Steven Hirsch and Associates

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A New Year's Resolution to be Survey Ready

Are you ready for your next Joint Commission (TJC) survey?? You do know that it could be tomorrow! Today is the day to start and stay prepared. How do you prepare for surveys? Below are a few tips to assist you to meet that goal.

1. Keep alert for changes in the standards and applicable regulations and interpretation of those requirements. Do that by reading the official publications of your accrediting organization (Joint Commission, HFAP, or DNV) and attendance at webinars, and conferences. Set in motion plans to get into compliance with those changes.
2. Ensure that the information on file at licensing agencies and accrediting bodies is correct and current. This includes changes in space utilization, management, ownership, etc.
3. Make survey readiness is a standing agenda item for each and every meeting.
4. Bring in a third party, consultant or sister facility, to look at your organization through a different set of eyes. It is amazing what is seen that you may have missed. Take that list of items that require corrective measures and make an action plan that assigns responsibility and accountability to team members.
5. Form a team of tracer experts (staff, managers, MDs) to routinely perform a set number of tracers within a defined time frame. Consider these topics: Plan of Care, Medication Pass and Management, Life Safety, and Infection Prevention and Control. Compile the results and then analyze why these measures are not being met. Based on that analysis, review or revise policies/procedures, educate involved staff, and monitor.
6. Policies/Procedures usually are high volume; so, divide them into thirds and tackle one-third each of the cycle years. That way they will get updated and staff will be able to absorb all the changes and incorporate them into practice.
7. Document all the education that staff receive and have compiled into one document in chronological order. This should include mandatory education on topics such as restraint use, point of care testing, cultural diversity, end of life care, etc. Pay attention to those items required on hire and those required annually.
8. Remember to educate the Medical Staff to the regulations and accreditation requirements. And, monitor their compliance especially to the time, date, and authentication of all documentation.
9. Create a pocket sized document which staff can use to affirm the proper action and response in a survey. This is best done with a Question/Answer format. Periodically, test that knowledge and reward staff with candy, entry into a drawing, or some other incentive.
10. Keep it fun by playing games, such as "Jeopardy" or "Wheel of Fortune." This makes it easy to learn, have fun, and of course, there needs to be a prize.

Sounds easy to me; but this does require discipline and hard work. You will thank yourself for taking these steps at the time of your survey and the great results. Happy New Year!

Multi-Drug Resistant Organism Alerts

Background

More than 70% of the bacteria that cause hospital-acquired infections are resistant to at least one of the drugs most commonly used to treat these infections. Multi-drug resistant organisms (MDROs) of particular concern include MRSA, VRE, extended spectrum beta-lactamases, Acinetobacter baumanii, carbapenem-resistant organisms, and C. difficile.

Two prominent guidelines exist regarding the control of MDROs; one from the Society of Healthcare Epidemiology in 2008, and one from the Healthcare Infection Control Practices Advisory Committee of the Centers for Disease Control and Prevention of 2006. These guidelines reflect universal concern in the infection control community about today's unprecedented levels of activity of MDROs. The two guidelines provide detailed reviews of pertinent issues and evidence-based, rated recommendations.

The two guidelines have a similar recommendation concerning tracking and trending the incidence of MDROs. Both recommend using a hospital computer system to alert healthcare workers when patients are known to be positive for MDROs and are transferred or readmitted to the organization. In both guidelines, this particular recommendation is categorized as Category IB – meaning that it is strongly recommended for implementation and supported by some experimental, clinical, or epidemiologic studies and a strong theoretical rationale.

Joint Commission Mandates

Hospitals lacking an MDRO alert system are subject to citation by The Joint Commission. A sequential review of the 2013 National Patient Safety Goals (NPSG) will provide guidance for The Joint Commission mandates concerning the tracking of MDROs. The first, NPSG.07.03.01 EP4, states that organizations must have a surveillance program for MDROs based on the annual Infection Control Risk Assessment. Once MDROs pertinent to the individual organization are identified, NPSG.07.03.01 EP8 states that a "laboratory-based alert system" must be implemented that identifies new patients with MDROs. The alert system can exist of telephones, faxes, pagers and electronic alerts, or a combination of these methods.

