


MAINTAINING SAFETY • REDUCING RISK

Special Report! Helpful Solutions for Meeting the 2006 National Patient Safety Goals

The Joint Commission's Sentinel Event Advisory Group has recommended National Patient Safety Goals and associated requirements for 2006, which were approved by the Joint Commission's Board of Commissioners at its May 2005 meeting. The 2006 goals that appear in this issue are program specific and apply, as indicated, to **ambulatory care, office-based surgery, assisted living, behavioral health care, critical access hospitals, disease-specific care, home care, hospitals, laboratories, long term care, integrated delivery systems, managed care organizations, and preferred provider organizations.**

Beginning January 1, 2006, all accredited organizations that provide care relevant to these goals and requirements will be expected to comply with them. Compliance with all National Patient Safety Goals and requirements that are relevant to your organization's services will be evaluated for continuous compliance throughout the accreditation cycle through on-site surveys, the Periodic Performance Review (PPR),* and Evidence of Standards Compliance (ESC). Surveyors will look for evidence of consistent implementation of the requirements. Regardless of when a survey is conducted during the year, scoring will be based on an expectation of continued compliance since January 1, 2006. Less than 100% compliance will result in a requirement for improvement (except in the case of Goal 2B and Goal 7A, which both require at least 90% compliance).

While implementing these goals and requirements, organizations *do not need to create any extra documentation* for the Joint Commission that they wouldn't already have created. To determine whether the requirements have been implemented and how consistently they are being performed, the surveyors will do the following:

- Look at whatever documentation an organization has that is relevant
- Interview the organization's leaders and direct caregivers
- Make direct observations of performance with respect to the goals to determine whether the requirements have been implemented and how consistently they are being performed

* For those programs required to complete a PPR.

However, if an organization has created policies and procedures or other documents that stipulate how the organization is to comply with a goal and its requirement(s), and a surveyor finds that the organization does not comply with its policies and procedures, an appropriate requirement for improvement will be written.

Clarifying the Applicability of the Goals

With program-specific National Patient Safety Goals, organizations find that some goals and requirements are listed as "not applicable." A goal or requirement may not be applicable to a particular organization for the following reasons:

- The goal is not relevant to the services provided by the organization.

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UP1: Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery

- The requirements associated with the goal were moved to a standard and/or an element of performance (EP) to be scored and reported.
- The goal or requirement has not been chosen as one of the year's priorities for the specific accreditation program.

The last reason, regarding the year's priorities, continues to raise questions about applicability for health care organizations. For example, Goal 11 (reduce the risk of surgical fires) is applicable, for accreditation purposes, only to ambulatory care and office-based surgery. Thus, Goal 11 is identified as "not applicable" to many organizations, including hospitals, even when it is clearly relevant to services that might be provided by those organizations. Please refer to Table 1 (page 20) to find out which goals apply to each accreditation program for 2006 as well as the goals that were retired for 2006.

Change Management

Since the launch of the National Patient Safety Goals, health care leaders have found different approaches to compliance; some of those approaches are universal to every goal because they involve elements of change management. *Change management* is the making of changes in a planned and managed or systematic fashion. The National Patient Safety Goals require health care leaders to be managers of change as they ensure that staff members are eliminating the use of prohibited abbreviations, following Centers for Disease Control and Prevention (CDC) hand hygiene guidelines, using two patient identifiers, taking time-outs before starting procedures, and so on. Some of the major elements of change management include the following:

- **Generate staff buy-in.** Before implementing a change, health care leaders must obtain buy-in from physicians, nurses, pharmacists, and other clinicians. A great way to get their buy-in is to ask for their input on

Retired National Patient Safety Goals

For 2006, the Sentinel Event Advisory Group has decided to retire the following goal requirements:

- **Goal 3A—Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from the patient care unit.** This requirement was retired because of consistently high levels of compliance. Also, this requirement continues as an element of performance under standard MM.2.20 in the "Medication Management" chapter.
- **Goal 5A—Ensure free-flow protection on all general-use and patient-controlled analgesia (PCA) intravenous infusion pumps used in the organization.** This requirement was retired because of consistently high levels of compliance and because problems with availability of free-flow-protected administration sets for certain types of pumps have been resolved by the manufacturers.

Finally, the advisory group has decided to retire Goal 9A (*Assess and periodically reassess each patient's risk for falling, including the potential risk associated with the patient's medication regimen, and take action to address any identified risks*) and require assisted living, critical access hospitals, disease-specific care, home care, hospitals, and long term care organizations to implement only Goal 9B (*Implement a fall reduction program and evaluate the effectiveness of the program*). The advisory group thought Goal 9B gives organizations more flexibility to comply with the overall goal of reducing the risk of patient harm resulting from falls.

the new procedural changes that will lead to compliance with each National Patient Safety Goal. In this way, the staff feels that they have contributed to the change and will then take ownership of that change.

- **Find a champion.** Find a physician, a nurse, a pharmacist, or another clinician to be the positive role model or spokesperson and a leader for change.
- **Use storytelling.** Health care leaders or champions can tell specific stories that emphasize the importance of change. Data or statistics can be difficult for the staff to connect to because the human element is removed. Staff members can connect to the human element when they

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hear a descriptive story about people who have made errors that were caused by an inappropriate process or flawed system and how the new process or system change will reduce the risk of that particular error.

- **Use evidence-based research.** While storytelling emphasizes why the previous procedure should not be used, evidenced-based research and expert consensus emphasize why the new procedure should be used. Health care leaders should cite specific literature studies, showing staff members that experts have examined and placed their stamp of approval on the proposed new change.
- **Empathize with the staff.** Find out why staff members may be resisting the change. It is understandable that the staff is frustrated by change if they have done a procedure the same way for years. Health care leaders need to be understanding of staff members' frustrations but assure them that these changes are necessary for their patients' safety and that the time staff members take now to change their behaviors and adjust to the change will pay off when they see improved patient safety results.
- **Individualize the process.** If time is available, health care leaders should work with staff members individually. In these individual discussions, leaders can (1) explain the importance and urgency of the change through storytelling and evidence-based research, (2) ask staff members for their input on the new change, (3) address staff members' specific concerns with the new change and empathize with them, and (4) focus on specific things that the staff member needs to improve upon to be in compliance with the new procedures.
- **Monitor the change.** Health care leaders must monitor their staff members' performance to ensure that they implement the new changes. Monitoring can take place through direct observation, self-report, patient interviews and follow-up surveys, files and charts audits, and other data gathering. For instance, with Goal 7A, health care leaders can observe staff members to make sure they are washing their hands or using hand gel appropriately. With Goal 2B, health care leaders should conduct audits of patient charts, including orders and other medication-related documentation, to find out how many times prohibited abbreviations are used.
- **Use the tracer methodology.** Leaders can observe for compliance with the National Patient Safety Goals while conducting individual tracers and individual-based system tracers, just as surveyors do on an accreditation survey. During the tracers, leaders should monitor staff members to ensure that they are complying

with the new changes and also ask staff members about the changes and what the new procedures entail.

- **Update staff members on their progress.** After monitoring staff members on their compliance with the new changes, leaders need to let staff members know their compliance rate. In this way, staff members will be congratulated for their improvement or will be aware of what they need to do to become compliant.

Alternative Approaches to the Requirements

If an organization believes it has an alternative approach that meets or exceeds the intent of a National Patient Safety Goal or its requirement(s) and wishes to implement that alternative approach in lieu of the published requirement, it must submit the details of the alternative to the Joint Commission for review, using the "Request for Review of an Alternative Approach to a 2006 National Patient Safety Goal Requirement" form that is available on the Joint Commission's Web site, at http://www.jcaho.org/accredited+organizations/patient+safety/06_npsg/06_rfr.doc. An organization must explain its alternative approach and submit the form to npsg@jcaho.org for review by the advisory group and Joint Commission staff members. Following review, the Joint Commission will inform the organization and the survey team of its decision about the acceptability of the alternative approach.

Scoring the National Patient Safety Goals

Accredited organizations that provide care relevant to the goals are required to demonstrate successful implementation of the published requirements, or acceptable alternatives to the requirements, applicable to each goal. Each requirement will be scored individually. When an organization does not fully comply with a requirement, the organization will be assigned a requirement for improvement at the goal level, in the same way that noncompliance with an EP generates a requirement for improvement at the standard level. All requirements for improvement can affect the accreditation decision and follow-up requirements, as determined by established accreditation decision rules. Failure to resolve a requirement for improvement can ultimately lead to loss of accreditation. Organizations will need to take the appropriate follow-up measures to address requirements for improvement.

The goals and their associated requirements appear as requirements in the "National Patient Safety Goals" chapter in the 2006 accreditation and certification manuals for applicable programs. An organization's performance regarding each goal's requirements will be publicly disclosed in the National Patient Safety Goals section of the 2006 Quality Report. **PS**

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National Patient Safety Goals, Joint Commission Requirements, and Compliance Solutions

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Goal 1: Improve the accuracy of patient identification.

Requirement 1A: Use at least two patient identifiers (neither to be the patient's room number^{*})[†] whenever administering medications or blood products,[‡] taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.[§] (Applicable to ambulatory care, assisted living, behavioral health care, critical access hospitals, disease-specific care, home care, hospitals, long term care, office-based surgery)

Requirement 1A: Use at least two patient identifiers (neither to be the patient's location) whenever collecting laboratory samples or administering medications or blood products, and use two identifiers to label sample collection containers in the presence of the patient. Processes are established to maintain samples' identity throughout the preanalytical, analytical, and postanalytical processes. (Applicable to laboratories)

Joint Commission Requirements

The intent of this goal and requirement is two-fold: (1) to reliably *identify* the individual as the person for whom the care, treatment, or service is intended and (2) to *match* the care, treatment, or service to that individual. Therefore, the two patient-specific identifiers must be directly associated with the individual, and the same two identifiers must be directly associated with the medication, blood products, or specimen tube (such as on an attached label).

