CMS approves DNV to accredit hospitals

CMS has announced the approval of DNV Healthcare, Inc., as a deeming authority for U.S. hospitals. DNV is the first new U.S. organization to receive deeming authority for hospitals in more than 30 years.

According to the pre-Federal Register announcement in September, DNV was recognized “as a national accreditation program for hospitals seeking to participate in the Medicare or Medicaid programs,” effective September 26, 2008, through September 26, 2012.

“We’re coming into this business not just as another option,” says Yehuda Dror, president of DNV Healthcare. “We want to take a leadership position.”

“I think a lot of people will explore the possibility,” says Bud Pate, REHS, vice president of content and development at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. “There are some hurdles that people will need to jump over. Since DNV is new, they’re going to need to work through some residency issues, contract issues that may exist ... but none of these are insurmountable.”

DNV has crafted a system intended to combine the CMS Conditions of Participation (CoP) with ISO 9001 quality management.

This program, called the National Integrated Accreditation for Healthcare Organizations (NIAHOSM), was created to streamline the accreditation process and identify means for improving current standards and promoting continual improvement.

“The ISO-9001 certification seems to be a logical progression as the focus on patient care quality assurance moves towards performance improvement in healthcare, primarily in hospitals,” says Larry Poniatowski, RN, BSN, CSHA, principal consultant for accreditation compliance services at the University HealthSystem Consortium in Oak Brook, IL. “The issue here now will be to see how well it’s embraced by hospitals as an alternative to Joint Commission accreditation.” So far, 27 U.S. hospitals in 22 states have been accredited by DNV Healthcare using the NIAHO™ program in addition to other accreditation services.

In mid-2007, DNV Healthcare acquired Cincinnati-based TUV Healthcare Specialists with the belief that the acquisition would help cement DNV’s application to CMS. TUV had previously applied for deeming authority unsuccessfully in 2006.

DNV Healthcare is a division of Houston-based DNV USA, a subsidiary of the Norwegian company Det Norske Veritas. DNV focuses on risk management and training in several industries, including healthcare.

“We’re coming into this business not just as another option. We want to take a leadership position.”

—Yehuda Dror

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Kurt Patton, MS, RPh, talks about preanesthesia assessments.

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DNV will conduct surveys annually rather than every three years.

“What we offer is something of a way of life,” says Dror. “It’s not a case where every three years, we come in, do an audit, and leave. We’re coming in every year. This leaves no time to prepare. It’s not punitive, but you don’t have time to prepare, so instead, it must be a way of life, making sure the core objectives are met.”

But it is the introduction of the ISO 9001 component to the healthcare setting that has many interested in the new accreditation organization’s process.

“It’s the ISO piece that organizations are going to have to explore further and look to see if they can fit within its mold,” says Poniatowski. “I think that hospitals that try to achieve that level of culture of safety may want to embrace something on this level. At this point in time, hospitals have been given a viable choice.”

Pate says he has observed growing frustration with National Patient Safety Goal changes and anticipates some initial problems with the rollout of the new Joint Commission standards in 2009. “Physicians have had it with [these things],” he says. “This [DNV] looks like an attractive alternative to them.”

Pate says the introduction of competition to the accreditation world is a win-win situation for accrediting organizations and hospitals.

“I see this, potentially, as a situation similar to Apple and Microsoft,” he says. “I think Joint Commission will continue to be the Microsoft [in this equation]. But I think Apple [DNV] will keep Microsoft honest. Many people will explore it, and a few will go for it. And over the years, they’ll find a niche in the healthcare industry.”

The emergence of a competitor in the accreditation world marries nicely with changes in leadership at The Joint Commission (formerly JCAHO), as the organization has voiced a renewed commitment to improving customer service, Pate notes.

“It comes at an opportune time,” Poniatowski says. “With a new Joint Commission president who is dedicated to measurement and improvement and embracing Six Sigma for process improvement, I think it’s going to be good for the entire healthcare field. We’re all going to learn something.”

