2022

# Anesthesia Joint Commission Readiness Handbook

# BIDMC 2022

## TIPS FOR A JOINT COMMISSION VISIT TO BIDMC

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## About the Joint Commission

The Joint Commission (TJC) is an independent, not-for-profit group that administers voluntary accreditation programs for hospitals and other healthcare organizations. TJC is one of several organizations approved by CMS (Center for Medicaid/Medicare Services) to certify hospitals. If a hospital is certified by TJC, it is eligible to receive Medicaid and Medicare reimbursement. The Joint Commission conducts unannounced surveys on a triennial schedule (a minimum of once every 36 months) to evaluate standards compliance. BIDMC was last surveyed in March 2019 over a 5-day period.

## The Survey Process

During an accreditation survey, The Joint Commission will evaluate BIDMC's performance and process measures aimed at continuously improving patient outcomes. The Joint Commission will send a team of highly trained expert surveyors (physician, a nurse, a life safety specialist, and an administrator) who each have a specialized role in examining our processes. During the survey, they select a sampling of patients and use their medical records as a roadmap to evaluate compliance with Joint Commission standards. The Joint Commission survey will last approximately 4-5 days.

**BIDMC is Evaluated by The Joint Commission on the Following:**

- Tracing Care Delivered to Patients
- Verbal and Written information provided to The Joint Commission
- On-Site Observations and Interviews by The Joint Commission Surveyors
- Documents provided by the organization

The Joint Commission conducts the survey using an evaluation process known as the "Tracer Method". The surveyor will review a patient's record and go to each of the areas where the patient received care to interview staff and assess the environment. The surveyor might also choose a provider to follow their steps through the care process. As surveyors trace a patient's experience through a health care organization, they observe delivery of care and processes and talk to staff who are part of the care team or who have interacted with the patient. They may also speak to the patients themselves.

For example, a patient presents to the Emergency Room with a complaint of chest pain. The patient was sent to the Cath Lab and it was determined that the patient would need surgery. The patient receives the necessary surgery and then is sent on to the PACU to recover before being sent to a unit.

The patient's path would be: ED - Cath Lab - OR - PACU - Unit(s) - Discharge

The surveyor may interview other staff members who are not directly involved in the patient's care. The surveyor may also conduct a record review of any other patient's records.

In addition to Patient Tracers, each surveyor will also assess the environment in which care is provided. Please always remember to keep the environment clean and in compliance with BIDMC Standards.

Special group interviews will be conducted during the week of the survey on specific topics such as Medication Management, Infection Control, Data Use, Competencies, Credentialing and Privileging. Those who are to participate in these meetings will be notified and briefed.

## Survey Etiquette

Review BIDMC's Code of Conduct and be prepared to discuss how you support these standards

**Tips for Surveyor Interaction:**

- Wear your ID Badge at **ALL** times with your **picture visible** and at **eye level**
- Be polite and patient with surveyor questions. Stay calm, they want you to do well! Questions are intended to help surveyors understand our practices. This is our chance to share and show the high-quality care that we give.
- Answer ONLY the questions that you are asked. Do not volunteer unrelated information.
- It is fine to ask to repeat or rephrase a question
- Be honest. If you don't know the answer to a question, instead of saying "I don't know", tell them where/how you would find the information. Don't guess if you don't know. Instead, respond with "I would ask my supervisor," (e.g. Service Chief)
- Have a positive attitude and avoid being defensive.
- Patient care comes first. If you need to leave a surveyor to check on a patient, be polite and offer to meet with the surveyor again as soon as possible.

## National Patient Safety Goals

Every year, the Joint Commission collects information and patient safety issues from recognized experts and stakeholders in the field. This information serves as the foundation for the National Patient Safety Goals program and helps to inform the processes, sentinel event alerts, standards and performance measures that drive the work of the Joint Commission Center for Transforming Health Care.

*BIDMC has adopted the National Patient Safety Goals into our everyday policies, procedures, & protocols. Refer to the updated card on your ID Badge.*

**What are the National Patient Safety Goals (NSPG) Effective 2022 for the Hospital Program?**

### i. Improve the Accuracy of Patient Identification

- ✓ Use two patient identifiers (CP-21 Patient Identification)
- ✓ Include the patient in the identification process

### ii. Improve Communication Among Caregivers

- ✓ Report critical results of tests and diagnostic procedures on a timely basis
- ✓ Write it down and read it back for critical information (CP-25 Oral Communication of Critical Test Results)
- ✓ Give/receive pertinent information at handoff

### iii. Improve Medication Safety

- ✓ Label all medications, solutions, and containers (e.g. syringes, medicine, cups, basins)- (CP-32 Med Labeling)
- ✓ Follow Safe Syringe Practice: One Needle, One Syringe, Only One Time (04-07-01 Multiple & Single Dose Vials)
- ✓ Anticoagulant safety (Anticoagulant & Antiplatelet Therapy Manual)
- ✓ Reconcile medications (CP-36 Med Reconciliation)
- ✓ Store medications securely (03-07-07 Medication Storage)

## Some Basic Rules for Medication Handling

**DO THIS**

- Draw up only those medications you intend to use
- Label medications that are preloaded for case or are partially administered and placed on Omnicell surface
- Exception is medications that are drawn up, immediately administered to patient and disposed.
    - Also use the label maker since it has audible feedback on the medication being scanned
- Label multidose vials with use-by date when first opened (28 days from day of opening)
    - Use the "Use By" sticky labels on the block Omnicells

**CLEAN UP**

- Dispose all medications from previous case into the sharps bin before starting a new case
- Dispose opened multidose vials that are sitting around without any labels
- Dispose any syringe seen in a patient care/public access space into the sharps bin

**REVIEW YOUR CURRENT MEDICATION HANDLING WORKFLOW**

- NEVER draw up medications for multiple cases off one patient account
- NEVER keep unlabeled syringes on surfaces or in the omnicell drawer
- NEVER split a single dose vial for multiple patient use
- NEVER walk around with syringes in your pockets for "just in case" scenarios
- NEVER leave medications in Preop holding area/PACU/public access areas

## iv. Improve the Safety of Clinical Alarm Systems

Clinical alarms are intended to alert caregivers of potential patient problems, but if they are not managed properly, they can compromise patient safety. Sometimes alarms are difficult to detect and other times there are too many signals resulting in high levels of noise that may cause staff to miss, ignore or even disable them. Standardization is important for alarm safety but solutions may have to be customized by unit, patient group or individual.

