HEALTH PERSPECTIVES

A NON-PROFIT TAX EXEMPT ORGANIZATION

Vol. 2, No. 2 PUBLISHED BY THE CONSUMER COMMISSION ON THE ACCREDITATION OF HEALTH SERVICES, INC. Mar.-Apr. 1975

HOSPITAL ACCREDITATION — WHERE DO WE GO FROM HERE?

QUALITY—WHO IS THE JUDGE?

Patients know very little about the quality of hospital services. There is a lack of standards, reports or guidelines that consumers can use when faced with the reality that they will be hospitalized. The medical practitioners and other health workers have a greater ability to judge the quality of care offered by hospitals. Yet, even among these more sophisticated and knowledgeable health providers the range of criteria used to measure quality varies as much as the outcome of their ratings of hospitals.

Even where a group of hospitals appear to be recognized for their above standard care, the various clinical services (i.e. medicine, obstetrics-gynecology, surgery and pediatrics) may significantly vary in quality. And to complicate things further, the range and quality of special services available (i.e., open-heart surgical facilities—see Health Perspectives, Vol. 1, No. 5, May-June 1974) may vary even more.

So consumers rely on the professionals to judge these matters. Most patients, being either unaware of their options or unsure of their right to seek an option not offered by a professional will, for instance, allow themselves to be admitted to almost any hospital without question.

Why should consumers—about to become patients—have any questions in the first place? Aren't all hospitals licensed? Aren't they all inspected? Aren't they all required to meet standards? Aren't they all accredited?

Yes, most hospitals are either licensed, certified, or accredited. Hospital regulation is a big business—with federal, state, local and non-governmental quasi-public agencies involved in many areas in the U.S. But, just a few years ago the hospital industry was unregulated and uncontrolled. In those days, private agencies guided, planned and reviewed hospitals. The foremost private agency—the Joint Commission on the Accreditation of Hospitals (JCAH)—was looked upon as the pinnicle of what private interests could do to guarantee high quality of care. So respected was the JCAH, that Congress, with prodding from hospitals, the AMA and other provider groups, enacted the Medicare program with a major role for the JCAH. The law stated that any hospital accredited by JCAH was automatically eligible to receive Medicare funds.

Since 1965, when the Medicare law changed the financing of health services for the aged, the JCAH assumed a role to ensure the quality of care for the aged, and therefore, had to stand the test of public scrutiny.

That exposure has raised some serious questions in the minds of the public, its representatives and professionals about the JCAH's ability to ensure quality. The JCAH leadership voiced through its Director, John D. Porterfield, M.D., admits that somewhere, somehow, something is wrong. "People began using JCAH accreditation, evidence of an institution wanting to improve itself, as a warranty. But, accreditation was not and is not meant to be a warranty that every outcome will be good. It is only that accredited institutions are trying to improve, continuously, and present no clear and present danger to the safety of patients."

PRESENT AND CLEAR DANGERS DO EXIST!

When Congress established the Medicare program in 1965, it retained limited responsibility to assure that the public funds spent on hospital care for older people would be used to purchase decent quality care. But there was great pressure applied at that time to prohibit the government from policing and interfering with the private practice of medicine. The federal government decided that any hospital that was good enough to get JCAH approval was good enough to serve Medicare patients and receive Medicare money. If a hospital was accredited by the JCAH it was "deemed" to meet federal health and safety requirements.

Under the original legislation, the Federal Government could not question the accreditation of any hospital. If federal officials received complaints about a hospital, they could forward them to the JCAH, but there was no requirement that the JCAH had to take any action.

In 1972, however, Congress passed amendments to the Social Security Act (P.L. 92-603) which authorized the Secretary of HEW to make hospital surveys of accredited hospitals, either on a selective sample basis or in response to a substantial complaint. This gives the federal government the right to spot-check the reliability of JCAH surveys. It also gives consumers, patients, and hospital staff members the right to appeal directly to the Secretary about hospital conditions they note as adverse to the health and safety of patients. If significant deficiencies are found during a validation survey, the federal government can require that the hospital be re-surveyed by the State Certification Agency if it wishes to stay in the medical program. In New York State, this Agency is the State Department of Health.

