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**Anesthesia
Committee Meeting**

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~~NAC 631.2211 Scope~~

**PROPOSED REVISIONS TO ANESTHESIA REGULATIONS
FIRST DRAFT**

NAC 631.0051. "Evaluation" Defined. "Evaluation" means the screening and assessment of the proper administration and safe practice of conscious sedation, deep sedation, and general anesthesia to insure that anesthesia services meets the minimum standard of care, as well as the compliance with the proper procedures in the event of an emergency related to the administration of the same by at least two members or designated representatives of the Board without a conflict of interest or any other ethical or legal impediment.

NAC 631.0056 "Facility" Defined. "Facility" means the site where a permit holder administers general anesthesia, deep sedation and conscious sedation services, including but not limited to the operating theater, physical plant and office.

NAC 631.0071 "Inspection" Defined. "Inspection" means the observation and visual review of the facility by at least two members or designated representatives of the Board without a conflict of interest or any other ethical or legal impediment, to determine if a facility is supplied, equipped, staffed, and maintained in a condition to support provision of anesthesia services that meet the minimum standard of care.

NAC 631.2211 Scope. (NRS 631.190, 631.265) NAC 631.2213 to 631.2256, inclusive, do not apply to the administration of:

1. Local anesthesia;

2. Nitrous oxide-oxygen analgesia, if the delivery system for the nitrous oxide-oxygen contains a mechanism which guarantees that an oxygen concentration of at least 25 percent will be administered to the patient at all times during the administration of the nitrous oxide; and

3. Oral medication that is administered to a patient to relieve anxiety in the patient, if the medication is not given in a dosage that is sufficient to induce in a patient a controlled state of depressed consciousness or unconsciousness similar to the state produced pursuant to the administration of general anesthesia, deep sedation or conscious sedation.

(Added to NAC by Bd. of Dental Exam'rs, eff. ~~10-21-83~~10-21-83; A by R005-99, ~~9-7-2000~~9-7-2000)

NAC 631.2212 Board to determine degree of sedation. (NRS 631.190, 631.265) In a proceeding of the Board at which the Board must determine the degree of sedation or level of consciousness of a patient, the Board will base its findings on:

1. The type and dosage of medication that was administered or is proposed for administration to the patient; and

2. The degree of sedation or level of consciousness that should reasonably be expected to result from that type and dosage of medication.

(Added to NAC by Bd. of Dental Exam'rs by R005-99, eff. ~~9-7-2000~~9-7-2000)

NAC 631.2213 ~~PA~~Administrator permit required; qualifications of applicants; evaluations. (NRS 631.190, 631.265)

1. Except as otherwise set forth in NAC 631.2211 to 631.2256, inclusive, no dentist may:

~~(a) Use general anesthesia or deep sedation for dental patients, except in a facility accredited by the Joint Commission on Accreditation of Healthcare Organizations, unless he first obtains a general anesthesia permit; or~~

~~(b) Use, deep sedation, or conscious sedation [expand definition of Healthcare Organizations accrediting agencies], unless he or she first obtains a general anesthesia permit or conscious sedation permit.~~

~~E A separate general anesthesia permit or conscious sedation permit, as appropriate, is required for each location at which a dentist administers general anesthesia, deep sedation or conscious sedation.~~

~~2-administrator permit.~~

2. To obtain a general anesthesia permit or conscious sedation administrator permit, a dentist must apply to the Board for such a permit on a form prescribed by the Board, submit any fees that are set by the Board, receive a passing grade for an evaluation pursuant to NRSAC 631.3452233 and NAC 631.2235, and produce evidence showing that he is a dentist who is licensed in this State, and:

(a) For a conscious sedation administrator permit, the applicant must show evidence of:

(1) The completion of a course of study, subject to the approval of the Board, of not less than 60 hours dedicated exclusively to the administration of conscious sedation, and the successful management of the administration of conscious sedation to not less than 20 patients; or

(2) The completion of a program for specialty training which is approved by the Commission on Dental Accreditation of the American Dental Association and which includes education and training in the administration of conscious sedation that is equivalent to the education and training described in subparagraph (1) and completion of an Advanced Cardiac Life Support course given by the American Heart Association or, if licensed as a specialist in pediatric dentistry, completion of a Pediatric Advanced Life Support course given by the American Heart Association.

(b) For a general anesthesia ~~administrator~~ permit, the applicant must show evidence of the completion of an Advanced Cardiac Life Support course given by the American Heart Association and:

(1) The completion of a program, subject to the approval of the Board, of advanced training in anesthesiology and related academic subjects beyond the level of undergraduate dental school in a training program as described in Part II of the Guidelines for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry, published by the Council on Dental Education and available from the American Dental Association, 211 East Chicago Ave., Chicago, Illinois 60611; or

(2) The completion of a graduate program in oral and maxillofacial surgery which has been approved by the Commission on Dental Accreditation of the American Dental Association.

(Added to NAC by Bd. of Dental Exam'rs, eff. ~~10-21-83~~10-21-83; A by R005--99, ~~9-7-2000~~9-7-2000)

NAC 631.2217 ~~Review of holder of permit; annual renewal of permit~~4 Temporary administrator permits. (NRS 631.190, 631.265)

1. The holder of Board may grant a temporary general anesthesia permit and/or conscious sedation permit is subject to review by the Board at any time.

~~2. Each general anesthesia permit and conscious sedation permit must be renewed annually.~~

~~_____ administrator permit to an applicant who meets the qualifications for a permit to administer that type of anesthesia or sedation pursuant to NAC 631.2213.~~

2. A temporary permit is valid for not more than 90 days, but the Board may, in any case it deems appropriate, grant a 90-day extension of the permit.

3. Before the expiration of the temporary permit, the dentist must pass an evaluation in accordance with NAC 631.2235.

(Added to NAC by Bd. of Dental Exam'rs, eff. ~~10-21-83~~11-28-90; A by R005--99, ~~9-7-2000~~9-7-2000)

NAC 631.2219 ~~Inspection and evaluation; reevaluation.~~ (NRS 631.190, 631.265)

~~_____ 1. The Board will require an inspection and evaluation of the facility, equipment, personnel, records of patients and the procedures used by every dentist who seeks or holds~~2215 Administrator Permits: Renewals.

~~1. The holder of a general anesthesia permit or conscious sedation permit, and of the dentist himself, before issuing such an original permit to the dentist, and at least once in every 5-year period thereafter.~~

~~_____ 2. administrator permit is subject to review by the Board at any time.~~

2. Each general anesthesia and conscious sedation administrator permit must be renewed annually.

3. The Board will renew general anesthesia ~~permits~~ and conscious sedation administrator permits annually unless the holder is informed in writing, 60 days before the date for renewal, that ~~a reevaluation~~ another evaluation of his credentials is required. In determining whether ~~reevaluation~~ another evaluation is necessary, the Board will consider, among other factors, complaints by patients and reports of adverse occurrences. ~~A reevaluation~~ Another evaluation will, if appropriate, include an inspection of the facility, equipment, personnel, and records of patients and an evaluation of the procedures used by the holder, and an examination of his qualifications.

(Added to NAC by Bd. of Dental Exam'rs, eff. ~~10-21-83~~10-21-83; A 7-30-04; R005-99, ~~9-7-2000~~9-7-2000)

~~_____ NAC 631.2221 Inspectors and evaluators; participation of members of Board. (NRS 631.190, 631.265)~~

~~_____ 1. When an inspection or evaluation is required to issue or renew~~

4. A holder of a general anesthesia permit and/or conscious sedation permit, the Board will designate two or more persons, each of whom holds a general anesthesia permit or conscious sedation permit and has practiced general anesthesia, deep sedation or conscious sedation, as applicable, for a minimum of 3 years preceding his appointment, exclusive of his training in administrator permit is subject to further evaluation at least once

in every 5-year period after the initial evaluation.

NAC 631.2216 Site permit required: facilities.

1. A dentist who is licensed in this State and who desires to receive a permit for a facility to be utilized for the administration of anesthesia or sedation. ~~At least one of the inspectors or evaluators must have had experience in the evaluation of dentists using general anesthesia, deep sedation or conscious sedation, as applicable. At least one member of~~ must obtain a site permit by:

(a) Submitting to the Board an application for a site permit or for the renewal of a site permit, in a form approved by the Board;

(b) Payment of a fee for the inspection or evaluation team ~~must have had substantial experience in the administration of the type of anesthesia contemplated for use by the dentist being evaluated and must hold the type of permit for which the dentist is applying.~~

~~2. Any member of the Board who is a dentist may observe or consult in any inspection or evaluation. A member of the Board who is not a dentist may be present at an observation but may not participate in any grading or evaluation resulting from the inspection or evaluation.~~

~~(Added to NAC by Bd. of Dental Examiners, eff. 10-21-83; A 7-30-84; R005-99, 9-7-2000)~~

~~NAC 631.2223 Inspections and evaluations: General requirements. (NRS 631.190; 631.265) An inspection or evaluation ordered by the Board must be conducted in all offices whereof a facility which is established by the Board;~~

(c) Submitting to the Board written documentation which demonstrates that the applicant or an anesthesiologist or dentist who is to be employed by the applicant to administer the general anesthesia, deep sedation or conscious sedation ~~is holds an appropriate license or permit issued by the appropriate board in this State to be administered and, except as otherwise required in NAC 631.2236, must consist of:~~

~~1. An evaluation of the office's facilities and equipment, records and emergency medications; and~~

~~2. A demonstration of:~~

~~(a) The administration to a patient who is receiving dental treatment of the type of administer such anesthesia or sedation for which the dentist is applying for a permit;~~

~~(b) Simulated emergencies in the surgical area of the dental office with participation by the members of the staff who are trained to handle emergencies;~~

~~(c) A dental procedure utilizing the type of anesthesia or sedation for which the dentist is applying for a permit;~~

~~(d) Any anesthesia or sedation technique that is routinely employed during the administration of anesthesia or sedation;~~

~~(e) The appropriate monitoring of a patient during anesthesia or sedation; and~~

~~(f) The observation of a patient during recovery and the time allowed for recovery;~~

~~(Added to NAC by Bd. of Dental Examiners, eff. 10-21-83; A by R005-99, 9-7-2000)~~

~~NAC 631.2225 Inspections and evaluations: Simulated emergencies, and if the person to be employed is an anesthesiologist, that the anesthesiologist maintains unrestricted active staff privileges within the department of anesthesiology at a hospital or surgical center approved by the Joint Commission, and~~

(d) Obtaining a passing grade on the inspection conducted pursuant to Subsection 2 herein.

2. Upon receipt of an application for a site permit, the Board will appoint one of its members or a representative of the Board to inspect the facility of the applicant to determine whether the facility complies with the requirements set forth in NAC 631.2227, 631.2229 and 631.2231. The person conducting the inspection shall report his or her determination to the Board's Executive Director.

3. If the person conducting the inspection determines that the facility complies with the requirements of NAC 631.2227, 631.2229 and 631.2231 and the applicant has otherwise met the requirements of this section, the Executive Director shall issue a site permit to the applicant.

4. Each site permit issued by the Executive Director must be renewed annually.

5. A holder of a site permit is subject to further inspection at least once in every 5-year period after the initial inspection.

6. A holder of a permit for a facility shall maintain the information described in paragraph (c) of subsection 1 at his office at all times.

NAC 631.2221 Inspection and evaluation; participation of members of Board. (NRS 631.190, 631.265) ~~A dentist's office inspected or evaluated for the issuance or renewal of~~

1. When an inspection and evaluation is required to issue or renew a site and/or an administrator permit, the Board will designate two or more persons, each of whom holds a general anesthesia permit or conscious sedation permit ~~must meet the following minimum standards with regard to simulated and has practiced general anesthesia, deep sedation or conscious sedation, as applicable, for a minimum of 3 years preceding his or her appointment, exclusive of his or her training in the administration of anesthesia or sedation. At least one of the evaluators must have had experience in the administration of the type of anesthesia contemplated for use by the dentist being evaluated and must hold the type of permit for which the dentist is applying.~~

2. Any member of the Board who is a dentist may observe or consult in any inspection

or evaluation. A member of the Board who is not a dentist may be present to observe but may not participate in any evaluation or inspection.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A 7-30-84; R005-99, 9-7-2000)

NAC 631.2223 Evaluations: General requirements. (NRS 631.190, 631.265) An evaluation of the dentist ordered by the Board must include a demonstration of:

(a) The administration to a patient who is receiving dental treatment of the type of anesthesia or sedation for which the dentist is applying for a permit;

(b) Simulated emergencies in the surgical area of the facility with participation by the members of the staff who are trained to handle emergencies;

(c) A dental procedure utilizing the type of anesthesia or sedation for which the dentist is applying for a permit;

(d) Any anesthesia or sedation technique that is routinely employed during the administration of anesthesia or sedation;

(e) The appropriate monitoring of a patient during anesthesia or sedation; and

(f) The observation of a patient during recovery and the time allowed for recovery.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000)

NAC 631.2225 Evaluations: Simulated emergencies. (NRS 631.190, 631.265) The dentist and his staff or her personnel must demonstrate a knowledge of and a method of treatment for the following types of emergencies:

1. Airway obstruction laryngospasm;

2. Bronchospasm;

3. Emesis and aspiration of foreign material under anesthesia;

4. Angina pectoris;

5. Myocardial infarction;

6. Hypotension;

7. Hypertension;

8. Cardiac arrest;

9. Allergic reaction;

10. Convulsions;

11. Hypoglycemia;

12. Asthma;

13. Respiratory depression;

14. Allergy to or overdose from local anesthesia;

15. Hyperventilation syndrome; and

16. Syncope.

(Added to NAC by Bd. of Dental Exam'rs, eff. ~~10-21-83~~10-21-83; A by R005-99, ~~9-7-2000~~)

~~NAC 631.2227 Inspections and evaluations~~9-7-2000)

NAC 631.2226 Inspections: General. An inspection pursuant to NAC 631.2226(2) must be conducted in all offices where general anesthesia, deep sedation or conscious sedation is to be administered and consist of an inspection of the physical facilities and equipment, records of patients and emergency medications.

~~NAC 631.2227 Inspections: Physical facilities and equipment. (NRS 631.190, 631.265) A dentist's office facility inspected or evaluated for the issuance or renewal of a general anesthesia site permit, conscious sedation permit or certificate of site approval must meet the following minimum standards with regard to physical facilities and equipment:~~

1. The operating theater must be large enough to accommodate the patient adequately on a table or in a dental chair and to allow an operating team consisting of at least three persons to move freely about the patient.

2. The operating table or dental chair must:

(a) Allow the patient to be placed in a position such that the operating team can maintain the airway;

(b) Allow the operating team to alter the patient's position quickly in an emergency; and

(c) Provide a firm platform for the management of cardiopulmonary resuscitation.

3. The lighting system must be adequate to allow an evaluation of the patient's skin and mucosal color. An alternate lighting system must derive its power from batteries and must be sufficiently intense to allow completion of any procedure underway at the time of a general power failure.

4. Suction equipment must be available that allows aspiration of the oral and pharyngeal cavities. An alternate suction device that will function effectively during a general power failure must be available.

5. A system for delivering oxygen must have adequate full-face masks and appropriate connectors, and be capable of delivering oxygen to the patient under positive pressure. An adequate alternate system for delivering oxygen is also required.

6. A recovery area must be provided that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area may be the operating theater. A member of the staff must be able to observe the patient at all times during the recovery.

7. Except as otherwise provided in this subsection, ancillary equipment must include:

(a) A laryngoscope complete with an adequate selection of blades and spare batteries and bulbs;

(b) Endotracheal tubes and appropriate connectors;

(c) Oral airways;

(d) A tonsillar or pharyngeal suction tip adaptable to all office suction outlets;

(e) An endotracheal tube type forcep;

(f) A sphygmomanometer and stethoscope;

(g) An electrocardioscope and defibrillator;

(h) Adequate equipment for the establishment of an intravenous infusion; and

(i) A pulse oximeter.

~~A dentist's office facility inspected or evaluated for the issuance or renewal of a site permit where only conscious sedation permit shall be administered is not required to have the ancillary equipment described in paragraphs (a), (b), (e) and (g).~~

~~(Added to NAC by Bd. of Dental Exam'rs, eff. 40-21-8310-21-83; A by R005--99, 9-7-2009-7-2000)~~

~~NAC 631.2229 Inspections and eEvaluations: Records of patients. (NRS 631.190, 631.265) A dentist's office An inspected or evaluated ion for the issuance or renewal of a general anesthesia permit, conscious sedation permit or certificate of site approval must~~

meet the following minimum standards with regard to the records of patients:

1. site permit and an evaluation for issuance or renewal of an administrator permit shall determine that, at a minimum, the following records of the patient are maintained by the dentist:

1. Adequate medical history and records of physical evaluation;
2. Records of the administration of anesthesia must include:
 - (a);
 2. Medications administered and dosages;
 3. Informed Consent;
 4. The patient's blood pressure and pulse;
 - (b) The names of the drugs before and the amounts administered after anesthesia is utilized;
 - (c)
 5. The length of the procedure; and
 - (d) A,
6. The response to anesthesia, including any complications of anesthesia.

(Added to NAC by Bd. of Dental Exam'rs, eff. ~~10-21-83~~10-21-83; A by R005-99, ~~9-7-2000~~9-7-2000)

NAC 631.2231 Inspections and evaluations: Emergency drugs. (NRS 631.190, 631.265) Except as otherwise provided in this section, a dentist's office facility inspected or evaluated for the issuance or renewal of a general anesthesia permit, conscious sedation permit or certificate of site approval must maintain site permit must maintain appropriately emergency drugs of the following categories which must be immediately available for use on the patient:

1. Vasopressor;
2. Corticosteroid;
3. Bronchodilator;

4. Muscle relaxant;
5. Intravenous medication for the treatment of cardiopulmonary arrest;
6. Appropriate drug antagonist;
7. Antihistaminic;
8. Anticholinergic;
9. Antiarrhythmic;
10. Coronary artery vasodilator;
11. Anti-hypertensive; and
12. Anti-convulsive.

A dentist's office facility that is inspected or evaluated for the issuance or renewal of a site permit where only conscious sedation permit shall be administered is not required to maintain the emergency drugs described in subsections 4, 5, 9 and 11.

(Added to NAC by Bd. of Dental Exam'rs, eff. ~~10-21-83~~10-21-83; A by R005-99, ~~9-7-2000~~9-7-2000)

NAC 631.2233 Inspections and evaluations: Recommendations of inspectors and evaluators; decision of Board. (NRS 631.190, 631.265)

1. The persons performing an inspection of a facility and/or the evaluation of a dentist's office dentist for the issuance or renewal of a general anesthesia permit or conscious sedation site and/or administrator permit shall grade the office facility and/or dentist as passing or failing. Within ~~five~~ five business days after completing the inspection

and evaluation, each inspector or evaluator shall report his or her recommendation for passing or failing to the Board, setting forth the details supporting his or her conclusion. The Board is not bound by these recommendations.

~~2. The Board will make the final determination whether the office has passed or failed the inspection or evaluation and will notify the dentist whose office is the subject of the inspection or evaluation in writing, of its findings within 30 days after~~

2. After the Board receives a recommendation from each inspector or evaluator who inspected or evaluated the office:

and evaluator, the Board will make the final determination whether the facility and/or the dentist has passed or failed the inspection and/or the evaluation and will provide prompt notice in writing of the final determination to the dentist and/or facility that is the subject of the inspection and evaluation.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83 10-21-83; A by R005--99, 9-7-2000 9-7-2000)

NAC 631.2235 Inspections and evaluations: Failure to pass; requests for reinspections and/or reevaluations. (NRS 631.190, 631.265)

1. A dentist whose office/facility that the Board determines has failed the inspection and/or a dentist the Board determines has failed the evaluation is not entitled to have a general anesthesia permit or conscious sedation site and/or administrator permit issued or renewed.

~~2. A renewed.~~

2. Prior to a final determination by the Board, the Executive Director may immediately suspend the site and/or administrator permits if all of the inspectors of a facility or evaluators of a dentist have recommended a fail, or in the event a unanimous recommendation is not received, Chairperson of the Anesthesia Committee recommends temporary suspension.

3. The Executive Director shall promptly notify the facility and dentist of a temporary suspension in writing.

4. A facility or dentist who has received a written notice of failure from the Board or notice of temporary suspension from the Executive Director may, within 15 days after receiving the date of the notice, forward to the Executive Director a request to the Board in writing for a reevaluation. Reinspection of the request for facility and/or a reevaluation must state specific grounds supporting it.

3. If the reevaluation is granted by the Board, it of the dentist along with the payment of the applicable fee.

5. Upon a timely request for reinspection and/or reevaluation and payment of the applicable fees, the reinspection and/or reevaluation will be conducted by different persons in the manner set forth by NAC 631.2219 to 631.2233, inclusive, for an original inspection and/or evaluation.

6. No facility and/or dentist who has received a notice of failing an inspection or evaluation from the Board may request more than one reinspection and/or reevaluation within any period of a 12 month period.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83 10-21-83; A by R005--99, 9-7-2000)

NAC 631.2236 Certificate of site approval: General requirements 9-7-2000)

NAC 631.2237 Procedures required before administration of anesthetic or sedation. (NRS 631.190, 631.265)

~~1. A dentist who is licensed in this State may employ:~~

- ~~(a) An anesthesiologist who is licensed as such by the State of Nevada; or~~
- ~~(b) A dentist who is licensed in this State and who holds~~

1. Written consent of the patient must be obtained before the administration of a general anesthesia permit, anesthetic, deep sedation or conscious sedation permit, to administer, unless the dentist determines that an emergency situation exists in which delaying the procedure to obtain the consent would likely cause permanent injury to the patient. If the patient is a minor, the consent must be obtained from his parent or legal guardian.

2. A medical history must be taken before the administration of a general anesthesia, anesthetic, deep sedation or conscious sedation. A patient should be asked to describe any current medical conditions or treatments, including, without limitation, medications, drug allergies, impending or past operations and pregnancy, and to give other information that may be helpful to the person administering the anesthetic or sedation. The dentist is not required to make a complete medical examination of the patient and draw medical diagnostic conclusions. If a dentist suspects a medical problem and calls in a physician for an examination and evaluation, he may then rely upon that conclusion and diagnosis. Questions asked of and answers received from the patient must be permanently recorded and signed by the patient before the administration of any general anesthetic, deep sedation or conscious sedation, as appropriate, to his patients at his office if he holds a certificate of site approval issued pursuant to this section.

2. A dentist who is licensed in this State and who desires to receive or renew a certificate of site approval must submit to the Board:

- ~~(a) An application for a certificate or for the renewal of a certificate, in a form~~

approved by the Board;

~~_____ (b) The fee for the inspection of a facility which is established by the Board pursuant to NRS 631.345; and~~

~~_____ (c) Written documentation which demonstrates that the anesthesiologist or dentist who is to be employed to administer the and this record must be a permanent part of the patient's record of treatment.~~

~~(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000)~~

~~NAC 631.2239 Properly equipped facility required; qualifications of auxiliary personnel. (NRS 631.190, 631.265)~~

~~1. A dentist using general anesthesia, deep sedation or conscious sedation holds an appropriate license or permit issued by the appropriate board in this State to administer such anesthesia or sedation, and if the person to be employed is an anesthesiologist, that the anesthesiologist maintains unrestricted active staff privileges within the department of anesthesiology at a hospital or surgical center approved by the Joint Commission on Accreditation of Healthcare Organizations;~~

~~_____ 3. Upon receipt of an application pursuant to this section, the Board will appoint one of its members or a representative of the Board to inspect the office of the applicant to determine whether the office complies with the requirements set forth in NAC 631.2227, 631.2229 and 631.2231. The person conducting the inspection shall report his determination to the Board.~~

~~_____ 4. If the person conducting the inspection determines that the office of the applicant complies with the requirements of NAC 631.2227, 631.2229 and 631.2231 and the applicant has otherwise met the requirements of this section, the Executive Director shall issue a certificate of site approval to the applicant.~~

~~_____ 5. A holder of a certificate of site approval shall maintain the information described in paragraph (c) of subsection 2 at his office at all times.~~

~~_____ 6. Each certificate of site approval issued by the Board must be renewed annually.~~

~~_____ 7. The Board may reinspect the office of the holder of a certificate of site approval at any time.~~

~~(Added to NAC by Bd. of Dental Exam'rs by R005-99, eff. 9-7-2000; A by R231-03, 5-25-2004)~~

~~NAC 631.2237 Procedures required before administration of anesthetic or sedation. (NRS 631.190, 631.265)~~

~~_____ 1. Written consent of the patient must be obtained before the administration of a general anesthetic, deep sedation or conscious sedation, unless the dentist determines that an emergency situation exists in which delaying the procedure to obtain the consent would likely cause permanent injury to the patient. If the patient is a minor, the consent must be obtained from his parent or legal guardian.~~

~~_____ 2. A medical history must be taken before the administration of a general anesthetic, deep sedation or conscious sedation. A patient should be asked to describe any current medical conditions or treatments, including, without limitation, medications, drug allergies, impending or past operations and pregnancy, and to give other information that may be~~

~~helpful to the person administering the anesthetic or sedation. The dentist is not required to make a complete medical examination of the patient and draw medical diagnostic conclusions. If a dentist suspects a medical problem and calls in a physician for an examination and evaluation, he may then rely upon that conclusion and diagnosis. Questions asked of and answers received from the patient must be permanently recorded and signed by the patient before the administration of any general anesthetic, deep sedation or conscious sedation, and this record must be a permanent part of the patient's record of treatment.~~

~~(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000)~~
~~_____ NAC 631.2239 Properly equipped facility required; qualifications of auxiliary personnel. (NRS 631.190, 631.265)~~

~~_____ 1. A dentist using general anesthesia, deep sedation or conscious sedation shall maintain a properly equipped facility for the administration of the anesthesia or sedation which is staffed with supervised auxiliary personnel who are capable of reasonably handling procedures, problems and emergencies incident thereto.~~

~~_____ 2. A dentist using general anesthesia, deep sedation or conscious sedation shall ensure that his auxiliary personnel are certified in basic cardiopulmonary resuscitation by the American Heart Association.~~

~~(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000)~~

~~NAC 631.224 Employment of certified registered nurse anesthetist. (NRS 631.190, 631.265)~~

~~1. Any dentist who holds a general anesthesia permit pursuant to the provisions of NAC 631.2211 to 631.2256, inclusive, may employ a certified registered nurse anesthetist to administer the general anesthesia, deep sedation or conscious sedation to a patient if the dentist is physically present and directly supervises the administration of the general anesthesia, deep sedation or conscious sedation to the patient. The holder of the permit must maintain at his office evidence in writing that the certified registered nurse anesthetist is licensed to practice in the State of Nevada and maintains unrestricted active staff privileges within the department of anesthesiology at a hospital or surgical center which is certified by the Joint Commission on~~

~~Accreditation of Healthcare Organizations:~~

~~_____ 2. Except as otherwise provided in NAC 631.2236, a dentist who does not hold a general anesthesia permit may not allow any person to administer general anesthesia, deep sedation or conscious sedation to his patients unless the treatment is rendered within a facility approved by the Joint Commission on~~

~~Accreditation of Healthcare Organizations:~~

~~(Added to NAC by Bd. of Dental Exam'rs, eff. 10-7-85 10-7-85; A by R005--99, 9-7-2000 9-7-2000)~~

NAC 631.2241 Report of injuries to patients. (NRS 631.190, 631.265) Each holder of a general anesthesia permit, conscious sedation permit or certificate of site approval shall submit to the Board a complete report regarding any mortality or unusual incident which occurs outside a facility accredited by the Joint Commission ~~on Accreditation of Healthcare Organizations~~ and produces permanent injury to a patient or requires the hospitalization of a patient, as a direct result of the administration of general anesthesia, deep sedation or conscious sedation. The report must be submitted within 30 days after the date of the incident. If a dentist fails to report any incident as required by this section, his permit may be revoked.

~~(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83 10-21-83; A by R005--99, 9-7-2000 9-7-2000)~~

~~NAC 631.2254 Temporary permits. (NRS 631.190, 631.265)~~

~~1. The Board may grant a temporary permit to administer general anesthesia and deep sedation or a temporary permit to administer conscious sedation to an applicant who meets the qualifications for a permit to administer that type of anesthesia or sedation pursuant to NAC 631.2243.~~

~~2. A temporary permit is valid for not more than 90 days, but the Board may, in any case it deems appropriate, grant a 90-day extension of the permit.~~

~~3. The Board may require the holder of a temporary permit to pass an on-site inspection as a condition of retaining the permit. If the holder fails the inspection, his permit will be revoked. In case of revocation, the holder of a temporary permit may apply to be reinspected in accordance with the procedures set forth in NAC 631.2235.~~

~~(Added to NAC by Bd. of Dental Exam'rs, eff. 11-28-90; A by R005--99, 9-7-2000)~~

~~NAC 631.2256 9-7-2000)~~

NAC 631.2256 Continuing education required. (NRS 631.190, 631.265, 631.342) Every 2 years, the holder of a general anesthesia permit or conscious sedation permit must complete at least 3 hours in courses of study that specifically relate to anesthesia or sedation, as applicable, before his permit may be renewed. This training will be credited toward any continuing education required by NAC 631.173.

~~(Added to NAC by Bd. of Dental Exam'rs, eff. 11-28-90 11-28-90; A by R005--99, 9-7-2000 9-7-2000)~~

**PROPOSED REVISIONS TO ANESTHESIA REGULATIONS
FIRST DRAFT**

NAC 631.0051. "Evaluation" Defined. "Evaluation" means the screening and assessment of the proper administration and safe practice of conscious sedation, deep sedation, and general anesthesia to insure that anesthesia services meets the minimum standard of care, as well as the compliance with the proper procedures in the event of an emergency related to the administration of the same by at least two members or designated representatives of the Board without a conflict of interest or any other ethical or legal impediment.

NAC 631.0056 "Facility" Defined. "Facility" means the site where a permit holder administers general anesthesia, deep sedation and conscious sedation services, including but not limited to the operating theater, physical plant and office.

NAC 631.0071 "Inspection" Defined. "Inspection" means the observation and visual review of the facility by at least two members or designated representatives of the Board without a conflict of interest or any other ethical or legal impediment, to determine if a facility is supplied, equipped, staffed, and maintained in a condition to support provision of anesthesia services that meet the minimum standard of care.

NAC 631.2211 Scope. (NRS 631.190, 631.265) NAC 631.2213 to 631.2256, inclusive, do not apply to the administration of:

1. Local anesthesia;
2. Nitrous oxide-oxygen analgesia, if the delivery system for the nitrous oxide-oxygen contains a mechanism which guarantees that an oxygen concentration of at least 25 percent will be administered to the patient at all times during the administration of the nitrous oxide; and
3. Oral medication that is administered to a patient to relieve anxiety in the patient, if the medication is not given in a dosage that is sufficient to induce in a patient a controlled state of depressed consciousness or unconsciousness similar to the state produced pursuant to the administration of general anesthesia, deep sedation or conscious sedation.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000)

NAC 631.2212 Board to determine degree of sedation. (NRS 631.190, 631.265) In a proceeding of the Board at which the Board must determine the degree of sedation or level of consciousness of a patient, the Board will base its findings on:

1. The type and dosage of medication that was administered or is proposed for

administration to the patient; and

2. The degree of sedation or level of consciousness that should reasonably be expected to result from that type and dosage of medication.

(Added to NAC by Bd. of Dental Exam'rs by R005-99, eff. 9-7-2000)

NAC 631.2213 Administrator permit required; qualifications of applicants; evaluations. (NRS 631.190, 631.265)

1. Except as otherwise set forth in NAC 631.2211 to 631.2256, inclusive, no dentist may use general anesthesia, deep sedation, or conscious sedation for dental patients, except in a facility accredited by [expand definition of accrediting agencies], unless he or she first obtains a general anesthesia or conscious sedation administrator permit.

2. To obtain a general anesthesia or conscious sedation administrator permit, a dentist must apply to the Board for such a permit on a form prescribed by the Board, submit any fees that are set by the Board, receive a passing grade for an evaluation pursuant to NAC 631.2233 and NAC 631.2235, and produce evidence showing that he is a dentist who is licensed in this State, and:

(a) For a conscious sedation administrator permit, the applicant must show evidence of:

(1) The completion of a course of study, subject to the approval of the Board, of not less than 60 hours dedicated exclusively to the administration of conscious sedation, and the successful management of the administration of conscious sedation to not less than 20 patients; or

(2) The completion of a program for specialty training which is approved by the Commission on Dental Accreditation of the American Dental Association and which includes education and training in the administration of conscious sedation that is equivalent to the education and training described in subparagraph (1) and completion of an Advanced Cardiac Life Support course given by the American Heart Association or, if licensed as a specialist in pediatric dentistry, completion of a Pediatric Advanced Life Support course given by the American Heart Association.

(b) For a general anesthesia administrator permit, the applicant must show evidence of the completion of an Advanced Cardiac Life Support course given by the American Heart Association and:

(1) The completion of a program, subject to the approval of the Board, of advanced training in anesthesiology and related academic subjects beyond the level of undergraduate dental school in a training program as described in Part II of the Guidelines

for Teaching the Comprehensive Control of Pain and Anxiety in Dentistry, published by the Council on Dental Education and available from the American Dental Association, 211 East Chicago Ave., Chicago, Illinois 60611; or

(2) The completion of a graduate program in oral and maxillofacial surgery which has been approved by the Commission on Dental Accreditation of the American Dental Association.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000)

NAC 631.2214 Temporary administrator permits. (NRS 631.190, 631.265)

1. The Board may grant a temporary general anesthesia and/or conscious sedation administrator permit to an applicant who meets the qualifications for a permit to administer that type of anesthesia or sedation pursuant to NAC 631.2213.

2. A temporary permit is valid for not more than 90 days, but the Board may, in any case it deems appropriate, grant a 90-day extension of the permit.

3. Before the expiration of the temporary permit, the dentist must pass an evaluation in accordance with NAC 631.2235.

(Added to NAC by Bd. of Dental Exam'rs, eff. 11-28-90; A by R005-99, 9-7-2000)

NAC 631.2215 Administrator Permits: Renewals.

1. The holder of a general anesthesia or conscious sedation administrator permit is subject to review by the Board at any time.

2. Each general anesthesia and conscious sedation administrator permit must be renewed annually.

3. The Board will renew general anesthesia and conscious sedation administrator permits annually unless the holder is informed in writing, 60 days before the date for renewal, that another evaluation of his credentials is required. In determining whether another evaluation is necessary, the Board will consider, among other factors, complaints by patients and reports of adverse occurrences. Another evaluation will, if appropriate, include an inspection of the facility, equipment, personnel, and records of patients and an evaluation of the procedures used by the holder, and an examination of his qualifications.

4. A holder of a general anesthesia and/or conscious sedation administrator permit is subject to further evaluation at least once in every 5-year period after the initial evaluation.

NAC 631.2216 Site permit required: facilities.

1. A dentist who is licensed in this State and who desires to receive a permit for a facility to be utilized for the administration of anesthesia or conscious sedation must obtain a site permit by:

(a) Submitting to the Board an application for a site permit or for the renewal of a site permit, in a form approved by the Board;

(b) Payment of a fee for the inspection of a facility which is established by the Board;

(c) Submitting to the Board written documentation which demonstrates that the applicant or an anesthesiologist or dentist who is to be employed by the applicant to administer the general anesthesia, deep sedation or conscious sedation holds an appropriate license or permit issued by the appropriate board in this State to administer such anesthesia or sedation, and if the person to be employed is an anesthesiologist, that the anesthesiologist maintains unrestricted active staff privileges within the department of anesthesiology at a hospital or surgical center approved by the Joint Commission, and

(d) Obtaining a passing grade on the inspection conducted pursuant to Subsection 2 herein.

2. Upon receipt of an application for a site permit, the Board will appoint one of its members or a representative of the Board to inspect the facility of the applicant to determine whether the facility complies with the requirements set forth in NAC 631.2227, 631.2229 and 631.2231. The person conducting the inspection shall report his or her determination to the Board's Executive Director.

3. If the person conducting the inspection determines that the facility complies with the requirements of NAC 631.2227, 631.2229 and 631.2231 and the applicant has otherwise met the requirements of this section, the Executive Director shall issue a site permit to the applicant.

4. Each site permit issued by the Executive Director must be renewed annually.

5. A holder of a site permit is subject to further inspection at least once in every 5-year period after the initial inspection.

6. A holder of a permit for a facility shall maintain the information described in paragraph (c) of subsection 1 at his office at all times.

NAC 631.2221 Inspection and evaluation; participation of members of Board. (NRS 631.190, 631.265)

1. When an inspection and evaluation is required to issue or renew a site and/or an administrator permit, the Board will designate two or more persons, each of whom holds a general anesthesia permit or conscious sedation permit and has practiced general anesthesia, deep sedation or conscious sedation, as applicable, for a minimum of 3 years preceding his or her appointment, exclusive of his or her training in the administration of anesthesia or sedation. At least one of the evaluators must have had experience in the administration of the type of anesthesia contemplated for use by the dentist being evaluated and must hold the type of permit for which the dentist is applying.

2. Any member of the Board who is a dentist may observe or consult in any inspection or evaluation. A member of the Board who is not a dentist may be present to observe but may not participate in any evaluation or inspection.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A 7-30-84; R005-99, 9-7-2000)

NAC 631.2223 Evaluations: General requirements. (NRS 631.190, 631.265) An evaluation of the dentist ordered by the Board must include a demonstration of:

(a) The administration to a patient who is receiving dental treatment of the type of anesthesia or sedation for which the dentist is applying for a permit;

(b) Simulated emergencies in the surgical area of the facility with participation by the members of the staff who are trained to handle emergencies;

(c) A dental procedure utilizing the type of anesthesia or sedation for which the dentist is applying for a permit;

(d) Any anesthesia or sedation technique that is routinely employed during the administration of anesthesia or sedation;

(e) The appropriate monitoring of a patient during anesthesia or sedation; and

(f) The observation of a patient during recovery and the time allowed for recovery.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000)

NAC 631.2225 Evaluations: Simulated emergencies. (NRS 631.190, 631.265) The dentist and his or her personnel must demonstrate a knowledge of and a method of treatment for the following types of emergencies:

1. Airway obstruction laryngospasm;
2. Bronchospasm;
3. Emesis and aspiration of foreign material under anesthesia;
4. Angina pectoris;
5. Myocardial infarction;
6. Hypotension;
7. Hypertension;
8. Cardiac arrest;
9. Allergic reaction;
10. Convulsions;
11. Hypoglycemia;
12. Asthma;
13. Respiratory depression;
14. Allergy to or overdose from local anesthesia;
15. Hyperventilation syndrome; and
16. Syncope.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000)

NAC 631.2226 Inspections: General. An inspection pursuant to NAC 631.2226(2) must be conducted in all offices where general anesthesia, deep sedation or conscious sedation is to be administered and consist of an inspection of the physical facilities and equipment, records of patients and emergency medications.

NAC 631.2227 Inspections: Physical facilities and equipment. (NRS 631.190, 631.265) A facility inspected for the issuance or renewal of a site permit must meet the following minimum standards with regard to physical facilities and equipment:

1. The operating theater must be large enough to accommodate the patient adequately

on a table or in a dental chair and to allow an operating team consisting of at least three persons to move freely about the patient.

2. The operating table or dental chair must:

(a) Allow the patient to be placed in a position such that the operating team can maintain the airway;

(b) Allow the operating team to alter the patient's position quickly in an emergency; and

(c) Provide a firm platform for the management of cardiopulmonary resuscitation.

3. The lighting system must be adequate to allow an evaluation of the patient's skin and mucosal color. An alternate lighting system must derive its power from batteries and must be sufficiently intense to allow completion of any procedure underway at the time of a general power failure.

4. Suction equipment must be available that allows aspiration of the oral and pharyngeal cavities. An alternate suction device that will function effectively during a general power failure must be available.

5. A system for delivering oxygen must have adequate full-face masks and appropriate connectors, and be capable of delivering oxygen to the patient under positive pressure. An adequate alternate system for delivering oxygen is also required.

6. A recovery area must be provided that has available oxygen, adequate lighting, suction and electrical outlets. The recovery area may be the operating theater. A member of the staff must be able to observe the patient at all times during the recovery.

7. Except as otherwise provided in this subsection, ancillary equipment must include:

(a) A laryngoscope complete with an adequate selection of blades and spare batteries and bulbs;

(b) Endotracheal tubes and appropriate connectors;

(c) Oral airways;

(d) A tonsillar or pharyngeal suction tip adaptable to all office suction outlets;

(e) An endotracheal tube type forcep;

(f) A sphygmomanometer and stethoscope;

(g) An electrocardioscope and defibrillator;

(h) Adequate equipment for the establishment of an intravenous infusion; and

(i) A pulse oximeter.

A facility inspected for the issuance or renewal of a site permit where only conscious sedation shall be administered is not required to have the ancillary equipment described in paragraphs (a), (b), (e) and (g).

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000)

NAC 631.2229 Inspections and Evaluations: Records of patients. (NRS 631.190, 631.265) An inspection for the issuance or renewal of a site permit and an evaluation for issuance or renewal of an administrator permit shall determine that, at a minimum, the following records of the patient are maintained by the dentist:

1. Adequate medical history and records of physical evaluation;

2. Medications administered and dosages;

3. Informed Consent;

4. The patient's blood pressure and pulse before and after anesthesia is utilized;

5. The length of the procedure; and,

6. The response to anesthesia, including any complications.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000)

NAC 631.2231 Inspections: Emergency drugs. (NRS 631.190, 631.265) Except as otherwise provided in this section, a facility inspected for the issuance or renewal of a site permit must maintain appropriately emergency drugs of the following categories which must be immediately available for use on the patient:

1. Vasopressor;

2. Corticosteroid;

3. Bronchodilator;

4. Muscle relaxant;

5. Intravenous medication for the treatment of cardiopulmonary arrest;

6. Appropriate drug antagonist;
7. Antihistaminic;
8. Anticholinergic;
9. Antiarrhythmic;
10. Coronary artery vasodilator;
11. Anti-hypertensive; and
12. Anti-convulsive.

A facility that is inspected for the issuance or renewal of a site permit where only conscious sedation shall be administered is not required to maintain the emergency drugs described in subsections 4, 5, 9 and 11.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000)

NAC 631.2233 Inspections and evaluations: Recommendations of inspectors and evaluators; decision of Board. (NRS 631.190, 631.265)

1. The persons performing an inspection of a facility and/or the evaluation of a dentist for the issuance or renewal of a site and/or administrator permit shall grade the facility and/or dentist as passing or failing. Within five business days after completing the inspection and evaluation, each inspector or evaluator shall report his or her recommendation for passing or failing to the Board, setting forth the details supporting their conclusion. The Board is not bound by these recommendations.

2. After the Board receives a recommendation from each inspector and evaluator, the Board will make the final determination whether the facility and/or the dentist has passed or failed the inspection and/or the evaluation and will provide prompt notice in writing of the final determination to the dentist and/or facility that is the subject of the inspection and evaluation.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000)

NAC 631.2235 Inspections and evaluations: Failure to pass; requests for reinspections and/or reevaluations. (NRS 631.190, 631.265)

1. A facility that the Board determines has failed the inspection and/or a dentist the Board determines has failed the evaluation is not entitled to have a site and/or

administrator permit issued or renewed.

2. Prior to a final determination by the Board, the Executive Director may immediately suspend the site and/or administrator permits if all of the inspectors of a facility or evaluators of a dentist have recommended a fail, or in the event a unanimous recommendation is not received, Chairperson of the Anesthesia Committee recommends temporary suspension.

3. The Executive Director shall promptly notify the facility and dentist of a temporary suspension in writing.

4. A facility or dentist who has received a written notice of failure from the Board or notice of temporary suspension from the Executive Director may, within 15 days after the date of the notice, forward to the Executive Director a request in writing for a reinspection of the facility and/or a reevaluation of the dentist along with the payment of the applicable fee.

5. Upon a timely request for reinspection and/or reevaluation and payment of the applicable fees, the reinspection and/or reevaluation will be conducted by different persons in the manner set forth by NAC 631.2219 to 631.2233, inclusive, for an original inspection and/or evaluation.

6. No facility and/or dentist who has received a notice of failing an inspection or evaluation from the Board may request more than one reinspection and/or reevaluation within a 12 month period.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000)

NAC 631.2237 Procedures required before administration of anesthetic or sedation. (NRS 631.190, 631.265)

1. Written consent of the patient must be obtained before the administration of a general anesthetic, deep sedation or conscious sedation, unless the dentist determines that an emergency situation exists in which delaying the procedure to obtain the consent would likely cause permanent injury to the patient. If the patient is a minor, the consent must be obtained from his parent or legal guardian.

2. A medical history must be taken before the administration of a general anesthetic, deep sedation or conscious sedation. A patient should be asked to describe any current medical conditions or treatments, including, without limitation, medications, drug allergies, impending or past operations and pregnancy, and to give other information that may be helpful to the person administering the anesthetic or sedation. The dentist is not required to make a complete medical examination of the patient and draw medical diagnostic

conclusions. If a dentist suspects a medical problem and calls in a physician for an examination and evaluation, he may then rely upon that conclusion and diagnosis. Questions asked of and answers received from the patient must be permanently recorded and signed by the patient before the administration of any general anesthetic, deep sedation or conscious sedation, and this record must be a permanent part of the patient's record of treatment.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000)

NAC 631.2239 Properly equipped facility required; qualifications of auxiliary personnel. (NRS 631.190, 631.265)

1. A dentist using general anesthesia, deep sedation or conscious sedation shall maintain a properly equipped facility for the administration of the anesthesia or sedation which is staffed with supervised auxiliary personnel who are capable of reasonably handling procedures, problems and emergencies incident thereto.

2. A dentist using general anesthesia, deep sedation or conscious sedation shall ensure that his auxiliary personnel are certified in basic cardiopulmonary resuscitation by the American Heart Association.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000)

NAC 631.224 Employment of certified registered nurse anesthetist. (NRS 631.190, 631.265)

1. Any dentist who holds a general anesthesia permit pursuant to the provisions of NAC 631.2211 to 631.2256, inclusive, may employ a certified registered nurse anesthetist to administer the general anesthesia, deep sedation or conscious sedation to a patient if the dentist is physically present and directly supervises the administration of the general anesthesia, deep sedation or conscious sedation to the patient. The holder of the permit must maintain at his office evidence in writing that the certified registered nurse anesthetist is licensed to practice in the State of Nevada and maintains unrestricted active staff privileges within the department of anesthesiology at a hospital or surgical center which is certified by the Joint Commission.

2. Except as otherwise provided in NAC 631.2236, a dentist who does not hold a general anesthesia permit may not allow any person to administer general anesthesia, deep sedation or conscious sedation to his patients unless the treatment is rendered within a facility approved by the Joint Commission.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-7-85; A by R005-99, 9-7-2000)

NAC 631.2241 Report of injuries to patients. (NRS 631.190, 631.265) Each holder of a general anesthesia permit, conscious sedation permit or certificate of site approval shall submit to the Board a complete report regarding any mortality or unusual incident which

occurs outside a facility accredited by the Joint Commission and produces permanent injury to a patient or requires the hospitalization of a patient, as a direct result of the administration of general anesthesia, deep sedation or conscious sedation. The report must be submitted within 30 days after the date of the incident. If a dentist fails to report any incident as required by this section, his permit may be revoked.

(Added to NAC by Bd. of Dental Exam'rs, eff. 10-21-83; A by R005-99, 9-7-2000)

NAC 631.2256 Continuing education required. (NRS 631.190, 631.265, 631.342) Every 2 years, the holder of a general anesthesia permit or conscious sedation permit must complete at least 3 hours in courses of study that specifically relate to anesthesia or sedation, as applicable, before his permit may be renewed. This training will be credited toward any continuing education required by NAC 631.173.

(Added to NAC by Bd. of Dental Exam'rs, eff. 11-28-90; A by R005-99, 9-7-2000)

**OUTLINE OF REGULATIONS PERTAINING TO
ADMINISTRATION OF GENERAL ANESTHESIA, CONSCIOUS
SEDATION OR DEEP SEDATION**

SECTION	EXPLANATION
631.002	Definition of "Certificate of Site Approval" [Revised]
631.0056	Definition of "facility" [New]
631.0071	Definition of "inspection" [New]
631.2211	Scope of Administration of General Anesthesia, conscious sedation or deep sedation regulations [No revisions]
631.2212	Board to determine degree of sedation [No revisions]
631.2213	Administrator Permit Required; qualifications of applicants; evaluations [Revised]
631.2214	Temporary administrator permits [New]
631.2215	Administrator permits: renewal [New - Combination of 631.2217 and 2219]
631.2216	Site permit required: facilities [New]
631.2217	Deleted
631.2219	Deleted
631.2221	Inspection and evaluation: participation of members of Board [Revised]
631.2223	Evaluations: General Requirements [Revised]
631.2225	Evaluations: Simulated Emergencies [Revised]
631.2226	Inspections: General [New]
631.2227	Inspections: Physical facilities and equipment [Revised]
631.2229	Inspection and evaluation: Records of patients [Revised]
631.2231	Inspections: Emergency drugs [Revised]

631.2233	Inspections and evaluations: Recommendations of inspectors and evaluators; decision of Board [Revised]
631.2235	Inspections and evaluations: Failure to pass; requests for reinspections and/or reevaluations [Revised]
631.2236	Re-numbered as NAC 631.2216.
631.2237	Procedures required before administration of anesthetic or sedation [Revised]
631.2239	Properly equipped facility required; qualifications of auxiliary personnel. [Revised]
631.224	Employment of certified registered nurse anesthetist. [No revisions]
631.2241	Report of injuries to patients [Revised]
631.2254	Temporary Permits [Revised into NAC 631.2214]]
631.2256	Continuing education required. [No revisions]

COMMENTARY

Airway, Airway, Airway

The protection mantra in the dental surgery suite

The following is a modified, abridged version of an article originally published in the Nevada Dental Association Quarterly Journal (Fall 2007;9:4-6). Reprinted with permission from the Nevada Dental Association.

After recently receiving a certified overnight envelope from an attorney, I was reminded of my "most important slides" in lectures I had given to the American Dental Society of Anesthesiology and at the University of Nevada, Las Vegas School of Dental Medicine. The attorney who sent the missive wanted to know if negligence is involved when a patient ingests an endodontic file during treatment. The records he provided were sparse, but the bottom line was that a patient swallowed a file during endodontic therapy. The file passed through the gastrointestinal system over the course of a week or two, as documented by serial abdominal flat plates; a legal claim was being considered.

Absent further investigation my preliminary opinion was, first, that dentists have a duty to act reasonably in preventing foreign bodies from being inadvertently ingested or aspirated during treatment. Second, if reasonable airway protection measures are used, that is, direct supervision by the dentist, rubber dam, gauze pharyngeal screens, absorbent triangles etc., then there is likely no negligence. Third, however, if no airway protection measures are taken, negligence may be present. The chart did not indicate if any airway protection was used.

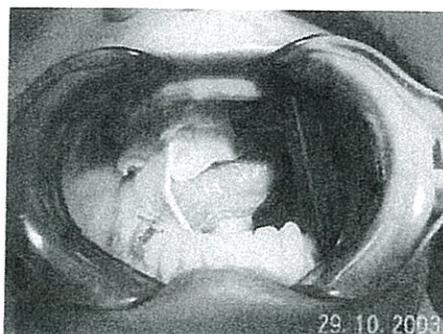


Figure 1. Protection of the airway for a mandibular procedure, such as removal of teeth.

During my residency training in anesthesiology and oral and maxillofacial surgery (OMS) at Los Angeles County/University of Southern California Medical Center in the late 1970s, I was contacted by the Hygienic Company, which had been referred to me by a fellow OMS who had heard a talk I had given on aspirated foreign bodies. The Hygienic Company was subsequently provided with a chest radiograph that showed an aspirated endodontic file. The company used the chest x-ray in a rubber dam advertisement titled "Practice Protection."

My "most important slides" show a patient and the airway protection I typically place for mandibular procedures, such as removal of teeth (Figure 1). The protection includes a 3×3- or 4×4-inch gauze pharyngeal screen, a mouth prop and an absorbent triangle placed between the lingual surface of the posterior teeth and the tongue. With regard to mouth props, I usually place a child-size (not "infant"-size) prop even in adults, unless the patient's range of motion is greater than average (i.e., perhaps 40 mm) or unless one or both posterior arches are edentulous. When completing procedures in the maxillary arch, such as tooth removal, I usually do not use a mouth prop or triangle but place only gauze. I use the same protocol after anesthetic administration—no matter if the patient is being treated via general, sedation or local anesthesia—and whenever I place instruments, fluids or other foreign bodies intraorally.

Endodontic files do not really show up that well on abdominal or chest radiographs, so included here is a chest x-ray showing a prosthetically treated molar in the right main stem just off the midline (Figure 2).

