Mock surveys make a difference in staff education

“While managing 70 people for tracer teams may prove to be challenging, we have found so much value in the ability to spread knowledge about Joint Commission standards throughout the entire organization.”
—Laura Weber, RN, MBA/HCM

“When I arrived in November of 2006, we didn’t have any sort of formal readiness process and we were up for our Joint Commission [formerly JCAHO] survey in 2007,” says Carach.

However, the facility had a survey readiness committee that decided it would institute mock drills and tracers.

“That’s where we got started,” says Carach. “We [looked at] maybe three units as part of our initial drill and then instituted a more formal tracer.”

An initial sign-up sheet garnered teams for two patient care units immediately, and the facility was able to begin tracers in all units roughly six months later.

“We leave it up to the teams to schedule the tracers with their partners. They are encouraged to invite the unit manager or a designee,” says Carach. “We don’t surprise the unit; we invite them to participate in the learning process.”

“While managing 70 people for tracer teams may prove to be challenging, we have found so much value in the ability to spread knowledge about Joint Commission standards throughout the entire organization,” says Laura Weber, RN, MBA/HCM, director of quality management at Medical City.

“This level of involvement from both clinical and nonclinical staff drives our continuous readiness efforts.” The purpose is not to catch the unit off guard, but to teach each unit to look for areas in which to improve, Weber says.
Team building

Medical City has 35 two-person tracer teams roving the halls to cover the facility’s 645 beds. Maintaining those teams can be somewhat of a challenge.

After the first round of recruiting, Medical City had 25 teams and ran tracers for all units that had teams assigned to them while it tried to fill in the blanks.

“There was some recruiting at first, but we got very good participation, generally,” says Carach.

There were certain areas that required more active recruiting and, in more challenging cases, unit managers selected or assigned their team members. The team members were educated on the tracer process and took this knowledge to their units. They were then assigned to trace another department.

“Part of the setup is that you do not trace your own unit. You’ll pass over things that are not in compliance” simply because of familiarity, says Carach.

The turnover rate has been small but regular, leading Carach to actively recruit new managers or staff members recently assigned to a leadership role to see whether they want to be a part of the tracer team.

Education

“There was some recruiting at first, but we got very good participation, generally,” says Carach.

The teams are also encouraged to communicate with one another. Twice per year, the 35 teams meet to share experiences and tips on running tracers.

And education isn’t only for the survey teams. “It is important to increase awareness of survey accreditation requirements, not only among the teams, but the staff and people they talk to while they are surveying the units,” says Carach. “The tracer teams become educators there. The staff feel more comfortable being interviewed, and they are better able to communicate the standards. More exposure means more familiarity with the lingo.”

Reporting process

Team reports can prove time-consuming. Carach notes. “We used to have the teams verbally report the findings at the survey readiness meeting, but that became too time-consuming,” she says.

Instead, Medical City transitioned the reporting process into a database on a shared drive in the hospital.
“Each team puts their findings into the database, and they leave a copy of their report with the manager of the unit,” says Carach.

Team members also send the names of staff members and physicians they interviewed to the HR and medical staff department so their files can be checked.

Make the time

One consistent challenge for the teams was making sure they blocked off sufficient time to conduct their tracers.

“People have very good intentions; they want to help out, and they’re very willing to do so. But at the end of the month, they find they’ve run out of time,” says Carach. To prevent this, she sends messages reminding team members to schedule their monthly tracer.

“I send these messages out at the beginning of the month,” says Carach. “If they have it on the calendar, it gets done. But like most people, if they say, ‘We’ll get it done when …’ there’s a good chance it falls [by] the wayside.”

How the teams handle their scheduling is up to them. Some have a standing appointment established. Others keep a more informal schedule to complete the tracer.

Tools of the trade

“We have a form intended to guide the team through the tracer,” says Carach. “We do tell the teams they’re not expected to fill in every blank on the form every time they do a tracer.”

