Regulatory Readiness
Resource Guide
2015
At Massachusetts General Hospital, Excellence Every Day means striving to provide the best possible care to every patient and family in every moment of every day. It is our philosophy and our commitment. Our efforts to achieve Excellence Every Day include validation by external regulatory agencies in the form of on-site surveys and through our designation as a Magnet hospital. We are all focused upon meeting the needs of patients and creating systems that support the highest level of quality and safety.

We are visited by the Joint Commission every 3 years to validate that we are meeting standards and continue to provide exemplary, safe care to our patients.

The Massachusetts Department of Public Health (DPH) conducts periodic Infection Control surveys of area hospitals. The preparation materials in this guide related to infection control practices are pertinent to the DPH survey process.

Based upon your feedback about the most helpful process for preparing to host regulators, this Resource Guide has been developed for your learning. We hope that it supports your commitment to Excellence Every Day for all our patients and families, those already here and those still to come.
Joint Commission National Patient Safety Goals

Goal 1: **Improve the accuracy of patient identification.**
- Use at least two patient identifiers when providing care, treatment and services.
- Eliminate transfusion errors related to patient misidentification.
- Perform universal protocol (pause) during invasive procedures to ensure correct patient, correct procedure, correct site, and correct equipment.

Goal 2: **Improve the effectiveness of communication among caregivers.**
- Report critical results of tests and diagnostic procedures on a timely basis.

Goal 3: **Improve the safety of using medications.**
- Label all medications, medication containers, or other solutions on and off the sterile field in perioperative and other procedural settings.
- Reduce the likelihood of patient harm associated with use of anticoagulant therapy.
- Maintain and communicate accurate patient medication information.

Goal 6: **Improve the safety of clinical alarm systems.**
- Every alarm warrants action.
- Individualize parameters to decrease unnecessary alarms.
- Remove monitoring when no longer needed.

Goal 7: **Reduce the risk of healthcare associated infections.**
- Implement evidence-based practices to prevent:
  - Health care associated infections due to multiple drug-resistant organisms in acute care hospitals.
  - Central line-associated bloodstream infections.
  - Surgical site infections.
  - Indwelling catheter-associated urinary tract infections.

Goal 15: **The organization identifies safety risks inherent in its patient population.**
- Identify individuals at risk for suicide.
Universal Protocol

- Conduct a pre-procedure verification process
- Mark the procedure site
- Perform time out (pause)

Massachusetts General Hospital
Patient Care Services
Performance Improvement Initiatives

Quality
- Implementation of Innovation Units
- Increase use of Interpreter Services
- Prepare for eCare implementation

Safety
- Implement iPASS for handovers
- Share errors and near misses through narratives and filing of safety reports
- Identify opportunities for improvement that reduce patient harm

Excellence Every Day
- Prevent CAUTI and CLABSI
- Enhance the patient experience:
  o Staff responds to patient needs
  o Ensure clean and quiet environment
The Joint Commission Hospital Survey

What will the survey be like? The JC general hospital survey will be 5 days in length. Using the patient’s medical record as a road map, surveyors will assess the care provided to patients in both inpatient and outpatient sites. A surveyor will arrive at your practice area accompanied by MGH leadership. The surveyor will review a patient’s record with caregivers, observe care, tour the unit, interview clinicians, and, in some cases, interview patients.

Who will be involved? The nurse caring for the patient and the Clinical Nurse Specialist and/or Nursing Director will participate in the record review. Because the surveyor will not know the MGH patient record, the nurse will help locate the documentation for which he or she is looking. As the surveyor tours the unit and observes care, he or she may interview other members of the healthcare team including therapists, OAs, PCAs, NPs, and physicians.

What will the JC surveyors look at during the general hospital survey?

- Advance directive documentation
- Initial Nursing Assessment completed, dated and signed within 24 hours of admission
- Consults initiated based on screening criteria in initial nursing assessment e.g. nutrition or smoking cessation
- Initial assessments by consults e.g. PT, OT, SLP, social work, nutrition
- Initial Plans of Care are based on the initial assessment findings
- No medical interventions or diagnostic tests without an MD order
- Progress Notes reflect the current plan of care
- Progress notes reflect interdisciplinary planning and follow-through
- Fall risk assessment (Morse scale on admission and daily)
- Pain assessment and patient’s response to medications and other interventions
- Patient understanding of education
- Handovers including shift-to-shift, unit-to-unit and unit-to-diagnostic and procedural areas
- Restraint orders and restraint documentation
• Universal protocol checklist completed for invasive procedures (includes those done at bedside)
• Discharge planning
• No unapproved abbreviations
• *Date/time, legible signature and licensure present for all documentation.*
• Specimens collected using appropriate precautions
• Specimens labeled in the presence of the patient
• Doctor’s order present for all specimens
• Glucometers cleaned between patients with hospital-approved disinfectant
• Glucometer control solutions (hi/lo) initialed, dated when opened; not expired (within 90 days of opening)
• Blood transfusions verified and vital signs recorded
• Critical values read back and appropriate response initiated
• Lab-related policies and procedures located by staff

What types of questions will surveyors ask?

