Survey survival

Mock survey findings: Beware premature post-op notes, expired infection-control supplies

A post-op note written by a physician before an operation is complete will not go over well with a surveyor. Physicians taking this course not only run the risk of inaccuracy and future patient harm, but put your hospital at risk of denied accreditation or at least an RFI.

Yet a mock survey revealed precisely this problem at a 350-bed hospital, says Glenn Krasker, president of Critical Management Solutions in Wilmington, Del. and former Joint Commission director for hospital accreditation.

(See mock surveys, p. 6)

Medical records

Restrict time stamping to physicians and you will avoid citations

Add date and time stamping to your electronic order entry system to avoid a Joint Commission citation. If your facility still uses a paper-based system, physicians must be solely responsible for providing time and date authentication.

As part of the commission’s RC.01.01.01 Medical Record standard, physicians or other providers authorized to make entries in medical records are required to sign, date and time all entries.

(See time stamping, p. 8)

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New standard follows alarm fatigue warning

The new standard comes in the wake of a Sentinel Event Alert issued by the commission in April that noted more than 560 alarm-related patient deaths in a four-year period, many to what it termed “alarm fatigue” — when so many alarms are going off, clinicians begin to not hear them. Since April, hospitals nationwide have been scrambling to find guidelines to manage alarms within their facilities, often looking to hospitals and patient safety groups with experience in the subject.

Experts from both ECRI Institute in Plymouth Meeting, Pa., and the Arlington, Va.-based Association for the Advancement of Medical Instrumentation (AAMI) have recommended setting up multidisciplinary teams that include doctors, nurses and other clinicians, as well as representatives from clinical engineering, information technology, risk management and patient safety (IJC, 5/6/13).

Beth Israel Deaconess Medical Center formed such a team almost a decade ago to address cardiac monitoring alarms, and it is still working to improve
the Boston hospital's use of the equipment so that only those alarms needed to alert medical staff to a serious patient condition are set and truly heard.

“We know that patients complain about noise. We know that clinicians complain about noise, and when there's too much noise, no one hears anything,” says Tricia Bourie, RNMS, who was named Beth Israel's program director of nursing informatics last year, and for nine years before that managed the hospital's cardiac floor.

“The biggest thing we've done in the last year is look at our alarm defaults.”

While often the habit with any hospital equipment is to default to the manufacturer's instructions, what Beth Israel's cardiac telemetry team found was that systems monitoring heart rates or arrhythmia were going off too frequently.

When the team checked into the issue, it found that the manufacturer established its default settings according to common customer experiences, rather than research into true clinical need, notes Bourie.

Some settings were to help staff monitor trends in a patient's condition, information which can be tracked better, and more quietly, through new technologies, Bourie notes.

The alarms were reset according to the clinical needs outlined in the hospital’s standards of care. While the hospital is still putting together data on how much the change helped reduce unnecessary alarms, the response anecdotally from nurses and physicians is that it has been a success.

Investigate individual alarm types

“One of the other things that we've done is really try to think about... the high-risk situations that people need to pay attention to,” Bourie says.

For instance, in cardiac telemetry, a “leads off” alarm could signal a critical clinical event. That was escalated to what Bourie called a three-star alarm, with a standard of care to respond within three minutes.

But sometimes it's an equipment error, such as when the electrodes slip off or lose contact with the patient after a certain period of time. After attending a summit on clinic alarm fatigue sponsored by ECRI and AAMI, Beth Israel instituted a practice of replacing electrodes every 24 hours, regardless of how well they seemed to be adhering, Bourie says. The hospital also went to using lead sets that snapped into place, rather than clips, which were not as reliable.

Every hospital is going to have different equipment, different goals and different resources. The new NPSG notes that there is no universal solution, “but it is important for a hospital to understand its own situation and to develop a systematic, coordinated approach to clinical alarm system management.”

