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New JCAHO standards are here: What changes do you need to make now?

'Major culture change' needed; staff must be more involved during surveys

Now that the long-awaited revised accreditation standards from the Joint Commission on Accreditation of Healthcare Organizations have been unveiled, what changes should you make in the way you prepare for surveys?

The new standards, which become effective Jan. 1, 2004, give you a chance to review the changes before they officially are published this fall, says **Paula Swain**, MSN, CPHQ, FNAHQ, director of clinical and regulatory review at Presbyterian Hospital in Charlotte, NC. "The era of serious continuous survey readiness is here," she says. "This means a daily process of honing the organization to practice what gets preached."

Taken as a three-pronged package, the revised standards, the national patient safety goals, and continuous readiness and assessment will call for a "major culture shift" at your facility, says **Frederick P. Meyerhoefer**, MD, principal of the Canton, OH-based Meyerhoefer Organization, a consulting firm specializing in compliance with Joint Commission standards.

"Quality managers are definitely concerned that this will require additional personnel resources that will not be met," he says.

If you're like most quality managers, you're already seeing an increased workload for Joint Commission preparation, without senior management supporting and acknowledging this trend, Meyerhoefer adds.

"Hospital leadership may not yet recognize the time needed to be continuously prepared, the self-assessment process, and the hovering knowledge that surveys will shortly be unannounced," he says.

In fact, many quality managers may need an altogether different reporting structure to get needed access to senior management, Meyerhoefer says. Most quality managers are concerned about the continuous preparedness that is required, he reports. "I've heard no one dispute that the hospital should always be ready, and this is a laudable goal. But the reality from the past is that many hospitals did last-minute crunches to prepare for the survey."

So how much of your time will continuous preparedness really require? Estimates vary widely, according to Meyerhoefer. "One concerning estimate

that I've heard is that it will take thirty days to do the self-assessment," he says.

The patient safety issues, the revised standards, and increased emphasis on data-supported and evidence-based patient care, which also includes physician and hospital staff competencies, are all at issue, he says. "This puts the role of the quality manager even more in the spotlight," Meyerhoefer stresses. "The role can't be performed if the hospital doesn't accept the need for increased support of the quality manager."

To prepare for compliance with the new standards, consider the following:

- **More is left to individual interpretation.**

It is true that the standards are simplified in their language, but this leaves a lot to interpretation, says Swain. "The burden is on the facility to figure out how the elements of performance apply," she notes.

Just because many standards were combined, that is no guarantee that the amount of time you spend on paperwork and preparation will decrease, Meyerhoefer says. "It remains to be seen how the surveyors will interpret and score the 2004 standards."

There is more room for surveyor inconsistency, and some surveyors are more rigorous than others, says Swain. "The proof will be in the divergence between the facility scoring rationale and JCAHO's interpretation of their standards."

You should keep a close watch on the interpretations of surveyors as they return, and listen to "survey stories" around the country, she says. "Then tweak as you must."

For now, Swain recommends focusing on your own problem areas first. "Take the standards that have been in noncompliance and start there with your scoring," says Swain. Use the crosswalks provided by the Joint Commission to see where your chronic areas of noncompliance land in the 2004 standards, she suggests.

While the standards are less fragmented, there is concern about how facilities will show compliance.

"I'm a little concerned regarding how an organization will demonstrate compliance with some of the standards, especially in light of the loss of the document review session," says **Virginia Hay**, RN, CIC, service director for quality care management at Champlain Valley Physicians Hospital Medical Center in Plattsburgh, NY. "I'm not convinced that brief observations alone will give a true picture."

Champlain Valley will continue to have material together for each standard as if there still was a formal document review session, she reports. "If nothing else, it will serve to help us focus quickly during survey should the need arise."

Since the next scheduled survey is mid-2004, the self-assessment tool will not be submitted, Hay says. "But, we plan to complete it as soon as it becomes available and have it on site for use during the survey," she says.

- **There is increased focus on staff interactions with surveyors.**

Interviews with staff will be a major factor in determining whether you are compliant, says Swain. "It is clear that the staff need to know *why* they are doing things."

It's not enough for staff to give rote answers anymore, Swain says. "The staff need to be able to describe what the aggregate organizational

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Editor: **Staci Kusterbeck**, (631) 425-9760.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Managing Editor: **Russ Underwood**, (404) 262-5521, (russ.underwood@ahcpub.com).
Senior Production Editor: **Ann Duncan**.

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Editorial Questions

For questions or comments, call **Staci Kusterbeck** at (631) 425-9760.

data means and how they interpret it on their unit," she says. "If staff shrug and state, 'that's just how we do it' without regard for the reason, red flags start to go off."