In 1974, the Consumer Commission asked HEW to conduct validation surveys of eight JCAH accredited hospitals in New York City. The Bureau of Health Insurance received two additional requests for validation surveys in 1975. These requests were based on evidence of substantial violation of federal law. Three of the hospitals had a single egress, which is a violation of the life-safety provisions of the Social Security Act. Most of the hospitals have been inspected. As a result of these surveys nine have lost their "deemed" status.

Also in 1974, the first year of validation surveys, a selected sample of 105 hospitals in 33 states (four hospitals in New York City) were selected for validation surveys by HEW.

Of these 105 hospitals, 68 were declared to be delivering sub-standard care because they had significant health and safety deficiencies. Three of the four hospitals surveyed in New York City were found to be deficient. Many of the hospitals did not meet fire safety requirements, had inadequate exits, no fire detection system or sprinklers, or inadequate fireproofing. Other shortcomings included incomplete drug records, so that patients were in danger of receiving improper medications; inadequate numbers of nurses, so that it was impossible to properly care for all patients; lack of controls in the dietary departments, so that patients were not being given the foods prescribed for them and in some cases were subject to malnutrition; and poorly kept medical records, so that proper follow-up treatment could not be performed.

When Dr. Porterfield was asked to comment on the results of the federal spot-check he said that the JCAH surveys might not have stressed fire safety because ". . . we're not fire inspectors, we're physicians and nurses." He added that fires were rare in hospitals and perhaps the federal government's stringent fire regulations were not necessary.

TO DEEM OR NOT TO DEEM?

Regardless of Dr. Porterfield's opinion, the hospitals where serious deficiencies were found were notified that they had lost their "deemed" status. That is, they no longer were deemed to meet federal regulations by virtue of their accreditation by the JCAH. This is the first step in preparing to disallow a hospital from continuing to receive Medicare funds. The hospitals have 30 days in which to submit a plan of correction to the State Certification Agency, which rules on the acceptability of the plan. The JCAH is also given an opportunity to rebut the findings of the federal survey.

While the hospital lacks "deemed" status, it is treated as if it were unaccredited, and is inspected annually by the Medicare survey team. If the deficiency is structural, deemed status can return once the deficiency is corrected. In other cases, the structural deficiency is of such magnitude that it cannot be corrected, which could lead to a cutoff of federal funds. However, if the hospital has recurrable deficiencies, such as shortages of nurses or other staff, "deemed" status is taken away for a period of two years. Most hospitals have taken steps to correct deficiencies found during validation surveys, thus avoiding severe financial penalty.

There is nothing in the law that allows HEW to reduce Medicare payments to hospitals with deficiencies. Hospitals are so dependent on federal funds now, that cutting off these funds would be tantamount to closing a hospital, an action which officials are reluctant to take.

THE ACCREDITATION PROCESS– CAN IT BE BETTER?

With so many official and non-official agencies relying on the JCAH and with so much at stake in accreditation, one would expect the process to be carefully thought out and stringently applied. In fact, few things could be less strict.

The vast majority of JCAH surveys are conducted as friendly consultations. The JCAH determines whether or not a hospital should be accredited on the basis of the hospital's answers to a questionnaire, and on an inspection of the hospital by a survey team. Only JCAH surveyors and hospital officials are present during the inspection. Survey teams are made up of at least one doctor, an administrator or a nurse or former hospital administrators. Sometimes additional doctors or nurses are on the team. The staff is usually made up of retired professionals, who travel about the country making inspections.

The hospitals usually receive at least a four week notice before an impending survey. What most often happens is that the hospital, given this advance notice, prepares itself for the inspection. The team comes, looks around (usually for two days), meets with the administrator, and prepares a preliminary report, including its recommendations about continued accreditation to the JCAH Board of Commissioners. The Board makes the final decision about

accreditation. On the basis of this procedure, billions of tax dollars are disbursed to hospitals each year.

The JCAH usually does not make surprise visits to hospitals. It has never actively sought the views of hospitals workers or the people who use the hospitals during a survey. During the last few years, theoretically, consumers can make their views known by requesting to appear at a public interview, but these interviews have been discouraged by the JCAH. The JCAH bestows the same seal of approval on a 1,000 bed hospital with medical school affiliation and major research and training programs as it does on a 29 bed hospital with none of these programs or affiliations. The JCAH approves the whole hospital, even though many specific life-saving services and specialized units may be deficient or non-existent.

