Critical Access Hospitals (CAH)

CMS Conditions of Participation (CoPs) 2013: Part 2
TELNET 2864 September 19, 2013 10-11:30 am EDT
Rules for the storage, handling, dispensing, and administration of drugs and biologicals,

Need to store drugs in accordance with acceptable standards of practice,

Keep accurate records of the receipt and disposition of all scheduled drugs,

And all outdated, mislabeled, or otherwise unusable drugs are not available for patient use,
The pharmacy director, with input from appropriate CAH staff and committees, develops, implements and periodically reviews and revises P&P on the provision of pharmaceutical services,

- Store drugs as required by manufacturer,
- Pharmacy records detailed to follow the flow of drugs from entry to dispensing and administration,
- Employees provide pharmacy services within scope of license and education,
- Pharmacy must maintain control over all drugs and medications including floor stock,

The following must be inspected:
- ED services and how services are available 24 hours a day,
- Availability of equipment, blood, drugs, and supplies,
- Physical plant and environment as part of life safety code,
- Drug storage area (C276),
- Direct care services; how are diagnostic and therapeutic services provided (C281),
- Lab services-CLIA certificate,
Drugs must be dispensed by licensed pharmacist,
Only pharmacists or pharmacy supervised personnel compound, label and dispense drugs or biologicals,
How do you make sure accurate records of receipt and disposition of scheduled drugs,
Who has access and keys to drug area?
How do you make sure no outdated drugs or mislabeled drugs?
Will inspect the pharmacy,

Pharmaceutical services can be provided as direct services or through an agreement,
Does not require continuous on-premise supervision at the CAH’S pharmacy,
May be accomplished through regularly scheduled visits, and/or telemedicine in accordance with law and regulation and accepted professional principles,
A single pharmacist must be responsible for the overall administration of the pharmacy,
- The pharmacist must be responsible for developing, supervising, and coordinating all the activities of the CAH-wide pharmacy service,
- And must be thoroughly knowledgeable about CAH pharmacy practice and management,
- Job description or the written agreement for the responsibilities of the pharmacist should be clearly defined and include development, supervision and coordination of all the activities of pharmacy services,

- Pharmacy must have sufficient staff in types, numbers, and training to provide quality services, including 24 hour, 7-day emergency coverage,
- Must have enough staff to provide accurate and timely medication delivery, ensure accurate and safe medication administration,
- Staff to participate in PI,
- System so medication orders get to the pharmacy and drugs back to patients promptly,
Must keep records of the receipt and disposition of all scheduled drugs,
Pharmacist must make sure all drug records are in order and that an account of all scheduled drugs is maintained and reconciled,
From point of entry to administration to patient or destruction or return of drug to manufacturer,
Must have a P&P and system to identify loss or diversion of all controlled substances,

The P&P established to prevent unauthorized usage and distribution must provide for an accounting of the receipt and disposition of drugs,
All prescribers’ medication orders (except in emergency situations) should be reviewed for appropriateness by a pharmacist before the first dose is dispensed,
Note in next slide where CAH cited if no initial pharmacy review done when pharmacy closed (use tele-pharmacy)
- Therapeutic appropriateness of a patient’s medication regimen;
- Therapeutic duplication,
- Appropriateness of the route and method of administration;
- Medication-medicine, medicine-food, medicine-laboratory test and medicine-disease interactions;
- Clinical and laboratory data to evaluate the efficacy of medication therapy to anticipate or evaluate toxicity and adverse effects; and
- Physical signs and clinical symptoms relevant to the patient’s medication therapy.
Drug Interaction Checker

Sterile products should be prepared and labeled in a suitable environment by appropriately trained and qualified personnel,

Remember the USP 797, officially introduced on 1-1-04 and became enforceable by the FDA,

Also adopted by TJC and many state pharmacy boards,

Information is available at www.usp.org
Pharmacy should participate in CAH decisions about emergency medication kits,

Supply and provision of emergency medications stored in the kits must be consistent with standards of practice,

And appropriate for a specified age group or disease treatment,

Pharmacy should be involved in the evaluation, use and monitoring of drug delivery systems (IV pumps, PCA)

Schedule Drugs and potential for error of administration devices,

And automated drug-dispensing machines (Pyxis, Omnicell, Meditol et. al.),
Medications must be prepared safely,
Safe preparation procedures could include;
- Only the pharmacy compounds or admixes all sterile medications, intravenous admixtures, or other drugs except in emergencies or when not feasible (for example, when the product’s stability is short).
- Staff uses safety materials and equipment while preparing hazardous medications.

Whenever medications are prepared, staff uses appropriate techniques to avoid contamination during medication preparation, which include, but are not limited, to the following:
- Using clean or sterile technique as appropriate;
- Maintaining clean, uncluttered, and functionally separate areas for product preparation to minimize the possibility of contamination;
- Using a laminar airflow hood or other appropriate environment while preparing any intravenous (IV) admixture in the pharmacy, any sterile product made from non-sterile ingredients, or any sterile product that will not be used with 24 hours; and
- Visually inspecting the integrity of the medications.

- All drugs must be kept in a locked room or container,
- If the container is mobile or readily portable, when not in use, it must be stored in a locked room, monitored location, or secured location that will ensure the security of the drugs,
- Must be stored in a manner to prevent access by unauthorized individuals,
Persons without legal access to drugs cannot have unmonitored access to drugs,

Cannot have keys to medication storage rooms, carts, cabinets, or containers (housekeepers, security),

Drug storage is a big issue with both CMS and the Joint Commission

When not in use, nursing medication carts, anesthesia carts, and other medication carts that contain drugs,

Must be locked or stored in a locked storage room,

If cart is in use and unlocked, someone with legal access to the drugs in the cart must be close by and directly monitoring the cart (276),
Must have a pharmacy labeling, inspection, and inventory management system that ensures that outdated, mislabeled, or otherwise unusable drugs are not available for patient use,

Surveyor will make sure staff is familiar with medication P&P,

Need policy to ensure P&P are periodically reviewed,

Will look to see if access to concentrated solutions is restricted (KCL, NaCl greater than 0.9%),

Look for policy for the safeguarding, transferring and availability of keys to the locked storage area,

Inspect the pharmacy and where medications are stored,

Inspect patient-specific and floor stock medications to identify expired, mislabeled or unusable medications,

If the unit dose system is utilized, verify that each single unit dose package bears name and strength of the drug, lot and control number equivalent, and expiration date.
Review P&P to determine who is designated to remove drugs from the pharmacy or storage area,

Determine if the pharmacist routinely reviews the contents of the after-hours supply to determine if it is adequate to meet the after-hours needs of the CAH.