Different areas may have different procedures, and staff need to understand the reasoning behind these, Swain says. "For example, if the fall rate of a unit is higher than any other unit in the facility, that unit will have initiated fall precautions that exceed what might be found in other units," she explains.

To address this, Swain's facility uses a "rate card" which is different for every unit, posted where staff can easily see it.

The card shows the organizational data for that individual unit, such as infection rate, turnover rate, performance improvement projects under way, and sentinel events affecting the unit, says Swain. "As the values on the rate card change, the staff can see the progress they are making at reducing wound infections or falls, for example."

Staff are the real experts

At Champlain Valley, staff are continually reminded that they are the true experts and should be the ones interacting with surveyors, Hay says. "We will be reinforcing this throughout the mock survey process. We will promote this as a good thing — that the changing survey process will be more interactive with staff." The goal is to have staff step right up to surveyors, eager to show what they do so well, rather than shy away or revert to yes/no answers, she says.

Use of restraints is a good example of the need for discussion at the unit level, she adds. "While it is often easy to let others do the talking, a unit nurse can best describe the alternate strategies she would try in order to avoid using a restraint."

The unit nurse is also the best candidate to explain the policy for time-limited orders, monitoring of the patient in restraints, and documentation requirements, says Hay.

"Once the dialogue is started with the surveyor, that provides a great opportunity to review the hospital approach to ensure a safer environment by reducing restraint use," she explains.

In this case, Hay then would step in and describe the restraint team that developed the facility's policy, and the restraint reduction initiative that reviews the overall use of restraints and looks for trends that can further reduce their use.

Another prime opportunity for staff involvement would be the assessment of compliance with the Joint Commission's patient safety goals, says Hay.

"This is a big topic during surveys, and a staff member in any department might be able to speak to one or more of the goals that directly impacts their work," she says.

Hay encourages staff to "seize the opportunity" to talk about different initiatives related to compliance with the goals during mock surveys. "We remind staff that there is ongoing evaluation of compliance, and the results of monitoring get reported to medical staff leadership and the board," she says.

These discussions usually draw in others, and provide an educational opportunity that is more compelling than an article in a newsletter or on a bulletin board, says Hay.

During mock surveys, small prizes such as candy, pens, and stickers are given to staff who actively participate, says Hay. "Active participants offer us the best opportunity to coach and teach," she says.

"For example, we can suggest other examples they could use to respond to questions and remind them of performance improvement initiatives related to the topic," she explains.

Prizes are given not only for those answering a question correctly, but also to individuals who are willing to describe a system of care being reviewed, says Hay. "We take this opportunity to coach them through so they will feel comfortable discussing our care processes with a real surveyor," she says.

- **Increased emphasis on the medical staff.**

This is a subtle but significant change in the medical staff standards, Meyerhoefer says. "There is an increased emphasis on the medical staff's leadership and responsibilities in the quality and safety of patient care," he notes.

This increases the role and responsibility of the medical staff leaders and will call for increased time commitments, involvement, and knowledge of their roles, he says. "Because of the changing nature of the medical staff and [their] relationship with the hospital, this may be difficult to obtain," he says.

In most hospitals, the number of active physicians is decreasing continually for several reasons, Meyerhoefer explains.

Many primary care physicians have fewer hospitalized patients due to increased ability to care for higher acuity patients in their offices, and inpatients also have a higher acuity and now frequently are admitted to subspecialists such as

cardiologists, he says. "Thus, there are fewer incentives to devote time to medical staff activities," Meyerhoefer says.

There also is tension between the hospital and the medical staff regarding coverage of the emergency department, and physicians are expecting remuneration for performing on-call responsibilities, he notes.

All this results in fewer physicians willing to take leadership roles, says Meyerhoefer. "Even now, many medical staffs and their leaders don't fully understand the safety goals and their importance to the hospital and the physician's role in implementation," he adds.

The most successful quality managers have found physician champions to carry the banner for performance improvement activities, advises Meyerhoefer.

This calls for a lot of one-on-one attention from the quality manager, he says. "It also means that the quality manager must have the necessary data gathering and analytical tools to present the information to physicians. They can't waste the physician's time or give the physician the illusion that their time is being wasted."

