Providence Saint Joseph Medical Center in Burbank, CA, had a random unannounced survey nearly two years ago, and as a result, the 498-bed hospital revamped its survey preparation activities to ease the initial chaos that may result when a surveyor arrives unexpectedly, says Sue Kohl, RN, the hospital’s director of risk management and regulatory compliance and patient safety officer. The hospital tested its plan in late spring, and the results were

--- INSIDE ---

Seven tips for unannounced surveys

Follow these essential steps to help your organization navigate an unannounced survey on p. 3.

Unannounced survey checklist

Use the tool on p. 4 before, during, and after an unannounced survey or during your mock unannounced survey activities.

Are your patients satisfied?

Learn how to write a patient satisfaction survey that will help you know for sure on p. 5.

Patient flow in five steps

Tremendous patient flow problems experienced by hospitals could be mitigated by following five sequential steps on p. 7. Read how it works in one ED on p. 9.

CMS survey Q&A

Experts answer questions about H&P requirements, interpretive guidelines, and surveyor focus areas on p. 10.

Clarification

Due to incorrect information, the July article “Involve physicians in H&P form development” contained an incorrect statement about completing histories and physicals if physicians could not finish them before going to the operating room (OR). Physicians, not nursing staff, should complete the form in the OR if they cannot complete it shortly after admission.

--- INSIDE ---

‘Disaster plan’ helps staff prep for unannounced survey

Learning objectives: After reading this article, you will be able to
1. Identify the JCAHO’s focus areas for survey
2. List the necessary steps to take when a surveyor arrives unannounced
3. Discuss ways to prepare staff for unannounced surveys

Having a strategy similar to a disaster plan will help your organization prepare for an unannounced survey, which will be critical when the JCAHO moves to the unannounced format in 2006.

JCAHO fixes software ‘glitch’

An error in a software program that some hospitals use to track and report JCAHO compliance recently caused a brief panic among those who learned about it from a newspaper report.

The New York Times reported on June 24 that Accreditation Manager Plus (AMP), an expensive software program sold by the JCAHO’s publishing and consulting division, Joint Commission Resources Inc. (JCR), had a serious flaw. If left unfixed, it could prevent organizations from reporting compliance data to the JCAHO and, somewhat more alarmingly, to the Centers for Medicare & Medicaid Services (CMS).

According to the Times report, the APM program was missing an identification marker that alerts hospital to the 250 standards among the 1,300 that the JCAHO and its auditors regard as essential. The Times further speculated that without the marker, a hospital might overlook essential categories in which it must verify its compliance and therefore maintain CMS funding.

In a brief posting on the JCR Web site (www.jcrinc.com), the missing “marker” is revealed to be measure of success (MOS) information.

The posting reads: “Due to a production glitch in the 2005 AMP Update 2, the MOS > p. 2

> p. 3
Unannounced survey

impressive.

“Amazingly, it worked beautifully,” Kohl says. “[An unannounced survey] tends to put an organization into momentary chaos, wondering what [surveyors] are going to look at, what they are going to need.”

‘Code Survey’
The hospital’s plan goes into effect as soon as surveyors identify themselves, Kohl says. Someone pages “Code Survey,” notifying key departments and officials, such as the chief executive officer, nursing director, quality officials, and JCAHO compliance officials.

The hospital also established a phone tree to notify key people who would need to be in attendance if they are not on site, Kohl says.

**Tip:** Identify a backup person to fill in for the JCAHO compliance officer or other key officials who can step in should a surveyor arrive and those officials are out of the office.

**Know your documents**
The hospital segregated key documents, policies, and procedures into notebooks so staff would be able to locate them and deliver them to surveyors if requested, Kohl says. She timed how long it took staff to locate documents during the test run, and the process expedited the search for policies.

“It took no time at all because the documents were in a binder already,” Kohl says.

National Patient Safety Goals will be a surveyor focus this year, as will the priority focus areas: infection control, patient safety, and assessment and care, says Elizabeth Di Giacomo-Geffers, RN, MPH, CNAA, BC, a healthcare consultant in Trabuco Canyon, CA.

