Unannounced JCAHO visits also now hit certified stroke centers

Prepare now for your hospital’s JCAHO-certified stroke center to undergo an unannounced recertification review.

Unannounced reviews for JCAHO’s disease-specific care programs took effect on Jan. 1. They take place about 12 months after certification – up to 45 days before or after the due date.

The new policy and the $9,450 initial fee hospitals pay the Joint Commission for the disease-specific care certification do not seem to be deterrents. In August 2005, there were 147 JCAHO-certified stroke programs nationwide (IJC, 08/29/05). Today, there are 205 “primary stroke centers” across the nation.

JCAHO-certified hospitals get a 25% discount on the $9,450 stroke certification fee. Primary stroke centers pay this fee every two years to remain certified.

There’s also a $1,575 fee for JCAHO’s “intra-cycle assessment and verification,” the recertification test that takes place around 12 months after the initial review.

Among the 7,560 U.S. hospitals, most have not established certified stroke programs. And the clot-busting drug t-PA is still not being administered to as many ischemic stroke patients across the country as it could be, stroke authorities say.

“You can read between the lines the frustration of the researchers not understanding why we’re not being more aggressive in implementing a stricter standard of care,” says Kilby Brandt, project director for the stroke program at the Sullivan Group, a consulting firm in Oakbrook Terrace, Ill.,

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March 27, 2006
Vol. 11, No. 7

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that addresses risk, quality and emergency medicine.

**Tip:** To improve care for stroke patients, make EMS workers in your region front-line members of your hospital’s stroke team, Brandt says. They most likely will see stroke patients first and make crucial decisions about their care and where they should be transported.

Historically, EMS workers have taken patients to the closest hospital, says RN Christina Binn, the stroke program coordinator at Waukesha (Wis.) Memorial Hospital (302 beds), which JCAHO certified in January as a primary stroke center. But this is changing, especially in Florida.

EMS workers there and, in various degrees, across the nation are being trained to transport stroke patients to primary stroke centers when it’s reasonable to do so. Certified stroke centers often provide equipment and expertise to help stroke patients much quicker than do hospitals that aren’t certified.

“The biggest obstacle is the time constraint,” Brandt says. “The ER doctor has to conduct a comprehensive assessment quickly and send the patient to radiology for a head CT, and receive the report back confirming the diagnosis. Also, many times they want lab tests before ordering the t-PA. So, everything has to fall in place very quickly.”

**States considering stroke-related legislation**

Several states are considering legislation intended to improve treatment for stroke victims, including: Alabama, California, Georgia, Kentucky, Mississippi, New Jersey, New Mexico, North Carolina and Pennsylvania, according to the American Heart Association/American Stroke Association (AHA/ASA).

Among the measures are those that would create primary stroke centers, establish stroke education programs and make data about this topic available to the general public and emergency care providers. Some states have passed or proposed resolutions to create stroke systems of care.
Florida is leading this effort by recommending that EMS systems and stroke treatment hospitals statewide work closer to provide timely and effective treatment for stroke patients. The Texas Board of Health plans to appoint 12 members to a Council on Cardiovascular Disease and Stroke who will lead efforts in the Lone Star State.

JCAHO’s involvement is expected to “rapidly drive improvement in stroke care in hospitals across the country,” the AHA/ASA predicts in a written statement.

A primary stroke center in Florida

JCAHO certified the North Broward Medical Center (409 beds) in Deerfield Beach, Fla., as a primary stroke center in January. In fiscal year 2005, the hospital treated 584 stroke patients, says Nora Uhrig, a registered nurse and coordinator of the hospital’s stroke program.

Tip: “We just looked at the [JCAHO] standards and developed an action plan for each one of those,” Uhrig says, noting that the hospital created a stroke team, a planning team and a “brain-attack” team to lead this effort. North Broward’s team approach to stroke care includes a focus on prevention, treatment and rehabilitation.

The Brain Attack Team follows protocols to make sure eligible ischemic stroke patients rapidly receive the clot-dissolving drug t-PA, hospital officials say. Members of the team – which comprises emergency medicine physicians, neurologists, neurosurgeons, interventional radiologists, radiologists, first-responders (EMS/paramedics) and nursing staff – are available 24 hours each day.

North Broward’s stroke program also includes seven certified neurological registered nurses and a multi-disciplinary team of physicians, nurses, physical, occupational and speech therapists, dieticians and rehabilitation specialists who create a customized long-term treatment plan for each patient.

