Inside the Joint Commission

Independent news and guidance to ensure rigorous compliance and accreditation excellence

August 2, 2010 | Volume 15, Issue 15

IN THIS ISSUE

Medication management/Leadership

Communication breakdown, lack of standards proves deadly

Coordinate among departments in your hospital to standardize procedures. It is crucial in your position as quality director. It can help prevent RFIs and fines and, as one California hospital found out, may be the difference between life and death.

An incorrect administration of a drug that resulted in the death of a patient had ramifications across multiple departments of Alameda County Medical Center (236 beds), Oakland, Calif. The resulting investigation by the California Department of Public Health found errors in nursing services, as well as pharmaceutical services that left the hospital quality director with a multiple page Plan of Correction to implement.

A patient at the hospital died Oct. 7, 2009 after a nurse administered 1 gram of Dilantin by intravenous push within

*(see **Leadership**, pg. 2)*

Environment of care

Sleep tight … and don't let the bedbugs bite!

The tiny little bedbug, that innocuous little creature your parents used to warn you about right before they switched out the lights, has been popping up all over the country recently, making headlines and causing quite a stir. Bedbug sightings have also been popping up in many hospitals, drawing the kind of attention that health care facilities could do without.

The little parasite forced Kings County Hospital (627 beds) in New York City to shut down a triage room in order to fumigate the area as a precaution after a bedbug was found on a patient there. The sighting caused regional news agencies and even national news organizations like the Wall Street Journal to treat the sighting of one bug as if it were the second coming of the plague.

While the sightings of the parasite have been getting big press recently, bedbug infestations have been on the rise over

*(see **Bedbugs**, pg. 4)*

Leadership

(continued from pg. 1)

5 minutes. The drug "should have been given slowly over an hour as ordered by the physician," according to the California Dept. of Public Health Statement of Deficiencies. The Immediate Jeopardy condition cost the medical center $75,000 in an administrative fine.

"The role of the QA Director would come into play after the fact, in response to an event like this," says Glenn Krasker, former Joint Commission director for hospital accreditation. Mistakes at the department level can sometimes be beyond your control as a quality director, but coordination and communication can go a long way in helping to prevent problems. Take a look at the scenario below to see if a situation like this is possible in your facility so that you can prevent disaster before it happens.

Here's what happened

A patient with a history of hypertension and end stage renal disease, identified by the state as Patient 14, was admitted to the hospital Oct. 5 for sudden shortness of breath and chest pain. While undergoing hemodialysis two days later, the patient experienced seizures, high blood pressure and lung congestion that required intubation and a transfer to the ICU. A physician's order specifically stated to "give 1 gm (gram) Dilantin over 1 hr (hour) IV (into the blood through a vein access), don't push quickly," the Statement of Deficiencies says.

The nurse pushed the full 1 gram dose into the patient's vein in 5 minutes.

Six minutes after the Dilantin was given, the Statement continues, "Code Blue was called in the intensive care unit" because the patient developed bradychardia (heart rate less than 60 per minute) with PEA (pulse less electrical activity of the heart). The resuscitation efforts failed … there was no heart activity. Patient 14 died at 10:24 p.m.

Lessons learned and best practices

Aside from the fact that a drug intended to be administered over one hour was instead administered in five minutes, multiple errors occurred during this incident, as the Statement of Deficiencies points out and medication safety and accreditation experts confirm. Some of these are likely RFIs. Best practices could have been used to avoid most. Here is a rundown:

- **Mix all compounded IVs, high-risk drugs in particular, in the pharmacy.** Failure to do so is a violation of Joint Commission standard **MM.05.01.07, EP 1** (A pharmacist, or pharmacy staff under the supervision of a pharmacist, compounds or admixes all compounded sterile preparations except in urgent situations…). The hospital pharmacy instead had instructed the nurse to mix four ampoules of Dilantin 250 mg in a 250 ml bag of saline.

"If the pharmacy is open 24 hours, Dilantin should only be stocked in the pharmacy and the pharmacy should prepare all IV Dilantin solutions," says Phil

Subscriber Information ▸ Have questions on a story? Call or email us.

Inside the Joint Commission is published 24 times each year by DecisionHealth, LLC. Copyright 2010.

OUR EDITORIAL PROMISE: We will provide you with the most accurate, fair and balanced information available anywhere. If you ever feel we're not living up to this standard, we want to know about it. Please call Editor Sandra Yin directly at 1-301-287-2411.