This goal and its requirement do *not* require that two distinct methods of identification be used or that the identifiers be physically separate; rather, this goal and its requirement specify that two *pieces of patient-specific information* be used to identify the patient (for example, the patient's name and date of birth). It would be acceptable to use an identification (ID) band that includes the patient's name and unique number to correctly

* Replace "room number" with "physical location" for **ambulatory care** and **office-based surgery**.

† Remove "(neither to be the patient's room number)" for **home care**.

‡ "Blood products" does not apply to **behavioral health care**.

§ Remove "treatments or" for **behavioral health care**.

identify the patient (the name and the unique number would be the two pieces of information).

Compliance Solutions

Organizations can use information such as the patient's name, an assigned ID number, the patient's birth date, or bar coding that includes two or more patient-specific identifiers (*not* the patient's room number). The same two identifiers do not have to be used throughout the organization. Different identifiers may be used in different settings, as long as their use is consistent with the intent of this requirement and is consistent within each setting, not just whatever the individual practitioner or staff member wishes to use.

For example, one organization's laboratory department added an additional four-digit number to the ID band when taking blood samples. The laboratory will not accept any blood samples if the two patient identifier documentation does not include the unique four-digit number. The unique number can only be found on the patient's ID band, which ensures that the patient's ID has at least been checked.

Requirement 1B: Prior to the start of any invasive procedure, conduct a final verification process^{*} to confirm the correct patient or resident, procedure, site, and availability of appropriate documents.[†] This verification process uses active—not passive—communication techniques. (Applicable to assisted living, disease-specific care, home care, long term care)

Requirement 1B: Immediately prior to the start of any invasive procedure, conduct a final verification process to confirm the correct patient, procedure, site, and availability of appropriate documents. This verification process uses active—not passive—communication techniques. The patient's identity is re-established if the practitioner leaves the patient's location prior to initiating the procedure. Marking the site is required unless the practitioner is in continuous attendance from the time of the decision to do the procedure and patient consent to the initiation of the procedure (for example, bone marrow collection, fine needle aspiration). (Applicable to laboratories)

* Add "such as a time out" for **home care**, **long term care**, and **assisted living**.

† Remove "availability of appropriate documents" for **home care**, **long term care**, and **assisted living**.

Goal 1: Specifically for Your Program...

Home care: In any situation of continuing one-on-one care in which the nurse “knows” the individual (there is an established nurse-to-patient relationship), for Goal 1A, one of the identifiers can be direct facial recognition. In the home, the correct address (an acceptable identifier when used in conjunction with another person-specific identifier) can also be confirmed, as can the patient’s Social Security number or driver’s license number.

Ambulatory care: Make sure the room, bed, cubicle, or bay number is not used as one of the identifiers for Goal 1A.

Behavioral health care: Goal 1A does not apply to self-administered medications or psychosocial interventions. For long-stay programs, such as group homes, direct facial recognition is only appropriate when the staff and client population are both stable.

Long term care: For cognitively impaired residents, the staff might use a photograph in the clinical record to serve as visual identification. Direct facial recognition of residents is acceptable when the staff and resident population are stable.

Laboratory: It is expected that all specimens come to the laboratory with a minimum of two identifiers on them, however, laboratories should not reject specimens that arrive without two identifiers because some samples are irretrievable, expensive to recollect, or will cause a treatment delay if recollected. Laboratories should establish written guidelines for specimen rejection and should include a cautionary statement on the laboratory report indicating the specimen was received in the laboratory without complete identification.

Joint Commission Requirements

To meet this requirement, organizations need to verify (1) the correct patient or resident, (2) the correct procedure, and (3) the correct procedure site. This verification should occur where the procedure is to be performed, immediately before the procedure is to begin. (In some cases, the patient may already be under anesthesia or sedation.) All the staff involved

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Goal 2:

Improve the effectiveness of communication among caregivers.

Requirement 2A: For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result “read back” the complete order or test result. (Applicable to ambulatory care, assisted living, behavioral health care, critical access hospitals, disease-specific care, home care, hospitals, laboratories, long term care, office-based surgery)

Joint Commission Requirements

Policy and practice should discourage the use of verbal orders as much as possible. When verbal orders are unavoidable, an

in the procedure should pause—that is, take a “time-out”—to verify that it is the correct patient or resident, the correct procedure, and the correct site.

Some organizations may not perform operative procedures, but they must still conduct a final verification process for any invasive procedure that exposes a patient or resident to more than minimal risk. Most procedures that involve puncture or incision of the skin or insertion of an instrument or a foreign material into the body are within the scope of this goal (for example, percutaneous aspirations, biopsies, cardiac and vascular catheterizations). Minor procedures such as venipuncture, peripheral intravenous (IV) line placement, insertion of a nasogastric (NG) tube, and Foley catheter insertion are not within the scope of the goal. Organizations should define the procedures that are performed at their organizations that put their patients or residents at more than minimal risk, and surveyors will evaluate the organizations’ performance with respect to their policies.

For **ambulatory care, critical access hospital, office-based surgery, and hospital organizations**, this requirement is addressed under the Universal Protocol. See page 19 for more information on the Universal Protocol.

Compliance Solutions

The verification process must be interdisciplinary. All members of the team must be involved in the final verbal verification process. All activity in the room should cease to allow for this participation. The patient’s name, procedure, and site should be stated aloud, exactly as they appear on the informed consent form, and each member of the team should actively acknowledge agreement. (Any disagreements must be reconciled before starting the procedure.) Remember also to monitor compliance with these procedures. **PS**

organization should first review its verbal orders policy to ensure consistency with practice. The process should stipulate that the qualified person taking the order should write down the order and then read it back verbatim to the practitioner who initiated it. The practitioner should then verbally confirm that the order was received correctly.

The read-back requirement applies to all verbal and telephone orders (not just medication orders) and all critical test results (not just laboratory test results). *See the definitions of critical tests and critical results under Goal 2C on page 7.* For most organizations, this includes all tests and results reported verbally or by telephone. If a subset of test results is not defined by the organization as “critical,” surveyors will consider all verbal or telephone reports of diagnostic tests to be critical.

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Compliance Solutions

In emergency situations or during sterile procedures, verbal orders are a necessary form of communication between nurses and physicians. For some organizations, physician behavior should be addressed to discourage the use of verbal orders unless the circumstances make it impossible to write the order (for example, in an emergency or surgical situation). When verbal orders are unavoidable, organizations can improve order accuracy and help ensure safety by doing the following:

- Medication order recipients should repeat the name of the drug and dosage order to the prescriber and request or provide correct spelling, using aids such as “B as in ball” and “M as in Mary.” All numbers should also be spelled out; for example, “16” should be stated as “one six” to avoid confusion with the number 60.
- Avoid using abbreviations. For example, “1 tab tid” should be stated as “Take/give one tablet three times daily.”
- The person who receives the order should sign, date, and note the time of the order.
- Use an order sheet that is longer than the actual chart so that part of the sheet hangs out above the chart when it is closed. In this way, it is easier for physicians to find and sign their verbal orders. Once the physician signs the order, he or she rips off the perforated end of the sheet so the order sheet becomes a regular-sized piece of paper.
- Do not accept voice mail orders. When an order is not received directly, the nurse or pharmacist must call the prescriber back to get the order directly and read back the information.

Requirement 2B: Standardize a list of abbreviations, acronyms, and symbols that are not to be used throughout the organization. (Applicable to ambulatory care, assisted living, behavioral health care, critical access hospitals, disease-specific care, home care, hospitals, laboratories, long term care, office-based surgery)

Joint Commission Requirements

Organizations are only required to enforce the official “do not use” list of abbreviations, acronyms, and symbols that the Joint Commission introduced in January 1, 2004, and has reaffirmed as a minimum requirement for 2006 (see the list at http://www.jcaho.org/accredited+organizations/patient+safety/06_dnu_list.pdf). However, an organization may add other items to this minimum list to develop, with the involvement of physicians, an organization-specific list of unacceptable abbreviations, acronyms, and symbols not to use. (If an organization-specific list is created and used, surveyors will evaluate whether the staff prohibits the additional abbreviations, acronyms, and symbols on their list.)

Since December 2004, the Joint Commission has made the following modifications to this requirement:

- The scope of the requirement has been reduced to apply only to orders (all orders, not just medication orders) and all medication-related documentation that is handwritten, uses free-text entry, or employs preprinted forms.
- The expected compliance for preprinted forms is 100%.
- The minimum expected level of compliance for handwritten and free-text entry orders and medication-related documentation is 90%.
- Organizations are no longer required to choose and enforce an additional three do-not-use abbreviations.

In addition, the Joint Commission has provided specific guidance to surveyors for scoring compliance, wherein surveyors will count occurrences of do-not-use abbreviations, acronyms, and symbols. The surveyors will follow the three-strike rule, which entails the following:

- One occurrence equals one or more “slips” per clinician, per record. (One or more “slips” by the same clinician in the same record counts as a single occurrence.)
- Clarification of an order prior to implementation is expected but does not eliminate that occurrence from being counted.
- Immediate correction of the order by the clinician (before it is transcribed/transmitted) is not counted as an occurrence. However, correction after the order has been transcribed/transmitted results in that use of a prohibited abbreviation being counted as an occurrence.
- Three occurrences generate a requirement for improvement.
- Surveyors will score *satisfactory compliance* if only two occurrences or fewer are noted.

