

The ED: Legal and Risk Management Issues



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Speaker



- Sue Dill Calloway RN, Esq.
CPHRM, CCMSCP
- AD, BA, BSN, MSN, JD
- President of Patient Safety and
Education Consulting
- 5447 Fawnbrook Lane
- Dublin, Ohio 43017
- 614 791-1468 (Call with questions, no emails)
- sdill1@columbus.rr.com

Objective

- Describe legal and risk management issues in the ED.
- Develop risk reduction recommendations including managing medication errors.
- Explain new and revised standards, regulations, and laws put forth by CMS, TJC and the federal government.
- Evaluate compliance requirements and penalties.

EMTALA Update

Emergency Medical Treatment and Labor Act



Location of EMTALA CoP

State Operations Manual

Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases

(Rev. 60, 07-16-10)

www.cms.gov/EMTALA/

Transmittals for Appendix V

Part I- Investigative Procedures

- I. General Information
- II. Principal Focus of Investigation
- III. Task 1 - Entrance Conference
- IV. Task 2 - Case Selection Methodology
- V. Task 3- Record Review
- VI. Task 4- Interviews
- VII. Task 5-Exit Conference
- VIII. Task 6- Professional Medical Review
- IX. Task 7- Assessment of Compliance and Completion of the Deficiency Report
- X. Additional Survey Report Documentation

New website for all manuals
[www.cms.hhs.gov/manuals/downloads/so
m107_Appendixtoc.pdf](http://www.cms.hhs.gov/manuals/downloads/so
m107_Appendixtoc.pdf)

Part II - Interpretive Guidelines - Responsibilities of Medicare Participating Hospitals in Emergency Cases

EMTALA CMS Region 4 and 5

- Posting signs regarding guidelines regarding narcotic policy might be considered to be coercive or intimidating to patients who present to the ED with painful medical conditions
- Therefore violating both the language and intent of the EMTALA statute and regulation
- Some patients with legitimate need for pain control might be unduly coerced to leave the ED before receiving an appropriate medical screening exam
 - Consider removing the ED guidelines that may be posted in your ED although no prohibition against following SOC

Posters Regarding Prescribing Pain Medication

ACEPNow
The Official Voice of Emergency Medicine

NAVIGATION



ED Waiting Room Posters on Prescribing Pain Medications May Violate EMTALA

By Richard E. Wild, MD, JD, MBA, FACEP | on January 8, 2014 | 0 Comment

Uncategorized



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Statement from CMS region 4 office could have far-reaching implications for EDs nationwide

Proposed Changes by the OIG

- The OIG has proposed changes to the EMTALA law and possible out in 2016
- This was posted in the FR on May 12, 2014
- Discusses and clarifies many existing sections
- Does make a couple of important proposed changes
- Hospitals should be familiar with this document and watch for the final changes when they become available

Proposed Changes in Summary

- Clarify that on-call physicians at any participating hospital subject to EMTALA, including the hospital a patient initially presents to and the hospital with specialized capabilities or that has received a request to accept a transfer, face potential CMP and exclusion liability under EMTALA; and
- Revise the factors to clarify that aggravating circumstances include: a request for proof of insurance or payment prior to screening or treatment, patient harm, unnecessary risk of patient harm, premature discharge, or a need for additional services or subsequent hospital admission that resulted or could have resulted from the incident, and whether the individual presented with a medical condition that was an emergency medical condition.

Proposed EMTALA Changes



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Part III

Department of Health and Human Services

Office of Inspector General

42 CFR Parts 1003 and 1005

Medicare and State Health Care Programs: Fraud and Abuse; Revisions to the Office of Inspector General's Civil Monetary Penalty Rules; Proposed Rule

Proposed EMTALA Changes

- Put the EMTALA authorities all in one section
- Removed outdated references to the pre-1991 knowing requirement
- Clarify the CMP may be assessed for each violation
- Clarified that all participation hospitals are subject to EMTALA
 - Including those hospitals with specialized capabilities

Proposed EMTALA Changes

- Proposed to revise responsible physician to clarify that the on-call physician at any participating hospital is subject to EMTALA
- Clarifies that this includes taking care of a patient when the hospital has received a request to accept an appropriate transfer
- Otherwise the physician can be excluded and face a fine
- Any physician, including on-call physician, who fails to exam, treat, or transfer a patient appropriately can be penalized

Proposed EMTALA Changes

- On-call physician who fails to appear within a reasonable amount of time or refuses to show up is subject to EMTALA liability
- This includes on-call physicians at the hospital where the patient appears and the other hospital that has specialized capabilities
 - ie refusing to accept an appropriate transfer
- CMS is modifying the definition of responsible physician to make it clear between the on-call physician at the hospital the patient presents and where they would send the patient

Proposed EMTALA Changes

- Wanted to clarify the OIG's enforcement policy
- Lists factors that will be considered in making both CMP (civil monetary penalties) and exclusion criteria
 - Removed mitigating factors
 - See list of aggravating factors
 - OIG will consider if physician failed to follow EMTALA in the past
 - Violations involve a case by case inquiry
 - This would include if the hospital failed to screen the patient in a timely manner and they left

Legal and Risk Management Issues



Duty to Treat

- All patients who “come to the ED” requesting treatment must be evaluated
- A medical screening exam must be done to determine if patient is in an emergency medical condition and if so must stabilize
- Treatment must be provided without regards to whether patient can pay
- Need to maintain medical record on all patients
- Duty is established by EMTALA

Four Elements of Malpractice

- In order for the plaintiff to be successful in a malpractice case the following four elements must be proven;
 1. A duty was owed to the patient
 2. There was a breach of duty or breach of the standard of care
 3. There was direct or proximate cause and
 4. There was some damage

ED High Risk Problems

- The killer aorta, subarachnoid hemorrhage
- Alcohol intoxication, febrile child
- Ectopic pregnancy, wound infection
- Spinal cord injury
- Medication errors
- Failure to diagnose septicemia
- Failure to diagnosis bowel obstruction and appendicitis

Top Ten ED Liability Problems

- Chest pain, febrile child
- Ectopic Pregnancy, wound infection
- Missed fractures
- Abdominal Pain
- Appendicitis
- The Killer Aorta
- Subarachnoid Hemorrhage/CVA

Top Risk Areas in the Emergency Dept

- Charting and documentation
- Confidentiality and HIPAA
- EMTALA, Boarding and care of psych patients in the ED
- Malpractice, High risk complaints
- Informed consent and refusal of care
- Top areas of vulnerability; knowledge deficit, failure to take an adequate history, do adequate exam, etc
- What else should we add?

High Risk Patients

- ACEP has many clinical policies on high risk patients such as;
 - Good resources to have in your ED
 - Prescribing Opioids in the ED
 - Patients with suspected appendicitis, Pulmonary Emboli
 - Patients presenting with acute headaches
 - Patients presenting with syncope, acute heart failure, acetaminophen overdose, carbon monoxide poisoning
 - Management of adult psychiatric patients
 - Source: ACEP website at <http://www.acep.org/clinicalpolicies/>

ACEP Clinical Policies

Clinical & Practice
Management

www.acep.org/clinicalpolicies/

ACEP Clinical Policies

These ACEP Board-approved documents describe ACEP's policies on the clinical management of emergency department patients.

If you are having trouble viewing these documents, [download Adobe Reader 9.1.](#)

Sort by:

 ACEP Members

[Clinical Policy: Critical Issues in the Evaluation and Management of Adult Patients Presenting to the Emergency Department With Seizures](#)

Seizure

[Clinical Policy: Procedural Sedation and Analgesia in the Emergency Department](#)

Procedural Sedation and Analgesia

[Clinical Policy: Critical Issues in the Evaluation and Management of Adult Patients in the Emergency Department With Asymptomatic Elevated Blood Pressure](#)

Asymptomatic Elevated Blood Pressure

[Clinical Policy: Use of Intravenous tPA for the Management of](#)

Clinical & Practice Management

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Related Links

[Clinical policies](#) >

» [ACEP Clinical Policy: Blunt Abdominal Trauma](#)

[\[-\] Feedback](#)

Intoxicated Patients

- Intoxicate patients are at high risk patients for cerebral bleeds and subdural hematomas
- Do not be in a hurry to discharge and don't just leave them alone all night "to sleep it off"
- Assessment and reassessment is key
- Reassess before discharge and document the assessment and vital signs
- Documentation should be meticulous in patients who come in intoxicated

Intoxicated Patients

- If incompetent the patient can not sign out AMA
- Knowledge of state and federal laws on blood alcohol levels is important
- Feed them, observe the patient ambulate and document everything before discharge
- If patient admitted for alcohol detox provide training to staff and have standing orders that are evidenced based

ALCOHOL DETOX ADMITTING STANDING ORDERS

Page 1 of 2

1. Admit to _____
2. History & Physical by _____ Date/time notified/Initial _____
3. ATP Assessment (if not done)
4. Full vital signs q 1 hour for total of 4 hours if patient in significant withdrawal, otherwise full vital signs every 4 hours x 48 hours while awake then q shift thereafter.
5. Blood pressure and pulse prior to each medication dose.
6. Detox Assessment q 1 hour for total of 4 hours if patient in significant withdrawal, otherwise q 4hours for 48 hours.
7. Diet: _____
8. Stat Labs/Tests:
 - CMP (if not done within last 30 days)
 - Serum HCG female patients. Call MD if results positive.
 - CBC (if not done within 7 days)
 - Chest x-ray (if not done within last 12 mo). On females: obtain only after negative Serum HCG.
 - RPR
 - PT
 - PPD (routine)
 - BAL on admission *or*
 - UA

9. Medication:

- Therapeutic multi-vitamin 1 PO every morning
- Thiamine 100 mg IM on admission then
- Thiamine 100 mg PO every morning
- Acetaminophen 650 mg PO every 4 hours PRN for pain, not to exceed 4 doses within 24 hours
- Milk of Magnesia concentrate 10 mL PO at bedtime PRN every day for constipation
- Maalox Plus 30 mL PO PRN q 4 hours for gastric discomfort, not to exceed 4 doses in 24 hours
- Kaolin-pectin 30 mL PO every 4 hours PRN for loose stools
- Trimethobenzamide 200 mg suppository every 12 hours PRN for vomiting or
- Metoclopramide 10 mg PO q 8 hours PRN for vomiting
- Diazepam as per alcohol Detox Orders
- Lorazepam as per alcohol Detox Orders
- _____
- _____
- _____

11. Precautions: EP SP Fall Close Observation for _____

10. May Smoke Patient has been informed of risks of smoking and alternatives

11. Old Charts to Unit

12. ATP Psycho/Social History

13. Patient may enter ATP Program upon completion of ATP Assessment.

Boarding of Psych Patients in The ED

- Boarding of patients in the ED is one of the most concerning issues
- TJC has patient flow standards for hospitals accredited by them
- TJC made 3 changes to standards in 2013 and 2 in 2014
- Goal to get boarded patients to their rooms within 4 hours (EP 6)
 - Some EDs have behavioral health beds to keep patients safe until a bed opens up or will admit patients to the unit and ED safe beds

LD.04.03.11 Boarding of Psych Patients

- EP 6 and 9 went into effect January 1, 2014
- EP 9 States that the hospital determines if it has a population at risk for boarding due to behavioral health emergencies
- Hospital leaders must communicate with the behavioral health providers to improve coordination and make sure this population is appropriately served
- There is a shortage of behavioral health beds in this country leading to times where these patients have camped out in the ED sometimes for days

Boarding of Behavioral Health Patients PC

- Hospitals should also be familiar with two sections of PC.01.01.01 under EP4 and EP24
- EP 4 Hospitals that do not primarily provide psychiatric or substance abuse services must have a written plan that defines how the patient will be cared for which includes the referral process for patient who are emotional ill, or who suffer from substance abuse or alcoholism
 - This means that hospitals that do not have a behavioral health unit or substance abuse unit, how do you care for the patient until you transfer them out?

Boarding of Behavioral Health Patients PC

- PC.01.01.01 EP 24
- EP 24 requires boarded patients with an emotional illness, alcoholism or substance abuse be provided a safe and monitored location that is free of items that the patients could use to harm themselves or others
- Hospitals often use sitters and have a special safe room
- EP24 requires orientation and training to both clinical and non-clinical staff that care for these patients

Boarding of Behavioral Health Patients PC

- PC.01.01.01 EP 24 (Continued)
- This includes medication protocols and de-escalation techniques
- Assessments and reassessments must be conducted in a manner that is consistent with the patient's needs
- Free guide on how to create a safe room called the Design Guide for the Built Environment of Behavior Health Facilities, April 2014, at <https://www.naphs.org/index>

Boarding of Behavioral Health Patients

- Some hospitals have instituted processes to support the flow such as stat cleans of room by environmental services when a patient is waiting in the ED
- Some hospitals have posted ED physicians or NP at triage to expedite care in the ED
- Some ED have direct boarding where patients arriving go immediately to an ED bed if one is open (pull to full)
- Others keep ambulatory patients vertical when their condition allows this

Boarding of Behavioral Health Patients

- Some hospitals have a revised process in which each of the departments accepted one overflow patient
- The thought being it was easier for a department to take care of one additional patient then to have 12 boarded patients in the ED
- Some hospitals require daily rounds be made by a specified time so current patients are discharged home timely freeing up beds for patients who are being boarded
- Some ensure services are available on weekends so surgeons will not just do elective cases at beginning of week but spread cases out all week

Abnormal Vital Signs

- Failure to re-evaluate abnormal vital signs is a common finding so be sure to repeat VS and assessment
 - 16% of patients with abnormal vital signs are discharged without a single repeat (9,000)
 - No defending these cases so need a system to manage this critical issue
 - Failure to identify abnormal vital sign is recurrent theme in sepsis malpractice cases
 - Do assessments as per the 5 ESI levels and acuity

■ Source: Dr. Dan Sullivan

Resident Orders No CPOE

- Resident who is working in the ED can write orders on the ED order sheet as approved by the ED physician
- Do not allow the resident who is admitting the patient to write orders on the ED physician's sheet
- Should use sheet marked "ED Orders by LIPs other than the ED Physician" or CPOE is clear
- ED physician should NOT write admission orders (ACEP position statement)
 - Recently some have basic **transition orders** just to get patient to the floor but attending writes the regular orders but make sure ED doctor is **privileged** to do this

Writing Admission & Transition Orders

- ACEP has a position statement on this
- ACEP has a policy resource and education paper (PREP) on this topic also
- Should the ED physician write these?
- Survey found a wide variation in practice from writing no orders to wide spread use
 - If ED physician does make sure C&P to do this
 - Usually ED physician does not have inpatient privileges only outpatient
- Admitting orders are fraught with peril

Writing Admission & Transition Orders

- However, writing holding or transition orders may be appropriate
- If hospital allows make sure ED policy clearly delineates this and granted privileges to write
- “Transition orders” as those written by the EP as a means to facilitate the safe transition of the patient from the ED to the inpatient setting, until formal admitting orders are written by the responsible AP
 - Transition orders are skeletal by nature, and only cover basic patient maintenance, not inpatient evaluation, diagnosis and treatment

Name: _____

Room #: _____

STAT

EMERGENCY DEPARTMENT EXPEDITED ADMISSION ORDERS

Page 1 of 1

1. Patient admitted as observation patient to Dr. _____.
2. Page attending physician every 15 minutes until response. If no response after one hour, contact designated backup.
3. Vitals q shift
4. IV 0.9% Sodium Chloride *or* D5W (circle one) at _____ mL/hour
5. Heplock
6. Other: _____

ED Physician Signature: _____

Date: _____ Time: _____

ACEP ED Doctor Writing Admission Orders

Writing Admission and Transition Orders

Revised and Approved by the ACEP Board of Directors October 1993; and Revised titled, "Writing Admission and Transition Orders" April 2010
Reaffirmed by the ACEP Board of Directors October 1992, 1997, and 2001
Originally Approved by the ACEP Board of Directors October 1989

The American College of Emergency Physicians (ACEP) believes that the best patient care occurs when there is no ambiguity as to who is the physician responsible for the patient. Medical orders establish which physician is in charge of a patient's care. Emergency physicians generally do not have admitting privileges and do not provide continuing inpatient care.