Although sedation and general anesthesia administered by appropriately trained dentists have extremely

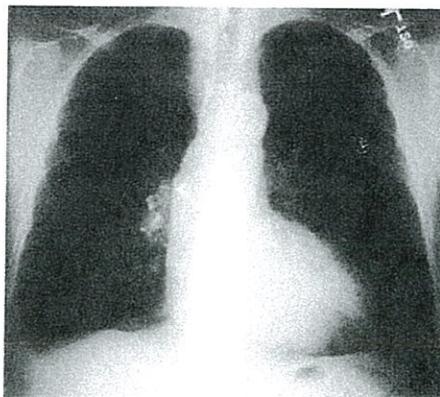
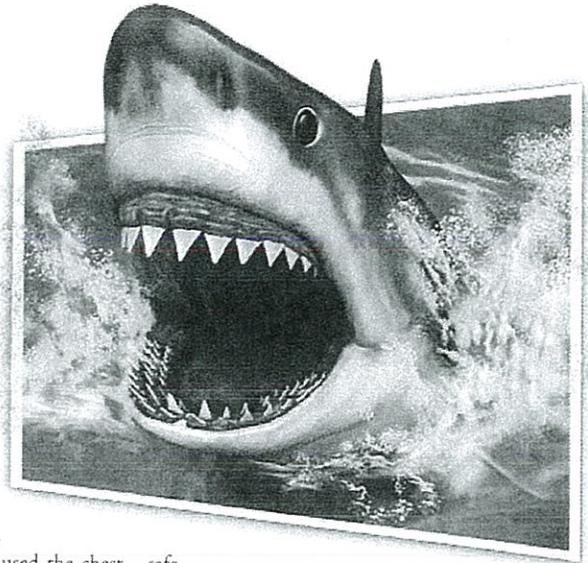


Figure 2. Chest x-ray of prosthetically treated molar in the right main stem just off the midline.



safe

records, the national dental community has been apprised of several pediatric deaths. It seems the common denominator in these cases is almost always airway compromise. Furthermore, papoose boards also often are involved. Although papoose boards are recognized as a valuable aid when used appropriately, their utilization requires even more vigilance as far as airway protection is concerned. The reason for this is that a significant part of a patient's own reflexive protective airway response is compromised by the use of this device.

Think of the last time a bit of food or drink inadvertently tickled your epiglottis, perhaps at a restaurant. One's reflexive response to this insult involves an animated reaction from the muscles of mastication as they try to correct the nonoptimal passage of the food bolus. But more than the medial and lateral pterygoids, masseters and temporalis are involved in mastication. Recall how a shark eats by propelling itself forward, throwing its head back, then striking, biting and aggressively activating whatever muscles are necessary to separate the morsel from its donor.

Similarly, choking individuals respond by using much more than the muscles that insert on the mandible directly. The muscles of the neck, respiration and beyond are recruited as the choker contorts in any way possible to get the foreign body out and clear the airway. The responses of feeding sharks and choking humans are explosive, intense and impressive, as survival is dependent on these reactions. Patients who are secured on a papoose board are not able to use these auxiliary muscles of mastication and airway protection. Thus, additional vigilance is required on the part of the dentist with regard to foreign bodies or materials, fluids, fatigued assistants leaning on a patient's chest or any other situation that may compromise the restrained patient's airway.

We'll end by informally relating a case report, with the permission of a local OMS. For years, this surgeon used airway protection when administering sedation or general anesthesia, but often deferred when using local anesthesia only. In the case discussed here, a patient needed a mandibular bridge sectioned in order to remove the molar abutment and pontic, while retaining the anterior premolar abutment. Local anesthetic was administered, the bridge was

see *dental* page 116

PRN**DENTAL** CONTINUED FROM PAGE 14

sectioned, and guess what happened when the molar and abutment were being removed? Nothing at all happened; the tooth and abutment were successfully delivered.

However, the patient then mentioned that the pre-molar crown was a little rough. The OMS offered to smooth it off. While smoothing off the irregularity, the crown rattled loose and disappeared down the throat. There was no clinical evidence of coughing or

distress of any type from the patient. Appropriately, the patient was informed that the crown's location was in question and advised that he obtain a diagnostic radiograph.

At the hospital later that day, the crown was seen to be in the right main stem bronchus. The patient was lined up for thoracoscopy and crown removal. To make a long story short, the thoracoscopy failed and the patient had to undergo a partial pneumonectomy to remove the crown. Kind of a bad day all around.

The surgeon involved is second to none as an

individual and as a surgeon. This OMS also is teachable and a quick learner, and if asked about airway protection now, the OMS advises others that when the mail is dropped off at the office, the letter carrier gets a throat pack.

Keep those airways protected.

—Daniel L. Orr, II, DDS, PhD, JD, MD

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Guideline for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures

Developed and Endorsed by

American Academy of Pediatrics and the American Academy of Pediatric Dentistry

Adopted

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Abstract

The safe sedation of children for procedures requires a systematic approach that includes the following: no administration of sedating medication without the safety net of medical supervision, careful pre-sedation evaluation for underlying medical or surgical conditions that would place the child at increased risk from sedating medications, appropriate fasting for elective procedures and a balance between depth of sedation and risk for those who are unable to fast because of the urgent nature of the procedure, a focused airway examination for large tonsils or anatomic airway abnormalities that might increase the potential for airway obstruction, a clear understanding of the pharmacokinetic and pharmacodynamic effects of the medications used for sedation as well as an appreciation for drug interactions, appropriate training and skills in airway management to allow rescue of the patient, age- and size-appropriate equipment for airway management and venous access, appropriate medications and reversal agents, sufficient numbers of people to both carry out the procedure and monitor the patient, appropriate physiologic monitoring during and after the procedure, a properly equipped and staffed recovery area, recovery to pre-sedation level of consciousness before discharge from medical supervision, and appropriate discharge instructions.

Introduction

Invasive diagnostic and minor surgical procedures on pediatric patients outside the traditional operating room setting have increased in the last decade. As a consequence of this change and the increased awareness of the importance of providing analgesia and anxiolysis, the need for sedation for procedures in physician offices, dental offices, subspecialty procedure suites, imaging facilities, emergency departments, and ambulatory surgery centers also has markedly increased.¹⁻³⁷ In recognition of this need for both elective and emergency use of sedation in nontraditional settings, the American Academy of Pediatrics (AAP) and American Academy of Pediatric Dentistry (AAPD) have published a series of guidelines for the monitoring and management of pediatric patients during and after sedation for a procedure.³⁸⁻⁴² The purpose of this updated statement is to unify

the guidelines for sedation used by medical and dental practitioners, add clarifications regarding monitoring modalities, provide new information from medical and dental literature, and suggest methods for further improvement in safety and outcomes. With the revision of this document, the Joint Commission on Accreditation of Healthcare Organizations, the American Society of Anesthesiologists (ASA), the AAP, and the AAPD will use similar language to define sedation categories and the expected physiologic responses.⁴¹⁻⁴⁴

This revised statement reflects the current understanding of appropriate monitoring needs both during and after sedation for a procedure.^{45,51,52,21,22,26,45-53} The monitoring and care out-lined in this guideline may be exceeded at any time, based on the judgment of the responsible practitioner. Although intended to encourage high-quality patient care, adherence to this guideline cannot guarantee a specific patient outcome. However, structured sedation protocols designed to incorporate the principles in this document have been widely implemented and shown to reduce morbidity.^{29,33-34,37,54,55} This guideline is proffered with the awareness that, regardless of the intended level of sedation or route of administration, the sedation of a pediatric patient represents a continuum and may result in respiratory depression and the loss of the patient's protective reflexes.^{46,57-60}

Sedation of pediatric patients has serious associated risks, such as hypoventilation, apnea, airway obstruction, laryngospasm, and cardiopulmonary impairment.^{2,6,22,45,46,54,60-69} These adverse responses during and after sedation for a diagnostic or therapeutic procedure may be minimized, but not completely eliminated, by a careful preprocedure review of the patient's underlying medical conditions and consideration of how the sedation process might affect or be affected by these conditions.³⁴ Appropriate drug selection for the intended procedure as well as the presence of an individual with the skills needed to rescue a patient from an adverse response are essential. Appropriate physiologic monitoring and continuous observation by personnel not directly involved with the procedure allow for accurate and rapid diagnosis of complications and initiation of appropriate rescue interventions.^{46,51,54}

The sedation of children is different from the sedation of adults. Sedation in children often is administered to control behavior to allow the safe completion of a procedure. A child's ability to control his or her own behavior to cooperate for a procedure depends both on his or her chronologic and developmental age. Often, children younger than 6 years and those with developmental delay require deep levels of sedation to gain control of their behavior.⁵⁷ Therefore, the need for deep sedation should be anticipated. Children in this age group are particularly vulnerable to the sedating medication's effects on respiratory drive, patency of the airway, and protective reflexes.⁴⁶ Studies have shown that it is common for children to pass from the intended level of sedation to a deeper, unintended level of sedation.^{36,59,70} For older and cooperative children, other modalities, such as parental presence, hypnosis, distraction, topical local anesthetics, and guided imagery, may reduce the need for or the needed depth of pharmacologic sedation.^{31,71-81}

The concept of rescue is essential to safe sedation. Practitioners of sedation must have the skills to rescue the patient from a deeper level than that intended for the procedure. For example, if the intended level of sedation is "minimal," practitioners must be able to rescue from "moderate sedation"; if the intended level of sedation is "moderate," practitioners must have the skills to rescue from "deep sedation"; if the intended level of sedation is "deep," practitioners must have the skills to rescue from a state of "general anesthesia." The ability to rescue means that practitioners must be able to recognize the various levels of sedation and have the skills necessary to provide appropriate cardiopulmonary support if needed. Sedation and anesthesia in a nonhospital environment (private physician or dental office or freestanding imaging facility) may be associated with an increased incidence of "failure to rescue" the patient should an adverse event occur, because the only backup in this venue may be to activate emergency medical services (EMS).^{46,62} Rescue therapies require specific training and skills.^{45,54,83,84} Maintenance of the skills needed to perform successful bag-valve-mask ventilation is essential to successfully rescue a child who has become apneic or developed airway obstruction. Familiarity with emergency airway management procedure algorithms is essential.⁸³⁻⁸⁷ Practitioners should have an in-depth knowledge of the agents they intend to use and their potential complications. A number of reviews and handbooks for sedating pediatric patients are available.^{32,48,53,88-93} This guideline is intended for all venues in which sedation for a procedure might be performed (hospital, surgical center, freestanding imaging facility, dental facility, or private office).

There are other guidelines for specific situations and personnel that are beyond the scope of this document. Specifically, guidelines for the delivery of general anesthesia and monitored anesthesia care (sedation or analgesia), outside or within the operating room by anesthesiologists or other practitioners functioning within a department of anesthesiology, are addressed by policies developed by the ASA and by individual departments of anesthesiology.⁹⁴ Also, guidelines for the sedation

of patients undergoing mechanical ventilation in a critical care environment or for providing analgesia for patients postoperatively, patients with chronic painful conditions, and hospice care are beyond the scope of this document.

Definitions of Terms for This Report

- "Pediatric patients": all patients through 21 years of age, as defined by the AAP.
- "Must" or "shall": an imperative need or duty that is essential, indispensable, or mandatory.
- "Should": the recommended need and/or duty.
- "May" or "could": freedom or liberty to follow a suggested or reasonable alternative.
- "Medical supervision" or "medical personnel": a current, licensed practitioner in medicine, surgery, or dentistry trained in the administration of medications used for procedural sedation and the management of complications associated with these medications.
- "Are encouraged": a suggested or reasonable action to be taken.
- "ASA Physical Status Classification": guidelines for classifying the baseline health status according to the ASA (see Appendix B).
- "Minimal sedation" (old terminology "anxiolysis"): a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.
- "Moderate sedation" (old terminology "conscious sedation" or "sedation/analgesia"): a drug-induced depression of consciousness during which patients respond purposefully to verbal commands (eg, "open your eyes" either alone or accompanied by light tactile stimulation—a light tap on the shoulder or face, not a sternal rub). For older patients, this level of sedation implies an interactive state; for younger patients, age-appropriate behaviors (eg, crying) occur and are expected. Reflex withdrawal, although a normal response to a painful stimulus, is not considered as the only age-appropriate purposeful response (eg, it must be accompanied by another response, such as pushing away the painful stimulus so as to confirm a higher cognitive function). With moderate sedation, no intervention is required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. However, in the case of procedures that may themselves cause airway obstruction (eg, dental or endoscopic), the practitioner must recognize an obstruction and assist the patient in opening the airway. If the patient is not making spontaneous efforts to open his/her airway so as to relieve the obstruction, then the patient should be considered to be deeply sedated.
- "Deep sedation" ("deep sedation/analgesia"): a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully (see discussion of reflex withdrawal above) after repeated verbal or painful stimulation (eg, purposefully pushing away the noxious stimuli). The

ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. A state of deep sedation may be accompanied by partial or complete loss of protective airway reflexes.

• “General anesthesia”: a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive-pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Goals of Sedation

The goals of sedation in the pediatric patient for diagnostic and therapeutic procedures are: 1) to guard the patient's safety and welfare; 2) to minimize physical discomfort and pain; 3) to control anxiety, minimize psychological trauma, and maximize the potential for amnesia; 4) to control behavior and/or movement so as to allow the safe completion of the procedure; and 5) to return the patient to a state in which safe discharge from medical supervision, as determined by recognized criteria, is possible (Appendix A).

These goals can best be achieved by selecting the lowest dose of drug with the highest therapeutic index for the procedure. It is beyond the scope of this document to specify which drugs are appropriate for which procedures; however, the selection of the fewest number of drugs and matching drug selection to the type and goal of the procedure are essential for safe practice.^{33,88,91-93,95-97} For example, analgesic medications such as opioids are indicated for painful procedures. For nonpainful procedures, such as computed tomography or magnetic resonance imaging (MRI), sedatives/hypnotics are preferred. When both sedation and analgesia are desirable (eg, fracture reduction), either single agents with analgesic/sedative properties or combination regimens commonly are used. Anxiolysis and amnesia are additional goals that should be considered in selection of agents for particular patients. However, the potential for an adverse outcome may be increased when 3 or more sedating medications are administered.^{98,99} Knowledge of each drug's time of onset, peak response, and duration of action is essential. Although the concept of titration of drug to effect is critical, one must know whether the previous dose has taken full effect before administering additional drug. Such management will improve safety and outcomes. Drugs with long durations of action (eg, chloral hydrate, intramuscular pentobarbital, phenothiazines) will require longer periods of observation even after the child achieves currently used recovery and discharge criteria.^{45,99,100} This concept is particularly important for infants and toddlers transported in car safety seats who are at risk of resedation after discharge because of residual prolonged drug effects with the potential for airway obstruction.^{45,46}

General Guidelines

Candidates

Patients who are in ASA classes I and II are frequently considered appropriate candidates for minimal, moderate, or deep sedation (Appendix B). Children in ASA classes III and IV, children with special needs, and those with anatomic airway abnormalities or extreme tonsillar hypertrophy present issues that require additional and individual consideration, particularly for moderate and deep sedation.⁵¹ Practitioners are encouraged to consult with appropriate subspecialists and/or an anesthesiologist for patients at increased risk of experiencing adverse sedation events because of their underlying medical/surgical conditions.

Responsible Person

The pediatric patient shall be accompanied to and from the treatment facility by a parent, legal guardian, or other responsible person. It is preferable to have 2 or more adults accompany children who are still in car safety seats if transportation to and from a treatment facility is provided by 1 of the adults.¹⁰¹

Facilities

The practitioner who uses sedation must have immediately available facilities, personnel, and equipment to manage emergency and rescue situations. The most common serious complications of sedation involve compromise of the airway or depressed respirations resulting in airway obstruction, hypoventilation, hypoxemia, and apnea. Hypotension and cardiopulmonary arrest may occur, usually from inadequate recognition and treatment of respiratory compromise. Other rare complications may also include seizures and allergic reactions. Facilities providing pediatric sedation should monitor for, and be prepared to treat, such complications.

Back-up Emergency Services

A protocol for access to back-up emergency services shall be clearly identified, with an outline of the procedures necessary for immediate use. For nonhospital facilities, a protocol for ready access to ambulance service and immediate activation of the EMS system for life-threatening complications must be established and maintained. It should be understood that the availability of EMS services does not replace the practitioner's responsibility to provide initial rescue in managing life-threatening complications.

On-Site Monitoring and Rescue Equipment

An emergency cart or kit must be immediately accessible. This cart or kit must contain equipment to provide the necessary age- and size-appropriate drugs and equipment to resuscitate a nonbreathing and unconscious child. The contents of the kit must allow for the provision of continuous life support while the patient is being transported to a medical facility or to another area within a medical facility. All equipment and drugs must be checked and maintained on a scheduled basis (see Appendices C and D for suggested drugs and emergency life support equipment to consider before the need for rescue

occurs). Monitoring devices, such as electrocardiography (ECG) machines, pulse oximeters (with size-appropriate oximeter probes), end-tidal carbon dioxide monitors, and defibrillators (with size-appropriate defibrillator paddles), must have a safety and function check on a regular basis as required by local or state regulation.

Documentation Before Sedation

Documentation shall include, but not be limited to, the guidelines that follow:

1. Informed consent. The patient record shall document that appropriate informed consent was obtained according to local, state, and institutional requirements.¹⁰²
2. Instructions and information provided to the responsible person. The practitioner shall provide verbal and/or written instructions to the responsible person. Information shall include objectives of the sedation and anticipated changes in behavior during and after sedation. Special instructions shall be given to the adult responsible for infants and toddlers who will be transported home in a car safety seat regarding the need to carefully observe the child's head position so as to avoid airway obstruction. Transportation by car safety seat poses a particular risk for infants who have received medications known to have a long half-life, such as chloral hydrate, intramuscular pentobarbital, or phenothiazine.^{45,46,100,103} Consideration for a longer period of observation shall be given if the responsible person's ability to observe the child is limited (eg, only 1 adult who also has to drive). Another indication for prolonged observation would be a child with an anatomic airway problem or a severe underlying medical condition. A 24-hour telephone number for the practitioner or his or her associates shall be provided to all patients and their families. Instructions shall include limitations of activities and appropriate dietary precautions.

Dietary Precautions

Agents used for sedation have the potential to impair protective airway reflexes, particularly during deep sedation. Although a rare occurrence, pulmonary aspiration may occur if the child regurgitates and cannot protect his or her airway. Therefore, it is prudent that before sedation, the practitioner evaluate preceding food and fluid intake. It is likely that the risk of aspiration during procedural sedation differs from that during general anesthesia involving tracheal intubation or other airway manipulation.^{104,105} However, because the absolute risk of aspiration during procedural sedation is not yet known, guidelines for fasting periods before elective sedation generally should follow those used for elective general anesthesia. For emergency procedures in children who have not fasted, the risks of sedation and the possibility of aspiration must be balanced against the benefits of performing the procedure promptly (see below). Further research is needed to better elucidate the relationships between various fasting intervals and sedation complications.

Before Elective Sedation

Children receiving sedation for elective procedures should generally follow the same fasting guidelines as before general anesthesia (Table 1). It is permissible for routine necessary medications to be taken with a sip of water on the day of the procedure.

For the Emergency Patient

The practitioner must always balance the possible risks of sedating nonfasted patients with the benefits and necessity for completing the procedure. In this circumstance, the use of sedation must be preceded by an evaluation of food and fluid intake. There are few published studies with adequate statistical power to provide guidance to the practitioner regarding safety or risk of pulmonary aspiration of gastric contents during procedural sedation.^{104,109} When protective airway reflexes are lost, gastric contents may be regurgitated into the airway. Therefore, patients with a history of recent oral intake or with other known risk factors, such as trauma, decreased level of consciousness, extreme obesity, pregnancy, or bowel motility dysfunction, require careful evaluation before administration of sedatives. When proper fasting has not been ensured, the increased risks of sedation must be carefully weighed against its benefits, and the lightest effective sedation should be used. The use of agents with less risk of depressing protective airway reflexes may be preferred.¹¹⁰ Some emergency patients requiring deep sedation may require protection of the airway before sedation.

Use of Immobilization Devices

Immobilization devices, such as papoose boards, must be applied in such a way as to avoid airway obstruction or chest restriction. The child's head position and respiratory excursions should be checked frequently to ensure airway patency. If an immobilization device is used, a hand or foot should be kept exposed, and the child should never be left unattended. If sedating medications are administered in conjunction with an immobilization device, monitoring must be used at a level consistent with the level of sedation achieved.

Documentation at the Time of Sedation

1. Health evaluation. Before sedation, a health evaluation shall be performed by an appropriately-licensed practitioner and reviewed by the sedation team at the time of treatment for possible interval changes. The purpose of this evaluation is not only to document baseline status but also to determine whether patients present specific risk factors that may warrant additional consultation before sedation. This evaluation will also screen out patients whose sedation will require more advanced airway or cardiovascular management skills or alterations in the doses or types of medications used for procedural sedation.

A new concern for the practitioner is the widespread use of medications that may interfere with drug absorption or metabolism and, therefore, enhance or shorten the effect time of sedating medications. Herbal medicines (eg, St. John's

wort, echinacea) may alter drug pharmacokinetics through inhibition of the cytochrome P450 system, resulting in prolonged drug effect and altered (increased or decreased) blood drug concentrations.¹¹¹⁻¹¹⁶ Kava may increase the effects of sedatives by potentiating gamma-aminobutyric acid inhibitory neurotransmission, and valerian may itself produce sedation that apparently is mediated through modulation of gamma-aminobutyric acid neurotransmission and receptor function.^{117,118} Drugs such as erythromycin, cimetidine, and others also may inhibit the cytochrome P450 system, resulting in prolonged sedation with midazolam as well as other medications competing for the same enzyme systems.¹¹⁹⁻¹²² Medications used to treat human immunodeficiency virus infection, some anticonvulsants, and some psychotropic medications also may produce clinically important drug-drug interactions.¹²³⁻¹²⁵ Therefore, a careful drug history is a vital part of the safe sedation of children. The clinician should consult various sources (a pharmacist, textbooks, online services, or handheld databases) for specific information on drug interactions.¹²⁶

The health evaluation should include:

- Age and weight
- Health history, including: 1) allergies and previous allergic or adverse drug reactions; 2) medication/drug history, including dosage, time, route, and site of administration for prescription, over-the-counter, herbal, or illicit drugs; 3) relevant diseases, physical abnormalities, and neurologic impairment that might increase the potential for airway obstruction, such as a history of snoring or obstructive sleep apnea;^{127,128} 4) pregnancy status; 5) a summary of previous relevant hospitalizations; 6) history of sedation or general anesthesia and any complications or unexpected responses; and 7) relevant family history, particularly related to anesthesia
- Review of systems with a special focus on abnormalities of cardiac, pulmonary, renal, or hepatic function that might alter the child's expected responses to sedating/analgesic medications
- Vital signs, including heart rate, blood pressure, respiratory rate, and temperature (for some children who are very upset or noncooperative, this may not be possible and a note should be written to document this occurrence)
- Physical examination, including a focused evaluation of the airway (tonsillar hypertrophy, abnormal anatomy—eg, mandibular hypoplasia) to determine whether there is an increased risk of airway obstruction^{124,129,130}
- Physical status evaluation (ASA classification [see Appendix B])
- Name, address, and telephone number of the child's medical home

For hospitalized patients, the current hospital record may suffice for adequate documentation of presedation health;

however, a brief note shall be written documenting that the chart was reviewed, positive findings were noted, and a management plan was formulated. If the clinical or emergency condition of the patient precludes acquiring complete information before sedation, this health evaluation should be obtained as soon as feasible.

2. Prescriptions. When prescriptions are used for sedation, a copy of the prescription or a note describing the content of the prescription should be in the patient's chart along with a description of the instructions that were given to the responsible person. **Prescription medications intended to accomplish procedural sedation must not be administered without the benefit of direct supervision by trained medical personnel.** Administration of sedating medications at home poses an unacceptable risk, particularly for infants and preschool-aged children traveling in car safety seats.⁴⁶

Documentation During Treatment

The patient's chart shall contain a time-based record that includes the name, route, site, time, dosage, and patient effect of administered drugs. Before sedation, a "time out" should be performed to confirm the patient's name, procedure to be performed, and site of the procedure.⁴³ During administration, the inspired concentrations of oxygen and inhalation sedation agents and the duration of their administration shall be documented. Before drug administrations, special attention must be paid to calculation of dosage (ie, mg/kg). The patient's chart shall contain documentation at the time of treatment that the patient's level of consciousness and responsiveness, heart rate, blood pressure, respiratory rate, and oxygen saturation were monitored until the patient attained predetermined discharge criteria (see Appendix A). A variety of sedation scoring systems are available and may aid this process.^{76,109} Adverse events and their treatment shall be documented.

Documentation After Treatment

The time and condition of the child at discharge from the treatment area or facility shall be documented; this should include documentation that the child's level of consciousness and oxygen saturation in room air have returned to a state that is safe for discharge by recognized criteria (see Appendix A). Patients receiving supplemental oxygen before the procedure should have a similar oxygen need after the procedure. Because some sedation medications are known to have a long half-life and may delay a patient's complete return to baseline or pose the risk of re sedation,^{45,103,131,132} some patients might benefit from a longer period of less-intense observation (eg, a step-down observation area) before discharge from medical supervision.¹³³ Several scales to evaluate recovery have been devised and validated.^{76,134,135} A recently described and simple evaluation tool may be the ability of the infant or child to remain awake for at least 20 minutes when placed in a quiet environment.¹⁰⁰

Continuous Quality Improvement

The essence of medical error reduction is a careful examination of index events and root cause analysis of how the event could be avoided in the future.¹³⁷⁻¹⁴¹ Therefore, each facility should maintain records that track adverse events, such as desaturation, apnea, laryngospasm, the need for airway interventions including jaw thrust, positive pressure ventilation, prolonged sedation, unanticipated use of reversal agents, unintended or prolonged hospital admission, and unsatisfactory sedation/analgesia/anoxiolysis. Such events can then be examined for assessment of risk reduction and improvement in patient satisfaction.

Preparation and Setting up for Sedation Procedures

Part of the safety net of sedation is to use a systematic approach so as to not overlook having an important drug, piece of equipment, or monitor immediately available at the time of a developing emergency. To avoid this problem, it is helpful to use an acronym that allows the same setup and checklist for every procedure. A commonly used acronym useful in planning and preparation for a procedure is SOAPME:

- S = Size-appropriate suction catheters and a functioning suction apparatus (eg, Yankauer-type suction)
- O = An adequate oxygen supply and functioning flow meters/other devices to allow its delivery
- A = Airway: size-appropriate airway equipment (nasopharyngeal and oropharyngeal airways, laryngoscope blades [checked and functioning], endotracheal tubes, stylets, face mask, bag-valve-mask or equivalent device [functioning])
- P = Pharmacy: all the basic drugs needed to support life during an emergency, including antagonists as indicated
- M = Monitors: functioning pulse oximeter with size-appropriate oximeter probes^{141,142} and other monitors as appropriate for the procedure (eg, noninvasive blood pressure, end-tidal carbon dioxide, ECG, stethoscope)
- E = Special equipment or drugs for a particular case (eg, defibrillator)

Specific Guidelines for Intended Level of Sedation

Minimal Sedation

Minimal sedation (old terminology "anoxiolysis") is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Children who have received minimal sedation generally will not require more than observation and intermittent assessment of their level of sedation. Some children will become moderately sedated despite the intended level of minimal sedation; should this occur, then the guidelines for moderate sedation apply.³⁷

Moderate Sedation

"Moderate sedation" (old terminology "conscious sedation" or "sedation/analgesia") is a drug-induced depression of consciousness during which patients respond purposefully to verbal

commands or following light tactile stimulation (see Definition of Terms for This Report). No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function usually is maintained. The caveat that loss of consciousness should be unlikely is a particularly important aspect of the definition of moderate sedation. The drugs and techniques used should carry a margin of safety wide enough to render unintended loss of consciousness highly unlikely. Because the patient who receives moderate sedation may progress into a state of deep sedation and obtundation, the practitioner should be prepared to increase the level of vigilance corresponding to what is necessary for deep sedation.⁵⁷

Personnel

The Practitioner

The practitioner responsible for the treatment of the patient and/or the administration of drugs for sedation must be competent to use such techniques, to provide the level of monitoring provided in this guideline, and to manage complications of these techniques (ie, to be able to rescue the patient). Because the level of intended sedation may be exceeded, the practitioner must be sufficiently skilled to provide rescue should the child progress to a level of deep sedation. The practitioner must be trained in, and capable of providing, at the minimum, bag-valve-mask ventilation so as to be able to oxygenate a child who develops airway obstruction or apnea. Training in, and maintenance of, advanced pediatric airway skills is required; regular skills reinforcement is strongly encouraged.

Support Personnel

The use of moderate sedation shall include provision of a person, in addition to the practitioner, whose responsibility is to monitor appropriate physiologic parameters and to assist in any supportive or resuscitation measures, if required. This individual may also be responsible for assisting with interruptible patient-related tasks of short duration.⁴⁴ This individual must be trained in and capable of providing pediatric basic life support. The support person shall have specific assignments in the event of an emergency and current knowledge of the emergency cart inventory. The practitioner and all ancillary personnel should participate in periodic reviews and practice drills of the facility's emergency protocol to ensure proper function of the equipment and coordination of staff roles in such emergencies.

Monitoring and Documentation

Baseline

Before administration of sedative medications, a baseline determination of vital signs shall be documented. For some children who are very upset or noncooperative, this may not be possible and a note should be written to document this happenstance.

During the Procedure

The practitioner shall document the name, route, site, time of administration, and dosage of all drugs administered. There shall be continuous monitoring of oxygen saturation and heart

rate and intermittent recording of respiratory rate and blood pressure; these should be recorded in a time-based record. Restraining devices should be checked to prevent airway obstruction or chest restriction. If a restraint device is used, a hand or foot should be kept exposed. The child's head position should be checked frequently to ensure airway patency. A functioning suction apparatus must be present.

After the procedure

The child who has received moderate sedation must be observed in a suitably equipped recovery facility [eg, the facility must have functioning suction apparatus as well as the capacity to deliver more than 90% oxygen and positive-pressure ventilation (eg, bag and mask with oxygen capacity as described previously)]. The patient's vital signs should be recorded at specific intervals. If the patient is not fully alert, oxygen saturation and heart rate monitoring shall be used continuously until appropriate discharge criteria are met (see Appendix A). Because sedation medications with a long half-life may delay the patient's complete return to baseline or pose the risk of re sedation, some patients might benefit from a longer period of less-intense observation (eg, a step-down observation area where multiple patients can be observed simultaneously) before discharge from medical supervision (see also Documentation Before Sedation for instructions to families).^{45,103,131,132} A recently described and simple evaluation tool may be the ability of the infant or child to remain awake for at least 20 minutes when placed in a quiet environment.¹⁰⁰ Patients who have received reversal agents, such as flumazenil or naloxone, will also require a longer period of observation, because the duration of the drugs administered may exceed the duration of the antagonist, which can lead to re sedation.

Deep Sedation

Deep sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully after repeated verbal or painful stimulation (see Definition of Terms for this report). The state and risks of deep sedation may be indistinguishable from those of general anesthesia.

Personnel

There must be 1 person available whose only responsibility is to constantly observe the patient's vital signs, airway patency, and adequacy of ventilation and to either administer drugs or direct their administration. At least 1 individual must be present who is trained in, and capable of, providing advanced pediatric life support, and who is skilled in airway management and cardiopulmonary resuscitation; training in pediatric advanced life support is required.

Equipment

In addition to the equipment previously cited for moderate sedation, an electrocardiographic monitor and a defibrillator for use in pediatric patients should be readily available.

Vascular Access

Patients receiving deep sedation should have an intravenous line placed at the start of the procedure or have a person skilled in establishing vascular access in pediatric patients immediately available.

Monitoring and Documentation

A competent individual shall observe the patient continuously. The monitoring shall include all parameters described for moderate sedation. Vital signs, including oxygen saturation and heart rate, must be documented at least every 5 minutes in a time-based record. The use of a precordial stethoscope or capnograph for patients difficult to observe (eg, during MRI, in a darkened room) to aid in monitoring adequacy of ventilation is encouraged.¹⁴³ The practitioner shall document the name, route, site, time of administration, and dosage of all drugs administered. The inspired concentrations of inhalation sedation agents and oxygen and the duration of administration shall be documented.

Postsedation Care

The facility and procedures followed for postsedation care shall conform to those described under "Moderate Sedation."

Special Considerations

Local Anesthetic Agents

All local anesthetic agents are cardiac depressants and may cause central nervous system excitation or depression. Particular attention should be paid to dosage in small children.^{64,66} To ensure that the patient will not receive an excessive dose, the maximum allowable safe dosage (ie, mg/kg) should be calculated before administration. There may be enhanced sedative effects when the highest recommended doses of local anesthetic drugs are used in combination with other sedatives or narcotics (see Tables 2 and 3 for limits and conversion tables of commonly used local anesthetics).^{64,144,157} In general, when administering local anesthetic drugs, the practitioner should aspirate frequently so as to minimize the likelihood that the needle is in a blood vessel; lower doses should be used when injecting into vascular tissues.¹⁵⁸

Pulse Oximetry

The new generation of pulse oximeters is less susceptible to motion artifacts and may be more useful than older oximeters that do not contain the updated software.¹⁵⁹⁻¹⁶³ Oximeters that change tone with changes in hemoglobin saturation provide immediate aural warning to everyone within hearing distance. It is essential that any oximeter probe is positioned properly; clip-on devices are prone to easy displacement, which may produce artifactual data (eg, under- or overestimation of oxygen saturation).^{141,142}

Capnography

Expired carbon dioxide monitoring is valuable to diagnose the simple presence or absence of respirations, airway obstruction, or respiratory depression, particularly in patients sedated in

less-accessible locations, such as magnetic resonance imaging or computerized axial tomography devices or darkened rooms.^{42,49, 90,143,164-173} The use of expired carbon dioxide monitoring devices is encouraged for sedated children, particularly in situations where other means of assessing the adequacy of ventilation are limited. Several manufacturers have produced nasal cannulae that allow simultaneous delivery of oxygen and measurement of expired carbon dioxide values.^{164,165} Although these devices can have a high degree of false-positive alarms, they are also very accurate for the detection of complete airway obstruction or apnea.^{166,168,172}

Adjuncts to Airway Management and Resuscitation

The vast majority of sedation complications can be managed with simple maneuvers, such as supplemental oxygen, opening the airway, suctioning, and bag-mask-valve ventilation. Occasionally, endotracheal intubation is required for more prolonged ventilatory support. In addition to standard endotracheal intubation techniques, a number of new devices are available for the management of patients with abnormal airway anatomy or airway obstruction. Examples include the laryngeal mask airway (LMA), the cuffed oropharyngeal airway, and a variety of kits to perform an emergency cricothyrotomy.

The largest clinical experience in pediatrics is with the LMA, which is available in a variety of sizes and can even be used in neonates. Use of the LMA is now being introduced into advanced airway training courses, and familiarity with insertion techniques can be life saving.^{174,175} The LMA also can serve as a bridge to secure airway management in children with anatomic airway abnormalities.^{176,177} Practitioners are encouraged to gain experience with these techniques as they become incorporated into pediatric advanced life support courses.

An additional emergency device with which to become familiar is the intraosseous needle. Intraosseous needles also are available in several sizes and can be life saving in the rare situation when rapid establishment of intravenous access is not possible. Familiarity with the use of these adjuncts for the management of emergencies can be obtained by keeping current with resuscitation courses, such as Pediatric Advanced Life Support and Advanced Pediatric Life Support or other approved programs.

Patient Simulators

Advances in technology, particularly patient simulators that allow a variety of programmed adverse events (eg, apnea, bronchospasm, laryngospasm), response to medical interventions, and printouts of physiologic parameters, are now available. The use of such devices is encouraged to better train medical professionals to respond more appropriately and effectively to rare events.¹⁷⁸⁻¹⁸⁰

Monitoring During MRI

The powerful magnetic field and the generation of radiofrequency emissions necessitate the use of special equipment to provide continuous patient monitoring throughout the MRI scanning procedure. Pulse oximeters capable of continuous function during scanning should be used in any sedated or restrained pediatric patient. Thermal injuries can result if appropriate precautions are not taken; avoid coiling the oximeter wire and place the probe as far from the magnetic coil as possible to diminish the possibility of injury. Electrocardiogram monitoring during magnetic resonance imaging has been associated with thermal injury; special MRI-compatible ECG pads are essential to allow safe monitoring.¹⁸¹⁻¹⁸⁴ Expired carbon dioxide monitoring is strongly encouraged in this setting.

Nitrous Oxide

Inhalation sedation/analgesia equipment that delivers nitrous oxide must have the capacity of delivering 100% and never less than 25% oxygen concentration at a flow rate appropriate to the size of the patient. Equipment that delivers variable ratios of nitrous oxide to oxygen and that has a delivery system that covers the mouth and nose must be used in conjunction with a calibrated and functional oxygen analyzer. All nitrous oxide-to-oxygen inhalation devices should be calibrated in accordance with appropriate state and local requirements. Consideration should be given to the National Institute of Occupational Safety and Health standards for the scavenging of waste gases.¹⁸⁵ Newly constructed or reconstructed treatment facilities, especially those with piped-in nitrous oxide and oxygen, must have appropriate state or local inspections to certify proper function of inhalation sedation/analgesia systems before any delivery of patient care.

Nitrous oxide in oxygen with varying concentrations has been successfully used for many years to provide analgesia for a variety of painful procedures in children.^{15,186-210} The use of nitrous oxide for minimal sedation is defined as the administration of nitrous oxide (50% or less) with the balance as oxygen, without any other sedative, narcotic, or other depressant drug before or concurrent with the nitrous oxide to an otherwise healthy patient in ASA class I or II. The patient is able to maintain verbal communication throughout the procedure. It should be noted that although local anesthetics have sedative properties, for purposes of this guideline, they are not considered sedatives in this circumstance. If nitrous oxide in oxygen is combined with other sedating medications, such as chloral hydrate, midazolam, or an opioid, or if nitrous oxide is used in concentrations greater than 50%, the likelihood for moderate or deep sedation increases.^{211,212} In this situation, the clinician must be prepared to institute the guidelines for moderate or deep sedation as indicated by the patient's response.²¹³

Table 1. APPROPRIATE INTAKE OF FOOD AND LIQUIDS BEFORE ELECTIVE SEDATION*

Ingested Material	Minimum Fasting Period (h)
Clear liquids: water, fruit juices without pulp, carbonated beverages, clear tea, black coffee	2
Breast milk	4
Infant formula	6
Nonhuman milk: because nonhuman milk is similar to solids in gastric emptying time, the amount ingested must be considered when determining an appropriate fasting period	6
Light meal: a light meal typically consists of toast and clear liquids. Meals that include fried or fatty foods or meat may prolong gastric emptying time. Both the amount and type of foods ingested must be considered when determining an appropriate fasting period.	6

* American Society of Anesthesiologists. Practice Guidelines for Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures. A Report of the American Society of Anesthesiologists. Available at: "http://www.asahq.org/publicationsAndServices/npoguide.html".

Table 2. COMMONLY USED LOCAL ANESTHETIC AGENTS: DOSES, DURATION, AND CALCULATIONS*

Local Anesthetic	Maximum Dose with Epinephrine (mg/kg)†		Duration of Action (min) ‡
	Medical	Dental	
Esters			
Procaine	10.0	6	60-90
Chlorprocaine	20.0	12	30-60
Tetracaine	15	1	180-600
Amides			
Lidocaine	7.0	4.4	90-200
Mepivacaine	7.0	4.4	120-240
Bupivacaine	3.0	13	180-600
Levobupivacaine	3.0	2	180-600
Ropivacaine	3.0	2	180-600
Articaine		7	60-230

* Maximum recommended doses and duration of action. Note that lower doses should be used in very vascular areas.

† These are maximum doses of local anesthetics combined with epinephrine; lower doses are recommended when used without epinephrine. Doses of amides should be decreased by 30% in infants younger than 6 months. When lidocaine is being administered intravascularly (eg, during intravenous regional anesthesia), the dose should be decreased to 3 to 5 mg/kg; long-acting local anesthetic agents should not be used for intravenous regional anesthesia.

‡ Duration of action is dependent on concentration, total dose, and site of administration; use of epinephrine; and the patient's age.

Table 3. LOCAL ANESTHETIC PERCENT CONCENTRATION: CONVERSION TO mg/mL

Concentration (%)	mg/mL
3.0	30.0
2.5	25.0
2.0	20.0
1.0	10.0
0.5	5.0
0.25	2.5
0.125	1.25

Appendix A. Recommended Discharge Criteria

1. Cardiovascular function and airway patency are satisfactory and stable.
2. The patient is easily arousable, and protective reflexes are intact.
3. The patient can talk (if age appropriate).
4. The patient can sit up unaided (if age appropriate).
5. For a very young or handicapped child incapable of the usually expected responses, the pre-sedation level of responsiveness or a level as close as possible to the normal level for that child should be achieved.
6. The state of hydration is adequate.

Appendix B. ASA Physical Status Classification

- Class I A normally healthy patient.
- Class II A patient with mild systemic disease (eg, controlled reactive airway disease).
- Class III A patient with severe systemic disease (eg, a child who is actively wheezing).
- Class IV A patient with severe systemic disease that is a constant threat to life (eg, a child with status asthmaticus).
- Class V A moribund patient who is not expected to survive without the operation (eg, a patient with severe cardiomyopathy requiring heart transplantation).

Appendix C. Drugs* That May Be Needed to Rescue a Sedated Patient†‡

- Albuterol for inhalation
- Ammonia spirits
- Atropine
- Diphenhydramine
- Diazepam
- Epinephrine (1:1000, 1:10 000)
- Flumazenil
- Glucose (25% or 50%)
- Lidocaine (cardiac lidocaine, local infiltration)
- Lorazepam
- Methylprednisolone
- Naloxone
- Oxygen
- Fosphenytoin
- Racemic epinephrine
- Rocuronium
- Sodium bicarbonate
- Succinylcholine

* The choice of emergency drugs may vary according to individual or procedural needs.

Appendix D. Emergency Equipment† That May Be Needed to Rescue a Sedated Patient ‡

- Intravenous Equipment**
- Assorted IV catheters (eg, 24-, 22-, 20-, 18-, 16-gauge)
- Tourniquets
- Alcohol wipes
- Adhesive tape
- Assorted syringes (eg, 1-, 3-, 5-, 10-mL)
- IV tubing
- Pediatric drip (60 drops/mL)
- Pediatric burette
- Adult drip (10 drops/mL)
- Extension tubing
- 3-way stopcocks
- IV fluid
- Lactated Ringer solution
- Normal saline solution
- D, 0.25 normal saline solution
- Pediatric IV boards
- Assorted IV needles (eg, 25-, 22-, 20-, and 18-gauge)
- Intraosseous bone marrow needle
- Sterile gauze pads

Airway Management Equipment

- Face masks (infant, child, small adult, medium adult, large adult)
- Breathing bag and valve set
- Oropharyngeal airways (infant, child, small adult, medium adult, large adult)
- Nasopharyngeal airways (small, medium, large)
- Laryngeal mask airways (1, 1.5, 2, 2.5, 3, 4, and 5)
- Laryngoscope handles (with extra batteries)
- Laryngoscope blades (with extra light bulbs)
- Straight (Miller) No. 1, 2, and 3
- Curved (Macintosh) No. 2 and 3
- Endotracheal tubes (2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, and 6.0 uncuffed and 6.0, 7.0, and 8.0 cuffed)
- Stylettes (appropriate sizes for endotracheal tubes)
- Surgical lubricant
- Suction catheters (appropriate sizes for endotracheal tubes)
- Yankauer-type suction
- Nasogastric tubes
- Nebulizer with medication kits
- Gloves (sterile and nonsterile, latex free)

† The choice of emergency equipment may vary according to individual or procedural needs.

‡ The practitioner is referred to the SOAPME acronym described in the text in preparation for sedating a child for a procedure.

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Knowing your patients

Stanley F. Malamed, DDS
 Guest Editor

The prevention and treatment of dental disease, maintenance of masticatory function and improvement of cosmetic appearance are among the prominent goals of contemporary dentistry. Accomplishing these goals without difficulty or surprise is considered the norm. The occasional patient whose mouth is difficult to numb or who exhibits a behavioral management problem remains in the memory of many dentists. Standing out also are those rare, but inevitable, medical emergencies that may occur during the dental visit.

Medical emergencies can, and do, happen in the practice of dentistry. In a survey of 2,704 dentists throughout North America,¹ reported a total of 13,836 emergencies occurring within a 10-year period (Table 1). None of these emergencies were truly dental emergencies. They were potentially life-threatening medical problems that patients developed while they were in a dental office.

This supplement to *The Journal of the American Dental Association* is designed to aid the dentist and staff members in preventing, preparing for, recognizing and effectively managing such emergencies.

The other articles in this supplement explore important topics that aid the dentist in equipping the office and in preparing office staff members to quickly and efficiently manage medical emergencies. Dr. Daniel Haas² stresses the importance of preparing dental office staff members by developing a basic action plan. Another element of preparation—emergency drugs and equipment—is addressed by Dr. Morton Rosenberg.³ Dr. Kenneth Reed⁴ focuses on the basic management of medical emergencies and recognizing a patient's distress.

More gratifying than treating emergencies, however, is preventing them. Three-quarters of all of the medical emergencies reported in my survey potentially developed as sequelae of pain (for example, inadequate local anesthesia), the dentist's failure to recognize and treat a patient's fear of dental care, or both (Table 1¹). Some medical emergencies that develop during dental care are unrelated to these two factors, such as allergy, postural hypotension and local anesthetic overdose (toxicity).

Preventing medical emergencies permits the dentist to carry out the planned dental treatment

in an optimal environment. Therefore, dentists must obtain as much information as possible about their patients' medical status before starting any dental treatment.

COMPONENTS OF PHYSICAL EVALUATION

Four steps constitute the basic physical evaluation of potential dental patients.

Medical history questionnaire. Completion of the medical history questionnaire before the start of any dental treatment is usual practice. The questionnaire may be completed by the patient, his or her guardian or, in the case of a minor, his or her parent. In recent years, computerized medical history forms have become available and have simplified the history-taking process.⁵

Dialogue history. The dentist reviews the completed form with the patient and asks additional questions about any medical problems that the patient has reported. Through this dialogue, the dentist seeks to determine the significance of any reported medical disorder to the proposed dental treatment plan. For example, if a patient has had a myocardial infarction (MI), the dialogue history will include the following questions:
 ■ When (month, year) did the MI occur?^{6,7}
 ■ What degree of damage occurred to the myocardium? Is the patient chronically short of breath? Does he or she tire easily? Does he or she experience chest pain?
 ■ What medications is the patient taking?

Physical examination. A physical examination, including visual inspection of the patient and monitoring of his or her baseline vital signs, is the next step in the evaluation process. Vital signs provide valuable real-time information about the status of the patient's cardiovascular system. When possible, dentists should record baseline vital signs for all new patients as a routine part of their pretreatment evaluation.

Assessment of risk. After completion of the medical history questionnaire, dialogue history and physical examination, the dentist assigns the patient to a physical status category. For more than 40 years, hospitals worldwide have used the American Society of Anesthesiologists physical status (ASA PS) classification system^{8,9} to predict perioperative adverse outcomes in patients receiving general anesthesia (Table 2,¹⁰ page 5S).

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TABLE 1

Medical emergencies reported by 2,704 dentists.*	
EMERGENCY SITUATION	NO. (%) OF EMERGENCIES REPORTED†
Syncope‡	4,161 (30.1)
Mild Allergic Reaction	2,583 (18.7)
Postural Hypotension	2,475 (17.9)
Hyperventilation‡	1,326 (9.6)
Insulin Shock (Hypoglycemia)	709 (5.1)
Angina Pectoris‡	644 (4.6)
Seizures‡	644 (4.6)
Asthmatic Attack (Bronchospasm)‡	385 (2.8)
Local Anesthetic Overdose	204 (1.5)
Myocardial Infarction	187 (1.4)
Anaphylactic Reaction	169 (1.2)
Cardiac Arrest	148 (1.1)

* Source: Malamed.¹
 † A few emergencies with low numbers were omitted from the table.
 ‡ Emergencies that potentially are stress related.

Khuri and colleagues¹¹ used this system in a study of patients' risks and outcomes. The system consists of six classifications—PS 1 to PS 6—that indicate the potential risk of an adverse medical event's developing while a patient is under general anesthesia. McCarthy and Malamed¹⁰ adapted the ASA PS system for use in dentistry. The dentist assigns the ASA PS classification after considering all available medical history information, as described earlier.

PS 1. A patient in the PS 1 category is defined as normal and healthy.⁹ After reviewing the available information, the dentist determines that the patient's heart, lungs, liver, kidneys and central nervous system are healthy and his or her blood pressure is below 140/90 millimeters of mercury. The patient is not unduly phobic and is younger than 60 years. A patient in the PS 1 category is an excellent candidate for elective surgical or dental care, with minimal risk of experiencing an adverse medical event during treatment.

PS 2. Patients in the PS 2 category have a mild systemic disease⁹ or are healthy patients (PS 1) who demonstrate extreme anxiety and fear toward dentistry or are older than 60 years. Patients classified as PS 2 generally are somewhat less able to tolerate stress than are patients classified as PS 1; however, they still are at minimal risk during dental treatment. Elective dental care is warranted in a patient classified as PS 2, with minimal increased risk during treatment. However, the den-

tist should consider possible treatment modifications (see Stress Reduction Protocols below).

PS 3. A patient in the PS 3 category has severe systemic disease that limits activity but is not incapacitating.⁹ At rest, a patient in the PS 3 category does not exhibit signs and symptoms of distress (such as undue fatigue, shortness of breath, chest pain); however, when stressed, either physiologically or psychologically, the patient does exhibit such signs and symptoms. An example is a patient with angina who is pain free while in the waiting room but develops chest pain when seated in the dental chair. Like PS 2, the PS 3 classification indicates that the dentist should proceed with caution. Elective dental care is not contraindicated, though the patient is at an increased risk during treatment. The dentist should give serious consideration to implementing treatment modifications.

PS 4. A patient in the PS 4 category has an incapacitating systemic disease that is a constant threat to life.⁹ Patients with this classification have a medical problem or problems of greater significance than the planned dental treatment. The dentist should postpone elective dental care until the patient's physical condition has improved to at least a PS 3 classification. A patient in the PS 4 category exhibits clinical signs and symptoms of disease at rest. The risk in treating this patient is too great to permit elective care. In dental emergencies, such as cases of infection or pain, clinicians should treat patients conservatively in the dental office until their conditions improve. When possible, emergency treatment should be noninvasive, consisting of drugs such as analgesics for pain and antibiotics for infection. When the dentist believes that immediate intervention is required (for example, incision and drainage, extraction, pulpal extirpation), I suggest that the patient receive care in an acute care facility (that is, a hospital) whenever possible.

PS 5. A PS 5 classification indicates a moribund patient not expected to survive 24 hours without surgery.⁹ Patients in this category almost always are hospitalized and terminally ill. In many institutions, these patients are not to be resuscitated if they experience respiratory or cardiac arrest. Elective dental treatment is contraindicated; however, emergency care, in the

ABBREVIATION KEY. ASA PS: American Society of Anesthesiologists physical status. BP: Blood pressure. CHF: Congestive heart failure. COPD: chronic obstructive pulmonary disease. CVA: Cerebrovascular accident. MI: Myocardial infarction.

realm of palliative treatment (that is, relief of pain, infection or both) may be necessary. (PS 6 refers to a patient declared brain-dead and whose organs are being removed for donor purposes.⁹)

The ASA PS classification system is not meant to be inflexible; rather, it is meant to function as a relative value system based on a dentist's clinical judgment and assessment of the available relevant clinical data.¹⁰ When the dentist is unable to determine the clinical significance of one or more diseases, I recommend he or she consult with the patient's physician or other medical or dental colleagues. In all cases, however, the treating dentist makes the final decision regarding whether to treat or postpone treatment. The ultimate responsibility for the health and safety of a patient lies solely with the dentist who decides to treat or not treat the patient.

STRESS REDUCTION PROTOCOLS

Dentists in private practice assign most patients (85 percent) to PS 1 or PS 2 status, about 14 percent to PS 3 and the remainder to PS 4.¹² All dental and surgical procedures potentially are stress inducing.¹³ Such stress may be of a physiological (pain, strenuous exercise) or psychological (anxiety, fear) nature. One response of the body to stress is to increase the release of catecholamines (epinephrine and norepinephrine) from the adrenal medulla into the cardiovascular system. This results in an increased workload for the heart (that is, increased heart rate and strength of myocardial contraction and an increased myocardial oxygen requirement). Although patients classified as PS 1 may be quite able to tolerate such changes in cardiovascular activity, patients classified as PS 2, 3 or 4 are increasingly less able to tolerate these changes safely.

A patient with stable angina (PS 3) may respond with an episode of chest discomfort, and

TABLE 2

American Society of Anesthesiologists physical status (ASA PS) classification system.*†

ASA PS*	DEFINITION*	EXAMPLE	TREATMENT RECOMMENDATIONS
1	Normal healthy patient	—	No special precautions
2	Patient with mild systemic disease	Pregnancy, well-controlled type 2 diabetes, epilepsy, asthma, thyroid dysfunction, BP‡ 140-159/90-94 mm Hg‡	Elective care OK; consider treatment modification
3	Patient with severe systemic disease that limits activity but is not incapacitating	Stable angina pectoris, postmyocardial infarction > six months, post-CVA§ > six months, exercise-induced asthma, type 1 diabetes (controlled), epilepsy (less well controlled), symptomatic thyroid dysfunction, BP 160-199/95-114 mm Hg	Elective care OK; serious consideration of treatment modification
4	Patient with an incapacitating systemic disease that is a constant threat to life	Unstable angina pectoris, postmyocardial infarction < six months, uncontrolled seizures, BP > 200/115 mm Hg	Elective care contraindicated; emergency care: noninvasive (for example, drugs) or in a controlled environment
5	Moribund patient not expected to survive 24 hours without surgery	End-stage cancer, end-stage infectious disease, end-stage cardiovascular disease, end-stage hepatic dysfunction	Palliative care

* The ASA physical status classification system is adapted with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, Ill. 60068-2573.⁹
 † Source: American Society of Anesthesiologists⁹; McCarthy and Malamed.¹⁰
 ‡ BP: Blood pressure.
 § mm Hg: Millimeters of mercury.
 ¶ CVA: Cerebrovascular accident.