Patient Safety and Quality Improvement

**Q** Describe a quality improvement initiative you’ve implemented on your unit during the last year? How has it improved patient care? What data do you have that demonstrates improvement?

**A** (Varies by unit; ex. hourly safety rounds, patient falls, and CAUTI.)

**Q** When do you take verbal orders and telephone orders? Tell me what you do when you take a verbal or telephone order.

**A** Verbal and telephone orders are only taken in exceptional circumstances when the physician cannot write the order. When taking a verbal order, I write down and read back and receive confirmation.

**Q** Can you tell me any of the unapproved abbreviations that should not be written in the medical record?

**A** Examples: MS04, MS, MgS04, ss (for sliding scale), U or u (for units), QD, QOD, HS.
Tell me how you report an adverse event.
By submitting a report through the Safety Reporting System.

What is a sentinel event?
A sentinel event is an unanticipated death or permanent loss of function not related to the patient’s illness. Examples: death after a fall or overdose of a medication.

Patient Identification

How are you sure you are performing a treatment or giving a medication to the correct patient? (NPSG)
By using two identifiers to match the patient to the treatment or medication. For inpatients, the two identifiers are name and MRN. For outpatients, they are name and date of birth. (Procedural areas, therapies and social work, check which two identifiers are used in your area.)

When is it necessary to label medications and solutions in procedural areas?
It is necessary to label medications and solutions on and off the sterile field when they are not administered immediately. If there is an intermediate step before administering a medication, it must be labeled, even if it is the only medication being given at that time.

If the person who labels the medication is not the one administering it, what do you do to ensure the right medication is being administered at the right time? (NPSG)
Two individuals, including the one who will administer the medication, verify the medication label both verbally and visually.

Scope of Practice
When is a doctor’s order required?
A doctor’s order is required for all medical interventions and diagnostics. Examples include medications, blood tests, urinary catheter irrigations, EKG’s, point-of-care tests. When a nurse implements a medical intervention or test without an order, he or she is practicing out of the scope of nursing practice.
Q  *When can oxygen be administered without an order?*
A  Only in an emergency can oxygen be initiated prior to a doctor’s order; the doctor must write the order within 12 hours.

Assessment and Care Planning

Q  *Where do caregivers document their initial assessments?*
A  All caregivers document in the body of the patient record.
   •  Nurses document initial assessment findings on the Initial Nursing Assessment and in the Nursing Admit Note.
   •  MD’s, SLP’s and social workers document in the progress notes.
   •  PT and OT document on discipline specific forms.

Q  *What do nurses do when a patient problem is identified?*
A  RNs individualize interventions based on assessment and reassessment findings and the patient’s specific risk factors. The Progress Note is the “source of truth” for nursing care related to problems, goals, and plans. The progress note is considered the plan of care.

Restraints

Q  *Describe to me a patient’s behavior that would warrant restraint for behavioral reasons vs. non-behavioral reasons.*
A  Non-behavioral (non-violent/non-self destructive): When the patient is at risk of injury to self or interference with medical healing, e.g. is pulling at invasive lines/tubes.
   Behavioral (violent/self destructive): when a patient is putting self or others a significant risk of injury, e.g. demonstrating violent/aggressive behaviors such as biting, kicking, hitting, clawing or cutting related to a behavioral health diagnosis.

Q  *Describe your training regarding use of restraints? When were you trained and what did your training include?*
A  Trained during orientation; training is repeated annually. Training included alternatives to restraint, reasons for use, safe application and removal of restraints, assessment and monitoring of response, and documentation.
Q  *Give me an example of least restrictive measures you would try before applying restraints.*
A  Move the patient to a more visible location, provide an observer, provide a visual/auditory cue not to get up without assistance, use bed/chair alarms, maintain a quiet environment.

Q  *Is chemical restraint used as an alternative to physical restraint at MGH?*
A  No. Medications are not used to involuntarily restrain patients (restricting their freedom of movement). Medications are used to treat medical conditions such as delirium, acute alcohol withdrawal or are administered in an emergency to prevent immediate irreversible deterioration of serious mental illness.

Q  *How often are non-behavioral restraint orders written?*
A  Restraint orders are written
  - Before restraints are applied except in emergency situations
  - When a different type or number of restraints is needed because the patient’s behavior has changed.

Q  *When the patient’s behavior requiring restraint resolves and you assess that restraints can be discontinued what do you do?*
A  Remove the restraints; and as soon as possible I get the doctor’s order to discontinue restraints no later than the end of the shift. I document the time the restraints were discontinued and the rationale on the Nursing Restraint Note.

Q  *If the behavior recurs and patient needs to be restrained again, do you need a new doctor’s order?*
A  Yes because this is a new episode of restraint; this is true even if the patient has only been out of restraints a short time.

