Critical Access Hospital CoPs 2026 Part 4 of 5

Infection Prevention & Control and ASP, Clinical Records, Provision of Services: Outpatient, Laboratory, Nursing

Speaker



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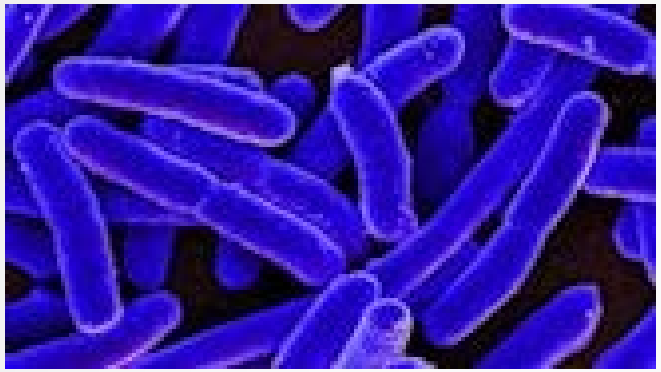
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DISCLAIMER

The information provided during this program/webinar is informational only. It is not intended to be legal advice or to establish an attorney-client relationship. Please consult with your in-house counsel or professional legal representative for advice.

Objectives

- Recall: the infection preventionist must be appointed by the Board
- Describe: responsibilities of the Board toward infection prevention and ASP program
- Explain: three time-frames in which to administer medications
- Discuss: CMS requirement that a plan of care be developed and completed



Infection Prevention and Control (IPC) and Antibiotic Stewardship Programs

Tag Nos. 1200 – 1250

Introduction

- Major updates in 2019: Burden Reduction Rule
  - Starts on page 495
- Updates published in 2026 manual and regulation of August 2025
  - Interpretive Guidelines and Survey Procedures pending
- June 2022 – published Interpretive Guidelines and Survey Procedures for Acute in Appendix A only
  - Consider using Appendix A – regulations very similar

4 Revised Requirements

- 1. Infection prevention and control program organization and policies
- 2. Antibiotic stewardship program organization and policies
- 3. Leadership responsibilities
- 4. Unified and integrated infection prevention and control and antibiotic stewardship programs – multi-hospital systems
  - Added for CAHs August 2025

Facility Wide Programs 1200

- **Condition:** Must have an active facility-wide program for surveillance, prevention, and control of HAI and other infectious diseases
  - Must follow nationally recognized infection prevention and control (IPC) guidelines
  - Include best practices to reduce transmission of HAI and antibiotic resistance
- Infection prevention and control problems and antibiotic use issues identified must be addressed in the QAPI program
- Guidelines & Survey procedures pending

Infection Control Organizations

- Examples: CDC, APIC, SHEA, AORN and OSHA
  - CDC: Center for Disease Control
  - AORN: Association for periOperative Registered Nurses
  - APIC: Association for Professionals in Infection Control and Epidemiology
  - SHEA: Society for Healthcare Epidemiology of America
  - IDSA: Infectious Disease Society of American

Infection Preventionist C1204

- Standard: Infection prevention and control program organization and policies
- Hospital must demonstrate that the (individual/individuals) responsible for the prevention and control program is/are
  - Qualified through education, training, experience, or certification
  - Board must appoint after approval of Medical Staff leadership and nursing leadership
  - Interpretive guidelines are pending
- APIC has a competency model

APIC Self Assessment

Name: _____

Date: _____

Competency Self-Assessment Activity for Novice or Becoming Proficient IPs

CBIC Core Competencies – APIC Competency Model Future-Oriented Competency Domains

Self-Assessed Rating Scale and Comfort Level (Knowledge/Skills/Experience/Confidence):
1. No idea 2. Unsure 3. Some knowledge 4. Know it

Competency categories, CBIC domains	IP practice areas as identified in CBIC practice analysis	Assessment of personal competency in each practice area	For each category list one specific question you have and/or learning goal (something you would like to learn more about!)
For more details on the CBIC exam content categories visit https://www.cbic.org/CBIC/Exam-Prep-Resources.htm			
Identification of infectious disease processes (CBIC) *22 exam items	a. Interpret the relevance of diagnostic and laboratory reports	1 2 3 4	• Specific IPC question you have (could be related to your own facility) and/or learning goal (area you want to learn more about).
	b. Identify appropriate practices for specimen collection, transportation, handling, and storage	1 2 3 4	
	c. Correlate clinical signs and symptoms with infectious disease process	1 2 3 4	
	d. Differentiate between colonization, infection and contamination	1 2 3 4	
	e. Differentiate between prophylactic, empiric and therapeutic uses of antimicrobials	1 2 3 4	
Surveillance and epidemiologic	a. Design of surveillance systems	1 2 3 4	• Specific IPC question you have (could be related to your own facility) and/or learning goal (area you want to learn more about).
	b. Collection and compilation of surveillance data	1 2 3 4	

Prevent & Control Transmission C1206

- Program, as documented, must:
  - Prevent and control the transmission of infections
  - Includes preventing infections within the hospital and between the hospital and other institutions and settings
- Guidelines and Survey procedures are pending

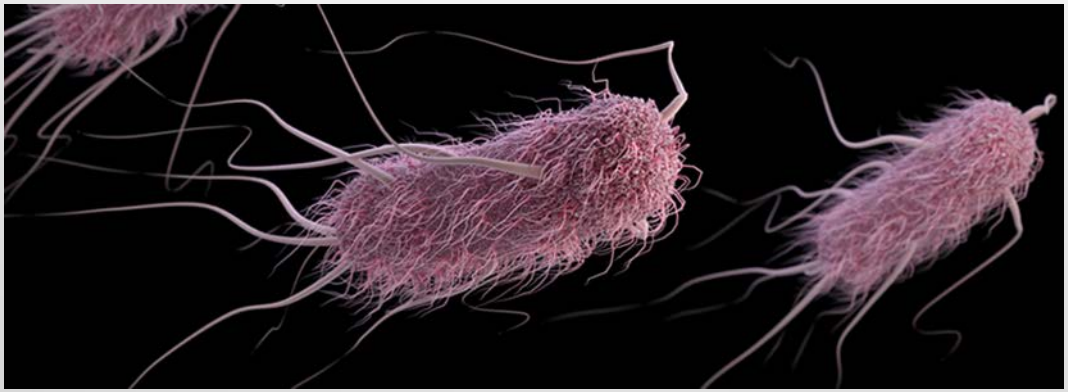


Program Essentials C1208

- Prevention and control includes surveillance, prevention, and control of HAIs
- Includes maintaining a clean and sanitary environment to avoid sources and transmission of infection
  - No blood on the walls or floor
  - Proper hand hygiene
- Plus – program must address any issues identified by public health authorities

Scope and Complexity C1210

- IC program reflects the scope and complexity of the hospital service provided
  - Program must look at all departments/services
  - I.e., - transplant service, labor and delivery, chemo unit



ASP Organization & Policies C1212

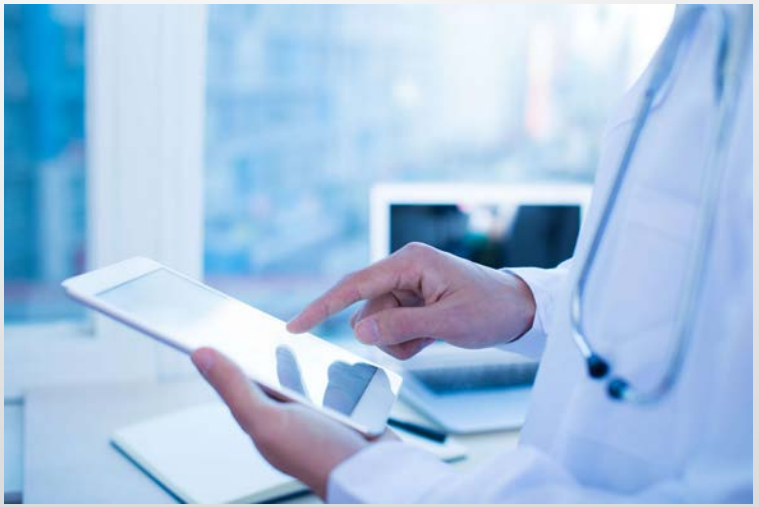
- Standard: Antibiotic stewardship program organization and policies
- Governing body appoints the individual/individuals as leader(s) of the antibiotic stewardship program
  - Based on recommendations of medical staff and pharmacy leadership
- Must be qualified
  - Education – training – experience in infectious diseases
- Organization and policies must ensure such
- Guidelines and survey procedures pending

Facility Wide Program C1218

- Antibiotic Stewardship Program (ASP) must
  - Be facility wide
  - Show coordination among all components responsible for the ASP
  - Includes the IC program, QAPI program, nursing and medical services, and pharmacy services
- Guidelines and survey procedures pending

Documentation C1219 & 1220

- Document
  - Use of evidence-based antibiotics in all departments and services (C1219)
  - Improvements in proper antibiotic use
    - I.e., - reductions in CDI (C-diff) and antibiotic resistance in all departments (C1220)



Control, Prevention, ASP and Leadership

- Must use best practices and nationally recognized guidelines in the ASP (C1221)
- Program reflects the scope and complexity of the hospital services provided (C1223)
- Standard: Leadership responsibilities
- The board must make sure systems are in place:
  - Track all infection surveillance, prevention, and control
  - Antibiotic use activities
  - To show success and that activities are sustainable (C1225)

Board & Preventionist's Duties

- Board – ensure all HAI and infectious diseases identified by the IP are identified in the ASP and with QAPI leadership (C1229)
- IP responsible to
  - Develop and implement hospital wide policies (C1231)
    - Surveillance, prevention, and control policies
    - Make sure follow national guidelines
  - Document the infection control program
    - Including its surveillance, prevention, and control activities (1235)

Preventionist's Responsibilities

- Communicate and collaborate with the QAPI program on IC issues (C1237)
- Provide competency-based training to the
  - All staff and those providing contracted services (C1239)
  - On practical application of the IC guidelines and P&Ps
- For the prevention and control of HAIs (C1240)
  - Includes auditing the IC policies
- Communicate and collaborate with ASP (C1242)

Question

Creek CAH has experienced a spike in surgical site infections over the past 6 months. The Infection Preventionist conducted an audit of the surgery and PACU units only. No other unit or service was reviewed or included in the audit.

State arrived for a Complaint-based survey. Will Creek be cited under Infection Prevention and Control?

- Yes – did not include all areas in the care cycle: Med-Surg, central supply – tray processing
- No – as SSI were probably limited to what happened in or after surgery
- Not sure – hard to pinpoint where a lapse might have occurred

ASP Leader Responsibilities

- Develop & implement the hospital wide ASP (C1244)
  - Based on nationally recognized guidelines
  - Monitor and improve the use of antibiotics
- Document all activities (C1246)
- Communicate and collaborate on antibiotic use with (C1248)
  - Medical staff >Nursing leadership
  - Pharmacy leadership >Infection Prevention & Control
  - QAPI program

ASP Leader Responsibilities – cont'd

- Ensure competency-based training and education to
  - Hospital personnel
  - Staff/medical staff
  - Contract employees
  - On ASP guidelines and P&Ps (C1250)



CDC Core Elements of an ASP

- CDC updated core elements has examples of leadership commitment to the ASP
- Highlights the priority interventions and process measures
- Emphasizes the key role of the pharmacists and nurse in improving antibiotic use
- Assessment tool available (see next slide)

Introduction

Antibiotics have transformed the practice of medicine, making once lethal infections readily treatable and making other medical advances, like cancer chemotherapy and organ transplants, possible. Prompt initiation of antibiotics to treat infections reduces morbidity and save lives, for example, in cases of sepsis (1). However, about 30% of all antibiotics prescribed in U.S. acute care hospitals are either unnecessary or suboptimal (2, 3).

On This Page

Introduction

Summary of Updates

CDC Efforts to Support Antibiotic Stewardship

References

www.cdc.gov/antibiotic-use/core-elements/hospital.html

The Core Elements of Hospital Antibiotic Stewardship Programs, 2019 [PDF – 40 pages]

Antibiotic Stewardship Program Assessment Tool (Print Only) [PDF – 8 pages]



What's New in the *Core Elements of Hospital Antibiotic Stewardship Programs, 2019* [Video – 5:24]

Core Elements Small and CAHs

- CDC, AHA, Office of Rural Health and Pew Charitable Trusts have practical strategies to implement ASP
- Implementation strategies include:
  - Leadership commitment and accountability
  - Pharmacist leader with drug expertise
  - Evidenced based actions
  - Tracking – such as days of therapy
    - Use the CDC Net
  - Reporting and education

Core Elements Small and CAH

- https://www.cdc.gov/antibiotic-use/healthcare/pdfs/core-elements-small-critical.pdf



Respiratory Illness Reporting New*

- CAH must electronically report information on acute respiratory illnesses
- Including influenzas, SARS-CoV-2/COVID-19, and RSV
- Report must be in standardized format and frequency specified by Secretary

- Memo's rationale: help ensure hospitals have appropriate insight related to evolving infection control needs
- *Memo: https://www.cms.gov/files/document/qso-25-05-hospitals-cahs.pdf

Reporting – cont'd

- Report must include:
  - Confirmed infections for limited set of illnesses among newly admitted and hospitalized patients
    - COVID-19
    - Influenza
    - RSV
  - Total bed census and capacity
    - Including critical care units and age groups
  - Limited patient demographic information
    - Including age

Public Health Emergency Reporting

- In the event Secretary declares a national, State or local PHI for acute respiratory illnesses
- Must also electronically report the following in standardized format and frequency specified by Secretary
  - Supply inventory shortages
  - Staffing shortages
  - Relevant medical countermeasures and therapeutic inventories, usage or both
  - Facility structure and operating status
    - Including CAH/ED diversion status

Information and Frequency

- From the 2024 memo – not in the August regulation
- ALL hospitals and CAHs
  - Exceptions: Psychiatric and Rehab hospitals and distinct part units for each
  - Submit annually in January
- Must submit daily data values on a weekly basis to NHSN
  - Submitted by Tuesday 11:59 pm PT
- Include daily data for each day of the previous week
  - Sunday through Saturday

Second Available Process

- Due to comments provided second process for reporting under certain conditions
- New admissions with confirmed respiratory illnesses
  - COVID-19, influenza, RSV by age group
- Report data as ***weekly totals instead of providing daily data values*** (emphasis added)
- PLUS – staffed bed capacity and occupancy, prevalence of hospitalizations and ICU patient by respiratory illness – ***one-day-a-week snapshot*** (emphasis added)

Benefits and Options

- The one-day-a-week snapshots and weekly total new admits provides a new pathway for weekly reporting
- Strikes a balance between value and burden
- Changes can be made over time based on patient and population health needs and technology advances
- For 2025 information collection will include:

One-Day-a-Week Snapshot	Weekly Total New Hospital Admissions
• Staffed bed capacity and occupancy including adult and pediatric • Hospitalizations prevalence by respiratory illness and bed type	• Total new hospital admissions for adult and pediatric patients by age range, over a defined weekly period

Unified & Integrated System - NEW

- If part of a multi-facility system of separately certified hospitals using governing body legally responsible for 2 or more hospitals can elect to have one
  - Comply with State and local laws
- Must show
  - Integrated programs consider each hospitals unique circumstances, patients, services
  - Establish and implement policies procedures to ensure needs/concerns of each hospital considered
  - Issues to particular facility considered and addressed
- Qualified person(s) with expertise in both communicate and provide training on the program

NHSN Reporting

- From 2019 Hospital Improvement Rule
  - Must optimize antibiotic use via stewardship
  - Program must demonstrate adherence to nationally recognized infection control guidelines and best practices for improving antibiotic use
  - Follow CDC National Healthcare Safety Network
    - Reporting, tracking requirements
      - https://www.cdc.gov/nhsn/cms/cms-faq-aur.html
  - Beginning 2024 – Acute hospitals must attest to reporting Antibiotic Use and Resistance (AUR) to receive credit
  - CAH – must confirm eligibility to participate

NHSN
NHSN Login
About NHSN +
Enroll Here +
Materials for Enrolled Facilities −
Ambulatory Surgery Centers +
Acute Care Hospitals/Facilities +
Long-term Acute Care Hospitals/Facilities +
Long-term Care Facilities +
Outpatient Dialysis Facilities +
Inpatient Rehabilitation Facilities +
Inpatient Psychiatric Facilities +
MDRO & CDI LabID Event Calculator
VAE Calculator
HAI & POA Worksheet Generator
FAQs about HCP Influenza Vaccination Summary Reporting in NHSN
FAQs About the Hemovigilance Module
2015 Rebaseline
Group Users +
Analysis Resources +

Surveillance Reporting for Enrolled Facilities

Reporting & Surveillance Resources for Enrolled Facilities

Acute Care Hospitals/Facilities



Urgent care or other short-term stay facilities (e.g. critical access facilities, oncology facilities, military/VA facilities

More >

Ambulatory Surgery Centers



Outpatient surgery centers.

More >

Long-term Acute Care Facilities



Long-term acute care hospitals (LTACs).

More >

Long-term Care Facilities



Nursing homes, assisted living and residential care, chronic care facilities and skilled nursing facilities.

More >

Outpatient Dialysis Facilities



Outpatient dialysis clinics.

More >

Inpatient Rehabilitation Facilities



Inpatient Rehabilitation Facilities.