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specific patient or disease process. The dentist is seeking information to aid in determining the degree of risk and which modifications in therapy might be beneficial.

Premedication. Many apprehensive patients report that their fear of dentistry or surgery is so great that they are unable to sleep well the night before their appointment. Fatigued the next day, they are less able to tolerate any stress placed on them during treatment. In a patient who is medically compromised, the risk of an acute exacerbation of his or her medical problem is increased. In a patient in the PS 1 category, such stress might provoke a psychogenically induced response.

When heightened anxiety exists, the dentist should determine whether it interferes with the patient's sleep. Restful sleep the night before an appointment is desired. One means of achieving this goal is to administer an oral sedative. The dentist may prescribe a sedative-hypnotic drug, such as diazepam, triazolam, flurazepam, zaleplon or zolpidem, for administration one hour before the patient goes to bed. As the appointment approaches, the patient's anxiety level heightens. The dentist can administer a sedative-hypnotic drug about one hour before the scheduled start of treatment to permit the attainment of a therapeutic blood level of the agent. Whenever possible, oral sedatives should be administered in the dental office.

Appointment scheduling. Apprehensive or medically compromised patients are better able to tolerate stress when rested. Consequently, for most of these patients, including children, the ideal time to schedule dental treatment is early in the day.

Minimize waiting time. Once in the dental office, an apprehensive patient should not have to wait in the reception area or dental chair for extended periods before treatment begins. Anticipation of a procedure can induce more fear than the actual procedure.¹³

Preoperative and postoperative vital signs. Before treating a medically compromised patient, the dentist or a staff member should monitor and record the patient's vital signs (blood pressure, heart rate and rhythm, and respiratory rate). Comparing these preoperative vital signs with the patient's baseline values recorded at an earlier visit serves as an indicator of the patient's physical and emotional status that day. Although especially relevant to patients with cardiovascular disease, preoperative and postoperative vital signs should be recorded for all medically compromised patients

(that is, all patients classified as PS 3 or PS 4 and appropriate patients classified as PS 2).

Sedation during treatment. Should additional stress reduction procedures be required, the dentist may consider using any available sedation technique or general anesthesia. Nondrug techniques include intrasession (including music and video) and hypnosis; the more commonly used pharmacosedative procedures include oral, inhalational, intramuscular, intranasal and intravenous (minimum or moderate) sedation.^{14,15} The primary goal of intrasession and pharmacosedative techniques is to decrease or eliminate stress. Used properly, these techniques achieve the goal without adding risk to the patient.

Pain control. For stress reduction to be successful, the patient's pain must be controlled. Successful pain management is of greater importance in medically compromised patients than it is in patients in the PS 1 category. The potential adverse actions of endogenously released catecholamines on cardiovascular function in a patient with significant cardiovascular disease (PS 3 and PS 4 classifications) warrant inclusion of vasoconstrictors in the local anesthetic solution.¹⁶ In the absence of adequate pain control, stress reduction cannot be achieved, making it almost impossible for the dentist to sedate the patient.

Treatment duration. The duration of treatment is significant for medically compromised and anxious patients. In the absence of factors dictating a need for shorter appointments (that is, PS 3 and PS 4 classifications), the dentist determines the appointment length after considering the patient's desires. In many instances, a healthy but fearful patient may wish to have as few dental appointments as possible, regardless of their length. However, satisfying a patient's (or parents' or guardians') desire for longer appointments is inadvisable if the dentist believes there are appropriate reasons for shorter appointments.

A medically compromised patient should not undergo unduly long appointments. To subject a patient at higher risk to extended treatment may increase his or her risk unnecessarily. Dental appointments for patients in PS 3 and PS 4 categories should not exceed the patient's tolerance limit. Fatigue, restlessness, sweating and evident discomfort are signs that the patient has reached this limit. The dentist also can ask the patient if he or she would like to stop. The most prudent means of managing the care of the patient is to terminate the procedure as expeditiously as possible

and reschedule.

POSTOPERATIVE CONTROL OF PAIN

Postoperative management of pain and anxiety is equally as important as preoperative and perioperative management. This is especially relevant for a patient who has undergone a potentially traumatic procedure (that is, endodontics, periodontal or oral surgery, extensive oral reconstruction or restorative procedures). The dentist must consider carefully complications that might arise during the 24 hours after treatment, discuss these with the patient and take steps to assist him or her in managing them. These steps may include any or all of the following:

- availability of the dentist via telephone around the clock;
- pain control: a prescription for analgesic drugs, as needed;
- antibiotics: a prescription for antibiotics if the possibility of infection exists;
- anti-anxiety drugs if the dentist believes that the patient may require them;
- muscle relaxant drugs after prolonged therapy or if the patient has received multiple injections in one area (for example, inferior alveolar nerve block).

Should the possibility exist of posttreatment discomfort or pain, the patient should be forewarned and an analgesic drug (such as ibuprofen 800 mg three times a day or 600 mg four times a day) made available.^{17,18}

The stress reduction protocols described above have made it possible to manage the dental health care needs of a broad spectrum of anxious and medically compromised patients with a low complication rate.

CONCLUSIONS

When medical emergencies occur in the dental office, they represent a possible threat to the patient's life and a hindrance to the delivery of dental care. Preventing medical emergencies is predicated on gathering information about any pre-existing medical conditions, drugs and other medications the patient may be taking and the patient's level of dental care-related anxiety. The dentist obtains this information through a physical evaluation before the start of treatment. The four components of a physical evaluation are medical history questionnaire, dialogue history, physical examination (including monitoring and recording of vital signs and visual examination) and assessment of risk.

To assess risk, the dentist assigns an ASA PS classification to the patient (1 through 5). PS 1, 2 and 3 represent candidates for elective dental treatment, albeit with increasing degrees of medical compromise evident. Patients who are more medically compromised may require treatment modifications to enable them to tolerate the stresses involved in treatment. The stress reduction protocols described above are designed to minimize the stress associated with the delivery of dental care. ■

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Basic management of medical emergencies Recognizing a patient's distress

Kenneth L. Reed, DMD

Early recognition of medical emergencies begins at the first sign or symptom.¹ Familiarity with the patient's medical profile aids immensely in recognition; knowing what to expect and what to look for promotes a faster response. The dentist needs to focus on what is happening with a patient minute by minute because distractions slow response time.

By performing a simple visual inspection of the patient, the dentist can determine if he or she has various diseases such as obesity, a history of cerebrovascular accident (CVA) (stroke), Parkinson disease, jaundice, exophthalmos, breathing difficulties and heart failure (orthopnea).

When treatment is indicated, the dentist should proceed without hesitation. Often, management of medical emergencies in the dental office is limited to supporting patients' vital functions until emergency medical services (EMS) arrives. This is especially true in the case of major morbidity such as myocardial infarction or CVA. Treatment should consist minimally of basic life support and monitoring of vital signs.² The dentist never should administer poorly understood medications.

An emergency management plan, as described by Haas³ in this supplement and by Peskin and Siegelman,⁴ is of paramount importance. The dental team's ultimate goal

Background and Overview. Medical emergencies can happen in the dental office, possibly threatening a patient's life and hindering the delivery of dental care. Early recognition of medical emergencies begins at the first sign of symptoms. The basic algorithm for management of all medical emergencies is this: position (P), airway (A), breathing (B), circulation (C) and definitive treatment, differential diagnosis, drugs, defibrillation (D). The dentist places an unconscious patient in a supine position and comfortably positions a conscious patient. The dentist then assesses airway, breathing and circulation and, when necessary, supports the patient's vital functions. Drug therapy always is secondary to basic life support (that is, PABCD).

Conclusions and Clinical Implications. Prompt recognition and efficient management of medical emergencies by a well-prepared dental team can increase the likelihood of a satisfactory outcome. The basic algorithm for managing medical emergencies is designed to ensure that the patient's brain receives a constant supply of blood containing oxygen.

Key Words. Medical emergencies; basic life support; seizures; hypoglycemia; chest pain; angina pectoris; acute myocardial infarction; bronchospasm; syncope; allergy. *JADA* 2010;141(5 suppl):20S-24S.

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is the prevention of life-threatening emergencies.

While the focus of this article is the recognition of patients in distress, I should point out that dentists initially should manage all medical emergencies in the same way by using what is known as the basic algorithm^{6,9,60}:

- position (P) the patient;
- airway (A);
- breathing (B);
- circulation (C);
- definitive treatment, consisting of differential diagnosis, drugs and defibrillation (D).

Although many different medical emergencies may occur in the dental office, some are seen more often than others. I will not attempt to be exhaustive in this article; for a comprehensive review, readers should refer to one of the textbooks on the topic.^{5,6} This article serves as a brief review of some of the commonly encountered medical emergencies in the dental office. I examine some of these medical emergencies and their most common manifestations and lightly touch on some potential treatments.

RESPIRATORY DISTRESS

Respiratory distress in a dental patient may take one of many forms. For example, the precipitating problem may be asthma, an allergic reaction, tachypnea (hyperventilation, a pulmonary embolus, acute congestive heart failure, diabetic ketoacidosis, hyperosmolar hyperglycemic nonketotic syndrome) or unconsciousness.

Clinicians can recognize respiratory distress in a patient through a variety of manifestations. Probably the most common cause of respiratory distress seen in dental patients is asthma, also known as acute bronchospasm.⁷ Patients with this type of respiratory distress typically will want to sit upright (position). The dentist follows this with an evaluation of the patient's airway. Is it patent? By definition, conscious patients who can talk have a patent airway, are breathing and have sufficient cerebral blood flow and blood pressure to remain conscious. Definitive treatment includes administration of a bronchodilator. For conscious patients, this bronchodilator commonly is albuterol, administered via a metered-dose inhaler. If the patient loses consciousness or is uncooperative with administration of albuterol via inhalation or if bronchospasm is refractory to administration of albuterol, telephoning EMS (9-1-1) and administering epinephrine parenterally (intramuscularly) are indicated. Subcuta-

neous administration no longer is thought to be most efficacious.^{8,9}

CHEST PAIN

Another potential medical emergency seen in dental offices is chest pain.¹⁰ Many factors may precipitate chest pain, such as acute myocardial infarction (AMI), angina, paroxysmal supraventricular tachycardia, gastroesophageal reflux disease, anxiety and costochondritis.

When describing their chest pain, many patients do not describe the feeling as pain per se. They commonly use terms such as "squeezing," "tightness," "fullness," "constriction," "pressure" or "a heavy weight" on the chest. There are many potential causes of chest pain. I will examine two that the dentist can manage, or begin to treat, in the dental office. I will not address chest pain of noncardiac origin, although it certainly is valid and somewhat common in the population at large.

If a patient is experiencing chest pain, he or she will let the dentist know, so recognition of the problem will not be difficult. A conscious patient experiencing chest pain is free to be in any position that is comfortable. As stated earlier, these patients often will want to sit upright. Conscious patients who can talk have a patent airway, are breathing and have sufficient cerebral blood flow and blood pressure to retain consciousness. The difficulty for the dentist is the differential diagnosis of chest pain.¹¹

Angina pectoris and AMI are the two most likely cardiac problems in a conscious patient who is exhibiting chest pain in the dental office. Other possibilities exist, but this article focuses on the recognition and early treatment of these two common entities. If the patient had experienced cardiac arrest, he or she would not be conscious.

Differential diagnosis. A differential diagnosis of chest pain involves looking at a number of signs and symptoms. One consideration is the patient's history. Has he or she ever experienced anginal chest pain? If so, it is likely that the current chest pain is angina pectoris. However, if this is the patient's first episode of chest pain, the dentist should treat him or her as if it were an AMI and have EMS transfer the patient as

ABBREVIATION KEY: AMI: Acute myocardial infarction. CVA: Cerebrovascular accident. EMS: Emergency medical services. MONA: Morphine, oxygen, nitroglycerin and aspirin. PABCD: Position, airway, breathing, circulation, definitive treatment.

quickly as possible to a hospital.

The differential diagnosis of chest pain in a conscious patient in the dental office also includes an evaluation of the quality of the pain. If the pain is significant but not severe, the chances are better that it is caused by angina pectoris, not AMI. Pain that radiates, commonly to the left side of the body—the left mandible, left arm, left shoulder—more likely is caused by AMI than by angina pectoris.^{12,16,60} However, not all pain associated with AMI radiates, and some patients have atypical pain when experiencing an AMI. For example, patients with diabetes and women often experience an unusual shortness of breath, an unexplained elevation of blood sugar levels or both as a symptom of an AMI but often experience no chest pain at all (that is, silent myocardial infarction).¹³

Blood pressure. Blood pressure also might indicate whether the patient is experiencing angina pectoris or an AMI. If the patient's blood pressure is elevated during this episode of chest pain, angina more likely is the cause.¹⁰ This elevation may be a response to the pain being experienced. If the blood pressure falls below the patient's baseline value or the immediate preoperative value, the dentist should consider an AMI; if the pump (the heart) has been injured, it is less efficient, resulting in a decreased cardiac output and subsequent drop in blood pressure.^{10,47,61}

Definitive treatment. Definitive treatment for angina pectoris requires the administration of a nitrate, commonly nitroglycerin, via sublingual tablet or translingual or transmucosal spray. Prehospital treatment of a patient suspected of having AMI typically involves the administration of morphine, oxygen, nitroglycerin and aspirin (MONA), in addition to notifying EMS. Given that most dental offices do not have morphine, the dentist may substitute nitrous oxide/oxygen in a 50:50 concentration.¹⁴

ALTERED CONSCIOUSNESS

As with respiratory distress, altered consciousness or unconsciousness may occur owing to a variety of precipitating factors. Some of these include significant hypotension from any cause, hypoglycemia, CVA, illicit drug use, AMI and seizure.

Dizziness developing in the dental office may have many origins, but low blood pressure in the brain often is the ultimate cause. The easiest and least invasive way to increase blood flow to the

brain is to place the patient in a supine position. Patients in whom dizziness is the only symptom are conscious and able to talk (airway, breathing and circulation have been assessed and ensured). Definitive treatment consists simply of placing the patient properly in a supine position. Once the patient is positioned, the dentist should determine the cause of the dizziness. Was it initiated by vasovagal syncope? Hypoglycemia? Hypovolemia?

Vasovagal syncope. Vasovagal syncope in the dental office often is caused by anxiety, which needs to be addressed properly. For some patients, this may mean that the dentist simply needs to take more time explaining the dental procedure to them, thus allaying their fears. Other patients may require pharmacological intervention (that is, sedation). Inhalation sedation (nitrous oxide/oxygen) may be ideal for some patients, while enteral sedation may be more appropriate for others. Some patients benefit most from parenteral (that is, intramuscular, intranasal) moderate sedation and others may require general anesthesia to properly address their anxiety.

Hypoglycemia. Dentists also should consider hypoglycemia in a differential diagnosis of dizziness. Frequently, the patient has a history of diabetes. Patients with type 1 diabetes (and some with type 2) self-administer insulin to lower a high glucose level (hyperglycemia) toward the upper limit of normal (120 milligrams/deciliter). Patients with diabetes must ingest food immediately after administering insulin to prevent the development of hypoglycemia as a result of the insulin injection. The most common cause of hypoglycemia in patients with type 1 diabetes is not eating after administering insulin.

Patients with clinically significant hypoglycemia may be recognizable because they commonly experience diaphoresis and tachycardia and feel faint. Subsequently, they may experience mental confusion and, ultimately, the loss of consciousness. As long as the patient retains consciousness, the clinician should allow him or her to remain in a comfortable position. Conscious patients with hypoglycemia have a patent airway, are breathing and have an adequate pulse. The treatment of choice for patients with hypoglycemia is administration of sugar. Unconscious patients with hypoglycemia require parenteral administration of sugar. Absent a proficiency in venipuncture, the dentist should activate EMS. Malamed^{36,39} recommends that a dentist never

place any drug or other substance in the mouth of an unconscious patient that is a liquid or might become a liquid at body temperature.

Fainting, or vasovagal syncope, is the most common medical emergency seen in the dental office.¹⁴ The basic algorithm for dealing with it is the same as that for dizziness described earlier. The dentist or a team member should place the patient in a supine position. Most patients with syncope have a patent airway, are breathing and demonstrate an adequate pulse. Patients who faint typically respond to positional changes within 30 to 60 seconds. If the patient does not respond in this time frame, he or she did not simply faint, and the dentist must consider a more complete differential diagnosis of loss of consciousness. Although many possible explanations exist, the more common reasons a patient loses consciousness in the dental office (assuming no medications have been administered) are syncope, low glucose level, CVA and cardiac arrest.

In each of these examples of unconsciousness, the initial management of the emergency is the same. The dentist should place the patient in a supine position. If he or she has not responded within one minute, the clinician probably can rule out syncope. The dentist then should open the airway and assess breathing ("look, listen and feel"¹⁵). If the patient is breathing, the next step is to check his or her circulation. Does the patient have a palpable pulse at the carotid artery (brachial artery in infants)?

Patients who are breathing spontaneously and normally may be experiencing hypoglycemia or a CVA, but not cardiac arrest. In cardiac arrest, the patient does not breathe spontaneously (agonal breathing notwithstanding). A patient with apnea requires positive pressure ventilation with 100 percent oxygen.

Patients placed in a supine position who do not respond within 30 to 60 seconds but are breathing spontaneously likely are experiencing hypoglycemia or a CVA. If the patient's blood pressure is normal (that is, close to baseline values—part of assessing circulation), the problem probably is a low glucose level. If the patient's blood pressure is alarmingly high, the dentist must strongly consider the possibility that the event is a CVA.

SEIZURES

Seizures are rare in dental offices, especially in patients who never have had them. Patients who convulse in the dental office typically have a

seizure history and often are characterized as having epilepsy.¹⁷ The initial treatment for seizures is the same as that for any other medical emergency. The patient experiencing a generalized tonic-clonic seizure is unconscious and should be placed in a supine position. The dentist should perform a "head tilt and chin lift" to the extent possible. Patients who are seizing are breathing and have adequate cardiovascular function, which the dentist can verify by checking for and finding a strong pulse.

The dentist or a team member must remove all dental instruments and supplies from the patient's mouth and protect the patient from harm. No one should place anything in the mouth of a patient who is seizing. If someone familiar with the patient is present (such as a parent, spouse or professional caregiver), a team member should bring the person into the operatory and ask him or her to evaluate the patient. He or she may determine that this is a typical seizure for the patient, in which case simple monitoring is sufficient, or he or she may feel that this seizure is unusually severe and suggest that someone contact EMS.

ALLERGY-RELATED EMERGENCIES

Allergy-related emergencies are rare but possible in the dental office. The most common allergen in the dental environment today is latex.¹⁸ An allergy can be mild or severe. If the patient has itching, hives, rash or a combination of these, the allergy may be considered mild (non-life threatening). However, if the patient experiences respiratory or cardiovascular compromise—that is, the loss of consciousness due to difficulty in breathing or inadequate blood pressure and blood flow to the brain—the dentist should treat the allergy as a life-threatening situation.

Mild allergy. If the allergy is mild (that is, itching, hives, rash or a combination of these) and the patient remains conscious, he or she should be made comfortable. The conscious patient who is talking has verified that the airway is patent, he or she is breathing and he or she has cardiovascular function adequate to maintain consciousness. In this case, the dentist should administer a histamine blocker, such as diphenhydramine, via intramuscular or intravenous injection.

Severe allergy. If the allergy is severe, the patient has lost, or soon will lose, consciousness. The dentist should place the patient in a supine position, open the airway and evaluate breathing.

Often, breathing is spontaneous. If the patient is not breathing, the clinician must administer positive pressure oxygen via a bag-valve-mask device. If the patient has lost consciousness, his or her cerebral blood pressure is too low. To support circulation, as well as to dilate the bronchioles and minimize any potential swelling of laryngeal tissues, the dentist must administer epinephrine as soon as possible. Someone also must contact EMS, as the patient requires additional treatment in a hospital's emergency department.

BLEEDING

Dentists deal with bleeding every day, so it rarely constitutes a significant medical emergency. However, there are times when significant bleeding may turn into a medical emergency. If the greater palatine artery is inadvertently cut, for example, the dentist must control the bleeding quickly or the outcome may be poor. Patients who are hemorrhaging typically are conscious, so keeping them comfortable is a key component in managing the emergency. Placing the patient in a supine position will increase blood pressure in the head and generally is not indicated. Although it is important to verify that the airway is patent at all times, only the most severe and unrelenting cases of intraoral hemorrhage require placement of an advanced airway (that is, nasopharyngeal airway, laryngeal mask airway, supraglottic airway [King LT airway, King Systems, Noblesville, Ind.] or endotracheal tube).¹⁹ These conscious, spontaneously ventilating patients who are bleeding profusely are treated most commonly with local measures only. Pressure to the affected site, with or without suturing, addresses the problem adequately in most cases.²⁰

CONCLUSION

Medical emergencies can occur in the dental office, and it is important for the entire dental

team to be prepared for them. Regardless of their specific type, they are best managed in basically the same way: position the patient; assess the airway, breathing and circulation; and provide definitive treatment. ■

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Preparing for medical emergencies

The essential drugs and equipment for the dental office

Morton Rosenberg, DMD

Every dentist can expect to be involved in the diagnosis and treatment of medical emergencies during the course of clinical practice. These emergencies may be related directly to dental therapy, or they may occur by chance in the dental office environment. Although just about any medical emergency can occur during the course of dental treatment, best practice dictates that dental personnel must be prepared to provide effective basic life support (BLS) and seek emergency medical services in a timely manner.¹

Dentists also must be able to diagnose and treat common emergent problems (for example, syncope or hyperventilation syndrome), as well as respond effectively to certain less common, or even rare, but potentially life-threatening emergencies, especially those that may arise as a result of dental treatment (for example, anaphylactic reaction to an administered drug). Although many medical emergencies can be treated properly without drugs, every dental office must have a basic emergency kit that contains drugs and equipment appropriate to the training of the dentist, state requirements, the type of patients being treated (for example, geriatric, special-needs, pediatric or medically compromised patients), the procedures performed (for example, whether sedation or general anesthesia is induced) and the geographical location (for

Background. Acute medical emergencies can and do occur in the dental office. Preparing for them begins with a team approach by the dentist and staff members who have up-to-date certification in basic life support for health care providers. The ability to react immediately to the emergency at hand, including telephoning for help and having the equipment and drugs needed to respond to an emergency, can mean the difference between successful management and failure.

Overview. The purpose of this article is to provide a vision of the training, basic and critical drugs, and equipment necessary for staff members in general dental offices to manage the most common and anticipated medical emergencies.

Conclusions and Clinical Implications. Completion of annual continuing education courses and office medical emergency drills ensure a rapid response to emergency situations. It is the combination of a knowledgeable and skilled dental team with the equipment for basic airway rescue and oxygenation, monitoring equipment, an automated external defibrillator and a basic drug emergency kit that make the dental office a safer environment for patients and enhance dental professionals' capability to render competent and timely aid.

Key Words. Blood pressure; cardiac arrest; dental team; coronary heart disease; automated external defibrillator; dental office staff members; drug therapy; medical emergencies; epinephrine.

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example, an urban setting in which emergency help is close at hand versus a rural location in which there may be a significant delay until help arrives). Many factors determine the degree of preparedness needed for medical emergencies in a specific dental practice, but all dental offices must be ready at some minimum level. An overall emergency preparedness plan that includes equipment and a drug kit is essential for all dental practices (Box 1).

Continuing education courses incorporating task training and high-fidelity human simulators (that is, computer-controlled simulated patients) that emphasize crisis management for life-like practice in managing medical emergencies are gaining popularity among dentists and clinical staff members. No drug can take the place of properly trained health care professionals in diagnosing conditions and treating patients in emergency situations. Nevertheless, having an appropriate emergency drug kit and equipment often plays an integral role in the course and outcome of emergency treatment.^{3,7}

EQUIPMENT

Oxygen is of primary importance in any medical emergency and must be available in a portable E cylinder that can be transported easily to any office location in which an emergency may arise. A dental office should be equipped with a device for the administration of supplemental oxygen to a spontaneously breathing patient—such as nasal cannulae, nonbreathing masks with an oxygen reservoir or a nitrous oxide-oxygen nasal hood.

Every office must have the ability to deliver oxygen under positive pressure for use in situations in which the patient is unconscious and not ventilating adequately. Although mouth-to-mask devices such as pocket masks are useful, the best and most efficient method of ventilating with high concentrations of inspired oxygen in apneic patients is with a bag-valve-mask device with an oxygen reservoir connected to an oxygen source or a manually triggered oxygen-powered device (Table 1).

Oropharyngeal airways come in several sizes

(7, 8 and 9 centimeters for adults) and are a useful adjunct in overcoming airway soft-tissue obstruction in an unconscious patient. Magill forceps can be lifesaving in retrieving foreign objects lost in the hypopharynx during dental therapy.

The immediate availability of an automated external defibrillator (AED) adhering to the American Heart Association's (AHA) 2005 guidelines⁸ is an evolving standard of care in all health care settings. The AHA has made early defibrillation an integral part of the BLS chain of survival

ABBREVIATION KEY. ACLS: Advanced cardiac life support. AED: Automated external defibrillator. AHA: American Heart Association. BLS: Basic life support. PALS: Pediatric advanced life support.

BOX 1

Emergency preparedness checklist.*

- All staff members have specific assigned duties.
- Contingency plans are in place in case a staff member is absent.
- All staff members have received appropriate training in the management of medical emergencies.
- All clinical staff members are trained in basic life support for health care providers.
- The dental office is equipped with emergency equipment and supplies that are appropriate for that practice.
- Unannounced emergency drills are conducted at least quarterly.
- Appropriate emergency telephone numbers are placed prominently near each telephone.
- Oxygen tanks and oxygen delivery systems are checked regularly. Other emergency respiratory support equipment is present, in good working order and located according to the emergency plan.
- All emergency medications are checked monthly and replacements are ordered for specific drugs before their expiration dates have passed.
- All emergency supplies are restocked immediately after use.
- One staff member is assigned the task of ensuring that the above procedures have been completed and to document this checklist review.

* Adapted from Fast and colleagues.²

TABLE 1

Inspired oxygen concentration with different delivery systems.

DELIVERY SYSTEM	INSPIRED OXYGEN CONCENTRATION (%)
Spontaneous Breathing	
Nasal cannula	25-45
Simple face mask	40-60
Nonbreathing mask with oxygen reservoir	90-100
Positive Pressure Ventilation	
Mouth-to-mouth	17
Mouth-to-mask (oxygen flow to mask, 10 liters/minute)	80
Bag-valve-mask device with room air	21
Bag-valve-mask device with supplemental oxygen reservoir	75-95
Manually triggered oxygen-powered breathing device	75-95

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BOX 2

Suggested basic emergency equipment for the dental office.

- Portable oxygen cylinder (E size) with regulator
- Supplemental oxygen delivery devices
 - Nasal cannula
 - Nonbreathing mask with oxygen reservoir
 - Nasal hood
- Bag-valve-mask device with oxygen reservoir
- Oropharyngeal airways (adult sizes 7, 8, 9 centimeters)
- Magill forceps
- Automated external defibrillator
- Stethoscope
- Sphygmomanometer with adult small, medium and large cuff sizes
- Wall clock with second hand

for the treatment of patients in cardiac arrest.⁹ Since January 1998, the AHA's BLS health care provider cardiopulmonary resuscitation courses have included a mandated module regarding AED use. Some states (Florida, Washington, Illinois) have mandated the presence of an AED in dental offices. The immediate availability of an AED has been demonstrated to increase the success of resuscitation.¹⁰ Early defibrillation with these easy-to-operate devices will convert two of the most common lethal cardiac dysrhythmias—ventricular fibrillation and ventricular tachycardia—into a normal sinus rhythm and restore perfusion to vital organs.

Monitoring equipment that provides basic information for primary assessment should include a stethoscope and a sphygmomanometer with adult small, medium and large cuff sizes. An automated vital signs monitor can provide physiological data, including systolic, diastolic and mean blood pressure, along with the patient's oxygen saturation level, heart rate and temperature. A wall clock with a second hand is invaluable in assisting with the determination of heart rate and in documenting contemporaneous events and interventions (Box 2).

EMERGENCY DRUG KITS

Practitioners can organize emergency kits themselves or purchase them. Many dentists are not comfortable choosing and purchasing individual drugs for their emergency kits, and a high-quality, commercially available emergency drug kit modified for dentistry can provide consistent drug availability (an automatic drug updating service often is included) in an organized fashion.¹¹ Emergency drugs generally are powerful, rapidly acting

compounds. The correct approach to using drugs in any medical emergency essentially should be supportive and conservative.

BASIC EMERGENCY DRUGS

All dentists must keep a fresh supply of critical drugs in the office for immediate administration (Table 2). Dentists must know reflexively when, how and in what doses to administer these specific agents for life-threatening situations. The drugs described should be included in a basic medical emergency kit for the general dental practice. They consist of agents that are noninjectable or can be administered via subcutaneous, intramuscular or sublingual routes, and, for dentists with advanced training, via intravenous or intraosseous routes.

Oxygen. Oxygen is of primary importance in any medical emergency in which hypoxemia might be present. These emergencies include, but are not limited to, acute disturbances involving the cardiovascular system, respiratory system and central nervous system. In the hypoxic patient, breathing enriched oxygen elevates the arterial oxygen tension, which, in turn, improves oxygenation of peripheral tissues. Because of the steepness of the oxyhemoglobin dissociation curve, a modest increase in oxygen tension can significantly alter hemoglobin saturation in the hypoxic patient. Hypoxemia leads to anaerobic metabolism and metabolic acidosis, which often diminish the efficacy of pharmacological interventions in emergencies.

Epinephrine. Epinephrine is the single most important injectable drug in the emergency kit. Epinephrine is an endogenous catecholamine with both α - and β -adrenergic receptor-stimulating activity. It is the drug of choice for treating cardiovascular and respiratory manifestations of acute allergic reactions. The beneficial pharmacological actions of epinephrine, when administered in resuscitative dosages, include bronchodilation and increased systemic vascular resistance, arterial blood pressure, heart rate, myocardial contractility, and myocardial and cerebral blood flow.¹²

For effective treatment of life-threatening signs and symptoms of an acute allergic reaction, the clinician must administer epinephrine immediately after recognizing the condition. He or she can inject the drug subcutaneously (0.3 to 0.5 milligram of a 1:1,000 solution) or intramuscularly for a more serious emergency (0.4 to 0.6 mg of the

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TABLE 2

Suggested basic emergency drugs for the general dental office.			
INDICATION	DRUG	ACTION	ADMINISTRATION
Bronchospasm (Severe Allergic Reaction)	Epinephrine	α - and β -adrenergic receptor agonist	Autoinjectors or preloaded syringes, ampules; 1:1,000 solution subcutaneously, intramuscularly or sublingually; adults, 0.3 milligram; children, 0.15 mg
Mild Allergic Reaction	Diphenhydramine	Histamine blocker	50 mg intramuscularly; 25 to 50 mg orally every three to four hours
Angina	Nitroglycerin	Vasodilator	Sublingual tablet: one every five minutes up to three doses; translingual spray: one spray every five minutes up to three times
Bronchospasm (Mild Asthma)	Bronchodilator such as albuterol	Selective β_2 -adrenergic receptor agonist	Two or three inhalations every one to two minutes, up to three times if needed
Bronchospasm (Severe Asthma)	Epinephrine	α - and β -adrenergic receptor agonist (bronchodilator)	Autoinjectors or preloaded syringes, ampules; 1:1,000 solution subcutaneously, intramuscularly or sublingually; adults, 0.3 mg; children, 0.15 mg
Hypoglycemia	Glucose, as in orange juice	Antihypoglycemic	If the patient is conscious, ingest
Myocardial Infarction	Aspirin	Antiplatelet	One full-strength tablet (165-325 mg) chewed and swallowed
Syncope	Aromatic ammonia	Respiratory stimulant	Inhalant crushed and held four to six inches under nose

same solution). Epinephrine should be available in preloaded syringes or autoinjectors for immediate use, as well as in ampules.¹³ Because of its profound bronchodilating effects, epinephrine also is indicated for the treatment of acute asthmatic attacks that are unrelieved by sprays or aerosols of β_2 -adrenergic receptor agonists.¹⁴

Diphenhydramine. Histamine blockers reverse the actions of histamine by occupying H₁ receptor sites on the effector cell and are effective in patients with mild or delayed-onset allergic reactions.

Nitroglycerin. Although nitroglycerin is available in many preparations—long-acting oral and transmucosal preparations, transcutaneous patches and intravenous solutions—the appropriate forms for the dental office are the sublingual tablet or translingual spray. Nitroglycerin is the treatment of choice for an episode of acute chest pain in a patient with a history of angina pectoris. It acts primarily by relaxing vascular smooth muscle, dilating systemic venous and arterial vascular beds, and leading to a reduction in venous return and systemic vascular resistance. These actions combine to reduce myocardial oxygen consumption.

If the patient does not bring his or her own nitroglycerin to the dental office, the clinician should administer one tablet or metered spray (0.4 mg). This dosage may be repeated twice at five-minute intervals for a total of three doses. Relief should occur within one to two minutes; if

the discomfort is not relieved, the dentist must consider a diagnosis of evolving myocardial infarction. If the patient has never received a diagnosis of angina pectoris and develops symptoms of a possible acute myocardial infarction, such as chest pain or chest pressure, the clinician should consider administering 0.4 mg of sublingual nitroglycerin if the patient's systolic blood pressure is acceptable (> 90 to 100 millimeters of mercury) after first calling 9-1-1 and administering aspirin.

Contraindications to the administration of nitroglycerin are chest pain and hypotension or treatment with drugs prescribed for erectile dysfunction, such as sildenafil (Viagra, Pfizer, New York City), tadalafil (Cialis, Lilly USA, Indianapolis) or vardenafil (Levitra, Bayer HealthCare, Leverkusen, Germany). The combination of nitroglycerin and these compounds may lead to profound hypotension and unconsciousness.

Bronchodilator. Inhalation of a β_2 -adrenergic receptor agonist such as metaproterenol or albuterol is used to treat acute bronchospasm that may be experienced during an asthmatic attack or anaphylaxis. This results in bronchial smooth muscle relaxation and the inhibition of chemical mediators released during hypersensitivity reactions. Albuterol is an excellent choice because it is associated with fewer cardiovascular adverse effects than are other bronchodilators.

Glucose. Clinicians use glucose preparations

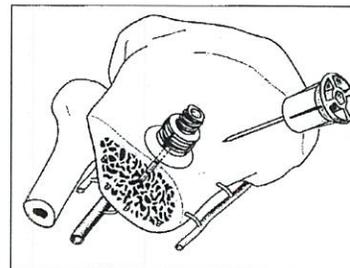


Figure. Intraosseous injection. Reproduced with permission of Vidacare, San Antonio.

to treat hypoglycemia resulting from fasting or an imbalance between insulin and carbohydrate in a patient with diabetes mellitus or in nondiabetic patients with hypoglycemia. If the patient is conscious, oral carbohydrates such as orange juice, a chocolate bar, cake icing or a cola drink act rapidly to restore circulating blood sugar. On the other hand, if the patient is unconscious and the dentist suspects acute hypoglycemia, he or she never should administer oral drugs because of the potential for airway obstruction and/or aspiration. There is no place for insulin in the vast majority of dental offices.

Aspirin. The antiplatelet properties of aspirin decrease myocardial mortality dramatically by preventing further clot formation when administered to patients during an evolving myocardial infarction.¹⁶ There is no substitute for aspirin for this indication, and contraindications to its use include allergy to aspirin and severe bleeding disorders. Patients who exhibit chest pain suggestive of ischemia and an evolving myocardial infarction should chew the aspirin and then swallow it.

Aromatic ammonia. Aromatic ammonia is a commonly used respiratory stimulant in dentistry. It is a general arousal agent that clinicians administer to patients experiencing vasodilator syncope after ascertaining the patency of the patient's airway, repositioning him or her and administering oxygen.

SUPPLEMENTAL INJECTABLE DRUGS AND EQUIPMENT

Dentists with advanced training may consider including drugs and equipment in addition to

those described earlier. These might include the following injectable drugs:

- analgesics;
- anticholinergics;
- anticonvulsants;
- antihypertensives;
- antihypoglycemics;
- corticosteroids;
- vasopressors.

ADJUNCTIVE GENERAL ANESTHESIA DRUGS AND EQUIPMENT

Educationally qualified dentists¹⁶ who use deep sedation and general anesthesia must have additional emergency drugs immediately available (for example, if they use depolarizing neuromuscular blocking agents, they must have dantrolene sodium, as well as other drugs specific to these practices, such as those for advanced cardiac life support [ACLS]), and additional equipment, such as advanced monitoring systems and airway rescue equipment.

REVERSAL DRUGS

If dentists administer opioids or benzodiazepines to induce moderate or deep sedation, general anesthesia or both, they must include antidotal drugs in the emergency kit. Naloxone is a specific opioid antagonist that reverses opioid-induced respiratory depression.¹⁷ Flumazenil is a specific benzodiazepine antagonist that reverses sedation and respiratory depression resulting from benzodiazepine administration.¹⁸

INJECTABLE DRUG ACCESS

The injection of many emergency drugs into the vascular system is crucial to speed drug action. The intravenous route is rapid but requires skill in venipuncture. The intramuscular route, either into the vastus lateralis or mid-deltoid regions, results in slower uptake but perhaps easier access for many dentists, as does the sublingual approach. Establishing intravenous access may be difficult or impossible during medical emergencies. As advocated in the AHA's ACLS/PALS guidelines, intraosseous access often can save a significant amount of time, which can benefit patients in medical emergencies by decreasing the time needed to achieve access and administer medications and other fluids, especially in pediatric patients.^{19,21} Establishing intraosseous access requires specialized equipment and training (Figure). All of these routes of adminis-

tration require adequate circulation for the drugs to be effective.

ADVANCED CARDIAC LIFE SUPPORT

ACLS for adults and pediatric advanced life support (PALS) for children are the standards of care for comprehensive resuscitation by health care providers with advanced skills and training. Pharmacotherapy plays an important role in the treatment of these patients, with guidelines for specific drug therapies centering on the use of many antidysrhythmic and vasoactive drugs.^{4,19}

ADVANCED AIRWAY DEVICES

Dentists with advanced training may wish to include advanced airway devices in their emergency kits. The indications for, the technique in using, and ensuring correct placement of these devices require training and clinical experience. Endotracheal intubation is accomplished with the use of a laryngoscope and an endotracheal tube. Gaining in popularity in airway rescue are supra-glottic devices such as the laryngeal mask airway.²⁰

CONCLUSION

Urgent and emergent medical emergencies can and do occur in the dental office. Early diagnosis, telephone calls for help and proper management will increase the likelihood of a successful response. Accomplishing this depends on the combination of training and preparation by the dentist and staff members and the immediate availability of basic and critical emergency drugs and equipment. ■

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Preparing dental office staff members for emergencies

Developing a basic action plan

Daniel A. Haas, DDS, PhD

The dentist's role in managing any medical emergency begins with prevention. This requires that all staff members, including dentists, dental hygienists, dental assistants and receptionists, be prepared for such emergencies. A team approach should be used,¹ and each staff member can play an important role. Appropriate preparation makes this team-work effective and should improve the patient's chance of achieving a good result.^{2,3}

How does one develop a basic action plan for an unforeseen event? There are numerous potential medical emergencies and numerous protocols to follow. Ideally, the dentist and support staff members should be knowledgeable about all of them. However, when an emergency first develops, the precise diagnosis may not be clear. Without a diagnosis, how can one formulate a treatment plan? This problem can be circumvented by following a key principle: the most important objective of nearly all medical emergencies in the dental office is to prevent or correct insufficient oxygenation of the brain or heart.

On a simple level, if a patient has lost consciousness, it is a result of a lack of oxygenated blood in the brain. If a patient is experiencing an episode of acute angina pectoris, it is a result of a relative lack of oxygenated blood to specific sites in the cardiac muscle. The management of all medical emergencies in a dental office should include

Background and Overview. A medical emergency can occur in any dental office, and managing it successfully requires preparation. The dentist should develop a basic action plan that is understood by all staff members. The goal is to manage the patient's care until he or she recovers fully or until help arrives. The most important aspect of almost all medical emergencies in dentistry is to prevent or correct insufficient oxygenation of the brain or heart. The dentist or a staff member needs to position (P) the patient appropriately. He or she then needs to assess and, if needed, manage the airway (A), breathing (B) and circulation (C). The dentist and staff members then can consider "D," which stands for definitive treatment, differential diagnosis, drugs or defibrillation. A team approach should be used, with each staff member trained in basic life support and understanding the role expected of him or her ahead of time. Clear and effective communication is essential during any emergency.

Conclusions. All staff members should understand the basic action plan so that they can put it into effect should any emergency arise in the dental office.

Clinical Implications. Preparing staff members is integral to the successful management of a medical emergency in the dental office.

Key Words. Medical emergencies; basic life support.
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ensuring that oxygenated blood is being delivered to the brain and heart. If the dentist and team members remember this principle, then everything else should make sense. If this approach makes sense to each member of the office staff, knowing what to do becomes straightforward.

In fact, this principle is the basis of the training in basic life support (BLS), also known as cardiopulmonary resuscitation (CPR).⁴ The goal of BLS is to keep the brain oxygenated and, therefore, protected until something more definitive can be done. Clinicians always should begin with the "PABC" approach, particularly if the diagnosis is not clear.¹ The dentist or a staff member needs to position (P) the patient appropriately. He or she then needs to assess and, if necessary, manage the airway (A), breathing (B) and circulation (C). After the dentist and staff members have addressed the PABCs, they can consider "D," which stands for definitive treatment, differential diagnosis, drugs or defibrillation. Therefore, all team members should be trained and competent in BLS/CPR.

BASIC ACTION FOR EVERY EMERGENCY

What should be done in every medical emergency? The goal is to manage the care of the patient until he or she recovers fully or help arrives. Team members should position the patient and initiate the ABCs. Assess and, if needed, manage each one of A, then B and then C. This orderly approach will help staff members avoid missing a step.

P: Position. If conscious, the patient should sit in any position that is comfortable. If unconscious, the patient should be supine with the legs elevated slightly to about 10° to 15° (Figure 1). This position facilitates blood flow to the brain, thus helping to correct any deficient oxygen delivery.

A: Airway. Practitioners must consider airway assessment. If the patient is conscious, this should not be an issue, and one typically can move quickly to breathing. If the patient is talking, then the airway is patent, but the clinician should look at the throat in cases of allergy to rule out airway compression from laryngeal edema, which is a sign of anaphylaxis. He or she should remove any foreign objects, such as cotton rolls, to eliminate the potential for airway blockage or aspiration.

If the patient is unconscious, assessing and managing the airway becomes crucial. Practi-

tioners and staff members must ensure patency by tilting the patient's head and lifting his or her chin immediately (Figure 2). By itself, this maneuver may prevent brain damage, as it moves the tongue away from the back of the pharynx, thereby eliminating the obstruction (the tongue). In turn, this permits oxygenation. If the airway is not patent after this maneuver, the clinician should reposition the patient's head once more. If the airway still is not opened, the clinician should perform a jaw-thrust maneuver by placing his or her thumbs posterior to the angle of the patient's mandible and advancing them (and the mandible) anteriorly.

B: Breathing. The dentist and staff members should consider the second step—breathing—immediately after taking care of the patient's airway. If he or she is conscious, this usually is not a problem, and the team can move on quickly to circulation. If the patient is talking, then he or she is breathing, but in cases of asthma or allergy, the dentist must rule out wheezing (bronchospasm). He or she also needs to consider whether the patient is breathing too slowly or rapidly. Any team member can monitor the respiratory rate and adequacy of respiration. In adults, the normal respiratory rate is 12 to 15 breaths per minute. In children, the rate is higher, with an 8-year-old averaging 18 breaths per minute and a 3-year-old averaging 22 breaths per minute.⁵

Bradypnea is any respiratory rate significantly below the normal rate; it may result in hypoventilation and inadequate oxygenation. Tachypnea, often a sign of anxiety, is any respiratory rate significantly above the normal rate; it may lead to hyperventilation syndrome. For offices in which the clinician induces moderate or deep sedation or administers a general anesthetic, a pulse oximeter should be available and can be used to assess the adequacy of oxyhemoglobin saturation. Monitoring the adequacy of respiration also includes observing the color of the mucosa, skin and blood to rule out signs of cyanosis.

If the patient is unconscious, dealing with breathing becomes crucial. As taught in BLS, "look, listen and feel."⁶ If the patient is not breathing, administer two slow deep breaths, with each breath lasting one second. The clinician

ABBREVIATION KEY. BLS: Basic life support.

BP: Blood pressure. BPM: Beats per minute.

CPR: Cardiopulmonary resuscitation. D: Definitive treatment. EMS: Emergency medical services.

PABC: Position, airway, breathing, circulation.

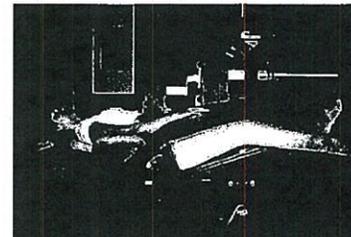


Figure 1. The correct position for an unconscious patient.

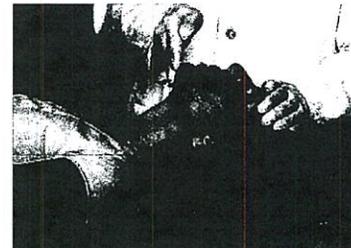


Figure 2. The head-tilt chin-lift maneuver.

or staff member should use a barrier device, such as a pocket mask or the mask from a bag-valve-mask device, if available. He or she should see the chest rise with each ventilation. However, he or she should not ventilate too rapidly or administer excessive volumes. The clinician should administer rescue breaths at a rate of 10 to 12 per minute for an adult. In children younger than the age of adolescence—defined as the age just before the onset of puberty, as determined by the presence of secondary sex characteristics—the rate should be 12 to 20 breaths per minute.⁶

C: Circulation. The dental team should assess the patient's circulation immediately after the breathing step. If the patient is conscious, a team member should check the pulse by using the radial, brachial or carotid artery. The team member can palpate the radial artery by placing the ends of two fingers on the lateral and ventral aspects of the patient's wrist. The brachial artery can be palpated on the medial aspect of the antecubital fossa. To locate the carotid pulse, the team member palpates the patient's thyroid cartilage

and moves his or her fingers laterally into the groove formed by the sternocleidomastoid muscle (Figure 3).

Pulse. In an unconscious patient, the carotid is the best artery for assessing the pulse. BLS training for laypeople recommends skipping the pulse check, but that rule does not apply to health care providers, including those of us in dentistry. Health care professionals are expected to be able to detect a pulse. If no pulse can be palpated after 10 seconds, the dentist or a staff member should assume that the patient has experienced cardiac arrest and begin chest compressions at a rate of 100 per minute, consistent with current BLS training.⁴

Chest compressions. The health care professional should place his or her hands over the lower half of the patient's sternum between the nipples. He or she should push down by using the heel of one hand with the other hand on top. Each compression should depress the chest 1½ to 2 inches. It is important that the clinician push hard and fast and allow full chest recoil. The compression to ventilation ratio for adults is 30:2. For children older than 1 year but younger than the age of adolescence, the compressions should depress the chest by one-third to one-half its depth. The compression to ventilation ratio for one-person CPR in children is the same as that in adults, but for two-person CPR in children, the ratio should be 15:2.⁶

Heart rate. In addition to noting the presence or absence of a pulse, a team member should record the heart rate (in beats per minute (BPM)), its quality (weak or strong) and its rhythm (regular or irregular). A tachycardia is a rapid rate, defined in an adult as anything above 100 BPM. A bradycardia is a slow rate, defined as anything below 60 BPM. Not all bradycardias need management. For example, the well-trained athlete or the patient receiving treatment with a β -blocker could have a rate below 60 BPM and not require treatment. Only when a bradycardia is accompanied by symptoms such as lightheadedness, nausea or chest pain should health care professionals act to manage it. Heart rates typically are higher in children and decrease with increasing age. For example, the normal ranges are from 80 to 130 BPM in a 2-year-old and 70 to 110 BPM in a 10-year-old.^{5,7} A full or bounding pulse often is associated with high blood pressure (BP). A weak and thready pulse is associated with hypotension. The team member should record an irregular rhythm as an abnormality.

It is important to note that assessing circulation involves more than just a pulse check. Health care professionals should check BP for a better indication of the adequacy of the patient's circulation.

Measuring BP. Blood pressure can be measured in a number of ways; I describe the auscultatory method here. A standard BP cuff, also called a sphygmomanometer, can be used along with a stethoscope. Alternatively, a team member can use an automated device. Even if an automated device is in the office, a standard cuff and stethoscope should be available to confirm any readings that the dentist may question. An automated device also may not be as accurate as a standard cuff in the event of an irregular heart rate, such as that found in atrial fibrillation.

To measure BP, a team member wraps the deflated BP cuff evenly and firmly around the patient's upper arm, about one inch above the antecubital fossa with the artery indicator resting on the patient's brachial artery, which should be palpated. With the earpieces of the stethoscope facing forward, the team member places the diaphragm firmly over the brachial artery, being careful not to touch the BP cuff. With the other hand, he or she closes the valve on the inflating bulb of the BP cuff by turning it fully clockwise. He or she inflates the cuff to about 20 to 30 millimeters of mercury above the point at which pulsations disappear from the palpated radial pulse. The staff member then reduces the pressure slowly at a rate of 2 to 3 mm Hg per second by turning the valve on the inflating BP cuff counterclockwise until he or she hears the first sound through the stethoscope. This first sound indicates the systolic BP produced by turbulent blood flow through the partially collapsed underlying artery. These are known as "Korotkoff sounds."⁷ The team member continues to deflate the cuff slowly until the sounds become muffled and disappear; this is the diastolic BP. The blood flow through the artery returns to a smooth (laminar) flow and, thus, no sounds are produced. At this stage, the staff member deflates the cuff fully and records the measurements obtained.

The accuracy of BP readings can depend on a few factors. Proper BP cuff size is important. The cuff's bladder should extend at least halfway around the arm, with the width of the cuff being at least 25 percent greater than the diameter of the arm. Another means of determining the appropriate size is that the bladder length is 80 percent of the arm's circumference and the width

is 40 percent of the circumference.⁸ A cuff that is too narrow may result in a large overestimation of systolic BP. Conversely, a cuff that is too wide may lead to underestimation of systolic BP. Firm placement is important because a cuff that is too loose results in falsely elevated readings.

The accuracy of BP readings can be affected by what is known as the "auscultatory gap." This is defined as Korotkoff sounds that cannot be heard through part of the range from systolic to diastolic pressure.⁹ It is most common in patients with hypertension and can lead to an inaccurate diastolic measurement. Fear and anxiety also can cause transient elevations in BP, primarily with systolic BP. Normal BP in an adult approximates 120/80 mm Hg. Blood pressures typically are lower in children and increase with age. These approximate from 100/60 mm Hg in a 4-year-old to 110/60 mm Hg in a 10-year-old.^{5,7}

One sign of circulation adequacy is the color of the mucosa, with pink and red indicating good peripheral circulation and pale or blue (cyanosis) indicating inadequate circulation. Capillary filling is another indicator, which can be determined by depressing the nail bed and noting whether or not it blanches and then quickly regains color. To assess central perfusion, the dentist or a staff member notes the patient's orientation to person, place and time.

TEAM MEMBERS' ROLES

The dental office should have a written plan that describes the expected roles of team members. These roles should be reviewed regularly during staff meetings. The dentist should arrange emergency simulations or drills to enable team members to practice their roles periodically. The emer-



Figure 3. Palpation of the carotid artery. Reprinted with permission of Elsevier from Malamed.⁵ Copyright © 2007 Elsevier.

BOX 1

Emergency duties of a four-member dental team.*

- TEAM MEMBER 1: LEADER**
- Directs team members
 - Positions the patient and stays with him or her
 - Performs "ABCs" of cardiopulmonary resuscitation (CPR)
 - Takes command and appears calm
 - States instructions directly and clearly
 - Requests acknowledgment from team members that instructions are understood
 - Fosters open exchange among team members
 - Concentrates on what is right for the patient, not who is right[†]
- TEAM MEMBER 2**
- Brings emergency kit
 - Brings oxygen tank and attaches appropriate delivery system
 - Brings automated external defibrillator
 - Assists with ABCs of CPR, including monitoring vital signs
 - Checks oxygen tank regularly
 - Checks emergency kit regularly
 - Prepares drugs for administration
- TEAM MEMBER 3**
- Telephones emergency medical services (9-1-1)
 - Meets paramedics at building entrance
 - Keeps chronological log of events
 - Assists with ABCs of CPR
- TEAM MEMBER 4**
- Assists with ABCs of CPR
 - Assists with other duties as needed

* Source: Malamed.¹

† ABC: Airway, breathing, circulation. Source: American Heart Association.²

‡ Source: Gaba and colleagues.²

gency medical services (EMS) telephone number should be posted if it is other than 9-1-1.