There also is a 26-bed dedicated stroke unit at the hospital with nurses on the unit, along with ICU and ED nurses, who undergo extensive training in stroke assessment, treatment and rehabilitation. JCAHO requires staff in the stroke program to complete eight hours of continuing education in stroke education each year.

“A barrier I’ve come across talking with colleagues is who’s going to pay for the eight hours each year,” says Binn, the stroke program coordinator at Waukesha (Wis.) Memorial Hospital.

In December 2005, 100 employees from Waukesha Memorial and Oconomowoc (Wis.) Memorial attended a stroke symposium there. ProHealth Care owns both hospitals.

“Our facilities believe it’s appropriate to offer stroke education to a wide range of staff,” Binn says.

Actor Robert Guillaume, who had a stroke, is scheduled to speak May 2 at Waukesha Memorial’s community education series on this topic. An annual public education event is another JCAHO requirement to remain certified.

“A neurosurgeon and our neurology physicians provided funds for this,” Binn notes.

In Florida, North Broward’s stroke center also includes diagnostic technology such as an ultra-speed CT and MRI, which they say can offer physicians accurate test results in minutes. The hospital also offers community education programs, support groups and screenings focused on stroke.

5 tips to improve your hospital’s stroke care

Improve stroke care in your emergency department by taking several crucial steps, advises Kilby Brandt, an RN and project director for the stroke program at the Sullivan Group. The consulting firm in Oakbrook Terrace, Ill., addresses
health care risk, quality and emergency medicine. Brandt’s five tips are:

1. **Include a physician leader interested in stroke in your hospital’s effort to gain certification.** “This might be a neurologist, an internist interested in stroke, an emergency physician or radiologist,” says Brandt, noting that the Joint Commission wants hospitals to have a medical director for stroke. “A successful model is when the chief nursing officer partners with an emergency physician or neurologist on staff [to head the effort].”

2. **To avoid a malpractice lawsuit, make sure there are notes in the chart to explain a discrepancy between a nurse’s and a physician’s evaluation of the patient.** “Our company reviewed a case where a nurse documented a patient had weakness on the left side. But when the doctor examined the patient, he didn’t see the weakness,” Brandt says. “We recommend the physician really look at the nursing documentation and say, ‘I have reviewed the nurse’s documentation, but in my examination I did not find any left-sided weakness.’” If it isn’t documented, Brandt says, it isn’t done. There has been no jury determination on this case but the attorney who reviewed it for the Sullivan Group said this discrepancy between what the nurse and the physician said would lead to difficulties for the defendant during a trial.

3. **Develop a systems approach to coordinate care for stroke patients quickly.** A systems approach sometimes is very difficult to achieve, she warns, because it takes various departments working together all with the same goal. The biggest obstacle is the time constraint, she says. There’s a three-hour window during which stroke patients must receive the largest amount of treatment to ensure the best possibility for a full recovery.

4. **Outline the hospital’s stroke protocol on paper and always stick with the official policy.** “There have been studies that show there can be differences in the way patients are treated based on age, race, etc.,” Brandt says, even when it involves two patients with the same symptoms and presentation. “We recommend that the medical staff work together in good faith and establish its protocol. Educate everybody about it and stick with it 100% of the time.”

5. **Provide stroke center staff with regular opportunities for continuing education on stroke care and continuous quality improvement.** “The hospital must develop indicators they check on regularly by doing chart reviews and tightening up any areas they could do better in as they go through time,” Brandt says. “Also, there’s so much research being done on stroke all the time. The committee [or team] has to also be reviewing the literature to make sure that what they did in 2005 is what they should be doing in 2006.”

### New FDA advisory stresses need to test old bed systems

Start making plans now to follow new FDA recommendations that urge you to measure entrapment zones on hospital beds to ensure patient safety.

The Joint Commission helped develop the non-binding recommendations, released March 10. It also issued a sentinel event alert in September 2002 on bed rail-related entrapment deaths.

But JCAHO standards do not require hospitals to measure entrapment zones.

The alert notes that JCAHO standards require health care organizations to have a patient safety program that addresses “performance improvement, environmental safety and risk management.”

The standards do not prescribe how these activities should be structured but you could get dinged for not having a procedure in place to address bed rail-related entrapment deaths.
The “Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment” potentially could mean that about 23,000 U.S. health care facilities should begin assessing their beds for patient safety, FDA officials say.