EDITOR: Kevin McDermott; 1-301-287-2696; *kmcdermott@decisionhealth.com*

PRESIDENT: Doreen Bieryla; 1-301-287-2734; *dbieryla@decisionhealth.com*

SUBSCRIPTIONS: $447/year for 24 issues. For questions about newsletter delivery and account status, call toll-free 1-877-602-3835 or email *customer@decisionhealth.com.*

FREE LISTSERV: *JCAHO-Watch* is a free chat group where you can get advice from your peers and share your experience on daily challenges such as surveys, TJC standards, patient safety and more. To sign up, visit: *www.decisionhealth.com/jcaho-watch-enroll.*

ELECTRONIC VERSION: To get other helpful tips, news and tools you won't find in the hardcopy version, sign up for your free e-version of *IJC*. Just email *customer@decisionhealth.com* and tell us to add your email address to your subscription.

MULTIPLE COPIES, SITE LICENSES AND REPRINTS: Could more than one person at your company benefit from a subscription to *Inside the Joint Commission*? Learn about our multiple copy and electronic site license options and get information on how to order reprints by calling Gary Belski toll-free at 1-866-265-0148 or email *gbelski@decisionhealth.com.*

Klein, managing consultant, Pharmacy Healthcare Solutions, Solano Beach, Calif. "If the pharmacy is not open 24 hours, the pharmacist should be called in to mix the drug or if that is not possible, the drug should be stocked in the afterhours storage locations with the appropriate instructions, labels, auxiliary labels, drug and IV bag, and require the order be double-checked by the nurse supervisor and the nurse."

- **Perform first-order review.** This basic medication safety requirement can be found in Joint Commission standard **MM.05.01.01, EP1** (… a pharmacist reviews all medication orders or prescriptions). "It was identified that the order written … was not reviewed by pharmacy … ," the medical center says in its Plan of Correction. The Statement of Deficiencies notes that "during an interview on 11/19/09 at 9:30 a.m., the Director of Pharmacy acknowledged that Dilantin order for Patient 14 was not reviewed in advance of administration as required by the [hospital's own] current policy and procedure on medication administration. There was no evidence that the pharmacy received and reviewed the scanned physician's order for Dilantin…."
- **Review and follow the medication order.** The nurse who administered the Dilantin "failed to review and follow the physician's order to give Dilantin over an hour," the Statement of Deficiencies says. This is a violation of **MM.05.01.07** (Medications are prepared and administered in accordance with the orders of a licensed independent practitioner responsible for the patient's care …).
- **Standardize drug concentration and administration rate.** This should be true for all IV drugs, not just Dilantin, says Klein, who adds that "their concentration, total volume and rate of administration should be readily available for reference on the patient care units." Failure to standardize drug concentrations violates **MM.02.01.01, EP 6** (The hospital standardizes and limits the number of drug concentrations available to meet patient care needs).

"There should be a hospital-approved list, through the P&T committee, that identifies the IV medications acceptable for use in the hospital, who is authorized to administer them, the dilation that is required, the rate at which it can be administered, and any other cautions," says Patricia Kienle, director of accreditation and medication safety for Cardinal Health. She adds that dissemination of the information "cannot be a stealth process" and should be formalized into policy that is regularly updated, with the date of the last update visible.

In the case at Alameda County Medical Center, the Statement of Deficiencies shows confusion between the nurse and the pharmacist involved as to how the Dilantin was to have been administered, each providing the state surveyor with a different version of what happened. The nurse told the surveyor "she called the pharmacy and requested the pharmacy to mix Dilantin … the pharmacist instructed her to get ampoules of Dilantin 250 mg from the Pyxis and give the medication IV, without any recommendation on how to give it."

"It shouldn't have happened. I shouldn't have listened to the pharmacist, and it didn't sound right to give four vials IV push. I should have refused," the nurse, who the medical center says has since been placed on Do Not Return, told the surveyor.

The pharmacist told the surveyor the she instructed the nurse to mix the four Dilantin ampoules in a 250 mg bag of saline and use a 22 micron filter when administering it. The pharmacist, however, "failed to indicate the rate of administration," the Statement of Deficiencies says.

Actions you can take

"Depending upon the size of the hospital and how responsibilities are assigned, the QA director or risk manager should have facilitated a root cause analysis to identify the system breakdowns that led to this tragic event and help design/redesign processes to make sure it never happens again," says Krasker, now president of Critical Management Solutions in Wilmington, Del.