The form includes a chart review, so team members randomly choose a chart from the unit and look it over for specific items, including the:

- History and physical
- Time, date, and signature on medical record entries
- Home medication list
- Interdisciplinary patient education

The tool also includes a staff review section, and mock surveyors try to choose the nurse who is taking care of the patient for the reviewed chart, when possible. “We also ask National Patient Safety Goal–related questions to give staff the chance to practice answering the sort of questions they should expect when actual surveyors come,” says Carach.

Other components of the form include a section on:

- Patient interviews
- Medication management
- Environment of Care

“Overall, the form is about nine pages,” says Carach. “What we learned was that when you first start using the form, there will be units so different that certain parts of the tracer tool won’t apply to them.”

—Carol Carach, RN, BSN, MPH

Recognition

The semiannual team meeting not only serves the purpose of sharing information and lessons learned, but also recognizing excellence and improvement.

“We have some incentive programs,” says Carach. “We recognize the most-improved team and unit, as well as the most consistent team and unit.”

Honorees are rewarded with a small party and recognition in the hospital’s newsletter. The tracer team and unit share the reward as a method of building a sense of partnership. For the first two quarters, Medical City recognized consistent excellence on the orthopedic surgery floor and saw improvements on the pediatric unit.
Florida hospital system weathers survey surprises

“Our plan got blown up the first day,” says Crawford. Lee Memorial had initially anticipated that the surveyors would break up and go to different hospitals, with one surveyor to each hospital, two surveyors to the outpatient and ambulatory sites, and a Life Safety Code® (LSC) surveyor. In anticipation of this, each hospital had a vice president of patient care service ready to act as a chaperone, as well as someone who knew the system well to act as a scribe.

“Of course, the surveyors made the decision to stay together and do each hospital as a group,” Crawford says. This led to some quick thinking and restructuring of the health system’s plan.

“We had to rethink who we had stationed at each hospital,” says Crawford. “As soon as we walked out of the opening conference [with the surveyors] … we immediately met to deploy staff to the hospital that would have all five surveyors at once.” This meant redistributing experts already primed for the survey.

“That first day, we recruited vice presidents from other campuses on short notice to be scribes at the lead campus,” says Lisa Sgarlata, RN, MS, MSN, CEN, vice president of patient care services at Lee Memorial’s campus.

“Everyone was educated in their roles for survey,” says Chris Crawford, RN, MHA, LHRM, system director of standards and quality at Lee Memorial. “We had a command center set up, and if the surveyor had a need, the scribe could call the command center to ensure that whatever documentation the surveyor was looking for was made available to them.”

The scribe also kept the command center aware of the surveyor’s location, next destination, and his or her findings and concerns. At the end of each day, the health system held a debriefing session and discussed possible requirements for improvement officials believed were imminent.

‘Our plan got blown up’

The Joint Commission (formerly JCAHO) sent eight surveyors to survey the five hospitals and their combined 1,400 beds, plus 44 related outpatient and ambulatory sites.
By comparison, unexpected tactics by surveyors were not nearly as difficult to deal with as a natural disaster. On day one, five surveyors remained in the first hospital while two others surveyed the ambulatory and outpatient centers. The LSC specialist worked independently.

“He moved much more rapidly,” says Crawford. “We really didn’t know where the LSC specialist was going to next or where they’d be the next day.”

The ambulatory settings checked in with the command center to get updates on findings and surveyor progress. “They were using the command center just like the other campuses,” says Crawford.

The command center was composed of a quality standards department program manager and administrative assistant, members from the information management and HR departments, as well as other staff members.

“We had them log all calls that came in as well as the [notes] scribes would send in … at the end of the day,” says Crawford. “They acted as a repository of information.”

An opportunity for collaboration

The Lee Memorial campus was selected first by the surveyors. “It was interesting to see how they were going to work,” says Sgarlata. “We had an opportunity to see what they were looking for, themes of where they would be headed for the rest of the campuses.”