The specific roles of team members will depend, in part, on the number of people on the team. Most dental offices have at least three team members: a dentist, a dental assistant and a receptionist. As the size of the staff increases, duties can be shared among more members. Team member 1 is the leader, but the other roles often are interchangeable. Box 1 provides suggestions for the roles of a four-member team.^{1,4}

Leader. Team member 1 is the leader and usually is the patient's dentist. However, depending on individual circumstances, another team member may be the leader. The leader's role is to be in charge and lead the management of the crisis. The leader decides when to announce an emergency situation. If in doubt, it is better to call an emergency early rather than late; however, bear in mind that calling for help unnecessarily too often may be detrimental when help truly is needed. The leader assigns a team member to telephone for outside assistance, posi-

tions the patient and initiates the ABCs until assistance arrives. The leader should remain with the patient throughout the emergency until he or she has recovered or until EMS has arrived and takes the patient to a hospital.

Being the leader requires leadership skills that include knowing how to prioritize actions by determining what is most important at any time relative to the actions that can be deferred. Leadership skills include the ability to appear calm and in control. Although the leader may be worried about the events unfolding, a calm demeanor must prevail. Panic can be infectious. If team members see the leader panicking, they may follow suit. Remaining calm and collected will help the leader and team members think and act rationally during a stressful time.

Team member 2. Team member 2 knows the location of the emergency kit, portable oxygen and automated external defibrillator and brings them as instructed. He or she also can be assigned to check the emergency kit on a regular basis to ensure that all contents are present and within the expiration date. This team member ensures that sufficient oxygen remains in the tank and assists the team leader with BLS, including monitoring vital signs. He or she also can prepare emergency drugs for administration.

Team member 3. Team member 3, or team member 4 if present, can fulfill various functions, including telephoning EMS (9-1-1) and walking to the building's main entrance to meet the paramedics and lead them to the patient. One of these team members keeps a written chronological record of all events, including the patient's vital signs, timing and amount of drug administered, and the patient's response to treatment.

Additional team members may be other dentists or support staff in the office. All of them should be able to relieve other team members as required.

TEAM COMMUNICATION

In addition to understanding each other's roles, members of an effective team need to communicate effectively. The team leader should consider using a "closed-loop" approach.²² This means that when the leader sends a message, the team member acknowledges receiving the instruction, thereby confirming that he or she heard and understood the message. Pilots and air traffic controllers use this model successfully, and many gourmet coffee shops use it as customers place their orders. Consequently, this model should work easily in a dental office.

The team leader should state clearly the next task to be assigned only after he or she has received a clear response from the team member that the first task was understood. This approach reduces the likelihood of key steps being missed through oversight, such as shouting "call 9-1-1" to no one in particular; everyone assumes that someone else has made the telephone call, when in fact no one has acted on this command.

An example of a correct scenario is as follows. The leader states, "Mary, call 9-1-1." Mary then replies, "I am going to call 9-1-1." The team leader then listens for confirmation that the task has been performed. Mary returns and says, "I've called 9-1-1 and the paramedics are on their way." In another example of a correct scenario, the leader states, "John, bring the oxygen tank." John acknowledges having received the instruction by replying, "I am going to get the oxygen tank." When he returns, John says, "Oxygen tank is here." The team leader responds, "Good. Now attach the bag-valve-mask device." This communication continues in a similar way with all team members.

Effective communication requires each team member to speak clearly and directly. Good eye contact should be maintained when giving instructions. It is not appropriate to let the stress of the situation result in yelling or shouting. If any instruction is unclear, the recipient should ask for clarification. The best teams are composed of members who respect each other and work together in a supportive and collegial way.² There should be an open exchange such that any team member can speak freely to any other team member without fear or embarrassment. No one should feel patronized and any perceived dental office hierarchy should be ignored for this purpose. For example, any team member should feel comfortable making a suggestion to the team leader, in particular if he or she believes that something important has been missed or is being performed incorrectly. The team leader should welcome any comment that might benefit the patient. The team must concentrate on what is right for the patient, not who is right, during management of the medical emergency.³

It is useful to have a planned protocol regarding what to say when calling EMS (9-1-1).¹ Box 2 summarizes the information that should be communicated clearly when talking with the dispatcher.¹ This protocol should be documented in writing, and team members should review it periodically.

BOX 2

Information to provide when calling emergency medical services (9-1-1).*

- Preliminary diagnosis (for example, "possible myocardial infarction")
- Information about the patient (for example, "58-year-old man with chest pain; conscious; blood pressure of 152 over 90; heart rate of 84 beats per minute")
- What is being done for the patient (for example, "The patient is being given 6 liters of oxygen per minute by face mask")
- Provide exact street address with office number and names of cross streets, if possible (for example, "Dr. Jones's dental office at 123 Main St., Suite 202, one block east of the intersection at Pine and Oak streets")
- Telephone number from which the call is being made

* Source: Malamed.¹

CONCLUSION

Each team member should understand the basic action plan described above to permit its effective implementation in emergencies that may arise in the dental office. Differences exist in the level of training that dentists receive in the management of medical emergencies.³ The final decision regarding the exact roles of each team member will be determined by a number of factors, including the dentist's and staff members' training and ability. Clearly, dentists need to do what they can to prevent emergencies in the dental office but, unfortunately, they still may arise despite dentists' best efforts. However, taking the time to prepare staff members and develop a basic action plan for all emergencies may save a life. ■

Disclosure. Dr. Haas did not report any disclosures.

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Sandra Spilsbury

Subject: FW: FW: UPDATED Material for Anesthesia Committee Mtg - 7/18/12

From

Sent: Tuesday, July 17, 2012 1:54 PM

To: Sandra Spilsbury

Subject: Re: FW: UPDATED Material for Anesthesia Committee Mtg - 7/18/12

Sandra,

I am going to try to get to the meeting tomorrow but I would like you to show the following document which should be adopted by our state being that NAC 631.2213 states that a licensee can take a course to perform conscious sedation but does not specify Adults or children. With the story from 20/20 we as a board need to address the issue of dentists sedating children without the proper training. With the way 631.2213 is written someone can do a course seeing 20 patients and they can be all adults with no experience seeing children. I think this is an important subject and we need to look into.

The following adopted by State of California:

Licensed Dentists

ORAL CONSCIOUS SEDATION FOR MINOR PATIENTS PERMITS

Business and Professions Code, Section 1647.10, defines Oral Conscious Sedation for Minor Patients as, "...a minimally depressed level of consciousness produced by oral medication that retains the patient's ability to maintain independently and continuously an airway, and respond appropriately to physical stimulation or verbal command." This permit applies to dental patients under the age of 13 years.

Business and Professions Code Sections 1647.10 to 1647.17 and 1680(z), as well as Title 16, California Code of Regulations, Section 1044, provide specific information regarding Oral Conscious for Minor Patients Permits.

Applying for an Oral Conscious Sedation for Minor Patients Permit

The primary requirements for a certificate to administer oral conscious sedation for a minor patient include, but may not be limited to:

- A completed application form with fee, ensuring that any office setting where oral conscious sedation is administered to minor patients complies with the requirements set in regulations adopted by the Board (Title 16, California Code of Regulations, Section 1044.5).
- A completed application form
- A current, active license to practice dentistry in this state, or a current permit issued pursuant to Business and Professions Code, Section 1638 or 1640.
- Provide documentation of one of the following:
 - Successful completion of a postgraduate program in oral and maxillofacial surgery, pediatric dentistry, or periodontics approved by the Commission on Dental Accreditation or a comparable organization approved by the Board.
 - Successful completion of a periodontics or general practice residency or other advanced education in a general dentistry program approved by the Board.
 - Successful completion of a Board-approved educational program on oral medications and sedation. Applicant must provide a copy of their certificate or diploma.

- o If qualification method is a general residency or other advanced education in a general dentistry program, you must also have your educational institution complete the Certification of Oral Conscious Sedation for Minors Training (OCSM-2) form.
- o Non-refundable application fee: \$200

BOARD-APPROVED PROGRAMS

The Board has approved courses in minor patient oral conscious sedation offered by the following providers:

- LLU, Dept. of Continuing Dental Education (909-558-4685)
- UCLA, Dept. of Continuing Dental Education (310-206-8388)
- CME Associates, Orange (714-998-2208)
- UCSF, Continuing Dental Education (415-476-1101)
- USC, Continuing Oral Health Professional Education (213-821-2127) or e-mail cedental@usc.edu
- DOCS Education (866-592-9618) DOCS Education **Part of the 20/20 show may want to reconsider**

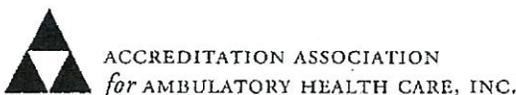
RENEWING YOUR PERMIT

Oral Conscious Sedation Certificates for Minor Patients expire when the qualifying license expires and must be renewed every two years. The fee for renewal is \$75. The Continuing Education requirement for renewal is seven units of approved courses related to oral conscious sedation of minors.

For more information, contact David Wolf 916-263-2356 or at David.Wolf@dca.ca.gov.

Thanks,

Dr. Saxe



August 3, 2012

Ms. Kathleen Kelly
Nevada State Board of Dental Examiners
6010 S. Rainbow Blvd., Ste. A-1
Las Vegas, NV 89118

Via E-mail: nsbde@nsbde.nv.gov and Regular Mail

RE: NAC 631.2213

Dear Ms. Kelly,

Thank you for your follow-up phone call on July 30, 2012 regarding our request for an amendment to regulation NAC 631.2213 1(a) and (b) concerning the use of general anesthesia, deep sedation, and conscious sedation for dental patients in accredited facilities. As you are aware, The Joint Commission is the only accreditation organization named in this regulation. In 2010, the State Board of Health approved AAAHC as a nationally recognized accreditation organization for office-based surgery practices that offer general anesthesia, conscious sedation or deep sedation pursuant to NRS 449.442. We request that NAC 631.2213 be similarly amended to include the Accreditation Association for Ambulatory Health Care (AAAHC) as an approved accreditation organization.

Dentist Representation

The AAAHC is an Illinois not-for-profit corporation, incorporated in 1979 and accredits more ambulatory health care organizations than any other accrediting body in the country. Currently, over 5,000 organizations worldwide are accredited by the AAAHC.

Practicing dentists are integral to our accreditation decisions, development of standards and surveyor training and education. The AAAHC Board of Directors enjoys representation from various practice settings, including dentistry. The American Academy of Dental Group Practice (AADGP) first became a member organization in 1987 and currently appoints two members to the AAAHC board. In the past, a dentist member of the AADGP also served as President of the AAAHC Board of Directors. Further, for many years, The American Dental Association was an observer to the AAAHC meetings. This past April, the AAAHC was pleased to welcome the American Dental Association as its newest member organization and is looking forward to their participation on our Board.

The AAAHC Committees with dentist representation include the Accreditation Committee, the Bylaws Committee, Surveyor Training & Education Committee, and the Standards and Survey Procedures Committee. The AAAHC also creates Advisory Committees and Task Forces that are charged with particular tasks related to the improvement of our accreditation services. Many of these groups include dentist representation, including the Office Based Surgery Task Force, charged with improving the Office Based Surgery accreditation process.

Dental Facility Accreditation

AAAHC has a long history of dental facility accreditation and currently accredits almost 250 dental practices, including satellite offices in 10 states. Some notable dental practices that the AAAHC accredits include the following.

- Kaiser Foundation Health Plan of the Northwest offers dental benefits and services at 16 dental offices located in Washington and Oregon to its subscribers and was first accredited by the AAAHC in 1993.
- Associated Dental Care Providers operates 12 dental practices in Arizona and was first accredited in 1999.
- Carus Dental, PC has 12 satellite offices in Texas and was first accredited by AAAHC in 2000.

Standards

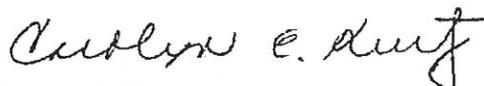
AAAHC standards, published annually, are developed by professionals representing the highest levels of achievement in clinical practice and health care management. The standards are designed to be dynamic to reflect evolving trends in health care. In addition to the Core Chapters, AAAHC has developed Adjunct Chapters to specifically address Dental Services (*See Chapter 14*) and related services such as Anesthesia (*Chapter 9*) and Pharmaceutical Services (*Chapter 14*). Notably, in 2009, a group of dentists worked with the Medical Home Task Force to develop a set of Dental Home standards. These standards were first approved for publication in the 2011 Accreditation Handbook. Included with this correspondence, please find a copy of the AAAHC 2012 Accreditation Handbook Including Medicare Requirements for Ambulatory Surgery Centers.

Surveyors

AAAHC accreditation surveys are conducted by surveyors who are dentists, physicians, registered nurses, and administrators actively involved health care organizations. Only experienced professionals who meet stringent recruitment qualifications are selected to be surveyors. These individuals are screened by the Surveyor Training and Education Committee, approved by the Board of Directors, and trained by the AAAHC. Surveyors must attend re-training every two years.

Clearly, the AAAHC's expertise qualifies us as an accreditor of dental facilities in the State of Nevada. If you would like to schedule a phone conference or meeting please contact me directly at 847-853-6072 or ckurtz@aaaahc.org.

Sincerely,



Carolyn E. Kurtz
AAAHC General Counsel &
Vice President Government/Public Affairs

Enc. CC: Robert Talley, DDS, Executive Director, Nevada Dental Association nda@lasvegas.net
Daniel Orr, II, DDS, PhD, JD, MD dlorrii@pol.net



ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

Important addition to the 2012 Accreditation Handbook Including Medicare Requirements for Ambulatory Surgery Centers (ASCs)

This addendum is to correct an omission in the 2012 Accreditation Handbook Including Medicare Requirements for Ambulatory Surgery Centers (ASCs).

page 46: 4.K-MS(3) OR 4.K-MS(4)

CMS requires Medicare Certified ASCs to have *either*

4.K-MS (3)a written transfer agreement with a hospital that meets the requirements of 4.K-MS (2)

OR

4.K-MS (4)ensure all physicians performing surgery in the ASC have admitting privileges at a hospital that meets the requirements of 4.K-MS (2) (page 46).

All AAAHC/Medicare Deemed Status accredited organizations and those seeking Medicare Deemed Status accreditation from AAAHC are being notified of this omission.

We recommend that you make note of this in your 2012 Handbook. We sincerely apologize for any inconvenience.

If you have questions regarding these changes, contact accreditation services at 847-853-6060.

Sincerely,



John E. Burke, PhD
Executive Vice President and CEO

**AAAHC/CMS crosswalk changes for the 2012 Accreditation Handbook
Including Medicare Requirements for Ambulatory Surgery Centers (ASCs)**

This addendum is to notify organizations currently accredited through a Medicare deemed status survey, or seeking a Medicare deemed status survey, of changes by CMS that have resulted in revision to the AAAHC/CMS crosswalk. The complete, revised crosswalk can be accessed at www.aaahc.org/Global/2012%20AAAHC-CMS%20Crosswalks%207-16-12.pdf.

Major changes are noted below. All changes are effective July 16, 2012.

Significant changes include:

- Organizations are no longer required to adhere to a specified list of emergency equipment. Instead, organizations must craft an appropriate emergency equipment plan based on the procedures performed and population served. The emergency equipment must be immediately available for use during emergency situations.
- In May 2009, CMS incorporated Infection Control as a condition-level requirement. At that time, CMS standards related to infection control were included under the condition for Physical Environment. Earlier this year, CMS eliminated this duplication of standards by removing these infection control-related standards from the Physical Environment condition and retaining them exclusively under the Infection Control condition for coverage.

We recommend that you make note of this in your 2012 *Handbook*. We sincerely apologize for any inconvenience.

If you have questions regarding these changes, contact accreditation services at 847-853-6060.

Sincerely,



John E. Burke, PhD
President and CEO

Important policy change in the 2012 Accreditation Handbook Including Medicare Requirements for Ambulatory Surgery Centers (ASCs)

This addendum is to revise policies *as required by CMS* for organizations seeking an Early Option Survey/Initial Medicare Deemed Status Survey in the 2012 *Accreditation Handbook Including Medicare Requirements for Ambulatory Surgery Centers (ASCs)*. The policy changes become effective with applications received on or after July 1, 2012.

page 12: Types of Surveys

Early Option Survey/Initial Medicare Deemed Status Survey

The AAAHC's early option survey (EOS) is for ASCs that are newly constructed, operational, and actively providing surgical procedures to adequately demonstrate compliance with AAAHC accreditation requirements including Medicare requirements. Some ASCs may require accreditation for third-party reimbursement, and a six-month wait for a survey would entail financial hardship; or have been providing services for less than six months and are seeking AAAHC accreditation and Medicare deemed status *for the first time*.

When an EOS is requested, the ASC must provide evidence of the following with its Application for Survey:

- The date the ASC is open and operational and actively providing surgical procedures to adequately demonstrate compliance with AAAHC accreditation requirements including Medicare requirements.
- Licensure or provisional licensure has been obtained from the state licensing authority. If the ASC is not subject to the facility licensure law, then it should provide evidence from the appropriate regulatory authority confirming this fact, as well as evidence that the organization is eligible to achieve Medicare certification.
- The building in which patient care services will be provided is built and ready to support such care, as evidenced by reports of any inspections conducted by local and state fire marshals, local or state health departments, or other code enforcement agencies.
- All governance and administrative structures are in place, including bylaws, policies, and procedures.
- Key executives are employed and medical staff have been credentialed and privileged by the governing body.
- All necessary equipment is in place and has been appropriately tested and/or calibrated; written up-to-date maintenance logs are in place.
- Documented full compliance with the NFPA 101[®] Life Safety Code,[®] 2000 Edition, based on the completed AAAHC *Physical Environmental Checklist*.
- A non-denial statement (refer to the *Application for Survey*) completed and signed by an authorized person at the ASC.

An EOS is conducted during the ninety (90) day survey window on an unannounced basis after the ASC has opened. A minimum of ten (10) medical records must be available for review. The names of the surveyors are not disclosed prior to the survey. The surveyors will observe a surgical procedure during the survey.

(over)

Organizations undergoing an EOS will receive a three-year term of accreditation or be denied accreditation. See Term of Accreditation for further information. These organizations must undergo an unannounced interim survey to maintain the term. All applicable Standards will be applied during the interim survey.

All organizations seeking Medicare Deemed Status accreditation from AAAHC are being notified of these changes.

We recommend that you make note of this in your 2012 *Handbook*. We sincerely apologize for any inconvenience.

If you have questions regarding these changes, contact accreditation services at 847-853-6060.

Sincerely,

A handwritten signature in black ink, appearing to read "John E. Burke". The signature is written in a cursive style with a large initial "J" and "B".

John E. Burke, PhD
President and CEO

Accreditation Handbook

Including Medicare Requirements
for Ambulatory Surgery Centers (ASCs)



Our mission

The Accreditation Association's mission is to maintain its position as the preeminent leader in developing standards to advance and promote patient safety, quality, value, and measurement of performance for ambulatory health care through peer-based accreditation processes, education, and research.

5250 Old Orchard Road, Suite 200, Skokie, IL 60077
Website: www.aaahc.org E-mail: info@aaahc.org Phone: 847/853-6060

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References are made throughout this Handbook to the NFPA 101® Life Safety Code® 2000 Edition. Both are registered trademarks of the National Fire Protection Association, Quincy, Massachusetts.

The pronouns used in the Handbook were chosen for ease of reading. They are not intended to exclude references to either gender.

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Foreword

The past twelve months have been a banner year for AAAHC in terms of milestones. It has seen us surpass the 5,000th accreditation — a welcome indication that our organization continues to stride confidently into the future. At the same time, we realize that success is not a reason to sit back and congratulate ourselves. We view it only as a stepping stone to even greater achievements as we continually take stock of our organization, searching for ways to improve and raise AAAHC above the landscape.

Among the many changes enacted in 2011 are:

- All accreditation surveys for which 2012 Standards are applied will now have only two possible outcomes: a three-year term or a denial of accreditation. This change will apply to all types of surveys: Initial, Reaccreditation and Early Option, as well as Medicare deemed status surveys. We believe this change will benefit accredited facilities and patients alike.
- Beginning with the 2012 publication cycle, organizations accredited at the time of the book's release will receive a complimentary electronic copy of the appropriate publication. Printed copies will still be available for purchase if preferred.
- Ambulatory care organizations that have been surveyed and accredited with AAAHC since July 1, 2011, may be eligible to participate free of charge in a study of their choosing through the AAAHC Institute for Quality Improvement.
- The Association of periOperative Registered Nurses (AORN) will now have a representative on the AAAHC Board of Directors, giving a voice to an important sector of the health care industry and bringing the number of associations represented to 17.

During 2011, we also surveyed our accredited organizations. Over 1,500 responded and we're happy to report that the feedback was overwhelmingly positive. Nevertheless, we continue to look for ways to evolve and grow, investigating new opportunities where we can exert a positive influence on quality care and patient safety — as demonstrated in our rapidly burgeoning International Initiatives.

While we attribute much of this success to our peer-based, collaborative survey process, we must acknowledge a considerable debt of gratitude to our supportive Board of Directors, our dedicated surveyors, the AAAHC staff and all our accredited organizations. Through their combined efforts we will continue to be the leader in ambulatory health care accreditation.

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John E. Burke, PhD
Executive Vice President and CEO

Acknowledgments

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Without the dedication and commitment of these individuals, this edition would not have been possible.

Acknowledgments

Note to readers:

This 2nd edition of the *Accreditation Handbook Including Medicare Requirements for Ambulatory Surgery Centers (ASCs)* is a guide for ambulatory surgery centers interested in seeking accreditation and Medicare deemed status. This *Handbook* has been developed to assist an Ambulatory Surgery Center (ASC) in realistically assessing its compliance with the AAAHC Standards and Medicare requirements for ASCs. Results of the self-assessment review may indicate areas needing improvement in the organization's overall provision of patient care.

The chapters are presented in a checklist format to provide an easy mechanism for organizations to determine their current status regarding each of the applicable accreditation Standards.

The following are the definitions of the compliance ratings for Standards. These compliance ratings will also appear in the organization's survey report.

SC — Substantial Compliance indicates that the organization's current operations are acceptable and meet the Standards.

PC — Partial Compliance indicates that a portion of the item is acceptable, but other areas need to be addressed.

NC — Non-Compliance indicates that the organization's operations in the area do not meet the Standard(s).

N/A — Not Applicable indicates that the Standard does not apply to the organization (only present in adjunct chapters).

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Applying for an Accreditation Survey

Survey Eligibility Criteria

Organizations are considered for survey by the AAHC on an individual basis. An organization is eligible for an accreditation survey by the AAHC if the organization meets all of the following criteria. The organization:

- Has been providing health care services for at least six months before the on-site survey, excluding organizations seeking accreditation/Medicare deemed status through an AAHC Early Option Survey (EOS)/initial Medicare deemed status survey (see page 12).
- Is either a formally organized and legally constituted entity that primarily provides health care services, or a sub-unit that primarily provides such services within a formally organized and legally constituted entity that may be, but need not be, health related.
- Is in compliance with applicable federal, state, and local laws and regulations, or for organizations operating outside of the United States, all applicable laws and regulations.
- Is licensed by the state in which it is located, if the state requires licensure for that organization, unless the organization is applying for a survey that will be used to obtain licensure in a state that recognizes AAHC accreditation for this purpose.
- Provides health care services under the direction of one of the following health care professionals (these individuals or groups of professionals must accept responsibility for the health care provided by the organization and be licensed in accordance with applicable state laws):
 - doctor of medicine or osteopathy (MD/DO),
 - doctor of dental surgery or dental medicine (DDS/DMD),
 - doctor of podiatric medicine (DPM),
 - doctor of optometry (OD),
 - doctor of chiropractic (DC).

- advanced practice registered nurse (APRN) practicing in compliance with state law and regulation.
- licensed clinical behavioral health professional in a behavioral health setting.
- Shares the facilities, equipment, business management, and records involved in patient care among the members of the organization.
- Operates in compliance with the U.S. Equal Employment Opportunity Commission laws.
- Submits the completed, signed *Application for Survey*, all supporting documents, and application fee in advance of the survey.
- Pays the appropriate fees in accordance with AAHC policies; see Survey Fees, page 10.
- Acts in good faith in providing to AAHC complete and accurate information during the accreditation process and during a term of accreditation.

The AAHC reserves the right to reject any application. If the AAHC determines that the Standards cannot be applied, a survey will not be conducted and the AAHC will inform the organization of the reason for such a decision. If a survey is conducted and the AAHC decides that the Standards cannot be appropriately applied in order to reach an accreditation decision, the survey will be deemed to be a consultation and no accreditation decision will be made. Fees for such a consultation will not be refunded.

In December 2008, the AAHC was granted a renewal of its deemed status for Medicare by the Centers for Medicare and Medicaid Services (CMS). Ambulatory surgery centers (ASCs) may apply for a combined AAHC/Medicare deemed status (MDS) survey. ASCs applying for an AAHC/MDS survey are required to meet AAHC Standards as well as *Additional Medicare Requirements*.

Enrolling in Medicare for the First Time

Note to ASCs seeking Medicare certification for the first time: Before you can apply for the AAHC/Medicare deemed status survey process, you must enroll to become a Medicare supplier. The process is outlined below and diagrammed on the following page.

For ASCs that are currently Medicare certified, please proceed to AAHC/Medicare Deemed Status Surveys of Ambulatory Surgery Centers (ASCs) on page 9.

Ambulatory Surgery Centers (ASCs) seeking initial Medicare certification must initiate the Medicare enrollment process before applying for an AAHC/Medicare deemed status survey. The process outlined in this section and diagrammed on the following page must be followed by ASCs that wish to enroll in Medicare for the first time.

Obtaining an NPI Number

The Centers for Medicare and Medicaid Services (CMS) requires that all providers and suppliers obtain their National Provider Identifier (NPI) number prior to enrolling in Medicare. A Medicare fee-for-service contractor will not process the 855B enrollment application without the NPI and a copy of the NPI notification letter. Providers and suppliers can obtain their NPI by accessing the following website: <https://nppes.cms.hhs.gov> or by calling 1-800-465-3203.

855 Enrollment Process

- An ASC that wishes to enroll in Medicare can obtain an application on the following website: <http://www.cms.gov/CMSForms/CMSFcrme/1st.asp>. Download and complete the form.
 - 855A is used for home health agencies (HHA), hospices, critical access hospitals (CAH), and hospitals (Providers). (AAHC does not accredit organizations that complete the 855A application.)
 - 855B is used for ASCs (Suppliers) [updated 7/2011].

- Applicants must submit their completed 855B enrollment application, electronically or by hard copy, to the appropriate Medicare fee-for-service contractor. A list of Medicare fee-for-service contractors can be found by accessing the following website: <http://cms.hhs.gov/MedicareProviderSupEnroll/>; or for information about CMS's new internet-based Medicare enrollment Provider Enrollment, Chain and Ownership System (PECOS) visit: https://www.cms.gov/MedicareProviderSupEnroll/04_internetbasedPECOS.asp. This provides various downloadable instructional documents that provide information regarding completing a Medicare enrollment application.

- The Medicare fee-for-service contractor verifies the information on the 855B enrollment application and provides the State Agency (SA), the CMS Regional Office (RO), and the applicant with a written recommendation for approval of enrollment within 30 calendar days.

- Applicants that submit an incomplete 855B application to Medicare will be required to resubmit the 855B with the missing information. Submission of an incomplete application will delay enrollment into the Medicare program. In most cases, requests for additional information will be made within 60 calendar days of the initial receipt of the application by the Medicare fee-for-service contractor. The 30 calendar day period for processing an application restarts when the additional information is received by the Medicare fee-for-service contractor.

- The applicant ASC will provide evidence of its completeness notification from the Medicare fee-for-service contractor to the Accreditation Organization (AO)—AAHC. Upon receipt of the completeness notification, the AO (AAHC) may schedule a survey.

- The AAHC surveys the ASC to determine compliance with the AAHC Standards and the Medicare Conditions for Coverage (CIC). The AAHC sends the survey results to the ASC and the RO.

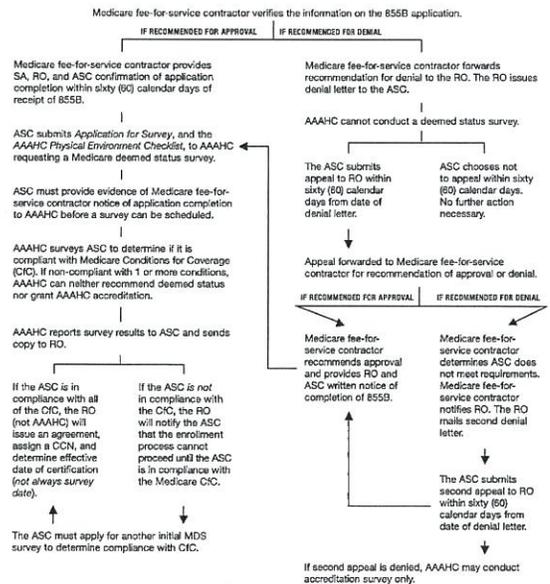
Initial Medicare Certification Process

855B Enrollment Process

The ASC must obtain its National Provider Identification (NPI) number prior to submitting its 855B to CMS. It takes approximately ten (10) days to receive the NPI number. Use this link: <https://nppes.cms.hhs.gov> or call 1-800-465-3203 for instructions and forms for obtaining NPI numbers.

The ASC must complete the CMS 855B enrollment application form. Use this link to obtain the 855B enrollment application: <http://www.cms.gov/CMSForms/downloads/cms855b.pdf> or access CMS's Internet-based PECOS: https://www.cms.gov/MedicareProviderSupEnroll/04_internetbasedPECOS.asp

Within 10 days of receiving completed application, Medicare fee-for-service carrier will send copy to SA and RO.



AAHC/Medicare Deemed Status Surveys of Ambulatory Surgery Centers (ASCs)

In December 2008, the AAHC was granted a renewal of its deemed status for Medicare by the Centers for Medicare and Medicaid Services (CMS). To participate in the AAHC/Medicare deemed status program, ASCs must be in compliance with the Medicare Conditions for Coverage (CIC) as evidenced through a combined AAHC/Medicare deemed status on-site survey. An AAHC/Medicare deemed status survey is performed using AAHC Standards. These AAHC Standards that are comparable to a specific Medicare requirement are indicated by a CMS icon (CMS) at the end of the Standard (please refer to the AAHC/CMS Crosswalk located in the Resources section of this Handbook). Any of these specially indicated Standards that are marked PC or NC are considered Medicare deficiencies. See Condition-Level Deficiency and Standard-Level Deficiency elsewhere in the "Policies and Procedures for Ambulatory Surgery Centers Seeking AAHC/Medicare Deemed Status" section.

Some Medicare requirements are only applicable to and assessed during an AAHC/Medicare deemed status survey. Those requirements are listed as *Additional Medicare Requirements* at the end of all core chapters (except Chapter 3, Administration) and at the ends of the following adjunct chapters:

- Chapter 9: Anesthesia Services
- Chapter 10: Surgical and Related Services
- Chapter 11: Pharmaceutical Services
- Chapter 13: Diagnostic and Other Imaging Services

An ASC must be in compliance with all Medicare requirements; therefore, any Standard identified by a CMS icon or included in the *Additional Medicare Requirements* section rated PC or NC are considered Medicare deficiencies.

As outlined in an ASC's supplier agreement with CMS, the ASC must meet the CIC specified in Title 42 CFR 416.2, 416.25 and 416.40-416.52.

The CIC can be accessed in two ways:

1. Electronic Code of Federal Regulations: <http://efc.gpoaccess.gov/index.html>

Step 1: From the drop-down box, select Title 42 > Public Health > GO.

Step 2: Select #3 — 414-426, Centers for Medicare and Medicaid Services, Department of Health and Human Services.

Step 3: Select 416.100 to 416.200 Ambulatory Surgical Services.

Step 4: Select Subpart B — General Conditions and Requirements 416.25 to 416.35.

Step 5: Select Subpart C — Specific Conditions for Coverage 416.40 to 416.52 are all the Conditions for Coverage for ASCs.

2. CMS webpage: Conditions for Coverage (CICs) & Conditions of Participations (CoPs) (https://www.cms.gov/CFCsAndCoPs/16_ASC.asp#TopOfPage). Scroll to the bottom of the page and select: **CONDITIONS FOR COVERAGE: AMBULATORY SURGERY CENTERS**. On the same page, CMS has included a link to **Appendix I of the State Operations Manual**, which contains the ASC Interpretive Guidelines.

AAHC/Medicare Deemed Status Application and Scheduling Process

Obtaining an Application for Survey

The Application for Survey is completed by ASCs applying for initial AAHC/Medicare deemed status accreditation and by currently-accredited/Medicare deemed status ASCs applying for continuation of AAHC accreditation following a three-year term. Any interested individual may obtain the Application for Survey by visiting the AAHC website, www.aaahc.org. Except where prohibited by law, a non-refundable application fee must accompany each Application for Survey.

By submitting the Application, the ASC 1) attests to the accuracy and veracity of the statements in the Application, and of other information and documents provided to the AAHC and to the survey team during the survey process; 2) agrees to comply with all applicable AAHC policies and procedures; and 3) understands that AAHC and its non-profit subsidiary, AAHC Institute for Quality Improvement, may use the information supplied in the Application and information collected during the survey for quality improvement purposes. Information will not be identified by organization.

An ASC's completed Application for Survey, all supporting documents, and the application fee must be submitted prior to the scheduling of a survey. Staff will review the Application and may request clarification of any information contained therein.

An Application for Survey is valid for six months from the date of receipt by the AAHC office. If the Application is incomplete when received, and is not considered by AAHC as complete within six months, or if the ASC does not schedule a survey during the six-month period, the Application will expire and the ASC must submit a new Application for Survey, along with an additional application fee.

The Application for Survey requires an ASC to attest to its compliance with the Survey Eligibility Criteria. Any ASC that meets the Survey Eligibility Criteria of the AAHC may apply for an accreditation survey.

AAHC Physical Environment Checklist for Ambulatory Surgical Centers

An important component of the Medicare certification process for an ASC is determining that the ASC is compliant with the NFPA 101[®] Life Safety Code[®] 2000 Edition (LSC), which CMS adopted effective March 11, 2003. In addition, for a facility to operate as a Medicare certified ASC, Chapter 20 (New Ambulatory Health Care Occupancy), or Chapter 21 (Existing Ambulatory Health Care Occupancy), of the LSC shall apply, regardless of the number of patients served. The ASC cannot be considered a Business Occupancy for purposes of determining LSC compliance.

When the ASC requests a combined AAHC/Medicare deemed status survey, the organization must submit a completed copy of the AAHC Physical Environment Checklist for Ambulatory Surgical Centers (PEC) to determine that the ASC meets the requirements of the Life Safety Code (LSC). The PEC is available for purchase from the AAHC office or the AAHC website, www.aaahc.org. The PEC provides a format for schematic review of the fire and life safety issues involved with surgical facilities desiring certification by the CMS as an ASC. It is based on the CMS-approved requirements of the applicable National Fire Protection Association (NFPA) codes and standards, as referenced from the NFPA 101[®] LSC, 2000 Edition.

The procedure for the proper application and completion of the PEC is included with the PEC. The ASC is responsible for assessing whether it meets the LSC requirements. The ASC is required to complete and retain its original completed PEC and submit a copy of the completed PEC to the AAHC along with the completed Application for Survey and other required supporting documents. The AAHC survey team is provided with a copy of the organization's completed PEC prior to the on-site survey.

Survey Fees

The survey fee is determined from information obtained from the ASC's Application for Survey and supporting documentation. Factors considered in determining survey fees include the size, type, and range of services provided by the ASC. An automated email will be sent upon completion of an application. Duration and cost of survey will be provided to the applicant at this time.

The survey fee must be paid no later than 20 calendar days prior to the first day of the "survey window." If fewer than 20 calendar days exist between invoicing of the survey fee and the beginning of the survey window, the ASC must pay the survey fee upon receipt of invoice. Failure to pay the survey fee as outlined will result in cancellation of the survey.

Scheduling

ASCs requesting AAHC/Medicare deemed status surveys should note that CMS requires that such surveys be conducted on an unannounced basis within a 90 calendar day "survey window," which is established with the ASC in advance. The date of the survey and the names of the surveyor(s) are not disclosed to the ASC prior to the survey.

Survey dates are determined by the AAHC in cooperation with the organization being surveyed. Every attempt is made to schedule the survey at a convenient time for the requesting organization. The survey must be conducted when the organization is open for business and providing services (may not apply for an EOS, see page 12).

Once a survey has been scheduled, the AAHC sends the ASC written confirmation that the survey has been scheduled, as well as the survey agenda and other information about the survey.

Cancellation Policies

A request for postponement or cancellation of a scheduled accreditation survey must be received by the AAHC office in writing.

If an organization cancels or postpones its survey thirty (30) calendar days or more prior to the survey or 90-day survey window, the entire survey fee is refundable.

If the organization cancels or postpones its scheduled survey between fifteen (15) and twenty-nine (29) calendar days before the survey, the AAHC will assess a \$500 administrative fee. For cancellation due to any circumstance, the organization will be responsible for all direct and indirect nonrefundable costs associated with the survey, including, but not limited to, the cost of survey transportation and lodging.

If the organization cancels or postpones its AAHC accreditation survey fewer than fifteen (15) calendar days before the survey, no refunds or credits will be given.

If an organization cancels or postpones a scheduled survey more than one time, additional fees will be assessed at the discretion of the AAHC, and the fees must be paid prior to scheduling the next survey.

All fees due must be paid prior to scheduling the next survey.

Calendar Days	Application Fee	Survey Fee	Administrative Fee
30 days or more	No refund	Full refund	None
15-29 days before survey	No refund	Full survey fee refund less \$500 admin fee plus incurred cost	\$500
<15 days before survey	No refund	No refund	No admin fee
Cancel or postpone more than once per cycle	No refund	Must pay survey fee before scheduling next survey	Admin fee at the discretion of AAHC

In addition, an ASC that is undergoing an AAHC/Medicare deemed status survey may not decide to cancel the Medicare portion of the survey during the conduct of that survey.

Surveyor Conduct During Survey

Surveyors are representatives of AAHC. It is AAHC policy that their first and foremost priority when conducting surveys is to be ambassadors of AAHC, objective fact finders, and educators when appropriate.

It is the policy and practice of AAHC that surveyors decline from participating in surveys of organizations which may be in direct competition with the surveyor's business interests, or which bear any significant beneficial interest to the surveyor or the surveyor's immediate family.

AAHC policy also states that, while serving as representatives of AAHC, surveyors may not solicit personal business or take part in any activities that appear to be in furtherance of any of their personal, entrepreneurial endeavors.

In support of these policies, AAHC requests that surveyed organizations refrain from offering consultative or other types of business to their AAHC surveyors, and/or to members of the surveyors' immediate families.

All information, including, but not limited to, non-public information submitted on a confidential basis by parties seeking accreditation, schedule lists for future site visits, survey report forms, report of the internal proceedings and deliberations of AAHC's standing and ad hoc committees, interviews, reports, statements, memoranda, and other data used in the course of business are to remain strictly confidential and will not be disclosed to any other party, except as described below.

Confidentiality

The AAHC will maintain as confidential all information provided to it with respect to any ASC that is seeking or has obtained accreditation, will use such information solely for purposes of reaching an accreditation decision, and will not disclose such information to any third party except (i) on prior written authorization from the organization; (ii) as otherwise provided in the Handbook; or (iii) as otherwise required by law.¹

In submitting its signed Application for Survey, the ASC either provides or authorizes the AAHC to obtain required official records and reports of public or publicly recognized licensing, examining, reviewing, or planning bodies.

In the event that the AAHC determines that an ASC has supplied it with false, misleading, or incomplete information, the AAHC reserves the right to disclose any information about the ASC to obtain accurate or complete information about the ASC.

Types of Surveys

Early Option Survey/Initial Medicare Deemed Status Survey

The AAHC's early option survey (EOS) is for ASCs that are newly constructed, operational, and require accreditation for third-party reimbursement, and a six-month wait for a survey would entail financial hardship; or have been providing services for less than six months and are seeking AAHC accreditation and Medicare deemed status for the first time.

When an EOS is requested, the ASC must provide evidence of the following with its Application for Survey:

- The date the ASC is/will be open and operational and actively providing surgical procedures to adequately demonstrate compliance with AAHC accreditation requirements including Medicare requirements.
- License or provisional license has been obtained from the state licensing authority. If the ASC is not subject to the facility licensure law, then it should provide evidence from the appropriate regulatory authority confirming this fact, as well as evidence that the organization is eligible to achieve Medicare certification.
- The building in which patient care services will be provided is built and ready to support such care, as evidenced by reports of any inspections conducted by local and state fire marshals, local or state health departments, or other code enforcement agencies.
- All governance and administrative structures are in place, including bylaws, policies, and procedures.
- Key executives are employed and medical staff have been credentialled and privileged by the governing body.

- All necessary equipment is in place and has been appropriately tested and/or calibrated; written up-to-date maintenance logs are in place.
- Documented full compliance with the NFPA 101[®] Life Safety Code[®] 2000 Edition, based on the completed AAHC Physical Environment Checklist.
- A non-denial statement (refer to the Application for Survey) completed and signed by an authorized person at the ASC.

An EOS is conducted during the ninety (90) day survey window on an unannounced basis after the ASC has opened. The names of the surveyors are not disclosed prior to the survey. The surveyors will observe a surgical procedure during the survey.

Organizations undergoing an EOS will receive a three-year term of accreditation or be denied accreditation. See Term of Accreditation for further information. These organizations must undergo an unannounced interim survey to maintain the term. All applicable Standards will be applied during the interim survey.

Initial Accreditation/Initial Medicare Deemed Status Survey

This survey is conducted for an ASC that is seeking AAHC accreditation for the first time. The ASC may or may not be currently Medicare-certified and is not currently participating in the AAHC/Medicare deemed status survey process.

Re-accreditation/Initial Medicare Deemed Status Survey

This survey is conducted for an ASC that is currently AAHC accredited and is having a re-accreditation survey. The ASC may or may not be currently Medicare-certified, but the ASC is not currently participating in the AAHC/Medicare deemed status survey process.

Re-accreditation Medicare Deemed Status Survey

This survey is conducted for an ASC that is currently AAHC accredited and is having a re-accreditation survey and continuation of AAHC/Medicare deemed status.

¹For example, the AAHC is required to provide relevant survey information to the administrator of the Centers for Medicare and Medicaid Services (CMS) as part of the AAHC/Medicare deemed status accreditation process and to report certain negative actions or findings, such as a final determination of termination of accreditation status to the National Practitioner Data Bank (NPDB).

Core Chapters

The core chapters will be applied to all organizations seeking accreditation.

1. Rights of Patients
An accrediting organization recognizes the basic human rights of patients. Such an organization has the following characteristics.

Compliance	SC	PC	NC
A.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A. Patients are treated with respect, consideration, and dignity.
B. Patients are provided appropriate privacy.
C. Patient disclosures and records are treated confidentially, and patients are given the opportunity to approve or refuse their release, except when release is required by law.
D. Patients are provided to the degree known, complete information concerning their diagnosis, evaluation, treatment, and prognosis. When it is medically advisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
E. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons. **NEW**
416.50 (e)(1)(ii) Standard:
Exercise of rights and respect for property and person
The patient has the right to the following:
Voice grievances regarding treatment or care that is (or fails to be) furnished.

Information is available to patients and staff concerning:
1. Patient rights, including those specified in A., B., C., D., and E above.
2. Patient conduct, responsibilities, and participation.
3. Services available at the organization.
4. Provisions for after-hours and emergency care.
5. Fees for services.
6. Payment policies.
7. Patient's right to refuse to participate in experimental research.
8. Advance directives, as required by state or federal law and regulations.
9. The credentials of health care professionals.

Compliance	SC	PC	NC
A.M.S.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.M.S.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.M.S.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.M.S (1).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.M.S (2).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.M.S (3).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.M.S (4).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.M.S (5).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.M.S (6).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.M.S (7).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.M.S (8).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.M.S (9).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F.M.S.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F.M.S (1).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Medicare Requirements
A.M.S. The patient has the right to be free from all forms of abuse or harassment [416.50(e)(9) Standard: Privacy and safety].
B.M.S. The patient has the right to personal privacy [416.50(f)(1) Standard: Privacy and safety].
C.M.S. The ASC must comply with the Department's rules for the integrity and security of individually identifiable health information as specified in this 42 CFR parts 160 and 164. [416.50(g) Standard: Confidentiality of clinical records].
D.M.S (1). The patient has the right to be fully informed about a treatment or procedure and the expected outcome before it is performed. [416.50(h)(1)(a) Standard: Exercise of rights and respect for property and person].
D.M.S (2). If a patient is adjudged incompetent under applicable State laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf. [416.50(h)(2) Standard: Exercise of rights and respect for property and person].
D.M.S. From the patient or, as appropriate, the patient's representative of the patient's right to make informed decisions regarding the patient's care. [416.50(i)(2) Standard: Advance directives].
D.M.S (3). If a state court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance with State law may exercise the patient's rights to the extent allowed by State law. [416.50(i)(3) Standard: Exercise of rights and respect for property and person].
F.M.S. The ASC must inform the patient or the patient's representative or surrogate, if applicable, [416.50 Condition: Patient Rights].
F.M.S (1). An ASC must, prior to the start of the surgical procedure, provide the patient, the patient's representative or the patient's surrogate with verbal and written notice of the patient's rights in a language and manner that the patient, the patient's representative, or the surrogate understands all of the patient's rights as set forth in Title 42 CFR 416.50.
The ASC's notice of rights must include the name, address and telephone number of the State agency to which patients may report complaints, as well as the Website for the Office of the Medicare Beneficiary Ombudsman. [416.50(e)(9) Standard: Notice of rights].

Compliance
SC PC NC
G. Prior to receiving care, patients are informed of patient responsibilities. These responsibilities require the patient to:
1. Provide complete and accurate information to the best of their ability about their health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities.
2. Follow the treatment plan prescribed by their provider and participate in their care.
3. Provide a responsible adult to transport them home from the facility and remain with them for twenty-four (24) hours, if required by their provider.
4. Inform their provider about any drug, medical, or other power of attorney, by their insurance.
5. Accept personal financial responsibility for any charges not covered by their insurance.
6. Be respectful of all the health care professionals and staff, as well as other patients.
H. Patients are informed of their right to change their provider if other qualified providers are available.
I. Representation of accreditation to the public must accurately reflect the Accredited entity.
J. Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.
K. Patients are provided with appropriate information regarding the absence of malpractice insurance coverage.
L. Patients are informed about procedures for expressing suggestions, complaints, and grievances, including those required by state and federal regulations. **NEW**
416.50 (e)(1)(ii) Standard:
Exercise of rights and respect for property and person
The patient has the right to the following:
Voice grievances regarding treatment or care that is (or fails to be) furnished.

2. Governance

An accredited organization has a governing body that sets policy and is responsible for the organization, such an organization has the following characteristics.

Compliance
SC PC NC

Subchapter 1 – General Requirements: This subchapter describes general requirements to an organization and its governing body.					
A. The organization is a legally constituted entity, or an organized sub-unit of a legally constituted entity, or is a sole proprietorship in the state(s) in which it is located and provides services.					
1. The names and addresses of all owners or controlling parties (whether individuals, partnerships, trusts, corporate bodies, or subdivisions of other bodies, such as public agencies or regions, internal or other philanthropic organizations) are available upon request and furnished to the Accreditation Association for Ambulatory Health Care (AAAHC).					
2. A legally constituted entity is documented by at least one of the following: articles of organization, operating agreement, legalistic or executive partnership agreement, or incorporation.					
3. The governing body addresses and is fully and legally responsible, either directly or by appropriate professional delegation, for the operation and performance of the organization. Governing body responsibilities include, but are not limited to:					
1. Determining the mission, goals, and objectives of the organization.					
2. Ensuring that facilities and personnel are adequate and appropriate to carry out the mission.					
3. Establishing an organizational structure and specifying functional relationships among the various components of the organization.					
4. Adopting bylaws or similar rules and regulations for the orderly development and management of the organization.					
5. Adopting policies and procedures necessary for the orderly conduct of the organization, including the organization's scope of critical activities.					
6. The organization develops and maintains a policy defining the care of pediatric patients, if relevant. Specific components of pediatric care are listed in Standard 10.L.2.					
7. Ensuring that the quality of care is evaluated and that identified problems are appropriately addressed.					
8. Reviewing all legal and ethical matters concerning the organization and its staff and, when necessary, responding appropriately.					

F-6-MS. The ASC must comply with the following requirements: [16.50(c)(1) Standard: Advance directives]

Compliance
SC NC

(1) The ASC must provide the patient or, as appropriate, the patient's representative with written information concerning the patient's options regarding health care decisions, including a description of available State advance directives, including a description of applicable State health and safety laws and, if required, other State election directives. [16.50(c)(2) Standard: Advance directives]					
(2) Document in a permanent part of the patient's current medical record, whether or not the individual has executed an advance directive. [16.50(c)(3) Standard: Advance directives]					
L-MS. The patient has the right to the following: Be free from any act of discrimination or reprisal. [16.50(a)(1) Standard: Exercise of rights and respect for property and person]					
F-6-MS (2). [16.50(c)(1) Standard: Advance directives]					
F-6-MS (1). [16.50(c)(1) Standard: Advance directives]					
L-MS. The patient has the right to the following: Be free from any act of discrimination or reprisal. [16.50(a)(1) Standard: Exercise of rights and respect for property and person]					

2 Governance

Compliance
SC PC NC

8. Maintaining effective communication throughout the organization, including ensuring a bridge between quality management and improvement activities and other management functions of the organization.					
9. Establishing a system of financial management and accountability.					
10. Determining a policy on the rights of patients.					
11. Approving and ensuring compliance of all major contracts or arrangements involving the medical and dental care provided under its auspices and ensuring that services are provided in a safe and effective manner, including, but not limited to, those concerning: a. The employment or contracting of health care professionals. [16.41 (a) Standard: Contract services]					
b. Laboratory services. [16.41 (a) Standard: Contract services]					
c. The use of external laboratories. [16.41 (a) Standard: Contract services]					
d. The provision of care by other health care organizations, such as hospitals. [16.41 (a) Standard: Contract services]					
e. The provision of education to students and postgraduate trainees. [16.41 (a) Standard: Contract services]					
f. The provision of after-hours patient information or telephone triage services, including the review of protocols. [16.41 (a) Standard: Contract services]					

2 Governance

Compliance
SC PC NC

12. Formulating long-range plans in accordance with the mission, goals and objectives of the organization.					
13. Operating the organization without violating federal or state anti-discrimination laws.					
14. Ensuring that all of the marketing and advertising concerning the organization does not imply that it provides care or services that it is not capable of providing.					
15. Developing a program of risk management appropriate to the organization.					
16. Determining a policy on continuing education for personnel and/or patient education that comply with all applicable occupational health and safety regulations for health care workers, such as the Occupational Safety and Health Administration (OSHA) rules on Occupational Exposure to Bloodborne Pathogens (Title 29 CFR 1910.1030).					
17. Developing policies that comply with all applicable occupational health and safety regulations for health care workers, such as those addressing the National Fire Protection Association (NFPA) 704, and reporting to the National Fire Protection Association (NFPA).					
18. Establishing a mechanism to fulfil all applicable obligations under local, state, and federal laws and regulations, such as those addressing the National Fire Protection Association (NFPA) 704, and reporting to the National Fire Protection Association (NFPA).					
19. Developing, implementing, and oversight of the organization's infection control and safety programs to ensure a safe environment of care.					
20. Adopting policies/procedures to resolve grievances and external appeals, as required by state and federal law and regulations.					