More >

Inpatient Psychiatric Facilities



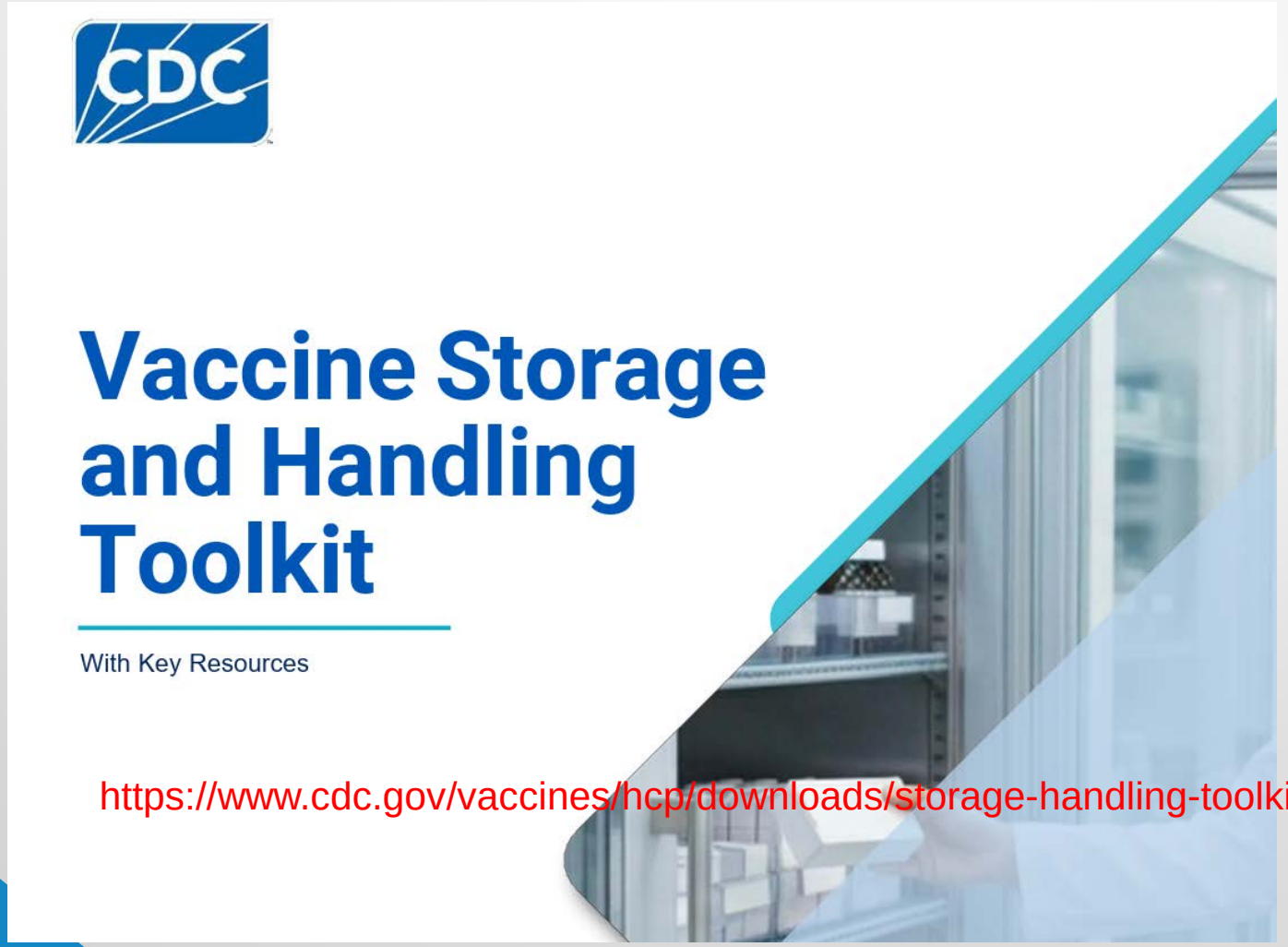


CDC Vaccine Storage and Handling
Safe Injection Practices

CDC Toolkit

- Updated 2022 and an addendum in January 2024
- Discusses cold-chain storage
  - Follow manufactures' recommendations
  - Do not store vaccines in dorm like refrigerators
  - Temperature to range between 36 and 46 degrees
  - State may also have specific requirements
  - Use a medical (biological) refrigerator – monitors temperature and set at mid range (40 degrees)
  - E-mail specific questions to CDC: NIPInfo@cdc.gov

CDC Vaccine Storage & Handling Toolkit



Toolkit - Training

- Ensure staff familiar with storage and handling P&Ps and document training
  - Train in orientation and annually
  - When new vaccines added to inventory
  - CDC has online training programs
- Keep standard operating procedures (SOP) for storage and handling near storage units
- Storage/handling plan can help staff ensure vaccines properly managed

CDC Infection Control in HC Personnel

- From 2019
- 8 elements of occupational health services
  - Provide sufficient resources on immunization program
  - Promote an organizational culture
  - Make sure all staff know the occupational IC P&Ps
  - Monitor performance measures for occupational IC
  - Have job descriptions with infection risks

Infection Control in HC Personnel

Infection Control in Healthcare Personnel

Infrastructure and Routine Practices for Occupational Infection Prevention and Control Services (2019)

Print Version

Infection Control in Healthcare Personnel: Infrastructure and Routine Practices for Occupational Infection Prevention and Control Services (2019) [PDF – 70 pages]

Recommendations Only [PDF – 8 pages]

This document is an update of 4 sections of Part I of the *Guideline for infection control in health care personnel, 1998* and their corresponding recommendations in Part II:

- C. Infection Control Objectives for a Personnel Health Service
- D. Elements of a Personnel Health Service for Infection Control
- H. Emergency-Response Personnel
- J. The Americans With Disabilities Act

www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/index.html

Recommendations in other sections of the 1998 Guideline are current.

Recommendations Table of Contents

1. Leadership and Management
2. Communication and Collaboration
3. Assessment and Reduction of Risks for Infection among Healthcare Personnel Populations
4. Medical Evaluations
5. Occupational Infection Prevention and Control: Education and Training
6. Immunization Programs
7. Management of Potentially Infectious Exposures and Illnesses
8. Management of Healthcare Personnel Health Records



Clinical Records

Tags 1102 – 1128

Requirements C1102

- **Condition:** Clinical Records C1100
- Standard: CAH maintains clinical records system
  - In accordance with P&Ps
- A system of patient records
  - Ways to identify the author
  - Protect security of MR
- Ensure MR are secure – not:
  - Lost – stolen – altered – reproduced in unauthorized manner
- Limit access to only those authorized persons

Requirements – cont'd

- Must have:
  - Current list of authenticated signatures (signature cards)
  - Computer codes
  - Signature stamps
- Be adequately protected and authorized by governing body
- Cross reference inpatients and outpatients
- If transfer to swing bed – can use one MR but need divider

Content of Medical Record

- Content includes (as applicable):
  - Admission
  - Discharge orders
  - Progress notes
  - Nursing notes
  - Graphics – EKGs, fetal monitoring strips
  - Laboratory support documents
  - Other pertinent documents
  - Discharge summaries

Retention and Survey Procedure

- Must be properly filed and retained
- Must have system to be able to retrieve any MR within past **6 years** (C1126)
  - 24/7
- Surveyor will
  - Verify there is a MR for every patient
  - Look to be stored in place protected from damage, flood, fire, theft, etc.
  - Verify confidentiality of medical records is protected
  - Verify department adequately staffed

Medical Records C1104 & 1106

- Must be legible, complete, accurate, readily accessible and systematically organized (C1104)
- "Accurate and complete" = documentation of all:
  - Orders - test results – evaluations – treatments – interventions – care provided
  - Patient's response to those treatments, interventions and care
- Must have director of MR that has been appointed by governing board (C1106)
  - Must have one unified MR service
    - Includes inpatient and outpatient records

What a Record Must Contain C1110

- Identification and social data
- Evidence of properly executed informed consent forms
- Pertinent medical history
- Assessment of the health status and health care needs of the patient
- Brief summary: episode, disposition, and instructions to the patient

Informed Consent

- Include evidence of properly executed informed consent forms
  - For any procedures or surgical procedures
  - Specified by the medical staff
  - Any Federal or State laws that require written patient consent
- Give to patient or representative:
  - Information, explanations, consequences, and options
  - Needed to consent to a procedure or treatment

Example List of Procedures

Procedure Name	Requires Consent
Ablations	Yes
Amniocentesis	Yes
Angiogram	Yes
Angiography	Yes
Angioplasties	Yes
Arthrogram	Yes
Arterial Line insertion (performed alone)	Yes
Aspiration Cyst (simple/minor)	No

Properly Executed Informed Consent

- Name of patient/ legal guardian
- Name of CAH
- Name of procedure(s)
- Name of practitioner(s) performing the procedures(s)
- Signature of patient or legal guardian
- Statement procedure was explained to patient/guardian
- Signature of professional person witnessing the consent
- Name/signature of person who explained the procedure to the patient/guardian
- Date & time consent obtained

Additional Necessary Information

- Information to:
  - Justify admission
  - Support the diagnosis
  - Describe the patient's progress
  - Describe the patient's response to medications
  - Describe the patient's response to services such as interventions, care, treatments



Medical Records - Overall

- Must maintain confidentiality of records
- Take precautions to ensure confidentiality and prevent unauthorized persons from gaining access*
  - Remember OCR and security
- Retention period is 6 years
  - May be longer per state regulation

- AHIMA has practice briefs that can be helpful to hospitals at www.ahima.org
- See Appendix

Discharge Summary

- Discharge summary discusses:
  - Outcome of the hospital stay
  - Disposition of the patient
  - Follow-up care
    - Any post appointments such as home health, hospice, assisted living, LTC, swing bed services
- Required for all hospitals stays and prior to and after swing bed admission
  - Can delegate to NP or PA if state allows
  - See discharge planning standards

Survey Procedures

- Will verify Medical Staff have specified which procedures or treatments need informed consent
- Will verify consent forms contain all the elements
- Will review closed and open medical records
  - At least 10% of average daily census
- Will review to ensure records are complete and accurate
- Will ensure consent policies include CMS requirements, state laws and AO standards

History and Physicals C1114

- All or part of H&P may be delegated to other practitioners – NP/PA
  - Per state law
  - CAH P&P
  - MD/DO assume full responsibility and sign
- Surveyor will look at bylaws to determine when H&P must be done
- Ensure H&P on chart before patient goes to surgery unless an emergency
  - Important issue with CMS and TJC and AO

Responses from CMS

- Question: Does a patient need an H&P done when placed in a swing bed when one was done when they were in an acute care bed?
  - Yes, a new history and physical will need to be complete for the swing bed admission since the swing bed admission is a new patient encounter and not part of the acute inpatient stay
  - If from another facility, you must have a H&P completed if admitted directly to a swing bed
- Question: Is an H&P required for an observation patient?
  - Yes

Response to Treatment C1116

- Must describe the patient's response to treatment:
  - All orders
  - Reports of treatment and medications
  - Nursing notes
  - Complications
  - Other information used to monitor the patients such as progress notes, lab tests, graphics
- All medical records must be promptly filed and completed

Medical Records Must Contain

- All orders – promptly authenticated
- All nursing notes
- All reports of treatment – including complications, HAI
- All medication records – including unfavorable reactions
- All laboratory, radiology reports
- All vital signs
- All other information to monitor patient's condition

Entries in the MR C1118

- All entries must be dated, timed, and authenticated – signed off
  - By MD, DO or other health care professional
  - MS policies specify who may make entries into MR
  - Policies must identify method to identify author
    - Written signature – Initials – Computer key – Other code
- If rubber stamps used – person must sign they will be the only one who uses it
  - NO delegation to someone else
  - Best to NOT use rubber stamps

Computer Codes and Signatures

- List of computer codes, written signatures must be readily available and secured
- Must have sanctions for improper use of stamp, computer key or code signature
- Must have policies/procedures in place and implemented before EHR deemed acceptable



Authentication of Entries

- All entries must be authenticated
  - Method to establish identify of author each entry
  - Author must take specific action to very entry
  - Timing of entry noted and correct
  - Auto-authentication – authenticates before transcription – **not** consistent with requirements

Confidentiality of MR C1120

- Standard: Protection of record information
- Must maintain confidentiality of information
- Must safeguard against
  - Loss
  - Destruction
  - Unauthorized use or dissemination
- Access limited to authorized people
- Release only with written authorization of patient or authorized representative
- Paper, video, computer-stored information

Release of Records C1122 & 1124

- Need written P&P that govern
  - Use and removal of records
  - Conditions for release of information
- Remember:
  - HIPAA law on confidentiality and privacy
  - ARRA, HITECH
  - Breach notification law
- Written consent of patient required to **release** not required by law (C1124)

Retention of MR C1126

- Standard: CAH retains records for at least **6** years from date of last entry
  - May be longer by State or federal law (OSHA, FDA, EPA)
  - Or if the records needed in any pending proceeding
- Forms
  - Hard copy
  - Microfilm
  - Computer memory banks
- AHIMA has practice brief on retention periods*
  - Ties in with the destruction policies

Federal & State Retention Periods

- https://library.ahima.org/PB/RetentionDestruction#.YTuD5J1Kjro.

Appendix A: Federal Record Retention Requirements

Type of Documentation	Retention Period	Citation/Reference
Abortions and related medical services documentation	Maintain for three years.	42 CFR 50.309
Ambulatory surgical services	Retention periods are not specified	42 CFR 416.47
Clinics, rehabilitation agencies, and public health agencies as providers of outpatient physical therapy and speech-language pathology services	As determined by the respective state statute, or the statute of limitations in the state. In the absence of a state statute, five years after the date of discharge; or in the case of a minor, three years after the patient becomes of age under the state law or five years after the date of discharge, whichever is longer.	42 CFR 485.721 (d)
Clinics, rural health	Six years from date of last entry and longer if required by state statute.	42 CFR 491.10 (c)
Competitive medical plans (See HMOs, competitive medical plans, healthcare prepayment plans)		
Comprehensive outpatient rehabilitation facilities (CORFs)	Five years after patient discharge.	42 CFR 485.60 (c)

Electronic Notifications C1128

- Standard: electronic notifications
- If use an EHR conformant with exchange standards – must demonstrate
- 1. Notification capacity if fully operational and used per all state and Federal statues and regulations on exchange of information
- 2. System sends notifications that includes at least
  - Patient name
  - Treating practitioner name
  - Sending institution name

Electronic Notifications C1128

- 3. To extent permissible – laws and regulations – and not inconsistent with patient's expressed privacy preference
- Send notification directly or via intermediary either immediately prior to or at time of
  - Discharge or transfer from CAH's ED
  - Discharge or transfer from CAH's inpatient service
- 4. to extent permissible…system send notification directly or via intermediary prior to or at time of
  - Discharge or transfer from CAH's ED
  - Discharge or transfer from CAH's inpatient services

Notifications - continued

- 5. CAH has made a reasonable effort to ensure system sends notice to applicable post-acute care service, providers and suppliers plus
  - Patient's established PCP
  - Patient's established primary care practice group or entity
  - Other practitioner or group/entity identified by the patient as primarily responsible for care



Information Blocking and Security Risk Assessment

CMS – HIPAA – OCR

Question

Hospital D recently updated its EMR and now patients can access their medical records whenever they wish. The process requires the patient to have a computer or access to one. JD is an elderly patient with no computer or internet access. He has asked for to review his records and arranged for a time at the hospital to do so. The HIM administrator refused his request. Will Hospital D be cited?

- Yes
- No – no other patient has made such a request and so no accommodation
- Not sure

General Right - HIPAA

- Covered entities must provide access to PHI
  - Upon request
- ***May*** require patient to request access in writing
  - Provided the entity informs the patient of the requirement
- Unreasonable measures – cause delay/barriers:
  - Physically come in and request with proof of identity
  - Use a web portal to request – not everyone has
  - Mail access request – delays receipt of request

Timeliness & Entirety

- Patients have a right to get their records timely
  - HIPAA says 30 days unless stored off site then 60 days
  - Caveat: State law can be more stringent
- Have a right to get their entire medical record
- Patients can request a specific portion of the records
- Medical record must include the discharge planning documents

Information Blocking

- Definition – a practice likely to interfere with access, exchange, or use of electronic health information
  - unless required by law or meets an exception:
- Provider knows
  - Such practice is unreasonable
  - Likely to interfere with, prevent or materially discourage
  - Access, exchange or use of electronic health information
- Impacts participation in Interoperability Program
- Not part of the manual - yet

Excluded – Rule Not Apply

- 1. Psychotherapy notes separated from rest of individual's medical record
  - Recorded by HCP who is mental health professional
  - Documenting or analyzing content(s) of conversation during private counseling session, group, joint or family session
- 2. Information complied in reasonable anticipation of or use in:
  - Civil, criminal or administrative action proceeding

4 Exceptions – Not "Blocking"

- Can "block" patient access to electronic information
  - Must meet all applicable requirements and conditions at all relevant times
- Preventing harm
- Privacy exception
- Security exception
- Infeasibility exception

1. Preventing Harm

- Must meet BOTH:
  - A *reasonable belief* practice will substantially
    - Reduce a risk of harm
    - To a patient
    - That would otherwise arise from the access, exchange or use of the information
  - Practice must be *no broader than necessary*
    - Substantially reduce the risk of harm the practice implemented to reduce

Type of Risk of Harm

- Risk of harm must be determined on individual basis
  - Exercise of professional judgement by licensed health care professional
  - Current/prior clinician-patient relationship
- Harm arises from data known or reasonably suspected
  - Mis-identified or mis-matched
  - Corrupt due to technical failure
  - Erroneous for another reason

Right to Request Review of Harm

- Where the risk of harm exists
  - HCP must implement the practice in a manner consistent with any rights the patient has per Federal, State or trial law
  - To have determination reviewed and potentially reversed
- All must be met



Organizational Policy or Fact Specific

- Practice must be consistent with a written organizational policy
  - Based on relevant clinical, technical and other appropriate expertise
  - Implemented in a consistent, non-discriminatory manner
- Determination must be based on facts and circumstances
  - Known/reasonably believed at the time determination made
  - Based on expertise relevant to implement the practice consistent with all conditions

2. Privacy Exception

- Practice implemented in a consistent and non-discriminatory manner
  - Conforms to written policies and procedures
  - Specify criteria used to determine restriction to access
  - Must have training on P&P
  - Must have documentation of criteria used to determine

Privacy Exception - continued

- If provider receives authorization/consent that does not satisfy all elements for restricted access:
  - Give person a consent/authorization that does satisfy all requirement
  - Cannot improperly encourage/induce individual to withhold consent/authorization
  - Must have uniform privacy policies and procedures to address restrictive preconditions

Requests – Not to Share

- If provider receives request not to share information may agree if:
  - Individual does not try to improperly encourage or induce the provider
    - "I will pay you $$$ if you don't share my records with the other attorney"
  - Provider documents request w/n reasonable timeframe
- Exception – if share information required by law

Termination Request Not To Share

- Provider may terminate the request for restriction to access only if:
  - Person agrees or requests termination in writing
  - Person orally agrees to termination and agreement documented by provider
  - Provider informs person it is terminating agreement to not provide access

3. Security Exception

- Practice - to protect security
  - Directly related to safeguarding confidentiality, integrity and availability of EHI
  - Tailored to specific security risk being addressed
  - Is implemented in a consistent, non-discriminatory manner
  - Organizational security policy has been implemented

Security – Organizational Policy

- Policy must be
  - In writing
  - Prepared on basis of and directly responsive to security risks identified and assessed on or behalf of the provider
  - Align with one or more applicable consensus-based standards or best practice guidance
  - Provides objective timeframes and other parameters for identifying, responding to and addressing security incidents

Security – No Policy

- If no organizational security policy provider must:
  - Make determination in each case based on particularized facts and circumstances
  - Practice necessary to mitigate security risk to information
  - Are no reasonable and appropriate alternatives to the practice

4. Infeasibility Exception

- When cannot provide access due to infeasibility
- Required conditions:
  - Uncontrollable events – disasters, PHE, terrorists attack
  - Segmentation – cannot unambiguously segment the requested EHI from remaining EHI
    - Cannot be made available due to individual's preference or by law
  - Infeasible under the circumstances (next slide)

Infeasible Under Circumstances

- Access for type and purposes for which needed
- Cost to comply in manner requested
- Financial/technical resources available to the actor
- In determining circumstances – does not consider whether manner requested would have
  - Facilitated competition with the provider
  - Prevented provider from charging fee/reduced fee

Responding to Requests

- If provider does not fulfill a request for access, exchange or use of EHI for any reason must:
  - Provide written reason(s) why request infeasible
  - Within 10 *business days* of receipt of request



#54 – Failure to Provide Access

HHS' Office for Civil Rights Settles HIPAA Right of Access Investigation with Concentra, Inc.

