National Patient Safety Goals

New NPSG updates medication safety requirements

The Joint Commission has released the long awaited national patient safety goal on reconciling medication information. The new NPSG.03.06.01 replaces NPSG Goal 8 and is effective July 1, 2011. Hospitals were not required to adhere to Goal 8 since 2009 as it was determined that the goal, as it stood, “was too prescriptive and detailed,” according to TJC. Since that time, Joint Commission has been working on streamlining the goal while still maintaining its patient safety focus.

Because The Joint Commission, and many others in the field, felt that medication reconciliation was a crucial patient safety issue, TJC revised the NPSG, subjecting it to a field review in the second quarter of 2010. However, the implementation of the NPSG was delayed because many of those reviewing the goal felt compliance was not achievable. According to comments from the field, (see NPSG on pg. 6)

Survey readiness

Ring in the New Year: trends, standards and initiatives for 2011

With the holidays, and 2010 behind us, now is the time to focus on the challenges that lie ahead in 2011. Inside the Joint Commission has compiled a list of standards, goals and trends that you’ll want to make sure are on your to-do list in 2011.

Notable new standards

New EPs for LD.04.01.01. Legislation that went into effect in 2010 means that you are now required to have a utilization review plan as of January 2011. The Joint Commission added two new elements of performance (EPs 17 and 18) to its leadership standard to comply with the Medicare Improvements for Patients and Providers Act (MIPPA). This means that you have to establish a committee consisting of at least two members of your hospital (and at least two members who are doctors of medicine or osteopathy).
The committee is responsible for reviewing the medical necessity of admissions, length of stay and services performed for Medicare and Medicaid patients. The patient surveys can be performed on a sample basis based on cases that stand out from the majority of cases for extraordinary cost or length of stay.

**Note:** If your hospital is so small as to make it impractical to establish your own committee, it is permissible to establish a committee in collaboration with hospitals and the medical community in your area.

**Updates to your medical staff bylaws.** Standard MS.01.01.01 got an extreme makeover and the changes go into effect on March 31, 2011. This means you’ll need to review the goals, accountabilities and responsibilities of your medical staff and how they relate to the governing body of the hospital.

While you have until March to make sure your bylaws are ship shape, the new standard contains 15 new elements of performance and revises 9 more. The elements of performance provide specific guidelines as to what TJC expects to see in your MS bylaws including the process for privileging independent practitioners, rules for adopting new standards and guidelines, and suggestions for conflict resolution between the medical staff and the governing body of the hospital.

The new standard, along with its EPs, is included in the 2011 CAMH and The Joint Commission has published a list of frequently asked questions to help assist you in reviewing your own bylaws. Find it at [www.jointcommission.org/assets/1/18/FAQs_MS_01_01_01.pdf](http://www.jointcommission.org/assets/1/18/FAQs_MS_01_01_01.pdf).

**Revisions to NPSGs.** While the big news for 2011 is the introduction of NPSG.03.06.01, which becomes effective July 1 (see related article on pg. 1) there are several smaller changes you’ll want to take note of.

Changes to NPSG.01.03.01 allow you to use automated identification technology as an alternative to a second clinician when verifying patient and blood sample before transfusions (see the 11/22/2010 issue of JC).

Minor revisions to NPSG.03.05.01, EP 6 change the lab tests required for heparin therapies to include all anticoagulants. NPSG.07.04.01, EP 11 changes the requirements for preparation of a central venous catheter insertion from using a chlorhexidine-based antiseptic to using any antiseptic endorsed by professional organizations or cited in professional literature. NPSG.07.05.01, EPs 7&8 increase your options for preventing surgical site infections to include the use of any preventative agents cited in professional literature or endorsed by a professional organization.

**2011 Survey Prep**

If you’ve got a survey coming up in 2011, take note: The Joint Commission revised the way it scores your hospital to reduce some confusion and changes the way it conducts follow-up surveys when problems are cited.

**Revised Accreditation Decision Categories.** The big change in these categories is the elimination of the "provisional" and "conditional" accreditation. Those two categories are replaced with "accredited with follow-up survey" and "contingent" accreditation status. While the
two categories closely mirror their retired counterparts, there is some new language explaining what each new category means.