Therefore, ACEP endorses the following principles:

- Patients are best served when there is a clear delineation of patient care responsibility.
- The emergency physician is responsible for care of the patient only while the patient is physically present in the emergency department under their care.
- The admitting physician is responsible for care of the patient after they have accepted responsibility for the patient's admission, regardless of the patient's physical location within the hospital.
- When an emergency physician is compelled to write orders that appear to extend control and responsibility for the patient beyond treatment in the emergency department to the inpatient setting, it is understood that the admitting physician retains responsibility for providing inpatient care.
 - However, in the interest of patient care and safety, an emergency physician may be compelled to write transition orders.
 - These transition orders may include essential treatment and assessment parameters required before preparation of suitable admission orders.
- Hospital and emergency department policies should clearly delineate responsibility for writing admission or transition orders. Policies must define an appropriate period of time for the admitting physician to see the patient and prepare admission orders.

ACEP Writing Admission & Transition Orders



The screenshot shows the ACEP website interface. At the top, there is a navigation bar with links for 'Join ACEP', 'My ACEP', 'Account Settings', and 'Welcome Sue, Logout'. Below this is the ACEP logo and a search bar. A secondary navigation bar contains links for 'Clinical & Practice Management', 'Continuing Education', 'Professional Development', 'Meetings & Events', 'Advocacy', 'Membership', and 'Bookstore'. The main content area features a breadcrumb trail: 'Clinical & Practice Management > ACEP Policy Statements'. Below this is a banner image of a hand using a stethoscope, with the text 'Clinical & Practice Management' overlaid. The main article title is 'Writing Admission and Transition Orders – Policy Resource and Education Paper (PREP)'. A sub-header reads 'www.acep.org/Clinical---Practice-Management/Writing-Admission-and-Transition-Orders---Policy-Resource-and-Education-Paper-(PREP)'. The article text begins with 'This policy resource and education paper (PREP) was developed as an explanation of the ACEP policy statement, "Writing Admission and Transition Orders."' and includes a 'Background' section discussing emergency medicine's role in hospital admissions.

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Clinical & Practice Management

Writing Admission and Transition Orders – Policy Resource and Education Paper (PREP)

[www.acep.org/Clinical---Practice-Management/Writing-Admission-and-Transition-Orders---Policy-Resource-and-Education-Paper-\(PREP\)](http://www.acep.org/Clinical---Practice-Management/Writing-Admission-and-Transition-Orders---Policy-Resource-and-Education-Paper-(PREP))

This policy resource and education paper (PREP) was developed as an explanation of the ACEP policy statement, "Writing Admission and Transition Orders."

Background

Emergency medicine stands at the juncture between outpatient and inpatient care. While the majority of emergency department (ED) patients are discharged from the ED, a significant minority is admitted to the hospital or to an observation unit within the hospital. In most hospitals, the ED is the single largest source of admissions to the facility; with about 50% of all US inpatients originating from the ED.¹ It has been said that emergency physicians make "the most expensive decision in healthcare."²

Hospitals are increasingly filled to capacity with a resultant lack of available bed

Feedback

Alarm Fatigue



- Recent risk management issue
- Brought to light by several articles in the press including Boston Globe article
- Hospital staff fails to hear a cardiac monitor and patient was found flat lined for more than two hours
- With increased use of alarms they are either ignored or just not heard
- Staff have forgotten to turn them back on
- Staff can tune out the alarm noise
- Cardiac monitors, infusion pumps, ventilators, etc.

Patient Alarms Often Unheard or Unheeded

SPECIAL REPORT

The Boston Globe

Patient alarms often unheard, unheeded

The incessant din of beeping monitors can numb or distract hospital staff; the consequences can be deadly



Alarm Fatigue

- ECRI Institute issues a report and finds 216 deaths from 2005 to mid 2010 in which problems with monitor alarms occurred
- ECRI published top hazards for 2011, through 2015 and alarm hazards makes the top ten list
- Staff overwhelmed by sheer number of alarms (alarm overload)
- Staff improperly modified the alarm settings
- Staff become desensitized to alarms leading to slow response time
 - CMS cited hospital under staffing when staff did not respond timely and hospital gets monitor watchers

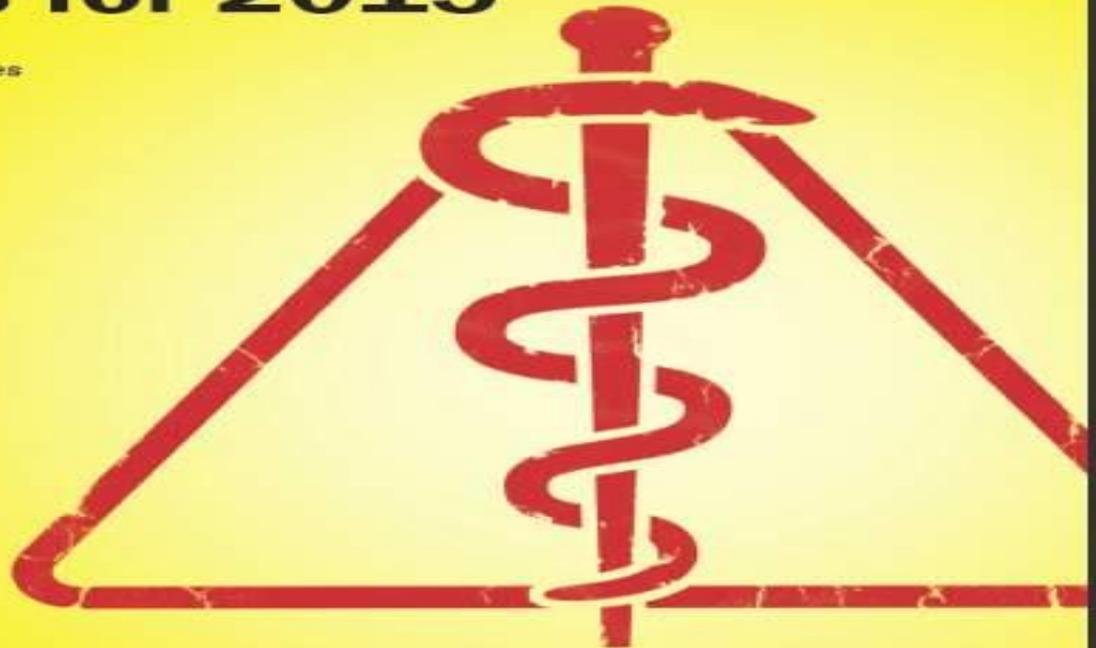
Alarm Fatigue

- Alarm settings not restored to their normal levels
- Alarms not properly relayed to ancillary notification systems
 - Paging systems, wireless phones, etc.
- ECRI makes recommendations
 - Establish protocols for alarm system settings
 - Ensure adequate staffing
 - Establish alarm response protocols and ensure each alarm will be recognized
 - Assign one person responsible for addressing the alarms

Alarm Top 10 Hazard in 2015 by ECRI

Top 10 Health Technology Hazards for 2015

A Report from *Health Devices*
November 2014



health.
DEVICES

ECRIInstitute
The Discipline of Science. The Integrity of Independence.

Alarm Hazard also Top 10 Patient Safety Concern



TJC NPSG

- Identify most important alarm signals to manage
- What is risk to patient if not attended to
- If the alarm signal needed or does it contribute to alarm noise and alarm fatigue?
- Look at best practices and guidelines
- January 1, 2016 establish P&P that address the issues identified by TJC
- Must educate staff and LIPs on the purpose and proper operation of alarm systems that they are responsible for by January 1, 2016

Alarm Management is TJC NPSG Goal

APPLICABLE TO HOSPITALS AND CRITICAL ACCESS HOSPITALS

Effective January 1, 2014

National Patient Safety Goal (NPSG)

NPSG.06.01.01

Improve the safety of clinical alarm systems.

Rationale for NPSG.06.01.01

Clinical alarm systems are intended to alert caregivers of potential patient problems, but if they are not properly managed, they can compromise patient safety. This is a multifaceted problem. In some situations, individual alarm signals are difficult to detect. At the same time, many patient care areas have numerous alarm signals and the resulting noise and displayed information tends to desensitize staff and cause them to miss or ignore alarm signals or even disable them. Other issues associated with effective clinical alarm system management include too many devices with alarms, default settings that are not at an actionable level, and alarm limits that are too narrow. These issues vary greatly among hospitals and even within different units in a single hospital.

There is general agreement that this is an important safety issue. Universal solutions have yet to be identified, but it is important for a hospital to understand its own situation and to develop a sys-

* Additional information on alarm safety can be found on the AAMI website <http://www.aami.org/htsi/alarms/>. Also, the ECRI Institute has identified alarm hazards as one of the top technology hazards for 2013; more information on this hazard list can be found at http://www.ecri.org/Forms/Pages/Alarm_Safety_Resource.aspx.

tematic, coordinated approach to clinical alarm system management. Standardization contributes to safe alarm system management, but it is recognized that solutions may have to be customized for specific clinical units, groups of patients, or individual patients. This NPSG focuses on managing clinical alarm systems that have the most direct relationship to patient safety. As alarm system management solutions are identified, this NPSG will be updated to reflect best practices.*

Elements of Performance for NPSG.06.01.01

- A 1.** As of July 1, 2014, leaders establish alarm system safety as a [critical access] hospital priority. **R**
- A 2.** During 2014, identify the most important alarm signals to manage based on the following: **R**
 - Input from the medical staff and clinical departments
 - Risk to patients if the alarm signal is not attended to or if it malfunctions
 - Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue
 - Potential for patient harm based on internal incident history
 - Published best practices and guidelines(For more information on managing medical equipment risks, refer to Standard EC.02.04.01.)
- A 3.** As of January 1, 2016, establish policies and procedures for managing the alarms identified in EP 2 above that, at a minimum, address the following: **R**
 - Clinically appropriate settings for alarm signals
 - When alarm signals can be disabled
 - When alarm parameters can be changed

TJC Sentinel Event Alert 50 Alarm Safety

The Joint Commission Sentinel Event Alert

A complimentary publication of
The Joint Commission

Issue 50, April 8, 2013

Medical device alarm safety in hospitals

Many medical devices have alarm systems, among them are bedside physiologic monitors that include ECG (electrocardiogram) machines, pulse oximetry devices, and monitors of blood pressure and other parameters; bedside telemetry; central station monitors; infusion pumps; and ventilators. These alarm-equipped devices are essential to providing safe care to patients in many health care settings; clinicians depend on these devices for information they need to deliver appropriate care and to guide treatment decisions. However, these devices present a multitude of challenges and opportunities for health care organizations when their alarms create similar sounds, when their default settings are not changed, and when there is a failure to respond to their alarm signals.

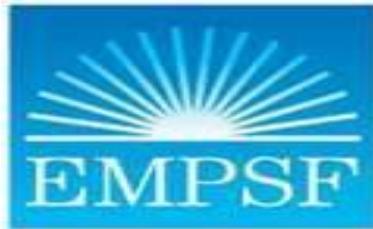
The number of alarm signals per patient per day can reach several hundred depending on the unit within the hospital, translating to thousands of alarm signals on every unit and tens of thousands of alarm signals throughout the hospital every day. It is estimated that between 85 and 95 percent of alarm signals do not require clinical intervention, such as when alarm conditions are set too tight; default settings are not adjusted for the individual patient or for the patient population; ECG electrodes have dried out, or sensors are mispositioned.¹ As a result, clinicians become desensitized or immune to the sounds, and are overwhelmed by information – in short, they suffer from “alarm fatigue.” In response to this constant barrage of noise, clinicians may turn down the volume of the alarm, turn it off, or adjust the alarm settings outside the limits that are safe and appropriate for the patient – all of which can have serious, often fatal, consequences.² One such example occurred in the summer of 2010. According to a Boston Globe article, a 60-year-old man died in the intensive care unit of a hospital – not from the injury he suffered to his head from a fallen tree branch – but from a system failure that resulted in delayed response to an alarm signal that indicated significant changes in his condition.³ These changes – that set off alarms – included rapidly increasing heart rate and falling blood oxygen levels. Staff responded only after one hour, when a critical alarm condition signaled that the patient had stopped breathing –

Published for Joint Commission accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel events, describes their common underlying causes, and suggests steps to prevent occurrences in the future.

Accredited organizations should consider information in an Alert when designing or redesigning relevant processes and consider implementing relevant suggestions contained in the Alert or reasonable alternatives.

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Alarm Problems in the ED



EMERGENCY
MEDICINE
PATIENT SAFETY
FOUNDATION

Addressing Alarm Problems in the Emergency Department

By Kathryn M Pelczarski

Director, Applied Solutions Group, ECRI Institute

September 2012

Stand for a few moments in the middle of your emergency department (ED) to just listen and observe. How many alarms do you hear? Can you distinguish where each alarm is coming from and whether it's a physiologic monitor or ventilator or infusion pump alarm? Does each alarm connote the level of urgency needed for the nurse to respond promptly and appropriately? Do you observe the nurses scurrying to respond? Or do the alarms continue to perpetuate while no one responds?

Device alarms should provide an effective safety net to alert caregivers to critical changes in patient conditions or safety-related problems with devices. Does this statement hold true in your organization? Do device alarms provide an effective safety net in your ED?

Unfortunately, as many experts agree, there are serious problems with both the design and use of clinical alarms. In fact, ECRI Institute identified alarm hazards as Number 1 in its Top Ten Technology Hazards in 2012.¹ Many medical devices such as physiologic monitors, ventilators, and infusion pumps rely on alarms to help protect patients, but there are times when alarms actually contribute to the occurrence of adverse events. The reality is that alarm events frequently occur, and the consequences of these events are often serious. Alarm events are those accidents waiting to happen, the results of a perfect storm in a error-prone system.