If the JCAH survey team finds serious deficiencies in a hospital it may issue a (provisional) one-year accreditation or it may disaccredit the hospital completely. Each year about 20% of hospitals visited are given a one-year accreditation, in the hope that this will put great pressure on the hospital to improve. Three consecutive one-year accreditations leads to automatic loss of JCAH accreditation. Another 2% to 5% of surveyed hospitals are refused accreditation, which means that theoretically they should no longer be considered good enough to receive Medicare funds, participate in several Blue Cross plans, or have approved training programs for interns and residents. However, if a disaccredited hospital requests a review of the survey findings, the JCAH will consider it "administratively accredited" pending the outcome of the review. This serves to maintain the hospital's accredited status until the JCAH can resurvey the hospital. In effect, administrative accreditation is equivalent to a continuation of accreditation until the review by JCAH is complete. When a hospital loses accreditation, the federal government then makes a hospital inspection, utilizing state survey personnel under contract to HEW, *using federal guidelines and instructions* to see if federal funding is to be continued. Although state personnel are utilized in the survey, they follow federal guidelines. The survey is different from the state licensure survey, which utilizes individual state standards that vary from state to state.

How The System Fails To Work—Sometimes!

On March 31, 1975, the New York Times ran a front page story on Linden General Hospital in Brooklyn which ". . . has lost its accreditation and been declared hazardous, unneeded and irremediably obsolete by government inspectors. But the hospital continues to function because of an unabated flow of government Medicaid payments that are its main source of support."

For over a year, inspectors from the New York State Department of Health had reported that the hospital had serious fire safety violations, inadequate toilet facilities, and poor sanitation. One physician-inspector reported that the circumstances at Linden General created a condition ". . . that is not only a serious one with respect to the protection of the public health, but is virtually an irremediable situation." In spite of this, in August, 1974, the hospital was given a two-year renewal of its operating certificate by the State Health Department.

Two years ago, the JCAH declared Linden General non-accredited based on its deficiencies. Because government funds were disbursed on the basis of JCAH accreditation, the JCAH is supposed to notify government officials when a hospital is not meeting standards. But when Linden General requested a review of the findings, the Joint Commission considered the hospital "administratively accredited" pending the outcome of the review. Government officials learned of the non-accreditation afterwards, and only then by accident.

In May, 1975 Linden General was notified that federal funding would be stopped because of fire hazards and other deficiencies. Earlier in the year, the JCAH *finally* decided to withdraw its accreditation.

IMPLICATIONS OF CONFUSED JCAH ROLE

Unless, the role of JCAH is changed to protector of the public purse, every citizen and consumer will continue to subsidize many substandard hospitals with their tax dollars. In 1974, one billion Medicare and more than one billion Medicaid dollars went to hospitals in New York State. (The federal government generally provides one half of the Medicaid payments with state and local governments sharing the remaining costs.)

JCAH Consumer Policy

on Accreditation Surveys

The JCAH policies state that upon written request to the hospital and JCAH:

—JCAH will provide the past accreditation history of the hospital.

—JCAH will provide a listing of the hospitals to be surveyed during the quarter.

—The hospital must provide the exact date that the hospital will be surveyed.

—And, the hospital and the JCAH must hold a Public Information Interview (PII).

Recent changes in JCAH policy now include: the posting of the dates that the JCAH is scheduled to survey the hospital four weeks in advance of the survey date; and a requirement that anyone wishing to make a presentation write to the JCAH two weeks in advance.

These new requirements, although appearing to encourage consumer participation are not too helpful to most consumers, especially those not in the hospital at the right time.

This enormous expenditure of public funds calls for adequate public safeguards to ensure that hospital services of decent quality are delivered. The use of JCAH accreditation as a means of quality control is inadequate, and JCAH spokesmen deny that the JCAH accreditation guarantees quality.

