Emergency Services: Complying with the CMS Hospital CoPs 2016
Speaker

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- CMS email hospitalscg@cms.hhs.gov
You Don’t Want One of These
The Conditions of Participation (CoPs)

- Many revisions since manual came out in 1986
- Manual updated more frequently now
- Has section numbers called tag numbers and goes from 1 to 1164 and Emergency Services starts at tag 91 and second section starts at tag 1100
- First regulations are published in the Federal Register then CMS publishes the Interpretive Guidelines and some have survey procedures
  - Hospitals should check this website once a month for changes
  2 www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp
Subscribe to the Federal Register

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Topics:
- Html_Attached
- Html_Forget

http://listserv.access.gpo.gov/cgi-bin/wa.exe?SUBED1=FEDREGTOC-L&A=1
How to Keep Up with Changes

- First, periodically check to see you have the most current CoP manual and sign up to get the Federal Register.
- Once a month go out and check the survey and certification website.
- Once a month check the CMS transmittal page.
- Have one person in your facility who has this responsibility.

2 http://www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage
3 http://www.cms.gov/Transmittals
Policy & Memos to States and Regions

CMS Survey and Certification memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices.

Select From The Following Options:

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  - Show only items whose date is within the past
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Click on Policy & Memos

There are 455 items in this list.
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<td>15-45-CAH</td>
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Example of Survey Memo

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C-15-32 Hospitals/CAHs/ASCs

DATE: April 3, 2015
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group

SUBJECT: Alert Related to Outbreaks of Carbapenem-Resistant Enterobacteriaceae (CRE) during gastrointestinal endoscopy, particularly Endoscopic Retrograde Cholangiopancreatography (ERCP)

Memorandum Summary

• **Situation:** Recent newspaper articles, medical publications, and adverse event reports associate multidrug-resistant bacterial infections caused by CRE with patients who have undergone ERCP. Duodenoscopes used to perform ERCP are difficult to clean and disinfect, even when manufacturer reprocessing instructions are followed correctly, and have been implicated in these outbreaks. The U.S. Food and Drug Administration (FDA) has issued a Safety Communication warning, with related updates, that the design of duodenoscopes may impede effective cleaning.

• **Expectations for Reprocessing Duodenoscopes:** Hospitals, critical access hospitals (CAHs), and ambulatory surgical centers (ASCs) are expected to meticulously follow the manufacturer’s instructions for reprocessing duodenoscopes, as well as adhere to the nationally recognized Multisociety consensus guidelines developed by multiple expert organizations and issued in 2011.
Location of CMS Hospital CoP Manual

Medicare State Operations Manual
Appendix

Questions to hospitalscg@cms.hhs.gov

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.

- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.

- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers.

New website


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<td>AA</td>
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Important interpretive guidelines for hospitals and to keep handy

- A- Hospitals and C-Critical Access Hospitals
- C-Labs
- V-EMTALA
- Q-Determining Immediate Jeopardy
- I-Life Safety Code Violations
- All CMS forms are on their website
- Consider gap analysis
State Operations Manual
Appendix A - Survey Protocol,
Regulations and Interpretive Guidelines for Hospitals

Table of Contents
(Rev. 151, 11-20-15)

Transmittals for Appendix A

Introduction
Task 1 - Off-Site Survey Preparation
Task 2 - Entrance Activities
Task 3 - Information Gathering/Investigation
Task 4 - Preliminary Decision Making and Analysis of Findings
Task 5 - Exit Conference
Task 6 – Post-Survey Activities

Psychiatric Hospital Survey Module
Psychiatric Unit Survey Module
Rehabilitation Hospital Survey Module
Inpatient Rehabilitation Unit Survey Module
Hospital Swing-Bed Survey Module

