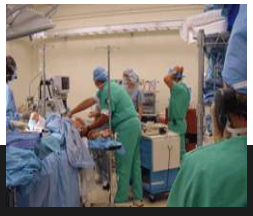
CMS HOSPITAL CONDITIONS OF PARTICIPATION (COPS) 2017

Surgery, PACU and Anesthesia Standards

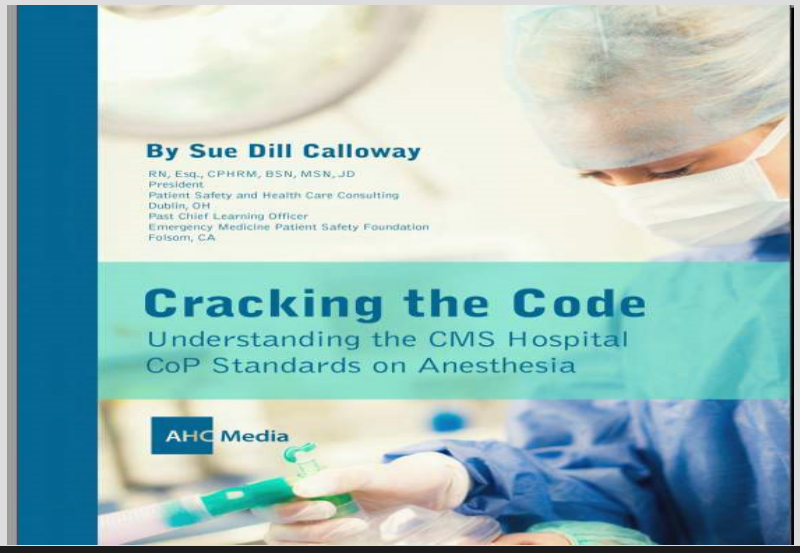


Speaker

- Sue Dill Calloway RN, Esq. CPHRM, CCMSCP
- AD, BA, BSN, MSN, JD
- President of Patient Safety and Education Consulting
- 5447 Fawnbrook Lane
- Dublin, Ohio 43017
- 614 791-1468 (Call with Questions, No emails)
- sdill1@columbus.rr.com
- **CMS Email hospitalscg@cms.hhs.gov**

2

Author of Book on the CMS Anesthesia Standards

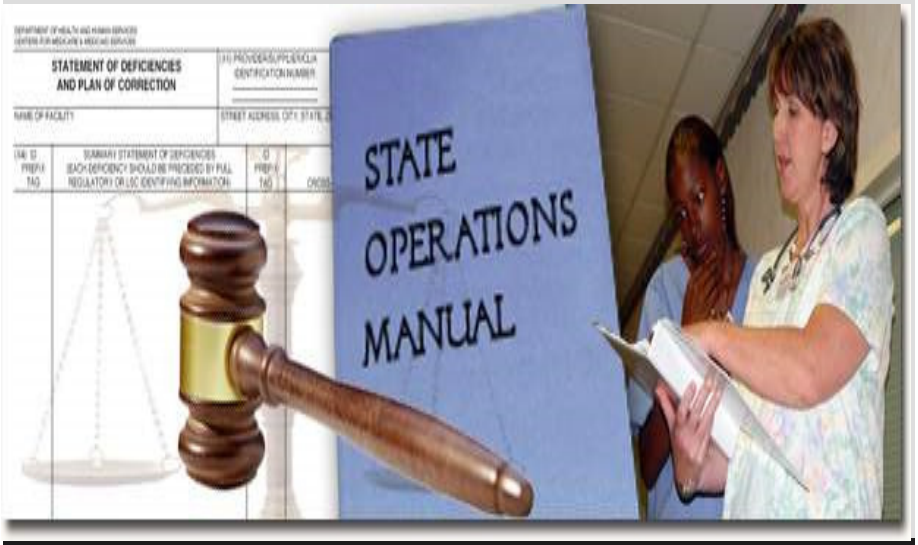


3

Introduction

4

You Don't Want One of These



5

The Conditions of Participation (CoPs)

- Many revisions since first published in 1986
- Manual updated more frequently now
  - Tag numbers go from 1 to 1164
- First regulations are published in the **Federal Register** then CMS publishes the **Interpretive Guidelines** and some have **survey procedures** [2]
  - Hospitals should check this website once a month for changes to see if updated manual, survey memos or transmittals

[1] http://www.gpo.gov/fdsys/browse/collection.action?collectionCode=FR

[2] www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp

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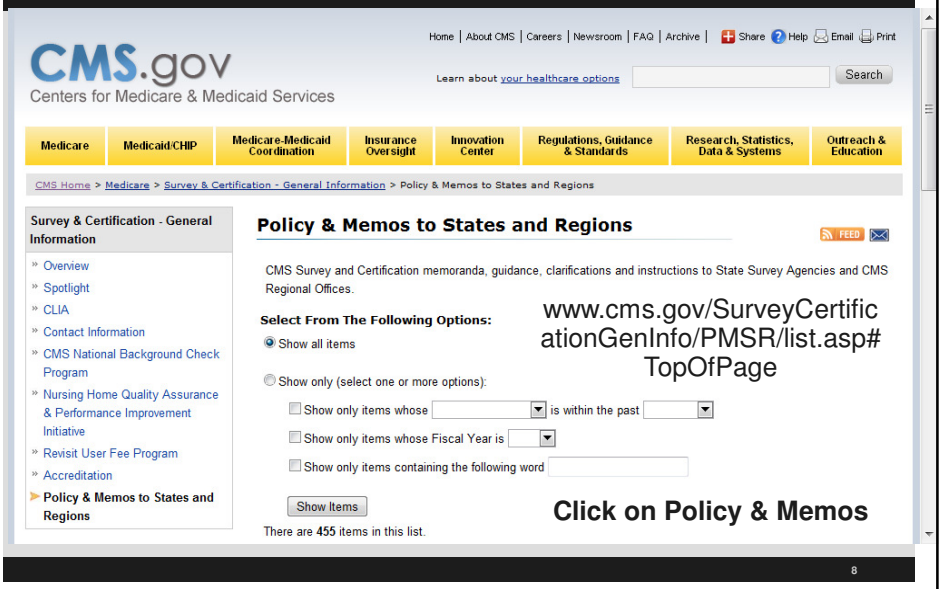
Subscribe to the Federal Register

CMS Survey and Certification Website



CMS Survey Memos

Policy & Memos to States and Regions

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

Show entries: 10

Filter On:

Title	Memo #	Posting Date	Fiscal Year
Implementation Issues, Long-Term Care Regulatory Changes: Substandard Quality of Care (SQC) and Clarification of Notice before Transfer or Discharge Requirements	17-27-NH	2017-05-12	2017
Psychiatric Residential Treatment Facilities (PRTF) Frequently Asked Questions (FAQs)	17-28-PRTF	2017-05-12	2017
Notice of Proposed Regulation Changes to Requirements Related to Survey Team Composition and Investigation of Complaints	17-26-NH	2017-04-28	2017
Electronic Staffing Submission - Payroll-Based Journal Update	17-25-NH	2017-04-21	2017
Notice of Proposed Regulation Changes for Accrediting Organizations (AOs) Transparency and Termination Notices	17-24-ALL	2017-04-14	2017

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CMS Transmittals

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Transmittals
- 2017 Transmittals
- 2016 Transmittals
- 2015 Transmittals
- 2014 Transmittals
- 2013 Transmittals
- CMS Program Memoranda

2017 Transmittals www.cms.gov/Transmittals/01_overview.asp

Show entries: 10

Filter On:

Transmittal #	Issue Date	Subject	Implementation Date	CR #	MM Article #	MM Article Release Date
SE17002		Additional Guidance for Clinical Laboratories as Data Reporting Begins			SE17002	2017-01-04
SE17004		Revised Centers for Medicare & Medicaid Services (CMS) 855S Application – Durable Medical			SE17004	2017-01-05

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Medicare State Operations Manual

Appendix

Email questions to CMS hospitalscg@cms.hhs.gov

- 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

New website at
www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

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

CoP Manual Also Called SOM

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

Table of Contents
(Rev. 151, 11-20-15)

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

Transmittals for Appendix A

Survey Protocol

Introduction

- Task 1 - Off-Site Survey Preparation
- Task 2 - Entrance Activities
- Task 3 - Information Gathering/Investigation
- Task 4 - Preliminary Decision Making and Analysis of Findings
- Task 5 - Exit Conference
- Task 6 – Post-Survey Activities

Psychiatric Hospital Survey Module

Psychiatric Unit Survey Module

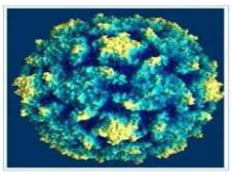
Rehabilitation Hospital Survey Module

Inpatient Rehabilitation Unit Survey Module

Hospital Swing-Bed Survey Module

Regulations and Interpretive Guidelines

Email questions
hospitalscg@cms.hhs.gov



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CMS Survey Memos Issued

- IV, Medications, Safe Opioid Use
- Emergency Preparedness Checklist and Emergency Preparedness
- Radiology and Nuclear Medicine
- Hospital Equipment Maintenance
- Privacy and confidentiality, CRE and ERCP
- Complaint manual updated
- Access to hospital deficiency data
- Use of insulin pens issue
- Single dose and infection control breaches
- Humidity in OR and second memo on effect of low humidity
- Reporting to internal PI
- Luer Misconnections

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CMS Memo on Safe Injection Practices

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CMS Memo on Safe Injection Practices

- June 15, 2012 CMS issues a 7 page memo on safe injection practices
- Discusses the safe use of single dose medication to prevent healthcare associated infections (HAI)
- Notes new exception which is important especially in medications shortages
- General rule is that single dose vial (SDV)can only be used on one patient
- Will allow SDV to be used on multiple patients if prepared by pharmacist under laminar hood following USP 797 guidelines

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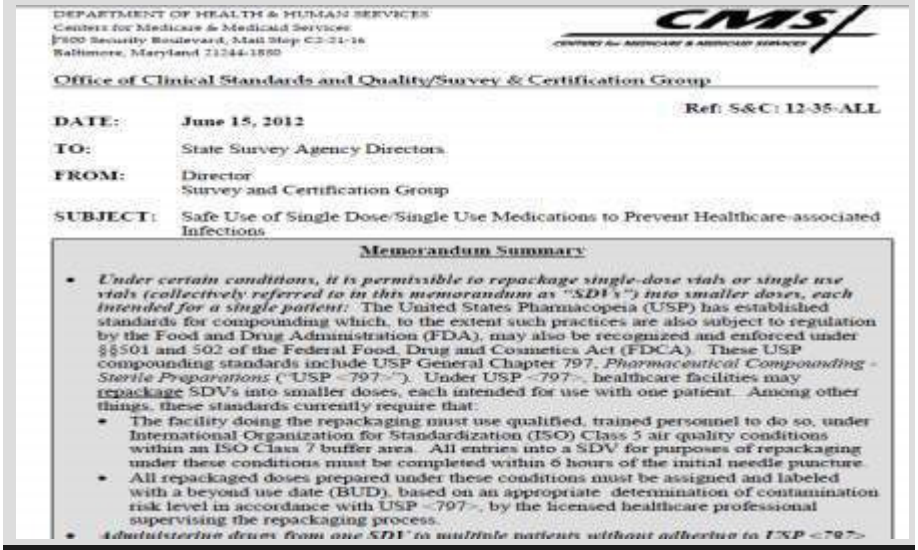
Single Dose CMS Memo



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

CMS

Office of Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 12-35-ALL

DATE: June 15, 2012

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Safe Use of Single Dose/Single Use Medications to Prevent Healthcare-associated Infections

Memorandum Summary

- *Under certain conditions, it is permissible to repackage single-dose vials or single use vials (collectively referred to in this memorandum as "SDVs") into smaller doses, each intended for a single patient:* The United States Pharmacopeia (USP) has established standards for compounding which, to the extent such practices are also subject to regulation by the Food and Drug Administration (FDA), may also be recognized and enforced under §§501 and 502 of the Federal Food, Drug and Cosmetics Act (FDCA). These USP compounding standards include USP General Chapter 797, *Pharmaceutical Compounding - Sterile Preparations* ("USP <797>"). Under USP <797>, healthcare facilities may repackage SDVs into smaller doses, each intended for use with one patient. Among other things, these standards currently require that:
  - The facility doing the repackaging must use qualified, trained personnel to do so, under International Organization for Standardization (ISO) Class 5 air quality conditions within an ISO Class 7 buffer area. All entries into a SDV for purposes of repackaging under these conditions must be completed within 6 hours of the initial needle puncture.
  - All repackaged doses prepared under these conditions must be assigned and labeled with a beyond use date (BUD), based on an appropriate determination of contamination risk level in accordance with USP <797>, by the licensed healthcare professional supervising the repackaging process.
- *Administering doses from one SDV to multiple patients without adhering to USP <797>*

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CMS Memo on Safe Injection Practices

- All entries into a SDV for purposes of repackaging must be completed with 6 hours of the initial puncture in pharmacy following USP guidelines
- Only exception of when SDV can be used on multiple patients
- Otherwise using a single dose vial on multiple patients is a violation of CDC standards
- CMS will cite hospital under the hospital CoP infection control standards since must provide sanitary environment
  - Also includes ASCs, hospice, LTC, home health, CAH, dialysis, etc.

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CMS Memo on Safe Injection Practices

- Bottom line is you can not use a single dose vial on multiple patients
- CMS requires hospitals to follow nationally recognized standards of care like the CDC guidelines
- SDV typically lack an antimicrobial preservative
- Once the vial is entered the contents can support the growth of microorganisms
- The vials must have a beyond use date (BUD) and storage conditions on the label

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CMS Memo on Safe Injection Practices

- So if they make it in a single dose vial, you need to buy it in a single dose vial
- If they do not then if use multi-dose vial try and use it on one patient only
- Mark the multi-dose vial expires in 28 days unless sooner by manufacturer
- Do not want you to take multi-dose vials into the OR so if you do treat it as a single dose and dispose of it at the end of the case
- Clean off top when opening vial

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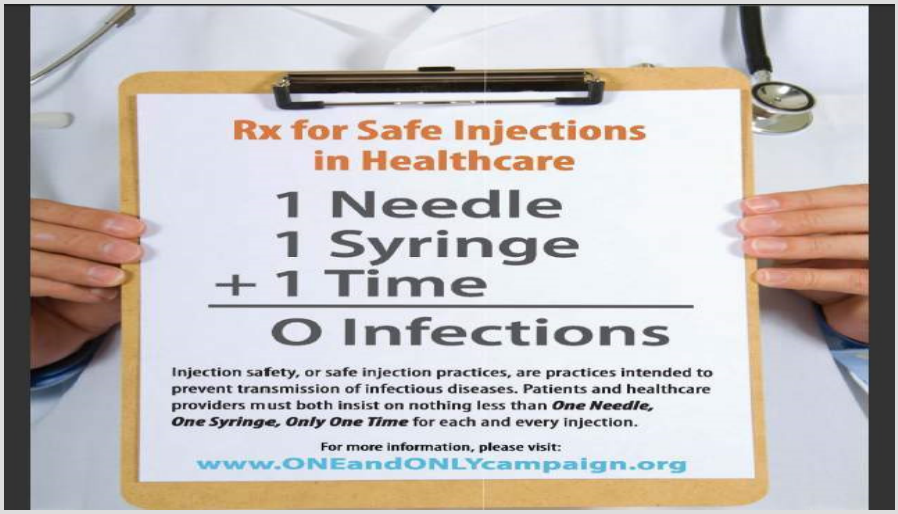
Safe Injection Practices Posters



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ISMP IV Push Medication Guidelines

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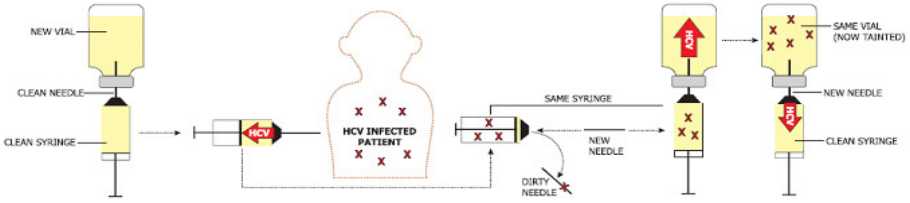
Unsafe Injection Practices and Disease Transmission

Reuse of syringes combined with the use of single-dose vials for multiple patients undergoing anesthesia can transmit infectious diseases. The syringe does not have to be used on multiple patients for this to occur.



1. A clean syringe and needle are used to draw the sedative from a new vial.

2. It is then administered to a patient who has been previously infected with hepatitis C virus (HCV). Backflow into the syringe contaminates the syringe with HCV.

3. The needle is replaced, but the syringe is reused to draw additional sedative from the same vial for the same patient, contaminating the vial with HCV.

4. A clean needle and syringe are used for a second patient, but the contaminated vial is reused. Subsequent patients are now at risk for infection.

Source: www.**southernnevadahealthdistrict**.org

CDC

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

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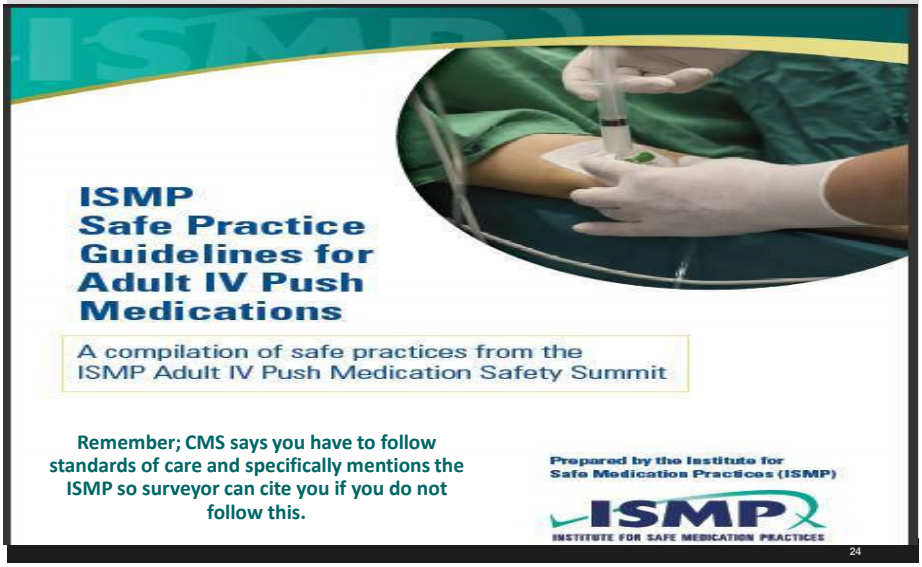
IV Push Medicine Guidelines



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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

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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 glass ampules should be used 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

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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

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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

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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

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CMS Infection Control Worksheet

Section on Safe Injection Practices

CMS Hospital Worksheets History

- October 14, 2011 CMS issues a 137 page memo in the survey and certification section and it was pilot tested in hospitals in 11 states
- Memo discusses surveyor worksheets for hospitals by CMS during a hospital survey
- Addresses discharge planning, **infection control,** and QAPI (performance improvement)
  - Final ones issued November 26, 2014
  - Has section on safe injection practices, antibiotic stewardship and surgery tracer

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Final 3 Worksheets QAPI

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

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

REF: S&C: 15-12-Hospital

DATE: November 26, 2014

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

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

SUBJECT: Public Release of Three Hospital Surveyor Worksheets

Memorandum Summary

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

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Infection Control Program and Resources

Module 1: Infection Prevention Program

Section 1.A. Infection Prevention Program and Resources

Elements to be assessed		Su
1.A.1 The hospital has designated one or more individual(s) as its Infection Control Officer(s).	◯ Yes ◯ No	
1.A.2 The hospital has evidence that demonstrates the Infection Control Officer(s) is qualified and maintain(s) qualifications through education, training, experience or certification related to infection control consistent with hospital policy.	◯ Yes ◯ No	
1.A.3 The Infection Control Officer(s) can provide evidence that the hospital has developed general infection control policies and procedures that are based on nationally recognized guidelines and applicable state and federal law.	◯ Yes ◯ No	
If no to any of 1.A.1 through 1.A.3, cite at 42 CFR 482.42(a) (Tag A-748)		
1.A.4 The Infection Control Officer can provide an updated list of diseases reportable to the local and/or state public health authorities.	◯ Yes ◯ No	
1.A.5 The Infection Control Officer can provide evidence that hospital complies with the reportable diseases requirements of the local health authority.	◯ Yes ◯ No	
No citation risk for questions 1.A.4 and 1.A.5		
1.A.6 The hospital has infection control policies and procedures relevant to construction, renovation, maintenance, demolition, and repair, including the requirement for an infection control	◯ Yes ◯ No	

