2011 Joint Commission National Patient Safety Goals (NPSG)

What every hospital needs to know about the TJC Patient Safety Goals

Objectives

- Recall that universal protocol standards are intended to help prevent wrong site surgery
- Describe what is required to reduce healthcare associated infections due to multiple drug-resistant organisms (MDROs), central line-associated bloodstream infections and surgical site infections
- Discuss the most recent changes to the NPSGs
- Recall can now use one person verification of blood if using bar coding technology

Many Changes

- This presentation will overview the major changes that have made throughout 2010 for 2011
- The 4 elements of performance announced in the August 2010 Perspective marked a concerted effort to move away from prescriptive requirements
- The move is toward allowing hospitals to keep up with the emerging clinical research
- Don’t be confused
- Many of the changes were of things that currently are recommended by the standard of care

Revisions for 2011

- However, in the future perhaps new literature may show something more superior to the discard of razors and current use of clippers
- This way TJC does not have to go back and keep changing the NPSG
- Instead the standard will be what the literature shows is the best evidenced based practice currently
- So it allows hospitals to choose practices that reflect current science and medical knowledge validated by an authoritative source

Four Changes
July 1, 2010 Changes

- NPSG.03.05.01 EP 6: A written policy addresses baseline and ongoing laboratory tests that are required for anticoagulants

- NPSG.07.04.01 EP 11: Use an antiseptic for skin preparation during central venous catheter insertion that is cited in scientific literature or endorsed by professional organizations (such as chlorhexidine alcohol and not povidone iodine but this specific wording removed)

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Revised NPSG.01.03.01 EP 1

- Before initiating a blood or blood component transfusion:
  - Match the blood or blood component to the order.
  - Match the patient to the blood or blood component.
  - Use a two-person verification process or a one-person verification process accompanied by automated identification technology, such as bar coding

- Effective September 2010
**Blood Transfusion**
- TJC previously allowed the use of automated identification technology in place of one person only if two people were not available
- TJC was asked to reconsider this
- Based on the position that bar coding, when used properly, can be as safe as a two person process
- TJC reviews the evidence and talked with safety experts
- TJC Standard and Survey Procedure Committee approved

**Medication Reconciliation**
- Board approved the revisions effective July 1, 2011
- Was NPSG.08.01.01 but now NPSG.03.06.01
- Revised based on feedback from the field about the difficulties in implementing
- Looks at critical risk points in the MM process
- Revised version underwent a field review in the second quarter of 2010 and confirmed it is an important patient safety issue
- NPSG.03.06.01 replaces the four sections of goal 8
  - .08.01.01 through .08.04.01

**Proposed for 2012**
- TJC is seeking comments on NPSGs for 2012
- Looking at two proposed additions
  - Ventilator-associated pneumonia (VAP)
    - Has seven elements of performance
  - Catheter-associated urinary tract infections (CAUTI)
    - Has four elements of performance
- Comment period ended January 27, 2012

**2012 National Patient Safety Goals**
- NPSG.08.01
  - Implementation of evidence-based practices to prevent ventilator-associated pneumonia (VAP)
  - Has seven elements of performance
- NPSG.03.06.01
  - Implementation of evidence-based practices to prevent catheter-associated urinary tract infections (CAUTI)
  - Has four elements of performance

**Reconciliation Medication Information**
- Board approved the revisions effective July 1, 2011
- Was NPSG.08.01.01 but now NPSG.03.06.01
- Revised based on feedback from the field about the difficulties in implementing
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**National Patient Safety Goal on Reconciliation Medication Information (NPSG.03.06.01)**
- Board approved the revisions effective July 1, 2011
- Was NPSG.08.01.01 but now NPSG.03.06.01
- Revised based on feedback from the field about the difficulties in implementing
- Looks at critical risk points in the MM process
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Case Studies on NPSGs

- HI$S$, American Society for Quality (ASQ), National Patient Safety Foundation (NPSF), and National Committee for Quality Assurance (NCQA) are publishing Stories of Success
- Case studies to show how hospitals are meeting the national patient safety goals
- Case studies from the inaugural all call are posted at www.himss.org/storiesofsuccess
- Initially selected 16 real world and peer reviewed case study submissions

Stories of Success

- Reduction of Blood Transfusions
- Reduction of Medication Errors and Improved Medication Reconciliation
- Facilitating Safe and Effective Handoffs
- Reducing DVT Using a Clinical Decision Support Alert in the Medical Record
- Use of Clinical Decision Support Interventions to Reduce Harm from Anticoagulants

History

- Purpose of goals is to promote specific improvements in patient safety
- Goals highlight problematic areas
- Describe evidence and expert based solutions
- Focus on systems approach and ones that negatively impact patient safety
- One with solutions to address the issue
- First started in 2003, updated yearly and for each area

2011 NPSGs

- Ambulatory care (Amb), Behavioral Health (BH),
- Critical access hospitals (CAH),
- Office based surgery (OBS),
- Home care (HC),
- Hospital,
- Lab, Long term care (LTC),
- Medicare/Medicaid LTC,
- Some variation in above since specific to that area,
History

- Sentinel event advisory group (now Patient Safety Advisory Group) works with experts and TJC staff on continuous basis
- Evaluates RCA, FMEA, and human factor engineering
- Reviewed data from NPSG compliance, literature, surveyor experience, and feedback from field by SIG
- New numbering system started in 2009 and continued in 2011

New goals are recommended by Patient Safety advisory group to TJC Board of Commissioners

