Steven Hirsch and Associates

Accreditation News

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Steven Hirsch and Associates

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OUR MISSION

Our mission is to provide dynamic integrated expertise that supports health care organizations in meeting and exceeding patient care standards as mandated by the regulatory environment.

OUR VISION

To provide a positive and supportive environment that fosters professionalism while providing the highest quality client centric consulting expertise in the health care industry.

OUR VALUES

CREDIBLE • ETHICAL
EXPERT • INTEGRITY
PROFESSIONAL
RESPONSIVE

2015 Recap

As 2015 comes to an end, we all have probably had the opportunity to read articles on top health care issues as defined by a particular author and or organization.

The ECRI Institute provided a Top Ten List of Health Technology Hazards to be aware of for 2016. This list identifies potential areas for focused attention in the coming year.

The Joint Commission has also shared the most challenging standards found in the first half of 2015.

We at Steven Hirsch and Associates have compiled a list of our frequent mock survey findings for 2015. They are as follows and are in no particular ranking or order.

- Documentation of the patient's care plan lacked individualization, specific goals with timelines, updating and closure of goals when achieved, and the documentation provided was not in congruence with the hospital specific policy and procedure on documentation of care plans.
- Incomplete documentation of checking crash carts, medication and patient refrigerators, blanket and fluid warmers, eye wash stations, temperature and humidity monitoring, and negative pressure rooms.
- Storage and labeling of medical gas cylinders not in compliance with requirements, to identify and separate full from empty cylinders.
- Scope reprocessing every five days not conducted nor documented, for those scopes not utilized at least every five days.
- Lack of updated orientation, training and competency for staff performing high level disinfection and sterilization.
- Personal protective equipment not used appropriately.
- Containers of disinfectant wipes not closed properly.
- Hinged instruments sterilized in the closed position.
- Maintenance and appropriate documentation of temperature and humidity in interventional locations lacking.
- Unsecured medications and unsecured procedural trays with medications.
- Documentation of orientation, education and competencies for employees and for contract employees incomplete.

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2015 Recap Continued…

- Authentication, including signature, date, and time lacking in the medical record.
- Quality Assurance and Performance Improvement information not provided to unit based staff.
- Employees not aware of, or not following hospital specific policies and procedures.
- Accountability.

Having said all of this, it also must be said that our team has been very fortunate in having the opportunity to work with leadership and staff that are interested, open, willing and eager to improve and to deliver the highest possible quality of patient care in order to achieve the best patient care outcomes in the safest possible environment available.

Written by Linda Paternie, RN, BS, MHA

Best Practices

We all have heard and read numerous references to "best practices" both in the realm of healthcare as well as in day-to-day life. But what exactly are best practices? Best practices can be defined as methods or techniques that have consistently shown results superior to those of other means. Best practices are used to maintain quality and can be considered alternatives to mandated legislated standards. Individual organizations/hospital systems may base their best practices on results of self-assessments as well as on externally published benchmarks. The Joint Commission defines best practices as "Clinical, scientific or professional practices that are recognized by a majority of professionals in a particular field as being exemplary. These practices are typically evidence based and consensus driven."

As a member of Steven Hirsch and Associates (SHA), I have had the good fortune of seeing many best practices in use at the organizations in which I am working. My colleagues at SHA as well have commented on their observations and experiences with best practices at the sites we serve.

Some of the remarked upon best practices include the following:

Weekly performance improvement meetings in which departmental managers review data results that are not compliant to the items identified for data collection. Such data collection items may include documentation that is correct, accurate and timely for critical values, for pain assessment or for restraints. Hand hygiene compliance is addressed. Prevention of falls and fall data is reported. The presence of history and physicals in the medical record in accordance with timelines mandated by the organization is reviewed as is the presence of an updated history and physical prior to surgery or to a procedure.

The performance improvement meetings are rapid. Participants include clinical managers; environmental, biomedical and facilities leaders; ancillary department managers and staff from the quality improvement department. Attendance is required. Improvement strategies are discussed and thus known by the entire team, and soon the strategies spread throughout the organization.

Another practice that is instrumental in achieving compliance to mandated standards is the implementation of a National Patient Safety Goal data collection form. Data elements are abstracted from medical record review and aggregated. The aggregate result is then compared to the goal for compliance as identified by the organization. The organization therefore has a tabulation of current compliance to the National Patient Safety Goals.

Organizations have also chosen to introduce unit/departmental specific tracer exercises. The tracer tool provides documentation of specific assessments/findings per an identified Joint Commission standard with an accompanying action plan, identified responsible party and anticipated completion date. Certainly the objective of this ongoing exercise is to achieve and maintain maximum compliance to the standards.

Compliance to hand hygiene requirements seems to be particularly challenging across the healthcare continuum. One organization chose to handle their challenges in the following manner.

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Best Practices Continued…

All employees signed an attestation that they had received a copy of the hand hygiene policy and that they understood the policy. Part of that understanding was that the hand hygiene policy had the same weight as policies on medication administration and on attendance. Observed failures to the policy would result in progressive discipline. A month of observations and verbal reminders/warnings then followed. Observers included managers of various units, and observers from administration, quality and infection prevention.

