Massachusetts General Hospital
55 Fruit Street
Boston, MA 02114

Date(s) of Survey: 12/11/2006 - 12/15/2006

PROGRAM(S)

Hospital Accreditation Program

Executive Summary

As a result of the accreditation activity conducted on the above date, your organization must submit Evidence of Standards Compliance (ESC) within 45 days from the day this report is posted to your organization's extranet site. If your organization does not make sufficient progress in the area(s) noted below, your accreditation may be negatively affected.

The results of this accreditation activity do not affect any other Requirement(s) for Improvement that may exist on your current accreditation decision.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Assessment and Care/Services

Standard: PC.8.10

Program: HAP

Standard Text: Pain is assessed in all patients.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : C
1. A comprehensive pain assessment is conducted as appropriate to the patient's condition and the scope of care, treatment, and services provided.

Scoring Category : C
3. Regular reassessment and follow-up occur according to criteria developed by the hospital.

Surveyor Findings

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

EP 1
Observed in [redacted] at Main site.
During a tracer it was noted that the pain assessment and reassessment were not conducted as per hospital policy and procedure.

Observed in [redacted] at main site.
During an individual patient tracer, it was noted that the patient had a surgical procedure on 12/11. He was received to the transplant unit at 3:40 pm on 12/11. There was no indication on the medical record that a pain assessment was conducted on the patient until 8 am on 12/12 (16 hours later). Hospital policy requires that all patients are assessed for pain after a surgical or invasive procedure.

Observed in [redacted] at main site.
During an individual patient tracer, it was noted on 12/12 that a patient admitted from surgery did not have a pain assessment completed for 22 hours. Hospital policy states that "pain is assessed on admission (acute care) and transfer to another unit."

Observed in [redacted] at main site.
During an individual tracer activity: in dialogue with the nurse and in review of the patient's [redacted] medical record, it was not evident that a comprehensive pain assessment was completed during the patient's stay in the [redacted] from 1137-1900 on 12/12/06. The patient was admitted to the [redacted] at 1900 where pain assessments were carried out and the patient subsequently medicated for discomfort.

EP 3
Observed in [redacted] at main site.
During an individual patient tracer it was noted that a patient received pain medication at 2:05 am and was not reassessed for pain until 4:10. The hospital policy states that intervals for reassessment post pharmacological intervention should be done 10-30 minutes following IV administration, 20-40 minutes following IM administration, 30-60 minutes following PO administration.

Observed in [redacted] at main site.
During an individual patient tracer, it was noted that pain was identified as 8/10 at 4:15 on 12/7 and reassessed on 12/8 at 7a, 13 hours later. The patient had a PCA with Dilaudid. Hospital policy states that reassessment for pain with a continuous PCA will occur every 4 hours.

Observed in [redacted] at main site.
During an individual patient tracer, it was noted that a patient was on a PCA pump. The patient complained of pain of 8/10 at 7am on 12/8 and reassessment of pain did not occur until 12 noon, 5 hours later. Hospital policy states that patients on a PCA pump should be reassessed within 4 hours after pain is identified.

Observed in [redacted] at main site.
During an individual patient tracer, it was noted that reassessment of pain for the patient did not comply with the hospital policy. The policy requires that pain assessment is to be done on all patients once per shift. On 12/12, the patient was assessed for pain once in 24 hours.

Observed in [redacted] unit at main site.
During an individual tracer activity: on 12/13/06 and during review of a patient's care with the nurse, the surveyor observed several entries for ongoing assessments of pain at 0710, (6/10); 1145, (3/10); and 1500, (8/10). The patient was medicated for each instance, however, it was not evident in the patient's medical record that a pain reassessment was completed after pain medication administration to determine effectiveness of pain management for the patient. The hospital policy 16-07-01, Guidelines for Pain Assessment and Management, p. 4 recommends reassessment of pain 30-60 minutes after administration of PO pain agents.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

Standard: PC.11.70

Program: HAP

Standard Text: Patients in restraint are monitored.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
2. A patient in restraints is monitored at least every two hours or sooner according to patient need and hospital policy.

