

MEMORANDUM

To: Board of Regents
From: Board Office
Subject: Re-accreditation of the University of Iowa Hospitals and Clinics
Date: September 9, 2002

Recommended Action: Receive the report.

Executive Summary: On June 27, 2002, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) informed the University of Iowa Hospitals and Clinics (UIHC) of its full re-accreditation.

Specifically, JCAHO indicated that 13 "Type I" recommendations noted in its November 7, 2001 report had been responded to by UIHC in an effective manner. (Type I recommendations are placed on an accreditation status for partial compliance, minimal compliance, or no compliance with JCAHO Standards and require a written progress report within six months from notification of such recommendations.) The analysis section of this report contains examples of the JCAHO Type I recommendations and the actions/implementations made by UIHC based on those recommendations.

The re-accreditation is effective for three years from October 27, 2001, for all services surveyed using appropriate standards from the *Comprehensive Accreditation Manual for Behavioral Health Care* and the *Comprehensive Accreditation Manual for Hospitals*.

Link to Strategic Plan: This report addresses the following Key Result Areas (KRA) in the Board's Strategic Plan:

KRA 1.0.0.0	Become the best public education enterprise in the United States.
Action Step 1.1.3.2	Report data in the relevant governance reports and presentations to the Board.
KRA 4.0.0.0	Meet the objectives of the Board and institutional strategic plans and provide effective stewardship of the institutions' state, federal, and private resources.

Background:

Type I
Recom-
mendations

Although JCAHO granted re-accreditation to the UIHC in November 2001, it identified a number of "Type I" recommendations and requested a written progress report. (Type I recommendations are placed on an accreditation status for partial compliance, minimal compliance, or no compliance with JCAHO Standards and require a written progress report within six months from notification of such recommendations.) In June 2002, JCAHO indicated that compliance was reached in all areas. The following table details the original ranking in the November 2001 (11/01) report and the final ranking in June 2002 (6/02). See pages 3-6 for a description of the JCAHO Type I recommendations and UIHC's actions/implementations (as of May 2002) to address those recommendations.

Hospital Accreditation Services			
Service Area	Patient-Focused Functions	11/01	6/02
Patient Rights & Org. Ethics	Patient Rights	3	1
Assessment of Patients	Initial Assessment	3	1
Assessment of Patients	Additional Requirements for Specific Patient Populations	3	1
Care of Patients	Planning and Providing Care	3	1
Care of Patients	Operative and Other Procedures	3	1
Care of Patients	Special Procedures	3	1
Organizational Functions			
Leadership	Planning	3	1
Management of Human Resources	Human Resources Planning	3	
Management of Human Resources	Assessing Competence	4	1
Management of Information	Patient-Specific Data and Information	3	1
Structures with Functions			
Medical Staff	Credentialing	5	1
Key: 1 = Substantial Compliance 3 = Partial Compliance 5 = No Compliance 2 = Significant Compliance 4 = Minimal Compliance N = Not Applicable			

Behavioral Health Accreditation Services			
Service Area	Resident-Focused Functions	11/01	6/02
Care	Treatment Planning	3	1
Organizational Functions			
Management of Human Resources	Qualifications, Competencies, and Clinical Responsibilities	3	1
Key: 1 = Substantial Compliance 3 = Partial Compliance 5 = No Compliance 2 = Significant Compliance 4 = Minimal Compliance N = Not Applicable			

Value of
Accreditation

The accreditation of colleges is of major importance. It signifies that an appropriate professional organization, recognized by the U.S. Department of Education, has judged that the programs of the college have met its standards.

Application for
Survey

The UIHC submitted an *Application for Survey* to the JCAHO prior to its most recent visit in October 2001. This document is submitted by all hospitals to the JCAHO to begin the accreditation process. It provides a profile of the hospital, including its ownership, demographics, and types and volumes of services provided.

Comparison with Self-Studies A formal "Self-Study" is not part of the JCAHO survey process. The UIHC does conduct multiple reviews, makes program assessments, and evaluates its compliance with all JCAHO Standards, but the reporting format is not similar to the more traditional academic self-studies.

Analysis: The following are summaries of the JCAHO Type I recommendations, along with brief descriptions of actions taken by UIHC staff as of May 2002. The JCAHO Standards are listed in parentheses.

Recommendations

**Hospital Accreditation Services
Patient-Focused Functions**

Patient Rights Documentation of advance directives was not always available in patient medical records. Not all directives had been reviewed with patients and their families. (RI.1.2.5; TX.7.1.3)

Implementation of Recommendation *A new Advance Directives form has been developed and implemented to provide a stand-alone means for capturing information and to improve communication between members of the health care team on patient advance directives. A new pre-surgical information packet has been developed which includes a reminder for patients to provide a copy of any executive advance directives.*

A policy has been developed by the SUI Behavioral Health leadership team outlining the specific process by which staff assess the existence of advance directives for behavioral health patients.

Initial Assessment Patients are to be screened within 24 hours by nursing staff using criteria on the Adult Admission Assessment Record. Some nutritional screening procedures are not being followed. Behavioral Child and Adolescent records reviewed did not show a nutritional screen for the determination of risk. (PE.1.2) There is a need to have current and updated patient histories and medical records. (PE.1.8)

Implementation of Recommendation *A new screening form has been developed with specific criteria that clearly designate and prioritize high-risk patients requiring dietetic consultation. The form and process will be adopted house-wide in June.*

The UIHC pre-surgical evaluation process on the day of surgery requires the presence of a current history and physical (H & P), patient consent for surgery, confirmation of appropriate site of surgery and other important items prior to initiation of the surgical procedure. The same process has been adopted in the Center for Digestive Diseases for all procedures including gastroenterology endoscopy procedures.

