Memo

To: MH-MH Medical Staff
From: Trey Eubanks, III, M.D., President of Medical Staff and Thomas Gray, M.D., Chief of Staff
Date: August 6, 2012
Re: Regulatory and Accreditation Compliance Educational Reminders

Methodist Healthcare will have a Joint Commission survey in 2013; and our ongoing regulatory readiness program has identified opportunities for medical staff improvement pertaining to key standards.

We appreciate your support to improve performance on the following:

History & Physicals – performed and documented within 30 days of a patient's admission to the Hospital and updated within 24 hours; for operative or invasive procedures the H&P and update must occur prior to the procedure.

Pre-anesthesia evaluation – completed within 48 hours prior to procedure by person qualified to administer anesthesia. Elements of this evaluation include: history, physical, potential problems, laboratory or diagnostic findings, ASA class, and anesthesia care plan.

Pre-induction assessment – documented immediately prior to sedation or anesthesia.

Post-anesthesia assessment – completed within 48 hours after surgery (preferably when the patient can participate). Elements of this assessment include: respiratory and cardiac function, mental status, temperature, pain, nausea/vomiting, and hydration.

Immediate Post-Operative/High Risk Procedure Note - If the full operative report cannot be viewed immediately after the operation or procedure (and before transfer to the next level of care), then a note shall be entered into the record containing the following elements: name of operating physician, assistants, procedure performed and description, findings, estimated blood loss, specimens removed and post-operative diagnosis.

Authenticate all entries in the record with signature and ID#.

Verbal and telephone orders should be authenticated electronically within 48 hours.

Date and time all entries in the medical record.

Medication reconciliation should take place either on paper or electronically upon admission and at discharge.

Universal Protocol – site marking (when appropriate) and timeout required for procedures performed at bedside, as well as for all operative and invasive procedures. Everyone must pause and participate in the timeout. Document the timeout on the consent form (including bedside procedures).

Moderate sedation – documentation requirements include a pre-sedation assessment, a reassessment immediately prior to sedation, and assessment of physiological status immediately after procedure; the moderate sedation form should be used.

Restraints – order should be provided by physician or LIP to initiate the restraints (or obtained immediately after); attending notified as soon as possible. Physician or LIP is required to assess and document restraint orders every calendar day.