About Nursing
HealthTechS3 is a 45 year old, award-winning healthcare consulting and strategic hospital services firm based in Brentwood, Tennessee with clients across the United States.

We are dedicated to the goal of improving performance, achieving compliance, reducing costs, and ultimately improving patient care. Leveraging consultants with deep healthcare industry experience, HealthTechS3 provides actionable insights and guidance that supports informed decision making and drives efficiency in operational performance.

Our consultants are former hospital leaders and executives. HealthTechS3 has the right mix of experienced professionals that service hospital clients across the nation. HealthTechS3 offers flexible and affordable services, consulting, and technology as we focus on delivering solutions that can be implemented and provide a positive, measurable impact.
GOVERNANCE & STRATEGY
- Affiliation Consulting
- Executive & Management Leadership Development
- Strategic Planning & Market share Analysis
- Community Health Needs Assessment
- Compliance Consulting Services

FINANCE
- Performance Optimization / Margin Improvement
- Revenue Cycle & Business Office Operations
- Productivity & Staffing Consulting - Optimum Productivity Toolkit

CLINICAL CARE & OPERATIONS
- Continuous Survey Readiness
- Quality Assurance Performance Improvement
- Lean Culture
- Customer Experience
- Clinical Resource Management
- Care Coordination – Primary Care Practice
- Physician Practice & Clinic Assessment
- Long Term Care Consulting
- Swing Bed Consulting
- Perioperative Services Consulting

RECRUITMENT
- Executive Recruitment
- Manager and Clinical Positions
- Physician / Provider Recruitment
- Information Technology Professionals
- Interim Placement
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<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Topic</th>
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<tr>
<td>April 6</td>
<td>12:00PM—1:00PM</td>
<td>Compliance and Ethics Programs in Long-Term Care</td>
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<td>April 10</td>
<td>12:00PM—1:00PM</td>
<td>The Basics of Medical Staff Credentialing and Privileging</td>
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<td>April 17</td>
<td>12:00PM—1:00PM</td>
<td>The New World of Healthcare Innovation</td>
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<td>April 20</td>
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<td>Using Lean in Your Revenue Cycle</td>
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<td>The First 90 Days as a CNO Panel</td>
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<td>May 5</td>
<td>12:00PM—1:30PM</td>
<td>The Conditions of Participation for Critical Access Hospitals—About Nursing</td>
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<td>May 10</td>
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<td>Why An Interim Leader Might Be Right For Your Hospital Now</td>
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<td>Creating Community Partners to Capitalize on Grant Opportunities</td>
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<td>June 16</td>
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<td>Swing Bed – What You Really Need to Know</td>
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<td>June 26</td>
<td>12:00PM—1:00PM</td>
<td>Transforming Patient Engagement through Family Centered Care</td>
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All above times are Central Time Zone

Hope you will join us!
Instructions for Today’s Webinar

- You may type a question in the text box if you have a question during the presentation.
- We will try to cover all of your questions – but if we don’t get to them during the webinar we will follow-up with you by e-mail.
- You may also send questions after the webinar to Carolyn St.Charles (contact information is included at the end of the presentation).
- The webinar will be recorded and the recording will be available on the HealthTechS3 web site www.healthtechs3.com.

www.healthtechs3.com

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Regional Chief Clinical Officer

Carolyn began her healthcare career as a staff nurse in Intensive Care. She has worked in a variety of staff, administrative, and consulting roles and has been in her current position as Regional Chief Clinical Officer with HealthTechS3 for the last fifteen years.

In her role as Regional Chief Clinical Officer, Carolyn St.Charles is the lead consultant for development of Community Health Needs Assessments. She also conducts mock surveys for Critical Access Hospitals, Acute Care Hospitals, Long Term Care, Rural Health Clinics, Home Health, and Hospice.
WHAT WE’LL COVER

1. Nurse Executive Role and Responsibilities

2. Assessment
   - Pain
   - Skin
   - Fall
   - Nutrition
   - Abuse

3. Nursing Care Plans

4. National Patient Safety Goals

5. Other Standards
   - Verbal Orders
   - Rapid Response
   - Hand-off-Communication
   - Restraints
   - Patient Education
   - Discharge Planning

12. Staffing

13. Competency
CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the CoPs / CfCs. (Source CMS.gov)

**Hospitals:** Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals

**Critical Access Hospitals:** Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs
Organizations with Deemed Status

Know the Rules

• The Joint Commission (TJC)
• Det Norske Veritas (DNV) - GL
• Healthcare Facilities Accreditation Program (HFAP)
• Others.............
State Regulations
Nurse Executive
Roles and Responsibilities

Calling nurse leaders!
Senior Leader

CAH C-0294
The CAH designates an individual who is responsible for nursing services.....

NR.01.01.01
The nurse executive directs the delivery of nursing care, treatment and services.

1. Functions at the senior leadership level

3. Assumes active leadership role with the governing body, senior leadership, medical staff, management and other clinical leaders in the hospital’s decision-making structure and process

4. Participates in defined and established meetings

5. Responsibilities are defined in writing
Qualifications

**CAH C-0294**
The designated individual (responsible for nursing service) is expected to be a registered nurse.

**NR.01.02.01**
The nurse executive is a licensed professional registered nurse qualified by advanced education and management experience.