OCR Settlement Marks OCR's 54th HIPAA Right of Access Enforcement Action to Advance Individual Access to Medical Records

WASHINGTON— December 16, 2025 — Today, the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR) announced a settlement with Concentra, Inc., (Concentra), an occupational health services provider headquartered in Texas, for a potential violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule. The settlement resolves an investigation of a complaint alleging a failure to provide timely access to an individual's protected health information (PHI). OCR's investigation determined Concentra failed to provide timely access to an individual's PHI within 30 days. OCR's settlement with Concentra marks the 54th enforcement action in OCR's Right of Access Enforcement Initiative, which OCR initiated during the first term of the Trump Administration.

The HIPAA Privacy Rule's "Right of Access" provisions require that individuals or their personal representatives have timely access to health information within 30 days, with the possibility of one 30-day extension. OCR enforces the HIPAA Privacy Rule, which establishes national standards to protect individuals' medical records; sets limits and conditions on the uses and disclosures of protected health information; and gives individuals certain rights, including the right to timely access and to obtain a copy of their health records for a reasonable cost.

"Under the HIPAA Privacy Rule, individuals or their personal representatives have the right to timely access their medical records," **said OCR Director Paula M. Stannard**. "Individuals should not have to make multiple requests and file a complaint with OCR to gain access to their health information."

The enforcement action stems from an investigation that OCR initiated after receiving a complaint that an individual was not given timely access to his health information, despite making six requests beginning in February 2018. The individual did not receive access to his health information until March 2019, more than a year after his initial request. OCR's investigation determined that Concentra failed to take timely action in response to the individual's right of access requests in accordance with the HIPAA Privacy Rule's right of access standard. On June 29, 2021, OCR issued a Notice of Proposed Determination proposing to impose a civil money penalty, and Concentra subsequently requested a hearing before an administrative law

Security Rule – Risk Assessment

- Requires entities to evaluate risks and vulnerabilities in their environments
  - Implement reasonable and appropriate security measures to
  - Protect against reasonably anticipated threats or hazards to security or integrity
- Organizations must
  - Implement policies and procedures to prevent, detect, contain and correct security violations
  - Conduct accurate and thorough assessment of potential risk and vulnerabilities

Origins of Risk

- Unauthorized (malicious or accidental) disclosure, modification or destruction of information
- Unintentional errors and omissions
- IT disruptions due to natural or man-made disasters
- Failure to exercise due care and diligence in implementation and operation of the IT system

OCR Risk Analysis* – Briefly

- Determine scope of the analysis – all forms of electronic media
- Gather relevant data
- Identify and document potential threats and vulnerabilities
- Assess current security measures
- Determine likelihood of threat occurrence
- Determine potential impact of threat occurrence
- Determine level of risk
- Document the analysis

Resource and Caveat

- OCR recognized not single method/best practice for conducting an SRA to ***guarantee*** compliance
- OCR and Office of National Coordinator for Health Information Technology (ONC) has a tool
  - New caveat: tool does not capture technical vulnerabilities
  - Use as one method for gap analysis
- https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool

Risk Analysis Tool Limitations

- Is really a gap analysis that maps a CE's current practices and assesses if met
- Uses the Security Risk Analysis tool with no ePHI asset inventory or technical details
- Is based on another cybersecurity framework that does not explicitly include an ePHI inventory and threats to that ePHI
  - Such as NIST
- Overall – do not capture the entire spectrum that OCR want to see in a compliant SRA
- https://www.bakerdatacounsel.com/blogs/its-officially-enforcement-season-ocr-announces-first-penalty-under-new-risk-analysis-initiative/

Proposed New Regulations* – Highlights

- https://www.hipaajournal.com/new-hipaa-regulations/
  - Allow patients to inspect PHI in person and take notes or photos of PHI
  - Changing maximum time to provide access to PHI from 30 days to 15 days
  - When individuals should be provided ePHI without charge
  - Wording change – expand ability of CE to disclose PHI to avert threat to health/safety when harm is "seriously and reasonably foreseeable"
    - Currently – when "serious and imminent"





Provision of Services

Patient Services/Outpatient

Laboratory

Nursing

Question

- Our CAH provides: (check all that apply)
  - Laboratory
  - Radiology
  - OB services
  - Dedicated behavioral health unit
  - ICU/CCU
  - Routine medical/surgical services

Provision of Services – "C" Tag Nos.

- Scope of services (1010)
- Emergency medical services (1012)
- Referral, medical records & evaluation of services(1014)
- Drugs and biologicals (1016)
- Food and nutrition (1020)
- **Patient services/Outpatient Department (1024,1026)**
- **Laboratory(1028)**
- Radiology (1030)
- Emergency procedures (1032)
- Services via Agreements/Arrangements (1034, 1036, 1038, 1040, 1042, 1044)
- **Nursing (1046, 1048, 1049, 1050)**
- Rehab (1052)
- Visitation rights (1054, 1056, 1058)

Patient Services C1024

- Standard: Patient Services
- Provide diagnostic and therapeutic services
  - Commonly provided in doctor's office
  - Or at entry of healthcare organization
    - Such as outpatient department or ED
- Must have supplies typically found in an ambulatory healthcare setting and a physician's office
  - Services include medical history, physical examination, specimen collection, assessment of health status, and treatment for a variety of medical conditions

Outpatient Department

- Provide adequate services, equipment, staff, and facilities adequate to provide outpatient services
- Follow acceptable standards of practices
  - ACR, AMA, ACOS, etc.,
- Must be integrated with inpatient services
  - MR – lab – radiology – anesthesia – other diagnostic services
- Can be provided directly or under an arrangement or contract

Outpatient - continued

- Physician/non-physician practitioner must be available to treat patients at the CAH
  - When such outpatient services are provided
  - For those outpatient services that fall only within the scope of practice of a physician or non-physician practitioner



Inpatient Services C1026

- Hospital furnishes acute care inpatient services
  - Average LOS is 96 hours
  - CAH provides less complex, specialized inpatient services to meet the LOS requirement
  - Will look at data to make sure patients who need inpatient care are admitted
  - Must certify that Medicare patients may be expected to be discharged or admitted to a hospital within 96 hours
  - Does not believe in best interest to transfer a patient that can be cared for locally

Census

- Recognizes CAH may have seasonal variations
- Not required to maintain a minimum average daily census of inpatients
  - Nor required to maintain a minimum number of inpatient
- For compliance will look at:
  - Volume of ED and outpatient services
  - Number of certified beds and dedicated observation beds
  - Average annual occupancy
  - Average inpatient beds – quarterly and annually
  - % of ED patients admitted, etc.

Ensuring Compliance

- Do not have an excess number of observation beds
- Do not transfer patients from the ED to another hospital when the CAH could care for them
  - Data shows about ½ the number of patients who visit a rural hospital are admitted than in a non-rural hospital (8.3 % vs. 16%)
- CMS: If admits 8% of its ED patients annually, CAH says are compliant with inpatient services, and surveyors do not need to investigate further

Tag C1026 – Page 137

Given that a CAH may offer fewer services than even the average rural hospital and is expected to achieve a 96-hour average length of stay or less, there is no expectation that every CAH is expected to admit 8 percent of its ED patients. This benchmark can, however, provide a useful starting point for assessing compliance.

- Generally, if a CAH admits at least 8 percent of its ED patients annually, it would be considered compliant with the requirement to provide inpatient services and surveyors do not have to investigate further.

- If a CAH admits less than 8 percent of its ED patients annually, this is **not** in and of itself evidence of noncompliance. More investigation is needed to assess compliance by determining whether the volume of activity and number of staff the CAH has for its ED, other outpatient, and inpatient services are reasonably related to each other. There can be great variation among CAHs in their volume and types of activities, despite their relative similarity in size, making a "one size fits all" formula inappropriate. Researchers in one State with 79 CAHs found that they averaged 3,851 ED visits annually, but that visits for individual CAHs ranged from a low of 389, or a little more than one patient per day, to a high of 14,425, or about 40 patients per day. CAHs in this State averaged 19,705 other types of outpatient visits annually, but again the range was very large, from a low of 89 to a high of 86,367 per year. For inpatient admissions the annual average was 836, ranging from a low of 100 to a high of 3,838[3]. Presentation of the data found in this State is not intended to provide benchmarks for CAHs in other States, but rather to emphasize the tremendous range in the volume of activity among CAHs, even within one State.

- A couple of extreme but illustrative examples are presented below to indicate the types of factors to be considered when assessing whether the CAH satisfies the requirement to provide inpatient services:



Laboratory Services

Laboratory Services C1028

- Must provide basic lab services to essential to immediate diagnosis and treatment 24/7
- Meet CLIA standards
- Can be direct or contracted out
  - If contract out – confirm have current CLIA certificate
- Need written policy
  - Ensure all lab tests are recorded in the MR
  - For collection preservation, transportation, receipt and reporting of tissue specimen results

Laboratory Services Include

- Scope of services and complexity must be adequate to meet the needs of the patients
- 6 mandatory tests:
  - Urine dipstick or tablet including urine ketones
  - Hemoglobin or hematocrit
  - Blood glucose
  - Stool for occult blood
  - Pregnancy tests
  - Primary culturing for transmittal to certified lab



Nursing

Nursing Services C1046

- Standard: Nursing Services
- Nursing service must meet the needs of patients
  - RN must provide or assign nursing care to each patient
  - Care must be in accordance with patient's needs
  - Specialized qualifications and competence of available staff



Nursing Service and Leadership

- Nursing service must be well-organized
- Need designated person responsible for nursing services
  - Responsible for development of nursing P&Ps
  - Expected to be an RN
  - Title: CNO, DNO, Nurse manager

Nursing Leadership Duties

- Responsible for overall management and evaluation of nursing care including
  - Development and maintenance of P&P
  - Supervision of nursing staff
    - Direct or via manager
  - Ongoing review and analysis of nursing care
- All agency nurses must be oriented and supervised

Nursing Care – Requirements

- Must have RN, LPN, or CNS on duty whenever have has 1 or more inpatients
  - Ensure appropriate staffing for outpatient nursing services
  - Have enough supervisory and non-supervisory personnel to meet patient needs
  - Be competent, educated, trained, oriented, and licensed
  - All nursing staff must be aware of P&P
  - Need procedure for assigning and coordinating nursing care

Survey Procedures

- Surveyor will
  - Interview RN and ask:
    - How are nursing needs of patients are determined?
    - How are staff assigned to provide care?
    - How are staff trained and oriented?
  - Observe nursing care – determine adequacy of staff
  - Look at written staffing schedules to make sure staff are following the P&Ps
  - Review personnel files to make sure nurses are licensed

Supervision & Evaluation of Care C1048

- RN or, where permitted by state law, a PA, must
  - Supervise and evaluate nursing care for each patient
  - Including Swing-Bed patients
- Care must be provided in accordance with patient needs
- Nursing care plans do not have to be developed for outpatients
  - But follow acceptable standards for medication administration

Survey Procedure

- Will look at written staffing plans
  - Determine that RN (or PA) supervises and evaluates nursing care for each patient
  - Interview one or more RNs who supervise and evaluate care

File Wishes Ranges Patterns Options Debugger Phases

	1	2	3	4	5	6	7	8	9	10	11	12	13	14
KarinG	0	0	2	2	2	2	2	0	1	1	0	0	2	2
Hilde	0	1	1	1	3	3	0	0	2	2	2	3	3	0
Gerda	1	3	3	0	0	0	2	2	2	2	2	0	0	3
Gerd	0	1	1	1	2	2	0	2	3	3	0	0	1	1
Hubert	0	2	2	3	3	3	0	0	1	1	1	1	1	0
Anna	2	2	2	0	1	1	0	0	0	1	1	2	2	2
Norbert	2	3	3	0	0	1	1	1	1	2	0	0	0	0
EddaA	1	2	0	2	2	2	3	3	0	0	0	1	1	1
EddaB	3	0	0	1	1	1	1	1	0	0	2	2	2	2
Ina	0	1	1	2	0	0	0	0	3	3	3	0	0	0

Legend: '0' free (shift), '1' morning shift, '2' evening shift, '3' night shift

Drugs and IVs C1049

- All drugs and IVs must be administered by or under the supervision of RN, MD/DO, or a PA if allowed by state law
- Need a signed order
  - Verify there is signature, date, and time on all orders
- Orders must be written within the acceptable standard of care
- Must be consistent with both State and Federal laws
- Guidelines list out several nationally recognized organizations with expertise in medication administration

Written Policies and Procedures

- Must have for administration
- Must be prepared in accordance with the standard of care
  - Mentions multiple resources
- Must specify who can administer meds
- Need signed order by one authorized by P&P
- Need P&P for verbal and standing orders
- Need minimum content of medication orders
  - Name, dose, route, frequency, etc.

Must Ensure Compliance – Acceptable Practices

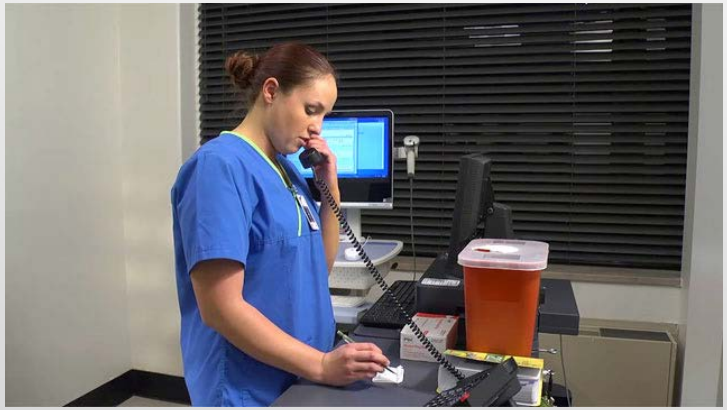
- Self administration of medications
- Training
- Basic safe practices
- Timing of medication
- IV medication
- Documentation
- Assessment of patients receiving medications

Content of Medication Order

- Patient name
- Age and weight – dose calculation
- Date and time of order
- Drug name
- Exact strength or concentration (when applicable)
- Dose, frequency and route
- Dose calculation requirements (if applicable)
- Quantity and/or duration (when applicable)
- Name of prescriber

Verbal Orders

- Regulation requires written & signed order
  - BUT not precluded from using verbal orders
- Practitioner must authenticate orders ASAP
  - Need P&Ps for both
  - Policy need to include what must be in the verbal order



Verbal Order Policy – Minimum

- Describe when may be used plus limitation or prohibition in use
- Provide mechanism to establish identity/authority of practitioner issuing a verbal order
- List of element required for verbal order process
- Protocols for clear, effective communication and verification – "read-back"
- ID categories of staff who can receive and act on
- Require prompt documentation of verbal order in MR

Standing Order Policy – Minimum

- Process on how
  - Developed
  - Approved
  - Monitored
  - Evaluated and updated
- For each standing order – staff that may initiate
- Under what circumstances
- Requirement for subsequent authentication by practitioner responsible for patient

Blue Box: Verbal & Standing

For Information Only – Not Required/Not to Be Cited

Verbal Orders

CAHs are encouraged to minimize the use of verbal orders as much as possible and not permit their use merely as a convenience to practitioners. Verbal orders carry a higher risk of miscommunication and error and thus should only be used when necessary. With the increasing use of Electronic Health Records and Computerized Physician Order Entry systems, the need for verbal orders is expected to decline.