Compliance Solutions

Because this goal has existed since 2003, most organization leaders have effectively communicated the list of do-not-use abbreviations, acronyms, and symbols to the staff (see tips for educating and communicating to staff members about dangerous abbreviations, acronyms, and symbols at <http://www.jcaho.org/accredited+organizations/patient+safety/05+npsg/tips.htm>). However, it has proven difficult to change these behaviors in the staff. Even though they know which abbreviations, acronyms, and symbols not to use, many staff members are still continuing to “slip.”

At this point, leaders should continue to enforce the do-not-use list by consistently monitoring staff compliance with this goal. Leaders can consider the following tips for enforcing and monitoring do-not-use abbreviations, acronyms, and symbols within their organizations:

- Review open records for evidence of eliminated use of prohibited abbreviations, symbols, and acronyms.
- Review closed records as necessary for validation of findings and track record assessment.
- Copy the page of the order or medical-related document with one or more do-not-use abbreviations and send it to the clinician who is not in compliance with the goal. Direct notification will help change individual compliance faster than tracking overall compliance rates. If the clinician continues to use unapproved abbreviations, acronyms, or symbols, the noncompliance should be documented in his or her credentials file.

Requirement 2C: Measure, assess, and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values. (Applicable to ambulatory care, behavioral health care, critical access hospitals, disease-specific care, home care, hospitals, laboratories, office-based surgery)

Joint Commission Requirements

The Joint Commission requires that critical tests and critical results be reported and received by the appropriate caregivers in a timely manner. Organizations are required to measure, assess, and, if necessary, take action to improve the timely reporting and receipt of critical test results and values.

This goal applies to all tests and results defined as critical by the organization and may include imaging studies, laboratory tests, electrocardiograms, and other diagnostic tests and studies. Critical *tests*, often identified as stat exams, always require rapid communication of results, whether normal or abnormal. Critical *results*, also known as critical values, are test results that fall significantly outside the normal range and may represent life-threatening values. Critical results also require rapid communication, even if they are from routine tests. Both critical tests and critical results must be reported to a responsible licensed caregiver within time frames established by the organization. The timeliness of this reporting must be determined through appropriate measurement activities. Actions to improve the timeliness of reporting are based on an assessment of data collected.

Compliance Solutions

Failure to follow up on critical test results and values in a timely manner represents a significant patient safety concern in health care organizations. It is important for all licensed caregivers to manage test results in a reliable, efficient, and evidence-based manner. An organization should develop a formal reporting system that clearly identifies how clinicians

are made aware of critical tests and results and how the staff documents that necessary communication. The following tips may help organizations design and maintain such reporting systems:

- Create a flowchart process for reporting critical tests and results.
- Establish time frames for reporting by consulting with the diagnostic and clinical staff (see below for details of the relevant time frames to be measured for critical tests and critical results/values).
- Define critical tests and critical results/values for each type of diagnostic testing provided by the organization.
- Document the report of each test result, including patient name, test, result, date, time, reporter, receiver, responsible licensed caregiver notified (if not the receiver), and action taken.
- Report all critical tests or results to the appropriate responsible licensed caregiver or authorized agent of the responsible licensed caregiver. (Authorized agents are acceptable if the organization can demonstrate that there is no significant additional delay in getting the test result to the responsible licensed caregiver so that the patient can be promptly treated.)
- Include a procedure to contact an alternate licensed caregiver who can provide timely follow-up with the patient when the primary licensed caregiver cannot be reached. (An alternate licensed caregiver must be someone who, like the primary responsible licensed caregiver, is qualified and authorized to act on the test results being reported.)

After an organization creates and implements a formal reporting system, it must also effectively assess and measure whether staff members are adhering to the reporting system. The Joint Commission does not recommend specific time frames for reporting, but it does require the organization to establish its own time frames and adhere to them. For critical results, measurement and assessment activities should focus on the interval from the time the result is first known to be critical to the time it is reported to the licensed responsible caregiver (that is, the result known-to-reporting interval). For critical tests, the organization should measure the ordering-to-reporting time frame (that is, the turnaround time of the critical test).

For more tips on reporting critical tests and results, see the April 2005 issue of *Perspectives on Patient Safety*.

Requirement 2D: All values defined as critical by the laboratory are reported to a responsible licensed caregiver within time frames established by the laboratory (defined in cooperation with the nursing and medical staff). When the

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patient's responsible licensed caregiver is not available within the time frames, there is a mechanism to report the critical information to an alternate responsible caregiver.

(Applicable to laboratories)

Joint Commission Requirements

This requirement focuses on the timely reporting of critical laboratory values. Delays in reporting critical laboratory results can produce subsequent delays in patient care, which can negatively affect the patient's outcome. Such delays are preventable when a laboratory has a well-defined reporting system that includes contacting an alternative caregiver when the primary caregiver cannot be reached. The language of this goal has changed for 2006 as the Joint Commission no longer requires that critical values be reported *directly* to the responsible licensed caregiver (see the discussion of "authorized agent" above).

Compliance Solutions

This requirement is intended to provide laboratories with guidance on the appropriate elements of a well-designed critical reporting system, which includes not only defining the critical values but also establishing policies for (1) the expected time frames for reporting, (2) who can receive the critical values, and (3) an alternative reporting mechanism.

NEW Requirement 2E: Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions. (Applicable to ambulatory care, assisted living, behavioral health care, critical access hospitals, disease-specific care, hospitals, laboratories, long term care, office-based surgery, home care)

Joint Commission Requirements

The primary objective of a handoff is to provide accurate, clear, and complete information, using interactive communication about a patient's (1) care, treatment, and services, (2) current condition, and (3) any recent or anticipated changes. To successfully complete a handoff, staff members must allocate specific time to this important task and also allow for the opportunity to ask and respond to questions. Interruptions during a handoff must be limited to minimize the possibility that information could fail to be conveyed or could be forgotten.

Compliance Solutions

Verbal reports that occur at shift changes, when off-duty caregivers are eager to leave, are often hurried. Small pieces

Goal 2: Specifically for Your Program...

Behavioral health care: For Goal 2C, organizations need to define critical tests and results and determine which they receive. In addition, for Goal 2E, organizations that provide around-the-clock care have many handoffs, such as from teacher to child care worker, at change of shift, or from the clinical staff to the program staff.

Ambulatory care: For Goal 2C, organizations should assess contract reference laboratories, using the timeliness expectation criteria outlined in the written contract. Also, they should assess internal reporting against organization policies relating to timely reporting of critical values for those tests being performed in-house.

of relevant information that could signal a change in a patient's condition can be overlooked or miscommunicated. In addition, there are many other patient care/caregiver transitions during which poor communication places the patient at risk, including the following:

- Physician transferring complete responsibility for a patient
- Physician transferring on-call responsibility
- Temporary responsibility for the staff leaving the unit for a short time
- Anesthesiologist report to postanesthesia department to inpatient units
- Transition in level of care (for example, from the emergency department to the intensive care unit)
- Transfer to another facility (to another ambulatory care, assisted living, behavioral health care, home care, hospital, or long term care organization)
- Written or taped reports between shifts that do not allow for questions to be asked

An organization should standardize its approach to the information communicated during handoff communications to make sure information about a patient's status and care plan is not lost or forgotten during the precarious transitions in care. To standardize the approach to hand off communications, organizations can consider using the Situation-Background-Assessment-Recommendation (SBAR) technique and, when appropriate, other repeat-back mechanisms. (See the February 2005 issue of *Patient Safety* for more information on the SBAR technique.) The information that organizations decide to include during handoff communications varies by setting and discipline but can include a summary of the patient's current medical status, recent changes in condition, potential changes to watch for, resuscitation status, recent lab values, allergies, a problem list, and a to-do list for the covering physician or nurse. It is important to get input from the frontline staff to identify what should be included in the report. **PS**

3

Goal 3: Improve the safety of using medications.

Requirement 3B: Standardize and limit the number of drug concentrations available in* the organization. (Applicable to ambulatory care, behavioral health care, critical access hospitals, disease-specific care, home care, hospitals, long term care, office-based surgery)

Joint Commission Requirements

An organization needs to limit the number of drug concentrations available in the organization and standardize those concentrations that are made available. Each organization will choose which drugs and which concentrations to make available based on its clinical need. “Some people have interpreted it as prohibiting more than one concentration of a drug,” says Richard Croteau, M.D., the Joint Commission’s executive director for patient safety initiatives. “This would be problematic in certain clinical situations, including pediatric and especially neonatal care.” With the exception of a few oral products compounded by the pharmacy, all oral medications need to be limited to concentrations provided by the manufacturer. Thus, this goal primarily relates to injectable solutions of drugs administered by infusion.

Compliance Solutions

When multiple concentrations of a drug are clinically necessary (such as on a pediatric unit), the staff should take special precautions to avoid dosing errors. For example, the order should specify actual drug dose, not volume, and the dose calculation—including specific data elements, such as the patient’s weight, dose per unit weight, and rate of administration—should be written as part of the order. This provides sufficient information for the pharmacist who reviews the order and prepares the medication and the nurse who administers the medication to recalculate the dose as a check.

Pediatric and neonatal units should not use the “Rule of Six” to calculate patient-specific drug concentrations. To achieve a given dose of an infused drug while being compliant with Goal 3B, organizations must vary the rate of infusion and keep the concentration constant (standardized). The Rule of Six varies the concentration of the drug while keeping the rate constant, which is not in compliance with Goal 3B.

Although many organization requests for continued use of the Rule of Six have been approved on a temporary basis, organizations must be committed to creating and implementing a plan to change over to standardized drug concentrations.

* Insert “used by” in the place of “available in” for home care.

Because there are always potential risks associated with revising an established process, the Joint Commission conferred with experts in the pediatric and neonatal critical care fields—including the American Academy of Pediatrics (AAP), the National Association of Children’s Hospitals and Related Institutions (NACHRI), and the American Society of Health-System Pharmacists (ASHP)—and has set a three-year transition period for the move to standardized concentrations. All providers are expected to have made the transition by **December 31, 2008.**

For more information on the Joint Commission’s expectations for transitioning from the Rule of Six, see “Moving to Standardized Concentrations” in the June 2005 issue of *Patient Safety*.

Requirement 3C: Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in* the organization, and take action to prevent errors involving the interchange of these drugs. (Applicable to ambulatory care, behavioral health care, critical access hospitals, home care, hospitals, long term care, office-based surgery)

Joint Commission Requirements

The Joint Commission developed a list of look-alike, sound-alike medications that create the greatest risk for medication error (<http://www.jcaho.org/accredited+organizations/patient+safety/05+npsg/lasa.pdf>). Organizations must choose 10 pairs of look-alike, sound-alike medications from this list and take action to prevent errors involving the interchange of these drugs. An organization may choose to include more look-alike, sound-alike medications on its organization-specific list, but those medications must be in addition to the 10 pairs chosen from the Joint Commission’s list.

If an organization has reason to believe that other drug pairs present a higher risk to its patients (based on the services provided), then it must present this for consideration by the Joint Commission. To do so, the organization must submit a Request for Review of an Alternative Approach by filling out the form located at http://www.jcaho.org/accredited+organizations/patient+safety/06_npsg/rfr_06.doc.

Compliance Solutions

To ensure that the correct medication is being administered, be sure that staff members are well informed, especially because so many drug names sound alike. To reduce look-alike/sound-alike drug misunderstandings, the staff should do the following:

- Provide both the brand and generic drug names on the medication label and patient’s chart.

* Replace “in” with “by” for home care.

Continued on Page 10

- Consider the potential for dispensing errors when adding medications to the organization's formulary.
- Group drugs by category rather than by alphabetical order.
- Add alerts to the pharmacy computer system.
- Look into carousel technology for pharmacy inventory and storage. With this technology, when a pharmacist is fulfilling a medication order, the carousel spins to the correct storage area, and a light directs the pharmacist to the exact bin where the medication is stored.
- Use brightly colored labels, TALL-MAN lettering, and physical separation to differentiate drugs during dispensing activities.
- Include in the order the indication for the medication to help the pharmacist identify potential errors. Explain to the patient the purpose of the medication he or she will be taking and, if possible, describe what the pill will look like.

NEW Requirement 3D: Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings. (Applicable to ambulatory care, critical access hospitals, hospitals, and office-based surgery)

Joint Commission Requirements

Errors have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. Medications or other solutions in unlabeled containers cannot be identified. This unsafe practice neglects basic principles of medication management safety yet has been routine with respect to medications transferred to the *sterile field* or used during the administration of anesthesia in many organizations. Therefore, when medications or solutions are transferred from the original packaging to another container, the new container must be labeled. Medications and solutions both on and off the *sterile field* must be labeled even if only one medication or solution is being used.

All original containers from medications or solutions must remain available for reference in the perioperative area until the procedure is completed. After the procedure is complete, the contents held in all labeled containers on the sterile field must be discarded. In addition, medications and solutions both on and off the *sterile field* (and their labels) must be reviewed by personnel who are going on breaks or at shift change.

Compliance Solutions

The following medications and solutions that fall under Goal 3D and should be labeled when removed from their original packaging:

Goal 3: Specifically for Your Program...

Home care: Goal 3B applies to medications stored in the home care organization, not to medications already dispensed by a pharmacy to the patient's residence. In addition, organizations should focus on preparations of insulin, heparin, antibiotics, and antineoplastics.

Ambulatory care: For Goal 3B, organizations should focus on preparations of insulin, heparin, antibiotics, and antineoplastics.

Long term care: Goal 3B applies to all medications stored in the organization, even medications dispensed to the organization by an outside pharmacy. Residents are often at risk for Goal 3C because they are taking so many medications. The staff should separate medications for each resident to also prevent the possibility of a look-alike, sound-alike resident.

- Prescription medications and any other product designated by the Food and Drug Administration (FDA) as a drug
- Over-the-counter drugs, herbal remedies, dietary supplements, and vitamins
- Nutraceuticals
- Vaccines
- Diagnostic and contrast agents used on or administered to persons to diagnose, treat, or prevent disease or other abnormal conditions
- Radioactive medications
- Respiratory therapy treatments
- Parenteral nutrition
- Blood derivatives
- IV solutions (plain or with electrolytes and/or drugs)
- Chemicals and reagents such as formaline, saline, sterile water, Lugol's solution, radiopaque dyes, glutaraldehyde, and chlorhexidine
- Chemotherapeutic medications

In addition, organizations can adhere to the following tips for creating, using, and enforcing the use of labels on medications and solutions:

- Include on the label the name, date, and strength of the medication or solution and the initials of the person preparing the label.
- Develop distinct labels or purchase commercially available sterile labels.
- Have two qualified individuals verify labels both verbally and visually.
- Do not label more than one medication or solution at the same time.
- Discard any medications or solutions that are found without labels.
- Have no distraction during medication preparation.
- Separate over-the-counter drugs from prescription drugs. **PS**

4

Goal 4: Eliminate wrong-site, wrong-patient, and wrong-procedure surgery.

Requirement 4A: Create and use a preoperative verification process, such as a checklist, to confirm that appropriate documents (for example, medical records, imaging studies) are available. (Applicable to disease-specific care)

Requirement 4B: Implement a process to mark the surgical site and involve the patient in the marking process. (Applicable to disease-specific care)

Joint Commission Requirements

This goal and its requirements (as well as Goal 1B) don't apply just to operative procedures; they apply to any invasive procedure that exposes patients to more than minimal risk, including procedures performed in settings other than the OR, such as a special procedures unit, an endoscopy unit, an

interventional radiology suite, and so forth. Certain routine minor procedures such as venipuncture, peripheral IV line placement, insertion of a nasogastric tube, or insertion of a Foley catheter are not within the scope of this goal.

Organizations are required to mark sites involving right/left distinction, multiple structures, or multiple levels. However, organizations *do not need* to mark the site for other types of procedures, including midline sternotomies, cesarean sections, and interventional procedures for which the insertion site is not predetermined, such as cardiac catheterizations. Organizations not marking the site in these cases will not be scored noncompliant for requirement 4B.

For more information about wrong site, wrong patient, and wrong procedure surgery, see the sections on compliance tips and site marking under the Universal Protocol section (page 19). For **ambulatory care, critical access hospitals, office-based surgery, and hospitals**, Goal 4 is addressed under the Universal Protocol. **PS**

6

Goal 6: Improve the effectiveness of clinical alarm systems.

Requirement 6A: Implement regular preventive maintenance and testing of alarm systems. (Applicable to disease-specific care)

Requirement 6B: Assure that alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit. (Applicable to disease-specific care)

Joint Commission Requirements

The Sentinel Event Advisory Group considers this goal and its requirements relevant to the entire array of alarm systems that are triggered by physiologic monitoring of the patient or by variations in measured parameters of medical equipment directly applied to the patient. Essentially, this goal applies to alarm systems that are patient specific and are used for the purpose of alerting the staff to a patient emergency (for example, cardiac monitor alarms, apnea alarms, elopement/abduction alarms, infusion pump alarms). Most commonly, the staff is alerted using an audible alarm, but other signaling methods (for example,

visual, pager) are acceptable, as long as they reliably alert the staff to the patient's need for attention. For alarm systems that meet these criteria, organization policy may specify when the alarm may be disabled. The Joint Commission doesn't specify which alarms should be used or when they can be disabled. However, these judgments should be based on organization policy, not on individual caregiver preference.

The expectation with this goal is that the organization identifies and manages each clinical alarm system within some organized program; the organization decides which alarms should be managed by which programs—whether they are biomedical equipment programs or facilities management programs, for example. Someone must be aware of and examine these systems.

Activating the alarms and involving the clinical staff in the testing process to ensure that each alarm is audible applies to the testing of the alarm system, not to the preventive maintenance of the alarm device. The method and intervals for inspecting, testing, and maintaining clinical alarms should be based on criteria such as manufacturers' recommendations, risk levels, common industry practice, and organization experience.

Note: Please refer to the September 2004 issue of Patient Safety for compliance solutions for this goal. **PS**

7

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

Requirement 7A: Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.*† (Applicable to ambulatory care, assisted living, behavioral

health care, critical access hospitals, disease-specific care, home care, hospitals, laboratories, long term care, office-based surgery)

* Organizations are required to comply with all IA, IB, IC CDC requirements.
† Add "when providing services to a high-risk population or administering physical care" for behavioral health care.

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Joint Commission Requirements

Organizations must comply with all current “Category I” recommendations (including IA, IB, and IC) in the CDC hand hygiene guidelines. (Find the CDC’s full report at .) In general, the CDC hand hygiene guidelines require the staff to decontaminate hands with a hygienic hand rub or by washing with disinfectant soap before and after direct contact with a patient or objects immediately around a patient.

Compliance with the hand hygiene guidelines will be surveyed through interviews with the caregiver staff and direct observation. A minimum of 90% compliance will be expected. The surveyors will follow the three-strike rule, which entails the following:

- One occurrence equals one observation of noncompliance with CDC Category I recommendations.
- Three occurrences equals a requirement for improvement.
- Surveyors will score *satisfactory compliance* if only two occurrences or fewer are noted.

Compliance Solutions

Over the past year, many organizations have initiated innovative programs to meet this goal. For example, Ingham Regional Medical Center, Lansing, Michigan, worked with Dr. Maryanne McGuckin and Steris Corporation to implement the Partners in Your Care™ program, which encourages patients to ask their caregivers if they have washed their hands. (See the April 2005 issue of *Patient Safety* for more information on this program.) In addition, Ingham has installed a speaker outside the doors on each room in the cardiac intensive care unit that replays a recorded reminder—“Please remember to wash your hands before leaving room 334”—whenever a staff member leaves the room. Finally, organizations should measure and monitor compliance with this goal through observing the staff, interviewing the staff and patients, and monitoring the volume of alcohol-based hand rub used per 1,000 patient days.

Many organizations have installed alcohol-based hand rub dispensers to help staff members comply with this goal. Previously, the Centers for Medicare & Medicaid Services (CMS) allowed organizations to install the dispensers only in patient rooms, treatment rooms, suites and other appropriate locations, but on March 25, 2005, CMS began to allow organizations to also install dispensers in egress or exit corridors as well. The Joint Commission also allows for the installation of dispensers in egress or exit corridors but reminds organizations that dispensers should never be installed near a heat or ignition source, an electrical outlet, or a light switch. The Joint Commission and the Association for Professionals in Infection Control and Epidemiology (APIC) also advise organizations to obtain and follow the advice of state and local fire marshals.

Goal 7: Specifically for Your Program...

Long term care: For Goal 7B, this determination is based on the condition of the patient at the time of admission to the organization.

Behavioral health care: For Goal 7A, organizations should teach their clients about hand hygiene as well. In addition, a death or major permanent loss of function associated with a health care–associated infection usually only occurs in inpatient programs such as crisis stabilization, residential, corrections, forensics, and opioid treatment programs. Although sentinel events may be infrequent in outpatient settings, Goal 7B is still applicable.

Requirement 7B: Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care–associated infection. (Applicable to ambulatory care, assisted living, behavioral health care, critical access hospitals, disease-specific care, home care, hospitals, laboratories, long term care, office-based surgery)

Joint Commission Requirements

Even though the requirement for root cause analysis (RCA) in response to an unanticipated death or major permanent loss of function is not new, many cases that meet this definition have not been considered sentinel events—apparently because infection was associated with the outcome. In other words, there has been an assumption that the presence of infection excludes a case from consideration as a sentinel event. This is not, and never has been, an intended exclusion. As a result, there are very few cases of infection–associated sentinel events in the Sentinel Event Database (in relation to other types of sentinel events and to the number of infection–associated cases reported by the CDC and others to be occurring annually). The Joint Commission believes that managing these cases as sentinel events will provide additional information, not so much about the infection itself, but about managing patients who are at risk for infections and who have acquired infections. In this manner, the new goal, while not necessarily a new requirement, will contribute to reducing the risk of patient harm from health care–associated infections (HAIs).

Compliance Solutions

Determining whether a death is related to an HAI can be difficult, but in fact, establishing that relationship is not necessary for determining whether a death is a sentinel event. A death or major permanent loss of function should be considered a sentinel event if the outcome was not the result of the natural course of illness or underlying condition at the time of admission. If at the time of admission, the patient’s condition is such that he or she has a high likelihood of

not surviving the episode of care, then that patient's death would not be considered a sentinel event. The following suggestions and clarifications will help organizations build compliance with this requirement:

- Organizations should review all in-hospital deaths to identify those that were unanticipated. If an HAI was part of the clinical picture, an infection control professional should participate in the RCA.
- Organizations do not have to change their surveillance methods to be compliant with Goal 7B.
- Managing these cases as sentinel events is complementary

to, not a replacement for, the traditional rate-based analysis of HAIs.

- An RCA is only required for HAIs that result in death or major injury.
- When conducting the RCAs for sentinel events associated with HAIs, the organization should remember that the objective is a comprehensive analysis of the care of the patient, not just the infection itself.
- The determination of whether an adverse outcome was "unanticipated" is based on the condition of the patient at the time of entry into the organization. **PS**

8 **Goal 8:** **Accurately and completely reconcile medications across the continuum of care.**

Requirement 8A: Implement a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission* to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.† (Applicable to ambulatory care, assisted living, behavioral health care, critical access hospitals, disease-specific care, home care, hospitals, long term care, office-based surgery)

Requirement 8B: A complete list of the patient's medication is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner, or level of care within or outside the organization. (Applicable to ambulatory care, assisted living, behavioral health care, critical access hospitals, disease-specific care, home care, hospitals, long term care, office-based surgery)

Joint Commission Requirements

Throughout the rest of 2005, surveyors will expect to see development of a standardized process for compiling (using forms, if necessary, and including the information in the patient's record), reviewing, and using the patient's current medication information. When staff members are compiling information about a patient's current medications, they must, to the extent possible, involve the patient in this process. In addition, staff members are expected to communicate the updated medication reconciliation information to the next provider of service. The updated

* Insert "entry" in the place of "admission" for **ambulatory care, behavioral health care, and office-based surgery.**

† For **home care**, replace the previous sentence with "This process includes a comparison of the medications ordered for the patient while under the care of the organization to those on the list."

medication list that will be transferred to the next provider of care should contain only the medications to be continued following discharge or transfer—not the medications that were taken only while in the organization. After January 1, 2006, surveyors will be making sure that this standardized process for compiling, reviewing, and communicating a patient's complete list of medications has been fully implemented.

To completely reconcile medications, staff members must compare what the patient is taking at the time of admission or entry with what the organization is planning to prescribe. Ideally, organizations will not prescribe a medication before attaining the complete list of medications that the patient is currently taking. However, if there is an urgent situation in which the resulting delay would harm the patient, an organization can prescribe without attaining the complete list of current medications. After staff members stabilize the patient, they should take steps to compile a complete list of the patient's medications and compare it to the medications currently being provided. This process will help avoid errors of transcription, omission, duplication of therapy, and drug-drug and drug-disease interactions.

An important aspect of the reconciliation process at the time of discharge or transfer from the organization is comparison of the medications to be continued postdischarge/posttransfer with the list of medications the patient was taking prior to entry into the organization. This will help to avoid duplication and ensure that necessary ongoing therapy is not discontinued.

The only required documentation is the compiled list of medications. However, organizations will likely establish their own documentation requirements to implement and manage the reconciliation process.

Compliance Solutions

Medication reconciliation is important because medications

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have become more numerous and complicated, there are more physicians prescribing different medications to the same patient, and patients are no longer going to a single local pharmacy to fill their prescriptions. In addition, reconciling medications actually reduces the duplication of work because one person gathers the information and passes that information along to other caregivers rather than each caregiver gathering the same information.

Over the past year, many organizations have recognized this need for reconciling medications and have developed helpful solutions to meet this goal and its requirements, including the following:

- Create a medication reconciliation form, to be used as a template for gathering information about current medications. (The South Carolina Hospital Association provides a reconciliation form at http://scha.org/document.asp?document_id=2,3,32,34913494, and the Massachusetts Coalition for the Prevention of Medical Errors provides examples of form as well as instruction for designing a form at <http://www.macoalition.org/Initiatives/RMToolkit.shtml>.) The form should let staff members visually see that the medications have been reconciled.
- Include the reasons for changing medications in the reconciliation information so that the next provider of care understands why the patient was transferred to a new type of medication.
- When conducting a patient interview about medications taken, don't forget over-the-counter drugs, herbals, and dietary supplements. Patients may not view these as "medications," but they are. Other commonly missed medications are eye drops, inhalers, patches, and contraceptives.
- Involve the pharmacist in compiling the patient's medication list when the patient is taking more than a certain number of medications (for example, more than 10 medications).
- Put ordering prescribers in charge of the process—that is, they will not order medications until they receive the patient's current list of medications—but have nurses and pharmacists contribute significantly to the process.
- Include medication reconciliation information in the change-of-shift procedures as well as in the physician's progress notes.
- Improve the interviewing process with patients to find out what medications they are on. Prompt patients with open-ended, specific questions about their health as well

Goal 8: Specifically for Your Program...

Home care: The home health agency should share its assessment information with the dispensing pharmacy, and the pharmacy should share any medication profile it has on record with the home health agency.

Behavioral health care: For organizations that do not prescribe medication, the medication reconciliation list includes medications as known or reported by the client or guardian.

as their medications. For example, go down the list of a patient's conditions, asking what medications he or she takes for each, or prompt the patient for medications prescribed by each of his or her physicians.

- Educate the community (possibly through the primary care physician) so that patients know to bring their medication list as well as their insurance cards when entering a health care organization.
- Establish time frames for reconciling different types of medications so that caregivers are not called early in the morning to reconcile a medication that could have waited until business hours. For example, medications can be classified as needing reconciliation within 4 hours, within 24 hours, or before the next prescribed dose.
- For outpatient services, staff members do not need to document a medication list or reconcile medications when a patient's medications are not relevant to the services provided. However, if medications are prescribed or the risk or results of the procedure might be affected by medications, then the medication list should be obtained from the patient.
- When collecting data on whether or not medications are being reconciled, use open charts (charts of patients that have been on the unit for 24 hours) to prevent errors immediately.
- Before automating a medication reconciliation process, organization leaders must make sure there is a stable paper process. Leaders should also consider a careful design that designates who can enter the information initially and who can update and change information so that new errors are not introduced.
- Keep the staff focused on reconciliation by producing a monthly report that honors staff members who caught potentially dangerous medication problems by reconciling.

In addition, organizations can find helpful resources at the Web sites of the Massachusetts Coalition (<http://www.macoalition.org>) and the Institute for Healthcare Improvement (<http://www.ihl.org>). **PS**

9

Goal 9:

Reduce the risk of patient harm resulting from falls.

Requirement 9B: Implement a fall reduction program and evaluate the effectiveness of the program. (Applicable to assisted living, critical access hospitals, disease-specific care, home care, hospitals, long term care)

Joint Commission Requirements

For appropriate settings of care and patient populations, the fall reduction program will still include the assessment and reassessment of a patient's risk for falls (as required by Goal 9A, to be retired after 2005). However, Goal 9B should give organizations more flexibility to comply with the overall goal of reducing the risk of patient harm resulting from falls. In this way, organizations must implement a fall reduction program and evaluate the effectiveness of the program. As appropriate, this program should include an assessment process, risk reduction strategies, transfer protocols, in-services, involvement of patients/families in education, and evaluation of environment of care issues.

Compliance Solutions

Organizations that have been implementing fall reduction programs have found the following tips helpful:

- Identify some of the drugs/drug classes that are most frequently associated with an increased risk for falling. Some suggested medication classifications are hypnotics, sedatives, analgesics, psychotropics, antihypertensives, laxatives, and diuretics.
- Use a transfer protocol to guide the staff in how a patient or resident can be transferred safely from a wheelchair, chart, stretcher, or bed.
- Evaluate how long it takes for the staff to address patient calls (and shorten that time, if necessary) and ensure that food, liquid, and toileting needs are met.

Goal 9: Specifically for Your Program...

Home care and long term care: It is especially important to identify medications the patient might be taking for which there would be side effects of drowsiness, motor disturbances, and ataxia that would make them prone to falls.

Critical access hospitals and hospitals: Reassess patients in the postoperative setting for their change in risk for falls after surgery (sedation places patients at risk for falls). In addition, hospitals should consider the pediatric population in their fall reduction programs.

Long Term Care: Use bed adaptations and a safe space layout with low beds and mattresses or pads placed on the floor.

- Promote a normal sleep pattern for patients.
- Use a reliable and valid instrument to predict and identify prone-to-fall patients.
- Communicate a patient's fall risk to the patient and family and remind patients to call for assistance before getting out of bed or getting up from a chair (reassure them that this does not bother the staff).
- Understand the patient by knowing that some are prone to falls because of recent changes in levels of independence, slow adaptation to environmental changes, short-term memory changes, poor impulse control, sensory changes (for example, visual, auditory, balance, awareness of elimination needs), fine motor changes, and communication difficulties.
- Make sure there is enough staff coverage during shift changes.
- Consider the environment of care by (1) making sure the patient's needed objects are accessible at all times, (2) improving lighting, (3) controlling noise, and (4) moving higher-risk patients closer to the nurses' station.
- Provide visual cueing (for example, special colored ID bands, identifier on the door or bed) for staff members so that they know which patients are at high risk for falls. **PS**

10

Goal 10:

Reduce the risk of influenza and pneumococcal disease in older adults.

Requirement 10A: Develop and implement a protocol for administration and documentation of the flu vaccine. (Applicable to assisted living, disease-specific care, long term care)

Requirement 10B: Develop and implement a protocol for administration and documentation of the pneumococcal vaccine. (Applicable to assisted living, disease-specific care, long term care)

Requirement 10C: Develop and implement a protocol to

identify new cases of influenza and to manage an outbreak. (Applicable to assisted living, disease-specific care, long term care)

Joint Commission Requirements

Influenza and pneumococcal vaccinations are recommended for persons aged 65 years and older and for persons of any age who have medical conditions that place them at high risk for complications from influenza. Organizations need to develop appropriate protocols for determining whether to vaccinate after a patient is admitted. Although influenza vaccinations are administered annually, the pneumococcal vaccine is generally

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a once-in-a-lifetime vaccination that can be given at any time. Both influenza and pneumococcal vaccinations are covered preventive service benefits under Medicare Part B. Although coverage of immunizations for adults is an optional service under Medicaid, virtually all states cover immunizations for high-risk groups such as residents of nursing facilities.

Compliance Solutions

Although there were frustrations with the influenza vaccine shortage in 2005, the special populations that are featured in this goal usually take a high-priority for receiving vaccinations, making this goal achievable despite vaccine shortages.

When evaluating interventions that may effectively reduce the risk of influenza and pneumococcal disease in older adults, one of the first steps is to consider preventive measures. If a health care organization has ambulatory services such as primary care clinics, it can consider developing performance measures to remind health care providers to offer both flu and pneumococcus vaccines to older adult patients. Have staff members and physicians review the medical record in advance or during the patient's visit to ensure that the patient has been offered the vaccinations. If the patient refuses the vaccinations, document that the benefits of the vaccines were discussed and that the patient refused administration of them. If the patient has received the vaccinations, include that information as part of the admission process. If the patient does not remember if he or she has received a vaccination, the organization should administer the vaccine again (the CDC has found little data to

support any significant increase in complications for patients who have been reimmunized).

Organizations can review the number of cases of older adults who contracted influenza and pneumococcal disease during their stay to identify opportunities in which they might have been vaccinated but were not. Results can be trended for significant patterns, such as missed vaccinations from the clinic, the providers, and so forth. Feedback can then be provided to the ambulatory sites. For organizations that do not own their clinics, it is just as important for patients to be assessed for these immunizations on admission. These data can be shared with providers at the appropriate medical staff meetings. In addition, organizations need to define the age range of "older adult" to ensure consistency of data collection and data analysis.

Organizations should consider offering vaccinations for older adults who come through urgent care facilities and emergency departments because of other health care issues. With the number of uninsured patients increasing, and as more older adults use urgent care and emergency departments as a source of primary care, these avenues may be the only way for some adults to receive the immunizations.

Organizations should continuously monitor the success of their efforts to prevent these diseases by capturing and analyzing data. The performance measures should be reported to those who oversee infection control on a regular basis and to the organizations' performance improvement infrastructures. The data should also be shared with staff members, as appropriate, so they can see the success rate of reducing the risk of influenza and pneumococcal disease in older patients. **PS**

11

Goal 11: Reduce the risk of surgical fires.

Requirement 11A: Educate staff, including operating licensed independent practitioners and anesthesia providers, on how to control heat sources and manage fuels, and establish guidelines to minimize oxygen concentration under drapes. (Applicable to ambulatory care, office-based surgery)

Joint Commission Requirements

Three elements are required for a fire to ignite—fuel, oxygen, and an ignition source. Staff education is key to proper management of these elements, and proper education can help to significantly reduce the risk of surgical fires. It is important to educate the staff, including operating licensed independent practitioners and anesthesia providers, on how to control ignition sources and manage fuels. A wide range of combustibles and flammables are found in the surgical suite, and education

on the use of alcohol or alcohol-based products can help reduce risk. Proper management of oxygen and surgical devices is also necessary to prevent fires. Organizations must establish guidelines to minimize oxygen concentration under drapes and to ensure that preparation solutions, which may be alcohol based, are dry before the patient is draped.

Surveyors will determine compliance with this requirement by completing the following:

- Interviewing perioperative staff members, surgeons, and anesthesia providers
- Observing the surgical environment
- Reviewing selected personnel and staff training files

Compliance Solutions

Creating a fire plan and educating the staff is one step organizations can take to reduce the risk of surgical fires. The facility manager, risk manager, safety director, and operating room manager can work together to make sure the staff is educated on the special fire risks involved in the surgical suite and how to deal

with them. For example, leaders can conduct mock scenarios to condition staff members for appropriate and quick reactions.

In addition, organizations can implement the following tips to reduce the risk of surgical fires:

- Question the need for 100% oxygen during surgery (especially during facial surgery).
- Do not drape patients until all flammable preparations have fully dried.
- Soak gauze/sponges used with tracheal tubes to resist ignition.
- Control heat sources by holstering surgical equipment or placing it in standby modes. (For example, the surgeon might place the electrosurgical electrodes in a holster.)
- Take special precaution to prevent fires during anesthesia

induction. (For more information, see the February 2005 issue of *Patient Safety*.)

- Include fire emergency procedures in the presurgery checklist.
- Empower the surgical staff to have the confidence to warn the surgeon that there might be the possibility for a fire during the surgery.
- Reorganize the floor plan of the operating room, considering the location of fire extinguishers, alarm pull boxes, fire doors, oxygen shutoffs, and potential evacuation routes.

Organizations can also find helpful recommendations for preventing surgical fires at the ECRI Web site (<http://www.ecri.org>). **PS**

12

Goal 12:
Implementation of applicable National Patient Safety Goals and associated requirements by components and practitioner sites.

Requirement 12A: Inform and encourage components and practitioner sites to implement the applicable National Patient Safety Goals and associated requirements. (Applicable to integrated delivery systems, managed care organizations, preferred provider organizations)

Joint Commission Requirements

Integrated delivery systems, managed care organizations, and preferred provider organizations should assess all the National Patient Safety Goals and requirements to see which are applicable to the components and practitioner sites that comprise their networks. Integrated delivery systems, managed care organizations, and preferred provider organizations should communicate

information about the National Patient Safety Goals and requirements to their applicable components (ambulatory care, office-based surgery, assisted living, behavioral health care, critical access hospitals, disease-specific care, home care, hospitals, laboratories, long term care, practitioner sites)

Compliance Solutions

Organizations should be familiar with the National Patient Safety Goals and know which goals are applicable to their components or practitioner sites. In addition, organizations should inform their components and practitioner sites about the goals by doing any of the following:

- Incorporating the topic into provider handbooks or newsletters
- Administering contractual performance evaluations
- Conducting audits of components and practitioner sites

Finally, organizations should encourage component and practitioner sites to implement the goals. **PS**

13

NEW! Goal 13:
Encourage the active involvement of patients and their families in the patient's own care as a patient safety strategy.

NEW Requirement 13A: Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so. (Applicable to assisted living, disease-specific care, laboratories, home care)

Joint Commission Requirements

Interactive communication with patients and families about all aspects of their care, treatment, or services is an important characteristic of a culture of safety. When patients are engaged as

active participants in their own care, they are more aware of possible complications and treatment choices. Patients and their families can be an important source of feedback about actual or potential adverse events because, with their unique perspective, they often observe things that busy health care providers may not. By encouraging communication about errors or near misses, patients and their families can be effectively integrated into an organization's patient safety work processes.

Compliance Solutions

Just as organizational cultures are changing to promote a safer environment, patients are also changing to become more active in their own care. When educated properly, many

Continued on Page 18

patients and families welcome the opportunity to contribute to efforts to prevent or recover from systems failure. For example, patients and families can play important roles in helping their health care providers (1) reach an accurate diagnosis, (2) ensure that treatment plans are appropriate and effective, and (3) identify side effects or adverse events quickly and take appropriate action. Organization reporting systems that do not provide pathways for patient reporting miss the opportunity to capture information that can contribute to error prevention and quality improvement work.

The following tips can help improve patient communication and education:

- Explain to patients and their families that the single most important way they can help health care providers to prevent errors is to be active members of the health care team.
- Provide explicit information to patients and their families about the risks associated with their particular procedures or courses of care and what to watch out for during or after particular procedures or courses of care.

- Provide written information about the side effects that a medicine could cause so that patients will be better prepared if known side effects do occur or if something unexpected happens instead. Encourage patients to report a problem right away so that they can get help before it gets worse.
- Explain to patients that they should not assume that no news is good news after they have a test. Patients can help by asking about the results and reporting to providers when they don't receive any results.
- Through interactive communication, encourage the patient and family to feel comfortable enough to speak up about any concerns they have about errors or their quality of care.
- Encourage patients and their families to learn about their conditions and treatments by asking their physicians and nurses and by using other reliable sources.

*For more information on involving patients in their care, view the Joint Commission's Speak Up initiatives at <http://www.jcaho.org/accredited+organizations/speak+up/speak+up+initiatives.htm>. **PS***

14

NEW! Goal 14:

Prevent health care–associated pressure ulcers (decubitus ulcers).

NEW Requirement 14A: Assess and periodically reassess each patient's risk for developing a pressure ulcer (decubitus ulcer) and take action to address any identified risks. (Applicable to long term care)

Joint Commission Requirements

Pressure ulcers continue to be problematic in health care, and the incidence of pressure ulcer rates for long term care is 2.2% to 23.9%. Many pressure ulcers can be prevented, and deterioration at Stage I can be halted. "Some pressure ulcers are unavoidable. The idea that the development of all pressure ulcers represents suboptimal care is mistaken," says David O. Staats, M.D., associate professor, Department of Geriatrics, University of Oklahoma Health Sciences Center. "In a fair number of patients, skin breakdown reflects the advanced state of debilitation—malnourishment, chronic infections, or a progressive underlying disease. When flexion contractures and weakness are present, it is difficult to position a patient to lie without pressure on some prominence." The use of clinical practice guidelines can effectively identify patients at risk for pressure ulcers and define early intervention for prevention of ulcers.

Compliance Solutions

A systematic risk assessment tool, such as the Braden Scale or

Norton Scale, can help improve assessment and identification of at-risk patients. An effective plan for preventing pressure ulcer includes the following:

- Recognizing at-risk individuals and the specific factors that place them at risk
- Identifying a prevention program that is specific to each at-risk individual
- Maintaining and improving tissue tolerance to pressure in order to prevent injury
- Protecting against the adverse effects of external mechanical forces
- Meeting the patient's nutritional support needs
- Reducing the incidence of pressure ulcers through education programs

Some organizations create pressure ulcer (or wound care) programs to place emphasis on the importance of preventing pressure ulcers and to improve the consistency of care for patients with pressure ulcers.

Preventing pressure ulcers requires a complex interaction of the following interventions:

- Skin inspection, skin cleansing, care for dry skin, use of moisture barriers, and massage
- Improvement in positioning, transferring, and turning techniques to reduce skin injury caused by friction and shear forces
- Continued focus on increasing or maintaining patient activity or mobility
- Staff education programs **PS**



Universal Protocol

UP 1 The organization fulfills the expectations set forth in the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™ and associated implementation guidelines.

Requirement 1A: Conduct a preoperative verification process, as described in the Universal Protocol.

Requirement 1B: Mark the operative site as described in the Universal Protocol.

Requirement 1C: Conduct a “time-out” immediately before starting the procedure as described in the Universal Protocol.

The Universal Protocol and its requirements are applicable to **ambulatory care, critical access hospitals, hospitals, and office-based surgery.**

Many organizations have put forth great effort to initiate, build awareness about, and implement the Universal Protocol. For instance, North Colorado Medical Center kicked off its implementation of the protocol with a sports theme where perioperative nurses wore referee outfits with whistles and passed out information on the protocol. The slogan for the festivities was “TIME OUT in the dugout, it’s a whole new ballgame!” In addition, Ohio Hospital Association took the lead on its state’s implementation of the protocol by developing a systematic statewide procedure. Having a statewide procedure avoids the problem of physicians having to learn multiple versions of implementation of the protocol, which helps prevent errors.

For More Information

Your organization might continue to have questions about how to meet specific National Patient Safety Goals and their requirements. Many of the questions will be answered in upcoming issues of *Patient Safety*. In addition, FAQs about these goals and their requirements are updated regularly on the Joint Commission’s Web site, at <http://www.jcaho.org>. For more specific questions that might not be addressed by the FAQs, you can also contact the Standards Interpretation Group at 630/792-5000 or via the online question form.

See also [pages 21 and 22](#) for Joint Commission Resources products and publications that can make your compliance with the 2006 National Patient Safety Goals an easier transition.

Still, some organizations continue to struggle with the following areas of the Universal Protocol:

- The mark must be made using a marker that is sufficiently permanent to remain visible **after** completion of the skin preparation. Adhesive site markers should not be used as the sole means of marking the site.
- The goal is to have the person performing the procedure do the site marking (while involving the patient).
- The verification process should take place at many points preoperatively, including (1) at the time the surgery/procedure is scheduled, (2) at the time of admission or entry into the facility, (3) anytime the patient is transferred to another caregiver, and (4) before the patient leaves the preoperative area or enters the operating room. The verification process should also involve the patient. A time-out is taken immediately before starting the procedure to assure the team that they have the correct person, procedure, and site. A time out cannot take place in the preoperative holding area or hallway. Some organizations place a reminder sticker on each disposable procedure pack to remind the staff to initiate the protocol before the procedure.
- Misinformation or errors in paperwork can potentially lead to a wrong-site procedure. To improve the information gathering part of the protocol, staff members should review and cross-check patient paperwork to clarify incorrect or missing information.

Organizations can find more information about the Universal Protocol at the Joint Commission Web site (http://www.jcaho.org/accredited+organizations/patient+safety/universal+protocol/wss_universal+protocol.htm). **PS**

Table 1. Program-Specific Retired and New National Patient Safety Goals for 2006

	AMB	ALF	BHC	CAH/HAP	DSC	LAB	LTC	OBS	OME	MCO/ IDS/PPO
Goal 1A: Patient IDs	X	X	X	X	X	X	X	X	X	N/A
Goal 1B: time out	N/A	X	N/A	N/A	X	X	X	N/A	X	N/A
Goal 2A: read back	X	X	X	X	X	X	X	X	X	N/A
Goal 2B: abbrev	X	X	X	X	X	X	X	X	X	N/A
Goal 2C: timely test report	X	N/A	X	X	X	X	N/A	X	X	N/A
Goal 2D: Lab timely report	N/A	N/A	N/A	N/A	N/A	X	N/A	N/A	N/A	N/A
Goal 2E: handoff	N	N	N	N	N	N	N	N	N	N/A
Goal 3A: electro	R	N/A	N/A	R	R	N/A	R	R	R	N/A
Goal 3B: standard/limit con	X	N/A	X	X	X	N/A	X	X	X	N/A
Goal 3C: Look/sound meds	X	N/A	X	X	N/A	N/A	X	X	X	N/A
Goal 3D: labels	N	N/A	N/A	N	N/A	N/A	N/A	N	N/A	N/A
Goal 4A: wrong patient surgery	N/A	N/A	N/A	N/A	X	N/A	N/A	N/A	N/A	N/A
Goal 5A: infusion	R	R	R	R	R	N/A	R	R	R	N/A
Goal 6A/B: alarms	N/A	N/A	N/A	N/A	X	N/A	N/A	N/A	N/A	N/A
Goal 7A/B: hand hygiene	X	X	X	X	X	X	X	X	X	N/A
Goal 8A/B: reconcile meds	X	X	X	X	X	N/A	X	X	X	N/A
Goal 9A: assess for falls	N/A	R	N/A	R	N/A	N/A	R	N/A	R	N/A
Goal 9B: fall reduction program	N/A	N*	N/A	N*	N	N/A	X	N/A	N*	N/A
Goal 10A/B/C: influenza	N/A	X	N/A	N/A	X	N/A	X	N/A	N/A	N/A
Goal 11A: surgical fires	X	N/A	N/A	N/A	N/A	N/A	N/A	X	N/A	N/A
Goal 12A: MCO/IDS/PPO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	X
Goal 13A: patient involvement	N/A	N	N/A	N/A	N	N	N/A	N/A	N	N/A
Goal 14A: pressure ulcer	N/A	N/A	N/A	N/A	N/A	N/A	N	N/A	N/A	N/A
Universal Protocol	X	N/A	N/A	X	N/A	N/A	N/A	X	N/A	N/A

*AMB, ambulatory care; ALF, assisted living facility; BHC, behavioral health care; CAH, critical access hospital; HAP, hospital; DSC, disease-specific care; LAB, laboratory; LTC, long term care; OBS, office-based surgery; OME, home care; MCO, managed care organization; IDS, integrated delivery system; PPO, preferred provider organization.

X = Applicable in 2005 and 2006

R = Retired for 2006

N = New for 2006

N* = Goal 9B actually replaces Goal 9A

N/A = Does not apply in 2005 or in 2006

Helpful Solution-Oriented Products to Meet the 2006 National Patient Safety Goals

Joint Commission Resources is ready to supply your organization with helpful, solutions-oriented products that will improve your compliance with the 2006 National Patient Safety Goals. See the following products and publications that can make your transitions to compliance easier:



2006 National Patient Safety Goals Posters

This blazing, four-color poster is just what you need to remind your staff of the 2006 National Patient Safety Goals. Thick, dry manuals, though containing essential information like the National Patient Safety Goals, are easily forgettable by busy, frontline staff. Why not spice up this vital information with an eye-catching wall poster containing *all* the 2006 National Patient Safety Goals for your program?

This poster is an ideal way to communicate goals to staff and a nice, graphical reminder that incorporating safety into everyday activities is essential to providing excellent patient care and services. Make a statement about the importance of patient safety to your staff and order your posters today!

For **hospitals**, these 18" x 24" posters are sold in sets of 10 and are shipped in a protective canister to guarantee safety. Also conveniently available in a smaller 8 1/2" x 11" size, all the same great information in half the wall space.

18" x 24" Price: \$95 for a 10-pack
Order Code: **NPSGH-06BHF**

8 1/2" x 11" Price: \$35 for a 10-pack
Order Code: **NPSGHL-06BHF**

For **ambulatory care, behavioral health care, home care, laboratories, and long term care organizations**, the 8 1/2" x 11" size is available.

Ambulatory Care 8 1/2" x 11" laminated cards
Price: \$35 for a set of 10
Order Code: **NPSGALP-06BHF**

Home Care 8 1/2" x 11" laminated cards
Price: \$35 for a set of 10
Order Code: **NPSGHCLP-06BHF**

Long Term Care 8 1/2" x 11" laminated cards
Price: \$35 for a set of 10
Order Code: **NPSGLTLP-06BHF**

Behavioral Health Care 8 1/2" x 11" laminated cards
Price: \$35 for a set of 10
Order Code: **NPSGBCLP-06BHF**

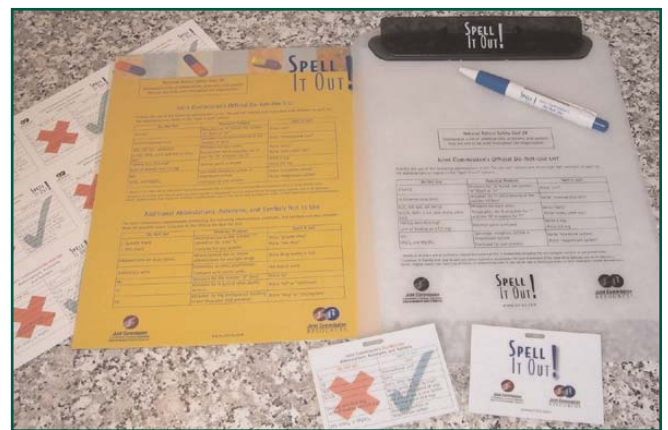
Laboratory 8 1/2" x 11" laminated cards
Price: \$35 for a set of 10
Order Code: **NPSGLLP-06BHF**

Spell it Out! Do-Not-Use Abbreviations Kit

The Spell it out! Do-Not-Use Abbreviation Kit will help you build awareness about and compliance with the Joint Commission's list of Do-Not-Use Abbreviations, Acronyms, and Symbols, which is required through National Patient Safety Goal 2B. Communication between healthcare providers must be clear and precise to avoid life-threatening medical errors. A pharmacist could misread a prescription or a nurse could administer the wrong dose to a patient if they misinterpret the physician's handwritten abbreviations. By using this kit with repetitive messages to prohibit the use of Joint Commission-required abbreviations, organizations will reduce the risk of medication errors and improve communication and patient safety.

The Kit provides you and your staff with information about the abbreviations, acronyms, and symbols that staff members should spell out rather than abbreviate, as well as a rationale for spelling out the term. This do-not-use abbreviation information is placed on common workplace items, including the following:

- Two clipboards
- 10 laminated posters (8.5" X 11")
- 10 quick reference, pocket-sized laminated cards
- 10 sticker sheets (90 stickers)
- 5 multi-click pens with a window that displays all the do-not-use abbreviations and reminds staff to *Spell it out!*



Add to your kit by purchasing the following items separately:

- One clipboard for \$5.95 (order code: **ACLP-05BHF**)
- 10 laminated posters for \$15 (order code: **APST-05BHF**)
- 10 quick reference, pocket-sized cards for \$10 (order code: **ALC-05BHF**)
- 10 sticker sheets (90 stickers) for \$10 (order code: **AST-05BHF**)
- 5 multi-click pens for \$14.95 (order code: **AP-05BHF**)

Order Code: **KAB-05BHF**

Price: \$49.00 Save 20% on all items when purchasing the complete kit!

Hand Hygiene Buttons

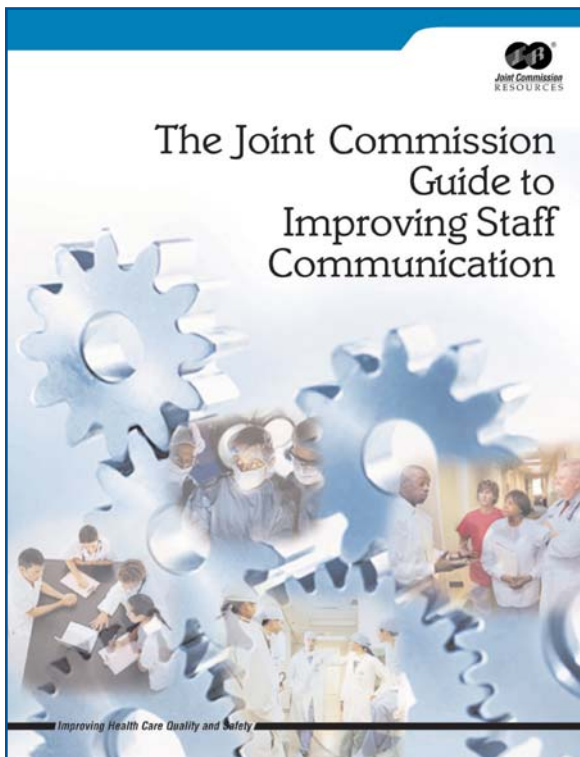
The CDC estimates that the annual costs of hospital-acquired infections are \$6.7 billion. Use these hand hygiene buttons to prevent the spread of infections in your health care organization. You will save money and, most importantly, you will save patients' lives.

Encourage your patients to be involved in their own safety by asking and, if necessary, reminding staff to wash their hands before and after patient encounters.

These colorful buttons are perfect for staff to wear on a lab coat or smock. They come in packs of 10 for only \$5. Buy enough for all your staff, and re-commit your organization to infection control and reduction through proper hand hygiene.

Price: \$5 for pack of 10

Order code: **HHB-05BHF**



The Joint Commission Guide to Improving Staff Communication

Creating a workplace where the staff is working toward the same goals, rules, and strategies is the key to bringing about effective communication. *The Joint Commission Guide to Improving Staff Communication* will guide your organizational improvement efforts in the care, treatment, and services provided to patients and among your staff. Health care organizations should proactively coordinate these efforts so that methods of communicating are conveyed in a uniform and consistent manner within the organizational structure. By improving the effectiveness of communication among caregivers, organizations will also be complying with the Joint Commission's National Patient Safety Goal 2.

The Joint Commission Guide to Improving Staff Communication provides supportive tips and techniques for improving staff communication, and includes the following special features:

- Discussions of the importance of quality communication and its impact on safe care
- "What would you do?" sidebars and case scenarios that challenge readers to resolve communication breakdown
- Practical tips and strategies for improving communication for all levels of staff
- Discussion of the importance of training health care professionals in accepted communication standards

Price: \$75.00

Order code: **JCGSC-05BHF**

COMING SOON!

Joint Commission Resources will soon be offering the following products to help boost compliance with the 2006 National Patient Safety Goals:

- Medication Reconciliation Handbook
- Meeting the Joint Commission's 2006 National Patient Safety Goals (CD-ROM)
- Reducing the Risk of Falls in Your Health Care Organization