Wednesday August 5th, 2015

Avoiding Legal Hazards in Documentation:
CMS and TJC Requirements for Hospitals and Nurses

Speaker

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Objectives

- Identify ways to improve documentation to reduce the risk of liability.
- Explain the importance of and what should be documented in the medical record.
- Explain the specific requirements for documenting orders.
- Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate compliance requirements and penalties.

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Documentation

The following will be discussed:

- Legal Issues and regulatory issues
  - CMS Hospital CoP Regulations (Centers for Medicare and Medicaid Services)
  - Joint Commission (TJC Standards and no longer called JCAHO)
- Clinical Issues, Standards of Care, Legal, Risk Management, Patient Safety and other standards
- Tips important to be incorporated into fields as all hospitals follow the trend to computerized records

Charting Bloopers

- The patient refused an autopsy.
- She is quite hard of hearing. In fact, she can't hear at all in the left eye.
- He went to see the chef of surgery.
- Between you and me, we ought to be able to get this lady pregnant.
- The pelvic exam will be done later on the floor.
- Patient was seen in consultation by Dr. Blank, who felt we should sit on the abdomen and I agree.

Charting Bloopers

- For his impotence we will discontinue the meds and let his wife handle him,
- He was advised to force fluids through his interpreter,
- I have suggested that he loosen his pants before standing, and then, when he stands with the help of his wife, they should fall to the floor.
- Source: http://www.medleague.com/Articles/humor/charting_orders.htm

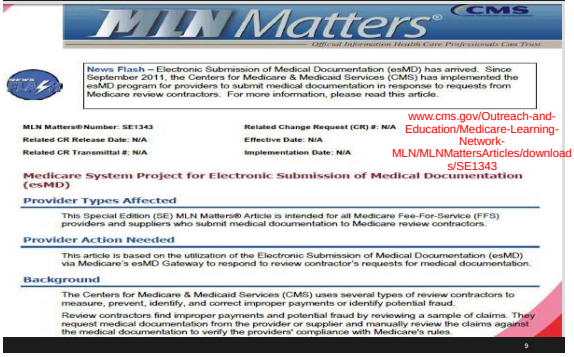
Why Document?

- Documentation is one of the best ways to keep you out of the courtroom,
  - Along with good PR and communication,
- Medical records often serve a variety of purposes such as business and evidentiary purposes and as business records,
- Primary purpose is to document care and services provided to patients for patient care,
- There are other reasons to document besides keeping you out of the courtroom,

Other Reasons to Document

- They are important to defend yourself in a malpractice suit if you do get sued,
- To maintain your nursing and medical license,
- Charting for dollars so you can be reimbursed by payers
  - CMS has Hospital Acquired Conditions and 29 NQF Never Events
  - CMS has two midnight rule (which is delayed at present) so can document intent to stay on inpatient admission statement form to comply with documentation requirements

CMS Requests Documentation



MLN Matters®

CMS

Official Information Health Care Professionals Can Trust

News Flash – Electronic Submission of Medical Documentation (esMD) has arrived. Since September 2011, the Centers for Medicare & Medicaid Services (CMS) has implemented the esMD program for providers to submit medical documentation in response to requests from Medicare review contractors. For more information, please read this article.

MLN Matters® Number: SE1343 | Related Change Request (CR) #: N/A

Related CR Release Date: N/A | Effective Date: N/A

Related CR Transmittal #: N/A | Implementation Date: N/A

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1343

Medicare System Project for Electronic Submission of Medical Documentation (esMD)

Provider Types Affected

This Special Edition (SE) MLN Matters® Article is intended for all Medicare Fee-For-Service (FFS) providers and suppliers who submit medical documentation to Medicare review contractors.

Provider Action Needed

This article is based on the utilization of the Electronic Submission of Medical Documentation (esMD) via Medicare's esMD Gateway to respond to review contractor's requests for medical documentation.

Background

The Centers for Medicare & Medicaid Services (CMS) uses several types of review contractors to measure, prevent, identify, and correct improper payments or identify potential fraud.

Review contractors find improper payments and potential fraud by reviewing a sample of claims. They request medical documentation from the provider or supplier and manually review the claims against the medical documentation to verify the providers' compliance with Medicare's rules.

Other Reasons to Document

- Need order for admission, certification and the factors that lead to the two-midnight expectation
- To prevent claims of fraud and abuse, especially with the OIG and the RAC (recovery audit contractors),
- To maintain accreditation status
  - Like TJC, AOA (HFAP), DNV Healthcare, CMS, CIHQ, NCQA, CAP, COLA, AAAHC, AAAASF, CIHQ, et al.,

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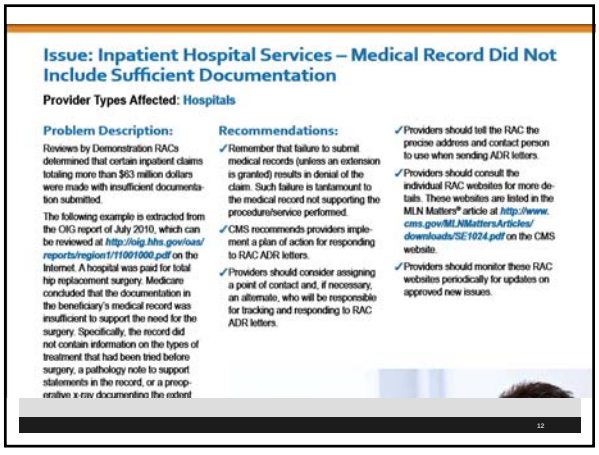
Why Document?

- Used as a criteria for credentialing for physicians and LIPs,
- Improves patient care such as use in QAPI and in peer review process,
- Improved continuity of care,
- To show compliance with CMS CoPs for validation or complaint survey or TJC survey or other accreditation organization survey,
- To show compliance with regulations in case of an OIG audit, insurance audit, HIPAA or other audit



Issue: Inpatient Hospital Services – Medical Record Did Not Include Sufficient Documentation

Provider Types Affected: Hospitals

Problem Description:

Reviews by Demonstration RACs determined that certain inpatient claims totaling more than $63 million dollars were made with insufficient documentation submitted.

The following example is extracted from the OIG report of July 2010, which can be reviewed at *http://oig.hhs.gov/oas/reports/region1/11001000.pdf* on the Internet. A hospital was paid for total hip replacement surgery. Medicare concluded that the documentation in the beneficiary's medical record was insufficient to support the need for the surgery. Specifically, the record did not contain information on the types of treatment that had been tried before surgery, a pathology note to support statements in the record, or a preop-erative x-ray documenting the extent

Recommendations:

- ✓Remember that failure to submit medical records (unless an extension is granted) results in denial of the claim. Such failure is tantamount to the medical record not supporting the procedure/service performed.
- ✓CMS recommends providers implement a plan of action for responding to RAC ADR letters.
- ✓Providers should consider assigning a point of contact and, if necessary, an alternate, who will be responsible for tracking and responding to RAC ADR letters.
- ✓Providers should tell the RAC the precise address and contact person to use when sending ADR letters.
- ✓Providers should consult the individual RAC websites for more details. These websites are listed in the MLN Matters® article at *http://www.cms.gov/MLNMattersArticles/downloads/SE1024.pdf* on the CMS website.
- ✓Providers should monitor these RAC websites periodically for updates on approved new issues.

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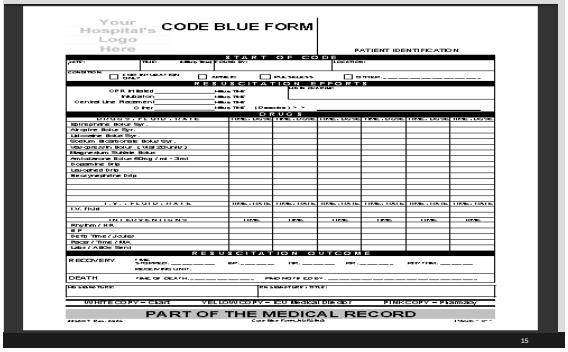
Documentation

- The court held “where a doctor did not make any notations in the medical records of a woman in labor, the jury could concur no monitoring was done.” (Wagner v. Kaiser Foundation Hospital),
  - Thus the saying, “If wasn’t documented, it wasn’t done.”
- Another court warned the hospital and nurses that the availability and accuracy of the medical records is not a mere technicality, it is a requirement
  - It is a legal requirement (Valcin v. Public Health Trust of Dade County),

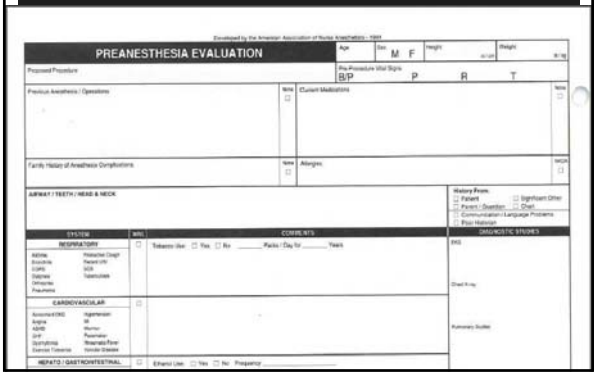
Documentation

- Can you introduce standardized forms and flowcharts to create a routine for documenting a patient’s clinical status or RRT or during a code,
  - Stamps, stickers, or electronic form to place in the medical record for specific issues such as certification of false labor or stopping or changing antiretroviral therapy,
  - Modify forms for H&P to add check boxes such as updating information when admitted for elective surgery,
- Incorporate required information into fields so do not have to rely on memory,
- Incorporate legislative requirements regarding documentation,

Code Blue Form



Pre-anesthesia Assessment Evaluation


PREANESTHESIA EVALUATION

Common Charting Pointers

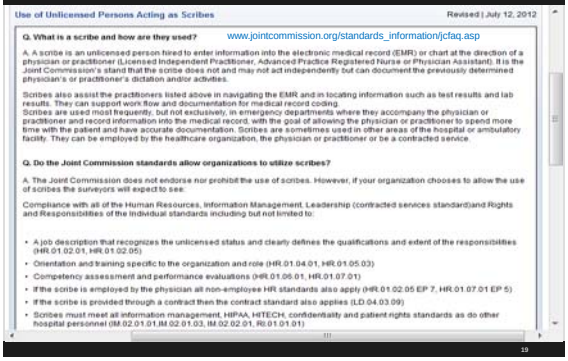
Fading memories;

- Need to preserve evidence,
- Most practitioners have no independent recollection of the patient,
- So the only thing to defend yourself is what is documented in the medical record!
- Have checklists that are helpful to get information documented timely,

Common Charting Pointers

- Write legibly and non-erasable,
  - Illegible writing can cause medication and other medical errors,
  - Creates problems in defending any malpractice case,
  - Destroys credibility of witness who is embarrassed when you can't read your own writing,
  - Print if handwriting is not legible or use CPOE,
  - Can use a **scribe** but scribe must document and sign, date and time and physician immediately under this with signature, date and time also,
  - Scribed for Dr. X by name of the scribe and title with the date and time of the entry and then doctor signs

TJC FAQ on UAP as Scribes



Use of Unlicensed Persons Acting as Scribes — Revised | July 12, 2012

Q. What is a scribe and how are they used? www.jointcommission.org/standards_information/jcfaq.asp

A. A scribe is an unlicensed person hired to enter information into the electronic medical record (EMR) or chart at the direction of a physician or practitioner (Licensed Independent Practitioner, Advanced Practice Registered Nurse or Physician Assistant). It is the Joint Commission's stand that the scribe does not and may not act independently but can document the previously determined physician's or practitioner's dictation and/or activities.

Scribes also assist the practitioners listed above in navigating the EMR and in locating information such as test results and lab results. They can support work flow and documentation for medical record coding.
Scribes are used most frequently, but not exclusively, in emergency departments where they accompany the physician or practitioner and record information into the medical record, with the goal of allowing the physician or practitioner to spend more time with the patient and have accurate documentation. Scribes are sometimes used in other areas of the hospital or ambulatory facility. They can be employed by the healthcare organization, the physician or practitioner or be a contracted service.

Q. Do the Joint Commission standards allow organizations to utilize scribes?

A. The Joint Commission does not endorse nor prohibit the use of scribes. However, if your organization chooses to allow the use of scribes the surveyors will expect to see:

Compliance with all of the Human Resources, Information Management, Leadership (contracted services standard)and Rights and Responsibilities of the Individual standards including but not limited to:

- A job description that recognizes the unlicensed status and clearly defines the qualifications and extent of the responsibilities (HR.01.02.01, HR.01.02.05)
- Orientation and training specific to the organization and role (HR.01.04.01, HR.01.05.03)
- Competency assessment and performance evaluations (HR.01.06.01, HR.01.07.01)
- If the scribe is employed by the physician all non-employee HR standards also apply (HR.01.02.05 EP 7, HR.01.07.01 EP 5)
- If the scribe is provided through a contract then the contract standard also applies (LD.04.03.09)
- Scribes must meet all information management, HIPAA, HITECH, confidentiality and patient rights standards as do other hospital personnel (IM.02.01.01,IM.02.01.03, IM.02.02.01, RI.01.01.01)

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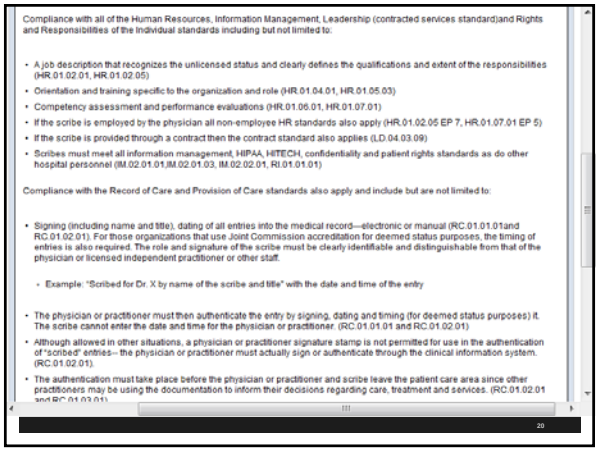

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Compliance with the Record of Care and Provision of Care standards also apply and include but are not limited to:

- Signing (including name and title), dating of all entries into the medical record—electronic or manual (RC.01.01.01and RC.01.02.01). For those organizations that use Joint Commission accreditation for deemed status purposes, the timing of entries is also required. The role and signature of the scribe must be clearly identifiable and distinguishable from that of the physician or licensed independent practitioner or other staff.
  - Example: "Scribed for Dr. X by name of the scribe and title" with the date and time of the entry
- The physician or practitioner must then authenticate the entry by signing, dating and timing (for deemed status purposes) it. The scribe cannot enter the date and time for the physician or practitioner. (RC.01.01.01 and RC.01.02.01)
- Although allowed in other situations, a physician or practitioner signature stamp is not permitted for use in the authentication of "scribed" entries-- the physician or practitioner must actually sign or authenticate through the clinical information system. (RC.01.02.01).
- The authentication must take place before the physician or practitioner and scribe leave the patient care area since other practitioners may be using the documentation to inform their decisions regarding care, treatment and services. (RC.01.02.01 and RC.01.03.01)

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Legibility

- If illegible, author should rewrite the entry on the next available line or at side by on order sheet directly after verifying order with prescribe,
  - Also make note in nursing notes,
- Illegible if 2 or more can not read it,
- Define what entry is for referring back to,
- Part of TJC medication tracer is that staff know policy of what to do if entry is illegible,
- Need P&P and make sure staff know what to do if illegible entry,

Legibility Forms Checklists

- Example: Clarified entry of February 1, 2015 and rewrite entry, date, and sign,
  - If nurse has to call to clarify order, then document beside entry such as "clarified order with Dr Jones that it is Lasix 20 mg IV stat/ S Dill RN 8:00 Feb 1, 2015
- Use of encounter forms, checklists, flow-sheets, computerized assisted documentation for high volume activities can save time and reduce miscommunication and errors caused by illegible handwriting,
- CMS Hospital CoP requires legibility and not as common now since most use CPOE and EMR