Between Jan. 1, 1985, and Jan. 1, 2006, the FDA received 691 hospital-bed entrapment reports in which 413 people died, 120 were injured and 158 were identified as near-miss events.

“Any bed you buy now is likely to conform to the dimensional guidance recommendations in the FDA guidance document,” says Mark Bruley, an issues group leader on the FDA-sponsored Hospital Bed Safety Workgroup (HBSW). Created in 1999, the HBSW developed the recommendations as well as those in its 2003 companion, “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long-term Care Facilities, and Home Care Settings.”

The latest recommendations are geared toward manufacturers that design new hospital beds. They also are designed to help hospitals and other facilities reduce the patient entrapment risk posed by legacy beds, a term that describes beds currently in use at hospitals — sometimes for 15 to 20 years. A legacy bed could be any bed in use at a hospital that does not conform to FDA guidelines.

Once hospital workers learn how to conduct the bed assessments, they could be done in a few minutes, Bruley says. He also is vice president of accident and forensic investigation at ECRI, a nonprofit health services research agency.

“It’s not likely you have to test every bed in the hospital,” he adds. **Tip:** Define your hospital’s bed systems — comprised of a frame, cer-
tain types of rails, and a mattress – and assess those systems, he advises.

**How to test beds**

For example, your hospital might have three different bed models and mattresses from four different companies. “If you only use Brand X mattress on Brand A bed, that’s one system,” Bruley says. “You may find you have only a dozen different bed systems that need to be assessed.”

The dimensional guidelines focus on testing four of seven entrapment zones on hospital beds by using a cone, cylinder and spring scale tools. The cone and cylinder together weigh 15 pounds and make it easier to measure the four most problematic zones to identify the extent to which they might pose a hazard, FDA officials say. *(See chart on Page 5).*

The four most problematic zones pertain to how a patient’s head, neck or chest could become trapped: (1) within the bed rail; (2) under the rail, between rail supports or next to a single rail support; (3) between the rail and mattress; and (4) under the rail, at the ends of the rail.

The final guidance can be accessed on the FDA’s Web site at [www.fda.gov/cdrh/beds/](http://www.fda.gov/cdrh/beds/).

**Checking beds could take time, effort**

Not everyone agrees that assessing the hospital beds will be simple. “If you go through the steps for doing the testing, that could be a significant amount of time, effort and energy to get good test results that tell you which bed system passes or fails,” says Paul Smith, president-elect of the American Society for Healthcare Risk Management. Smith was ASHRM’s representative on the FDA-sponsored workgroup and also is vice president and general counsel for Cabell Huntington (W. Va.) Hospital (322 beds).

“If they fail, you still have a bed system you paid a lot of money for,” Smith adds. “And then you still have to figure out if there’s a way to mitigate the danger of entrapment, and does that pose new and different risks.”

Conducting assessments with the cone-and-cylinder will require workers from various departments, Smith says.

“Hospitals ought to make sure they become acquainted with the clinical guidance and the latest guidance,” he says. “Traditionally, this might be something that would only [affect] a risk manager.”

For example, the FDA recommends that hospitals and other facilities conduct a risk-benefit analysis and take steps such as checking with bed system manufacturers to identify compatible mattresses, rails and accessories.

Beds excluded from the scope of the guidance include air-fluidized therapy beds, bariatric (obesity) beds, pediatric beds and infant cribs, as well as stretchers not used for extended-stay, examination tables, operating room tables, and radiology tables, among others.

“The challenge is to bring everyone together to make sure your decisions about how you’re going to approach this are uniform,” Smith advises.

An example he shares involves a hospital’s purchasing department being told to get new beds “within budget.” Traditionally, getting beds or updating them has been handled by the purchasing, maintenance or engineering departments.

**Tip:** “You need to bring in different people to talk about this – representatives from purchasing, representatives from the clinical staff, representatives from risk management, representatives from maintenance and engineering or whichever department is responsible for testing,” Smith says. “There are implications that involve more than one department.”

Other tips include:
For beds that fail or are borderline on the assessment, make a decision about what the hospital will do next, Smith says.

Question what mitigation strategies are available and appear to be the safest. Bed manufacturers can help with this.

Determine how the hospital will pay for what is needed.

Conduct an assessment of which bed system may pose an entrapment risk, based on the new dimensions promulgated, Bruley says.

If you are buying new beds, in your purchase spec ask the vendor whether the bed complies with the FDA guidance.

**9 tips to help ensure your hospital beds are safe**

Here are nine bed rail safety guidelines from the “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings.”

