2014 Complete Overview of DNV Standards

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Presented by: Patrick Horine, MHA
2014 Overview of the DNV GL Healthcare NIAHO Accreditation Requirements and Recent Revisions

Common Survey Findings – Medical Staff

NIAHO® - Medical Staff
MS.1 ORGANIZED MEDICAL STAFF
MS.2 ELIGIBILITY
MS.3 ACCOUNTABILITY
MS.4 RESPONSIBILITY
MS.5 EXECUTIVE COMMITTEE
MS.6 MEDICAL STAFF PARTICIPATION
MS.7 MEDICAL STAFF BYLAWS
MS.8 APPOINTMENT
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MS.11 GOVERNING BODY ROLE
MS.12 CLINICAL PRIVILEGES
MS.13 TEMPORARY CLINICAL PRIVILEGES
MS.14 CORRECTIVE OR REHABILITATION ACTION
MS.15 ADMISSION REQUIREMENTS
MS.16 MEDICAL RECORD MAINTENANCE
MS.17 HISTORY AND PHYSICAL
MS.18 CONSULTATION
MS.19 AUTOPSY
MS.20 TELEMEDICINE

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CORRESPONDING CONDITIONS OF PARTICIPATION

- 482.12 Governing Body
- 482.22 Medical Staff
- 482.30 Utilization Review
- 482.51 Surgical Services
- 482.52 Anesthesia Services

Common Findings

1. Life Safety Management – Various issues not meeting LSC and NFPA requirements (20%)
2. Anesthesia Services – Incomplete/missing documentation included within the pre/post anesthesia evaluations (16%)
3. Medical Record Content – Dating and timing of medical record entries / orders (13%)
4. Infection Control – activities related to carrying out infective control plan, surveillance issues and monitoring (13%)
5. Medication Security – Medications storage / security of medications (13%)
6. Advance Directives – Missing documentation regarding patient’s Advance Directive – not present in the record or not following process when requested by a patient (11%)
7. Patient Rights – Restraint and Seclusion – Physician or other LIP orders (10%)
8. Informed Consent – Missing elements of the Informed Consent (8%)
9. Medical Staff – Missing/Limited quality/performance data for practitioners (Quality Profile)
10. Care Plan – Incomplete or not updated Plan of Care for the patient
11. Quality Management (Measure, monitoring and Analysis) process of evaluation/measurement of all organized services.
12. CRNAs – Supervision by Qualified Physician (Opt-Out vs. Non-Opt-Out)
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**MS.6 MEDICAL STAFF PARTICIPATION**
The medical staff shall participate in at least the following organization activities:
SR.1 Medication management oversight;
SR.2 Infection control oversight;
SR.3 Tissue review;
SR.4 Utilization review;
SR.5 Medical record review; and,
SR.6 Quality Management System.
SR.7 Reports and recommendations from these activities shall be prepared and shared with the medical executive committee and the governing body.

**MS.7 MEDICAL STAFF BYLAWS**
**MS.7 Medical Staff Bylaws (Top Findings)**
• No mechanism for immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner’s Medicare or Medicaid status

**Compliance Notes:**
• This provides a means to review the circumstances and then determine the appropriate action of the medical staff. The difficulty is addressing the means of controlling this when the practitioner is still permitted privileges.

**MS.8 APPOINTMENT**
**MS.10 CONTINUING EDUCATION**
3) **MS.10 Continuing Education**
• Lack of verification or other means to determine completion or attestation of completion of required CME

**MS.9 PERFORMANCE DATA**
Practitioner specific performance data evaluated, analyzed and action taken
Performance data will be collected periodically within the reappointment period or as required as a part of the peer review process.
– SR.1 Blood use (may include AABB transfusion criteria);
– SR.2 Prescribing of medications: Prescribing patterns, trends, errors and appropriateness of prescribing for Drug Use Evaluations;
– SR.3 Surgical Case Review: appropriateness and outcomes for selected high-risk procedures as defined by the medical staff;
– SR.4 Specific department indicators that have been defined by the medical staff;
– SR.5 Anesthesia/ Moderate Sedation Adverse Events;
– SR.6 Readmissions/ unplanned return to surgery (as defined)
– SR.7 Appropriateness of care for non-invasive procedures/interventions;
– SR.8 Utilization data;
– SR.9 Significant deviations from established standards of practice; and,
– SR.10 Timely and legible completion of patients’ medical records;
– SR.11 Any variant that should be analyzed for statistical significance.
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1) MS.9 Performance Data
   - Lacking of indicators or profile of measures to be evaluated at the time of reappointment.

