Sentinel Event Alert stresses medication reconciliation efforts

The JCAHO on January 25 issued a Sentinel Event Alert urging hospitals to increase medication reconciliation efforts during transitions of care, citing the increased risk of injury or death due to errors in these situations.

Reconciliation should occur whenever a patient moves from one location to another within a facility or from one practitioner to another, the JCAHO alert said. Otherwise, the patient could receive duplicate medications, wrong doses, or wrong dosage forms.

“Accurate and complete medication reconciliation can prevent numerous prescribing and administration errors,” the JCAHO said in the alert. “This means medication reconciliation applies to all care settings—including ambulatory, emergency and urgent care, long-term care, and home care—as well as inpatient services.”

According to the JCAHO, medication reconciliation consists of the following five steps:

- Create a list of current medications for the patient
- Create a list of medications to be prescribed to the patient
- Compare the medications on the two lists
- Provide information about the patient to all caregivers
- Review the patient’s current medications

Systemwide efforts help hospital prevent drug diversion problems

Preventing drug diversion begins with a look at the hospital’s overall system, not just at the individuals suspected of stealing drugs.

“Focus on the system, not the employee,” says Mitch Sobel, RPh, assistant director of pharmacy for operations at Saint Barnabas Medical Center in Livingston, NJ. “Otherwise, you’re never going to figure out what’s going on with your system.”

JCAHO standard MM.4.80 requires hospitals to have processes in place to address diversion prevention and account for all unused, expired, or returned medications.

Track with technology

Saint Barnabas uses Pyxis automated dispensing units and software to help track medications used in the hospital. Combined with other diversion-prevention efforts (e.g., cosignatures on reports and collaboration from the nursing, security, and medical staff departments), the hospital has had few problems during the past two years, Sobel says.
**Sentinel Event Alert**

- Make clinical decisions based on the two lists
- Communicate the new list to the correct caregivers and the patient

Medications include prescriptions, over-the-counter drugs, vitamins, herbs, and nutraceuticals, the JCAHO said.

The JCAHO’s Sentinel Event Database shows that 63% of reported medication errors resulting in death or serious injury were the result of communication breakdowns and that medication reconciliation could have prevented more than half of those. Those data helped prompt the JCAHO to make medication reconciliation a National Patient Safety Goal for 2006. All hospitals must reconcile medications across the continuum of care, and the JCAHO has said it will expect full compliance this year because hospitals have had 12 months to prepare.

**Surveyors to scrutinize goal**

Surveyors will place added emphasis on medication management this year, says a source close to the JCAHO. The medication management tracer will follow a high-risk medication through the organization, the source says.

“Reconciliation will be a big hit because few people are doing it well,” the source adds. “One of the expectations is that discharge is another hand-off [in which] reconciliation and education of the patient and caregiver [occurs] on instructions including medications, why they are taking them, and side effects.”

The JCAHO will require surveyors to obtain a list of patients discharged during the 48 hours prior to survey, the source says. Surveyors will then conduct telephone interviews with patients—after obtaining their permission—to learn about the education they received, the source adds.

Following are tips the JCAHO provided in the alert:

- Put the list of medications in a highly visible place in the patient’s chart and include essential information about dosages, drug schedules, immunizations, and drug allergies.
- Reconcile medications at each interface of care—specifically during admission, transfer, and discharge. The patient and responsible physicians, nurses, and pharmacists should be involved in this process.
- Provide patients with a complete medication list that they will take after leaving the hospital, as well as instructions about how and how long to take any new medications. Staff should encourage patients to carry this list and share it with any caregivers who provide follow-up care.

"Reconciliation will be a big hit because few people are doing it well," the source adds. “One of the expectations is that discharge is another hand-off [in which] reconciliation and education of the patient and caregiver [occurs] on instructions including medications, why they are taking them, and side effects.”

Editor’s note: The April Briefings on JCAHO will contain a report about medication reconciliation and a sample form for you to use at your facility.
Drug diversion

“Discrepancy issues may occur several times per year on the floors, but now they can be identified and resolved quickly,” Sobel says.

The system allows the hospital to run reports by user to see who removes which drugs, how many patients a nurse may have, and how many doses staff remove.