The UIHC's Procedural Sedation Assessment and Monitoring form has been revised to confirm the presence of a current H & P.

Additional Requirements for Specific Patient Populations.	Documentation of impact of certain data (e.g., spiritual orientation) was minimal. Documentation of its utilization in treatment planning and record of progress is needed. (PE.7)
<i>Implementation of Recommendation</i>	<i>A revised bio-psychosocial assessment process and form that captures additional information on patient spirituality was implemented in February.</i>
Planning and Providing Care	Need for better documentation of treatment plans and results of treatment (based on a sample review of Behavioral Health Unit records). Some medical/surgical units used the care pathways to demonstrate the care planning process. For patients who do not have a care pathway evident, the multidisciplinary and collaborative care planning process should be improved. (TX.1)
<i>Implementation of Recommendation</i>	<i>A new management team has assumed responsibility for the new partial hospitalization and intensive outpatient chemical dependency programs. These leaders will train staff to be specific in documenting identified problems and interventions. Further, treatment plan reviews are completed at appropriate intervals. The SUI Behavioral Health leadership team is revising the overall treatment planning process for all Behavioral Health Services. Pilot projects have been implemented and audited.</i>
Operative and Other Procedures	Records need to show evidence of consent form, indicating the need for and risk of blood transfusion, with available alternatives, and that there was a discussion with patient and/or family before the procedure. (TX.5.2.2).
<i>Implementation of Recommendation</i>	<i>The Transfusion Subcommittee has revised its policy regarding informed consent for blood transfusions. The new procedure requires completion of a modified form used to obtain informed consent for elective blood transfusions. The Transfusion Subcommittee will audit this information and report quarterly on individual physician compliance.</i>
Special Procedures	A physician or other licensed independent practitioner must evaluate a patient within one hour of the initiation of restraint or seclusion, as required by HCFA's Interim Final Rule for Patient Rights. (TX.7.1.6) Other documentation is needed for restraints needed after time-limited orders of two hours, four hours, or eight hours, as well as notification of appropriate clinical leadership. (TX.7.1.7; TX.7.1.8; TX.7.1.9)
<i>Implementation of Recommendation</i>	<i>A new medical record sticker system has been developed and implemented. The sticker provides a detailed outline of the process for ordering restraint and seclusion and ensures documentation of all necessary evaluations.</i>

Hospital Accreditation Services Organizational Functions

Planning	Evidence of a comprehensive "Plan of Care" for the provision of patient care services was lacking, including all patient care services and departments in all settings of care. (L.D.1.3)
<i>Implementation of Recommendation</i>	<i>A new comprehensive Plan of Care has been developed which includes department-specific information regarding staffing, skill mix, processes for acting on staff variances and plans for improving quality of care.</i>
Human Resources Planning	Clarification is needed on "on-call" procedures for dietitians on weekends and speech therapists, as well as clarification on variances between actual and targeted staffing levels. (HR.2)
<i>Implementation of Recommendation</i>	<i>A new nutrition assessment form is being utilized to identify patients who require assessment on weekends. The Speech Pathology service implemented an on-call schedule in April to ensure availability of services on weekends and holidays.</i> <i>A process for recording staffing activity and documenting variances from planning staffing to actual staffing has been developed and piloted in several units.</i>
Assessing Competence	In a sampling of personnel files, some performance appraisals were not recorded as completed within the time frame established by the organization. (HR.5) The timely completion record is 98.57%.
<i>Implementation of Recommendation</i>	<i>Information on specific departmental compliance is provided in monthly reports to UIHC Management Staff and the University Hospital Advisory Committee. UIHC Senior Leadership is closely monitoring departmental performance. The institutional completion rate for performance appraisals is now 98.8%.</i>
Patient-Specific Data & Information	Some verbal orders in a sample of open records were not signed in the appropriate time period, as required by Hospital policy and Iowa law. (IM.7.7)
<i>Implementation of Recommendation</i>	<i>SUI Hospitals and Clinics' prescribers, nurses, pharmacists, and other staff have received a broadcast message regarding the requirements for verbal orders. Clinical department heads have been briefed on these requirements at a meeting of the University Hospital Advisory Committee.</i>

**Hospital Accreditation Services
Structures with Functions**

Credentialing The UIHC Bylaws do not include the requirement for medical staff members to acknowledge their responsibility to provide for continuous care for their patients. (MS.5.10.2)

Implementation of Recommendation *The Bylaws and all initial and reappointment forms have been amended to include the continuous care pledge.*

**Behavioral Health Accreditation Services
Resident-Focused Functions**

Treatment Planning In some closed and open clinical records that were reviewed, individualized transfer/discharge/termination criteria were not consistently documented. Also, criteria tailored to individual clients and related to clinical/behavioral manifestations/target symptoms varied in specificity throughout behavioral programs. (TX.1.9)

Implementation of Recommendation *The documentation process has been revised in all applicable Behavioral Health programs to reflect patient discharge criteria. All affected forms have been modified to incorporate these changes.*

**Behavioral Health Accreditation Services
Organization Functions**

Qualifications, Competencies, and Clinical Responsibilities Some performance expectations/performance standards in personnel records were formulated in general and non-specific terms, making assessment of competence in an objective manner more difficult. Comments by supervisory staff varied in specificity as well. (HR.4)

Implementation of Recommendation *Supervisory staff have been trained in the completion of performance evaluations to include specific narratives that supports the evaluation process.*

Copy of Materials A complete copy of the materials on this accreditation action, including the Application for Survey, on-site visiting team report, institutional response, and letter of formal notification of accreditation is on file in the Board Office.


Charles R. Kniker

Approved: 
Gregory S. Nichols