AUGUSTA MENTAL HEALTH INSTITUTE
AUGUSTA, MAINE

DATES OF SURVEY
DECEMBER 1-2, 1988

SURVEYORS
RAYMOND F. PATTERSON, MD
LEROY B. LAMM, MD
GEORGE B. LITTLE, JR,FACHE
PATRICIA ANN HASSEL, RN,CNA
JOAN M. GANNON, RN

ACCREDITATION DECISION: Your organization has been awarded accreditation for three years from the day following the last day of survey noted above, contingent upon compliance with the recommendations in this report preceded by the symbol (C).

CONTINGENCY: A focused survey will be scheduled within approximately six (6) months from the date of the attached letter, October 6, 1989. This visit will be conducted by a physician surveyor for two (2) days and will address only the recommendations on the following pages in the Accreditation Program for Psychiatric Facilities section preceded by the symbol (C) and relating t the following topics:

1. Direction and Staffing of Clinical Services/Departments

2. Assessment

3. Treatment Planning Process

4. Patient Rights

PRA

The written progress report for Life Safety should be in the form of a plan of correction and should include:

a. The deficiencies addressed by the plan;

b. Actions being taken to correct the deficiencies;

c. The source and availability of funding for the plan of correction; and

d. A schedule of correction.

Your organization will be notified of the date of this focused survey visit.

CONTINGENCY: A written progress report will be required within approximately three (3) months from the date of the attached letter, October 6, 1989. This report should address only the recommendations on the following pages in the Hospital Accreditation Program section preceded by the symbol (C) and relating to the following topics:

1. Medical Staff Organization (MS.3.9 and MS.3.11)

2. Life Safety (Residential Occupancies)

The written progress report for Life Safety should be in the form of a plan of correction and should include:

a. The deficiencies addressed by the plan;

b. Actions being taken to correct the deficiencies;

c. The source and availability of funding for the plan of correction; and

d. A schedule of correction.

The written progress report should be completed and sent to:

Progress Report Coordinator
Hospital Accreditation Program
Joint Commission
875 North Michigan Avenue
Chicago, Illinois 60611

CONTINGENCY: A focused survey will be scheduled within approximately six (6) months from the date of the attached letter, October 6, 1989. This visit will be conducted by a nurse surveyor and will address only the recommendations on the following pages in the Hospital Accreditation Program section preceded by the symbol (C) and relating to the following topics:

1. Nursing Process

2. Nursing Direction and Staffing

3. Monitoring and Evaluation of Nursing Services

4. Infection Control

5. Monitoring and Evaluation of Dietetic Services

6. Monitoring and Evaluation of Social Work Services

Your organization will be notified of the date of this focused survey visit.

CONTINGENCY: A focused survey will be scheduled within approximately six (6) months from the date of the attached letter, October 6, 1989. This visit will be conducted by a HAP psychiatrist surveyor and will address only the recommendations on the following pages in the Hospital Accreditation Program section preceded by the symbol (C) and relating to the following topics:

1. Clinical Privileges

2. Monitoring and Evaluation of Medical Staff/Department Care

3. Medical Record Review

4. Pharmacy and Therapeutics Review

5. Evidence of Action Taken in the Quality Assurance Program

6. Monitoring and Evaluation of Emergency Services

7. Monitoring and Evaluation of Radiology Services

8. Use of Quality Assurance Results in Competence Appraisal/Clinical Privileges

Your organization will be notified of the date of this focused survey visit.

CONTINGENCY: A written progress report will be required within approximately six (6) months from the date of the attached letter, October 6, 1989. This report should address only the recommendations on the following pages in the Hospital Accreditation Program section preceded by the symbol (C) and relating to the following topics:

1. Safety Management (General Safety and Emergency Preparedness)

2. Equipment Management (Electrically Powered Equipment)

3. Governance

4. Monitoring and Evaluation of Pharmaceutical Services

5. Monitoring and Evaluation of Rehabilitation Services

The written progress report should be completed and sent to:

Progress Report Coordinator
Hospital Accreditation Program
Joint Commission
875 North Michigan Avenue
Chicago, Illinois 60611

IMPLEMENTATION MONITORING: Some recommendations in the attached report are standards which are currently in implementation monitoring status. They are identified by the symbol (M). While these recommendations do not presently affect the accreditation decision, compliance with these standards should be pursued. Special attention will be focused on compliance with these standards during the next survey of your organization.

LABORATORY FINDINGS: Your accreditation report does not include our review of the findings from the College of American Pathologists survey of your laboratory. Your accreditation status may be affected by these results. These findings will be forwarded as soon as possible.

ADDITIONAL RECOMMENDATIONS: The attached report reflects additional recommendations for future compliance. The recommendations preceded by the symbol (+) should be given high priority and must be corrected prior to your next survey.

RECOMMENDATIONS FOR FUTURE COMPLIANCE

THE FOLLOWING RECOMMENDATIONS QUOTE STANDARDS IN THE CONSOLIDATED STANDARDS MANUAL, 1987. THE SPECIFIC STANDARDS REFERENCED ARE NOTED IN PARENTHESES FOLLOWING THE RECOMMENDATION.

WRITTEN PLAN FOR PROFESSIONAL SERVICES AND STAFF COMPOSITION

(C) 1. Within the scope of its activities, the facility has enough appropriately qualified health care professional, administrative, and support staff available to adequately assess and address the identified clinical needs of patients. (WP.2)

IT WAS NOTED THAT THE ORGANIZATION HAS 9 VACANCIES FOR NURSE II, 1 VACANCY FOR NURSE III AND 3 VACANCIES FOR NURSE IV POSITIONS.

GOVERNING BODY

(C) 2. The governing body, through the chief executive officer, develops policies and makes sufficient resources available (e.g., funds, staff, equipment, supplies, and facilities) to assure that the program is capable of providing appropriate and adequate services to patients. (GB.8)

IT WAS NOTED THAT THE ORGANIZATION HAS VACANCIES FOR 9 NURSE II POSITIONS, 1 VACANCY FOR A NURSE III POSITION AND 3 VACANCIES FOR A NURSE IV POSITION.

ASSESSMENT

(C) 3. The assessment includes, but is not necessarily limited to, physical, emotional, behavioral, social, recreational, and, when appropriate, legal, vocational, and nutritional needs. (AS.1.1)

IT WAS NOTED THAT A PATIENT'S PHYSICAL HEALTH NEED TO BE FURTHER ADDRESSED.

(C) 4. The social assessment includes a determination of the need for participation of family members or significant others in the patient's treatment. (AS.5.2)

IT WAS NOTED THAT SOCIAL ASSESSMENTS DO NOT CONSISTENTLY REFLECT THE FAMILY MEMBERS OR SIGNIFICANT OTHERS INVOLVEMENT.

(C) 5. An activities assessment of each patient is undertaken and includes information relating to the individual's current skills, talents, aptitudes, and interests. (AS.6)

IT WAS NOTED THAT ACTIVITIES ASSESSMENTS DO NOT CONSISTENTLY REFLECT A PATIENT'S SKILLS, APPTITUDES AND INTERESTS AND ARE NOT INCLUDED IN THE PATIENT'S TREATMENT PLAN.

TREATMENT PLANNING PROCESS

(C) 6. For each patient, there is a written, comprehensive, individualized treatment plan that is based on assessments of the patient's clinical needs. (TP.1)

IT WAS NOTED THAT TREATMENT PLANS ARE NOT ADEQUATELY BASED ON ASSESSMENTS. IN ADDITION, TREATMENT PLANS INADEQUATELY REFLECT THE PATIENT'S HEALTH PROBLEMS. FURTHER, TREATMENT INTERVENTIONS ARE NOT ADEQUATELY ADDRESSED AND THE OBJECTIVES OF SUCH INTERVENTIONS ARE NOT MEASURABLE.

(C) 7. Provision is made for periodic reevaluation of the patient and for revisions of the individualized treatment plan based on changes in the patient's condition. At the minimum, the treatment plan is reviewed at major key decision points in each patient's treatment course. These decision points include: (TP.1.3.2)

(C) a. the time of a major change in the patient's condition. (TP.1.3.2.1.2)

IT WAS NOTED THAT TREATMENT PLANS ARE NOT CONSISTENTLY REVISED WHEN THE PATIENT'S NEEDS OR CONDITION CHANGES.

(C) 8. The treatment plan reflects the patient's clinical needs and condition and identifies functional strengths and limitations. (TP.1.5)

IT WAS NOTED THAT TREATMENT PLANS DO NOT ADEQUATELY REFLECT THE PATIENT'S CLINICAL NEEDS AND CONDITIONS.

(C) 9. The treatment plan specifies the services necessary to meet the patient's needs. (TP.1.6)

IT WAS NOTED THAT FOR STANDARDS TP.1.6-TP.1.6.1.3: TREATMENT PLANS DO NOT CONSISTENTLY SPECIFY THE SERVICES NECESSARY TO MEET THE PATIENT'S NEEDS NOR DO THEY ADEQUATELY ADDRESS THE PATIENT'S ACTIVITIES OF DAILY LIVING SKILLS.

