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

2014 Survey Readiness

As we are aware, there are repeating themes in survey findings, whether the surveys are conducted by The Joint Commission, the Centers for Medicare and Medicaid Services or by individual state agencies. The following are common themes found in surveys over the past year… for your information and for your avoidance as you prepare for success!

Document Review

The Joint Commission has added the following to their Document Review List: your agreement with the Organ Procurement Organization (OPO); Organ, Tissue and Eye procurement policies; written fire response plan; Interim Life Safety Measure policy; Fire drill evaluations; annual review of the Infection Control program; autopsy policy; blood transfusion policy; restraint and seclusion policy; waived testing policy and quality control plan.

Infection Control

Cleaning before disinfection/sterilization is essential. Reprocessing is a multistep process that includes cleaning as well as disinfection or sterilization. Surveyors may quiz your staff on the steps involved and/or observe your staff during the reprocessing of instruments and devices. Of importance is whether instruments in surgical trays and peel packs are in their "open" position to assure that all surfaces are exposed to sterilant. Failure can be cited as Immediate Jeopardy (IJ). Is your staff comfortable and competent in performance of their duties? Has the staff been observed in performance of their duties? Are your policies and procedures updated and followed by your staff? Can your equipment/instruments be tracked to a specific patient? Are the solutions used appropriate to their application? Hospital acquired infections are yet to be eradicated in the very places, hospitals, where infections should be least present. All infection prevention and control practices and related topics are of prime focus for surveyors.

Temperature and Humidity

Why is the correct humidity in anesthetizing locations so important? Too much moisture in the air can lead to mold growth, while too little presents an opportunity for static electricity. CMS issued a Life Safety Code waiver in April 2013 that permits hospitals to operate with a relative humidity of 20%-60%. This waiver does not apply to states/local areas requiring more strin-

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2014 Survey Readiness Continued…

gent humidity levels. Remember, if your hospital has elected to use the 20%-60% range, written documentation/disclosure of such must be presented to any survey agency assessing Life Safety Code compliance. It should also be disclosed in the notes attached to the e-SOC.

Leadership

Safety, quality of care, treatment and services depend on many factors, including leadership. Leadership standards are being cited much more frequently than in the past. Areas of focus include: adequate staffing; patient/staff/visitor safety; hospital culture related to safety and the elimination of risk; communication, and communication as specific as the requirement to be informed of the patient's primary language AND the patient's preferred language; oversight of and awareness of quality provided by contracted services; patient flow… and not just patient flow in the Emergency Department but throughout the organization; and of course, Life Safety and Environment of Care practices.

Documentation Documentation Documentation

Areas that continue to be problematic include: documentation of care plans and patient assessment/reassessment in the medical record; medication administration including the use of preprinted and electronic standing orders, order sets and protocols that have been reviewed by the medical staff, by nursing and by pharmacy AND that are evidence based; all entries into the medical record are timed and dated; pain management; and both pre-operative/pre-procedure as well as post-operative and post-procedure documentation. Do you need to have some type of concurrent medical record review in place that helps identify your vulnerable areas as related to documentation?

QAPI

Quality Assessment and Performance Improvement (QAPI) is addressed in many ways in all aspects of surveys. A more formal approach is being used by CMS which has published a risk evaluation tool. The tool is used to assess/determine compliance with the QAPI Conditions of Participation. Has your organization completed a self-assessment using this tool?

Environment of Care, Emergency Management and Life Safety

Several of the Joint Commission standards with the related CMS Conditions of Participation remain on the most frequently cited list. In California, if your organization has a fire pump to support fire suppression systems, weekly testing must be performed by a licensed (by the State Fire Marshal) individual. Remember, if a patient care area looks cluttered, it is cluttered. Do areas in your hospital look cluttered? Are your hospital's negative and positive pressures appropriate to the location and function? For example, is the endoscopy processing room negative to the egress corridor? Endoscopy suites in California are required to have negative airflow. So, if endoscopy is performed in an operating room, the organization likely is out of compliance, since operating rooms are required to have positive airflow. All soiled utility spaces must also have negative airflow. Are the medical gas systems in compliance? Is your fire safety training consistent with your fire plan? Is a leader appointed to oversee emergency management? Don't forget, if you are in California, hospitals are expected to conduct quarterly internal disaster drills, in addition to fire drills, on each shift.

And a final note… why do we do all of these things?

Because of law? Yes
Because of regulation? Yes
Because we want accreditation? Yes
Because we want to provide the best patient care and care outcomes possible?
Absolutely YES!

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

Understanding Rapid Influenza Diagnostic Tests Part 2 of 2

In Part 1 of this article, the advantages and disadvantages of Rapid Influenza Diagnostic Tests (RIDTs) in diagnosing influenza were discussed. Although RIDTs are point-of-care tests which can bear results in fifteen minutes, they carry the disadvantage of having sensitivity as low as 60%. False-negative results in a setting of influenza can negatively impact patient care and infection control decisions.

