Rule for Part II Regulatory Provisions to Promote Program Efficiency, Transparency, an - PDF document, 493 KB
- Comments to CMS Regarding the 2013 Proposed Rule for Part II Regulatory Provisions to Promote Progra - PDF document, 417 KB
- Comments to CMS Regarding the 2011 Proposed Rule for Medicare and Medicaid Programs; Reform of Hospi - PDF document, 852 KB
- Medicare Reimbusement Rates
- Coverage with Evidence Development
- Grants, Awards, and Scholarships
- Education Program
- Barry A. Siegel, MD, Receives 2014 Benedict Cassen Prize for Research in Nuclear Medicine

NM Tech Scope of Practice



Nuclear Medicine Tests





- Normal hepatobiliary scan (HIDA scan) used to detect gallbladder disease

- Normal pulmonary ventilation and perfusion V/Q scan