Most EDs are plagued by a myriad of alarm problems, such as:

Abnormal X-ray

- Are patients notified timely of all abnormal EKG and x-ray results
- Is follow up clearly documented in the medical record
- With telemedicine can have 24 hour review of x-rays by radiologist
- TJC RC.02.01.01 EP4 requires documentation of all communication with the patient including telephone calls or e-mail such as when calling discharged patients with abnormal test results
- Are these logged on a sheet and reviewed for PI purposes

Abnormal X-ray

- Missed rate should be within acceptable limits, track errors, document nature, severity, frequency
- KEEP radiologist preliminary readings on ED patients in the permanent medical record
 - This includes preliminary readings from off site teleradiology services
 - Make sure meet CMS teleradiology standards
- Special studies (MRI, CT, US) should be read by the radiologist in real time while patient is still in ED and not the next morning (See ACEP position statement of Interpretation of Diagnostic Imaging)

X-rays

- All preliminary readings should be communicated to the ED physician within a reasonable period of time (less than one hour) after completion of the study
- Should be interpreted before the patient is discharged from the ED
- If over reading must be done next morning any discrepancy must be communicated timely
- It is not appropriate for the hospital's radiology techs to wait until a "batch" of CTs or other studies is completed before waking the night radiologist or transmitting the studies to a radiologist covering electronically from home

Document in Chart all ED Follow-Up

EMERGENCY DEPARTMENT TELEPHONE FOLLOW-UP

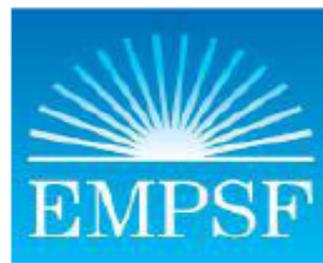
M.D. / R.N. INITATING ACTION	DATE:																				
TREATING E.D. M.D.	DATE OF TREATMENT:																				
REASONS FOR TELEPHONE CALL: <input type="checkbox"/> POSITIVE X-RAY REPORT _____ <input type="checkbox"/> POSITIVE CULTURE REPORT _____ <input type="checkbox"/> CHECK ON PATIENT STATUS _____ <input type="checkbox"/> OTHER (SPECIFY): _____																					
FINDINGS: _____ _____ _____																					
ACTION: <input type="checkbox"/> APPROPRIATE CARE IN E.D. M.D. CALL BACK NECESSARY <input type="checkbox"/> ATTEMPTED TELEPHONE CONTACT																					
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">PHONE NO.</th> <th style="width: 15%;">DATE</th> <th style="width: 10%;">TIME</th> <th style="width: 40%;">NAME OF PERSON CONTACTED</th> <th style="width: 10%;">INITIAL</th> </tr> </thead> <tbody> <tr> <td style="padding: 2px;">1. _____</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding: 2px;">2. _____</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding: 2px;">3. _____</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	PHONE NO.	DATE	TIME	NAME OF PERSON CONTACTED	INITIAL	1. _____					2. _____					3. _____					
PHONE NO.	DATE	TIME	NAME OF PERSON CONTACTED	INITIAL																	
1. _____																					
2. _____																					
3. _____																					

PLAN:

- RETURN TO E.D.
- F/U WITH P.M.D. DR. _____ WHEN _____
- PMDS OFFICE NOTIFIED NAME _____ DATE _____
- OTHER _____

UNABLE TO CONTACT PATIENT VIA TELEPHONE WITHIN 24 - 48 HRS.

- MAILGRAM SENT DATE: _____
- RECEIPT RECEIVED DATE: _____
- PATIENT CONTACTED ED PERSON _____
REGARDING CONTENTS OF DATE: _____ TIME _____ RECEIVING CALL _____
LETTER
- NO RESPONSE 48 HRS. DATE: _____ TIME _____ SIGNATURE _____



EMERGENCY
MEDICINE
PATIENT SAFETY
FOUNDATION

WORKING EFFECTIVELY WITH RADIOLOGY

Emergency Department Patient Safety Briefing

August 2011

ED physicians have been interpreting traditional x-rays to rule out fractures, pneumothorax, etc. for many years and by and large the studies show they are pretty skilled at it. Most ED physicians view plain films even when they know they will receive a real-time report by the radiologist prior to patient discharge. In fact, the American College of Emergency Physicians (ACEP) encourages ED providers to interpret and record the results of diagnostic studies at the time of service (ACEP, 2000). Radiologists are not infallible and the ED provider may well diagnose a fracture or other finding missed by the radiologist. ED groups must ensure that their physicians are competent at reading plain films by monitoring miss rates and considering competency minimally at time of reappointment.

However, it is clearly not the standard for EM providers to be reading CT scans, MRIs or ultrasounds and

Follow-up of Abnormal Lab Results

- Follow up on all pertinent abnormal culture reports
- Call prescriptions in for unexpected positive STD or abnormal cultures
- Follow up with letter if patient is not home when nurse phones and unable to reach
- Document follow-up in the medical record
 - TJC RI has an informed consent requirement that says if it has to be reported to the state department of health then the patient must be notified and this must be documented in the medical record
- Make sure your follow up system is effective

CT Scans

- CT scan should be ordered timely
- CT scan needs to be reviewed by radiologist timely
- Important in light of EMTALA and AHA protocol in diagnosis of patient with possible CVA
- Should be aware of recent issue of concerns about radiation exposure especially with brain CTs
 - Some patients lost their hair or a circular band of hair and redness associated with receiving too much
 - Parents may have a card for their children asking ED staff to document tests done

CT Scans

- Increased focus to make sure they are truly medically necessary
- If tele-radiology, make sure radiologists are credentialed, licensed, insured, privileged and credentialed and meet TJC and CMS standards
- ACEP says both preliminary and final reports must be documented in writing and in MR for all diagnostic tests
- CMS says to be sure there is order documented in the order sheet even if done via protocol
 - CMS rewrote all the radiology standards July 2015

CMS Radiology Regulations

- Must have P&P and written protocols for radiology safety and that acceptable standards are met
- CMS notes that X-rays can cause cataracts, skin damage, & cancer
 - Women are at higher lifetime risk for developing radiation associated cancer
 - Risk is greater for x-rays at a younger age
- Principle of as low as reasonably achievable (ALARA)
- Radiology must identify patients at high risk of an adverse event; pregnant, allergic to contrast, implanted devices

Hair Loss In Radiation Overdoses



Radiation Safety

- Image gently campaign was launched to raise awareness about measures to reduce radiation dose during pediatric medical imaging exams
 - Parent may give nurse a card to fill out with information on exam performed
 - Has many free resources available off the website including pediatric CT protocol
- Image wisely is an awareness program of the American College of Radiology and others to address concerns about patient exposure to ionizing radiation from medical imaging

Image Gently Radiation Safety in Pediatrics



The Alliance for Radiation Safety
in Pediatric Imaging

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Procedures

Current Events

Education

FAQs & More



The Image Gently ALARA CT summit was held February 21, 22, 2014 in Orlando Florida.

Current issue

www.pedrad.org/associations/5364/ig/Home.aspx

Butterfly Effect Newsletter



Child's Medical Imaging Record



FOLD HERE

Date	Exam	Where Exam Performed

Child Sized Protocols



American Registry of Radiologic Technologists Supports Image Gently Campaign...

Adjust Your Action Plans to Ensure 'Child-Size' Protocols

The goal of the Alliance for Radiation Safety in Pediatric Imaging, sponsors of the "Image Gently" campaign, is to raise awareness of the opportunities to lower radiation dose in the imaging of children. Visit their website at www.imagegently.org for simple educational resources to inform radiology practices on what can be done now to improve radiation protection for children. In the meantime, the Image Gently alliance calls for technologists to get on board by following these five recommendations.

1 Increase awareness for the need to decrease radiation dose to children during CT scanning. Encourage your fellow professionals to get involved in the effort.

Work with your medical physicist, radiologist, and department manager to review your adult CT protocols; then use the simple CT protocols on the Image Gently website to down-size for kids. More is *not* better; adult-size KV and mAs are not necessary for small bodies.

4

2 Be committed to make a change in your daily practice by working as a team with your radiologist, medical physicist, referring doctors, and parents to decrease the radiation dose. You can even sign a pledge found on the Image Gently website at www.imagegently.org.

Be involved with your patients. Be the patient's advocate. Ask the questions required to ensure that you child-size the scan and that you scan only the area required to obtain the necessary information.

5

3 Know the practice standards ("The Practice Standards for Medical Imaging and Radiation Therapy" from ASRT). Standards 1 and 2 on assessment and analysis are your guide to ensuring an appropriate action plan is established for completing a CT exam.

Your patients and their families will thank you.

For more information on "Image Gently," visit www.imagegently.org

CT Scans in Children Linked to Later Cancer

www.usatoday.com
LATE SPORTS



Let the hype begin

Clock is ticking toward Sunday. Full report, 1-4C
► 10 years ago, war was on our minds, IC
► Coming Friday: Bonus Section

THE NATION'S NEWSPAPER



NO. 1 IN THE USA

Monday, January 22, 2001

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Get the latest news, stocks, scores and more right now at USA TODAY's 24-hour online news site, all with a clean new interface. Plus, a stand-alone Tech section.

Election still s

Friction over justices' ruling on ballot count in Florida continues to cause hard feelings, draw angry letters.

By Joan Bridgus
USA TODAY

WASHINGTON — Six weeks after an uneasy U.S. Supreme Court cleared the way for Republican George W. Bush to become president, the scars left on the nation's highest court by the Florida election case are evident. The court's new custom, uncomfortable

THE NEW ENGLAND JOURNAL OF MEDICINE

REVIEW ARTICLE

CURRENT CONCEPTS

Computed Tomography — An Increasing Source of Radiation Exposure

David J. Brenner, Ph.D., D.Sc., and Eric J. Hall, D.Phil., D.Sc.

CT scans in children linked to cancer later

By Steve Sternberg
USA TODAY

Each year, about 1.6 million children in the USA get CT scans to the head and abdomen — and about 1,500 of those will die later in life of radiation-induced cancer, according to research out today.

What's more, CT or computed tomography scans given to kids are typically calibrated for adults, so children absorb two to six times the radiation needed to produce clear images, a second study shows. These doses are "way bigger than the sorts of doses that people at Three Mile Island were getting,"

David Brenner of Columbia University says. "Most people get a tenth or a hundredth of the dose of a CT."

Both studies appear in February's *American Journal of Roentgenology*, the nation's leading radiology journal. The first, by Brenner and colleagues, is the first to estimate the risks of "radiation-induced fatal cancer" from pediatric CT scans. Until a decade ago, CT scans took too long to perform on children without giving them anesthesia to keep them still. Today's scanners spiral around the patient in seconds, providing cross sections, or "slices," of anatomy.

Doctors use CT scans on children to

search for cancers and ailments such as appendicitis and kidney stones.

"There's a huge number of people who don't just receive one scan," says Fred Mettler of the University of New Mexico, noting that CT scans are used for diagnosis and to plan and evaluate treatment. "The breast dose from a CT scan of the chest is somewhere between 10 and 20 mammograms. You'd want to think long and hard about giving your young daughter 10 to 20 mammograms unless she really needs it."

Mettler recently published a study showing that 11% of the CT scans at his center are done in children under 15,

and they get 70% of the total radiation dose given to patients. Children have more rapidly dividing cells than adults, which are more susceptible to radiation damage. Children also will live long enough for cancers to develop.

Researchers led by Lane Donnelly at Cincinnati's Children's Hospital found that children often get radiation doses six times higher than necessary. Cutting the adult dose in half would yield a clear image and cut the risk a like amount, Brenner says. "Radiologists genuinely believe the risks are small," he says. "I suspect they've never been confronted with numbers like this."

Guide on Pediatric CT Radiation Risk



MENU



CONTACT



DICTIONARY



SEARCH

Radiation Risks and Pediatric Computed Tomography (CT): A Guide for Health Care Providers



The use of pediatric CT, which is a valuable imaging tool, has been increasing rapidly. However, because of the potential for increased radiation exposure to children undergoing these scans, pediatric CT is a public health concern. This page discusses the value of CT and the importance of minimizing the radiation dose, especially in children. It will address the following issues:

- CT as a diagnostic tool
- Unique considerations for radiation exposure in children
- Radiation risks from CT in children
- Immediate strategies to minimize CT radiation exposure to children

www.cancer.gov/about-cancer/causes-prevention/risk/radiation/pediatric-ct-scans

CT as a Diagnostic Tool

CT can be a life saving tool for diagnosing illness and injury in children. For an individual child, the risks of CT are small and the individual risk-benefit balance favors the benefit when used appropriately.

Approximately 5 to 9 million CT examinations are performed annually on children in the United States. The use of CT in adults and children has increased about eightfold since 1980, with annual growth estimated at about 10 percent per year. Much of this increase is due to its utility in common diseases, as well as to technical improvements.

Despite the many benefits of CT, a disadvantage is the inevitable radiation exposure. Although CT scans comprise up to about

ASRT Practice Standards

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American Society of Radiologic Technologists

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We know it's important for you to keep up with the latest professional standards and state and federal regulations that matter to your practice and your career.

Radiologic Technology Practice Standards

Find out everything you need to know about practice standards for registered technologists and read ASRT's position statements.

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Brush up on the code of ethics for your profession.

[Radiologic Technologist Code of Ethics](#)

[Radiation Therapist Code of Ethics](#)

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Find out more about proposed federal laws that will improve patient care and advance the radiologic technology profession.

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NEW

Learn more about radiation safety specific to fluoroscopy. Be more informed about safe adult fluoroscopy imaging.

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<http://www.imagewisely.org/Imaging-Modalities/Fluoroscopy>

36 060

Choosing Wisely

- Another important website is Choosing Wisely
- Helps patients choose by selecting care that is evidenced based
- Has a list of things that providers and patients should question
- List first published in Archives of Internal Medicine
- Many prestigious organizations are partners
- Have a list of things that should be questioned and helps educate patients on making wise decisions



SEARCH:



Lists

Read the Lists of Tests or Procedures that Should be Questioned



On May 1, the **ABIM Foundation** announced the **findings of a new physician survey** sponsored by the **Robert Wood Johnson Foundation (RWJF)** aimed at gauging attitudes and awareness of the *Choosing Wisely®* campaign. The announcement also introduced the campaign's expansion to include non-physician partners, with the American Academy of Nursing, the American Dental Association and American Physical Therapy

 **UPDATES FROM THE FIELD** ▶

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Lists

United States health care provider organizations representing more than one million providers developed lists of *Things Physicians and Providers Should Question* in recognition of the importance of conversations to improve care and eliminate unnecessary tests and procedures.

[Download a pdf of all specialty society lists](#)

These lists represent specific, evidence-based recommendations providers and patients should discuss together in order to make wise decisions about the most appropriate care based on their individual situation. Each list provides information on when tests and procedures may be appropriate, as well as the methodology used in its creation.

Choosing Wisely recommendations should not be used to establish coverage decisions or exclusions. Rather, they are meant to spur conversation about what is appropriate and necessary treatment. As each patient situation is unique, providers and patients should use the recommendations as guidelines to determine an appropriate treatment plan together.

In collaboration with the partner organizations, Consumer Reports has created resources for consumers and providers to engage in these important conversations about the overuse of medical tests and procedures that provide little benefit and in some cases harm.

Specialty Society Lists of Five Things Physicians and Patients Should Question (for physicians):

- [AMDA – Dedicated to Long Term Care Medicine](#)
- [American Academy of Allergy, Asthma & Immunology](#)
- [American Academy of Dermatology](#)
- [American Academy of Family Physicians](#)
- [American Academy of Hospice and Palliative Medicine](#)
- [American Academy of Neurology](#)
- [American Academy of Ophthalmology](#)
- [American Academy of Orthopaedic Surgeons](#)
- [American Academy of Otolaryngology – Head and Neck Surgery Foundation](#)
- [American Academy of Pediatrics](#)
- [American Association for Pediatric Ophthalmology and Strabismus](#)
- [American Association for the Study of Liver Diseases](#)

Patient-Friendly Resources from Specialty Societies and Consumer Reports:

- [Allergy tests: When you need them and when you don't](#)
- [Antibiotics for ear infections in children: when you need them...](#)
- [Antibiotics for pink eye...](#)
- [Antibiotics for urinary tract infections in older people](#)
- [Antibiotics for your skin: When you need them...](#)
- [Antibiotics: When children need them for respiratory illness](#)
- [Bone-density tests: When you need them...](#)
- [Cancer care at the end of life: When to choose supportive care](#)
- [Chest X-rays before surgery: When you need them...](#)
- [Choosing pain relievers with kidney disease/heart problems](#)
- [Chronic kidney disease: Making hard choices](#)
- [Colonoscopy: When you need it...](#)



ACEP's 5 Tests & Procedures Not Effective

- ACEP lists five tests or procedures that may not be effective
- Avoid CT scans of the head in ED patients with minor head injury who are a low risk based on validated decision rules
 - CT scans exposes patients to ionizing radiation which increases lifetime cancer risk
- Avoid placing indwelling foley in the ED for urine output monitoring in stable patients who can void or for patient or staff convenience
 - Follow CDC standards and reduce CAUTI

Healthcare-associated Infections (HAIs)

www.cdc.gov/HAI/ca_uti/uti.html

Healthcare-associated Infections

- Data and Statistics
- Types of Infections
 - Central Line-associated Bloodstream Infections
 - Surgical Site Infection
 - Catheter-associated Urinary Tract Infection**
 - FAQs about CAUT
 - Ventilator-associated Pneumonia
- Diseases and Organisms
- Preventing HAIs
- Map: HAI Prevention Activities
- Research
- Patient Safety
- Outpatient Settings
- Laboratory Resources
- Outbreak and Patient Notifications
- Widgets, Buttons and Badges

[Healthcare-associated Infections](#) > [Types of Infections](#)

Recommend 18 Tweet 4 Share

Catheter-associated Urinary Tract Infections (CAUTI)

A urinary tract infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney. UTIs are the most common type of healthcare-associated infection reported to the [National Healthcare Safety Network \(NHSN\)](#). Among UTIs acquired in the hospital, approximately 75% are associated with a urinary catheter, which is a tube inserted into the bladder through the urethra to drain urine. Between 15-25% of hospitalized patients receive urinary catheters during their hospital stay. The most important risk factor for developing a catheter-associated UTI (CAUTI) is prolonged use of the urinary catheter. Therefore, catheters should only be used for appropriate indications and should be removed as soon as they are no longer needed.

