



EDUCATIONAL RESOURCES

Acute Care Hospital 2023 New and Revised Standards

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Objectives

- Provide ACHC customers with an overview of new and revised Acute Care Hospital Clinical Standards that align with CMS.
- ACHC revised standards are tentatively effective as of March 1, 2023.

Important Notice

- The 2023 Acute Care Hospital Manual contains:
 - New Standards
 - Revised Standards
 - New or Revised Required Elements

- All revisions or new additions to the standards are in **BOLD** in the prepublication version, pending CMS approval.



EDUCATIONAL RESOURCES

Chapter 01

Governing Body

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Chapter 01: Update

01.01.22 Contracted Services – Revised

- Consolidated Standards into 01.01.22
 - 01.01.23 – Contractor Quality Monitoring
 - 01.01.24 – List of Contracted Services
- The governing body must ensure that the services performed under a contract are provided in a safe and effective manner.
- The hospital must maintain a list of all contracted services, including the scope and nature of the services provided. § 482.12(e), § 482.12(e) (1), § 482.12(e) (2)
- Patient care and patient care associated services provided under contract are subject to the same hospital-wide quality assessment and performance improvement (QAPI) evaluation as other services provided directly by the hospital.

Chapter 01: Update

01.01.22 Contracted Services – Scoring Revised

- Scoring Revision
 - The list for contracted services includes all contractual providers (including shared service or joint venture). The list includes the scope and nature of the services provided.
 - The process used to evaluate the quality of care for *each patient care and patient care-associated* contracted service.

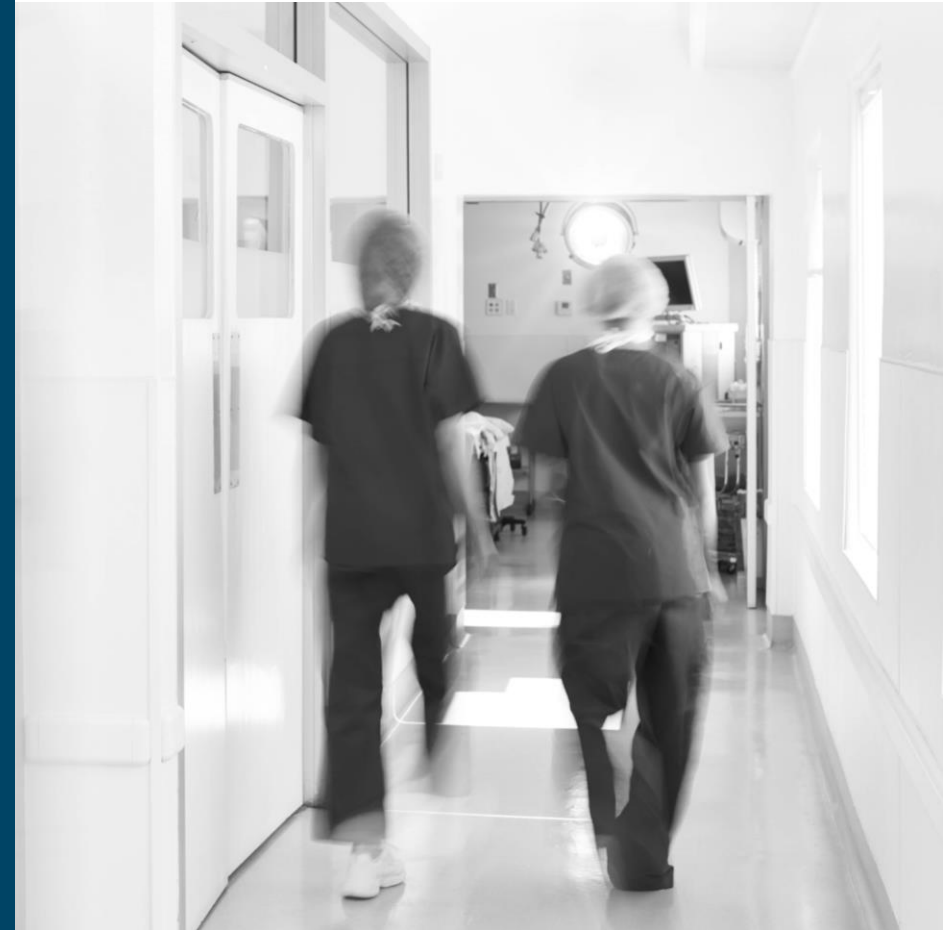


EDUCATIONAL RESOURCES

Chapter 03

Medical Staff

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Chapter 03: Update

03.00.02 Periodic appraisal of members – Revised

Required Elements:

- The medical staff must at regular intervals appraise the qualifications of all practitioners appointed to the medical staff/granted medical staff privileges. In the absence of a state law that establishes a time frame for periodic reappraisal, an appraisal is to be conducted at a minimum, every **36 months** for each practitioner.

Scoring Procedure:

- The reappraisal period is conducted at a minimum every 36 months, or sooner if required by state law or other regulation.

Chapter 03: Update

03.15.01 Ongoing professional practice evaluation – Revised

Required Elements:

- Data will be collected on an ongoing basis and summarized at least three times during each three-year appointment cycle.
- At least every 36 months, the medical staff identify and approve performance measurements that are specific to the services provided by the practitioners.

Scoring Procedure:

- Credential files reflect the ongoing professional practice evaluation is performed at least three times during the three-year appointment cycle. This quality data is reviewed as part of the reappointment process.



EDUCATIONAL RESOURCES

Chapter 07

Infection Control and Antibiotic Stewardship

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Chapter 07: Updates

- 07.00.00 Condition of Participation
- 07.02.01 Risk Mitigation Measures for Infection Prevention
- 07.02.06 Reduce Risk of Legionella in Water Systems
- 07.03.03 Employee Health Vaccines for Healthcare Workers
- 07.04.01 Decontamination and Sterilization Policies
- 07.04.03 **NEW STANDARD:** High-Level Disinfection/Sterilization and Processing of Endoscopes
- Renumbered Standards

Chapter 07: 07.00.00

- **07.00.00 Condition of Participation – Required Elements Revised**
 - The infection control program includes processes to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems.

Chapter 07: 07.02.01

- **07.02.01 Risk Mitigation Measures for Infection Prevention – Revised**
 - MAINTENANCE OF A SANITARY PHYSICAL ENVIRONMENT
 - Techniques for infection control risk mitigation for corrugated cardboard boxes.
 - HOSPITAL STAFF-RELATED MEASURES
 - Risk mitigation measures are implemented to decrease infectious risk associated with corrugated containers to ensure a safe, sanitary environment. Diligence is demonstrated to remove corrugated containers throughout the facility, including from high-risk areas, such as Central Sterile, Procedural Areas, Compounding Pharmacy, specialty patient care units, etc. Receiving, breakdown, and distribution of supplies is an important aspect of sterility.
 - Infection risk assessments should be conducted for specific items that cannot be removed from corrugated boxes, which stratifies the risk of potential infection to the loss or damage of product.

Chapter 07: 07.02.06

■ **07.02.06 Reduce Risk of Legionella in Water Systems – Revised**

- The infection control leader collaborates with a multi-disciplinary team to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in the water systems.
- The hospital must implement a water management program that considers the ASHRAE industry standard and the CDC toolkit and includes control measures such as physical controls, temperature management, disinfectant level control, visual inspections, and environmental testing for pathogens.

Chapter 07: 07.02.06

■ 07.02.06 Reduce Risk of Legionella in Water Systems – Revised

- The Infection Control Committee (function):
 - Verifies the water management plan has been implemented as designed.
 - Reviews and approves the hospital risk assessment to identify where Legionella and other opportunist waterborne pathogens could grow and spread.
 - Reviews and approves the water management program, including actions taken to reduce the growth and spread of Legionella and other opportunist water pathogens.
 - Validates conditions and outcomes to ensure the water management program is effective. This validation must be completed and documented annually.

Chapter 07: 07.02.06

- **07.02.06 Reduce Risk of Legionella in Water Systems – Revised**
 - Procedures for measuring and monitoring the water system are implemented, and testing is conducted based on the hospital risk assessment and in accordance with hospital policy and nationally recognized standards of practice.
 - Once the water management plan has been implemented, a communication plan is developed and shared with the staff on a routine basis as established by the hospital policy.

Chapter 07: 07.02.06

■ 07.02.06 Reduce Risk of Legionella in Water Systems – Revised Scoring

- A water management multi-disciplinary team has been identified and roles developed.
- A description of the building water system is available in text and diagram formats.
- A risk assessment has been completed to identify patient risks along with water sources that are opportunistic to pathogen growth.
- Control points have been identified with measures and monitoring procedures implemented.
- Outbreak and contingency plans have been developed and implemented.
- A communication plan is developed and provided to hospital staff as per the hospital policy.
- The infection control plan addresses a water management program.

Chapter 07: 07.03.03

- **07.03.03 Employee Health Vaccines for Healthcare Workers – Revised**
 - Vaccinations are made available to all healthcare workers in accordance with state and federal law. The vaccination status of all employees will be maintained.
 - A process is in place for ensuring all employees are vaccinated as required by hospital policy or have been granted an exemption.
 - Scoring procedure revised to verify a policy is in place to include a process to ensure all employees are vaccinated or have been granted an exemption, and that all employees have been offered the recommended vaccines.

Chapter 07: 07.03.03

■ 07.03.03 Employee Health Vaccines for Healthcare Workers – Revised

Healthcare workers (HCWs) are at risk for exposure to serious, and sometimes deadly, diseases. HCWs who work directly with patients or handle material that could spread infection get appropriate vaccines to reduce the chance they will get or spread vaccine-preventable diseases.

Recommended vaccines for HCWs include:

- Hepatitis B – Serologic evidence of immunity or complete Hep B vaccine series
- Flu (Influenza) – One dose annually
- MMR (Measles, Mumps, & Rubella) – Serologic evidence of immunity or MMR vaccine
- Varicella (Chickenpox) – Serologic evidence of immunity or prior vaccine
- Tdap (Tetanus, Diphtheria, Pertussis) – Tdap and booster every 10 years. Pregnant HCWs should have Tdap during pregnancy.
- COVID-19

Chapter 07: 07.04.01

■ 07.04.01 Decontamination and Sterilization Policies

- The policies address the equipment used for manual and automated processes. The policies are based on the manufacturer's instructions for use and nationally recognized organizational guidelines such as AST and IAHCMM. Policies and procedures are easily accessible to personnel.
- After use, instruments are properly cleaned and sterilized.
- The hospital provides appropriate education, training, and competence to staff handling, cleaning, sterilizing, and storing instrumentation and assesses competency with these tasks.
- Hinged instruments should be opened as wide as possible for proper cleaning. The use of decontamination stringers may be helpful in keeping hinged instruments open throughout the cleaning process.
- To protect sharp and delicate instruments, approved instrument protectors should be used. Heavy items should be placed below lighter, more delicate items. Every effort should be made to evenly distribute the weight within the tray to facilitate sterilant contact, as well as even heating and drying in steam sterilization processes.
- When peel packaging items for sterilization, care should be taken to keep hinged instruments opened and ensure there is adequate space in the package for the sterilant to contact all parts of the instrumentation. Care should also be taken to help ensure excess stress is not placed on the sides or seals of the peel pack.

