Public notification

Turn to p. 5 to learn about how to comply with a new JCAHO requirement that calls for hospitals to provide public notification about how to communicate quality of care and safety concerns to accreditors. Find examples of public notices on p. 6.

Emergency management session

Be even better prepared for an unannounced survey by checking out p. 7 for an early look at the JCAHO’s emergency management session.

Tough IM standards

Information management standards continue to pose a challenge for hospitals. See p. 9 for a rundown of some of the most-cited IM standards in 2005.

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Unannounced survey monitor

First unannounced JCAHO survey catches AZ medical center by surprise

Editor’s note: This story is the first in an ongoing series about the experiences of facilities that have undergone unannounced JCAHO surveys this year.

Performance Improvement Coordinator Eileen Pressler, RN, had been expecting JCAHO surveyors to show up unannounced at her hospital’s door no earlier than February, based on the fact that her hospital was due for its triennial survey in March. You can imagine her surprise when she arrived at work to find JCAHO surveyors waiting inside Kingman (AZ) Regional Medical Center at 7:30 a.m. on Monday, January 23.

“They came two weeks earlier than we had anticipated,” says Pressler. “We had a plan in place but didn’t get to institute it.”

On the day of the JCAHO’s arrival, Kingman personnel were planning to affix educational storyboards in the hospital cafeteria about questions and issues that

Comes next month

Check out the May Briefings on JCAHO for another look at an unannounced survey experience from a hospital. Learn from your colleagues’ experiences as you prepare for your own unannounced survey.

Learning objectives: After reading this article, you will be able to
- discuss the need for a patient grievance committee
- list which items a patient grievance policy should include
- explain the procedure for the submission of grievances

How hospitals address patient rights is a key area highlighted by both the JCAHO’s standards and the Centers for Medicare & Medicaid Services’ (CMS) Conditions of Participation (CoP). But a new area of focus for CMS in 2006 is how hospitals handle and resolve patient grievances.

Both CMS and the JCAHO require that inpatients and outpatients are informed about their rights. JCAHO standards are more specific about rights centered around care and treatment and cultural, spiritual, psychosocial, and personal dignity. The JCAHO also addresses patient responsibility information, whereas CMS does not.

Hospitals must have a formal patient grievance process
Unannounced survey

JCAHO surveyors might ask staff, “We put them up anyway,” says Pressler. “This was our plan and we went ahead with it.”

“I don’t think you can ever feel 100% prepared for an announced survey—we would have liked a couple of more weeks,” she adds.

Kingman’s five-day survey included a physician surveyor, two nurse surveyors (with an additional preceptor for one of the nurse surveyors), and a life safety surveyor because Kingman has more than 200 beds. The life safety surveyor arrived on the second day and stayed one day. The other four surveyors stayed for all five days.

The 219-bed medical center includes home health and hospice facilities, outpatient clinics, an imaging center, a cancer center, and a medical education program.

The surveyors got a quick start, conducting the first tracer by 10 a.m. Monday, says Pressler.

Read JCAHO’s survey prep guide

The survey approximated the process outlined in the JCAHO’s survey prep guide, which is available in the hospital area of the JCAHO’s Web site (www.jcaho.org), says Pressler.

Each morning began with a briefing during which surveyors reviewed that day’s schedule. Hospital personnel had to provide information about bed census and the day’s schedule of procedures. The surveyors used the schedule to choose their tracers for the day. The meetings also covered what was found on the previous day, allowing for both sides to clarify issues that had been raised.

There were a couple of other meetings during the day, which allowed for further resolution or clarification when issues arose, says Pressler.

“It went almost exactly the way the survey guide said it would,” says Pressler. “Get to know the survey guide.”

Mock surveys were helpful

Kingman Regional conducted two mock tracer surveys in 2005, the latest in December, just a month before its actual survey. “It really helped our staff get more comfortable with the [survey] procedure,” says Pressler.

