Steven Hirsch and Associates

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Steven Hirsch and Associates

18837 Brookhurst Street
Suite 209
Fountain Valley, CA 92708

Toll Free: (800) 624-3750
Phone: (714) 965-2800
Fax: (714) 962-3800

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Don't Let ASP Bite

For the past years, there has been an ongoing effort to implement Antimicrobial Stewardship Programs (ASP) at all levels of care. The implementation of the ASP has now become an element of the Centers for Medicare Services (CMS) survey process, and thus has also become a standard with The Joint Commission (TJC) and other accrediting organizations. Each hospital, long-term care, ambulatory care, and home-care organization, or for that matter, any agency that prescribes antibiotics, should develop a program that will meet the required elements, but be manageable within their abilities.

The Joint Commission new Medication Management Standards MM.09.01.01 et seq. which becomes effective January 1, 2017, require that all organizations have an ASP based on evidence based guidelines (EP1). EP2 requires that "Leaders establish antimicrobial stewardship as an organizational priority," and EP3 identifies the need for education of both hospital staff and the licensed independent practitioners, and the education should be continued as an annual event. EP4 discusses the composition of the team. There is an expectation that this team include a Pharmacist, an Infectious Disease physician, and the Infection Preventionist, some of whom can be part time in small organizations including critical access hospitals.

Every organization should develop the following elements to facilitate an ASP. The development of an antibiotic formulary, standards for prescribing, a committee to oversee and coordinate the activities, and a system to monitor the program.

Each organization should perform an assessment and gap analysis to determine where they are within the context of the guidelines. This should be objective and realistic, for example if you do not have a surgical service, a discussion of prophylaxis for surgery would be unnecessary. There are some organizations who have been quite successful with requiring preauthorization, recognizing that this will require consideration of time and expertise.

The preparation of an antibiogram is a useful document both in terms of determining risks e.g. 65% of all *E. coli* are resistant to fluoroquinolone antibiotics would be a starting point for making suggestions about restrictions and guidelines.

A review by both Pharmacy and Infection Prevention regarding prophylaxis (agent and duration) is essential in the monitoring process. A "match" be-

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Don't Let ASP Bite Continued…

tween the suspected pathogen ie. S. aureus in joint surgery, anaerobes in GYN surgery, should occur. Essentially, make sure that the prophylaxis is appropriate for the intended surgery. The surveillance program with the IP involvement can also help identify those patients who are being treated unnecessarily (colonization, particularly with asymptomatic bactiuria).

The implementation of an ASP can, on first view, be overwhelming. However, if one dissects the recommendations, it becomes somewhat more manageable. The first task is to find the evidence-based guidelines that will provide a structure and framework for the program based on the structure of the organization. All organizations should, as the Infectious Disease Society of America (IDSA) suggests, incorporate this commitment into the core mission statement and to allocate financial resources.

The next step is to develop a system of education. This recommendation is vague in its interpretation, but minimally there should be evidence of making the prescribers aware of the mission, and the process that the organization is using to develop and implement the program. The guidelines, however, are very clear that "passive" education is of little or no value. For teaching facilities, the leaders should, if at all possible, have formal training in infectious diseases. The rationale for the Committee/Team being chaired by an Infectious Disease physician is that he/she can provide the clinical intervention and guidance. The IDSA is also supportive of having an infectious diseases trained pharmacist and a clinical microbiologist involved.

As many organizations have progressed to CPOE, this too offers an opportunity to better manage and track antibiotic usage. Having as many protocols in place as possible will decrease the excursions into the world of new antibiotics.

Syndromic surveillance – is influenza being treated with Azithromycin, or is an oral agent reasonable and appropriate? An organization could cycle through the various sites of infection, i.e. lower respiratory tract, gu, skin and soft tissue and limit aggressive monitoring to only select sites for given time frames. Part of this picture should include looking at the high-volume types of cases where antimicrobials are being used and setting a priority based on that.

Regardless of the model for implementation, the organization must obtain, review, and implement the most current iterations of evidence-based guidelines for use of antibiotics.

Resources are available on-line, and this is a brief list and does not indicate endorsement nor is it intended to be all inclusive.

California, not unexpectedly has an entire website devoted to the program.
http://www.cdph.ca.gov/programs/hai/Pages/AntimicrobialStewardshipProgramInitiative.aspx
This website has linkage to various methodologies based on the mission of the organization.
www.hopkinsmedicineorg/AMP
http://cid.oxfordjournals.org/content/62/10/e51
https://dason.medicine.duke.edu/sites/dason.medicine.duke.edu/files/april_2016_dason_newsletter_-_ar_atlas_final.pdf
http://dev.shea-online.org/PriorityTopics/AntimicrobialStewardship.aspx

Written by David Woodard, M.Sc., MT(AMT), CLS, CIC, CPHQ, FSHEA

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.