- Previously the SE Advisory Group
- Also conference calls with key stakeholders, focus groups, and based on web based survey
- Board is final approver and reviewer
- The Joint Commission (TJC) and no longer called JCAHO

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First time program specific goals were established for programs in 2005 and same continues in 2011

- 9th annual issuance of goals
- 2011 goals with no new ones but many changes in 2010 except medication reconciliation
- 2011 goals also include Universal Protocol for preventing wrong site surgery or wrong procedure

In 2011 continues to be called EPs and not Implementation Expectations

- Changed in 2009
- FAQs about the NPSGs
- Check for periodic updates
- Good source of information

There are 6 standard sections with 80 elements of performance in 2011

- www.jointcommission.org or www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/
- www.jointcommission.org/AccreditationPrograms/Hospitals/Standards/09_FAQs/default.htm

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Resources

- Standards department at TJC at 630 792-5900
- Use online question form on TJC’s website at www.jointcommission.org/Standards/OnlineQuestionForm/online_question_form.htm
- Sign up for free emails and newsletters at www.jointcommission.org/Library/Newsletters/list_serve.htm

Sign up for Free e/Emails/newsletters at TJC

Goals are mandatory!

- All TJC facilities will be surveyed from January 1, 2011 except for Medication Reconciliation which is effective July 1, 2011
- Also can be surveyed in unannounced surveys
- Compliance with these will be scored as an element of performance if requirement is in the standard
- Otherwise scored as the level of NPSG as an Accreditation Participation Requirement

Goals are Mandatory

- Many surveyors ask for measurement data as proof of compliance with NPSGs
- However, TJC states that there are no prescribed requirements for measurement or data collection relative to most of the NPSG, but do need to know how you are in compliance, except use to be 2C on timely reporting critical tests and results but changed in 2010
- Have policies and procedure for each
- Remember the leadership standards require leaders to set priorities for improving the safety and quality of care
- PI standards require data collection related to those priorities, Will get RFI or Requirement for Improvement

Alternative Approaches

- Must be at least as effective
- Complete the request for review of an alternative approach form
- If not accepted, will tell the organization the rationale
- Can attempt to revise the request
- Reviewed by the Patient Safety Advisory Committee
- Has information on the website on how to file out the form

www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/npsg_rfr.htm
Sentinel Event Alerts (SEA)

- Sign up on the Joint Commission website to get new ones sent to you
- Have a committee to review each
- Develop a plan of action to incorporate the recommendations into practice
- Important to redesign relevant processes
  - Example, PCA by proxy; policy, nurse education, patient education flier, labeling PCA machines, preventing suicides and violence, preventing maternal deaths etc.
- These are not scored unless NPSG or standard

### 2011 Hospital NPSG  How Many Sections?

1. Patient identification  2 (5 EP)
2. Communication among caregivers  1 (3 EP)
4. Medication Reconciliation  5 EP
6. Reconciliation of medications—moved to .03.06.01
7. Suicide Risk  1 (3 EP)
8. Universal Protocols  3 (13 EP)
Goals Integrated into the Standard

- Abbreviations 02.02.01 (now IM.02.02.01)
- LASA 03.03.01 (now MM.01.01.03, MM.01.02.01, MM.04.01.01)
- Falls 09.02.01 (now PC.01.02.08, PC.02.03.01, PI.01.01.01, and HR.01.05.03)
- RRT/ Early Response 16.01.01 (now PC.02.01.09)
  - Focus on process for recognitions and response and not solution

Goal 1: Improve the Accuracy of Patient Identification

Recommendations: Use at least two patient identifiers when providing care, treatment or services

1. Use two identifiers in administering meds or hanging blood or blood products, when collecting blood samples or other specimens for clinical testing and (EP 2)
   - Revised EPs September 22, 2010
   - Reference to what to do before starting a blood transfusion under NPSG.01.03.01 EP1
   - Before initiating a blood a blood or blood component transfusion:
     - Match the blood to the order
     - Match the patient to the blood
     - Use two person verification or one person process accompanied by automated identification technology such as bar coding
     - Recall that as of September 22, 2010 TJC allows the use of automated identification technology in place of one person

2. Must label blood and other specimens in presence of patient
   - No batching or pre-labeling the vials
   - References NPSG.01.03.01, EP 1 regarding elimination of transfusion errors related to patient misidentification, as discussed above
   - EP1 is one that says match the blood to make sure there is an order
   - Match the blood to the patient such as checking the blood bracelet identification process
Eliminate Transfusion Errors 3 EPs

- NPSG 01.03.01 Eliminate transfusion errors related to patient misidentification,

  1. Before starting blood transfusion (or blood component)
     - Patient is matched to the order
     - Match the patient to the blood
     - Use two person verification or one person process accompanied by automated identification technology such as bar coding
     - This was discussed previously

Goal 1: Improve the Accuracy of Patient Identification

- TJC clarified that you have to use patient identifiers when doing other treatment and procedures
- Make sure right patient for when respiratory does breathing treatments, and procedures like moderate sedation, etc.
- Could be matching patient name and medical record number with bracelet
- Two identifiers on arm band more reliable than memory of third party staff member
- Applies to patients getting special diet to make sure right patient
- If use armband must be attached to patient and not taped on bed

Goal 1: Improve the Accuracy of Patient Identification

- Unconscious patients in the ED can have a temporary name like Jane Doe 1 and ED number or medical record number
- In home care where staff know patient, one of identifiers can be facial recognition and correct address
- LTC can be visual recognition
- Photographs can be used especially in behavioral health