Chapter 07: 07.04.01

■ 07.04.01 Decontamination and Sterilization Policies

- Scoring Procedure
 - Policies and procedures address disinfection and sterilization procedures.
 - Through observation and interview, determine that staff are familiar with policies and procedures and follow them.

Chapter 07: 07.04.03

- **07.04.03 NEW: High-Level Disinfection/Sterilization and Processing of Endoscopes**
 - Reusable flexible endoscopes are visually inspected and evaluated for cleanliness, missing parts, clarity of lenses, integrity of seals and gaskets, moisture, damage, and function after disinfection/sterilization and again before use. Flexible endoscopes and endoscope accessories are stored to minimize contamination and protect the device or item from damage.

Chapter 07: 07.04.03

▪ **07.04.03 NEW: High-Level Disinfection/Sterilization and Processing of Endoscopes**

The hospital has policies and procedures consistent with nationally accepted guidelines for processing and high-level disinfection/sterilization of endoscopes that address:

- Precleaning of flexible endoscopes
- Transport of endoscope to ensure compliance with infection control practices and to maintain integrity of the scope
- Leak testing
- Manual cleaning
- Mechanical processing

After processing is complete, endoscopes are stored according to manufacturer recommendation and hospital policy in an appropriate cabinet.

The hospital maintains records of endoscope processing including date, time, scope details, method, verification, identity of mechanical processor if indicated, lot numbers of solutions, and identity of the individual performing processing.

A multidisciplinary team that includes infection preventionists, endoscopists, endoscopy processing personnel, and other identified individuals may evaluate the need to implement a surveillance program for endoscopes through the QAPI Program to ensure appropriate handling and storage of chemicals used during sterilization.

The hospital follows recommendations of nationally recognized practices from CDC, APIC, AAMI, etc.

Chapter 07: 07.04.03

■ 07.04.03 NEW: High-Level Disinfection/Sterilization and Processing of Endoscopes

- Scoring Procedure – Verify
 - The policy on processing endoscopes includes precleaning, leak testing, manual cleaning including appropriate rinsing, inspection of scopes, mechanical cleaning, transport, and storage (including the length of time scopes may be stored before recleaning is required).
 - Cleaning and sterilization of endoscopes for adherence to policy and manufacturer's IFU.
 - Expiration dates and loads and lot number validation for chemicals and test strips used for cleaning and disinfection/sterilization and appropriate storage of each.
 - Through interview, determination that there is a process used to ensure effective processing and sterilization of endoscopes.
 - Determine if incorporated into QAPI program.

Chapter 07

■ Standards Renumbered Only

- 07.04.04 Immediate Use Steam Sterilization (IUSS) in Surgical Settings
- 07.04.05 Sterilization and Decontamination Devices
- 07.04.06 Sterilization Data Requirements
- 07.04.07 Preparing, Assembling, Wrapping, Storage, and Distribution of Sterile Equipment and Supplies
- 07.04.08 Shelf Life of Sterilized Products
- 07.04.09 Environmental Requirements in Decontamination Rooms

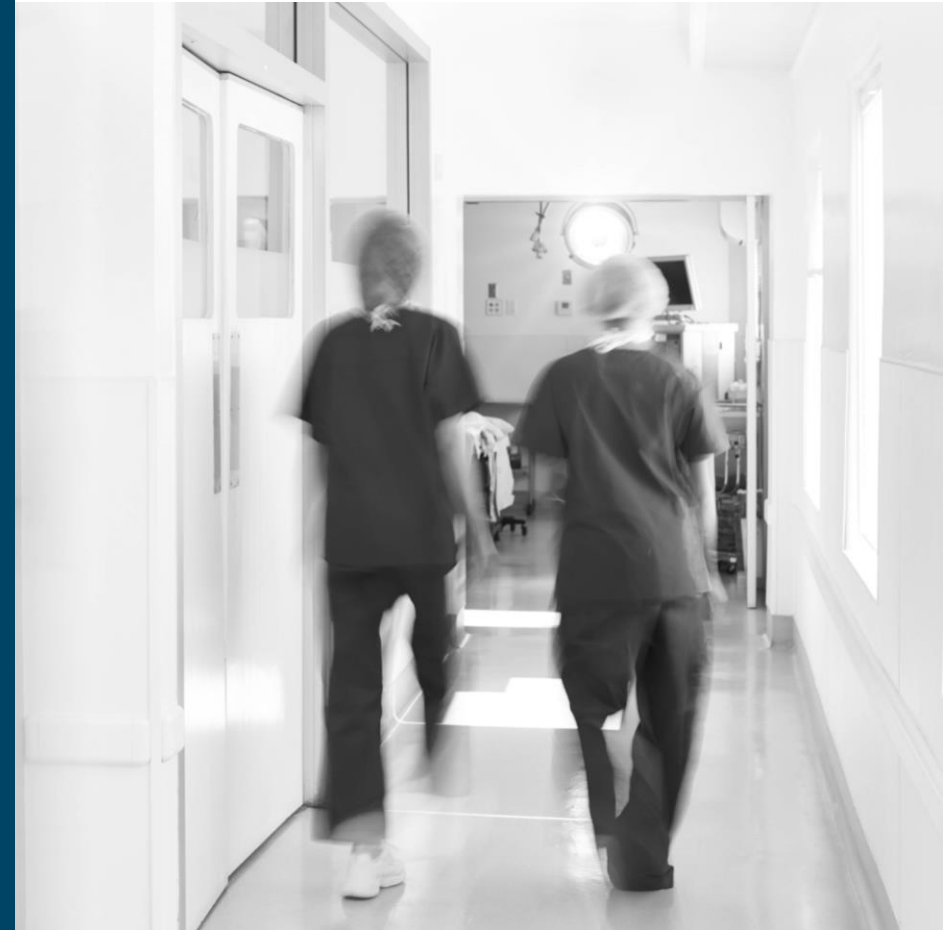


EDUCATIONAL RESOURCES

Chapter 08

Materials Management

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Chapter 08: Updates

- 08.00.03 Safe Storage of Supplies
- 08.00.06 Product Recall

Chapter 08: 08.00.03

■ 08.00.03 Safe Storage of Supplies

- Supplies are stored off above floor surfaces in accordance with nationally recognized standards of practice. For example, the FDA requires at least 6 inches of floor clearance for non-sterile supplies and food items. AAMI requires 8 inches of floor clearance for sterile supplies.
 - Lowest shelf has a solid surface/barrier to ensure supplies are kept clean.
- ## ■ Scoring Procedure
- Supplies are stored off the floor based on nationally recognized guidelines.
 - Supplies and supply carts, cabinets, and storerooms meet the requirements.

Chapter 08: 08.00.06

■ 08.00.06 Product Recall

- A recall log is maintained to verify all elements of the process are completed.
- Scoring Procedure
 - A policy covers each standard requirement, and the recall log is maintained.

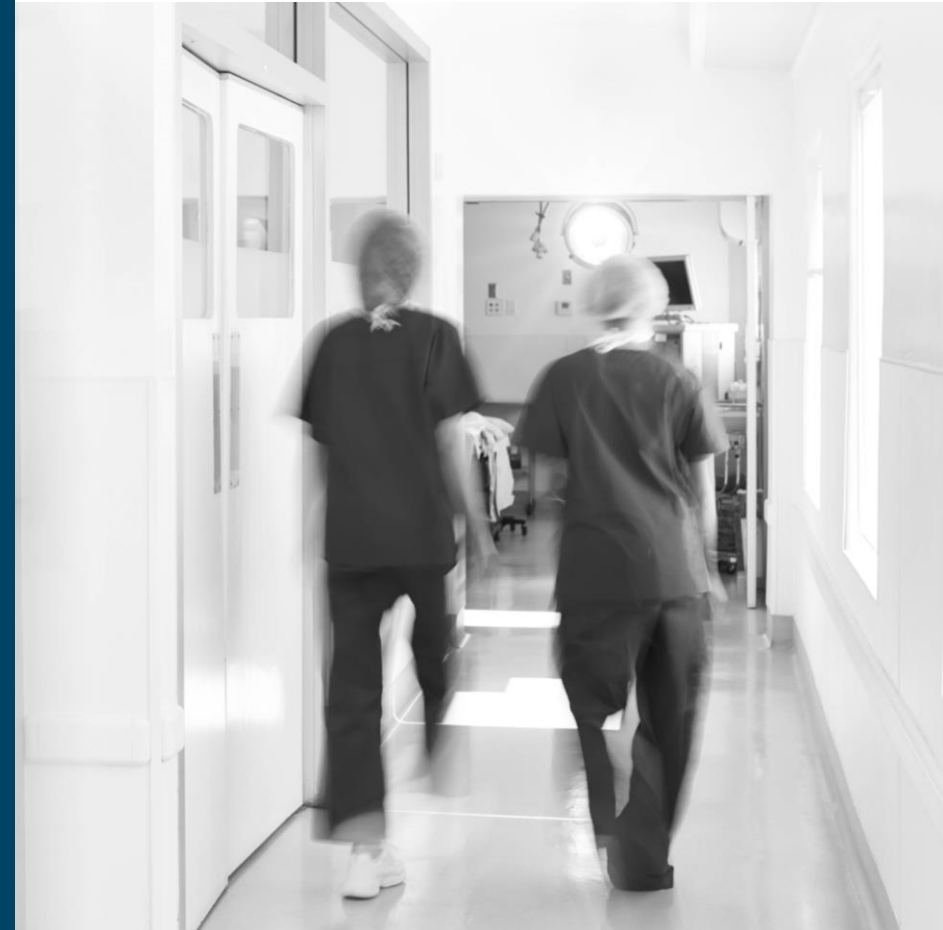


EDUCATIONAL RESOURCES

Chapter 9

Emergency Management

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Chapter 9: Updates

- 09.00.01 – Condition of Participation: Emergency Preparedness
- 09.00.02 – Hazard Vulnerability Analysis
- 09.00.03 – Emergency Operations Plan
- 09.00.05 – Services
- 09.00.06 – Continuity of Operations
- 09.01.01 – Policies & Procedures
- 09.01.03 – Supplies
- 09.01.04 – Utilities
- 09.01.06 – Evacuation
- 09.02.02 – Contact information
- 09.02.06 – Hospital Information
- 09.03.01 – Emergency Training
- 09.03.02 – Emergency Exercises
- 09.04.01 – Emergency Power

Chapter 9: 09.00.01

- 09.00.01 – Condition of Participation: Emergency Preparedness
- Required Elements/Additional Information
 - The Emergency Preparedness Program must describe a facility’s comprehensive approach to meeting the health, safety, and security needs of the staff and patient population during an emergency situation. The program must also address how the facility will coordinate with other healthcare facilities, as well as the whole community, during an emergency situation.
 - **The term “comprehensive” in this requirement is to ensure that facilities do not choose only one potential emergency that may occur in their area but rather demonstrate that they have considered multiple events during development of the program.**
 - **As emerging infectious disease outbreaks may affect any facility in any location across the country, a comprehensive Emergency Preparedness Program should include emerging infectious diseases and pandemics during a public health emergency (PHE).**
 - **The program’s plan for emerging infectious disease should encompass how facilities will plan, coordinate, and respond to a localized and widespread pandemic, similar to the 2019 Novel Coronavirus (COVID-19) PHE.**
 - **Facilities should ensure their Emergency Preparedness Programs are aligned with their state and local emergency plans/pandemic plans.**

Chapter 9: 09.00.02

- 09.00.02 – Hazard Vulnerability Analysis
- Required Elements / Additional Information
 - **For public health emergencies, such as emerging infectious diseases (EID) or pandemics: Facilities should consider risk assessments to include the needs of the patient population they serve in relation to a communicable or EID outbreak.**
 - **Planning should include a process to evaluate the facility's needs based on the specific characteristics of an EID that includes, but is not limited to:**
 - Increased need for PPE.
 - Considerations for screening patients and visitors; which may also include testing considerations for staff, visitors, and patients for infectious diseases.
 - Transfers and discharges of patients.
 - Home-based healthcare settings.
 - Physical environment, including but not limited to changes needed to achieve distancing, isolation, or capacity/surge.

