Monitor alarms by evaluating staff perception of noise, and more

When it comes to complying with the JCAHO’s patient safety goal to monitor alarms, many people struggle with the nuances behind checking various alarm systems.

Patient safety goal number six requires organizations to perform regular preventive maintenance testing of alarm systems attached to equipment that monitors and treats patients. Staff must ensure alarms are appropriately set and that people can hear them regardless of distance and competing noise on the unit.

Such equipment includes cardiac monitors, apnea alarms, oximeters, ventilators, and infusion pump alarms.

Many gray areas in testing alarms exist, such as how staff perceive what each alarm means and how to respond. Staff must also determine appropriate sound settings, another area that lends itself to subjectivity. The JCAHO doesn’t specifically recommend a decibel level, so consider the alarm’s location when making your decision, according to the goals’

Standard of the month
Recognize when you need to turn to external peer review

Does your hospital have a policy clearly describing when it would seek an external peer review organization?

If not, create one before your next JCAHO survey. JCAHO standards MS.8–MS.8.4 require organizations to define the situations in which they seek external peer review. They also detail the rights of practitioners subject to review, such as holding a fair hearing and appeals process. You must incorporate definitions into your medical staff policies.

“The real value of defining specific peer review situations into your by-laws is when you get into a legal situation,” says a source close to the JCAHO. “You will be better protected since your policies show that you review and treat all practitioners in the same manner. Most people lack a thorough peer review policy.”

External peer review is an impartial evaluation of a physician’s clinical performance or professional conduct which, for whatever reason, hospitals cannot resolve internally.
Monitor alarms <p. 1

frequently asked questions (FAQs), posted at www.jcaho.org (look for the FAQ icon on the home page).

Your colleagues want to know the best way to systematically review alarm safety, monitor audibility, and check staff response to clinical alarms. In this issue, BOJ looks at the following issues behind this goal, and how to comply:

• Performing an alarm inventory
• Testing whether you can hear alarms
• Observing staff perception of alarm noise
• Creating a high-risk equipment list
• Making sense of data on equipment errors

Take stock of your alarms
Start from scratch with your inventory. Don’t assume that your current preventive maintenance inventory includes all the alarms that it should, says John Rosing, FACHE, a senior consultant for The Greeley Company, a division of HCPro, in Marblehead, MA.

The electronic services department staff are the most appropriate employees to step back and determine what equipment belongs on this list.

Note: The list of alarms offered on the JCAHO Web site may not be all-inclusive, Rosing says. “Some hospitals use unique equipment that falls below the radar screen,” he says.

TIP: Approach inventory by including any device with an alarm used for diagnosis, treatment, and monitoring of patients. “A printer may have an ‘out of paper’ chime, but not having paper is not necessarily a patient safety concern,” Rosing says. “However, you should include a printer in an area that receives faxed orders, like in the pharmacy, on the inventory list.”

Check for audibility
Test equipment on the units and departments where staff use it daily, rather than carrying infusion pumps, for example, to an area with limited noise, Rosing says. “Guarantee that the alarms work in the actual environment where they are stationed,” he says.

TIP: Perform field checks during busy or noisy times of day to guarantee that staff can hear them. For example, the 3 p.m. shift change when the night staff comes in, visiting hours, and during afternoon housekeeping are busy times. See a sample checklist for audibility on p. 4. “This way you can see while the vacuum runs whether staff can hear the alarm in room 220 down the hall,” Rosing says. If staff can’t hear the alarm, it shouldn’t be located that far away.

Understand staff priorities
Involve staff members, such as nurses and respiratory therapists who work with equipment, in field testing. Apart from what appears in your policy and procedure, staff may have their own method for responding to alarms.

For example, on a busy nursing unit, staff members continually prioritize tasks. A nurse must decide whether administering a drug to a patient takes precedent over an alarm that sounds in an adjoining room. An apnea alarm takes priority over a nurse call signal, for instance. “Part of this goal is to get inside the heads of your nursing staff and those who respond to alarms and ask how they go about their daily practice,” Rosing says.