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CMS Hospital Worksheets

- Hospitals should be familiar with the three worksheets
- Will use whenever a validation survey or certification survey is done at a hospital by CMS
- CMS says worksheets are used by State and federal surveyors on all survey activity in assessing compliance with any of the three CoPs
- Hospitals are encouraged by CMS to use the worksheet as part of their self assessment tools which can help promote quality and patient safety

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CMS Hospital Worksheets

- However, some of the questions asked might not be apparent from a reading of the CoPs
  - A worksheet is a good communication device
  - It will help clearly communicate to hospitals what is going to be asked in these 3 important areas
  - Anesthesia can not give single dose medications to more than one person unless prepared in pharmacy such as Diprivan (Propofol)
  - One needle, one syringe every time
  - Hospitals might want to consider putting together a team to review the 3 worksheets and complete the form in advance as a self assessment

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Section 2. B Injection Practices and Sharps Safety (Medications, Saline, Other Infusates)

Elements to be assessed		Manner of Assessment Code (check all that apply) & Surveyor Notes		Manner of Assessment Code (check all that apply) & Surveyor Notes
Injections are given and sharps safety is managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
2. B.1 Injections are prepared using aseptic technique in an area that has been cleaned and free of visible blood, body fluids, or contaminated equipment.	☐ Yes ☐ No ☐ N/A	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ Yes ☐ No ☐ N/A	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
2. B.2 Needles are used for only one patient.	☐ Yes ☐ No ☐ N/A	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ Yes ☐ No ☐ N/A	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
2. B.3 Syringes are used for only one patient (this includes manufactured prefilled syringes and insulin pens).	☐ Yes ☐ No ☐ N/A	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5	☐ Yes ○ No ○ N/A	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Interview = 1 Observation = 2 Infection Control Document Review = 3 Medical Record Review = 4 Other Document Review = 5

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Page 11 of 42

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Infection Control Pilot

- CMS published proposed changes in the infection control worksheet as a pilot program in 2017
- The infection control worksheet was drafted to be used in long term care (LTC)
- However, proposed changes were made to the hospital infection control worksheet
- The plan was to use the draft worksheets and to do 40 hospitals to be paired with the LTC one
- CMS has provided copies of the draft infection control worksheets

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CMS Infection Control Pilot

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 17-09-ALL

DATE: November 18, 2016

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Infection Control Pilot: 2017 Update

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.html

Memorandum Summary

- **Project Overview:** The Centers for Medicare & Medicaid Services (CMS) is in the second year of a three year pilot project to improve assessment of infection control and prevention regulations in Long Term Care (LTC) facilities, hospitals, and during transitions of care. All surveys during the pilot will be educational surveys (no citations will be issued) and will be conducted by a national contractor.
- **Second Year Activities:** Using draft surveyor Infection Control Worksheets (ICWS) based on the new Long Term Care regulation as well as a revised hospital surveyor ICWS, 40 hospital surveys will be paired with surveys of LTC facilities, in order to provide an opportunity to assess infection prevention during transitions of care. In addition, CMS will pilot technical assistance opportunities for facilities in efforts to

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CMS Infection Control Pilot

- The survey memo is 64 pages long
- All surveys during the pilot will be educational
- No citations will be issued
- These are being conducted by a national contractor and not CMS surveyors
- As mentioned, 40 hospital surveys will be paired with surveys of LTC
- This is being done to assess infection prevention during the transition of care

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Injection Practices & Sharps Safety 2 B

- Injections prepared using aseptic technique in area cleaned and free of blood and bodily fluids
- Is rubber septum disinfected with alcohol before piercing?
- Are single dose vials, IV bags, IV tubing and connectors used on only one patient?
- Are multidose vials dated when opened and discarded in 28 days unless shorter time by manufacturer?
- Make sure expiration date is clear as per P&P
- If multidose vial found in patient care area must be used on only one patient

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Safe Injection Practices Patient Safety Brief

EMERGENCY MEDICINE PATIENT SAFETY FOUNDATION

www.empsf.org

Safe Injection Practices Patient Safety Brief
Emergency Medicine Patient Safety Foundation

By: Sue Dill Calloway RN MSN JD CPHRM
Ruth Carrico PhD RN FSHEA CIC

July 2012

The Centers for Disease Control and Prevention (CDC) says there are 1.7 million healthcare-associated infections in the US every year. Of these, it is estimated that about 99,000 deaths occur as a result. Infection prevention

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Emergency Physicians Insurance eXchange

EPIX Patient Safety Briefs
(Previously known as EPIX Email Alerts)

Safe Injection Practices in the Emergency Department

Written by Sue Dill Calloway RN MSN JD

Safe injection practices should be on the radar screen of all urgent care and emergency department physicians, midlevels and nursing staff. There is an increased focus on safe injection practices by regulators such as the Center for Medicare and Medicaid Services (CMS) in the hospital Conditions of Participations (CoPs) and accreditation organizations like the Joint Commission, DNV Healthcare, the Healthcare Facilities Accreditation Program (HFAP), and the Center for Improvement in Healthcare Quality (CIHQ). The recommendations have come from documents that are discussed in this brief and cited at the bottom of the article. It is recommended that this EPIX Patient Safety Brief be shared among physicians, midlevels, nursing staff, infection preventionists, and pharmacists.

On November 26, 2014 CMS issued three hospital surveyor worksheets. One of which is an infection control worksheet that contains a section on safe injection practices for hospitals. The worksheets are used during any validation or certification survey. CMS recently sent 110 surveyors to hospitals for two days to assess using the three CMS worksheets. CMS suggested that all hospitals use the worksheets as

Injection Practices & Sharps Safety

- Are all sharps disposed of in resistant sharps container?
- Are sharp containers replaced when fill line is reached?
  - Are sharps disposed of in accordance with state medical waste rules
  - Hospitals should have a system in place where someone has the responsibility to check these and ensure they are replaced when they are full

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Not All Vials Are Created Equal

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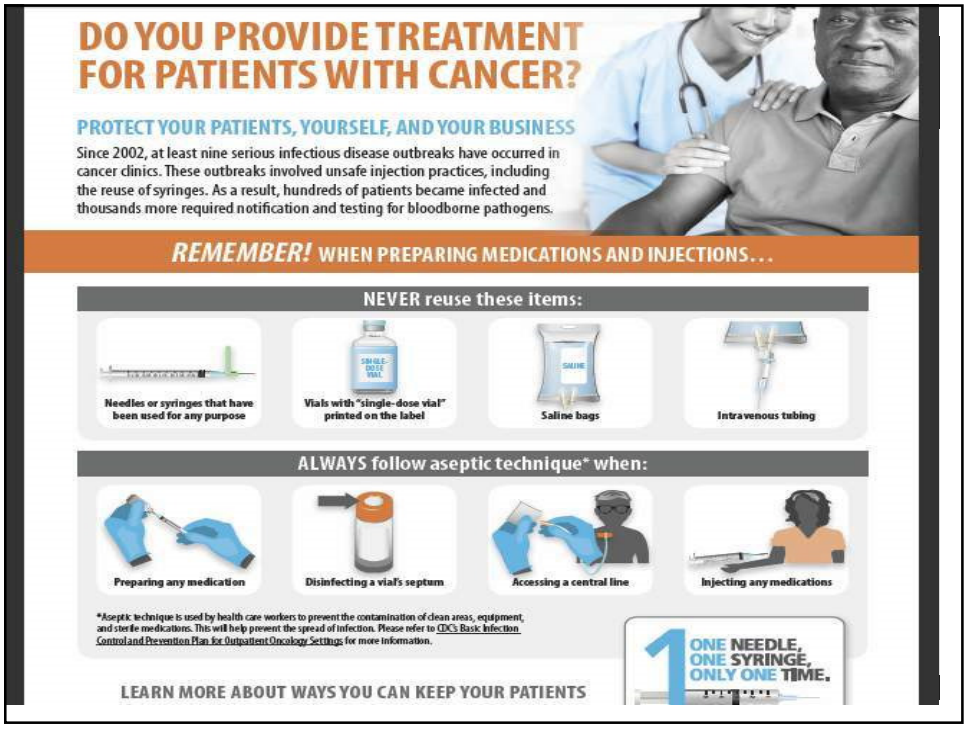

The Safe Injection Practices Coalition Releases Two New Videos

Dear colleagues,
CDC continues to investigate outbreaks as a result of unsafe injection practices. These mistakes and knowledge gaps put healthcare providers and patients at risk. CDC's *One & Only Campaign* created two short videos to help make healthcare safer, one injection at a time.

- Check Your Steps! Make Every Injection Safe - For Healthcare Providers, 3:45
- Managing Patient Safety, One Injection at a Time - For Healthcare Managers, 2:33

These videos detail critical information to help all providers and facility managers double check their injection safety knowledge

Get Connected

with the *One & Only Campaign*! There are several ways to follow us, join the conversation, and receive updates:

Facebook
One & Only Campaign

Twitter

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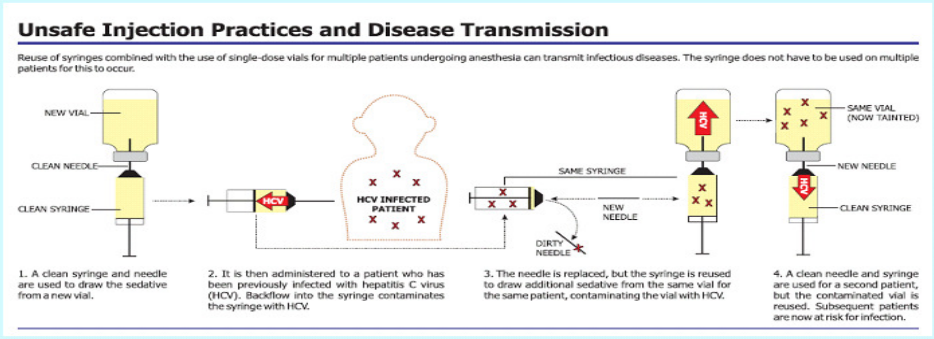
The CDC on Safe Injection Practices

CDC on Infection Control

- The CDC says there are 1.7 million healthcare infection (HAI) in America every year
  - There are 75,000 deaths in American hospitals every year
  - Healthcare-Associated Infections (HAIs) are one of the top ten leading causes of death in the US[1]
- Leadership need to make sure there is adequate staffing and resources to prevent and manage infections
- Issue came to light in Nevada after GI doctor reuses syringes to save money in two ambulatory clinics

1 www.cdc.gov/ncidod/dhqp/hai.html

How Did This Issue Get Started?



Source: www.**southernnevadahealthdistrict**.org

CDC

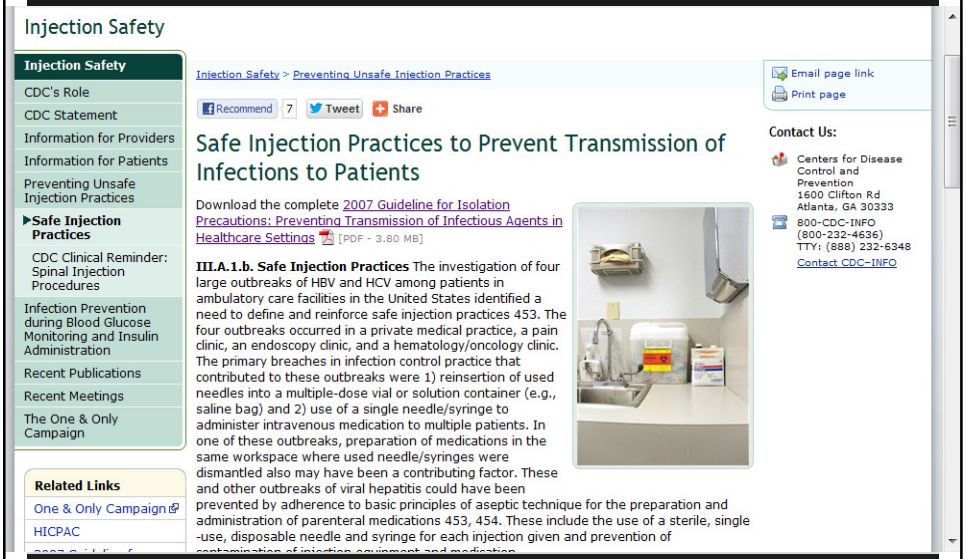
CDC 10 Safe Injection Practices

- CDC has a publication called 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings
- Has a section on Safe Injection Practices (III.A.1.b. and starts on page 68) which has the **10 safe injection practices**
- Discusses four large outbreaks of HBV and HCV among patients in ambulatory facilities
- Identified a need to define and reinforce safe injection practices

www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

50

10 CDC Standards Safe Injection Practices



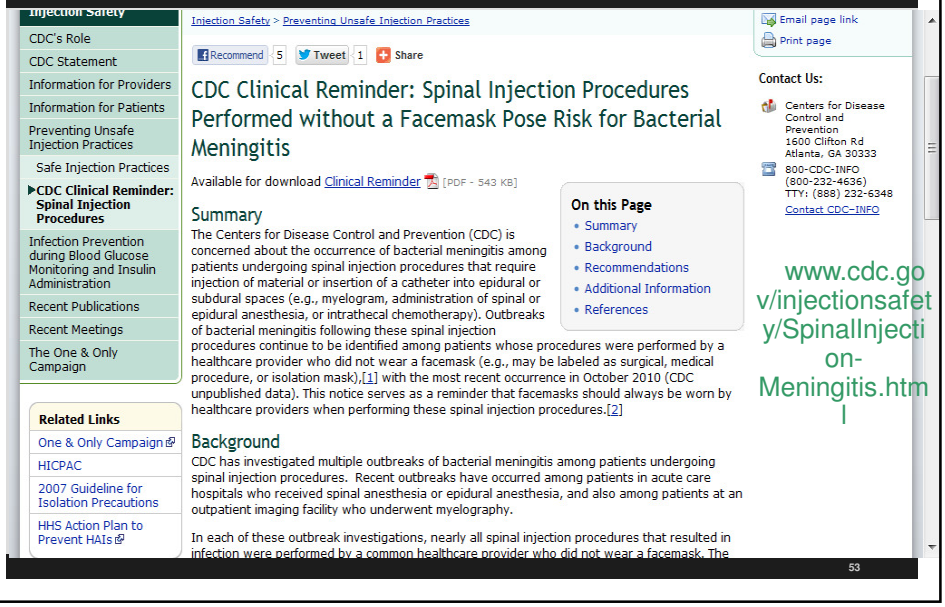
51

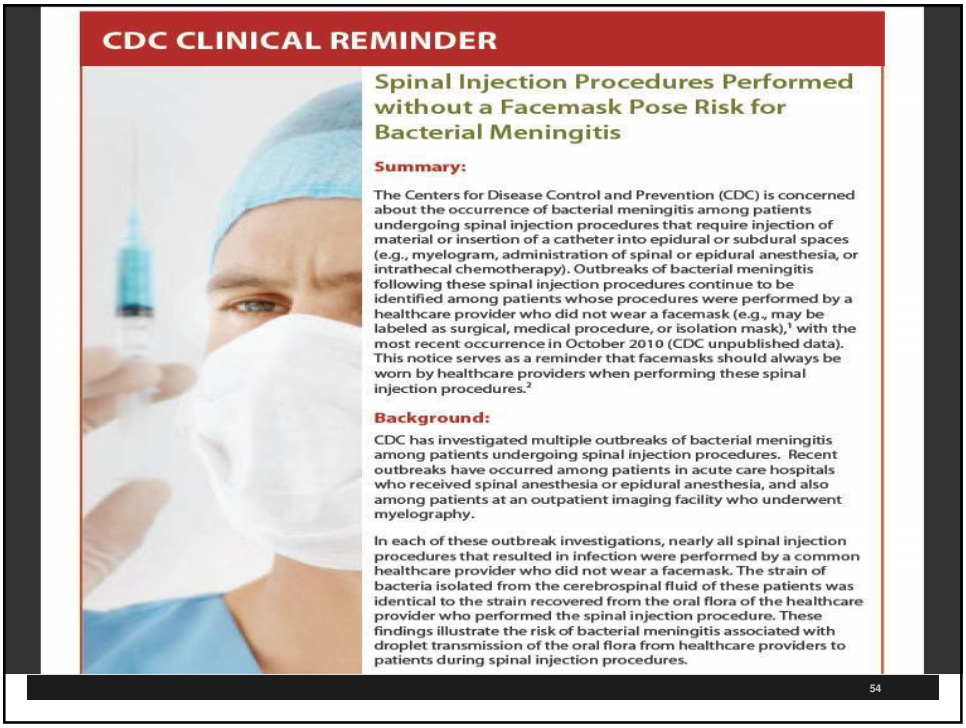
Wear a Mask Wear A Mask Wear A Mask

- Need to wear a mask to prevent bacterial meningitis
- During all spinal injection procedures
- During all injections into epidural or subdural space
  - Myelogram
  - Intrathecal chemotherapy
  - Administration of spinal or epidural anesthesia
  - LP done in the emergency department
- Bottom line is facemasks need to be worn by healthcare providers performing these procedures

52

Spinal Injection and Masks





Since facemasks have been shown to limit spread of droplets arising from the oral flora,[3] the CDC has recommended their use by healthcare providers when performing spinal injection procedures.[2]

In addition to wearing a facemask, healthcare providers should ensure adherence to all CDC recommended safe injection practices including using a single-dose vial of medication for only one patient.[2]

Recommendations:

Anyone performing a spinal injection procedure should review the following CDC recommendations to ensure that they are not placing their patients at risk for infections such as bacterial meningitis.

- Facemasks should always be used when injecting material or inserting a catheter into the epidural or subdural space.[2]
- Aseptic technique and other safe injection practices (e.g., using a single-dose vial of medication or contrast solution for only one patient) should always be followed for all spinal injection procedures.[2]

These recommendations apply not only in acute care settings such as hospitals, but in any setting where spinal injection procedures are performed, such as outpatient imaging facilities, ambulatory surgery centers, and pain management clinics.

Additional information is available at:

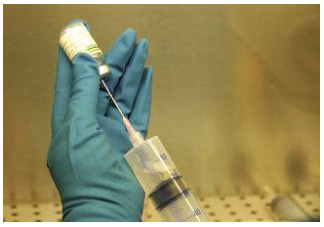
http://www.cdc.gov/hicpac/2007IP/2007ip_part3.html

References:

1. Centers for Disease Control and Prevention. Bacterial meningitis after intrapartum spinal anesthesia - New York and Ohio, 2008-2009. *MMWR Morb Mortal Wkly Rep.* 2010;59(3):65-9.
2. Centers for Disease Control and Prevention. 2007 Guideline for isolation precautions: preventing transmission of infectious agents in healthcare settings. Available at: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf. Accessed January 25, 2011.
3. Philips BJ, Fergusson S, Armstrong P, Anderson FM, Wildsmith JA. Surgical face masks are effective in reducing bacterial contamination caused by dispersal from the upper airway. *Br J Anaesth.* 1992;69(4):407-8.