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Executive Briefings: CAMH, numbering changes top RFIs

After reading this article, you will be able to:

- Discuss the new numbering system used in the Comprehensive Accreditation Manual for Hospitals
- Identify new chapters added to the 2009 Joint Commission Standards
- Discuss the year’s most challenging standards

During this year’s Joint Commission Executive Briefings in New York City, the talk of the day was of change—and there is certainly plenty of change happening for hospitals, particularly those that are dealing with The Joint Commission.

Several presenters, including Pat Adamski, RN, MS, MBA, director of the Standards Interpretation Group, went into detail about what Joint Commission-accredited facilities can expect in the coming year.

Among the top stories this year are changes to the Comprehensive Accreditation Manual for Hospitals (CAMH), standards renumbering, and scoring changes, as well as Executive Briefings staples such as reviews of National Patient Safety Goals and most-cited standards.

The 2009 CAMH has undergone an extensive overhaul, not just in terms of renumbering (see sidebar at right) but also in terms of language. According to the opening remarks of Mark Chassin, MD, MPP, MPH, president and CEO of The Joint Commission (formerly JCAHO), a PhD in English was brought on board to clarify the language used in the CAMH and do away with traditionally confusing verbiage.

Electronic manual

Hospitals will no longer have access to PDF versions of the CAMH, but instead will have an online edition (“e-dition”) as well as a print manual.

The e-dition will contain the same content as the print manual, but it will also include additional features for ease of use.

Adamski said the goal was to make the electronic version so user-friendly that everything would be accessible within three clicks of a mouse.

Every site has one complimentary single-user license for all its organizations. Additional user licenses are available.

New chapters

Six new chapters were added in 2009. The following five affect hospitals:

- Emergency Management (EM)
- Life Safety (LS)
- Record of Care (RC), Treatment, and Services

> continued on p. 4

What does the new numbering system mean?

The new numbering system involves a two-letter chapter designation, followed by three sets of two-digit numbers. Existing numbers start with the two-letter designation for chapter, as well as one additional set of numbers. For example, IC.4.15 will now be known as IC.03.04.01.

The four components of the numbering system translate into the following:

- Chapter (in this case, IC)
- Numeral (in this case, 03)
- Letter in the outline
- 2009 standard number

Get talking

Want to bounce ideas off of your peers? Join “Patient Safety Talk,” a busy online community of accreditation professionals who talk about National Patient Safety Goals, Joint Commission surveys, and more. To sign up, send an e-mail request to owner-patientsafety_talk@hcpro.com.

Subscribers who want to receive all postings for the day in one message can do so. Just send in your request asking for the digest version rather than the regular version.
Executive Briefings

➤ Transplant Safety (TS)
➤ Waived Testing

The Joint Commission also added an Equipment Management chapter for its home care program only.

The EM chapter was built out of current emergency management standards and elements of performance previously contained in the Environment of Care (EC) chapter, primarily.

Other standards that were split and included in part in the EM chapter are Medication Management (MM) (specifically, how the facility obtains and replenishes medications and supplies during an emergency). Medical Staff standards regarding privileging requirements during a disaster, and HR standards regarding responsibilities of volunteers during disaster response.

The LS chapter was born from a separate document, currently scored under EC standards, which The Joint Commission has incorporated directly into the standards.

The RC chapter will discuss documentation in the medical record drawn primarily from existing Information Management (IM) standards, as well as the Provision of Care (PC), Treatment, and Services chapter.

The RC chapter will also address documentation requirements for high-risk procedures, administration of sedation, medical surgical restraints, receiving and recording verbal orders, and means for tracking the medical record.

Note: Join Jean Clark, CREDS, on November 6 for her presentation on the new IM standards, in which she will discuss key components of IM changes.

The new TS chapter has been pulled together from requirements previously filed under Leadership and the PC chapter. The former requirements deal with procurement and donation of organs and tissue, whereas the latter directly address procedures for managing those tissues.