[For more information on the new JCAHO standards, contact:

- ***Virginia Hay**, RN, CIC, Service Director, Quality Care Management, Champlain Valley Physicians Hospital Medical Center, 75 Beekman St., Plattsburgh, NY 12901. Telephone: (518) 562-7323. Fax: (518) 562-7397. E-mail: ghay@cvph.org.*
- ***Frederick P. Meyerhoefer**, MD, The Meyerhoefer Organization, 1261 White Stone Circle N.E., Canton, OH 44721. Telephone: (330) 966-6717. E-mail: Meyerorg@aol.com.*
- ***Paula Swain**, MSN, CPHQ, FNAHQ, Director of Clinical and Regulatory Review, Presbyterian Hospital, 200 Hawthorne Lane, Charlotte, NC 28204. Telephone: (704) 708-6591. E-mail: Paula@snaconsulting.com.]* ■

Credential volunteers during disasters

You'll need a policy before disaster strikes

After the terrorist attacks of 9/11, area hospitals all reported a deluge of volunteer clinicians. This may sound like good news when your facility is suddenly overwhelmed with patients, but it also can be dangerous.

"We have an obligation to provide safe, quality care," stresses **Marianne Klass**, RN, MN, accreditation and safety director at Swedish Medical Center in Seattle.

"During times of chaos, it is not unlikely that certain people may enter a system and [impersonate] someone they aren't, such as a physician. Systems must be in place to safeguard this from happening."

When developing a policy for credentialing of volunteers, consider the following:

- **Comply with new Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards.**

In September 2002, the Joint Commission issued a new standard which allows a hospital to grant privileges to health care professionals who volunteer their services during an emergency, says **Charlotte Jefferies**, of the Pittsburgh-based health care law firm Horty, Springer & Mattern.

The JCAHO standard was created after the Joint Commission's debriefing of health care personnel involved in the 2001 flood in Houston and in response to the terrorist attacks on 9/11, Jefferies says.

"Physicians and hospital personnel involved in those disasters identified a specific need for rapid access to clinicians to assist the hospital in meeting patient care demands in those emergency situations," she says.

JCAHO requires an emergency management plan to design, implement, and evaluate a total response and recovery system, and this includes emergency credentialing for physicians, says Klass. "It makes sense to extend this standard to any clinician," she says.

The standard encourages hospitals to develop credentialing and privileging policies or protocols that can be implemented when a hospital determines to activate its emergency management plan, says Jefferies.

The standard outlines acceptable sources of identification of volunteer licensed independent practitioners. Those sources of identification include:

— a current picture hospital ID card;

— a current license to practice and a valid picture ID issued by a state, federal, or regulatory agency;

— identification indicating that the individual is a member of a disaster medical assistance team;

— identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity;

— verification of the volunteer practitioner's identity by a current hospital or medical staff member.

- **Understand Good Samaritan laws.**

Although specific documentation may be required in the event of a disaster, this may not be followed to the letter in the event of a mass casualty incident, in the eyes of some quality managers.

"Our policy does require documentation, but in a real 9/11-type emergency, our chances of getting all of that documentation is slim — and who knows when we will be able to do all of the verifications," says **Kathy Downs**, CMSC, CPCS, CPHQ, director of medical staff services at Paradise Valley Hospital in National City, CA. **(See the facility's policy, right.)**

"I also think that depending on the situation, some hospitals will just need all of the medical personnel available and will have to worry about the consequences later," says Downs.

When an individual truly acts in a voluntary capacity to aid another whom he or she is not required to aid, that individual is deemed to have acted as a "Good Samaritan" and is exempt from liability, says Jefferies.

Some form of Good Samaritan legislation has been enacted in all 50 states and the District of Columbia, Jefferies says. No volunteer physician who in good faith renders aid is liable for civil damages as a result of acts or omissions in rendering such aid, she says.

If federal law grants immunity to hospitals for their use of volunteers when they activate an emergency management plan, then the hospital would not be liable for the acts of the volunteer, unless it failed to follow its own identification process before granting privileges, says Jefferies.

But if the volunteer was incompetent and the hospital knew, or from information in its possession should have known, of the individual's incompetence, then the question is whether the hospital acted in good faith, she explains.

Therefore, how you handle the credentialing of volunteers is important, Jefferies stresses. "In a real disaster, time is of the essence, and we know from experience that there is usually very little or no time to check the qualifications of persons who volunteer to provide care."

Jefferies notes that the JCAHO standard, like

Sample Policy for Credentialing Volunteers

Shown here is the policy that is followed at Paradise Valley Hospital in National City, CA, for credentialing of volunteer clinicians during a disaster:

INFORMATION REQUIRED FOR EMERGENCY TEMPORARY PRIVILEGES

A. The following information must be available in order to be granted temporary emergency privileges:
   1. Current professional license number.
   2. Photo identification issued by the state in which the practitioner holds licensure OR a current hospital picture identification card.
   3. Name of current hospital affiliation where the practitioner maintains medical staff membership (if applicable).
   4. Current malpractice insurance coverage.

