SENATOR DENNIS G. RODRIGUEZ, JR.
I MINA' TRENTAI KUÅTTRO NA LIHESLATURAN GUÅHAN
CHAIRMAN, COMMITTEE ON HEALTH, TOURISM, MILITARY AFFAIRS & SENIOR CITIZENS

February 2, 2018

GL# 34-18-1495
Speaker Benjamin J.F. Cruz

FEB 0 2 2018
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Received By: ____

Honorable Benjamin J.F. Cruz
Speaker
I Mina'Trentai Kuåttro na Liheslaturan Guåhan
Guam Congress Building
163 Chalan Santo Papa
Hagatna, Guam 96910

Re: Transmittal of Communications from Guam Memorial Hospital

Håfa Adai Speaker Cruz:

We are in receipt of a public document that has not yet been entered upon the collections of public records within the Executive Branch, where this document should reside. Thus, the Legislature now is the custodian of this document and, as it appears in the enclosure constitutes all public parts of a report of the Joint Commission outlining reasons for denial of Guam Memorial Hospital accreditation.

We ask for your immediate due diligence in providing copies to the other members of the Legislature and immediately uploading the digital copy to the Messages and Communications portion of the Legislature's website. Reporters have been asking to view this document once we receive it. While, according to the legal opinion of the Executive Branch, it may have somehow been the prerogative of hospital officials to deny reporters or anyone else for that matter the right to inspect this document, our offices are under no such delusion.

The contents of this report are crucial to the public interest. In instances where the subject matter pertains to the actual safety and care of patients undergoing surgery and to the failure to report medical errors to the appropriate review bodies, it is inimical to the public interest to hide these findings.

The health committee conducted due diligence in striking out information that the Freedom of Information Act clearly exempts from disclosure.

2018 FEB -2 PM 2:15

Si Yu'os Ma'åse'!

Dennis G. Rodriguez, Jr.

Attachments

1495

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The Joint Commission

January 19, 2018

Subject: ACCREDITATION DECISION
PLEASE READ: TIME SENSITIVE

Peter John Camacho
Hospital Administrator/CEO
Guam Memorial Hospital Authority
850 Governor Carlos G Camacho Road
Tamuning, Guam 96913

HCO ID:#434037

Dear Mr. Camacho:

We have completed our review of the findings from the January 4 - 5, 2018 Onsite Validation Survey of the Hospital program. Based on this review, your survey findings continue to meet the criteria for Preliminary Denial of Accreditation because the organization was not able to demonstrate that corrective action had been implemented for all previous not compliant standards from the August 2017 survey. All follow-up activities are summarized in your Accreditation Report. Please consult your accreditation manual for details about this process.

Your organization's areas of risk include:

High Risk Drivers

Environment of Care

• Some security cameras for general areas and for the infant care area were inoperable therefore providing inadequate monitoring.

• Soiled surgical instruments were transported to the decontamination room in a container lacking a biohazard label.

• The soiled surgical instrument cleaning room had an improper air pressure relationship to adjacent spaces.

• (Repeat) Multiple locations with stained ceiling tile.

• A chair in the Emergency Department treatment area had torn and ripped plastic covering.

Human Resources

• Staff were unable to identify where the Malignant Hyperthermia supplies and medication were stored.

• Performance appraisal for the [redacted] was not documented since [redacted].

Infection Prevention and Control

• Pre-cleaning of instruments was not standardized.

• Three medical devices (heparin locks) and five blood tubes were expired.

Leadership

• The Performance Improvement Committee and the Governing Body were not meeting monthly per policy.

• (Repeat) Patient Safety Committee meeting minutes from 11/2017 had not yet been transcribed.

• The organization was not able to demonstrate they had an effective way to communicate emergencies to staff as the hospital's Public Announcement (PA) system became inoperable on 12/22/17, nor was there an alternate communication method for staff to communicate emergencies.

• Sterile compounding hoods certification expired 11/2017. The follow up certification inspection is scheduled to be completed in 01/2018.

• (Repeat) No evidence that at least once a year, the leaders provided governance with written reports on whether patients and the families were informed of sentinel events and all actions taken to improve safety.

• Staff were not using communication devices provided (Motorola phones) to respond to emergencies but were using their personal (cell phones) devices.

• Medical Staff leaders could not articulate how they would ensure physicians received Team Stepps training as required.

• 3 of 3 Pharmacy policies were approved [redacted] on the behalf Pharmacy and Therapeutics Committee (P&T) in 2017, however, the P & T Committee had not functioned since 07/2016.

• (Repeat) Staff were not held accountable for their responsibilities. For example:

o Respiratory staff not carrying emergency phones to respond to emergencies.

o Physicians not participating in mandatory education

o Pharmacist not following policy for policy approval

o Staff not participating in performance improvement activities as required.

