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Workshops

TABLE OF CONTENTS

FOR WORKSHOPS

From: Jennifer Paul [mailto:jennifer.paul@protrainings.com]
Sent: Sunday, September 16, 2012 11:37 AM
To: Kathleen Kelly
Subject: ProTrainings: CPR/AED and First Aid certification provider

Hello Kathleen,

In searching your website, I noticed in your administrative code under Chapter 631, Dentistry and Dental Hygiene, NAC 631.2239 and NRS 631.190, 631.265, dentists that use general anesthesia, deep sedation, or conscious sedation must be certified in CPR through the American Heart Association. We, at ProTrainings, LLC are an organization that provides CPR and First Aid Certifications that are nationally recognized, and we are equivalent. We have been approved by a number of states to provide CPR certification and training to their dental professionals.

We are seeking approval from your state to provide training for your dental professionals. Attached is a letter that gives you our information, as well as links to our training materials. The ProCPR curriculum follows the latest ILCOR and American Heart Association ECC published guidelines. Experts in the field of CPR Instruction have reviewed and deemed the ProCPR certification equivalent to the American Heart Association BLS-Healthcare Provider and American Red Cross CPR-For the Professional Rescuer certifications.

In addition, we have approvals from DANB, as well as the American Dental Academy PACE, regarding our training programs. I will attach the DANB approval letter, the AGD PACE approval letter, as well as a sample of our certification card.

Please comment back to me, so that I know that you have received this information and that it is in process. I would also appreciate it if you could provide me a timeframe that is expected for a response from your board.

(4 attachments)

I look forward to hearing from you soon.

In kind,

Jennifer Mantegani-Paul
ProTrainings, LLC
Phone: 616-723-8060, Ext. 1018
Toll Free: 888-406-7487, Ext. 1018
Mobile: 616-206-3839
email: Jennifer.paul@protrainings.com
web address: www.protrainings.com

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ProTrainings, LLC
Quality Training: When you want it, where you want it.

September 16, 2012

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

Dear Kathleen J. Kelly,

We are seeking approval by the Nevada State Board of Dental Examiners for personnel to use our ProCPR-CPR/AED for the Healthcare Provider classroom and blended certifications.

ProTrainings LLC has recently received approval as a provider for the Academy of General Dentistry PACE. Our approval number is #343086. In addition, we have been approved by the Dental Assisting National Board (DANB) as well as other approving agencies such as CECBEMS, USA Swimming, and others.

(see these specific letters of approval, and many others, in the compliance packet link below)
http://downloads.protrainings.com/compliancepacket.pdf

The ProCPR curriculum follows the latest ILCOR and American Heart Association ECC published guidelines. Experts in the field of CPR Instruction have reviewed and deemed the ProCPR certification equivalent to the American Heart Association BLS-Healthcare Provider and American Red Cross CPR-For the Professional Rescuer certifications.

As in your Nevada Administrative Code, Chapter 631: Dentistry and Dental Hygiene,
Under NAC 631.2239: Properly equipped facility required; qualifications of auxiliary personnel. (NRS 631.190, 631.265)

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

We, at ProTrainings, LLC are an organization that also provides CPR and First Aid Certifications, and has been proven as providing a "substantially similar course" that follows the same guidelines as the American Heart Association and American Red Cross.

Understanding your regulations, we believe that these two certifications meet and exceed your requirements for obtaining CPR certification for your dental professionals. We look forward to the Dental Board of NV accepting these two certifications from ProTrainings LLC:

ProCPR - Healthcare Provider Adult/Child/Infant CPR/AED
ProFirstAid Advanced- Healthcare Provider Adult/Child/Infant CPR/AED and First Aid

Students complete the classroom and blended courses by watching training videos, performing skills practice with an Instructor/Skill Evaluator, completing a hands-on skill evaluation, and passing a written test with at least 80% correct. As a national organization, ProTrainings, LLC can provide assistance for students to find local instructors to take a classroom course or complete the hands-on skills evaluation. Students can simply search on www.blendedcpr.com for registered ProTrainings, LLC Instructors or call our customer solutions phone number for assistance.

As mentioned before, both of these hands-on certifications can be obtained in the blended and classroom formats, and meet all of the requirements listed in your states dental board regulations. The course content for each course is listed on the back of the certification cards. You may also view our training materials anytime at http://downloads.protrainings.com . If you require printed copy materials prior to approval, please contact me and I will mail those out to you right away.

I have attached a sample copy of the approved certification cards that can be submitted by your states dental professionals that are seeking licensure. I have also provided a sample copy of the online only version that will not meet the requirement so you will easily be able to distinguish the approved ProCPR and ProFirstAid Advanced courses. If a dentist takes the online only recertification, it is simply the wrong course. Our customer solutions team (Phone: 888-406-7487) will be happy to assist your dental professionals and direct them to the correct course if they submit the wrong CPR credentials.

We look forward to providing an excellent option for Nevada dental professionals to complete high quality approved BLS/CPR training.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Donna Wilson
Compliance Coordinator, ProTrainings, LLC
Office: 888-406-7487 (M-F 9am-5pm EST)
Voice Mail: 616-723-8060 ext.1017
Direct: 616-887-0613 or Cell: 616-633-0999
Fax: 810-592-5007
email: donna.wilson@protrainings.com
web address: www.protrainings.com

Dental Assisting National Board, Inc.
Measuring Dental Assisting Excellence™

DANB
444 N. Michigan Ave.
Suite 900
Chicago, IL 60611-3985

toll-free phone number:
1-800-FOR-DANB
(1-800-367-3262)

fax: 312-642-1475
or 312-642-8507

for calls outside the US:
312-642-3368

March 4, 2009

Jody Marvin, EMT-S
ProCPR Training and Compliance Manager
4630 Plainfield Ave NE, Suite A
Grand Rapids, MI 49525

RE: ProCPR acceptance

Mr. Marvin,

The Dental Assisting National Board, Inc. (DANB) is pleased to inform you that ProCPR's Blended CPR Course is now a DANB-accepted CPR certification course. All candidates for DANB national exams may now submit a front and back copy of the ProCPR card as proof of CPR completion, as long as the Skill Evaluator name and number are present. The online course will not be accepted at this time.

Please feel free to contact me with any questions you may have.

Thank you.

Christopher Hoel
Assistant Director, Testing

Academy
of General Dentistry

September 7, 2011

Provider ID# 343086
ProTrainings, LLC
Jody Marvin, Training & Compliance Manager
5005 Plainfield Ave NE Ste B
Grand Rapids, MI 49525

Dear Ms. Marvin:

Congratulations! On behalf of the Academy of General Dentistry (AGD), I am pleased to inform you that **ProTrainings, LLC**, provider ID # **343086**, has received approval from the AGD Program Approval for Continuing Education (PACE) Council. Please use your provider ID number on all correspondence. The approval period extends from **9/1/2011** to **8/31/2013**. Check your listing on the *Find a Provider* page of the AGD Website. E-mail PACE@agd.org if there are any corrections or updates to your information. The AGD e-mails approval renewal notices to providers approximately eleven months and six months before their expiration date.

–Additional proprietary content has been omitted in this space for this public displayable copy–

Hands-on ProCPR and ProFirstAid Advanced SAMPLE Certification Cards

When the participant successfully completes the training, skills practice, skills evaluation, and written test, the Skill Evaluator/Instructor has his or her digital signature printed on the back of the card on the skill evaluator line and/or Instructor line. After successful completion the participant is issued a certification valid for 2 years.

Front

ProCPR®
a ProTrainings.com company

This card certifies that the individual has successfully completed the National Cognitive & Skills Evaluation in accordance with Pro-Trainings Curriculum and American Heart Association® guidelines

JIM SMITH

has completed Adult/Child/Infant CPR & AED Certification for Health Care Provider (BLS)

Date Issued: **01 Jan 2011** Renew By: **01 Jan 2013**

Certificate # **129083355777**

Back

This Certification includes the following objectives and is consistent with national consensus 2010 ECC/ILCOR and American Heart Association® Guidelines.

- AED
- 2 Person CPR
- Bag Valve Mask
- Bleeding Control
- Adult, Child, Infant CPR (Health Care Provider)
- Choking, Conscious and Unconscious
- Shock Management
- Heart Attack
- Breathing Emergency
- Universal Precautions

Instructor: ROY W. SHAW

Skill Evaluator: JODY MARVIN #1000

1-888-406-7487 www.procpr.org support@protrainings.com

ProFirstAid® Advanced

a ProTrainings.com company

This card certifies that the individual has successfully completed the National Cognitive & Skills Evaluation in accordance with Pro-Trainings Curriculum and American Heart Association® guidelines

JIM SMITH

has completed Healthcare Provider CPR/AED & First Aid Certification

Date Issued: **01 Jan 2011** Renew By: **01 Jan 2013**

Certificate # **129083355777**

This Certification includes the following objectives and is consistent with national consensus 2010 ECC/ILCOR and American Heart Association® Guidelines.

- AED
- 2 Person CPR
- Bag Valve Mask
- Heart Attack
- Stroke
- Breathing Emergencies
- Universal Precautions
- Bleeding Control
- Choking, Conscious and Unconscious
- Adult, Child, Infant CPR (Health Care Provider)
- Shock Management
- Poisoning
- Burns
- Musculoskeletal Injuries
- Bites and Stings
- Diabetic Emergencies
- Allergic Reactions
- Seizures
- Heat and Cold Emergencies

Instructor: ROY W. SHAW

Skill Evaluator: JODY MARVIN #1000

1-888-406-7487 advanced.profirstaid.com support@protrainings.com

The hands-on BLS/CPR certification card will state, "cognitive and **skills** evaluation" and have a Skill Evaluator and Instructor line. Both lines can be the same person dependant upon where it was taught and who taught the course.

Online Only SAMPLE Recertification Card

The online only recertification card can be obtained by individuals who are recertifying and are not required to complete hands on training for their workplace or regulatory bodies.

ProCPR®
a ProTrainings.com company

This card certifies that the individual has successfully completed the National Cognitive Evaluation in accordance with ProTrainings Curriculum and the American Heart Association® guidelines

JIM SMITH

has completed Adult/Child/Infant CPR & AED Certification for Health Care Provider (BLS)

Date Issued: **01 Jan 2011** Renew By: **01 Jan 2013**

Certificate # **129083355777**

This Certification includes the following objectives and is consistent with national consensus 2010 ECC/ILCOR and American Heart Association® Guidelines.

- AED
- 2 Person CPR
- Bag Valve Mask
- Bleeding Control
- Adult, Child, Infant CPR (Health Care Provider)
- Choking, Conscious and Unconscious
- Shock Management
- Heart Attack
- Breathing Emergency
- Universal Precautions

Instructor: ROY W. SHAW

1-888-406-7487 www.procpr.org support@protrainings.com

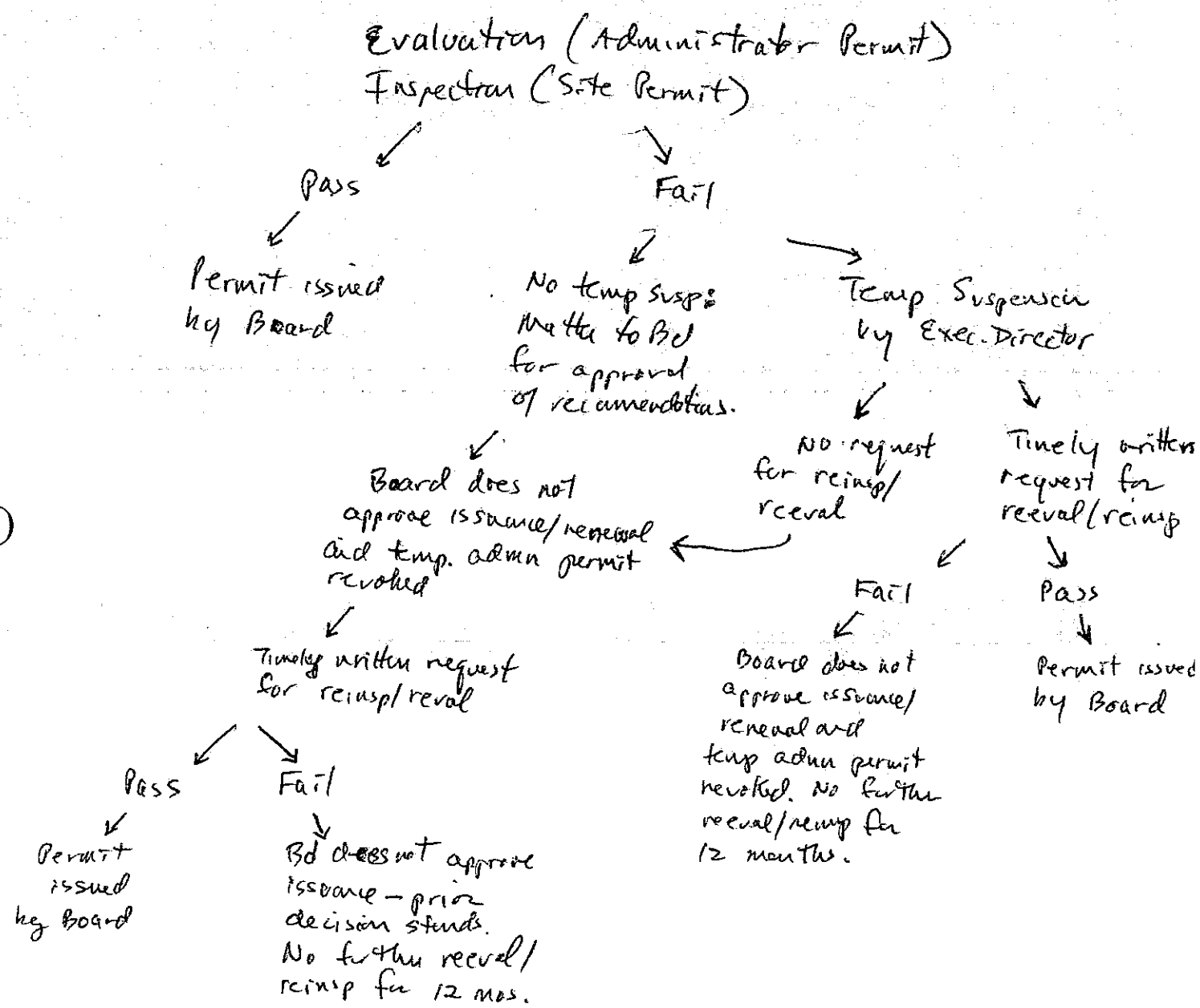
The online only BLS/CPR recertification card will state, "cognitive evaluation" and have only an Instructor line.

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 anesthestist. [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]

OVERVIEW OF REINSPECTION/REEVALUATION PROCESS (NAC 631.2235)



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)

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.

- 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.
- 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-mailcedental@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

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.

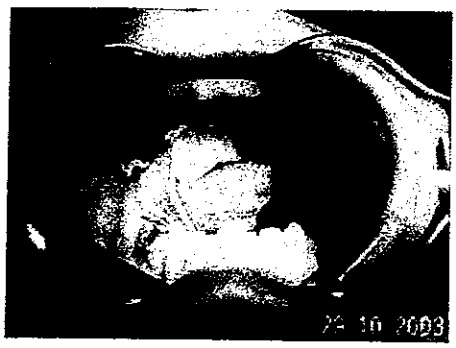
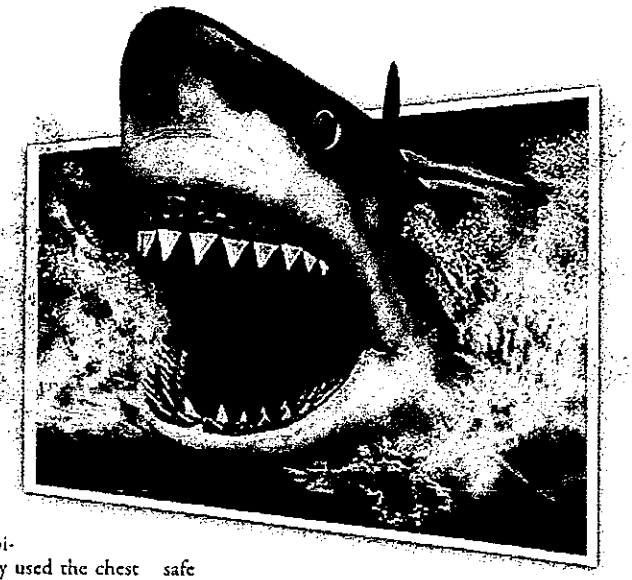


Figure 1. Protection of the airway for a mandibular procedure, such as removal of teeth.

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 3x3- or 4x4-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 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.

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

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 premolar 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

Dr. Orr is professor and director of Oral and Maxillofacial Surgery and Advanced Pain Control, at the University of Nevada School of Dental Medicine in Las Vegas.

THE JOURNAL OF THE AMERICAN DENTAL ASSOCIATION
JADA

Knowing Your Patients
Stanley F. Malamed
JADA 2010;141;3S-7S

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, I[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 Haas[2] 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 Reed[4] 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 1[1]). 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,[8-10] page 5S).

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 colleagues[11] 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 Malamed[10] 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 disease[9] 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 dentist 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.

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]
† Sources: American Society of Anesthesiologists[5]; McCarthy and Malamed.[10]
‡ BP: Blood pressure.
§ mm Hg: Millimeters of mercury.
¶ CVA: Cerebrovascular accident.

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 various dysrhythmias may develop. Pulmonary edema may develop in patients with heart failure. In addition, patients with noncardiovascular disorders may respond adversely when faced with increasing levels of stress. A patient with asthma may develop an acute episode of respiratory distress, and a patient with epilepsy may experience a seizure. Unusual degrees of stress in patients in the PS 1 category may be responsible for psychogenically induced emergency situations, such as hyperventilation or vasodepressor syncope.

Stress reduction protocols are procedures that minimize stress during treatment, thereby decreasing the risk to the patient.[10,12] These protocols are predicated on the belief that the prevention or reduction of stress should begin before treatment, continue throughout treatment and, if indicated, continue into the postoperative period.

Medical consultation. When the dentist is uncertain about the degree of risk to the patient, he or she may consider consulting a physician. Medical consultation is neither required nor recommended for all medically compromised patients. In all cases, clinicians must keep in mind that consultation is a request for information concerning a

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 iatrosedation (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 iatrosedative 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 pos-

sible 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;
- antianxiety 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 preexisting 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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J A D A

Basic Management of Medical Emergencies : Recognizing a Patient's Distress
Kenneth L. Reed
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Basic management of medical emergencies

Recognizing a patient's distress

Kenneth L. Reed, DMD

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.

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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 Haas[3] in this supplement and by Peskin and Siegelman,[4] is of paramount importance. The dental team's ultimate goal

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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[5(p60)]:

- 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. Subcutaneous 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(p460)] 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.[12(p475)]

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[5(p283)] 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.[15] 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"[16]). 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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J A D A

Preparing for Medical Emergencies : The Essential Drugs and Equipment for the Dental Office

Morton Rosenberg

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Preparing for medical emergencies

The essential drugs and equipment for the dental office

Morton Rosenberg, DMD

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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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

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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[2]).

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]

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
Nonrebreathing 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

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, nonrebreathing 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 guidelines[8] 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 2

Suggested basic emergency equipment for the dental office.

- Portable oxygen cylinder (E size) with regulator
- Supplemental oxygen delivery devices
  - Nasal cannula
  - Nonrebreathing 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 hypoxemic 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 hypoxemic 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 bronchodilatation 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

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 H_1 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

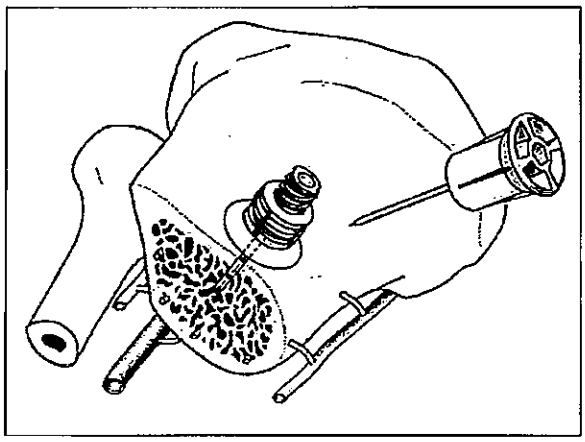

Figure. Intraosseous injection. Reproduced with permission of Vidacare, San Antonio.

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.[15] 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 vasodepressor 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 dentists[16] 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.[8,19]

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 supraglottic devices such as the laryngeal mask airway.[22]

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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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
2006

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 presedation 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 presedation 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.[4,5,12,19,21,22,26,45-53] 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. How-ever, structured sedation protocols designed to incorporate the principles in this document have been widely implemented and shown to reduce morbidity.[29,32-34,37,54,55] 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.[43,57-60]

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.[54] 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.[56,59,70] 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).[46,82] Rescue therapies require specific training and skills.[46,54,83,84] 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.[32,48,55,88-93] 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 parent 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.[53,88,91-93,95-97] 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.[44,98] 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 re-search 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[54,129,130]
- 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.[70,100] 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 resedation,[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.[70,134,135] 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/anxiolysis. 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 "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. 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.[57]

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 resedation, 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 resedation.

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 oxy-gen 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.[47,49,50,143,164-173] 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.[166,168,173]

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*

	Maximum Dose with Epinephrine (mg/kg)†		Duration of Action (min) ‡
Local Anesthetic	Medical	Dental	
Esters			
Procaine	10.0	6	60-90
Chloroprocaine	20.0	12	30-60
Tetracaine	1.5	1	180-600
Amides			
Lidocaine	7.0	4.4	90-200
Mepivacaine	7.0	4.4	120-240
Bupivacaine	3.0	1.3	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
025	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 presedation 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[44]

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_5 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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J A D A

Preparing Dental Office Staff Members for Emergencies : Developing a Basic Action Plan

Daniel A. Haas

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Preparing dental office staff members for emergencies

Developing a basic action plan

Daniel A. Haas, DDS, PhD

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.

JADA 2010;141(5 suppl):8S-13S.

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 teamwork 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

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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. Practitioners 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."[4] 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.

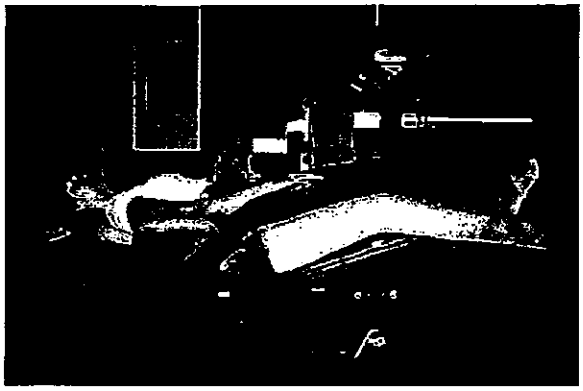

Figure 1. The correct position for an unconscious patient.

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.[6]

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." 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.

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

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.[8] 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-

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.[4]
‡ Source: Gaba and colleagues.[3]

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.[1,3,4]

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, positions 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.[2,3] 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.[9] 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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ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

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: nsbdc@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.

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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@aaahc.org.

Sincerely,

Carolyn E. Kurtz

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

Enc. CC: Robert Talley, DDS, Executive Director, Nevada Dental Association nda@lasvegas.net
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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,

John E. Burke, PhD
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 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

IMPROVING HEALTH CARE QUALITY THROUGH ACCREDITATION

Accreditation **Handbook**

Including Medicare Requirements for Ambulatory Surgery Centers (ASCs)

ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE, INC.

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

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.

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.

Jack Egnatinsky, MD
President

John E. Burke, PhD
Executive Vice President and CEO

Acknowledgments

We gratefully acknowledge the efforts of the AAAHC Board of Directors and the AAAHC Standards and Survey Procedures Committee:

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

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).

Contents

AAAHC Policies and Procedures for Ambulatory Surgery Centers (ASCs) Seeking AAAHC/Medicare Deemed Status

Introduction

The purpose of the Accreditation Association for Ambulatory Health Care (Accreditation Association/AAAHC) is to encourage the voluntary attainment of high-quality care in organizations providing health care services in ambulatory settings. To help organizations achieve this standard of care, and to recognize organizations' achievements, the AAAHC has developed an accreditation program that adheres to the highest standards and established best practices and includes the requirements of the Medicare Conditions for Coverage (CfCs) for Ambulatory Surgery Centers (ASCs). Organizations are invited to study the policies and Standards and the Medicare requirements contained within this publication, and request a formal AAAHC/Medicare deemed status survey by an AAAHC survey team.

ASCs have found the AAAHC Standards and survey procedures particularly appropriate and helpful in improving the quality of care they provide.

AAAHC Standards

The Standards contained in the *AAAHC Handbook Including Medicare Requirements for Ambulatory Surgery Centers (ASCs)* describe characteristics that the AAAHC believes to be indicative of an accreditable ASC. Most AAAHC Standards are written in general terms to allow an organization to achieve compliance in the manner that is most compatible with its particular situation and most conducive to the attainment of high-quality patient care. Where the acceptable methods of achieving compliance with a Standard are limited, the Standard is written in specific terms. Whether a Standard is stated in general or specific terms, the AAAHC is concerned about compliance with the intent of the Standard first and with the letter of the Standard second.

Medicare Conditions for Coverage for ASCs

Ambulatory Surgical Centers (ASCs) are required to be in compliance with the federal requirements set forth in the Medicare Conditions for Coverage (CfC) in order to receive Medicare/Medicaid payment. The survey of an ASC determines whether or not it is in compliance with the definition of an ASC, ASC general conditions and requirements, and the conditions for coverage (CfCs) at Title 42 CFR 416 Subparts A through C (see page 9 for instructions on accessing the CfC).

Evidence of ASC compliance with the regulatory requirements is accomplished through observations, interviews, and document/record reviews. The survey process focuses on an ASC's delivery of patient care, including its organizational functions and processes for the provision of care. The ASC survey is the means used to assess compliance with federal health, safety, and quality standards to ensure that patients receive safe, quality care and services. (CMS SOM, Appendix L, Guidance for Surveyors: Ambulatory Surgical Centers.)

Application of the Standards

The core Standards contained in Chapters 1–8 will be applied to all organizations seeking an accreditation survey. The adjunct Standards, contained in Chapters 9–27, will be applied as appropriate to the services provided by the organization.

Ambulatory surgery centers must meet the core Standards, plus the adjunct Standards for anesthesia services and surgical and related services, as well as all other relevant adjunct Standards. Any questions about the applicability or non-applicability of Standards and chapters should be directed to the AAAHC office.

Throughout the *Handbook*, reference is made to specific documents or standards published by other organizations. Subsequent editions of these publications become the authoritative reference of the AAAHC only after they have been approved as such by the Board of Directors. All organizations seeking accreditation and Medicare certification through the Medicare deemed status survey program, regardless of name, mission statement, or primary service provided, must meet the same high Standards described in the *Handbook*.

Applicable Version of the Standards

An organization will be surveyed according to the 2011 Standards if (1) the *Application for Survey* is received at the AAAHC office on or before February 29, 2012, and (2) the organization's survey begins on or before June 30, 2012.

An organization will be surveyed according to the 2012 Standards if (1) the *Application for Survey* is received at the AAAHC office on or after March 1, 2012, and/or (2) the organization's survey begins on or after July 1, 2012.

Comments and Suggestions about the AAAHC Standards

The AAAHC welcomes comments or suggestions at any time regarding the reasonableness or clarity of any of its Standards. These comments and suggestions should be sent to info@aaahc.org.

Annually, any proposed revisions, deletions, or additions to the AAAHC Standards recommended for the next year by the Standards and Survey Procedures Committee are subject to a public comment period of 30 calendar days. Such revisions, deletions, and additions are posted at www.aaahc.org. The AAAHC solicits and invites comments regarding proposed Standards from its member organizations and all other interested parties.

The Standards and Survey Procedures Committee submits to the AAAHC Board of Directors, for review and final approval, any recommended revisions, deletions, or additions to the existing Standards, all relevant public comments received, and any other recommendations the Committee makes in response to the comments.

The CfC are determined by CMS. CMS requires AAAHC to survey for compliance with the CfC during an AAAHC/Medicare deemed status survey. Comments or suggestions regarding the CfC should be directed to the ASC's CMS Regional Office.

California Outpatient Organizations

In addition to the AAAHC Standards found in this *Handbook*, outpatient organizations in California must also be in compliance with the following laws*:

California Business and Professions Code, Section 2216, effective July 1, 1996

Section 2216 of California Business and Professions Code states: "no physician and surgeon shall perform procedures in an outpatient setting using anesthesia, except local anesthesia or peripheral nerve blocks, or both, complying with the community standard of practice, in doses that, when administered, have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes, unless the setting is specified in Section 1248.1 of the Health and Safety Codes. Outpatient settings where anxiolytics and analgesics are administered are excluded when administered, in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes."

This law prohibits any physician or surgeon from performing surgery in an outpatient surgery setting using specified anesthesia levels unless the setting is one of an enumerated care setting(s), including a setting accredited by an approved accrediting organization or Medicare-certified as an ambulatory surgery center. In accordance with the law, the Medical Board of California adopted standards for approval of accreditation agencies to perform the accreditation of outpatient settings. In 2009, the AAAHC received re-approval from the Medical Board of California as a recognized accrediting organization.

According to Health and Safety Code, Section 1248.3. (a), certificates of accreditation issued to outpatient settings by an accreditation organization shall be valid for not more than three years.

Accredited organizations reported for compliance with Section 1248 of the Health and Safety Codes may not have an accreditation term that exceeds 36 months. Therefore, such organizations are required to submit their application for re-accreditation at least six months prior to their accreditation expiration date.

Continued on following page >

**The information provided with regard to California law is not intended to be a complete listing of all laws applicable to California Outpatient Facilities.*

Effective January 1, 2012, California Health and Facilities Code, Section 1248, has been amended.

This amendment includes updates to the definition of an outpatient setting and additional requirements for accrediting organizations and facilities applying for accreditation. These changes include, but are not limited to the following:

- The definition of "Outpatient setting" has been expanded to include facilities that offer in vitro fertilization.
- Outpatient settings that have multiple service locations shall have all of the sites inspected.
- The accrediting organization shall conduct a reasonable investigation of the prior history of the outpatient setting, including all licensed physicians and surgeons who have an ownership interest, to determine whether there have been any adverse accreditation decisions rendered against them.
- Any outpatient setting that has been denied accreditation shall disclose the accreditation report to any other accrediting organization to which it submits an application. The new accrediting organization shall ensure that all deficiencies have been corrected.
- During the allotted time to correct the deficiencies, the plan of correction, which includes the deficiencies, shall be conspicuously posted by the outpatient setting in a location accessible to public view. Within 10 days after the adoption of the plan of correction, the accrediting organization shall send a list of deficiencies and the corrective action to be taken to the board.
- Outpatient settings shall post the certificate of accreditation in a location readily visible to patients and staff.
- Outpatient settings shall post the name and telephone number of the accrediting organization with instructions on the submission of complaints in a location readily visible to patients and staff.
- All final survey records, which include the survey report, list of deficiencies, plans of correction or plan for improvements and correction, and corrective action completed, shall be public records open to public inspection.
- The Medical Board must obtain and maintain the list for all accredited outpatient settings, and to notify the public, by placing the information on its website, http://mbc.ca.gov, whether the setting is accredited or the setting's accreditation has been revoked, suspended, or placed on probation by the accreditation organization.

California Business and Professions Code, Sections 61638.2 and 2259.8, effective January 1, 2000, which have the following requirements:

- The certificate of accreditation must be posted in a location readily visible to patients and staff.
- The name, address, and telephone number of the accrediting organization, with instructions on the submission of complaints, must be posted in a location readily visible to patients and staff.
- Written discharge criteria must exist.
- A minimum of two staff persons must be on the premises, one of whom shall be a licensed physician and surgeon and/or a licensed health care professional with current certification in advanced cardiac life support (ACLS), as long as a patient is present who has not been discharged from supervised care. Transfer of a patient who does not meet the above required written discharge criteria to an unlicensed setting is not acceptable.
- Physicians must maintain adequate security by malpractice liability insurance or by participation in an interindemnity trust, for claims resulting from surgical procedures performed outside of a hospital. The law calls for the Medical Board to determine the appropriate amount of required insurance.
- Physicians performing or supervising a scheduled medical procedure outside of a hospital that results in death or transfer to a hospital or emergency center for medical treatment for a period exceeding 24 hours are required to report the occurrence within 15 days. Copies of the reporting forms can be obtained from the Medical Board of California at 916/263-2389.

California Business and Professions Code, Section 680.5, amended

- As of June 27, 2010, physicians in California are required to inform their patients that they are licensed by the Medical Board of California, and include the board's contact information. Complete information is available at http://www.mbc.ca.gov/licensee/notices_to_consumers.html.

Acronyms and Definitions

AO	Accreditation Organization
ASC	Ambulatory Surgery Center
CCN	CMS Certification Number
CfC	Conditions for Coverage
CMS	Centers for Medicare/Medicaid Services
EOS	Early Option Survey
EOSM	Early Option Survey with Medicare
FI	Fiscal Intermediary
LSC	Life Safety Code
MDS	Medicare Deemed Status
NPI	National Provider Identifier number
OR	Operating Room
PEC	Physical Environment Checklist
PoC	Plan of Correction
RO	Regional Office
SA	State Agency
SOM	CMS State Operations Manual

Applying for an Accreditation Survey

Survey Eligibility Criteria

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

1. 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 AAAHC Early Option Survey (EOS)/Initial Medicare deemed status survey (see page 12).
2. 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.
3. 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.
4. 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 AAAHC accreditation for this purpose.
5. 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):
    a. doctor of medicine or osteopathy (MD/DO).
    b. doctor of dental surgery or dental medicine (DDS/DMD).
    c. doctor of podiatric medicine (DPM).
    d. doctor of optometry (OD).
    e. doctor of chiropractic (DC).
    f. advanced practice registered nurse (APRN) practicing in compliance with state law and regulation.
    g. licensed clinical behavioral health professional in a behavioral health setting.
6. Shares the facilities, equipment, business management, and records involved in patient care among the members of the organization.
7. Operates in compliance with the U.S. Equal Employment Opportunity Commission laws.
8. Submits the completed, signed *Application for Survey*, all supporting documents, and application fee in advance of the survey.
9. Pays the appropriate fees in accordance with AAAHC policies; see Survey Fees, page 10.
10. Acts in good faith in providing to AAAHC complete and accurate information during the accreditation process and during a term of accreditation.

The AAAHC reserves the right to reject any application. If the AAAHC determines that the Standards cannot be applied, a survey will not be conducted and the AAAHC will inform the organization of the reason for such a decision. If a survey is conducted and the AAAHC 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 AAAHC 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 AAAHC/Medicare deemed status (MDS) survey. ASCs applying for an AAAHC/MDS survey are required to meet AAAHC 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 AAAHC/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 AAAHC/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 AAAHC/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

1. An ASC that wishes to enroll in Medicare can obtain an application on the following website: http://www.cms.hhs.gov/CMSForms/CMSForms/list.asp. Download and complete the form.
   - 855A is used for home health agencies (HHA), hospices, critical access hospitals (CAH), and hospitals (Providers). (AAAHC does not accredit organizations that complete the 855A application.)
   - 855B is used for ASCs (Suppliers) (updated 7/2011).
2. 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.
3. 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.
4. 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 60 calendar day period for processing an application restarts when the additional information is received by the Medicare fee-for-service contractor.
5. The applicant ASC will provide evidence of its completeness notification from the Medicare fee-for-service contractor to the Accreditation Organization (AO)—AAAHC. **Upon receipt of the completeness notification, the AO (AAAHC) may schedule a survey.**
6. The AAAHC surveys the ASC to determine compliance with the AAAHC Standards and the Medicare Conditions for Coverage (CfC). The AAAHC sends the survey results to the ASC and the RO.

7. The RO reviews the survey results and all other relevant information. If the applicant is in compliance with all federal requirements, the RO will issue a provider agreement and assign a CMS certification number (CCN).

8. If an applicant is not in compliance with any of the federal requirements, the RO will issue a letter explaining that the enrollment process cannot proceed until the applicant comes into compliance.

Note: The Regional Office of CMS is the authority for approval of an ASC to participate in the Medicare certification program. If your ASC has ever been denied Medicare certification or terminated (voluntarily or involuntarily) from participation in the Medicare program, the ASC must obtain approval through written consent from a CMS Regional Office to undergo an AAAHC/ Medicare deemed status survey.

Important:

- Providers and suppliers must notify the designated fee-for-service contractor within 90 days of any change in their enrollment information. Changes in information are submitted on the same applications used to initiate the Medicare enrollment process. A change of ownership or control must be reported within 30 days.
- **Note (per CMS):** All providers/suppliers who enrolled in the Medicare program *prior to Friday, March 25, 2011*, will be required to revalidate their enrollment under new risk screening criteria required by the *Affordable Care Act* (section 6401a). *MACs will be in contact between now and March 2015.* For further information, please visit the following link: http://www.cms.gov/MLNMattersArticles/ downloads/SE1126.pdf.
- CMS retains the authority to conduct random and validation surveys and complaint investigations for Medicare certified ASCs. AAAHC accreditation is voluntary, and seeking deemed status through AAAHC is optional. AAAHC accreditation and Medicare deemed status surveys do not eliminate current state licensure requirements.

Important Points to Remember

- The 855B enrollment application is only one part of the process to obtain a provider agreement and CCN with Medicare.
- The applicant must complete all requirements in order to obtain a provider agreement and CCN with Medicare. This includes an 855 enrollment application, relevant SA forms for the particular provider type, an accreditation survey documenting that the applicant meets all Medicare conditions, and notification that the AO is awarding accreditation and recommending deemed status for the facility.
- The RO is responsible for reviewing all documents, issuing the provider agreement, and assigning a CCN. The AAAHC has no role in this process.
- Providers or suppliers will be required to submit an updated CMS-855 if six months has passed since the Medicare fee-for-service contractor sent its recommendation for approval to the state.
- The effective date for Medicare is the date on which the applicant has met all federal requirements, which is determined by the RO. The AAAHC has no role in this determination.

For questions related to the enrollment process, please visit the CMS website, www.cms.gov/ MedicareProviderSupEnroll/01_overview.asp#TopofPage.