55

CMS Other Survey Memos



56

Medication and Safe Opioid Use

- CMS issues 32 page memo on medication administration and safe opioid use March 14, 2014 and effective June 6, 2014
  - Risk and patient safety need to review this besides nursing, pharmacy, MEC, and nurse educator
- Concerned about the number of patients with adverse events when taking opioids
- Must have a P&P
- Must train staff and include information that must be in the assessment
- Must document process
  - **Questions to hospitalscg@cms.hhs.gov**

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CMS Memo Med & 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

58

CMS Memo May 30, 2014

- CMS publishes 4 page memo on infection control breaches and when they warrant referral to the public health authorities
- This includes a finding by the state agency (SA), like the Department of Health, or an accreditation organization
  - TJC, DNV Healthcare, CIHQ, or AOA HFAP
- CMS has a list and any breaches should be referred
- Referral is to the state authority such as the state epidemiologist or State HAI Prevention Coordinator

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Infection Control Breaches

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: 14-36-All

DATE: May 30, 2014

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Infection Control Breaches Which Warrant Referral to Public Health Authorities

Memorandum Summary

- ***Infection Control Breaches Warranting Referral to Public Health Authorities:*** If State Survey Agencies (SAs) or Accrediting Organizations (AOs) identify any of the breaches of generally accepted infection control standards listed in this memorandum, they should refer them to appropriate State authorities for public health assessment and management.
- ***Identification of Public Health Contact:*** SAs should consult with their State's Healthcare Associated Infections (HAI) Prevention Coordinator or State Epidemiologist on the preferred referral process. Since AOs operate in multiple States, they do not have to confer with State public health officials to set up referral processes, but are expected to refer identified breaches to the appropriate State public health contact identified at: http://www.cdc.gov/HAI/state-based/index.html

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CMS Memo Infection Control Breaches

- Using the same needle for more than one individual
- Using the same (pre-filled/manufactured/insulin or any other) syringe, pen or injection device for more than one individual
- Re-using a needle or syringe which has already been used to administer medication to an individual to subsequently enter a medication container (e.g., vial, bag), and then using contents from that medication container for another individual
- Using the same lancing/fingerstick device for more than one individual, even if the lancet is changed

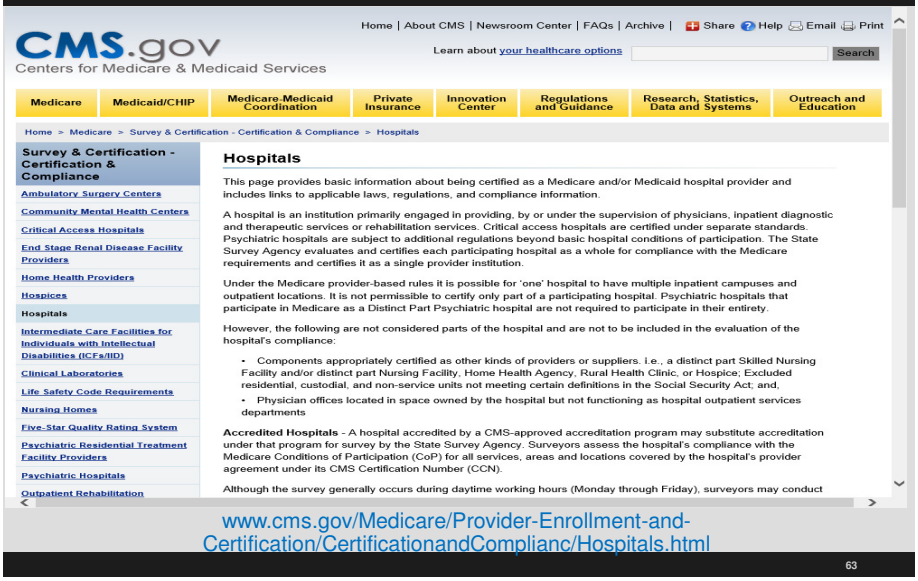
61

Access to Hospital Complaint Data

- CMS issued Survey and Certification memo on March 22, 2013 regarding access to hospital complaint data
- Includes acute care and CAH hospitals
  - Does not include the plan of correction but can request
  - Questions to bettercare@cms.hhs.com
- This is the CMS 2567 deficiency data and lists the tag numbers
- Updating quarterly
  - Available under downloads on the hospital website at www.cms.gov

62

Updated Deficiency Data Reports



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

63

Can Count the Deficiencies by Tag Number

	A	B	C	D	E	F	G	H	I	J
240	DOCTORS' HOSPITAL OF MICHIGAN	23	461	MI	48341	Short Term	A	0364	AUTOPSIES	7/18/2012 Based on record review and interview, the facility failed to ensure that 1
241	MARTHA JEFFERSON HOSPITAL	49	500	VA	22911	Short Term	A	0364	AUTOPSIES	9/8/2011 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
242	SAINT LOUISE REGIONAL HOSPITAL	05	940	CA	95020	Short Term	A	0364	AUTOPSIES	1/18/2012 Based on interview and record review, the hospital failed to have a syste
243	EDGERTON HOSPITAL AND HEALTH SERVICES	52	111	WI	53534	Critical Access H	C	0201	AVAILABILITY	10/2/2012 Based on review of MR, review of staffing guidelines, review of P&P, and
244	HOLZER MEDICAL CENTER JACKSON	36	500	OH	45640	Critical Access H	C	0205	BLOOD AND BLOOD PRODUCTS	1/20/2011 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
245	BRANDON REGIONAL HOSPITAL	10	119	FL	33511	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	4/8/2011 Based on clinical record review, staff interview and review of policy and
246	CHRISTUS ST PATRICK HOSPITAL	19	524	LA	70601	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	3/9/2012 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
247	COLUMBUS REGIONAL HEALTHCARE SYSTEM	34	500	NC	28472	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	4/13/2011 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
248	DANA-FARBER CANCER INSTITUTE	22	450	MA	02115	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	9/7/2011 Based on review of documentation and confirmed by staff interviews, tw
249	GOOD SAMARITAN MEDICAL CENTER	10	130	FL	33401	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	2/12/2013 Based on clinical record review and staff interview the facility failed to e
250	LONG BEACH MEDICAL CENTER	33	455	NY	11561	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	12/22/2011 Based on record review, the facility failed to ensure that the patient ' s t
251	MANATEE MEMORIAL HOSPITAL	10	206	FL	34208	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	4/16/2012 Based on record review, policy review and staff interview it was determ
252	MISSOURI BAPTIST MEDICAL CENTER	26	301	MO	63131	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	4/11/2012 Based on observation, interview, and record review, the facility failed to
253	NORTHWEST MEDICAL CENTER	10	280	FL	33063	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	8/2/2011 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
254	RESTON HOSPITAL CENTER	49	185	VA	20190	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	11/2/2012 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
255	SAINT AGNES HOSPITAL	21	900	MD	21229	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	2/22/2012 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
256	SAINT CATHERINE REGIONAL HOSPITAL	15	220	IN	47111	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	12/13/2011 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
257	SOUTHEASTERN REGIONAL MEDICAL CENTER	34	300	NC	28359	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	12/14/2011 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
258	STANFORD HOSPITAL	05	300	CA	94305	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	3/15/2012 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
259	WAKEMED, CARY HOSPITAL	34	190	NC	27518	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	3/14/2013 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
260	WILKES-BARRE GENERAL HOSPITAL	39	575	PA	18764	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	1/14/2013 Based on review of facility policy, facility documents, medical records (M
261	WILSON MEDICAL CENTER	34	170	NC	27893	Short Term	A	0409	BLOOD TRANSFUSIONS AND IV MEDICATIONS	2/10/2011 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
262	RIVERSIDE GENERAL HOSPITAL	45	320	TX	77004	Short Term	A	0063	CARE OF PATIENTS	11/9/2012 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
263	CIVISTA MEDICAL CENTER	21	05	GA	MD	20646	Short Term	A	0067	CARE OF PATIENTS - MD/DO ON CALL
264	MILFORD HOSPITAL, INC	07	300	CT	06460	Short Term	A	0067	CARE OF PATIENTS - MD/DO ON CALL	9/22/2011 Based on review of hospital documentation and interviews with facility
265	PLAZA MEDICAL CENTER OF FORT WORTH	45	900	TX	76104	Short Term	A	0067	CARE OF PATIENTS - MD/DO ON CALL	7/1/2011 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDEN
266	CLARA MAASS MEDICAL CENTER	31	0	ONE	NJ	07109	Short Term	A	0068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE
267	GEISINGER - COMMUNITY MEDICAL CENTER	39	182	PA	18510	Short Term	A	0068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE
268	SENTARA NORTHERN VIRGINIA MEDICAL CE	49	230	VA	22191	Short Term	A	0068	CARE OF PATIENTS - RESPONSIBILITY FOR CARE

12/6/2012 Based on a complaint investigation, document review and interview, the

Sheet1

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Surgery and PACU Deficiencies

Tag	Section	July 14, 2017
940	Surgical Services	109
941	Organization of Surgical Services	19
942 943/944	OR Supervision OR scrub and circulating nurse	6 9
945	Surgery Privileges	16
951	OR Policies and Procedures	186
952	H&P	34

65

Surgery and PACU Deficiencies

Tag	Section	July 14, 2017
458	H&P in Medical Records section	28
955 466	Informed Consent Informed Consent in MR Chapter	51 65
956	Required OR Equipment	5
957	PACU	15
958	OR Register	17
959	OP Report	40 **Total 611**

66

Anesthesia Deficiencies

Section	Tag Number	July 14, 2017
Anesthesia Services	1000	22
Organization of Anesthesia	1001	4
Delivery Anesthesia Services	1002	17
Pre-Anesthesia Evaluation	1003	15
Intra-Operative Record	1004	13
Post Anesthesia Evaluation	1005	35 Total 109

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CMS Hospital CoPs Section on Surgery, PACU, and Anesthesia

Surgery

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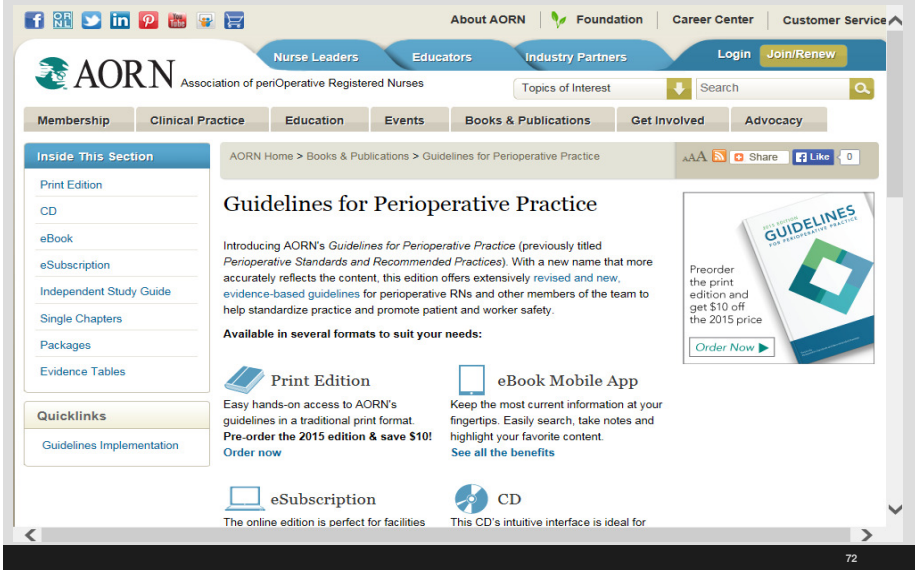
Surgical Services 940

- Standard: If provide surgical services, which is optional, service must be well organized
- If outpatient surgery, must be consistent in quality with inpatient care
- Must follow acceptable standards of practice, AMA, ACOS, APIC, AORN, ASA, or ASPAN
- Must be integrated into hospital wide QAPI
- Will inspect all OR rooms
- Access to OR and PACU must be limited to authorized personnel

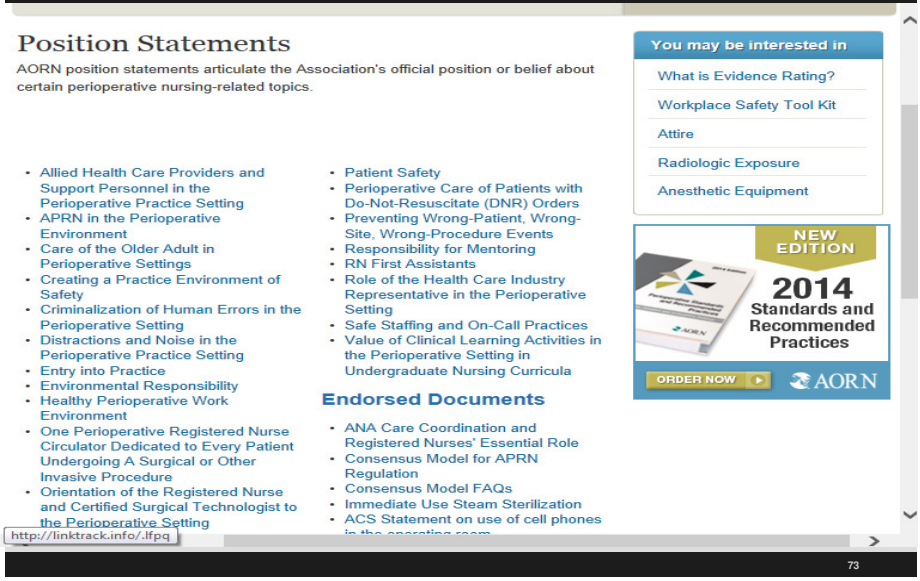
70

AORN

Previously the AORN Perioperative Standards



AORN Position Statements



American College of Surgeons

APIC Assoc for Professionals in Infection Control

www.apic.org

75

Surgical Services 940

- Conform to aseptic and sterile technique
- Appropriate cleaning between cases
- Room is suitable for kind of surgery performed
- And it is monitored, inspected and maintained by biomed program
- Equipment available for rapid and routine sterilization which is called immediate use steam sterilization or IUSS
- Temperature and humidity controlled
- ACS and AORN have P&P on many of these

76

Now Called Immediate Use Steam Steriliation

Immediate-Use Steam Sterilization

"Flash sterilization" has traditionally been used to describe steam sterilization cycles where unwrapped medical instruments are subjected to an abbreviated steam exposure time and then used promptly after cycle completion without being stored. This is in contrast to traditional "terminal sterilization" cycles, where instruments are sterilized within containers, wrappers, or primary packaging designed to maintain the instruments' sterility and allow the devices to be stored for later use. The term "flash" arose out of the abbreviated time of exposure of the unwrapped device.

Today, however, "flash sterilization" is an antiquated term that does not fully describe the various steam sterilization cycles now used to process items not intended to be stored for later use. Current guidelines may require longer exposure times and/or the use of single wrappers or containers designed to allow for aseptic transfer of an item to the point of use. The term "immediate-use steam sterilization" more accurately reflects the current use of these processes. The same critical reprocessing steps (such as cleaning, decontaminating, and transporting sterilized items) must be followed regardless of the specific sterilization cycle employed; a safe process does not include short-cuts or work-arounds.

"Immediate use" is broadly defined as the shortest possible time between a sterilized item's removal from the sterilizer and its aseptic transfer to the sterile field. Immediacy implies that a sterilized item is used during the procedure for which it was sterilized and in a manner that minimizes its exposure to air and other environmental contaminants. A sterilized item intended for immediate use is not stored for future use, nor held from one case to another. Immediacy, rather than being defined according to a specific time frame, is established through the critical analysis and expert collaboration of the health care team.

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Immediate Use Steam Sterilization IUSS

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

Center for Clinical Standards and Quality /Survey & Certification Group

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

DATE: **August 29, 2014**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

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

Memorandum Summary

- ***Change in Terminology: "Flash" Sterilization vs. IUSS:*** Nationally recognized organizations with expertise in infection prevention and control and instrument sterilization processes, and other professional organizations recommend abandoning the use of the term "flash" sterilization, which is now considered outmoded, and replacing it with the term "IUSS."
- ***Update of S&C Memorandum 09-55 Regarding Standards for Immediate Use Sterilization in Surgical Settings:*** This memo reiterates and updates information regarding nationally recognized infection prevention and control guidelines and professionally acceptable standards of practice with respect to immediate use sterilization and supersedes S&C Memorandum 09-55.

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CMS Memo April 19, 2013

- CMS issues memo related to the relative humidity (RH)
- AORN use to say temperature maintained between 68-73 degrees and humidity between 30-60% in OR, PACU, cath lab, endoscopy rooms and instrument processing areas
- CMS says if no state law can write policy or procedure or process to implement the waiver
- Waiver allows RH between 20-60%
- In anesthetizing locations- see definition in memo

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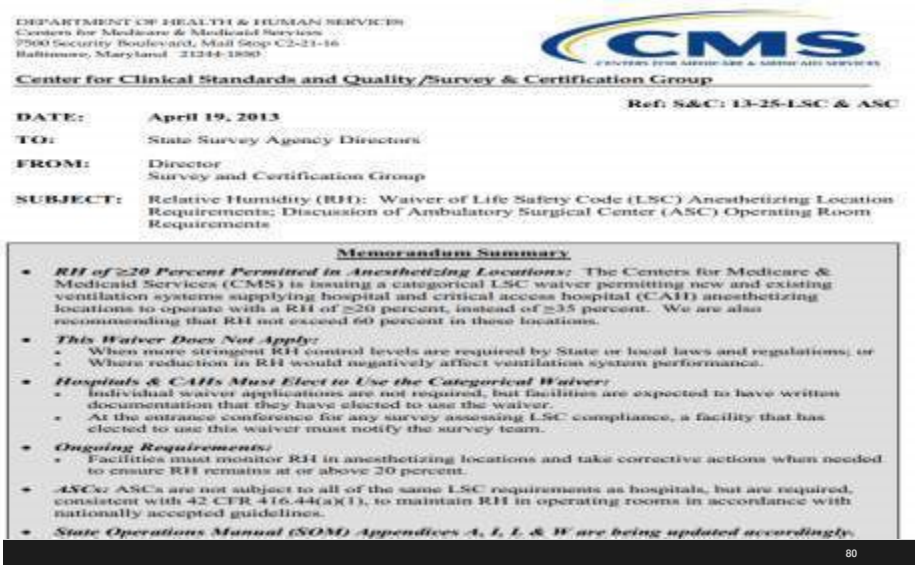
Humidity in Anesthetizing Areas



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: 13-25-LSC & ASC

DATE: April 19, 2013

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Relative Humidity (RH): Waiver of Life Safety Code (LSC) Anesthetizing Location Requirements; Discussion of Ambulatory Surgical Center (ASC) Operating Room Requirements

Memorandum Summary

- ***RH of ≥20 Percent Permitted in Anesthetizing Locations:*** The Centers for Medicare & Medicaid Services (CMS) is issuing a categorical LSC waiver permitting new and existing ventilation systems supplying hospital and critical access hospital (CAH) anesthetizing locations to operate with a RH of ≥20 percent, instead of ≥35 percent. We are also recommending that RH not exceed 60 percent in these locations.
- ***This Waiver Does Not Apply:***
  - When more stringent RH control levels are required by State or local laws and regulations; or
  - Where reduction in RH would negatively affect ventilation system performance.
- ***Hospitals & CAHs Must Elect to Use the Categorical Waiver:***
  - Individual waiver applications are not required, but facilities are expected to have written documentation that they have elected to use the waiver.
  - At the entrance conference for any survey assessing LSC compliance, a facility that has elected to use this waiver must notify the survey team.
- ***Ongoing Requirements:***
  - Facilities must monitor RH in anesthetizing locations and take corrective actions when needed to ensure RH remains at or above 20 percent.
- ***ASCs:*** ASCs are not subject to all of the same LSC requirements as hospitals, but are required, consistent with 42 CFR 416.44(a)(1), to maintain RH in operating rooms in accordance with nationally accepted guidelines.
- ***State Operations Manual (SOM) Appendices A, I, L & W are being updated accordingly.***

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Impact of Lowering the Humidity

- Lowering humidity can impact some equipment and supplies
- Can affect shelf life and product integrity of some sterile supplies including EKG electrodes
- Some electro-medical equipment may be affected by electrostatic discharge especially older equipment
  - Can cause erratic behavior of software and premature failure of the equipment
  - It can affect calibration of the equipment
- Follow the manufacturers instructions for use that explains any RH requirements

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CMS Memo on Low Relative Humidity

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality /Survey & Certification Group

Ref: S&C: 15-27-Hospital, CAH & ASC

DATE: **February 20, 2015**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Potential Adverse Impact of Lower Relative Humidity (RH) in Operating Rooms (ORs)

Memorandum Summary

- ***Information on OR RH*** is provided for Ambulatory Surgical Centers (ASCs) & Supplemental Information for Hospitals & Critical Access Hospitals (CAHs) Using the Categorical Waiver of Life Safety Code (LSC) Anesthetizing Location RH Requirements
  - The Association for the Advancement of Medical Instrumentation (AAMI) coordinated the release on January 5, 2015 of a Joint Communication of multiple healthcare-related organizations on how a RH of <30% in ORs may affect the performance of some sterile supplies and electro-medical equipment.
- ***S&C 13-25-LSC & ASC*** permits hospitals and CAHs to use a LSC categorical waiver to establish an RH level <35% in anesthetizing locations. Before electing or continuing to use this categorical waiver, hospitals and CAHs are expected to ensure that the humidity levels in their ORs are compatible with the manufacturers' instructions for use (IFUs) for the supplies and equipment used in that setting.
- ***ASCs do not require a categorical waiver*** in order to use a lower RH level in their ORs but also need to ensure they comply with the IFUs for their OR supplies and equipment.