Q  *Can you do a “trial” to see how the patient does out of restraints?*
A  No; if the patient is taken out of restraints to “see how they do” and needs to be put back in, this is a new episode and a new order is required. Restraints removed to provide care are acceptable as long as they are reapplied within a short period of time.
Q **Are mitts considered a restraint?**
A **It depends.** If the mitts restrict the use of the patient’s fingers (i.e. white padded mitts) they are considered a restraint. This is true even when mitts are not attached to wrist restraints. The **blue sensory mitts** are not considered a restraint because they allow for finger freedom (i.e. patient can scratch nose easily) and should be loosely fit (patient can remove).

Q **When are siderails considered a restraint and when are they not considered a restraint?**
A Siderails are considered a restraint when the **intent** is to **restrict** the patient from getting out of bed; this is true even if there are fewer than 4 siderails.
Siderails are not considered restraint if used to **prevent** a patient from sliding or **rolling out of bed**; this includes padded side rails for seizure precautions.
Siderails are not considered a restraint if used in conjunction with another restraint. They are treated as a safety precaution.

Q **Where do you document your assessment and interventions re: patient in restraint?**
A The Nursing Restraint Note. Documentation includes specific behaviors requiring restraint, type and location of restraint, least restrictive measures tried; patient’s response to the restraint. (An initial note related to need for restraints should be included in the Progress Note.)

Q **Where do you document the updated care plan?**
A The Nursing Restraint Note.

**Pain Assessment and Reassessment**

Q **What do you do to assess a patient for pain?**
A I ask about the nature, intensity, and location of the pain.

Q **How do you assess for pain? What pain scale do you use?**
A Describe which pain scale you used based on your patient population. Examples:
• Verbal adults: Numeric pain scale, verbal descriptor scale, functional pain scale
• Pediatrics: The Neonatal, Pain, Agitation & Sedation Scale (N-PASS), Faces Pain Scale, the Face, Legs, Activity, Cry, Consolability (FLACC)
• Non-verbal on General Care or the Checklist of Non-verbal Pain Indicators (CNPI), or patients with Delirium or Dementia: Pain Assessment in Advanced Dementia (PAINAD)
• Critically Ill: Care Pain Observation Tool (CCPOT), Adult Nonverbal Pain Scale or assume Pain is Present (APP) if chemically paralyzed or extremely agitated.

Q **How frequently do you reassess for pain?**
A I reassess after medication administration (or alternative interventions) for pain relief within one (1) hour after a single dose and repeated at least every four (4) hours with ongoing treatment (e.g. Fentanyl patch, PCA, epidural, etc.)

Q **Where do you document the patient’s response to pain interventions?**
A Nurses document pre and post pain assessments in EMAR or in the Progress Note. All disciplines document in the progress notes re: current treatment, response to therapy, and adjustments if needed.

**Fall Prevention**

Q **Describe your falls prevention program.**
A All inpatients are assessed for fall risk on admission and daily using an age-appropriate scale e.g. Morse Scale, GRAF PIF scale.
• If the patient is at risk, the nurse initiates a fall prevention plan and documents specifics in the nursing progress notes.
• Interventions are matched to the specific risk.
• Patient/family is instructed about fall risk and interventions.

Q **Can you give me examples of interventions?**
A Hourly rounding, call light within reach, placement near nurses station, consults to PT or OT, assisted toileting, assistive devices, bed alarms, teaching regarding side effects of medications, removal of clutter.
Q Do you know how your unit is doing with patient falls?
A I review the Excellence Every Day bulletin board for fall trends. We discuss falls at our staff meetings and review improvement strategies for continued effectiveness.

Q When the patient is transferred off the unit to a test or procedure, how do staff receiving the patient know the patient is on fall precautions?
A The risk is noted on the “Sticker to Ride.”

Q What initiatives have you implemented on your unit to reduce the number of falls and falls with injury?
A Varies by unit; includes implementing hourly-rounds, bed alarms, and remaining close by when patients are in the bathroom.

Skin Integrity

Q Describe your program to prevent pressure ulcers.
A Skin integrity is assessed as a part of the initial nursing assessment. The Braden scale is used to assess the patient’s level of risk for development of a pressure ulcer. The Braden Scale is completed on admission and on a daily basis. Interventions are guided by the level of risk in the subscale scores (risk factors) which include sensory perception, moisture, activity, mobility, nutrition, friction or sheer.

Q Can you give me examples of interventions to prevent pressure ulcers?
A Interventions are matched to the specific risk. Examples: To manage nutrition, consult dietician; to relieve pressure and/or manage sheer and friction, consult PT to mobilize the patient, reposition, protect elbows and heels; to manage moisture, use 3M Cleanser with each incontinent episode, scheduled toileting, use absorbent cloth incontinent pads.

Q Describe what you do if the patient has a pressure ulcer?
A • Clean and irrigate the wound per hospital standards and provide wound care as ordered.
• Consult CNS for Pressure Ulcers stage III and above.
• Measure and document the wound on admission, weekly or whenever acute changes are noted.
• Document location, wound bed, exudate and periwound areas with dressing changes.
• Document the patient response to treatment.
• Document measurements within 24 hours prior to discharge.

