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Accreditation News

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Use of CRNAs in Hospitals and Surgical Care Settings

By Joann Saporito, RN, MBA, HACP and Sharon Cox-Salazar

For many healthcare facilities, the use of Certified Registered Nurse Anesthetists (CRNAs) has morphed into the chosen model for providing anesthesia care. In fact, the use of CRNAs in both rural and under-insured geographic areas has become essential in providing this care (www.anesthesiafacts.com 2022/11). The American Association of Nurse Anesthetists (AANA) claims that "CRNAs/nurse anesthesiologists are the sole anesthesia provider in approximately one-third of all U.S. hospitals, and more than two-thirds of rural hospitals" (Scope of Practice for CRNAs: A Complete Guide, obtained 8/16/22 at malpracticeinsurance.aana.com). However, hospitals have still been receiving citations, sometimes at the "Immediate Jeopardy" (IJ) level, for allowing CRNAs to practice outside of their scope, leaving organizations to wonder whether this model can continue.

For example, an acute care hospital in the Central Valley of California was recently issued an Immediate Jeopardy (IJ) because a CRNA changed the anesthesia type that was originally ordered by the anesthesiologist. A second, near-by short-stay hospital also was issued an IJ due to a CRNA claiming to oversee the entire anesthesia group (Scope of Practice Concerns Lead to Hospital's Temp Ban on CRNAs, A. Audit, 6/26/24, obtained 8/16/24 at Medscape.com). In California, there is no requirement for direct physician supervision. In fact, more than half of all U.S. states have no physician supervision requirement for CRNAs (malpracticeinsurance.aana.com). So, what exactly does a CRNA/nurse anesthetist have the autonomy to do independently?

It is first important to define what a Certified Registered Nurse Anesthetist is. CRNAs are highly educated, advanced practice nurse specialists who must complete several years of education, hundreds of hours of clinical work, and administer a minimum number of anesthetics before they qualify to sit for their national certification examination. Once the education and certification have been completed, the actual scope of practice for CRNAs/nurse anesthetists is determined by state regulation. Thus, what is allowed in one state may be quite different than what is permitted in another. For example, in California and Minnesota, CRNAs are permitted to work without direct physician supervision. In Maryland, CRNAs are not allowed to work independently.

Just as the state allows or prohibits the autonomy of nurse anesthetists, so, too, does the practice model used at the facility. The "CRNA Only Model" is often used in physicians' offices and outpatient care settings as well as in rural hospitals for obstetric care and pain management. In the "CRNA Only Model," the CRNAs are responsible for planning and providing all anesthesia care.

Under the "Collaborative Care Model," CRNAs may consult with, ask advice, and ask questions of the physician anesthesiologists on the care team. And with the "Anesthesia Care Model," an anesthesiologist medically directs 2-4 CRNAs at a time (CRNA Supervision Requirements by State, obtained 8/16/24 at nursejournal.org).

In addition to the care model, the practice setting itself may determine the independence of the nurse anesthetists. Examples might range from a large, educational healthcare system to a short-stay surgery center to a dental office.

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Use of CRNAs in Hospitals and Surgical Care Settings

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Lastly, just because a state has "opted out" of the CMS requirement for CRNA supervision by a physician, this does not make it the rule. Facilities still have the flexibility to determine whether physician oversight is needed. In other words, the state may allow for independent practice of CRNAs, but the organization may still require supervision.

For those states for which physician supervision is required, or for those medical staffs who have imposed supervision regardless of the state requirements, the oversight may be provided through a variety of mechanisms. Examples might include approval of each patient's anesthesia plan by the Anesthesiologist prior to the procedure, immediate availability of an Anesthesiologist by phone for consultation, and retrospective review of medical records. Oversight may be provided by an Anesthesiologist or by the operating practitioner. The details should be clearly defined within the Medical Staff Bylaws or Rules and Regulations.

CRNAs are privileged and credentialed through the Medical Staff Office and are subject to the same vetting that physicians undergo when joining the medical staff. Proctoring requirements should mirror what is required of the Anesthesiologists and include evaluating pre- and post-anesthesia assessment/management and documentation, intra-operative technique, judgement, documentation, and the recognition and treatment of complications (if any). CRNAs and nurse anesthetists should also be included in the Ongoing Professional Practice Evaluation (OPPE) process and include a minimum of two specialty-specific indicators as is required for the Anesthesiologists.