Standing Orders

There is no standard definition of a "standing order" in the healthcare community, but the terms "pre-printed standing orders," "electronic standing orders," "order sets," and "protocols for patient orders" are various ways in which the term "standing orders" has been applied. The lack of a standard definition for these terms and their interchangeable and indistinct use by health care facilities professionals may result in confusion

CAHs are encouraged to focus on those situations where their use of "standing orders" permits treatment that is outside the scope of practice of a non-practitioner, such as a nurse, to be initiated by the non-practitioner without a prior specific order from a practitioner responsible for the care of the patient. Such treatment is typically initiated when a patient's condition meets certain pre-defined clinical criteria. For example, standing orders may be initiated as part of an emergency response or as part of an evidence-based treatment regimen where it is not practical for a nurse to obtain either a written, authenticated order or a verbal order from a practitioner prior to the provision of care.

Appropriate use of standing orders can contribute to patient safety and quality of care by promoting consistency of care, based on objective evidence. Much of the evidence on the

Self-Administered Meds & Training

- Self administered meds – optional
  - Need an order
  - Can include medications brought from home
  - Must have P&Ps
- Training
  - Medication administration training and education during orientation and CNE to include:
    - Safe handling and preparation of drugs
    - Knowledge of side effects, ADE, and dose limits
    - How to use equipment and need P&P

Question

Baker CAH experienced a medication adverse reaction – anaphylaxis – even though the allergy was listed in the patient's record. RCA revealed the error revolved around patient's name and date of birth. The patient's last name was common in the community. There were 2 patients on the same unit with the same last name, but different date of birth.

What would you recommend Baker do to address the issue?

- Nothing – continue with 5 rights but add full name
- Modify the policy to include full name and DOB as an additional "right"
- Use 7 or 9 "rights"

Basic Safe Practices

- Basic safe practices
  - Five rights
  - Culture of safety where staff feel free to ask questions
- Focus is on the process of administration – 5 stages:
  - Ordering/prescribing
  - Transcribing & verifying
  - Dispensing & delivery
  - Administering
  - Monitoring/reporting

Blue Box – 9 Rights

For Information – Not Required/Not to be Cited

Recent literature* identifies up to nine "rights" of medication administration including:

- Right patient
- Right drug
- Right route
- Right time
- Right dose
- Right documentation
- Right action (appropriate reason)
- Right form
- Right response

However, other sources refer to 8 or 10 "rights, and some of these topics, such as right action, appear to involve prescribing and/or dispensing. Accordingly, there does not (yet) appear to be consensus about expanding beyond the 5 "rights."

*Reference: Elliott, M. and Lis, Y. (2010). The Nine Rights of Medication Administration: An Overview. British Journal of Nursing, Vol. 19, 5, 300-305.

Timing of Medication

- P&P needs to include the timing of medication based on the
  - Nature of the medication
  - Clinical application – why used
- 4 items policy must address for times:
  - Medications **Not eligible**
  - Medications **Eligible**
  - Eligible meds outside dosing window
  - Evaluation of timing policies



Medications ***Not*** Eligible

- These medications require exact time based on diagnosis type, treatment requirements or therapeutic goals
  - Stat drugs
  - Loading dose
  - One time dose for scheduled procedure
  - Doses timed for serum drug level
  - PRN
  - Investigational drugs

Medications ***Eligible***

- These medications are those prescribed on a repeated cycle of frequency
  - Daily
  - BID
  - TID, etc.
- Goal - achieve therapeutic blood level
- Policy needs standardized times so pharmacy knows when to send to unit or nurse can assess VS or review blood work

Eligible Medications P&P

- P&P must address:
  - First dose of medication
  - Using judgment regarding next dose
  - Retiming of missed or omitted doses
  - Medications that can be given outside of their scheduled dosing time
- Evaluation of the medication timing policy and including adherence rate
  - Track medication errors related to timing of medications and include in the PI process

3 Time Frames for Administration

- Time Critical Medicine
- 1 hour before or after
- 2 hours before or after

Time Critical Scheduled Medications

- 30 minute or 1-hour total window
  - Medications where an early or late administration of greater than 30 minutes might cause harm or have significant, negative impact on the intended therapeutic or pharmacological effect
  - P&P must include whether these drugs are always time critical
  - Examples: Antibiotics, Anticoagulants, Insulin, Anticonvulsants, Immunosuppressive agents, Non-IV Pain medication, medication more frequently than every 4 hours, and administered within a specified period of time in the order

Non-Critical Scheduled Medications

- Medications for which a longer or shorter interval of time since the prior dose does not significantly change the medication's therapeutic effect or otherwise cause harm
  - Those given **1 hour** before/after but not to exceed 2 hours
    - Medications scheduled more frequently than daily but less than every 4 hours – bid, tid
  - Those within **2 hours** before/after but not to exceed 4 hours
    - Medications given once daily, weekly, or monthly

Missed or Late Administration

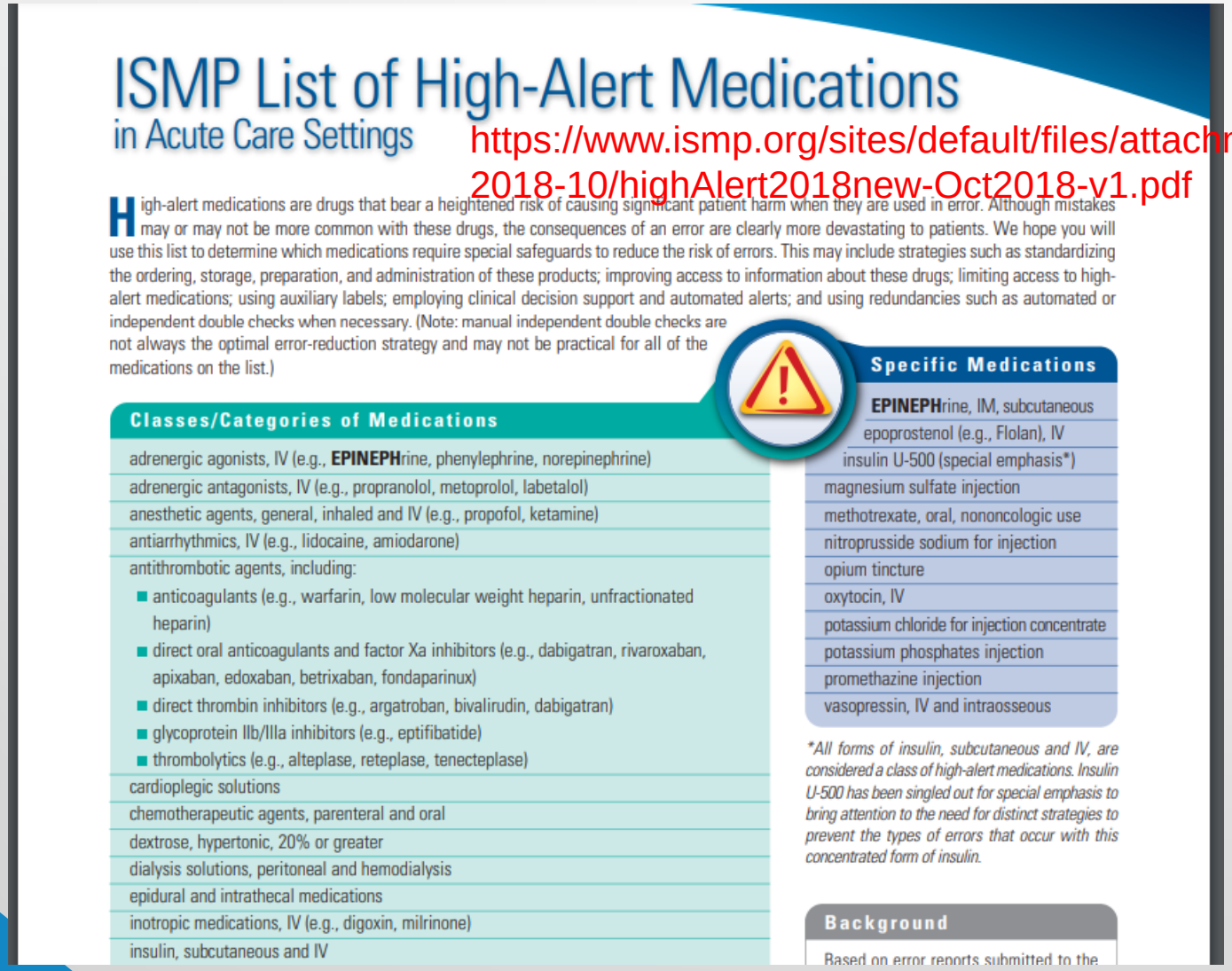
- Policy must include:
  - What action to take if missed or not given in permitted window of time
    - Patient out of the department
    - Patient refusal
    - Medication not available or other reasons
  - Parameters of when nursing staff may use own judgment on the rescheduling of late or missed doses
- Missed/late doses must be reported to the attending physician

Assessment/Patient Monitoring

- Very concerned about patient having respiratory depression or ADR from opioids
- Must carefully monitor to include:
  - Respiratory status, BP, pulse ox and ETCO2
  - Evaluate for confusion, agitation, unsteady gait, itching, lethargy, etc.
- Opioids are considered high risk medications



ISMP List of High Alert Medication



ISMP List of High-Alert Medications
in Acute Care Settings

https://www.ismp.org/sites/default/files/attachments/2018-10/highAlert2018new-Oct2018-v1.pdf

High-alert medications are drugs that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are clearly more devastating to patients. We hope you will use this list to determine which medications require special safeguards to reduce the risk of errors. This may include strategies such as standardizing the ordering, storage, preparation, and administration of these products; improving access to information about these drugs; limiting access to high-alert medications; using auxiliary labels; employing clinical decision support and automated alerts; and using redundancies such as automated or independent double checks when necessary. (Note: manual independent double checks are not always the optimal error-reduction strategy and may not be practical for all of the medications on the list.)

Classes/Categories of Medications

- adrenergic agonists, IV (e.g., **EPINEPH**rine, phenylephrine, norepinephrine)
- adrenergic antagonists, IV (e.g., propranolol, metoprolol, labetalol)
- anesthetic agents, general, inhaled and IV (e.g., propofol, ketamine)
- antiarrhythmics, IV (e.g., lidocaine, amiodarone)
- antithrombotic agents, including:
  - anticoagulants (e.g., warfarin, low molecular weight heparin, unfractionated heparin)
  - direct oral anticoagulants and factor Xa inhibitors (e.g., dabigatran, rivaroxaban, apixaban, edoxaban, betrixaban, fondaparinux)
  - direct thrombin inhibitors (e.g., argatroban, bivalirudin, dabigatran)
  - glycoprotein IIb/IIIa inhibitors (e.g., eptifibatide)
  - thrombolytics (e.g., alteplase, reteplase, tenecteplase)
- cardioplegic solutions
- chemotherapeutic agents, parenteral and oral
- dextrose, hypertonic, 20% or greater
- dialysis solutions, peritoneal and hemodialysis
- epidural and intrathecal medications
- inotropic medications, IV (e.g., digoxin, milrinone)
- insulin, subcutaneous and IV

Specific Medications

- **EPINEPH**rine, IM, subcutaneous
- epoprostenol (e.g., Flolan), IV
- insulin U-500 (special emphasis*)
- magnesium sulfate injection
- methotrexate, oral, nononcologic use
- nitroprusside sodium for injection
- opium tincture
- oxytocin, IV
- potassium chloride for injection concentrate
- potassium phosphates injection
- promethazine injection
- vasopressin, IV and intraosseous

**All forms of insulin, subcutaneous and IV, are considered a class of high-alert medications. Insulin U-500 has been singled out for special emphasis to bring attention to the need for distinct strategies to prevent the types of errors that occur with this concentrated form of insulin.*

Background

Based on error reports submitted to the

IV Opioids

- CMS notes a recommendation by the Patient Safety Movement Foundation
- Patients on **IV opioids** need:
  - Continuous pulse ox (through motion and low perfusion pulse oximetry)
  - Patients on supplemental oxygen has continuous respiratory rate monitoring (end tidal CO_2)
  - Monitoring system needs to be linked with notification system to staff
  - Calls for an escalation protocol if staff does not acknowledge it in 60 seconds a second person is notified

The Patient Safety Movement Foundation

For Information – Not Required/Not to be Cited

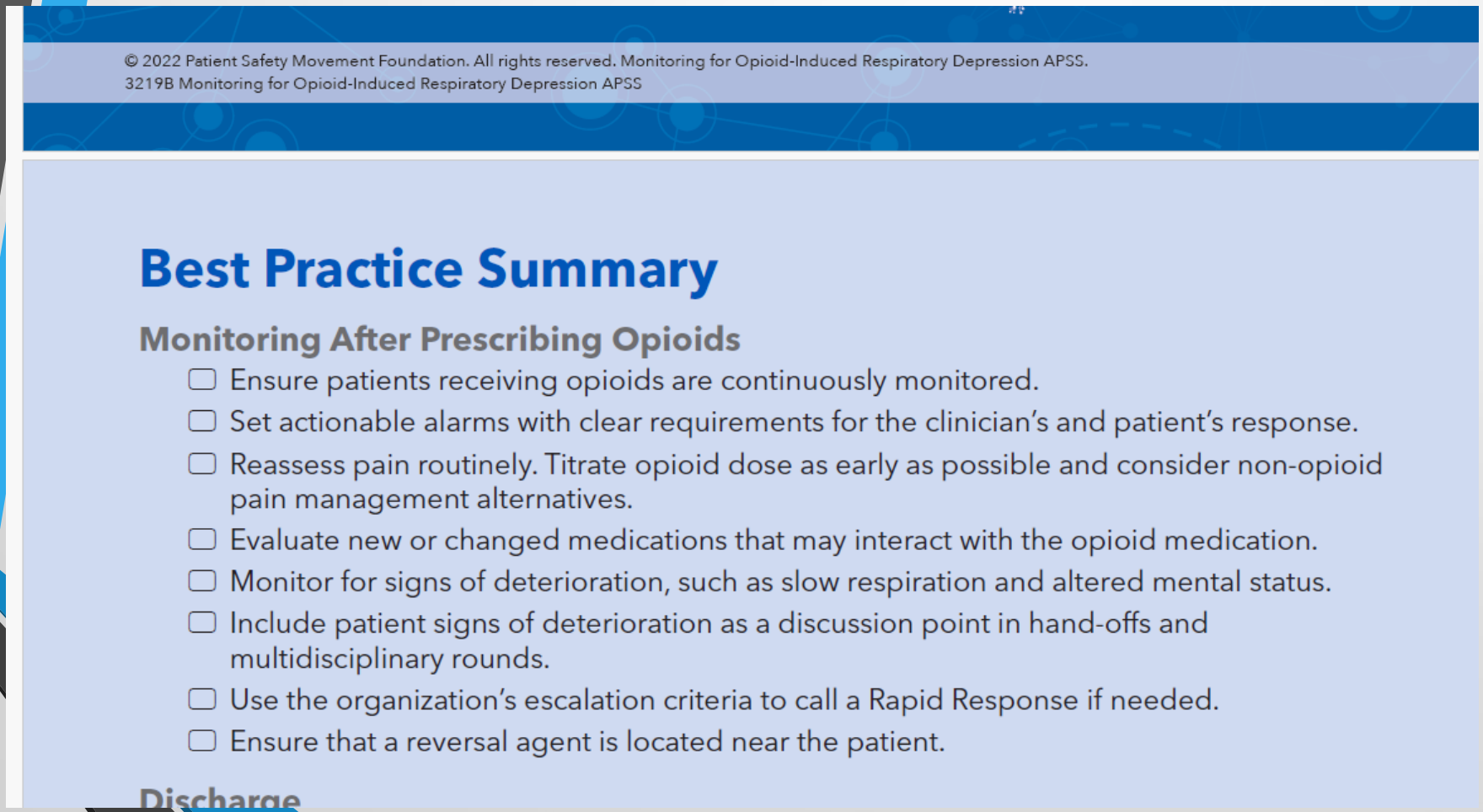
The Patient Safety Movement Foundation

PSMF recommends all patients receiving IV opioids have continuous measure-through motion and low perfusion pulse oximetry, and that patients on supplemental oxygen also have continuous respiration rate monitoring. It also calls for the monitoring system to be linked with a notification system to clinical staff who can respond immediately. It calls for an escalation protocol so that if a staff person does not acknowledge the alert in 60 seconds a second person will be notified.

The Patient Safety Movement Foundation - Actionable Patient Safety Solution (APSS) #1: Failure to Rescue: Post-Operative Respiratory Depression. January 13, 2013

PSMF Solutions – Best Practices

- https://psmf.org/additional-aebps/



© 2022 Patient Safety Movement Foundation. All rights reserved. Monitoring for Opioid-Induced Respiratory Depression APSS.
3219B Monitoring for Opioid-Induced Respiratory Depression APSS

Best Practice Summary

Monitoring After Prescribing Opioids

- ☐ Ensure patients receiving opioids are continuously monitored.
- ☐ Set actionable alarms with clear requirements for the clinician's and patient's response.
- ☐ Reassess pain routinely. Titrate opioid dose as early as possible and consider non-opioid pain management alternatives.
- ☐ Evaluate new or changed medications that may interact with the opioid medication.
- ☐ Monitor for signs of deterioration, such as slow respiration and altered mental status.
- ☐ Include patient signs of deterioration as a discussion point in hand-offs and multidisciplinary rounds.
- ☐ Use the organization's escalation criteria to call a Rapid Response if needed.
- ☐ Ensure that a reversal agent is located near the patient.

