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CMS tightens regulations around compounding medications

Medications that are prepared outside the pharmacy will soon come under more intense scrutiny by state surveyors, based on recent CMS updates related to pharmacy services.

On October 30, 2015, CMS announced revisions to the survey process and Interpretive Guidelines for the pharmaceutical services and nursing services *Conditions of Participation (CoP)*. The changes:

- Update parts of the pharmaceutical services *CoP* to better align with accepted pharmacy standards of practice. The revised guidance addresses issues related to compounding (custom-preparing) medications, determining beyond-use dates, safe storage, and policies and procedures surrounding high-alert medications and minimizing drug errors.
- Clarify that hospital staff must follow accepted standards of practice when preparing compounded sterile preparations (CSP) outside the pharmacy.

The revisions reflect current pharmacy standards in practice under U.S. Pharmacopeia (USP) 795 and 797, says **Jeff Dandurand, PharmD, BCPS,** lead pharmacy consultant for Compass Clinical Consulting and director of clinical consulting for Clinical Pharmacy Associates. However, while pharmacists will be familiar with these standards, nurses and other staff members who prepare medications outside the pharmacy may not. As a result, hospitals will need to educate nurses and review their practices for preparing medications outside the pharmacy to ensure compliance, Dandurand says.

The changes also give CMS the ability to enforce that hospitals are following accepted pharmacy practices. "By putting [compounding standards] into the *CoP,* whether it's in the Interpretive Guidelines or in the survey procedures section, it gives it more teeth so that the surveyors can actually cite hospitals for noncompliance," says **Victoria Fennel, PhD, RN-BC, CPHQ,** director of accreditation and clinical compliance for Compass Clinical Consulting.

Compounding concerns

The changes come in the wake of a 2012 meningitis outbreak caused by contaminated compounded medications

prepared by the New England Compounding Center. The outbreak led to 64 deaths and sickened hundreds of people.

Health organizations have also raised concerns over sterile compounding practices. An article published in the Institute for Safe Medication Practices' January 15, 2015 newsletter asserted that the Institute "has observed unsafe practices associated with sterile compounding in hospitals" and that pharmacies have failed to learn from serious compounding errors at other facilities.

After the meningitis outbreak, the Office of Inspector General (OIG) led an investigation into hospitals' use of compounding pharmacies. In January 2015, the OIG issued a follow-up report on CMS' and other accrediting organizations' oversight of compounded pharmaceuticals used in hospitals. The report recommended that CMS ensure hospital surveyors are trained on nationally recognized standards for safe compounding practices.

In response, CMS has revised its guidance in Appendix A of the *State Operations Manual* to include more information about compounding and medication administration, updating the following sections:

- The guidance for the Hospital Pharmaceutical Services *CoP* at 42 *CFR* 482.25
- The Nursing Services *CoP* at 42 *CFR* 482.23

Along with these revisions, CMS also announced that it would provide targeted surveyor training related to compounding.

What's changing?

The revisions clarify several issues related to pharmacy standards, including:

- What constitutes "compounding" medications
- Requirements for personnel who prepare, store, or transport compounded medications
- Beyond-use dating for medications

Fennel and Dandurand say they have observed confusion about what is considered compounding or even "mixing" medications among nurses. The revised guidelines use the USP definition of compounding, which is the "preparation, mixing, assembling, altering, packaging and labeling of a drug, drug-delivery device, or device in accordance with a licensed practitioner's prescription, medication order or initiative based on the practitioner/patient/pharmacist/compounder relationship in the course of professional practice."

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The revised guidelines state that all compounding of medications used or dispensed by hospitals must meet or exceed the standards in the USP compounding chapters, which are 795 and 797. USP 795 addresses non-sterile compounding practices, which are typically used for ointments or capsules, which are considered lower risk than CSPs.

USP 797 outlines minimum standards that must be followed by all healthcare personnel responsible for preparing, storing, and transporting CSPs, which are generally administered to patients by injection or infusion and considered higher-risk products.

The revised guidelines clarify that CSPs prepared for immediate use outside the pharmacy must involve mixing no more than three products in a container, in accordance with USP 797.