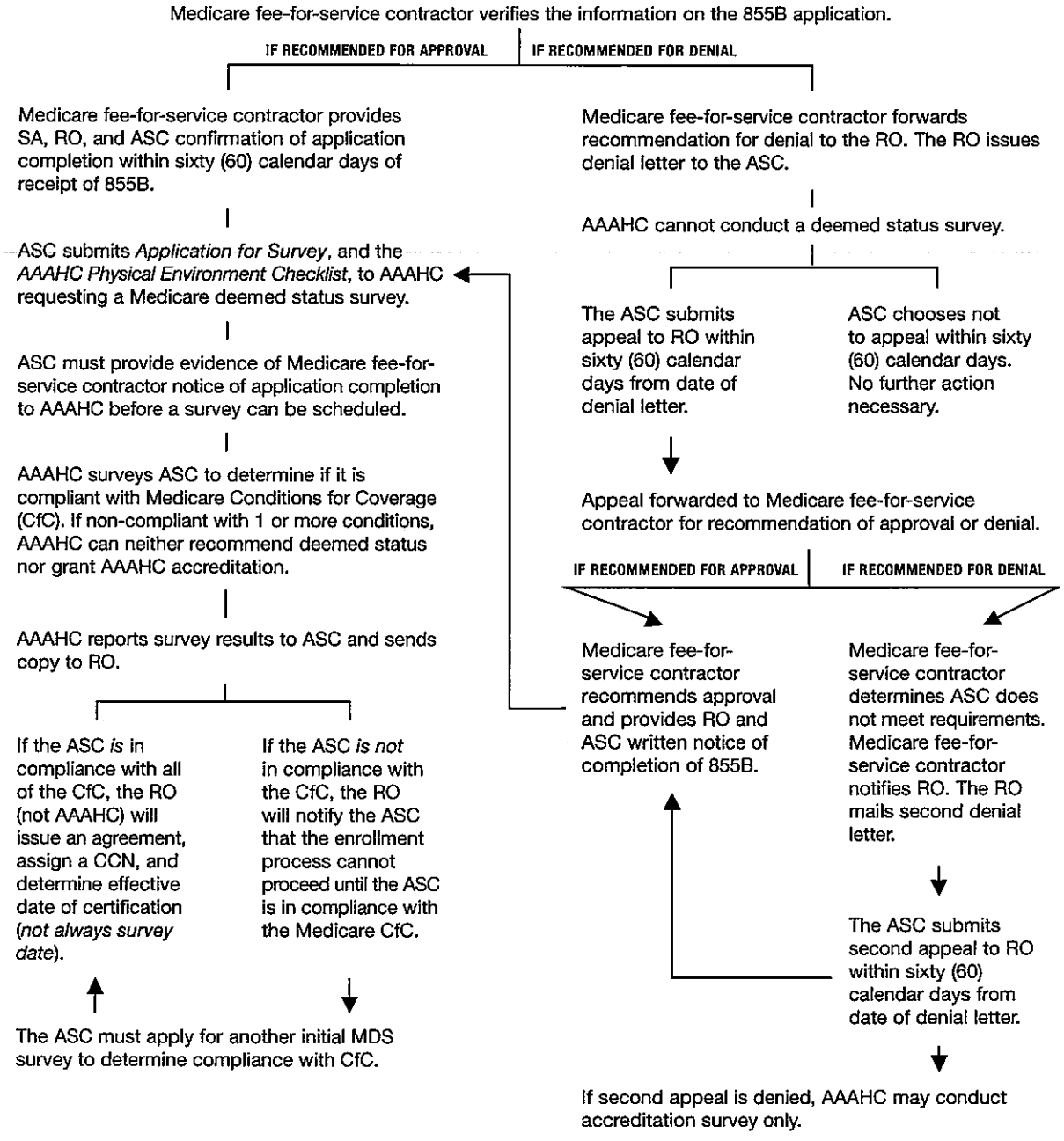
Initial Medicare Certification Process

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.



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

In December 2008, the AAAHC was granted a renewal of its deemed status for Medicare by the Centers for Medicare and Medicaid Services (CMS). To participate in the AAAHC/Medicare deemed status program, ASCs must be in compliance with the Medicare Conditions for Coverage (CfC) as evidenced through a combined AAAHC/Medicare deemed status on-site survey. An AAAHC/Medicare deemed status survey is performed using AAAHC Standards. Those AAAHC 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 AAAHC/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 AAAHC/Medicare Deemed Status" section.

Some Medicare requirements are only applicable to and assessed during an AAAHC/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 CfC specified in Title 42 CFR 416.2, 416.25 and 416.40–416.52.

The CfC can be accessed in two ways:

1. Electronic Code of Federal Regulations: http://ecfr.gpoaccess.gov/index.html

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

Step 2: Select #3 — 414–429, 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 (CfCs) & 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 L of the State Operations Manual, which contains the ASC Interpretive Guidelines.

AAAHC/Medicare Deemed Status Application and Scheduling Process

Obtaining an *Application for Survey*

The *Application for Survey* is completed by ASCs applying for initial AAAHC/Medicare deemed status accreditation and by currently-accredited/Medicare deemed status ASCs applying for continuation of AAAHC accreditation following a three-year term. Any interested individual may obtain the *Application for Survey* by visiting the AAAHC 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 AAAHC and to the survey team during the survey process; 2) agrees to comply with all applicable AAAHC policies and procedures; and 3) understands that AAAHC and its non-profit subsidiary, AAAHC 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 AAAHC office. If the *Application* is incomplete when received, and is not considered by AAAHC 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 AAAHC may apply for an accreditation survey.

AAAHC 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 AAAHC/Medicare deemed status survey, the organization must submit a completed copy of the *AAAHC 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 AAAHC office or the AAAHC 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 AAAHC along with the completed *Application for Survey* and other required supporting documents. The AAAHC 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 AAAHC/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 AAAHC 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 AAAHC 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 AAAHC 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 AAAHC 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 surveyor transportation and lodging.

If the organization cancels or postpones its AAAHC 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 AAAHC, 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 AAAHC

In addition, an ASC that is undergoing an AAAHC/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 AAAHC. It is AAAHC policy that their first and foremost priority when conducting surveys is to be ambassadors of AAAHC, objective fact finders, and educators when appropriate.

It is the policy and practice of AAAHC 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.

AAAHC policy also states that, while serving as representatives of AAAHC, 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, AAAHC requests that surveyed organizations refrain from offering consultative or other types of business to their AAAHC surveyor(s), 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 AAAHC'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 AAAHC 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.*

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

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

In the event that the AAAHC determines that an ASC has supplied it with false, misleading, or incomplete information, the AAAHC 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 AAAHC'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 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/will be 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. 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 AAAHC accreditation for the first time. The ASC may or may not be currently Medicare-certified and is not currently participating in the AAAHC/Medicare deemed status survey process.

Re-accreditation/Initial Medicare Deemed Status Survey

This survey is conducted for an ASC that is currently AAAHC 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 AAAHC/Medicare deemed status survey process.

Re-accreditation Medicare Deemed Status Survey

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

Medicare Follow-up Surveys

After receipt of an acceptable Plan of Correction (PoC), a Medicare Follow-up Survey is required when an AAAHC requirement, that is identified as a condition in the *Accreditation Handbook Including Medicare Requirements for Ambulatory Surgery Centers (ASCs)*, is not in compliance. In addition, all chapters rated less than Substantially Compliant (SC) will also be assessed. The ASC will be assessed a survey fee.

Interim Surveys

An unannounced interim survey is performed (1) when an ASC has deficiencies, but is in compliance with all AAAHC requirements identified as a condition in the *Accreditation Handbook Including Medicare Requirements for Ambulatory Surgery Centers (ASCs)*; and (2) to assess sustained compliance of the ASC's Plan of Correction (PoC). A survey fee will be assessed. Following the interim survey, the organization's three-year accreditation term may be maintained or revoked.

For organizations that undergo an Early Option Survey, an interim survey will be required.

***Life Safety Code* Survey**

The AAAHC can conduct a *Life Safety Code* survey for ASCs seeking an AAAHC/Medicare deemed status survey, but who are unable to provide documented compliance with the *NFPA 101® Life Safety Code®* 2000 Edition. Please note: A *Life Safety Code* survey does not result in an accreditation decision or a recommendation for Medicare deemed status. The ASC will be assessed a separate fee for this survey.

Random Surveys

To support the AAAHC's ongoing quality assurance initiatives, an accredited ASC may be selected for a random survey from 9 to 30 months after an accreditation survey. Random surveys are unannounced. ASCs are selected on a proportionate basis across practice settings, geographic areas, and accreditation decision categories. These unannounced surveys, which are conducted by one surveyor and may last one full day, are a means by which the AAAHC can evaluate the consistency and quality of its program, while also demonstrating to the public and regulators that accredited ASCs remain committed to the AAAHC Standards throughout the accreditation cycle. Random surveys also provide the AAAHC and its surveyors with opportunities to further consult with accredited ASCs in the interval between regular surveys. No fee shall be charged to the ASC when a random survey is conducted.

If AAAHC conducts a random survey and the ASC is judged not to be in substantial compliance with AAAHC Standards although it did not result in a Medicare condition-level deficiency, its accreditation term may be reduced or revoked and the accreditation decision will be reported to CMS. Refer to Denial or Revocation of Accreditation, pages 21–22.

If the surveyor finds one or more Medicare condition-level deficiencies or a series of standard-level deficiencies that could result in a condition-level deficiency, the ASC will be required to submit an acceptable Plan of Correction (PoC). In addition, the ASC will be required to undergo an unannounced follow-up survey to ensure that the Plan of Correction (PoC) has been implemented appropriately for all Medicare condition-level deficiencies cited. (Refer to Plan of Correction on page 20.)

If the surveyor finds one or more standard-level deficiencies, the ASC will be required to submit an acceptable Plan of Correction (PoC). (Refer to Plan of Correction on page 20.)

Discretionary Surveys

Discretionary surveys are conducted "for cause," when concerns have been raised about an accredited ASC's continued compliance with Standards. An accredited ASC may undergo a discretionary survey without advance notice, at any time, and at the discretion of the AAAHC. A fee may be charged to the ASC when a discretionary survey is conducted.

Generally, complaints received by the AAAHC concern specific cases or incidents that occurred in the past. However, AAAHC evaluates ASCs only for their current compliance or non-compliance at the time of the survey. Nevertheless, if an investigation of a complaint substantiates a violation in the past of one or more of the AAAHC Standards and/or CfC requirements, and there is no evidence that the ASC subsequently implemented effective corrective action, then the findings substantiating the violation are documented in the AAAHC survey report.

If an allegation of a violation is substantiated, but the ASC subsequently implemented effective corrective action and the survey reveals no current non-compliant practices, then the ASC is in current compliance and is not cited for a deficiency based on the past non-compliance.

If AAAHC conducts a discretionary survey and the ASC is judged not to be in substantial compliance with AAAHC Standards although it did not result in a Medicare condition-level deficiency, its accreditation term may be reduced or revoked and the accreditation decision will be reported to CMS. Refer to Denial or Revocation of Accreditation, pages 21–22.

In addition, if the surveyor finds one or more Medicare condition-level deficiencies or a series of standard-level deficiencies that could result in a condition-level deficiency, the ASC will be required to submit an acceptable Plan of Correction (PoC). The ASC will be required to undergo an unannounced Medicare follow-up survey to ensure that the Plan of Correction (PoC) has been implemented appropriately for all condition-level deficiencies cited. (Refer to Plan of Correction on page 20.)

The Medicare follow-up survey will focus on assessing the ASC's current compliance with the condition-level deficiencies cited on the previous survey. The AAAHC must receive an acceptable PoC from the ASC before it conducts a Medicare follow-up survey. (Refer to Plan of Correction on page 20.)

If the surveyor finds one or more standard-level deficiencies, the ASC will be required to submit an acceptable Plan of Correction (PoC). (Refer to Plan of Correction on page 20.)

Multi-Site Organizations Seeking an AAAHC/Medicare Deemed Status Survey

ASCs with multiple service locations that have unique CMS Certification Numbers (CCN) must apply for and be surveyed as separate, independent ASCs.

An AAAHC/Medicare deemed status survey may only be requested by a currently Medicare certified ASC or one that is seeking Medicare certification. Any other associated entity must request accreditation separately from the ASC seeking AAAHC/Medicare deemed status.

The Accreditation Process

Although the accreditation/Medicare deemed status survey is of necessity evaluative, AAAHC emphasizes the educational and consultative benefits of accreditation. AAAHC uses health care professionals and administrators who are actively involved in ambulatory health care settings to conduct accreditation/Medicare deemed status surveys. These dedicated individuals offer their time to serve as surveyors and use their practical knowledge in the consistent application of the Standards.

Each survey is tailored to the type, size, and range of services offered by the ASC seeking accreditation/ Medicare deemed status. The length of the on-site visit and the number of surveyors sent by the AAAHC are based on a careful review of the information provided in the *Application for Survey* and supporting documents submitted by the ASC. Questions regarding the scope of a survey should be directed to the AAAHC office before the survey.

Accreditation decisions are made by the AAAHC after careful review of the information gathered during the survey and documented in the survey report, any other applicable supporting documents, and recommendations of surveyors and staff. All documents reflecting the opinions or deliberations of any AAAHC surveyor, staff member, committee member, or its officers or directors constitute peer review materials and will not be disclosed to the organization seeking accreditation/Medicare deemed status or to any third party.

AAAHC expects substantial compliance with the applicable AAAHC Standards and Medicare requirements. Accreditation is awarded to ASCs that demonstrate compliance with the AAAHC Standards and adhere to the AAAHC accreditation policies. Medicare deemed status is recommended for ASCs that demonstrate compliance with the Medicare Conditions for Coverage (CfC). Compliance is assessed through at least one of the following means:

1. Documented evidence.
2. Answers to detailed questions concerning implementation.
3. On-site observations and interviews by surveyors.

ASCs receive a copy of the factual findings after the survey as part of the survey process.

Responsibilities of the Applicant ASC

Information provided by an ASC seeking AAAHC accreditation and Medicare deemed status or re-accreditation is a critical component of the assessment process. The accuracy and veracity of that information is essential to the integrity of the AAAHC's accreditation program. Such information may be verbal in nature, may be obtained through direct observation by AAAHC surveyors, or may be derived from documents supplied by the ASC. The AAAHC requires that each ASC enter into the accreditation relationship and process in good faith.

Failure to participate in good faith during the accreditation process and during any subsequently awarded term of accreditation with Medicare deemed status, including, but not limited to, the submission to AAAHC of falsified, inaccurate, or incomplete documents or information, or failure to pay applicable fees, may be grounds for denial or revocation of an ASC's accreditation status; the basis for terminating an application or an appeal; or the basis for ceasing to do business with the ASC. When an ASC fails to act in good faith, it forfeits its right to appeal or reconsideration of any such action by the AAAHC.

In the event an application or appeal is terminated, the AAAHC is entitled to retain the application and survey fees or any other applicable fees paid by the ASC. Any actions taken by AAAHC will be reported to the CMS Regional Office.

An ASC's duty to provide complete and accurate information continues during the entire accreditation experience. If an ASC experiences significant changes after it submits its *Application for Survey*, but before an accreditation decision is reached, the ASC must notify the AAAHC in writing within five (5) business days of this change. Failure to notify the AAAHC promptly may result in immediate termination of an application for accreditation or immediate revocation of accreditation.

Public Notice of AAAHC/Medicare Deemed Status Survey

For all types of surveys (except random and discretionary), AAAHC policy requires that the *Notice of Accreditation Survey* be posted prominently throughout the ASC's premises for 30 calendar days prior to the scheduled survey start date. The *Notice* invites interested individuals to present relevant information.

For AAAHC/Medicare deemed status surveys, the *Notice* must be posted 30 calendar days prior to the beginning of the 90-day survey window period. The *Notice* must be posted until the end of the survey. In the event that the organization has less than 30 days' notice before the survey window, the *Notice* is required to be posted for a minimum of 30 calendar days or through the end of the survey, whichever occurs later.

To assist ASCs and to ensure consistency in posting public notice, the AAAHC sends copies of the *Notice of Accreditation Survey* form to each ASC for posting. The *Notice* is also available on the AAAHC website at www.aaahc.org. The ASC may download and photocopy the *Notice* in order to achieve wide distribution.

If the ASC fails to post the *Notice*, the survey will be conducted, but no accreditation decision will be made until the ASC posts the *Notice* for a period of 30 calendar days. This allows interested individuals time to request the opportunity to present information relevant to the survey. If such a request is received, a surveyor may be sent, at the surveyed ASC's expense, to receive the information.

The On-Site Survey Process

The accreditation/Medicare deemed status survey of an ASC is conducted by surveyors selected by the AAAHC. Surveyors are physicians, dentists, podiatrists, pharmacists, registered nurses, ambulatory health care facility administrators and other health care professionals who are in active practice and/or have substantial experience in ambulatory health care. Specific survey team members are selected, to the extent possible, on the basis of their knowledge of and experience with the range of services provided by the organization seeking an accreditation survey. In the interest of objectivity, the AAAHC cannot honor requests for specific surveyors.

ASCs are notified in advance to have specific documents and other information available for surveyor review during the on-site visit. This allows surveyors to review and gather information with minimal disruption to the daily activities of the ASC being surveyed. Surveyors may, however, ask to see additional documents or may request additional information during the on-site survey.

It is required for the surveyors to observe a surgery or procedure during an AAAHC/Medicare deemed status survey. An ASC's failure to provide information requested by the AAAHC or by the surveyors, or an ASC's failure to allow surveyors to observe a surgery or procedure, may be grounds for termination of the survey or accreditation process.

During the on-site survey and as stated in the *Notice of Accreditation Survey*, the AAAHC provides an opportunity for members of the general public, as well as patients and staff of the ASC, to present to AAAHC surveyors pertinent and valid information about the surveyed ASC's provision of health care or its compliance with the AAAHC Standards and Medicare requirements. Alternatively, individuals may present such information in writing to the AAAHC office. All information received from individuals will be considered in the accreditation process.

The opportunity for individuals to present information in person will be scheduled by AAAHC. Such presentations normally do not exceed a total of one hour in length. The time and length of the session will be coordinated with the AAAHC Survey Chairperson. The surveyed ASC will provide reasonable accommodations for the session, which is chaired by the AAAHC surveyor.

The session will consist of the orderly presentation of information, verbally or in writing, within the scheduled time. All information received will be considered for pertinence and accuracy, and the findings may be included in the survey report if applicable.

A request to present information during the on-site survey will be handled by the AAAHC office. Any such requests received by the ASC to be surveyed will be referred to the AAAHC office. The AAAHC will inform the requesting individual of the date, time, and place for the presentation of information to the surveyor.

At the conclusion of the on-site survey, the surveyors hold a summation conference at which they present their findings to representatives of the organization for discussion and clarification. As the surveyors are "fact finders" for the AAAHC and do not render the final accreditation decision, no information regarding the organization's compliance with the AAAHC Standards or the accreditation decision is provided during this conference. Members of the organization's governing body, medical staff, and administration are encouraged to take this opportunity to comment on or rebut the findings, as well as express their perceptions of the survey.

Consultant participation in an on-site AAAHC accreditation survey is limited to the consultant's attendance at the survey opening conference and/or the summation conference. The AAAHC Survey Chairperson has the right to limit or exclude the participation of any individual(s) in any or all parts of the AAAHC on-site accreditation survey activities.

AAAHC works with a third-party calling center to conduct an evaluation of our survey process and our surveyors.

A representative from the third-party calling center will contact the organization's designated primary contact approximately one week after the survey to discuss the recent survey experience.

Obtaining this input by telephone will provide AAAHC with a faster, more efficient means of receiving feedback. An organization's feedback will have no bearing on the accreditation decision.

Additions to the Survey Team

An organization that applies for an AAAHC survey accepts additions to the survey team as determined by the AAAHC, as follows:

- **Observers**
  AAAHC staff and individuals approved by AAAHC may observe a survey as part of staff development and ongoing quality improvement of the accreditation process. Observers do not participate in the on-site survey process in any manner.

- **Additional Surveyors**
  The AAAHC reserves the right to assign additional AAAHC surveyors as part of ongoing surveyor education procedures. All surveyors may actively participate in the on-site survey process.

The presence of observers or extra surveyor(s) does not result in any additional charge to the ASC, nor may it serve as grounds for any challenge to the accreditation outcome.

Medicare Deficiencies

Early Option Survey (EOS) and Initial Accreditation/ Initial Medicare Deemed Status Survey

After an EOS or initial accreditation/Medicare deemed status survey is performed, the following will occur (See page 18):

Condition-Level Deficiency

If a Medicare CfC **condition-level deficiency** or a series of Standard-level deficiencies that could result in a condition-level deficiency has been identified during the survey or in the survey report, the following will occur:

- The ASC will *not* be granted an accreditation term or recommended for Medicare deemed status.
- The AAAHC will send the ASC a Medicare deficiency letter within ten (10) business days after the survey.
- The ASC is required to develop and submit an acceptable Plan of Correction (PoC) to AAAHC within ten (10) calendar days.
- If the ASC disagrees with any of the survey findings, it can indicate this in the PoC, but this is the only mechanism by which a survey finding can be contested. It is acceptable to contest a finding if the ASC believes it was in compliance at the time of the survey. The ASC must provide evidence to support its position (**Note:** This process does not include corrections made during or after the survey).

- AAAHC will send notification to the ASC that it is not accredited and is not recommended for Medicare deemed status. The ASC is informed that it may apply for another AAAHC/Medicare deemed status survey.

If the ASC was seeking initial Medicare certification, it is urged to check on the status of the 855B enrollment application to make sure it has not expired. If it has expired, the ASC will need to re-submit the 855B application before applying for another AAAHC/Medicare deemed status survey.

If the ASC seeks to apply for another AAAHC/Medicare deemed status survey, please note:

- If a new 855b has been submitted, AAAHC will require that the ASC submit the most current letter from the fiscal intermediary or carrier stating that the application has been accepted and is complete.
- The ASC will need to submit a new *Physical Environment Checklist* (if a version older than the May 2010 version was previously submitted)
- There is no application fee, but a new survey fee will apply.

Standard-Level Deficiency

After the survey report is submitted to AAAHC, and if a Medicare CfC **Standard-level deficiency** has been identified, the following will occur:

- The ASC will be eligible for an accreditation term and a recommendation for Medicare deemed status.
- The AAAHC will send the ASC a Medicare deficiency letter within ten (10) business days after the survey.
- The ASC is required to develop and submit an acceptable Plan of Correction (PoC) to AAAHC within ten (10) calendar days.
- If the ASC disagrees with any of the survey findings it may indicate this in the PoC, but this is the only mechanism by which a survey finding can be contested. It is acceptable to contest a finding if the ASC believes it was in compliance at the time of the survey. The ASC must provide evidence to support its position (**Note:** This process does not include corrections made during or after the survey).
- Upon submission of an acceptable PoC, the ASC will receive a notification of the accreditation decision and recommendation for Medicare deemed status. The effective date for both the AAAHC accreditation and Medicare deemed status will be the date of the receipt of the acceptable PoC. The accreditation decision and recommended effective date for Medicare deemed status will be reported to the CMS RO.

Re-accreditation AAAHC/Medicare Deemed Status Survey

After a re-accreditation AAAHC/Medicare deemed status survey is performed, the following will occur (see page 18).

Condition-Level Deficiency

After the survey report is submitted to AAAHC, and if a Medicare CfC **condition-level deficiency** or a series of standard-level deficiencies that could result in a condition-level deficiency has been identified, the following will occur:

- ASC may be eligible for accreditation and continued Medicare deemed status.
- The AAAHC will send the ASC a Medicare deficiency letter within ten (10) business days after the survey.
- The ASC is required to submit an acceptable Plan of Correction (PoC) to AAAHC within ten (10) calendar days.
- If the ASC disagrees with any of the survey findings it can indicate this in the PoC, but this is the only mechanism by which a survey finding can be contested. It is acceptable to contest a finding if the ASC believes it was in compliance at the time of the survey. The ASC must provide evidence to support its position (**Note:** This process does not include corrections made during or after the survey).
- The ASC will receive notification of the accreditation decision and recommendation for Medicare deemed status. The effective date for both the accreditation and Medicare deemed status will be the date of the receipt of the acceptable PoC.
- The ASC must undergo an unannounced Medicare follow-up survey to ensure that correction of the condition-level deficiency(ies) has been implemented appropriately. A survey fee will be assessed.
- The accreditation decision and recommendation for Medicare deemed status will be reported to the CMS RO.

Steps Following an AAAHC/Medicare Deemed Status Survey

Initial deemed status survey (not currently deemed)	PoC request letter	PoC required	AAAHC may grant accreditation	AAAHC may recommend deemed status	Medicare follow-up survey	Recommend MDS after follow-up survey, if in compliance	Eligible for an interim survey
No CMS CFR or accreditation deficiencies	No	No	Yes (effective date of accreditation/ last day of the survey)	Yes (effective date of accreditation/ last day of the survey)	NA	NA	No
CMS CFR condition-level deficiencies	Yes	Yes	No	No	NA	NA	No
CMS CFR standard-level deficiencies	Yes	Yes	Yes (effective date of acceptable PoC receipt)	Yes (effective date of acceptable PoC receipt)	NA	NA	Yes
Accreditation requirements deficiencies	Yes	Yes	Yes (effective date of accreditation/ last day of the survey)	Yes (effective date of accreditation/ last day of the survey)	NA	NA	Yes

Note: If a currently Medicare-certified ASC has an *initial deemed status survey* and is not recommended for deemed status, the AAAHC will report to CMS that deemed status was not recommended. CMS forwards the information to the state agency that will be responsible for that ASC.

Continued

Reaccreditation deemed status survey (currently in the deemed status program)	PoC request letter	PoC required	AAAHC may grant continued accreditation	AAAHC may recommend continued deemed status	Medicare Follow-up survey	Recommend MDS after follow-up survey, if in compliance	Eligible for an interim survey
No CMS CFR or accreditation deficiencies	No	No	Yes	Yes	No	NA	No
CMS CFR condition-level deficiencies	Yes	Yes	Yes	Yes	Yes	Yes	Yes
CMS CFR standard-level deficiencies	Yes	Yes	Yes	Yes	No	NA	Yes
Accreditation requirements deficiencies	Yes	Yes	Yes	Yes	No	NA	Yes

Note: If a currently Medicare-certified ASC has a *re-accreditation deemed status survey* and fails to come into compliance with a Medicare condition, it could result in termination of AAAHC and Medicare deemed status. The AAAHC will report this termination to the CMS central office and the applicable regional office.

- If an ASC fails to come into compliance with a Medicare condition as identified during the Medicare follow-up survey, it could result in termination from AAAHC and Medicare deemed status. The AAAHC will report this termination to the CMS central office and the applicable regional office.

Standard-Level Deficiency

After the survey report is submitted to AAAHC, and if a Medicare CfC **Standard-level deficiency** has been identified, the following will occur:

- The ASC will be eligible for an accreditation term and continuation for Medicare deemed status.
- The AAAHC will send the ASC a Medicare deficiency letter within ten (10) business days after the survey.
- The ASC is required to submit an acceptable Plan of Correction (PoC) to the AAAHC within ten (10) calendar days. If the ASC disagrees with any of the survey findings it may indicate this in the PoC, but this is the only mechanism by which a survey finding can be contested. It is acceptable to contest a finding if the ASC believes it was in compliance at the time of the survey. The ASC must provide evidence to support its position. (**Note:** This process does not include corrections made during or after the survey.)
- Upon submission of an acceptable PoC, the ASC will receive a notification of the accreditation decision and recommendation for Medicare deemed status. The effective date for both, the AAAHC accreditation and Medicare deemed status, will be the date of the receipt of the acceptable PoC.
- The accreditation decision and continuation of Medicare deemed status will be reported to the CMS RO.

Accreditation Decision and Notification

The AAAHC carefully reviews information supplied by the organization, obtained during the survey, and any other relevant information before making an accreditation decision. An individual (a surveyor, staff member, or member of the AAAHC Board of Directors) whose participation creates a conflict of interest due to affiliation with an organization is not allowed to participate in deliberations or voting relative to the accreditation status of that organization. The organization will be notified in writing of the accreditation decision and will receive a detailed report of the survey findings.

In the event that a decision is made to deny accreditation, generally, the organization has an opportunity to provide additional information before a final denial decision is rendered, and the final denial decision is subject to an organization's right of appeal. When the accreditation decision is based upon findings from an AAAHC survey, the decision is based on the organization's compliance with the AAAHC Standards in effect at the time of the survey.

In the event that a decision is made to revoke accreditation, the organization will be notified of the revocation of accreditation, including the effective date of the revocation. See Denial or Revocation of Accreditation on pages 21–22 and Appendix B.

Term of Accreditation for AAAHC/Medicare Deemed Status Surveys

Following an AAAHC/Medicare Deemed Status survey, an organization will be awarded a three-year term of accreditation without intra-cycle activity, a three-year term with intra-cycle activities (e.g., PoC, Medicare Follow-up survey, Interim surveys) or be denied accreditation. For organizations that undergo an EOS, intra-cycle activities (e.g, PoC and Interim surveys) are required.

Plan of Correction (PoC)

The AAAHC requires that an organization submit a Plan of Correction (PoC) when a deficiency is identified as a condition in the *Accreditation Handbook Including Medicare Requirements for Ambulatory Surgery Centers (ASCs)* or the sum of deficiencies warrants a PoC. The PoC must be submitted within 10 calendar days following the organization's receipt of the decision letter. The PoC must include at least the following: Standard identifier or CFR identifier, survey findings, corrective actions, title of the responsible party for implementation, implementation timeline and completion date, and monitoring activities. If an organization fails to submit its PoC within the required time frame, accreditation may be revoked.

Note: ASCs that are owned by a solo health care provider and either (1) the ASC or the solo health care provider is the subject of a governmental investigation or criminal indictment (other than a traffic violation); or (2) the provider's license to practice is on probationary status will be required to undergo an interim survey each year of the term or until the physician's license is no longer on probationary status. Such ASCs should submit the Application for Survey and the supporting documentation, the AAAHC *Physical Environment Checklist for Ambulatory Surgical Centers*, and application fee for a re-accreditation survey six months prior to the expiration of the accreditation term in order to avoid a lapse in accreditation. A survey fee is assessed.

Public Recognition

The AAAHC publishes the list of organizations that are currently AAAHC-accredited on its website, www.aaahc.org. AAAHC-accredited organizations are encouraged to publicly display the AAAHC Certificate of Accreditation except in states where such posting is regulated by law. Please note that the AAAHC Certificate will reflect the legal name of the organization, as well as one additional name, if appropriate (i.e., "doing business as"). Representation of AAAHC accreditation to the public must accurately reflect the AAAHC-accredited entity.

All certificates remain the property of the AAAHC and must be returned if the organization loses its accreditation for any cause.

Denial or Revocation of Accreditation

Denial of Accreditation Following an AAAHC/Medicare Deemed Status Survey

Condition-level deficiencies cited

The AAAHC denies accreditation to an ASC when the survey team finds one or more Medicare **condition-level deficiencies** or a **series of standard-level deficiencies** that could result in a condition-level deficiency. The ASC will *not* be granted an accreditation term or be recommended for Medicare deemed status. The right to appeal is not applicable to such ASCs.

The ASC is informed that it may apply for another AAAHC/Medicare deemed status survey. When the AAAHC denies accreditation, the results will be reported to the appropriate CMS RO.

Deficiencies with AAAHC Policies and Procedures and/or Standards

The AAAHC also denies accreditation to an ASC when it concludes the ASC is not in substantial compliance with the AAAHC Standards and/or AAAHC policies and procedures and/or Standards, even if this did not result in a Medicare condition-level deficiency. When the accreditation decision is based upon findings from an AAAHC/Medicare deemed status survey, the decision is based on the ASC's compliance with the AAAHC Standards in effect at the time of the survey.

When the AAAHC denies accreditation, the results will be reported to the appropriate CMS RO.

Reasons for Denial or Revocation

The AAAHC reserves the right to revoke or deny the accreditation of any organization at any time without prior notice. Revocation or denial of accreditation may occur if it is determined that an organization:

1. No longer satisfies AAAHC Survey Eligibility Criteria.
2. Is no longer in compliance with AAAHC policies, procedures, or Standards.
3. Has significantly compromised or jeopardized patient care.
4. Fails to act in good faith in providing data and other information to the AAAHC.
5. Fails to notify the AAAHC within 15 calendar days of any significant change. For a list of what may constitute a significant change, see Continuation of Accreditation Following a Significant Change on page 23.
6. Fails to notify the AAAHC within 15 calendar days of an imposed sanction, changes in license or qualification status, governmental investigation, criminal indictment, guilty plea or verdict in a criminal proceeding (other than a traffic violation), or any violation of state or federal law with respect to the organization, its owners, or its health care professionals.
7. Fails to allow a surveyor timely access to the organization to conduct a survey.

In addition, the AAAHC may reduce or revoke the term of accreditation of an organization when it determines that there is a material change in the organizational structure, financial viability, operations, ownership or control of the organization, or its ability to perform services which requires a new survey by the AAAHC to determine the organization's compliance with the AAAHC Survey Eligibility Criteria or the AAAHC Standards. Revocation may be retroactive to the date of the material change, the imposition of sanctions, or the violation of law.

Appeal of Accreditation Decision

A decision of denial or revocation of accreditation by the AAAHC generally may be appealed. The appeal of any decision is governed by the AAAHC's appeal procedures which are in effect at the time of the appeal. Refer to Appendix B, Organization's Right of Appeal Following Denial or Revocation of Accreditation.

In the unlikely event that an applicant, after exercising its right to appeal and upon final decision by the AAAHC Board of Directors, seeks further appeal, the applicant shall have the right to submit such decision for settlement by arbitration administered by the American Arbitration Association in Chicago, IL in accordance with its Commercial Arbitration Rules. Judgment on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof.

An ASC that is not granted accreditation, or that has its accreditation revoked based solely on failure to comply with AAAHC policies and procedures and/or Standards, may apply for another full survey at any time following the decision, as long as it has not exercised its right to appeal. The ASC must submit a completed, signed *Application for Survey* and supporting documentation, AAAHC *Physical Environment Checklist for Ambulatory Surgical Centers* and application fee when applying for another survey. (Refer to Denial or Revocation of Accreditation, pages 21–22.)

Limitations on Other Rights

The applicant waives all other rights to sue or to resolution of any such claims against the AAAHC, its officers, directors, employees, agents, surveyors, and members of its committees in a court of law. The applicant recognizes and agrees that it shall not be entitled to monetary damages, whether compensatory, consequential, collateral, punitive, or otherwise, from the AAAHC, its officers, directors, employees, agents, surveyors, and members of its committees as a result of any controversy or claim with the AAAHC arising out of any procedures or decision with respect to accreditation.

Continuation of Accreditation

Accredited ASCs are required to maintain their operations in compliance with the most current AAAHC Standards and policies and Medicare CfC throughout their accreditation term. The AAAHC reserves the right to amend its Standards and policies so long as it provides all accredited organizations with notice of such amendments, or includes such amendments in the most recent edition of the *Handbook*.

Medicare deemed status is a voluntary program. An ASC indicates in its *Application for Survey* that it requests an AAAHC/Medicare deemed status survey. If an ASC underwent a previous MDS survey and would like to continue its deemed status, it must request the AAAHC/Medicare deemed status survey.

If a previously deemed ASC no longer wants AAAHC/Medicare deemed status, it is required to submit to AAAHC a written request to withdraw from Medicare deemed status. Withdrawals are reported to the appropriate CMS Regional Office. The ASC will be subject to routine surveys by its state survey agency to determine compliance with Medicare CfC.

Currently-accredited ASCs must undergo full, regular surveys at least once every three years in order to retain accreditation status. Such ASCs must complete and submit an *Application for Survey*, supporting documentation and application fee for their subsequent full accreditation/deemed status survey (referred to as a re-accreditation survey). After review of the completed *Application for Survey* and supporting documentation, the AAAHC will contact ASCs to establish survey dates. To prevent a lapse in accreditation, ASCs should ensure that all documentation is submitted to the AAAHC at least five (5) months prior to their accreditation expiration date. In states where accreditation is mandated by law, ASCs should submit the completed *Application for Survey* and other required documentation a minimum of six (6) months prior to their accreditation expiration date. **Submission of an application, even if complete, less than 60 calendar days prior to the accreditation expiration date will result in a lapse of accreditation and an initial accreditation survey will be scheduled for the ASC.**

Continuation of Accreditation Following a Significant Change

Accredited ASCs must notify the AAAHC in writing within fifteen (15) calendar days of any significant organizational, operational, or financial changes including, but not limited to:

- Mergers.
- Change in controlling interest/ownership.
- Consolidation.
- Name change.
- ASC relocation to another physical location.
- Additional services or locations.
- Major renovations.
- Expansion.
- Any interruption in delivery of health care service that exceeds 30 calendar days.
- Adverse publicity or adverse media coverage related to the ASC or its providers.
- Death or incapacitation of the health care provider or dentist in solo provider ASCs.
- Changes in state license or other applicable license, (e.g., business license), federal certification, or qualifying status.
- Significant changes in managed care enrollment.
- Significant changes in a managed care organization or staff membership.
- Bankruptcy or other significant change in the financial viability of the ASC.
- Any governmental investigation, including local, state, or federal authorities involving, directly or indirectly, the ASC or any of its officers, administrators, medical staff, or other staff in their role within the ASC.
- Criminal indictment, guilty plea, or verdict in a criminal proceeding (other than a traffic violation) involving directly or indirectly the ASC or any of its officers, administrators, medical staff, or other staff in their role within the ASC.

An ASC's duty to provide this information continues during the entire accreditation process and term. In the event that the ASC is exercising its right of reconsideration or appeal, the ASC must notify the AAAHC in writing immediately of any such changes. Failure to notify the AAAHC in writing may result in an immediate revocation of accreditation, or termination of the right to reconsideration or appeal.

Accreditation is not automatically maintained when an accredited organization undergoes significant changes as described above. The AAAHC will determine whether the current accreditation term will be maintained and establish the conditions of such.

End of Accreditation

When an ASC's accreditation term has expired and the ASC is not seeking re-accreditation, AAAHC requires the ASC to do the following:

- Return all AAAHC *Certificates of Accreditation* to the AAAHC, Attn: Accreditation Services, at 5250 Old Orchard Road, Suite 200, Skokie, Illinois 60077.
- Review the ASC's internal information, e.g., letterhead, fax forms, and internal recorded phone messages, to ensure that the AAAHC name or logo has been removed.
- Review the ASC's marketing materials, website, radio or television ads, telephone directory advertisements, and all other materials to ensure the removal of references to the AAAHC name, logo, and accreditation status.