TIP: Sit down with staff and ask them what happens on their unit each day. When an alarm sounds, what do they do? “Find out how nurses prioritize duties, listen for certain sounds, and form a hierarchy in their minds,” Rosing says.

TIP: Talk with staff in a nonconfrontational manner so they feel free to discuss circumstances when they nearly miss an alarm.
Troubleshoot the challenges
Consider this common challenge: A piece of equipment is located too far down the hallway so staff can’t always hear the alarm.

Solution: Place patients hooked up to the device closer to the nursing station or install alarm amplification devices.

Staffing levels also correlate with how quickly caregivers can respond to alarms. In talking with staff, you may learn that they can respond to alarms immediately during certain times of the day. But when more than one thing is going at the same time, such as nurses giving medications during high levels of admittances, staff just can’t react right away, Rosing says.

Create a high-risk list
Establish time frames for preventive, corrective, and metered maintenance checks. Metered maintenance is based on the amount of use, similar to changing one’s automobile oil every 3,000 miles, Rosing says.

Make equipment that is most critical to patient care and carries the most risks a priority for maintenance. The JCAHO suggests breaking down the criteria for equipment into the following three categories:
1. Whether staff use equipment for diagnosis, care, treatment, and monitoring
2. The physical risk associated with use, such as getting electrocuted
3. The equipment history, such as if a piece of machinery has had reported failures or a certain model needs more rigorous maintenance

For example, an exercise bike in the physical therapy department isn’t used for diagnosis, care, treatment, or monitoring, so you wouldn’t need to conduct preventive maintenance on it, Rosing says.

Make sense of your data
The data that you collect on equipment maintenance is the place to begin your analysis when looking for problems, user reports, and patterns associated with a particular model.

**TIP:** Look for data across different shifts, days of the week, and units to pick up on trends. “This is basic performance improvement work; use the data to work for you in identifying patterns,” Rosing says.

Equipment failures typically occur for one of the following reasons:
- A flawed system or process exists. “No matter how well you train staff and how compliant they are, you will still end up with certain amount of failures since a process allows that to occur,” Rosing says.
- In spite of having a relatively foolproof system or process, staff don’t have adequate training.
- A system works and staff are well-trained, but some decide not to follow policies on use.

If data shows errors occur randomly—all days, all units—a system or process issue is the likely culprit. If information shows failures contained to a particular unit during a specific shift, then you can figure it’s a training issue.

Finally, if all errors occur during the same shift in a certain wing and when a certain person is working, it’s probably a compliance issue.

**TIP:** Remind staff that most equipment has its own alarm testing method, such as a smoke detector’s test button.

**TIP:** Include contract staff in equipment training and testing. “We hear surveyors will check this area,” Rosing says.

“They will look for competency verification for contracted staff, such as respiratory therapists, for example.”

Editor’s note: You can contact Rosing at jrosing@execpc.com.
Sample checklist for audibility of clinical alarms

This checklist is one way to comply with the JCAHO’s requirement for clinical alarms to be audible when they sound. This questionnaire is not all-inclusive, nor is it the only way to measure compliance with this national patient safety goal. Your hospital will likely find other pertinent concerns to ask about as well.

***

Date: ____________________
Name: __________________________ Department: ______________________________
Equipment/item tested (including model): ___________________________________________________________
Manufacturer (if known): _________________________________________________________________________
Location of the equipment/item: ___________________________________________________________________
Day of the testing (e.g., Monday, Tuesday, etc.): _____________________________________________________
Time of the testing: ________________
Was the alarm for the item on and working properly?  Yes  No
If no, please explain further: _______________________________________________________________________
Describe how far away you stepped from the equipment/item, and in each case, whether you could hear the alarm:
Distance: _____________________ Could you hear the alarm? __________________
Distance: _____________________ Could you hear the alarm? __________________
Distance: _____________________ Could you hear the alarm? __________________
In cases where you couldn’t hear the alarm, why was the alarm inaudible? ___________________________________
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..............................................................................................................................................................
Were there other noises “competing” with the clinical alarm (e.g., a paging system, nursing station conversation, etc.)? _____________________________________________________________
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..............................................................................................................................................................
..............................................................................................................................................................
Is this equipment/item critical to patient care?  Yes  No
Do you have any suggestions for improvement? __________________________________________________________
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Peer review

The most common needs for outside reviews include conflict of interest situations and a lack of internal expertise, especially at rural hospitals that have limited numbers of specialty physicians on staff (see a list of the six most common circumstances on p. 6).