The standards in USP 797 also address the physical layout of the location where medications are compounded, as well as precautions and quality assurance measures for preparing, transporting, and storing CSPs, based on the level of risk for microbial contamination. The goal of USP 797 is to prevent harm to patients as a result of contamination, variability in strength, or other potential risks associated with compounding.

Dandurand says that while this information isn't new to pharmacists, he thinks the added references to USP 797 will enhance compliance and knowledge around the *CoP*s in the pharmacy community.

"I think where you'll see the most significant changes to compliance in the hospital would be the education of nursing staff and their process and procedure for compounding immediate-use drugs," he says.

Labeling and beyond-use dating

Other significant additions to the *CoP*s are related to labeling and determining beyond-use dates for medications.

The revised guidelines specify that safe medication use requires proper packaging and labeling. Specifically, each floor stock drug container should be labeled with:

- The name and strength of the drug
- Lot and control number equivalent
- Expiration date
- Appropriate cautionary and accessory statements, as well as expiration date and beyond-use date, as applicable

For unit-dose systems, each single package should be labeled with the same information as specified for floor stock containers. Individual drug containers for patients should be labeled with the patient's full name and quantity of drug dispensed.

The revisions also add information about beyond-use dating, which identifies the date and time when a medication must no longer be used, stored, or transported. The beyond-use date takes into account factors that could lead to deterioration or microbial growth during or after the original packaging is opened, and can never be later than the expiration date.

The revisions also reiterate that under USP 797 standards, the beyond-use date is 28 days for multidose medication vials with antimicrobial preservatives that have been opened or needle-punctured, unless otherwise specified by the manufacturer. Beyond-use dates must be determined conservatively and be based on manufacturer's instructions, when available, the revisions state. Also, hospitals must have policies and procedures for pharmacy staff to determine beyond-use dates when not available from the manufacturer, which must meet or exceed USP standards for beyond-use dating.

The revisions clarify that unless a CSP is immediately and completely administered by the preparer (or its administration is witnessed by the preparer), the CSP must be labeled with:

- Patient identification information
- Names and amounts of all ingredients
- Name or initials of the preparer
- The exact hour beyond-use date

Not clearly labeling medications is an issue that Fennel says she often sees in hospitals. For example, a nurse might open a vial and date it, but not specify whether the date is the open date, the expiration date, or the beyond-use date. When this happens, "you have no choice but to throw that medication away. You cannot administer it to the next patient because you don't know whether or not that was the day it was drawn up or the day it actually expired," Fennel says.

Also, when the beyond-use date is 28 days from the open dates, it's important to precisely calculate exactly 28 days later rather than estimating a date approximately a month later, she says.

What to expect from surveyors

As a result of the updates to the revisions, surveyors are likely to more closely examine medications that are prepared outside of the pharmacy.

"I think one of the things that nursing needs to be aware of is that they may be asked questions about what types of medications they have to prepare for patients," Fennel says. If nurses mention several types of medications they're preparing, that may lead to questions for the pharmacy department, she says.

For years, CMS has admonished hospitals to limit the amount of compounding nurses perform outside the pharmacy, Fennel says. In the revised guidelines, CMS reinforces that CSPs should only be prepared by the pharmacy, except during emergencies or when a patient needs a CSP immediately and it's not feasible for the pharmacy to do the preparation.

However, in hospitals without 24-hour pharmacies, nurses often compound medications, and their practices are likely to be scrutinized more under the revised *CoP*s. The revised survey process under the nursing *CoP*s asks surveyors to observe whether immediate-use CSPs prepared outside the pharmacy follow the standards specified in USP 797.

Dandurand says surveyors will be looking to see if nurses who compound medications:

- Have appropriate equipment
- Follow appropriate processes for compounding
- Use aseptic technique
- Properly label and date medications, particularly in regard to beyond-use dating

Surveyors will ask to observe medication passes, which allows them to track several items, including positive patient identification, aseptic technique, handwashing, and patient education, Fennel says.

"[Surveyors] will be observing the preparation of the medication, and they'll be doing it with a closer scrutiny," she notes. "There have been so many different outbreaks of infections related to medications not being prepared correctly that they feel that it is an obligation to ensure that [compounding] is being done correctly outside of the pharmacy—that all of the controls that are possible are being put into place so we can reduce the risk of transmitting an infection to a patient."

