



Welcome to this first edition of *Hospital Happenings*, a newsletter published by the North Dakota Department of Health, Division of Health Facilities. *Hospital Happenings* is designed to help hospitals and critical access hospitals stay up-to-date on various issues. Please share with your staff.

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Most Commonly Cited Deficiencies

Following is a breakdown of the most common deficiencies cited in the North Dakota Critical Access Hospital (CAH) program from Oct. 1, 2006, through Sept. 30, 2007.

Life Safety Code

K0017-Corridors must be separated from other spaces by walls constructed with at least ½-hour fire resistance rating. In buildings with sprinklers, partitions are required only to resist the passage of smoke. In buildings without sprinklers, corridor walls extend to the deck above. Penetrations through corridor walls must be sealed with material to maintain the fire and smoke resistance rating.

K0029-One-hour fire rated construction (with ¾-hour fire-rated doors) or an automatic sprinkler system must be provided for hazardous areas. Where an automatic sprinkler system is provided, the areas must be separated from other spaces by smoke resisting partitions and doors. Hazardous area doors must be provided with self-closing devices. Doors to hazardous areas in areas without sprinklers must be fire rated and provided with appropriate gaskets. Penetrations through hazardous area walls must be sealed with material to maintain the fire and smoke resistance rating.

K0038-Means of egress must be arranged to be readily accessible at all times. Hard surfaces that lead to a public way must be provided at the exterior of all required exits. Dead bolt locks and other multi-latching devices must not be used on doors in the means of egress.

K0069-The kitchen hood fire suppression system must be connected to the fire alarm system and must be inspected and serviced every six months. The kitchen hood suppression system must comply with UL300, and there must be a K-type portable fire extinguisher available. Appliances located under the hood must have an automatic fuel/electric shut off.

K0130-Miscellaneous Life Safety Code deficiencies include testing and maintenance of emergency lighting and transfer switches and proper location of alcohol-based hand rub solutions.

Health

C0241-GOVERNING BODY

The CAH's governing body is responsible for determining, implementing and monitoring policies governing the CAH's total operation and for ensuring those policies are administered so as to provide quality care in a safe environment. The governing body must ensure medical staff appointments/reappointments occur consistent with the approved bylaws and the medical staff adhere to and follow the bylaws approved by the governing board.

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C0276-POLICIES-DRUG MANAGEMENT

The CAH must have rules for the storage, handling, dispensation and administration of drugs and biologicals. Pharmaceutical services must be administered in accordance with accepted professional principles.

C0277-POLICIES-MED ERRORS & ADRs

The CAH must have procedures and a proactive system for reporting adverse drug reactions and errors in the administration of drugs.

C0278-POLICIES-INFECTON CONTROL

The CAH must have a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. The CAH must have an active surveillance program.

C0280-PATIENT CARE POLICIES

The CAH's patient care policies must be reviewed at least annually by the professional group that includes at least a physician, one mid-level practitioner and at least one member who is not a member of the CAH staff.

C0293-AGREEMENTS-CEO RESPONSIBILITIES

The CAH must ensure a contractor of services furnishes services that enable the CAH to comply with all applicable conditions of participation and standards for the contracted services.

C0330-PERIODIC EVALUATION & QA REVIEW

The CAH must conduct a comprehensive annual program evaluation and have an effective quality assurance program.

C0331-ANNUAL PROGRAM EVALUATION

The CAH must conduct an annual program evaluation.

C0333-PERIODIC EVALUATION OF PATIENT RECORDS

The CAH must conduct an annual program evaluation that includes a review of both active and closed medical records.

C0334-PERIODIC EVALUATION OF POLICIES

The CAH must conduct an annual program evaluation that includes a review of health-care policies.

C0335-PERIODIC EVALUATION

The CAH must conduct an annual program evaluation to determine whether the utilization of services was appropriate, the established policies were followed and if any changes are needed.

C0336-QA-QUALITY OF PATIENT CARE

The CAH must have an effective quality assurance program to evaluate the quality and appropriateness of the diagnosis and treatment furnished.

C0337-QUALITY ASSURANCE

As part of an effective quality assurance program, the CAH must evaluate all patient care services and other services affecting patient health and safety. The quality assurance program must be hospital wide.

C0338-QA-MEDS & INFECTIONS

As part of an effective quality assurance program, the CAH must evaluate nosocomial infections and medication therapy.

Take a look at your facility to see if it is deficient in these areas. If so, take corrective action to fix the problem areas before your next survey. Look for the most common deficiencies cited in General Acute Hospitals in the Summer 2008 newsletter.