Narcotics are not the only drugs to worry about. For example, the hospital once had a problem with the antidiarrhea drug Lomotil, losing 10,000 tablets per month, Sobel says. However, the hospital only had five patients per month on the drug.

Sobel was able to view the purchase history report to determine how much the hospital bought compared to how many patients used the drug, he says. Now the drug is stored in the hospital’s narcotic safe system.

Sobel can also run a report to track practitioner use. For example, a nurse might say he or she has 20 patients per day, although most only have between five and 10, he says. The Pyxis machine can tell whether a nurse pulls more doses than the patient receives, he says.

Human error—not deliberate diversion—is often the cause of discrepancies, Sobel says. Sometimes a staff member may type too fast and enter the wrong quantity into the Pyxis machine and take too much by mistake, he says.

“We’re able to catch and correct the error [with an electronic system] before it [affects] or reaches the patient,” Sobel says. “We won’t hurt the patient with too much medication.”

Saint Barnabas has its own employee assistance program for employees who might have a drug dependence problem, Sobel says. If staff are caught diverting drugs, they are referred to the program and the proper authorities are alerted, he says.

“We want to help the practitioner as well, so [he or she doesn’t] hurt [him- or herself] or others,” Sobel says.

Keep a log

Sobel receives help with tracking and investigating diversions from Information Systems Pharmacist Drew Plowman, RPh, and Corporate Security Officer Orlando Caprio, BS, MA, MS. Plowman can see whether a drug was sent to the wrong unit or patient, and Caprio—a former police officer—can investigate issues further.

The patient care staff at Saint Barnabas count narcotics every day so if a discrepancy occurs, they only have to look back at the previous 24 hours to determine where the problem occurred, Sobel says.

Tip: Keep a discrepancy monitoring log, which you can use to show the JCAHO and state agencies how you track narcotic discrepancies, Sobel says. The agencies want to know that controlled substances are documented and that the information is retrievable.

Watch wasted meds

JCAHO standards also want hospitals to focus on wasted drugs—those that are no longer suitable for patient use.

Drug diversion methods

Following are common drug-diversion methods, says Mitch Sobel, RPh, assistant director of pharmacy for operations at Saint Barnabas Medical Center in Livingston, NJ:

- Pulling narcotics for an excessive number of patients
- Pulling larger doses than the patient receives
- Removing drug from IV drips
- Patterns of “accidents” in which staff say the drug must be thrown out because the vial broke
- Heating a needle and inserting it through a vial or IV bag to remove the drug
- Making transactions during times not scheduled for work
- Creating fictitious users for Pyxis machines and later deleting them
“We don’t always think about waste when thinking about diversion,” Sobel says.

Sobel purchased a street mailbox in which staff deposit wasted medications. The box remains locked until the medications are discarded, he says. The system eliminated waste diversion.

**Keep documentation**

Documentation is one key to preventing future diversion. Significant losses must be reported to the Drug Enforcement Administration (DEA) and state and local officials, Sobel says.

Significant losses can be determined by the quantity—one bottle or container versus one pill—and the type of drug missing, Sobel says.

**Tip:** If a question exists about whether a loss is significant, err on the side of caution and report it, Sobel says.

Document and file any small quantities of medications that may go missing. For example, if one tablet of percocet is missing, document it. However, there is no need to report it to authorities, Sobel says.

The documentation can help pharmacists determine whether the small quantity missing will develop into a pattern of diversion, which should then be reported, Sobel says.

Hospitals should maintain discrepancy and diversion data for at least five years, Sobel says. The DEA says hospitals must be able to retrieve two years’ worth of diversion information, but keeping the documents on-site for longer is a good policy, he says.

**Focus on all drugs**

Although diversion-prevention efforts typically focus on narcotics and other controlled substances, other drugs could be involved, says John Uselton, BPharm, vice president of operations improvement for Cardinal Health in Houston. Uselton spoke during the American Society of Health-System Pharmacists’ Midyear Clinical Meeting in Las Vegas in December 2005.

“Certainly any drug can be diverted,” Uselton says. “Expensive drugs are as at risk for diversion as narcotics and controlled substances.”

**Tip:** Look at dumbwaiters or tube systems and check whether medications come out in unsecured areas, Uselton says.

If certain areas of the hospital have experienced problems with diversion in the past, pay attention to those areas when preparing for a JCAHO survey, Uselton says. Particular areas of interest include controlled drugs and automated distribution, he says.

