ED Hot Legal & Regulatory Issues for 2017

Sue Dill Calloway

RELIAS LEARNING

Speaker

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  hospitalscg@cms.hhs.gov

Objectives

- Describe legal and risk management issues in the ED.
- Explain the importance of using interpreters for patients with English as a second language.
- Discuss how the visitation law requires patients to receive written information about their rights.

EMTALA Update

Emergency Medical Treatment and Labor Act

RELIAS | LEARNING

Location of EMTALA CoP

State Operations Manual

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

(Rev. 60, 07-16-10)

Transmittals for Appendix V

Email questions to hospitalscg@cms.hh.gov

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/som107_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

ACEP Now
The Official Voice of Emergency Medicine

NAVIGATION

www.acepnow.com/article/ed-waiting-room-posters-prescribing-pain-medications-may-violate-emtala/

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

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 states will be published in 2017
- 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

https://oig.hhs.gov/authorities/docs/2014/fr-79-91.pdf

FEDERAL REGISTER

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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 appears 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
  - I.e. 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

EMTALA Penalties 2017

- It is especially important for physicians and hospitals to make sure they are in compliance with the federal EMTALA law
  - The penalties have recently gone up significantly
  - In fact, it more than doubled now
- This is as a result of the Federal Civil Penalties Inflation Adjustment Act of 2015
- From $50,000 to 103,139.00 for hospitals with 100 beds or more and Feb 2017 inflation to **104,826**
- From 25,000 to $51,570 hospitals less than 100 with Feb 2017 inflation to **$52, 421**

EMTALA Revised Penalties

CALCULATION OF CMP ADJUSTMENTS

Citation		Description[2]	Pre-Inflation Penalty($)	Date of Last Penalty Figure or Adjustment[3]	Percentage Increase[4]	Increase ($)[5]	Maximum Adjusted Penalty ($)
U.S.C.	CFR[1]						
1395dd(d)(1)	42 CFR Part 1003	Penalty for a hospital or responsible physician dumping patients needing emergency medical care, if the hospital has 100 beds or more.	50,000	1987	106.278	53,139	103,139
		Penalty for a hospital or responsible physician dumping patients needing emergency care, if the hospital has less than 100 beds	25,000	1987	106.278	26,570	51,570

[1]Some HHS components have not promulgated regulations regarding their civil monetary penalties-specific statutory authorities.
[2]The description is not intended to be a comprehensive explanation of the underlying violation; the statute and corresponding regulation, if

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/LTC-HHA-CLIA-Specific-CMP-Adjustments.pdf

TABLE 2—HARDNESS DEFAULTS WITHIN EACH LEVEL III ECOREGION IN OREGON—Continued

Level III ecoregion	Hardness mg/L)
9 Eastern Cascades Slopes and Foothills	36.08
10 Columbia Plateau	58.82
11 Blue Mountains	43.49
12 Snake River Plain	123.5
78 Klamath Mountains	40.61
80 Northern Basin and Range	98.62

(d) *Applicability.* (1) The criterion in paragraph (b) of this section applies to freshwaters in Oregon where fish and aquatic life are a designated use, and applies concurrently with other applicable water quality criteria.

(2) The criterion established in this section is subject to Oregon's general rules of applicability in the same way and to the same extent as are other federally promulgated and state-adopted numeric criteria when applied to freshwaters in Oregon where fish and aquatic life are a designated use.

(i) For all waters with mixing zone regulations or implementation

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 102

RIN 0991–AC0

Annual Civil Monetary Penalties Inflation Adjustment

AGENCY: Department of Health and Human Services, Office of the Assistant Secretary for Financial Resources.

ACTION: Final rule.

SUMMARY: The Department of Health and Human Services (HHS) is updating its regulations to reflect required annual inflation-related increases to the civil monetary penalties in its regulations, pursuant to the Federal Civil Penalties Inflation Adjustment Act Improvement Act of 2015.

DATES: This rule is effective February 3, 2017.

FOR FURTHER INFORMATION CONTACT: Andrea Brandon, Deputy Assistant Secretary for Grants and Acquisitions, Office of the Assistant Secretary for Financial Resources, Room 514–G, Hubert Humphrey Building, 200 Independence Avenue SW., Washington DC 20201: 202–690–6396; FAX 202–

the required annual adjustment. The cost-of-living adjustment multiplier for 2017, based on the CPI–U for the month of October 2016, not seasonally adjusted, is 1.01636.

Using the 2017 multiplier, HHS adjusted all its applicable monetary penalties in 45 CFR 102.3.

III. Statutory and Executive Order Reviews

The 2015 Act Requires Federal Agencies To Publish Annual Penalty Inflation Adjustments Notwithstanding Section 553 of the Administrative Procedure Act

A. Executive Order 12866: Regulatory Planning and Review and Executive Order 13563: Improving Regulation and Regulatory Review

Section 4 of the 2015 Act directs federal agencies to publish annual adjustments no later than January 15, 2017. In accordance with section 553 of the Administrative Procedure Act (APA), most rules are subject to notice and comment and are effective no earlier than 30 days after publication in the **Federal Register**. However, Section 4(b)(2) of the 2015 Act provides that each agency shall make the annual

Non-Discrimination, Signs, Interpreters: Compliance with Section 1557

RELIAS LEARNING

Nondiscrimination Provision ACA 2016

- Section 1557 is the part in the Affordable Care Act (ACA) that addresses the non-discrimination law
- **This law prohibits discrimination based on race, color, national origin, sex, age, or disability in certain health programs and activities**
- It builds on longstanding non-discrimination rights and adds new civil rights protections
- It is the first federal civil law to broadly prohibit **sex discrimination** in health programs and activities

Copy of Law PDF Version

www.gpo.gov/fdsys/pkg/FR-2016-05-18/pdf/2016-11458.pdf

FEDERAL REGISTER

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Part IV

Department of Health and Human Services

Office of the Secretary

45 CFR Part 92

Nondiscrimination in Health Programs and Activities; Final Rule

Non-discrimination Law

- It includes sex discrimination including **pregnancy,** related medical conditions, termination of pregnancy, gender identity, and sex stereotypes
- It also enhances language assistance for patients with limited English proficiency (LEP) such as the patient who only speaks Spanish
  - Interpreters must be qualified and available timely
- It affects hospitals and healthcare facilities that accept federal funds such as Medicare or Medicaid
- Must make sure patients have auxiliary aids

Auxiliary Aids and Services

- One hospital has the following auxiliary and services:
- Large print materials and copies of things such as patient rights, consent form, etc.
  - And staff can enlarge any document on their copier
- TDD phones for the hearing impaired (text telephone)
- White boards for intubated patients to write on
- Lighted magnifying glasses for patients with impaired vision
- Has closed captioned on the TV for hearing impaired

Auxiliary Aids and Services

- Telephone handset with amplifier
- Qualified interpreters both onsite and through high functioning video remote interpreting
- Braille materials and displays
- Optical readers and screen reader software
- Qualified readers
- HHS also mentions voice, text, and video based telecommunication products, accessible electronic and information technology, computerized assisted transcription services and more

Compliance with Section 1557

- Must post a sign so patients come in places like admitting and the emergency they can see it
  - OCR has a sample notice
- Train all ED staff on this
- Make sure ED staff aware of policy and procedure
- Post a sign in 15 languages or taglines so patients who do not speak English will see they can interpreting services available at no charge
  - OCR has a list for each state of the 15 top languages
- Have a person in charge to handle any grievances

OCR has Sample Notice in English

Appendix A to Part 92—Sample Notice Informing Individuals About Nondiscrimination and Accessibility Requirements and Sample Nondiscrimination Statement:

Discrimination is Against the Law

[Name of covered entity] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. [Name of covered entity] does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

www.hhs.gov/sites/default/files/sample-ce-notice-english.pdf

[Name of covered entity]:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

List 15 Top Language Spoken in Every State

Resource for Entities Covered by Section 1557 of the Affordable Care Act
Estimates of at Least the Top 15 Languages Spoken by Individuals with Limited English Proficiency for the 50 States, the District of Columbia, and the U.S. Territories.

Covered entities may use this information to implement the tagline requirement at § 92.8(d)(1)-(2) of the Section 1557 rule (45 C.F.R. pt. 92), although nothing in the rule requires a covered entity to use this particular resource. For more information about this resource and the data used, refer to the Frequently Asked Questions on these topics.

Rank	State	Language	Estimate
1	AL	Spanish	75,000
2	AL	Chinese	5,405
3	AL	Korean	4,554
4	AL	Vietnamese	3,708
5	AL	Arabic	1,440
6	AL	German	1,411
7	AL	French	1,278
8	AL	Gujarati	888
9	AL	Tagalog	856
10	AL	Hindi	818
11	AL	Laotian	681
12	AL	Russian	586
13	AL	Portuguese	516
14	AL	Turkish*	505
15	AL	Japanese	484
1	AK	Tagalog	7,021
2	AK	Spanish	5,975

www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/top15-languages/index.html

Complaints

- Special process if patient complains about discrimination
- Must include in the written patient rights statement
- Must have dedicated staff person to respond
- Patient must file letter within 60 days
- Hospital must respond in writing within 30 days
- Patient can appeal to board or CEO within 15 days and they must respond again in 30 days
- Can file complaint directly with the OCR also

How to File a Civil Rights Complaint

Complaint Requirements

Your complaint must:

- Be filed in writing by mail, fax, e-mail, or via the OCR Complaint Portal
- Name the health care or social service provider involved, and describe the acts or omissions, you believe violated civil rights laws or regulations
- Be filed within 180 days of when you knew that the act or omission complained of occurred. OCR may extend the 180-day period if you can show "good cause"

File a Civil Rights Complaint Online

Open the OCR Complaint Portal and select the type of complaint you would like to file.
Complete as much information as possible, including:

- Information about you, the complainant
- Details of the complaint
- Any additional information that might help OCR when reviewing your complaint

You will then need to electronically sign the complaint and complete the consent form. After completing the c[illegible]m you will be able to print out a copy of your complaint to keep for your records

top

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;

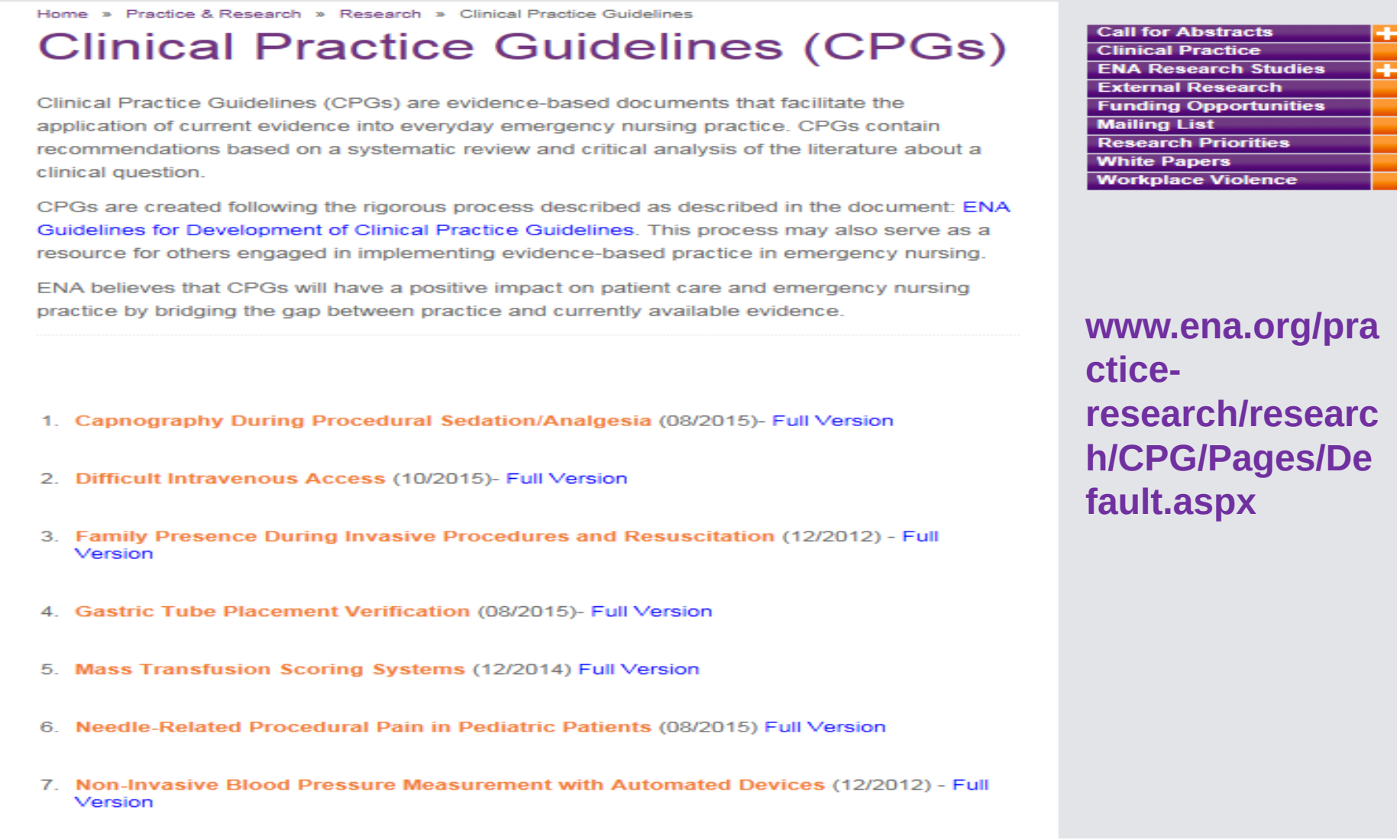
1. A duty was owed to the patient
2. There was a breach of duty or breach of the standard of care
3. There was direct or proximate cause and
4. There was some damage

ENA and ACEP Position Statements

- It is important to ensure practice is done according to the standard of care
- It is important to keep up with current and new ENA and ACEP position statements
- These can be used in a court room to show evidence of the standard of care
- CMS wants evidenced based policies so can cited these
- Do not have to be a member to access these
- Staff should be aware

ENA www.ena.org

ENA Clinical Practice Guidelines



Home » Practice & Research » Research » Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs)

Clinical Practice Guidelines (CPGs) are evidence-based documents that facilitate the application of current evidence into everyday emergency nursing practice. CPGs contain recommendations based on a systematic review and critical analysis of the literature about a clinical question.

