2025 Patient Care Assessment (PCA) Plan Worksheet

Please ensure that each area is addressed in your plan. Many facilities include their Quality Assurance Performance Improvement (QAPI) Plans as PCA Plans. This is an excellent way to provide information regarding your organizations' quality assurance processes and initiatives. However, please also be certain that the plan also includes all the required element of a PCA Plan as noted below.

If your plan states "see attached policy/protocol", the policy/protocol needs to be included in your plan.

Please ensure that your PCA plan is representative of actual PCA activities at your organization.

Element:	Regs 243 CMR
1.Facility Bylaws: The facility and medical staff bylaws must either authorize all the elements from the regulations, *243 CMR 3.00 et seq,* or contain a general statement as follows: *"The hospital shall establish and maintain a qualified Patient Care Assessment Program that complies with the requirements of 243 CMR 3.00 et seq. and that has been approved by the Massachusetts Board of Registration in Medicine. Said bylaws specifically incorporate those provisions of the hospital's Patient Care Assessment Plan, as from time to time amended, which, pursuant to 243 CMR 3.00 et seq., must be established by or described in these bylaws."* **Please include this statement and/or include the bylaws.**	3.07(1)(3), 3.09(1), 3.11(1)
2. Governing Body Responsibility: The Governing body shall be responsible for the organization and functioning of each PCA Committee and ensure the adequacy of resources and support for the PCA Program. **Please include this statement and brief explanation regarding these activities.**	3.03(1)(a)
3. Patient Care Assessment Committee: A medical peer review committee, as defined by 243 CMR 3.02, and consistent with M.G.L. c. 111, §§ 1 and 204, that is created by the bylaws at the governing body level of a health care organization. **Describe your patient care assessment committee membership. The committee must include at least one member from the governing body of the hospital/clinic. Please include roles of members (for example: CMO, Medical Director, CNO, Chair of Board Quality Committee, etc.). Names are not needed.**	3.06(1)(a)(b)(c)
4. Patient Care Assessment Coordinator: The governing body of the hospital/clinic must appoint an individual PCA Coordinator (or group of individuals, to collectively carry out the duties of the PCA Coordinator), who shall be charged with the responsibility of implementing – by delegation, oversight of otherwise – the hospital's qualified patient care assessment program. The name(s) of the PCA Coordinator shall be reported to the Board of Registration in Medicine within 10 days of appointment or replacement. To be qualified, the Patient Care Assessment Coordinator shall evidence by education, training or experience the ability to carry out the functions and activities of the Patient Care Assessment Program. **Please include this statement and provide the name, credentials, title of the PCA Coordinator.**	3.06(2)

5. <u>Policies governing responsibilities of the PCA Coordinator and Committee:</u> The hospital/clinic must develop and include as part of its PCA Plan the responsibilities of its PCA Committee and Coordinator. **Please list the responsibilities and mission/goals of the committee. State how often the committee meets.**	3.03(1)(e)
6. <u>Credentialing:</u> **At a minimum, the following statement must be present as a policy in your PCA Plan:** (Name of hospital/clinic) **shall undertake and repeat at least biennially all the credentialing requirements pursuant to 243 CMR 3.05 (and clinics include 243 CMR 3.14).** **Notwithstanding any other provision in 243 CMR 3.05, the hospital/clinic shall undertake and repeat at least biennially all the credentialing requirements set forth in 243 CMR 3.05.** For clinics: **(3.14) If the licensee is not currently at a health care facility, then the facility shall undertake the credentialing requirements contained in 243 CMR 3.05. Please include the policy or include elements of the policy as above here.** It is preferable that your policy (or a summary) is included.	3.05(1)(2)(3) And 3.14 (clinics)
7. <u>Internal Incident Reporting System:</u> The Hospital/Clinic shall develop and implement an internal incident reporting system. The system will include the analysis and tendering of data collected through focused occurrence reporting criteria, focused occurrence screening criteria, and the major incident reporting system. As part of the internal incident reporting system, procedures shall be in writing and given to all employees involved in patient care within five days of new employment. Within 30 days, new employees involved in patient care will receive orientation and training, including information pertaining to patient rights (M.G.L. c. 111, sec. 70E). Every year, all employees involved in the PCA Program will be provided with three hours of education and training in patient care assessment and quality assurance techniques, with emphasis on timely and accurate incident reporting and patient rights. **Please include a statement that internal incident reporting system has been implemented and in documented in a policy which includes focused occurrence reporting criteria, focused occurrence screening criteria, and the major incident reporting system.** **<u>Please provide details regarding the education provided to employees per the regulatory requirements listed above.</u>** **The actual data should then be reported in the Internal Reporting and Screening Systems section of the PCA QA Report when filed.**	3.07(3)(a-d)
8. <u>Focused Occurrence Reporting Criteria:</u> These criteria should be designed to reveal, through a chart review process, adverse or potentially adverse patient occurrences that might not otherwise be evident. Please submit the list of criteria which your hospital/clinic has designated as focused occurrence reporting and screening criteria. Please note that these are two separate sets of criteria as defined below:	3.07(3)(c)(d)

