Steven Hirsch and Associates

Accreditation News

Summer 2014

Volume 6, Issue 2

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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.

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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

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Focus on Discharge Planning

Increased focus on Discharge Planning has been noted during accreditation, licensing, and Medicare certification surveys for multiple reasons. Cost management is the first reason in the reduction of preventable readmissions and decreased length of stay. Safety and quality are two additional reasons. To increase focus on discharge planning, The Joint Commission (TJC), Centers for Medicare and Medicaid Services (CMS), and other survey agencies are conducting tracers on the entire discharge planning process. A well designed and implemented discharge planning process involves the patient care provider, hospital staff, community resources, and the patient and/or their representative.

There are multiple standards and agencies addressing the discharge planning process. These include standards from: The Joint Commission Accreditation Manual for Hospitals, Provision of Care, Treatment, and Services Chapter (PC. 04.01.01, PC. 04.01.03, and PC. 04.02.01); CMS Conditions of Participation "Discharge Planning 482.43(a-e), and individual states with specific standards, such as California Title XXII, §70717(f)(1-3), and §70753).

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) has added three more discharge planning questions to make a total of five in its survey. These are:

1. During this hospital stay, did doctors, nurses, or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
2. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
3. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
4. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
5. When I left the hospital, I clearly understood the purpose for taking each of my medications.

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Focus on Discharge Planning Continued...

With the increased focus on discharge planning, there must be a Discharge Plan, developed for each inpatient, as well as policies and procedures written and well understood by staff. The list of components below provides guidance for development of Discharge Planning related policies and procedures. Suggested components include:

- Patient education (detail to follow)
- Quality Assurance / Performance Improvement (QAPI)
- Discharge Plan to include all inpatients
- Discharge Plan to involve the patient and/or representative
- Discharge Plan written by a registered nurse, social worker or other qualified individual
- Documentation in the medical record of the discharge plan
- Time frames for screening, evaluation, and re-evaluation of discharge planning needs
- Care Plan
- On-going assessment to include change in patient condition, environment, or caregiver
- Process for requesting discharge planning by Patient Care Provider, or Patient
- Content of the discharge planning evaluation should include ability of the patient to perform activities of daily living, specialized equipment needs or environment modification prior to discharge, ability of the patient or support person to provide care, community-based services that would meet the patient's post hospital needs, insurance coverage, and changes in environment from pre-hospitalization
- Information is to be provided to the patient or their representative on transfer or discharge
- Information to be provided that is pending at time of transfer or discharge
- Contact person to notify in event of a change in the patient's condition
- If the patient is a Medicare participant, a list of participating Home Health Agencies and Skilled Nursing Facilities geographically appropriate is to be provided to the patient for their selection.

Patient/representative education is very important. Education begins in the hospital using techniques such as read back, repeat back, and simulation. Education is based on an assessment of the patient's ability to learn and identifies any barriers to learning. Printed materials must be legible, non-technical, and printed in a language and at a reading level that the patient can understand. Education covers use and care of medical equipment the patient will be using at home; medications being taken both in the hospital and on discharge, and any procedures such as self-injection. Copies of educational materials should be provided to and reviewed with patient or their representative. Documentation in the medical record should include the written educational materials and verbal information provided, and evidence of the patient's comprehension of the education. A medication list should be provided at the end of the hospitalization and be thoroughly reviewed with the patient and/or their representative highlighting medications that have changed, been discontinued, or that have been added. Information regarding symptoms or health problems that may arise and require notification of the health care provider should be given to the patient and/or representative.

Quality/Performance Improvement data regarding discharge planning allows the organization to analyze and improve HCAHPS scores, decrease readmissions, and reduce length of stay. Data needs to be collected on:

- Readmissions within 30 days of discharge
- Preventable readmissions
- Delays in discharge due to a failure of a portion of the discharge plan
- Collection of feedback from post-acute providers in the community about the effectiveness of the discharge planning process

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Focus on Discharge Planning Continued…

- Review of the discharge plan and processes
- HCAHPS' 5 questions related to discharge planning

Documentation requirements include screening, evaluation, reassessment, and the plan of care in the medical record. This documentation must be accessible to all members of the health care team. Upon transfer to another level of care, the following documents must accompany the patient: reason for transfer; patient's physical and psychosocial status; summary of care, treatment, and services provided to the patient; patient's progress toward goals; list of community resources or referrals made or provided to the patient; and provision for test results not available at the time of discharge to be sent to the patient or post hospital provider of care.

