The JCAHO will switch to unannounced surveys

Medication

Check out an age-specific competency assessment tool for yearly pharmacy staff performance evaluations on pp. 4-5.

JCAHO updates

The JCAHO announces two new accreditation participation requirements for 2004, and more on p. 8.

Survey prep

Survey monitor: The JCAHO zeroes in on safety reports and building maintenance records at a Northwestern hospital on p. 9.

The second issue of Survey Trend Watch, a new, quarterly benchmarking report and exclusive subscriber benefit, is enclosed in this issue!

Stay tuned for the June issue of BOJ where a Virginia regulatory compliance director reveals the ins and outs of using the JCAHO’s self-assessment, which the hospital tested out last year.

Med use series

Educate and test pharmacists on age-related drug needs

Only competent staff can care for patients. And that care includes handling age-specific needs. But are your pharmacists also included in that competency expectation?

The draft medication standard MM.1.10 requires organizations to keep patient information, including age, height, and weight, on hand when prescribing and giving out drugs (see a synopsis on p. 3).

Note: The overhaul of the JCAHO’s hospital accreditation manual entails placing all medication standards in a Medication Management chapter, thus making them “MM” standards rather than TX.

The accreditor approved the MM standards and is due to post them at www.jcaho.com in June, a source close to the JCAHO tells BOJ.

Needs dictated by age

Pharmacists must understand age-specific needs since drug metabolism changes as people grow older. Organs also function differently.

The JCAHO will switch to unannounced surveys

Editor’s note: This is an expanded version of the fax express sent to your facility on April 3.

Many of you have resisted last-minute preparations for your triennial survey, but didn’t have the necessary ammunition to tell staff and physician leaders that they must take care of any needed system changes you propose now.

But the JCAHO’s plan to switch to unannounced surveys alone in 2006 changes all that.

“This will support my efforts to maintain a continuous readiness mindset among leadership and staff and to focus on ‘real time’ processes and outcomes rather than just having them on paper,” says Carol Ford, manager of performance improvement at Wardenburg Health Center, at the University of Colorado at Boulder.

Mae McCarthy, BSN, RN, CPHQ, the regulatory coordinator at Bellin Health System in Green Bay, WI, agrees.

“I have been bucking the procrastination to ‘ramp up’ every three years for years,” she says. “It seems the next logical step in
differently with age, which affects how pharmacists set dose levels and frequency.

How to monitor patients also varies by age. For example, pharmacists need to know pediatric patients’ weight since they calculate drug doses based on a milligram (mg) to kilogram (kg) basis, and doses are weight-dependant, says Michael Hoying, the pharmacy director for Fairview and Lutheran Hospitals in Cleveland. Also, the mg/kg dosing of intravenous ampicillin differs for a neonate less than a week old v. an infant who is older than one week.

Pharmacists must monitor elderly patients for high serum creatinine levels—a sign of kidney damage—because that age population experiences a normal decline in renal function, which may affect the dose and frequency selected for a particular drug regimen, Hoying says.

“There are various factors that change as patients age that you must consider when evaluating whether a dose is correct for the patient,” Hoying says.

Considering age-specific competencies in the pharmacy is an area that continues to be problematic, says Jodi Eisenberg, CMSC, CPHQ, coordinator of accreditation and licensure at Northwestern Memorial Hospital in Chicago.

“One thing to consider is that pharmacists serve patients of different ages. When they receive their license, they are deemed competent.

However, if a pharmacist works primarily with elderly patients and the hospital introduces a new drug, learn how that drug affects these patients, Eisenberg says.

Another example could relate to the care of a child on an oncology unit. Because of the high-risk nature of chemotherapy, hospitals should update staff on the needs of that patient population as it relates to chemotherapy, Eisenberg says. You can regularly update pharmacists during staff meetings, inservices, or through written communication.

The key is to record this training in the pharmacist’s personnel file, Eisenberg says. A matrix format listing out the topics covered and the methods used to teach them is one of the easiest ways to document this training, Eisenberg says.

Noting competency is not just about giving a class and then testing staff. Patient or peer feedback indicating that the staff member effectively provides care or can improve upon the care of a particular age group is another acceptable method for assessing competency, Eisenberg says.

Managers must record all of the methods used—such as observation, testing, feedback, and the number of patient complaints or incidents—to address age-specific competencies. Staff can pass a test but may fail at applying knowledge to actual patient care.