Smaller staff, fewer reviewers
The 46-bed Shawano (WI) Medical Center noticed situations particular to them that prompt external peer reviews. First of all, the hospital lacks a sufficient number of specialty physicians, says Steven Schenk, RN, BSN, the center’s quality resource manager.

For example, the hospital has one ear, nose, and throat (ENT) physician on staff who practices there twice a month. Having another ENT physician perform a peer review on this physician is impossible, since he is the only one. Just two general surgeons are on staff at the hospital. They are also partners at the same clinic. These two surgeons therefore cannot review one another’s work since that sparks a conflict of interest.

Outsourcing for external review
Shawano Medical Center staff take one credentialing issue off their plate by contracting with Rural Wisconsin Health Cooperative’s external peer review services. The cooperative offers networking opportunities for rural hospitals in Wisconsin (visit www.rwhc.com for more information and other links in the box below).

The process is simple. Schenk calls the cooperative and lets it know he is sending a physician record for external peer review. He fills out a form, attaches the physician’s records, and he’s done.

TIP: Remove all references to physicians, patients, and the hospital when sending external peer review documents. “We go through the records and either white or black out identifiers so it is an objective review,” Schenk says.

The cost is minimal for the time and headaches saved trying to find outside peer physicians, Schenk says. Costs vary per contract.

“For us, this is pretty valuable because we save external peer review for these rare instances,” he says. “It is not as if every file goes to them, but rather for certain situations, like when we question a potential conflict of interest.”

Additional resources for external peer review

Editor’s note: This list is not exclusive and provides just a few of the many peer review services.

- **Veteran’s Health Administration’s external peer review program**—This national program gathers information on the quality of medical care and provides feedback to clinicians and administrators. www.wvmi.org/eprp.htm.

- **National Peer Review Corporation**—This service offers three levels of external peer reviews for physician performance and disruptive practitioners. www.nationalpeerreview.com/EPRS.htm.

- **The Greeley Company**—This is the consulting arm of HCPro, in Marblehead, MA, which publishes BOJ. External peer review activities include assisting with appropriate review tactics, supervising on- and off-site cases, and analyzing and consolidating external peer review findings, among others. www.credentialinfo.com/cred/epr/tgc.cfm.

- **CIMRO external peer review**—This peer review network includes more than 500 physician reviewers representing 69 specialties and subspecialties. www.cimro.com/peerrevw.htm.
The six general situations below require external peer review, according to Laura Harrington, RN, CPHQ, practice director for external peer review, ambulatory services, and credentialing and privileging consulting services for The Greeley Company, a division of HCPro Inc., Marblehead, MA. HCPro publishes BOJ.

1. **Litigation**—Hospital legal counsel often contacts outside peer reviewers when the hospital faces a potential medical malpractice suit. These external organizations can provide an expert opinion regarding quality of care.

2. **Ambiguity**—Confusion can arise when groups conducting an internal review reach conflicting conclusions that affect a practitioner’s membership or privileges. When internal reviewers submit conflicting or vague recommendations or fail to agree, an external organization can resolve the situation by reviewing the applicable records.

3. **Lack of internal expertise**—Many hospitals, particularly rural facilities, must occasionally rely on external peer reviewers because medical staff lack the expertise in the specialty under review. External peer review organizations can help when the only practitioners on the medical staff with the expertise to review the specialty are associates, partners, or direct competitors of the practitioner under review.

4. **Conflict of interest**—If an organization has two general surgeons on staff who are partners at the same clinic, one reviewing another’s performance triggers a conflict of interest. Note: Your medical staff policy regarding external peer review may specify using external organizations if the medical executive committee (MEC) or governing board can’t resolve potential conflicts of interest.

5. **New technology**—Hospitals that acquire new technology may discover they do not have the necessary tools to assess whether a medical staff member requesting privileges possesses the required skills and competence.