Healthcare organizations will need to review their own local regulations, Medical Staff Bylaws, Rules and Regulations and policies to determine what is permitted in their particular setting, and by what care model anesthesia care will be delivered if CRNAs are on staff, as well as what extent of supervision that should be implemented.

For more information on the Use of CRNAs in Hospitals and Surgical Care Settings contact Steven Hirsch & Associates at (800) 624-3750.

Background Checks

By Joann Saporito, RN, MBA, HACP

Hospitals, Nursing Homes, Assisted Living Facilities, and several other healthcare settings may be required to perform pre-employment and periodic background checks on staff, and sometimes even on volunteers or students, based on local or state regulations and hospital policies. The requirements can vary by the particular health care setting as well as by state. It is important for an organization to understand their particular requirements, and to develop and implement policies that address the requirements.

For example, the Joint Commission at *HR.01.01.01 EP 4* requires the acute care hospital to obtain "a criminal background check on the applicant as required by law and regulation or hospital policy." These may be completed also for applicants to the Medical Staff, students, and volunteers who will provide care, treatment, and services. If the state law, regulation, or organizational policies require background checks for ***all*** employees (regardless of direct patient care duties), then this is what the Joint Commission will survey for. Similar requirements can be found from other accrediting organizations such as the Accreditation Commission for Health Care (ACHC) at *15.01.09 Privacy and Safety: Free From Abuse* which directs surveyors to verify that the hospital has conducted criminal background checks as required by state law for all potential new hires.

Furthermore, federal law within the Patient Protection and Affordable Care Act (PPACA) requires background checks on employees in long-term care facilities.

There are most certainly some exceptions and nuances that should be considered. For example, volunteers and students may be exempt based on local regulations. Temporary or contract workers may be vetted by their staffing agency if permitted by regulations, and emergencies and disasters may allow for temporarily hiring staff without full background checks being completed. In some states or particular settings, subsequent background checks may also be mandatory (such as in nursing homes) on a periodic basis.

Healthcare settings should familiarize themselves with their federal and state statutes, local regulations, and hospital policies to ensure compliance with any requirements for conducting background checks.

Revised Infection Prevention and Control Chapter for Joint Commission Accreditation

By Marietta Hickman, BSN, CIC and David Woodard, MSc, CIC, FSHEA

The Joint Commission (TJC) has published revised Infection Prevention and Control (IC) Standards with an effective date of July 1, 2024. This is a major revision of the Standards and Elements of Performance. The new standards replace all standards (IC.01.01.01 – IC.03.01.01) that were previously in place. This process brings the standards more in line with current regulatory, professional, and evidence-based data.

Executive Summary:

The accredited organization must ensure that the designated individual for Infection Prevention (IP) has been appointed by the Governing Body following the recommendation of the nurse leaders and the Medical Staff. There must be documentation of designation of the Infection Prevention Officer.

The Governing Body must act on the findings of the infection prevention and surveillance program. This can be interpreted as looking at the minutes of the Infection Prevention and Control Committee for identified issues, problems, or concerns, and seeing some action statement in the minutes of the Medical Executive Committee and the Governing Body.

The organization is expected to have an active surveillance program that reports to the Governing Body that includes all aspects of surveillance. While not called out in the TJC document, this would include summary and analysis of National Healthcare Safety Network surveillance activity, rounding for hygiene and regulatory compliance, and any other activity selected and implemented by the Governing Body. Additionally, the organization must have an active occupational health program that manages provision of immunizations for communicable diseases, as well as screening and education related to exposure and prevention. All these activities must be documented, and the documentation must be incorporated into the Governing Body report.

The hospital must be prepared to manage the emergence of "high consequence" infectious diseases or special pathogens. This includes the implementation and maintenance of existing COVID-19 plans, as well as plans for emerging diseases like Mpox and other potential infectious threats that may arise globally, nationally, or within the hospital's catchment area. To effectively manage these threats, the Infection Preventionist (IP) must have access to the Health Alert Network (HAN) from both the CDC and state health departments, along with other relevant communications.