Accreditation does not mean that a hospital is safe, or that it provides acceptable medical care; all it means is that the institutions are trying to improve. *Minimal standards of fire safety and nursing care have not been met in many accredited hospitals, and nearly 67% of the hospitals surveyed for validation of JCAH accreditation didn't meet federal standards.*

The federal government must accept the confidential hospital-JCAH relationship. There is no way, short of inspecting a hospital, to determine which aspects of a hospital's services are good, bad or excellent. The JCAH survey reports are still completely confidential. The hospitals do not receive a copy of the report; but instead receive a letter listing serious deficiencies. Under certain circumstances, HEW can receive a copy of this letter, but even the government lacks the right to see the full report.

This is true despite the fact that Section 1865 (a) of the Social Security Act requires hospitals to authorize the JCAH to release survey reports to the Secretary of Health Education and Welfare. The JCAH has taken the position that the statute does not require it to release survey reports to the Social Security Administration. It feels that the intent of the statute is served if it releases to the Secretary the letters of deficiency that are sent to surveyed hospitals.

The federal Freedom of Information Act does not help to attain access to JCAH survey reports. This act specifically excludes JCAH survey reports from being disclosed by HEW and reinforces the unnecessary confidential status of these reports. There is no law requiring the proprietary, voluntary or public hospitals to disclose JCAH reports or most other information on their activities to the public. The use of JCAH accreditation to justify the expenditure of Medicare and Medicaid funds, thus, leaves no mechanism for public accountability. The Consumer Commission has appealed to the Secretary of HEW to compel hospitals to make the letters of deficiencies available to the public under the Freedom of Information Act. As a result of this appeal, the Social Security Administration released to the Consumer Commission copies of the deficiency letters sent by JCAH to the 105 hospitals that were subjected to a validation survey.

The JCAH immediately sued the Social Security Administration to stop further release of its reports. The JCAH also announced that it will not release any more reports to the government.

The Consumer Commission's appeal to open all deficiency letters to public view has been denied.

Curiously enough, nursing homes were never considered eligible for Medicare funds simply because they were accredited by the JCAH. The responsibility for inspecting nursing homes has remained with the state or local government acting as an agency of HEW. The current expose of conditions in nursing homes in New York and other Northeastern states is possible only because the state and federal inspection reports for nursing homes are available to the public. Unless there is full disclosure of JCAH inspection reports of hospitals, the public will not know if unsafe and dangerous conditions continue to exist in hospitals.

RECOMMENDATIONS

The Consumer Commission recommends that
(a) the federal government:

1. cease to rely on private organizations, such as the JCAH, to guarantee the quality of medical care paid for by public funds and assume the full responsibility for inspecting hospitals.
2. develop a national inspection program to be set up under HEW.
3. set up standards by major categories of hospital (voluntary, government, proprietary), and by the size and services offered by the hospital, (open-heart, premature nursury, intensive care units, etc.).
4. HEW be empowered to reduce payments to hospitals until deficiencies are corrected.

(b) the JCAH:

5. resume and strengthen its original pre-Medicare role; that is, it acts as a consultant for those hospitals seeking to improve services.
6. amend its present procedures about advance notification to hospitals, and schedule more unannounced visits (including nights and weekends).
7. request all consumers and hospital workers to comment on hospital services by requiring that a brochure on JCAH be given to each patient, by interviewing patients and workers in the hospital, emergency room and clinics and by placing a notice in local papers inviting comments by the community on the hospitals' services.

and (c) that:

8. consumers write to the Secretary of HEW, requesting validation surveys of local hospitals where substantial threats to the health and safety of patients exist.
9. all survey reports on hospitals, either public or private, be made public and available on request.

CONSUMER ACTION CAN FORCE IMPROVEMENTS IN HOSPITAL SERVICES

Are you concerned?

- billions of Medicare dollars are paid out to hospitals based on JCAH accreditation.
- nearly 70% of hospitals randomly selected for a validation survey failed to meet federal standards.
- JCAH spokepersons state that JCAH is not a watchdog over the quality of care.
- JCAH director wants reports to remain confidential.

Do substantial or significant deficiencies exist?