Resources for Patients and Healthcare Providers

- [Frequently Asked Questions about CAUTIs](#)
- [October 2008 Supplement of Infection Control and Hospital Epidemiology](#) (Volume 29, Number S1)

FAQ's about Catheter-associated Urinary Tract Infection

8.5" by 11" poster is available in the following formats:

- [FAQs about Catheter-associated Urinary Tract Infection](#) [PDF - 208 KB]
- [FAQs about Catheter-associated Urinary Tract Infection - Black and White format](#) [PDF - 180 KB]
- [Download FAQs about UTI Larger text PDF for printing](#) [PDF - 210 KB]



On this Page

- [Resources for Patients and Healthcare Providers](#)
- [Prevention](#)
- [Toolkit](#)
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 1600 Clifton Rd
 Atlanta, GA 30333

800-CDC-INFO
 (800-232-4636)
 TTY: (888) 232-6348
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CDC HICPAC Recommendations

Guidelines for the Prevention of CLABSI, 2011

Latest guidelines on CLABSI.
[More...](#)

Guideline for Prevention of Catheter-associated Urinary Tract Infections, 2009

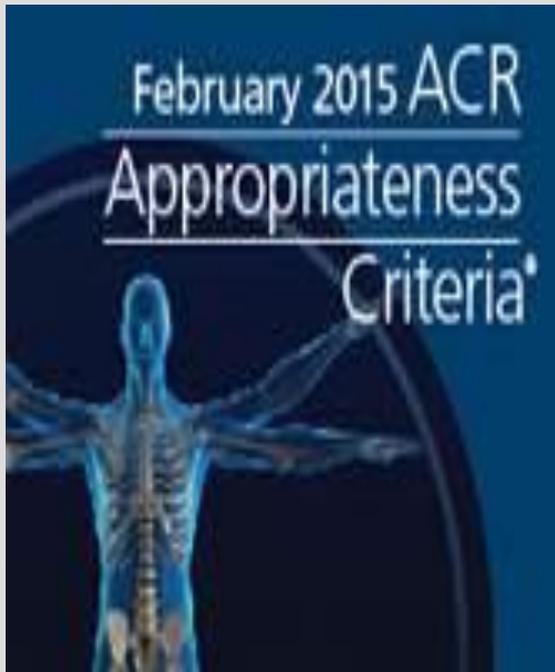
Related Guidelines

[Guidelines for the Prevention of Intravascular Catheter-Related Infections, 2011](#)

ACEP's 5 Tests & Procedures Not Effective

- Don't delay engaging available palliative and hospice services in the ED for patients likely to benefit such as patients with terminal illness
- Avoid antibiotics and wound cultures in patients with uncomplicated skin abscesses after successful I&D with adequate follow up
 - Abscesses become walled off and form pus under the skin and antibiotics offer no benefit after I&D done
- Avoid IV fluids before doing a trial of oral rehydration in cases of mild to moderate dehydration in children

ACR Appropriateness Criteria



- The ACR Appropriateness Criteria (AC) are evidence-based guidelines to assist referring providers in making the most appropriate imaging or treatment decision for a specific clinical condition.
- Employing these guidelines helps providers enhance quality of care and contribute to the most efficacious use of radiology.

CT Scans Interference

- Many patients in the ED have CT scans
- First we heard risk of cancer is 1:1000 per CT scan and 15,000 patients die every year from cancer caused by radiation exposure
- FDA reports about defibrillators, pacemakers or other electronic medical devices can malfunction during a CT scan
- Insulin infusion pumps, neurostimulators (and unintended shocks), cochlear implants, and retinal implants
- Implanted or externally worn devices

ACR Statement on CT Scans and Cancer



QUALITY IS OUR IMAGE

http://www.acr.org/MainMenuCategories/media_room/FeaturedCategories/other/PositionStatements/StatementonRecentStudiesRegardingCTScans.aspx

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ACR Statement on Recent Studies Regarding CT Scans and Increased Cancer Risk

Medical imaging exams have been directly linked to greater life expectancy, declines in cancer mortality rates, and are generally less expensive than the invasive procedures that they replace. However, widespread use has resulted in increased radiation exposure for Americans.

The American College of Radiology (ACR) advises that no imaging exam should be performed unless there is a clear medical benefit that outweighs any associated risk. The ACR supports the 'as low as reasonably achievable' (ALARA) concept which urges providers to use the *minimum* level of radiation needed in imaging exams to achieve the necessary results. ACR is a founding participant in the *Image Gently™ campaign* for dose reduction in pediatric imaging and has launched an adult radiation dose reduction effort.

While imaging growth is in line with, or below that of other physician services, appropriate use of imaging can be addressed by wider adoption of [ACR Appropriateness Criteria®](#), which help physicians prescribe the most appropriate imaging exam for more than 200 clinical conditions (particularly when an imaging exam that does not use radiation may be more appropriate for a given condition), and point of entry physician ordering systems based on this tool, such as the 2010 Medicare pilot project mandated by the Medicare Improvements for Patients and Providers Act of 2008. Accreditation of imaging facilities, to be mandated under Medicare, effective Jan. 1, 2012, can cut down on radiation dose received from duplicative scans and help to ensure that patients receive appropriate dose per scan.

Specific to the *Archives of Internal Medicine* studies:

There is significant debate and uncertainty regarding the cancer risks associated with the X-rays used for diagnostic imaging. However, some studies of large populations exposed to radiation have demonstrated slight

CT Scan Interference

- ED staff closely check and monitor equipment after a CT because the FDA discovered it could cause equipment problems like the MRI
- Has affected pacemakers, IV pumps, implantable pumps, neurostimulators,
- Shut off neurostimulator
- Remove external devices out of scan range
- www.fda.gov/cdrh/safety/071408-ctscanning.html
- See radiation risk and pediatric CT guide for healthcare providers at National Cancer Institute

CT Scans Cause Interference with Equipment

U.S. Department of Health & Human Services www.hhs.gov

FDA U.S. Food and Drug Administration

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Medical Device Safety
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FDA Preliminary Public Health Notification: Possible Malfunction of Electronic Medical Devices Caused by Computed Tomography (CT) Scanning

Date July 14, 2008

Dear Healthcare Professional:

This is to alert you to the possibility that the x-rays used during CT examinations may cause some implanted and external electronic medical devices to malfunction, and to provide recommendations to reduce the potential risk.

Most patients with electronic medical devices undergo CT scans without any adverse consequences. However, FDA has received a small number of reports of adverse events in which CT scans may have interfered with electronic medical devices, including pacemakers, defibrillators, neurostimulators, and implanted or externally worn drug infusion pumps. There have been similar reports in the literature.²⁻⁴

It is possible that this interference is being reported more frequently now because of the increased utilization of CT, the higher dose-rate capability of newer CT machines, an increase in the number of patients with implanted and externally worn electronic medical devices, and better reporting systems.

We are continuing to investigate this issue while working with device manufacturers and raising awareness in the healthcare community. To date, no patient deaths have been reported from CT scanning of implanted or externally worn electronic medical devices.

Adverse events

In the reports received by FDA, the following adverse events were likely to have been caused by x-rays from CT scans:

- Unintended "checks" (i.e., stimuli) from neurostimulators

www.fda.gov/MedicalDeviceSafety/AlertsandNotices/PublicHealthNotifications/ucm061994.htm

Policies and Procedures (P&P)

- Failure to follow your own rules and policies and procedures is legally risky
- Plaintiff attorney can subpoena P&Ps
- Can be introduced into court by plaintiff's attorney to show you violated your own standards
- Can be used by CMS and Accreditation Organization (TJC, AOA, DNV, CIHQ) to show your facility's standard of care
- CMS and TJC will hold to you to what is in your P&P

Policies and Procedures

- Can be ED policies, administrative, or nursing service policies
- Make sure policies are realistic and down to earth
- Provide education in orientation to important P&P (a TJC requirement)
- Make sure you have all the P&P required by CMS CoPs and TJC standards
- Make sure all ED are aware when changes are made or new policies implemented

Policies and Procedures

- State and federal laws should be incorporated into a P&P
 - State DNR law and state consent law, reporting of gunshots wounds etc.
- ED must give patient written information advance directive policy (CMS hospital CoP requirement)
- Important ENA and ACEP guidelines should be incorporated into P&P and cite as authority
- Policies should be reviewed as per your policy
 - This must be, at a minimum, every 3 years, except every year by CAH
 - Consider annual review

Policies and Procedures

- Revise as necessary and signed by responsible authority
- Should not be unnecessarily detailed
- Should be within capability of staff to perform
- Date the P&P to show time of last review
- Have staff review to make sure it is consistent with practice
- Use evidenced based practice to incorporate into policies (See www.guidelines.gov)
- Cite in the policy the evidenced based literature used and the CMS or TJC section

Protocols

- Advanced triage protocols or triage based protocols are one approach to optimize ED front end operations
- Make sure approved by Medical Staff (such as MEC), order entered into the medical record, and consistent with scope of practice and state law
- Decreases patient length of stay
- Standardized pathways for specific conditions or complaints
 - Ordering x-rays for things like ankle injury, oral analgesic for pain or fever, institute elopement precautions for suicidal patients, EKG for chest pain patient, rapid strep protocol, urine for dysuria etc.

ACEP Position Nurse Implemented Orders

Clinical & Practice Management

Clinical & Practice Management

Clinical Policies >

Policy Statements v

Resources >

EMS & Disaster Preparedness

Find a Physician Group >

Use of Nurse Implemented Order Sets

Approved by the ACEP Board of Directors June 2010

The American College of Emergency Physicians (ACEP) recognizes the practice of utilizing nurse implemented **order sets**. These sets are predetermined collections of departmental orders initiated based upon nursing assessment of the patient and are consistent with high-quality emergency care, enhanced patient safety and satisfaction.

It is the position of the College that the use of such **order sets** does not, in and of itself, create a physician-patient relationship.

www.acep.org/Content.aspx?id=48946&terms=order%20sets

Need Order for All Drugs/Biologicals 406

- CMS requires an order for all drugs and biologicals
- An exception is flu and pneumovax which can be given by protocol approved by the MS after assessment of contraindications
- Nurses in the ED may give these also but still document them in the order sheet
- If ED has a protocol allowing nurse to start an IV on a chest pain patient need to go to the order sheet and write it as a standing order and doctor must sign off

Protocols, Pre-printed Orders, Order Sets

- Besides tag 405, 406, and 450 CMS also has guidelines on this in a tag 457
 - Tag 457 is the main section on protocol requirements
 - Also issued memo October 24, 2008
- Must educate and train new ED staff and ED physicians on the protocols
- Protocols must be approved by the MEC first
- Must write down the order and must be signed off by the ED physician

Protocols, Pre-printed Orders, Order Sets

- Must be appropriate to the situation such as patient with chest pain needs an IV
- Asthmatic patients get breathing treatment and may be seen by RT if physician tied up
- Nurse or RT write the order, sign it and date and time and then physician or LIP signs off later
- Hospitals needs process on how they are developed and revised
- Must be reviewed and approved by MS, nursing and pharmacy and review on ongoing basis such as annually
- Includes change to verbal order policy also

Standing Orders CMS Tag 406 2013

- CMS recognizes difference between protocols and standing orders
- Trauma protocol that all staff will use needs to be approved by the MS and placed in the order sheet and authenticated by the ED physician
 - Must include list of all orders not just mention the protocol
- If one physician wants to use standing orders only specific to them then the physician
 - Signs that it is page 3 of 3
 - Initials any changes, additions, or deletions
 - Some need to be approved by the Medical Staff (MS)

CMS Standing Order Protocol Memo

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-09-10

DATE: October 24, 2008
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group
SUBJECT: "Standing Orders" in Hospitals – Revisions to S&C Memoranda

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

Memorandum Summary

- A. Standing Order Clarification:** We are clarifying a portion of S&C-08-12 and S&C-08-18, issued on February 8 and April 11, 2008 respectively, regarding use of standing orders in hospitals. The use of standing orders must be documented as an order in the patient's medical record and signed by the practitioner responsible for the care of the patient, but the timing of such documentation should not be a barrier to effective emergency response, timely and necessary care, or other patient safety advances.
- B. Future Directions:** We express our interest in working with the professional community to advance safe practices and develop a common understanding of both best practices and important operational definitions as they pertain to standing orders, preprinted order sets, and effective methods to promote evidence-based medicine.
- C. Signatures on Order Sets:** We are also clarifying the circumstances under which signatures are required on pre-printed order sets.
- D. Use of Rubber Stamps:** We add an information-only note to the Guidance as an alert to note that some payers, including Medicare, do not accept the use of rubber stamps for payment purposes. The Conditions of Participation (CoPs), however, do not prohibit such use.



Patient Safety Brief
Emergency Medicine Patient Safety Foundation

CMS Requirements on Order Sets, Protocols, Preprinted Orders, and Standing Orders

Sue Dill Calloway RN MSN JD

There are three separate tag numbers that hospitals must review in order to understand the Center for Medicare and Medicaid Services (CMS) requirements for standing orders, protocols, and order sets. Additionally, CMS included information on this topic in the changes to the hospital CoPs which was published in the Federal Register and which became effective July 16, 2012. Any hospital that accepts Medicare or Medicaid reimbursement must follow the conditions of participation (CoPs) and they must be followed for all patients seen in the hospital.