Members of Kingman’s steering committee donned JCAHO badges and followed JCAHO survey guidelines, making the rounds to the units of the hospital, examining policies and procedures, and asking staff about the care they provide. Surveyors asked staff to be familiar with the JCAHO survey guides and identified areas that needed work.

“The actual survey process was much more intense, but the mock survey gave us a good indication of the kinds of things to look for,” says Pressley. “Not too many things came up during the survey that didn’t come up during the mock survey.”

Consequently, the staff performed well during the actual survey, says Pressler. The surveyors put staff at ease, but they were also direct with their questions and immediately verified any answers they received from staff, Pressler adds.

For example, she says, a surveyor asked the radiology nurse, “Who responds to codes in x-ray when you are off?” The answer was the emergency room (ER). The surveyor immediately went there and asked personnel whether they respond to codes in x-ray.

Focus on National Patient Safety Goals

Surveyors asked many questions about the National Patient Safety Goals, says Pressler. “They wanted to see us monitoring the goals we had been working on,” she adds. “They asked for data on monitoring. They also asked general questions related to the goals, such as what kinds of identifiers we used.”

Surveyors visited the nursing units and examined forms used for hand-offs and medication reconciliation. They talked to staff about how they used the forms and what the benefits and advantages were, says Pressler.
Medication reconciliation went smoothly, says Pressler. “We [had] just instituted a policy at the beginning of the year, but they liked our form and I think that helped.”

Unapproved abbreviations proved to be a thorny issue for Kingman Medical. “I think this is one of the hardest goals,” says Pressler. “You think an issue is fixed and then [surveyors] find one thing and write it down.”

Get rid of old forms
The “one thing” surveyors found was an old preprinted order form that had an unapproved abbreviation on it. “Out of all the patients, they picked the chart that had the one [outdated] form on it,” Pressler says. “I don’t know where it came from.”

Old, outdated forms appearing at inopportune times are an issue that every hospital must deal with, she adds.

Surveyors also wanted to see evidence of clarification after use of an unapproved abbreviation, says Pressler.

In addition, surveyors watched hand-hygiene practices closely. “They observed hand hygiene during each tracer activity,” says Pressler.

Attention paid to infection control tracer
The surveyors were particularly interested in the infection control (IC) tracer, says Pressler. They wanted to look at a patient who was an IC risk and visiting other places in the hospital.

“We talked about precautions with the patient, how we protected a patient’s privacy, and how we protected staff. We looked at the whole process,” Pressler says.

Surveyors also examined how Kingman Medical’s home health/hospice programs are integrated into IC and performance improvement activities at the main hospital. Kingman Medical couldn’t produce specific data about home health infections, although they have few that can be attributed to home health.

“It wasn’t enough that home health/hospice reported at each infection control committee,” says Pressler.

“The surveyors] wanted a specific plan and data.” Other issues that arose during the survey, according to Pressler, included the following:

■ Pain assessment was a big issue. Surveyors found no evidence of reassessment of pain after medication in several patient records in the acute-care hospital as well as home health and hospice, says Pressler.
■ Make sure that all sites know how to contact the JCAHO if there is a concern. “We covered the main hospital but forgot about our clinics and home health patients,” she notes.
■ Have a procedure for rapidly notifying staff that the pediatric emergency medication cart must be brought to a specific area, says Pressler. “We are working on a way to announce pediatric codes but do not have the procedure in place,” she says.
■ Surveyors wanted to see a completed failure mode and effects analysis.

General presentation
The physician surveyor asked for a presentation from hospital leadership on the first day, says Pressler. Although Kingman was prepared with a PowerPoint presentation, the session turned into a roundtable discussion. The physician surveyor spent much of the presentation asking questions of the hospital CEO and a board member representative.

“It was very casual, off the cuff,” says Pressler. “As a whole, everyone seemed really comfortable. We talked about who we are and what we do.”

Tell us about your unannounced survey experience!