This approach sets clear expectations for a fully functioning Infection Prevention department. Given the requirements outlined, the Governing Body of the hospital must ensure that adequate support is provided, which includes appropriate staffing levels, management and information technology.

IC.04.01.01. "The hospital has a hospital-wide infection prevention and control program for the surveillance, prevention, and control of health care-associated infections (HAIs) and other infectious diseases."

This standard defines the program and its supervision and leadership. It requires that the IP has been appointed by the Governing Body after recommendations from nurse leaders and the Medical Staff.

There is codification of the responsibility of the duly appointed IP for the development and implementation of the surveillance program; the development and implementation of policies and procedures that will guide the activities including prevention measurement; it requires the development and implementation of policies and procedures for cleaning, disinfection, and sterilization of all reusable medical and surgical devices and equipment with particular attention to the cleaning of such equipment.

The policies are to be developed to reflect the complexity of hospital services as well as the size and scope to include all locations and the patient population served. The organization must implement the program through surveillance, prevention, and control activities and these activities must be documented.

Lastly within this Standard, the hospital must implement processes to support the ability of the organization to manage high-consequence infectious diseases or special pathogens (NB. This was originally disease specific but has been broadened to include all such disease or pathogens.)

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IC.05.01.01. "The hospital's governing body is accountable for the implementation, performance, and sustainability of the infection prevention and control program."

The Elements of Performance for this standard define the responsibility of the Governing Body for the overall program and are required to ensure that adequate resources are provided. The resource commitment can include adequate clerical support, space, as well as computer connectivity.

The Governing Body is also charged to ensure that the problems identified by the Infection Preventionist (IP) are addressed through integration with the Quality Management program. It would be expected that the minutes of the Governing Body will reflect any actions taken based on reported infection prevention issues.

IC.06.01.01. "The hospital implements its infection prevention and control program through surveillance, prevention, and control activities."

This standard defines the Infection Prevention and Control program beginning with the requirement for a risk assessment, which is not changed from the prior requirements, with a proviso for a review at least annually. Given the dynamic nature of infection prevention issues, emerging infectious disease, and changing regulatory requirements, best practice would be to review the risk assessment quarterly.

EP 3 defines the implementation requirement including the maintenance of a clean environment, responsiveness to current public health issues, as well as the routine findings from surveillance and reporting.

EP 4 is the outbreak management requirement. It is important that the organization's plan for response to an outbreak is not a litany of steps copied from the epidemiology textbook, but rather a mini plan that defines the roles, responsibilities, and reactions should there be an outbreak amongst the patients, staff, or in the community.

In keeping with the general topic of the program EP 5, the hospital must develop and implement policies for what will minimize the risk of exposure or acquisition of infections that is in compliance with state, local, and federal requirements. These policies must include details for the:

- Screening and medical evaluations for infectious diseases.
- Immunizations required to control, prevent, or minimize the effects of communicable diseases.
- Staff education and training that is documented for all involved employees. It should be noted that this training requirement will be different based on the role of the attendees.
- Management of staff with potentially infectious exposures or communicable illnesses.

IC.07.01.01. "The hospital implements processes to support preparedness for high-consequence infectious diseases or special pathogens."

Similar to IC 6, the IC 7 standard focuses on the management of new and emerging diseases within an organization. This standard requires organizations to have a structured approach to addressing any new or emerging infections. A key aspect of IC 7 is the emphasis on education, training, and ensuring staff competency when faced with a new disease. Organizations are mandated to have an organized response plan that includes provision of essential, documented training on the transmission, epidemiology, prevention, and patient care requirements/protocols related to the specific disease, whether it is newly emerging or re-emerging.

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Revised Infection Prevention and Control Chapter for Joint Commission Accreditation

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As organizations respond to these new standards, emphasize the importance of organizations to adhere to new standards, particularly in healthcare, and ensure that cross-references like "See also EC.03.01.01 EP" are properly addressed. These standards are often revised in response to emerging issues, such as gaps identified in previous versions of regulatory requirements or findings from surveys. The updated standards are designed to clarify the role of Infection Prevention practitioners and help organizations better address new and emerging health threats, such as Mpox, COVID-19, Carbapenem-resistant Enterobacteriaceae (CRE), and Candida auris (C. auris).

Written in part with assistance of CHAT-GPT (Section Seven)

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