Goal 2: Improve Effectiveness of Communication Among Caregivers

- NPSG.02.03.01 Report critical results of tests and diagnostic procedures
  - 2C is only one left in this section for hospitals with 3 EPs
- EP 1 Develop written procedures for managing the critical results of tests and diagnostic procedures that address the following;
  - Definition of critical test results and diagnostic procedures
  - By who and to whom critical results are reported
  - Acceptable length of time between availability of results and calling
Goal 2: Critical Test Results

- EP 2 Implement the procedure for managing critical results of tests and diagnostic procedures
- EP 3 Evaluate the timeliness of reporting critical test results and diagnostic procedure results
- Term "critical tests" has been removed and now talks about critical results
- Critical results are tests and diagnostic procedures which fall significantly outside the normal range and could indicate a life threatening situation
- Want to be sure patient is promptly treated so let doctor know blood sugar is 760

Critical test reports

- Will look at how quickly you turn around the abnormal test result and make the call to the practitioner
- Important to get the critical test results into the hands of the practitioner quickly
- Document times in the medical record
- Can have different time frames for calling back a lab result based on how serious it is out of whack

Critical Test Results EPs

- How are you going to evaluate the timeliness of reporting?
- Are you going to collect data on timeliness of reporting results?
- Assess your data and evaluate if there is a need for improvement
- Take appropriate steps to improve timely reporting of critical results (not the test) and measure effectiveness also

Reporting Critical Results

- Hospitals are now only required to list only critical tests that will necessitate a call to physicians and practitioners when the results are abnormal
- The hospital must define when results are abnormal
- The hospital must define what are considered critical results and diagnostic procedures
- The focus is on the critical results and not the test

Goal 3: Improve the Safety of Using Medications

- There are only 2 of the 5 sections left in 2011 and medication reconciliation now added
- This is NPSG.03.04.01 (3D) on labeling of medications and
  - Also NPSG.03.05.01 (3E) on reducing harm from anticoagulants
- There are 8 elements of performance to NPSG.03.04.01
  - 2010 revision to include the preparation date and expiration date and time
- There are also 8 elements of performance to NPSG.03.05.01

Label all Medication

- Label all medications and medication containers (syringes, medicine cups, basins), and other solutions on and off the sterile field or procedural setting
- EP 1 In perioperative and other procedural setting you must label all medications and solutions that you are not going to immediately administer
  - Need to do this even if only one medication is being used and even if obvious
  - Immediately administered medicines is where you draw it up and take it directly to the patient without any break in the process
Label all Medication and Solutions

2. In the perioperative and procedural setting, labeling occurs any time a medication or solution (normal saline) is transferred from the original packaging to another container.

3. Need name of medication on label, strength, amount, quantity, diluent and volume, preparation date, expiration date if not used within 24 hours and time if expires in less than 24 hours.
   ▪ Preparation date was removed March 2010
   ▪ Expiration date and time are required

Label all Medication and Solutions

4. All medications or solutions are verified by 2 persons verbally and visually if person preparing it will not be administering it.

5. Label each medication or solution as soon as it is prepared unless immediately administered.
   ▪ Want you to prepare medications one at a time

6. Discard any unlabeled medication or solution immediately.

Label all Medications 03.04.01

▪ Use extended definition of medicine by TJC
▪ Applies to anesthesia meds, and other procedural settings and not just invasive procedures
▪ Pre-labeled empty syringes or containers are not acceptable
▪ Can purchase prefilled, pre-labeled syringes for procedure trays

Label all medications

▪ MM.05.01.09 EP 3 and 4 state what has to be on label
▪ Label to include name, strength, amount (if not apparent from the container), expiration date if not used within 24 hours or if it expires in less than 24 hours, IV's date prepared and diluent.
▪ Label can be developed by the facility or commercially available, Sterile labels can be purchased
▪ All labels are verified both verbally and visually by two qualified persons
▪ No more than one medication or solution labeled at one time
▪ Shift change or break, all meds and solutions and their labels are reviewed by entering and exiting persons
▪ Focus on single dose vials and multi-dose vials now

Anesthesia

▪ Would not apply if anesthesiologist draws up medication and immediately gives it and disposed of entire content of syringe without leaving area
  ▪ Remember USP 797 requirements that drugs should not be prepared more than an hour in advance unless prepared in pharmacy
▪ However, if medication is prepared and slowly administered over course of procedure must be labeled
▪ Must be labeled if prepared for bulk of day's cases or if prepared by someone other than the administering provider
▪ Use preprinted adhesive labels that can be applied to syringes and checked against original container
▪ Meds prepared by pharmacist in the OR would not require second person to verify
Anticoagulant Therapy  03.05.01

Requirement: Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.

Rationale:
- This only applies to hospitals that provide anticoagulation therapy and long term anticoagulant prophylaxis such as atrial fibrillation.
- Does not apply to routine situations in which short term anticoagulant prophylaxis is used to prevent DVT or PE related to procedures or hospitalization.
- If the expectation is that lab values for coagulation will remain close or within normal limits.