CPGs are created following the rigorous process described as described in the document: ENA Guidelines for Development of Clinical Practice Guidelines. This process may also serve as a resource for others engaged in implementing evidence-based practice in emergency nursing.

ENA believes that CPGs will have a positive impact on patient care and emergency nursing practice by bridging the gap between practice and currently available evidence.

1. Capnography During Procedural Sedation/Analgesia (08/2015)- Full Version
2. Difficult Intravenous Access (10/2015)- Full Version
3. Family Presence During Invasive Procedures and Resuscitation (12/2012) - Full Version
4. Gastric Tube Placement Verification (08/2015)- Full Version
5. Mass Transfusion Scoring Systems (12/2014) Full Version
6. Needle-Related Procedural Pain in Pediatric Patients (08/2015) Full Version
7. Non-Invasive Blood Pressure Measurement with Automated Devices (12/2012) - Full Version

Call for Abstracts
Clinical Practice
ENA Research Studies
External Research
Funding Opportunities
Mailing List
Research Priorities
White Papers
Workplace Violence

www.ena.org/practice-research/research/CPG/Pages/Default.aspx

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ENA Position Statements

www.ena.org/practice-research/Practice/Position/Pages/PositStmts.aspx

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

ACEP Policy Statements

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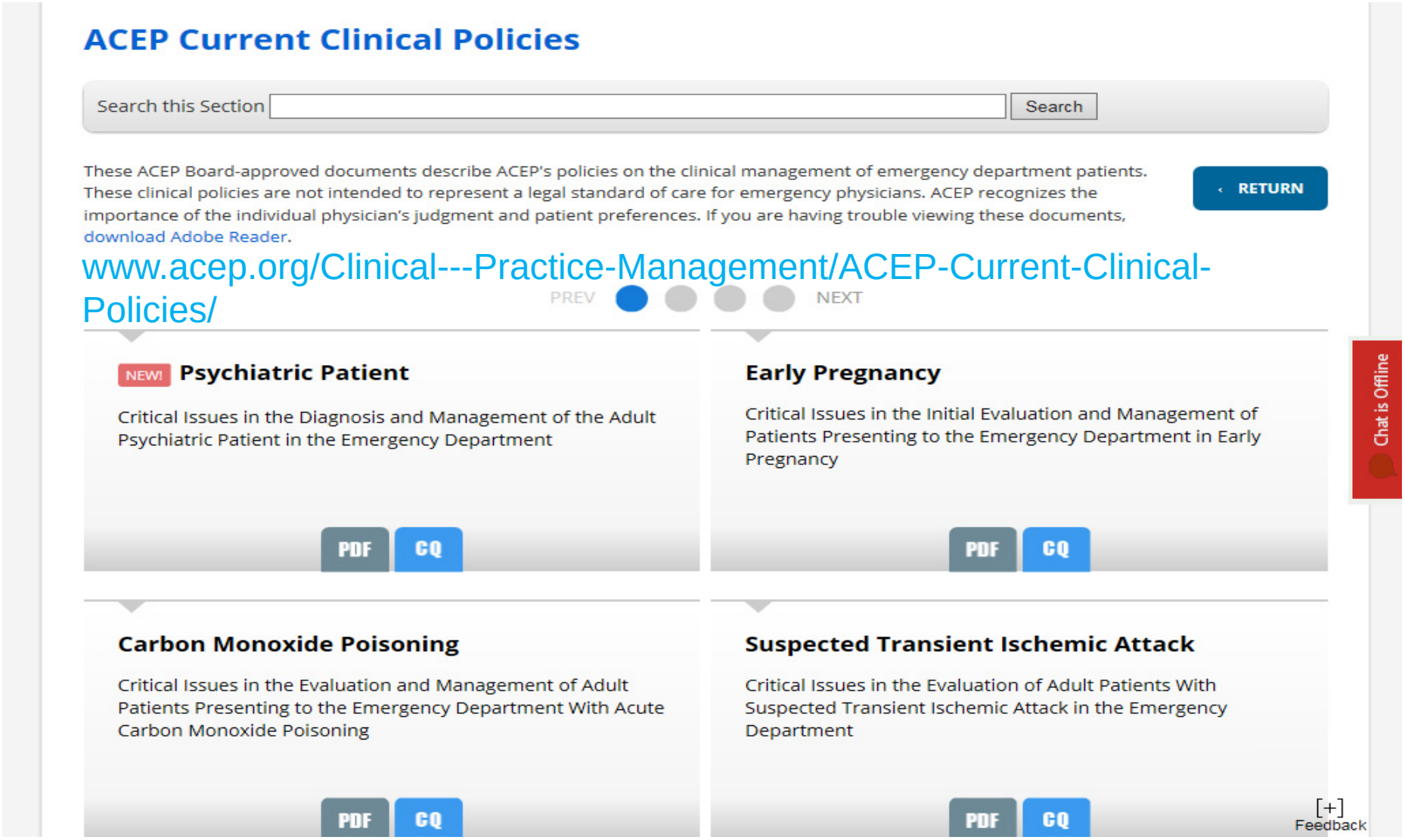
ACEP Clinical Policies



ACEP Clinical Policies

- Suspected TIA, acute heart failure syndromes
- Carbon monoxide poisoning, PE
- Fevers infants and children under 2
- IV tPA for acute stroke, seizures, opioids
- Syncope, community acquired pneumonia
- Acute MI Reperfusion Therapy, procedural sedation
- Appendicitis, acute blunt abdominal trauma
- Mild traumatic brain injury, headache, BP, etc.

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

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

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)

☐ CBC (if not done within 7 days)

☐ RPR

☐ PT

☐ BAL on admission ***or***

☐ Serum HCG female patients. Call MD if results positive.

☐ Chest x-ray (if not done within last 12 mo). On females obtain only after negative Serum HCG.

☐ PPD (routine)

☐ 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.

RELIAS LEARNING

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 accredited hospitals and 9 EPs
- The goal to get boarded patients to their rooms within 4 hours (EP 6)
  - Some EDs have separate dedicated behavioral health beds to keep patients safe until a bed opens up or will admit patients to the unit and ED safe rooms
  - Some use sitters and telemedicine for psychiatrist for evaluation if none on staff

LD.04.03.11 Boarding of Psych Patients

- 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
    - Also increase in the % of patients with BH issues

www.jointcommission.org/r3_report_issue4/

R³ Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission Issue 4, December 19, 2012

Published for Joint Commission accredited organizations and interested health care professionals, *R³ Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also provide a rationale, the rationale provided in *R³ Report* goes into more depth. The references provide the evidence that supports the requirement. *R³ Report* may be reproduced only in its entirety and credited to The Joint Commission. To receive by e-mail, visit www.jointcommission.org.

Patient flow through the emergency department

Requirements

Standards LD.04.03.11 and PC.01.01.01 are revised standards that address an increased focus on the importance of patient flow in hospitals. These revised elements of performance (EPs) go into effect January 1, 2013, with two exceptions: LD.04.03.11, EPs 6 and 9 will be effective January 1, 2014. They will be included in the 2013 standards manual, but any findings from the on-site survey will not affect the organization's final accreditation decision. Information on the implementation of these requirements will be collected by Joint Commission surveyors and staff throughout 2013, and will be used to inform the survey process.

Standard LD.04.03.11: The hospital manages the flow of patients throughout the hospital.

EP 5. The hospital measures and sets goals for the components of the patient flow process, including the following:

- The available supply of patient beds
- The throughput of areas where patients receive care, treatment, and services (such as inpatient units, laboratory, operating rooms, telemetry,

Tell us what you think about *R³ Report*

The Joint Commission is interested in your thoughts about this issue of *R³ Report*. Please take a few minutes to complete a short on-line survey. The survey will be open through Friday, **January 18, 2013**.

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, at Facility Guideline Institute
    - Includes self assessment tool

April 2016 Edition 7.1

www.fgiguidelines.org/wp-content/uploads/2016/04/DesignGuideBH_7.1_1604.pdf

Design Guide for the Built Environment of Behavioral Health Facilities

Now with
Patient Safety Risk Assessment Tool

by James M. Hunt, AIA, NCARB
and David M. Sine, DrBE, CSP, ARM, CPHRM

Distributed by the
The Facility Guidelines Institute

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Increasing Patient Flow

- 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

Increasing Patient Flow

- 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

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

1 in 5 Discharges Have Abnormal VS

- 2016 study found 20% patients had abnormal vital signs such as elevated HR or low BP
- Found this was associated with increased risk of death and hospital readmissions
  - Looked at EHRs of 32,835 patients at six Dallas hospitals
- Discharge guidelines should include objective VS criteria
- Patients with 2 or more instabilities should most likely remain in the hospital
  - Nguyen, O.K., Makam, A.N., Clark, C. et al. J GEN INTERN MED (2016). doi:10.1007/s11606-016-3826-8

2016 Study Finds 1 in 5 Discharged Abn VS

1 in 5 are discharged from hospital with unstable vital signs, and experience higher readmission and death rates

Aug 09, 2016

www.utsouthwestern.edu/newsroom/news-releases/year-2016/august/vital-signs-discharge-halm.html

Dr. Oanh Nguyen (left), Dr. Anil Makam (center), and Dr. Ethan A. Halm (right) of UT Southwestern's Center for Patient-Centered Outcomes Research.

DALLAS — August 9, 2016 — Twenty percent of people hospitalized are released before all vital signs are stable, a pattern that is associated with an increased risk of death and hospital readmission, a new study by UT Southwestern Medical Center researchers shows.

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

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

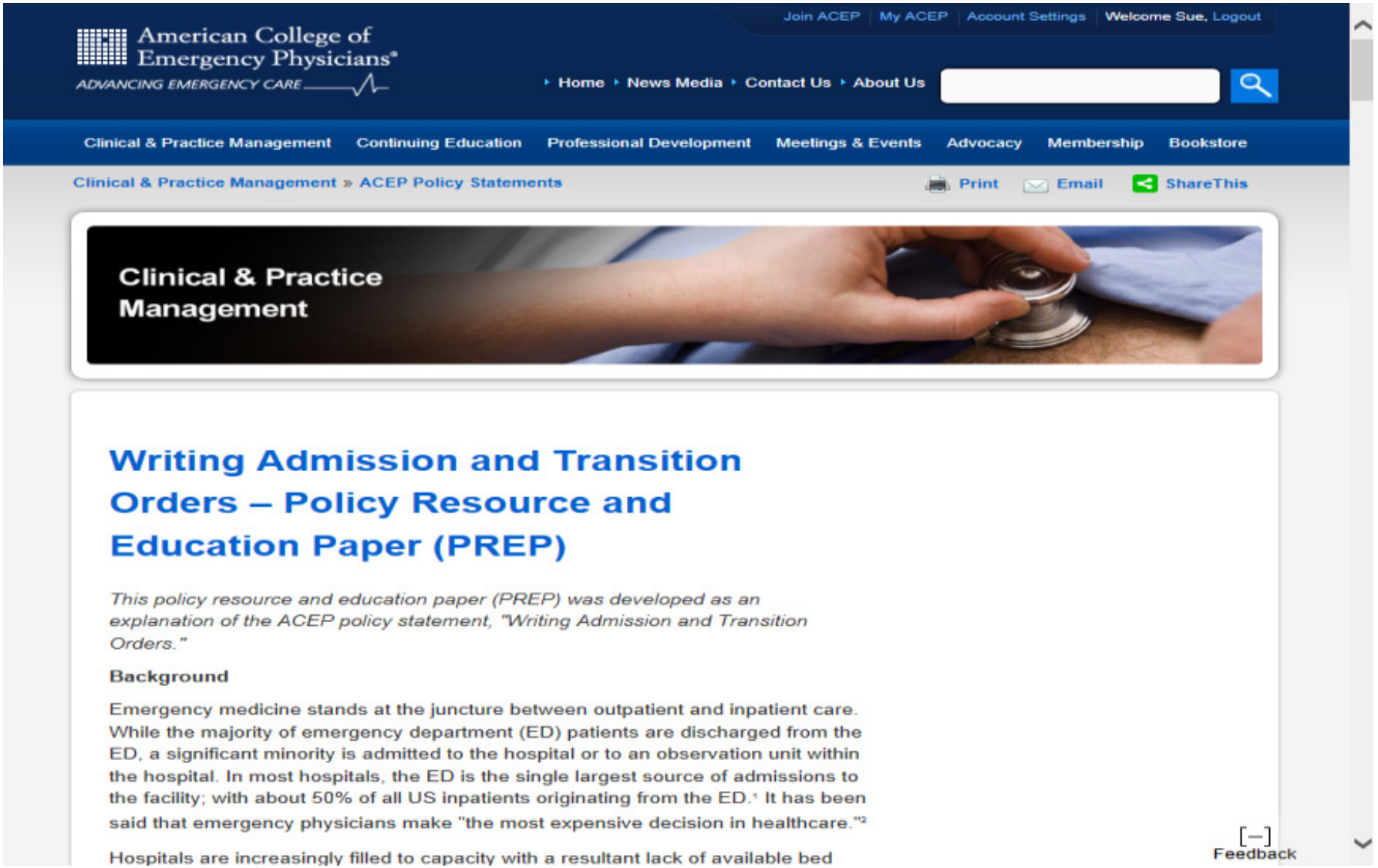
Revised and Approved by the ACEP Board of Directors October 1993; and Revised titled, "Writing Admission and Transition Orders" April 2010
Reaffirmed by the ACEP Board of Directors October 1992, 1997, and 2001
Originally Approved by the ACEP Board of Directors October 1989

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



RELIAS LEARNING

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.