Finally, the Waived Testing chapter came out of the PC chapter as well. These standards address the context in which waived testing should be used, responsibility and supervision of waived testing, training, orientation, competency, quality checks, and a recording policy.
2008’s most challenging standards

Adamski also reviewed the least-compliant standards in the past year, based on 1,365 full surveys in 2007 and another 259 full surveys in the first quarter of this year.

Unsurprisingly, EC.5.20 (which will now comprise the LS chapter) topped the list, with 45% of hospitals receiving an RFI (up from 29% in 2007). With a Life Safety Code® engineer accompanying every survey, more EC RFIs were expected this year.

Adamski said 2009 standards to look out for include LS.02.01.20 (maintaining the integrity of egress means) and LS.02.01.30 (fire and smoke hazard protections).

Hospitals also had difficulty with IM.6.50 (RC.02.03.07 in 2009), verbal order authenticity. This jumped from 25% of hospitals receiving RFIs in 2007 to 35% of hospitals this year.

Wording changes “tie directly into CMS requirements,” Adamski said.

Still a top five problem, but with a significant drop-off from 2007, is MM.2.20 (split into MM.02.01.01 and MM.03.01.01 in 2009), medication storage, down from 43% to 31%.

“You need to decide how medications are stored if not administered right away,” said Adamski.

Other top-cited standards in 2008

The following are more standards for which a large proportion of hospitals received RFIs this year:

- HR.1.20 (split into HR.01.02.01, HR.01.02.05, HR.01.02.07, HR.01.06.01, and HR.07.01), staff qualifications and responsibilities, 18% (up from 15% in 2007)
- MM.3.20 (MM.04.01.01), medication orders, 16% (down from 20% in 2007)
- PC.8.10 (PC.01.02.07), pain assessment, 16% (up from 15% in 2007)
- EC.7.40 (EC.02.05.07), emergency power systems, 16% (up from 8% in 2007)
- PC.13.20 (split into EC.03.01.01 and EC.03.01.03), moderate sedation, 15% (down from 18% in 2007)

She recommended speaking with licensed independent practitioners about which methods work best. Get feedback from those handling medications before implementing a policy to make sure it works and is sustainable.

Another EC standard, EC.5.40 (EC.02.03.05), increased from an 18% RFI rate in 2007 to 30% this year. This fire safety equipment and features standard often causes trouble when hospitals outsource testing and maintenance and do not verify that they are performed appropriately.

Make sure your facilities staff is aware of what should be reported, Adamski said.

Rounding out the top five RFIs is IM.6.10 (split into seven standards in the RC chapter in 2009), with 24% of hospitals receiving RFIs this year. Organizations continue to struggle with requirements to maintain a complete and accurate medical record for all patients the hospital cares for.
Spotlight on pain management

Editor’s note: This feature explores problematic Joint Commission standards with expert advice from BOJ advisors. This month, Elizabeth Di Giacomo-Geffers, RN, MPH, CNAA, BC, CSHA, a healthcare consultant in Trabuco Canyon, CA, and former Joint Commission surveyor, discusses recent changes in the area of pain management.

The Joint Commission has brought a renewed focus to the area of pain management with its recently released brochure, “What You Should Know About Pain Management,” as part of the accrediting body’s Speak Up program.

Pain management has been on The Joint Commission’s radar for quite some time. Since 2000, it has been a part of The Joint Commission’s national standards as well as the accreditation process.

Pain is one of the major reasons patients seek care. However, hospitals continue to struggle with the issue. According to Joint Commission officials at the 2009 Executive Briefings, pain assessment and reassessment is a top 10 most-cited standard under PC.8.10 (soon to be PC.01.02.07), for which hospitals received RFIs in 16% of surveys in 2007 and the first quarter of this year.

The brochure provides some excellent advice for pain management but has a few holes your facility should watch for:

➤ Be aware of your patients’ cultural needs. The Joint Commission (formerly JCAHO) brochure is available in Spanish, but be prepared to communicate about pain in the languages and dialects common to your area.

