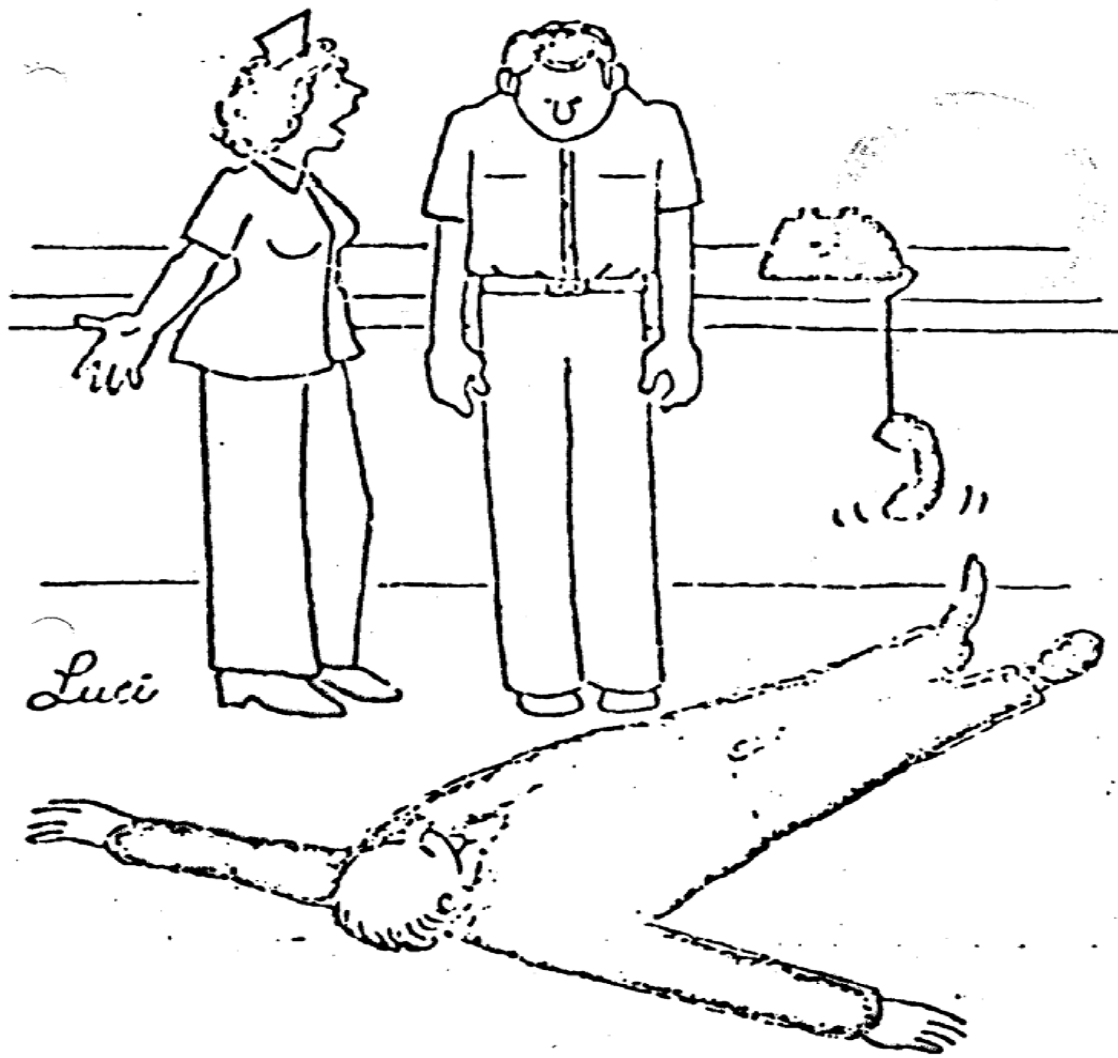


Hot Topics in CAH Survey

Rural Health Resources Live

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"The survey team phoned to say they understand his problems and accept his explanations."

Hot Topics in CAH Survey

- Restraints – New CMS and State Requirements
- Medicare Discharge Instructions – More Paperwork for All!
- Teleradiology – To Privilege or Not To Privilege?
- Evidence-Based Practice: How To Impress Your Surveyor

Restraint/Seclusion

- Patient Rights CoP 482.13 - Does not apply to CAHs unless they have a distinct part psych or rehab unit
- However! Standards (e) and (f) will apply to all hospitals if adopted into State rules.

