



HFAP NEWS



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HFAP News is a Newsletter developed to facilitate communication between the Division of Healthcare Facilities Accreditation, HFAP accredited health-care facilities, HFAP surveyors, and other interested parties.

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HFAP Welcomes Newly Accredited Healthcare Facilities

Fourteen (14) new healthcare facilities were accredited by HFAP at the May 2006 Bureau of Healthcare Facilities Accreditation meeting. Please welcome these newcomers!

- City of Angels Medical Center, Los Angeles, CA
- Columbus Regional Hospital, Columbus, IN
- Delano Regional Medical Center, Delano, CA
- Hazleton General Hospital, Hazleton, PA
- Methodist Hospital of Chicago, Chicago, IL
- New Horizons Medical Center, Owenton, KY
- Parkland Health Center, Farmington, MO
- Pulaski Memorial Hospital, Winamac, IN
- Renaissance Hospital, Groves, TX
- Salem Township Hospital, Salem, IL
- Swedish Covenant Hospital, Chicago, IL
- The Methodist Hospital, Gary, IN
- The Methodist Hospital, Merriville, IN
- Woodland Healthcare LLC, Michigan City, IN

“COMMUNITY ACQUIRED AND HEALTHCARE ACQUIRED INFECTIONS”

Revised Terminology with HFAP Standards

#03.02.02

#07.01.08

#10.01.14

Terminology Change

To be consistent with terminology currently used by the Centers for Disease Control and Prevention (CDC), HFAP has adopted the terms “community acquired” and “healthcare acquired” infection. These changes to the February 2005 HFAP manual are effective May 2006.

HFAP Standard #03.02.02 “Required QAPI Functions”

Revise Column 1 to read, “B. Infection control—including community **acquired** and **healthcare acquired** infections in patients and health care workers.”

HFAP Standard #07.01.08 “Classification of Infections”

Revise Column 1 to read, “There is a means of classifying infections into community **acquired** and **healthcare acquired** (nosocomial).”

HFAP Standard #10.01.14 “Required Documentation”

Revise Column 3 to read, “Through interview and review of medical records, determine that each record contains reports of complications, **healthcare** acquired infections, and unfavorable reactions to drugs and anesthesia.”

(Note: Column 1 makes reference to “hospital acquired infections.” This will not be changed. The expectation will remain as written in the Medicare Condition of Participation 482.24 (c)(2)(iv).

“Physician Staffing in Special Care Units (Intensivists)”

HFAP Standard #29.00.17

At the May 2006 Bureau of Healthcare Facilities Accreditation (BHFA) meeting, the membership continued to review the issues associated with Intensivists in the Special Care Units.

Action:

The Bureau decided to continue the moratorium for HFAP standard #29.00.17. A special task force of practitioners has been appointed to further examine the issues and impact of the standard.





Patient Safety Initiative

“Safe Labeling Practices in Perioperative Settings” New HFAP Standards

Inpatient Surgery

In recent years, there have been numerous reports of death or serious physical injury secondary to the administration of undesired medications or solutions stored in unlabeled medication cups, basins, and syringes on the sterile field during invasive procedures. In 2004, two national leaders, the American Operating Room Nurses (AORN) and the Institute for Safe Medication Practices (ISMP) published recommendations for the safe labeling of medications and solutions used in perioperative settings.

This new patient safety initiative was approved at the May 2006 Bureau of Healthcare Facilities Accreditation (BHFA) meeting. The initiative impacts five (5) sections of the 2005 HFAP Acute Care Hospital Manual including inpatient surgery, outpatient surgery, cardiovascular procedures, endoscopic procedures, and Pharmacy. After careful consideration, it was determined that the new standards will be scored only in the Pharmacy chapter. The rationale for this decision is the fact that Pharmacy maintains ultimate responsibility and oversight of medications in the hospital.

This HFAP Patient Safety Initiative applies to hospitals, ambulatory surgical centers, and other facilities in which surgery is performed. The new standards becomes effective January 1, 2007.

The five new HFAP standards are:

- HFAP #30.00.19, “Label Medications and Solutions on the Sterile Field” (Inpatient Surgery)
- HFAP #30.04.24, “Label Medications and Solutions on the Sterile Field” (Outpatient Surgery)
- HFAP #18.00.24, “Label Medications and Solutions on the Sterile Field” (Cardiovascular Procedures)
- HFAP #21.00.25, “Label Medications and Solutions on the Sterile Field” (Endoscopic Procedures)
- HFAP #25.01.26, “Label Medications and Solutions on the Sterile Field” (Pharmacy)

(For the new standard, see pages 4 through 6.)

DID YOU KNOW?

Pharmacy maintains ultimate responsibility and oversight for medications?
This responsibility includes oversight of medication practices in the OR, Ambulatory Centers, Ambulatory Surgical Centers, and all off-site facilities with the same hospital Medicare provider number.



***NEW! HFAP Patient Safety Initiative
Effective January 1, 2007***

**“Label Medications and Solutions on the Sterile Field”
New HFAP Standards**

Inpatient Surgery	#30.00.19
Outpatient Surgery	#30.04.24
Cardiovascular	#18.00.24
Endoscopy	#21.00.25
Pharmacy	#25.01.26

Column 1:

The facility must develop and implement policies for safe labeling of medications and solutions used on and off the sterile field in the perioperative settings.

The facility must have policies and processes in place including, but not limited to:

1. The required labeling of medications and solutions, regardless of container, used on and off the sterile field throughout the perioperative experience.
2. The methods used to differentiate and label look-alike products and solutions with similar names.
3. The process used to verify and confirm each medication / solution and the respective matching label.

Column 2:

In recent years, there have been numerous reports of death or serious injury secondary to unlabeled medications and solutions on the sterile field.

All surgery settings and procedure rooms are expected to handle chemicals, reagents, specimen preservation agents, and diluents with the same caution as medications.