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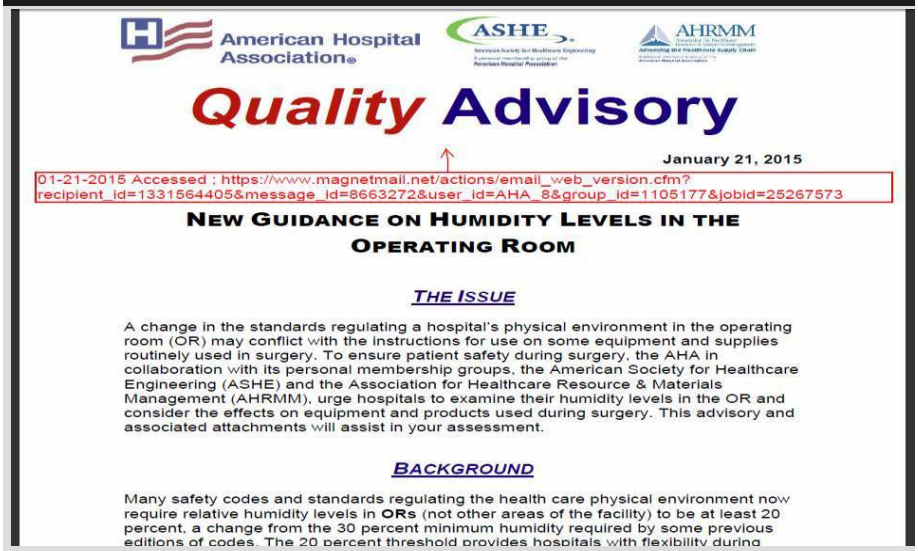
Impact of Lowering the Humidity



American Hospital Association

ASHE

AHRMM

Quality Advisory

January 21, 2015

01-21-2015 Accessed ; https://www.magnetmail.net/actions/email_web_version.cfm?recipient_id=1331564405&message_id=8663272&user_id=AHA_8&group_id=1105177&jobid=25267573

NEW GUIDANCE ON HUMIDITY LEVELS IN THE OPERATING ROOM

THE ISSUE

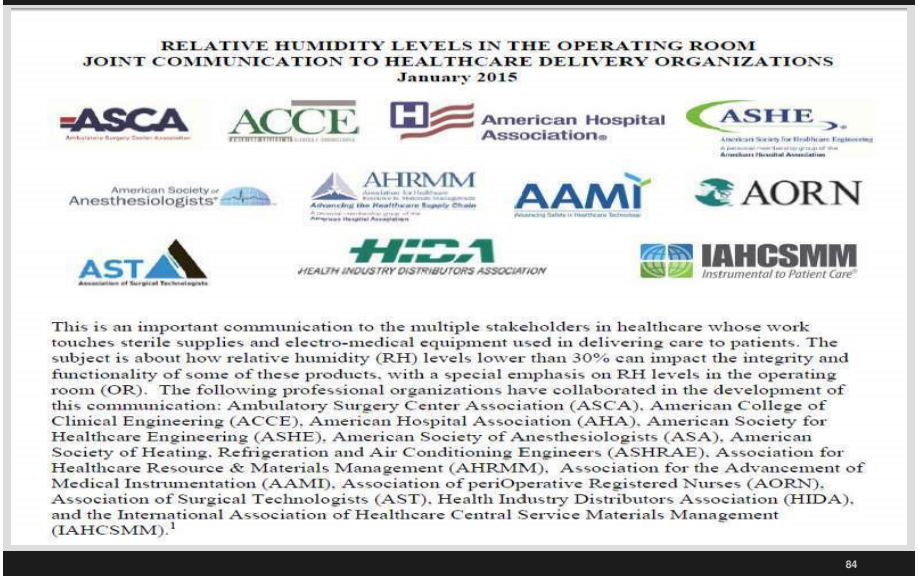
A change in the standards regulating a hospital's physical environment in the operating room (OR) may conflict with the instructions for use on some equipment and supplies routinely used in surgery. To ensure patient safety during surgery, the AHA in collaboration with its personal membership groups, the American Society for Healthcare Engineering (ASHE) and the Association for Healthcare Resource & Materials Management (AHRMM), urge hospitals to examine their humidity levels in the OR and consider the effects on equipment and products used during surgery. This advisory and associated attachments will assist in your assessment.

BACKGROUND

Many safety codes and standards regulating the health care physical environment now require relative humidity levels in **ORs** (not other areas of the facility) to be at least 20 percent, a change from the 30 percent minimum humidity required by some previous editions of codes. The 20 percent threshold provides hospitals with flexibility during

83

Lowering Humidity Can Have Other Effects



RELATIVE HUMIDITY LEVELS IN THE OPERATING ROOM
JOINT COMMUNICATION TO HEALTHCARE DELIVERY ORGANIZATIONS
January 2015

ASCA · ACCE · American Hospital Association · ASHE · American Society of Anesthesiologists · AHRMM · AAMI · AORN · AST · HIDA Health Industry Distributors Association · IAHCSMM Instrumental to Patient Care

This is an important communication to the multiple stakeholders in healthcare whose work touches sterile supplies and electro-medical equipment used in delivering care to patients. The subject is about how relative humidity (RH) levels lower than 30% can impact the integrity and functionality of some of these products, with a special emphasis on RH levels in the operating room (OR). The following professional organizations have collaborated in the development of this communication: Ambulatory Surgery Center Association (ASCA), American College of Clinical Engineering (ACCE), American Hospital Association (AHA), American Society for Healthcare Engineering (ASHE), American Society of Anesthesiologists (ASA), American Society of Heating, Refrigeration and Air Conditioning Engineers (ASHRAE), Association for Healthcare Resource & Materials Management (AHRMM), Association for the Advancement of Medical Instrumentation (AAMI), Association of periOperative Registered Nurses (AORN), Association of Surgical Technologists (AST), Health Industry Distributors Association (HIDA), and the International Association of Healthcare Central Service Materials Management (IAHCSMM).[1]

84

Organization and Staffing 941

- Standard: The organization of surgical services must be appropriate to the scope of services offered
- Must have the appropriate equipment
- Must have the appropriate types and numbers of qualified personnel to furnish surgical services
  - Department director, scrub nurse, circulator, etc.
- The surveyor is to review the organizational chart to indicate lines of authority and delegation

85

Safe Staffing in the OR

AORN

AORN Position Statement on Perioperative Safe Staffing and On-Call Practices

POSITION STATEMENT

Staffing for the perioperative setting is dynamic in nature and depends on clinical judgment, critical thinking, and the administrative skills of the perioperative registered nurse (RN) administrator. Patients undergoing operative and other invasive procedures require perioperative nursing care provided by a perioperative RN, regardless of the setting. This position statement articulates AORN's position regarding safe staffing and on-call practices for perioperative RNs based on the available research. It is intended to serve as a guide for perioperative RN administrators; however, it is the responsibility of each facility to determine specific policies and procedures based on patient need and available resources to ensure safe staffing and on-call practices. The purpose of this position statement is to provide a framework for developing a staffing plan throughout the continuum of perioperative patient care, beginning with scheduling an operative or other invasive procedure through the postoperative phase, and provide staffing strategies to accommodate safe perioperative patient care while promoting a safe work environment. It includes an addendum with suggested staffing formulas to meet safe staffing and on-call practices.

Perioperative RN administrators should identify workforce requirements with a focus on the effect of environmental factors, the setting in which the procedure will be performed, and the unique needs of the patient. AORN believes that patient and workforce safety must be the foundation for all staffing plans. To this end AORN supports the following:

- Perioperative clinical staffing guidelines should be based on individual patient needs, patient acuity, technological demands, staff member competency, skill mix, practice standards, health care regulations, accreditation requirements, and state staffing laws.[1-3] Staffing requirements are relative to department functions and assigned role expectations.
- An effective staffing plan should be flexible and responsive to short-term and long-term patient and organizational demands. Effective planning involves determining staffing needs,

86

Surgery OR Director 942-944

- Standard: OR must be supervised by experienced RN or doctor (MD/DO)
- Must have specialized training in surgery and management of surgical service operation
- Will review job description
- LPN's and OR techs can serve as scrub nurses under supervision of RN
- Qualified RN may perform circulating duties in OR
- LPN or surgery tech may assist in circulating duties if allowed by state law & under supervision of RN who is immediately available

87

Surgery 942-944

- Circulating RN must be in the operating suite and available to immediately and physically respond in emergencies
- Can not be outside the department or engaged in other activities to prevent immediate intervention
- Hospital must have P&P on this

88

RN Circulator for Every Patient

AORN

AORN Position Statement on One Perioperative Registered Nurse Circulator Dedicated to Every Patient Undergoing an Operative or Other Invasive Procedure

POSITION STATEMENT

The goal of perioperative nursing practice is to assist patients to achieve a level of wellness equal to or improved from the preoperative level, and to support the patients' family members and significant others during the perioperative period. AORN is committed to the provision of safe perioperative nursing care by ensuring that every patient undergoing an operative or other invasive procedure is cared for by minimum of one registered nurse (RN) in the circulating role. To this end, AORN believes the following:

- At a minimum, one perioperative RN circulator should be dedicated to each patient undergoing an operative or other invasive procedure and be present during that patient's entire intraoperative experience.[1]
- Patient care in the perioperative setting is dynamic in nature and depends on the clinical knowledge, judgment, and clinical-reasoning skills possessed by the perioperative RN.
- The perioperative RN circulator delegates, supervises, and evaluates the activities of other team members while simultaneously executing immediate directives and interventions in urgent or emergent situations.[2]
- The foundation of perioperative nursing practice is based on both the art and science of nursing, including scientific principles, best practices, and patient advocacy.
- A practice environment that acknowledges the unique education of an RN empowers perioperative nurses to provide the highest quality of patient care in the surgical arena.
- Scientific research and the identification of nursing quality indicators, such as those found in the language of the Perioperative Nursing Data Set (PNDS), are the best means to monitor the relationship between appropriate nurse staffing and patient outcomes in the surgical setting.

89

Surgical Privileges 945

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

90

Surgical Privileges

- MS bylaws must have criteria for determining privileges
- Surgical privileges are granted in accordance with the competence of each
- MS appraisal procedure must evaluate each practitioner's training, education, experience, and demonstrated competence
- As established by the QAPI program, credentialing, adherence to hospital P&P, and laws

91

Surgical Privileges 945

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

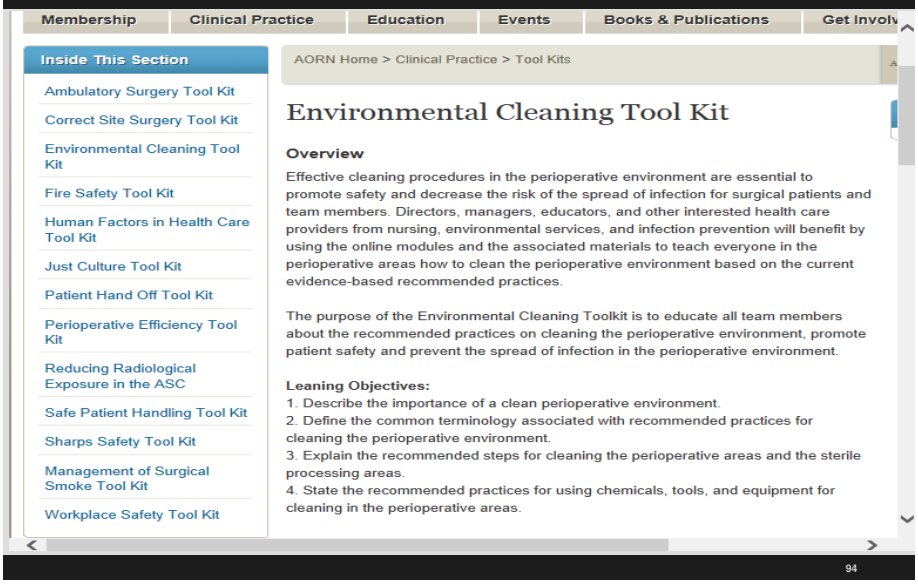
92

Surgery Policies 951

- Aseptic and sterile surveillance and practice, including scrub technique
- Identify infected and non-infected cases
- Housekeeping requirements/procedures
- Patient care requirements
  - pre-op work area
  - patient consents and releases
  - safety practices
  - patient identification process and clinical procedures

93

Extensive Toolkit on Environmental Cleaning



94

Environmental Cleaning: It's Important!

Promote patient safety

Prevent the spread of infection

95

Surgery Policies 951

- Duties of scrub and circulating nurses
- Safety practices
- Surgical counts
- Scheduling of patients for surgery
- Personnel policies in OR
- Resuscitative techniques
- DNR status
- Care of surgical specimens

96

Policy on Preventing Wrong Site Surgery UP

Verification of Correct Site, Correct Procedure, and Correct Patient for Invasive or Surgical Procedures

Purpose:

To provide steps to assist in minimizing avoidable risks during invasive or surgical procedures. The expected outcome is that the patient's procedure is performed on the correct site, side, and level.

Policy:

It is the policy of [*insert name of facility*] that the following steps must be completed before every invasive or surgical procedure, unless noted on the exception list. This policy shall be followed for all invasive or surgical procedures throughout the facility.

- In the preprocedure/preoperative area, a confirmation of the correct site, procedure, and patient shall occur.
- In the preprocedure/preoperative area, the patient shall be involved whenever possible. If the patient is unable to participate, a designated caregiver shall participate.
- All patients who undergo an invasive or surgical procedure involving laterality, multiple structures (eg, fingers and toes), or multiple levels (eg, spinal surgery) must have their surgical site marked.
- If a patient refuses site marking, the patient's physician will review the rationale for site marking and the implications for refusing site marking.
- A licensed independent practitioner or other provider who is privileged or permitted to perform the intended invasive or surgical procedure [*determined by facility*] will mark the procedure/surgical site before the patient enters the procedure/operating room unless the anatomical site is exempt per policy guidelines.
- A discrepancy at any point in time must be resolved before continuing the procedure. All team members and the patient, if possible, must agree on resolution of the identified discrepancy.
- A time out will be performed for all cases, including those not requiring site marking.
- Two patient identifiers [*determined by facility*] will be used to verify a patient's identity (eg, full name, date of birth). A patient room number should not be used as an identifier.
- If a treatment (eg, anesthesia block) or medication administration (eg, eye drops) must be performed before the site has been marked (in the holding area), the patient verification process as outlined

97

COMPREHENSIVE SURGICAL CHECKLIST

Blue = World Health Organization (WHO) Green = The Joint Commission - Universal Protocol (JC) 2010 National Patient Safety Goals Orange = JC and WHO

PREPROCEDURE CHECK-IN	SIGN-IN	TIME-OUT	SIGN-OUT
In Holding Area	**Before Induction of Anesthesia**	**Before Skin Incision**	**Before the Patient Leaves the Operating Room**
Patient/patient representative actively confirms with Registered Nurse (RN): Identity ☐ Yes Procedure and procedure site ☐ Yes Consent(s) ☐ Yes Site marked ☐ Yes ☐ N/A by person performing the procedure **RN confirms presence of:** History and physical ☐ Yes Preanesthesia assessment ☐ Yes Diagnostic and radiologic test results ☐ Yes ☐ N/A Blood products ☐ Yes ☐ N/A Any special equipment, devices, implants ☐ Yes ☐ N/A Include in Preprocedure check-in as per institutional custom: Beta blocker medication given (SCIP) ☐ Yes ☐ N/A Venous thromboembolism prophylaxis ordered (SCIP)	**RN and anesthesia care provider confirm:** Confirmation of: identity, procedure, procedure site and consent(s) ☐ Yes Site marked ☐ Yes ☐ N/A by person performing the procedure Patient allergies ☐ Yes ☐ N/A Difficult airway or aspiration risk? ☐ No ☐ Yes (preparation confirmed) Risk of blood loss (> 500 ml) ☐ Yes ☐ N/A # of units available _____ Anesthesia safety check completed ☐ Yes **Briefing:** All members of the team have discussed care plan and addressed concerns ☐ Yes	**Initiated by designated team member** All other activities to be suspended (unless a life-threatening emergency) Introduction of team members ☐ Yes **All:** Confirmation of the following: identity, procedure, incision site, consent(s) ☐ Yes Site is marked and visible ☐ Yes ☐ N/A Relevant images properly labeled and displayed ☐ Yes ☐ N/A Any equipment concerns? **Anticipated Critical Events** **Surgeon:** States the following: ☐ critical or nonroutine steps ☐ case duration ☐ anticipated blood loss **Anesthesia Provider:** ☐ Antibiotic prophylaxis within one hour before incision ☐ Yes ☐ N/A ☐ Additional concerns? **Scrub and circulating nurse:** ☐ Sterilization indicators have been confirmed ☐ Additional concerns?	**RN confirms:** Name of operative procedure Completion of sponge, sharp, and instrument counts ☐ Yes ☐ N/A Specimens identified and labeled ☐ Yes ☐ N/A Any equipment problems to be addressed? ☐ Yes ☐ N/A **To all team members:** What are the key concerns for recovery and management of this patient? _____ _____ _____ _____ _____ _____ _____ _____ April 2010

98

Surgery Policies 951

- Malignant hyperthermia
- Protocols for all surgical procedures
- Sterilization and disinfection procedures
- Handling infectious and biomedical waste
- Outpatient surgery post op planning
- Acceptable OR attire
  - AORN has guidelines on this and says all scrubs must be laundered by the hospital
  - Recommended Practices for Surgical Attire

99

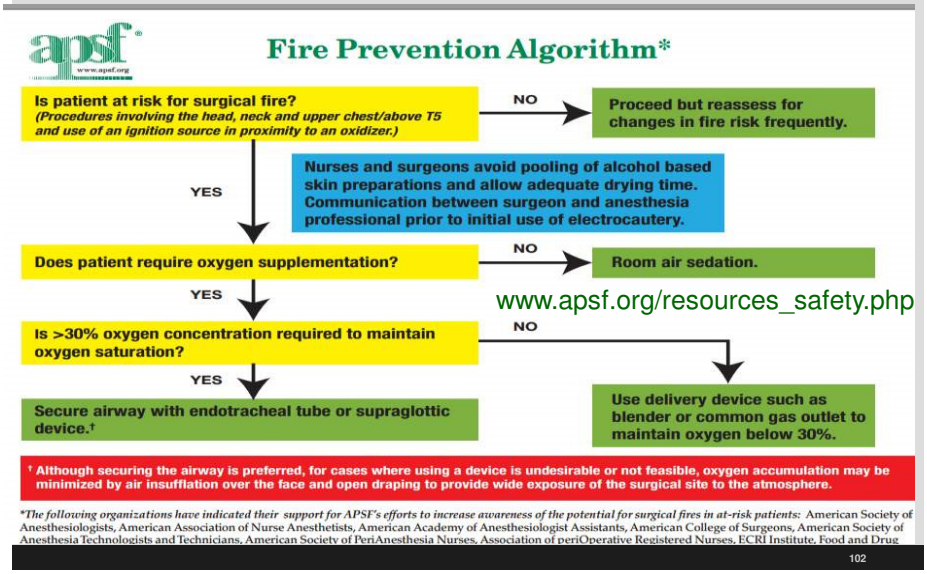
Preventing OR Fires 951

- Read detailed section on use of alcohol based skin prep and how to prevent an OR fire
- AORN has toolkit on preventing OR fires and detailed policy on flammable prep in the OR and how to prevent fires
- Special precautions developed by NFPA and incorporated into NPSG by TJC
- ASA has good document on preventing fires in the OR
- Pa Patient Safety Authority has great recommendations

