The New Accreditation Process

What is the Joint Commission?

- The Joint Commission is an independent, not-for-profit organization that evaluates and accredits nearly 15,000 healthcare organizations throughout the United States. Hospital accreditation is achieved by compliance with quality of care and patient safety standards (258).
- 1,150 elements are associated with those standards. Compliance with standards is determined through onsite surveys approximately every three years.
- UTMC currently is certified for general hospital services including behavioral health and our stroke program.

Starting January 2006 the Joint Commission began conducting its regular accreditation surveys on an unannounced basis. This means that the earliest notification University of Toledo Medical Center will have is 7:00 am the morning of the Surveyor arrival. They have chosen this method for the following reasons:
- To enhance the credibility of the process
- To reduce unnecessary costs of a "hurry and prepare" effort every three years
- To assure an accurate reflection of a hospital's "usual" status
- To help hospitals focus on safe and high quality care at all times

This means we must always be ready. A survey may happen tomorrow. Policies, protocols, documentation requirements and other such tools are created to guide us in our daily activities of safe, high quality care. The single most important thing you can do to aid the institution in patient safety and in being prepared for a survey is to know your policies, procedures and standards of practice and adhere to them. When the surveyors visit, they will again use the Tracer Methodology. This means they will select a patient from the unit census, usually with one of our key diagnoses (Acute Coronary Syndrome, Pneumonia, CHF or orthopedic cases). They then review the record and follow the patient throughout the entire process of hospitalization. This includes looking at how physicians and other practitioners greet the patient, wash their hands, interview the patient, treat the patient and document care of the patient. This tracer survey method places us in a position to demonstrate that we practice what our policies and protocols require. From admission to diagnostics to surgery to transport services, they will watch our interactions and patient "hand-offs". They will watch the nursing shift changes. They will observe what residents do and say when they hand off patients to the oncoming shift. Always seeking to understand, they will ask us questions about what and why we do things in a particular manner. To learn about quality practices at the University of Toledo Medical Center you may contact the Director of Quality at extension 3968. We prefer that employees contact the quality department and use internal channels to report patient care or patient safety issues. However, employees do have the ability to contact the Joint Commission directly at (630) 792-5000.

CLINICAL OUTCOMES AND PERFORMANCE IMPROVEMENT

Performance improvement is a continuous process involving measuring the function of a process or service and when indicated, implementing changes that enhance performance. The performance is then monitored over time to assure that improvements are attained and sustained. The focus of performance improvement at University of Toledo Medical Center is on outcomes of care, treatment and service.

The performance improvement topics established for Fiscal Year 2007 are as follows:
- Improve Access to Care
- Improve Resource Utilization
- Improve Patient Satisfaction
- Reduce Infection Rates (Ventilator Associated Pneumonias, Central line bacteremias and Urinary Tract Infections)
- Monitor Compliance with National Patient Safety Goals
- Monitor external regulatory compliance indicators

Some featured indicators are:
- Core Measures
- Restraints
- Falls
- Blood Utilization
- Pain

Evaluation of hospital performance on the above topics has concluded that certain actions are necessary to attain or sustain improvements in particular areas. These clinical outcome areas are featured below.

**Infection Control**

Proper hand hygiene is the most basic and important element of infection prevention. It is an expectation of staff at all levels.
- Hand hygiene is expected to be performed before and after patient contact, after contact with the patient's environment, before and after eating, or using the restroom.
- Sinks are found in strategic areas of the facility. Traditional hand washing should be performed before preparing food, before eating and after using the restroom and whenever hands are visibly soiled.
- Waterless hand gels can be substituted for traditional hand washing when the hands do not have visible debris on them.
- Waterless hand cleaner stations have been provided throughout the facility for easy access and frequent use.

**REDUCING SURGICAL SITE INFECTION**

Use Prophylactic Antibiotics Appropriately

"An estimated 40-60 percent of surgical site infections are preventable with appropriate use of prophylactic antibiotics. Overuse, under use, improper timing and misuse of antibiotics occurs in 25-50 percent of operations. A large number of hospitalized patients develop infections caused by Clostridium difficile and 18 percent of this type of infection in surgical patients can be attributed to inappropriate prophylaxis use alone." ([www.ihi.org](http://www.ihi.org))
- Follow hospital protocols for appropriate antibiotic use
- Give antibiotics on time (within 60 minutes of incision time) for each case
- Follow appropriate surgical site preparation protocols. Clip instead of using razors.
- Educate patients before surgery about not shaving as appropriate.
- Control post operative glucose

**REDUCE INFECTION RATE FOR VENTILATOR ASSOCIATED PNEUMONIAS**

Ventilator associated pneumonia (VAP) is an airway infection that is developed more than 48 hours after the patient is intubated. VAP is the leading cause of death among hospital acquired infections. VAP prolongs time spent on the ventilator, increases length of stay and increases the cost of patient care.

