Steven Hirsch and Associates

Accreditation News

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Steven Hirsch and Associates

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OUR MISSION

Our mission is to provide dynamic integrated expertise that supports health care organizations in meeting and exceeding patient care standards as mandated by the regulatory environment.

OUR VISION

To provide a positive and supportive environment that fosters professionalism while providing the highest quality client centric consulting expertise in the health care industry.

OUR VALUES

CREDIBLE • ETHICAL
EXPERT • INTEGRITY
PROFESSIONAL
RESPONSIVE

Patient Safety Systems

Well have you read it? Have you realized its importance?

The Joint Commission (TJC) has placed a Patient Safety System (PSS) chapter in the Comprehensive Accreditation Manual with the intention of helping to inform and educate hospital Leadership about patient safety. After all, the ultimate purpose of the TJC accreditation process is to enhance quality of care and patient safety. The intention of the PSS chapter is to assist hospitals in applying existing requirements to help achieve improved patient safety.

The impact of strong hospital leadership in support of an effective patient safety system cannot be overemphasized. Hospitals are complex organizations that succeed by use of collaboration, communication and shared accountability among the various departments and all the way up to the governing body level. Leaders are responsible for the care, treatment and services the hospital provides as well as for management of the hospital's culture of safety.

An interesting fact about the PSS chapter is that it includes standards on Environment of Care (EC), Human Resources (HR), Infection Prevention and Control (IC), Information Management (IM), Medication Management (MM), Medical Staff (MS), Nursing (NR), Provision of Care, Treatment and Services (PC), Performance Improvement (PI), and Record of Care, Treatment and Services (RC) as well as thirteen Leadership (LD) standards. The standards are all also found in their original chapters, where they are scored during accreditation surveys. TJC will cite the standards found to be deficient AND will also cite applicable LD standards that are related to the findings.

These LD standards have been placed into the PSS chapter:

LD.02.01.01 Supporting patient safety and quality through the organization's mission, vision and values
LD.02.03.01 Communicating on safety and quality at hospital and medical staff leadership and board levels
LD.02.04.01 Managing conflict between leaders to protect quality and safety
LD.03.01.01 Maintaining a culture of safety and quality
LD.03.02.01 Using data and information to understand variation in performance and to support quality and safety

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Patient Safety Systems Continued…

LD.03.03.01 Planning that focuses on safety and quality
LD.03.04.01 Communicating information on safety and quality at the staff level, medical staff, patients, and their families
LD.03.05.01 Changes implemented to improve performance
LD.03.06.01 Individual focus on safety and quality improvement
LD.04.01.01 Complying with applicable laws and regulations
LD.04.01.05 Holding staff accountable for their responsibilities
LD.04.04.01 Prioritizing performance improvement activities
LD.04.04.05 Integrating patient safety programs organization-wide

You are encouraged to read the entirety of the Patient Safety Systems chapter and to perform a self-assessment of your organization's provision of safety and quality. After reading the chapter, can you determine whether your organization is where it needs to be and where you want it to be in 2016… and beyond? Are you improving the safety of patient care? Is everyone on board with improvement initiatives? Are members of your organization held accountable? Leadership is required at all levels, from staff to Board, to provide safe quality of care for the patients that are being served.

Written by Linda Paternie, RN, BS, MHA of Associates

Care Plans

Documentation of the patient care plan remains very challenging for clinical staff in many hospitals. During mock accreditation, licensing and certification surveys provided by the Steven Hirsch and Associates team, documentation in the care plan is frequently found to be deficient per Joint Commission standards and CMS Conditions of Participation. As stated in the Joint Commission Comprehensive Accreditation Manual for Hospitals, a care plan is defined as "A written plan based on data gathered during assessment that identifies care needs and treatment goals, describes the strategy for meeting those needs and goals, outlines the criteria for terminating any interventions, and documents progress toward meeting the patient's objectives. The plan may include care, treatment, and services; habilitation and rehabilitation."

Our team is aware of an increase in findings by The Joint Commission and CMS in 2015 surveys related to documentation on the care plan. What follows are some observations and reminders as related to documentation of the patient's care plan.

TJC and CMS state that the patient plan of care is to be:

- Individualized to meet the patient's unique needs as identified in patient assessment, and results of diagnostic testing.
- Maintained and revised based on patient response as well as on current needs for care, treatment and services.
- Modified or "closed out" based on the patient's reassessment and the patient's achievement of goals.