VERIFICATION OF INFORMATION

A. Verification licensure, malpractice insurance, and hospital affiliation will be done as soon as feasible by the medical staff office/designee(s). A record of this information will be retained in the medical staff office on the temporary emergency privileges form.
B. The National Practitioner Data Bank and the Office of the Inspector General will be queried as soon as possible.
C. Emergency privileges will be immediately terminated in the event information received through the verification process indicates any adverse information or suggests the person is not capable of rendering services in an emergency.

CONDITIONS OF EMERGENCY PRIVILEGES

A. The emergency designee must practice under the direction and supervision of an existing member of the Paradise Valley Hospital medical staff.
B. The emergency designee will sign a statement attesting that the information given to the hospital is accurate.
C. The emergency designee agrees to be bound by all hospital policies and rules, as well as medical staff bylaws, rules, and regulations, and any directives from the clinical service chairperson, supervising physician, or any other hospital or medical staff leader.
D. Emergency privileges will be valid only for the duration of the disaster or emergency and will automatically terminate at the end of needed services.

many state disaster plans and regulations, does not require, recommend, or suggest that the hospital conduct an evaluation of the volunteer's education, experience, training, work history, character, ethics, or ability.

The key element addressed by the JCAHO standard and other state rules, regulations, and statutes is having a procedure to verify the identity of the volunteer, she explains.

- **You need a system to verify competencies and licensure.**

There is a risk to any organization choosing to accept nonprivileged or unknown staff, says Klass. "If we're desperate for help, we certainly don't want to turn away volunteers, but we must do so under the framework of caution for liability and for patient safety," she says.

There should be a designated role in your incident command system for collecting documents from volunteer physicians, nurses, respiratory therapists, and pharmacists, to track name, licensure, and other pertinent clinical information, says Klass. If a person shows up barehanded without any of these items, other methods of identification and tracking should be implemented, such as taking Social Security numbers or other personal facts, she says.

"If the computers are functional, then there is the ability to tap into the state licensure system for verification, but the 'paper-and-pencil' method needs to be in place as a contingency," she adds.

The facility has procedures in place to assign a volunteer clinician alongside a staff person, says Klass. "This enables a buddy system to eye the competencies and skills of the volunteering person. If there are any concerns, this can be immediately addressed.

If there is any doubt as to a volunteer's capability, he or she might not be accepted at all, says Klass. "If we aren't desperate for help, we won't accept their help, or obviously, we could place them in nonrisky activities, such as making sandwiches or shoveling debris," she says.

- **Reduce need for volunteers.**

There may be less of a need for volunteers than you expect, since during actual disasters staff typically "step up to the plate," says Klass. "Staff will come in when they are not scheduled or work extra long hours to get us through the disaster," she says.

As a result, the facility has rarely had to accept the help of volunteer clinicians, she says. To reduce the need for volunteers, Klass recommends working with staff to have solid home preparedness plans, so that if they are at work when a disaster occurs, you can count on them to stay and be focused.

At Swedish Medical Center, all staff have been asked to develop home preparedness plans for whatever is needed to survive independently for three days, such as shelter, food, water, medications, clothing, battery-operated radio, first-aid kits, battery-operated flashlights with extra batteries, candles, and portable generators.

"Those who do not have sound home plans are more likely to leave work or not come in, since their first obligation is to secure the home front," Klass says. "Hence, personal disaster plans are crucial to a successful hospital emergency management plan."

[For more information about credentialing of volunteers during disasters, contact:

- ***Kathy Downs**, CMSC, CPCS, CPHQ, Director of Medical Staff Services, Paradise Valley Hospital, 2400 E. Fourth St., National City, CA 91950. Telephone: (619) 470-4156. Fax: (619) 472-4502. E-mail: DownsKA@PVH.AH.ORG.*
- ***Charlotte Jefferies**, Horty, Springer & Mattern, 4614 Fifth Ave., Pittsburgh, PA 15213. Telephone: (412) 687-7677. Fax: (412) 687-7692. E-mail: cjefferies@hortyspringer.com. Web: www.hortyspringer.com.*
- ***Marianne Klass**, RN, MN, Accreditation and Safety Director, Swedish Medical Center, 747 Broadway, Seattle, WA 98122-4307. Telephone: (206) 386-2549. Fax: (206) 215-3071. E-mail: Marianne.Klaas@swedish.org.]* ■

Are you complying with restraint standards?

How to benchmark using your own data

You already should know that Joint Commission on Accreditation of Healthcare Organizations surveyors want to see compliance with restraint and seclusion standards. But to improve quality in this area, you'll need to do more.

"I think it goes beyond just compliance," says **Shari Hughes Scott**, MS, LMFT, LPC, RN, psychiatric consult nurse at Children's Medical Center of Dallas. "Surveyors want to see evidence that we are using appropriate clinical judgment to provide respectful and safe care to patients and families."