Chapter 9: 09.00.03

- 09.00.03 – Emergency Operations Plan
- A written Emergency Operations Plan (EOP) is developed, maintained, and available to the staff for crisis preparation and response.
- The Emergency Operations Plan must include strategies for addressing emergency events identified by the risk assessment.
 - The EOP is based on the priorities established in the current Hazard Vulnerability Analysis (HVA). The EOP is reviewed with the community's emergency response agencies to synchronize responses to common emergency events.
 - **The hospital develops or makes revisions to its emergency preparedness plan that considers EIDs as potential threats that can impact operations and continuity of care within the healthcare setting.**
 - The EOP is reviewed every two years (biennially) by the emergency management oversight committee to ensure relevancy and accuracy. Adjustments are documented and changes made based on lessons learned during actual emergency events and during planned exercises.

Chapter 9: 09.00.03

- 09.00.03 – Emergency Operations Plan
- Required Elements / Additional Information
 - The written EOP includes a plan for the possibility of a widespread infection outbreak or pandemic.
 - This approach is specific to the location of the facility and considers particular hazards most likely to occur in the surrounding area. These include, but are not limited to:
 - Natural disasters
 - Man-made disasters,
 - Facility-based disasters that include but are not limited to:
 - Care-related emergencies.
 - Equipment and utility failures, including but not limited to power, water, gas, etc.
 - Interruptions in communication, including cyber-attacks.
 - Loss of all or portion of a facility; and
 - Interruptions to the normal supply of essential resources, such as water, food, fuel (heating, cooking, and generators), and in some cases, medications and medical supplies (including medical gases, if applicable).
 - **Emerging infectious diseases (EIDs) such as Influenza, Ebola, Zika Virus, COVID-19 or SARS-CoV-2 and others.**
 - **These EIDs may require modifications to facility protocols to protect the health and safety of patients, such as location and personal protective equipment (PPE) measures.**

Chapter 9: 09.00.03

- 09.00.03 – Emergency Operations Plan
- Required Elements / Additional Information
 - **Emerging Infectious Diseases (EIDs)**
 - **The type of infectious diseases to consider or the care-related emergencies that are a result of infectious diseases are not specified. Adding EIDs within a facility’s risk assessment ensures that facilities consider having infection prevention personnel involved in the planning, development, and revisions to the EOP, as these individuals would likely be coordinating activities within the facility during a potential surge of patients. Some examples of EIDs may include but are not limited to:**
 - **Potentially infectious bio-hazardous waste.**
 - **Bioterrorism.**
 - **Pandemic influenza.**
 - **Highly communicable diseases (such as Ebola, Zika Virus, SARS, or novel COVID-19 or SARS-CoV-2)**
 - **EID’s may be localized to a certain community or be widespread (as seen with the COVID-19 PHE) and therefore plans for coordination with local, state, and federal officials are essential. Facilities should engage and coordinate with their local healthcare systems and healthcare coalitions, and their state and local health departments when deciding on ways to meet surge needs in their community.**

Chapter 9: 09.00.03

- 09.00.03 – Emergency Operations Plan
- Required Elements / Additional Information
 - **Surge Planning**
 - **Hospitals must have policies and procedures which include emergency staffing strategies and plan for emergencies resulting in a surge of patients. These strategies encompass procedures to preserve the healthcare system while continuing to provide care for all patients at an appropriate level (e.g., home-based care, outpatient, urgent care, emergency room, or hospitalization). Facilities must have policies which address their ability to respond to a surge in patients. As required, these policies and procedures must be aligned with a facility's risk assessment and should include planning for EIDs. Concentrated efforts will be required to mobilize all aspects of the healthcare system to reduce transmission of disease, direct people to the right level of care, and decrease the burden on the healthcare system.**
 - **Surge Planning During Natural Disasters**
 - **In most circumstances, staffing strategies and surge planning for natural disasters are event-specific and focus on evacuations, transfers, and staffing assistance from areas that are not impacted by the emergency.**
 - **Surge Planning for Infectious Diseases/Pandemics:**
 - **Infectious diseases may rise to the level of pandemic, causing severe impact to response and staffing strategies within the healthcare system. The primary goals in planning for infectious disease pandemics are to:**
 - **Reduce morbidity and mortality.**
 - **Minimize disease transmission.**
 - **Protect healthcare personnel.**

Chapter 9: 09.00.03

- 09.00.03 – Emergency Operations Plan
- Required Elements / Additional Information
 - **Preserving hospital/system functioning**
 - **Facilities are encouraged to consider developing policies and procedures that could be implemented during an emergency to reduce non-essential healthcare visits and slow surge within the facility, such as:**
 - **Instructing patients to use available telehealth options, advice lines, patient portals, and/or on-line self-assessment tools.**
 - **Call options to speak to an office/clinic staff member and identification of staff to conduct phone interactions with patients.**
 - **Development of protocols for rapid triage and assessment.**
 - **Algorithms to identify which patients can be managed by telephone and advised to stay home, and which patients will need to be sent for emergency care or come to the facility.**

Chapter 9: 09.00.05

■ 09.00.05 – Services

- The Emergency Operations Plan (EOP) must address the type of services the hospital has the ability to provide in an emergency.
- §482.15(a)(3)
- **The EOP also addresses services needed that cannot be provided by the facility during an emergency as part of assessing continuity of operations and services.**
- Scoring Procedure
- Verify:
 - The EOP identifies the type of services that the hospital has the ability to provide during an emergency.
 - **Does the EOP addresses how the hospital plans to continue to provide these services during an emergency? Services needed that cannot be provided during an emergency.**
 - Services to be provided. If specific equipment is required for service, validate the provisions to keep the specific equipment available for use. In general, equipment that can be plugged into red emergency outlets is presumed to be available for the continuation of services during an emergency.

Chapter 9: 09.00.06

- 09.00.06 Continuity of Operations
- Required Elements / Additional Information
 - When creating the EOP, consideration should be given to:
 - How the hospital will continue to operate the facility during the emergency event, and
 - Who is delegated as the authority during the emergency event, and
 - How the succession of that authority is provided.
 - An Incident Command System (ICS) as described by the US Department of Homeland Security, Federal Emergency Management Agency (FEMA) is an effective means to provide for the continuity of operations.
 - The Incident Command System (ICS) is a management system designed to enable effective and efficient incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure across multiple entities.
 - **The emergency plan must identify which staff would assume specific roles in another's absence through succession planning and delegations of authority. Succession planning is a process for identifying and developing internal people with the potential to fill key positions in the hospital. Succession planning increases the availability of experienced and capable employees that are prepared to assume these roles as they become available. During times of emergency, facilities must have employees who are capable of assuming various critical roles in the event that current staff and leadership are not available. At a minimum, there should be a qualified person who "is authorized in writing to act in the absence of the administrator or person legally responsible for the operations of the facility."**

Chapter 9: 09.01.01

- 09.01.01 – Policies & Procedures *addition*
 - Required Elements / Additional Information
 - **Facilities should also consider updates to their emergency preparedness policies and procedures during the course of a disaster, including planning for an emergency event with a duration longer than expected (for instance, during public health emergencies such as pandemics, the Centers for Disease Control and Prevention (CDC) and other public health agencies may issue periodic, on-going, event-specific guidance and recommendations to healthcare workers).**
 - **Facilities should ensure their programs have policies in place to update or provide additional emergency preparedness procedures to staff. This may include a policy delegating an individual to monitor guidance by public health agencies and issuing directives and recommendations to staff such as use of PPE when entering the building; isolation of patients under investigation (PUIs); and any other applicable guidance in a public health emergency.**

Chapter 9: 09.01.03

- 09.01.03 – Supplies
 - Required Elements / Additional Information
 - **Anticipate Supply Shortages**
 - **Hospital policies identify:**
 - **Actions to take when the organization experiences shortages of medications or supplies.**
 - **Strategies recommended by state and federal health agencies including how to access the national stockpile of medications and supplies.**
 - **Medications and doses used to treat the communicable disease.**
 - **Pharmaceutical sources and suppliers of the medications.**
 - **Suppliers of the emergency equipment and supplies, and when possible, back-up suppliers.**
 - **In advance of a communicable disease outbreak or pandemic, the hospital determines the types and quantities of equipment, supplies, and medications needed for continuity of patient care. While stockpiling is not required, the hospital determines the quantities of supplies needed for a one-month period of time:**
 - **Beds**
 - **Ventilators PPE: Facemasks, gowns, gloves**
 - **Hand sanitizer**
 - **Cleaning supplies**
 - **Paper products, such as toilet paper, paper towels**
 - **Others**

Chapter 9: 09.01.03

- 09.01.03 – Supplies
 - Required Elements / Additional Information
 - **PERPETUAL INVENTORY**
 - **During a widespread communicable disease outbreak or pandemic, a shortage of supplies should be anticipated.**
 - **The hospital has a process to update the Incident Command Center regarding available equipment/supplies, such as:**
 - beds
 - ICU beds
 - ventilators
 - gloves, facemasks, gowns
 - IV infusion pumps
 - Quantities of medications used to treat the communicable disease.
 - **The organization considers an electronic report of the current availability of supplies to post on the facility's intranet. Facilities have flexibility to identify appropriate tools for tracking of inventory, however facilities may consider electronic tracking tools consistent with state recommendations and guidelines.**

Chapter 9: 09.01.03

■ 09.01.03 – Supplies

- Scoring Procedure
- Verify:
 - Through interview of the person in charge of Emergency Management that there are medical supplies, pharmaceutical supplies and general equipment inventoried and stored for immediate response in an emergency.
 - The organization has reviewed and updated the inventory of emergency response supplies on a semi-annual basis.
 - It provides for the supplies and equipment needed in the initial phase of an emergency event.
 - Policies & Procedures have been reviewed and updated per 9.01.01.
 - **Verify the organization has a policy that includes the anticipation of supply shortages and contingencies in the event of a communicable disease outbreak or pandemic.**
 - Review written agreements with vendors and/or suppliers to verify that they have been updated annually.
 - **Verify the organization has a process for providing updates to the Incident Command Center regarding availability of equipment/supplies.**

Chapter 9: 09.01.04

- 09.01.04 – Utilities *addition*
 - Required Elements / Additional Information
 - **If used, portable generators are connected to a facility's electrical circuits via a power transfer system, as recommended by the generators' manufacturer. A power transfer system typically consists of a transfer switch, generator power cord and power inlet box in accordance with manufacturer instructions and NFPA 70, Article 400.8. Extension cords or other temporary wiring devices may not be used to connect electrical equipment in the facility to a portable and mobile generator.**