- fire hazards (single exit, dead-end corridors)
- poor construction (wooden, stairs and elevators not useable)
- unsafe or inadequate equipment (outdated

X-ray equipment, electrical wiring frayed)

- lack of supplies (no drugs, needles, clean sheets)
- shortages of staff (not enough nurses, technicians)
- overcrowding (excessive occupancy, no reserve beds for emergencies)

What you can do!

- write to the Secretary, HEW, Washington, D.C.

or

- write to your local Social Security office to ask for an HEW validation (of JCAH) survey, where substantial or significant deficiencies endanger the health or safety of patients.

History of JCAH

1918—American College of Surgeons (ACS) develops minimum standards for hospitals. 700 hospitals inspected, 89 pass. List of failing hospitals is burned in basement of hotel where ACS was having meeting.

1919-1951—ACS performs hospital standardization program, using standards contained on *one* page.

1951—ACS invites American College of Physicians, American Hospital Association, American Medical Association, and Canadian Medical Association to form a joint commission. For the next ten years individuals from three organizations perform surveys on part-time basis.

1959—Canadian Medical Association withdraws to form own national program.

1961—JCAH develops own survey staff.

1964—JCAH establishes survey fee paid by hospitals seeking voluntary accreditation.

1965—Medicare act states that JCAH accreditation makes hospitals automatically eligible for Medicare program.

1965—J.D. Porterfield, M.D., former U.S. Public Health Service Deputy Surgeon General and past President, American Public Health Association becomes JCAH Executive Director.

1965—American Association of Homes for Aging and American Nursing Home Association are each given one representative commissioner position in JCAH.

1967—Health Insurance Benefits Advisory Council, Medicare Program, charges JCAH standards inadequately applied by individual inspectors and some standards too low.

1967—JCAH develops survey teams and reduces JCAH accreditation approval from three to two years.

1969—JCAH develops new "tougher" standards which are distributed for discussion and review. Tougher standards seen as tightening of old standards by many.

1970—New standards are adopted by JCAH. New standards contain Preamble outlining "patients' rights".

1970—Consumers attack JCAH in courts and through the press. Consumers claim that JCAH approved inadequate and dangerous hospitals in California in violation of Medicare law. Consumers meet with JCAH officials demanding full disclosure of accreditation reports, putting consumers on JCAH Board of Commissioners, having consumers on survey teams and obtaining greater public accountability of JCAH decisions.

1971-72—California Medical Association (CMA) sets up own hospital accreditation program—results—CMA does not approve many JCAH accredited hospitals in California.

1971-72—Sen. Ted Kennedy holds subcommittee hearings on health. Attacks JCAH as poor mechanism to control quality of services rendered under Medicare program. Calls for establishment of Federal Commission on Quality Control.

—Accreditation Council for Long-Term Care Facilities established—American Association of Homes for the Aging and American Nursing Home Association removed from Board of Commissioners.

1972—Medicare amended to give Secretary of HEW right to do selective sample validation of JCAH accreditation where substantial allegations of the existence of deficiencies that adversely affect the health and safety of patients are made and to promulgate standards higher than the JCAH Standards for the Accreditation of Hospitals.

1974—HEW undertakes 105 validation of JCAH surveys. 68 hospitals lose "deemed" eligibility status in Medicare program because of deficiencies.

1975—Social Security Administration (SSA) releases deficiency letters sent by JCAH to the 105 hospitals selected for federal validation study. Dr. Porterfield states that JCAH will stop releasing confidential information to the SSA. Consumer Commission presses for full release of all JCAH Reports.

The Consumer Commission has spearheaded several actions to force public disclosure of so-called "confidential" documents on the costs or quality of hospital services.

Recently, the JCAH deficiency letters sent to 105 hospitals which were surveyed to validate JCAH accredition were released to the Consumer Commission by a federal agency. The JCAH immediately brought suit against the federal government to prevent further release of those and other JCAH materials.

Below is the full text of the deficiency letter sent by the JCAH to Jamaica Hospital, located in Queens County, New York City—one of the 105 letters the JCAH refuses to release to the public, and now refuses to even release to the Secretary of the Department of Health Education and Welfare.

For comparison purposes, the Federal Validation Survey for Jamaica Hospital is also shown below.

The release of this material may show (1) the poor state of affairs at a hospital or (2) the poor state of the art regarding JCAH accreditation of hospitals. Obviously, there are no state secrets being given away in these reports, but we ask you to drawn your own conclusions.

