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Hospital Moves to the Brink of Top Joint Commission Stroke Certification

By Tyler Smith

University of Colorado Hospital wrapped up months of preparation and a two-day Joint Commission site visit May 29 with recertification as a Comprehensive Stroke Center (CSC) all but assured.

The Stroke Program received five "recommendations for improvement" (RFIs) after an exhaustive review that included scrutinizing "tracers" of the medical records of a dozen stroke patients treated at UCH, said Sarah Livesay, RN, DNP, one of three Joint Commission surveyors. The hospital will have either 45 days or 60 days, depending on the RFI, to submit corrective action plans to the Joint Commission.

"I'm not able to say today that you have been recertified," Livesay told staff and providers gathered in a conference room in AIP 2. "However, we don't see anything on the report that would impede recertification." She added that six to 12 RFIs have been "typical" recently for hospitals seeking CSC recertification.

The heat is on. The hospital was among the first 30 or so in the nation in March 2013 to earn CSC certification, which means it can provide a wide range of clinical care and services for the most complex stroke cases. Since that time, the number of CSC facilities has increased, but so has the intensity of the Joint Commission reviews, said Angela Williams, RN, CCNS, the hospital's stroke clinical program director.

"All the Joint Commission reviewers are upping their game," said Williams, who has been through four site visits for facilities seeking Primary Stroke Center certification in the past decade. This was her first experience leading preparations for a CSC site visit.

"The surveyors are looking at the best of the best programs, so they dig deeply into the patient tracers and the program," Williams said.

The six RFIs touched on documentation, patient assessments and plans of care, and patient education. Williams said they all represent opportunities for improvement, but added they don't reflect consistent gaps in care.

"Tracers are snapshots of the overall care we provide," Williams said.

Plenty to like. After summarizing each of the RFIs, Livesay spent considerable time describing the Stroke Program's strengths, including its expanding Telestroke initiative, its commitment to post-discharge care and coordination, and a stroke survivor support group launched last summer. She praised the program's "overall culture" and its leadership team, which emphasizes collaboration between providers. "You have a true interdisciplinary approach to taking care of patients," Livesay said.

As it turned out, the tracers showed that the teamwork extends beyond the teams most often involved in stroke care, such as Neurosurgery, Neurosciences, and the Emergency Department, Williams said. The surveyors reviewed the medical records of two stroke patients admitted to the Oncology and Medical Intensive Care units, respectively. Caring for stroke patients is a relatively

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rare occurrence for both units, Williams said, yet when the surveyors showed up unannounced, the providers there were ready to respond to questions.

"The staff and management were exceptional during the tracers," Williams said. "We very much appreciate their hard work."

Livesay also noted favorably the Stroke Program's commitment to using data to drive process improvement initiatives, singling out Data Analyst Doreen Smith for special mention.

"She is one of the best in the nation," Livesay said.

"The data is the glue that holds the program together. It drives our processes, identifies where we have outliers, and where we need to focus our resources," Williams added. "Without Doreen, we would fail."

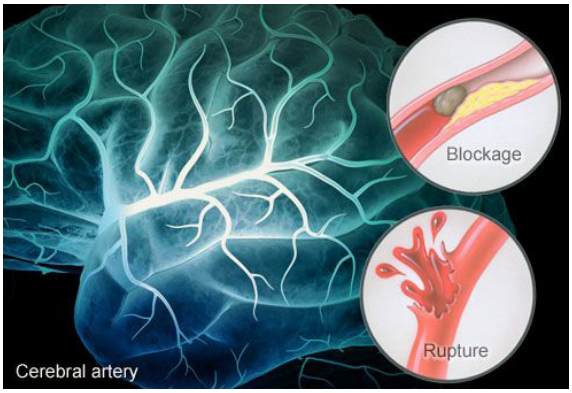
From blocks to ruptures. The exit conference concluded with Livesay offering a look forward for the Stroke Program. She urged program leaders to devote additional attention to solidifying processes of care for hemorrhagic stroke. Unlike ischemic strokes, which are caused by obstructions, such as blood clots, that constrict blood flow to the brain, hemorrhagic strokes are the result of blood vessels weakening and rupturing.

"This should be the year of hemorrhagic stroke for you," Livesay told the audience.

Williams said that like many hospitals, UCH has focused on responding to treating ischemic stroke, which requires administering clot-busting medications to patients as quickly as possible to save brain tissue and reduce the risk of death or disability. The hospital's Stroke Alert, which summons a large team of providers, is built around a well-defined set of protocols and processes to treat ischemic stroke, Williams said.

"Our processes are much less defined around hemorrhagic stroke," she said.

The steps for treating hemorrhagic stroke, which account for one-fifth to one-tenth of total strokes, differ from those used in ischemic stroke, she noted. Providers must find the source of the bleeding and treat it accordingly: endovascular procedures to insert clips or coils for aneurysms, craniotomies to reduce pressure in the skull, or surgical procedures to relieve tangles of blood vessels called arteriovenous malformations, for example. Increasing blood pressure in patients with ischemic strokes is good; the opposite is true for those with hemorrhagic strokes. Similarly, the anticoagulants that save ischemic stroke patients would devastate a patient with a brain bleed.



Joint Commission surveyors challenged the hospital to develop protocols and policies for hemorrhagic stroke (bottom right) that match those in place for ischemic stroke (top right). Illustration courtesy WebMD.

Given all that, a goal for the next two years will be to incorporate guidelines for hemorrhagic stroke into the Stroke Alert, Williams said. The issue is not one of adding procedures that providers don't presently do, but rather that the program define and document roles and procedures as plainly as it has for ischemic stroke, she said.

Managing growth. Livesay also cautioned that the hospital's steadily growing patient volume could offer another challenge to the Stroke Program.

"You are very busy and have grown considerably," she said. "You've managed well, but there are hints that you are reaching the breaking point." She noted instances of stroke patients "overflowing" from the Neuro ICU and Neurosciences units to other areas of the hospital. Step-down units for stroke patients, she said, are considered best practice.

"You'll want to look at the management of continued growth to ensure that you sustain your practices," Livesay said.

Even the program's success offers an avenue for improvement. Livesay urged those in attendance to get the best practices she observed during her two-day visit in front of a wider audience.

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"You're not as present as others in research and publications in stroke care," she said.

"We've been focused on what we're doing and on our patients, so that has gone to the back burner," Williams agreed.

"It was an intense, thorough review," Williams concluded. Four days after the exit conference, work was well under way to address the RFIs, she added. "I had Saturday and Sunday to decompress, but my brain didn't switch off."