Educating staff members

Dandurand and Fennel say it's important for hospitals to educate nursing and other staff members responsible for preparing medications outside of the pharmacy to ensure they're in compliance with the pharmacy standards addressed in the *CoP*s.

When it comes to providing education for nursing, "the most effective resource is already in their own hospital, which is the pharmacy staff," Dandurand says. He recommends working with the pharmacy staff and the quality department to ensure nurses are educated about the standards and have the appropriate resources for compounding on the nursing unit. The American Society of Health-System Pharmacists also provides a comprehensive program for sterile and non-sterile compounding techniques.

Hospitals can add training about pharmacy standards to orientation for staff members responsible for compounding medications outside of the pharmacy, as well as make the subject a competency for existing staff members, Fennel says. It's important to not only test staff members' knowledge about the process, but to observe their process to ensure they're correctly compounding, labeling, and administering medications.

For more information

Check out the following resources for more information about the revisions to CMS' *Conditions of Participation,* as well as pharmacy standards and best practices:

- **CMS Survey and Certification letter 16-01:** Visit *www.cms.gov* and search for "Survey and Cert Letter 16-01." The memo is dated October 30, 2015.
- **OIG report on Medicare oversight of compounded pharmaceuticals:** *http://oig.hhs.gov/oei/reports/oei-01-13-00400.pdf*
- **U.S. Pharmacopeial Convention:** *www.usp.org*
- **American Society of Health-System Pharmacists Sterile Compounding Resource Center:** *www.ashp.org/sterilecompounding*
- **Institute for Safe Medication Practices:** *www.ismp.org*

Where to find updates related to compounding and pharmacy standards

State Operations Manual, Appendix A		
Section	**Subsection**	**Subject**
A-0405 (revised)	482.23 (c)	Standard on preparing and administering drugs
A-0489 (revised)	482.25	Pharmaceutical services *Condition of Participation*
A-0490 (new)	482.25	Standard-level tag for pharmaceutical services Condition for Coverage
A-0491 (revised)	482.25 (a)	Pharmacy management and administration standard
A-0492 (revised)	482.25	Requirements for hospital pharmacy or drug storage area management and supervision
	482.25 (a)(1)	Requirements for hospital pharmacy services supervision and oversight
A-0500 (revised)	482.25 (b)	Delivery of services standard
A-0501 (revised)	482.25 (b)(1)	Requirements for oversight and governing laws for compounding, packaging, and dispensing drugs
A-0502 (revised)	482.25 (b)(2)(i)	Requirements for secure drug storage
A-0505 (revised)	482.25 (b)(3)	Requirements for managing outdated, mislabeled, or otherwise unusable drugs/biologicals
A-0507 (revised)	482.25 (b)(5)	Requirements for stopping delivery of drugs/biologicals without prescription or dose-based end times
A-0510 (revised)	482.25 (b)(8)	Requirements about the availability of critical drug information, such as interactions or side effects, for professional staff

Source: www.cms.gov.

Get ready for changes to CMS discharge planning requirements

Healthcare providers could see significant changes to CMS' requirements for discharge planning later this year.

On November 3, 2015, CMS announced proposed revisions to the discharge planning *Conditions of Participation (CoP)* for hospitals, home health agencies, and critical access hospitals. The proposed changes would require hospitals to create discharge plans for all inpatients and certain types of outpatients, rather than simply identifying which patients should have discharge plans. The changes would also add more specific requirements about providers' process for discharge planning as well as the information that must be included and considered in discharge plans.

The proposed changes implement the discharge planning requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, which requires hospitals, critical access hospitals, and certain postacute care providers to use data on quality and resource use measures to help with discharge planning.

CMS says a key piece of the proposed changes requires hospitals to take the goals and preferences of patients and their families into account during discharge planning.

"If this policy is adopted, individuals will be asked what's most important to them as they choose the next step in their care—whether it's a nursing home or home care," CMS Acting Administrator **Andy Slavitt** said in a press release.

The proposed changes will have "some major impact" on hospitals, says **Sue Dill Calloway, RN, MSN, JD, CPHRM, CCMSP,** president of Patient Safety and Healthcare Consulting, Inc.