Anticoagulants

- There are 8 EPs
  1. Use only oral unit dose products, prefilled syringes, and pre-mixed bags, when these products are available
     - Helps prevent compounding errors
  2. Make sure preloaded syringes with pediatric doses for pediatrics patients when available
  3. Big issue with the Joint Commission

Anticoagulants

2. Use approved protocols for the start and maintenance of anticoagulation therapy
   - Also appropriate to the condition being treated, and to the potential for drug interactions
   - Example would be Heparin protocol and Coumadin protocols
3. When starting a patient on Coumadin (Warfarin) you need to have a baseline INR and need INR on patients receiving this drug to adjust the dosage and document in the medical record
4. Use authoritative resources to manage potential food and drug interactions for patients taking Coumadin
5. Make sure all IV continuous Heparin is on an IV programmable pump in order to provide consistent and accurate dosing
6. Have a written policy that addresses baseline and ongoing lab tests that are required for anticoagulants
   - August 2010 Perspective changed removed “Heparin and LMW (low molecular weight heparin) therapies” and replaced it with “anticoagulants”

Anticoagulants

7. Provide education regarding anticoagulation therapy to prescribers, staff, patients, and families
   - Patient/family education includes the importance of follow-up monitoring, compliance issues, drug food interactions (dietary restrictions), and potential for ADR and interactions
   - Added prescribers to the list of those who need educated as reported in the December 2009 Perspective

Anticoagulants

8. Evaluates anticoagulation safety practices and take action to improve practices and measure how effective those actions are in the time frame set by the hospital
   - See MM.08.01.01
   - Hospitals should evaluate the effectiveness of its medication management system
   - This is an important thing to do
   - Collecting data on the performance of the medication management system can tell you if the process is working well or not
Anticoagulant Therapy

- Need a policy and procedure and make sure staff educated on policy
- Policy should address what lab tests are required for heparin and LMW heparin and baseline
- Patients on Coumadin need current INR to monitor and adjust
- Use approved protocols for the initiation and management of anticoagulant therapy

Anticoagulant Therapy

- Consider high risk such as double checks, product selection, dose calculation, patient identification, settings on IV pump, and proper IV line
- Have a formalized education program for both staff and patients
- To reduce compounding and labeling errors use only oral and parental unit dose and premix infusions
- Make sure all concentrations available are really needed

Anticoagulant Therapy

- Make sure you have enough IV pumps
- Make sure no more than one or two types of IV pumps (CMS hospital CoP requirement)
- Follow anticoagulant safety practices
- Medications should be clearly labeled
- Separate LASA and the Heparin errors
- Computer order entry, bar coding with eMAR, and automated dispensing units may help

Medication Reconciliation .03.06.01

- Standard: Maintain and communicate accurate patient medication information
- EP1 Obtain a list of medications the patient is taking when admitted or treated as an outpatient
  - The medications the patient is taking can be documented in another format that is useful to the hospital
  - Current medications include PRN medications
  - It is often difficult to obtain complete information on medications from some patients but a good faith effort must be made to get the information from the patient or other source

Medication Reconciliation .03.06.01

- EP2 The type of information to be obtained needs to be defined in non-24 hour settings and different patient circumstances
  - Examples would include the emergency department, primary care, outpatient radiology, ambulatory surgery and diagnostic settings
  - Medication information to be collected might include name, dose, route, frequency, and frequency
  - Patients are to be educated on medications under MM.06.01.03, PC.02.03.01 and PC.04.01.05

Medication Reconciliation .03.06.01

- EP3 The medication information brought in by the patient needs to be compared with the medications ordered
  - A qualified person, who is determined by the hospital, has to do the comparison
  - Discrepancies would include omissions, duplications, contraindications, unclear information, and changes
  - References HR.01.06.01 Staff are competent to perform their responsibilities
Medication Reconciliation .03.06.01

• EP4 Provide the patient with a list or written information on the medications they need to take when discharged from the hospital or at the end of the outpatient encounter
  • An example would be to include the name of the medication, dose, route, frequency and purpose
  • The information is given to the family when indicated
  • Note: When the only additional medications prescribed are for a short duration, the medication information the hospital provides may include only those medications
  • References PC.04.02.01 about communicating to providers when the patient is discharged

Medication Reconciliation .03.06.01

• EP5 Explain the importance of managing medication information
  • This is to be done when the patient is discharged from the hospital
  • This is also to be done at the end of the outpatient care provided
  • This could be instructing the patient to give a list to their primary care physician
  • Also to update the information list when medications are discontinued or added
  • This should also include OTC medications

Medication Education

• MM.06.01.03 Self administered medications are administered safety and accurately (has 7 EPs)
• PC.02.03.01 The hospital provides patient education and training based on each patient’s needs and abilities (27 EPs but only 6 apply to hospitals)
• PC.04.01.05 The patient is informed and educated about follow-up care before discharge or transfer (8 EPs but only 6 apply to hospitals)

CDC Cost of HAI

• CDC published 16 page document on the direct medical costs of HAI in US Hospitals and the Benefits of Prevention
  1. 4.5 HAIs per 100 admissions
  2. Direct medical costs ranges from $28.4 to $33.8 billion dollars a year
  3. Benefit of prevention range from $5.7 to $6.8 billion dollars based on 20% are preventable
  4. CMS got $50 million grant in 2010 and 2011 to enforce infection control standards

Goal 7: Reduce the Risk of HAI

• Goal: Reduce the risk of HAI
• 4 of 5 sections remain in 2011
• Deleted 7 B on HAI as a sentinel event
• In August 2010 Perspective noted changes to NPSG.07.04.01 and 07.05.01
• NPSG.07.04.01 EP 11
  • Added to use an antiseptic for skin preparation during insertion of central line that is cited in the scientific literature
  • Removed “use chlorohexidine” even though currently the standard of care but in the event it changes
### Reduce Risk of HAI Infections