Chapter 9: 09.01.06

- 09.01.06 – Evacuation
 - Required Elements / Additional Information
 - **Patient safety is the priority and any existing guidance on patient rights and safe setting (e.g., §482.13(c)(2) for hospitals) should be continued. Facilities should consider how they would address a situation where a patient/resident refuses to evacuate; leaving a patient in an unsafe environment is not acceptable.**
 - Scoring Procedure
 - **How would staff handle a situation in which a patient refused to evacuate?**

Chapter 9: 09.02.02

- 09.02.02 – Contact information *addition*
 - Required Elements / Additional Information
 - **Emergency preparedness officials may include, but are not limited to, emergency management agencies which may be local to the community as well as local officials who support the Incident Command System depending on the nature of the disaster (e.g., fire, police, public health, etc.).**
 - **Additionally, emergency management officials also include the state public health departments and federal emergency preparedness officials (FEMA, ASPR, DHS, CMS, etc.) and tribal emergency officials, as applicable.**
 - **Facilities have discretion in the formatting of this information but it should be readily available and accessible to leadership and staff during an emergency event. Facilities that use electronic data storage should be able to provide evidence of data back-up with hard copies or demonstrate capability to reproduce contact lists or access this data during emergencies. Contact information contained in the communication plan must be accurate and current. Any changes to information for entities on the contact list are updated in the Contact Information when changes are discovered and at a minimum as follows (reference 09.01.01):**
 - **Staff rosters must be updated on a semi-annual basis. Facilities must update contact information for incoming new staff and departing staff throughout the year. Real-time electronic tracking systems of staff members meet the requirement for semi-annual updates to the call-back roster.**
 - **Entities providing services under arrangement must be updated annually.**

Chapter 9: 09.02.06

- 09.02.06 – Hospital Information
 - Required Elements / Additional Information
 - Communicating critical information to the authorities having jurisdiction regarding the hospital during an emergency is vital to a well-organized response to an emergency.
 - The hospital may have multiple authorities having jurisdiction they need to communicate their capabilities with during an emergency: Local, regional, tribal, and or State authorities.
 - **Reporting a Facility's Needs:**
 - **Generally, in small community emergency disasters, reporting the facility's needs will be coordinated through established processes to report directly to local and state emergency officials. Reporting needs may include but are not limited to shortages in PPE; need to evacuate or transfer patients; requests for assistance in transport; temporarily loss of part or all facility function; and staffing shortages.**

Chapter 9: 09.02.06

- 09.02.06 – Hospital Information
 - Required Elements / Additional Information
 - **In large scale emergency disasters or pandemics, reporting of needs specific to a facility may be altered by local, state, and federal public health and emergency management officials due to the potential volume of requests. Some emergency management officials at all levels of governance may require facilities to report specific data or slow reporting to manage volume.**
 - **Reporting a Facility's Ability to Provide Assistance:**
 - **During widespread disasters, reporting a facility's ability to provide assistance is critical within a community. Pre-planning and collaborating with emergency officials before an emergency to determine what assistance may be necessary directly supports surge planning within a community.**
 - **During widespread disasters, facilities may be required to report the following to local officials:**
 - **Ability to care for patients requiring transfer from different healthcare settings;**
 - **Availability of PPE;**
 - **Availability of staff who may be able to assist in a mass casualty incident;**
 - **Availability of electricity-dependent medical and assistive equipment, such as ventilators and other oxygen equipment (BiPAP, CPAP, etc.), renal replacement therapy machines (e.g., home and facility-based hemodialysis, peritoneal dialysis, continuous renal replacement therapy and other machines, etc.), and wheelchairs and beds.**

Chapter 9: 09.03.01

- 09.03.01 – Emergency Training
 - Required Elements / Additional Information
 - The training provided by the facility must be based on the facility's risk assessment policies and procedures as well as the communication plan. The intent is that new and existing staff, volunteers and individuals providing services at the facility are familiar and trained on the facility's processes for responding to an emergency. Training should include individual-based response activities in the event of a natural disaster, such as what the process is for staff in the event of a forecasted hurricane. It should also include the policies and procedures on how to shelter-in-place or evacuate. Training should include how the facility manages the continuity of care to its patient population, such as triage processes and transfer/discharge during mass casualty or surge events. Furthermore, the facility must train staff based on the facility's risk assessment. Training for staff should mirror the facility's emergency plan and should include training staff on procedures that are relevant to the hazards identified. For example, for EID's this may include proper use of PPE, assessing needs of patients and how to screen patients and provide care based on the facility's capacity and capabilities and communications regarding reporting and providing information on patient status with caregiver and family members.

Chapter 9: 09.03.01

- 09.03.01 – Emergency Training
 - Required Elements / Additional Information
 - Facilities must also be able to demonstrate additional training when the emergency plan is significantly updated. Hospitals that have changed their EOP should plan to conduct initial training to all staff on the new or revised sections of the plan. If a facility determines the need to add additional policies and procedures based on a new risk identified in the facility's risk assessment, the facility must train all staff on the new policies and procedures and the staff responsibilities. Facilities are not required to retrain staff on the entire emergency plan but can choose to train staff on the new or revised element of the emergency preparedness program. For example, a facility identifies during an influenza outbreak that additional policies and procedures and adjustments to the risk assessment are needed to address a significant influx of patients/clients/residents. The facility identifies clinical locations in which contagious patients can be triaged in a manner to minimize exposure to non-infected individuals. The training for this new or revised policy can be done without needing to re-train staff on the entire program.

Chapter 9: 09.03.01

- 09.03.01 – Emergency Training
 - Scoring Procedure
 - Review the training program to ensure all staff are educated on the emergency preparedness program. **Refer back to the facility's risk assessment to determine if the training and testing program is reflecting risks and hazards identified within the facility's program.**
 - Are staff (including contract workers and physicians) have received receiving training on emergency preparedness every two years?
 - **Verify documentation is available and accurate for training and testing.**

Chapter 9: 09.03.02

■ 09.03.02 – Emergency exercises

- Required Elements / Additional Information

- Participation

- Regulations do not specify a minimum number of staff, or the roles of staff in the exercises, but it is strongly encouraged that facility leadership and department heads participate. If an exercise is conducted at the individual facility-based level and is testing a particular clinical area, staff who work in this clinical area should participate in the exercise for a clear understanding of their roles and responsibilities. Facilities can review which members of staff participated in the previous exercise to ensure participation in subsequent exercises. A sign-in roster for the exercise is acceptable to substantiate staff participation. A sufficient number of staff should participate in the exercise to thoroughly assess the risk, policy, procedure, or plan being tested.

Chapter 9: 09.03.02

- 09.03.02 – Emergency exercises
 - Required Elements / Additional Information
 - **EXEMPTION BASED ON ACTUAL EMERGENCY**
 - **An actual emergency event or response of sufficient magnitude that requires activation of the relevant emergency plans meets the full-scale exercise requirement and exempts the facility from engaging in their next required full-scale exercise (community- or facility-based) following the actual event. The hospital must be able to demonstrate this through written documentation. Documentation may include but is not limited to a section 1135 waiver issued to the facility (time limited and event-specific); documentation alerting staff of the emergency; documentation of facility closures; meeting minutes which addressed the time and event-specific information. The hospital must also complete an after action report of the actual emergency and identify corrective actions integrated into the emergency preparedness program.**
 - **Example: If a hospital completed the full-scale exercise in January 2020 and is scheduled to conduct an exercise of choice in November 2020 but experiences an actual emergency in March 2020 which required activation of its emergency plan, the hospital is exempt from the next required full-scale exercise in January 2021 but must complete the exercise of choice. If the hospital conducted an exercise of choice prior to the actual emergency and had a full-scale exercise scheduled for November 2020, then the hospital would be exempt from that full-scale exercise.**

Chapter 9: 09.04.01

- 09.04.01 – Emergency Power
 - Required Elements / Additional Information
 - **NFPA 99 covers emergency power requirements for lighting, fire detection systems, extinguishing systems, and alarm systems. NFPA 99 does not specify emergency power requirements for maintaining supplies and its facility temperature requirements are limited to heating equipment for operating, delivery, labor, recovery, intensive care, coronary care, nursery, infection/isolation rooms, emergency treatment spaces, and general patient/resident rooms. NFPA 99 does not require heating in general patient rooms during the disruption of normal power where the outside design temperature is higher than 20 degrees Fahrenheit or where a selected room(s) is provided for the needs of all patients (where patients would be internally relocated), then only that room(s) needs to be heated.**
 - **Therefore, Essential Electrical Systems (EES) in hospitals should include/accommodate any additional electrical loads the facility determines necessary to meet all subsistence needs required by emergency preparedness plans, policies, and procedures, unless the facility's emergency plans, policies and procedures determine that the hospital will relocate patients internally or evacuate in the event of an emergency.**

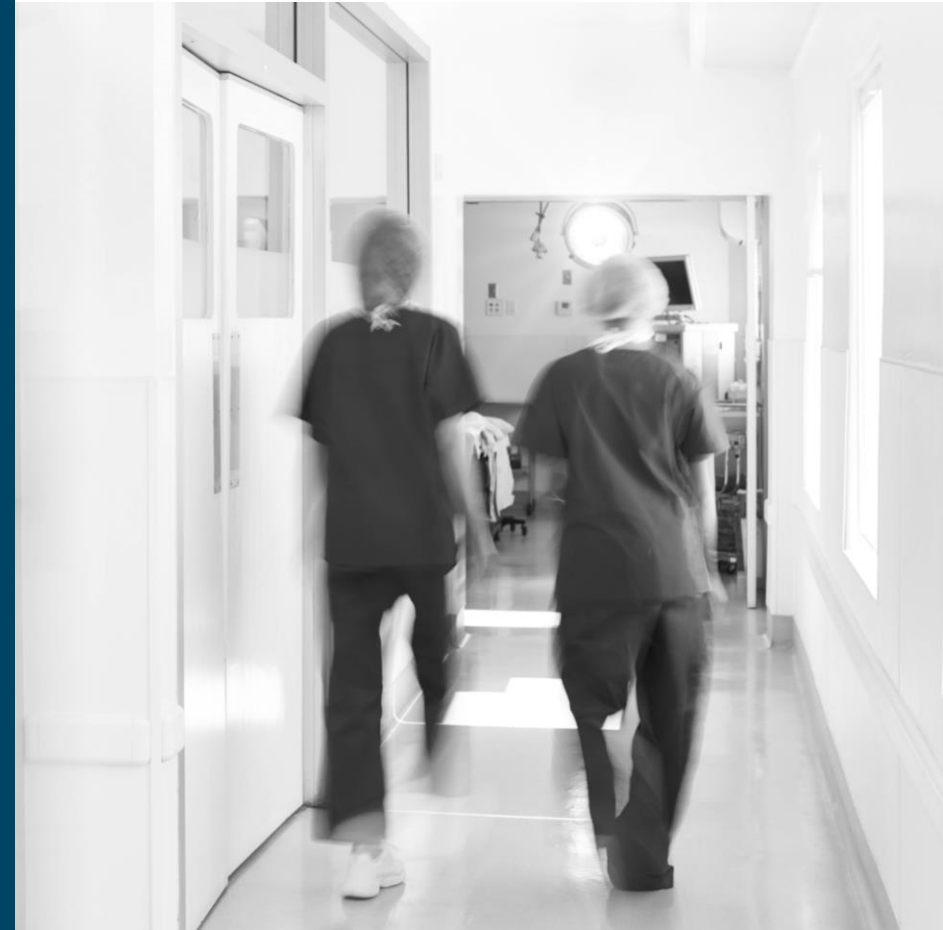


EDUCATIONAL RESOURCES

Chapter 10

Health Information Management

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Chapter 10: Updates

- 10.01.28 Obstetric Patients
- 10.01.29 Newborn Care

Chapter 10: 10.01.28

■ 10.01.28 Obstetric Patients

- Hospital policy describes the expectations relative to forwarding prenatal records and diagnostic test results as well as the contents of the prenatal record.
- The prenatal record may include information regarding the findings from ultrasounds, laboratory data such as CBC, blood group - RH screen for irregular antibodies, rubella screen (titer), RPR, sexually transmitted diseases, genetic testing, and most recent PAP Smear; UA, and any other testing performed.
- Scoring Procedure
 - When the prenatal record is forwarded to the hospital in advance of admission, it is updated by the physician or non-physician practitioner upon admission.
 - Obstetric prenatal records include all assessments required by the organization.