Legibility

- Can use a scribe for really terrible handwriting
  - They then review and sign, date and time (not considered a verbal order)
  - Then physician immediately reviews and signs, dates, and **times** the entry
  - TJC has FAQ on use of scribes as discussed previously
- If illegible, author should rewrite the entry on the next available line or at side by on order sheet directly
  - Also, make note in nursing notes
  - Important because nurse often clarified but if only wrote in nursing notes not read and errors occurred

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Common Charting Pointers

- Record the date and time of care given;
- Make sure the correct date appears on every page,
  - Correct patient name on every page,
  - Every entry needs date and time (CMS and TJC),
  - Including exact time of assessment and time medication given,
- No block charting, like slept well 11pm-7 am, or 7-3 had a good day,
- Do not skip lines or leave blanks between entries,
- Entries should be in chronological order,

Common Charting Pointers

Record the name of the care giver,

- All entries in the medical records must be signed or authenticated by the person so you can determine who wrote every entry
  - Also a TJC and CMS requirement,
- Important to defend cases to identify who wrote what entry in the medical record,
- AHA showed patient safety issue that during patient safety walk abouts could not tell who wrote the order,
  - CMS requires physician signatures to be legible now

Objective Documentation

- Chart the facts, do not speculate,
  - Strong odor of alcohol noted on patient's breath, gait unsteady, speech slurred, pupils dilated to 7 mm, blood alcohol level is 2.0
- Avoid the use of personal opinion,
  - Do not say "patient is obviously intoxicated"
- Document what you see, touch, and smell,
- Use permanent black or blue ink and not felt pens or pencils in paper records,

Objective Documentation

- Be specific and create a picture in your mind if you were to review your charting from 6 months,
  - Patient has IV 1000 cc of 0.9% NaCl running at 125 cc/hr in right hand IV without redness or edema
  - Foley is draining clear yellow urine
  - Patient has 4.0 cm laceration over distal right thumb that is jazzed, edematous, and draining a large amount of yellow purulent drainage
- If using computerized documentation use the narrative to create the picture,

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Objective Documentation

- Documentation should be accurate, true and honest,
- Reflective of observations not of unfound conclusions, value judgments or labeling,
- Retrievable,
- Timely and completed only during or after care,
- Avoid duplication of information in the medical record,
- Avoid “appears to” or “seems to” when describing observations with some exceptions,

Chart all Nursing Actions

- The nurse and physician should chart everything that has been done for the patient in addition to taking a pertinent history and charting the assessment done,
  - Document presence of pressure ulcer and consider picture on admission
  - Make sure physician documents or no reimbursement for treatment if Medicare patients to show not a HAC in order to show patient had it arrival and did not get it in the hospital
- Documentation should be complete record of nursing care provided,
  - It should include assessments, identification of health issues, plan of care, implementation and evaluation.

Chart All Nursing Actions

- Chart everything being done for the patient,
  - Nurses should document IV site, solution hanging, is IV on pump, foley catheter and what is draining, presence of NG tube and verify placement, dressings, assessments, skin assessment on admission and periodically as indicated by patients condition, fall assessment, later two at least every 24 hours and more frequently if indicated, etc.
  - TJC has a Record of Care chapter which includes what must be documented in an admission assessment
  - Consider nurse driven protocol for timely removal of foley catheters

Chart all Nursing Actions Plan of Care

- Failure to chart the plan of care is a frequent CMS and TJC problematic standard
- Need to have a plan of care (POC) and in writing
- Needs to be started soon after admission and updated
- Do not need separate nursing POC if nurse participates in interdisciplinary POC and it is complete
- Need to keep copy in the medical record after discharge
- CMS made changes to the rehab plan of care

Plan of Care

- Exact format for plan of care varies slightly from place to place
- Generally include nursing diagnosis or problem list, goals and outcome criteria, nursing orders, and evaluation
  - North American Nursing Diagnosis Organization-International (NANDA-I) says nursing diagnosis is used to define the right plan of care for the patient and drives interventions and patient outcomes
- Provides standard nomenclature for EMR
- CMS says must involve patient in plan of care

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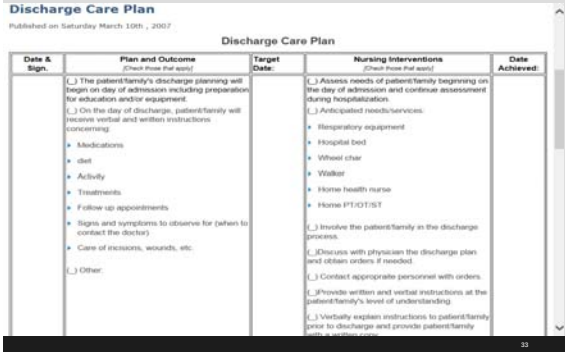
Discharge Care Plan



Discharge Care Plan

Published on Saturday March 10th , 2007

Discharge Care Plan

Date & Sign.	Plan and Outcome [Check those that apply]	Target Date:	Nursing Interventions [Check those that apply]	Date Achieved:
	(_) The patient/family's discharge planning will begin on day of admission including preparation for education and/or equipment. (_) On the day of discharge, patient/family will receive verbal and written instructions concerning: • Medications • diet • Activity • Treatments • Follow up appointments • Signs and symptoms to observe for (when to contact the doctor) • Care of incisions, wounds, etc. (_) Other:		(_) Assess needs of patient/family beginning on the day of admission and continue assessment during hospitalization. (_) Anticipated needs/services: • Respiratory equipment • Hospital bed • Wheel chair • Walker • Home health nurse • Home PT/OT/ST (_) Involve the patient/family in the discharge process. (_)Discuss with physician the discharge plan and obtain orders if needed. (_) Contact appropriate personnel with orders. (_)Provide written and verbal instructions at the patient/family's level of understanding. (_) Verbally explain instructions to patient/family prior to discharge and provide patient/family with a written copy.	

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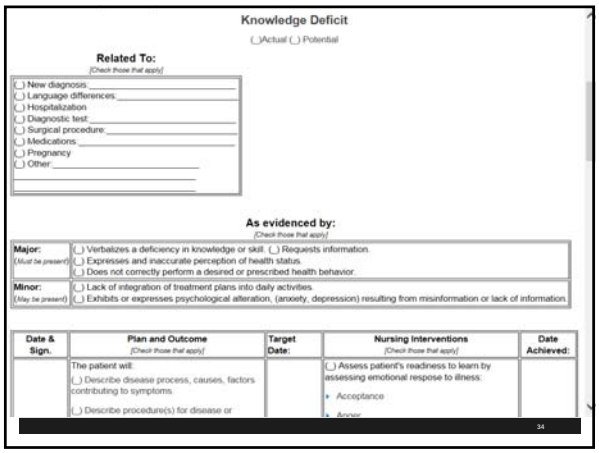

Knowledge Deficit

(_)Actual (_) Potential

Related To:

[Check those that apply]

(_) New diagnosis:_____
(_) Language differences:_____
(_) Hospitalization
(_) Diagnostic test:_____
(_) Surgical procedure:_____
(_) Medications:_____
(_) Pregnancy
(_) Other:_____

As evidenced by:

[Check those that apply]

Major: *(Must be present)*	(_) Verbalizes a deficiency in knowledge or skill. (_) Requests information. (_) Expresses and inaccurate perception of health status. (_) Does not correctly perform a desired or prescribed health behavior.
Minor: *(May be present)*	(_) Lack of integration of treatment plans into daily activities. (_) Exhibits or expresses psychological alteration, (anxiety, depression) resulting from misinformation or lack of information.

Date & Sign.	Plan and Outcome *[Check those that apply]*	Target Date:	Nursing Interventions *[Check those that apply]*	Date Achieved:
	The patient will: (_) Describe disease process, causes, factors contributing to symptoms. (_) Describe procedure(s) for disease or		(_) Assess patient's readiness to learn by assessing emotional respose to illness: ▸ Acceptance ▸ Anger	

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Rehab Services Plan of Care CMS 1134

- Standard: The provision of care and the personnel qualifications must be in accordance with national acceptable standards of practice and must also meet the following requirements which sets forth what must be in the plan of care*.*
- Need an order first
- Then need to develop a plan of care
- This includes physical therapy, occupational therapy, and speech-language pathology
- Discusses establishing a plan, content and changes

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Establishing a Plan of Care 1134

- The plan must be established before treatment begins by one of the following:
  - (1) A physician
  - (2) A nurse practitioner, a clinical nurse specialist or a physician assistant
  - (3) The physical therapist furnishing the physical therapy services
  - (4) A speech-language pathologist furnishing the speech-language pathology services
  - (5) An occupational therapist furnishing the occupational therapy services

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RAC and Documentation Issues

- The CMS Recovery Audit Contractor (RAC) program is now operating in every state
  - They review charts and look to determine if the care rendered in certain cases are medically necessity to look for improper payments
  - Importance of documentation to show medical necessity
  - Some of the approved medically necessity reviews included chest pain, syncope & collapse, RBC disorders, heart failure & shock, COPD, esophagitis, gastroenteritis, therapy services, and Misc digestive disorders

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Visitation Rights for All Patients

- CMS had issued 34 page memo on visitation based on the federal law
  - Applies to all hospitals that accept Medicare and Medicaid reimbursement
  - This includes all critical access hospitals
  - Discusses patient advocate or support person and gives them specific rights
  - Made changes not to visitation but also to advance directives, plan of care, informed consent, notification requirements, attestation requirements and more

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CMS Visitation Transmittal

CMS Manual System
Pub. 100-07 State Operations
Provider Certification
Transmittal 78

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Date: December 2, 2011

SUBJECT: Revised Appendix A, Interpretive Guidelines for Hospitals, and Appendix W, Interpretive Guidelines for Critical Access Hospitals (CAHs)

I. SUMMARY OF CHANGES: Clarification is provided for existing hospital regulations 42 CFR 482.13(a) and (b), and new regulations 42 CFR 482.13(h), concerning hospital patients' rights, including visitation rights. Clarification is provided for existing CAH regulations at 42 CFR 485.635(a), concerning compliance with Federal laws and regulations, including regulations governing advance directives and required patient disclosures. Guidance is provided for new 42 CFR 485.635(f), concerning CAH patients' visitations rights.

NEW/REVISED MATERIAL - EFFECTIVE DATE: December 2, 2011
IMPLEMENTATION December 2, 2011

The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: *(N/A if manual not updated.)*
(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Appendix A (482.13(a) Standard: Patient's Rights-A-0111
R	Appendix A (482.13(b) Standard: Exercise of Rights-A-0116
R	Appendix A (482.13(b) Standard: Exercise of Rights-A-0131
R	Appendix A (482.13(b) Standard: Exercise of Rights-A-0132
R	Appendix A (482.13(b) Standard: Exercise of Rights-A-0133
N	Appendix A (482.13(h) Standard: Patient Visitation Rights-A-0115
N	Appendix A (482.13(h) Standard: Patient Visitation Rights-A-0116
R	Appendix W (485.635(a) Standard: Compliance With Federal Laws and Regulations-A-0131
N	Appendix W (485.635(f) Standard: Patient Visitation Rights-C-1000
N	Appendix W (485.635(f) Standard: Patient Visitation Rights-C-1001
N	Appendix W (485.635(f) Standard: Patient Visitation Rights-C-1002

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2011 operating budgets.

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/index.html?redirect=/Transmittals/01_overview.asp

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Notification of Attending Doctor and Family

- Requires that staff ask patients about the following two when admitted (CMS 133)
- If they want a family member notified of their admission
- If they want primary care physician notified
  - If physician is same let patient know their physician has been notified
  - Must document both in the medical record with date and time and method of notification

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Patient Visitation Rights

- All hospitals would have to inform all patients of their visitation rights in **writing** in advance of care furnished
  - Should give all patients a written copy of their rights
- This includes the right to decide who may and may not visit them
- Some hospitals may give a one page sheet to each patient upon admission
- Could have also brochure in admission packet and document during admission assessment also

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CMS Visitation Interpretive Guidelines

- Give patients advance directive P&P information to all inpatients, ED, observation, and same day surgery patients
  - Document in chart and suggest you have patient sign that they receive them
- Make sure staff are trained in the visitation policy and document in their HR file
- Must inform each patient of their visitation rights and any restrictions (CMS 215)
  - You want to put this in writing and have the patient sign that they have received this information

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CMS Visitation Guidelines

- Ask the patient who is competent if they have a patient representative (PR) or support person
  - If yes document this
  - Suggest that you get it in writing and not just orally
  - Patient representative could be a support person (patient advocate/visitation advance directive), parent for a child, guardian, or DPOA for a patient who is incapacitated
  - If they have a patient representative then you must **also** give a copy of the patient rights to the patient representative in addition to the patient (117)

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CMS Visitation Guidelines

- If patient is incapacitated then give a copy of the patient rights to the DPOA or other similar document and document in the medical record
- If patient is incapacitated and no AD on file then give patient rights to who ever asserts they are the spouse, domestic partner, parent for minor child, or other family member who becomes the patient representative
  - Document this process
  - No prohibition on having them sign attestation
  - Can not demand supporting documentation unless two people show up claiming to be the patient representative unless state law specifies

44

CMS Visitation Interpretive Guidelines

- A refusal by the hospital of an individual's request to be treated as a patient representative must be documented in the medical record as well as the refusal (117)
- Must give Medicare patients a copy of their IM notice and have them sign, date, and time form
  - If discharged and more than two days when they received a copy must give them another copy and have them sign it
- Must involve patient representative in the plan of care even if patient is competent (130)

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Physician Ownership

- If physician owned hospital must put in it writing and have patient sign it (131)
- Physicians who send patients in from their office must also notify patients of ownership
  - Hospital must have medical staff bylaws or polices on this as a condition for credentialing them
- If physician owned but no physicians refer to their hospital then sign an attestation that it has no referring physicians with an ownership or investment interest in the hospital

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TJC Record of Care Chapter

- Emergency treatment given prior to arrival
- Progress notes
- Medications ordered or prescribed
- Plan of care and revisions
- Orders for tests and procedures
- Medication dispensed upon discharge
- Advance directives
- Informed consent

47

TJC Record of Care Chapter

- Records of communication including telephone calls or emails
- Patient generated information
- ED patients records include
  - Time and means of arrival
  - If patient left AMA
- Conclusions reached at termination of care such as final disposition, conditions, discharge instructions

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RC Chapter Topics

- RC also called the documentation chapter
- H&P
- Verbal orders
- Summary list by third outpatient visit
- Discharge information RC.02.04.01
- Operative or high risk procedures and use of moderate sedation under RC.02.01.03
- Unanticipated outcomes and disclosure

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Correct Spelling

- Spelling errors can diminish credibility of witness,
- Consult dictionary if unsure of correct spelling of word or use spell check with EHR systems,
- Or use spell check on the computerized charting
- Nurse documented "The patient vominited x1 appears to contan much gren flim aftar taking aspirn."
- Plaintiff attorney put on overhead screen and had her read this to the jury

Make Sure Status is Documented

- When a patient needs to stay in the hospital the nurse needs to make sure the right status is documented
- The order needs to be correctly written such as
  - Place patient in outpatient observation bed and give information so patient understands this is observation
  - Inpatient: Place patient in inpatient bed on 3 tower
- Need to certify the reasons services medically required & documented in H&P, order and progress note
  - Physician certification signed PRIOR to discharge

51

Kardexes and Work Sheets

- Kardexes and worksheets may be in paper or electronic form,
  - These are used to coordinate the care to be provided,
  - They are a communication tool used to convey current orders and upcoming tests,
  - Shred temporary worksheets when done since contains protected health information (PHI),
  - Information can be erasable as long as permanent medical records reflect nursing assessment and care provided,
  - If Kardex is only document of the patient's care plan then it must be retained,

Documenting for Others

- Document only procedures you have done,
- Person who saw the event or performed the action should document it to show accountability for actions,
- Documentation of care given by others,
  - There are exceptions to the rule to have a designated documenter (codes, supervisor starts IV, etc),
  - May be other special circumstances that are appropriate,

Documenting for Others

- Nurse assists another nurse in providing care it is acceptable for one nurse to document action and responses,
- Critical incident such as a fall or a code where one person may document the episode,
- Recording nurse should make sure that the name of the person is clearly identified so information is clearly attributed to the source,

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Charting on the Wrong File

- Simply draw a line through it if a paper record,
- Mark “wrong chart” with your initials,
- Correct notation can be made above the entry if one word or below if longer,
- Do not use white out or liquid fluid correction,
- Do not erase or obliterate entry,
- Be aware of your facility’s policy,
- If computerized charting then also follow your P&P,

Charting after Complaint is Filed

- Do not alter or update existing documentation after legal claim is filed such as a lawsuit,
- Practitioners can tell story when deposition is taken,
- Can review incident report if one created to refresh memory,
  - Do not write in chart if incident report is written
  - Do record instances in medical record
- Facility should consider making a copy of the chart and locking it up and any copies are produced from copies (Formatting for electronic records can look different when reprinted).