**Q** What initiatives have you implemented on your unit to reduce the number and severity of pressure ulcers?

**A** (Varies by unit; includes implementing Safety Rounds.)

Anticoagulation Therapy (NPSG)

**Q** How are you competent to care for a patient on anticoagulant therapy?

**A** I received education during orientation. There are additional online and electronic resources including a HealthStream course. The CNS and resource nurse are also available for questions. The AMS (Anticoagulation Management Service) staff also provides education.

**Q** Describe the steps you take to reduce the harm related to anticoagulation therapy.

**A**
• Assess for potential food and drug interactions.
• Infuse **premixed** infusion bags through a programmable **infusion pump**.
• Monitor anticoagulation lab data.
• Provide education to patients and their families.

**Q** What does the patient and family education need to include?

**A** Each patient who is started on warfarin receives a copy of the “Guide to Using Warfarin.” This provides information regarding the importance of follow-up monitoring – especially the concept of who their “warfarin manager” is and how communication will proceed. It also informs the patient about why periodic blood testing (INR) is important and how to identify their pill size and color. The patient and family should be able to accurately describe the daily dose regimen, food-drug-herbal interactions, and recognize signs and symptoms of complications and subsequent actions to take as a result of the education provided.
Medication Reconciliation (NPSG)

Q  Describe your process for reconciling medications across the continuum.
A  Medications are reconciled at admission and on discharge.
   •  Within 24 hours of admission, a medication list is generated using the Preadmission Medication List (PAML)
   •  The nurse verifies the list with the patient and communicates discrepancies to the prescriber;
   •  The pharmacist reconciles all ordered medications with the PAML medications to ensure accuracy of drug, dose, frequency and route.

Q  What is the reconciliation process at discharge?
A  •  At discharge, the prescriber reconciles each medication on the Pre-Admission Medication List (PAML) with the inpatient orders to generate a discharge medication list.
   •  The nurse reviews the list, and gives the patient a copy of his/her Discharge Medication List (PDML) which includes medication instructions to follow after discharge.

Q  What is the reconciliation process when the patient is discharged to another health care facility?
A  A copy of the PAML and the PDML are sent to the next health care facility. Electronic copies are also available to providers within the Partners system.

Q  (Procedural areas) What is your reconciliation process for outpatients who come in for a procedure?
A  Medication information is collected and documented prior to the procedure. The level of detail included varies depending upon the procedure and the patient’s condition. If chronic medications are changed following the procedure, the patient is given a new, complete medication list which will include both the new and ongoing medications.
Transfusion Therapy (NPSG)

Q  **How do you verify the identity of a patient who is receiving a transfusion?**
A  Two qualified clinicians, one of whom is the transfuser, in the presence of the patient positively identify the patient and match the blood component to the patient through the use of the two independent identifiers.

Q  **What is your procedure for monitoring vital signs before and after transfusion of blood products.**
A  Stay with patient for the first 5 minutes. Obtain temperature and vital signs at the start of the infusion; during the infusion if > 30 minutes (recommended @ 5-30 minutes) and at the end of the infusion.

Q  **What are the signs of a transfusion reaction? What would you do if you suspected one was occurring?**
A  Fever, chills, rigor, changes in VS, respiratory symptoms, pain, nausea, vomiting, flushing, urticaria, and pruritis are possible signs of transfusion reactions. Stop the transfusion; remove the blood product and tubing but do not discard; slowly administer .9% NaCl IV to keep IV patent; obtain VS; notify responding clinician, draw a 10cc blood specimen in a lavender top tube; place blood bag, tubing, and lavender top tube in plastic bag along with a Request for Investigation of Suspected Transfusion Reaction form and send to blood bank. Send urine for hemaglobinuria to Hematology.

Critical Results (NPSG)

Q  **What is a critical result?** A critical result, also called a critical value, is a result that, if left untreated, could be life threatening or place the patient at serious risk. e.g. elevated K⁺.

Q  **What is your process when the laboratory reports a critical result by phone?**
A  The lab personnel report the critical result to a responsible licensed caregiver. A “read back” of the result, patient name and MRN is given back to the lab personnel who ask for the name and role of the person taking the results.
Patients at Risk for Suicide (NPSG)

Q  What is done at MGH to protect patients who may be at risk for suicide?
A  All inpatients are screened to identify those who may be at risk for suicide. Those screened to be potentially at risk are fully assessed by the responsible physician or psychiatric consult and next steps are determined. If a nurse assesses a patient to be at immediate risk for suicide, he or she may institute suicide precautions and contact the responsible clinician who will determine next steps while the patient is in the hospital. When a patient at risk for suicide leaves the care of the hospital, the hospital provides the appropriate referrals and information to the patient and family such as crisis hotlines.

Universal Protocol

Q  How do you know a surgical or invasive procedure is being done on the correct patient?
A  Universal protocol: time out (pause) verification of correct patient, correct procedure, correct site, and correct equipment. Site marking should be visible after patient is prepped and draped.

Q  Which procedures require universal protocol to be followed?
A  All invasive procedures that require an informed consent. There are some exemptions, for example procedures done during a code.

