

Physician Guide to Patient Safety & Accreditation Review



2010

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Introduction

FMC, MPH and the provider-based practices of FMC will undergo an unannounced accreditation survey between now and October 2010. Our goal is to achieve a state of “constant readiness” for any outside agency review. The focus is on patient safety.

Physicians will be included in the survey process. The surveyors are interested in your perspective and understanding of how the hospital and its facilities work.

This “primer” is intended to assist and refresh your memory on some processes and accomplishments and is not intended to be all encompassing. Feel free to contact Dr. Allen, Dr. Healy, Regina Hardy or Jill Puckett should you have a specific question(s) or issues.

The medical staff has accomplished many great things in the past years and the surveyors should easily recognize that the staff and facility is proud of their accomplishments.

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Questions and Answers

Q. What are some key efforts that have targeted improving patient safety or have addressed the National Patient Safety Goals?

- using two patient identifiers for all procedures or medication administration (patient name and date of birth)
- critical test result “read back” and tracking of timeliness,
- unapproved abbreviations,
- verbal order “read back” and “confirmed”,
- handoff communication improvements,
- standardize drug concentrations,
- look-alike-sound-alike med mix-up prevention strategies,
- medication labeling requirements on and off the sterile field

- hand hygiene and reporting a death related to a healthcare-acquired infection
- fall reduction program (Hendrich II program)
- patient grievance process including Joint Commission as a resource to call if we do not resolve the issue.
- suicide risk assessment (New 2009) for Behavioral Health and substance abuse patients
- procedural and surgical – Universal Protocol which includes a pre-verification process, “time-out” and site marking in the holding area with the patient involved if possible and a double check by the physician during the “Time-out” or “purposeful pause”

Q. What are the Mission, Vision, and Values for Novant?

Mission: To improve the health of our community one person at a time

Vision: We, the employees of Novant and our physician partners, will deliver the most remarkable patient experience, in every dimension, every time.

Values: Compassion: We treat our customers and their families, staff and other healthcare providers as family members by showing them kindness, patience, empathy and respect.

- **Diversity:** We recognize that every person is different, each shaped by unique life experiences. This enables us to better understand one another and our customers.
- **Personal Excellence:** We strive to grow personally and professionally, and we approach each service opportunity with a positive, flexible attitude. Honesty and personal integrity guide all that we do.
- **Teamwork:** The needs and expectations of any one customer are greater than that which one person's service efforts can satisfy. We support each other so that together as a team, we can be successful in the eye of the customer as a quality service provider.

Q. How do Physicians lead?

- A.** -- They are responsible for the quality of care delivered to patients.
 -- They participate in policy development, strategic planning, and budget process.
 -- They help resolve issues as they relate to the medical staff.
 -- They attend meetings and educational sessions.

Q. How do new members of the staff receive orientation to Forsyth Medical Center?

- A.** All new members to the medical staff receive a formal presentation from the Leaders of Forsyth Medical Center. This orientation educates the practitioner about the bylaws, rules and regulations. A copy of these documents is included with their initial application. This orientation also includes information about the “environment of care”.

Q. How does the Medical Staff play a role in strategic planning for the hospital?

A. Physicians participate in the Physician Leadership Summit as well as having joint meetings with the Board of Trustees. Physicians provide input on strategic initiatives as well as budget requests. The President of the Medical Staff is a voting member of the Board of Trustees.

Q. What do you see happening at Forsyth Medical Center in the next few years?

A. Continued expansion with the North Pavilion, ED and ICU growth, and continued growth of technology in the ORs. Roll-out of the new Patient Safety Program – First Do NO Harm.

Medical Staff Structure

The key point to remember is that many of the processes involving the medical staff and its officers are clearly defined in the bylaws. This includes selection and removal of the officers, corrective actions and suspensions, and a grievance system.

Q. What are the mechanisms designed for corrective action, including procedures for automatic and summary suspension of an individual's medical staff membership or clinical privileges?

A. 1) Included in the bylaws 2) Corrective action can be taken as necessary by an officer of the staff, division director, and administrator of the board. 3) If there is a need for corrective action, an adhoc committee is appointed by the Executive Committee to investigate. 4) Summary suspension is whenever action needs to be taken immediately. 5) Automatic suspension is immediate if medical license is revoked and member is on probation.

Q. What is the method and basis for selecting and removing officers and MEC members?

A. Selection-elected by staff. Removal is stated in the bylaws. The bylaws provide that officers may be recalled upon the petition of majority of staff. Petition submitted to Executive Committee. Vacancies are filled by the Executive Committee, except for the position of president, that position would be filled by the president elect.

Q. Is there a grievance system in place for medical staff if they feel suspension is not warranted?

A. Yes, it is documented in the bylaws

Q. Describe the medical staff's involvement in development of hospital wide programs, policies, and procedures.

A. Medical staff has membership and input on the Joint Practice Teams and other committees. Policies and Procedures that require medical staff approval are taken to the Medical Executive Committee.

