HAP     Standard EC.1.10     The hospital manages safety risks.

Surveyor Findings

The Main Kitchen freezer door lacked an emergency door release handle on the inside of the freezer to prevent staff entrapment in the freezer. Unsecured compressed gas cylinders were noted within the Maintenance shop (that was corrected during the survey) and the Respiratory Services Department. No mechanism was provided to “lock out” the trash compactor from unauthorized use when staff was not in the immediate areas. Several emergency stairwell doors were locked on the stairwell side into the building; however, no “Door Locked- No Entry” signage was posted on the stairwell side of the door. A metal portable fire extinguisher was housed in the corridor recessed cabinet immediately outside the MRI Unit that could be mistakenly used to combat a fire within the MRI Unit. Additionally, neither of the two non-ferrous fire extinguishers present within the MRI Unit were identified as being “MRI Compatible”, thereby authorizing their use in combating an MRI Unit fire. This was corrected during the survey. Sprayed on fireproofing was delaminating in several locations within the Sydenstricker building elevator penthouse. Cleaning chemicals were stored on top of the housekeeping cart within the corridor of 4 Children’s permitting unauthorized patient access to chemicals while housekeeping was busy within the patient room. The wall mounted electric switch box within the McDonalds Unit contained several open & unprotected switch slots. Not all of the staff members in the adult psychiatric unit had keys to the locked fire extinguisher cabinets. During the survey, keys for the fire extinguisher cabinets were given to all members of the staff. There was a five gallon white bucket found in the labor and delivery utility room that contained several glass test tubes, glass bottles and a test tube of blood. There was no cover or signage on the bucket. There were appropriate sharps containers available in the room but were not being used.

Elements of Performance:

1. The hospital develops and maintains a written management plan describing the processes it implements to effectively manage the environmental safety of patients, staff, and other people coming to the hospital’s facilities.

Scoring Category:     B
Corrective Action Taken:

EP 1P: The written management plan, as previously developed, has been reviewed at the Safety Committee meeting in January 2005. This written management plan is being shared with hospital-wide staff at the January 2005 Management Information Forum.

4. The hospital conducts proactive risk assessments that evaluate the potential adverse impact of buildings, grounds, equipment, occupants, and internal physical systems on the safety and health of patients, staff, and other people coming to the hospital’s facilities.

Scoring Category: B

Corrective Action Taken:

EP 4: A redesign of the Hazard Surveillance Process was done in November 2004 by the Director of Safety and Security, Director of Infection Control, VP for Facilities and Director of Organizational Learning. The hazard surveillance process was revised to expand the areas of review to include hazard areas identified by the recent JCAHO survey. A self assessment by the manager has been incorporated to enhance accountability at the management level. The redesigned hazard surveillance process is being shared with hospital-wide staff at the January 2005 Management Information Forum.

5. The hospital uses the risks identified to select and implement procedures and controls to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people coming to the hospital’s facilities.

Scoring Category: C

Corrective Action Taken:

The Hazard Surveillance reporting process has been updated to better assign responsibility for abating hazards in the workplace. Senior Management will receive the report of hazard surveillance activities on a regular basis. A trending/tracking report will be analyzed at Safety Committee to assure all hazards are addressed appropriately. The new Hazard Surveillance reporting process was reviewed with the Nurse Executive Committee 1/18/05 by the Director of Safety and Security and the Director of Epidemiology.

Evaluation Method:

The Safety Committee will be reviewing the hazard surveillance tours completed compared to those scheduled using a compliance report generated by our database.

Measure of Success Goal (%): 95

HAP Standard MM.3.20 Medication orders are written clearly and transcribed accurately.

Surveyor Findings:

During an individual tracer, two unclarified blanket orders (“resume previous orders” and
“resume all trauma service orders”) were noted in one postoperative record reviewed.