Q  Can you give me an example of procedures on a general unit that require universal protocol?
A  Insertion of a PICC line, chest tube insertion.
Response to Change in Patient Condition

Q  *What do you do if the patient’s condition begins to worsen and you need additional assistance?*
A  Call the Rapid Response Team by dialing 6-3333 and letting the operator know whether I need the adult or pediatric response team. I also notify the patient’s care team if they don’t already know.

Q  *How do you know when to call the Rapid Response Team?*
A  MGH has identified early warning signs for adult, pediatric patients and newborns that should trigger a call to the RRT.

Patient Rights

Q  *What resources are available for patients and families with complaints or concerns?*
A  Representatives from the Office of Patient Advocacy. The Patient Rights pamphlet also contains resources for patients.

Q  *What do you do if the patient is unable to be asked about the Health Care Proxy (HCP) due to his/her condition?*
A  Look in CAS to see if patient has one on record, check with the family; if patient does not have one, document it in the medical record.

Q  *How do you communicate with a non-English speaking patient or a patient who is deaf or hard of hearing? What resources are available to you? What do you do on weekends and off shift?*
A  For non-English speaking patients, interpreter services; (available 24/7) and IPOPs. For deaf or hard of hearing patients, we use devices provided by communications. We also write messages and use cue cards.

Q  *What resources are available to you for ethical issues?*
A  Representatives from Optimum Care Committee are available to clinicians and patients to help address ethical issues.
Interdisciplinary Communication

Q **How do you communicate with other members of the health care team?**
A Interdisciplinary rounds and one-on-one discussion with other providers. Also through documentation in the record.

Handovers

Q **What information do you receive about a patient when they are transferred to your unit from another unit?**
A Patient history, all active problems, status of the problems and next steps, information about the family/significant others. (Specialty areas such as OR may have additional handover requirements.)

Q **(Nurses) I understand that on this unit, you get report by reading the progress note of the nurse on the previous shift, what do you do if you have questions?**
A I ask the nurse handing over the patient to me. The nurse doesn’t leave until I’ve read the progress notes to be sure I have no questions.

Q **(Therapists and social work). If a different therapist or social worker is seeing a patient, what is your process for handovers? What do you do if you have questions?**
A (Check department policy)

Q **How do you communicate pertinent patient information to staff in procedural and testing areas?**
A The nurse completes the “Sticker to Ride” which contains relevant information that the receiving area needs upon arrival of the patient.

Patient/Family Involvement and Education

Q **How do you encourage patient’s active involvement in their care?**
A Teach the patient/family hand hygiene and respiratory hygiene at admission. We also teach them the skills and knowledge that they will need for discharge. We evaluate their understanding and document it in the record.
Q What do you consider when you are teaching the patient and family?
A Their ability to learn, preferences, desire, motivation, and readiness. We also consider cultural and religious practices and emotional, physical, cognitive, or language barriers.

Q Where do you document the patient’s understanding of your teaching?
A In the progress notes.

Medication Administration

Q How do you store insulin in order to prevent administering the wrong one?
A Different types of insulin are physically separated in Omnicell.

Q What does your pharmacy do to prevent errors with sound-alike/look-alike drugs (SALAD)? Can you give me examples of these drugs?
A Pharmacy uses tall man lettering, visual warnings such as “shelf talkers”. The pharmacy also physically separates sound-alike/look alike medications. Examples include: oxyCONTIN and OXYcodone; hyrdoCODone and hydroMORPHone.

Q Does a patient who receives a new medication receive special monitoring during the first dose?
A Patients are monitored closely after a first dose for adverse effects and anaphylaxis. The patient’s response is documented in the progress notes.

Competency and Credentialing

Q How are you competent to do your job?
A Through basic education, orientation, continuing education, and annual training.
If a provider shows up on your unit that you do not know to do a procedure, how do you know he or she is privileged?

I can look the provider up through the MGH Delineation of Privileges Intranet site (Partners Application ► Clinical References ► MGH Delineation of Privileges Intranet Site).

Specimen Collection and Point of Care Testing (POCT)

Describe your procedure for obtaining specimens? (NPSG)

Match the patient’s name and unit number on the label with the name and unit number on the patient’s wristband. Label the specimens in the presence of the patient. Label the container, not the cap.

What POCT do you perform on your unit?

Units vary. Examples include blood glucose and stool for occult blood.

How are you competent to perform POCTs?

I demonstrate competency during orientation and as part of annual required training. Annually I complete a training module in HealthStream and complete the required quiz. I also successfully perform a quality control test at least once a year.

Who performs phlebotomy on your unit? When and how are they trained? How is competency evaluated?

Patient Care Associates (PCAs) perform phlebotomy. During orientation, PCAs receive classroom training, and complete a precepted practicum during which they demonstrate competencies on the skills checklist. RNs who have the skill when hired can continue to perform phlebotomy if they demonstrate competency by completing the skills checklist. Competency is maintained through frequent performance of blood draws.

How do you prevent spread of infections while performing POCTs?