- ✓ Review EOC-34 Managing Clinical Alarms
- ✓ Recognize and differentiate the various types of clinical alarms within your clinical setting
- ✓ Respond to alarms which you are responsible for in a timely manner in accordance with hospital policy

## v. Prevent the Transmission of Infection

- ✓ Clean your hands before AND after all patient and environmental contacts
- ✓ Use Standard Precautions for ALL patient encounters
- ✓ Always wear an N95 respirator or PAPR when entering an Airborne Precautions room
- ✓ Assess your patients' need for vascular and urinary catheters regularly
- ✓ Disinfect all patient care equipment (e.g. stethoscope) before AND after each use

## Anesthesia Equipment Disinfection

### *Low level disinfection*

- This includes laryngoscope handles and ultrasound probes

**Wipes Rules:**

1. Oxivir (Hydrogen peroxide based, **1 minute contact time**) our primary wipe used for most surfaces, equipment and items.

2. PDI Super Sani Cloths (**Purple Tops** – Alcohol based, **2 minute contact time**) for all Laryngoscopes (handles, McGraths, Glidescope handles; pre-cleaning of Storz re-usable blades)

3. PDI AF-3 (**Gray Tops** – Alcohol free quaternary ammonium **3 Minute contact time**) for all Ultrasound. Any other wipe can destroy the VERY expensive US probes.

### *High level disinfection*

- High Level Disinfection is required for items the placed intra-cavity
- This includes laryngoscope blades, flexible fiberoptic bronchoscopes (FOB) and TEE probes

**Process:**

- ✓ Place the used laryngoscope blade in the basin for processing at case-end by tech
- ✓ Call the anesthesia tech when using the FOB or TEE and leave a patient label on the cart to audit the patient contact history
- ✓ Techs will handle the immediate disinfection process as per code
- ✓ Only Techs who are trained and signed off as internally certified can perform this function

## vi. Identify Safety Risks for Patients

✓ Assess & document risks for suicide, falls, pressure ulcers

## vii. Use the Universal Protocol on Wrong Side/Site Invasive Procedures

- ✓ The Joint Commission requires us to participate in using the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery.
- ✓ Review PSM 100-105 Universal Protocol in Perioperative Environment and CP-33 Universal Protocol Outside of OR
  - Conduct pre-procedure verification process: Confirm Patient/Procedure/Site/Side/Equipment/ Supplies/Documentation
- ✓ Mark procedure site
- ✓ Complete pre-procedure "time-out". During this time, the team members all agree at a minimum on the following: correct patient, correct site, correct procedure to be done.

### Time-Out

The purpose of the time-out is to conduct a final assessment that the correct patient, site and procedure are identified. This is the minimum requirements of the time. Some believe that is important to conduct the time-out before anesthesia for several reasons, including involvement of the patient. A hospital may conduct the

time-out before anesthesia or may add another time-out at that time. It must be conducted immediately before starting the invasive procedure or making the incision. If there is more than one procedure being done, a time-out should be done before each procedure is initiated. **Expect that they will want to audit a surgical time-out**. **They will also likely audit the conduct of a pre-regional anesthesia time-out. This includes spinal anesthesia in the OR**.

## Projects & Initiatives to Address the National Patient Safety Goals

| ***National Patient Safety Goal*** | **Initiatives to Address Goal** |
|---|---|
| *Improve the accuracy of patient identification* | ▪ Time Out |
| *Improve Communication Among Caregivers* | ▪ Neuroanesthesia Handoff Project<br>▪ Intraop Pause Project |
| *Improve Medication Safety* | ▪ Regional team working hard to dispose of syringes in patient care/public access spaces<br>▪ Talis medication reconciliation process helps streamline wasting and identify diversion<br>▪ Use of codonics labels to allow for barcode scanning and import of drug info into Talis<br>▪ Interface between Talis and Omnicell helps ensure proper drugs administered are documented in record |
| *Improve the Safety of Clinical Alarm Systems* | ▪ Managing alerts within Talis<br>▪ Alerts developed for possible awareness under anesthesia and missing BP for > 10 mins |
| *Prevent the Transmission of Infection* | ▪ Scope Tracking for techs to manage cleaning of scopes |
| *Identify Safety Risks for Patients* | ▪ Addition of Code Stroke attestation in emergency procedure(s) |
| *Right Site/Right Side* | ▪ Time Out |

## Patient Rights and Responsibilities: Advance Directives, Health Care Proxy, DNAR

- BIDMC is committed to providing dignity & respect to all of our patients and to uphold patients' rights
- Per PR-04 Patients' Rights, inform patient/surrogate of:
    - his/her right to participate in decisions about his/her own medical treatment and to consent or to refuse treatment (PR-02 Informed Consent & Decision Making)
    - the prognosis and its implications
    - the choices available to the patient
    - the roles & identity of his/her care team
    - right to receive or restrict visitors
- Interpreters approved by BIDMC are available via person, phone, or video for LEP, Deaf, Deaf-Blind, & Hard of Hearing patients (PR-17 Interpreter Services)
- **Health Care Proxy:** Asked at admission by Nursing. Physicians should confirm & review with patient
- Decision to limit, withhold or terminate life-sustaining treatment must be discussed directly with the patient or with the patient's surrogate decision-maker if the patient is not capable of making the required decision
    - Review PR-18 Advance Directives