Compliance with Omnibus Reconciliation Act of 1980

For any health care organization that pays the AAAHC $10,000 or more in any 12-month period to comply with Section 952, PL 96-499, the Omnibus Reconciliation Act of 1980, the AAAHC hereby stipulates that only those AAAHC records, contracts, documents, or books that are necessary to verify the extent and nature of AAAHC costs will be available for four years after the survey, consultation, or contracted services are completed to the Secretary of the Department of Health and Human Services (DHHS), the Comptroller General of the United States, or any of their duly authorized representatives. This stipulation is provided as a matter of policy by AAAHC in lieu of providing separate contracts for each affected organization. These same conditions will apply to any subcontracts the AAAHC has with related organizations if such payments amount to $10,000 or more in any 12-month period. This policy applies to all contracts, surveys, and AAAHC records as of December 5, 1980, and so long as these regulations remain in force.

Core Chapters

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

1. Rights of Patients

An accreditable organization recognizes the basic human rights of patients. Such an organization has the following characteristics.

		Compliance		
		SC	PC	NC
A. Patients are treated with respect, consideration, and dignity.	A.	☐	☐	☐
B. Patients are provided appropriate privacy.	B.	☐	☐	☐
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.	C.	☐	☐	☐
D. Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.	D.	☐	☐	☐
E. Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons. CMS	E.	☐	☐	☐
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.*				
F. Information is available to patients and staff concerning:	F.	☐	☐	☐
1. Patient rights, including those specified in A, B, C, D, and E above.	1.	☐	☐	☐
2. Patient conduct, responsibilities, and participation.	2.	☐	☐	☐
3. Services available at the organization.	3.	☐	☐	☐
4. Provisions for after-hours and emergency care.	4.	☐	☐	☐
5. Fees for services.	5.	☐	☐	☐
6. Payment policies.	6.	☐	☐	☐
7. Patient's right to refuse to participate in experimental research.	7.	☐	☐	☐
8. Advance directives, as required by state or federal law and regulations.	8.	☐	☐	☐
9. The credentials of health care professionals.	9.	☐	☐	☐

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

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.

		Compliance	
Additional Medicare Requirements		SC	NC
A-MS. *The patient has the right to be free from all forms of abuse or harassment. [416.50(f)(3)* **Standard:** *Privacy and safety]*	A-MS.	☐	☐
B-MS. *The patient has the right to personal privacy. [416.50(f)(1)* **Standard:** *Privacy and safety]*	B-MS.	☐	☐
C-MS. *The ASC must comply with the Department's rules for the privacy and security of individually identifiable health information, as specified at Title 45 CFR parts 160 and 164. [416.50(g)* **Standard:** *Confidentiality of clinical records]*	C-MS.	☐	☐
D-MS (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(e)(1)(iii)* **Standard:** *Exercise of rights and respect for property and person]*	D-MS (1).	☐	☐
D-MS (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(e)(2)* **Standard:** *Exercise of rights and respect for property and person]*	D-MS (2).	☐	☐
D-MS. *Inform 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(c)(2)* **Standard:** *Advance directives]*	D-MS.	☐	☐
D-MS (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(e)(3)* **Standard:** *Exercise of rights and respect for property and person]*	D-MS (3).	☐	☐
F-MS. *The ASC must inform the patient or the patient's representative or surrogate of the patient's rights, and must protect and promote the exercise of these rights as set forth in Title 42 CFR 416.50. The ASC must also post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients waiting for treatment or by the patient's representative or surrogate, if applicable. [416.50* **Condition:** *Patient Rights]*	F-MS.	☐	☐
F-MS (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(a)* **Standard:** *Notice of rights]*	F-MS (1).	☐	☐

		Compliance	
		SC	NC
F-8-MS.	*The ASC must comply with the following requirements: [416.50(c)(1)* ***Standard:*** *Advance directives]*		
(1)	*The ASC must provide the patient or, as appropriate, the patient's representative with written information concerning its policies on advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms. [416.50(c)(1)* ***Standard:*** *Advance directives]*	F-8-MS (1). ☐	☐
(2)	*Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive. [416.50(c)(3)* ***Standard:*** *Advance directives]*	F-8-MS (2). ☐	☐
L-MS.	*The patient has the right to the following: Be free from any act of discrimination or reprisal. [416.50(e)(1)(i)* ***Standard:*** *Exercise of rights and respect for property and person]*	L-MS. ☐	☐

2. Governance

An accreditable 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 I — General Requirements: This subchapter describes general requirements for an organization and its governing body.	I.	☐	☐	☐
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.	A.	☐	☐	☐
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 religious, fraternal, or other philanthropic organizations) are available upon request and furnished to the Accreditation Association for Ambulatory Health Care (AAAHC).	1.	☐	☐	☐
2. A legally constituted entity is documented by at least one of the following: articles of organization, articles of incorporation, partnership agreement, operating agreement, legislative or executive act, or bylaws, unless the organization is a sole proprietorship.	2.	☐	☐	☐
B. 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:	B.	☐	☐	☐
1. Determining the mission, goals, and objectives of the organization.	1.	☐	☐	☐
2. Ensuring that facilities and personnel are adequate and appropriate to carry out the mission.	2.	☐	☐	☐
3. Establishing an organizational structure and specifying functional relationships among the various components of the organization.	3.	☐	☐	☐
4. Adopting bylaws or similar rules and regulations for the orderly development and management of the organization.	4.	☐	☐	☐
5. Adopting policies and procedures necessary for the orderly conduct of the organization, including the organization's scope of clinical activities.	5.	☐	☐	☐
a. The organization develops and maintains a policy defining the care of pediatric patients, if relevant. Specific components of perioperative care are listed in Standard 10.I.Z.	a.	☐	☐	☐
6. Ensuring that the quality of care is evaluated and that identified problems are appropriately addressed.	6.	☐	☐	☐
7. Reviewing all legal and ethical matters concerning the organization and its staff and, when necessary, responding appropriately.	7.	☐	☐	☐

	Compliance		
	SC	PC	NC
8. Maintaining effective communication throughout the organization, including ensuring a linkage between quality management and improvement activities and other management functions of the organization.	8. ☐	☐	☐
9. Establishing a system of financial management and accountability appropriate to the organization.	9. ☐	☐	☐
10. Determining a policy on the rights of patients.	10. ☐	☐	☐
11. Approving and ensuring compliance of all major contracts or arrangements affecting 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:	11. ☐	☐	☐
a. The employment or contracting of health care professionals. CMS	a. ☐	☐	☐
416.41 (a) Standard: Contract services *When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner.*			
b. The provision of radiology services and pathology and medical laboratory services. CMS	b. ☐	☐	☐
416.41 (a) Standard: Contract services *When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner.*			
c. The use of external laboratories. CMS	c. ☐	☐	☐
416.41 (a) Standard: Contract services *When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner.*			
d. The provision of care by other health care organizations, such as hospitals. CMS	d. ☐	☐	☐
416.41 (a) Standard: Contract services *When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner.*			
e. The provision of education to students and postgraduate trainees.	e. ☐	☐	☐
f. The provision of after-hours patient information or telephone triage services, including the review of protocols.	f. ☐	☐	☐

	Compliance		
	SC	PC	NC
g. The Centers for Medicare & Medicaid Services (CMS) requirements, if the organization participates in the Medicare/Medicaid program. CMS	g. ☐	☐	☐
416.41 (a) Standard: Contract services *When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner.*			
h. The policies/procedures related to utilization, quality improvement, risk management, credentialing, patient's rights, etc., of a managed care organization, if the organization/provider has contracts with managed care organizations.	h. ☐	☐	☐
i. The activities or services delegated to another entity.	i. ☐	☐	☐
12. Formulating long-range plans in accordance with the mission, goals and objectives of the organization.	12. ☐	☐	☐
13. Operating the organization without violating federal or state anti-discrimination laws.	13. ☐	☐	☐
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.	14. ☐	☐	☐
15. Developing a program of risk management appropriate to the organization.	15. ☐	☐	☐
16. Determining a policy on continuing education for personnel and/or patient education for members/enrollees, if applicable.	16. ☐	☐	☐
17. Developing policies 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. ☐	☐	☐
18. Establishing a mechanism to fulfill all applicable obligations under local, state, and federal laws and regulations, such as those addressing disabilities, medical privacy, fraud and abuse, self-referral, and reporting to the National Practitioner Data Bank (NPDB).[1]	18. ☐	☐	☐
19. Development, implementation, and oversight of the organization's infection control and safety programs to ensure a safe environment of care.	19. ☐	☐	☐
20. Adopting policies/procedures to resolve grievances and external appeals, as required by state and federal law and regulations.	20. ☐	☐	☐

[1] *For information on the National Practitioner Data Bank, see http://www.npdb-hipdb.hrsa.gov.*

	Compliance		
	SC	PC	NC
21. Establishing processes for the identification, reporting, analysis, and prevention of adverse incidents and ensuring consistent and effective implementation by developing a system that includes: CMS	21. ☐	☐	☐
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.*			
a. Definition of an adverse incident that, at a minimum, includes:	a. ☐	☐	☐
i. An unexpected occurrence during a health care encounter involving patient death or serious physical or psychological injury or illness, including loss of limb or function, not related to the natural course of the patient's illness or underlying condition.	i. ☐	☐	☐
ii. Any process variation for which a recurrence carries a significant chance of a serious adverse outcome.	ii. ☐	☐	☐
iii. Events such as actual breaches in medical care, administrative procedures, or other events resulting in an outcome that is not associated with the standard of care or acceptable risks associated with the provision of care and service for a patient.	iii. ☐	☐	☐
iv. Circumstances or events that could have resulted in an adverse event.	iv. ☐	☐	☐
b. Review of frequency of occurrences, severity of outcomes, and reportable events.	b. ☐	☐	☐
c. A process for conducting a thorough analysis when an adverse incident occurs in order to identify the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of an adverse incident; the analysis identifies potential improvements in processes or systems that would tend to decrease the likelihood of such incidents in the future, or determines, after analysis, that no such improvement opportunities exist.	c. ☐	☐	☐
d. A process for reporting adverse incidents through established channels within the organization and, as appropriate, to external agencies in accordance with law and regulation.	d. ☐	☐	☐
e. An action plan that identifies the strategies that the organization intends to implement to reduce the risk of similar incidents occurring in the future; the plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions.	e. ☐	☐	☐

	Compliance		
	SC	PC	NC
C. Accredited organizations must notify the AAAHC in writing within fifteen (15) calendar days of significant organizational, ownership, operational, or quality of care events, including criminal indictment, guilty plea or verdict in a criminal proceeding (other than a traffic violation) involving directly or indirectly the organization or any of its officers, administrators, physicians/health care professionals, or staff within their role in the organization. Any such change/event that negatively affects the public's perception of the accredited organization or AAAHC, as the accrediting body, must also be reported. An organization's duty to provide this information continues during the entire accreditation term.	C. ☐	☐	☐
D. The governing body meets at least annually and keeps such minutes or other records as may be necessary for the orderly conduct of the organization.	D. ☐	☐	☐
1. Items to be reviewed should include, but are not limited to:	1. ☐	☐	☐
a. Rights of patients.	a. ☐	☐	☐
b. Delegated administrative responsibilities.	b. ☐	☐	☐
c. Quality of care.	c. ☐	☐	☐
d. The quality management and improvement program.	d. ☐	☐	☐
e. The organization's policies and procedures.	e. ☐	☐	☐
f. The appointment/reappointment process.	f. ☐	☐	☐
g. The infection control program.	g. ☐	☐	☐
h. The safety program.	h. ☐	☐	☐
i. Compliance with all other applicable Standards.	i. ☐	☐	☐
E. If the governing body elects, appoints, or employs officers and administrators to carry out its directives, the authority, responsibility, and functions of all such positions are defined.	E. ☐	☐	☐

Compliance

Subchapter II — Credentialing and Privileging: This subchapter describes the requirements for credentialing and privileging of health care professionals to provide patient care in an accreditable organization. Organizations may find use of the *Credentialing Records Worksheet* located in the back of this *Handbook* to be helpful in creating medical staff applications and measuring compliance with credentials verification processes.

Credentialing is a three-phase process of assessing and validating the qualifications of an individual to provide services. The objective of credentialing is to establish that the applicant has the specialized professional background that he or she claims and that the position requires. An accreditable organization: 1) establishes minimum training, experience, and other requirements (i.e., credentials) for physicians and other health care professionals; 2) establishes a process to review, assess, and validate an individual's qualifications, including education, training, experience, certification, licensure, and any other competence-enhancing activities against the organization's established minimum requirements; and 3) carries out the review, assessment, and validation as outlined in the organization's description of the process.

	SC	PC	NC
II.	☐	☐	☐

A. The medical staff must be accountable to the governing body. The governing body establishes and is responsible for a credentialing and reappointment process, applying criteria in a uniform manner to appoint individuals to provide patient care for the organization. The governing body approves mechanisms for credentialing, reappointment, and the granting of privileges, and suspending or terminating clinical privileges, including provisions for appeal of such decisions. CMS

	SC	PC	NC
A.	☐	☐	☐

416.45 Condition: Medical staff

The medical staff of the ASC must be accountable to the governing body.

B. The governing body, either directly or by delegation, makes (in a manner consistent with state law) initial appointment, reappointment, and assignment or curtailment of clinical privileges of medical staff members based on professional peer evaluation. This process shall have the following characteristics:

	SC	PC	NC
B.	☐	☐	☐

1. The governing body has specific criteria for the initial appointment and reappointment of physicians and dentists.

	SC	PC	NC
1.	☐	☐	☐

2. Provisions are made for the expeditious processing of applications for clinical privileges.

	SC	PC	NC
2.	☐	☐	☐

3. On an application for initial credentialing and privileges, the applicant is required to provide sufficient evidence of training, experience, and current documented competence in performance of the procedures for which privileges are requested. At a minimum, the following credentialing and privileging information shall be provided for evaluation of the candidate:

	SC	PC	NC
3.	☐	☐	☐

   a. Education, training, and experience: Relevant education and training are verified at the time of appointment and initial granting of clinical privileges; the applicant's experience is reviewed for continuity, relevance, and documentation of any interruptions in that experience.

	SC	PC	NC
a.	☐	☐	☐

   b. Peer evaluation: Current competence is verified and documented.

	SC	PC	NC
b.	☐	☐	☐

		Compliance		
		SC	PC	NC
c.	Current state license: Current licensure is verified and documented at the time of appointment.	c. ☐	☐	☐
d.	Drug Enforcement Administration (DEA) registration, if applicable.	d. ☐	☐	☐
e.	Proof of current medical liability coverage meeting governing body requirements, if any.	e. ☐	☐	☐
f.	Information obtained from the National Practitioner Data Bank (NPDB)[1] **Note:** The NPDB Proactive Disclosure Services (PDS) is an acceptable service for meeting the requirement for querying the NPDB (see Resources).	f. ☐	☐	☐
g.	The organization shall require and review other pertinent information which includes, but need not be limited to:	g. ☐	☐	☐
	i. Professional liability claims history.	i. ☐	☐	☐
	ii. Information on licensure revocation, suspension, voluntary relinquishment, licensure probationary status, or other licensure conditions or limitations.	ii. ☐	☐	☐
	iii. Complaints or adverse action reports filed against the applicant with a local, state, or national professional society or licensure board.	iii. ☐	☐	☐
	iv. Refusal or cancellation of professional liability coverage.	iv. ☐	☐	☐
	v. Denial, suspension, limitation, termination, or nonrenewal of professional privileges at any hospital, health plan, medical group, or other health care entity.	v. ☐	☐	☐
	vi. DEA and state license action.	vi. ☐	☐	☐
	vii. Disclosure of any Medicare/Medicaid sanctions.	vii. ☐	☐	☐
	viii. Conviction of a criminal offense (other than minor traffic violations).	viii. ☐	☐	☐
	ix. Current physical, mental health, or chemical dependency problems that would interfere with an applicant's ability to provide high-quality patient care and professional services.	ix. ☐	☐	☐
	x. Signed statement releasing the organization from liability and attesting to the correctness and completeness of the submitted information.	x. ☐	☐	☐

[1] *For information on the National Practitioner Data Bank, see http://www.npdb-hipdb.hrsa.gov.*

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-3a-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. ☐	☐	☐
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. ☐	☐	☐
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. ☐	☐	☐
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. ☐	☐	☐

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.

Compliance

		SC	PC	NC
C. The scope of procedures must be periodically reviewed by the governing body and amended as appropriate.	C.	☐	☐	☐
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. CMS	D.	☐	☐	☐

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.

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.	☐	☐	☐
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.	☐	☐	☐
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.	☐	☐	☐

Additional Medicare Requirements

			SC	NC
I.A-MS.	*The ASC must comply with State licensure requirements. [416.40* ***Condition:*** *Compliance with State licensure law]*	I.A-MS.	☐	☐
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.	☐	☐

			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).	☐	☐
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(d)* ***Standard:*** *Submission and investigation of grievances]*	I.B-20-MS.	☐	☐
I.B-20-MS (1).	*All alleged violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented. [416.50(d)(1)* ***Standard:*** *Submission and investigation of grievances]*	I.B-20-MS (1).	☐	☐
I.B-20-MS (2).	*All allegations must be immediately reported to a person in authority in the ASC. [416.50(d)(2)* ***Standard:*** *Submission and investigation of grievances]*	I.B-20-MS (2).	☐	☐
I.B-20-MS (3).	*Only substantiated allegations must be reported to the State authority or the local authority, or both. [416.50(d)(3)* ***Standard:*** *Submission and investigation of grievances]*	I.B-20-MS (3).	☐	☐
I.B-20-MS (4).	*The grievance process must specify timeframes for review of the grievance and the provisions of a response. [416.50(d)(4)* ***Standard:*** *Submission and investigation of grievances]*	I.B-20-MS (4).	☐	☐
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(d)(5)* ***Standard:*** *Submission and investigation of grievances]*	I.B-20-MS (5).	☐	☐
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(d)(6)* ***Standard:*** *Submission and investigation of grievances]*	I.B-20-MS (6).	☐	☐
II.C-MS.	*Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate. [416.45(b)* ***Standard:*** *Reappraisals]*	II.C-MS.	☐	☐
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.	☐	☐

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

	Compliance		
	SC	PC	NC
i. Linkage between the quality improvement program to meet performance improvement/quality indicators and quality improvement activities.	i. ☐	☐	☐
ii. Ensuring accurate, timely, and complete data in a consistent manner as appropriate for the organization.	ii. ☐	☐	☐
iii. Maintaining collected data in a standardized format to the extent feasible and appropriate.	iii. ☐	☐	☐
13. Addressing the relationships with competing health care organizations to avoid antitrust and restraint of trade concerns.	13. ☐	☐	☐
14. Dealing with inquiries from governmental agencies, attorneys, consumer advocate groups, reporters, and the media.	14. ☐	☐	☐
B. Personnel policies are established and implemented to facilitate attainment of the mission, goals, and objectives of the organization. Personnel policies:	B. ☐	☐	☐
1. Define and delineate functional responsibilities and authority.	1. ☐	☐	☐
2. Require the employment of personnel with qualifications commensurate with job responsibilities and authority, including appropriate licensure or certification.	2. ☐	☐	☐
3. Reflect the requirement for documentation of initial orientation and training according to position description. Initial orientation and training shall be:	3. ☐	☐	☐
a. Completed within 30 days of commencement of employment.	a. ☐	☐	☐
b. Provided annually thereafter and when there is an identified need.	b. ☐	☐	☐
c. Provided by a qualified person(s) designated by the organization.	c. ☐	☐	☐
4. Require periodic appraisal of each person's job performance, including current competence.	4. ☐	☐	☐
5. Describe incentives and rewards, if any exist.	5. ☐	☐	☐
6. Require periodic review of employee compensation.	6. ☐	☐	☐
7. Specify privileges and responsibilities of employment, including compliance with an adverse incident reporting system, as described in Standard 2.I.B-21. CMS	7. ☐	☐	☐
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.*			
8. Are made known to employees at the time of employment.	8. ☐	☐	☐
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. ☐	☐	☐

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

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. ☐	☐	☐
B. Health care professionals practice their professions in an ethical and legal manner.	B. ☐	☐	☐
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. ☐	☐	☐
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.II, 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.I.	D. ☐	☐	☐
E. The organization facilitates the provision of high-quality health care as demonstrated by the following:	E. ☐	☐	☐
1. Health care provided is consistent with current professional knowledge. CMS	1. ☐	☐	☐
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.*			
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. ☐	☐	☐
3. Appropriate and timely diagnosis based on findings of the current history and physical examination. CMS	3. ☐	☐	☐
416.47 (b)(2) Standard: Form and content of record *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.*			

	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. ☐	☐	☐
5. Treatment that is consistent with clinical impression or working diagnosis.	5. ☐	☐	☐
6. Appropriate and timely consultation.	6. ☐	☐	☐
7. Absence of clinically unnecessary diagnostic or therapeutic procedures.	7. ☐	☐	☐
8. Appropriate and timely referrals.	8. ☐	☐	☐
9. Appropriate and timely follow-up of findings and tests. CMS	9. ☐	☐	☐

416.47 (b)(3) Standard: Form and content of record

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.

10. Patient participation.	10. ☐	☐	☐
11. Continuity of care and patient follow-up.	11. ☐	☐	☐
12. Patient satisfaction.	12. ☐	☐	☐
F. The organization provides for accessible and available health services and ensures patient safety by at least the following:	F. ☐	☐	☐
1. Provision for and information about services when the organization's facilities are not open.	1. ☐	☐	☐
2. Adequate and timely transfer of information when patients are transferred to other health care professionals.	2. ☐	☐	☐
3. An increased likelihood of desired health outcomes through participation in performance measurement and quality improvement activities.	3. ☐	☐	☐
4. An adverse incident reporting system, as described in Standard 2.I.B-21.	4. ☐	☐	☐
5. A mechanism to notify public health authorities of reportable conditions. CMS	5. ☐	☐	☐

416.44 (a)(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.

G. The organization maintains appropriate, accurate, complete, and timely clinical record entries.	G. ☐	☐	☐

	Compliance SC	PC	NC
H. The organization establishes procedures to obtain, identify, store, and transport laboratory specimens or biological products.	H. ☐	☐	☐
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. ☐	☐	☐
J. When the need arises, patients are transferred from the care of one health care professional to the care of another with:	J. ☐	☐	☐
1. Adequate specialty consultation services being available by prior arrangement.	1. ☐	☐	☐
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.	2. ☐	☐	☐
K. When hospitalization is indicated to evaluate, stabilize, and transfer when emergencies or unplanned outcomes occur, the organization shall have one of the following:	K. ☐	☐	☐
1. Written transfer agreement for transferring patients to a nearby hospital.	1. ☐	☐	☐
2. Policy of credentialing and privileging only physicians and dentists who have admitting and similar privileges at a nearby hospital.	2. ☐	☐	☐
3. Detailed procedural plan for handling medical emergencies, with the plan submitted to AAAHC for review during the survey process.	3. ☐	☐	☐
L. Concern for the costs of care is demonstrated by the following:	L. ☐	☐	☐
1. The relevance of health care services to the needs of the patients.	1. ☐	☐	☐
2. The absence of duplicative diagnostic procedures.	2. ☐	☐	☐
3. The appropriateness of treatment frequency.	3. ☐	☐	☐
4. The use of the least expensive alternate resources when suitable.	4. ☐	☐	☐
5. The use of ancillary services that are consistent with patients' needs.	5. ☐	☐	☐
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. ☐	☐	☐

		Compliance	
		SC	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).	☐	☐
K-MS (2). This 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 482.2. [416.41(b)(2) ***Standard:*** *Hospitalization]*	K-MS (2).	☐	☐
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)(i) ***Standard:*** *Hospitalization]*	K-MS (3).	☐	☐
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)(ii) ***Standard:*** *Hospitalization]*	K-MS (4).	☐	☐

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. CMS

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.

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:	Compliance SC	PC	NC
	I. ☐	☐	☐
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. ☐	☐	☐
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.)	B. ☐	☐	☐
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. Peer review as part of an employee's performance evaluation is acceptable.	1. ☐	☐	☐
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. ☐	☐	☐
D. Health care professionals participate in the development and application of the criteria used to evaluate the care they provide.	D. ☐	☐	☐

	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. ☐	☐	☐
F. The results of peer review activities are reported to the governing body.	F. ☐	☐	☐
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. ☐	☐	☐
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:	H. ☐	☐	☐
1. Provides convenient access to reliable, up-to-date information pertinent to the clinical, educational, administrative, and research services provided by the organization.	1. ☐	☐	☐
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.	2. ☐	☐	☐
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. ☐	☐	☐
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. ☐	☐	☐
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:	A. ☐	☐	☐
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.	1. ☐	☐	☐
2. Identification of the specific committee(s) or individuals responsible for the development, implementation, and oversight of the program.	2. ☐	☐	☐
3. Participation in the program by health care professionals, one or more of whom is a physician.	3. ☐	☐	☐
4. Quality improvement goals and objectives.	4. ☐	☐	☐

	Compliance		
	SC	PC	NC
5. Development of processes to identify important problems or concerns that are appropriate to address for improving the quality of services provided by the organization. CMS	5. ☐	☐	☐

416.43 (b)(1) Standard: Program data

The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC.

416.43 (b)(2) Standard: Program data

The ASC must use the data collected to—

(i) Monitor the effectiveness and safety of its services, and quality of its care.

(ii) Identify opportunities that could lead to improvements and changes in its patient care.

6. Identification of quality improvement activities such as studies, including methods for performing internal and external benchmarking to support the goals of the program. CMS	6. ☐	☐	☐

416.43 (b)(1) Standard: Program data

The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC.

416.43 (b)(2) Standard: Program data

The ASC must use the data collected to—

(i) Monitor the effectiveness and safety of its services, and quality of its care.

(ii) Identify opportunities that could lead to improvements and changes in its patient care.

7. Defined linkages between quality improvement activities, peer review, and the risk management program.	7. ☐	☐	☐
8. Evaluation of the overall effectiveness of the program at least annually.	8. ☐	☐	☐
9. Identification of processes to report findings from the quality improvement activities to the organization's governing body and throughout the organization, as appropriate.	9. ☐	☐	☐

	Compliance		
	SC	PC	NC
B. The organization conducts specific quality improvement activities that support the goals of the written QI program. Written reports of QI activities must demonstrate that each activity includes at least the following elements:	B. ☐	☐	☐
1. A statement of the purpose of the QI activity that includes a description of the process or situation being reviewed, or a known or suspected problem, and explains why it is significant to the organization (see *Analyzing Your Quality Management Program and Creating Meaningful Studies* in the Worksheets and Forms section in the back of this *Handbook*).	1. ☐	☐	☐
2. Identification of the performance goal against which the organization will compare its current performance in the area of study. CMS	2. ☐	☐	☐
416.43 (b)(1) Standard: Program data *The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC.*			
3. Description of the data that will be collected in order to determine the organization's current performance.	3. ☐	☐	☐
4. Evidence of data collection.	4. ☐	☐	☐
5. Data analysis that describes findings about the frequency, severity, and source(s) of the problem(s). CMS	5. ☐	☐	☐
416.43 (b)(1) Standard: Program data *The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC.* **416.43 (b)(2) Standard:** Program data *The ASC must use the data collected to—* *(i) Monitor the effectiveness and safety of its services, and quality of its care.* *(ii) Identify opportunities that could lead to improvements and changes in its patient care.*			
6. A comparison of the organization's current performance in the area of study against the previously identified performance goal. CMS	6. ☐	☐	☐
416.43 (b)(2) Standard: Program data *The ASC must use the data collected to—* *(i) Monitor the effectiveness and safety of its services, and quality of its care.* *(ii) Identify opportunities that could lead to improvements and changes in its patient care.*			

Compliance

	SC	PC	NC
7. Implementation of corrective action(s) to resolve identified problem(s). CMS	7. ☐	☐	☐

416.43 (b)(2) Standard: Program data

The ASC must use the data collected to—

(i) Monitor the effectiveness and safety of its services, and quality of its care.

(ii) Identify opportunities that could lead to improvements and changes in its patient care.

8. Re-measurement (a second round of data collection and analysis as described in Standard 5.II.B.4-6) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement. CMS	8. ☐	☐	☐

416.43 (b)(2) Standard: Program data

The ASC must use the data collected to—

(i) Monitor the effectiveness and safety of its services, and quality of its care.

(ii) Identify opportunities that could lead to improvements and changes in its patient care.

9. If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued re-measurement until the problem is resolved or is no longer relevant. CMS	9. ☐	☐	☐

416.43 (b)(2) Standard: Program data

The ASC must use the data collected to—

(i) Monitor the effectiveness and safety of its services, and quality of its care.

(ii) Identify opportunities that could lead to improvements and changes in its patient care.

10. Communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's educational activities ("closing the QI loop").	10. ☐	☐	☐

Compliance

	SC	PC	NC
C. The organization's written quality improvement program must include participation in external performance benchmarking activities that allow for the comparison of key performance measures with other similar organizations or with recognized best practices of national or professional targets or goals.	☐	☐	☐
1. The organization's benchmarking activities include, but are not limited to:	☐	☐	☐
a. The use of selected performance measures that are appropriate for improving the processes or outcomes of care relevant to the patients served. CMS	☐	☐	☐

416.43 (b)(2) Standard: Program data

The ASC must use the data collected to—

(i) Monitor the effectiveness and safety of its services, and quality of its care.

(ii) Identify opportunities that could lead to improvements and changes in its patient care.

b. Systematically collecting and analyzing data related to the selected performance measures.	☐	☐	☐
c. Ensuring the validity and reliability of data.	☐	☐	☐
d. Measuring changes in performance related to the performance measures.	☐	☐	☐
e. Demonstrating and sustaining performance improvement over time.	☐	☐	☐
f. Using benchmarks that are based on local, state, or national standards, i.e., performance measures.	☐	☐	☐
2. Results of benchmarking activities must be incorporated into other quality improvement activities of the organization. CMS	☐	☐	☐

416.43 (b)(1) Standard: Program data

The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC.

3. Results of benchmarking activities must be reported to the organization's governing body and throughout the organization, as appropriate.	☐	☐	☐

	Compliance		
		SC	NC
Subchapter III – Risk Management: An accreditable 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. ☐	☐	☐
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. ☐	☐	☐
B. A designated person or committee is responsible for the risk management program.	B. ☐	☐	☐
C. Elements of a risk management program address safety of patients and other important issues, which include:	C. ☐	☐	☐
1. Consistent application of the risk management program throughout the organization, including all departments and all service locations.	1. ☐	☐	☐
2. Methods by which a patient may be dismissed from care or refused care.	2. ☐	☐	☐
3. Reporting, reviewing, and appropriate analysis of all incidents reported by employees, patients, health care professionals, and others.	3. ☐	☐	☐
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. ☐	☐	☐
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. ☐	☐	☐
6. Periodic review of all litigation involving the organization and its staff and health care professionals.	6. ☐	☐	☐
7. Review of patient complaints.	7. ☐	☐	☐
8. Communications with the professional liability insurance carrier.	8. ☐	☐	☐
9. Managing a situation in which a health care professional becomes incapacitated during a medical or surgical procedure.	9. ☐	☐	☐
10. Impaired health care professionals.	10. ☐	☐	☐
11. Establishment and documentation of coverage after normal working hours.	11. ☐	☐	☐
12. Methods for prevention of unauthorized prescribing.	12. ☐	☐	☐

	Compliance		
		SC	NC
13. Processes to identify and/or designate the surgical site and involve the patient in those processes.	13. ☐	☐	☐
14. Active surveillance of processes and techniques for detection and prevention of disease, infection, and potential communicable infective sources.	14. ☐	☐	☐
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. ☐	☐	☐
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, surveyors, etc.) including evidence of patient consent.	E. ☐	☐	☐
F. The risk management program requires a periodic review of clinical records and clinical record policies.	F. ☐	☐	☐
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. CMS	G. ☐	☐	☐

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.

Additional Medicare Requirements

			SC	NC
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(a)(1) **Standard:** Program scope]*	II.A-MS (1).	☐	☐
II.A-MS (2).	*The ASC must set priorities for its performance improvement activities that--*	II.A-MS (2).	☐	☐
(i)	*Focus on high risk, high volume, and problem-prone areas. [416.43(c)(1) **Standard:** Program activities]*	II.A-MS (2)(i)	☐	☐
(ii)	*Consider incidence, prevalence, and severity of problems in those areas. [416.43(c)(1) **Standard:** Program activities]*	II.A-MS (2)(ii)	☐	☐
(iii)	*Affect health outcomes, patient safety, and quality of care. [416.43(c)(1) **Standard:** Program activities]*	II.A-MS (2)(iii)	☐	☐

		Compliance	
		SC	NC
II.A-MS (3).	*Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time. [416.43(c)(2)* ***Standard:*** *Program activities]*	II.A-MS (3). ☐	☐
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). ☐	☐
II.A-MS (5).	*The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results. [416.43 (d)(2) Standard: Performance improvement projects]*	II.A-MS (5). ☐	☐
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). ☐	☐
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). ☐	☐
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). ☐	☐
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). ☐	☐
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). ☐	☐
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 in the ASC. [416.43(a)(2)* ***Standard:*** *Program scope]*	III.C-MS (1). ☐	☐
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(c)(3)* ***Standard:*** *Program activities]*	III.C-MS (2). ☐	☐

6. Clinical Records and Health Information

An accreditable 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. CMS

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. CMS	A. ☐	☐	☐
416.47 (a) Standard: Organization *The ASC must develop and maintain a system for the proper collection, storage, and use of patient records.*			
B. An individual clinical record is established for each person receiving care. Each record includes, but is not limited to: CMS	B. ☐	☐	☐
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.*			
1. Name.	1. ☐	☐	☐
2. Identification number (if appropriate).	2. ☐	☐	☐
3. Date of birth.	3. ☐	☐	☐
4. Gender.	4. ☐	☐	☐
5. Responsible party, if applicable.	5. ☐	☐	☐
C. All clinical information relevant to a patient is readily available to authorized personnel any time the organization is open to patients.	C. ☐	☐	☐

	Compliance		
	SC	PC	NC
D. Clinical record entries are legible and easily accessible within the record by the organization's personnel. CMS	D. ☐	☐	☐
416.47 (b) 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:*			
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. ☐	☐	☐
F. A designated person is in charge of clinical records. This person's responsibilities include, but are not limited to: CMS	F. ☐	☐	☐
416.47 (b) 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:*			
1. The confidentiality, security, and physical safety of records.	1. ☐	☐	☐
2. The timely retrieval of individual records upon request.	2. ☐	☐	☐
3. The unique identification of each patient's record.	3. ☐	☐	☐
4. The supervision of the collection, processing, maintenance, storage, and appropriate access to and usage of records.	4. ☐	☐	☐
5. The maintenance of a predetermined, organized, and secured record format.	5. ☐	☐	☐
G. Policies concerning clinical records address, but are not limited to:	G. ☐	☐	☐
1. The retention of active records.	1. ☐	☐	☐
2. The retirement of inactive records.	2. ☐	☐	☐
3. The timely entry of data in records.	3. ☐	☐	☐
4. The release of information contained in records.	4. ☐	☐	☐
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. ☐	☐	☐

	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 consultations) are reviewed and incorporated into the record in a timely manner. CMS	I. ☐	☐	☐

416.47 (b)(2) 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:

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 be accurate, legible, and promptly completed. Medical records must include at least the following:

Pre-operative diagnostic studies (entered before surgery), if performed.

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. ☐	☐	☐
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. CMS	K. ☐	☐	☐

416.47 (b)(5) 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:

Any allergies and abnormal drug reactions.

L. Entries in a patient's clinical record for each visit include, but are not limited to:	L. ☐	☐	☐
1. Date (and department, if departmentalized).	1. ☐	☐	☐
2. Chief complaint or purpose of visit.	2. ☐	☐	☐
3. Clinical findings. CMS	3. ☐	☐	☐

416.47 (b)(2) 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:

Significant medical history and results of physical examination.

	Compliance		
	SC	PC	NC
4. Discharge diagnosis or impression. CMS	4. ☐	☐	☐

416.47 (b)(2) 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:

Significant medical history and results of physical examination.

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:

Discharge diagnosis.

5. Studies ordered, such as laboratory or x-ray studies. CMS	5. ☐	☐	☐

416.47 (b)(3) 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:

Pre-operative diagnostic studies (entered before surgery), if performed.

6. Care rendered and therapies administered.	6. ☐	☐	☐
7. Any changes in prescription and non-prescription medication with name and dosage, when available.	7. ☐	☐	☐
8. Disposition, recommendations, and instructions given to the patient.	8. ☐	☐	☐
9. Authentication and verification of contents by health care professionals.	9. ☐	☐	☐
10. Documentation regarding missed and canceled appointments.	10. ☐	☐	☐
11. Signature of physician or other author of the clinical record entry.	11. ☐	☐	☐
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. ☐	☐	☐
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. ☐	☐	☐

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. ☐	☐	☐
1. Obtained from the other (external) provider(s) or organization and incorporated into the patient's clinical record.	1. ☐	☐	☐
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. ☐	☐	☐
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. CMS	P. ☐	☐	☐

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.

Additional Medicare Requirements		SC	NC
*K-MS. Adverse reactions must be reported to the physician responsible for the patient and must be documented in the record. [416.48(a)(1) **Standard:** Administration of drugs]*	K-MS.	☐	☐
	K-MS.	☐	☐

7. Infection Prevention and Control and Safety

An accreditable organization provides health care services while adhering to safe practices for patients, staff, and all others. The organization maintains ongoing programs designed to (1) prevent and control infections and communicable diseases, and (2) to provide a safe and sanitary environment of care.

	Compliance		
	SC	PC	NC

Subchapter I — Infection Prevention and Control: An accreditable organization maintains an active and ongoing infection prevention and control program as evidenced by the following characteristics: I. ☐ ☐ ☐

416.51 Condition: Infection control

The ASC must maintain an infection control program that seeks to minimize infections and communicable diseases.

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

416.44 (a)(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.

B. The infection prevention and control program includes documentation that the organization has considered, selected, and implemented nationally-recognized infection control guidelines. The program is: CMS B. ☐ ☐ ☐

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—

1. Approved by the governing body. 1. ☐ ☐ ☐
2. An integral part of the organization's quality improvement program. CMS 2. ☐ ☐ ☐

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—

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

Compliance

	SC	PC	NC
3. Under the direction of a designated and qualified health care professional who has training and current competence in infection control. CMS	☐	☐	☐

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—

Under the direction of a designated and qualified professional who has training in infection control;

4. Appropriate to the organization and meets all applicable state and federal requirements.	☐	☐	☐
5. Responsible for providing a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement. CMS	☐	☐	☐

416.51(b)(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—

Responsible for providing a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement.