Has your hospital had its unannounced triennial survey yet? BOJ wants to know about it. What happened when the surveyors showed up? How did staff handle the surprise? Contact Senior Managing Editor Jay Kumar at 781/639-1872, Ext. 3144 or jkumar@hcpro.com, and your experiences may be featured in a future article.
Patient grievances

and mechanism that has been approved by the organization’s governing board. The CMS interpretative guidelines define a patient grievance as “a written or verbal complaint by a patient, or the patient’s representative, regarding the patient’s care, abuse or neglect, issues related to the hospital’s compliance with CMS Hospital CoPs, or a Medicare beneficiary billing complaint related to rights and limitations.”

Billing issues are not considered grievances unless the complaint also contains issues about patient service or care. The hospital must inform the patient of the grievance process and provide a written response to each patient’s grievance.

If the grievance will not be resolved or the investigation has not been or will not be completed within seven days, the hospital should inform the patient or his or her representative that the hospital is still working to resolve the grievance and will follow up with a written response within a stated number of days based on the hospital’s grievance policy. The hospital must attempt to resolve all grievances in a timely manner.

In the past, hospitals “didn’t always tell patients that we did something negligent,” says Sue Dill Calloway, RN, MSN, JD, hospital risk management director at OHIC Insurance in Columbus, OH. With the new CMS revisions, that has changed.

Grievance committee is a must

CMS revisions to its CoP on patient grievances took effect September 19, 2005 (read the CMS memo at http://tinyurl.com/o2o6o). A key requirement is that the hospital must establish a multidisciplinary grievance committee, which would develop the hospital’s grievance policy and meet once a month, says Dill Calloway. Previously, hospitals were not required to have such a committee.

If the hospital already has a grievance policy in place that empowers another board (e.g., the performance improvement committee) to serve in the same role, Dill Calloway says it meets the CMS requirement.

The committee should not actually make decisions on individual grievances because it would be inconvenient and inefficient to convene such a panel more than once per month, notes Dill Calloway. Even though it’s not specified in the CoPs, “common sense tells you that you need to have one person in charge to decide grievances,” she adds. That person could be the nursing supervisor, consumer advocate, or another administrator.

A complaint is only defined as a grievance if it comes from a patient or his or her representative. If the patient is satisfied with his or her care but a family member is not and complains, that is not by definition a grievance, Dill Calloway says.

Complaints involving abuse or neglect are always considered grievances “because that’s one of CMS’ hot points,” says Dill Calloway.

JCAHO not as focused on grievances

Hospitals should worry about meeting the CMS grievance requirements because they are much stricter and most hospitals seek reimbursement for Medicare and Medicaid patients, Dill Calloway says.

“The JCAHO has never really focused on grievances,” she adds. “Nobody ever gets cited because it’s so basic.”

JCAHO standard RI.2.120 requires that a patient grievance resolution process exist and that complaints be addressed. There are five elements of performance requiring that

- patients, family, and staff be informed about the grievance process
- the hospital receives, reviews, and, when possible, resolves complaints
- the hospital defines “significant” complaints and responds appropriately
- the hospital informs patients of their right to file a complaint with the state authority
- patients can freely voice complaints and recommend changes
Accreditation Participation Requirement (APR) 8 is seemingly straightforward: Hospitals must continuously provide public notice about how anyone—including staff—can contact the Joint Commission if concerns about patient care or safety in the hospital aren’t being addressed. But your colleagues at several hospitals recently visited by the JCAHO say surveyors are not glossing over APR 8. Therefore, they recommend investing time and attention to APR 8 to ensure compliance during survey and not be cited for something that they believe is straightforward.

Surveyor scrutiny

“We were just surveyed, and I was astonished [by] how hard they were surveying [APR 8],” says Maureen Barnes, vice president for risk management and insurance at Cooper University Hospital in Camden, NJ. The facility was surveyed February 14-17.