The list of accreditation categories you can receive in 2011 are as follows:

- **Preliminary.** Applicable under the early survey policy.
- **Accredited.**
- **Accredited with follow-up.** Deemed if you have one or more condition level deficiencies. You’ll be paid a second visit by surveyors to determine if you’ve corrected the problem. The first visit will most likely occur within 45 days, according to TJC Director of Standards Interpretation Group, Pat Adamski. In some cases, The Joint Commission could do a follow-up survey within 30 days to up to six months after the original survey.
- **Contingent.** Deemed if you fail to address the issues found in your accredited with follow-up survey. Expect a secondary follow-up survey within 30 days.
- **Preliminary denial** is deemed if, among other reasons, you fail to resolve problems found in your accredited with follow-up survey after two more tries, or you fail to resolve the requirements of your contingent accreditation status.
- **Denial of Accreditation.**

**Accreditation and Certification Decision Rules.**

Changes to the certification decision rules are largely a result of the restructuring of the decision categories but The Joint Commission has reworded some of its rules for denial of accreditation and made some significant changes to the newly-named accreditation with follow-up survey category.

**What to expect from a survey in 2011.** The Joint Commission has taken some heat from CMS. “They review us [The Joint Commission] the same way we review you,” says Adamski. As a result, TJC will be cracking down in a few areas in 2011.

- **More patient tracers.** Joint Commission must review at least 30 patient records or 10 percent of your average daily census, whichever is greater. Smaller hospitals (those of you with an average daily census of less than 20 patients) will have at least 20 patients reviewed.
- **More Life Safety scrutiny.** Responding to questions of increased surveyor time on life safety issues, TJC acknowledged that the life safety survey process would increase by one to three days, depending on the size of your organization. The reason: Joint Commission is not uncovering the same amount of violations as CMS and they want to narrow the validation disparity rate.
- **Increased leadership scrutiny.** The Joint Commission is now required by CMS to cite your hospital under **LD.04.01.05** if you get a condition level deficiency during your survey. According to TJC, “this change is being made to align Joint Commission scoring practices with the CMS philosophy that the governing body is ultimately accountable for ensuring compliance with the [CMS regulated] Conditions of Participation throughout the organization.”
- **Follow-up surveys** will be conducted for any condition level deficiency within 45 days of the end of your survey.

**Campaigns and Targeted Solutions**

**Joint Commission’s TST campaigns.** In 2010 The Joint Commission’s Center for Transforming Healthcare released two free tools for hospitals to use to improve their infection control, and their hand off communication between caregivers. These Targeted Solutions Tools (TSTs) – available through accredited hospitals’ extranet site – are the result of evidence-based study between TJC’s Center for Transforming Healthcare and several hospitals across the country.

Expect more in 2011 and expect surveyors to be paying attention. The Center plans to roll out tools on surgical site infections and preventing wrong-site surgery. While you are not required to use the tools, experts believe that if you know you have problems in these targeted areas and are not using tools made readily available to you that could garner a poor scoring under the leadership standards.

**Communications Roadmap.** This will be a big deal in 2011 with surveyors taking note of new standards that run the gamut from Provision of Care to Human Resources. Even though surveyors will be scoring on these standards, they won’t affect your accreditation until 2012. Still, The Joint Commission is recommending that you begin to establish teams within your hospital to start picking apart the recommendations and determine the best way to implement them in your organization. *(See related story on page 5).*
One and only campaign focuses on infection prevention by ensuring that clinicians do not re-use syringes or needles. Their goal is “one needle, one syringe, only one time for each and every injection.” Currently running pilot campaigns in New York and Nevada, the organization plans to introduce campaigns nationwide in the future and provides both patients and health care workers tips and information on preventing infection by safeguarding a sterile environment. Information can be found at www.oneandonlycampaign.org.

Sentinel Events

Sentinel Event alert #46: Suicide prevention outside behavioral care

There are no quick fixes to suicide prevention techniques that can be applied to a specific hospital area. Risk factors reach across Environment of Care, Medication Management, Medical Staff and Leadership. The Joint Commission Sentinel Event alert (#46) (www.jointcommission.org/assets/1/18/SEA_46.pdf) focuses attention on suicide risks outside behavioral care units, such as in medical/surgical units and the emergency department. Expect surveyors to increase their attention here. Surveyors do not automatically change their behavior to correspond to new Sentinel Event alerts, but they do keep Joint Commission priorities in mind.

“While psychiatric settings are designed to be safe for suicidal individuals and have staff with specialized training, typically, medical/surgical units and emergency departments are not designed or assessed for suicide risk and do not have staff with specialized training to deal with suicidal individuals,” says the alert. Specifically, it notes that, of 827 inpatient suicides reported since 1995:

- 14.25% occurred in non-behavioral health units.
- 8% occurred in emergency departments.
- 2.45% occurred in other non-psychiatric settings, such as critical access hospitals, long term care hospitals and physical rehabilitation hospitals.

