Safe Surgical and Anesthesia Care Webinar

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In the News!

C&A E-Newsletter April 28, 2011

Focus on Pediatrics

Hot Topic! Special Populations: Pediatrics

Sharon Dills, MSN, RN

Do you have a pediatric unit and wonder if you are sufficiently prepared for tracer and/or survey activity? Well, read on for some thoughts on how to approach this special population!

First and most importantly, remember that pediatric patients are not simply small adults! Children have unique needs, anxieties and communication methods. Assure that pediatric staff are trained in, and appropriately use, age-specific language. Special attention should be given to be sure that the pediatric patient is involved in their own care. Ask questions of and listen to the patient – they know what hurts or feels "strange" and can express concerns – just differently than our adult patients.

Assess pain using an age-appropriate pain scale. If the child is older and able to understand, a numeric scale or one that uses faces to illustrate pain levels can be used. If the child is less than

Senior Consultant, Darlene Christiansen, RN, MBA, EdD, has been published in *Synergy*, a magazine by National Association of Medical Staff Services (NAMSS).

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one year old, consider using the Neonatal Infant Pain Scale (NIPS). NIPS consider breathing, arm movement, facial expression, arousal and other factors.

We all know that children are prone to falls; children in the hospital are especially at risk as they are ill, out of their usual environment, on medications, etc. Take caution to use a suitable falls risk assessment. It is not necessary to use the full Morse scale falls risk scale, traditionally used for adults. Consider using a tool that takes into account age, gender, diagnosis, environmental factors, surgery and medications to provide a more accurate assessment. These can be found by searching pediatric falls risk assessment on the intranet. Use caution to be sure the tool is from a reliable source and is accompanied by research. One such tool is the Humpty Dumpty Falls Prevention Program™ developed by Miami Children's Hospital.

Medication can create many issues in the pediatric population. Best practice is to obtain weight in kilograms when calculating any medication dosage. Define which pediatric medications will require a second check before being administered. Also assure that smart pumps are in use for all intravenous (IV) medications. Pediatric crash carts should be readily available, with only pediatric dosages and the most up-to-date Broselow® tape. The organization must determine the requisite training and competencies for staff and assure those are appropriately maintained. For example, if your organization does not require pediatric advanced life support (PALS) for all staff on the pediatric unit; then best practice might be that at least one staff should be PALS certified within the organization and available on each shift.

Educate the parents. Talk to them about infection control, safety, and the increased risk for falls while in the hospital. Teach parents the signs and symptoms that would indicate the child is not doing well. If appropriate in your organization, teach the parents how to call a rapid response.

Focus on infection control matters. Create and follow the organization's policy for toy cleaning. Toys should be cleaned after every use (between each patient). If there are common areas, these areas need frequent cleaning as well as daily terminal cleaning. Teach the parents that they should ask everyone about hand hygiene and they should also wash their hands. If the child is on isolation precautions, teach them why they should also follow procedure and assure that others do.

The care planning process should involve the patient and the parent. Instruct staff to view the child holistically. Of course, any medical/surgical issues and safety issues should be addressed on

the care plan; but also family, emotional, cultural and spiritual factors.

Remind staff to *always* use the two unique patient identifiers. This is extremely important. No matter how well we think we know our patients, it is imperative that the two identifiers be used before administering any medication or performing any procedure.

Stay tuned for more "Special Population" survey tips in future editions of our newsletter.

If you have a request for a Special Population to be addressed, please contact us via email at **info@courtemanche-assocs.com** or by phone at (704) 573-4535.

Informed Consent: Some Tips for Simplifying the Process

Sharon Dills, MSN, RN with Contributors: Nancy McLean, MSHA, RN and Jill Ryan

If your organization is like most, you struggle with informed consent - a seemingly innocuous topic at first glance. What does it mean? Who is legally authorized to obtain consent? For what situations do we need to obtain informed consent? The saga goes on and on! So, how can we simplify things a bit?

Informed consent is more than a document in the clinical record. It is so important that it is addressed in three different locations in the Center for Medicare and Medicaid Services (CMS) Conditions of Participation (CoPs) and in at least ten Joint Commission (TJC) elements of performance; not to mention, legal requirements. The CoPs state that informed consent is the *responsibility of the practitioner performing the surgery/procedure*. Physicians must explain the procedure and discuss the required elements of the process. Nursing staff may not assume this duty. During the informed consent process, the physician must provide the patient/legal guardian information on the following items:

- Risks
- Benefits
- Alternatives
- Possible outcomes

In addition, CoP §482.51(b)(2), states that at a minimum the following elements constitute informed consent:

- Name of the hospital
- Name of the specific procedure
- Name of specific practitioner performing the procedure
- Statement that the procedure or treatment, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient's legal representative
- Patient Name
- Signature of patient/legal guardian
- Date/time patient/legal guardian signed