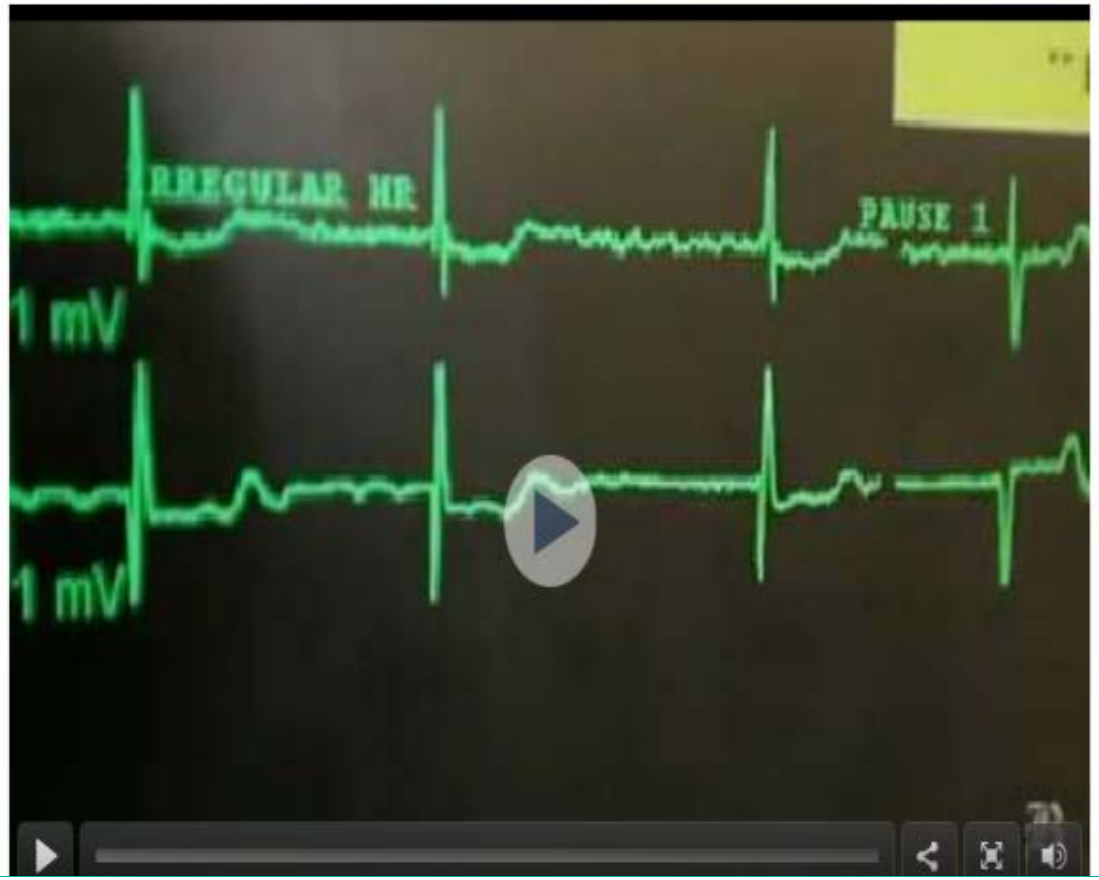
Patient Alarms Often Unheard or Unheeded

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 2016 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
  - Top 10 hazard for many years including ventilator alarms

EXECUTIVE BRIEF

Top 10 Health Technology Hazards for 2017

A Report from *Health Devices*
November 2016

8.00 x 10.25 in

RELIAS LEARNING

Alarm Top 10 Hazard by ECRI

Executive Brief
TOP 10
Patient Safety
Concerns
for Healthcare Organizations
2016
ECRI Institute

Alarm Hazard also Top 10 Patient Safety Concern

TJC NPSG

- Identify most important alarm signals to manage
- What is a 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
- Must 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

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 systematic, 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.*

* Additional information on alarm safety can be found on the AAMI website http://www.aami.org/hts/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.

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

www.jointcommission.org/assets/1/18/PREPUB-06-25-2013-NPSG060101.pdf

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

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.

Please route this issue to appropriate staff within your organization. *Sentinel Event Alert* may only be reproduced in its entirety and credited to The Joint Commission. To receive by email, or to view past issues, visit www.jointcommission.org

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 99 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 *mis*positioned.[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 –

RELIAS | LEARNING

Alarm Problems in the ED

EMERGENCY MEDICINE PATIENT SAFETY FOUNDATION

www.empsf.org

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-rays

- 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 you meet the 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:

- ☐ POSITIVE X-RAY REPORT _____
- ☐ POSITIVE CULTURE REPORT _____
- ☐ CHECK ON PATIENT STATUS _____
- ☐ OTHER (SPECIFY): _____

FINDINGS: _____

_____

_____

ACTION:

- ☐ APPROPRIATE CARE IN E.D. M.D. CALL BACK NECESSARY
- ☐ ATTEMPTED TELEPHONE CONTACT

	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 REGARDING CONTENTS OF LETTER DATE: _____ TIME _____ PERSON RECEIVING CALL _____
- ☐ NO RESPONSE 48 HRS. DATE: _____ TIME _____ SIGNATURE _____

RELIAS LEARNING

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 a letter if patient is not home when nurse phones and unable to reach
- Document follow-up 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

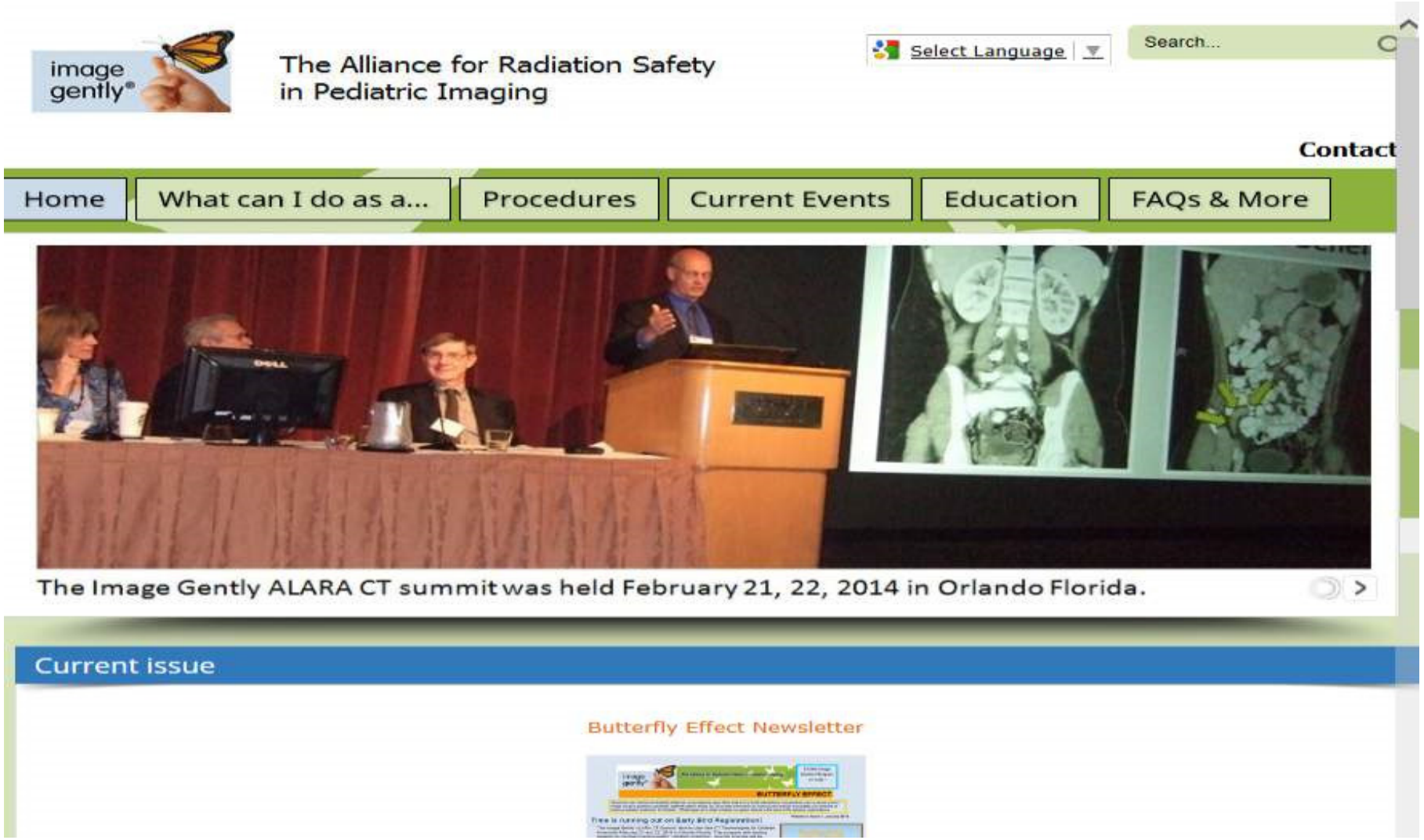
The New York Times August 1, 2010

Hair loss in patients who received 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



RELIAS LEARNING

Child's Medical Imaging Record

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.

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.

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.

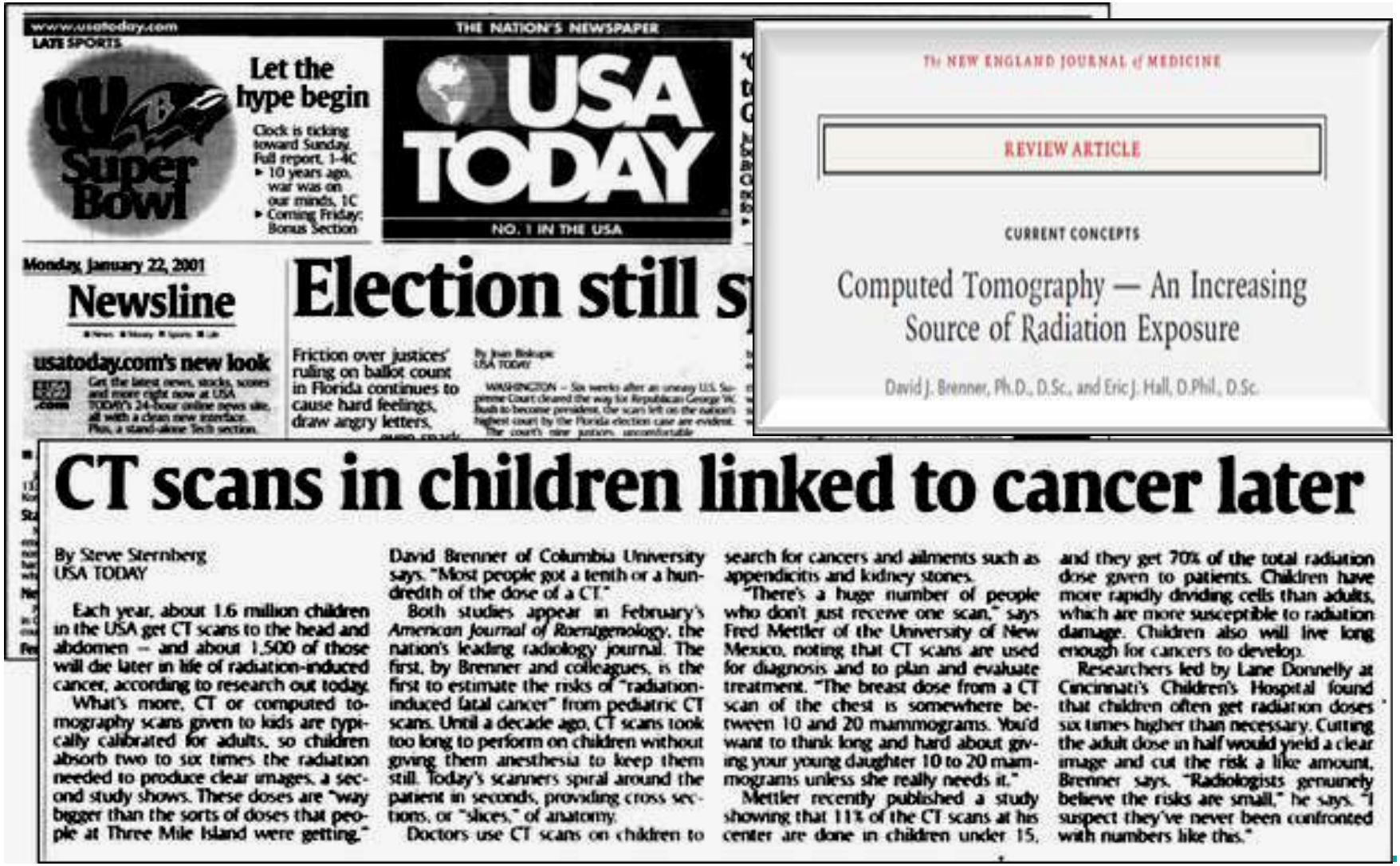
4 Work with your medical physicist, radiologist, and department manager to review your adult CT protocols; then use the simple CT protocols on the Image Gently website to down-size for kids. More is *not* better; adult-size KV and mAs are not necessary for small bodies.