Alternative tests exist with significantly higher sensitivities than the RIDT. One of these, the Reverse Transcription-Polymerase Chain Reaction (RT-PCR) is considered a gold standard test for influenza infection. This test is often performed by a reference lab, which can result in a total turnaround time of 3 to 4 days. RT-PCR is a molecular assay test that can detect the presence of viral RNA in respiratory specimens, and is one of the most sensitive tests for influenza. Some are able to detect and discriminate between infections with influenza A and B viruses, and others can identify influenza A virus subtypes.

Although RT-PCR is highly sensitive and specific, negative results can occur in patients with influenza. One influencing factor is the amount of viral shedding that is occurring. Influenza viral shedding in the upper respiratory tract generally declines after four days in patients with uncomplicated influenza, resulting in a false-negative RT-PCR result.

Hospitalized patients with lower respiratory tract influenza may have longer lower respiratory tract viral replication than in the upper respiratory tract. For critically ill patients with suspected influenza with negative upper respiratory tract RT-PCR results, consideration should be given to collecting lower respiratory tract specimens, such as bronchial washings. Some laboratories, however, do not accept lower respiratory tract specimens for testing. Laboratories should be contacted prior to sending these specimens.

Influenza Testing - The Future

Improvements in sensitivities of RIDTs will likely require several approaches, including 1) improvement of specimen quality by early collection and adherence to manufacturers' recommendations for specimen collection, 2) improvements in swab material for better viral capture, and 3) improvements in RIDT test assay chemistry.

Molecular assays such as RT-PCR that can be used at the point-of-care would significantly improve care of the patient with influenza. The necessity of sending specimens to a reference lab can cause crucial delays in diagnosis and management. To bring molecular assays to the point-of-care, however, will necessitate decreasing the test's complexity and require substantial institutional investment.

References

1. Kumar and Henrickson, "Update on Influenza Diagnostics: Lessons from the Novel H1N1 Influenza A Pandemic". In: Clinical Microbiology Review Vol. 25 Number 2, April 2012, pp. 344-361.
2. Guidance for Clinicians on the Use of Rapid Influenza Diagnostic Tests. www.cdc.gov.flu.

Written by Judy Hagerty, RN, MS, CIC 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, 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.

The Value of Peer References

Peer reference letters are only of real value if one asks the right questions. The Joint Commission requires peer references to verify experience, ability, and current clinical competence in performing the requested privileges. The best peer is someone who is knowledgeable about the applicant's professional performance. The peer reference is someone within the same specialty, but a valuable peer is someone who can attest to the practitioner's current clinical competency. This may be a consultant, a referring physician or an anesthesiologist who can attest to the competence of a practitioner who is requesting clinical privileges.

The questions should include how does the peer know the applicant? The peer should be a colleague, a training director, department chair, or someone who they refer to for specialized or surgical procedures. The peer should not be a family member and most Medical Staff Bylaws will only allow one or two peer references to be an associate.

How long has the peer known the applicant? I would accept someone who has known the applicant for a minimum of six months. One wants to avoid references who have only known the applicant for a few months and on the other side, the peer should not be someone who has not recently seen the applicant.

In order to have a comprehensive peer reference questionnaire, it is recommended that the reference attest to the applicant's ability to practice the privileges requested by answering questions including those related to the applicant's physical and mental health status. The Joint Commission in the 2014 Comprehensive Accreditation Manual for Hospitals requires that peer reference letters address the following six General Competencies.

1. ***Patient care*** – practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
2. ***Medical knowledge*** – practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.
3. ***Practice-based learning and improvement*** – practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
4. ***Interpersonal and communication skills*** – practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
5. ***Professionalism*** – practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude towards their patients, their profession, and society.
6. ***Systems-based practice*** – practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

The questions can be scored using a numbering system 1-5, with 5 being excellent or a "fair to excellent" scoring system. Whatever system is used, any question scored a 3 or lower or any questions answered "fair" should be followed up by a physician leader, e.g. Credentials Committee Chair or designee, Department or Division Chair, or the Chief of Staff, whoever the Medical Staff Bylaws have designated as the person responsible for oversight of the credentialing process.

The questionnaire can have as many questions as the medical staff leadership determines that they need to evaluate an applicant. Try not to have a letter that has too many questions or more than 2 pages, as most respondents will more than likely read each question and complete the form if it can be done within a few minutes.

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The Value of Peer References Continued...