Staff should also pay attention to anesthesia and respiratory therapy, Uselton adds.

About 90% of the patient medication inventory at Saint Barnabas is stored in the hospital’s Pyxis units, which makes it easier to track access to drugs, says Sobel.

**Use a team approach**

Even if your hospital uses manual distribution and documentation systems, you can still fight diversion effectively. The hospital should organize a committee and delegate responsibilities, Sobel says.

For example, one person should handle the ordering, one person should review distribution practices, and another person should investigate discrepancies.

Everyone should have someone else cosign when documenting their actions, Sobel says.

The system administrator—typically a pharmacy director—is the person with the most liability for the controlled substance monitoring program, Sobel says. Even that person requires a double-check, he says.

“When a person is isolated, that’s when a diversion could occur,” Sobel says.
Learning objectives: After reading this article, you will be able to
1. identify the JCAHO standards that govern competency assessment
2. list ways to make orientation more efficient
3. discuss who should be an assessor

If you are trying to streamline your facility’s competency assessment program, don’t get discouraged. Instead, look to the folks who have walked that path before.

Sally Strong, RN, APN-CNS, CNRN, CRRN, clinical nurse specialist and staff educator at Marianjoy Rehabilitation Hospital in Wheaton, IL, is just one of the many people who managed to transform her facility’s original competency program into a more structured process.

JCAHO standards HR.3.10 and HR.3.20 require organizations to assess competency and conduct performance evaluations.

Hospitals may define the time frame for competency assessments and performance evaluations, but they must be conducted at least once during a three-year accreditation cycle, according to the JCAHO.

Strong began by tackling the competency assessment checklists’ vague and broad language. For example, the skill for the orientation checklist read, “Able to care for a spinal cord injury patient.” That doesn’t tell you much about the person’s competency, says Strong.

Instead, Strong recommends reviewing your facility’s checklists and making them more specific and therefore more useful for assessing staff’s competency.

Strong and her colleagues made the skills more specific by adding the different types of braces and transfer techniques used when caring for patients with spinal cord injuries.

“Now it’s a combination of tasks, equipment, and critical thinking,” Strong says.

Self-assessments
Upon their arrival at the program, orientees fill out a self-assessment form, rating their competency levels in certain skills. The scale ranges from one (no experience) to four (very experienced), Strong explains.

Because new staff rate their abilities up-front, training goals are laid out for the educator, preceptors, and manager so they know which areas to focus on, says Strong.

For example, if an orientee has never worked with a continuous passive motion machine, she allows more time in the orientation schedule for that particular piece of equipment.

The self-assessment information and evaluation checklist are both on one six-page form, which allows the person performing the competency assessment to pay special attention to areas in which a staff member said he or she has trouble, Strong says.

Assessment teams
Strong tries to foster the professional development of all levels of caregivers by asking eligible staff—not just clinical nurse specialists and managers—to act on the assessment teams.

To become assessors, staff must score “independent” or “able to teach others” on their assessments, Strong says. Assessors tend to be the preceptors, but the door is still open for others to participate.

Tip: Make a concerted effort to not allow people to assess colleagues who work on the same unit. This can be difficult for smaller facilities, but it’s not impossible, Strong says.

Assessors come in handy during the facility’s annual mandatory skills fair, Strong says. With the added help, Strong managed to shave off two hours from her staff’s average completion time for the skills fair.
Hospitals should defer to tougher standards when creating informed consent policies, procedures

Learning objectives: After reading this article, you will be able to
1. discuss when to use an informed consent form
2. list which items a form should include
3. explain how the form should be documented in the patient's record

When questions arise about whether a hospital should use an informed consent form, it may be better to be safe than sorry.

JCAHO standard RL.2.40 requires organizations to obtain informed consent from a patient regarding a procedure. The Centers for Medicaid & Medicare Services (CMS) Condition of Participation (CoP) 482.13 says patients or their representatives have the right to make informed decisions regarding their care, and CoP 482.24 says the medical record must document properly executed informed consent forms.

The JCAHO standard differs from the CMS regulations in that it does not require a specific informed-consent form, only a policy saying where the physician should document the consent.