Q. How is the medical staff involved in leadership concerning measurement, assessment, and improvement?

A. Through various committees such as Joint Practice and P&T. Metrics are shared at division meetings as well. Division and Section Chiefs are provided with this information about the providers and do peer review when significant departures from established patterns or clinical practice is noted.

Patient Care / Patient Safety

Q. Do you have a process for handling disruptive behavior?

A. To ensure quality care and to promote a culture of safety, Novant Health strives to provide a work environment that is free of behaviors that threaten the performance of the healthcare team. Without fear of reprisal, any incidents of disruptive behavior should be reported to the VPMA, one-up leader, department head, facility administration, Employee Relations / Human Resources Department or the Novant Alert Line.

Q. What is the policy around compliance with the Universal Protocol for site marking, procedural time out and pre-procedure verification process?

A. *According to the Board of Trustees approved policy* - The ultimate responsibility for the avoidance of wrong site surgery shall always rest with the attending physician involved. In order to help prevent the occurrence of wrong-site surgery, a formal Patient Verification/Surgical Site Marking/ Deliberate Pause protocol has been established; compliance with this protocol is mandatory. Alleged violations of the protocol ("The Pre Procedure Pause") will be immediately investigated, and, if substantiated, sanctions will be imposed on the physician involved

Q. How does the medical staff participate in measuring, assessing, and improving the coordination of care with other practitioners and hospital personnel?

A. Participate in multidisciplinary teams and committees (e.g. Tumor Boards). Make rounds with the nursing staff. Chart reviews. Approve contracts for outside service.

Q. How do you ensure uniform performance of patient care throughout the facility?

A. Clinical Practice Committee reviews practice (Policies and Procedures). All patients can expect an assessment prior to surgery, appropriate labs, patient education, and a post procedural evaluation. **Policies are routed through Clinical Practice Council and MEC. Policies are designed to provide consistent care throughout the hospital.**

Q. Do you have a working knowledge of the policy on nonviolent (medical/surgical) restraint use?

A. Yes 1) Medical staff was involved and approved the policy to work towards a restraint-free environment. 2) We only restraint patients when alternatives are not effective and always use the least restrictive means. 3) Orders are time-limited for 24 hours initially and then to each calendar day thereafter. Physicians must sign the original order within 24 hours and examine the patient each calendar day to determine the need for continued restraints. If indicated, a new order is required each calendar day.

Q. Do you ever write an order for restraints prn?

A. NO! NEVER

Q. What is your role in patient/family teaching?

A. Physicians educate patients and/or family members/designee and assure informed consent is delivered. We are involved in development of teaching tools, P&T Committee with food and drug interaction team, and discharge instructions.

Q. What is your process for transfer to another acute care facility?

A. The physician discusses this with the patient and/or family member/designee. A transfer form is filled out. We confirm the patient is in stable condition. A copy of the pertinent parts of the medical record (including medications) is sent with the patient for continuity of care. Patients receive a copy of their medication list.

Q. How do you identify when an autopsy should be performed?

A. By Criteria as defined in the bylaws:

1) At the families request. 2) Unexpected or unexplained deaths during surgery or within 24 hours of surgery. 3) Deaths occurring in patients who have participated in clinical trials (protocols) approved by institutional reviewed boards. 4) Sudden, unexpected deaths which are apparently natural and not subject to a forensic medical jurisdiction. 5) Natural deaths that are subject to forensic jurisdiction such as the following: persons dead on arrival at the hospital, deaths occurring in the hospital within 24 hours of admission, deaths in which the patient sustained or apparently sustained an injury while hospitalized. 6) Deaths resulting from high-risk infectious and contagious diseases. 7) All obstetric deaths. 8) All neonatal and pediatric deaths. 9) Deaths of any age in which it is felt that autopsy would disclose a known or suspected illness, which may also have a bearing on survivors or recipients of transplant organs. 10) Deaths known or suspected to have resulted from environment or occupational hazards.

Q. What do you do when an outside reviewer decides that the managed care company or the insurance company will no longer pay for continued hospital stay?

A. Nothing if the physician and the nurse believe that the patient should stay for appropriate care whether the system will get reimbursed or not.

Q. Explain your process for giving phone or verbal orders.

A. When a phone or verbal order is given to the nurse she **writes** it down in the chart then **reads it back** to the **physician to confirm**. The same applies to Critical Test Results. Verbal orders are discouraged.

Q. Does the organization use clinical pathways?

A. FMC has clinical pathways for Orthopedics, Cardiovascular Surgery, and Cardiology. Clinical pathways are used for these patient populations. We also have a large number of order sets which help physicians be more efficient and reduces variation in care.