Literacy is important here: Does your facility have written materials you can provide to patients in their native language to help them understand and assess their pain needs?

Pain is population specific, varying with factors such as age, cultural diversity, and cognitive impairments. It takes a delicate understanding to sense, using verbal and nonverbal communication, the level of pain a patient is experiencing, especially when he or she is ventilated or cognitively impaired, such as a patient with Alzheimer’s.

Pain is in the eye of the beholder. As pain management pioneer Margo McCafferey wrote in 1968, “Pain is what the patient says it is, and it’s as bad as the patient says.”

➤ Know how to educate those who are caring for a population that cannot communicate its pain.

The Joint Commission brochure focuses on adult pain management quite well but does not specifically address the pediatric population. With pediatric medication errors so high, it will benefit your facility to take the time to understand the pain management and pain assessment needs for children, particularly those too young to explain their own pain.

The real key here is knowledge. We must educate everyone involved with the patient. Nurses, physicians, respiratory therapists, physical therapists, dietitians, residents, and even counselors should receive education on how to assess and manage pain in their patients. Most healthcare providers do well when it is expected that the patient will experience pain (e.g., after surgery). However, without cues such as an incision site, providers may forget to ask about pain.

It boils down to assessment and reassessment. If you don’t educate people on pain pathophysiology, they will not be able to get their arms around this issue.
➤ **Policy.** Take a look at your policy. When it comes to pain management, an RFI can be a self-inflicted wound. Is your pain assessment and management policy too tight? Does it need to be clarified or simplified? Did staff members have input into its design?

Like any policy, a pain assessment policy that is too stringent can leave your organization open to an RFI simply because it is impossible for staff members to reasonably comply with it.

Speak with frontline staff members. Listen to how they assess pain and the steps they go through to determine the level of pain in their patients and craft an effective policy from that information.

➤ **Documentation.** A successful pain management policy can be derailed by a lack of documentation. Many facilities assess pain but fail to document it in accordance with their policies.

Examine your policies: Can your staff comply with the policies as written? Does the practice follow the policies? If not, why not?

If you find that people are not documenting their assessments or reassessments, ask why. Is it a knowledge deficit? Is it a process problem? Are you requiring documentation in multiple places? Is the documentation too detailed, taking up too much time, or interfering with other patient needs?

Drill down to the root cause of the problem. This may vary from organization to organization. The number of RFIs has increased 1% this year—why is it still so high when we know most caregivers are doing an excellent job? What we know is, very often, caregivers are not capturing their excellence in writing or they are documenting it but not in accordance with existing policies.

We need to find out why caregivers are not capturing their practices in writing. Is it a practitioner issue or is it a global issue?

Look at the system, the technology involved, and the policy for where holes might exist.

➤ **Other standards.** Where should hospitals focus to make sure they are meeting patient needs in pain assessment and management?

Let’s start with the basics. RI.2.160 (in 2009 identified as standard RI.01.01.01, element of performance [EP] 8, an A EP) states that patients have the right to pain management.

Education for patients and their families is key. Also, look at what your facility is using to assess pain. There are many pain rating scale tools available on the Web (one excellent resource is UCLA’s pain management center at [www.uclapainmanagement.com](http://www.uclapainmanagement.com)). Are your tools simple to use?

Remember, it’s not just nursing that needs to use this scale. MS.03.01.03, EP 2 (an A EP), requires hospitals to

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**Sentinel Event Alert targets anticoagulants**

The Joint Commission has released its most recent Sentinel Event Alert, targeting anticoagulant use and medical errors. This is the fourth alert The Joint Commission has issued this year. There have been several high-profile medical errors involving anticoagulants in the national media, and The Joint Commission’s alert is intended to offer methods for preventing further errors.