Barnes estimates that surveyors quizzed 25 employees on how the hospital complies with APR 8. And although Cooper was in the clear, Barnes advises other facilities that it’s not enough to simply educate employees about APR 8 or for them to know where to locate information. “They must also be able to verbalize [that] they know they will not be subject to disciplinary action if they do report something.”

Barnes also suspects that APR 8 is an area at which surveyors are encouraged to look because it’s new for the unannounced survey process. It replaced the old system of requiring notification postings 30 days prior to survey date. Now, because survey dates are not known, notice must be available 24/7.

One source close to the JCAHO doesn’t believe that all surveyors scrutinize APR 8 and says surveyors have not been told to do so. The source says some surveyors actually give hospitals a little slack because it’s new.

Complying with APR 8

APR 8 is one of 14 requirements hospitals must meet to participate in the accreditation process and maintain accreditation status. All of the APRs are outlined in the Comprehensive Accreditation Manual for Hospitals (CAMH).

APRs are scored as either compliant or noncompliant. And although most APRs are straightforward, noncompliance with some (e.g., APR 10 [falsification of information]) can thrust a facility into preliminary denial of accreditation. Noncompliance with APR 8 will only earn a facility a requirement for improvement (RFI), but hospitals are only allowed 10 RFIs during an entire survey before meeting conditional accreditation and 15 for preliminary denial of accreditation, according to the JCAHO. It’s not worth overlooking APR 8 and winding up with an RFI when there are many other standards to be assessed.

The source close to the JCAHO says the best way to comply is to keep the language of the notice simple. The notice should be put in admission packets in an area in which numbers are listed for making complaints to the Centers for Medicare & Medicaid Services, state health department, etc. Also post the notice in the emergency department and other outpatient areas or have it available as a handout, the source says.

“I think an organization should place/link the JCAHO phone number and e-mail on the hospital’s Web site or within the patient information packet and on a bulletin board in a public place, such as near the cafeteria,” says John R. Rosing, MHA, FACHE, practice director of accreditation and regulatory compliance services with The Greeley Company, a division of HCPro. Rosing agrees that organizations should keep it simple and says you don’t need to go overboard to comply, so there’s no need for 48-point type or neon signs to meet the requirement and satisfy surveyors.

What the field is doing

Surveyors were pleased with how Cedars Medical Center in Miami met the requirement during a survey in 2004, says Kathleen Lavergne, RN, CPHQ, LHRM, associate vice president for regulatory...
compliance. The notice is in the community’s three main languages—English, Spanish, and Creole—and posted in the lobby, on the Web site, and in a booklet given to surveyors.

“[Surveyors] started reading it and they stopped because they recognized the language immediately as coming from the Manual, so they didn’t scrutinize it further,” Lavergne says. It’s generally Cedars’ policy to stick to the book whenever possible to stay on the safe side with surveyors. “Whenever we write policies, if there’s language in the standards that clearly says what they’re looking for, it’s our practice to use it,” she says. “Sometimes getting creative can get you into trouble.”

However, the JCAHO no longer provides sample language for the notice in the CAMH (the 2005 edition does, but the 2006 edition does not). The source close to the JCAHO says the sample language found in the 2005 CAMH remains valid and usable. “They can write anything they want so long as they tell people how they can file a complaint,” the source says.

At Centro San Vicente (CSV) in El Paso, TX, the notice is in English and Spanish and posted in the front entrance, in waiting areas, and by the laboratory. Because the notice isn’t just for the public, Gina Briones, performance improvement/risk management manager, says it is also put in areas where employee notices are posted.

But at CSV, Briones says the relationship with the public is so strong that staff work to resolve complaints before they make their way to the JCAHO.

“I think this shows the patients we are willing to try to solve it at our facility instead of just having them contact JCAHO,” she says.