Restraint/Seclusion

- 42 CFR 482.13 - Patient Rights Final Rule – December 8, 2006
 - Single standard for all uses of restraint or seclusion (Standard e)
 - New definitions of restraint and seclusion
 - Expanded training requirements (Standard f)
 - Expanded death reporting requirements (S&C 06-31, September 2006; Standard g)

Restraint/Seclusion

- 1999 Hospital Rules – WAC 246-320-345(5)(g)
 - “Hospitals will have patient care policies which address use of restraints.”
- New 2008 rules will adopt the CMS restraints regulations 42 CFR 482.13 (e) & (f)
- Standard (g) Reporting Death in Restraints will not apply to CAH’s
 - CAH’s will report death in restraint under State AEs

Restraint/Seclusion

- “A restraint is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely...
- Or a drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition”

- Children’s Health Act

Restraint/Seclusion

- “Does not include devices such as orthopedically prescribed devices, surgical dressings, or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests.”
- “Does not include devices used to protect the patient from falling out of bed.”

Restraint/Seclusion

- Siderails as a restraint:
 - Most of the time siderails function as a restraint; can create more risk
 - Look at how siderails are being used; what is the purpose?
 - Any intervention must be based on the assessment of the patient
 - Cannot be used solely at the request of the family without an assessment, order, etc.

Restraint/Seclusion

- Physically Restraining intubated patients
 - Used inappropriately if all intubated patients are restrained
 - Must be based on individual assessment
- Chemical sedation of intubated patients not a chemical restraint if patient can respond
 - Pavulon for all intubated patients = inappropriate use of a chemical restraint

Restraint/Seclusion

- Protocols for restraints are generally ok, but still need an individual order to implement the protocol
- Cannot be ordered prior to the assessment, ie on a preprinted order set

Restraint/Seclusion

- Chemical Restraints: “Standard Treatment or Dosage”:
 - “The medication is used within the pharmaceutical parameters approved by the FDA and the manufacturer for the indications it is manufactured and labeled to address, including listed dosage parameters”
 - The use of the medication follows national practice standards established or recognized by the medical community or a professional medical association”

Restraint/Seclusion

- “The use of the medication to treat a specific patient’s clinical condition is based on that patient’s symptoms, overall clinical situation, and on the physician’s/LIPs knowledge of that patient’s expected and actual response to the medication.”
- “Enables the patient to more effectively or appropriately function than would be possible without the use of a medication.”

Restraint/Seclusion

- Bottom line: Can the patient engage in activities, function more effectively?
- If impairs function/sedates patient, the medication is being used as a restraint

Restraint/Seclusion

- Seclusion: “The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving.”
 - If a child is directed to sit in a room for a defined period of time and the door is open, this is NOT seclusion.
- Seclusion may only be used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others.

Restraint/Seclusion

- Monitoring (Standard e):
 - Old rule: “The condition of the restrained patient must be continually assessed, monitored, and reevaluated”
 - New rule: “The condition of the patient who is restrained or secluded must be monitored by a physician, other LIP, or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy”

Restraint/Seclusion

- Monitoring (Standard f)
 - “Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to:
 - Respiratory and circulatory status
 - Skin integrity
 - Vital signs
 - Any special requirements specified by hospital policy associated with the 1-hour, face-to-face evaluation

Restraint/Seclusion

■ Training

- “Before performing any of the actions specified in this paragraph,
- As part of orientation; and
- Subsequently on a periodic basis consistent with hospital policy”
- “Physician and LIP training requirements must be specified in hospital policy. At a minimum...a working knowledge of hospital policy regarding the use of restraint or seclusion” (defined by facility)

Restraint/Seclusion

- Face-to-face evaluation within 1 hr. for self-destructive behavior
 - Physician or LIP
 - OR RN or PA who has been trained in accordance with the requirements specified in paragraph (f) to evaluate:
 - The patient immediate situation
 - The patient's reaction to the intervention
 - The patient's medical and behavioral condition; and
 - The need to continue or terminate the restraint/seclusion

Restraint/Seclusion

- “The patient’s medical and behavioral condition”
 - To identify and/or rule out possible medical or behavioral problems that are contributing to the behavior
 - Medication interactions/adverse reaction
 - Pain
 - UTI
 - Alcohol/drug withdrawal
 - High-level medical evaluation; similar to delegation of the Medical Screening Exam in the ED
 - Must be well-defined in policy, delegated by Medical Staff

Restraint/Seclusion

- Death Reporting Requirements (Standard g) Will not pertain to CAHs
- Reporting death in restraints – State AE #23:
 - “Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility

Medicare Discharge Notification

- Notification of right to appeal discharge to QIO (Qualis)
- Required as result of lawsuit settlement

Medicare Discharge Notification

- 42 CFR 489.27(b) July 2007 - Beneficiary notice of discharge rights
 - 42 CFR 482.13(a)(1) Notification of rights
 - Letter has instructions and required forms
- Also applies to CAHs! – C0150 “Compliance with applicable federal, state, and local laws and regulations”

Medicare Discharge Notification

- Provide “Important Message from Medicare” within 2 days of admission
 - Must use CMS forms (English/Spanish)
- Provide second notice within 2 days of discharge
- Signed notice in chart required
- Hospital stay 2 days or less: 1 notice

Medicare Discharge Notification

- Applies to swing bed transfers
 - Pt. is impacted by possible out-of-pocket expenses
- Does not apply to discharges from acute care/
readmissions to PPS Psych or Rehab
 - Pt. is not impacted by possible out-of-pocket expenses
- If in doubt, call QIO

Medicare Discharge Notification

- To determine compliance:
 - Check chart for admission notices
 - Check charts on patients ready for discharge
 - Is signed notice in chart?
 - Does patient have copy?
 - Was discharge notice given with enough time allowed for patient to call QIO?