6. Clear to include direct intervention to prevent infection, as needed.	☐	☐	☐
C. The infection control and prevention program reduces the risk of health care-acquired infection as evidenced by education and active surveillance, consistent with: CMS	☐	☐	☐

416.44 (a)(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.

	Compliance		
	SC	PC	NC
1. WHO, CDC, or other nationally-recognized guidelines for hand hygiene.	1. ☐	☐	☐
2. CDC or other nationally-recognized guidelines for safe injection practices.	2. ☐	☐	☐
3. Precautions to minimize communicable disease exposure to patients, health care staff, and others.	3. ☐	☐	☐
D. The organization provides a functional and sanitary environment for the provision of services. The organization adheres to professionally accepted standards of practice, manufacturer's recommendations, and state and federal guidelines, including but not limited to the cleaning, disinfection, and sterilization of instruments, equipment, supplies, and implants. CMS	D. ☐	☐	☐
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.*			
E. A sharps injury prevention program must be present in the organization. Such a program will include:	E. ☐	☐	☐
1. Documentation of employee orientation and annual staff education.	1. ☐	☐	☐
2. Disposal of intact needles and syringes into appropriate puncture-resistant sharps containers, in accordance with current state and federal guidelines.	2. ☐	☐	☐
3. Placement of sharps containers in appropriate care areas, secured from tampering.	3. ☐	☐	☐
4. Replacement of sharps containers when the fill line is reached.	4. ☐	☐	☐
5. Handling and disposal of filled sharps containers in accordance with applicable regulations.	5. ☐	☐	☐
F. A safe environment for treating patients, including adequate safeguards to protect the patient from cross-infection, is assured through the provision of adequate space, equipment, supplies, and personnel. CMS	F. ☐	☐	☐
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.*			

	Compliance		
	SC	PC	NC
G. Procedures must be available to minimize the sources and transmission of infections, including adequate surveillance techniques. CMS	G. ☐	☐	☐

416.44 (a)(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)(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—

Responsible for providing a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement.

H. A process is in place for the monitoring and documentation of the cleaning, high-level disinfection, and sterilization of medical equipment, accessories, instruments, and implants. Sterile packs of equipment and instruments are within current dates.	H. ☐	☐	☐
I. A policy addresses the identification and processing of medical equipment and instruments that fail to meet sterilization parameters.	I. ☐	☐	☐
J. Policies are in place for the isolation or immediate transfer of patients with a communicable disease.	J. ☐	☐	☐
K. The organization's written policies address cleaning of patient treatment and care areas which, at a minimum, address:	K. ☐	☐	☐
1. Cleaning before use.	1. ☐	☐	☐
2. Cleaning between patients.	2. ☐	☐	☐
3. Terminal cleaning at the end of the day.	3. ☐	☐	☐
Subchapter II — Safety: An accreditable organization adheres to safe practices for patients, staff, and others as evidenced by the following characteristics:	II. ☐	☐	☐
A. Elements of a safety program address the organization's environment of care and the safety of patients, staff, and others, and must meet or exceed local, state, or federal safety requirements. The elements of the safety program include, but are not limited to:	A. ☐	☐	☐
1. Processes for the management of identified hazards, potential threats, near misses, and other safety concerns.	1. ☐	☐	☐

	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.	2. ☐	☐	☐
3. Processes to reduce and avoid medication errors.	3. ☐	☐	☐
4. Policies regarding food and drink, if made available.	4. ☐	☐	☐
5. Policies addressing manufacturer or regulatory agency recalls related to medications, medical equipment and devices, and food products.	5. ☐	☐	☐
6. Prevention of falls or physical injuries involving patients, staff, and all others.	6. ☐	☐	☐
B. There is a person or committee designated by the governing body who is responsible for the organization's safety program.	B. ☐	☐	☐
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:	C. ☐	☐	☐
1. Infection prevention and control program.	1. ☐	☐	☐
2. Safety program.	2. ☐	☐	☐
D. Unique patient identifiers are consistently used throughout care. CMS	D. ☐	☐	☐

416.47 (b)(1) Standard: Form and content of record

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:

Patient identification.

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.	E. ☐	☐	☐
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. CMS	F. ☐	☐	☐

416.41 (c)(1) Standard: Disaster preparedness plan

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.

	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.	G. ☐	☐	☐
H. Fire safety, fire prevention, and fire drills are included in the surveillance activities of personnel responsible for safety and risk management.	H. ☐	☐	☐
I. Environmental hazards associated with safety are identified and safe practices are established.	I. ☐	☐	☐
J. Measures are implemented to prevent skin and tissue injury from chemicals, cleaning solutions, and other hazardous exposure.	J. ☐	☐	☐
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.	K. ☐	☐	☐
L. Patients are educated about prescribed medical devices and associated protocols and guidelines. Patient competence with each device is verified before independent use.	L. ☐	☐	☐
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.	M. ☐	☐	☐
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:	N. ☐	☐	☐
1. Sources of recall information (FDA, CDC, manufacturers, and other local, state, or federal sources).	1. ☐	☐	☐
2. Methods for notification of staff that need to know.	2. ☐	☐	☐
3. Methods to determine if a recalled product is present at the organization or has been given or administered to patients.	3. ☐	☐	☐
4. Documentation of response to recalled products.	4. ☐	☐	☐
5. Disposition or return of recalled items.	5. ☐	☐	☐
6. Patient notification, as appropriate.	6. ☐	☐	☐
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.	O. ☐	☐	☐

	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.	P. ☐	☐	☐
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.	1. ☐	☐	☐

Additional Medicare Requirements

		SC	NC
*II.F-MS. The ASC coordinates its disaster preparedness plan with State and local authorities, as appropriate. [416.41(c)(2) **Standard:** Disaster preparedness plan]*	II.F-MS.	☐	☐

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:	A. ☐	☐	☐
1.	Applicable state and local building codes and regulations.	1. ☐	☐	☐
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]	2. ☐	☐	☐
3.	Applicable federal regulations.	3. ☐	☐	☐
4.	Periodic inspection by the local or state fire control agency, if this service is available in the community.	4. ☐	☐	☐
B.	The organization ensures that its facilities:	B. ☐	☐	☐
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.	1. ☐	☐	☐
2.	Have prominently displayed illuminated signs with emergency power capability at all exits, including exits from each floor or hall.	2. ☐	☐	☐
3.	Have emergency lighting, as appropriate to the facility, to provide adequate illumination for evacuation of patients and staff, in case of an emergency.	3. ☐	☐	☐
4.	Have stairwells protected by fire doors, when applicable.	4. ☐	☐	☐
5.	Provide reception areas, toilets, and telephones in accordance with patient and visitor volume.	5. ☐	☐	☐
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.	6. ☐	☐	☐
7.	Provide adequately marked patient and visitor parking, when appropriate.	7. ☐	☐	☐
8.	Are operated in a safe and secure manner.	8. ☐	☐	☐

[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. ☐	☐	☐
D. The organization provides documented periodic instruction of all personnel in the proper use of safety, emergency, and fire-extinguishing equipment.	D. ☐	☐	☐
E. The organization requires at least one (1) drill each calendar quarter of the internal emergency and disaster preparedness plan.[2] 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. CMS	E. ☐	☐	☐
416.41 (c)(3) Standard: Disaster preparedness plan *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.*			
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. ☐	☐	☐
G. Smoking is prohibited within the facility.	G. ☐	☐	☐
H. Hazards that might lead to slipping, falling, electrical shock, burns, poisoning, or other trauma are eliminated.	H. ☐	☐	☐
I. Provisions are made to reasonably accommodate disabled individuals.	I. ☐	☐	☐
J. Adequate lighting and ventilation are provided in all areas.	J. ☐	☐	☐
K. Facilities are clean and properly maintained.	K. ☐	☐	☐
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. ☐	☐	☐

[2] *Appropriate to the facility's activities and environment. Examples include medical emergencies, building fires, surgical fires, tornados, 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. CMS	M. ☐	☐	☐
416.44 (a)(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.*			
1. The system includes, but is not limited to, infectious, radioactive, chemical, and physical hazards.	1. ☐	☐	☐
2. The system provides for the protection of patients, staff, and the environment.	2. ☐	☐	☐
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/imagery 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. ☐	☐	☐
O. Appropriate emergency equipment and supplies are maintained and are readily accessible to all areas of each patient care service site.	O. ☐	☐	☐
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. ☐	☐	☐
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. ☐	☐	☐
R. Testing of fire alarm and inspection of fire suppression systems, including verification of signal transmission, are performed and documented, as applicable.	R. ☐	☐	☐
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. ☐	☐	☐
1. Safety measures are implemented based on the results of the assessment.	1. ☐	☐	☐
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. ☐	☐	☐

		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.	☐	☐
B-MS. The patient has the right to receive care in a safe setting. [416.50 (f)(2) **Standard:** *Privacy and safety]*	B-MS.	☐	☐
N-MS. The ASC must have a separate recovery room and waiting area. [416.44(a)(2) **Standard:** *Physical environment]*	N-MS.	☐	☐
O-MS. Emergency equipment available to the operating rooms must include at least the following [416.44(c) **Standard:** *Emergency equipment]:*	O-MS.	☐	☐
(1) Emergency call system.	O-MS (1)	☐	☐
(2) Oxygen.	O-MS (2)	☐	☐
(3) Mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator.	O-MS (3)	☐	☐
(4) Cardiac defibrillator.	O-MS (4)	☐	☐
(5) Cardiac monitoring equipment.	O-MS (5)	☐	☐
(6) Tracheostomy set.	O-MS (6)	☐	☐
(7) Laryngoscopes and endotracheal tubes.	O-MS (7)	☐	☐
(8) Suction equipment.	O-MS (8)	☐	☐
(9) Emergency medical equipment and supplies specified by the medical staff.	O-MS (9)	☐	☐

Medicare Conditions for Coverage (CfC) require that every Medicare-certified ASC must meet the provisions of the *NFPA 101® Life Safety Code®*, 2000 Edition that are applicable to ASCs.

Note: AAAHC will determine whether the ASC is in compliance with the Medicare CfC 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 purposefully[1] 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 purposefully[1] 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.*

	Compliance			
Standards A through I will be applied at 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.	SC	PC	NC	N/A
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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
C. Policies and procedures are developed for anesthesia services which include, but are not limited to:	C. ☐	☐	☐	☐
1. Education, training, and supervision of personnel.	1. ☐	☐	☐	☐
2. Responsibilities of non-physician anesthetists.	2. ☐	☐	☐	☐
3. Responsibilities of supervising physicians and dentists.	3. ☐	☐	☐	☐
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. ☐	☐	☐	☐
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.T. CMS	E. ☐	☐	☐	☐

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 supersede AAAHC 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.II.*

	Compliance			
	SC	PC	NC	N/A
F. Anesthesia is administered by anesthesiologists, other qualified physicians, dentists, certified registered nurse anesthetists, or other qualified[3] 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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
1. Reliable and adequate source of oxygen delivery.	1. ☐	☐	☐	☐
2. A device such as a self-inflating hand resuscitator bag capable of administering at least 90% oxygen.	2. ☐	☐	☐	☐
3. Appropriate emergency drugs, supplies, and equipment.	3. ☐	☐	☐	☐
4. Appropriate monitoring equipment for the intended anesthesia care.	4. ☐	☐	☐	☐
5. Reliable suction source and appropriate equipment to ensure a clear airway.	5. ☐	☐	☐	☐
H. All clinical support personnel with direct patient contact maintain at a minimum skills in basic cardiac life support (BLS).	H. ☐	☐	☐	☐
I. Clinical records include entries related to anesthesia administration. CMS	I. ☐	☐	☐	☐

416.47 (b)(6) 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 at 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 (EKG) 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. ☐	☐	☐	☐
K. The organization maintains a written policy with regard to assessment and management of acute pain.	K. ☐	☐	☐	☐
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. ☐	☐	☐	☐

	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.	☐	☐	☐	☐
2. Before medical discharge from the facility, each patient must be evaluated by a physician, dentist, or delegated, qualified[3] 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[3] 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.	☐	☐	☐	☐
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.	☐	☐	☐	☐
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.	☐	☐	☐	☐
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.	☐	☐	☐	☐
Q. Alternate power adequate for the type of surgery/service being performed is available in operative and recovery areas. Q.	☐	☐	☐	☐
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.	☐	☐	☐	☐
1. Be posted and immediately available in each location where triggering agents might be used. 1.	☐	☐	☐	☐
2. Include the use of dantrolene and other medications and methods of cooling and monitoring of the patient. 2.	☐	☐	☐	☐

	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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
U. No patient shall receive moderate or deep sedation or general anesthesia unless a physician, dentist, or other qualified[3] 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. ☐	☐	☐	☐
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 9.F, is privileged to administer these drugs.	V. ☐	☐	☐	☐
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. ☐	☐	☐	☐
Standards A through X will be applied at organizations that administer general anesthesia.				
X. The administration of general anesthesia requires:	X. ☐	☐	☐	☐
1. End-tidal CO_2 monitoring.	1. ☐	☐	☐	☐
2. A readily available means of measuring body temperature.	2. ☐	☐	☐	☐

		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 Boards 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(c)(1) **Standard:** State exemption]*[4]	B-MS (1).	☐	☐	☐
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).	☐	☐	☐
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(a)(1) **Standard:** Anesthetic risk and evaluation]*	D-MS.	☐	☐	
F-MS (1).	*Anesthetics must be administered by only: A qualified anesthesiologist; or [416.42(b)(1) **Standard:** Administration of anesthesia]*	F-MS (1).	☐	☐	
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 410.69(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 (d) (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).	☐	☐	
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 410.69(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.	☐	☐	
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.	☐	☐	

[4] For 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/CFCsAndCoPs/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 I — General Requirements: This subchapter describes general requirements for an organization that provides surgical and related services.	I.	☐	☐	☐	☐
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. CMS	A.	☐	☐	☐	☐
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.	☐	☐	☐	☐
C. Surgical procedures must be performed in a safe manner only by qualified providers who: CMS	C.	☐	☐	☐	☐
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.	☐	☐	☐	☐
2. Have been granted clinical privileges to perform those procedures by the governing body in accordance with Chapter 2.II.	2.	☐	☐	☐	☐

	Compliance			
	SC	PC	NC	N/A
D. 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 thirty (30) days, or according to local or state requirement, prior to the scheduled surgery/procedure. CMS	D. ☐	☐	☐	☐

416.47 (b)(2) 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:

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 be accurate, legible, and promptly completed. Medical records must include at least the following:

Pre-operative diagnostic studies (entered before surgery), if performed.

416.52 (a)(3) Standard: Patient admission, assessment and discharge

The patient's medical history and physical assessment must be placed in the patient's clinical record prior to the surgical procedure.

E. The use and timeliness of administration of appropriate pre-operative antibiotics is monitored to ensure maximum effectiveness.	E. ☐	☐	☐	☐
F. Specific instructions for discontinuation or resumption of medications prior to and after a procedure are provided to the patient.	F. ☐	☐	☐	☐
G. 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.	G. ☐	☐	☐	☐
H. Registered nurse(s) and other health care professionals assisting in the provision of surgical services are appropriately trained and supervised, and are available in sufficient numbers for the surgical and emergency care provided.	H. ☐	☐	☐	☐
I. Each operating room is designed and equipped so that the types of surgery conducted 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 nonflammable agents are present in an operating room, and the room is constructed and equipped in compliance with applicable state and local fire codes.	I. ☐	☐	☐	☐

Compliance

	SC	PC	NC	N/A

J. All clinical support staff with direct patient contact maintain at a minimum skills in basic cardiac life support (BLS). J. ☐ ☐ ☐ ☐

1. If moderate sedation/analgesia, deep sedation/analgesia, regional anesthesia, or general anesthesia is provided, 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 all 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. 1. ☐ ☐ ☐ ☐

K. 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. CMS K. ☐ ☐ ☐ ☐

416.44 (d) 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.

L. With the exception of those tissues exempted by the governing body after medical review, tissues removed during surgery are examined by the pathologist, whose signed report of the examination is made a part of the patient's clinical record. CMS L. ☐ ☐ ☐ ☐

416.47 (b)(4) 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:

Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body.

	Compliance			
	SC	PC	NC	N/A
M. The findings and techniques of a procedure are accurately and completely documented immediately after the procedure by the health care professional who performed the procedure. This description is immediately available for patient care and becomes a part of the patient's clinical record. CMS	M. ☐	☐	☐	☐
416.47 (b)(4) 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:* *Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body.*				
N. A safe environment for treating surgical patients, including adequate safeguards to protect the patient from cross-infection, is ensured through the provision of adequate space, equipment, supplies, and personnel.	N. ☐	☐	☐	☐
1. Provisions have been made for the isolation or immediate transfer of patients with a communicable disease.	1. ☐	☐	☐	☐
2. All persons entering operating or procedure rooms are properly attired as defined by the organization's written policy.	2. ☐	☐	☐	☐
3. Acceptable aseptic techniques are used by all persons in the surgical area.	3. ☐	☐	☐	☐
4. A written policy outlines the appropriate and timely surgical hand antisepsis (scrub) using either an antimicrobial soap or an alcohol-based hand rub according to product manufacturer's recommended guidelines.	4. ☐	☐	☐	☐
5. Only authorized persons are allowed in the surgical or treatment areas, including laser rooms.	5. ☐	☐	☐	☐
6. Environmental controls are implemented to ensure a safe and sanitary environment.	6. ☐	☐	☐	☐
7. Suitable equipment is provided for the regular cleaning of all interior surfaces.	7. ☐	☐	☐	☐
8. Operating/procedure rooms are appropriately cleaned before each procedure.	8. ☐	☐	☐	☐
9. Freshly laundered attire is donned in an area inside of the organization prior to entry into areas designated as restricted.	9. ☐	☐	☐	☐
10. Attire used for personal protective equipment (PPE) or attire contaminated with blood or body fluid is laundered by a laundry that adheres to CDC or other nationally recognized guidelines and is approved by the organization.	10. ☐	☐	☐	☐
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.	11. ☐	☐	☐	☐

	Compliance			
	SC	PC	NC	N/A
12. Measures are implemented to prevent skin and tissue injury from chemicals, cleaning solutions, and other hazardous exposure, and to minimize the risk of fire.	12. ☐	☐	☐	☐
13. Policies are in place for pre-procedure site antisepsis, as appropriate to service(s) provided and patient requirements and needs.	13. ☐	☐	☐	☐
O. Suitable equipment for rapid and routine sterilization is available to ensure that operating room materials are sterile. Sterilized materials are packaged, labeled, and stored in a consistent manner to maintain sterility and identify sterility dates.	O. ☐	☐	☐	☐
1. The processes for cleaning and sterilization of supplies and equipment adhere to manufacturer's instructions and recommendations.	1. ☐	☐	☐	☐
2. Internal and external indicators are used to demonstrate the safe processing of items undergoing high-level disinfection and sterilization.	2. ☐	☐	☐	☐
P. 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.	P. ☐	☐	☐	☐
Q. Organizations that perform procedures where blood loss and subsequent blood replacement is a potential have policies and procedures to address this type of situation and/or need.	Q. ☐	☐	☐	☐
R. Alternate power adequate for the type of surgery performed is available in operative and recovery areas.	R. ☐	☐	☐	☐
S. Periodic calibration and/or preventive maintenance of equipment is provided.	S. ☐	☐	☐	☐
T. The informed consent of the patient or, if applicable, of the patient's representative, is obtained before the procedure is performed. CMS	T. ☐	☐	☐	☐
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.*				
U. 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 dental procedures, the operative tooth may be marked on a radiograph or a dental diagram.	U. ☐	☐	☐	☐

	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 devices 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 this verification have been satisfactorily completed immediately prior to beginning the procedure.	V. ☐	☐	☐	☐
W. The organization has a procedure to address when sponge, sharps, 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. ☐	☐	☐	☐
X. A process is in place for the observation, care, and communication of such care in all perioperative 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. ☐	☐	☐	☐
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. ☐	☐	☐	☐

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. ☐	☐	☐	☐
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. ☐	☐	☐	☐

		Compliance			
			SC	NC	
	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. ☐	☐	☐	☐
A.	Policies and procedures should be established and implemented for these devices. Policies and procedures include, but are not limited to:	A. ☐	☐	☐	☐
	1. Safety programs.	1. ☐	☐	☐	☐
	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. ☐	☐	☐	☐
B.	The organization ensures that its facility is a safe environment, including:	B. ☐	☐	☐	☐
	1. Granting privileges for each specific device. CMS	1. ☐	☐	☐	☐
	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.*				
	2. Ensuring that only authorized persons are allowed in treatment areas.	2. ☐	☐	☐	☐
	3. Utilization of door and window coverings, where appropriate.	3. ☐	☐	☐	☐
	4. Prominently displayed warning signs being present only during procedures at the entrance to treatment areas.	4. ☐	☐	☐	☐
	5. When necessary, utilization of protective eyewear by personnel in treatment areas as recommended by the device manufacturer.	5. ☐	☐	☐	☐
	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. ☐	☐	☐	☐
	7. Utilization of appropriate disinfectant or sterilization of components that have direct patient contact.	7. ☐	☐	☐	☐
	8. Ensuring appropriate fire protection, including:	8. ☐	☐	☐	☐
	a. The immediate availability of electrical-rated fire extinguishers for equipment fires.	a. ☐	☐	☐	☐
	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. ☐	☐	☐	☐
	c. The use of safe equipment and/or techniques, especially for procedures in and around the airway.	c. ☐	☐	☐	☐

Compliance

		SC	NC	
d.	The utilization of non-combustible materials, supplies, and solutions as appropriate.	☐	☐	☐ ☐
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.	☐	☐	☐ ☐
9.	Documenting that maintenance logs are present that confirm the inspection and testing of these devices.	☐	☐	☐ ☐
C.	The organization ensures patient safety, including:	☐	☐	☐ ☐
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.	☐	☐	☐ ☐
2.	Protection of the patient's eyes, skin, hair, and other exposed areas.	☐	☐	☐ ☐
3.	When available, the use of non-reflective surgical instruments and supplies.	☐	☐	☐ ☐
4.	Appropriate patient education regarding procedure risks and potential complications.	☐	☐	☐ ☐

Additional Medicare Requirements

I.MS. Basic requirements

Participation as an ASC is limited to facilities that—

(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]*

	SC	NC
I.MS. Basic requirements	☐	☐

I.MS. ASC Definition

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.MS. ASC Definition	☐ ☐

I.C-MS. 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.C-MS.	☐ ☐

I.D-MS. 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.D-MS.	☐ ☐

		Compliance	SC	NC
I.D-MS (1).	*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(r) 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.D-MS (1).	☐	☐
I.D-MS (2).	*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.D-MS (2).	☐	☐
I.H.MS (1).	*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.H-MS (1).	☐	☐
I.H-MS (2).	*Patient care responsibilities must be delineated for 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(a) **Standard:** Organization and staffing]*	I.H-MS (2).	☐	☐
I.I-MS (1).	*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(a)(1) **Standard:** Physical environment]*	I.I-MS (1).	☐	☐
I.X-MS (1).	*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.X-MS (1).	☐	☐
I.X-MS (2).	*Post-surgical needs must be addressed and included in the discharge notes. [416.52(b)(2) **Standard:** Post-surgical assessment]*	I.X-MS (2).	☐	☐
I.Y-MS (1).	*The ASC must provide each patient with written discharge instructions and overnight supplies. When appropriate, make a followup 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 followup care. [416.52(c)(1) **Standard:** Discharge]*	I.Y-MS (1).	☐	☐
I.Y-MS (2).	*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.Y-MS (2).	☐	☐

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. CMS	A. ☐	☐	☐	☐
416.48 Condition: Pharmaceutical services *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.*				
B. Pharmaceutical services are provided in accordance with ethical and professional practice and applicable federal and state laws. CMS	B. ☐	☐	☐	☐
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. CMS	C. ☐	☐	☐	☐
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. CMS	D. ☐	☐	☐	☐
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. CMS	E. ☐	☐	☐	☐
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. CMS	F. ☐	☐	☐	☐

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. CMS	G. ☐	☐	☐	☐

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. CMS	H. ☐	☐	☐	☐

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. CMS	I. ☐	☐	☐	☐

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. ☐	☐	☐	☐
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. CMS	K. ☐	☐	☐	☐

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. CMS	L. ☐	☐	☐	☐

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. CMS	M. ☐	☐	☐	☐

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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
P. Patients are not required to use a pharmacy owned or operated by the organization.	P. ☐	☐	☐	☐

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). ☐	☐		
*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). ☐	☐		

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.	I.	☐	☐	☐	☐
A. An accreditable organization:	A.	☐	☐	☐	☐
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.	☐	☐	☐	☐
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. CMS	2.	☐	☐	☐	☐
416.49 (a) Standard: Laboratory services *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.*					
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.	☐	☐	☐	☐
C. Pathology and medical laboratory services include, but are not limited to:	C.	☐	☐	☐	☐
1. Conducting laboratory procedures that are appropriate to the needs of the patients.	1.	☐	☐	☐	☐
2. Performing tests in a timely manner.	2.	☐	☐	☐	☐
3. Distributing test results after completion of a test and maintaining a copy of the results.	3.	☐	☐	☐	☐

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.	4. ☐	☐	☐	☐
5. Ensuring that staff performing tests has adequate training and competence to perform the tests.	5. ☐	☐	☐	☐
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.	D. ☐	☐	☐	☐
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.	II. ☐	☐	☐	☐
A. An accreditable 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. CMS	A. ☐	☐	☐	☐

416.49 (a) Standard: Laboratory services

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.

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. ☐	☐	☐	☐
C. Pathology and medical laboratory services include, but are not limited to:	C. ☐	☐	☐	☐
1. Conducting laboratory procedures that are appropriate to the needs of the patients.	1. ☐	☐	☐	☐
2. Performing tests in a timely manner.	2. ☐	☐	☐	☐
3. Distributing test results after completion of a test and maintaining a copy of the results in the laboratory.	3. ☐	☐	☐	☐
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.	4. ☐	☐	☐	☐
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.	D. ☐	☐	☐	☐

	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 assume professional, organizational, and administrative responsibility for the quality of services rendered.	E. ☐	☐	☐	☐
F. Sufficient adequately trained and experienced personnel are available to supervise and conduct the work of the laboratory.	F. ☐	☐	☐	☐
G. Established procedures are followed in obtaining, identifying, storing, and transporting specimens.	G. ☐	☐	☐	☐
H. Complete descriptions are available of each test procedure performed by the laboratory, including sources of reagents, standards, and calibration procedures, and information concerning the basis for the listed "normal" ranges is also available.	H. ☐	☐	☐	☐
I. Sufficient space, equipment, and supplies are provided to perform the volume of work with optimal accuracy, precision, efficiency, and safety.	I. ☐	☐	☐	☐
J. Requirements of the Department of Health & Human Services (HHS) certification for medical review officer drug testing are met if the lab is testing for Department of Transportation (DOT) regulated industries or federal agency employees.	J. ☐	☐	☐	☐

13. Diagnostic and Other Imaging Services

Imaging services, including those used for diagnosing, monitoring, or assisting with procedures 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.

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 diagnosing, 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.	A. ☐	☐	☐	☐
B. Imaging services include, but are not limited to:	B. ☐	☐	☐	☐
1. Providing radiographic, fluoroscopic, ultrasonic, or other imaging services that are appropriate to the organization's function.	1. ☐	☐	☐	☐
2. Interpreting images and ensuring appropriate documentation in a timely manner.	2. ☐	☐	☐	☐
3. Maintaining appropriate records or reports of services provided.	3. ☐	☐	☐	☐
4. Providing adequate space, equipment, and supplies to ensure the provision of quality services.	4. ☐	☐	☐	☐
C. Health care professionals providing imaging services and/or interpreting results:	C. ☐	☐	☐	☐
1. Have appropriate training and credentials.	1. ☐	☐	☐	☐
2. Have been granted privileges to provide these services.	2. ☐	☐	☐	☐
3. Have appropriate safety training and provide their services in a safe manner.	3. ☐	☐	☐	☐
D. Policies that address the safety aspects of the imaging services include, but are not limited to:	D. ☐	☐	☐	☐
1. Regulation of the use, removal, handling, and storage of potentially hazardous materials.	1. ☐	☐	☐	☐
2. Precautions against electrical, mechanical, magnetic, ultrasonic, radiation, and other potential hazards.	2. ☐	☐	☐	☐
3. Proper shielding where radiation, magnetic field, and other potentially hazardous energy sources are used.	3. ☐	☐	☐	☐

	Compliance			
	SC	PC	NC	N/A
4. Acceptable monitoring devices or processes to ensure the safety of all personnel who might be exposed to radiation, magnetic fields, or otherwise harmful energy; if radiation exposure is not monitored, documentation exists within the organization to support this decision.	4. ☐	☐	☐	☐
5. Maintenance of appropriate exposure records.	5. ☐	☐	☐	☐
6. Instructions to personnel in safety precautions and in dealing with accidental hazardous energy field exposure.	6. ☐	☐	☐	☐
7. Periodic evaluation by qualified personnel of energy sources and of all safety measures followed, including calibration of equipment and testing the integrity of personal protective devices in compliance with federal, state, and local laws and regulations.	7. ☐	☐	☐	☐
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:	E. ☐	☐	☐	☐
1. Pregnant females.	1. ☐	☐	☐	☐
2. In cases of magnetic resonance imaging:	2. ☐	☐	☐	☐
a. Patients with metal implantations.	a. ☐	☐	☐	☐
b. Patients or personnel with magnetically inscribed credit cards, where appropriate.	b. ☐	☐	☐	☐
c. Patients or personnel wearing metallic objects capable of potentially dangerous motion.	c. ☐	☐	☐	☐
d. Patients with pacemakers or internal defibrillators.	d. ☐	☐	☐	☐
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.	F. ☐	☐	☐	☐
G. A radiologist authenticates all examination reports, except reports of specific procedures 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.	G. ☐	☐	☐	☐
H. Authenticated, dated reports of all examinations performed are made a part of the patient's clinical record.	H. ☐	☐	☐	☐
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.	I. ☐	☐	☐	☐
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.	J. ☐	☐	☐	☐
K. Diagnostic images are maintained in a readily accessible location for the time required by applicable laws and policies of the organization.	K. ☐	☐	☐	☐
L. A policy addresses the storage and retention of diagnostic images.	L. ☐	☐	☐	☐

		Compliance	YES	NO
Additional Medicare Requirements				
A-MS (1).	*The ASC must have procedures for obtaining radiology services from a Medicare approved facility to meet the needs of patients. [416.49(b)(1)* **Standard:** *Radiologic services]*	A-MS (1).	☐	☐
A-MS (2).	*Radiologic services must meet the hospital conditions of participation for radiologic services specified in Title 42 CFR 482.26. [416.49(b)(2)* **Standard:** *Radiologic services]*	A-MS (2).	☐	☐

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.

Subchapter I — 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.

Compliance

	SC	PC	NC	N/A
I.	☐	☐	☐	☐
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.	☐	☐	☐	☐
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.	☐	☐	☐	☐
C. Dental procedures are performed only by dental health professionals who:	☐	☐	☐	☐
1. Are licensed to perform such procedures within the state or jurisdiction in which the organization is located.	☐	☐	☐	☐
2. Have been granted privileges to perform those procedures by the governing body of the organization, in accordance with Chapter 2.II.	☐	☐	☐	☐
D. Personnel assisting in the provision of dental services are appropriately qualified and available in sufficient numbers for the dental procedures provided.	☐	☐	☐	☐
E. An appropriate history and physical is conducted and periodically updated, which includes an assessment of the hard and soft tissues of the mouth.	☐	☐	☐	☐
F. The organization develops policies and procedures related to the identification, treatment, and management of pain.	☐	☐	☐	☐
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.	☐	☐	☐	☐
H. The informed consent of the patient is obtained and incorporated into the dental record prior to the procedure(s).	☐	☐	☐	☐
I. Clinical records are maintained according to the requirements found in Chapter 6.	☐	☐	☐	☐

	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. ☐	☐	☐	☐
K. Anesthesia provided or made available meets the Standards contained in Chapter 9.	K. ☐	☐	☐	☐
L. Surgical and related services provided or made available meet the Standards contained in Chapter 10.	L. ☐	☐	☐	☐
M. Imaging services provided or made available meet the Standards contained in Chapter 13.	M. ☐	☐	☐	☐
1. The organization has guidelines to address the type, frequency, and indications for diagnostic radiographs.	1. ☐	☐	☐	☐
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. ☐	☐	☐	☐
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. ☐	☐	☐	☐

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. ☐	☐	☐	☐
1. The patient can identify his/her dentist and patient care team members.	1. ☐	☐	☐	☐
2. The dentist explains information in a manner that is easy to understand (to include Standard 1D).	2. ☐	☐	☐	☐
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. ☐	☐	☐	☐
4. The dentist speaks to the patient about his/her health problems and concerns.	4. ☐	☐	☐	☐

	Compliance			
	SC	PC	NC	N/A
5. The dentist provides easy-to-understand instructions about taking care of health concerns.	☐	☐	☐	☐
6. The dentist knows important facts about the patient's health history.	☐	☐	☐	☐
7. The dentist spends sufficient time with the patient.	☐	☐	☐	☐
8. The dentist is as thorough as the patient feels is needed.	☐	☐	☐	☐
9. The staff keeps the patient informed with regard to his/her appointment when delayed.	☐	☐	☐	☐
10. The dentist addresses specific principles to prevent dental-related diseases.	☐	☐	☐	☐
11. The dentist speaks with the patient about making lifestyle changes to help prevent dental-related disease.	☐	☐	☐	☐
12. The dentist inquires as to the patient's concerns/worries/stressors regarding his/her dental health.	☐	☐	☐	☐
13. The Dental Home provides services within a team framework, and that "team" provider concept has been conveyed to the patient.	☐	☐	☐	☐
14. The family is included, as appropriate, in patient care decisions, treatment, and education.	☐	☐	☐	☐
15. The Dental Home treats its patients with cultural sensitivity.	☐	☐	☐	☐
B. Continuity of Care	☐	☐	☐	☐
1. A significant number (more than 50%) of the dental home visits of any patient are with the same dentist/dental care team.	☐	☐	☐	☐
2. If a consultation is ordered for the patient, it is documented in the clinical record.	☐	☐	☐	☐
3. Referrals for services (external to the Dental Home), are documented in the clinical record.	☐	☐	☐	☐
4. Consultations (medical or dental opinions obtained from other health care professionals) are recorded in the clinical record.	☐	☐	☐	☐
5. Referrals are disease- or procedure-specific.	☐	☐	☐	☐
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.	☐	☐	☐	☐
7. Follow-up appointments are documented in the clinical record.	☐	☐	☐	☐
8. After-hour encounters are documented in the clinical record.	☐	☐	☐	☐

	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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
12. Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards, including consultations, referrals, and lab results.	12. ☐	☐	☐	☐
C. Comprehensiveness of Care	C. ☐	☐	☐	☐
1. If the Dental Home limits the population served, those limitations are disclosed to prospective patients.	1. ☐	☐	☐	☐
2. The Dental Home scope of service includes, but is not limited to:	2. ☐	☐	☐	☐
a. Preventive care (including surveillance and screening for special needs or assessment).	a. ☐	☐	☐	☐
b. Wellness care (healthy lifestyle issues—appropriate diet, tobacco cessation, home care, etc.).	b. ☐	☐	☐	☐
c. Acute pain and injury care.	c. ☐	☐	☐	☐
d. Chronic disease management.	d. ☐	☐	☐	☐
e. Advanced geriatric care.	e. ☐	☐	☐	☐
3. Patient education and self-management resources are provided.	3. ☐	☐	☐	☐
4. Knowledge of community resources that support the patient's (and family's, as appropriate) needs are known by the Dental Home.	4. ☐	☐	☐	☐
5. The community's service limitations are known and alternate sources are coordinated by the Dental Home.	5. ☐	☐	☐	☐
6. Referrals are appropriate to the patient's needs. When referrals occur, the Dental Home collaborates with the specialist.	6. ☐	☐	☐	☐
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. ☐	☐	☐	☐
8. Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards.	8. ☐	☐	☐	☐

	Compliance			
	SC	PC	NC	N/A
D. Accessibility	D. ☐	☐	☐	☐
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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
3. Patients are provided information about how to obtain dental care at any time (365/24/7).	3. ☐	☐	☐	☐
4. The Dental Home assures on-call coverage (pre-arranged access to a clinician) when the Dental Home is not open.	4. ☐	☐	☐	☐
5. Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards.	5. ☐	☐	☐	☐
E. Quality	E. ☐	☐	☐	☐
1. Patient care is dentist-directed.	1. ☐	☐	☐	☐
2. The Dental Home incorporates evidence-based guidelines and performance measures in delivering clinical services including:	2. ☐	☐	☐	☐
a. Preventive care (including surveillance and screening for special needs or assessment).	a. ☐	☐	☐	☐
b. Wellness care (healthy lifestyle issues—(appropriate diet, tobacco cessation, home care, etc.).	b. ☐	☐	☐	☐
c. Acute pain and injury care.	c. ☐	☐	☐	☐
d. Chronic disease management.	d. ☐	☐	☐	☐
e. Advanced geriatric care.	e. ☐	☐	☐	☐
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. ☐	☐	☐	☐
4. Patient care is supervised by the Dental Home as evidenced by:	4. ☐	☐	☐	☐
a. Appropriate ordering of diagnostic radiographs (avoidance of redundancies and unnecessary exposure).	a. ☐	☐	☐	☐
b. Appropriate management of patient referrals (avoidance of unnecessary referrals).	b. ☐	☐	☐	☐
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. ☐	☐	☐	☐

	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. ☐	☐	☐	☐
a. Patient/dentist relationship.	a. ☐	☐	☐	☐
b. Continuity of care.	b. ☐	☐	☐	☐
c. Comprehensiveness of care.	c. ☐	☐	☐	☐
d. Accessibility to care.	d. ☐	☐	☐	☐
e. Clinical study.	e. ☐	☐	☐	☐
7. Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards.	7. ☐	☐	☐	☐

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.

Subchapter I — General Services: This subchapter applies to organizations that provide other professional and technical services.