Discharge

Patient Risk Factors

- Patients at greater risk for adverse events and respiratory depression
  - Liver or kidney failure
  - History of sleep apnea or snoring
  - Age, thoracic or other surgical incisions
  - History of smoking, pulmonary or cardiac disease
  - First time medication use, receiving benzodiazepines, antihistamines
  - Asthma
  - Patient weight

Medication & Patient Assessment

- Assess sedation level with high alert medications
- Staff are expected to include patient reports of their experience of medication's effects
- Educate the patient and family to notify nurse if any difficulty breathing or ADEs
- P&Ps must discuss manner and how frequent to monitor patient

IV Medication Administration

- Need correct choice of vascular access devise to deliver blood and medications
  - Peripheral catheters, PICC, midlines, central lines, implanted ports and other types of devices
- Need P&P to address which ones can be given IV and via what type of access
- Trace lines and tubes for correct connections and prior to giving meds
- Verify IV pump is properly programmed

Trace the Line



Pasero Opioid-induced Sedation Scale

Pasero Opioid-induced Sedation Scale (POSS)

https://secure.tha.com/surveys/files/pasero-opioid-induced-sedation-scale-poss.pdf

S = Sleep, easy to arouse
Acceptable; no action necessary; may increase opioid dose if needed

1. Awake and alert
Acceptable; no action necessary; may increase opioid dose if needed

2. Slightly drowsy, easily aroused
Acceptable; no action necessary; may increase opioid dose if needed

3. Frequently drowsy, arousable, drifts off to sleep during conversation
Unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory; decrease opioid dose 25% to 50% or notify prescriber or anesthesiologist for orders; consider administering a non-sedating, opioid-sparing nonopioid, such as acetaminophen or an NSAID, if not contraindicated.

4. Somnolent, minimal or no response to verbal or physical stimulation
Unacceptable; stop opioid; consider administering naloxone; notify prescriber or anesthesiologist; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.

Richmond Agitation Sedation Scale

Richmond Agitation Sedation Scale (RASS) *

www.icudelirium.org/docs/RASS.pdf

Score	Term	Description	
+4	Combative	Overtly combative, violent, immediate danger to staff	
+3	Very agitated	Pulls or removes tube(s) or catheter(s); aggressive	
+2	Agitated	Frequent non-purposeful movement, fights ventilator	
+1	Restless	Anxious but movements not aggressive vigorous	
0	Alert and calm		
-1	Drowsy	Not fully alert, but has sustained awakening (eye-opening/eye contact) to *voice* (≥10 seconds)	Verbal Stimulation
-2	Light sedation	Briefly awakens with eye contact to *voice* (<10 seconds)	Verbal Stimulation
-3	Moderate sedation	Movement or eye opening to *voice* **(but no eye contact)**	Verbal Stimulation
-4	Deep sedation	No response to voice, but movement or eye opening to *physical* stimulation	Physical Stimulation
-5	Unarousable	No response to *voice or physical* stimulation	Physical Stimulation

Procedure for RASS Assessment

1. Observe patient
   a. Patient is alert, restless, or agitated. **(score 0 to +4)**
2. If not alert, state patient's name and *say* to open eyes and look at speaker.
   b. Patient awakens with sustained eye opening and eye contact. **(score –1)**
   c. Patient awakens with eye opening and eye contact, but not sustained. **(score –2)**
   d. Patient has any movement in response to voice but no eye contact. **(score –3)**
3. When no response to verbal stimulation, physically stimulate patient by shaking shoulder and/or rubbing sternum.

Comparison of Sedation Scales



Pain Management Nursing

Comparsion of Selected Sedation Scales for Reporting Opioid–Induced Sedation Assessment

Allison Theresa Nisbet, MSN, CPN, AOCNS, RN-BC, Florence Mooney-Cotter, MSN, CNS-BC, RN-BC | Disclosures

Pain Manag Nurs. 2009;10(3):154-164.

Comment Print

Abstract and Introduction
Nurse Assessment of Sedation Using a Sedation Scale
Study Aims and Methods
Results
Limitations
Summary Recommendations
References

Study Aims and Methods

The present research study was designed to report measures of reliability and validity of three sedation scales currently used to measure sedation as an outcome of opioid administration for pain management in non-critical care settings: the Inova Health System Acute Care Sedation Scale (ISS), the RASS, and the POSS. Reliability and validity had not been previously established for any of these scales in the non-critical care setting. The following research questions were addressed by the study:

Research question 1: Is there a significant difference in validity or reliability between three commonly used sedation scales when used by non-critical care nurses for the measurement of postopioid sedation?

Research question 2: Is there a significant difference in means observed between scales in the total correct score obtained by the nurses (sedation score and nursing actions chosen)?

Research question 3: Is there a significant difference in means observed between scales in the nurses' total combined rating of each scale's performance regarding ease of use, information provided to inform clinical decision making, and confidence (in

score obtained and actions chosen)?

The study aims had immediate organizational Significance, because the scale (the ISS) used to assess opioid-induced sedation at the facility in which the research was conducted had not previously been tested for

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SELECTIVE. CORRECTIVE.
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Experience free water clearance

SAMSCA is contraindicated in the following conditions:
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— Hypovolemic hyponatremia
— Concomitant use of strong CYP 3A inhibitors
— Anuric patients
FULL PRESCRIBING INFORMATION including Boxed WARNING

EDITORS' RECOMMENDATIONS

Vital Signs: Overdoses of Prescription Opioid Pain Relievers and Other Drugs Among Women

Deaths and Severe Adverse Events Associated With Anesthesia-Assisted Rapid Opioid Detoxification

Chronic Pain Treatment With Opioid Analgesics

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www.medscape.com/viewarticle/708387_3

ISMP Use a Standard Sedation Scale

For Information – Not Required/Not to be Cited

In addition to assessing risk for respiratory depression, the Institute for Safe Medication Practices recommends hospitals use a standard sedation scale when assessing patients receiving PCA. Scales such as the Richmond Agitation Sedation Scale, Pasero, Ramsey, or Glasgow Coma Scale are useful in assessing sedation.

Institute for Safe Medication Practices (ISMP), Medication Safety Alert – Fatal PCA Adverse Events Continue to Happen…Better Patient Monitoring is Essential to Prevent Harm. May 30, 2013

For Information – Not Required/Not to be Cited

Institute for Safe Medication Practices Guidelines for PCA Monitoring

Assessment of Opioid Tolerance	*Vital Signs*	*Pain*	*Sedation*	*Respiratory*		
				Rate	*Quality*	*SPO_2* &/or $ETCO_2$***
Baseline Assessment before PCA	*X*	*X*	*X*	*X*	*X*	*X*
PCA Initiation or Change in Drug/Syringe *Q 15 minutes x 1 hour* *Q 1 hour x 4 hours* *Then Q 2 hours*	*X*	*X*	*X*	*X*	*X*	*X*
PCA Dose Change or Bolus *Q 1 hour x 4 hours* *Then Q 2 hours*	*X*	*X*	*X*	*X*	*X*	*X*
Adverse Event or Patient Deterioration (e.g., adverse change in sedation score) *Q 15 minutes x 1 hour* *Q 1 hour x 4 hours* *Then Q 2 hours*	*X*	*X*	*X*	*X*	*X*	*X*
Hand-offs/Shift Change	*X*	*X*	*X*	*X*	*X*	*X*

Institute for Safe Medication Practices (ISMP), Medication Safety Alert – Fatal PCA Adverse Events Continue to happen…Better Patient Monitoring is Essential to Prevent Harm. May 30, 2013 ISMP adapted these recommendations from the San Diego Patient Safety Council

* *SPO_2: Saturation of peripheral oxygen via pulse oximetry*

Policies and Procedures: IV Meds & Blood

- Expected to address:
  - Monitoring for fluid and electrolyte imbalance
    - Electrolyte imbalance can occur with IV meds or blood
  - Monitoring of patients receiving high alert medication including opioids
    - How often and what devices such as pulse ox or ETCO2, and document pain level, vital signs, respiratory status and sedation level
  - Monitoring for over-sedation and respiratory depression related to opioid in post-op patients

Blood Administration

- Confirm correct patient
- Verify correct blood product
- Standard calls for two qualified persons, one who is administering the transfusion
  - TJC NPSG allows one person hanging blood if use bar coding
- P&P
  - Frequency and what monitor
  - Documentation
  - How identify, treat and report any adverse transfusion reaction



Nursing Care Plan C1050

- Must develop and keep a current nursing care plan for each inpatient
- Starts on admission and need to keep current
  - Includes planning for patient's care while in hospital
  - Includes planning for transfer
- Considers treatment goals, physiological and psychosocial factors and discharge planning

Nursing Care Plan – cont'd

- Plan develops appropriate nursing interventions based on identified needs
- Must be part of the permanent medical record
- Nursing can do it as part of the interdisciplinary plan of care
  - BUT - must still do a nursing care plan
- Surveyor will check to make sure plan of care started soon after admission
  - Will also make sure it is revised as necessary

Final Discussion

Hill CAH has 4 physicians and several NPs and PAs. One of the physicians – Dr. B – is in a professional liability action involving care of a patient in the ER. Medical records for the ER are paper; the rest of Hill is electronic. ER records are eventually scanned into the electronic record.

The main allegation of the suit was failure to thoroughly evaluate a patient (MC) who presented with left chest pain, nausea and dyspnea. VS were elevated. He had decreased breath sounds to the left upper lobe. EKG was inconclusive for AMI. CXR showed cloudiness, possibly due to inadequate inspiration during the exam.

Final Discussion – cont'd

Dr. B ordered a "GI cocktail", ASA, and oxygen at 3L/min NC. Labs included CBC, H&H, troponin level. All labs returned within limits. MC reported very slight relief with the GI cocktail and decrease of his dyspnea with rest and the oxygen. The oxygen was DC'd and MC was observed for another hour. With no change or increase in symptoms, MC was discharged home with instructions to see his PCP within 2 days.

Two hours after discharge, the patient returned to Hill in full arrest and resuscitation was unsuccessful

Final Discussion – cont'd

Per Hill policy, the record was reviewed, and it was discovered the notes from first ED visit had different ink from other entries by Dr. B. The later entries mentioned that the patient denied pain or SOB and wanted to go home. Plus, after a lengthy discussion on potential risks of leaving, the patient left AMA.

Conversations with the staff on duty with the first admission did not recall any such discussion or demand by the patient. Also, that Dr. B only examined the patient once.

Dr. B had no comment when asked about the medical record entries.

Final Discussion

What are possible concerns with the record or ER medical records in general?

- Lack of security
- Incomplete record management – addition of the medical record once it is closed
- Alteration issues
- Others?

Thank You



- Laura A. Dixon, Esq.
- BS, JD, RN, CPHRM
- President, Healthcare Risk Education and Consulting, LLC
- ldesq@comcast.net

162

Appendix

Resources

and

Internet Links

Burden Reduction & Discharge Planning Memo

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

https://www.cms.gov/files/document/burden-reduction-discharge-planning-som-package.pdf

Ref: QSO-20-07-ALL

DATE: **December 20, 2019**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Burden Reduction and Discharge Planning Final Rules Guidance and Process

Memorandum Summary

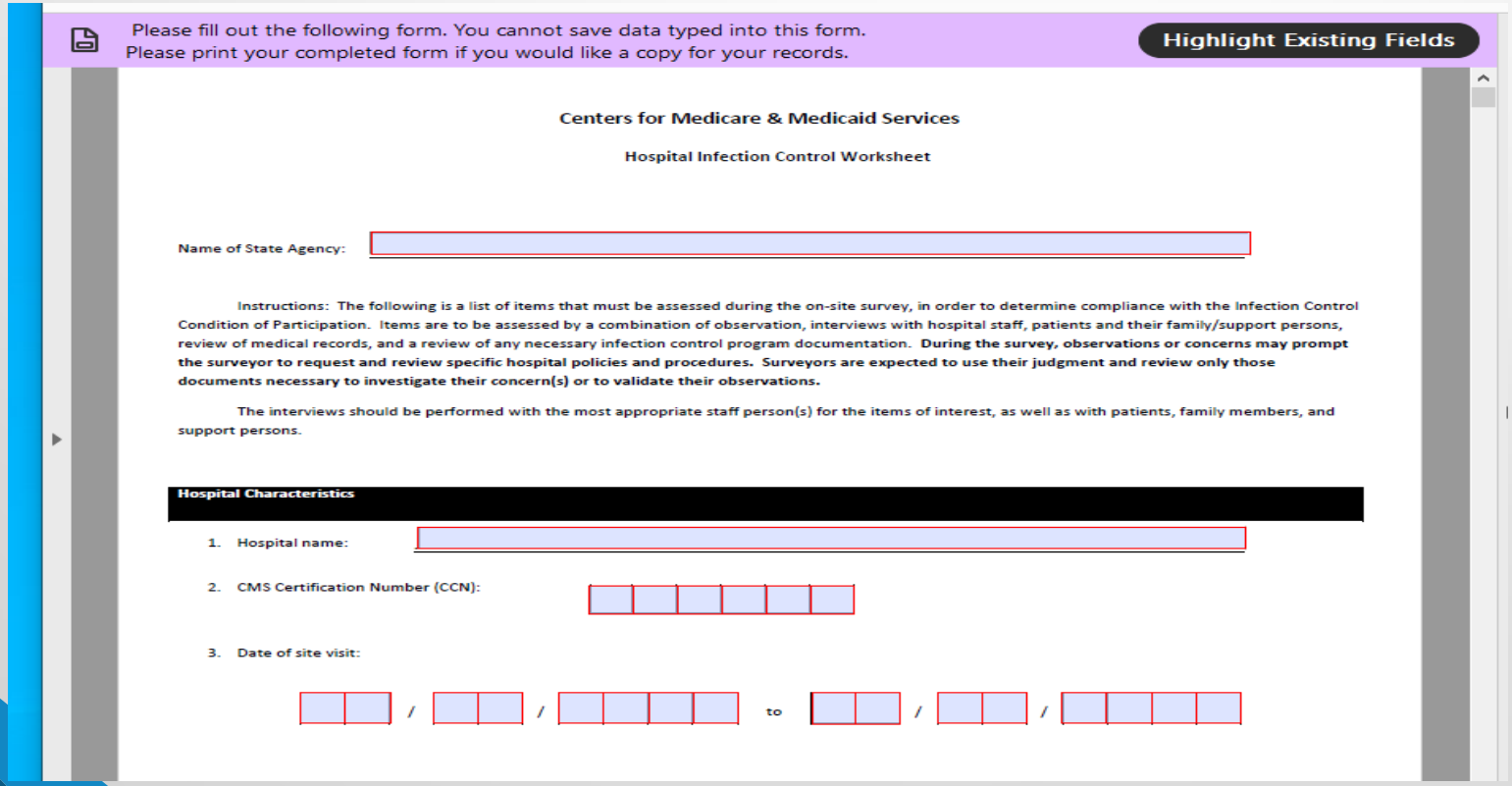
- On September 30, 2019, the Centers for Medicare & Medicaid Services (CMS) published the *Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction* Final Rule, as well as the *Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies* Final Rule.
- This policy memorandum provides guidance to the CMS Regional Offices (ROs), the State Survey Agencies (SAs) and the Accrediting Organizations (AOs) regarding the changes to the regulations and our approach for updating the State Operations Manual (SOM) and applicable surveyor systems.

Background

On September 30, 2019, CMS published two final rules which revised regulatory requirements for the various certified provider and supplier types.

Infection Control Worksheet

- Great self-assessment tool – help to understand how to comply with infection control standards



Please fill out the following form. You cannot save data typed into this form.
Please print your completed form if you would like a copy for your records.

Highlight Existing Fields

Centers for Medicare & Medicaid Services

Hospital Infection Control Worksheet

Name of State Agency:

Instructions: The following is a list of items that must be assessed during the on-site survey, in order to determine compliance with the Infection Control Condition of Participation. Items are to be assessed by a combination of observation, interviews with hospital staff, patients and their family/support persons, review of medical records, and a review of any necessary infection control program documentation. **During the survey, observations or concerns may prompt the surveyor to request and review specific hospital policies and procedures. Surveyors are expected to use their judgment and review only those documents necessary to investigate their concern(s) or to validate their observations.**