1. Licensed in the State

2. Postgraduate degree – or – knowledge and skills associated with an advanced degree – or – written plan to obtain qualifications

When appointing the nurse executive, the critical access hospital considers:

3. Education and experience required for peer leadership positions

4. Scope of services and complexity

5. Scope and complexity of major patient population(s)

6. Availability of nursing and administrative staff & services to assist nurse executive
Role and Responsibilities

CAH C-0294
The nurse leaders is responsible for the overall management and evaluation of nursing care in the CAH, including, but not limited to:

• Supervision of nursing staff, either directly, or, depending on the size of the CAH, indirectly through other nursing managers

NR.02.01.01
The nurse executive directs the critical access hospital’s nursing services.

The nurse executive coordinates:
1. Organization-wide plans to provide nursing care, treatment and services
2. Organizationwide programs, policies and procedures that address how nursing care needs of the patient population are assessed, met and evaluated
3. Development of effective, ongoing program to measure, analyze and improve the quality of nursing care, treatment, and services

The nurse executive directs:
4. Implementation of organization wide plans to provide nursing care, treatment and services
5. Implementation of organization wide programs, policies and procedures that address how nursing care needs of the patient population are assessed, met and evaluated
6. Implementation of an effective, ongoing program to measure, analyze and improve the quality of the nursing care, treatment and services
Role and Responsibilities

CAH C-0294
The nurse leaders is responsible for the overall management and evaluation of nursing care in the CAH, including, but not limited to:

• Development and maintenance of nursing policies and procedures

NR.02.02.01
The nurse executive establishes guidelines for the delivery of nursing care, treatment, and services.

The nurse executive, registered nurses, and other designated nursing staff write:

1. Standards of nursing practice

2. Nursing standards of patient care, treatment, and services

3. Nursing policies and procedures

4. Nurse staffing plan(s)

5. Standards to measure, assess, and improve patient outcomes
Role and Responsibilities

CAH C-0294
The nurse leaders is responsible for the overall management and evaluation of nursing care in the CAH, including, but not limited to:

- Ongoing review and analysis of the quality of nursing care

The CAH must ensure that all CAH nursing staff are aware of CAH nursing policies and procedures.

NR.02.03.01
The nurse executive directs the implementation of nursing policies and procedures, nursing standards, and a nurse staffing plan(s).

The nurse executive or designee:
1. Approves nursing policies, nursing standards of patient care, treatment, and services, and standards of nursing practice before implementation
2. Implements nursing policies, procedures, and standards that describe and guide how the staff provide nursing care, treatment, and services
3. Provides access to all nursing policies, procedures, and standards to the nursing staff
4. Responsible for monitoring the effectiveness of the nurse staffing plan
5. Exercises final authority over staff who provide nursing care, treatment, and services
Responsibility for Nursing Care

All departments that provide nursing care, even if there is not a direct reporting relationship:

• Cath Lab
• Imaging
• Clinic
Assessment

Risk of Skin Breakdown

Nutritional Risk

Fall Risk

Abuse

Pain Assessment
Assessment

C-0271
The CAH’s health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

C-0298
A nursing care plan is based on assessing the patient’s nursing care needs (not solely those needs related to the admitting diagnosis). The assessment considers the patient’s treatment goals and, as appropriate, physiological and psychosocial factors and patient discharge planning.

The nursing care plan is kept current by ongoing assessments of the patient’s needs and of the patient’s response to interventions, and updating or revising the patient’s nursing care plan in response to assessments.

PC.01.02.01
The critical access hospital assesses and reassesses its patients.

1. The CAH defines, in writing, the scope and content of screening, assessment, and reassessment information it collects.

2. The CAH defines, in writing, criteria that identify when additional, specialized, or more in-depth assessments are performed.

4. Based on the patient’s condition, information gathered in the initial assessment includes the following:
   - Physical, psychological, and social assessment
   - Nutrition and hydration status
   - Functional status
   - For patients who are receiving end-of-life care, the social, spiritual, and cultural variables that influence the patient’s and family members perception of grief
Assessment

C-0271
The CAH’s health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

C-0298
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The nursing care plan is kept current by ongoing assessments of the patient’s needs and of the patient’s response to interventions, and updating or revising the patient’s nursing care plan in response to assessments.

PC.01.02.03
The critical access hospital assesses and reassesses the patient and his or her condition according to defined time frames.

The Critical Access Hospital:
1. Defines, in writing, the time frame(s) within which it conducts the patient’s initial assessment, in accordance with laws and regulations

2. Performs initial patient assessments within its defined time frame

3. Each patient is reassessed as necessary based on his or her plan for care or changes in his or her condition

6. A registered nurse completes a nursing assessment within 24 hours after the patient’s inpatient admission
Swing-Bed Assessment

C-0388

The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident’s functional capacity.

(b) Comprehensive assessment.

(1) Resident assessment instrument. A facility must make a comprehensive assessment of a resident’s needs. The assessment must include at least the following:

(i) Identification and demographic information.

(ii) Customary routine.

(iii) Cognitive patterns.

(iv) Communication.

(v) Vision.

(vi) Mood and behavior patterns.

(vii) Psychosocial well-being.

(viii) Physical functioning and structural problems.

(ix) Continence.

(x) Disease diagnoses and health conditions.

(xi) Dental and nutritional status.

(xii) Skin condition.