Surveyor Findings

EP 2
Observed in [redacted] at main site.
During an individual patient tracer, it was noted that there was a physician order for soft limb restraints at 6:18 am on 12/11. There was no indication on the restraint flow sheet or in the nurses notes when the restraints were applied. The restraint flow sheet indicated that the monitoring for the restraints did not occur until 1pm. Hospital requires that the patient should be monitored every 2 hours. Based on the physician order given at 6:18, the monitoring should have begun by 8:18.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Infection Control

Standard: NPSG 7

Program: HAP

Standard Text: Reduce the risk of health care-associated infections.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
Requirement 7A - Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.**Organizations are required to comply with all 1A, 1B, 1C CDC recommendations.

Surveyor Findings

Requirement 7A
Observed in [redacted] at main site.
During direct observation, it was noted that the [redacted] technician placed the patient on the procedure table and positioned him. She then opened the drawer containing normal saline solution, obtained a syringe and drew up the saline flush and administered it to the patient. She did not cleanse her hands with soap and water or with any type of gel prior to preparation of the saline flush. Hand hygiene compliance rates since 2005 1st quarter, show a range of 71-78% compliance after contact and 52-55% compliance before patient contact. The 3rd quarter of 2006 showed a compliance rate of 55% before contact and 78% after contact.

Observed in [redacted] at main site.
During direct observation, a second [redacted] technician helped to position the patient on the table, did not use any type of hand hygiene after positioning the patient and immediately went to the computer console and started typing. This does not comply with CDC guidelines for hand hygiene.

Observed in [redacted] at main site.
During direct observation, it was noted that a [redacted] technician worked with the patient intravenous site, adjusted the contrast injector, walked into the control room, picked up some papers, and handed the papers to another technician in the back of the control room. She did not cleanse her hands after touching the patient and prior to handling papers.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Information Management

Standard: IM.6.10

Program: HAP

Standard Text: The hospital has a complete and accurate medical record for patients assessed, cared for, treated, or served.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : C
4. Medical record entries* are dated, the author identified and, when necessary according to law or regulation or hospital policy, authenticated, either by written signature, electronic signature, or computer key or rubber stamp**.

*For paper-based records, counter-signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulations or organization policy. For electronic records, electronic signatures will be date-stamped.

**Authentication is shown by written signatures or initials, rubber-stamp signatures, or computer key. Authorized users of signature stamps or computer keys sign a statement assuring that they alone will use the stamp or key.

Surveyor Findings

EP 4
Observed in [redacted] at main site.
During an individual patient tracer, it was noted that the physician assessment of the [redacted] patient was not timed. It could not be determined when this patient had been seen by the physician. The patient had been in the [redacted] for over 16 hours. Discussion with the medical director indicated that the expectation is that initial assessments are timed and dated.

Observed in [redacted] at main site.
A second medical record reviewed indicated that the physician assessment of the patient had not been timed.

Observed in [redacted] at main site.
During an individual patient tracer, it was noted that the medical history and physical was not dated as required by policy.

Observed in [redacted] at main site.
During an individual patient tracer, it was noted that the post procedure note was not dated.

Observed in [redacted] at main site.
During tracer activity, it was identified that the physicians initial assessment recorded on the [redacted] record did not have a time. According to the medical director the expectation is that the assessment would be timed and dated.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Medication Management

Standard: MM.2.20

Program: HAP

Standard Text: Medications are properly and safely stored.

Secondary Priority Focus Area(s): Physical Environment

Element(s) of Performance

Scoring Category : A
2. Medications are stored under conditions suitable for product stability.

Scoring Category : A
5. Unauthorized persons, in accordance with the hospital's policy and law and regulation, cannot obtain access to medications.

Scoring Category : A
7. All expired, damaged, and/or contaminated medications are segregated until they are removed from the hospital.

