The Joint Commission (TJC) will be visiting Vanderbilt Medical Center prior to July 27, 2015. The purpose of this Frequently Asked Question document is to present challenging areas where providers are needed to assist Vanderbilt to achieve compliance.

**FAQ: Medical Management**

PRN orders must have the **indication for use** documented as a part of the order. For all other medications, an indication for use must be somewhere in the medical record. When multiple PRN medications are ordered for the same indication (i.e., pain, nausea, constipation) the comments must contain clear instructions for when to administer each medication. Orders must be clear to avoid duplication of therapy and so that the nurse is not making prescribing decisions.

Use of the patient’s **home medications** should be limited to situations where the medication is not on formulary and there is not an appropriate alternative on formulary or where there use has been approved by the Pharmacy and Therapeutics (P&T) Committee as identified in Computer Provider Order Entry System. A provider order and pharmacy verification is required to utilize home medications.

Medication **Titration Orders** include 6 elements: Bolus amount, starting amount, how much and how frequent to increase or decrease, what parameters are being titrated to and maximum dose before calling the provider.

Nursing may not begin medication orders without a **provider order**. Examples of issues: pre-operative areas where IV fluids cannot be started without a patient specific provider order. Even standing protocols must be initiated by the provider.

**Narcotics** are locked or under constant surveillance at all times. This includes ICUs, ORs, PACUs and procedure areas.

**Verbal orders** always require a “read-back” to the provider. Verbal orders are limited to situations where the provider is unable to enter them into the Computer Provider Order Entry System. Verbal orders are authenticated within 48 hours.

**Single dose vials** are not used as multiple dose vials. Exception being for **ONE** patient during the course of **ONE** procedure and a new needle and a new syringe is used for each dose. You must also discard the vial and all syringes within **ONE** hour.

**Sample medications** are now required to be approved through Pharmacy and Therapeutics (P&T) Committee.

Handwritten or typed orders shall not contain the following **abbreviations**: “IU”, “MS”, “MSO4”, “MgSO4”, “Q.D.”, “q.d.”, “Q.O.D.”, “QOD”, “U”, “u”, Trailing zero (X.O mg), Lack of leading zero (.x mg).

**Medication Reconciliation**: The list of medications that the patient was taking at home (documented in the Med list Tool- MLT) must be considered when prescribing medications at the time of: admission, ED Visit, Clinic visit, transfer and discharge. Any discrepancies should be “reconciled”. A list must be provided to the patient at discharge or at the end of an outpatient visit and the patient must be educated...
about the importance of managing medication information (included in the Discharge Letter for inpatients and on the printed med List or Clinical Summary for outpatient).

**FAQ: Infection Prevention**

*High Level Disinfection:* Contaminated items must be in a covered impermeable container marked “dirty” to transport to the reprocessing area regardless of the distance (short or long).

Be able to articulate how various scopes used in your practice are reprocessed through sterilization or High Level Disinfection.

**Temperature and Humidity** monitoring is required for all sterile procedure areas and storage of sterile supplies.

Provider **food and drinks** may not be consumed at the bedside, nursing stations or procedure areas.

Providers entering **Isolation** rooms must follow VUMC policy; wear the required personal protective equipment (PPE) regardless of how much contact with either the patient or the patient’s environment.

**FAQ: National Patient Safety Goals**

Use at least **Two Patient Identifiers** when providing treatment or procedures. Approved positive identifiers are: name, date of birth, Medical record number, last 4 digits of SSN, government issued photo identification, photo in VPH and Newborn Nursery.

Improve the safety of **Clinical Alarm Systems:** This NPSG focuses on managing clinical alarm systems that have the most direct relationship to patient safety. The top two alarms identified is pulse oximeters and cardiac monitor alarms. There is an Alarm Safety committee working on solutions and policy for VUMC.

**Medication Labeling:** When a medication or solution is drawn up by the nurse/provider and is not immediately given, the following is required to be documented on the label. (Administration must begin within one hour)

- Drug name,
- Drug strength/concentration,
- Quantity/volume (if not apparent on the container),
- Diluent (if not apparent on the container),
- Date and Time of preparation,
- Initials of preparer,
- Expiration date and time
FAQ: Patient Rights

Privacy: The patient must be given an opportunity to object to having their information discussed in front of family and visitors. Never assume it is okay to discuss patient information in front of visitors and family members.

Compliance with HIPAA includes not discussing patient information in elevators, cafeteria and other public locations.

The informed consent process includes a discussion about the patient's proposed care, treatment, and services.

The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment.

FAQ: Provision of Patient Care

History and Physical (H&P) is completed and documented within 24 hours of inpatient admission. May use previous H&P documented within 30 days prior or 24 hours after admission or registration that includes an update. The update includes an examination and any changes to the patient’s condition. If no change in patient assessment, the update must include: “I have examined the patient and there are no changes or the following has changed.” H&P and/or update must be documented prior to any procedure.

For scheduled operative and other procedure where the H&P is completed prior to their admission and within 30 days an update must be documented on the H&P.

A pre-anesthesia evaluation is completed and documented by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requiring anesthesia services (moderate or deep sedation and anesthesia). The hospital re-evaluates the patient immediately (within 5 minutes) before administering moderate or deep sedation or anesthesia.

A post-anesthesia evaluation is completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services.

Consent must be obtained from each patient or the patient’s legally authorized representative prior to any invasive diagnostic, therapeutic, or operative procedure, or any procedure or any procedure or treatment which presents a significant risk to the patient.

The duration of the signed Informed consent is 60 days prior to an elective procedure, surgery or treatment.

*Multidisciplinary Plan of Care:* providers participate in the multidisciplinary plan of care through physician orders and through the plan they enter via Team Summary and/or Daily Progress Notes. These documents can be accessed via the Overview of Patient Care which is one portion of the plan of care.

Restraints provider documentation includes daily provider assessment of restraints and daily provider order for restraints.

* Indicates TJC citation in 2012
FAQ: Universal Protocol

Universal Protocol standards are focused on avoiding errors during surgical or other invasive procedures.

Pre-procedure verification is to identify correct patient, correct procedure, correct side. Involve the patient when possible in this verification.

Marking the procedural site, side is done when there is more than one possible location for the procedure.

Time Out: Operative and other Procedures: All relevant team members must be present, stop and actively verbally participate in the time out to confirm the correct patient, procedure and site/side immediately before starting the invasive procedure or making the incision. If the time out is interrupted at any point by a new member entering the OR suite, the time out must be started over from the beginning.

FAQ: Record of Care

All entries on the Medical Record must be dated, timed & authenticated

Immediate Note: A brief note must be written or electronically entered in the record immediately following the operation. Immediate is prior to the patient moving to the next level of care. This note should include the following (template in StarPanel):

1. Name of surgeon, proceduralist and assistants;
2. Procedure(s) performed and description of the procedure;
3. Findings;
4. Estimated blood loss;
5. Specimen(s) removed, if any:

Operative Report is required to be in the Electronic Medical Record within 24 hours of surgery.

Verbal Orders are limited to situations where immediate written or electronic communication of orders is not feasible. The receiver of the order writes it down or enters it electronically and then reads it back verbatim. The prescriber then verifies the accuracy.

Test Results: Before taking action on a verbal order or verbal report of a critical test result, staff uses a record and "read back" process to verify the information.