The most important part of the peer reference letter is when it is reviewed by the medical staff coordinator. There are two types of coordinators, the "gatherer" who only checks that the letter has been received and does not read the answers, and the "assessor," who reads and evaluates the responses. Assessors are more likely to point out any unfavorable or questionable responses. It is important that the form be checked to ensure that all the questions have been answered, that the answers are favorable to the applicant and most importantly, that if the respondent states, "call me," that the letter is shared with the medical staff personnel who are responsible for oversight of the credentialing process and that a call is made to the respondent. This will help to identify possible problems with the applicant.

A good peer reference questionnaire is a valuable source of information for gathering information on an applicant's current clinical competency, professionalism, communication skills and other attributes that will assist the medical staff leaders in making their credentialing and privileging recommendations.

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

The Joint Commission Accreditation Survey… The Competency Review Session

Your hospital accreditation survey is coming to a close and The Joint Commission surveyor is preparing to conduct the competency review session. The surveyor has accumulated names of various staff members and contract staff during the course of the proceedings of the past few days. It is typical that these names are used in requesting personnel files for competency review. Your organization is to promptly gather and provide the personnel files, along with appropriate leadership staff to assist in accessing the records. It is common to include members from the Human Resources Department, from the Education Department, the Employee Health/Occupational Health nurse and appropriate department managers with the authority to access information located in personnel files. It is essential that your hospital representatives are familiar with the contents of the records and the locations in the files where the specific contents/competencies are located. This is not the time to be rapidly dashing through reams of paper trying to locate the documentation required for the specific standards being reviewed. Practice is usually quite beneficial for hospital leaders participating in this review. This session may last 30 to 60 minutes, which does not give time to rifle through paperwork. Organization is essential to success.

However, the review of the files themselves is not the primary focus of this session. The surveyor verifies process-related information through the documentation found in the personnel files. During this time, the surveyor learns about your organization's competency assessment process for staff, as well as organization's orientation, education, and training processes as they relate to the specific staff files selected for review.

There are many Joint Commission standards that reference staff orientation, education and competency. These standards include requirements for staff education on anticoagulation therapy, prevention of health care associated infections, central line blood stream infections, and surgical site infections (National Patient Safety Goals).

Provision of Care, Treatment and Services standards call for staff training and competence on restraint and seclusion utilization, as well as on recognition of and intervention for patients who may be victims of abuse, physical assault, sexual assault, domestic abuse, elder or child abuse or fiduciary abuse. Transplant Safety standards include reference to training related to potential organ, tissue or eye donations. Waived Testing standards require specific staff orientation, training and competency

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The Joint Commission Accreditation Survey… The Competency Review Session Continued…

for each test the staff performs.

Human Resources standard HR.01.06.01 states that staff performing patient care, treatment and services are competent to perform their responsibilities. Most hospitals include the specific role competency for each staff member as reflected in their job description, which is signed by the individual. Orientation is to be provided before the staff member provides the care, treatment or services and is to include: infection prevention and control, assessing and managing pain, cultural sensitivity and diversity, environment of care, life safety, and patient rights and ethical aspects of care. In addition, as appropriate, law enforcement and security personnel are to be oriented on how to interact with patients, responding to unusual clinical events and incidents, distinction between clinical and administrative seclusion and restraint, and channels of clinical, security and administrative communication.

Remember to document staff participation in ongoing education and training whenever staff responsibilities change. Staff education and training is to be specific to the needs of the patient population served at the hospital. Team communication, collaboration and coordination of care are also topics to be covered in the education and training processes. Fall reduction activities, identification and responses to a change in patient condition as well as the need to report unanticipated events are also requirements that need to be addressed through staff education.

An area that is at times overlooked by hospitals is the need to provide education and alternative procedures to be used when electronic information systems become unavailable. Be sure that your organization's resources used by staff, such as reference books and materials, are current and authoritative.

It is essential that the same level of orientation, training and competence is required of contract staff that is required for personnel employed by the hospital, and that the timelines for achieving the education are the same for staff and contract staff. Documentation of orientation and competency needs to be complete for contract staff as it is for hospital employees.

A focus in all Joint Commission accreditation surveys is the reduction of risk of infection through use of equipment, supplies and devices. It is essential that the hospital makes sure that routine staff competency validation for disinfection of devices is completed not only at orientation and during training, but as a matter of periodic assessment of competency and that documentation is complete for each person performing cleaning and disinfection functions.

Of course, maintenance of documentation of staff training and current certification on resuscitation and moderate sedation is essential for staff performing these functions. Primary source verification and documentation is required when law, regulation or the organization requires the individual to be currently licensed, certified or registered to practice his/her role.

Documentation of employee health screening as required by law and regulation or hospital policy is also expected, and is reviewed in the competency assessment session, as is validation that the hospital evaluates staff performance at least once every three years, or more frequently as required by hospital policy or in accordance with law or regulation. Once your organization has a successful system in place, maintenance of personnel files is an ongoing, never ending process.

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