Regulations and Interpretive Guidelines


Email questions hospitalscg@cms.hhs.gov
Transmittals

Access to Hospital Complaint Data

- CMS issued Survey and Certification memo on March 22, 2013 regarding access to hospital complaint data and quarterly since then
- Includes acute care and CAH hospitals
  - Does not include the plan of correction but can request
  - Questions to bettercare@cms.hhs.com
- This is the CMS 2567 deficiency data and lists the tag numbers
- Updating quarterly
  - Available under downloads on the hospital website at www.cms.gov
Access to Hospital Complaint Data

DATE: March 22, 2013
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group

Memorandum Summary

- **Survey Findings Posted on [http://www.cms.gov](http://www.cms.gov):** In July 2012, the Centers for Medicare & Medicaid Services (CMS) began posting redacted Statements of Deficiencies (CMS-2567s) for skilled nursing facilities and nursing facilities on Nursing Home Compare. In March 2013, CMS began posting CMS-2567s for short-term acute care hospitals and critical access hospitals (CAHs) for surveys based on complaint investigations. This memorandum describes the contents and location of those files.

- **Other Web-based Tools Based on These Data:** At least two additional websites, provided by private parties (ProPublica and the Association for Health Care Journalists), publish information based on the CMS-2567 data. These websites are independent of CMS. CMS does not endorse or sponsor any particular private party application.

- **Plans of Correction (POC):** The posted CMS data do not contain any POC information. State Survey Agencies (SAs) and CMS Regional Offices (RO) may see an increase in requests for both the CMS-2567 and any associated POCs.

- **Questions & Answers:** We plan to issue an update to this memorandum that will include an attachment of frequently asked questions in order to provide answers to other queries that may arise.

Background – Nursing Home Survey Findings

In July 2012, CMS began posting nursing home statements of deficiencies, derived from the Form
Hospitals

This page provides basic information about being certified as a Medicare and/or Medicaid hospital provider and includes links to applicable laws, regulations, and compliance information.

A hospital is an institution primarily engaged in providing, by or under the supervision of physicians, inpatient diagnostic and therapeutic services or rehabilitation services. Critical access hospitals are certified under separate standards. Psychiatric hospitals are subject to additional regulations beyond basic hospital conditions of participation. The State Survey Agency evaluates and certifies each participating hospital as a whole for compliance with the Medicare requirements and certifies it as a single provider institution.

Under the Medicare provider-based rules it is possible for 'one' hospital to have multiple inpatient campuses and outpatient locations. It is not permissible to certify only part of a participating hospital. Psychiatric hospitals that participate in Medicare as a Distinct Part Psychiatric hospital are not required to participate in their entirety.

However, the following are not considered parts of the hospital and are not to be included in the evaluation of the hospital's compliance:

- Components appropriately certified as other kinds of providers or suppliers, i.e., a distinct part Skilled Nursing Facility and/or distinct part Nursing Facility, Home Health Agency, Rural Health Clinic, or Hospice; Excluded residential, custodial, and non-service units not meeting certain definitions in the Social Security Act; and,
- Physician offices located in space owned by the hospital but not functioning as hospital outpatient services departments

Accredited Hospitals - A hospital accredited by a CMS-approved accreditation program may substitute accreditation under that program for survey by the State Survey Agency. Surveyors assess the hospital's compliance with the Medicare Conditions of Participation (CoPs) for all services, areas and locations covered by the hospital's provider agreement under its CMS Certification Number (CCN).

Although the survey generally occurs during daytime working hours (Monday through Friday), surveyors may conduct...
Can Count the Deficiencies by Tag Number

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Emergency Services

- In the introduction to the manual, CMS tells the surveyors to visit the emergency department (p 12)
- Also tells surveyors to count beds if hospitals that has less than 100 beds and has swing beds but do not count the beds in the emergency department (35)
- Tag 1 is rarely discussed since most hospitals accept Medicare and as are govern by the CoPs
- However, if trauma and squad takes a Medicare patient to a non-Medicare hospital, the bill may still be paid as long as meet certain requirements are met
Emergency Services

- Remember to see the EMTALA separate CoP
  - Revised May 29, 2009 and amended July 2010 and now 68 pages
  - Consider doing yearly education on EMTALA to your ED staff and for on call physicians
- If hospital has an ED, you must comply with this section
- If no ED services, Board must be sure hospital has written P&P for emergencies of patients, staff and visitors
State Operations Manual
Appendix V – Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases

(Rev. 60, 07-16-10)

Transmittals for Appendix V

Part I- Investigative Procedures

I. General Information
II. Principal Focus of Investigation
III. Task 1 - Entrance Conference
IV. Task 2 - Case Selection Methodology
V. Task 3 - Record Review
VI. Task 4- Interviews
VII. Task 5-Exit Conference
VIII. Task 6- Professional Medical Review
IX. Task 7- Assessment of Compliance and Completion of the Deficiency Report
Emergency Services

- If emergency services are provided at the hospital but not at the off campus department then you need P&P on what to do at the off-campus department when they have an emergency
  - Do whatever you can to initially treat and stabilize the patient etc
  - Call 911 (off campus only!)
  - Provide care consistent with your ability
  - Includes visitors, staff and patients
  - Make sure staff are oriented to the policy
Emergency Services  Tag 91

- Emergency services starts at Tag A-91
- If staff emails CMS to ask a question be sure to give tag number such as A-91
  - A signifies that is Appendix A which is for larger hospitals as opposed to Critical Access Hospitals that are governed under Appendix W
  - The tag number allows CMS to know what section your question is on
- Email questions to hospitalscg@cms.hhs.gov
Emergency Services Starts at Tag 91

§482.12(f) Standard: Emergency Services

Interpretive Guidelines §482.12(f)

The hospital must ensure the emergency services requirements are met.

§482.12(f)(1) If emergency services are provided at the hospital, the hospital must comply with the requirements of §482.55.

§482.12(f)(2) If emergency services are not provided at the hospital, the governing
Emergency Services

- **Standard:** The hospital must ensure that emergency services requirements are met (Tag 91)

- **Standard:** If emergency services are provided at the hospital then the hospital must comply with section 482.55 which is a second section in the manual on Emergency Services which starts at tag 1100 (Tag 92)

- **Standard:** If emergency services are not provided at the hospital, then the board must make sure the medical staff has written P&P to evaluate and initial treat emergencies and do referrals when appropriate (93)
This requirement applies hospital wide when the hospital does not provide emergency services

- This includes on-campus and off-campus

- Note difference in care provided depending on whether the patient is on-campus or off-campus

- For example, a person comes into the hospital’s off-campus physical therapy and arrests

- The staff start CPR and call 911 to help stabilize the patient and take him to the closest emergency department
Emergency Services

- Hospitals without an ED must have P&P to address an individual's emergency needs 24 hour per day and 7 days a week.

- These P&P have to be approved by the Medical Staff such as the Medical Executive Committee (CME).

- The following must be in this P&P:
  - RN must be immediately available to provide bedside care to a patient who needs it.
  - Some hospitals use the nursing supervisor.
Emergency Services

- The following must be in this P&P: (continued)

- Qualified RN must be able to assess patients to determine if patient has a need for emergency care

- The physician on call or on-site can evaluate the emergency or provide medical care to the person

- It is prudent for the hospital to evaluate the patient population the hospital routinely cares for in order to anticipate potential emergency care scenarios
  - For example, an outpatient is receiving dialysis and codes and the physician makes the patient a direct admit to ICU
Emergency Services

- There needs to be adequate staffing to provide safe and adequate initial care of an emergency.

- If the patient’s care exceeds the hospital capability then should transfer the patient or make a referral.

