WASHINGTON HOSPITAL MOVES TO DNV ACCREDITATION

For one Washington hospital, making the move from Joint Commission accreditation to DNV Healthcare, Inc.’s NIAHO™ accreditation was a matter of research, timing—and moving at a lightning pace.

Group Health Central Hospital in Seattle is part of Group Health Cooperative, an integrated delivery and financing system providing care to approximately 400,000 residents in Washington and northern Idaho. The organization operates 26 primary care centers, three specialty centers, and one hospital.

“It all started out at the annual Institute for Healthcare Improvement National Forum,” says Elizabeth Rosen, RN, BSN, director of quality and regulatory compliance at Central Hospital. “DNV was there, and I discussed the situation with them and came back to share my interest with our leadership.”

Rosen, along with the hospital’s chief of medical staff and director of clinical operations, met with DNV to determine whether the change was worth pursuing. Next, they brought in hospital administration, the chief nursing officer, the vice president of acute care, and legal counsel.

“I had outlined a proposal with a comparison of the Joint Commission and NIAHO standards,” says Rosen. “People were all positive, though there was some concern about the time frame.”

The hospital was due for a Joint Commission (formerly JCAHO) survey any time after January 1. Regardless of whether it decided to change accrediting organizations, Group Health was subject to the survey and could not switch accrediting organizations if it had any outstanding RFIs with the old accrediting organization.

The decision went from hospital leadership to Group Health Cooperative’s CEO.

“The CEO, in consultation with the board of trustees, made the final decision,” says Rosen. “At the same time this decision-making process was going on, we did a high-level gap analysis to look at the differences between DNV and The Joint Commission to understand where our focus areas would be.”

The hospital’s legal counsel reviewed the contract template, and the application was completed during the decision-making process because everyone involved knew the change would have to happen fast.

“We made the final decision to withdraw from The Joint Commission, and immediately following withdrawal, [we] sent our application to DNV,” says Rosen.

After signing the contract, the hospital began working with DNV to establish a timeline for the survey process.

“We had to move very quickly. We needed to be very compliant in a very short time period.”

—Mary Lou Calise, RN, BS, MSQA, CPHQ

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New and revised standards and EPs arrived just days after the 2009 standards went into effect. Elizabeth Di Giacomo-Geffers, RN, MPH, CNAA, BC, CSHA, reviews those changes and recommends steps your facility should take to prepare for their implementation.

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About one month elapsed between the signing of the contract and the arrival of DNV surveyors.

“We had to move very quickly,” says Mary Lou Calise, RN, BS, MSQA, CPHQ, quality consultant for Group Health. “We needed to be very compliant in a very short time period.”

Given how closely aligned the NIAHO standards are to CMS regulations, Calise says they were “pleasantly surprised during this process.”

Because of the time gap between Joint Commission and DNV accreditation, Rosen worked with the state Department of Health and the local CMS office to keep them up to speed about the hospital’s accreditation status.

**Pros and cons**

The decision was made after weighing the benefits and drawbacks of the accrediting bodies.

“We went over the pros and cons,” says Rosen. “Central Hospital is a very limited hospital. We’d previously had two hospitals [in the system] but closed one in 2008 as part of an affiliation with an existing tertiary community hospital, so we went from a hospital system with a number of regular inpatient/acute care units to having obstetrics inpatient with all other hospital-based outpatient units.”

One concern Group Health had was the inpatient-oriented approach of The Joint Commission’s standards, which no longer made sense based on changes to Group Health’s services with the closing of the second hospital.

“This was the biggest reason for changing,” Rosen says. “Another was that, especially in 2008 and 2009, the Joint Commission standards were becoming so prescriptive that it wasn’t fitting with our services and population.”

The frequency and volume of The Joint Commission’s changes were hard on small hospitals, says Rosen. “Some of the standards wouldn’t apply to us or have limited results on our population,” she says. “Instead, we’re [now] able to focus our energies with more applicability.”

For example, Central Hospital has only a small number of overnight patients requiring anticoagulant management. A process for managing these patients was put in place, and the hospital stands behind it, but it might not have been a priority focus area given the hospital’s patient needs.

“What I looked at was the NIAHO standards in comparison with what was currently being done at our facility for compliance,” says Calise.