   **Compliance Notes:**
   - Selection of Applicable indicators
   - Mechanism for on-going measurement and acting on variation
   - Creating a standardized process for presenting measures

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MS.12 CLINICAL PRIVILEGES
SR.1 The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges.
SR.4 There shall be a provision in the medical staff bylaws for a mechanism to ensure that all individuals with clinical privileges provide services only within the scope of privileges granted.

1) MS.12 Clinical Privileges
   - Lack of documented evidence of meeting criteria for special privileges
   - Lack of specific training or certification for maintain specific privileges as defined

   **Compliance Notes:**
   - Clearly defining criteria for special privileges and distinctly separating these from “core”
   - Creating a means for listing any expiration of certification along with licensure and board certification
   - Specifying alternative criteria approved by the medical staff to demonstrate competence

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MS.17 HISTORY AND PHYSICAL
   - Content
   - Timeframe
   - Update

3) MS.17 History and Physical
   - Largely attributable to missing elements of the History & Physical
   - Timeframes for completing the History & Physical examination and update

   **Compliance Notes:**
   - Vigilance to review documentation and noting findings from Medical Record review to the appropriate parties
**NIAHO Accreditation Requirements and Interpretive Guidelines**

**Notable changes to Revision 11**

- Clarifying current standards and interpretive guidelines
- Encompassing changes reflected in the Conditions of Participation and State Operations Manual
- Moving sections to create the Appendices
- Introduction of New Standards

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**Glossary Additions**

- AANA – American Association of Nurse Anesthetists
- HAI - Hospital Acquired Infection
- MHAUS - Malignant Hyperthermia Association of the United States
- QLP - Qualified Licensed Practitioner
QUALITY MANAGEMENT (QM)  
The organization shall evaluate organized services and processes, both direct and supportive, including services provided by contracted services. The monitoring shall include the use of internal reviews (audits) of key processes as defined by the organization at scheduled intervals, not to exceed one year, and data related to these processes. Individuals assigned to perform internal reviews (audits) of key processes shall not review (audit) any processes they are assigned to or manage.

• QM.7 / SR.15 — page 17  

Clarification of the standard to address “all” departments and services.” It is not the expectation for organizations to encompass every department and service in the internal audit process on an annual basis. The organization will define the key processes and plan the internal audits based on intervals to ensure that processes are being carried out as defined through policy, procedure, protocol, etc.

Removed "other adverse events" and replaced with "unplanned readmissions and returns to surgery (as defined)"
GOVERNING BODY (GB)

GB.3 CONTRACTED SERVICES
Interpretive Guidelines
The organization will prioritize the review of contracted services to ensure that patient care services or those services that would also be carried out by staff employed by the organization to ensure these are comparable. Other contracts will be assessed in accordance with the organization’s policy as defined. It is not the expectation that such contracts as that for cable television or plumbing, for example, would be assessed in the same manner as those related to patient care services. However, if services provided under contract will have an impact in some manner for patient care services, the organization will review these services and monitor the appropriate measures to ensure the expectations of the organization and needs of the patient are being met.

MEDICAL STAFF (MS)

MEDICAL STAFF (MS)
• MS.9
Consolidated SR.5 and SR.6 Added new SR.6
SR.5 Anesthesia /Moderate Sedation Adverse Events;
SR.6 readmissions/ unplanned returns to surgery (as defined)

MEDICAL STAFF (MS)

MS.17 HISTORY AND PHYSICAL
SR.1 The H&P must be in the medical record prior to any high-risk procedure, surgery or other procedure requiring anesthesia services.

Wording changes to reflect “qualified licensed practitioner”
Which individuals can perform the H & P if other than Physician Assistant or Advance Practice Nurse in accordance with State Law and scope of practice.
Medication Management (MM)

MM.5 REVIEW OF MEDICATION ORDERS

SR.6 The licensed individual shall follow the pharmacy protocol for identification of the drug removed for verification of the drug by the pharmacist upon next arrival at the facility.

The Pharmacy needs to document and orient staff authorized to enter the Pharmacy after hours.

MM.8 Sterile Compounding Section – Moved to Appendix 2
  − Optional
  − Acceptance by State Board of Pharmacy

SURGICAL SERVICES (SS)

SURGICAL SERVICES (SS)

SS.5 AVAILABLE EQUIPMENT

• SS.5 SR.7 / SR.7a / SR.7b / SR.7c Page 79

Clarification for requirements added SR.7b and SR.7c as well as IG wording

SR.7 Malignant Hyperthermia (MH) rescue materials

SR.7a 36 vials of Dantrolene must be available for all anesthetizing locations within 10 minutes of the decision to treat for MH.