	Compliance			
	SC	PC	NC	N/A
A. Such services may include, but are not limited to: various medical services, rehabilitation services (physical, occupational, vocational therapy), massage therapy, acupuncture, registered dieticians, aesthetics, audiologists, and other individuals who provide services to patients and may submit separate charges for their services.	A. ☐	☐	☐	☐
B. Such services provided or made available are appropriate to the needs of the patients and adequately support the organization's clinical capabilities.	B. ☐	☐	☐	☐
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. ☐	☐	☐	☐
D. Such services are provided in accordance with ethical and professional practices and applicable federal and state laws and regulations.	D. ☐	☐	☐	☐
E. Such services will be evaluated using applicable Standards from other chapters of the *Handbook*.	E. ☐	☐	☐	☐

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. ☐	☐	☐	☐
1. Travel medicine services are provided by personnel who have appropriate training, skills, and resource materials to provide quality services.	1. ☐	☐	☐	☐
2. Travel medicine programs include:	2. ☐	☐	☐	☐
a. Appropriate medical oversight.	a. ☐	☐	☐	☐
b. Clearly defined standing orders and protocols, including management of adverse reactions to immunizations.	b. ☐	☐	☐	☐
c. Access to current Centers for Disease Control (CDC) and U.S. Department of State travel recommendations.	c. ☐	☐	☐	☐
d. Appropriate storage and management of vaccines.	d. ☐	☐	☐	☐

	Compliance			
	SC	PC	NC	N/A
3. Travel medicine services include:	3. ☐	☐	☐	☐
a. Comprehensive travel destination-specific risk assessment.	a. ☐	☐	☐	☐
b. Appropriate preventive medicine interventions.	b. ☐	☐	☐	☐
c. Education in risk and risk reduction.	c. ☐	☐	☐	☐
4. Entries in a patient's clinical record include:	4. ☐	☐	☐	☐
a. Travel destination and current health status.	a. ☐	☐	☐	☐
b. Immunization and vaccine name(s), dosage form, dosage, administered, lot number, and quantity.	b. ☐	☐	☐	☐
c. Prescription medications given, quantity and date, dosage, and directions for use.	c. ☐	☐	☐	☐
d. Preventive health education.	d. ☐	☐	☐	☐

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.

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.

	Compliance			
	SC	PC	NC	N/A
A. Services provided or made available by the organization are appropriate to the needs of the population served.	☐	☐	☐	☐
B. Health education and health promotion services are provided by personnel that:	☐	☐	☐	☐
1. Have necessary and appropriate training, education, credentials, and skills to carry out their responsibilities.	☐	☐	☐	☐
2. Have access to and utilize consultative services, as appropriate.	☐	☐	☐	☐
3. Have ready access to appropriate reference materials in health education and health promotion.	☐	☐	☐	☐
4. Participate in continuing professional education in health education and wellness.	☐	☐	☐	☐
C. Health education and health promotion programs should include, but may not be limited to:	☐	☐	☐	☐
1. Clearly defined educational goals and objectives.	☐	☐	☐	☐
2. Evaluation of whether the goals or objectives have been met.	☐	☐	☐	☐
D. The organization should have adequate resources for the health education and health promotion services available.	☐	☐	☐	☐
E. Marketing or advertising regarding the health education and health promotion activities accurately reflects the services provided by the organization.	☐	☐	☐	☐
F. Policies and procedures are established to assess satisfaction with the health education and health promotion services.	☐	☐	☐	☐
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.	☐	☐	☐	☐

	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. ☐	☐	☐	☐
1. Considers relevant health risks and health education needs.	1. ☐	☐	☐	☐
2. Uses a variety of data or data sources.	2. ☐	☐	☐	☐
3. Quantifies risk whenever possible.	3. ☐	☐	☐	☐
4. Uses data to direct programming.	4. ☐	☐	☐	☐
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. ☐	☐	☐	☐
1. Disease-specific screening and educational programs.	1. ☐	☐	☐	☐
2. Substance abuse prevention and education, including programs related to alcohol, tobacco, and other drugs.	2. ☐	☐	☐	☐
3. Promotion of healthy eating.	3. ☐	☐	☐	☐
4. Promotion of physical fitness.	4. ☐	☐	☐	☐
5. Sexuality education and skill building for healthy relationships.	5. ☐	☐	☐	☐
6. Sexual, physical, and emotional violence prevention.	6. ☐	☐	☐	☐
7. Promotion of and education about stress management and relaxation.	7. ☐	☐	☐	☐
J. Health education and disease prevention programs should be included in quality management and improvement activities.	J. ☐	☐	☐	☐

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. ☐	☐	☐	☐
1. Counseling or psychotherapy services.	1. ☐	☐	☐	☐
2. Crisis intervention and emergency services.	2. ☐	☐	☐	☐
3. Consultative and outreach services.	3. ☐	☐	☐	☐
4. Referral services.	4. ☐	☐	☐	☐
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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
F. An initial behavioral health history and medical history of each client is present in the clinical record.	F. ☐	☐	☐	☐

	Compliance			
	SC	PC	NC	N/A
G. The clinical record is periodically updated, and may include assessment and management of:	G. ☐	☐	☐	☐
1. Risk of harm to self or others.	1. ☐	☐	☐	☐
2. Known or potential addictive behaviors and substance abuse.	2. ☐	☐	☐	☐
3. Client self-understanding, motivation, and decision-making.	3. ☐	☐	☐	☐
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. ☐	☐	☐	☐
I. The organization develops and adopts written policies and procedures regarding:	I. ☐	☐	☐	☐
1. Consistent client confidentiality and privacy assurances.	1. ☐	☐	☐	☐
2. Maintenance of client records according to AAAHC Standards.	2. ☐	☐	☐	☐
3. Client flow and case assignment.	3. ☐	☐	☐	☐
4. Situations arising from outreach programs (when provided) such as identification of individuals who need immediate services.	4. ☐	☐	☐	☐
5. Management of referrals and transfers to and from the facility.	5. ☐	☐	☐	☐
6. Cooperation with and coordination of medical care with behavioral health care.	6. ☐	☐	☐	☐
7. Safety and security of staff, clients, and the organization.	7. ☐	☐	☐	☐

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. ☐	☐	☐	☐
1. The terms and conditions of reimbursement or other compensation.	1. ☐	☐	☐	☐
2. The reasonableness of the time spent away from direct patient care and administrative activities.	2. ☐	☐	☐	☐
3. The training of all students and postgraduate trainees, including the extent of their involvement in patient care activities.	3. ☐	☐	☐	☐
4. The requirement or non-requirement for liability coverage.	4. ☐	☐	☐	☐
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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
C. Policies concerning publishing activities address:	C. ☐	☐	☐	☐
1. The need for governing body approval when the views, policies, and procedures expressed in the publication are attributed to the organization.	1. ☐	☐	☐	☐
2. The terms and conditions of compensation from publication and the cost of publication.	2. ☐	☐	☐	☐

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. ☐	☐	☐	☐
B.	The written protocols for conducting research are approved by the governing body or its designee after medical (or dental) and legal review.	B. ☐	☐	☐	☐
C.	Any research activities carried out within the organization are appropriate to the expertise of staff and the resources in the organization.	C. ☐	☐	☐	☐
D.	Individuals engaged in research are provided with adequate facilities.	D. ☐	☐	☐	☐
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. ☐	☐	☐	☐
F.	All professional staff is informed of the organization's research policies.	F. ☐	☐	☐	☐

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. ☐	☐	☐	☐
1.	Physicians who refer and admit patients to the program.	1. ☐	☐	☐	☐
2.	Staff who provide the care and services.	2. ☐	☐	☐	☐
3.	Potential patients in advance of their referral to the program.	3. ☐	☐	☐	☐
4.	Other health care professionals and relevant community agencies.	4. ☐	☐	☐	☐
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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
1.	At least one physician is present or immediately available by telephone whenever patients are present.	1. ☐	☐	☐	☐
D.	Providers may admit patients to this program if they:	D. ☐	☐	☐	☐
1.	Are licensed to treat patients or supervise care and services in this setting.	1. ☐	☐	☐	☐
2.	Have been granted such privileges by the governing body of the organization, in accordance with Chapter 2.II.	2. ☐	☐	☐	☐
E.	Policies and procedures are clearly specified that include, but are not limited to:	E. ☐	☐	☐	☐
1.	Clinical criteria for determining eligibility for admission.	1. ☐	☐	☐	☐
2.	Clinical responsibilities for each patient during his/her stay.	2. ☐	☐	☐	☐
3.	Arrangements for emergency services.	3. ☐	☐	☐	☐
4.	Arrangements for transfer to other health care services as needed.	4. ☐	☐	☐	☐

		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. ☐	☐	☐	☐
G.	The overnight care unit meets applicable local and state codes, including licensing requirements if the state licenses such units.	G. ☐	☐	☐	☐
H.	Registered nurses and other health care professionals are appropriately trained and supervised and are available in sufficient numbers to meet patient needs.	H. ☐	☐	☐	☐
I.	At least one registered nurse is on duty at all times when patients are present.	I. ☐	☐	☐	☐
J.	Treatment rooms are provided or made available to meet patient needs and physician requirements.	J. ☐	☐	☐	☐
K.	Emergency power adequate for the size of the unit is available to protect the life and safety of patients.	K. ☐	☐	☐	☐
L.	Appropriate isolation procedures are followed when any patient is admitted with a suspected or diagnosed communicable disease.	L. ☐	☐	☐	☐
M.	Food service and refreshments are provided to meet the needs of patients.	M. ☐	☐	☐	☐
	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. ☐	☐	☐	☐
	2. Special dietary requirements for patient care are met.	2. ☐	☐	☐	☐
	3. Personnel providing food services meet local health department requirements.	3. ☐	☐	☐	☐
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. ☐	☐	☐	☐
	1. A current history and physical examination.	1. ☐	☐	☐	☐
	2. Treatment orders.	2. ☐	☐	☐	☐
	3. Nursing notes.	3. ☐	☐	☐	☐
	4. Follow-up instructions to patients.	4. ☐	☐	☐	☐
O.	If overnight care is the only service provided by the organization, that organization meets all other applicable Standards contained in the *Handbook*.	O. ☐	☐	☐	☐
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. ☐	☐	☐	☐
Q.	Overnight care and services are reviewed as part of the organization's quality improvement program.	Q. ☐	☐	☐	☐

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. ☐	☐	☐	☐
1.	The purpose and scope of the evaluation and the role of the examiner.	1. ☐	☐	☐	☐
2.	Confidentiality protections and information that may be conveyed to the employer.	2. ☐	☐	☐	☐
3.	Whether medical follow-up is necessary.	3. ☐	☐	☐	☐
B.	Occupational health services are accurately portrayed to patients, employees, and purchasers of the services.	B. ☐	☐	☐	☐
C.	Occupational health services are provided by personnel who:	C. ☐	☐	☐	☐
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. ☐	☐	☐	☐
2.	Have ready access to appropriate reference materials in occupational health and participate in occupational health continuing medical education.	2. ☐	☐	☐	☐
D.	The provision of high-quality occupational health services is demonstrated by the following, as appropriate:	D. ☐	☐	☐	☐
1.	An understanding of the specific workplace hazards for each employee/patient served.	1. ☐	☐	☐	☐
2.	An understanding of the relationship of the condition or finding to workplace conditions and exposures.	2. ☐	☐	☐	☐
3.	Determination of whether the individual is able to perform essential functions of the job and whether accommodations are needed.	3. ☐	☐	☐	☐
4.	Preventive counsel concerning measures to reduce occupational exposures and hazards, including use of protective equipment.	4. ☐	☐	☐	☐

	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. ☐	☐	☐	☐
a. Training and credentials of personnel.	a. ☐	☐	☐	☐
b. Policies, procedures, and forms.	b. ☐	☐	☐	☐
c. Equipment, including calibration and maintenance.	c. ☐	☐	☐	☐
d. Clinical records and record management.	d. ☐	☐	☐	☐
E. Entries in a patient's clinical record for each visit include, as appropriate:	E. ☐	☐	☐	☐
1. An occupational and exposure history, including essential job functions, conditions of work, and hazards of the job.	1. ☐	☐	☐	☐
2. The individual's current functional abilities.	2. ☐	☐	☐	☐
3. Whether the individual is able to perform essential job functions and suggestions for accommodations or restrictions.	3. ☐	☐	☐	☐
4. The relationship of medical conditions or abnormal findings to workplace conditions and exposures.	4. ☐	☐	☐	☐
5. Preventive counsel concerning reduction of workplace exposures and use of personal protective equipment.	5. ☐	☐	☐	☐
6. Relevant communications concerning the patient, work activities, or exposures, including communications with employers, insurance carriers, union representatives, and attorneys.	6. ☐	☐	☐	☐
F. Medical management of injury or illness minimizes disability and promotes functional recovery, directing special attention to cases in which:	F. ☐	☐	☐	☐
1. Recovery has been delayed.	1. ☐	☐	☐	☐
2. Functional abilities have decreased during treatment.	2. ☐	☐	☐	☐
3. Injury or illness is recurrent.	3. ☐	☐	☐	☐
4. There is permanent impairment, disability, or restriction.	4. ☐	☐	☐	☐
G. Work placement evaluations such as preplacement, transfer, or fitness for duty examinations assess current health and ability to perform the job as well as the extent and duration of recent health changes affecting job performance.	G. ☐	☐	☐	☐

	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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
2. Whenever possible, surveillance data are statistically analyzed for health trends and effects of exposure.	2. ☐	☐	☐	☐
3. The results of workplace data for similar workers with similar exposures are considered in the evaluation of the employee.	3. ☐	☐	☐	☐
I. Organizations providing certification examinations mandated under state or federal statutes ensure that:	I. ☐	☐	☐	☐
1. The health care professional performing the evaluation has access to the Standard and related materials.	1. ☐	☐	☐	☐
2. The health care professional understands the statute as it relates to the exam.	2. ☐	☐	☐	☐
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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
2. Under the supervision of a licensed physician or, if allowed, another health care professional.	2. ☐	☐	☐	☐
3. Reviewed and updated periodically.	3. ☐	☐	☐	☐
K. Organizations providing consulting services ensure that the role and responsibilities of the consultant are clearly defined.	K. ☐	☐	☐	☐
L. Organizations providing training and educational programs ensure that each program:	L. ☐	☐	☐	☐
1. Has written objectives.	1. ☐	☐	☐	☐
2. Is tailored to the specific worker population and work conditions.	2. ☐	☐	☐	☐
3. Includes an evaluation process and uses the results to improve program quality.	3. ☐	☐	☐	☐

	Compliance			
	SC	PC	NC	N/A
M. If the organization is responsible for emergency and/or community preparedness planning, it ensures that:	M. ☐	☐	☐	☐
1. The disaster plan:	1. ☐	☐	☐	☐
a. Includes likely worksite scenarios for disasters, estimating potential morbidity and mortality.	a. ☐	☐	☐	☐
b. Includes appropriate plans for medical segregation, decontamination, evacuation, and transportation in collaboration with local emergency planning committees.	b. ☐	☐	☐	☐
2. The toxicologic exposure plan:	2. ☐	☐	☐	☐
a. Provides counsel on the identification, decontamination, and evacuation of potentially exposed individuals or communities.	a. ☐	☐	☐	☐
b. Ensures appropriate emergency treatment protocols for potentially acute exposures to toxic agents handled by employees.	b. ☐	☐	☐	☐
c. Provides appropriate medical expertise for the case management of individual acute toxic exposures.	c. ☐	☐	☐	☐
d. Provides sufficient training and exercises to ensure that the plan will be effective.	d. ☐	☐	☐	☐

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 meets 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.	A. ☐	☐	☐	☐
B.	Such organizations, unless they also provide emergency services, do not solicit patients with life-threatening conditions.	B. ☐	☐	☐	☐
C.	Patients seeking immediate/urgent care services are seen without prior appointments.	C. ☐	☐	☐	☐
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.	D. ☐	☐	☐	☐
E.	During hours of operation, at least one qualified physician is present or immediately available.	E. ☐	☐	☐	☐
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.	F. ☐	☐	☐	☐
G.	Equipment, drugs, and other agents necessary to provide immediate/urgent care services are available.	G. ☐	☐	☐	☐
H.	Communications are maintained with local police departments, fire departments, community social service agencies, ambulance services, poison control centers, and hospitals as needed to ensure high-quality patient care.	H. ☐	☐	☐	☐
I.	Laboratory and imaging services described in Chapters 12 and 13 are available to meet the needs of patients receiving immediate/urgent care.	I. ☐	☐	☐	☐
J.	Arrangements have been made to ensure that adequate specialty consultation services are available.	J. ☐	☐	☐	☐
K.	Health care professionals who maintain skills in advanced cardiac life support (ACLS) or advanced trauma life support (ATLS) are present.	K. ☐	☐	☐	☐
L.	All clinical support staff with direct patient contact maintain at a minimum skills in basic cardiac life support (BLS).	L. ☐	☐	☐	☐

23. Emergency Services

If an accreditable organization implies by its activities, advertising, or practice 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.	A. ☐	☐	☐	☐
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.	B. ☐	☐	☐	☐
C.	At least one qualified physician is present at all times.	C. ☐	☐	☐	☐
D.	Health care professionals assisting in the provision of emergency services are appropriately qualified, trained, and supervised and are available in sufficient numbers for the emergency services provided.	D. ☐	☐	☐	☐
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.	E. ☐	☐	☐	☐
F.	Laboratory and imaging services described in Chapters 12 and 13 are immediately available.	F. ☐	☐	☐	☐
G.	Communications are maintained with local police departments, fire departments, community social service agencies, ambulance services, poison control centers, and hospitals as needed to ensure high-quality patient care.	G. ☐	☐	☐	☐
H.	Adequate specialty consultation services are immediately available.	H. ☐	☐	☐	☐
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 present. When pediatric patients are served, medical personnel who are currently trained in pediatric advanced life support (PALS) and age- and size-appropriate resuscitative equipment must be available at all 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.	I. ☐	☐	☐	☐

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.	A. ☐	☐	☐	☐
B. Radiation oncology services appropriate to the organization's function include, but are not limited to:	B. ☐	☐	☐	☐
1. Consultation services.	1. ☐	☐	☐	☐
2. Treatment planning.	2. ☐	☐	☐	☐
3. Simulation of treatment.	3. ☐	☐	☐	☐
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.	4. ☐	☐	☐	☐
5. Clinical treatment management including but not limited to the use of teletherapy and brachytherapy.	5. ☐	☐	☐	☐
6. Appropriate follow-up care of all patients.	6. ☐	☐	☐	☐
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 services rendered.	C. ☐	☐	☐	☐
D. The radiation oncology service has written safety and quality control policies and procedures, including policies and procedures for teletherapy and brachytherapy, that must be reviewed at least annually by a qualified medical physicist. The policies and procedures include, but are not limited to:	D. ☐	☐	☐	☐
1. The designation of a radiation safety officer and committee that meets on a periodic basis.	1. ☐	☐	☐	☐
2. A program to maintain personnel exposure records.	2. ☐	☐	☐	☐
3. Annual calibration of teletherapy units.	3. ☐	☐	☐	☐
4. Annual review of the radiation safety program by a qualified medical physicist.	4. ☐	☐	☐	☐
5. A program to inspect interlock systems of all treatment units.	5. ☐	☐	☐	☐
6. Maintenance of the records of machine performance, maintenance, and malfunctions.	6. ☐	☐	☐	☐

	Compliance			
	SC	PC	NC	N/A
7. Periodic testing of all sealed sources, satisfying all pertinent radiation regulations.	7. ☐	☐	☐	☐
8. A program for maintenance and repair of equipment.	8. ☐	☐	☐	☐
9. Quality control procedures for all therapeutic equipment.	9. ☐	☐	☐	☐
10. Regulation of the acquisition, use, removal, handling, and storage of potentially hazardous materials.	10. ☐	☐	☐	☐
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. ☐	☐	☐	☐
1. A radiation technologist certified by the American Registry of Radiologic Technologists (ARRT), or state-licensed technologist.	1. ☐	☐	☐	☐
2. Dosimetrist.	2. ☐	☐	☐	☐
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. ☐	☐	☐	☐
F. Radiation oncology service should have adequate facilities and equipment to provide appropriate treatments and related treatments, which include:	F. ☐	☐	☐	☐
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. ☐	☐	☐	☐
2. A kilovoltage x-ray source or electron-beam for skin lesions.	2. ☐	☐	☐	☐
3. Access to computerized dosimetry.	3. ☐	☐	☐	☐
4. Access to simulation and/or CT imaging equipment.	4. ☐	☐	☐	☐
5. Access to patient transport.	5. ☐	☐	☐	☐
6. Personal immobilization devices with procedures to ensure proper identification to match each device to the proper patient.	6. ☐	☐	☐	☐
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. ☐	☐	☐	☐
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. ☐	☐	☐	☐

	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. ☐	☐	☐	☐
1. A recognized methodology for diagnosis and treatment, including but not limited to the use of teletherapy and brachytherapy.	1. ☐	☐	☐	☐
2. The performance of therapeutic services on the written order of a radiation oncologist.	2. ☐	☐	☐	☐
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. ☐	☐	☐	☐
4. Weekly chart and port film review for on-going therapies.	4. ☐	☐	☐	☐
5. Periodic new patient review.	5. ☐	☐	☐	☐
6. Signed informed consent obtained prior to treatment.	6. ☐	☐	☐	☐
7. Photo documentation of treatment setups.	7. ☐	☐	☐	☐
8. Access to emergency treatment.	8. ☐	☐	☐	☐
H. The facility has access to appropriate supporting facilities, including diagnostic laboratories and imaging facilities.	H. ☐	☐	☐	☐
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. ☐	☐	☐	☐
1. Confirmation of the presence of malignancy by histopathology or a statement of benign condition.	1. ☐	☐	☐	☐
2. Definition of tumor location, extent, and stage.	2. ☐	☐	☐	☐
3. Definition of treatment volume.	3. ☐	☐	☐	☐
4. Selection of dose.	4. ☐	☐	☐	☐
5. Selection of treatment modality.	5. ☐	☐	☐	☐
6. Selection of treatment technique.	6. ☐	☐	☐	☐
7. Dosimetry calculations.	7. ☐	☐	☐	☐
8. Supervision of treatment and record of patient progress and tolerance.	8. ☐	☐	☐	☐
9. Summary of completion with statement of follow-up plan.	9. ☐	☐	☐	☐

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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
2. The organization establishes written procedures for review of an adverse determination.	2. ☐	☐	☐	☐
3. The review procedures are available to the patient and any provider acting on behalf of a patient.	3. ☐	☐	☐	☐
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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
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. ☐	☐	☐	☐

	Compliance			
	SC	PC	NC	N/A
C. Information is provided to patient members concerning:	C. ☐	☐	☐	☐
1. Specialty referral policy.	1. ☐	☐	☐	☐
2. When to seek direct access to emergency care or utilize 911 services.	2. ☐	☐	☐	☐
3. Policies regarding services obtained outside the managed care organization's network and procedures for obtaining them.	3. ☐	☐	☐	☐
4. Policies on patient member charges (if any).	4. ☐	☐	☐	☐
5. Procedures for patient member notification on benefit changes and/or termination of benefits, services, or service delivery.	5. ☐	☐	☐	☐
6. Procedures for appealing decisions regarding coverage, benefits, or services, as required by applicable state or federal law and regulations.	6. ☐	☐	☐	☐
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. ☐	☐	☐	☐
E. Procedures are in place to periodically assess patient satisfaction with the organization's services and provide feedback to providers.	E. ☐	☐	☐	☐
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. ☐	☐	☐	☐
G. A Utilization Management Program has been established and includes:	G. ☐	☐	☐	☐
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. ☐	☐	☐	☐
2. Decision protocols based on medical evidence.	2. ☐	☐	☐	☐
3. Policies and procedures to evaluate the appropriate use of new medical technologies, procedures, drugs, or devices.	3. ☐	☐	☐	☐
4. Evaluation of the Utilization Management Program, including patient member and provider satisfaction data.	4. ☐	☐	☐	☐
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. ☐	☐	☐	☐

	Compliance			
	SC	PC	NC	N/A
I. The managed care organization sets policies and procedures for the quality management and improvement program as required in Chapter 5, including but not limited to patient rights, as required in Chapter 1 (grievances, appeals, satisfaction, etc.); governance and credentialing, as required in Chapter 2; administration, as required in Chapter 3 (patient continuity, patient health education, etc.); and other patient access, cost, and quality of care issues as required in Chapter 4.	I. ☐	☐	☐	☐
1. Goals of the quality improvement program are established and designed to achieve the greatest benefit to the patient members.	1. ☐	☐	☐	☐
2. Identification and selection of appropriate quality improvement activities are based on information obtained from sources including, but not limited to:	2. ☐	☐	☐	☐
a. Patient member demographics.	a. ☐	☐	☐	☐
b. Patient member and provider surveys.	b. ☐	☐	☐	☐
c. Reports of high-risk, high-volume diagnoses and services.	c. ☐	☐	☐	☐
3. The governing body, at least annually, reviews the effectiveness of the program goals and initiates changes, as appropriate.	3. ☐	☐	☐	☐
J. 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.	J. ☐	☐	☐	☐
1. Records in the patients' primary clinical record include a summary of significant surgical procedures and past and current diagnoses or problems.	1. ☐	☐	☐	☐
K. 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.	K. ☐	☐	☐	☐
L. 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.	L. ☐	☐	☐	☐
1. Procedures should include, but are not limited to:	1. ☐	☐	☐	☐
a. Methods for notifying providers of a participation decision.	a. ☐	☐	☐	☐
b. Methods for filing an appeal when privileges are denied, reduced, suspended, or terminated.	b. ☐	☐	☐	☐

	Compliance			
	SC	PC	NC	N/A
M. The managed care organization sets policies and procedures for reporting, reviewing, and appropriate analysis of all incidents reported by employees, patients, providers, and others.	M. ☐	☐	☐	☐
N. The managed care organization is accountable for the oversight of any functions or services that are delegated[1] to another entity.	N. ☐	☐	☐	☐
1. Prior to delegation, a system must be in place to evaluate the services of the delegated entity.	1. ☐	☐	☐	☐
2. A written agreement must be in place that outlines the services to be performed by the delegated entity, including reporting responsibilities and the ability to revoke the delegated services for unsatisfactory performance.	2. ☐	☐	☐	☐
3. Ongoing monitoring of the performance of the entity must be conducted at least annually, with corrective measures taken as appropriate.	3. ☐	☐	☐	☐
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.	4. ☐	☐	☐	☐
O. The managed care organization works to improve the health status of its members with chronic conditions.	O. ☐	☐	☐	☐
P. The governing body of the managed care organization is responsible for confirming that provider organizations that it contracts with, such as surgery centers, hospitals, home health agencies, nursing homes, behavioral health providers, and pathology and medical laboratories (those services listed in the adjunct chapters), 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.	P. ☐	☐	☐	☐

Note: Standard P focuses on the managed care organization's system-wide mechanisms for evaluating individual physicians' offices or other contractor practice sites and for ensuring Standards compliance.

[1] *Delegation is defined as a formal process by which a managed care organization gives another organization the authority to perform certain administrative functions on its behalf, such as credentialing, utilization management, and quality improvement. Although a managed care organization can delegate the authority to perform a function, it cannot delegate the responsibility for ensuring that the function is performed appropriately and in compliance with AAAHC Standards. The organization fulfills its responsibility and exercises its authority by providing oversight of the delegate.*

26. Lithotripsy Services

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 provider who is qualified to assume clinical responsibility for the quality of services rendered.	A. ☐	☐	☐	☐
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.	B. ☐	☐	☐	☐
C. The organization establishes written policies and procedures to provide trained and experienced allied health care personnel who are able to conduct duties necessary to assist in the provision of lithotripsy. These include, at a minimum:	C. ☐	☐	☐	☐
1. Meeting state and federal licensure requirements for operation of radiation equipment.	1. ☐	☐	☐	☐
D. The organization must have written policies and procedures providing guidelines, adequate supplies and equipment to provide appropriate treatment in accordance with manufacturer's guidelines, which include:	D. ☐	☐	☐	☐
1. Indications.	1. ☐	☐	☐	☐
2. Contraindications.	2. ☐	☐	☐	☐
3. Maximum power setting.	3. ☐	☐	☐	☐
4. Maximum number of shocks.	4. ☐	☐	☐	☐
5. Position of patient.	5. ☐	☐	☐	☐
6. Patient size and weight.	6. ☐	☐	☐	☐
7. Utilization of equipment.	7. ☐	☐	☐	☐
E. The organization has written policies addressing:	E. ☐	☐	☐	☐
1. A recognized methodology for diagnosis and treatment, including pre-procedure evaluation (lab work, x-rays, etc.).	1. ☐	☐	☐	☐
2. That a provider shall perform the treatment and be present during treatment.	2. ☐	☐	☐	☐
3. Criteria for patient selection.	3. ☐	☐	☐	☐

	Compliance			
	SC	PC	NC	N/A
4. The requirement that signed consent forms be obtained prior to treatment.	4. ☐	☐	☐	☐
5. Administration of anesthesia/medication. (A wide choice of anesthetic methods is available and appropriate. Successful lithotripsy requires the appropriate administration of anesthesia/ medication for patient comfort and compliance. A patient's health, habits, and history must be such that he/she can safely undergo anesthesia/analgesia for lithotripsy.)	5. ☐	☐	☐	☐
6. Appropriate monitoring during treatment must be provided using American Society of Anesthesiology (ASA) guidelines.	6. ☐	☐	☐	☐
7. Correction of medication-related and other medical conditions contributing to coagulopathy and the relationship to lithotripsy.	7. ☐	☐	☐	☐
8. Pre- and post-procedure teaching.	8. ☐	☐	☐	☐
F. The organization has written policies addressing the safety aspects of the treatment, including:	F. ☐	☐	☐	☐
1. Log of daily lithotripter calibration/equipment checks on days when lithotripsy is provided.	1. ☐	☐	☐	☐
2. Preventive maintenance logs and maintenance records including malfunctions and current documentation from the service contract provider that malfunctions have been corrected.	2. ☐	☐	☐	☐
G. In addition to the applicable clinical record requirements in Chapter 6, the following elements must be included:	G. ☐	☐	☐	☐
1. History and physical indicate presence, location, and size of urinary stone.	1. ☐	☐	☐	☐
2. Method of determining location and confirmation of presence of stone immediately prior to treatment.	2. ☐	☐	☐	☐
3. Operative treatment record.	3. ☐	☐	☐	☐
a. Selection of treatment modality.	a. ☐	☐	☐	☐
b. Number of shocks.	b. ☐	☐	☐	☐
c. Energy level.	c. ☐	☐	☐	☐
d. Radiation exposure.	d. ☐	☐	☐	☐
H. The organization provides sponsorship of lithotripsy continuing education.	H. ☐	☐	☐	☐

27. Medical Home

The services provided by an accreditable 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.

	Compliance			
	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).	A. ☐	☐	☐	☐
1. The patient can identify his/her physician and patient care team members.	1. ☐	☐	☐	☐
2. The physician explains information in a manner that is easy to understand (to include Standard 1.D).	2. ☐	☐	☐	☐
3. The physician 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. ☐	☐	☐	☐
4. The physician speaks to the patient about his/her health problems and concerns.	4. ☐	☐	☐	☐
5. The physician provides easy-to-understand instructions about taking care of health concerns.	5. ☐	☐	☐	☐
6. The physician knows important facts about the patient's health history.	6. ☐	☐	☐	☐
7. The physician spends sufficient time with the patient.	7. ☐	☐	☐	☐
8. The physician is as thorough as the patient feels is needed.	8. ☐	☐	☐	☐
9. The staff keeps the patient informed with regard to his/her appointment when delayed.	9. ☐	☐	☐	☐
10. The physician addresses specific principles to prevent illness.	10. ☐	☐	☐	☐
11. The physician speaks with the patient about making lifestyle changes to help prevent illness.	11. ☐	☐	☐	☐
12. The physician inquires as to the patient's concerns/worries/stressors.	12. ☐	☐	☐	☐
13. The physician inquires as to the patient's mental health status (i.e., sad/empty or depressed).	13. ☐	☐	☐	☐

**As permitted by state law/regulation*

		Compliance			
		SC	PC	NC	N/A
14.	The Medical Home provides services within a team framework, and that "team" provider concept has been conveyed to the patient.	14. ☐	☐	☐	☐
15.	The family is included, as appropriate, in patient care decisions, treatment, and education.	15. ☐	☐	☐	☐
16.	The Medical Home treats its patients with cultural sensitivity.	16. ☐	☐	☐	☐
B.	Continuity of care	B. ☐	☐	☐	☐
1.	A significant number (more than 50%) of the Medical Home visits of any patient are with the same physician/physician team.	1. ☐	☐	☐	☐
2.	If a consultation is ordered for the patient, it is documented in the clinical record.	2. ☐	☐	☐	☐
3.	Referrals for services (external to the Medical Home), are documented in the clinical record.	3. ☐	☐	☐	☐
4.	Consultations (medical opinions obtained from other health care professionals) are recorded in the clinical record.	4. ☐	☐	☐	☐
5.	Referrals are disease- or procedure-specific.	5. ☐	☐	☐	☐
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.	6. ☐	☐	☐	☐
7.	Follow-up appointments are documented in the clinical record.	7. ☐	☐	☐	☐
8.	After-hour encounters are documented in the clinical record.	8. ☐	☐	☐	☐
9.	Missed appointments are documented in the clinical record and managed appropriately depending on the patient's care needs and diagnosis.	9. ☐	☐	☐	☐
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. ☐	☐	☐	☐
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. ☐	☐	☐	☐
12.	Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards, including consultations, referrals, and lab results.	12. ☐	☐	☐	☐
C.	Comprehensiveness of care	C. ☐	☐	☐	☐
1.	If the Medical Home limits the population served, those limitations are disclosed to prospective patients.	1. ☐	☐	☐	☐

	Compliance			
	SC	PC	NC	N/A
2. The Medical Home scope of service includes, but is not limited to:	2. ☐	☐	☐	☐
a. Preventive care (including surveillance and screening for special needs).	a. ☐	☐	☐	☐
b. Wellness care (healthy lifestyle issues -- appropriate sleep, stress relief, etc.).	b. ☐	☐	☐	☐
c. Acute illness and injury care.	c. ☐	☐	☐	☐
d. Chronic illness management.	d. ☐	☐	☐	☐
e. End-of-life care.	e. ☐	☐	☐	☐
3. Patient education and self-management resources are provided.	3. ☐	☐	☐	☐
4. Knowledge of community resources that support the patient's (and family's, as appropriate) needs are known by the Medical Home.	4. ☐	☐	☐	☐
5. The community's service limitations are known and alternate sources are coordinated by the Medical Home.	5. ☐	☐	☐	☐
6. Referrals are appropriate to the patient's needs; when referrals occur, the Medical Home collaborates with the specialist.	6. ☐	☐	☐	☐
7. The needs of the patient's personal caregiver (see definition in Standard 27.A-3), when known, are assessed and addressed to the extent that they impact the care of the patient.	7. ☐	☐	☐	☐
8. Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards.	8. ☐	☐	☐	☐
D. Accessibility	D. ☐	☐	☐	☐
1. The Medical Home establishes standards in writing to support patient access, such as provider availability, information, clinical record contents, advice, routine care, and urgent care; the Medical Home's data supports that they meet those standards.	1. ☐	☐	☐	☐
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).	2. ☐	☐	☐	☐
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.	3. ☐	☐	☐	☐
4. The Medical Home ensures on-call coverage (pre-arranged access to a clinician) when the Medical Home is not open.	4. ☐	☐	☐	☐
5. Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards.	5. ☐	☐	☐	☐

	Compliance			
	SC	PC	NC	N/A
E. Quality	E. ☐	☐	☐	☐
1. Patient care is physician-directed.	1. ☐	☐	☐	☐
2. The Medical Home incorporates evidence-based guidelines and performance measures in delivering clinical services, including:	2. ☐	☐	☐	☐
a. Preventive care (including surveillance and screening for special needs).	a. ☐	☐	☐	☐
b. Wellness care (healthy lifestyle issues – appropriate sleep, stress relief, etc.).	b. ☐	☐	☐	☐
c. Acute illness and injury care.	c. ☐	☐	☐	☐
d. Chronic illness management.	d. ☐	☐	☐	☐
e. End-of-life care.	e. ☐	☐	☐	☐
3. The Medical Home periodically assesses its use of evidence-based guidelines and performance measures to ensure that they are being used effectively and appropriately.	3. ☐	☐	☐	☐
4. Supervision of patient care by the Medical Home, as evidenced by:	4. ☐	☐	☐	☐
a. Medication review and update including prescription, over-the-counter, and diet supplements.	a. ☐	☐	☐	☐
b. Appropriate ordering of diagnostic tests (avoidance of redundancies and unnecessary testing).	b. ☐	☐	☐	☐
c. Appropriate management of patient referrals (avoidance of unnecessary referrals).	c. ☐	☐	☐	☐
5. The Medical Home assesses and continuously improves the services it provides; measurements, quality studies, data trending, and benchmarking are key tools in a quality improvement/ management program.	5. ☐	☐	☐	☐
6. In addition to the Standards presented in Chapter 5.II, the Medical Home's quality improvement program should include at least one (1) study every three (3) years on each of the following topics:	6. ☐	☐	☐	☐
a. Patient/physician relationship.	a. ☐	☐	☐	☐
b. Continuity of care.	b. ☐	☐	☐	☐
c. Comprehensiveness of care.	c. ☐	☐	☐	☐
d. Accessibility to care.	d. ☐	☐	☐	☐
e. Clinical study.	e. ☐	☐	☐	☐
7. Electronic data management is continually assessed as a tool for facilitating the above-mentioned Standards.	7. ☐	☐	☐	☐

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-Waved 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

1.G-6 "Providers" was replaced by "professionals."

Chapter 2 – Governance, Subchapter I, General Requirements

2.I.C "Practitioners" was replaced by "health care professionals."

Chapter 2 – Governance, Subchapter II, Credentialing and Privileging

2.II.B "Of medical staff members" was added after "assignment or curtailment of clinical privileges."

2.II.D "The health care professional must be legally and professionally qualified for the privileges granted" was added consistent with Medicare language.

2.II.E "Health care professional's" was replaced by "medical staff member's."

Chapter 5 – Quality Management and Improvement, Subchapter I, Peer Review

5.I.C "By individual practitioners, as well as practitioners in the aggregate," was removed.

Chapter 9 – Anesthesia Services

9.D "Individual" was replaced by "health care professional."

9.M-2 "Individual' was replaced by "health care professional."

9.N "Medical personnel" was replaced in two places by "health care professionals."

9.R This Standard was revised to include patient safety as the focus of required written protocols.

9.W This Standard was modified to clarify when it is applicable.