5 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.

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



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LATE SPORTS

Super Bowl

Let the hype begin

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

USA TODAY
NO. 1 IN THE USA

Monday, January 22, 2001

Newsline

usatoday.com's new look

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 Biskupic
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 nine justices 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 got 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.

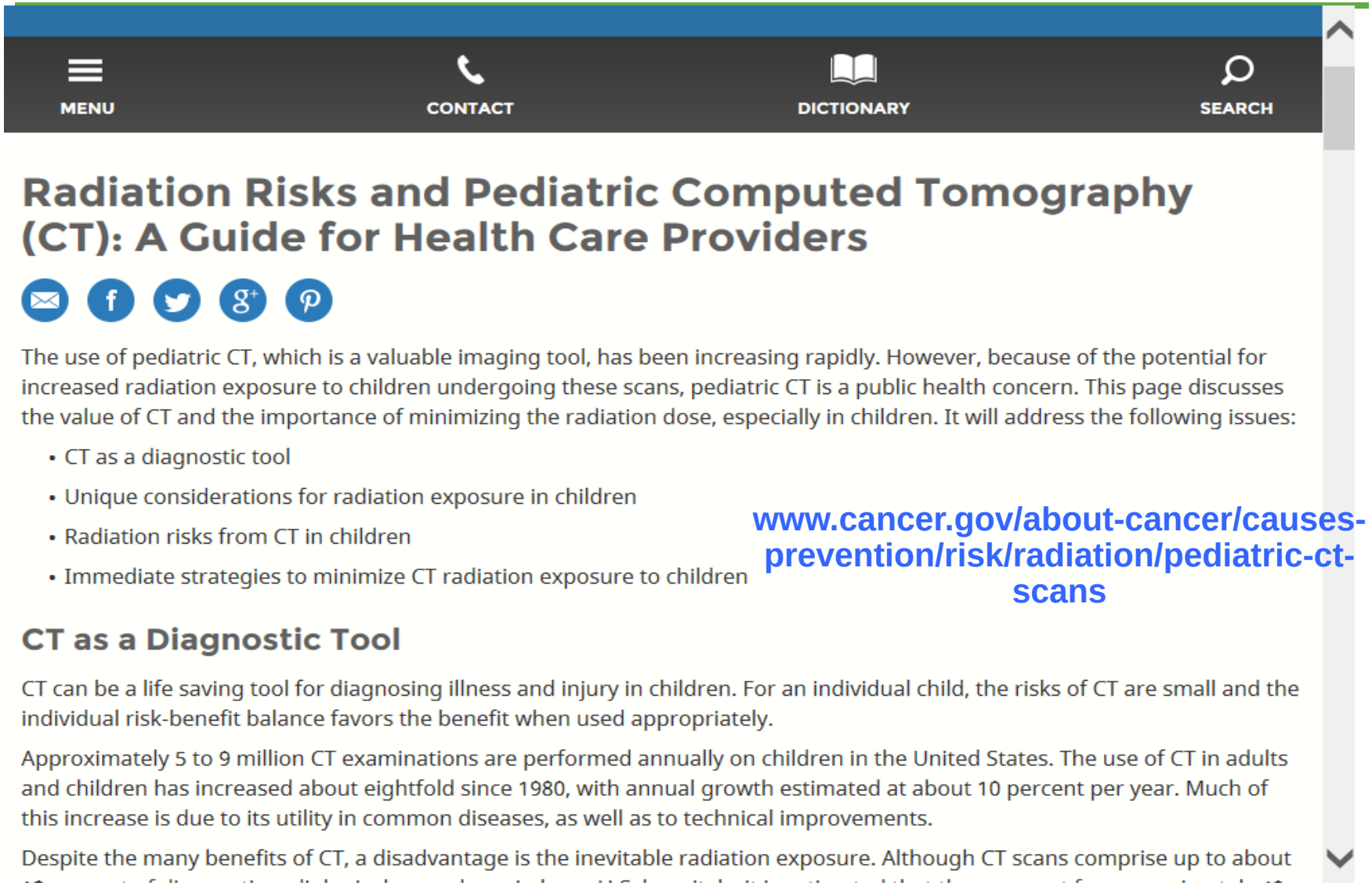
Doctors use CT scans on children to search for cancers and ailments such as appendicitis and kidney stones.

"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

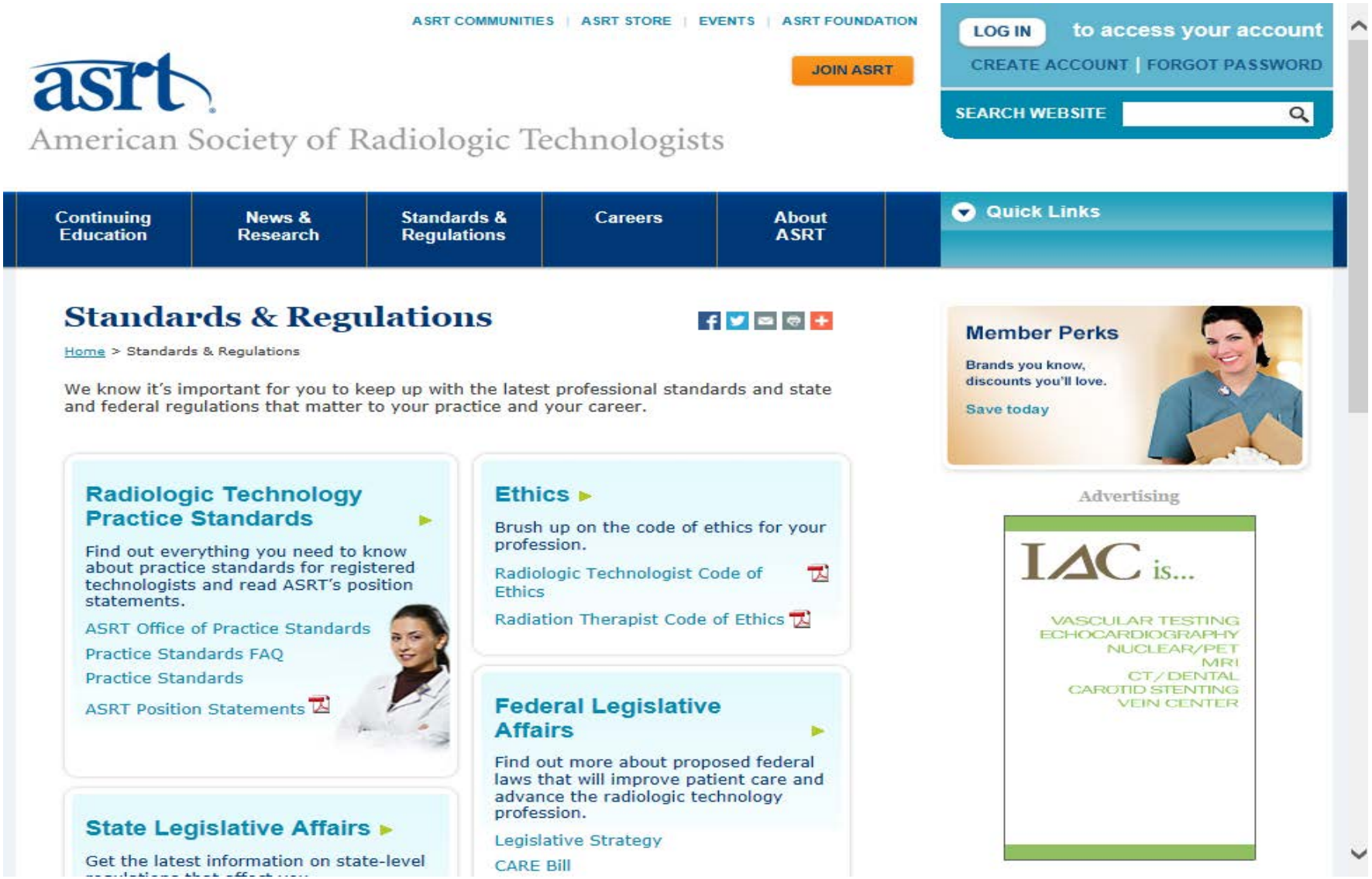


Image Wisely Radiation Safety

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

Choosing Wisely®

An initiative of the ABIM Foundation

About | Lists | Partners | Grantees | Resources

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

Sign up for monthly updates and highlights from

RELIAS | LEARNING

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...

http://www.choosingwisely.org/doctor-patient-lists/antibiotics-for-pink-eye/

RELIAS | LEARNING

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
  - Also note TJC revised CaUTI NPSGs in 2017

CDC Home

Centers for Disease Control and Prevention

CDC 24/7: Saving Lives. Protecting People.™

SEARCH

A-Z Index A B C D E F G H I J K L M N O P Q R S T U V W X Y Z #

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
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- Laboratory Resources
- Outbreak and Patient Notifications
- Widgets, Buttons and Badges

Related Guidelines

Guidelines for the Prevention of Intravascular Catheter-

Healthcare-associated Infections > Types of Infections

Email page link

Print page

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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.

On this Page

- Resources for Patients and Healthcare Providers
- Prevention
- Toolkit
- Resources for State Health Departments
- Monitoring CAUTI

Resources for Patients and Healthcare Providers

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

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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]

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Contact Us:

Centers for Disease Control and Prevention
1600 Clifton Rd
Atlanta, GA 30333

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

Contact CDC–INFO

CDC HICPAC Recommendations

Guidelines for the Prevention of CLABSI, 2011

Latest guidelines on CLABSI.

More...

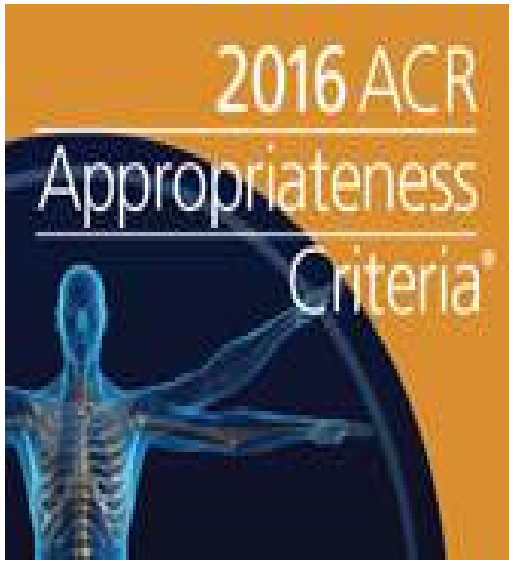
Guideline for Prevention of Catheter-associated Urinary Tract Infections, 2009