This is not the first time The Joint Commission has targeted anticoagulants. Requirements introduced into the 2008 National Patient Safety Goals are scheduled for full implementation January 1, 2009. The Joint Commission also addresses anticoagulants under the Medication Management standards.

Common factors in anticoagulant errors highlighted in The Joint Commission’s report include labeling and packaging issues, documentation errors, communication failures, and inappropriate use of medication.

For more information or to view the Sentinel Event Alert, go to The Joint Commission’s Web site at [www.jointcommission.org/NewsRoom/NewsReleases/nr_09_24_08.htm](http://www.jointcommission.org/NewsRoom/NewsReleases/nr_09_24_08.htm).
STANDARD OF THE MONTH (cont.)

educate all licensed independent practitioners about pain management and assessment. This is new for 2009.

HR.01.04.01, EP 4 (a C EP, requiring a measure of success and documentation, designated in the manual with M and D), also addresses staff education, requiring hospitals to orient staff members on assessment and management of pain.

PC.03.01.07, EP 2 (a C EP, requiring a measure of success and a direct effect requirement), looks at operative or high-risk procedures and monitoring pain. For this EP, you should track the frequency and intensity of pain as it relates to the potential effect of the operative or high-risk procedure.

PC.8.10/PC.01.02.07 (all EPs) similarly requires hospitals to assess pain consistently with regard to the patient’s age and cognitive ability.

Information provided to the patient should include discussion of the patient’s pain, activities that increase the pain, and the importance for the patient to effectively manage his or her pain.

Many practitioners fear providing pain medicine because of the possibility of addiction. However, many medications are not as effective if they are not administered early when the onset of pain begins, as opposed to later when the pain reaches its apex.

Properly addressing pain assessment and management boils down to education on all sides. Facilities need to target and increase knowledge in caregivers. Training caregivers about the value of adequate pain management should begin in medical and nursing school.

Editor’s note: The fishbone below is meant to supplement Di Giacomo-Geffers’ column “Hospitals continue to struggle with heparin overdoses,” which appeared in the September BOJ. It can also be viewed online by visiting www.bojextra.com.

Log on to www.bojextra.com to access bonus features in this issue—available to all readers.

Source: Elizabeth Di Giacomo-Geffers, RN, MPH, CNA, BC, CSHA, and Eileen Willey, MS, RN, CPHQ. Reprinted with permission.

Source: Elizabeth Di Giacomo-Geffers, RN, MPH, CNA, BC, CSHA, and Eileen Willey, MS, RN, CPHQ. Reprinted with permission.
Restraints Interpretive Guideline: Questions answered

Editor’s note: The following question and answer session took place during HCPro’s September 18 audio conference “CMS Interpretive Guidelines: Understand Changes and Challenges for Restraint, Infection Control.” Speaker Susan Hendrickson, MHRD/OD, RN, CPHQ, FACHE, director of clinical quality and patient safety at the Via Christi Wichita (KS) Health Network, answered questions from the field on new restraint requirements.

Additional questions and answers are available online at www.bojextra.com for all BOJ subscribers. To order the complete audio conference, visit www.hcmarketplace.com/ prod-6863.html.

If a patient is in restraints and it looks like he can do without them, and I take them off, can I then put them back on if, after 30–40 minutes, it looks like he is going to need them after all?

No, you may not. That is called a trial release, and a trial release constitutes an as-needed situation. Once a staff member ends an order for restraint intervention, the staff member has no authority to reinstate it without a new order.

Using your example, if the patient is released because a staff member assesses that he or she didn’t need to be in restraint, and the patient later exhibits behavior indicating otherwise, the staff member must go back and get an order.

If a patient is removed from restraints before the time limit for the physician to come in and assess him or her, does the physician still have to perform the assessment?

The physician still has to come in and assess the patient to give the order. But you’re better off if you can get the patient out of restraints before the time limit ends. So it’s fine to take the patient out of the restraints ahead of time.

The physician needs to document that the short period of time during which the patient was in restraints was okay with the patient.

