2007 predictions and issues to loose sleep over

BOJ asked a long-time surveyor, who asked to remain anonymous, to look into a crystal ball and predict what we might expect from the JCAHO in 2007. Of course, what would predictions be without cautions? So we also asked the surveyor, “What about these predictions keeps you up at night?” Read on to see how your predictions compare.

BOJ also asked several of its advisors (listed in the Editorial Advisory Board on p. 2) and other field professionals to summarize their impressions of the JCAHO’s Hospital Executive Briefings sessions and what changes they expect for 2007 (see “Field notebooks from the JCAHO’s Hospital Executive Briefing sessions, taken by your peers” on p. 3). The JCAHO surveyor revealed many items on “the worry list” for organizations to contend with during 2007:

Medical staff (MS) standards: “I am worried about the MS standards surrounding competence and focused review. I predict that many hospitals will receive requirements for improvement in that area,” the surveyor says. The JCAHO revised its MS standards for 2007 (see the November 2006 BOJ). The surveyor says organizations may have to hire more people to do the work that will be needed to comply, and even if they can’t, compliance with the MS standards will create added costs, similar to how the ORYX/core measures have for many facilities.

> Medication reconciliation: “I have not seen that a lot of facilities have this figured out,” the surveyor says. It’s also costly for some organizations to implement. Cost is a concern for each new National Patient Safety Goal that the JCAHO adds, the surveyor says. “I want to tell the JCAHO, ‘Please stop, let us breathe for a minute’ because the JCAHO keeps piling it on, and each pile adds more cost to the organizations that are already strapped with Medicare and Medicaid reductions and with an increasing volume of uninsured.”

> Surveyor variability: “I still see inconsistent interpretation of standards by surveyors,” the surveyor admits, adding that the JCAHO hasn’t done enough to address and reduce the problem.

> Physician shortages: It’s more common to hear about impending nursing shortages, but the surveyor says there is a physician shortage, and it is troublesome. Staff physicians are often worked to the point of exhaustion, resulting in many preventable errors.

> Patient flow: Overcrowding in the emergency department, despite the JCAHO’s focus on the problem with a leadership standard, remains a worry going into 2007. “Every time you have a fix, overcrowding recurs,” the surveyor says. If organizations can’t fix overcrowding, how will they handle a possible surge in patients for an influenza pandemic?
**Q&A with Kurt Patton**

**‘Don’t complain to JCAHO’—good advice?**

We recently completed our JCAHO hospital survey and weren’t pleased with the outcome. Issues relative to surveyor behavior arose. We question the appropriateness of several requirements for improvement. Our consultant advised that we not complain or seek to clarify the findings. His advice was that the JCAHO would be angered and make approval of our evidence of standards compliance more difficult. Did we receive good advice?

You received bad advice on this issue on two counts. First, if there was a behavior issue that made the organization or organization staff uncomfortable or dissatisfied, it is imperative that the hospital reach out to the JCAHO’s senior leadership to let them know. They rely on feedback from accredited organizations and they react to that information. Just like hospitals need feedback about employee behaviors that may be less than optimal to initiate corrective actions, so too does the JCAHO. The JCAHO has invested a lot of time, energy, and money into the process of enhancing surveyor performance. It has field directors specifically assigned to supervise and act as role model for surveyors. These senior managers will make an on-site evaluation if issues arise. Too often, organizations remain silent on their dissatisfaction, but remember that and factor it into future decisions to withdraw or reapply for accreditation.

The advice of not dealing with the clarifications also was incorrect. The survey report process only has expert content review by the standards interpretation group if the report resulted in an adverse decision (e.g., conditional accreditation or preliminary denial of accreditation). It is possible that a technical scoring error was made or a misinterpretation occurred. It is part of the routine postsurvey process for hospitals to clarify such issues so they don’t try to fix something that isn’t broken. There should be no fear of retribution. The account representative and the standards interpretation expert will not be offended if a clarification is the appropriate thing to do. During this year’s Executive Briefings, Darlene Christiansen, the executive director of accreditation and certification operations, reiterated the JCAHO’s willingness to review early submissions of clarifications so organizations can be confident that their clarification will be acceptable. JCAHO staff do not want organizations to waste time and effort changing practices unnecessarily.