SR.7b Dantrolene must be available for all anesthetizing locations where MH trigger agents are used.

SR.7c Required components to safely administer Dantrolene must be readily accessible

SURGICAL SERVICES (SS) Continued

Interpretive Guidelines

All facilities, including ambulatory surgery centers and offices, where Malignant Hyperthermia (MH) triggering anesthetics (isoflurane, desflurane, sevoflurane, enflurane, halothane and succinylcholine) are administered, should stock a minimum of 36 vials of dantrolene, along with the other drugs and devices necessary to treat an MH reaction. If none of these agents are ever in use in the facility, then dantrolene need not be kept as hand.

It is often not practical to have a large supply of Dantrolene in every area where anesthesia is administered. For example anesthesia administration is now common in locations far from the operating rooms such as interventional radiology suites. Dantrolene must be available within 10 minutes. This new guideline follows the recommendations of the Malignant Hyperthermia Association of the United States (MHAUS).
SURGICAL SERVICES (SS)

SS.8 OPERATIVE REPORT

SR.1 An operative report describing techniques, findings, and tissues removed or altered shall be dictated or documented, and authenticated by the surgeon immediately following surgery.

Anesthesia Services (AS)

AS.2 ADMINISTRATION

SR.4 For CRNAs to be exempt from the CMS supervision requirement, the governor of the State must have received an exemption from CMS for that particular State;

SR.7 If a patient has received epidural analgesia, there will be a physician or other qualified licensed practitioner immediately available to manage any complication for the analgesia or the specific obstetrical condition.

Laboratory Services (LS)

LS.2 POTENTIALLY INFECTIOUS BLOOD AND PRODUCTS

Potentially infectious blood (such as human immunodeficiency virus (HIV) or hepatitis C virus (HCV) and blood products (as identified in 21 CFR 610.47) can come from prior collections from a donor who: tested negative at the time of donation but tests repeatedly reactive for the antibody to the HIV or HCV on a later donation, tests positive on the FDA-licensed, more specific test or other follow up testing recommended or required by FDA, and the timing of seroconversion cannot be precisely estimated.
PATIENT RIGHTS (PR)

Revised this standard to reflect the process regarding advance directive and communication with the patient.

SR.1 The organization will provide written notice of its policies regarding the implementation of patients' rights to make decisions concerning medical care, such as the right to formulate advance directives.

SR.1a The organization shall document in the patient’s medical record whether or not the patient has executed an advance directive for all inpatients, emergency room patients, observation status patients and day surgery patients.

SR.4 The organization shall provide education for staff concerning its policies and procedures regarding the advance directives.

PATIENT RIGHTS (PR) Continued

Added definitions as this pertains to psychiatric patients and clarification to the interpretive guidelines. Although both inpatients and outpatients have the same rights under §482.13(a)(1), §489.102(b)(1) requires that notice of the hospital’s advance directive policy be provided at the time an individual is admitted as an inpatient.

The hospital should also provide the advance directive notice to outpatients (or their representatives) who are in the emergency department, who are in an observation status, or who are undergoing same-day surgery. The notice should be presented at the time of registration. Notice is not required for other outpatients, given that they are unlikely to become incapacitated.

PATIENT RIGHTS (PR)

SR.3 Order for Restraint or Seclusion:

- SR.3a The use of restraint or seclusion must be in accordance with the order of a physician or other qualified licensed practitioner (QLP) who is responsible for the care of the patient as specified under § 482.12(c) and is authorized to order restraint or seclusion by hospital policy in accordance with State law.

- IG A qualified licensed practitioner (QLP) is any individual permitted by State law and hospital policy to order restraints and seclusion for patients independently within the scope of the individual’s license and consistent with the individually granted clinical privileges.
**Medical Record Services (MR)**

**MR.7 REQUIRED DOCUMENTATION**

SR.1 All medical records of inpatients and all outpatient medical records for patients having same day surgery or a procedure requiring anesthesia must contain evidence of a physical examination, including a health history, must be performed no more than thirty (30) days prior to admission or registration or within twenty-four (24) hours after admission.

**DISCHARGE PLANNING (DC)**

**DC.2 DISCHARGE PLANNING EVALUATION**

SR.5 If the results of the discharge evaluation so indicate, or at the request of the patient’s physician, a registered nurse, social worker, or other appropriately qualified personnel shall develop, or supervise the development of, a discharge plan and associated educational materials.

SR.5a The results of the discharge planning evaluations must be discussed with the patient or individual acting on their behalf.