6. **Miscellaneous issues**—Most hospitals adopt external peer review policies that allow the MEC and governing board to use external reviewers whenever appropriate (e.g., when the medical staff need an expert witness for a fair hearing, evaluation of a credentials file, or assistance developing benchmarks for quality monitoring).

Note: If your hospital relies on external reviewers, find a credible resource to provide that service.
Critical access hospital surveys:
Shorter, but more intense
Surveyors zero in on pain management and patient safety

When conducting a critical access hospital (CAH) survey this winter at Mendota (IL) Community Hospital, the surveyor further delved into pain management presented during the performance improvement (PI) presentation, by looking at it throughout the hospital.

Homing in on a PI theme is fairly typical during surveys, but during a shorter survey, the subject under scrutiny—in this case pain management—appears to receive more intense attention.

Your colleagues who switched over from hospital accreditation to the CAH program noticed a shorter but more focused survey. Since the organizations knew the JCAHO standards already, the transition to a more condensed set of standards was quite smooth.

The JCAHO launched its CAH program in 2001.
Read more about CAHs on p. 9.

Similar standards
Mendota (IL) Community Hospital obtained CAH status in January 2001 and underwent its survey in December 2002, shortly after the JCAHO received deemed status, says Kris Goodbred, RN, MS, Mendota’s director of patient care services. Goodbred didn’t notice a major difference between the hospital and CAH standards.

The JCAHO boiled down many existing hospital standards to form the CAH manual, Goodbred says. The JCAHO did not include, for example, the new staffing standards in the CAH manual.

It was also new to see one surveyor, an administrator, for two days as opposed to previous hospital surveys when a team of three surveyors conducted the three- to four-day visit, Goodbred says.

“It seemed like our surveyor knew what he was looking for, and once he saw proof of compliance, he moved on to the next standard,” she says. “But he was very thorough.”

The top hot spots were pain management and patient safety, Goodbred says.

A painless presentation
Staff started the survey with a PI presentation about their pain management program, including the education of patients on their right to have their pain treated. A certified registered nurse anesthetist and pharmacist delivered the PI presentation.

Mendota (IL) Community Hospital has been JCAHO accredited for more than 30 years. The organization has 38 licensed beds and an average daily inpatient census of nine. The facility offers outpatient services, such as emergency and operating rooms, cardiac rehabilitation, physical and respiratory therapy, radiology, and more.

Peach Regional Medical Center, in Fort Valley, GA, has been JCAHO-accredited since 1957. The hospital has 25 beds and an average daily patient census of 4.8. The facility offers outpatient services, such as emergency and operating rooms, cardiac rehabilitation, physical and respiratory therapy, laboratory, and radiology, among others.
TIP: The JCAHO wants brief and concise PI presentations with just key staff members rather than a group of people, Goodbred says.

TIP: Be prepared for the surveyor to seek compliance in the areas described during the PI presentation. For example, following the PI overview that focused on pain management, the surveyor how staff treat pain during the rest of the survey, says Goodbred.

Consistency of staff assessments
The surveyor examined how staff assess and reassess for pain in every area of care, Goodbred says. The surveyor wanted to know how staff handle those patients whose pain does not change.

Staff won kudos for using consistent assessment forms in all departments. For example, everyone explains the 0-10 scale in the same manner and encourages patients to speak up about their pain.

If patients can’t understand the pain scales, staff use the smiley to sad faces chart or judge by patients’ facial expressions and other nonverbal clues indicating pain, especially in places such as the recovery room. That approach also won approval, Goodbred says.

Additionally, the surveyor looked at safety throughout the facility, encompassing the building, staff, and patient safety. “He asked in every area how we can make it a safer environment for all patients,” she says.

Since the survey was so much shorter than hospital visits, the surveyor had less time to interview patients, Goodbred says.

On your own with survey maintenance
However, it is the tasks between surveys—such as keeping up with JCAHO updates—that challenged Kathleen Morris, the continuous quality improvement and regulatory services coordinator at Peach Regional Medical Center in Fort Valley, GA. Peach Regional Medical Center moved to CAH status in 2000.