(xiii) Activity pursuit.

(xiv) Medications.

(xv) Special treatments and procedures.

(xvi) Discharge potential.

(xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols.

(xviii) Documentation of participation in assessment.

The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members.

PC.01.02.01

26. For swing beds in critical access hospitals: The comprehensive assessment of the resident includes the following:

- Identifying and demographic information
- Customary routines
- Cognitive patterns
- Communication needs
- Vision needs
- Psychosocial wellbeing
- Mood and behavior patterns
- Physical functioning and structural problems
- Continence
- Disease(s), diagnoses, and health conditions
- Dental and nutritional status
- Skin
- Pursuit of activity
- Medications
- Need for special treatment(s) and procedure(s)
- Potential for discharge

27. The comprehensive assessment of the resident includes documentation of summary information about the additional assessment(s) performed through the resident assessment protocols.

28. The comprehensive assessment of the resident includes documentation of the resident’s participation in the assessment.

Join our webinar on June 16
Pain Assessment and Reassessment
C-0271
The CAH’s health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

CAH C-0297
Of particular concern are patients receiving IV opioids post-operatively. The effects of IV opioids in post-operative patients must be monitored vigilantly via serial assessments of pain, respiratory status, and sedation levels.

PC.01.02.07
The critical access hospital assesses and manages the patient’s pain

The critical access hospital:
1. Conducts a comprehensive pain assessment that is consistent with its scope of care, treatment, and services and the patient’s condition.
2. Uses methods to assess physical pain that are consistent with the patient’s age, condition, and ability to understand.
3. Reassesses and responds to the patient’s pain, based on its reassessment criteria.
4. Either treats the patient’s pain or refers the patient for treatment.

PC.02.03.01
10. Based on the patient’s condition and assessed needs, the education and training provided to the patient by the CAH includes the following:
   • Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management.
Use the Right Tool

Wong-Baker FACES™ Pain Rating Scale

Children between the ages of two months and seven years or in persons unable to communicate.
Reassessment – Build Hard Stops

Wong-Baker FACES™ Pain Rating Scale

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
<td>No Hurt</td>
</tr>
<tr>
<td>2</td>
<td>Hurts Little Bit</td>
</tr>
<tr>
<td>4</td>
<td>Hurts Little More</td>
</tr>
<tr>
<td>6</td>
<td>Hurts Even More</td>
</tr>
<tr>
<td>8</td>
<td>Hurts Whole Lot</td>
</tr>
<tr>
<td>10</td>
<td>Hurts Worst</td>
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FLACC scale

<table>
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<tr>
<th>Category</th>
<th>Scoring</th>
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<tr>
<td>Face</td>
<td>0, 1, 2</td>
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<tr>
<td>Legs</td>
<td>0, 1, 2</td>
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<tr>
<td>Activity</td>
<td>0, 1, 2</td>
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<tr>
<td>Cry</td>
<td>0, 1, 2</td>
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<tr>
<td>Consolability</td>
<td>0, 1, 2</td>
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Behavioral Observation Pain Rating Scale

Children between the ages of two months and seven years or in persons unable to communicate.

Pain Assessment IN Advanced Dementia PAINAD

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<tr>
<th>Parameter</th>
<th>Score</th>
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<tbody>
<tr>
<td>Facial Expression</td>
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<tr>
<td>Eyes Open</td>
<td></td>
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<tr>
<td>Grimacing</td>
<td></td>
</tr>
<tr>
<td>No cry</td>
<td></td>
</tr>
<tr>
<td>Whimper</td>
<td></td>
</tr>
<tr>
<td>Vigorous crying</td>
<td></td>
</tr>
<tr>
<td>Breathing Patterns</td>
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<tr>
<td>Relaxed</td>
<td></td>
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<tr>
<td>Change in breathing</td>
<td></td>
</tr>
<tr>
<td>Arms</td>
<td></td>
</tr>
<tr>
<td>Restrained</td>
<td></td>
</tr>
<tr>
<td>Relaxed</td>
<td></td>
</tr>
<tr>
<td>Flexed</td>
<td></td>
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<tr>
<td>Extended</td>
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<tr>
<td>Legs</td>
<td></td>
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<tr>
<td>Restrained</td>
<td></td>
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<td>Relaxed</td>
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<td>Flexed</td>
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<tr>
<td>Extended</td>
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<tr>
<td>State of Arousal</td>
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<td>Sleeping</td>
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<td>Awake</td>
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<td>Fussy</td>
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Better Pain Management
Gallup Survey

**Patient & Staff Interventions**

- Set patient expectations appropriately
- Anticipate the pain medication schedule
- Stay in constant communication with patients while trying to control their pain
- Understand that pain is emotional as well as physical
- Record current pain levels on a whiteboard
- Educate patients about how to manage their pain after being discharged

**Staff & Hospital Interventions**

- Initiate a pain-control policy
- Review the process for pain medicine delivery from the pharmacy to the nursing unit
- Educate all hands-on providers about pain assessment and management
- Become familiar with non-medication pain control to provide patients with "high-touch" pain management options

Risk of Skin Breakdown – Pressure Ulcers
Risk for Skin Impairment

C-0271
The CAH’s health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

C-0298
A nursing care plan is based on assessing the patient’s nursing care needs (not solely those needs related to the admitting diagnosis). The assessment considers the patient’s treatment goals and, as appropriate, physiological and psychosocial factors and patient discharge planning.