- Example, there is a row of houses across the street from the hospital.
  - A babysitter is giving a child a bath and gets distracted by the second child and she leaves the room.
  - The toddler turns on the hot water and is severely burned.
  - The babysitter brings the child to the hospital and care is provided and the child transferred to a burn hospital.
Emergency Services

- So need P&P when patient’s needs exceed hospital’s capacity
- Train staff on what to do in case of an emergency
- Need P&P on appropriate transport
- Need to follow the regulations and interpretive guidelines in the discharge planning section (2016 amendments)
  - Notify the other hospital of the transfer
  - Be sure to send copies of the medical records
  - Send transfer form or continuity sheet
Emergency Services

- Can transport patient by several methods
  - Hospital’s own ambulance, receiving hospital’s ambulance, helicopter, contracted ambulance service
  - Only in extraordinary circumstances can the hospital call 911 to access EMS for transport
- Should **not** rely on 911 for on-campus to provide the patient’s care
- Hospitals need trained staff to respond to the code or emergency and provide the care needed
Emergency Services

- Surveyor will verify that MS has P&P on how to address emergency procedures
- The surveyor is instructed to review the emergency care policies
- The surveyor will ensure the policies address emergency procedures for both on-campus and off-campus
- The surveyor will interview staff at various located so they know what they are suppose to do if an individual experiences an emergency such as a MI or a stroke
**Standard:** If emergency services are provided at the hospital but not at one or more of the off-campus department

Then the board must make sure the Medical Staff has written P&P at the off-campus location

Example, the hospital owns a lab located in a physician’s office practice but does not own the physician practice

The lab test is drawing blood and the patient grabs his chest and collapses
Emergency Services

- The lab tech pushes a button for assistance and 911 is called to transport the patient to the ED
- If off-campus make sure staff know about the P&P and what they are expected to do
- For example, for off-campus emergencies, use whatever you have to stabilize the patient and call 911
- A person arrests at an outpatient surgery department and staff call 911, start CPR, and insert an IV and push Atropine for the bradycardic rate
Emergency Services 1100

- There is a second section in the manual that addresses emergency services
- This starts at tag 1100

**Standard:** The hospital must meet the emergency needs of patients in accordance with standards

- For example. The patient arrives in the emergency department after stepping on a wasp and is having a severe allergy reaction
- The patient is immediately assessed, IV started, EPI given, IV Benadryl is given along with a steroid
- The patient is carefully monitored
Second Section on Emergency Services

A-1100
(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

§482.55 Condition of Participation: Emergency Services

The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice.

A-1101
(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)

§482.55(a) Standard: Organization and Direction. If emergency services are provided at the hospital --

Interpretive Guidelines §482.55(a):

If emergency services are provided at the hospital, the hospital must ensure that specific emergency services organization and direction requirements are met.

A-1102
(Rev. 37, Issued: 10-17-08; Effective/Implementation Date: 10-17-08)
Emergency Services 1101

- **Standard;** If emergency services are provided then must ensure specific emergency services organization and direction requirements are met (1101)

- Hospital must meet needs of patients

- Must follow acceptable standards of practice such as ACEP and ENA
  - ACEP is the American College of Emergency Physicians at www.acep.org
  - ENA is the Emergency Nurses Association at www.ena.org

- Must be integrated into hospital wide QAPI
ACEP Clinical Policies

These ACEP Board-approved documents describe ACEP's policies on the clinical management of emergency department patients. These clinical policies are not intended to represent a legal standard of care for emergency physicians. ACEP recognizes the importance of the individual physician's judgment and patient preferences. If you are having trouble viewing these documents, download Adobe Reader.
Position Statements

A Position Statement is an assertion of the beliefs held, encouraged and supported by ENA, and adopted in accordance with ENA's bylaws, policies, and procedures.

It should be recognized that these position statements are recommendations only and are not codified in law or regulations.

- **ENA Position Statements** - Position statements are recommendations for a course of action or statement of beliefs that reflects ENA's stance regarding an issue of importance to safe practice, safe care, and optimal patient outcomes.
  - Guidelines for Writing ENA Position Statements

- **ENA Joint Statements** - Joint position statements are an assertion of the beliefs held, encouraged and supported but written in collaboration with other external organizations with mutual interest.

- **ENA Supported Statements** - Supported position statements are statements written by an external organization with content expertise identifying a course of action or statement of belief. These statements are officially supported by ENA.