RELIAS LEARNING

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

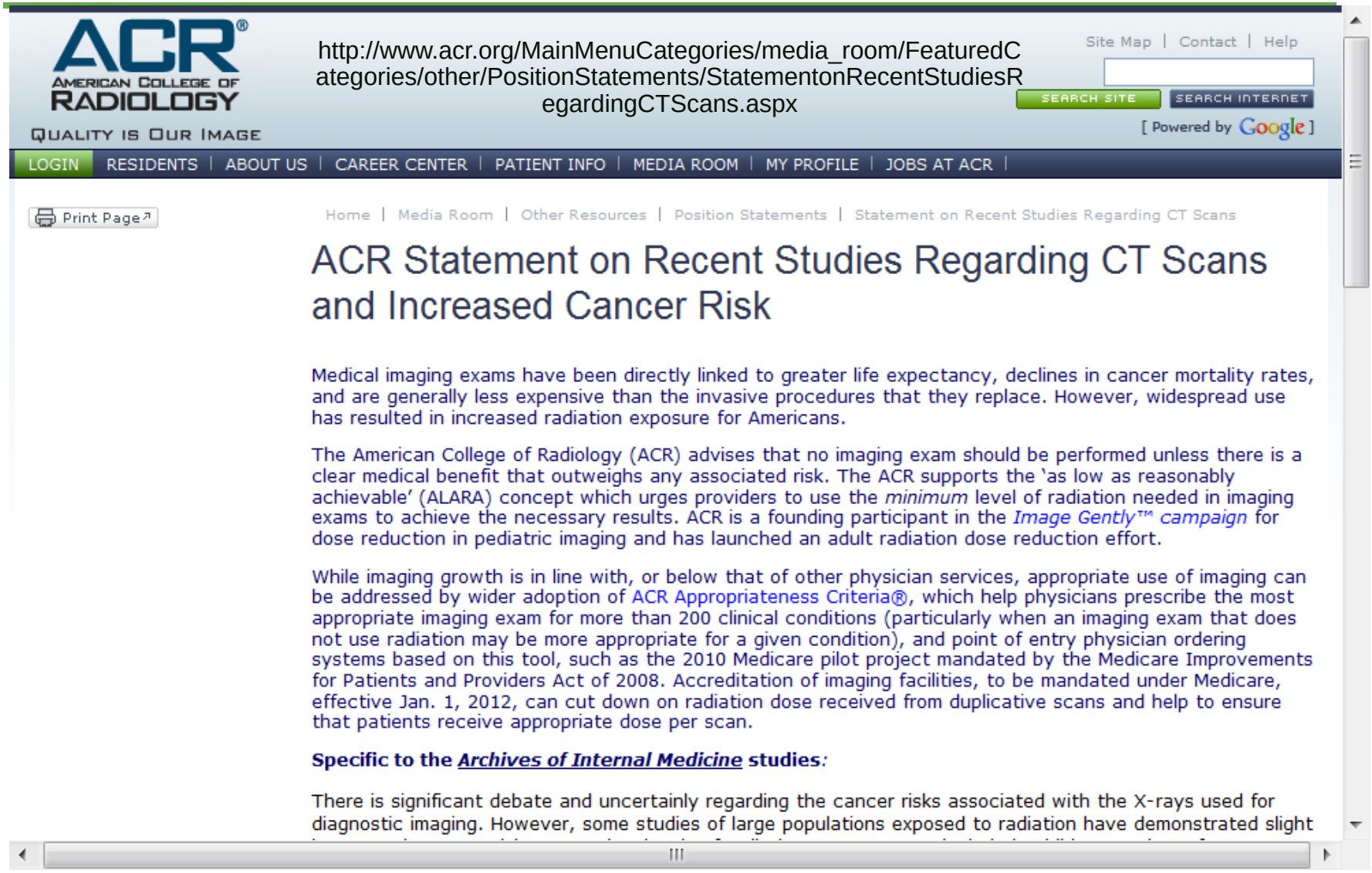


- The ACR Appropriateness Criteria (AC) are evidence-based guidelines to assist referring providers in making the most appropriate imaging or treatment decision for a specific clinical condition.
- Employing these guidelines helps providers enhance quality of care and contribute to the most efficacious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



ACR® AMERICAN COLLEGE OF RADIOLOGY
QUALITY IS OUR IMAGE

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

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LOGIN | RESIDENTS | ABOUT US | CAREER CENTER | PATIENT INFO | MEDIA ROOM | MY PROFILE | JOBS AT ACR |

Print Page

Home | Media Room | Other Resources | Position Statements | Statement on Recent Studies Regarding CT Scans

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 uncertainly 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 Devices

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Home > Medical Devices > Medical Device Safety > Alerts and Notices (Medical Devices)

Medical Device Safety

Alerts and Notices (Medical Devices)

Public Health Notifications (Medical Devices)

Archived Safety Alerts, Public Health Advisories and Notices

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:

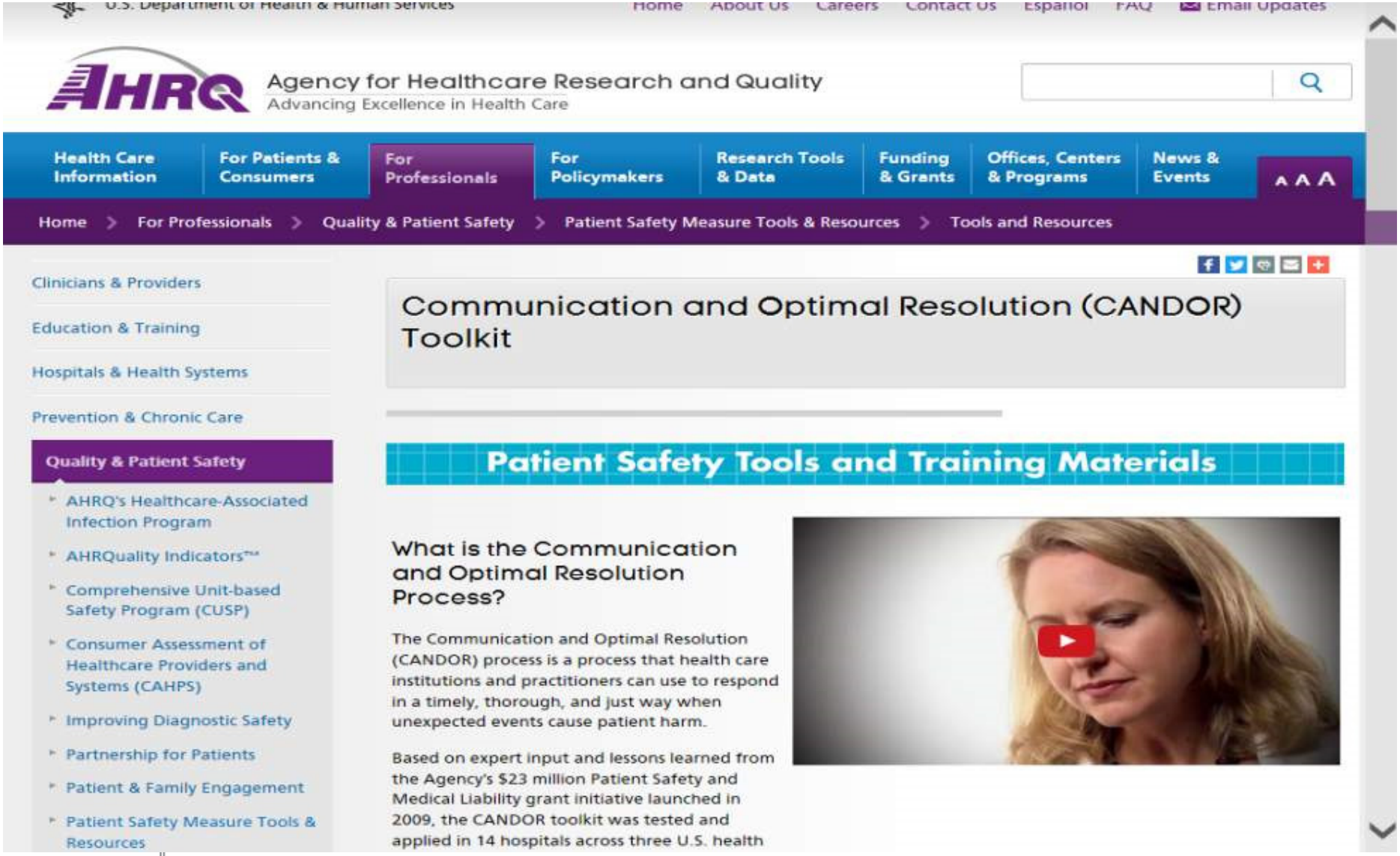
- Unintended "shocks" (i.e., stimuli) from neurostimulators

www.fda.gov/MedicalDevices/Safety/AlertsandNotices/PublicHealthNotifications/ucm061994.htm

AHRQ CANDOR 2016

- AHRQ publishes CANDOR-Communication and Optimal Resolution Toolkit
- Toolkit to use when patient is harmed unexpectantly and how to disclose & respond
  - Need to be honest and transparent with what happened
- Lessons learned from the 23 million dollar Patient Safety and Medical Liability Grant
  - www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/candor/introduction.html
- 8 modules and some contain tools, resources, and videos

AHRQ Candor



RELIAS LEARNING

Improving Diagnostic Safety

- Diagnostic errors are a major cause of liability
- The IOM book in 2015 found that most patients experience at least one diagnostic error in their lifetime
  - Improving Diagnosis in Healthcare
- AHRQ also has tools to help physicians and providers to improved diagnostic safety
  - www.ahrq.gov/professionals/quality-patient-safety/diagnostic-safety/index.html
- Toolkit includes checklist on how patients can help

Clinicians & Providers
Education & Training
Hospitals & Health Systems
Prevention & Chronic Care
Quality & Patient Safety
- AHRQ's Healthcare-Associated Infection Program
- AHRQuality Indicators™
- Comprehensive Unit-based Safety Program (CUSP)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Improving Diagnostic Safety
- Partnership for Patients
- Patient & Family Engagement
- Patient Safety Measure Tools & Resources

Improving Diagnostic Safety

Diagnostic error is a significant and under-recognized threat to patient safety. AHRQ is funding research to better understand how these errors happen and what can be done to prevent them.

AHRQ is the lead Federal agency investing in research to improve diagnostic safety. According to the AHRQ-sponsored report, Improving Diagnosis in Health Care, published by the Institute of Medicine (IOM) in 2015, most patients will experience at least one diagnostic error in their lifetime. These errors occur in all settings of care, contribute to about 10 percent of patient deaths, and are the primary reason for medical liability claims.

Since 2007, AHRQ has invested in research to discover findings that advance the knowledge of diagnostic safety and to develop practical tools and resources to improve diagnostic safety.

Tools to Improve Diagnostic Safety

Access tools and other materials that clinicians and patients can use to improve diagnostic safety.

Funding Announcements Related to Diagnostic Errors

Find out what funding is available to investigate diagnostic safety.

Resources Related to Diagnostic Errors

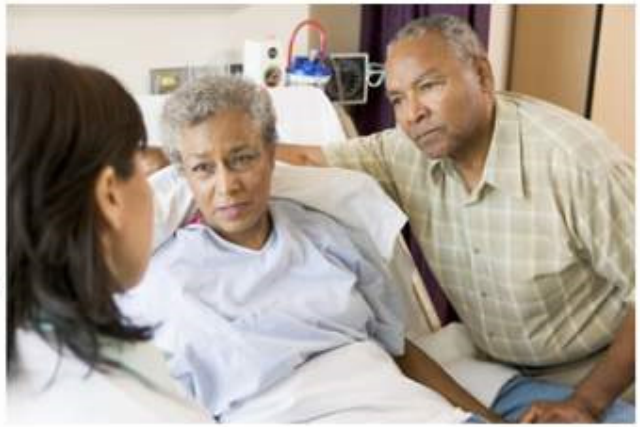
Learn more about diagnostic safety and what can be done to improve it.

RELIAS | LEARNING

Guide to Patient and Family Engagement in Hospital Quality and Safety

Research shows that when patients are engaged in their health care, it can lead to measurable improvements in safety and quality. To promote stronger engagement, the Agency for Healthcare Research and Quality (AHRQ) developed a guide to help patients, families, and health professionals work together as partners to promote improvements in care.

The *Guide to Patient and Family Engagement in Hospital Quality and Safety* focuses on four primary strategies for promoting patient/family engagement in hospital safety and quality of care:



- Encourage patients and family members to participate as advisors.
- Promote better communication among patients, family members, and health care professionals from the point of admission.
- Implement safe continuity of care by keeping the patient and family informed through nurse bedside change-of-shift reports.
- Engage patients and families in discharge planning throughout the hospital stay.

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, AAAHC HCFA, 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 on 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

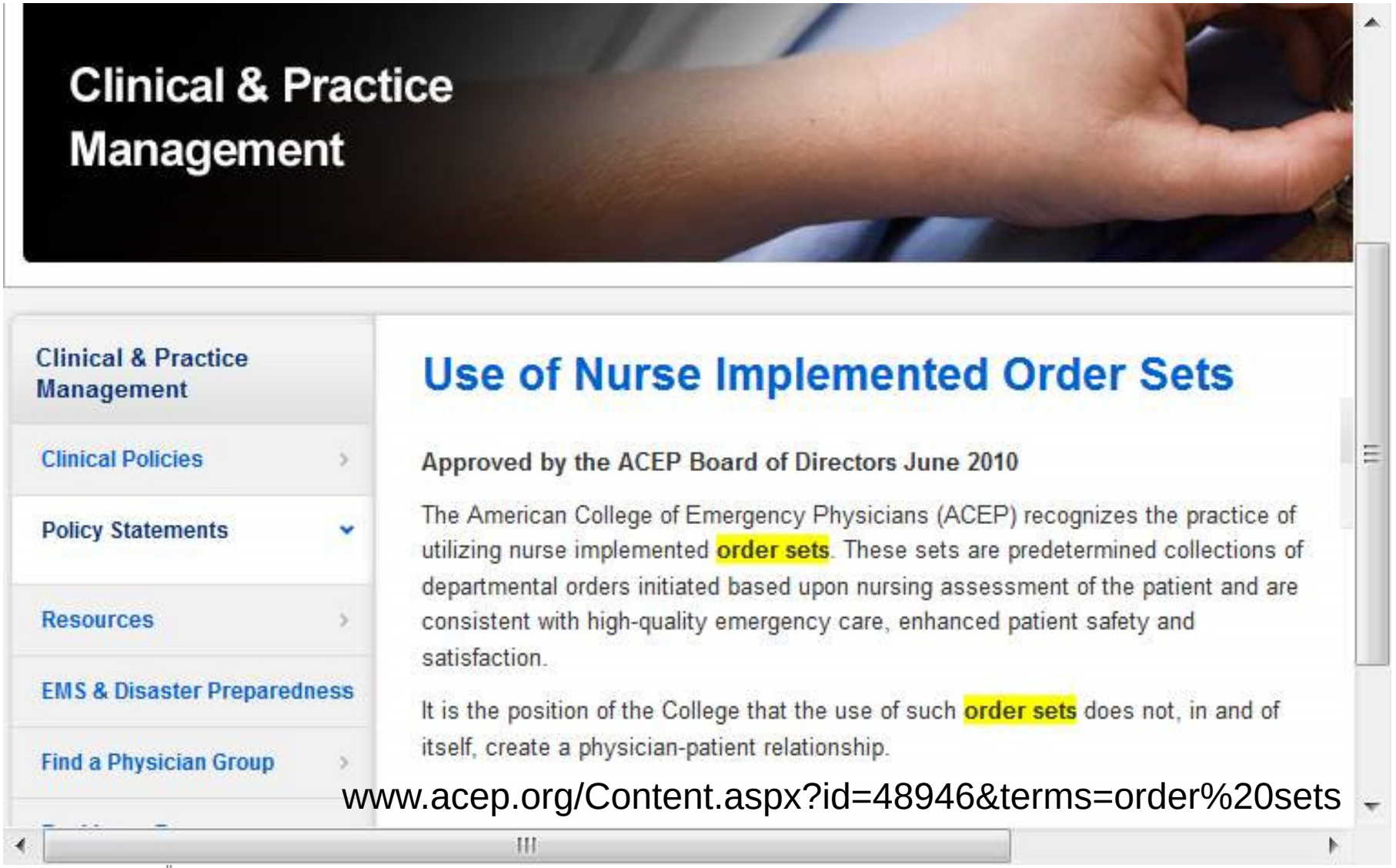
Policies and Procedures

- 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



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

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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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.