Finally, NPSG.07.03.01 EP9 stipulates that an alert system must be implemented that identifies MDRO positive patients transferred or readmitted to the organization. This alert system may be manual, electronic, or a combination of both.

California Senate Bill 1255.8

In California, complying with SB 1255.8 will inevitably add to an organization's MDRO line listing. This bill, passed in 2008, requires MRSA screening for five categories of patients: 1) patients having scheduled inpatient surgery with certain documented medical conditions, 2) those discharged from acute care in the previous 30 days, 3) patients being admitted to ICU or burn unit, 4) patients receiving inpatient dialysis, and 5) patients transferred from skilled nursing facilities. Patients who test positive for MRSA will need to be identified by the alert system in addition to other MDROs.

Developing an Alert System

Identifying patients with MDROs in the medical record requires a substantial amount of time for the Infection Preventionist. For facilities lacking a computerized alert system, it presents an even more considerable task. The chart in Table 1 can be used as a template for tracking organisms. This chart can be easily modified to accommodate active surveillance test results by adding an additional column.

Table 1
LINE LISTING OF MDRO INFECTIONS

Month _____ **Year** _____

Room ___ Unit ___ Name_____ Admission date _____ Colonization Infection	Symptoms Date	Culture results Date _____	Date isolated	HAI or CAI
Room ___ Unit ___ Name_____ Admission date _____ Colonization Infection	Symptoms Date	Culture results Date _____	Date isolated	HAI or CAI
Room ___ Unit ___ Name_____ Admission date _____ Colonization Infection	Symptoms Date	Culture results Date _____	Date isolated	HAI or CAI
Room ___ Unit ___ Name_____ Admission date _____ Colonization Infection	Symptoms Date	Culture results Date _____	Date isolated	HAI or CA

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Multi-Drug Resistant Organism Alerts Continued…

Integration

No MDRO alert system can exist in a vacuum. Unless staff is aware of where in the patient's medical record the MDRO alerts exist, patients will not be identified for proper isolation. In this author's experience, there is frequently a knowledge deficit of MDRO alerts among Emergency Department staff. Because isolation room assignments are often made while a patient is in the Emergency Room, ongoing staff education regarding MDRO alerts is of paramount importance. Addressing staff turnover poses an additional challenge. This challenge can be met by discussing MDROs and alerts at Nursing Orientation, using visuals that demonstrate where MDRO alerts will appear in the medical record.

Evaluation

Is the use of automated prompts effective? In a literature review of trials to evaluate the effectiveness of clinical decision support systems, Garg et al found that improved performance was associated with systems that use automatic (computerized) prompts rather than prompts that require user activation (manual). 73% of trials with automatic prompts were successful versus 47% of trials with prompts that require user activation (p=.02). Whether the use of automated prompts decreases transmission of MDROs remains a phenomenon for future study.

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Written by Judy Hagerty, RN, MS, CIC of Associates

Patient Flow Standards Updated

We all are aware that The Joint Commission first implemented standards related to patient flow in 2005. These standards have been amended and several changes go into effect January 1, 2013, with two additional elements of performance becoming effective January 1, 2014. The standards are aimed toward managing patient flow in order to prevent crowding and boarding of patients in the Emergency Department and in other temporary locations throughout the hospital.

According to studies, crowding in hospitals is worsening. Emergency Department overcrowding is growing twice as fast as Emergency Department visits in many areas of the United States. Potential factors associated with overcrowding include throughput issues such as availability of laboratory tests, advanced imaging, administration of intravenous fluids, and the performance of clinical procedures which all take time for completion. Overcrowding has been linked with adverse patient outcomes, higher rates of medical errors and more frequent complications.

Let us review The Joint Commission standards that address the issues of crowding in hospitals. The patient flow standard is contained in the Leadership Chapter, LD.04.03.11, and has nine elements of performance that must be met to assure compliance.

Remember, hospital leaders create the culture, set the expectations, and provide support for effective collaboration on patient flow across units, departments and functions throughout the hospital. Leaders have the responsibility to evaluate patient flow and have the authority to take action to improve patient flow.