Focused Occurrence Reporting Criteria – incidents, which shall be reported to the PCA Coordinator within 24 hours of occurrence. For example, major transfusion reaction, wrong surgical procedure performed, etc. Focused Occurrence Screening Criteria – criteria or events which one uses to screen medical records. Screening criteria should focus on the potentially adverse events that are more likely to be examined through chart review, for example, documentation of informed consent, transfers to the I.C.U., follow-up of abnormal lab results, etc. **Focused Occurrence Reporting Criteria-List the criteria that your hospital/clinic has chosen to be reported to the PCA Coordinator within 24 hours of occurrence (examples may include but are not limited to: wrong site surgery, falls with injury, medication errors and/or adverse reactions, retained foreign objects, self-harm, suicide, elopement, patient assault).** **Data is not included here but should be included in the Internal Reporting and Screening Systems section of the PCA QA report when filed.** **Focused Occurrence Screening Criteria – List the criteria or events that your hospital/clinic has chosen to monitor by retrospective chart review. (Examples may be but are not limited to: compliance with informed consent, admission assessments, cancelation of same day procedures, compliance with medication reconciliation, IV infiltrates, transfer to hospital, healthcare associated infections, burns, complications of procedures).** **Data is not included here but should be included in the Internal Reporting and Screening Systems section of the PCA QA report when filed.**	
9. Major Incident Reporting or SQR reports. The hospital/clinic shall report all Major Incidents as defined in 243 CMR 3.08 to the Board of Registration in Medicine on a quarterly basis. **Please provide this statement.**	3.08(1)(2)(3)(4)(5)
10. Maintenance of Reports: **Please include a statement indicating that all incident reports, summary reports, written recommendations maintained for three years.**	3.07(3)(h)
11. Patient Complaint system: The hospital/clinic shall develop a Patient Complaint policy and system for the central collection of, investigation of, analysis of, and timely response to patient complaints which relate to patient care and the quality of medical services. **The actual data is not included here but is reported in the Patient Complaint section of the PCA QA Report when filed.** Ensure that a **process/policy/procedure for patient/family complaints/grievances exists.** **For clinics: If no complaints have been noted, please review your complaint process and how you educate patients and family regarding the process and their rights as patients. Please also refer to your patient satisfaction survey feedback. On occasion, patient and/or family complaints are embedded in the comments. Please also include information regarding your process of educating patients regarding your complaint process.**	3.07(3)(f)

12. <u>Informed Consent Policy:</u> The hospital/clinic must develop as part of their PCA Plan a policy on Informed Consent which complies with 243 CMR 3.10(1). **Please include a statement that the hospital/clinic has a policy on Informed Consent which complies with 243 CMR 3.10(1) and/or include the policy. <u>Please ensure the following is included in your policy.</u>** (a) The health care facility must have written policies and procedures designed to address the informed consent process. At a minimum, the policies should address: 1. Medical procedures and treatments for which informed consent is required and the content of the information provided. 2. Designation of persons responsible for obtaining informed consent from the patient. 3. The manner of documentation of consent, consistent with 243 CMR 3.00. 4. Designation of appropriate persons, other than the patient, from whom consent may be obtained, and the circumstances when consent may be obtained from a person other than the patient. (b) Consent should be obtained for all major therapeutic and diagnostic procedures where disclosure of significant medical information, including major risks involved, would assist a patient in making an intelligent decision whether to undergo the proposed procedure. (c) It shall be a physician's responsibility to obtain the informed consent of the patient, and to discuss sufficient medical information to enable the patient to decide whether to undergo the proposed treatment. Although the physician is responsible for informing the patient, health care facility personnel may assist in the completion of documentation. (d) A patient's consent shall be documented with sufficient clarity and detail so as to satisfy the reader that the patient was given and understood the medical information provided.	3.10(a)(b)(c)(d) 3.10(1)
13<u>. Impaired Health Care Provider Provision:</u> **Please include the following statement and ensure a process/policy/procedure exists:** "(Name of hospital/clinic) has developed a procedure for ongoing review and counseling of health care providers impaired by drugs or alcohol or arrange for and monitor participation in other established review and counseling programs. The procedure developed above will not relieve the hospital or any health care provider at the hospital from his or her obligation to report impaired physicians to the BORIM, under M.G.L. c. 112, sec.5F".	3.09(1)
14. <u>Prescription Practice and Medication Errors:</u> **Please refer to your accreditation body standards (Joint Commission, DNV, AAAHC, etc.) and include the following statement and ensure a process/policy/procedure exists:** "All licensees shall adhere to the requirements for the safe administration of drugs and biologicals, set forth in the current accreditation manual published by (the accreditation body of the hospital or clinic). Please insert the name of the organization that provides accreditation at your hospital/clinic.	3.10(3)

