JOINT COMMISSION READINESS GUIDE

McLaren

MHCC-548 8.5x14 (10.22)

TIPS FOR A SUCCESSFUL SURVEY

- Always wear your hospital ID Badge (with name visible). Not wearing your badge is a Safety and Security concern.
- Be aware that surveyors may stop to talk to you any time during the survey. Remember that quality patient care comes first. If it is not a good time to talk to the surveyor, politely let them know that the patient is your first priority and you would be happy to speak with them in 15 minutes, for example.
- Answer any and all questions in positive terms. If you are not sure of the answer, tell them what you do know and indicate where you would go to get the information, or try to direct them to the correct personnel.
- Answer questions by referring to hospital processes and policies. For example: "Our process is…" Avoid using phrases such as: "I usually" or "On this unit we…" or "What I do is…"
- Be professional – make eye contact.
- Only answer the question that is asked.
- Know your responsibilities to protect and maintain patient confidentiality. This includes choosing appropriate settings to discuss confidential patient information, insuring appropriate access to computer-stored information and keeping the medical record data confidential.
- Know the common terms for emergency codes (you may refer to your badge card)
- Refer to your departments bulletin boards to discuss PI.

NATIONAL PATIENT SAFETY GOALS

Identify patients correctly

- Use at least two unique patient identifiers (name and date of birth) to confirm patient identity before any care or treatment.
- Label containers used for blood or other specimens in the presence of the patient
- Use distinct methods of identification for newborn patients

Improve staff communication

- Critical Test results reporting - get important test results to the right staff person in a timely manner.

Use medicines safely

- Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups and basins. Do this in the area where medicines and supplies are set up.
- Take extra care with patients who take medicines to thin their blood.
- Medication reconciliation - record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Use alarms safely

- Be aware of alarm fatigue. Reduce noise and properly use alarming devices so that critical alarms can be heard and responded to quickly.
- The complete list of medication is also provided to the patient/family on discharge from the organization. The list is explained to the patient/family and is documented.

Prevent infection

- **WASH YOUR HANDS!** Use the hand hygiene guidelines from the Centers for Disease Control and Prevention or the World Health Organization.
- **FOAM IN/FOAM OUT**… every room, every time regardless of your intended purpose in the room.

Suicide Risk Assessment – Identify patient safety risks

- Conduct Columbia Suicide Severity Rating Scale pre-screening assessment on all patients; conduct full assessment on patients identified at risk.
- Complete Behavioral Health Safety Checklist for those patients identified at risk for self-harm.

UNIVERSAL PROTOCOL/TIME OUT

Prevent surgical or procedural mistakes

- Conduct pre-procedure verification: Verify the correct procedure, for the correct patient, at the correct site. Make sure all items are available for the procedure.
- Mark the site: correct place on the patient's body where the procedure is to be done.
- **TIME OUT** – Final assessment! Standardized process to confirm correct patient, correct procedure, correct side/site and all necessary items are available. Document the time-out.

PATIENT RIGHTS

Confidentiality

- Do not discuss patient heatlh information in public areas, e.g., elevators, cafeteria.
- Use screen saver to prevent unauthorized persons from viewing the computer screen. Patient medical record access is restricted only to care providers involved in the patients care.

Privacy

- Appropriate use of cubical curtains, blinds, etc.
- Knock before entering patient's room.
- Modesty is protected.

Interpreter Services

- Patients have a right to interpreter services if unable to communicate in English, at no cost to them. Resources available:
  - Certain documents may be available in translated languages.
  - Language Line

Advance Directives

Advance Directives are documents that patients use to communicate their wishes regarding the medical care they want to receive in the event that they become incapacitated and unable to make decisions. Patients are asked upon admission whether they have an Advance Directive and the system is flagged with a "yes" or "no". If yes, family members are requested to bring it to the hospital so that a copy can be placed in the medical record, and followed by the healthcare team. Patients who do not have an Advance Directive are provided with information about making an Advance Directive while hospitalized, if they choose to do so. Patients wishing to make an Advance Directive should be referred to the appropriate person at your facility.

Gift of Life – Organ and Tissue Donation

- Call the Gift of Life for all expirations (**1-800-482-4881**) within one hour (or less) of the time of death.
- Gift of Life will provide information about the patient's suitability for tissue/eye donation.

ENVIRONMENT OF CARE

Regulatory agencies not only examine our medical and nursing care, but also examine the **physical environment** to make sure we are protecting everyone who enters our hospital.