Samples of public notification about JCAHO surveys

Cooper University Hospital/the Cooper Health System of New Jersey, Camden
On the hospital Web site:
Individuals are encouraged to contact Cooper University Hospital management regarding any concerns about patient care and safety in the hospital that the hospital has not addressed. If the concern continues, you may contact the Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Boulevard, Oakbrook Terrace, IL 60181.

In Cooper’s patient safety handbook, newsletter, and on intranet for employees:
The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has indicated that any concerns about safety or quality of care may be reported to them at One Renaissance Boulevard, Oakbrook Terrace, IL 60181. Employees should not be concerned that the hospital will take retaliatory disciplinary action against them if they inform the JCAHO of safety or quality-of-care issues.

Avera Queen of Peace Hospital, Mitchell, SD
Avera Queen of Peace Hospital wishes to promote open communication regarding your hospital experience. We encourage you to call the respective Department Director at 605/995-2000 or call the Director of Quality/Risk Management at 605/995-2464 to voice complaints or concerns or to ask questions.

Should you have a concern that is unresolved, you have the right to contact the South Dakota Department of Health, 600 E. Capitol Avenue, Pierre, SD 57501 (605/773-3361) and/or the Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Boulevard, Oakbrook Terrace, IL 60181 (800/994-6610 or complaint@jcaho.org).

Source: Cooper University Hospital/the Cooper Health System of New Jersey. Reprinted with permission.

Source: Avera Queen of Peace Hospital. Reprinted with permission.
What to expect from the JCAHO’s new EM session

Learning objectives: After reading this article, you will be able to

- identify the six key emergency management (EM) standards
- discuss which areas JCAHO surveyors will examine
- list the disaster scenarios developed by the JCAHO

Although the JCAHO has surveyed hospital disaster plans for years, in the wake of recent calamities such as Hurricane Katrina, a new focus on this matter has emerged.

If you work in a hospital with 200 or more beds, the JCAHO will now evaluate your EM policies more stringently through a new effort that started in January. As part of this new process, surveyors will conduct special EM sessions in larger hospitals, which start with a discussion phase in the incident command center and then proceed to disaster plan tracers within the facility.

Six standards in the core
According to the JCAHO’s Surveyor Survey Activity Guides, the EM session will focus on the following six standards from the environment of care (EC), infection control (IC), information management (IM), leadership (LD), and medical staff (MS) chapters of the Comprehensive Accreditation Manual for Hospitals:

- **EC.4.10**—Establishing and carrying out an emergency plan
- **EC.4.20**—Conducting emergency drills
- **IC.6.10**—Responding to an influx of infectious patients
- **IM.2.30**—Maintaining information continuity during a disaster, such as with patient records
- **LD.3.15**—Maintaining efficient patient flow
- **MS.4.110**—Granting temporary privileges to outside physicians during a disaster

EC.4.20 will become even tougher as of July 1, when a significant revision takes effect. These changes apply to all hospitals, regardless of bed counts.

“The JCAHO put extra meat into [EC.4.20],” says Dean Samet, CHSP, director of regulatory compliance services at Smith Seckman Reid, Inc., in Nashville, TN. Among the biggest changes is that the JCAHO wants “at least one person who is solely responsible for monitoring performance—although a large hospital will need more,” Samet says.

**Perceived risks and local input**
For hospitals with 200 or more beds, surveyors will scrutinize their EM plan, with a particular focus on the hazard vulnerability analysis. Surveyors will look at overall emergency operations and activities and discuss the four major EM provisions under EC.4.10: planning, response, mitigation, and recovery.

They will also examine a hospital’s relationship to the surrounding community, such as other hospitals and emergency responders. This is of particular concern in light of a “multiple-disaster” scenario, such as that precipitated by Katrina, which shut down many hospitals and cut power to large areas.

After surveyors talk to EM team members, they’ll choose one scenario from the organization’s hazard vulnerability analysis and conduct a tracer on that event (see the list on p. 8 to learn more about these scenarios).