Elements of Performance:

9. In addition, the hospital specifies that blanket reinstatement of previous orders for medications are not acceptable.

Scoring Category:   A

Corrective Action Taken:

Policy, Safe Medication Practices (#14.97) revised to include statement “Blanket orders to ‘resume’ medications are not permitted.” A complete order (drug, dose, route, frequency, etc.) must be written for each medication. The use of “renew”, “repeat”, or “continue order” is not acceptable, except for medications covered by the Hospital’s Automatic Stop Policy (e.g., narcotic or antibiotic) and for hyperalimentation fluids. This policy revision was initiated at Medication Error Prevention Committee on 11/11/04, approved by Pharmacy and Therapeutics Committee on 11/16/04 and approved by the Medical Center Medical Executive Committee on 11/19/04 with Children’s Medical Center Medical Executive Committee approval obtained on 12/1/04. Joint Conference Committee of the Board of Directors reviewed and approved the policy revision on 1/19/05. The VP for Patient Care Services communicated the policy changes to patient care management team in November. The November/December 2004 Pharmacy Newsletter is distributed to all patient care areas, clinics, pharmacists and selected administrators, as well as all medical staff (attending and resident physicians). The Chief Residents were informed of the ‘no resume’ order policy at Chief Residents meeting on December 16, 2004 by the President of the Medical Staff. The Medical Director of the Medical Center and the Medical Director of the Children’s Medical Center reminded the entire medical staff/ house staff of the ‘no resume order’ policy via an e-mail communication in January 2005. The policy revision will be reviewed at the Management Information Forum on January 2005.

HAP     Standard IM.6.40     For patients receiving continuing ambulatory care services, the medical record contains a summary list of all significant diagnoses, procedures, drug allergies, and medications.

Surveyor Findings:

The problem summary list when used is in varying places in each ambulatory department record. It is a paper list in pediatrics, it is an electronic record in geriatrics and it is not available in dermatology, plastic surgery or the comprehensive cancer center. Four of six active ambulatory records lacked a complete summary list of all significant diagnoses, procedures, drug allergies and medications. Only geriatrics, family health center, infectious disease and general pediatrics clinics maintained summary lists.

Elements of Performance:

2. The list is always stored in the same location to help practitioners access needed information quickly and easily.

Scoring Category:   C
Corrective Action Taken:

An electronic system to generate and store the Summary List was implemented on January 31, 2005. A data collection worksheet has been created that will allow patients/families to list any medication allergies as well as all prescription, over-the-counter and herbal preparations. The worksheet will be given to the patient/family upon check-in for the visit. The list will be given to the caretaker for review during the patient visit and the physician/caregiver will sign off that the information was reviewed with the patient/family during the visit. The list of allergies and medications will be entered into the electronic system either during or after the visit. All patient diagnoses and procedures (if any are performed) are recoded on the outpatient Encounter form. The diagnoses and procedures (if applicable) will also be entered into the electronic system during or after the visit. This will enable all required elements to be present in the electronic system, which will be located in the same location in each patient chart. The development, approval, and implementation of this electronic system involved the following: Senior Vice President, Ambulatory and Network Services; Director, Ambulatory Patient Care Services; Vice President, Information Services; Director of Information Services, Client Services; Director, Information Services, Applications; Senior Business Analyst, Interim Project Manager for Powerchart; Business Analyst, Information Services; Director, Health Information Management Services; Senior Vice President, Medical Affairs, Chief Medical Officer; Medical Director, Children’s Medical Center; Vice President, Children’s Medical Center. Titles of those trained are Physicians, Physicians Assistants, Nurse Practitioners, Nurse Clinicians, Senior Staff Nurses, Staff Nurses, Licensed Practical Nurses, Patient Care Assistants, Practice Site Coordinators, Practice Site Managers, Administrative Directors for Practice Sites, Medical Assistants. Policy was written relating to the Summary List Data Collection and Entry which was reviewed and approved by Senior Leadership in December of 2004 and reviewed and approved by the Academic Practice Group Committee (physician leadership committee) in January 2005. Staff, including physicians, were trained on the electronic system previously with specific training to be initiated on January 24, 2005 prior to the implementation of this new module throughout the 80 practice sites.