Late Entries

- If the day nurse forgets to chart do not leave her or him a space,
- Late entries should be identified as such so mark it as a late entry,
- Write down the date and time the care was rendered and the time of the documentation,
  - Same for electronic records
- Be aware of your facility’s policy,

Know Your Hospital P&P

ADMINISTRATIVE POLICY MANUAL

SUBJECT: MEDICAL RECORD DOCUMENTATION PRACTICES

POLICY NUMBER: IM10

POLICY

For purposes of this policy, Pennsylvania Hospital includes all off campus licensed facilities, including but not limited to the Surgery Center of Pennsylvania Hospital.

Medical record entries shall be documented in a manner that meets the requirements of the legal and regulatory agencies with jurisdiction over the Hospital and the Joint Commission accrediting standards. The medical record, whether paper or electronic, shall be free from inadvertent or intentional alterations. There shall be no change or deletion whatsoever of recorded data in the medical record. Entries shall be made only by users who are authorized to document within the medical record. Authorized users shall provide clear and legible documentation of the patient's condition according to all guidelines.

PURPOSE

The purpose of this policy is to identify the personnel who are authorized to document in the medical record and to outline guidelines for medical record entries including corrections, alterations, legibility, late entries and addenda.

PROCEDURE

AUTHORIZED USERS:

Persons who may document in the medical record include the following:

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GENERAL ENTRIES

- Entries in the medical record shall be continuous with no blank pages, lines or spaces. A line shall be drawn to the end of the page when an entry does not fill the page.
- Entries shall be made in permanent black ink (preferred) or blue ink. Using other colors is discouraged. Pencil may not be used.
- All entries must be in chronological order. All entries shall be dated, timed and signed at the time the entry is written. Signatures shall include credentials. Each electronic entry shall be individually authenticated by use of user identification and password.
- Symbols and abbreviations may be used only if approved by the Medical Records Committee. Abbreviations on the "Dangerous Abbreviations" List are not to be used.
- The attending Professional Staff appointee for each patient shall be responsible for the preparations and completion of the medical record. However, he/she can countersign history and physical examinations written by a member of the House Staff. He/she does not have to countersign progress notes, treatment orders or other entries written by House Staff in accordance with the Professional Staff Rules and Regulations.
- The patient's name must appear on every page or document that contains patient information.
- All entries must be legible.

CORRECTIONS AND ALTERATIONS

- Corrections shall be done in a manner that does not obliterate the original entry. Use of white-out is not permitted. No erasure or eradication is permitted. If an error has been made, a single line shall be drawn through the error, labeled as an error, the correction made, dated and initialed.
- Pages of medical records shall not be removed, torn out or cut. Any actions which may be construed as tampering with the record must be avoided.
- Patient requests to amend records shall be handled in accordance with the Hospital's "Patient's Right to Request Amendment of their Protected Health Information (HIP3)" policy.

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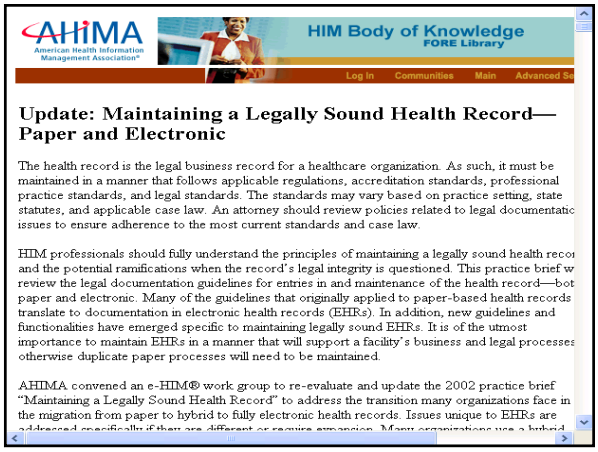
Amendments

- An amendment is a type of late entry that is used to provide additional information,
- A previous note has been made and the addendum provides additional information to address a specific situation or incident,
- Write addendum and state reason for addendum,
  - Example: Unanticipated outcome and disclosure made but physician did not document and Risk Management reminds doctor of hospital policy to document conversation (TJC requirement)
- Refer back to original entry,
- Complete as soon as possible after original note,

Amendments

- If electronic record can link to original or symbol to show amendment.
  - ASTM and HL7 have standards related to amendments.
- Source: AHIMA Maintaining Legally Sound Health Record
- There is also a section in HIPAA that allows patients to file an amendment in the medical record,
- Patient has the right to request that medical record be amended or corrected if inaccurate or incomplete.



HIPAA Amendment

- Hospital can refuse if information is accurate or not created by that facility,
- HIPAA law requires a process for denying or granting the request,
  - Hospital must have a P&P on this
- Have to give written statement if you deny request,
- Have to tell them how to file a statement of disagreement which must be disclosed when information is disclosed,
- Just easier to allow an amendment and just add the piece of paper to the medical record.

HIPAA Law Updated Sept 23, 2013

- Referred to as the 563 Page Omnibus HIPAA Rule or the "Long Awaited Mega Rule"
- HHS's Office of Civil Rights (OCR) published the final regulations on January 17, 2013
- The official notice was filed in the Federal Register (FR) on January 25, 2013
  - 78 FR 5566 and available at www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- Effective March 26, 2013 but compliance for covered entities (like a hospital) is Sept 23, 2013
  - Except grandfathered BAs which is Sept 23, 2014

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HIPAA Law Changes

- OCR has taken kids gloves off on HIPAA and many high fines so need to make sure you do this right
- Changes were made to the following four sections:
  - HIPAA Privacy rules
  - HIPAA Security rules
  - HITECH rule (Health Information Technology for Economic and Clinical Health)
  - GINA (Genetic Information Nondiscrimination Act of 2008)

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HIPAA Law FR January 25, 2013

www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf

FEDERAL REGISTER

Vol. 78 Friday,
No. 17 January 25, 2013

Part II

Department of Health and Human Services

Office of the Secretary
45 CFR Parts 160 and 164
Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules; Final Rule

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CMS Privacy & Confidentiality Memo

- CMS issues memo to hospitals regarding HIPAA on March 2, 2012 which hospitals should be aware
- Discusses privacy & confidentiality consistent with HIPAA
- Discusses incidental uses and disclosures
- Combines tag 441, 442, and 442 and amends 143 and 147 in the hospital CoP manual
  - Allows name on spine of chart
  - Allows name on outside of patient room
  - Allows signs such as fall risk or diabetic diet

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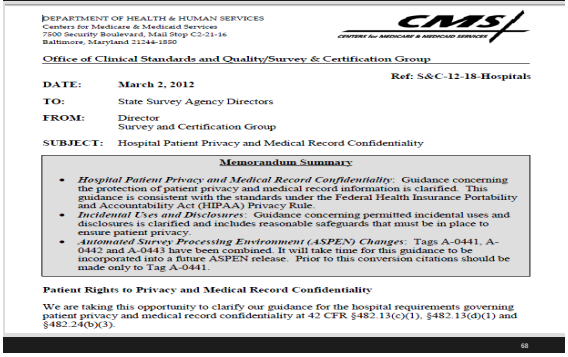
CMS Privacy & Confidentiality Memo



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-12-18-Hospitals

DATE: March 2, 2012

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Hospital Patient Privacy and Medical Record Confidentiality

Memorandum Summary

- ***Hospital Patient Privacy and Medical Record Confidentiality***: Guidance concerning the protection of patient privacy and medical record information is clarified. This guidance is consistent with the standards under the Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.
- ***Incidental Uses and Disclosures***: Guidance concerning permitted incidental uses and disclosures is clarified and includes reasonable safeguards that must be in place to ensure patient privacy.
- ***Automated Survey Processing Environment (ASPEN) Changes***: Tags A-0441, A-0442 and A-0443 have been combined. It will take time for this guidance to be incorporated into a future ASPEN release. Prior to this conversion citations should be made only to Tag A-0441.

Patient Rights to Privacy and Medical Record Confidentiality

We are taking this opportunity to clarify our guidance for the hospital requirements governing patient privacy and medical record confidentiality at 42 CFR §482.13(c)(1), §482.13(d)(1) and §482.24(b)(3).

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Signing your Chart Properly

- Generally the nurse's first initial and last name,
- Include professional designation or title such as RN or LPN, (CMS)
- Consider drawing lines through any blank spaces,
- Do not write in margins,
- Do not skip lines or leave blanks between the entries,
- If computerized medical record use electronic signature.

Standing Orders CMS Tag 450

- Need an order for all drugs and biologicals
- Order must be documented and signed by a practitioner who is authorized to write orders as allowed by hospital policy and state law,
- Standing order or written protocol be sure nurse writes in in order sheet so doctor can sign later,
  - Code drugs are given,
  - Emergency department gives Atrovent and albuterol treatment for asthma attack,
  - Nurse in ED starts an IV for chest pain patient,
  - See also 405, 406, and 457

Preprinted Order Sheets CMS Tag 450

- If 3 pages doctor or prescriber needs to indicate on the last page the total number of pages in the order set,
  - So write page 3 of 3 orders,
  - If wants to delete or strike out something in the order sheet must initial each one,
  - Includes any additions to the order sheet,
- Must be dated, signed and timed,
- May want to audit this,
- Be sure to let the physicians know about this in memo or in meetings.

Standing Orders CMS Tag 457 2013

- CMS issues new tag number 457 on standing orders
  - Must be for well defined scenarios
- Standard: hospitals can use preprinted and electronic standing orders, order sets, and protocols for patient orders only if the hospital has the following 4 things:
- Must be approved by MEC in conjunction with nursing and pharmacy leadership
- Must be consistent with nationally recognized standards of care and practice

Standing Orders

- Must review periodically to make sure they are still current and useful
- Make sure you don't just order trauma protocol without the specific orders listed in detail so if 20 things in protocols should all be listed
- Ensure that the standing orders are dated, timed, and authenticated by the ordering physician or other practitioner responsible for the care of the patient
  - As long as practitioner is acting in accordance with state law, Scope of practice, Hospital P&P and MS bylaws and R/R

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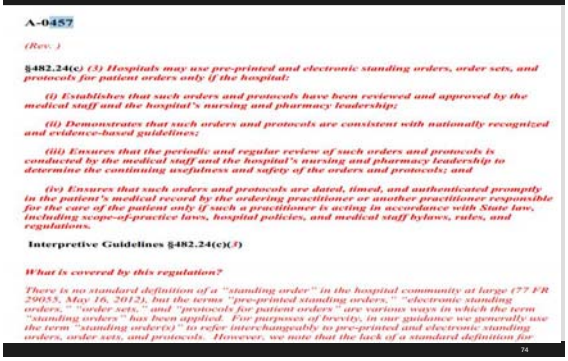
Final IGs on Standing Orders



A-0457

(Rev.)

§482.24(c) *(3) Hospitals may use pre-printed and electronic standing orders, order sets, and protocols for patient orders only if the hospital:*

(i) Establishes that such orders and protocols have been reviewed and approved by the medical staff and the hospital's nursing and pharmacy leadership;

(ii) Demonstrates that such orders and protocols are consistent with nationally recognized and evidence-based guidelines;

(iii) Ensures that the periodic and regular review of such orders and protocols is conducted by the medical staff and the hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the orders and protocols; and

(iv) Ensures that such orders and protocols are dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or another practitioner responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

Interpretive Guidelines §482.24(c)(3)

What is covered by this regulation?

There is no standard definition of a "standing order" in the hospital community at large (77 FR 29053, May 16, 2012), but the terms "pre-printed standing orders," "electronic standing orders," "order sets," and "protocols for patient orders" are various ways in which the term "standing orders" has been applied. For purposes of brevity, in our guidance we generally use the term "standing order(s)" to refer interchangeably to pre-printed and electronic standing orders, order sets, and protocols. However, we note that the lack of a standard definition for

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Co-signing Entries

- Co-signing entries made by other care providers is not a standard of care and can blur accountability,
- But there are some recognized exceptions,
  - Co-signing the disposal of a narcotic to show nurse witnessed it,
  - Co-signing to verify high risk medications such as heparin or insulin check,
  - Co-signing for student to show that nursing instructor reviewed the entry to show agreement with the entry or for unlicensed assistive personnel,
- Have a policy to provides for clear written expectations for when and if these co-signatures are required,

Flow Charts and Flow Sheets

- Flow sheets can be helpful to ensure all actions get documented into the medical record,
- Generally, should be supplemented with some type of narrative charting,
- Whether paper or computerized system,
- Good way to ensure the elements of a full assessment are done,
- Can use TJC and CMS required elements to the computerized screen or paper record

Common Charting Pointers

Record all pertinent information;

- Chart all allergies and the reaction,
- Chart medication reconciliation and list of meds to patient upon discharge,
- Chart current medications, doses, frequency, reason for taking,
- Chart pertinent history,
- Document appropriate assessment, interventions, and evaluation of outcomes,

Common Charting Pointers

- Document what another practitioner in same position would consider important,
  - What would a triage nurse document in the emergency department to comply with the ENA standards,
  - What would the PACU nurse document to comply with the ASPAN documentation standards,
  - What would the nurse in the operating room chart to comply with the AORN guidelines for perioperative standards,
  - Document advance directives the patient has on admission and put copies in the chart
  - Document pain assessment and reassessment

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Generalizations

- Avoid generalizations and vague expressions:
- Chart should contain meaningful information,
- Use specific language in the medical record,
- Phases like “ate fair, patient doing well, confused, anxious, status quo, usual day, up and about, having a good day” are useless,
- Unless you follow up with specific examples,
- Want entries to be factual and descriptive,
- Important to maintain credibility in the courtroom.

Common Charting Pointers

- Informed consent discussions
  - CMS, TJC RI.01.03.01, and state law requirements,
- Description of pertinent patient behaviors such as missed appointments or failure to follow recommendations,
- Complete AMA form with risks
  - EMTALA requirement
- Document problem list for office and clinic settings by third visit and use a form for this,
- Follow up referral for test consult

Documenting Telephone Orders

- The difference between telephone orders and verbal orders (discussed later),
- If nurse takes an order over the phone it is a verbal order by CMS and TJC
- How to document telephone orders,
- Document specific information given to physician and time when you talk to them on the phone,
- Document interventions and follow up,
- Example: Dr. Smith was called at office and informed that the WBC is 26,000. Orders received.

