Steven Hirsch and Associates

Accreditation News

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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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WWW.SHASSOCIATES.COM

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

Hospitals, Critical Access Hospitals, and Ambulatory Surgical Centers

CMS made revisions to the Hospital and Critical Access Hospital Conditions of Participation on May 16, 2012, and on March 15, 2013 issued Guidance to Hospitals, Critical Access Hospitals and Ambulatory Surgical Centers in the form of revised Interpretive Guidelines. Revisions have been made to Appendix A, Appendix W, and Appendix L of the State Operations Manual.

A summary of the changes is provided below, as provided by the Centers of Medicare and Medicaid Services, with minor editorial changes. Should you have any questions regarding these changes in the Interpretive Guidelines or require assistance in their implementation, please do not hesitate to contact us.

Hospitals

Multi-Hospital Governing Body

If a hospital is part of a hospital system of separately certified hospitals, the system has the option of having a single governing body serve as the governing body for each hospital within that system. Each separately certified hospital must continue to demonstrate its compliance with the Medicare CoPs on a hospital-specific basis.

Medical Staff Membership on the Governing Body

Revisions to the Conditions of Participation include a new requirement for a member of the medical staff to serve on the governing body. However, consistent with SC-12-36 HOSPITAL, issued June 15, 2012, CMS is not providing guidance on this provision at this time. Subsequent to adoption of the regulation, numerous questions and concerns were raised by various stakeholders that affect survey and certification assessment of compliance with this requirement, including the questions about interaction of this requirement with other Federal, State or local laws. In addition, a recent notice of proposed rulemaking published on February 7, 2013 (78 FR 9216) proposes to amend this requirement. Therefore, surveyors should not interpret on their own the requirement concerning medical staff membership on the governing body, and must not issue citations related to this specific provision. In addition, CMS has instructed TJC, HFAP, and DNV not to revise their accreditation standards related to this aspect of the composition of the governing body until CMS has addressed the issue completely.

Patients' Rights Restraint/Seclusion Death Reporting

- Soft wrist restraints only: Hospitals must maintain an internal log of all deaths associated with the use of restraints where the only restraints used were two-point soft wrist restraints. There is no longer a need for them to submit reports of these cases directly to CMS.
- All other cases: All other deaths associated with use of restraint or seclusion must be reported to the CMS Regional Office no later than close of business on

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the next business day following knowledge of the patient's death. Reporting may be by telephone, facsimile or electronically, as determined by CMS. CMS has created a new worksheet that is to be used by hospitals for facsimile or electronic submission.

Medical Staff

- Non-physician members: The revised regulation clarifies that hospitals have the flexibility, consistent with state scope of practice laws, to include non-physician practitioners on the medical staff in addition to physician practitioners. According to the final rule preamble, all practitioners granted privileges must be members of the medical staff. Please note that the revised regulation may conflict with state law requirements that limit medical staff membership to physicians, dentists and podiatrists. CMS is expected to issue revised guidance at a later time. In addition, CMS is reportedly instructing the three accreditation organizations (TJC, HFAP, and DNV) that they are not required to include this provision in their accreditation standards at this time.
- Medical staff leadership: As permitted under state law, hospitals have the flexibility to assign a doctor of podiatric medicine to be responsible for the organization and conduct of the medical staff.

Nursing Services

- Interdisciplinary care plan: Hospitals have the flexibility to incorporate the nursing care plan required for each inpatient into an interdisciplinary care plan.
- Standing orders: Drugs and biologicals may be prepared and administered on the orders contained in preprinted and electronic standing orders, order sets and protocols (collectively referred to as "standing orders" in the CMS guidance) only if the standing orders meet the requirements of the medical records CoP.
- Blood transfusion training: The requirement that personnel who administer blood transfusions, other than doctors of medicine or osteopathy, have special training has been eliminated.
- Self-administered medications/Medications brought from home: Hospitals have a new option to permit self-administration by patients (or the patient's caregiver/support person) of hospital-issued medications and/or medications brought by the patient from home.

Medical Records

- Authentication of orders: All orders, including verbal orders, must be dated, timed and promptly authenticated by the ordering practitioner or another practitioner responsible for the care of the patient, in accordance with state law, including scope of practice laws, hospital policy and medical staff bylaws, rules and regulations. A specific timeframe for authentication of verbal orders has been eliminated.
- Standing orders criteria: Standing orders may be used only if the hospital: ensures the orders are reviewed and approved by the medical staff (i.e. Pharmacy and Therapeutics Committee) and the hospital nursing and pharmacy leadership; demonstrates the orders are consistent with nationally recognized and evidence based guidelines; ensures periodic review (annual) to determine their continuing usefulness and safety; and ensures that the orders are dated, timed and authenticated promptly.

Pharmaceutical Services

Internal reporting: The provision concerning internal reporting of drug administration errors, adverse drug reactions and incompatibilities has been revised to correct the name of the program receiving such reports to "Quality Assessment and Performance Improvement Program." Thus, not only must these reports be made to the attending physician, but also, if appropriate, to the hospital's quality assessment and performance improvement program.