"The QA director should then follow-up with the individuals assigned responsibility for implementing corrective actions/process improvements to make sure that they stay on track and that the risk of future, similar occurrences is reduced," he says.

Here are the required corrective actions the hospital had to undertake. Make sure your institution has similar precautions in place:

- All nursing staff are educated on medication administration policy and transcribing medication physician's orders.
- Dilantin is added to high-risk medication policy.

- All Dilantin will now be mixed in the pharmacy.
- Dilantin is removed from Pyxis ADCs, since it will now always be prepared in the pharmacy.
- Pharmacy will review Dilantin orders before administration.
- Pharmacy will label Dilantin with the drug name, dose, route and administration rate
- ICU will conduct 12-hour chart checks for nursing to check all medication administration records (MAR) for complete drug information, including drug, dose, route and rate of administration, as well as compare the MAR to the physician's orders. Nursing will review 30 charts each month to do the same.

While two separate departments had differing views on the cause of the incident, the larger issue is communication between departments and understanding and following protocol. The state concluded that it was the "**facility's** [emphasis added] failure to ensure its medication distribution and administration policies were followed … caused, or is likely to cause, serious injury or death to the patient and therefore constitutes an Immediate Jeopardy." ◆

Bedbugs

(continued from pg. 1)

the last decade. "We started seeing the calls for emergency services really pick up about four years ago," says Jennifer Erdogan of Bell Environmental Services (BES), a Parsippany, NJ-based pest-control company that contracts with health care facilities in the New York region and throughout the country.

Erdogan told *IJC* that the infestations have really spiked in the last six months. "It is to the point where we receive five emergency calls a day," from hospitals for us to come out and eliminate a bedbug problem, she says.

Anatomy of a bloodsucker

The common bedbug *Cimex lectularius* is a tiny, reddish-brown insect, typically ¼ inch long that is partial to human blood as its main source of nourishment. Unlike other bloodsucking insects like ticks and mosquitoes, the bedbug is not known to transfer communicable disease from one host to the next and so poses little health risk to humans.

However, the insects, which typically nest in mattresses and blankets or clothing and mainly come out at night to feed, can cause skin irritation in its victims, especially if the victim receives multiple bites. And, while some victims might not show any visible signs of bedbug bites, others can exhibit itchy, red, swollen marks, similar to those left by mosquitoes or fleas.

Be prepared – What you need to do in your facility

A bedbug outbreak is certainly not something you want to have in an environment that is supposed to be sterile. While the sightings of the tiny critters are hardly a major catastrophe, you should be aware of how any type of pest infestation may affect your hospital. A recent paper published by the American Society for Healthcare Environmental Services (ASHES) notes that "infestations are common and becoming more so in health care settings, and when they occur, they evoke – right or wrong – the impression that infested facilities are unsanitary and of low quality."

"If the Joint Commission were to become aware of a bed bug infestation they would explore and evaluate what the hospital did about it," says former Joint Commission Executive Director of Accreditation Services Kurt Patton.

Failure to control the spread of the bugs would be evaluated under the leadership standards, says Patton, now CEO of Patton Healthcare Consulting in Glendale, Ariz. If the surveyor wanted to issue RFI's just for having the bed bugs, **EC.02.01.01, EP 5** (the hospital maintains all grounds and equipment) is a possibility. Another potential RFI could be **EC.04.01.05, EP 1** (the hospital takes action on the identified opportunities to resolve environmental safety issues), Patton says. "It is always possible that a patient brings the pest into the hospital with their personal belongings," Patton says, "but the actions taken by the hospital to prevent the spread of the pest would be key."

Editor's note: Find out what environment of care RFIs surveyors look for at the 14th Annual EC Summit (*www.ECSummit.com*) on October 4-6 in Las Vegas, Nev.

Watch out when using pesticides

Infestation of any pest requires quick action, but the methods your facility uses are equally important. If you use chemical pesticides to eradicate bedbugs, or any other type of pest such as cockroaches, lice, or scabies, make sure your facilities manager is diligent about the handling of the toxic chemicals or it could cost you an RFI under **EC.02.02.01** (the hospital manages risks related to hazardous materials and waste) and **EC.02.06.01** (the hospital establishes and maintains a safe, functional environment).

(See the work tool provided on pg. 7 of your newsletter for a Joint Commission pest control checklist)

New advances mean less risk, downtime

A bedbug sighting doesn't necessarily mean that you need to bother with toxic chemicals or even need to shut down areas of your facility for extended amounts of time. New thinking in the methods of pest extermination have made the process chemical-free and time-sensitive. Companies like BES, which specialize in pest control for hospitals and other large institutions, have developed chemical-free alternatives that are less invasive than previous means of pest control.