(C) 10. When the patient's identified needs include the development skills related to activities of daily living, the treatment team identifies the training program to be utilized, specifying (TP.1.6.1)

(C) a. the behavioral objectives of the training program. (TP.1.6.1.1)

(C) b. the methods to be used. (TP.1.6.1.2)

(C) c. the training schedule. (TP.1.6.1.3)

(C) 11. The treatment plan includes referrals for needed services that are not provided directly by the facility. (TP.1.7)

IT WAS NOTED THAT TREATMENT PLANS DO NOT CONSISTENTLY INCLUDE REFERRALS FOR NEEDED SERVICES THAT ARE NOT PROVIDED BY THE ORGANIZATION.

(C) 12. The treatment plan contains specific objectives that relate to the goals, are written in measurable terms, and include expected achievement dates. (TP.1.9)

IT WAS NOTED THAT TREATMENT OBJECTIVES ARE NOT CONSISTENTLY WRITTEN IN MEASURABLE TERMS.

(C) 13. The treatment plan delineates the specific criteria to be met for termination of treatment. (TP.1.12)

IT WAS NOTED THAT TERMINATION CRITERIA HAVE NOT BEEN ADEQUATELY DELINEATED IN THE TREATMENT PLAN.

THERAPEUTIC ENVIRONMENT

(+) 14. Good standards of personal hygiene and grooming are taught and maintained, particularly in regard to bathing, brushing teeth, caring for hair and nails, and using the toilet. (TH.16)

IT WAS NOTED THAT A NUMBER OF PATIENTS WERE OBSERVED DURING THE SURVEY TO HAVE POOR PERSONAL HYGIENE.

PATIENT RIGHTS

(C) 15. Facilities support and protect the fundamental human, civil, constitutional, and statutory rights of each patient. (PI.1)

DEFICIENCIES IN COMPLIANCE WITH STANDARD (PI.1) WERE PREVIOUSLY REPORTED.

IT WAS NOTED THAT THE ORGANIZATION HAS NOT YET ENCLOSED ALL OGF THE EXPOSED PIPES IN THE PATIENTS BEDROOMS. IN ADDITION, THE ORGANIZATION HAS NOT ADDRESSED THE EXCESSIVE USE OF RESTRAINT AND SECLUSION PROCEDURES.

REHABILITATION SERVICES

(+) 16. Activity schedules are posted in places accessible to patients and staff. (RH.5.3)

IT WAS NOTED THAT ACTIVITIES SCHEDULES ARE NOT POSTED ON THE ADMISSION, OLDER ADULT AND OVERFLOW UNITS.

(+) 17. Activity services that are included in a patient's treatment plan reflect an assessment of the patient's needs, interests, life experiences, capacities, and deficiencies. (RH.6.1)

IT WAS NOTED THAT ALTHOUGH ACTIVITIES ASSESSMENTS ARE CONDUCTED, THE RESULTS ARE NOT INTEGRATED INTO THE PATIENT'S MASTER TREATMENT PLAN.

(+) 18. Activity service staff collaborate with other professional staff in delineating goals for patients' treatment, health maintenance, and vocational adjustment. (RH.6.2)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

THE FOLLOWING RECOMMENDATIONS QUOTE STANDARDS IN THE LONG TERM CARE STANDARDS MANUAL, 1988. THE SPECIFIC STANDARDS REFERENCED ARE NOTED IN PARENTHESES FOLLOWING THE RECOMMENDATION.

QUALITY ASSURANCE

(+) 19. The quality assurance program addresses all major patient/resident care activities. (QA.2)

20. The quality and appropriateness of care are monitored and evaluated in clinical areas including: (QA.2.1)

(+) a. Patient/resident activities. (QA.2.1.1)

(+) b. Medical care. (QA.2.1.3)

IT WAS NOTED THAT ALTHOUGH IMPORTANT ASPECTS OF CARE HAVE BEEN IDENTIFIED AND INDICATORS HAVE BEEN DEVELOPED, THRESHOLDS FOR THE EVALUATION OF INDICATORS HAVE NOT BEEN ESTABLISHED. ALTHOUGH DATA IS BEING COLLECTED, MOST DATA ADDRESSES QUANTITY RATHER THAN QUALITY AND APPROPRIATENESS ISSUES.

21. The quality assurance program consists of: (QA.3.1)

a. The evaluation of (QA.3.1.3)

(+) 1. patient/resident and family comments. (QA.3.1.3.4)

(+) 2. findings from patient/resident and family/visitor councils relating to patient/resident care. (QA.3.1.3.5)

SPECIFIC REFERENCE IS MADE TO THE LACK OF EVALUATION OF THE ABOVE.

ROLES AND RESPONSIBILITIES

22. Medical Director

a. The medical director is either appointed by the administrator or designated by the organized medical staff. (RR.3.1)

1. The appointment or designation of the medical director is approved by the governing body. (RR.3.1.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF EVIDENCE THAT THE APPOINTMENT OF THE MEDICAL DIRECTOR WAS APPROVED BY THE GOVERNING BODY.

STAFF DEVELOPMENT AND EDUCATION

23. The supervising dentist provides professional auxiliary personnel with in-service education on oral health care. (SD.4)

IT WAS NOTED THAT ORAL HEALTH IN-SERVICES ARE ONLY PROVIDED BY NURSING STAFF.

PATIENT/RESIDENT RIGHTS AND QUALITY OF LIFE

(+) 24. There is a patient/resident council to provide patients/residents with a mechanism for voicing grievances and for participating in decision making. (RQ.1.2)

IT WAS NOTED THAT THE PATIENT/RESIDENT COUNCIL HAS NOT MET SINCE THE LAST QUARTER OF 1987.

CARE MANAGEMENT SYSTEM

(+) 25. The patient/resident care management system is implemented by members of an interdisciplinary team and is designed to assure coordinated participation of all appropriate health care professionals. (CM.1.3)

IT WAS NOTED THAT CARE PLANNING IS CONDUCTED BY EACH DISCIPLINE AND IS THEN REVIEWED AND UPDATED AT THE CARE PLANNING CONFERENCES. THERE IS NO INTEGRATION OF THE VARIOUS DISCIPLINES IN THE CARE PLANNING PROCESS.

(+) 26. Based on information obtained during the admission process, an interim plan of care is developed as soon as possible after admission. (CM.2.2)

IT WAS NOTED THAT INTERIM PLAN OF CARE IS THE NURSING ADMISSION NOTE. IT DOES NOT INCLUDE INTERIM GOALS FOR THE PATIENT/RESIDENT.

(+) 27. Each patient/resident has an individualized interdisciplinary plan of care. (CM.4)

(+) 28. The interdisciplinary plan of care is based on the comprehensive assessments. (CM.4.1)

29. The interdisciplinary plan of care includes: (CM.4.3)

(+) a. Identified patient/resident needs. (CM.4.3.1)

(+) b. Identified goals, which are realistic and measurable. (CM.4.3.2)

(+) c. Specification of the members of the interdisciplinary team who are responsible for working with the patient/resident to meet specific goals. (CM.4.3.4)

(+) d. The frequency with which services are to be provided and designation of which interdisciplinary team member is responsible for their provision. (CM.4.3.5)

IT WAS NOTED THAT THE MULTIDISCIPLINARY PLAN OF CARE DOES NOT INCLUDE ALL OF THE PATIENT'S/RESIDENT'S NEEDS. THIS IS DUE TO THE LACK OF INTEGRATION OF EACH DISCIPLINES CARE PLAN.

30. Interdisciplinary team members' responsibilities include: (CM.5.3)

(+) a. Development and implementation of a comprehensive, individualized plan of care that is based on the assessments of the patient/resident. (CM.5.3.2)

IT WAS NOTED THAT THE CARE PLAN DOES NOT INCLUDE ALL IDENTIFIED PATIENT'S/RESIDENT'S NEEDS.

PROVISION OF PATIENT/RESIDENT CARE

31. Social Services

a. Social services personnel provide: (PC.10.2)

(+) 1. Assistance in the development and operation of a patient/resident council. (PC.10.2.5)

SPECIFIC REFERENCE IS MADE TO THE LACK OF A PATIENT/RESIDENT COUNCIL.

(+) 2. Assistance in the development and operation of a family/visitor council. (PC.10.2.10)

SPECIFIC REFERENCE IS MADE TO THE LACK OF A FAMILY/VISITOR COUNCIL.

MEDICAL RECORD SERVICE

32. Each medical record contains patient/resident identification data and pertinent information on the patient's/resident's status and on the provision of and response to treatment and care. (MR.2.5)

a. The provision of and response to nursing care is documented in the medical record. (MR.2.5.8)

1. Documentation includes: (MR.2.5.8.1)

a. A summary of the patient's/resident's condition at least monthly, or more often if the patient's/resident's condition warrants, by staff on one of the nursing shifts. (MR.2.5.8.1.4)

1. The extent of the achievement of the nursing goals that are included in the interdisciplinary plan of care is contained in the summary. (MR.2.5.8.1.4.1)

IT WAS NOTED THAT NURSING SUMMARIES RARELY INCLUDE THE EXTENT OF ACHIEVEMENT OF NURSING GOALS.

