



# Joint Commission International Accreditation

## FINAL ACCREDITATION SURVEY FINDINGS REPORT

### Hospital de Neurorehabilitació Institut Guttmann Badalona/Barcelona, Spain

International Health Care Organization (IHCO) Identification Number: 60000449

<b>Survey Dates:</b>	29 November - 3 December 2021
<b>Program:</b>	Hospital
<b>Survey Type:</b>	Triennial
<b>Surveyor Team:</b>	Juan Ferrer, MD, Physician, Team Leader Deborah E. Lee, MBA, RN, Nurse/Admin

## **OUTCOME:**

Based on the findings of the Triennial Hospital survey of 29 November 2021 to 3 December 2021 and the Decision Rules of Joint Commission International (JCI), Hospital de Neurorehabilitació Institut Guttmann has been granted the status of ACCREDITED.

Upon confirmation from the JCR Finance Department indicating that all survey related fees have been paid, you will receive the JCI Hospital certificates and, if necessary, your organization's entry on the JCI website will be updated. You also have access to The JCI Gold Seal of Approval™, the JCI Accreditation Gold Seal of Approval™ Guidelines, and the JCI Accreditation Publicity Guide under the "Resources" tab in JCI Direct Connect.

The Joint Commission International Hospital Standards are intended to promote continuous, systematic and organization-wide improvement in daily performance and in the outcomes of patient care. It is our expectation that all of the issues identified in the following survey report will have been satisfactorily resolved and full compliance with each identified standard will be demonstrated at the time of your next accreditation survey. Therefore, Hospital de Neurorehabilitació Institut Guttmann is encouraged to immediately place organization-wide focus on the standards with measurable elements scored as "Not Met" and "Partially Met" and to implement the actions necessary to achieve full compliance.

Between surveys, Hospital de Neurorehabilitació Institut Guttmann will be expected to demonstrate compliance with the most current edition of the JCI standards at the time, which includes the JCI accreditation policies and procedures published on the JCI website.

JCI will continue to monitor Hospital de Neurorehabilitació Institut Guttmann for compliance with all of the JCI Hospital standards on an ongoing basis throughout the three-year accreditation cycle. The compliance monitoring activities may include but not be limited to document and record reviews, the review of data monitoring reports, leadership interviews and staff interviews. The monitoring activities may take place on-site or off-site. JCI also reserves the right to conduct an unannounced, onsite evaluation of standards compliance at its discretion.

## **REQUIRED FOLLOW-UP:**

Some of the findings identified in this report suggest that if not attended to in a timely manner can evolve into a generalized threat to patient and/or staff health and safety and may over time result in a sentinel event. These health and safety risks would be counter to the improvement efforts your organization has accomplished to date, and counter to the spirit of continual improvement in quality and continual reduction of risk that are considered part of the accreditation process. This is of concern to us and we believe should be a priority concern for your organization. For this reason, a Strategic Improvement Plan (SIP) describing the sustainable measures that will be implemented to achieve full compliance is required for the following standard(s) and measurable element(s):

- PCI.12.2, ME #2

The SIP must be submitted to JCI within the next 60 days or by 04 Feb 2022 for review and acceptance. Details regarding access to the SIP system will be sent to you by way of a separate notification.

## Survey Analysis for Evaluating Risk (SAFER)

Joint Commission International (JCI) has implemented the Survey Analysis for Evaluating Risk (SAFER) matrix, which is a comprehensive visual representation of survey findings. This will provide your healthcare organization with the information it needs to prioritize resources and focus strategic improvement plans in areas that are most in need of compliance activities and interventions.

SAFER will help your organization to:

- More easily identify Measurable Elements (ME) with higher risk
- Identify potential for widespread quality initiatives
- Better organize survey findings by level of potential patient, staff, and/or visitor impact

Each Measurable Element (ME) scored “Partially Met” or “Not Met” is placed on the SAFER matrix according to the likelihood the observation could harm a patient(s), staff and/or visitor(s) and the scope at which non-compliance was observed. As the risk level increases, the placement of the standard and ME moves from the bottom left corner (lowest risk level) to the upper right (highest risk level) of the matrix.