**Editor’s note:** Kurt Patton, MS, RPh, is a former JCAHO executive director of accreditation services and principal of Patton Healthcare Consulting, LLC, in Glendale, AZ. To ask Kurt a question, e-mail BOJ editor Amy Anthony at aanthony@hcpro.com and look for the answer in an upcoming issue!
The following are highlights from notes taken by BOJ advisors and other field professionals who attended JCAHO’s Hospital Executive Briefings sessions in fall 2006.

Many who attended the sessions said there were few surprises. Some believe this is because the JCAHO has improved at letting the field know about changes earlier in the year, but some believe that the value of the one-day, pay-to-attend sessions is fading because of it. Regardless, it is still considered the venue for the JCAHO to announce standards and survey process changes for the next year.

If you attended a session, see how your notes compare to these field notebooks. If you were unable to attend, keep this issue handy as you plan training and other activities throughout the year.

**Notebook #1**

**Jodi Eisenberg, CPHQ, CPMSM, is a program manager of accreditation and clinical compliance at Northwestern Memorial Hospital in Chicago.**

**Focus on data and measurement**

2007 is sure to bring changes and challenges to the healthcare field. I believe the increased focus on information and outcomes measurement will pose challenges related to ensuring and increasing the accuracy of the performance data collected. The introduction of the strategic surveillance system (S3) is focused on increasing the consistency of data to the surveyors and the organization as well as on enhancing access to reliable information for the public. S3 will consist of two reports, a performance risk assessment and a performance measurement comparison. The JCAHO has assured the field that it will exclude voluntary reporting data (e.g., sentinel event reports). In addition, the JCAHO has plans to create a national healthcare organization database including data from non-JCAHO-accredited organizations.

**New and challenging standards**

Of all the new standards, I feel that the newly announced standards within the medical staff chapter pose the most challenges. Three new concepts have been introduced in the revised standards: six areas of general competency, focused professional practice evaluation (FPPE), and ongoing professional practice evaluation (OPPE).

The six competencies are patient care, medical/clinical knowledge, practice-based learning and improvement, professionalism, systems-based practice, and communication. They will need to be folded into OPPE as part of continuous evaluation to identify performance problems early and resolve them. The goal is to have an evidence-based privilege renewal process.

Effective in 2008 is the FPPE, which will need to be done for all initial privileges. The elements of performance (EP) require that written and approved criteria be developed for evaluating performance when issues

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affecting care are identified. Medical staff leadership will need to define triggers, which will indicate a need for performance monitoring. Performance monitoring will need to be implemented to measure and resolve performance issues on a consistent and continuous basis.

Unannounced survey process

It is important to note that after an unannounced survey, the survey window flexes to 18–39 months from the date of survey based on the priority focus process (PFP) data and S3 data (risk-adjusted scale). This means that organizations that have identified issues in their PFP and S3 data will likely receive visits earlier, or perhaps more frequently during the triennial period.

National Patient Safety Goals

The National Patient Safety Goals (NPSG) continue to serve as an important reminder of the need to focus our efforts on patient safety. The NPSG format has changed to more closely mirror that of the standards and EPs. The scoring has been relaxed slightly. I believe these will continue to pose the most challenges for healthcare organizations.

Notebook #2

Kathryn A. Chamberlain, CPHQ, is an independent consultant.

Compliance with standards and NPSGs dropped somewhat in the first half of 2006 with the introduction of the unannounced survey. It comes as no surprise, because the JCAHO adjusted the requirement for improvement cutoffs for conditional accreditation and preliminary denial of accreditation categories during 2006.

Standard chapters will be rewritten at the rate of two chapters per year, as opposed to four. I had hoped that they would slow down with this until everyone was through one cycle of unannounced survey. In 2007, the new chapters are human resources (HR) and medical staff (MS), with more changes to MS than HR. Next year, the JCAHO will revise the leadership chapter and perhaps another as well. The JCAHO is trying very hard to make a case for its need for patient-level data.

It was somewhat disappointing to have this subject consume a chunk of time during the Executive Briefings, leaving some of the details of standards changes to later in the day.

During the Q&A session, the JCAHO officials commented that they now will allow medications to be kept at the bedside as long as they are out of sight and, of course, not narcotics. This is a change from their previous stance.

Emergency management will be a strong focus of all surveys in 2007. Expect surveyors to select a threat from your hazard vulnerability analysis and then drill you on your plan.

Also, organizations should drill for multiple calamities and the compounding effects of having more than one issue occur (e.g., a flood leads to loss of power, which leads to civil unrest). There was a continuous theme of, “Call us with any questions; we are here to help; we want to keep you out of trouble.” This wasn’t quite a change, but it seemed stronger than I have ever heard it in the past.