Telephone Nursing Care

- Nurses who provide telephone care are required to document the telephone interaction (TJC),
- Generally, ED nurses should not provide telephone advise to patients who have not been seen,
  - Nurse may call back ambulatory surgery patients,
  - Anesthesia may need information to call back if outpatient not seen postoperatively (CMS regulations),
- Should document in the medical record,
- Some situations such as OB department, may need to document encounter in a log book if no medical record.

Telephone Nursing Care

- P&P should address this issue,
- Document date and time of call and information about person,
- Document reason for the call and assessment of needs, follow up,
  - Nurse calls patient who was discharged from the ED with results of positive cultures such as chlymidia
- Document any advise given,
- If calling post op patients get their permission in advance and verify number to call them at,

Interpreter

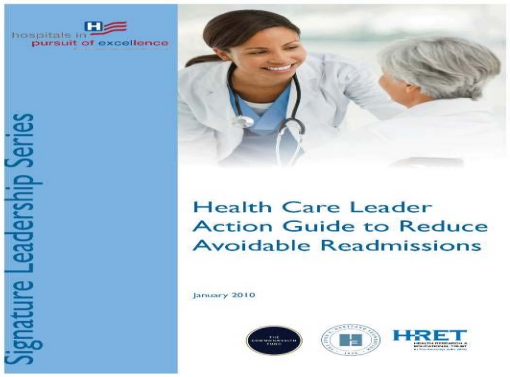
- Document that patient does not speak English or is hearing impaired (deaf),
- Document the presence of the qualified interpreter,
  - If language bank or web based system or what ever system is used, document time and identity of interpreter,
- Document name and arrival of interpreter,
- Patients have a right to a qualified interpreter (CMS, Civil Rights Law),
- TJC standards on patient centered communication including document age and ethnicity

Observation or Inpatient Status

- Every patient who is going to stay in the hospital needs the correct status,
  - An order for observation should read “place in observation status”,
  - Inpatient order should read “admit as an inpatient”,
  - Date and time order,
  - Can still have chest pain, CHF, or asthma as diagnostic requirement,
- There are other qualifying diagnosis (ED visit or clinic visit and other diagnosis and not surgery)

Discharge Instructions and Summary

- Important to take action to prevent hospital readmissions
  - 1 out of every five Medicare patients are readmitted within 30 days (17% in 2015)
  - CMS also rewrites all of the discharge planning hospital standards July 19, 2013
  - CMS has final discharge planning worksheet
- Hospitals need to have physician dictate discharge summary when patient discharged and get it into the hand of the primary care physician
- 1 www.hret.org/care/projects/guide-to-reduce-readmissions.shtml



Discharge Planning

- CMS issues 39 page memo
- Revises discharge planning standards
- Includes advisory practices to promote better patient outcomes called blue boxes
  - Only suggestions and will not cite hospitals
- The discharge planning CoPs have been reorganized
- A number of tags were eliminated
  - The prior 24 standards have been consolidated into 13

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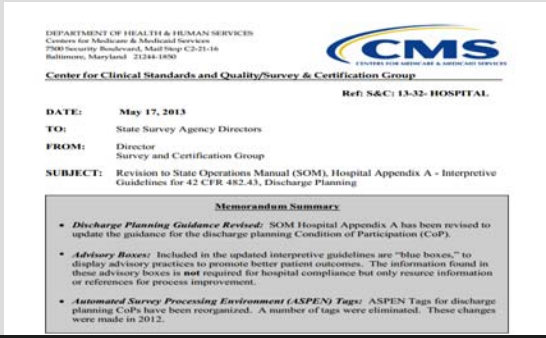
Discharge Planning Revisions



DEPARTMENT OF HEALTH & HUMAN SERVICES
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Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-32- HOSPITAL

DATE: May 17, 2013

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Revision to State Operations Manual (SOM), Hospital Appendix A - Interpretive Guidelines for 42 CFR 482.43, Discharge Planning

Memorandum Summary

- ***Discharge Planning Guidance Revised:*** SOM Hospital Appendix A has been revised to update the guidance for the discharge planning Condition of Participation (CoP).
- ***Advisory Boxes:*** Included in the updated interpretive guidelines are "blue boxes," to display advisory practices to promote better patient outcomes. The information found in these advisory boxes is **not** required for hospital compliance but only resurce information or references for process improvement.
- ***Automated Survey Processing Environment (ASPEN) Tags:*** ASPEN Tags for discharge planning CoPs have been reorganized. A number of tags were eliminated. These changes were made in 2012.

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Discharge Instructions

- Document in writing in plain language discharge instructions and document repeat back or read back,
  - Remember the issue of low health literacy and 1 out of every 5 patients read at a sixth grade level,
- Include activity level, medications and education on medications, potential drug food interactions and follow up information,
- Keep copies of all written discharge instructions
- Document what instructions sheets are provided to patient; suture, care of fractures, crutch instructions, medication educational sheets,

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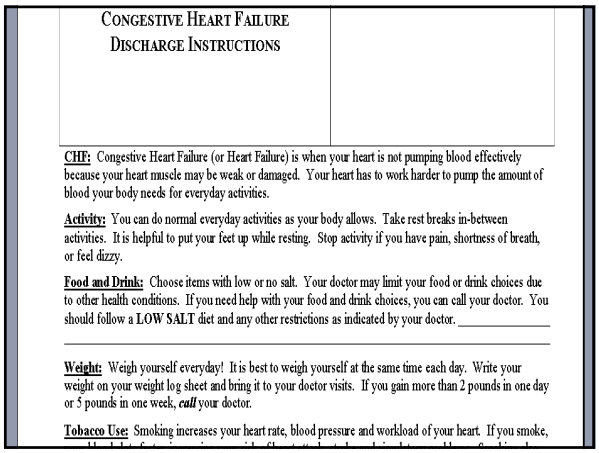

CONGESTIVE HEART FAILURE
DISCHARGE INSTRUCTIONS

CHF: Congestive Heart Failure (or Heart Failure) is when your heart is not pumping blood effectively because your heart muscle may be weak or damaged. Your heart has to work harder to pump the amount of blood your body needs for everyday activities.

Activity: You can do normal everyday activities as your body allows. Take rest breaks in-between activities. It is helpful to put your feet up while resting. Stop activity if you have pain, shortness of breath, or feel dizzy.

Food and Drink: Choose items with low or no salt. Your doctor may limit your food or drink choices due to other health conditions. If you need help with your food and drink choices, you can call your doctor. You should follow a **LOW SALT** diet and any other restrictions as indicated by your doctor. _____

Weight: Weigh yourself everyday! It is best to weigh yourself at the same time each day. Write your weight on your weight log sheet and bring it to your doctor visits. If you gain more than 2 pounds in one day or 5 pounds in one week, ***call*** your doctor.

Tobacco Use: Smoking increases your heart rate, blood pressure and workload of your heart. If you smoke,

Discharge Instructions

- Make sure discharge instructions are specific
  - For example, discharging a patient with CHF,
  - Document that brochure on CHF was given (make sure you examine contents before use, put copy in MR or specific reference to it),
  - Document patient received CHF patient education handout which provided patient information on diet, exercise, weight monitoring, and what to do if symptoms worsen and this was discussed with patient,
- Document adequate discharge instructions on six areas (TJC does a tracer);
  - Discharge medications, diet, activity level, follow up, weight monitoring, and what to do if heart failure symptoms worsen,

Discharge Instructions

- Make the appointment for the patient's first post hospital visit
- Ensure that that primary care physician has a copy of the discharge summary or medical record information before the first visit
  - If no appointment set then within 7 days
- CMS has added this to the discharge planning worksheet
- Studies show that 78% of all patient who went for first post hospital visit no discharge summary was available

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Admission Assessment

- Need to have a comprehensive admission assessment
- This can help assess what is needed to provide an appropriate discharge for patient
  - Includes things such as activities of daily living, fall risk, risk of developing a pressure ulcer (such as a Norton or Braden), allergies to medication and food, past medical history, immunization status, history of smoking or alcohol use, family history, activity level, functional assessment etc.
- TJC has provision of care chapter (PC)which includes many things that must be in admission assessment

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Assessment and Reassessment PC.01.02.01

- EP1 The scope and content of screening, assessment and reassessment must be defined in writing
  - Consider obtaining information from the family or care givers with the patient's permission and check medical jewelry
  - Assessment includes the patient's perception of how well the medications are working and any side effects
- EP2 Criteria needs to be developed to determine when a more in-depth assessment needs to be performed
  - Criteria could include if a functional, nutritional, or pain assessment needs to be done for patients at risk

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Assessment and Reassessment PC.01.02.01

- EP3 Include criteria that identifies when nutritional plans are developed
  - Nurse does admission assessment and look at nutritional issues and may need to consult a dietician
  - Also references PC that says nutritional screen by nurse must be done within 24 hours (or shorter time frame if hospital policy says)
- EP4 Initial information that needs to be obtained, based on the patients condition includes the following:

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Assessment and Reassessment PC.01.02.01

- Physical, psychological and social assessment
- Nutritional and hydration status, and functional status
- Spiritual, social, and cultural issues for patients receiving end of life care
- Assessment of these will help identify factors and possible barriers to the patients reaching their goals
- Will help determine social barriers including cultural and language barriers as reflected in the patient centered care standards

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Assessment and Reassessment PC.01.02.01

- References RC.02.01.01 EP 2 The medical record must contain certain information like allergies to food, allergies to medications, initial diagnosis, diagnostic impression, findings of the assessments, H&P, consult notes, adverse drug reactions, treatment goals, any medications administered,
- The medical record must also include the strength, dose, and route, any access site for medication, administration devices used, and rate of administration, plan of care and revisions to plan of care, results of all tests, discharge diagnosis and plan etc.

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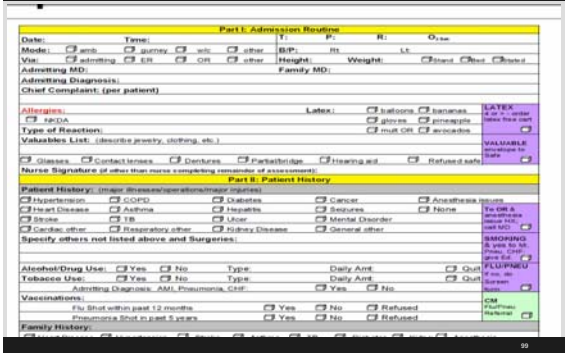
Nurses Admission Assessment



Part I: Admission Routine

Date: Time: T: P: R: O_{2sat}

Mode: ☐ amb ☐ gurney ☐ wlc ☐ other B/P: Rt Lt

Via: ☐ admitting ☐ ER ☐ OR ☐ other Height: Weight: ☐ Stand ☐ Bed ☐ Seated

Admitting MD: Family MD:

Admitting Diagnosis:

Chief Complaint: (per patient)

Allergies: Latex: ☐ balloons ☐ bananas ☐ gloves ☐ pineapple ☐ NKDA ☐ mult OR ☐ avocados

LATEX

Type of Reaction:

Valuables List: (describe jewelry, clothing, etc.)

VALUABLE envelope to Safe

☐ Glasses ☐ Contact lenses ☐ Dentures ☐ Partial/bridge ☐ Hearing aid ☐ Refused safe

Nurse Signature (if other than nurse completing remainder of assessment):

Part II: Patient History

Patient History: (major illnesses/operations/major injuries)

☐ Hypertension ☐ COPD ☐ Diabetes ☐ Cancer ☐ Anesthesia issues

☐ Heart Disease ☐ Asthma ☐ Hepatitis ☐ Seizures ☐ None

To OR & anesthesia if not ok call MD

☐ Stroke ☐ TB ☐ Ulcer ☐ Mental Disorder

☐ Cardiac other ☐ Respiratory other ☐ Kidney Disease ☐ General other

Specify others not listed above and Surgeries:

SMOKING & yes to hx Pneu, CHF, give flu

Alcohol/Drug Use: ☐ Yes ☐ No Type: Daily Amt: ☐ Quit

FLU/PNEU If no, do Screen Apply

Tobacco Use: ☐ Yes ☐ No Type: Daily Amt: ☐ Quit

Admitting Diagnosis: AMI, Pneumonia, CHF ☐ Yes ☐ No

Vaccinations:

CM Flu/Pneu Referral

Flu Shot within past 12 months ☐ Yes ☐ No ☐ Refused

Pneumonia Shot in past 5 years ☐ Yes ☐ No ☐ Refused

Family History:

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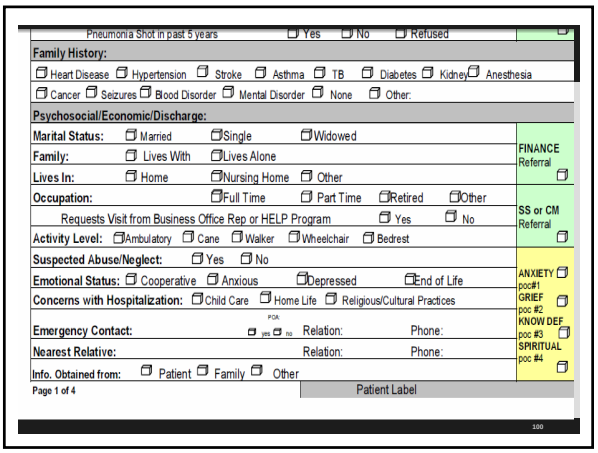

Pneumonia Shot in past 5 years ☐ Yes ☐ No ☐ Refused

Family History:

☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Asthma ☐ TB ☐ Diabetes ☐ Kidney ☐ Anesthesia
☐ Cancer ☐ Seizures ☐ Blood Disorder ☐ Mental Disorder ☐ None ☐ Other:

Psychosocial/Economic/Discharge:

Marital Status: ☐ Married ☐ Single ☐ Widowed
Family: ☐ Lives With ☐ Lives Alone
Lives In: ☐ Home ☐ Nursing Home ☐ Other
Occupation: ☐ Full Time ☐ Part Time ☐ Retired ☐ Other
Requests Visit from Business Office Rep or HELP Program ☐ Yes ☐ No
Activity Level: ☐ Ambulatory ☐ Cane ☐ Walker ☐ Wheelchair ☐ Bedrest
Suspected Abuse/Neglect: ☐ Yes ☐ No
Emotional Status: ☐ Cooperative ☐ Anxious ☐ Depressed ☐ End of Life
Concerns with Hospitalization: ☐ Child Care ☐ Home Life ☐ Religious/Cultural Practices
Emergency Contact: POA ☐ yes ☐ no Relation: Phone:
Nearest Relative: Relation: Phone:
Info. Obtained from: ☐ Patient ☐ Family ☐ Other

FINANCE Referral ☐
SS or CM Referral ☐
ANXIETY poc#1 ☐
GRIEF poc #2 ☐
KNOW DEF poc #3 ☐
SPIRITUAL poc #4 ☐

Page 1 of 4 Patient Label

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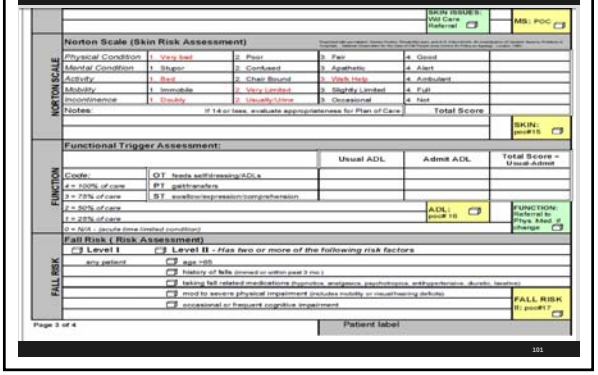
Functional Assessment



SKIN ISSUES: Wd Care ☐ Referral ☐ MS: POC ☐

Norton Scale (Skin Risk Assessment)