THE FOLLOWING RECOMMENDATIONS QUOTE STANDARDS IN THE ACCREDITATION MANUAL FOR HOSPITALS, 1988. THE SPECIFIC STANDARDS REFERENCED ARE NOTED IN PARENTHESES FOLLOWING THE RECOMMENDATION.

DIAGNOSTIC RADIOLOGY SERVICES

(C) 33. The diagnostic radiology department/service has a planned and systematic process for the monitoring and evaluation of the quality and appropriateness of patient care services and for resolving identified problems. (DR.4.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF A PLANNED AND SYSTEMATIC MONITORING AND EVALUATION PROCESS.

(+) 34. The quality and appropriateness of patient care services are monitored and evaluated in all major clinical functions of the diagnostic radiology department/service. (DR.4.2)

IT WAS NOTED THAT MONITORING AND EVALUATION ACTIVITIES ONLY ADDRESS STATISTICAL ISSUES SUCH AS THE NUMBER OF FILMS TAKEN.

35. Such monitoring and evaluation are accomplished through: (DR.4.2.1)

(C) a. routine collection in the diagnostic radiology department/service, or through the hospital's quality assurance program, of information about important aspects of diagnostic radiology or therapy services. (DR.4.2.1.1)

(C) b. periodic assessment by the diagnostic radiology department/service of the collected information in order to identify important problems in patient care services and opportunities to improve care. (DR.4.2.1.2)

IT WAS NOTED THAT THE COLLECTION AND ASSESSMENT OF INFORMATION ONLY ADDRESSES STATISTICAL ISSUES, RATHER THAN CLINICAL ASPECTS OF CARE.

36. When important problems in patient care services or opportunities to improve care are identified: (DR.4.3)

(C) a. actions are taken. (DR.4.3.1)

(C) b. the effectiveness of the actions taken is evaluated. (DR.4.3.2)

(C) 37. The findings from the conclusions of monitoring, evaluation, and problem-solving activities are documented and, as appropriate, are reported. (DR.4.4)

IT WAS NOTED THAT THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN ONLY ADDRESS STATISTICAL ISSUES, RATHER THAN CLINICAL ASPECTS OF CARE.

(C) 38. As part of the annual reappraisal of the hospital's quality assurance program, the effectiveness of monitoring, evaluation, and problem-solving activities in the diagnostic radiology department/service is evaluated. (DR.4.6)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ANNUAL EVALUATION.

(C) 39. When an outside source(s) provides diagnostic radiology services, or when there is no designated diagnostic radiology department/service, the quality and appropriateness of patient care services provided are monitored and evaluated, and identified problems are resolved. (DR.4.7)

SPECIFIC REFERENCE IS MADE TO THE LACK OF EVIDENCE OF PLANNED AND SYSTEMATIC MONITORING AND EVALUATION OF THE APPROPRIATENESS OF PATIENT REFERRALS TO THE OUTSIDE SOURCE(S).

DIETETIC SERVICES

40. Such monitoring and evaluation are accomplished through: (DT.7.2.1)

(C) a. periodic assessment by the dietetic department/service of the collected information in order to identify important problems in patient care services and opportunities to improve care. (DT.7.2.1.2)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF A PERIODIC ASSESSMENT OF THE COLLECTED INFORMATION.

41. When important problems in patient care services or opportunities to improve care are identified: (DT.7.3)

(C) a. actions are taken. (DT.7.3.1)

(C) b. the effectiveness of the actions is evaluated. (DT.7.3.2)

(C) 42. The findings from and conclusions of the monitoring, evaluation, and problem-solving activities are documented and, as appropriate, are reported. (DT.7.4)

IT WAS NOTED THAT THE ACTIONS TAKEN AND FOLLOW-UP ACTIONS TAKEN WHEN PROBLEMS ARE IDENTIFIED ARE NOT DOCUMENTED.

EMERGENCY SERVICES

(+) 43. Emergency patient care is guided by written policies and procedures. (ER.5)

IT WAS NOTED THAT THE ORGANIZATION HAS NOT FORMALIZED WRITTEN POLICIES ADDRESSING EMERGENCY PATIENT CARE WITH THE EXCEPTION OF A PARAGRAPH WHICH LISTS SOME CONDITIONS WHICH A PATIENT SHOULD BE TRANSFERRED TO THE COMMUNITY HOSPITAL.

(C) 44. When an outside source(s) provides emergency services, or when there is no designated emergency department/service, the quality and appropriateness of patient care provided are monitored and evaluated, and identified problems are resolved. (ER.9.7)

SPECIFIC REFERENCE IS MADE TO MINIMAL EVIDENCE OF PLANNED AND SYSTEMATIC MONITORING AND EVALUATION OF THE APPROPRIATENESS OF PATIENT REFERRALS TO THE OUTSIDE SOURCE(S). IN ADDITION, ALTHOUGH PROBLEMS HAVE BEEN IDENTIFIED, THERE IS A LACK OF DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN.

GOVERNING BODY

45. The bylaws specify: (GB.1.2)

a. the requirement for the establishment of auxiliary organizations, if applicable. (GB.1.2.7)

IT WAS NOTED THAT THE GOVERNING BODY BYLAWS DO NOT ADDRESS AUXILIARY ORGANIZATIONS.

46. Any auxiliary organizations and individual volunteers delineate their purpose and function for approval by the governing body. (GB.1.6)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

47. A record of governing body proceedings is maintained. (GB.1.7)

IT WAS NOTED THAT GOVERNING BODY MEETINGS WERE NOT DOCUMENTED UNTIL JANUARY, 1988.

(+) 48. The governing body acts on recommendations concerning medical staff appointments, reappointments, terminations of appointments, and the granting or revision of clinical privileges within a reasonable period of time, as specified in the bylaws of the medical staff. (GB.1.13)

IT WAS NOTED THAT THE GOVERNING BODY BYLAWS DO NOT SPECIFY THE PERIOD OF TIME THAT APPOINTMENTS OR REAPPOINTMENTS TO THE MEDICAL STAFF ARE GRANTED. IN PRACTICE, ALL REAPPOINTMENTS ARE DONE ON THE PRACTITIONER'S ANNIVERSARY DATE.

49. The governing body requires a process or processes designed to assure that all individuals who provide patient care services, but who are not subject to the medical staff privilege delineation process, are competent to provide such services. (GB.1.15)

(C) a. The quality of patient care services provided by these individuals is reviewed as part of the hospital's quality assurance program. (GB.1.15.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

50. All members of the governing body understand and fulfill their responsibilities. (GB.3)

a. All new members of the governing body participate in an orientation program. (GB.3.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

INFECTION CONTROL

51. A basic element(s) of the infection control program include(s): (IC.1.2)

(C) a. a practical system for reporting, evaluating, and maintaining records of infections among patients and personnel. (IC.1.2.2)

IT WAS NOTED THAT A SYSTEM FOR REPORTING, EVALUATING AND MAINTAINING RECORDS OF INFECTIONS AMONG PATIENTS AND PERSONNEL HAS ONLY BEEN IMPLEMENTED FOR 10 MONTHS PRIOR TO SURVEY. POST SURVEY INFORMATION: THE INFECTION CONTROL COMMITTEE HAS BEEN REVISED AND A PRACTICAL SYSTEM FOR REPORTING, EVALUATING AND MAINTAINING RECORDS OF INFECTIONS AMONG PATIENTS AND PERSONNEL IS INADEQUATELY IMPLEMENTED.

b. participation in the content and scope of the employee health program. (IC.1.2.7)

IT WAS NOTED THAT THE PRESENT EMPLOYEE HEALTH PROGRAM ONLY REQUIRES A TB TEST AND A HEALTH HISTORY OF EACH EMPLOYEE. THIS PROGRAM HAS NOT BEEN REVIEWED BY THE INFECTION CONTROL COMMITTEE AND THERE HAS BEEN NO ONGOING COLLECTION AND REVIEW OF DATA.

(C) c. coordination with the medical staff on action relative to the findings from the regular evaluation of the clinical use of drugs. (IC.1.2.9)

SPECIFIC REFERENCE IS MADE TO THE LACK OF COORDINATION WITH THE MEDICAL STAFF AND THERE IS MINIMAL REVIEW OF DRUGS.

52. An effective hospitalwide infection control program includes elements that may be implemented to varying degrees depending on the hospital and the services provided. (IC.1.3)

(C) a. These elements include: (IC.1.3.1)

(C) 1. the institution of antibiotic susceptibility/resistance trend studies as appropriate. (IC.1.3.1.4)

(C) 2. consultation regarding the purchase of all equipment and supplies used for sterilization, disinfection, and decontamination purposes. (IC.1.3.1.5)

(C) 3. the periodic review of cleaning procedures, agents, and schedules in use throughout the hospital, and consultation regarding any major change in cleaning products or techniques. (IC.1.3.1.6)

(C) 4. the monitoring of all findings from any patient care quality assessment activities that relate to infection control. (IC.1.3.1.7)

IT WAS NOTED THAT FOR STANDARDS IC.1.3.1, IC.1.3.1.4-IC.1.3.1.7: THESE ACTIVITIES HAVE NOT BEEN ADDRESSED.