The Hospital Conditions of Participation CoP

- The Center for Medicare and Medicaid Services (CMS) has a manual for hospitals
- It applies to all patients treated in hospitals that accept Medicare and Medicaid reimbursement
- It is referred to as the CoP manual
- The section numbers are called tag numbers and go from Tag 001 to 1164
- For copy of manuals go to www.cms.gov and under search engine write in appendix A for hospitals or Appendix W for critical access hospitals

Location of CMS Hospital CoP Manuals

Medicare State Operations Manual Appendix

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

CMS Hospital CoP Manuals new address

www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

App. No.	Description	PDF File
A	Hospitals	 2,185 KB
AA	Psychiatric Hospitals	 606 KB

The Hospital Conditions of Participation CoP

- Many revisions since with final interpretive guidelines since first published in 1986
 - CMS has discharge planning standards and final worksheet November 26, 2014
 - April 1, 2015 changes which include no physician or pharmacist for radiopharmaceuticals on evening and weekends
- First regulations are published in the Federal Register then CMS publishes Interpretive Guidelines and some have Survey Procedures ²
 - Hospitals should check this website once a month for changes

CMS Survey and Certification Website

CMS.gov

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CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

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CMS Medication and Safe Opioid Use

- CMS issues 32 page memo on medication administration and safe opioid use
 - Standards went into effect June 6, 2014 and April 7, 2015 for CAH
- Any hospital that accepts Medicare or Medicaid patients must follow and must follow for all ED patients
- Has a section on educations recommended for all nurses and need policies and procedures
- Includes a section on IV and blood transfusions requirements and safe opioid use

Medication and Safe Opioid Use

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



Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 14-15-Hospital

DATE: March 14, 2014

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Requirements for Hospital Medication Administration, Particularly Intravenous (IV) Medications and Post-Operative Care of Patients Receiving IV Opioids

Memorandum Summary

- **Medication Administration:** We are updating our guidance for the hospital medication administration requirements to:
 - Make clear that the medication administration requirements under the nursing services condition of participation (CoP) are related to only some components of the overall hospital medication process, but that hospitals are expected, through this and the related requirements under the pharmaceutical services and quality assessment/performance improvement CoPs, to take a comprehensive approach to the medication process.
 - Update our guidance for IV medications and blood transfusions in general; and
 - Reflect the need for patient risk assessment and appropriate monitoring during and after medication administration, particularly for post-operative patients receiving IV opioid medications, in order to prevent adverse events.
- **Immediate Post-operative Care:** Clarification is also being made to the guidance for the surgical services CoP requirement for hospitals to have adequate provisions for immediate post-operative care, to emphasize the need for post-operative monitoring of patients

Assess and Monitor Patients Opioids

- Need to assess and monitor the effects of the medications
- To allow for early identification of adverse effects
- Some may need to use clinical and lab data to evaluate efficacy of medication therapy
- For **opioids** may need to monitor respiratory status, BP, O₂ sat, and carbon dioxide levels
- Evaluate symptoms such as confusion, agitation, unsteady gait, pruritus, somnolence etc.
- Be aware of high alert medications

Safe Opioid Use & Safe Medication Use

- Patients at great risk for adverse events include age, liver or kidney failure, history of sleep apnea, history of smoking, drug-drug interaction, first time medication use and weight
 - Obesity could increase apnea and smaller patients could more sensitive to dose levels of medications
- Risk factors need to be considered in determining how often to monitor and what type of monitoring
- Must communicate important information in hand-offs such as change of shift reporting and when calling report for admitted patient

Safe Opioid Use & Safe Medication Use

- ADR, such as opioid-induced respiratory depression require timely intervention as per established hospital protocols
- Must also report to physician or LIP immediately
- High alert medications would want to check VS, O₂ sat, (ETCO₂), and sedation levels to prevent respiratory depression and arrest
- Staff are expected to include patient's reports of his experience of the medication's effects
- Educate the patient and family about notifying staff if difficulty breathing

Safe Opioid Use & Safe Medication Use

- Hospital policy is expected to address the manner and frequency of monitoring
- Hospital P&P is expected to include information to be communicated at shift change
- It is important to document order, medication record, lab reports, vital signs etc.
- Document after actual administration of medication and no documentation in advance
- Surveyor will make sure staff is knowledgeable about intervention protocol if ADE occurs

Visitation Law

- Federal law became on visitation and CMS interpretive guidelines effective December 2, 2011
- Policy on visitation must be consistent with this including visiting hours in the ED
 - Most ED restrict visitors to two persons and you can do this but can not tell patients who these two visitors will be
- Must inform each patient of their visitation rights in writing and document in the medical record
- Must include any restrictions on those rights

Visitation Law

- Restrictions could include things like exclusion of visitors for patient suspected of having an infection such as bacterial meningitis or patient who is a danger to self or others
- Can not restrict or deny visitation privileges on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity or disability
 - For example same sex partner may present visitation advance directive and if married is considered the spouse
 - If patient allowed to have two visitors in the ED can pick who their visitors will be including same sex partners, spouse, neighbor etc.

Other Changes in the Visitation IG

- If overcrowding and boarding in the ED staff should know must ask admitted patient if wants family member and PCP notified
- Must document in the medical record
- If patient incapacitated must document notification of family member in the medical record
- Made changes to plan of care, advance directives, and informed consent for patient representatives
- Find out if patient has one and document
 - Need to take reasonable steps to determine patient wishes concerning designation of a representative

Other CMS Patient Rights

- Say a patient has a support person or patient advocate
- This person is one of those who are considered patient representative
- Patient representative must be given a copy of the patient rights statement even if the patient is competent
- A consent is signed by a competent patient in the ED and ask the support person to sign
 - Signing more like a witness since no legal authority to consent but CMS requirement

CMS Plan of Care 130

- If patient is incapacitated and unable to communicate and no ADs then an individual who is the spouse or domestic partner, parent of minor child, and other family member must be involved in plan of care
 - Hospital not expected to demand documentation unless more than one person claims to be the representative
 - Refusal to allow must be documented in the medical record along with the refusal
 - State law can define this as far as order of priority

- In advance directive can delegate decision making to another person
- Patient may also delegate support person
 - Also referred to as the patient advocate
- Designation in the AD takes precedence
- Notice of the hospital's AD policy must be provided to inpatients when admitted at time of registration
 - Such as right to make an AD & document this in the MR
- Also to outpatients or their representatives in the **ED**, observation or undergoing same day surgery

The Exact Language Tag 132

§489.102 also requires the hospital to:

- Provide written notice of its policies regarding the implementation of patients' rights to make decisions concerning medical care, such as the right to formulate advance directives. If an individual is incapacitated or otherwise unable to communicate, the hospital may provide the advance directive information required under §489.102 to the individual's "family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law." (§489.102(e)) The guidance concerning the regulation at §482.13(a)(1) governing notice to the patient or the patient's representative of the patient's rights applies to the required provision of notice concerning the hospital's advance directive policies. Although both inpatients and outpatients have the same rights under §482.13(a)(1), §489.102(b)(1) requires that notice of the hospital's advance directive policy be provided at the time an individual is admitted as an inpatient. However, in view of the broader notice requirements at §482.13(a)(1), the hospital should also provide the advance directive notice to outpatients (or their representatives) who are in the emergency department, who are in an observation status, or who are undergoing same-day surgery. The notice should be presented at the time of registration. Notice is not required for other outpatients, given that they are unlikely to become incapacitated.

Federal Register Visitation Changes

§ 167.1332 In the Strait of Georgia.

In the Strait of Georgia, the following are established:

(a) Precautionary area "GS," which is bounded by a line connecting the following geographical positions:

Latitude	Longitude
48°52.30' N	123°07.44' W
48°54.81' N	123°03.66' W
48°49.49' N	122°54.24' W
48°47.93' N	122°57.12' W
48°47.78' N	122°59.12' W
48°48.19' N	123°00.84' W
48°52.30' N	123°07.44' W

(b) A separation zone bounded by a line connecting the following geographical positions:

Latitude	Longitude
48°53.89' N	123°05.04' W
48°56.82' N	123°10.08' W
48°56.30' N	123°10.80' W
48°53.39' N	123°05.70' W

(c) A traffic lane for north-westbound traffic located between the separation zone described in paragraph (b) of this section and a line connecting the following geographical positions:

Latitude	Longitude
48°54.81' N	123°03.66' W
48°57.68' N	123°08.76' W

(d) A traffic lane for south-eastbound traffic between the separation zone described in paragraph (b) of this section and a line connecting the following geographical positions:

Latitude	Longitude
48°55.34' N	123°12.30' W
48°52.30' N	123°07.44' W

(e) Precautionary area "PR," which is bounded by a line connecting the following geographical positions:

Latitude	Longitude
48°55.34' N	123°12.30' W
48°57.68' N	123°08.76' W

Latitude	Longitude
49°02.51' N	123°23.76' W
49°00.00' N	123°19.69' W

Dated: November 9, 2010.

Dana A. Goward,

U.S. Coast Guard, Director of Marine Transportation Systems Management.

[FR Doc. 2010-29165 Filed 11-18-10; 8:45 am]

BILLING CODE 9110-04-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 482 and 485

[CMS-3228-F]

RIN 0938-AQ06

Medicare and Medicaid Programs: Changes to the Hospital and Critical Access Hospital Conditions of Participation To Ensure Visitation Rights for All Patients

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

ACTION: Final rule.

SUMMARY: This final rule will revise the Medicare conditions of participation for hospitals and critical access hospitals (CAHs) to provide visitation rights to Medicare and Medicaid patients. Specifically, Medicare- and Medicaid-participating hospitals and CAHs will be required to have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that

with developing proposed requirements for hospitals (including Critical Access Hospitals (CAHs)), that would address the right of a patient to choose who may and may not visit him or her. In the memorandum, the President pointed out the plight of individuals who are denied the comfort of a loved one, whether a family member or a close friend, at their side during a time of pain or anxiety after they are admitted to a hospital. The memorandum indicated that these individuals are often denied this most basic of human needs simply because the loved ones who provide them comfort and support do not fit into a traditional concept of "family."

Section 1861(e)(1) through (9) of the Social Security Act—(1) Defines the term "hospital"; (2) lists the statutory requirements that a hospital must meet to be eligible for Medicare participation; and (3) specifies that a hospital must also meet other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the facility. Under this authority, the Secretary has established in the regulations at 42 CFR part 482 the requirements that a hospital must meet in order to participate in the Medicare program. This authority extends as well to the separate requirements that a CAH must also meet to participate in the Medicare program, established in the regulations at 42 CFR part 485. Additionally, section 1820 of the Act sets forth the conditions for designating certain hospitals as CAHs. Section 1905(a) of the Act provides that Medicaid payments may be applied to hospital services. Regulations at 42 CFR 440.10(a)(3)(iii) require hospitals to meet the Medicare CoPs to receive

RI.01.01.01 TJC Patient Advocate

- Standard: Hospital respects, promotes, and protects patient rights
- EP28 The hospital allows a family member or friend to be with patient during the course of stay for emotional support
 - As long as does not infringe on the other patients' rights
 - Does not have to be the patient surrogate or legal decision maker
 - CMS calls support person and TJC patient advocate
 - Patients should be able to define who they want to visit

Informed Consent

- Both CMS and TJC gives the patient the right to an informed consent
- Consent required for surgery unless **an emergency**
- Hospital must have a list of procedures with yes or no as to whether a consent is required
 - Paracentesis, Thoracentesis, cardioversion, chest tube insertion, central line insertion, etc.
- This includes the right to refuse care but make sure it is an educated one
- Patients have the right to know the side effects, risks, benefits, alternatives etc.

Informed Consent

- CMS and TJC require a P&P on informed consent and needs to contain requirements from both
 - Must include state law requirements on consent
 - Must document consent in the medical record
 - Consent is a process and not a form
 - CMS has six mandatory elements and optional ones that hospitals can select
- Make sure use interpreter if patient has LEP and remember the issue of low health literacy
 - CMS Tag 131, 465 and 955 and TJC RC.02.01.04 and RI.01.03.01 with 11 EP for hospitals

Minimum (Mandatory) Elements Required 466

- Name of the hospital where the procedure or other type of medical treatment is to take place
- Name of the specific procedure, or other type of medical treatment for which consent is being given
- Name of the responsible practitioner who is performing the procedure or administering the medical treatment

CMS 6 Mandatory Elements Required

- Statement that the procedure or treatment, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient's legal representative
- Same discussion of likelihood and severity
- Signature of patient or representative
- Date and time signed by patient
- Any applicable state law requirements

Blood and IV Medications Tag 409 2014

- CMS requires staff to be trained in IV medications and blood transfusions
- Have to train staff in orientation and have continuing education and document in HR file that it was done
 - CMS changed this standard in effective June 6, 2014 and April 7, 2015 for CAH
- Now will just have to follow your hospital policy and procedure on what is needed to train on blood and blood products and IV medications but staff must be **competent** in these areas
- The policy must be approved by the Medical Staff (MEC) in conjunction with pharmacy and nursing

Blood Transfusions and IVs 409

- Discusses peripheral lines, PICC lines, arterial lines, central lines, and arterial lines
- Hospital P&P must discuss what medications can given in each type of access
- Trace lines and tubes prior to administration
- Verify proper programming of infusion devices such as flow rate, concentration, and dose rate
- Must have P&P to address appropriate IV medication monitoring requirements
 - Must include frequency of monitoring and risk factors

Blood Transfusions and IVs 409 2014

- Hospital P&P is expected to address:
 - Monitoring for fluid and electrolyte balance
 - Monitoring patients for high alert medications including opioids
- Expected to address monitoring for over-sedation and respiratory depression for **safe opioid use**
 - Can erroneously assume patient is asleep when they are having progressive symptoms of respiratory compromise
 - Factors that put patients at high risk include snoring, history of sleep apnea, first time use of IV opioids, increased opioid dose, longer length of time receiving general anesthesia, pulmonary or cardiac disease or thoracic or surgical incisions

Blood and IV Medications Tag 409

- Have P&P on both and must be consistent with state law and scope of practice for nurses
 - In some states an LPN can not hang blood or push certain IV medications
- Need definitions of ADRs, drug errors and drug incompatibilities
 - Must notify the ED physician of these three
 - Must document in the medical record
 - Must report event to the PI program such fill out an incident report or other process

Nurses Must be Competent

- ED nursing staff must be competent in these so many mandate training and this is reflected in your policy and procedure
- Fluid and electrolyte balance
- Venipuncture techniques including both demonstration, and supervised practice; and, for blood transfusion training: blood components
- Blood administration procedures
 - Nationally recognized standards of practice such as the CDC intravascular guidelines; how to start a peripheral IV, when to replace, how long the tubing is good for etc. and discussed later

Competency Required A-409

- Requirements for patient monitoring
 - Including frequency
 - Documentation of monitoring
 - Process for verification of the right blood product for the right patient
 - Identification and treatment of transfusion reactions and
 - Reporting requirements for transfusion reactions

CMS Anesthesia Standards

- CMS puts topicals, locals, moderate sedation, and minimal sedation in the pain bucket
 - Staff must be qualified to give any of the above
 - Need P&P and must be consistent with state law
 - If moderate sedation need to do pre-sedation and post sedation assessment
 - Has six FAQs which talks about sedation in the ED

CMS Anesthesia Standards

- CMS puts regionals (epidural, spinal), general, deep sedation and MACs in the anesthesia bucket
 - Remember deep sedation, such as use of propofol, is considered anesthesia
 - Requires a preanesthesia and postanesthesia assessment
 - CMS and TJC are specific about what must be documented in each of these
 - Person must be qualified such as anesthesia, CRNA, AA, dentist, podiatrist or physician who is C&P to give
 - Need national position statement that says okay to give certain drugs such as ACEP or ENA position

Moderate Sedation

- VA National Center for Patient Safety has a free toolkit on moderate sedation for non-anesthesiologist such as for use in the ED
 - Has nine different sections
 - Available at www.patientsafety.gov
- Consider having capnography available for selected patients having moderate sedation
- American Society of Anesthesiologist publishes standards for basic anesthetic monitoring effective July 1, 2011 use capnography for moderate sedation

Moderate Sedate Toolkit

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The NCPS was established in 1999 to develop and nurture a culture of safety throughout the Veterans Health Administration. Our goal is the nationwide reduction and prevention of inadvertent harm to patients as a result of their care. Patient safety managers at 153 VA hospitals and patient safety officers at 21 VA regional headquarters participate in the program.



Veterans Health Administration

Office of Quality

www.patientsafety.gov/

The primary intended audience for our public Web site is health care professionals and health care administrators.

We encourage veterans and the general public to explore our site, especially the Patient Safety for Patients section, and familiarize themselves with patient safety issues and the wide range of actions VA has taken to improve patient safety.

