Steven Hirsch and Associates

Accreditation News

April 18, 2018

Volume 10, Issue 1

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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

CREDIBLE • ETHICAL
EXPERT • INTEGRITY
PROFESSIONAL
RESPONSIVE

Patient Activity Logs: Do You Really Need Them?

When credentialing a practitioner for appointment or reappointment and they are requesting privileges, do you obtain an activity log to support the privileges requested? The delineation of privileges should state how many cases are needed to have been performed within the previous two years to assist in determination of current clinical competence. Do you really need this information?

When your Credentials Committee is reviewing applications / reapplications, do they look at the activity logs? They should!

The regulatory agencies are looking to see whether the medical staff is granting privileges to the practitioner who continues to request privileges for procedures that they have not performed in years. If the medical staff is granting these privileges and there have been none performed, how is current clinical competency determined? It's not.

It is better to have the practitioner withdraw those privileges. In the event that the practitioner wants to request them, he/she would have to demonstrate competency in order to be granted the privilege. If the practitioner succeeds, he/she would have to be proctored. If a practitioner has been granted a clinical privilege for a procedure that he/she has not performed in recent years and then schedules a case, there is always the possibility of a bad outcome.

Physicians, especially those that are winding down their practice, are reluctant to give up their clinical privileges, in the same way as many elderly people are unwilling to give up their driver's license.

As the gate keeper, it is our responsibility, as medical staff office professionals, to review the delineation of privileges requested, compare it to the activity log and flag any privileges for procedures that have not been performed in the previous two years. If the practitioner has privileges at another hospital, request the patient activity from there, and if the procedures have not been performed, the privilege should be denied. This denial is not a reportable event; the practitioner does not meet the criteria for the granting of the privilege(s). It may take a senior member of the department to discuss this with the requesting practitioner, so that they understand why this action was taken.

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Hand-Off Communication

When I first set out to draft this article on hand-off communication, I thought, "Well this should be rather straightforward." Ummm… maybe not so.

Have you considered the influence of human factors on what we do and how we do it? Staff may think that they are providing adequate and meaningful information on patients when giving a patient report, but that report may be less effective than what it was intended to be. There are barriers to effective communication, which may include: availability of personnel, staffing, workload, what may be happening with patients at time of the report, lack of assistance/back-up, training, language barriers, and cultural and ethnic considerations.

A culture of safety, one that promotes teamwork, respect and patient focused care is one that provides support to a hand-off communication process. A process that is standardized throughout the organization, effective, efficient and one in which the importance of the information being shared is prioritized. A sometimes overlooked but critical component to the process is the opportunity to ask questions during the hand-off.

To get started in evaluating hand-off communication, your organization may opt to conduct an internal assessment of the hand-off communication processes that are currently being used. For example:

- Is the hand-off communication process promoted by leadership?
- Is the hand-off communication process effective?
- Is there adequate time in which to complete the hand-off process?
- Are distractions during hand-off eliminated/minimized?
- Are certain times of the day more challenging in completing hand-off?
- Is there a standardized process to conduct hand-off?
- Are short-cuts taken?
- Does the provider of the hand-off supply up to date and accurate patient information?
- Does the provider of the hand-off possess current knowledge of the patient?
- Does the receiver of the hand-off have competing priorities and thus is unable to focus on the communication?
- Was pre-notification given to the receiver that a patient was being transferred?
- Did the receiver have the opportunity to follow-up on areas that were not clear with the provider of the information?

Per The Joint Commission, September 12, 2017, "Communication failures in U.S. hospitals and medical practices were at least partly responsible for 30% of all malpractice claims resulting in 1744 deaths and $1.7 billion in costs over 5 years, according to a 2015 study."

The Joint Commission issued Sentinel Event Alert #58 "Inadequate Hand-off Communication" on September 12, 2017, in which hand off was defined as "a transfer and acceptance of patient care responsibility achieved through effective communication. It is a real-time process of passing patient specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient's care."

