Top 14 Compliance Issues for Clinical Care Providers

1. **RESTRAINTS: FACE-TO-FACE ASSESSMENT & ORDERS**
   - DAILY document face-to-face assessment which validates need for continued restraint use. It is no longer part of the restraint order as it was in Compass.
     - Epic BPA prompts timely documentation; “accept” the BPA and follow instructions to locate Face-to-Face Navigator; simply click “yes” and click pre-printed statement
   - Order Non-Violent (Medical) Restraints each calendar day.
   - Order ICU Non-Violent (Medical) Restraints once per restraint episode for only soft wrist and/or wrap/roll belt when in chair/bad and only for reason of invasive device protection; other reasons or restraint types require regular Non-Violent (non-ICU) Restraint order.
   - Order Violent/Self-Destructive (Behavioral) for each four-hour episode.

2. **HAND HYGIENE: Follow the “Five Moments”**
   - The five moments of hand hygiene applies to the necessary times to perform hand hygiene during a point of care episode. They include:
     - Before patient contact
     - After patient contact
     - After a bodily fluid exposure risk
     - Before a clean/aseptic task
     - After contact with the patient environment

3. **TRANSMISSION BASED PRECAUTIONS: PPE**
   - Wear appropriate PPE; requirements are listed on patient door orange sign
   - Tie isolation gowns
   - Remove PPE prior to exiting room of use (even if needing to retrieve forgotten items)

4. **SURGICAL ATTIRE**
   - Head and facial hair coverings must NOT allow hair to be exposed when in semi-restricted and restricted areas
   - Never wear masks around neck; dispose after use; do not place in pocket
   - Shoe covers must be removed and/or replaced when used outside the surgical environment.

5. **MEDICATION SECURITY**
   - Secure ALL medications; do not place multidose vials in random unlocked drawers
   - Lock anesthesia carts

6. **MEDICATION ORDERS**
   - When ordering medications that have a duplicate therapeutic action with currently prescribed medications, explicit direction must be written to instruct which med to give for what reason (e.g., “pain;” “fever”); or which med to give first, second, etc.
   - PRN med orders require an indication.

7. **TELEPHONE AND VERBAL ORDERS / READ-BACK**
   - Verbal orders only if emergency and cannot write/enter order.
   - Phone orders only if EMR system cannot be accessed.
   - Staff must “read back” TO/VO to confirm accuracy. Prompt staff to do so if not done.
   - When receiving notice of critical results, provider must “read back” to confirm result that was heard (“fifty” can sound like “fifteen).

8. **HAND OFFS**
   - Be able to speak to when hand-offs are to be performed (shift change, transfers between levels of care, etc.)
   - Be able to speak to how hand-off is performed (varies by type of hand off; e.g., postoperative to ICU hand off uses checklist)
9. **MEDICATION LABELING**
   - Required when meds/solutions are transferred from original containers, even if only one med or solution is being used. Exception: medication is immediately administered (never laid down; not placed in pocket).
   - One at a time, completely prepare and then label each medication or solution.
   - Label includes name, total dose, concentration; INCLUDE preparation time (from which expiration time can be calculated) when expiration occurs in less than 24 hours (e.g. propofol, fibrin sealant, etc.)
   - Two qualified persons must verbally and visually verify labels if person preparing is not person administering.
   - Any medications or solutions found unlabeled are immediately discarded.

10. **HISTORY AND PHYSICAL: TIMELINESS AND QUALITY**
    - Required to be on record within 30 days prior to or within 24 hours of admission.
      - Ensure reflective of pertinent diagnoses/conditions
      - Document physical findings reflective of anticipated procedures/surgeries
    - Must be signed by attending within 24 hours of admission to be considered complete.
    - May use H&P if within 30 days of admission and/or same-day surgery/procedure date if H&P update note recorded:
      - Referenced H&P must be made part of current chart. If referenced H&P available within Epic or ClinDesk, indicate date/source (e.g., “ClinDesk Clinic H&P of 5/26/18”)
      - CMS requires that note states the patient was re-examined and the H&P findings are endorsed as written or indicate changes/updates.

11. **INFORMED CONSENT**
    - Signature on consent form attests to discussion of risks, benefits and alternatives; best practice to also document this discussion in progress note.
    - Consent must include:
      - Name of licensed independent provider performing procedure (cannot state “fellow” or “ENT team”)
      - Procedure name and site fully spelled out (no “L” or “R” or any other abbreviated words)
      - Patient and provider signatures, including date and TIME of signatures
      - Ensure any blanks or checkboxes are addressed

12. **BRIEF POST PROCEDURE, POSTOPERATIVE NOTES**
    - Required immediately post-procedure pending completion of full note. Seven required elements:
      - Names of attending surgeon/procedure physician and any assistant(s)
      - Pre-op/pre-procedure diagnosis
      - Post-op/post-procedure diagnosis
      - Name of the procedures(s) performed
      - Description of procedure findings
      - Names of attending surgeon/procedure physician and any assistant(s)
      - Specimen(s)/tissue removed (or must document “None”)
      - Estimated blood loss (or must document “None”)

13. **PRE-ANESTHESIA / PRE-SEDATION ASSESSMENT**
    - Documented in full prior to induction/sedation administration
    - Complete all fields prompted; must be completed similarly whether by anesthesiologist or non-anesthesiologist/sedation provider
    - May only be performed by provider privileged to provide anesthesia/sedation (no PA/NP)
    - An IMMEDIATE pre-induction/pre-sedation assessment must be documented (follow prompts; typically VS and equipment check)

14. **UNIVERSAL PROTOCOL FOR PREVENTING WRONG PATIENT/SITE/PROCEDURE EVENTS**
    - **Pre-Op Verification Checklist**: Document and verify applicable items on checklist as prompted in Epic.
    - **Mark Procedure Site**:
- Only clinician(s) present and actively involved in performing the procedure may mark site
- “YES” is the ONLY way to mark sites (exceptions for anesthesia “ANE” and/or certain sites/approaches; see policy for details)
- Involve patient when possible.

- **Time Out: Surveyors Will Observe Entire Process**
  - Even if a briefing is held pre-procedure, MUST always perform the “Time Out” just prior to procedure start
  - Time Out is required regardless of type/location of procedure; TWO people (one of whom is the procedure provider) must be involved
  - Uses a verified “source of truth” (e.g. consent form; order; progress note which references includes patient name, DOB, intended procedure(s) and site(s)
  - ALL ACTIVITY STOPS to focus on speaker; speaker calls out patient name, DOB, name of procedure and site
  - EACH person verbally states agreement