Surveyor Findings

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

EP 2
Observed in [redacted] at main site.
During environment of care tour: the logs for the Omnicell medication refrigerator had recorded temperatures documented on 10/29, 10/30, 11/16, 17, &19, 2006 for zero degrees Celsius. There was no documented evidence of notification to the plant/facilities department for refrigeration adjustment, nor notification to the [redacted] for evaluation of refrigerated products stability.

EP 5
Observed in [redacted] at Main site.
In unlocked cabinets at one end of the unlocked [redacted] multiple classes of medications are kept such as antibiotics, and anesthetic agents used for induction. There are often individuals working in this room, however the room is relatively long and narrow, and these individuals are not present to insure security of these medication. Hospital staff said that at least 200 individuals such as physicians, nurses, and cleaning personnel have access to this room, and consequently these medication are not secure from possible diversion.

Observed in [redacted] at Main site.
During a tracer it was noted that the [redacted] medication refrigerator in the holding area could not be locked. After hours, unauthorized personnel did have access to the area.

Observed in [redacted] at main site.
During an individual patient tracer, it was noted that persons not authorized by policy, law or regulation (such as [redacted] techs) have access to the medication room and the multiple medications in patient bins which are not secured in the OmniCell.

Observed in [redacted] at main site.
During patient tracer activity, it was noted that large volume intravenous fluids containing potassium chloride are stored on a wire rack in the supply room. Persons unauthorized by policy, law, and regulation ([redacted] technicians, [redacted] technicians, and unit secretaries) have access to this medication.

Observed in [redacted] at main site.
During individual patient tracer activity, it was noted that the medication room contained medications that were not in the Omnicell and were located on open shelves in the room. Persons not authorized to obtain access to medications had access to this room (OA/Unit secretary).

Observed in [redacted] at main site.
During patient tracer activity, it was noted that large volume intravenous fluids containing potassium chloride were stored in the supply room where persons unauthorized by policy, law, and regulation could obtain access to this medication.

Observed in [redacted] at main site.
During tracer activity, it was noted that the contrast is kept in a locked cabinet; however, the key was found in the lock. The staff stated that this is the general practice.

Observed in [redacted] at main site.
During tracer activity it was noted that unauthorized persons ([redacted] technicians) have access to the medication room in which patient medications are stored in open bins on a shelf.

Observed in [redacted] at main site.
During tracer activity, it was noted that large volume intravenous fluids containing potassium chloride are stored in the general supply room and are not secure. All levels of personnel have access to this room.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

Observed in [redacted] at main site.
During an environmental tour of the unit: several ampules of medications, i.e., atropine, anectine, propanalol, were located in the top drawer of the anesthesia machine. This machine is located in a procedure room, where sedation is administered. The room cannot be observed at all times when there are no personnel in the room or the room is not in use, the room was not in use during the surveyor visit. The drawer on the anesthesia machine cannot be locked. Other non clinical staff have access to the procedure room during the day. A nurse stated that the medications are removed from the machine at the end of the day and are locked up.

Observed in [redacted] at main site.
During an environmental tour of the unit: the surveyor observed patient medications, i.e., an IV med solution, several antibiotic (Nafcillin) IV mini bags sitting in two yellow plastic containers on a shelf within the "pneumatic tube" system area. The pneumatic tube system is located at an open end of the nurses' station with heavy people traffic walking to and fro' in this area. Some of the traffic is unit based staff and some of the traffic is not unit based staff. In dialogue with staff, it was shared that the meds may have been removed from the tube system by someone who may not have access to the med room, but that the meds would be placed in the med room as soon as possible.

Observed in [redacted] at main site.
During an individual tracer activity: the surveyor observed at a minimum six antibiotics, i.e., Piperacillin and Ampicillin IV mini bags and at a minimum four Pharmacy prepared medications in 30 ml syringes, i.e., Ranitidine 50 mg being held in a blue plastic bin container alongside the pneumatic tube system at one end of the nurse's station. This area is a heavy foot traffic area for unit and non unit clinical and non clinical staff moving back and forth across the unit. In dialogue with the unit manager, it was explained that the medications come to the unit from Pharmacy via the pneumatic tube system. Staff remove the medications from the pneumatic tubes on arrival to the unit and the medications are placed in the blue plastic container until someone with access to the medication room can move the medications to that area. It should also be noted that under the blue medication container, the surveyor noted that there was a red plastic container marked for medications to be returned to Pharmacy.

