Accreditation, Quality, Risk & Patient Safety
Accreditation

• The Joint Commission (TJC)

• Centers for Medicare & Medicaid Services (CMS)

• Wyoming Department of Health (DOH)
Joint Commission:
- Joint Commission is an independent, voluntary accrediting organization.

Centers for Medicare and Medicaid Services (CMS):
- Federal Organization—Oversees all Medicare participating hospitals
- Deemed status (accreditation) required in order to treat and bill for Medicare/Medicaid patients
- Deemed status granted through Joint Commission
- WY Dept of Health follows all CMS Conditions of Participation (CoP’s)

Surveys:
- Patient tracer methodology
- Last JC survey was August 2014, survey window 18-36 months
- Be prepared for any survey
  - Know how to look up policies
  - Know where to get answers – “I’ll check with my supervisor”
For Quality of Care Concerns

- Patients, families, and staff can contact Joint Commission, CMS, and/or the Department of Health directly.

- CRMC’s Patient Advocates can also assist patients and families with concerns. 633-7768
Quality Improvement

Affordable Care Act (ACA)

Performance Improvement (PI) Plans
• What is the Affordable Care Act:

- IN 2010, The ACA was enacted to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of healthcare for individuals and the government.

- Pay for **Quality** not Quantity
- Value-Based Purchasing (2%)
- Hospital Acquired Condition (HAC) Reduction program (1%)
- Readmission Reduction program (3%)
Value Based Purchasing

FY2017 – 2% of Base DRG

HCAHPS- “Patient Satisfaction” 25%
Outcomes- Mortalities  25% (MI, Heart Failure, PNE)
Safety- hospital acquired conditions & infections 25%
Efficiency- Medicare Spending per beneficiary 25%
Hospital Acquired Condition (HAC) Reduction Program (1% of base DRG)

-HACs are a group of reasonably preventable conditions that patients did not have upon admission to a hospital, but which developed during the hospital stay.

The AHRQ PSI 90 composite measure includes the following eight PSIs:
- PSI 03 - Pressure Ulcer
- PSI 06 - Iatrogenic Pneumothorax
- PSI 07 - Central Venous Catheter-Related Bloodstream Infections
- PSI 08 - Postoperative Hip Fracture
- PSI 12 - Perioperative Pulmonary Embolism or Deep Vein Thrombosis
- PSI 13 - Postoperative Sepsis
- PSI 14 - Postoperative Wound Dehiscence
- PSI 15 - Accidental Puncture or Laceration

Central Line-Associated Blood Stream Infection (CLABSI)
Catheter-Associated Urinary Tract Infection (CAUTI)
Surgical Site Infections (SSI)- Colon and Abdominal Hysterectomy
MRSA Infections
Clostridium Difficile Infections
3% of Medicare Funding is at stake in FY2017 for hospital’s with what CMS determines to be excessive readmissions in the following categories:

- 30 day Readmissions for **Acute Myocardial Infarction**
- 30 day Readmissions for **Heart Failure**
- 30 day Readmissions for **Pneumonia**
- 30 day Readmissions for **Chronic Obstructive Pulmonary Disease**
- 30 day Readmissions for **Total Hip and Knee Arthroplasty**
- 30 day Readmissions for **Coronary Artery Bypass Graft (CABG)**
Core Measures

- Measures developed by the Agency for Healthcare Research and Quality (AHRQ) and approved by CMS and Joint Commission
  - Immunization (flu vaccine)
  - Emergency Department
  - Surgical Care
  - Perinatal Care (elective deliveries)
  - Venous Thromboembolism
  - Inpatient Psychiatric
  - Stroke
  - Sepsis
Why do we care?

- It is what is best for our patients
- Results are publicly reported
- CMS Hospital Compare
  - [http://www.medicare.gov/hospitalcompare/search.html](http://www.medicare.gov/hospitalcompare/search.html)
Performance Improvement (PI) Plans:

- All Departments must participate in Performance Improvement
- Ask your preceptor/manager what the plan is for your area- know your part in the process
- Goal- To continually improve our ability to provide safe and quality care, treatment, and services for our patients.
Patient Rights

How are patient’s informed of their patient rights?

- At the time of admission/registration, each patient/legal representative is offered a copy of Cheyenne Regional’s “Patient Rights Brochure”.
Patient Safety

Patient safety is every employee’s responsibility.
Occurrence Reporting

How do you report something that is out of the ordinary?
- Report any unsafe situations to your supervisor.
- We have an electronic occurrence reporting system called Midas.

What to report in Midas?
- Falls
- Medication Errors
- Missed orders, tests, or treatments
- LWBS, AMA
- HIPAA issues
- Documentation events
ALL STAFF: Health Risk Assessment – Still Not Available

Thank you for being patient with us while the Health Risk Assessment (HRA) is being adjusted. Our partner in wellness, US Corporate Wellness, is using an updated assessment this year and we ran into unexpected problems.

The HRA should be up and running correctly by Friday, October 10, 2014. An email will be sent out next week once the HRA is available.

We are keeping November 14, 2014 as the deadline for the HRA this year, so make sure you go to one of the scheduled blood draws.