That means continually looking at the risk vs. the benefit of interventions on an individual basis, Scott says. "I also think that they want to see concrete evidence that we are actively involving patients and families in the process of reducing aggression and successful coping from the very beginning of treatment."

In addition, it is important for clinicians to partner with the patient to meet therapeutic goals, she adds. "This is opposed to planning care in a way that requires exerting control and power over patients in order for them to make progress with the goals we set for them."

To dramatically improve the way restraint and seclusion is addressed at your facility, consider the following:

- **Benchmark using your own data.**

It's very difficult to obtain benchmarking information from other facilities, says **Darcy Jaffe**, ARNP, director of inpatient psychiatry, psychosocial consultation, and involuntary treatment services at Seattle-based Harborview Medical Center.

"Building a database from which to benchmark with your own facility over time seems to provide the most useful information to gauge how the facility is doing," she says.

Start with these basics, Jaffe advises: Compliance with obtaining orders, number of patients in restraints, why the patient is being restrained, and for how long. "Once the database is established, the best performance indicators to use seem to become apparent naturally."

Your monitoring system must be broad, since the use of restraints encompasses the entire clinical staff, she notes. At Harborview Medical Center, these steps are taken:

— Weekly audits of documentation are done to ensure it meets standards and that the restraint use is necessary.

— Daily charge nurse rounds are conducted in which all patients who are in restraints are reported.

— Closed-record reviews are done on a quarterly basis.

— The psychiatric clinical nurse specialist keeps track of all patients who are in behavioral restraints on the medical/surgical floors. On the psychiatric units, the manager reviews all restraint orders and plans for patients in any kind of restraint.

At Children's Medical Center, an overall baseline assessment was done to assess both behavioral restraints and the use of medical restraint and medical immobilization throughout the facility, Scott says. "Having those baseline numbers, we formed a multidisciplinary task force that continues to meet monthly," she says. "The initial goal was to achieve 100% compliance with regulatory mandates for restraint and seclusion in our institution."

Since that time, the restraint initiative has broadened to include improving the facility's approach to care through education, policy, and practice, Scott says.

- **Make sure your policy addresses Joint Commission standards.**

To comply with Joint Commission standards for restraint and seclusion, you'll need clear, comprehensive policies that clinicians are accountable to follow, says Jaffe.

Surveyors want to see documentation that easily shows that the patient was properly assessed regarding the reason for restraints, that all other options were tried first, and that the restraints were discontinued as soon as possible, she says. "They also want to see that the patient/family was included and has a voice in the plan."

Here are ways to comply:

— Develop documentation and order templates that force staff to enter correct information and to view restraints as a priority problem, says Jaffe.

— Consider creating a position that is solely responsible for restraint practices if there are a significant number of patients who need restraints at your facility, she recommends.

— Invest the appropriate resources into staff education. "Don't stop with a one-time education process," Jaffe says. "There must be thought to include a long-term plan."

— Standardize your documentation and policy and procedure across the institution, advises Scott. "In addition, we have housewide competencies for all direct-care staff regarding the use of restraint and seclusion."

To ensure that each standard or condition of participation was met with each incident of restraint or seclusion, a detailed documentation flowsheet was developed that follows requirements of both the Centers for Medicare & Medicaid Services and the Joint Commission, says Scott. If the clinician follows the written prompts and documents accordingly, it will ensure compliance, she says.

The facility's policy requires that a performance improvement checklist be completed for each restraint or seclusion that occurs, says Scott.

"Each incident of restraint or seclusion is reviewed by the corresponding manager," she explains. "Trends are noted, which may result in specific improvement plans being put into action."

Have a clinical nurse specialist talk with nurses and physicians when they have a patient in restraints, to help formulate a plan to get the patient out of restraints, recommends Jaffe.

"The more often this happens, the faster the staff get at figuring it out on their own," she says.

- **Monitor restraint use.**

At Children's Medical Center, a restraint and seclusion hotline was set up, Scott says.

"All occurrences of restraint or seclusion occurring anywhere in our institution are called in to this data bank with information provided corresponding to regulatory mandates," she explains.

These demographics and variables are placed into a database, which allows trends and patterns to be identified, she says. "This breakdown can provide clues for making important changes, which might reduce the incidence of these procedures."