Interview the Pharmacy Director, pharmacist and pharmacy employees to determine their understanding of the controlled drug policies,

- Procedures for reporting adverse drug reactions and errors in the administration of drugs,
- Written P&P to require these be reported immediately to practitioner who ordered the drug,
- Entry should be made in the MR,
- Significant ADRs should be reported to the FDA in accordance with MedWatch program,
Important to flag new types of mistakes as they occur and create systems to prevent their recurrences (system analysis approach),

- System should work through those mistakes and continually improve and refine things, based on what went wrong (example RCA),
- See sample forms to use for RCA and FMEA,

Reduction of medication error and adverse reactions by effective reporting systems that proactively identify causative factors and are used to implement corrective actions to reduce or prevent reoccurrences (FMEA),

- Need to develop definition of medication error that includes near misses,
System to minimize high risk medications (chemo, insulin, Heparin),

Need to have a policy on high alert drugs and what you do (double checks)

Such systems could include: checklists, dose limits, pre-printed orders, special packaging, special labeling, double-checks and written guidelines,

Getting Started Kit: Prevent Harm from High-Alert Medications

How-to Guide

A nationwide initiative led by the 5 Million Lives Campaign aims to dramatically reduce the errors of American healthcare by preventing patients from receiving harmful doses of harm between December 2005 and December 2009. The link is

www.ihi.org/NR/rdonlyres/8B2475CD-56C7-4D9B-B359-801F3CC3A056/0/HighAlertMedicationsHowToGuide.doc

WISCONSIN PATIENT SAFETY INSTITUTE

MODEL HIGH-ALERT MEDICATIONS POLICY & PROCEDURES

PURPOSE

- To provide guidance to acute care organizations for the safe handling and administration of medications designated as High Alert Medications.
- To increase awareness of High Alert Medications, thereby improving patient safety.

DEFINITION

High Alert Medications are drugs that bear a higher risk of causing significant patient harm when they are used in error.

POLICY

A. The following medications are appropriate for inclusion in a High Alert Medications policy.
   - Epidural infusions
   - Fentanyl
   - Heparin (>100 units, flushes exempt)
   - Insulins (including regular, aspart, NPH, and glargine)
   - Lidocaine with epinephrine vials

B. The following medications may also be appropriate for inclusion in a High Alert Medications policy in addition to the medications above.
   - Glycoprotein IIb/IIIa inhibitors (e.g., abciximab, tirofiban)
   - Iron Dextran
   - Adrenergic antagonists agents (e.g., esmolol)
   - Anticoagulants

C. Concentrated electrolyte vials (e.g., potassium chloride) should not be stocked in patient care areas.

PROCEDURES

Safety procedures during the ordering, preparation, dispensing and administration of High Alert Medications include:

Prescribing

A. Verbal orders for High Alert Medications should
Mention NCCMERP definition of medication error,
Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.”
Can’t just rely on just incident reports to identify medication errors and ADE,
Proactive includes observation of medication passes,
Concurrent and retrospective review of patient’s clinical records,
ADR surveillance team,

Implementation of medication usage evaluations for high-alert drugs,
and identification of indicator drugs or “patient signals” that, when ordered, or noted automatically generate a drug regimen review for a potential ADE,
IHI calls them trigger drugs and has three tools for hospitals to reduce errors
Monitor Digibind usage and develop protocol for appropriate use,
Monitor use of reversals agents such as Romazicon and Narcan to look for unreported cases of adverse events,
Narcan, antihistamines, Vitamin K,
IV glucose, glucagon,
Epinephrine, topical calamine,
Phentolamine, digibind, protamine, hyaluronidase,
Kayexalate, anti-emetics and anti-diarrheas,
Must have method to measure the effectiveness of its reporting system,
And whether system is identifying as many med errors and ADE as would be expected by benchmark studies,
Need non-punitive reporting system or people will not report errors (many balance with Just Culture),
Pharmacist should be readily available by telephone or other means to discuss drug therapy, interactions, side effects, dosage etc,
The CAH should have a means to incorporate external alerts and/or recommendations from national associations and governmental agencies for review and facility policy and procedure revision consideration.

National associations could include Institute for Safe Medications Practice, National Coordination Council for Medication Error Reporting and Prevention, The Joint Commission (no longer called JCAHO), ISMP, IHI, USP, and ASHP etc.

Governmental agencies may include:
- Food and Drug Administration (FDA),
- Med Watch Program, and
- Agency for Health Care Research and Quality (AHRQ).
Websites:

- National Patient Safety Foundation at the AMA - www.ama-assn.org/med-sci/npsf/htm
- The Institute for Safe Medication Practices - www.ismp.org
- U.S. Pharmocopiedia (USP) Convention, Inc. - www.usp.org
- U.S. Food and Drug Administration MedWatch - www.fda.gov/medwatch
- Institute for Healthcare Improvement - www.ihi.org
- AHRQ - www.ahrq.gov
- Sentinel event alerts at www.jointcommission.org

Additional Resources:

- American Pharmaceutical Association - www.aphanet.org
- American Society of Heath-System Pharmacists - www.ashp.org
- Enhancing Patient Safety and Errors in Healthcare - www.mederrors.com
- National Coordinating Council for Medication Error Reporting and Prevention - www.nccmerp.org
Pharmacy must ensure that drug orders are accurate and that medications are administered as ordered,

When medications are returned unused, the pharmacy should determine the reason the medication was not used (CMS calls this medication reconciliation and different from Joint Commission (TJC),

Example: Did the patient refuse the medication, was there a clinical reason the medication was not used, was the medication not used due to error?

Policies should include:

- High-alert medications with dosing limits, administration guidelines, packaging, labeling and storage;
- Limiting the variety of medication-related devices and equipment. For example, limit the types of general-purpose infusion pumps to one or two;
- Availability of up-to-date medication information;
- Availability of pharmacy expertise such as having a pharmacist available on-call when pharmacy does not operate 24 hours a day,
- Standardization of prescribing and communication practices,

- These are drugs that should be avoided in patients who are over 65!
- Updated in 2012
- Includes drugs not to be used for certain diseases
  - **High risk drugs** include Indocin, Talwin, Tigan, Dalmane, Muscle relaxants (Robaxin, Somam Flexeril etc.), Elavil, Triavil, Equanil, Librium, Aldoment, Diabense, all barbituates except Pb, Demerol, Ticlid, Toradol, Norflex, Ismelin, Hylorel, Mellaril, Mineral oil, etc.
- Heart failure- Norpace, high sodium drugs,
- HTN-pseudoephedrine, diet pills,
- Seizure- Clozaril, Thorazine, Navane, Mellaril,
- Anticoagulants-ASA, Plavix, Persantine, Ticlid,
- Categories for depression, Insomnia, Anorexia, Stress incontinence, syncope, etc.