Behavior Management Committee: A Way to Provide Positive Intervention

The practice of medicine can be very difficult in the current environment of government regulations, hospital policies, importance of patient satisfaction and the practitioners' personal stresses. Practitioners may act out inappropriately, i.e., yelling, cursing, tossing items, etc. There needs to be a mechanism to promptly deal with these issues.

Many medical staff department chairs have expressed concern that these types of issues should not be discussed at the committee level, since the purpose of peer review is usually seen as a mechanism for discussing clinical issues. The department chair may decide to speak to the practitioners face to face, which may occur in an informal setting, i.e., doctor's lounge, hallway, etc., with no documentation that the conversation was held.

Eventually, there may be several of these types of issues with the same practitioner and at some point, the medical staff leadership may consider taking action, but with lack of documentation this can make the disciplinary process difficult. Establishing a Behavior Management Committee may help both the practitioner and the medical staff.

This Committee serves as an intermediary and does not replace the Physician Aid or Well-Being Committee. The function is to speak to the practitioner about the events reported and give the involved practitioner an opportunity to improve without having to refer the issue to the Physician Aid Committee. This Committee's composition should include the Chief of Staff, the medical staff service professional, the appropriate department chair and the involved practitioner, and may include a representative from the Quality Department.

The quality review report which details the incident will be discussed with the practitioner in the committee setting. The practitioner is then given an opportunity to present their side of the event. Once the discussion has been concluded, the practitioner will be sent a letter summarizing the meeting. The letter will be placed in the practitioner's credentials file.

Each hospital will need to develop its own policy to determine the number of times a practitioner can be summoned to the Behavior Management Committee before being referred to the Physician Aid or Well-Being Committee, or when actions are severe and disciplinary action is indicated. The Behavior Management Committee does not make recommendations for outside counseling; that is a function assigned to the Physician Aid Committee.

It has been my experience that once a practitioner has met with the Behavior Management Committee, the practitioner often is not aware of how their actions are perceived and they make a concerted effort to not repeat their behavior.

The Behavior Management Committee is a quick meeting and does not report to any medical staff committee, but the Quality Department and/or the Medical Staff Office maintains the summary letters and they can be tracked as part of the reappointment process. If the medical staff leadership decides to implement a Behavior Management Committee, it should follow the rules in the Medical Staff Bylaws/Code of Conduct as to describing inappropriate behavior and should define the levels of actions that can be taken, e.g, referring to Physician Aid Committee or to the medical staff leadership for disciplinary action. As with all policies that may affect a practitioner's right to practice, it is best to consult your medical staff attorney before implementing a Behavior Management Committee.

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

Titratable Medications… Is Your Organization in Compliance?

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- PPR Preparation

We at Steven Hirsch Associates have found that in The Joint Commission surveys recently, orders for titration of medications are a focus of attention. MM.04.01.01 EP1 states that the hospital is to have a policy that identifies the specific types of medication orders that it deems appropriate for use. These orders commonly include titration orders.

Titration orders are orders in which the dose of the medication is either progressively increased or decreased in response to the patient's status. We advise all organizations to review their policy on what elements are required for medications whose doses are titrated and to make sure to include a definition of the elements for a complete titration order for medications.

Elements of medication titration orders include:

- Does the order include an initial rate for the starting dose? (i.e. Initiate infusion at xxx).
- Are goal parameters for giving a certain dose included? (i. e. Titrate to RASS goal of -2).
- Is the maximum dose specified in the order? (i.e. Notify provider for dose greater than xxx) or (Maximum dose of xxx should not be exceeded).
- Are adjustments included in the order? (i.e. Titrate by xxx as needed every 5 minutes to reach goal parameter of xxx).
- Is a specific weaning order included? (i.e. Wean sedation by xxx every 5 minutes).

There should be no option available for the nurse to select dosing increments or frequencies for changing doses independently. Physiologic parameters need to be written in a specific manner in the order.

It is important to assure that the order provides enough direction to allow the nurse to safely carry out the order. Clinical staff are to assess and document the patient's status after every incremental dose or more often as indicated by the patient's clinical condition and in accordance with hospital policy. For example, if the policy and procedure states that documentation of the RASS score is required at a minimum of every four hours and as needed for titration, this documentation must be complete and recorded in a timely manner.

A best practice is to develop an order set or order template for titratable medications, while allowing modification by the prescriber.

Unacceptable orders may be as follows:

- "Start norepinephrine infusion titrated to a MAP greater than 65."
- "Propofol IV titrate for light sedation."
- "Initiate Dobutamine. Start at 5 mcg/kg/min and titrate to improve perfusion up to 10 mcg/kg/min."

For example, our team has observed numerous situations in which the appropriate sedation scale is not used correctly, is not documented completely or accurately, or is not documented in a timely manner consistent with changes in dosage.

MM.04.01.01 EP13 states that the hospital implements its policies for medication orders. It is important for the organization to review its documentation and practices of those who adjust doses of titration medications to ensure their process is consistent with the medication order and with policy.

Following a well developed policy and procedure is essential.

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