NORTON SCALE					
Physical Condition	1. Very bad	2. Poor	3. Fair	4. Good	
Mental Condition	1. Stupor	2. Confused	3. Apathetic	4. Alert	
Activity:	1. Bed	2. Chair Bound	3. Walk Help	4. Ambulant	
Mobility:	1. Immobile	2. Very Limited	3. Slightly Limited	4. Full	
Incontinence	1. Doubly	2. Usually/Urine	3. Occasional	4. Not	

Notes: If 14 or less, evaluate appropriateness for Plan of Care Total Score

SKIN: poc#15 ☐

Functional Trigger Assessment:

FUNCTION		Usual ADL	Admit ADL	Total Score = Usual-Admit
Code:	OT feeds self/dressing/ADLs			
4 = 100% of care	PT gait/transfers			
3 = 75% of care	ST swallow/expression/comprehension			
2 = 50% of care			ADL: poc# 16 ☐	FUNCTION: Referral to Phys. Med if change ☐
1 = 25% of care				
0 = N/A - (acute time limited condition)				

Fall Risk (Risk Assessment)

☐ Level I ☐ Level II - *Has two or more of the following risk factors*

FALL RISK	
any patient	☐ age >65
	☐ history of falls (immed or within past 3 mo.)
	☐ taking fall related medications (narcotics, analgesics, psychotropics, antihypertensive, diuretic, laxatives)
	☐ mod to severe physical impairment (includes inability or visual/hearing deficits)
	☐ occasional or frequent cognitive impairment

FALL RISK R: poc#17 ☐

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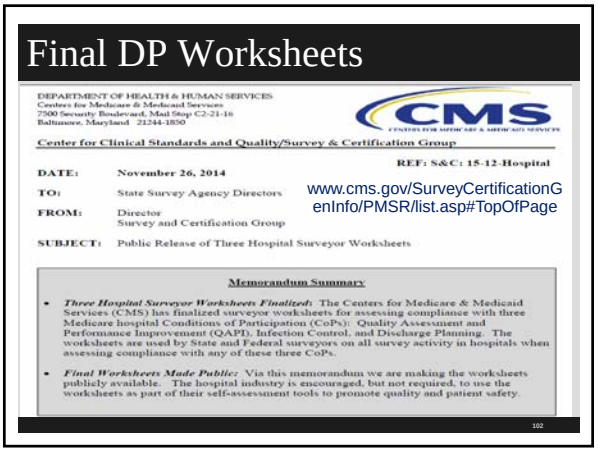
Final DP Worksheets



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: 15-12-Hospital

DATE: November 26, 2014
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group
SUBJECT: Public Release of Three Hospital Surveyor Worksheets

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

Memorandum Summary

- ***Three Hospital Surveyor Worksheets Finalized:*** The Centers for Medicare & Medicaid Services (CMS) has finalized surveyor worksheets for assessing compliance with three Medicare hospital Conditions of Participation (CoPs): Quality Assessment and Performance Improvement (QAPI), Infection Control, and Discharge Planning. The worksheets are used by State and Federal surveyors on all survey activity in hospitals when assessing compliance with any of these three CoPs.
- ***Final Worksheets Made Public:*** Via this memorandum we are making the worksheets publicly available. The hospital industry is encouraged, but not required, to use the worksheets as part of their self-assessment tools to promote quality and patient safety.

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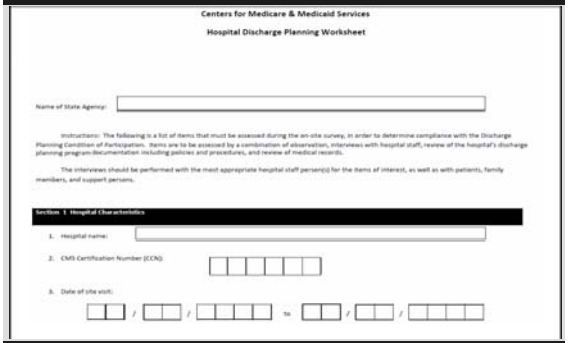
Final Discharge Planning Evaluation Tool


Centers for Medicare & Medicaid Services

Hospital Discharge Planning Worksheet

Name of State Agency:

Instructions: The following is a list of items that must be assessed during the on-site survey, in order to determine compliance with the Discharge Planning Condition of Participation. Items are to be assessed by a combination of observation, interviews with hospital staff, review of the hospital's discharge planning program documentation including policies and procedures, and review of medical records.

The interviews should be performed with the most appropriate hospital staff person(s) for the items of interest, as well as with patients, family members, and support persons.

Section 1 Hospital Characteristics

1. Hospital name:
2. CMS Certification Number (CCN):
3. Date of site visit: / / to / /

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CMS Discharge Checklist

- CMS website recommends the discharge planning team use a checklist to make transfer more efficient
- The discharge planning one finally revision made in November 26, 2014
- Previously research showed the value of hospital discharge planners using a discharge checklist
- We need to dictate the discharge summary immediately when the patient is discharged
- We need to document that it is in the hands of the family physician

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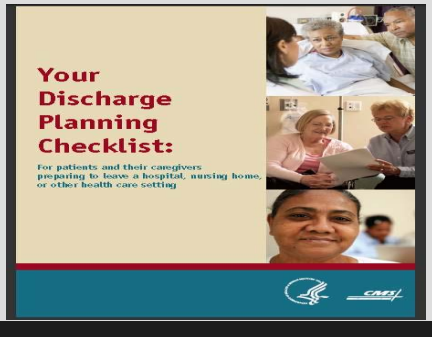
CMS Your Discharge Planning Checklist



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Things to Consider

- Form a committee on redesigning the discharge process
- Do a literature search and pull articles
- Look at the different transition studies that have been done and which ones have been successful
  - Care Transition, Transition of Care, RED, Guided care, H2H, IHI Transforming Care at the Bedside, STAAR, Boost, GRACE, Interact, Evercare, etc.
- Have physician dictate discharge summary as soon as patient is discharge
- Hospitals needs to get it into the hands of the primary care physician and document this in the chart

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Things to Consider

- Medical staff should dictate what needs to be in the discharge summary beyond what CMS and TJC require
- Hospital should schedule all follow up appointments with practitioners for the patients
- Hospital should put in writing for the patient and in the discharge summary
  - Any tests that are pending that are not back yet
  - Any future tests and these should be scheduled before the patient leaves the hospital

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Things to Consider

- Use a discharge checklist for staff to use
  - Pa Patient Safety Authority has one called “Care at Discharge” at http://patientsafetyauthority.org/EducationalTools/PatientSafetyTools/Pages/home.aspx
  - Society of Hospital Medicine has one at www.hospitalmedicine.org/AM/Template.cfm?Section=Quality_Improvement_Tools&Template=/CM/ContentDisplay.cfm&ContentID=8363
- Give patients a copy of the CMS checklist “Your Discharge Planning Checklist” at www.cfmc.org/caretransitions/patient_resources.htm or www.Medicare.gov
- Give a list of medications with times and reason for taking

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Things to Consider

- Ensure education on all new meds and use teach back to ensure education and give information in writing
- Ensure patient is given a copy of the plan of care
- Give patient in writing their diagnosis and written information about their diagnosis
- Have patient repeat back in 30 seconds understanding of their discharge instructions
- Includes symptoms that if they occur what you want to do and who to call

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Things to Consider

- Call back all patients discharged and review information and reinforce discharge instructions
- Have a call back number that patients and families can use 24 hours a day, seven days a week
- Reconciling the discharge plan with national guidelines and critical pathways when relevant
- Assess your hospital's readmission rate
- Pull charts and review for any patient who is readmitted within 30 days
- CMS revised worksheet says make follow up appt and make sure discharge summary to PCP before first appointment

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Medication List RED Program

What medicines do I need to take?

Each day, follow this schedule:

Morning Medicines			
Medicine name (generic and name brand) and amount	Why am I taking this medicine?	How much do I take?	How do I take this medicine?

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Appointments for Follow Up

When are my next appointments?

Day	Date
Time asdfasdf	
Doctor's name	Specialty
Address	
Reason for appointment	
Doctor's phone number	

Questions for my appointment

Check any of the boxes below and write notes to remember what to discuss with your doctor.

I have questions about:

- ☐ My medicines
- ☐ My test results
- ☐ My pain
- ☐ Feeling stressed

Other questions or concerns

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Document Outstanding Labs or Tests

Outstanding Labs or Tests

Are any lab tests/studies pending? ☐ yes ☐ no ☐ unknown

PENDING LAB TEST/STUDIES

Lab test/ study name	Date done	Name of clinician to review/location	Day/Date subject will see clinician to discuss results?
1.		Same as PCP	Same as PCP
2.			
3.			

Some tests have been done while you have been in the hospital, but the results are not yet ready. A (test/study name) was done on (date of test/study). (Name of PCP) will review the results and discuss them with you during your appointment.

Depending on the results of your lab test(s)/studies, your doctor might adjust your treatment. We just talked about your scheduled appointment with (name of PCP). It is very important that you see your doctor on (date/time to see PCP) to find out if anything needs to be done or changed as a result of these tests. Again, if there is anything you don't understand or you are having trouble making an appointment, please call me. If I am not there, leave a message and we will call you back.

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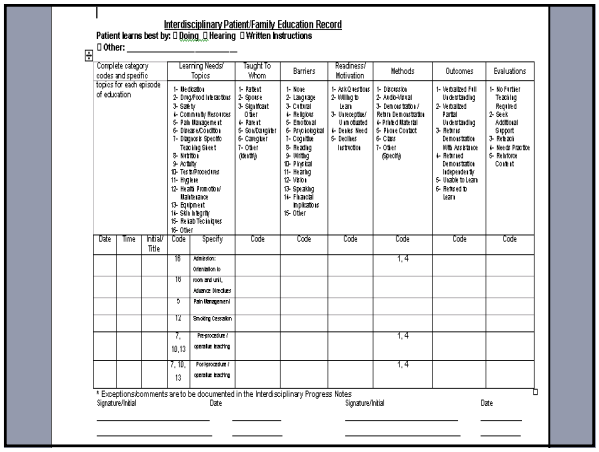
Document Patient Education

Document as appropriate:

- Big issue with TJC (PC.02.03.01),
- Training is based on patient's need,
- Patient's learning needs must be assessment,
- Assessment including cultural and religious,
- Includes desire and motivation to learn,
- Includes barriers to communication and physical or cognitive limitations,
- Multi disciplinary,

Document Patient Education

- Includes, based on condition, explanation of plan of care,
- Basic health practices and safety,
- Education on safe use of medications and medical equipment,
- Nutritional interventions,
- Discussion of pain, pain assessment and how to manage,
- Information on oral health,
- What teaching is done,



Interdisciplinary Patient/Family Education Record

Patient learns best by: ☐ Doing ☐ Hearing ☐ Written Instructions

☐ Other: _____

Complete category codes and specific topics for each episode of education			Learning Needs/ Topics	Taught To Whom	Barriers	Readiness/ Motivation	Methods	Outcomes	Evaluations
			1- Medication 2- Drug/Food Interactions 3- Safety 4- Community Resources 5- Pain Management 6- Disease/Condition 7- Diagnostic Specific Teaching Sheet 8- Nutrition 9- Activity 10- Tests/Procedures 11- Hygiene 12- Health Promotion/ Maintenance 13- Symptoms 14- Skin Integrity 15- Rehab Techniques 16- Other	1- Patient 2- Spouse 3- Significant Other 4- Parent 5- Son/Daughter 6- Caregiver 7- Other (Identify)	1- None 2- Language 3- Cultural 4- Religious 5- Emotional 6- Psychological 7- Cognitive 8- Reading 9- Writing 10- Physical 11- Hearing 12- Vision 13- Speaking 14- Financial limitations 15- Other	1- Aware/Motivated to Learn 2- Willing to Learn 3- Unreceptive/ Unmotivated 4- Denies Need 5- Declined Instruction	1- Discussion 2- Audio-Visual 3- Demonstration / Return Demonstration 4- Printed Material 5- Phone Contact 6- Class 7- Other (Specify)	1- Verbalized Full Understanding 2- Verbalized Partial Understanding 3- Return Demonstration With Assistance 4- Return Demonstration Independent 5- Unable to Learn 6- Referred to Learn	1- No Further Teaching Required 2- Seek Additional Support 3- Refuses 4- Needs Practice 5- Reinforce Content
Date	Time	Initial/ Title	Code	Specify	Code	Code	Code	Code	Code
			16	Admission: Orientation to room and unit, Alliance Brochure			1, 4		
			5	Pain Management					
			12	Smoking Cessation					
			7, 10,13	Pre-procedure / operative teaching			1, 4		
			7, 10, 13	Post-procedure / operative teaching			1, 4		

* Exceptions/comments are to be documented in the Interdisciplinary Progress Notes

Signature/Initial _____ Date _____ Signature/Initial _____ Date _____

_____ _____ _____ _____

Document Patient Education

- Education on rehab,
- Document handouts, videos, or other teaching material used,
- Document ability of patient or family to do the care,
- Document patient and family's understanding of the information,
- **Teach back** where patient can repeat back the information,

Patient Noncompliance

- Important to clearly document when patients are non compliant because of contributory/comparative negligence laws,
- Use as an educational opportunity,
- Document importance of why the patient is noncompliant, and document risks discussed,
- Be specific and do not use judgmental language such as patient is non-compliant but patient reminded to keep right foot elevated and ice bag on same

Charting Promptly

- Chart as soon as possible,
- Timely recording of nursing care helps to reduce likelihood of forgetting important information,
- Important to communicate information to others,
- Timelines of entries is critical to admissibility in courtroom,
- Entries need to be timely for continuity of care and to prevent medical errors from occurring,
  - Nurse told by mother later she removed ticks from both boys, didn't document until after first child died,

Change in Condition

- Every change should be clearly document until patient stable,
  - Monitor and report changes promptly such as excessive blood loss, changes in vital signs and pulse oximetry etc.
- Ensure timely notification of practitioner and document same,
- Document orders followed,
- Documentation of follow through is critical,
  - Hospital recognizes and responses to changes in a patient's condition. TJC PC.02.01.19

Never Document Ahead of Time

- Can subject to loss of licensure,
  - LTC nurse documented medications she intended to give and got sick and went home and Board of Nursing disciplined,
- Care should be document while being done or after care in provided but never before,
- Can be embarrassing especially if patient is deceased and documentation in record,
  - Nurse documented patient resting comfortably at 7am when died at 6:30am
- Can compromise integrity of the chart,

Medications

- Medication errors are the most common type of medical error in healthcare,
- Transcribe orders carefully,
- Medication reconciliation is important and document home med list and then list on admission,
- Document complete information about medications,
- Question order if not clear,
- Teams to reduce medication errors,

Medications

- Bar coding with eMar can reduce errors in the administrative stage by 40%,
- CMS has many CoPs on medications
  - CMS requires meds to be given within **3 time frames** and do PI to ensure timely administration (Tag 405)
- TJC has medication management chapter and medication reconciliation standard in NPSG
- Document important issues such as site of injection, if medication held, adverse reaction to medications, time medication administered etc.
  - Have a safe injection policy and use single dose when available
  - Multi-dose vials for one patient if possible

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TJC Medication Reconciliation 7-1-2011

NPSG.03.06.01

Maintain and communicate accurate patient medication information.

Elements of Performance for NPSG.03.06.01

1. Obtain information on the medications the patient is currently taking when he or she is admitted to the hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications.
   Note 1: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications.
   Note 2: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.
2. Define the types of medication information to be collected in non–24-hour settings and different patient circumstances.
   Note 1: Examples of non–24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings.
   Note 2: Examples of medication information that may be collected include name, dose, route, frequency, and purpose.
3. Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies.
   Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the hospital, does the comparison. (See also HR.01.06.01, EP 1.)
4. Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose).
   Note: When the only additional medications prescribed are for a short duration, the medication information the hospital provides may include only those medications. For more information about communications to other providers of care when the patient is discharged or transferred, refer to Standard PC.04.02.01.
5. Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.
   Note: Examples include instructing the patient to give a list to his or her primary care physician; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. (For information on patient education on medications, refer to Standards MM.09.01.03, PC.02.03.01, and PC.04.01.05.)