Also interesting was how the surveyors worked together. The five surveyors who surveyed the five hospital campuses had never worked together previously and were typically in a leadership role in other surveys.

“I thought they worked well together as a team themselves,” says Mary Kirkwood, system director of medical staff quality at Lee Memorial. “They worked well with us but also collaboratively with each other—it was one of the best teams I’ve encountered.”

Ground rules established for communication were beneficial to both sides. Surveyors went through their team leader with requests for information, and information was funneled back through the team leader from the hospital rather than sent directly to the requesting surveyor to keep the transfer of information steady and accurate.

Representatives of the health system were pleased at the collaborative nature of the survey. “Because we were small teams supporting the surveyors, there was opportunity—if there was need for immediate clarification—for it to be very collaborative,” says Cindy Boily, RN, MSN, vice president of patient care at Southwest Florida Regional Medical Center/Gulf Coast Hospitals, a branch of Lee Memorial.

Survey preparation team members also noted that the level of staff preparedness dovetailed well with the interest in education surveyors demonstrated.

“On the occasions when the questions were directed at the staff, I think the staff felt less threatened,” says Cindy Brown, RN, BSEd, MHA, CAAMA, vice president of patient services at Lee Memorial’s Health Park Medical Center branch. “We really enjoyed the time with the surveyors. There were two times when they brought staff and educators to the boardroom in Lee Memorial to talk about the process of education and how to prepare staff and make sure they’re confident. It wasn’t a ‘gotcha’ discussion; it was a ‘share what we’ve learned’ discussion.”

There were numerous opportunities to learn on the fly. For example, early on surveyors spotted a hand washing sink without a clock in one of the cath labs. When the command center discovered that this was something the surveyors were looking for, clocks were immediately installed over all sinks in cath labs systemwide.

“They were very impressed with how quickly a big system responded to an item like that,” says Bridge-Liles.

“One thing we learned is to be very flexible,” says Brown. “We went in with a plan in our mind that we’d rehearsed and educated everyone on many times. On a dime, we had to change our whole strategy.”

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A look at Joint Commission scoring 101

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

During its Standards Improvement Initiative, The Joint Commission’s goal was to review its scoring and decision process to get a more accurate look at each organization’s performance in terms of patient safety and quality.

The Joint Commission (formerly JCAHO) has created a clearer and more concise overall view of scoring with these revisions. The number of elements of performance (EP) has jumped from approximately 1,200 to more than 1,700.

All findings of less-than-full compliance to the standards will be cited by surveyors as an RFI. These must be resolved through an Evidence of Standards Compliance (ESC) submission.

No more B EPs

Let’s look at the basics. The first question you must ask yourself is, “Which type of a standard am I looking at?”

B EPs are gone. Put supplemental findings out of your head. We are now dealing only with A and C EPs.

The A EPs can be broken down as structural requirements (e.g., policies or plans) or they may address an issue even though it focuses on performance or outcomes (e.g., the National Patient Safety Goals). A EPs are there or they’re not. There’s no middle ground. They are scored as 0 or 2.

C EPs are frequency-based, with hospitals scored between 0 and 2 depending on occurrences. C EPs are broken down by the following:

➤ One or no occurrences of noncompliance. The hospital receives a score of 2.
➤ Two occurrences of noncompliance. The hospital receives a score of 1.
➤ Three or more occurrences of noncompliance. The hospital receives a score of 0.

Note: Even though a C element might be scored as 1, the standard will still be scored as 0. In 2008, any EP scored as 1 results in a standard score of 2, whereas in 2009, any EP score of 1 results in a standard score of 0.