Chapter 10: 10.01.29

■ 10.01.29 Newborn Care

- A newborn record, which is separate from that of the mother, is initiated and maintained. Nursing and medical data sheets can include state mandated protocols and evidence-based care practices and all relevant maternal medical information defined by hospital policy and consistent with standards of care.
- This record reflects almost continuous observations during the first hours of transition, from birth until physiological stabilization has occurred, including all treatment provided and the response to the treatment. A physician physical assessment is documented for newborns at the frequency defined by hospital policy and consistent with standards of practice and state and local law.

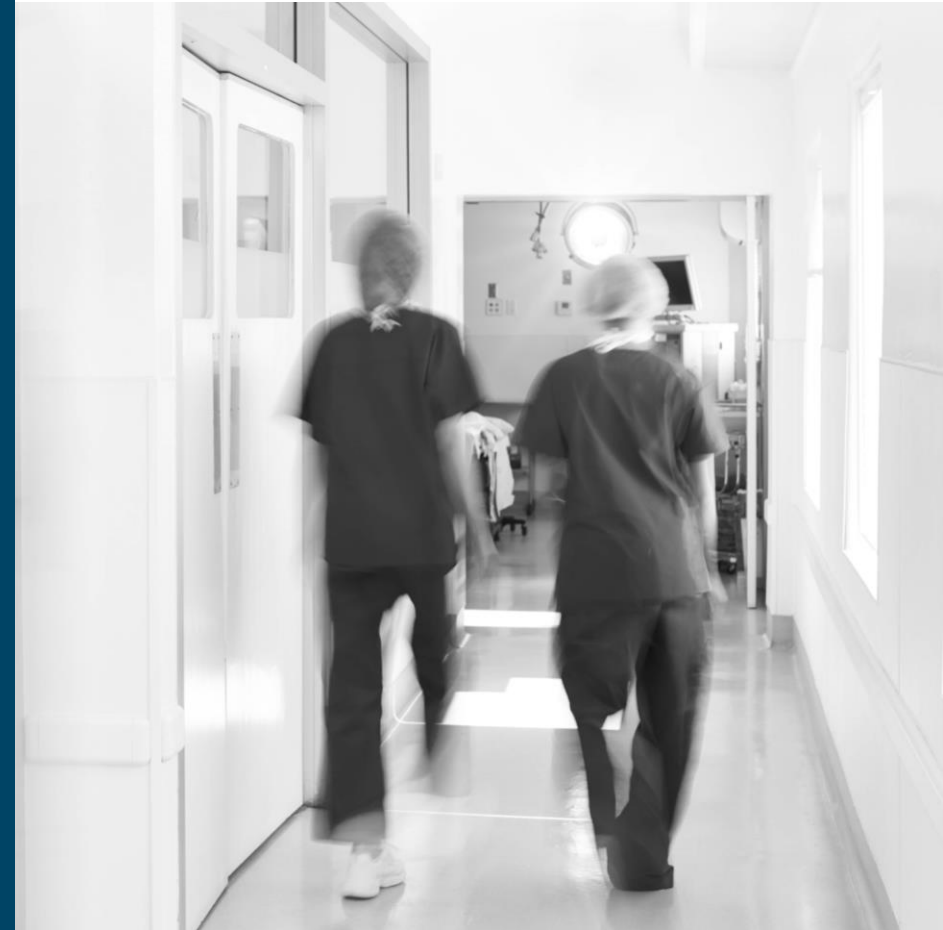


EDUCATIONAL RESOURCES

Chapter 11

Physical Environment

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Chapter 11: Updates

- 11.04.02 Fire Drills
- 11.06.03 **NEW STANDARD:** Water management plan
- ~~11.06.07 Potable Water~~
- ~~11.06.12 Water Temperature Control~~

Chapter 11: 11.04.02

■ 11.04.02 Fire Drills – Revised

- Fire drills shall be conducted at least quarterly on all shifts in all buildings classified as healthcare occupancy or ambulatory healthcare occupancy.
- For buildings classified as business occupancy (or other occupancies), fire drills are conducted annually on all shifts.
- **The transmission of a fire alarm signal shall be tested quarterly during fire drills from the alarm panel in the protected premise, to the emergency response force.**
- All fire drills are documented.

Chapter 11: 11.04.02

■ 11.04.02 Fire Drills – Revised Required Elements

- The fire plan is practiced without prior warning to the occupants of the building(s). Observers document actual reactions to the event.
- Fire drills expectations include:
 - Simulation of emergency fire conditions.
 - A coded announcement is permitted between 9:00 pm and 6:00 am in lieu of activating the audible notification devices on the fire alarm system, but the fire alarm system still needs to be activated for each drill.
 - Actual patients are not required to be moved during drills.
 - Evacuation of simulated patients to the nearest smoke compartment barrier door.
 - Non-customary shifts such as 12-hour shifts and weekend staffing patterns.
 - Staff participation in the drills inasmuch as the hospital's fire response plan requires their response to fire alarms.
 - **Quarterly, the transmission of the fire alarm signal and simulation of fire conditions must be tested during fire drills per NFPA 101 Life Safety Code (2012 edition), 18/19.7.1.4.**
 - **For Fire alarm systems – transmitting signal, see standard 13.02.03.**

Chapter 11: 11.04.02

■ 11.04.02 Fire Drills – Revised Scoring

- Participation is based upon staff's role in accordance with the Fire Control Plan, which may be at the point of alarm and away from the point of alarm.
- Review logs to ensure:
 - Each healthcare occupancy and each ambulatory healthcare occupancy had one drill per shift per quarter.
 - Off-site business occupancies have had annual fire drills on each shift.
 - **Fire drill records indicate the fire alarm system signal is transmitted quarterly from the fire alarm panel to the emergency response force when fire drills are conducted. Note: A deficiency in transmitting the signal during a fire drill is cited at 13.02.03.**

Chapter 11: 11.06.03

■ 11.06.03 Water Management Plan

- Monitoring of water quality and temperatures are identified as control points in the Water Management Program.
- Potable water is tested annually and treated as necessary.

Chapter 11: 11.06.03

■ 11.06.03 Water Management Plan

- Monitoring of water quality and temperatures are identified as control points in the Water Management Program.
- Potable water is tested annually and treated as necessary.

Chapter 11: 11.06.03

■ 11.06.03 Water Management Plan

- Required Elements / Additional Information
 - Reports for water testing quality monitoring will be reported to the water management team and Safety Committee.
 - The facility leader will attend the scheduled water management team meetings with reports for water testing and monitoring.
 - For specific water management program compliance activities, refer to Infection Prevention and Control standard 07.02.06.
 - Precautions are taken to assure compliance with state and local standards related to domestic hot water temperature to protect patients against scalding or burning.

Chapter 11: 11.06.03

■ 11.06.03 Water Management Plan

- Scoring Procedure
- Verify:
 - Water reports and annual testing are submitted to the water management team and Safety Committee.
 - Through interview with the maintenance director, that domestic hot water temperature is maintained based on state and local standards and talk with risk manager to assess any incidents or patient safety incident-related reports.

Chapter 11: 11.06.07

~~11.06.07 Potable Water~~

- Requirements moved to 11.06.03 Water management plan

Chapter 11: 11.06.12

~~11.06.12 Water Temperature Control~~

- Requirements moved to 11.06.03 Water management plan

Chapter 11: 11.06.12

~~11.06.12 Water Temperature Control~~

- Requirements moved to 11.06.03 Water management plan



EDUCATIONAL RESOURCES

Chapter 12

Quality Assessment/ Performance Improvement (QAPI)

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Chapter 12: Updates

- 12.00.01 Data Collection and Analysis: Program Scope
- 12.02.01 Culture of Safety
- 12.02.02 Adverse Event Review Process

Chapter 12: 12.00.01

■ 12.00.01 Data Collection and Analysis: Program Scope

- The facility can determine the amount and frequency of reporting for each department and contracted service based on performance and level of risk associated with each service.
- Scoring Procedure
 - The hospital has a QAPI program that is ongoing and includes a QAPI plan that is reviewed and revised annually.
 - The plan includes the frequency and detail of data collection.
 - The quality program has identified improvement indicators that will improve health outcomes and identify and reduce medical errors.
 - Data collection activities include:
 - Every hospital department and service
 - Each patient care and patient care-associated contracted service.
 - External data is used to benchmark program effectiveness and identify opportunities for improvement

Chapter 12: 12.02.01

■ 12.02.01 Culture of Safety

- The organization will promote a culture of safety.
- Policies and procedures are in place to:
 - Communicate patient safety issues present within the organization to leadership and continuously involve leadership in processes to ensure that the issues are appropriately addressed and that patient safety is improved.
 - Implement proactive risk assessments to identify opportunities and implement measures that reduce the potential for patient harm to occur.
- Responsibility for risk reduction is shared throughout the hospital. Free and open communication and non-punitive reporting of adverse events and patient safety concerns are promoted. Organizational objectives and rewards are clearly aligned with the goal of improving patient safety.
- Proactive risk assessment methods enable hospitals to identify potential failures in process and implement strategies that would reduce the potential for medical errors that may result in patient harm before it occurs. A variety of tools and methods may be used, including Failure Modes and Effect Analysis (FMEA).
- Scoring Procedure: Documentation of proactive risk assessment(s) to confirm that at least one risk assessment is performed.

Chapter 12: 12.02.02

■ 12.02.02 Adverse Event Review Process

- Adverse events are injuries resulting from medical care, as opposed to adverse outcomes arising from underlying disease.
- The hospital adopts a nationally recognized tool such as the CMS's Hospital-Acquired Conditions and the National Quality Forum's Serious Reportable Events (SRE) to identify events requiring Root Cause Analysis (RCA). A review of the nationally recognized tool for alignment with hospital policy is completed annually. The hospital retains its RCA for review by Surveyors.
 - Note: Due to the confidential nature of information in the RCA, it is not to be submitted to ACHC.