She worked to marry the two sets of requirements, looking for weaknesses and areas in which the facility needed to change or stay on course. The process was very site-specific.
“For example, CMS has extended their restraints standards,” says Calise. “We were in compliance, but we don’t have a psychiatric unit. We use restraints very infrequently. We had to take a closer look at what we were doing and where we needed to go.”

**Timing of surveys**

Also in the plus column for DNV: annual surveys.

“We saw a benefit to an annual survey,” which DNV requires, says Rosen. The upside of this frequency would be having some sense of when to anticipate the survey, and also keeping on top of everything all the time, she adds.

“Coming once a year … those of us working in quality are all for it,” Calise says. DNV offers to train one person in the facility to be a surveyor—the facility pays for travel expenses. This designee, who is also trained in ISO 9001, must survey three other facilities per year.

“We liked the idea of a collaborative approach,” says Rosen. “We liked the idea of having one of our own internal quality folks become a DNV surveyor and becoming our in-house expert.”

In Group Health’s case, that person is Calise.

“I used to be a surveyor for the Commission on Accreditation of Rehabilitation Facilities,” says Calise. “When I’d see a different way of doing something well, I’d bring that knowledge back to my facility. You’re always learning, finding different ways to accomplish your goals.”

Calise says she is looking forward to the challenges of NIAHO certification.

“I’m very pro data, and this is looking at your data, doing an analysis of it, and looking for where the faults are, tweaking it to get your system where it needs to be,” says Calise.

The concept of “no tipping point” for findings was another selling point for Group Health, says Rosen. Hospitals are instead required to have a corrective action plan in place and meet the time frames established for that plan.

“I can’t deny, I didn’t understand the scoring system for The Joint Commission,” says Rosen. “You didn’t really know if there was a tipping point with the new [2009] scoring.”

**Leaving The Joint Commission**

After submitting the withdrawal notice, the Group Health hospital administrator received a call from a Joint Commission account representative to schedule an exit interview.

“Towards the end of the interview they wanted to know the actual date of withdrawal,” says Rosen. The letter had said immediately. Whatever date is specified for the withdrawal, The Joint Commission sends a notification to CMS stating that the facility is no longer subject to accreditation by The Joint Commission. It was unclear what implications, if any, the notice to CMS might have concerning the hospital’s continuing Medicare certification.

“Our understanding was that our [Joint Commission accreditation] certificate was effective through mid-March 2009,” says Rosen.

According to the Joint Commission representative, the minute you withdraw, you go into nonaccreditation status, Rosen says. This left the hospital in a quandary: If you do not withdraw immediately, you are still subject to a Joint Commission survey at any time, even if the hospital is in the process of changing to a different accreditation body.

“We were a little surprised at that,” says Rosen. “So we reviewed the situation with our attorney and with our accreditation consultant at The Greeley Company and were assured it was not a significant issue.”

**State surveys**

Coincidentally, one week after the DNV survey is scheduled, the hospital will undergo its regular state licensing survey. Under current Washington state law, the state’s Department of Health is required to conduct periodic hospital surveys but may forego conducting a survey during a year in which a hospital is surveyed by The Joint Commission or the American Osteopathic Association (AOA). The law reflects that for more than 30 years, The Joint Commission and the AOA were the only hospital
accreditation entities approved by CMS. This changed in fall 2008 when CMS approved DNV Healthcare as another option for achieving deemed status under Medicare.

“Because the state of Washington has not yet added DNV as an option, we still need to have a licensing survey,” says Rosen.

Group Health is working closely with the Washington State Hospital Association and the Department of Health to change the law and recognize DNV for purposes of future state surveys. Once NIAHO accreditation has been achieved, the next step will be implementing the second component to DNV accreditation: use of ISO 9001.

“ISO 9001 is centered around quality,” says Calise. “Industry has been doing it for a long time. It’s looking at processes, making sure you’re meeting the standards you’re reaching for, and if not, adjusting them to make sure you do.”

Reports from the field indicate that validation surveys by state surveyors on behalf of CMS are happening with greater frequency this year. Validation surveys are unannounced surveys used to validate an organization’s accreditation process. These surveys are conducted on a representative sample basis or in response to substantial allegations of noncompliance. Unlike for-cause surveys, hospitals are selected randomly for validation surveys. It could be that CMS is requesting more validation surveys to be ready to review The Joint Commission’s soon-to-be-submitted applications for continued deeming authority.