The definitions for the likelihood to harm a patient/staff/visitor and scope are as follows:

Likelihood to harm a patient/staff/visitor:

- Low: harm could happen, but would be rare
- Moderate: harm could happen occasionally
- High: harm could happen any time

Scope:

- Limited: unique occurrence that is not representative of routine/regular practice
- Pattern: multiple occurrences with potential to impact few/some patients, staff, visitors and/or settings
- Widespread: multiple occurrences with potential to impact most/all patients, staff, visitors and/or settings

SAFER Matrix Placement	Strategic Improvement Plan (SIP) Required
<b>High/Limited High/Pattern High/Widespread</b>	<ul style="list-style-type: none"> <li>• Not Met and Partially Met MEs will require a SIP</li> </ul>
<b>Moderate/Pattern Moderate/Widespread</b>	<ul style="list-style-type: none"> <li>• Only Not Met MEs will require a SIP</li> </ul>
<b>Moderate/Limited Low/Pattern Low/Widespread</b>	<ul style="list-style-type: none"> <li>• Not Met and Partially Met MEs will not require a SIP</li> </ul>
<b>Low/Limited</b>	

## SAFER Matrix

### Program Name: Hospital

<b>Likelihood to harm a patient/visitor/staff</b>	<b>ITL</b>			
	<b>High</b>			
	<b>Moderate</b>	PCI.5 ME 3 GLD.7.1 ME 1 GLD.7.1 ME 2 GLD.7.1 ME 3	IPSG.4.1 ME 2 COP.5.1 ME 2 MMU.1.1 ME 3 MMU.3 ME 6 PCI.9 ME 2 SQE.8.1 ME 4	IPSG.4 ME 2 PCC.4.3 ME 1 PCI.5.1 ME 1 PCI.12.2 ME 2*
	<b>Low</b>	QPS.10 ME 3 FMS.7.2 ME 2	AOP.1.2 ME 1 COP.3.1 ME 5 COP.3.3 ME 2 GLD.6.1 ME 1* GLD.11.2 ME 2 SQE.1.1 ME 3 SQE.11 ME 2	GLD.3 ME 3
		<b>Limited</b>	<b>Pattern Scope</b>	<b>Widespread</b>

\*Indicates Not Met

## REPORT OF SURVEY FINDINGS:

Note: The Accreditation Committee may request follow-up for any or all of the standards after the accreditation decision.

### International Patient Safety Goals

**IPSG.4 The hospital develops and implements a process for the preoperative verification and surgical/invasive procedure site marking.**

**Measurable Element #2**

The hospital uses an instantly recognizable and unambiguous mark for identifying the surgical/invasive site that is consistent throughout the hospital.

**Partially Met**

**Likelihood to Harm: Moderate**

**Scope: Widespread**

An "X" mark was consistently used for surgical site marking; however, pain invasive treatments used an "O."

**IPSG.4.1 The hospital develops and implements a process for the time-out that is performed immediately prior to the start of the surgical/invasive procedure and the sign-out that is conducted after the procedure.**

**Measurable Element #2**

Before the patient leaves the area in which the surgical/invasive procedure was performed, a sign-out process is conducted, which includes at least d) through g) in the intent.

**Partially Met**

**Likelihood to Harm: Moderate**

**Scope: Pattern**

The sign- out process was not verbally conducted before the patient left the surgical area. The process did not formally include element d) name of the procedure and f) labeling of specimens.

### Patient-Centered Care

**PCC.4.3 Patients and families receive adequate information about the patient's condition, proposed treatment(s) or procedure(s), and health care practitioners so that they can grant consent and make care decisions.**

**Measurable Element #1**

Patients are informed of elements a) through h) in the intent as part of the informed consent process when informed consent is required for the treatment(s) or procedure(s).