If approved, the proposed changes will require hospitals to update their discharge planning policies, processes, and forms. "That all takes a lot of time," Dill Calloway says.

Reducing readmissions and the IMPACT Act

The changes come as hospitals are under pressure to reduce readmissions thanks to the Hospital Readmissions Reduction Program, which cuts Medicare payments to hospitals with readmission rates above the national average for certain diagnoses.

In the Background section of the proposed changes to the discharge planning *CoP*s, CMS cites research that estimates one-third of readmissions could be prevented with better transitions of care from the hospital to the community. CMS refined its discharge planning standards in 2004, in response to "a growing recognition of the need to make discharge from the hospital to another care environment safer, and to reduce the rise in preventable and costly hospital readmissions."

Later in 2014, the IMPACT Act required modifications to the *CoP*s and Interpretive Guidelines to mandate postacute care providers, hospitals, and critical access hospitals to consider quality, resource use, and other measures to improve discharge planning.

In response to the IMPACT Act and efforts to reduce avoidable readmissions, CMS proposed changes to discharge planning *CoP*s.

"Patients and their caregivers frequently are not meaningfully involved in the discharge planning process and are unable to name their diagnoses; list their medications, their purpose, or the major side effects; cannot explain their follow-up plan of care; or articulate their treatment preferences and goals of care ... This puts patients at risk for serious complications and increases their chances of being re-hospitalized," according to CMS' introduction to the proposed *CoP*.

What's new

CMS' proposed changes would make several updates to the discharge planning *CoP* for hospitals at 482.43, addressing:

- Hospital discharge planning processes
- Which patients require discharge plans
- Time frames for developing discharge plans and the information discharge plans must contain
- Discharge planning requirements for patients discharged to home or the community
- Discharge planning requirements for patients discharged to another healthcare facility

Currently, hospitals are only required to identify patients for whom a discharge plan is necessary, "but this does not necessarily lead to a discharge plan," CMS states in the introduction accompanying the proposed changes. Discharge planning varies from hospital to hospital, as some facilities use criteria to determine which patients require discharge plans, while others develop discharge plans for all inpatients.

The proposed changes would require hospitals to develop discharge plans for:

- All inpatients
- Outpatients receiving observation services
- Outpatients undergoing surgery or same-day procedures that involve anesthesia or moderate sedation
- Emergency department patients identified in the hospital's discharge planning policies and procedures
- Any other category of patients specified by the hospital's discharge planning policies and procedures, approved by the hospital's governing board

Timelines and written instructions

The updates add time frames for when discharge planning and related tasks must occur. Under the proposed changes, hospitals must begin discharge planning within 24 hours of admission or registration, and complete it before the patient is discharged. If a patient's stay is less than 24 hours, hospitals would be required to complete the discharge planning process before the patient leaves the hospital.

For patients who are discharged home, hospitals would need to provide a copy of discharge instructions and summary to the practitioner responsible for follow-up care, if known, within 48 hours. Pending test results would need to be provided to the practitioner within 24 hours of their availability.

The proposed changes also specify the information hospitals must provide within discharge plans.

For patients who will return home after discharge, hospitals must provide the patient and/or the patient's caregiver:

- Instructions on post-hospital care to be used at home, based on the patient's discharge plan
- Written information about warning signs that require immediate attention and information about who to contact if warning signs arise
- Information about prescriptions and over-the-counter medicines required after discharge

- Reconciliation of post-discharge and preadmission medications
- Written instructions, either on paper or in electronic format, about follow-up care, appointments, pending or planned diagnostic tests, and pertinent contact information, including any providers involved in follow-up care

For patients who will be transferred to another healthcare facility, the proposed changes specify 21 items to be included in the information that hospitals must send to the receiving facility during the transfer.

Giving patients data and choices

The proposed changes to the discharge planning *CoP*s include several provisions focused on providing patients with quality data to make choices about their care after discharge, as well as using patient preferences to determine discharge plans.

Hospitals would be required to help patients and their families select postacute care providers by using or sharing data about the quality and cost of home health agencies, skilled nursing facilities, inpatient rehab facilities, long-term care hospitals, and other providers.

"Patients and their families that are well informed of their choices of high-quality PAC providers, including providers of community services and supports, may reduce their chances of being re-hospitalized," according to the background section of CMS' proposed changes.