EMERGENCY MEDICINE PATIENT SAFETY FOUNDATION

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

CMS Survey and Certification Website

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

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 and changes in 2017
  - 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

[1]www.gpoaccess.gov/fr/index.html [2]www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp

Proposed Discharge Planning CMS

- Transfer form would need to be revised to include 21 things
- Discharge instructions and discharge summary must be in hands of PCP within 48 hours
- Must give medication information including side effects including OTC medications
- Discharge instructions must be in writing
- Discharge instructions must include 5 things; medication reconciliation, follow up care, all Rx and OTC medications, and contact information of provider for follow up including phone number

CMS Proposed Discharge Planning

FEDERAL REGISTER

Vol. 80 Tuesday,
No. 212 November 3, 2015

www.gpo.gov/fdsys/pkg/FR-2015-11-03/pdf/2015-27840.pdf

Part IV

Department of Health and Human Services

Centers for Medicare and Medicaid Services

42 CFR Parts 482, 484, 485
Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies; Proposed Rule

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 and what and how often
- 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 aw became on visitation and CMS interpretive guidelines effective December 2, 2011 and hospitals still struggling to comply
- 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 a 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 can 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

Advance Directives 132

- In advance directive can delegate decision making to another person- need to ask patient if they have
- Patient may also delegate support person
  - Also referred to a 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 "CS," 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
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

- 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
- 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

- 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 erroneous 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

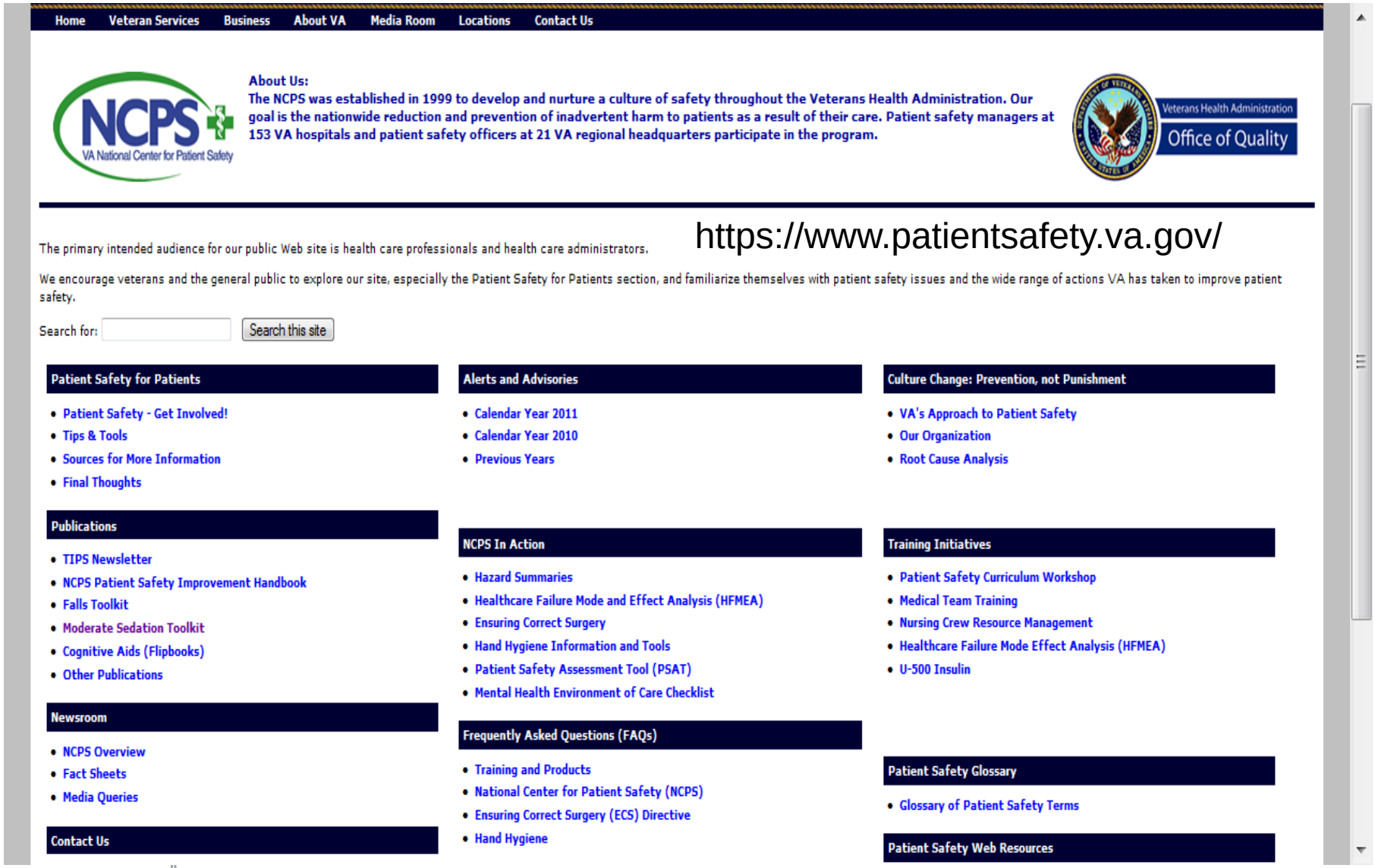
CMS Anesthesia Standards

- 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 pre anesthesia and post anesthesia 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



RELIAS | LEARNING

Moderate Sedation Toolkit for Non-Anesthesiologists

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.

RELIAS | LEARNING

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.*

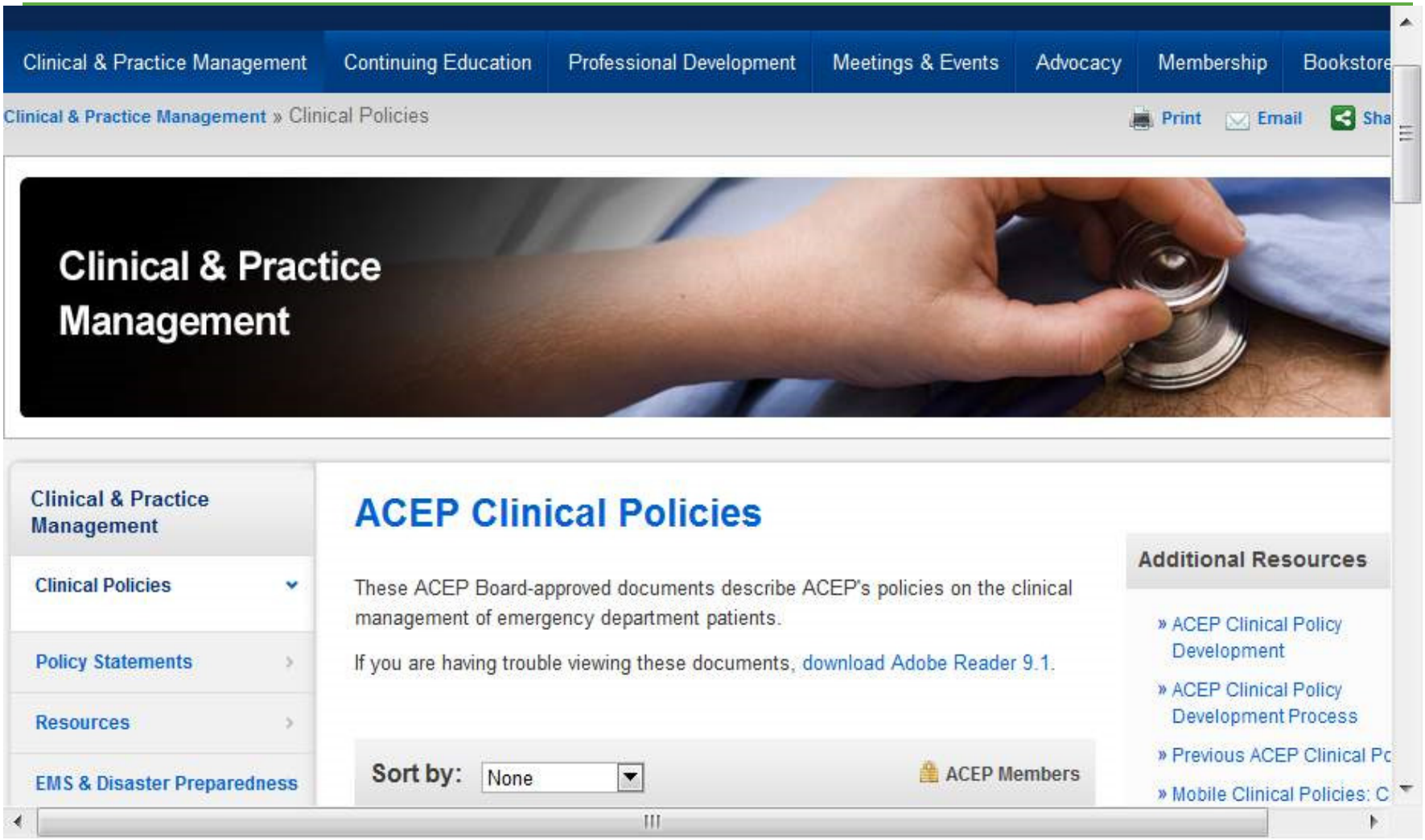
3.2.3 When ventilation is controlled by a mechanical ventilator, there shall be in continuous use a device that is capable of detecting disconnection of components of the breathing system. The device must give an audible signal when its alarm threshold is exceeded.

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



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

ACEP Sedation in the ED

Sedation in the Emergency Department

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

ACEP Policy Statement

Approved by the ACEP Board January 13, 2011

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

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)
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Scott M. Silvers, MD
Francis M. Fesmire, MD (Committee Chair)

www.acep.org/clinicalpolicies/

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Douglas Bernstein, MD (EMRA Representative 2011-2013)
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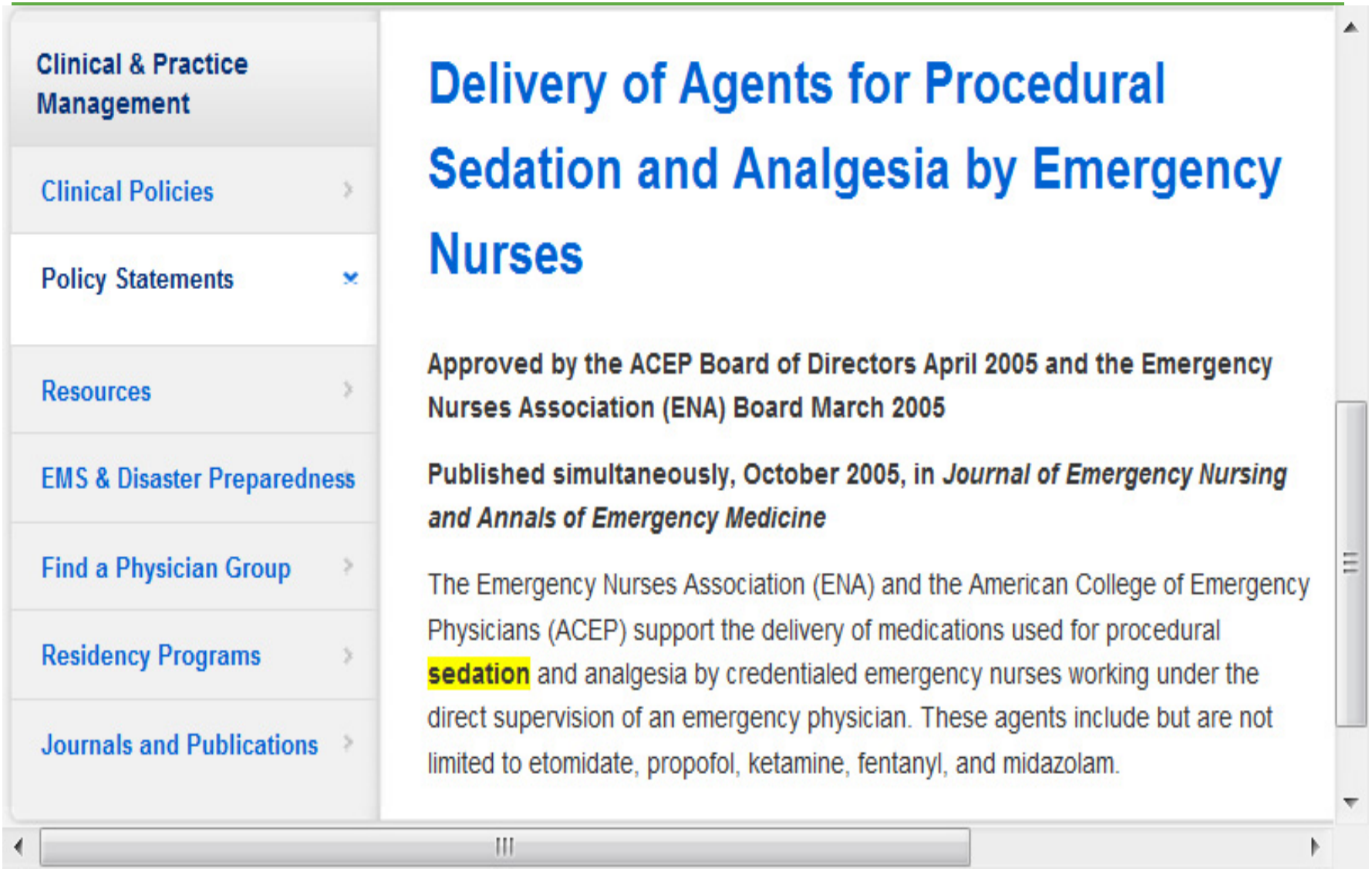
Stephen V. Cantrill, MD (Liaison with Quality and Performance Committee)
Robert E. O'Connor, MD, MPH (Board Liaison 2010-2013)
Rhonda R. Whitson, RHIA, Staff Liaison, Clinical Policies Committee and Subcommittees