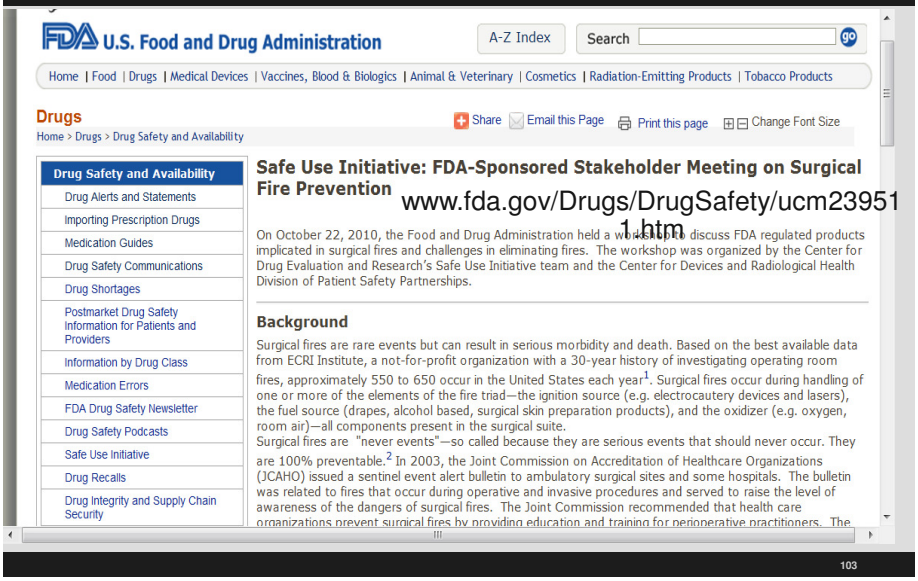
100

Fire Safety Video

APSF Fire Prevention Algorithm Mar 2013

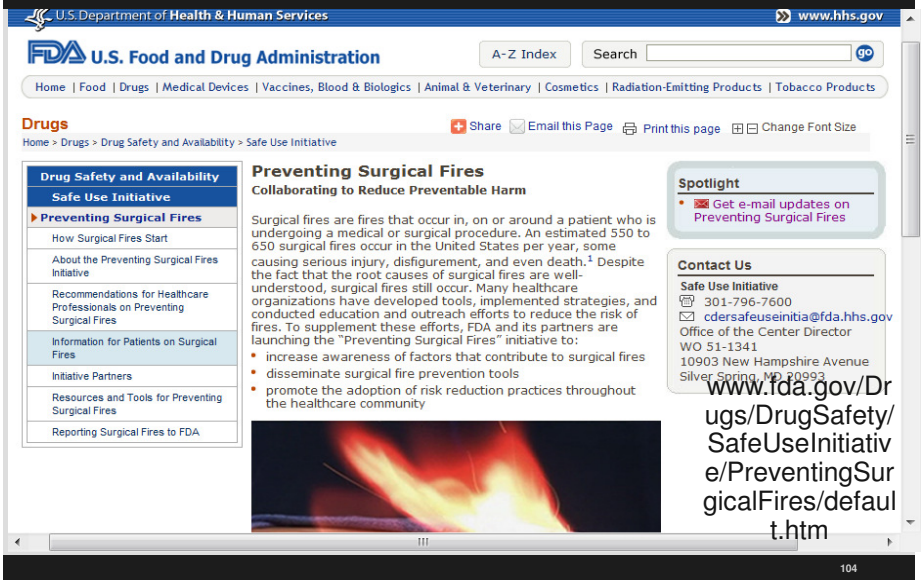


FDA Surgical Fire Prevention



www.fda.gov/Drugs/DrugSafety/ucm239511.htm

Sign Up to Get Email Updates TJC



www.fda.gov/Drugs/DrugSafety/SafeUseInitiative/PreventingSurgicalFires/default.htm

FDA Resources FDA Video Toolkit

www.fda.gov/Drugs/DrugSafety/SafeUseInitiative/PreventingSurgicalFires/ucm272680.htm

TJC has taken over the website

- **Prevention of Surgical Fires**
  Continuing Medical Education (CME) credits are available to physicians for this video.
  Please see the Medscape.org site for CME details. (Registration required.)
- Prevention and Management of Operating Room Fires
  With the assistance of ECRI Institute, The Anesthesia Patient Safety Foundation (APSF) has produced this 18-minute long video describes best practices to prevent the potentially devastating complication of a fire in the operating room. The intended audience is everyone who works in the OR during surgery. Watch the video online or request a complementary DVD.
- FDA Patient Safety News: Preventing Fires in the Operating Room
  This 3 minute FDA video clip for health care professionals, summarizes the main points of APSF's video, "Prevention and Management of Operating Room Fires."

www.cspsteam.org/TJCSurgicalFireCollaborative/preventingsurgicalfires.html

CSPS COUNCIL ON SURGICAL & PERIOPERATIVE SAFETY — One Team. One Goal. Surgical Patient Safety.

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EMAIL SHARE

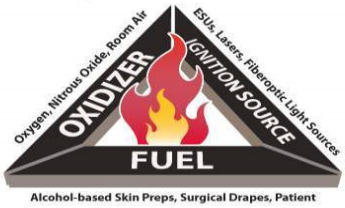
Preventing Surgical Fires

Collaborating to Reduce Preventable Harm

Surgical fires are fires that occur in, on or around a patient who is undergoing a medical or surgical procedure. An estimated 550 to 650 surgical fires occur in the United States per year, some causing serious injury, disfigurement, and even death.[1] Despite the fact that the root causes of surgical fires are well-understood, surgical fires still occur. Many healthcare organizations have developed tools, implemented strategies, and conducted education and outreach efforts to reduce the risk of fires. To supplement these efforts, FDA and its partners launched the "Preventing Surgical Fires" initiative to:

- increase awareness of factors that contribute to surgical fires
- disseminate surgical fire prevention tools
- promote the adoption of risk reduction practices throughout the healthcare community

[1] ECRI Institute New Clinical Guide to Surgical Fire Prevention. Health Devices October 2009



Information About Surgical Fires

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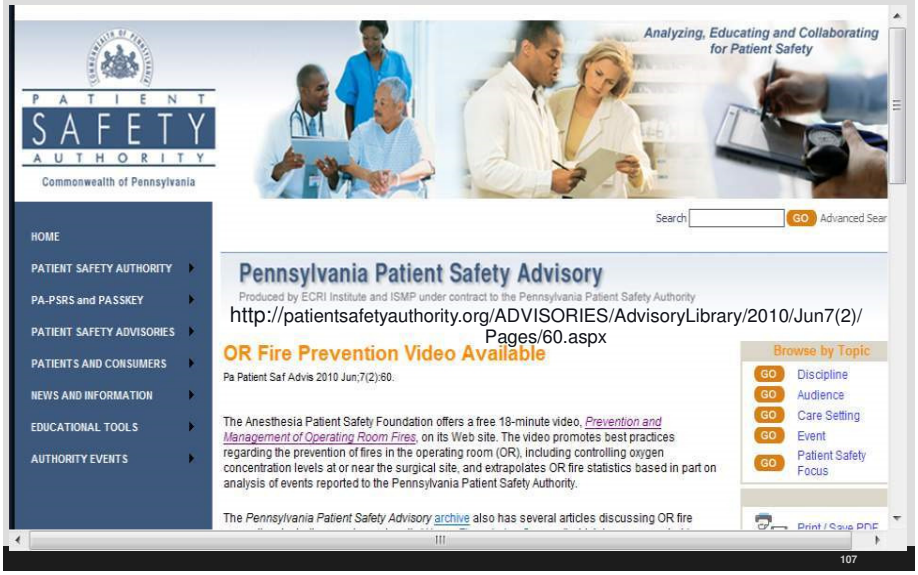
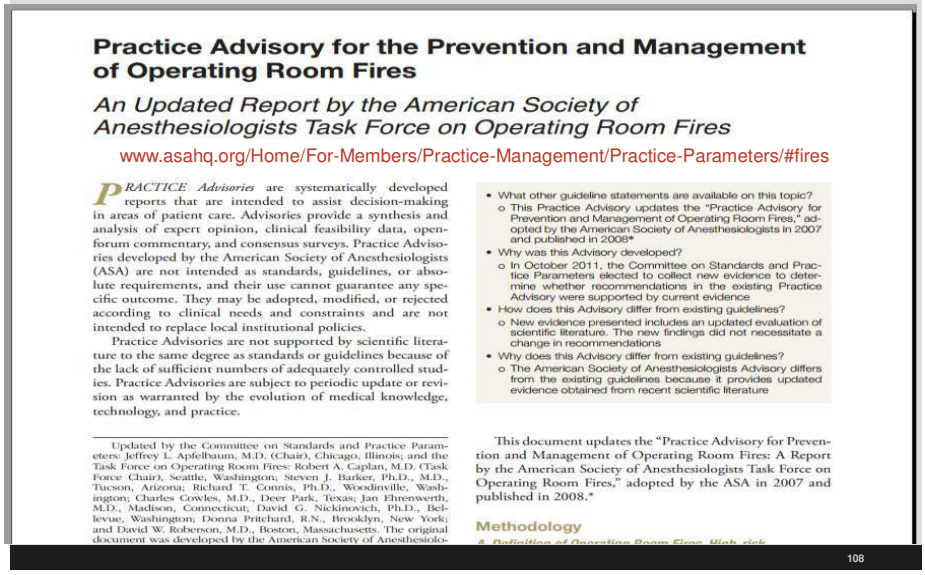
Pa Patient Safety Authority



http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2010/Jun7(2)/Pages/60.aspx

ASA Updated February 2013



Practice Advisory for the Prevention and Management of Operating Room Fires

An Updated Report by the American Society of Anesthesiologists Task Force on Operating Room Fires

www.asahq.org/Home/For-Members/Practice-Management/Practice-Parameters/#fires

PRACTICE Advisories are systematically developed reports that are intended to assist decision-making in areas of patient care. Advisories provide a synthesis and analysis of expert opinion, clinical feasibility data, open-forum commentary, and consensus surveys. Practice Advisories developed by the American Society of Anesthesiologists (ASA) are not intended as standards, guidelines, or absolute requirements, and their use cannot guarantee any specific outcome. They may be adopted, modified, or rejected according to clinical needs and constraints and are not intended to replace local institutional policies.

Practice Advisories are not supported by scientific literature to the same degree as standards or guidelines because of the lack of sufficient numbers of adequately controlled studies. Practice Advisories are subject to periodic update or revision as warranted by the evolution of medical knowledge, technology, and practice.

Updated by the Committee on Standards and Practice Parameters: Jeffrey L. Apfelbaum, M.D. (Chair), Chicago, Illinois; and the Task Force on Operating Room Fires: Robert A. Caplan, M.D. (Task Force Chair), Seattle, Washington; Steven J. Barker, Ph.D., M.D., Tucson, Arizona; Richard T. Connis, Ph.D., Woodinville, Washington; Charles Cowles, M.D., Deer Park, Texas; Jan Ehrenwerth, M.D., Madison, Connecticut; David G. Nickinovich, Ph.D., Bellevue, Washington; Donna Pritchard, R.N., Brooklyn, New York; and David W. Roberson, M.D., Boston, Massachusetts. The original document was developed by the American Society of Anesthesiolo-

- What other guideline statements are available on this topic?
  - This Practice Advisory updates the "Practice Advisory for Prevention and Management of Operating Room Fires," adopted by the American Society of Anesthesiologists in 2007 and published in 2008*
- Why was this Advisory developed?
  - In October 2011, the Committee on Standards and Practice Parameters elected to collect new evidence to determine whether recommendations in the existing Practice Advisory were supported by current evidence
- How does this Advisory differ from existing guidelines?
  - New evidence presented includes an updated evaluation of scientific literature. The new findings did not necessitate a change in recommendations
- Why does this Advisory differ from existing guidelines?
  - The American Society of Anesthesiologists Advisory differs from the existing guidelines because it provides updated evidence obtained from recent scientific literature

This document updates the "Practice Advisory for Prevention and Management of Operating Room Fires: A Report by the American Society of Anesthesiologists Task Force on Operating Room Fires," adopted by the ASA in 2007 and published in 2008.*

Methodology

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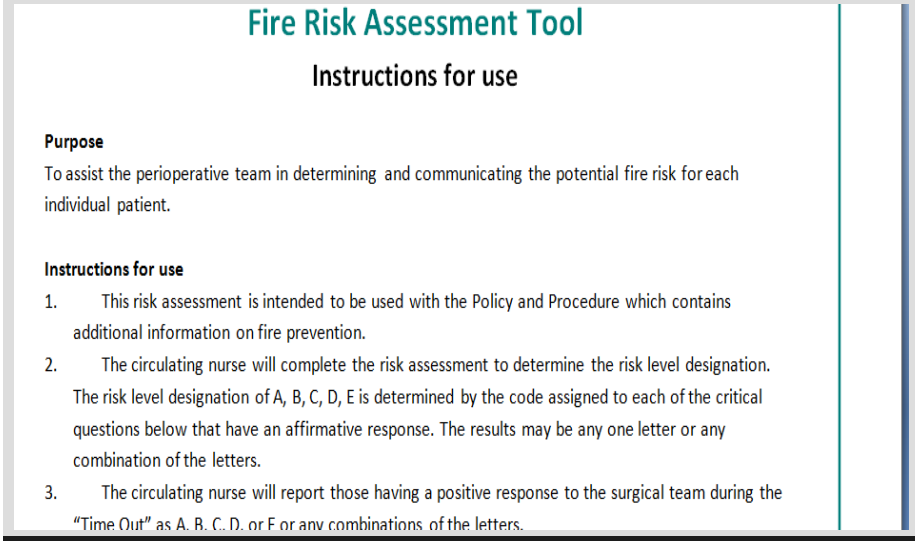
AORN Fire Risk Assessment Tool



Fire Risk Assessment Tool

Instructions for use

Purpose

To assist the perioperative team in determining and communicating the potential fire risk for each individual patient.

Instructions for use

1. This risk assessment is intended to be used with the Policy and Procedure which contains additional information on fire prevention.
2. The circulating nurse will complete the risk assessment to determine the risk level designation. The risk level designation of A, B, C, D, E is determined by the code assigned to each of the critical questions below that have an affirmative response. The results may be any one letter or any combination of the letters.
3. The circulating nurse will report those having a positive response to the surgical team during the "Time Out" as A, B, C, D, or E or any combinations of the letters.

109

H&P 952

- H&P must be on the chart before the patient goes to surgery
- Must make sure H&P is no older than 30 days
- Must update the day of surgery before surgery except in emergencies
- Must be on chart 24 hours after admission
- P&P must specify what is an emergency
  - See tag 358 on H &P in medical records section

110

Consent 955

- Informed consent is in three sections of the CoPs and each is different and not a repeat
- Third section in the surgery chapter
- Surgical services
- Consent must be in chart before surgery
  - Exception for emergencies
- Tag 466 in medical records section sets out the mandatory elements that must be in a consent form

111

Informed Consent MR Mandatory Elements

- Name of hospital
- Name of procedure or treatment
- Name of responsible practitioner who is performing
- Statement that benefits, material risks and alternatives were explained
- Signature of patient with date and time

112

Informed Consent 955

- Recommend anesthesia consent
- Lists elements for well designed process, which are the optional elements
- Specifies what must be in the consent policy
- Who can obtain
- Which procedures need consent

113

Informed Consent Policy

- When is surgery an emergency
- Content of consent form
- Process to obtain consent
- If consent obtained outside hospital how to get it into medical records

114

Informed Consent 955

- Must disclose if residents, RNFA, Surgical PAs Cardiovascular Techs are doing important tasks
- **Important surgical tasks** include: opening and closing, dissecting tissue, removing tissue, harvesting grafts, transplanting tissue, administering anesthesia, implanting devices and placing invasive lines
- But requirement to have this in writing in under optional list or well designed list

115

Surgery Equipment 956

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

116

OR Register 958

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

117

OR Register 958

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

118

Operative Report 959

- Name and identity of patient
- Date and time of surgery
- Name of surgeons, assistants
- Pre-op and post-op diagnosis
- Name of procedure
- Type of anesthesia

119

Operative Report 959

- Complications and description of techniques and tissue removed
- Grafts, tissue, devises implanted
- Name and description of significant surgical tasks done by others
  - See list-opening, closing, harvesting grafts etc.

120

CMS Hospital CoPs Section on PACU

PACU 957

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

PACU 957

- PACU assessment includes level of activity, level of pain, respiration, BP, LOC, patient color
  - Such as Aldrete, PADSS or post anesthesia discharge scoring system, PAS, modified Aldrete, PARS or post anesthesia recovery scale etc.
- If not sent to PACU then close observation of patient until has gained consciousness by a qualified RN
- Surveyor is instructed to observe care provided in the PACU to make sure they are monitored and assessed prior to transfer or discharge
- Will look to determine if hospital has system to monitor needs of post-op patient transferred from PACU to other areas of the hospital

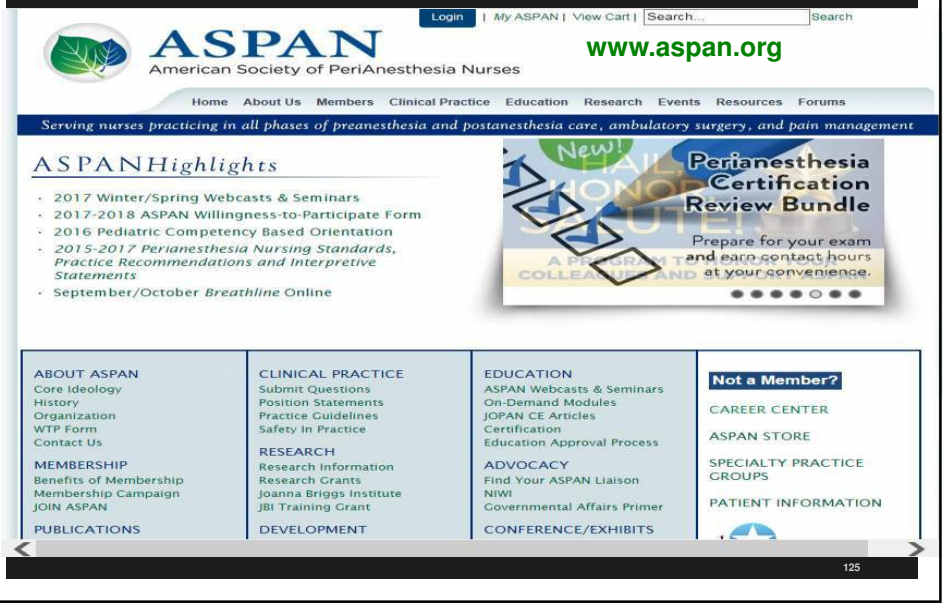
123

Post-Operative Monitoring 2014

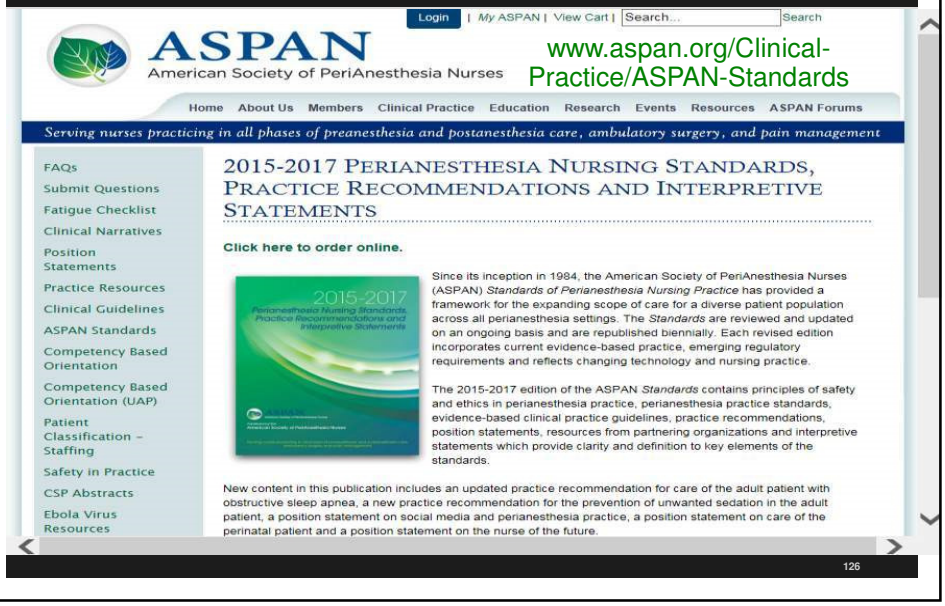
- Hospitals are expected to have P&P on the minimum scope and frequency of monitoring in post-PACU setting
- Must be consistent with the standard of care
- Concerned about post-op patients receiving opioids
- Concern about risk for over-sedation and respiratory depression
- Once out of PACU not monitored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

124

ASPAN



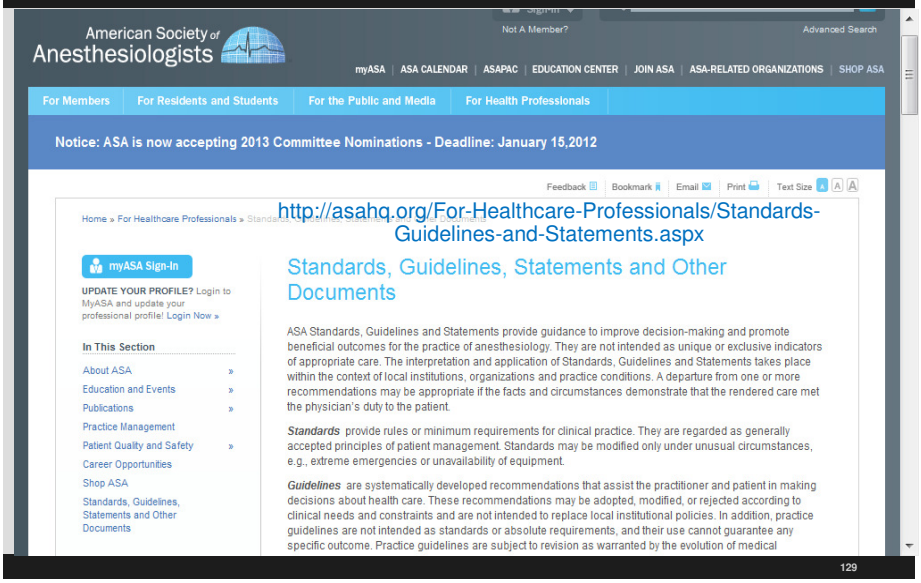
PeriAnesthesia Nursing Standards



ASPAN Position Statements

The CMS Anesthesia Standards

ASA Guidelines and Standards



http://asahq.org/For-Healthcare-Professionals/Standards-Guidelines-and-Statements.aspx

129

Anesthesia 1000

- Must be provided in well organized manner under qualified doctor (an example is the Director of Anesthesiology)
  - Even in states where CRNAs do not need to be supervised need qualified doctor to be medical director of anesthesia (not in CAH)
  - Final revision changed the section on the criteria for the qualification of the anesthesia director
  - Service responsible for all anesthesia administered in the hospital
- Optional service and must be integrated into hospital QAPI

130

ASA Position on Director of Anesthesiology

STATEMENT ON THE ANESTHESIA CARE TEAM

http://asahq.org/

Committee of Origin: Anesthesia Care Team

(Approved by the ASA House of Delegates on October 18, 2006, and last amended on October 21, 2009)

Anesthesiology is the practice of medicine including, but not limited to, preoperative patient evaluation, anesthetic planning, intraoperative and postoperative care and the management of systems and personnel that support these activities. In addition, anesthesiology involves perioperative consultation, the prevention and management of untoward perioperative patient conditions, the treatment of acute and chronic pain, and the care of critically ill patients. This care is personally provided by or directed by the anesthesiologist.