**TABLE 1: MEDICATIONS TO AVOID OR USE WITHIN SPECIFIED DOSE AND DURATION RANGES IN ELDERLY PATIENTS**

<table>
<thead>
<tr>
<th>MEDICATION(s)†</th>
<th>EXPLANATION OF PROBLEM</th>
<th>SEVERITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSYCHOTROPIC MEDICATIONS</td>
<td>Strong anticholinergic and sedating properties</td>
<td>High</td>
</tr>
<tr>
<td>Amitriptyline, alone or in combination products</td>
<td>Side effects and addictive properties</td>
<td>High</td>
</tr>
<tr>
<td>Barbbiturates (other than phenobarbital)</td>
<td>Long half-lives, risk of sedation and increased falls</td>
<td>High</td>
</tr>
<tr>
<td>Chlorzoxazone (alone or in combination) or diazepam</td>
<td>Strong anticholinergic and sedating properties</td>
<td>High</td>
</tr>
<tr>
<td>Doxepin</td>
<td>Not proven effective at doses studied</td>
<td>Low</td>
</tr>
<tr>
<td>Ergot mesylates, cyclophylate isoxsuprins</td>
<td>Long half-life; risk of sedation and increased falls</td>
<td>High</td>
</tr>
<tr>
<td>Flurazepam</td>
<td>Doses &gt; 3mg/day should be avoided; residents with psychotic disorders may require higher doses</td>
<td>High</td>
</tr>
<tr>
<td>Haloperidol†</td>
<td>Total daily doses should not exceed these amounts, in the nursing facility resident, avoid any single dose of oxazepam &gt; 30 mg or triazolam &gt; 0.25 mg</td>
<td>Low</td>
</tr>
<tr>
<td>Lorcetam 3 mg, oxazepam 60 mg, alprazolam 2 mg, temazepam 15 mg</td>
<td>Not effective orally and has disadvantages compared with other narcotic analgesics</td>
<td>High</td>
</tr>
<tr>
<td>Zolpidem 5 mg, triazolam 0.25 mg</td>
<td>Highly addictive and sedating</td>
<td>High</td>
</tr>
<tr>
<td>Meperidine</td>
<td>Avoid unless patient is already</td>
<td>High</td>
</tr>
</tbody>
</table>
• Standardization of prescribing and communication practices;
• Avoidance of certain abbreviations (TJC IM Chapter has nine, no longer NPSG);
• All elements of the order such as dose, strength, units (metric), route, frequency, and rate;
• Alert systems for look-alike and sound-alike drug names (now 2 times the number);

### TJC Do Not Use Abbreviations

<table>
<thead>
<tr>
<th>Set</th>
<th>Item</th>
<th>Abbreviation</th>
<th>Potential Problem</th>
<th>Preferred Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.</td>
<td>U (for unit)</td>
<td>Mistaken as zero, four or cc</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
<td>IU (for International unit)</td>
<td>Mistaken as IV (intravenous) or 10 (ten)</td>
<td>Write “International unit”</td>
</tr>
<tr>
<td>3.</td>
<td>3. 4.</td>
<td>Q.D., Q.O.D. (Latin abbreviation for once daily and every other day)</td>
<td>Mistaken for each other. The period after the Q can be mistaken for an “I” and the “O” can be mistaken for “I”.</td>
<td>Write “daily” and “every other day”</td>
</tr>
</tbody>
</table>
Be sure to take action when a problem is noted,
Decide if you will take thru risk management, pharmacy, medical staff, or use the PI process
Look at your list on at least a yearly basis and update as necessary,
ISMP newsletters are a good source of information on current cases of look alike/sound alike drugs,

TJC has MM standard on LASA
Policy need to includes precautions for LASA medications
It is a much bigger problem according to recent research so USP has database hospitals can check for LASA drugs
8th Annual MedMaRX report issued in 2008 shows problems with 3,170 drug pair names which is doubled number since 2004
- Is an internet accessible, anonymous reporting data bank for hospitals and healthcare,
- Used to track and trend medication errors in the US,
- No longer owned by USP
- Issued many reports of interest (annual),
- USP now has on its website free LASA checking software anyone can use!
Use of facility approved pre-printed order sheets whenever possible;

A voluntary, non-punitive, reporting system to monitor and report adverse drug events (including medication errors and adverse drug reactions);

The preparation, distribution, administration and proper disposal of hazardous medications;

Medication recalls;

Policies and procedures are reviewed and amended secondary to facility-generated reports of adverse drug events,
Studies showed that if you have punitive environment errors will not be reported,
Most of serious errors are made by long term employee with unblemished records,
It was the system that actually lead to the error,
Change the environment or culture-called system analysis,
Important to have a non-punitive environment,
We need to move beyond the culture of blame so we can find out what errors are occurring,
Balance this with Just Culture,

What drug information is available at the nursing stations?
Will look at the pharmacy P&P, formulary and, if there is a pharmacy and therapeutic committee, the minutes of the committee meetings,
Are the above P&P present,
Review medical records to make sure medication errors are reported promptly,
Make sure generated sufficient number of medication errors,
A system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel,

- Must have an active surveillance program that includes specific measures for prevention,

- Early detection, control, education, and investigation of infections and communicable diseases,

- Remember the IC Worksheet

- CMS gets $50 million grant in 2011 to enforce IC standards and in 2013 HHS gets a billion dollars and some hospitals report increased scrutiny
Must be a mechanism to evaluate the effectiveness of the program (IC plan) and to provide corrective action when necessary,

Program must include implementation of nationally recognized systems of infection control guidelines,

So what’s in your IC Plan?