		Compliance		
		SC	PC	NC
4.	Upon completion of the application, the credentials are verified according to procedures established in the organization's bylaws, rules and regulations, or policies. The organization has established procedures to obtain information necessary for primary or secondary source verification of the credentials and is responsible for obtaining this information. An accreditable organization may use information provided by a Credentials Verification Organization (CVO) after proper assessment of the capability and quality of the CVO. Alternatively, a CVO may demonstrate such capability and quality by becoming accredited or certified by a nationally recognized accreditation organization. Primary or acceptable secondary source verification is required for items listed in 2.II.B-3e-f, unless a CVO or an organization performing primary source verification that is accredited or certified by a nationally recognized body is used. If the organization utilizes a CVO or another organization to verify credentials, those entities must perform primary source verification unless such sources do not exist or are impossible to verify.	4.	<input type="checkbox"/>	<input type="checkbox"/>
5.	Medical staff must apply for reappointment every three (3) years, or more frequently if state law or organizational policies so stipulate. At reappointment, the organization requires completion of a reappointment application and verifies items listed in Standard 2.II.B-3c-g and peer review activities as described in Chapter 5.I.	5.	<input type="checkbox"/>	<input type="checkbox"/>
6.	The organization shall monitor and document current licensure, professional liability insurance if required, certifications, and DEA and other registrations, where applicable, on an ongoing basis.	6.	<input type="checkbox"/>	<input type="checkbox"/>
7.	In a solo medical or dental practice, the provider's credentials file shall be reviewed by an outside physician (for a medical practice) or an outside dentist (for a dental practice) at least every three (3) years, or more frequently, if state law or organizational policies so stipulate, to ensure currency, accuracy, and completeness of his/her credentials. The provider is required to complete an application or reapplication, and the documentation identified in Standard 2.II.B-3 must be present in the credentials file, including a list of procedures that will be performed by the provider in the organization/practice setting and evidence of appropriate education, training, and experience to perform the privileged procedures. Applications are available for other providers requesting credentialing and privileges to perform procedures in the solo provider's organization, including any anesthesia providers. In a solo provider's practice, the granting of privileges shall be reviewed by an outside physician (for medical practices) or dentist (for dental practices).	7.	<input type="checkbox"/>	<input type="checkbox"/>
<p>Privileging is a three-phase process. The objective of privileging is to determine the specific procedures and treatments that a health care professional may perform. An accreditable organization: 1) determines the clinical procedures and treatments that are offered to patients; 2) determines the qualifications related to training and experience that are required to authorize an applicant to obtain each privilege; and 3) establishes a process for evaluating the applicant's qualifications using appropriate criteria and approving, modifying, or denying any or all of the requested privileges in a non arbitrary manner.</p>				

		Compliance		
		SC	PC	NC
C.	The scope of procedures must be periodically reviewed by the governing body and amended as appropriate.	C.	<input type="checkbox"/>	<input type="checkbox"/>
D.	Privileges to carry out specified procedures are granted by the organization to the health care professional to practice for a specified period of time. The health care professional must be legally and professionally qualified for the privileges granted. These privileges are granted based on an applicant's qualifications within the services provided by the organization and recommendations from qualified medical personnel.	D.	<input type="checkbox"/>	<input type="checkbox"/>
<p>416.45 (a) Standard: Membership and clinical privileges <i>Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel.</i></p>				
E.	Mechanisms are in place for the organization to notify licensing and/or disciplinary bodies or other appropriate authorities, including the NPDB, when a medical staff member's privileges are suspended or terminated, as required by state or federal law and regulations.	E.	<input type="checkbox"/>	<input type="checkbox"/>
F.	The organization has its own independent process of credentialing and privileging. The approval of credentials or the granting of privileges requires review and approval by the organization's governing body. Credentials may not be approved, nor privileges granted, solely on the basis that another organization, such as a hospital, approved credentials or granted privileges, without further review. Such status at another organization may be included in the governing body's consideration of the application.	F.	<input type="checkbox"/>	<input type="checkbox"/>
G.	The governing body provides a process in a manner consistent with state law and based on evidence of education, training, experience, and current competence, for the initial appointment, reappointment, and assignment or curtailment of privileges and practice for allied health care professionals.	G.	<input type="checkbox"/>	<input type="checkbox"/>
<p>Additional Medicare Requirements</p>				
I.A.-MS.	The ASC must comply with State licensure requirements. [416.40 Condition: Compliance with State licensure law]	I.A.-MS.	<input type="checkbox"/>	<input type="checkbox"/>
I.A.-1-MS.	The ASC must also disclose, in accordance with Title 42 CFR Part 420, and where applicable, provide a list of physicians who have financial interest or ownership in the ASC facility. Disclosure of information must be in writing. [416.50(b) Standard: Disclosure of physician financial interest or ownership]	I.A.-1-MS.	<input type="checkbox"/>	<input type="checkbox"/>

		SC	NC
I.B.-MS (1).	The ASC must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the ASC's total operation. The governing body has oversight and accountability for the quality assessment and performance improvement program, ensures that facility policies and programs are administered so as to provide quality health care in a safe environment, and develops and maintains a disaster preparedness plan. [416.41 Condition: Governing Body and management]	I.B.-MS (1).	<input type="checkbox"/>
I.B.-20-MS.	The ASC must establish a grievance procedure for documenting the existence, submission, investigation, and disposition of a patient's written or verbal grievance to the ASC. The following criteria must be met. [416.50(a) Standard: Submission and investigation of grievances]	I.B.-20-MS.	<input type="checkbox"/>
I.B.-20-MS (1).	All alleged violations/grievances resulting, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented. [416.50(a)(1) Standard: Submission and investigation of grievances]	I.B.-20-MS (1).	<input type="checkbox"/>
I.B.-20-MS (2).	All allegations must be immediately reported to a person in authority in the ASC. [416.50(a)(2) Standard: Submission and investigation of grievances]	I.B.-20-MS (2).	<input type="checkbox"/>
I.B.-20-MS (3).	Only substantiated allegations must be reported to the State authority or the local authority, or both. [416.50(a)(3) Standard: Submission and investigation of grievances]	I.B.-20-MS (3).	<input type="checkbox"/>
I.B.-20-MS (4).	The grievance process must specify timelines for review of the grievance and the provision of a response. [416.50(a)(4) Standard: Submission and investigation of grievances]	I.B.-20-MS (4).	<input type="checkbox"/>
I.B.-20-MS (5).	The ASC, in responding to the grievance, must investigate all grievances made by a patient or the patient's representative, or the patient's surrogate, regarding treatment or care that is or fails to be furnished. [416.50(a)(5) Standard: Submission and investigation of grievances]	I.B.-20-MS (5).	<input type="checkbox"/>
I.B.-20-MS (6).	The ASC must document how the grievance was addressed, as well as provide the patient, the patient's representative, or the patient's surrogate with written notice of its decision. The decision must contain the name of an ASC contact person, the steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed. [416.50(a)(6) Standard: Submission and investigation of grievances]	I.B.-20-MS (6).	<input type="checkbox"/>
II.C.-MS.	Medical staff privileges must be periodically reassessed by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate. [416.45(d) Standard: Reassessing]	II.C.-MS.	<input type="checkbox"/>
II.G.-MS.	If the ASC assigns patient care responsibilities to practitioners other than physicians, it must have established policies and procedures, approved by the governing body, for overseeing and evaluating their clinical activities. [416.45(c) Standard: Other practitioners]	II.G.-MS.	<input type="checkbox"/>

3. Administration

An accreditable organization is administered in a manner that ensures the provision of high-quality health services and that fulfills the organization's mission, goals, and objectives. Organizations may find it helpful to use the **Personnel Records Worksheet** to evaluate compliance with some Standards found in this chapter. The **Worksheets and Forms** section is located in the back of this **Handbook**.

		Compliance		
		SC	PC	NC
A.	Administrative policies, procedures and controls are established and implemented to ensure the orderly and efficient management of the organization. Administrative responsibilities include, but are not limited to:	A.	<input type="checkbox"/>	<input type="checkbox"/>
1. Enforcing policies delegated by the governing body.		1.	<input type="checkbox"/>	<input type="checkbox"/>
2. Employing qualified management personnel.		2.	<input type="checkbox"/>	<input type="checkbox"/>
3. Long-range and short-range planning for the needs of the organization, as determined by the governing body.		3.	<input type="checkbox"/>	<input type="checkbox"/>
4. Taking all reasonable steps to comply with applicable laws and regulations.		4.	<input type="checkbox"/>	<input type="checkbox"/>
5. Protecting the assets of the organization.		5.	<input type="checkbox"/>	<input type="checkbox"/>
6. Implementing fiscal controls, including, but not limited to:		6.	<input type="checkbox"/>	<input type="checkbox"/>
a. Authorization and record procedures that are adequate to provide accounting controls over assets, liabilities, revenues, and expenses.		a.	<input type="checkbox"/>	<input type="checkbox"/>
b. Policies and procedures for controlling accounts receivable and accounts payable and for handling cash and credit arrangements.		b.	<input type="checkbox"/>	<input type="checkbox"/>
c. Rates and charges for services provided by the organization.		c.	<input type="checkbox"/>	<input type="checkbox"/>
d. Methods of collection of unpaid accounts that are reviewed before referral to a collection agency.		d.	<input type="checkbox"/>	<input type="checkbox"/>
7. Using methods of communicating and reporting designed to ensure the orderly flow of information within the organization.		7.	<input type="checkbox"/>	<input type="checkbox"/>
8. Controlling the purchase, maintenance, and distribution of the equipment, materials, and facilities of the organization.		8.	<input type="checkbox"/>	<input type="checkbox"/>
9. Establishing lines of authority, accountability, and supervision of personnel.		9.	<input type="checkbox"/>	<input type="checkbox"/>
10. Establishing controls relating to the custody of the official documents of the organization.		10.	<input type="checkbox"/>	<input type="checkbox"/>
11. Maintaining the confidentiality, security, and physical safety of data on patients and staff.		11.	<input type="checkbox"/>	<input type="checkbox"/>
12. Maintaining a health information system that collects, integrates, analyzes, and reports data as necessary to meet the needs of the organization.		12.	<input type="checkbox"/>	<input type="checkbox"/>
a. Characteristics of the system should include, but are not limited to:		a.	<input type="checkbox"/>	<input type="checkbox"/>

		Compliance		
		SC	PC	NC
I.	Linkage between the quality improvement program to meet performance improvement/quality indicators and quality improvement activities.	i.	<input type="checkbox"/>	<input type="checkbox"/>
	Ensuring accurate, timely, and complete data in a consistent manner as appropriate for the organization.	ii.	<input type="checkbox"/>	<input type="checkbox"/>
	Maintaining collected data in a standardized format to the extent feasible and appropriate.	iii.	<input type="checkbox"/>	<input type="checkbox"/>
13.	Addressing the relationships with competing health care organizations to avoid antitrust and restraint of trade concerns.	13.	<input type="checkbox"/>	<input type="checkbox"/>
14.	Dealing with inquiries from governmental agencies, attorneys, consumer advocate groups, reporters, and the media.	14.	<input type="checkbox"/>	<input type="checkbox"/>
B.	Personnel policies are established and implemented to facilitate attainment of the mission, goals, and objectives of the organization. Personnel policies:	B.	<input type="checkbox"/>	<input type="checkbox"/>
1.	Define and delineate functional responsibilities and authority.	1.	<input type="checkbox"/>	<input type="checkbox"/>
2.	Require the employment of personnel with qualifications commensurate with job responsibilities and authority, including appropriate licensure or certification.	2.	<input type="checkbox"/>	<input type="checkbox"/>
3.	Reflect the requirement for documentation of initial orientation and training according to position description. Initial orientation and training shall be:	3.	<input type="checkbox"/>	<input type="checkbox"/>
a.	Completed within 30 days of commencement of employment.	a.	<input type="checkbox"/>	<input type="checkbox"/>
b.	Provided annually thereafter and when there is an identified need.	b.	<input type="checkbox"/>	<input type="checkbox"/>
c.	Provided by a qualified person(s) designated by the organization.	c.	<input type="checkbox"/>	<input type="checkbox"/>
4.	Require periodic appraisal of each person's job performance, including current competence.	4.	<input type="checkbox"/>	<input type="checkbox"/>
5.	Describe incentives and rewards, if any exist.	5.	<input type="checkbox"/>	<input type="checkbox"/>
6.	Require periodic review of employee compensation.	6.	<input type="checkbox"/>	<input type="checkbox"/>
7.	Specify privileges and responsibilities of employment, including compliance with an adverse incident reporting system, as described in Standard 2.I.B-21. NEW	7.	<input type="checkbox"/>	<input type="checkbox"/>
<p>416.43 (c)(3) Standard: Program activities <i>The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies.</i></p>				
8.	Are made known to employees at the time of employment.	8.	<input type="checkbox"/>	<input type="checkbox"/>
9.	Comply with federal and state laws and regulations regarding verification of eligibility for employment, such as I-9 (Immigration and Naturalization form) and visas, as required.	9.	<input type="checkbox"/>	<input type="checkbox"/>

		Compliance		
		SC	PC	NC
C.	The organization has a written exposure control plan that is:	C.	<input type="checkbox"/>	<input type="checkbox"/>
1.	In compliance with current OSHA bloodborne pathogen regulations.	1.	<input type="checkbox"/>	<input type="checkbox"/>
2.	Reviewed and updated at least annually, including an evaluation for the availability of safer medical devices and changes in technology.	2.	<input type="checkbox"/>	<input type="checkbox"/>
3.	Made a part of employee initial orientation and annual retraining.	3.	<input type="checkbox"/>	<input type="checkbox"/>
D.	Health care workers are protected from biologic hazards, consistent with state, federal, and CDC guidelines through:	D.	<input type="checkbox"/>	<input type="checkbox"/>
1.	An effective program addressing bloodborne pathogens, including:	1.	<input type="checkbox"/>	<input type="checkbox"/>
a.	Exposure control plan designed to eliminate or minimize employee exposures.	a.	<input type="checkbox"/>	<input type="checkbox"/>
b.	Hepatitis B vaccination program.	b.	<input type="checkbox"/>	<input type="checkbox"/>
c.	Post-exposure evaluation and treatment.	c.	<input type="checkbox"/>	<input type="checkbox"/>
d.	Appropriate training in and communication of hazards to employees.	d.	<input type="checkbox"/>	<input type="checkbox"/>
e.	Appropriate record keeping and management.	e.	<input type="checkbox"/>	<input type="checkbox"/>
2.	An immunization program for other infectious agents of risk to health care workers and their patients.	2.	<input type="checkbox"/>	<input type="checkbox"/>
3.	A tuberculosis respiratory protection program.	3.	<input type="checkbox"/>	<input type="checkbox"/>
4.	Programs addressing other relevant biological hazards, such as bioterrorism, as needed for employee safety and health.	4.	<input type="checkbox"/>	<input type="checkbox"/>
E.	A program is maintained to assess and reduce risks associated with occupational chemical exposures, including:	E.	<input type="checkbox"/>	<input type="checkbox"/>
1.	Hazard assessment of chemicals used in the workplace.	1.	<input type="checkbox"/>	<input type="checkbox"/>
2.	Engineering measures to reduce the risk of chemical exposure.	2.	<input type="checkbox"/>	<input type="checkbox"/>
3.	Worker training programs.	3.	<input type="checkbox"/>	<input type="checkbox"/>
F.	A program is maintained to assess and, where necessary, reduce risks associated with physical hazards, such as ergonomic exposures, violence at the workplace, and external physical threats such as terrorism.	F.	<input type="checkbox"/>	<input type="checkbox"/>
G.	Records of work injuries and illnesses are maintained, consistent with reporting requirements, and employee health records are managed appropriately.	G.	<input type="checkbox"/>	<input type="checkbox"/>
H.	The organization periodically assesses patient satisfaction with services and facilities provided by the organization. The findings are reviewed by the governing body and, when appropriate, corrective actions are taken.	H.	<input type="checkbox"/>	<input type="checkbox"/>
I.	When students and postgraduate trainees are present, their status is defined in the organization's personnel policies.	I.	<input type="checkbox"/>	<input type="checkbox"/>

4. Quality of Care Provided

An accreditable organization provides high-quality health care services in accordance with the principles of professional practice and ethical conduct, and with concern for the costs of care and for improving the community's health status. Such an organization has the following characteristics.

		Compliance		
		SC	PC	NC
A.	All health care professionals have the necessary and appropriate training and skills to deliver the services provided by the organization.	A.	<input type="checkbox"/>	<input type="checkbox"/>
B.	Health care professionals practice their professions in an ethical and legal manner.	B.	<input type="checkbox"/>	<input type="checkbox"/>
C.	All personnel assisting in the provision of health care services are appropriately trained, qualified, and supervised and are available in sufficient numbers for the care provided.	C.	<input type="checkbox"/>	<input type="checkbox"/>
D.	The organization, with active participation of the medical staff, must conduct an ongoing, comprehensive self-assessment of the quality of care provided as described in Chapter 5.I., including medical necessity of care or procedures performed and appropriateness of care, and use findings, when appropriate, in the revision of the organization's policies as described in Chapter 2.I and consideration of clinical privileges as described in Chapter 2.II and Chapter 5.II.	D.	<input type="checkbox"/>	<input type="checkbox"/>
E.	The organization facilitates the provision of high-quality health care as demonstrated by the following:	E.	<input type="checkbox"/>	<input type="checkbox"/>
1.	Health care provided is consistent with current professional knowledge. NEW	1.	<input type="checkbox"/>	<input type="checkbox"/>
<p>416.43 (c)(3) Standard: Program activities <i>The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies.</i></p>				
2.	Education of, and effective communication with, those served concerning the diagnosis and treatment of their conditions, appropriate preventive measures, and use of the health care system.	2.	<input type="checkbox"/>	<input type="checkbox"/>
3.	Appropriate and timely diagnosis based on findings of the current history and physical examination. NEW	3.	<input type="checkbox"/>	<input type="checkbox"/>
<p>416.47 (b)(2) Standard: Form and content of record <i>The ASC must maintain a clinical record for each patient. Every record must be accurate, legible, and promptly completed. Clinical records must include at least the following: Significant medical history and results of physical examination.</i></p>				

4 Quality of Care Provided

		Compliance		
		SC	PC	NC
4.	Review and update of all individual patient medications at each visit, including over-the-counter products and dietary supplements when information is available.	4.	<input type="checkbox"/>	<input type="checkbox"/>
5.	Treatment that is consistent with clinical impression or working diagnosis.	5.	<input type="checkbox"/>	<input type="checkbox"/>
6.	Appropriate and timely consultation.	6.	<input type="checkbox"/>	<input type="checkbox"/>
7.	Absence of clinically unnecessary diagnostic or therapeutic procedures.	7.	<input type="checkbox"/>	<input type="checkbox"/>
8.	Appropriate and timely referrals.	8.	<input type="checkbox"/>	<input type="checkbox"/>
9.	Appropriate and timely follow-up of findings and tests. NEW	9.	<input type="checkbox"/>	<input type="checkbox"/>
<p>416.47 (b)(3) Standard: Form and content of record <i>The ASC must maintain a clinical record for each patient. Every record must be accurate, legible, and promptly completed. Clinical records must include at least the following: Pre-operative diagnostic studies (entered before surgery), if performed.</i></p>				
10.	Patient participation.	10.	<input type="checkbox"/>	<input type="checkbox"/>
11.	Continuity of care and patient follow-up.	11.	<input type="checkbox"/>	<input type="checkbox"/>
12.	Patient satisfaction.	12.	<input type="checkbox"/>	<input type="checkbox"/>
F.	The organization provides for accessible and available health services and ensures patient safety by at least the following:	F.	<input type="checkbox"/>	<input type="checkbox"/>
1.	Provision for and information about services when the organization's facilities are not open.	1.	<input type="checkbox"/>	<input type="checkbox"/>
2.	Adequate and timely transfer of information when patients are transferred to other health care professionals.	2.	<input type="checkbox"/>	<input type="checkbox"/>
3.	An increased likelihood of desired health outcomes through participation in performance measurement and quality improvement activities.	3.	<input type="checkbox"/>	<input type="checkbox"/>
4.	An adverse incident reporting system, as described in Standard 2.I.B-21.	4.	<input type="checkbox"/>	<input type="checkbox"/>
5.	A mechanism to notify public health authorities of reportable conditions. NEW	5.	<input type="checkbox"/>	<input type="checkbox"/>
<p>416.44 (a)(3) Standard: Physical environment <i>The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.</i></p>				
G.	The organization maintains appropriate, accurate, complete, and timely clinical record entries.	G.	<input type="checkbox"/>	<input type="checkbox"/>

	Compliance		
	SC	PC	NC
H. The organization establishes procedures to obtain, identify, store, and transport laboratory specimens or biological products.	H. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. When clinically indicated, patients are contacted as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings that have been identified.	I. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. When the need arises, patients are transferred from the care of one health care professional to the care of another with: <ol style="list-style-type: none"> 1. Adequate specialty consultation services being available by prior arrangement. 2. Referral to a health care professional that is clearly outlined to the patient and arranged with the accepting health care professional prior to transfer. 	J. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. When hospitalization is indicated to evaluate, stabilize, and transfer when emergencies or unplanned outcomes occur, the organization shall have one of the following: <ol style="list-style-type: none"> 1. Written transfer agreement for transferring patients to a nearby hospital. 2. Policy of credentialing and privileging only physicians and dentists who have admitting and similar privileges at a nearby hospital. 3. Detailed procedural plan for handling medical emergencies, with the plan submitted to AAAHC for review during the survey process. 	K. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Concern for the costs of care is demonstrated by the following: <ol style="list-style-type: none"> 1. The relevance of health care services to the needs of the patients. 2. The absence of duplicative diagnostic procedures. 3. The appropriateness of treatment frequency. 4. The use of the least expensive alternate resources when suitable. 5. The use of ancillary services that are consistent with patients' needs. 	L. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. When the need arises, reasonable attempts are made for health care professionals and other staff to communicate in the language or manner primarily used by patients.	M. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Compliance		
	SC	PC	NC
Additional Medicare Requirements			
K-MS (1). The ASC must have an effective procedure for the immediate transfer to a hospital of patients requiring emergency medical care beyond the capabilities of the ASC. [416.41(b)(1) Standard: Hospitalization]	K-MS (1). <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K-MS (2). The hospital must be a local, Medicare-participating hospital or a local, nonparticipating hospital that meets the requirements for payment for emergency services under Title 42 CFR 462.2. [416.41(b)(2) Standard: Hospitalization]	K-MS (2). <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K-MS (3). The ASC must have a written transfer agreement with a hospital that meets the requirements of 4.K-MS (2). [416.41(b)(3) Standard: Hospitalization]	K-MS (3). <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K-MS (4). The ASC must ensure that all physicians performing surgery in the ASC have admitting privileges at a hospital that meets the requirements of K-MS (2). [416.41(b)(3)(i) Standard: Hospitalization]	K-MS (4). <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Quality Management and Improvement

In striving to improve the quality of care and to promote more effective and efficient utilization of facilities and services, an accreditable organization maintains an active, integrated, organized, ongoing, data-driven, peer-based program of quality management and improvement that links peer review, quality improvement activities, and risk management in an organized, systematic way. **1621**

416.43 Condition: Quality assessment and performance improvement

The ASC must develop, implement and maintain an ongoing, data-driven quality assessment and performance improvement (QAPI) program.

Organizations may also find it useful to refer to *Analyzing Your Quality Management Program and Creating Meaningful Studies in the Worksheets and Forms section in the back of this Handbook.*

Note: The intent of this chapter is that administrative and clinical personnel be involved in the quality management and improvement activities of the organization.

	Compliance		
	SC	PC	NC
Subchapter I – Peer Review: An accreditable organization maintains an active and organized process for peer review that is integrated into the quality management and improvement program and is evidenced by the following characteristics:	I. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. The health care professionals understand, support, and participate in a peer review program through organized mechanisms that are consistent with the organization's policies and procedures, and are responsible to the governing body. The peer review activities are evidenced in the quality improvement program.	A. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. At least two (2) physicians (or dentists in dental practices) are involved to provide peer-based review. (In solo physician or dental organizations, such as office-based surgical practices, independent practice associations, and dental practices, an outside physician or dentist is involved to provide peer-based review.) <ol style="list-style-type: none"> 1. At least two (2) health care professionals, one of whom may be a physician or dentist, are involved to provide peer-based review within their scope of practice for professionals such as nurse practitioners, certified registered nurse anesthetists, and physician assistants. Their review as part of an employee's performance evaluation is acceptable. 	B. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. The organization provides ongoing monitoring of important aspects of the care provided by physicians, dentists, and other health care professionals. Monitoring important aspects of care is necessary for monitoring performance and establishing internal benchmarks.	C. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Health care professionals participate in the development and application of the criteria used to evaluate the care they provide.	D. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5 Quality Management and Improvement

	Compliance		
	SC	PC	NC
E. Data related to established criteria are collected in an ongoing manner and are periodically evaluated to identify acceptable or unacceptable trends or occurrences that affect patient outcomes.	E. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. The results of peer review activities are reported to the governing body.	F. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. The results of peer review are used as part of the process for granting continuation of clinical privileges, as described in of Chapter 2.II.	G. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. To improve the professional competence and skill, as well as the quality of performance, of the health care professionals and other professional personnel it employs, the organization: <ol style="list-style-type: none"> 1. Provides convenient access to reliable, up-to-date information pertinent to the clinical, educational, administrative, and research services provided by the organization. 2. Encourages health care professionals to participate in educational programs and activities, as demonstrated in the organization's policies or procedures; these educational programs may be internal or external, and are consistent with the organization's mission, goals, and objectives. 	H. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. The organization provides a monitoring function to ensure the continued maintenance of licensure and/or certification of professional personnel who provide health care services at the organization.	I. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Subchapter II – Quality Improvement Program: An accreditable organization maintains an active, integrated, organized, and peer-based quality improvement (QI) program as evidenced by the following characteristics:	II. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. The organization develops and implements a quality improvement program that is broad in scope to address clinical, administrative, and cost-of-care performance issues, as well as actual patient outcomes, i.e., results of care, including safety of patients. Characteristics of the written program must include, but are not limited to: <ol style="list-style-type: none"> 1. A description of the program that addresses the scope of the organization's health care delivery services and how the quality improvement plan for these services is assessed. 2. Identification of the specific committee(s) or individuals responsible for the development, implementation, and oversight of the program. 3. Participation in the program by health care professionals, one or more of whom is a physician. 4. Quality improvement goals and objectives. 	A. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Compliance		
	SC	PC	NC
Subchapter III – Risk Management: An accountable organization develops and maintains a program of risk management, appropriate to the organization, designed to protect the life and welfare of an organization's patients and employees. Such an organization has the following characteristics:	III	<input type="checkbox"/>	<input type="checkbox"/>
A. The governing body of the organization is responsible for overseeing the program of risk management that includes the elements listed in Standard 5.III.C, and as appropriate to the organization, the requirements described in Chapter 2.I and Chapter 3.	A	<input type="checkbox"/>	<input type="checkbox"/>
B. A designated person or committee is responsible for the risk management program.	B	<input type="checkbox"/>	<input type="checkbox"/>
C. Elements of a risk management program address safety of patients and other important issues, which include:	C	<input type="checkbox"/>	<input type="checkbox"/>
1. Consistent application of the risk management program throughout the organization, including all departments and all service locations.	1	<input type="checkbox"/>	<input type="checkbox"/>
2. Methods by which a patient may be dismissed from care or refused care.	2	<input type="checkbox"/>	<input type="checkbox"/>
3. Reporting, reviewing, and appropriate analysis of all incidents reported by employees, patients, health care professionals, and others.	3	<input type="checkbox"/>	<input type="checkbox"/>
4. Review of all deaths, trauma, and other adverse incidents as defined in Standard 2.I.B-21, including reactions to drugs and materials.	4	<input type="checkbox"/>	<input type="checkbox"/>
5. Review and analysis of all actual and potential infection control occurrences and breaches, surgical site infections, and other health care-acquired infections in accordance with the plan of action as detailed in 7.I.B-5.	5	<input type="checkbox"/>	<input type="checkbox"/>
6. Periodic review of all litigation involving the organization and its staff and health care professionals.	6	<input type="checkbox"/>	<input type="checkbox"/>
7. Review of patient complaints.	7	<input type="checkbox"/>	<input type="checkbox"/>
8. Communications with the professional liability insurance carrier.	8	<input type="checkbox"/>	<input type="checkbox"/>
9. Managing a situation in which a health care professional becomes incapacitated during a medical or surgical procedure.	9	<input type="checkbox"/>	<input type="checkbox"/>
10. Impaired health care professionals.	10	<input type="checkbox"/>	<input type="checkbox"/>
11. Establishment and documentation of coverage after normal working hours.	11	<input type="checkbox"/>	<input type="checkbox"/>
12. Methods for prevention of unauthorized prescribing.	12	<input type="checkbox"/>	<input type="checkbox"/>

	Compliance		
	SC	PC	NC
II.A-MS (3). Performance improvement activities must track adverse patient events, describe their causes, implement improvements, and ensure that improvements are sustained over time. [416.43(c)(2) Standard: Program activities]	II.A-MS (3)	<input type="checkbox"/>	<input type="checkbox"/>
II.A-MS (4). The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations. [416.43(d)(1) Standard: Performance improvement projects]	II.A-MS (4)	<input type="checkbox"/>	<input type="checkbox"/>
II.A-MS (5). The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reasons for implementing the project, and a description of the project's results. [416.43 (d)(2) Standard: Performance improvement projects]	II.A-MS (5)	<input type="checkbox"/>	<input type="checkbox"/>
II.A-MS (6). The governing body must ensure that the QAPI program is defined, implemented, and maintained by the ASC. [416.43(e)(1) Standard: Governing body responsibilities]	II.A-MS (6)	<input type="checkbox"/>	<input type="checkbox"/>
II.A-MS (7). The governing body must ensure that the QAPI program addresses the ASC's priorities and that all improvements are evaluated for effectiveness. [416.43(e)(2) Standard: Governing body responsibilities]	II.A-MS (7)	<input type="checkbox"/>	<input type="checkbox"/>
II.A-MS (8). The governing body must ensure that the QAPI program specifies data collection methods, frequency, and details. [416.43(e)(3) Standard: Governing body responsibilities]	II.A-MS (8)	<input type="checkbox"/>	<input type="checkbox"/>
II.A-MS (9). The governing body must ensure that the QAPI program clearly establishes its expectations for safety. [416.43(e)(4) Standard: Governing body responsibilities]	II.A-MS (9)	<input type="checkbox"/>	<input type="checkbox"/>
II.A-MS (10). The governing body must ensure that the QAPI program adequately allocates sufficient staff, time, information systems and training to implement the QAPI program. [416.43(e)(5) Standard: Governing body responsibilities]	II.A-MS (10)	<input type="checkbox"/>	<input type="checkbox"/>
III.C-MS (1). The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished at the ASC. [416.43(f)(2) Standard: Program scope]	III.C-MS (1)	<input type="checkbox"/>	<input type="checkbox"/>
III.C-MS (2). The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies. [416.43(f)(3) Standard: Program activities]	III.C-MS (2)	<input type="checkbox"/>	<input type="checkbox"/>

	Compliance		
	SC	PC	NC
13. Processes to identify and/or designate the surgical site and involve the patient in those processes.	13	<input type="checkbox"/>	<input type="checkbox"/>
14. Active surveillance of processes and techniques for detection and prevention of disease, infection, and potential communicable infective sources.	14	<input type="checkbox"/>	<input type="checkbox"/>
D. Only persons authorized by the governing body to perform or assist in the procedure are allowed in patient care areas except as identified in the organization's policy regarding observers in patient care areas.	D	<input type="checkbox"/>	<input type="checkbox"/>
E. The organization must have a written policy that addresses all other persons allowed in patient care areas that are not authorized staff (students, interested physicians, health care industry representatives, survivors, etc.) including evidence of patient consent.	E	<input type="checkbox"/>	<input type="checkbox"/>
F. The risk management program requires a periodic review of clinical records and clinical record policies.	F	<input type="checkbox"/>	<input type="checkbox"/>
G. Education in risk management activities, including infection control and safety policies and processes, is provided to all staff within thirty (30) days of commencement of employment, annually thereafter, and when there is an identified need. xxx	G	<input type="checkbox"/>	<input type="checkbox"/>
<p>416.43 (c)(3) Standard: Program activities The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies.</p>			
<p>Additional Medicare Requirements</p>			
II.A-MS (1). The program must include, but not be limited to, an ongoing program that demonstrates measurable improvement in patient health outcomes, and improves patient safety by using quality indicators or performance measures associated with improved health outcomes and by the identification and reduction of medical errors. [416.43(g)(1) Standard: Program scope]	II.A-MS (1)	<input type="checkbox"/>	<input type="checkbox"/>
II.A-MS (2). The ASC must set priorities for its performance improvement activities that—	II.A-MS (2)	<input type="checkbox"/>	<input type="checkbox"/>
(i) Focus on high risk, high volume, and problem-prone areas. [416.43(g)(1) Standard: Program activities]	II.A-MS (2)(i)	<input type="checkbox"/>	<input type="checkbox"/>
(ii) Consider incidence, prevalence, and severity of problems in those areas. [416.43(g)(1) Standard: Program activities]	II.A-MS (2)(ii)	<input type="checkbox"/>	<input type="checkbox"/>
(iii) Affect health outcomes, patient safety, and quality of care. [416.43(g)(1) Standard: Program activities]	II.A-MS (2)(iii)	<input type="checkbox"/>	<input type="checkbox"/>

6. Clinical Records and Health Information

An accredited organization maintains electronic and/or paper clinical records and a health information system from which information can be retrieved promptly. Clinical records are complete, comprehensive, legible, documented accurately in a timely manner, and readily accessible to health care professionals. **xxx**

416.47 Condition: Medical records

The ASC must maintain complete, comprehensive, and accurate medical records to ensure adequate patient care.

The **Clinical Records Worksheet**, found in the **Worksheets and Forms** section in the back of this **Handbook**, may be useful in assessing your organization's compliance with Chapter 6 Standards.

	Compliance		
	SC	PC	NC
A. The organization develops and maintains a system for the proper collection, processing, maintenance, storage, retrieval, and distribution of clinical records. xxx	A	<input type="checkbox"/>	<input type="checkbox"/>
<p>416.47 (a) Standard: Organization The ASC must develop and maintain a system for the proper collection, storage, and use of patient records.</p>			
B. An individual clinical record is established for each person receiving care. Each record includes, but is not limited to: xxx	B	<input type="checkbox"/>	<input type="checkbox"/>
<p>416.47 (b)(1) Standard: Form and content of record The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: Patient identification.</p>			
1. Name.	1	<input type="checkbox"/>	<input type="checkbox"/>
2. Identification number (if appropriate).	2	<input type="checkbox"/>	<input type="checkbox"/>
3. Date of birth.	3	<input type="checkbox"/>	<input type="checkbox"/>
4. Gender.	4	<input type="checkbox"/>	<input type="checkbox"/>
5. Responsible party, if applicable.	5	<input type="checkbox"/>	<input type="checkbox"/>
C. All clinical information relevant to a patient is readily available to authorized personnel any time the organization is open to patients.	C	<input type="checkbox"/>	<input type="checkbox"/>

Compliance

	SC	PC	NC
D. Clinical record entries are legible and easily accessible within the record by the organization's personnel. 1202	D. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.47 (b) Standard: Form and content of record <i>The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</i>			
E. Except when otherwise required by law, any record that contains clinical, social, financial, or other data on a patient is treated as strictly confidential and is protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure.	E. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. A designated person is in charge of clinical records. This person's responsibilities include, but are not limited to: 1203	F. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.47 (b) Standard: Form and content of record <i>The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</i>			
1. The confidentiality, security, and physical safety of records.	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The timely retrieval of individual records upon request.	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The unique identification of each patient's record.	3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The supervision of the collection, processing, maintenance, storage, and appropriate access to and usage of records.	4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The maintenance of a predetermined, organized, and secured record format.	5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Policies concerning clinical records address, but are not limited to:	G. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. The retention of active records.	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The retirement of inactive records.	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The timely entry of data in records.	3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The release of information contained in records.	4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Except when otherwise required by law, the content and format of clinical records, including the sequence of information, are uniform. Records are organized in a consistent manner that facilitates continuity of care.	H. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Compliance

	SC	PC	NC
I. Reports, histories and physicals, progress notes, and other patient information (such as laboratory reports, x-ray readings, operative reports, and consultative) are reviewed and incorporated into the record in a timely manner. 1204	I. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.47 (b)(2) Standard: Form and content of record <i>The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</i> <i>Significant medical history and results of physical examination.</i>			
416.47 (b)(3) Standard: Form and content of record <i>The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</i> <i>Pre-operative diagnostic studies (entered before surgery), if performed.</i>			
J. If a patient has had multiple visits/admissions, or the clinical record is complex and lengthy, a summary of past and current diagnoses or problems, including past procedures, is documented in the patient's record to facilitate the continuity of care.	J. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. The presence or absence of allergies and untoward reactions to drugs and materials is recorded in a prominent and consistent location in all clinical records. This is verified at each patient encounter and updated whenever new allergies or sensitivities are identified. 1205	K. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.47 (b)(5) Standard: Form and content of record <i>The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</i> <i>Any allergies and abnormal drug reactions.</i>			
L. Entries in a patient's clinical record for each visit include, but are not limited to:	L. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Date (and department, if departmentalized).	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Chief complaint or purpose of visit.	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Clinical findings. 1206	3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.47 (b)(2) Standard: Form and content of record <i>The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</i> <i>Significant medical history and results of physical examination.</i>			

Compliance

	SC	PC	NC
4. Discharge diagnosis or impression. 1207	4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.47 (b)(2) Standard: Form and content of record <i>The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</i> <i>Significant medical history and results of physical examination.</i>			
416.47 (b)(8) Standard: Form and content of record <i>The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</i> <i>Discharge diagnosis.</i>			
5. Studies ordered, such as laboratory or x-ray studies. 1208	5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.47 (b)(3) Standard: Form and content of record <i>The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</i> <i>Pre-operative diagnostic studies (entered before surgery), if performed.</i>			
6. Care rendered and therapies administered.	6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Any changes in prescription and non-prescription medication with name and dosage, when available.	7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Disposition, recommendations, and instructions given to the patient.	8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Authentication and verification of contents by health care professionals.	9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Documentation regarding missed and canceled appointments.	10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Signature of physician or other author of the clinical record entry.	11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Significant medical advice given to a patient by telephone or online, is entered in the patient's clinical record and appropriately signed or initialed, including medical advice provided after-hours.	M. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. Any notation in a patient's clinical record indicating diagnostic or therapeutic intervention as part of clinical research is clearly contrasted with entries regarding the provision of non-research related care.	N. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Compliance

	SC	NC
O. The organization is responsible for ensuring a patient's continuity of care. If a patient's primary or specialty care provider(s) or health care organization is elsewhere, the organization ensures that timely summaries or pertinent records necessary for continuity of patient care are:	O. <input type="checkbox"/>	<input type="checkbox"/>
1. Obtained from the other (external) provider(s) or organization and incorporated into the patient's clinical record.	1. <input type="checkbox"/>	<input type="checkbox"/>
2. Provided to the other (external) health care professional(s) or consultant and, as appropriate, to the organization where future care will be provided.	2. <input type="checkbox"/>	<input type="checkbox"/>
P. Discussions with the patient concerning the necessity, appropriateness, and risks of proposed care, surgery, or procedure, as well as discussions of treatment alternatives and advance directives, as applicable, are incorporated into the patient's clinical record. 1209	P. <input type="checkbox"/>	<input type="checkbox"/>
416.47 (b)(7) Standard: Form and content of record <i>The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:</i> <i>Documentation of properly executed informed patient consent.</i>		
Additional Medicare Requirements		
K-MS. Adverse reactions must be reported to the physician responsible for the patient and must be documented in the record. 416.46(b)(1) Standard: Administration of drugs	K-MS. <input type="checkbox"/>	<input type="checkbox"/>
K-MS. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Infection Prevention and Control and Safety

An accredited organization provides health care services while adhering to safe practices for patients, staff, and all others. The organization maintains ongoing programs designed to prevent and control infections and communicable diseases, and (2) to provide a safe and sanitary environment of care.

Subchapter I – Infection Prevention and Control: An accredited program as evidenced by the following characteristics:

416.51 Condition: Infection control

The organization must establish a program for identifying and preventing infections and communicable diseases.

416.51(a)(1) Standard: Physical environment

The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.

416.51(a)(2) Standard: Infection control program

The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program is –

416.51(b) Standard: Infection control program

The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program is –

416.51(c) Standard: Physical environment

An integral part of the organization's quality improvement program, and improvement program, and

An integral part of the ASC's quality assessment and performance improvement program, and

An integral part of the organization's quality improvement program, and

Approved by the governing body.

416.51(d)(1) Standard: Infection control program

The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program is –

416.51(d)(2) Standard: Infection control program

The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program is –

416.51(d)(3) Standard: Infection control program

The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program is –

416.51(d)(4) Standard: Physical environment

The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.

416.51(d)(5) Standard: Infection control program

The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program is –

416.51(d)(6) Standard: Physical environment

The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.

416.51(d)(7) Standard: Infection control program

The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program is –

416.51(d)(8) Standard: Physical environment

The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.

Compliance

SC PC NC

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7 Infection Prevention and Control and Safety

3. Under the direction of a designated and qualified health care professional who has training and current competence in infection control, **ASC**

416.51(b)(1) Standard: Infection control program

The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program is –

416.51(b)(2) Standard: Infection control program

The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program is –

416.51(b)(3) Standard: Physical environment

The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.

416.51(b)(4) Standard: Infection control program

The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program is –

416.51(b)(5) Standard: Physical environment

The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.

416.51(b)(6) Standard: Infection control program

The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program is –

416.51(b)(7) Standard: Physical environment

The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.

416.51(b)(8) Standard: Infection control program

The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program is –

416.51(b)(9) Standard: Physical environment

The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.

416.51(b)(10) Standard: Infection control program

The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program is –

416.51(b)(11) Standard: Physical environment

The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.

416.51(b)(12) Standard: Infection control program

The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program is –

416.51(b)(13) Standard: Physical environment

The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.

416.51(b)(14) Standard: Infection control program

The ASC must maintain an ongoing program designed to prevent, control, and investigate infections and communicable diseases. In addition, the infection control and prevention program must include documentation that the ASC has considered, selected, and implemented nationally recognized infection control guidelines. The program is –

416.51(b)(15) Standard: Physical environment

The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.

Compliance

SC PC NC

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		Compliance		
		SC	PC	NC
2.	An awareness of, and a process for, the reporting of known adverse incidents to appropriate state and federal agencies when required by law to do so.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Processes to reduce and avoid medication errors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Policies regarding food and drink, if made available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Policies addressing manufacturer or regulatory agency recalls related to medications, medical equipment and devices, and food products.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Prevention of falls or physical injuries involving patients, staff, and all others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.	There is a person or committee designated by the governing body who is responsible for the organization's safety program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.	Medical staff members, employees, volunteers, and others abide by the program, and receive education and training to include but not necessarily be limited to:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.	Infection prevention and control program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Safety program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D.	Unique patient identifiers are consistently used throughout care. 100%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.47 (b)(1) Standard: Form and content of record				
<i>The ASC must maintain a clinical record for each patient. Every record must be accurate, legible, and promptly completed. Clinical records must include at least the following:</i>				
<i>Patient identification.</i>				
E.	The organization has written policies regarding procedures and treatments that are offered to patients, which include criteria for patient selection, the need for anesthesia support, and post-procedural care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F.	The organization has a comprehensive written emergency and disaster preparedness plan to address internal and external emergencies, including participating in community health emergency or disaster preparedness, when applicable. The written plan must include a provision for the safe evacuation of individuals during an emergency, especially individuals who are at greater risk. 100%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.41 (c)(1) Standard: Disaster preparedness plan				
<i>The ASC must maintain a written disaster preparedness plan that provides for the emergency care of patients, staff and others in the facility in the event of fire, natural disaster, functional failure of equipment, or other unexpected events or circumstances that are likely to threaten the health and safety of those in the ASC.</i>				

		Compliance		
		SC	PC	NC
G.	The organization adopts the appropriate policies and procedures to educate providers and personnel in fire prevention and fire hazard reduction.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H.	Fire safety, fire prevention, and fire drills are included in the surveillance activities of personnel responsible for safety and risk management.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I.	Environmental hazards associated with safety are identified and safe practices are established.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J.	Measures are implemented to prevent skin and tissue injury from chemicals, cleaning solutions, and other hazardous exposures.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K.	Evidence of compliance with local, state, and federal guidelines is present and adhered to regarding preparing, serving, disposal, and storing of food and drink for patient use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L.	Patients are educated about prescribed medical devices and associated protocols and guidelines. Patient competence with each device is verified before independent use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M.	Reprocessing of single-use devices must comply with FDA guidelines, and the devices must have been cleared under the FDA 510(k) process. Policies must clearly dictate the cleaning and handling of these devices in-house before sending them out for reprocessing. A written log must be maintained on all reprocessed devices.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N.	The organization has a policy and process that addresses the recall of items including drugs and vaccines, blood and blood products, medical devices, equipment and supplies, and food products. At a minimum, the policy addresses:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.	Sources of recall information (FDA, CDC, manufacturers, and other local, state, or federal sources).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Methods for notification of staff that need to know.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Methods to determine if a recalled product is present at the organization or has been given or administered to patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Documentation of response to recalled products.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Disposition or return of recalled items.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Patient notification, as appropriate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O.	Products, including medications, reagents, and solutions, that carry an expiration date are monitored. The organization has a policy for disposal or return of expired medications and supplies that is in accordance with local, state, and federal guidelines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Compliance		
		SC	PC	NC
P.	Prior to use, appropriate education is provided to intended operators of newly-acquired devices or products to be used in the care of patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.	The organization shall designate a person to be responsible for ensuring that appropriate clinical education occurs prior to allowing the use of the device in the care of a patient. Vendor representatives are not used as the sole source for clinical education.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional Medicare Requirements				
IF-MS.	The ASC coordinates its disaster preparedness plan with State and local authorities, as appropriate. [416.41(c)(2) Standard: Disaster preparedness plan]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Facilities and Environment

An accreditable organization provides a functionally safe and sanitary environment for its patients, personnel, and visitors.

		Compliance		
		SC	PC	NC
A.	The organization provides evidence of compliance with the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.	Applicable state and local building codes and regulations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Applicable state and local fire prevention regulations, such as the NFPA 101® Life Safety Code,® 2000 Edition, published by the National Fire Protection Association, Inc. ¹	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Applicable federal regulations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Periodic inspection by the local or state fire control agency, if this service is available in the community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B.	The organization ensures that its facilities:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.	Contain fire-fighting equipment to control a limited fire, including appropriately maintained and placed fire extinguishers of the proper type for each potential type of fire.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have prominently displayed illuminated signs with emergency power capability at all exits, including exits from each floor or hall.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have emergency lighting, as appropriate to the facility, to provide adequate illumination for evacuation of patients and staff, in case of an emergency.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Have stairwells protected by fire doors, when applicable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Provide reception areas, toilets, and telephones in accordance with patient and visitor volume.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Provide examination rooms, dressing rooms, and reception areas that are constructed and maintained in a manner that ensures patient privacy during interviews, examinations, treatment, and consultation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Provide adequately marked patient and visitor parking, when appropriate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Are operated in a safe and secure manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

¹ Life Safety Code and NFPA 101 are registered trademarks of the National Fire Protection Association, Inc., Quincy, Massachusetts. For those organizations desiring assistance in reviewing applicable NFPA 101 code, a suitable reference is the Physical Environment Checklist for Ambulatory Surgical Centers, available from AAAHC.

	Compliance		
	SC	PC	NC
C. The organization has the necessary personnel, equipment, and procedures to deliver safe care, and to handle medical and other emergencies that may arise.	C.	<input type="checkbox"/>	<input type="checkbox"/>
D. The organization provides documented periodic instruction of all personnel in the proper use of safety, emergency, and fire-extinguishing equipment.	D.	<input type="checkbox"/>	<input type="checkbox"/>
E. The organization requires at least one (1) drill each calendar quarter of the internal emergency and disaster preparedness plan. ³ One (1) of the annual drills must be a documented cardiopulmonary resuscitation (CPR) technique drill, as appropriate to the organization. The organization must complete a written evaluation of each drill, and promptly implement any needed corrections or modifications to the plan. 416.41 (c)(3) Standard: Disaster preparedness plan <i>The ASC conducts drills, at least annually, to test the plan's effectiveness. The ASC must complete a written evaluation of each drill and promptly implement any corrections to the plan.</i>	E.	<input type="checkbox"/>	<input type="checkbox"/>
F. Personnel trained in cardiopulmonary resuscitation and the uses of cardiac and all other emergency equipment are present in the facility to provide patient care during hours of operation.	F.	<input type="checkbox"/>	<input type="checkbox"/>
G. Smoking is prohibited within the facility.	G.	<input type="checkbox"/>	<input type="checkbox"/>
H. Hazards that might lead to slipping, falling, electrical shock, burns, poisoning, or other trauma are eliminated.	H.	<input type="checkbox"/>	<input type="checkbox"/>
I. Provisions are made to reasonably accommodate disabled individuals.	I.	<input type="checkbox"/>	<input type="checkbox"/>
J. Adequate lighting and ventilation are provided in all areas.	J.	<input type="checkbox"/>	<input type="checkbox"/>
K. Facilities are clean and properly maintained.	K.	<input type="checkbox"/>	<input type="checkbox"/>
L. Food services and refreshments provided to patients meet their clinical needs and are prepared, stored, served, and disposed of in compliance with local, state, and federal health department requirements.	L.	<input type="checkbox"/>	<input type="checkbox"/>

³ Appropriate to the facility's activities and environment. Examples include medical emergencies, building fires, surgical fires, tornadoes, hurricanes, earthquakes, bomb threats, violence, and chemical, biological, or nuclear threats.

	Compliance		
	SC	PC	NC
M. A system exists for the proper identification, management, handling, transport, treatment, and disposal of hazardous materials and wastes, whether solid, liquid, or gas. 416.44 (a)(3) Standard: Physical environment <i>The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.</i>	M.	<input type="checkbox"/>	<input type="checkbox"/>
1. The system includes, but is not limited to, infectious, radioactive, chemical, and physical hazards.	1.	<input type="checkbox"/>	<input type="checkbox"/>
2. The system provides for the protection of patients, staff, and the environment.	2.	<input type="checkbox"/>	<input type="checkbox"/>
N. The space allocated for a particular function or service is adequate for the activities performed therein, including space allocated for pathology and medical laboratory services, radiology/imaging services, pharmaceutical services, examination and treatment rooms, offices, operating/procedure rooms, recovery areas, storage rooms, reception areas, clinical records, and other special-function areas.	N.	<input type="checkbox"/>	<input type="checkbox"/>
O. Appropriate emergency equipment and supplies are maintained and are readily accessible to all areas of each patient care service site.	O.	<input type="checkbox"/>	<input type="checkbox"/>
P. Policies and procedures regarding medical equipment include its standardized use, and documented evidence of periodic testing and scheduled preventive maintenance according to manufacturer's specifications.	P.	<input type="checkbox"/>	<input type="checkbox"/>
Q. Alternate power, adequate for the protection of the life and safety of patients and staff, is available in all patient care areas, including operative and recovery areas for surgical services, treatment areas, and where emergency services are provided.	Q.	<input type="checkbox"/>	<input type="checkbox"/>
R. Testing of fire alarm and inspection of fire suppression systems, including verification of signal transmission, are performed and documented, as applicable.	R.	<input type="checkbox"/>	<input type="checkbox"/>
S. When an organization undergoes demolition, construction, or renovation projects, the organization performs a proactive and ongoing risk assessment for existing or potential environmental hazards.	S.	<input type="checkbox"/>	<input type="checkbox"/>
1. Safety measures are implemented based on the results of the assessment.	1.	<input type="checkbox"/>	<input type="checkbox"/>
T. Ongoing temperature monitoring is performed for items that are frozen, refrigerated, and/or heated per product manufacturer's recommendations. Stated temperature ranges are readily available to staff performing the monitoring function.	T.	<input type="checkbox"/>	<input type="checkbox"/>

	Compliance	
	SC	NC
Additional Medicare Requirements		
MS. The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. [416.44 Condition: Environment]	MS.	<input type="checkbox"/>
B-MS. The patient has the right to receive care in a safe setting. [416.50 (f)(2) Standard: Privacy and safety]	B-MS.	<input type="checkbox"/>
N-MS. The ASC must have a separate recovery room and waiting area. [416.44(a)(2) Standard: Physical environment]	N-MS.	<input type="checkbox"/>
O-MS. Emergency equipment available to the operating rooms must include at least the following [416.44(e) Standard: Emergency equipment]:	O-MS.	<input type="checkbox"/>
(1) Emergency call system.	O-MS (1)	<input type="checkbox"/>
(2) Oxygen.	O-MS (2)	<input type="checkbox"/>
(3) Mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator.	O-MS (3)	<input type="checkbox"/>
(4) Cardiac defibrillator.	O-MS (4)	<input type="checkbox"/>
(5) Cardiac monitoring equipment.	O-MS (5)	<input type="checkbox"/>
(6) Tachycastomy suit.	O-MS (6)	<input type="checkbox"/>
(7) Laryngoscopes and endotracheal tubes.	O-MS (7)	<input type="checkbox"/>
(8) Suction equipment.	O-MS (8)	<input type="checkbox"/>
(9) Emergency medical equipment and supplies specified by the medical staff.	O-MS (9)	<input type="checkbox"/>
Medicare Conditions for Coverage (COC) require that every Medicare-certified ASC must meet the provisions of the HIPAA 1917 Life Safety Code [®] 2003 Edition that are applicable to ASCs.		
Note: AAAHC will determine whether the ASC is in compliance with the Medicare COC as stated in Title 42 CFR 416.2, 416.25, and 416.40-416.52.		

Adjunct Chapters

The adjunct chapters will be applied based on the services provided by the organization seeking accreditation.

9. Anesthesia Services

Anesthesia services in an accreditable organization are provided in a safe and sanitary environment by qualified health care professionals who have been granted privileges to provide those services by the governing body.

The provisions of this chapter apply to all care involving administration of sedation and anesthesia in all ambulatory settings, including office-based settings. The following definitions are used in determining application of this chapter or Standards thereof depending on the level of anesthesia and sedation administered by an organization:

Standards A through I of this chapter will be applied to organizations in which only local or topical anesthesia or only minimal sedation is administered.

Definitions:

Local or topical anesthesia is the application of local anesthetic agents, in appropriate doses adjusted for weight.

Minimal sedation (anxiolysis) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Inhaled nitrous oxide in low concentrations that would not reasonably be expected to result in loss of the patient's life-preserving protective reflexes would be considered minimal sedation.

Standards A through W of this chapter will be applied to organizations that administer moderate sedation/analgesia, regional anesthesia, or deep sedation/analgesia.

Moderate sedation/analgesia (conscious sedation) is a drug-induced depression of consciousness during which patients respond purposefully¹ to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Regional anesthesia is the application of anesthetic medication around the nerve or nerves in a major region of the body, which supply the area that is targeted for the abolition of painful neural impulses. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Deep sedation/analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully¹ following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

All Standards of this chapter, A through X, will be applied to organizations that administer general anesthesia.

General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Note: Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Individuals administering minimal or moderate sedation/analgesia or regional anesthesia should be able to support the respiratory and cardiovascular system of patients who enter a state of deep sedation/analgesia, while those administering deep sedation/analgesia should be able to support the respiratory and cardiovascular system of patients who enter a state of general anesthesia.