Evaluation Method:

Method of Evaluation- Random audit of 70 outpatient visits will be conducted to determine location. Source of Data Used in Evaluation- Patient Recorded List of Medication & Allergies Worksheet Frequency of Evaluation- Monthly audit.

Measure of Success Goal (%): 90

3. The list contains the following information: known significant medical diagnosis and conditions; known significant operative and invasive procedures; known adverse and allergic drug reactions; known long-term medications, including current prescriptions, over-the-counter drugs, and herbal preparations.

Note: “Known” refers to information gathered during ambulatory care assessment and treatment.

Scoring Category: C

Corrective Action Taken:
An electronic system to generate and store the Summary list was implemented on January 31, 2005. A data collection worksheet has been created that will allow patients/families to list any medication allergies as well as all prescription, over-the-counter and herbal preparations. The worksheet will be given to the patient/family upon check-in for the visit. This list will be given to the caretaker for review during the patient visit and the physician/caregiver will sign off that the information was reviewed with the patient/family during the visit. The list of allergies and medications will be entered into the electronic system either during or after the visit. All patient diagnoses and procedures (if any are performed) are recorded on the outpatient Encounter form. The diagnoses and procedures (if applicable) will also be entered into the electronic system during or after the visit. This will enable all required elements to be present in the electronic system, which will be located in the same location in each patient chart. The development, approval, and implementation of this electronic system involved the following: Senior Vice President, Ambulatory and Network Services; Director, Ambulatory Patient Care Services; Vice President, Information Services; Director of Information Services, Client Services; Director, Information Services, Applications; Senior Business Analyst, Interim Project Manager for Powerchart; Business Analyst, Information Services; Director, Health Information Management Services; Senior Vice President, Medical Affairs, Chief Medical Officer; Medical Director, Children’s Medical Center; Vice President, Children’s Medical Center. Titles of those trained are Physicians, Physicians Assistants, Nurse Practitioners, Nurse Clinicians, Senior Staff Nurses, Staff Nurses, Licensed Practical Nurses, Patient Care Assistants, Practice Site Coordinators, Practice Site Managers, Administrative Directors for Practice Sites, Medical Assistants. Policy was written relating to the Summary List Data Collection and Entry, which was reviewed and approved by Senior Leadership in December of 2004 and reviewed and approved by the Academic Practice Group Committee (physician leadership committee) in January 2005. Staff, including physicians, were trained on the electronic system previously with specific training to be initiated on January 24, 2005 prior to the implementation of this new module throughout the 80 practice sites.

**Evaluation Method:**

Method of Evaluation- Random audit of 70 outpatient visits will be conducted to determine location. Source of Data Used in Evaluation- Patient Recorded List of Medication & Allergies Worksheet Frequency of Evaluation- Monthly audit.

**Measure of Success Goal (%):** 90

HAP   Standard EC.5.40   The hospital maintains fire-safety equipment and building features.

**Surveyor Findings:**

Approximately 1/3 of the portable fire extinguishers inspected lacked evidence of a monthly extinguisher inspection. Specific examples include extinguisher # CW151-949, # AV494339, # FU929159, # KR294281, # BD955199 (this extinguisher was also not secured to the wall), helipad vestibule as well as other areas. Approximately 1/5 of the portable fire extinguishers lacked evidence of an annual extinguisher service. Specific locations include Talmadge elevator penthouse, Sydenstricker penthouse, Prison Unit, Helipad vestibule, etc. The portable fire extinguishers housed within corridor recessed cabinets within the Children’s Units were not readily visible.
Elements of Performance:

12. Documentation is available that all portable fire extinguishers are clearly identified, inspected at least monthly, and maintained at least annually. Note: For additional guidance, see NFPA 10-1998 edition (sections 1-6, 4-3, and 4-4).

Scoring Category:  
C

Corrective Action Taken:

Inventory of extinguishers in ALL buildings completed on 11/15/04. Floor Plans of the facility were updated to include physical location of fire extinguishers. Monthly inspections and annual testing needed were completed on 12/17/04. Internal database is being expanded to track, produce work orders, and monitor monthly inspections and annual maintenance of fire extinguishers.