Hospitals would be expected to document the post-acute care data used to help patients with discharge planning in the medical record. In the proposed changes to the discharge planning *CoP,* CMS advises providers to use data available through the Nursing Home Compare and Home Health Compare websites until the IMPACT Act finalizes its quality and resource use measures for postacute care.

While hospitals are expected to gather data related to options for post-discharge care, CMS emphasizes that providers should use the information to increase patient participation in discharge planning, rather than make decisions for patients.

The proposed changes also include a new requirement for discharge plans to address the patient's goals of care and treatment preferences. CMS would expect providers to discuss the patient's goals and preferences with the patient and his or her family, document those preferences in the medical record, and take them into account throughout the discharge planning process. Although healthcare providers should already be involving patients in these decisions, this doesn't always happen, Dill Calloway says.

"In the past sometimes we've just said, 'You're going to do this and you're going to do that' instead of asking the patient," she adds.

What's next

The public comment period for the proposed updates to the discharge planning *CoP*s was expected to close on January 4, 2016. After reviewing the comments, CMS will publish a discussion of the comments and eventually issue a final decision on the proposed rule.

With more than 20 pages of proposed changes, it's likely that hospitals will have a good deal of work to do to prepare for them, Dill Calloway says.

"There's just a lot that hospitals have to do," she says. "They're going to have to redo their discharge planning evaluation to include the requirements."

To start getting ready for updates to the discharge planning requirements, she recommends that hospital staff members attend webinars or prepare their own presentations to educate staff members about the changes.

For more information

For more details about the revisions to discharge planning requirements for hospitals, critical access hospitals, and home health agencies, visit:

http://federalregister.gov/a/2015-27840

For more information about the IMPACT Act:

- Go to ***www.cms.gov***
- Select the Medicare tab
- Scroll down to the Quality Initiatives/Patient Assessment Instruments section and select **Post-Acute Care Quality Initiatives**
- In the left navigation, select **IMPACT Act of 2014 Data Standardization & Cross Setting Measures**

Dill Calloway suggests that hospitals convene a committee responsible for updating discharge planning processes to comply with the new requirements, including physicians and midlevel providers, social workers, and discharge planners. The committee should identify actions the hospital needs to take to comply with changes, such as:

- Updating discharge planning policies and procedures
- Rewriting discharge planning evaluation tools
- Revising transfer forms

She recommends appointing a leader for the discharge planning committee, such as the chief nursing officer or director of social work, to ensure committee members accomplish all required tasks on time.

How to comply with the updated staff education and training requirements from Joint Commission, CMS

Editor's note: The following article was written by healthcare consultants ***Marlene Strader, PhD, RN,*** *and* **BOAQ** *advisor* ***Elizabeth Di Giacomo-Geffers, RN, MPH, CSHA.*** *Both are former surveyors for The Joint Commission.*

It has now been 20 years since The Joint Commission and CMS have required training and education for staff. Each year there are more topics for hospitals to include in their training and education programs. From approximately 27 topics appearing in various standards in 2010, the list now is up to more than 40 topics and growing (see table on pp. 10–12). One topic was dropped off the list by both The Joint Commission and CMS: the requirement regarding education and training for appropriate staff on blood transfusions and IV medications.

The Human Resources (HR) chapter of the *Comprehensive Accreditation Manual for Hospitals (CAMH)* is not the only chapter where education and training is addressed. There are multiple other chapters identifying education, including Environment of Care, Information Management, Infection Control, Medical Staff, Rights and Responsibilities, National Patient Safety Goals, Leadership, and Provision of Care; education and training is also addressed in *Sentinel Event Alerts* (see table).

To locate the primary resource standards and element of performance requirements also takes time. In addition, there is a new requirement that has just appeared in the latest proposed prepublication standards: Standard MM.09.01.01, which relates to the new antimicrobial stewardship program. It requires education of staff and LIPs involved in antimicrobial ordering, dispensing, administration, and monitoring about antimicrobial resistance and antimicrobial stewardship practices. This education should take place upon hire and annually thereafter.