EDUCATIONAL RESOURCES

Chapter 13

Life Safety

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Chapter 13: Updates

- 13.00.05 Facility Demographic Report (FDR)
- 13.02.03 Fire alarm systems – transmitting signal
- 13.03.05 Fire pumps: Annual test

Chapter 13: 13.00.05

■ 13.00.05 Facility Demographic Report (FDR) - revised

- Required Element/Additional Information
 - ACHC does not set qualifications for the designated individual. However, since the FDR is technical in manner, a person with technical knowledge must be designated.
 - The hospital must complete the Facility Demographic Report on at least an annual basis, or more often as needed, **for example, when construction or renovations are completed for areas comprising more than 50% of a smoke compartment or 4500 square feet. An FDR must be completed and maintained as currently accurate** for each **individual** facility identified as a healthcare occupancy or an ambulatory healthcare occupancy. Business occupancies are not required to have an FDR.
- Revised Scoring Procedure

Chapter 13: 13.00.05

- **13.00.05 Facility Demographic Report (FDR) – revised scoring procedure**
 - Revised Scoring Procedure
 - Review the documentation in the FDR that designates the responsible individual, and assess the qualifications listed.
 - Review the FDR to determine if it has been updated within the past 12 months and is current and maintained.
 - **Has the FDR been updated because of renovations or construction?**
 - Review the FDR to ensure the organization completed the assessment and maintains the accuracy of the information. Verify that each question was answered accurately.

Chapter 13: 13.02.03

■ 13.02.03 Fire alarm systems – transmitting signal

- The fire alarm system shall transmit an appropriate signal to an offsite monitoring station, or directly to the emergency response force.
- This signal shall be tested annually from the alarm panel in the protected premise, to the emergency response force.
- **The transmission of a fire alarm signal shall be tested quarterly during fire drills from the alarm panel in the protected premise, to the emergency response force.**
- All results of the tests are documented.
- §482.41(b)(1)

Chapter 13: 13.02.03

■ 13.02.03 Fire alarm systems – transmitting signal

- Required Elements / Additional Information
 - This standard does not require the fire alarm system to transmit all three signals, but when the fire alarm system activates an alarm signal, supervisory signal, or a trouble signal, it must be transmitted to an approved location, such as an Auxiliary Fire Alarm System, a Central Station, a Proprietary System, or a Remote Supervising Station.
 - Manual reporting systems and methods are not permitted.
 - Annually, the off-premises monitoring transmission equipment must be tested to ensure the local fire-responding agency received an alarm signal, even if the transmission of that signal is through a third-party entity.
 - **Quarterly, the transmission of the fire alarm signal and simulation of fire conditions must be tested during fire drills per NFPA 101 Life Safety Code (2012 edition), 18/19.7.1.4.**
 - NFPA 72 (2010 edition) Table 14.4.2.2 (18) (a) through (e), and Table 14.4.5 (22) describes in detail the methods and procedures to follow for each type of system.

Chapter 13: 13.02.03

■ 13.02.03 Fire alarm systems – transmitting signal

- Scoring Procedure
 - Review hospital records to determine whether the fire alarm system signal is transmitted annually from the fire alarm panel to the emergency response force.
 - **Review hospital fire drill records to determine whether the fire alarm system signal is transmitted quarterly from the fire alarm panel to the emergency response force when fire drills are conducted.**

Chapter 13: 13.03.05

■ 13.03.05 Fire pumps: Annual test

- Required Elements / Additional Information
 - Review hospital records to determine whether the fire alarm system signal is transmitted annually from the fire alarm panel to the emergency response force.
 - A hospital is not required to have a fire pump installed, but if present, the fire pump must be tested according to the standard.
 - An annual water-flow test is required for all fire pumps, which consists of:
 1. A churn test
 2. The pump operated at design flow (100% nameplate capacity)
 3. The pump operated at peak flow (150% nameplate capacity)
Note: If available suction supplies do not allow flowing of 150 percent of the rated pump capacity, the fire pump shall be permitted to operate at maximum allowable discharge.
 4. During peak flow, a power failure is simulated on electric-motor driven pumps equipped with automatic transfer switches to ensure emergency power supply is connected, and confirmation of peak flow continues
 5. After peak flow has been confirmed and documented, normal power is restored to ensure circuit protection devices have not opened
 - Additional readings and measurements are required during this annual flow test. If peak flow is not attainable due to limitations in water supply, that shall not constitute an unsuccessful test.



EDUCATIONAL RESOURCES

Chapter 15

Patient Rights and Safety

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Chapter 15: Updates

Restructured, Renumbered & Retitled Standards

- 15.03.03 **NEW STANDARD** – Emergency Care During Clinical Deterioration
- 15.03.04 **NEW STANDARD** – Clinical Emergency Supplies
- 15.03.05 **NEW STANDARD** – Identify Patients Correctly

Chapter 15: 15.01.11 (renumbered 15.01.04) 15.01.09 (renumbered 15.01.02) 15.01.10 (renumbered 15.01.03)

15.01.03 Participation in the Plan of Care, 15.01.04 Participation in Decision-Making, 15.01.02 Notice and Promotion of Patient Rights

- Revised to remove required elements
- For example:
 - ~~Some facilities may wish to include “freedom to unhampered exercise of religious or spiritual practices, within constraint of law” or other similar statements.~~
 - ~~Hospitals are expected to take reasonable... [section deleted as redundant of 15.01.00 Required Elements]~~
 - ~~When a patient who is not incapacitated... [section deleted as redundant of 15.01.00 Required Elements]~~

Chapter 15: 15.01.09 (renumbered 15.01.02)

■ 15.01.02 Notice and Promotion of Patient Rights

EMERGENCY DEPARTMENT PATIENT RIGHTS

- Emergency department patient rights must be posted in a conspicuously place(s) likely to be noticed by all individuals seeking care.
- Section 1866(a)(1)(N)(iii) of the Social Security Act requires the posting of signs which specify the rights of individuals with Emergency Medical Conditions (EMCs) and women in labor.
- Suspicion of EMTALA violations would be reported to the appropriate agency within the Centers for Medicare and Medicaid Services.

Chapter 15

■ 15.01.19 (renumbered 15.03.01) Identifying Patients At Risk

- The hospital identifies patients at risk and implements appropriate mitigation strategies to provide care in a safe setting.

■ 15.02.00 Restraint and Seclusion

- Scoring Procedure:
 - Verify the facility has an accurate process to track patients in restraint and/or seclusion.
 - Review data on the use of restraint and seclusion for a specified time period (e.g., 3 months) to determine any patterns in their use (QAPI)

Chapter 15: 15.02.05

■ 15.02.05 Least Restrictive Intervention

- The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.
- When restraint or seclusion is used, there must be documentation in the patient's medical record of the following:
 - A description of the patient's behavior and the intervention used.
 - Alternatives or other less restrictive interventions attempted (as applicable).
 - The patient's condition or symptom(s) that warranted the use of the restraint or seclusion.
 - The patient's response to the interventions(s) used, including the rationale for continued use of the intervention.

§482.13(e)(2-3) §482.13(e)(16)(ii-v)

Chapter 15: 15.02.05

■ 15.02.05 Least Restrictive Intervention

- The patient's behavior should be documented in descriptive terms to evaluate the appropriateness of the interventions used.
- The documentation should include a detailed description of the patient's physical and mental status assessments, and of any environmental factors (e.g., physical, milieu, activities, etc.) that may have contributed to the situation at the time of the intervention.
- The use of restraint or seclusion must be selected only when less restrictive measures have been judged to be ineffective to protect the patient or others from harm.
- It is not always appropriate for less restrictive alternatives to be attempted prior to the use of restraint or seclusion.
- When a patient's behavior presents an immediate and serious danger to him- or herself, or others, immediate action is needed.
 - For example, when a patient physically attacks someone, immediate action is needed.
- While staff should be mindful of using the least intrusive intervention, it is critical that the intervention selected be effective in protecting the patient or others from harm.
- A comprehensive, individualized patient assessment is necessary to identify the most appropriate intervention to effectively manage a patient's condition or symptom(s).
- When staff use a restraint or seclusion intervention, the patient's condition or symptom(s) must be identified and documented in the patient's medical record.

Chapter 15: 15.02.05

■ 15.02.05 Least Restrictive Intervention – Scoring Procedure

- Is there clear documentation in the patient's medical record describing the steps or interventions used prior to the use of the needed restraint or seclusion? That is, what documentation is in the medical record to explain the rationale for the use of restraint or seclusion?
- If the time of restraint or seclusion use is lengthy, look for evidence that the symptoms necessitating the use of restraint or seclusion have persisted.
- Is there evidence to indicate that the staff have evaluated whether or not the restraint or seclusion can be safely discontinued?
- Does the patient's medical record include a clear description of the patient's behavior that warranted the use of restraint or seclusion?
- Was the intervention employed appropriate for the identified behavior?
- What was the effect of less restrictive interventions, if attempted by staff?
- Does the patient's medical record include descriptions of the impact of the intervention on the patient behavior that resulted in the use of restraint or seclusion?
- Does the patient's medical record include a detailed assessment of the patient's response to the intervention and a well-reasoned plan for the continued use of restraint or seclusion?

Chapter 15: 15.02.10 (renumbered 15.02.08)

■ 15.02.08 Orders for Restraint or Seclusion

- Scoring Procedure
 - Do physician's or other LIP's orders specify the reason for restraint or seclusion, the type of restraint, and the duration of restraint or seclusion?

Chapter 15: 15.02.15 (renumbered 15.02.11)

■ 15.02.11 Non-Violent Restraint: Renewal Orders

- Renewal order timeframes should support an ongoing evaluation of the need for continued use of restraints. It is recommended that renewal orders are obtained each calendar day.
- Scoring Procedure: Does hospital policy align with medical record documentation of restraint duration orders?

Chapter 15: 15.02.14

■ 15.02.14 Violent Restraint and/or Seclusion: One-Hour Face-to-Face Assessment

- When restraint or seclusion is used, there must be documentation in the patient's medical record of the one-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior.
- States are free to have requirements by statute or regulation that are more restrictive than those contained in paragraph (e)(12)(i) of 42 CFR 482.13.
- Scoring revised to verify the medical record documentation of the 1-hour face-to-face medical and behavioral evaluation when restraint or seclusion is used to manage violent or self-destructive behavior and prior to survey to determine whether there are stricter State requirements.

Chapter 15: 15.02.17

■ 15.02.17 Monitoring of the Patient

- Hospital policies should address monitoring:
 - Frequencies of monitoring and assessment should be appropriate for the patient condition. ACHC recommends that patients with violent or self-destructive behavior are monitored at least every 15 minutes, although patient condition may warrant continuous monitoring. The recommendation for non-violent patients in restraints is monitoring at least every two hours.

Chapter 15: 15.02.41 (renumbered 15.02.32)

- **15.02.32 Death Related to Restraint or Seclusion: Reporting Requirements**

- Content that repeats language in the standard is deleted.
- Refer to CMS electronic form CMS-10455:
https://restraintdeathreport.gov1.qualtrics.com/jfe/form/SV_5pXmjIw2WAzto8J

Chapter 15: 15.03.03 New Standard

■ 15.03.03 NEW: Emergency Care During Clinical Deterioration

- An approved policy and procedure must be in place for early recognition and response to signs of patient deterioration, ensuring prompt rescue and treatment.
- Early response to clinical deterioration may reduce cardiopulmonary arrests and patient mortality.
- The organization has a policy and procedures approved by the Medical Staff that address:
 - Identification of and response to clinical deterioration.
 - Written criteria for assessment(s) and when to seek additional assistance, e.g., activation of a Rapid Response System.
 - Documentation requirements for vital signs, treatments, medications, and patient response to treatments addressing clinical deterioration.
 - Coordination of care if assessment identifies the need to transfer patient to another level of care.

