Common Conditions in Decision Reports

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QUALITY PROFESSIONALS • HEALTHY SYSTEM • PUBLIC TRUST

Objective:

Review the most common sections of the OHPIP Standards where there are outstanding conditions following Committee review for:

- Premises that receive a Pass with Conditions rating
- Reassessments specific to medical record-keeping
- Premises that receive a Fail rating

These will be listed in order by frequency with most frequent listed first

Decision Reports:

Common Conditions

In order of frequency by section of OHPIP Standards:

- **Section 4:** Physical Standards (page 14)
- **Section 5:** Qualifications (page 18)
- **Section 7:** Infection Control (page 32)
  - Includes all content from PIDAC's *Infection Prevention and Control for Clinical Office Practice*
- **Section 6:** Procedure Standards (page 22)
- **Section 8:** Quality Assurance (page 33)
- **Section 2:** Medical Director Responsibilities (page 7)

Section 4:

Physical Standards (page 14)

This section refers to the OHPIP Standards specific to premises layout, electrical, equipment, medication, and controlled substances.

Most common conditions in order of frequency:

- Electrical equipment is used appropriately (i.e. is made to be used for medical reasons) and is certified by the CSA or licensed for use in Canada (*4.1.2.1 General Physical Standards, Electrical*)

Section 4:

Physical Standards

- Equipment is inspected annually by a biomedical technician, including refurbished equipment purchased as new for the premises (*4.2.3.1 Procedure Room/OR Physical Standards, Equipment*)
- All materials in the reprocessing area are made of a non-porous material (i.e. walls, backsplashes, countertops, cabinets) and there are no cracks or holes in the walls and/or ceiling (*4.1.5.2 (f) General Physical Standards, Layout, Reprocessing- overlaps with section 7 Infection Control*)

Section 4:

Physical Standards

- There is an evacuation policy and a way to transport patients downstairs if elevators are not working (*4.1.6.1 General Physical Standards, Emergency Measures*)
- A log must be kept for all medical devices (*4.2.3.2 (c) Procedure Room/OR Physical Standards, Equipment*)
- The oxygen tubing, mask and regulator are attached to the portable oxygen tank (*4.3.3 Recovery Area Physical Standards*)

Section 4:

Physical Standards

- There is a refrigerator that is appropriate for medication storage where meds need to be stored at a certain temperature. Food is not stored in the same refrigerator. (*4.4.1 (e) General Medication*)
- There is an available resource onsite to determine appropriate drug dosages and usage (*4.4.1 (i) General Medication*)
- Controlled substances are stored in a designated, fixed locked cabinet and accounted for (*4.5.2 Controlled Substances*)

Section 4:

Physical Standards

- All required medications are on the crash cart appropriate for the level of the premises and they are not expired (*4.6 Drugs for Resuscitation*)
- All required resuscitation and monitoring equipment appropriate for the level of the premises is available onsite (*4.7 Monitoring and Resuscitation*)

  The most common missing equipment include:

  - laryngeal masks
  - defibrillator that is able to deliver synchronized cardioversion
  - endotracheal tubes
  - capnography machine to verify end-tidal CO_2 (qualitative and quantitative)

Section 5:

Staff Qualifications (page 18)

This section refers to the qualifications and education of staff at the premises, including physicians, nurses, sterilization/reprocessing staff and other regulated health professionals.

The most common conditions in order of frequency include:

- Physicians administering sedation must have current ACLS (*5.5 Physicians Administering Sedation*)
- RNs monitoring or recovering sedated patients must have current ACLS (*5.6 Nurse Qualifications*)

Section 5:

Staff Qualifications

- All Nurses have a minimum current BLS to work at the premises (*5.6 Nurse Qualifications*)
- BLS and ACLS for staff is current and includes a hands-on and a theory component (*5 OHP Staff Qualifications*)
- Staff responsible for sterilizing/reprocessing have a College-recognized sterilization certificate valid within 5 years and manufacturer training (for endoscopy premises) (*5.7 Other Staff Qualifications*)

Section 7:

Infection Control (page 32)

Incorporates issues identified using the Infection Prevention and Control checklists and outlined in the PIDAC document.

The most common conditions in order of frequency include:

- Improper use of multi-dose vials
- Improper sterilization of surfaces and equipment
- Not using biological indicators to ensure the sterilizer is functioning properly
- Re-use of single use or disposable equipment
- Lack of related section in Policy & Procedures Manual
- Improper education of staff responsible for reprocessing and sterilization

Section 6:

Procedure Standards (page 22)

This section refers to pre-procedure, intra-procedure and post-procedure processes.