¹ Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

9 Anesthesia Services

	Compliance			
	SC	PC	NC	N/A
Standards A through I will be applied to organizations involved in the administration of sedation and anesthesia as defined on page 74, including those where only local or topical anesthesia or only minimal sedation is administered.				
A. Anesthesia services provided in the facilities owned or operated by the organization are limited to those techniques that are approved by the governing body upon the recommendation of qualified professional personnel. Anesthesia services are performed only by health care professionals who have been credentialed and granted clinical privileges by the organization in accordance with Chapter 2.II.	A.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Adequate supervision of anesthesia services provided by the organization is the responsibility of one or more qualified physicians or dentists who are approved and have privileges for supervision granted by the governing body. ²	B.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Policies and procedures are developed for anesthesia services which include, but are not limited to:	C.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Education, training, and supervision of personnel.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Responsibilities of non-physician anesthetists.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Responsibilities of supervising physicians and dentists.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. A physician, dentist, or qualified ³ health care professional supervised by a physician or dentist, and approved by the governing body, examines the patient immediately prior to administration of the anesthetic to evaluate the risks of anesthesia relative to the procedure to be performed and develops and documents a plan of anesthesia. ²	D.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. The informed consent of the patient or, if applicable, of the patient's representative, is obtained before the procedure is performed. One consent form may be used to satisfy the requirements of this Standard and Standard 10.I.V. ^{2,3}	E.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

416.47 (b)(7) Standard: Form and content of record
The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:
Documentation of properly executed informed patient consent.

² For organizations that are Medicare certified or seeking Medicare certification, the Additional Medicare Requirements section that begins on page 79 supersedes AAHC Standards B, D, F, M-2, and O.

³ Other qualified health care professionals are qualified by virtue of education, experience, competence, professional licensure, and state laws, rules, and regulations. Other health care professionals must be approved for the administration of anesthesia by the governing body pursuant to Chapter 2.E.

9 Anesthesia Services

	Compliance			
	SC	PC	NC	N/A
F. Anesthesia is administered by anesthesiologists, other qualified physicians, dentists, certified registered nurse anesthetists, or other qualified ² health care professionals approved by the governing body pursuant to Chapter 2.II. Other qualified health care professionals must be directly supervised by a physician or dentist who has been privileged for such supervision. ²	F.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. The facility must be established, constructed, equipped, and operated in accordance with applicable local, state, and federal laws and regulations. At a minimum, all settings in which sedation or anesthesia is administered should have the following equipment for resuscitation purposes:	G.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Reliable and adequate source of oxygen delivery.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. A device such as a self-inflating hand resuscitator bag capable of administering at least 60% oxygen.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Appropriate emergency drugs, supplies, and equipment.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Appropriate monitoring equipment for the intended anesthesia care.	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Reliable suction source and appropriate equipment to ensure a clear airway.	5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. All clinical support personnel with direct patient contact maintain at a minimum skills in basic cardiac life support (BLS).	H.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Clinical records include entries related to anesthesia administration. ^{2,3}	I.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

416.47 (b)(8) Standard: Form and content of record
The ASC must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following:
Entries related to anesthesia administration.

Standards A through W will be applied to organizations that administer moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia, or general anesthesia.

J. A patient's oxygenation, ventilation, and circulation must be continually evaluated and documented. Intra-operative physiologic monitoring must include: continuous use of a pulse oximeter, blood pressure determination at frequent intervals, and electrocardiogram (ECG) monitoring for patients with significant cardiovascular disease during moderate sedation, and for all patients during deep sedation/analgesia or general anesthesia. Monitoring for the presence of exhaled CO ₂ is recommended during the administration of deep sedation.	J.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. The organization maintains a written policy with regard to assessment and management of acute pain.	K.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. The patient is observed and monitored in a post-anesthesia care unit or in an area that provides equivalent care by methods appropriate to the patient's medical condition and sedation or anesthesia.	L.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Compliance			
		SC	PC	NC	N/A
M. 1.	A physician or dentist is present until the medical discharge of the patient following clinical recovery from surgery/procedure and anesthesia.	M1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Before medical discharge from the facility, each patient must be evaluated by a physician, dentist, or delegated, qualified health care professional, supervised by a physician or dentist and approved by the governing body, to assess recovery. If medical discharge criteria have previously been set by the treating physician or dentist, and approved by the governing body, a delegated, qualified health care professional may determine if the patient meets such discharge criteria, and if so, may discharge the patient when those criteria are met. ²	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N.	Health care professionals currently trained in advanced cardiac life support (ACLS), with documentation of successful completion and appropriate privileging to provide advanced resuscitative techniques, are present until all patients operated on that day have been physically discharged. When pediatric patients are served, health care professionals who are currently trained in PALS and age- and size-appropriate resuscitative equipment must be available at all times until pediatric patients operated on that day have been physically discharged. Initial ACLS and PALS training and subsequent retraining shall be obtained from the American Heart Association or another vendor that includes "hands-on" training and skills demonstration of airway management and automated external defibrillator (AED) use.	N.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O.	Patients who have received moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia, or general anesthesia are discharged in the company of a responsible adult. ²	O.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P.	A safe environment for providing anesthesia services is assured through the provision of adequate space, equipment, supplies, medications, and appropriately trained personnel. Written policies must be in place for safe use of injectables and single-use syringes and needles. All equipment should be maintained, tested, and inspected according to the manufacturer's specifications. A log is kept of regular preventive maintenance.	P.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q.	Alternate power adequate for the type of surgery/service being performed is available in operative and recovery areas.	Q.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
R.	Education and training in the recognition and treatment of malignant hyperthermia must occur before triggering agents are made available within the organization. Education and malignant hyperthermia drills are conducted at least annually thereafter when triggering agents are present within the organization. Organizations that have anesthetic and resuscitative agents available that are known to trigger malignant hyperthermia must have written protocols to promote patient safety, such as the Malignant Hyperthermia Association of the United States (MHAUS) protocol. (See Appendix C, Malignant Hyperthermia Guidelines.) These treatment protocols must:	R.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.	Be posted and immediately available in each location where triggering agents might be used.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Include the use of dantrolene and other medications and methods of cooling and monitoring of the patient.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Compliance			
		SC	PC	NC	N/A
S.	The organization has a written protocol in place for the safe and timely transfer of patients to a predetermined alternate care facility when extended or emergency services are needed to protect the health or well-being of the patient. Standard 4.K addresses medical emergencies that arise in connection with surgical procedures.	S.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standard T will be applied to organizations that provide anesthesia services to children.					
T.	If anesthesia services are provided to infants and children, the required equipment, medication, and resuscitative capabilities appropriate to pediatric patients are on site.	T.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
U.	No patient shall receive moderate or deep sedation or general anesthesia unless a physician, dentist, or other qualified individual supervised by a physician or dentist, in addition to the one performing the surgery, is present to monitor the patient. The operating physician or dentist may be the supervising physician or dentist. During moderate sedation, the additional individual may assist with minor, interruptible tasks.	U.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
V.	Organizations that provide sedative, hypnotic, or analgesic drugs that do not have an antagonist medication (for example, propofol) will identify who in the organization, as noted in Standard 6.F, is privileged to administer these drugs.	V.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W.	In settings where anesthesia may be provided by other than an anesthesiologist, oral and maxillofacial surgeon, certified registered nurse anesthetist, or an anesthesiologist assistant within his/her scope of practice, the organization has a written protocol that explains how the organization will respond in the event that a deeper-than-intended level of sedation occurs.	W.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standards A through X will be applied at organizations that administer general anesthesia.					
X.	The administration of general anesthesia requires:	X.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1.	End-tidal CO ₂ monitoring.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	A readily available means of measuring body temperature.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Compliance		
		SC	NC	N/A
Additional Medicare Requirements				
B-MS (1).	An ASC may be exempted from the requirement for physician supervision of CRNAs as described in 42 CFR 416.42 (b)(2) (see F-MS 2), if the State in which the ASC is located submits a letter to CMS signed by the Governor, following consultation with the State's Board of Medicine and Nursing, requesting exemption from physician supervision of CRNAs. The letter from the Governor must attest that he or she has consulted with State Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the State and has concluded that it is in the best interests of the State's citizens to opt-out of the current physician supervision requirement, and that the opt-out is consistent with State law. [416.42(b)(1) Standard: State exemption.]	B-MS (1).	<input type="checkbox"/>	<input type="checkbox"/>
B-MS (2).	The request for exemption and recognition of State laws, and the withdrawal of the request may be submitted at any time, and are effective upon submission [416.42(c)(2) Standard: State exemption]	B-MS (2).	<input type="checkbox"/>	<input type="checkbox"/>
D-MS.	A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed. [416.42(b)(1) Standard: Anesthetic risk and evaluation]	D-MS.	<input type="checkbox"/>	<input type="checkbox"/>
F-MS (1).	Anesthetics must be administered by one: A qualified anesthesiologist; or [416.42(b)(1) Standard: Administration of anesthesia]	F-MS (1).	<input type="checkbox"/>	<input type="checkbox"/>
F-MS (2).	A physician qualified to administer anesthesia, a certified registered nurse anesthetist (CRNA) or an anesthesiologist's assistant as defined in Title 42 CFR 416.55(b), or a supervised trainee in an approved educational program. In those cases in which a non-physician administers the anesthesia, unless exempted in accordance with Title 42 CFR 416.42 (f) (see B-MS-1 and 2), the anesthetist must be under the supervision of the operating physician, and in the case of an anesthesiologist's assistant, under the supervision of an anesthesiologist. [416.42(b)(2) Standard: Administration of anesthesia]	F-MS (2).	<input type="checkbox"/>	<input type="checkbox"/>
M-MS.	Before discharge from the ambulatory surgery center, each patient must be evaluated by a physician or by an anesthetist as defined in Title 42 CFR 416.55(b), in accordance with applicable State health and safety laws, standards of practice, and ASC policy, for proper anesthesia recovery. [416.42(a)(2) Standard: Anesthetic risk and evaluation]	M-MS.	<input type="checkbox"/>	<input type="checkbox"/>
O-MS.	The ASC must ensure that all patients are discharged in the company of a responsible adult, except those patients exempted by the attending physician. [416.52(c)(3) Standard: Discharge]	O-MS.	<input type="checkbox"/>	<input type="checkbox"/>

²For more information on the states that have opted out of the requirement for physician supervision of CRNAs, use the following link and scroll down to "Anesthesia Supervision": http://www.cms.hhs.gov/CFRtoACA/DCPs/02_Spotlight.asp.

10. Surgical and Related Services

Surgical and related services in an accreditable organization are performed in a safe and sanitary environment by qualified health care professionals who have been granted privileges to perform those procedures by the governing body. The Standards in this chapter apply to organizations that provide any invasive procedures, such as pain management, endoscopy procedures, cardiac catheterization, lithotripsy, and in-vitro fertilization, as well as surgery. Such an organization has the following characteristics.

In this chapter and throughout this Handbook, the terms "surgery," "procedure," and "operation" are used interchangeably. The use of any of these terms is to reference any such skill, method, or technique that involves cutting, abrading, suturing, laser, or otherwise physically entering or changing body tissues and organs, including invasive pain management procedures.

Note: Some Standards may not apply to organizations that only perform minor, superficial procedures without anesthesia or under local or topical anesthesia.

		Compliance			
		SC	PC	NC	N/A
Subchapter 1 – General Requirements: This subchapter describes general requirements for an organization that provides surgical and related services.		L.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A.	Surgical procedures must be performed in a functional and sanitary environment and are limited to those procedures that are approved by the governing body upon the recommendation of qualified medical staff.	A.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.44 (a) Standard: Physical environment The ASC must provide a functional and sanitary environment for the provision of surgical services.					
416.51 (a) Standard: Sanitary environment The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice.					
B.	Adequate supervision of surgery conducted by the organization is a responsibility of the governing body. It is recommended that supervision be provided by an anesthesiologist or another physician or dentist.	B.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C.	Surgical procedures must be performed in a safe manner only by qualified providers who:	C.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.45 (a) Standard: Membership and clinical privileges Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel.					
1.	Are licensed to perform such procedures within the state in which the organization is located.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Have been granted clinical privileges to perform those procedures by the governing body in accordance with Chapter 2.B.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Compliance	SC	PC	NC	N/A
12. Measures are implemented to prevent skin and tissue injury from electrical, cutting, suction, and other hazardous exposure, and to minimize the risk of fire.				
13. Policies are in place for pre-procedure site inspections, as appropriate to services, provided and patient requirements and needs.				
14. Policies are in place for rapid and routine sterilization is available to ensure that operating room materials are sterile. Sterilized materials are packaged, labeled, and stored in a container manner to maintain sterility and identify sterility dates.				
1. The processes for cleaning and sterilization of surgical and equipment on all issues removed during surgery, except those exempted by the governing body.				
2. Internal and external indicators are used to demonstrate the safe adherence to manufacturer's instructions and recommendations.				
3. Processing of single-use devices must comply with FDA guidelines, and the devices must have been decontaminated under the FDA 514(c) process. Policies must clearly dictate the cleaning and handling of these devices in house before sending them out for processing. A written log must be maintained on all processed devices.				
4. Organizations that perform procedures where blood loss and subsequent blood replacement is a potential have policies and procedures to address the type of situation and/or need.				
5. Adequate power adequate for the type of surgery performed is available in operative and recovery areas.				
6. Periodic calibration and/or preventive maintenance of equipment is provided.				
7. The informed consent of the patient or, if applicable, of the patient's representative, is obtained before the procedure is performed.				
8. The ASC must maintain a medical record for each patient. Every record must include at least the following: Documentation of properly executed informed patient consent.				
9. The organization utilizes a process to identify and/or designate the surgical procedure to be performed and the surgical site, and involves the patient in that process. The person performing the procedure marks the site, for example, with a bandage or other non-removable marker, and a diagram or dental diagram.				

Compliance	SC	PC	NC	N/A
1. At direct report date with direct patient contact maintain a minimum 365 in basic cardiac life support (BLS).				
2. If moderate sedation/analgesia, deep sedation/propofol, regional anesthesia, or general anesthesia is provided, health care professionals currently trained in advanced cardiac life support (ACLS), with documentation of successful completion and sign-off on the day of procedure, are available to provide resuscitative techniques and patient care. Patients operated on that day have been physically decontaminated. When patients are currently trained, health care professionals who are currently trained in PALS and ages- and size-appropriate resuscitative equipment must be available at all procedure sites operated on that day. Subsequent training shall be obtained from the American Heart Association or another minor that includes "rescue" training and skills demonstration of every manager and available training distribution (ACLS) use.				
3. Health care professionals trained in the use of emergency equipment and BLS must be available whenever there is a patient in the facility. At least one (1) physician or dentist is present or immediately available by telephone whenever patients are physically present in the facility.				
4. 416.47 (a) Standard: Emergency personnel Personnel trained in the use of emergency equipment and in cardiopulmonary resuscitation must be available whenever there is a patient in the ASC.				
5. The use and timeliness of administration of appropriate pre-operative antibiotics is monitored to ensure maximum effectiveness.				
6. Specific instructions for discontinuation or resumption of medication prior to and after a procedure are provided to the patient.				
7. The necessity or appropriateness of the proposed surgery, as well as any available alternative treatment techniques, have been discussed with the patient prior to scheduling for surgery.				
8. Registered nurses and other health care professionals assisting in the provision of surgical services are appropriately trained and supervised, and are available in sufficient number for the surgical and emergency care provided.				
9. Each operating room is assigned and equipped so that the types of surgery performed can be performed in a manner that protects the lives and ensures the physical safety of all persons in the area. At least one operating room is available for surgery. Only non-removable agents are present in an operating room, and the room is constructed and equipped in compliance with applicable state and local fire codes.				
10. 416.47 (b)(2) Standard: Form and content of record The ASC must maintain a medical record for each patient. Every record must include at least the following: Significant medical history and results of physical examination. 416.47 (b)(3) Standard: Form and content of record The ASC must maintain a medical record for each patient. Every record must include at least the following: Documentation of properly executed informed patient consent. 416.47 (b)(4) Standard: Form and content of record The ASC must maintain a medical record for each patient. Every record must include at least the following: Fringes and techniques of the operation, including a pathologist's report on all issues removed during surgery, except those exempted by the governing body.				

Compliance	SC	PC	NC	N/A
1. An appropriate and current health history must be completed, with a list of current prescription and non-prescription medications and dosages, when available, physical examination, and pertinent pre-operative diagnostic studies incorporated into the patient's clinical record within 30 days, according to local or state requirements, prior to the scheduled surgery/procedure.				
2. 416.47 (b)(1) Standard: Form and content of record Provisions have been made for the isolation of immediate transfer of patients with a communicable disease. Patients with a communicable disease are properly entered into the organization's infection control policy. 3. Acceptable aseptic techniques are used by all persons in the surgical area. 4. A written policy outlines the appropriate and timely surgical hand antisepsis (scrub) either after an antiseptic soap or alcohol-based hand rub according to product manufacturer's recommended guidelines. Only authorized persons are allowed in the surgical or treatment areas, including laser rooms. 5. Environmental controls are implemented to ensure a safe and sterile environment. 6. Suitable equipment is provided for the regular cleaning of all suite or procedure rooms are appropriately cleaned before each procedure. 7. Freshly laundered linens are stored in an area inside the organization prior to entry into areas designated as restricted. 8. Airtight used for personal protective equipment (PPE) or other contaminated with blood or body fluid is laundered by a laundry that is approved by the organization. 9. 11. As needed to minimize the potential contamination of the surgical environment and surgical staff, patient clothing is removed or covered prior to the patient's entry into a surgical area.				

	Compliance			
	SC	PC	NC	N/A
V. Immediately prior to beginning a procedure, the operating team verifies the patient's identification, intended procedure, and correct surgical site, and that all equipment routinely necessary for performing the scheduled procedure, along with any implantable device to be used, are immediately available in the operating/procedure room. The provider performing the procedure is personally responsible for ensuring that all aspects of the verification have been satisfactorily completed immediately prior to beginning the procedure.	V. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
W. The organization has a procedure to address when sponge, sharp, and instrument counts will occur, the items that will be counted, and the types of procedures requiring counts, when applicable. When appropriate, there is a process to ensure that counts are done before and after the procedure.	W. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
X. A process is in place for the observation, care, and communication of such care in all peroperative areas of the patient's facility experience. The organization must define and implement a process in which information about the patient's care is communicated consistently. The process must include means to educate the staff and medical care providers about the process and support implementation consistently throughout the organization.	X. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Y. The organization follows established protocols for instructing patients in self-care after surgery, including the provision of written instructions to patients who receive moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia, or general anesthesia.	Y. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standard Z will be applied to organizations that provide surgical, diagnostic, and/or therapeutic services to children.				
Z. A safe environment for treating pediatric surgical patients is ensured through the provision of adequate space, equipment, supplies, medications, and personnel.	Z. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AA. Organizations that receive/store/issue blood and blood products for transfusion or human cells or tissues for transplantation must have written protocols for handling, maintenance, and storage, consistent with those of a nationally-recognized authority, such as the American Association of Tissue Banks (AATB) or the U.S. Food and Drug Administration (FDA).	AA. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Compliance			
	SC	PC	NC	N/A
Subchapter II – Laser, Light-Based Technologies, and Other Energy-Emitting Equipment: This subchapter addresses surgery or procedures that involve laser, light-based technologies, or other energy emitting equipment.	II. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Policies and procedures should be established and implemented for these devices. Policies and procedures include, but are not limited to:	A. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Safety programs.	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Education and training of personnel, including a requirement for all personnel working with these devices to be adequately trained in the safety and use of each type of device utilized in patient care.	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. The organization ensures that its facility is a safe environment, including:	B. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Granting privileges for each specific device. 11111	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.45 (a) Standard: Membership and clinical privileges <i>Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges granted. The ASC grants privileges in accordance with recommendations from qualified medical personnel.</i>				
2. Ensuring that only authorized persons are allowed in treatment areas.	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Utilization of door and window coverings, where appropriate.	3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Prominently displayed warning signs being present only during procedures at the entrance to treatment areas.	4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. When necessary, utilization of protective eyewear by personnel in treatment areas as recommended by the device manufacturer.	5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. When appropriate, utilization of smoke evacuators and utilization of appropriate devices to control tissue debris, and high filtration masks and/or wall suction with filters to minimize laser plume inhalation.	6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Utilization of appropriate disinfectant or sterilization of components that have direct patient contact.	7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Ensuring appropriate fire protection, including:	8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. The immediate availability of electrical-rated fire extinguishers for equipment fires.	a. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The maintenance of a wet environment around the operative field and the immediate availability of an open container of saline or water where ignition of flammable materials is possible.	b. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. The use of safe equipment and/or techniques, especially for procedures in and around the airway.	c. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Compliance			
	SC	PC	NC	N/A
d. The utilization of non-combustible materials, supplies, and solutions as appropriate.	d. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. That drape material is not positioned in front of the laser beam; drapes should be checked prior to use of laser to ensure that material has not shifted during the procedure.	e. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Documenting that maintenance logs are present that confirm the inspection and testing of these devices.	9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. The organization ensures patient safety, including:	C. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Assurance that procedures are done in accordance with device manufacturer's guidelines and are consistent with the current version of the ANSI Standard for Safe Use of Lasers in Health Care Facilities.	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Protection of the patient's eyes, skin, hair, and other exposed areas.	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. When available, the use of non-reflective surgical instruments and supplies.	3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Appropriate patient education regarding procedure risks and potential complications.	4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional Medicare Requirements				
I.M.S. Basic requirements <i>Participation as an ASC is limited to facilities that—</i>				
(a) Meet the definition in Title 42 CFR 416.2, and				
(b) Have in effect an agreement obtained in accordance with Title 42 CFR Part 416, Subpart B – General Conditions and Requirement, [416.25 Condition: Basic requirements]	I.M.S. Basic requirements	<input type="checkbox"/>	<input type="checkbox"/>	
I.M.S. ASC Definition <i>Ambulatory surgical center or ASC means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed twenty-four (24) hours following admission. The entity must have an agreement with CMS to participate in Medicare as an ASC, and must meet the conditions set forth in Title 42 CFR Part 416, Subparts B – General Conditions and Requirements and C – Specific Conditions for Coverage of Title 42 CFR 416, [416.2 Standard: Definitions].</i>	I.M.S. ASC Definition	<input type="checkbox"/>	<input type="checkbox"/>	
I.C-MS. <i>Surgical procedures must be performed in a safe manner by qualified physicians who have been granted clinical privileges by the governing body of the ASC in accordance with approved policies and procedures of the ASC. [416.42 Condition: Surgical services]</i>	I.C-MS.	<input type="checkbox"/>	<input type="checkbox"/>	
I.D-MS. <i>The ASC must ensure each patient has the appropriate pre-surgical and post-surgical assessments completed and that all elements of the discharge requirements are completed. [416.52 Condition: Patient admission, assessment and discharge]</i>	I.D-MS.	<input type="checkbox"/>	<input type="checkbox"/>	

	Compliance			
	SC	PC	NC	N/A
LD-MS (1). <i>Not more than 30 days before the date of the scheduled surgery, each patient must have a comprehensive medical history and physical assessment completed by a physician (as defined in section 1861(b) of the Social Security Act) or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and ASC policy. [416.52(a)(1) Standard: Patient admission, assessment and discharge]</i>	LD-MS (1).	<input type="checkbox"/>	<input type="checkbox"/>	
LD-MS (2). <i>Upon admission, each patient must have a pre-surgical assessment completed by a physician or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and ASC policy that includes, at a minimum, an updated medical record entry documenting an examination for any changes in the patient's condition since completion of the most recently documented medical history and physical assessment, including documentation of any allergies to drugs and biologicals. [416.52(a)(2) Standard: Patient admission, assessment and discharge]</i>	LD-MS (2).	<input type="checkbox"/>	<input type="checkbox"/>	
I.H-MS (1). <i>The nursing services of the ASC must be directed and staffed to assure that the nursing needs of all patients are met. [416.46 Condition: Nursing services]</i>	I.H-MS (1).	<input type="checkbox"/>	<input type="checkbox"/>	
I.H-MS (2). <i>Patient care responsibilities must be delegated to all nursing service personnel. Nursing services must be provided in accordance with recognized standards of practice. There must be a registered nurse available for emergency treatment whenever there is a patient in the ASC. [416.46(b) Standard: Organization and staffing]</i>	I.H-MS (2).	<input type="checkbox"/>	<input type="checkbox"/>	
I.I-MS (1). <i>Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the fire and assures the physical safety of all individuals in the area. [416.44(a)(1) Standard: Physical environment]</i>	I.I-MS (1).	<input type="checkbox"/>	<input type="checkbox"/>	
I.X-MS (1). <i>The patient's post-surgical condition must be assessed and documented in the medical record by a physician, other qualified practitioner, or a registered nurse with, at a minimum, post-operative care experience in accordance with applicable State health and safety laws, standards of practice, and ASC policy. [416.52(b)(1) Standard: Post-surgical assessment]</i>	I.X-MS (1).	<input type="checkbox"/>	<input type="checkbox"/>	
I.X-MS (2). <i>Post-surgical needs must be addressed and included in the discharge notes. [416.52(b)(2) Standard: Post-surgical assessment]</i>	I.X-MS (2).	<input type="checkbox"/>	<input type="checkbox"/>	
I.Y-MS (1). <i>The ASC must provide each patient with written discharge instructions and overnight supplies. When appropriate, make a follow-up appointment with the physician, and ensure that all patients are informed, either in advance of their surgical procedure or prior to leaving the ASC, of their prescriptions, post-operative instructions and physician contact information for follow-up care. [416.52(c)(1) Standard: Discharge]</i>	I.Y-MS (1).	<input type="checkbox"/>	<input type="checkbox"/>	
I.Y-MS (2). <i>The ASC must ensure each patient has a discharge order, signed by the physician who performed the surgery or procedure in accordance with applicable State health and safety laws, standards of practice, and ASC policy. [416.52(c)(2) Standard: Discharge]</i>	I.Y-MS (2).	<input type="checkbox"/>	<input type="checkbox"/>	

11. Pharmaceutical Services

Pharmaceutical services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

Note: This chapter applies to any organization that uses drugs or pharmaceutical medical supplies, regardless of the presence or absence of an on-site pharmacy.

	Compliance			
	SC	PC	NC	N/A
A. Pharmaceutical services are provided or made available in a safe and effective manner, in accordance with accepted professional practice and under the direction of an individual designated responsible for pharmaceutical services in accordance with Standard 11.J. 416.48	A. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.48 Condition: Pharmaceutical services <i>The ASC must provide drugs and biologicals in a safe and effective manner, in accordance with accepted professional practice, and under the direction of an individual designated responsible for pharmaceutical services.</i>				
B. Pharmaceutical services are provided in accordance with ethical and professional practice and applicable federal and state laws. 416.48	B. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.48 (a) Standard: Administration of drugs Drugs must be prepared and administered according to established policies and acceptable standards of practice.				
C. Staff demonstrates knowledge of applicable state and federal pharmaceutical laws. 416.48	C. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.48 (a) Standard: Administration of drugs Drugs must be prepared and administered according to established policies and acceptable standards of practice.				
D. Records and security are maintained to ensure the control and safe dispensing of drugs, including samples, in compliance with federal and state laws. 416.48	D. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.48 (a) Standard: Administration of drugs Drugs must be prepared and administered according to established policies and acceptable standards of practice.				
E. Staff informs patients concerning safe and effective use of medications consistent with legal requirements and patient needs. 416.48	E. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.48 (a) Standard: Administration of drugs Drugs must be prepared and administered according to established policies and acceptable standards of practice.				

Compliance

	SC	PC	NC	N/A
F. Measures have been implemented to ensure that prescription pads are controlled and secured from unauthorized patient access, and pre-signed and/or postdated prescription pads are prohibited. 416.48	F. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.48 (a) Standard: Administration of drugs Drugs must be prepared and administered according to established policies and acceptable standards of practice.				
G. All medications, including vaccines and samples, are checked for expiration dates on a regular basis; expired items are disposed of in a manner that prevents unauthorized access, protects safety, and meets state and federal requirements. 416.48	G. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.48 (a) Standard: Administration of drugs Drugs must be prepared and administered according to established policies and acceptable standards of practice.				
H. All injectable medications drawn into syringes and oral medications removed from the packaging identified by the original manufacturer must be appropriately labeled if not administered immediately. 416.48	H. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.48 (a) Standard: Administration of drugs Drugs must be prepared and administered according to established policies and acceptable standards of practice.				
I. The organization must have policies in place for safe use of injectables and single-use syringes and needles that at minimum include the CDC or comparable guidelines for safe injection practices. 416.48	I. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.48 (a) Standard: Administration of drugs Drugs must be prepared and administered according to established policies and acceptable standards of practice.				
J. Pharmaceutical services provided by the organization are directed by a licensed pharmacist or, when appropriate, by a physician or dentist who is qualified to assume professional, organizational, and administrative responsibility for the quality of services rendered.	J. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Providers or other health care professionals who prescribe, dispense, administer, and provide patient education on medications have easy access to current drug information and other decision support resources. 416.48	K. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.48 (a) Standard: Administration of drugs Drugs must be prepared and administered according to established policies and acceptable standards of practice.				

	Compliance			
	SC	PC	NC	N/A
L. If look-alike or sound-alike medications are present, the organization identifies and maintains a current list of these medications, and actions to prevent errors are evident. 416.48	L. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.48 (a) Standard: Administration of drugs Drugs must be prepared and administered according to established policies and acceptable standards of practice.				
M. Procedures are established by the organization for maintenance, cleaning, distribution, and use of devices such as nebulizer units, intravenous infusion pumps, or any other mechanical device used in the medication delivery process. 416.48	M. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.48 (a) Standard: Administration of drugs Drugs must be prepared and administered according to established policies and acceptable standards of practice.				
N. A pharmacy owned or operated by the organization is supervised by a licensed pharmacist.	N. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. Pharmaceutical services made available by the organization through a contractual agreement are provided in accordance with the same ethical and professional practices and legal requirements that would be required if such services were provided directly by the organization.	O. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P. Patients are not required to use a pharmacy owned or operated by the organization.	P. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional Medicare Requirements				
B-MS (1). Blood and blood products must be administered by only physicians or registered nurses. 416.48(a) Standard: Administration of drugs	B-MS (1). <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B-MS (2). Orders given orally for drugs and biologicals must be followed by a written order, signed by the prescribing physician. 416.48(a) Standard: Administration of drugs	B-MS (2). <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Pathology and Medical Laboratory Services

Pathology and medical laboratory services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

	Compliance			
	SC	PC	NC	N/A
Subchapter I — CLIA-Waived Tests: This subchapter applies only to health care organizations providing services that meet the Clinical Laboratory Improvement Amendments (CLIA) of 1988 requirements for waived tests.	L. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. An accreditable organization:	A. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Meets the requirements for waived tests under CLIA [part 493 of Title 42 of the Code of Federal Regulations] if it performs its own laboratory services, performs only waived tests, and has obtained a certificate of waiver, and/or	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with CLIA if it does not perform its own laboratory services. 416.49	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
416.49 (a) Standard: Laboratory services <i>If the ASC performs laboratory services, it must meet the requirements of Part 493 Title 42 of the Code of Federal Regulations. If the ASC does not provide its own laboratory services, it must have procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with Part 493 of Title 42 of the Code of Federal Regulations. The referral laboratory must be certified in the appropriate specialties and subspecialties of service to perform the referred tests in accordance with the requirements of Part 493 of Title 42 of the Code of Federal Regulations.</i>				
B. Pathology and medical laboratory services provided or made available are appropriate to the needs of the patients and adequately support the organization's clinical capabilities.	B. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Pathology and medical laboratory services include, but are not limited to:	C. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Conducting laboratory procedures that are appropriate to the needs of the patients.	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Performing tests in a timely manner.	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Distributing test results after completion of a test and maintaining a copy of the results.	3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Compliance	SC	PC	NC	N/A
E. Pathology and medical laboratory services provided by the organization are directed by a pathologist or another physician who is qualified to supervise and conduct the work of the laboratory.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Sufficient adequately trained and experienced personnel are available to supervise and conduct the work of the laboratory.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Established procedures are followed in obtaining, identifying, storing, and transporting specimens.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Complete descriptions are available of each test procedure performed and "normal" ranges is also available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Sufficient space, equipment, and supplies are provided to perform the test.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Requirements of the Department of Health & Human Services (HHS) certification for medical review center drug testing are met if the lab is testing for Department of Transportation (DOT) regulated industries or federal agency employees.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Compliance	SC	PC	NC	N/A
4. Performing and documenting appropriate quality control procedures, including but not limited to, calibrating equipment periodically and validating test results.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Ensuring that staff performing tests has adequate training and competence to perform the tests.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. The organization has a policy that ensures that test results are reviewed (appropriately and that documents that test results are reviewed by the ordering physician or another privileged provider.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Pathology and medical laboratory services provided or made available are appropriate to the needs of the patients and adequately support the organization's critical capabilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Pathology and medical laboratory services include, but are not limited to: Conducting laboratory procedures that are appropriate to the needs of the patient.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Performing tests in a timely manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Performing tests in a timely manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Distributing test results after completion of a test and maintaining a copy of the results in the laboratory.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Performing and documenting appropriate quality assurance procedures, including but not limited to, calibrating equipment periodically and validating test results through use of standardized control specimens or laboratories.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. The organization has a policy that ensures that test results are reviewed (appropriately and that documents that test results are reviewed by the ordering physician or another privileged provider.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Subchapter II – CLIA Laboratories: This subchapter applies only to health care organizations providing laboratory services that require certification under the Clinical Laboratory Improvement Amendments (CLIA) of 1988. An accredited organization providing laboratory services meets the requirements of CLIA (part 493 of Title 42 of the Code of Federal Regulations) and has obtained a CLIA certificate. **416.49 (a) Standard – Laboratory Services**
 If ASC performs laboratory services, it must meet the requirements of Part 493 Title 42 of the Code of Federal Regulations. If the ASC does not provide its own laboratory services, it must have procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with Part 493 of Title 42 of the Code of Federal Regulations. The nearest laboratory must be certified in appropriate specialties and subspecialties of service to perform the 42 of the Code of Federal Regulations.

13. Diagnostic and Other Imaging Services

Imaging services, including those used for diagnosing, monitoring, or assisting with procedures provided in accordance with ethical and professional practices and legal requirements, such an organization has the following characteristics.

Standards A through F will be applied to organizations providing only diagnostic imaging services. Standards A through L will be applied to organizations that provide imaging services used for diagnosis, monitoring, or assisting with procedures.

Compliance	SC	PC	NC	N/A
A. Imaging services provided or made available by the organization are appropriate to the needs of the patient and adequately support the organization's capabilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Imaging services include, but are not limited to: <ol style="list-style-type: none"> 1. Providing radiographic, fluoroscopic, ultrasonic, or other imaging services that are appropriate to the organization's function. 2. Interpreting images and ensuring appropriate documentation in a timely manner. 3. Maintaining appropriate records or reports of services provided. 4. Providing adequate space, equipment, and supplies to ensure the production of quality services. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Health care professionals providing imaging services and/or interpreting results: <ol style="list-style-type: none"> 1. Have appropriate training and credentials. 2. Have been granted privileges to provide these services. 3. Have appropriate safety training and provide their services in a safe manner. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Policies that address the safety aspects of the imaging services include, but are not limited to: <ol style="list-style-type: none"> 1. Regulation of the use, removal, handling, and storage of potentially hazardous materials. 2. Protection against electrical, mechanical, magnetic, ultrasonic, radiation, and other potential hazards. 3. Proper labeling where radiation, magnetic field, and other potentially hazardous energy sources are used. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Compliance	SC	PC	NC	N/A
4. Appropriate monitoring devices or processes to ensure the safety of all persons who might be exposed to radiation, magnetic fields, or ionizing thermal energy, if radiation exposure is not monitored.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Appropriate monitoring devices or processes to ensure the safety of all persons who might be exposed to radiation, magnetic fields, or ionizing thermal energy, if radiation exposure is not monitored.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Maintenance of appropriate exposure records.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Instructions to personnel in safety practices and in dealing with accidental hazardous energy field exposure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Periodic evaluation by qualified personnel of energy sources and all safety measures (covered including calibration of equipment and being the highly or special mobile devices in compliance with federal, state, and local laws and regulations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Proper warning signs are in place, alerting the public and personnel to the presence of hazardous energy fields, emphasizing concern for particularly susceptible individuals, including: <ol style="list-style-type: none"> 1. Pregnant females. 2. Patients with metal implants. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Patients with metal implants.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Patients or personnel with magnetically restricted credit cards, where appropriate.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Patients or personnel wearing magnetic objects capable of potentially dangerous motion.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Patients with pacemakers or internal defibrillators.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. The organization implements a process to identify the correct site and correct service that is to be performed and involves the patient in the process.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. A radiologist authenticates all examination reports, except reports of studies produced that may be authenticated by specialist physicians or dentists who have been granted privileges by the governing body or its designee to authenticate such reports.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Authenticated, dated reports of all examinations performed are made a part of the patient's clinical record.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Diagnostic imaging services provided by the organization are directed by a physician or dentist who is qualified to assume professional, organizational, and administrative responsibility for the quality of the services rendered.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Diagnostic imaging tests are performed only upon the order of a health care professional. Such orders are accompanied by a concise statement of the reason for the examination.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Diagnostic images are maintained in a readily accessible location for the time required by applicable laws and policies of the organization.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. A policy addresses the storage and retention of diagnostic images.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		Compliance	
		YES	NO
Additional Medicare Requirements			
A-MS (1)	The ASC must have procedures for obtaining radiologic services from a Medicare approved facility to meet the needs of patients. [416.45(b)(1) Standard: Radiologic services]	A-MS (1)	<input type="checkbox"/> <input type="checkbox"/>
A-MS (2)	Radiologic services must meet the hospital conditions of participation for radiologic services specified in Title 42 CFR 482.26. [416.45(b)(2) Standard: Radiologic services]	A-MS (2)	<input type="checkbox"/> <input type="checkbox"/>

14. Dental Services

Dental services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements.

	Compliance			
	SC	PC	NC	N/A
Subchapter 1 – Dental Services: This chapter will be applied to organizations that provide primary dental care and general dentistry and/or oral maxillofacial services. For multi-specialty ASCs in which dentistry and oral maxillofacial surgery are some of the specialties provided, this chapter will not be applicable. For those multi-specialty ASCs, chapters 9 and 10 will be applied.	I	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A. Dental services provided or made available are appropriate to the needs of the patients and are consistent with the definition of dentistry according to state regulation.	A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Dental services performed in the facilities owned and operated by the organization are limited to those procedures that are approved by the governing body upon the recommendation of qualified dental personnel.	B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Dental procedures are performed only by dental health professionals who:	C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Are licensed to perform such procedures within the state or jurisdiction in which the organization is located.	1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have been granted privileges to perform those procedures by the governing body of the organization, in accordance with Chapter 2.11.	2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Personnel assisting in the provision of dental services are appropriately qualified and available in sufficient numbers for the dental procedures provided.	D	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. An appropriate history and physical is conducted and periodically updated, which includes an assessment of the hard and soft tissues of the mouth.	E	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. The organization develops policies and procedures related to the identification, treatment, and management of pain.	F	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. The necessity or appropriateness of the proposed dental procedure(s), as well as alternative treatments and the order of care, have been discussed with the patient prior to delivery of services.	G	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. The informed consent of the patient is obtained and incorporated into the dental record prior to the procedure(s).	H	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Clinical records are maintained according to the requirements found in Chapter 6.	I	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14 Dental Services

	Compliance			
	SC	PC	NC	N/A
J. The organization develops policies and procedures to evaluate dental laboratories to ensure that they meet the needs of the patient and adequately support the organization's clinical capabilities.	J	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Anesthesia provided or made available meets the Standards contained in Chapter 9.	K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Surgical and related services provided or made available meet the Standards contained in Chapter 10.	L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Imaging services provided or made available meet the Standards contained in Chapter 13.	M	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. The organization has guidelines to address the type, frequency, and indications for diagnostic radiographs.	1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. Health care professionals providing dental, surgical, or anesthesia services are prepared to evaluate, stabilize, and transfer medical emergencies that may occur or arise in conjunction with services provided by the organization. All clinical support staff with direct patient contact maintain at a minimum skills in basic cardiac life support (BLS).	N	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. The organization has a mechanism in place to evaluate and monitor dental products that the organization makes available for sale to patients to ensure that such practices are done in an ethical manner.	O	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Subchapter II – Dental Home: The Dental Home subchapter will apply to organizations that choose this subchapter in the Application for Survey.

The services provided by an accreditable Dental Home are patient-centered, dentist-directed, comprehensive, accessible, continuous, and organized to meet the needs of the individual patient served. The foundation of a Dental Home is the relationship between the patient, his/her family, as appropriate, and the Dental Home. As used in these Standards, a Dental Home is the primary point of care for the patient.

The Dental Home will be assessed from the perspective of the patient on the following characteristics as evidenced by:

A. Relationship – communication, understanding, and collaboration. (In this context, "dentist" refers to the dentist or the physician- or dentist-directed health care team.)	A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. The patient can identify his/her dentist and patient care team members.	1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The dentist explains information in a manner that is easy to understand (to include Standard 1D).	2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The dentist listens carefully to the patient and, when appropriate, the patient's personal caregiver(s). Caregivers may include a parent, legal guardian, or person with the patient's power of attorney.	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The dentist speaks to the patient about his/her health problems and concerns.	4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14 Dental Services

	Compliance			
	SC	PC	NC	N/A
5. The dentist provides easy-to-understand instructions about taking care of health concerns.	5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The dentist knows important facts about the patient's health history.	6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. The dentist spends sufficient time with the patient.	7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. The dentist is as thorough as the patient feels is needed.	8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. The staff keeps the patient informed with regard to his/her appointment when delayed.	9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. The dentist addresses specific principles to prevent dental-related diseases.	10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. The dentist speaks with the patient about making lifestyle changes to help prevent dental-related disease.	11	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. The dentist inquires as to the patient's concerns/worries/stressors regarding his/her dental health.	12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. The Dental Home provides services within a team framework, and that "team" provider concept has been conveyed to the patient.	13	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. The family is included, as appropriate, in patient care decisions, treatment, and education.	14	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. The Dental Home treats its patients with cultural sensitivity.	15	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Continuity of Care	B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. A significant number (more than 50%) of the dental home visits of any patient are with the same dentist/dental care team.	1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. If a consultation is ordered for the patient, it is documented in the clinical record.	2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Referrals for services (external to the Dental Home), are documented in the clinical record.	3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Consultations (medical or dental opinions obtained from other health care professionals) are recorded in the clinical record.	4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Referrals are disease- or procedure-specific.	5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The patient's results of a referral are recorded in the clinical record. Follow-up procedures exist and the results of the referral are appropriately reported to the Dental Home as they are made available.	6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Follow-up appointments are documented in the clinical record.	7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. After-hour encounters are documented in the clinical record.	8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Compliance			
	SC	PC	NC	N/A
9. Missed appointments are documented in the clinical record and managed appropriately depending on the patient's care need and diagnosis.	9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Critical referrals, critical consultations, and critical diagnostic studies are tracked and appropriate follow-up is made when the results are not received within a timely manner.	10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Transition of care (e.g., pediatric to adult or adult to geriatric) is proactively planned, coordinated, and documented in the clinical record when indicated or when appropriate.	11.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards, including consultations, referrals, and lab results.	12.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Comprehensiveness of Care	C.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. If the Dental Home limits the population served, those limitations are disclosed to prospective patients.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The Dental Home scope of service includes, but is not limited to:	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Preventive care (including surveillance and screening for special needs or assessment).	a.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Wellness care (healthy lifestyle issues—appropriate diet, tobacco cessation, home care, etc.).	b.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Acute pain and injury care.	c.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Chronic disease management.	d.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Advanced geriatric care.	e.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Patient education and self-management resources are provided.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Knowledge of community resources that support the patient's (and family's, as appropriate) needs are known by the Dental Home.	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The community's service limitations are known and alternate sources are coordinated by the Dental Home.	5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Referrals are appropriate to the patient's needs. When referrals occur, the Dental Home collaborates with the specialist.	6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. The needs of the patient's personal caregiver (in 14.II.A-3), when known, are assessed and addressed to the extent that they impact the care of the patient.	7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards.	8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Compliance			
	SC	PC	NC	N/A
6. In addition to the Standards presented in Chapter 5, Subchapter II, the Dental Home's quality improvement program should include at least one (1) study every three (3) years on each of the following topics:	6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Patient/dentist relationship.	a.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Continuity of care.	b.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Comprehensiveness of care.	c.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Accessibility to care.	d.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Clinical study.	e.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards.	7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Compliance			
	SC	PC	NC	N/A
D. Accessibility	D.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. The Dental Home establishes standards in writing to support patient access (e.g., provider availability, information, clinical record contents, advice, routine care, and urgent care). The Dental Home's data supports that they meet those standards.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Patients are routinely and continuously assessed for their perceptions about access to the Dental Home (e.g., provider availability, information, clinical record contents, advice, routine care, and urgent care).	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Patients are provided information about how to obtain dental care at any time (365/24/7).	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The Dental Home assures on-call coverage (pre-arranged access to a clinician) when the Dental Home is not open.	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards.	5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Quality	E.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Patient care is dentist-directed.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The Dental Home incorporates evidence-based guidelines and performance measures in delivering clinical services including:	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Preventive care (including surveillance and screening for special needs or assessment).	a.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Wellness care (healthy lifestyle issues—appropriate diet, tobacco cessation, home care, etc.).	b.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Acute pain and injury care.	c.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Chronic disease management.	d.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Advanced geriatric care.	e.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The Dental Home periodically assesses its application of available evidence-based guidelines and/or performance measures to ensure that they are being used effectively and appropriately.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Patient care is supervised by the Dental Home as evidenced by:	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Appropriate ordering of diagnostic radiographs (avoidance of redundancies and unnecessary exposure).	a.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Appropriate management of patient referrals (avoidance of unnecessary referrals).	b.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The Dental Home assesses and continuously improves the services they provide. Measurements, quality studies, data trending, and benchmarking are key tools in a quality improvement/management program.	5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Other Professional and Technical Services

Professional and technical services provided or made available by an accreditable organization, even though they are not specifically mentioned in the *Handbook*, meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

	Compliance			
	SC	PC	NC	N/A
Subchapter I – General Services: This subchapter applies to organizations that provide other professional and technical services.				
A. Such services may include, but are not limited to: various medical services, rehabilitation services (physical, occupational, vocational therapy), massage therapy, acupuncture, registered dietitians, aestheticians, audiologists, and other individuals who provide services to patients and may submit separate charges for their services.	A.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Such services provided or made available are appropriate to the needs of the patients and adequately support the organization's clinical capabilities.	B.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Such services are provided by allied health professionals who have been credentialed/privileged in accordance with Standard 2.II.G or who have job descriptions outlined by the organization.	C.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Such services are provided in accordance with ethical and professional practices and applicable federal and state laws and regulations.	D.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Such services will be evaluated using applicable Standards from other chapters of the <i>Handbook</i> .	E.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Subchapter II – Travel Medicine: This subchapter applies only to organizations that provide travel medicine services.				
A. Organizations providing travel medicine services will ensure that these services are appropriate to the needs of the patient and are adequately supported by the organization's clinical capabilities.	A.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Travel medicine services are provided by personnel who have appropriate training, skills, and resource materials to provide quality services.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Travel medicine programs include:	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Appropriate medical oversight.	a.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Clearly defined standing orders and protocols, including management of adverse reactions to immunizations.	b.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Access to current Centers for Disease Control (CDC) and U.S. Department of State travel recommendations.	c.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Appropriate storage and management of vaccines.	d.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Compliance			
	SC	PC	NC	N/A
3. Travel medicine services include:	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Comprehensive travel destination-specific risk assessment.	a.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Appropriate preventive medicine interventions.	b.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Education in risk and risk reduction.	c.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Entries in a patient's clinical record include:	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Travel destination and current health status.	a.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Immunization and vaccine name(s), dosage form, dosage administered, lot number, and quantity.	b.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Prescription medications given, quantity and date, dosage, and directions for use.	c.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Preventive health education.	d.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. Health Education and Health Promotion

AAAHC encourages all health care organizations to provide or make available health education and health promotion services to meet the needs of the population served. These services should be provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

	Compliance			
	SC	PC	NC	N/A
<i>Standards A through G will be applied to all health education and health promotion services. Standards A through J will be applied to organizations providing comprehensive health education and disease prevention programs.</i>				
A. Services provided or made available by the organization are appropriate to the needs of the population served.	A.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Health education and health promotion services are provided by personnel that:	B.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Have necessary and appropriate training, education, credentials, and skills to carry out their responsibilities.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have access to and utilize consultative services, as appropriate.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have ready access to appropriate reference materials in health education and health promotion.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Participate in continuing professional education in health education and wellness.	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Health education and health promotion programs should include, but may not be limited to:	C.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Clearly defined educational goals and objectives.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Evaluation of whether the goals or objectives have been met.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. The organization should have adequate resources for the health education and health promotion services available.	D.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Marketing or advertising regarding the health education and health promotion activities accurately reflects the services provided by the organization.	E.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Policies and procedures are established to assess satisfaction with the health education and health promotion services.	F.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. When appropriate, health education and health promotion services, whether they occur within the context of a clinical visit or not, should be referenced or documented in the patient's clinical record.	G.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16 Health Education and Health Promotion

	Compliance			
	SC	PC	NC	N/A
H. Health education and disease prevention programs should be based on a complete needs assessment for the population served, which:	H.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Considers relevant health risks and health education needs.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Uses a variety of data or data sources.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Quantifies risk whenever possible.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Uses data to direct programming.	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Health education and disease prevention programs should be comprehensive and consider the medical, psychological, social, and cultural needs of the population. Topics that should be considered include:	I.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Disease-specific screening and educational programs.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Substance abuse prevention and education, including programs related to alcohol, tobacco, and other drugs.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Promotion of healthy eating.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Promotion of physical fitness.	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Sexuality education and skill building for healthy relationships.	5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Sexual, physical, and emotional violence prevention.	6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Promotion of and education about stress management and relaxation.	7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Health education and disease prevention programs should be included in quality management and improvement activities.	J.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. Behavioral Health Services

Behavioral health services are provided or made available by an accreditable organization to meet the needs of its clients and the population served. Behavioral health services are provided in accordance with all ethical practices, professional practices, and legal requirements. Behavioral health services are designed to improve and enhance the emotional, mental, and behavioral health of the organization's targeted client population. Such an organization has the following characteristics.

	Compliance			
	SC	PC	NC	N/A
A. Behavioral health services are limited to those services that are approved by the governing body, consistent with the overall mission of the organization, and are responsive and specific to the diverse needs of the population being served. Behavioral health services may include but are not limited to the following:	A.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Counseling or psychotherapy services.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Crisis intervention and emergency services.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Consultative and outreach services.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Referral services.	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. When behavioral health services are provided by an organization, those services are under the direction of a licensed professional who has been designated by the organization's governing body to provide such oversight.	B.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Behavioral health services are provided only by health care professionals who are competent to perform such services. Such services are provided in accordance with AAAHC Standards and adhere to all applicable federal, state, and local requirements, and to appropriate professional ethics standards.	C.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Other personnel assisting in the provision or administration of behavioral health services are carefully selected and are subject to supervision by a licensed professional.	D.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. The organization has appropriate and adequate resources to provide quality behavioral health services. These resources include but are not limited to facilities, equipment, providers, and clinical and administrative support staff.	E.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. An initial behavioral health history and medical history of each client is present in the clinical record.	F.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Compliance

	SC	PC	NC	N/A
G. The clinical record is periodically updated, and may include assessment and management of:	G. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Risk of harm to self or others.	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Known or potential addictive behaviors and substance abuse.	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Client self-understanding, motivation, and decision-making.	3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. The written and signed informed consent of the client is obtained and incorporated into the treatment plan, which may include but is not limited to procedures, therapies, medication management, and other modalities of care and treatment.	H. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. The organization develops and adopts written policies and procedures regarding:	I. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Consistent client confidentiality and privacy assurances.	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Maintenance of client records according to AAHC Standards.	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Client flow and case assignment.	3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Situations arising from outreach programs (when provided) such as identification of individuals who need immediate services.	4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Management of referrals and transfers to and from the facility.	5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Cooperation with and coordination of medical care with behavioral health care.	6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Safety and security of staff, clients, and the organization.	7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. Teaching and Publication Activities

If staff is involved in teaching or publishing, an accreditable organization has policies governing those activities that are consistent with its mission, goals, and objectives. Such an organization has the following characteristics.

Compliance

	SC	PC	NC	N/A
A. Policies concerning teaching activities address the formal relationship and responsibilities between the organization and the training institution and its trainees. Such policies include but are not limited to:	A. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. The terms and conditions of reimbursement or other compensation.	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The reasonableness of the time spent away from direct patient care and administrative activities.	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The training of all students and postgraduate trainees, including the extent of their involvement in patient care activities.	3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The requirement or non-requirement for liability coverage.	4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Adherence by trainees to organizational policies, including state and federal guidelines such as The Health Insurance Portability and Accountability Act (HIPAA) and OSHA.	5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. The policy concerning the provision of health care by personnel in any student or postgraduate trainee status provides for close and adequate supervision and for informing the patient of the status of the health care professional.	B. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Policies concerning publishing activities address:	C. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. The need for governing body approval when the views, policies, and procedures expressed in the publication are attributed to the organization.	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The terms and conditions of compensation from publication and the cost of publication.	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. Research Activities

If research is conducted, an accreditable organization establishes and implements policies governing research that are consistent with its mission, goals, and objectives, and with its clinical capabilities. Such an organization has the following characteristics.