CMS also has been including more topics for education, including some that carry heavy weight and could create an immediate jeopardy situation. For example, in some areas of the country, hospitals have received an immediate jeopardy finding because they failed to show adequate training and education for security guards who assist staff in holding patients in the emergency department who are violent and aggressive when restraints are applied (see table). Another immediate jeopardy finding is related to glucometer testing. Nurses and others who perform the test are finding themselves out of compliance with infection control practices: specifically, the multiple wipe-downs of the glucometer and multiple uses of hand hygiene, and glove changes between steps. CMS also has a requirement for training that sometimes gets overlooked—namely, first aid techniques and certification in use of cardiopulmonary resuscitation for all staff who are involved in restraints, including security guards who participate in "holds" (see table).

While the list of Joint Commission topics is somewhat daunting, there have been other additions to the

requirements regarding education and training for specific staff. The HR chapter does not address physicians, LIPs, or allied health practitioners, such as NPs and PAs; however, the expectation is that these individuals are included in many of the requirements.

Frequency of education and training

There are specific time frames for education and training set out by The Joint Commission and CMS. For topics that do not specify education/training at hire and annually, the hospital can determine frequency; many hospitals are adopting a biennial time frame, if it meets applicable law and regulation.

Specific requirements for education and training to occur at hire and annually are as follows:

- Training and education on radiation dose reduction techniques—annually and ongoing
- Safe practices in MRI environment—annually and ongoing
- Prevention of multidrug-resistant organisms (MDRO)—at hire and annually
- Prevention of central line infections—at hire and annually
- Prevention of surgical site infections—at hire and annually
- Proposed education about antimicrobial resistance and antimicrobial stewardship practices—at hire and annually
- Restraint education, training, and competency—at hire and implied annually
- Glucometer training—at hire
- Waived testing—at hire and annually

Required personnel

LIPs, NPs, and PAs should receive education regarding prevention of MDROs, central line infections, and surgical site infections at hire and annually. While education about MDROs applies to most providers in the hospital and off-site services, the hospital can define which category of staff requires education about central line and surgical site infections. Certainly, providers who are not involved in central line insertion (or care of these patients) and surgical procedures would not be required to have this education. The requirement for restraint education for physicians, other LIPs, NPs, and PAs authorized to order restraint or seclusion by hospital policy, in accordance with state law, is to have at minimum a working knowledge of hospital policy regarding the use of restraint and seclusion. It is important to make sure NPs and PAs are included when personnel files are reviewed.

Often contract and agency personnel are a forgotten group. The hospital must define the expectations for these individuals and how they will comply with the requirements. Contractors and agencies may provide education and training that has been approved by the hospital. One important thing to remember: These personnel files will almost assuredly be requested during the HR interview.

Hospitals are expected to educate radiology staff who are monitored for radiation exposure about the appropriate use of the monitoring meters or badges (or through use of a "personal radiation monitoring device," which employs modern technology for the same measurement purpose). These individuals must be educated on the importance of tracking their radiation exposure over various time frames, such as the most recent month and year, as well as their cumulative exposure through work. They also must be educated about the appropriate storage of the meters and/or badges as well as procedures to follow if exposure exceeds cumulative dosage parameters specified per hospital policy. The expectation is for proactive monitoring of staff cumulative dosage and taking appropriate steps if an individual staff member's cumulative dosage level exceeds parameters. Most hospitals have a robust educational program for their radiology staff; however, the new requirement is to make sure this is documented annually and ongoing in personnel files.

It is also important to identify who is required to obtain the necessary education—this will take some thought-provoking decision-making. For example, are respiratory therapists required to have education about organ donation? Some hospitals put everyone in the education basket as it seems easier to achieve compliance by doing so, but this is a burden for those individuals who have neither responsibility nor any relationship to the topic, and it can be costly for the hospital.

It would be appropriate to perform a risk assessment of an individual's need for education and training specific to his or her job description.

Reducing the burden

It can be overwhelming for hospitals to take into account the Joint Commission and CMS requirements, figuring out how to include all of them along with their own areas of mandatory education.