The different interpretations could cause confusion, says John Rosing, MHA, FACHE, practice director of accreditation and regulatory compliance services for The Greeley Company, the Marblehead, MA–based consulting division of HCPro, Inc., the publisher of this newsletter.

“There has always been some uncertainty as to whether [a form is] required,” Rosing says. “It has been unclear from the regulatory bodies—both the Joint Commission and CMS—as to whether there needs to be something in the patient record signed by the physician.”

To avoid confusion among the various standards, Rosing recommends that organizations have an informed consent form to show that the patient understood the procedure and the risks involved.

Look to the JCAHO and CMS
When creating a form, hospitals should look at both the appropriate JCAHO standards and the CMS CoPs, understand which elements of informed consent they require to be documented, and base a policy and form on those requirements, Rosing says.

The form should include a paragraph stating that the physician “discussed the benefits, risks, [and] consequences of nontreatment [and] alternative therapies, answered patient questions, and obtained consent to proceed as planned,” Rosing says.

Hospitals should avoid outlining every risk associated with a procedure in an informed consent form because the possibility exists that the form could omit one, which could lead to legal issues should something happen, Rosing says.

The best course of action is to show that the physician spoke with the patient and the patient understood the procedure, Rosing says. The physician can then place the form in the patient's medical record or, if the consent took place in the physician's office, fax or send it to the hospital. The reason the form must be sent to the hospital is often because the physician's office record does not go to the hospital with the patient, Rosing says.

Tell us about your unannounced survey experience!

Has your hospital had its unannounced triennial survey yet? BOJ wants to know about it. What happened when the surveyors showed up? How did staff handle the surprise? Contact Senior Managing Editor Jay Kumar at 781/639-1872, Ext. 3144, or jkumar@hcpro.com, and your experiences might be featured in a future article.
JCAHO official corrects statement about dispenser rule

The JCAHO has clarified its stance regarding the distance from ignition sources at which alcohol-based hand gel dispensers must be mounted, a commission official said January 20.

Hand-gel equipment must be mounted 6 in. to the right or left of center from the dispenser to an ignition source (e.g., an electrical switch or an outlet), said George Mills, FASHE, CHFM, CEM, a senior engineer with the JCAHO Standards Interpretation Group. Mills spoke during a January 20 HCPro audioconference.

The clarification comes in response to an article that Mills authored in the January 2006 Environment of Care News, published by Joint Commission Resources, a JCAHO affiliate. Mills said in the article that the dispensers must be located 12 in. to the left or right of center from an ignition source.

The misstep came after Mills told attendees during the National Fire Protection Association World Safety Conference & Exposition in June 2005 in Las Vegas that dispensers must be 6 in. to the left or right of center. Six inches is the official JCAHO stance on the issue.

If six inches still poses a problem for organizations, hospitals may conduct a risk assessment using sound data about the product in the dispenser, Mills said. If the product does not emit flammable vapors or the height of the dispenser won’t cause safety problems, the dispenser may be mounted closer than 6 in., he said.

This clarification comes at a time when surveyors are being told to focus even more on hand hygiene and infection control, according to a source close to the JCAHO. The continued existence of drug-resistant diseases has prompted closer scrutiny this year, the source says.

Mills also put to rest rumors that a life-safety specialist can stay at a hospital for one to three days depending on the size of the organization. The life-safety specialist will spend one day at the hospital during the survey if the organization has 200 or more beds, Mills said. Any change to that policy would require comments from accredited organizations, he said.

But Mills had no qualms with the idea of staying longer. “Personally, I’d love to see us there [for] a second day if your organization is 750,000 sq. ft. or more,” Mills said. “I’d like to see us there long enough to do what we’re [there to do].”

Overheard

The following chatter was seen recently on the “BOJ Talk” e-mail group:

Q: Are operating room staff required to write verbal orders for medications used for wound irrigation? Or, does the physician preference card meet the requirement for an order?

A: We have an intraoperative order form in which the staff write any verbal orders given during the procedure (after repeating them back) and the physician signs it at the conclusion of the procedure.

Q: As a sequel to my previous question about what facilities are doing for hand-off communication, let me add this: What kind of documentation is being placed in the medical record? Is documentation in the medical record a requirement or do we just need to have a process in place?