- **Archived Position Statements** - A position statement is archived when it is deemed to be no longer pertinent or significant to current practice; is no longer an assertion of a belief held.
ENAA Position Statements

2. Advanced Practice in Emergency Nursing (2/2012)
3. Appropriate Credential Use/Title Protection For Nurses With Advanced Degrees (5/2013)
4. Care of Patients with Chronic/Persistent Pain in the Emergency Setting (1/2014)
6. Communicable Diseases in the Emergency Department (05/2010)
7. Cultural Diversity in the Emergency Setting (5/2012)
8. Disaster and Emergency Preparedness for All Hazards (1/2014)
12. Facilitating the Interfacility Transfer of Emergency Care Patients (07/2015)
15. Healthy Work Environment (3/2013)
18. Immunizations (07/2015)
20. Mobile Electronic Device Use in the Emergency Setting (9/2013)
21. Nurse Leaders in Emergency Care (10/2012)
22. Nurse Practitioners and Retail Health Care Clinics (02/2012)
23. Observation Units (5/2011)
Emergency Services

- **Standard**: Emergency services must be organized under the direction of a qualified member of the MS (1102)

- Need qualified MS director such as MD/DO
  - For example, the ED medical director is board certified in emergency medicine with ten years of experience

- The criteria may be different for each ED and CMS says is up to the Medical Staff to determine the criteria for the qualifications of the medical director

- Must be a single medical director
Emergency Services 1103

- **Standard**: Services must be integrated with other departments in hospital
- So if lab ordered needs to draw timely
- If need old records then need to make sure ED gets them
- Must be integrated with other departments so if patient needs emergency surgery or radiology tests it gets done
Emergency Services 1103

- Includes coordination with other departments and communications between departments
- Immediate availability of services, equipment, personnel, and resources of other hospital departments
- Length of time to transport between departments is appropriate
- Other departments must provide emergency patients the care within safe and appropriate times
Emergency Services

- Delays in diagnosis can affect the health and safety of ED patients

- If offer urgent care on premises or in provider based clinics must follow the CoP regulations

- Urgent care clinics can be part of their outpatient department or the emergence department

- If urgent care meets the definition of DED under EMTALA or hold its self out as providing emergency care then meet the ED CoPs
  - Otherwise will be need to meet the outpatient services CoP
Emergency Services

- Remember there is a separate COP on EMTALA under Appendix V
  - High number of deficiencies against hospitals for EMTALA violations
- Will review policies, including triage policy
- **Standard:** The ED must have P&P and these are a responsibility of the Medical Staff (1104)
  - Must have ongoing assessment of the care provided in the ED by the Medical Staff
Emergency Services

- ED P&P must be current and revised as needed
- ED P&P must be revised based on ongoing monitoring by the MS or results of the QAPI
- Will review policies, including triage policy

**Standard**: Must make sure personnel requirements are met (1110)
  - Have enough staff to take care of patients

**Standard**: ED must be supervised by qualified member of MS (1111)
The prior section discussed having a medical director of the ED.

This section is more about having a qualified member of the MS providing supervision when care is being provided.

- MS determines who is qualified and must be C&P.

For example, the ED physicians staff the department 24 hours a day and supervise the ED care provided.

In some states and in smaller hospital ED, it may be staffed by a PA or a NP, based on the state law.
**Standard:** Must have adequate number of and qualified medical and nursing personnel

- Need to determine the categories and numbers of staff needed such as physicians, nurses, mid levels, EMTs, support staff etc.

- Must follow acceptable standards of care

- Must follow any state law requirements

- Periodically assess to determine staffing, training, additional P&P or if other resources are needed

- Need clear chain of command
Emergency Services

- Must have appropriate equipment
- Periodic assessments of needs (ESI levels)
- Work with state and feds in emergency preparedness
- Surveyor will interview staff to see if knowledgeable about blood, IV fluids, parenteral administration of electrolytes, injuries to extremities, CNS and prevention of infection
There are many other sections in the CMS CoP manual that affect EDs;

- Safe opioid use, blood and IV standards
- Consent, verbal orders
- Visitation, infection control
- Grievances, discharge instructions
- Restraint and seclusion
- Advance directives
- Medications
Restraints  #1 Problematic CMS Standard