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



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 456,
  - 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

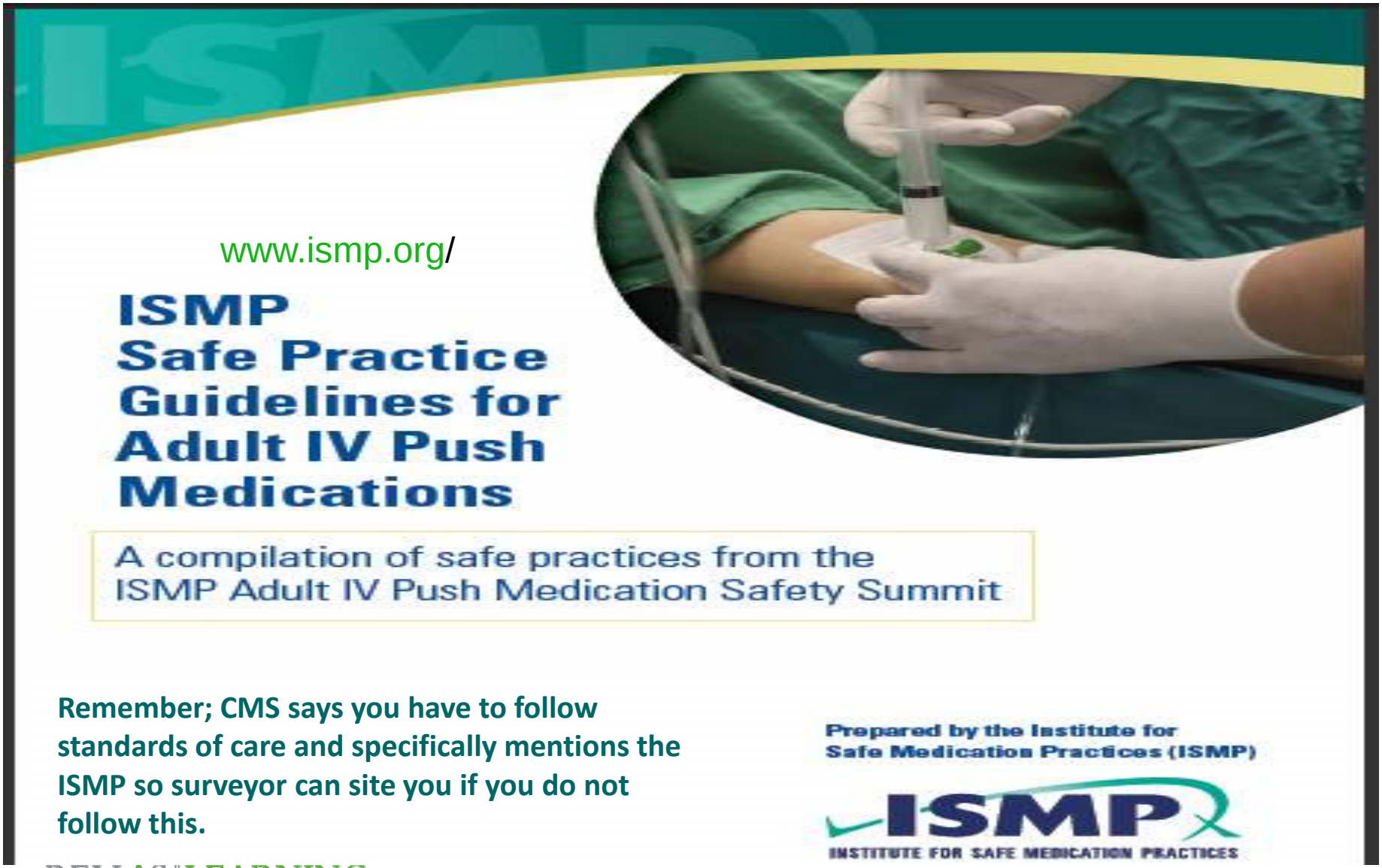
Naomi P. O'Grady, M.D.[1], Mary Alexander, R.N.[2], Lillian A. Burns, M.T., M.P.H., C.I.C.[3], E. Patchen Dellinger, M.D.[4], Jeffery Garland, M.D., S.M.[5], Stephen O. Heard, M.D.[6], Pamela A. Lipsett, M.D.[7], Henry Masur, M.D.[1], Leonard A. Mermel, D.O., Sc.M.[8], Michele L. Pearson, M.D.[9], Issam 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].

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

ISMP IV Push Medications Guidelines

- ISMP has published a 26 page document called “ISMP Safe Practice Guidelines for Adult IV Push Medications
- The document is organized into factors that increase the risk of IV push medications in adults,
  - Current practices with IV injectible medications
  - Developing consensus guidelines for adult IV push medication and
  - Safe practice guidelines
  - About 90% of all hospitalized patients have some form of infusion therapy

IV Push Medicine Guidelines



IV Push Medications Guidelines

- Provide IV push medications in a ready to administer form
- Use only commercially available or pharmacy prepared prefilled syringes of IV solutions to flush and lock vascular access devices
- If available in a single dose vial then need to buy in single dose vial
- Aseptic technique should be used when preparing and administering IV medication
    - This includes hand hygiene before and after administration

IV Push Medications Guidelines

- The diaphragm on the vial should be disinfected even if newly opened
  - The top should be cleaned using friction and a sterile 70% isopropyl alcohol, ethyl alcohol, iodophor, or other approved antiseptic swab for at least ten seconds to it dry
- Medication from a glass ampule should be with a filter needle unless the specific drug precludes this
- Medication should only be diluted when recommended by the manufacturer or in accordance with evidence based practice or approved hospital policies

IV Push Medications Guidelines

- If IV push medication needs to be diluted or reconstituted these should be performed in a clean, uncluttered, and separate location
- Medication should not be withdrawn from a commercially available, cartridge type syringe into another syringe for administration
- It is also important that medication not be drawn up into the commercially prepared and prefilled 0.9% saline flushes
  - This are to flush an IV line and are not approved to use to dilute medication

3.6 Do NOT dilute or reconstitute IV push medications by drawing up the contents into a commercially-available, prefilled flush syringe of 0.9% sodium chloride.

Discussion: Commercially available prefilled syringes of saline and heparin are regulated by the US Food and Drug Administration as *devices*, not as medications. These devices have been approved for the flushing of vascular access devices, but have NOT been approved for the reconstitution, dilution, and/or subsequent administration of IV push medications. Such use would be considered "off label" and not how manufacturers intended these products to be used, nor have prefilled flush syringes been tested for product safety when used in this manner.

Warnings intended to limit the use of prefilled syringes for medication preparation and administration appear on some syringe barrels, clearly stating "IV flush only." Some manufacturers have also limited or removed the gradation markings on the prefilled flush syringes in order to prevent measurement of a secondary medication in the flush syringe. When prefilled syringes are used in an off-label manner, the practitioner and employer bear the legal liability for any adverse events occurring from this practice.[31]

The mislabeling that occurs when medications are added to a prefilled syringe and a secondary label is not applied creates significant risk for errors. In many cases, the manufacturer's label is permanently affixed to the syringe barrel and contains product codes and a barcode as well as specific information about the fluid and its volume. When another medication is added to this syringe, there is no adequate method to amend the manufacturer's label, without covering the current information.[31] Thus, the syringe frequently remains labeled as 0.9% sodium chloride, when it also contains the diluted or reconstituted medication.

Although this unsafe practice is widespread, and many who use it mistakenly believe the risk of an error is insignificant—a belief clearly reinforced during public comment regarding this guidance statement—summit participants arrived at a consensus that the practice must be eliminated.

3.7 When necessary to prepare more than one medication in a single syringe for IV push administration

IV Push Medications Guidelines

- Combination of more than one medication is a single syringe is seldom necessary and could result in unwanted changes in the medication
- Never use IV solution or mini bags as a common source to flush an IV as to dilute for more than one patient
- Label syringes of IVP medication unless prepared and immediately given with no break
- Administer IV push medication at rate recommended by manufacturer or supported by evidenced based practices and often given too fast

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 injures and can save 60,000 lives

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Partnering to Heal:

TEAMING UP AGAINST HEALTHCARE-ASSOCIATED INFECTIONS

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;

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

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

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

RELIAS LEARNING

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 rade 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

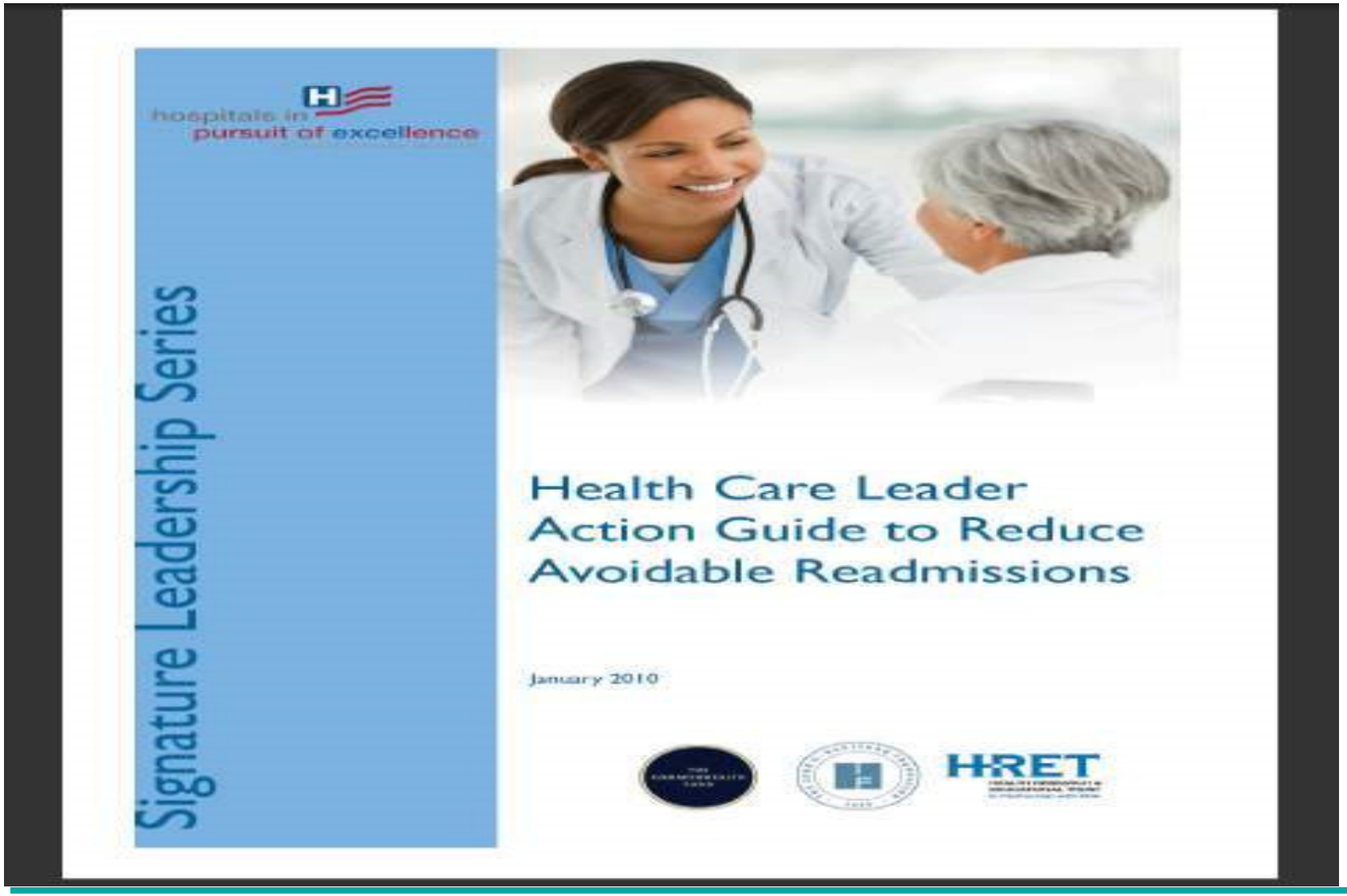
Readmissions and Discharges

- One in 5 hospital discharges (15.4% in 2017) 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
  - Hospital Readmission Program-in 2017 2,597 hospitals forfeited 528 million dollars
- 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