One hospital, 30 outpatient practices

Central Maine Medical Center in Lewiston faced a slightly different challenge than the average hospital: The facility is a 250-bed hospital but is interconnected with 30 outpatient practices as part of the hospital’s license.

“CMS goes to all sites,” says Patricia Roy, RN, MSN, CPHQ, director of professional quality services at Central Maine. “We had to have multiple surveyors out to every physical location we have.”

The five-day survey, which took place five weeks after the close of the Joint Commission survey, involved up to 11 surveyors each day.

“The [CMS] visit was a surprise. When they came to the door I thought, ‘You’ve got to be kidding!’” says Roy. “On the upside, however, the entire facility was still very much in survey mode.

“We still had binders we hadn’t put away from the Joint Commission visit,” says Roy. “As soon as they came in, we went right into response mode. They let us do an opening presentation, and we had it updated and ready.”

State to state

The surveyors did not arrive together as they would in a Joint Commission survey.

“They sort of staggered in on the first day rather than arriving en masse,” says Roy. “The lead surveyor showed up first, then a few more, then we had the rest arrive a few hours later.”
This allowed additional time to get escorts ready for surveyors and to prepare staff members. The engineer surveyor arrived on day two, and the pharmacist surveyor arrived on day four.

“The amount of resources and people needed as opposed to a Joint Commission survey just to play host is quite a bit more,” says Roy. “Managers and directors always want to be back in their departments to help them get ready, but we really had to have eight or nine people playing host.”

With so many outpatient facilities, transportation was a unique problem. “Just to have enough people to drive them around was tough,” says Roy. “We had two fire marshals for all of the days as well, who also had to go to every physical site. It was an awful lot of traveling.”

To help keep things streamlined and organized in preparation for its most recent survey, Central Maine developed a command center concept. “This worked very well for us, so we did the same for the CMS survey,” says Roy.

Dedicated staff members served at the command center, passing out information to survey hosts and acting as the repository for requests coming in from staff members regarding what surveyors were looking for and which files they wanted.

“It helped us coordinate who was with who, where they were going, printing out the right schedules,” says Roy. “We had a managers briefing every night after the surveyors left, with notes about what they were seeing, what their concerns were, so that the managers and staff could be prepared and calm.”

Roy found the focus varied between surveys.

“Compared to the Joint Commission survey, the CMS team focused tremendously on performance improvement and quality,” says Roy. “Hours and hours and hours spent discussing minutes, when did [a certain decision go] to the board, and details around one chapter of the regulations.”

**15 surveyors, four days**

For Norwood (MA) Hospital, the validation survey team arrived January 12, almost one month to the day following the hospital’s triannual Joint Commission survey. “We need to prepare our staffs for validation surveys because they seem to be occurring more frequently,” says Karen Reed, CPHQ, director of quality and safety at Norwood.

The validation survey featured many more surveyors than the Joint Commission survey, Reed says. Fifteen surveyors arrived at Norwood, including a mix of nurses, pharmacists, social workers, and nutritionists.

The survey took four days. Among the unique challenges of the CMS survey was the variability of surveyor hours. “Some of the surveyors work seven and a half hours, some work 10 hours,” says Reed.

As with the Central Maine survey, surveyors arrived at different hours of the morning, making it more challenging to ensure that all surveyors had escorts. A larger contingent of surveyors arriving at all hours created a different sort of logistical process than the standardized Joint Commission survey team.

**Electronic medical records**

Hospitals with electronic medical records should plan ahead to address how surveyors will access these records, Reed says. At Norwood, surveyors reviewed records using a staff member’s password, with the staff member present to log in and monitor access.

“We have asked our information technology group to investigate alternatives for access for regulators in the future,” says Reed. “Despite logistical considerations like these, the survey was considered a success. We felt really good by the time it was over.”

Reed says the biggest lesson of the validation survey is the need for continual survey readiness.
It has been a little more than six months since Det Norske Veritas (DNV) was awarded hospital deeming authority by CMS, and Greeley clients have been asking whether DNV is a realistic alternative to Joint Commission accreditation. Our answer: It depends.