A process must be in place to label all solutions used in the surgical area including, but not limited to intravenous fluids, medications, body fluids, hydrogen peroxide, formalin, Lugol's solution, radiopaque dyes, sterile saline, sterile water, isopropyl alcohol, skin preparation solutions, chlorhexidine, glutaraldehyde, and the like.

(Continued, see page 5)



NEW STANDARD EFFECTIVE
JANUARY-1, 2007

“Label Medications and Solutions on the Sterile Field”

Column 2 (Continued from page 4)

Many of the above “look alike” as they are clear / colorless solutions.

Labels must be applied to solutions stored in all types of container used on and off the surgical field in the perioperative area including, but not limited to medicine cups, solution basins, syringes, and specimen cups.

A label is required even if only one solution is involved with the procedure.

It would be unacceptable to write onto plastic containers such as IV bags with marking pens, as there is evidence that the ink may penetrate into the solution.

Sterile medications / solutions that are placed onto the sterile field in the original packaging with the manufacturer’s original label on the container that indicates the name and strength of the medication do not require additional labeling.

Use sterile markers and labels that can be opened onto the sterile field. Commercially prepared products are available for this purpose, but labels prepared by the facility are acceptable if sterilization is maintained. Labels are to clearly state the medication / solution and strength. When feasible, include these labels and markers in pre-made surgical packs.

Many medications and solutions have similar names. A process must be identified and implemented when preparing labels to differentiate these.

A process must be in place to verify each medication or solution and complete its preparation, labeling, and delivery to the sterile field before preparing the next solution. Label only one medication / solution at a time. Use two staff to verbally and visually confirm each medication / solution and respective label; one of these staff must be a licensed professional involved with the procedure.

(Continued, see page 6)



NEW STANDARD EFFECTIVE
JANUARY-1, 2007

“Label Medications and Solutions on the Sterile Field”

Column 2 (Continued from page 5)

A process must be in place to discard any unlabeled solution or medication found in the perioperative area. Unlabeled solutions should be considered a hazardous condition and reported using the facility incident reporting protocol.

At shift change or relief for breaks, require the entering and exiting staff to concurrently read container labels and verify all medications on the sterile field.

Keep original medication / solution containers in the surgical room until completion of the procedure for follow-up reference, if indicated.

References:

1. Medication Safety Alert, *The Institute for Safe Medication Practices*, December 2, 2004.
2. *AORN Guidance Statement: Safe Medication Practices in Perioperative Practice Settings*, 2004.

Column 3: DOCUMENT REVIEW

Review policies and practices relative to medication preparation. Determine that systems are in place relating to:

1. Required labeling of solutions and medications on and off the sterile field.
2. Procedure for differentiating look-alike and sound-alike medications / solutions.
3. Procedure for individually verifying medications / solutions and respective labels.

Column 4: Scoring

Scoring is deferred to 25.01.26.

Rationale: Pharmacy is responsible and maintains oversight for all medications throughout the facility.



FEATURE ARTICLE

The HFAP PRIMARY STROKE CENTER Certification Program

HFAP is pleased to announce its first disease certification program. In response to multiple requests from HFAP accredited facilities, the HFAP Primary Stroke Center certification program has been developed based upon the recommendations of the Brain Attack Coalition (BAC).^{*} This two year HFAP Primary Stroke Center certification is limited to HFAP accredited healthcare facilities. Onsite survey is required every two years to validate ongoing compliance with standards requirements.

^{*}Source: Alberts, et al, "Recommendations for the Establishment of Primary Stroke Centers," *JAMA*, June 21, 200, Vol. 283, No. 23, 3102—3109.

Stroke

Approximately 700,000 people in the United States are affected annually by stroke. In America, stroke is the third leading cause of death and the primary cause of long-term disability among adults. There are two types of acute stroke, ischemic and hemorrhagic. With ischemic strokes, a blood vessel blockage stops the flow of oxygen enriched blood from reaching the brain. Without oxygen, parts of the brain stop functioning causing brain cell death and disability. The goal for treating acute ischemic stroke is to preserve the healthy tissue in the brain. Today, there are treatments available to assist with restoring the blood flow to the brain associated with ischemic stroke. Interventional drug therapy is one method; mechanical removal of clots is another.

With an intracranial hemorrhage / hemorrhagic stroke, bleeding occurs directly into the brain. While only 15% of all strokes are hemorrhagic, these have higher mortality than ischemic strokes.

The 1996 FDA approval of the "clot busting" drug tissue-type plasminogen activator (tPA) changed the treatment of acute stroke and thus raised hope for reducing mortality and morbidity. Yet, Bateman et al, through analysis of the Nationwide Inpatient Sample (NIS) database between 1999 and 2002, identified that the use of IV tPA was "distressingly low" at only 1% of applicable cases. Reasons for this include the delay with presenting for treatment within the three hour window. Other reasons include minor or improved neurological deficits and difficulty accessing community neurological expertise. (Source: Bateman, BT, Schumacher, HC, Boden-Albala B, Berman MF, Moberg JP, Sacco RL, Pile-Spellman J; "Factors associated with in-patient hospital mortality after administration of thrombolysis in acute ischemic stroke patients: an analysis of the Nationwide Inpatient Sample 1999 to 2002. *Stroke*. 2006; 37: 440-446.)

Primary Stroke Centers

The Brain Attack Coalition (BAC), a voluntary, group of professionals and government organizations found that despite the advances in diagnosis and treatment, many hospitals have neither the organization nor the infrastructure to efficiently triage and treat patients with symptoms of acute stroke. Recognizing the success of trauma centers, the multidisciplinary Brain Attack Coalition formed with the goals of improving the level of care provided to stroke patients and to standardize some of the aspects of care. In 2000, the BAC published recommendations that identify the infrastructures needed to quickly evaluate and treat acute stroke patients.

The Brain Attack Coalition recommends two levels of stroke centers. The first, the Primary Stroke Center, has the responsibility to stabilize and provide the initial emergency treatment required for patients experiencing an acute stroke. Following stabilization, the patient may either be admitted for continued care or transferred when a higher level of care is indicated. The Comprehensive Stroke Center, the second level of care, has the capability of providing care to patients requiring more complex services such as neurosurgery or other specialized interventions.