Such as CDC, OSHA, and APIC, SHEA, AORN,

**nosocomial infections are more recently referred to as Healthcare- associated infections (HAI),**
### PRIORITY AREA | ACTION REQUIRED | MEASUREMENT OF PROGRESS | LEAD | PRIORITY | COMPLETION DATE
--- | --- | --- | --- | --- | ---
Management and Communication of Critical Data and Information | 1. Establish a process for thorough review and appropriate action steps related to the following:  - Hospital in deaths or serious harm associated with infections, including mechanisms to share action plans and findings hospital-wide to prevent recurrence.  - Notification to inclusion of ICP leaders in renovation or new construction design and incidence of infection control breakdown | Established review process and action plans drafted | Patient Safety Center with assistance of multidisciplinary ICP workgroup | HIGH | March '09
 | 2. Evaluate available ICP alert and reporting software to maximize ICP efficiency, documentation, screening and surveillance | Completed evaluation with recommendation of ICP alert and reporting software | Patient Safety Center with assistance of multidisciplinary ICP workgroup | HIGH | September '09
 | 3. Define metrics for:  - Appropriate use of targeted antibiotics  - HICs  - ISO  - VAP  - CBOSS  - CAUTI | Monthly report of metrics | Hospital Infection Prevention & Control Workgroup | HIGH | July '09

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### GETTING TO ZERO

**INFECTION CONTROL AND PREVENTION (ICP) ACTION PLAN**

**Action Area Order: Collaborative Approach/View Ways of Thinking**

**Key Issues: Tackling healthcare associated infections requires commitment from all levels of the organization and an enhanced local and system infrastructure**

**Recommended to: Getting to Zero**

| PRIORITY AREA | ACTION REQUIRED | MEASUREMENT OF PROGRESS | LEAD | PRIORITY | COMPLETION DATE |
--- | --- | --- | --- | --- | ---
Infrastructure | 1. Form a hospital wide multidisciplinary Infection Control and Prevention (ICP) workgroup from inpatient and outpatient services, including Physicians, Nursing, Pharmacy, Laboratory, Housekeeping, Facilities, Risk, Quality and Safety departments, etc.  - Oversee the development and implementation of Hospital's Infection Control and Prevention strategies  - Monitor performance against the action plan  - Review standard metrics (including all deaths associated with infections)  - Serve as champions to facilitate intervention strategies | Formation of ICP workgroup with quarterly progress reports | VP Clinical Safety, Local Infection Disease physician to oversee ICP workgroup | HIGH | January '09
 | 2. Assess and recommend appropriate local structure to ensure accountability in meeting "getting to zero" goal | Distribution of draft recommendations for local accountability structure | VP Clinical Safety, VP Medical Services, Physician Leadership Council, Nursing Leadership Council | HIGH | February '09
<table>
<thead>
<tr>
<th>PRIORITY AREA</th>
<th>ACTION REQUIRED</th>
<th>MEASUREMENT OF SUCCESS</th>
<th>LEAD</th>
<th>PRIORITY</th>
<th>COMPLETION DATE</th>
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<tr>
<td>Management and Communication of Critical Data and Information</td>
<td>Establish a process for thorough review and appropriate action steps related to the following:</td>
<td>Established review process and action plan drafted</td>
<td>Patient Safety Center with assistance of multidisciplinary ICP workgroup</td>
<td>H324</td>
<td>March ’09</td>
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<td>• Hospital-wide deaths or serious harm associated with infections, including mechanisms to share action plans and findings hospital-wide to prevent recurrence.</td>
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<td>September ’09</td>
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<td>3. Define metrics for:</td>
<td>Monthly report of metrics</td>
<td>Hospital Infection Prevention and Control, Pharmacy &amp; Therapeutics Committee, Quality Management Department and Patient Safety Center</td>
<td>H324</td>
<td>July ’09</td>
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<td>• Appropriate use of targeted antibiotics</td>
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- Association for Professionals in Infection Control and Epidemiology (APIC) infection control guidelines at [www.apic.org](http://www.apic.org).
- Centers for Disease Control and Prevention- [www.cdc.gov](http://www.cdc.gov),
- Occupational Health and Safety Administration (OSHA)- [www.osha.gov](http://www.osha.gov),
- The National Institute for Occupational Safety and Health NIOSH- [www.cdc.gov/niosh/homepage.html](http://www.cdc.gov/niosh/homepage.html),

AORN in the Perioperative Standards and Recommended Practices has a chapter on sterilization and disinfection including many on steam sterilization.

APIC is a good source of information.

2. www.apic.org
2011 CDC Guidelines for Prevention of Intravascular Catheter Related Infections,

CDC Guidelines for the Prevention of catheter-Induced Urinary Tract Infections, December 2009,


AHRQ toolkit

- http://www.ahrq.gov/qual/haiflyer.htm
HHS has published a training video that every nurse, physician, infection preventionist and healthcare staff should see. This includes risk managers. It is an interactive video. Called Partnering to Heal: Teaming Up Against Healthcare-Associated Infections. Go to http://www.hhs.gov/partneringtoheal. HHS wants to decrease HAI by 40% in 2013, want 1.8 million fewer injuries and can save 60,000 lives.
Pa Patient Safety has toolkit to prevent CA-UTIs,
APIC guidelines to eliminate catheter-associated UTI
AORN article Jan 2010 on new scip measure regarding urinary catheter removal
  - at
    www.aorn.org/News-Managers/November2009Issue/Catheter/
IDSA as the “Diagnosis, Prevention, and Treatment of Catheter-Associated Urinary Tract Infections in Adults: 2009 International Clinical Practice Guidelines from the Infectious Disease Society of America
- [http://cid.oxfordjournals.org/content/50/5/625.full](http://cid.oxfordjournals.org/content/50/5/625.full)

Iowa Healthcare Collaborative toolkit
- [http://www.ihi.org/IHI/Programs/ImprovementMap/PreventCatheterAssociatedUrinaryTractInfections.htm](http://www.ihi.org/IHI/Programs/ImprovementMap/PreventCatheterAssociatedUrinaryTractInfections.htm)

- Definition of nosocomial infections (now called HAI or healthcare-associated infections) and communicable diseases;
- Measures for identifying, investigating, and reporting nosocomial infections and communicable diseases;
- Measures for assessing and identifying patients and health care workers, including personnel, contract staff (e.g., agency nurses, housekeeping staff), and volunteers, at risk for infections and communicable diseases;
Methods for obtaining reports of infections and communicable diseases on inpatients and health care workers,

Including all personnel, contract such as agency nurses, housekeeping staff, and volunteers, in a timely manner;

Measures for the prevention of infections, especially infections caused by organisms that are antibiotic resistant or in other ways epidemiologically important; device-related infections (e.g., those associated with intravascular devices, ventilators, tube feeding, indwelling urinary catheters, surgical site infections; and those infections associated with trach care, respiratory therapy, burns, immunosuppressed patients, and other factors which compromise a patient’s resistance to infection; (VAP bundle, central line bundle, SCIP,)
- Measures for prevention of communicable disease outbreaks, especially tuberculosis;
- Provision of a safe environment consistent with nationally recognized infection control precautions, such as the current CDC recommendations for the identified infection and/or communicable disease;
- Isolation procedures and requirements for infected or immunosuppressed patients;
- Use and techniques for standard precautions;

- Education of patients, family members and caregivers about infections and communicable diseases;
- Methods for monitoring and evaluating practices of asepsis;
- Techniques for hand washing, respiratory protections, asepsis, sterilization, disinfection, food sanitation, housekeeping, fabric care, liquid and solid waste disposal, needle disposal, separation of clean from dirty, as well as other means for limiting the spread of contagion;
APIC has a number of educational brochures that hospitals can download and provide to staff and patient.