ALL STAFF: Lobby Construction Update

The lobby project is going well and on schedule. We are looking forward to our grand opening in December as planned. I wanted to update you on some changes to the floor plans:

...
Occurrence Report (Midas+)

Welcome to the Cheyenne Regional Medical Center page for Occurrence Reporting. Please enter your occurrence within the appropriate form below. If you have questions, please contact Risk Management at 633-6041. If you are entering a staff work-related injury and have questions, please contact Occupational Health at 633-6022.

Admission/Discharge/Transfer Event (A/D/T)
Please use this form to report an admission, discharge, or transfer event.

This type of event can include: an AMA Issue, a Delay in A/D/T, an EMTALA Issue, a Hand-Off Communication Issue, an Inadequate Transfer, Left Without Being Seen, a Maternal/Necrotic Custody Issue, a Refusal, a Transportation Issue, an Unexpected Transfer, an Unscheduled Transfer, or the Wrong Patient.

Documentation/HIPAA/Privacy Event
Please use this form to report a documentation, HIPAA, or privacy event.

This type of event can include: an Advanced Directive Issue, a Disclosure Issue, Inappropriate Use of Patient Information, Incomplete Documentation, Misfiled Documentation, Personal Privacy Issue, a Power of Attorney Issue, or a Risk Assessment Issue.

Equipment Event
Please use this form to report an equipment event

This type of event can include: an Equipment Alarm, Contaminated Equipment, Equipment Failure, Inadequately Checked Equipment, Inappropriately Disconnected Equipment, Inappropriate Disposal of Sharp, Leaking Equipment, Malfunctioning Equipment, Missing Equipment, an Equipment Safety Issue, an Unauthorized Device In Use, Unauthorized Equipment, or User Error.

HIM Deficiencies
HIM ONLY! Please use this form to report HIM deficiencies.

Medication Event
Please use this form to report any medication event

This type of event can include: an Adverse Drug Event or Reaction, an Allergic Drug Administered, a Delayed or Missed Dose/Odcr, Omitted, Unordered; Wrong Dose; Wrong Drug, Wrong Patient, Wrong Route, or Wrong Time.

Other Events
Please use this form to report an event that is not reportable within any other form

This type of event can include: a Patient or Staff Behavior Issue, an Emergency Detainment; a Patient Complaint or Grievance, a Physician Quality of Care Issue; or Missing, Lost, Stolen, or Damaged Property.
National Patient Safety Goals

- Patient identification
- Medication reconciliation
- Reduce infections
- Critical values
- Anticoagulant therapy
- Suicide
- Site marking
- Time out
- *National Patient Safety Goals; listed in the Fast Facts for Survey Readiness book, as well as on the intranet home page under JOINT COMMISSION*
Sentinel Events

A sentinel event is a patient safety event (not primarily related to the natural course of the patient’s illness or underlying condition) that reaches a patient and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm and intervention required to sustain life

An event is also considered sentinel if it is one of the following:
- Suicide of any patient receiving care, treatment, or services in a staffed around-the-clock care setting or within 72 hours of DC, including from the hospital’s ED
- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, and services
- Rape, assault, or homicide of a patient or staff member while on hospital grounds

What happens if a sentinel event does occur?
A Root Cause Analysis (RCA) is performed to determine if any system or process issues need to be changed.
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*Other includes: Unexpected Additional Care/Extended Care, and Psychological Impact

The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore these data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.
A Florida Teen Impersonated a Doctor for a Whole Month

"I am really getting old because these young doctors look younger every year," one physician thought.

A teenager in Florida managed to fool an entire medical center into thinking he was a doctor for a whole month before he was found out.

The teen wore a white coat that read “Anesthesiology” on the back as he walked through the corridors of St. Mary’s Medical Center in Palm Beach, KCTV 5 News reports.

“He presented himself with a patient of our practice and introduced himself as Dr. Robinson,” Dr. Sebastian Kent said. “The first thing I thought was, ‘I am really getting old because these young doctors look younger every year.’”

The teen was discovered after being caught in an examination room with a patient while wearing a mask and a stethoscope.

His mother told police he had an undisclosed illness and had not been taking his medication. Both police and the hospital decided not file charges.
Johns Hopkins Malpractice Study: Surgical ‘Never Events’ Occur At Least 4,000 Times per Year

Researchers advocate public reporting of mistakes

Release Date: December 19, 2012

After a cautious and rigorous analysis of national malpractice claims, Johns Hopkins patient safety researchers estimate that a surgeon in the United States leaves a foreign object such as a sponge or a towel inside a patient’s body after an operation 39 times a week, performs the wrong procedure on a patient 20 times a week and operates on the wrong body site 20 times a week.

The researchers, reporting online in the journal Surgery, say they estimate that 80,000 of these so-called "never events" occurred in American hospitals between 1990 and 2010 - and believe their estimates are likely on the low side.
Malpractice Insurance

- Risk Services coordinates the insurance for the hospital-malpractice, auto, property, etc.

- You will be covered under the CRMC malpractice umbrella as long as you are practicing within your scope of practice.

- Questions??? Call Roxanne @ 6039