The nursing care plan is kept current by ongoing assessments of the patient’s needs and of the patient’s response to interventions, and updating or revising the patient’s nursing care plan in response to assessments.

PC.01.02.01
The critical access hospital assesses and reassesses its patients.

4. Based on the patient's condition, information gathered in the initial assessment includes the following:
   • Physical, psychological, and social assessment
Braden & Norton Tools

**Braden Scale**
The Braden Scale is made up of six subscales (sensory perception, moisture, activity, mobility, nutrition, friction/shear) scored from 1 to 4 or 1 to 3 (1 for low level of functioning and 4 for the highest level or no impairment).

Total scores range from 6 to 23. A lower Braden Scale score indicates higher levels of risk for pressure ulcer development.

**Scores of 18 or less generally indicate at-risk status.** This threshold may need to be adjusted for the specific patient population on your unit or according to your hospital guidelines.

**Norton Scale**
The Norton Scale is made up of five subscales (physical condition, mental condition, activity, mobility, incontinence) scored from 1-4 (1 for low level of functioning and 4 for highest level of functioning).

The subscales are added together for a total score that ranges from 5 to 20.

**A lower Norton Scale score indicates higher levels of risk for pressure ulcer development.** Scores of 14 or less generally indicate at-risk status.

Source: AHRQ
Each year, more than 2.5 million people in the United States develop pressure ulcers. These skin lesions bring pain, associated risk for serious infection, and increased health care utilization. The aim of this toolkit is to assist hospital staff in implementing effective pressure ulcer prevention practices through an interdisciplinary approach to care.
AHRQ Best Practices Checklist

1. Identify a bundle of best practices
2. A clinical pathway has been created
3. Key elements of a comprehensive skin assessment have been identified
4. Approaches to document and report results of skin assessment have been explored
5. A tool for assessing risk has been chosen
6. An appropriate bundle of best practices has been identified for our organization
7. Develop pressure ulcer care plan based on identified risk
8. Approaches to document and communicate care plan have been identified
9. A system linking care planning to assessment has been developed
10. All levels of staff are aware of care plan
11. Customize the bundle for specific work units
12. ARE THERE !@????????
Leaves are supposed to fall. **People** aren’t.
Fall Risk

C-0271
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C-0298
A nursing care plan is based on assessing the patient’s nursing care needs (not solely those needs related to the admitting diagnosis). The assessment considers the patient’s treatment goals and, as appropriate, physiological and psychosocial factors and patient discharge planning.

The nursing care plan is kept current by ongoing assessments of the patient’s needs and of the patient’s response to interventions, and updating or revising the patient’s nursing care plan in response to assessments

PC.01.02.08
The critical access hospital assesses and manages the patient’s risks for falls.

The Critical Access Hospital:
1. Assesses the patient’s risk for falls based on the patient population and setting
2. Implements interventions to reduce falls based on the patient’s assessed risk

PC.02.03.01
The CAH provides patient education and training based on each patient’s needs and abilities.

10. Based on the patient’s condition and assessed needs, the education and training provided to the patient by the CAH includes the following:
• Fall Reduction Strategies
Each year, somewhere between 700,000 and 1,000,000 people in the United States fall in the hospital. A fall may result in fractures, lacerations, or internal bleeding, leading to increased health care utilization. Research shows that close to one-third of falls can be prevented. Fall prevention involves managing a patient’s underlying fall risk factors and optimizing the hospital’s physical design and environment. This toolkit focuses on overcoming the challenges associated with developing, implementing, and sustaining a fall prevention program.
AHRQ Best Practices Checklist

1. Identify a set of best practices
2. Create a clinical pathway
3. Identify key elements of a fall risk factor assessment
4. Choose a tool for assessing risk factors
5. Explore approaches to documenting and reporting results of fall risk factor assessment
6. Develop fall prevention care plan based on identified risk factors
7. Identify approaches to documenting and communicating care plan
8. Develop system linking changes in fall risk factors to changes in care plan
9. Ensure all levels of staff are aware of care plan
10. Develop system linking care planning to actual interventions
11. Choose or develop post fall assessment protocol
12. Customize the set of practices for specific work units
Nutritional Screening
Nutritional Screening

C-0279
(vii) Procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of §483.25(i) of this chapter is met with respect to inpatients receiving post hospital SNF care.

PC.01.02.01
3. The critical access hospital has defined criteria that identify when nutritional plans are developed

4. Based on the patient’s condition, information gathered in the initial assessment includes the following:
   • Nutrition and hydration status

PC.01.02.03
7. The Critical Access Hospital completes a nutritional screening (when warranted by the patient’s needs or condition) within 24 hours after inpatient admission

PC.02.03.01
10. Based on the patient’s condition and assessed needs, the education and training provided to the patient by the CAH includes the following:
   • Nutrition interventions
Screening Tool Example
Mini Nutritional Assessment - MNA

1. Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?

2. Weight loss during the last 3 months

3. Mobility

4. Has suffered psychological stress or acute disease in the past 3 months?

5. Neuropsychological problems

6. Body Mass Index – or – Calf circumference (CC) in cm.

12 – 14 points : Normal nutrition status
8 – 11 points: At risk of malnutrition
0 – 7 points: Malnourished

Maximum screening score 14 points
Abuse

Child abuse casts a shadow the length of a lifetime.

