JCAHO changes its name to The Joint Commission

On January 7, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) became known as simply The Joint Commission.

The shortened name is what most people in the field already call the organization, including most officials at the accreditor’s headquarters outside of Chicago.

A December 11, 2006, memo from Joint Commission President Dennis O’Leary to all employees first revealed the name change plans.

“This change is simply intended make our name more memorable than the . . . 18-syllable Joint Commission on Accreditation of Healthcare Organizations,” read O’Leary’s memo, obtained by BOJ. “The shortened name signals and acknowledges the reality of progressive broadening of Joint Commission services and products in order to fulfill our mission. We have lived this reality over the past two decades, and we will likely live it to an ever greater degree in the future.” Along with the name change came a new logo, a new tagline—“Helping healthcare organizations help patients”—and an updated Web design (www.jointcommission.org).

Similar modifications also were made to the Web sites for The Joint Commission’s consulting company, Joint Commission Resources, Inc. (JCR), its Joint Commission International division, and its International Center for Patient Safety, all of which may be accessed via The Joint Commission’s homepage.

Additionally, the Jayco extranet site is now called The Joint Commission Connect. According to sources close to BOJ, the changes were announced during The Joint Commission’s annual surveyor conference and training in Chicago during the first week of January. BOJ editors were denied access to the event.

The Joint Commission communications office has not responded to inquiries made about the name change. Previously, spokesperson Charlene Hill said the organization hired a company to develop a brand strategy, and a name change was one of its recommendations.

Some speculate that the name change has less to do with brand strategy and more to do with an open Government Accountability Office (GAO) investigation into the firewall between The Joint Commission and JCR.

Absent the popular “JCAHO” acronym, perhaps people won’t associate the organization with possible negative findings in the GAO report, the thinking goes.

“[Is the name change] a knee-jerk reaction to a pending GAO report or genuine?”

—Unidentified source

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Q&A with Kurt Patton

Who should perform med rec at transfer?

We are struggling with our medication reconciliation process at the time of transfer. Who, specifically, has to perform transfer reconciliation? Do the sending unit and physician reconcile medications, and then the receiving unit and physician reconcile again?

The requirement for transfer reconciliation only applies when the hospital is transferring the patient to a different level of care. For example, if the patient is moved from a regular unit to the intensive care unit, or from regular to extended care.

When this transfer occurs, it is usually hospital policy to discontinue all medications followed by a reevaluation of which medications should be given in the new environment and changing clinical picture.

Thus, it is only pertinent to reconcile at the receiving unit level and not the sending unit level.

Of course, the sending unit needs to provide a detailed medication list, but then the receiving unit will evaluate that list and the clinical picture to decide which medications will be prescribed after transfer.

The easiest tool to use to facilitate this process is the sending unit’s medication administration record (MAR). The most recent MAR will contain all of the medications that the patient was taking prior to the transfer.

The physician in the receiving unit, in conjunction with the receiving nurse—if time allows—can review the MAR and make decisions about what drug treatment to provide in the new unit.

Many hospitals have had their software vendors modify their MAR to create a transfer reconciliation form by adding a C/D column—for continue/discontinue—that makes the ordering process convenient for the physician. These forms also contain blank spaces to order additional or new medications.

However, a word of caution regarding these forms: If you’re transferring to a unit that uses multiple preprinted order sets or protocols, it can get confusing if you have medications continued from the MAR, new medications ordered by hand on the reconciliation form, and multiple medications ordered from a preprinted order set.

You need to carefully review or reconcile the three lists—MAR, new, and preprinted—to avoid duplications of either the same drug or therapeutic class.

Editor’s note: Kurt Patton, MS, RPh, is former Joint Commission executive director of accreditation services and principal of Patton Healthcare Consulting, LLC, in Glendale, AZ. To ask Kurt a question, e-mail BOJ editor Amy Anthony at aanthony@hcpro.com and look for the answer in an upcoming issue!
Meeting EC 5.20 more challenging in 2007  
‘It’s going to be a full-time-plus job just to maintain the Statement of Conditions’

“Meeting EC 5.20 more challenging in 2007  
‘It’s going to be a full-time-plus job just to maintain the Statement of Conditions’”

Editor’s note: This feature explores problematic Joint Commission standards with expert advice from BOJ advisors Jodi Eisenberg, CPMSM, CPHQ, program manager of accreditation and clinical compliance at Northwestern Memorial Hospital in Chicago, and Elizabeth Di Giacomo-Geffers, RN, MPH, CNAA, BC, a healthcare consultant in Trabuco Canyon, CA.