At time of survey, the surveyor might ask questions of the discharge planner, social worker, staff, or patient. Questions cover a variety of components of discharge planning. Here is a sample of what might be asked:

1. How is discharge planning conducted at this hospital?
2. How are patients identified for discharge planning?
3. What education is provided to the patient in regards to post hospital care needs?
4. Is discharge planning integrated into the plan of care?
5. Is the patient who was admitted from home or another setting, given a full range of realistic options for post hospital continuation of care?
6. Does the hospital use its QAPI program to determine whether the discharge planning process effectively identifies patients in need of discharge planning, and whether the discharge plans are adequate and appropriately executed?

References

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CMS Pre-Decisional Surveyor Worksheet: Discharge Plan, 2012
Provision of Treatment, Care, and Services, "The Joint Commission Hospital Accreditation Standards", 2014
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HCAHPS Hospital Survey

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

Bloodstream Infections - Isolate or Not?

Often the first sign that a patient is infected with a multidrug-resistant organism (MDRO) is admission to the hospital with a bloodstream infection. In the course of admission, this question often arises among hospital staff: "Should the patient be placed on Contact Isolation?" The answer, all too frequently, is that isolation is not necessary because the organism is "contained", like a bloodborne pathogen, which we do not isolate. Unfortunately, this thinking is misguided and results in a delay in properly isolating the patient.

By the time a bloodstream infection develops, it is safe to assume that the organism causing the infection has established residence on the patient's skin for a certain time period. A study of MRSA bacteremia revealed that blood isolates were identical to nasal isolates in 82% of patients. In addition to the nares, MRSA is frequently cultured from the axilla and groin areas. Access to the bloodstream then occurs when the skin is penetrated, as in the occurrence of a decubitus ulcer or the placement of an intravenous catheter. Similarly, in a study of patients with VRE bloodstream infection, 74% were colonized rectally with the same organism. From the rectal site, VRE then migrates

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Bloodstream Infections - Isolate or Not? Continued…

to the skin, and by the same mechanism as MRSA, gains access to the bloodstream. Reducing this bacteria on the skin is the principle behind chlorhexidene bathing, which has proven to significantly reduce MRSA and VRE bloodstream infections in ICUs.

Multidrug-resistant organisms, therefore, do not usually begin their bodily invasion in the bloodstream. Rather, the process of infection begins at body sites from which they can be transmitted to other patients if precautions are not taken.

Finally, the current CDC and SHEA guidelines for prevention of MDRO transmission recommend the following: Contact Isolation for patients suspected to be colonized or infected with MDROs, regardless of the site of infection.

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Written by Judy Hagerty, RN, MS, CIC of Associates

Carbapenem Resistant Enterobacteriacae

Multi-drug resistant organisms (MDRO) are not a new phenomena in health care, although the spectrum of organisms and the degree of resistance is becoming increasingly more worrisome. The CDC has been regularly publishing alerts regarding this new and emerging problem facing hospitals, both in terms of having proper antibiotics to manage infected patients, and requisite and enforced infection prevention policies and procedures.

Carbapenems are a newer class of antibiotics that have shown great efficacy in the intensive care units, and have fewer side-effects than some of the classical agents. The development of this type of resistance has rendered entire classes of antibiotics ineffective, including penicillins and the penicillin-like antibiotics; the cephalosporins and cephalosporin-like drugs; and the other antibiotics whose actions are based on the substitution of the beta-lactam ring into the cell wall of susceptible bacteria.

The CDC recommends that clinicians take the following steps to control this emerging epidemic:

- Know if patients with CRE are hospitalized at your facility, and maintain an awareness of CRE infection rates. Determine if patients have received medical care somewhere else, including another country.
- Place patients currently or previously colonized or infected with CRE on Contact Precautions. Whenever possible, dedicate rooms, equipment, and staff to CRE patients. There is some discussion amongst infection prevention specialists to use the same types of precautions used with C. difficile infected patients with CRE patients which includes the use of soap and water for hand hygiene, and a “terminal clean” at discharge.
- Wear a gown and gloves when caring for patients with CRE.
- Perform hand hygiene – use alcohol-based hand rub or wash hands with soap and water before and after contact with patients or their environment.
- Alert the receiving facility when you transfer a CRE patient, and find out when a patient with

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Carbapenem Resistant Enterobacteriacae Continued…

CRE transfers into your facility.