Evaluation Method:

A monthly report will be prepared by Facilities staff to review compliance with monthly fire extinguisher inspections. This will be produced from a random selection of fire extinguisher serial numbers maintained from the inventory listing. These reports will be reviewed for compliance by the Director of Hospital Systems Safety and Security and discussed at Safety Committee on a monthly basis. First monthly report will be reviewed at the January 2005 meeting of the Safety Committee.

Measure of Success Goal (%):   95

HAP  Standard PC.2.120  The hospital defines in writing the time frame(s) for conducting the initial assessment(s).

Surveyor Findings:

One surgical record contained a history and physical that was not updated at the time of admission for surgery.

Elements of Performance:

7. Some of these elements may have been completed ahead of time, but must meet the following criteria, updates to the patient’s condition since the assessment(s) are recorded at the time of admission.

Scoring Category:  
A

Corrective Action Taken:

Medical Staff Rules and Regulations were revised (Medical Center of MCG- 12/17/04, Children’s Medical Center- 12/1/04) to clearly require an update to the History and Physical at the time of admission. Medical Staff Rules and Regulations were communicated to medical staff and house staff by the President of the Medical Staff at Chief Resident’s Meeting on 12/16/04. The Medical Staff and House staff were reminded by an e-mail by the
Medical Director of the Medical Center and The Medical Director of the Children’s Medical Center of the change in the Medical Staff Rules and Regulations relating to updating the History and Physical upon admission in January 2005.

HAP Standard PC.5.50 Care, treatment, and service are provided in an interdisciplinary, collaborative manner.

Surveyor Findings:

Three of six inpatients traced did not have a complete nursing plan of care or written evidence of a coordinated interdisciplinary plan of care. The components lacking included co-morbidities and lack of incorporation of referrals into the on-going nursing plan.

Elements of Performance:

1. Care, treatment, and services are provided in an interdisciplinary, collaborative manner as appropriate to the needs of the patient and the hospital’s scope of services.

Scoring Category: B

Corrective Action Taken:

An electronic Care Plan Constructor has been purchased and use of this process implemented as of January 15, 2005. The electronic Care Plan Constructor is used as a resource to individualize care plans. The care plan is printed for quick access by nursing staff. The template provided via the electronic Care Plan Constructor has been approved by the Forms Committee on December 16, 2004. Nursing staff are trained on accessing and adapting the Care Plan to meet the needs of the patient during the month of January 2005 during Nursing Unit Staff meetings and one-on-one training by the nurse managers.

HAP Standard PC.8.10 Pain is assessed in all patients.

Surveyor Findings:

Pain assessments were not documented in two out of three Physical Therapy records reviewed at the Sports Medicine Center. A long term quadriplegic trauma patient had pain rated but not a complete pain assessment. There was no notation in 3 recent entries as to the location or the site of the pain or alternatives that were tried before narcotics were given. Pain was assessed every two hours for postpartum patients. A C-section patient received medication for pain three times without an intensity documented at the time of medication administration. All previous reassessments prior to the medication indicated zero pain. There was no documentation in the medical record indicating the reasons for the pain medication to be given. A patient in the bone marrow transplant unit received Morphine 2 mg IV at 1 AM. The last pain assessment recorded at midnight was zero. There was no documentation as to the reasons or effects of the medication being administered.