- Review PR-05 Withholding, Withdrawing or Limiting Life- Sustaining Treatment, Including Resuscitation
- Review CG-23 Guidelines for the use of the MOLST form

## Interdisciplinary Care Plan

- Review MS-18 Patient Acceptance, Initial Assessment, & Care Planning
- Priorities for care are individualized care plans based upon iterative assessments by the care team and the patient goals. Document in the patient record
- Document progress with care goals /discuss with team at patient rounds

**All Staff Will Need to Demonstrate**:

- how the multidisciplinary team coordinates care
- how care and treatment decisions are communicated among the team – including patient and family

## Organ and Tissue Donation

- Review PR-09 Organ & Tissue Donation
- Contact **New England Donor Services (NEDS)** 24-hour line to report impending brain deaths & withdrawals of support in ventilator-dependent patients
- All deaths must be reported by the declaring physician to Admitting (x4-2210) **≤ 30 minutes** of declaration
- **NEDS initiates conversation with the family, NOT BIDMC**
- In collaboration with BIDMC staff, NEDS screens each referral (via onsite or phone) for medical suitability for tissue, organ, and eye donation

## Patient Assessment & Documentation Requirements

- Per MS-18, Patient Acceptance, Initial Assessment & Care Planning, initial assessment of each patient's physical and psychological status must be documented to determine the patient's need for care, type of care to be provided, and need for further assessment
- Refer to your department, service, and clinic for specific requirements for additional patient assessment and reassessment policies and procedures
- **Pain** must be assessed upon admission and after every intervention. It must include onset, location, intensity, duration, and pain management
- **History/Physical:** The H&P must occur within 24 hours of admission, prior to surgery, and before anesthesia. Ambulatory surgery requires H&P ≤ 30 days with an update at the time of the procedure.
- As per MS-21 Documentation Requirements of Medical History and Physical Exam Prior to a Procedure, the H&P includes, but is not limited to:
  - Chief complaint and details of presenting illness
  - Past medical and surgical history
  - Current medications, allergies to meds/foods, ADRs
  - Social and family history
  - Any advance directives/DNAR/HCP/MOLST
  - Physical Exam specific to illness/condition and evaluation of body systems including heart, lungs, pain
  - Summary of history, examination and diagnostic data
  - Plan of care for the patient
  - A note of review and authentication by attending MD

- **Re-assessment** is mandatory for patient transfers to/from a special care unit, post-operatively, and times of significant change in a patient's condition.

## Pre-Anesthesia Evaluation

Per the CMS conditions of participation and the Joint Commission regulations, several key elements of the pre-anesthesia evaluation need to be completed AND DOCUMENTED within 48 hours before the injection of the medication intended to produce surgical anesthesia. The specified elements need to be PERFORMED/REVIEWED and DOCUMENTED by an anesthesia attending or CRNA or resident.

**Elements that must be performed within the 48-hour timeframe:**

- ✓ Review of the medical history, including anesthesia, drug and allergy history
- ✓ Interview if possible, given the patient's condition, and examination of the patient

**Elements that must be reviewed and updated as necessary within 48 hours, but which may also have been performed during or within 30 days prior to the 48-hour time period:**

- ✓ Notation of anesthesia risk according to established standards of practice (e.g., ASA classification of risk)
- ✓ Identification of potential anesthesia problems (e.g., assessment of difficult airway, ongoing infection, limited intravascular access)
- ✓ Documentation of review of additional pre-anesthesia data or information if applicable (e.g., stress tests, additional specialist consultation)
- ✓ Documentation of patient's anesthesia plan and consent

***Joint Commission Survey Procedures §482.52(b)(1)***

- *Review a sample of inpatient and outpatient medical records for patients who had surgery or a procedure requiring administration of anesthesia*
  - o *This may include "live" auditing of the pre-anesthesia evaluation in holding*
- *Determine whether each patient had a pre-anesthesia evaluation by a practitioner qualified to administer anesthesia*
- *Determine whether each patient's pre-anesthesia evaluation included at least the elements described above*
- *Determine that the pre-anesthesia evaluation was updated, completed and documented within 48 hours prior to the delivery of the first dose of medication(s) given for the purpose of inducing anesthesia for the surgery or a procedure requiring anesthesia services*

## Post-Anesthesia Evaluation

A post-anesthesia evaluation must be completed and documented no later than 48 hours after surgery or a procedure requiring anesthesia services. The calculation of the 48-hour timeframe begins at "D-time".

Elements of the evaluation must include:

- ✓ Respiratory function, including respiratory rate, airway patency, and oxygen saturation
- ✓ Cardiovascular function, including pulse rate and blood pressure
- ✓ Mental status
- ✓ Temperature
- ✓ Pain
- ✓ Nausea and vomiting
- ✓ Postoperative hydration

- The post-anesthesia evaluation must be completed and documented by any practitioner who is qualified to administer anesthesia. This need not be the same practitioner who administered the anesthesia. It requires patient participation in the evaluation.