Enhancing age-relevant drug knowledge

Pharmacy staff at Lutheran and Fairview hospitals undergo continuing education (CE) programs and the pharmacy (which is American Council on Pharmaceutical Education–accredited) offers CE credits to staff. The CE credit certificates indicate the age populations,
such neonates, toddlers, adults, and geriatrics, covered in the presentations, Hoying says. A copy of the certificate goes into staff members' files.

The JCAHO does not expect hospitals to write out specific competencies for those who serve a range of age groups, such as infants to elders. But you still must build on skills in areas where staff need help, Hoying says.

For example, a couple years ago, Hoying staged pediatric competency education and testing. In 2002, staff underwent CE for neonatal and adult total parenteral nutrition (TPN). “This year, we will look at antipsychotic medications for the elderly population since we have a geriatric psychiatric unit,” he says.

Hoying likes training to focus on the areas where staff need to learn more. For example, regarding neonates, he looks at this age group’s physiological makeup and how that impacts medication effectiveness. He goes over TPN therapy on neonates and antipsychotics for geriatrics.

### Tie in age-specifics with evaluations

Hoying also uses an age-specific competency assessment checklist for yearly staff performance evaluations (see the checklist on p. 4).

The simple check sheet verifies staff skills for each population. Pharmacy department supervisors then identify whether staff members meet age-specific expectations. The completed checklist goes into employee files.

**Note:** It’s critical to prove ongoing, demonstrated competency, thus it’s key to create a checklist for supervisors to note after observing staff, a source close to the JCAHO says.

A goal is to make available on the hospitals’ intranets a competency testing program that’s grouped into age-specific categories, Hoying says.

“This way it could be a staff-driven program where people go on the intranet and take a test,” he says. “Since everyone has access to the intranet, they just need to sign on and take the test, which goes to their administrator to ensure they passed.”

Surveyors can check out test results electronically if they have a question about age-specific competencies for pharmacists, Hoying adds.

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**The draft MM.1.10**

Patient-specific information is readily accessible to those involved in the medication management system.

### Rationale

The lack of timely information often causes medication-related sentinel events and errors. Staff involved in the medication management system must access critical patient information to obtain an accurate medication history and list of current medications.

### Elements of performance

A written policy outlines the minimum amount of patient information necessary that will be readily accessible, except in emergency situations when time does not allow.

At a minimum, the information includes the following information about the patient:

- Age, gender, and pregnancy and lactation status
- Current medications
- Diagnosis, comorbidities, and conditions
- Relevant laboratory values
- Allergies and past sensitivities
- Weight and height

**Editor’s note:** This draft standard is subject to change. At press time, discussions among JCAHO committees continue about how realistic some requirements in the MM standards will be to adopt. However, the essence of the standard should remain unchanged, a source close to the JCAHO tells BOJ.
## Sample age-specific criteria-based performance appraisal

Name: ____________________________  Title: Pharmacist  Department: Pharmacy

Age-specific criteria are intended as a guideline, recognizing that individual variations in growth and development may exist.

### Neonate or infant (0–12 months)

1. Explains medication instructions in understandable terms to parents or caregivers.
2. Keeps baby warm and comfortable.
3. Provides protective environment.
4. Protects from constant, intense stimulation and a noisy, bright environment.
5. Calculates medications correctly for age/weight group.
6. Allows parents/guardian to remain with infant as much as possible.

- Demonstrates the minimum knowledge, skills, and abilities for the above age group.
- Needs improvement in the following areas:
- Not applicable

### Toddler (one–four years)

1. Explains medication instructions in understandable terms to parents/caregivers.
2. Speaks softly to the child.
3. Gives directions one at a time shortly before event or procedure.
4. Calculates and administers medications correctly for age/weight group.
5. Allows participation and choices in care whenever possible.
6. Allows parent/guardian to remain with toddlers as much as possible.

- Demonstrates the minimum knowledge, skills, and abilities for the above age group.
- Needs improvement in the following areas:
- Not applicable

### School age (five–12 years)

1. Explains plan of medication instructions to child and parents using appropriate terminology.
2. Allows privacy as much as possible.
3. Encourages active participation and decision-making.
4. Allows child time to think about requests made to him or her about events/procedures.
5. Allows child time to express fears and offers assurance.
6. Calculates and administers medications correctly for age/weight group.
7. Involves parents or caregiver and child in care whenever possible.

