

## Meet C&A at the NAHQ Annual Conference!

Meet C&A at Booth #216 in the Exhibit Hall at the NAHQ Annual Conference in Kansas City: Sept. 30 - Oct. 2, 2010, to learn about C&A and register for your chance to win an iPod or an educational TJC & CMS Webinar Series subscription!

Contact C&A for more information: Phone (704) 573-4535 or [www.courtemanche-assocs.com](http://www.courtemanche-assocs.com).

## Congratulations Bellevue Medical Center!

Bellevue Medical Center, Nebraska, recently received Honorable Mention in Modern Healthcare's Design Awards!

[Click here](#) to read more about this award and see pictures of their beautiful new facility.

## Were You Aware?

- Some changes to the TJC accreditation decision categories have been made for 2011:
  - The Provisional Accreditation category will be eliminated
  - To eliminate the confusion between TJC's Conditional Accreditation decision category and the term Condition-Level findings related to CMS requirements, Conditional Accreditation will be eliminated and the following categories implemented:
    - Accredited with Follow-Up Survey
      - Requires follow-up survey (either related to a TJC requirement OR because a CMS Condition-Level deficiency was identified)
      - Between 30 days – six months
      - Example: first failed Condition-Level deficiency
    - Contingent Accreditation
      - Requires follow-up survey within 30 days
      - Example: Second failed Condition-Level deficiency survey
  - Preliminary Accreditation, Accreditation with or without Requirements for Improvement, Preliminary Denial of Accreditation and Denial of Accreditation categories will remain unchanged
  - [Click here](#) to see an example of an organization with Condition-Level findings and look for a future edition of *C&A News* for more information and guidance on these accreditation decision categories and the follow-up survey process.
- CMS requires that accrediting organizations review the greater of 30 medical records or 10% of the hospital's average daily census. For some smaller hospitals this means the survey includes closed medical record review.
- Additionally, CMS requires that when a Condition-Level finding is identified during survey, that a Requirement for Improvement (RFI) also be made in the Leadership standards to address governing body oversight.
- There has been an increase in RFIs under PC.01.02.03 related to histories and physicals. This is partly attributable to the CMS requirement that the H&P update note **MUST** include the following: the H&P was reviewed, the patient was *examined again and either note no changes or document any changes*. Organizations are encouraged to review policies, procedures and forms related to the H&P update and assure that LIPs understand the importance of these documentation requirements.

## Celebrate National Healthcare Quality Week!

### Save the Date for C&A's 2011 Annual Conference!

**C&A's 2011  
Annual Conference  
will be in St. Louis,  
MO Wednesday,  
May 11 - Friday,  
May 13 at the  
Hyatt Regency St.  
Louis Riverfront.**

Stay tuned to the  
C&A newsletter for  
more information.  
Specific topics and  
registration will be  
available soon.

It's time to celebrate our quality professionals! We all play a role in patient safety and that certainly holds true for the quality department. They are the ones who "crunch all the numbers" and run all the reports that show us how we compare to our benchmarks, which in turn, helps us to provide quality patient care. During the week of October 17-23, 2010 show them you appreciate what they do and recognize their work by celebrating National Healthcare Quality Week.

According to the Agency for Healthcare Research & Quality (AHRQ), research has shown that science-based measures can be used to assess quality. The following elements should be incorporated into creating quality healthcare:

- Do the right thing
- Perform at the right time
- Do it in the right way
  - Follow all regulatory and accrediting guidelines
- Achieve the best possible results

Providing quality healthcare also means striking the right balance among all of the elements below:

- Avoid underuse
- Avoid overuse
- Eliminate misuse

Here are some ways that you can celebrate and recognize the work of the quality department in your organization:

- Design a poster contest to increase awareness of what the quality department does and how it impacts patient care
- Present an award to a member of the quality department
- Provide a quality luncheon for the entire quality team
- Display graphs demonstrating how you have improved/sustained initiatives related to quality patient care
- Develop your own logo/slogan for National Healthcare Quality Week
  - Involve staff – have a contest
- Print an article in your organization's newsletter
  - Add a picture of the quality department
- Encourage departments/units to write thank you notes to the quality department and/or members of the quality department
- Create activities that promote a greater understanding of the role and impact of healthcare quality professionals, adapting the messages to your organization's needs
- Use publicity to promote National Healthcare Quality Week activities
- Engage patients and visitors in activities
- Involve senior leadership, including the medical staff
  - Present an award
  - Attend the luncheon
  - Thank each staff member personally
- Decorate your organization
  - Hang banners outside and inside the hospital
  - Display messages on screen savers celebrating the work of the quality department
- Download the 2010 HQW logo and use it on table tent cards, t-shirts, tray liners, and other items

Visit the National Association for Healthcare Quality (NAHQ) website at <http://www.nahq.org/hqw/> for a host of resources and materials which can be adapted to meet the needs of your organization.