Observed in [redacted] at main site.
During an environment of care tour: the surveyor observed a red plastic "tackle" box on a shelf as one enters the [redacted] Patients pass by the tackle box when entering this area and housekeeping staff work in the area after hours when the Center's clinical staff are not present. In looking into the tackle box, which did not contain any type of a securing device, i.e., numerical plastic lock, the surveyor observed numerous medications for emergency use, two expired (02/06) 250 ml normal saline bags, numerous syringes/needles/IV tubing etc. Staff shared that they did not have a log for/nor checked the tackle box to assure integrity of the box and its contents by a schedule.

Observed in [redacted] at main site.
During an environmental tour of area: in one procedure room that was not in use during the time of visit by the surveyor, an anesthesia cart containing medications was observed to be unsecured and readily accessible. The nurse in attendance at the time of survey was not aware that the cart was open and stated that the cart would normally be secured when not in use. Other staff, i.e., housekeeping, may clean procedure rooms after hours when the Suite's clinical staff are not present.

EP 7
Observed in [redacted] at Main site.
During a tracer, the narcotics in the Omnicell automatic dispensing machine were checked. It was noted that demerol 50 mg and Phenobarbitol 20 mg had expired .

Observed in [redacted] site.
During an individual patient tracer activity, a vial of medication expired 05/2006 was noted in the front of the top drawer of the medication cart.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

Standard: NPSG 8

Program: HAP

Standard Text: Accurately and completely reconcile medications across the continuum of care.

Secondary Priority Focus Area(s): Communication

Element(s) of Performance

Scoring Category : A
Requirement 8A - Implement a process for obtaining and documenting a complete list of the patient current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.

Surveyor Findings

Requirement 8A
Observed in [redacted] at main site.
During an individual tracer activity: the surveyor had the opportunity to directly observe the patient's discharge process from the hospital. While reviewing the overall care of the patient from date of admission on 12/10/06 through 12/14/06, the surveyor noted that the electronic pre-admission medication list (PAML) was not evident as part of the hospital's process for medication reconciliation on admission.

Observed in [redacted] at main site.
During an individual patient tracer, it was noted that medication reconciliation had not occurred at admission to the unit from the emergency department. There was no indication that PAML process had been done.

Observed in [redacted] at main site.
During an individual tracer activity: it could not be determined if a medication reconciliation occurred on admission; the PAML was not completed, nor when the patient was transferred from a general medical unit to the [redacted] after undergoing a procedure in the [redacted] During the transfer to a higher level of care, previous orders were stopped, some orders were rewritten, and new orders were added to the treatment regimen.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Patient Safety

Standard: EC.7.50

Program: HAP

Standard Text: The hospital maintains, tests, and inspects its medical gas and vacuum systems.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
1. The hospital inspects, tests, and maintains critical components of piped medical gas systems including master signal panels, area alarms, automatic pressure switches, shutoff valves, flexible connectors, and outlets.

Surveyor Findings

EP 1
Observed in Medical Gas alarm panel locations at Main site.
Medical gas alarms located through out hospital are not tested monthly for operation

None of the remote alarm panels are being tested to insure operation during a fault.

Standard: UP 1

Program: HAP

Standard Text: The organization fulfills the expectations set forth in the Universal Protocol.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
Requirement 1A - Conduct a pre-operative verification process as described in the Universal Protocol.

Scoring Category : A
Requirement 1C -Conduct a “time out” immediately before starting the procedure as described in the Universal Protocol

Surveyor Findings

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

Requirement 1A
Observed in [redacted] at Main site.
In a chart reviewed of a patient that had an invasive procedure there was no documentation of the initial patient identification as required in UP1.