[For more information on restraint use, contact:

- ***Darcy Jaffe**, ARNP, Director, Inpatient Psychiatry, Psychosocial Consultation, Involuntary Treatment Services, Harborview Medical Center. Telephone: (206) 731-6630. E-mail: dmjaffe@u.washington.edu.*
- ***Shari Hughes Scott**, MS, LMFT, LPC, RN, Psychiatric Consult Nurse, Children's Medical Center of Dallas. Telephone: (214) 456-6477. E-mail: shari.scott@childrens.com.]* ■

ACCREDITATION
Field Report

Tips from a recent survey

[Editor's note: This column will be a regular feature in Hospital Peer Review *profiling a facility that recently has been surveyed by the Joint Commission on Accreditation of Healthcare Organizations. If your facility was recently surveyed, please contact Staci Kusterbeck, Editor,* Hospital Peer Review, *280 Nassau Road, Huntington, NY 11743. Telephone: (631) 425-9760. Fax: (631) 271-1603. E-mail: stacikusterbeck@aol.com.]*

When surveyors from the Joint Commission come knocking at your door, they will want to see proof of compliance with each one of the six patient safety goals, says **Kathy Brandeis**, RN, BSN, performance improvement/JCAHO coordinator for Saint Joseph's Hospital of Atlanta, whose facility recently was surveyed.

"Be prepared to demonstrate how you're complying with every single one of these," she warns. "They are looking for 100% compliance."

Surveyors quizzed various staff members about each safety goal, including hospital board members and surgeons, she reports. For example, surveyors asked, "What do you do before you give a medication or before you draw blood?" In this case, they wanted to see that staff knew to check for two patient identifiers, and asked what they were, then looked to see if other staff were really doing this, says Brandeis.

Surveyors wanted to see that a time-out is done to verify correct patient, procedure, and site, and that this is documented in the chart — not just for surgery, but for any invasive procedure, such as putting in chest tubes, she says.

Here are other areas of focus during the survey:

- **Health status of physicians.**

The physician surveyor asked about the facility's policy for assessing the health status of physicians, says Brandeis. "There have been new standards related to that in the past couple years, and they are looking to see how they have been incorporated." For example, the surveyor asked about the process that occurs if an impaired physician is identified.

"They really want to know how the process is done and that it encompasses all that is required," she says.

- **Infusion pumps.**

Surveyors asked about the process to ensure that all PCA and infusion pumps are free-flow protected, says Brandeis. "Make sure you have your biomedical person in that interview. At our facility, he spoke to the surveyors about how he had written the company and ensured that these pumps are free-flow protected, and also explained our process for this."

It was explained that for the facility's hyperbaric unit, free-flow protected pumps cannot be used, says Brandeis. The surveyor was informed of the following triple-check mechanism to ensure that the infusion pumps do not leave the hyperbaric unit:

— A red plate on each pump says, "This machine is not free-flow protected and may not leave hyperbaric unit."

— Each pump has a serial number and has to be accounted for every single morning.

— If a pump is needed in another unit, the

facility's policy states that another pump should be obtained from central supply, instead of borrowing one from the hyperbaric unit.

- **Infection control.**

Surveyors wanted to know the process for keeping track of which scopes were used for which patients, says Brandeis. Each scope is numbered, and this is tracked electronically in the OR, and manually documented in other areas.

"On your documentation sheet, you already have the patient's name, medical record number and findings, and you can just add, 'Bronchoscope #1,'" she advises. "Writing down serial numbers is too long, and you can make mistakes."

- **Medications.**

In the OR, surveyors wanted to see the system used to account for all narcotic and medication use, says Brandeis. "That is a biggie, because there have been cases of anesthesiologists misusing narcotics."

The surveyor observed anesthesiologists returning narcotics to pharmacy and were looking for a double-check mechanism to see that whatever was not used actually was brought back, she says.

- **Failure mode and effect analysis (FMEA).**

"You better have a hospital board member present when you are developing this, and they need to be involved in the grunt work — the actual process of writing it," says Brandeis. "Many people really hadn't done that." Fortunately, the facility's pharmacy and therapeutics director was a member of the hospital board at the time of the survey, she says, and for the current year, a surgeon who is a board member will participate with the FMEA development.

- **Documentation.**

Surveyors checked that physicians documented that they have informed the patient of the alternatives, risks and benefits and that the patient has agreed to the procedure, says Brandeis.

"The patient can sign the consent form, or the physician can document this in the history and physical or in their progress notes," she says. "They cannot document it in the operative report because that is after the fact."

[For more information about the facility's recent Joint Commission survey, contact:

- ***Kathy Brandeis**, RN, BSN, Performance Improvement/JCAHO Coordinator, Saint Joseph's Hospital of Atlanta, 5665 Peachtree Dunwoody N.E., Atlanta, GA 30342-1764. Telephone: (404) 851-7506. Fax: (404) 851-5604. E-mail: kbrandeis @sjha.org.]* ■

THE QUALITY - CO$T CONNECTION

Don't let impairments jeopardize patient safety

Separate health matters from discipline

By **Patrice Spath**, RHIT
Brown-Spath & Associates
Forest Grove, OR

Recognizing and effectively responding to impaired physicians is a critical component of a hospital's patient safety initiative. The Joint Commission on Accreditation of Healthcare Organizations has an explicit requirement that the hospital medical staff have a process to identify and manage matters related to individual physician health (MS.2.6).