Glucometers are wiped between patients with a hospital-approved disinfectant such as Super Sani-cloth. Appropriate precautions are used depending on the patient.
Q **How do you know the glucometer is working properly?**
A A hi/lo control test is performed every 24 hours by either an RN or PCA. If a PCA performs the test and the result is out of range, he or she reports to the RN. The RN arranges for the meter to be replaced.

Q **How long are glucometer controls good for?**
A Both Hi and Lo controls are labeled with the manufacturer’s expiration date. However, once a vial is open it is good for 90 days. Vials must be labeled with the date of opening.

Q **What do you do if a glucometer result is 462?**
A Results above 400 are considered a critical value. If the procedure was performed by a PCA, he or she notifies the RN immediately. The RN notifies the physician who then orders a venous specimen.

Q **What do you do if a glucometer result is 42?**
A Results below 50 are considered a critical value. Same as above.

Q **What is a hemoccult slide used for?**
A To check for blood in the stool. It is not designed to check for blood in other specimens such as gastric contents.

Q **How do you ensure that the hemoccult slides perform correctly?**
A By storing them away from moisture and light, and by conducting the performance monitor (QC) with each test; QC’s are documented on the log.

Q **Where do you document results of a hemoccult test?**
A On the Hemoccult QC log and in the patient record e.g. progress notes, flowsheets.

Q **What do you do if a hemoccult test is positive?**
A Report the result to the physician.
Infection Control - What will the surveyor look at?

- Hand Hygiene
- Standard precautions
- Transmission-based precautions (Contact, Contact Plus, Droplet)
- Contact: Hand Hygiene before donning gloves; gloves to enter room is key
- Contact Plus: Hand Hygiene before donning gloves; hand washing after glove removal is key
- Droplet: Surgical Mask within 6 feet of patient
- Airborne isolation: N95 mask or PAPR; room is negative pressure
- Aseptic technique
- Available personal protective equipment and supplies
- Precaution gowns tied minimally at the neck (untied gowns do not offer protection)
- Gloves pulled over cuff of gown
- Gloves and gowns removed before leaving the room (gloves first)
- Needle boxes present and not overfilled
- Equipment cleaned and disinfected between patients with hospital-approved disinfectant
- Clean equipment identified - what is used to identify it and properly stored
- High-touch surfaces in patient rooms are cleaned daily
- Checklist completed during central venous catheter and pulmonary artery catheter insertion
- Patient and family education documented (e.g. hand hygiene, prevention of surgical site and central line infections, isolation precautions)
- Refrigerator temperatures checked and documented
- Patient food labeled, dated, and discarded after 3 days
- Staff food and drink limited to approved areas
- No expired supplies, no external shipping boxes; no supplies on floor, or underneath sinks
- Clean supplies/linen on covered cart or in cabinet/container or clean supply room
- Clean and soiled utility rooms doors closed
- Sterile water and sterile saline are single use ONLY; toss out after use
• Patient room- no supplies or linen on floor and no excess supplies or linen on the windowsill; area for a dressing change or procedure must be cleared and cleaned before task
• Staff are trained in infection control practices

What Type of Questions Will the Surveyor Ask?

Q  What are the most common ways you prevent transmission of infections from one patient to the next?
A  Hand hygiene before and after contact with the patient and the patient’s environment (NPSG) and early identification of patients requiring isolation and timely placement on appropriate precautions.

Q  How do you know if one of your patients has MRSA, VRE, C-difficile or an MDRO? (NPSG)
A  There are several ways that I find out:
   • I review laboratory reports; Infection Control or Microbiology laboratory notifies the nursing unit; physicians also inform us.
   • Patients identified at MGH by Infection Control are “flagged” in CAS with a red “P” in the corner of the screen. Caregivers can click on the “P” and it opens a window with information on the organism and precautions required.
   • When patients are transferred from another hospital, I read the history. And when I transfer a patient or send them for a test I pass on the information regarding precautions.

Q  What precautions do you use for patients with MRSA or VRE? (NPSG)
A  Patients with known or suspected MRSA or VRE are placed on Contact Precautions.
   • They’re placed in a private room or a semi-private room with another patient infected or colonized with MRSA or VRE.
   • Gloves are worn on entry into the room; gowns are worn when there is contact with the patient, surfaces, and equipment.
   • Equipment is dedicated to the patient if possible. If equipment is shared it is cleaned and disinfected with hospital-approved disinfectant (Virex or Super Sani Cloth).
Q What precautions do you use with patients who have C-diff? (NPSG)
A Patients with known or suspected C. diff are placed on Contact Precautions PLUS. This is similar to contact precautions with two primary differences. After contact with the patients, hands must be washed with soap and water first then disinfected with Cal Stat. Patient rooms and equipment are cleaned daily with bleach-based disinfectant.

Q Describe the procedure for donning and removing gown and gloves.
A Perform hand hygiene, place the gown over the shoulders, tie or Velcro the precaution gowns at both the neck and waist. Ensure that the gown provides full coverage of clothing both front and back. Put on gloves, pulling them up to cover the cuffs of the gown. When leaving the room, take gloves off first, then gown, then appropriate hand hygiene.