1. The bars within the bed rails should be closely spaced to prevent a patient’s head from passing through the openings and becoming entrapped.

2. The positioning of the mattress and bed rail should prevent a patient from falling between the mattress and bed rails and possibly smothering.

3. Check to make sure the mattress does not shrink over time or after cleaning. This could increase the potential space between the rails and the mattress.

4. Check for compression of the mattress’ outside perimeter. Easily compressed perimeters can increase the gaps between the mattress and the bed rail.

5. Ensure that the mattress is appropriately sized for the selected bed frame, as not all beds and mattresses are interchangeable.

6. The space between the bed rails and the mattress and the headboard and the mattress should be filled either by an added firm inlay or a mattress that creates an interface with the bed rail that prevents an individual from falling between the mattress and bed rails.

7. Latches securing bed rails should be stable so that the bed rails will not fall when shaken.

8. Older bed rail designs that have tapered or winged ends are not appropriate for use with patients assessed to be at risk for entrapment.

9. Maintenance and monitoring of the bed, mattress and accessories such as patient/caregiver assist items should be ongoing.

**Involve surgeons more to avoid mistakes in your OR**

Here’s how you can jump-start your hospital’s universal protocol to prevent-wrong site, wrong-procedure and wrong-person surgery.

A key to success: Require the surgeon to initial the body part where the surgery is to take place.

That’s the policy Lancaster (Pa.) General Hospital (563 beds) uses with its 250 surgeons.

“Most hospitals are identifying the surgical site but not having the surgeons actively involved by initialing the site,” says Diane
Skorupski, the Level II trauma center’s director of surgical services.

Since implementing the new policy nine months ago, Lancaster General, which performs about 37,000 surgeries annually in five inpatient and outpatient surgical areas, has had no related near misses or sentinel events, Skorupski says.

“Before that these potentials, like at any hospital, existed here,” she says.

“For example, we had a patient prepped for a hernia,” she adds. “But one side was prepped instead of the other, and the physician caught it.”

Wrong-site surgery is second only to patient suicide in terms of the total number of sentinel events the Joint Commission reviewed since January 1995, according to the latest statistics from JCAHO.

Of the 3,548 sentinel events reported during that period, 455, or 12.8%, were related to wrong-site surgery. Patient suicide comprised 464, or 13.1%, of the total number of sentinel events during that same time frame.

As part of the universal protocol, the Joint Commission notes that hospitals must adopt “a robust approach” to this problem “using multiple, complementary strategies.” The universal protocol appears in the CAMH (JCAHO’s Comprehensive Accreditation Manual for Hospitals) after the nine National Patient Safety Goals for 2006.

It essentially involves three steps: (1) a preoperative verification process, (2) marking the operative site, and (3) performing a “time out” immediately before starting the procedure.

The Joint Commission notes that these steps are not followed when they involve:

- Single-organ cases (such as Cesarean section or cardiac surgery);
- Interventional cases for which the catheter/instrument insertion site is not predetermined. An example JCAHO offers is cardiac catheterization;
- Teeth. Option: Indicate operative tooth name(s) on documentation or mark the operative tooth on the dental X-rays or dental diagram, the protocol states;
- Premature infants, for whom the mark may cause a permanent tattoo.

In addition to the above exemptions, here are instances when Lancaster General surgeons do not initial the patient’s skin:

The hospital does not initial the patient’s skin when the surgery is in a body orifice. Lancaster General surgeons do initial for single-organ cases, however, unlike JCAHO’s universal protocol.

“We have found that there still can be issues with that,” Skorupski says, referring to mistakes with single-organ cases.

An example she offers involves a surgical patient with a gall bladder problem. To avoid any mishaps, the surgeon initials the patient to confirm that the patient is in the right room and is to have a specific surgical procedure done. This decreases the potential for error, Skorupski says.

Other exemptions at Lancaster General:

- If it’s an obvious site like a gunshot wound, stabbing or an abscess;
- When there’s a potential for loss of life, limb or sight;
- Circumcisions. “We found that we didn’t need to initial the body organ, to avoid potential embarrassment for the patient,” she says.

In addition to the above exemptions, here are instances when Lancaster General surgeons do not initial the patient’s skin:
Key steps can help your surgeons prevent mistakes

Here’s how surgeons became the primary driver after Lancaster (Pa.) General Hospital (563 beds) implemented the universal protocol to prevent wrong-site, wrong-procedure and wrong-person surgery.