Q. How long does it take to get a STAT CBC?

A. Less than one hour.

Credentialing

Q. If you have a new physician who wants to be on staff, what is the process?

A. The physician completes a preapplication to determine if he/she is eligible to apply for medical staff membership. If so, the physician is provided an application which is completed in its entirety and returned to Medical Staff Services. Processing of the application is performed by the Novant CVO (Central Verifications Office). After primary source verification is complete, the file is released to the Medical Staff Services department where it is reviewed by the chief of the section. The chief makes a recommendation and the file is forwarded to the Credentials Committee for review and recommendation. It then must be approved by the MEC and the Board of Trustees.

Q. Can a physician list any privilege he or she wants?

A. No. Each specialty and subspecialty have core privileges defined and there are criteria for these privileges within each specialty. If additional privileges are requested beyond the core, specific criteria developed by the medical staff must be met. All privileges are site specific. If a procedure is not offered at a particular site, the privilege will not be listed on the Delineation of Privilege form.

Q. What verifications do you have for this process?

A. Primary source verification is conducted through state medical boards, medical education, internship, and residency/fellowship programs. A list of privileges being requested is sent to training programs for competency of privileges. Other verifications are obtained from the AMA profile, Databank, OIG (Office of the Inspector General) for any fraudulent activity, peer and affiliate hospital recommendations and criminal background check.

Q. Are members of the medical staff and others with clinical privileges subject to the requirements of the medical staff bylaws and to peer review?

A. Yes, the behavior of all medical staff is governed by the by-laws. Ongoing peer review is performed for all members of the medical staff.

Q. Do you ever grant temporary privileges?

A. We do but on a limited basis. We will grant temporary privileges to fill an urgent need for coverage of a service. In addition we do grant temporary privileges to new members of the medical staff if there will be a gap between the approval of the MEC and the next meeting of the Board of Trustees, but only if it is a clean application which has no issues of concerns

Q. How do you know physicians are still competent who have been on staff for 20 plus years?

A. Ongoing credentialing process with peer input and through peer review. Charts are reviewed by division directors that fall out of the pre-set criteria. Reappointment is done every two years and division directors review at that time along with other supporting documents to include Databank and current license. Division director recommends members for reappointment. In addition, we conduct ongoing professional performance evaluation (OPPE) every 6 months which is reviewed by the Division Chief.

Q. Tell me about the peer review process—how does it work? What kind of data are you getting regarding quality medical practice?

A. Peer review is an ongoing process and is described in our peer review policy. It may involve generic screens that are defined by each section or division. It also involves issues of concern that are identified through, Journey reports through risk management, and other reports to the medical staff office or the peer review office. The chief of each section is involved in peer review. Some sections or divisions have a QA Committee which meets regularly.

Q. How do you perform primary source verification? What are Primary Source Verification companies you use?

A. Letters with evaluation forms are submitted directly to training facilities and peer references. A National Practitioner Data Bank report is obtained. Medical licenses are verified directly from the State Medical Board. In addition, we conduct a criminal background check and obtain a malpractice loss run report. Primary source verification of DEA is obtained directly from the NTIS.

Environment of Care

Q. Describe the medical staff's involvement in planning and designing the environment of care, including life safety, consistent with the hospital's mission and vision.

A. Medical staff are involved with restructuring of the OR's, ED, and ICU's, control to assure that life safety practices are current. We provide the staff and physicians feedback on the Hand Hygiene results.

Q: What is your role in a disaster?

A: Medical staff will be assigned to posts by incident command center

Patient's Rights

Q: What is your role in disclosing adverse medical outcomes to patients/families?

A: It is the physician's responsibility to disclose or guide in the disclosure of adverse medical outcomes.

Q. What is the medical staff's role in developing and implementing a mechanism for addressing patient rights?

A. The Medical Executive Committee reviewed and approved the policy. Any changes are approved by the Medical Executive Committee. There is an Ethics Committee consisting of physicians, nursing staff, and community representation.

Q. How is the medical staff involved in developing policies regarding procurement and donation of organs and other issues?

A. All policies and procedures are approved by the Medical Executive Committee and the Board. The organization is Carolina Donor Services. We recently received a National Award for improving our rate of conversion.

Medical Records and Information Management

Q. What is required for each medical record entry?

A. Signature, Timing and Dating.

Q. Are verbal orders discouraged? When must authenticated for verbal telephone orders be completed?

A. Yes, verbal orders are discouraged due the nature of this type of communication leading to errors and mistakes and as required by the CMS.

Signature, timing and dating is required. Authentication within 24 hours for chemotherapy, restraint, investigational drugs and DNR orders and 48 hours for all other verbal telephone orders is required by the Med Staff Rules and Regulations and CMS Conditions of Participation.