(The numbers to the extreme left indicate the JCAH's priority scale. The highest number (9) indicates those items which should be acted on first. It should be noted that the report is labeled Recommendations and Comments, not Deficiencies or Problems. Also note that the words "should" and "must" are sprinkled throughout, but specific timetables and exact procedures for correction are not stated or are vague.)

JCAH SURVEY OF JAMAICA HOSPITAL

RECOMMENDATIONS AND COMMENTS

Date of Survey: April 30, May 1, 1974
Surveyors: Edward T. Lawless, M.D., G.T. Barteb, FACHA

D-GOVERNING BODY AND MANAGEMENT

2 1. Personnel records should contain reports of outside seminars and workshops attended.

E-MEDICAL STAFF

6 1. In making application for clinical privileges, each applicant must sign an agreement to abide by the current medical staff bylaws, rules and regulations and by the hospital bylaws.

6 2. A profile reflecting the clinical performance of each medical staff member should be maintained and periodically updated.

6 3. There must be evidence that the applicant is required to pass through a provisional period of appointment.

6 4. The medical staff must continue to develop criteria for use in medical care evaluation studies in all services. Medical care data must be collected and compared with the audit criteria in order to evaluate the quality of medical care. Where corrective action must be taken, such as continuing education programs, changes in bylaws, rules and regulations, changes in privileges or other medical staff or hospital-wide changes, a procedure to follow-up on the results must be instituted. Reports of all medical care evaluation activities must be presented to the governing body for review and action.

F-NURSING SERVICES

9 1. Periodic evaluation of all nursing performance, in outpatient, emergency, and special care areas as well as in inpatient care areas, must be conducted by means of a nursing care audit which includes the development of criteria, the measurement and comparison of nursing care data and the evaluation of any deviation from the standards of practice. The findings and any subsequent corrective activities should be documented and reported to the director of the nursing service for action and reflected in the instructional content of inservice and continuing education, individual counseling, changes in hospital policies or procedures, and changes in facilities or equipment.

2 2. The revision of the Policy and Procedure Manual should be completed.

H-DIETETIC SERVICES

4 1. There should be educational programs for dietary employees that include instruction in personal hygiene; food handling, preparation and serving; and proper cleaning and safe operation of equipment.

4 2. The operations of the dietetic service must be safe and sanitary.

I-EMERGENCY SERVICES

6 1. The credentials of physicians serving in the emergency room should be reviewed in the same manner as the credentials of other physicians on the active medical staff. All physicians must sign an agreement to abide by the medical staff bylaws and rules and regulations and the hospital bylaws.

4 2. Every patient receiving emergency service must have an official hospital record that contains final disposition, including instructions given to the patient and/or family relative to necessary follow-up care. The medical staff bylaws, rules and regulations or procedures must require that patients and/or family be given instructions in regard to follow-up care.

J-ENVIRONMENTAL SERVICES

6 1. Every 150 feet of corridor length on any hospital sleeping floor should have either a smokestop partition or a horizontal exit. Reference: North, East and South Wings.

6 2. Doors in fire separations, horizontal exits and smokestop partitions must be built of at least one-hour fire-resistive material. It is noted in the statement of construction that in the North Wing some doors are missing.

6 3. Any door in a fire separation, horizontal exit or a smokestop partition may be held open only by an electrical device approved by the National Fire Protection Association, and should not be held open by door stops or other such methods. (Reference: Life Safety Code 101, 10-1244)

6 4. There should be documented evidence of active safety and preventive and corrective maintenance programs that include written procedures to use in the event of a breakdown in mechanical systems or utilities.

4 5. There must be documented evidence that the ventilation system ensures a controlled and regularly inspected filtered air supply in critical areas such as the surgical suite, recovery rooms, nurseries, special care units and isolation rooms.

2 6. Engineering department must have a written procedure to guide personnel in providing a hygienic environment.

K-MEDICAL RECORD SERVICES

3 1. If symbols and abbreviations are used in the medical record:

a) They must be approved by the medical staff.
b) A legend should be available for general use.

4 2. There must be documented evidence that programs for medical record staff education and training include orientation, inservice education and continuing education.