- **In August 2010** Perspective changes to NPSG.07.05.01 EP 7 and 8 on implementing evidenced based practices for preventing surgical site infections (SSI)
  - EP7 Administer antimicrobial agents for prophylaxis for a procedure or disease
    - Removed "evidenced based practices"
    - Added to do this according to methods cited in the scientific evidence or endorsed by professional organizations
    - Removed give antibiotics one hour before the surgery and discontinue within 24 hours or 48 for cardiothoracic patients

- **In March 2010** Perspective change to NPSG.07.03.01
  - The word “prevention” was accidentally omitted from EP3 in the 2010 NPSG publication
  - Patients and families should be educated, when needed, who are colonized with MDRO about health-care associated infection prevention strategies
  - Retained hand hygiene, MDRO, reducing central line associated blood steam infections, and preventing surgical site infections
    - Good resource is the April 2010 updates to the NQF 34 Safe Practices for Better Healthcare

### Hand Hygiene NPSG.07.01.01

- **Reduce the Risk of HAI:** Comply with current CDC or WHO hand hygiene guidelines
  - Has 3 EPs
  - EP1 Implement a program that follows categories 1A, 1B, and 1C on one of the above
  - EP2 Set goals for improving compliance with hand hygiene guidelines
  - EP3 Improve compliance with hand hygiene guidelines based on established goals

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### WHO Guidelines on Hand Hygiene in Health Care

- **First Global Patient Safety Challenge Clean Care is Safer Care**
  - WHO Guidelines on Hand Hygiene in Health Care
  - Clean Care is Safer Care

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**Reduce Risk of HAI Infections**

- EP8 Removed the section to “use clippers or depilatories” when hair is removed
- Removed the note that shaving is an inappropriate hair removal method
- Added to use a method that is cited in the scientific literature or endorsed by professional organizations
- This is currently the standard of care
- However, this new wording is flexible so if the new literature shows a new standard of care TJC does not have to go back and revise the standard

- Infection control important in 2011 with CMS getting 50 million grant to enforce standards
- CMS Hospital CoP 2011 has 12 pages of standards and TJC IC chapter is 8 pages
- Infection control being hit hard
  - Wash glucometers between patient use as recommended by the manufacturer
  - Consider using bleach wipe or solution (See APIC recommendation)
  - Finger stick devices are single patient use only
  - Use single dose vials when available
CDC Hand Hygiene Recommendations

- In CDC MMWR Recommendations and Reports,
- Report available at www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm or go to www.cdc.gov
- TJC published document in 2009 on Measuring Hand Hygiene Adherence: Overcoming the Challenges and this is an important document
  - See TJC Hand Hygiene Project
  - Monitored during infection control tracer

Hand Hygiene: Overcoming the Challenges

Hand Hygiene IHI CDC

- Project with CDC, APIC and Society of Healthcare Epidemiology of America (SHEA) and available at www.ihi.org
- Hand hygiene one of most important IC measures
- 2 million health-care associated infections (HAIs) and 100,000 deaths per year
- CDC has free posters on hand washing at www.cdc.gov

Hand Hygiene

- WHO Guidelines on Hand Hygiene in Health Care; Clean Hands are Safer Hands at www.who.int/patientsafety/events/05/HH_en.pdf
- Good website for children on importance of washing hands
- Colorful posters, puzzles, and quiz
- Henry the Hand at henrythehand.com

CDC Hand Hygiene

- Category 1A-strongly recommended for implementation and strongly supported by research
- 1B- strongly recommended and supported by certain experimental, clinical research
- 1C-required for implementation, as mandated by state or federal law
- Hospitals must comply with all three above
- Category II- are suggested for implementation and supported by suggestive clinical studies
Infection Control

- TJC requires all facilities to comply with ALL category 1 recommendations
- Category II recommendations should be considered
- Artificial nails is a category IA recommendation so it is required for those who provide direct care to high risk patients
- However, ¼ inch nail tips is category II so it should be considered

Hand Hygiene

- Facility must provide alcohol based hand rub product (ABHR)
- However, staff doesn't have to use it
- May be used instead of soap and water, remember to use soap and water for patients with C-diff
- LSC allows for installation of ABHR gel dispensers in egress corridors, with some limitations (6 ft corridor, at least 4 ft apart, not over plug, no more 1.2 liters for dispensers in room and corridor, foam with same rules, etc.)
- But suggest hand hygiene in presence of patient,

CDC Hand Hygiene

- If hands not visible soiled, use alcohol based hand rub in all settings
- If hand visibly soiled or contaminated with protein material, blood or other body fluids then soap and water
- Monitor volume of ABHR used per 1000 patient days
- Periodically monitor and record adherence to hand hygiene compliance and provide feedback
- This direct observation is necessary for corrective action

What Do you Do to Reduce Infections?