53. The infection control committee determines the type of surveillance and reporting programs to be used. (IC.2.5)

(C) a. The committee recommends corrective action based on records and reports of infections and infection potential among patients and hospital personnel. (IC.2.5.3)

IT WAS NOTED THAT ALTHOUGH CORRECTIVE ACTIONS HAVE BEEN DOCUMENTED BY THE INFECTION CONTROL NURSE FOR THE 10 MONTHS PRIOR TO SURVEY, THESE ACTIONS WERE NOT REFLECTED IN THE INFECTION CONTROL COMMITTEE MINUTES. IN ADDITION, THE MINUTES ADDRESSED A PROBLEM REGARDING THE LACK OF DOCUMENTATION OF WHAT IS BEING DONE WHEN POSITIVE CULTURES ARE IDENTIFIED IN URINALYSIS TESTS. FURTHER, THERE WAS A LACK OF DOCUMENTATION THAT THESE POSITIVE CULTURES WERE BEING TREATED.

54. In assessing the effectiveness of the hospital infection control program, the infection control committee reviews: (IC.2.10)

(C) a. the results of any antimicrobial susceptibility/resistance trend studies. (IC.2.10.3)

SPECIFIC REFERENCE IS MADE TO THE LACK OF IMPLEMENTATION.

(C) b. proposals and protocols for all special infection control studies to be conducted throughout the hospital, and any subsequent findings. (IC.2.10.4)

SPECIFIC REFERENCE IS MADE TO THE LACK OF IMPLEMENTATION.

55. There are specific written infection control policies and procedures for all services throughout the hospital. (IC.3)

a. The written policies and procedures are developed in cooperation with: (IC.3.3)

1. the dietetic department/service. (IC.3.3.5)

IT WAS NOTED THAT THE DIETETIC POLICY DOES NOT ADDRESS THE COMMUNITY KITCHEN ON THE FORENSIC UNIT WHERE PATIENTS MAY COOK FOR EACH OTHER.

2. the pharmaceutical department/service. (IC.3.3.12)

SPECIFIC REFERENCE IS MADE TO THE LACK OF A POLICY THAT ADDRESSES THE PHARMACEUTICAL SERVICE.

3. the radiology department/service. (IC.3.3.13)

4. the respiratory care department/service. (IC.3.3.14)

SPECIFIC REFERENCE IS MADE TO THE LACK OF SUCH POLICIES.

5. the rehabilitation service. (IC.3.3.15)

SPECIFIC REFERENCE IS MADE TO THE LACK OF A POLICY THAT ADDRESSES PHYSICAL THERAPY.

6. the support services, including central services, housekeeping, laundry, and engineering and maintenance. (IC.3.3.17)

SPECIFIC REFERENCE IS MADE TO THE LACK OF POLICIES FOR ENGINEERING AND MAINTENANCE SERVICES.

7. the surgical suite: (IC.3.3.18)

a. Specific policies and procedures relate to protective clothing and drapes, sterilization techniques, management of septic cases, routine cleaning techniques, and handling of materials. (IC.3.3.18.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF POLICIES THAT ADDRESS THE MEDICAL CLINICS WERE PATIENT EXAMS ARE CONDUCTED.

(C) 56. Specific written guidelines are available for all personnel involved with procedures that are commonly used in patient care and known to be associated with nosocomial infection potential. (IC.3.4)

a. Example(s) of such procedures include: (IC.3.4.1)

(C) 1. the use of thermometers. (IC.3.4.1.4)

SPECIFIC REFERENCE IS MADE TO THE LACK OF A POLICY THAT ADDRESSES THERMOMETERS.

(C) 57. There are written guidelines for the selection, storage, handling, use, and disposition of disposable items. (IC.3.5)

SPECIFIC REFERENCE IS MADE TO THE LACK OF WRITTEN GUIDELINES.

58. Central services is provided with adequate direction, staffing, and facilities to perform all required functions. (IC.4)

a. There are written policies and procedures for the decontamination and sterilization activities performed in central services and elsewhere in the hospital, and for related requirements. (IC.4.5)

1. These policies and procedures relate to: (IC.4.5.1)

a. the recall and disposal or reprocessing of outdated sterile supplies. (IC.4.5.1.7)

SPECIFIC REFERENCE IS MADE TO THE LACK OF A WRITTEN POLICY AND PROCEDURE ADDRESSING THE RECALL AND DISPOSAL OF OUTDATED STERILE SUPPLIES.

59. Steam and hot-air sterilizers are tested with live bacterial spores at least weekly. (IC.4.9)

IT WAS NOTED THAT BIOLOGICAL TESTING OF HOT AIR STERILIZERS ARE NOT TESTED FOR SEVERAL PERIODS UP TO 14 DAYS IN THE YEAR PRIOR TO SURVEY.

(+) 60. The housekeeping service is provided with adequate direction, staffing, and facilities to perform all required functions. (IC.5)

IT WAS NOTED THAT HOUSEKEEPING STAFF ARE NOT SCHEDULED FOR WEEKENDS. IT WAS NOTED THAT NURSING SERVICES PERFORMS HOUSEKEEPING DUTIES ON THE WEEKENDS.

a. To guide personnel in providing a hygienic environment for patients and staff, departmental procedures are developed for: (IC.5.5)

1. the maintenance of liaison with the infection control committee to determine appropriate action based on the results of any microbiological evaluations performed. (IC.5.5.6)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

61. There is an adequate supply of clean linen that is handled and stored in such a way as to minimize contamination from surface contact or airborne deposition. (IC.6.3)

IT WAS NOTED THAT CLEAN LINEN ARE UNPROTECTED WHILE STORED IN PATIENT CORRIDORS.

62. Soiled linen is collected in such a manner as to minimize microbial dissemination into the environment. (IC.6.4)

IT WAS NOTED THAT SEVERAL SOILED LINEN HAMPERS WERE OBSERVED TO BE NEXT TO UNPROTECTED CLEAN LINEN.

MANAGEMENT AND ADMINISTRATIVE SERVICES

63. The chief executive officer, through the management and administrative staff, provides for personnel policies and practices that pertain to: (MA.1.5)

a. a periodic performance evaluation, based on a job description, of each employee. (MA.1.5.5)

IT WAS NOTED THAT PERFORMANCE EVALUATIONS ARE NOT BASED ON JOB DESCRIPTIONS.

MEDICAL RECORD SERVICES

(+) 64. Inpatient medical records include: (MR.2.2)

(+) a. the report of the physical examination. (MR.2.2.3)

(+) 1. The report reflects a comprehensive current physical assessment. (MR.2.2.3.1)

IT WAS NOTED THAT PELVIC AND RECTAL EXAMS WERE NOT CONDUCTED OR DEFERRED IN 4 OF 11 RECORDS REVIEWED. IN ADDITION, THERE WAS A LACK OF DOCUMENTATION OF THE REASON FOR NOT CONDUCTING A PELVIC AND RECTAL EXAM.

(+) b. progress notes made by the medical staff. (MR.2.2.9)

IT WAS NOTED THAT THERE IS MINIMAL DOCUMENTATION OF THE PATIENT'S PHYSICAL PROBLEMS.

(+) c. conclusions at termination of hospitalization. (MR.2.2.15)

(+) 1. The clinical resume concisely recapitulates the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge, and any specific instructions given to the patient and/or family, as pertinent. (MR.2.2.15.3)

(+) a. Consideration is given to instructions relating to physical activity, medication, diet, and follow-up care. (MR.2.2.15.3.1)

IT WAS NOTED THAT ALTHOUGH CLINICAL RESUMES ADDRESS THE PATIENT'S MEDICATIONS, THERE IS A LACK OF DOCUMENTATION OF THE INSTRUCTIONS GIVEN TO THE PATIENT REGARDING THE MEDICATIONS AND THE PATIENT'S ACTIVITY LEVEL.

MEDICAL STAFF

(+) 65. Medical staff bylaws include provisions for: (MS.2.4)

(+) a. fair-hearing and appellate review mechanisms, which may differ for medical staff members and other individuals holding clinical privileges and for applicants for such membership or privileges. (MS.2.4.2)

IT WAS NOTED THAT THERE IS NO FAIR HEARING AND APPELLATE REVIEW MECHANISMS in

(+) b. mechanisms for corrective action, including indications and procedures for automatic and summary suspension of an individual's medical staff membership and/or clinical privileges. (MS.2.4.3)

IT WAS NOTED THAT THERE ARE NO MECHANISMS FOR CORRECTIVE ACTION AND INDICATIONS FOR AUTOMATIC AND SUMMARY SUSPENSION OF AN INDIVIDUAL'S MEDICAL STAFF MEMBERSHIP AND/OR CLINICAL PRIVILEGES.

(C) 66. The written policies assure appropriate physician involvement in and approval of the multidisciplinary treatment plan. (MS.2.6.4.1)

IT WAS NOTED THAT THE WRITTEN POLICIES DO NOT REQUIRE APPROPRIATE INVOLVEMENT OF THE PHYSICIAN IN THE MULTIDISCIPLINARY TREATMENT PLANNING PROCESS.