If a patient is assessed for needing a chemical restraint and you cannot order a chemical restraint as needed, does the nurse have to call every four hours if he or she thinks the patient needs it, or would the doctor write an order for a chemical restraint?

The nurse would have to call. The order can be removed for up to 24 hours, so the physician needn’t come back every time the nurse calls.

With regard to education requirements, does CMS want to see specialized training for those who provide restraint education to facility staff members?

Yes, you need to show that the staff member providing the training is competent.

You can develop training within your hospital that’s not specific, but you must show that staff members have education, whether it’s a specialized education course or something similar.

CMS is not prescriptive as to what you must do. But you need to be able to delineate what makes a person competent in your policy. You may end up conducting a train-the-trainer activity.

Are hand mitts considered restraints?

Hand mitts are not considered restraints unless you confine the patient’s hands by tying the hand mitts to the side rail, or if the hand mitts are so bulky that they prevent the patient from moving freely. It depends on how the mitts are used.

If you put a light hand mitt on and the patient is still able to move his or her fingers and hands, and you don’t...
**Restraints**  
< continued from p. 9

tie the mitt to the hand rail, then it’s not considered a restraint. But if it’s a big bulky hand mitt and you have restricted the range of movement of the patient’s fingers, then it would be considered a restraint. It depends on the hand mitt and your intent.

A patient with dementia falls and breaks a hip and is placed in traction.

Is this considered restraint because it limits the patient’s mobility and the patient does not understand why he or she is in traction?

This is not considered restraint because it is part of the accepted medical procedure for treating a fracture; the dementia has nothing to do with the traction.

I’m unclear about what is required in physician files regarding educational documentation on restraints.

Must there be documentation in physician files that physicians have training on the policy, or does the requirement apply only if they are going to be applying restraints?

If the physician is solely going to order restraint, you must at least cover the hospital’s policy on restraints in your general orientation. Documentation should demonstrate that the physician is aware of the policy and has read it.

However, if the physician is going to apply restraint, you also need to show competency in the application of the restraint.

What should we have available to show a CMS surveyor regarding the Innovations of Patient Care program?

You could keep a binder that would be available for a surveyor containing information on the overview of your program.

Make sure the information includes who’s responsible for the program, how surveillance is performed, data management, what data you have related to your surveillance plan, and what actions you have performed to prevent or reduce healthcare-associated infections (consider referring to your policies).

The information should also include all the logs that surveyors want to see.

If hard copies of the logs are not available for direct examination, inform surveyors where they can be found electronically.

When determining a medical condition or a reason that a patient is in need of restraint, does chronic dementia qualify for either category or is it considered separate from treating a medical condition?

If you are prescribing a drug for a patient with a psychiatric disorder, and the idea is that the patient will function more appropriately with the prescription, then it is not a restraint.

However, if your intent is to keep the patient from moving around freely, and you’re doing it because the patient has dementia, is confused, and may wander off without the prescription, then it would be considered a restraint.

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Recommendation to avoid errors with drug samples

Editor's note: Sue Dill Calloway, RN, MSN, JD, director of hospital risk management at OHIC Insurance Company, The Doctor's Company, in Columbus, OH, is the “CMS corner” lead contributor. Submit a topic idea to her by contacting BOJ Senior Managing Editor Matt Phillion at mphillion@hcpro.com.

The National Coordinating Council for Medication Error Reporting and Prevention is an organization with the goal of ensuring that no patient will be harmed by a medication error. Earlier this year, the council issued recommendations for avoiding medication errors with drug samples.

The document provides guidance for a standardized approach to distribution of drug samples in all practice settings, with 18 process recommendations.

Drug samples should only be provided by licensed practitioners in accordance with state laws and regulations. Most state boards of pharmacy have specific regulations that govern the use of sample medications in each state.

There should be policies and procedures that address procurement, storage, access, distribution, dispensing, and proper disposal of drug samples. All providers and appropriate employees should be trained on and have access to the policies and procedures.