The JCAHO revises the CAH manual once a year, rather than issuing quarterly updates like with the hospital manual. So for people who rely on the updates, this is a big change, Morris says. She carefully reads all JCAHO publications and Web site broadcasts to determine whether announcements on new changes—such as the new 2004 survey process—apply to CAHs.

“We have to go by the book and keep up with the JCAHO,” she says. “Anything that they say will take effect for all accreditation programs—like the patient safety goals and new survey process—apply to us.”

Also, it’s sometimes unclear when the JCAHO writes an article in its newsletters whether a hospital survey process change pertains to CAHs. “So the challenge is keeping up with new or revised standards since the JCAHO has released the CAH manual,” Morris says.

Morris did speak to the JCAHO about clarifying what changes apply to CAHs, which the accreditor said it would look at, she says.

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You may also not know that for hospitals to change to CAH status, staff must demonstrate four months of standards compliance rather than 12 months because they just entered a new program. The JCAHO will expect a 12-month track record for subsequent surveys, however.

Why CAH status is cost effective
Small hospitals that qualify for Medicare’s CAH program do so to change their payment system to cost-based rather than prospective payment. Cost-based reimbursement means that Medicare bases its payment each year on what it actually costs the hospital to care for the Medicare patient.

Medicare gets this information from a cost report that hospitals fill out each year. Based on that information, Medicare pays hospitals a daily rate for each Medicare patient rather than per diagnosis-related group (DRG) or procedure. The advantage for CAHs is that their rate varies each year based on actual costs, while DRGs are fixed and not always reflective of how much it costs to provide care in small hospitals where inpatient census is low, yet minimum staffing and overhead are still a factor, Goodbred says.

Sources

Kris Goodbred, RN, MS, director of patient care services, Mendota (IL) Community Hospital. kgoodbred@mendotahospital.org

Kathleen Morris, continuous quality improvement and regulatory services coordinator, Peach Regional Medical Center, Fort Valley, GA. kmorris@peachregional.com

About the critical access hospital program

The JCAHO launched its critical access hospital (CAH) accreditation program in 2001. CAHs (outlined in the Balanced Budget Act of 1997) provide limited but vital health services to rural communities.

The Department of Health and Human Services certifies these facilities—which must have a patient census of less than 25—as eligible for cost-based reimbursement from the Medicare program. Cost-based reimbursement means that Medicare bases its payment each year on what it actually cost the hospital to provide care to the Medicare patient.

Nearly 700 hospitals across the country have already converted to critical access hospital status; another 500 hospitals may be eligible for this designation, according to the JCAHO. CAHs provide essential services to patients seeking care in underserved communities.

The JCAHO accredited 43 CAHs in 2002 and scheduled 32 surveys through May of this year, the accredditor says.

The Joint Commission created standards specifically adapted to CAHs’ special services and developed a streamlined survey process for assessing compliance with the standards.

The Centers for Medicare & Medicaid Services (CMS) granted deeming authority for CAHs to the JCAHO on November 21, 2002. The CMS designation means that critical access hospitals accredited by the JCAHO meet Medicare certification requirements.
A hospital test-pilots the JCAHO’s new self-assessment

At a Georgia hospital, the most critical change to the JCAHO’s new survey process was moving away from semantics to looking at and correcting problems in a more consultative fashion.

Tift Regional Medical Center, a 191-bed facility in Tifton, was among the nine hospitals last year that tested the JCAHO’s new survey initiatives for 2004, known as “Shared Visions-New Pathways.”

Shared Visions overhauls the JCAHO survey to look at systems rather than standards compliance (see box, right). It aims to redirect surveyors’ focus away from “the muffin left on the counter” and put it where health care experts believe it should fall—on the delivery of safe and effective patient care.

The new survey method—particularly the self-assessment—requires all departments to comply with JCAHO standards and “will not allow you to pass because of a few shining units or departments,” says Angie King, quality management director at Tift. “It’s not individual units that the JCAHO surveys now, but the entire care process.”