(C) 67. Each clinical department or major clinical service (or medical staff, for a nondepartmentalized medical staff) holds monthly meetings to consider findings from the ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients. (MS.3.7)

IT WAS NOTED THAT ALTHOUGH THE MEDICAL STAFF MEETS EACH WEEK, THEY MAINLY ADDRESS ADMINISTRATIVE ISSUES.

(C) a. A record that includes the resultant conclusions, recommendations, and actions taken is maintained. (MS.3.7.2)

IT WAS NOTED THAT THERE IS INADEQUATE DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN.

(C) 68. Responsibilities of department chairmen are specified in the medical staff bylaws and rules and regulations. (MS.3.9)

IT WAS NOTED THAT THE RESPONSIBILITIES OF THE MEDICAL STAFF AND/OR THE CLINICAL DIRECTOR'S ARE NOT SPECIFIED IN THE MEDICAL STAFF BYLAWS, RULES AND REGULATIONS.

(C) 69. There is a mechanism to assure the same level of quality of patient care by all individuals with delineated clinical privileges, within medical staff departments, across departments/services, and between members and nonmembers of the medical staff who have delineated clinical privileges. (MS.3.11)

SPECIFIC REFERENCE IS MADE TO THE LACK OF SUCH A MECHANISM.

70. Professional criteria specified in the medical staff bylaws and uniformly applied to all applicants for delineated clinical privileges constitute the basis for granting clinical privileges. (MS.4.2.2)

(C) a. The criteria include, at the least, evidence of current licensure, relevant training and/or experience, current competence, and health status. (MS.4.2.2.2)

IT WAS NOTED THAT A PRACTITIONER'S CURRENT COMPETENCE AND RELEVANT TRAINING ARE NOT ADDRESSED IN THE PRIVILEGING PROCESS.

71. Privileges are related to: (MS.4.2.7.3.3)

(C) a. an individual's documented experience in categories of treatment areas or procedures. (MS.4.2.7.3.3.1)

(C) b. the results of treatment. (MS.4.2.7.3.3.2)

(C) 72. When privilege delineation is based primarily on experience, the individual's credentials record reflects the specific experience and successful results that form the basis for the granting of privileges. (MS.4.2.7.3.4)

IT WAS NOTED THAT ALL PRIVILEGES ARE GENERAL FOR MEDICAL/PSYCHIATRIC CARE AND THERE IS A CHECKLIST FOR SPECIAL MODALITIES. THESE PRIVILEGES ARE NOT RELATED TO THE PRACTITIONER'S EXPERIENCES OR THE RESULTS OF TREATMENT.

(M) 73. The reappraisal includes information concerning the individual's professional performance, judgment, and clinical/technical skills, as indicated by the results of quality assurance activities. (MS.5.3.1)

IT WAS NOTED THAT QUALITY ASSURANCE FINDINGS ARE NOT CONSISTENTLY USED IN THE REAPPOINTMENT/REPRIVILEGING PROCESS.

74. <u>Monitoring and Evaluation of the Quality and Appropriateness of Patient Care Provided by All Individuals with Clinical Privileges</u>

(+) a. Departmental or medical staff monitoring and evaluation encompass all major clinical activities of the department. (MS.6.1.1.2)

IT WAS NOTED THAT MONITORING AND EVALUATION ACTIVITIES MAINLY ADDRESS STATISTICAL ISSUES, RATHER THAN CLINICAL ASPECTS OF CARE.

b. Departmental or medical staff monitoring and evaluation include: (MS.6.1.1.3)

(C) 1. the routine collection of information about important aspects of patient care provided in the department and about the clinical performance of its members. (MS.6.1.1.3.1)

(C) 2. the periodic assessment of this information to identify opportunities to improve care and to identify important problems in patient care. (MS.6.1.1.3.2)

IT WAS NOTED THAT ONLY STATISTICAL INFORMATION IS COLLECTED AND THIS INFORMATION HAS NOT BEEN ADEQUATELY ASSESSED.

c. When important problems in patient care and clinical performance or opportunities to improve care are identified: (MS.6.1.1.4)

(C) 1. actions are taken; and (MS.6.1.1.4.1)

(C) 2. the effectiveness of the actions taken is evaluated. (MS.6.1.1.4.2)

(C) d. The findings from and conclusions of monitoring, evaluating, and problem-solving activities are documented and reported monthly. (MS.6.1.1.5)

SPECIFIC REFERENCE IS MADE TO INADEQUATE DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN.

75. Drug Usage Evaluation

(M) a. Drug usage evaluation is performed by the medical staff as a criteria-based, ongoing, planned and systematic process for monitoring and evaluating the prophylactic, therapeutic, and empiric use of drugs to help assure that they are provided appropriately, safely, and effectively. (MS.6.1.3.1)

IT WAS NOTED THAT ALTHOUGH THE ORGANIZATION CONDUCTS A DIFFERENT DRUG STUDY EACH MONTH, THE PROPHYLACTIC, THERAPEUTIC AND EMPERIC USE OF DRUGS IS NOT ADEQUATELY ADDRESSED AND THERE IS A LACK OF DOCUMENTATION OF THE OPPORTUNITIES TO IMPROVE CARE.

(M) 1. This process includes the routine collection and assessment of information in order to identify opportunities to improve the use of drugs and to resolve problems in their use. (MS.6.1.3.1.1)

(M) b. There is ongoing monitoring and evaluation of selected drugs that are chosen because: (MS.6.1.3.2)

(M) 1. based on clinical experience, it is known or suspected that the drug causes adverse reactions or interacts with another drug (or drugs) in a manner that presents a significant health risk. (MS.6.1.3.2.1)

IT WAS NOTED THAT LITHIUM HAS NOT BEEN REVIEWED EVEN THOUGH IT IS THE HIGHEST RISK AND HIGHEST VOLUME DRUG USED.

c. The process for monitoring and evaluating the use of drugs: (MS.6.1.3.3)

(M) 1. is performed by the medical staff in cooperation with, as required, the pharmaceutical department/service, the nursing department/service, management and administrative staff, and other departments/services and individuals. (MS.6.1.3.3.1)

IT WAS NOTED THAT THE STUDIES ARE CONDUCTED BY THE PHARMACIST WITH REPORTS GOING TO THE CLINICAL DIRECTORS AND MINIMAL OR NO INVOLVEMENT OF OTHER SERVICES.

(M) d. Written reports of the findings, conclusions, recommendations, actions taken, and results of actions taken are maintained and reported at least quarterly through channels established by the medical staff. (MS.6.1.3.4)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN.

76. The Medical Record Review Function

(C) a. Written reports of conclusions, recommendations, actions taken, and the results of actions are maintained. (MS.6.1.4.4)

SPECIFIC REFERENCE IS MADE TO INADEQUATE DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN. FOR EXAMPLE, DOCUMENTATION OFTEN ONLY STATED "REPORTED TO ADMINISTRATION" OR "CONTINUE TO MONITOR" WITHOUT EVIDENCE OF FOLLOW-UP ACTIONS.

77. The Pharmacy and Therapeutics Function

a. The pharmacy and therapeutics monitoring function includes: (MS.6.1.6.2)

(C) 1. the definition and review of all significant untoward drug reactions. (MS.6.1.6.2.4)

IT WAS NOTED THAT A DEFINITION OF UNTOWARD DRUG REACTIONS WAS DEVELOPED 3 MONTHS PRIOR TO SURVEY. IT WAS NOTED THAT 9 UNTOWARD DRUG REACTIONS HAVE BEEN REPORTED BUT HAVE NOT BEEN REVIEWED BY THE PHARMACY AND THERAPEUTICS FUNCTION.

NURSING SERVICES

78. The nursing department/service is organized to assure that nursing management functions are effectively fulfilled. (NR.3.3)

a. Nursing management functions include: (NR.3.3.1)

(C) 1. reviewing and approving policies and procedures that relate to the qualifications and employment of nursing department/service members. (NR.3.3.1.1)

IT WAS NOTED THAT NURSING MANAGEMENT DO NOT REVIEW POLICIES RELATED TO THE QUALIFICATIONS OF EMPLOYEES.

2. establishing standards of nursing care and mechanisms for evaluating such care. (NR.3.3.1.2)

IT WAS NOTED THAT ALTHOUGH STANDARDS OF CARE HAVE BEEN DEVELOPED, THEY HAVE NOT YET BEEN UTILIZED TO EVALUATE CARE.

79. Job descriptions for each position classification of registered nurses and other nursing personnel specify standards of performance and delineate the functions, responsibilities, and specific qualifications of each classification. (NR.3.7)

80. Job descriptions are reviewed periodically and revised as needed to reflect current job requirements. (NR.3.7.2)

IT WAS NOTED THAT JOB DESCRIPTIONS DO NOT IDENTIFY ALL OF THE RESPONSIBILITIES OF A PATICULAR POSITION AND ARE NOT EVALUATED ON AN ANNUAL BASIS. IN ADDITION, EACH UNIT DIRECTOR DEVELOPS THEIR OWN JOB DESCRIPTIONS WITHOUT COORDINATION WITH THE NURSING ADMINISTRATOR.