- Includes 10 tips to prevent the spread of infection and hand hygiene for patients and one for healthcare workers.
- Information to patients is on standard precautions (hand hygiene) and transmission precautions for patients with certain diseases (contact precautions).

[www.apic.org](http://www.apic.org)
- Authority and indications for obtaining microbiological cultures from patients;
- A requirement that disinfectants, antiseptics, and germicides be used in accordance with the manufacturers' instructions to avoid harming patients, particularly central nervous system effects on children;
- Orientation of all new personnel to infections, communicable diseases, and to the infection control program;

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**DEPARTMENT OF HEALTH & HUMAN SERVICES**
Center for Medicare & Medicaid Services
7000 Security Boulevard
Baltimore, Maryland 21244-1000

Center for Medicaid and State Operations/Survey & Certification Group

**DATE:** September 4, 2009
**TO:** State Survey Agency Directors
**FROM:** Director Survey and Certification Group

**SUBJECT:** Flash Sterilization Clarification - FY 2010 Ambulatory Surgical Center (ASC) Surveys

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**Memorandum Summary**

**Flash Sterilization Clarification:** State survey agencies (SAAs) using the new survey process in FY 2009, including completing the Infectious Control Survey Worksheet, have experienced challenges in evaluating use of "Flash sterilization" by ASCs. Attachment 1 clarifies what this term means, and how to distinguish appropriate from inappropriate use of flash sterilization.

**Background**

We are clarifying the issue of the Infectious Control Survey Worksheet and flash sterilization. This is an area in which technological changes require changes in the way surveyors assess compliance of sterilization practices in ASCs. Attachment 1 is a set of bullets the Centers for Medicare & Medicaid Services (CMS) has developed with assistance from the Centers for Disease Control and Prevention (CDC) for state surveyors. This material was informally distributed to FY 2009 ASC-HAI volunteer SAAs, and will be reviewed at the October 20-22 surveyor training.
- Measures for the screening and evaluation of health care workers, including all staff, contract workers such as agency nurses, housekeeping staff, and volunteers, for communicable diseases, and for the evaluation of staff and volunteers exposed to patients with non-treated communicable diseases;
- Employee health policies regarding infectious diseases and when infected or ill employees, including contract workers and volunteers, must not render patient care and/or must not report to work;

- A procedure for meeting the reporting requirements of the local health authority (such as the state department of health);
- Policies and procedures developed in coordination with Federal, State, and local emergency preparedness and health authorities to address communicable disease threats and outbreaks,
Recommended that the infection control officer or officers maintain a log of all incidents related to infections and communicable disease,

- Including those identified through employee health services,

- Log is not limited to HAI,
  - Deleted by July 16, 2012 for FR for PPS hospitals but not from the CAH manual yet

- All incidents of infection and communicable disease should be included in the log,

- Log documents infections and communicable diseases of patients and all staff (patient care, non patient care, employees, contract staff and volunteers).

CEO, MS, and CNO must ensure there is hospital wide QAPI program,

- And infection control training programs that address problems identified through the IC program,

- Then revise the program,

- Designate an infection control officer,
  - Now called an infection preventionist by APIC

- Person must be qualified and is responsible for IC functions and is responsible to implement the P&P developed by IC Committee,
**Infection Preventionist**

Is responsible for (should include in job description);

- Developing a system for identifying, investigating, reporting, and preventing the spread of infections and communicable diseases among patients and personnel, including contract staff and volunteers;
- Identifying, investigating and reporting infections and outbreaks of communicable diseases among patients and personnel, including contract staff and volunteers, especially those occurring in clusters;

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**Infection Control Preventionist**

- Preventing and controlling the spread of infections and communicable diseases among patients and staff;
- Cooperating with CAH-wide orientation and in-service education programs;
- Cooperating with other departments and services in the performance of quality assurance activities; and
- Cooperating with disease control activities of the local health authority.
CDC Recommendations for Halting the Spread of Multidrug-Resistant Organisms

The 2006 Centers for Disease Control and Prevention (CDC) guideline Management of Multidrug-Resistant Organisms in Healthcare Settings offers general recommendations for preventing and controlling the spread of multidrug-resistant organisms and suggests additional, intensified interventions to halt a multidrug-resistant organism outbreak. In addition to methicillin-resistant Staphylococcus aureus, other multidrug-resistant organisms covered in the guidance include some or all strains of vancomycin-intermediate S. aureus, vancomycin-resistant S. aureus, vancomycin-resistant enterococci, K. pneumoniae, K. oxytoca, Pseudomonas aeruginosa, Acinetobacter baumannii, Stenotrophomonas maltophilia, Burkholderia cepacia, Ralstonia pickettii, and Streptococcus pneumoniae.

General recommendations for routine use, regardless of the prevalence of multidrug-resistant organisms in the facility, include the following:

- Ensure that prevention programs are funded and adequately staffed.
- Carefully track infection rates and related data to monitor the impact of prevention efforts.
- Ensure that workers use standard infection control practices and follow guidelines regarding the correct use of antibiotics.
- Promote best practices through health education campaigns to increase adherence to established recommendations.
- Design robust prevention programs customized to specific settings and local needs.

Facilities should implement additional controls, such as those following, when basic measures are insufficient to control multidrug-resistant organisms.