Elements of Performance:

1. A comprehensive pain assessment is conducted as appropriate to the patient’s condition and the scope of care, treatment, and services provided.
Scoring Category:  C

Corrective Action Taken:

11/04/2004- PRN Medications Administration Record revised to include Pain Assessment and Reassessment documentation on back of form. Information to be documented includes: date, time, pain scale used, pain score, location of pain, interventions, time reassessment completed, pain score when reassessed, reassessment comments, and signature of person completing the assessment/reassessment. If additional action is taken to reduce pain it is to be documented in the Progress Notes. Separate Assessment/Reassessment Form created for use in Clinics, Emergency Department, and Outpatient areas when medication not administered. 12/9/2004- Revised PRN Medication Administration Record and new assessment and Reassessment Form approved through Pain Management Committee. 12/16/2004- Revised PRN Medication Administration Record and new Assessment and Reassessment form approved through Forms Committee. 12/20/2004- Pain Assessment and Reassessment Monitoring Tool created. 12/29/2004-01/05/2005- Licensed and Unlicensed staff responsible for pain assessment/reassessment educated on new and revised assessment/reassessment forms. Education completed by Nurse Managers in unit staff meetings, one-on-one communication, and memo posted on unit. 01/03/2005- PRN MAR to be implemented for all inpatient areas. Separate Assessment/Reassessment Form implemented in Clinics, Emergency Department and Outpatient areas.

Evaluation Method:

On 01/03/2005, the nurse managers became responsible for monitoring compliance with documentation of Pain Assessment/Reassessment requirements on a weekly basis. The Pain Assessment and Reassessment Monitoring Tool is used for measuring compliance. The data collected is sent to the Administrative Assistant to the VP for Adult Patient Care Services, to be collated. Feedback is then given to the Nurse Managers for their review. It is also presented to the JCAHO Leadership Committee where compliance is analyzed.

Measure of Success Goal (%):  95

3. Regular reassessment and follow-up occur according to criteria developed by the hospital.

Scoring Category:  C

Corrective Action Taken:

11/04/2004- PRN Medications Administration Record revised to include Pain Assessment and Reassessment documentation on back of form. Information to be documented includes: date, time, pain scale used, pain score, location of pain, interventions, time reassessment completed, pain score when reassessed, reassessment comments, and signature of person completing the assessment/reassessment. If additional action is taken to reduce pain it is to be documented in the Progress Notes. Separate Assessment/Reassessment Form created for use in Clinics, Emergency Department, and Outpatient areas when medication not administered. 12/9/2004- Revised PRN Medication Administration Record and new assessment and Reassessment Form approved through Pain Management Committee. 12/16/2004- Revised PRN Medication Administration Record and new Assessment and Reassessment form approved through Forms Committee. 12/20/2004- Pain Assessment and Reassessment Monitoring Tool created. 12/29/2004-01/05/2005- Licensed and Unlicensed staff responsible for pain assessment/reassessment educated on new and revised assessment/reassessment forms. Education completed by Nurse Managers in unit staff meetings, one-on-one communication, and memo posted on unit. 01/03/2005- PRN MAR to be implemented for all inpatient areas. Separate Assessment/Reassessment Form implemented in Clinics, Emergency Department and Outpatient areas.
Reassessment Monitoring Tool created. 12/29/2004-01/05/2005- Licensed and Unlicensed staff responsible for pain assessment/reassessment educated on new and revised assessment/reassessment forms. Education completed by Nurse Managers in unit staff meetings, one-on-one communication, and memo posted on unit. 01/03/2005- PRN MAR to be implemented for all inpatient areas. Separate Assessment/Reassessment Form implemented in Clinics, Emergency Department and Outpatient areas.

Evaluation Method:

On 01/03/2005, the nurse managers became responsible for monitoring compliance with documentation of Pain Assessment/Reassessment requirements on a weekly basis. The Pain Assessment and Reassessment Monitoring Tool is used for measuring compliance. The data collected is sent to the Administrative Assistant to the VP for Adult Patient Care Services, to be collated. Feedback is then given to the Nurse Managers for their review. It is also presented to the JCAHO Leadership Committee where compliance is analyzed.

Measure of Success Goal (%): 95

HAP Standard PC.11.40 Any use of restraint (to which these standards apply) is initiated pursuant to either an individual order (standard PC.11.50) or an approved protocol (standard PC.11.60), the use of which is authorized by an individual order.

Surveyor Findings:

During tracer activity it was noted that daily renewal orders are not obtained when patients in the MICU are placed in restraints for medical reasons. This was noted in one medical record and interviews with the staff revealed that this is the common practice.