In the interest of patient safety and quality of care, the American Society of Anesthesiologists believes that the involvement of an anesthesiologist in the perioperative care of every patient is optimal. Almost all anesthesia care is either provided personally by an anesthesiologist or is provided by a nonphysician anesthesia provider directed by an anesthesiologist. The latter mode of anesthesia delivery is called the Anesthesia Care Team and involves the delegation of monitoring and appropriate tasks by the physician to nonphysicians. Such delegation should be specifically defined by the anesthesiologist and should also be consistent with state law or regulations and medical staff policy. Although selected tasks of overall anesthesia care may be delegated to qualified members of the Anesthesia Care Team, overall responsibility for the Anesthesia Care Team and the patients' safety rests with the anesthesiologist.

Core Members of the Anesthesia Care Team

The Anesthesia Care Team includes both physicians and nonphysicians. Each member of the team has an obligation to accurately identify themselves and other members of the team to patients and family members. Anesthesiologists should not permit the misrepresentation of nonphysician personnel as resident physicians or practicing physicians. The nomenclature below is appropriate terminology for this purpose.

Physicians:

ANESTHESIOLOGIST – **director of the anesthesia care team - a physician** licensed to practice medicine who has successfully completed a training program in anesthesiology accredited by the ACGME, the American Osteopathic Association or equivalent organizations.

131

Anesthesia Definitions 1000

- **Anesthesia** involves administration of medication to produce a blunting or loss of;
  - Pain perception (analgesia)
  - Voluntary and involuntary movements
  - Autonomic function
  - Memory and or consciousness
- **Analgesia** (pain) is use of medication to provide pain relief thru blocking pain receptor in peripheral and or CNS where patient does not lose consciousness but does not perceive pain.

132

Anesthesia Bucket 4 Things 1000

- Anesthesia exists on a continuum
- There is not a bright line that distinguishes when the drug's properties from analgesia to anesthesia
- CMS has definitions of what constitutes anesthesia: general anesthesia, regional (spinal or epidural), monitored anesthesia care (MAC), including deep sedation
- For the most part, definitions follow the ASA practice guidelines
  - Anesthesiology 2002; 96:1004-17

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- **General anesthesia**: a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory support is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired. For example, a patient undergoing major abdominal surgery involving the removal of a portion or all of an organ would require general anesthesia in order to tolerate such an extensive surgical procedure. General anesthesia is used for those procedures when loss of consciousness is required for the safe and effective delivery of surgical services;

- **Regional anesthesia**: the delivery of anesthetic medication at a specific level of the spinal cord and/or to peripheral nerves, including epidurals and spinals and other central neuraxial nerve blocks, is used when loss of consciousness is not desired but sufficient analgesia and loss of voluntary and involuntary movement is required. Given the potential for the conversion and extension of regional to general anesthesia in certain procedures, it is necessary that the administration of regional and general anesthesia be delivered or supervised by a practitioner as specified in 42 CFR 482.52(a).

Monitored Anesthesia Care (MAC)

- Anesthesia care that includes monitoring of patient by a person qualified to give anesthesia (like anesthesiologist or CRNA)
- Include potential to convert to a general or regional anesthetic (MAC)
- Deep sedation/analgesia is included in a MAC
- Deep sedation where drug induced depression of consciousness during which patient can not easily be aroused but responds purposefully following repeated or painful stimulus
  - Removed : An example of deep sedation is when Propofol is used for a screening colonoscopy

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Definition of MAC by CMS

- **Monitored anesthesia care (MAC)**: anesthesia care that includes the monitoring of the patient by a practitioner who is qualified to administer anesthesia as defined by the regulations at §482.52(a). Indications for MAC depend on the nature of the procedure, the patient's clinical condition, and/or the potential need to convert to a general or regional anesthetic. Deep sedation/analgesia is included in MAC.

  - Deep sedation/analgesia: a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. Because of the potential for the inadvertent progression to general anesthesia in certain procedures, it is necessary that the administration of deep sedation/analgesia be delivered or supervised by a practitioner as specified in 42 CFR 482.52(a).

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Anesthesia Services Pain Bucket 1000

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

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Definitions of Analgesia (Pain)

- **Moderate sedation/analgesia: ("Conscious Sedation"):** *a* drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. CMS, consistent with ASA guidelines, does not define moderate or conscious sedation as anesthesia (71FR 68690-1).
- **Minimal sedation**: *a* drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilator and cardiovascular functions are unaffected. This is also not anesthesia.
- **Topical or local anesthesia**: *the application or injection of a drug or combination of drugs to stop or prevent a painful sensation to a circumscribed area of the body where a painful procedure is to be performed. There are generally no systemic effects of these medications, which also are not anesthesia, despite the name.*

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Anesthesia Services 1000

- Rescue capacity
  - Sedation is a continuum
  - It is not always possible to predict how any individual patient will respond
  - So may need to rescue by one with expertise in airway management and advanced life support
  - Must have procedures in place to rescue patients whose sedation becomes deeper than initially intended

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Anesthesia Services 1000

- TJC has standards also on how to safely perform moderate or procedural sedation and anesthesia in the PC chapter
- Still need to do a **pre-sedation assessment** and post-sedation assessment but since not anesthesia not a pre or post-anesthesia assessment
- Also references the need to follow **nationally standards of practice** such as ASA (American Society of Anesthesiologists), ACEP (American College of Emergency Physicians) and ASGE (American Society for GI Endoscopy), AGA, ENA, ADA, etc.
  - Listed at the end as additional resources

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One Anesthesia Service 1000

- Anesthesia services must be under one anesthesia services under direction of qualified physician no matter where performed through out the hospital
- Including if done in any of the following:
  - Operating room for both inpatients and outpatients
  - OB
  - Radiology (interventional radiology),
  - ED
  - Psychiatry (ECT)
  - Endoscopy, pain management clinics etc.

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Anesthesia Services under Qualified Director

- Anesthesia services must be under the direction of one individual who is a qualified doctor (1000)
- Need to have medical staff rules and regulations establishing the criteria for the qualifications for the director of anesthesia services
- MS establishes this criteria for director's qualifications
- The board approves after consideration of the medical staff's recommendation
- Must be consistent with state law and acceptable standards of practice

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Interpretation from CMS

- The regulation states, "…under the direction of a qualified doctor of medicine or osteopathy." This means the anesthesia service can be directed by any type of MD or DO who is qualified.
- You are correct that in most hospitals with an anesthesia service, an anesthesiologist would "generally" be the director. However, some hospitals do not have an anesthesiologist on staff. If a hospital provides any type of anesthesia service, the hospital would have to find an MD or DO that has the **qualifications** to be the Director of Anesthesia Services in the hospital.
- The hospital would establish criteria for determining that a particular MD or DO was qualified to be the director (such as knowledge of anesthesia procedures, anesthesia/sedation/analgesia medications, State scope of practice rules, National Standards of practice, administrative skills, management, and other criteria). Hospitals already must establish criteria for determining whether a physician is qualified to provide care and which types of care. Therefore, a hospital should be able to ensure that whichever MD or DO they select as the Director of Anesthesia Services is qualified for that position.

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CMS Manual

The anesthesia services must be under the direction of one individual who is a qualified doctor of medicine (MD) or doctor of osteopathy (DO). Consistent with the requirement at §482.12(a)(4) for it to approve medical staff bylaws, rules and regulations, the hospital's governing body approves, after considering the medical staff's recommendations, medical staff rules and regulations establishing criteria for the qualifications for the director of the anesthesia services. Such criteria must be consistent with State laws and acceptable standards of practice.

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Anesthesia Services Who Can Give? 1000

- Hospital needs to have policies and procedures that are based on nationally recognized guidelines as to whether it is anesthesia or analgesia
  - Be sure to cite standard such as ASA, ASGE, ACEP etc.
- Hospitals need to determine if sedation done in the ED or procedures rooms is anesthesia or analgesia
- Must take into consideration for P&P characteristics of patients served, skill set of staff and what medications are being used
- This standard also sets forth the supervision requirements for staff who administer anesthesia

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Supervision and Privileges 1000

- P&Ps need to establish minimum qualifications and supervision requirements including moderate sedation
  - MS credentialing standards and the nursing standards exist to make sure staff are qualified and competent
  - Want to make sure that staff administering drugs are qualified
  - Drugs must be given with accepted standards of practice
  - MS bylaws address criteria for determining privileges and to apply the criteria to those who request privileges

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Supervision and Privileges 1000

- If nursing staff give IV medication then must have be competent in specified areas
  - This is one of the education requirements of CMS
  - Also training on restraint and seclusion, infection control and hand hygiene, abuse and neglect, advance directives, organ donation, IV and blood and blood products and ED staff with ED common emergencies, timing of medication, medication error, ADE and drug incompatibilities
- Must have P&P to look at adverse events, medication errors and other safety and quality indicators
  - Must periodically re-evaluate these and include in PI

147

Anesthesia Services 1000

- Hospital Medical Staff determine the qualifications for the Director of Anesthesia
- Must be in accordance with the state law and acceptable standards of practice
- Anesthesia service is responsible for developing policies and procedures governing all categories of anesthesia service
- This includes the minimum qualification for each category of practitioner who is permitted to provide anesthesia services

148

Anesthesia Survey Procedure 1000

- Surveyor is suppose to ask for a copy of the organizational chart for anesthesia
- Make sure MD or DO has authority and responsibility for directing anesthesia services throughout the hospital
- Anesthesia must be integrated into the QAPI program
  - Every department has a role in PI including anesthesia
  - See Anesthesia Quality Institute (AQI) which is home to national anesthesia clinical outcomes registry (NACOR) and has list of things to measure

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What PI Do You Measure??

Process indicators: on time starting, prophylactic antibiotic administration, adherence to central line bundle, normothermia in the PACU, number of patient complaints

Are anesthesia staff educated on the CMS grievance and TJC Complaint standard?
Yes__No__

Clinical outcome indicators-patient satisfaction, number of cases completed without any event, number of each critical event occurring by location (high spinal, epidural hematoma, infection after regional, perioperative MI, death, unplanned difficult airway, local anesthesia toxicity, medication error, incorrect patient, OR fire, transfusion reaction, new stroke, visual loss, Intraoperative awareness, peripheral neurologic deficit, etc)

CMS 2011 outpatient surgical measure is antibiotic timing and is described by CMS as "Percentage of outpatients having surgery who were given the right kind of antibiotic at the right time (within one hour before surgery) to help prevent infection of surgical wounds." This measure is already in place for inpatient data and will be used in conjunction to obtain a more comprehensive view of the quality of care being provided in hospitals.

Case information; no untoward event, significant delay, case cancelled, equipment problem, extended PACU stay, unanticipated ICU admission, unanticipated hospital admission, death, cardiac arrest, anaphylaxis, malignant hyperthermia, transfusion reaction, visual loss, stroke, PONV, PACU pain control in adequate, hypotension or hypothermia in the PACU, vascular access complication, infection after regional anesthesia, high spinal, postdural puncture headache,

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What Do You Measure?

Reason for Review
An-1 CNS complication
An-2 Peripheral neurologic deficit
An-3 AMI post anesthesia
An-4 Cardic Arrest post anesthesia
An-5 Respiratory Arrest post anesthesia
An-6 Death w/in 48 hous of anesthesia
An-7 Unplanned adm w/in 24 hours d/t anesthesia
An-8 Unplned adm to ICU w/in 24 hours of anes
An-9 Pulmonary Edema w/in 24 hrs of anesthesia
An-10 Aspiration pneumonitis w/in 48 hours
An-13 Anesthesia Awareness
M-1 Death w/i 48 hours of surgical/invasive proc
M-2 Intra-operative death
M-3 Death w/i immediate recover time of surg/inv
M-4 Death w/i 48 hours of IV sedation
S-1 Unscheduled admission following outpt proc

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What Do You Measure?

S-1 Unscheduled admission following outpt proc
S-2 Unplanned return to surgery
S-3 Foreign object/material found/left in wound
S-4 Burn or non-surgical trauma
S-5 Wrong procedure or wrong pt
S-9 Nerve damage noted post-operatively
S-12 Any untoward patient reaction in OR/PACU/ENDO
S-16 Post Operative Complication
S-17 Path/operative dx mismatch
S-20 Accidental puncture or laceration during proc
S-23 Mismatch pre and post op diagnosis
ModSed-1 Reversal Agent Administered
ModSed -2 Hemodynamic Instability
ModSed -3 Extended recovery time
ModSed -4 Unplanned Admission
ModSed -5 Unplanned Surgery
ModSed-7 Decreased O2 Sat

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AQI Has Data Capture Sheets

Anesthesia Quality Improvement PACU Discharge

Case Info		Anesthesia type	
Date		Provider ID	
MR #		CRNA ID	
ASA Class		Additional provider	

www.aqihq.org/qualitymeasurementtools.aspx

	Yes	No
Patient is awake and able to contribute to assessment		

Patient Physical Exam:	Yes	No
Mental Status at baseline (Y/N)		
Vital Signs at baseline (Y/N)		
Airway patency at baseline (Y/N)		

Pain Score (10-point VAS scale):		
on PACU admission		
Highest pain score		
Pain score at time of assessment		

Nausea or vomiting requiring treatment		
Any occurrence of vomiting		

Did the patient experience an unexpected event during perioperative care?	Yes	No		Yes	No
Unplanned ICU admission			Anaphylaxis		
Unplanned hospital admission			Other medication reaction		
Intraoperative awareness			Delayed emergence		
Epidural hematoma			Respiratory arrest		
Peripheral neurologic deficit			Reintubation		
Corneal abrasion			Dental trauma		
Agitation requiring treatment			Aspiration		
Seizure			Cardiac arrest		

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Anesthesia Quality Improvement Intra-Operative

Case Info		Anesthesia type	
Date		Provider ID	
MR #		CRNA ID	
ASA Class		Additional provider	

NO UNTOWARD EVENT		Death (Excludes ASA 6 patients presenting for harvesting)			
Case Cancelled		Unplanned ICU Admission		Operation on incorrect site	
Case Delayed		Unplanned admission of outpatient		Operation on incorrect patient	
Incorrect procedure					
Pulmonary Edema		Cardiac Arrest		Bronchospasm req treatment	
Hypotension requiring unanticipated therapy with a continuous infusion or pressor agents		New PVC's, bradycardia, atrial fibrillation, or other dysrhythmias requiring unanticipated therapy		Myocardial ischemia, indicated by ST segment changes or echocardiography	
Unanticipated difficult airway		Unplanned reintubation		Aspiration	
Inability to secure an airway		Unplanned respiratory arrest		Laryngospasm	
Anaphylaxis		Transfusion Reaction		Delayed emergence	
Other unanticipated adverse reaction to medication		Use of sedation/narcotic reversal agents		Inability to reverse neuromuscular blockade	
Malignant Hyperthermia		Medication error			
High spinal		Failed regional anesthetic		Unintended dural puncture	
Vascular access complication - vessel injury		Vascular access complication - pneumothorax		Local anesthesia systemic toxicity	

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AQI Core Measures Outcomes of Anesthesia

Intraoperative Events.

- Death (Excludes ASA 6 patients presenting for organ harvest)
- Cardiac
  - Cardiac arrest
  - New PVCs, bradycardia, atrial fibrillation, or other dysrhythmias requiring unanticipated therapy
  - Myocardial ischemia, indicated by ST segment changes or echocardiography
  - Hypotension requiring unanticipated therapy with a continuous infusion of pressor agents
  - Pulmonary edema
- Respiratory
  - Unanticipated difficult airway
  - Inability to secure an airway
  - Unplanned reintubation
  - Unplanned respiratory arrest
  - Aspiration
  - Laryngospasm
  - Bronchospasm requiring unanticipated treatment
- Medication
  - Anaphylaxis
  - Other unanticipated adverse reaction to a medication
  - Malignant hyperthermia
  - Transfusion reaction
  - Medication error
  - Use of sedation/narcotic reversal agents (e.g. flumazenil, naloxone)
  - Inability to reverse neuromuscular blockade
  - Delayed emergence
- Procedural
  - Vascular access complication: vessel injury
  - Vascular access complication: pneumothorax
  - High spinal
  - Local anesthesia systemic toxicity
  - Failed regional anesthetic
  - Unintended dural puncture

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Anesthesia Survey Procedure 1000

- Surveyor to look in directors file
- Will review job or position description of MD/DO director and look for appointment
- Will make sure privileges and qualifications are consistent with the criteria adopted by the board
- Will confirm directors responsibilities include;
  - Planning, directing, and supervision of all activities
  - Removed section on establishing staffing schedules
  - Evaluate the quality and appropriateness of anesthesia services provided to patients as part of PI process

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Anesthesia Survey Procedure 1000

- Surveyor is suppose to request and review all of the anesthesia policies and procedures
- Will make sure the anesthesia apply to every where in the hospital where anesthesia services are provided
- Will make sure the P&P indicate the necessary qualifications that each clinical practitioner must possess in order to administer anesthesia as well as moderate sedation or other forms of analgesia

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Anesthesia Survey Procedure 1000

- Surveyor is to make sure that the clinical applications are considered involving analgesia such as moderate sedation as opposed to anesthesia
- Document what national guidelines are being followed
- The surveyor will make sure the hospital has an adverse event system related to both anesthesia and analgesia
  - Are they tracked and acted upon (incident report, RCA, etc.)

158

Organization and Staffing 1001

- Anesthesia (general, regional, MAC including deep sedation) can only be administered by;
  - Qualified anesthesiologist or CRNA
  - Anesthesiology assistant (AA) under the supervision of anesthesiologist who is immediately available if needed
  - Dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under state law
  - A MD or DO other than anesthesiologist (must be qualified)
    - Lots of discussion on this
    - Hospital needs to follow standards of anesthesia care when establishing P&P *governing* anesthesia administration by these types of practitioners as well as MDs or DOs who are **not** anesthesiologists

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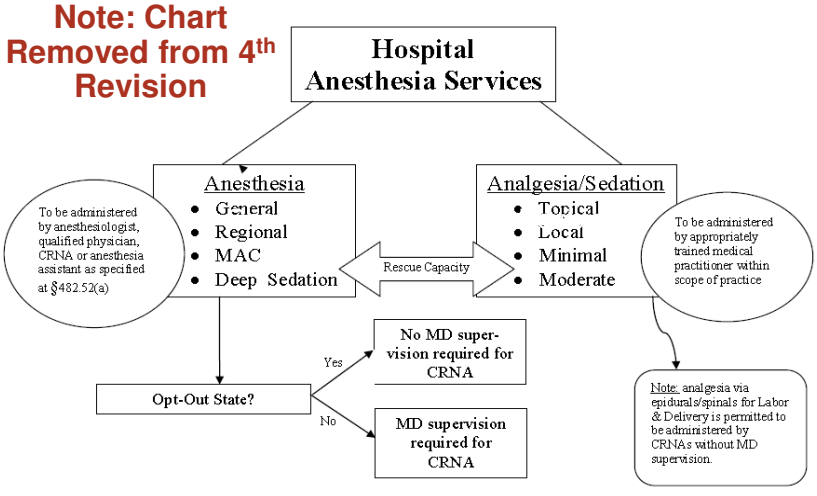
Who Is Qualified to Give Anesthesia

Note: Chart Removed from 4th Revision



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Who Can Administer Anesthesia

Administration by an MD/DO/dentist/oral surgeon/podiatrist

The hospital's anesthesia services policies must address the circumstances under which an MD or DO who is not an anesthesiologist, a dentist, oral surgeon or podiatrist is permitted to administer anesthesia. In the case of a dentist, oral surgeon or podiatrist, administration of anesthesia must be permissible under State law and comply with all State requirements concerning qualifications. Hospitals should conform to generally accepted standards of anesthesia care when establishing policies governing anesthesia administration by these types of practitioners as well as MDs or DOs who are not anesthesiologists.