- Demonstrates the minimum knowledge, skills, and abilities for the above age group.
- Needs improvement in the following areas:
- Not applicable
### Adolescents (13–18 years)

1. Establishes rapport and explains medication instructions to adolescent, using adult language, allowing time for questions.
2. Demonstrates sensitivity to the teenager's need for privacy and other emotional needs.
3. Empathizes with adolescent if loss of control of emotions, but places reasonable limits on adolescent's behavior.
4. Calculates medications correctly for age/weight group.

- Demonstrates the minimum knowledge, skills, and abilities for the above age group.
- Needs improvement in the following areas:
- Not applicable

### Adult (19–64 years)

1. Explains medications clearly, and validates understanding of instructions.
2. Calculates medications correctly for age/weight group.
3. Demonstrates knowledge in using proper supplies for age/weight level.
4. Assesses risk factors of adult and exercises appropriate judgments.

- Demonstrates the minimum knowledge, skills, and abilities for the above age group.
- Needs improvement in the following areas:
- Not applicable

### Geriatric (Age 65 and older)

1. Speaks clearly and directly to patient, repeating information if necessary. Instructs one item at a time.
2. Involves patient in decision-making.
3. Demonstrates understanding of physical changes when filling medication orders.
4. Calculates medications correctly for age/weight group.
5. Assesses risk factors of patient and exercises appropriate judgment.
6. Alters physical environment to assure patient comfort and safety.
7. Promotes independence and assists individual in self-care.

- Demonstrates the minimum knowledge, skills, and abilities for the above age group.
- Needs improvement in the following areas:
- Not applicable

Areas identified as needing improvement on this form will appear in the performance evaluation and may establish a goal for improvement.

I have observed the performance of the staff member and he or she demonstrates the required performance to deliver care to identified age groups listed above.

**Evaluator signature:** ________________________ **Date:** __________

**Employee signature:** ________________________ **Date:** __________

*Source: Lutheran and Fairview Hospitals, Cleveland, OH. Reprinted with permission.*
quality performance.”

The JCAHO on April 3 announced the plan to conduct all regular accreditation surveys on an unannounced basis beginning in January 2006. The accreditor will test its plan at volunteer hospitals during 2004 and 2005 to work out any potential kinks.

Beginning in 2006, the JCAHO will conduct unannounced surveys anywhere between two years and four years after an organization’s last full survey, says JCAHO spokesperson Mark Forstneger.

To keep you on your toes
Both the Joint Commission and industry experts say that the evolution to unannounced surveys is a logical progression of the JCAHO’s new survey process, which takes effect in 2004.

Under Shared Visions–New Pathways, the JCAHO wants to forge a continuous readiness approach to accreditation through new initiatives geared toward constantly assessing standards compliance. An example is the self-assessment tool, (now called a periodic performance review), where hospitals fix their own problems through a Web-based program and continually work with the JCAHO to improve.

“The new accreditation process creates the expectation that each accredited organization will be in compliance with 100% of the Joint Commission’s standards 100% of the time,” said Dennis O’Leary, MD, the JCAHO’s president, in a press release.

Many hospital administrators agree that conducting all regular accreditation surveys on an unannounced basis is the next logical step to Shared Visions, O’Leary added.

“The heart of the new process is ongoing assessments all the time,” says Rick Wade, the American Hospital Association’s senior director of communications.

But it all depends on how smoothly the JCAHO introduces this process, how hospitals can adapt, and whether unannounced surveys combined with Shared Visions answer the issues of quality improvement rather than standards compliance “on the face of it,” Wade says.

Today’s hospitals are not at the point where they embrace unannounced surveys, and they “need to feel comfortable,” Wade says.

Motivation for change
The switch to unannounced surveys will help Jane Haithcock, the director of quality management at Maria Parham Medical Center in Henderson, NC, do her job.

“I’ve tried to keep our staff ready at all times, but there are probably still some hospitals that wait until the last minute,” she says. “That will have to stop.”

However, Haithcock (whose organization faces the unannounced survey in January 2006) will now have to keep her staff up-to-date on all standard changes and additions to guarantee that everyone will be ready for a pop survey.

TIP: Hold monthly committee meetings to discuss all regulatory compliance issues and troubleshoot areas of concern.

“Since we now must resolve these issues right away, staff will be more motivated,” says Haithcock, who chairs these meetings at her facility. “I do think this new process will help by encouraging more teamwork.”