Tips to improve your alarm management

- **Even if resources are tight, emphasize patient safety.** Document events that could have a connection to alarms and how they are monitored, Bourie suggests. Use it to inform your hospital’s standard of care regarding alarm management.

- **Start simple.** For instance, changing electrodes is not cost prohibitive, Bourie notes. Or just check your equipment clocks. One of the first things Beth Israel's team discovered 10 years ago was that the electronic clocks in patient monitoring equipment were not set to the same time as other clocks used on the floor, such as in defibrillation equipment. That meant that in researching patient events involving clinical alarms, time stamps did not match. Resetting all the clocks to the same time helped in recognizing system vulnerabilities.

- **Start with your cardiac unit.** Use it as a testing ground for how you identify and standardize your alarm management procedures, Bourie advises. Standardizing procedures doesn't have a cost associated with it.

- **Get onto the floor.** Make sure you do a walkthrough and ensure nurses can hear the alarms they need to hear, Bourie recommends. Some hospitals are going with a war room — one area where all the monitors are centralized for all patients. — A.J. Plunkett (aplunkett@decisionhealth.com)

Resources:

- NPSG.06.01.01 (effective Jan. 1, 2014): [www.jointcommission.org/standards_information/prepublication_standards.aspx](http://www.jointcommission.org/standards_information/prepublication_standards.aspx)
- Sentinel Event Alert No.50: [www.jointcommission.org/assets/1/18/SEA_50_alarms_4_5_13_FINAL1.PDF](http://www.jointcommission.org/assets/1/18/SEA_50_alarms_4_5_13_FINAL1.PDF)
Compliance

Survey Activity Guide now includes medical records statistics form

A rare mid-year revision of The Joint Commission’s Survey Activity Guide offers two updates that could help you pass your next accreditation review: the recently rewritten Hospital Medical Record Statistics Form, and a strong reminder for your leadership on how to communicate with surveyors onsite.

The statistics form — added to the guide “per customer request,” according to the commission — is tailored to determine a hospital’s compliance with a single element of performance, EP 4 under RC.01.04.01 (The hospital audits its medical records.). (For more on what EP 4 requires and tips on using the form, see box, p. 5.)

The first EPs under this Record of Care, Treatment and Services standard require a hospital to audit its medical records regularly and to measure medical record delinquency rates at least every three months, or quarterly.

While the form looks formidable, it helps each hospital determine which records can be included in the formula, and how to do the math.

It’s important to note that this EP is in Category A, which means “if you’re not compliant with this element of performance, then you are not compliant with the standard and that’s an RFI,” says Joe Gordon, technical adviser for Inside the Joint Commission and president of Survey Resources LLC, of Manchester, N.J.

The scoring rules at the bottom of the form were revised recently to underscore that partial compliance is not allowed with EP4, said the commission in releasing the updated form in January 2013.

While the form itself has been around for a while — Gordon notes that it is similar to one used by the commission several years ago when he was a surveyor — its inclusion in the Survey Activity Guide is new.

The guide is usually only updated once a year, but the commission released a revised version at the beginning of July, primarily to include changes to accreditation programs involving nursing and rehabilitation centers as well as behavioral health care facilities.

Besides the statistics form, Gordon notes that the only other substantial change in the guide affecting hospitals is a reminder from the commission that hospital leadership should use the opening conference on the first day of the accreditation visit to convey what they expect out of the survey.

Coach your leadership on expectations

Obviously, the main expectation is to earn accreditation, Gordon says, but the commission also wants to hear feedback from the leadership. Make sure your leadership understands that, and is prepared to answer the question, whatever the individual expectations of your hospital might be.

The guide is a useful tool to prepare both your hospital and your leadership on what to expect during the on-site accreditation visit, he says.

For instance, Gordon advises, copy the section on the leadership session (page 79 of the updated guide), take it to your hospital leadership and go over it with them to make sure they know what to expect, what questions are going to be asked and what their answers are going to be. That’s what the guide is for, he says.