- For patients transferred to ICU, and are unable to participate in the post-anesthesia evaluation (e.g., postoperative sedation, mechanical ventilation, etc.), a post-anesthesia evaluation should be completed and documented within 48 hours with notation that the patient was unable to participate and reason

- For patients who are given long-acting regional anesthesia that is expected to last beyond the 48-hour timeframe:
  - Post-anesthesia evaluation must still be documented within 48 hours.
  - However, there should be a notation that the patient is otherwise able to participate in the evaluation, but full recovery from regional anesthesia has not occurred and is not expected within the stipulated timeframe for the completion of the evaluation.

***Joint Commission Survey Procedures §482.52(b)(3)***
*• Review a sample of medical records for patients who had surgery or a procedure requiring general, regional or monitored anesthesia to determine whether a post- anesthesia evaluation was documented*
*• Determine whether the evaluation was conducted by a practitioner who is qualified to administer anesthesia*
*• Determine whether the evaluation was completed and documented within 48 hours after the surgery or procedure*
*• Determine whether the appropriate elements of a post-anesthesia evaluation are documented in the medical record*

## Medical Record Documentation

- All documentation must be **signed**, **dated**, & **timed**
- Avoid prohibited abbreviations, acronyms & symbols on the Prohibited Abbreviations list.
- Document pre-procedure assessment and informed consent prior to any invasive procedure, including anesthesia
- Consents must be **signed**, **dated**, & **timed**, by the treating provider **AND** by the patient or his/her representative
- Write a brief operative note immediately after surgery (MS-27 Brief & Final OR Note)
- Complete full operate report within 48 hours of surgery
- Complete and sign patient notes ASAP after each clinical encounter, but no later than:
  - **7 calendar days from the date of service** for ambulatory notes (ADM-24A Medical Records Ambulatory)
  - the same calendar day of service for inpatient notes (ADM-24B Medical Records Inpatient)

## Information Security and Privacy

- Review Keep Information Private on portal
- **NEVER** share passwords or give someone access to a website using your password or login information
- Secure **ALL** mobile devices (laptops, smartphones, tablets, etc.) that access BIDMC/BIDMC-related email or other systems. Use password protection and encrypt devices.
- Log out of all clinical systems when finished. If using a web application, be sure to close browser
- Never discuss patient information in elevators, public areas, or on social networking sites

- Do not transport patient information unless necessary with no alternative option to access. Secure while travelling. Never leave patient information unattended in public areas or your vehicle
- Dispose of patient or personal information by placing it in designated locked bins or Shred-it secure containers
- **DO NOT** access a medical record unless it is required as part of your legitimate job function. Only access the information that is necessary for you to complete your job
- In the event that information ends up in the wrong hands:
  - *Tell your manager or leader, or*
  - *Contact your Integrity and Compliance staff directly.*
  - *You can also report through the BILH Speak Up Hotline at 888-753-6533, or at bilh.ethicspoint.com.*

## Policies, SOPs, Guidelines, IFUs

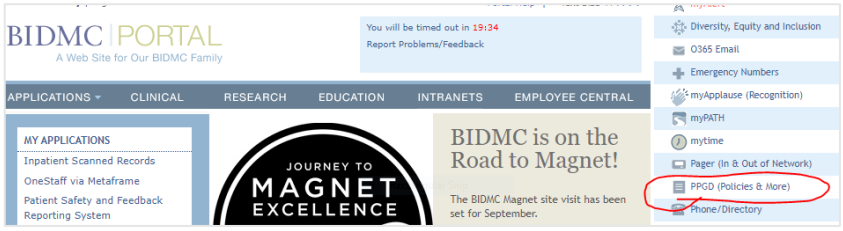
The classification is based on the following definitions:

1. **Policy:** Mandatory, meaning violations are to be identified and corrective action taken
   - Some policies are mandated by TJC, other regulatory bodies or hospital, outside of our department
   - In general, a lot of SOPs are erroneously classified as policy
2. **SOP**: Standard Operating Procedure
   - Refers to documents that detail the steps of how to perform a standard task
   - Standard refers to the local SOC we expect to see in every relevant patient episode
3. **Guideline**: Guiding principles, non-mandatory recommendations

### Accessing the documentation:

Policies, SOPS and guidelines are located either on the PPGD page of the BIDMC portal for hospital documents, or the landing page of the Anesthesia Intranet.

PPGD site: https://bilh.ellucid.com/




Anesthesia Intranet: https://anesthesia.bidmc.harvard.edu/Policies/Admin_Policies.aspx

- There are 5 tabs for primary areas of Policies, SOPs and Guidelines
  - Administrative, Education, Clinical, HMFP, and Hospital PPGD (documents point to BIDMC PPGD site)
- Some tabs have additional sub-headings
  - Documents are organized below each under their main classification type
- Check out the **search tab functionality** to get to your needed documents ASAP

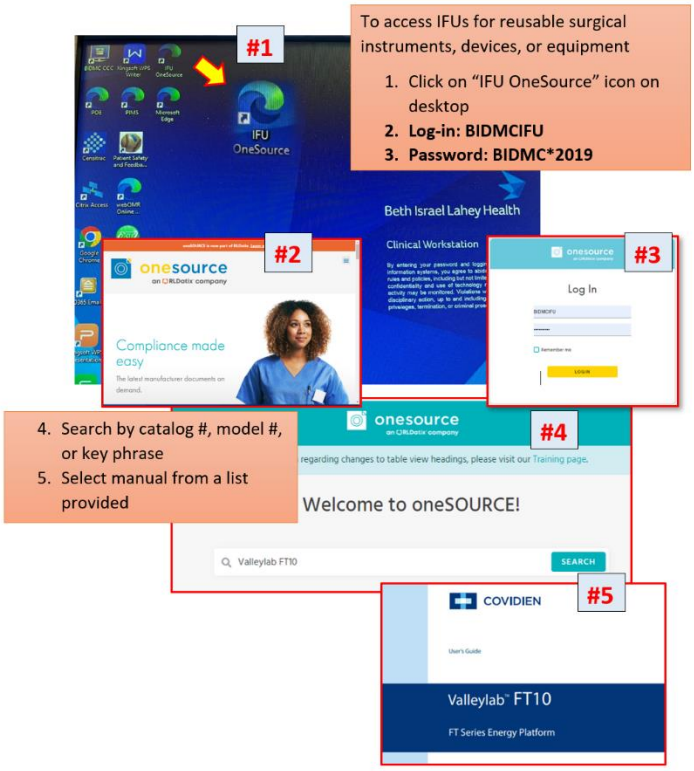
Medical Direction Policy: This policy dictates the staffing and scheduling requirements for the compliant anesthesia care team model