Q. How does the medical staff participate in measuring, assessing and improving accurate, timely and legible completion of medical records?

A. The medical staff receives reports of data collected from chart reviews which are conducted at the point of care and action is taken as necessary. Physician serves as a liaison between medical staff and medical records department to be involved in form management and procedures specific to documents in medical records. The VP of Medical Affairs is personally involved in the timeliness issue, receiving reports weekly and taking action (suspension) when warranted

Q. What types of aggregate data are available to medical staff leaders to support patient care and operations decisions?

A. Aggregate reports on any procedures, number of patients by any particular physician, number of cases that are coded infectious, run charts on an on going basis for case load by inpatient and outpatient. We have results of CMS Quality Measures reported to the staff on a regular basis.

Q. Are there adequate resources and services available to meet the knowledge based on information needs of the medical staff?

A. Yes, reports from medical records include delinquencies, results of physician chart review, and information on the number of inpatient and outpatient case load.

Q. What are the Hospital Quality Measures?

A. *Acute Myocardial Infarction: Congestive Heart Failure, Community Acquired Pneumonia, SCIP(Surgical Care Improvement Project), and Related pregnancy and conditions: Neonatal Mortality, VBAC, third or fourth degree lacerations.* The Stroke Center also has a series of Quality Measures which include dysphagia screens, lipid screening among other measures.

Q. Do you have internet access?

A. Yes, internet access is available without a password on any NH personal computer.

Process Improvement

Q. What is the hospital's approach to Process Improvement?

A. The model for improvement focuses around three questions: 1) What are we trying to accomplish? (**AIM**) 2) How will we know if a change is an improvement? (**measures**) 3) What changes can we make that will result in an improvement? (**actions**).We use the PLAN, DO, STUDY, ACT (**PDSA**) Model.

Q. What are some of the processes that have been improved upon over the last year?

A. All process improvement activities are documented in the Clinical Improvement Department. Each Joint Practice Team, Committee, Department, Section, and Division has information on file in CI (e.g. patient safety, core measures, and infection control).

Q. How was the medical staff educated in approaches and methods of performance improvement?

A. Classes on process improvement, just in time training, committee orientation for new members.

Q. Tell me about other education for the medical staff.

A. Tumor Board, Tuesday conference, presentations by division directors, CME Saturday conferences. Pharmacy programs on

medication and adverse events, risk management, General Surgery M&M, Vascular Surgery M&M, division and section meetings, and quarterly staff meetings.

Q. Describe your hospital's processes for collecting data needed for Process Improvement.

A. Ongoing collection and observation, concurrent and open chart review, medical staff indicators, (e.g. unplanned returns to OR, readmissions within 31 days, bleeding, and data), medication errors/usage, blood usage, and patient satisfaction.

Q. How do you determine priorities for Performance Improvement?

A. Process Improvement has set criteria: high risk, low volume, problem prone, patient safety related and new procedures. CMS Quality Measures are also a top priority for this hospital

Q. Do you carry out performance activities in a collaborative and interdisciplinary way among departments and disciplines?

A. Yes, members of Clinical Improvement, medical staff, clinical and surgical nursing, laboratory, pharmacy, dietary, medical records, and administration work collaboratively with nursing and other health care providers.

Important Definitions

Here are some important terms or issues to know for the survey. You are probably aware of these, yet this list may prove helpful as a refresher.

Medication Reconciliation: a process for obtaining and documenting the most accurate list of a patient's medications when the patient enters or is "admitted" to your system. This documentation should include medication name; doses, time and date of last dose taken. This should involve the patient if possible and a comparison of what is given to what the patient was taking. At discharge, the list must be transmitted ASAP to the next provider of care and a copy given to the patient and/or family member/designee.

Sentinel Event: an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. These events are sentinel because they signal the need for immediate investigation and response.

FMEA: Stands for Failure Mode Effect Aalysis. This is a tool used to analyze processes to learn where the process has the most chance to fail or cause problems.

National Patient Safety Goals: Refer to your laminated card as this lists the patient safety goals.

Your Role In A Disaster

If a disaster occurs, an Incident Command Center will be set up. Physicians will be informed of the event via communication from Medical Staff Services. The Medical Director at Incident Command will determine the specific physicians need and these physicians will be notified and will be requested to report to the Medical Center.

Contacting Joint Commission

If you have questions or concerns, you may contact the Joint Commission at their toll free telephone number, (800) 994-6610, 8:30 to 5 p.m., Central Time, weekdays.

Conclusion

Thank you for taking the time to review this booklet. You are probably already familiar with all the concepts, but we hope this is a helpful refresher.

Remember your efforts have been outstanding in providing quality care to our community. Be proud of your efforts and results!

If you have any comments about this booklet or other issues with the survey, don't hesitate to call Dr. Allen, or Dr. Healy

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