—Herbert Ward

There's no excuse for elder abuse.
Abuse

C-0271
The CAH’s health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

C-0382 (Swing Bed)
The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

PC.01.02.09
1. The CAH has written criteria to identify those patients who may be victims of physical assault, sexual assault, sexual molestation, domestic abuse, or elder or child abuse and neglect.

3. The CAH educates staff about how to recognize signs of possible abuse and neglect and about their roles in follow-up.

4. The CAH uses its criteria to identify possible victims of abuse and neglect upon entry into the critical access hospital and on an ongoing basis.

5. The CAH either assesses the patient who meets criteria for possible abuse and neglect or refers the patient to a public or private community agency for assessment.
Nursing Care Plan

It may be called a nursing care plan but it’s the patient’s plan!
A nursing care plan must be developed and kept current for each inpatient.

A nursing care plan is based on assessing the patient’s nursing care needs (not solely those needs related to the admitting diagnosis). The assessment considers the patient’s treatment goals, and, as appropriate, physiological and psychosocial factors and patient discharge planning. The plan develops appropriate nursing interventions in response to the identified during needs.

The nursing care plan is kept current by ongoing assessments of the patient’s needs and of the patient’s response to interventions, and updating or revising the patient’s nursing care plan in response to assessments.

PC.01.03.01
1. The CAH plans the patient’s care, treatment, and services based on needs identified by the patient’s assessment, reassessment, and results of diagnostic testing

5. The written plan of care is based on the patient’s goals and the time frames, setting and services required to meet those goals

22. Based on the goals established in the patient’s plan of care, staff evaluate the patient’s progress

23. The CAH revises plans and goals for care, treatment, and services based on the patient’s needs

PC.02.01.01
1. The CAH provides the patient with care, treatment, and services, according to his or her individualized plan of care

PC.02.01.05
1. Care, treatment, and services are provided to the patient in an interdisciplinary, collaborative manner
Care Planning Challenges

Problems

Care Plans often don’t reflect important patient needs ---- and often bear little resemblance to the assessment

There are so many options in most EMRs for choosing problems – goals – interventions - nurses frequently check too many or not enough

Interventions may not be followed (or updated) - unless you have a system that converts interventions in to a task list

Care Plans often do not reflect interdisciplinary planning or goals

Care Plans often are not discussed or reviewed with the patient

Consider

Concentrate on “important” few – don’t try to include everything, especially things that won’t be addressed during the hospitalization

Review and revise your EMR to the most common diagnosis / problems

Document to interventions and revise care plans daily

Implement bedside rounds with provider and interdisciplinary team

Review plan with patient – use white board in room with goals
The Joint Commission
National Patient Safety Goals
NPSG: Patient Identifiers

C-0297
The CAH's policies and procedures must reflect accepted standards of practice that require the following be confirmed prior to each administration of medication (often referred to as the “five rights” of medication administration practice):

- **Right patient:** the patient’s identity

C-0297
In addition to the safe practices and other safety considerations that apply to all IV medication administration, policies and procedures must address blood administration procedures that are consistent with accepted standards of transfusion practice, including but not limited to:

Confirming the following prior to each blood transfusion:

- **the patient’s identity**
- **verification of the right blood product for the right patient**

The standard of practice calls for two qualified individuals, one of whom will be administering the transfusion, to perform the confirmation.

- **Requirements for patient monitoring, including frequency and documentation of monitoring**
- **How to identify, treat, and report any adverse reactions the patient may experience during or related to transfusion**

NPSG.01.01.01
Use at least two patient identifier when providing care, treatment and services.

NPSG.03.04.01
Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

NPSG.01.03.01
Eliminate transfusion errors related to patient misidentification.
C-0271
The CAH’s health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

C-0276
The CAH’s written patient care policies must include rules governing pharmacy services within the CAH.

These CAH rules must address storage, handling, dispensing, and administration of drugs and biologicals within the CAH.

The rules must be in accordance with accepted professional principles of pharmacy and medication administration practices.

Accepted professional principles include compliance with applicable Federal and State law and adherence to standards or guidelines for pharmaceutical services and medication administration issued by nationally recognized professional organizations, including, but not limited to: U.S. Pharmacopeia (www.usp.org), the American Society of Health-System Pharmacists (http://www.ashp.org/), the Institute for Safe Medication Practices (http://www.ismp.org/default.asp), the National Coordinating Council for Medication Error Reporting and Prevention (www.nccmerp.org); the Institute for Healthcare Improvement (http://www.ihi.org/ihi); or the Infusion Nurses Society (http://www.ins1.org).

NPSG. 3. 06. 01
Maintain and communicate accurate patient medication information.

1. Obtain information on the medications the patient is currently taking when he or she is admitted to the critical access hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications.

2. Define the types of medication information to be collected in non-24-hour settings and different patient circumstances.

3. Compare the medication information the patient brought to the critical access hospital with the medications ordered for the patient by the critical access hospital in order to identify and resolve discrepancies.

4. Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the critical access hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose).