“The Survey Activity Guide is not used by hospitals anywhere near as much as it should be,” Gordon says. “The Joint Commission follows it.” And you should too, he warns. — A.J. Plunkett (aplunkett@decisionhealth.com)

The Joint Commission

Draft standard on sample medications offered for field review

If you have lingering questions about how to handle those sample medications in your hospital, The Joint Commission is seeking comment on a new standard on this issue, to be added to the Medication Management (MM) section.

In addition, the commission has gone through all of the MM standards and highlighted those that should also be applied to sample medications — and that’s most of them.

But at the beginning of the proposed new standard, which would be MM.09.01.01, the commission clearly states: “Note: Through this standard, The Joint Commission is not endorsing the use of sample medications.”
The standard requires that, when hospitals permit the use of sample medications, they are safely managed. The standard has six elements of performance.

Those EPs require, among other things, that a hospital should have a policy addressing the storage, control, labeling and dispensing of sample medications; that patients and their families are educated on the sample medication they are given; that patients given such medications are provided follow-up; and that the hospital documents the use of sample medications.

**Commission: sample meds are safety concern**

These proposed MM revisions are in the field review stage, which means that the issue has become enough of a quality or safety concern that the commission believes it needs to be formally addressed.

The commission’s website states, “New standards are added only if they relate to patient safety or quality of care, have a positive impact on health outcomes, meet or surpass law and regulation, and can be accurately and readily measured.”

Draft standards are first reviewed by the field-specific advisory committees of the commission’s governing board, then are distributed for comment.

If indicated, revisions are made and reviewed again by commission experts, before they are sent for approval by the Standards & Survey Procedures committee and the full board.
To read the draft standard on sample medications, go to www.jointcommission.org/standards_information/field_reviews.aspx?StandardsFieldReviewId=xhZqWdpjvSP4OxN2u3KLSSxj94p3tyeGG6bZxNj%2fsMo%3d.

To comment, you can follow the link to an online survey page. Or you can submit comments in writing to: The Joint Commission, Standards and Survey Methods, Sample Medication Field Review, One Renaissance Blvd., Oakbrook Terrace, IL, 60181.

Comments will be accepted through Aug. 6. — A.J. Plunkett (aplunkett@decisionhealth.com)

mock surveys
(continued from p. 1.)

The physician’s post-op note for an endoscopy patient was signed at 8:30 a.m., yet referred to pre-procedure vital signs taken by the nurse at 8:55 a.m., and an endoscopy sedation assessment and medication list, both completed by the nurse at 9:10 a.m.

All of this documentation occurred prior to the completion of the endoscopy procedure. This violates the Joint Commission standard requiring the hospital to provide accurate information throughout the accreditation process.

“Theyir argument is that it’s for the sake of efficiency, that an operation like an endoscopy is very standardized, the outcomes are always the same and that if something is different, they’ll change it after the surgery,” says Krasker, noting that it is nonetheless wrong. “You’re falsifying the medical record. This calls into question the validity of any information in the medical records.”

Expired supplies used for high-level disinfection are another egregious finding that both endangers patient safety and runs a serious RFI risk.

“In the radiology department ultrasound area, the container of Cidex OPA solution expired in July 2011 and the test strips expired in October 2010,” Krasker noted in his report on an April 2012 mock survey. “The entire quality control process needs to be redesigned.” In addition, Krasker found that quality control on the opened Cidex OPA solution was performed only monthly (rather than immediately before each use, as the manufacturer requires) and that there was no quality control on newly opened containers of Cidex OPA or test strips.

These practices could result in an RFI because they violate the Joint Commission infection-control standard requiring hospitals to reduce the risk of infections associated with medical equipment, devices and supplies. They could also be interpreted as an “immediate threat to health or safety,” thus triggering a preliminary denial of accreditation, Krasker says.