CMS appears to approve of the DNV process since it awarded DNV deeming authority for four years, rather than the expected one or two years. At least a dozen hospitals have already been accredited by DNV (see “Washington hospital switches to DNV accreditation” on p. 1), with another 100 or so in the queue, indicating respectable traction for the newcomer.

We have mixed results when we compare the NIAHO standards—as DNV’s accreditation program is formally called—with the Conditions of Participation (CoP) and Joint Commission (formerly JCAHO) requirements.

For example, DNV does not have a prescriptive set of patient safety goals—a large contributor to RFIs during Joint Commission surveys—relying instead on the hospital’s own data to set priorities for and approaches to patient safety. Like the CoP, NIAHO standard QM.7 requires internal reviews or audits (which may be met through ongoing data collection) of all internal and contracted departments and services at scheduled intervals. QM.7 also lists 18 subjects for data collection. A few of these subjects are new, although some readers may have been collecting them anyway: medication reconciliation, use of dangerous abbreviations, the effectiveness of the pain management system, and patients held in the emergency department or postanesthesia recovery area longer than eight hours.

Unlike The Joint Commission, DNV specifies the ISO 9001 approach to quality improvement, which can be phased in during the first few years of accreditation. Whereas The Joint Commission merely requires that performance expectations be set for contractors, NIAHO GB.3 requires annual indicator-based contractor reviews.

DNV’s Medical Staff chapter requires the collection of rate-based, comparable, practitioner-specific data for medication prescribing errors, surgical and moderate sedation outcomes, appropriateness of care for nonsurgical specialties, and deviations from established standards of practice. On the other hand, the NIAHO Medical Staff chapter does not require ongoing or focused professional practice evaluation and allows a three-year reappointment cycle, rather than the two-year frequency mandated by The Joint Commission.

The annual DNV surveys have the advantage of maintaining momentum, continuity—with the same surveyors coming back for repeated visits—and predictability. On the other hand, they are annual.

There also appear to be few external roadblocks to choosing DNV, since health plans and residencies have so far accepted the accreditation without reservation.

So how do you choose? It depends on your hospital’s situation. However, we continue to view the addition of DNV as a win for clients regardless of which accreditation they ultimately choose. Competition is good for customers and strengthens the competitors. It’s as simple as that. ■
Community Memorial Hospital (CMH) in Hicksville, OH, was expecting The Joint Commission sometime in April, but when surveyors showed up on the morning of January 27 for the facility’s critical access survey, staff members were prepared.

“Going by the last time we were surveyed, which was April 2006,” CMH wouldn’t have reached a full three years between surveys until April, says Jane Zachrich, RN, MSN, chief nursing officer.

In fall 2006, CMH began weekly preparation meetings for the facility’s next unannounced survey.

“We took each standard and went step by step through all of them,” Zachrich says. “We went through each element of performance one by one and determined if documentation was needed, who had the necessary documentation, was the documentation complete, was the policy in place, and did it need updating.”

CMH also held monthly manager meetings. Because staff members had reviewed each standard, the survey was more of a confirmation than anything else, says Zachrich. During the three-day survey, a typical day at CMH consisted of the lead surveyor conducting an opening session in which he would go over everything he planned to do that day. He would review the schedule of people he needed to meet with that day, as well as on following days. As the lead surveyor conducted the survey, the first thing that caught his eye was the Universal Protocol™ process CMH had in place.

“He said that we had followed Universal Protocol exactly as it was written and he was very impressed with that,” Zachrich says. “According to [the surveyor], very few organizations are as compliant with the guidelines as we demonstrated here.”

For every positive remark during unannounced surveys, there is usually negative feedback to go along with it.

CMH received two indirect impact RFIs and one direct impact RFI. The indirect impact RFIs dealt with the focused professional practice evaluation (FPPE) CMH has in place and medication storage.

“With the first RFI, our FPPE did not say on-site that the competence of the physician requesting the privilege was verified. We have a new process in place but had not completed the evaluation tool,” Zachrich says. “We did not have a place where you could identify which physician or surgeon would oversee the competence for the requested privilege, but this is easily fixed.”

CMH received an indirect impact RFI for medication storage because one of the freezers the hospital uses did not have its alarm ranges set to the medication manufacturer’s instructions.