Testing your own compliance
The self-assessment requires organizations to rate their compliance with all JCAHO standards. If your hospital indicates that it doesn’t meet with a specific standard, you must write a corrective plan and send it to the JCAHO at 18 months into the three-year accreditation cycle.

The self-assessment questions mimic those that surveyors typically ask while conducting the traditional on-site survey, King says.

For example, the self-assessment questions about medical staff standards primarily relate to bylaws, King says. Check out these questions from the self-assessment:

- Do the medical staff bylaws define the functions of the medical executive committee (MEC)?
- Do medical staff policies detailed in the bylaws conflict with one another?
- Do the medical staff bylaws specify the frequency of medical staff meetings and meeting attendance requirements?

The questions cover issues that hospitals must include in their bylaws. “Answering these questions in the self-assessment eliminated the time-consuming task of searching for these answers during the actual survey,” King says.

Note: Indicating that your medical staff bylaws comply with JCAHO standards does not guarantee that JCAHO surveyors won’t ask to see the document while on-site. Be prepared for surveyors to spot-check answers provided in the self-assessment for accuracy.

Time to find a remedy
Some of you may wonder why an organization would rate noncompliance with a JCAHO standard while completing the self-assessment form. The

Key components to Shared Visions–New Pathways

- **Organization self-assessment**—Hospitals will fix their own problems through this Web-based program. You will receive the self-assessment software by the fourth quarter of 2003.

- **Tracer methodology**—Surveyors will follow a number of patients through the organization’s entire health care process. They randomly select open records and trace patients’ care from admission through each applicable department.

- **Priority focus process**—This targeted approach centers on issues most relevant to your hospital by using presurvey information such as core measure data.
answer to this question requires organizations to change the way they think of the JCAHO—to consider the accreditor’s increased role as an educator rather than an inspector, King says.

Answering “no” to a self-assessment question in the midpoint of the survey cycle gives organizations time to not only submit a correction report, but ensure that staff fix the problem in time for the actual survey. Surveyors will look for evidence that the organization has taken steps to guarantee compliance, King explains.

For example, if your self-assessment indicates your MEC does not make credentialing and privileging recommendations to the governing board, designate an MEC member to attend every board meeting. JCAHO surveyors will note your corrective action plan and look for proof during the survey that you indeed adopted that plan.

Note: The JCAHO will also use completed self-assessments to identify critical patient care issues at your facility.

Linking assessment findings
Tift’s completed self-assessment led surveyors to identify the organization’s intensive care unit as an area of critical focus during the survey. Did Tift’s other departments breathe a collective sigh of relief? No. The JCAHO’s new “tracer methodology” means that other units remained subject to scrutiny. Surveyors began by asking for a list of current patients and top diagnoses, King says. From that list, the surveyors selected a pediatric patient who came into the hospital through the emergency department (ED) and spent time in the intensive care unit (ICU). The surveyors reviewed the patient’s file, spoke to the patient, and discussed the case with physicians and nurses in the pediatric unit. From there, they moved on to the ICU and ED.

The surveyors use the patient’s chart to guide them through the organization’s departments, policies, and procedures. For example, during this process, the surveyors reviewed credentials files for the pediatrician and ED physician involved in the case, and also asked how staff obtain consults.

“The focus is on the continuum of care,” King explains. “There must be interdisciplinary communication and collaboration.”

Note: Although surveyors may check credentials files while tracking a patient’s care, be prepared for them to pull random files from your shelves as they did in the past, King warns.

Questions? Comments?
Contact Executive Editor Julia Fairclough
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Consulting opportunity
The Greeley Company, a division of HCPro, in Marblehead, MA, seeks experienced JCAHO survey coordinators to provide interim and contract staffing. Candidates must know the JCAHO standards and survey process, and effectively communicate at all levels within a health care organization. Qualified candidates should have the ability to carry out assessment findings, effect change, and manage ongoing survey preparation efforts within the organization. Strong training and educational skills are required. Travel is a must. The Greeley Company will also consider candidates with expert knowledge in credentialing and privileging. Please send your résumé and letter of introduction to Human Resources HCPro, Inc.
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Quick tip: Understand which practitioners need privileges

JCAHO standards require organizations to credential everyone who practices medicine within a hospital. The extent of the credentials verification and approval process, however, depends on the role of the individual in question, says Carol Cairns, CMCS, CPCS, president of PRO-CON, Morris, IL.