Q If a patient on precautions is leaving the unit to go to x-ray, how does the transporter know the patient is on precautions? How does radiology know? (NPSG)
A The transporter is informed by the sign on the door or by talking with the nurse. The nurse also writes the type of precautions on the “Sticker to Ride” which is placed on the front of the patient record.

Q What training have you received regarding infection control and what does it include? (NPSG)
A I’ve received training about general infection control practices such as hand hygiene, blood borne pathogens and tuberculosis guidelines; and other MGH practices to prevent healthcare-associated infections such as MRSA, VRE, C-diff, central-line associated blood stream infections, surgical site infections and catheter-associated urinary tract infections.

Q When did you receive this training? (NPSG)
A During orientation; it is repeated each year as part of required annual training. We are also discussing the need for urinary catheters and central lines in daily rounds on the unit.
Q Describe the steps that are taken to prevent infection when inserting a central line. (NPSG)

A We do the following:
- Perform hand hygiene prior to catheter insertion
- A qualified individual monitors for breaks in sterile technique and completes the Central Line Infection Prevention Checklist
- Use a standardized kit and protocol
- Educate patients and families about prevention of infection

Q Describes steps that are taken to prevent surgical site infections. (NPSG)

A We do the following:
- Use aseptic technique during invasive procedures; this includes use of sterile equipment, skin preparation, and managing the environment
- Use aseptic technique during dressing changes and closely monitor wounds
- Educate patients and families about ways to prevent surgical site infections

Q Describe a few ways you prevent urinary tract infections. (NPSG)

A We do the following:
- Limit the use of urinary catheters and remove them as soon as possible. Insert using sterile technique and equipment
- Clean the catheter per procedure, secure the catheter, do not disconnect the catheter from the drainage tube unless necessary to irrigate; avoid routine irrigations
- Obtain specimens through the specimen port; avoid kinking of the tube, keep the urine bag lower than the bladder and off the floor

Q How do you prevent hospital acquired pneumonia?

A We do the following:
- Take steps to prevent aspiration, use hand hygiene and other appropriate measures to prevent cross-contamination
- We also ensure that the respiratory equipment is appropriately cleaned
- We administer vaccines against influenza, pneumococcal pneumonia and educate patients/families about infection
Q **What do you do if a patient is suspected of having TB?**
A The patient is placed on airborne precautions. Staff entering the room must wear an N95 mask. The patient is placed in a private room with negative air pressure; the negative air pressure is checked every day either by looking at the pressure gauge or performing the tissue test.

Q **What other precautions do you take when caring for patients on Airborne Precautions?**
A I wear an N-95 respirator when in the room. The respirator has been sized and fitted for me. Patients leaving the room must wear a surgical mask and should leave only for necessary procedures.

Q **When must you wash your hands with soap and water?**
A When hands are visibly soiled, after using the toilet and before eating. Hands must also be washed with soap and water after caring for a patient on precautions for *C. diff*.

Q **When are gloves worn?**
A Clean, non-sterile, gloves must be worn when touching blood, body fluids, secretions, excretions, mucous membranes, and contaminated medical equipment.

Q **Where are infection control policies located?**
A In the Infection Control Manual which is on the MGH Policy and Procedure intranet site

Q **What is your policy regarding employees and volunteers who have symptoms of, or have been exposed to, infectious disease/illness?**
A Employees and volunteers must contact Occupational Health Service if they have: Skin lesions and/or rash, especially if lesions are weeping or fever is present; non-intact skin or dermatitis; conjunctivitis or “pink eye”; diarrheal illness; cough of more than two weeks (unless explained by a non-infectious disease); new onset of jaundice; exposure to chickenpox, TB or other contagious condition or when their primary diagnoses is a communicable disease such as chickenpox, staph skin infections, influenza.
Q  **How do you know that equipment has been cleaned between patients?**
A  Clean equipment located on the LEAN cart is tagged by Materials Management. Equipment that is cleaned on the unit is kept in the clean utility room and/or another designated area. Items in the hallway that are covered with a clear bag are clean. Dirty equipment is kept in the dirty utility room. If I am not sure about a particular piece of equipment, I assume it’s dirty and clean it prior to patient use.

Q  **Where are you permitted to have food and drink on the patient care units?**
A  We can only eat in the staff lounge, conference room or private offices. We can drink at the nurses’ station in areas where there is no risk for contamination. For example, we can place covered drinks on the low interior surfaces. Drinks are not allowed in the hallway such as WOW’s, bedside tables outside patient rooms, counters between patient rooms, portable chart racks.

Q  **Do you know the contact (drying) times for cleaning products to assure effective disinfection?**
A  The contact time for Super-Sani Clothes is 2 minutes, for Virex, 10 minutes, and for Dispatch 5 minutes.

### Environment of Care Tour

**Who will be involved?** The JC surveyor will tour the unit or department accompanied by the MGH escorts, unit or department leadership. During the tour, the surveyor will observe practice and will ask staff questions about the work environment and fire safety.

