Strong Memorial Hospital
Summary of Joint Commission Findings
Survey Dates: May 20-24, 2013

Requirements for Improvement

1. ### Environment of Care Goal 02.03.01: The hospital manages fire risks.

    - The hospital minimizes the potential for harm from fire, smoke and other products of combustion.

    What did the Joint Commission find during their review?

    The Joint Commission found an open electrical junction box with exposed wiring above the ceiling in two offices.

    Why is this Important?

    It is important to reduce any risk in the environment that could result in fire or smoke to ensure the safest environment for patients, families and staff.

    This is what we are doing about it:

    Junction box covers were installed at the time both open boxes were identified. Identifying and correcting open junction boxes have been added as a preventative maintenance task for the team that performs other regular preventative maintenance tasks above the ceiling.

    What is the current status?

    Ongoing preventative maintenance process ensures that the environment above the ceiling is monitored and maintained routinely minimizing risk to patients, families and staff.

2. ### Environment of Care Goal 02.05.01: The hospital manages risks associated with its utility systems.

    - The hospital labels utility system controls to facilitate emergency shut downs. In areas designed to control airborne contaminants, the ventilation system provides appropriate pressure relationships.

    What did the Joint Commission find during their review?

    The Joint Commission found two electrical circuit breaker panels that did not have a schedule label to identify the electrical circuits controlled by each breaker. They also found in Central Sterile Processing, a room had a negative air pressure differential when positive air pressure differential was required.

Why is this Important?

It is important to have electrical circuit breakers panel schedule labels posted in the event that a partial or complete emergency shutdown is required to fully understand the impact of the shutdown. Having correct air pressure differentials is necessary in areas designed to ensure control of airborne contaminants.

This is what we are doing about it:

All branch circuits breakers were surveyed and traced to determine the loads served. New panel box labels were created and installed. The air pressure differential was corrected on site with the Joint Commission surveyor verifying that a positive air pressure differential was present as required.

What is the current status?

During routine inspections of electrical closets the presence of panel box labels are being verified. The air pressure differential is evaluated daily to ensure positive differential is present as required for this area.

3. Medication Management Goal 05.01.07: The hospital safely prepares medications.

- Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for product preparation to avoid contamination of medications.

What did the Joint Commission find during their review?

The Joint Commission found that staff did not always prepare medications in an uncluttered and separate area (i.e., a bedside cart with several items placed on it).

Why is this Important?

Patients and families need to be confident that medications prepared by staff are free from contamination. Steps to ensure this include use of a clean, uncluttered and separate area to prepare medications.

This is what we are doing about it:

Hospital policy on Medication Use was reviewed and revised to include what to do if a medication is contaminated and what to use to clean medication preparation areas. Education was provided to all staff on the appropriate way to prepare medications in an uncluttered and separate area and avoid contamination of the medications.

What is the current status?

Update of Medication Use policy and education of staff on policy and procedure for medication preparation completed in June 2013. Medication preparation practices will be directly observed monthly

for a four month auditing period to ensure practices align with hospital policy and procedure and will be reported to the Joint Commission.

4. ## Provision of Care Treatment and Services Goal 01.02.07: The hospital assesses and manages the patient's pain.

- The hospital conducts a comprehensive pain assessment that is consistent with its scope of care, treatment, and services and the patient's condition.

What did the Joint Commission find during their review?

When reviewing 2 patient records, the Joint Commission Surveyor found that though there was documentation of the patients' pain score the record did not contain a comprehensive pain assessment.

Why is this important?

The identification and treatment of pain is an important component of monitoring the status of a patient's condition as well as the effectiveness of treatments being provided. A comprehensive assessment can include; intensity, location, level, quality, orientation, and previous experience with interventions.

This is what we are doing about it:

The hospital pain policy was reviewed and the electronic medical record was revised to include all components of the required pain assessment. Staff were educated on the need to assess for pain on admission and complete a comprehensive assessment if pain was identified. Each patient's level of pain is assessed at regular intervals depending on the extent of the pain and the type of pain relief being provided. This assessment is included in nursing documentation just like blood pressure and temperature are documented.

What is the current status?

The electronic medical record revisions and education of staff were completed in June 2013. Random audits of medical records of patients with complaint of pain on admission will be conducted for a period of 4 months to ensure compliance with policy and procedures. The results will be reported to the Joint Commission and will be used to improve quality.

5. ## Provision of Care Treatment and Services Goal 03.01.03: The hospital provides the patient with care before initiating operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia.

- The hospital conducts a presedation or preanesthesia patient assessment. The hospital provides the patient with preprocedural treatment and services, according to his or her plan for care.

What did the Joint Commission find during their review?

The Joint Commission found that there were 3 instances where the preanesthesia assessment did not include an airway assessment. It was also identified for 1 patient that the American Society of Anesthesiologists Practice Guidelines for Preoperative Fasting was not followed.

Why is this important?

There is a certain amount of risk of complications for patients receiving sedation or anesthesia. A presedation or preanesthesia assessment is conducted to identify risks and adjust the plan of care to reduce or mitigate them. Patients undergoing sedation or anesthesia should be assessed for food and fluid intake to schedule non-emergenprocedures to reduce the likelihood of complications related to aspiration (stomach contents getting into lungs).

This is what we are doing about it:

Re-education of all physicians and providers on required elements for preanesthesia/presedation patient assessment including airway assessment and ASA Practice Guidelines for Preoperative Fasting was completed in June 2013. Changes were made to the electronic medical record to improve the ease of documenting this information.

What is the current status?

Ongoing monitoring is taking place to ensure compliance with documentation requirements and improve quality.

6. Record of Care, Treatment, and Services: The medical record contains information that reflects the patient's care, treatment, and services.

- The medical record contains documentation of any observations or response relevant to care, treatment, and services and any informed consent.

What did the Joint Commission find during their review?

The Joint Commission found 2 incidents where there was no documentation of communication to provider of critical lab values in the medical record, 1 incidence where the patient's response to education provided was not documented and 3 incidents where informed consent documents did not contain required information.

Why is this important?

Documentation in the medical record is an important way to communicate the information needed to reflect the care, treatment and services that were provided. Though appropriate care, treatment and services were rendered to each of the above patients, the lack of documentation could have impacted care.

This is what we are doing about it:

Hospital policy on Verbal Patient Care Orders and Verbal Reports of Critical Test Results was reviewed. The Keeping Current education included information on the requirement to document provider notification of critical test results and where in eRecord to document this information. Re-education of staff on documentation of patient's response to education was completed. Re-education of all physicians and providers on required elements to be documented on consent forms was done.

What is the current status?

All education was completed in June 2013. We are currently monitoring compliance with these processes and will report data to the Joint Commission.