### Material Data Safety Sheets (MSDS)

Another frequent review question involves the use of MSDS
material safety data sheets and how to look up a material to see if it's hazardous, how to handle and store it, etc. You can go to the BIDMC portal and type MSDS into the search bar to get to MSDSOnline.

### Instructions for Use (IFU)

A surveyor may ask you how to access information about
operating equipment or caring for instruments AKA **Instructions for Use** (IFU). OneSource is an on-line database that you can access at onesourcedocs.com or through a shortcut on the desktop of all Clinical Workstations.




## Pain Management

Patients are screened using most appropriate scale (e.g., numeric scale, Wong-Baker scale, FLACC, PAINAD)

- Involve patients in decisions about managing their pain
- Review pain scores with care team and adjust medication orders as appropriate

## Emergency Response/Disaster Readiness

- Check **Life Safety Squares** and postings for evacuation map, Emergency Response Quick Reference Flipchart, and yellow power fail phone.
- Critical info regarding emergency events is available on the **Red Line** banner on the portal homepage, via **email**, **myAlert** or the **Event Update Line** at 617-632-0009

## Restraints

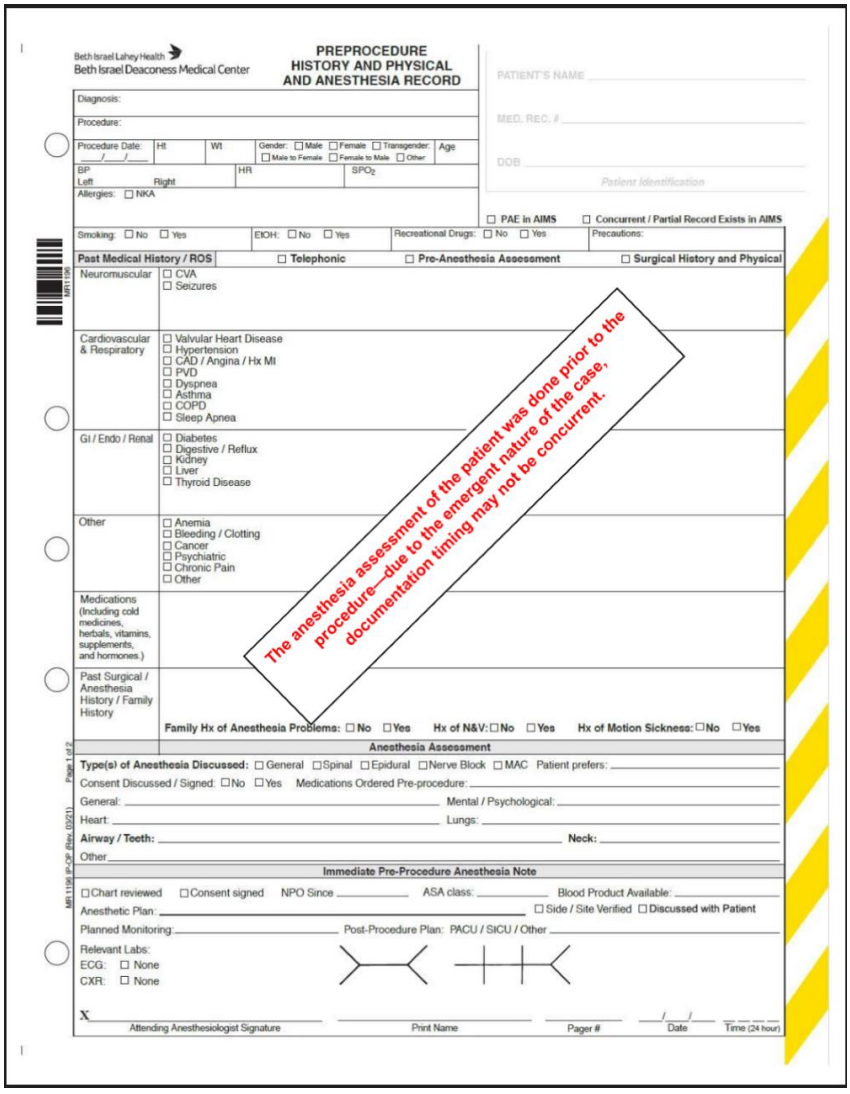
- Review CP-28 Use of Restraints or Seclusion
- **Limit the use of restraints to clinically, justified situations, only after preventative or alternative strategies have failed or are not appropriate**
- Requires **Immediate** MD order with time limits and indications for use which puts the patient at risk
  - *(Order limits: violent = 4 hrs., non-violent = 24 hrs.*)
- MD/LIP must assess the patient **in-person in a timely manner:** *(Violent = within 1 hr of initial order; Non-violent = within 24 hrs of initial order)*
- Documentation of the in-person evaluation is required, which includes:
  - evaluation of the patient's immediate situation
  - reaction to the intervention
  - medical/behavioral condition
  - need to continue/terminate the intervention
- A Face-to-Face Re-evaluation is required prior to re-ordering beyond 24 hours; Re-evaluations must be documented in progress notes