Leadership at one Navy hospital requests a briefing each week on a specific problem, followed up with a quarterly report on the hospital as a whole.
Finding space at quick notice

The logistics of scheduling staff and space for meetings at the last minute concerns your colleagues. “Although by then we will have fewer scheduled conferences and interviews, we will still need to have a dedicated space for surveyors for some parts of the survey,” comments another “BOJ Talk” user. “Our conference rooms are booked solid with either in-services or departmental meetings, education programs with out-of-town speakers, or community groups.”

However, you needn’t worry about finding formal “sit down” space, since only a leadership interview will occur under the new survey process, says Steve Bryant, practice director of accreditation and regulatory compliance for The Greeley Company, a sister company to HCPro, which publishes BOJ.

The leadership interview with key administrative and physician leaders will occur at the beginning of the survey for a couple hours. Surveyors may request additional leadership interview time towards the end of the survey if they need closure on a certain issue, Bryant says.

“For the most part, under Shared Visions–New Pathways, surveyors will be on patient care units and will not need the use of conference rooms or audio/visual equipment,” Forstneger says.

Available docs to talk to

Additionally, it’s often difficult to involve physicians during the survey—which the JCAHO wants to happen—when people don’t have prior notice.

“We had a big enough problem this last survey with physicians complaining that they had taken time off from their busy practices to be a part of the survey and felt it was a waste of their time,” says another “BOJ Talk” user. “Can you imagine what they will say when I call them up the morning of the survey to ask them to drop what they are doing, cancel their patients, lose that income, and meet with a surveyor?”

However, the new survey process will not entail holding credentialing or medical staff leader interviews that physicians typically prepared for in the past, since the days of formal meetings will cease, Bryant says. Surveyors will seek out available physicians if they have a question about a chart. “You won’t necessarily have to ask your physician leaders to place a hold on their schedules during the survey process,” he says.

Engaging physicians—part of the new survey process—means that surveyors may pull aside an anesthesiologist and say, “Help me understand your process of providing moderate sedation,” and “How do you ensure that your patients receive a presedation assessment and a second assessment immediately prior to sedation administration?” Bryant says.

Guaranteeing senior leadership presence

People also wonder what to do if senior leaders are on vacation when the JCAHO unexpectedly arrives. Leaders may be able to clarify certain hospital practices.

For example, some confusion exists about whether hospitals must write down when nurses read back a physician phone order. This expectation is not listed in the patient safety goal recommendation nor required, as explained on the JCAHO’s frequently asked questions on the goals posted at www.jcaho.org.

Yet some hospitals have received a Type I for failing to document that the physician’s phone order was read back, Bryant says. The JCAHO’s patient safety goal simply requires a method to ensure that phone orders are read back for accuracy purposes. The compliance mechanism you choose is up to your organization.

“If a surveyor is rigid in his or her thinking, who in the organization, if not senior leaders, can help articulate and help surveyors understand why they handle a process a certain way, and why it’s in the patient’s best interest?” he says.

Senior leaders must therefore build better systems rather than figure out ways to comply with...
Unannounced surveys

standards that don’t enhance quality, Bryant says. “Then, if one or two senior leaders are not around, it should be alright as good systems ensure quality outcomes on a continuum,” he says.

And since, for the most part, surveyors will involve themselves with direct caregivers, “it may not be as crucial for senior leadership to be available,” says Forstneger.

Testing the new process

Many of your colleagues wait with interest to see how the pilot process works out and how the JCAHO will address the myriad challenges that range from available space to leadership representation.

One issue that Bryant contests and wonders about is the 100% standards compliance 100% of the time because he feels it’s not realistic.

Next year, the JCAHO will test the unannounced triennial survey process at 100 volunteer hospitals. Children’s Memorial Hospital in Chicago will be the first to participate.

In 2005, the Joint Commission will continue to conduct voluntary unannounced surveys on a limited basis, “opening up the option to all types of accredited organizations” and then transition to a completely unannounced survey program in 2006.

During this time, the JCAHO will work with its advisory groups and accredited organizations to seek input and refine the new process to make this transition as smooth as possible, according to a JCAHO press release.

Finally, on the upside, perhaps hospitals won’t have to worry about the public postings or public interviews anymore since, “How can we announce it if we don’t know when it’s happening or arrange an interview?” an East Coast quality professional muses.

Shared Visions–New Pathways update

The JCAHO last month announced some changes for its new survey process, Shared Visions–New Pathways, to take effect in 2004, which are as follows:

- **Renaming the self-assessment exercise**—The JCAHO will change the name of the self-assessment to “periodic performance review” to more accurately reflect everything encompassed in the self-evaluation element of Shared Visions–New Pathways,” according to an April 2 e-mail from Joint Commission Resources.