81. A written evaluation of the performance of registered nurses and other nursing personnel is made at the end of the probationary period and at a defined interval thereafter. (NR.3.8)

(C) a. The evaluation is criteria based and relates to the standards of performance specified in the individual's job description. (NR.3.8.1)

IT WAS NOTED THAT PERFORMANCE EVALUATIONS ARE NOT CRITERIA BASED.

(C) 82. Nursing department/service assignments in the provision of nursing care are commensurate with the qualifications of nursing personnel and are designed to meet the nursing care needs of patients. (NR.4)

(C) 83. A sufficient number of qualified registered nurses are on duty at all times to give patients the nursing care that requires the judgment and specialized skills of a registered nurse. (NR.4.1)

IT WAS NOTED THAT THERE IS INSUFFICIENT REGISTERED NURSING STAFF. FOR EXAMPLE, 3 WEEKS OF STAFFING WERE REVIEWED WHICH COMPRISED OF 168 SHIFTS. 18 OF 168 SHIFTS REVIEWED THE WEEK OF AUGUST 2, 1987 LACKED REGISTERED NURSE COVERAGE, 33 OF 168 SHIFTS REVIEWED THE WEEK OF DECEMBER 27, 1987 LACKED REGISTERED NURSE COVERAGE AND 30 OF 168 SHIFTS REVIEWED THE WEEK OF OCTOBER 2, 1988 LACKED REGISTERED NURSE COVERAGE AS PER THE ORGANIZATION'S STAFFING PLAN. POST INTERVIEW INFORMATION: THE ORGANIZATION HAS BEEN ALLOCATED A LARGE AMOUNT OF MONEY IN ORDER TO HIRE NURSING STAFF. VACANCIES STAILL EXIST BUT THE ORGANIZATION IS TRYING TO FILL THE VACANCIES.

(C) 84. Nursing personnel staffing also is sufficient to assure prompt recognition of any untoward change in a patient's condition and to facilitate appropriate intervention by the nursing, medical, or hospital staffs. (NR.4.2)

IT WAS NOTED THAT THERE IS INSUFFICIENT NURSE STAFFING TO ASSURE PROMPT RECOGNITION OF UNTOWARD CHANGES IN THE PATIENT'S CONDITION. STAFFING ON THE UNITS MAINLY COMPRISES OF MENTAL HEALTH WORKERS WHO ARE NOT BEING SUPERVISED BY A REGISTERED NURSE ACCORDING TO THE ORGANIZATIONS OWN POLICY.

85. To assure quality nursing care and a safe patient environment, nursing personnel staffing and assignment are based on: (NR.4.3)

(C) a. A registered nurse plans, supervises, and evaluates the nursing care of each patient. (NR.4.3.1)

IT WAS NOTED THAT THERE IS ONE REGISTERED NURSE SUPERVISOR ON EACH SHIFT TO COVER 350 PATIENTS IN 9 UNITS AND 3 SEPARATE BUILDINGS. REGISTERED NURSES ARE SUPPOSED TO BE SUPERVISING MENTAL HEALTH WORKERS AND THE ADMINISTRATION OF MEDICATIONS BY THE MENTAL HEALTH WORKERS. THIS POLICY IS NOT BEING FOLLOWED.

(C) b. The patient care assignment is commensurate with the qualifications of each nursing staff member, the identified nursing needs of the patient, and the prescribed medical regimen. (NR.4.3.4)

IT WAS NOTED THAT THE PATIENT ASSIGNMENT SYSTEM DOES NOT COMMENSURATE WITH THE QUALIFICATIONS OF EACH NURSING STAFF MEMBERS AND THE IDENTIFIED NEEDS OF THE PATIENTS. THERE ARE ACUTELY ILL PATIENTS WHO ARE TAKING CARDIAC, HYPERTENSIVE AND PSYCHOTROPIC MEDICATIONS. THESE PATIENTS ARE ADMINISTERED THESE MEDICATIONS AND MONITORED BY MENTAL HEALTH WORKERS WHO ARE NOT BEING SUPERVISED BY A REGISTERED NURSE OR A PHYSICIAN AS SPECIFIED IN THE ORGANIZATION'S OWN POLICY.

(C) 86. The nursing department/service defines, implements, and maintains a system for determining patient requirements for nursing care on the basis of demonstrated patient needs, appropriate nursing intervention, and priority for care. (NR.4.4)

IT WAS NOTED THAT THE ORGANIZATION DEVELOPED AN ACUITY SYSTEM SIX MONTHS PRIOR TO SURVEY AND THE NEW SYSTEM DETERMINED THAT THE ORGANIZATION WAS UNDERSTAFFED BY 54.6 REGISTERED NURSE FULL TIME EQUIVILENTS AND 42.9 NONREGISTERED NURSING EQUIVILENTS.

(C) 87. Specific nursing personnel staffing for each nursing care unit, including, as appropriate, the surgical suite, obstetrical suite, ambulatory care department/service, and emergency department/service, are commensurate with the patient care requirements, staff expertise, unit geography, availability of support services, and method of patient care delivery. (NR.4.4.1)

IT WAS NOTED THAT NURSING STAFF ARE REQUIRED TO DO MANY NON-NURSING FUNCTIONS SUCH AS HOUSEKEEPING ON THE WEEKENDS, NURSING STAFF FILL IN FOR DIETARY WHEN THEY ARE SHORT STAFFED AND REGISTERED NURSES ARE RETRIEVING ALL OF THE QUALITY ASSURANCE DATA FOR ALL DISCIPLINES.

(C) 88. Individualized, goal-directed nursing care is provided to patients through the use of the nursing process. (NR.5)

(C) 89. The nursing process (assessment, planning, intervention, evaluation) is documented for each hospitalized patient from admission through discharge. (NR.5.1)

IT WAS NOTED THAT THE NURSING PROCESS IS ONLY EVIDENT AT THE TIME OF ADMISSION, AFTER ADMISSION THE NURSING PROCESS IS NOT ADEQUATELY DOCUMENTED.

(C) 90. Each patient's nursing needs are assessed by a registered nurse at the time of admission or within the period established by nursing department/service policy. (NR.5.2)

IT WAS NOTED THAT A REGISTERED NURSE DOES NOT ASSESS A PATIENT'S NURSING NEEDS IN APPROXIMATELY 50 PERCENT OF THE 30 RECORDS REVIEWED.

(C) 91. A registered nurse plans each patient's nursing care. (NR.5.3)

IT WAS NOTED THAT REGISTERED NURSES ONLY PLAN EACH PATIENTS INITIAL NURSING CARE WITH MINIMAL DOCUMENTATION THAT THEY PLAN SUBSEQUENT NURSING CARE.

a. Whenever possible, nursing goals are mutually set with the patient and/or family. (NR.5.3.1)

IT WAS NOTED THAT NURSING GOALS ARE NOT MUTUALLY SET WITH THE PATIENT AND/OR FAMILY IN 75 PERCENT OF THE 30 RECORDS REVIEWED.

(C) b. Nursing goals are based on the nursing assessment and are realistic, measurable, and consistent with the therapy prescribed by the responsible medical practitioner. (NR.5.3.2)

IT WAS NOTED THAT NURSING GOALS WERE NOT WRITTEN IN MEASURABLE TERMS AND WERE NOT REALISTIC IN APPROXIMATELY 50 PERCENT OF THE 30 RECORDS REVIEWED.

92. Patient education and patient/family knowledge of self-care are given special consideration in the nursing plan. (NR.5.4)

IT WAS NOTED THAT PATIENT EDUCATION WAS NOT ADDRESSED IN 90 PERCENT OF THE 30 RECORDS REVIEWED.

93. The plan of care is documented and reflects current standards of nursing practice. (NR.5.5)

(C) a. As appropriate, such measures include physiological, psychosocial, and environmental factors; patient/family education; patient discharge planning. (NR.5.5.2)

IT WAS NOTED THAT A PATIENT'S PHYSIOLOGICAL NEEDS WERE NOT ADDRESSED IN 50 PERCENT OF THE 30 RECORDS REVIEWED, PATIENT/FAMILY EDUCATION IS NOT ADDRESSED IN 90 PERCENT OF THE 30 RECORDS REVIEWED, INFECTION CONTROL ISSUES WERE NOT ADDRESSED IN 90 PERCENT OF THE 30 RECORDS REVIEWED AND DISCHARGE PLANNING NEEDS WERE NOT ADDRESSED IN 75 PERCENT OF THE 30 RECORDS REVIEWED.

(C) b. The scope of the plan is determined by the anticipated needs of the patient and is revised as the needs of the patient change. (NR.5.5.3)

IT WAS NOTED THAT THE SCOPE OF THE CARE PLAN IS NOT REVISED WHEN THE PATIENT'S NEEDS CHANGED IN 50 PERCENT OF THE 30 RECORDS REVIEWED. FOR EXAMPLE, 12 OF THE 30 RECORDS REVIEWED PATIENT'S EXPERIENCED HYPERTENSIVE EPISODES, EDEMA OF THE FEET, CELLULITIS, AND EXTREME BEHAVIOR PROBLEMS WHICH REQUIRED 5 POINT RESTRAINTS. IN ADDITION, ONE PATIENT HAD TB WITHOUT A CLEAR DETERMINATION AS TO THE STATUS OR NEED FOR ISOLATION.