Chapter 10 – Surgical and Related Services

The introduction was modified to clarify that Chapter 10 Standards are applicable in settings where invasive pain management procedures are performed.

Chapter 10, Subchapter I, General Requirements

10.I.A "Personnel" was changed to "staff" for consistency.

10.I H "Personnel" was replaced by "health care professionals."

10.I.J "Personnel" was replaced by "support staff."

10.I.J-1 "Personnel" and "medical personnel" were changed to "health care professionals."

10.I.K "Personnel" was replaced by "health care professionals."

10.I.AA This is a new Standard addressing blood/blood products and human cells or tissues.

Chapter 11 – Pharmaceutical Services

11.K "Or other health care professionals" was added after "providers" for clarity.

Chapter 14 – Dental Services

14.N "Personnel" was replaced by "health care professionals" and "clinical support personnel" was changed to "clinical support staff."

Chapter 15 – Other Professional and Technical Services, Subchapter I, General Services

15.I.C "Personnel" was replaced by "allied health professionals."

Chapter 20 – Overnight Care and Services

20.C "Personnel" was replaced by "staff."

20.H "Personnel" was replaced by "health care professionals."

Chapter 21 – Occupational Health Services

21.I "Health care" was added before "professional" for clarity.

Chapter 22 – Immediate /Urgent Care Services

22.D "Personnel" was replaced by "staff."

22.L "Personnel" was replaced by "support staff."

Chapter 23 – Emergency Services

23.B "Personnel" was replaced by "staff."

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."

Appendix B

Organization's Right of Appeal Following Denial or Revocation of Accreditation

Initial Decision and Opportunity to Submit Additional Material

Any proposed recommendation with respect to accreditation by the AAAHC is reported to the chief medical executive and the administrative head of the organization. If the proposed recommendation is to deny accreditation or revoke accreditation, such notice will include an explicit statement of the reasons for the decision and generally provide the organization with the opportunity to submit additional material to the AAAHC office within 14 calendar days of receipt of the notice. Unless otherwise indicated by the AAAHC, the information provided should be limited to that available at the time of the survey and relative to the Standards identified by the AAAHC as less than substantially compliant. The information that is provided will be considered by the AAAHC in rendering the accreditation decision. Organizations that are notified that accreditation has been revoked will have the right to appeal.

Final Decision Subject to Right to Appeal

Any decision to deny or revoke accreditation by the AAAHC will be accompanied by an explanation of the reasons for the decision and of the organization's right to a hearing before an Appeals Hearing Panel. Unless otherwise specified by the AAAHC, the panel will be composed of three individuals designated by the Executive Director of the AAAHC. The panel will not include: (i) any person who participated in the accreditation decision on behalf of the AAAHC; (ii) any person who is or ever has been a surveyor of the organization; (iii) more than one director from the AAAHC Board of Directors; or (iv) any person who is in direct economic competition with or has a bias with respect to the organization seeking accreditation. The organization's written request for a hearing to appeal a decision to deny or revoke accreditation must be received within ten (10) calendar days of the date of the notification, along with a one-time nonrefundable payment of $3500.00 to defray administrative costs incurred in planning and convening the appeals hearing. If the organization fails to request such a hearing on a timely basis, or fails to include payment of $3500.00 at the time of the request, the decision becomes final. The appeal of any decision is governed by the AAAHC's appeal procedures that are in effect at the time of the appeal.

Hearing Before the Appeals Hearing Panel

A hearing requested by an organization before the Appeals Hearing Panel is ordinarily held within 60 calendar days following the AAAHC's receipt of its written request, including the administrative payment of $3500.00. In the event that the organization is not available for an appeals hearing within 60 calendar days following the AAAHC's receipt of its written request, the organization will be deemed to have waived its right to an appeal unless the AAAHC, in its sole discretion, agrees to extend the period for the appeal.

Approximately 14 calendar days before the hearing, the organization is provided notice of the time and place of the hearing, and the name, specialty, and location of the panel members. When the decision is based on findings from an AAAHC on-site survey, the organization will also be provided the factual findings included in the survey report. The hearing will be held at the AAAHC office, unless otherwise agreed by the organization and the AAAHC. Panel members may be convened by conference call, and 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 presentations, offer testimony, and interview any available surveyor(s) who participated in the survey. At least 14 calendar days before any such hearing, the organization may request, in writing, the presence at the meeting of any such surveyor(s) it wishes to interview. Surveyors who are requested to participate in the hearing may be convened by conference call. If the organization makes a written submission to the panel, the submission should be submitted to the AAAHC prior to the hearing. The Appeals Hearing Panel will consider all materials submitted to it on a timely basis. When the accreditation decision is based on findings from an AAAHC survey, the recommendation of the Appeals Hearing Panel will be based on the organization's compliance with the AAAHC's Standards at the time of the survey.

Following the hearing before the Appeals Hearing Panel, the organization will be notified promptly of the panel's recommendation. If the panel's recommendation is to uphold the original decision to deny or revoke accreditation, the organization has the right to appeal directly to the AAAHC Board of Directors. The organization's written

request for appeal to the Board must be received within ten (10) calendar days from the date of the notification of the Appeals Hearing Panel's recommendation.

If the Appeals Hearing Panel recommends granting accreditation, the organization will be notified of the panel's recommendation, and the Accreditation Committee will be afforded the opportunity to consider the recommendation of the Appeals Hearing Panel at their next regularly scheduled meetings. Following these meetings, the organization will be notified promptly of the accreditation decision. If the decision to deny or revoke accreditation is not modified or reversed by the Accreditation Committee, the organization has ten (10) calendar days from the date of such notice to appeal directly to the AAAHC Board of Directors.

Appeal to the AAAHC Board of Directors

The Board of Directors will consider any appeal at its first regular meeting that is at least 30 calendar days after receipt of the request for appeal. Members of the Accreditation Committee will not participate in the discussion or the vote by the Board of Directors relative to the accreditation of the organization. Similarly, any AAAHC director who has an interest in the organization, who is a direct economic competitor of the organization, who was a surveyor of the organization, or who was a member of the Appeals Hearing Panel will not participate in the discussion or vote by the Board of Directors.

The organization may submit, at least 20 calendar days prior to the Board meeting, a written response or comments for review by the Board. The Board will review any such written response and comments submitted, 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 AAAHC survey, the Board's decision will be based on the organization's compliance with the AAAHC Standards in effect at the time of the survey.

Exceptions with Respect to the Above Appeal Procedures

The AAAHC 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's failure to satisfy the AAAHC Standards may result in imminent danger to the health of any individual or individuals. Under such circumstances, the AAAHC shall provide subsequent notice and the opportunity to appeal.

The AAAHC also reserves the right to deny an organization the right to an appeal if:

(1) The organization no longer satisfies the AAAHC's Survey Eligibility Criteria.

(2) There is a significant change (for a complete list of what constitutes significant changes, see Continuation of Accreditation Following a Significant Change on page 23).

(3) Any imposition of sanctions, any changes in license or qualification status, governmental investigation or proceedings, or any violation of state or federal law with respect to the organizations, its officers, administrators, physicians/practitioners, or staff occurs.

(4) The organization fails to notify the AAAHC immediately of any such change.

Conditions with Respect to the Appeal Process

An appeal of an accreditation decision generally does not extend or otherwise affect the term of accreditation. If accreditation is revoked, the organization is not accredited during the appeals 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 appeals process.

Any appeal conducted pursuant to these procedures 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 any use during the appeal of an accreditation decision may result, at the discretion of the AAAHC Board of Directors, in termination of the organization's right to appeal the decision and immediate termination of the appeal.

Any organization that exercises its right to an appeal is obligated to notify the AAAHC immediately of any significant change as outlined in Continuation of Accreditation Following a Significant Change on page 23.

No organization may exercise its right to an appeal at the same time that it applies for a new AAAHC accreditation survey. Organizations that apply for an AAAHC accreditation survey should be aware that information about the basis for the denial or revocation will be provided to the surveyor.

Appendix C

Malignant Hyperthermia Guidelines

For resources, listings of safe and unsafe anesthetic agents, and further general information regarding malignant hyperthermia, contact the Malignant Hyperthermia Association of the United States (MHAUS), 11 East State Street, PO Box 1069, Sherburne, NY 13460-1069, non-emergency information 800/986-4287. Available at www.mhaus.org are the malignant hyperthermia emergency treatment protocol in poster format and many educational resources for medical professionals and the general public.

To assist organizations, the following official statement was obtained from the MHAUS. "All facilities where MH triggering anesthetics (i.e., chloroform (trichloromethane, methyl trichloride), halothane, enflurane, isoflurane, desflurane, sevoflurane, methoxyflurane, trichloroethylene, xenon and succinylcholine) are administered (including ambulatory surgery centers and offices) should stock a minimum of 36 vials of dantrolene sodium for injection. If potent volatile agents are not used, and succinylcholine is available for resuscitation, a minimum of 36 vials of dantrolene should be available. If none of these are used or available, then dantrolene need not be present."

Appendix D

History of the AAAHC

A Solid Foundation

A sense of obligation coupled with a willingness to critically evaluate one's own performance is a time-honored tradition of the medical profession. This same tradition is the foundation on which the Accreditation Association for Ambulatory Health Care (Accreditation Association/AAAHC) is built. From this solid base, the Accreditation Association has grown strong and successful 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 AAAHC was incorporated in 1979, but its history began more than 30 years ago with independent and cooperative efforts by many national organizations, all dedicated to high-quality ambulatory health care. This is the story of how those efforts culminated in the formation of the AAAHC 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 Group Practice Association (now 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 AGPA Board of Trustees formed its Commission on Accreditation with the charge to develop an accreditation program under AGPA'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 AGPA planned for their standards to emulate both the format of medical records and the format used by the Joint Commission on Accreditation of Hospitals (JACH), now The Joint Commission (TJC).

The AGPA also spelled out other essential organizational aspects to be reviewed: the logical process of clinical care, educational activities, research by health care professionals, technological support, qualifications and functions of staff physicians, organizational effectiveness, ethical considerations, and the environment. Other aspects included the size and scope of the practice and its orientation, philosophy, and geographic location. To allow the program to grow with the profession, flexibility was a key factor in the standards and their application.

The AGPA Commission conducted its first on-site visits in 1969. During the years that AGPA conducted its accreditation program, the Medical Group Management Association (MGMA) provided health care administrators to participate in the survey process. By their 1976 annual meeting, AGPA had conducted a total of 182 initial surveys and had scheduled 47 additional re-surveys, evidence of the growing interest in accreditation.

ACHA Launches an Accreditation Program

Around this same time, the American College Health Association (ACHA) began looking at accreditation of its members. ACHA conducted a pilot survey in 1967. The pilot was successful and ACHA launched its certification program. Over the next 13 years, more than 80 college and university health centers were surveyed.

Change and Cooperative Efforts

A number of interrelated factors influenced the next phase in the development of ambulatory health care accreditation. In the late 1960s and early 1970s, the focus of the health care delivery system began to change, shifting from the hospital to other health care delivery settings. Grants from the federal government spurred this change by funding new centers for primary care. These centers and the burgeoning number of neighborhood health centers and surgical centers found themselves ineligible to participate in any existing, formally organized quality assessment program.

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 Practice 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 1999, 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 1996, 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 multi-specialty 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, 1996, 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:

Alphabetical by organization and listed with their CEO or Designated Representative

Ambulatory Surgery Foundation (ASF);
William M. Prentice

American Academy of Cosmetic Surgery (AACS);
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 (AAFPRS); Stephen C. Duffy

American Association of Oral & Maxillofacial Surgeons (AAOMS); Robert C. Rinaldi, PhD

American College of Gastroenterology (ACG);
Bradley C. Stillman

American College Health Association (ACHA);
Doyle E. Randol, 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 Conte, CGCS

American Society of Anesthesiologists (ASA);
John Thorner, JD, CAE

American Society for Dermatologic Surgery Association (ASDSA); Katherine J. Duerdoth, 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 Bradle, MA, CMP

Official Observer

American Dental Association

Current Officers

Jack Egnatinsky, MD; President, 2011-
Karen M. McKellar; Vice-President, 2011-
Margaret E. Spear, MD; Treasurer, 2011-
Lawrence S. Kim, MD, FACG, AGAF; Secretary, 2011-

Executive Vice President and CEO

John E. Burke, PhD, 1997-

Current Board of Directors

In alphabetical order

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Edward S. Bentley, MD, 2006-
W. Dore Binder, MD, 2010-
Frank J. Chapman, MBA, 2005-
W. Patrick Davey, MD, MBA, 2003-
Jan Davidson, MSN, RN, CPHRM, 2011-
Mark S. DeFrancesco, MD, MBA, 2000-
Meena Desai, MD, 2009-
Richard L. Dolsky, MD, 2004-
Jack Egnatinsky, MD, 2000-
Richard D. Gentile, MD, 2006-
Steven A. Gunderson, DO, 2002-
Susan M. Hughes, MD, 2004-
Girish P. Joshi, MD, 2006-
Lawrence S. Kim, MD, 2004-
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Ross Levy, MD, 2012-
W. Elwyn Lyles, MD, FACG, 2011-
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Beverly K. Philip, MD, 2000-
Jerome R. Potozkin, MD, 2009-
Kenneth M. Sadler, DDS, MPA, FACD, 2005-
James Schall, DDS, 2011-
Edwin W. Slade, DMD, JD, 2004-
Margaret E. Spear, MD, 2006-
Scott Tenner, M.D., FACG, M.P.H., 2007-
Arnaldo Valedon, MD, 2010-
Mary Ann Vann, MD, 2008-
Christopher J. Vesy, MD, 2011-
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Timothy Peterson, MD
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William H. Beeson, MD, 1999-2001
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Bernard A. Kershner, 1995-1997
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Frank J. Newman, MD, 1991-1993
Carl J. Battaglia, MD, 1989-1991
Nicholas D. Wing, MD, 1987-1989
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Gerald G. Edds, MD, 2001-2003
C. William Hanke, MD, 1999-2001
William H. Beeson, MD, 1997-1999
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Sam J.W. Romeo, MD, MBA, 1991-1993
Frank J. Newman, MD, 1989-1991
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Barry W. Averill, 1983-1985
John R. Johnson, 1981-1983
William E. Costello, 1979-1981

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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

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Christopher A. Damon, 1990-1997
Ronald S. Moen, Sr., 1979-1990

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Rodney C. Armstead, MD, 1992-1994
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William E. Costello, 1979-1981
Boyden L. Crouch, MD, 1983-1985
Thomas Curtin, MD, 1995-1996
Beth S. Derby, 1994-2002
Francis P. DiPlacido, DMD, 1992-2008
Gerald G. Edds, MD, 1996-2006
Scott Endsley, MD, MSc, 2003-2005
Thomas H. Faerber, MD, DDS, 1999-2003
Robert Fenzl, MD, 1991-1999
Alan P. Feren, MD, 1983-1986
Robert F. Fike, MD, 1987-1994
Forrest Flint, 1990-1993
William W. Funderburk, MD, 1983-1987
Louis S. Garcia, 1979-1980
John S. Gilson, MD, 1979-1980
Stanley R. Gold, MD, 1985-1989
Roy C. Grekin, MD, 1993-2011
Thomas E. Gretter, MD, 1987-1990
Raymond E. Grundman, 1998-2010
C. William Hanke, MD, 1993-2004
Raafat S. Hannallah, MD, 2000-2008
Dudley H. Harris, MD, 1988-1995
Theodore R. Hatfield, MD, 1989-1990
Paul J.M. Healey, MD, 1979-1983
Ronald A. Hellstern, 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, 1995-1996
Scott H. Kirk, MD, 1999-2006
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. Menaker, MD, 2004-2012
James W. Merritt, MD, 1984-1987
John W. Montgomery, 1981-1984
Frank J. Newman, MD, 1986-1995
Irvin O. Overton, 1980-1982
Michael H. Owens, MD, 1986-1992
Louie L. Patseavouras, MD, 1989-2002
Wallace A. Reed, MD, 1979-1984
Clifford B. Reifler, MD, MPH, 1981-1982
Jack Richman, MD, 1990-1994
Bruce N. Rogers, DDS, MBA, 1993-2011
Sam J.W. Romeo, MD, MBA, 1989-2004
John F. Rose, Jr., MD, 1979-1983
Conrad Rosenberg, MD, 1979-1981
Leonard Rubin, MD, 1979-1984
Michael A. Safdi, MD, MPA, FACD, MACG, 2005-2010
Stanley E. Salzman, 1986-1989
Samuel O. Sapin, MD, 1979-1981
Blane Schilling, MD, 1999-2003
Dennis Schultz, MD, 1994-2003
Benjamin S. Snyder, 1987-2006
J. Craig Strafford, MD, 2003-2006
Ronald W. Strahan, MD, 1989-1999
Christopher Strayhorn, MD, 1995-2000
Lance A. Talmage, MD, 2000-2003
Nancy Eve Thomas, MD, 2007-2008
Howard A. Tobin, MD, 1984-1996
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, 2000-2006/2007-2009
George W. Whiteside, 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 accreditable organization maintains an active, integrated, organized, ongoing, data-driven program of quality management and improvement that links peer review (Chapter 5.I), quality improvement programs (Chapter 5.II), and risk management (Chapter 5.III) in an organized, systematic way. CMS

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 I: Peer Review

An accreditable 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. ☐	☐
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. ☐	☐
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. ☐	☐

	YES	NO
4. Does your organization provide ongoing monitoring of important aspects of the care provided by its health care professionals? (Monitoring of important aspects of care, when it includes comparing group (or aggregate) performance to individual performance, is internal benchmarking.) If no, (a) identify the aspects to be monitored (for example: compliance rate for screening for chronic illness, or compliance with a pre-surgical antibiotic administration policy) and (b) describe the individual and group monitoring process(es) to be created and implemented.	4. ☐	☐
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.	5. ☐	☐
6. Does your organization collect data related to established criteria (see #5 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.	6. ☐	☐

	YES	NO
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.	7. ☐	☐
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.II and in Standard 5.I.G? If no, describe the plan to ensure compliance.	8. ☐	☐
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.	9. ☐	☐
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.	10. ☐	☐

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.

Chapter 5, Subchapter II.A: 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.

	YES	NO
1. Does your organization have, and has it implemented, a written description 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 to any of these questions, describe the actions or steps planned to achieve compliance with Standard 5.II.A-1. _____	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.II.A-2. _____	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. _____	3. ☐	☐
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. _____	4. ☐	☐

	YES	NO
5. Does the QI program include process(es) to identify opportunities for improving the quality of service provided by your organization? If no, describe the process(es) to be planned and implemented. CMS	5. ☐	☐
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.II.A-6. CMS	6. ☐	☐
7. Does your organization's QI program define the linkages between peer review, quality improvement activities, and the risk management program? If no, identify the missing linkages and describe the plan to become compliant with Standard 5.II.A-7.	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.II.A-8.	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.II.A.9.	9. ☐	☐

Chapter 5, Subchapter II.B: Quality Improvement Studies

An accreditable organization conducts specific quality improvement studies that support the goals of the overall QI program.

The first task is to identify a topic for study. Some sample topics, and/or sources of information about potential topics, are listed below. Note that this 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 in a given organization at a given point 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, malpractice cases, lack of follow-up on abnormal test results, radiology film retakes, medication errors, specific misdiagnoses, near misses, etc.
2. The clinical performance and practice patterns of health care professionals
3. Variances from expected performance identified through clinical record review of the quality of care, completeness of entries, and/or maintaining clinical record policies
4. Variances from expected results identified by quality control processes, diagnostic imaging, pathology, medical laboratory, and pharmaceutical services
5. Other professional, technical, and ancillary services provided
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. Medical/legal issues
11. Wasteful practices
12. Overutilization or underutilization of services
13. Provision by the organization of prevention, screening, evaluation, treatment, or management of prevalent diseases, 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 established health care goals
16. Short- or long-range planning goals

The following template is designed to help you think through the process of conducting and documenting a study in your organization. Feel free to photocopy pages 154 to 158 for use with multiple studies.

AAAHC Standard	What the Standard requires	Hints for getting started
5.II.B-1.	A statement of the purpose of the QI activity that includes a description of the known or suspected problem, and explains why it is significant to the organization	1. Briefly state your known or suspected problem. 2. Describe why it is important for your organization to address this problem.

Use the space below to state the purpose of the QI study you are conducting, and to describe why it is important for your organization to address this problem:

AAAHC Standard	What the Standard requires	Hints for getting started
5.II.B-2. CMS	Identification of the *performance goal* against which the organization will compare its *current performance* in the area of study	Determine and describe the level of performance your organization wants to achieve in the area of study. For example, if you are studying medication error rates, your goal might be to have zero medication errors. If you are studying rates of compliance with a particular policy, your goal might be to have 100% compliance. Before setting your goal, it is often useful to determine if there are internal or external benchmarks available to help you decide on a goal that is both realistic and constructive. Zero occurrences or 100% compliance may or may not be realistic for every issue you study.

Use the space below to identify the performance goal for the QI study you are conducting:

AAAHC Standard	What the Standard requires	Hints for getting started
5.II.B-3.	Description of the data that will be collected in order to determine the organization's current performance in the area of study	Determine the following: 1. What data are needed in order to verify: • Whether the problem actually exists (if this is uncertain) • The frequency and severity of the problem expressed as a number or percentage • The source(s) of the problem 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 QI study you are conducting, and how you will collect it:

AAAHC Standard	What the Standard requires	Hints for getting started
5.II.B-4.	Evidence of data collection	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 F? What did you look at in those charts? What information did you extract from them? 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 QI STUDY, use the space below to briefly describe the data collected.

AAAHC Standard	What the Standard requires	Hints for getting started
5.II.B-5.	Data analysis that describes findings about the frequency, severity, and source(s) of the problem(s).	1. Carefully analyze the data you have collected. (The complexity of the analysis you need to do will depend on various factors, such as the amount and type of data you have collected.) 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. 3. If the problem DOES exist, determine what the data tell you about the frequency, severity, and source(s) of the problem(s), and proceed to 5.II.B-6. 4. If the problem DOES NOT exist, proceed as described in 5.II.B-10. then choose another known or suspected problem and begin again at 5.II.B-1.

Use the space below to briefly record your findings for the QI study you are conducting:

AAAHC Standard	What the Standard requires	Hints for getting started
5.II.B-6.	A comparison of the organization's current performance in the area of study against the previously identified performance goal.	Compare the results of your data analysis to the performance goal you identified in Standard 5.II.B-2. For example, if the data indicate that you currently have 65% compliance and the goal is 90% compliance, a simple statement to that effect is sufficient.

Use the space below to briefly state your comparison of current performance vs. goal for the QI study you are conducting:

AAAHC Standard	What the Standard requires	Hints for getting started
5.II.B-7. CMS	Implementation of corrective action(s) to resolve identified problem(s)	1. Based on what you have learned about the frequency, severity, and source(s) of the problem(s), determine what corrective action(s) you will take to improve your performance in the area of study. 2. Implement the selected corrective action(s) and determine the appropriate length of time until re-measurement is to occur.

Use the space below to describe what corrective action(s) were taken for the QI study you are conducting, including how the corrective actions were implemented:

AAAHC Standard	What the Standard requires	Hints for getting started
5.II.B-8. CMS	Re-measurement (a second round of data collection and analysis as described in 5.II.B-4 to B-6) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement	1. At the designated re-measurement time, repeat the steps shown for Standards 5.II.B-4 and 5.II.B-5. 2. Compare the results of your second round of data collection and analysis to the performance goal you identified in Standard 5.II.B-2, and determine whether the corrective actions have achieved the desired performance goal.

Use the space below to describe the second round of data collected and how you collected it. Also state your comparison of the new current performance vs. goal for the QI study you are conducting:

AAAHC Standard	What the Standard requires	Hints for getting started
5.II.B-9. CMS	If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued re-measurement until the problem is resolved	1. Determine whether this step is applicable to the study you are conducting. If you have met and are sustaining your performance goal, this step does not apply. 2. If this step does apply, repeat the steps shown for Standards 5.II.B-7 to 5.II.B-8 until your performance goal has been achieved in a sustainable manner.

Use the space below to indicate whether this step applies to the QI study you are conducting. If it applies, describe what additional corrective action(s) were taken for the QI study you are conducting, including how the corrective actions were implemented. Also describe the additional round of data collected and how you collected it, and state your comparison of the new current performance vs. goal for the QI study you are conducting:

AAAHC Standard	What the Standard requires	Hints for getting started
5.II.B-10.	Communication of the findings of the quality improvement activities to the governing body and throughout the organization, as appropriate, and incorporation of such findings into the organization's educational activities ("closing the QI loop")	1. Report your QI study and its results to your governing body. ***Ensure that the governing body's review of the report is appropriately documented.*** 2. Determine who else in the organization needs to know about the results of the study. Communicate the findings to those people, ***and document that this has occurred.*** 3. Determine whether other educational activities of the organization should reflect the findings of the study. If so, take appropriate steps to have this occur.

Use the space below to describe how the results of the study will be reviewed by the governing body, and how this review will be documented. Also describe other groups and educational activities that will be notified of the study's results, and how this notification will occur.

Chapter 5, Subchapter II.C. Including External Benchmarking in Your Quality Improvement Program

An accreditable organization must participate in external performance measurement activities as part of its overall quality improvement program. The following questions may be used to evaluate and identify elements of an organization's current quality improvement approach that are less than compliant with AAAHC Standards for external benchmarking. CMS

	YES	NO
1. Does your organization's QI program include external performance benchmarking activities, and does this benchmarking compare internal key performance measures with (a) similar external organizations, or (b) recognized best practice measures of national or professional scope? If no, continue with the elements shown below to identify the specific steps necessary to bring your organization into compliance with the individual elements of Standards 5.II.C-1 through 3.	1. ☐	☐
2. The accredited organization's benchmarking activities include, but are not limited to, the following elements.		
a. A performance measure is a clearly defined statement or question describing information to be collected for purposes of improving processes and outcomes of care. Does your organization use selected performance measures to improve the processes or outcomes of care relevant to the patients served? CMS If no, identify the performance measures pertinent to your organization's processes and outcomes of care that you will begin to use. _____ _____ _____	2a. ☐	☐
b. Once performance measures are in place, data related to the measures is systemically collected and analyzed. Identify the data to be collected for your performance measures and the process or procedures for its collection and analysis. _____ _____ _____ _____	2b. ☐	☐
c. Both the data and its source(s) should be valid and reliable. What steps will you take to ensure the reliability and validity of the data you collect? _____ _____ _____ _____	2c. ☐	☐

		YES	NO
d.	Organizations should monitor their performance measures on a regular basis in order to identify any changes in performance. If your organization does not monitor for and measure such changes, identify the plan to accomplish this.	2d. ☐	☐
e.	The results of benchmarking activities provide a means for assessing whether or not your organization has achieved and is sustaining its performance improvements. If your organization is not using its benchmarking data for this purpose, describe the plan for doing so in the future.	2e. ☐	☐
f.	Benchmarking may be based on local, state, or national standards. If your organization's benchmarking is not based on local, state, or national standards, describe the plan for doing so in the future.	2f. ☐	☐
3.	Are the results of benchmarking activities incorporated into other quality improvement activities of your organization? CMS If no, describe the plans to incorporate benchmarking into other QI activities.	3. ☐	☐
4.	Are results of benchmarking activities reported to your organization's governing body and throughout the organization, as appropriate? If no, describe the plan needed to report these results to the governing body and to others, as appropriate.	4. ☐	☐

Subchapter III: Risk Management

An accreditable organization must develop and maintain a program of risk management, appropriate to the organization, and designed to protect the life and welfare of an organization's patients and employees. The following questions are designed to assist the organization in assessing its risk management program for overall appropriateness and effectiveness.

	YES	NO
1. Is the governing body of your organization responsible for overseeing the risk management program? If no, describe the plan to ensure that the governing body provides oversight to the risk management program. _____	1. ☐	☐
2. Is a designated person or committee responsible for the risk management program? If no person or committee currently has responsibility for the risk management program, describe the plan to bring your organization into compliance with this Standard. _____	2. ☐	☐
3. Has your organization developed and implemented a risk management program to address the following important issues? CMS		
a. Safety of patients.	3a. ☐	☐
b. Consistent application of the risk management program throughout the organization, including all departments and all service locations.	3b. ☐	☐
c. Methods by which a patient may be dismissed from care or refused care.	3c. ☐	☐
d. Review and analysis of all adverse incidents unexpected for the clinical setting which may include, but not be limited to, actual and potential infection control occurrences and breaches, surgical site infections, and other health care associated infections, involving or reported by employees, patients, health care professionals, and others.	3d. ☐	☐
e. Periodic review of all litigation involving the organization and its staff and health care professionals.	3e. ☐	☐
f. Review of all deaths, trauma, or other adverse incidents as defined in Standard 2.I.B-21, including reactions to drugs and materials.	3f. ☐	☐
g. Review of patient complaints.	3g. ☐	☐
h. Communication with the professional liability insurance carrier.	3h. ☐	☐

		YES	NO
i.	Managing a situation in which a health care professional becomes incapacitated during a medical or surgical procedure.	3i. ☐	☐
j.	Impaired health care professionals.	3j. ☐	☐
k.	Establishment and documentation of coverage after normal working hours.	3k. ☐	☐
l.	Methods for prevention of unauthorized prescribing.	3l. ☐	☐
m.	Active surveillance of processes and techniques for detection and prevention of disease, infection, and potential communicable infective sources.	3m. ☐	☐
n.	Development and recommendation of infection control policies and procedures as appropriate to the organization and to meet all applicable state and federal requirements.	3n. ☐	☐
o.	Direct intervention to prevent infection as needed.	3o. ☐	☐
p.	Processes to identify and involve the patient in surgical site designation.	3p. ☐	☐

If no, describe the plans to ensure compliance with each item listed in #3 above.

4. Only persons authorized by the governing body to perform or assist in the procedure are allowed in patient care areas. Exceptions are addressed in an organization's policies. Does your organization have a policy regarding observers in patient care areas? If no, describe your plan to become compliant. 4. ☐ ☐

	YES	NO
5. Does your organization have a written policy that addresses (a) all others allowed in patient care areas that are not authorized staff, and (b) evidence of patient consent? If no, describe your plan to become compliant with this Standard.	5. ☐	☐
6. Does the organization require a periodic review of clinical records and clinical record policies? If no, describe your plan to become compliant with this Standard.	6. ☐	☐
7. Does the organization provide education in risk management activities, including infection control and safety policies and processes, to all staff within thirty (30) days of commencement of employment, annually thereafter, and when there is an identified need? CMS If no, describe your plan to become compliant.	7. ☐	☐

Organizations are expected to develop an application document appropriate to its operations and services. This is a sample document for reference only and is not available in template format.

Sample Application for Privileges

(Organization Name)

(Street Address)

(City, State and ZIP Code)

Instructions:

1. **Information must be typed or printed.**
2. **All questions must be answered and forms must be signed where indicated. Please initial the bottom of each page of this application.**
3. **If more space is needed, please attach additional sheets and reference the questions being answered.**
4. **If there is a break in the continuity of your medical education, internship, residency, hospital affiliations, medical practice, etc., please explain.**
5. **Please return the following with your application:**
   a. Curriculum vitae
   b. Copy of your current state license
   c. Current IRS W-9s, if applicable
   d. Copy of narcotic registration (federal/state) (DEA and CDS)
   e. Request for Privileges (completed and signed)
   f. Copy of front sheet of professional liability insurance policy including applicant's name, effective date, expiration date, and policy limits
   g. Copy of Board Certification (if applicable)
   h. Copy of professional school/diploma, residency certificates, and Fellowship certificates
   i. Copy of hepatitis-B vaccination or waiver
   j. Copy of most recent tuberculosis PPD test, if applicable
   k. Current CLIA certificate, if applicable

Identifying Information

Last Name (Jr., Sr., etc.) First Name Middle S. S. #

List other names by which you have been known: Last Name First Name Middle

Primary Professional Group Name and Address Years Associated (YYYY-YYYY)

City State ZIP

Telephone Number Fax Number E-mail

Home Address Home Telephone Number

City State ZIP

Alternate Telephone Number

Date of Birth Place of Birth Citizenship

Physician Providing Coverage Telephone Number Fax Number E-mail Cell Phone

Medicare Unique Provider ID Number NPI Number Medicaid Number

Medical Licensure/Certification

State License Number Original Date of Issue (mm/dd/yyyy) Expires (mm/dd/yyyy)

Controlled Substances Registration Certification Number (Your State Name) Expires (mm/dd/yyyy)

DEA Registration Number Expires (mm/dd/yyyy)

Applicant Initials _____ Date _____

(Organization Name)

(Street Address)

(City, State, and ZIP Code)

Other State Medical Licenses — Past and Present:

State License Number | Original Date of issue (mm/dd/yyyy) | State License Number | Original Date of Issue (mm/dd/yyyy)

Do you currently practice in this state? Yes No | Explain:

Pre-Medical Education

College/University | Degrees/Honors

Address | Date of Graduation (mm/dd/yyyy)

City | State | ZIP

Medical Education

Medical/Professional School | Degree/Honors

Address | Date of Graduation (mm/dd/yyyy)

City | State | ZIP

Other Professional Education

Name of Institution | Degree/Honors

Address | Date of Graduation (mm/dd/yyyy)

City | State | ZIP

Internship

Name of Institution | Dates Attended (mm/dd/yyyy-mm/dd/yyyy)

Address | Full Name of Program Director or Department Chair

Type | Kind (Medical, Surgical, etc.)

Program successfully completed? If no, attach an explanation..... ☐ Yes ☐ No

☐ Rotating ☐ Straight If straight, list specialty: _____

Were you the subject of any disciplinary actions during your attendance at this institution? If yes, attach an explanation..... ☐ Yes ☐ No

☐ If more than one internship, check here and attach additional information including responses to the above items specific to the additional internships.

Applicant Initials _____ Date _____

____
(Organization Name)

____
(Street Address)

____
(City, State, and ZIP Code)

Residency Programs

Name of Institution ____________________ Dates Attended (mm/dd/yyyy-mm/dd/yyyy) ____________________

Address ____________________

City ____________________ State ________ ZIP ________

Type of Residency ____________________ Full Name of Program Director or Department Chair ____________________

Program successfully completed? If no, attach an explanation. .... ☐Yes ☐ No

Name of Institution ____________________ Dates Attended (mm/dd/yyyy-mm/dd/yyyy) ____________________

City ____________________ State ________ ZIP ________

Type of Residency ____________________ Full Name of Program Director or Department Chair ____________________

Program successfully completed? If no, attach an explanation. .... ☐Yes ☐ No

Training, Fellowships, Preceptorships, Postgraduate Education

List in chronological order. Give complete school or hospital name and address, including ZIP code, beginning and ending dates, and name of your immediate superior.

Name of Institution ________ Address ________ City ________ State ________ ZIP ________

Dates Attended (mm/dd/yyyy-mm/dd/yyyy) ________ Name of Immediate Superior ________ Type of Fellowship ________

Did you successfully complete this program? If no, please attach an explanation.......... ☐ Yes ☐ No

Were you the subject of any disciplinary actions during your attendance at this institution? If yes, attach an explanation. .... ☐ Yes ☐ No

Name of Institution ________ Address ________ City ________ State ________ ZIP ________

Dates Attended (mm/dd/yyyy-mm/dd/yyyy) ________ Name of Immediate Superior ________ Type of Fellowship ________

Did you successfully complete this program? If no, please attach an explanation.......... ☐ Yes ☐ No

Were you the subject of any disciplinary actions during your attendance at this institution? If yes, attach an explanation. .... ☐ Yes ☐ No

Name of Institution ________ Address ________ City ________ State ________ ZIP ________

Dates Attended (mm/dd/yyyy-mm/dd/yyyy) ________ Name of Immediate Superior ________ Type of Fellowship ________

Did you successfully complete this program? If no, please attach an explanation.......... ☐ Yes ☐ No

Were you the subject of any disciplinary actions during your attendance at this institution? If yes, attach an explanation. .... ☐ Yes ☐ No

Applicant Initials ________ Date ________

(Organization Name)

(Street Address)

(City, State, and ZIP Code)

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.

Name of Institution (1) | Address | City | State | ZIP

Dates Affiliated (mm/dd/yyyy-mm/dd/yyyy) | Membership status (Active, Courtesy, Consulting, Adjunct, Suspended/Terminated/Resigned, Active Professional Staff, Senior Staff, Associate, Provisional, Affiliate, Pending, Other [specify])

Department/Division | Dept. Chief/Chair (Full Name)

Do you currently have privileges at this institution? ☐ Yes ☐ No

If yes, please list the type of privileges granted (Provisional, Limited, Conditional, etc.). _____

Name of Institution (2) | Address | City | State | ZIP

Dates Affiliated (mm/dd/yyyy-mm/dd/yyyy) | Membership status (Active, Courtesy, Consulting, Adjunct, Suspended/Terminated/Resigned, Active Professional Staff, Senior Staff, Associate, Provisional, Affiliate, Pending, Other [specify])

Department/Division | Dept. Chief/Chair (Full Name)

Do you currently have privileges at this institution? ☐ Yes ☐ No

If yes, please list the type of privileges granted (Provisional, Limited, Conditional, etc.). _____

Name of Institution (3) | Address | City | State | ZIP

Dates Affiliated (mm/dd/yyyy-mm/dd/yyyy) | Membership status (Active, Courtesy, Consulting, Adjunct, Suspended/Terminated/Resigned, Active Professional Staff, Senior Staff, Associate, Provisional, Affiliate, Pending, Other [specify])

Department/Division | Dept. Chief/Chair (Full Name)

Do you currently have privileges at this institution? ☐ Yes ☐ No

If yes, please list the type of privileges granted (Provisional, Limited, Conditional, etc.). _____

Name of Institution (4) | Address | City | State | ZIP

Dates Affiliated (mm/dd/yyyy-mm/dd/yyyy) | Membership status (Active, Courtesy, Consulting, Adjunct, Suspended/Terminated/Resigned, Active Professional Staff, Senior Staff, Associate, Provisional, Affiliate, Pending, Other [specify])

Department/Division | Dept. Chief/Chair (Full Name)

Do you currently have privileges at this institution? ☐ Yes ☐ No

If yes, please list the type of privileges granted (Provisional, Limited, Conditional, etc.). _____

Applicant Initials _____ Date _____

(Organization Name)

(Street Address)

(City, State, and ZIP Code)

Previous Group/Medical Practice

Type of Organization	Name of Organization	Address	
City	State	ZIP	Dates Practicing (mm/dd/yyyy-mm/dd/yyyy)
Type of Organization	Name of Organization	Address	
City	State	ZIP	Dates Practicing (mm/dd/yyyy-mm/dd/yyyy)
Type of Organization	Name of Organization	Address	
City	State	ZIP	Dates Practicing (mm/dd/yyyy-mm/dd/yyyy)

Certification

Certified by American Board of (Specialty)	Certification #	Dates (Certification/Recertification/Expiration) (mm/dd/yyyy)
Subspecialty Board Status (Name of Board)	Certification #	Dates (Certification/Recertification/Expiration) (mm/dd/yyyy)
If Not Certified, Give Present Status	Date	Date of Exam

Professional Societies, Awarded Fellowships (ACS, ACP, etc.)