This process should be separate from the medical staff disciplinary function. Traditional medical staff bylaws have contained no provision for modifying behavior, only for punishing behavior. Generally, the only actions provided for in the medical staff bylaws are: corrective action, summary suspension, automatic suspension, automatic termination, and due process.

The purpose for separating health matters from disciplinary matters is to encourage the implementation of a process that will not damage the physician's reputation as a result of impairment. The goal is to identify health-related problems at an early stage, put supportive services in place, and implement necessary safeguards to protect the safety of patients while (if possible) allowing the physician to remain in practice.

The Joint Commission standards do not define what is meant by "health-related problems." However, many facilities use the Chicago-based American Medical Association (AMA) definition of impairment: *The inability to practice medicine with reasonable skill and safety to the patient by reason of physical or mental illness or alcoholism or drug dependency.*

Staff member education about the warning signs of physician impairment and how to report suspected problems is an important step toward minimizing patient safety problems.

Physicians and staff members should be

educated about the signs/symptoms of a health-impaired physician. The AMA statement about impaired physicians can be used as a basis for this education.

According to the AMA, evidence of impairment includes observation of slurred speech, confusion, unsteady gait, tremulousness, failure to answer pages, and the perception of an odor of alcohol or alcohol on the breath.

Objective evidence of consumption is the presence of any alcohol in the blood and/or a positive qualitative urine drug screen. There are other, more subtle signs to watch for: outbursts of anger, a disorganized schedule, patient or staff complaints, unexplained absences or inaccessibility, and other inappropriate or unpredictable behavior.

A question that often comes up during discussions of physician impairment is, "What about the disruptive physician?" Repeated loud yelling or other verbal abuse directed toward patients, visitors, hospital staff members, or other physicians should not be tolerated. The recent Institute of Medicine report, *To Err is Human,* described the importance of teamwork and free exchange of ideas among members of the health care team.

Any member of the team who is disruptive will have a damaging effect on collaboration. If everyone is afraid to talk to the physician for fear of being verbally abused, there is a significant potential for patient harm.

The medical staff should have a definition of what is meant by "disruptive." The AMA definition might serve as a starting point: *A style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care*.

The key phrase is "style of interaction" — a physician who has a one-time outburst of anger, but who is generally easy to work with, would not be labeled disruptive. To be considered disruptive, a physician would exhibit a pattern of repeated inappropriate verbal acts that have the potential for decreasing the quality of patient care.

Of course, if a physician commits one act of physical abuse toward any person, the medical staff should take immediate action.

A pattern of disruptive behavior or a sudden change in a physician's ability to work well with other team members is a sign of possible impairment. For this reason, staff members should be encouraged to report such behaviors. There may be physical as well as mental causes for the behaviors or substance abuse concerns. In these circumstances, the medical staff impaired physician policy would apply.

Notification and action

The organization should have a formal notification process that physicians and other staff members are encouraged to use for reporting suspicious behavior problems. Everyone should be made aware of this process. Many hospitals allow for an oral report of concerns if the problem requires immediate attention.

This report can be directed to the chief executive officer, the chief of staff, or their designee. Don't require that the person making the report have absolute proof of the physician's impairment; however, he or she should be encouraged to state the facts that caused suspicions and any collaborating opinions from other people who observed the incident.

There should be a mechanism by which physicians suspected of health-related problems are referred to a medical staff committee or other group for further investigation. This process should include an objective evaluation of the credibility of the allegation. The impaired physician policy should include a procedure for immediate action when hospital team members, a patient, or a patient's family expresses concern that a physician appears acutely impaired. The ranking nurse manager on duty or hospital administrator should be involved in these situations, ideally in consultation with a member of the medical staff executive committee. If warranted, immediate coverage should be arranged for the physician's patient(s) and appropriate testing done (e.g., urine drug screen and blood alcohol). Label laboratory specimens as "John Doe" or another alias to protect the confidentiality of the affected individual.

Disruptive behavior may fall under the professional conduct policy of the medical staff. There should be a provision allowing the physician's medical staff membership and/or privileges to be reduced or revoked if the disruptive behavior adversely impacts the ability of the health care team to provide quality patient care. By linking the unacceptable behavior to quality of care, courts generally will uphold the medical staff's decision if the physician in question chooses to sue the medical staff. Because disruptive behavior is a complex problem, the traditional peer review process investigation may not be appropriate;

however, if changes in the physician's privileges or medical staff membership are contemplated, all aspects of due process should be followed.