Notebook #3

Elizabeth Di Giacomo-Geffers, RN, MPH, CNAA,BC, is a healthcare consultant in Trabuco Canyon, CA. She is also a former JCAHO surveyor.

Standard and NPSG highlights

- **NPSG #3** (medication safety)—Prelabeled empty syringes are not acceptable.
- **NPSG #7** (handhygiene)—The Centers for Medicare & Medicaid Services will accept alcohol-based hand gel dispensers mounted in egress corridors, but you must check with your local fire authority.
- **NPSG #8** (medication reconciliation)—Using “resume home meds” is not recommended. It is not a requirement or a standard, but it may be in the future.
- **NPSG #13** (patient-centered care)—Surveyor questions might be about your method of encouraging patients to report their concerns about safety.
Future NPSGs (2008–2009)—Possibly will include anticoagulant management, unapproved abbreviations (e.g., greater than [>] and less than [<] symbols), abbreviations and acronyms for drug names, and heparin outpatient management.

MM.4.20—Policy should address (ban) the use of fanypacks to store medications.

LD.3.110—Rationale revised to include leadership in the process of organ procurement.

PC.8.10—Pain management policy shouldn’t be too restrictive so that the organization is set up to fail.

PC.4.10—Plan of care needs to be individualized to each patient.

Notebook #4

Candace J. Hammer, RN, MA, vice president of care management for Northwest Hospital Center, a LifeBridge Health Center, in Randallstown, MD.

The main focus of Executive Briefings seemed to be on getting buy-in for the JCAHO wanting patient-specific data from hospitals. Not enough time was spent on the changes for 2007. Emphasis was placed on the 2007 NPSGs. The JCAHO is revisiting medication reconciliation in relationship to outpatient care and emergency departments. No changes have been made, but the JCAHO made it clear that it was rethinking the application of the goal.

Emergency management was discussed in some detail with references made to the lessons learned from Hurricane Katrina. There was emphasis on not only being prepared, but on practice. The changes were from the March 2006 update and give the impression that emergency management will be front and center for 2007. When you look at it from a bird’s-eye view, you see that emergency management was emphasized on four different fronts and three different chapters in the standards manual, so it seemed quite clear that the surveyors will focus on our level of readiness.

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Notebooks

Highlights of ongoing challenges with changes made in March 2006 include the following:

- EC.4.20 (drills) includes a more formalized drill evaluation process. An observer is now required for all drills. Opportunities for improvement must be documented. Medical staff must be involved in critique of the drill.
- New HR standards for assigning duties to volunteers who are not licensed independent practitioners (LIP) made to ensure a similar process to the one in the MS standards. Conditions for utilizing volunteers were added to the standards—emergency management plan must be activated, and you must be unable to provide care to all of your patients.
- Revisions to MS standards on volunteer LIPs during disaster include the criteria stated above (plan activated and unable to provide care) and tightened up oversight process (MS. 4.110).

Highlights of ongoing challenges with changes made in September 2006 include the following:

- A revision of the standards for credentialing and privileging of the medical staff. Many of the same components are there, in a different order, but a few new things were added (e.g., assessing for interpersonal skills, diversity sensitivity, and understanding the complexity of health systems).
- New standards were added that address the credentialing and privileges of LIPs. These new standards identify the hospital’s responsibility to know whether it can truly support the privileges requested before granting them. There must be a criteria- and evidence-based process for granting and renewing privileges, how a practitioner is notified of the decision regarding privileges, and the expedited credentialing process.

The following were the significant questions asked during the Q&A session, answered by the JCAHO officials:

Q: What is the purpose of providing a patient the list of reconciled medications at the time of discharge? Is this to take the place of discharge instructions that contain medication information? Or, is this so patients can provide the list themselves to their next provider of care?
A: Rick Croteau, JCAHO patient safety director, said that it was to help educate patients and give them a convenient reference to take with them as they go to different healthcare practitioners. This education part may be a little challenging if hospitals are using their computer software to print reconciliation logs, and that software uses routine approved medical abbreviations. Unfortunately, the answer as to how this new process interfaces with discharge counseling was confusing.