## Moderate Sedation

- Only medications and doses in the CP-03: Moderate Sedation are permitted
- Any team member can request an Anesthesia consult at any time, at which point the Anesthesiologist will make a decision regarding the patient's appropriateness for moderate sedation
- Physicians must have privileges to perform moderate sedation and for the procedure itself. Appropriate lifesaving response is required & achieved via BLS, ACLS.
- **Requires TWO (2) LIPs**: credentialed MD doing the procedure & credentialed monitor (RN, PA, NP, MD)
- Recredentialing is required every 2 years
- Privileges are documented in credentials files with training records
- Pre-assessment can be delegated to mid-level (PA, NP) but must be reviewed and signed off before moderate sedation begins
- An **immediate pre-procedure assessment** (vital signs, etc.) must occur prior to administration of any moderate sedation medication

## Code Stroke

In a previous Joint Commission visit, it was discovered that there were cases where there was no documentation of an airway assessment by Anesthesia prior to thrombectomy. After the survey, we were required to implement an action plan to improve the areas cited by TJC. Due to the emergent nature of the thrombectomy cases, the documentation of the pre-procedure assessment done by Anesthesia may not be concurrent with the timing of the actual assessment. Therefore, a one-line attestation should be documented by the Anesthesia provider to state this.




This can be done by one of two ways:

1. Sign and date the paper form seen to the right which is available in the INR suite in the baskets by the nurses' desk.

2. Indicate that the case is being done as an emergency case in Talis and add the following text to the "other" section on the last page of the PAE: *"The anesthesia assessment of the patient was done prior to the procedure—due to the emergent nature of the case, documentation timing may not be concurrent."*

## Professional Practice Evaluation at BIDMC

One area of focus for the Joint Commission regards how BIDMC evaluates members of the medical staff. In 2021, we revised our policy, MS-30 Medical Staff Professional Practice Evaluation to clarify our processes for clinician review. The new policy also led to changes to the Medical Staff Bylaws which was adopted in November 2021. Advanced Practice Providers were added to the Medical Staff, in 2021, and we continue to develop processes for their review, as well. The Joint Commission surveyors might ask how you are evaluated and you should be aware of the terms below:

Initial Professional Practice Evaluation (IPPE)***:** Every medical staff member requesting new clinical privileges at BIDMC is evaluated using measures developed by and specific for clinicians in their department relevant to the privileges related to the appointment (generally 6 months after being granted the privileges either existing or new member).

Ongoing Professional Practice Evaluation (OPPE)***:** Every medical staff member holding clinical privileges at BIDMC is evaluated on a regular basis (every 8 months) using measures developed by and specific for clinicians in their department.

Focused Professional Practice Evaluation (FPPE)*****: If during the course of a medical staff member's appointment a determination is made that a clinician did not perform according to the set standard including during the IPPE and OPPE processes, this clinician enters an FPPE process. FPPEs consist of an evaluation of the clinician's performance within the department and a follow up with appropriate interventions.

*Professional Practice Evaluation (PPE) information for the IPPE, OPPE and FPPE may include, but is not limited to, medical record review, monitoring clinical practice patterns and outcomes data, simulation, proctoring, internal and external peer review, multisource feedback data and discussion with other individuals involved in the care of each patient (i.e. consulting physicians, assistants, nursing, or administrative personnel), and other criteria defined in the departmental plan.

## Preparing for a Joint Commission Visit in Ambulatory Units

### Staff Preparation

Notify all staff, including physicians, that Joint Commission has arrived and remind them:

- ☐ All staff should wear ID badges above the waist
- ☐ Staff should wear PPE appropriate for role/setting
- ☐ No food or drink in patient care areas
- ☐ Log out of computers when not using
- ☐ Know how to get someone out of a locked **patient** bathroom and how to respond if the pull cord is engaged in the patient bathroom (what it sounds like, what to do)
- ☐ If they don't know the answer to a question, state "I don't know, let me find out"
- ☐ Patient care should not be interrupted – have a plan
- ☐ Fingernails must be in compliance; no gels, fingernails not visible over fingertips when looking at palms

They should be ready to speak to:

- ☐ fire safety (RACE, PASS, Evacuation Plan, location of fire extinguishers/pull stations)
- ☐ next nearest code cart

- ☐ how to call a code
- ☐ the correct process for managing emergencies in the unit
- ☐ low level disinfection/wet time according to IFUs
- ☐ high level disinfection (recommend staff role play if asked by surveyor/act it out)
- ☐ cleaning medical equipment before and after use
- ☐ how they were trained and deemed competent
- ☐ who can shut off medical gases
- ☐ proper disposal of PHI (in gray bins)
- ☐ IFUs for equipment and supplies (and be able to locate if needed)
- ☐ a performance improvement project

## Manager Preparation

- ☐ Know how to locate a policy or guideline quickly
- ☐ Be able to produce documentation of staff competencies, or know who to refer to who can produce them
- ☐ Be able to produce documentation of staff requirements, like fit testing, vaccine compliance, and more
- ☐ Be able to produce updated MSDS
- ☐ Be able to articulate process for regularly reviewing and updating forms, consents, and patient materials
- ☐ Ensure process in place for tracking equipment that was sent out for repairs and that all equipment is in good working order (upholstery is intact)

## Documentation

- ☐ Review patient appointment schedule for unit and prepare a chart to be reviewed. If applicable, should be a patient who had a procedure recently
- ☐ Determine which provider will be called upon for document review