**What will the surveyor observe?**

*In addition to the environmental items mentioned in the Infection Control Section of this booklet the surveyors will observe:*

- Compliance with HIPAA regulations
- Security of medications and IVs (med carts, med and IV closets locked)
• Code Cart locks checked daily
• Fire extinguisher not blocked by equipment
• Oxygen tanks secured and stored per standards
• Access to exit doorways not blocked
• Corridors kept clear (all equipment on one side of hallway)
• Response to clinical alarms and call lights
• Patient food refrigerator checked; out of range actions noted; patient food dated
• No food or drink in patient care areas, clean supply or soiled areas, or where specimens collected

What will the surveyor ask while touring the area?

Equipment

Q  What do you do if a piece of medical equipment malfunctions or fails?
A  Remove the device, sequester, call Biomedical Engineering to report; submit a safety report, complete a yellow tag.

Q  How do you know a medical device is safe to use?
A  Each piece of equipment has a sticker which shows when it was inspected by Biomedical Engineering.

Q  What is the process if there is a recall or hazard alert on a piece of equipment?
A  MGH has a recall officer; Biomed and Materials Management work together to act on the alert.

Q  What is your policy regarding checking the defibrillator on the general units?
A  Nursing staff check the defibrillator every 24 hours. This includes checking to see that the defibrillator is plugged in and that all the needed supplies are there e.g. paddles, pads, gel, and that the pads are not expired. A biomedical engineer discharges the defibrillator weekly on the general units.
Medication Storage and Security

Q  *How do you ensure that medications are secure in all locations?*
A  Medications not under direct observation of the RN are secured in approved closets, Omnicells, patient and pharmacy bins etc., not left on the counters. This includes insulin and IV solutions.

Q  *How do you know none of the medications on the code cart are expired?*
A  The date of the first medication to expire is noted on the outside of the cart.

Spills

Q  *What do you do if there is a chemo spill on this unit?*
A  The chemo spill kit, which is available on the unit, is used to clean it up. The materials used to clean it up are placed in the chemo bucket.

Q  *Show me your MSDS (Material Safety Data) sheets.*
A  MSDS sheets for drugs are available through pharmacy. MSDS sheets for other chemicals are available on the MGH Safety website (Partners Applications→Utilities→MSDS Material Safety Data Sheets). The User Name and Password are both MGH.

Disaster and Fire Safety

Q  *What is your role in a disaster that results in an influx of patients to your organization?*
A  Follow directions of my nursing director, charge nurse, or supervisor.

Q  *What would you do if you saw smoke coming out of a patient’s room?*
A  I would implement the hospital’s fire plan which, is R.A.C.E., by "R"escuing the patient, sounding the "A"larm, "C"ontaining the fire by closing the door to the room after the patient has been evacuated, and, finally, if it is safe to do so, "E"xtinguish the fire.
Q  **Show me the fire extinguishers and fire alarms on this unit.**
A  *(Fire alarm pull stations are usually located by exit doors and by the nurses station.)*

Q  **Where are the oxygen shut off valves? Under what circumstances would you turn off the oxygen supply?**
A  *(Locate in your practice area.)* If a patient is on oxygen in the room where the fire is and I couldn’t get in the room safely to turn off the bedside oxygen flowmeter.

**Unit Refrigerators**

Q  **How long can patient food remain in the refrigerator before you must throw it away?**
A  Three days.

Q  **What do you do if you find out that the temperature in the refrigerator has been out of range?**
A  Call Buildings and Grounds and/or notify the OM.

**Patient Interview**

*Who will be involved?* The JC surveyor will ask the nurse caring for the patient if the patient is able to be interviewed. If yes, the JC surveyor will interview the patient and family without other members of the healthcare team present.

*Questions to patients and families may include:*
- Patient and family education and preparation for discharge
- Advance directives (Health Care Proxy)
- Understanding of medications
- Participation in care planning and response to questions
- Pain management
- Environment e.g. noise, cleanliness
- Help when they need it
Remember!

- Surveyors know the standards, but YOU know your practice and your patients and families.
- Relax and take your time answering the surveyor’s questions, but be direct and to the point with your response.
- You will not be alone, your Nursing Director, CNS and others will be there to help you.
- If you don’t know the answer to a question, it’s okay to say “I don’t know but I know where to find it.”
- Tell positive stories! If the surveyor asks you a question that relates to special project on your unit or in the hospital, tell about it!

Patient Care Services Resources

- Your Nursing Director, Clinical Nurse Specialist, Resource Nurses, Operations Managers, Collaborative Governance Champions

- Your Infection Control Liaison

- Staff from the PCS Office of Quality and Safety (ext. 3-0140)
  - Colleen Snydeman RN, Director
  - Linda Akuamoah-Boateng, BSPT, Project Manager
  - Gennady Beyzarov, Senior Project Manager
  - Judi Carr, RN, Staff Specialist
  - Deb Frost, RN, Staff Specialist
  - Patti Shanteler RN, Staff Specialist
  - Mary Anne Walsh RN, Nurse Clinician

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