For example, if your hazard analysis anticipates an industrial chemical spill, surveyors could visit the emergency department to check on preparation strategies, evaluate any decontamination rooms or tents, and talk to staff about how they’d respond to this type of incident, says George Mills, FASHE, CHFM, CEM, associate director of standards for the JCAHO.

Mills spoke during a Joint Commission Resources, Inc., audioconference in January.

Surveyors might not target your top threat. “The scenario . . . won’t necessarily be the most obvious one,” Samet says. “For example, a hospital in California might be asked what [its] plan is for a hurricane, or one in the Gulf Coast might be asked about [its] plans in the event of an earthquake.” > p. 8
A hospital’s preparation is key
Whatever the scenario, surveyors will tour the hospital and visit staff to assess their knowledge of their roles and responsibilities.

They’ll also look at the hospital’s availability of supplies and equipment, including communication devices and backup systems.

Communications failures are troublesome for hospitals. “During one of the disasters I’ve read about, an organization lost cell phone communication—the towers had been knocked down—and realized that [it] didn’t have the necessary backup satellite phones,” Samet says.

Surveyors also will probe whether staff have personal protective equipment on hand for biological or chemical responses.

Although hospitals with fewer than 200 beds won’t experience these designated EM sessions at this point, those sites may eventually deal with an amended version of it, Mills says.

Staff must know their disaster duties
With the looming changes to emergency drills under EC.4.20, Samet urges hospitals to develop a thorough training program for anyone who might participate in these exercises (e.g., clinicians, engineering workers, and support staff).

These drills—which the JCAHO will instead call “tests” starting in July—should include several training activities and exercises that validate the effectiveness of the disaster plan.

Critiquing tests is a key point of EC.4.20’s revisions.

“You may have a great plan and think people are trained properly, but when you have a drill, you might see room for improvement,” Samet says.

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JCAHO lists possible disaster tracer scenarios

As part of its emergency management session at hospitals with 200 or more beds, the JCAHO will choose one of 18 disaster scenarios on which to conduct a tracer.

Some of the scenarios depict escalating emergencies. For example, a incident may start with an influx of victims from the community arriving at the hospital and progress to a point at which the facility is severely affected by the consequences of the disaster.

During the tracers, hospitals must demonstrate that they have tested their staffs’ abilities to handle the conditions presented in the selected scenario.

Here is the list of scenarios developed by the JCAHO as of January:
- Transportation system collision
- Fire and collapse of a public building
- Tornado
- Heat wave and drought
- Severe winter storm
- Detonation of a truck bomb
- Suicide bomber
- Toxic industrial accident
- Tanker truck chemical spill
- Terrorist attack using a chemical agent
- Botulism
- Anthrax
- Tularemia
- Smallpox
- Tuberculosis
- Flu outbreak
- Nuclear power station accident
- Detonation of a radiological bomb

Source: Adapted from the JCAHO’s Surveyor Survey Activity Guides.
IM standards continue to challenge in hospital surveys
3.10, 6.10, and 6.50 on JCAHO’s list of most-cited standards for 2005

Learning objectives: After reading this article, you will be able to
- list the JCAHO’s most-cited information management (IM) standards for 2005
- explain strategies to comply with the most-cited standards

Organizations preparing this year for JCAHO surveys should take a close look at the health information management (HIM) department. The JCAHO in January released its list of most-cited standards during surveys it conducted January–July 2005, and three IM standards made the top 10 list.

The JCAHO’s list reflects data from surveyed hospitals, with the percentages of hospitals receiving noncompliance findings. The list includes

- **IM.3.10** (processes to manage information)—44%
- **IM.6.10** (every patient has complete medical record)—15%
- **IM.6.50** (verbal orders handled appropriately)—15%

IM.3.10, which includes the unapproved abbreviations requirement, topped the list for the second straight year. In 2004, 27% of hospitals were cited, according to the JCAHO.

