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Celebrate Patient Safety Awareness Week!

March 7-13 is Patient Safety Awareness Week

By: Sharon Dills, MSN

Patient Safety Awareness Week will be celebrated this year March 7 – 13, 2010. The goal is to provide education and awareness for improving patient safety. The theme this year is "Let's Talk: Healthy Conversations for Safer Healthcare." This is a wonderful opportunity to engage and partner with patients, staff, physicians and visitors to foster communication and encourage action around patient safety.

Here are a few ideas to make your organization's Patient Safety Awareness Week celebration extra special through staff and patient involvement:

- Patient Safety Innovations Fair
 - Reserve a room and let staff and their families run the booths
 - Have game booths related to solving health and safety issues with practical and unique solutions
- "Risky Business" Rolling Information Carts
 - Take the education & information to staff and patients on the units
 - Let's talk - ask questions and give answers
 - Provide sample size hand gels and safety tip cards
 - Prizes for everyone who plays!
- Rounding for Patient Safety – increase or initiate
 - Team up senior leaders, medical staff and board members
 - Script safety messages for patients, families and friends
 - Ask about their healthcare concerns and ideas
 - Provide campaign pins – XYZ Hospital - Patient Safety Advocate
- Partnering for Safety Poster Contests
 - Address various healthcare/safety topics
 - Display them in visible places
 - Provide prizes for the best posters
- Fostering Safety Survey
 - Annual Culture of Safety Survey
 - Engaging staff and patients
 - Focus on communication concerns and recommendations for improvement
 - Free lunch in cafeteria for all who complete survey
- Speakers to Lead the Charge
 - Keynote speakers are among us!
 - Talk about safety

compliance with each CMS Condition of Participation (CoP), standard, tag and requirement.

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- Invite a family member or former patient who has had a patient safety related experience to share their story with staff and physicians
- Newsletters
 - Get creative with patient safety articles, messages, slogans
 - Share good news about patient safety success stories
 - Puzzles/crosswords related to patient safety (award prizes)

Regardless of how you choose to celebrate, make it informative and FUN! Reward creativity and efforts that engage staff, patients and leaders. Encourage chatter that seeks solutions and spreads the message. Solicit ideas and incorporate them into celebration themes that are appropriate for your organization. Don't forget the theme is "Let's Talk" – so make sure there is lots of face-to-face communication about patient safety.

For more information about Patient Safety week, go to npsf.org. There is a wealth of information related to Patient Safety Awareness Week as well as ongoing education related to patient safety.

Survey Experiences - Emergency Management

What Surveyors are Looking For

By: Marty Piepoli

If you've been surveyed this year, you know that there continues to be an increasing focus on emergency preparedness and management. The Emergency Management tracer has become a separate Joint Commission survey activity, no longer paired with the Environment of Care session. In addition, surveyors are looking for solid emergency and contingency plans, communication mechanisms and staff education and knowledge throughout the survey process. Here's a snapshot of what surveyors are looking for:

- Evidence of leadership and medical staff involvement in pre-planning and development of the Emergency Operations Plan (EOP)
- A solid hazard vulnerability analysis (HVA) that is prioritized with involvement of community agencies and used to develop mitigation and preparation activities
- A comprehensive EOP that includes detailed processes and instructions related to the six critical areas of emergency response (communication, resources & assets, safety & security, staff responsibilities, utilities management and patient & clinical support activities). The EOP must also address the capabilities and response of the hospital should it not have community support for a 96 hour period.
- Credentialing and privileging processes for disaster situations – how are they defined; how have they been implemented.
- How are emergency management drills conducted and evaluated? How are improvements to the EOP developed and implemented as a result of such exercises?

Requirements that were once a component of the Environment of Care standards now comprise 12 standards with over 110 elements of performance. As we know from the events of September 11, 2001, Hurricane Katrina and countless other manmade and natural disasters, preparing for the unthinkable is the responsibility of every healthcare organization.

To learn more about emergency management and surge capacity planning, using HVAs to develop and refine solid EOPs and the latest information from surveyed organizations, join our [Emergency Management & Surge Capacity workshop](#) on April 26th in Baltimore Maryland.



CMS Revises Interpretive Guidelines for Anesthesia Condition of Participation

Changes Went Into Effect December, 2009

By: Jill Ryan

The Centers for Medicare & Medicaid Services (CMS) published revised interpretive guidelines for anesthesia services in its memorandum to State Survey Agency Directors dated December 11, 2009. The revised interpretive guidelines focus on the types of anesthesia services subject to the requirements as well as requirements related to the pre-, intra- and post-operative anesthesia periods. A full review of these changes is recommended to assure that hospital policies, procedures and practices are in compliance.

The clarifications and changes, which were effective in December, include:

- Definitions of anesthesia and analgesia/sedation
- Identification of anesthesia services that are and are not subject to the requirements of this Condition of Participation (COP) (482.52) including moderate sedation
- Delineation of who may administer anesthesia and under what circumstances, including clarifications regarding state exemptions for anesthesiologist oversight of Certified Registered Nurse Anesthetists (CRNAs)
- Required elements of the pre-anesthesia evaluation and plan for anesthesia
- Required elements of the intraoperative anesthesia record
- Clarification related to the required timeframe for the post-anesthesia evaluation (generally within 48 hours of the patient having been moved to the recovery area, but after sufficient time that the patient can participate in the evaluation)

For a complete review of these requirements, [download the revised Anesthesia interpretive guidelines](#).

Were You Aware?

1. In accordance with NPSG.03.04.01, organizations must label all medications with the following elements: medication name, strength, quantity, diluent and volume, preparation date, expiration date (when not used within 24 hours) and expiration time when expiration occurs in less than 24 hours. Within Element of Performance (EP) 3, The Joint Commission (TJC) provides a note that date and time may not be required for short procedures as defined by the organization. A few words of caution about this NPSG:

- Labeling as described in this EP is required even for routine solutions created from single dose containers, i.e., saline and Hibiclens.
- Organizations must define what constitutes “short procedures,” keeping in mind their patient population, nature of procedures, etc.
- To assure safe medication practices, define procedures for discarding unused medications
- Volume cannot be determined by having the original “single dose” containers as a reference for how much solution was placed in the large container on the sterile field
(Courtesy of a response from the TJC Standards Interpretation Group)

2. The Joint Commission has received approval from the Centers for Medicare & Medicaid Services (CMS) as a designated accreditor of advanced diagnostic imaging centers. Such centers must receive accreditation by a CMS-designated accrediting organization in order to bill for MRI, PET, CT and nuclear medicine services to Medicare beneficiaries. Note: it is not necessary for hospital based services to undergo separate accreditation.

3. TJC provided a further revision to the 2010 Universal Protocol related to site marking to clarify that marking is not required for procedures for which insertion sites are not predetermined. (See the February 2010 edition of The Joint Commission Perspectives.)

4. Leaders in the healthcare field have recently published a perspective on today’s healthcare environment that is a “must read” for all of us in the field. Click here to access, [“Cottage industry to postindustrial care – the revolution in health care delivery.”](#) published in the January 20, 2010 edition of The New England Journal of Medicine.