## Entering the Unit

- ☐ Corridors are clear and unobstructed
- ☐ There is nothing stored in stairwells
- ☐ Signage is clear, professional, well organized, laminated and there is not too much of it (use your judgment)
- ☐ There are no posters on tripod easels

## Walking Through the Unit

- ☐ Ceiling tiles are not stained – contact Service Response if needed
- ☐ Escutcheon plates are flush to ceiling/no gaps – contact Service Response if needed
- ☐ Walls are free of holes, chipped paint, missing/cracked electrical covers
- ☐ Area is clean and free of dust
- ☐ Doors are not wedged open and latch properly – contact Service Response if needed for latches
- ☐ There are no wires or cords that present trip hazards
- ☐ No storage under or around sinks – check splash radius if needed
- ☐ Patient information is not visible/accessible
- ☐ Linen (including pillows) is covered and not in open areas

  Pull cords in **patient** bathrooms
  - ☐ Are not wrapped around the grab bar

- ☐ Are 4” from the floor (use splash guard on wall as guidance). If too short, contact Clinical Engineering.

☐ There are no tripods, wires or cords that present trip hazards
☐ Cal Stat on walls is not empty and is not expired
☐ Evacuation plan(s) or Life Safety Plan(s) are posted and updated
Emergency equipment is unobstructed, including the following:
- ☐ fire pull stations
- ☐ fire extinguishers
- ☐ gas shut off areas if present
- ☐ code carts
- ☐ eyewash stations

### Code Cart

- ☐ Appropriate overhead signage in place
- ☐ Supplies, including ambu bag and defibrillator pads, are not expired
- ☐ Defibrillator light is green
- ☐ Defibrillator time is accurate
- ☐ Oxygen tank is at least ½ full
- ☐ Log is readily available with only most recent logs
- ☐ Log is appropriately filled out (daily, weekly and monthly checks – ensure code card was opened on weekly checks, i.e. lock number should change weekly)
- ☐ Lock ID number matches what is recorded in log for most recent check

☐ Clinical equipment is tagged with bar code and PM sticker OR “no maintenance required” sticker
☐ All fire extinguishers are checked monthly and have been serviced within 1 year
☐ O2 gas cylinders are secured in rack/bracket and labeled full/empty appropriately. All “full”, i.e. never used oxygen tanks, have a cap over the nipple
☐ Glucometers - check all solutions/strip bottles for dates opened and dates of expiration

## Blood Drawing Station/Area

☐ Tubes are not expired
☐ Area is clean and well organized
☐ PPE is available in adequate supply (gloves in 3 sizes)
☐ Lab logs are complete
☐ Patient specimens are labelled and stored appropriately
☐ No storage under or around the sink

## Exam Rooms

☐ Hand Hygiene supplies available (Calstat within expiration, soap, paper towels)
☐ Needles, syringes and medications are stored in secured location. Secured means locked or under constant staff supervision
☐ Supplies are labeled with date opened (if applicable)
☐ Supplies are labeled with expiration date
☐ Supplies are not expired
☐ PPE readily available and well stocked (gloves in 3 sizes, masks & other required PPE present)
☐ Antimicrobial wipes have a closed top to prevent wipes from drying out

- ☐ Patient information is not up on computer screens; no PHI visible
- ☐ Biohazard bags are used appropriately – only biohazard material stored inside
- ☐ Sharps container, if present, is not more than 1/3 full (per Policy NPM 400-1)
- ☐ Nothing stored under or around the sink

## Clean/Dirty Utility Rooms

- ☐ No storage on floor or 18" from bottom of sprinkler head
- ☐ Door is closed
- ☐ Supplies are labeled with date opened (if applicable)
- ☐ Supplies are labeled with expiration date
- ☐ No expired supplies
- ☐ Dirty room is free of clean equipment and supplies
- ☐ Be sure instruments inside dirty CPD instrument collection bin are visibly wet. Ensure use of enzymatic spray
- ☐ Single use disposable instruments are disposed of after single use
- ☐ Biohazard bags are used appropriately – only biohazard material stored inside

## Supply Closet

- ☐ Supply closet is locked
- ☐ Supplies are well organized
- ☐ Supplies are stored at least 18" from bottom of sprinkler head
- ☐ There is no corrugated cardboard
- ☐ There are no supplies on the floor
- ☐ Bottom shelf is lined with impermeable liner if wire rack
- ☐ Linen is covered and not in open areas
- ☐ Supplies are in stock
- ☐ Supplies are labeled with date opened (if applicable)
- ☐ Supplies are labeled with expiration date
- ☐ Supplies are not expired
- ☐ Sterile supplies are not wrapped in rubber bands (can compromise peel packs)
- ☐ Sterile supplies are not opened
- ☐ Biohazard bags are used appropriately – only biohazard material stored inside
- ☐ There is a process in place/documentation is present for tracking supply expiration dates

## Medication Room

- ☐ Medication room is locked
- ☐ Medications are well organized
- ☐ There is nothing on the floor
- ☐ Needles and syringes are in secured location. Secured means locked or under constant staff supervision.
- ☐ 28-day expiration date calendar posted
- ☐ PINCH list is on display
- ☐ LASA is on display with meds used in area highlighted
- ☐ There are no open single-use products
- ☐ Opened multi-dose vials are dated with expiration date

- ☐ Opened multi-dose vials are dated with appropriate “use by” date (manufacturer date or 28 day expiration, whichever comes first)
- ☐ IV tubing is dated and timed, IV bags have patient label, no pre-spiked IV bags are present

