Steven Hirsch and Associates

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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
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Abuse - A Dirty Secret

Abuse and neglect can happen anywhere—poor, middle class, and upper income households, hospitals, skilled nursing facilities, and other institutions. It is a problem without demographic or ethnic boundaries. Family members, friends, or staff of the healthcare facility can be the culprits of physical, emotional, financial, sexual, or mental abuse and neglect. These abuses often are not revealed due to fear of further abuse or reprisals, or that the victim may be abandoned. This raises the question of how do healthcare organizations detect abuse/neglect, and what are the appropriate actions required when it is uncovered.

Joint Commission Standard PC 01.02.09 and RI 01.06.03 and Medicare Conditions of Participation 42CFR482.12(c)(3) address abuse and neglect. They state that the healthcare provider organization has the duty and responsibility to assess, investigate, report, and refer any incidences of suspected abuse and neglect. Patients are to be assessed for signs and symptoms of potential abuse and neglect each time they present to the healthcare organization. Guidelines for this function should be developed through an Abuse Prevention Program.

The Joint Commission provides clarity of each form of abuse with its associated definitions. Abuse is defined as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well being." Sexual Abuse is "the intentional mistreatment of a sexual nature that includes, but is not limited to sexual harassment, sexual coercion, or sexual assault." Physical Abuse includes "hitting, slapping, pinching, and kicking. It also includes controlling behavior through restraints or corporal punishment." Mental Abuse includes, but is not limited to, "humiliation, harassment, and threats of punishment or deprivation." Verbal Abuse is defined as "any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability." Neglect is defined as "the absence of the minimum services or resources required to meet basic needs. Neglect includes withholding or inadequately providing medical care, food, hydration, clothing, or good hygiene. It may also include placing an individual in an unsafe or unsupervised condition."

Here are some action steps that a healthcare provider organization should include in its Abuse Prevention Program.

1. Develop written criteria to identify potential victims of abuse. Age, sex, and circumstances may clarify them. Each patient is to be screened for abuse and neglect on each visit to the organization.
2. Educate ALL staff to recognize signs of possible abuse, reporting, and

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Abuse - A Dirty Secret Continued...

their role in prevention of abuse or neglect during new hire orientation and on an on-going basis.
3. Ensure adequate staffing, especially nights, holidays, and weekends.
4. Perform a pre-hire applicant background screening for a record of abuse or neglect.
5. Discipline/terminate healthcare workers if found to have committed acts of abuse or neglect on patients or co-workers.
6. Maintain a list of agencies, public and private, for referrals.
7. Internally report and investigate all cases of suspected abuse or neglect.
8. Report cases, in accordance with law and regulation, to external authorities or agencies.
9. Support electronic health record documentation with prompts/fields.
10. Monitor documentation on a periodic basis to ensure the capture of appropriate information.

By so doing the above 10 steps, the healthcare organization fulfills an important role in helping to protect their patients.

Written by Beatrice "Betty" Newsom, RN, BSN, MA, CNAA of Associates

References:

Joint Commission Hospital Accreditation Standards 2012
The CMS State Operations Manual, 12/2/11

Public Reporting of Healthcare-Associated Infections

As early as 2004, a small number of states required reporting of healthcare-associated infections (HAIs). Today, 30 states mandate some form of process and outcome reporting related to HAIs. In addition, the federal government now requires hospitals that receive funding from CMS to report not only process measures such as measures endorsed by the Surgical Care Improvement Project (SCIP), but outcome measures as well.

The reduction of HAIs became a top priority for the Department of Health and Human Services (HHS) and in January 2009, the federal government announced the HHS Action Plan to Prevent Healthcare-Associated Infections. The Action Plan was designed to reduce selected HAIs by as much as 50% by 2013. An update issued by HHS in September 2011 indicated that hospitals are on target to achieve the goals that were set, with the exception of a reduction in *Clostridium difficile* infection.