List all memberships past, present, or pending in professional societies. Please include dates of membership. Please give complete names and addresses, including ZIP codes in all instances. Attach an additional sheet if necessary.

Applicant Initials _____ Date _____

(Organization Name)

(Street Address)

(City, State, and ZIP Code)

Professional Peer References

List three professional references familiar with the applicant's qualifications during the three years immediately preceding this application. One professional reference must be from the Chief of the department or service where the applicant last furnished professional services.

Last Name (1)	First	Middle	Degree	Title	Professional Relationship	Specialty	Years Known
Address				City		State	ZIP
Phone		Fax			E-mail		
Last Name (2)	First	Middle	Degree	Title	Professional Relationship	Specialty	Years Known
Address				City		State	ZIP
Phone		Fax			E-mail		
Last Name (3)	First	Middle	Degree	Title	Professional Relationship	Specialty	Years Known
Address				City		State	ZIP
Phone		Fax			E-mail		

Professional Liability

Insurance Carrier	Address	City	State	ZIP
Policy limits	Per Occurrence ($)	Aggregate ($)		
Policy #	Agent	Effective Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)	

Type of coverage: ☐ Claims made ☐ Occurrence

Have any professional liability lawsuits been filed against you during the past ten years (including those closed)? ☐ Yes ☐ No

Are there any now still pending? ☐ Yes ☐ No

Has any judgment, payment of claim, or settlement ever been made against you in any professional liability cases? ☐ Yes ☐ No

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage? ☐ Yes ☐ No

Have you ever been denied professional insurance, or has your policy ever been cancelled? ☐ Yes ☐ No

If yes to any of the above, please explain on a separate sheet.

Applicant Initials _____ Date _____

(Organization Name)

(Street Address)

(City, State, and ZIP Code)

Professional Sanctions

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled, and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? ☐ Yes ☐ No
2. Have you ever been reprimanded and/or fined, been the subject of a complaint, and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil, or disciplinary action by any state or federal agency that licenses providers? ☐ Yes ☐ No
3. Have you lost any board certification(s), and/or failed to rectify? ☐ Yes ☐ No
4. Have you been examined by a Capital Certifying Board but failed to pass? ☐ Yes ☐ No
5. Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and any other practitioner data bank? ☐ Yes ☐ No
6. Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended, or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration? ☐ Yes ☐ No
7. Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation, or non-renewed? ☐ Yes ☐ No
8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? ☐ Yes ☐ No
9. Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license? ☐ Yes ☐ No
10. Have you ever been reprimanded, censured, excluded, suspended, and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS, and/or any other governmental health-related programs? ☐ Yes ☐ No
11. Have Medicare, Medicaid, CHAMPUS, PRO authorities, and/or any other third-party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues? ☐ Yes ☐ No
12. Have you been denied membership and/or been subject to probation, reprimand, sanction, or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g., hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO? ☐ Yes ☐ No
13. Have you withdrawn an application or any portion or an application for appointment or reappointment for clinical privileges or staff appointment or for license or membership in an IPA, PHO, professional group or society, health care entity, or health care plan prior to a final decision to avoid a professional review or an adverse decision? ☐ Yes ☐ No
14. Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country? ☐ Yes ☐ No
15. Have you been the subject of a civil or criminal or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal, or administrative action regarding sexual misconduct, child abuse, domestic violence, or elder abuse? ☐ Yes ☐ No

If yes to any of the above, please explain on a separate sheet.

Health Status

1. Do you have a medical condition, physical defect, or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety? ☐ Yes ☐ No
2. Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation? ☐ Yes ☐ No

If yes to any of the above, please explain on a separate sheet.

Applicant Initials _____ Date _____

(Organization Name)

(Street Address)

(City, State, and ZIP Code)

Chemical Substances or Alcohol Abuse

1. Are you currently engaged in illegal use of any legal or illegal substances? ☐ Yes ☐ No
2. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? ☐ Yes ☐ No

If yes to any of the above, please explain on a separate sheet.

By *applying* for clinical privileges, I hereby signify my willingness to appear for interviews in regard to my application, and I authorize the "Organization," its medical staff, and their representatives to consult with members of management and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice insurance carriers, who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to inspection by the "Organization," its medical staff, and its representatives of all records and documents, including medical and credential records at other hospitals, which may be material to an evaluation of my qualifications for staff membership. I hereby release from liability all representatives of the "Organization" and its medical staff, in their individual and collective capacities, for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the "Organization" or to members of its medical staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges. I hereby consent to the release of information by other hospitals, other medical associations, and other authorized persons, on request, regarding any questions the "Organization" may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability and hold harmless the "Organization" and any other third party for so doing. I understand and agree that I, as an applicant for clinical privileges, have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics, and other qualifications and for the resolution of any doubts about such qualifications.

By *accepting* appointment and/or reappointment to the medical staff at (insert organization name), I hereby acknowledge and represent that I have read and am familiar with the bylaws, rules, and regulations of the "Organization," as well as the principles, standards, and ethics of the national, state, and local associations and state law and regulations that apply to and govern my specialty and/or profession, which are the "Governing Standards." I further agree to abide by such further Governing Standards as may be enacted from time to time.

In addition, I agree to notify the "Organization" of any circumstances that would change my status in licensure, DEA, Medicare participation, liability insurance coverage, board certification status, or hospital privileges.

I understand and agree that any significant misstatements in or omissions from this application shall constitute cause for denial of appointment or cause for summary dismissal from the medical staff with no right of appeal. All information submitted by me in this application is true to the best of my knowledge and belief.

I further authorize a photocopy or facsimile of the requests, authorizations, and releases to this application to serve as the original.

Signature of Applicant Date

Print Name

_____
(Organization Name)

_____
(Street Address)

_____
(City, State, and ZIP Code)

RE: _____
(Applicant Name, Title)

Temporary Privileges

☐ Appointment recommended to the category of _____ staff with the following clinical privileges:

☐ As requested ☐ As requested with the following changes:

_____

_____

_____

☐ Appointment not recommended

_____
Executive Director

_____
Date

_____
Medical Director

Medical Executive Committee

☐ Appointment recommended to the category of _____ staff with the following clinical privileges:

☐ As requested ☐ As requested with the following changes:

_____

_____

_____

☐ Appointment not recommended

_____
Date

_____
Medical Executive Committee Member

Board of Directors

☐ Appointment recommended to the category of _____ staff with the following clinical privileges:

☐ As requested ☐ As requested with the following changes:

_____

_____

_____

☐ Appointment not recommended

_____
Date

_____
Board of Directors Member

(Organization Name)

(Street Address)

(City, State, and ZIP Code)

RE: (Applicant Name, Title)

Dear Sir or Madam:

The above practitioner has applied for medical staff appointment (or clinical privileges) to the staff of (Organization Name). The applicant has given your name as a reference, and we are asking you to render an opinion in the following categories. This is an important part of the evaluation of this practitioner's application for clinical staff privileges. Your response will be treated as confidential.

Please do not hesitate to call us if you feel your comments could be best expressed directly.

	Reliable	Usually Reliable	Problems
Clinical knowledge	☐	☐	☐
Clinical judgment	☐	☐	☐
Technical proficiency	☐	☐	☐
Professional relations with patients	☐	☐	☐
Ethical conduct	☐	☐	☐
Record keeping	☐	☐	☐
Ability to understand and speak English	☐	☐	☐
Participation in medical staff affairs	☐	☐	☐

What is your opinion regarding the applicant's competency in performing the privileges shown on the attachment?

Additional comments:

Recommendation:

Signature Title Date

Name (Please print)

_____
(Organization Name)

_____
(Street Address)

_____
(City, State, and ZIP Code)

Medical Staff Office

Regarding the appointment of: _____
(Applicant Name, Title)

Dear Sir or Madam:

The applicant named above is seeking medical staff privileges at our organization. We would appreciate answers to the questions found below.

This physician's current staff status: _____

QUESTIONS	Yes	No	Do Not Know
Have this practitioner's privileges been restricted, suspended, revoked, or surrendered?	☐	☐	☐
Has this practitioner's professional performance been within or above the acceptable standard of care within the last two years?	☐	☐	☐
Has the practitioner's morbidity rate, mortality rate, infection rate, or complication rate exceeded your organization's criteria for the standards of practice?	☐	☐	☐
Has the practitioner been suspended for clinical records violations within the last two years? If yes, how many times? _____	☐	☐	☐
Has this practitioner's behavior been disruptive to patient care?	☐	☐	☐
Have there been written complaints about this practitioner by patients, hospital staff, or members of the medical staff?	☐	☐	☐
Has the practitioner been subjected to any disciplinary action by this hospital or licensing body during the past two years?	☐	☐	☐
To the best of your knowledge, has this individual been involved in a malpractice claim or action during the past two years? If yes, please provide us with the information regarding the malpractice claim or action during the past two years.	☐	☐	☐
At the appropriate time, will you likely re-appoint this individual to your medical staff?	☐	☐	☐

Thank you for your effort and assistance with this request.

_____
Signature Title Date

_____
Name (Please print)

Credentialing Records Worksheet

Instructions:

Mark each box as:

Adequate – **A**
Inadequate – **I**
Not Applicable – **N/A**

Related 2012 Standard(s)	*Please indicate the license type for each individual (e.g., MD, RN, RT) as part of the file identifier. >*	File Identifier									
2.II.B-3; 2.II.B-3gx	File contains a complete, signed application, including liability release and attestation.										
2.II.B-3a; 4	Education was verified.										
2.II.B-3a; 4	Training or other pertinent experience was verified.										
2.II.B-3b	Current competence was verified.										
2.II.B-3c; 2.II.B-6; 5.I.I	State medical license and, if applicable, board certification (or non-physician license, certification or registration) is verified, monitored, and documented on an ongoing basis.										
2.II.B-3a; 2.II.D CMS	Privileges granted are consistent with practitioner's license and experience, and with the services provided by the organization.										
2.II.B-3d; 2.II.B-6; B-5;	Proof of DEA registration is verified, monitored, and documented on an ongoing basis.										
2.II.B-3e; 2.II.B-6	File contains proof of current medical liability coverage meeting governing body requirements.										
2.II.B-3f; B-5	File contains information obtained from the NPDB.										
2.II.B-3g	File contains evidence that the credentialing process required submission of other pertinent information as required by 2.II.B-3g and, if such information was submitted, it is in the file:										
2.II.B-3gi	Professional liability claims history.										
2.II.B-3gii	Information on licensure revocation, suspension, voluntary relinquishment, licensure probationary status, or other licensure conditions or limitations.										
2.II.B-3giii	Complaints or adverse action reports filed against the applicant with a local, state, or national professional society or licensure board.										
2.II.B-3giv	Refusal or cancellation of professional liability coverage.										
2.II.B-3gv	Denial, suspension, limitation, termination, or non-renewal of professional privileges at any hospital, health plan, medical group, or other health care entity.										
2.II.B-3gvi	DEA and state license action.										
2.II.B-3gvii	Disclosure of any Medicare/Medicaid sanctions.										
2.II.B-3gviii	Conviction of a criminal offense (other than minor traffic violations).										
2.II.B-3gix	Current physical, mental health, or chemical dependency problems that would interfere with an applicant's ability to provide high-quality patient care and professional services.										
2.II.B-4	Credentials were verified according to procedures established in the organization's bylaws, rules and regulations, or policies. Primary or secondary source verification was performed.										
2.II.B-2, 5	The credentialing process was completed in a timely manner and in accordance with the organization's policies and procedures.										

Continued on the next page

Related 2012 Standard(s)	*Please indicate the license type for each individual (e.g., MD, RN, RT) as part of the file identifier.* >	File Identifier									
2.II.B-2, 5	File reflects medical staff reappointment every three years, or more frequently if specified by state law or organization policy.										
5.I.H-1, 2	File contains up-to-date records of CE courses/hours (if required by the organization and/or state).										
2.II.D, CMS 10.II.B-1	File contains a list of specific procedures and devices for which privileges have been requested and granted by the organization for a specified period of time with evidence of recommendations from qualified medical personnel.										
2.II.G	Organization has an appointment/reappointment process for allied health care professionals.										
2.II.B-7; 5.I.B	If a solo medical or dental practice, the provider's credential file is reviewed by an outside physician (for a medical practice) or an outside dentist (for a dental practice).										
The following items must be reviewed during AAAHC/Medicare deemed status surveys:											
2.II.C-MS [CfC 416.45(b)]	Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate.										
2.II.G-MS [CfC 416.45(c)]	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.										

Record file identifier and comments below.

File Identifier	Comments

Clinical Records Worksheet

Instructions:

Mark each box as:

Adequate – **A**
Inadequate – **I**
Not Applicable – **N/A**

Related 2012 Standard(s)		File Identifier									
4.E-3 CMS	The diagnosis is appropriate for the findings in the current history and physical examination.										
4.E-4	The record reflects a current review and update at each visit of all individual patient medications, including over-the-counter products and dietary supplements when information is available to provider.										
4.E-5, 7	Treatment, diagnostic, and therapeutic procedures are consistent with clinical impression or working diagnosis.										
4.E-6, 8, 9 CMS	The record documents appropriate and timely consultation and follow-up of referrals, tests, and findings.										
6.B CMS	The record includes appropriate patient identifiers including, at least: name, identification number (if appropriate), date of birth, gender, and responsible party (if applicable).										
6.D CMS	Clinical record entries are legible and easily accessible within the record by the organization's personnel.										
6.H	Content and format of the record are uniform and consistent with the organization's clinical records policies.										
6.I CMS	Reports, histories and physicals, progress notes, and other patient information (such as laboratory reports, x-ray readings, operative reports, and consultations) were reviewed and incorporated into the record in a timely manner.										
6.J	For records with multiple visits/admissions OR complex and lengthy records, diagnostic summaries are utilized in accordance with organization policies and procedures.										
6.K CMS	The presence or absence of allergies and untoward reactions to drugs or materials is recorded in a prominent and consistent location, verified at each patient encounter, and updated when new allergies or sensitivities are identified.										
6.L	**Entries for patient visits include the following, as applicable:**										
6.L-1	Date (and department, if departmentalized).										
6.L-2	Chief complaint or purpose of visit.										
6.L-3 CMS	Clinical findings.										
6.L-4 CMS	Diagnosis or impression.										
6.L-5 CMS	Studies ordered (e.g., laboratory or x-ray studies).										
6.L-6	Care rendered and therapies administered.										
6.L-7	Changes in prescription and non-prescription medication(s) with name and dosage when available.										
6.L-8	Disposition, recommendations, and instructions given to the patient.										
6.L-9	Authentication and verification of contents by health care professionals.										
6.L-10	Documentation regarding missed and canceled appointments.										
6.L-11	Signature of physician or other author of the clinical record entry.										

Continued on the next page

Related 2012 Standard(s)		File Identifier									
6.M	Significant patient advice given by telephone, online, or provided after hours is entered in the clinical record and appropriately signed or initialed.										
6.N	Any notation in the 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.										
6.O	If applicable, records of patients treated elsewhere or transferred to another health care provider are present.										
6.P CMS; 10.I.G	If applicable, the record reflects 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.										
Review records for the following Standards if the adjunct chapters are applicable to the organization:											
9.E CMS; 10.I.T CMS	Properly executed informed consent(s) was (were) obtained prior to anesthesia administration and pre-operatively. One consent form may be used to satisfy the requirements of these two Standards.										
9.I CMS	The record includes entries related to anesthesia administration.										
10.I.D CMS	An appropriate and current health history with a list of current medications and dosages, physical examination, and pertinent diagnostic studies are present in the record within thirty (30) days or according to local/state requirements prior to the scheduled surgery/procedure.										
10.I.L CMS	With the exception of those tissues exempted by the governing body after medical review, tissues removed during surgery were examined by the pathologist, whose signed report was made a part of the patient's record.										
10.I.M CMS	The findings and techniques of a procedure are accurately and completely documented immediately after the procedure and authenticated by the health care professional who performed the procedure; this description was immediately available for patient care and became a part of the patient's record.										
14.I.E	For dental services, the clinical record includes an appropriate history and physical that is periodically updated and includes an assessment of the hard and soft tissues of the mouth.										
The following items must be reviewed during AAAHC/Medicare deemed status surveys:											
1.F-8-MS (2) [CfC 416.50(a)(2)(iii)]	Is there documentation in a prominent part of the record of whether or not the individual has executed an advance directive?										
6.K-MS [CfC 416.48(a)(1)]	Were adverse reactions reported to the physician responsible for the patient and documented in the record?										
9.D-MS [CfC 416.42(a)(1)]	Is there documentation in the clinical record that a physician examined the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed?										
9.M-MS [CfC 416.42(a)(2)]	Is there documentation in clinical records that each patient was evaluated by a physician or by an anesthetist for proper anesthesia recovery before discharge from the ASC?										
10.I.MS (1) [CfC 416.52(a)(1)]	Was a comprehensive medical history and physical completed by a physician not more than 30 days before date of surgery?										
10.I.D-MS (2) [CfC 416.52(a)(2)]	Is the pre-surgical assessment documented in the clinical record?										
10.I.MS *ASC Definition* [CfC 416.2]	Do clinical records note the patient's admission and discharge time? If duration is greater than 24 hours, is there documentation in the record of why it was reasonable to expect timeframe would not have exceeded 24 hours?										

Continued on the next page

Related 2012 Standard(s)		File Identifier									
10.I.X-MS (1) [CfC 416.52(b)(1)]	Is there documentation of assessment of the patient's post-surgical condition in the clinical record and was it completed by a physician, other qualified practitioner, or a registered nurse with, at a minimum, post-operative care experience?										
10.I.X-MS (2) [CfC 416.52(b)(2)]	Were post-surgical needs addressed and included in the discharge notes?										
10.I.Y-MS (1) [CfC 416.52(c)(1)]	Were written discharge instructions provided to each patient?										
10.I.Y-MS (2) [CfC 416.52(c)(2)]	Is there documentation that each patient has a discharge order, signed by the physician who performed the surgery or procedure?										
11.B-MS (1) [CfC 416.48(a)(2)]	Blood and blood products were administered only by physicians or registered nurses.										
11.B-MS (2) [CfC 416.48(a)(3)]	Orders given orally for drugs and biologicals were followed by a written order and signed by the prescribing physician.										

Record file identifier and comments below.

File Identifier	Comments

Personnel Records Worksheet

Instructions:

Mark each box as:

Adequate – **A**
Inadequate – **I**
Not Applicable – **N/A**

File Identifier

Related 2012 Standard(s)	*Please indicate the license type for each individual (e.g., MD, RN, RT) as part of the file identifier. >*									
3.B	File contains employment-related items as required by the organization's personnel policies (job application, resume, job description, verification of references, results of background check, employee benefit forms, etc.).									
2.I.B-18	File contains evidence of the completion of corporate compliance and HIPAA training.									
2.I.B-17; 3.C, D, E	File contains evidence of participation in annual OSHA in-service training/updates (if applicable).									
2.II.B-6, E, G; 3.B-2	File contains verification of professional license/certification (if applicable) and documentation of ongoing monitoring.									
3.B-2	File contains evidence that the person holds qualifications commensurate with job responsibilities and authority including, if applicable, appropriate licensure or certification.									
3.B-3	File contains documentation of initial orientation within thirty (30) days of hire, and annual/ongoingtraining to familiarize the employee with the organization's policies, procedures, and facilities.									
3.B-4	File contains evidence of periodic performance appraisals including current competence.									
3.B-6	File reflects periodic review of employee compensation.									
3.B-8	File reflects that personnel policies were made known to the employee at the time of employment.									
3.B-9	File contains copies of I-9 (Immigration and Naturalization Form), and visas if applicable (NOTE: Organization may choose to keep I-9 forms separate from personnel files).									
8.F; 9.N; 10.I.J, K CMS	File contains documentation of BLS, ACLS, PALS, ATLS training (if required); PEARS training is not accepted in lieu of PALS training.									
Health care professionals:										
3.D-1b	File contains signed hepatitis-B immunization acceptance/declination (if applicable).									
3.D-2	File contains evidence of employee acceptance/declination of immunizations, based on applicable state and organization policies, if any. Evidence of immunization(s) program and employee acceptance/ declination, based on state and/or organization policy (if applicable).									
3.D, G	File contains documentation of significant workplace exposures, injuries.									
4.A	All health care professionals have the necessary and appropriate training and skills to deliver the services provided by the organization.									
5.III.G, CMS 7.II.C	File contains evidence of education in risk management, infection control and safety policies/processes, provided within first 30 days of employment, annually thereafter, and when there is an identified need.									
7.I.E	File contains evidence of education in sharps injury prevention, provided within first 30 days of employment, annually thereafter, and when there is an identified need.									

Continued on the next page

Related 2012 Standard(s)	*Please indicate the license type for each individual (e.g., MD, RN, RT) as part of the file identifier.* >	File Identifier									
The following items must be reviewed during AAAHC/Medicare deemed status surveys:											
2.II.G-MS [CfC 416.45(c)]	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.										
10.I.H-MS (1) [CfC 416.46]	Are the nursing services of the ASC directed and staffed to ensure that the nursing needs of all patients are met?										
10.I.H-MS (2) [CfC 416.46(a)]	Are patient care responsibilities delineated for all nursing service personnel? Are nursing services provided in accordance with recognized standards of practice? Is there a registered nurse available for emergency treatment whenever there is a patient in the ASC?										

Record file identifier and comments below:

File Identifier	Comments

Resources

Internet Resources

The following are Internet resources that may provide helpful information for ambulatory health organizations. Organizations are also encouraged to seek any available resources from national professional associations, such as the American College Health Association (http://www.acha.org) or the American Congress of Obstetricians & Gynecologists (http://www.acog.org). Use of these resources does not imply compliance with AAAHC accreditation Standards.

Chapter 1

- U.S. Office of Civil Rights (http://www.hhs.gov/ocr/civilrights/index.html)
- Federation of State Medical Boards (http://www.fsmb.org/directory_smb.html)
- American Academy of Family Physicians (http://www.aafp.org)

Chapter 2

- American Academy of Pediatrics (http://www.aap.org)
- Centers for Medicare and Medicaid Services (http://www.cms.gov)
- Occupational Safety and Health Administration, Bloodborne Pathogens and Needlestick Prevention (http://osha.gov/SLTC/bloodbornepathogens/index.html)
- Americans with Disabilities Act (http://www.ada.gov)
- U.S. Office of Civil Rights (http://www.hhs.gov/ocr/privacy/index.html)
- Centers for Medicare and Medicaid Services, Medicare Fraud & Abuse (https://www.cms.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf)
- National Practitioner Data Bank (http://www.npdb-hipdb.hrsa.gov)
- NPDB Proactive Disclosure Service (http://www.npdb-hipdb.hrsa.gov/pds.html)
- American Medical Association Physician Master Profile (http://www.ama-assn.org/amaprofiles)
- Drug Enforcement Agency (http://deanumber.com)
- National Student Clearinghouse (http://www.studentclearinghouse.org/dvev/default.htm)
- National Council of State Boards of Nursing Nursys® (https://www.nursys.com)
- American Osteopathic Information Association (https://www.doprofiles.org)
- American Board of Medical Specialties (http://www.abms.org/Products_and_Publications/Certification_Verification)
- American Board of Podiatric Surgery (http://www.abps.org/content/credentialers/PrimarySourceInfo.aspx)
- American Nurses Credentialing Center (http://www.nursecredentialing.org/Certification/VerifyCertification.aspx)
- American Midwifery Certification Board (http://www.amcbmidwife.org/index.php)
- Educational Commission for Foreign Medical Graduates (http://www.ecfmg.org/cvs/index.html)
- National Commission on Certification of Physician Assistants (https://www.nccpa.net/pa/credentialpublic.aspx)
- Federation of Chiropractic Licensing Boards (http://www.fclb.org)
- American Association of Dental Boards (http://www.dentalboards.org)
- Association of American Medical Colleges (http://www.aamc.org/medicalschools.htm)
- American Association of Colleges of Nursing (http://www.aacn.nche.edu/CCNE/reports/accprog.asp)
- American Association of Colleges of Podiatric Medicine (http://www.aacpm.org/html/collegelinks/cl_schools.asp)
- Federation of State Medical Boards (http://www.fsmb.org/directory_smb.html)
- American Academy of Physician Assistants (http://www.aapa.org)
- Accreditation Council for Graduate Medical Education (http://www.acgme.org/acWebsite/home/home.asp)
- American Osteopathic Association (http://www.osteopathic.org/index.cfm?pageid=ado_license)
- American Association of Nurse Anesthetists (http://www.aana.com/Pages/default.aspx)
- American Dental Association (Specialty Boards Recognized by ADA) (http://www.ada.org/494.aspx)
- American Podiatric Medical Association (Specialty Boards Recognized by the APMA) (http://www.apma.org/cpme/specialcertify.html)
- Commission on Dietetic Registration (CDR) (http://www.cdrnet.org)

Chapter 3

- The 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/osels/ph_surveillance/nndss/nndsshis.htm)
- U.S. Office of Civil Rights, Limited English Proficiency (LEP) (http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/)

Chapter 5

- AAAHC Institute for Quality Improvement (http://www.aaahciqi.org)
- Ambulatory Surgery Center Association, Benchmarking (http://ascassociation.org/benchmarking)
- Surgical Outcomes Information Exchange (http://www.soix.com)

Chapter 6

- U.S. National Library of Medicine National Institutes of Health (http://www.nlm.nih.gov/services/medical_records.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/en/)
- Association for Professionals in Infection Control and Epidemiology, Inc. (http://www.apic.org//AM/Template.cfm?Section=Home1)
- The Society for Healthcare Epidemiology of America (http://www.shea-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 Guideline for Reprocessing Flexible Gastrointestinal Endoscopes (http://www.shea-online.org/Assets/files/position_papers/SHEA_endoscopes.pdf)
- Society of Gastroenterology Nurses and Associates, Inc. (http://www.sgna.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.gi.org)
- American Gastroenterological Association (http://www.gastro.org)
- Occupational Safety and Health Administration, Safety and Health Topics, Healthcare Facilities (http://www.osha.gov/SLTC/healthcarefacilities)
- 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, Toolkit and Resource Descriptions (http://www.ahrq.gov/qual/pips/grants.htm#contents)

Chapter 8

- National Fire Protection Association (http://www.nfpa.org/index.asp)
- Federal Emergency Management Agency, Multi-Hazard Mitigation Planning (http://www.fema.gov/plan/mitplanning/index.shtm)
- World Health Organization, Community Emergency Preparedness: A Manual for Managers and Policy-Makers (http://whqlibdoc.who.int/publications/9241545194.pdf)

Chapter 9

- American Society of Anesthesiologists (ASA) (http://www.asahq.org)
- Society for Ambulatory Anesthesia (SAMBA) (http://www.sambahq.org)
- Society for Pediatric Anesthesia (http://www.pedsanesthesia.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.sgna.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/MedicalDevices/ProductsandMedicalProcedures/DeviceApprovalsandClearances/510kClearances/default.htm)
- American National Standards Institute, Standard for Safe Use of Lasers in Health Care Facilities (http://webstore.ansi.org/RecordDetail.aspx?sku=ANSI+Z136.1+and+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.aaoms.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_Attire.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://wwwn.cdc.gov/clia/default.aspx)
- 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/HowObtainCertificateofWaiver.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://wwwnc.cdc.gov/travel)

Chapter 16

- American Association for Health Education (http://www.aahperd.org/AAHE)
- National Commission for Health Education Credentialing, Inc. (http://www.nchec.org)

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/content/contentgroups/Helpline1/Mental_Health_Professionals_Who_They_Are_and_How_to_Find_One.htm)

Chapter 18

- Accreditation Council for Graduate Medical Education (www.acgme.org/acWebsite/home/home.asp)
- Alliance for Clinical Education (www.allianceforclinicaleducation.org/about/about.htm)

Chapter 19

- U.S. Food and Drug Administration, Information Sheet Guidance for Institutional Review Boards (IRBs), Clinical Investigators, and Sponsors (http://www.fda.gov/ScienceResearch/SpecialTopics/RunningClinicalTrials/GuidancesInformationSheetsandNotices/ucm113709.htm)

Chapter 20

- Association of Ambulatory Surgery Centers (www.ascassociation.org/resources/411medicareovernight.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/CertificationStandards/tabid/134/Default.aspx)

Chapter 23

- American College of Emergency Physicians (www.acep.org)

Chapter 24

- American Registry of Radiologic Technologists (https://www.arrt.org)

Chapter 26

- American Society of Anesthesiologists (http://www.asahq.org)

Chapter 27

- American Academy of Family Physicians (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 Resources Online (http://www.acponline.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 AAAHC/Medicare deemed status survey. Those requirements are listed as *Additional Medicare Requirements* and are only shown in the *AAAHC 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 AAAHC 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 orthopedics 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. This professional organization has established a well-recognized surgical risk classification system.
ASC	Ambulatory surgery center.
Asepsis	Prevention from contamination with microorganisms. Includes sterile conditions on tissues, on materials, and in rooms, as obtained by excluding, removing, or killing organisms.
Audit	An examination of records (e.g., clinical records, financial records, personnel records, etc.) to verify contents and/or check accuracy. When the results of an audit reveal missing or inaccurate information, appropriate quality improvement activities should be undertaken to ensure that improvement occurs.
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 practitioners to identify the best practices known to date 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. Recognized and reliable sources of benchmarking data may be available from professional organizations and societies, and from agencies such as the CDC and AHRQ. Refer to the Resources section of this *Handbook* for other suggested sources.
Benchmarking, External	A type of benchmarking that compares the performance of one organization with another similar organization, or with a group of similar organizations.
Benchmarking, Internal	Internal benchmarking compares performance within an organization, such as by physician or department, or over time. For purposes of accreditation, the internal benchmarking standard does not apply to organizations with fewer than three practitioners.
Bioburden	The degree of microbial contamination. The microbiological load (i.e., number of viable organisms *in or on* the object or surface) or organic material on a surface or object prior to decontamination or sterilization. Also known as "bioload" 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.
Bloodborne pathogens	Disease-producing microorganisms spread by contact with blood, or other body fluids contaminated with blood, from an infected 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 loading of the sterilizer, 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, 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	Clinical support staff works under the direct supervision or order of a licensed health care professional. Clinical support staff provides vital assistance in treating and caring for patients or performing diagnostic tests. In some cases, they are involved in looking after the general well-being and comfort of patients. These roles have a direct impact on patients' lives. The professionals may be licensed or certified. Examples: Registered nurses (RN), licensed practical nurses (LPN), licensed vocational nurses (LVN), certified nurse assistants (CNA), medical assistants, dental assistants, pharmacy technician, ultrasound technicians, radiation therapists, surgical technicians. An organization determines whether a registered nurse is considered an allied health care professional or clinical support staff.
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 unexposed 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 AAAHC 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).
Credentials Verification Organization (CVO)	A service company providing primary source verification of practitioners' credentials on behalf of an accredited organization.
CRNA	Certified registered nurse anesthetist.

Decontamination	A process or treatment that renders a medical device, instrument, or environmental surface safe to handle. According to OSHA, "the use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal" [29 CFR 1910.1030].
Deemed status	If an accrediting organization is recognized by CMS as having standards for accreditation that meet or exceed Medicare requirements, any provider entity accredited by the national accrediting body's approved program would be deemed to meet the Medicare conditions. A national accrediting organization applying for deeming authority under part 488, subpart A must provide reasonable assurance that the accrediting organization requires the accredited provider entities to meet requirements that are at least as stringent as the Medicare Conditions for Coverage.
Disinfectant	A chemical agent used on inanimate objects (nonliving objects such as floors or sinks) to destroy virtually all recognized pathogenic microorganisms, but not necessarily all microbial forms (e.g., bacterial endospores). The Environmental Protection Agency (EPA) groups disinfectants according to whether the product label claims "limited," "general" or "hospital" disinfectant. See also High-Level Disinfection.
Discharge, Medical	Medical discharge may occur when a patient is determined to be medically stable but not yet ready for physical discharge from a health care facility. Before medical discharge, a patient must be medically evaluated by the appropriate professional.
Discharge, Physical	The actual physical discharge of a patient from a health care facility.
Disinfection	The destruction of pathogenic and other kinds of microorganisms by physical or chemical means. Disinfection is less lethal than sterilization, because it destroys *most* recognized 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., sharps disposal containers, self-sheathing needles, and safer medical devices, such as sharps with engineered sharps injury protections and needleless systems) that isolate or remove the bloodborne pathogens hazard from the workplace.
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).
FI	Fiscal intermediary; private insurance companies that serve as agents 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, science-based information they need to use medicines and foods to improve their health.

Germicide	An agent that destroys microorganisms, especially pathogenic organisms. Other terms with the suffix "–cide" (e.g., virucide, fungicide, bactericide, tuberculocide, sporicide) indicate an agent that destroys the microorganism identified by the prefix. Germicides may be used to inactivate microorganisms in or on living tissue (antiseptic) or on environmental surfaces (disinfectants).
Hand hygiene	A general term that applies to hand washing, antiseptic hand wash, antiseptic hand rub, and surgical hand antisepsis.
Health care-acquired infection (HAI)	Any infection associated with a medical or surgical intervention. The term "health care-acquired" replaces the outdated term "nosocomial."
Health care professional	Any individual that provides health services to a patient. Individual organizations determine whether a registered nurse is considered an allied health care professional or clinical support staff.
High-level disinfection (HLD)	A disinfection process that inactivates vegetative bacteria, mycobacteria, fungi, and viruses, but not necessarily high numbers of bacterial spores. The FDA further defines a high-level disinfectant as a sterilant used under the same contact conditions except for a shorter contact time.
Hospital disinfectant	A germicide that is registered by EPA for use on inanimate objects in hospitals, clinics, dental offices, or any other medical-related facility. Efficacy is demonstrated against *Salmonella choleraesuis, Staphylococcus aureus,* and *Pseudomonas aeruginosa.*
Immunization	The process by which a person becomes immune, or protected against a disease. This term is often used interchangeably with "vaccination" or "inoculation."
Implantable device	Device placed into a surgically or naturally formed cavity of the human body and intended to remain there for >30 days.
Injection safety	A set of measures taken to perform injections in an optimally safe manner for patients, health care personnel, and others.
Intermediate-level disinfection	A disinfection process that inactivates vegetative bacteria, most fungi, mycobacteria, and most viruses (particularly the enveloped viruses), but not bacterial spores.
Intermediate-level disinfectant	A liquid chemical germicide registered by the EPA as a hospital disinfectant and with a label claim of potency as a tuberculocidal.
Low-level disinfectant	A liquid chemical germicide registered by the EPA as a hospital disinfectant. OSHA requires low-level disinfectants also to have a label claim for potency against HIV and HBV if used for disinfecting clinical contact surfaces.
Low-level disinfection	A process that will inactivate most vegetative bacteria, some fungi, and some viruses, but cannot be relied on to inactivate resistant microorganisms such as mycobacteria or bacterial spores.
MAC	Medicare Administrative Contractor.
Malignant hyperthermia (MH)	A biochemical chain reaction response triggered by commonly used general anesthetics and the paralyzing agent succinylcholine within the skeletal muscles of susceptible individuals. The general signs of the MH crisis include tachycardia (a rise in heart rate), a greatly increased body metabolism, muscle rigidity and/or fever that may exceed 110 degrees F. Severe complications include: cardiac arrest, brain damage, internal bleeding, or failure of other body systems. Thus, death, primarily due to a secondary cardiovascular collapse, can result. Also refer to Appendix C, page 139.

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 parenteral 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 HBV (hepatitis B virus)-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.
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.II and 5.I, 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 QI 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 preservative.
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: • 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 the 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 hematoma, 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 *minimum* 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 "QI."
Quality improvement (QI) program	A systematic, ongoing process to achieve and sustain measurable improvements in performance. A QI program includes various activities to measure and improve performance. Examples of *measurement* activities include (but are not limited to) benchmarking, monitoring, auditing, and QI 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 QI program approved by its governing body.
Quality improvement (QI) study	A type of QI 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 micro-biological 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.

Understanding, Planning, and Preparing for an AAAHC/Medicare Deemed Status (MDS) Survey

AAAHC has compiled the following information to assist an ambulatory surgery center (ASC) in preparing for a positive AAAHC/MDS survey experience. By using the AAAHC/Medicare deemed status (MDS) survey information contained elsewhere in this publication and entering significant events into the grid below, the user can construct a planning timeline to achieve AAAHC accreditation and receive AAAHC's recommendation to CMS for Medicare deemed status for its ASC.

Before requesting an AAAHC/MDS survey, an ASC must have previously obtained from CMS its National Provider Identification (NPI) number and have applied for and received recommendation for approval of the organization's CMS 855B enrollment. For more information, please refer to the AAAHC *Handbook*'s description for the 855B enrollment process.

Pre-survey Preparation

Step 1

Obtain a current *AAAHC Handbook Including Medicare Requirements for Ambulatory Surgery Centers (ASCs)* and the current *AAAHC Physical Environment Checklist for Ambulatory Surgical Centers* (the *"PEC"*). In order to receive a post-survey recommendation to CMS for Medicare deemed status, your ASC must demonstrate compliance with all elements of *NFPA 101® Life Safety Code® (LSC)*, 2000 Edition. **At this time, no other LSC edition is recognized by CMS.** The *AAAHC Physical Environment Checklist* is based on these requirements. The *Handbook* and the *PEC* are available for purchase at www.aaahc.org. Consider attendance at an official AAAHC Achieving Accreditation conference; further information and upcoming conference dates are posted at www.aaahc.org.

Step 2

Determine your ASC's *eligibility for survey* (refer to *Handbook* page 5).