Requirement 1C
Observed in the [redacted] at Main site.
In a patient with leukemia a triple lumen Hickman Catheter was placed, however there was no documentation of a time out prior to the procedure being done. In the same patient there was no documented time out prior to a bone marrow biopsy being performed. It is noted that the hospital requires that UP1 be done for all invasive and operative procedures. It was suggested where feasible the procedure that is used in the main operating room to satisfy UP1 be instituted system wide as the OR system works well.

Observed in [redacted] at Main site.
While conducting a tracer on a 16 year old with head trauma it was noted that for 2 of the invasive procedures the time out documentation was not in the medical record.

Observed in [redacted] at Main site.
During a tracer it was noted that a patient who had an endoscopy, did not have a time out form in the medical record.

Observed in [redacted] at Main site.
During individual patient tracer, it was noted that a central line was inserted on 12/4/06. There was no indication in the medical record that a "time out" occurred prior to the procedure. Hospital policy states that an invasive or surgical procedure requires a "time out".

Observed in [redacted] at main site.
During individual patient tracer activity, it was noted that an arterial line was placed in the patient on 12/6/06. There is no indication that a "time out" was performed prior to the procedure as required by hospital policy.

Observed in [redacted] at main site.
During patient tracer activity, it was noted that an angiogram was performed on 12/9/06. There was no indication in the medical record that a "time out" was performed as required by hospital policy prior to the procedure.

Observed in [redacted] at main site.
During tracer activity, it was noted that a central line was placed in the patient on 12/9/06 with no indication in the medical record that a "time out" was performed prior to the procedure.

Observed in [redacted] at main site.
During an individual patient tracer, it was noted that a central line was inserted on 12/10 and there was no indication that a "time out" was conducted.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Physical Environment

Standard: EC.5.50

Program: HAP

Standard Text: The hospital develops and implements activities to protect occupants during periods when a building does not meet the applicable provisions of the Life Safety Code®.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : A
3. Each hospital implements ILSMs as defined in its policy.

Surveyor Findings

EP 3
Observed in the main emergency exit at [redacted] site.
During an individual patient tracer activity, it was noted that construction had been taking place for the past two weeks immediately outside the principle emergency exit for the healthcenter including a hole two feet deep. Discussions with the clinical managers indicated that there have been no risk assessment for the center nor any ILSMs put in place.

The Joint Commission

Accreditation Survey Findings

Requirement(s) for Improvement

These are the Requirements for Improvement related to the Primary Priority Focus Area:

Rights & Ethics

Standard: RI.2.80

Program: HAP

Standard Text: The hospital addresses the wishes of the patient relating to end of life decisions.

Secondary Priority Focus Area(s): N/A

Element(s) of Performance

Scoring Category : C
4. Documentation indicates whether or not the patient has signed an advance directive.

Scoring Category : B
8. The hospital has a mechanism for health care professionals and designated representatives to honor advance directives within the limits of the law and the hospital's capabilities.

Surveyor Findings

EP 4
Observed in the [redacted] at Main site.
In a patient that had surgery for cholelithiasis one could not determine if the a patient had an advanced directive or been offered information with respect to generating one.

Observed in [redacted] at main site.
During an individual patient tracer, it was noted that the medical record did not indicate whether or not the patient had signed an advance directive. The Health Care Proxy Questionnaire had not been completed per hospital policy and there was no notation in the record regarding an advance directive.

Observed in [redacted] at main site.
During an individual patient tracer, it was noted that the medical record did not indicate whether or not the patient had signed an advance directive. The Health Care Proxy Questionnaire had not been completed per policy.

Observed in [redacted] at main site.
During patient tracer activity, it was noted that there was no documentation to indicate whether or not the patient had signed an advance directive. The Health Care Proxy Questionnaire had not been completed.

Observed in [redacted] at main site.
During an individual patient tracer, it was noted that there was no indication whether or not the patient has signed an advance directive.

EP 8
Observed in [redacted] at main site.
During an individual patient tracer, it was noted that the patient stated that he had an advance directive. There was not a copy of the directive on the medical record and no indication of what his wishes were based on the advance directive. The patient had been admitted for 7 days.