Steven Hirsch & Associates

Accreditation News

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Steven Hirsch & Associates

This issue offers important updates on licensing issues that may impact your successful accreditation.

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Elements of the Antimicrobial Stewardship Program

By David Woodard, M.Sc., MT(AMT), CLC, CIC, CPHQ, FSHEA

For the past several years, at least as early as 2014, there has been an increasingly strong effort to better utilize antibiotics in patient care. This effort originated with the CDC with its call for practitioners to better manage the use of antibiotics both in the inpatient and outpatient settings due to concern related to resistance of bacteria to commonly used antibiotics. Antimicrobial Stewardship is one of the ECRI Institute's top patient safety concerns for 2020.

In September of 2019 CMS finalized the rule that requires all acute-care and critical access hospitals that are participating in Medicare or Medicaid programs to develop and implement an **Antimicrobial Stewardship Program (ASP)** as part of their infection control efforts. This is also an explicit requirement of The Joint Commission (TJC); the DNV includes this in their "core measures" DNV-CL.T

The CDC publication Core Elements of Hospital Antibiotic Stewardship Programs: 2019 https://www.cdc.gov/antibiotic-use/healthcare/pdfs/hospital-core-elements-H.pdf provides guidance and explanations for the programs and recommends key membership of the Antibiotic Stewardship Committee. We are including some expanded roles for other members of the Committee. Hopefully this will assist hospitals with the full development and implementation of this critical program.

Roles and Responsibilities for Committee Members:

The **Pharmacist** is the key player in this Committee and should bear the responsibility for the organization, conduct, and outcomes of the program's activities. They are the subject matter experts and are the party with the closest access to the data, research, and standards.

The **Pharmacist** should have intimate involvement with the development of the **Drug Use Evaluation (DUE)** and disposition of the findings; and they should oversee the production and provision of educational material for practitioners. The **Pharmacist** is also in a position to immediately intervene when there are variations in practice that may have an immediate impact on the outcomes for the patient.

The **Pharmacist** must work collaboratively with the Infection Prevention Practitioner on the ongoing activities in the hospital within the areas of antimicrobials and, infections and pathogens.

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The **Infection Prevention Practitioner (IP)** is responsible to interface with the microbiologist with regard to infections, changes in pathogen prevalence, emergence of new pathogens and rates of healthcare associated infections. This conduit should be established and maintained to ensure the currency of data to the Committee.

The **IP** is the other individual in the organization that has real-time association between the patient, the pathogen, and the prescribing of antibiotics. They should have frequent interactions with the microbiologist to discuss the ongoing activities in the hospital with respect to patients and epidemiological events. Additionally, the IP can have direct interactions with various practitioners to discuss antimicrobial therapy.

The **Microbiologist** is responsible for the preparation of the hospital antibiogram. This document is an essential component of the program and should be developed and periodically updated by the microbiology laboratory. The technique for preparing an antibiogram is explained in the Clinical and Laboratory Standards Institute (CLSI) document M-32. The essential elements include:

> The document should be prepared annually and avoid overlaps e.g. 1/1/2019-12/31/19; 1/1/2020-12/31/2020. There are some separate considerations including expanding the dates to ensure that there are statistically significant numbers of isolates, ideally 30 discrete isolates. An isolate must be counted one time, and one time only (if a patient has MRSA in January, it should not be counted again (if it occurs again); isolates from the "urine" source should be documented as a separate category.
>
> "Pooled" (use of data from multiple facilities such as SNF or Clinics) antibiograms should be prepared with caution as the background demography and genetic pressures are different from each site.
>
> The rates should be expressed as percentage sensitive. That is, the calculation is # of organisms sensitive to an agent / total number of organisms tested for the agent and multiply by 100.
>
> Some facilities do not include the results for agents not on the general formulary. Note also, that MRSA should be considered separately from MSSA. Coagulase Negative Staphylococcus is not a good marker as it represents as entire group of organisms. The results should be genus and species specific such as S. epidermidis, *S. capitis* or *S. hominis.* VRE should be considered as two separate organisms *E. faecium and E. faecalis.* Screening cultures must not be included in the data set.

The **Registered Nurse** has one of the less well identified, but equally important roles in the **Antimicrobial Stewardship Program**. The nurse is with the patient for 8-12 hours per day and is able to monitor the hour-to-hour changes in the patient's condition and their response to therapy. The nurse is one of the few people who has "facetime" with the physician and who can also prompt the practices including a "time out", or a "reassessment" pause in therapy, or even identify what may appear to be a treatment failure.

The **Registered Nurse** should also ensure that antibiotics are administered within the time frames defined by the hospital. Many organizations have established time frames for the initial administration of antibiotics in cases of suspected sepsis, meningitis, and even something as straight forward as prophylaxis. Failure to administer the agents within the prescribed time frame can alter the effectiveness and mask outcomes.

Lastly, the **Registered Nurse** has shared responsibility for patient and family education. They should ensure that the patient, the family, and any related care providers are aware of the antibiotic agent, the duration of therapy (many patients will not complete their course of antibiotic therapy as an outpatient), and the importance of dosing intervals, including making up "missed doses".