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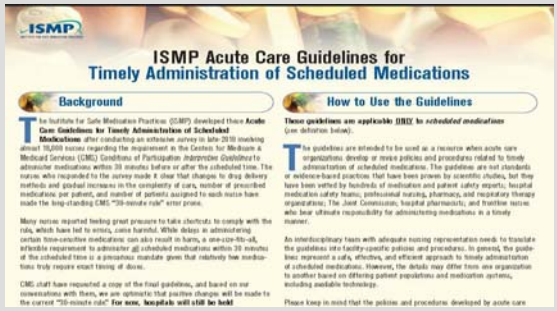
ISMP Resources at www.ismp.org



ISMP

ISMP Acute Care Guidelines for Timely Administration of Scheduled Medications

Background

The Institute for Safe Medication Practices (ISMP) developed these **Acute Care Guidelines for Timely Administration of Scheduled Medications** after conducting an extensive survey in late 2010 involving almost 19,000 nurses regarding the requirement in the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation *Interpretive Guidelines* to administer medications within 30 minutes before or after the scheduled time. The nurses who responded to the survey made it clear that changes to drug delivery methods and gradual increases in the complexity of care, number of prescribed medications per patient, and number of patients assigned to each nurse have made the long-standing CMS "30-minute rule" error prone.

Many nurses reported feeling great pressure to take shortcuts to comply with the rule, which have led to errors, some harmful. While delays in administering certain time-sensitive medications can also result in harm, a one-size-fits-all, inflexible requirement to administer all scheduled medications within 30 minutes of the scheduled time is a precarious mandate given that relatively few medications truly require exact timing of doses.

CMS staff have requested a copy of the final guidelines, and based on our conversations with them, we are optimistic that positive changes will be made to the current "30-minute rule." **For now, hospitals will still be held**

How to Use the Guidelines

These guidelines are applicable ONLY to *scheduled medications* (see definition below).

The guidelines are intended to be used as a resource when acute care organizations develop or revise policies and procedures related to timely administration of scheduled medications. The guidelines are not standards or evidence-based practices that have been proven by scientific studies, but they have been vetted by hundreds of medication and patient safety experts; hospital medication safety teams; professional nursing, pharmacy, and respiratory therapy organizations; The Joint Commission, hospital pharmacists; and frontline nurses who bear ultimate responsibility for administering medications in a timely manner.

An interdisciplinary team with adequate nursing representation needs to translate the guidelines into facility-specific policies and procedures. In general, the guidelines represent a safe, effective, and efficient approach to timely administration of scheduled medications. However, the details may differ from one organization to another based on differing patient populations and medication systems, including available technology.

Please keep in mind that the policies and procedures developed by acute care

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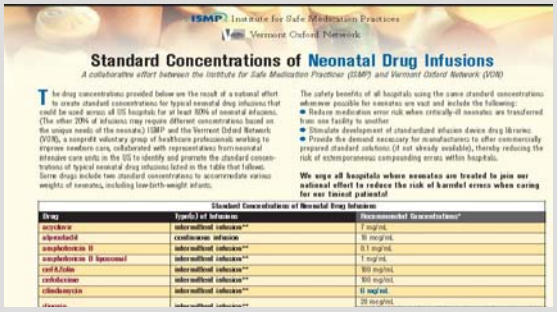
Neonatal Drug Infusions at ISMP



ISMP Institute for Safe Medication Practices

Vermont Oxford Network

Standard Concentrations of Neonatal Drug Infusions

A collaborative effort between the Institute for Safe Medication Practices (ISMP) and Vermont Oxford Network (VON)

The drug concentrations provided below are the result of a national effort to create standard concentrations for typical neonatal drug infusions that could be used across all US hospitals for at least 80% of neonatal infusions. (The other 20% of infusions may require different concentrations based on the unique needs of the neonate.) ISMP and the Vermont Oxford Network (VON), a nonprofit voluntary group of healthcare professionals working to improve newborn care, collaborated with representatives from neonatal intensive care units in the US to identify and promote the standard concentrations of typical neonatal drug infusions listed in the table that follows. Some drugs include two standard concentrations to accommodate various weights of neonates, including low-birth-weight infants.

The safety benefits of all hospitals using the same standard concentrations whenever possible for neonates are vast and include the following:

- Reduce medication error risk when critically-ill neonates are transferred from one facility to another
- Stimulate development of standardized infusion device drug libraries
- Provide the demand necessary for manufacturers to offer commercially prepared standard solutions (if not already available), thereby reducing the risk of extemporaneous compounding errors within hospitals.

We urge all hospitals where neonates are treated to join our national effort to reduce the risk of harmful errors when caring for our tiniest patients!

Standard Concentrations of Neonatal Drug Infusions

Drug	Type(s) of Infusions	Recommended Concentrations*
acyclovir	intermittent infusion**	7 mg/mL
alprostadil	continuous infusion	15 mcg/mL
amphotericin B	intermittent infusion**	0.1 mg/mL
amphotericin B liposomal	intermittent infusion**	1 mg/mL
cefAzolin	intermittent infusion**	100 mg/mL
cefotaxime	intermittent infusion**	100 mg/mL
clindamycin	intermittent infusion**	6 mg/mL
dopamine	intermittent infusion**	20 mcg/mL

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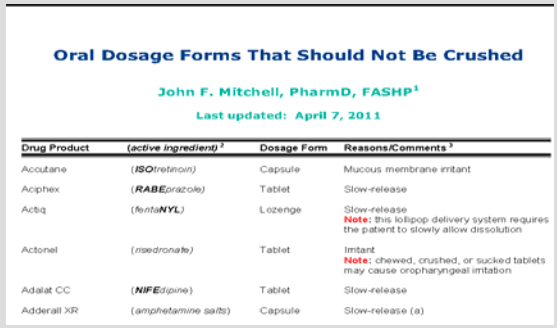
ISMP Do Not Crush Meds



Oral Dosage Forms That Should Not Be Crushed

John F. Mitchell, PharmD, FASHP[1]

Last updated: April 7, 2011

Drug Product	(active ingredient) [2]	Dosage Form	Reasons/Comments [3]
Accutane	(**ISO**tretinoin)	Capsule	Mucous membrane irritant
Aciphex	(**RABE**prazole)	Tablet	Slow-release
Actiq	(fenta**NYL**)	Lozenge	Slow-release **Note:** this lollipop delivery system requires the patient to slowly allow dissolution
Actonel	(risedronate)	Tablet	Irritant **Note:** chewed, crushed, or sucked tablets may cause oropharyngeal irritation
Adalat CC	(**NIFE**dipine)	Tablet	Slow-release
Adderall XR	(amphetamine salts)	Capsule	Slow-release (a)

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LASA or Confused Drug Names

Institute for Safe Medication Practices

ISMP's List of *Confused Drug Names*

This list of confused drug names, which includes look-alike and sound-alike name pairs, consists of those name pairs that have been involved in medication errors published in the *ISMP Medication Safety Alert!*® and the *ISMP Medication Safety Alert!*® Community/Ambulatory Care Edition. The errors involving these medications were reported to ISMP through the ISMP Medication Errors Reporting Program (MERP).

This list also contains the names that appear on The Joint Commission's list of look-alike and sound-alike names. The Joint Commission established a National Patient Safety Goal that requires each accredited organization to identify a list of look-alike or sound-alike drugs used in the organization. Those names that appear on The Joint Commission's list have been noted with an asterisk (*) below.

Drug Name	Confused Drug Name
Abelcet®	amphotericin B®
Accupril	Aciphex
acetaZOLAMIDE®	acetoHEXAMIDE®
acetic acid for irrigation	glacial acetic acid
acetoHEXAMIDE®	acetaZOLAMIDE®
Aciphex	Accupril
Actiq	Amrix®
Actonel	Cathflo Actinase

Drug Name	Confused Drug Name
amLODIPine	aMILOride
amphotericin B®	Abelcet®
amphotericin B®	Ambisome®
Amrix	Anacin-3
Anacin-3	Amrix
antacid	Atenanol
Antivert	Avert
Anzemet	Ancobon®

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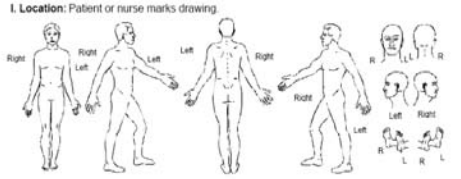
Documenting Pain

- Assess every patient on admission and if pain every assessment,
- Have patient rate the pain (1-10 scale, Wong-Baker faces),
- Document after all pain meds given if relief on pain scale,
- Intensity of pain (scale used, pain worst when, acceptable level of pain, pain present),
- Onset, duration, variations,
- What relieves the pain or increases it?
- Effects of pain (sleep, appetite, concentration, physical activity, relationship with others etc.)

Initial Pain Assessment Tool

Date _____
Patient's Name _____ Age _____ Room _____
Diagnosis _____ Physician _____
Nurse _____

I. Location: Patient or nurse marks drawing.



II. Intensity: Patient rates the pain. Scale used _____
Present: _____
Worst pain gets: _____
Best pain gets: _____
Acceptable level of pain: _____

III. Quality: (Use patient's own words, e.g. prick, ache, burn, throb, pull, sharp)

IV. Onset, duration, variations, rhythms: _____

V. Manner of expressing pain: _____

CMS Safe Opioid Use, IV Meds

- June 6, 2014 CMS publishes standards on safe opioid use, IV medication, and blood transfusions
- Make sure include this information in orientation and periodically
- Ensure you have a policy and make sure approved by the Medical Staff such as the MEC committee
- Must assess all patients receiving opioids
- Use CMS's criteria to determine who is high risk
  - Make sure staff know how to assess, VS, pulse ox, ETCO2, sedation scale and how often to do the assessments

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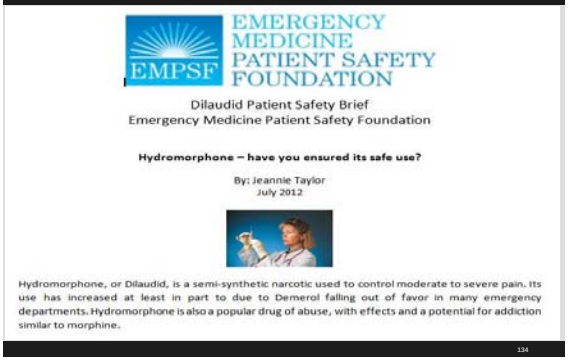
PCA

- Is pain assessed after pain medicine or during PCA,
- Document use of Pulse Ox or ET CO2 readings,
- Document response of patient and any side effect such as nausea or over sedation,
- Know PCA by proxy,
- Document PCA instructions and don't let family or friends push the button for patient,
- Do you post a sign or provide a pamphlet for the patient.

PCA

- Document the conversation with patient and family,
- Don't let your patient die from an accidental overdose,
  - Don't confuse Hydromorphone with Morphine
  - Always refer to HydromMORphone as Dilaudid
- Provide training during orientation and reminders at skills lab,
- Have a policy and procedure,
- TJC Sentinel Event Alert, ISMP Alert and MedMarRx research that this can occur,

Dilaudid Safety Brief

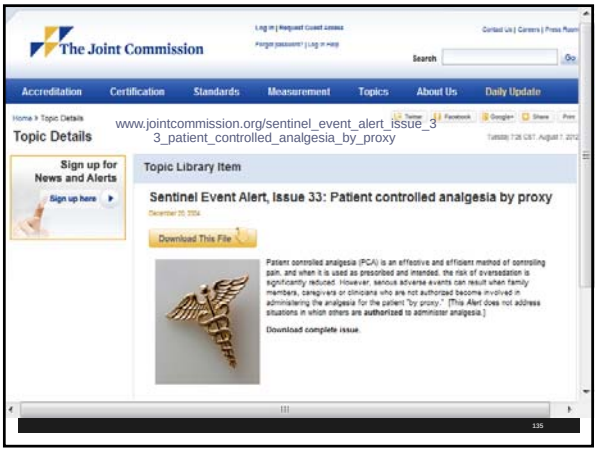

EMERGENCY MEDICINE PATIENT SAFETY FOUNDATION

Dilaudid Patient Safety Brief
Emergency Medicine Patient Safety Foundation

Hydromorphone – have you ensured its safe use?

By: Jeannie Taylor
July 2012

Hydromorphone, or Dilaudid, is a semi-synthetic narcotic used to control moderate to severe pain. Its use has increased at least in part to due to Demerol falling out of favor in many emergency departments. Hydromorphone is also a popular drug of abuse, with effects and a potential for addiction similar to morphine.



Advanced Beneficiary Notices

- ABN should be given to patients when indicated
- Form should be completely filled out
- Document that ABN was given
- Have a policy so staff understand this issue
- All Medicare patients must be given a copy of the IM Notice or Important Message from Medicare
- Be sure patient signs and dates and times form

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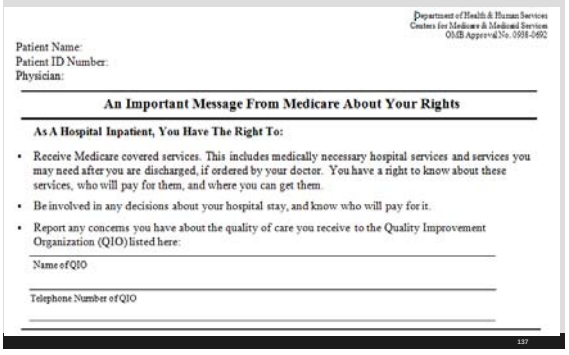
IM Notice Form for Medicare Patients



Department of Health & Human Services
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

Patient Name:
Patient ID Number:
Physician:

An Important Message From Medicare About Your Rights

As A Hospital Inpatient, You Have The Right To:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

Name of QIO

Telephone Number of QIO

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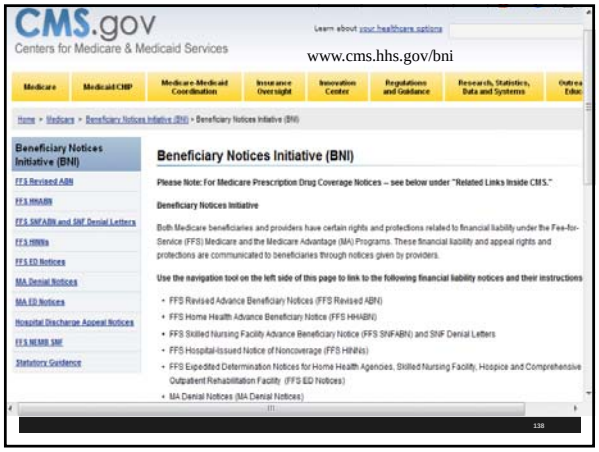

www.cms.hhs.gov/bni

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Document OR Checklist

- Create checklist to document things are done as required,
- TJC requirement to have standardized list,
- Communication breaks lead to medical errors in healthcare,
  - Studies show communication failures can occur in the OR-about 30% of team exchanges,
  - Check list was used before 18 surgical procedures,
  - Checklist was documented and retained in medical record,
  - Check list was efficient tool to promote information exchange and team cohesion,
- L Lingard, S Espin, B Rubin, S Whyte, M Colmenares, G R Baker, D Doran, E Grober, B Orser, J Bohnen, and R Reznick Getting teams to talk: development and pilot implementation of a checklist to promote interprofessional communication in the OR Qual. Saf. Health Care, October 1, 2005; 14(5): 340 - 346