- CMS Hospital CoPs has 50 pages of restraint standards from Tag 0154-0214
- TJC has 10 standards in PC chapter (deemed status)
- Need to rewrite policies and procedures, order sheet and documentation sheet to comply
- Need to train all staff in accordance with requirements
- Physicians must be trained on R&S P&P
- CMS calls it violent or self destructive and TJC behavioral or non-behavioral health
Restraint and Seclusion Patient Safety Briefing
Emergency Medicine Patient Safety Foundation

Written by: Sue Dill Calloway RN MSN JD CPHRM
Michael Gerardi, MD, FAAP, FACEP
John (Jack) Kelly DO, FACEP, FAAEM

March 2012
Revised July 16, 2012

Introduction

Restraint and seclusion is a very important patient safety issue. Appropriately applied restraints can protect patients from harming
Restraint and Seclusion

- Patient has a right to be free from unnecessary R&S
- Leadership has responsibility to create culture that supports right to be free from R&S
- Should not considered as part of routine part of fall prevention
- If use protocol you still need an order
- Know the CMS definition of restraint and seclusion
- Know if drug used as a restraint
- Mitt is restraint if boxing glove style
Restraint and Seclusion

- Know what it does include such as freedom splints, and all 4 side rails if patient cannot lower them
- Try or consider and document less restrictive interventions and alternatives
- Document the assessment
- Need order from physician or LIP
- If LIP gives order notify doctor ASAP
- Amend plan of care
- Consider debriefing although not required by CMS on V/SD patients
Restraint and Seclusion

- End at the earliest time
- Do PI
- Use as directed
- If V/SD need one hour face to face
- Time limited orders for V/SD patients
- Need P&P on R&S
- Educate staff and document this
- Follow any stricter state law, and
- Report restraint deaths as required
Grievances and Complaints

- Every ED practitioner should be aware that CMS has grievance standards
  - CMS standards start at tag 118 and complete copy of the hospital CoP can be downloaded off the CMS website
  - TJC has also but calls them complaints under RI.01.07.01
  - CMS has BFCC QIO in which patients can report grievances to and include their name and information in patient rights to patients
Grievances and Complaints

- Patients have the right to file a grievance
- ED must investigate
- If meets definition of grievance then CMS requires the patient be given information in writing as to what was done and when it was done
- Must provide in writing the name of person at the hospital that patient can contact with a complaint
- Make sure know P&P
- Must investigate timely and if cannot resolve in 7 days must send the patient a letter
Grievances and Complaints

- If patient is not competent then give information to surrogate decision maker
- A written complaint is always a grievance
- Billing issues are not generally a grievance unless a quality of care issue
- Information on a patient satisfaction survey is not a grievance unless patient asks for resolution
- Staff should know the definition of what constitutes a grievance and must give patient answer in writing
- Should document process in case CMS shows up
Standing Orders Protocols

- CMS issued standing orders
  - Includes order sets, preprinted orders, electronic orders, and protocols
- Primarily located in tag 457 but also in 405, 406, and 450
- Make sure all standing orders approved by the Medical Staff (MEC)
- If medications then must be approved by nursing and pharmacy leadership
- Must educate staff on all standing orders
Standing Orders Protocols 457

- Must make sure P&P reflects these requirements
- Must be consistent with national recognize standards and standards of care
- Must be well-defined clinical situations with evidence to support standardized treatments
- Can be initiated as emergency response
- Document in order sheet and practitioner must then sign, date and time the standing order
  - if electronic make sure entire order is present
- Must be medically appropriate
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- Make sure there is periodic and regular review of the orders and protocols to determine the continued usefulness and safety.
- P&P must address how it is developed, approved, monitored, initiated by staff and signed off or authenticated.
- Make sure new ED physicians and staff are trained on existing protocols.
- Audit to make sure they are dated, timed, and authenticated both by the person taking the order and the practitioner.
The End!

Questions???

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