FEATURE ARTICLE

The HFAP PRIMARY STROKE CENTER Certification Program**“Time is Brain”**

With stroke, the concern is the greater the delay, the greater the damage. Remember, brain cells control bodily functions. Any interruption of blood and oxygen to the brain results in physical disability; therefore, “time is brain.” With stroke, the goal of treatment is to minimize the damage through quick interventions.

Primary Stroke Centers provide care based upon nationally approved patient protocols. Working like the proverbial “fine tuned machine” they provide services during the “hyperacute” phase of care. Whereas the clot-busting drug must be administered within three hours of symptom onset, Primary Stroke Centers in collaboration with the Emergency Medical Services (EMS) must quickly determine a diagnosis, ruling out hemorrhagic stroke and other conditions that mimic acute stroke. While tPA may be beneficial for many patients with ischemic stroke, it is not for everyone.

Ineligible for tPA treatment are those with hemorrhagic stroke as this drug may extend the bleeding. Likewise, patients taking blood thinners are excluded, as are those with hypertension, recent surgery, elevated blood glucose, end stage liver disease, low platelet count, and certain renal disorders. For individuals with hemorrhagic stroke, surgery may be indicated. Neurosurgery must be available within two hours of need, according to the Brain Attack Coalition recommendations. If neurosurgical services are not provided onsite, the Primary Stroke Center must have a pre-specified transfer agreement in place.

Brain Attack Coalition (BAC) Recommendations

To build an infrastructure, the Brain Attack Coalition prepared recommendations for Primary Stroke Centers that focus on eleven (11) aspects of organization and stroke care. The recommendations are grouped as:

1. The formation of Acute Stroke Teams
2. The use of written patient care protocols
3. The role of emergency medical service (EMS) personnel with the initial care of acute stroke patients
4. The role of the Emergency Department as the first point of hospital contact with the stroke patient
5. The efficacy of Stroke Units
6. Availability of Neurosurgical Services
7. Commitment and support of the medical organization
8. Availability of Neuroimaging
9. Availability of Laboratory Services
10. Outcomes and Quality Improvement Programs
11. The provision of ongoing professional educational programs (continued on page 9)



FEATURE ARTICLE

HFAP PRIMARY STROKE CENTER Certification Program
(continued from page 8)**HFAP Primary Stroke Center Standards**

Based on the eleven Brain Attack Coalition recommendations, a special HFAP task force consisting of cardiology and neurological clinicians, developed standards leading to Primary Stroke Center certification. In all, there are forty (40) HFAP Primary Stroke Center standards. Samples of these standards are listed below.

HFAP PRIMARY STROKE CENTER Standards (samples)

- 01.00.01 The leadership of the facility demonstrates its commitment to the stroke program.
- 01.00.04 The Stroke Center has an individual appointed as the Medical Director.
- 01.00.07 The program has a designated Acute Stroke Team that is available 24 hours a day, every day.
- 01.00.09 A member of the Acute Stroke Team is expected to arrive at the patient's bedside within 15 minutes of notification to evaluate and manage the care.
- 01.01.01 Written Patient Care Protocols are available in all areas involved with the evaluation and treatment of individuals with acute stroke.
- 01.02.03 The Stroke Center provides education and training for the community Emergency Medical System (EMS) minimally twice a year.
- 01.05.01 Neurosurgical services are available within two (2) hours of when it is deemed to be clinically necessary. For facilities without a neurosurgeon, this expectation can be accomplished by transferring the patient to a facility with a neurosurgeon.
- 01.05.04 Neuroimaging Services are available 24 hours a day, every day, which have the capability of providing computerized tomography of the head or a magnetic resonance imaging scan within 25 minutes of the order being written.
- 01.07.01 Patients on the Acute Stroke Protocol receive an initial evaluation by physical therapy, speech and language pathology, and occupational therapy within 72 hours of hospital arrival.

(Continued on page 10)



FEATURE ARTICLE

HFAP PRIMARY STROKE CENTER Certification Program (continued from page 9)

HFAP Primary Stroke Center Outcomes and Quality Improvement Standards

As recommended by the Brain Attack Coalition, the HFAP Primary Stroke Center standards require data collection and a Quality Assessment / Performance Improvement Program. Samples of the standards are listed below.

HFAP Primary Stroke Center Quality Assessment / Performance Improvement Standards (Standards Samples)

01.09.01 The Stroke Center has a Quality Assessment / Performance Improvement subcommittee. The Stroke Center QAPI subcommittee meets at least three times a year to review data relative to the Stroke Center and establish internal and external benchmarks. The subcommittee selects two (2) patient care performance improvement activities annually.

01.09.03 The Primary Stroke Center consistently exhibits superior outcomes and explores opportunities for further improvement. The PSC collects data including, but not limited to:

- The Acute Stroke Team arrives at bedside within 15 minutes of notification
- Laboratory studies are collected, processed, and reported within 45 minutes of order.
- “Door—to– Needle” time for administration of tPA is less than 60 minutes.

The Value of Certification

The literature provides a multitude of reports describing substantial benefits of primary stroke centers. Across America, state and/or local legislation influence healthcare facilities to offer Primary Stroke Centers; thus providing the community with access to a higher quality of stroke care. The significant impact of these centers, as measured by improved clinical outcomes (including reduced lengths of stay and reduced overall costs of care for the acute stroke patient) has been recognized by many third party payors who direct their insured members with these symptoms to seek Primary Stroke Centers for treatment when possible.

Often, Primary Stroke Centers are developed as a collaborative community initiative to bring quality neurological care to its citizens. In certain areas, state or local legislation have deemed acute stroke patients as priority calls for ambulance dispatch. Other communities have identified the need to expand this level of expertise into rural areas. Thus, through teleradiology and helicopter transport, these regions have built programs to treat acute stroke patients where this technology had not previously been possible.