## Medication Refrigerator

- ☐ Signage present indicating refrigerator is a medication fridge
- ☐ Thermometer is set at 2-8 C or 36-46 F
- ☐ Thermometer alarm is on
- ☐ Thermometer calibration date is not expired
- ☐ Log book is present and is up to date with daily checks
- ☐ Refrigerator is clean
- ☐ Nothing stored in refrigerator door if applicable
- ☐ There are no expired medications
- ☐ Only medications are stored in this refrigerator
- ☐ 28 day expiration calendar posted nearby
- ☐ Opened multi-dose vials are dated and labeled with correct expiration date (manufacturer or 28 days, whichever comes 1st)
- ☐ Opened single use vials are discarded, including hydrogen peroxide 3% and isopropyl alcohol 70%
- ☐ Reagents are stored in a separate refrigerator from medications

## Patient Food Refrigerator (if applicable)

- ☐ There is no log but sign indicating no dairy (if applicable)
- ☐ If no sign, check for food that expires
- ☐ If food that expires, check for temperature log and whether it is up to date
- ☐ Refrigerator is clean and organized

## Eye Wash Stations

- ☐ Appropriate signage present
- ☐ Caps are on
- ☐ Nothing is blocking access
- ☐ Water temperature is not extremely cold or extremely hot (so that someone can reasonably irrigate for 15 minutes)- call Service Response if needed
- ☐ Weekly log is readily available and up to date with only recent log sheets (older sheets should be stored elsewhere, recommend manager office)
- ☐ Policy EC-73 readily available in log book

## EKG Machines

- ☐ Plugged in when not in use
- ☐ Open electrode packets are closed appropriately (folded from top) and dated with open date

## Blanket Warmers (if applicable)

- ☐ Temperature set appropriately
- ☐ Sticker on the blanket warmer unit indicating max temperature
- ☐ Log readily available with only recent log sheet (older sheets should be stored elsewhere, recommend manager office)

## Possible questions you may be asked:

1. **How do you know you are using a product or equipment properly?**

   An appropriate answer would be that you were trained to use it by an in-service and/or preceptor and you have access to written instructions.

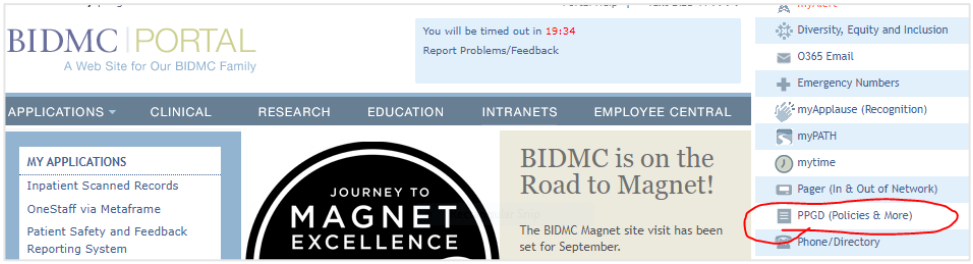
2. **What is the acronym IFU?**

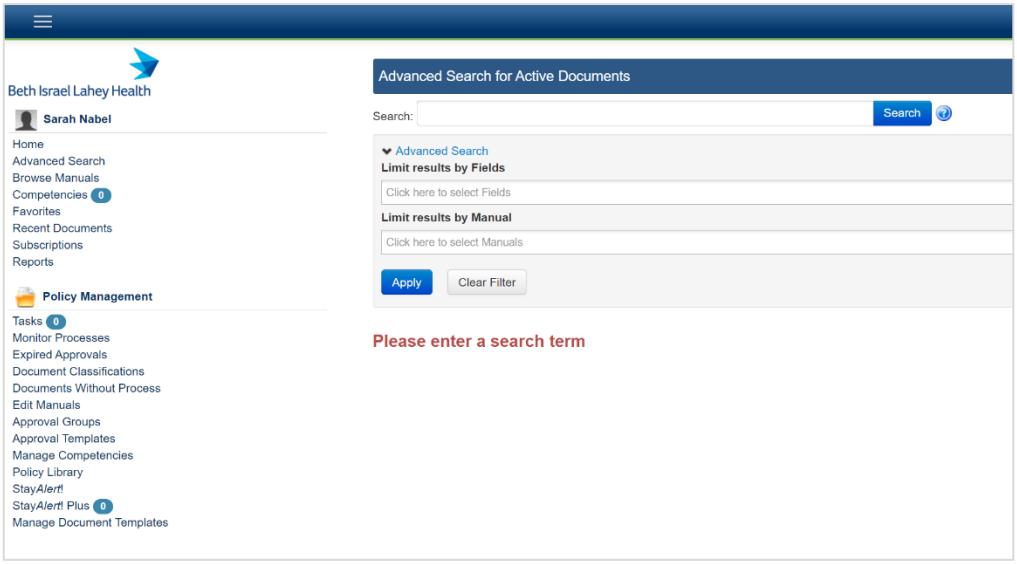
   It stands for Instructions for Use. Please see the Policies, SOPs, Guidelines, FIUs section of this document which gives instructions on how to access the IFUs for products and equipment in the medical center. There should be a copy of this teach-back in every OR near or attached to the nursing work station.

3. **How do you know what the periop policy is for counts or handling specimens or proper OR attire etc?**

   Go to the BIDMC Portal home page and look for PPGD in the upper right corner. Click on it to access the choice of BIDMC or BIDMC Needham. Please choose the first one and choose advanced search. Type some key words into the search bar.

   https://bilh.ellucid.com/




**REMEMBER:**

- Answer ONLY the questions that you are asked. Do not volunteer unrelated information.
- It is fine to ask to repeat or rephrase a question
- Be honest. If you don't know the answer to a question, instead of saying "I don't know", tell them where/how you would find the information. Don't guess if you don't know. Instead, respond with "I would ask my supervisor," (e.g. Service Chief)