As stated in a June 2017 AHRQ article, "Discontinuity of providers of patient care creates an opportunity for error when clinical information is not accurately transferred between providers." Much information exists on a variety of methods, tools, checklists and team training that improve hand-off communication. One key to success is the adoption and utilization of a standardized format for hand-off. Other successful processes include interactive communication, up to date and accurate first hand information, limited interruptions, processes for verification of information and opportunities to review the information.

IPASS is an approach to hand-off communication using a standardized hand-off bundle.

Continued on the Next Page...

Hand-Off Communication Continued...

I Illness severity (such as stable, unstable)
P Patient summary (diagnosis and treatment plan)
A Action list (to do items to be completed by the clinician)
S Situation awareness and contingency plan (if-then scenarios)
S Synthesis by the receiver (asks questions and confirms plan of care)

SBAR is another example for an approach that can be used in hand-off communication.

S Situation
B Background
A Assessment
R Recommendations

As referenced in the Joint Commission article on the Sentinel Event Alert #58, a “PSYCH” communication tool is sometimes used for psychiatric patients in the Emergency Department.

P Patient information/background
S Situation leading to the hospital visit
Y Your assessment
C Clinical information
H Hindrance to discharge

Most hospitals and organizations have challenges in providing consistent hand-off communication. For example, one hospital uses a specific paper SBAR hand-off communication tool for patients who were admitted from the Emergency Department. However, this tool is not utilized when patients are transferred from surgery. The report on patients arriving from surgery is verbal. Is this an effective approach?

Keys to successful hand-off communication include:

- Leadership commitment in creating the expectations
- A systematic approach
- Standardized content by the sender of the information
- Minimal content may include (as defined by the organization) illness assessment and severity, patient summary, actions to be done, laboratory results, medications, vital signs, code status and plan of care
- Enough time in which to complete an appropriate hand-off
- Face to face dialogue
- Freedom from interruptions
- Training
- Integration of hand-off into work-flow and into the electronic health record

As organizations are reviewing and identifying areas for improvement in the hand–off communication processes, as with every performance improvement activity, the organization should collect data, monitor the effectiveness and make sure that the improvements are sustained.

References:

The Joint Commission
TJC P.C. 02.02.01 EP2
TJC P.I. 03.01.01
TJC CTS.04.01.01 EP3
AHRQ

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Patient Activity Logs: Do You Really Need Them? Continued from Page 1…

It is not always easy to convince the practitioners that it is in their best interest to not request privileges for procedures that they have not performed in the recent years. It is not in their best interest or in the patients who may be subject to potentially disastrous outcomes as a serious injury or even death, which could affect the practitioners' malpractice and possibly their license to practice medicine.

The best practice is to check the privileges requested, review the activity log and flag any procedures on the privileges request that are not performed. The medical staff leadership will then have to follow up with those whose privileges should be denied.

Emergency Generator Fuel Testing

The Joint Commission in 2017 issued an Element of Performance, EP8, under EC.02.05.07, which reads "At least annually, the hospital tests the fuel quality to ASTM standards. The test results and completion dates are documented." During many of our survey preparation visits, clients have asked what the parameters are for this test. The Joint Commission refers to NFPA 110, 2010 Edition, Section 8.3.8, that states "A fuel quality test shall be performed at least annually using tests approved by ASTM Standards."

ASTM publishes a standard in which specifications for diesel fuel oils are defined, as well as test methods for existing diesel fuels. It is expected that the organization will have annually conducted testing of diesel fuel oil for moisture levels, sediment, and microbial growth.

Testing of diesel fuel oil should be based upon the recommendations of the generator manufacturer for fuel oil, which generally would be included in the operator's manual. Manufacturer's recommendations list the type and grade of fuel, as well as the allowable levels of impurities that can remain within the diesel fuel oil that would not pose a threat of damage or operational interruption to the emergency generator. A diesel fuel test report should be prepared in accordance with the manufacturer's guidelines for "clean" fuel to ensure integrity of the existing fuel, and to determine whether fuel may be replenished or must be replaced. It should be noted that while periodic fuel "polishing" may extend the life of the diesel fuel that remains in storage on site, fuel polishing is not the same nor does it take the place of the annual fuel quality test.

Written by Steven Hirsch, FACHE 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, 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.

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