Credentialing verifies a practitioner’s professional qualifications to care for patients (i.e., education, training, experience), whereas privileging delineates which clinical tasks he or she may carry out.

Hospitals must credential all practitioners, but only medical staff members and other designated practitioners may hold privileges. Hospitals must credential the following individuals:

• All employees who come into contact with patients

• Medical staff members and those privileged through the medical staff structure

• Allied health practitioners (AHPs) who work as solo practitioners or are employed by or under contract with a medical staff member

• Contract employees who undergo credentialing through the institution or contract service

• Medical device representatives allowed into the operating room

To evaluate whether an AHP should undergo privileging via the medical staff structure, organizations must consider the JCAHO’s requirements. Standard MS.5.14 states that all individuals who are permitted by law and by the hospital to care for patients independently in the hospital must have delineated clinical privileges, whether or not they are medical staff members.

For a practitioner to hold privileges, both the law and hospital must permit him or her to practice independently. “Both of those criteria must be met,” explains JCAHO spokesperson Mark Forstneger.
Directions:

• Complete this continuing education (CE) quiz by writing the letter corresponding to the correct choice for each question on the answer sheet found on p. 4. There is only one answer for each question. You can find the answers to each question in the specific issues of BOJ, and you may refer to them as you take the quiz. (Back issues of BOJ are available. Send $15 per issue with your request, and we’ll mail them right out to you.)

• Send only the answer sheet (p. 4) back to us by May 15, with a $39 payment for each person completing the quiz. To qualify for CE credits, you must get at least 75% of the answers correct—that’s 22 out of 30 questions.

• We’ll send you a certificate of completion that you may use for display and documentation of three credits toward Certified Professional in Healthcare Quality (CPHQ) recertification by the Healthcare Quality Certification Board (HQCB). Approval for CE hours for CPHQ recertification by the HQCB is pending.

• If you’d like to purchase and take your CE quiz online, please check our e-learning Web site at www.hcprofessor.com. Quizzes taken online contain the same series of questions included in the print version, but will be scored instantly and offer immediate access to your certificate of completion.

Editor’s note: The biannual CE quizzes are now offered on a quarterly basis. Therefore, instead of offering two CE quizzes per year based on six months of BOJ, you now have four quizzes each year based on three issues of BOJ. Further, you can receive three credits for each quarterly quiz instead of six credits for the biannual quiz.

January 2003

1. Drug theft in hospitals occurs most often through which of the following means?
   a. substitution  
   b. falsifying charts  
   c. all of the above  
   d. none of the above

2. Drug theft through falsifying charts can go undetected for years for which of the following reasons?
   a. lack of chart audits  
   b. lack of interest in clamping down on drug theft  
   c. lack of a drug theft policy  
   d. staff forming conspiracy rings

3. Which of the following are examples of charting techniques commonly used to disguise theft?
   a. forged signatures  
   b. backdated or missing signout sheets  
   c. signatures of people who do not exist  
   d. all of the above

4. How can you detect whether a staff member is substituting drugs?
   a. You can’t detect this form of drug diversion.  
   b. through chart audits  
   c. looking for small needle holes in the packaging of drugs  
   d. none of the above
5. The Drug Enforcement Agency's Title 21 Code of Federal Regulations deals with the handling and storage of Class II–IV narcotics.
   a. true
   b. false

6. Which of the following describe tabletop exercises?
   a. staff jumping off a table to practice running out of a building on fire
   b. staff sitting down at a table to discuss emergency drills
   c. none of the above
   d. all of the above

7. Which of the following are benefits to performing a tabletop exercise?
   a. to increase the coordination of emergency drills among staff and local agencies
   b. to improve personal relationships among staff and local agencies
   c. to increase training opportunities
   d. all of the above

8. A revision to standard EC.1.4 states that if a hospital grants emergency privileges during a disaster response, it must follow MS.5.14.4.1.
   a. true
   b. false