In 2011, the CMS Hospital Inpatient Quality Reporting Program required reporting of Central Line-Associated Bloodstream Infection in adult and pediatric intensive care units via the National Healthcare Safety Network (NHSN). This year hospitals are required to report surgical site infections associated with colon resection and abdominal hysterectomy procedures and Catheter-Associated Urinary Tract infection in adult, pediatric ICU patients and rehabilitation facilities. This information will be included in CMS' HospitalCompare tool as well.

Not only is public reporting of healthcare-associated infections here to stay, it now affects reimbursement policy by CMS and other payers. In an attempt to reduce costs associated with healthcare, the Acute Inpatient Prospective Payment System (IPPS) for hospitals requires Hospital-Acquired Conditions and Present on Admission Indicator Reporting. Hospitals will not receive the higher payment for cases when one of the selected conditions is acquired during hospitalization.

In addition to understanding CMS reporting requirements, it is important to know your state requirements as well. Infection Prevention consultants at Steven Hirsch & Associates can assist your facility in complying with the mandates by navigating you through NHSN methodology of data collection and reporting. Once the data is entered, an analysis can then be performed to determine areas where improvements can be made by implementing HAI elimination strategies.

Steven Hirsch & Associates Consultants can also assist your infection prevention program with evidence-based strategies to reduce transmission of *Clostridium difficile* in your facility.

Written by Shannon Oriola, RN, BSN, CIC, COHN of Associates

Proctoring the Allied Health Professional Staff

Focused Professional Practice Evaluation (FPPE) is the process required by the Joint Commission for all members of the medical staff and the Allied Health Professional (AHP) staff who have been granted clinical privileges through the medical staff credentialing process. This process should be described in your medical staff bylaws or a credentialing policies and procedures.

Proctoring is an objective and focused professional practice review, and evaluation of a practitioner's clinical competence. For the purpose of this article, FPPE will be referred to as "proctoring."

The proctoring process can be difficult to complete for medical staff members, but it can be an even more difficult task to accomplish for the AHP's who have been granted clinical privileges.

If you have a large AHP staff with multiple providers in the same specialties, proctoring should not be an issue. But if you have only one practitioner of a specialty, who can serve as their proctor?

Here are some examples of who can assist in the proctoring process when there is only one provider of an AHP specialty on the staff:

- CRNA – An anesthesiologist, or if your facility only utilizes the CRNA, the surgeons can evaluate the skills and judgment of the CRNA.
- Physician Assistant (PA) – The supervising physicians, or if you also utilize nurse practitioners (NP), they could evaluate a PA.
- Nurse Practitioner – A PA can evaluate the NP on procedures for which each practitioner has been granted clinical privileges, i.e. lumbar puncture, wound debridement.
- Psychologist – A psychiatrist can evaluate the psychologist.

Are you seeing a pattern? Proctors can be of another specialty if the privileges are similar or, as in the case of the CRNA, where the physicians have direct interaction with the AHP.

Proctoring may utilize a combination of the following methods to obtain the best understanding of the care provided by the practitioner:

Prospective Evaluation: Presentation of cases with planned treatment outlined for treatment concurrence, review of case documentation for treatment concurrence or completion of a written or oral examination or case simulation.

Concurrent Proctoring: Direct observation of the procedure being performed or medical management, either through observation of practitioner interactions with patients and staff or review of clinical history and physical, and review of treatment orders during the patient's hospital stay. Practitioners who have been granted privileges to perform invasive procedures or who are providing anesthesia should be proctored on a concurrent basis.

Retrospective Evaluation: Review of case records after care has been completed. May also involve interviews of personnel directly involved in the care of the patient.

Proctoring of the AHP staff should be completed in the same timeframe that has been approved for the medical staff. The cases should be a variety of diagnoses and/or procedures that reflect the scope of clinical privileges granted. Proctoring forms should be designed so that the evaluation reflects the duties/tasks/procedures/functions performed by the AHP.

At the conclusion of the proctoring period, the appropriate Department Chairperson/Division Chief should review all available information and make a recommendation in keeping with the reporting structure as approved at the facility. There should be a signed statement submitted indicating that the AHP has met all the requirements of the department/division, and indicating that the AHP has satisfactorily demonstrated his or her ability to exercise the clinical privileges initially granted to him or her.