5. Explain the importance of managing medication information to the patient when he or she is discharged from the critical access hospital or at the end of an outpatient encounter.
Define the Steps in the Reconciliation Process
A first step in having an accurate listing of medications is defining the steps in obtaining a complete medication history. IHI suggests three steps to the process: (1) verify by collecting the list of medications, vitamins, nutritional supplements, over-the-counter drugs, and vaccines; (2) clarify that the medications and dosages are appropriate; and (3) reconcile and document any changes. Each health care setting needs to develop standards for who is responsible and how the process will be completed. Whittington and Cohen reported that the accuracy of medication lists went from 45 percent to 95 percent with the implementation of reconciliation standards.

Clearly Identify Responsibilities for the Process
Health care professionals need to clearly identify team roles and responsibilities for medication reconciliation. This needs to include evaluating existing processes; identifying a standard location in the patient chart where the medication history is kept; and determining who will put the medication history onto the agreed upon place in the chart, the time frame for resolving variances, and how to document medication changes. These processes would eliminate the duplication of history taking and documentation that currently exists in many settings.

Consider Use of a Standardized Form
Many settings have found the use of a standardized medication form facilitates an accurate list that is accessible and visible. Numerous examples are available on the IHI and Joint Commission Web sites.

Have an Explicit Time Frame for Completion
Many organizations have a process in place that calls for reviewing the patients’ medication list at every primary care visit and within 24 hours of an inpatient admission. High-risk medications such as antihypertensives, antiseizures, and antibiotics may need to be reconciled sooner, for example, within 4 hours of admission.

Design Education Programs for Health Care Professionals
Medication reconciliation is a complex process. Education programs need to include the research about medication reconciliation and the steps being put into place to make a safer system for patients.

Design and Implement a Monitoring Process
Implement a reconciliation review of open and/or closed patient records. Assess adherence to the process and identify the potential for and any actual harm associated with unreconciled medications. Auditing tools such as the Improvement Tracker on the IHI Web site may assist health care settings in tracking their findings over time. Share results with providers so they are able to note progress over time.

Educate Patients and Family Members To Serve as Advocates
Patient education needs to be a major focus in medication reconciliation. Patients may not be accurate historians. Recognition that information is being gathered from laypeople needs to be acknowledged and assistance needs to be offered to make the information as accurate as possible. A number of approaches have been identified to assist patients and families—for example, reconcile the medication list at every ambulatory visit. Establish a process where patients bring their medications, including all over-the-counter preparations, to every health care encounter. Use of a universal patient medication form has shown promise in North Carolina; the form can be found at www.scha.org. In addition, educating patients about their medications allows them to keep better track of the medications they are taking.

THE MEDICATION RECONCILIATION CONUNDRUM

The complexity of medication reconciliation has caused a real conundrum (definition: something that is puzzling or confusing; a riddle) for pharmacists, physicians, and nurses. According to the EHR Incentive Program for Meaningful Use Stage 1/CMS, medication reconciliation is the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider. The Joint Commission (TJC) also included medication reconciliation through a National Patient Safety Goal (NPSG) 03.06.01 which states that “Record and pass along correct information about a patient’s medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.” This goal was first implemented in January 2006, therefore one might suggest that between CMS and TJC emphasizing medication reconciliation that we need to do a better job at collecting a comprehensive list of patient’s medications, and one might add over-the-counter medications and herbs that people are taking more frequently.
NPSG: Prevent Infections

C-0271
The CAH’s health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

C-0278
The CAH must have policies and procedures in place to mitigate the risks that contribute to healthcare-associated infections. They must incorporate infection control techniques and standard precautions including, but not limited to:

- Hand Hygiene
- Respiratory Hygiene/Cough Etiquette
- Use of Transmission-Based Precautions such as: contact precautions, droplet precautions, and airborne precautions
- Use of personal protective equipment (PPE) for healthcare personnel such as gloves, gowns, masks, and respirators
- Safe work practices to prevent healthcare worker exposure to bloodborne pathogens, such as safety needles and safety engineered sharps devices
- Safe medication preparation and administration practices including, but not limited to:
  - Routine preparation of medications

C-0278 Multi-Drug Resistant Organisms (MDROs)
The prevention and control of MDROs is a national priority - one that requires that all healthcare facilities and agencies assume responsibility and participate in community-wide control programs. MDROs are defined as microorganisms – predominantly bacteria – that are resistant to one or more classes of antimicrobial agents. A notable example is methicillin-resistant Staphylococcus aureus (MRSA), an MDRO pathogen which is transmitted within and between healthcare facilities, as well as in the community setting. Options for treating patients with MDRO infections are very limited, resulting in increased mortality, as well as increased length of stay and costs. During the last several decades the prevalence of MDROs in hospitals has increased steadily.

CAHs are encouraged to have mechanisms in place for the early identification of patients with targeted MDROs prevalent in their CAH and community, and for the prevention of transmission of such MDROs. When ongoing transmission of targeted MDROs in the CAH is identified, the infection prevention and control program should use this event to identify potential breaches in infection control practice.

NPSG.07.01.01
Comply with either the current CDC hand hygiene guidelines or the current WHO hand hygiene guidelines.

NPSG.07.03.01
Implement evidence based practices to prevent health care-associated infections due to multidrug-resistant organisms in CAHs.

NPSG.07.04.01
Implement evidence-based practices to prevent central line-associated bloodstream infections.

NPSG.07.05.01
Implement evidence-based practices for preventing surgical site infections.