Look for these high-risk violations

But these are not the only high-risk violations hospitals engage in. We’ve compiled a list of others to look for so you’ll find them before a Joint Commission surveyor does:

- **Incompetent or untrained people in key positions.** Your hospital must have a process in place to validate the training, experience and competency of the people you assign, even if those people are simply filling in for regular personnel. For instance, when Kurt Patton, president of Patton Healthcare Consulting in Glendale, Ariz., and former Joint Commission executive director of accreditation services, visited an infusion center at a large teaching hospital as part of a mock survey, he asked the pharmacist how he keeps track of chemo doses and cycles. But the pharmacist was unable to answer. “He didn’t really know anything about it because he was a per diem, helping out for the day,” and suggested Patton come back the next day to speak with the full-time pharmacist. This is a major issue with CMS and The Joint Commission and can lead to a declaration of immediate threat, which places your accreditation status in jeopardy, Patton says. “You can’t afford to have someone placed in a high-risk setting who is not absolutely competent, familiar with your policies and procedures.”

- **Lack of accuracy in providing information.** During a mock survey, a member of Krasker’s team visiting the medical/surgical unit of a 220-bed hospital noted that although the adult-code-cart log book showed the defibrillator had been most recently checked and discharged on May 6, the defibrillator strip indicated that the defibrillator had most recently been discharged on May 3. “This discrepancy in documentation has been interpreted as misrepresentation of information by The Joint Commission in the past and has resulted in a preliminary denial of accreditation,” Krasker says. It violates the Joint Commission standard requiring that the
hospital provide accurate information throughout the accreditation process.

- **Failure to follow, or being unaware of, basic medication safety processes.** “We went to the ICU (at a community hospital) and the medication refrigerator door was open, water all over the place, towels soaking up the water. Someone was attempting to defrost the freezer, but they had not taken any of the meds out for temporary storage during this process,” Patton says. “This could render frozen or refrigerated vaccines unusable,” and was also a violation of the medication management standard dealing with medication storage. “There should also be a sense of embarrassment for the organization looking at the Joint Commission accreditation process.

Inside the Joint Commission

You can have every hospital department well prepared and answer every surveyor question correctly, yet still cast a negative light on your hospital during a Joint Commission survey when staff members behave inappropriately. Avoid the following:

- **Hospital department heads introducing themselves to each other in front of surveyors.** Don’t make things worse for yourself when you don’t have to. During a Joint Commission survey of a 250-bed Mid-Atlantic hospital, as the surveyors were introducing themselves to hospital officials, so too were many of the department heads, says Joe Gordon, at the time one of the Joint Commission surveyors at the hospital and now technical adviser for *Inside the Joint Commission* and founder of Survey Resources, LLC in Manchester, N.J. He was “astonished,” he says, as “leadership is supposed to ‘demonstrate cohesiveness’ to show that they work together, and here were several who did not even know” each other. In the final Joint Commission survey report, Gordon wrote that it was difficult to understand how department heads could work together if they did not know each other, he says.

- **Staff running for cover.** This phenomenon typically occurs after the announcement that surveyors, or mock surveyors, are in the hospital, says Kurt Patton, president of Patton Healthcare Consulting in Glendale, Ariz. and former Joint Commission executive director of accreditation services, who has seen it in several organizations. “People know a survey is going on, surveyors come out of the elevator, everyone disappears, leaving the least senior person, who doesn’t have a clue as to what the survey is about.” During one of Patton’s mock surveys, surveyors visited a unit, asked for the charge nurse, and were instead addressed by the unit clerk, who asked if they had an appointment and what the visit was in reference to. While not a violation in and of itself, it just makes the hospital look unprepared during a survey, Patton says. “There should be a game plan, so that when the surveyor comes off the elevator, everyone knows who does what.”

