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Privileged Communication

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New Rules for Restraint Use

In an effort to improve patient safety, the Centers for Medicare and Medicaid (CMS) have issued new rules for use of restraints in the hospital setting. These rules took effect February 6, 2007. The new rules no longer differentiate between restraints used for medical/surgical purposes and those used for behavioral purposes.

The 3 major changes relate to:

1. **Expanding the categories of practitioners who can conduct patient evaluations when restraints are initiated.** Previously, the attending or other licensed independent practitioner (LIP) needed to see and evaluate the need for restraints within one hour of initiation, when the restraint was initiated for behavioral purposes. The new rule states that when a restraint is used for the management of violent or self-destructive behavior that jeopardizes the safety of the patient, staff or others, a physician or other LIP OR a registered nurse or PA who has received additional training, can evaluate the patient within the one hour time frame. If the evaluation is not performed by the attending or LIP, they must be consulted as soon as possible after the evaluation. In situations where the restraint is used for other reasons, the new rules require only that the condition be monitored by a physician, LIP or appropriately trained staff (not just RNs and PAs) at intervals determine by hospital policy.

2. **Strengthening staff training standards and specifying components of the training.** Staff must be trained and able to demonstrate competency in the application of restraints and monitoring, assessment and providing care to a patient in restraints a) BEFORE using restraints, b) as part of orientation, and c) subsequently on a periodic basis consistent with hospital policy.

3. **Reporting requirements when a patient died while restraints are used or shortly thereafter.** The hospital must report to CMS: each death that occurs while a patient is restrained; each death that occurs within 24 hrs after the patient has been removed from restraints; each death that occurs within a week after restraint where it is reasonable to assume that use of restraints contributed to the death.

If you need assistance with a case that involves restraints, give us a call. *Source: www.cms.hhs.gov*

MRI More Sensitive than CT

In a recently published study conducted at the National Institute of Neurological Disorders and Stroke (NINDS), a part of the National Institutes of Health (NIH), MRI was found to be more sensitive than CT in diagnosing ischemic strokes, the most common form, resulting from blood clots.

This study showed that approximately 25 percent of stroke patients who came to the hospital within three hours of onset, the time frame for approved clot-busting medication, have no detectable signs of damage.

The study showed immediate non-contrast MRI is about five times more sensitive and twice as accurate as immediate non-contrast CT for diagnosing ischemic strokes. Both non-contrast CT and MRI were equally as effective in diagnosing acute intracranial hemorrhage (bleeding into brain). Non-contrast CT has been the standard in emergency stroke treatment, primarily to exclude hemorrhagic strokes, which cannot be treated with clot-busting medication.

Sources: NIH News at www.nih.gov.news or The Lancet, Jan. 27, 2007.

Medical Errors Commonly Reported by Family Physicians

In a group of studies about medical errors in family medicine, the five error types most often observed and reported by U.S. family physicians were:

- Errors in **prescribing** medications
  - Prescribing contraindicated medications
  - Prescribing the wrong medication dose
- Errors in **implementing** laboratory investigations, especially
  - Requested lab test not done
  - Lab performed wrong test
  - Abnormal lab test result not reported promptly
- **Filing system** errors, especially
  - Wrong file used in the office visit
  - Report lost or filed on wrong chart
- Errors in **implementing** medication orders, especially
  - Wrong dose dispensed
  - Wrong drug dispensed
- Errors in **responding** to abnormal laboratory test results, especially
  - Failing to recognize abnormal results
  - Failing to interpret lab results in the context of the clinical picture

"Errors in prescribing medications" was the only one of these five error types that was also commonly reported by family physicians in other countries. *Source: Am Fam Physician 2003,67:697* http://tinyurl.com/2uu4b3

One Word Change in CMS Regs

Risk Managers have been pushing for years for time entries in the medical record to help document the sequence and timeliness of care, but most hospital that have not gone to electronic charting have very few timed entries. Effective January 26th, 2007 **EVERY** entry in the medical record **MUST** be timed. This change is mandated by the regulations known as the Conditions of Participation (CoP) by the Center for Medicaid and Medicare Services (CMS).

"The first applications of this rule are likely to be encountered in EMTALA investigations in the dedicated Emergency Departments of a hospital. CMS has always focused very closely on times and the lack of timed entries will now be a potential STANDARDS violation for medical records that could mushroom into an EMTALA 21 Day Notice of Termination (EMTALA citation)." Policy changes, staff education and intense quality auditing will be required in most facilities. *Source: www.medlaw.com*

Danger Signs During Labor

- Intrauterine pressure above 75 mm Hg.
- Contractions lasting longer than 60 seconds
- Contractions occurring more than every 2 mins
- Fetal bradycardia, tachycardia [slow or fast fetal heart rate] Normal = 120-160.
- Irregular fetal heart rate
- Absence of fetal heart rate
- Thick meconium staining or bloody amniotic fluid
- Umbilical cord as presenting part
- Declining or arrested progress in dilatation/effacement of cervix and descent of fetal part. *Source: Medical-Legal Quick Tips, 2000 and Essentials of Maternity Nursing.*

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