**Appendix 3 – New Standards**

**SAFETY RISK MANAGEMENT (RM)**

The risk management system is established that addresses patient safety as well as other safety risks that may impact on patients, staff or other visitors to the hospital approach to risk assessment is defined with respect to its scope, nature and timing so that suitable methodologies for assessing and recording risks are identified, implemented, and maintained is proactive rather than reactive ensure suitable methodologies for the allocation of actions resulting from risk assessments, including time lines, responsible persons and associated reporting and approval mechanisms are identified, implemented and maintained.

The hospital shall have documented procedures to define record, analyze and learn from incidents that impact safety

- To be surveyed for compliance in January 2015
Final Rule - Promoting Program Efficiency, Transparency, and Burden Reduction; Part II
aka Burden II

§482.12 was revised to remove the requirement that the hospital's governing body must include a member or members of the medical staff, in favor of required consultation.

§482.12(a) was revised to add a new requirement at §482.12(a)(10) for the governing body to consult directly with the individual responsible for the organization and conduct of the hospital’s medical staff, or his/her designee. The consultation is required to be periodic throughout the year and to include discussion of matters related to the quality of medical care provided to the hospital’s patients. For a multi-hospital system using a single governing body, there must be consultation directly with the individual (or designee) responsible for the medical staff in each hospital within its system.

§482.22(a) was revised to indicate that the medical staff must include MDs or DOs, but may also include other categories of physicians listed at §482.12(c)(1), as well non-physician practitioners. A prior rule change inadvertently omitted the reference to other categories of physicians.

§482.22(b) was revised to add new §482.22(b)(4), which permits a hospital which is part of a hospital system consisting of multiple separately certified hospitals to have a unified, integrated medical staff for its member hospitals, in accordance with State law. Each separately certified hospital in a system using a unified, integrated medical staff must demonstrate that:
- The medical staff members holding privileges at each separately certified hospital have voted by majority, in accordance with medical staff bylaws, to accept a unified, integrated medical staff, or to opt out of such a structure and to maintain a separate and distinct medical staff for their respective hospital.
The unified, integrated medical staff has bylaws, rules and requirements describing its processes for self-governance, appointment, credentialing, privileging, oversight, peer review policies and due process rights guarantees. Members of the medical staff at each separately certified hospital must be advised of their right to opt out after a majority vote to maintain a separate and distinct medical staff for their hospitals;

The unified, integrated medical staff is established in a manner that takes into account each member hospital’s unique circumstances and any significant differences in patient populations and services offered in each hospital; and

The unified, integrated medical staff establishes and implements policies and procedures to ensure the needs and concerns expressed by members at each separately certified hospital are given due consideration, and that there are mechanisms to ensure that issues localized to particular hospitals are duly considered and addressed.

Food and dietetic services, §482.28

§482.28 (b)(1) and (2) were revised to permit a qualified dietitian or qualified nutrition professional to order diets if authorized by the medical staff and in accordance with State law governing dietitians and nutrition professionals. This includes therapeutic diet ordering. This means that ordering of diets is no longer restricted to practitioners responsible for the care of the patient.

Nuclear Medicine Services, §482.53

§482.53(b)(1) was revised to remove the requirement for “direct” supervision of in-house preparation of radiopharmaceuticals is by an appropriately trained registered pharmacist or MD/DO. This means it is no longer required that a supervising physician or pharmacist must always be present when radiopharmaceuticals are being prepared.

Outpatient Services, §482.54

A new standard at §482.54(c) was added to the hospital Outpatient Services CoP which codifies current SOM Interpretive Guidelines regarding the ordering of outpatient services. Outpatient services can be ordered by any practitioner responsible for the care of the patient, who is licensed and acting within his or her scope of practice in the State where he or she provides care to the patient; and who has been authorized by the medical staff and approved by the governing body to order specific outpatient services. Applies to members of the medical staff who have been granted privileges to order outpatient services and practitioners not on the medical staff but who are authorized to order outpatient services and refer patients for outpatient services by meeting the criteria listed.
Recent emails from hospitals regarding the surveys.....

“I am so impressed with the DNV philosophy of teaching, celebrating, analyzing, confronting and correcting. I can speak on behalf of our hospital family that we are motivated to do better, embrace the process while we continue to learn and grow. I am confident it will be a strong partnership for each of us with our patients benefiting the most.”

“It was definitely not the easiest survey I have ever been through. But it was definitely the best. All of the surveyors were extremely thorough and were a wealth of information throughout the week. The feedback I received from the staff was overwhelmingly positive and we have already begun to address our corrective actions. We thank you for a great first experience and look forward to the next one. Now there’s something I never said before regarding a survey!”

Patrick Horine, CEO
Patrick.Horine@dnvgl.com
(513) 388-4888