- **Two new accreditation participation requirements (APR) for 2004**—The new APRs are:

  1. Requiring organizations to perform the periodic performance review, create a corrective action plan at the 18-month mark in the accreditation cycle, and submit it to the JCAHO. Failure to comply within 30 days of the assessment due date can result in provisional accreditation status and within 60 days, a conditional accreditation ranking, which can lead to the denial of accreditation.

  2. Prohibiting the use of JCAHO surveyors as consultants on accreditation-related issues. Meaning, organizations cannot knowingly use JCAHO surveyors to provide consulting services that cover JCAHO accreditation issues. The JCAHO expects hospitals to ask beforehand whether a consultant is also a JCAHO surveyor.

Failure to comply with this APR can enable the JCAHO to immediately deny or remove accreditation status, if need be.
Surveyors zero in on safety reports and building maintenance records at a Northwestern hospital

Surveyors hunted for documentation on patient safety, medication use and storage, and life safety issues when they visited Affiliated Health Services in Mount Vernon, WA, this past February.

Between state department of health surveys, a surprise random unannounced JCAHO inspection, and a JCAHO “extension” survey associated with the disaffiliation of the organization’s two hospitals, Arne Eriksen, RN, BSN, CIC, saw Affiliated Health through nearly one survey each year since 1999. He hoped that with all that scrutiny, the facility would by now be in tip-top shape—truly “continually ready.” But surveyors seemed to think otherwise.

Be blatant when it comes to patient safety
Though the February visit didn’t deliver any Type I’s in the area, surveyors were very attentive to patient safety issues, including the 2003 National Patient Safety Goals, says Eriksen, the manager of clinical services and a JCAHO coordinator at Affiliated Health. They particularly wanted to see evidence that staff sent an annual summary report on patient safety to the hospital board.

Surveyors didn’t specify exactly what kind of documentation they wanted in the report. “We had a devil of a time proving it because we had not done a formal ‘patient safety summary’ report to the board,” says Eriksen.

*TIP:* Create an annual presentation to the board that includes Failure Mode and Effects Analysis results. This way you can prove that you have presented patient safety to the board, says a source close to the JCAHO.

Staff had sent along plenty of reports that dealt with patient safety under other headings, such as quality improvement, safety, or environment of care. But they hadn’t included the words “patient safety” in the titles of any of the reports or consolidated them into one annual report, instead focusing on patient safety in relevant committees.

They finally managed to ferret out enough documentation to prove that they included patient safety topics in other reports, “but it was still a bit tough,” says Eriksen.

Jibe medication policies and staff behavior
Every part of the hospital’s medication process—from how staff store drugs to how they dispense them—drew surveyors’ interest. They showed particular concern about whether employees followed the hospital’s policies. “They were watching staff actually perform everything from checking the chart to delivering [medication] to the patient,” says Eriksen.

Small details did not escape notice. For instance, the hospital uses a computer-generated medication administration record [MAR] that preprints the times when staff are due to deliver medications.

One surveyor observed that staff simply signed the preprinted times, and wondered whether the MAR truly reflected the exact time patients received their medications.

About the facilities . . .

Affiliated Health Services in Mount Vernon, WA, is licensed for 234 beds with a patient census of 137. It comprises two public hospitals (which are in the process of disaffiliating), two clinics, an outpatient kidney dialysis center, and a hospice.
Safety reports < p. 9

medications. (This relates to standard TX.3.3, which states that medication processes should be organized and systematic throughout the hospital, and that policies and procedures should be consistent with ordering.)

Until now, Affiliated Health allowed one hour of variation on either side of the preprinted time—but it will now make sure that staff only sign off on the exact time.

“There’s a whole issue about how you do that,” says Eriksen. Charting before giving the medication isn’t always accurate because nurses might be delayed by patient requests—such as a trip to the bathroom—once they enter the room. If they write it down after giving the medication, nurses still have to check the chart beforehand, “but then you have another chart contact that eats into your time,” he says. “Which is better?”