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 and physicians can be reimbursed now
- 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

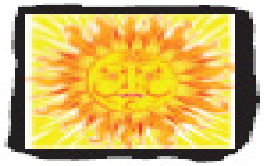
Things the ED Can Do

- 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

THE SULLIVAN GROUP

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

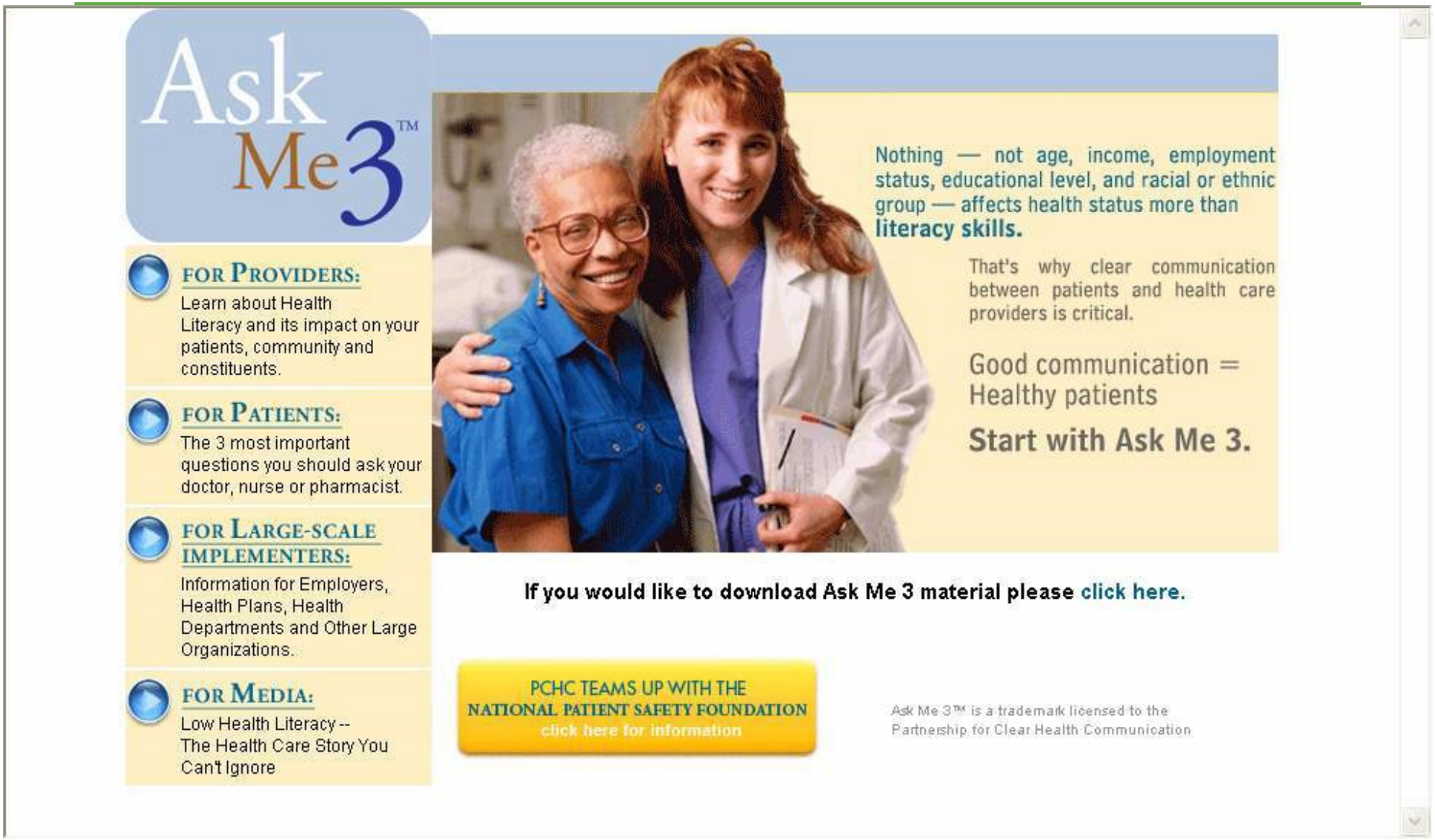
Discharge Instructions

- 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



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

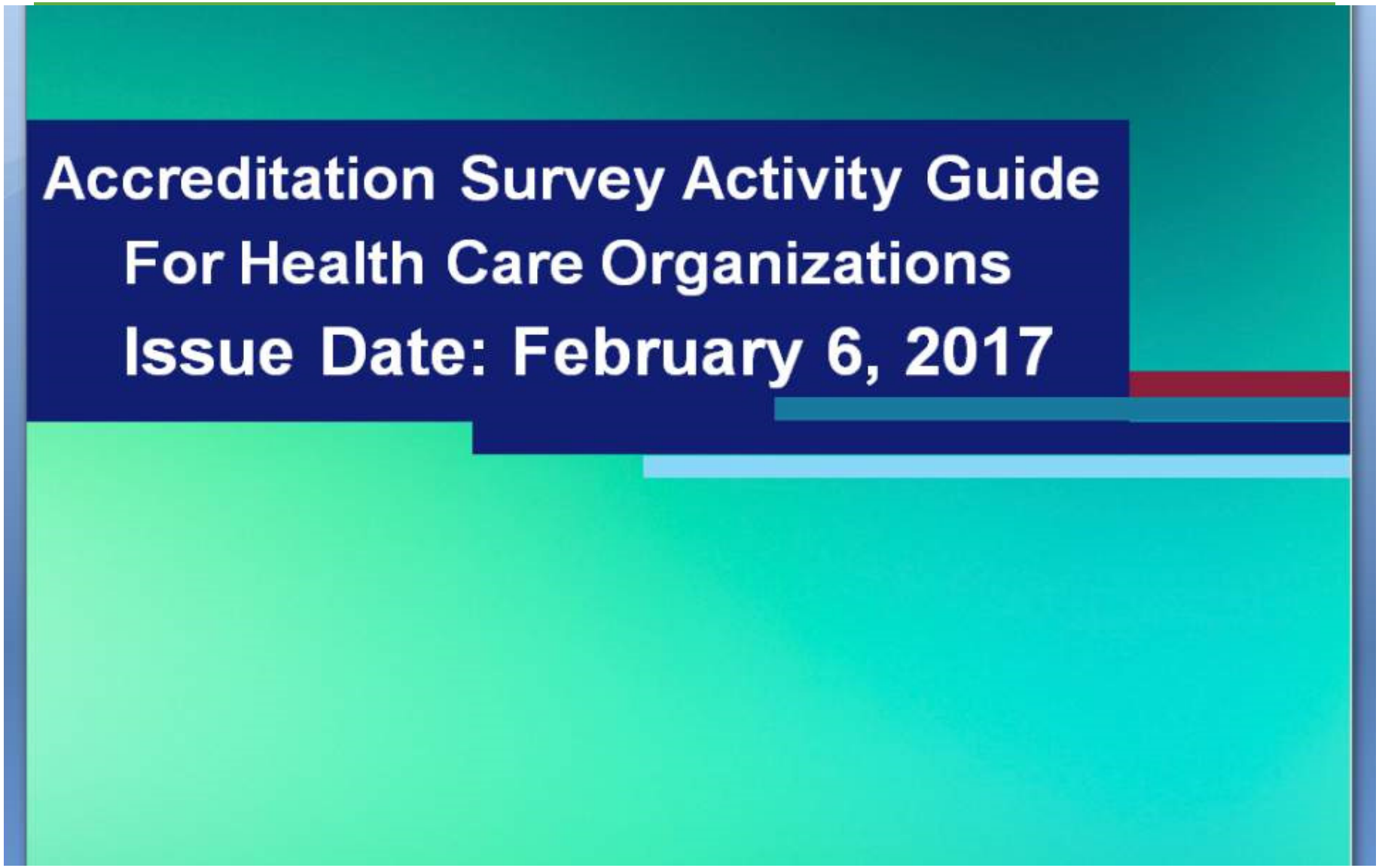
Discharge Instruction Case

- 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 nurses

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 Survey Activity Guide



RELIAS LEARNING

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

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;26:658-661.

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

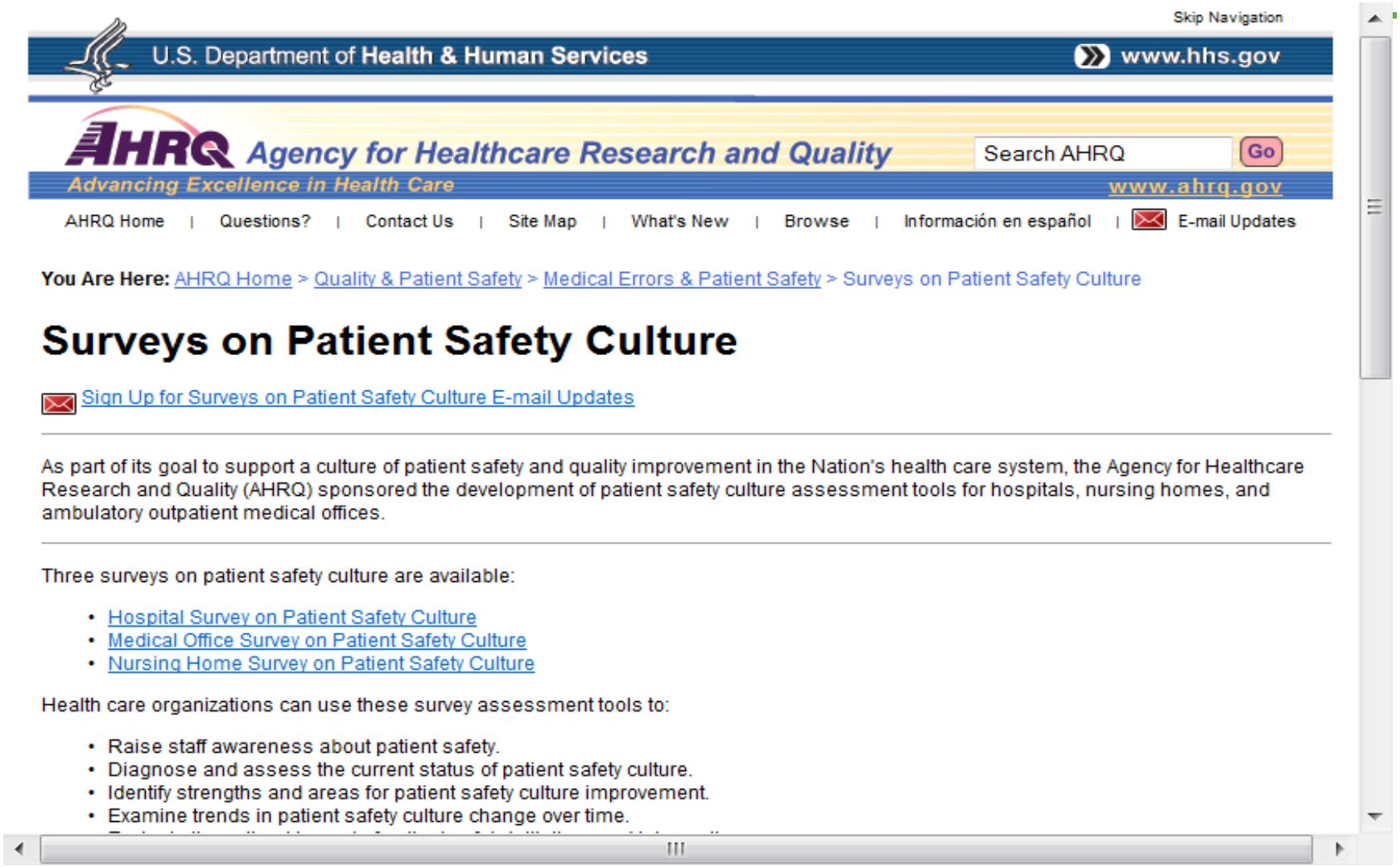
Watch This Video Bedside Nurse Report

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.

www.ahrq.gov/qual/patientsafetyculture/



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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 ½ 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 usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than ⅓ 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 ½ 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.				
FRICTION & 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				

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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 injectable with information on top

Labeling of Injectables

Copyright © 2010 The United States Pharmacopeial Convention

Recommendations to Reduce Errors

- Consider adding a pharmacist to the ED during busy times especially larger EDs
- 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 mix-up DTaP-Tdap and Epi , etc.

Issued June 16, 2010

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 anticholingeric 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, FASHP[1]

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)
Afeditab 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
ALPRAZolam 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???

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- Email questions to CMS at hospitalscg@cms.hhs.gov

THANK YOU

RELIAS | LEARNING