Steven Hirsch and Associates

Accreditation News

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Steven Hirsch and Associates

18837 Brookhurst Street
Suite 209
Fountain Valley, CA 92708

Toll Free: (800) 624-3750
Phone: (714) 965-2800
Fax: (714) 962-3800

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WWW.SHASSOCIATES.COM

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

Are you Ready?

As members of Steven Hirsch and Associates, our consulting team has the opportunity to conduct comprehensive surveys at healthcare organizations across the nation in order to assess regulatory and accreditation survey preparation and readiness. The following is a compilation of the most frequent findings from our team in 2014.

Environment of Care

- Storage and labeling of medical gas cylinders. Cylinders must be secure in storage racks and be segregated in racks labeled as Full or Empty
- Unattended Environmental Services carts found to be unlocked, which permits unauthorized access to the chemicals contained in the cart
- Obstructed access to medical gas shut-off valves
- Stained ceiling tiles
- Chipped laminate, because intact surfaces are required in order to be resistant to the potential harboring of organisms
- Documentation and maintenance of temperature and humidity in anesthetizing locations. Conducting surgery in an operating room whose temperature and/or humidity is not maintained within the required range is closely observed during regulatory and accreditation surveys and can be a survey stopper if not in compliance!
- Corridor clutter
- Obstructed fire extinguishers

Orientation, Competency and Ongoing Education

- Lack of visual acuity/color blindness screening upon hire
- Lack of complete documentation of orientation for all employees, volunteers and contract staff
- Lack of documented education on team communication, fall reduction practices, reporting of errors, death and dying, and organ donation
- Lack of documented competencies specific to staff performing high level disinfection

Infection Control

- Dirt and dust is found in numerous areas including on horizontal surfaces, and shelving, storage bins, interiors and bins in automated drug dispensing machines, crash carts and other types of supply carts, and air vents

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Are you Ready? Continued…

- Cleaning, disinfecting and storage of endoscopes
- Cleaning, disinfecting and storing of rectal and vaginal ultrasound probes, as well as maintenance of proper documentation logs
- Use of towels or Chux to lay over surfaces
- Sticky residue from tape
- Storage on the floor
- Mineral build up on/in ice machines
- Use of personal skull caps in operating rooms
- Improper wearing of isolation gowns
- Lack of hand hygiene
- Containers of disinfectant wipes having lids open/unsealed
- Unwrapped laryngoscope blades and handles
- Use of donated hand made items such as quilts, baby caps and blankets, and pillows without appropriate laundering prior to use

Miscellaneous

- Lack of confidentiality of patient information, especially as seen on computer screens, patient labels on discarded intravenous bags, paperwork that is accessible and visible
- Expired supplies and medications
- Lack of consistent use of two patient identifiers, especially when passing meal trays
- Timing, dating and authenticating entries in the medical record
- Complete and individualized documentation on the patient's care plan
- Documentation of patient education
- Documentation of pain assessment and reassessment
- Documentation of restraint utilization and patient assessment

Continuous survey readiness is doable. Many successful organizations conduct weekly or monthly rounds to assess and document survey readiness. Areas that need to be improved are identified and improved. Therefore, there should be no surprises during survey. Our team wishes all of you successful survey results; results that highlight your organization's strengths and emphasize the care of the patient. That's what it is all about! Are you ready?

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

Plan of Care

The Plan of Care standards are often cited as deficient during an accreditation or licensing/certification survey. What is missing or incomplete? Here are some of the top reasons, not in order of frequency:

- Excessive number of problems listed
- Not individualized to the patient
- No prioritization assigned to identified problems
- No resolution of problems even on discharge
- Failure to include fall prevention, restraints, or pain management
- Disciplines other than Nursing are not involved in development of the Plan of Care
- Documentation lacking for the listed problems
- No update of problems/interventions/goals/outcomes
- Electronic Medical Record System selects problems based on data provided
- Failure of staff to read the Plan of Care to provide continuity of care
- Goals and outcomes not defined

How do we correct all of these system failures to ensure plans of care are accurate, complete, and that the documentation addresses the identified problems?

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Plan of Care Continued…

A Plan of Care flows from each patient's unique list of diagnoses and specific needs, as identified beginning with the admission assessment. It exists to serve as a means of communicating and organizing the actions to meet those patient specific needs through written format and at hand off. The Plan of Care promotes coordination and continuity of care among care givers.

A Plan of Care has the following components: Nursing diagnosis or problem list, goals and outcome criteria, specific actions to meet the goals, and evaluation. These can be expressed within a variety of formats.

Licensing and certification regulations and accreditation standards require development of a Plan of Care. The Joint Commission addresses this in Provision of Care, Treatment, and Services (PC 01.03.01) which states "The hospital plans the patient's care."