Find a command center
When “Code Survey” is called, staff involved in the survey know to head to a command center, Kohl says. All survey operations take place out of that one room, she says.

Within an hour of the surveyors’ arrival, staff locate a meeting room for the command center. Any meetings scheduled for that room will be moved or cancelled, Kohl says.

The best rooms are large and have computer and phone access, which is important for surveyors because they can communicate with the JCAHO office in Illinois, Kohl says.

The food service director at Providence Saint Joseph is responsible for the main calendar, so he knows which rooms would be available on survey day, Kohl says.

**Establish a comfort level**
To train staff for survey, Providence Saint Joseph uses tracer drills every two to three weeks, Kohl says.

“You need to get staff very comfortable to answer questions,” Kohl says. “Staff become very nervous when a surveyor is asking them questions.”

To achieve a comfort level, “chapter chairs,” or department managers responsible for a chapter of JCAHO standards, received a one-hour training session on how to run a tracer before conducting a mock tracer on the units, Kohl says.

Kohl developed a scorecard to show each unit how it performs regarding JCAHO compliance and what it can do to improve, she says.

Expect the unexpected . . .
Join HCPro live for Unannounced Survey: Tips to Prepare, Train, and React to Surprise Surveys, an August 18 audioconference.
Your peers—who have survived both JCAHO and CMS unannounced surveys—share tips and strategies to train staff along with valuable insight into what to expect on actual survey day.

To register or purchase the tape, call 800/650-6787 and mention your source code NEWSAD.
Follow these seven unannounced survey tips

The following tips, provided by Elizabeth Di Giacomo-Geffers, RN, MPH, CNAA, BC, a health-care consultant in Trabuco Canyon, CA, will help a hospital during an unannounced survey:

1. Surveyors typically arrive between 8:00 and 8:30 a.m. Ask to see their identification, notify the chief executive officer (CEO), and escort the surveyors to the CEO or a designated second in command. Never leave surveyors unattended.

2. Make sure the CEO or designee asks to see a letter signed by a JCAHO executive that explains the surveyors’ purpose for the visit.

3. Call a designated code so everyone knows to assemble in a “command center.” Have a room for the surveyors to use that includes telephone access, photocopiers, and sufficient outlets for their computer and Internet access.

4. Appoint a senior leader to serve as an ambassador to follow the surveyor. Pairing a senior leader with a surveyor shows the JCAHO that executives take pride in the care the hospital gives.

5. Have a scribe take notes on the survey and what information the surveyor will look for. This person should be someone who can multitask and who understands the survey process, such as a quality manager or JCAHO coordinator.

6. Have a runner, or someone who can quickly grab a policy or chart if the surveyor requests it.

7. Keep track of every medical record the surveyor uses in tracer activities and all human resource and medical staff files reviewed. This will enable the organization to accurately review any issues that may arise during or after survey.

Glitch

designations are not appearing in the AMP tool after the Update 2 Migration Wizard is performed."

AMP users are directed to download and run a software patch available at this address: www.jcrinc.com/publications.asp?durki=10257.

An initial site license purchase of AMP costs $3,595, according to the JCR Web site. One of the capabilities of the program allows users to upload data, such as a completed periodic performance review (PPR), to Jayco™, the JCAHO’s extranet site. Use of the program is not required for JCAHO accreditation.

Statistics were not available from the JCAHO on how many organizations were affected, although it is believed that about 1,000 hospitals and more than 450 outpatient facilities, behavioral health facilities, home health agencies, and nursing homes could be affected.

No customers lost any information or data as a result of the problem, says JCAHO spokesperson Mark Forstneger.

Because of the glitch, the JCAHO suspended PPR uploads, thus disabling the function, on AMP in June. The JCAHO directed organizations with June PPR due dates to call their account representatives to seek a 30-day extension.