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- [Glossary of Patient Safety Terms](#)

Patient Safety Web Resources

To assist VA facilities in assuring that the practice of moderate sedation is reliable and safe, the VA National Center for Patient Safety (NCPS) has developed a [Moderate Sedation Toolkit for Non-Anesthesiologists](#), based upon work done at the Durham VAMC Patient Safety Center of Inquiry.

The toolkit is composed of nine components:

1. [Facilitator's Guide](#) This introductory guide describes the moderate sedation toolkit components and provides guidelines for the sedation training facilitator including answers to frequently asked questions..
2. [Learner Objectives](#) These 18 objectives describe the knowledge, skills and behaviors that should be demonstrated by individuals who administer moderate sedation.
3. [Curriculum Guide](#) This document provides detailed information about moderate sedation practice. Topics include:
 - Introduction - general principles of moderate sedation
 - Pharmacology of commonly used medications
 - Relevant anatomy and physiology
 - Principles of pre-procedural patient assessment and education
 - Monitoring guidelines and techniques
 - Intra-Procedure Guideline - required safety equipment and common complication recognition and treatment
 - Special situations and high-risk patients
4. [Pre-Procedure Evaluation Template](#) This template identifies key features of patient evaluation that should be performed prior to beginning a procedure that requires moderate sedation. Facilities may use this as a guide for creating CPRS templates.
5. [Moderate Sedation Study Aid](#) This colorful graphic summary includes key elements of moderate sedation practice, including many of the topics from the curriculum guide. This 8.5- by 11-inch front and back reference guide may be posted for practitioners in all sites where moderate sedation is administered.
6. [Moderate Sedation Cognitive Aid](#) Modeled after the NCPS Cognitive Aid for Anesthesiology, this colorful 8.5- by 11-inch front and back reference guide provides bulleted guidelines for managing common complications of moderate sedation (hypotension, hypertension, bradycardia, tachycardia, hypoxemia and agitation/difficult to sedate). Each complication is addressed in three parts: initial response; follow-up response; and things to consider. It is intended to be available to practitioners in all sites where moderate sedation is administered.
7. [Call for Help Card](#) This template identifies key resources for assistance. Facilities must customize this card for local use. The local version should be posted and CLEARLY VISIBLE in all sites where moderate sedation is administered.
8. [High-Fidelity Simulation Cases](#) Four cases are available for use in facilities that have the capability to conduct simulation training using a high-fidelity medical simulator. The cases demonstrate the common and important problems encountered during sedation practice.
 - Case 1: Orientation to Simulator and Training Sessions
 - Case 2: Upper Airway Obstruction
 - Case 3: A Difficult to Sedate Patient
 - Case 4: Medically Compromised Patient
9. [Table Top Simulation Cases](#) Four cases are available for use in all facilities, specifically those that do not have the capability to conduct simulation training using a high-fidelity medical simulator. These cases cover the same material available in the high-fidelity sedation simulation cases described above.

Moderate Sedation Use Capnography

of endotracheal tube/laryngeal mask placement, until extubation/removal or initiating transfer to a postoperative care location, shall be performed using a quantitative method such as capnography, capnometry or mass spectroscopy.* When capnography or capnometry is utilized, the end tidal CO₂ alarm shall be audible to the anesthesiologist or the anesthesia care team personnel.*

3.2.3 When ventilation is controlled by a mechanical ventilator, there shall be in continuous use a device that is capable of detecting disconnection of components of the breathing system. The device must give an audible signal when its alarm threshold is exceeded.

3.2.4 During regional anesthesia (with no sedation) or local anesthesia (with no sedation), the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs. During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment.

Moderate Sedation and Capnography

- ED managers should consider the ASA standards along with ED literature along with CMS Safe Opioid Use requirements
 - Should consider budgeting for capnography if not already present
- They should be reflected in the ED policies and procedures
- This includes staff training
- Use of capnography should be documented during procedural sedation

ACEP Policies

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ACEP Clinical Policies

These ACEP Board-approved documents describe ACEP's policies on the clinical management of emergency department patients.

If you are having trouble viewing these documents, [download Adobe Reader 9.1](#).

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Additional Resources

- » ACEP Clinical Policy Development
- » ACEP Clinical Policy Development Process
- » Previous ACEP Clinical Policies
- » Mobile Clinical Policies: C

<http://www.acep.org/content.aspx?id=30060>

Clinical Policy: Procedural Sedation and Analgesia in the Emergency Department

**From the American College of Emergency Physicians Clinical Policies Subcommittee (Writing Committee) on
Procedural Sedation and Analgesia:**

Steven A. Godwin, MD, Chair

David A. Caro, MD

Stephen J. Wolf, MD

Andy S. Jagoda, MD

Ronald Charles, MD

**Benjamin E. Marett, RN, MSN, CEN, CNA, COHN-S (ENA
Representative 2002-2003)**

**Jessie Moore, RN, MSN, CEN (ENA Representative 2001-
2002)**

www.acep.org/content.aspx?id=30060

Members of the American College of Emergency Physicians Clinical Policies Committee (Oversight Committee) included:

**William C. Dalsey, MD (Chair 2000-2002, Co-Chair 2002-
2003)**

**Andy S. Jagoda, MD (Co-Chair 2002-2003, Chair 2003-
2005)**

**Michael Moon, RN, CNS, MSN, CEN (ENA Representative
2003-2004)**

**Jessie Moore, RN, MSN, CEN (ENA Representative 2001-
2002)**

ACEP Policy Statements

Clinical & Practice Management



www.acep.org/policystatements/?pg=2

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ACEP Policy Statements

Search Policy Statements:

ACEP board-approved policy statements highlight the scope of issues being addressed in emergency medicine. New policies are initially distributed to ACEP members via Annals of Emergency Medicine and posted here. In addition, the ACEP Board of Directors has directed that all policy statements undergo automatic review when they are seven years old. Unless a policy still contains relevant information, it will then sunset. Due to the extensive time required to review seven-year-old or older policies, some are still under review.

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ACEP Sedation in the ED

Sedation in the Emergency Department

ACEP Policy Statement

Approved by the ACEP Board January 13, 2011

www.acep.org/Content.aspx?id=75479&terms=sedation

Revised and approved by the ACEP Board of Directors January 2011 by replacing two rescinded policy statements, "Procedural **Sedation** in the Emergency Department" approved October 2004 and "The Use of Pediatric **Sedation** and Analgesia" originally approved March 1992; revised January 1997 and April 2008; and reaffirmed October 2001

Sedation in the Emergency Department

Procedural **sedation** involves the use of sedative and analgesic agents to reduce the anxiety and pain suffered by patients during procedures. Procedural **sedation** decreases the length of time necessary to perform a procedure, increases the likelihood of success, and reduces the potential risk of injury to the patient or healthcare worker due to uncontrolled movements.

Procedural **sedation** encompasses a continuum of altered levels of consciousness including minimal, moderate, deep, and dissociative **sedation** levels.

Procedural **sedation** is a critically important component of comprehensive emergency care and a required core competency of emergency medicine residency training. This training includes rescue airway interventions for support of patient

ACEP Sedation in the ED 2014

Clinical Policy: Procedural Sedation and Analgesia in the Emergency Department

From the American College of Emergency Physicians Clinical Policies Subcommittee (Writing Committee) on Procedural Sedation and Analgesia:

Steven A. Godwin, MD (Subcommittee Chair)
John H. Burton, MD
Charles J. Gerardo, MD
Benjamin W. Hatten, MD
Sharon E. Mace, MD
Scott M. Silvers, MD
Francis M. Fesmire, MD (Committee Chair)

www.acep.org/clinicalpolicies

Members of the American College of Emergency Physicians Clinical Policies Committee (Oversight Committee):

Francis M. Fesmire, MD (Chair 2011-2013)
Douglas Bernstein, MD (EMRA Representative 2011-2013)
Deena Brecher, MSN, RN, APN, ACNS-BC, CEN, CPEN (ENA Representative 2012-2013)
Michael D. Brown, MD, MSc
John H. Burton, MD
Deborah B. Diercks, MD, MSc
Steven A. Godwin, MD
Sigrid A. Hahn, MD
Jason S. Haukoos, MD, MSc (Methodologist)
J. Stephen Huff, MD
Bruce M. Lo, MD, CPE, RDMS
Sharon E. Mace, MD
Edward R. Melnick, MD

Devorah J. Nazarian, MD
Susan B. Promes, MD
Richard D. Shih, MD
Scott M. Silvers, MD
Stephen J. Wolf, MD
Stephen V. Cantrill, MD (Liaison with Quality and Performance Committee)
Robert E. O'Connor, MD, MPH (Board Liaison 2010-2013)
Rhonda R. Whitson, RHIA, Staff Liaison, Clinical Policies Committee and Subcommittees

Approved by the ACEP Board of Directors, October 11, 2013

Endorsed by the Emergency Nurses Association, December 6, 2013

Policy statements and clinical policies are the official policies of the American College of Emergency Physicians and, as such, are not subject to the same peer review process as articles appearing in the journal. Policy statements and clinical policies of ACEP do not necessarily reflect the policies and beliefs of *Annals of Emergency Medicine* and its editors.

ENA and ACEP Position

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Delivery of Agents for Procedural Sedation and Analgesia by Emergency Nurses

Approved by the ACEP Board of Directors April 2005 and the Emergency Nurses Association (ENA) Board March 2005

Published simultaneously, October 2005, in *Journal of Emergency Nursing and Annals of Emergency Medicine*

The Emergency Nurses Association (ENA) and the American College of Emergency Physicians (ACEP) support the delivery of medications used for procedural **sedation** and analgesia by credentialed emergency nurses working under the direct supervision of an emergency physician. These agents include but are not limited to etomidate, propofol, ketamine, fentanyl, and midazolam.

Verbal Orders

- Common problematic standard with CMS and TJC
- Should not be a common practice
- Physician is not allowed to give if standing in nursing station absent an emergency
- May take if needed and physician not in the department
- Nurse needs to write it down and **read** it back
- Nurse needs to sign name, date and **time**
- Physician must sign name, date and **time** also

Verbal Orders

- Physician must sign off the VO (including date time, and sign their name)
 - Most states say 24 or 48 hours and must follow stricter state law
 - If state does not say then CMS use to say 48 hours but now within your hospital P&P and many are now changing to 30 days but make sure **you sign off ASAP**
- CMS will allow PA or NP to sign off VO for the physician if state and hospital allows and within their scope of practice
- Any physician on the case can sign off the VO for any other doctor including ED doctors signing for each other when relieving them

Verbal Orders

- Have a P&P on who can accept VO in your facility
 - Must be qualified staff
 - Policy may allow pharmacist for pharmacy orders, dietician for dietary orders, nurses, etc.
- Include in P&P when will not take VO
 - Such as many hospitals do not take a VO for chemotherapy
 - CMS 407-408 and 454 and 457,
 - TJC RC.02.03.07. PC.02.02.07 and PC.01.01.01

CDC Intravascular Guidelines

- Need to make sure all ED physicians and staff are familiar with the CDC intravascular guidelines
- Discusses how to prep the skin when putting in IV lines, central lines, etc.
- Prep skin with antiseptic (70% alcohol, tincture of iodine, an iodophor or best to use Chlorhexidine gluconate) and let dry
- Discusses how to select the catheter and the site and when to replace catheters
- Requires full maximal sterile barrier precautions when putting in a central line, arterial line or PICC line

CDC Intravascular Catheter Guidelines



<http://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.

*1*National Institutes of Health, Bethesda, Maryland
*2*Infusion Nurses Society, Norwood, Massachusetts
*3*Greenwich Hospital, Greenwich, Connecticut

Infection Control Video

- HHS has published a training video that every nurse, physician, infection preventionist and healthcare staff should see
- This includes risk managers
- It is an interactive video
- Called Partnering to Heal: Teaming Up Against Healthcare-Associated Infections
- Go to <http://www.hhs.gov/partneringtoheal>
- HHS wants to decrease HAI by 40% in 2013, want 1.8 million fewer injuries and can save 60,000 lives

HHS Home > ASH Home > Initiatives > Healthcare-Associated Infections > Training

ASH Home
Key Personnel
Regional Health Administrators
Initiatives
Viral Hepatitis
Tobacco Control and Prevention
Healthcare-Associated Infections
Action Plan
National Targets and Metrics
Projects
Steering Committee
Events
Training
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Partnering to Heal is a computer-based, video-simulation training program on infection control practices for clinicians, health professional students, and patient advocates.

The training highlights effective communication about infection control practices and ideas for creating a "culture of safety" in healthcare institutions to keep patients from getting sicker. Users assume the identity of the following five main characters and make decisions about preventing healthcare-associated infections (HAIs):



A Physician, Nathan Green, Director of a Hospital Post-op Unit, ready to start new prevention efforts in the unit;



A Registered Nurse, Dena Gray, working to learn effective communications skills that could make the difference for her patients;



An Infection Preventionist, Janice Upshaw, a new employee charged with using a team-based approach

www.hhs.gov/ash/initiatives/hai/training/

PLAY FULL VERSION []

System Requirements

- Adobe Flash Player 10+
- Speakers/headphones
- Web Browser: Internet Explorer, Firefox, Opera, Safari

Facilitator's Guide

[Download the Partnering to Heal Facilitator's Guide](#) (PDF 96Kb) []

Fact Sheet

[Download the Partnering to Heal fact sheet](#) (PDF 321Kb) []

Promote

Grab either the badge or button below for your own site, blog, or newsletter and link back to

TJC Medication Reconciliation

- ED staff should be familiar with the Joint Commission Reconciliation standards
 - Were effective July 1, 2011 and in CMS IC worksheet
- ED staff need to get a complete list of all medications including over the counter meds and herbal agents
- Includes dosages and frequency of medications
- Consult list if a medication is ordered in the ED
- If prescribe new medication provide information on that medication

Reconciling Medication Information

Hospital Accreditation Program

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

TJC Patient Centered Communication

- TJC Patient-Centered Communication standards
- Has important standards that impact the ED
- Must ask all ED patients for information on race and ethnicity
- Need to put things in a level that patients can understand- called **low health literacy**
 - Most patients read at a 6th to 8th grade level and will read at two levels below their education level such as high school graduate
- Discusses when you need an interpreter for an ED patient
 - When are interpreters qualified and or certified?