All drug samples should have a label on them that contains the name of the patient, the name of the drug, the drug’s strength, and clear directions for use. For example, the Ohio State Board of Pharmacy requires five items on the label that must be verified by the physician.

Patients should be educated about the safe and proper use of the medication. Patients should include any sample drugs in their list of currently used medications.

Patient-specific information must be available at the time the sample medications are provided to the patient to check for allergies and other interactions or contraindications.

Study finds bar-coding problems

A recent study published in the Journal of the American Medical Informatics Association found that the use of bar-coding helps reduce medication errors (the study is available online at http://tinyurl.com/3krjdn). It looks at how nurses in the hospital identify the correct patient with the proper dose.

However, the process needs refinement, and the study found that the use of this technology can create new types of medication errors. It looked at nearly 500,000 instances in which nurses and other staff members scanned patients and medications.

The study examined the issue of nurses using workarounds when using barcode medication administration (BCMA) systems. It found that nurses scanning the barcode on the medication or the patient’s ID bracelet overrode BCMA alerts for 4.2% of patients charted and for 10.3% of medications charted.

In fact, nurses found 15 ways to work around the bar-coding system. These included affixing patient ID bar codes to computer carts, scanners, door jambs, or nurses’ belt rings and carrying several patients’ prescanned medications on carts.

The authors determined 31 causes of workarounds. These included unreadable or missing medication bar codes, malfunctioning scanners, unreadable or missing patient ID wristbands, non-bar-coded medications, failing batteries, uncertain wireless connectivity, and emergencies.

The shortcomings of the system and integration problems caused the workarounds. Redesigning the system would prevent some of them from occurring.
Who is responsible for preanesthesia reevaluation?

2009 standard PC.03.01.03, element of performance (EP) 8, requires that hospitals reevaluate patients immediately before administering moderate or deep sedation or anesthesia. Does this mean that the anesthesia provider no longer has to be the one that performs the immediate reevaluation?

The 2008 manual, under PC.13.20, had two pertinent EPs, 10 and 12. These were for the presedation assessment and the immediate reassessment just prior to induction.

Neither of these EPs explicitly stated that the anesthesiologist or certified RN anesthetist performed the assessments. However, that has been the expectation from The Joint Commission (formerly JCAHO). The theory behind this is that the person performing assessments has to have appropriate credentials and privileges.

The CMS Conditions of Participation regulations for medically directed anesthesia are very explicit in 415.110. These regulations state that the physician conducts the assessment and prescribes the anesthesia plan. In this section, the regulations further state that the physician alone inclusively documents the preanesthetic exam in the medical record. CMS leaves no ambiguity regarding who has to conduct the preanesthesia assessment. Thus, if you were anticipating a change or relaxation of your existing preanesthesia assessment process as a result of this wording change in the standards, you will want to cancel any anticipated changes.

While discussing this standard, I should also mention how frequently this particular standard is scored on Joint Commission surveys.

In the September Perspectives, the end-of-year 2007 scoring data were released, and PC.13.20 was scored in 18% of hospital surveys. This often arises because the assessment is not conducted according to the hospital’s requirements when done outside of the main operating room or performed by a physician other than an anesthesiologist.

For example, if the hospital policy requires an American Society of Anesthesiologists (ASA) or Mallimpati score, then there has to be an ASA or Mallimpati score, regardless of who performs the assessment.

In addition, I often see the immediate reassessment missing from preanesthesia assessments. It is important to remember that this is a two-step process in the Joint Commission standards, with the assessment, followed by an immediate reassessment prior to induction.

This two-step process is to occur regardless of how close in timing the full assessment was to initiating the procedure.

Editor’s note: Patton is the former Joint Commission executive director of accreditation services and principal of Patton Healthcare Consulting, LLC, in Glendale, AZ. To ask him a question, e-mail Matt Phillion at mphillion@hcpro.com and look for the answer in an upcoming issue.