- Ensure there is a system in place to have the clinical laboratory immediately alert clinical and infection prevention staff when CRE are identified.
- Prescribe and use antibiotics wisely.

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

A Review of Restraint Documentation

Restraint documentation continues to prove challenging to many organizations. In a June 2013 memo from the Centers for Medicare and Medicaid Services (CMS), it was stated that hospitals were cited for being out of compliance with the restraint and seclusion standards 362 times. It is important to remember that hospital leadership is responsible for creating a culture that supports the patient's right to be free from restraints.

The following is a review of documentation requirements as defined by CMS.

- The decision to use a restraint must be driven by a comprehensive patient assessment that is documented.
- The use of less restrictive measures must be evaluated prior to the initiation of restraints and this assessment must be demonstrated in the documentation. This is a frequent "missing step" in the documentation process.
- Included in the definition of restraints are: net beds/enclosed beds, freedom splints, mittens (if they cannot be intentionally removed by the patient in the same manner as applied by staff… most cannot be), 4 raised side rails, and wrist restraints.
- The use of restraint must be documented in the patient's plan of care. Be sure that your hospital policies and procedures reflect the definitions of restraints as used in your organization.
- Education of patients/family related to the use of restraint must also be documented. This is a frequently omitted portion of documentation.
- An order from the physician or licensed independent practitioner responsible for the care of the patient is required prior to the application of restraints and for each episode of restraint use. Orders must never be written as standing orders or as a PRN order.
- Hospitals have the flexibility to determine time frames for the renewal of orders for restraints. The time frames for renewal orders should be addressed in the hospital policy and procedure. Please note, that it is up to your organization, based on policy and procedure, to determine the required renewal of orders by the physician. In our experience in reviewing hospitals, some hospitals opt to mandate a daily order and some do not. The requirement is for you to adhere to your policies.
- Documentation of patient monitoring and assessment should include such areas as: offering fluids/nourishment, toileting/elimination, range of motion, release/exercise of limbs, circulation, neurological evaluation, vital signs, and skin integrity. This area is frequently lacking in our review of documentation related to the use of restraints.
- Additional documentation is to include an assessment regarding the continued need for restraint.

The use of restraints should not be considered a routine part of care. Restraints are used only when clinically justified to ensure the immediate physical safety of the patient. Does YOUR hospital have a Restraint Freedom Program? It should!

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

Sterile Compounding

Effective July 1, 2014, California Senate Bill 294 requires all pharmacies that perform sterile compounding to have a separate California State Board of Pharmacy license. A currently held certification by an accrediting agency such as The Joint Commission will no longer be valid. A pharmacy located outside the State of California which performs sterile compounding and ships product to California for providers or patients, must be registered as a non-resident sterile compounding pharmacy.

The new law defines sterile compounding as compounding drug products for injection, administration in the eye or for inhalation.

The new law also requires all sterile compounding pharmacies to undergo an annual inspection by the California Board of Pharmacy before issuance or renewal of the sterile compounding license, whether the pharmacy is located in California or another state (a non-resident pharmacy that wants to ship sterile product to a provider or patient in California).

Use the following California Code of Regulations (CCR) web site to access all the sterile compounding requirements:

http://ccr.oal.ca.gov/ Click on CCR Titles; then on Title 16; then on Division 17; and finally on Article 7 (sterile injectable compounding).

Article 7 § 1751 Self-Assessment:

(a) Conform to Article 4.5 § 1735 Compounding in Licensed Pharmacies.

(b) Must have a designated area: 1) Clean room § 1250 of Title 24 Part 2, Chapter 12 of CCR; 2) Walls, Ceilings and Floor comply with § 1250 of Title 24 Part 2, Chapter 12 of CCR; 3) Ventilation in accordance with § 505.12 of Title 24 Chapter 5 of the CCR; 4) Annual certification of laminar flow hood; 5) Maintain an aseptic environment according to § 1250 of Title 24 Part 2, Chapter 12 of CCR; 6) Provide a sink according to § 1250 of Title 24 Part 2 of the CCR; and, 7) A refrigerator with sufficient capacity.

(c) If compounding a product with one or more sterile ingredients you must comply with Business & Professions Code § 4127.7.