LD.04.03.11, EP1 requires the hospital to have processes to support the flow of patients throughout the hospital. These processes may include opening of overflow units or areas, implementation of "stat" cleaning processes for patient rooms, a defined policy for allocation of overflow patients to appropriate inpatient units rather than boarding in the Emergency Department, every shift or every four hour "bed board review" to assure oversight of prompt patient discharge in order to free up beds for new admissions, and the assurance of adequate staffing on weekends as well as during the week in order to support patient flow.

LD.04.03.11, EP2 requires the hospital to plan and care for patients who are admitted and whose beds are not immediately available. Temporary overflow areas such as the Post Anesthesia Care Unit or the Emergency Department may be used.

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Patient Flow Standards Updated Continued…

LD.04.03.11, EP3 requires the hospital to plan the care for patients in overflow areas that is appropriate to their clinical conditions and diagnoses, and that is comparable to patient care provided for like patients admitted to other parts of the hospital. Remember, staffing and clinical documentation must also be consistent with that provided in the non-overflow areas of the hospital.

LD.04.03.11, EP4 requires hospitals to develop criteria that can be used to guide decisions to initiate ambulance diversion. The criteria should be in policy format and as such, undergo appropriate review and approval processes that include input from the medical staff and hospital leadership.

LD.04.03.11, EP5 is new for 2013. The hospital leaders will need to set goals and measurements for components of the patient flow process used in the hospital. These components may include: available bed capacity; throughput to areas where patients receive care, treatment or services such as inpatient units, clinical lab, imaging, operating rooms, telemetry, and Post Anesthesia Care Unit; the provision of safe care in these areas; the efficiency of nonclinical support services such as housekeeping and transportation; and the access to support services such as case management and social services.

LD.04.03.11, EP6 goes into effect January 1, 2014. Hospital leaders will need to facilitate assessment and evaluation processes required to assist them in setting goals and measurements for mitigating and managing boarding of patients who come through the Emergency Department. Attention should be paid to patient acuity and best practice. In the best interest of patient safety and quality of care, it is recommended that boarding timeframes do not exceed four hours, although the four hour timeframe is not a stated requirement.

LD.04.03.11, EP7 requires the hospital to have the individuals and staff members who manage patient flow processes receive and review measurement results for the identified goals, in order to better assess whether the defined hospital goals were met.

LD.04.03.11, EP8 requires leaders to take action when the improvement goals have not been achieved. Leaders include members of the Governing Body, the Chief Executive Officer, members of the medical staff, senior leadership as well as staff members in leadership positions. Additionally PI.03.01.01, EP4 states that the hospital will take action when it does not achieve or sustain the improvements it had anticipated, through establishment of goals.

LD.04.03.11, EP9 goes into effect January 1, 2014. Once the hospital has determined that its population at risk for boarding includes patients with behavioral health emergencies, the hospital leaders (as defined by the hospital) will need to communicate with behavioral health providers and/or community authorities to foster coordination of care for this patient population.

Be sure to prepare your organization by review of all standards related to patient flow.

PC.01.01.01, EP24 states that if a patient is boarded while awaiting care for emotional illness, alcoholism or substance abuse, the hospital must provide a location for the patient that is safe, monitored and clear of items that the patient could use to harm himself or others. A risk assessment of the physical facility in which this specialized care is provided should be completed and documented.

NPSG.15.01.01.01, EP 1 and 2 addresses the patient's immediate safety needs and the most appropriate setting for treatment. EP1 calls for a suicide risk assessment to be conducted that identifies the patient's characteristics as well as the hospital's features that may impact the risk for suicide. EP2 addresses the need to provide the most appropriate setting for treatment based on the patient's immediate safety needs.

NR.02.02.01, EP4 calls for written staffing plans in order to provide an appropriate level of care, regardless of where in the facility, the patient will receive their care.

Be sure to know The Joint Commission definition of boarding: "Boarding is the practice of holding patients in the Emergency Department or another temporary location after the decision to admit or transfer has been made."

The Joint Commission R3 report, Issue 4, December 19, 2012, explains the revised patient flow requirements, in particular patient flow through the Emergency Department. The file can be downloaded through The Joint Commission website.

In conclusion, there is increasing focus on patient flow in hospitals. Patient overflow, patient boarding and patient crowding in the Emergency Department are common problems in hospitals across the nation and are ones that can result in increased risk for patients and produce inefficiencies for staff. With proper assessment and implementation of solutions, patient safety and the patient experience can be improved.

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