Prepare to prove Life Safety Code compliance

During the building tour, surveyors asked for proof of compliance with various Life Safety Code issues—particularly those that related to environment of care standards EC.2.10.2 and EC.2.10.4, which deal with maintenance of a safe environment and safe utility systems. The following are some of the documentation they asked for:

• Airflow records
• Records of how specialty areas, such as the delivery room, measured positive and negative air flow
• Records of the number of air exchanges per hour per specialty area
• Past inspection dates for equipment such as duct smoke detectors

“They wanted proof that those things were in compliance,” says Eriksen. “You say it’s negative pressure, but can you prove that it’s negative pressure? Can you prove where the airflow goes?”

For all the scrutiny, the survey wasn’t a complete disappointment. Surveyors offered the hospital many compliments—such as for having high staffing levels and high morale even in turbulent organizational times. They were impressed with the clinical guidelines, root-cause analyses, and the number of specialty trained staff.

“This [survey] still leaves a bad taste in my mouth, but in the same vein, this is probably what inspections maybe should be,” says Eriksen. “It would just be nice if they were all this thorough so you would be more prepared for this kind of thing.”

Survey at a glance

Hot spots: Patient safety reports to the board, medication use, and building maintenance records

Critical advice: Be sure that you send reports with the words “patient safety” in the title to your board. If you don’t have a formal report, write down when and where you reported on patient safety to the board, and have that documentation ready to show surveyors.

Quote of note: “It’s interesting how with of all the inspections we had previously, [many of the issues surveyors found were] not brought to attention before. But as one of our department of health inspectors said, ‘Well, there’s always the difference in surveyors.’”
Choices for HIPAA’s transactions and code sets rule

Editor’s note: Come October, health care providers must comply with the new transactions and code sets rule that is part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The following is an excerpt from HIPAA Transactions Made Simple: Achieving the Benefits of Electronic Data Interchange. Visit www.hcmarketplace.com/Prod.cfm?id=1528.

HIPAA’s transactions and code sets rule applies to organizations that provide or receive payment for health care and transmit health information electronically. This also includes any organizations that send paper claims to clearinghouses, where they are later processed electronically. The new rule will standardize health care transactions that currently vary significantly among providers. For example, centers will have to follow the X12N standards, which differ from those previously required.

The data and code sets you need to use in the X12N claims vary significantly from the current UB-92 and CMS 1500 (formerly known as HCFA 1500) claim forms. Also consider the specific requirements for processing electronic eligibility verification, claim status, and referral certification. The X12N transactions are not images of the paper form, but a stream of data that include both required and transmission control information.

The transactions and code sets law also requires most providers who submit claims to Medicare to do so electronically by Oct. 16. Covered providers have the following options for adopting the transactions:

✓ Direct transmission where providers and payers exchange transactions directly.

✓ A clearinghouse with the standard transactions can include a mix of direct transmission as well as using a clearinghouse. Typically, if you send claims several different ways, they go directly to Medicare (and possibly Medicaid), BlueCross/BlueShield, and a few major commercial payers. You would use a clearinghouse to send claims to other payers.

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, affect 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.
200 Hoods Lane
Marblehead, MA 01945
or e-mail careers@hcpro.com

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Quick tip: Peer support can increase hand gel use at your facility

Creating a hand gel policy doesn’t mean that every caregiver will abide by it. A variety of reasons exist why health care workers don’t wash their hands, and changing their behaviors must include the promotion of hand gels, says Russell Olmsted, MPH, CIC, an epidemiologist at Saint Joseph Mercy Health System in Ann Arbor, MI, who spoke during a March audioconference on infection control.*

Studies found that attending physicians and surgeons influence the safety habits of those who work with them, such as nurses and other doctors. If a surgeon uses an antiseptic hand scrub before procedures—rather than bringing out the scrub brush—others may follow that lead.

So-called informal leaders may be even more effective. Fellow staff members often respect informal leaders, such as a unit nurse who’s dependable in the department.

For example, at Detroit Medical Center, an orthopedic surgeon championed the use of hand gels, which convinced others to also use these products. About 70% of operating room employees now regularly wash their hands with antiseptic gels, says Tammy Lundstrom, MD, audioconference cospeaker and chief quality and safety officer at Detroit Medical Center.

Seeking peoples’ opinions also has long-term effects on hand gel use. The following questions offer ways to draw out employee views:

- What do you think of the antiseptic gel’s fragrance?
- Did the gel dry your hands out after use?
- Did the gel irritate your hands after use?

*Visit www.hcmarketplace.com/Prod.cfm?id=1552 for more information about “Infection Control Initiatives: Increase patient safety by improving hygiene practices,” presented by The Greeley Company in Marblehead, MA.