Most important, have fun, celebrate and recognize your quality department and keep your focus on quality healthcare always.

References:

Agency for Healthcare Research and Quality (2010). [www.ahrq.gov](http://www.ahrq.gov).  
National Association for Healthcare Quality (2010). [www.nahq.org](http://www.nahq.org).



## First and Last Impressions - How to Make the Best of Both

**By: Sharon Dills, MSN, RN**

We have all heard the phrase, “make a good first impression because it is the one that people will remember”. While that may be true, The Joint Commission (TJC) has given us the opportunity to also make a good last impression during the opening and leadership sessions of your accreditation survey. Many times, organizations do not understand the importance of both of these sessions and how they can affect your survey.

An organization should always be prepared for TJC to walk through the door. TJC provides a list of performance improvement (PI) data and documents they will want to review immediately. This information can be found in the Survey Activity Guide (SAG). Other elements that organizations should have data on are the elements in PI.01.01.01. It is recommended that you keep all of this data in a notebook and on a rolling 12 month basis. Depending on the size of your organization and the number of surveyors, you may want to have more than one book available for surveyors to review. Remember to analyze and use the data that is collected. Many organizations collect data – lots of data - but fall short when it comes to talking about and demonstrating how they analyze the data for patient safety improvements. All of the required documents and performance improvement data should be readily available and organized; this will make a very good first impression.

The opening session and orientation to the organization is leadership’s first opportunity to demonstrate their involvement in regulatory issues and more importantly, patient safety. There is no need to prepare a power point or presentation for this session. Leadership, however, may want to have a presentation or notes for their use during this session. The opening session and orientation to the organization will occur on the first day early in the morning. This session typically lasts about one hour. During this session, the surveyors get to know you and your

organization.

The leadership session typically occurs the morning of the last day of survey and also lasts approximately one hour. The surveyors have had an opportunity to perform several system and patient tracers, interview staff and patients and conduct a review of the environment. During this session, the surveyors will discuss anything they perceive to be a system issue – something that is found throughout the organization. The topics that are discussed during this session should not be a surprise. Listen carefully during the surveyor's briefing sessions and review scribe notes for issues that appear repeatedly. The leadership session is your last chance to clear up any misconceptions the surveyors may have regarding an accreditation issue.

An organization can and should prepare for both of these sessions. At a minimum, the organization should practice each of these sessions on a quarterly basis. Don't forget to prepare your board members and medical staff leaders. Ensure that all necessary players are at the table. For both sessions, consider who will be a "back-up" for each member if someone is not available. The team should be represented by senior leadership, medical staff, a board member and others who may be able to address the questions posed by the surveyors. Make sure that those present are familiar with and can speak to the following:

- How you create a culture of safety
- Clinical Service Groups (CSGs)
- Priority Focus Areas (PFAs)
- How staff is held accountable
- How you know patients receive quality care

In addition, each person should be familiar with TJC's leadership pillars. The five pillars are planning, data use, changing performance, staffing and communication. Integrate CSG, PFA and the TJC leadership pillars when answering questions about your organization. These are good items to include on your preparation notes.

Another good idea is to think about the top three patient safety initiatives you have achieved and sustained in your organization. Include each of these on your notes and a few minor details about each success. It is also important to think globally when answering surveyor questions and then get in to the grass roots. For example, the surveyor may ask you to talk about how you decide what data to collect and how you use it to make improvements for patient safety. It would be good to begin talking globally about leadership's performance improvement initiatives and then let others interject how those goals are met at the unit level.

Survey time can be a stressful time but you can take a lot of the stress out of the survey by always being prepared. An organization can never do too many tracers or too much practicing for the sessions. Remember . . . practice makes perfect. If you are interested in learning more about how to have a successful survey, please contact us at [info@courtemanche-assocs.com](mailto:info@courtemanche-assocs.com) or call us at 704-573-4535.