Q: Must the list of reconciled medications provided to the patient be written out in a format with complete English language frequency instructions? Or are standardized and approved medical abbreviations, such as BID or TID, acceptable?
A: Croteau did not specifically address the issue of abbreviation. He suggested Spanish if the patient speaks Spanish. So we don’t really know what this means relative to abbreviations that might be created by the hospital software.

Q: May a patient refuse authorization to send the reconciliation list to the next provider of service if that next provider is not part of the treating organization? Should consent to send the list routinely be sought?
A: Routine consent for this issue is not needed, but a patient may refuse.

Q: PC.13.20, EP 10 requires a presedation assessment, whereas EP 12 requires a reevaluation before induction. Today, these two events usually happen within minutes of each other in a hospital. Years ago, the first assess-

Notebook #5

Kurt Patton, MS, RPh, is former JCAHO executive director of accreditation services and principal of Patton Healthcare Consulting, LLC, in Glendale, AZ.
JCAHO collects field comment on proposed 2008 National Patient Safety Goals through January 26
Anticoagulants, fatigue, sleep apnea, and other topics up for review

The JCAHO invites you to comment on its list of proposed 2008 National Patient Safety Goals (NPSG) and requirements by January 26.

The field review opened on December 4, 2006, for all accreditation programs. For the hospital program, the proposed NPSGs and requirements are as follows (consult the JCAHO Web site [www.jcaho.org] for the exact wording):

► New Goal #16—Recognition and response to changing patient conditions with six IEs. This is essentially a requirement for a rapid response team.

► New Goal #17—Reduce the risk of postoperative complications for patients with sleep apnea with four IEs.

► New Goal #18—Prevent harm associated with worker fatigue with three IEs.

► New Goal #19—Prevent catheter misconnections with four IEs.

The field review comment form is electronic and it may be found by clicking on the “Standards” tab on the JCAHO homepage and choosing “Field Reviews and Draft Standards” from the drop-down menu.

The JCAHO says the Sentinel Events Advisory Group, JCAHO collects field comment on proposed 2008 National Patient Safety Goals through January 26 Anticoagulants, fatigue, sleep apnea, and other topics up for review

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► A new implementation expectation (IE) for Goal #1 (patient identification)—Hospitals must plan to implement an electronic system to help identify patients. Planning includes choosing a type of technology (e.g., RFID, bar coding, etc.), a timeline for implementation, allocating resources, and doing a risk assessment.

► A new requirement under Goal #3 (medication safety)—Reduce harm associated with anticoagulants with five IEs.

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The JCAHO says the Sentinel Events Advisory Group,
Having a defined medication storage policy is key to compliance with MM.2.20

2006 and will continue to challenge hospitals in 2007. The best way to comply with this standard is to create a good policy and follow it.

“I think the primary issue is really [hospitals] not following their own policy,” Eisenberg says. “But I think a lot of hospitals don’t even have the policy.”

So what does a good policy consist of? There are many facets to storing medications safely and properly.

“When you write a policy addressing the storage of meds, capturing the whole process, your policy needs to talk about not only safe storage but safe handling, security, and distribution,” says Eisenberg.

One of the places in which Di Giacomo-Geffers sees hospitals failing to comply with this standard is EP 2, which calls for drugs to be stored under conditions that will maintain their stability. This often translates to making sure that temperature controls have been set for medications that must be refrigerated or kept in the freezer. The only way to verify that temperatures are accurate is to either send an authorized staffer to make sure that refrigerator and freezer temperatures are within range or invest in an electric monitoring system that does this on its own.

“This is one that frustrates me, because we have better technology in today’s world that can help us get the work done,” says Di Giacomo-Geffers. “Organizations might want to cost benefit electronic monitoring and look at the return on their investment.” She advocates the use of an electronic thermometer hooked up to an alarm system so that there is less chance of human error.

Another area that hospitals often find troubling is...
EP 5, which states those people who are not authorized to have contact with medications based on the hospital’s standards shall not have contact with such. Di Giacomo-Geffers says facilities often run into problems with medications being stored in areas to which unauthorized people have access.

She recommends that medications be secured or kept under constant surveillance (i.e., in direct line of sight) in a locked room to which only authorized people have access, or on a locked cart in a medication room. Either way, a list with who is authorized to have access to medications should be readily available, and staff should be periodically updated on authorized access.

The emergency room is like a minefield for managing medications. It’s important to be extra cautious here. “It’s a fast-paced, busy place, and you can usually find medications that are not secure,” says Eisenberg.