(Continued on page 11)



FEATURE ARTICLE

HFAP PRIMARY STROKE CENTER Certification Program
(continued from page 10)**HFAP Primary Stroke Center—Alpha Sites**

Alpha sites for the new HFAP Primary Stroke Center Certification Program have been selected. One of these is Hazleton General Hospital, Hazleton, Pennsylvania. According to Quality Management Director Andrea Andrews, "Hazleton General is committed to providing quality acute stroke care to the members of our community. Two of our neurologists have agreed to be physician champions on our Stroke Alert Team. They are experienced in diagnosing and treating cerebrovascular diseases. Our team is in the process of implementing our hospital-wide stroke alert program. The planning team meets on a regular basis to build our infrastructure, establish expectations, and prepare our patient care protocols."

The HFAP Primary Stroke Center Certification Process

The HFAP Primary Stroke Center certification is a two step process. First, facilities must demonstrate compliance with all Primary Stroke Center standards. This is accomplished through an onsite survey in which two specially trained HFAP surveyors (one physician and one nurse) evaluate standards compliance.

The second step requires the facility to demonstrate superior outcomes. The Bureau of Healthcare Facilities Accreditation believes a Primary Stroke Center must consistently demonstrate superior outcomes to earn this certification. It is the expectation that HFAP Primary Stroke Centers demonstrate ongoing compliance of 85% or higher with specific internal processes and performance indicators.

The two year HFAP Primary Stroke Center certification is limited to HFAP accredited healthcare facilities. An onsite survey is required every two years to validate continued compliance with standards requirements.

**For More Information and Primary Stroke Center
Certification Application**

Contact Mr. George Reuther, HFAP Director

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FEATURE ARTICLE

HFAP PRIMARY STROKE CENTER Certification Program **(continued from page 11)**

Pre-Hospital Delays to Acute Stroke Treatment

For ischemic stroke, the tPA drug must be administered within three hours of symptom onset; otherwise, the individual is ineligible for this treatment option. Studies show that the single factor with the greatest impact for reducing pre-hospital delays is the decision to call the EMS. It is of interest to note that individuals arriving to the ED by ambulance also had shorter delays in the time from ED to CT scan. This has been attributed to the fact that ambulance patients avoid triage and registration and, in certain cases, the Acute Stroke Team is alerted prior to patient arrival. It was also noted that in some situations, there was a perception among ED staff that ambulance patients need to be seen sooner.

Studies show that pre-hospital time is reduced when a witness, e.g., family member, friend, or co-worker, makes the decision to call an ambulance.

The second factor with the greatest impact on pre-hospital delay was awakening with symptoms of acute stroke. Often, due to the three hour treatment window; these individuals are excluded from tPA treatment.

Source: Morris et al, "Prehospital and Emergency Department Delays After Acute Stroke – The Genentech Stroke Presentation Survey," *Stroke*, 2000, 31: 2585—2590.

Community Education

Community education programs are an effective means to raise public awareness about stroke. When the public becomes more knowledgeable of the symptoms and availability of time limited treatment options, studies have demonstrated a reduction with pre-hospital delays.

Community education program coordinators should understand the reasons for pre-hospital delays then focus on the desired outcome—taking action. Among the reasons patients do not take action are:

- Denial / symptoms are not serious (e.g., I just need to rest)
- Waited for a ride or waited for the doctor to return a telephone call, and
- Cost of an ambulance.

By understanding the reasons patients give for delays, educators can assist with changing behaviors by addressing:

1. Recognition of stroke symptoms
2. Seriousness of these symptoms
3. Making the decision to seek help, and
4. Take action—call an ambulance.

Studies also show that time is saved when a witness, e.g., family member, friend, or co-worker, makes the decision to call an ambulance.

Community Education Topics

1. Risk Factors Modification
2. Recognition of signs and symptoms of stroke
3. Availability of time-sensitive acute stroke therapy
4. Reasons people delay seeking medical attention, e.g., denial, self-treatment, mild symptoms, lives alone, finances, and incapacitation due to stroke.
5. What to do – Take Action—Call the EMS



The American Osteopathic Association Annual Convention

The 2006 Council of Hospitals Forum

This year, the annual American Osteopathic Association (AOA) Convention will take place in exciting Las Vegas, Nevada. Again this year, the Council of Hospitals (COH) has invited HFAP to present breakout sessions on October 16 and 17, 2006. These two days will include not only HFAP updates but also representatives from accredited facilities will share their successes relative to 1) “Core Measures” or 2) “Quality Initiatives That Impact Quality of Care, Patient Safety, and the Bottom Line.”

While the Council of Hospitals membership is not limited to HFAP accredited healthcare facilities, only HFAP accredited facilities were eligible to submit abstracts. The response was overwhelming as healthcare facilities large and small, representing the East, West, South and Midwest responded. The decision making was difficult as we received so many high level, quality abstracts. We are very pleased with the final selection of topics for the Council of Hospitals 2006 Forum (see page 14.)

What You Will Learn

The slate of presentations includes a Six Sigma Black Belt who will share how this county hospital used the Six Sigma principles to improve patient safety. Learn about the success another facility has experienced after implementing their “Beta-Blocker for Non-Cardiac Surgical patients” performance improvement program. During the 2006 Forum, you will learn first hand how one Texas community evacuated all medical facilities as Hurricane Rita approached. What were the triggers for evacuation? Where were the patients taken? And most remarkable, how was it possible to re-open in a mere three days? These speakers will demonstrate how they used HFAP standards to improve quality, patient safety, and the bottom line.

The Council of Hospitals

The AOA Council of Hospitals provides its members with an enhanced role in AOA policy and advocacy. The Council serves to provide better communications with colleagues and the profession. The Council of Hospitals is undergoing a name change and has become the **Bureau of Hospitals** in recent weeks.