Many of the environmental factors that contribute to suicide risk in behavioral care units do the same elsewhere in the hospital. These include potential anchor points for hanging (like ceiling pipes and door-closer arms), and material that can be used for self-injury. However, removing all these risks throughout a hospital, particularly in areas without large concentrations of psych patients, may not be practical, says Glenn Krasker, former Joint Commission director for hospital accreditation.

“The Joint Commission recognizes that general hospitals do not have the resources to implement many of these strategies since most patients are admitted for short-term stays or to the emergency department.”

Your primary responsibility in response to this Sentinel Event alert is to:

1. Assess what is right for your hospital. This may include reviewing previous events in your hospital and examining the risk factors still present in your facility. Or, research suicide events in other hospitals and determine if your facility has the same potential risks throughout various wards.

2. Educate staff as to the risks and warning signs. You may want to take a page from your behavioral health ward (or the ward of another hospital) and apply it to the rest of your facility. “General hospitals may want to consider training programs as a strategy to help better prepare their staff who care for or oversee (e.g., security guards) individuals at risk for suicide,” the alert advises. Your hospital can move to reduce suicide risk by, among other ways, “monitoring and screening patients whose behavior, mental status and conditions show signs of acute depression, anxiety, agitation, delirium or dementia; medical or psychological problems that impact judgment, including alcohol/drug intoxication; and chronic pain or other debilitating problems.”

Physical environment of care and its contribution to suicide risk

Back in 1998, The Joint Commission published its first Sentinel Event alert aimed at reducing suicide risk. One of the biggest issues was ensuring that the physical environment in your hospital does not allow for increased opportunity for a suicidal patient to take his or her own life.

Some tips from the original alert that can be applied to areas outside of the behavioral health ward:

- Remove or replace any bars, rods or safety rails that are not designed to break away from their foundation if too much weight is applied (hanging risk).
- Regular testing of the breakaway hardware should be performed. This adheres to Joint Commission standard EC.02.01.01 (The hospital manages safety and
security risks), specifically EP 1 (the hospital identifies safety and security risks associated with the environment of care); and EP 3 (the hospital takes action to minimize or eliminate identified safety and security risks in the physical environment). Note that EP 3 requires a measurement of success.

- Examine items such as shower heads, shower bars and closet bars to ensure they do not "easily suggest" the means to act as hanging bars.
- Do not leave objects in the room that could pose harm (needles, glass, mirrors).
- Do not leave harmful solutions such as cleaning materials or other harsh chemicals.

Leadership

Navigating the new communications Roadmap

Surveyors will start to take notice as to how you are providing communication and support services to your patients in 2011 and will be surveying based on some new standards included in the 2011 Comprehensive Accreditation Manual for Hospitals (CAMH). The standards are designed to help hospitals overcome patient-oriented communication hurdles such as language or cultural differences, hearing or visual impairment, knowledge of health terminology, mental impairments, disease and disability.

The new standards won't actually affect your accreditation status until 2012, but don't wait until the end of the year before you start to implement them in your hospital. You may need to make major revisions to hospital policy, update credentialing of current staff, or even bring in additional manpower.

These standards have been included in the new Joint Commission publication; Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals, which is intended to provide hospitals with additional guidance on dealing with these patient needs.

Breaking it down

The changes to the standards are spread across the CAMH (see box, at right). The Joint Commission recommends that hospitals form a task force now to address the issues one by one by taking a comprehensive approach to the guidelines. The Roadmap itself is broken down into the different stages along the patient care continuum: Admission Assessment, Treatment, End-of-Life Care, Discharge and Transfer. However, there are two major issues that are constant throughout all of these stages. They boil down to:

1. identifying and documenting patient needs including communication, mobility, dietary and religious needs; and

Updates to standards affecting hospital/patient communication

The new elements of performance, which are included in the 2011 CAMH, include the following updates:

- HR.01.02.01, EP 1 (Note 4: Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience.)
- PC.02.01.21, EP 1 (The hospital identifies the patient’s oral and written communication needs, including the patient’s preferred language for discussing health care.)
- PC.02.01.21, EP 2 (The hospital communicates with the patient during the provision of care treatment and services in a manner that meets the patient’s oral and written communication needs.)
- RC.02.01.01, EP 1 (The medical record contains the following: The patient’s communication needs, including preferred language for discussing health care (if the patient is a minor, the communication preferences of the patient’s guardian) … and the patient’s race and ethnicity.)
- RI.01.01.01, EP 28 (The hospital provides language interpreting and translation services. Note: Language interpreting options may include hospital employed language interpreters, contract interpreting services, or trained bilingual staff, and may be provided in person or via telephone or video. The hospital determines which translated documents and languages are needed based on its patient population.)
2. identifying a support person of the patient's choosing and including that person or persons in the patient's process of care.