The self-assessment must be completed by the Pharmacist-in-Charge (PIC) before the initial licensure and before July 1st of each odd numbered year.

In addition, you must have Policies and Procedures, Training guidelines and evidence of personnel training, a prescription, a master formula, applicable compounding records, Quality Assurance procedures, and a beyond use date (BUD) not to exceed 180 days.

A sterile product prepared for a one-time dose to be administered within 24 hours is exempt.
If you have not done so, submit an application to the State Board of Pharmacy as soon as possible. Applications are available on the California State Board of Pharmacy website:

http://pharmacy.ca.gov/ Publications –> Applications and Forms

Written by Mervyn Kalman, BS Pharm., MBA of Associates

What is the Difference Between Nurse Practitioners and Physician Assistants?

Nurse Practitioners (NP) and Physician Assistants (PA) are categories defined as Allied Health Professionals (AHP), and both provide healthcare who work under the supervision of a licensed physician. The laws governing the scope of practice for NPs and PAs vary by state, with information usually available at the State Medical Board, Allied Health Board or Nursing Board, depending on how they are licensed in the specific state. In some states, the Board of Nursing has sole authority, and in others, a physician is involved in order to practice.

Education for Nurse Practitioners: There are approximately 300 nurse practitioner programs, leading to a master's degree, which can be in any of the following areas of concentration:

- Acute Care
- Adult Health
- Emergency Medicine
- Family Practice
- Geriatric Medicine
- Home Health Nursing
- Neonatal Care
- Occupational Health
- Oncology
- Pediatrics
- Psychiatric & Mental Health
- Public Health
- Women's Health

The American College of Nurse Practitioners requires that the education be specific to an area of practice of nursing.

Education for Physician Assistants: There are approximately 130 accredited PA programs, and about 75% award a master's degree. The students receive a general education and all programs are accredited by the Accreditation Review Commission on Education for the Physician Assistant. The PA can choose to work in one of the following subspecialties:

- General Internal Medicine
- Orthopedics
- Geriatrics
- Family Medicine
- Pediatrics
- Emergency Medicine
- General Surgery
- Thoracic Surgery

Duties of Nurse Practitioners: Based on the additional education that a NP must have, they are not limited to manage only most common illnesses and some chronic diseases. Nurse practitioners can be authorized to write prescriptions and order tests; many NPs do work within hospitals or clinics and focus on disease prevention, health maintenance, and patient education.

Duties of Physician Assistants: PA duties can include but are not limited to examine, diagnose and treat patients, in addition to ordering x-rays and lab tests, and interpreting their results. PAs may also be allowed to prescribe medications, as allowed by the State in which they practice. The PAs may work in the specialty of internal medicine, emergency medicine, family medicine, pediatrics

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What is the Difference Between Nurse Practitioners and Physician Assistants? Continued…

or surgery. The duties of Physician Assistants are dictated by supervising physicians, as well as state law.

Credentialing AHPs: Both NP's and PAs must possess a valid State nursing or physician assistant certificate. Nurses must have an advanced degree, i.e., Master's Degree in Nursing and must hold a Registered Nurse license. PAs are not required to have any specific advanced degree and can enter a PA program at any time, though all states and the District of Columbia require PAs to pass the Physician Assistant National Certification Examination as a condition for licensure. Verification of work history can be burdensome if the work experience is coming from a physician's office or clinic prior to them applying for hospital privileges. The best practice is to verify employment and see if there is a pattern of moving from practice to practice which could be considered as a "red flag." Peer references, ideally, should be from someone who is also a NP or PA, but if they were working as a solo AHP in an office setting, the next best reference would be the practitioner that they worked for and if there were other nurses in the office who can attest to the person's competency and interpersonal communication skills.

The practitioner should have professional liability insurance; often they are included with the supervising physician's coverage. Certifications are at the discretion of the facility.

Do you require CPR, ACLS certification? It may depend on the area in which the AHP will be practicing, i.e., the Emergency Department may require all the staff to have at minimum a CPR or BLS certification, but usually they require ACLS certification.

National certification may not be a requirement for hospital privileges, but many hospitals are now requiring certification from the appropriate certification board. To verify the PA's certification, the National Commission on Certification of Physician Assistants can be queried online with no fee required. Certification for the NP from American Association of Nurse Practitioners can be verified online for a fee.

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, 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.