One source close to the JCAHO believes that the AMP problem may have been discovered shortly after the release of the last update, which is delivered to subscribers on CD-ROM, and that the accreditor was waiting until a future update to offer a fix.

The source believes the Times article put pressure on the JCAHO to expedite a solution.

JCR sent Update 2 to subscribers in late May, and the glitch was discovered in mid-June, Forstneger says.
### Sample unannounced survey checklist

<table>
<thead>
<tr>
<th>Early survey activities</th>
<th>Completed?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surveyors arrive on campus and proceed to administration</td>
<td></td>
<td></td>
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<tr>
<td>Escort surveyors to predetermined conference room</td>
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<td></td>
</tr>
<tr>
<td>Immediately notify survey coordinator(s) of JCAHO arrival</td>
<td></td>
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<tr>
<td>Surveyors meet and greet administration</td>
<td></td>
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<tr>
<td>Review the agenda and required documentation with administrator and survey coordinator</td>
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<tr>
<td>Send out organizationwide notice that surveyors are on campus and include the type and focus of survey</td>
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<tr>
<td>Notify leadership of times for scheduled interview sessions and secure conference rooms for interviews</td>
<td></td>
<td></td>
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<tr>
<td>Provide active daily census listing when requested</td>
<td></td>
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<tr>
<td>Provide surgical schedule when requested</td>
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<tr>
<td>Provide list of units, surgical suites, and postanesthesia care unit beds when requested</td>
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</tr>
<tr>
<td>Provide current roster of physicians when requested</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide survey ambassadors, scribes, and runners with department head list and contact phone numbers</td>
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<tr>
<td>Provide scribes with notepads and pens/pencils</td>
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<td></td>
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<tr>
<td>Provide runners with list of requested documentation</td>
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<tr>
<td><strong>During the survey</strong></td>
<td></td>
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<tr>
<td>Pair survey ambassadors with surveyors</td>
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</tr>
<tr>
<td>Pair a scribe with each survey ambassador</td>
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<tr>
<td>Assist runners in locating requested documentation, if needed</td>
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<tr>
<td>Send scouts out to the next unit to look for and correct obvious deficiencies</td>
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<tr>
<td>Communicate frequently with organizational leaders on outcomes of survey activities</td>
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</tr>
<tr>
<td>Debrief survey participants and organizational leaders at the end of each survey day about the findings of survey activities</td>
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<tr>
<td><strong>After the survey</strong></td>
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<tr>
<td>Hold a closing conference with actual findings to administrator and senior leadership</td>
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<tr>
<td>Briefly summarize survey findings to staff</td>
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<tr>
<td>Celebrate survey successes</td>
<td></td>
<td></td>
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<tr>
<td>Begin action planning to address required improvements</td>
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</table>

*Source: Adapted from a tool provided in the HCPro book Unannounced Survey: Frontline Strategies to Prepare Your Organization for Surprise Surveys, written by Missi Halvorsen, RN, BSN.*
Hospitals get satisfaction through patient surveys

Meet JCAHO requirements, obtain picture of quality via questionnaires

Learning objectives: After reading this article, you will be able to
1. identify ways to use results from patient satisfaction surveys
2. explain the importance of patient satisfaction surveys
3. recognize JCAHO standards related to patient satisfaction

Keep your hospital’s patient satisfaction survey concise and to the point. This strategy will help keep the patient’s attention when taking the survey and help the organization obtain more meaningful responses.

Ideally, the entire questionnaire should be 15 questions, says John Rosing, MHA, FAHCE, practice director of accreditation and regulatory compliance services for The Greeley Company, the Marblehead, MA–based division of HCPro, Inc., which publishes this newsletter.

If the hospital conducts a phone interview, it should last no longer than four minutes, Rosing says. If the interview is longer than that, the organization risks losing the patient’s attention when taking the survey, Rosing says.

“The shorter the better,” Rosing says. “It’s up to the organization to determine what its needs and expectations are [when creating survey questions].”