Physicians were included in the observations and the results were reported to peer review for implementation of the medical staff improvement strategies. Within about three months after implementation, compliance to hand hygiene reached 90% and that rate remained stable over eight months.

Certainly we all aim for 100% compliance and perhaps, hopefully, this organization will be able to achieve that goal in the upcoming months. A notable success factor is that a rate of 90% was achieved and maintained!

In conclusion, a sincere thank you to all the organizations with whom SHA has had the opportunity to observe best practices and to contribute to the formulation and implementation of work leading to exemplary results.

Written by Linda Paternie, RN, BS, MHA of Associates

The Importance of Patient Triage in the Emergency Department

After reading the title of this article, you may be saying, "Well, of course." Failing to properly triage patients presenting to the Emergency Department (ED) can lead to delays in care and poor patient outcomes. With our work at client hospitals in the past year, we have come across several citations and sanctions brought forth by the state Department of Public Health (DPH) to hospitals who were surveyed by DPH and found to be not in compliance with standards/practices or their own policies and procedures related to the triage of Emergency Department patients.

At present, hospitals are most often using the Emergency Service Index (ESI), a five level triage system, as a method for prioritizing patients presenting to the ED. The ESI triage is conducted by a Registered Nurse competent to do so. More about that in a minute.

The triage RN performs the triage assessment and determines the priority of care necessary for the patient and the appropriate area/room for the patient to receive evaluation and treatment. All patients who present seeking medical attention are also to receive a medical screening exam by a licensed practitioner.

The ESI most commonly used is a five level tiered system. A brief description of the five levels follows:

ESI 1 (Imminent) Any condition presenting immediate threat to life or limb requiring immediate interventions to save a life or prevent irreversible damage.
ESI 2 (Emergent) Potentially life or limb threatening and could worsen without intervention.
ESI 3 Any condition that requires evaluation and treatment, is not time critical and will not worsen if untreated for a few hours.
ESI 4 Any condition that requires evaluation and treatment, is not time critical, and will not worsen if left untreated for several hours.
ESI 5 Any condition that requires minimal interventions and will not worsen if treatment is delayed for many hours.

Certainly, the ESI algorithm is more complex than the brief descriptions listed here. The algorithm yields rapid, reproducible and clinical stratification of patients from most urgent to least urgent. More information can be found at Gilboy N, Travers D, Rosenau AM. Emergency Severity Index (ESI): A Triage Tool for emergency Department Care, Version 4. Implementation Handbook 2012 Edition. AHRQ Publication No. 12-0014. Rockville MD.

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- Pre-accreditation, Medicare certification, and Licensing surveys
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- Management of the Environment of Care (including Life Safety Assessment)
- Joint Commission Survey Interview Training
- PPR Preparation

The Importance of Patient Triage in the Emergency Department Continued…

Deficiencies that our SHA team has identified at some hospitals include:

1. Lack of comprehensive education and training on the ESI system including lack of documentation of the education and of the testing results. (A post test is to be given to help validate staff knowledge and understanding).
2. Lack of documented competency for the registered nurse performing triage.
3. Lack of education and training to promote understanding by the entire team working in the ED related to ESI triage.
4. Lack of retrospective and concurrent monitoring (audits) of the triage process and of the triage levels assigned to patients.
5. Lack of defined competency standards for the staff performing triage. For example, is a score of 80% appropriate for testing of the triage assessment or is a score of 90% more appropriate? Determination then must be made for steps to be taken to provide remedial education and a follow-up testing process for those not achieving the required competency score.
6. Lack of annual competencies for ESI triage.
7. Lack of an appropriate policy and procedure to help guide the triage process and to state the hospital's defined timeframes for time to treatment, assessment, reassessment, vital signs, assessment of pain, response to interventions, any specific requirements for patients designated as 5150 and any specific requirements for reassessment prior to discharge.
8. Lack of clear direction and policy for reassessment of patients once they have been assigned an ESI level and are waiting in the ED waiting room to be seen.

ESI triage assessment is only one aspect of the care for patients presenting to the Emergency Department. With the influx of patients to most ED's, where lines of patients waiting to be seen may be long and wait times for screening may be longer than desired, ESI triage is a crucial aspect of care to assist in providing care immediately to the most acute patients.

It is recommended that hospitals take a look at their current triage processes and make sure that they have defined criteria for nurses to achieve before they are assigned the triage role. Criteria may include a defined length of time for clinical practice in the ED, demonstrated competency validated by a competent preceptor, completion of the education program utilizing ESI, and of completing the competency exam at a passing score as defined by the hospital. Some hospitals our team has surveyed have assigned temporary or relief staff to the triage role. Is this best practice? The hospital needs to determine that for its specific setting and needs.

It is important to remember that when the Department of Public Health comes to survey a hospital, the survey is conducted based on regulations, standards and on the hospital's own policies and procedures. Maybe now is the time to review your policies and procedures as related to triage in the ED. We all are aware of the importance of complying with standards and practices for triage of patients in the ED as we work together on activities to improve patient safety and the quality of healthcare delivery.

Written by Linda Paternie, RN, BS, MHA of Associates