Safety Management

It is reporting unsafe conditions such as wet floors and uneven pavement. Employees can prevent injury to themselves and others by following policies and procedures and reporting unsafe conditions.

Fire Safety Management

Knowing and understanding the important terms such as RACE and PASS are just a start. Preventing fires is number one on the list. Do not use unapproved personal appliances. Do not overload electrical circuits. Remember to keep storage at least 18 inches from the ceiling.

Utility Management

Your role is to make sure you understand how you and your patients stay safe during water interruptions, electrical system testing, ventilation system interruptions and possible flooding. Do not block electrical panels or medical gas shut offs.

Security Management

Everyone can do their part by reporting suspicious persons to Security, always wearing your badge and keeping your personal belongings locked in a secure location.

Medical Equipment Management

Every piece of medical equipment that enters the hospital or is used in the Ambulatory departments must be safety checked. Biomedical engineering then places the equipment on the appropriate preventive maintenance schedule.

Hazardous Material and Waste Management

All medical waste and chemical waste must be managed and disposed of properly. Remember that Red bucket waste is different than yellow or black bucket waste. Refer to the signage posted in the soiled utility rooms. Do not place non-medical waste such as paper or gloves in the red buckets.

Regulated Medical Waste – Red Bin

- Blood Administration: bag & tubing
- Hemovacs / JP
- Pleurovac system
- Thoracentesis/Paracentesis vacuum bottle
- Blood saturated dressings and PPE

Chemo Waste – Yellow Bin

- Empty IV bags, bottles, tubing, syringes and close system devices
- PPE used in preparation, administration and disposal
- Blue Pads used as bedside table cover during Chemo administration

Chemo Waste – Black Bin

- Partially (not empty) filled/infused chemo agents (i.e., bags, syringes, bottles, and tubing)
- All items used in Chemo compounding
- All materials used in chemo spill clean-up
- Any materials used in the administration of arsenic
- Date the container

Keep lids closed at all times. Only lock lid on full containers.

Sharps Container

- Dispose of all sharps in designated sharps container - never overfill!

EMERGENCY MANAGEMENT

An **EMERGENCY** is any incident/situation/event that requires responsive action to protect or save lives, protect property, and public health and safety, or to lessen or avert the threat of a catastrophe. An emergency event includes but is not limited to severe weather/tornadoes, loss of utilities, bomb threats, hostage situations, active shooter incidents, or infant abductions.

Be familiar with your hospital's Emergency Operations Plan and what your role is in an emergency.

INFECTION CONTROL AND PREVENTION

1. Hand hygiene Saves Lives:
   - Best prevention for stopping the spread of infection.
   - Wash your hands or use the alcohol foam every time you enter a patient's room and when you exit.
   - Perform hand hygiene often to help keep you and your patients safe.
2. Use Standard Precautions with all patients. Protect Yourself:
   - Wear gloves if coming in contact with non-intact skin, mucous membranes, or blood and body fluids.
   - Wear a mask, goggles, and/or face shield when you anticipate splashes.
   - Gowns should be worn to protect yourself and clothes when coming in contact with body substances.
3. Prevent Exposures to Blood and Body Fluids (BBFE) from a sharps or a splash:
   - Activate all safety devices.
   - Protect yourself from splashes and wear the proper PPE.
   - Following an exposure:
     - Wash and rinse site.
     - Notify Supervisor.
     - Report to Occupational Health Services or ED as required per your hospital's procedure.
4. Equipment Cleaning and Environmental Cleaning in the Patient Care Environment:
   - Use only approved products for cleaning and disinfection. Follow manufacturers' guidelines.
   - Keep lid of disinfectant wipe closed so wipes do not dry out.
   - Clean and disinfect patient care equipment between each patient. **Always clean the glucometer after every patient use.**
   - Follow proper procedure for cleaning and disinfection. Understand correct contact times for approved disinfectant.
5. Understand the reason your patient is placed in isolation or precautions.
   - Give specific isolation instruction to your co-workers and all who enter an isolation room.
   - When an isolation patient leaves the unit or is transferred, communicate the isolation to the receiving department.
   - Follow all directions on isolation/precaution signs.

RESTRAINTS

Restraints may be used and applied by trained personnel in response to emergent situations as an adjunct to planned medical care. Alternatives to restraints should be tried first. When the use of restraint is necessary, the least restrictive method must be used to ensure a patient's safety. Every attempt is made to remove the patient from restraint as soon as possible. Patient assessment is ongoing throughout the episode of restraint. The assessments and documentation of those assessments must be ongoing in order to demonstrate a continued need for restraint.