Go above JCAHO requirements

Standard PI.1.10, element of performance (EP) 3, requires hospitals to collect data on patients’ perception of care, treatment, and services provided, including specific needs and expectations, how well the hospital met those needs, how the hospital can improve safety, and the effectiveness of pain management.

The JCAHO is moving from using the word “satisfaction” to “perception of care, treatment, and services,” which allows the organization to assess patients’ satisfaction with care but also whether the organization met their needs and expectations, according to the Comprehensive Accreditation Manual for Hospitals.

Although the JCAHO only outlines four areas for hospitals to collect satisfaction data, organizations should add more, Rosing says, including the following:
- Wait times
- Communication
- Comfort, including room temperature, noise, and distractions
- Staff attention to a patient’s needs

Fairlawn Rehabilitation Hospital in Worcester, MA, asks questions about admissions and registration procedures, nursing care, pain management, physicians, food and facilities, discharge, and overall satisfaction, says Patricia Garvey, MSN, RN, director of quality management and education.

Present info to the board

Garvey presents information gleaned from survey results to the hospital board of trustees each quarter. Garvey’s “quality grid,” or scorecard, allows the board to measure Fairlawn’s success and performance against other HealthSouth rehab facilities, she says. Fairlawn is owned by HealthSouth.

“You also can see any statistically significant changes in data,” Garvey says.

The board takes particular interest in questions such as a patient’s “likelihood to recommend the facility to others,” Garvey says. Most of the time, Fairlawn meets or exceeds other organizations’ results, she says.

Use the results

Garvey distributes survey results to directors responsible for various departments at the hospital, she says. If the results fail to meet those of other HealthSouth facilities, she asks for a corrective action plan.

For example, scores were consistently low in food services at one point, Garvey says, partly because the kitchen had flooded and cafeteria workers had to cook out of a mobile trailer. Some patients...
complained on the survey, and the hospital changed its coffee vendor for better quality and service, she says.

Another example involves the timeliness of physician response, Garvey says. She brought survey results concerning that issue to the physician group, who developed an action plan to improve response times, she says.

Garvey also uses the results to let staff know patients have a positive perception of care, she says.

“You can give staff a pat on the back,” Garvey says.

Garvey also looks at any handwritten comments from patients. Sometimes they are as simple as “everyone was wonderful,” but sometimes patients ask for a phone call to talk about their concerns, and Garvey obliges, she says.

Management should be interested
The medical staff also have a regulatory interest in patient satisfaction. JCAHO standard MS.2.10, EP 5 requires medical staff to provide oversight in the process of analyzing and improving patient satisfaction.

Senior management should review and evaluate results from satisfaction surveys, Rosing says. Leaders need to assess the results and then determine what changes should be made in the context of the organization’s current climate.

“They have to look at [results] wisely,” Rosing says. “They can’t leap to conclusions.”

Survey help exists
Using an outside vendor to conduct the survey and compile the results gives hospitals the added bonus of having benchmarks against other organizations, Rosing says. Fairlawn uses NRC+Picker, a Lincoln, NE–based research company, to conduct its surveys.

Press Ganey Associates, Inc., of South Bend, IN, is another company that provides survey services, and The Gallup Organization of Princeton, NJ, widely known for its Gallup Poll on public opinion, has a healthcare division, Rosing says.

Hospitals may struggle to write their own surveys, Garvey says.

“They’re hard to write and have them valid and tested,” Garvey says. “For us and most organizations, I think it’s worth the commitment of money [to use a vendor] because it’s valid and reliable.”

Satisfaction goes national
The Centers for Medicare & Medicaid Services is planning its own patient satisfaction survey, known as HCAHPS. The 27-question survey includes questions about communication with physicians and nurses, pain control, staff responsiveness, and discharge information.

The survey will supplement existing questionnaires already in use at hospitals, and Medicare will be able to collect standardized data on patient perceptions to post on its Web site, www.medicare.gov.

Medicare anticipates beginning a test run of the survey this summer, with a nationwide implementation in early 2006. Go to www.cms.hhs.gov/quality/hospital/ to view the survey.