The following are tips that can be used for complying with MM.2.20:

1. Have a clearly defined policy for medication storage in all instances.
2. If your practice did not follow policy relative to documenting or monitoring the temperature of medication refrigerators and freezers, don’t fill out the log/form as if you did it correctly. That puts you at risk for falsification. Write “not documented” and initial or follow your hospital policy for late entry.
3. Be clear on the dating of multidose vials and be sure that staff completely understand the procedure for this. “If your policy is to date when [vials are] opened, consider putting a fancy-colored mini poster on every refrigerator in a little vial with a big arrow that says ‘date when opened,’ ” says Di Giacomo-Geffers.
4. Make sure the pharmacy conducts random surveys at intervals specified by hospital policy to be sure that medication storage is up to standards. “You want to look for any patterns or trends, and you want to take opportunities for improvement based on the findings of the aggregate data of the periodic inspection,” says Di Giacomo-Geffers. “You can’t just say, ‘Well, pharmacy does it.’ Everybody plays a part to ensure this standard is compliant.”
5. Always segregate any expired, damaged, or contaminated discharged patients’ medications that are going to be picked up by the pharmacy.
6. Make sure hospital policy defines who is authorized by law and regulation to have access to medications.
7. Make staff aware of what can affect the stability of a medication. “If pharmacy came up with a pocket card that said what can affect product stability—light, temperature, etc.—it could be helpful,” says Di Giacomo-Geffers.

Spreading the word

For any part of this standard, both Eisenberg and Di Giacomo-Geffers say it is imperative for hospitals to have a clearly defined policy and spend time and resources educating staff about that policy.

“The key is continually doing surveillance, and teaching your staff and talking to your staff about why it’s important to have medications secured,” says Eisenberg. “Why from a patient safety perspective it’s important to have them secured and labeled so that they’re not mistakenly used on the wrong patient.”

2008 NPSGs

which decides the list of NPSGs each year, is expected to recommend retention of most of the 2007 NPSGs and requirements when it announces the 2008 list in the spring. Curiously, the accreditor had not yet at presstime released its frequently asked questions document for the 2007 NPSGs. The document is eagerly anticipated by the field because it clarifies common questions about the goals that need to be implemented now.

Also, missing from the field review list are topics that were on the 2006 list, such as disruptive clinician behavior (see the December 2006 BOJ). It is unclear whether the topic could make the final list of 2008 NPSGs.
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Four changes to CMS regs take effect this month
New rule addresses H&Ps, verbal orders, drug security, and postanesthesia assessment

The Centers for Medicare & Medicaid Services (CMS) on November 27, 2006, published four changes in the Federal Register that every hospital should be aware of. The four requirements, effective January 26, are as follows:

► History and physical (H&P)—CMS changed its requirement to align with the JCAHO’s requirement that H&Ps be done within 24 hours of admission and completed no more than 30 days after. Also, CMS now allows physicians to delegate a physician assistant or advanced nurse practitioner to perform H&Ps, although physicians are still responsible for their contents and must authenticate them with signature and date.

► Authentication of verbal orders—This change requires that all orders, including verbal orders, be timed, dated, and authenticated by the prescribing practitioner or another practitioner responsible for the care of a patient, even if the order did not originate with that practitioner. This change will be allowed for a period of five years. According to CMS, this temporary change “will reduce burden and provide flexibility for hospitals until health information technology is sufficient to allow the prescribing practitioner to authenticate his or her own orders promptly and efficiently.” If there is no law in your state specifying a time frame for authentication of verbal orders, they must be authenticated within 48 hours. The JCAHO also has highlighted verbal orders in its National Patient Safety Goals (#2a) and its standards (IM.6.10).

► Security of medications—CMS requires that all drugs and biologicals be kept in secure areas and locked up when appropriate. The revision provides flexibility for hospitals in determining control over nonscheduled drugs. Some hospitals would like to allow nitroglycerin at the bedside or allow patients to keep inhalers at the bedside, both of which previously had to be locked.

► Postanesthesia evaluation—This change permits postanesthesia evaluation for inpatients to be completed and documented by any individual qualified to administer anesthesia versus only the individual who administered anesthesia. Remember, assessments must be completed and documented within 48 hours after surgery.

Editor’s note: Sue Dill, RN, MSN, JD, director of hospital risk management for OHIC Insurance Company in Columbus, OH, is the CMS corner lead contributor. Submit a topic idea to her by contacting BOJ editor Amy Anthony at aanthony@hcpro.com.