TJC Patient-Centered Communication

- All interpreters and translators must be qualified
- This can be met through language proficiency assessment, education, training and experience
 - Example, person who has attended a 40 hour healthcare interpreting course is qualified to be an interpreter or now new designation level
 - There are two organization who have oral and written exam to become certified
- Hospital , including the ED, must collect race and ethnicity data on all patients

Oral & Written Communication

- Hospital needs to identify the patient's oral and written communication needs
 - Including patient's preferred language for discussing healthcare
 - Patient with hearing needs may need an amplifier on the phone
 - Hearing impaired may need TDD phone
 - Identify the preferred sign language for patient who signs such as American sign language or signed English
 - Document preferred language including patients who do not speak English or has limited English proficiency

Interpreters and Repeat Back

- Be sure to have patients repeat back information because of issue of low health literacy (called teach back and document you did this)
- Make sure interpreter is used if patient has limited English proficiency
- Make sure you document that an interpreter was used
- Make sure interpreter is qualified
- Use certified deaf interpreters
- Do not use children and do not use family members (with exceptions)

TJC Interpreters

- The hospital allows a family member or friend to be with patient during the course of stay for emotional support
 - As long as does not infringe on the other patients' rights
 - Does not have to be the patient surrogate or legal decision maker
 - CMS has similar section in hospital CoP regarding visitation rights with a support person
 - Patients should be able to define who they want to visit

Readmissions and Discharges

- One in 5 hospital discharges (20%) is complicated by adverse event within 30 days
 - 20% were readmitted within 30 days with 1/3 leading to disability (17% in 2015)
- Often leads to visits to the ED and rehospitalization
- 6% of these patients had preventable adverse events
- 66% were adverse drug events
 - The incidence and severity of adverse events affecting patients after discharge from the hospital. Forster AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. Ann Intern Med. 2003;138:161-167

Preventing Readmissions

- A federal law, the Patient Protection and Coverage Act, has provision to prevent this
- There are penalties against hospitals with excess readmission rates
- Hospitals and ED will need to re-engineer the system to prevent unnecessary readmissions and returns to the ED
- AHA publishes An Action Guide to Prevent Avoidable Readmissions

www.hret.org/readmissions

Signature Leadership Series

hospitals in
pursuit of excellence



Health Care Leader Action Guide to Reduce Avoidable Readmissions

January 2010



Things the ED Can Do to Prevent Returns

- Use teach back to educate patients about diagnosis and care and discharge instructions
- Discuss end of life treatment wishes
- Schedule the patient's appointment with the physician during the week
- Make sure the primary care physician has a copy of the emergency department record
- Help patients manage their medications
 - Clearly explain new medications prescribed in the emergency department

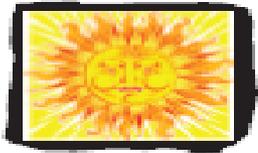
Things the ED Can Do

- Follow up high risk patients with a **phone call**
- Use telehealth and telemedicine if needed
- Facilitate discharge to nursing homes with discharge instructions and use standardized referral forms
- AHRQ has the PSNet which is a great place to locate patient safety and quality articles
 - <http://www.psnet.ahrq.gov/>
- Also the patient safety primer with evidence based information on adverse events after discharge
 - <http://www.psnet.ahrq.gov/primer.aspx?primerID=11>

Things the ED Can Do

- Ensure education on all new meds and use teach back to ensure education and give information in writing
- Give patient in writing their diagnosis and written information about their diagnosis
 - See delayed CMS transition measure
 - Include what tests were performed
- 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

Medication List



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?

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

Discharge Instructions

- One study found 78% of ED patients did not understand one area of their discharge instructions
- Another study showed that patients are 30% less likely to be admitted or return to the ED if they understand their discharge instructions
- Source: Discharge Instructions: A Commitment to Patient Safety and Risk Reduction, Dr. Dan Sullivan at www.thesullivangroup.com/pdf/news/TSG_DischargeInstructionAnalysis.pdf



Discharge Instructions:

A COMMITMENT TO PATIENT
SAFETY AND RISK REDUCTION

Daniel Sullivan, MD, JD, FACEP

Are your discharge instructions (DIs) leaving you exposed to clinical and legal risks? The right DIs can dramatically improve clinical outcomes and reduce the risk of malpractice litigation.

Nowhere is the discharge process more important than in emergency and acute care medicine. Because it is often impossible to know with certainty the cause of a patient's distress or discomfort without more extensive testing and procedures, emergency department (ED) practitioners typically discharge patients with an "initial impression," not a final diagnosis. In order to ensure adequate post-discharge care, therefore, the patient must receive clear DIs before they leave the ED. With high-quality DIs, patients are more likely to pursue appropriate follow-up care and be able to recognize potentially adverse changes in their conditions.

Lack of appropriate patient information can result in poor patient care, more frequent readmissions to the

Discharge Instructions

- Should be time specific such as call in the morning to get an appointment to be have stitches taken out in 5 days
- Make action specific such as soak right hand in warm, soapy water for 20 minutes, 4 times a day instead of warm soaks to hand
- Remember low health literacy so instructions should be understandable and remember 20% of population read at a fifth grade reading level,
- Written so patient can understand with no Latin terms such as bid, prn, or f/u

Discharge Instructions

- TJC RC.02.04.01 requires documentation of the patient's discharge information
- Document if you give patient specific patient education sheets like fracture care sheet and should have a copy on chart
- Ask Me 3 is three most important questions that can help during discharge instructions
- What is the main problem? What does the patient need to do? Why it is important for them to do this? (www.npsf.org/askme3)

Ask Me 3 Website

Ask
Me3™

FOR PROVIDERS:

Learn about Health Literacy and its impact on your patients, community and constituents.

FOR PATIENTS:

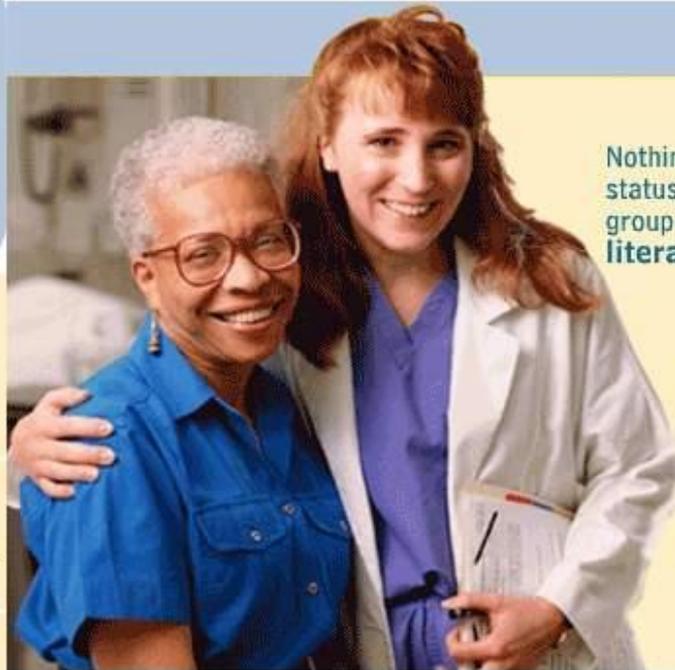
The 3 most important questions you should ask your doctor, nurse or pharmacist.

FOR LARGE-SCALE IMPLEMENTERS:

Information for Employers, Health Plans, Health Departments and Other Large Organizations.

FOR MEDIA:

Low Health Literacy -- The Health Care Story You Can't Ignore



Nothing — not age, income, employment status, educational level, and racial or ethnic group — affects health status more than **literacy skills.**

That's why clear communication between patients and health care providers is critical.

Good communication =
Healthy patients
Start with Ask Me 3.

If you would like to download Ask Me 3 material please [click here](#).

PCHC TEAMS UP WITH THE
NATIONAL PATIENT SAFETY FOUNDATION
[click here for information](#)

Ask Me 3™ is a trademark licensed to the
Partnership for Clear Health Communication

TJC Discharge Planning Tracer

- TJC will look at patient being discharged
- Review order and MR, observe person discharging with activity, diet, medications post discharge, wound care, S&S to be aware, name and number of doctor if problem
- Patient's understanding (purpose for new medication)
- Will review written material and interview patient to determine level of understanding

Discharge Instruction Case

- This is important to do right from a legal perspective and many large verdicts if it not done correctly
 - Also to prevent readmission or returns to the ED
- Jury awarded \$23 million dollars to 41 YO man who was rendered quadriplegic after discharge from the ED
- Undetected neck fracture and patient complained could not move his feet after cervical collar taken off
- Hospital had unqualified and improperly trained ED

TJC Tracer Emergency Services

- During each individual TJC tracer surveyor will interview staff about the following:
 - Who is responsible for direction of services
 - Who supervises emergency services
 - How emergency services are integrated with other departments or services of the hospital
 - How the hospital provides for medical and nursing personnel qualified in emergency care to meet the needs anticipated by the facility
 - MS involvement in the ED and responsibility for the ED

TJC Emergency Services Tracer

- Discuss immediate availability of services, equipment, personnel, and resources for providing patient care
- Integration and communication of emergency services with other departments such as lab, ICU, and diagnostic services
- Provision of follow up care to patients not admitted or transferred
- Process for MS review of P&P (new)

TJC Emergency Services Tracer

- Process or length of time it takes to transport ED patients to another department and get them back
- This is also important with CMS so patients do not sit around waiting to be brought back to the ED
- Time it takes to get interventions or tests done
- Time it takes to deliver equipment and supplies to the ED
- Will review P&P to appraise emergencies, provide initial treatment, and refer patients when needed in hospitals that do not provide emergency services

10 Reasons Your ED May Not Be as Safe

- Article called “Ten Reasons Your ED May Not Be As Safe As You Think It Is” at <http://www.thesullivangroup.com/>
- The ED is send patients home with abnormal vital signs
 - Be sure to repeat any abnormal vital signs and reassess patient
 - Studies show association between discharging patients with abnormal vital signs and morbidity and mortality
- Risk Factor Analysis
 - John Ritter came the ED with chest pain

10 Reasons Your ED May Not Be as Safe

- No one asked about a family history
- If they had he would have told them that his father died of a thoracic aortic dissection and likely doctor would have ordered a CT scan and discovered it (clinical decision support system can help)
- Patients in severe pain are not getting their pain meds within one hour
- ED is not taking full advantage of the power of discharge instructions
 - Patient riding his motorcycle gets something in his eye
 - ED doctor diagnosis as corneal abrasion and applied eye patch

10 Reasons Your ED May Not Be as Safe

- Patient gets back on the motorcycle to drive home
- Hits and kills a mother and three children
- No warning about impaired vision
- Analysis of immunization status of febrile children is inadequate
- Also has new emerging patient safety and risk issues
- Evaluation of the immunization status is a critical part of the history
 - Some children are poorly immunized
 - Could fail to recognize a life threatening infection



Ten Reasons Your Emergency Department May Not Be As Safe As You Think It Is

The Emergency Medicine Risk Initiative (EMRI) is a proven System Solution designed to reduce risk and improve patient safety in the emergency department. The Sullivan Group's work with over 600 hospitals in the United States and extensive research have disclosed a number of critical risk and safety issues of which you may not be aware.

The issues and comments below represent observations based upon an analysis of thousands of emergency medicine medical malpractice cases and TSG published research on over 170,000 high-risk patients in several hundred U.S. emergency departments.

The data is powerful and compelling, and probably represents the profile of care in your facility. Unless you have implemented a System Solution in the following areas, then this is your department!



1

The ED Is Sending Patients Home With Very Abnormal Vital Signs

Communication

- Communication break downs are the leading system failure that contributes to error
- TJC sentinel event data support this which is why it became a NPSG
 - Document when the ED physicians is notified of panic values and
 - Most common root cause of sentinel events is communication and accounts for 70% of all errors
- A communication model (like SBAR or standard report sheet form, ticket to ride, hall pass, or report template) could help
 - Improving communication in the emergency department. Redfern E, Brown R, Vincent CA. Emerg Med J. 2009;26:658-

Communication Bedside Shift Report

- Important in giving report for ED nurses and physicians going off duty
 - TJC standard on handoff
 - Bedside shift report improves patient safety and nurse accountability
 - Bedside shift report improves patient safety and nurse accountability. Baker SJ. J Emerg Nurs. 2010;36:355-358
 - Watch chasing zero by Dennis Quade at <http://safetyleaders.org/Quaid/>
- Good communication is also important for preventing lawsuits

Watch This Video Bedside Nurse Report

**TMIT Research
Test Bed**

SafetyLeaders.org

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Dennis Quaid: Our New SafetyLeaders TMIT Teammate

The Quaid Foundation Has Merged with TMIT

As of April 12, 2010, The Quaid Foundation has merged with TMIT. The Quaid Foundation was formed by Dennis and Kimberly Quaid in 2007 after hospital personnel administered an overdose of heparin, a blood thinner, to their 12-day-old twins, putting their lives at great risk. The Quaid family is joining forces with TMIT to raise public awareness about our broken medical system, to eliminate human error, and to make caregivers aware that patients have the right to know all information that could have an impact on their health and well-being, with major focus on increasing awareness of the dangers of medication errors.

Over the last year, Dennis Quaid and TMIT have been actively involved in a number of other initiatives that have global reach and impact.

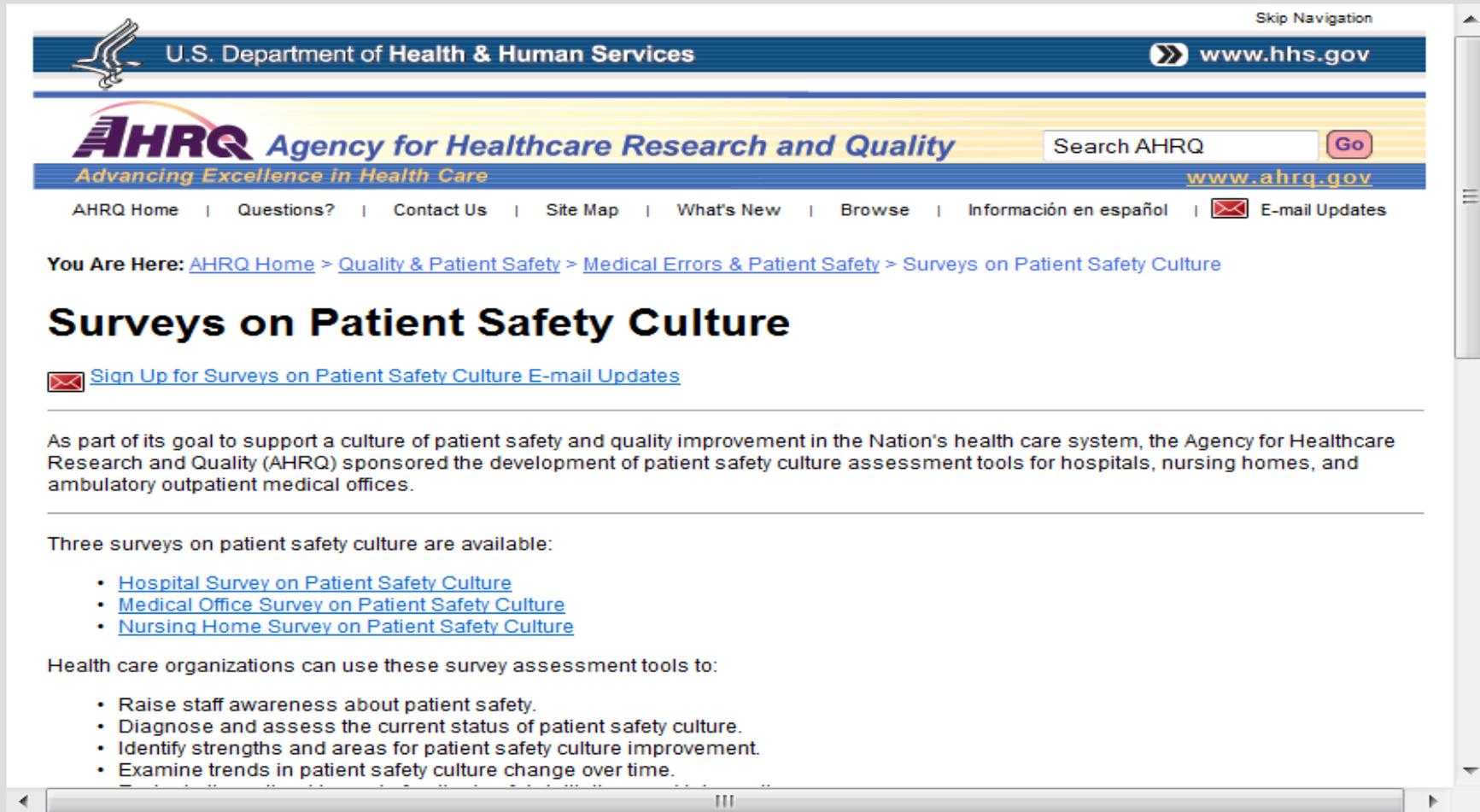


Heparin Mix Up Almost Killed Their Twins



Communication

- Have a culture where staff feel comfortable in asking questions and clarifying orders
- Hospitals accredited by TJC must do a culture survey which asks this question
- AHRQ has a survey that hospitals can use and can benchmark against other hospitals
- Can confirm communications by asking patient to repeat back information
- Study: [The Emergency Medical Services Safety Attitudes Questionnaire.](#) Patterson PD, Huang DT, Fairbanks RJ, Wang HE. Am J Med Qual. 2010;25:109-115.