- Evaluate healthcare system or facility factors for their role in causing or perpetuating multidrug-resistant organism transmission; such factors may include staffing levels, education and training, availability of consumable and durable resources, communication processes, and adherence to infection control measures.
- Make educational efforts more frequent, especially for

- Store multidrug-resistant organism isolates for molecular typing, perform typing if needed.
- Develop protocols for and implement active surveillance of patients in high-risk populations; surveillance methods used will depend on the multidrug-resistant organism being targeted.
- Conduct point-prevalence surveys for the multidrug-resistant organism at routine intervals (e.g., weekly) and at patient discharge or transfer to determine whether transmission has ceased.
- Obtain cultures to determine whether infected patients’ contacts or healthcare workers are colonized.
- Implement contact precautions for all patients colonized or infected with the target multidrug-resistant organism.
- Use isolation in single rooms or cohorting for patients known or suspected multidrug-resistant organism colonization or infection.
- Stop receiving new admissions if transmission continues despite intensified control measures.
- Dedicate non-technical equipment to a single patient.
- Intensify training of environmental staff.
- Assign dedicated environmental staff to the affected unit or units to ensure consistent disinfection and cleaning.
- Monitor cleaning, especially for high-touch sites (e.g., bedsills) and surfaces close to the patient.
- Obtain environmental cultures only when surfaces are implicated in transmission.
- Vacate units for environmental assessment and cleaning if previous efforts to control environmental transmission have failed.
- Perform decontamination of patients and workers on a case-by-case basis; decontaminate only workers implicated in transmission.
- Before decontamination, test the multidrug-resistant organism for susceptibility to the decontamination agent.
If the CAH furnishes inpatient services,
- Procedures must be in place that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practice,
- A CAH is not required to prepare meals itself.
- Can obtain meals under contract,
- Infection control issues in dietary hit hard

Food and dietetic services must be organized,
- Directed and staffed in such a manner to ensure that the nutritional needs of the patients are met in accordance with practitioners’ orders,
- And recognized dietary practices,
- Availability of a diet manual and therapeutic diet menus to meet patients’ nutritional needs,
- Frequency of meals served,
- System for diet ordering and patient tray delivery,
- Accommodation of non-routine occurrences such as enteral nutrition (tube feeding), total parenteral nutrition, peripheral parenteral nutrition, change in diet orders, early/late trays, nutritional supplements, etc.,

- Integration of the food and dietetic service into the PI and Infection Control programs;
- Guidelines for acceptable hygiene practices of food service personnel; and
- Guidelines for kitchen sanitation.
Must be in compliance with Federal and State licensure requirements for food, and dietary personnel as well as food service standards, laws and regulations.

Must have qualified director of food and dietetic services

- Employed or contracted,

Must be delegated this responsibility by Board and MS,

- Safety practices for food handling;
- Emergency food supplies;
- Orientation, work assignments, supervision of work and personnel performance;
- Menu planning, purchasing of foods and supplies, and retention of essential records such as cost, menus, personnel, training records, QAPI reports, etc.; and
- Dietary service PI program
The dietitian’s responsibilities include (put in job description), but are not limited to:

- Approving patient menus and nutritional supplements;
- Patient, family, and caretaker dietary counseling;
- Performing and documenting nutritional assessments and evaluating patient tolerance to therapeutic diets when appropriate;

- Collaborating with other services (e.g., medical staff, nursing services, pharmacy service, social work service, etc.) to meet the nutritional needs of the patients; and

- Maintaining pertinent patient data necessary to recommend, prescribe, or modify therapeutic diets as needed to meet the nutritional needs of the patients.
  - Need a physician’s order for the therapeutic diet
  - If consulted make sure verbal order from doctor or doctor write the order
Must have dietary support staff,
HR file should document their competency,
Must follow recognized dietary practices,
Must follow national standards such as current Recommended Dietary Allowances (RDA) or the Dietary Reference Intake (DRI) of the Food and Nutrition Board of the National Research Council.
**IOM recommended dropped name of RDA in favor of DRI or dietary reference intakes,**
**“Dietary Guidelines for Americans 2011” published- www.dietaryguidelines.gov**
Menus must be nutritionally balanced,
Must meet needs of patients,
Screening criteria should be developed to identify patients at nutritional risk (usually done as part of nursing admission assessment),
Is identified as an altered nutritional status, a nutritional assessment should be performed,

All patients requiring artificial nutrition by any means (i.e., enteral nutrition (tube feeding), total parenteral nutrition, or peripheral parenteral nutrition);
Patients whose medical condition, surgical intervention, or physical status interferes with their ability to ingest, digest or absorb nutrients;
Patients whose diagnosis or presenting signs/symptoms indicates a compromised nutritional status (e.g., anorexia nervosa, bulimia, electrolyte imbalances, dysphagia, malabsorption, end stage organ diseases, etc.); and

Patients whose medical condition can be adversely affected by their nutritional intake (e.g., diabetes, congestive heart failure, patients taking certain medications, renal diseases, etc.).

Therapeutic diets must be prescribed by practitioner in writing by the practitioner responsible for patient’s care,

Documented in the MR including information about the patient’s tolerance,

Evaluate for nutritional adequacy,

Manual must be available for nursing, FS, and medical staff,

Dieticians can only make recommendations and can’t order at this time,
The P&Ps must be reviewed at least once a year,
Reviewed by group of professional personnel,
Make sure P&P are consistent with the standard of care
Cite the authority in the reference section at the end of the policy such as the AORN Perioperative Standards and Recommended Practices or ASPAN

Must provide basic services as those provided in doctor’s office or at entry of healthcare organization like an outpatient department and ED,
- Changed from Direct Services to Patient Services
- Can provide directly or under contract
Must provide diagnostic and therapeutic services and have supplies as that typically found in an ambulatory healthcare setting and a physician’s office
These services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions.
Must provide adequate services, equipment, staff, and facilities adequate to provide the outpatient services,

Must follow acceptable standards of practices such as ACR, AMA, ACOS, etc.,

OP Dept must be integrated with inpatient services such as MR, lab, radiology, anesthesia or other diagnostic services,

CAH physician or non-physician practitioner must be available to treat patients at the CAH when such outpatient services are provided

- For those outpatient services that fall only within the scope of practice of a physician or non-physician practitioner
Must provide basic lab services to include,
- Urine dipstick or tablet including urine ketones,
- Hemoglobin or hematocrit,
- Blood glucose,
- Stool for occult blood,
- Pregnancy tests,
- Primary culturing for transmittal to certified lab,
Must have these basic lab services,
Must provide emergency services 24 hours/7 days a week,
Must have current CLIA certificate and if contracted out make sure they have a CLIA certificate
Scope of services and complexity must be adequate to meet the needs of the patients,
Can be employed or contract services,
Patient lab results are medical records and must comply with the MR chapter
Must have written P&P for collecting, preserving, transport, receipt if tissue specimen results,
Interpretive Guidelines §485.635(b)(2)

Laboratory services that must be provided on-site at the CAH’s main campus are the tests specified in the regulation, which would be considered the minimum necessary for diagnosis and treatment of a patient:

- Chemical examination of urine by stick or tablet method or both (including urine ketones);
- Hemoglobin or hematocrit;
- Blood glucose;
- Examination of stool specimens for occult blood;
- Pregnancy tests; and
- Primary culturing for transmittal to a certified laboratory.