"We use a special method of carbon-dioxide freezing" Erdogan says. It kills the bedbugs and their eggs and doesn't require you to shut down a wing or even close down a room for an extended period of time. "This type of treatment doesn't require any type of evacuation of the facility," Erdogan says. "Even the rooms that are treated can be re-occupied right away."

A good offense is your best defense

There is no way to keep bedbugs completely out of a facility, Erdogan says. So, preventative care and monitoring is the best way to keep your hospital pest free and standard strong.

- **Train your staff** to be watchful for the tell tale signs of the insects, Erdogan recommends. "Many of our facilities have requested in-service training by our staff on what to look for," she says. The easiest thing to look for is the bug itself on any clothing or bedding. In facilities like hospitals, where patients are constantly coming and going, a bedbug can hitch a ride on the clothing or belongings of a new patient. So, even an area that might have been free from bedbugs one day, might have some unwanted new occupants the next.
- **Do pro-active screenings**, Erdogan recommends. BES actually uses three canines, trained in sniffing out bedbugs and other pests. "We can bring the dogs into the facility after hours or when areas are unoccupied," she says. "The dogs can actually locate any areas with bedbugs and our staff will then immediately treat the area."

Ultimately, there is no way to keep them out, she says, but the best way to keep your facility safe is by being proactive. Train staff in what to look for, sweep areas when space permits and take action quickly to avoid any major problems. ◆

Newsbriefs

Preventable CRBSIs can cost your hospital plenty

The average cost for a patient that develops a catheter-related bloodstream infection (CRBSI) can reach $30,000, according to a recent study. Added to the fact that 80,000 patients per year are estimated to develop CRBSIs – 30,000 of which prove to be fatal – and the numbers add up to costing the U.S. health care system more than $2 billion per year.

The most tragic part of this is that these types of infections are almost 100% preventable. A federally funded program conducted in hospital ICUs followed the simple five-step checklist developed by Dr. Peter Pronovost, MD, PhD, FCCM, with Johns Hopkins University School of Medicine, which reduced CRBSIs by two thirds.

1. Wash hands prior to insertion. The accompanying nurse is required to directly observe this procedure or, if this step isn't observed, to confirm that the physician performed the procedure.
2. Clean patient's skin with chlorhexidine antiseptic.
3. Place sterile drapes over the entire patient.
4. Wear a sterile mask, hat, gown, and gloves. This is important to ensure that sterility is not broken at any point during the procedure.
5. Put a sterile dressing over the catheter.

That figure represents 1,500 lives saved in the first 18 months of the program and translated into $200 million for the hospitals involved. In fact, these types of infections are thought to be so preventable that CMS considers them to be a "never event," meaning that they believe

they should not occur with proper procedures in place and will not reimburse facilities for the cost associated with them. "Many, if not most CRBSIs can be prevented through consistent application of best practices," said Association for Professionals in Infection Control and Epidemiology (APIC) CEO Kathy Warye. "Elimination of CRBSIs needs to be the goal of every health care institution," she said.

Despite high success rates, a recent survey released by APIC revealed that many hospitals still struggle with prevention of CRBSIs. Some of the results of the survey were unsettling, such as:

- Half of survey respondents strongly agree that administration at their facility knows the extent to which CRBSIs are a problem
- Only 30% strongly feel that their administration is willing to spend the money necessary to prevent CRBSIs
- Only 25% strongly believe that their facility monitors compliance with best practices or that their staff is held accountable for these practices.

"Preventing infections requires the full commitment of hospital leadership to ensure adequate resources and instill a culture of patient safety within the institution," said Pronovost,

To see the study on CRBSIs and their affect on hospitals and health care, go to the Center for Disease Control site at: *www.cdc.gov/mmwr/preview/mmwrhtml/rr5110a1.htm*

Large multi-hospital organizations can get concurrent surveys

You can get all of your survey anxiety over and done with at once, now that The Joint Commission allows large, multi-hospital health care facilities the option of having all of their locations surveyed concurrently. Aside from the obvious benefit of "getting it over with," TJC feels that health care facilities can benefit in other ways from this option, including:

- sharing leading practices from one site in the system that could be adopted at other sites
- identifying opportunities for standardization across the system
- identifying solutions for implementing complex standards and NPSGs system-wide
- increasing communication and collaboration between the many facilities within the system.