**Designating a support person**

If your hospital has a policy that specifically restricts visitors and decision makers to family members only, you will need to significantly expand your definitions of who can be present during the patient's treatment and care.

Upon admission, ask the patient to designate a "support person." This can be broadly defined to include family, friends and same-sex partners. You should have a system in place that will inform hospital staff of the patient's chosen support person. The patient also has the right to designate the support person as the designated decision-maker should the patient be unable to make decisions on their own. Inform the patient that the support person may be present with him or her during the course of stay and allow the patient access to the support person at all times.

**Note:** The hospital retains the right to remove any individual, be it support person or family member, from the area of care if that person is causing a disruption to the care of the patient and/or surrounding patients or is preventing the staff from performing their duties of care.

Ask if the patient would like to involve the chosen support person during rounds, patient education and other crucial decision-making and care processes.

**Document the patient's choice**

You may have to update your patient records to include an area on the record for designated support person. That person should be added to the patient's medical record and staff should be informed of the decision.

Ask the patient which, if any, family members he or she would like to involve in care discussions. As the Roadmap points out, some patients may have family members who do not agree with the patient's choice of support and may try to exclude that individual from visitation or decision making. This can occur when patients are in same-sex unions that may not be recognized in certain states or when patients are estranged from their immediate family members.

"Exclusion of a primary caregiver may compromise patient adherence with treatment recommendations," The Joint Commission says. Even if the person is not legally related to the patient they should not be excluded from the patient's care if that is the specific wish of the patient.

Access TJC's Roadmap for more information on how you need to incorporate the patient's chosen caregiver throughout the process of care. The publication is available on The Joint Commission website. [www.jointcommission.org/NewsRoom/NewsReleases/nr_08_04_10.htm](http://www.jointcommission.org/NewsRoom/NewsReleases/nr_08_04_10.htm).

**We want to hear from you**

Tell us how your hospital is implementing the requirements of Effective Communication, Cultural Competence, and Patient- and Family-Centered Care Roadmap. Email Inside the Joint Commission editor Kevin McDermott at kmcdermott@decisionhealth.com and pass along your success stories in implementing new hospital policy, or the hurdles you face in affecting change. We'll continue to cover the challenges posed by the new guidelines and pass along best-practices from other hospitals implementing new policy.

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**NPSG**

(continued from pg. 1)

the goal involved issues beyond a hospital’s control, namely having to depend on patients to provide accurate information regarding their medication usage.

The new NPSG, which now resides among the medication safety goals of Goal 3, streamlines what had once been spelled out over four complete NPSGs. The five new elements of performance are spelled out below.

EP 1: Obtain information on the medications the patient is currently taking when he or she is admitted to the hospital. Simple enough. But, “this was an issue in the last iteration of the safety goal,” says former Executive Director of Joint Commission Accreditation Services, Kurt Patton. Often, patients could not remember what medications they were taking and staff would leave spaces on the medical record blank, Patton explained, giving the impression that the hospital didn’t try to obtain the information.

Patton recommends indicating somewhere on the admission form that an attempt was made at obtaining medication information. “Patient can’t remember,” or “Patient doesn’t know” at least shows that an attempt was made.

The note to EP 1 acknowledges that efforts to obtain a complete medication list from a patient can be difficult. It allows for “a good faith effort” on the part of the
hospital to get this information as satisfying the intent of the NPSG.

**TIP:** The Joint Commission doesn’t clarify details such as what “a good faith effort” might be. If you or your hospital has concerns about conforming to this element of performance (or other details in the goal) you should contact the Joint Commission’s Standards Interpretation Group for clarification, Patton — currently CEO of Patton Healthcare Consulting, Glendale, Ariz. — recommends. “The Joint Commission used to publish a list of clarifications whenever it would publish new standards or goals,” Patton explained. These days they wait until they gather a list of issues that hospitals approach them with and publish an FAQ posthumously.

**EP 2:** Define the types of medication information to be collected in non-24-hour settings and different patient circumstances.