4 3. Medical record personnel should participate in medical staff clinical audit activities.

N-PHARMACEUTICAL SERVICES

3 1. The director of the pharmaceutical service should be responsible for the admixture of parenteral products.

S-SPECIAL CARE UNITS

6 1. There must be documentation that all nursing personnel assigned to special care units have completed an educational course specifically oriented to their level of participation in the care of patients in this unit.

4 2. A continuing education program must be developed and documented specifically for the personnel of special care units.

4 3. There should be written specifications as to who may perform special procedures.

It is recognized that some of the recommendations above, particularly those concerning criteria-based medical care evaluation, may not have been made at the summation conference. These recommendations have not influenced the present accreditation status of the hospital. However, at the time of the next survey, progress toward a program of criteria-based medical care evaluation will be a requirement for full accreditation. The recommendation is made here for the hospital's information and education.

REFER TO: "ACCREDITATION MANUAL FOR HOSPITALS."

RATING BY BOARD OF COMMISSIONERS: ACCREDITATION FOR TWO YEARS.

VALIDATION SURVEY, JAMAICA HOSPITAL,

Survey Date: July 2, 3, 1974

NOTE: This document contains a listing of the deficiencies cited by the surveying State Agency as requiring correction. The Summary Statement of Deficiencies is based on the surveyor's professional knowledge and interpretation of Medicare and/or Medicaid requirements. In the column Provider's Plan of Correction, the statements should reflect the facility's plan for corrective action and anticipated time for correction. (Not included) Copies of this form will be kept on file at local Social Security and Public Assistance Offices, to be made available to the public, upon request.

A. Life Safety Code (NFPA 101, 1967 edt)

1. Additional smoke barrier partitions are required on several patient floors. No more than 150' of corridor length is permitted without smoke barrier protection. If these barriers are to be held open, electro-magnetic devices, interconnected with the fire alarm and sprinkler system and activated by smoke detectors on both sides of the barrier are required. *10-2312, 2245.*

2. Of those smoke barriers presently existing only those with electro-magnetic devices may be held open (1963 Bldg.) All other barriers must be kept closed at all times, or provided with electro-magnetic devices as in #1. *10-2245.*

3. All stairwell doors are required to be positive latching, and vision panels may not exceed 100 sq. inches in total area. *10-2321.*

4. All stairwell doors require signs indicating "Fire Exit—Please Keep Door Closed." *5-2133.*

5. Many patient room doors have plain glass vision panels or thin wood covers over the panel openings. Also, no positive latching or pressure devices are provided. Patient room doors are required to be 1¾" solid wood core construction or equivalent, with positive latching devices provided. *10-1332*

6. Additional illuminated exit signs are required. Signs should be placed on both sides of smoke barriers and at corridor intersections (at dead-ends). *10-2272, 5-113.*

7. There are dead-end corridors of approximately 60 ft. (1926 Bldg.) and 50 ft. (1963 Bldg.) *10-1234.*

8. There are large plain glass panels (approx. 3½" x 7') in the corridor walls in the nursery unit. *10-1331.*

9. Stairwell doors are propped open in some areas, including the doors by the pathological lab, located off stairwell. Also, the stair door in stairwell #1 was sprung and could not be closed properly. Also, in some areas there is storage located in stairwells. (e.g. file cabinets adjacent to the medical library). *10-2246, 5-3156.*

10. Street access from building exits was partially obstructed with foilage. These areas should be maintained in a clear condition. *5-1221.*

11. Documentation regarding flame-spread rating of carpeting located off stairwell (5-North) in the medical library should be submitted to this office. *NFPA 255.*

12. Sprinkler tests must be conducted on a monthly basis. Records available indicate last test done—3/74. *6.4131.*

13. Electrical supervision is required on main sprinkler control valves to provide at least a local alarm if the valve is closed. *10-2342.*

14. No documentation was available to indicate that at least weekly testing of the sprinkler system is available. . .

15. Boiler room is not properly separated and is not provided with heat detectors. *10-2351.*

16. The main laboratory has one corridor door which is not one-hour rated (plain glass) *10-2351.*

17. Storage areas located in rooms larger than 100 sq. ft. require one-hour rated doors or an automatic sprinkler system (e.g. 4-N storage room, medical library, medical records). *10-2351.*