- Central line bundle, Sepsis bundle, VAP bundle See www.ihi.org for how to do kits
- Good infection control plan with adequate staffing in infection control
- Be aware of CMS interpretive guidelines on infection control
- Participate in the SCIP to improve surgical outcomes?
- Activities related to C-diff, VRE, and MRSA
- Infection control is important

Implement Evidenced Based Practices

- Implement evidenced based practices to prevent HAI due to multi-drug resistant organisms (MDROs), 07.03.01 (7C)
- 9 EPs
- Applies to, but not limited to, MRSA, VRE, C-Diff, and MDRO gram negative bacteria
- Patients continue to acquire health care associated (HAI) infections at an alarming rate
- Need prevention and control strategies

Implement Evidenced Based Practices

- Increased focus on cleaning and disinfecting equipment appropriately (IC.02.02.01)
- Proper use of flash sterilization (now called immediate use)
- Making sure all scopes are cleaned according to the manufacturer
- Cleaning the patient environment is also important
Evidenced Based HAI Prevention

1. Conduct periodic risk assessment for MDROs acquisition and transmission
   - In time frame set by hospital
   - See IC.01.03.01, EPs 1-5 that talks about identifying the risk of acquiring and transmitting infections
   - Following slides on this provided for reference
   - TJC infection control chapter very important and dovetails with these infection control NPSGs

Identify Risks for Transmitting Infections

- IC.01.03.01 The hospital identifies risks for acquiring and transmitting infections
  - EP1 Hospital identifies risks based on geographic location, community, and population served
    - NPSG.07.03.01 EP1 Conduct periodic risk assessments in time frames set by hospital for multidrug-resistant organisms (MDRO) acquisitions and transmission
    - MDRO includes methicillin-resistant Staphylococcus Aureus (MRSA), Vancomycin-resistant Enterococcus (VRE), Klebsiella, and Acinetobacter
    - CDC has free MDRO infection (and CDAD) surveillance and training on the National Healthcare Safety Network (NISN) - http://www.cdc.gov/nhsn/wc_MDRO_CDAD.html

- IC.01.03.01 EP2 Hospital identifies risk for acquiring and transmitting infections based on the care and treatment it provides (on MDRO)
- EP3 Look at risk for acquiring or transmitting an infection by doing an analysis of surveillance activities and other infection control data (including MRDO and adverse tissue reactions)
- EP4 Review and identify risks annually and when there is a significant change and get input from IP, MS, nursing, and leadership including MRDO
- EP5 Prioritize these risks

Educate staff and LIPS about HAI, MDROs, and preventive strategies in orientation
   - At hire and annually
   - Use information from your risk assessment
   - Education must reflect their diverse roles

Educate patient and their families about HAI strategies who are infected or colonized with MRDO, as needed

Implement a MDRO surveillance program based on your risk assessment
   - Surveillance may be targeted rather than hospital wide
   - CDC has MDRO surveillance training at http://www.cdc.gov/nhsn/wc_MDRO_CDAD.html
   - Has many resources including training videos on MDRO surveillance, slide sets, protocols, reporting plan etc.
Evidenced Based HAI Prevention MDRO

5. Measure and monitor MDRO prevention processes and outcomes including: MDRO infection rates using evidence based metrics, compliance with evidenced based practice, and evaluate education provided.

6. Provide MRDO process and outcome data to key stakeholders, nurses, doctors, LIPs and other clinicians.

7. Implement P&Ps to reduce transmission of MRDOs which meet CDC and other professional organization standards (APIC, SHEA, OSHA, AORN).

Evidenced Based Practices MDRO

8. Implement a laboratory based alert system that identifies new patients with MDRO when indicated by the risk assessment.
   - The alert system can be manual or electronic and can use faxes, pages, telephones etc.,

9. Implement an alert system that identifies readmitted or transferred MRDO positive patient when indicated by risk assessment.
   - Alert system can be in a separate database or integrated and can manual or electronic.

MRDOs Resources CDC

- Provides strategies and practices to prevent MRSA, VRE and other MDROs.
- Includes gram neg bacilli (GNB), E. coli and Klebsiella pneumoniae, stenotrophomonas maltophila, burkholderia cepacia, and ralstonia picketti.

MRDOs Resources

- CDC MRSA resources at www.cdc.gov/ncidod/dhqp/ar_mrsa.html,
  - Includes fact sheet on MRSA, MRSA in healthcare setting 2007, educational material, data, lab testing and practices etc,
  - Isolation precaution 2007 at www.cdc.gov/ncidod/dhqp/gl_isolation.html,
- VRE resources at www.cdc.gov/ncidod/dhqp/ar_vre.html,
- Guidelines for Prevention of Surgical Site Infections,
- Resources
  - APIC resources at www.apic.org and see standards and guidelines,
  - Guidelines for Environmental Infection Control in Health Care Facilities,
  - Guidelines for Prevention of Surgical Site Infections,
  - Recommendations for Preventing the Spread of VRE,
  - Guidelines to Prevent Intravascular Catheter Related Infections,
Central Lines 07.04.01 (7D)

- Implement best practices to prevent central line associated bloodstream infections,
- 13 EPs
- IHI has how to guides and other resources at www.ihi.org (Keystone project)
- EP1 Educate staff and LIPs involved in procedures about HAI, central line infection and importance of prevention
- Must do education in orientation and annually and if procedure added to your job

Revised How to Kit Central Lines

Getting Started Kit: Prevent Central Line Infections
How-to-Guide

Central Lines

- Note that under reform law hospitals with ICUs or NICU must report central lines infections on the CDC National Healthcare Safety Network (NHSN)

2. Educate patients and families before inserting central line about central line associated bloodstream infection prevention (BSI), as needed

3. Implement P&Ps to reduce risk of BSI that meet regulatory and evidenced based standards

Central Lines

- P&P need to meet the regulatory requirements
- Need to be aligned with the CDC requirements
- And professional standards of care (APIC, AORN, SHEA, etc.)

