A New Hospital Accrider: What are the Implications for Chaplains?

by Terry Ruth Culbertson BCC

"Simply better accreditation." This tagline represents the philosophy and intent of the latest agency granted "deeming authority" for accrediting hospitals on September 26, 2008 by the United States Centers for Medicare and Medicaid (CMS). DNV, or Det Norske Veritas, is a global, independent, tax-paying foundation established in 1864 in Oslo, Norway that has been operating since 1898 in the U.A. It has 9,000 employees working in 300 worldwide offices in 100 countries. The other current accreditating agencies for hospitals include the American Osteopathic Association/Healthcare Facilities Accreditation Program (AOA/HFAP), the Center for Improvement in Healthcare Quality (CIHQ) and, of course, the Joint Commission.

DNV has already enrolled over 300 hospitals. This brief article is to inform APC members of this development and share the work of a designated task force under the APC Commission on Quality in Chaplaincy Care. Task force members include Bob Kidd, Lerrill White, David Plummer and Terry Culbertson. Each of us has worked, or is working in, a facility accredited by DNV.

There are a number of significant differences between a DNV accreditation and that of other agencies. First, a site survey team visits yearly rather than every three years like the Joint Commission. Task force members made several positive comments about DNV's focus on continual improvement and the power of constant readiness vs. "hurry up and get ready." Part of the DNV accreditation process is a quality management system (QMS) called "ISO 9001" that focuses on consistency, customer satisfaction and systematic quality improvement. Compliance with the ISO 9001 standard must occur within three years after the initial deemed National Integrated Accreditation for Healthcare Organizations (NIAHO) accreditation. DNV appears more interested in processes rather than just content. Patient safety issues and outcomes are a primary focus. DNV seeks to empower a hospital to do its own problem solving. These are some of the positive experiences of chaplains going through DNV accreditation.

The task force reviewed the NIAHO Interpretive Guidelines and Surveyor Guidance, version 10.1, effective November 1, 2012. These guidelines are based upon the CMS Conditions of Participation for Hospitals 422 C.F.R. 482 and State Operations Manual Regulations and Interpretive Guidelines for Hospitals. The importance of having a strong quality management methodology, practice and related policies is an essential part of a QM plan. The essentials of ISO 9001 are (1) to provide a consistent product or service, (2) Improve patient/customer satisfaction and (3) continually improve the organization. Although chaplaincy and spiritual care are not referenced in any of the current DNV survey materials, we noted several places where chaplaincy care departments could begin to advocate for inclusion and integration into the overall accreditation process.

For example, in establishing the QMS, the organization is required to have an interdisciplinary group to oversee this system with representation from every department from administration to nursing, including ancillary services. This might be one place chaplains could advocate to be part of (QM.6). QM.7 calls for the evaluation of all organized services and processes, both direct and supportive, including services provided by any contracted service. This includes the use of internal reviews (audits) of each department or service at scheduled intervals. SR. 11 Customer Satisfaction, both clinical and support areas, is the one function that probably most pertains to chaplaincy. All departments and services are to be included, so here is another opportunity to make sure chaplaincy care is included.

Nursing Services includes Assessment and Plan of Care (SR,1.2.3) which must be kept current for each patient and completed within 24 hours of admission. It should reflect the findings of a completed nursing assessment and input of other disciplines, "as appropriate." Interpretive guidelines state that "if interdisciplinary findings are indicated, these shall also be a part of the plan of care and documented in the medical record." Chaplaincy care could advocate for inclusion in the SR.2a list of what must be included in this nursing assessment.

DNV Accreditation requirements define qualifications, reliability and accountability of the CEO, medical staff, governing body and nursing services. It is under Staffing Management (SM) SM.1-7 where chaplains and chaplaincy care departments should document compliance. The organization must have a policy and practice for outlining and verifying that each staff member possesses a valid and current license or certification, as required by the organization and federal and state law (SM.1). It is here that chaplains could advocate for their organizations to require board certification or eligibility as the standard of our chaplaincy practice. We must create clear scope of services and job responsibilities (SM5) and orientation (SM.6) to delineate the different functions of BCC chaplains, contract staff, students and any volunteers serving in our departments (SM.2, 3). Determining and modifying staffing (SM.4), requires a method that links staffing with
patient and process outcomes. This could be another place to justify additional staffing in relationship with untoward patient events or process failures. The section SM.7 on staff evaluations states that we shall be evaluated initially on hire and then on an ongoing basis against indicators that measure issues and opportunities for improvement. We could utilize the common core standards for acute care chaplaincy that relate to BCC competencies on a continuum to assess chaplaincy staff. Under this section, each staff (including contract) must participate in professional education as required by individual licensure/certification, professional association, law or regulation, or organization policy. This is a great opportunity to be supported in our required annual 50 continuing education hours and quinquennial peer reviews.

Some additional sections of the DNV accreditation requirements could also pertain to chaplaincy and spiritual care. Rehabilitation Services (RS) provided in a manner that ensures the patient's health and safety could potentially include spiritual care through a "qualified and licensed practitioner" (RS.3, SR.1). The Emergency Department (ED) must be integrated with the other departments of the hospital and accessible in the delivery of emergency care for patients according to the interpretive guidelines. These guidelines also suggest that the hospital "must staff the ED with the appropriate numbers of types of professionals and other staff who posses the skills, education, certifications, specialized training and experience in emergency care when emergency services are provided." Dietary Services (DS) as outlined in DS.2 must provide menus/diets that meet the needs of patients. Chaplains could serve as consultants, especially regarding issues related to the religious diets requiring kashrut, hallal and vegetarian foods. Curiously, DNV's accreditation requirements for Patient Rights (PR) only mention religion in respect to patient visitation rights (PR.1, SR.12 (d)). This could be a clear place of advocacy to pursue.

The section on Medical Records Service (MR) requires our organizations to have a process for completion, filing and retrieval of the medical record, including time frames. Record content (MR.5, SR.1c and MR.7, SR.3) describing the patient's progress, and response to medications and services would be a place where we can demonstrate careful and clinical pastoral documentation of our assessment, interventions and outcomes. We could be proactive in our involvement in Discharge Planning (DC) by weighing in on the discharge planning evaluation regarding our knowledge of community resources to meet post-discharge clinical and social needs (DC.2, SR.1a). Even the Physical Environment (PE) section could be utilized to support chaplaincy care, as the hospital is required to maintain adequate facilities for its services, including equipment, location and complexity related to the services offered (PE.1.SR.2). I couldn't help but think about chapel accessibility and inclusivity here. Under this requirement is the Emergency Management System (PE.7). I imagine many of us are already part of a comprehensive EMS to respond to emergencies in the organization or within the community and region that may impact the organization's ability to provide services.

Finally, Organ, Tissue and Eye Procurement (TO) is an accreditation requirement in which all chaplains should be involved. For example, we have established that opening a potential donor case would result in an automatic trigger for referral for chaplaincy care. This requirement also specifies in TO.4 Respect for Patient Rights that the organ donor process shall demonstrate the respect for individual patient and family rights "that reflect their views, religious beliefs and other specific circumstances that have been communicated by the patient and/or family to the organization personnel." We would also sit on the Organ Donor Council that reviews cases.

There is potential to impact DNV's regulatory focus to broaden and include chaplaincy care. Notably missing in current DNV requirements is any mention of palliative care, end-of-life care and bereavement care – major parts of any hospital chaplain's role. It is our hope that we have begun to encourage both your awareness and involvement in impacting DNV to truly live up to its philosophy of transformative process and teamwork with our discipline.

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