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

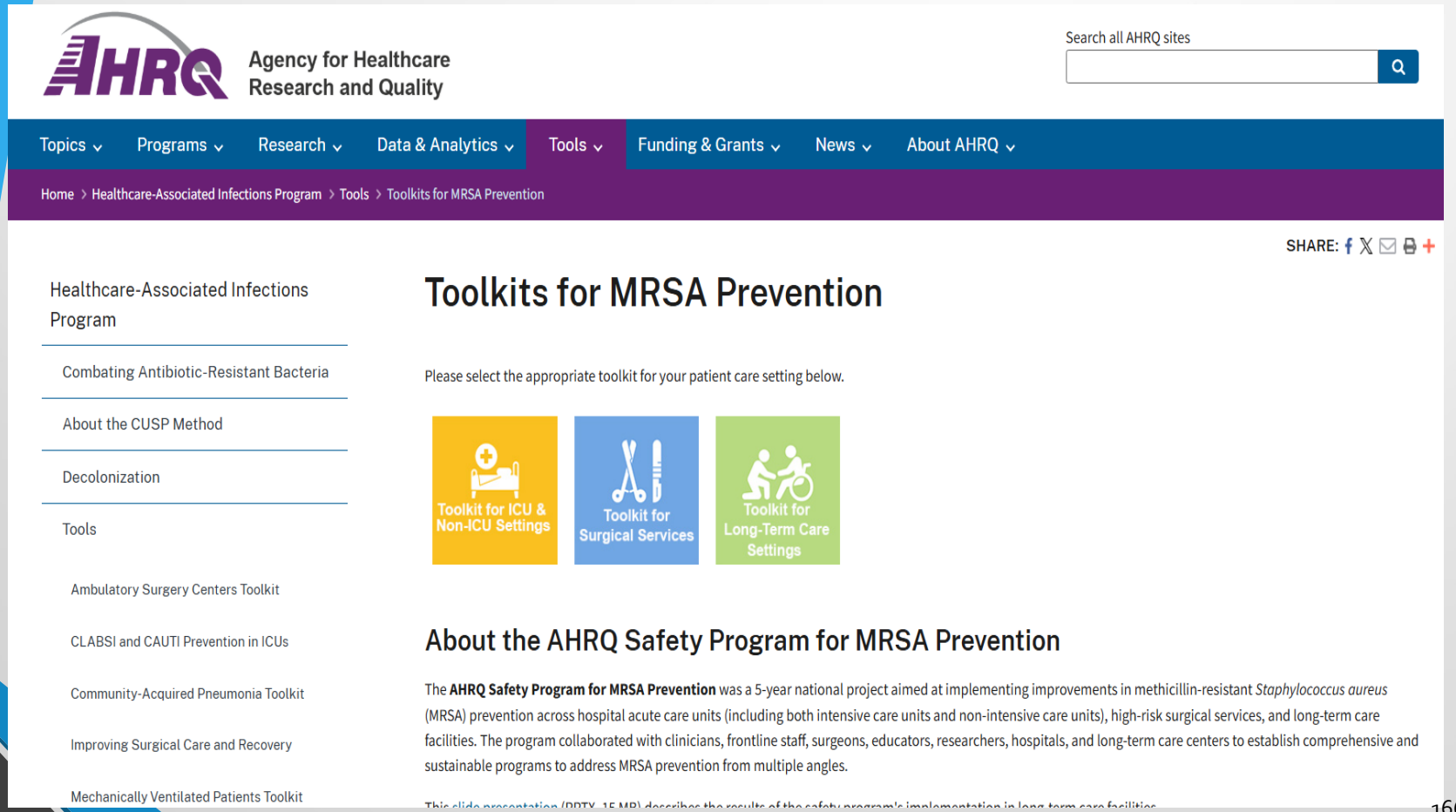
Hospital Characteristics

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

/ / to / /

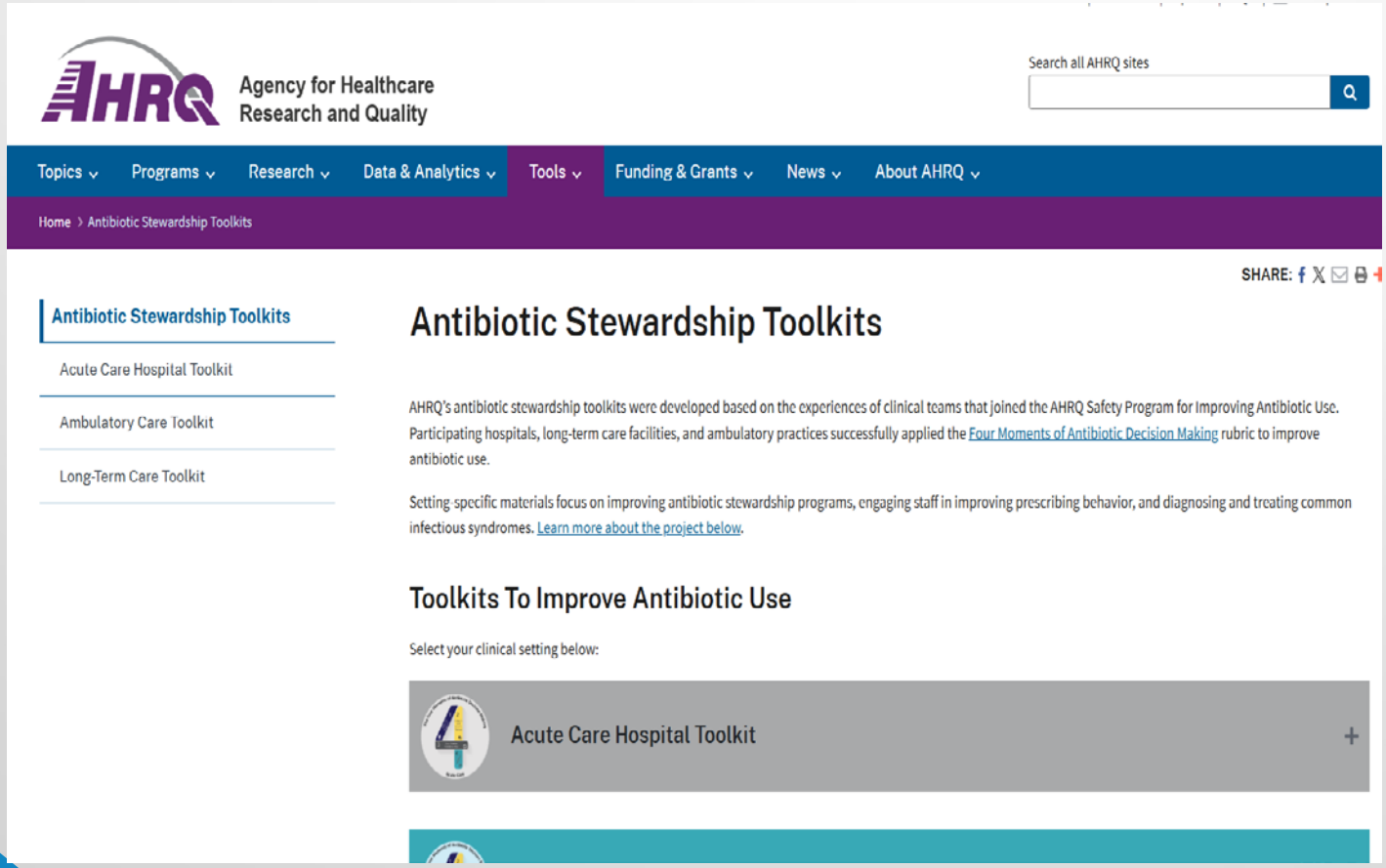
AHRQ Toolkits

https://www.ahrq.gov/hai/tools/mrsa-prevention/toolkit/index.html



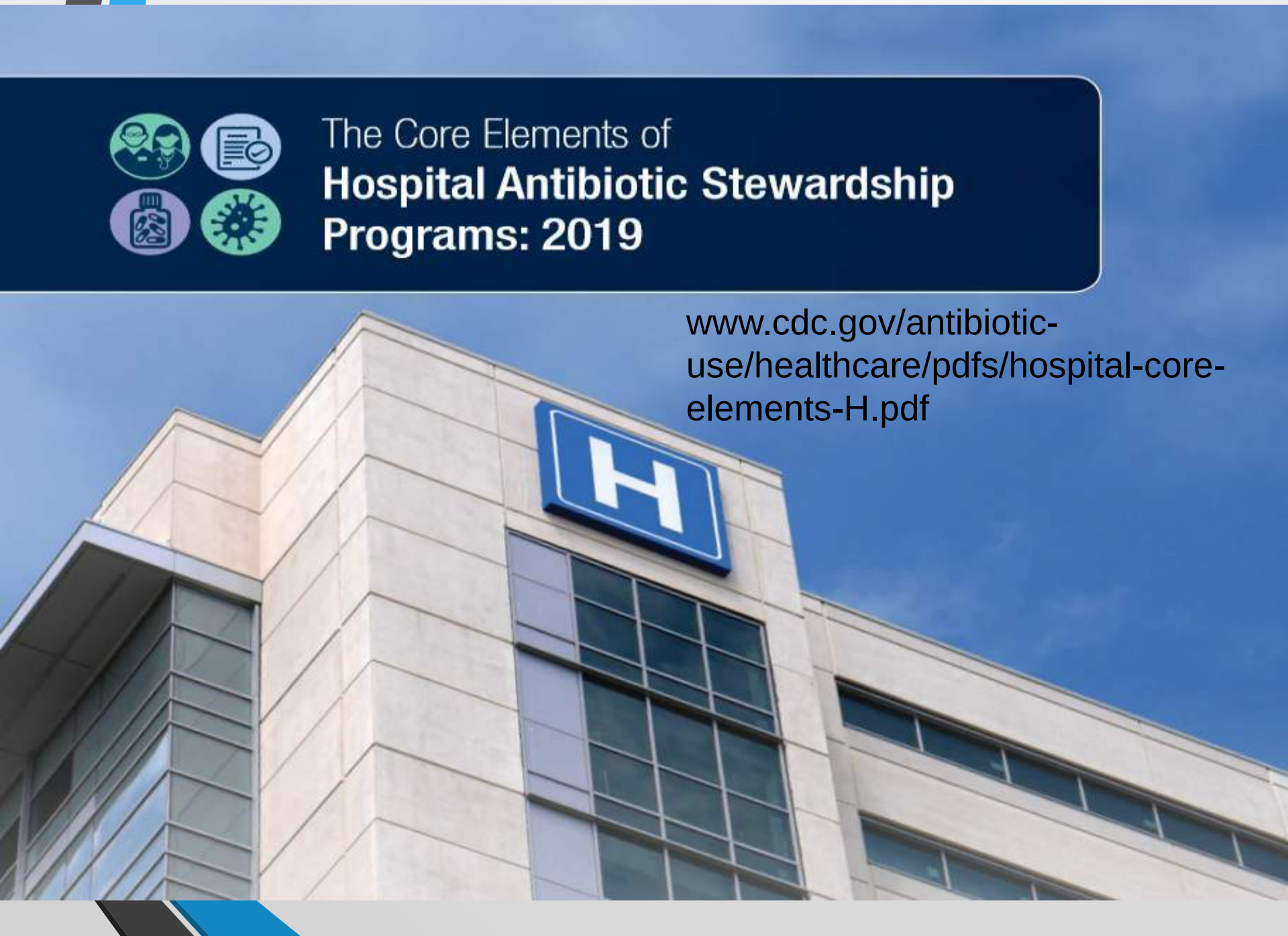
AHRQ Toolkits

https://www.ahrq.gov/antibiotic-use/index.html

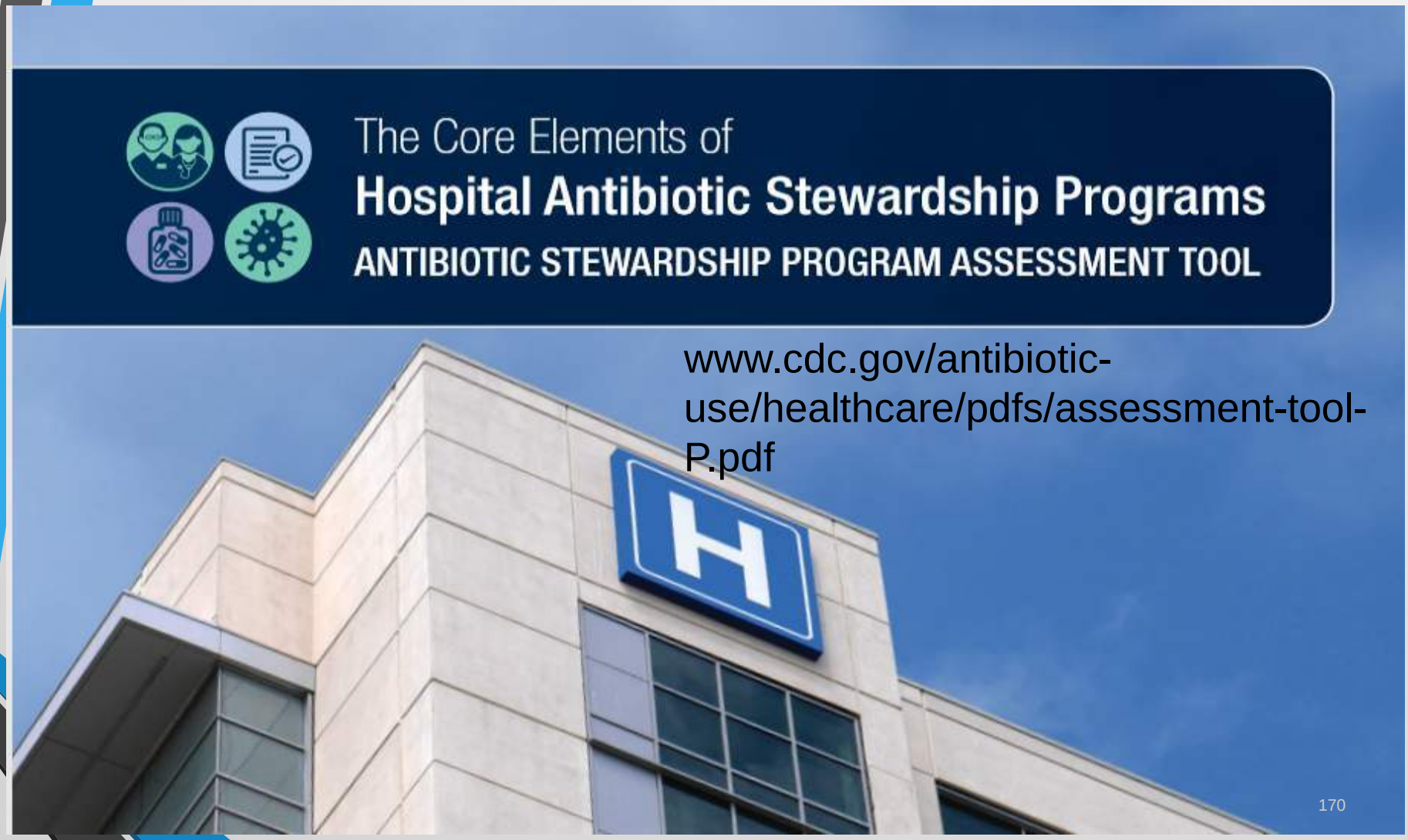


Additional Links

- Burden Reduction: https://www.cms.gov/files/document/burden-reduction-discharge-planning-som-package.pdf.
- Isolation precautions
- https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html/Isolation2007.pdf

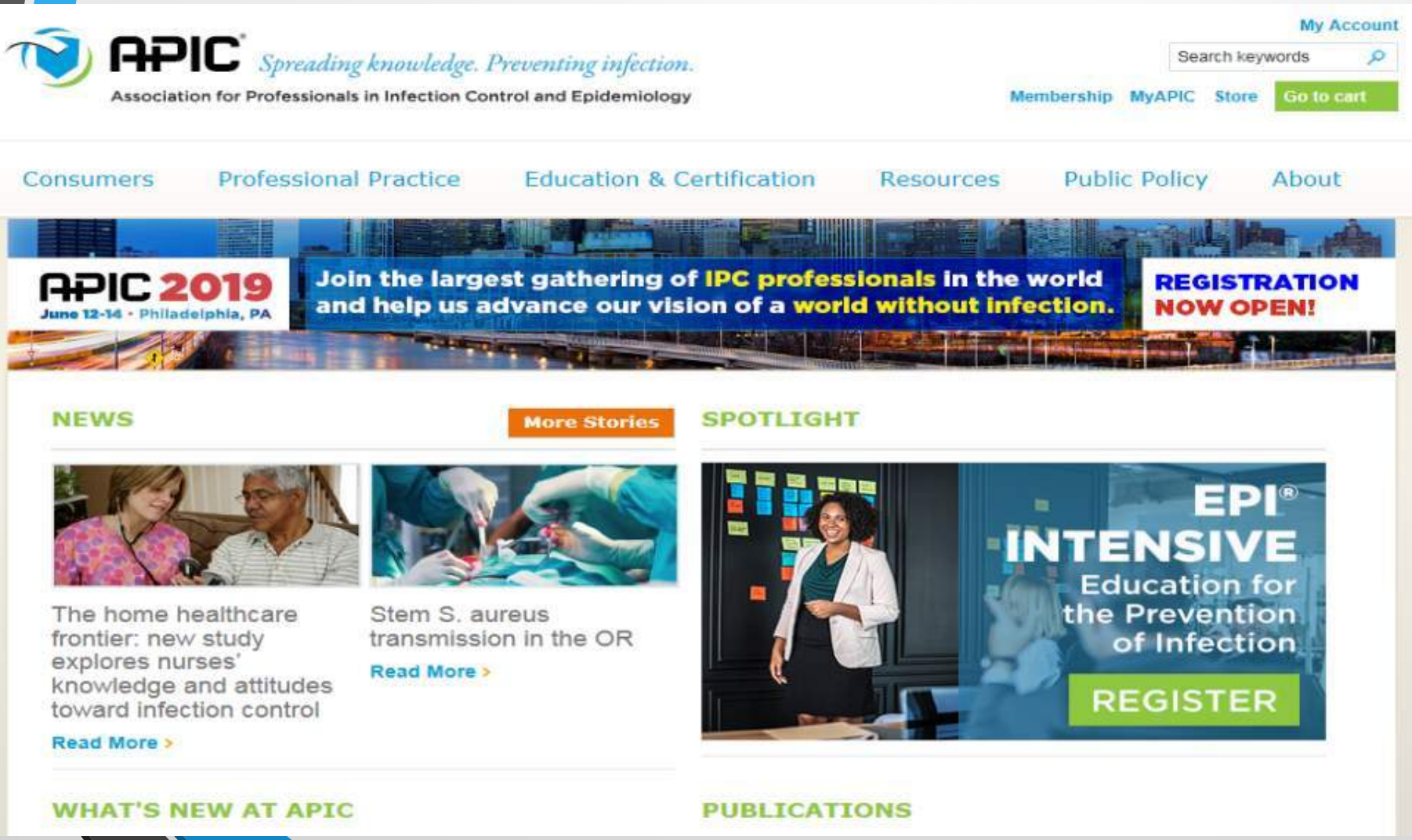

The Core Elements of
Hospital Antibiotic Stewardship Programs: 2019
www.cdc.gov/antibiotic-use/healthcare/pdfs/hospital-core-elements-H.pdf

Program Assessment Tool



APIC Website

www.apic.org



SHEA Website

www.shea-online.org/



OSHA Website



CDC Website www.cdc.gov/



Professional Practice

- Overview
- Developmental path of the infection preventionist
- Infection preventionist (IP) competency model
- APIC Fellows Program
- Implementation guides
- Practice resources
- Scientific guidelines
- Research
- Emergency preparedness
- AJIC
- International Infection Prevention Week
- MegaSurvey 2020
- Practice Guidance Committee Activities

