Tips, lessons from a recent Joint Commission survey

What’s the Joint Commission looking for when it surveys departments where surgery and other invasive procedures are performed? Tips, observations, and lessons were gleaned from a recent 5-day Joint Commission survey by John R. Rosing, MHA, FACHE, who was present for the survey. He consults on Joint Commission and Centers for Medicare and Medicaid Services (CMS) issues as vice president and principal of Patton Healthcare Consulting.

History and physical update
The patient’s history and physical (H&P) can be performed no more than 30 days before or must be completed within 24 hours after admission.

“Though the standard is now 5 or 6 years old, there is still confusion about the 24 hours,” says Rosing.

Some think that if a physician sees a patient in the office at 4 pm, performs the H&P, and then schedules a surgical procedure for 7 am the next morning, no update is required because fewer than 24 hours have elapsed.

“In fact, this is not the case,” he says.

The Joint Commission requires that the update be conducted after the patient’s registration or inpatient admission to the hospital or before the procedure takes place, whichever comes first. The documentation that the surgeon enters in the record needs to state: “I examined the patient, I reviewed the H&P, and there are no changes to that H&P.” When there are changes, the surgeon must document them. The surgeon must sign the entry and enter the date and time the entry was made. Finally, the “rules” pertaining to H&Ps (what constitutes an H&P, when it is to be performed and updated, who may perform it, etc) need to be spelled out in the medical staff bylaws, not merely the rules and regulations or other policies as had been allowed previously.

Informed consent
All entries in the medical record, including signatures on the consent form for surgery, including the patient’s signature, must be dated and timed. Often, patients don’t write in the date and time on the form, even when the form prompts them to, which can cause problems, says Rosing.

“You can’t go back and ask patients on the day of surgery to back-date and time the consent form when they signed the form a week before in the physician’s office. What you need to do is prompt your physicians’ offices to encourage patients to date and time their signatures as they sign the form,” he says.

One part of the informed consent often left out is discussion of the likelihood of the desired outcome.

“Make sure your informed consent policy and form include language that captures this discussion,” says Rosing.
Postoperative report
The postoperative report must be written or dictated by the surgeon before the patient is transferred to the next level of care, unless a postoperative note is entered immediately after the procedure. In that case, the report may be written or dictated in a timeframe defined in hospital policy. A note must also be written if the dictated report is not transcribed immediately.

“These postop note requirements help subsequent caregivers learn what occurred during the surgery,” says Rosing.

The report and note (if done) should include at a minimum the name of the physician, procedure name and description, findings, estimated blood loss, any specimens removed, and postoperative diagnosis.

The postoperative report policy should be in the rules and regulations for the medical staff but does not need to be in the medical staff bylaws.

Postanesthesia assessment
The postanesthesia assessment must occur and be documented within 48 hours of recovery from anesthesia—not while the patient is still in the operating room, says Rosing.

“The surveyor is going to look very carefully at the time of entry of the postanesthesia assessment and can easily catch a premature assessment,” he says.

The reason for not conducting the assessment too soon: The patient has to be able to participate in the assessment for the anesthesia provider to determine whether the patient is safely recovered from anesthesia.

For outpatients, the assessment can be based on data collected by an RN. When a patient is discharged from same-day surgery, the nurse notes the patient’s mental status, respirations, and so forth. The anesthesia provider can write an assessment based on that data even though the patient may have already been discharged.

Important to note: CMS and the Joint Commission do not consider sedation cases to be anesthesia for purposes of this standard, so no postsedation assessment by a physician is required, Rosing says. All that is needed are an assessment and discharge by the RN according to approved criteria, including a date and time.

Medication orders
Preoperative medications and testing can now be performed by standing order or protocol, based on CMS’s relaxation of the standing order rule, says Rosing. The revision is part of the revised Medicare Conditions of Participation for hospitals and critical access hospitals effective July 16, 2012 (July 2012 OR Manager, pp 25-26).

This means preoperative medications can be given and preoperative testing can be performed by protocol without getting a physician’s signature or verbal order in advance. The orders can be signed after they are executed.

“This can happen as long as the protocol has been prepared by the surgeon or specialty group and approved by the medical staff, and as long as you treat it as if it’s a verbal order, meaning it is cosigned within the timeframe required by the hospital and state.”