Situational decision requirements

There are 12 elements of performance (EP) that fall under situational decision requirements. The requirements are:

➤ Five requirements in the Accreditation Participation Requirements chapter: APR.01.01.01, EP 1; APR.01.02.01, EP 1; APR.02.01.01, EP 1; APR.03.01.01, EP 1; and APR.06.01.01, EP 1
➤ Two HR chapter requirements: HR.01.02.07, EPs 1 and 2
➤ One Leadership chapter requirement: LD.04.01.01, EP 1
➤ Two Life Safety chapter requirements: LS.01.01.01, EP 3, and LS.01.02.01, EP 3
➤ Two Medical Staff chapter requirements: MS.03.01.01, EP 2, and MS.06.01.05, EP 1

Source: Elizabeth Di Giacomo-Geffers, RN, MPH, CNA, BC, CSHA.
Criticality

The Joint Commission defines criticality as how immediate the risk to quality or patient safety a situation of noncompliance of a requirement creates. The Joint Commission has established four levels:

➤ **Level 1: Immediate threat to life.** Immediate threat to life results in a preliminary denial of accreditation directly from The Joint Commission's president, which remains in effect until corrective action is taken and subsequently verified in a follow-up survey. They are frequently based on *Life Safety Code®* violations but can also be the result of transfusion errors and other medical mistakes.

➤ **Level 2: Situational decision rules.** Situational decision rules are identified in the manual by a 2 inside a triangle. This may result in a preliminary denial of accreditation or conditional accreditation ruling.

➤ **Level 3: Direct impact requirements.** Direct impact requirements are based on implementation of care processes. A requirement has a direct impact when, in a case of noncompliance, there is the opportunity to create an immediate risk to patient safety or quality. What makes a Level 3 requirement different from others is that there are no or few processes that act as a protective barrier to patient safety or quality of care should the requirement be noncompliant. There is a 45-day period to address ESC. There are approximately 328 EPs that are considered direct impact requirements (91 based on National Patient Safety Goals and 237 from other standards).

➤ **Level 4: Indirect impact requirements.** Indirect impact requirements are based on planning and evaluation of the hospital's care processes, the failure of which cause an increased level of risk to quality of care or to patient safety. There is a 60-day period of time to respond to a Level 4 requirement with the ESC.

> continued on p. 8

**Decision methodology**

As of January 1, the use of thresholds to determine conditional accreditation and preliminary denial of accreditation no longer exists. Or rather, thresholds are now viewed as a screen or informal benchmark when looking at either of these decisions. Screens are now different depending on the size of the facility being surveyed, as well as the length of the survey. Effective immediately, the number of RFIs per surveyor days are:

<table>
<thead>
<tr>
<th>Threshold screens</th>
<th># of surveyor days</th>
<th># of direct impact RFIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>One to four</td>
<td>Seven</td>
<td></td>
</tr>
<tr>
<td>Five to eight</td>
<td>Eight</td>
<td></td>
</tr>
<tr>
<td>Seven to nine</td>
<td>Nine</td>
<td></td>
</tr>
<tr>
<td>10–13</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>≥ 14</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** To calculate surveyor days, multiply the number of surveyors by the duration of the survey.

According to The Joint Commission, the use of screens will be monitored throughout the year, and thresholds may be reconsidered for 2010 and beyond.

Source: Elizabeth Di Giacomo-Geffers, RN, MPH, CNAA, BC, CSHA.

Hospitals have 45 days to submit corrective action ESC in the case of conditional accreditation decisions, followed by an on-site survey to validate.

➤ **Level 3: Direct impact requirements.** Direct impact requirements are based on implementation of care processes. A requirement has a direct impact when, in a case of noncompliance, there is the opportunity to create an immediate risk to patient safety or quality. What makes a Level 3 requirement different from others is that there are no or few processes that act as a protective barrier to patient safety or quality of care should the requirement be noncompliant. There is a 45-day period to address ESC. There are approximately 328 EPs that are considered direct impact requirements (91 based on National Patient Safety Goals and 237 from other standards).