The hospital began requiring surgeons to initial surgical sites on patients after the chair of surgical services, the AVP musculoskeletal & surgical services director, and Diane Skorupski, the Level II trauma center’s director of surgical services, presented the idea to surgeons at an evening dinner last year. The policy called for marking their initials directly on the patients’ skin before moving them to the operative area.

Patients give marking pens to surgeons

After patients arrive in the pre-op area, a nurse gives them a marking pen and tells them that their surgeon will be coming in to answer questions they might have. When the surgeon arrives, the patient hands him the pen. The surgeon discusses where the incision site will be and places his initials there. “The patient will not leave the pre-op area unless they’re initialed,” Skorupski says.

When the patient enters the operating room, hospital staff take part in the time out to make sure to identify and confirm they have the correct patient for the specific procedure. “It’s active communication, not one person doing this but the entire surgery team,” Skorupski says.

The team often includes: a surgical technologist, registered nurse, the surgeon and the anesthesiologist. Team members verbally confirm the patient’s name, along with details describing why he or she is in the operating room and in what position the patient will be on the table. The staff also confirms when the patient received antibiotics; there’s a 60-minute window for administering them before surgery.

Not all surgeons at Lancaster General embraced the new policy. “There has been some reluctance. It’s a change,” Skorupski says, noting that some surgeons complained that this step would delay their start times in the operating room. “But when they saw the data, the risk factors involved, and how many wrong-site surgeries there are [nationwide], they did buy into it.”

Tip: To implement the universal protocol, gather your data on what your incidence of wrong-site surgery is, and show this data to your surgeons. “Have a meeting with them and talk about the risk of wrong-site surgery, what the incidence is nationally, and really involve them from the [beginning] – and stress patient safety,” she says.

At Lancaster General, the hospital attorney also spoke with the surgeons. “He talked about lawsuits and outcomes,” she says. “I think the surgeons need to hear that.”
Surgeons were told about the proposed policy a few months before its start date. “We told them we wanted to implement it now and work out the bugs and that we wanted to partner with them,” she says. “I said, ‘Anything you can see that would prevent us from having a good outcome, we need to hear.’”

The more collaboration you can have the more success you will have, she says.

**JCAHO lobs criticism at hospital accreditation competitor**

The Joint Commission strongly questions TÜV Healthcare Specialists’ ability to offer a “rigorous” hospital accreditation program in its public comments to the Centers for Medicare and Medicaid Services (CMS).

The Cincinnati-based TÜV Healthcare Specialists (TÜVHS) is scheduled to be informed officially in late June whether CMS will approve it as the third national accreditation organization for U.S. hospitals that participate in the Medicare program. The formal decision will be published in a final notice in the Federal Register. JCAHO and the American Osteopathic Association currently are the only national accreditation organizations granted this authority.

Under the Medicare program, a hospital can provide health care services and be reimbursed by the federal government if certain state survey agencies or national accrediting organizations (JCAHO and AOA) with “deeming authority” from CMS confirm that the facility meets Medicare conditions of participation (CoPs).

TÜVHS submitted its application to CMS in December. The public comment period on the company’s application ended in February.

“CMS must ensure that TÜVHS has the financial stability and necessary resources to offer a rigorous hospital accreditation program,” writes Trisha Kurtz, JCAHO’s director of federal relations, in the Joint Commission’s three-page, single-spaced letter to CMS.

**Conflict of interest alleged**

“Second, the Joint Commission requests that CMS consider the unusual situation and apparent conflict that is posed by TÜVHS offering consulting services to prepare hospitals for Joint Commission accreditation reviews, while asking to be competitive for deeming authority,” Kurtz says.

No other organization that offers Joint Commission accreditation consulting services conducts hospital accreditation services on behalf of Medicare, the letter states.

Darrel Scott, senior vice president for regulatory and legal affairs at TÜVHS, declined to comment about the Joint Commission’s concerns.

In October, Scott told *IJC*: “We’re presenting an alternative if [hospitals] want to look at a different way of being accredited. We’ll be that alternative and let the marketplace decide.”

(11/07/05, *IJC*)

Comments from 14 individuals and organizations were posted online at [www.cms.hhs.gov/eRulemaking/ECCMSR/list.asp#TopofPage](http://www.cms.hhs.gov/eRulemaking/ECCMSR/list.asp#TopofPage) under docket ID No. CMS-2228-PN.

CMS is reviewing the comments before it issues a final decision.

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