Chapter 15: 15.03.03 (continued)

■ 15.03.03 NEW: Emergency Care During Clinical Deterioration

- A Rapid Response System is an effective process for assembling doctors, nurses, and other medical professionals to respond to a patient with early signs of clinical deterioration. The intent of a Rapid Response System is to provide interventions to prevent further deterioration.
- Scoring Procedure:
 - Written policies and procedures are approved by the Medical Staff. The policy describes the required assessments and identifies all required elements.
 - Medical records meet documentation requirements.
 - Procedures clearly indicate communication method for and documentation of response to patient deterioration.

Chapter 15: 15.03.04 New Standard

■ 15.03.04 NEW: Clinical Emergency Supplies

- The organization maintains an adequate inventory of supplies and equipment to respond to a medical emergency.
- An approved policy and procedure must be in place for early recognition and response to signs of patient deterioration, ensuring prompt rescue and treatment. Policies should address:
 - How contents are secured after use and during transport to be restocked.
 - Individuals authorized to transport carts.
 - Process to clean and restock carts.
 - Secure locations with limited access where carts may be stored prior to use by floors/departments.
 - The process and frequency of checking for outdated supplies in carts and emergency trays/boxes.
 - Frequency of cart/tray/box lock check (at minimum once per day).

Chapter 15: 15.03.04 New Standard

■ 15.03.04 NEW: Clinical Emergency Supplies (continued)

- Adequate equipment must be available to respond to emergencies in more than one location simultaneously.
- Adequate equipment must be available to respond to all patient populations under the scope of services, e.g., if the facility treats bariatric, neonatal, or pediatrics patients, appropriately sized resuscitation equipment is immediately available.
- At a minimum, the following equipment must be available:
 - Defibrillator.
 - Oxygen tank.
 - Suction equipment/vacuum.
 - Bag valve mask (BVM) device.
 - Medication (as applicable, based on type of emergency cart).

Chapter 15: 15.03.04 New Standard

- **15.03.04 NEW: Clinical Emergency Supplies (continued)**
 - Scoring Procedure: Verify
 - A policy or process defining required emergency equipment exists.
 - Adequate supplies are available.
 - Supplies address all patient populations.

Chapter 15: 15.03.05 New Standard

■ 15.03.05 NEW: Identify Patients Correctly

- The hospital has a written patient safety policy that requires at least two methods for patient identification prior to medication administration, testing, treatment, and procedures.
- Correct patient identification is a safety measure to ensure each patient receives the correct medicine, testing, and treatment. Factors for identification might include:
 - Patient's first and last name AND
 - Date of birth OR
 - Medical Record number
- Hospital policy details the process to identify and validate patient identity when the patient is unable to confirm identity.
- Scoring Procedure: Verify the hospital has the required policy and validate through the observation of patient care that the policy is followed consistently.



EDUCATIONAL RESOURCES

Chapter 16

Nursing Services

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Chapter 16: Updates

- 16.01.02 **NEW STANDARD** Pain Assessment and Reassessment

Chapter 16: 16.01.02

■ 16.01.02 NEW: Pain Assessment and Reassessment

- Observing the effects of pain medications is part of the medication administration process. Patient pain is monitored for efficacy of medication administration and to allow for early identification of adverse effects and timely initiation of appropriate corrective action.
- Required Elements: Patients have the right to pain management through assessment, intervention, and reassessment. Each patient has the right to expect his/her report of pain to be accepted and to have interventions provided. Hospital policies and procedures address the manner and frequency of monitoring, the use of standardized tool(s), documentation requirements for assessment and reassessment, and information to be communicated at shift changes including the hospital's requirements for the method(s) of communication.

Chapter 16: 16.01.02 (continued)

■ 16.01.02 NEW: Pain Assessment and Reassessment

- Required Elements (continued): COMPREHENSIVE PAIN ASSESSMENT
- A comprehensive pain assessment includes patient's acceptable level of pain, pain history (including pain identification and assessment), and medication and non-medication interventions used in the past that were effective.
- Pain assessment/reassessment uses a standardized tool and includes onset/duration, intensity or level of pain (based on facility approved assessment scales), quality of pain and location, as well as hemodynamic and physiological assessment. Pain scales approved by the facility are appropriate for the age and condition of the patient. Examples of tools include:
 - Visual Analogue Scale/Graphic Rating Scale
 - Numerical Rating Scale
 - Verbal Rating Scale
 - Pain Drawing
- Pain assessment occurs before administration of pain medication and as needed after administration while meeting the criteria of nationally recognized standards of practice as defined in policy.

Chapter 16: 16.01.02 (continued)

■ 16.01.02 NEW: Pain Assessment and Reassessment

- Required Elements (continued): ONGOING MONITORING
- Depending on the medication and route/delivery mode, monitoring may include assessment of:
 - Clinical and laboratory data to evaluate the efficacy of medication therapy to anticipate or evaluate toxicity and adverse effects. For some medications, including opioids, this may include clinical data such as respiratory status, blood pressure, and oxygenation and carbon dioxide levels.
 - Physical signs and clinical symptoms relevant to the patient's medication therapy, including but not limited to, somnolence, confusion, agitation, unsteady gait, pruritus, etc.
 - Certain types of medications are considered inherently high risk for adverse drug events.
- The assessment and monitoring process must be explained to the patient and/or the patient's representative to communicate the rationale for vigilant monitoring. In addition, hospitals are encouraged to educate the patient and his/her representative and/or family members about notifying nursing staff promptly when there is difficulty breathing or other changes that might be a reaction to medication.

Chapter 16: 16.01.02 (continued)

16.01.02 NEW: Pain Assessment and Reassessment

- Scoring Procedure: Verify
 - There is an effective method assessment and reassessment of pain medication administration.
 - There are policies and procedures for pain assessment and reassessment. These policies have been approved by appropriate individuals/committees.
 - Patients are assessed and reassessed by nursing per hospital policy and during acceptable evidence-based timeframes.
 - Interview personnel who administer pain medications to verify their understanding of assessment and reassessment regarding pain medication management.
 - Interview patients to verify that their pain is assessed and reassessed in a method they understand.



EDUCATIONAL RESOURCES

Chapter 18

Anesthesia Services

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Chapter 18: Updates

- 18.00.04 Required Policies

Chapter 18: Updates

■ 18.00.04 Required Policies

- Patient consent. Policy defines the categories of practitioners eligible to obtain informed consent for the delivery of anesthesia. Informed consent requires a discussion of the risks, benefits, and alternatives to anesthesia. An individual acting within their scope of practice must participate in the discussion with the patient and/or patient's representative regarding the anesthesia plan of care, risks, benefits, and alternatives.
- Documentation of the patient consent for anesthesia is included in the medical record. This may be accomplished through a separate written informed consent for the administration of anesthesia or integrated into the surgical informed consent if the practitioner responsible for the administration of anesthesia has participated in the informed consent process and discussion of the planned anesthesia care.

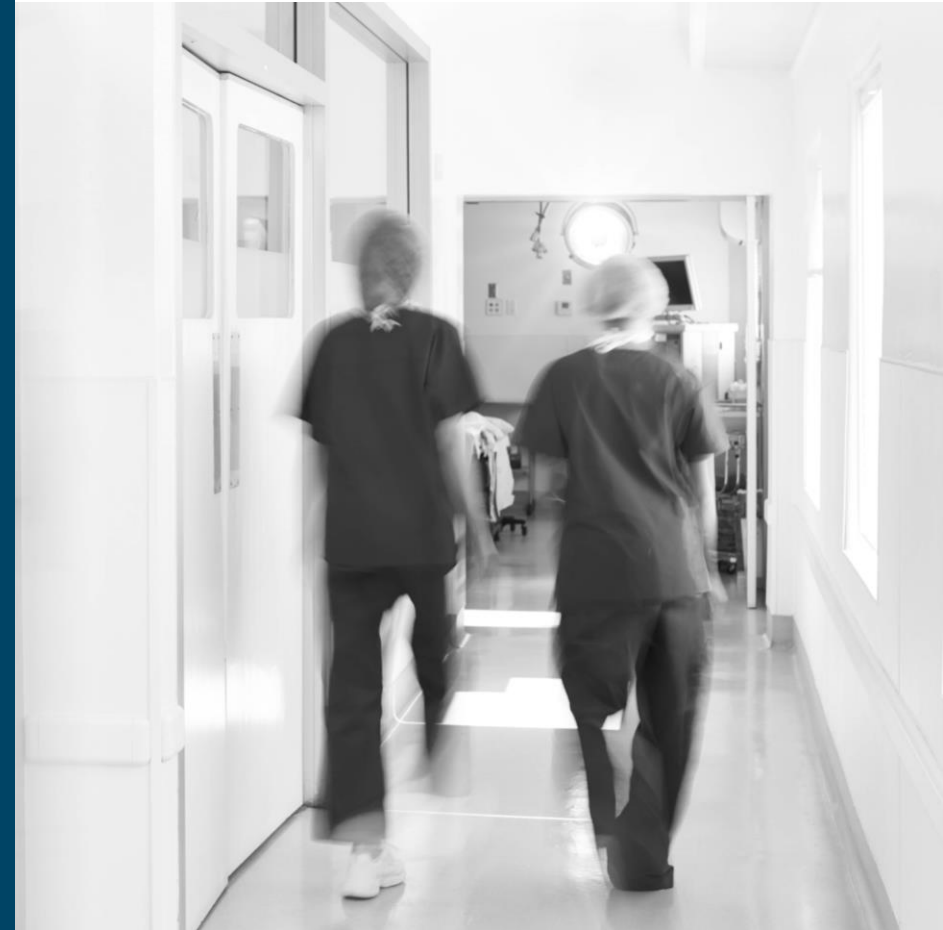


EDUCATIONAL RESOURCES

Chapter 23

Nuclear Medicine

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Chapter 23: Updates

- 23.00.05 In-House Preparation of Radiopharmaceuticals

Chapter 23: 23.00.05

■ 23.00.05 In-House Preparation of Radiopharmaceuticals

- Most hospitals follow the supervision recommendations of the Society of Nuclear Medicine and Molecular Imaging. Regardless of the source of professional guidelines chosen, the hospital must be able to explain the basis for the supervision policies and procedures it has developed.