A: We just had an unannounced survey and the surveyor discussed this issue with us. She made it clear that it was her impression that “paper was not the answer.” They weren’t going to be looking for documentation for this one, but clearly drilling into the questions of ‘what were you told about this patient when they were sent here?’ —

Editor’s note: “BOJ Talk” is a subscriber benefit for Briefings on JCAHO readers. E-mail owner-boj_talk@hcpro.com to sign up.
Learning objectives: After reading this article, you will be able to
1. identify documents necessary for a JCAHO survey
2. explain how to organize meeting minutes
3. discuss when to review policies and procedures

Although the JCAHO emphasizes individual patient and system tracers, do not underestimate the importance of documentation. Documents are still key evidence to prove compliance with standards and elements of performance.

Specific documents are to be readily available for the survey planning session that will occur shortly after the surveyors arrive at your hospital. During additional sessions, a surveyor may request to see specific items (e.g., a policy, procedure, plan, or meeting minutes).

Nevertheless, it is unrealistic to attempt to maintain current copies of these documents within a single binder for continuous survey readiness—you and your staff would be forever pushing papers and playing a game of seek-and-replace. Instead, consider organizing the many documents generated from your facility’s daily operations.

Meeting agenda, handout materials, and minutes

An agenda should serve as the roadmap of your meeting. Attendees should be able to review an agenda and know immediately what handout material corresponds to the topics discussed. Look around at the people in attendance: Are they continuously shuffling papers or looking for the item being discussed, or have they given up and started working on something totally unrelated to the meeting? If either is happening at your organization, it might be time to try something different.

An agenda should include the name of a presenter and reference a document number. Documents can be numbered easily with purchased or preprinted numbering. Try using colored paper for handout materials and noting on the agenda the color of each topic.

Whichever mechanism you choose, remember that sequential ordering of handout packets is critical if the attendee is to locate the material quickly.

Meeting minutes should be designed to capture the decisions and actions of the committee. Lengthy narrative notes are neither necessary nor helpful to the reader. Because action items must be followed to resolution, list them as unfinished business on the subsequent meeting’s agenda.

Because surveyors may request meeting minutes, it is wise to maintain 12 months of minutes in one location (e.g., a notebook or file). At the conclusion of a meeting, simply remove the oldest meeting materials and add in the new ones. For those functions that require a 12-month track record, you will already have assembled the necessary documentation to comply with this requirement.

PI reporting

At any given time, multiple performance improvement (PI) activities are being conducted throughout an organization. Unfortunately, when it comes time to report the findings, analysis, and action, the lack of a standardized reporting format may be associated with superficial information and exclusion of key elements. See p. 10 for a reporting form that is easy to complete and contains the typical steps of a PI process.

Human resources employee files

At the time of competency review, the surveyors will

About the book

expect that the appropriate documents are contained and orderly within the file. Be ahead of the curve by establishing an employee file that is tabbed and in a defined order.

Determine which orientation and competency documents will be housed in the employee file within the human resources department and which will be maintained by the department directors in their employee files. Not only will this step save time in avoiding duplication, it also will help in pulling the appropriate materials for the JCAHO competency review. Depending on the surveyors and their collection of employee names, minimal time could be allotted for document retrieval prior to this review session. See p. 11 for a list of common tabs used in organizing employee files.

Appointment and reappointment files
Medical staff offices are often meticulous in their file maintenance practices. Several vendors offer preprinted tabs and specially designed file folders to decrease the labor intensity of filing multiple documents.

To promote consistency in filing, create an outline of the file tabs and the order of items behind each tab. As with the competency review, the selection of the practitioners for credentials review will occur during patient tracers. The time allotted for pulling credentialing files will not be generous enough to allow staff to file loose items and organize a file that is in disarray. Therefore, each time a credentialing file is handled, examine it for loose filing and items that are out of order. Consistent file maintenance is a necessary component of continuous survey readiness.

Policies and procedures
Institutions have struggled to identify the most efficient method of defining and then housing their organizationwide and departmental policies and procedures. Some have even debated whether a policy should be separated from the procedure as another document.

The one thing on which we can all agree is that there is not one correct answer. Perhaps the most important factor is consistency.