Registration and Membership Information

Current dues-paid members of the Council may send two representatives to the 2006 Forum free of charge. Non-member hospitals may register their representatives for \$250 each.

To register for this program or to learn about membership benefits and information, kindly contact Elizabeth Harano at 800-621-1773 (ext 8183) or Margaret Hardy at 800-962-9008 (ext 0155.)

Advance Registration

Advance registration will be accepted through September 15, 2006. Limited registration will be available onsite. We cannot guarantee availability of program books for onsite registrants.

Online Registration

To register online, go to www.do-online.org. Click on the “AOA 111th Annual Convention” icon to the right to get to the convention home page. From there follow the registration link to register online, by mail, or via fax. Note: Council of Hospitals registration is on page three.



The American Osteopathic Association Annual Convention

The Council of Hospitals 2006 Forum, Las Vegas, NV

October 16 and 17, 2006

The Indianapolis Patient Safety Coalition—Patient Safety in a Competitive Market— How Hospitals in One Community Came Together for Safety

Donald Kerner, MD, Associate Medical Director
St. Francis Hospital, Indianapolis, IN

Quality Measures in a Large Community Hospital: Heart Failure and Pneumonia Core Measures

Bernie McDonnell, DO, VP of Medical Affairs, HFAP Surveyor
Eileen Jaskuta, RN, BSN, Assistant VP Quality Improvement and Risk Management, HFAP Surveyor
Mercy Suburban Hospital, East Norriton, PA

Quality in a Small Community Hospital: Heart Failure Core Measures

Andrea Andrews, A.R.N., CHCQM, Director of Quality and Case Management
Greater Hazleton Health Alliance, Hazleton, PA

Quality Measures: Surgical Infection Prevention Core Measures

Anita Trackwell, MSN, RN, CPHQ, Clinical Director, St. Francis Hospital, Mooresville, IN

Analysis of Data—Using Six Sigma to Improve Patient Safety and Quality of Care

Shereé Fernandez, RN, MHS, Six Sigma Black Belt, Supervisor of Performance Improvement
Arrowhead Medical Center Colton, CA

Disaster Preparedness and Hurricane Rita—

How A Community Hospital Evacuated and Return to Business in Three Days

Sharon Dauterive, Director of Public Relations Renaissance Hospital, Groves, TX

A Comprehensive Patient Safety Process—

Ensuring Compliance with HFAP Patient Safety Standards

Claudia Gering, MA, CPHQ, Director of Quality Management
Garden City Hospital Garden City, MI

Patient Safety with Improved Patient Outcomes—

Use of Beta Blockers with Non-Cardiac Surgical Patients

Mary Setterding, RN, MS, Clinical Nurse Specialist
Columbus Hospital, Columbus, IN

Rapid Response Teams

Sharon Garretson, RN, BSc, Manager, ICU and Step-down
Mary Beth Rauzi, RN, MSN Manager of Learning Services
University Hospital Richmond Medical Center, Richmond Heights, OH



Frequently Asked Questions

Contract Services—Teleradiology

Question: “What are HFAP’s requirements for credentialing teleradiologists? We are exploring the possibility of contracting with a group of teleradiologists to provide services for evenings, nights, and weekends. This group of 20+ teleradiologists provides a scope of services to several states.”

New HFAP Interpretation

CMS Response:

“Regardless of who provides this service, the Medicare hospital Conditions of Participation (CoPs) hold the governing body and the medical staff responsible for ensuring the quality of medical care and for credentialing and privileging the medical staff. The medical staff is responsible for evaluating a practitioner’s credentials and making recommendations to the governing body regarding privileges to be granted. The governing body considers the medical staff recommendations and grants privileges and appoints members to the medical staff. Hospitals must credential and privilege contract licensed independent practitioners, including teleradiologists, with the same care used for non-contract medical staff. The practice of credentialing and privileging by proxy is not consistent with Medicare requirements. For this reason, a hospital would be out of compliance with the Condition of Participation if they had a practice of credentialing and privileging by proxy.”

Can We Contract with Professional Credentialing Organizations (PCO)?

In recent years, Professional Credentialing Organizations (PCO) have offered credentialing services to health-care facilities. A Professional Credentialing Organization is defined as “an independent contractor who has no clinical or financial affiliation with the people on whom data is being collected. There can be no evidence of any relationship that could raise the question of a conflict of interest.” Typically, PCO’s assist in the accumulation of data needed for the credentialing and re-credentialing process. This could include the collection of personal references, verification of privileges at all facilities where the candidate maintains privileges, verification of education and certification, and so forth.

The responsibility for granting privileges always remains with the facility.

Healthcare facilities that make the decision to use an PCO must keep these principles in mind:

1. The facility granting privileges must, at a minimum, personally obtain:
 - a. Verification of state licensure
 - b. Query of the National Practitioner Data Bank
2. Copies of both documents must be kept in each candidate’s file.
3. Both documents must be verified immediately prior to re-appointment.
4. The Professional Credentialing Organization can have no clinical or financial affiliation with the people on whom data is being collected. There can be no evidence of any relationship that could raise the question of a conflict of interest.
5. State regulations may have additional requirements or regulations relating to PCOs. (This must be considered during the survey process.)
6. Organizations may use PCOs to assist with data collection for the credentialing and re-credentialing process, but the responsibility for granting privileges always remains with the facility.



(continued on page 16)

Frequently Asked Questions

Contract Services—Teleradiology (continued from page 15)



New HFAP Interpretation

HFAP—What This Means:

The facility must credential and privilege contracted practitioners, in this case teleradiologists, with the “same care” used for the medical staff. Credentialing/privileging “by proxy” or through an other source, is not acceptable. To demonstrate “the same care used for the medical staff,” a facility must:

1. Use the same medical staff credentialing criteria as outlined in HFAP Chapter 3.
2. Prepare a folder for each teleradiology candidate that will provide services to your facility.
3. Ensure the candidate has a current license to practice in your state.
4. Conduct a primary source verification; check the “National Practitioner Data Bank”
5. Complete a criminal background check, per protocol
6. Ensure the list of competencies is current
7. Ensure each Teleradiologist that will provide services to your facility is approved using the medical staff credentialing process, that is:
 - a) Applications are submitted to the Credentialing Committee,
 - b) Credentialing Committee recommendations are submitted to the Governing Body; and
 - c) The Governing Body provides candidate approval.