• (Repeat) Policies were not reviewed as revised within the designated time frame required by policy. For example:

o 'Root Cause Analysis/Sentinel Events' policy last reviewed/revised 10/2011

o 'Interim Life Safety Measure/Infection Control Risk Assessment - Construction by Outside Contractors' policy last reviewed/revised 2012

o 'Pain Management' policy last reviewed/revised 6/2014

• The 'Grievances/Complaints' policy which required data collected to be reported to the Performance

• Critical areas did stock the emergency medications required to respond to malignant hyperthermia or have a response plan for this.

• 3 of 3 records did not have a RASS assessment for a sedated patient was not completed as required per policy.

Medical Staff

• The Medical Executive Committee (MEC) minutes for 2017 noted that the committee did not consistently review and approve performance improvement reports from the Infection Prevention Committee and Pharmacy Department as required.

• P&T committee meeting had not met quarterly as required by bylaws.

• A high-risk process has not been selected for analysis since 2015. There was no documented evidence that medical staff participated in high-risk process related to patient safety.

• (Repeat) 64% of the medical staff received mandatory Team Stepps training. 100% compliance was required for 2017.

• 4 of 4 Patient Safety Event Reports involving physicians, were not communicated to the Credentials Committee or to the MEC.

• A triggered focused professional practice evaluation (FPPE) due to performance issues on 06/29/2017 had not been submitted for implementation.

• A Patient Safety incident that occurred on [redacted] involving a medical staff practitioner was not communicated to the Department of Medicine and MEC.

National Patient Safety Goals

• Infection control data collected did not provide an in-depth analysis to allow leadership to provide appropriate corrective actions.

• 2 of 3 records of patients at a high risk for suicide, did not have evidence of 1:1 continuous observation as required by policy.

Provision of Care, Treatment, and Services

• An initial nursing assessment was not completed within 24 hours as required by policy.

• Defibrillator pads on the pediatric crash cart were expired.

• The temperature of the refrigerator in which breast milk is stored was out of range for the month of [redacted] without evidence of corrective action.

Performance Improvement

• (Repeat) There was no evidence that the data collected for reported events were analyzed and compared overtime to identify levels of performance, patterns, trends and variations.

Improvement Committee was not implemented.

• Leaders did not comply with recommendations from prior survey which includes the following areas:

o Environment of Care

o Medication Management

o Medical Staff

o Patient Care

o Performance Improvement

o Rights and Responsibilities

• Through tracer activity, discussion with staff and document review, processes with a high likelihood to harm a patient/visitor/staff were found in the areas:

o Environment of Care (widespread)

o Life Safety

o Leadership (widespread)

o Medical Staff (widespread)

o Provision of care

o National Patient Safety Goals (widespread)

o Performance Improvement (widespread)

• (Repeat) A Patient Safety Officer had not been designated as required by policy.

• There was no evidence that a high-risk process had been selected and a proactive risk assessment was completed within the last eighteen months.

• There was no evidence that lessons learned from the comprehensive systematic analysis of a patient safety event had been communicated to staff.

Life Safety

• Identified inoperable fire alarm smoke and heat detectors without interim life safety measure assessment and implementation.

Medication Management

• The door to the pharmacy did not completely close and as a result the pharmacy was not secure.

The Joint Commission

• (Repeat) There was no documented evidence that the hospital analyzed data related to results of resuscitation.

Rights and Responsibilities of the Individual

• (Repeat) There was no evidence that the Governing Body had met since July 2017 which has resulted in:

o There was no evidence that the delegation of the complaint resolution process to a complaint resolution committee as required by policy.

o No evidence that the governing body is responsible for the effective operation of the complaint resolution process

Based on this review, the following change(s) were made to your final report:

LD.04.04.05, EP 13
An observation has been scored at this element of performance as appropriate.

Next Steps:

You now have the opportunity to submit evidence to clarify the Requirements for Improvement documented in your organization's most recent report. Please be aware that this evidence needs to have existed prior to your survey. Document this evidence of compliance on a form available via Joint Commission Connect within the next ten business days.

Upon receipt of this clarifying evidence, Joint Commission staff will review it to determine if your survey findings continue to meet criteria for Preliminary Denial of Accreditation. If so, your organization will be presented to the Executive Leadership Team for a final decision. If a final decision of Preliminary Denial of Accreditation is rendered, the decision will be reflected in your organization's Quality Report on Quality Check.

Please call me directly at (630) 792-5738 for assistance in any part of this process.

Sincerely,

Monica Y. Argue

Monica Y. Argue
Senior Account Executive, Accreditation Committee Support
Accreditation and Certification Operations

cc: Nina Smith, Field Director, Accreditation and Certification Operations

The Joint Commission
SAFER™ Matrix
Program: Hospital

