



Medical Staff Newsline

DHS Clarifies CALS Medical Staff Survey Expectations

Surveyors for the Institute for Medical Quality (IMQ) now have a clearer idea of what to look for regarding compliance with Title 22 during the CALS survey. Mindel D. Spiegel, MD, Los Angeles regional consultant to the Department of Health Services (DHS) for healthcare facilities, emphasized four important areas hospitals must be aware of during her presentation at the annual IMQ workshop on Jan. 19, 2001.

These areas overlap the JCAHO's medical staff standards, but the licensure expectations are more specific in some areas. Always insightful, and projecting her strong views as a patient advocate, Dr. Spiegel charged the surveyors to interpret DHS requirements from the standpoint of their enhancement of patient safety. In addition, because hospitals have a growing concern regarding federal and state compliance, Spiegel told IMQ surveyors to look for those areas of the HCFA Conditions of Participation reflected in Title 22 requirements.

- **Reporting sentinel events to DHS.** Whether a facility chooses to report a sentinel event to the JCAHO, DHS expects it will be promptly reported as an "unusual occurrence" as specified in 70737 (a). Because a sentinel event usually represents major injury to a patient, or the risk thereof, as a result of the failure of a system or process that might adversely affect the health or safety of future patients, personnel or visitors, the local health officer will expect to be informed. In preparation for the almost inevitable DHS

visit to follow such a report, the facility should have conducted a prompt, thorough root/cause analysis and developed and implemented a credible, corrective action plan. DHS surveyors have always emphasized that the best action an institution can take in mitigation of an unusual occurrence or sentinel event is to demonstrate its strong commitment to prevent the next one. During the CALS survey, surveyors may ask if any adverse events have been reported to DHS and to view the paperwork that describes the response.

- **Quality assurance/performance improvement expectations.** Whereas the JCAHO often has flirted with the concept that only a few indicators can reflect the totality of the institution's quality efforts, DHS has always expected that the "full scope of practice" will be covered. It is not necessary to review every service all of the time, but all services—including those provided by outside contractors—must be assessed in a systematic way and reported to the medical executive committee and governing board. Surveyors will look for clinically valid indicators that focus on outcomes or key process elements, rather than relatively insignificant documentation or peripheral components. If a medical staff or hospital chooses to perform an intensive review as part of quality improvement, it should be able to support the choice by demonstrating relevance to its service or mission.

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Medical Staff: Write the Record Like It Counts — It Does

Documenting in the medical record is the stepchild of the clinical encounter. Despite the obvious relationship between reimbursement and chart entry (simply put, if it wasn't written, it didn't happen and therefore won't be paid for), physicians continue to write notes to fill a page rather than convey information.

Despite the findings of the Institute for Safe Medication Practices showing that medication errors are directly traceable to illegible handwriting, practitioners' penmanship assumes an unwarranted level of clairvoyance on the part of the nurse and pharmacist in divining the prescriber's intent.

Much of this rampant illegibility is attributed to the demands for haste imposed by managed care. Granted, time is short in the current healthcare delivery model; however, skimping on documentation is not the answer. Physicians decry phone calls from nurses or pharmacists who can't make out the writing or understand why a given order is appropriate in the face of a poorly articulated or incoherent treatment plan.

For many emergency physicians, dictation of the ER exam note is the substitute. Unfortunately, in many institutions, the result is the admission of a patient to a critical care unit without the

description of the initial findings to guide the nurse or intensivist for as long as it takes for the note to be transcribed and reach the floor. In some facilities, that may be 24 hours. A brief note by the ER doctor describing the location of the rales or the nature of the pain would go a long way toward facilitating the evaluation of the patient's progress during the first few critical hours.

Perhaps the most disturbing example is the result of the shift to AM admission for serious surgery under general anesthesia. Some facilities allow such patients to proceed to the operating

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- **Physician performance evaluations.** Physicians must be proctored according to the medical staff requirements, which may be service specific. The cases proctored must be among the first few performed by the practitioner. Before proctoring requirements are removed, a sample of procedures representing the scope and complexity of privileges granted should be evaluated. Adverse proctoring reports must be flagged immediately and the medical staff must respond to them in a meaningful way, consistent with the nature of the problem identified. Individual physician performance must be reviewed at least every two years. Reviews must be based on measures that are reasonably reflective of the full scope of privileges exercised or requested, as cited in 70701 (a) (7). Some components of an acceptable physician profile include volume data, resource use, comparison with peers, reviews of specific adverse events, mandated medical staff monitors, evaluations by

patients and colleagues, third party complaints or sanctions. Even if the medical staff has to withhold reappointment because documentation isn't in or committees have not met, the reappraisal of the physician must be documented by the department chair or appropriate medical staff committee within the two-year cycle.

- **Compliance with restraint policies and regulations.** Surveyors will look for evidence that the facility has implemented a meaningful program to reduce restraint use. Emergency need for restraints must be the occasion for a prompt (in one hour) physical and mental reassessment of the patient to be sure the observed behavior is not due to a serious medical cause such as hypoxia, high fever, hypoglycemia, sepsis or stroke. Requirements for reevaluation of the restrained patient must be consistent with the organization's policies, usually per time limitations of the JCAHO. Review JCAHO standards TX.7.1 to 7.1.16 and the *HCEA Hospital Interpretive Guidelines - Patients' Rights* for a full discussion.

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room with the *pro forma* short form H and P that characterizes the pre-assessment for outpatient endoscopy. In some hands, even these get abbreviated unacceptably. A patient who receives a general anesthetic for a major procedure is at risk for multi-system complications that call for a well-delineated pre-procedure baseline picture for adequate management.

The absence of an adequate preoperative H and P, consistent with the risk of the surgery and anesthesia, creates an unacceptable risk to patient safety and an indefensible situation at the time of liability or regulatory review.

Recognizing the above, the JCAHO has incorporated legibility in its expectations for medical staff record review. Institutions with errors or adverse events attributable to poor communication

resulting from inadequate medical records will be expected to show effective corrective action plans and improvement. In doing so, the JCAHO will follow the lead of state and federal agencies, including the Office of the Inspector General which, along with other elements, will look at the record for evidence that attendings supervise house staff and bill appropriately.

Write it like it counts. It does.



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