Sources:

Condition of Participation: Governing Body, CFR 482.12(a)(2) “The governing body must appoint members of the medical staff after considering the recommendations of the existing members of the medical staff.”

Condition of Participation: Medical Staff, CFR 482.22, “The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.”

CFR 482.22(a), “The medical staff must be composed of doctors of medicine or osteopathy and, in accordance with State law, may also be composed of their practitioners appointed by the governing body.”

CFR 482.22(a)(2) “The medical staff must examine credentials of candidates for medical staff membership and make recommendations to the governing body on the appointment of the candidates.”

HFAP Standards: 03.01.07; 03.01.12; 03.01.13; 03.01.14; and 03.01.15



Frequently Asked Question

Joint Ventures

Question: “We have entered into a Billing Under Arrangement joint venture with three outpatient entities. How will they be surveyed? My assumption is that they will be surveyed under the same acute care regulations as outpatient entities within the hospital. The joint ventures feel they may fall under outpatient regulations because they are solely outpatient.”

Answer:

The process for surveying joint venture outpatient entities is determined according to their Medicare provider number.

If the joint ventures bills using a different number than the hospital Medicare provider number, they would be surveyed under the outpatient regulations.

However, if the joint ventures bill using the same hospital Medicare provider number, they would be considered a part of the hospital. Thus, these outpatient entities would be surveyed with the hospital, and in accordance with the standards in the Acute Care Hospital manual. In this case, all three outpatient joint venture entities must be fully integrated into the hospital processes, including the medication management, patient safety, medical records, life safety code, and they must participate with the hospital QAPI program.

Post Anesthesia Assessment

Question: Regarding the new Post-Anesthesia Assessment standard printed in the April 2006 HFAP Newsletter, “For outpatient surgery, would it be acceptable for nursing to do the post-anesthesia assessment based on criteria developed and approved by the anesthesiologists and medical staff?”

Answer:

No, registered nurses cannot be held accountable to perform this high-risk post-anesthesia assessment, even with the assistance of medical staff approved criteria. The HFAP standard, consistent with Medicare, states, “The post-anesthesia evaluation must be completed by someone qualified to administer anesthesia.”

www.hfap.org

Have you visited the HFAP website? If so, you probably know that HFAP shares the website with the American Osteopathic Association. A password is **ONLY** required for the Doctors of Osteopathy to access their secure membership information.

A log-on password is **not required** for HFAP affiliates to access HFAP information, including the HFAP NEWS newsletters. Simply bypass the log-in request located in the upper right hand corner and scroll down the page. Along the right side, you will find an icon for the newsletters.

At this time, the “Frequently Asked Questions” section is not available.



THE TOP TEN HFAP HOSPITAL DEFICIENCIES (DECEMBER 2005)

HFAP posts the ten most common deficiencies to assist facilities with prioritizing their survey preparedness efforts. We hope you find this beneficial.

#1 HFAP Standard 16.01.03 “Supervision of Care”

Requirement: “A registered nurse must supervise and evaluate the nursing care for each patient.”

Key Point: Every patient must have a Registered Nurse assigned to oversee care. Also, it would be unacceptable to have a Licensed Practical Nurse (LPN) assigned as the charge nurse or supervisor.

#2 HFAP Standard 16.01.04 “Nursing Care Plan”

Requirement: “The hospital must ensure that the nursing staff develops, and keep current, a nursing care plan for each patient.”

Key Point: Care plans must be updated to reflect changes in care.

#3 HFAP Standard 10.01.16 “Adequacy of Available Information”

Requirement: “The medical records must contain all practitioner’s orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient’s condition.”

Key Point: Be sure all diagnostic reports are placed in the medical record AND in a timely manner.

#4 HFAP Standard 15.01.08 “Patient Rights”

Requirement: “The patient has the right to receive care in a safe setting.”

Key Point: Be sure your list of Patient Rights include the phrase, “You have the right to receive care in a safe setting.”

#5 HFAP Standard 10.01.05 “Legible and Complete” (Authentication of entries in records.)

Requirement: “All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must authenticate his or her entry. Authentication may include signatures, written initials or computer entry.”

Key Point: In a word, the problem is legibility.



THE TOP TEN HFAP HOSPITAL DEFICIENCIES (DECEMBER 2005)

- #6 HFAP Standard 10.01.18 “Medical Record Delinquency” (Final diagnosis with completion of medical records within 30 days following discharge.)
Requirement: “The medical records must contain the final diagnosis with completion of medical records within 30 days following discharge.”
Key Point: The medical record is to be completed within 30 days of patient discharge. Doing this provides a variety of benefits to both the hospital and the patient’s various care givers who bill for their services. Many Medical Records Departments submit these quarterly data to the QAPI Committee and / or Medical Executive Committee. Does your Medical Director or CEO need to get involved?
- #7 HFAP Standard 11.08.03 “Maintenance Ensures Safety and Quality”
Requirement: “Facilities, supplies, and equipment shall be maintained to ensure an acceptable level of safety and quality.”
Key Point: Be sure storage practices do not violate state / local fire codes. Keep shipping boxes of supplies off the floor. Do not use door stoppers. Hospital and medical equipment must be maintained to ensure they are safe to use. Does your plan describe safety inspections for generators, fire extinguishers, ventilators, and etc.? The plan should address the frequency of these inspections as well as the person(s) responsible for performing these inspections. Finally, be sure the equipment is inspected according to the plan. Keep these inspection records current and readily available.
- #8 HFAP Standard 11.02.02 “Building Safety”
Requirement: “The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well being of patients, visitors, and staff.”
Key Point: Be sure the Emergency Plan addresses requirements relative to safety. Also, be sure the physical plant is maintained in a safe manner. Be sure sidewalks are maintained so there are no tripping / slipping hazards. Have an effective process in place for the repair and routine maintenance of equipment.
- #9 HFAP Standard 12.00.09 “Program Accountability”
Requirement: “The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital service and operations.”
Key Point: Minimally, each of the processes below must be in the QAPI Plan, monitored, and analyzed.
1. Medication therapy
 2. Infection control
 3. Surgical/invasive and manipulative procedures
 4. Blood product usage
 5. Data management
 6. Discharge planning
 7. Utilization management
 8. Complaints
 9. Restraint/seclusion use
 10. Mortality review