Patient satisfaction survey companies

The following companies provide services to help hospitals conduct patient satisfaction surveys:

- The Gallup Organization: www.gallup.com
- NRC+Picker: http://nrcpicker.com/
- Professional Research Consultants: www.prconline.com
Manage patient flow in five sequential steps

Leadership plays a key role in establishing goals

Learning objectives: After reading this story, you will be able to
1. list five ways to improve patient flow
2. describe the JCAHO’s patient flow standard, LD.3.15

Hospitals continue to struggle with patient flow in their emergency departments (ED), operating rooms, and other key areas.

Influxes of patients, staff scheduling conflicts, increased time from admission to discharge, and the number of available beds are only some of the challenges faced by facilities of all sizes.

Moving patients through your facility efficiently, despite the challenges, is required by the JCAHO in LD.3.15 (leaders develop/implement plans to identify/remove barriers to patient flow organizationwide).

The only sustainable solution to the tremendous flow problems experienced by hospitals, particularly larger hospitals, requires that the institution follow five sequential steps, according to consultants with The Greeley Company, a division of HCPro, Inc., which publishes this newsletter.

Each step is based on the one before and is illustrated in the pyramid on p. 8. “If you follow this pyramid, you will begin to significantly impact flow issues,” says Bud Pate, REHS, practice director of clinical operations improvement for The Greeley Company.

The steps are as follows:

Step 1: Establish true leadership commitment.
Truly successful organizations have patient flow at the top of their priority list. It is not enough to list flow problems among the top 50 hospital priorities.

Lasting improvements require that flow issues be elevated to the vital few things motivating and focusing the leadership team. This is easy to say, but difficult to accomplish until a tangible connection is made between flow and financial performance, institutional stability and clinical quality.

Patient flow pyramid

Source: The Greeley Company in Marblehead, MA.
**Patient flow** < p. 7

**Step 2: Assess flow problems.** Only when true leadership commitment is established will a comprehensive assessment of utilization, admitting, discharge practices, and other aspects of current performance be fruitful.

Flow assessment findings often languish because leadership have not yet committed to making the difficult changes that such an assessment certainly will highlight. (Remember, the easy problems have already been fixed. The remaining are difficult.)

**Step 3: Establish goals.** Three overarching strategic goals must be established for the entire organization centered on patient flow. One goal should focus on the inpatient discharge process, one on the inpatient admission process, and one on the medical screening process.

All departments and services are held accountable to achieving these goals.

Here are some suggested goals (see them illustrated in the box below):

- **Goal 1:** 70% of inpatients will be discharged before 11:30 a.m.
- **Goal 2:** 70% of inpatients admitted through the ED will be processed (admit order to inpatient bed placement) within one hour.
- **Goal 3:** 70% of patients presenting for emergency care will be seen by the treating physician for the beginning of the medical screening examination within 30 minutes of arrival.

By establishing these or similar goals, all departments along the inpatient continuum are aligned for improvement.

**Step 4: Set targets.** Your strategic goals won’t be achieved until each department establishes a balanced scorecard that puts specific flow-related performance targets alongside issues such as performance to budget, employee recruitment and retention, patient satisfaction, and clinical quality.

**Step 5: Manage performance.** Use the balanced scorecards that reflect specific targets and are aimed at achieving overall goals focused on flow leverage.

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**Patient flow goals**

<table>
<thead>
<tr>
<th>Patient flow goals</th>
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<tbody>
<tr>
<td><strong>Goal 1</strong></td>
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<tr>
<td><strong>ED In</strong></td>
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<tr>
<td><strong>Emerg. department</strong></td>
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<tr>
<td><strong>Consultants</strong></td>
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<tr>
<td><strong>Transportation</strong></td>
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<tr>
<td><strong>Pharmacy</strong></td>
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**Source:** The Greeley Company in Marblehead, MA.

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The flow pyramid in practice

Use LD.3.15 to bring everyone to the table

Half the battle of any large-scale initiative, such as managing patient flow, is gaining the support of hospital leadership.