“This was not a problem to fix because all we had to do was obtain a package insert and recalibrate the temperature and alarm to fit with the instructions,” says Zachrich.

The direct impact RFI regarded the National Patient Safety Goal addressing medication labeling.

“An orthopedic surgeon’s practice for a surgical procedure was mixing three medications in a single syringe. We did have a label, but the syringe was pre-labeled instead of with each separate medication,” Zachrich explains. “This was the only direct impact RFI we received, and we were able to correct it before [the surveyor] left.”

CMH officials are proud of the fact that the facility did not receive a single RFI for its Life Safety Code® (LSC) processes.

“We were surprised by this because it is unusual not to be cited for something. One advantage might be because our facility is only two years old,” Zachrich says.

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Being such a new facility, CMH invited an environmental care specialist from another facility to conduct an evaluation and offer a list of improvements, says Zachrich.

The environmental care specialist came in for half a day and suggested that CMH label all doors and create a matrix to document any work done.

Another suggestion was to require contractors and vendors to submit their plans for approval before any work was performed, and then to check for fire penetration once the work was completed.

“This was the best thing that we could have done as a facility,” Zachrich says. “I think this put us way ahead of things.”

To keep up with the LSC regulations, CMH continues to make monthly environmental care rounds during which administrators and other staff members aim to identify potential problems.

“We use a grid to help determine what standard the infraction applies to, what the issue is, who is responsible, and what the follow up should be,” Zachrich says. “This grid applies for anything that is environmental care or any other issue that we may find.”

When asked whether CMH would be updating the tool soon, Zachrich says it works well and has brought them success during the past two years.

Although CMH had its unannounced survey in late January, officials continue to ready themselves for the next one by conducting monthly manager meetings at which Joint Commission updates are discussed.

“It is important to know your standards and it can be tedious to get people together and go through each standard, but it helps people to be prepared,” explains Zachrich. “Staff education included the whole building because we wanted to make sure everyone knew what to expect. Preparation is always in the forefront for us.”

Insider insight

Our compliance advisors note that The Joint Commission’s current process schedules a hospital’s survey randomly during the year it is due (up to a maximum of 39 months from the prior survey). However, in a small number of cases, the survey can be pulled into the year before it is due based on The Joint Commission’s Priority Focus Area process, which allows the commission to resurvey in as few as 18 months since the prior review.

Also, our compliance experts advise us that the surveyor may have erred by issuing the solutions-labeling RFI. We commend the institution on its outstanding performance, and we urge our readers to clarify any finding they feel may be inaccurate.
Establish compliance with new and revised 2009 standards

Editor’s note: This feature explores problematic Joint Commission standards with expert advice from BOJ advisors. This month, Elizabeth Di Giacomo-Geffers, RN, MPH, CNAA, BC, CSHA, a healthcare consultant in Trabuco Canyon, CA, and a former Joint Commission surveyor, discusses recent changes to The Joint Commission’s standards.

Just days after the new 2009 standards went into effect, The Joint Commission released a 46-page document containing new and revised standards, effective immediately, intended to bring many Joint Commission standards more in line with CMS’ Conditions of Participation (CoP). In the long run, greater consistency in Joint Commission and CMS requirements is a good thing—hospitals will benefit from a more closely aligned relationship between both sets of requirements.

However, it did leave facilities scrambling to examine the newly announced changes and preparing to bring their facilities into compliance. There are also now rumors of discussion between CMS and The Joint Commission (formerly JCAHO) that some of the new elements of performance (EP) may not actually be needed as the intent was already stated sufficiently in another EP.

Fortunately, facilities have until July 1 before these standards are officially scored. At presstime, information regarding how these new and revised standards will be scored—as ‘A’ or ‘C’ EPs—had not been publicly released. However, you must immediately begin to assess your facilities’ compliance with these standards and determine areas of deficiency so you can put action plans in place to comply with them. Surveyors are already looking at these new requirements, even though they do not factor into the final scoring decision prior to July 1.

The changes affect nearly 70 standards and more than 150 new or revised EPs scattered throughout the accreditation manual. The documents surveyors have been specifically asking for include:

- Agreement with organ procurement organization
- Grievance process and grievance log
- Medical staff bylaws
- Organization budget information
- Organization chart related to clinical responsibilities of the anesthesia, emergency, nursing, outpatient, and respiratory departments

Next, you should ask how these new changes can be surveyed. Although the exact survey process is still unknown, understanding how related standards and EPs are surveyed can help facilities make educated guesses.