These services may be provided by the by the CAH staff or under arrangement or agreement, or through a combination of CAH staff and a laboratory under arrangement. Laboratory services, whether provided directly by the CAH or under an arrangement with a laboratory contractor, must have a current Clinical Laboratory Improvement Act (CLIA) certificate or waiver for all tests performed and meet the laboratory requirements specified in Part 493 of this chapter. Compliance with Part 493 is not assessed by CAH surveyors evaluating compliance with the CAH conditions of participation, but surveyors are expected to refer potential issues they may identify to the program responsible for CLIA certification.

Given that the CAH must provide emergency services 24 hours a day, 7 days a week, the CAH must determine which laboratory services are to be immediately available to meet the emergency needs.

- Radiology services must be provided by qualified staff,
  - Can be provided as a direct service or through a contract,
- And do not expose patients or staff to radiation hazards,
- Must have services to meet the needs of its patients at all times,
- Can offer minimal set or more complex, according to needs of the patients including nuclear medicine,
- Hospital has flexibility to decide the types and complexities of radiologic services offered
- Interpretation can be contracted out
- Diagnostic, therapeutic, and nuclear medicine, must be provided in accordance with acceptable standards of practice and must meet professionally approved standards for safety

- Scope or what you do has to be in P&Ps approved by board or responsible party,
  - Must be consistent with state law
  - If telemedicine is used must comply with telemedicine standards
- And by standards recommended by nationally recognized professions such as the AMA, Radiology Society of North America, Alliance for Radiation Safety in Pediatric Imaging, ACC, American College of Neurology, ACP, and ACR,
  - Example would be the ACR 2013 MRI safety standards and 2013 contrast manual
- P&P on adequate radiation shielding for patients, personnel and facilities which includes:
  - Shielding built into the physical plant
  - Types of personal protective shielding to use and under what circumstances
  - Types of containers to be used for radioactive materials
  - Clear signage identifying hazardous radiation area

- Labeling of all radioactive materials, including waste with clear identification of the material
- Transportation of radioactive materials between locations within the CAH;
- Security of radioactive materials, including determining who may have access to radioactive materials and controlling access to radioactive materials;
- Periodic testing of equipment for radiation hazards;
Periodic checking of staff regularly exposed to radiation for the level of radiation exposure, via exposure meters or badge tests

Storage of radio nuclides and radio pharmaceuticals as well as radioactive waste; and

Disposal of radio nuclides, unused radio pharmaceuticals, and radioactive waste,

To ensure periodic inspections of equipment,
  - Make sure problems are corrected in timely manner and have evidence of inspections and corrective actions

There must be written policies developed and approved by the medical staff to designate which radiological tests must be interpreted by a radiologist,

MR chapter standards apply

Make sure patient shielding aprons are maintained properly and inspected

Surveyor will review equipment maintenance reports (PM)

Make sure staff know P&Ps
Radiology Policies

- Supervision must include that all files, scans, and images are kept in a secure place and are retrievable,
- Written policy, consistent with state law on which personnel can operate radiology equipment and do procedures,
- Need copies of all reports and printouts,
- Written policy to ensure integrity of authentication,
- See tag 283 for required signage on hazardous radiation areas and more
Must provide medical emergency services as a first response to common life threatening injuries and acute illness,

- Emergency services can be done directly or through contracted services
- Individuals providing the services must be able to recognize a patient need for emergency care
- Must provide initial interventions, treatment, and stabilization of any patient who requires emergency services

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§485.635(c) Standard: Services Provided Through Agreements or Arrangements

(1) The CAH has agreements or arrangements (as appropriate) with one or more providers or suppliers participating under Medicare to furnish other services to its patients, including—

(5) In the case of distant-site physicians and practitioners providing telemedicine services to the CAH's patients under a written agreement between the CAH and a distant-site telemedicine entity, the distant-site telemedicine entity is not required to be a Medicare-participating provider or supplier.

Interpretive Guidelines §485.635(c)(1) & (c)(5)

All agreements for providing health care services to the CAH's patients must be with a provider or supplier that participates in the Medicare program, except in the case of an agreement with a distant-site telemedicine entity for the provision of telemedicine services. The agreements should describe routine procedures (e.g., for obtaining outside laboratory tests); and there should be evidence in the agreement or arrangement that the governing body (or responsible individual)
CAH has to have agreements with one or more providers or suppliers participating under Medicare to furnish services to patients

CMS made an exception since distant-site telemedicine entity (DSTE) is not required to be a Medicare provider

Agreements such as for obtaining outside lab tests

Must have agreement or arrangement with one or more providers or supplies participating under Medicare to provide services to patients,

Need to describe routine procedures such as for obtaining outside lab tests,

 Governing body is responsible for these services provided,

These must be evaluated thru PI and board must take action if problems occur,
CAH must have agreements with 1 or more facilities to provide care to inpatients,

Arrangement with 1 or more doctors to provide care,

If labs provide additional diagnosis and clinical lab services must be in compliance with CLIA and lab will be surveyed separately for compliance,

Arrangements for food and inpatient nutritional needs to be meet,

Surveyor will review medical records of patients transferred to make sure,

Transfer patients were accepted,

Patients referred for lab or dx tests had the tests performed,

Need to keep list of all services provided under contract or agreement,
Nursing service must meet the needs of patients,
Nursing service must be well organized service of CAH,
Must be under direction of a RN,
Nursing staff must be trained and oriented,
Adequately supervised,
Nursing personnel must know P&Ps,
CAH RN must conduct the supervision and evaluation of each non-CAH nursing staff,

Surveyor is to observe nursing care in progress,
To determine if staffing is adequate,
Will look at nursing care plans, medical records, accident and investigative reports, staff schedules, and P&P,
Will review the method for orientation and needs to include nursing P&P, emergency procedures, CAH and unit, and safety P&P,
- RN must provide the care for each patient or assign care to other personnel,
- Including SNF and swing bed patients,
- Care must be provided in accordance with patient needs,
- RN must make all patient care assignments,
- Assignments must take into consideration complexity of patient’s care,
- Will look at written staffing plans,
- Staff must be competent,
- Make sure if temporary nurses used they are oriented and supervised,