When the JCAHO began organizing its standards manual by functions, many hospitals patterned their policies and procedures in the same manner. Departmental policies and procedures were discouraged unless a true exception to the organizationwide practice could be substantiated. By formulating housewide policies and procedures, the leadership standard (LD.3.20) of “patients with comparable needs receiving the same standard of care, treatment, and services throughout the hospital” was more often compliant by promoting a single level of care.

Whichever methods your organization has selected, ensure that your policies and procedures are reviewed as frequently as your hospital’s policy mandates and updated as needed to remain current with the industry. Resist the common language of an annual review; 12 months roll by quickly, and you could be out of compliance with your own policy.

Historically, healthcare institutions have generated a multitude of policies and procedures. Rethink the need to define all basic professional procedures when published resources exist (e.g., nursing procedure manuals). By adopting a manual and supplying the most recent edition to each nursing unit, think of the many procedures you can retire from review, rewrite, and storage. At any time during your survey, you may be requested to provide a specific policy or procedure. It stands to reason that staff should be able to locate the document if they are familiar with its existence and have incorporated its contents into their daily work.

Whether your policies and procedures are in hard copy books or online versions, the chapter teams should have created a crosswalk of the standards and elements of performance during the periodic performance review (PPR) and as any changes in requirements occurred.

Use the PPR and crosswalks to identify relevant policies and procedures during your survey. A notation of who is most knowledgeable and who should be responsible for reviewing and updating the document could be helpful. Contact that person for assistance.
### Smith Regional Medical Center

**Department:**

**Activity:**

**Population/sample:**

**Source of collected data:**

<table>
<thead>
<tr>
<th>Indicator(s)</th>
<th>Goal</th>
<th>Results</th>
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(attach graphs/charts)

**Analysis/conclusions:**

**Recommendations/actions:**

**Reevaluation planned:**

Submitted by: ______________________________________________            _____________

  (signature)                         (date)

## Sample HR employee file organization

<table>
<thead>
<tr>
<th>Tab</th>
<th>Contents</th>
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<tbody>
<tr>
<td>Application</td>
<td>Employment application(s) initial and subsequent if employee had a period of separation.</td>
</tr>
<tr>
<td>Job description</td>
<td>Current and previous positions.</td>
</tr>
<tr>
<td>Verifications</td>
<td>Primary source verification of license, certifications, or registrations. Include verifications of qualifications as listed in the job description (e.g., education, experience, or specific skill).</td>
</tr>
<tr>
<td>Orientation</td>
<td>Documentation of general orientation and department orientation.</td>
</tr>
<tr>
<td>Competency</td>
<td>Beginning with the completion of orientation and subsequent as required by organizational policy.</td>
</tr>
<tr>
<td>Performance appraisals</td>
<td>Initial and subsequent as required by organizational policy.</td>
</tr>
<tr>
<td>Salary</td>
<td>Initial and subsequent as changes occur.</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>Background checks, correspondence, confidentiality agreements, conflict of interest, etc.</td>
</tr>
</tbody>
</table>

The JCAHO will post a hospital's survey agenda and surveyor information on the organization's secure extranet Web site by 7 a.m. Eastern time on the day of the inspection, commission spokesperson Mark Forstneger says.

Confusion had arisen regarding whether the commission would post the information by 7 a.m. using Eastern time or the time zone in which the organization was located.

The posting time gives West Coast hospitals a decided advantage because they have the opportunity to learn about an unannounced survey by 4 a.m. Pacific time.

The information regarding the survey will be posted on the right side of the “Jayco” extranet site (www.jcaho.org/jaycobhome/jaycobhomepage.asp) under the link “Notification of Scheduled Events.” The posting will contain a letter signed by Russell Massaro, executive vice president of accreditation operations at the JCAHO, as well as surveyor biographies and photographs, a survey agenda, and priority focus process information.

The surveyor photographs should be available by March, a source close to the JCAHO tells Briefings on JCAHO. The verification information is a result of imposter surveyors arriving at organizations in 2005, the source says.

Hospitals should give five or six people access to the secure extranet site, the source says, and they should check it regularly to see whether a survey has been scheduled. Those people should include the survey coordinator, quality director, chief nursing officer, CEO, and a couple of nursing directors.

They should provide adequate coverage in case surveyors arrive when someone is on vacation, the source says.