(C) 94. Documentation of nursing care is pertinent and concise and reflects patient status. (NR.5.6)

IT WAS NOTED THAT NURSING DOCUMENTATION DOES NOT CONSISTENTLY REFLECT THE PATIENT'S STATUS IN 50 PERCENT OF THE 30 RECORDS REVIEWED.

(C) a. Nursing documentation addresses the patient's needs, problems, capabilities, and limitations. (NR.5.6.1)

(C) b. Nursing intervention and patient response are noted. (NR.5.6.2)

IT WAS NOTED THAT DAILY HYGIENE AND ORAL CARE ARE NOT DOCUMENTED. IN ADDITION, NURSING INTERVENTIONS ARE NOT CONSISTENTLY DOCUMENTED.

c. When a patient is transferred within or discharged from the hospital, a nurse notes the patient's status in this medical record. (NR.5.6.3)

IT WAS NOTED THAT THE PATIENT'S STATUS AT DISCHARGE WAS ONLY DOCUMENTED IN 1 OF 3 CLOSED RECORDS REVIEWED.

d. As appropriate, patients who are discharged from the hospital requiring nursing care receive instructions and individualized counseling prior to discharge. (NR.5.6.4)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION IN ALL 3 RECORDS REVIEWED.

1. Evidence of the instructions and the patient's or family's understanding of these instructions is noted in the patient's medical record. (NR.5.6.4.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

(+) 95. Nursing department/service policies and procedures relate to: (NR.7.2)

(+) a. the assignment of nursing care consistent with patient needs, as determined by the nursing process. (NR.7.2.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF SUCH A POLICY.

(+) b. medication administration. (NR.7.2.3)

SPECIFIC REFERENCE IS MADE TO THE LACK OF SUCH A POLICY.

(+) c. the role of the nursing staff in patient and family education. (NR.7.2.6)

SPECIFIC REFERENCE IS MADE TO THE LACK OF SUCH A POLICY.

(+) d. the maintenance of required records, reports, and statistical information. (NR.7.2.7)

IT WAS NOTED THAT THESE ACTIVITIES ARE NOT ADDRESSED IN AA POLICY.

96. Additional policies and procedures are usually required for units in which special care is provided. (NR.7.3)

IT WAS NOTED THAT NURSING STAFF CONDUCT RESPIRATORY THERAPY BUT THE POLICY REGARDING OXYGEN ADMINISTRATION IS INCOMPLETE AND THERE IS NO POLICY ADDRESSING IPPB TREATMENTS WHICH ARE OCCASIONALLY DONE BY NURSING STAFF.

(+) 97. The quality and appropriateness of patient care are monitored and evaluated in all major clinical functions of the nursing department/service. (NR.8.2)

IT WAS NOTED THAT MAINLY MANAGEMENT FUNCTIONS ARE MONITORED AND EVALUATED, RATHER THAN CLINICAL ASPECTS OF CARE.

98. Such monitoring and evaluation are accomplished through: (NR.8.2.1)

(C) a. routine collection in the nursing department/service, or through the hospital's quality assurance program, of information about important aspects of nursing care. (NR.8.2.1.1)

(C) b. periodic assessment by the nursing department/service of collected information in order to identify important problems in patient care and opportunities to improve care. (NR.8.2.1.2)

IT WAS NOTED THAT THE INFORMATION COLLECTED AND ASSESSED MAINLY RELATE TO ADMINISTRATIVE ISSUES.

99. When important problems in patient care or opportunities to improve care are identified: (NR.8.3)

(C) a. actions are taken; and (NR.8.3.1)

(C) b. the effectiveness of the actions taken is evaluated. (NR.8.3.2)

(C) 100. The findings from and conclusions of monitoring, evaluation, and problem-solving activities are documented and, as appropriate, are reported. (NR.8.4)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OR INADEQUATE DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN.

(C) 101. As part of the annual reappraisal of the hospital's quality assurance program, the effectiveness of the monitoring, evaluation, and problem-solving activities in the nursing department/service is evaluated. (NR.8.6)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ANNUAL EVALUATION.

PHARMACEUTICAL SERVICES

102. The director of the pharmaceutical department/service is responsible for: (PH.3.3)

(+) a. assuring the monitoring and evaluation, with medical staff input, of the quality and appropriateness of patient services provided by the pharmaceutical department/service. (PH.3.3.12)

(+) b. participating in those aspects of the hospital's overall quality assurance program that relate to drug utilization and effectiveness. (PH.3.3.13)

SPECIFIC REFERENCE IS MADE TO MINIMAL DOCUMENTATION.

103. Written policies and procedures include the following: (PH.5.2)

(+) a. Medication errors and adverse drug reactions are reported immediately in accordance with written procedures. (PH.5.2.6)

IT WAS NOTED THAT ALTHOUGH SEVERAL CASES OF ADVERSE DRUG REACTIONS HAVE BEEN REPORTED SINCE THIS POLICY WAS INSTITUTED A FEW MONTHS PRIOR TO SURVEY, THERE IS A LACK OF DOCUMENTATION OF AN INVESTIGATION AND REVIEW OF THESE INCIDENTS.

104. When important problems in patient care services or opportunities to improve care are identified: (PH.6.3)

(C) a. actions are taken; and (PH.6.3.1)

(C) b. the effectiveness of the actions taken is evaluated. (PH.6.3.2)

(C) 105. The findings from and conclusions of monitoring, evaluation, and problem-solving activities are documented and, as appropriate, are reported. (PH.6.4)

SPECIFIC REFERENCE IS MADE TO INADEQUATE DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN. IN ADDITION, FOLLOW-UP ACTIONS ARE NOT DOCUMENTED.

(C) 106. As part of the annual reappraisal of the hospital's quality assurance program, the effectiveness of the monitoring, evaluation, and problem-solving activities in the pharmaceutical department/service is evaluated. (PH.6.6)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ANNUAL EVALUATION.

PHYSICAL REHABILITATION SERVICES

107. In the organization of the physical rehabilitation service or services: (RH.1.1)

(+) a. A sufficient number of qualified, competent professional and support personnel are available to meet the objectives of the service and the needs the of patient population. (RH.1.1.8)

SPECIFIC REFERENCE IS MADE TO INSUFFICIENT STAFF COVERAGE BY PHYSICAL THERAPISTS.

108. In the process of providing for any physical rehabilitation service to patients: (RH.1.2)

a. A treatment plan is developed based on the functional assessment and evaluation of the patient, unless he is being referred to a single service as an outpatient. (RH.1.2.3)

(+) 1. The patient and the family participate as appropriate in the development and implementation of the treatment plan. (RH.1.2.3.1)

IT WAS NOTED THAT FAMILY MEMBERS ARE RARELY INVOLVED IN THE THE DEVELOPMENT AND IMPLEMENTATION OF THE PATIENT'S TREATMENT PLAN.

109. Such monitoring and evaluation are accomplished through: (RH.4.2.1)

(C) a. routine collection in the comprehensive physical rehabilitation program or unit or rehabilitation service(s), or through the hospital's quality assurance program, of information in order to identify important problems in patient care and opportunities to improve care. (RH.4.2.1.1)

(C) b. periodic assessment by the comprehensive physical rehabilitation program or unit or by the rehabilitation service(s) of collected information in order to identify important problems in patient care and opportunities to improve care. (RH.4.2.1.2)

IT WAS NOTED THAT THERE IS MINIMAL DOCUMENTATION OF THE ROUTINE COLLECTION AND PERIODIC ASSESSMENT OF PATIENT CARE INFORMATION.

110. When important problems in patient care or opportunities to improve care are identified: (RH.4.3)

(C) a. actions are taken; and (RH.4.3.1)

(C) b. the effectiveness of the actions taken is evaluated. (RH.4.3.2)

(C) 111. The findings from and conclusions of monitoring, evaluation, and problem-solving activities are documented and, as appropriate, are reported. (RH.4.4)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN.

(C) 112. As part of the annual reappraisal of the hospital's quality assurance program, the effectiveness of the monitoring, evaluation, and problem-solving activities in the comprehensive physical rehabilitation program or unit or in the rehabilitation service(s) is evaluated. (RH.4.6)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ANNUAL EVALUATION.

PLANT, TECHNOLOGY, AND SAFETY MANAGEMENT

113. Building

(C) a. Buildings in which patients are housed overnight or receive treatment are in compliance with the provisions of the 1981 edition of the Life Safety Code of the National Fire Protection Association (NFPA). (PL.1.1)

The Life Safety Code recommendations contained in this report are based upon a survey technique of sampling. Where a specific reference is indicated, that is where the surveyor noted a problem. It is expected that the organization, as a part of its Life Safety Management program, will conduct a self-survey to ascertain that all areas of the physical plant are in compliance with the specific Life Safety Code requirement.

1. Residential Occupancies

(C) a. There are two remote approved exits on each floor. (NFPA 101, 1981: 20-2.1.1, 2.1.3) [RS.1A]

IT WAS NOTED THAT THERE IS ONLY ONE STAIRWELL IN THE BURLEIGH ANNEX AND THE NORTON HOUSE BUILDINGS.