4. Conduct periodic risk assessments for central line infection, measure BSI (blood stream infection) rate, and monitor compliance with best practices and how effective the prevention efforts are
- Need to do risk assessment conducted in the time frames defined by the hospital
- Surveillance is hospital wide and not targeted

Central Lines

5. Provide CLAI (central line associated infection) rate data and prevention outcome measurement to staff and LIPs and clinicians

6. Use a catheter checklist and standard protocol for central line insertion

7. Perform hand hygiene before catheter insertion or manipulation

8. Do not put in femoral vein unless last resort for adult patients

9. Use standardized supply care or kit for central lines
Central Lines

10. Use standardized protocol for maximum sterile barrier precautions during insertion

11. Use antiseptic for skin prep in patients during insertion that is cited in the scientific literature or endorsed by professional organizations

12. Use standardized protocol to disinfect catheter hubs and injection ports before accessing
   - Such as wipe vigorously for 15 sections and let dry
   - Surveyor will ask to see the protocol or P&P

13. Evaluate all central lines routinely and remove none essential catheters

Surgical Site Infections (SSI)

- Implement best practices to prevent surgical site infections
- There are 8 EPs
  - 1. Educate hospital staff and LIPs involved in procedures about HAI, surgical site, and the importance of prevention
     - Educate during orientation, annually, and if added to your job

Surgical Site Infections

2. Educate patients and families, who are undergoing surgical procedures, about preventing surgical site infections (SSI)

3. Implement P&P to reduce SSI that meet regulations and evidenced based practice (such as the CDC and other professional organizations)

4. Conduct periodic risk assessments for SSI, select measures using best practices or evidence based guidelines and monitor compliance with them and how effective they are

Surgical Site Infections

5. Measure surgical site infection rates for the first 30 days following a procedure that does not involve inserting implantable devices
   - Measure for the first year procedures involving implantable devices
   - Need to follow evidence based guidelines
   - Surveillance may be targeted to certain procedures based on hospital risk assessment

6. Provide process and outcome data on SSI to stakeholders etc, such as the SS infection rate

Surgical Site Infections

7. Antimicrobial agents for prophylaxis are administered according to methods cited in the scientific literature or endorsed by professional organizations
   - Still want to be sure that prophylactic antibiotics are administered timely in the operating room and reboled when indicated

8. When hair removal is necessary, use a method that is cited in the scientific literature or endorsed by professional organizations
15. Patient suicide risk

- Goal 15: State the hospital identifies safety risks inherent in its patient population
- The hospital needs to identify patients at risk for suicide
- Only 1 left of 2 standards
- Remember TJC Sentinel Event issued
- NPSG.15.01.01 has 3 EPs
- This section only applies to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

Patient Suicide Risk

1. Risk assessment must be conducted that includes factors that increase or decrease the risk for suicide
2. Need to address the immediate safety needs of a suicidal patient and the most appropriate setting
3. Must provide information to patients at risk for suicide when they leave the hospital such as a crisis prevention hotline

Suicide risk

- Suicide ranks as the 11th most frequent cause of death (3rd most frequent in young people) in the United States
- With one person dying from suicide every 16.6 minutes
- Suicide of a care recipient while in a staffed, round-the-clock care setting has been the #2 most frequently reported type of sentinel event
- For data through June 30, 2010 there were 816 reports of suicide of the 6923 reports which is 11.8% of all reports

Patient Suicide

- Identification of individuals at risk for suicide while under the care of or following discharge from a facility is an important first step in protecting and planning the care of these at-risk individuals
- Applies to all patients in the behavioral health unit
- Applies to any patient in the hospital if their primary diagnosis or primary complaint (DSM diagnosis) is of an emotional or behavioral disorder
- Gives a number of examples since initially gave contradictory information on scope of this NPSG

General Hospitals

- Identify patients at risk,
- Patient seen in ED for fracture sustained in act of attempting suicide, admission risk assessment not required by TJC because you know the patient is suicidal but as recovers would need to assess degree of ongoing risk for suicide,
- Patient admitted ICU for detoxification, but again as patient recovers may determine underlying problem,
- Patient admitted to OB in active labor and has history of severe post partum depression after last child, same,
Patient Suicide
- Assess patients at triage and admission and ask if patient has any thoughts about injuring himself or others
- Use sitters for patients at risk
- Have safe room for suicidal patients, especially those admitted outside the behavioral health unit
- Do a FMEA on suicidal patients
- Do assessment of the facility for safety as above
- Don’t have to have own crisis hotline just information on how to access one

Patient Suicide
- Be sure to do an assessment of the environment to ensure there are safe rooms
- Education for nurse on risk of suicidal patients
- Policy on same

Patient Safety Goals
- Are you up for the challenge?

TJC NPSG Goal 1: UP Universal Protocol
- Organization must meet expectation of UP
- UP 01.01.01 Conduct a pre-procedure verification process, changed because of universal protocol that is now a standard, effective July 1, 2004 changed 2009 and 2010 and continue into 2011.
- To prevent wrong site and wrong procedure surgery,
- Process must be briefly documented,
- TJC has great information on their website on this!
- 3 parts,

Pre-procedure verification process
- It is an ongoing process that starts with decision to do procedure and continues up and includes time out before start of procedure,
- Want to be sure all documents and equipment is available before the procedure,
- That everything is correctly labeled and matched to the patient’s identifiers,
- Reviewed and consistent with patient’s expectation and team’s understanding of the procedure and site,
Pre-procedure verification process

1. Implement a pre-procedure process to verify correct patient, site, and procedure
2. Identify what needs to be available for the procedure and use a standardized list (check list) to verify their availability and must include
   - Relevant documentation (H&P, consent form, nursing assessment and pre-anesthesia assessment)
   - Labeled diagnostic and radiology films, pathology, and biopsy reports and make sure properly displayed