A physician cannot sign postoperative anesthesia or postoperative surgical orders preoperatively.

“This is catching a lot of people with electronic orders off guard,” says Rosing. With paper orders, the anesthesiologist or surgeon could write the postsurgical orders in the chart and sign them in advance (often omitting the time), which was allowed, or at least overlooked, but electronic orders capture the time automatically, he says.

Surveyors now look for these orders to be written based on a current assessment
of a patient, meaning postoperative orders should be based on a postoperative assessment. “TJC may revisit this issue once hospitals realize the workflow implications of this requirement and protest that the logic used by TJC (ie, ‘current assessment’) does not jibe with similar, long-standing circumstances, for example, when an admitting physician writes admission orders in the ED, which are then initiated by a nurse on the floor sometime (hours?) later. There is no expectation that the admitting physician travel to the floor to conduct a ‘current assessment’ prior to the RN initiating the earlier written/entered orders.”

Intraoperative verbal orders still need to be countersigned by the physician, whether on paper or electronically. One thing to be on the lookout for with verbal orders: Surveyors are checking that the nurse is performing a read-back to clarify any unclear order.

“Unless there is clarification, they may cite you for an unclear order,” says Rosing.

**Label all medications**

Labeling all medications on and off the sterile field is a Category A element of performance for the Joint Commission, meaning full compliance is expected.

“This means surveyors only have to find something unlabeled once, and you’re going to get a finding. You can’t argue it,” says Rosing.

Any container that holds fluids or solutions needs to be labeled, including sterile water, saline, and disinfectants in a basin.

“Propofol is easy to spot because of its white milky nature. If a surveyor sees a syringe still containing some propofol, and it is not labeled, they will cite you,” he says.

There’s one exception, notes Rosing. If an anesthesia provider draws up propofol and gives it all immediately, he or she doesn’t need to label it. But if the anesthesia provider doesn’t use it all and sets the syringe down on the cart, it must be labeled. The label on a partially used syringe should also include an expiration time because propofol has a 6-hour shelf life once drawn into a syringe.

“Surveyors look at all basins and syringes for labels as they walk into a room. Don’t get caught on this one. It’s a no-brainer,” he says.

**Surgical time-out**

One of the things surveyors look for is that the time-out for preprocedure patient verification is conducted in the room where the procedure will be performed just before starting the procedure.

“They think this step is one where there’s still a window of opportunity to make an error, and they’re highlighting this because errors are still being reported at a rate suggesting 6 wrong-site cases per day in the US,” says Rosing.

There are some nuances to meeting the National Patient Safety Goal requiring use of at least 2 patient identifiers.

If the patient’s armband is visible, the nurse is able to compare 2 identifiers on the armband with the medical record. But if the armband is not visible because of the draping, one of the following options must be used:

- Two team members confirm the patient ID upon arrival in the OR using 2 identifiers. One of the team members remains with the patient during the entire procedure. During the final time-out, this team member confirms the patient’s ID.
- Two team members identify the patient upon arrival in the OR. The 2 identifiers are written on a whiteboard in the room and confirmed by the 2 team members. These 2 team members do not have to stay with the patient during the proce-
dure. They can be replaced by others who confirm the patient ID against the information on the whiteboard during the final time-out.

- A patient ID band is placed on an exposed extremity, and then the 2 identifiers on this ID band are referenced during the final time-out.

Environment of care or crisis issues
The OR suite cannot have equipment blocking fire alarm pull boxes, fire extinguishers, electrical breaker panels, or medical gas shut-off valve boxes. These areas are “no parking zones” for equipment, says Rosing. They should be marked off so staff don’t inadvertently park equipment in front of one of them.

Surveyors will ask staff about the preparation and training they have received to prevent surgical fires and how they would respond if a fire were to happen.

“They are looking to see if you have studied the best practices associated with preventing and responding to fires,” he says.

Best practices are available from ECRI Institute (www.ecri.org) and the Anesthesia Patient Safety Foundation (www.apsf.org/resources_video.php).

Make sure the code cart, pediatric code cart, and malignant hyperthermia carts are all checked daily to ensure that the contents have not expired and that all required contents are there.