Step 3

Determine the *type of survey* your ASC is eligible to request (see Types of Surveys, *Handbook* page 12)

Step 4

Carefully review the *Handbook*'s policies and procedures for AAAHC/Medicare deemed status surveys, the core chapters and applicable adjunct chapters. Obtain and review the CMS Conditions for Coverage (CfC) for ASCs and Interpretive Guidelines, which can be accessed at this link: http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr416_04.html, and the *PEC*. Determine organization's compliance with Medicare CfC, including *NFPA 101® Life Safety Code,®* 2000 Edition, AAAHC core chapter Standards, and applicable adjunct Standards. Using these determinations, create and implement a prioritized action plan to bring your ASC into compliance for any identified problems. Determine your ASC's time requirement to achieve substantial compliance with all CMS requirements, including the *LSC*, and with applicable AAAHC Standards.

Step 5

Obtain the *AAAHC Application for Survey*; review and begin to gather required *Application* information and supporting documents.

Step 6

Determine preliminary preferred dates of availability for AAAHC/MDS survey. Applicants intending to undergo an AAAHC/MDS survey must keep in mind the following items:

- CMS requires Medicare deemed status surveys to be conducted on an unannounced basis.
- CMS requires a 90-day survey window and allows up to five (5) blackout dates within the 90 day survey window.
- If applicable, consider the ASC's current AAAHC accreditation/MDS expiration date.
- To be considered for the maximum term of accreditation and be recommended for Medicare deemed status, a procedure or surgery must be performed during the survey and must be observed by the surveyor.
- Submitted application materials and documents remain valid for six (6) months from date of AAAHC receipt.

Step 7

An *Application for Survey* is valid for six (6) months from the date it is received at AAAHC. Submit required documentation with supporting information and the application fee not sooner than six (6) months prior to your organization's desired survey date. Consider progress on your prioritized action plan (step 4 above) as you determine the submission date for application materials and as you identify preferred dates of survey. Allow 30 days for AAAHC internal review of your ASC's submitted application documents.

Step 8

While AAAHC reviews your submitted materials, identify your ASC's availability for survey, keeping in mind the CMS requirement for an unannounced survey to occur within a 90-day survey window. As Chapter 10, Surgical and Related Services, is applicable, identify dates on which procedures or surgeries will occur. During an AAAHC/MDS survey, a procedure or a surgery MUST be observed. During this step, remember to consider known days or periods of non-availability of physicians, key leaders, and administrators.

Step 9

When your application materials review is complete, anticipate a personal contact from an AAAHC Survey Scheduling Coordinator to discuss your ASC's available survey dates. Maximum effort will be made to schedule your 90-day window at a time convenient for your ASC. You will receive a written confirmation of the agreed-upon 90-day survey window, the survey fee, and a survey information packet prior to the first day of the survey window. The Survey Scheduling Coordinator is able to answer questions you might have about your upcoming survey.

Step 10

Post the *Notice of Accreditation Survey* prominently throughout your ASC no later than the first day of the ninety (90)-day survey window. In all cases, posted *Notices of Accreditation Survey* must remain posted for a minimum of 30 days. One copy of the *Notice* will be provided in your survey information packet, and the form is also available at www.aaahc.org. The *Notice* may be photocopied to ensure adequate distribution throughout your ASC.

Step 11

The AAAHC/MDS survey occurs and the surveyor team submits its written survey results report to AAAHC Accreditation Services within ten (10) business days.

Post-Survey Events

For surveys where no Medicare deficiencies are identified:

Accreditation Services presents survey results to the Accreditation Committee. The Accreditation Committee considers the survey results, surveyor comments, and the organization's previously-submitted supporting documents. The Accreditation Committee determines (1) a term decision for AAAHC accreditation, and (2) assuming compliance with all Medicare requirements, a recommendation to CMS for Medicare deemed status. The organization receives a written letter of accreditation term decision, including AAAHC's recommendation to CMS for Medicare deemed status and a comprehensive written survey report.

For surveys where Medicare deficiencies are identified:

Accreditation Services prepares a letter of deficiency for the ASC within ten (10) business days. Based on the letter of deficiency, the ASC is required to create and submit a Plan of Correction (PoC) to AAAHC within ten (10) calendar days (enter PoC due date into planning grid). Based on the **type** of MDS survey and the **level of Medicare deficiency** (Medicare condition level or Medical standard level), AAAHC may recommend Medicare deemed status. Review and use pages 16–17 and the table on pages 18–19 for a further explanation of important post-survey steps when Medicare deficiencies are present at survey.

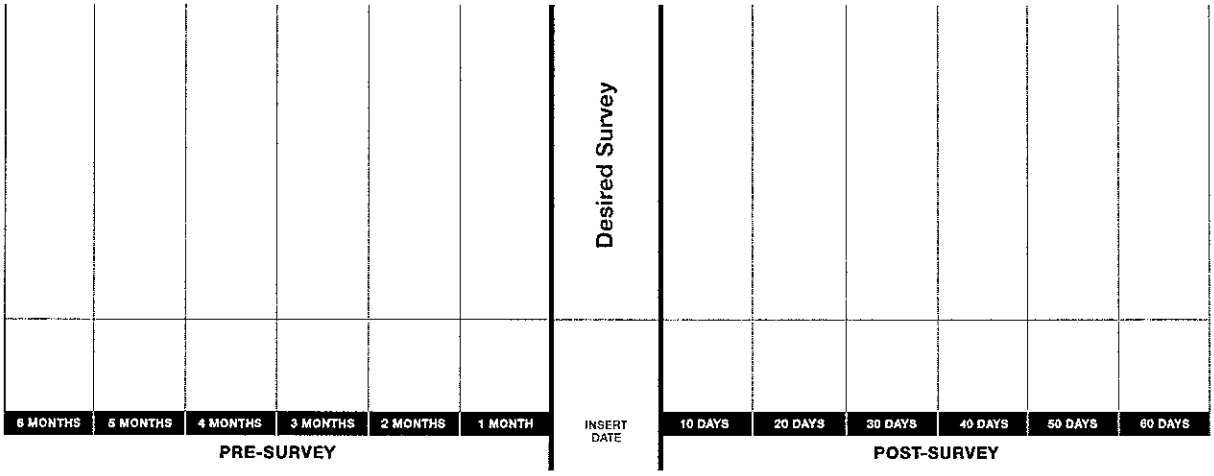
Use the following timeline to help you plan your accreditation survey process.

Enter the month or timeframe during which the organization wishes to have its on-site AAAHC/Medicare deemed status survey performed in the appropriate place on the grid (step 6).

For **initial** AAAHC/Medicare deemed status surveys and surveys of currently-accredited AAAHC/Medicare deemed status organizations **following a three-year term of accreditation**, enter **A** to indicate when your completed *Application for Survey* and its supporting materials are due at AAAHC office, keeping in mind the *Application* will remain valid for a period of six (6) months from the date of its receipt at AAAHC offices (step 7).

Enter **N** to indicate when the *Notice of Accreditation Survey* will be posted.

For surveyed organizations where Medicare deficiencies are identified, enter the PoC due date on the grid.



AAAHC/CMS Crosswalk

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.25 ***Condition:***	Participation as an ASC is limited to facilities that— (a) Meet the definition in §416.2; and (b) Have in effect an agreement obtained in accordance with this subpart.	*10.I.MS* ***Basic Requirements***	Participation as an ASC is limited to facilities that— (a) Meet the definition in §416.2; and (b) Have in effect an agreement obtained in accordance with Title 42 CFR Part 416 Subpart B.
416.2 ***Definitions:***	*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 24 hours following an admission. The entity must have an agreement with CMS to participate in Medicare as an ASC, and must meet the conditions set forth in subparts B and C of this part.	*10.I.MS* ***ASC Definition***	*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 an 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 and C.
416.40 ***Condition:*** *Compliance with State licensure law*	The ASC must comply with State licensure requirements.	*2.I.A–MS*	The ASC must comply with State licensure requirements.
416.41 ***Condition:*** *Governing body and management*	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.	*2.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.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.41 (a) ***Standard:*** *Contract services*	When services are provided through a contract with an outside resource, the ASC must assure that these services are provided in a safe and effective manner.	*2.I.B-11a, b, c, d, and g*	11. Approving and ensuring compliance of all major contracts or arrangements affecting the medical and dental care provided under its auspices and assuring 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. b. the provision of radiology services and pathology and medical laboratory services. c. the use of external laboratories. d. the provision of care by other health care organizations, such as hospitals. g. the Centers for Medicare & Medicaid Services (CMS) requirements, if the organization participates in the Medicare/Medicaid program.
416.41 (b)(1) ***Standard:*** *Hospitalization*	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.	*4.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)(2) ***Standard:*** *Hospitalization*	This hospital must be a local, Medicare-participating hospital or a local, nonparticipating hospital that meets the requirements for payment for emergency services under §482.2 of this chapter.	*4.K-MS (2)*	This 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 482.2.
416.41 (b)(3)(i) ***Standard:*** *Hospitalization*	The ASC must— Have a written transfer agreement with a hospital that meets the requirements of paragraph (b)(2) of this section; or	*4.K-MS (3)*	The ASC must— Have a written transfer agreement with a hospital that meets the requirements of 4.K-MS-2; or
416.41 (b)(3)(ii) ***Standard:*** *Hospitalization*	The ASC must— Ensure that all physicians performing surgery in the ASC have admitting privileges at a hospital that meets the requirements of paragraph (b)(2) of this section.	*4.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 4.KMS-2.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.41 (c)(1) ***Standard:*** *Disaster preparedness plan*	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.	*7.II.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.
416.41 (c)(2) ***Standard:*** *Disaster preparedness plan*	The ASC coordinates the plan with State and local authorities, as appropriate.	*7.II.F-MS*	The ASC coordinates its disaster preparedness plan with State and local authorities, as appropriate.
416.41 (c)(3) ***Standard:*** *Disaster preparedness plan*	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.	*8.E*	The organization requires at least one (1) drill each calendar quarter of the internal emergency and disaster preparedness plan. 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 corrections or modifications to the plan.
416.42 ***Condition:*** *Surgical services*	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.	*10.I.C-MS*	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 (a)(1) ***Standard:*** *Anesthetic risk and evaluation*	A physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed.	*9.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 (a)(2) ***Standard:*** *Anesthetic risk and evaluation*	Before discharge from the ASC, each patient must be evaluated by a physician or by an anesthetist as defined at §410.69(b) of this chapter, in accordance with applicable State health and safety laws, standards of practice, and ASC policy, for proper anesthesia recovery.	*9.M-MS*	Before discharge from the ASC, each patient must be evaluated by a physician or by an anesthetist as defined at Title 42 CFR 410.69(b), in accordance with applicable State health and safety laws, standards of practice, and ASC policy, for proper anesthesia recovery.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.42 (b)(1) ***Standard:*** *Administration of anesthesia*	Anesthetics must be administered by only— A qualified anesthesiologist; or	*9.F-MS (1)*	Anesthetics must be administered by only— A qualified anesthesiologist; or
416.42 (b)(2) ***Standard:*** *Administration of anesthesia*	A physician qualified to administer anesthesia, a certified registered nurse anesthetist (CRNA) or an anesthesiologist's assistant as defined in §410.69(b) of this chapter, 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 paragraph (d) of this section, 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.	*9.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 410.69(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(d), 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 (c)(1) ***Standard:*** *State exemption*	An ASC may be exempted from the requirement for physician supervision of CRNAs as described in paragraph (b)(2) of this section, if the State in which the ASC is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards 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.	*9.B-MS (1)*	An ASC may be exempted from the requirement for physician supervision of CRNAs as described in Title 42 CFR 416.42(b)(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 Boards 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 (c)(2) ***Standard:*** *State exemption*	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.	*9.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.
416.43 ***Condition:*** *Quality assessment and performance improvement*	The ASC must develop, implement and maintain an ongoing, data-driven quality assessment and performance improvement (QAPI) program.	*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.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.43 (a)(1) ***Standard:*** *Program scope*	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.	*5.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 (a)(2) ***Standard:*** *Program scope*	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 in the ASC.	*5.III.C-MS (1)*	The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that include care and services furnished in the ASC.
416.43 (b)(1) ***Standard:*** *Program data*	The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC.	*5.II.A-5-6*	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: 5. Development of processes to identify important problems or concerns that are appropriate to address for improving the quality of services provided by the organization. 6. Identification of quality improvement activities such as studies, including methods for performing internal and external benchmarking to support the goals of the program.
		5.II.B-2, 5	The organization conducts specific quality improvement activities that support the goals of the written QI program. Written reports of QI activities must demonstrate that each activity includes at least the following elements: 2. Identification of the performance goal against which the organization will compare its current performance in the area of study. 5. Data analysis that describes findings about the frequency, severity and source(s) of the problem(s).

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.43 (b)(1) ***Standard:*** *Program data*	The program must incorporate quality indicator data, including patient care and other relevant data regarding services furnished in the ASC.	*5.II.C-2*	The organization's written quality improvement program must include participation in external performance benchmarking activities that allow for the comparison of key performance measures with other similar organizations or with recognized best practices of national or professional targets or goals. 2. Results of benchmarking activities must be incorporated into other quality improvement activities of the organization.
416.43 (b)(2) ***Standard:*** *Program data*	The ASC must use the data collected to— (i) Monitor the effectiveness and safety of its services, and quality of its care. (ii) Identify opportunities that could lead to improvements and changes in its patient care.	*5.II.A-5-6*	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: 5. Development of processes to identify important problems or concerns that are appropriate to address for improving the quality of services provided by the organization. 6. Identification of quality improvement activities such as studies, including methods for performing internal and external benchmarking to support the goals of the program.
		5.II.B-5-9	The organization conducts specific quality improvement activities that support the goals of the written QI program. Written reports of QI activities must demonstrate that each activity includes at least the following elements: 5. Data analysis that describes findings about the frequency, severity and source(s) of the problem(s). 6. A comparison of the organization's current performance in the area of study against the previously identified performance goal. 7. Implementation of corrective action(s) to resolve identified problem(s). 8. Re-measurement (a second round of data collection and analysis as described in Standard 5.II.B-4-6) to objectively determine whether the corrective actions have achieved and sustained demonstrable improvement.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.43 (b)(2) ***Standard:*** *Program data*	The ASC must use the data collected to— (i) Monitor the effectiveness and safety of its services, and quality of its care. (ii) Identify opportunities that could lead to improvements and changes in its patient care.	*5.II.B-5-9*	9. If the initial corrective action(s) did not achieve and/or sustain the desired improved performance, implementation of additional corrective action(s) and continued remeasurement until the problem is resolved or is no longer relevant.
		5.II.C-1a	The organization's benchmarking activities may include, but are not limited to: a. The use of selected performance measures that are appropriate for improving the processes or outcomes of care relevant to the patients served.
416.43 (c)(1) ***Standard:*** *Program activities*	The ASC must set priorities for its performance improvement activities that— (i) Focus on high risk, high volume, and problem-prone areas. (ii) Consider incidence, prevalence, and severity of problems in those areas. (iii) Affect health outcomes, patient safety, and quality of care.	*5.II.A-MS (2)*	The ASC must set priorities for its performance improvement activities that— (i) Focus on high risk, high volume, and problem-prone areas. (ii) Consider incidence, prevalence, and severity of problems in those areas. (iii) Affect health outcomes, patient safety, and quality of care.
416.43 (c)(2) ***Standard:*** *Program activities*	Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.	*5.II.A-MS (3)*	Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.
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.	*2.I.B-21*	Governing body responsibilities include, but are not limited to: 21. Establishing processes for the identification, reporting, analysis, and prevention of adverse incidents and ensuring consistent and effective implementation by developing a system that includes: a. Definition of an adverse incident that, at a minimum, includes: i. An unexpected occurrence during a health care encounter involving patient death or serious physical or psychological injury or illness, including loss of limb or function, not related to the natural course of the patient's illness or underlying condition. ii. Any process variation for which a recurrence carries a significant chance of a serious adverse outcome.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
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.	*2.I.B-21*	iii. Events such as actual breaches in medical care, administrative procedures or other events resulting in an outcome that is not associated with the standard of care or acceptable risks associated with the provision of care and service for a patient. iv. Circumstances or events that could have resulted in an adverse event. b. Review of frequency of occurrences, severity of outcomes, and reportable events. c. A process for conducting a thorough analysis when an adverse incident occurs in order to identify the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of an adverse incident. The analysis identifies potential improvements in processes or systems that would tend to decrease the likelihood of such incidents in the future, or determines, after analysis, that no such improvement opportunities exist. d. A process for reporting adverse incidents through established channels within the organization and, as appropriate, to external agencies in accordance with law and regulation. e. An action plan that identifies the strategies that the organization intends to implement to reduce the risk of similar incidents occurring in the future. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time lines, and strategies for measuring the effectiveness of the actions.
		3.B-7	Specify privileges and responsibilities of employment, including compliance with an adverse incident reporting system, as described in Standard 2.I.B-21.
		4.E-1	The organization facilitates the provision of high-quality health care as demonstrated by the following: 1. Health care provided is consistent with current professional knowledge.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
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.	*5.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.
		5.III.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.
416.43 (d)(1) ***Standard:*** *Performance improvement projects*	The number and scope of distinct improvement projects conducted annually must reflect the scope and complexity of the ASC's services and operations.	*5.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)(2) ***Standard:*** *Performance improvement projects*	The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results.	*5.II.A-MS (5)*	The ASC must document the projects that are being conducted. The documentation, at a minimum, must include the reason(s) for implementing the project, and a description of the project's results.
416.43 (e)(1) ***Standard:*** *Governing body responsibilities*	The governing body must ensure that the QAPI program— Is defined, implemented, and maintained by the ASC.	*5.II.A-MS (6)*	The governing body must ensure that the QAPI program— Is defined, implemented, and maintained by the ASC.
416.43 (e)(2) ***Standard:*** *Governing body responsibilities*	The governing body must ensure that the QAPI program— Addresses the ASC's priorities and that all improvements are evaluated for effectiveness.	*5.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)(3) ***Standard:*** *Governing body responsibilities*	The governing body must ensure that the QAPI program— Specifies data collection methods, frequency, and details.	*5.II.A-MS (8)*	The governing body must ensure that the QAPI program— Specifies data collection methods, frequency, and details.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.43 (e)(4) ***Standard:*** *Governing body responsibilities*	The governing body must ensure that the QAPI program— Clearly establishes its expectations for safety.	*5.II.A-MS (9)*	The governing body must ensure that the QAPI program— Clearly establishes its expectations for safety.
416.43 (e)(5) ***Standard:*** *Governing body responsibilities*	The governing body must ensure that the QAPI program— Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program.	*5.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.
416.44 ***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 (a) ***Standard:*** *Physical environment*	The ASC must provide a functional and sanitary environment for the provision of surgical services.	*10.I.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.
416.44 (a)(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.I.I-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 (a)(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.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.44 (a)(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.I.A	The organization must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities.
		7.I.C	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.I.G	Procedures are available to minimize the sources 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.

CfC #	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 — (i) 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 ABHR dispensers

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.44 (b)(5) ***Standard:*** *Safety from fire*	(ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls; (iii) The dispensers are installed in a manner that adequately protects against inappropriate access; (iv) 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 liters) for dispensers in rooms, corridors, and areas open to corridors. (2) 0.5 gallons (2.0 liters) 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 ABHR 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 (5) (v) The dispensers are maintained in accordance with dispenser manufacturer guidelines.	*Physical Environment Checklist (PEC) for Ambulatory Surgical Centers*	See requirements for 6.2 ABHR dispensers

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.44 (c) ***Standard:*** *Emergency equipment*	Emergency equipment available to the operating rooms must include at least the following:	*8.O-MS*	Emergency equipment available to the operating rooms must include at least the following:
416.44 (c)(1) ***Standard:*** *Emergency equipment*	Emergency equipment available to the operating rooms must include at least the following: Emergency call system.	*8.O-MS (1)*	(1) Emergency call system.
416.44 (c)(2) ***Standard:*** *Emergency equipment*	Emergency equipment available to the operating rooms must include at least the following: Oxygen.	*8.O-MS (2)*	(2) Oxygen.
416.44 (c)(3) ***Standard:*** *Emergency equipment*	Emergency equipment available to the operating rooms must include at least the following: Mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator.	*8.O-MS (3)*	(3) Mechanical ventilatory assistance equipment including airways, manual breathing bag, and ventilator.
416.44 (c)(4) ***Standard:*** *Emergency equipment*	Emergency equipment available to the operating rooms must include at least the following: Cardiac defibrillator.	*8.O-MS (4)*	(4) Cardiac defibrillator.
416.44 (c)(5) ***Standard:*** *Emergency equipment*	Emergency equipment available to the operating rooms must include at least the following: Cardiac monitoring equipment.	*8.O-MS (5)*	(5) Cardiac monitoring equipment.
416.44 (c)(6) ***Standard:*** *Emergency equipment*	Emergency equipment available to the operating rooms must include at least the following: Tracheostomy set.	*8.O-MS (6)*	(6) Tracheostomy set.
416.44 (c)(7) ***Standard:*** *Emergency equipment*	Emergency equipment available to the operating rooms must include at least the following: Laryngoscopes and endo-tracheal tubes.	*8.O-MS (7)*	(7) Laryngoscopes and endotracheal tubes.
416.44 (c)(8) ***Standard:*** *Emergency equipment*	Emergency equipment available to the operating rooms must include at least the following: Suction equipment.	*8.O-MS (8)*	(8) Suction equipment.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.44 (c)(9) ***Standard:*** *Emergency equipment*	Emergency equipment available to the operating rooms must include at least the following: Emergency medical equipment and supplies specified by the medical staff.	*8.O-MS (9)*	(9) Emergency medical equipment and supplies specified by the medical staff.
416.44 (d) ***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.	*10.I.K*	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.
416.45 ***Condition:*** *Medical staff*	The medical staff of the ASC must be accountable to the governing body.	*2.II.A*	The medical staff must be accountable to the governing body. The governing body establishes and is responsible for a credentialing and reappointment process, applying criteria in a uniform manner to appoint individuals to provide patient care for the organization. The governing body approves mechanisms for credentialing, reappointment and the granting of privileges, and suspending or terminating clinical privileges, including provisions for appeal of such decisions.
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.	*2.II.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 professionals must be legally and professional 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.
		10.I.C	Surgical procedures must be performed in a safe manner only by qualified providers who: 1. Are licensed to perform such procedures within the state in which the organization is located. 2. Have been granted clinical privileges to perform those procedures by the governing body, in accordance with Chapter 2.II.
		10.II.B-1	The organization ensures that its facility provides a safe environment, including: 1. Granting privileges for each specific device.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.45 (b) ***Standard:*** *Reappraisals*	Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate.	*2.II.C-MS*	Medical staff privileges must be periodically reappraised by the ASC. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate.
416.45 (c) ***Standard:*** *Other practitioners*	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.	*2.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.
416.46 ***Condition:*** *Nursing services*	The nursing services of the ASC must be directed and staffed to assure that the nursing needs of all patients are met.	*10.I.H-MS (1)*	The nursing services of the ASC must be directed and staffed to assure that the nursing needs of all patients are met.
416.46 (a) ***Standard:*** *Organization and staffing*	Patient care responsibilities must be delineated for 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.	*10.I.H-MS (2)*	Patient care responsibilities must be delineated for 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.
416.47 ***Condition:*** *Clinical records*	The ASC must maintain complete, comprehensive, and accurate medical records to ensure adequate patient care.	*6, Clinical Records and Health Information*	An accreditable 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.
416.47 (a) ***Standard:*** *Organization*	The ASC must develop and maintain a system for the proper collection, storage, and use of patient records.	*6.A*	The organization develops and maintains a system for the proper collection, processing, maintenance, storage, retrieval, and distribution of clinical records.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.47 (b) ***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:	*6.D*	There is a designated person in charge of clinical records whose responsibilities include, but are not limited to: 1. The confidentiality, security, and physical safety of records. 2. The timely retrieval of individual records upon request. 3. The unique identification of each patient's record. 4. The supervision of the collection, processing, maintenance, storage, and appropriate access to and usage of records. 5. The maintenance of a predetermined, organized and secured record format.
		6.F	Clinical record entries are legible and easily accessible within the record by the organization's personnel.
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	*6.B*	An individual clinical record is established for each person receiving care. Each record includes, but is not limited to: 1. Name. 2. Identification number (if applicable). 3. Date of birth. 4. Gender. 5. Responsible party, if applicable.
		7.II.D	Unique patient identifiers are consistently used throughout care.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.47 (b)(2) ***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: Significant medical history and results of physical examination	*4.E-3*	The organization facilitates the provision of high-quality health care as demonstrated by the following: 3. Appropriate and timely diagnosis based on findings of the current history and physical examination.
		6.I	Reports, histories and physicals, progress notes, and other patient information (such as laboratory reports, x-ray readings, operative reports, and consultations) are reviewed and incorporated into the record in a timely manner.
		6.I.-3,4	Entries in a patient's clinical record for each visit include, but are not limited to: 3. Clinical findings. 4. Discharge diagnosis or impression.
		10.I.D	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 thirty (30) days prior to the scheduled surgery/procedure.
416.47 (b)(3) ***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: Pre-operative diagnostic studies (entered before surgery), if performed	*4.E-9*	The organization facilitates the provision of high-quality health care as demonstrated by the following: 9. Appropriate and timely follow-up of findings and tests.
		6.I	Reports, histories and physicals, progress notes, and other patient information (such as laboratory reports, x-ray readings, operative reports, and consultations) are reviewed and incorporated into the record in a timely manner.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.47 (b)(3) ***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: Pre-operative diagnostic studies (entered before surgery), if performed	*6.L-5* *10.I.D*	Entries in a patient's clinical record for each visit include, but are not limited to: 5. Studies ordered, such as laboratory or x-ray studies. 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 thirty (30) days prior to the scheduled surgery/procedure.
416.47 (b)(4) ***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: Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body.	*10.I.L* *10.I.M*	With the exception of those tissues exempted by the governing body after medical review, tissues removed during surgery are examined by the pathologist, whose signed report of the examination is made a part of the patient's record. The findings and techniques of a procedure are accurately and completely documented immediately after the procedure by the health care professional who performed the procedure. This description is immediately available for patient care and becomes a part of the patient's record.
416.47 (b)(5) ***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: Any allergies and abnormal drug reactions	*6.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.
416.47 (b)(6) ***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	*9.I*	Clinical records include entries related to anesthesia administration.
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	*6.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 medical record.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
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	*9.E*	The informed consent of the patient, or if applicable, of the patient 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.T
		10.I.T	The informed consent of the patient, or if applicable, of the patient's representative, is obtained before an operation is performed.
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: Discharge diagnosis.	*6.L-4*	Entries in a patient's clinical record for each visit include, but are not limited to: 4. Discharge diagnosis or impression
416.48 ***Condition:*** *Pharmaceutical services*	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.	*11.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) ***Standard:*** *Administration of drugs*	Drugs must be prepared and administered according to established policies and acceptable standards of practice.	*11.B*	Pharmaceutical services are provided in accordance with ethical and professional practice and applicable federal and state laws.
		11.C	Staff demonstrates knowledge of applicable state and federal pharmaceutical laws.
		11.D	Records and security are maintained to ensure the control and safe dispensing of drugs, including samples, in compliance with federal and state laws.
		11.E	Staff informs patients concerning safe and effective use of medications consistent with legal requirements and patient needs.
		11.F	Measures have been implemented to ensure that prescription pads are controlled and secured from unauthorized patient access, and pre-signed and/or postdated prescriptions pads are prohibited.
		11.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.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.48 (a) ***Standard:*** *Administration of drugs*	Drugs must be prepared and administered according to established policies and acceptable standards of practice.	*11.H*	All injectable medications drawn into syringes or oral medications removed from the packaging identified by the original manufacturer must be appropriately labeled if not administered immediately.
		11.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.
		11.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.
		11.L	If such medications are present, the organization identifies and maintains a current list of look-alike and sound-alike medications, and actions to prevent errors are evident.
		11.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 (a)(1) ***Standard:*** *Administration of drugs*	Adverse reactions must be reported to the physician responsible for the patient and must be documented in the record.	*6.K-MS*	Adverse reactions must be reported to the physician responsible for the patient and must be documented in the record.
416.48 (a)(2) ***Standard:*** *Administration of drugs*	Blood and blood products must be administered by only physicians or registered nurses.	*11.B-MS (1)*	Blood and blood products must be administered by only physicians or registered nurses.
416.48 (a)(3) ***Standard:*** *Administration of drugs*	Orders given orally for drugs and biologicals must be followed by a written order, signed by the prescribing physician.	*11.B-MS (2)*	Orders given orally for drugs and biologicals must be followed by a written order, signed by the prescribing physician.
416.49 ***Condition:*** *Laboratory and Radiologic Services*	There is no crosswalked text.		

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.49(a) ***Standard:*** *Laboratory services*	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.	*12.II.A* *12.I.A-2*	An accreditable 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. An accreditable organization: 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(b)(1) ***Standard:*** *Radiologic services*	The ASC must have procedures for obtaining radiological services from a Medicare approved facility to meet the needs of patients.	*13.A-MS (1)*	The ASC must have procedures for obtaining radiology services, from a Medicare approved facility to meet the needs of patients.
416.49(b)(2) ***Standard:*** *Radiologic services*	Radiologic services must meet the hospital conditions of participation for radiologic services specified in §482.26 of this chapter.	*13.A-MS (2)*	Radiologic services must meet the hospital conditions of participation for radiologic services specified in Title 42 CFR 482.26.
416.50 ***Condition:*** *Patient rights*	The ASC must inform the patient or the patient's representative or surrogate of the patient's rights, and must protect and promote the exercise of these rights, as set forth in this section. The ASC must also post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients waiting for treatment or by the patient's representative or surrogate, if applicable.	*1.F-MS*	The ASC must inform the patient or the patient's representative or surrogate of the patient's rights, and must protect and promote the exercise of these rights, as set forth in Title 42 CFR 416.50. The ASC must also post the written notice of patient rights in a place or places within the ASC likely to be noticed by patients waiting for treatment or by the patient's representative or surrogate, if applicable.
416.50(a) ***Standard:*** *Notice of rights*	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 ensures the patient, the patient's representative, or the surrogate understand all of the patient's rights as set forth in this section. The ASC's notice of rights must include the 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.	*1.F-MS (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 ensures the patient, the patient's representative, or the surrogate understand all of the patient's rights as set forth in Title 42 CFR 416.50. The ASC's notice of rights must include the 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.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.50(b) ***Standard:*** *Disclosure of physician financial interest or ownership*	The ASC must disclose, in accordance with Part 420 of this subchapter, and where applicable, provide a list of physicians who have financial interests or ownership in the ASC facility. Disclosure of information must be in writing.	*2.I.A-1-MS*	The ASC must disclose, in accordance with Title 42 CFR Part 420 of this subchapter, and where applicable, provide a list of physicians who have financial interests or ownership in the ASC facility. Disclosure of information must be in writing.
416.50(c)(1) ***Standard:*** *Advance directives*	The ASC must comply with the following requirements: Provide the patient or, as appropriate, the patient's representative with written information concerning its policies on advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms.	*1.F-8-MS (1)*	The ASC must provide the patient or, as appropriate, the patient's representative with written information concerning its policies on advance directives, including a description of applicable State health and safety laws and, if requested, official State advance directive forms.
416.50(c)(2) ***Standard:*** *Advance directives*	Inform the patient or, as appropriate, the patient's representative of the patient's right to make informed decisions regarding the patient's care.	*1.D-MS*	Inform 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(c)(3) ***Standard:*** *Advance directives*	Document in a prominent part of the patient's current clinical record, whether or not the individual has executed an advance directive.	*1.F-8-MS (2)*	Document in a prominent part of the patient's current medical record, whether or not the individual has executed an advance directive.
416.50(d) ***Standard:*** *Submission and investigation of grievances*	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:	*2.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(d)(1) ***Standard:*** *Submission and investigation of grievances*	All alleged violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented.	*2.I.B-20-MS (1)*	All alleged violations/grievances relating, but not limited to, mistreatment, neglect, verbal, mental, sexual, or physical abuse, must be fully documented.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.50(d)(2) ***Standard:*** *Submission and investigation of grievances*	All allegations must be immediately reported to a person in authority in the ASC.	*2.I.B-20-MS (2)*	All allegations must be immediately reported to a person in authority in the ASC.
416.50(d)(3) ***Standard:*** *Submission and investigation of grievances*	Only substantiated allegations must be reported to the State authority or the local authority, or both.	*2.I.B-20-MS (3)*	Only substantiated allegations must be reported to the State authority or the local authority, or both.
416.50(d)(4) ***Standard:*** *Submission and investigation of grievances*	The grievance process must specify timeframes for review of the grievance and the provisions of a response.	*2.I.B-20-MS (4)*	The grievance process must specify timeframes for review of the grievance and the provisions of a response.
416.50(d)(5) ***Standard:*** *Submission and investigation of grievances*	The ASC, in responding to the grievance, must investigate all grievances made by a patient, the patient's representative, or the patient's surrogate regarding treatment or care that is (or fails to be) furnished.	*2.I.B-20-MS (5)*	The ASC, in responding to the grievance, must investigate all grievances made by a patient, the patient's representative, or the patient's surrogate regarding treatment or care that is (or fails to be) furnished.
416.50(d)(6) ***Standard:*** *Submission and investigation of grievances*	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.	*2.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(e)(1)(i) ***Standard:*** *Exercise of rights and respect for property and person*	The patient has the right to the following— Be free from any act of discrimination or reprisal.	*1.L-MS*	The patient has the right to the following— Be free from any act of discrimination or reprisal.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.50(e)(1)(ii) ***Standard:*** *Exercise of rights and respect for property and person*	Voice grievances regarding treatment or care that is (or fails to be) furnished.	*1.E*	Patients are given the opportunity to participate in decisions involving their health care, except when such participation is contraindicated for medical reasons.
		1.L	Patients are informed about procedures for expressing suggestions, complaints and grievances, including those required by state and federal regulations.
416.50(e)(1)(iii) ***Standard:*** *Exercise of rights and respect for property and person*	Be fully informed about a treatment or procedure and the expected outcome before it is performed.	*1.D-MS (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(e)(2) ***Standard:*** *Exercise of rights and respect for property and person*	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.	*1.D-MS (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(e)(3) ***Standard:*** *Exercise of rights and respect for property and person*	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.	*1.D-MS (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(f)(1) ***Standard:*** *Privacy and safety*	The patient has the right to: Personal privacy.	*1.B-MS*	The patient has the right to personal privacy.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.50(f)(2) ***Standard:*** *Privacy and safety*	Receive care in a safe setting.	*8.B-MS*	The patient has the right to receive care in a safe setting.
416.50(f)(3) ***Standard:*** *Privacy and safety*	Be free from all forms of abuse or harassment.	*1.A-MS*	The patient has the right to be free from all forms of abuse or harassment.
416.50(g) ***Standard:*** *Confidentiality of clinical records*	The ASC must comply with the Department's rules for the privacy and security of individually identifiable health information, as specified at 45 CFR parts 160 and 164.	*1.C-MS*	The ASC must comply with the Department's rules for the privacy and security of individually identifiable health information, as specified at Title 45 CFR parts 160 and 164.
416.51 ***Condition:*** *Infection control*	The ASC must maintain an infection control program that seeks to minimize infections and communicable diseases.	*7.I*	Subchapter I — Infection Prevention and Control: An accreditable organization maintains an active and ongoing infection control and prevention program as evidenced by the following characteristics:
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.	*7.I.D*	The organization provides a functional and sanitary environment for the provision of services. The organization adheres to professionally accepted standards of practice, manufacturer's recommendations, and state and federal guidelines, including but not limited to the cleaning, disinfection, and sterilization of instruments, equipment, supplies, and implants.
		7.I.F	A safe environment for treating patients, including adequate safeguards to protect the patient from cross-infection, is assured through the provision of adequate space, equipment, supplies, and personnel.
		10.I.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.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
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--	*7.I.B*	The infection control and prevention program includes documentation that the organization has considered, selected, and implemented nationally-recognized infection control guidelines. The program is: 1. Approved by the governing body. 2. An integral part of the organization's quality improvement program. 3. Under the direction of a designated and qualified health care professional who has training and current competence in infection control. 4. Implemented with a plan of action to: a. Prevent, identify, minimize, and manage infections and communicable diseases. b. Immediately implement corrective and preventive measures that result in improvements.
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— Under the direction of a designated and qualified professional who has training in infection control;	*7.I.B-3*	The infection control and prevention program is under the direction of a designated and qualified professional who has training in infection control.
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— An integral part of the ASC's quality assessment and performance improvement program; and	*7.I.B-2*	The infection control program is an integral part of the ASC's quality assessment and performance improvement program; and

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.51(b)(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— Responsible for providing a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement.	*7.I.B-5* *7.I.G*	The infection control program is responsible for providing a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement. Procedures must be available to minimize the sources and transmission of infections, including adequate surveillance techniques.
416.52 ***Condition:*** *Patient admission, assessment and discharge*	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.	*10.I.D-MS*	The ASC must ensure that each patient has the appropriate pre-surgical and post-surgical assessments completed and that all elements of the discharge requirements are completed.
416.52(a)(1) ***Standard:*** *Patient admission, assessment and discharge*	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(r) of the Act) or other qualified practitioner in accordance with applicable State health and safety laws, standards of practice, and ASC policy.	*10.I.D-MS (1)*	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(r) 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)(2) ***Standard:*** *Patient admission, assessment and discharge*	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.	*10.I.D-MS (2)*	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.

CfC #	CMS Requirements	AAAHC Chapter & Standard Identifier	AAAHC Standards
416.52(a)(3) ***Standard:*** *Patient admission, assessment and discharge*	The patient's medical history and physical assessment must be placed in the patient's medical record prior to the surgical procedure.	*10.I.D*	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 thirty (30) days prior to the scheduled surgery/procedure.
416.52(b)(1) ***Standard:*** *Post-surgical assessment*	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.	*10.I.X-MS (1)*	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)(2) ***Standard:*** *Post-surgical assessment*	Post-surgical needs must be addressed and included in the discharge notes.	*10.I.X-MS (2)*	Post-surgical needs must be addressed and included in the discharge notes.
416.52(c)(1) ***Standard:*** *Discharge*	The ASC must— Provide each patient with written discharge instructions and overnight supplies. When appropriate, make a followup 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 followup care.	*10.I.Y-MS (1)*	The ASC must— Provide each patient with written discharge instructions and overnight supplies. When appropriate, make a followup 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 followup care.
416.52(c)(2) ***Standard:*** *Discharge*	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.	*10.I.Y-MS (2)*	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)(3) ***Standard:*** *Discharge*	The ASC must— Ensure all patients are discharged in the company of a responsible adult, except those patients exempted by the attending physician.	*9.O-MS*	The ASC must— Ensure all patients are discharged in the company of a responsible adult, except those patients exempted by the attending physician.

Index

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