Infection Control

Incident log: The requirement to maintain a line listing of incidents of infection and communicable diseases has been eliminated. Hospitals are still expected to conduct appropriate surveillance activities, consistent with nationally recognized infection control standards of practice.

Outpatient Services

Direction of outpatient services: Hospitals are no longer required to have a single individual directing all outpatient services, providing more flexibility for hospitals to organize their management of these services in the manner they find most efficient and effective, so long as one or more individuals is assigned responsibility for each outpatient service.

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Hospitals, Critical Access Hospitals, and Ambulatory Surgical Centers Continued...

Outpatient staffing: Hospitals must have appropriate professional and nonprofessional personnel available at each location where outpatient services are offered, based on the scope and complexity of outpatient services.

CAH CoP Changes

Personnel Qualifications
The qualifications to be considered a clinical nurse specialist have been updated to be consistent with the statutory definition.

Definition & Physical Plant and Environment; Provision of Services

- The definition of "direct services," i.e., services provided by employees of the CAH, has been removed.
- All references to the CAH providing certain services "directly" have been removed. CAHs now have the flexibility to provide required services either directly, i.e., through staff employed by the CAH, or under arrangement. However, regardless of whether the services are provided directly or under arrangement, the minimum required services listed under §485.635(b) must be available on-site at the CAH.

Surgical Services
The regulatory text has been clarified to state explicitly that surgical services are optional services for a CAH.

Written by Steven Hirsch, MPA, FACHE of Associates

Intracycle Monitoring 2013

The Joint Commission created the Intracycle Monitoring Process (ICM) to help promote continuous compliance to standards by formalizing the assessment of the standards. All Joint Commission accredited organizations will have an ICM profile, located on the organization's Joint Commission Connect 'TM' extranet site.

Within the Intracycle Monitoring is the Focused Standards Assessment (FSA). Use of this tool gives the organization the opportunity to assess its compliance with The Joint Commission standards, the Accreditation Participation Requirements (APRs) and with the National Patient Safety Goals.

APR.03.01.01 requires Joint Commission accredited organizations to complete a Focused Standards Assessment (FSA) and to develop as needed "Plans of Action" (POA) with necessary "Measures of Success" (MOS) for the standards found to be out of compliance. It is important for the accredited organizations to involve physicians in the completion of the FSA and in the formation of the POAs. In addition to the Measures of Success (MOS), the POA should include target dates for implementation of the corrective action plan.

There are four ways in which the accredited organization can fulfill the Focused Standards Assessment requirement:

1. Full FSA: Complete the full FSA of the requirements and standards appropriate to your organization, develop a "Plan of Action" to bring non-compliant standards into compliance and submit the FSA electronically to The Joint Commission.
2. Option 1: Complete the FSA, formulate the POA and attest to completion without submitting data to The Joint Commission.
3. Option 2: Request and undergo an on-site visit from a Joint Commission surveyor who will leave a written report. The hospital will need to submit a POA within 30 days with Measures of Success (MOS) identified for the non-compliant standards.
4. Option 3: Request and undergo an onsite visit from a Joint Commission surveyor with no written report to the hospital nor transmitted to The Joint Commission. Findings are communicated verbally to the accredited organization.

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Intracycle Monitoring 2013 Continued…

Regardless of which option is chosen, the accredited organization will need to plan for the Focused Survey Assessment, conduct the assessment, report the results and correct any identified areas not achieving compliance with the standards.

RISK-RELATED STANDARDS

The Joint Commission has identified risk-related standards. These standards are identified by risk icons in the Comprehensive Accreditation Manual for Hospitals (CAMH) and also in the Focused Standards Assessment tool. The risk-related standards for hospitals include:

1. All National Patient Safety Goals
2. Standards related to specific risk areas for hospitals including:
    - Assessments
    - Cleaning, disinfection and sterilization
    - Contract services
    - Coordination of care
    - Diagnostic imaging
    - Information technology
    - Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE)
    - Patient-centered communication/disparities of care
    - Patient flow
    - Staffing
    - Transplant services
3. All direct impact and select indirect impact standards. Remember, direct impact means requirements that, if not met, are likely to create an immediate risk to patient safety or quality of care.
4. Standards listed as Requirements for Improvement (RFIs) from the accredited organization's previous survey.

Anytime we are asked to survey ourselves, there is a potential that a thorough and comprehensive assessment may not be done, especially in today's fast-paced healthcare environment with so many competing priorities and demands on staff time, staff focus and staff energy. It is to your organization's benefit to proactively identify actual problem areas and then to work on development and implementation of improvement initiatives. The most significant results of those activities will be the enhanced safety and quality of care in your organization as well as continuous standards compliance. Issues then become corrected in a timely manner and are not just "fixed" right before your Joint Commission survey. Continuous survey readiness should be the mantra for all organizations that are accredited by The Joint Commission.

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

About Steven Hirsch & Associates

As recognized experts on Joint Commission, HFAP, and DNV accreditation, licensure preparedness and facility management issues, 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.

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 go to our web site at www.shassociates.com.