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Dear reader,

Welcome to the second issue of “Survey Trend Watch,” BOJ’s new quarterly survey benchmarking report that offers the latest on hot survey areas and surveyor approaches.

Thirty-two of your colleagues participated in this effort and underwent a JCAHO survey during the second half of 2002 and the first quarter of 2003.

People saw further evidence of surveyors tracking care by following a number of patients through their hospital stay. Formally called tracer methodology, this process scrutinizes open patient charts as surveyors compare everything from what staff write to the care actually delivered out on the units.

Surveyors also asked every staff member they encountered about their understanding of the patient safety goal recommendations and how they adopt and monitor them. In particular, people dealt with questions about how they identify patients, particularly for receiving medication and when undergoing diagnostic testing.

Another trend entails looking at drug theft and how staff account for narcotics used during surgery. Know that surveyors will scour patient units for any concentrated electrolytes, as well as check on after-hours access to the pharmacy when it’s not open 24 hours.

Read on to see what your colleagues say about their most recent survey. I encourage you to participate in the electronic surveys for “Survey Trend Watch” so we can make it the most informative and accurate survey preparation tool available. Many thanks to those who participated!

Sincerely,

Julia Fairclough
Executive Editor
Briefings on JCAHO

A supplement to Briefings on JCAHO
Surveyors zero in on competency assessments, medication control, and patient safety goals compliance

All 32 respondents who participated in this survey work in hospitals, but many also experienced surveys under the JCAHO’s other programs, such as ambulatory and home health/hospice.

The average hospital survey score was 93, with scores ranging from 84 to 99. The inaugural issue of “Survey Trend Watch” (enclosed in the February issue) reported similar statistics, with the average score also a 93. The average hospital survey score in 2001 was 91, according to the JCAHO, which is due to release the 2002 average survey score this month.

Once again, the common Type I recommendations that respondents revealed resemble the JCAHO’s perennial hot button list. Medication use, assessing competence, and recording history and physical results on the chart prior to surgery top the list.

Surveying staffing
Surveyors’ tendency to check into practitioners’ training, how staff handle medical errors, and the adequacy of staffing continues (see “Hot button areas during survey” on this page). For example, 72% of respondents say competency issues were a “strong area of focus,” while 9% say they were not.

“They reviewed our human resources files very thoroughly,” one respondent wrote in.

While 16% say performing statistical correlations to comply with the staffing standards was a strong focus, 66% say surveyors only “touched on the subject.” Respondents also wrote in comments that surveyors had for them.

“They wanted to know which staffing effectiveness indicators we use, the results, and actions taken as a result,” one person writes. “If we had no [successful] correlations, they wanted to see that we changed the indicators.”

The JCAHO will revise the staffing standards to make certain hospitals get the most out of performing the correlations as currently, for many, “it is misleading and meaningless,” another survey participant’s surveyor says.

Looking at medication
Additionally, learn from one hospital that received a supplemental recommendation because the nursing supervisor often retrieved non-urgent medications from the pharmacy when it was closed. How hospitals handle access to pharmacies without 24-hour-a-day service has been a surveyor pet peeve for the past year, your colleagues tell BOJ.

“They wanted to know if nurses go into the pharmacy after-hours to mix potassium,” a respondent writes.

Most respondents agree surveyors look for concentrated electrolytes on all units, as well as other high-alert medications. The majority also say surveyors focused on drug theft more than ever, such as how staff dispose of surgery medications and whether they can easily pilfer them.

Asking about identifiers
Checking out how hospitals consider the patient safety goals recommendations was a surveyor priority majority of respondents, 47%, say.
“Surveyors asked each department manager how the goals affect their department, as well as how they adopt and monitor compliance,” a respondent writes. Surveyors also asked staff members to talk about the goals to gauge their familiarity with them.

Respondents overwhelmingly agree surveyors asked most frequently how they identify patients. “The surveyors asked almost everyone they came into contact with, ‘What two identifiers do you use?’” a respondent writes.

Surveyors were impressed with the staff members who could speak confidently and consistently about how they identify patients, especially prior to treatment or a procedure. “They wanted to see that we consistently look at multiple acceptable means of patient identification [ID],” a respondent writes.

Many of your colleagues identify patients with photographs, but prepare for surveyors to ask how you handle retaking photographs. Others resort to wrist band IDs and asking patients their names prior to any treatment.

