The Joint Commission

Official Accreditation Report

Somervell County Hospital District
1021 Holden Street
Glen Rose, TX 76043

Organization Identification Number: 2907

Unannounced OQM Event: 12/11/2014 - 12/11/2014

Report Contents

Executive Summary

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Opportunities for Improvement

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Executive Summary

Program(s)
Hospital Accreditation

Survey Date(s)
12/11/2014-12/11/2014

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	HR.01.02.01	EP1
	IC.02.02.01	EP4
	LD.03.01.01	EP2,EP7,EP8

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CoP: §482.51 **Tag:** A-0940 **Deficiency:** Standard

Corresponds to: HAP - IC.02.02.01/EP4

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP: §482.21 **Tag:** A-0263 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.21 Condition of Participation: Quality Assessment and Performance Improvement Program

The hospital must develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.

CoP Standard	Tag	Corresponds to	Deficiency
§482.21(b)(2)(ii)	A-0283	HAP - LD.03.01.01/EP2	Standard

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Requirements for Improvement – Detail

Chapter: Human Resources

Program: Hospital Accreditation

Standard: HR.01.02.01

ESC 60 days

Standard Text: The hospital defines staff qualifications.

Element(s) of Performance:

1. The hospital defines staff qualifications specific to their job responsibilities. (See also IC.01.01.01, EP 3 and RI.01.01.03, EP 2)
Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control).
Note 2: Qualifications for laboratory personnel are described in the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88), under Subpart M: 'Personnel for Nonwaived Testing' 493.1351-493.1495. A complete description of the requirement is located at http://wwwn.cdc.gov/clia/Regulatory.
Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements.
Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
Observed in Competency Session at Glen Rose Medical Center (1021 Holden Street, Glen Rose, TX) site. During review of the HR file of a RN who had recently advanced from an LPN position after gaining her RN credentials, it was discovered that this nurse had started work in the hospital as a RN in June of 2014. At the time of the survey (December, 2014), a job description specifying her tasks as an RN had not yet been developed and presented for agreement and approval. It was the hospital's expectation that such a job description is presented and signed upon hire to that position.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.02.01 ESC 60 days

Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Element(s) of Performance:

4. The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 4
§482.51 - (A-0940) - §482.51 Condition of Participation: Condition of Participation: Surgical Services
This Standard is NOT MET as evidenced by:
Observed in Tracer Visit at Glen Rose Medical Center (1021 Holden Street, Glen Rose, TX) site for the Hospital deemed service.
During an inspection of the crash cart in the PACU, the oral intubation kit was opened and a laryngoscope blade was found stored unwrapped and at risk for contamination.

Observed in Tracer Visit at Glen Rose Medical Center (1021 Holden Street, Glen Rose, TX) site for the Hospital deemed service.
During an inspection of the crash cart in the PACU, the oral intubation kit was opened and a second laryngoscope blade was found stored unwrapped and at risk for contamination.

Observed in Tracer Visit at Glen Rose Medical Center (1021 Holden Street, Glen Rose, TX) site for the Hospital deemed service.
During an inspection of the crash cart in the PACU, the oral intubation kit was opened and 8 other laryngoscope blades were found stored unwrapped and at risk for contamination..

Chapter: Leadership

Program: Hospital Accreditation

Standard: LD.03.01.01 ESC 60 days

Standard Text: Leaders create and maintain a culture of safety and quality throughout the hospital.

Element(s) of Performance:

2. Leaders prioritize and implement changes identified by the evaluation.

Scoring Category : A
Score : Insufficient Compliance

7. Leaders establish a team approach among all staff at all levels.

Scoring Category : A
Score : Insufficient Compliance

8. All individuals who work in the hospital, including staff and licensed independent practitioners, are able to openly discuss issues of safety and quality. (See also LD.04.04.05, EP 6)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.21(b)(2)(ii) - (A-0283) - [The hospital must use the data collected to--]

(ii) Identify opportunities for improvement and changes that will lead to improvement.
This Standard is NOT MET as evidenced by:
Observed in Document Review at Glen Rose Medical Center (1021 Holden Street, Glen Rose, TX) site for the Hospital deemed service.
During review of the 2014 Board Quality Committee minutes from 2014, it was noted that a hospital staff Employee Culture of Safety Survey was conducted in 2014. The results of the survey showed the lowest scores involved Non-Punitive Response to Errors, Teamwork across departments, and Hand-offs and Transitions. During discussion with the hospital leadership, it was noted that there were no concrete plans formulated yet to improve these deficiencies.

EP 7
Observed in Tracer Activities at Glen Rose Medical Center (1021 Holden Street, Glen Rose, TX) site.
During tracers involving one on one interviews with healthcare staff in the medical surgical ward and the manager and nursing staff of the Emergency department, it was noted that there was a high level of distrust by the ED personnel of the abilities of the healthcare staff in the medical surgical ward, for example, in the area of code blue resuscitation. Likewise, the staff in the medical surgical ward expressed great anxiety and disappointment over these perceptions. The 2014 Employee Culture of Safety Survey conducted by the hospital revealed a low score on the staff perception of teamwork across hospital departments/units.

EP 8
Observed in Tracer Activities at Glen Rose Medical Center (1021 Holden Street, Glen Rose, TX) site.
During staff interviews in the medical-surgical ward and Emergency Department, the staff interviewed all expressed that they could freely speak up to leadership regarding issues involving adverse patient events and reporting errors. However, the 2014 Employee Culture of Safety survey showed poor scores in this area, with the reason given that such reporting meant "tattling on each other."

Opportunities for Improvement – Summary

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Program:	Hospital Accreditation Program	
Standards:	HR.01.06.01	EP6

Opportunities for Improvement – Detail

Chapter:	Human Resources
Program:	Hospital Accreditation
Standard:	HR.01.06.01
Standard Text:	Staff are competent to perform their responsibilities.

Element(s) of Performance:

6. Staff competence is assessed and documented once every three years, or more frequently as required by hospital policy or in accordance with law and regulation.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP6
Observed in Competency Session at Glen Rose Medical Center (1021 Holden Street,Glen Rose,TX) site. During review of the HR files of a nurse who advanced in the hospital from a LPN to a RN in June, 2014 after obtaining her credentials and licensure, it was discovered that 90 day post hire competency evaluations were not performed as per the hospital's policy.

Plan for Improvement - Summary

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs: 0