Most common conditions in order of frequency:

- Policies are in place regarding the classification of patients and how the criteria is applied at the premises (*6.1 Pre-Procedures Patient Care Standards and 6.3 Pre-Procedures Requirements: OHP Levels 2 and 3*)
- Anesthesiologists should not be attending to patients in multiple rooms (*6.8 Intra-Procedure Care for Sedation, Regional Anesthesia, or General Anesthesia*)

Section 6:

Procedure Standards

- When physicians administering sedation are also performing the procedure, the patient must be attended by a second individual (Physician, respiratory therapist, RN or anesthesia assistant with ACLS who is NOT assisting in the procedure and who is trained to monitor patients undergoing sedation (*6.8.3.1 Intra-Procedure Care for Sedation, Regional Anesthesia, or General Anesthesia*)
- Patients are continuously monitored and oxygen saturation is documented at regular intervals when Propofol is administered or there is the potential for putting the patient in a state of deep sedation (*6.8.3.1 Intra-Procedure Care for Sedation, Regional Anesthesia, or General Anesthesia*)

Section 6:

Procedure Standards

- End-tidal CO_2 must be continuously monitored and documented at regular intervals if the trachea is intubated or an LMA is used(*6.8.3.1 Intra-Procedure Care for Sedation, Regional Anesthesia, or General Anesthesia*)
- Patient discharge information includes wording such as “The patient and accompanying adult are instructed to notify the premises staff of any unexpected admission to a hospital within 10 days of the procedure” (*6.10 Patient Discharge*)

Section 8:

Quality Assurance (starts at page 33)

This section refers to quality assurance measures at the premises.

Most common conditions in order of frequency:

- There is representation from all staff providing patient care on the Quality Assurance committee and regular meetings are held and minuted (*8 Quality Assurance*)
- There is a chart review process to review completeness and accuracy of entries (*8.1 Monitoring Quality Assurance*)

Section 8:

Quality Assurance

- Tier 1 and Tier 2 Adverse Events are monitored at the premises (*8.2 Monitoring and Reporting Adverse Events*)
- All Adverse Events reports and quality assurance monitoring findings are reviewed by the Medical Director over a 12-month period (*8.3 Review of Adverse Events and Other QA Monitoring Activities*)

Section 2.2:

Medical Director Responsibilities (starts at page 7)

This section refers to role and responsibilities of the Medical Director.

Most common conditions in order of frequency:

- There is a Medical Director present at the premises or an Acting Medical Director is in place (*2.2 Medical Director Responsibilities*)
- Medical Directors notify online for a new premises, have it inspected, and receive permission to begin procedures at the location (*2.2.1 Notification to Operate a New OHP*)

Section 2.2:
Medical Director Responsibilities

- There is a Policy and Procedures Manual with the minimum sections outlined in the OHPIP Standards (*2.2.6 OHP Policies and Procedures*)
- All physicians performing OHP procedures at the premises have notified the OHP program at the College using the online portal and have received permission from College staff prior to working at the premises (*2.2.6.1.1 OHP Policies and Procedures, Administrative*)
    - This may include the need to complete a Change in Scope process prior to working at the premises.

Reassessments:

Medical Record-Keeping

Frequently, PIC directs a reassessment due to medical record-keeping concerns.

- This can be for an individual physician or a group of physicians (e.g. a random selection of anesthesiology records)

PIC may also refer a physician to the *Quality Assurance Committee (QAC)* or the *Inquiries, Complaints and Reports Committee (ICRC)* for further review and consideration.

Reassessments:

Medical Record-Keeping

Most common reasons for a medical record-keeping reassessment:

- Detailed pre-procedure assessment is not documented
- No detailed post-procedure documentation
- Anesthetic/sedation forms do not capture all of the required charting elements as outlined in *OHPIP Standard 6.8.4*
- Records are incomplete on the date of the assessment as per OHPIP Standard 2.2.2 and the CPSO *Medical Record Keeping* policy

Reassessments:

Medical Record-Keeping

- Missing documentation for:
  - The patient ASA classification
  - Patient discussion of procedure/anesthesia risks
  - Airway and dentition assessments
  - IV fluids given to the patient
  - Respiratory rates
  - Level of sedation and sedation scoring
  - Responsibility of discharge and discharge criteria
  - Pathology
  - Consultation notes

Fail Outcomes

Most common reasons for a Fail outcome:

- Regulation breaches (Part XI of Ontario Regulation 114/94 made under the Act)
  - Performing OHP procedures at a new location prior to Committee approval (relocation)
  - Performing OHP procedures at a location, without notification to CPSO
- Lapsed OHPIP Standard requirements since 1st cycle assessment. (e.g. physicians or nursing staff without appropriate qualifications)
- Medical Director lack of oversight at premises

Fail Outcomes

Most common reasons for a Fail outcome:

- Lack of staff with appropriate qualifications for the responsibility of sterilizing/reprocessing
- Significant and/or numerous infection control issues.
- Renovations completed without first completing an online notification to Program Staff and awaiting Committee approval.
- Non-compliance with annual reporting of Tier 2 Adverse Events

QUESTIONS…