Computer-based training modules have been developed by many hospitals. This may be the simplest method to provide education and training, but not all of it should be conducted in this manner. However, if a computer-based format meets most of a hospital's needs, it is strongly suggested that some prioritization of topics occur. In other words, what is the most/least important? Does a topic contribute to improving patient care or provide compliance with requirements that are difficult to consistently maintain (e.g., pain management education)? Patients still complain their pain needs are not met; thus, this particular topic may be seen as an ongoing priority, which might suggest annual rather than biennial training.

In addition, it also seems that many of the topics could be reduced by including them under one major heading. For example, infection control could include glucometer training, education about prevention of MDROs, CLABSIs, and SSIs, as well as influenza vaccine. Education about National Patient Safety Goals could also include a majority of topics required. If hospitals should decide to reduce the number by including these topics under one section, it is important to identify where surveyors can locate the required topics. Some hospitals highlight or tab the areas where the relevant information is located.

While the list keeps growing, there are proposed changes by The Joint Commission. It will be important to review the accreditor's reduction in required EPs that will be performed in stages beginning in July 2016. There may be deletions in the education and training chapters.

Reference

Comprehensive Accreditation Manual for Hospitals e-dition, January 2016.

2016 hospital education and training requirements: Joint Commission, CMS

#	Topic	Standard *CoP*	Orientation and ongoing education	Required personnel *
1.	Employees reporting safety concerns (to hospital management or Joint Commission without fear of retaliation)	APR 09.02.01	Orientation Ongoing education	Staff and LIPs
2.	Fire safety, security, haz mat, etc., MRI risk reduction, emergency management	EC.03.01.01 §482.41(a) §482.41(b)(7)	Orientation Ongoing education Hospital defines frequency	Staff, LIPs, PAs, NPs
3.	Training for interpreters	HR.01.02.01	Hospital defines frequency	Staff
4.	Pain assessment and management	HR.01.04.01 MS.03.01.03	Orientation and ongoing education Hospital defines frequency	Staff and LIPs, PAs, NPs
5.	Cultural diversity	HR.01.04.01	Orientation	Staff
6.	Orientation	HR.01.04.01	Organizational and departmental orientation, 30-day grace	All employees
7.	Patient rights and ethics	HR.01.04.01 RI.01.01.01	Orientation	
8.	Advanced directives	§482.23(b)(3)	Ongoing	Appropriate staff
9.	Infection control	HR.01.04.01 §482.42	Orientation Hospital defines frequency	Staff
10.	Glucometer training	§482.42	Hospital defines frequency	Staff who perform glucometer testing

2016 hospital education and training requirements: Joint Commission, CMS (cont.)

#	Topic	Standard *CoP*	Orientation and ongoing education	Required personnel *
11.	Forensic restraint, interaction with patients	HR.01.04.01	Orientation	Law enforcement, security personnel
12.	Team training and communication	HR.01.05.03	Ongoing education Hospital defines frequency	Staff
13.	How to report unanticipated adverse events	HR.01.05.03	Ongoing education Hospital defines frequency	Staff
14.	Population (age specific) education and competency	HR.01.05.03	Ongoing education Hospital defines frequency	Staff, agency and contract staff
15.	Fall reduction program	HR.01.05.03	Ongoing education Hospital defines frequency	Staff
16.	Early warning signs change in condition	HR.01.05.03	Ongoing education Hospital defines frequency	Staff and LIPs as necessary
17.	Training and education on radiation dose reduction techniques, addressed in Image Gently & Image Wisely, and safe procedures for operation of types of CT equipment used	HR.01.05.03	Annual and ongoing	Radiologic technologists who perform CT examinations
18.	Safe MRI practices in MRI environment	HR.01.05.03	Annual and ongoing	MRI technologists who perform MRIs
19.	Safe practices in radiology	§482.26(b)	Ongoing	Radiology staff
20.	Orientation, competency, training HCWs who are processing devices, medical equipment and supplies	IC.02.02.01	Orientation Ongoing education as necessary for new employees	All staff as applicable: high-level disinfection, OR, ultrasound GI, central sterile, etc.
21.	Health screening PPD	IC.02.03.01	Required—annual fit testing Hospital determines frequency	Staff, agency and contract staff
22.	Influenza vaccine	IC.02.04.01	Hospital determines frequency	Staff and LIPs
23.	Alternate procedures to follow when electronic systems are not available	IM.01.01.03	Ongoing education Hospital defines frequency	Staff and LIPs
24.	Mission, vision, goals	LD.02.01.01	Orientation	Staff
25.	Safety and quality for all individuals, including code of conduct	LD.03.01.01	Ongoing education	Staff
26.	PI and change management QAPI	LD.03.05.01 §482.21	Ongoing education Hospital defines frequency	Staff
27.	Proposed education about antimicrobial resistance and antimicrobial stewardship practices	MM.09.01.01	At hire and annually	Staff and LIPs involved in antimicrobial ordering, dispensing, administration, and monitoring
28.	Anticoagulation therapy	NSPG 3 03.05.01	Ongoing education Hospital defines frequency	Prescribers, staff
29.	Purpose and proper operation of alarm systems for which they are responsible 01-2016	NPSG 6 06.01.01	Hospital determines frequency	Staff and LIPs
30.	HAIs, MDROs, and prevention strategies	NSPG 7 07.03.01	At hire and annually, based on risk assessment	Staff, PAs, and NPs