18. Some employee locker rooms are not provided with one-hour separation or sprinklers. *10-2351.*

19. The kitchen is not provided with an automatic extinguishing system or heat detectors, and is not properly separated from the main corridor (one door has plain glass panels, and doors are not positive latching). *10-2351.*

20. The gift shop is not provided with one hour separation (large plain glass corridor panels and plain glass in door, and is not provided with a sprinklering system. *10-2351.*

21. Fire drills are not conducted by authorized personnel. A certificate of fitness from the N.Y.C. Fire Dept. is required of the individual designated as fire drill marshall. *17-4113* and NYCFD Code.

B. Physical Environment – (405.1022)

1. Housekeeping is generally poor. Improved cleaning of walls, floors, doors and showers is required in all patient areas. (a)(2) & (c).

2. There is not effective separation of clean and dirty activities in the laundry area, due primarily to physical plant limitations. The possibility of cross-contamination from soiled to clean linens is increased due to the fact that the laundry is part of the same corridor used for the storage of clean linens and uniforms (doors to these rooms are kept open), and clean linens stored in carts was observed in the chute discharge room due to apparent lack of suitable storage space. Also, a cart full of dirty linen (including blood-stained) was observed uncovered in the corridor adjacent to the laundry.(c).

3. Increased utilization of infection control report forms should be encouraged to assure prompt reporting of infections to the infection control committee.(c)(1)(ii).

4. Infection control minutes should include review of procedures and techniques of personnel in food handling, laundry, and disposal of environmental and infections wastes.(c)(3).

5. Many multi-bedded rooms are crowded due to the presence of equipment and furniture necessary to patient support. In the eight-bedded room there was less than 3 ft. between beds. This makes proper cleaning difficult.(a)(3)(iii).

6. Proper facilities for the incineration of infections wastes are not provided. Potentially infectious wastes, including those from the operating room, are double-bagged and then placed in the commercial dumpster for disposal. This represents a significant environmental hazard, and immediate steps should be initiated to arrange for the proper disposal of pathological and biological waste.(c)(3)(5).

It is recommended that–

7. The wood frame structure adjacent to the hospital, which has large amounts of combustible storage in the basement, be provided with sprinklers or smoke detectors interconnected with the hospital alarm system. (A fire occurring in this building could present a smoke and fire hazard to the hospital). (a).

V. Nursing Department – (405.1024)

(d)(2) Surgical technicians and licensed practical nurses function as circulating nurses in the operating room.

(g)(3) Quality of Nursing Care Plans varied. Some were not current, others contained no information.

(g)(4) Nursing notes received were not informative and descriptive of Nursing Care given.

Dietary Service (405.1025)

(a) Standard: Due to the lack of department head meetings, there is a question as to the amount and/or degree of integration with other departments. (see documentation standard(d)).

(a)(2) The department is under the supervision of a Food Service Director, employed by the Food Management Company. One of the reponsibilities of this position is staff education. There is no formalized in-service training program.

(a)(6) The number of personnel appear adequate but a lack of a position for a porter might be responsible for the poor housekeeping in the kitchen area. See (b) Standard and (b)(3).

(b) Standard (b)(11)(b)(2)(b)(3)
Three areas due to the lack of equipment maintenance are accident hazards:

1. Dish machine leaking--water constantly on the floor.
2. Ice machine leaking–water constantly on the floor.
3. Tiles missing from floor in front of stoves–covered with a wooden insert.

(b)(3) There is no porter position on the table of organization.

(b)(8) Perishable foods some with mayonnaise, were not refrigerated during the serving period.

(b)(9) All cold foods were uncovered during the serving period. The "dishwashers" function during the serving time on the "line" serving food. This procedure is questionable due to the possibility of cross contamination.

(d) Standard: (d)(1)

There was no documentation about routine interdepartmental conferences. No minutes were available of any meetings.

PUBLISHED BY CONSUMER COMMISSION ON
THE ACCREDITATION OF HEALTH SERVICES INC.
381 PARK AVENUE SOUTH
TELEPHONE: 689-8959

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