**Partially Met**

**Likelihood to Harm: Moderate**

**Scope: Widespread**

Informed consent forms for anesthesia and for restriction use did not detail the type of the procedure planned. In nine of 15 (60% compliance) open and closed records reviewed, type of the procedure was included.

## Assessment of Patients

- AOP.1.2** The patient's medical and nursing needs are identified from the initial assessments, which are completed and documented in the medical record within the first 24 hours after admission as an inpatient or earlier as indicated by the patient's condition.

### Measurable Element #1

The initial medical assessment, including health history, physical exam, and other assessments required by the patient's condition, is performed and documented within the first 24 hours of admission as an inpatient or sooner as required by patient condition.

### Partially Met

#### Likelihood to Harm: Low

#### Scope: Pattern

The initial assessment for nutrition screening was undertaken within seven days and not 24 hours.

## Care of Patients

- COP.3.1** Reduce the risk of harm associated with clinical alarms by developing and implementing risk reduction strategies for managing clinical alarm systems used for patient care.

### Measurable Element #5

Staff responsible for the management of clinical alarms are trained and competent to do so.

### Partially Met

#### Likelihood to Harm: Low

#### Scope: Pattern

Staff responsible for the management of clinical alarms were trained in the strategies of the hospital program for the proper management of clinical alarms; however, this did not include element b) situations in which alarm systems could be disabled, and element c) circumstances under which alarm parameters can be changed.

- COP.3.3** Resuscitation services are available throughout the hospital.

### Measurable Element #2

Medical equipment for resuscitation and medications for basic and advanced life support are standardized and available for use based on the needs of the population served.

### Partially Met

#### Likelihood to Harm: Low

#### Scope: Pattern

Medical equipment for resuscitation and medication for advanced life support were standardized and available for use; however, portable suctions were not readily available on the resuscitation carts.

- COP.5.1** Patients at nutrition risk receive nutrition therapy.

### Measurable Element #2

A collaborative process is used to plan, to deliver, and to monitor nutrition therapy.

### Partially Met

#### Likelihood to Harm: Moderate

#### Scope: Pattern

The hospital had doctors, nurses, and pharmacists collaborate the plan, delivery and monitoring of nutritional therapy; however, no dietitians were involved in the process.

## Medication Management and Use

**MMU.1.1** The hospital develops and implements a program for the prudent use of antibiotics based on the principle of antibiotic stewardship.

### Measurable Element #3

The program includes guidelines for the optimal use of antibiotic therapy for treatment of infections, including the proper use of prophylactic antibiotic therapy.

### Partially Met

#### Likelihood to Harm: Moderate

#### Scope: Pattern

Prophylactic antibiotics were administered after they were no longer recommended. It was observed that prophylaxis were initiated after the induction time and finished after the start of incision. This practice did not adhere to current evidence-based guidelines.

**MMU.3** Medications are properly and safely stored.

### Measurable Element #6

Medications are protected from loss or theft throughout the hospital.

### Partially Met

#### Likelihood to Harm: Moderate

#### Scope: Pattern

In the Operating Theater, non-used doses of propofol were disposed without previously emptying the contents of the syringe. This practice might pose a risk of diversion of controlled substances.

## Quality Improvement and Patient Safety

**QPS.10** An ongoing program of risk management is used to identify and to proactively reduce unanticipated adverse events and other safety risks to patients and staff.

### Measurable Element #3

At least annually, a proactive risk reduction exercise is conducted on at least one of the priority risk processes.

### Partially Met

#### Likelihood to Harm: Low

#### Scope: Limited

The organization had undertaken as failure mode and effects analysis (FMEA) November 2020 on COVID-19; however, no reassessment had been undertaken to assess the benefits of changes made to reduce the risks. No other FMEA had been undertaken.