Learning objective: After reading this article, you will be able to
1. discuss where survey information will be posted for your organization

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• Fill out your contact information in the space provided. Include your e-mail address—we will send you an electronic certificate upon successful completion of the exam.

• Complete the exam by circling the letter that corresponds to the correct choice for each question. The questions are based directly on content from the January–March issues of BOJ, to which you may refer as you take the exam.

• Fax both the exam and evaluation to us by May 15, 2006. To qualify for three (3) nursing contact hours, you must answer at least 80% of the questions correctly—that’s 24 correct answers out of the 30 questions.

• We’ll e-mail you a certificate of completion that you may use for display and documentation of three continuing education (CE) credits toward your nursing certification. HCPro, Inc., is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation. The BOJ editorial advisory board members have signed a vested interest form declaring no commercial/financial stake in this activity.

• If you have any questions or concerns, please contact customer service at 800/650-6787. Fax or mail your exam and evaluation by May 15, 2006, to Briefings on JCAHO CE Exam, P.O. Box 1168, Marblehead, MA 01945, fax: 781/639-2982, attn: Robin Flynn, CE Manager.

Name: ___________________________________________ Nursing license number: _________________________
Facility: ___________________________________________________________________________________________
Address (city, state, ZIP): __________________________________________________________________________
Telephone: ______________________________________ Fax: ______________________________
E-mail: __________________________________________________________________________________________

January 2006

1. Name one proposed 2007 National Patient Safety Goal.
   a. Providing a smoke-free environment
   b. Reducing errors associated with anticoagulants
   c. Increasing the number of visitors that a patient may have
   d. Improving patient satisfaction

2. How should staff assess a patient’s suicide risk?
   a. Evaluate factors that increase or decrease a patient’s suicide risk
   b. Address immediate safety needs
   c. Provide a crisis hotline or other information for the patient and family
   d. All of the above

3. Who should be members of a rapid response team?
   a. A respiratory therapist
   b. An intensive care nurse
   c. A physician assistant
   d. All of the above

4. What is one safeguard that staff should take when handling oral contrast media orders?
   a. Trained staff retrieve the media from a limited set of medications
   b. Any available nurse can retrieve the medication
   c. Only physicians can access contrast media
   d. None of the above
5. Identify pharmacists’ role in handling oral contrast media.
   a. Pharmacists have no role in oral contrast media
   b. Pharmacists create the policies for oral contrast media in the hospital
   c. Pharmacists are available to answer questions
   d. Only pharmacists at large hospitals are involved in the process

6. When should a pharmacist review a contrast order?
   a. When the contrast order is for a patient in a unit outside of radiology
   b. Always
   c. Never
   d. None of the above

7. Which JCAHO standard regulates patient flow?
   a. MM.4.10
   b. RI.2.20
   c. MS.1.10
   d. LD.3.15

8. Which staff are responsible for improving patient flow?
   a. Leadership
   b. Emergency department physicians
   c. Housekeeping
   d. All staff

9. How can data help a hospital improve patient flow?
   a. Studying patient census data can determine the greatest time of need
   b. Hospitals can enter numbers into a computer
   c. An intern can compile the data
   d. All of the above

10. How does laboratory accreditation affect hospital accreditation?
    a. Surveyors can revoke a hospital accreditation based on just a lab survey
    b. The JCAHO instituted this change in 2006
    c. The JCAHO views lab services as essential hospital services, and the hospital can receive the same adverse decision as its lab
    d. None of the above

11. Who should oversee laboratory accreditation in a hospital?
    a. Survey coordinator
    b. Lab quality improvement director or lab director
    c. Both; the hospital leadership must make sure that both cover any accreditation issues that overlap
    d. None of the above

12. Name an alternative laboratory accreditation body.
    a. College of American Pathologists
    b. Clinical Laboratory Accreditation and Education
    c. Both
    d. Neither

**February 2006**

1. What is the best way to write a plan of correction for the Centers for Medicare & Medicaid Services (CMS)?
   a. Include as much detail as possible, including dates of correction and any supplemental material
   b. Have department directors send their own clarifications to someone at CMS
   c. Call the JCAHO to complain
   d. CMS doesn’t require plans of correction