3. Match the items that are to be available in the procedure area to the patient
   - WHO has a surgical checklist
   - Can enlarge the individualized checklist to 2 by 3 feet and roll in before surgery and then do briefing and at end when you do debriefing

Getting It Right

- Do you verify that this is the right procedure at certain times to make sure you have it right such as:
  - Time procedure scheduled,
  - Time of PAT,
  - Time of admission or entry into facility,
  - Before patient leaves pre-procedure area,
  - Anytime responsibility is transferred to another member of procedure team (including anesthesia provider) at time of and during the procedure,
  - With the patient involved and awake and aware if possible,

Mark the Site

1. Procedure with incisions or percutaneous puncture or insertion, site is marked
   - when more than one possible location,
   - If performing in a different location would negatively affect quality or safety
   - For spinal procedures need special intraoperative image technique to mark the right spot
2. Mark before patient is moved to where procedure is to take place,

Mark the Site

- UP 01.02.01 Mark the procedure site,
- Patient should be involved if possible when marking the site.
- Site marking by LIP or other provider who is ultimately accountable for the procedure
  - Must be present when the procedure is performed
  - In limited circumstances LIP can delegate to another who is permitted by hospital and who meets the following qualification
  - In medical residency program and is supervised by LIP performing the procedure

Mark the Site

- Licensed person who requires collaborating or supervising agreement with the LIP such as PA or NP
- Must be familiar with the patient and present when the procedure is done
4. Method of marking the site is unambiguous and is used consistently throughout the hospital
   - Mark is made at or near the site
   - Mark must be present after draped and prepped.
Mark the Site

5. Alternative process if patient refuses or if anatomically impossible to mark
   • Put temporary unique wristband, draw on anatomical picture and also if impractical to mark the site (perineum),
   • Do not mark preemies as will be permanent.
   • For teeth mark on the dental x-rays or diagram,

Mark the Site

• Person doing the marking has to be present at time of final time out (this is usually the surgeon),
• Has to clear marking and consistent through out the hospital,
• Preferable the surgeon’s initials with or without proposed incision line marking,

Time Out before Procedure UP.01.03.01

1. Time out is done before immediately before starting the procedure,
2. Characteristics of the time-out
   • Standardized process Done by designated team member,
   • Initiated by designated member of the team
   • Involves immediate members of the team including proceduralists, anesthesia providers, circulating nurse, OR tech, and other active participants involved in procedure,

Time Out

• Includes active communication,
• Even if doing spinal or local,
• Other activities suspended during time out,
• Want all members to actively give thumbs up,
• If more than one procedure, need to repeat process for each one,

Time Out

4. Time out must address correct patient, correct site and procedure to be done
   • Be sure that the site is marked, accurate consent form, agreement on what is being done, correct position, x-rays are properly labeled and displayed,
   • need to administer antibiotics or fluids for irrigation, and safety precautions based on medication use,
5. Document the time out

Resources

• Agency for Healthcare Research and Quality http://www.ahrq.gov/consumer/
• Consumers Advancing Patient Safety (CAPS) (http://www.patientsafety.org/)
• Partnership for Patient Safety (p4ps) (http://www.p4ps.org/)
• Further information go to TJC International Center for Patient Safety http://www.jcipatientsafety.org/ and click on 13A,
Suicide Resources

- APA Practice guidelines - recommendations for assessing and treating patients with suicidal behaviors www.naphs.org/Teleconference/documents/Jacobs_AppendixA_ReviewArticle.pdf

Resources

- Persons United Limiting Substandards and Errors in Health Care (PULSE) (http://www.pulseamerica.org/)
- Speak Up™ Campaign of The Joint Commission (http://www.jointcommission.org/PatientSafety/SpeakUp/)
- Institute for Family Centered Care http://familycenteredcare.org/
- Picker Institute http://www.pickerinstitute.org/
- Institute for Healthcare Improvement www.ihi.org
- National Patient Safety Foundation www.npsf.org
- World Health Organization Patients for Patient Safety (PFPS) program (http://www.who.int/patientsafety/patients_for_patient/en/)

AHRQ Resources


ASHP Resources

- American Society of Health System Pharmacists,
- ASHP article that discontinuing Coumadin may be enough when the INR is over 6. (Warfarin Withdrawal May Not Be Enough if INR is over 6 at http://www.ashp.org/s_ashp/article_news.asp?CID=167&DID=2024&id=2598,

* "ASHP Therapeutic Position Statement on the Use of INR System to Monitor Anticoagulant Therapy" at http://www.ashp.org/s_ashp/bin.asp?CID=516&DID=5474&DOC=FILE.PDF,
- Another ASHP article discusses lowering the INR range from 3.6 to 4.8 to 3.0 to 4.0 to reduce bleeding event by 30%. (http://www.ashp.org/s_ashp/article_news.asp?CID=167&DID=2024&id=5034 and see also March 22, 2004 Archives of Internal Medicine
Guidelines.gov Resources

- Multiple resources on preventing deep vein thrombosis,
- Practice management guide for management in trauma patients,
- By multiple organizations such as American College of Chest Physicians, ACOG, ACR, Michigan Quality Improvement Consortium

Resources

- Anticoagulants are high risk medicine,
- IHI has a how to guide for high risk medications,
- At www.ihi.org/IHI/Programs/Campaign,
- IHI has other resources on high alert medications,

TJC NPSGs

- Are you up to the challenge?