CHRISTIANA CARE HEALTH SERVICES

UNIVERSAL PROTOCOL AND FIRE RISK ASSESSMENT

Planned Procedure: ______________________

Date of Procedure ______

COMPONENT #1 VERIFICATION PROCESS			
Mark all that apply ** indicates required field	Sending Unit	Prep & Holding	Unit Using Procedure
Name and date of birth confirmed **			
Patient/Decision maker verbalizes planned procedure			
Schedule confirms planned procedure			
Consent confirms planned procedure **			
History and Physical confirms planned procedure			
Diagnostic Study confirms planned procedure			
Progress Record/Consult confirms planned procedure			
Site marking required (go to Component 2)			
Site marking not required			
Date/Time:			
Initial:			

COMPONENT #3 TIME OUT			
The entire procedure team has performed a Time Out and all members have verbally agreed.			
Time out included the verification of:	1st	2nd	3rd
Correct patient identity			
Agreement on procedure to be done			
Correct site and side			
Diagnostic study confirmation of site and side			
Availability of implants			
Availability of special equipment			

1st Time Out Time:______ Initial:______
2nd Time Out Time:______ Initial:______
3rd Time Out Time:______ Initial:______

COMPONENT #2 SITE MARKING (if required)

After verification has been completed, the patient if able, will write "Yes" with a permanent marker on or as near the site as possible:

☐ RIGHT ______________ ☐ LEFT ______________

Side marked by:
☐ Patient ☐ Family member (relationship):________ ☐ Healthcare Provider
Initial:____________ Time:______

FIRE RISK ASSESSMENT		
Procedure site or incision above the xiphoid	1(Yes)	0(NO)
Open oxygen source (face mask/nasal cannula)	1(Yes)	0(NO)
Ignition source (cautery, laser, fiber optic light source)	1(Yes)	0(NO)
SCORE 1 or 2: ☐ Initiate Routine Protocol SCORE 3: ☐ Initiate High Risk Fire Protocol (see side 2 for specifics) Initial______	Total Score: ______	

Initials	Signature/Title	Print Name	Initials	Signature/Title	Print Name

OR – Universal Protocol

CDC Intravascular Guidelines www.cdc.gov

www.cdc.gov/hicpac/BSI/BSI-guidelines-2011.html

Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011

Naomi P. O'Grady, M.D.[1], Mary Alexander, R.N.[2] Lillian A. Burns, M.T., M.P.H., C.I.C.[3] E. Patchen Dellinger, M.D.[4] Jeffery Garland, M.D., S.M.[5] Stephen O. Heard, M.D.[6] Pamela A. Lipsett, M.D.[7] Henry Masur, M.D.[1] Leonard A. Mermel, D.O., Sc.M.[8] Michele L. Pearson, M.D.[9] Issam I. Raad, M.D.[10] Adrienne Randolph, M.D., M.Sc.[11] Mark E. Rupp, M.D.[12] Sanjay Saint, M.D., M.P.H.[13] and the Healthcare Infection Control Practices Advisory Committee (HICPAC)[14].

1National Institutes of Health, Bethesda, Maryland
2Infusion Nurses Society, Norwood, Massachusetts
3Greenich Hospital, Greenwich, Connecticut
4University of Washington, Seattle, Washington
5Wheaton Franciscan Healthcare-St. Joseph, Milwaukee, Wisconsin

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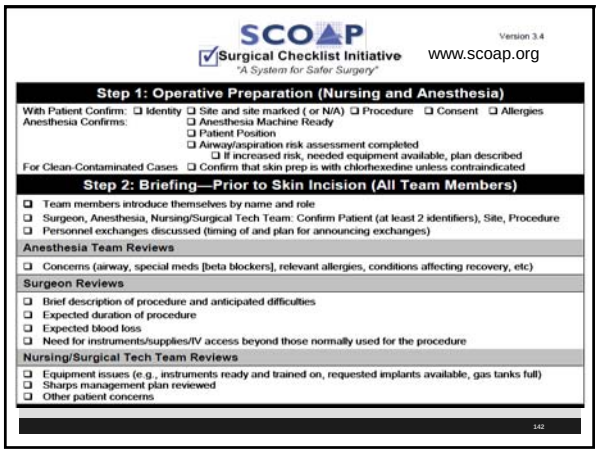
SCOAP
Surgical Checklist Initiative
"A System for Safer Surgery"
Version 3.4
www.scoap.org

Step 1: Operative Preparation (Nursing and Anesthesia)

With Patient Confirm: ❑ Identity ❑ Site and site marked (or N/A) ❑ Procedure ❑ Consent ❑ Allergies
Anesthesia Confirms: ❑ Anesthesia Machine Ready ❑ Patient Position ❑ Airway/aspiration risk assessment completed ❑ If increased risk, needed equipment available, plan described
For Clean-Contaminated Cases ❑ Confirm that skin prep is with chlorhexedine unless contraindicated

Step 2: Briefing—Prior to Skin Incision (All Team Members)

❑ Team members introduce themselves by name and role
❑ Surgeon, Anesthesia, Nursing/Surgical Tech Team: Confirm Patient (at least 2 identifiers), Site, Procedure
❑ Personnel exchanges discussed (timing of and plan for announcing exchanges)

Anesthesia Team Reviews

❑ Concerns (airway, special meds [beta blockers], relevant allergies, conditions affecting recovery, etc)

Surgeon Reviews

❑ Brief description of procedure and anticipated difficulties
❑ Expected duration of procedure
❑ Expected blood loss
❑ Need for instruments/supplies/IV access beyond those normally used for the procedure

Nursing/Surgical Tech Team Reviews

❑ Equipment issues (e.g., instruments ready and trained on, requested implants available, gas tanks full)
❑ Sharps management plan reviewed
❑ Other patient concerns

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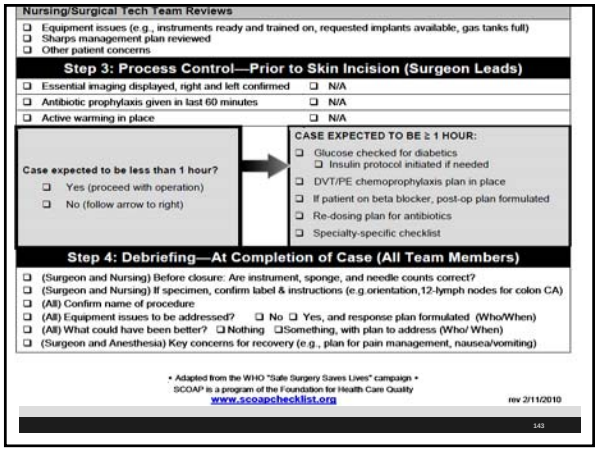
Nursing/Surgical Tech Team Reviews

❑ Equipment issues (e.g., instruments ready and trained on, requested implants available, gas tanks full)
❑ Sharps management plan reviewed
❑ Other patient concerns

Step 3: Process Control—Prior to Skin Incision (Surgeon Leads)

❑ Essential imaging displayed, right and left confirmed ❑ N/A
❑ Antibiotic prophylaxis given in last 60 minutes ❑ N/A
❑ Active warming in place ❑ N/A

Case expected to be less than 1 hour?
❑ Yes (proceed with operation)
❑ No (follow arrow to right)

CASE EXPECTED TO BE ≥ 1 HOUR:
❑ Glucose checked for diabetics ❑ Insulin protocol initiated if needed
❑ DVT/PE chemoprophylaxis plan in place
❑ If patient on beta blocker, post-op plan formulated
❑ Re-dosing plan for antibiotics
❑ Specialty-specific checklist

Step 4: Debriefing—At Completion of Case (All Team Members)

❑ (Surgeon and Nursing) Before closure: Are instrument, sponge, and needle counts correct?
❑ (Surgeon and Nursing) If specimen, confirm label & instructions (e.g.orientation,12-lymph nodes for colon CA)
❑ (All) Confirm name of procedure
❑ (All) Equipment issues to be addressed? ❑ No ❑ Yes, and response plan formulated (Who/When)
❑ (All) What could have been better? ❑ Nothing ❑Something, with plan to address (Who/ When)
❑ (Surgeon and Anesthesia) Key concerns for recovery (e.g., plan for pain management, nausea/vomiting)

• Adapted from the WHO "Safe Surgery Saves Lives" campaign •
SCOAP is a program of the Foundation for Health Care Quality
www.scoapchecklist.org
rev 2/11/2010

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www.scoap.org

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Document Notification of the Physician

- There are many times where it is expected that there be a notation in the medical record that the physician has been notified,
  - Unusual occurrences,
  - Accidents or falls,
  - Abnormal test results,
  - Errors in medications,
  - Inability to carry out a physician's order,
  - Information that could affect discharge,
  - Family concerns or questions,
  - Usual monitoring not done or missed.

Notify Nurse Supervisor

- There are also appropriate times when the nurse manager or supervisor should be notified,
- This should be documented in the medical record,
- Whenever there is a serious concern about a patient's care or safety,
- When unable to contact the physician,
- Whenever an incident report is completed for a serious problem or sentinel event,
- Whenever staffing levels are inadequate and could jeopardize patient safety,
- Remember chain of command policy,

Continuity of Entries

- Avoid contradictions in the records,
- Generally you want to avoid double documentation,
- Ongoing treatment should be noted (feeding tube, IV site and appearance, foley catheter, trach),
- Document current outcomes, observations, and progress,
- Document chronologically,
- Make sure monitoring strips are included in medical record (Fetal, cardiac, BP testing etc.)

Be Aware of Your Documentation Policy

MEDICAL RECORDS CONTENT/DOCUMENTATION

Purpose:

To define the definitions, capture, analysis, transformation, transmission and reporting of individual patient specific data and information related to the process(es) and/or of the outcome(s) of the patient's care. The organization has a complete and accurate medical record for every individual assessed or treated. Every medical record entry is timed and dated; its author identified and when necessary, treatment noted.

Policy:

A. All medical record entries must be legible, complete, dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the services provided, consistent with hospital policies and procedures.

B. Content of the Medical Record

1. The content of the medical record, which includes written and electronic documents, must be sufficiently detailed, legible and organized to enable:
   - the practitioner responsible for the patient to identify the patient, provide continuing care, determine the patient's condition at a specific time, review the diagnosis and therapeutic procedures performed and the patient's response to treatment;
   - a consultant to render an opinion after a patient examination and review of the medical record;
   - another practitioner to assume patient care at any time;
   - and the retrieval of information required for utilization review, quality review, transfer recommendations, etc.

2. The medical record contains the following demographic

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The Medical Record Will Contain

3. The medical record contains the following clinical information:
   a. The reason(s) for admission for care, treatment and services
   b. The patient's initial diagnosis, diagnostic impression(s) or conditions(s)
   c. Any findings of assessments and reassessments
   d. Any allergies to food or latex
   e. Any allergies to medication
   f. Any conclusions or impressions drawn from the patient's medical history and physical examination
   g. Any diagnoses or conditions established during the patient's course of care, treatment, and services
   h. Any consultations reports
   i. Any observations relevant to care, treatment and services
   j. The patient's response to care, treatment and services
   k. Any emergency care, treatment and services provided to the patient before his or her arrival
   l. Any progress notes
   m. All orders
   n. Any medications ordered or prescribed
   o. Any medications administered, including the strength, dose, frequency and route
   p. Any access site for medication, administration devices used and rate of administration
   q. Any adverse drug reactions
   r. Treatment goals, plan of care, and revisions to the plan of care
   s. Results of diagnostic and therapeutic tests and procedures
   t. Any medications dispensed or prescribed on discharge
   u. Discharge diagnosis
   v. Discharge plan and discharge planning evaluation

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Documentation

- Telephone instructions to patients or follow up after surgery or for abnormal test result,
- Nursing diagnosis,
- Cancelled or failed appointment,
- Return visit dates,
- Threats of lawsuits,
- Call backs of surgery patients with specific information asked and responses and document in medical record,
  - TJC requires documentation in RC chapter

NPO Status and I&O

- If the patient is to be NPO or on I&O then inform patient,
- Document this and reason for NPO,
- Patients, when ordered or indicated, should be on I&O,
- Provide bedside commode or hat or other equipment for measuring I&O,
- Document patient is educated about the need to record oral intake and how this is done,

Abnormal X-ray and EKG Results

- How do you document this?
- Important to make sure record shows that physician is also aware of abnormal test results
- Are patients notified timely of all abnormal EKG and x-ray results,
- EKG over reads reviewed timely by qualified physician (not next day, can fax or send by modem)
- Is follow up clearly documented in the medical record,
- Are these logged on a sheet and reviewed for QI purposes,
- Recent studies show EKG inconsistencies low but missed MI is larger dollar payout,
- Computerized EKG interpretations not sensitive enough to pick up all MIs,

Document Time Outs

- Use a separate form or sticker to document time out for surgeries and invasive procedures,
  - Not just in surgery but anywhere, insertion A-line or central line, Thoracentesis, Paracentesis, etc.
- Follow the recommendations by TJC on universal protocols,
- Ensures right patient for right procedure,
- This must be documented in the medical record or you will receive a deficiency (RFI),
- Include risk of catching fire

CHRISTIANA CARE HEALTH SERVICES

UNIVERSAL PROTOCOL AND FIRE RISK ASSESSMENT

Planned Procedure: ____________

Date of Procedure

COMPONENT # 1 VERIFICATION PROCESS	Sending Unit	Prep & Holding	Unit Using Procedure
Mark all that apply "" indicates required field			
Name and date of birth confirmed ""			
Patient/Decision maker verbalizes planned procedure			
Schedule confirms planned procedure			
Consent confirms planned procedure ""			
History and Physical confirms planned procedure			
Diagnostic Study confirms planned procedure			
Progress Record/Consult confirms planned procedure			
Site marking required (*go to Component 2*)			
Site marking not required			
Date/Time:			
Initial:			

COMPONENT # 3 TIME OUT	1st	2nd	3rd
The entire procedure team has performed a Time Out and all members have verbally agreed.			
Time out included the verification of:			
Correct patient identity			
Agreement on procedure to be done			
Correct site and side			
Diagnostic study confirmation of site and side			
Availability of implants			
Availability of special equipment			

1st Time Out Time:______ Initial:_____
2nd Time Out Time:______ Initial:_____
3rd Time Out Time:______ Initial:_____

COMPONENT # 2 SITE MARKING (if required)

After verification has been completed, the patient if able, will write "Yes" with a permanent marker on or as near the site as possible:
☐ RIGHT ____________ ☐ LEFT ____________

Side marked by:
☐ Patient ☐ Family member (Relationship):________ ☐ Healthcare Provider
Initial:__________ Time:______

FIRE RISK ASSESSMENT		
Procedure site or incision above the xiphoid	1(Yes)	0(NO)
Open oxygen source (face mask/nasal cannula)	1(Yes)	0(NO)
Ignition source (cautery, laser, fiber optic light source)	1(Yes)	0(NO)

SCORE 1 or 2: ☐ Initiate Routine Protocol
SCORE 3: ☐ Initiate High Risk Fire Protocol (see side 2 for specifics)
Initial:_____
Total Score: _____

Initials	Signature/Title	Print Name	Initials	Signature/Title	Print Name

CH – Universal Protocol

SITE VERIFICATION/MARKING AND TIME-OUT DOCUMENTATION

Department Performing Procedure:
☐ Surgery ☐ LDRP ☐ Nursery ☐ Endo ☐ Emergency Dept. ☐ Ambulatory Care
☐ Other: ____________

Patient Identified By: (✓ check all that apply, but at least 2 identifiers)
☐ Name, verbalized by patient/compared with Chart
☐ Birth date, verbalized by patient/compared with Chart
☐ Identification Band, compared with Chart
☐ Other: ____________

Marking of Operative Site: (✓ check all that apply)
☐ NA because single organ case, insertion site is not determined, teeth.
☐ Patient refuses because: ____________
☐ Patient/family participated in marking
☐ Other: ____________

Location of Marking: ____________

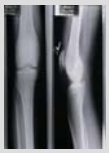
Site Marked by: ____________

Confirmed by: ____________

Date: ____________ Time: ____________

Verification of Site/Side:
Circle One: Left Center Right Unknown
(✓ check all that apply)
☐ Patient agrees to procedure as written on consent form
☐ Consistent with Consent

Circulation Checks



- Patients with injury or surgery to extremities should have this documented,
- Eg, patient complains of pain over rt medial malleolus after inversion injury 1 hr PTS stepping out of car onto curb. Minimal edema. 2/4 pedal pulse, cap refill 1 sec, all toes are pink and warm with no numbness,

Skin Assessment

- If patient is to be admitted, staff should do a full skin assessment**,**
- Reassess as needed and at least every 24 hours,
- Recommend documentation in the medical record or on a special assessment form,
  - Use a validated risk assessment tool such as Braden or Norton scale should be used,
  - Consider notifying ET nurse, implement plan of care, if pressure ulcer present
  - Consider picture of admission decubitus,
  - Include information in hand off communications.