161

Organization and Staffing 1001

- CRNA can be supervised by the operating surgeon or the anesthesiologist
- CRNA may not require supervision if state got an exemption from supervision[1]
- Governor sends a letter to CMS requesting this after attesting that the State Medical Board and Nursing Board were consulted and in best interests of the state
- List of 17 state exemptions at www.cms.hhs.gov/CFCsAndCoPs/02_Spotlight.asp
  - Iowa, Nebraska, Idaho, Minnesota, New Hampshire, New Mexico, Kansas, Kentucky, North Dakota, Washington, Alaska, Oregon, South Dakota, Wisconsin, Montana, Colorado, and California

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Administering 1001

- Need P&P concerning who may administer analgesia
  - Topical, local, minimal sedation and moderate sedation
  - Consistent with scope of practice set by state law
- General, regional, MAC and deep sedation can only be administered by the 5 categories mentioned
- Hospital must follow generally accepted standards of anesthesia care if anyone other than anesthesiologist, CRNA, or AA does
- Need policy on supervision also

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Who Can Administer Anesthesia 1001

- CRNA can administer anesthesia if under the operating surgeon or by an anesthesiologist
- If supervised by an anesthesiologist must be **immediately available**
- What does immediately available mean?
- Anesthesiologist must be physically located in the same area as the CRNA
- Example: in the same operative suite , same procedure room, same L&D unit and nothing prevents from immediate hands on intervention

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CRNA Supervision

- No supervision if in one of the 17 states that has opted out and so no longer requires it
- Otherwise must be supervised by
  - Operating practitioner who is performing the procedure or
  - Anesthesiologist who is immediately available
- Immediately available means anesthesiologist must be located within the same area of the CRNA and not occupied to prevent him/her from immediately conducting hands on intervention if needed
  - If CRNA in OR then anesthesiologist must be somewhere in the OR suite

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Administration by a CRNA

Unless the hospital is located in a State that has chosen to opt out of the CRNA supervision requirements, a CRNA administering general, regional and monitored anesthesia must be supervised either by the operating practitioner who is performing the procedure, or by an anesthesiologist who is immediately available.

Hospitals should conform to generally accepted standards of anesthesia care when establishing policies for supervision by the operating practitioner. An anesthesiologist is considered "immediately available" when needed by a CRNA under the anesthesiologist's supervision only if he/she is physically located within the same area as the CRNA, e.g., in the same operative suite, or in the same labor and delivery unit, or in the same procedure room, and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed.

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Improper Supervision of Anesthesia Services

- A federal qui tam whistle blower lawsuit was filed by former anesthesiologist and professor Dr. Dennis O'Connor
- Investigated by the US Dept of Justice
- Hospital in California pays $1.2 million to resolve claims of improper supervision of anesthesia services
- Said no supervisory anesthesiologist was present or immediately available in violation of federal law
- Anesthesia records pre-filled out to make it look like anesthesiologist were there

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Don't Want a False Claims Act Lawsuit

UC-Irvine to Pay $1.2M to Settle Claims of Improper Supervision for Anesthesia

Written by Molly Gamble | March 27, 2013

Social Sharing 0

The Regents of the University of California, the university's governing body, has agreed to pay $1.2 million to resolve allegations that anesthesia was routinely administered at University of California-Irvine by healthcare providers when a supervisory anesthesiologist was not present, according to a news release from the law offices of Louis J. Cohen, PC, which represented the whistleblower in this case.

The settlement stems from a 2008 lawsuit filed by a former UC-Irvine anesthesiologist. His complaint triggered a "multi-year" investigation by the Department of Justice, according to the release.

The complaint alleged that certified registered nurse anesthetists or residents at UC-Irvine administered anesthesia in many instances when the supervisory anesthesiologist was in another facility, which violates federal regulations.

The complaint also alleged that postoperative evaluations would routinely be provided by unsupervised or unlicensed residents, which is also a violation of federal regulations.

A comment from UC-Irvine was not provided in the release.

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Anesthesiology Assistant 1001

- Some states have a practice act for AAs or anesthesiology assistants
- An AA may administer anesthesia only when under the direct supervision of an anesthesiologist only
- Anesthesiologist must also be immediately available if needed
- This means physically in the same department and not occupied in a way to prevent immediate hands on intervention if needed

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Administration by an anesthesiologist's assistant

An anesthesiologist's assistant may administer anesthesia when under the direct supervision of an anesthesiologist. The anesthesiologist must be immediately available if needed. An anesthesiologist is considered "immediately available" to assist the anesthesiologist's assistant under the anesthesiologist's supervision only if he/she is physically located within the same area as the anesthesiologist's assistant, e.g., in the same operative suite, or in the same labor and delivery unit, or in the same procedure room, and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed.

An anesthesiologist's assistant is defined in §410.69(b) as a "…person who – (1) works under the direction of an anesthesiologist; (2) is in compliance with all applicable requirements of State law, including any licensure requirements the State imposes on nonphysician anesthetists; and (3) is a graduate of a medical school-based anesthesiologist's assistant education program that – (A) is accredited by the Committee on Allied Health Education and Accreditation; and (B) includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background."

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http://anesthesiaassistant.com/

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Anesthesia Services Policies 1001

- MS bylaws or R/R must include criteria for determining anesthesia privileges
- Board must approve the specific anesthesia service privilege for each practitioner who does anesthesia services
- Must address the type of supervision required, if any, and must specify who can supervise CRNA (unless exempted)
- Privileges must be granted in accordance with state law and hospital policy

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Supervision by Operating Surgeon 1002

- If hospital allows supervision by operating surgeon of CRNAs
- Medical staff bylaws or R/R must specify for each category of operating practitioners
- The type and complexity of the procedures that the category of practitioner may supervise
- See resources at the end that discuss standards of practice on credentialing and privileging

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Survey Procedure 1001

- Surveyor is to review the qualifications of individuals allowed to give anesthesia to make sure they are qualified
- Make sure licenses and certifications are current
- Determine if state has opted out for CRNA supervision
- Review the hospital P&P to make sure supervision of CRNA and AA meets requirements
- Review qualifications of other anesthesia services to make sure they are consistent with the hospital anesthesia policies

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Anesthesia Services and Policies 1002

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

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Anesthesia Policies Required 1002

- Policies required (continued);
  - Protocols for life support function such as cardiac or respiratory emergencies
  - Reporting requirements
  - Documentation requirements
  - Equipment requirements
  - Monitoring, inspecting, testing and maintenance of anesthesia equipment
  - Pre and post anesthesia responsibilities

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Pre-Anesthesia Assessment 1003

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

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Pre-anesthesia Evaluation 1003

- Must have policies to make sure the pre-anesthesia guidelines are met
- Pre-anesthesia evaluation must be completed, documented and done by one qualified to administer anesthesia within 48 hours
  - Can not delegate the pre-anesthesia assessment to someone who is not qualified which is 5 categories mentioned
  - Must be done within 48 hours of surgery or procedure

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5 Qualified to do Pre-Anesthesia Assessment

- Anesthesiologist
- CRNA under the supervision of operating surgeon or anesthesiologist unless state is exempt
- AA under supervision of anesthesiologist
- MD or DO other than an anesthesiologist
- A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law

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Pre-anesthesia Evaluation 1003

- Delivery of **first dose of medication** for inducing anesthesia marks end of 48 hour time frame
- Pre-anesthesia assessment must be done for generals, regional, or MAC which includes deep sedation
- If moderate sedation current practice dictates a pre-procedure assessment but not a pre-anesthesia assessment
- See TJC standards at the end of presentation on presedation assessment for patients having moderate sedation

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Pre-anesthesia Evaluation 1003

- CMS says pre-anesthesia must be done within 48 hours of procedure or surgery
- However, some of the elements in the evaluation can be collected prior to the 48 hours time frame but it can never be more than 30 days
  - If you saw a patient on Friday for Monday surgery would need to show that on Monday there were no changes
  - CMS also specifies the four of the six required elements that can be performed within 30 days

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Pre-Anesthetic Assessment 1003

- Must include;
  - Review of medical history, including anesthesia, drug, and allergy history (within **48 hours**)
  - Interview and exam the patient
    - Within **48 hours** and rest are updated in 48 hours but can be collected within 30 days
  - Notation of anesthesia risk (such as ASA level)
  - Potential anesthesia problems identification (including what could be complication or contraindication like difficult airway, ongoing infection, or limited intravascular access)

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Pre-Anesthetic Assessment 1003

- Pre-anesthetic Assessment to include (continued);
  - Additional data or information in accordance with SOC or SOP
    - Including information such as stress test or additional consults
  - Develop plan of care including type of medication for induction, maintenance, and post-operative care
  - Of the risks and benefits of the anesthesia

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Developed by the American Association of Nurse Anesthetists - 1991

PREANESTHESIA EVALUATION

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

Proposed Procedure | Pre-Procedure Vital Signs B/P P R T

Previous Anesthesia / Operations | None ☐ | Current Medications | None ☐

Family History of Anesthesia Complications | None ☐ | Allergies | NKDA ☐

AIRWAY / TEETH / HEAD & NECK

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

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

ASA Physical Status Classification System

- ASA PS I – normal healthy patient
- ASA PS II – patient with mild systemic disease
- ASA PS III – patient with severe systemic disease
- ASA PS IV – patient with severe systemic disease that is a constant threat to life
- ASA PS V – moribund patient who is not expected to survive without the operation
- ASA PS VI – declared brain-dead patient whose organs are being removed for donor purposes

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Survey Procedure Pre-anesthesia Evaluation

- Surveyor to review sample of inpatient and outpatient records who had anesthesia
- Make sure pre-anesthesia evaluation done and by one qualified to deliver anesthesia
- Determine the pre-anesthesia evaluation had all the required elements
- Make sure done within 48 hours before first does of medication given for purposes of inducing anesthesia for the surgery or procedure
- ASA and AANA has pre-anesthesia standards that hospitals should be familiar with

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ASA Guideline Pre-anesthesia

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

1 www.asahq.org/publicationsAndServices/standards/03.pdf American Society of Anesthesiologist

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STANDARDS FOR BASIC ANESTHETIC MONITORING

Committee of Origin: Standards and Practice Parameters

(Approved by the ASA House of Delegates on October 21, 1986, and last amended on October 20, 2010 with an effective date of July 1, 2011)

These standards apply to all anesthesia care although, in emergency circumstances, appropriate life support measures take precedence. These standards may be exceeded at any time based on the judgment of the responsible anesthesiologist. They are intended to encourage quality patient care, but observing them cannot guarantee any specific patient outcome. They are subject to revision from time to time, as warranted by the evolution of technology and practice. They apply to all general anesthetics, regional anesthetics and monitored anesthesia care. This set of standards addresses only the issue of basic anesthetic monitoring, which is one component of anesthesia care. In certain rare or unusual circumstances, 1) some of these methods of monitoring may be clinically impractical, and 2) appropriate use of the described monitoring methods may fail to detect untoward clinical developments. Brief interruptions of continual† monitoring may be unavoidable. These standards are not intended for application to the care of the obstetrical patient in labor or in the conduct of pain management.

1. STANDARD I

Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care.

1.1 Objective –

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$ETCO_2$ for Moderate and Deep Sedation ASA

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.

http://asahq.org/For-Healthcare-Professionals/Standards-Guidelines-and-Statements.aspx

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ASA Practice Advisory Preanesthesia Evaluation

http://asahq.org/For-Members/Practice-Management/Practice-Parameters.aspx

SPECIAL ARTICLE

Anesthesiology 2002; 96:485–96

Practice Advisory for Preanesthesia Evaluation

A Report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation

PRACTICE advisories are systematically developed reports that are intended to assist decision-making in areas of patient care where scientific evidence is insufficient to develop an evidence-based model. Practice advisories provide a synthesis of opinion from experts, open forums, and other public sources. Practice advisories report the current state of scientific literature, but are not supported by literature to the same degree as standards or guidelines due to the lack of sufficient numbers of adequately controlled studies.

Advisories are not intended as guidelines, standards, or absolute requirements. The use of practice advisories cannot guarantee any specific outcome. They may be adopted, modified, or rejected according to clinical needs and constraints. Practice advisories are subject to periodic revision as warranted by the evolution of medical knowledge, technology, and practice.

Definition of Preanesthesia Evaluation

the patient's medical records, interview, physical examination, and findings from medical tests and evaluations. As part of the preanesthesia evaluation process, the anesthesiologist may choose to consult with other healthcare professionals to obtain information or services that are relevant to perioperative anesthetic care. Preoperative tests, as a component of the preanesthesia evaluation, may be indicated for various purposes, including but not limited to (1) discovery or identification of a disease or disorder that may affect perioperative anesthetic care, (2) verification or assessment of an already known disease, disorder, medical or alternative therapy that may affect perioperative anesthetic care, and (3) formulation of specific plans and alternatives for perioperative anesthetic care. For this Advisory, *perioperative* refers to the care surrounding operations and procedures.

The assessments made in the process of a preanesthesia evaluation may be used to educate the patient, organize resources for perioperative care, and formulate

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ASA Standard on Preanesthesia Care

BASIC STANDARDS FOR PREANESTHESIA CARE

Committee of Origin: Standards and Practice Parameters

(Approved by the ASA House of Delegates on October 14, 1987, and last affirmed on October 20, 2010)

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

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

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

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

http://asahq.org/For-Healthcare-Professionals/Standards-Guidelines-and-Statements.aspx

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Standards for Nurse Anesthesia Practice

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

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AANA Standards for Nurse Anesthesia

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

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

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

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

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

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

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

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Intra-operative Anesthesia Record 1004

- Need policies related to the intra-operative anesthesia record
- Need intra-operative anesthesia record for patients who have general, regional, deep sedation or MAC
- Still need monitoring of moderate sedation before, during, and after but the monitoring required by this section does not apply to that
- See the TJC standards on this

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So What's In Your Policy?

MODERATE SEDATION POLICY FOR NON-ANESTHESIA STAFF

Purpose
The purpose of this policy is to set forth procedures for the management of all patients receiving moderate sedation while undergoing therapeutic, diagnostic or surgical procedures at Methodist Lebonheur Healthcare System Hospitals. These guidelines apply to all locations where moderate sedation is administered. These include, but are not limited to:

Endoscopy Suites
Critical Care areas
Emergency Department
Diagnostic Imaging
Operating Room
Cardiac Cath Lab
Starlight Room

Focus
This policy is not intended to apply to the following settings:

General anesthesia
Administration of medication intended solely to counteract anxiety
Administration of medication intended for deep sedation as defined by department(s) of anesthesia.
Management of pain before, after, or unrelated to a therapeutic or diagnostic procedure
The use of parental or oral medications in the setting of alcohol withdrawal management

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Moderate Sedation Toolkit

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

http://www.patientsafety.gov/pubs.html#sedate

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Guide To
Moderate Sedation / Analgesia By Non-Anesthesiologists

Drug	Onset of action (Dose-dependent)	Duration of effect (Dose-dependent)	Initial Dose ADULTS	Initial Dose CHILDREN	Titration	Special instructions
Miscellaneous Agents						
Chloral Hydrate (Noctec)	PO: 30 - 60 minutes PR: 30 - 60 minutes	PO: 4 - 8 hours PR: 4 - 8 hours	PO: 500 - 1000 mg PR: 500 - 1000 mg	PO: 25-100 mg/kg (max: 1.5 gm/ dose)	25 - 50 % of the initial dose every 30 - 45 minutes prn.	Give 30-60 minutes prior to procedure. Can cause nausea, vomiting. Can premedicate with promethazine (12.5-25 mg). (Max. 2 gm/ day)
Diphenhydramine (Benadryl)	PO: 10 – 30 minutes IV: 1 – 10 minutes	PO: 4 – 6 hours IV: 2 – 6 hours	PO: 25 - 50 mg IV: 10 - 50 mg	PO: 1 mg/kg IV: 0.5 - 1 mg/kg (max: 50 mg / dose)	25 - 50 % of the initial dose every 15 - 30 minutes prn.	Only use as adjunct. Evidence as only agent for conscious sedation are limited. Can cause excitation in young children.
Droperidol (Inapsine)	IV: 5 - 10 minutes	IV: 2 - 4 hours	IV: 2.5 - 10 mg	IV: 0.05 - 0.1 mg/kg Not a first-line agent	25 - 50 % of the initial dose every 5 - 15 minutes prn.	All patients should undergo a 12-lead EKG to assess QT interval prior to procedure. Avoid if risks of arrhythmias. Antiemetic properties. Can cause extrapyramidal symptoms.
Ketamine (Ketalar)	PO: 15 - 30 minutes IV: 30 - 60 seconds	PO: 15 - 30 minutes IV: 5 - 15 minutes	PO: 5 - 10 mg/kg IV: 1 - 3 mg/kg	PO: 5 - 10 mg/kg IV: 0.5 - 1 mg/kg	25 - 50 % of the initial dose every 5 - 15 minutes prn.	Sedation / analgesia. Can cause emergence reactions, cardiovascular side effects, hypersalivation. Infuse over 1-2 min. Can be given IM.
Pentobarbital (Nembutal)	PO,PR: 30 minutes IV: 30 - 60 seconds	PO,PR: 1 - 4 hours IV: 15 - 30 minutes	PO,PR: 60 - 200 mg IV: 50 - 100 mg	PR,PO: 3 - 6 mg/kg IV: 1 - 3 mg/kg (max: 100 mg / dose)	25 - 50 % of the initial dose every 5 - 15 minutes prn.	Sedation-hypnotic effects, no analgesia. Administered IV over 2-5 minutes. Accumulation with repeated doses. Can be given IM.

*** Droperidol ♦: -Should be used with extreme caution in patients with risk factors for prolonged QT syndrome (ie, CHF; bradycardia; cardiac hypertrophy; significant cardiac disease; diuretic use; hypokalemia; hypomagnesemia; concomitant use of antiarrhythmics, MAO inhibitor, erythromycin, haloperidol; age > 65 years; alcohol abuse.
-Continuous EKG should be done prior to treatment and 2-3 hours after treatment to monitor arrhythmias.

*** Ketamine: -Emergence reactions (hallucination, delirium) and cardiovascular side effects can be attenuated by administering midazolam or any other benzodiazepines prior to ketamine use.
-Hypersalivation can be attenuated by administering atropine (0.01 mg/kg) or glycopyrrolate (0.005 mg/kg) prior to ketamine use.
-Risk of respiratory depression if infused too rapidly. Infuse over 1-2 minutes.
-Use with caution in patients with poorly controlled hypertension, congestive heart failure, angina or any other coronary artery diseases.

*** Pentobarbital: -When given orally or rectally, pentobarbital should be given at least 30 minutes prior to performing a procedure.

*** In obese patients, the dose should be calculated based on adjusted body weight.

♦ See FDA Warning

Reversal Agents						
Flumazenil (Romazicon)	30-60 seconds	30-60 minutes	IV: 0.1 - 0.2 mg	(< 20kg): 0.01 mg/kg (> 20 kg): 0.2 mg/dose	May repeat after 1 minute IV prn.	Effective in reversing excessive sedation – not for repiratory depression. May wear off before benzo. Infuse over 15 - 30 seconds.
Naloxone (Narcan)	IV: 1-2 minutes	IV: 45 minutes	IV: 0.2 - 0.4 mg	IV: 0.005 - 0.01 mg/kg	May repeat after 2-3 minutes IV prn.	May wear off before effects of opioids. Infuse total dose over 15 - 30 seconds. Only for use to reverse opioids Can be given IM, SC.