15. Medical Records: **Please refer to your accreditation body standards (Joint Commission, DNV, AAAHC, etc.) and include the following statement and ensure a process/policy/procedure exists:** "(Name of hospital/clinic) shall prohibit the alteration of medical records when such alteration distorts any facts or circumstances reflected in the original writing. Medical records shall meet requirements , set forth in the current accreditation manual published by (the accreditation body of the hospital or clinic)". Please insert the name of the organization that provides accreditation at your hospital/clinic.	3.10(2)(a)(b)
16. Guidelines in Specialties (if applicable): **Please include the following statement and ensure a process/policy/procedure exists, if applicable:** "Anesthesiology: All licensees shall adhere to the Standards for Basic Intra-Operative Monitoring established by the American Society of Anesthesiologists". **This may not be applicable to some ambulatory clinics and some non-acute care hospitals.**	3.10(4)(a)
17. Facility Equipment Committee: **Please include the following statement and ensure a process/policy/procedure exists:** "The governing body has established a committee charged with overseeing safety and maintenance of facilities and equipment and the Patient Care Assessment Coordinator shall receive periodic reports".	3.07(3)(m)
18. Summary Suspension: **Please include the following statement and ensure a process/policy/procedure exists:** "Violation of any health care facility bylaws or regulation as part of a Qualified Patient Care Program may be grounds for summary suspension of employment, practice, and association for the purpose of providing patient care or privileges at the health care facility or on behalf of an HMO".	3.11(1)(b)
19. M.G.L.c.112, sec 5F: **Please include the following statement and ensure a process/policy/procedure exists:** "At least annually, every health care provider who is employed by or has privileges or provides patient care at (name of hospital/clinic), shall receive written notice of the requirements and rights in M.G.L. c. 112, sec. 5F".	3.11(1)(a) M.G.L.c.112, sec 5F
20. Documentation of Disciplinary Action: **Please include the following statement and ensure a process/policy/procedure exists:** "All disciplinary actions against physicians taken by (Name of hospital/clinic) must be in writing and be reported to BORIM on the required reporting forms to the appropriate division of the Board".	3.07(3)(i)]

21. <u>Comprehensive Evaluation:</u> **Please include the following statement and ensure a process/policy/procedure exists:** "At the request of BORIM, (name of hospital/clinic) will provide for the administration of a reasonable and comprehensive evaluation of a physician's clinical skills, competence, and judgment".	3.07(3)(1)]
22. <u>Audit Authority:</u> **Please include the following statement and ensure a process/policy/procedure exists:** "(Name of hospital/clinic) grants DPH and BORIM access and audit authority overqualified PCA program information and records during normal business hours".	3.07(3)(k)]
23. <u>Patient Rights:</u> **Please include the following statement and ensure a process/policy/procedure exists:** "(Name of hospital/clinic) will provide to all patients, prior to or within 24 hours of admission, written notice, in plain language, of their rights established by M.G.L. c. 111, sec 70E. These rights will be conspicuously posted in the hospital. All patients will be informed that they may file complaints with a designated office, person or committee established under 243 CMR 3.07(3)(f) and of the existence of the Board, the DPH, and their addresses and telephone numbers".	3.11(1)(c) M.G.L. c. 111, sec 70E