Skin Assessment

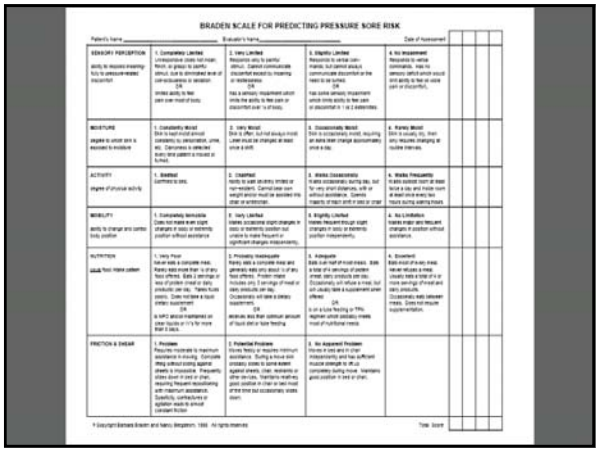
- Include information in hand off communications
- Remember that CMS has hospital acquired conditions (HACs) in which there is no additional payment
  - Staff need to make sure physician has documented in the medical record that the pressure ulcer was present on admission (POA)
  - If not CMS will deny any additional payment
  - Many hospitals have safe skin committees to ensure good skin assessment and treatment

Skin Assessment

- Document clearly interventions (inspect skin daily, moisturize dry skin, bathe with mild soap, no more than 30 degrees side lying position, or HOB elevation, wound care consult ordered, etc.,
- Document risk factors (contractures, cognitive impairment, poor skin turgor, bedfast, incontinent of bowel or bladder, deceased lower sensory perception, poor nutrition, friction and shear score of 2 or lower, etc.)
- *National Pressure Ulcer Definition or NPUAP, see AHRQ Pressure Ulcers and Patient Safety,

Skin Assessment

- Document location,
- Document stage (I-IV, non-observable),
- Document dimensions and include length, width, depth in centimeters,
  - Record undermining (deepest part such as 2.0 cm from 2-7 o'clock) or sinus tracks or tunneling (3.0 cm at 3 o'clock),
  - Document wound base description (wound base is 75% granulation tissue with 25% slough tissue) and include granulation, necrotic tissue, eschar, slough and epithelial,
  - Document drainage (amount, color, odor),
  - Document wound edges, pain with wound or infection and describe.



BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

SENSORY PERCEPTION	1. Completely Limited	2. Very Limited	3. Slightly Limited	4. No Impairment
MOISTURE	1. Constantly Moist	2. Very Moist	3. Occasionally Moist	4. Rarely Moist
ACTIVITY	1. Bedfast	2. Chairfast	3. Walks Occasionally	4. Walks Frequently
MOBILITY	1. Completely Immobile	2. Very Limited	3. Slightly Limited	4. No Limitation
NUTRITION	1. Very Poor	2. Probably Inadequate	3. Adequate	4. Excellent
FRICTION & SHEAR	1. Problem	2. Potential Problem	3. No Apparent Problem	

Norton Scale

Norton Scale

NOTE Scores of 14 or less rate the patient as 'at risk'

Name	Date	Physical Condition	Mental Condition	Activity	Mobility	Incontinence	Total Score
		Good 4 Fair 3 Poor 2 Very bad 1	Alert 4 Apathetic 3 Confused 2 Stupor 1	Ambulant 4 Walk-help 3 Chair-bound 2 Bedridden 1	Full 4 Slightly limited 3 Very limited 2 Immobile 1	Not 4 Occasional 3 Usually/urine 2 Doubly 1	

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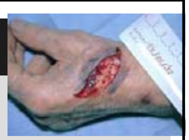
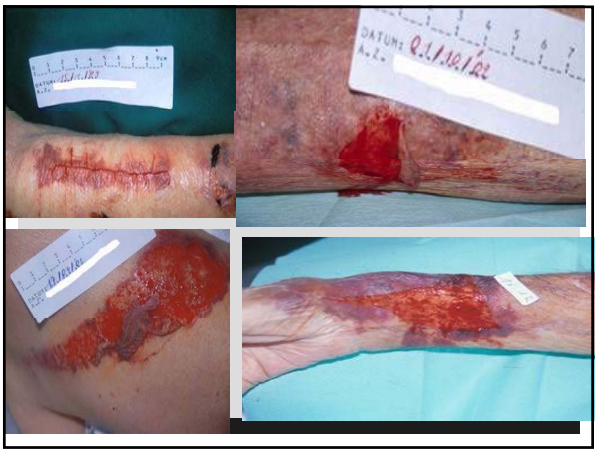
Skin Tears PSA

- Pa Safety Authority Reported 2,807 times or 2% of all reports,
- Painful, disfiguring, and preventable problem,
- Dearth of literature available,
- Developed a skin toolkit that contains poster, article, sample P&Ps, and streaming video on safe practices related to skin tears,
  - Guidelines provide framework for preventing also available at www.guideline.gov,

Treatment of Skin Tears



- Use normal saline to rinse wound,
- Let air dry or carefully pat dry,
  - Gently approximate the flap,
  - Petroleum based ointment or steri strips
  - Use moist non-adherent dressing,
  - Place arrow in direction of tear,
  - Document category I, II or III, Payne –Martine classification system,
  - Consider wound tracing,
  - Document assessment and treatment,



Restraints

- Be sure **orde**r for restraint is documented appropriately (reason, date, time, least restrictive, alternatives considered),
- Use special documentation sheet to meet needs of patient,
- Document monitoring, when removed and positioned, fluid and toileting offered, circ checks et al.,
- Document within time frame
  - Generally 2 hours medical and every 15 minutes behavioral health patients but follow your P&P,

Restraint Patient Safety Brief www.empsf.org

EMERGENCY MEDICINE PATIENT SAFETY FOUNDATION

Restraint and Seclusion Patient Safety Briefing
Emergency Medicine Patient Safety Foundation

Written by: Sue Dill Calloway RN MSN JD CPHRM
Michael Gerardi, MD, FAAP, FACEP
John (Jack) Kelly DO, FACEP, FAAEM

March 2012
Revised July 16, 2012

Introduction

Advance Directives

- Advance directive requirements from a federal law
  - Patient Self Determination Act, CMS Hospital CoP, and TJC and other accreditation standards
- Consider special form to document advance directives issues
- Document if patient has one
- Document if wants to make any changes (TJC)
- Obtain a copy and place on chart
- Document which ones patient has
  - Living will, DPOA, organ donor card, mental health declaration, DNR, visitation etc.

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IV Documentation Standards

- Nursing documentation should contain:
  - Complete information about infusion therapy and vascular access
  - Exact time medications given (Give most medications IV slow and document times such as given over 2 minutes)
  - Site appearance, what is infusing, rate, if pump used
  - Site appearance
  - What is infusing and rate
  - If pump used
  - Type, brand, length and size of vascular access device

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Infusion Therapy Documentation

- Relevant factors to assessment, intervention and patient response
  - A CMS and TJC requirement for procedures, also
- Number of attempts and care of site
- Extravasations and infiltrate with site assessments
- Patient response
- Use central line bundle
  - TJC requires a checklist in the chart on the central line bundle

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CDC Intravascular Guidelines

- The Center for Disease Control and Prevention (CDC) and Healthcare Infection Control Practices Advisory Committee (HICPAC) publish 2011 Guidelines for the Prevention of Intravascular Catheter-Related Infections
  - Updates the 2002 Guidelines
- These impact all nurses, physicians, and other healthcare providers who insert intravascular catheters
- Also impacts infection preventionist and others responsible for surveillance and control of infections
  - Includes hospitals, outpatient and home health settings

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www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf

Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011

Naomi P. O'Grady, M.D.[1], Mary Alexander, R.N.[2], Lillian A. Burns, M.T., M.P.H., C.I.C.[3], E Patchen Dellinger, M.D.[4], Jeffery Garland, M.D., S.M.[5], Stephen O. Heard, M.D.[6], Pamela A. Lipsett, M.D.[7], Henry Masur, M.D.[1], Leonard A. Mermel, D.O., Sc.M.[8], Michele L. Pearson, M.D.[9], Issam I. Raad, M.D.[10], Adrienne Randolph, M.D., M.Sc.[11], Mark E. Rupp, M.D.[12], Sanjay Saint, M.D., M.P.H.[13], and the Healthcare Infection Control Practices Advisory Committee (HICPAC)[14].

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CDC Intravascular Guidelines Implementation

- 83 page document
  - "Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011"
- Hospitals need to implement these guidelines into their education and training program
- Hospitals need to revise policies and procedures to reflect these guidelines
- Hospitals should incorporate these into their PI program to ensure compliance
- Make sure staff are familiar with these guidelines

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Policy on Verbal Orders

- Verbal orders are a top problematic standard with both CMS and TJC
- Maintain a policy on verbal orders
  - Limit the use of verbal orders
  - Identify who can accept verbal orders
    - Example pharmacist can take verbal orders for medications
    - Staff do not take Vancomycin order from medical assistant in the doctors office but only from licensed person
  - List documentation requirements
  - Include when would not want to take like hazardous orders such as chemotherapy orders

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Documenting Verbal Orders

- Document verbal orders and write it down and repeat it back
- List the elements for a complete VO (such as patient name, drug, dose, frequency, name of person giving and taking order, etc.)
- VO must be documented by nurse with name and date and time
- VO must be authenticated by doctor or LIP with name, date, and **time**
  - TJC RC.01.02.01 and CMS tag 407

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CMS Verbal Orders

- To be used infrequently and never for convenience of the physicians
  - Physician should not give verbal orders in nursing station if he or she can write them
- Can be used in emergency or if surgeon is scrubbed in during surgery
- CMS broadened category of practitioners who can sign orders such as NP or PA if they could have ordered it themselves
- Any physician on the case can sign off for any other physician (March 15, 2013)

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CMS Verbal Orders

- CMS and TJC states that verbal orders should be authenticated based on state law
  - Some states require order to be signed off in 24 hours or 48 hours or 7 days
- If no state law, use to say that verbal orders must be authenticated within 48 hours
  - Now have P&P and many hospitals picked 30 days
- Nursing staff need to be sure the doctor or LIP signs off the verbal order in the medical record

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Documentation Other Important Things

- Restraint
- Falls
- Central line bundle
- Ventilated associated pneumonia (VAP) bundle
- Admission assessments
- Code charting and RRT
- These are additional issues covered in the all day presentation on documentation and these are available to attendees

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Documentation Other Important Things

- TJC do not use abbreviations in documentation
- Cancelled or failed appointments
- Sign out AMA or refusal of treatment
- Sepsis documentation
- Foley catheter insertion and care
- Documenting under EMTALA
- MRI safety
- Advance directives
- Fall assessment

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Documentation Other Important Things

- Chain of command or communication
- Documentation standards and guidelines
  - AORN, ENA, ASPAN, AWHONN, etc.
- CMS anesthesia documentation standards including pre and post anesthesia standard
- Infant abductions
- Domestic violence
- Moderate sedation
- Anticoagulants, neuromuscular blockers etc.

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Documentation Other Important Things

- Ticket to ride and hand off communication
- Sponge counts
- Preventing wrong site surgery
- Organ donation
- Informed consent
- H&P
- Critical test results

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The End! Questions??

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Documentation

- Are you up for the challenge?
- See list of resources,

Resources

- Centers for Medicare and Medicaid Services. "**Documentation Guidelines** for E&M Services." Available online at www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp.
- CMS Manual for both PPS and CAH located at http://www.cms.hhs.gov/manuals/downloads/som107_Appendicestoc.pdf
- Joint Commission website at www.jointcommission.org

Resources Sepsis

- Surviving Sepsis Campaign website at http://www.survivingsepsis.org/
- Sepsis bundle at http://www.survivingsepsis.org/implement/bundles
- See also
- Dellinger RP, Carlet JM, Masur H, et al. Surviving Sepsis Campaign guidelines for management of severe sepsis and septic shock. Critical Care Medicine. 2004;32(3):858-873.
- See IHI, Defeating Sepsis; 25% by 2009, at http://www.ihi.org/IHI/Topics/CriticalCare/Sepsis/ImprovementStories/FSDefeatingSepsis25Percentby2009.htm

Resources Sepsis

- Sepsis bundle pocket card at http://ssc.sccm.org/files/images/Sepsis_Bundles_Badge_1__0.pdf,
- Product label information for Drotrecogin alfa (activated) or Xigris at http://www.fda.gov/cder/biologics/products/droteli112101.htm,
- Inspiratory plateau pressure toolkit at http://ssc.sccm.org/how_to_improve/measures_PPgoal,

Resources

- www.ahima.org,
- See evaluation and management documentation and coding technology adoption,
- Documentation to prevent fraud,
- Clinical documentation tips,
- Maintaining Legally Sound Health Record Update at http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_028509.hcsp?dDocName=bok1_028509

Suicide Resources

- Resource guide for implementing TJC patient safety goals on suicide at http://www.naphs.org,
- Assessment and assignment of suicidal risk at http://www.naphs.org/Teleconference/documents/Jacobs_ResourceMaterial.pdf
- APA Practice guidelines -recommendations for assessing and treating patients with suicidal behaviors http://www.naphs.org/Teleconference/documents/Jacobs_AppendixA_ReviewArticle.pdf

Suicide Resources

- Practice guideline for the assessment and treatment of patients with suicidal behaviors (184 pages) APA http://www.psych.org/psych_pract/treatg/pg/SuicidalBehavior_05-15-06.pdf
- APA quick reference assessing and treating suicidal behaviors at http://www.psych.org/psych_pract/treatg/quick_ref_guide/Suibehavs_QRG.pdf
- Stop a suicide today website at http://www.stopasuicide.org/

Fall Assessment Resources

- Great reference is Premier Safety Institute at http://www.premierinc.com/frames/index.jsp?pagelocation=/all/safety/resources/falls/index.html and includes,
- Extent of the problem: incidence and costs of falls.
- Definitions and measurement: trending and benchmarking fall data.
- Tool kit for preventing falls in seniors http://www.cdc.gov/ncipc/factsheets/nursing.htm,

Resources

- Changes in ICU nurse activity after installation of a third generation ICU information system, by Dr. Wong, Yvonne Gallegos, R.N., M.S.N., Matthew B. Weinger, M.D., *Critical Care Medicine* 31(10), pp. 2488-2494,
- Cost and benefits of health information technology. AHRQ Evidence Report 132 at http://www.ahrq.gov/downloads/pub/evidence/pdf/hitsyscosts/hitsys.pdf

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Thank you for attending!

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