**** Complete monitoring is necessary for at least 90 minutes following the use of any reversal agents.

**** Reversal agents should be used to reverse excessive sedation. (Note that flumazenil may not reverse hypotension or respiratory depression)

**** Use flumazenil cautiously in patients on long term benzodiazepine therapy, history of seizures. May need to redose after 30 – 45 minutes.

**** Careful monitoring should be continued after reversal is initiated.

**** In obese patients, the dose should be calculated based on adjusted body weight.

Intra-operative Anesthesia Record 1004

- Intra-operative Record must contain the following:
  - Include name and hospital id number
  - Name of practitioner who administer anesthesia
  - Techniques used and patient position, including insertion of any intravascular or airway devices
  - Name, dosage, route and time of drugs
  - Name and amount of IV fluids

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Intra-operative Anesthesia Record 1004

- Intra-operative Record must contain the following (continued):
  - Blood/blood products
  - Oxygenation and ventilation parameters
  - Time based documentation of continuous vital signs
  - Complications, adverse reactions, problems during anesthesia with symptom, VS, treatment rendered and response to treatment

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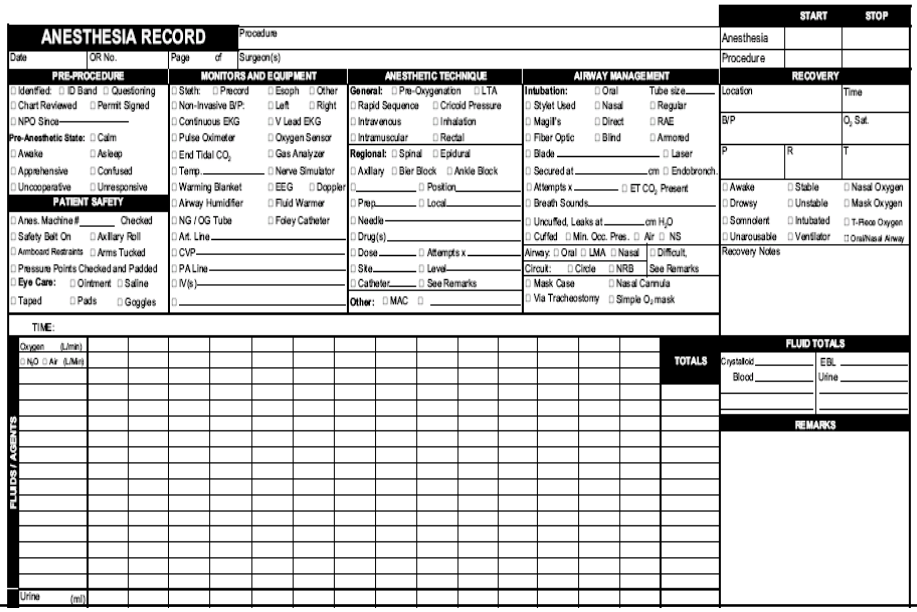


ANESTHESIA RECORD

Procedure

Date | OR No. | Page of | Surgeon(s)

START	STOP
Anesthesia	
Procedure	

PRE-PROCEDURE

☐ Identified: ☐ ID Band ☐ Questioning
☐ Chart Reviewed ☐ Permit Signed
☐ NPO Since
Pre-Anesthetic State: ☐ Calm
☐ Awake ☐ Asleep
☐ Apprehensive ☐ Confused
☐ Uncooperative ☐ Unresponsive

PATIENT SAFETY

☐ Anes. Machine ✓ ☐ Checked
☐ Safety Belt On ☐ Axillary Roll
☐ Armboard Restraints ☐ Arms Tucked
☐ Pressure Points Checked and Padded
☐ **Eye Care:** ☐ Ointment ☐ Saline
☐ Taped ☐ Pads ☐ Goggles

MONITORS AND EQUIPMENT

☐ Steth: ☐ Precord ☐ Esoph ☐ Other
☐ Non-Invasive B/P: ☐ Left ☐ Right
☐ Continuous EKG ☐ V Lead EKG
☐ Pulse Oximeter ☐ Oxygen Sensor
☐ End Tidal CO_2 ☐ Gas Analyzer
☐ Temp. ☐ Nerve Simulator
☐ Warming Blanket ☐ EEG ☐ Doppler
☐ Airway Humidifier ☐ Fluid Warmer
☐ NG / OG Tube ☐ Foley Catheter
☐ Art. Line
☐ CVP
☐ PA Line
☐ IV(s)
☐

ANESTHETIC TECHNIQUE

General: ☐ Pre-Oxygenation ☐ LTA
☐ Rapid Sequence ☐ Cricoid Pressure
☐ Intravenous ☐ Inhalation
☐ Intramuscular ☐ Rectal
Regional: ☐ Spinal ☐ Epidural
☐ Axillary ☐ Bier Block ☐ Ankle Block
☐ ☐ Position
☐ Prep ☐ Local
☐ Needle
☐ Drug(s)
☐ Dose ☐ Attempts x
☐ Site ☐ Level
☐ Catheter ☐ See Remarks
Other: ☐ MAC ☐

AIRWAY MANAGEMENT

Intubation: ☐ Oral Tube size
☐ Stylet Used ☐ Nasal ☐ Regular
☐ Magill's ☐ Direct ☐ RAE
☐ Fiber Optic ☐ Blind ☐ Armored
☐ Blade ☐ Laser
☐ Secured at cm ☐ Endobronch.
☐ Attempts x ☐ ET CO_2 Present
☐ Breath Sounds
☐ Uncuffed, Leaks at cm H_2O
☐ Cuffed ☐ Min. Occ. Pres. ☐ Air ☐ NS
Airway: ☐ Oral ☐ LMA ☐ Nasal ☐ Difficult,
Circuit: ☐ Circle ☐ NRB See Remarks
☐ Mask Case ☐ Nasal Cannula
☐ Via Tracheostomy ☐ Simple O_2 mask

RECOVERY

Location | Time
B/P | O_2 Sat.
P | R | T
☐ Awake ☐ Stable ☐ Nasal Oxygen
☐ Drowsy ☐ Unstable ☐ Mask Oxygen
☐ Somnolent ☐ Intubated ☐ T-Piece Oxygen
☐ Unarousable ☐ Ventilator ☐ Oral/Nasal Airway
Recovery Notes

TIME:

FLUIDS / AGENTS

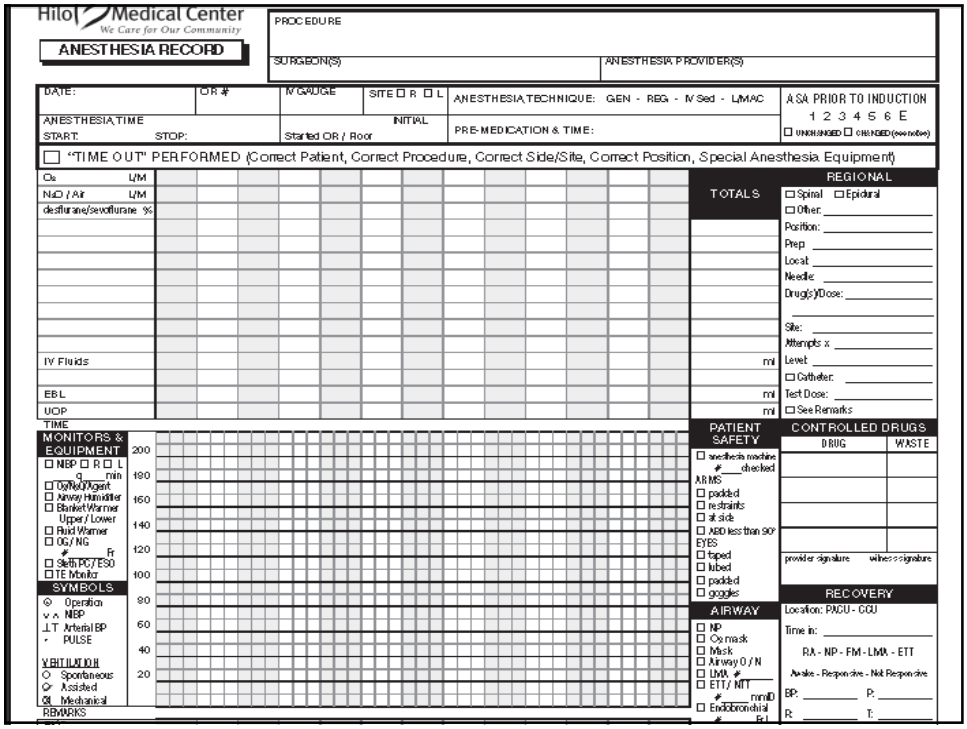
Oxygen (L/min)
☐ N_2O ☐ Air (L/Min)
Urine (ml)

TOTALS

FLUID TOTALS

Crystaloid | EBL
Blood | Urine

REMARKS



Hilo Medical Center
We Care for Our Community

ANESTHESIA RECORD

PROCEDURE
SURGEON(S)
ANESTHESIA PROVIDER(S)

DATE: | OR # | IV GAUGE | SITE ☐ R ☐ L | ANESTHESIA TECHNIQUE: GEN - REG - IV Sed - LMAC | ASA PRIOR TO INDUCTION 1 2 3 4 5 6 E ☐ UNCHANGED ☐ CHANGED (see notes)

ANESTHESIA TIME START: STOP: | INITIAL Started OR / Room | PRE-MEDICATION & TIME:

☐ "TIME OUT" PERFORMED (Correct Patient, Correct Procedure, Correct Side/Site, Correct Position, Special Anesthesia Equipment)

O2 L/M
N2O / Air L/M
desflurane/sevoflurane %
IV Fluids
EBL
UOP
TIME

TOTALS
ml
ml
ml

REGIONAL
☐ Spinal ☐ Epidural
☐ Other:
Position:
Prep
Local
Needle
Drug(s)/Dose:
Site:
Attempts x
Level
☐ Catheter:
Test Dose:
☐ See Remarks

MONITORS & EQUIPMENT
☐ NIBP ☐ R ☐ L
q min
☐ Oxy Mod Agent
☐ Airway Humidifier
☐ Blanket Warmer Upper / Lower
☐ Fluid Warmer
☐ OG / NG
Fr
☐ Sleth PC / ESO
☐ TE Monitor

SYMBOLS
⊙ Operation
v ^ NIBP
LT Arterial BP
• PULSE

VENTILATION
○ Spontaneous
◐ Assisted
● Mechanical

200 190 160 140 120 100 90 60 40 20

REMARKS

PATIENT SAFETY
☐ anesthesia machine # checked
ARMS
☐ padded
☐ restraints
☐ at side
☐ ABD less than 90°
EYES
☐ taped
☐ lubed
☐ padded
☐ goggles

AIRWAY
☐ NP
☐ Oxy mask
☐ Mask
☐ Airway O / N
☐ LMA #
☐ ETT / NTT # mmD
☐ Endobronchial # Fr

CONTROLLED DRUGS
DRUG | WASTE
provider signature | witness signature

RECOVERY
Location: PACU - CCU
Time in:
RA - NP - FM - LMA - ETT
Awake - Responsive - Not Responsive
BP: P:
R: T:

ASA Document Anesthesia Care

STATEMENT ON DOCUMENTATION OF ANESTHESIA CARE

Committee of Origin: Quality Management and Departmental Administration

(Approved by the ASA House of Delegates on October 15, 2003, and amended on October 22, 2008)

Documentation is a factor in the provision of quality care and is the responsibility of an anesthesiologist. While anesthesia care is a continuum, it is usually viewed as consisting of preanesthesia, intraoperative/procedural anesthesia and postanesthesia components. Anesthesia care should be documented to reflect these components and to facilitate review.

The record should include documentation of:

I. Preanesthesia Evaluation*

A. Patient interview to assess:
   1. Patient and procedure identification.
   2. Verification of admission status (inpatient, outpatient, "short stay", etc.)
   3. Medical history
   4. Anesthetic history
   5. Medication/Allergy history
   6. NPO status

B. Appropriate physical examination, including vital signs and documentation of airway assessment.

C. Review of objective diagnostic data (e.g., laboratory, ECG, X-ray) and medical records.

D. Medical consultations when applicable.

E. Assignment of ASA physical status, including emergent status when applicable.

F. Formulation of the anesthetic plan and discussion of the risks and benefits of the plan

http://asahq.org/For-Healthcare-Professionals/Standards-Guidelines-and-Statements.aspx

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Post-anesthesia Evaluation 1005

- Must have policies in place to ensure compliance with the post-anesthesia evaluation requirements
- Post-anesthesia evaluation must be done by some one who is qualified to give anesthesia
  - 5 who are qualified to give as previously mentioned
  - Can not delegate it to a RN, PA, or NP
- Must be done no later than 48 hours after the surgery or procedure requiring anesthesia services

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Post-anesthesia Evaluation 1005

- Must be completed as required by hospital policies and procedures
- Must be completed as required by any state specific laws
  - State law can be more stringent but not less stringent so if state wants to require it to be done in 24 instead of 48 hours you must comply
- P&Ps must be approved by the MS
- P&Ps must reflect current standards of care

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Post Anesthesia Evaluation 1005

- Document in chart within 48 hours for patients receiving anesthesia services (general, regional, deep sedation, MAC)
- For inpatients and outpatients now
  - So may have to call some outpatients if not seen before they left the hospital
  - Note different for **CAH hospitals** under their manual under tag 322 (perform before patient leaves the hospital)
- Does not have to be done by the same person who administered the anesthesia

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Post Anesthesia Evaluation 1005

- Has to be done only by anesthesia person (CRNA, AA, anesthesiologist) or qualified doctor, dentist, podiatrist, or oral surgeon
- 48 hours starts at time patient moved into PACU or designated recovery area (SICU etc.)
- 48 hour is an outside parameter
- Individual risk factors may dictate that the evaluation be completed and documented sooner than 48 hours
  - This should be addressed by hospital P&P

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Post Anesthesia Evaluation 1005

- Evaluation can not generally be done at point of movement to the recovery area since patient not recovered from anesthesia
  - Patient must be sufficiently recovered so as to participate in the evaluation e.g. answer questions, perform simple tasks etc.

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Post Anesthesia Evaluation

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

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Post-Anesthesia Assessment to Include 1005

- Respiratory function with respiratory rate, airway patency and oxygen saturation
- CV function including pulse rate and BP
- Mental status, temperature
- Pain
- Nausea and vomiting
- Post-operative hydration
  - Consider having a form to capture these requirements

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Post-Anesthesia Survey Procedure

- Surveyor is review medical records for patients having anesthesia and make sure post-anesthesia evaluation is in the chart
- Surveyor to make sure done by practitioner who is qualified to give anesthesia
- Surveyor to make sure all postanesthesia evaluations are done within 48 hours
- Surveyor to make sure all the required elements are documented for the postanesthesia evaluation

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Post Anesthesia ASA Guidelines

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

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STANDARDS FOR POSTANESTHESIA CARE

Committee of Origin: Standards and Practice Parameters

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

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

STANDARD I

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

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

STANDARD II

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

STANDARD III

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

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ASA Standard Post-anesthesia Care

STANDARDS FOR POSTANESTHESIA CARE

Committee of Origin: Standards and Practice Parameters

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

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

STANDARD II

A PATIENT TRANSPORTED TO THE PACU SHALL BE ACCOMPANIED BY A MEMBER OF THE ANESTHESIA CARE TEAM WHO IS KNOWLEDGEABLE ABOUT THE

http://asahq.org/For-Healthcare-Professionals/Standards-Guidelines-and-Statements.aspx

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ASA Practice Guideline Postanesthesia Care

http://asahq.org/For-Members/Practice-Management/Practice-Parameters.aspx

SPECIAL ARTICLE

Anesthesiology 2002; 96:742–52

Practice Guidelines for Postanesthetic Care

A Report by the American Society of Anesthesiologists Task Force on Postanesthetic Care

PRACTICE guidelines are systematically developed recommendations that assist the practitioner and patient in making decisions about health care. These recommendations may be adopted, modified, or rejected according to clinical needs and constraints.

Practice guidelines are not intended as standards or absolute requirements. The use of practice guidelines cannot guarantee any specific outcome. Practice guidelines are subject to periodic revision as warranted by the evolution of medical knowledge, technology, and practice. The Guidelines provide basic recommendations that are supported by analysis of the current literature and by a synthesis of expert opinion, open forum commentary, and clinical feasibility data (Appendix).

A. Definition of Postanesthetic Care

The literature does not provide a standard definition for postanesthetic care. For these Practice Guidelines, postanesthetic care refers to those activities undertaken to manage the patient following completion of a surgical procedure and the concomitant primary anesthetic. anesthesia or sedation and analgesia care. This is accomplished by evaluating available evidence and providing recommendations for patient assessment, monitoring, and management with the goal of optimizing patient safety. It is expected that each recommendation will be individualized according to the needs of each patient.

C. Focus

These Guidelines focus on the perioperative management of patients with the goal of improving postanesthetic quality of life, reducing postoperative adverse events, providing a uniform assessment of recovery, and streamlining postoperative care and discharge criteria.

These Guidelines apply to patients of all ages who have just received general anesthesia, regional anesthesia, or moderate or deep sedation. The Guidelines may need to be modified to meet the needs of certain patient populations, such as children or the elderly. The Guidelines do not apply to patients receiving infiltration local anesthesia without sedation, patients receiving minimal sedation (anxiolysis),[1] or patients receiving intensive care

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AANA Post-anesthesia Care Standards

Postanesthesia Care Standards for the Certified Registered Nurse Anesthetist

www.aana.com/resources2/professionalpractice/Pages/Postanesthesia-Care-Standards.aspx

Printer Friendly Version

Standard VII of AANA Scope and Standards for Nurse Anesthesia Practice:
Evaluate the patient's status and determine when it is safe to transfer the responsibility of care. Accurately report the patient's condition, including all essential information, and transfer the responsibility of care to another qualified healthcare provider in a manner that assures continuity of care and patient safety.

Standard VII is not specific to postanesthesia care, but includes all transfers of the responsibility of care for the patient from the CRNA to another qualified healthcare provider. For example, transfers of the responsibility of care may occur when the CRNA transfers care to another anesthesia professional during the provision of anesthesia care or when the CRNA transfers care to another qualified healthcare provider for postanesthesia recovery. During all transfers of care, the CRNA is responsible for first determining that it is safe to transfer the responsibility of care of the patient to another qualified healthcare provider and to accurately report all essential information to the qualified healthcare provider who accepts responsibility for the patient's care.

That said, the AANA believes that the postanesthesia period is an extension of the anesthesia process and warrants additional consideration. The anesthesia professional's responsibility to the patient extends through this period. Regardless of the practice setting, this responsibility includes a thorough knowledge of the patient's needs, the communication of those needs to qualified providers, and the assurance that the postanesthesia care will be consistent with the patient's needs.

Anesthesia services are being performed in increasingly diverse settings as medical care services expand and change. These standards shall apply to all settings where postanesthesia care is rendered.

The anesthesia professional, with specialized knowledge and skills, has a primary role in overseeing postanesthesia

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CAH Hospitals

- Anesthesia standard starts at tag C-0322 and see 323
  - Most of the sections are the same
- The PPS hospital anesthesia standards provide more detailed information on how this section will be surveyed
  - Will cover the differences for CAH hospitals
- Much shorter section
  - Does not mention CRNA going to OB unit to put in epidural but most likely is treated the same

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Anesthesia Standard CAH

C-0322

§485.639(b) Standard: Anesthetic Risk and Evaluation

(1) A qualified practitioner, as specified in paragraph (a) of this section, must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed.

(2) A qualified practitioner, as specified in paragraph (c) of this section, must examine each patient before surgery to evaluate the risk of anesthesia.

(3) Before discharge from the CAH, each patient must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in paragraph (c) of this section.

Interpretive Guidelines §485.639(b)

The pre-anesthesia evaluation must be performed prior to inpatient or outpatient surgery. The pre-anesthesia evaluation must be performed by an individual qualified to administer anesthesia. The pre-operative anesthetic evaluation should include:

- Notation of anesthesia risk

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CAH Pre-anesthesia Assessment C-322

- Must be done by qualified practitioner
  - Example would include CRNA and anesthesiologist
- Includes what must be in the preanesthesia assessment
  - Notation of anesthesia risk
  - Anesthesia, drug and allergy history
  - Any potential anesthesia problems identified
  - Patient's condition prior to induction of anesthesia

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Post Anesthesia Assessment CAH 322

- Cardiopulmonary status
- Level of consciousness
- Any follow-up care and/or observations and
- Any complications occurring during post-anesthesia recovery
- States that the post-anesthesia follow up report must be written prior to discharge from anesthesia services
  - This is different for other hospitals that have 48 hours

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The End ! Questions??

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