2. What is the process for receiving and responding to deficiencies?
   a. Hospitals have five days to respond to a CMS deficiency
   b. Hospitals have 10 calendar days from the date they receive the deficiency to respond
   c. Hospitals have 20 days to respond
   d. Hospitals can take as much time as they need

3. How should you follow up with CMS after submitting a plan of correction?
   a. There is no need to follow up
   b. Call the state survey agency and ask whether any additional information is needed
   c. Go to the state survey agency office and meet with the surveyors personally
   d. None of the above

4. What must hospitals do now to meet the JCAHO’s public information interview requirement?
   a. Allow the public into the hospital for tours to view patient care
   b. Tout patient care improvements to the media
   c. Appoint a public information officer
   d. Show surveyors how they inform the public about contacting the JCAHO with any patient-safety or quality concerns
5. What is one way to meet the JCAHO’s new public information requirement?
   a. Post regulatory contact information on the hospital Web site
   b. Print contact information in a brochure or patient admission package
   c. Include regulatory contact information in a community newsletter
   d. All of the above

6. What is one way to train staff for unannounced surveys?
   a. Hope that staff know what the JCAHO is
   b. Develop survey training just before your targeted survey date
   c. Send staff e-mails with relevant JCAHO topics and survey-related questions and answers
   d. None of the above

7. How do you use the periodic performance review (PPR) to prepare for survey?
   a. The PPR helps you determine areas of noncompliance
   b. It teaches you the JCAHO standards
   c. Staff learn how to perform a PPR
   d. Surveyors like to see that you conducted a PPR

8. What are other tools used to train for surveys?
   a. Videos
   b. Mock tracers
   c. Monthly evaluation of key staff to determine who is available during an unannounced survey
   d. All of the above

March 2006

1. When should a hospital use an informed consent form?
   a. Prior to any surgical procedure
   b. When the patient is admitted to the hospital
   c. None of the above
   d. All of the above

2. What should an informed consent form include?
   a. A statement saying that the physician explained the procedure and its risks
   b. The physician’s or a witness’ signature
   c. The patient’s or a representative’s signature
   d. All of the above

3. How should the form be documented in the patient’s medical record?
   a. There is no need to document the consent in the record
   b. The physician should place a copy in the patient’s medical record
   c. A copy should be sent to the JCAHO
   d. None of the above

4. What are some of the documents necessary for a JCAHO survey?
   a. Meeting agendas
   b. Performance improvement reports
   c. Policies and procedures
   d. All of the above

5. How should meeting minutes be organized?
   a. They should be placed in a secretary’s desk drawer
   b. They should be boxed up and stored for five years
   c. They should be placed in a notebook or file for a 12-month period
   d. They should be thrown out after five months

6. When should you review your policies and procedures?
   a. As defined by hospital policy
   b. Every other year
   c. Every five years
   d. Every month

7. Which JCAHO standards govern competency assessment?
   a. LD.3.10 and LD.5.20
   b. MS.1.20 and MS.4.30
   c. MM.4.10 and IM.1.20
   d. HR.3.10 and HR.3.20

8. How can you make new-employee orientation more efficient?
   a. Have orientation every month
   b. Have new employees fill out a self-assessment form to help personalize training
   c. Don’t have orientation; it wastes time
   d. Only orient employees who request it
9. Which staff should be on the competency assessment team?
   a. Physicians only
   b. Any staff member
   c. Staff who score “independent” or “able to teach others” on their assessments
   d. None of the above

10. Where will the JCAHO post survey information for your organization?
    a. Surveyors will bring it with them
    b. The Jayco extranet site under “Notification of scheduled events”
    c. The JCAHO will mail it to the organization
    d. None of the above

Evaluation

1. Did this CE activity relate to its stated learning objectives?  
   ________________________________________________________________  
   ________________________________________________________________

2. Was the format of this CE activity easy to use?  
   ________________________________________________________________  
   ________________________________________________________________

3. Did we avoid commercial bias in the presentation of our content?  
   ________________________________________________________________  
   ________________________________________________________________

4. Will this activity enhance your professional development?  
   ________________________________________________________________  
   ________________________________________________________________

5. How long did it take you to complete this activity (including reading, exam, and evaluation)?  
   ________________________________________________________________  
   ________________________________________________________________