Teleradiology: To Privilege or Not To Privilege?

- Telemedicine: A New Frontier
- Teleradiology is being provided on a global scale
 - Nighttime reads may be done by a radiologist on the opposite side of the planet

“Who are these people??”

Teleradiology

- Most common scenario: Teleradiology services are located nearby, within the state/US
- Should each of the individual radiologists in the contracted group be credentialed/ privileged by the hospital?

Teleradiology

- Teleradiology = Contracted Service
 - Hospital is ultimately responsible for the quality of care provided by contractors
- Contract must contain language that ensures radiologists are qualified (have proper “credentials”)
- Facility must have a way to verify qualifications/credentials of contract radiologists on request

Teleradiology

- At the time of the program evaluation/
evaluation of the contract:
 - Select a sample of radiologists who have read radiographs for the hospital within 6 months
 - Request the credentialing files from the teleradiology contractor

Teleradiology

- Verify that those radiologists are qualified
 - Use the RHQN/other network resources through PI program
- Include this information in your CAH program evaluation
 - Have available for review at time of survey

Evidence-Based Practice

- 2001 IOM Report –

“Crossing the Quality Chasm: A New Health System for the 21st Century”

- Challenged health professionals to provide care based on the best available scientific evidence

Evidence-Based Practice

- “Evidence-Based Practice in Nursing & Healthcare: A Guide to Best Practice”

- Melnyk and Fineout-Overholt 2005

- “Patients who receive care based on the best and latest evidence from well-designed studies experience 28% better outcomes.”
- “Only a small percentage of healthcare providers are incorporating research findings into patient care decisions.”

Evidence-Based Practice

- **Barriers to Evidence-Based Practice** (Cabana and colleagues, 1999)
 - Knowledge and lack of awareness (e.g. lack of familiarity with guidelines, guideline accessibility)
 - Attitudes (e.g. lack of confidence in the guideline developer, lack of confidence that the guideline will be effective; lack of motivation to perform the guideline recommendations)
 - Behaviors (e.g. the inability to incorporate patient preferences into clinical decision-making process)

Evidence-Based Practice

- **Overcoming Barriers** (Melnik and Fineout-Overholt, 2005)
 - Promoting Acceptance
 - Correcting Misperceptions
 - Questioning Clinical Practices: Developing Guidelines
 - Develop vision, plan, culture in which EBP is valued and expected.

Evidence-Based Practice

- 5 Steps of Evidence-Based Practice (Melnyk and Fineout-Overholt, 2005)
 - Ask the burning clinical question
 - Collect the most relevant and best evidence
 - Critically appraise the evidence
 - Integrate all evidence with one's clinical expertise, patient preferences, and values in making a practice decision or change
 - Evaluate the practice decision or change

Evidence-Based Practice

■ Examples of EBP

■ Medical Care

- Acute Myocardial Infarction (AMI)
- Congestive Heart Failure (HF)
- Community Acquired Pneumonia (PN)

■ Nursing Care

- Surgical Site Infection Prevention (SIP)
- Ventilator-Associated Pneumonia Prevention (VAP)
- Safety Initiatives (5 Million Lives)

Evidence-Based Practice

- “CMS Compare” Website – Information for Consumer
 - Heart Attack
 - Heart Failure
 - Pneumonia
 - Surgical Care Improvement/Surgical Infection Prevention
- Limitations: Not rated for under 25 cases
 - Often a problem for CAHs with low volumes

Evidence-Based Practice

- EBP and Survey
 - Adoption and application of practice guidelines and safety initiatives not required by State licensing rules
 - However! The surveyor may ask, “Why not?”

Evidence-Based Practice

- WAC 246-320-145 Leadership

“The hospital leaders will:

(2) Ensure all patients have access to safe and appropriate care;”

- Be prepared to discuss why or why not evidence-based practice is being incorporated into facility policies and procedures

Evidence-Based Practice

- Search for Best Evidence: Review evidence-based clinical practice guidelines
 - Websites:
 - National Guideline Clearinghouse
www.guideline.gov (AHRQ, AMA, AAHP)
 - Guideline “Toolkit”
www.rnao.org
 - Tutorials
http://www.urmc.rochester.edu/HSLT/miner/resources/evidence_based/index.cfm
 - Many, many more!

Questions?