It came easily for Carol Jones, MSN, CS-C, emergency department (ED) director at Morristown (NJ) Medical Center, thanks to the JCAHO.

“The true leadership commitment came on easily with the JCAHO’s patient flow standard,” Jones says. Before the standard (which took effect January 1, 2004), Jones says flow problems had been “piecemealed” individually in departments. Because LD.3.15 demands that patient flow be managed throughout the organization, Morristown could no longer take that approach. In effect, the standard brought everyone to the table, Jones says.

One of the issues that has been discovered because of the collaborative effort is that operating room demands influence the rest of the hospital based on a certain type of surgeon’s block time, Jones says. “We may have delays in critical care one day and the orthopedic unit the next day,” she explains.

Morristown is also starting to set strategic goals throughout the organization and set targets. But Jones concedes that they have not been successful yet with discharge time being around noon.

“We have some initiatives in place to get tests done earlier and to identify these patients that it will impact, but we have not really moved the bar yet down from there,” she says.

For example, the ED and laboratory have partnered to improve processes together. The hospital has succeeded with getting the laboratory to set goals with turnaround time and mislabeled specimens—driven mostly by safety demands.

When it comes to managing performance, a leadership patient flow card is used, which Jones says leadership reviews and is beginning to understand what is being presented to them.

Editor’s note: This story was adapted from the recent HCPro audioconference How to Measure Quality in the Emergency Department. For more information or to order a copy of the program, call customer service at 800/650-6787.

―Carol Jones, MSN, CS-C
**Ask the experts**

Experts provide 10 CMS survey prep tips

**Learning objectives:** After reading this story, you will be able to
1. explain the JCAHO’s and the Centers for Medicare & Medicaid Services’ (CMS) requirement for completion of history and physicals
2. recall compliance areas on which CMS surveyors have focused during recent surveys

**Editor’s note:** The following Q&A is adapted from the June 21 audioconference, “CMS Survey: Insider Tips to Prepare and Comply,” with Steven W. Bryant, vice president and managing director of The Greeley Company, a division of HCPro; Jeffrey T. Coleman, a former New York State Department of Health surveyor and manager; and Mae McCarthy, RN, BSN, CPHQ, a registered nurse at Bellin Health System in Green Bay, WI. Call HCPro customer service at 877/727-1728 for tape sales information.

**H&P rules**

**Q:** For history and physicals (H&P), the JCAHO standard mandates completing them within seven days or 48 hours after admission. This seems to be inconsistent with the CMS interpretive guidelines, which require a period of 30 days. Which is it?

**A:** The JCAHO changed its standard in January, and not many people are aware of it. If the H&P was done before the admission, you have to write an update note, even if it’s the day before admission or operative procedure. The note can be as simple as “no changes.” It’s a rule and regulation change. The federal law will also change and will be consistent with what JCAHO requires. **Note:** See the July BOJ for more on H&P guidelines.

**Q:** How should we deal with medical record authentication issues after discharge, especially in relation to timing issues of notes and orders?

**A:** When you authenticate something, date it at the time of authentication. A minimum of signature and date is necessary for completion. This applies to both JCAHO and federal law. Set reasonable expectations with time constraints.

**Q:** Where is it stated in the requirements that the physician’s authentication to an H&P must be dated?

**A:** It’s in CMS’ Conditions of Participation (COP); you’ll find it under the medical records. Entries into a medical record must be dated and the author identified. As long as it’s signed, some surveyors are willing to look past it, but the JCAHO is becoming stricter with documenting dates.

**Q:** We perform pediatric dental procedures in our outpatient surgery area. Children are sent to a pediatrician for the initial H&P, which is generally within the required seven days, but the rules say it must be updated by a qualified individual. How do we determine who this is?

**A:** Determine this by whomever is credentialed and privileged to conduct H&Ps. Some states allow licensed independent practitioners or nurse practitioners.

**Interpretive guidelines**

**Q:** Do you have to change your rules and regulations based on an interpretive guidelines from CMS?

**A:** If you’re cited on the guidelines, bring it up to your surveyor immediately. I’m hesitant to suggest putting it in your rules and regulations. Timing has presented a challenge for many organizations, so be realistic.

**Q:** We were cited for a COP under medical records and were provided a corrective action plan in which we had 60 days to comply. When should we expect them to appear at our door unannounced?

**A:** Expect them at any time now.

**Survey prep**

**Q:** Would you share two things for which you would recommend organizations to pay particular attention?

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Create a JCAHO prep tool with just a few clicks

Use interactive game to refresh staff about JCAHO goals

**Learning objectives:** After reading this story, you will be able to

1. explain how a common software program can be used to create a game that educates staff about JCAHO requirements and survey procedures

Kelly D. Young, MD, MS, learned special features of the PowerPoint software program during a conference. But it was back at her hospital where she put her newly acquired computer skill to use to create a JCAHO staff education tool that became an instant hit among her colleagues.

Young, who works in the pediatric emergency medicine department at Harbor-UCLA Medical Center in Torrance, CA, developed an interactive quiz game based on the Jeopardy! game show.

“The residents usually roll their eyes when we try to do a staff education game,” she says. “But with my game, I tried to make it fun.”

Staff like the game’s use of a hyperlink feature that clicks through to more information, not just the correct answer, and that the game can be projected on a screen. Those features make the game interactive, not stagnant like most traditional pen-and-paper games.

Candy and other prizes are awarded for correct answers.

To build the game board questions and answers, Young used JCAHO staff education materials already developed and in use in the hospital.

The game includes basic information, such as what JCAHO is and information about the new JCAHO survey process and the tracer methodology. A significant portion of the game covers the National Patient Safety Goals.

The game also includes department-specific information because it can easily be customized. There may be questions pertaining to where equipment is located, what to do in the event of a hazardous materials spill, and documentation requirements, as well as questions made up by other educational materials distributed by administrators, as appropriate.

To see a copy of Young’s game and possibly modify it for your facility or department, e-mail kyoung@emedharbor.edu.

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Q: We’re in the midst of construction. What do we need to do to prepare for survey?

A: Be sure patient care isn’t being interrupted. Take proper precautionary actions to prevent infection and other patient safety issues.

Q: What extent are surveyors looking at disaster preparedness response activity and whether it affects *Life Safety Code*® compliance?

A: Nothing specific, other than that you should have a disaster plan that addresses bioterrorism. Surveyors will make sure you’ve implemented a plan and have talked to other organizations concerning their disaster preparedness efforts.

Q: Do surveyors review board minutes?

A: They review nothing beyond what the standards already state. The governing body must have some mechanism to review quality in your organization.
After much speculation, the JCAHO has announced that the PPR will become an annual requirement in 2006.

The accreditator published the change in its May update of the Comprehensive Accreditation Manual for Hospitals (CAMH) under accreditation participation requirement (APR) 14. It takes effect January 1, along with the unannounced survey process.

Currently, organizations complete the PPR at the midpoint of their accreditation cycle. So it has long been believed that the PPR requirement would become annual to better align with the unannounced survey process, in which organizations will not know when they will be surveyed.

Don’t wait until 2006

“The JCAHO may have waited to announce the annual requirement to make sure that their systems were in order,” speculates Jodi L. Eisenberg, CPMSM, CPHQ, program manager of accreditation and clinical compliance at Northwestern Memorial Hospital in Chicago.

Anticipating the change, her facility already had made the decision to do the PPR annually.

“As I am putting it together for the second time, it is less of an ‘annual’ full exercise and more of an ongoing snapshot of compliance,” Eisenberg says. “It is now essential to maintain a pulse on the compliance issues so that once you get to the annual submission point, you have only the true issues to report.”

Building compliance into systems

By doing the PPR annually, Eisenberg believes organizations can reach a point where compliance becomes built into their systems.

Editor’s note: See the July BOJ for more information about the PPR options.