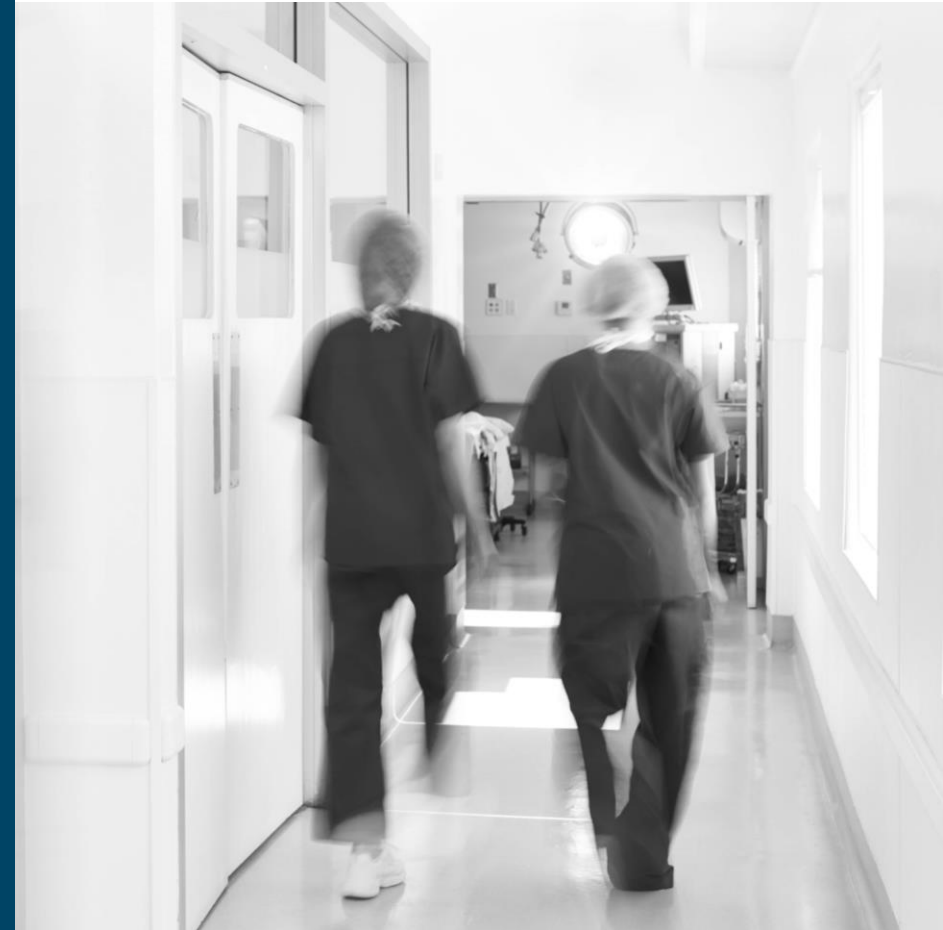


EDUCATIONAL RESOURCES

Chapter 24

Nutritional Services

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Chapter 24: Updates

- 24.00.06 Diet Menus Must Meet the Needs of the Patient
- 24.01.09 Lighting, Ventilation, and Temperature Control

Chapter 24: 24.00.06

- **24.00.06 Diet Menus Meet the Needs of the Patient**
 - The therapeutic diet manual must be in accordance with nationally recognized nutritional guidelines and standards of practice that are appropriate for the patient population (e.g., pediatrics).

Chapter 24: 24.01.09

- **24.01.09 Lighting, Ventilation, and Temperature Control**

- Setting the right temperature for the commercial dishwasher is critical to ensure properly sanitized cookware, dishes, and utensils to prevent foodborne illnesses.
 - Dishwasher temperatures are maintained per manufacturer's guidelines and in accordance with nationally recognized standards of practice (e.g., ANSI, FDA) for both:
 - High temperature settings with hot water sanitation
 - Low temperature setting with chemical sanitation
 - The hospital is in compliance with any relevant federal, state, and local regulations.

Chapter 24: 24.01.09 (continued)

- Scoring Procedure: Verify
 - Ensure federal, state, and local regulations are followed.
 - Interview nutritional services personnel about proper dishwashing temperatures.
 - Interview food services personnel about proper dishwashing temperatures.

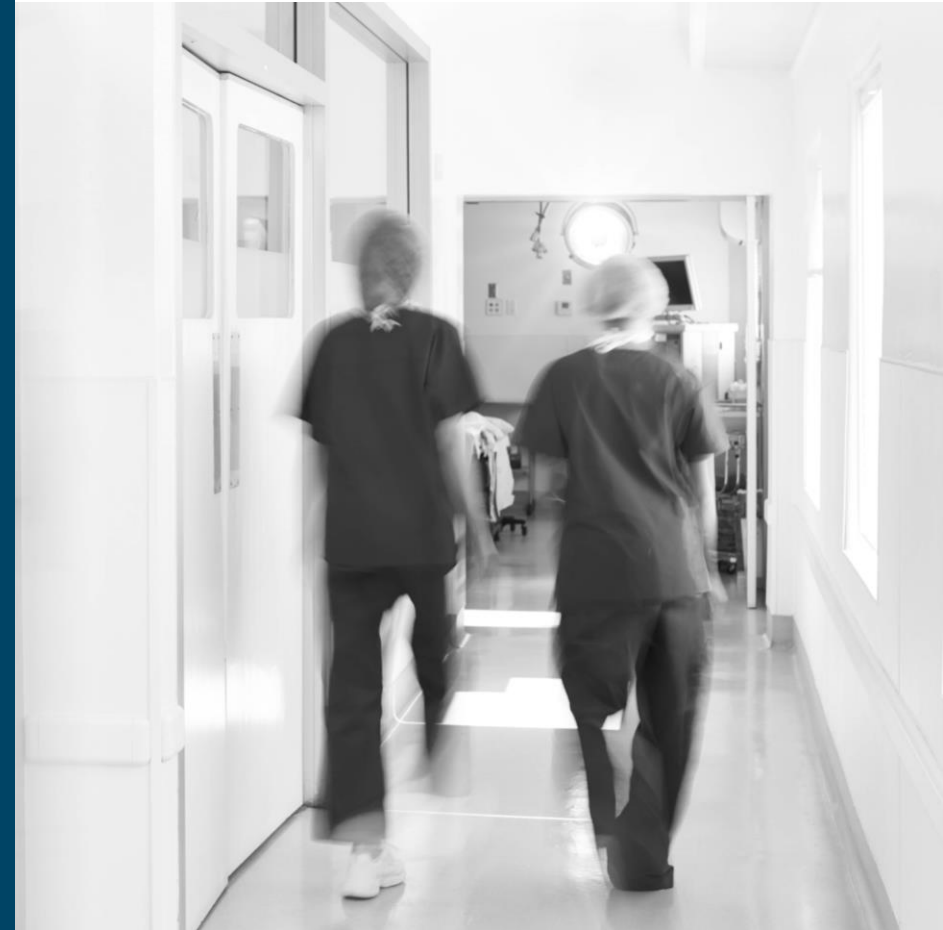


EDUCATIONAL RESOURCES

Chapter 25

Pharmacy Services

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Chapter 25: Updates

- 25.01.03 Security of Medications

Chapter 25: 25.01.03

■ 25.01.03 Security of Medications

- A secure area means that drugs and biologicals are stored in a manner to prevent unmonitored access by unauthorized individuals.
- RESTRICTED AREAS
 - Areas restricted to authorized personnel only would generally be considered “secure areas.” If there is evidence of tampering or diversion, or if medication security otherwise becomes a problem, the hospital must evaluate its current medication control policies and procedures and implement changes to ensure that the problem is corrected and that patient health and safety are maintained.
- LABOR AND DELIVERY, CRITICAL CARE, AND SURGERY
 - Generally, labor and delivery suites, critical care units, and surgical suites are considered secure if they are staffed and actively providing patient care. Hospital policies and procedures are expected to ensure that these areas are secure, with entry and exit limited to appropriate staff, patients, and visitors after patient care hours or when the unit is closed or not in use.



EDUCATIONAL RESOURCES

Chapter 30

Surgical Services

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE



Chapter 30: Updates

- 30.00.00 Condition of Participation: Surgical Services
- 30.00.11 Surgical Informed Consent
- 30.00.12 Required OR Equipment
- 30.02.06 PACU Requirement Equipment

Chapter 30: 30.00.00 Surgical Services

- The Condition of Participation was revised to remove language defining “What Constitutes ‘Surgery.’”
- For example:
 - ~~WHAT CONSTITUTES “SURGERY”?~~
 - ~~For the purposes of determining compliance with the hospital surgical services CoP, ACHC relies, with minor modification, on the definition developed by the American College of Surgeons.~~
- If a hospital provides any degree of surgical services to its patients, the hospital must comply with all the requirements of this Condition of Participation (CoP).

Chapter 30: 30.00.11

■ 30.00.11 Surgical Informed Consent: NOTE ON USE OF SURGICAL RESIDENTS

- For surgeries in which residents will perform important parts of the procedure, discussion with the patient should include disclose any/all of the following, if relevant:
 - Physicians who are in approved post-graduate residency training programs are expected to perform portions of the surgery, based on their availability and level of competence
 - Decisions that may be made at the time of the surgery regarding resident participation and their manner of participation will depend on the availability of residents with the necessary competence, knowledge the operating practitioner/teaching surgeon has of the resident's skill set, and the patient's condition.
 - Residents performing surgical tasks will be under the supervision of the operating practitioner/teaching surgeon.
 - Whether, based on the resident's level of competence, the operating practitioner/teaching surgeon will not be physically present in the same operating room for some or all the surgical tasks performed by residents.
 - Note: A "moonlighting" resident or fellow is a post-graduate medical trainee who is practicing independently, outside the scope of his/her residency training program and would be treated as a physician within the scope of the privileges granted by the hospital.
 - Whether, as permitted by state law, qualified medical practitioners who are not physicians will perform important parts of the surgery or administer the anesthesia, and, if so, the types of tasks each type of practitioner will carry out; and that such practitioners will be performing only tasks within their scope of practice for which they have been granted privileges by the hospital.

Chapter 30: 30.00.12

■ 30.00.12 Required OR Equipment

- Age-specific resuscitation equipment is required to meet the emergency needs of the patient. If the facility treats neonatal/pediatric patients, neonatal/pediatric-sized resuscitation equipment is immediately available.
- The organization has a policy that defines:
 - Supplies and equipment required for emergencies.
 - The process and frequency of checking for outdated supplies in carts.
 - How all types of emergency cart are managed after use and during transport to be restocked to ensure security of supplies and medications. Emergency carts may include, but are not limited to:
 - Resuscitation Carts
 - Medication Carts
 - Anesthesia Carts
 - OB Hemorrhage Carts
 - Malignant Hyperthermia Carts

Chapter 30: 30.00.12 (continued)

- The organization has a policy that defines:
 - Individuals authorized to transport carts.
 - Secure locations in which carts may be stored prior to use by floors/departments.
 - Frequency of cart lock check.
 - Management of carts when a unit is closed. Carts must be stored in a secure location.
- Scoring Procedure: Verify
 - All required systems in surgical and invasive procedure rooms are working.
 - Age-specific resuscitation equipment is readily available. If the facility treats neonatal/pediatric patients, ensure neonatal/pediatric-size endotracheal tubes/tracheostomy sets are immediately available.

Chapter 30: 30.02.06

30.02.06 Required PACU Equipment

- The organization has a policy that defines:
 - Supplies and equipment required for emergencies.
 - The process and frequency of checking for outdated supplies in carts.
 - How all types of emergency carts contents are managed after use and during transport to be restocked to ensure security of supplies and medications.Emergency carts may include, but are not limited to:
 - Resuscitation Carts
 - Medication Carts
 - Anesthesia Carts
 - OB Hemorrhage Carts
 - Malignant Hyperthermia Carts

Chapter 30: 30.02.06 (continued)

- The organization has a policy that defines:
 - Individuals authorized to transport carts.
 - Secure locations in which carts may be stored prior to use by floors/departments.
 - Frequency of cart lock check.
 - Management of carts when a unit is closed. Carts must be stored in a secure location.
- Scoring Procedure: Verify
 - If the facility treats neonatal/pediatric patients, neonatal/pediatric-size endotracheal tubes/tracheostomy sets are immediately available.



Questions?



EDUCATIONAL RESOURCES

Thank you

 ACUTE CARE HOSPITAL



ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE

