NATIONAL PATIENT SAFETY GOALS
PART 2

OCTOBER 13, 2017
HealthTechS3 is a 45 year old, award-winning healthcare consulting and strategic hospital services firm based in Brentwood, Tennessee with clients across the United States.

We are dedicated to the goal of improving performance, achieving compliance, reducing costs, and ultimately improving patient care. Leveraging consultants with deep healthcare industry experience, HealthTechS3 provides actionable insights and guidance that supports informed decision making and drives efficiency in operational performance.

Our consultants are former hospital leaders and executives. HealthTechS3 has the right mix of experienced professionals that service hospital clients across the nation. HealthTechS3 offers flexible and affordable services, consulting, and technology as we focus on delivering solutions that can be implemented and provide a positive, measurable impact.
GOVERNANCE & STRATEGY
• Affiliation Consulting
• Executive & Management Leadership Development
• Strategic Planning & Market share Analysis
• Community Health Needs Assessment
• Compliance Consulting Services

FINANCE
• Performance Optimization / Margin Improvement
• Revenue Cycle & Business Office Operations
• Productivity & Staffing Consulting - Optimum Productivity Toolkit

CLINICAL CARE & OPERATIONS
• Continuous Survey Readiness
• Quality Assurance Performance Improvement
• Lean Culture
• Customer Experience
• Clinical Resource Management
• Care Coordination – Primary Care Practice
• Physician Practice & Clinic Assessment
• Long Term Care Consulting
• Swing Bed Consulting
• Perioperative Services Consulting

RECRUITMENT
• Executive Recruitment
• Manager and Clinical Positions
• Physician / Provider Recruitment
• Information Technology Professionals
• Interim Placement
4th Quarter Webinars

Creating a Culture of Performance to Support Continual Improvement
Host: Diane Bradley
Date: October 27, 2017
Time: 12:00 Central
Registration Link: http://bit.ly/2fxaecY

Un-Complicating Swing Beds – Is it Really Possible?
Host: Carolyn St.Charles
Date: November 3, 2017
Time: 12:00 Central
Registration Link: http://bit.ly/2wRzGS1

Transforming Case Management for the Future; The Future is Now
Host: Diane Bradley
Date: November 10, 2017
Time: 12:00 Central
Registration Link: http://bit.ly/2y6riOP

Passing the Baton: Transitional Care Management and Beyond
Host: Faith Jones
Date: November 16, 2017
Time: 12:00 Central
Registration Link: http://bit.ly/2xyMN7B

Interim Leadership as a Career Path
Host: Mike Lieb
Date: November 30, 2017
Time: 12:00 Central
Registration Link: http://bit.ly/2wjZBqK

Challenges/Opportunities in Population Health Management IT
Host: Diane Bradley
Date: December 8, 2017
Time: 12:00 Central

Community Health Needs Assessment – Are you ready for 2018
Host: Carolyn St.Charles
Date: December 15, 2017
Time: 12:00 Central
Registration Link: http://bit.ly/2yrF2Qn

Understanding Team Based Care in the Primary Care Setting
Host: Faith Jones
Date: December 21, 2017
Time: 12:00 Central
Registration Link: http://bit.ly/2xDMAlf
INSTRUCTIONS FOR TODAY’S WEBINAR

- You may type a question in the text box if you have a question during the presentation.

- We will try to cover all of your questions – but if we don’t get to them during the webinar we will follow-up with you by e-mail.

- You may also send questions after the webinar to our team (contact information is included at the end of the presentation).

- The webinar will be recorded and the recording will be available on the HealthTechS3 web site:
  www.healthtechs3.com

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Carolyn began her healthcare career as a staff nurse in Intensive Care. She has worked in a variety of staff, administrative and consulting roles and has been in her current position as Regional Chief Clinical Officer with HealthTechS3 for the last fifteen years.

In her role as Regional Chief Clinical Officer, Carolyn St.Charles is the lead consultant for development of Community Health Needs Assessments and conducts mock surveys for Critical Access Hospitals, Acute Care Hospitals, Long Term Care, Rural Health Clinics, Home Health and Hospice. Carolyn also provides assistance in developing strategies for continuous survey readiness and developing plans of correction.
Covered in Part 1

- Goal 1: Improve the accuracy of patient and resident identification
- Goal 2: Improve the effectiveness of communication among caregivers
- Goal 3: Improve the safety of using medications
- Goal 6: Reduce the harm associated with clinical alarm systems

If you would like the presentation slides, please let me know

Recording Link: https://attendee.gotowebinar.com/recording/8971527084741276674
AGENDA FOR TODAY

• Why Should We Care? (If we’re not TJC accredited)

• Summary 2017/2018 National Patient Safety Goals

• Goal 7: Reduce the risk of health care-associated infections

• Goal 9: Reduce the risk of patient harm resulting from falls

• Goal 14: Prevent health care-associated pressure ulcers (decubitus ulcers)

• Goal 15: Identify patients at risk for suicide

• Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery
"Why should I care?"

Evidence-Based Care

Recognized as best practice

Specific guidance on elements of compliance

Adopted by many healthcare organizations

Right thing to do to improve patient/resident safety
OPEN ACCESS

NPSGs are available at
www.jointcommission.org

You do not need to be a TJC accredited organization to access the standards.
## TJC 2017/2018 National Patient Safety Goals

<table>
<thead>
<tr>
<th>Goal 1: Improve the accuracy of patient and resident identification</th>
<th>Hospital</th>
<th>CAH</th>
<th>Nursing Care Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPSG.01.01.01 Use at least two patient identifiers when providing care, treatment, and services.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>NPSG.01.03.01 Eliminate transfusion errors related to patient misidentification.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 2: Improve the effectiveness of communication among caregivers</th>
<th>Hospital</th>
<th>CAH</th>
<th>Nursing Care Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPSG.02.03.01 Report critical results of tests and diagnostic procedures on a timely basis.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 3: Improve the safety of using medications</th>
<th>Hospital</th>
<th>CAH</th>
<th>Nursing Care Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPSG.03.04.01 Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>NPSG.03.05.01 Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>NPSG.03.06.01 Maintain and communicate accurate patient and resident medication information.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

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## TJC 2017/2018 National Patient Safety Goals

<table>
<thead>
<tr>
<th>Goal 6: Reduce the harm associated with clinical alarm systems</th>
<th>Hospital</th>
<th>CAH</th>
<th>Nursing Care Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPSG.06.01.01 Reduce the harm associated with clinical alarm systems.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 7: Reduce the risk of health care-associated infections</th>
<th>Hospital</th>
<th>CAH</th>
<th>Nursing Care Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPSG.07.01.01 Comply with either the current CDC hand hygiene guidelines or the current WHO hand hygiene guidelines.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>NPSG.07.03.01 Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms.</td>
<td>Revised 1/1/18</td>
<td>Revised 1/1/18</td>
<td>New 1/1/18</td>
</tr>
<tr>
<td>NPSG.07.04.01 Implement evidence-based practices to prevent central line-associated bloodstream infections.</td>
<td>Revised 1/1/18</td>
<td>Revised 1/1/18</td>
<td>Revised 1/1/18</td>
</tr>
<tr>
<td>NPSG.07.05.01 Implement evidence-based practices for preventing surgical site infections.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>NPSG.07.06.01 Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Goal 9: Reduce the risk of patient harm resulting from falls</td>
<td>Hospital</td>
<td>CAH</td>
<td>Nursing Care Center</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
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</tr>
<tr>
<td>NPSG.09.02.01 Reduce the risk of falls.</td>
<td></td>
<td></td>
<td>X</td>
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</table>

<table>
<thead>
<tr>
<th>Goal 14: Prevent health care-associated pressure ulcers (decubitus ulcers)</th>
<th>Hospital</th>
<th>CAH</th>
<th>Nursing Care Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPSG.14.01.01 Assess and periodically reassess each patient’s and resident’s risk for developing a pressure ulcer and take action to address any identified risks.</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Goal 15: The hospital identifies safety risks inherent in its patient population</th>
<th>Hospital</th>
<th>CAH</th>
<th>Nursing Care Center</th>
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<tbody>
<tr>
<td>NPSG.15.01.01 Identify patients at risk for suicide.</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery</th>
<th>Hospital</th>
<th>CAH</th>
<th>Nursing Care Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>UP.01.01.01 Conduct a preprocedure verification process.</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>UP.01.02.01 Mark the procedure site.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>UP.01.03.01 A time-out is performed before the procedure.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
NPSG CHANGES 2018

• Revisions
  – NPSG.07.03.01 - MDROs
  – NPSG.07.04.01 - Central Line-Associated Bloodstream Infections

• New – for Nursing Care Centers January 1, 2018
  – NPSG.07.03.01 – MDROs
A WORD ABOUT EDUCATION

Learning Knows No Bounds
## Staff – Provider – Patient Education

<table>
<thead>
<tr>
<th>NPSG</th>
<th>Applies to</th>
<th>STAFF On-Hire</th>
<th>PROVIDERS When Privileges Granted</th>
<th>STAFF &amp; PROVIDERS Change in Responsibilities</th>
<th>STAFF &amp; PROVIDERS Periodically Determined by Organization</th>
<th>STAFF &amp; PROVIDERS Annually</th>
<th>STAFF &amp; PROVIDERS Competency</th>
<th>Patients Residents</th>
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<tbody>
<tr>
<td>MDRO NPSG.07.03.01 - EP 2</td>
<td>Hospital CAH Nursing Care Center</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Central line-associated Blood Stream Infections NPSG.07.04.01 - EP 1</td>
<td>Hospital CAH Nursing Care Center</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<td>EP 2</td>
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<tr>
<td>Surgical Site Infections NPSG.07.05.01 - EP 1</td>
<td>Hospital CAH</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<td>EP 2</td>
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<tr>
<td>CAUTI NPSG.07.06.01 - EP 1</td>
<td>Hospital CAH Nursing Care Center</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>EP 2</td>
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<tr>
<td>Fall Prevention NPSG.09.02.01 - EP 3</td>
<td>Nursing Care Center</td>
<td></td>
<td></td>
<td>X</td>
<td>X Staff Only</td>
<td></td>
<td></td>
<td>EP 4</td>
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<tr>
<td>Pressure Ulcers NPSG.14.02.01 - EP 6</td>
<td>Nursing Care Center</td>
<td></td>
<td></td>
<td>X</td>
<td>X Staff Only</td>
<td></td>
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<tr>
<td>Suicide Prevention NPSG.15.01.01 - EP 1</td>
<td>Hospital</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Universal Protocol</td>
<td>Hospital CAH</td>
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STAFF EDUCATION

• Develop policy about frequency of education (Surgical Site Infections required annually)
• Define WHO receives education – **NOT JUST NURSING ---Think about WHO may have contact with the patient**
  ➢ Non-Clinical: Engineering/Maintenance – EVS – Registration
• Develop education modules specific or appropriate to position
• Assess competency – don’t just provide information!

[Diagram showing least to most congruence with actual job performance]

• Providing data to key stakeholders is required for most of the NPSGs ----- this is an educational opportunity
• Evaluation of the education program is required for some of the NPSGs – DO IT FOR ALL!

*LEAST Congruence with Actual Job Performance MOST

WRITTEN TEST - COMPUTER TEST - RECORDS REVIEW - ANATOMIC MODEL - JOB SIMULATION - JOB SAMPLE (OBSERVATION)

*Source: Measuring the Competence of Healthcare Providers, Kak, Burhalter, and Cooper
Source: HealthTechS3 Clinical Connection Newsletter, Understanding and Measuring Competency, May/June 2017
**Provider Education**

- Develop policy about frequency of education (Surgical Site Infections required annually)
- Assess competency – don’t just provide information! Education for LIPs may be “different” than for staff but competency should still be assessed

*Least*  
**Congruence with Actual Job Performance**  
*Most*  
- Written test  
- Computer test  
- Records review  
- Anatomic model  
- Job simulation  
- Job sample (observation)

- Providing data is required for most NPSGs ------ this is an educational opportunity
- Evaluation of the education program is required for some of the NPSGs – DO IT FOR ALL!

*Source: Measuring the Competence of Healthcare Providers, Kak, Burkhalter, and Cooper  
Source: HealthTechS3 Clinical Connection Newsletter, Understanding and Measuring Competency, May/June 2017*
COMPETENCY CHECKLIST

Appendix 5: Central Line Insertion Care Team Checklist

Tools for Reducing Central Line-Associated Blood Stream Infections
These tools will help your unit implement evidence-based practices and eliminate central line-associated blood stream infections (CLABSI). When used with the CUSP (Comprehensive Unit-based Safety Program) Toolkit, these tools dramatically reduced CLABSI rates in more than 1,000 hospitals across the country.

Patient Name: ______________________________ Hx#:____________ Unit: ____________ Date/Time:____________

• A minimum of 5 supervised successful procedures in both the chest and femoral sites is required (10 total). If a physician successfully performs 5 supervised lines in one site, he or she is independent for that site only. A total of 3 supervised rewrites is required prior to performing a rewrite independently.

• Supervisor Role: 2nd year resident and above (approved for line placement). Assistant Role: RN, ClinTech, MD, NP, PA (responsible for completing checklist).

• If there is a deviation in any of the critical steps, immediately notify the operator and stop the procedure. If a correction is required, make a check mark in the “Yes With Reminder” column and note the correction in the comment space. Report uncorrected deviations and complications of line placement. Contact the attending if any item on the checklist is not adhered to or if there are any concerns. Return this completed form to the designated person in your area.


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The most important concept for providing education is to provide in a language / way in which information can be understood.

Examples of Education Methods
- Sign on Door (if patient is in isolation)
- Brochure / Written Information
- Verbal discussion
CULTURAL COMPETENCY

Cultural Competency in Health Services and Care published by the Washington State Department of Health outlines six strategies for improving interpersonal communication with culturally diverse patients or those with limited English proficiency or low health literacy rates:

- Slowing down your rate of speaking
- Using simple, non-medical language
- Showing, or drawing pictures
- Limiting the amount of information provided and repeating as necessary
- Using the “teach-back” or “show-me” technique
- Creating an accepting and respectful atmosphere

HealthTechS3 Clinical Connection Newsletter, Cultural Competency, July/August 2017
Understanding and Measuring Competency

Part 1: Developing a Framework for Competency Assessments

Welcome to our two part summer series on Competency. Part 1, May/June will focus on a framework for measuring competency. Part 2, July/August will focus on exams of competency including cultural competency.

Introduction

As healthcare providers we often struggle with how to measure competency effectively and to ensure that we are providing safe, effective, and culturally appropriate patient care to the populations we serve.

In their article, "Measuring the Competence of Healthcare Providers: Kolb, Butcher, and Cooper define competence as, "the ability to perform a specific task in a manner that yields desirable outcomes." In their newsletter, Developing a Competency Framework, defines competency as, "the integrated knowledge, skills, judgment, and attributes that people need to perform a job effectively.

Unfortunately, we sometimes confuse formal or informal education and/or years of experience with competency. Although both education and experience may have a positive impact, they are not in and of themselves reliable indicators of competency.

Patricia Berenice in her PSSM book, From Novice to Expert, describes five levels of proficiency:

- Novice
- Advanced Beginner
- Competent
- Proficient
- Expert

Although written for nursing, these levels can apply to any discipline. Adding information to the competency assessment regarding the level of skill can help establish realistic expectations. It can also help us think about competencies as a continuum and not a set point in time.

Available at

http://www.healthtechs3.com/newsletters-bulletins/
NATIONAL PATIENT SAFETY GOALS

• Goal 7: Reduce the risk of health care-associated infections

• Goal 9: Reduce the risk of patient harm resulting from falls

• Goal 14: Prevent health care-associated pressure ulcers (decubitus ulcers)

• Goal 15: Identify patients at risk for suicide

• Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery

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Goal 7: Reduce the risk of health care-associated infections  
**NPSG.07.03.01:** Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in hospitals / critical access hospitals

*Note: This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), carbapenem-resistant enterobacteriaceae (CRE) and other multidrug-resistant gram-negative bacteria.*

1. Conduct periodic risk assessments (in time frames defined by the organization) for multidrug-resistant organism acquisition and transmission.

2. REVISED 1/1/18: Educate staff and LIPs about multidrug-resistant organisms and prevention strategies. Education occurs upon hire, or granting of initial privileges and periodically thereafter as determined by the organization. Note: The education provided recognizes the diverse roles of staff and licensed independent practitioners and is consistent with their roles with the organization.

3. Educate patients and residents, and their families, as needed, who are infected or colonized with a multidrug-resistant organism about health care-associated infection prevention strategies.

4. Implement a surveillance program for multidrug-resistant organisms based on the risk assessment. Note: Surveillance may be targeted rather than hospital wide.

5. Measure and monitor multidrug-resistant organism prevention processes and outcomes, including the following:
   - Multidrug-resistant organism infection rates using evidence-based metrics
   - Compliance with evidence-based guidelines or best practices
   - Evaluation of the education program provided to staff and licensed independent practitioners

   Note: Surveillance may be targeted rather than hospital wide.

6. Provide multidrug resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.

7. Implement policies and practices aimed at reducing risk of transmitting multidrug-resistant organisms. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the CDC and/or professional organizations guidelines).

8. When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients with multidrug-resistant organisms. Note: The alert system may use telephone, faxes, pagers, automated and secure electronic alerts, or a combination of these methods.

9. When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multidrug-resistant organisms. Note: The alert information may exist in a separate electronic database or may be integrated into the admission system. The alert system may be either manual or electronic or a combination of both. Note: Each organization may define its own parameters in terms of time and clinical manifestation to determine which readmitted patients and residents require isolation.
CHANGES

• Applies to Nursing Care Centers 1/1/18
  – Nursing Home Residents are at high risk of acquiring MDROs
    • 20% of nursing home residents have methicillin-resistant staphylococcus aureus (MRSA)
    • 10% of nursing home residents are infected with vancomycin-resistant enterococci (VRE)
  • Revised to include carbapenem-resistant enterobacteriaceae (CRE) as an epidemiologically important organism
  • Education requirements for staff and licensed independent practitioners modified to no longer require annual education – but allows organizations to determine the appropriate time frame for education. Still requires education on hire or granting of initial privileges.
EP 1 - PERIODIC RISK ASSESSMENT

1. Establish the baseline incidence and/or prevalence MDRO rates for the whole healthcare facility or for specific unit(s) in the facility.

2. Identify high-risk populations and/or units based on incidence and/or prevalence rates, local demographic risk data, and known risk factors from scientifically based evidence.

3. Evaluate MDRO data for the facility and/or the specific unit(s) over time to characterize MDRO prevalence or transmission rates to determine if enhanced interventions are needed.

4. Conduct appropriate surveillance for MDROs, taking into account the above risk factors and MDRO data, in order to identify MDRO cases early for infection control.

5. Identify clusters in MDRO transmission in the patient population and/or unit(s) to determine if enhanced interventions are needed. Based on the institution’s MDRO surveillance and risk assessment, the healthcare institution should develop and implement an appropriate IPC program that targets MDROs in the facility.

Source: GUIDELINES FOR CONTROL AND PREVENTION OF MULTI-DRUG RESISTANT ORGANISMS (MDROS) IN HEALTHCARE FACILITIES
https://www.moh.gov.sg/content/moh_web/home/Publications/guidelines/infection_control_guidelines/MDRO_Guidelines.html

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SURVEILLANCE AND DATA

EP 4. Implement a surveillance program for multidrug-resistant organisms based on the risk assessment. Note: Surveillance may be targeted rather than hospital wide.

TJC FAQ: Targeted surveillance is allowable for MDROs. Please see EP 4, which states, "implement a surveillance program for multidrug-resistant organisms based on the risk assessment." Therefore, if an organization's risk assessment shows that risk is greatest for certain organisms, patient care units or service lines, the surveillance program may be targeted to focus resources on those high-risk issues.

EP 5. Measure and monitor multidrug-resistant organism prevention processes and outcomes, including the following:
- Multidrug-resistant organism infection rates using evidence-based metrics
- Compliance with evidence-based guidelines or best practices
- Evaluation of the education program provided to staff and licensed independent practitioners

EP 6. Provide multidrug resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians. (Can also be used as evidence of education)

EP 8. When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients with multidrug-resistant organisms. Note: The alert system may use telephone, faxes, pagers, automated and secure electronic alerts, or a combination of these methods.

EP 9. When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multidrug-resistant organisms. Note: The alert information may exist in a separate electronic database or may be integrated into the admission system. The alert system may be either manual or electronic or a combination of both. Note: Each organization may define its own parameters in terms of time and clinical manifestation to determine which readmitted patients and residents require isolation.
EP 7 - POLICIES & PRACTICES

These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the CDC and/or professional organizations guidelines).

Examples:

• Identification of MDROs
• Handwashing Compliance (Covered in Part 1)
• Isolation Techniques
• Sterilization, Disinfection, Terminal Cleaning Practices
• Antibiotic Stewardship
• And MORE

EP 5: Measure and monitor multidrug-resistant organism prevention processes and outcomes, including the following: Compliance with evidence-based guidelines or best practices.
## Centers for Medicare & Medicaid Services Hospital Infection Control Worksheet
### Section 1.C Systems to Prevent Transmission of MDROs and Promote Antimicrobial Stewardship

| 1.C.1: | The hospital has policies and procedures to minimize the risk of development and transmission of multidrug-resistant organisms (MDROs) within the hospital (applicable to all persons in the hospital). |
| 1.C.2: | Systems are in place to designate patients known to be colonized or infected with a targeted MDRO and to notify receiving units and personnel prior to movement of such patients within the hospital. |
| 1.C.3: | Systems are in place to designate patients known to be colonized or infected with a targeted MDRO and to notify receiving healthcare facilities and personnel prior to transfer of such patient between facilities. |
| 1.C.4: | The hospital can provide a list of targeted MDROs. |
| 1.C.5: | The hospital can demonstrate the criteria used to determine epidemiologically important MDROs on their list. |
| 1.C.6: | The hospital can provide justification for any epidemiologically important organisms not on their list and otherwise not targeted in their hospital. |
| 1.C.7: | The hospital has an established system(s) to ensure prompt notification to the Infection Control Officer when a novel resistance pattern based on microbiology results is detected. |
| 1.C.8: | Patients identified as colonized or infected with target MDROs are placed on Contact Precautions. |
| 1.C.9: | The hospital has written policies and procedures whose purpose is to improve antibiotic use (antibiotic stewardship). |
| 1.C.10: | The hospital has designated a leader (e.g., physician, pharmacist, etc.) responsible for program outcomes of antibiotic stewardship activities at the hospital. |
| 1.C.11: | The hospital’s antibiotic stewardship policy and procedures requires practitioners to document in the medical record or during order entry as indication for all antibiotics, in addition to other required elements such as dose and duration. |
| 1.C.12: | The hospital has a formal procedure for all practitioners to review the appropriateness of any antibiotics prescribed after 48 hours from the initial orders (e.g., antibiotic time out). |
| 1.C.13: | The hospital monitors antibiotic use (consumption) at the unit and/or hospital level. |
This change package is intended for hospitals participating in the Hospital Improvement Innovation Network (HIIN) project led by the Centers for Medicare & Medicaid Services (CMS) and Partnership for Patients (PFP); it is meant to be a tool to help you make patient care safer and improve care transitions.

This change package is a summary of themes from the successful practices of high performing health organizations across the country. It was developed through clinical practice sharing, organization site visits and subject matter expert contributions.

This change package includes a menu of strategies, change concepts and specific actionable items that any hospital can implement based on need or for purposes of improving patient quality of life and care.

This change package is intended to be complementary to literature reviews and other evidence-based tools and resources.

Accessed at www.hret-hiin.org


HRET MULTI-DRUG RESISTANT ORGANISM INFECTION CHANGE PACKAGE RESOURCES


Goal 7: Reduce the risk of health care-associated infections

**NPSG.07.04.01**: Implement evidence-based practices to prevent central line-associated bloodstream infections

Note: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

EP 1. Educate staff and LIPs who are involved in managing central lines about central line-associated bloodstream infections and the importance of prevention. Education occurs upon hire or granting privileges and periodically thereafter as determined by the organization.

EP 2. Prior to insertion of a central venous catheter, educate patients and, as needed, their families about central line-associated bloodstream infection prevention.

EP 3. Implement policies and practices aimed at reducing the risk of central line-associated bloodstream infections. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, CDC and/or professional organizations guidelines).

EP 4. Conduct periodic risk assessments for central line-associated bloodstream infections, monitor compliance with evidence-based practices, and evaluate the effectiveness of prevention efforts. The risk assessment are conducted in time frames defined by the hospital, and this infection surveillance activity is hospital wide, not targeted.

EP 5. Provide central line-associated bloodstream infection rate data and prevention outcome measures to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.

EP 6. Use a catheter checklist and a standardized protocol for central venous catheter insertion.

EP 7. Use a standardized supply cart or kit that contains all necessary components of the insertion of central venous catheters.

EP 8. Perform hand hygiene prior to catheter insertion or manipulation.


EP 10. For adult patients do not insert into femoral vein unless other sites are unavailable.

Education requirements for staff and licensed independent practitioners modified to no longer require annual education – but allows organizations to determine the appropriate time frame for education. Still requires education on hire, or granting of initial privileges.

For nursing care centers, the education requirements for staff, licensed independent practitioners, patients or residents, and families were not previously applicable to the program but have been added as EP 2.

Using an antiseptic for skin preparation, has been revised to specify the use of alcoholic chlorhexidine antiseptic.

Note: The Joint Commission considered adding an EP addressing the use of ultrasound guidance for jugular central venous catheter insertion, that requirement was not included in the revisions based on feasibility concerns from the field and an evaluation of the scientific literature.
EP 4 – PERIODIC RISK ASSESSMENT

EP 4. Conduct periodic risk assessments for central line-associated bloodstream infections,

– monitor compliance with evidence-based practices,
– and evaluate the effectiveness of prevention efforts.

INCORPORATE AS PART OF YOUR ANNUAL IC RISK ASSESSMENT.
SURVEILLANCE

EP 5. Provide central line-associated bloodstream infection rate data and prevention outcome measures to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.

TJC: Infection surveillance must be performed on all central lines; these lines carry significant risk of morbidity and mortality regardless of circumstances. Limiting surveillance to certain types of lines, patient care units or service lines is not allowable under NPSG.07.04.01.
Policies & Practices

EP 3. Implement policies and practices aimed at reducing the risk of central line-associated bloodstream infections. These policies and practices meet regulatory requirements and are aligned with evidence-based standard (for example, CDC and/or professional organizations guidelines).

EP 6. Use a catheter checklist and a standardized protocol for central venous catheter insertion.

- TJC: NPSG.07.04.01 EP 6 requires use of "a catheter checklist and a standardized protocol for central venous catheter insertion" The checklist or protocol is not required to be a part of the patient’s medical record. A simple indication that the checklist or protocol was completed, perhaps via a checkbox or brief note, is sufficient.

EP 7. Use a standardized supply cart or kit that contains all necessary components of the insertion of central venous catheters.

EP 8. Perform hand hygiene prior to catheter insertion or manipulation.

EP 9. Revised 1/1/18: Use maximum sterile barrier precautions during central line insertion. (Removed standardized protocol.)

EP 10. For adult patients do not insert into femoral vein unless other sites are unavailable.


- TJC: NPSG.07.04.01 requires use of a "standardized protocol to disinfect catheter hubs and injection ports before accessing the ports." This is not a patient-specific documentation requirement. Surveyors will ask to see each organization’s protocol; this may be in the form of a policy, protocol, etc.
Appendix 1. Weeks Without CLABSI Banner (PowerPoint Version)
Appendix 2. Central Line-Associated Bloodstream Infections Fact Sheet (Word Version)
Appendix 3: Guidelines to Prevent Central Line-Associated Blood Stream Infections (PowerPoint Version)
Appendix 4. Line Cart Inventory (Word Version)
Appendix 5. Central Line Insertion Checklist (Word Version)
Appendix 6. Central Line Maintenance Audit Form (Word Version)
Appendix 7. CLABSI Event Report Template (Word Version)
Appendix 8. CLABSI Investigation Nurse Letter (Word Version)
GOAL 7: REDUCE THE RISK OF HEALTH CARE-ASSOCIATED INFECTIONS
NPSG.07.05.01: IMPLEMENT EVIDENCE-BASED PRACTICES FOR PREVENTING SURGICAL SITE INFECTIONS.

1. Educate staff and LIPs involved in surgical procedures about surgical site infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in surgical procedures is added to an individual’s job responsibilities.

2. Educate patients, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention.

3. Implement policies and practices aimed at reducing the risk of surgical site infections. These policies and practices meet regulatory requirements and are aligned with evidence-based guidelines (for example, the CDC and/or professional organization guidelines).

4. As part of the effort to reduce surgical site infections:
   - Conduct periodic risk assessments for surgical site infections in a time frame determined by the CAH/Hospital
   - Select surgical site infection measures using best practices or evidence-based guidelines.
   - Monitor compliance with best practices or evidence-based guidelines.
   - Evaluate the effectiveness of prevention efforts.

5. Measure surgical site infection rates for the first 30 or 90 days following surgical procedures based on NHSN procedural codes. The CAH/Hospital measurement strategies follow evidence-based guidelines.

6. Provide process and outcome (for example, surgical site infection rate) measure results to key stakeholders.

7. Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to methods cited in scientific literature or endorsed by professional organizations.

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

APPLIES TO: HOSPITAL – CAH
**RISK ASSESSMENT & SURVEILLANCE**

EP 4. As part of the effort to reduce surgical site infections:
- Conduct periodic risk assessments for surgical site infections in a time frame determined by the CAH/Hospital
- Select surgical site infection measures using best practices or evidence-based guidelines.
- Monitor compliance with best practices or evidence-based guidelines
- Evaluate the effectiveness of prevention efforts

EP 5. Measure surgical site infection rates for the first 30 or 90 days following surgical procedures based on NHSN procedural codes. The CAH/Hospital measurement strategies follow evidence-based guidelines

EP 6. Provide process and outcome (for example, surgical site infection rate) measure results to key stakeholders.

**INCORPORATE AS PART OF YOUR ANNUAL IC RISK ASSESSMENT**
POLICIES & PRACTICES

EP 3. Implement policies and practices aimed at reducing the risk of surgical site infections. These policies and practices meet regulatory requirements and are aligned with evidence-based guidelines (for example, the CDC and/or professional organization guidelines).

EP 7. Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to methods cited in scientific literature or endorsed by professional organizations.

EP 8. When hair removal is necessary, use a method that is cited in scientific literature or endorsed by professional organizations.
Goal 7: Reduce the risk of health care-associated infections

**NPSG.07.06.01:** Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI)

1. Educate staff and LIPs involved in the use of indwelling urinary catheters about CAUTI and the importance of infection prevention. Education occurs upon hire or granting of initial privileges and when involvement in indwelling catheter care is added to an individual’s job responsibilities. Ongoing education and competence assessment occur at intervals established by the organization.

2. Educate patients who will have an indwelling catheter, and their families as needed, on CAUTI prevention and the symptoms of a urinary tract infection.

3. Develop written criteria using evidence-based guidelines, for placement of an indwelling urinary catheter. Written criteria are revised as scientific evidence changes.

4. Follow written procedures based on established evidence-based guidelines for inserting and maintaining an indwelling urinary catheter. The procedures address the following:
   - Limiting use and duration
   - Performing hand hygiene prior to catheter insertion or maintenance care
   - Using aseptic techniques for site preparation, equipment and supplies
   - Securing catheters for unobstructed urine flow and drainage
   - Replacing the urine collection system when required
   - Collecting urine samples

5. Measure and monitor catheter-associated urinary tract infection prevention and outcomes in high-volume areas by doing the following:
   - Selecting measures using evidence-based guidelines or gest practices
   - Having a consistent method for medical record documentation of indwelling urinary catheter use, insertion, and maintenance
   - Monitoring compliance with evidence-based guidelines or gest practices
   - Evaluating the effectiveness of prevention efforts

**APPLIES TO:**

**HOSPITAL – CAH – NURSING CARE CENTER**
POLICIES & PRACTICES

EP 3. Develop written criteria using evidence-based guidelines, for placement of an indwelling urinary catheter. Written criteria are revised as scientific evidence changes.

EP 4. Follow written procedures based on established evidence-based guidelines for inserting and maintaining an indwelling urinary catheter. The procedures address the following:

- Limiting use and duration
- Performing hand hygiene prior to catheter insertion or maintenance care
- Using aseptic techniques for site preparation, equipment and supplies
- Securing catheters for unobstructed urine flow and drainage
- Replacing the urine collection system when required
- Collecting urine samples
SURVEILLANCE

EP 5. Measure and monitor catheter-associated urinary tract infection prevention and outcomes in high-volume areas by doing the following:

– Selecting measures using evidence-based guidelines or gest practices
– Having a consistent method for medical record documentation of indwelling urinary catheter use, insertion, and maintenance
– Monitoring compliance with evidence-based guidelines or gest practices
– Evaluating the effectiveness of prevention efforts

TJC: NPSG.07.06.01 on CAUTI does not specify either hospital-wide or targeted surveillance. In fact, it does not specifically require that surveillance for CAUTI be performed at every accredited hospital. Rather, it allows for each organization to decide, based on its risk assessment (IC.01.03.01) whether CAUTI is a priority warranting surveillance. Having said this, The Joint Commission urges organizations to review the scientific literature and consensus-based guidelines when considering CAUTI surveillance. One summary of the epidemiology of CAUTI that bears consideration is the following excerpt from the CDC/HICPAC document entitled "Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009."
IC.02.02.01

For the first half of 2017, 70% of TJC surveyed hospitals had findings related to IC.02.02.01

High Level sterilization and disinfection processes

• Most frequently cited clinical standard (#1)
• Most frequent - Immediate Threat to Life (#1)
GOAL 9: REDUCE THE RISK OF PATIENT HARM RESULTING FROM FALLS

NPSG.09.02.01: REDUCE THE RISK OF FALLS

1. Assess the patient’s or resident’s risk for falls.

2. Implement interventions to reduce falls based on the patient’s or resident’s assessed risk.

3. Educate staff on the fall reduction program in time frames determined by the organization.

4. Educate the patient or resident and, as needed, the family on any individualized fall reduction strategies.

5. Evaluate the effectiveness of all fall reduction activities, including assessment interventions, and education.

APPLIES TO: NURSING CARE CENTER
**The Problem**

### Nursing Homes

- About 1,800 people living in nursing homes die each year from falls.
- About 10% to 20% of nursing home falls cause serious injuries; 2% to 6% cause fractures.
- Falls result in disability, functional decline and reduced quality of life. Fear of falling can cause further loss of function, depression, feelings of helplessness, and social isolation.

**Hospitals**

Between 700,000 and 1 million patients fall in hospitals each year. (Source: [Agency for Healthcare Research and Quality](https://www.ahrq.gov/))

The average increase in a hospital's operational costs for a serious fall-related injury is more than $13,000, and the patient's length of stay increases by an average of 6.27 days.

Source: [The Joint Commission](https://www.jointcommission.org/)

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Source: CDC - Falls in Nursing Homes
https://secure.in.gov/isdh/files/CDC_Falls_in_Nursing_Homes.pdf

Source: The Joint Commission
COMMON CONTRIBUTING FACTORS

• Inadequate assessment

• Communication failures

• Lack of adherence to protocols and safety practices

• Inadequate staff orientation, supervision, staffing levels or skill mix

• Deficiencies in the physical environment

• Lack of leadership


• Muscle weakness and walking or gait problems are the most common causes of falls among nursing home residents. These problems account for about 24% of the falls in nursing homes.

• Environmental hazards in nursing homes cause 16% to 27% of falls among residents. Such hazards include wet floors, poor lighting, incorrect bed height, and improperly fitted or maintained wheelchairs.

• Medications can increase the risk of falls and fall-related injuries. Drugs that affect the central nervous system, such as sedatives and anti-anxiety drugs, are of particular concern.
  – Fall risk is significantly elevated during the three days following any change in these types of medications.

• Other causes of falls include difficulty in moving from one place to another (for example, from the bed to a chair), poor foot care, poorly fitting shoes, and improper or incorrect use of walking aids.

Source: CDC - Falls in Nursing Homes
https://secure.in.gov/isdh/files/CDC_Falls_in_Nursing_Homes.pdf
RISK FACTORS

Intrinsic

- Advanced Age
- Previous Falls
- Muscle Weakness
- Gait & Balance Problems
- Poor Vision – Visual problems
- Postural Hypotension
- Chronic Conditions including arthritis, diabetes, stroke, Parkinson’s, dementia
- Urinary incontinence
- Fear of Falling
- Unrelieved pain
- Dehydration
- Sensory impairment
- Nutritional deficit
- Functional limitations
- Dizziness

Extrinsic

- Medications Sedatives, psychotropic agents, diuretics, antidepressants, CV agents, anticoagulants, bowel preparations
- Polypharmacy (>4 medications)
- Alcohol intake
- Foot wear or foot problems
- Unfamiliarity with new environment
- Lack of stair handrails
- Poor stair design
- Lack of bathroom grab bars
- Dim lighting or glare
- Obstacles & tripping hazards
- Slippery or uneven surfaces
- Improper use of walker or assistive device


Source: CDC: STEADI (Stopping Elderly Accidents, Deaths & Injuries)
FALL RISK ASSESSMENT TOOLS

Fall Risk Assessments

• Morse Fall Scale
  – http://www.patientsafety.gov/SafetyTopics/fallstoolkit/
• Hendrich II Scale (not as researched as Morse)
• St. Thomas Risk Assessment Tool (STRATIFY) (Primarily used for older adults)
  – http://www.injuryresearch.bc.ca/Publications/Repository/STRATIFY.pdf
• John Hopkins Fall Risk Assessment Tool (One Time Fee)

Gait and Balance Assessments

• Timed Up and Go (TUG)
• Get Up and Go Test
• Berg Balance Scale (BBS)
  – http://web.missouri.edu/~proste/tool/Berg-Balance-Scale.rtf
• Dynamic Gait Index
  – http://web.missouri.edu/~proste/tool/Dynamic-Gait-Index.rtf
• Tinetti Performance Oriented Mobility Assessment (POMA)
DO THE RISK ASSESSMENT TOOLS WORK?

Research has shown that scores from fall risk prediction tools do not actually predict falls any better than a clinician's judgment.

For this reason and others, the creator of one commonly used scale (Tool 3G, "STRATIFY Scale for Identifying Fall Risk Factors") argues against the scores being used for predictive purposes.


Source: AHRQ – Preventing Falls in Hospitals
NURSING CARE CENTER ASSESSMENT FREQUENCY

All older persons who are under the care of a health care professional (or their caregivers) should be asked at least once a year about falls, frequency of falling, and difficulties in gait or balance.

But it doesn’t matter how often -- --- if actions aren’t taken to prevent falls

Source: American Geriatrics Society/British Geriatric Society Clinical Practice Guidelines for prevention of falls in older adults. Available at www.americangeriatrics.org
Hospital Assessment Frequency

The patient’s clinical condition can change rapidly – surgery / procedure / change in medications, etc.

Most Hospitals assess fall risk AT LEAST DAILY

But it doesn’t matter how often --- -- if actions aren’t taken to prevent falls
STRATEGIES

1. Lead an effort to raise awareness of the need to prevent falls resulting in injury.

2. Establish an interdisciplinary falls injury prevention team or evaluate the membership of the team in place.

3. Use a standardized, validated tool to identify risk factors for falls.

4. Develop an individualized plan of care based on identified fall and injury risks, and implement interventions specific to a patient, population or setting.

5. Standardize and apply practices and interventions demonstrated to be effective, including:
   - A standardized hand-off communication process for communicating patient risk for falls with injury between caregivers that includes identifying specific areas of risk and patient-specific interventions to mitigate the risk.
   - One-to-one education of each patient at the bedside by trained health professionals using educational materials covering falls risk and causes, preventative strategies and goal setting and review.

6. Conduct post-fall management, which includes: a post-fall huddle; a system of honest, transparent reporting; trending and analysis of falls which can inform improvement efforts; and reassess the patient.

LTC STRATEGIES

1. Identify residents at high risk for falling, including those having poor vision, gait disturbances, weakness, cardiovascular disease, incontinence, and a history of falls.

2. Include specific measures in the care plan of high-risk residents to prevent falls.

3. Increase the sensitivity of the entire staff to the potential for accidents within and around the facility through ongoing education programs. Each employee must play a part in noticing, reporting, and reducing potential hazards.

4. Assess newly admitted residents for the presence of factors that increase their risk of falls, orient them to their environment, and observe them carefully during their first two weeks at the facility.

5. A current list of all residents in the facility’s fall prevention program should be posted at each nurses’ station. In addition, participating residents should wear colored identification bracelets. A star or dot may be placed on the outside door frame of the resident’s room, above the bed, at the nurses’ station call light area, on the spine of the medical chart, or on the nurse assistant worksheet.

6. Instruct residents on the proper use of the nurse call system, including when and how to call for assistance. Check that the nurse call systems are operational and accessible for all residents.

7. Encourage resident to wear their eyeglasses.

8. Teach safe transfer techniques from bed, chairs, toilet, and wheelchairs. Advise residents to change positions slowly, holding on to a stable object as they do.

9. Utilize exercise as a means of improving resident strength, balance, and coordination.

10. Utilize volunteers and family members to assist with monitoring.

11. Have the facility therapist evaluate residents for interventions such as physical therapy, restorative programs, and adaptive equipment such as positioning cushions or tilted seats.
12. Note and report changes in residents’ physical and mental status promptly.
13. Monitor medications; in particular minimize the use of sedatives and tranquilizers.
14. Discontinue unnecessary medications.
15. Encourage residents to use handrails.
16. Residents at risk for falls should be placed in rooms near the nurse’s station for easier observation.
17. Be sure that when residents need to be lifted, there is more than one staff member assisting. Even when using a Hoyer lift, two or even three staff members should be present. Make sure that safety straps are properly used.
18. A gait belt should be used whenever possible, especially when assisting a resident on or off a toilet seat in a cramped space. The shower is another source of major trouble, and residents should use safety straps while sitting in a shower chair.
19. Continuously assess for environmental hazards and eliminate as appropriate. Keep floors free from litter and clutter. Provide good lighting in all resident areas. Clean spills immediately. Maintain beds at their lowest position and keep bed wheels locked at all times. Use a low profile bed if needed.
20. Assure that residents use canes, walkers, and wheelchairs only when prescribed and that these aids are fitted to the individual and are used correctly. Make sure to check these mobility aids regularly to ensure they are in good repair, as broken equipment can cause injury.
21. Make sure that residents wear well-fitted, low-heeled shoes; prevent them from wearing long robes and pants that fall below the ankle.
22. Preventing falls is an issue for every staff member in the facility. Every department should be involved in developing strategies for fall prevention and in monitoring residents who are in danger of falling. Front-line staff members are a facility’s best resource in developing practical interventions that are tailored to the unique needs of each individual resident.

Source: Developing Successful Strategies for Preventing Falls II. Illinois Council on Long Term Care
UNIVERSAL PROTOCOL

- Familiarize the patient with the environment
- Have the patient demonstrate call light use
- Maintain call light within reach
- Keep the patient’s personal possessions within patient safe reach
- Have sturdy handrails in patient bathrooms, room, and hallway
- Place the hospital bed in low position when a patient is resting in bed; raise bed to a comfortable height when the patient is transferring out of bed
- Keep hospital bed brakes locked
- Keep wheelchair wheel locks in "locked" position when stationary
- Keep nonslip, comfortable, well-fitting footwear on the patient
- Use night lights or supplemental lighting
- Keep floor surfaces clean and dry. Clean up all spills promptly
- Keep patient care areas uncluttered
- Follow safe patient handling practices

WHAT ABOUT PATIENTS AT HIGH RISK?????
## Scheduled Rounding Protocol - 5 P’s

<table>
<thead>
<tr>
<th>PAIN:</th>
<th>Assess the patient’s pain level. Provide pain medicine if needed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERSONAL NEEDS:</td>
<td>Offer help using the toilet; offer hydration, offer nutrition, empty commodes/urinals.</td>
</tr>
<tr>
<td>POSITION:</td>
<td>Help the patient get into a comfortable position or turn immobile patients to maintain skin integrity.</td>
</tr>
<tr>
<td>PLACEMENT:</td>
<td>Make sure patient’s essential needs (call light, phone, reading material, toileting equipment, etc.) are within easy reach.</td>
</tr>
<tr>
<td>PREVENT FALLS:</td>
<td>Ask patient/family to put on call light if patient needs to get out of bed.</td>
</tr>
</tbody>
</table>
EP 5. Evaluate the effectiveness of all fall reduction activities, including assessment interventions and education.
RESOURCES

- AHRQ toolkit: Preventing Falls in Hospitals
- ECRI Institute: Falls
- ICSI: Prevention of Falls (Acute Care)
- IHI: Transforming Care at the Bedside How-to Guide: Reducing Patient Injuries from Falls
- Joint Commission Center for Transforming Healthcare: Preventing Falls Targeted Solutions Tool® (TST®)
- VA National Center for Patient Safety: Falls Toolkit
- VA National Center for Patient Safety: Implementation Guide for Fall Injury Reduction
- American Geriatrics Society (tool kit on falls and practice guidelines for prevention of falls in older persons)
  - http://www.americangeriatrics.org/education/falls.shtml
- National Center for Injury Prevention and Control (tool kit to prevent senior falls)
- Hospital Elder Life Program
**GOAL 14: PREVENT HEALTH CARE-ASSOCIATED PRESSURE ULCERS (DECUBITUS ULCERS)**

**NPSG.14.01.01: ASSESS AND PERIODICALLY REASSESS EACH PATIENT’S AND RESIDENT’S RISK FOR DEVELOP A PRESSURE ULCER AND TAKE ACTION TO ADDRESS ANY IDENTIFIED RISKS.**


EP 2. Perform an initial assessment at admission to identify patients and residents at risk for pressure ulcers.

EP 3. Conduct a systematic risk assessment for pressure ulcers using a validated risk assessing tool such as the Braden Scale or Norton Scale.

EP 4. Reassess pressure ulcer risk at intervals defined by the organization.

EP 5. Take action to address any identified risks to the patient or resident for pressure ulcers, including the following
   - Preventing injury to patients and residents by maintaining and improving tissue tolerance to pressure in order to prevent injury
   - Protecting against the adverse effects of external mechanical forces


**APPLIES TO: NURSING CARE CENTER**
ASSESSMENT

EP 2. Perform an initial assessment at admission to identify patients and residents at risk for pressure ulcers.

EP 3. Conduct a systematic risk assessment for pressure ulcers using a validated risk assessing tool such as the Braden Scale or Norton Scale.

EP 4. Reassess pressure ulcer risk at intervals defined by the organization.
Prevention of pressure ulcers and skin breakdown begins with a comprehensive risk assessment. Most providers use a skin risk assessment tool, such as the Braden or Norton scale.

While these tools have been validated to predict pressure ulcer development, their use alone isn’t considered a comprehensive assessment, and frequently the individual risk factors they identify aren’t carried through to the plan of care.

Source: Wound Care Advisor September 13, 2017. Jeri Lundgren, BSN, RN, PHN, CWS, CWCN
ASSESSMENT TOOLS

• **BRADEN SCALE** – For Predicting Pressure Sore Risk
  - **MILD RISK**: Total score 15-18
  - **MODERATE RISK**: Total score 13-14
  - **HIGH RISK**: Total score 10-12
  - **SEVERE RISK**: Total score 9

• **NORTON PRESSURE SORE RISK ASSESSMENT SCALE SCORING SYSTEM**
  - Over 18 LOW RISK
  - BETWEEN 18 AND 14 MEDIUM RISK
  - BETWEEN 14 AND 10 HIGH RISK
  - LESS THAN 10 VERY HIGH RISK

Staff DON’T understand scoring
Poor Inter-rater Reliability
EP 5. TAKE ACTION TO ADDRESS ANY IDENTIFIED RISKS TO THE PATIENT OR RESIDENT FOR PRESSURE ULCERS

- **Skin Care.** Protecting and monitoring the condition of the patient’s skin is important for preventing pressure sores and identifying Stage 1 sores early so they can be treated before they worsen.
  - Inspect the skin upon admission and at least daily for signs of pressure injuries.
  - Assess pressure points, temperature and the skin beneath medical devices.
  - Clean the skin promptly after episodes of incontinence, use skin cleansers that are pH balanced for the skin, and use skin moisturizers.
  - Avoid positioning the patient on an area of pressure injury.

- **Nutrition.** Hospitalized individuals are at great risk for undernutrition.
  - Use a valid tool to assess the patient’s risk for malnutrition.
  - Refer at-risk patients to a registered dietitian or nutritionist.
  - Assess the patient’s weight regularly, as well as the adequacy of oral, enteral and parenteral intake.
  - Provide supplemental nutrition as indicated.

- **Positioning and Mobilization.** Immobility can be a big factor in causing pressure injuries. Immobility can be due to several factors, such as age, general poor health condition, sedation, paralysis and coma.
  - Turn and reposition at-risk patients, if not contraindicated.
  - Plan a scheduled frequency of turning and repositioning the patient.
  - Consider using pressure-relieving devices when placing patients on any support surface.
  - Consider the patient’s body size, level of immobility, exposure to shear, skin moisture and perfusion when choosing a support surface.

*Resource: The Joint Commission, Division of Health Care Improvement Issue 25, July 2016*
**RESOURCES**


GOAL 15: THE HOSPITAL IDENTIFIES SAFETY RISKS INHERENT IN ITS PATIENT POPULATION

NPSG.15.01.01: IDENTIFY PATIENTS AT RISK FOR SUICIDE

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.

2. Address the patient’s immediate safety needs and most appropriate setting for treatment.

3. When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.

Applies to: Hospital
TJC FAQs

• NPSG.15.01.01 applies to all patients in organizations surveyed under the BHC (behavioral) standards, all patients in psychiatric hospitals, and to any patient in a general hospital with a primary diagnosis or primary complaint of an emotional or behavioral disorder, regardless of registration status (IP, OP, ED, Obs, etc.). At this time, suicide risk assessment of patients with secondary diagnoses or secondary complaints of emotional or behavioral disorders is encouraged but not required. For purposes of this requirement, the phrase "emotional or behavioral disorders" refers to any DSM diagnosis or condition, including those related to substance abuse. The phrase "being treated" is interpreted in terms of the patient's diagnosis or presenting "complaint." The nature of the treatment is really not the issue. Additional information regarding assessing suicide risk has been published in our Sentinel Event Alerts:

• The details of the risk assessment process, when required, are left to the individual organization to decide. A two-stage process—for example, screening followed by a comprehensive assessment, as appropriate—is acceptable. Additional information regarding assessing suicide risk has been published in our Sentinel Event Alerts:
For inpatient psychiatric hospitals, inpatient psychiatric units in general acute care hospitals, and non-behavioral health units DESIGNATED for the treatment of psychiatric patients (i.e. special rooms/safe rooms in Emergency Departments or Medical Units):

- The requirements found in the Environment of Care (EC) chapter of the accreditation manual at EC.02.06.01 require hospitals to establish and maintain a safe, functional environment. Element of Performance # 1 states “Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.” Therefore, ligature and self-harm risks must be identified and eliminated. While risks are in the process of being eliminated, policies and procedures must be developed and implemented to mitigate the harm posed by such risks. Mitigation plans must include, at a minimum the following:
  - Ensuring that leadership and staff are aware of the current environmental risks
  - Identifying patients’ risk for suicide or self-harm, then implement appropriate interventions based upon risk.
  - Ongoing assessments and reassessments of at-risk behavior as defined by the organization.
  - Ensuring the proper training of staff to properly identify patients’ level of risk and implement appropriate interventions
  - Incorporating suicide risk and self-harm reduction strategies into the overall Quality Assessment/Performance Improvement (QAPI) program - see LD.01.03.01 EP 21.
  - If equipment poses a risk but is necessary for the safe treatment of psychiatric patients (i.e. medical beds with side rails on a geriatric unit), the organization must consider these risks in patients’ overall suicide/self-harm risk assessments, then implement appropriate interventions to diminish those risks

In non-behavioral health units (i.e. Emergency Rooms or Medical Inpatient Units) that are NOT DESIGNATED specifically for the treatment of psychiatric patients; however, where psychiatric patients may temporarily reside, ligature/self-harm environmental risks must also be identified.

All physical risks not required for the treatment of the patient that can be removed, must be removed. Furthermore, an appropriate level of effective surveillance must be implemented if self-harm risks remain in the environment. Organizational policies and procedures must adequately guide staff in the assessment of patients’ risk for suicide/self-harm and the implementation of interventions based upon the patients’ individual needs.

For non-inpatient programs surveyed under The Hospital Accreditation manual, an environmental risk assessment should be completed. Based upon the results of that assessment, taking into account the individuals they serve, the organization determines if any modifications to the environment should be made. Policies and procedures should also be developed and implemented to address the immediate action to be taken by staff when a patient is assessed to be at risk for suicide.
EP 1 – CONDUCT A RISK ASSESSMENT

• Screen all patients for suicide ideation, using a brief, standardized, evidence-based screening tool

• Review screening questionnaires before the patient leaves the appointment or is discharged

• Review each patient’s personal and family medical history for suicide risk factors. Risk factors include:
  – Mental or emotional disorders, particularly depression and biopolar disorder
  – Previous suicide attempts or self-inflicted injury
  – History of trauma or loss, such as abuse as a child, a family history of suicide, bereavement or economic loss
  – Serious illness, or physical or chronic pain or impairment
  – Alcohol and drug abuse
  – Social isolation or a pattern/history of aggressive or antisocial behavior
  – Discharge from inpatient psychiatric care, within the first year after and particularly within the first weeks and months after discharge
  – Access to lethal means coupled with suicide thoughts

However, there is no typical suicide victim. There is a danger in considering only individuals with certain conditions or experiences in certain health care settings as being at risk for suicide. It’s imperative for health care providers in all settings to better detect suicide ideation in patients, and to take appropriate steps for their safety and/or refer these patients to an appropriate provider for screening, risk assessment, and treatment.

SUICIDE RISK ASSESSMENT TOOLS

• Patient Health Questionnaire (PHQ-9)

• PHQ-2 (If either question answered yes – PHQ-9 is used)

• ED-SAFE Patient Safety Screener

• Suicide Behaviors Questionnaire –Revised (SBQ-R)

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SAFETY MEASURES

Take the following actions, using assessment results to inform the level of safety measures needed.

– Keep patients in acute suicidal crisis in a safe health care environment under one-to-one observation

EP 3 – SUICIDE PREVENTION INFORMATION

Take the following actions, using assessment results to inform the level of safety measures needed.

• For patients at lower risk of suicide, make personal and direct referrals and linkages to outpatient behavioral health and other providers for follow-up care within one week of initial assessment, rather than leaving it up to the patient to make the appointment.

• For all patients with suicide ideation
  • Give every patient and his or her family members the number of the National Suicide Prevention Lifeline
  • Conduct safety planning
  • Restrict access to lethal means

1. Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site.

2. Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following:
   - Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment)
   - Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed
   - Any required blood products, implants, devices, and/or special equipment for the procedure

3. Match the items that are to be available in the procedure area to the patient.

Applies to: Hospital - CAH
1. Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.

2. Mark the procedure site before the procedure is performed and, if possible, with the patient involved.

3. The procedure site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications:
   - An individual in a medical postgraduate education program who is being supervised by the licensed independent practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed.
   - A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed independent practitioner performing the procedure (that is, an advanced practice registered nurse (APRN) or physician assistant (PA); who is familiar with the patient; and who will be present when the procedure is performed.

4. The method of marketing the site and the type of mark is unambiguous and is used consistently throughout the CAH / Hospital.

5. A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum).

Applies to: Hospital - CAH
1. **Conduct a time-out immediately before starting the invasive procedure or making the incision.**

2. **The time-out has the following characteristics:**
   - It is standardized, as defined by the CAH / Hospital
   - It is initiated by a designated member of the team
   - It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other actively participants who will be participating in the procedure from the beginning.

3. **When two or more procedures are being performed on the same patient, and the persons performing the procedure changes, perform a time-out before each procedure is initiated.**

4. **During the time-out, the team members agree, at a minimum on the following**
   - Correct patient identity
   - The correct site
   - The procedure to be done

5. **Document the completion of the time-out.**

**Applies to: Hospital - CAH**
COMMON CONTRIBUTING FACTORS

• Inaccurate information
  – Schedule, consent, history and physical, diagnostic report(s)/image(s)

• No verification of documents or site marking

• Local anesthesia given without conducting a time-out

• Patient positioning conceals surgical mark

• Proper time-out not completed

NOT JUST SURGERY
PRINCIPLES FOR RELIABLE PERFORMANCE OF CORRECT SITE SURGERY

1. The correct site of the operation should be specified when the procedure is scheduled.
2. The correct operation and site should be noted on the record of the history and physical examination.
3. The correct operation and site should be specified on the informed consent.
4. Anyone reviewing the schedule, consent, history and physical examination, or reports documenting the diagnosis, should check for discrepancies among all those parts of the patient’s record and reconcile any discrepancies with the surgeon when noted.
5. The surgeon should have supporting information uniquely found in the office records at the surgical facility on the day of surgery.
6. All information that should be used to support the correct patient, operation, and site, including the patient’s or family’s verbal understanding, should be verified by the nurse, anesthesia provider, and surgeon before the patient enters the operating room (OR).
7. All verbal verification should be done using questions that require an active response of specific information rather than a passive agreement.
8. Patient identification should always require two unique patient identifiers.
9. Any discrepancies in the information should be resolved by the surgeon, based on primary sources of information, before the patient enters the OR.
10. The site should be marked by a healthcare professional familiar with the facility’s marking policy, with the accuracy confirmed both by all the relevant information and by an alert patient, or patient surrogate if the patient is a minor or mentally incapacitated; the site should be marked before the patient enters the OR.
11. The site should be marked by the provider’s initials.
12. All information that should be used to support the correct patient, operation, and site, including the patient’s or family’s verbal understanding, should be verified by the circulating nurse upon taking the patient to the OR.
13. Separate formal time-outs should be done for separate procedures, including anesthetic blocks, with the person performing that procedure.
14. All noncritical activities should stop during the time-out.
15. The site mark should be visible and referenced in the prepped and draped field during the time-out.
16. Verification of information during the time-out should require an active communication of specific information, rather than a passive agreement, and be verified against the relevant documents.
17. All members of the operating team should verbally verify that their understanding matches the information in the relevant documents.
18. The surgeon should specifically encourage operating team members to speak up if concerned during the time-out.
19. Operating team members who have concerns should not agree to the information given in the time-out if their concerns have not been addressed.
20. Any concerns should be resolved by the surgeon, based on primary sources of information, to the satisfaction of all members of the operating team before proceeding.
21. Verification of spinal level, rib resection level, or ureter to be stented should require radiological confirmation, using a stable marker and readings by both a radiologist and the surgeon.
RESOURCES

• Joint Commission - *Sentinel Event*

• National Quality Forum - “*Serious Preventable Events*”

• Centers for Medicare & Medicaid Services - *Non-Coverage Determination*

• World Health Organization Patient Safety Alliance - *Patient Safety Goal*
Final Thoughts

Safety Culture
ELEMENTS OF A SAFETY CULTURE

1. Transparent, non-punitive approaches to reporting and learning from adverse events, close calls and unsafe conditions.

2. Clear, risk-based processes for recognizing and separating human error and error arising from poorly designed systems from unsafe or reckless actions.

3. Adoption of appropriate behaviors and championing efforts to eradicate intimidating behaviors.

4. Establishment, enforcement and communication of all policies that support safety culture and the reporting of adverse events, close calls and unsafe conditions.

5. Recognition of care team members who report adverse events, close calls and unsafe conditions or who have suggestions for safety improvements.


7. Assessment of safety culture survey results from across the organization to find opportunities for improvement.

8. Development and implementation of unit-based quality and safety improvement initiatives in response to information gained from safety assessments and/or surveys.

9. Implementation of safety culture team training into quality improvement projects.

10. Proactive assessment of system (such as medication management and electronic health records) strengths and vulnerabilities, and prioritizing them for enhancement or improvement.

11. Organizational reassessment of safety culture every 18 to 24 months to review progress and sustain improvement.
Thank you!
If you would like more information - or - have questions – or - would like to discuss a mock survey at your facility please feel free to contact me.