9. Which of the following examples correctly identify patients and comply with the patient safety goal about patient identification?
   a. attaching the patient's photograph to the medication administration record
   b. using the patient's room number
   c. writing down the patient's favorite color in his or her records
   d. none of the above

10. When a patient is considered a "John Doe," which of the following is useful in identifying him or her until a family member arrives?
    a. Identify the patient as "John Doe" on the ID band.
    b. Give the patient an ID band with a name such as "Trauma A" and the medical record number.
    c. Take his or her picture and paste it into the medical record.
    d. all of the above

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February 2003

1. When clamping down on nosocomial infections, the JCAHO wants hospitals to perform which of the following?
   a. more data collection
   b. Create more fever charts.
   c. Look at evidence-based best practices to improve on infection control.
   d. Write more policies.

2. Which of the following example of a standards compliance change will arise from conducting the self-assessment?
   a. You must show measured improvements for deficient areas discovered during your facility's self-assessment.
   b. You must write in-depth reports for each standard area describing how you comply with standards.
   c. none of the above
   d. all of the above

3. In 2003, a patient safety and medication interview will replace the patient care interview.
   a. true
   b. false

4. In 2004, the JCAHO will eliminate the full document review because surveyors will examine patient records throughout the survey.
   a. true
   b. false
5. Which of the following are new random unannounced survey (RUS) topics for 2003?
   a. IC, HR, TX
   b. EC, IC, HR
   c. IC, PI, HR
   d. CC, PE, EC

6. The JCAHO will not discuss patient safety goals compliance during the RUS.
   a. true
   b. false

7. Which of the following is a good way to prepare for the RUS?
   a. Hold ongoing training.
   b. Form a telephone tree.
   c. Have a manual ready.
   d. all of the above

8. The JCAHO wants organizations to remove concentrated electrolytes from patient units.
   a. true
   b. false

9. Regarding alarms, which of the following must you remember?
   a. The JCAHO wants all hospitals to upgrade equipment.
   b. It’s the system, not only the alarms, that are under scrutiny.
   c. all of the above
   d. none of the above

10. Surveyors are very strict about hospitals reappointing physicians no longer than three years.
    a. true
    b. false

March 2003

1. The JCAHO wants hospitals to adhere to which of the following for verbal medication orders?
   a. Minimize the use of verbally transmitted medication orders.
   b. Define how to validate the accuracy of verbal medication orders.
   c. all of the above
   d. none of the above

2. Many hospitals create a list of unacceptable medication abbreviations to avoid medication mistakes.
   a. true
   b. false

3. What is important about establishing standard times of giving doses of medications?
   a. Hospitals guarantee they have enough staff on duty.
   b. It helps pharmacists keep track of drug inventories.
   c. It helps to prevent medication errors and double doses.
   d. none of the above

4. Which of the following range order issues most often challenges hospitals?
   a. Staff fail to audit charts for range orders.
   b. Range orders are nonspecific and leave a lot of room for interpretation.
   c. Physicians write the range orders illegibly.
   d. none of the above

5. Writing .5 mg in a drug abbreviation is dangerous for which of the following reasons?
   a. Staff can misread it as 5 mg.
   b. The abbreviation is uncommon.
   c. The abbreviation is not universally accepted.
   d. none of the above
   a. true
   b. false

7. Which of the following tips are useful for the patient safety and medication systems interviews?
   a. Use this time to discuss Failure Modes and Effects Analysis results.
   b. Share a flow chart of your medication management process.
   c. none of the above
   d. all of the above

8. CMS’ 2000 LSC says it’s acceptable to use roller latches.
   a. true
   b. false

9. Which of the following should you keep in mind when creating a list of who can accept and transcribe verbal orders?
   a. Include only those staff members who know enough about medicine to question an order.
   b. Include on your list three members of the pharmacy department.
   c. Include on your list each department head.
   d. all of the above

10. When does the JCAHO consider incomplete records as delinquent?
    a. one week after staff discharge the patient
    b. the day after staff discharge the patient
    c. two weeks after staff discharge the patient
    d. none of the above

Answer sheet

Please write the letter corresponding to the correct answer next to the question numbers below.

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