NPSG.07.06.01
Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).
NPSG: Others

C-0271
The CAH’s health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

NPSG.02.03.01
Report critical results of tests and diagnostic procedures on a timely basis.

NPSG.03.05.01
Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

NPSG.06.01.01
Improve the safety of clinical alarm systems.
A Few More
Verbal Orders

C-0271
The CAH’s health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

C-0297
Although the regulation requires medication administration be based on a written, signed order, this does not preclude the CAH from using:
- Verbal orders; or
- Standing orders.

Establish protocols for clear and effective communication and verification of verbal orders. CMS expects nationally accepted read-back verification practice to be implemented for every verbal order.

PC.02.01.03.
20. 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.
Rapid Response

C-0271
The CAH’s health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law

PC.02.01.19
The CAH recognizes and responds to changes in patient condition.

PC.01.05.03
13. The critical access hospital provides education and training that addresses how to identify early warning signs of a change in a patient’s condition and how to respond to a deteriorating patient, including how and when to contact responsible clinicians.
Hand Off Communication

C-0271
The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

PC.02.01.19
1. The CAH has a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment, and services.

2. The CAH's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information.

3. The CAH coordinates the patient's care, treatment and services.
Restraints

C-0271
The CAH’s health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law

The only specific reference to restraints is in the section on Swing Bed

Considerations

1. Update your policy to include revised CMS information regarding when a restraint death must be reported

2. Maintain a restraint log

3. Don’t forget chemical restraints

4. Audit 100% of restraint episodes
Patient Education

C-0271
The CAH's health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

PC.02.03.01
1. The CAH performs a learning needs assessment, for each patient, which includes the patient’s cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication.

10. Based on the patient’s condition and assessed needs, the education and training provided to the patient by the CAH includes the following:
   • An explanation of the plan of care, treatment, and service
   • Basic health practices and safety
   • Information on the safe and effective use of medications
   • Nutrition interventions
   • Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management
   • Information on oral health
   • Information on the safe and effective use of medical equipment or supplies provided by the CAH
   • Habilitation or rehabilitation techniques to help the patient reach maximum independence
   • Fall Reduction Strategies

27. The CAH provides the patient education on how to communicate concerns about patient safety issues that occur before, during, and after care is received.
Discharge Planning

C-0271
The CAH’s health care services are furnished in accordance with appropriate written policies that are consistent with applicable State law.

C-0298
There must be a nursing care plan for every CAH inpatient. Nursing care planning starts upon admission. It includes planning the patient’s care while in the CAH as well as planning for transfer to a hospital, to a post-acute care facility or for discharge.

PC.04.01.03
1. The CAH begins the discharge planning process early in the patient's episode of care, treatment and service
2. The CAH identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer
3. The patient, the patient’s family, licensed independent practitioners, physicians, clinical psychologists, and staff involved in the patient’s care, treatment, and services participate in planning the patient’s discharge or transfer
4. Prior to discharge, the CAH arranges or assists in arranging the services required by the patient after discharge in order to meet his or her ongoing needs for care and services

PC.04.01.05
1. When the CAH determines the patient’s discharge or transfer needs, it promptly shares this information with the patient, and also with the patient’s family when it is involved in decision making or ongoing care
2. Before the patient is discharged, the CAH informs the patient, and also the patient’s family with information about why he or she is being discharged or transferred
3. Before the patient is transferred, the CAH provides the patient with information about any alternatives to the transfer
4. The CAHeducates the patient, and also the patient’s family when it is involved in decision making or ongoing care, about how to obtain any continuing care, treatment, and services that the patient will need.
5. The CAH provides written discharge instructions in a manner that the patient and/or the patient’s family or caregiver can understand.
Nurse Staffing

CAH C-0294
For both inpatient and outpatient services there must be sufficient numbers of supervisory and non-supervisory nursing personnel with the appropriate education, experience, licensure (as applicable), competence and specialized qualifications to respond to the nursing needs of the patient population of each CAH department or nursing unit.

NR.02.02.01
The nurse executive establishes guidelines for the delivery of nursing care, treatment, and services.

The nurse executive, registered nurses, and other designated nursing staff write:
4. Nurse staffing plan(s)

NR.02.03.01
5. The nurse executive or designee is responsible for monitoring the effectiveness of the nurse staffing plan.
Productivity 101: Tips, Tools, Technology
February 10, 2017
“Productivity is never an accident. It is always the result of a commitment to excellence, intelligent planning, and focused effort.” - Paul J. Meyer
Develop a Staffing Grid

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## Calculate Hours

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### Daily Variance
- Target Hours/Midnight Census: 233.25
- Cumulative Variance: 73.25

### Orientation Hours
- Target Hours/Aug Census: 197.33
- Orientation Hours: 8

### Daily Functional Variance
- RN 1 on 1: 8
- Tech: 2
- Night Census (7pm): 16
- Day Census (7am): 16
- Evening Census (12pm): 146.50

### Cumulative Functional Variance
- Daily Functional Variance: 89.25
- Cumulative Functional Variance: 89.25
Competency
Orientation

CAH C-0294
The CAH must ensure that all CAH nursing staff are adequately trained and oriented, aware of CAH nursing policies and procedures, supervised, and that their clinical activities are evaluated.