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

CMS Provides Flexibility for Life Safety Code Compliance in Hospitals… Or Do They?

In March of this year, CMS issued a memo to state survey agencies, allowing waivers of specific requirements of the 2012 edition of NFPA 101, the Life Safety Code®. What this means to hospitals is that CMS is acknowledging the updated Life Safety Code, which recognizes technology that heretofore had not been readily accepted. As healthcare facilities are replaced or upgraded, the new technology is being installed which is inconsistently accepted by state survey agencies who have been mandated to require compliance with the older, 2000 edition of NFPA 101, the Life Safety Code®.

The new instructions to state survey agencies from CMS verify, that projections into a corridor may extend up to 6 inches, provided that the corridor is a minimum of 6 feet in width. Hospital corridors have traditionally been constructed 8 feet wide. In addition, the code states that "projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met:

1. The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 inches (1525 MM).
2. The healthcare occupancy fire safety plan and training program addresses the relocation of the wheeled equipment during a fire or similar emergency.
3. The wheeled equipment is limited to the following:
    - Equipment in use and carts in use
    - Medical emergency equipment not in use
    - Patient lift and transport equipment

Based upon this revised language, it is clear that there continues to be an expectation that clear and unobstructed egress be maintained throughout the healthcare facility. Revised language of the 2012 Life Safety Code® provides clarification as to what may be maintained in the corridor, and that healthcare organizations should continue to consider equipment "in use" if it is accessed at least every 30 minutes.

The Life Safety Code® has been updated as well, to provide alternative types of kitchens/cooking arrangements in healthcare facilities. While this is not applicable to most general acute care hospitals, it may have applicability to those organizations providing rehabilitation services in which patient training kitchens are provided or nourishment stations on nursing units are equipped with cooking facilities.

The 2012 Life Safety Code® has been revised also to allow direct air vent gas fireplaces to be installed inside of smoke compartments containing patient sleeping areas, provided that a number of specific elements have been met. Fireplaces are occasionally found, in acute psychiatric or acute rehabilitation healthcare facilities. Such fireplaces are not permitted inside a patient's sleeping room, and the smoke compartment in which such fireplaces are installed must be equipped with an approved automatic fire sprinkler system. Fireplaces must have a sealed glass front with a wire mesh panel or screen, and the controls for the gas fireplace are required to be locked or located in a secure location. Carbon monoxide detection must be installed as well, in the room in which the fireplace is located. Revisions are also made within the 2012 edition of the Life Safety Code®, for solid fuel burning fireplaces in areas other than those in which sleeping areas are located. The area in which the solid fuel burning fireplace is located must be separated from patients' sleeping spaces by 1 hour fire resistant construction. Additional ventilation requirements also need to be considered wherever fireplaces are installed.

CMS has recognized that healthcare organizations may use decorations, however they do require that they be flame-retardant or treated with an approved fire retardant coating, and that such decorations meet the requirements as delineated in NFPA 701, the "Standard Method Fire Test For Flame Propagation of Textiles and Films." Additional provisions for testing and heat release are also noted in the 2012 edition of the Life Safety Code®. The guidance allows decorations such as photographs, paintings, and other art to be attached directly to walls, ceilings, and non-fire rated doors, provided that the decorations do not interfere with the operation or latching of the door, and they are limited to not more than 20% of the wall, ceiling, or door area if the space in which it is located is not covered by fire suppression, or 30% of surface area in a smoke compartment that is so protected. In a sleeping room, decorations may not exceed 50% of the wall, ceiling, or door area provided that the room capacity is not more than 4 persons, and the area is protected by a fire suppression system.

Before any of these policy changes are implemented by the healthcare organization, note that a waiver must be obtained from CMS. Additionally, one should review proposed changes related to these provisions in the 2012 Life Safety Code® with the local Authority Having Jurisdiction, so that the hospital can assure that it remains in compliance with all the provisions of NFPA 101, the Life Safety Code®, and applicable state and local regulations.

Written by Steven R. Hirsch, MPA, FACHE of Associates