THE TOP TEN HFAP HOSPITAL DEFICIENCIES (DECEMBER 2005)

#10 HFAP Standard 15.01.07 “Patient Notification of the Grievance Process”

Requirement: “In its resolution of the grievance, the hospital must provide the patient with a written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.”

Key Points:

A grievance is a formal or informal written or verbal complaint that is made to the hospital by a patient / patient representative when an issue cannot be resolved promptly by the staff present. If a complaint is referred to a complaint coordinator, patient advocate, hospital management, or whenever a patient / patient’s representative requests their complaint to be handled as a formal complaint, then the complaint is considered a grievance. Hospitals have two responsibilities in handling grievances as described below.

First: Through posters, patient handbooks, and etc., hospitals must inform patients of the following:

- 1) Whom to contact to file a grievance (complaint.)
- 2) The right to lodge a grievance with the State agency directly, regardless of whether he/she has first used the hospital's grievance process
- 3) The telephone number and address for lodging a grievance with the State agency.

Second: After a grievance has been made, the hospital must provide the patient with a written notice. In most cases, this notice is sent within seven (7) days of the grievance. The notice usually begins on a personal note such as, “We received your concern about _____. This is what we are doing about your concern. We are conducting an investigation but, we need a little more time to have a full understanding of the events. We will get back to you in approximately ____ days.”

The written notice must provide these elements:

- 1) Hospital decision
- 2) Hospital contact person
- 3) Steps taken to investigate the grievance
- 4) Investigation results
- 5) Completion date of the investigation

Grievance Resolution: The grievance may be considered resolved when either the patient is satisfied with the actions taken on their behalf or when the hospital is able to demonstrate that they have done every thing feasible to resolve the issue.

Documentation: The hospital must have a system for documenting grievances and efforts to resolve issues. Written notices to patients are maintained. Surveyors may ask to view your grievance process filing system.





Spotlight on Performance Improvement

Rapid Response Team
Cuyahoga Falls General Hospital
Cuyahoga Falls, Cuyahoga Falls, OH

Interview with Suzanne Gills, Director of Nursing

Why Did You Select This Project?

This project was selected in response to the IHI 100,000 lives campaign. Literature supports that patients exhibit signs and symptoms of physiological instability for a period of time before they experience a cardiac arrest. There are many warning signs within six hours of arrest such as a change of heart rate, altered mental status and chest pain to name a few. Once these sudden, acute changes of clinical symptoms are noted by a health care member, a Rapid Response Team is called.

The Institute for Healthcare Improvement's 100,000 Lives Campaign aims to save 100,000 lives within 18 months by enlisting more than 2,000 hospitals in a commitment to implement changes in care to prevent avoidable deaths. A Rapid Response Team is one of the recommendations. A Rapid Response Team is a group of expert health care professionals deployed to the bedside to assist with immediate patient evaluation and treatment before clinical deterioration progresses to cardiac arrest or other negative outcomes.

How Did You Gain support From Medical Staff and Administration?

This was very easy to do at our hospital. Our medical staff and senior administration recognized it is the right thing to do for our patients and families. Our hospital's focus is quality care and services for our patients and community, so we were committed to establishing a Rapid Response Team.

I did not encounter any obstacles from the medical staff nor administration. We were able to develop the team without any additional FTE's or additional expenses. All departments who were going to be team members were fully committed to this project.

Did You Encounter Any Obstacles?

We did not encounter any major obstacles because the formation of the team did not require additional dollars. The most difficult obstacle was trying to track the data. Staff was educated to complete the Rapid Response Team form for all calls to help track the reason for the call, interventions, outcomes, family notification and disposition of the patient. The forms were not always completed as the staff was caring for the patient and would forget to obtain the form for the medical record.

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Spotlight on Performance Improvement (continued from page 22)

Rapid Response Team Cuyahoga Falls General Hospital Cuyahoga Falls,

(Continued from page 21)

How Did You Overcome The Obstacles?

To help track data, I have changed the Rapid Response Team forms to be sent to me for review. I have included my pager as part of the Rapid Response Team so I can track all calls and follow up for completion of the forms and chart review if necessary. I also instructed the Unit Clerks to immediately addressograph a Rapid Response Team form and take to the location of the response. The Nursing Supervisors are helping to oversee completion of the form.

Clinical Outcomes—Total Number of Lives Saved (August 2005—May 2006)

During this period, 53 Rapid Response calls were placed. Of these, 11 (21%) patients expired. However, 42 lives (79%) were saved due to this initiative!

Conclusion

Cuyahoga Falls General Hospital is part of a team of community and teaching hospitals participating in a Rapid Response System Collaborative sponsored by Robert Wood Johnson Foundation with coordinating centers of the Delmarva Foundation and Association of American Medical Colleges. This collaboration has been very positive for our hospital because when obstacles are identified I am able to consult with a team of experts for consultation.

Operational benefits to having a Rapid Response Team include lower mortality rates, fewer codes each month, higher staff satisfaction, a commitment to a higher culture of patient safety and improved family involvement and satisfaction for hospital care and services. Chart review and patient outcome tracking tools validate patients are rescued, lives are saved, bedside nurses feel supported, empowered and best practice is a reality.