Compliance

	SC	PC	NC	N/A
A. Research activities are performed in accordance with ethical and professional practices and legal requirements, and these activities are periodically monitored. Such activities include, but are not limited to, clinical trials of drugs and other biologicals, devices, implants, or instruments that are classified as investigational or experimental, and techniques that are new, experimental, innovative, or otherwise not yet accepted as standard medical or dental practice.	A. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. The written protocols for conducting research are approved by the governing body or its designee after medical (or dental) and legal review.	B. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Any research activities carried out within the organization are appropriate to the expertise of staff and the resources in the organization.	C. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Individuals engaged in research are provided with adequate facilities.	D. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Provisions are made to ensure that the rights and welfare of all research subjects are adequately protected and that the informed consent of each subject is obtained by adequate and appropriate methods in the language spoken by him or her.	E. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. All professional staff is informed of the organization's research policies.	F. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. Overnight Care and Services

If an accreditable organization provides overnight care (i.e., has patients that are not discharged from the facility on the day they were admitted to the facility) and related services, such care and services meet the needs of the patients served and are provided in accordance with ethical and professional practices and legal requirements.

Note: This chapter applies to organizations, or sub-units thereof, that provide care, including overnight accommodations, for patients who do not require the full range of services of an acute care hospital. Such patients may be recovering from surgery and require observation by medical personnel, receiving treatment for non-critical illnesses, or need only short-term or custodial care.

Compliance

	SC	PC	NC	N/A
A. The scope and limitations of overnight care and services are clearly specified. Such information is communicated to:	A. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Physicians who refer and admit patients to the program.	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Staff who provide the care and services.	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Potential patients in advance of their referral to the program.	3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Other health care professionals and relevant community agencies.	4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. A patient is admitted or discharged only upon the order of a physician who is responsible for the medical care of that patient.	B. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Adequate supervision of overnight care and services is the responsibility of one or more qualified physicians who are approved by the governing body upon the recommendation of qualified medical staff.	C. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. At least one physician is present or immediately available by telephone whenever patients are present.	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Providers may admit patients to this program if they:	D. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Are licensed to treat patients or supervise care and services in this setting.	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have been granted such privileges by the governing body of the organization, in accordance with Chapter 2.11.	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Policies and procedures are clearly specified that include, but are not limited to:	E. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Clinical criteria for determining eligibility for admission.	1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Clinical responsibilities for each patient during his/her stay.	2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Arrangements for emergency services.	3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Arrangements for transfer to other health care services as needed.	4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Compliance			
	SC	PC	NC	N/A
F. The organization has a written transfer agreement with a nearby hospital or grants admitting privileges only to physicians who have admitting privileges at a nearby hospital.	F.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. The overnight care unit meets applicable local and state codes, including licensing requirements if the state licenses such units.	G.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Registered nurses and other health care professionals are appropriately trained and supervised and are available in sufficient numbers to meet patient needs.	H.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. At least one registered nurse is on duty at all times when patients are present.	I.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Treatment rooms are provided or made available to meet patient needs and physician requirements.	J.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Emergency power adequate for the size of the unit is available to protect the life and safety of patients.	K.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Appropriate isolation procedures are followed when any patient is admitted with a suspected or diagnosed communicable disease.	L.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Food service and refreshments are provided to meet the needs of patients.	M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Evidence of compliance with local, state, and federal guidelines is present and adhered to regarding preparing, serving, disposal, and storing of food and drink for patient use.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Special dietary requirements for patient care are met.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Personnel providing food services meet local health department requirements.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
N. In addition to the applicable clinical records and health information requirements found in Chapter 6, the records for overnight care and services include:	N.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. A current history and physical examination.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Treatment orders.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Nursing notes.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Follow-up instructions to patients.	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O. If overnight care is the only service provided by the organization, that organization meets all other applicable Standards contained in the Handbook.	O.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
P. If overnight care is only one of many services provided by the organization, these services shall be functionally integrated to ensure compliance with all other applicable Standards contained in the Handbook.	P.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Q. Overnight care and services are reviewed as part of the organization's quality improvement program.	Q.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21 Occupational Health Services

	Compliance			
	SC	PC	NC	N/A
5. Compliance with occupational regulations such as the Occupational Safety and Health Act (OSHA), Americans with Disabilities Act (ADA), and state Workers' Compensation statutes concerning the organization's:	5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a. Training and credentials of personnel.	a.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Policies, procedures, and forms.	b.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Equipment, including calibration and maintenance.	c.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Clinical records and record management.	d.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Entries in a patient's clinical record for each visit include, as appropriate:	E.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. An occupational and exposure history, including essential job functions, conditions of work, and hazards of the job.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The individual's current functional abilities.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Whether the individual is able to perform essential job functions and suggestions for accommodations or restrictions.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The relationship of medical conditions or abnormal findings to workplace conditions and exposures.	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Preventive counsel concerning reduction of workplace exposures and use of personal protective equipment.	5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Relevant communications concerning the patient, work activities, or exposures, including communications with employers, insurance carriers, union representatives, and attorneys.	6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Medical management of injury or illness minimize disability and promote functional recovery, directing special attention to cases in which:	F.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Recovery has been delayed.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Functional abilities have decreased during treatment.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Injury or illness is recurrent.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. There is permanent impairment, disability, or restriction.	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Work placement evaluations such as preplacement, transfer, or fitness for duty examinations assesses current health and ability to perform the job as well as the extent and duration of recent health changes affecting job performance.	G.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. Occupational Health Services

Occupational medicine is a specialty devoted to the prevention and management of occupational and environmental injury, illness, and disability, and promotion of health and productivity of workers, their families, and communities. This chapter will apply if an organization provides extensive services, complex services, or markets itself as an occupational health center. If an organization provides basic employee health services to its own employees, Standards 3.C through G will be used to evaluate these services.

	Compliance			
	SC	PC	NC	N/A
A. Individuals who agree to laboratory testing or medical examinations at the request of their employer are afforded the patient rights noted in Chapter 1. In addition, they are informed of:	A.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. The purpose and scope of the evaluation and the role of the examiner.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Confidentiality protections and information that may be conveyed to the employer.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Whether medical follow-up is necessary.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Occupational health services are accurately portrayed to patients, employees, and purchasers of the services.	B.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Occupational health services are provided by personnel who:	C.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Have access to and utilize, as appropriate, consultative services associated with evaluating workplace hazards such as industrial hygiene, ergonomics, toxicology, occupational health nursing, epidemiology, and occupational medicine physicians.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have ready access to appropriate reference materials in occupational health and participate in occupational health continuing medical education.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. The provision of high-quality occupational health services is demonstrated by the following, as appropriate:	D.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. An understanding of the specific workplace hazards for each employee/patient served.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. An understanding of the relationship of the condition or finding to workplace conditions and exposures.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Determination of whether the individual is able to perform essential functions of the job and whether accommodations are needed.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Preventive counsel concerning measures to reduce occupational exposures and hazards, including use of protective equipment.	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21 Occupational Health Services

	Compliance			
	SC	PC	NC	N/A
H. Organizations providing medical surveillance evaluations of employees to identify adverse effects from exposure to workplace hazards ensure that:	H.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. The health professionals performing or interpreting these evaluations have specific knowledge about the hazardous agent, including its effects, permissible and actual exposure levels, biologic monitoring, and regulatory requirements.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Whenever possible, surveillance data are statistically analyzed for health trends and effects of exposure.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The results of workplace data for similar workers with similar exposures are considered in the evaluation of the employee.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Organizations providing certification examinations mandated under state or federal statutes ensure that:	I.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. The health care professional performing the evaluation has access to the Standard and related materials.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The health care professional understands the statute as it relates to the exam.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Organizations providing occupational health testing and ancillary service programs such as urine collection for drugs of abuse, breath alcohol content testing, blood lead determinations, audiograms, or chest x-rays ensure that these programs are administered under appropriate written protocols, which are:	J.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Specific to the service provided, addressing all relevant topics such as specimen collection, handling, transportation, receipt and report of results, record management, equipment, equipment calibration, and maintenance.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Under the supervision of a licensed physician or, if allowed, another health care professional.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Reviewed and updated periodically.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Organizations providing consulting services ensure that the role and responsibilities of the consultant are clearly defined.	K.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Organizations providing training and educational programs ensure that each program:	L.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Has written objectives.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is tailored to the specific worker population and work conditions.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Includes an evaluation process and uses the results to improve program quality.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. Immediate/Urgent Care Services

If an accreditable organization implies by its activities, advertising, or practices that its primary mission is to provide medical care of an urgent or immediate nature on a non-appointment basis, such care needs the needs of the patients it intends to serve. Such immediate care and urgent care is provided in accordance with ethical and professional practices and adheres to applicable local, state, and federal requirements. Such an organization has the following characteristics.

Compliance	SC	PC	NC	N/A
A. The range of services offered by the organization and its hours of operation are clearly defined and communicated to the public and relevant organizations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Such organizations, unless they also provide emergency services, do not admit patients with life-threatening conditions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Patients seeking immediate/urgent care services are seen without prior appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Immediate/urgent care services are performed only by health care professionals who are licensed to perform such procedures within the state in which the organization is located and who have been granted privileges to perform those procedures by the governing body of the organization, upon the recommendations of qualified medical staff and after medical review of the health care professional's documented education, training, experience, and current competence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. During hours of operation, at least one qualified physician is present or immediately available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. The organization is prepared in terms of personnel, equipment, and procedures to evaluate, stabilize, and transfer medical emergencies that may present themselves or arise in conjunction with services provided by the organization.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Equipment, drugs, and other agents necessary to provide immediate/urgent care services are available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Communications are maintained with local police departments, poison control centers, and hospitals as needed to ensure high-quality patient care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Laboratory and imaging services described in Chapters 12 and 13 are available to meet the needs of patients receiving immediate/urgent care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Arrangements have been made to ensure that adequate specialty consultation services are available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
K. Health care professionals who maintain skills in advanced cardiac life support (ACLS) or advanced trauma life support (ATLS) are present.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. All clinical support staff with direct patient contact maintain at a minimum skills in basic cardiac life support (BLS).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24. Radiation Oncology Treatment Services

Radiation oncology treatment services provided or made available by an accreditable organization meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

Compliance	SC	PC	NC	N/A
A. Radiation oncology treatment services that are provided or made available by the organization are appropriate to the needs of the patient and are adequately supported by the organization's capabilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Radiation oncology services appropriate to the organization's function include, but are not limited to: <ol style="list-style-type: none"> 1. Consultation services. 2. Treatment planning. 3. Simulation of treatment. 4. Maintenance of reports of services and radiographic images appropriate to the therapy, for the time required by applicable laws and policy of the organization. 5. Critical treatment management including but not limited to the use of radiotherapy and brachytherapy. 6. Appropriate follow-up care of all patients. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Radiation oncology services provided by the organization are directed by a physician who is qualified to assume professional, organizational, and administrative responsibility for the quality of service rendered.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. The radiation oncology service has written safety and quality control policies and procedures, including policies and procedures for laboratory and radiology, that must be reviewed at least annually by a qualified medical physicist. The policies and procedures include, but are not limited to: <ol style="list-style-type: none"> 1. The designation of a radiation safety officer and committee that meets on a periodic basis. 2. A program to maintain personnel exposure records. 3. Annual calibration of ionization units. 4. Annual review of the radiation safety program by a qualified medical physicist. 5. A program to inspect interlock systems at all treatment units. 6. Maintenance of the records of machine performance, maintenance, and malfunctions. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23. Emergency Services

If an accreditable organization implies by its activities, advertising, or practices that it provides emergency services on a regular basis to meet life-, limb-, or function-threatening conditions, such services meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements. Such an organization has the following characteristics.

Compliance	SC	PC	NC	N/A
A. Emergency services are provided twenty-four (24) hours per day, every day of the year.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Emergency services are performed only by health care professionals who are licensed to perform such procedures within the state in which the organization is located and who have been granted privileges to perform those procedures by the governing body of the organization, upon the recommendations of qualified medical staff and after medical review of the health care professional's documented education, training, experience, and current competence.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. At least one qualified physician is present at all times.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Health care professionals assisting in the provision of emergency services are appropriately credentialed, trained, and supervised and are available in sufficient numbers for the emergency services provided.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Unless otherwise provided for by the governing body, equipment, drugs, and other agents recommended by the Emergency Care Guidelines of the American College of Emergency Physicians are available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Laboratory and imaging services described in Chapters 12 and 13 are immediately available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Communications are maintained with local police departments, poison control centers, and hospitals as needed to ensure high-quality patient care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Adequate specialty consultation services are immediately available.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. All clinical support staff with direct patient contact maintain at a minimum skills in basic cardiac life support (BLS). Medical personnel currently trained in ACLS or ATLS and privileged to provide advanced resuscitative techniques are present when patients are currently under inpatient care and are available to support BLS and age- and size-appropriate resuscitative equipment must be available at times. Initial ACLS, ATLS, and PALS training and subsequent retraining is obtained from the American Heart Association or another vendor that includes "hands-on" training and skills demonstration of airway management and automated external defibrillator (AED) use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Compliance

SC PC NC N/A

7. Periodic testing of all sealed sources, satisfying all pertinent radiation regulations.	7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. A program for maintenance and repair of equipment.	8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Quality control procedures for all therapeutic equipment.	9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Regulation of the acquisition, use, removal, handling, and storage of potentially hazardous materials.	10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. The radiation oncology treatment service maintains sufficient adequately trained and experienced personnel who are able to supervise and conduct work of the service, including the following:	E.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. A radiation technologist certified by the American Registry of Radiologic Technologists (ARRT), or state-licensed technologist.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Dosimetrist.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Such other appropriately trained health care professionals as may be in keeping with local practice and legal requirements, such as oncology nurses, nutritionists, and medical social workers.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Radiation oncology service should have adequate facilities and equipment to provide appropriate treatments and related treatments, which include:	F.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Supervoltage or megavoltage machine(s) capable of producing x-ray or gamma-ray beams for external beam treatments (includes isocentric and non-isocentric linear accelerators, GammaKnife, TomoTherapy, and cobalt 60 machines).	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. A kilovoltage x-ray source or electron beam for skin lesions.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Access to computerized dosimetry.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Access to simulation and/or CT imaging equipment.	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Access to patient transport.	5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Personal immobilization devices with procedures to ensure proper identification to match each device to the proper patient.	6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Technologies for shaping dose distributions, including but not limited to multi-leaf collimators, metal alloy, or sheet lead; procedures for proper identification of each device (or electronic file) to the patient and radiation field; and established procedures for identification, handling, storage, and removal of devices made of metal alloys.	7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. If brachytherapy or similar procedures using radioactive seeds or other devices that are implanted or injected are used, appropriate storage containers are utilized and equipment to test for safety of this storage is on site.	8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Compliance

SC PC NC N/A

G. The radiation oncology service has policies addressing the quality of care, including but not limited to policies providing for the following:	G.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. A recognized methodology for diagnosis and treatment, including but not limited to the use of teletherapy and brachytherapy.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The performance of therapeutic services on the written order of a radiation oncologist.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. A physician is present or immediately available during treatment; in those situations in which the physician is not present but is immediately available, qualified support personnel are present.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Weekly chart and port film review for on-going therapies.	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Periodic new patient review.	5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Signed informed consent obtained prior to treatment.	6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Photo documentation of treatment setups.	7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Access to emergency treatment.	8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. The facility has access to appropriate supporting facilities, including diagnostic laboratories and imaging facilities.	H.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. In addition to the applicable clinical records and health information requirements found in Chapter 6, the following characteristics indicate good-quality patient care in the radiation oncology setting and are documented:	I.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Confirmation of the presence of malignancy by histopathology or a statement of benign condition.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Definition of tumor location, extent, and stage.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Definition of treatment volume.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Selection of dose.	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Selection of treatment modality.	5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Selection of treatment technique.	6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Dosimetry calculations.	7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Supervision of treatment and record of patient progress and tolerance.	8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Summary of completion with statement of follow-up plan.	9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25. Managed Care Organizations

An accreditable managed care organization provides for the management of a system of health care and is accountable for the quality of services delivered. Managed care organizations seeking accreditation should complete the *Managed Care Organization Application for Survey*. Such an organization has the following characteristics.

Compliance

SC PC NC N/A

A. The managed care organization has a system in place to provide a network of primary and specialty care providers that meets the needs of the population served and has policies and procedures to communicate to all patient members information about its benefits, services, and network capability to provide a full spectrum of care.	A.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. The managed care organization has an organized and timely system for resolving patient members' grievances, with an expedited procedure for emergency cases, including provisions for identifying, analyzing, and evaluating grievances and appeals, and methods for notifying patient members/enrollees and/or providers of the resolution of grievances and appeals, if applicable.	B.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. The organization ensures that individuals reviewing a grievance involving an adverse determination have appropriate expertise. Individuals with the appropriate clinical expertise review grievances of a clinical nature.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. The organization establishes written procedures for review of an adverse determination.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. The review procedures are available to the patient and any provider acting on behalf of a patient.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. The organization issues a copy of the written decision of the review panel to the patient and to any provider who submits a grievance on behalf of a patient.	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The organization establishes written procedures for an expedited review of an urgent grievance. The expedited reviews are evaluated by appropriate clinical peers or peers who have not been involved in the initial adverse determination. In an expedited review, the organization makes a decision and notifies the patient, or provider acting on behalf of the patient, as expeditiously as the patient's medical condition requires.	5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. The organization provides a system for the reporting, collection, and analysis of patient member appeals and grievances, including methods for establishing a linkage between the organization's quality improvement activities and provider credentialing.	6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Compliance

SC PC NC N/A

C. Information is provided to patient members concerning:	C.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Specialty referral policy.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. When to seek direct access to emergency care or utilize 911 services.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Policies regarding services obtained outside the managed care organization's network and procedures for obtaining them.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Policies on patient member charges (if any).	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Procedures for patient member notification on benefit changes and/or termination of benefits, services, or service delivery.	5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Procedures for appealing decisions regarding coverage, benefits, or services, as required by applicable state or federal law and regulations.	6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Policies and procedures, including an established appointment system appropriate to the organization, are in place to ensure that services are accessible to patient members and that patient members are aware of access points to primary and specialty care and hospital services.	D.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Procedures are in place to periodically assess patient satisfaction with the organization's services and provide feedback to providers.	E.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. The managed care organization maintains a health information system that collects, integrates, analyzes, and reports data as necessary to meet the needs of the organization, maintaining appropriate data on patient/enrollees, health care professionals, and services provided to patient members.	F.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. A Utilization Management Program has been established and includes:	G.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Policies and procedures to evaluate medical necessity, criteria used, information sources, monitors for over/under-utilization, and the review and approval process used to provide medical services.	1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Decision protocols based on medical evidence.	2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Policies and procedures to evaluate the appropriate use of new medical technologies, procedures, drugs, or devices.	3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Evaluation of the Utilization Management Program, including patient member and provider satisfaction data.	4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Practice guidelines or protocols based on medical evidence and population demographics are adopted and monitored/measured for evidence of effectiveness of the program or for improvement. These protocols are updated periodically based on the monitoring process with the intent of continuous quality improvement.	H.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Renal lithotripsy services made available by the organization meet the needs of the patients and are provided in accordance with ethical and professional practices as well as legal requirements.

Compliance	SC	PC	NC	N/A
A. Lithotripsy services provided by the organization are directed by a physician who is qualified to assume clinical responsibility for the quality of services rendered.				
B. Radiation safety and quality control policies and procedures are established, specifically as they relate to patient and staff exposure, and are reviewed periodically by a qualified individual.				
C. The organization establishes written policies and procedures to provide trained and experienced radiologic technologists who are able to conduct duties necessary to assist in the provision of lithotripsy. These include, at a minimum: 1. Meeting state and federal licensure requirements for operation of radiation equipment. 2. The organization must have written policies and procedures that provide appropriate treatment in accordance with manufacturer's guidelines, which include: 1. Indications. 2. Contraindications. 3. Maximum power settings. 4. Maximum number of shocks. 5. Position of patient. 6. Patient size and weight. 7. Utilization of equipment.				
D. The organization has written policies addressing: 1. A recognized methodology for diagnosis and treatment, including pre-procedure evaluation (lab work, x-rays, etc.). 2. That a provider shall perform the treatment and be present during treatment. 3. Criteria for patient selection.				

26. Lithotripsy Services

Compliance	SC	PC	NC	N/A
4. The requirement that signed consent forms be obtained prior to treatment.				
5. Administration of anesthesia/medication. (A wide choice of anesthetic methods is available and appropriate. Successful induction and maintenance of anesthesia must be achieved.)				
6. Appropriate monitoring during treatment must be provided using American Society of Anesthesiology (ASA) guidelines.				
7. Correction of medication-related and other medical conditions continuing to coagulopathy and the relationship to lithotripsy.				
8. Pre- and post-procedure teaching.				
F. The organization has written policies addressing the safety aspects of the treatment, including: 1. Log of daily lithotripsy calibrator/equipment checks on days when lithotripsy is provided. 2. Preventive maintenance logs and maintenance records including malfunction and current documentation from the service contact provider that malfunctions have been corrected. 3. In addition to the applicable critical record requirements in Chapter 6, the following elements must be included: 1. History and physical indicate presence, location, and size of urinary stone. 2. Method of determining location and confirmation of presence of stone immediately prior to treatment. 3. Operative treatment record. a. Selection of treatment modality. b. Number of shocks. c. Energy level. d. Radiation exposure.				
H. The organization provides sponsorship of lithotripsy continuing education.				

25. Lithotripsy Services

**The managed care organization sets policies and procedures for patient access, cost, and quality of care issues as required in Chapter 4, Chapter 5, insurance, eligible, satisfaction, etc.; governance and credentialing, as required in Chapter 2; administration, as required in Chapter 1, including but not limited to patient rights, as required in Chapter 3. Identification and selection of appropriate quality improvement activities are based on information obtained from sources including, but not limited to:
a. Patient member demographics.
b. Patient member and provider surveys.
c. Reports of high-risk, high-volume diagnoses and services.
3. The governing body, at least annually, reviews the effectiveness of the program goals and relative changes, as appropriate.
4. The managed care organization sets policies and procedures for clinical records, performs a periodic review for conformance to Standards, and initiates corrective action when Standards are not met.
5. Records in the patients' primary clinical record include a summary of significant surgical procedures and past and current diagnoses.
6. The managed care organization sets policies and procedures for provider credentialing, performs a periodic review for conformance to the credentialing Standards, and initiates corrective action when Standards are not met.
7. The managed care organization sets written policies and procedures for the provider's participation, including reducing, suspending, or terminating a health care professional's privileges.
8. Procedures should include, but are not limited to:
a. Methods for notifying providers of a participation decision.
b. Methods for filing an appeal when privileges are denied, reduced, suspended, or terminated.**

Compliance	SC	PC	NC	N/A
1. Prior to delegation, a system must be in place to evaluate the functions or services that are delegated to another entity.				
N. The managed care organization is accountable for the oversight of any functions or services that are delegated to another entity.				
M. The managed care organization sets policies and procedures for reporting, reviewing, and appropriate analysis of all incidents reported by anesthesiologists, patients, providers, and others.				
3. Ongoing monitoring of the performance of the entity must be conducted at least annually, with corrective measures taken as appropriate.				
4. If the organization delegates selection of providers to another entity, the organization retains the right to approve, suspend, or terminate the individual provider or provider group.				
O. The managed care organization works to improve the health status of its members with chronic conditions.				
P. The governing body of the managed care organization is responsible for confirming that provider organizations that it contracts with, such as urgent centers, hospitals, home health agencies, nursing homes, behavioral health providers, and medical laboratories (those services listed in the subject checklist) have been reviewed and approved by a recognized accrediting body. The managed care organization must develop and implement standards of participation, if a recognized accrediting body has not approved the provider organization.				
Note: Standard P focuses on the managed care organization's system-wide mechanisms for evaluating individual physicians' access or other contractor practice sites and for ensuring Standards compliance.				

25. Managed Care Organizations

**Chapter 5. Insurance, eligible, satisfaction, etc.; governance and credentialing, as required in Chapter 2; administration, as required in Chapter 1, including but not limited to patient rights, as required in Chapter 3. Identification and selection of appropriate quality improvement activities are based on information obtained from sources including, but not limited to:
a. Patient member demographics.
b. Patient member and provider surveys.
c. Reports of high-risk, high-volume diagnoses and services.
3. The governing body, at least annually, reviews the effectiveness of the program goals and relative changes, as appropriate.
4. The managed care organization sets policies and procedures for clinical records, performs a periodic review for conformance to Standards, and initiates corrective action when Standards are not met.
5. Records in the patients' primary clinical record include a summary of significant surgical procedures and past and current diagnoses.
6. The managed care organization sets policies and procedures for provider credentialing, performs a periodic review for conformance to the credentialing Standards, and initiates corrective action when Standards are not met.
7. The managed care organization sets written policies and procedures for the provider's participation, including reducing, suspending, or terminating a health care professional's privileges.
8. Procedures should include, but are not limited to:
a. Methods for notifying providers of a participation decision.
b. Methods for filing an appeal when privileges are denied, reduced, suspended, or terminated.**

Compliance	SC	PC	NC	N/A
1. Prior to delegation, a system must be in place to evaluate the functions or services that are delegated to another entity.				
N. The managed care organization is accountable for the oversight of any functions or services that are delegated to another entity.				
M. The managed care organization sets policies and procedures for reporting, reviewing, and appropriate analysis of all incidents reported by anesthesiologists, patients, providers, and others.				
3. Ongoing monitoring of the performance of the entity must be conducted at least annually, with corrective measures taken as appropriate.				
4. If the organization delegates selection of providers to another entity, the organization retains the right to approve, suspend, or terminate the individual provider or provider group.				
O. The managed care organization works to improve the health status of its members with chronic conditions.				
P. The governing body of the managed care organization is responsible for confirming that provider organizations that it contracts with, such as urgent centers, hospitals, home health agencies, nursing homes, behavioral health providers, and medical laboratories (those services listed in the subject checklist) have been reviewed and approved by a recognized accrediting body. The managed care organization must develop and implement standards of participation, if a recognized accrediting body has not approved the provider organization.				
Note: Standard P focuses on the managed care organization's system-wide mechanisms for evaluating individual physicians' access or other contractor practice sites and for ensuring Standards compliance.				

25. Managed Care Organizations

27. Medical Home

The services provided by an accredited Medical Home are patient-centered, physician-, nurse practitioner- or physician assistant-directed, comprehensive, accessible, continuous, and organized to meet the needs of the individual patients served. The foundation of a Medical Home is the relationship between the patient, his/her family, as appropriate, and the Medical Home. As used in these Standards, a Medical Home is the primary point of care for the patient. The Medical Home chapter will apply to organizations that choose the chapter in the *Application for Survey*. The Medical Home will be assessed from the perspective of the patient on the following characteristics.

	SC	PC	NC	N/A
A. Relationship – communication, understanding, and collaboration. (In this context, "physician" refers to the physician or the physician-directed health care team.)				
1. The patient can identify his/her physician and patient care team members.				
2. The physician explains information in a manner that is easy to understand (to include Standard 1.0).				
3. The physician listens carefully to the patient and, when appropriate, the patient's parent caregiver(s). Caregivers may include a parent, legal guardian, or person with the patient's power of attorney.				
4. The physician speaks to the patient about his/her health problems and concerns.				
5. The physician provides easy-to-understand instructions about taking care of health concerns.				
6. The physician knows important facts about the patient's health history.				
7. The physician spends sufficient time with the patient.				
8. The patient keeps the patient informed with regard to his/her appointment when delayed.				
9. The physician addresses specific principles to prevent illness.				
10. The physician speaks with the patient about making lifestyle changes to help prevent illness.				
11. The physician inquires as to the patient's concerns/worries/status (i.e., sadness or depressed).				
12. The physician inquires as to the patient's mental health status (i.e., sadness or depressed).				
13. The physician inquires as to the patient's mental health status (i.e., sadness or depressed).				

	SC	PC	NC	N/A
2. The Medical Home scope of service includes, but is not limited to: a. Preventive care including surveillance and screening for special needs) b. Wellness care (healthy lifestyle issues – appropriate sleep, stress relief, etc.) c. Acute illness and injury care. d. Chronic illness management. e. End-of-life care.				
3. Patient education and self-management resources are provided.				
4. Knowledge of community resources that support the patient's (and family, as appropriate) needs are known by the Medical Home.				
5. The community's service limitations are known and alternate sources are coordinated by the Medical Home.				
6. Patients are appropriate to the patient's needs; when referrals occur, the Medical Home collaborates with the specialist.				
7. The needs of the patient's personal caregiver (as defined in Standard 27.A-3), when known, are assessed and addressed to the extent that they impact the care of the patient.				
8. Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards.				
D. Accessibility				
1. The Medical Home establishes standards in writing to support patient access, such as provider availability, information, critical information, clinical record contents, advice, routine care, and urgent care; the Medical Home's data support that they meet those standards.				
2. Patients are routinely and continuously assessed for their perceptions about access to the Medical Home (provider availability, information, clinical record contents, advice, routine care, and urgent care).				
3. Patients are provided information about how to obtain medical care at any time, twenty-four (24) hours per day, every day of the year.				
4. The Medical Home ensures on-call coverage (pre-arranged access to a clinician) when the Medical Home is not open.				
5. Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards.				

27 Medical Home

The Medical Home provides services within a team framework, and that team's provider concept has been conveyed to the patient. The family is included, as appropriate, in patient care decisions. The Medical Home hears its patients with cultural sensitivity.

	SC	PC	NC	N/A
14. The Medical Home provides services with a team framework, and that team's provider concept has been conveyed to the patient.				
15. The family is included, as appropriate, in patient care decisions.				
16. The Medical Home hears its patients with cultural sensitivity.				
B. Continuity of care				
1. A significant number (more than 50%) of the Medical Home visits are with the same physician/physician team.				
2. If a consultation is ordered for the patient, it is documented in the clinical record.				
3. Referrals for services (external to the Medical Home), are documented in the clinical record.				
4. Consultations (medical opinions obtained from other health care professionals) are recorded in the clinical record.				
5. Referrals are disease- or procedure-specific.				
6. The results of a patient referral are recorded in the clinical record; follow-up procedures exist, and the results of the referral are appropriately reported to the Medical Home as they are made available.				
7. Follow-up appointments are documented in the clinical record.				
8. After-hour encounters are documented in the clinical record.				
9. Missed appointments are documented in the clinical record and managed appropriately depending on the patient's care needs and diagnosis.				
10. Critical referrals, critical consultations, and critical diagnostic studies are tracked, and appropriate follow-up is made when the results are not received within a timely manner.				
11. Transition of care (e.g., patients to adult or geriatric) is proactively planned, coordinated, and documented in the clinical record when indicated or when appropriate.				
12. Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards, including consultations, referrals, and lab results.				
C. Comprehensiveness of care				
1. If the Medical Home limits the population served, those limitations are disclosed to prospective patients.				

	SC	PC	NC	N/A
E. Quality				
1. Patient care is physician-directed.				
2. The Medical Home incorporates evidence-based guidelines and performance measures to ensure that they are being used effectively and appropriately.				
3. The Medical Home periodically assesses the use of evidence-based guidelines and performance measures to ensure that they are being used effectively and appropriately.				
4. Supervision of patient care by the Medical Home, as evidenced by: a. Medication review and updates including prescription, over-the-counter, and diet supplements. b. Appropriate ordering of diagnostic tests (avoidance of redundant and unnecessary testing). c. Appropriate management of patient referrals (avoidance of unnecessary referrals)				
5. The Medical Home assesses and continuously improves the services it provides, using various quality studies, data trending, and benchmarking as key tools in a quality improvement management program.				
6. In addition to the Standards presented in Chapter 5.0, the Medical Home's quality improvement program should include at least one (1) study every three (3) years on each of the following topics: a. Patient/physician relationship. b. Continuity of care. c. Comprehensiveness of care. d. Accessibility to care. e. Critical study				
7. Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards.				

Summary Table

Indicate your organization's compliance level for the chapters and use this information to identify and prioritize areas for attention.

	SC	PC	NC	N/A
1. Rights of Patients				
2. Governance				
I. General Requirements				
II. Credentialing and Privileging				
3. Administration				
4. Quality of Care Provided				
5. Quality Management and Improvement				
I. Peer Review				
II. Quality Improvement Program				
III. Risk Management				
6. Clinical Records and Health Information				
7. Infection Prevention and Control and Safety				
I. Infection Prevention and Control				
II. Safety				
8. Facilities and Environment				
9. Anesthesia Services				
10. Surgical and Related Services				
I. General Requirements				
II. Laser, Light-Based Technologies, and Other Energy-Emitting Equipment				
11. Pharmaceutical Services				
12. Pathology and Medical Laboratory Services				
I. CLIA-Waived Tests				
II. CLIA Laboratories				
13. Diagnostic and Other Imaging Services				
14. Dental Services				
I. Dental Service				
II. Dental Home				
15. Other Professional and Technical Services				
I. General Services				
II. Travel Medicine				
16. Health Education and Health Promotion				
17. Behavioral Health Services				
18. Teaching and Publication Activities				
19. Research Activities				
20. Overnight Care and Services				
21. Occupational Health Services				
22. Immediate/Urgent Care Services				
23. Emergency Services				
24. Radiation Oncology Treatment Services				
25. Managed Care Organizations				
26. Lithotripsy Services				
27. Medical Home				

Appendices

Appendix A

Standards Revisions Since 2011

The following are the Standards revisions for 2012. Many Standards were modified to be consistent with glossary definitions.

Chapter 1 – Rights of Patients	10.I.J	"Personnel" was replaced by "support staff."
1.G-6 "Providers" was replaced by "professionals."	10.I.J-1	"Personnel" and "medical personnel" were changed to "health care professionals."
Chapter 2 – Governance, Subchapter I, General Requirements	10.I.K	"Personnel" was replaced by "health care professionals."
2.I.C "Practitioners" was replaced by "health care professionals."	10.I.AA	This is a new Standard addressing blood/blood products and human cells or tissues.
Chapter 2 – Governance, Subchapter II, Credentialing and Privileging	Chapter 11 – Pharmaceutical Services	
2.II.B "Of medical staff members" was added after "assignment or curtailment of clinical privileges."	11.K	"Or other health care professionals" was added after "providers" for clarity.
2.II.D "The health care professional must be legally and professionally qualified for the privileges granted" was added consistent with Medicare language.	Chapter 14 – Dental Services	
2.II.E "Health care professionals" was replaced by "medical staff members."	14.N	"Personnel" was replaced by "health care professionals" and "clinical support personnel" was changed to "clinical support staff."
Chapter 5 – Quality Management and Improvement, Subchapter I, Peer Review	Chapter 15 – Other Professional and Technical Services, Subchapter I, General Services	
5.I.C "By individual practitioners, as well as practitioners in the aggregate," was removed.	15.I.C	"Personnel" was replaced by "allied health professionals."
Chapter 9 – Anesthesia Services	Chapter 20 – Overnight Care and Services	
9.D "Individual" was replaced by "health care professional."	20.C	"Personnel" was replaced by "staff."
9.M-2 "Individual" was replaced by "health care professional."	20.H	"Personnel" was replaced by "health care professionals."
9.N "Medical personnel" was replaced in two places by "health care professionals."	Chapter 21 – Occupational Health Services	
9.R This Standard was revised to include patient safety as the focus of required written protocols.	21.I	"Health care" was added before "professionals" for clarity.
9.W This Standard was modified to clarify when it is applicable.	Chapter 22 – Immediate /Urgent Care Services	
Chapter 10 – Surgical and Related Services	22.D	"Personnel" was replaced by "staff."
The Introduction was modified to clarify that Chapter 10 Standards are applicable in settings where invasive pain management procedures are performed.	22.L	"Personnel" was replaced by "support staff."
Chapter 10, Subchapter I, General Requirements	Chapter 23 – Emergency Services	
10.I.A "Personnel" was changed to "staff" for consistency.	23.B	"Personnel" was replaced by "staff."
10.I.H "Personnel" was replaced by "health care professionals."	23.D	"Personnel" was replaced by "health care professionals."
	23.I	"Clinical personnel" was replaced by "clinical support staff."
	Chapter 24 – Radiation Oncology Treatment Services	
	24.E-3	"Personnel" was replaced by "professional."

The AAHC also reserves the right to deny an organization the right to an appeal if:

- (1) The organization no longer satisfies the AAHC's Survey Eligibility Criteria.
- (2) There is a significant change for a complete list of what constitutes significant changes, see Change on page 25.
- (3) Any imposition of sanctions, any changes in licensure or qualification status, governmental investigation or prosecution, or any violation of state or federal law with respect to the organization's officers, administrators, physician/practitioners, or staff occurs.
- (4) The organization fails to notify the AAHC immediately of any such change.

Conditions with Respect to the Appeal Process

An appeal of an accreditation decision generally does not determine the term of accreditation. If accreditation is revoked, the organization must be re-accredited during the appeal process. If an accredited organization seeking re-accreditation is denied, the organization generally remains accredited until the term of the accreditation expires, which could be during the appeal hearing process.

Any appeal conducted pursuant to these procedures requires all parties to act in good faith. An organization requires all parties to act in good faith. An organization's failure to participate in the appeal process in good faith, including, but not limited to, the submission of falsified, incomplete, or inaccurate documents or information for use during the appeal of the AAHC Board of Directors, in violation of the AAHC Board of Directors' decision and immediate revocation of the appeal. Any organization that exercises its right to an appeal at the same time it applies for a new AAHC accreditation survey. Organizations that wish to file an AAHC accreditation survey should be aware that information about the bases for denial or revocation will be provided to the surveyor.

A Solid Foundation

A state of obligation coupled with a willingness to succeed through the cooperation, mutual respect, and professional pride of its leaders and the physicians, dentists, administrators, and other ambulatory health care professionals who have contributed to its efforts. The AAHC was incorporated in 1973, but its history began more than 30 years ago with independent and cooperative efforts by many medical organizations dedicated to high-quality ambulatory health care. This is the story of how those efforts culminated in the formation of the AAHC and its accreditation program, where we are today, and where we're headed in the future.

American Group Practice Association Concern for Quality

As early as the mid-1960s, the American Medical Group Association began discussing the possibility of establishing a national accreditation program for medical group practices to ensure the provision of high-quality care.

After considerable study and deliberation, the AAHC Board of Trustees formed its Commission on Accreditation with the charge to develop an accreditation program under AAHC's auspices.

In 1968, the Commission began to develop standards and a method to apply the standards to evaluate the quality of care delivered in ambulatory health care settings. The AAHC planned for their standards to include both the format of medical records and the format used by the Joint Commission on Accreditation of Hospitals (JCAH), now the Joint Commission (J.C.C.).

For resources, listings of state and national anesthesia societies, and further general information regarding Malignant Hyperthermia, contact the Malignant Hyperthermia Association of the United States (MHAUS), 11 East State Street, P.O. Box 1080, Bloomington, IL 61802-1080, telephone 312/363-4217, website at www.mha-usa.org and the Malignant Hyperthermia Emergency Information Program (MHEIP) through the general public.

To assist organizations in the following critical statement regarding anesthesia (i.e., electrocardiogram, pulse oximetry, endotracheal intubation, and sedation) and other related procedures, the Malignant Hyperthermia Association of the United States (MHAUS) has developed a manual of 25 vital of anesthesia equipment and procedures. If you are unable to obtain a manual, please contact MHAUS at 312/363-4217, website at www.mha-usa.org and the Malignant Hyperthermia Emergency Information Program (MHEIP) through the general public.

Medical professionals and the general public.

In order to ensure the highest quality of care, the AAHC Board of Trustees formed its Commission on Accreditation with the charge to develop an accreditation program under AAHC's auspices.

In 1968, the Commission began to develop standards and a method to apply the standards to evaluate the quality of care delivered in ambulatory health care settings. The AAHC planned for their standards to include both the format of medical records and the format used by the Joint Commission on Accreditation of Hospitals (JCAH), now the Joint Commission (J.C.C.).

Initial Decision and Opportunity to Submit Appeal

A hearing requested by an organization before the Appeals Hearing Panel is normally held within 60 days following the AAHC's receipt of its written request. The organization will be deemed to have waived its right to an appeal unless the AAHC, in its sole discretion, agrees to extend the period for the appeal.

Approximately 14 calendar days before the hearing, the organization is provided a notice of the hearing, the hearing, and a copy of the AAHC's decision. When the decision is based on findings from an AAHC on-site survey, the organization will also be provided the factual findings included in the survey report. The hearing will be held at the AAHC's office, unless otherwise agreed by the organization and the AAHC. Panel members may be contacted by conference call, but the hearing may proceed with only two of the panel members participating.

At the hearing before the Appeals Hearing Panel, the organization may be accompanied by counsel, make oral comments to the Board meeting, a written response or appeal may be filed. The Board will review the survey report, and any other materials considered by the Appeals Hearing Panel, and make an accreditation decision that will be final. When the accreditation decision is based on findings from an AAHC survey, the Board's decision will be based on the organization's comments and the AAHC Standards in effect at the time of the survey. The AAHC reserves the right to immediately revoke or deny accreditation before providing notice and an opportunity to submit additional materials or appeal the accreditation decision. When among other things, the organization fails to satisfy the AAHC Standards, may request a hearing before the AAHC Board of Directors. The organization will be notified of the hearing and the opportunity to appeal. Individuals (other than consultants, the AAHC staff, or the organization) will be notified of the hearing and the opportunity to appeal.

Appeal to the AAHC Board of Directors

The organization may, at least 30 calendar days prior to the Board meeting, a written response or appeal may be filed. The Board will review the survey report, and any other materials considered by the Appeals Hearing Panel, and make an accreditation decision that will be final. When the accreditation decision is based on findings from an AAHC survey, the Board's decision will be based on the organization's comments and the AAHC Standards in effect at the time of the survey. The AAHC reserves the right to immediately revoke or deny accreditation before providing notice and an opportunity to submit additional materials or appeal the accreditation decision. When among other things, the organization fails to satisfy the AAHC Standards, may request a hearing before the AAHC Board of Directors. The organization will be notified of the hearing and the opportunity to appeal.

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History of the AAHC

Appendix D

Appendix C

Malignant Hyperthermia Guidelines

In response to demand for such a program, The Joint Commission and the National Association of Neighborhood Health Centers (now the National Association of Community Health Centers) began to develop standards and survey procedures for these new types of ambulatory health care organizations. At about the same time, the AGPA opened its accreditation program to nonmembers and began to explore the feasibility of forming an accreditation program for ambulatory health care within The Joint Commission's structure.

In early 1974, The Joint Commission, in response to AGPA interest, approved the formation of the Accreditation Council for Ambulatory Health Care. The Council was formally organized in May 1975, with its founding members representing the American Group Practice Association, American Hospital Association, American Medical Association, Group Health Association of America, and the Medical Group Management Association. Financial support for the Council's development was secured from the W. K. Kellogg Foundation and the Robert Wood Johnson Foundation.

Other Voices and New Horizons

In 1974, because ambulatory surgical facilities were not eligible for survey by The Joint Commission, the Society for the Advancement of Freestanding Ambulatory Surgical Care (later the Federated Ambulatory Surgery Association, FASA, and as of January 1, 2008, the Ambulatory Surgery Center Association, ASCA) identified the need to develop voluntary standards for its members.

Although many of the existing ambulatory health care standards were applicable to surgery centers, additional standards were needed for surgical and nursing care, the administration of anesthesia, and the environment of the operating room. FASA was also interested in developing standards for the cost of care and the use of alternative resources. In 1975, FASA began to develop an accreditation program for ambulatory surgery centers.

Renewed Commitment

In October 1978, when The Joint Commission decided to dissolve its accreditation councils and to replace them with professional and technical advisory committees, representatives from the member organizations of the Accreditation Council for Ambulatory Health Care urged The Joint Commission to modify its plans. They suggested several alternatives that would keep the ambulatory accreditation program intact — alternatives that were consistent with most aspects of The Joint Commission's reorganization plan. The Joint Commission, however, reaffirmed its decision to reorganize.

Most of the member organizations of the Accreditation Council for Ambulatory Health Care were unable to accept the loss of responsibility and authority that their original agreement with JCAH had encompassed. The feeling of ownership of the program was especially strong because of the previously existing programs and the expertise these member organizations had brought to the Accreditation Council. As a result, they withdrew from JCAH.

The American College Health Association, which had begun discussions with JCAH about cooperative accreditation efforts, suspended its discussions when JCAH reorganized. Likewise, the Federated Ambulatory Surgery Association suspended its pursuit of cooperative efforts with JCAH.

AAAHC Is Founded

The Accreditation Association for Ambulatory Health Care, Inc. was incorporated in Illinois as a not-for-profit corporation on March 22, 1979. Its purpose, as stated in its certificate of incorporation, was to organize and operate a peer-based assessment, education, and accreditation program for ambulatory health care organizations as a means of helping them provide the highest achievable level of care for recipients in the most efficient and economically sound manner.

Specifically, the corporation was organized to:

- Conduct a survey and accreditation program to promote and identify high-quality, cost-effective ambulatory health care programs and services.
- Establish standards for accreditation of ambulatory health care organizations and services.
- Recognize compliance with standards by issuance of certificates of accreditation.
- Conduct programs of education and research to further the other purposes of the corporation, to publish the results thereof, and to accept grants, gifts, bequests, and devices in support of the purposes of the corporation.
- Provide programs to facilitate communication, sharing of expertise, and consultation among ambulatory health care organizations and services.
- Assume such other responsibilities and conduct activities compatible with these survey, standard-setting, accreditation, and communication programs.

The six charter members of the corporation were the American College Health Association, the American Group Practices Association (now the American Medical Group Association), the Federated Ambulatory Surgery Association (now the Ambulatory Surgery Center Association), the Group Health Association of America (now the American Association of Health Plans), the Medical Group Management Association, and the National Association of Community Health Centers. Each of the organizations designated AAAHC as its national accrediting body, appointed members to the Board of Directors, and contributed funds to the development and operation of the program. Since AAAHC was founded, both the American College Health Association and the Federated Ambulatory Surgery Association have discontinued their own accreditation programs in order to fully support the AAAHC program.

Responsiveness to a Changing Profession

True to its basic purpose, AAAHC has over the years continued to expand its horizons to meet the changing needs of ambulatory health care organizations.

In 1983, the American Academy of Facial Plastic and Reconstructive Surgery joined AAAHC as a member organization.

In 1987, the American Academy of Dental Group Practice voted to discontinue its own accreditation program for dental group practices and became a member of AAAHC. Two years later in 1987, both the American Association of Oral and Maxillofacial Surgeons and the American Academy of Cosmetic Surgery also became members.

In 1993, the AAAHC Board of Directors approved the addition of the American Society for Dermatologic Surgery.

Since 1990, the AAAHC Board has approved the addition of the American College of Obstetricians and Gynecologists, the American Society of Anesthesiologists, the Society for Ambulatory Anesthesia, and the American Academy of Dermatology.

In 2004, the American Gastroenterological Association became a member of the AAAHC Board. The American College of Gastroenterology and the American Society for Gastrointestinal Endoscopy were approved as members in 2005. In 2011, the Association of periOperative Registered Nurses became the first professional nursing organization to be represented on the AAAHC Board.

A Collaborative Effort

AAAHC continues to review its Standards and survey procedures to ensure their relevance to the ever-changing health care profession. Pilot programs are developed to test the applicability of the Standards and procedures to new settings.

The AAAHC has always provided educational programs and presentations at major ambulatory health care conferences and annual meetings. In response to an expressed need for more training and education in quality assurance and accreditation Standards and procedures, the AAAHC has implemented full-length educational programming sponsored to supplement the workshops at other ambulatory organization meetings.

Although change is an inherent part of its philosophy, the basic AAAHC principles remain firmly intact. AAAHC intends to continue its tradition of using physicians, administrators, nurses, and other health care professionals who are actively involved in ambulatory health care to conduct its accreditation surveys.

Since its founding, AAAHC has conducted thousands of accreditation surveys of all types of ambulatory care organizations, including ambulatory surgery facilities, college and university health services, community health centers, single and multispecialty group practices, and managed care organizations. In this regard, it is significant to note that in September of 1995, AAAHC became the first accreditation organization to conduct an accreditation survey of a pure Independent Physician Association.

Because of the quality of its Standards and the thoroughness of its surveys, the AAAHC has been recognized and accepted by all types of third-party payers (Blue Cross and Blue Shield plans, commercial carriers, HMOs, governmental agencies) as meeting their conditions for participation in reimbursement programs. In recognition of the requirements for risk control and a quality assurance program in the AAAHC Standards, a number of major professional liability carriers extend a discount in premium coverage to ambulatory surgery centers and to single and multispecialty group practices accredited by AAAHC.

Of utmost significance was the recognition of AAAHC by the Centers for Medicare & Medicaid Services (CMS), formerly known as HCFA, on December 19, 1999, in granting the organization "deemed status" for Medicare certification for ambulatory surgery centers. In 2007, CMS again recognized the AAAHC and its accreditation program when it renewed the AAAHC deemed status for health maintenance organizations and preferred provider organizations participating in the Medicare Advantage (previously called Medicare+Choice) program.

The Future of the AAAHC

Since its founding, the AAAHC accreditation program has steadily gained acceptance and recognition from the health care community, government, and general public. It has truly established itself as a leader in the development and maintenance of high-quality, cost-effective health care in the United States.

In November 2004, while celebrating its 25th anniversary, AAAHC reached a milestone: 2,000 currently accredited organizations. As AAAHC began to celebrate its 30th anniversary, another milestone was achieved when the number of accredited organizations surpassed 4,000, doubling the number of accredited organizations in only five years. And before the 30th anniversary year came to a close, the AAAHC was awarded a contract from the Bureau of Primary Health Care (BPHC) to provide accreditation for federally supported Health Centers. In addition, an international subsidiary was created to perform accreditations in countries beyond the United States.

In 2010, the number of organizations accredited by the Accreditation Association surpassed 5,000. The continued growth and success of the AAAHC are assured because of the commitment of ambulatory health care professionals to improve the quality of care provided in their organizations; to compare their performance with nationally-recognized Standards; and to share their experiences through education and consultation.

The leaders and participants in the AAAHC believe that a consultative, peer-based approach will continue to improve health care services by fostering innovation and providing motivation. Above all, they believe that the ultimate beneficiaries of accreditation will always be the patients they serve.