Elements of Performance:

7. Such renewal or new order is issued no less often than once each calendar day and is based on the licensed independent practitioner’s examination of the patient.

Scoring Category: A

Corrective Action Taken:

The VP for Patient Care Services presented a revision to the Restrain and Seclusion Policy to the Medical Executive Committee on November 17, 2004. Final approval by the Board of Directors is anticipated Friday, January 21, 2005. The policy requires that a renewal or new order is issued no less often than once each calendar day and is based on the licensed independent practitioner’s examination of the patient. Per the revised policy, charge nurses on the medicine, cardiac and surgical ICU’s were instructed to check for compliance with physician order requirements during daily chart checks. The Nurse Managers for the medicine, cardiac, and surgical ICU’s review the Restraint and Seclusion Policy requirements with incoming physician teams on a monthly basis emphasizing that restraints require a daily exam by the physician with renewal order, irregardless if initiated per protocol. The President of the Medical Staff reviewed the revised Restrain and Seclusion Policy with physicians at the Chief Residents Meeting on December 16, 2004 emphasizing that restraints require a daily exam by the physician with renewal order, regardless if
initiated by protocol. The Nurse Manager for the Neuroscience Unit reviewed the revised Restrain and Seclusion Policy with nursing staff during the monthly staff meeting on December 20, 2004. The Medical Director of the Medical Center and the Medical Director of the Children’s Medical Center reminded the entire medical staff/house staff of the restraint policy requirements via an e-mail communication in January 2005 emphasizing that restraints require a daily exam by the physician with renewal order, regardless if initiated by protocol.

HAP     Standard PC.13.20     The administration of moderate or deep sedation or anesthesia are planned. Operative or other procedures and/or the administration of moderate or deep sedation or anesthesia are planned.

Surveyor Findings:

A final verification process for invasive procedures done in areas other than the operating room has only recently been implemented. The policy was outlined three months prior to the survey and finally approved just prior to the survey.

Elements of Performance:

9. The site, procedure, and patient are accurately identified and clearly communicated, using active communication techniques, during a final verification process, such as a time out, prior to the start of any surgical or invasive procedure.

Scoring Category:  A

Corrective Action Taken:

Held Town Hall Meeting at the conclusion of the JCAHO Survey on October 15, 2004. Meeting conducted by CEO/President, MCG Health, Inc. Preliminary findings communicated to Hospital staff, including Medical Staff members. Education of clinical staff regarding process for conducting “time outs” has been ongoing. Nurse Managers and Clinical Department Managers discussed the process in their staff meetings in November and December. Discussed requirement for conducting “time outs” with the Medical Staff at the Medical Center Medical Executive Committee Meeting on October 15, 2004. The President of the Medical Center Medical Staff presented the information. Discussed preliminary findings directly related to Medical Staff functions at the Children’s Medical Center Credentials Committee Meeting on October 26, 2004. Children’s Medical Center Medical Director presented the information. Discussed requirement for conducting “time outs” with the Medical Staff at the CMC Medical Executive Committee Meeting on November 3, 2004. CMC Medical Director presented the information. A handout outlining the preliminary findings directly related to the Medical Staff was reviewed. Conducted weekly audits to determine compliance level in all areas of the organization. Audits began November 1, 2004. Manager of each area is responsible to report findings each Monday to the Vice President, Pediatric Patient Care Services. Reviewed medical record documentation tools to enhance compliance with documentation of the “time out.” Revisions to documentation tools are ongoing. Revised electronic “Perioperative Report” (iPath) to include documentation of the “time out.” Operating Room sub-committee of Nursing Leadership approved the revision on November 17, 2004. Communicated to Operating Room staff revisions made to electronic “Perioperative Report.” Communication done via e-
mail message on December 8, 2004 by the Main OR Clinical Systems Administrator. Met with Chief Residents to review requirement for conducting a “time out” prior to any procedure performed, regardless of location on December 16, 2004, by the MC President of the Medical Staff and Director of Quality Management.