Check the biomedical stickers on the defibrillator and suction equipment and make sure those are not expired or out of date. Also check supplies such as defibrillator pads that have an expiration date on them.

Surveyors will open the carts and check the laryngoscope flashlight handle to see if the batteries are expired.

Because these carts are infrequently used, the handles may sit there for years without being checked. Also check to make sure any spare batteries in the cart aren’t expired.

“That is an easy gotcha for the surveyor,” says Rosing.

Laryngoscope blades
Laryngoscope blade storage continues to be problematic. These blades must be stored in a manner that prevents recontamination, notes Rosing.

A simple plastic bag can be used for storage. The bag does not need to be zipped and sealed; it simply needs to cover the blade and protect it from being contaminated by airborne substances that fall on a blade as it rests in a cart or on top of a cart, Rosing says.

Surveyors also ask staff how they test the light source. The correct answer is that the light source is tested in a way that ensures the blade doesn’t touch bare hands, he says. For example, “First use an alcohol hand rub and/or gloves, and leaving the blade in the bag or peel pouch, attach it to the light source to test the light.”

Endoscope cleaning and disinfection
Endoscope reprocessing is on the surveyors’ minds, says Rosing. Make sure manufacturers’ recommendations are followed, particularly for high-level disinfectant test strips.

“All test strips need to be dated when opened,” notes Rosing. “I just saw a finding where somebody overlooked doing that.”

There is also a requirement to test the strips themselves after opening a new bot-
tle. Do a positive and negative solution test using 3 strips in the positive and 3 in the negative to determine that strips are reading the appropriate color.

Document that the testing was performed on the same day the bottle was opened and the date that’s on the bottle.

The strips should be used to test the minimum effectiveness concentration (MEC) of the high-level disinfectant solution prior to each load.

“I still have hospitals saying they do this testing only once a day. The requirement is that you test the MEC for each load and document each test,” he says.

Surveyors look for proper air exchanges in the room where endoscopes are high-level disinfected. They also check to make sure there is separation of clean and dirty reprocessing areas to prevent cross-contamination of scopes.

If the reprocessing area is small, the staff should impress upon the surveyor that they are removing endoscopes from the high-level disinfectant when no other contaminated scopes are in the room.

It is also wise to have a time-out process in a small reprocessing area. That is, when a scope comes out of the washer sterilizer or scope washer, a time-out is called so no one else in the room moves or handles a dirty scope at that time to avoid the risk of cross-contamination, Rosing suggests.

**Immediate-use sterilization**

Avoid the outmoded term “flash” when referring to steam sterilization of instruments intended for immediate use, Rosing cautions.

The key document is the “Immediate-Use Steam Sterilization” position paper issued over a year ago by the Association for the Advancement of Medical Instrumentation, AORN, and others.

Two caveats regarding the position paper:

- Instrument inventories should be sufficient to meet the anticipated case volume to avoid the need for immediate use sterilization.
- A sterilized item intended for immediate use should not be stored for future use or held from one case to another.

What if more cases are scheduled than you have instruments?

Rosing says he’s observed that Joint Commission surveyors won’t cite an organization for sterilizing instruments for immediate use. Rather, they will check that data is being collected on instances when immediate-use sterilization is used and then check to see if action is being taken based on the data. If surveyors don’t find that, they may cite the organization under the performance improvement standards.

Pointers on data collection:

- The Joint Commission expects data to be collected routinely and aggregated monthly on the number of immediate-use sterilization episodes and on episodes attributed to a lack of instruments.
- The data needs to be evaluated by the OR leadership and submitted to the infection control committee for evaluation.
- The leadership group should know the number of immediate-use sterilization episodes owing to a lack of instrumentation so they can present the data to the hospital’s finance department to justify the need to buy more instruments.

—Judith M. Mathias, MA, RN

**Avoid using the outmoded term 'flash.'**

John Rosing will present an all-day seminar titled *An Update: Joint Commission Standards and CMS Regulations* on October 24, 2012, at the OR Manager Conference in Las Vegas. Learn more and register at www.ormanagerconference.com.
References


Have a question on the OR revenue cycle?
Keith Siddel will respond to questions in the column. Send your questions to editor@ormanager.com
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