Lessons To Share

We learned the value of having a supportive medical staff and administration. Without that support, the team would not have been successful. Larger hospitals have reported that additional staff were required to form a Rapid Response Team; thus, financial considerations need to be evaluated. We also learned that each team member must understand his/her role and how each is an integral part of the Rapid Response Team.

About the Author

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**ONLINE UPDATE AT WWW.HFAP.ORG
TO THE ACCREDITATION REQUIREMENTS FOR HEALTHCARE FACILITIES,
FEBRUARY 2005 EDITION OF THE ACUTE HOSPITAL MANUAL**

Over the past year, the HFAP NEWS newsletter has been the vehicle used to share new, revised, and deleted standards to the 2005 HFAP Acute Hospital Manual. Now, these standards are available online at www.hfap.org. Scroll along the gray box on the right to find "Updates to Manual" or go to this address:
http://www.do-online.osteotech.org/index.cfm?PageID=acc_hfaprevman0806.

Please print out the revised pages or sections provided and place the revised page(s) into the appropriate chapter or section of your manual. **DO NOT** delete original pages from your manual. Cross out the standard that has been changed and insert the new page. The changes are as follows:

<u>Chapter</u>	<u>Change</u>	<u>Approved</u>	<u>Effective Date</u>
<u>Table of Contents</u>	Revised	July 2006	July 1, 2006
Chapter 3 Medical Staff			
03.01.22 Fair Hearing Process	Revised	January 2006	Sept 1, 2006
03.02.02 Required QAPI Functions	Revised	May 2006	May 1, 2006
Chapter 7 Infection Control			
07.01.08 Classification of Infections	Revised	May 2006	May 1, 2006
Chapter 10 Medical Records Services			
10.01.14 Required Documentation	Revised	May 2006	May 1, 2006
Chapter 11 Physical Environment			
11.13.01 Alcohol Based Hand Rub (ABHR) Dispensers Installation	Revised	May 2005	July 1, 2005
11.13.02 Alcohol Based Hand Rub (ABHR) Dispensers Solution-Storage	New	May 2005	July 1, 2005
11.13.03 Alcohol Based Hand Rub (ABHR) Dispensers – Maintenance	New	May 2005	July 1, 2005
Core Function Grid	Revised	July 2006	July 1, 2006
Chapter 12 Quality Assessment & Performance Improvement			
12.00.23 Service Delivery Capability	Deleted	Jan 2006	Jan 1, 2006
Core Function Grid	Revised	July 2006	July 1, 2006

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**ONLINE UPDATE AT WWW.HFAP.ORG TO THE
ACCREDITATION REQUIREMENTS FOR HEALTHCARE FACILITIES,
FEBRUARY 2005 EDITION OF THE ACUTE HOSPITAL MANUAL**

(Continued from page 23)

<u>Chapter</u>	<u>Change</u>	<u>Approved</u>	<u>Effective Date</u>
Chapter 18 Cardiovascular Services			
18.00.24 Label Medications and Solutions on the Sterile Field	New	May 2006	Jan 1, 2007
Core Function Grid	Revised	July 2006	July 1, 2006
Chapter 21 Endoscopic Services			
21.00.25 Label Medications and Solutions on the Sterile Field	New	May 2006	Jan 1,
Core Function Grid	Revised	July 2006	July 1, 2006
Chapter 25 Pharmacy Services and Medication Use			
25.01.26 Label Medications and Solutions on the Sterile Field	New	May 2006	Jan 1, 2007
Core Function Grid	Revised	July 2006	July 1, 2006
Chapter 30 Surgical Services			
30.00.00 Surgical Services	Corrected	July 2006	July 1, 2006
30.00.19 Label Medications and Solutions on the Sterile Field	New	May 2006	Jan 1, 2007
30.01.03 Anesthesia Providers	Revised	May 2005	Oct 1, 2005
30.01.04 Moderate Sedation	Revised	May 2005	May 1, 2005
30.01.09 Post Anesthesia Reassessment	Revised	January 2006	Sept 1, 2006
30.04.23 Post Anesthesia Reassessment- Outpatients	New	January 2006	Sept 1, 2006
30.04.24 Label Medications and Solutions on the Sterile Field	New	May 2006	Jan 1, 2007
Core Function Grid	Revised	July 2006	July 1, 2006
<u>Index</u>	Revised	July 2006	July 1, 2006
<u>Appendix A</u>	Revised	July 2006	July 1, 2006



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*Accrediting Healthcare Facilities
For Over 60 years*

Patient Safety— Acute Stroke Symptoms

Studies over the past ten years show that most people do not know the symptoms of stroke. Of particular concern is that respondents who are at greatest risk, age 75 years and greater, could identify only one (1) symptom. People need to know that Stroke is a Medical Emergency. As every minute counts when it comes to stroke treatment, people must be able to recognize the symptoms so they can take immediate action.

Symptoms of Stroke

- Sudden numbness, weakness, or paralysis of the face, arm, or leg (especially on one side)
- Sudden confusion, trouble speaking or understanding speech
- Sudden difficulty seeing in one or both eyes
- Sudden difficulty walking or loss of balance/coordination; and
- Sudden severe headache without known cause.

HFAP—A Medicare Authorized Accreditation Organization (AO)

HFAP has been surveying hospitals since 1945. As you know, there are only two voluntary accreditation organizations in the United States authorized by the Centers for Medicare & Medicaid Services (CMS) to conduct accreditation surveys of hospitals under Medicare. HFAP is one of the two with Medicare deeming authority and has held this status since the inception of Medicare in 1965. Yet, certain third party payers or charitable organizations may be unaware of this designation and recognize only one accreditation organization.

From time to time, your organization may receive questions about your accreditation status from external sources. Should you need support, HFAP staff stands ready to assist you in responding to these situations.

The broad recognition of the HFAP hospital accreditation authority includes the following federal, state, and voluntary organizations:

- Deeming authority from CMS
- State Statutes
- The Accreditation Council for Graduate Medical Education (ACGME)
- The American Hospital Association (AHA)