2016 hospital education and training requirements: Joint Commission, CMS (cont.)

#	Topic	Standard *CoP*	Orientation and ongoing education	Required personnel *
31.	CLABSI	NSPG 7 07.04.01	At hire and annually based on risk assessment	Healthcare workers, as appropriate
32.	SSI	NSPG 7 07.05.01	At hire and annually based on risk assessment	Healthcare workers, as appropriate
33.	Impairment recognition of LIPs	MS.11.01.01	Ongoing education Hospital defines frequency	LIPs and other relevant staff, PAs, NPs
34.	Abuse and neglect & exploitation	PC.01.02.09 §482.13(c)(3)	Ongoing education Hospital defines frequency	Staff
35.	CPR/BLS/ACLS as required by hospital	PC.02.01.11	If required by job description, ongoing certification as per certification requirements	Hospital defines staff as required by applicable law/ regulation
36.	Needs of dying patient	PC.02.02.13	Ongoing education Hospital defines frequency	Staff
37.	Moderate, deep, sedation, anesthesia	PC.03.01.01	Ongoing demonstration of competency Hospital determines frequency	Nurses, PAs, NPs, LIPs who administer medications used for conscious sedation
38.	Restraint patient care	PC.03.03.07 non-deemed PC.03.05.17 deemed §482.13f	Orientation standard requires competency Ongoing education annually implied Hospital defines frequency	Staff, agency and contract staff LIPs about restraint policy, PAs, NPs
39.	Restraint education	§482.13(e)(11)	Working knowledge of hospital policy regarding use of restraint/ seclusion	LIPs, PAs, designated house staff
40.	Restraint training CMS	§482.13(f)(2)(vii)	Use of first aid techniques & certification in use of cardiopulmonary resuscitation, including required periodic recertification	All staff who are involved in restraint, including security guards who participate in "holds"
41.	Training (discretion & sensitivity to circumstances, beliefs, and desires of families of potential donors)	TS.01.01.01 §482.45(a)(5)	Ongoing education Hospital determines frequency	Staff
42.	Waived testing—evidence of two tests	WT.03.01.01	Education & training At hire and annually	Staff, physicians if instrument testing involved, credentialing, agency/contract staff
43.	Training that requires the use of an instrument—training on use and maintenance 06-01-2015	WT.03.01.01	Hospital determines frequency	Staff, physicians
44.	Education on radiation dosing and training on specific model of equipment used	*Sentinel Event Alert* 47	Ongoing education Hospital determines frequency	All applicable staff and LIPs
45.	Inspection safety and prevention of medication vial misuse	*Sentinel Event Alert* 52	Ongoing education Hospital determines frequency	Staff who administer medication, LIPs, PAs, NPs
46.	Safe handling & prep of authorized meds Equipment, devices, special procedures and/or techniques required for medication administration	§482.23(c)(2)	Ongoing education Hospital determines frequency	Pharmacists, nurses, others as determined by healthcare organization (HCO)
47.	Use of dose packaging system	§482.25(b)(1)	Ongoing education Hospital determines frequency	Pharmacists, nurses, others as determined by HCO
	* Staff, as appropriate to role and responsibilities. All people who provide care, treatment, or services, volunteers and students, not LIPs.			

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