The Medicare "Conditions of Participation" also contain language requiring a plan of care in 482.23(b)(4), which states: "The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient." Individual states may also have a requirement for a plan of care for each patient. For instance, in California, Title XXII, [70215(a-d)], requires a plan of care with the involvement of the patient, and as appropriate, their family, and adds an additional item; that of patient advocacy.

When surveyed, the hospital can expect the surveyor to link the admission assessment, diagnosis, and specific patient needs to the plan of care. The surveyor will conduct this activity in conjunction with the patient tracer. Staff will be asked to discuss the plan of care, policies and procedures, and documentation.

Some questions that may be asked include:

- How soon after admission is the Plan of Care initiated for each patient?
- Is the Plan consistent with the diagnosis and the MD's plan for medical care?
- Does the Plan describe the patient goals, physiological and psychosocial factors, and discharge planning?
- Is the Plan revised as the needs of the patient change?
- Who prepares the Plan? Who can add to or revise the Plan?

Hospitals are advised to review their policies and procedures, Standards of Care, and Standards of Practice to ensure they are current and address all the requirements of the accreditation standards and applicable law and regulation. There may also be a need to periodically audit care planning to assess compliance with organization polices and procedures.

As new employees enter the hospital, it is recommended that the care planning process be reviewed as a portion of the orientation to organization documentation systems. Periodically, care planning should be reviewed within the hospital's annual education update or reorientation. This will help to ensure that all staff are current and consistent in the use of the care planning process. Furthermore, the skills of the nurse for critical thinking and problem solving are enhanced.

For organizations that are entering into the electronic medical record, focus must be placed on how the care plan is initiated and the ability of the nurse to alter and tailor the plan to the individual patient's needs. In addition, all of the components must be reflected within the electronic plan of care. Staff must be able to access the nursing plan of care and any other disciplines' care plans.

Upon discharge, the goals must be resolved or be addressed. This is particularly true if the patient will be transferred to a skilled nursing facility or home health agency. As part of the transfer documentation, goals and interventions need to be listed for the receiving agency to continue the patient's care.

Care plans tell staff how to care for patients on an individualized level, not as a diagnosis, that will improve the patient's health status.

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

Waterless Alcohol for Hand Hygiene—An Overview

Almost 20 years have passed since alcohol-based hand rubs began to gain acceptance in the United States. This acceptance was not without controversy, largely because of the healthcare field's resistance to change. Tradition and ritual are ingrained in healthcare workers' perception of cleaning their hands. As the years passed, however, waterless alcohol became the standard product for hand hygiene in healthcare facilities, largely through the monumental efforts of one physician, Didier Pittet.

I had the recent privilege of hearing Dr. Pittet speak at the National APIC (Association for Practitioners in Infection Control and Epidemiology) Conference in Anaheim. For his efforts in the area of hand hygiene he was given the title of Commander of the British Empire and is on the list of Nobel Peace Prize candidates. His story is not only inspirational but educational.

In 1992, as Director of Infection Control at the University Hospital of Geneva, his concern with high hospital-acquired infection rates led him to observe hand hygiene compliance, which was low. Time constraint was the most frequent reason given by staff for lack of compliance. His observations in the ICU revealed that a nurse had an average of 22 occasions to wash his/her hands per hour and each handwashing episode took at least one minute. If they were vigilant, roughly one-half of a nurse's time would be spent handwashing, making it impossible to properly care for their patients. To make the process less time-consuming, Dr. Pittet worked with the hospital pharmacist on an alcohol hand rub formula for use in the hospital. When staff widely adopted the hand rub as their main method of cleaning their hands, compliance increased and hospital-acquired infections decreased by 50%. This method, known as the "Geneva Hand Hygiene Model," was adopted by the World Health Organization (WHO) and promoted globally, lead by Dr. Pittet.

Many years and hundreds of studies later, the advantages of using the alcohol hand gel over soap and water are well known. They include:

- Alcohol rubs reduce bacterial and viral counts on the hands to a greater degree than antimicrobial soaps.
- Alcohol rubs are tolerated better and are associated with better skin condition when compared with either plain or antiseptic soap.
- Alcohol rubs promote hand hygiene compliance due to their wide availability and ease of use.

Currently, alcohol hand rub is the preferred hand hygiene agent of most infectious disease and prevention organizations, including the CDC and the WHO. However, this does not eliminate soap and water as an acceptable product for hand hygiene. And it is important to remember that anything with protein, such as food, dirt, and blood, inactivates alcohol. Therefore, hands should be washed with soap and water after the following:

- Eating
- Using the bathroom
- Contact with Clostridium difficile and norovirus
- Contact with blood/body fluids
- When hands are visibly soiled

I encourage soap and water devotees to consider using an alcohol rub for routine de-germing of hands. It is better at removing germs, is better for your hands, and frees up valuable time to spend with your patients.

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