If the physician is suspected of having health-related problems, it is important that supportive actions are undertaken by the medical staff. This includes referral to outside organizations that can provide diagnosis, treatment, and rehabilitation services. Most state medical associations offer "Impaired Physician" assistance.

If treatment is recommended by the outside organization, the hospital medical staff may ask for periodic reports of the individual's progress, including compliance with the treatment and rehabilitation plan.

If the physician continues to care for patients at the hospital while undergoing treatment for the health problem, the medical staff must have stringent ongoing monitoring of the individual's performance to protect the safety of patients. If it is determined that the physician is unable to practice safely, the peer review mechanism detailed in the medical staff bylaws would be triggered.

Many hospitals ask impaired physicians to voluntarily request a medical leave of absence and stop seeing hospital patients while under active treatment. If the physician refuses to discontinue practice voluntarily, the physician's privileges are immediately suspended until treatment has concluded. ■

CE *questions*

5. Which of the following is true regarding new standards from the Joint Commission?
   A. Surveyors will spend less time with staff.
   B. Staff will need to interact with surveyors.
   C. Medical staff leadership will be less involved with the survey process.
   D. There is less emphasis on the patient safety goals.

6. Which is recommended regarding credentialing of volunteers during disasters?
   A. Volunteers should not be accepted under any circumstances.
   B. Any volunteer can be accepted without risk during a mass-casualty disaster.
   C. You should have a system to address credentialing for physicians only.
   D. You should have a procedure to verify the identity of volunteers including physicians, nurses, and pharmacists.

7. Which is an effective way to comply with JCAHO standards for restraint and seclusion?
   A. Use benchmarking data from other facilities instead of your own data.
   B. Build your own database to assess restraint use.
   C. Monitor restraint use only if adverse outcomes occur.
   D. Have different policies for individual units.

8. What did Joint Commission surveyors want to see at Saint Joseph's Hospital of Atlanta?
   A. that a system was in place to ensure that unused narcotics are returned to the pharmacy
   B. that only free-flow protected infusion pumps are used throughout the entire facility
   C. that serial numbers of all scopes are recorded on patient charts
   D. that physicians document informing patients of risks and benefits of procedures in the operative report

Answer Key: 5. B; 6. D; 7. B; 8. A

Web site is a boon to quality managers

If you're looking for resources to help with quality improvement programs in your facility, access the new National Quality Measures Clearinghouse web site (www.qualitymeasures.ahrq.gov).

The site is the first collection of summaries of evidence-based quality measures and measure sets publicly available on the web for use in evaluating and improving the quality of health care, says **Jean Slutsky**, acting director of the Center for Practice and Technology Assessment at the Agency for

COMING IN FUTURE MONTHS

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Healthcare Research and Quality (AHRQ), which launched the site in February 2003.

"Quality managers are able to go to one place to look for quality measures," she says. "The site is updated weekly and allows comparisons across measures."

The site allows you to "compare yourself against yourself," says Slutsky. "If you have identified a quality problem, this can show you how care has improved over a period of time."

Quality managers can use the site to make sure their data definitions are consistent with industry standards, use the same denominators that are recommended for the measure, or as a source of potential measures when a committee or group asks, "What should we be measuring?" says Slutsky.

For example, you may be looking for measures to implement that are used by accrediting organizations to evaluate quality of care given to heart failure patients. All measures related to heart failure and those used by accrediting organizations are accessible through the "Detailed Search" page.

After entering the condition, you can choose the option that allows you to retrieve those particular measures used by accrediting organizations.

The site is linked to the The National Guideline Clearinghouse database, which has more than 1,000 evidence-based clinical practice guidelines from 165 organizations, she adds.

"Because these sites are linked, if a measure has a guideline that it was developed from, you can go back and forth between them," explains Slutsky.

Developing guidelines is difficult and expensive, says Slutsky. "So if a guideline already exists, it's easier to see if it fits the needs of your facility, rather than start from scratch," she says.

[For more information about the site, contact:

- ***Jean Slutsky**, Acting Director, Agency for Healthcare Research and Quality, Center for Practice and Technology Assessment, 6010 Executive Blvd., Suite 300, Rockville, MD 20852. E-mail: info@qualitymeasures.ahrq.gov.]* ■

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To earn continuing education (CE) credit for subscribing to *Hospital Peer Review,* CE participants should be able to meet the following objectives after reading each issue:

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- Cite solutions to the problems associated with those issues based on guidelines from the Joint Commission on Accreditation of Healthcare Organizations or other authorities and/or based on independent recommendations from clinicians at individual institutions.

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