Appendix E

AAAHC Members and Leadership

The Accreditation Association for Ambulatory Health Care, Inc. (AAAHC) comprises the following organizations:

Alphabetically by organization and listed with their CEO or Designated Representative

Ambulatory Surgery Foundation (ASF);
William M. Prentice
American Academy of Cosmetic Surgery (AACCS);
Gail Fairhall, PhD
American Academy of Dental Group Practice (AADGP);
Robert A. Hankin, PhD
American Academy of Dermatology (AAD);
Ronald A. Henrichs, CAE
American Academy of Facial Plastic & Reconstructive Surgery (AAFFRS);
Stephen C. Duffly
American Association of Oral & Maxillofacial Surgeons (AAOMS);
Robert C. Rinaldi, PhD
American College of Gastroenterology (ACG);
Bradley C. Siliman
American College Health Association (ACHA);
Doyle E. Fendol, MS, Col. USA (Ret.)
American College of Mohs Surgery (ACMS);
Kim Schardin, CAE
American Congress of Obstetricians & Gynecologists (ACOG);
Hal C. Lawrence, MD
American Gastroenterological Association (AGA);
Jennifer Conite, CGCS
American Society of Anesthesiologists (ASA);
John Thomas, JD, CAE
American Society for Dermatologic Surgery Association (ASDSA);
Katharine J. Duerdort, CAE
American Society for Gastrointestinal Endoscopy (ASGE);
Patricia Blake, CAE
Association of periOperative Registered Nurses (AORN);
Linda Groah, MSN, RN, CNOR, NEA-BC, FAAN
Medical Group Management Association (MGMA);
Susan Turney, MD
Society for Ambulatory Anesthesia (SAMBA);
Nicole Bradlo, MA, CMP

Official Observer

American Dental Association

Current Officers
Jack Egnatnsky, MD; President, 2011-
Karen M. McKellar; Vice-President, 2011-
Margaret E. Spear, MD; Treasurer, 2011-
Lawrence S. Kim, MD, FAGC, AGAF; Secretary, 2011-

Executive Vice President and CEO
John E. Burke, PhD, 1997-

Current Board of Directors
In alphabetical order
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W. Dore Binder, MD, 2010-
Frank J. Chapman, MBA, 2005-
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Jan Davidson, MSN, RN, CPHRM, 2011-
Mark S. DeFrancesco, MD, MBA, 2000-
Meena Desai, MD, 2009-
Richard L. Dotzky, MD, 2004-
Jack Egnatnsky, MD, 2000-
Richard D. Gortle, MD, 2008-
Steven A. Gunderson, DO, 2002-
Susan M. Hughes, MD, 2004-
Girish P. Joshi, MD, 2006-
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Ross Levy, MD, 2012-
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James Schall, DDS, 2011-
Edwin W. Studo, DMC, JD, 2004-
Margaret E. Spear, MD, 2008-
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Arnaldo Valdeon, MD, 2010-
Mary Ann Vann, MD, 2005-
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Robert C. Williams, 2001-

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Timothy Peterson, MD
Dennis Schultz, MD

Past Officers

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Bruce N. Rogers, DDS, MBA, 2008-2009
Raymond E. Grundman, 2007-2008
Roy C. Grekin, MD, 2006-2007
Francis P. DiPiacido, DMD, 2005-2006
Gerald G. Edds, MD, 2003-2005
C. William Hanke, MD, 2001-2003
William H. Beeson, MD, 1999-2001
Margaret W. Bridwell, MD, 1997-1999
Bernard A. Kershner, 1995-1997
Sam J.W. Romeo, MD, MBA, 1993-1995
Frank J. Newman, MD, 1991-1993
Carl J. Battaglia, MD, 1989-1991
Nicholas D. Wing, MD, 1987-1989
David J. McIntyre, MD, 1985-1987
John R. Johnson, 1983-1985
Wallace A. Read, MD, 1981-1983
John F. Rose, Jr., MD, 1979-1981

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Marshall M. Baker, MS, FACMPE, 2009-2010
Mark S. DeFrancesco, MD, MBA, 2008-2009
Bruce N. Rogers, DDS, MBA, 2007-2008
Raymond E. Grundman, 2006-2007
Roy C. Grekin, MD, 2005-2006
Francis P. DiPiacido, DMD, 2003-2005
Gerald G. Edds, MD, 2001-2003
C. William Hanke, MD, 1999-2001
William H. Beeson, MD, 1997-1999
Margaret W. Bridwell, MD, 1995-1997
Bernard A. Kershner, 1993-1995
Sam J.W. Romeo, MD, MBA, 1991-1993
Frank J. Newman, MD, 1989-1991
Carl J. Battaglia, MD, 1987-1989
Joseph C. Bolche, MD, 1987-1988
Nicholas D. Wing, MD, 1985-1987
David J. McIntyre, MD, 1983-1985
F. Daniel Cantrell, 1981-1983
Wallace A. Read, MD, 1979-1981

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Jack Egnatinsky, MD, 2009-2010
Beverly K. Philip, MD, 2006-2009
Raymond E. Grundman, 2005-2006
Benjamin S. Snyder, 1999-2005
Stanley E. Salzman, 1996-1998
Bernard A. Kershner, 1995-1996
Bery W. Aweril, 1993-1995
John R. Johnson, 1981-1983
William E. Costello, 1979-1981

Secretary:

Margaret E. Spess, MD, 2010-2011
Karen M. McKellar, 2009-2010
Marshall M. Baker, MS, FACMPE, 2008-2009
Mark S. DeFrancesco, MD, 2007-2008
Bruce N. Rogers, DDS, MBA, 2006-2007
Beverly K. Philip, MD, 2005-2006
Raymond E. Grundman, 2003-2005
Dennis Schultz, MD, 2002-2003

Past Executive Directors

Christopher A. Damon, 1990-1997
Ronald S. Moen, Sr., 1979-1990

Past Directors

In alphabetical order

Kenneth Ackerman, 1979-1980
James T. Al-Hussaini, MD, 2006-2010
Jeffrey Apfelbaum, MD, 2003-2005
Rodney C. Armistead, MD, 1992-1994
Bery W. Aweril, 1979-1985
Richard D. Berg, MD, 2005-2010
Carl J. Battaglia, MD, 1987-1993
Carol Beebe, 1995-2000
William H. Beeson, MD, 1991-2003
Louis Bellafante, DDS, 1989-1992
Joseph C. Bolche, MD, 1983-1988
Gordon Berg, MD, 1985-1988
Margaret W. Bridwell, MD, 1988-2006
Aaron L. Brown, Jr., 1982-1983
Srin J. Bull, MD, 2006-2008
Kimberly J. Buttenwick, MD, 2003-2004
Daniel Cantrell, 1979-1983
Joan Chapman, MD, 1987-1989
Lester L. Cline, 1984-1987

Robin Collins, RN, 1993-1995
William J. Conroy, MD, 1979-1986
Mazy Conti, MD, 1995-2001
Gail Cooper, 1994-1999
William E. Costello, 1979-1981
Boydlen L. Crouch, MD, 1983-1985
Thomas Curkin, MD, 1995-1998
Barth S. Derby, 1994-2002
Francis P. DiPiacido, DMD, 1992-2008
Gerald G. Edds, MD, 1996-2005
Scott Endsley, MD, MSc, 2003-2005
Thomas H. Faerber, MD, DDS, 1999-2003
Robert Farol, MD, 1991-1999
Alan P. Faren, MD, 1983-1986
Robert F. Fike, MD, 1987-1984
Forrest Flint, 1990-1993
William W. Funderburk, MD, 1983-1987
Louie S. Garcia, 1979-1980
John S. Gilson, MD, 1979-1980
Stanley R. Gold, MD, 1985-1989
Roy C. Grekin, MD, 1993-2011
Thomas E. Grettler, MD, 1987-1990
Raymond E. Grundman, 1998-2010
C. William Hanke, MD, 1993-2004
Razafat S. Harnalath, MD, 2000-2008
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Theodore R. Hatfield, MD, 1980-1990
Paul J.M. Healey, MD, 1979-1983
Ronald A. Holstern, MD, 1983-1985
John T. Henley, MD, 1988-1991
Jesse Jampol, MD, 1980-1981
Charles Jerge, DDS, 1987-1989
Thomas A. Joas, MD, 2001-2006
John R. Johnson, 1981-1986
Dwight E. Jones, MD, 1982-1986
Bernard A. Kershner, 1981-2001
John Kingsley, MD, 1996-1998
Scott H. Kirk, MD, 1969-2005
M. Robert Knapp, MD, 1979-1981
Frank W. Kramer, MD, 1983-1984
Donald Kwait, DDS, 1987-1990
James E. Lees, 1979-1981
Donald Linder, MD, 1995-1996
William B. Lloyd, MD, 1979-1982
Francis F. Manning, 1983-1984
David J. McIntyre, MD, 1982-1989

Gregg M. Mieske, MD, 2004-2012
James W. Merritt, MD, 1984-1987
John W. Montgomery, 1981-1984
Frank J. Newman, MD, 1988-1996
Iwin O. Overton, 1980-1982
Michael H. Owens, MD, 1986-1992
Louie L. Palaseouras, MD, 1989-2002
Wallace A. Read, MD, 1979-1984
Clifford B. Raifer, MD, MPH, 1981-1992
Jack Reisman, MD, 1990-1994
Bruce N. Rogers, DDS, MBA, 1993-2011
Sam J.W. Romeo, MD, MBA, 1989-2004
John F. Rose, Jr., MD, 1973-1983
Conrad Rosenburg, MD, 1979-1981
Leonard Rubin, MD, 1979-1984
Michael A. Salfi, MD, MPA, FACD, MACG, 2006-2010
Stanley E. Salzman, 1986-1989
Samuel O. Sapin, MD, 1976-1981
Blane Schilling, MD, 1990-2003
Dennis Schultz, MD, 1994-2003
Benjamin S. Snyder, 1987-2006
J. Craig Strafford, MD, 2003-2005
Ronald W. Strahan, MD, 1969-1999
Christopher Strayhorn, MD, 1996-2000
Lance A. Talmage, MD, 2000-2003
Nancy Eve Thomas, MD, 2007-2008
Howard A. Tobin, MD, 1984-1998
Stephen H. Troyer, DDS, 1989-1996
Rebecca S. Twersky, MD, 2000-2001
Seymour Weiner, MD, 1989-1995
Ronald G. Wheeland, MD, 2000-2003
Duane C. Whitaker, MD, 2000-2009/2007-2009
George W. Whitehead, 1981-1983
Douglas Williamson, MD, 1986-1988
Thomas D. Wilson, 1991-1994
Nicholas D. Wing, MD, 1983-1990

Worksheets and Forms

The worksheets and forms provided in this section may be used as tools for assessing an organization's operations. As such, these tools contain only some of the AAAHC Standards. These worksheets are not intended to serve as a substitute for an organization's review and assessment of compliance with all applicable AAAHC Standards.

Analyzing Your Quality Management Program and Creating Meaningful Studies

An accredited organization maintains an active, integrated, organized, ongoing, data-driven program of quality management and improvement that links peer review (Chapter 5.1), quality improvement programs (Chapter 5.1), and risk management (Chapter 5.1) in an organized, systematic way.

The following questions may be used to evaluate and identify elements of an organization's current approach that are less than compliant with AAAHC Standards.

Chapter 5, Subchapter 1: Peer Review

An accredited organization must maintain an active and organized process for peer review that is integrated into the quality management and improvement program. The following questions are designed to assist in assessing the peer review program for overall appropriateness and effectiveness.

	YES	NO
1. Are at least two physicians (or dentists in dental practices) involved in providing peer-based review? If no, describe the plan to ensure the involvement of at least two physicians or dentists. _____	1. <input type="checkbox"/>	<input type="checkbox"/>
2. If the organization is a solo physician or dental organization, is an outside physician or dentist involved in providing peer-based review? If no, describe the plan that will result in the involvement of an outside physician or dentist in peer review. _____	2. <input type="checkbox"/>	<input type="checkbox"/>
3. Is peer review being performed on an ongoing basis for all physicians, dentists, and allied health professionals? For these professionals who are (1) employees of an accredited organization or (2) employees of a credentialed medical staff member of an accredited organization, peer review activity could be performed using ongoing peer-developed review criteria, independent of or as part of regularly-scheduled, performance reviews. Does the organization have the appropriate policies and procedures to support ongoing peer review of physicians, dentists, and allied health professionals, and are they being followed? If no, identify the plan to ensure compliance with your policies. _____	3. <input type="checkbox"/>	<input type="checkbox"/>

Chapter 5, Subchapter 11A: Quality Improvement (QI) Program

An accreditable organization develops and implements a quality improvement program that is broad in scope to address clinical, administrative, and cost-of-care issues as well as actual patient outcomes. The following questions are designed to assist the organization in assessing its written QI program for overall appropriateness and effectiveness.

1. Does your organization have, and has it implemented, a written decision of the quality improvement program? Does the written program address the scope of your organization's health care services? Does the written program address how the quality improvement plan for these services is assessed? If no compliance with Standard 5.I.A-1, _____

2. Does your organization's QI program identify the specific committee(s) or individual(s) responsible for the development, implementation, and oversight of the program? If no, identify the plan for becoming compliant with Standard 5.I.A-2. _____

3. Do clinical and administrative personnel, including at least one physician (or dentist if a dental organization), participate in the QI program? If no, describe plans to bring your organization into compliance. _____

4. Does your organization's QI program include specific quality improvement goals and objectives? If no, identify the plan for including these specific goals and objectives in your program. _____

Analyzing Your Quality Management Program and Creating Meaningful Studies

5. Do health care professionals participate in the development and application of the criteria used to evaluate the care they provide? For example, a physician participates in the development and application of medical care criteria, and a registered nurse participates in the development and application of nursing care criteria. If no, describe the plan to attain compliance. _____

6. Does your organization collect data related to established criteria (see 5.b above) in an ongoing manner? Does your organization periodically evaluate the data to identify acceptable or unacceptable trends or occurrences that affect patient outcomes? If no to either question, describe the necessary plan to attain compliance. _____

7. Are the results of peer review activities reported to the governing body? If no, describe the policy and process to be implemented to ensure compliance. _____

8. Does your organization use the results of peer review as part of the process for granting continuation of clinical privileges, as described in Chapter 2.I and in Standard 5.G.7? If no, describe the plan to ensure compliance. _____

9. Does your organization provide convenient access to reliable, up-to-date information pertinent to the clinical, educational, administrative, and research services provided by the organization? Does your organization encourage health care professionals to participate in educational programs and activities, as demonstrated in the organization's policies or procedures? If no to either question, identify the plan to attain compliance. _____

10. Does your organization provide a monitoring function to ensure the continued maintenance of licensure and/or certification of professional personnel who provide health care services at your organization? If no, describe the policy and the monitoring functions that will be created and implemented. _____

Analyzing Your Quality Management Program and Creating Meaningful Studies

1. Does your organization have, and has it implemented, a written decision of the quality improvement program? Does the written program address the scope of your organization's health care services? Does the written program address how the quality improvement plan for these services is assessed? If no compliance with Standard 5.I.A-1, _____

2. Does your organization's QI program identify the specific committee(s) or individual(s) responsible for the development, implementation, and oversight of the program? If no, identify the plan for becoming compliant with Standard 5.I.A-2. _____

3. Do clinical and administrative personnel, including at least one physician (or dentist if a dental organization), participate in the QI program? If no, describe plans to bring your organization into compliance. _____

4. Does your organization's QI program include specific quality improvement goals and objectives? If no, identify the plan for including these specific goals and objectives in your program. _____

5. Does the QI program include processes to identify opportunities for improving the quality of service provided by your organization? If no, describe the processes to be planned and implemented. _____

6. Does your organization's QI program include quality improvement activities that support the goals of the program? Activities may include, but are not limited to, quality improvement studies and internal and external benchmarking. If no, identify and describe the activities needed to become compliant with Standard 5.I.A-6. _____

7. Does your organization's QI program define the frequency between peer review, quality management activities, and the risk management program? If no, identify the frequency and describe the plan to become compliant with Standard 5.I.A-7. _____

8. Does your organization evaluate the overall effectiveness of the QI program at least annually? Please also refer to Standard 2.I.D. If the QI program is not evaluated for overall effectiveness at least annually, identify and describe the plan(s) to become compliant with Standard 5.I.A-8. _____

9. Is a process in place to ensure that QI findings are reported to your organization's governing body and throughout the organization as appropriate? If no, describe the plan to become compliant with Standard 5.I.A-9. _____

Analyzing Your Quality Management Program and Creating Meaningful Studies

After completing the questions above, review the responses and create a work plan to bring your organization into compliance with Chapter 5.I. Peer Review.

7. Are the results of peer review activities reported to the governing body? If no, describe the policy and process to be implemented to ensure compliance. _____

8. Does your organization use the results of peer review as part of the process for granting continuation of clinical privileges, as described in Chapter 2.I and in Standard 5.G.7? If no, describe the plan to ensure compliance. _____

9. Does your organization provide convenient access to reliable, up-to-date information pertinent to the clinical, educational, administrative, and research services provided by the organization? Does your organization encourage health care professionals to participate in educational programs and activities, as demonstrated in the organization's policies or procedures? If no to either question, identify the plan to attain compliance. _____

10. Does your organization provide a monitoring function to ensure the continued maintenance of licensure and/or certification of professional personnel who provide health care services at your organization? If no, describe the policy and the monitoring functions that will be created and implemented. _____

Analyzing Your Quality Management Program and Creating Meaningful Studies

<p>5.11.B-1. Compare the results of your data analysis to current performance in the area of study against the previously identified performance goal. For example, if the data indicate that you currently have 65% compliance and the goal is 80% compliance, a simple statement to that effect is sufficient.</p>	<p>AAHC Standard What the Standard requires</p> <p>Hints for getting started</p>
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<p>5.11.B-2. Determine what the data tell you about whether the suspected problem actually exists. Describe how the data were analyzed and your findings (conclusions) regarding whether or not the problem exists. If the problem DOES exist, determine what the data tell you about the frequency, severity, and source(s) of the problem(s), and proceed as described in 5.11.B-10. Then discuss whether known or suspected problem and begin again at 5.11.B-1.</p>	<p>AAHC Standard What the Standard requires</p> <p>Hints for getting started</p>
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<p>5.11.B-3. Determine the following: 1. What data are needed in order to verify organizations current performance in the area of study. 2. How will the data be collected? For example, if you are studying medication error rates, what information do you need in order to determine your current error rate? How will you collect that information? Use the space below to describe the data you will collect for the CI study you are conducting, and how you will collect it.</p>	<p>AAHC Standard What the Standard requires</p> <p>Hints for getting started</p>
---	--

<p>5.11.B-4. Describe the data you actually collected. For example, did you review X number of charts for patient visits that occurred from Month A to Month P? What did you look at in those charts? How did you record the data that you collected? Note that, at this point, you are not trying to describe your conclusions about the data – just the data itself. AFTER YOU HAVE COLLECTED THE DATA FOR THE CI STUDY, use the space below to briefly describe the data collected.</p>	<p>AAHC Standard What the Standard requires</p> <p>Hints for getting started</p>
--	--

<p>5.11.B-5. Data analysis that describes findings about the frequency, severity, and source(s) of the problem(s), and do will depend on various factors, such as the amount and type of data you have collected.</p>	<p>AAHC Standard What the Standard requires</p> <p>Hints for getting started</p>
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<p>5.11.B-6. Compare the results of your data analysis to current performance in the area of study against the previously identified performance goal. For example, if the data indicate that you currently have 65% compliance and the goal is 80% compliance, a simple statement to that effect is sufficient.</p>	<p>AAHC Standard What the Standard requires</p> <p>Hints for getting started</p>
--	--

<p>13. Provision by the organization of prevention, screening, evaluation, treatment, or management of prevalent disease, including chronic conditions, behavioral health, etc. 14. Testing new or enhanced processes or methods of care. 15. Benchmarking against best practices, professional practice guidelines, and performance measures, or organization of studies or may not be appropriate for study or a given organization is own part in time. Each organization needs to identify its own important issues for study. Sample topics and/or sources of information about potential topics: 1. Unacceptable or unexpected outcomes of monitoring of care, such as complications, hospital transfers, multiple cases, lack of follow-up on abnormal test results, pathology, medication errors, etc. 2. The clinical performance and practice patterns of health care professionals 3. Variations from expected performance identified through critical review of the quality of care, record policies, completeness of entries, and/or maintaining critical medical laboratory, and pharmaceutical services 4. Services from expected results derived by quality control processes, diagnostic testing, pathology, medical laboratory, and pharmaceutical services 5. Other professional, technical, and ancillary services surveys 6. Assessment of and response to patient satisfaction surveys 7. Direct observation of processes or practices 8. Staff concerns 9. Access to care and/or timeliness of services 10. Medication issues 11. Workflow practices 12. Overutilization or underutilization of services</p>	<p>Chapter 5, Subchapter 11B: Quality Improvement Studies An accreditable organization conducts specific quality improvement studies that support the goals of the overall CI program. The first task is to identify a topic for study. Some examples of topics, and/or sources of information about potential topics, are listed below. Note that the list provides only examples of subjects that may be worth studying in your organization. These potential topics may or may not be appropriate for study or a given organization is own part in time. Each organization needs to identify its own important issues for study. Sample topics and/or sources of information about potential topics: 1. Unacceptable or unexpected outcomes of monitoring of care, such as complications, hospital transfers, multiple cases, lack of follow-up on abnormal test results, pathology, medication errors, etc. 2. The clinical performance and practice patterns of health care professionals 3. Variations from expected performance identified through critical review of the quality of care, record policies, completeness of entries, and/or maintaining critical medical laboratory, and pharmaceutical services 4. Services from expected results derived by quality control processes, diagnostic testing, pathology, medical laboratory, and pharmaceutical services 5. Other professional, technical, and ancillary services surveys 6. Assessment of and response to patient satisfaction surveys 7. Direct observation of processes or practices 8. Staff concerns 9. Access to care and/or timeliness of services 10. Medication issues 11. Workflow practices 12. Overutilization or underutilization of services</p>
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Sample Application for Privileges

1. Hospital and University Affiliations
List all present and past affiliations in chronological order, indicate "Staff Status" as Active/Courtesy, etc., or Academic Title. (Use an additional sheet if necessary.)

Organization Name	Street Address	City, State and Zip Code
Organization 1		
Organization 2		
Organization 3		
Organization 4		
Organization 5		

2. Hospital and University Affiliations (Continued)
Do you currently have privileges at the institution? Yes No
If you have the type of privileges granted (Provisional, Limited, Courtesy, etc.)

3. Hospital and University Affiliations (Continued)
Do you currently have privileges at the institution? Yes No
If you have the type of privileges granted (Provisional, Limited, Courtesy, etc.)

4. Hospital and University Affiliations (Continued)
Do you currently have privileges at the institution? Yes No
If you have the type of privileges granted (Provisional, Limited, Courtesy, etc.)

5. Hospital and University Affiliations (Continued)
Do you currently have privileges at the institution? Yes No
If you have the type of privileges granted (Provisional, Limited, Courtesy, etc.)

Sample Application for Privileges

6. Other State Medical Licenses - Past and Present
Do you currently practice in the state? Yes No
If yes, please list the state and the type of license (e.g., Anesthesiologist, Anesthesiologist Assistant, etc.)

7. Pre-Medical Education
Degree/Field of Study
Institution
City, State and Zip Code

8. Medical Education
Degree/Field of Study
Institution
City, State and Zip Code

9. Other Professional Education
Name of Institution
Department
Address
City, State and Zip Code

10. Internship
Name of Institution
City, State and Zip Code

11. Hospital and University Affiliations (Continued)
Do you currently have privileges at the institution? Yes No
If you have the type of privileges granted (Provisional, Limited, Courtesy, etc.)

Sample Application for Privileges

12. Hospital and University Affiliations (Continued)
Do you currently have privileges at the institution? Yes No
If you have the type of privileges granted (Provisional, Limited, Courtesy, etc.)

13. Hospital and University Affiliations (Continued)
Do you currently have privileges at the institution? Yes No
If you have the type of privileges granted (Provisional, Limited, Courtesy, etc.)

14. Hospital and University Affiliations (Continued)
Do you currently have privileges at the institution? Yes No
If you have the type of privileges granted (Provisional, Limited, Courtesy, etc.)

15. Hospital and University Affiliations (Continued)
Do you currently have privileges at the institution? Yes No
If you have the type of privileges granted (Provisional, Limited, Courtesy, etc.)

16. Hospital and University Affiliations (Continued)
Do you currently have privileges at the institution? Yes No
If you have the type of privileges granted (Provisional, Limited, Courtesy, etc.)

Sample Application for Privileges

17. Residency Programs
List in chronological order, give complete name and address, including ZIP code, beginning and ending dates, and name of your preceptor(s) support.

Name of Institution	Address	City, State and Zip Code
Residency Program 1		
Residency Program 2		
Residency Program 3		

18. Training, Fellowships, Preceptorships, Postgraduate Education
List in chronological order, give complete name and address, including ZIP code, beginning and ending dates, and name of your preceptor(s) support.

Name of Institution	Address	City, State and Zip Code
Training Program 1		
Training Program 2		
Training Program 3		

19. Hospital and University Affiliations (Continued)
Do you currently have privileges at the institution? Yes No
If you have the type of privileges granted (Provisional, Limited, Courtesy, etc.)

20. Hospital and University Affiliations (Continued)
Do you currently have privileges at the institution? Yes No
If you have the type of privileges granted (Provisional, Limited, Courtesy, etc.)

Resources

Chapter 3

- **Journal of Ambulatory Care Management** (<http://www.ambulatorycaremanagement.com>)
- **Ambulatory Surgery Center Association** (<http://ascassociation.org>)
- **Medical Group Management Association** (<http://www.mgma.com>)
- **Centers for Disease Control and Prevention** (<http://www.cdc.gov>)
- **U.S. Citizenship and Immigration Services** (<http://www.uscis.gov>)
- **Immunization Action Coalition** (<http://www.immunize.org>)
- **The National Institute for Occupational Safety and Health (NIOSH)** (<http://www.cdc.gov/niosh>)

Chapter 4

- **Centers for Disease Control, National Notifiable Diseases Surveillance System** (<http://www.cdc.gov/nczod/ndss/index.html>)
- **U.S. Office of Civil Rights, Limited English Proficiency (LEP)** (<http://www.hhs.gov/ocr/civilrights/resources/special/lep.cfm>)

Chapter 5

- **AAHC Institute for Quality Improvement** (<http://www.aaahq.org>)
- **Ambulatory Surgery Center Association, Benchmarking** (<http://ascassociation.org/benchmarking>)
- **Surgical Outcomes Information Exchange** (<http://www.soiix.com>)

Chapter 6

- **U.S. National Library of Medicine National Institutes of Health** (http://www.nlm.nih.gov/ovoc/medical_resources.html)
- **The American Health Information Management Association (AHIMA)** (<http://www.ahima.org>)

Chapter 7

- **Centers for Disease Control** (<http://www.cdc.gov>)
- **World Health Organization** (<http://www.who.int/>)
- **Association for Professionals in Infection Control and Epidemiology, Inc.** (<http://www.apic.org/AAP/Template.cfm?Section=Home1>)
- **The Society for Healthcare Epidemiology of America** (<http://www.shes-online.org>)

Agency for Healthcare Research and Quality (AHRQ) National Guideline Clearinghouse (<http://www.guideline.gov>)

- **Infection Control Today** (<http://www.infectioncontroltoday.com>)
- **Multi-society Guidelines for Reprocessing Flexible Gastrointestinal Endoscopes** (http://www.shea-online.org/Assets/files/position_papers/SHA_Endoscopy.pdf)
- **Society of Gastroenterology Nurses and Associates, Inc.** (<http://www.sgan.org>)
- **American Society for Gastrointestinal Endoscopy** (<http://www.asge.org>)
- **Association for the Advancement of Medical Instrumentation** (<http://www.aami.org>)
- **U.S. Environmental Protection Agency** (<http://www.epa.gov>)
- **American College of Gastroenterology** (<http://www.acg.org>)
- **American Gastroenterological Association** (<http://www.gastro.org>)
- **Occupational Safety and Health Administration, Safety and Health Topics, Healthcare Facilities** (<http://www.osha.gov/SLTC/healthcare/facilities>)
- **U.S. Food and Drug Administration Services, MedWatch: The FDA Safety Information and Adverse Event Reporting Program** (<http://www.fda.gov/Safety/MedWatch/default.htm>)
- **Agency for Healthcare Research and Quality, Patient Safety Tools: Improving Safety at the Point of Care, Tools and Resource Descriptions** (<http://www.ahrq.gov/qual/pips/grants.html#ocriests>)

Chapter 8

- **National Fire Protection Association** (<http://www.nfpa.org/index.asp>)
- **Federal Emergency Management Agency, Multi-Hazard Mitigation Planning** (<http://www.fema.gov/planmitplanning/index.shtml>)
- **World Health Organization, Community Emergency Preparedness: A Manual for Managers and Policy-Makers** (<http://whqlibdoc.who.int/publications/9241545194.pdf>)

Resources

Chapter 9

- **American Society of Anesthesiologists (ASA)** (<http://www.asahq.org>)
- **Society for Ambulatory Anesthesia (SAMBA)** (<http://www.samba.org>)
- **Society for Pediatric Anesthesia** (<http://www.sposanesthesia.org>)
- **American Heart Association** (<http://www.americanheart.org>)
- **Malignant Hyperthermia Association of the United States** (<http://www.mhaus.org>)
- **Association of Peri-Operative Registered Nurses** (<http://www.aorn.org>)
- **Sedation Facts** (<http://sedation.sgn.org>)

Chapter 10

- **American College of Surgeons** (<http://www.facs.org>)
- **World Health Organization, WHO Surgical Safety Checklist and Implementation Manual** (http://www.who.int/patientsafety/safesurgery/ss_checklist/en/index.html)
- **U.S. Food and Drug Administration, 510(k) Clearances** (<http://www.fda.gov/oc/510k/Clearances/DeviceApprovalandClearances510kClearancesDefault.html>)
- **American National Standards Institute, Standard for Safe Use of Lasers in Health Care Facilities** (<http://webstore.ansi.org/RecordDetail.aspx?sku=ANSI-Z136.1-ansi-Z136.3+Combination+Set>)
- **American Academy of Cosmetic Surgery** (<http://www.cosmeticsurgery.org>)
- **American Academy of Dermatology** (<http://www.aad.org>)
- **The American Academy of Facial Plastic and Reconstructive Surgery** (<http://www.aafprs.org>)
- **American Association of Oral and Maxillofacial Surgeons** (<http://www.aasoms.org>)
- **American College of Mohs Surgery** (<http://www.mohscollege.org>)
- **American Society for Dermatologic Surgery** (<http://www.asds.net>)
- **Association of Surgical Technologists (AST) Recommended Standards of Practice for Laundering of Scrub Attire** (http://www.ast.org/pdf/Standards_of_Practice_RSOP_Laundering_Scrub_Atire.pdf)

Chapter 11

- **USP 797.org** (<http://usp797.org>)
- **U.S. Department of Justice Drug Enforcement Administration, Office of Diversion Control** (<http://www.deadiversion.usdoj.gov/index.html>)
- **U.S. Food and Drug Administration, Recalls, Market Withdrawals and Safety Alerts** (<http://www.fda.gov/safety/recalls/default.htm>)
- **U.S. Food and Drug Administration, MedWatch Safety Alerts for Human Medical Products** (<http://www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/default.htm>)
- **Institute for Safe Medication Practices** (<http://www.ismp.org>)

Chapter 12

- **Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments (CLIA)** (<http://www.cms.hhs.gov/clia>)
- **Centers for Disease Control and Prevention, Clinical Laboratory Improvement Amendments (CLIA)** (<http://www.cdc.gov/clia/default.asp>)
- **Centers for Medicare and Medicaid Services, Clinical Laboratory Improvement Amendments (CLIA), How to Obtain a CLIA Certificate of Waiver** (<http://www.cms.hhs.gov/CLIA/downloads/HowtoObtainCertificateofWaiver.pdf>)
- **U.S. Department of Transportation, Federal Highway Administration** (<http://www.fhwa.dot.gov>)

Chapter 13

- **Medline Plus, Diagnostic Imaging** (<http://www.nlm.nih.gov/medlineplus/diagnosticimaging.html>)

Chapter 14

- **American Dental Association** (<http://www.ada.org>)
- **American Academy of Dental Group Practice** (<http://www.aadgp.org>)

Chapter 15

- **Centers for Disease Control and Prevention, Travelers' Health** (<http://www.cdc.gov/travel/>)

Chapter 16

- **American Association for Health Education** (<http://www.aahce.org/AAH-E>)
- **National Commission for Health Education Credentialing, Inc.** (<http://www.nchec.org>)

Resources

Chapter 17

- **National Institute of Mental Health** (<http://www.nimh.nih.gov>)
- **National Alliance on Mental Illness, Mental Health Professionals: Who They Are and How to Find One** (http://www.nami.org/for-ent/center/groups/HelpLine/Mental_Health_Professionals_Who_They_Are_and_How_to_Find_One.html)

Chapter 18

- **Accreditation Council for Graduate Medical Education** (<http://www.acgme.org/acWebsite/home/home.asp>)
- **Alliance for Clinical Education** (<http://www.allianceforclinicaleducation.org/about/about.htm>)

Chapter 19

- **U.S. Food and Drug Administration, Information Sheet Guidelines for Institutional Review Boards (IRBs), Clinical Investigations, and Sponsors** (<http://www.fda.gov/ScienceResearch/SpecialTopics/RunningClinicalTrials/GuidanceInformationSheetsandNotices/ucm113709.html>)

Chapter 20

- **Association of Ambulatory Surgery Centers** (<http://www.aaahq.org/resources/411medcaresevent.pdf>)

Chapter 21

- **Department of Transportation, Federal Highway Administration** (<http://www.fhwa.dot.gov>)
- **Federal Aviation Administration** (<http://www.faa.gov>)
- **United States Nuclear Regulatory Commission** (<http://www.nrc.gov>)

Chapter 22

- **National Association for Ambulatory Care, National Urgent Care Practice Standards Certification** (<http://www.urgentcare.org/Content/Standards/Std134/Default.aspx>)

Chapter 23

- **American College of Emergency Physicians** (<http://www.acep.org>)

Chapter 24

- **American Registry of Radiologic Technologists** (<http://www.art.org>)

Chapter 26

- **American Society of Anesthesiologists** (<http://www.asahq.org>)

Chapter 27

- **American Academy of Family Physicians** (<http://www.aafp.org>)
- **American Academy of Pediatrics, Medical Home** (<http://www.aap.org/healthtopics/medicalhome.cfm>)
- **American College of Physicians, Patient-Centered Medical Home: ACP Delivers Expanded PCMH Resource Online** (http://www.tpconline.org/advocacy/where_we_stand/medical_home)

Glossary and Useful Terms

ADA	Americans with Disabilities Act (www.ada.gov).
Additional Medicare Requirements	Medicare requirements that are only applicable to and assessed during an AAHC/Medicare deemed status survey. Those requirements are listed as <i>Additional Medicare Requirements</i> and are only shown in the AAHC Accreditation Handbook including Medicare Requirements for Ambulatory Surgery Centers.
Administrative controls	The use of administrative measures (i.e., policies, procedures, and enforcement measures) to reduce risk.
Advance directives	The term refers to a formal document or a set of documents that details a person's wishes should that person become unable to make health care decisions, or become temporarily or permanently incapacitated. All fifty (50) states and the District of Columbia have adopted laws to legalize the use of living wills, health care proxies, and/or the durable power of attorney.
Alcohol-based hand rub (ABHR)	An alcohol-containing preparation designed for application to the hands to reduce the number of viable microorganisms on the hands. In the United States, such preparations usually contain 60%–95% ethanol or isopropanol. These are waterless antiseptic agents that do not require the use of exogenous water. After applying such an agent, the hands are rubbed together until the agent has dried.
Allergies	Allergies are abnormal reactions of the immune system that occur in response to allergens. An allergic reaction may occur on contact with an otherwise harmless substance or subsequent to medication administration.
Allied health professionals	For purposes of AAHC Standards interpretation and accreditation, "allied health professionals" is defined as, but not limited to, advance practice registered nurses and physician assistants. Accredited organizations may wish to include additional other categories of health care professionals within its organization's defined category of allied health professionals such as, but not limited to, dental assistants and orthopedic technicians, who are employed by a credentialed dentist or physician and assist in surgical procedures.
Alternate power source	Additional power source that maintains power when the normal power source fails.
APRN (also APN)	Advanced practice registered nurse includes clinical nurse specialist, nurse midwife, nurse practitioner, and nurse anesthetist. Educational and certification requirements and the legal scopes of practices are determined at the state level and vary considerably. Physician assistant (PA) is not included in the definition of APRN (see Physician assistant).
Antimicrobial soap	A soap (i.e., detergent) containing an antiseptic agent.
Antiseptic	A germicide that is used on skin or living tissue for the purpose of inhibiting or destroying microorganisms. Examples include alcohols, chlorhexidine, chlorine, hexachlorophene, iodine, chloroxylenol (PCMX), quaternary ammonium compounds and triclosan.
Antiseptic hand wash	Washing hands with water and soap or detergents containing an antiseptic agent.

Antiseptic hand rub	The process of applying an antiseptic hand rub product to all surfaces of the hands to reduce the number of microorganisms present.
AO	Accreditation organization.
ASA	American Society of Anesthesiologists. The professional organization has established a well-recognized surgical risk classification system.
ASC	Anesthesia surgery center.
Asepsis	Prevention from contamination with microorganisms. Includes sterile conditions on issues or materials, and in rooms, as obtained by including, removing, or killing organisms.
Audit	An examination of records (e.g., clinical records, financial records, personnel records, etc.) to verify compliance and/or check accuracy. When the results of an audit are used to make improvements, the audit is referred to as an internal audit. An examination of records (e.g., clinical records, financial records, personnel records, etc.) to verify compliance and/or check accuracy. When the results of an audit are used to make improvements, the audit is referred to as an internal audit.
Benchmark	A reference point against which other things can be evaluated or measured.
Benchmarking	A systematic comparison of products, services, or work processes of similar organizations, departments, or processes to identify the best practices from which to learn for the purpose of continuous quality improvement. When the results of benchmarking indicate that performance improvement is needed, appropriate quality improvement activities should be undertaken to ensure that improvement occurs.
Benchmarking, External	A type of benchmarking that compares the performance of one organization with another similar organization, or with a group of other organizations.
Benchmarking, Internal	Internal benchmarking compares performance within an organization, such as by physicians or department, or over time, for purposes of accountability, the handbook for other suggested sources.
Bioburden	The degree of microbial contamination. The microbiological load (i.e., number of viable organisms) on the object, or surface, or organism, also known as "load" or "microbial load."
Biological indicator	A device to monitor the sterilization process that consists of a standardized population of bacterial spores known to be resistant to the mode of sterilization being monitored. Biological indicators indicate that all the parameters necessary for sterilization were present.
Biohazardous pathogens	Disease-producing microorganisms spread by contact with blood, or other body fluids, contamination with blood, from a medical person.
Bloodborne Pathogen Standard	A standard developed, promulgated, and enforced by the Occupational Safety and Health Administration (OSHA) directing employers to protect employees from occupational exposure to blood and other potentially infectious material.
CCN	CMS Certification Number.

CFC	Condition for Coverage, a Medicare acronym.
Chemical indicator	A device to monitor the sterilization process that changes color or form with exposure to one or more of the physical conditions within the sterilizing chamber (e.g., temperature, steam). Chemical indicators are intended to detect potential sterilization failures that could result from incorrect packaging, incorrect labeling of the indicator, or malfunctions of the sterilizer. A pass response does not verify that the items are sterile.
Chemical sterilant	Chemicals used for the purpose of destroying all forms of microbial life, including bacterial spores.
Cleaning	The removal of visible soil, organic, inorganic, and inorganic contamination from a device or surface, using either the physical action of scrubbing with a surfactant or detergent and water, or an energy-based process (e.g., ultrasonic cleaners) with appropriate chemical agents.
CLIA	Clinical Laboratory Improvement Amendments (CLIA) – All laboratories must be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).
Clinical support staff	Health care personnel. Clinical support staff provides vital assistance in health care delivery. Clinical support staff includes but is not limited to: respiratory therapists, physical therapists, occupational therapists, medical assistants, dental assistants, pharmacy technicians, respiratory therapists, radiation therapists, registered nurses (RN), certified nurse assistants (CNA), medical assistants, dental hygienists, respiratory therapists, and other health care professionals. These roles may be performed by the professional staff, or by other personnel, as appropriate or certified. Examples:
CMS	Centers for Medicare and Medicaid Services.
Communicable disease	A disease the causative agents of which may pass or be carried from one person to another directly or indirectly.
Control biological indicator	A biological indicator from the same lot as a test indicator that is left unopened to the sterilization cycle and then incubated to verify the viability of the test indicator. The control indicator should yield positive results for bacterial growth.
Corrections log	A narrative document describing the corrections implemented for each AACHC Standard with which an organization was not in substantial compliance at the time of the last survey.
Credentialing	Initial evaluation of credentials or initial credentialing process (also see page 35).
Credentials	Evidence of qualifications (e.g., licenses, certifications, education, experience).
Credentialed	A services company providing primary source verification of practitioners' credentials on behalf of an accredited organization.
Credentialed Organization (CVO)	Certified registered nurse anesthetist.
CRNA	Certified registered nurse anesthetist.

Glossary and Useful Terms

Glossary and Useful Terms

Contamination	A process or treatment that renders a medical device, instrument, or environmental surface safe for use. According to OSHA, the use of physical or chemical means to remove, deactivate, or destroy biohazardous pathogens or a surface or item to the point where they are no longer capable of transmitting disease or infection to humans, livestock, or other animals.
Decontaminated	A medical device used on human objects (working objects such as forceps, retractors, etc.) that has been rendered safe for use. The decontamination process must be performed in a designated area, such as a decontamination chamber, and must be performed according to the manufacturer's instructions. See also High-Level Disinfection.
Decontamination, Medical	Medical decontamination may occur when a patient is determined to be medically unstable but not yet ready for physical discharge from a health care facility.
Discharge, Physical	The actual physical discharge of a patient from a health care facility.
Disinfection	The destruction of pathogens and other kinds of microorganisms by physical or chemical means. Disinfection is less lethal than sterilization, because it destroys most recognizable pathogenic microorganisms, but not necessarily all microbial forms, such as bacterial spores. Disinfection does not ensure the margin of safety associated with sterilization processes.
EES	Essential electrical system.
Engineering controls	Controls (e.g., traps, disposal containers, self-cleaning nozzles, and water medical devices), such as traps with engineered traps (fly protectors) that prevent the escape of pathogens from the work area.
Exposure time	A period of time during a sterilization or disinfection process in which items are exposed to the sterilant or disinfectant at the parameters specified by the manufacturer (e.g., time, concentration, temperature, pressure).
F1	Facial nerve stimulator; primary insurance company that serves as guarantor of the federal government in the administration of the Medicare program, including the payment of claims.
U.S. Food and Drug Administration (FDA)	FDA is an agency within the U.S. Department of Health and Human Services. The FDA is responsible for protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. The FDA is also responsible for advancing the public health by helping to speed innovations that make medicines and foods more effective, safer, and more affordable, and helping the public get the accurate, essential information they need to use medicines and foods to improve their health.

Glossary and Useful Terms

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CRNA	Certified registered nurse anesthetist.

Mechanical indicator	Device (e.g., gauge, meter, display, printout) that displays an element of the sterilization process (e.g., time, temperature, pressure).
Medical staff	Includes all credentialed and privileged health care professionals.
NIOSH	The National Institute for Occupational Safety and Health is the federal agency responsible for conducting research and making recommendations for the prevention of work-related disease and injury. The Institute is part of the Centers for Disease Control and Prevention (www.cdc.gov/niosh).
Occupational exposure	A reasonably-anticipated skin, eye, mucous membrane, or parental contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.
Operating room	A room equipped for performing surgery typically maintained as a sterile environment.
Other qualified licensed individuals	Those licensed practitioners who are authorized in accordance with their state scope of practice laws or regulations, such as advance practice registered nurses, registered nurses, physical therapists, and social workers.
OPIM	Other Potentially Infectious Materials. An OSHA term that refers to (1) The following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; (2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and (3) HIV-containing cell or tissue cultures, organ cultures, and HIV (human immunodeficiency virus)- or HSV (herpes B virus)-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HSV.
Peer evaluation	Formal documentation received during the application for staff privileges process. Peer evaluations may come from other professionals acquainted with the applicant's performance, training program mentors, past professional associates, etc.
Peer review	A participatory process that monitors important aspects of care provided by an organization's individual practitioners, as well as by the organization's practitioners in the aggregate. The results of peer review at the individual level are used in the medical staff reappointment process. When the results of peer review indicate a need for performance improvement at the individual and/or aggregate levels, appropriate quality improvement activities should be undertaken to ensure that improvement occurs.
Peer review vs. performance review	All members of the medical staff undergo peer review as described in Standards 2.11 and 5.1, and in accordance with the organization's peer review policy and procedure. In addition to other organizationally-defined allied healthcare professionals, advance practice registered nurses, physician assistants, and anesthesiologist assistants undergo peer review. Other allied healthcare professionals undergo performance review according to the organization's policy and at least annually.
Physician	A person who has been educated, trained, and licensed to practice the art and science of medicine. The term "physician" includes professionals who have earned MD, DO, DDS, DMD, or DPM degrees.
Physician assistant (PA)	A physician assistant is a licensed health professional who practices medicine as a member of a team with his/her supervising physician.

Performance goal	A statement of a desired level of performance, usually expressed numerically (e.g., "zero patient falls" or "zero medication errors") or as a percentage (e.g., "greater than 95% compliance"). A performance goal is set when a CI study is begun, so that after corrective action has been taken and re-measurement of performance has occurred, the organization may compare its new performance level against the stated goal and determine whether the corrective actions have enabled the organization to reach the performance goal. Whenever possible, performance goals should be based on established benchmarks of best practice performance.
Performance measure	A clearly defined statement or question describing information to be collected for purposes of improving processes and outcomes of care. Two examples are: (1) Percentage of cases in which each cataract surgeon in the ASC starts (makes the incision for) cataract surgery on or before the time the procedure is scheduled to start. (2) Percentage of visits for which each provider documents a recommendation for chlamydia screening for sexually active non-pregnant female patients age 24 years and younger who have a scheduled (not drop-in) visit.
Personal protective equipment (PPE)	Personal protective equipment is specialized clothing or equipment (e.g., gloves, masks, protective eyewear, gowns) worn by an employee for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts, or blouses) not intended to function as protection against a hazard are not considered to be personal protective equipment.
Plain or non-antimicrobial soap	Soaps or detergents that do not contain antimicrobial agents or contain very low concentrations of such agents; these agents are effective solely as product preservatives.
Plan for Improvement (PFI)	The Plan for Improvement is submitted when an accredited organization is notified of deficiencies determined during a survey. The PFI must be written and includes at least the following: Standard identifier, survey findings, corrective actions, party responsible for implementation, and implementation timeline.
Plan of Correction (PoC)	A Plan of Correction (PoC) is required for organizations that had a Medicare deemed status survey conducted in which Medicare deficiencies were identified. An acceptable PoC must contain the following: <ul style="list-style-type: none"> Action that will be taken to correct each specific deficiency cited Description of how the actions will improve the processes that led to the deficiency cited The procedure for implementing the corrective actions A completion date for correction of each deficiency cited Monitoring and tracking procedures to ensure the PoC is effective in bringing the ASC into compliance, and that the ASC remains in compliance with the regulatory requirements The plan must include the title of the person responsible for implementing the acceptable plan of correction The administrator or another individual in a leadership role must sign and date the written PoC.
Post-exposure evaluation and treatment	The evaluation of a health care worker and appropriate treatment, such as administration of medications, following an occupational exposure in an attempt to prevent infection.

Primary source verification	Primary source verification is documented verification by an entity that issued a credential, such as a medical school or residency program, indicating that an individual's statement of possession of a credential is true. Verification can be done by mail, fax, telephone, or electronically, provided the means by which it is obtained are documented and measures are taken to demonstrate that there was no interference in the communication by an outside party.
Privileging	An organization's formal process for evaluating an applicant's qualifications using appropriate criteria and approving, modifying, or denying any or all of the requested privileges in a non-arbitrary manner. See page 37.
Procedure/treatment room	A room, as designated by the organization, in which various treatments or procedures are performed, such as removing sutures, draining a horriortoma, endoscopy, cystoscopy, or laser procedures.
QAPI	A commonly-used CMS acronym for a Medicare certified organization's Quality Assessment and Performance Improvement program.
Quality assurance (QA)	Systematic monitoring and evaluation of the various aspects of a project, service or facility to maximize the probability that minimum standards of quality are being attained. This term is older and not as likely to be used today within health care, because of its focus on <i>minimum</i> standards of quality. The term "quality improvement" is more reflective of ongoing, measurable, and sustained improvements to the care and safety of patients. Throughout its Standards and processes, AAAHC uses the terms "quality improvement" and "CI."
Quality improvement (QI) program	A systematic, ongoing process to achieve and sustain measurable improvements in performance. A CI program includes various activities to measure and improve performance. Examples of measurement activities include (but are not limited to) benchmarking, monitoring, auditing, and CI studies. Performance improvement activities include corrective actions taken or other types of interventions implemented to improve performance. The AAAHC Standards require an accredited organization to have a written CI program approved by its governing body.
Quality improvement (QI) study	A type of CI activity that includes corrective actions and/or other interventions to improve performance, and demonstrates through measurement that performance improvement has occurred and is sustained.
Quality monitoring	The ongoing collection of data about a specific aspect of performance. The data are usually collected for a defined interval of time, and then compared to the same data collected for previous intervals in order to identify desirable and undesirable changes. When undesirable changes are identified, appropriate quality improvement activities should be undertaken to ensure that improvement occurs. Examples of aspects of performance that an organization might monitor include: complications, infections, patient falls, adverse incidents, building safety issues such as exit lighting and fire equipment, review of medical record documentation, on-time starts, no-shows, near misses, patient satisfaction, and access to care.
Reappointment	Renewal of membership in a health care service, such as a medical staff or medical group.
Recredentialing	Periodic re-evaluation and renewing of credentials.

Regulated waste	Liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials.
RO	CMS Regional Office.
SA	CMS State Agency.
Secondary source verification	Acceptable secondary source verification is documented verification of a credential by obtaining a verification report from an acceptable entity that has already performed primary source verification.
Spaulding classification	This classification system divides medical devices into categories based on the risk of infection involved with their use. It is widely accepted and used by the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), epidemiologists, microbiologists, and professional medical organizations to help determine the degree of disinfection or sterilization required for various medical devices.
SSI	Surgical site infection.
Sterile	Free from all living microorganisms; usually described as a probability (e.g., the probability of a surviving microorganism being 1 in 1 million).
Sterilization	The use of a physical or chemical procedure to destroy all microorganisms, including large numbers of resistant bacterial spores.
Surfactant	Surface-active agents that reduce surface tension and help cleaning by loosening, emulsifying, and holding soil in suspension, to be more readily rinsed away.
Surgical hand scrub	An antiseptic-containing preparation that substantially reduces the number of microorganisms on intact skin; it is broad-spectrum, fast-acting, and persistent.
Travel medicine	A branch of medicine that specializes in diseases and conditions that are acquired during travel. Travelers to different countries should be aware of the potential for acquiring diseases and injuries that are not common in their own country. Immunizations, preventive medications, and general precautions are encouraged prior to trips to different parts of the world.
Universal precautions	"Universal precautions," as defined by CDC, are a set of precautions designed to prevent transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other bloodborne pathogens when providing first aid or health care. Under universal precautions, blood and certain body fluids of all patients are considered potentially infectious for HIV, HBV, and other bloodborne pathogens.
Vaccine	A product that produces immunity, thereby protecting the body from a specific disease. Vaccines are administered through needle injections, by mouth, and by aerosol.
Work practice controls	Practices incorporated into the everyday work routine that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles using a two-handed technique).
Workers' Compensation laws	Workers' Compensation laws are regulations regarding employer requirements when employees are injured or disabled on the job. These laws are regulated by each state.

CIC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.43 (b)(4) Standard: Governing body responsibilities	The governing body must ensure that the OAPI program— Clearly establishes its expectations for safety.	5.6A-MS (6)	The governing body must ensure that the OAPI program— Clearly establishes its expectations for safety.
416.43 (b)(5) Standard: Governing body responsibilities	The governing body must ensure that the OAPI program— Adequately allocates sufficient staff, time, information systems and training to implement the OAPI program.	5.6A-MS (10)	The governing body must ensure that the OAPI program— Adequately allocates sufficient staff, time, information systems and training to implement the OAPI program.
416.44 Condition: Environment	The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients.	8.MS	The ASC must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients.
416.44 (b) Standard: Physical environment	The ASC must provide a functional and sanitary environment for the provision of surgical services.	10.LA	Surgical procedures must be performed in a functional and sanitary environment and are limited to those procedures that are approved by the governing body upon the recommendation of qualified medical staff.
416.44 (b)(1) Standard: Physical environment	Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area.	10.LA-MS	Each operating room must be designed and equipped so that the types of surgery conducted can be performed in a manner that protects the lives and assures the physical safety of all individuals in the area.
416.44 (b)(2) Standard: Physical environment	The ASC must have a separate recovery room and waiting area.	8.N-MS	The ASC must have a separate recovery room and waiting area.

CIC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.44 (b)(3) Standard: Physical environment	The ASC must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.	4.F-5	The organization provides for accessible and available health services and ensures patient safety by at least the following: 5. A mechanism to notify public health authorities of reportable conditions.
		7.1A	The organization must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.
		7.1C	The infection control and prevention program reduces the risk of healthcare associated infection as evidenced by education and active surveillance, consistent with: 1. WHO, CDC, or other nationally-recognized guidelines for hand hygiene. 2. CDC or other nationally-recognized guidelines for safe injection practices. 3. Precautions to minimize communicable disease exposure to patients, healthcare staff, and others.
		7.1G	Procedures are available to minimize the source and transmission of infections, including adequate surveillance techniques.
		8.M	A system exists for the proper identification, management, handling, transport, treatment, and disposal of hazardous materials and wastes, whether solid, liquid, or gas. 1. The system includes, but is not limited to, infectious, radioactive, chemical, and physical hazards. 2. The system provides for the protection of patients, staff, and the environment.

CIC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.44 (b)(1) Standard: Safety from fire	Except as otherwise provided in this section, the ASC must meet the provisions applicable to Ambulatory Health Care Centers of the 2000 edition of the Life Safety Code of the National Fire Protection Association, regardless of the number of patients served.	Physical Environment Checklist (PEC) for Ambulatory Surgical Centers	AAAHC Physical Environment Checklist for Ambulatory Surgery Centers is based on the 2000 LSC [The checklist is contained in a separate document.]
416.44 (b)(2) Standard: Safety from fire	In consideration of a recommendation by the State survey agency, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients.	Physical Environment Checklist (PEC) for Ambulatory Surgical Centers	NOTE: In consideration of a recommendation by the State survey agency, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon an ASC, but only if the waiver will not adversely affect the health and safety of the patients.
416.44 (b)(3) Standard: Safety from fire	The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in an ASC.	Will only be applied on a case-by-case basis	The provisions of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by state law adequately protects patients in an ASC.
416.44 (b)(4) Standard: Safety from fire	An ASC must be in compliance with Chapter 21.2.9.1, Emergency Lighting, beginning on March 13, 2006.	Physical Environment Checklist (PEC) for Ambulatory Surgical Centers	See requirements for 3. Exiting, 3.15
416.44 (b)(5) Standard: Safety from fire	Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, an ASC may place alcohol-based hand rub dispensers in its facility if — [] Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities;	Physical Environment Checklist (PEC) for Ambulatory Surgical Centers	See requirements for 6.2 ASHR dispensers

CIC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.44 (b)(5) Standard: Safety from fire	(i) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls; (ii) The dispensers are installed in a manner that adequately protects against inappropriate access; (iii) The dispensers are installed in accordance with the following provisions: (A) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1.8m); (B) The maximum individual dispenser fluid capacity shall be: (1) 0.3 gallons (1.2 liter) for dispensers in rooms, corridors, and areas open to corridors. (2) 0.5 gallons (2.0 liter) for dispensers in suites of rooms; (C) The dispensers shall have a minimum horizontal spacing of 4 ft (1.2m) from each other; (D) Not more than an aggregate 10 gallons (37.8 liters) of ASHR solution shall be in use in a single smoke compartment outside of a storage cabinet; (E) Storage of quantities greater than 5 gallons (18.9 liters) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code; (F) The dispensers shall not be installed over or directly adjacent to an ignition source; (G) In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces shall be permitted only in sprinklered smoke compartments; and (H) The dispensers are maintained in accordance with dispenser manufacturer guidelines.	Physical Environment Checklist (PEC) for Ambulatory Surgical Centers	See requirements for 6.2 ASHR dispensers

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