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The **Drug Use Evaluation (DUE)** or **Medication Use Evaluation (MUE)**
http://apps.who.int/medicinedocs/en/d/Js4882e/8.5.html#Js4882e.8.5
As with all things related to quality and outcome improvement, it is necessary to measure the variables to establish a "you are here" point. The **DUE** is a standard tool used to evaluate the ways medications are used in the facility.

A **DUE** is a systematic study of how drugs are used by comparing them with standard indications as published in the product insert, including dosing intervals, dose adjustment, frequency and duration of therapy data, and evaluating all patients who have received the drug during the study period. The goal of the **DUE** is to ensure that best therapy is being provided for each patient. The goal of a **DUE** or **MUE** is to promote optimal medication therapy and ensure that drug therapy meets current standards of care.

The **DUE** is a stepwise, organized procedure that includes:

- Establishment of an individual to oversee the process
- Establishment of the standards or criteria for medication utilization that will be used in the study
- Data must be collected from a suitable random sample of charts or prescription records from the health-care facility, usually selected by pharmacy personnel, but also by nurses or medical records personnel
- The treatment of at least 30 patients, or 100 patients for common clinical conditions, should be reviewed per health facility or hospital. The larger the facility and the more practitioners, the larger the number of records needed for review and analysis.

The **Physician** has the oversight responsibility to ensure that proper education is provided to the healthcare team. It is not necessary for the physician member to directly provide the education but to ensure that the information is provided. The **Pharmacy** and **Therapeutics Committee/Function** should be able to take actions where undesirable variation in practice is identified. Examples of this can include:

- Education, for example letters, in-service education, workshops, newsletters, face-to-face discussions
- Institution of drug order forms
- Institution of prescribing restrictions
- Changing the formulary list and/or manual
- Changing the standard treatment guidelines
- Using another **DUE** or continuing the present one.

As part of the ongoing education of providers, the "Committee" should ensure that the practitioners understand how to use the antibiogram; disseminate the educational materials to the appropriate discipline; and be available to answer questions to support the program.

The **ASP** should be developed without regard to the financial impact, although an effective program will result in savings from a decrease in *C. difficile* stay, a reduction in MRSA and other drug-resistant organisms, and lastly a decrease in antibiotic procurement costs.

Another issue that has not been well discussed is the potential legal issue. A scenario where a patient develops a Multiple Drug Resistant infection, files a law suit, and as part of the suit includes that fact that the hospital is not in compliance with CMS/accreditation requirements, and thus caused the issue by failure to address the standards/requirements. As with any quality program, it is essential that the entire process is a full and complete loop. From the identification of the problem, the analysis of the processes, and finally to the summary and solutions, it is critical that the **ASP** be codified and that the healthcare organization document their program.

Steven Hirsch & Associates has the expertise to support and assist hospitals with their Antimicrobial Stewardship Program from implementation to process development.

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Granting Deep Sedation to Non–Anesthesiologist

By Margo Smith, RHIT (Retired), CPMSM, CPHQ

When granting Deep Sedation privileges, it is important that the non-anesthesiologist providers be qualified and trained in the practice of deep sedation and be able to recognize and rescue a patient from general anesthesia. Other qualifications should also include a state medical license and DEA certificate.

What type of screening criteria does the medical staff utilize to grant Deep Sedation privileges? There are several options:

1. Have the provider watch a video and then take a post-test.
2. Provide the practitioner with a written tutorial and then complete a post-test.
3. Accept a test/screening result from another accredited facility.

If the provider is required to take a post-test examination, they should past the exam with a score of 90% or higher and should provide evidence of a current Advanced Cardiac Life Support (ACLS) certification. The non-anesthesiologist should be proctored/observed by a member of the medical staff who also holds privileges for deep sedation. The number of cases to be observed is usually determined by the department responsible for overseeing sedation privileges. In many facilities, this responsibility is under the direction of the Department/Section of Anesthesia. A proctoring form for each case should be completed and returned to the Medical Staff Services office.

Does the provider have to retake the exam every year or do they need to retake the test at the time of reappointment, or will the medical staff accept a specified number of cases performed within the past 24 months as evidence of continued competency and if they meet the threshold, they do not have to retake the test. Is that enough to continue to approve the privilege at the time of reappointment? When looking at the number of deep sedation procedures performed, are you also looking to see if there were any outliers, such as the number of patients needing reversal agents?

It is important that the non-anesthesiologist not delegate nor supervise the administration of deep sedation by individuals who are not themselves qualified and trained in deep sedation. There should be written policies and procedures specifying who can perform all levels of sedation, the qualifications needed to be granted the privileges for either Moderate or Deep Sedation, and in which locations sedation can be performed, i.e. Emergency Department, ICU, etc.

If your facility and State law allows for non-physicians to perform deep sedation, the qualifications should be the same as those required for physicians.

About Steven Hirsch & Associates

Steven Hirsch & Associates has been providing healthcare management consulting services including accreditation preparation services to hospitals and other healthcare related organizations throughout the United States since 1987. Beyond accreditation and licensure survey preparedness, our healthcare consulting team can provide assistance in a number of areas including Medicare certification, performance improvement, nursing management, infection prevention and control, Life Safety Code compliance, medical staff services (including credentialing and independent peer review), clinical lab management and compliance with HIPAA. For more information on how Steven Hirsch & Associates can assist you with accreditation and licensure preparedness, Medicare certification and other management challenges, please contact us at (800) 624-3750 or visit www.shassociates.com.