The inclusion of the three IM standards on the JCAHO’s list makes it more important than ever for HIM staff to understand what the standards require and maintain compliance. For guidance, we turned to Jean S. Clark, RHIA, service line director for HIM at Roper Saint Francis Hospital in Charleston, SC, and author of HCPro, Inc.’s Information Management: The Compliance Guide to the JCAHO Standards, Fifth Edition.

**IM.3.10**
IM.3.10 provides requirements for collecting, processing, storing, retrieving, reporting, and disseminating data and information. The standard can be applied to a paper or electronic environment in any type of healthcare setting and has the following 11 elements of performance (EP):

- The hospital requires the identification and use of uniform data definitions and data capture methods.
- The hospital must standardize abbreviations, acronyms, and symbols and publish a list of those that are not to be used. This EP is a former National Patient Safety Goal that has been incorporated into the standards.
- The hospital has quality control systems in place to monitor data content and collections activities.
- The hospital has storage and retrieval systems to meet the users’ needs.
- The hospital retains data and information as required by law.
- The hospital retains data and information for quality of care and other hospital needs.
- The hospital has the expertise and tools for collecting, retrieving, and analyzing data and transforming data into information.
- Data is organized and transformed into formats that are useful to decision-makers.
- Data and information is disseminated in an accurate and timely manner.
- The hospital uses standard formats and methods for data and information dissemination to meet user needs and make it easy to retrieve and interpret.
- Data display and transmission must use industry or hospital standards whenever possible.

Compliance tips: Establish and carry out policies and procedures that address each EP. Educate staff about the policies and monitor performance to ensure continuous compliance with these requirements.

For example, the organization has a system in place for storing and retrieving data and information. This system is overseen by the information steering committee, which includes representatives from all clinical disciplines, HIM, information services, and performance improvement.

This forum makes decisions about standardizing, collecting, analyzing, displaying, and formatting information. These representatives ensure
that approaches to data management and transformation to information meet the organization’s needs.

The committee also makes sure that ad hoc reports for projects and performance analysis are available on a timely basis, content is considered accurate, online data are available and meet most needs, and, when backup data are needed, they can be retrieved quickly. All clinical staff who write in patient records should receive a copy of the organization’s list of prohibited abbreviations, acronyms, and symbols. The organization must then monitor medical records for compliance.

**IM.6.10**

IM.6.10 addresses the medical record, specific requirements for some of its content, who can make entries, and time frames for completion. There are 16 EPs that outline expectations for this standard. They include the following:

- The hospital ensures that only authorized individuals make entries in the medical record.
- Hospital policy stipulates when countersignatures are needed for entries made by nonindependent practitioners.
- The hospital uses standardized formats to document all care, treatment, and services that patients receive.
- Hospital policy requires that every medical record entry is dated, identifies the author, and authenticated when necessary.
- The hospital authenticates history and physical examinations, operative reports, consultations, or discharge summary by written or electronic signature, a computer key, or a rubber stamp.
- Medical record information identifies the patient, supports the diagnosis, justifies the treatment and services, documents the course and result of care, and promotes continuity of care.
- The content of the discharge summary includes reason for admission, essential findings, any procedures or treatments performed, condition at discharge, and discharge instructions.
- Hospital policy establishes time requirements for various elements of the record.
- Hospital policy establishes time requirements for completion of the entire record of no more than 30 days after the patient is discharged.
- The medical record delinquency rate is measured at regular intervals, but no more frequently than every quarter.
- The delinquency rate is averaged from the last four quarterly measurements and cannot be greater than 50% of the average monthly discharge rate. No quarterly measurement is greater than 50% of the average monthly discharge rate.
- The organization conducts ongoing records review at the point of care.
- The organization defines indicators for review that consider the presence, timeliness, readability, quality, consistency, clarity, accuracy, completeness, and authentication of data and information in the medical record.
- The organization establishes retention and use requirements that are consistent with state and federal laws and regulations.
- The organization establishes conditions under which an original medical record may be released for removal, which usually is under court order or subpoena.
- Patients seen at the emergency department (ED) have the following information included in their records: time and mode of arrival, disposition and condition upon conclusion of treatment in the ED, discharge instructions, whether the patient left without being seen or against medical advice, and a statement that a copy of the record is available to the practitioner responsible for follow-up care.