The Joint Commission announced the new concurrent survey option as a more structured approach to the survey process, but stated that each organization with a separate CMS Certification Number (CCN) would receive a separate survey report and accreditation decision and each separate unit would be judged on the same accreditation standards on an individual basis.

While the concurrent survey option works best for organizations with 12 or fewer entities, arrangements for larger health care organizations that wish to utilize the concurrent survey option can still be made.

And, sorry, surveys will still remain unannounced.

JOINT COMMISSION PEST CONTROL CHECKLIST

Use this checklist to ensure you stay in compliance with **Environment of Care Standard EC.02.02.01** (The hospital manages risks related to hazardous materials and waste) when dealing with any pest-management issues.

Hazardous Materials and Hazardous Waste Management Plan

Create and maintain an inventory that identifies hazardous materials and waste used, stored or generated using criteria consistent with applicable law and regulation.

EVIDENCE OF COMPLIANCE

Facility has plans on file, readily accessible by appropriate staff, for pesticide:

Application:

- ☐ Selecting chemicals used in grounds keeping
- ☐ Ensuring restricted or prohibited pesticides not used
- ☐ Ensuring pesticide applicators appropriately trained, licensed
- ☐ Posting warning signs when pesticides applied

Disposal:

- ☐ Managing waste pesticides as hazardous waste
- ☐ Triple rinsing pesticide containers
- ☐ Managing rinsate as hazardous waste if not used
- ☐ Managing disinfectants and sterilants as pesticides

EVIDENCE OF PERFORMANCE IMPROVEMENT

Facility has plans on file, readily accessible by appropriate staff, for:

- ☐ Implementing an Integrated Pest Management (IPM) program

Hazardous Materials and Hazardous Waste Inventory

Create and maintain an inventory that identifies hazardous materials and waste used, using criteria consistent with applicable law and regulation.

EVIDENCE OF COMPLIANCE

- ☐ Hazardous materials inventory contains accurate list of pesticides

EVIDENCE OF PERFORMANCE IMPROVEMENT

- ☐ Quantity of hazardous materials (including pesticides) used over successive time periods tracked and documented
- ☐ Size of hazardous materials inventory reduced

(continued on pg. 8)

JOINT COMMISSION PEST CONTROL CHECKLIST (cont.)

(continued from pg. 7)

Implementation of Hazardous Material and Hazardous Waste Program

Establish and implement processes for selecting, handling, storing, transporting, using and disposing of hazardous materials and wastes from receipt or generation through use and/or final disposal, including managing the following: chemicals, chemotherapeutic materials, pharmaceuticals, radioactive materials and infectious and regulated medical waste including sharps.

EVIDENCE OF COMPLIANCE

- ☐ Pesticides classified for restricted use applied only by licensed applicators
- ☐ Pesticide containers triple rinsed
- ☐ Rinsate managed as hazardous waste if not used
- ☐ Hazardous waste determination made, documented for pesticides being discarded
- ☐ Warning signs posted, staff notified when pesticides applied

EVIDENCE OF PERFORMANCE IMPROVEMENT

- ☐ Restricted pesticides not used
- ☐ Facility has instituted Integrated Pest Management program with following elements:
- ☐ Pesticide application used only as last resort
- ☐ Only least toxic pesticides used
- ☐ Primary focus of program: pest identification, monitoring
- ☐ Non-chemical methods used for pest control (e.g. traps, barriers)
- ☐ Staff training component, e.g. actions that help prevent pests on premises
- ☐ Pesticide applicators licensed, trained by appropriate authorities
- ☐ Communication to staff, patients, visitors when pesticide applied

Hazardous Material and Hazardous Waste Documentation

Maintain documentation, including permits, licenses, and adherence to other regulations.

EVIDENCE OF COMPLIANCE

- ☐ Records indicate appropriate training for staff using disinfectants, cold sterilants, pesticides
- ☐ Pesticide applicator licenses maintained or in pest management contract
- ☐ Documentation maintained to ensure exposure monitoring, no restricted pesticides
- ☐ For federal facility, documentation that Integrated Pest Management program in place

EVIDENCE OF PERFORMANCE IMPROVEMENT

- ☐ Integrated Pest Management program in place
- ☐ Pesticide applicator licenses no longer needed due to no pesticides being applied at facility

Source: Adapted with permission from Hospitals for a Healthy Environment; www.healthcarepestcontrol.com