When creating a policy and procedure for informed consent, it is imperative that you check the CoPs, TJC standards and your state's legal requirements. In addition to the requirements above, the CoPs also outline recommendations for a well-designed informed consent process. The hospital's legal/risk department, medical staff representative, leadership and regulatory staff should all be at the table when it involves informed consent. Policies and procedures related to informed consent should address at a minimum the following:

- What procedures/surgeries require a consent
- Process for obtaining consent
    - Clearly state who has the authority and responsibility
- Exceptions
    - Only in urgent/emergent situations
    - Provide clear examples
- Content of the informed consent form and instructions for completion
- Mechanisms to assure consent is properly executed and in the medical record
- Special situations, including:
    - Minors
    - Legal guardians
    - ECT
    - Investigational medications
    - Psychotherapeutic medications
- Process for rescinding or suspending Advance Directives during the operative period
    - Who performs
    - How documented
    - What if patient refuses

When trying to decide when informed consent is required versus allowing the general hospital consent to suffice, it is best to involve the medical staff. Review the standards with the medical

staff and then create a list of procedures/surgeries that specifically require an additional informed consent to be obtained.

Additionally, while neither TJC nor CMS require an anesthesia consent, CMS recommends it to be good practice. Once these issues have been decided and added to the policy, then all medical staff and other applicable staff can be educated. Refer to CoP §482.24(c)(2)(v) for further information about medical staff involvement.

Remember to address patient rights in this process (TJC standard RI.01.05.01). There must be a policy addressing advance directives (AD). It is not acceptable to state that any AD will be suspended during surgery. A conversation with the patient should first occur. It is best practice to also document that this conversation occurred. This can be done by the anesthesiologist, the surgeon or both. Work with these medical staff departments to decide how they would like this to be accomplished. One of the easiest methods to address suspension of advance directives during elective surgery is to add a paragraph to the consent. Then have the patient initial that s/he has been informed. In addition, the organization must have in place a process if the patient refused to have his/her AD suspended.

Mitigate informed consent issues by employing the following techniques:

- Educate staff and physicians about who is responsible for obtaining informed consent
- Prohibit physician orders that state, "obtain informed consent"
- Develop/Implement your informed consent policy
- Create a method for staff to report concerns/violations
- Enforce informed consent policy and provide re-education and coaching, as necessary

If you have questions/concerns about your organization's consent process or need assistance with your policy, please contact us via email at info@courtemanche-assocs.com or by phone at (704)573-3545.

References:
CMS (June 2009). State Operations Manual, Appendix A. Retrieved from https://www.cms.gov/manuals/down`oads/som107ap_a_hospitals.pdf

TJC (2011). The Joint Commission Comprehensive Accreditation Manual for Hospitals.

Were You Aware?

- The Affordable Care Act (HR 3590) in action:
    - On April 12th, Health and Human Services Secretary Kathleen Sebelius announced the "Partnership for Patients" a patient harm reduction initiative designed to save 60,000 lives over the next three years. Read the press release for all the details.
    - Under the Act, (section 9007) tax-exempt hospitals will need to complete a Community Needs Assessment at least once every three years, beginning with the organizations first taxable year after March 23, 2012. This assessment will include input from the community and assistance from individuals with knowledge/expertise related to public health issues.
- CMS clarified, in Transmittal 128 dated May 2010, the requirement for physician supervision of outpatient diagnostics. See, especially, pages 8-9 of this transmittal which notes physicians must have "direct" supervision and be immediately available for emergency response. This does not require that they be in the room during the diagnostic procedure.
- Survey Coordinators, Risk Managers and other leaders have spent a lot of time over the past several years assuring that contracts for clinical services meet TJC expectations. C&A News provided some guidance on this topic in August 2010. Organizations should also pay close attention to CMS Conditions of Participation when analyzing contracts as well. Any clinical service that is contracted must meet the same requirements as hospital-owned services. See, especially, the following tags:
    - Governing Body – A0083 – contracted services must comply with COPs, standards of care, etc.
    - Governing Body – A0084 – contracted services are evaluated
    - Governing Body – A0085 – list of contracted services
    - Nursing – A0398 – supervision and evaluation of non-employee licensed nurses
    - Also see requirements in Rehab Services, Radiologic Services, Laboratory Services, Dietetic Services, etc.

- A note about survey process – be sure that you know whether or not your organization has indicated on its TJC application whether or not it uses TJC accreditation for CMS “deemed status.” Surveyors apply appropriate standards (i.e., include those identified “for deemed status purposes”) during survey based on what is submitted on the application. This is particularly important when assessing compliance with restraint and seclusion and other key requirements.

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