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> continued on p. 8

**Tagging chart**

<table>
<thead>
<tr>
<th>Key issue</th>
<th>Icon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written documentation required</td>
<td>D within a circle</td>
</tr>
<tr>
<td>Situational decision rules apply</td>
<td>2 within a triangle</td>
</tr>
<tr>
<td>Direct impact requirements</td>
<td>3 within a triangle</td>
</tr>
<tr>
<td>A elements of performance (EP): policies or plans scored 2 (satisfactory) or 0 (insufficient compliance)</td>
<td>A</td>
</tr>
<tr>
<td>C EPs: frequency-based policies or plans scored 2 (satisfactory), 1 (partial compliance), or 0 (insufficient compliance)</td>
<td>C</td>
</tr>
<tr>
<td>Measure of success required</td>
<td>M within a circle</td>
</tr>
</tbody>
</table>

Source: Elizabeth Di Giacomo-Geffers, RN, MPH, CNAA, BC, CSHA.
In summer 2006, Bellin Home Health Care in Green Bay, WI, created a tool to assess patients’ likelihood and risk of falling by using resources from hospital-affiliated home care.

However, the policy did not capture what was needed to assess home care patients, and Melissa Smits, RN, team leader, administrator of home health/home infusion, and Emily Nelson, RN, BSN, quality/regulatory coordinator, sat down to draw up a new fall assessment policy for home care patients.

Using the original policy as their basis, Nelson and Smits worked with nurses and physical and occupational therapists to help create the new policy.

Fall assessment policy raises the bar
Bellin’s upgraded fall assessment for home care receives praise from The Joint Commission

In summer 2006, Bellin Home Health Care in Green Bay, WI, created a tool to assess patients’ likelihood and risk of falling by using resources from hospital-affiliated home care.

However, the policy did not capture what was needed to assess home care patients, and Melissa Smits, RN, team leader, administrator of home health/home infusion, and Emily Nelson, RN, BSN, quality/regulatory coordinator, sat down to draw up a new fall assessment policy for home care patients.

Using the original policy as their basis, Nelson and Smits worked with nurses and physical and occupational therapists to help create the new policy.

The original care plan had staff members initiating the process and documenting the assessment on three different plans.

After sending the first draft and receiving feedback from the facility that it was too lengthy, it was decided Bellin needed something more concise.

“In January 2007, The Joint Commission [formerly JCAHO] came in and felt as if we needed to have the program beefed up, as it appeared our staff was not consistently following the policy,” says Smits.

“We needed to live it and breathe it and follow it completely,” says Nelson. “We had it going, but it wasn’t where it should have been.”

Examples include testing fire doors and use of patient identifiers when using restraint or seclusion for behavioral health purposes.

Tagging
The Joint Commission has established a series of tags for identifying key issues associated with a given requirement. EPs are identified in the manual by such tags, whether they are situational decision or direct impact requirements. Those that have not been identified by a tag 2 or 3 are by default a 4 or an indirect impact requirement.

Note: EPs are not tagged as immediate threat to life, but rather, immediate-threat-to-life situations are created by a combination of EPs from the other three categories.
Using the original assessment policy, key pieces were pulled aside that needed to be documented.

The update also included reducing the number of steps staff members had to complete to make it easier for them to follow through with the policy, says Smits.

The updated fall assessment policy was introduced in February 2007, and was Bellin’s first formal policy that staff members had to sign off on and begin implementing.

The policy outlines what is expected of each staff member. It covers its purpose, how to perform a fall risk assessment, how to document it correctly, and the staff members responsible for the procedure.

Upon reading the new policy, staff members were required to sign a form saying they had read and understood the policy. Documentation of their signatures ensured that staff members were held accountable for the patient.

Note: See an example of the fall risk assessment policy on pp. 10–11. Also, BOJ subscribers can view a sample form online at www.bojextra.com.

In August 2007, not long after the policy was introduced, Nelson and Smits decided to revisit the policy.

“We were assessing patients in home care and taking a step back,” says Nelson. “There was a policy change with the verbiage, so that we assess the patient on admission and when the patient gets out of a healthcare facility, transfers, or has any significant change in condition.”