Implementing the "Ventilator Bundle" requires implementing a series of steps that when accomplished together achieve better outcomes than when implemented individually. The interventions are:
- Elevation of the head of the bed
- Daily "sedation vacation" and extubation readiness evaluation
- Peptic ulcer disease prophylaxis
- Deep venous thrombosis prophylaxis
- Frequent mouth care and suctioning

Following hospital protocols that address these issues contributes to the reduction of VAP.

**REDUCE INCIDENCE OF CENTRAL LINE BACTEREMIA**

Central venous catheters are used increasingly to provide long-term venous access. Because they disrupt skin integrity, infection is a risk associated with these lines. About 90% of the catheter-related bloodstream infections occur with central venous catheters. ([www.ihi.org](http://www.ihi.org))
The Central Line Bundle is a group of evidence-based interventions for patients with intravascular central catheters that, when implemented together result in better outcomes than when implemented individually. The intervention components are:

- Hand Hygiene
- Maximal barrier precautions upon insertion
- Chlorhexidine skin antisepsis
- Optimal catheter site selection with subclavian vein as the preferred site for non-tunneled catheters
- Daily review of the line necessity

In review, maximal barrier precautions means:

- For the operator and those assisting, strict compliance with hand washing, wearing a cap, mask, sterile gown and gloves.
- For the patient, covering the patient from head to toe with a sterile drape with a small opening for the site of insertion.

Compliance with these actions will contribute to decreasing the risk of infection.

External Regulatory Compliance Measures

CORE MEASURES

Core Measures were designed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to permit more rigorous comparisons of hospitals through using standardized, evidenced based measures. This requirement was established to improve the safety and quality of care and to support performance improvement in hospitals. The systematic collection and aggregation of data in a "like" manner on the same indicators nation-wide has provided hospitals with a body of comparative data to use to improve patient care. The results of these measures are publicly reported for accredited hospitals in several places on the World Wide Web.

The University of Toledo Medical Center began submitting data on the Acute Myocardial Infarction and Congestive Heart Failure measure sets in July 2002. These two measure sets were chosen by the Performance Improvement Council based on internal and external data, high risk, high volume, and/or problem-prone areas. In addition, these sets were selected because of the University of Toledo Medical Center’s strong commitment to cardiac care. In January 2004, at which time the JCAHO Core Measure data submission requirements expanded from two to three measure sets, the University of Toledo Medical Center began submitting data on the Pneumonia measure set. This measure was chosen based on the University of Toledo Medical Center’s desire to continue to improve the care provided to the pneumonia patient population. Starting with January 2006, a fourth Core Measure set for surgical care infection prevention was implemented as (SCIP).

The indicators monitored for the AMI core measure include:

- smoking cessation education,
- aspirin at arrival,
- aspirin at discharge,
- ACE Inhibitor or ARB at discharge for left ventricular systolic dysfunction,
- beta blocker at discharge,
- beta blocker at arrival,
- time to PCI, and
- mortality

The University of Toledo Medical Center is consistently above the 90% compliance rate for all of these indicators except for ACE Inhibitor or ARB at discharge for left ventricular systolic dysfunction. Improvements in this rate can be achieved by:

- Adhering to hospital protocols for Acute Coronary Syndrome
• Documenting rationale in the medical record when deviation from the protocol occurs (such as when a contraindication exists for the ACE or ARB at discharge)

The indicators monitored for the CHF core measure include:

• smoking cessation education,
• ACE Inhibitor or ARB at discharge for left ventricular systolic dysfunction,
• complete set of discharge instructions,
• Evidence of a left ventricular assessment.

The University of Toledo Medical Center is consistently above the 90% compliance rate for all of these indicators except for ACE Inhibitor or ARB at discharge for left ventricular systolic dysfunction and LVF assessment. Improvements in these rates can be achieved by:

• Adhering to hospital protocols for management of CHF
• Documenting findings from previous LV assessment if one will not be done during the current admission
• Documenting rationale in the medical record when deviation from the protocol occurs (such as when a contraindication exists for the ACE or ARB at discharge).

The indicators monitored for the pneumonia core measure include:

• smoking cessation education,
• oxygenation within 24 hours of arrival,
• pneumococcal screen/vaccination,
• influenza screen/vaccination,
• blood cultures prior to antibiotics,
• antibiotics within 4 hours of arrival,
• antibiotics within 8 hours of arrival,
• initial antibiotic selection for ICU patients, and
• Initial antibiotic selection for non-ICU patients.

The University of Toledo Medical Center is consistently above the 90% compliance rate on all of these indicators except pneumococcal screen/vaccination, influenza screen/vaccination, blood cultures prior to antibiotics, antibiotics within 4 hours of arrival, and antibiotics within 8 hours of arrival. In December 2005, the University Medical Center initiated standing orders for the pneumovax and influenza vaccines. It is expected that this intervention will dramatically impact results of these two measures. Improvements in the blood culture and antibiotic timing indicators can be achieved by:

• adhering to the hospital protocol for the care of patients with pneumonia and initiating the protocol in the emergency department
• obtaining blood cultures prior to administering antibiotics in the emergency department
• making sure the antibiotics are initiated within 4 hours of hospital arrival (generally this can be initiated in the emergency department).