- **‘Have they left yet?’** During an actual Joint Commission survey at a 500-bed Veterans Administration hospital, the survey was just about over. “We’re packing up, laptops and roller boards,” when one hospital official in an office across the hall shouts to another in the hall, “’Have they (the Joint Commission surveyors) left you?’” recalls Gordon. While this did not relate to a specific standard violation, it nonetheless cast an unprofessional light on the hospital and the surveyors’ experience there, and it could easily have been avoided. Don’t do a great job during the survey itself, then at the last minute have an impolitic staff member damage all your hard work. — Robert Sperber (sperber1@aol.com)
for not having a process for defrosting a refrigerator,” Patton says, adding that the meds could have been placed in a cooler box with dry ice in it, which also would have prevented the water from spreading on the floor. —Robert Sperber (sperber1@aol.com)

**time stamping**

*(continued from p. 1.)*

Improper date and time stamping has long been a major cause of citations related to this standard.

The main reason behind the citation is when administrative assistants and other unauthorized parties are allowed to provide the time and date (sometimes retroactively) or signature for an entry using an electronic or rubber signature stamp, says Joe Gordon, technical adviser for *Inside the Joint Commission* and president of Survey Resources, LLC in Manchester, N.J.

“Physicians must do the date and time stamping on [their] orders, but sometimes that doesn’t happen, and hospitals get creative,” Gordon says. “The important part is who has control over the stamping mechanisms…If a doctor is the only person with control of a signature stamp, that is perfectly OK. But if an assistant has a drawer full of signature stamps that are being used, that is not OK.”

Electronic order entry systems can help alleviate the burden on physicians, as software can be easily tailored to automatically include a time, date and electronic “signature” with any order entry.

“It has been a couple years since we used a date/time stamp,” says Sandy Nelson, regulatory compliance coordinator at Winter Haven Hospital in Winter Haven, Fla. “We were using it mainly when we were having a problem getting physicians to authenticate their verbal orders. Now that we are electronic with most orders, we no longer are having this problem as much.”

**Electronic stamping has its own challenges**

However, while technology can help, it is not without its own complications. As with a physical or “analog” stamping process, hospital leadership must be able to demonstrate that only authorized parties are entering orders into the system.

“If the prescribing person has sole control or access, it is fine,” Gordon says. “But if that access is shared, then it weakens reliability. It’s a matter of developing a system where the doctor or the doctor’s partners are the only ones who can enter or authenticate an order.”

If analog rubber stamps and date-stamping devices are still in use, restrict access to the objects only to physicians and other authorized persons. Delegating responsibility for date/time stamping may be tempting, but creates an environment of non-compliance.

“Hospitals are having problems with this, because doctors often tell a nurse or another person to put the orders in,” Gordon says. “But as long as so many hospitals are not compliant, this won’t go away.”

Adopt electronic order-entry technology or find a way to clarify the appropriate boundaries of responsibility to physicians. Use citation data and other information, including the legal ramifications of improper authentication.

“At the end of the day, doctors have to do it,” Gordon says. “There are diplomatic ways of sugar-coating the message, and an electronic medical record is a stronger system and can help prevent litigation as well as a citation.” — Scott Harris (mscottharris@yahoo.com)

**HHS: OIG updates exclusion database**

HHS’ Office of the Inspector General (OIG) continues to upgrade its online database lookup of individuals and entities excluded from getting any money from federal health care programs such as Medicare or Medicaid.

Among the upgrades is that employers can now look up information by national provider identifiers. The List of Excluded Individuals/Entities (LEIE) database is available at [http://exclusions.oig.hhs.gov](http://exclusions.oig.hhs.gov).

The reason you need to know this is as simple as the database lookup: Employing an excluded individual violates the civil monetary penalties law. And that means you could be paying – and many have – thousands in penalties.

Also, The Joint Commission’s Human Resources standards require hospitals to check staff qualifications, including a criminal background check, as dictated by law or hospital policy.

To read more about the LEIE, go to [oig.hhs.gov/exclusions/exclusions_list.asp](http://oig.hhs.gov/exclusions/exclusions_list.asp). — A.J. Plunkett (aplunkett@decisionhealth.com)
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