## Prevention and Control of Infections

**PCI.5 The hospital uses a risk-based data-driven approach in establishing the focus of the health care–associated infection prevention and control program.**

**Measurable Element #3**

The hospital implements infection prevention and control strategies to reduce the rates of infection for the identified priorities.

**Partially Met**

**Likelihood to Harm: Moderate**

**Scope: Limited**

The following unsafe practices were observed:

1. In Unit 5 and in the Operating Theater clinical staff demonstrating the method of the daily check of the laryngoscope would contaminate the blade.
2. Magills Forceps were observed sterilized in the closed position in all crash carts.
3. Hinged instruments in the storage area in the Operating Theater were sterilized in a closed position.

**PCI.5.1 The hospital identifies areas at high risk for infections by conducting a risk assessment, develops interventions to address these risks, and monitors the effectiveness.**

**Measurable Element #1**

The hospital completes and documents a risk assessment, at least annually, to identify and prioritize areas at high risk for infections.

**Partially Met**

**Likelihood to Harm: Moderate**

**Scope: Widespread**

The hospital had completed a risk assessment for COVID-19; however, there was no other completed documented risk assessment of any other infection control risks.

**PCI.9 The hospital reduces the risk of infections associated with the operations of food services.**

**Measurable Element #2**

The hospital adopts and implements kitchen sanitation measures and guidelines for preparation areas to prevent the risk of cross contamination and infection.

**Partially Met**

**Likelihood to Harm: Moderate**

**Scope: Pattern**

The following were observed in the Kitchen:

1. Large areas of paint peeling off a wall in the food preparation area making it difficult to disinfect the room.
2. The Kitchen had color coded chopping boards to prevent cross contamination of foods; however, the boards were all stored together and not separated.
3. All the kitchen knives had black handles and were not color coded or separated to help prevent cross contamination.
4. Large numbers of cardboard boxes were used for long-term storage of dry food products with no risk assessment on the possible infestation of insects or invasion of humidity.



**PCI.12.2 The hospital develops, implements, and evaluates an emergency preparedness program to respond to the presentation of global communicable diseases.**

**Measurable Element #2**

The hospital identifies the first points of patient entry into the hospital system and targets education on early recognition and prompt action.

**Not Met**

**Likelihood to Harm: Moderate**

**Scope: Widespread**

The organization had hand sanitizer in the entrance of each point of entry; however there was no information or system for early recognition of infectious disease at any entrance so prompt action could be taken.

**Governance, Leadership, and Direction**

**GLD.3 Hospital leadership is identified and is collectively responsible for defining the hospital's mission and creating the programs and policies needed to fulfill the mission.**

**Measurable Element #3**

Hospital leadership is responsible for creating the policies and procedures necessary to carry out the mission.

**Partially Met**

**Likelihood to Harm: Low**

**Scope: Widespread**

The hospital leadership created policies to carry out the mission; however, the following were observed:

1. "Use of blood and blood products" (PT-4-NR-HEM-015000-CA) page eight referred to premature and newborn babies, which is outside the scope of service.
2. "Surgical process safety checklist" (PC-4-NR-QUI-069000-CA) explains when a site mark should be made; however, it does not explain what site mark should be used.
3. "High-alert medications" (PC-4-NR-FAR-044000-CA) was vague when stating that the list of high-alert might include any medication considered at potential risk of administration error by the Pharmacy Department.
4. Some policies exceeded the time required for revision as per hospital policy, for example, "Electrolyte therapy" (PC-NR-MIN-031000-CA) where time in between the last two versions was 10 years.

**GLD.6.1 Hospital leadership ensures that contracts and other arrangements are included as part of the hospital's quality improvement and patient safety program.**

**Measurable Element #1**

All contracts stipulate the quality data that are to be reported to the hospital, the reporting frequency and mechanism, and how the hospital will respond when quality requirements or expectations are not met.

**Not Met**

**Likelihood to Harm: Low**

**Scope: Pattern**

It was observed that three of eight (38% compliance) contracts stipulated quality data to be reported to the hospital.