**Compliance tips:** Write clear policies that describe the requirements for inpatient and ambulatory medical record management. The policy should define time limits for completion, authentication, format, and sufficient information. Either the same policy or a separate policy should stipulate retention and release requirements. The ED documentation policies usually stipulate the special requirements for that department. Compliance with the policies is monitored through ongoing records review.

To comply with medical record delinquency, a hospital should closely monitor record completion. For...
example, an organization may scrutinize records at discharge and flag all incomplete elements. Then incomplete records are placed in the doctors’ mailboxes and initial e-mails are sent notifying them of the pending record. Three additional e-mails are sent. If the record is still incomplete at 30 days, the physician and the chief of service are notified that the record is delinquent.

Further, the organization presents summary information on physicians with delinquent records at every medical executive committee meeting. Physicians may be suspended for more than five delinquent records or inclusion on the delinquent list for three successive months, regardless of the number of delinquent records.

**IM.6.50**

IM.6.50 requires designated, qualified personnel to accept and transcribe verbal orders from authorized individuals. There are four EPs, but the only new requirement is the National Patient Safety Goal mandate that verbal orders be read back and verified. The four EPs require the following:

- The hospital has a policy that conforms to state and federal regulations and identifies the disciplines allowed to take and record verbal and telephone orders
- All verbal or telephone orders are dated and include the names of the individuals giving, recording, and carrying out the orders
- All verbal or telephone orders are authenticated within the time stipulated by applicable state and federal requirements
- The hospital must have a process to take verbal and telephone orders or receive critical test results that require a verification read-back by the person receiving the orders or test results

**Compliance tips:** The standard requires an interdisciplinary policy on the process for accepting, recording, verifying, and carrying out verbal and telephone orders.

An example of compliance is that hospital policy may only allow verbal orders in an emergency situation. In those cases, registered nurses are allowed to take and record all verbal and telephone orders. However, pharmacists, dieticians, and rehabilitation professions are allowed to take and record telephone orders within their scope of practice.

When staff take and record verbal and telephone orders, policy dictates that they note the date and time, the name of the ordering licensing independent practitioners, and their own name. Once recorded, receivers read back what they have written to the ordering practitioner.

Editor’s note: The above is adapted from Information Management: The Compliance Guide to the JCAHO Standards, Fifth Edition by Jean S. Clark, RHIA. Go to www.hcmarketplace.com/prod-3589.html for more information or to order.
Notice about CPHQ credits

Briefings on JCAHO would like to inform you that the process for obtaining prior approval for continuing education programs for CPHQ credits will now be handled through the National Association for Healthcare Quality (NAHQ).

NAHQ’s policy on continuing education approvals states that it only accepts conferences, workshops, and online courses. It does not accept home study activities such as Briefings on JCAHO for consideration for continuing education approval.

Unfortunately, we will no longer be able to provide subscribers with credits towards the maintenance of their CPHQ certification. We will, however, continue to provide nursing contact hours on a quarterly basis.

For more information about NAHQ continuing education approval policies, visit www.cphq.org/pdf/2005NAHQCEApprovalApplication.pdf.

Upcoming events

HCPro audioconferences:

The following live audioconferences covering accreditation and patient safety topics are scheduled to take place in April. Each show features an hourlong presentation from a group of experts, followed by a 30-minute question-and-answer session.

April

April 11—Crew Resource Management: The flight plan to improve patient safety (Q041106)

April 19—The JCAHO’s Medication Management Standards: How to Overcome the Top Problem Areas (A041906)

April 26—Establishing a Rapid Response Team (Q042606)

For more information, call 800/650-6787 and mention the source code for the show.