C-1002
CAHs are expected to educate all staff who play a role in facilitating or controlling visitors on the CAH’s visitation policies and procedures, and are responsible for ensuring that staff implement the CAH’s policies correctly.

CAHs are urged to develop culturally competent training programs designed to address the range of patients served by the CAH.

C-0297
Medication administration education and training is typically included in the CAH’s orientation or other continuing education programs for nursing staff and other authorized healthcare personnel. Training or continuing education topics regarding medication administration may include but are not limited to the following:

- Safe handling and preparation of drugs, biologicals, and IV medications
- Knowledge of the indications, side effects, drug interactions, compatibility, and dose limits of administered medications
- Equipment, devices, special procedures, and/or techniques required for medication administration

HR.01.04.01
1. The CAH determines the key safety content of orientation provided to staff.

The CAH orients its staff:
2. To the key safety content before staff provides care, treatment, and services.

3. Relevant critical access hospital wide and unit specific policies and procedures.

4. Their specific job duties, including those related to infection prevention and control and assessing and managing pain.

5. Sensitivity to cultural diversity based on their job duties and responsibilities.

6. Patient rights, including ethical aspects of care, treatment, and services and the process used to address ethical issues based on their job duties & responsibilities.
CAH C-0294

The CAH must ensure that all CAH nursing staff are adequately trained and oriented, aware of CAH nursing policies and procedures, supervised, and that their clinical activities are evaluated.

HR.01.05.03

1. Staff participate in ongoing education and training to maintain or increase their competency.

Staff participate in education and training
5. That is specific to the needs of the patient population served by the critical access hospital
6. That incorporates the skills of team communication, collaboration, and coordination of care
7. That includes information about the need to report unanticipated adverse events and how to report these events
8. On fall reduction activities
13. The critical access hospital provides education and training that addresses how to identify early warning signs of a change in a patient’s condition and how to respond to a deteriorating patient, including how and when to contact responsible clinicians
Competency

CAH C-0294
The CAH must ensure that all CAH nursing staff are adequately trained and oriented, aware of CAH nursing policies and procedures, supervised, and that their clinical activities are evaluated.

HR.01.06.01
1. The CAH defines the competencies it requires of its staff who provide patient care, treatment, or services.
2. The critical access hospital uses assessment methods to determine the individual's competence in the skills being assessed. Note: Methods may include test taking, return demonstration, or the use of simulation.
3. An individual with the educational background, experience, or knowledge related to the skills being reviewed assesses competence.
4. Staff competence is initially assessed and documented as part of orientation.
5. Staff competence is assessed and documented once every three years, or more frequently as required by critical access hospital policy or in accordance with law and regulation.
6. The critical access hospital takes action when a staff member's competence does not meet expectations.
Competency Considerations

1. Initial competencies should not necessarily be the same as annual or periodic competency assessments.

2. Competencies are not just annual (although this is a good way to take care of some basic competency / training).
   - Before implementing any new procedure
   - Before using new equipment
   - High risk / Low volume procedures and/or events
   - When problems are identified

3. Competencies should reflect populations served
   - Mental Health
   - Drug Abuse
   - Bariatric
   - Pediatric
   - Geriatric
C. Care of Patients: In collaboration with the patient, the nurse will demonstrate the ability to apply the nursing process in a developmentally and culturally appropriate manner. Performs the following patient care tasks according to policies, procedures and standards.

### RESPIRATORY SYSTEM

<table>
<thead>
<tr>
<th>Task</th>
<th>Reference /Learning Activity</th>
<th>Date Evaluated</th>
<th>Evaluator’s Initials</th>
<th>Competency Method</th>
</tr>
</thead>
</table>
| 1. Able to administer oxygen via:  
• Face  
• Non-re-breather mask  
• Tracheostomy collar  
• Nasal cannula | Review: All applicable nursing policies and procedures, standards and patient care guidelines for each skill | | | ✓ Observed  
✓ Demonstrated  
✓ Verbalized  
✓ Test  
✓ NA |
| 2. Able to conduct suctioning via:  
• Oral pharynx  
• Nasal pharynx  
• Tracheostomy | | | | ✓ Observed  
✓ Demonstrated  
✓ Verbalized  
✓ Test  
✓ NA |
| 3. Able to collect a sputum sample. | | | | ✓ Observed  
✓ Demonstrated  
✓ Verbalized  
✓ Test  
✓ NA |
| 4. Able to administer an aerosol breathing treatment. | | | | ✓ Observed  
✓ Demonstrated  
✓ Verbalized  
✓ Test  
✓ NA |
✓ Demonstrated  
✓ Verbalized  
✓ Test  
✓ NA |
Summary

1. Know the standards – keep updated of any changes
2. Educate staff
3. Use tracers
4. It takes a team
5. It’s a journey
Florence “Seesee” Rigney started working as a student nurse at the Tacoma General School of Nursing, then part of Tacoma General Hospital in Washington in 1946.

Rigney is now 91 years old and still a working nurse at Tacoma General Hospital as an operating room surgical nurse.

Rigney remembers always wanting to be a nurse. Her father tried to dissuade her. “He thought I should become a secretary because they made more money,” she says.

August marked 70 years that she’s been in nursing. “I love what I do, I love nursing, I just wish I could do more,” she says.
Learning Knows No Bounds
If you are interested in information about a mock survey or have questions about other consulting products, please contact:

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