Also, be ready to explain how you identify patients in all diagnostic areas as well as guarantee that you have two methods of ID prior to giving out medications.

Checking on alarms

When looking at compliance with the clinical alarms monitoring goal, surveyors wanted to see that each department created a list of all equipment with alarms, including those for blood banks and patient beds.

Surveyors asked staff lots of questions about their perceptions of noise. “They asked about competing noise in the emergency department and critical care areas,” a respondent writes.

Many of your colleagues train staff to recognize alarm sounds and prioritize their response when busy handling various duties. Surveyors liked to hear about staff education in this area.

Other hot button areas

Additional hot topics varied greatly, but a few topped the list, such as the following:

• Having physician-specific data for reappointment
• Pharmacy medication use and narcotic waste
• Interdisciplinary approaches to patient education
• The assessment of pain in the emergency department
• The governing board’s adoption of recommendations, as noted in meeting minutes
• Medical staff involvement in performance improvement
• Patient privacy

Surveyor conduct

As noted in the first edition of “Survey Trend Watch,” your colleagues agree that surveyors are more consultative, educational, and reasonable these days.

Surveyors also involve themselves more with patients, an evolution your colleagues have seen through a handful of initiatives, most recent called “tracer methodology,” (officially to take effect in 2004) where surveyors follow a number of patients through the organization’s entire health care process.

“There was much more emphasis on patients and how they move through the system,” a respondent writes. Another says surveyors dug deeply into the organization’s patient care process from every angle.

With the tracer methodology—an evolution of the “individual-centered evaluation” where surveyors compare care given to what staff write down in the medical record—comes more scrutiny on the completeness and accuracy of patient charts.

“We experienced a much more thorough open chart review,” a respondent writes.

Another respondent says the surveyor focused on upcoming changes for 2004, such as eliminating the document review and the new patient tracking system.

The surveyor had the October issue of Joint Commission Perspectives in hand that highlighted the new Shared Visions—New Pathways process that takes place in 2004.

Another new JCAHO initiative for 2004 entails forbidding surveyors to also work as private consultants on accreditation-related issues.

“My surveyor said that although surveyors look forward to the survey process changes, many will leave the JCAHO before the 2004 implementation of Shared Visions,” a respondent writes.
Survey compliance tips from your peers

When asked to supply compliance tips on what worked for them during their survey, “Survey Trend Watch” respondents had some helpful advice. Here’s what they had to say:

**Patient safety goals**

- Create a poster display or goals compliance notebook to easily show surveyors your work on complying with and monitoring the recommendations.
- Include the goal recommendations in your medical staff rules and regulations/policies, especially the verbal order readback. “The surveyor asked our nurses whether they read back the verbal order to the physician after writing it down,” a respondent notes. You can write “RB” for “read back” in the patient record under the order.
- Keep a separate binder for each patient safety goal and demonstrate how you monitor compliance.
- Create a “boarding pass” for operating room patients to guarantee that staff write down the site/side marking, consent, and history and physical results, among others.

**Medication control/errors**

- Form a performance improvement (PI) subcommittee to look at how you handle medication errors, which one respondent calls the “medication event committee.”
  “This committee had been in place for almost a year and made several changes in processes to reduce medication errors,” the respondent writes. “It held the PI presentation for the surveyor and really had some accomplishments to show what we had achieved.”
- Set up an anonymous medication error hotline. “We use a patient safety hotline for reporting errors, near-misses, and other concerns,” one respondent writes. “Our staff spoke with conviction regarding the purpose of this project.”

**Statistical correlations/staffing**

- Create visual aids, such as graphs, to tell your story. “The surveyors liked our graph depicting our nursing staff variance rate with our medication error rate and fall rates superimposed,” one respondent writes.
- Educate staff about how you create and maintain staffing levels so that they know your processes. “Staff talked about how we adjust staffing to meet the needs of the patients and what we do if we don’t have adequate staffing,” a person writes.

**Overall survey prep**

- Keep all staff apprised of JCAHO compliance and work toward staff answering questions consistently.
- Encourage teamwork, since the JCAHO likes to see staff members working cohesively and with the active participation of physicians.
- Include a separate “patient safety” section in your policy and procedure manual for patient safety compliance. “The surveyors liked seeing all that information together, as it made it easier for them,” a respondent writes.
- Showcase a formal patient safety plan and Failure Mode and Effects Analysis during the PI presentation.

Illustration by Dave Harbaugh

“If an associate decides to whistle blow, have him or her report it verbally.”