Restraint Orders:

- An order is required to initiate, change, continue, and discontinue restraint.
- **PRN ORDERS ARE PROHIBITED.**
- The RN may ***initiate*** emergency use of restraints and must obtain a telephone order from the physician/NPP if the physician/NPP is unable to immediately assess the patient. The telephone order must be obtained as soon as possible (within minutes of restraint application).

Physician Documentation

History and Physical or Admission Notes

A complete admission history and physical examination appropriate to the condition shall be recorded within 24 hours of admission or prior to surgery or a procedure requiring anesthesia services, whichever comes first, and shall reflect a comprehensive physical assessment.

- If a complete history and physical has been performed within thirty days prior to the Patient's admission, a legible authenticated copy may be used in the Patient's hospital medical record to meet this requirement.

Nursing Documentation

Adult Admission History

Adult admission history is completed within 24 hours. A few key areas include:

- Nutrition screening and whether Dietary was consulted
- Functional screening
- Readiness and barriers to learning
- Allergies
- Screening for patients at risk for suicide or self harm

Plan of Care

- Upon admission, a patient's plan of care is developed with the patient based upon the patient's clinical presentation, nursing diagnosis, and needs identified during assessment and history completion.

Education

- Patient educational needs are identified, initiated, and documented upon admission and updated with educational session during stay to progress toward discharge.

MEDICATION MANAGEMENT

- All medication orders are reviewed by a pharmacist prior to administration, except in emergency situations when patient care would be compromised or when a physician is present during administration.
- Multi-dose vials are dated (with an EXPIRATION date 28 days from day of opening) and discarded within 28 days. Exceptions: vaccines, insulin, skin tests.
- Medication storage areas are kept locked.
- Medications requiring refrigeration are stored in specifically designated refrigerators and temperature is monitored.
- Effects of medication, including pain medication, are monitored throughout the patient's hospital stay.

Patient Safety and Medication Administration

Prior to administering medication, important information is communicated to pharmacy:

- Allergies, height and weight and pregnancy and lactation status are recorded on patient order sheets and on the initial patient admission database.
- Verify the medication selected is correct.
- Use 2 patient identifiers - match the identifiers with the patient and the MAR.
- Visually inspect and check expiration date.
- Remember the 5 "Rights": Right patient, right drug, right dose, right route, and right time.
- IV bags with attached tubing cannot be left in patient room unless attached to patient.
- When multiple IV lines, always trace IV lines from patient to medication bag when administering medications.

Adverse Drug Events

Adverse drug events include actual medication errors, near misses, and unusual, unexpected reactions to medications. When these situations occur, they are documented in the web-based incident reporting system. Tracking adverse events and working to correct the cause is part of our performance improvement process and helps to minimize these events.

Moderate Sedation

Physicians, RNs, and certified or licensed health care providers responsible for patients receiving sedation/analgesia are subject to relevant training and clinical experience, and demonstrated competence.

A designated Physician, RN, or certified or licensed health care provider other than the practitioner performing the procedure is present to monitor the patient throughout the course of the procedure.

In areas where moderate sedation is performed, emergency equipment and supplies are available:

- Pharmacologic antagonists (reversal agents)
- Appropriately-sized equipment for establishing intravenous access and patent airway
- Supplemental oxygen
- Advanced airway equipment and ACLS/PALS resuscitation drugs, as well as a cardiac defibrillator must also be immediately available.

PATIENT AND FAMILY/CAREGIVER EDUCATION

The purpose of patient/family education is to improve outcomes by providing an environment in which patients/families are actively involved in their care and care-related decisions, and given the knowledge and training to ensure their ability to safely perform and communicate short and long-term self-care skills/goals throughout the continuum of care.

Learning needs are assessed, individualized, adapted and evaluated to address the patients/families cancer care phase; age, health literacy, ***preferred learning language***, learning readiness and barriers, physical and cognitive abilities, cultural and religious beliefs, and motivation and personal goals.

Patients are educated regarding:

- Diagnosis/disease process
- Care and treatment plan
- Patient safety/fall risk reduction
- Safe and effective use of medication
- Nutrition interventions, modified diets, and oral care.
- Safe and effective use of medical equipment or supplies
- Pain management as a part of treatment
- Habilitation or rehabilitation techniques to help them become more functionally independent
- Available resources, and when necessary, how to obtain further care, services or treatment
- Discharge instructions are given to the patient and those responsible for continuing care, which include a listing of discharge medications to provide to the next caregiver.
- Communicating concerns about care and/or safety.