During the mock survey process, common findings include:

- Lack of inclusion in the care plan of goals specific to restraints or to hemodialysis (for patients receiving these modalities).
- Often the care plan is not individualized to the particular patient being reviewed. With some electronic health care documentation systems, there is often a "cookie cutter' approach and a list of patient goals for selection that often results in the same care plan documentation for every patient. Frequent and often repeated goals that are documented include patient safety, infection control and/or education deficit but these goals lack specificity to the individual patient.

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Care Plans Continued…

- Some electronic health care documentation systems do not provide an area for documentation of patient specific goals. Therefore documentation in the care plan sometimes states patient goals that are not reflective or specific to the problems found in patient assessment.
- Oftentimes the goals developed for the patient are not prioritized and do not include a timeline for achievement of the goal(s).
- In most instances, the care plan is not updated nor closed out when the goal(s) has been attained.
- Lastly, documentation on the patient care plan does not comply with documentation requirements stated in the hospital's policy and procedure on documentation of care plans.

So what about solutions?

Care plans provide a road map of sorts to guide patient care. Although long associated with nursing, care plans are to be interdisciplinary and are to be used as a mechanism to communicate actions to the interdisciplinary team.

Hospitals should consider addressing care planning in hospital orientation and re-education of clinical staff on the basics of care plan documentation per hospital policy and procedure.

Make sure the electronic health record (EHR) supports the documentation required for care plans. Perhaps direct contact with the EHR vendor would be beneficial. Audit documentation of the care plan and share audit results and plans for improvement (if required) with the interdisciplinary staff.

And perhaps most importantly, make the care plan a valuable asset to patient care and patient outcomes. Care plans are not just boxes to be checked off!

Written by Linda Paternie, RN, BS, MHA of Associates

Why is Claims History Important in Credentialing?

Verifying claims history from the professional liability carrier(s) will help your medical staff leadership use the information as a risk assessment and a quality measure indicator. Open/pending professional liability claims can show a pattern of malpractice claims filed against the practitioner.

When verifying claims history do you only use the information from the National Practitioner Data Bank (NPDB)? The NPDB should list all the claims where payment was awarded to a patient and/or family. In addition to the NPDB, many of the state medical boards, when verifying licensure, will also provide claims history, but again only claims that have been settled.

Have you made your decision to use only the NPDB when verifying malpractice history for applicants for initial/reappointment because too many of the insurance carriers are charging a fee to process your request? The fees can be up to $50.00 per physician. There are some alternatives to requesting the claims history directly from the insurance carrier.

Instead of using the standard release of information that is submitted with each application for Medical Staff Membership, you can develop a release form in which the practitioner authorizes the carrier to provide the information to the medical staff office. There is no guarantee that this special request will work with every carrier. Many of the carriers will provide the information directly to the physician. Request that the practitioner contact the carrier and have the information sent directly to the Medical Staff Office.

If the practitioner has been affiliated with a facility and was provided professional liability coverage by the hospital, the practitioner can contact the risk manager or insurance carrier and ask that his/her claims history be provided directly to the medical staff office.

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- Pre-accreditation, Medicare certification, and Licensing surveys
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- Human resources management and competencies assessment
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- Clinical laboratory management and CLIA
- Performance improvement (CQI) and Patient Safety consultation
- Management of the Environment of Care (including Life Safety Assessment)
- Joint Commission Survey Interview Training
- PPR Preparation

Why is Claims History Important in Credentialing? Continued…

Your application for medical staff membership or renewal has a section in which the practitioner is required to document all the professional liability claims filed against them, whether open/pending or closed. After gathering all the data you discover that the practitioner "forgot" to list all claims filed, you now will have to contact the applicant and request additional information, as the omission can be considered as "red flag."

Does your credentialing policy have a section that details the number of cases that might be considered as "red flags?" At a minimum, the following criteria should warrant an interview with the Department Chair and/or Credentials Committee. If any of the following occurred within a five year period where:

1. The practitioner has malpractice history with settlements greater than $100,000;
2. Malpractice case(s) where death was the patient outcome;
3. Malpractice case(s) where the practitioner removed the wrong limb/organ;
4. The number of cases where the plaintiff was successful against the practitioner, no matter the amount of the settlement.

When credentialing a new applicant, this is the time to scrutinize all the data available on a practitioner. If there are any "red flags," it may be beneficial to deny the applicant at this time rather than to have them approved and once on staff, a series of malpractice cases begin to surface.

At the time of reappointment, cases that have occurred and/or have been settled within the previous two years should be reviewed, based on the same criteria as for a new applicant.

The medical staff coordinator plays an integral role in identifying and flagging malpractice cases that should be reviewed by the medical staff leaders responsible for credentialing.

Written by Margo Smith, RHIT, CPMSM, CPHQ of Associates

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.