114. General Safety

(C) a. The hospital has a system that is designed to provide a safe environment for patients, personnel, and visitors and that is designed to monitor that environment. (PL.3)

IT WAS NOTED THAT THERE ARE PIPES HANGING FROM THE CEILINGS THROUGHOUT THE BUILDINGS WHICH ARE UNPROTECTED AND PROVIDE A HAZARD IN THAT TWO SUICIDES HAVE BEEN SUCCESSFUL BECAUSE OF THESE PIPES. POST INTERVIEW INFORMATION: THE ORGANIZATION IS STILL IN THE PROCESS OF ENCLOSING PIPES.

b. The safety system addresses: (PL.3.1)

(C) 1. the promotion and maintenance of an ongoing, hospitalwide hazard surveillance program to detect and report all safety hazards related to patients, visitors, and personnel. (PL.3.1.2)

(C) a. This hazard surveillance program includes a policy for responding to medical-device recalls and hazard notices from government agencies and manufacturers. (PL.3.1.2.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ONGOING HAZARD SURVEILLANCE PROGRAM EXCEPT FOR AN INCIDENT REPORTING SYSTEM.

(C) 2. methods for monitoring the results of the safety program (see Standard PL.3, Required Characteristic PL.3.2, of the "Plant, Technology, and Safety Management" chapter of the Accreditation Manual for Hospitals) and for analyzing the program at least annually. (PL.3.1.5)

(C) a. To determine the safety program's effectiveness, the analysis includes a review all of pertinent records and reports. (PL.3.1.5.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ANNUAL EVALUATION.

(C) c. The conclusions, recommendations, and actions of the safety committee are reported at least quarterly to the administrative, medical, and nursing staffs and others as appropriate. (PL.3.5.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN.

(C) d. There is evidence of information exchange and consultation between the safety committee and the various safety programs (for example, safety programs for engineering and maintenance, housekeeping, laboratory, nursing, and dietetic services), the infection control committee, the hospitalwide quality assurance function, and other standing committees. (PL.3.7)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

(C) e. There is evidence that the conclusions, recommendations, and actions of the safety committee are evaluated by the appropriate administrative directors of the areas affected and that proper action is documented in subsequent safety committee minutes. (PL.3.8)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

115. Education

a. The hospital has an organized safety education program. (PL.4)

1. There is evidence that the education programs are analyzed at least annually to determine their effectiveness. (PL.4.4)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ANNUAL EVALUATION.

116. Emergency Preparedness

a. The role of the hospital in communitywide disaster plans is identified in the emergency preparedness program. (PL.5.3)

b. The emergency preparedness program addresses hospital preparedness, including space utilization, supplies, communication systems, security, and utilities. (PL.5.4)

(C) c. The emergency preparedness program addresses staff preparedness, including staffing requirements and the designation of roles and functions, particularly in terms of capabilities and limitations. (PL.5.5)

(C) d. The emergency preparedness program addresses patient management, including modified schedules, criteria for the cessation of nonessential services, and patient transfer determinations, particularly in terms of discharge and relocation. (PL.5.6)

IT WAS NOTED THAT FOR STANDARDS PL.5.3-PL.5.6: THE EMERGENCY PREPAREDNESS PROGRAM DOES NOT ADEQUATELY ADDRESS THESE ACTIVITIES.

(C) e. The emergency preparedness program is implemented, evaluated, and documented semiannually. (PL.5.7)

(C) 1. Each implementation (whether a drill or an actual emergency) exercises emergency preparedness plan elements related to hospital preparedness, staff preparedness, and patient management; at least one implementation includes an influx of patients from outside the hospital. (PL.5.7.1)

IT WAS NOTED THAT ONLY ONE DISASTER DRILL HAS BEEN CONDUCTED.

f. It is recommended that on each work shift the hospital have appropriately trained personnel responsible for assisting with the implementation of the fire plan and the activation of the nonautomatic components of the fire safety systems. (PL.5.8.1)

(C) g. The fire plan is implemented at least quarterly for each work shift of hospital personnel in each patient-occupied building. (PL.5.8.1.1)

(C) 1. Documentation of the implementation of the plan includes, at a minimum, problems identified during implementation, corrective actions taken, and staff participation. (PL.5.8.1.1.1)

IT WAS NOTED THAT FOR STANDARDS PL.5.8.1-PL.5.8.1.1.1: THE ORGANIZATION HAS NOT CONDUCTED FIRE DRILLS ON EACH SHIFT IN ALL BUILDINGS. IT WAS NOTED THAT LESS THAN 50 PERCENT OF THE REQUIRED DRILLS HAVE BEEN CONDUCTED.

h. The emergency preparedness program is evaluated annually and is updated as needed. (PL.5.10)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ANNUAL EVALUATION.

117. Communication

(+) a. Appropriate maintenance for all equipment included in the communication systems is provided. (PL.8.2)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

(+) b. In those parts of the communication system where an equipment failure can have life-threatening consequences, the hospital has procedures for implementing an alternative means of communication. (PL.8.3.1)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

118. Electrically Powered Equipment

(C) a. The hospital has a program designed to assure that non-patient-care, electrically powered, line-operated equipment is electrically safe. (PL.10)

IT WAS NOTED THAT FOR STANDARDS PL.10-PL.10.4: THERE IS A LACK OF DOCUMENTATION OF AN ELECTRICALLY POWERED EQUIPMENT PROGRAM.

(C) b. There is a policy that identifies types of non-patient-care equipment that may pose an electrical hazard during intended use. (PL.10.1)

(C) c. Non-patient-care equipment identified by the policy is inspected prior to initial use and at intervals to determine electrical safety. (PL.10.2)

(C) 1. The intervals are determined by the requirements of the equipment. (PL.10.2.1)

(C) d. Documentation of inspections and appropriate corrective actions is maintained. (PL.10.3)

e. The safety committee develops and implements policies for the use and control of personal electrical equipment. (PL.10.4)

119. Electrical Distribution

(+) a. There is a program of preventive maintenance and periodic inspection designed to assure that the electrical distribution system operates safely and reliably. (PL.11.1)

1. Inspections and corrective actions are documented. (PL.11.1.1)

(C) b. periodic assessment by the social work department/service of the collected information in order to identify important problems in patient care services and opportunities to improve care. (SO.5.2.1.2)

IT WAS NOTED THAT INSUFFICIENT INFORMATION IS COLLECTED AND ASSESSED.

125. When important problems in patient care services or opportunities to improve care are identified: (SO.5.3)

(C) a. actions are taken. (SO.5.3.1)

(C) b. the effectiveness of the actions taken is evaluated. (SO.5.3.2)

(C) 126. The findings from and conclusions of monitoring, evaluation, and problem-solving activities are documented and, as appropriate, are reported. (SO.5.4)

SPECIFIC REFERENCE IS MADE TO MINIMAL DOCUMENTATION OF THE CONCLUSIONS, RECOMMENDATIONS, ACTIONS, AND EVALUATIONS OF ACTIONS TAKEN.

(C) 127. As part of the annual reappraisal of the hospital's quality assurance program, the effectiveness of the monitoring, evaluation, and problem-solving activities in the social work department/service is evaluated. (SO.5.6)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF AN ANNUAL EVALUATION.

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SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION OF A PREVENTATIVE MAINTENANCE PROGRAM.

2. In identifying components of the electrical distribution system to be included in the program, consideration is given to the reliability of receptacles, electrical feeds, and transformers. (PL.11.2)

IT WAS NOTED THAT ELECTRICAL PANELS ARE NOT TESTED.

(+) b. There is a current set of documents that indicate the distribution of and controls for partial or complete shutdown of each electrical system. (PL.11.4)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

120. Safety Devices and Practices

a. In toilet and bathing areas serving patients, there are grab bars and similar safety devices. (PL.19.2)

IT WAS NOTED THAT THERE ARE NO GRAB BARS OR A CALL SYSTEM IN THE PATIENT TOILETS IN THE X-RAY AREA.

QUALITY ASSURANCE

(C) 121. There is a written plan for the quality assurance program that describes the program's objectives, organization, scope, and mechanisms for overseeing the effectiveness of monitoring, evaluation, and problem-solving activities. (QA.1.3)

IT WAS NOTED THAT THE WRITTEN PLAN FOR QUALITY ASSURANCE IS DATED THE DAY BEFORE THE SURVEY. THEREFORE, THERE HAS BEEN INSUFFICIENT TIME FOR IMPLEMENTATION.

SOCIAL WORK SERVICES

(+) 122. Social work services are provided by a sufficient number of qualified personnel. (SO.1.9)

SPECIFIC REFERENCE IS MADE TO INSUFFICIENT STAFF COVERAGE BY SOCIAL WORKERS.

123. Education programs for social work department/service personnel are based, at least in part, on the findings from the monitoring and evaluation of the social work services provided. (SO.2.3.2)

SPECIFIC REFERENCE IS MADE TO THE LACK OF DOCUMENTATION.

124. Such monitoring and evaluation are accomplished through: (SO.5.2.1)

(C) a. routine collection in the social work department/service, or through the hospital's quality assurance program, of information about important aspects of social work services. (SO.5.2.1.1)