Infection preventionist (IP) competency model

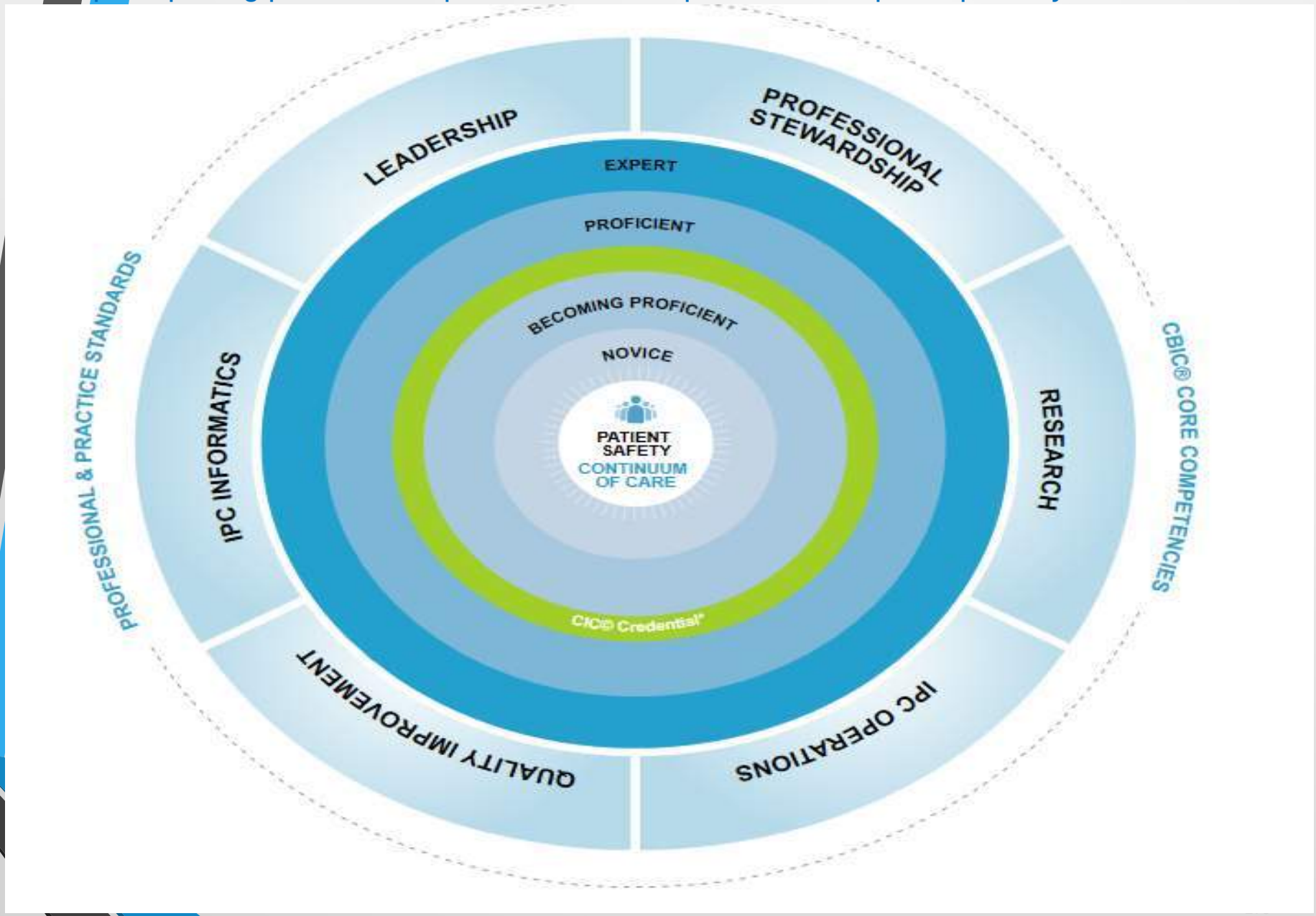
11

To meet the demands of the rapidly expanding field of infection prevention, and equip professionals for the challenges of the future, APIC created the first model for infection preventionist (IP) competency in 2012. Learn more about the May 2012 white paper in the American Journal of Infection Control (AJIC).

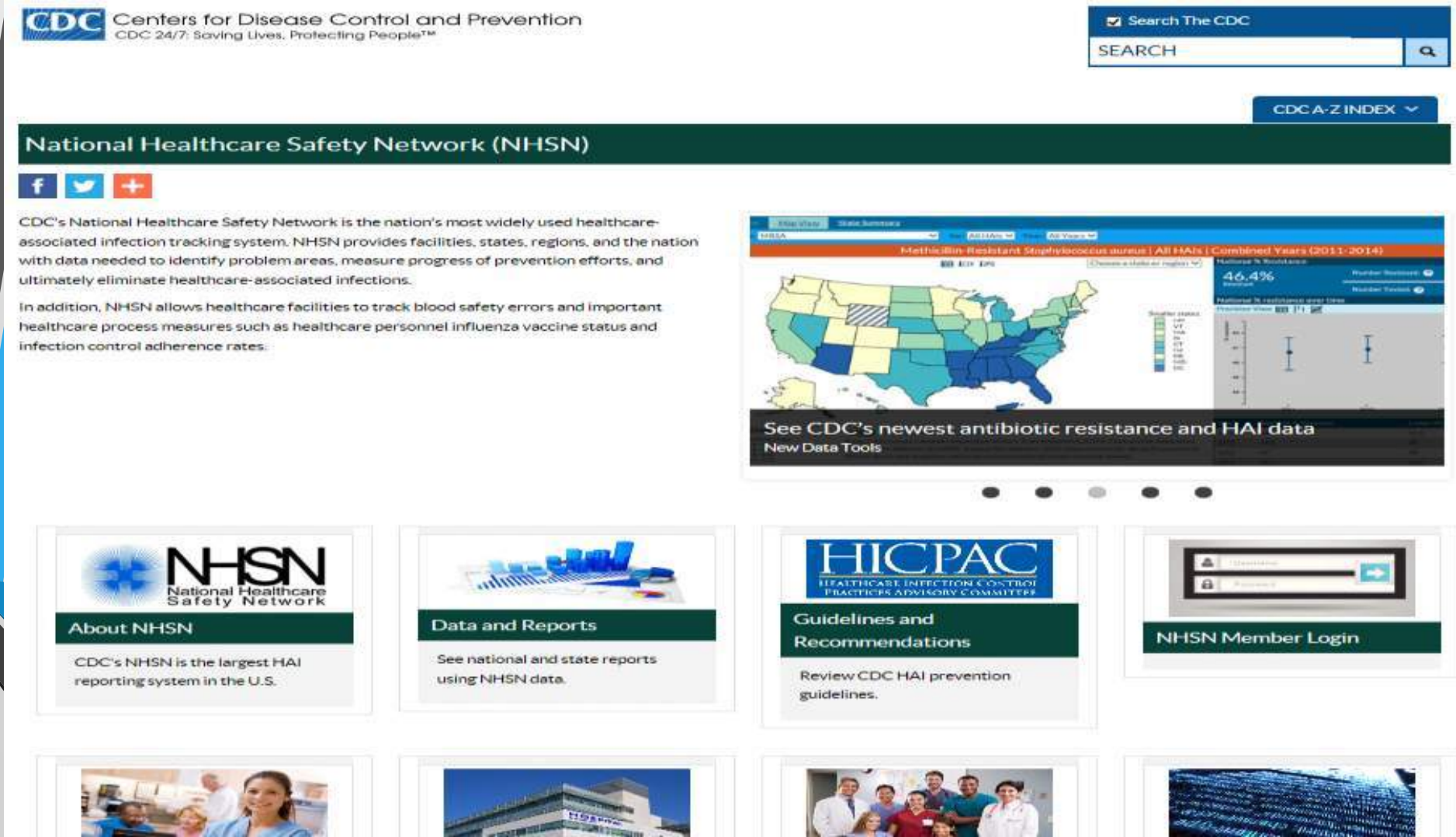
The updated **APIC Competency Model for the IP** (enclosed below) also reflects the dynamic nature of the IPC field. Patient safety remains the core of IPC practice. New to the updated model is a focus on the continuum of care. The updated model has four career stages (Novice, Becoming Proficient, Proficient, and Expert) and six future-oriented competency domains (each with subdomains) to guide IPs in progressing through the career stages and pursuing leadership roles.

- Access the **June 2019 *AJIC* white paper** introducing the updated model. It includes guidance on application and examples of competency statements across career stages.
- Access the **Summer 2019 *Prevention Strategist*** article featuring an interview with members of the Competency Model Revision Task Force.
- **Novice or Becoming Proficient IP self-assessment tool for the** CBIC core competencies and APIC Competency Model.
- **Sample job description** for an IP developed by the Professional Development Committee.
- **Explore the updated, interactive competency model below.** To see a definition for each element in the model, including for each future-oriented competency domain and subdomain, click on the screen.

https://apic.org/professional-practice/infection-preventionist-ip-competency-model/



CDC National Healthcare Safety Network



CDC NHSN Surveillance

National Healthcare Safety Network (NHSN)

CDC's National Healthcare Safety Network is the nation's most widely used healthcare-associated infection tracking system. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate healthcare-associated infections.

In addition, NHSN allows healthcare facilities to track blood safety errors and important healthcare process measures such as healthcare personnel influenza vaccine status and infection control adherence rates.

www.cdc.gov/nhsn/



NHSN National Healthcare Safety Network

About NHSN

CDC's NHSN is the largest HAI reporting system in the U.S.



Data and Reports

See national and state reports using NHSN data.

HICPAC Healthcare Infection Control Practices Advisory Committee

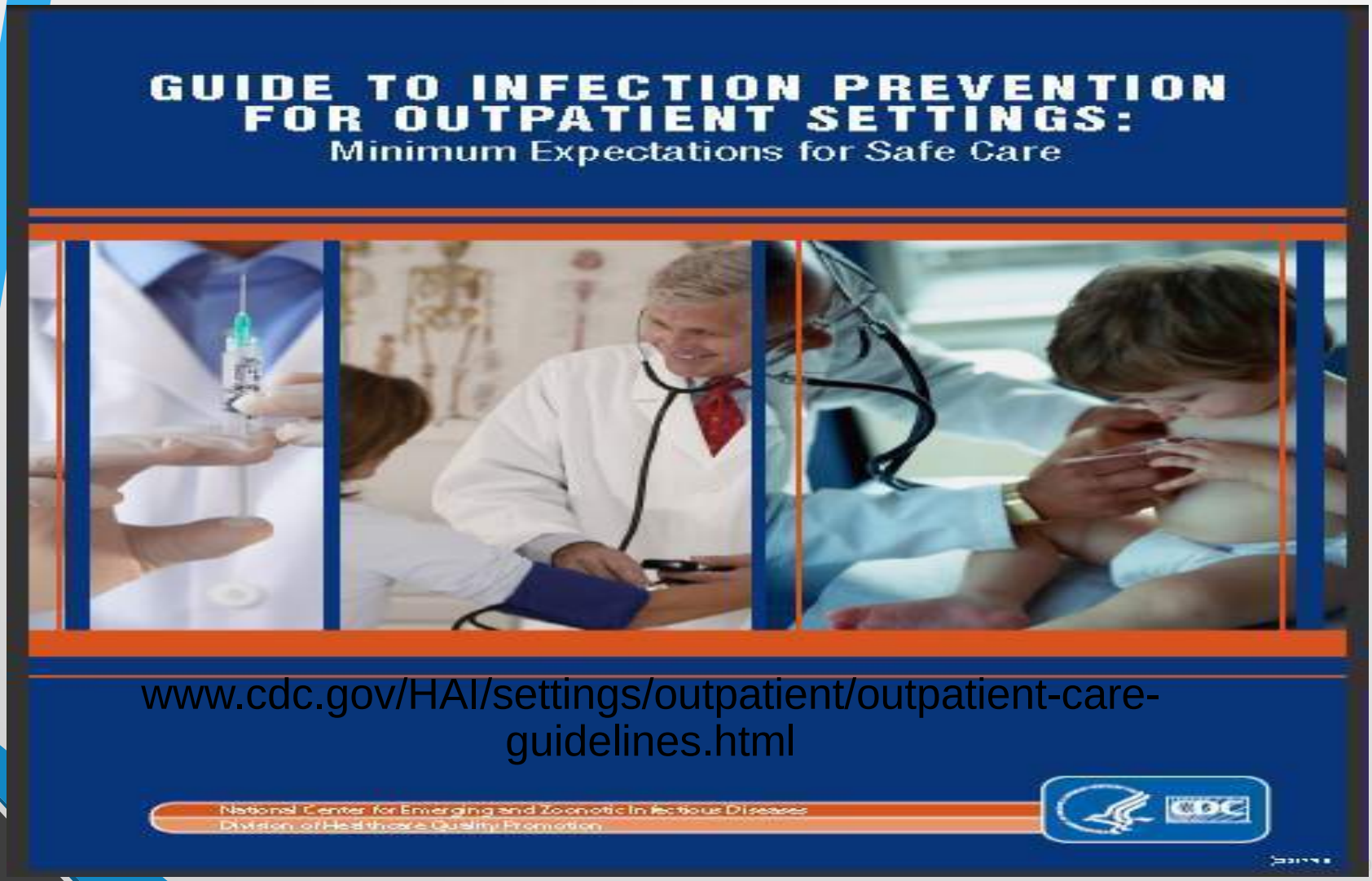
Guidelines and Recommendations

Review CDC HAI prevention guidelines.



NHSN Member Login

CDC Guide Infection Control Outpatients



Section 2: Infection Control Program and Infrastructure

I. Infection Control Program and Infrastructure

Elements to be assessed	Assessment	Notes/Areas for Improvement
A. Written infection prevention policies and procedures are available, current, and based on evidence-based guidelines (e.g., CDC/HICPAC), regulations, or standards. *Note: Policies and procedures should be appropriate for the services provided by the facility and should extend beyond OSHA bloodborne pathogens training*	○ Yes ○ No	
B. Infection prevention policies and procedures are re-assessed at least annually or according to state or federal requirements, and updated if appropriate.	○ Yes ○ No	
C. At least one individual trained in infection prevention is employed by or regularly available (e.g., by contract) to manage the facility's infection control program.	○ Yes ○ No	

Infection Prevention and Control Assessment Tool for Outpatient Settings

This tool is intended to assist in the assessment of infection control programs and practices in outpatient settings. In order to complete the assessment, direct observation of infection control practices will be necessary. To facilitate the assessment, health departments are encouraged to share this tool with facilities in advance of their visit.

Please note, Not Applicable should only be checked if the element or domain is not applicable to the types of services provided by the facility (e.g., the facility never performs point-of-care testing, controlled substances are never kept at the facility). If a particular service is provided by the facility but is unable to be observed during the visit (e.g., no injections were prepared or administered during the visit) that section should still be completed by interviewing relevant personnel about their practices.

www.cdc.gov/infectioncontrol/pdf/icar/outpatient.pdf

Overview

Section 1: Facility Demographics

Section 2: Infection Control Program and Infrastructure

Section 3: Direct Observation of Facility Practices

Section 4: Infection Control Guidelines and Other Resources



CDC Free Training Modules



ANNA Learning Leading Connecting
American Nephrology Nurses Association

About ANNA | Education | Practice | Health Policy | Resources

CDC/STRIVE Program Offers Free Infection Control Training Courses

Posted: July 25, 2019

A new national infection prevention and control program funded by the Centers for Disease Control and Prevention (CDC) features free training courses for health care professionals. The States Targeting Reduction in Infections via Engagement (STRIVE) curriculum will include over 40 individual training modules grouped into 11 courses that focus on foundational and targeted infection prevention strategies.

Three courses are currently available:

- Competency-Based Training, Audits, and Feedback
- Hand Hygiene
- Strategies for Preventing Health-Acquired Infections (HAIs)

www.annanurse.org/article/strive

Additional courses will be launched throughout the year. Courses can be taken in any order, and all courses offer free continuing education.

Go to CDC / STRIVE Infection Training Courses

About STRIVE

The States Targeting Reduction in Infections via Engagement (STRIVE) is a national infection prevention and control program, funded by the Centers for Disease Control and Prevention (CDC) and administered by the Health Research & Educational Trust (HRET) of the American Hospital Association. The STRIVE curriculum is intended for the infection prevention team, hospital leaders, clinical educators, nurse and physician managers, environmental services managers, all patient care staff, and patient/family advisors.

CDC Resource IP Training

- Is nursing home infection preventionist training
- Many of the same issues apply to hospitals
  - Has 23 modules
- Includes: water management, linen management, TB prevention, infection surveillance, injection safety, infection control plan, point of care testing, hand hygiene, cough etiquette, outbreak management and more
- Training is free and flexible
  - CNE available

CDC IP Training

www.train.org/cdctrain/training_plan/3814

Nursing Home Infection Preventionist Training

Back

To access content, you first need to create an account. If you already have an account, please login.

ID 3814

If you wish to earn continuing education (CME, CNE, or CEUs), *you must first register for the Nursing Home Infection Preventionist Training Course by selecting the blue Register button at the top right of this page.* Select the Show More link below for information about the course, including tips and resources to guide you in completing modules and obtaining continuing education (CE).

Program Description:
This course will provide infection prevention and control (IPC) training for individuals responsible for IPC programs in nursing homes so they can effectively implement their programs

Show More

Name	Completed Date	Score	Hours	Status
Module 1 - Infection Prevention & Control Program			0.75h	
Module 2- The Infection Preventionist			0.5h	
Module 3 - Integrating Infection Prevention and Control into the Quality Assurance Perform			0.42h	
Module 4 – Infection Surveillance			1h	
Module 5 - Outbreaks			0.75h	
Module 6A – Principles of Standard Precautions			0.75h	
Module 6B – Principles of Transmission-Based Precautions			0.75h	
Module 7 - Hand Hygiene			0.75h	
Module 8 - Injection Safety			0.92h	
Module 9 - Respiratory Hygiene and Cough Etiquette			0.42h	
Module 10A - Indwelling Urinary Catheters			1h	
Module 10B - Central Venous Catheters			0.5h	
Module 10C - Infection Prevention during Wound Care			0.5h	
Module 10D - Point-of-Care Blood Testing			0.5h	

CDC STRIVE Infection Control Training

- Developed by IPs by the Health Research & Education Trust
  - Courses can be taken in any order
  - There is no cost
- Great for new employee training, periodic training, and annual infection control training
- Includes many such as environmental cleaning, personal protective equipment, competency-based audits and feedback, hand hygiene, strategies to prevent HAIs, patient and family engagement etc.