Indicators monitored for the Surgical Care Improvement Project measures are

• % prophylactic antibiotics used within 1 hour of surgery
• Appropriate choice of antibiotic
• Discontinuing the antibiotic within 24 hours

The results to date indicate good practice with the choice of antibiotics. However, the overall administration of antibiotics within one hour prior to surgery is under 80% and discontinuing within 24 hours is only about 50%.

RESTRAINTS

The use of physical restraints for behavioral and medical reasons is monitored as a patient safety issue. While the rate of restraint utilization is at an acceptable level, the documentation associated with restraints is not always complete. To improve restraint documentation:

• Review restraint order forms for completeness each time an order is taken and/or renewed
Mark each verbal restraint order so that the order can be signed within one calendar day.

FALLS

The rate of patient falls is monitored as part of the patient safety program. The rate of falls is stable however the hospital is continuously focusing on ways to prevent injury associated with falls. Activities to achieve this objective are:

- Assess and periodically reassess each patient's risk for falling by attending to medication use, mobility, mental status, hemodynamic stability and self care needs.
- Implement actions to reduce injury of a patient at risk:
  - Tolting in advance of need
  - Dangle on bed prior to ambulating
  - Use bedside commode as an alternative to ambulating for toilet needs
  - Ambulate with assistance
  - Position near nursing station
  - Place the call light within reach

BLOOD UTILIZATION

Blood product utilization and administration is monitored to assure safe and effective handling of blood and blood products. The Type and Cross to Order ratio is 1.8%, above the 1.5% goal. An action that would improve this rate is to follow the recommendation from the blood bank on the "Maximum Surgical Blood Ordering Schedule" when ordering type and cross-match of blood. This schedule identifies a guideline for the number of units to have available for different types of surgeries.

The nursing documentation components associated with the administration of blood are monitored, such as two validation signatures, vital signs at the appropriate intervals and signed consent forms. The compliance rates for these indicators are not at desired levels. To improve these levels:

- Obtain proper patient consent prior to blood administration. Patients may need more than one consent form during each admission. Review hospital protocols to determine when a new consent is required.
- Document all elements required on the Blood Administration form, including start and finish times for blood administration and vital signs at the proper intervals.

PAIN MANAGEMENT

Pain management is a patient's right and a health care professional's responsibility. Pain is the most common reason patients seek health care.

To adequately manage a patient's pain a collaborative multidisciplinary approach is essential. The following activities will assure proper pain management:

- Assess pain using a 0-10 scale
- Assess pain on admission
- Assess pain every shift and every 4 hours for pain greater than 3, and when interventions have been taken
- Track and communicate pain levels, interventions and response to interventions on pain flow-sheets
- Partner with the patient in a pain management plan that is customized to their needs. Include pharmacological and non-pharmacological interventions.
  - Non-pharmacological interventions include positioning, warm or cold compresses, dimming lights, deep breathing, diversional activities
- Educate patients on how to manage pain. Discuss which medications to use, the side effects and limitations the medication can cause
- Provide materials for educational reinforcement.

Share information with co-workers relative to the interventions that achieve pain relief for the patient.
Performance Improvement Model and Information Sharing

The University of Toledo Medical Center uses an internally developed performance improvement model, it is Plan, Measure, Analyze, Act, and Review (PMAAR). It is felt that this model is more encouraging of analysis and more understandable to various disciplines and educational levels of hospital personnel. The PI teams utilize the PMAAR model to systematically address issues, track progress through data collection, implement actions based on areas identified for improvement, and sustain improvements through ongoing monitoring. This methodology has been effective in our performance improvement teams.

The following diagram depicts the cyclical model.

**PMAAR**

**Performance Improvement Cycle**

- **Plan**
  - Define opportunities
  - Determine what is to be accomplished
  - Identify performance indicators, how they will be obtained, how frequently they will be measured, what comparison values will be used
  - Identify responsible parties

- **Measure**
  - Collect measurement data
  - Display data over time on a "run chart"
  - Comparative data displayed simultaneously

- **Analyze**
  - Conduct quantitative analysis
    - How much – which direction?
    - How does this compare to benchmark?
    - Is the process in control or is variation excessive?
  - Conduct qualitative analysis
    - Why is this happening?
    - What are contributing factors?
    - What does the mean?

- **Act**
  - Determine an action that will impact the trend in the desired direction
  - Plan for actions to be executed appropriately
  - Communicate, initiate

- **Review**
  - Did actions produce desired results?
  - Why or why not?
  - Are additional actions necessary?
  - Is the “right” thing being measured?
  - What has been learned?
  - Continue the cycle, modify based on findings

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