The screenshot shows the AHRQ website header with the U.S. Department of Health & Human Services logo and navigation links. The main content area features a breadcrumb trail, a search bar, and a section titled 'Surveys on Patient Safety Culture'. Below the title, there is a link to sign up for e-mail updates and a paragraph explaining the agency's goal. Three survey options are listed: Hospital Survey, Medical Office Survey, and Nursing Home Survey. A list of objectives for these surveys is provided at the bottom.

Skip Navigation

U.S. Department of Health & Human Services www.hhs.gov

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care www.ahrq.gov

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You Are Here: [AHRQ Home](#) > [Quality & Patient Safety](#) > [Medical Errors & Patient Safety](#) > [Surveys on Patient Safety Culture](#)

Surveys on Patient Safety Culture

[Sign Up for Surveys on Patient Safety Culture E-mail Updates](#)

As part of its goal to support a culture of patient safety and quality improvement in the Nation's health care system, the Agency for Healthcare Research and Quality (AHRQ) sponsored the development of patient safety culture assessment tools for hospitals, nursing homes, and ambulatory outpatient medical offices.

Three surveys on patient safety culture are available:

- [Hospital Survey on Patient Safety Culture](#)
- [Medical Office Survey on Patient Safety Culture](#)
- [Nursing Home Survey on Patient Safety Culture](#)

Health care organizations can use these survey assessment tools to:

- Raise staff awareness about patient safety.
- Diagnose and assess the current status of patient safety culture.
- Identify strengths and areas for patient safety culture improvement.
- Examine trends in patient safety culture change over time.

Skin Assessment

- If patient is to be admitted from the ED, staff should consider doing a full skin assessment
 - Especially when boarding patient when no beds available
- Recommend documentation of this in the medical record or on a separate form
- If long delay in getting to room use a validated risk assessment tool such as Braden or Norton scale to predict risk
- If pressure ulcer is present consider notifying ET or wound care nurse
- Implement plan of care

Skin Assessment

- Essential to document this and make sure physician documents also
- Consider a picture on admission of the pressure ulcer
- Include information in hand off communications
- Important to document since it is one of the Medicare CMS hospital acquired conditions and no pay unless present on admission
- Failure to document that the pressure ulcer is present on admission (POA) will cost the hospital money

BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK

	Patient's Name _____	Evaluator's Name _____	Date of Assessment					
SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	1. Completely Limited Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body	2. Very Limited Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/3 of body.	3. Slightly Limited Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	4. No Impairment Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.				
MOISTURE degree to which skin is exposed to moisture	1. Constantly Moist Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	2. Very Moist Skin is often, but not always moist. Linen must be changed at least once a shift.	3. Occasionally Moist: Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. Rarely Moist Skin is usually dry, linen only requires changing at routine intervals.				
ACTIVITY degree of physical activity	1. Bedfast Confined to bed.	2. Chairfast Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. Walks Occasionally Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair	4. Walks Frequently Walks outside room at least twice a day and inside room at least once every two hours during waking hours				
MOBILITY ability to change and control body position	1. Completely Immobile Does not make even slight changes in body or extremity position without assistance	2. Very Limited Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. Slightly Limited Makes frequent though slight changes in body or extremity position independently.	4. No Limitation Makes major and frequent changes in position without assistance.				
NUTRITION <u>usual</u> food intake pattern	1. Very Poor Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement OR Is NPO and/or maintained on clear liquids or IV's for more than 5 days.	2. Probably Inadequate Rarely eats a complete meal and generally eats only about 1/3 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding	3. Adequate Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs	4. Excellent Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.				
FRICION & SHEAR	1. Problem Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction	2. Potential Problem Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. No Apparent Problem Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.					
					Total Score			

Medication Errors

- Medication errors are the most common medical error
- Staff should be familiar with common medication errors in the ED and problematic drugs
- Phenergan should be IM or given IV slow or piggyback and try 12.5 mg initially
 - Vesicant with low pH and can cause patient to lose fingers
- Be aware of high risk drugs such as Heparin, insulin, Coumadin, neuromuscular blockers etc.
- New labeling of injectibles with information on top

Labeling of Injectables



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Recommendations to Reduce Errors

- Consider adding a pharmacist to the ED during busy times
- CPOE for all medications prescribed in the ED
- Perform medication reconciliation in all ED patients
- Document allergies and contraindications
- Be careful in giving medications to patients who are being boarded because a bed is not available
 - If nurse is not familiar with the drug should look it up and check with pharmacist
 - ED overcrowding is associated with an increased frequency of medication errors. Kulstad EB, Sikka R, Sweis RT, Kelley KM, Rzechula KH. Am J Emerg Med. 2010;28:304-309.

Recommendations

- Implement automated dispensing unit in ED with pharmacy review
- Educate ED staff on safe medication administration techniques
- Monitor ED staff to ensure compliance with medications P&Ps
- Special warnings on neuromuscular blockers or stored in a separate place
- Have a ED medication champion to provide quarterly updates

Recommendations

- Educate ED staff and implement double checks on high-alert medications such as Heparin and insulin
- Make sure staff trained on all new equipment such as IV pumps and consider use of smart pumps

Check for look-alike/sound-alike (LASA) drugs stored in the ED and make certain they are separated to prevent confusion and possible error

Have a medication board with recent articles such as Darvocet pulled off market, need to give Tylenol liquid in oral syringe, don't mixup DTaP-Tdap and Epi , etc.

WARNING: RISK FOR SERIOUS OR FATAL MEDICATION ERROR

A National Alert Network message from the American Society of Health-System Pharmacists and the Institute for Safe Medication Practices

EPINEPHrine pre-filled syringe shortage

EPINEPHrine emergency syringes 1 mg/10 mL (0.1 mg/mL) are currently on backorder from the sole manufacturer of this product. Although the shortage is expected to resolve later this summer, practitioners should be aware of risk for error created by the shortage.

Although injectable **EPINEPH**rine is still available in 1 mg/mL in **1 mL ampuls or vials**, 1 mg/mL in **30 mL vials**, and 1 mg/10 mL (0.1 mg/mL) **emergency syringes with an intracardiac needle**, these products may not be safe alternatives for code carts, in emergency vehicles, and for other emergency needs, for the reasons that follow:

- **Misuse of syringe with intracardiac needle.** **EPINEPH**rine 0.1 mg/mL in 10 mL syringes have a 3.5 inch needle for intracardiac use, which is not removable and not compatible with needleless tubing/systems. Attempting to use this product for intravenous or endotracheal administration with the needle attached or attempting to remove the needle may result in injury to both patient and caregiver.
- **No option for pharmacy to prepare doses.** **EPINEPH**rine is sensitive to light, air, and pH, with a short stability time when extemporaneously prepared, making it unsuitable for bulk compounding by pharmacy departments.
- **Dose miscalculations.** Practitioners may not recognize or understand the difference between 1:1,000 (1 mg/mL) and 1:10,000 (0.1 mg/mL) strengths and may miscalculate when, for example, a

Beers List of Inappropriate Medications

- ED staff should know about the Beers list which was updated in 2012
 - Is a list of medications that should not be used in older adults who are 65 or older
- Medication toxic effects and drug related problems have profound effects on elderly
- Studies that show 4 or more or 8 or more drugs increase risk for falls
- Post the list on the medication bulletin board and provide a copy to all the physicians

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

MEDICATION(s) ^b	EXPLANATION OF PROBLEM	SEVERITY
PSYCHOTROPIC MEDICATIONS		
Amitriptyline, alone or in combination products	Strong anticholinergic and sedating properties	High
Barbiturates (other than phenobarbital)	Side effects and addictive properties	High
Chlordiazepoxide (alone or in combination) or diazepam	Long half-lives, risk of sedation and increased falls	High
Doxepin	Strong anticholinergic and sedating properties	High
Ergot mesylates, cyclandelate isoxsuprine ^c	Not proven effective at doses studied	Low
Flurazepam	Long half-life; risk of sedation and increased falls	High
Haloperidol ^c	Doses > 3mg/day should be avoided; residents with psychotic disorders may require higher doses	...
Lorazepam 3 mg, oxazepam 60 mg, alprazolam 2 mg, temazepam 15 mg, zolpidem 5 mg, triazolam 0.25 mg	Total daily doses should not exceed these amounts; in the nursing facility resident, avoid any single dose of oxazepam > 30 mg or triazolam > 0.25 mg	Low
Meperidine	Not effective orally and has disadvantages compared with other narcotic analgesics	High
Meprobamate	Highly addictive and sedating. Avoid unless patient is already	High

Do Not Crush Medication

- Should have list for staff of meds that should not be crushed, have in a book or on the wall in the ED
- Aciphex, actonel, accutane, Toporol XL, Prilosec, Procardia XL, aprevacide, Plendil, OxyContin, Oramorph SR, Opana ER (causes fatal OD) and 16 pages
- Especially enteric coated, drugs with ER or SR since slow release
- Wall chart can be purchased from www.factsandcomparisons.com/hospitalpharm/
- Free list available at www.ismp.org/Tools/DoNotCrush.pdf
- ED should put chart in medication room
- See Identified safety risks with splitting and crushing oral medications. Paparella S. J Emerg Nurs. 2010;36:156-158

List of Do Not Crush Medications

Oral Dosage Forms That Should Not Be Crushed

John F. Mitchell, PharmD, FASHP¹

Last updated: January 2014

www.ismp.org

Drug Product	Active Ingredient(s) ²	Dosage Form(s)	Reasons/Comments ³
AcipHex	RABE prazole	Tablet	Extended-release
Actiq	fenta NYL	Lozenge	Slow-release Note: this lollipop delivery system requires the patient to slowly dissolve in mouth
Actonel	risedronate	Tablet	Irritant Note: chewed, crushed, or sucked tablets may cause oropharyngeal irritation
Adalat CC	NIFE dipine	Tablet	Extended-release
Adderall XR	amphetamine salts	Capsule	Extended-release (a)
AeroHist Plus	combination	Tablet	Slow-release (h)
Afedintab CR	NIFE dipine	Tablet	Extended-release
Afinitor	everolimus	Tablet	Mucous membrane irritant
Aggrenox	combination	Capsule	Extended-release
Alavert Allergy (Sinus 12 Hour)	combination	Tablet	Extended-release
Allegra D	combination	Tablet	Extended-release
ALPRAZ olam ER	ALPRAZ olam	Tablet	Extended-release
Altoprev	lovastatin	Tablet	Extended-release
Ambien CR	zolpidem	Tablet	Extended-release
Amibid DM	combination	Tablet	Extended-release
Ampyra	dalfampridine	Tablet	Extended-release Note: formerly fampridine-SR

The End!

Questions?



- Sue Dill Calloway RN, Esq. CPHRM
- AD, BA, BSN, MSN, JD
- President of the Patient Safety and Education Consulting
- Chief Learning Officer for the Emergency Medicine Patient Safety Foundation
- 5447 Fawnbrook Lane
- Dublin, Ohio 43017
- 614 791-1468
- sdill1@columbus.rr.com

TJC RI Informed Consent

- Remember your state law on informed consent
- Remember CMS CoP provisions on informed consent discussed previously
- TJC has a standard on informed consent in the patient rights chapter or RI chapter
- RI.01.03.01 in 2010 (RI 2.40 previously) and RC.02.01.01
 - Include all 3 sources in your consent policy

RC.02.01.04

- EP4 The medical record needs to contain the following
 - Any informed consent as required by the hospital policy
 - TJC added language at the request of CMS
 - This change was in the March 2011 updates
 - The consent form must be in the chart unless it is an emergency

RC.02.01.04

- A properly executed consent form must contain
 - Documentation of a patient's mutual understanding of and agreement
 - For care, treatment, or services
 - Through written signatures or electronic signature
 - Or when a patient is unable to provide a signature
 - There must be documentation of verbal agreement by the patient or surrogate decision maker

TJC Informed Consent Rationale RI.01.03.01

- Obtaining informed consent presents opportunity to establish a mutual understanding between the patient and the LIP
- It is a **process** is not merely a signed form
- It considers the patient's needs and preferences
- It considers compliance with laws and regulations and patient education
- Informed consent process helps patient to participate fully in decisions about their care
- EP8 & 10 do not apply to hospitals

TJC Informed Consent

- Informed consent is a discussion of:
 - What the procedure is to accomplish
 - Reasonable known risks
 - Alternatives
 - Benefits
 - Prognosis
 - What can happen if the surgery or treatment is refused

TJC Informed Consent 01.03.01

There are 13 Elements of Performance but only 11 apply to hospitals:

- EP1 - The hospital has a written policy on informed consent
- EP2 - The policy identifies specific care and treatment that requires an informed consent and this must be consistent with law and regulations
- EP3 - Policy describes exceptions to the rule (such as emergencies then document in chart)

TJC Informed Consent 01.03.01

- EP4 - Policy describes the process to be followed
- EP5 - Describe in policy how to document consent in the medical record (on form, in progress notes)
- EP6 - Policy describes when a surrogate decision maker can give the informed consent (see RI.01.02.01 EP6)
 - If the patient is unable to make decisions about care, then it is made by surrogate decision maker

TJC Informed Consent 01.03.01

- EP7 - Consent process includes a discussion about the patient's proposed care, treatment and services
- EP9 - Process includes a discussion about potential benefits, risks, and side effects, likelihood of achieving the patient's goals and any potential problems that might occur during recuperation
- EP11 - Process includes a discussion of the reasonable alternatives to the patient's proposed care, risks, benefits, and side effects of the alternatives
 - Includes the risks of not having the proposed treatment

TJC Informed Consent 01.03.01

- EP12 - Informed consent process includes a discussion about any circumstance under which information about the patient must be disclosed or reported
 - Examples: mandatory reporting requirements for HIV, TB, viral meningitis, and other diseases to CDC or state department of health
- EP13 - Consent is obtained in accordance with the hospital policy and processes
 - RC.02.01.01 EP 4 requires the medical record to contain evidence of informed consent

RI.01.03.03 Consent for Photography

- TJC has a standard that requires the hospital to honor the patient's right to give or withhold informed consent
- To produce or use recordings, films, or other images of the patient
- For purposes other than his or her care
- There are 7 elements of performance
- RI.01.03.05 document research in consent form and 8 EPs

Sample Consent Form for Photography

- The American Health Information Management Association (AHIMA)
- has a practice brief on Patient Photography, Videotaping and other Imaging¹

¹ http://library.ahima.org/xpedio/groups/public/documents/ahima/bok2_000585.hcsp?dDocName=bok2_000585

Sample Consent for Photography/Videotaping (For Media or Educational Purposes)

Patient's Name: _____

Identification Number: _____

I hereby give my consent to have photographs, videotaped images, or other images made of myself or my family member and/or consent to interviews with a member of the news media or a representative of (name of organization). I understand and agree that these images may be used by the news media or by (name of organization) for the purpose outlined below:

Signature of Patient or Legal Representative

Date

Signature of Witness

Date

This presentation is intended solely to provide general information and does not constitute legal advice. Attendance at the presentation or later review of these printed materials does not create an attorney-client relationship with the presenter(s). You should not take any action based upon any information in this presentation without first consulting legal counsel familiar with your particular circumstances.

Thanks for Attending!



- Sue Dill Calloway RN, Esq.
CPHRM, CCMSCP
- AD, BA, BSN, MSN, JD
- President of Patient Safety and Education
- Board Member
Emergency Medicine Patient Safety
- 614 791-1468
- sdill1@columbus.rr.com