CDC/STRIVE Infection Control Training

States Targeting Reduction in Infections via Engagement (STRIVE)

www.cdc.gov/infectioncontrol/training/strive.html

Courses

- Foundational Infection Prevention (IP) Strategies
  - Competency-based Training, Audits and Feedback – WB4220
  - Hand Hygiene – WB4221
  - Strategies for Preventing HAIs – WB4223
  - Environmental Cleaning – WB4224
  - Personal Protective Equipment – WB4225
  - Patient and Family Engagement – WB4226
  - Building a Business Case for Infection Prevention – WB4227
- Targeted Prevention Strategies
  - Catheter-Associated Urinary Tract Infection (CAUTI) – WB4222
  - MRSA Bacteremia – WB4228
  - Central Line-Associated Blood Stream Infecti (CLABSI) – WB4229
  - *C. difficile* Infection (CDI) – WB4230

The CDC/STRIVE curriculum was developed by national infection prevention experts led by the Health Research & Educational Trust (HRET) for CDC.

Contact

HHS Infection Control Video

- Training video every nurse, physician, infection preventionist and healthcare staff should see
  - Includes risk managers
- Is an interactive video
- Called "Partnering to Heal: Teaming Up Against Healthcare-Associated Infections"
- Go to http://www.hhs.gov/partneringtoheal

CDC Injection Safety

- Mentions how unsafe injection practice put patients and healthcare providers at risk
- Have been associated with wide variety of procedures and settings
- Are part of Standard Precautions
- Worked with Healthcare Infection Control Practices Advisory Committee (HICPAC) to develop recommendations on Safe Injection Practices

- https://www.cdc.gov/injectionsafety/cdcsrole.html

Safe Injection Recommendations

- 8 recommendations
- 1. Use aseptic technique to avoid contamination of sterile injection equipment
- 2. Do not administer medication from a syringe to multiple patients
  - Even is needle or cannula is changed



Recommendations – cont'd

- 3. Use fluid infusion and administration sets for one patient only
  - Consider syringe/needle/cannula contaminated once entered
- 4. Use single-does vials whenever possible
- 5. Do not administer medications from single-dose vials/ampules to multiple patient nor combine leftovers for later use

Recommendations – cont'd

- 6. If multidose vials MUST be used – both needle/cannula and syringe used to access the vial must be sterile
- 7. Do not keep multidose vials in immediate patient treatment are
  - Store per manufacturer's recommendations
  - Discard if sterility compromised/questionable
- 8. Do not use bags/bottles of IV solution as common source of supply for multiple patients

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Search

Injection Safety

CDC > Injection Safety > Preventing Unsafe Injection Practices

https://www.cdc.gov/injectionsafety/ip07_standardprecaution.html

Injection Safety
CDC's Role
CDC Statement
Information for Providers +
Information for Patients +
Preventing Unsafe Injection Practices −
Safe Injection Practices
CDC Clinical Reminder: Spinal Injection Procedures
Drug Diversion +
Infection Prevention during Blood Glucose Monitoring and Insulin +

Safe Injection Practices to Prevent Transmission of Infections to Patients

Print

Download the complete 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings
[PDF – 226 pages]

On This Page
Safe Injection Practices
Infection Control Practices for Special Lumbar Puncture Procedures
Recommendations

III.A.1.b. Safe Injection Practices

The investigation of four large outbreaks of HBV and HCV among patients in ambulatory care facilities in the United States identified a need to define and reinforce safe injection practices 453. The four outbreaks occurred in a private medical practice, a pain clinic, an endoscopy clinic, and a hematology/oncology clinic. The primary breaches in infection control practice that contributed to these outbreaks were 1) reinsertion of used needles into a multiple-dose vial or solution container (e.g., saline bag) and 2) use of a single needle/syringe to administer intravenous medication to

Injection Safety Video – 4 minutes



www.youtube.com/watch?v=6D0stMoz80k&feature=youtu.b

Video on Preventing HAI

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

Health Care Quality and Patient Safety

- About +
- Health Care-Associated Infections +
- Adverse Drug Events +
- Trainings and Resources –
  - Partnering to Heal
  - ADEs: Diabetes Agents
  - Pathways to Safer Opioid Use
  - Resources

Get email updates

Sign up for emails about health care quality and patient safety

Partnering to Heal

Partnering to Heal:
TEAMING UP AGAINST HEALTHCARE-ASSOCIATED INFECTIONS

Partnering to Heal is a computer-based, video-simulation training program on infection control practices for clinicians, health professional students, and patient advocates.

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



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



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

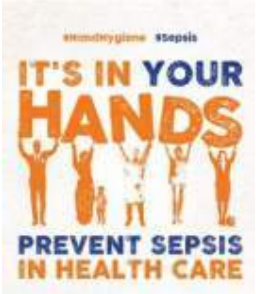


An Infection Preventionist, Janice Upshaw, a new employee charged with using a team-based approach to reducing infections;

CDC Guidelines on Hand Hygiene

Hand Hygiene in Healthcare Settings

Practicing hand hygiene is a simple yet effective way to prevent infections. Cleaning your hands can prevent the spread of germs, including those that are resistant to antibiotics and are becoming difficult, if not impossible, to treat. On average, healthcare providers clean their hands less than half of the times they should. On any given day, about one in 25 hospital patients has at least one healthcare-associated infection.



www.cdc.gov/handhygiene/



HEALTHCARE PROVIDERS
When and how to practice hand hygiene

SHOW ME THE SCIENCE
The truth about hand hygiene

PATIENTS
How to ask questions and protect yourself

CLEAN HANDS COUNT CAMPAIGN
Materials to promote hand hygiene

Additional Resources

Healthcare Antiseptics

CDC Guideline Library

Guidelines Library

www.cdc.gov/infectioncontrol/guidelines/index.html#page=12

Basic Infection Prevention and Control

- Disinfection and sterilization
- Environmental infection control
- Hand hygiene
- Isolation precautions

Antibiotic Resistance

- Multidrug-resistant organisms (MDRO)

Device-associated

- Catheter-associated urinary tract infections (CAUTI)
- Intravascular catheter-related infection (BSI)

Procedure-associated

- Organ transplantation
- Surgical site infection (SSI)

Disease / Organism-specific

- Ebola
- Influenza – A virus (novel)
- Influenza (seasonal)
- MERS-CoV
- Norovirus
- Pneumonia prevention
- Smallpox pre-event vaccination
- Tuberculosis (TB)

CDC Poster: Clean Hands

Clean Hands Save Lives!

- It is best to wash your hands with soap and warm water for 20 seconds.
- When water is not available, use alcohol-based products (sanitizers).
- Wash hands before preparing or eating food and after going to the bathroom.
- Keeping your hands clean helps you avoid getting sick.



When should you wash your hands?

- Before preparing or eating food
- After going to the bathroom
- After changing diapers or cleaning up a child who has gone to the bathroom
- Before and after caring for someone who is sick
- After handling uncooked foods, particularly raw meat, poultry, or fish
- After blowing your nose, coughing, or sneezing
- After handling an animal or animal waste
- After handling garbage
- Before and after treating a cut or wound
- After handling items contaminated by flood water or sewage
- When your hands are visible dirty

www.cdc.gov/h1n1flu/pdf/handwashing.pdf

Using alcohol-based sanitizers







- Apply product to the palm of one hand.
- Rub hands together.
- Rub product over all surfaces of hands and fingers until hands are dry.

Note: the volume needed to reduce the number of germs varies by product.

Washing with soap and water

- Place your hands together under water (warm if possible).
- Rub your hands together for at least 20 seconds (with soap if possible).
- Wash your hands thoroughly, including wrists, palms, back of hands, and under the fingernails.





CDC 8 Recommendations

IV.H. Safe injection practices

The following recommendations apply to the use of needles, cannulas that replace needles, and, where applicable, intravenous delivery systems.

#	Recommendation	Category
IV.H.1.	Use aseptic technique to avoid contamination of sterile injection equipment	IA
IV.H.2.	Do not administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed. Needles, cannulae and syringes are sterile, single-use items; they should not be reused for another patient nor to access a medication or solution that might be used for a subsequent patient	IA
IV.H.3.	Use fluid infusion and administration sets (i.e., intravenous bags, tubing and connectors) for one patient only and dispose appropriately after use. Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's intravenous infusion bag or administration set	IB
IV.H.4.	Use single-dose vials for parenteral medications whenever possible	IA
IV.H.5.	Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use	IA
IV.H.6.	If multidose vials must be used, both the needle or cannula and syringe used to access the multidose vial must be sterile	IA
IV.H.7.	Do not keep multidose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations; discard if sterility is compromised or questionable	IA
IV.H.8.	Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients	IB

Med Administration Organizations

- National Coordinating Council for Medication Error Reporting and Prevention, www.nccmerp.org
- Institute for Healthcare Improvement, http://www.ihi.org/ihi
- U.S. Pharmacopeia, www.usp.org
- Institute for Safe Medication Practices, which offers guidelines specifically – timely medication administration, www.ismp.org/Newsletters/acutecare/articles/20110113.asp
- • Infusion Nurses Society, http://www.ins1.org

Patient Safety Movement Foundation

https://patientsafetymovement.org

Patient Safety

ACTIONABLE SOLUTIONS | OUR NETWORK | ADVOCACY | NEWS | RESOURCES | EVENTS | LEAD US TO ZERO

The Problem

Medical Errors

The World's 14th Leading Cause of Death

Medical errors in hospitals are the third leading cause of death in the United States, just behind heart disease and cancer. Globally it is believed that medical errors kill more people than HIV, Malaria, and Tuberculosis, combined.



The Goal

ZERO Preventable Deaths

ZERO is not just a number – it's our mission

The Patient Safety Movement Foundation believes reaching ZERO preventable deaths in hospitals is not only the right goal, but an attainable one with the right people, ideas, and technology.





https://www.cms.gov/files/document/qso-23-16-hospitals.pdf

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-23-16-Hospitals

DATE: June 6, 2023

TO: State Survey Agency Directors

FROM: Director, Quality, Safety & Oversight Group (QSOG)

SUBJECT: Requirements for Hospital Discharges to Post-Acute Care Providers

Memorandum Summary

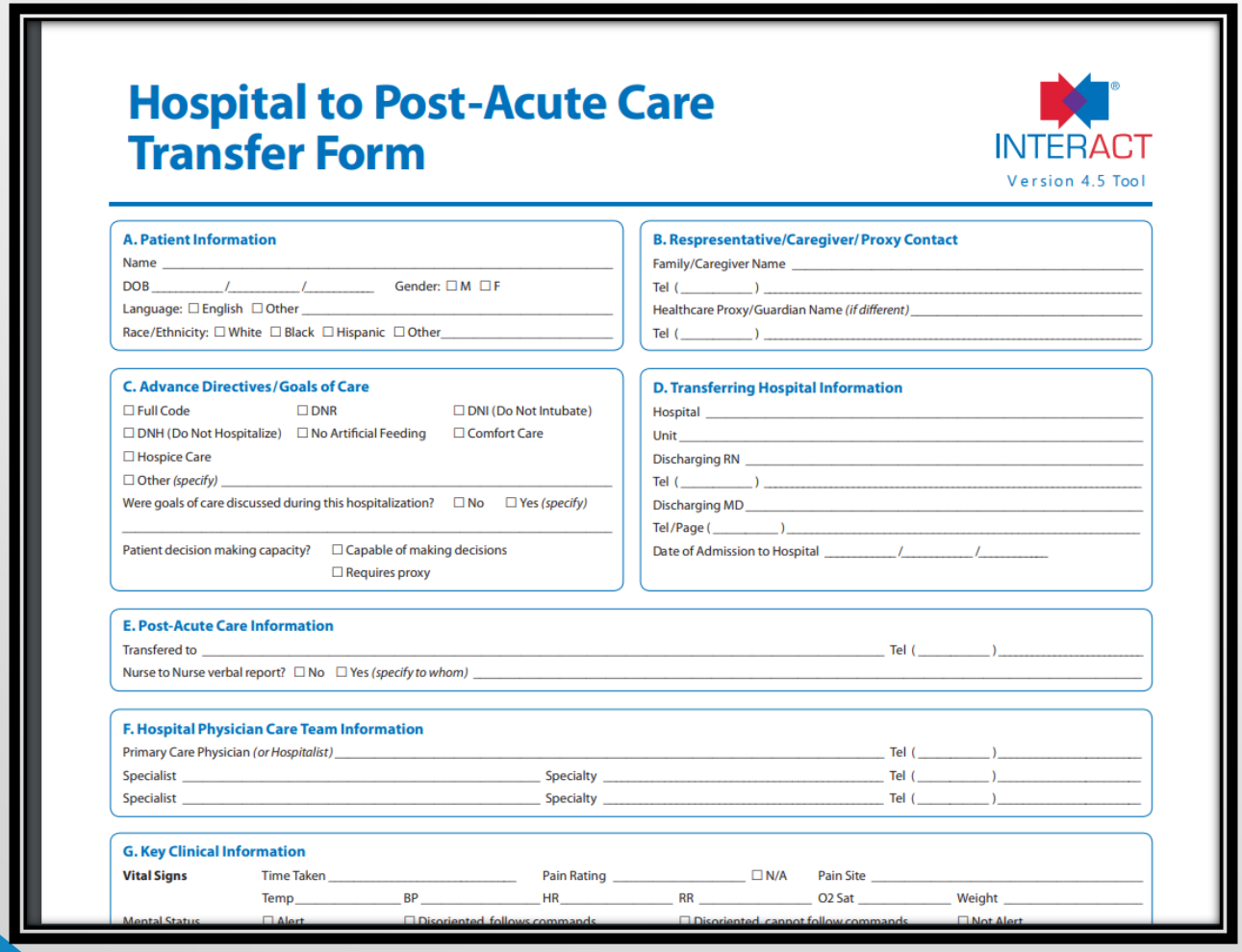
CMS is committed to ensuring that the health and safety of patients are protected when discharges from hospitals and transfers to post-acute care providers occur. Therefore, we are providing the following information:

- Reminding state agencies (SAs), accrediting organizations (AOs), and hospitals of the regulatory requirements for discharges and transfers to post-acute care providers.
- Highlighting the risks to patients' health and safety that can occur due to an unsafe discharge.
- Recommendations that hospitals can leverage to improve their discharge policies and procedures to improve and protect patients' health and safety.

Background:

When a patient is discharged from a hospital, it is important to provide their post-acute provider

Transfer Form – 2 pages (see memo)



Hospital to Post-Acute Care Transfer Form

INTERACT® Version 4.5 Tool

A. Patient Information

Name _____

DOB ____/____/____ Gender: ☐ M ☐ F

Language: ☐ English ☐ Other _____

Race/Ethnicity: ☐ White ☐ Black ☐ Hispanic ☐ Other _____

B. Respresentative/Caregiver/Proxy Contact

Family/Caregiver Name _____

Tel (____) _____

Healthcare Proxy/Guardian Name *(if different)* _____

Tel (____) _____

C. Advance Directives/Goals of Care

☐ Full Code ☐ DNR ☐ DNI (Do Not Intubate)

☐ DNH (Do Not Hospitalize) ☐ No Artificial Feeding ☐ Comfort Care

☐ Hospice Care

☐ Other *(specify)* _____

Were goals of care discussed during this hospitalization? ☐ No ☐ Yes *(specify)*

_____

Patient decision making capacity? ☐ Capable of making decisions ☐ Requires proxy

D. Transferring Hospital Information

Hospital _____

Unit _____

Discharging RN _____

Tel (____) _____

Discharging MD _____

Tel/Page (____) _____

Date of Admission to Hospital ____/____/____

E. Post-Acute Care Information

Transfered to _____ Tel (____) _____

Nurse to Nurse verbal report? ☐ No ☐ Yes *(specify to whom)* _____

F. Hospital Physician Care Team Information

Primary Care Physician *(or Hospitalist)* _____ Tel (____) _____

Specialist _____ Specialty _____ Tel (____) _____

Specialist _____ Specialty _____ Tel (____) _____

G. Key Clinical Information

Vital Signs Time Taken _____ Pain Rating _____ ☐ N/A Pain Site _____

Temp _____ BP _____ HR _____ RR _____ O2 Sat _____ Weight _____

Mental Status ☐ Alert ☐ Disoriented, follows commands ☐ Disoriented, cannot follow commands ☐ Not Alert

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

https://www.cms.gov/files/document/qso-25-05-hospitals-cahs.pdf

Ref: QSO-25-05-Hospitals/CAHs

DATE: **October 22, 2024**

TO: CMS Locations, State Agencies, Hospitals/CAHs, and other stakeholders

FROM: Directors, Quality, Safety & Oversight Group (QSOG), and Survey & Operations Group (SOG)

SUBJECT: Updates to the Condition of Participation (CoP) Requirements for Hospitals and Critical Access Hospitals (CAHs) To Report Acute Respiratory Illnesses

Memorandum Summary

- CMS is committed to taking critical steps to ensure America's healthcare facilities have appropriate insight related to evolving infection prevention and control needs.
- CMS has released new regulatory requirements for all hospitals and critical access hospitals (CAHs) at 42 C.F.R. §§482.42(e) and 485.640(d), respectively, to report information in accordance with a frequency and standardized format, as specified by the Secretary.
- Failure to report the specified data related to COVID-19, influenza, and respiratory syncytial virus (RSV), including confirmed infections of respiratory illnesses among hospitalized patients, hospital bed census and capacity (both overall and by hospital setting and population group [adult or pediatric]), and limited patient demographic information, including age, may lead to the termination of a hospital's participation from the Medicare and Medicaid programs.