In addition to changing the verbiage, a posttest for all staff members was created to ensure that the new policy was read and understood. Once the staff members had read the policy, they were required to take the test and receive a perfect score.

“By creating a posttest, we could validate their accountability to the policy and process,” says Nelson.

Now, each new staff member is required to read the policy at orientation, take the test, and sign that he or she has read the policy.

“The staff was really good about accepting the new policy changes,” says Nelson. “The more that you put it out there, the more you pull them aside, the more likely they are to be compliant.”

Nelson and Smits also say they believe that The Joint Commission’s visit to Bellin Home Health gave staff members another reason to be compliant with the new fall assessment policy.

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Senior Managing Editor
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Assessment policy < continued from p. 9

“The timing of The Joint Commission’s visit and all the hype that surrounded the development of a better fall risk assessment policy helped to get the staff on the right track,” says Nelson. “Coming only from us, there may not have been quite an impact [on the staff], but with The Joint Commission coming in, we were able to reiterate the importance of the new policy.”

Even the patients had few complaints when transitioning to the new policy. The patients who were already part of Bellin Home Health were a bit reluctant at the beginning because they viewed it as more paperwork to fill out, says Nelson.

New patients were open-minded to the new forms and paperwork because they had never known anything else, Smits says.

Additionally, each patient was educated about the entire process because staff members would cover each tool and slowly ease the patient into the paperwork and actual process. Nelson is unsure how often the new policy is going to be updated.

“We think what we have going is good, and for the most part, patient falls are down. Maybe we would change the policy if there is a new state or Joint Commission requirement we need to add.”

Although the program is in use for only adult patients at this time, its use may be expanded at a later date. Nelson and Smits say they would be willing to expand their fall assessment policy into the pediatrics unit in the future.

“Right now, our policy does not pertain to pediatrics. But further down the road, we would like to adapt the tool to a certain age group,” says Nelson.

One word of advice to other facilities reexamining their fall assessment policy is to look at their patient population, says Smits.

“It depends on the patients you have,” she says. “You always have to take a look at what is going on.”

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Sample fall risk assessment process

Purpose:
To assess all home care patients for risk factors of a fall and evaluate safety measures/fall reduction process effectiveness.

Policy:
1. All home care patients will be evaluated for their fall potential for the indicated instances:
   - On admission
   - After patient hospitalization (Resumption of Care)
   - Upon returning home from a healthcare facility (Resumption of Care)
   - Every 55–60 days (recertification)
   - With any significant change in condition
2. A completed variance form is required on all witnessed falls by staff members. The completed variance is to be given to the team leader and then to the quality/regulatory RN for review. The form is also submitted to Bellin System-wide Clinical Risk Management. All falls, witnessed or unwitnessed, are to be documented under Incident in the assessment part of the record.
3. All fall incidents are reviewed and analyzed by the quality/regulatory RN. Follow-up is conducted regarding implementation of a fall reduction plan, as well as conferencing with the corresponding primary clinician for the patient. If more than two fall incidents occur in a home setting, a multidisciplinary conference approach may be taken if
issues persist, which may include involvement of leadership, physical therapy/occupational therapy, social workers, or the home medical equipment supplier. An evaluation of falls reduction will also be conducted on a monthly basis.