Expect document review and tracers in the areas of environment of care, HR/competency, medication management, infection control, data use, and/or medical staff, credentialing, and privileging sessions. You may also see this in program-specific areas such as lab integration.

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STANDARD OF THE MONTH (cont.)

Tips for preparation

July 1 may feel far away, but the time to act is now. The following are some tips for establishing compliance with the new standards:

➤ Perform a comparative analysis of the new and revised standards/EPs. This can be done in a centralized way with a survey coordinator or decentralized through chapter chairs or champions.

➤ Ask yourself whether these processes already exist or whether new or revised policy and bylaws and/or practices need to be created.

➤ Don’t take it on alone. Delegate to chapter chairs using the “show me” approach. Don’t assume policy or practice is there. “Show me” where hospital policy, procedure, and/or process covers the new requirements.

➤ Update your policies or bylaws and make sure to reflect the dates of changes.

➤ Consider crosswalking the Joint Commission changes with CMS’ CoP. (You can find the revised Appendix A, “Interpretive Guidelines for Hospitals,” published October 17, 2008, online at www.cms.hhs.gov/transmittals/downloads/R37SOMA.pdf.)

➤ Review the CoP, interpretive guidelines, and survey procedures released by CMS.

➤ Make sure you’re covering all the bases. Use the sample table below to track the 68 changes, as well as hospital compliance with each.

2009 new/revised changes—hospitals

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<th>#</th>
<th>Standard/EP</th>
<th>2009 changes what is new</th>
<th>CMS/CoP standard/tag #</th>
<th>Compliance</th>
<th>Evidence of compliance and/or action plan</th>
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Source: Elizabeth Di Giacomo-Geffers, RN, MPH, CNAAC, BC, CSHA.
## New and revised 2009 accreditation requirements—hospitals

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<th>Chapter</th>
<th>Standards</th>
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<td>EC</td>
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<td>Radiation safety: staff checked periodically/radiation exposure; ionizing radiation: staff/patients free from hazards; nuclear medicine equipment: inspect, test, calibrate annually; sanitary environment</td>
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<td>HR</td>
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<td>Staffing: dietary, medical records, pharmacy; staff qualifications: operating room; special training: blood transfusion/IV meds; document completion of hospital/unit-specific orientation</td>
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<td>IC</td>
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<td>Infection control officer(s) responsibilities: developing/implementing policies and procedures (P&amp;P); identify, report, investigate, and control infections; log related to infections/communicable diseases</td>
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<td>Medical records: coding/indexing, timely retrieval of medical records by diagnosis and procedure</td>
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<td>Leaders’ responsibilities in infection control: development and implementation of an action plan; medical staff (MS) responsibilities for organization/conduct of MS; operating budget/capital expenditure plan; emergency services: integrated, directed/supervised by member of MS; MD/DO responsible—anesthesia, nuclear medicine, respiratory services; medical records service: completion, filing, and retrieval of records; emergency lab services; comparable needs/lab tests outside of lab must meet Conditions of Participation (CoP); Clinical Laboratory Improvement Amendments, contracted services list/scope and nature of services; performance improvement projects</td>
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<td>Document inspections/approvals by state and local fire control agencies</td>
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<td>Abuse/loss controlled meds report to pharmacy/CEO; radiopharmaceuticals: record of receipt/distribution; controlled meds locked/secured; pharmacy/drug storage areas; medication prepared and administered by licensed independent practitioner (LIP) order; preparation of radiopharmaceuticals by or under direct supervision of trained pharmacist or MD/DO; compounding, packaging, dispensing of drugs/biologicals under supervision of pharmacist/law and regulation; immediately reporting to attending physician: adverse drug reactions, medication administration errors, medication incompatibility</td>
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<td>MS</td>
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<td>MS bylaws: completing/documenting timely history and physical by physician/other qualified LIP; include duties/privileges each category of MS (e.g., active and courtesy); medical executive committee voting members (MD/DO); emergency department (ED) services: MS is responsible for policies and procedures (on- and off-site campuses), P&amp;P, off-site campuses assess, treat, refer when no ED; MD/DO on duty at all times; MD/DO responsible for care of patients with respect to medical or psychiatric problems present on admission (POA) or develop during hospitalization when not within scope of practice of certain practitioners; autopsies—unusual deaths, medical-legal, educational interest; permission defined, attending notified; radiologist supervises ionizing radiology services, radiologists interpret radiologic tests that are determined by the MS</td>
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<td>PC</td>
<td>25</td>
<td>Provision of care: H&amp;P documented no more than 30 days before/24 hours after registration; blood transfusions/IV meds; orders; current therapeutic diet manual; anesthesia; equipment must be available in the operating room; pre-/postanesthesia timeliness; tissue specimen P&amp;P; restraint and/or seclusion; discharge evaluation plan/planning and patient/family involvement; potentially infectious blood and blood components, outside blood collecting establishment; quarantine potentially infectious blood and blood components; blood and blood components at least 10 years; plan to transfer records if hospital ceases operation; potentially infectious blood and blood components notification of patients, testing, testing facilities, documentation, P&amp;P comply with FDA</td>
</tr>
<tr>
<td>RC</td>
<td>8</td>
<td>Medical record: complete, accurate, timely, authenticated; entries timed, retention; H&amp;P time frames, medical record contents; operating room register; verbal orders; discharge summary</td>
</tr>
<tr>
<td>RI</td>
<td>4</td>
<td>Patient right to access information in his/her medical record in a reasonable time frame; physician notified promptly of admission to hospital; end of life—permission to perform autopsy: obtain/document; complaint/grievance process</td>
</tr>
</tbody>
</table>