Authentication of Verbal Orders

In July 2004, at the request of the hospital industry, the Licensing Rules for Hospitals in North Dakota, North Dakota Administrative Code 33-07-01.1-20.1.i (2) was amended. The amendment removed the 48-hour time frame in which telephone and verbal orders needed to be written and signed or initialed by a licensed health care practitioner responsible for the care of the patient. Hospitals were expected to establish their own requirements for this time frame through bylaws and/or policy.

On Nov. 27, 2006, The Centers for Medicare and Medicaid Services (CMS) issued changes to the hospital conditions of participation (CoPs). Included in these changes at 42 CFR 482.24(c)(1)(i), (ii), (iii) is the requirement that the ordering practitioner date, time and authenticate all orders, including verbal orders, promptly. For the five-year period following Jan. 26, 2007, another practitioner responsible for the care of the patient can authenticate the orders. All verbal orders must be authenticated based upon federal and state law. If there is no state law that designates a specific time frame, verbal orders must be authenticated within 48 hours.

Since the time frame was taken out of the licensing rules in July 2004, North Dakota no longer has a state law or regulation that designates a specific timeframe. This means hospitals must now follow the more stringent federal requirement that verbal orders must be authenticated within 48 hours.

Authentication includes a method to establish the identity of the author of each entry. It also includes that authors take a specific action to verify the entries are theirs or, if they are responsible for the entry, that it is accurate. Authentication also includes the timing of the entry.

Timing documents the time and date of each entry. It establishes when an order was given, when an activity happened or when an activity is to take place. Timing and dating is necessary for patient safety and quality of care. Timing and dating of entries establishes a baseline for future actions or assessments and establishes a timeline of events. Many patient interventions or assessments are based on time intervals or time lines of various signs, symptoms or events.

Verbal orders must be used infrequently.

These changes to the federal regulations do not apply to the critical access hospital (CAH) regulations. However, a CAH is expected to authenticate verbal orders. The CAH needs to adopt bylaws and/or policy and procedure which address the facility's expectation. Timing of verbal orders may be identified as a deficient practice on a CAH survey if the facility is not following its approved bylaws and policies and procedures or if timing is critical for the care of the patient.

The changes to the federal conditions of participation were effective **Jan. 26, 2007**. The revised rule may be accessed at www.access.gpo.gov/su_docs/fedreg/a061127c.html.

If you have any additional questions regarding authentication of verbal orders, please contact Bridget Weidner at bweidner@nd.gov or 701.328.2352.

References: Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals
S&C 07-13





New Survey and Certification Letters

The Centers for Medicare and Medicaid Services (CMS) transmits memoranda, guidance, clarifications and instructions to state survey agencies and CMS regional offices through use of survey and certification (S&C) letters. Below is a list of the new S&C letters since Jan. 1, 2008, affecting hospitals and critical access hospitals. The S&C letters are available at: www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage.

- S&C 08-08 Requirements for Provider-based Off-campus Emergency Departments

Growth in the demand for hospital emergency services has resulted in a number of hospitals seeking to expand their emergency department (ED) services to off-site locations. Provider-based off-site hospital EDs are permitted and must demonstrate compliance with the hospital conditions of participation (CoPs). They also must be in compliance with the provider-based regulations at 42 CFR 413.65.

- S&C 08-11 Accreditation Option for Critical Access Hospital (CAH) Distinct Part Units

CMS has approved the American Osteopathic Association (AOA) for recognition as a national accreditation program for CAHs. This recognition includes CAH distinct part units.

- S&C 08-12 Revised Interpretive Guidelines for Hospital Conditions of Participation

Changes have been made to the interpretive guidelines that correspond to the regulatory changes published Nov. 27, 2006, amending hospital conditions of participation pertaining to requirements for history and physical examinations, authentication of verbal orders, securing medications, and post-anesthesia evaluations. The interpretive guidelines also include newly adopted additional changes that were incorporated into the calendar year 2008 Outpatient Prospective Payment System (OPPS) regulation.

DEATH REPORTING REQUIREMENT

The final rule for the general acute hospital condition of participation for patients' rights was published in the Federal Register on Dec. 8, 2006, and became effective Jan. 8, 2007. The death reporting requirement at 482.13(g) requires hospitals to report deaths associated with seclusion or restraint to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.

This includes:

- Deaths that occurs while a patient is in restraint or seclusion.
- Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
- Each death known to the hospital that occurs within one week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time or death related to chest compression, restriction of breathing or asphyxiation.

Staff must document in the patient's medical record the date and time the death was reported to CMS.

The reporting contact for CMS Region VIII is Helen Jewell at 303.844.7048. The revised regulation can be accessed at: www.access.gpo.gov/su_docs/fedreg/a061208c.html



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