Keeping up with the LSC has been troublesome in the past for many facilities. However, in 2007, facilities must work even harder to comply with the addition of the Electronic Statement of Conditions (eSOC).

As of July 1, all facilities will be responsible for uploading all SOC data to The Joint Commission’s Web site in the correct format.

Although hospitals have had fair warning about the eSOC, not all hospitals may have the resources necessary to keep updating the eSOC. Once the SOC is online, keeping it up to date will prove challenging, says Eisenberg.

“I think that's going to be one of the most difficult items to comply with, and it will certainly depend on the resources available at each of the organizations—and that's different everywhere you go,” she notes.

Di Giacomo-Geffers stresses the importance of continuously updating the SOC.

“The key issue here is [that the SOC] is a living document, it's a management tool, and you must review it [on an] ongoing [basis], not just before the next survey,” says Di Giacomo-Geffers. “The new eSOC almost places the organization in a position to treat this as a living document that they need to be on top of.”

According to The Joint Commission, the eSOC has been available to organizations since August 2005. This affects part two, Basic Building Information and part four, Plan for Improvement (PFI). The problem for many organizations concerns their existing versions of an eSOC that doesn’t fit the interface of The Joint Commission’s eSOC.

The original date for compliance for part two, January 1, was pushed to July 1. However, many facilities may still struggle with being ready by the later deadline.

“It’s going to be a full-time-plus job just to maintain the [SOC],” says Eisenberg.

Di Giacomo-Geffers says it will be harder for larger hospitals to complete their first eSOC.

“Larger hospitals need a good six months’ lead time because they most likely have more data to enter,” Di Giacomo-Geffers says.

LSC survey specialist: An added challenge

In addition to the eSOC component, hospitals with more than 200 beds have been dealing with an LSC surveyor since 2005.

In 2008, the LSC surveyor will be present for one day of all hospital surveys. Also in 2008, the LSC surveyor will spend two days at hospitals that are 750,000 square feet or larger.

Although both Eisenberg and Di Giacomo-Geffers feel that the increased presence of LSC surveyors has been and will continue to be a good thing, it has made
surveys stricter, requiring more preparation on the part of each facility. “Facilities need to train their Joint Commission coordinators to make sure [that] there is ongoing compliance with environment of care,” says Di Giacomo-Geffers.

Taking extra steps
Eisenberg’s facility, which spans four buildings and contains more than 800 beds, employs a consultant who assists staff with identification of issues in the SOC. This has proven to be even more helpful because of the construction of a new building.

“We’re taking into account how we need to set up the SOC for that particular building, which is different from the other buildings, as we build it,” says Eisenberg.

Tips for compliance
Education—“A team approach in getting the eSOC completed is the best approach,” Di Giacomo-Geffers says. “To accomplish this, everyone who needs to know must be educated. This is including, but not limited to, facilities or plant operation and maintenance staff, safety officers, facility director, and certainly The Joint Commission coordinator.”

Any team of people in charge of the eSOC must pay attention to making “sufficient progress.”

The Joint Commission says that “failure to make sufficient progress toward the corrective actions described in the approved SOC part four, PFI, will result in the recommendation for conditional accreditation.”

“I think people don’t understand what that means,” says Di Giacomo-Geffers. “So we need to educate them on how you demonstrate sufficient progress, and that is to treat the SOC as a management tool.”

Keeping on top of construction—Eisenberg says that facilities should consistently track construction within the organization.

“This means coming up with a preconstruction checklist so that before construction is ever approved, you’ve got the contingency plans in place to maintain the LSC and to keep track of issues that occur during construction,” Eisenberg says.

She also suggests inspecting the construction project on a regular basis, perhaps by surveillance rounds, as a good way to stay on top of LSC violations.

Common RFIs—Lack of positive latching hardware such as trash and linen chutes are frequent problem areas, says Di Giacomo-Geffers. Also, unsealed penetration in fire and smoke walls are a fire risk. Approved automatic sprinkler systems and lack of 18-inch clearance from sprinkler heads are found to be noncompliant, especially in morgues and storage refrigerators (as applicable).

Exit signs must be readily visible from any direction of access. Facilities often store equipment in hallways, leaving little room for an emergency exit. Obstruction of egress and visibility of exits are problematic, says Di Giacomo-Geffers.

Other problems cited include vision panels in doors that failed to meet code and doors that didn’t close properly because they were being held open with tape, wedges, or furniture.
Surveyor’s mastery of tracer methodology shows during lab survey, makes for educational experience

Tracers started at the end and ended at the beginning

After reading this article, you will be able to
1. Describe how a surveyor may conduct a patient tracer
2. Explain a way to meet the challenge of achieving hand-hygiene compliance

The biggest difference between LifeCare Hospitals of San Antonio’s lab survey in 2003 and its survey in November 2006 was that The Joint Commission surveyor did more than just look at competencies—he knew and used the tracer methodology.

LifeCare hosted one surveyor for one day for an arterial blood gasses (ABG) and point-of-care testing lab survey. During the survey, the surveyor completed three tracers: transfusions, blood glucose, and ABGs. Despite his mastery of the tracer methodology, which enabled him to do a more thorough survey than LifeCare expected, the 34-bed specialty and transplant hospital-within-a-hospital located in the South Texas Medical Center received zero RFIs.

“I learned from this guy,” says Marilyn Dillon, RN, director of quality management and infection control. “This surveyor was very sure of himself, and it was clear to me that he knew the tracer methodology very well. It was an excellent survey experience because of this process.”

Starting at the end

The method that the surveyor used for conducting the three tracers surprised Dillon and her staff and has changed the way in which they will conduct mock tracers in the future.

“He started from the end and traced back to the starting point,” Dillon explains. “I learned that if you start from the end of the patient’s visit and work forward, that’s how you pick up any problems that might have occurred. If you work from the start to the end, you’ll never find out what’s missing and what’s wrong. It was even easier to do than we thought.”

For the blood transfusions tracer, the surveyor wanted one patient who had received blood. He also wanted to interview the nurses who had administered the transfusion. Later, he turned his attention to the lab and looked at blood slips. There, he asked staff to explain the process. He asked the following questions:

► Who goes to get the blood?
► How is the blood picked up?
► How many forms of identification are used?

He also quizzed a staff nurse about the following:

► Who does the transfusion?
► How are transfusions ordered?
► How are orders communicated?
► In what time frame are orders executed?

He also wanted to see doctor’s orders and patient consents.

“Every step of the way, he wanted to know what our process was,” Dillon says.

Although LifeCare didn’t receive any RFIs, the surveyor questioned whether there were enough lines on the transfusion sheet to complete vital signs documentation, according to facility policy. “He was very perceptive,” Dillon says. He then asked to see the human resources (HR) file on the nurse who administered the blood and whom he had interviewed.

For the blood glucose tracer, the facility chose another chart for the surveyor to review for finger sticks. LifeCare has a docking station for the glucose machine into which all finger stick information is downloaded to the main lab. The surveyor asked how the facility got its reports and where they were located in the chart. He also

> continued on p. 6
**Tracer methodology**  
<continued from p. 5>

wanted to see a quality assurance report that showed the patient, the tech that performed the finger stick, the number of the machine, the time of procedure, and the results.

“The main lab was notified, and they faxed such a report,” Dillon says. The main lab printed information about the four patients whose charts showed they had finger sticks. By looking at the time frame, the surveyor was able to match which staff person did the blood.

He then asked for the records from HR to be sure that the staff competencies matched the work they were doing. The HR files were in order with up-to-date licenses and competencies, so the surveyor was able to zip through them.

“He did the same with the ABGs,” as well as TM reports and how the facility handles isolation procedures, Dillon said. The surveyor also asked the following questions:

- How are critical values reported and in what time frame?
- Do nurses know what to do with critical values?
- How is the process initiated?
- How are staff and patients/families educated about hand hygiene?
- How do you monitor hand-hygiene compliance?

Similar to many facilities, hand-hygiene education and compliance is a challenge for LifeCare. To meet the challenge, Dillon has initiated a different activity each quarter to raise awareness of hand hygiene. She and her assistant conduct 30 observations per month using the simple, one-page tool shown on p. 7. They focus on blocks of rooms and observe the hygiene technique of all who enter.

“For the families, we have educational pamphlets, hand gel samples, and we discuss the importance of hand-hygiene compliance in the hospital as well as in the community,” says Dillon.

**Other surveyor focus areas**

The surveyor also wanted to know about LifeCare’s environment of care (EC) rounds, how they are conducted and what departments are involved.

“We found out how important it is to have safety meetings and to show supportive documentation of those meetings,” Dillon offers. The surveyor reviewed the seven safety plans and asked some important questions about them.

Dillon, who recently took over as safety officer, says the facility has monthly safety meetings and a rotating calendar for EC rounds that picks up a new manager and staff member each month so everyone gets involved.

Those activities paid off on survey day when all staff could answer the surveyor’s questions.

Another area that the surveyor focused on was LifeCare’s eye flush apparatus. He pointed out that the splash was small, making the bottle hard to locate for someone who has something in his or her eye. Dillon says LifeCare is looking into how to make the flushes better when it opens a free-standing hospital in May or June. The 60-bed facility is under construction and will focus on long-term acute care.

**More changes, more survey prep**

Dillon knows that the next survey will be different, because the facility is changing, but LifeCare will again be ready. “We were really prepared this time,” she says. The CEO and medical director/pulmonologist both attended the opening conference, and the CEO attended the closing conference.

All staff were ready to answer the surveyor’s questions. And the respiratory director, Cindy Wagner, had been working year-round in preparation for survey day, including submitting the lab portion of the periodic performance review.

“We were doing everything we needed to be doing, going into the clinical documentation to see where our weak spots were based on our last survey,” Dillon says. “We’re a tiny lab, but we focus on continuous improvement.”
### Sample hand hygiene compliance tracker form

<table>
<thead>
<tr>
<th>Occupation</th>
<th>MD</th>
<th>Nurse</th>
<th>Other</th>
<th>Handwashing prior to or upon entry into patient room</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Handwashing performed after patient contact</td>
<td></td>
<td></td>
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Handwashing is defined as a minimum of 10 second wash under running water with a hospital approved agent. Hand disinfecting is defined as the use of Prevacare, on the palms and back of hands.

Source: LifeCare Hospitals, San Antonio. Reprinted with permission.
Dealing with physician-to-physician hand-offs
Meeting with residents may help gain consistency in the process

After reading this article, you will be able to
1. describe one reason why physician hand-offs are harder than nursing hand-offs
2. list some factors that improve hand-offs
3. describe the benefit of role-playing hand-offs during orientation
4. recall who to involve in streamlining the hand-off process
5. identify one way to begin the process of streamlining hand-offs

Editor’s note: The following story first appeared in the January Quality Improvement Report, published by HCPro, Inc.

In 2006, The Joint Commission made hand-offs a National Patient Safety Goal. Although hospitals struggle with nurse hand-offs, the problem is even more difficult among physicians, according to Kurt Patton, MS, RPh, former executive director of accreditation services at The Joint Commission and principal of Patton Healthcare Consulting, LLC, in Glendale, AZ.

“Physicians are doing hand-offs, but with different techniques,” says Patton, the author of HCPro’s Hand-off Communication. “There’s no consistency in the process.”

He advises meeting with medical residents to determine best practices, “because they’re usually adept at hand-offs.”

A challenge
But even among medical residents, hand-offs remain a challenge, says Lia Logio, MD, director of the internal medicine residency program at Indiana University School of Medicine in Indianapolis.

“There’s a lot of misfires in communication, there’s a lot of slang, there’s a lot of people talking quickly, telling you about a lot of patients and giving you a lot of details in a quick amount of time,” Logio says. “People don’t really understand what you said, but they don’t have the time to ask you what you meant.”

One reason why physician hand-offs are tougher than nursing ones is that doctors don’t work in shifts as nurses do, Logio says. Another factor is that physicians don’t work on one set unit, so there’s not a home base.

“There’s a lot of unpredictability in a doctor’s work, so at the time of hand-off, you might have to tend to an emergency elsewhere,” Logio says. “Even the best-laid plans go by the wayside.”

Longer resident hours
Exacerbating the problem are shorter resident hours, Logio says.

Vineet Arora, MD, MA, associate program director for the University of Chicago internal medicine residency program, agrees.

“Although the main driving force was to reduce sleep deprivation and improve patient safety, the unintended consequence was the increase in the number of hand-offs during patient care,” she wrote in a paper that she co-authored for The Joint Commission’s November 2006 Journal on Quality and Patient Safety.

“There are also a lot more hand-offs in the morning when residents leave,” Arora says. She stresses that sign-outs are not just exchanges of patient information.

“The transfer of content is also the transfer of responsibility. It’s an ownership issue,” she says. “You can’t just think of yourself as the covering physician, but the physician.” She suggests that residents taking over for postcall ones introduce themselves to the patient.

Both Logio and Arora agree that the following factors improve hand-offs:

- Meeting in a quiet room
- Conversing face to face
- Having something written with a key element that can be modified by the listeners
Anticipate what will happen

“Anticipation is big part of what they should be signing over,” Logio says. “So we say, ‘I don’t really need to know the patient’s allergies because I can find that somewhere else. I need to know what you anticipate might happen with that patient and when that happens, what you would like me to do about it.’ ”

At Logio’s facility, chief residents role-play a bad hand-off during orientation.

Interns are asked to pinpoint what was wrong and what should have been done differently.

“Then they demonstrate a good sign-off,” Logio says. “And just by demonstrating that, there are a lot of ‘ah-ha’ moments.”

Streamline the process

Streamlining hand-offs so they are in tandem with the work that physicians are already doing is critical, Logio says.

“Doctors don’t need any more work,” she says. “They are trying really hard to keep up with the pace of a very hectic life of taking care of patients. It has to be part of their regular work, it has to be streamlined. It can’t be an extra click, an extra program.”

Arora says senior leaders need to be behind creating better hand-offs, but frontline providers need to be engaged as well.

She suggests that you start small by organizing a task force.

“By engaging frontline staff and leaders, institutions can create protocols that best fit the needs of the users and local environment,” Arora says. “One size fits all doesn’t work with hand-offs.”

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This chapter addresses your role in EC tracers and EC activities so that you and your organization’s EC team are always survey-ready. We have provided many helpful tools to assist you in these efforts, printed at the end of this chapter and available on the CD-ROM that came with this book, so that you don’t have to recreate them (see a sample tool on p. 11).

In light of The Joint Commission’s increasing focus on issues relative to the Life Safety Code® (LSC), including the repurposing of the building tour to spotlight your organization’s compliance strategies and the addition of the emergency management tracer in 2006, it is likely that your EC team has never played a more prominent role in the survey process. From a practical survey-management standpoint, there are even certain processes (see rule CON04 in your Comprehensive Accreditation Manual for Hospitals) that can result in immediate findings of conditional accreditation or even preliminary denial of accreditation.

That being said, your first reaction is probably, “a lot of the activities and requirements in the Environment of Care chapter are out of my control,” and although it is true that the EC function has traditionally been somewhat isolated from the more clinical accreditation functions, it’s more important than ever to have a strong collaborative relationship with your organization’s EC team leaders.

The foundation of this relationship must be the identification of common goals and objectives (and a little bit of performance improvement know-how). If you can talk with the EC team, there’ll be no surprises or preparation stumbles when the Joint Commission surveyors ask a question of you or the EC team.

It’s true that your EC team owns the LSC, equipment management, and a host of other activities—activities without which clinical care could not safely be provided. But that doesn’t mean you need to feel like an outsider. Some survey coordinators are members of their organization’s EC committee and still don’t feel like they’re an integral part of the picture. Some even feel like it’s just an exercise in chasing committee members for essential data. A closer look at the EC standards reveals much more than an accounting of the seven EC management functions (i.e., safety, security, hazardous materials and wastes, emergency, life safety, medical equipment, and utility systems).

EC.9.10, 9.20, and 9.30 speak clearly of not just an expectation relative to performance improvement, but also collaboration between the EC forces and the organizational leaders responsible for overseeing the patient safety program; sound familiar?

The hospitals that do the best during surveys—perhaps especially in the wake of unannounced surveys—are those that have most seamlessly integrated the management of organizational safety—be it patient-related, worker-related, environmental conditions, or hazards—to anything that would be considered in the realm of safety.

Over time, this collaborative relationship between clinical and support, infection control and facilities, and regulatory compliance and whomever, achieves a transparency that consistently wins the approval of surveyors. That collaboration is the focus of this chapter.

Some survey coordinators sit on their hospital EC committees so they don’t feel like they’re chasing members for essential data. Hospitals with collaboration among EC, risk management, regulatory compliance, and even infection control rely on each other for feedback and, over time, create transparency that wins the approval of surveyors.
### Sample EC/infection control tracer checklist

<table>
<thead>
<tr>
<th>ID</th>
<th>Issue/Condition</th>
<th>Complaint?</th>
</tr>
</thead>
<tbody>
<tr>
<td>FS 1</td>
<td>Remove hallway clutter, have 8 feet of clearance in patient hallways/move all wheeled objects to one side. No piles of waste materials or &quot;nonwheeled&quot; storage.</td>
<td>Y N N/A</td>
</tr>
<tr>
<td>FS 2</td>
<td>Ensure that no fire exits, extinguishers, fire alarm pull stations, medical gas shut-off valves, or electrical panels are blocked.</td>
<td>Y N N/A</td>
</tr>
<tr>
<td>FS 3</td>
<td>Make sure all storage is 18 inches below the ceiling in a sprinklered room.</td>
<td>Y N N/A</td>
</tr>
<tr>
<td>FS 4</td>
<td>Make sure the fire extinguisher check dates on the tag are current. If not, call Maintenance at Ext. 2277 ASAP.</td>
<td>Y N N/A</td>
</tr>
<tr>
<td>FS 5</td>
<td>Ensure that <strong>NO</strong> doors are propped or wedged open.</td>
<td>Y N N/A</td>
</tr>
</tbody>
</table>

### Hazardous Materials Safety Function Referee

| HM 1 | Make sure there are no unsecured oxygen cylinders. Check the unit, beds, stretchers, and wheelchairs. Oxygen cylinders must be secured in a stand, rack, or cradle beneath a stretcher.                      | Y N N/A    |
| HM 2 | Make sure there are no more than 12 oxygen cylinders stored in one area. If there are more than 12, please contact Respiratory Dept. at Ext. 7212 to have them removed.                                                                                   | Y N N/A    |
| HM 3 | Make sure that all spray bottles, jugs, and other containers are appropriately labeled. If you don’t know what’s in a container, contact Env. Services at Ext. 7201 for disposal.                                                                 | Y N N/A    |
| HM 4 | Ensure that Material Safety Data Sheets are on hand for all hazardous materials.                                                                                                                                          | Y N N/A    |
| HM 5 | Make sure food, specimens/biohazards, and chemicals are not co-mingled.                                                                                                                                                   | Y N N/A    |
| HM 6 | Make sure that the sharps containers are safe for use (not overfilled).                                                                                                                                                  | Y N N/A    |
| HM 7 | Ensure that spill kits are available (blood and bodily fluid; chemo; chemical).                                                                                                                                           | Y N N/A    |
| HM 8 | Ensure that trash and linen are replaced in appropriate containers (not overfilled).                                                                                                                                       | Y N N/A    |

### Infection Control Function Referee

| IC 1 | Ensure that precaution rooms are equipped with appropriate signage.                                                                                                                                                     | Y N N/A    |
| IC 2 | Ensure that personal protective equipment is available and appropriate to precaution.                                                                                                                                   | Y N N/A    |
| IC 3 | Remind staff and physicians to wash their hands before and after providing patient care.                                                                                                                               | Y N N/A    |
| IC 5 | Make sure patient nutrition refrigerators and freezers have up-to-date temperature logs. Make sure you know where past period logs are maintained.                                                                          | Y N N/A    |
| IC 6 | Make sure all open food containers in patient refrigerators and freezers have patient names on them and are dated.                                                                                                       | Y N N/A    |
| IC 7 | Make sure there are no boxes or supplies on the floor. All boxes must be raised 6 inches off the floor.                                                                                                               | Y N N/A    |

Hospitals that accept Medicare or Medicaid patients must follow new regulations for patient rights that include 16 new standards for restraint and seclusion.

CMS published the final rules in the Federal Register on December 8, 2006—more than seven years after the interim rules were published in July 1999.

Hospitals will need to rewrite their policies about restraint and seclusion to be consistent with the new requirements.

The new regulations set forth new training requirements and standards about death reporting. The standards do not apply to critical access hospitals.

There are five sections to the patient rights standards. The first four sections were published without making any changes to the current Conditions of Participation. The fifth section includes the patient’s right to be free from unnecessary restraint and seclusion. This section combined two separate sections on medical and surgical restraints and behavioral health restraints.

It includes 16 rules on restraint and seclusion, including freedom from restraint and seclusion, less restrictive interventions, orders, notification, care plans, discontinuation, assessment and reassessment, performance improvement, use, time limits, renewal, staff education, monitoring, and death protocol. Important to note are the following changes in definition:

- **A physical restraint** is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to freely move his or her arms, legs, body, or head
- **Seclusion** is the involuntary confinement of a patient in a room that he or she is prevented from leaving.

To view the final rule, go to [http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/06-9559.pdf](http://a257.g.akamaitech.net/7/257/2422/01jan20061800/edocket.access.gpo.gov/2006/pdf/06-9559.pdf)

Editor’s note: Sue Dill, RN, MSN, JD, director of hospital risk management for OHIC Insurance Company in Columbus, OH, is the CMS Corner lead contributor. Submit a topic idea to her by contacting BOJ editor Amy Anthony at aantonyc@hcpro.com.

**Continuing Education | Learning Objectives**

After reading this article, you will be able to

1. define a physical restraint
2. define seclusion

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