- **A RN must supervise and evaluate** the nursing care for each patient (or if state law allows a PA),
- Includes SNF level is a swing bed,
- Must evaluate the patient’s needs,
- Make sure nurses are licensed,
- Will make sure staff have yearly evaluations,
➤ All drugs and IVs are administered under the supervision of RN or MD, (or a PA if allowed by state law),
➤ Make sure all orders are signed off,
  ▪ Be sure there is signature and date and TIME the order
➤ Orders must be written with the acceptable standard of care,

➤ Drugs must be administered and prepared in accordance with the standard of care,
➤ Will review medication record to make sure consistent with doctor’s orders,
➤ Observe nurse pass meds and determine if policies followed,
➤ How do you monitor drugs and IVs for PI?
All orders must be legible, dated, TIMED, and authenticated (signed) by the practitioner responsible for care,

Includes VERBAL ORDERS,

Ordering practitioner signs off the verbal order and it must include a date and time,

VO must be used infrequently or for convenience and limited to urgent situations,

- Describe limitations or prohibitions on use of verbal orders;
- List the elements required for inclusion in a complete verbal order;
- Describe situations in which verbal orders may be used;
- List and define the individuals who may send and receive verbal orders; and
- Provide guidelines for clear and effective communication of verbal orders.
CAHs should promote a culture in which it is acceptable, and strongly encouraged, for staff to question prescribers when there are any questions or disagreements about verbal orders,

Questions about verbal orders should be resolved prior to the preparation, or dispensing, or administration of the medication,

Verbal medication orders must include:

- Name of patient; Age and weight of patient, when appropriate; date and time of the order; drug name; dosage form (e.g., tablets, capsules, inhalants), exact strength or concentration; dose, frequency, and route; quantity and/or duration; purpose or indication; specific instructions for use; and name of prescriber.
Surveyor will select a patient, review their medication orders, review documentation of medications given, and observe nurse pass drugs,

- Will look at P&P, approved by MS, as to who can pass meds and that P&Ps are followed,
- Will look to see if id band checked or the nurse calls the patient by name,
- Will check PI to see if administration of drugs is regularly monitored,
- Will ask nurses if they permitted to take telephone orders,

A verbal order must be signed off as soon as possible which would be the earlier of the following:

- The next time the prescribing practitioner provides care to the patient, assesses the patient, or documents information in the patient’s medical record, or
- The prescribing practitioner signs or initials the verbal order within time frames consistent with Federal and State law and CAH policy
- Must repeat back VO to prescriber,
- All verbal orders must immediately be commenced to writing and signed by the person receiving the order,
- VO must be documented in the medical record,
- Covering physician can sign the VO for his or her partner,
- PA or NP can not co-sign MD/DO order,
- Must include above information in your policy on verbal orders!
Must have P&P and process on visitation
  - Including any reasonable restrictions or limitations
Discusses 2004 JAMA article encouraging open visitation in the ICU
Includes inpatients and outpatients
  - Discusses role of support person for both
  - Patient may want support person present during pre-op preparation or post-op recovery

Infection control issues
Can interfere with the care of other patients
Court order restricting contact
Disruptive or threatening behavior
Room mate needs rest or privacy
Substance abuse treatment plan
Patient undergoing care interventions
Restriction for children under certain age
- Need to train staff on the P&P
- Need to determine role staff will play in controlling visitor access
- Surveyor will verify you have a P&P
- Will review policy to determine if restrictions
- Is there documentation staff is trained?
- Will make sure staff are aware of P&P on visitation and can describe the policy for the surveyor

- Must inform each patient or their support person, when appropriate, of their visitation rights
- Must include notifying patient of any restrictions
- Patient gets to decide who their visitors are
- Can not discriminate against same sex domestic partners, friend, family member etc.
- The patient gets to decide
- Support person does not have to be the same person as the DPOA
- Support person can be friend, family member or other individual who supports the patient during their stay
  - TJC calls it a patient advocate
- Support person can exercise patient’s visitation rights on their behalf if patient unable to do so

[Ask a trusted family member or friend to be your advocate (advisor or supporter).

- Your advocate can ask questions that you may not think about when you are stressed. Your advocate can also help remember answers to questions you have asked or write down information being discussed.
- Ask this person to stay with you, even overnight, when you are hospitalized. You may be able to rest better. Your advocate can help make sure you get the correct medicines and treatments.
- Your advocate should be someone who can communicate well and work cooperatively with medical staff for your best care.
- Make sure this person understands the kind of care you want and respects your decisions.
- Your advocate should know who your health care proxy decision-maker is; a proxy is a person you choose to sign a legal document so he or she can make decisions about your health care when you are unable to make your own decisions. Your advocate may also be your proxy under these circumstances. They should know this ahead of time.
- Go over the consents for treatment with your advocate and health care proxy, if your proxy is available, before you sign them. Make sure you all understand exactly what you are about to agree to.
- Make sure your advocate understands the type of care you will need when you get home. Your advocate should know what to look for if your condition is getting worse. He or she should also know who to call for help.

www.jointcommission.org/speak_up_help_prevent_errors_in_your_care/
- Hospital must accept patient’s designation of an individual as a support person
  - Either orally or in writing
  - Suggest you get it in writing from the patient

- When patient is incapacitated and no advance directives on file then must accept individual who tells you they are the support person
  - Must allow person to exercise and give them notice of patients rights and exercise visitation rights

- Hospital expected to accept this unless two individuals claim to be the support person then can ask for documentation
  - This includes same sex partners, friends, or family members
  - Need policy on how to resolve this issue

- Any refusal to be treated as the support person must be documented in the medical record along with specific reason for the refusal
- Patient can withdraw consent and change their mind
- Must document in the medical record that the notice was given
- Surveyor is to look at the standard notice of visitation rights
- Will review medical records to make sure documented
- Will ask staff what is a support person and what it means

- Must have written P&P
- Must not restrict visitors based on race, color, sex, gender identity, sexual orientation etc.
- In other words, if a unit is restricted to two visitors every hour the patient gets to pick their visitors not the hospital
- Suggest develop culturally competent training programs
Nursing care plan must be developed and kept current on all inpatients,

Starts on admission and includes discharge planning,

Nursing care plans should include all pertinent information and is based on assessment,

Must be kept as part of the medical record,

Plan must describe goals, discharge planning, physiological and psychosocial factors,
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