Note: Refer to The Joint Commission’s elements of performance and CMS’ CoP for specific details (http://tinyurl.com/awcqkg).

Source: Elizabeth DiGiacomo-Geffers, RN, MPH, CNAA, BC, CSHA.
Q&A with LARRY PONIATOWSKI

CMS and physician supervision: Off-site physicians

Editor’s note: Each month, BOJ invites an expert in the field to answer a question from one of our readers. This month, Larry Poniatowski, RN, BSN, CSHA, principal consultant for accreditation compliance services at the University Health System Consortium in Oak Brook, IL, answers a question on CMS and physician supervision.

CMS has clarified its ruling on the physician supervision of on-campus hospital outpatient therapeutic services in the 2009 outpatient prospective payment system (OPPS) final rule. CMS stated that it expects direct physician supervision of all hospital outpatient therapeutic services, regardless of whether they are on- or off-campus. Does this mean a physician must be present in the provider-based department located off-site, but not directly in the room with each patient?

The short answer is yes. The physician needs to be physically present in the department but does not have to be present in the room with each patient. The 2009 OPPS final rule states:

410.27(f) requires that the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. In the April 7, 2000, OPPS … we define on the premises … must be present on the premises of the entity accorded status as a department of the hospital and therefore, immediately available to furnish assistance and direction for as long as patients are being treated at the site. We also stated that this does not mean that the physician must be physically in the room where a procedure or service is furnished.

This document makes three essential points about physician supervision. First, a physician must be present on the premises (in the department). Second, the physician does not have to be in the room where the patient receives services. Third, the physician must be immediately available to furnish assistance and direction as long as patients are being treated at that site.

Physician supervision has numerous meanings in healthcare. It can be as indirect as cosigning a medical record entry or as direct as bedside observation of a resident performing a patient procedure for the first time. In the 2009 OPPS final rule, CMS is very specific about physician supervision requirements for diagnostic and therapeutic hospital outpatient services.

This interpretation of physician supervision matches that taken by The Joint Commission (formerly JCAHO) when announcing two exceptions to the standard (MM.05.01.01, element of performance [EP] 1, previously known as MM.4.10, EP 1 under the old standards numbering system) in July 2007, relating to pharmacist review of medication orders that are still applied: A licensed independent practitioner (LIP) in the emergency department (ED) did not have to remain at a patient’s bedside after ordering medication for that patient.

However, the standard states that the LIP is required to remain in the area in the event that he or she is needed to provide immediate intervention—specifically, if the patient in question has an adverse reaction to that medication.

“Immediately available” means the LIP is in the ED, not answering a code in the ICU or busy elsewhere outside of the ED. The same essential points are made about physician supervision in the 2009 OPPS final rule.