**GLD.7.1 Hospital leadership seeks and uses data and information on the safety of the supply chain to protect patients and staff from unstable, contaminated, defective, and counterfeit supplies.**

**Measurable Element #1**

Hospital leadership outlines the steps in the supply chains for supplies defined as at most risk.

**Partially Met**

**Likelihood to Harm: Moderate**

**Scope: Limited**

The hospital had a process to outline the supply chain from local producers; however, there was no process in place for suppliers at most risk beyond the local health authority.

**Measurable Element #2**

Hospital leadership identifies any significant risk points in the steps of the supply chains.

**Partially Met**

**Likelihood to Harm: Moderate**

**Scope: Limited**

The hospital had a process to outline the supply chain from local producers; however, no risk points had been identified for producers outside the local health authority.

**Measurable Element #3**

Hospital leadership makes resource decisions based on their understanding of the risk points in the supply chains.

**Partially Met**

**Likelihood to Harm: Moderate**

**Scope: Limited**

The hospital had a process to outline the supply chain from local producers; however, no risk points had been identified for producers outside the local health authority.

**GLD.11.2 Department/service leaders select and implement clinical practice guidelines, and related clinical pathways and/or clinical protocols, to guide clinical care.**

**Measurable Element #2**

Department/service leaders follow the process described in a) through h) of the intent in selecting and implementing clinical practice guidelines.

**Partially Met**

**Likelihood to Harm: Low**

**Scope: Pattern**

Clinical guidelines followed the process described in the intent; however, this did not include element d) assessed for their scientific evidence, and h) periodically updated based on changes in the evidence and evaluation of processes and outcomes.

## Facility Management and Safety

**FMS.7.2** The hospital's program for the management of hazardous materials and waste includes the types, handling, storage, and disposal of hazardous waste.

### Measurable Element #2

The hazardous materials and waste program establishes and implements procedures and the proper protective equipment required for safe handling and storage of hazardous waste.

### Partially Met

#### Likelihood to Harm: Low

#### Scope: Limited

The following were observed:

1. There was no personal protective equipment available in the hazardous waste store.
2. There was a sink available in the hazardous waste store; however, there was not soap to wash hands.
3. All the waste bins in the hazardous waste store had the lids open; three of the large bins for waste had no lids risking contamination of the air.

## Staff Qualifications and Education

**SQE.1.1** Each staff member's responsibilities are defined in a current job description.

### Measurable Element #3

Job descriptions are current according to hospital policy.

### Partially Met

#### Likelihood to Harm: Low

#### Scope: Pattern

The hospital had a "Job Description Protocol," which stated job descriptions had to be renewed if there was any changes in the job, or reviewed every three years in order to be current; however, five of 10 (50% compliance) job descriptions reviewed met the criteria of being current.

**SQE.8.1** Staff members who provide patient care are trained and demonstrate competence in the resuscitative techniques specific to the level of training identified.

### Measurable Element #4

The desired level of training for each individual is repeated based on the requirements and/or time frames established by a recognized training program, or every two years if a recognized training program is not used.

### Partially Met

#### Likelihood to Harm: Moderate

#### Scope: Pattern

For medical staff on duty, the organization required an immediate-advanced life support training repeated every two years. Files of staff privileged to be on medical duty reviewed had no evidence of passing the training in the last two years.

**SQE.11** The hospital uses an ongoing standardized process to evaluate the quality and safety of the patient care provided by each medical staff member.

**Measurable Element #2**

The ongoing professional practice evaluation process identifies areas of achievement and potential improvement related to the behaviors, professional growth, and clinical results of the medical staff member, and the results are reviewed with objective and evidence-based information as available. These results are compared to other department/service medical staff members.

**Partially Met**

**Likelihood to Harm: Low**

**Scope: Pattern**

Annual performance evaluation for medical staff included the areas of achievement in the intent, although clinical results were not reviewed with evidence-based information at the department level or included comparisons for internal or external benchmarking.