**Performed by:**  
The RN and physical therapist

**Procedure:**
1. Use the Fall Risk Assessment Tool to score the patients on their fall risk potential. Answer “yes” or “no” to each question in the five categories listed.
2. Score the patient as a fall risk in the computer documentation system as:
   - High risk if there are “yes” answers from three or more of the categories
   - Medium risk if there are “yes” answers from two categories
   - Low risk if there are “yes” answers from one category or less
3. If the patient is identified as high risk, implement the Fall Reduction Plan. The Fall Reduction Plan may be implemented if the patient is identified as medium or low risk based on clinician judgment. If the patient appears to be unsafe in his or her home, immediately notify the physician and team facilitator or team leader.
4. Implementation of the Fall Reduction Plan:
   - Review the fall prevention information listed in the patient orientation booklet
   - Conduct a physical therapy evaluation for such items as the patient’s mobility, transfers, and ambulation, if applicable
   - Implement an occupational therapy evaluation for such activities as patient bathing, dressing, and toileting routines, if applicable
   - Consult Bureau of the Blind for those patients who are blind or visually impaired, if applicable
   - Request patient’s pharmacist to review medications, if applicable, when the patient is taking the following medications: sedatives, psychotropics, antihypertensives, tranquilizers, and/or narcotics
5. Ensure that a specific patient safety goal and the following assessments and interventions are added to each discipline pathway:
   - Safety—the fall risk reason and level are included under this assessment
   - Teach safety
   - Exercise/gait, if applicable
   - Ortho device, if applicable
   - Incident—found under Assessments, which allows the clinician to document a patient fall if it occurs

**Documentation:**
1. Fall Risk Assessment Tool
2. Patient information note in record: Type “Fall Risk (High, Medium, or Low)” found under Admin Items from the patient overview screen
3. Safety assessment in record

**References:**

**Bellin Home Health Care:**
Effective ____________
Policy/procedure manual

Supersedes the February 2007 fall risk assessment process
This policy has been reviewed by:
Home Health Care center leader
__________________________________ Date: __________
Home Health Care team leader
__________________________________ Date: __________
Home Health Care educator/team facilitator
__________________________________ Date: __________

Q&A with KURT PATTON

Clarifying processes for patient identifiers

Our cardiopulmonary staff members have a short period of time to perform EKGs on patients coming into the emergency department with chest pain. This time frame has been established so that we can provide our patients with the best quality of care possible and also to meet core measure requirements.

The patient may not be wearing an identification (ID) bracelet before the cardiopulmonary staff member arrives to complete the EKG.

What process do you suggest for identifying the patient? The patient may or may not be responsive and have a family member or caregiver with him or her at the time.

The best place to start is to remember why this National Patient Safety Goal (NPSG) was created. Misidentification of patients was a problem in healthcare with sometimes disastrous outcomes due to delivery of the service to the wrong patient or omission of the service to the intended patient.

In a busy ED, it is quite likely that two middle-aged patients may be there with a presumed myocardial infarction, or two cases of any other diagnosis. We know that we must avoid using a technique that relies on a room assignment or physical description, such as “50-year-old male in the hallway bed.”

The Joint Commission (formerly JCAHO) has not posted on its Web site FAQs for 2009 that would provide clear guidance on this subject. There was one FAQ in 2008 that dealt with unidentified patients known as John Does, but that is somewhat different from your question.

With any of the NPSGs, genuine emergency treatment always takes precedence, but it would not be correct to state as policy that the EKG service for ED patients could commonly bypass the two-person identifier technique. Such a bypass of the two-person identification technique should be a rare emergency situation. A system should be developed in your organization that allows you to use the two-person identification technique routinely.

Patients arrive at the ED via emergency medical service (EMS), family and friends, or they drive themselves. In most cases, the EMS service will initiate the ID process or family or friends who brought the patient. Patients who are alert can self-identify or may be carrying ID that allows us to know their name.

Only a limited subset of patients should be unidentifiable, and they will be temporarily identified as John or Jane Doe and have a medical record number shortly after arrival.

In true emergency situations, assessment and stabilization may be occurring while other staff members are working on ID. In most cases, we will be able to identify the patient. The problem is developing a system that allows caregivers to use that information routinely and rapidly.

You mentioned that the patient may not yet have an ID bracelet in place before EKG service has to be rendered. An issue that should be examined is how long it takes to create a name bracelet in your hospital. Ideally, this should happen immediately upon arrival.

If a remote department is creating ID bracelets that must be processed and delivered to the ED, you may need to examine an alternative technique for emergency patients.

Editor’s note: Patton, MS, RPh, 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.