**EP 3:** Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies.

“This was also a difficult issue in the last iteration of the NPSG,” Patton explains. A good way for you to adhere to this EP is for the physician to go down the list of medications the patient is currently taking and indicate either “continue” or “discontinue” on the patient record, Patton recommends.

The note to EP 3 explains that “a qualified individual, identified by the hospital, does the comparison.” Your hospital should define who is qualified to do the comparison. Reference is made to HR.01.06.01, EP 1 which requires the hospital to define competencies it requires of its staff.

**EP 4:** Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital (name, dose, route, frequency, purpose). The EP refers to PC.04.02.01 – when a patient is discharged or transferred, the hospital gives information about the care, treatment and services provided to the patient to other service providers who will provide the patient with care, treatment or services.

Do this as part of your transfer materials, Patton suggests. Send a printout of the patient’s medication administration record. Even though documentation is not explicitly required in this EP, Patton recommends that a note be made in the patient record that medication reconciliation information was sent to the patient’s subsequent care provider, primary care physician, or with the patient or family member if no other care provider exists.

**EP 5:** Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.

Make sure you have a process for medication management even after discharge. Here are some items you need to make sure you follow before sending your patient home:

- Instruct the patient to give a list of medications he or she is on and received at the hospital to his primary care physician.
Instruct the patient to update their medication information on an “as needed” basis; when new medications are introduced, current medications are discontinued or when doses change.

Remind the patient to include over-the-counter drugs on their list of medications.

Emphasize to the patient the importance of carrying medication information with them at all times in case of emergency.

Educate the patient about self-administered drugs prior to discharge including the process of administration, time, frequency, route and does, potential side effects and monitoring for adverse effects of the medication (also covered under standard MM.06.01.03).

**Changes to your documentation.** The addition of the word “purpose” in the new NPSG will require you to take direct action before the goal becomes effective in July. Joint Commission now requires you to include the name of the medication, the dose, route, frequency and *purpose*, which was not included on the original medication reconciliation requirements, Patton notes. This means that you will have to modify your med. rec. forms or your electronic record to ensure you capture this information and stay compliant with the requirements.

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**Proposed NPSGs address HAIs**

In addition to new NPSG.03.06.01, The Joint Commission has released two proposed NPSGs that address ventilator-associated pneumonia (VAP) and catheter-associated urinary tract infections (CAUTI). While the proposed new goals won’t take effect until 2012, TJC is accepting comments on the standards until January 27.

**NPSG.07.06.01** (Implement evidence-based practices to prevent ventilator-associated pneumonia (VAP)).

EP, 1: During 2012, plan for the full implementation of this NPSG by January 1, 2013. **Note:** Planning may include a number of different activities, such as assigning responsibility for implementation activities, creating timelines, identifying resources and pilot testing.

EP, 2: Perform hand hygiene before and after providing care to ventilated patients. (See also NPSG.07.01.01)

EP, 3: Position and maintain ventilated patients (except those with medical contraindications) in semi-recumbent positions.

EP, 4: Provide regular antiseptic oral care to patients in accordance with product guidelines.

EP, 5: Perform daily assessment of ventilated patients to determine their readiness to wean off the ventilator or to be extubated. **Note:** This requirement is not applicable for patients that do not have a medical plan for weaning off the ventilator.

EP, 6: Perform daily sedation interruption in accordance with the patient’s medical plan of care. **Note:** This requirement is not applicable for patients that do not have a medical plan for weaning off the ventilator.

EP, 7: Measure and monitor ventilator-associated pneumonia prevention processes and outcomes by doing the following:
   a. Selecting measures using evidence-based guidelines or best practices
   b. Monitoring compliance with evidence-based guidelines or best practices
   c. Evaluating the effectiveness of prevention efforts

**NPSG.07.07.01** (Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI)).

EP, 1: During 2012, plan for the full implementation of this NPSG by January 1, 2013. **Note:** Planning may include a number of different activities, such as assigning responsibility for implementation activities, creating timelines, identifying resources, and pilot testing.

EP, 2: Insert indwelling urinary catheters to prevent infection according to established evidence-based guidelines that address the following:
   a. Limiting use and duration to situations necessary for patient care
   b. Using aseptic techniques for site preparation, equipment and supplies

EP, 3: Manage indwelling urinary catheters to prevent infection according to established evidence-based guidelines that address the following:
   a. Securing catheters for unobstructed urine flow and drainage
   b. Maintaining the sterility of the urine collection system
   c. Replacing the urine collection system when required
   d. Collecting urine samples

EP, 4: Measure and monitor catheter-associated urinary tract infection prevention processes and outcomes by doing the following:
   a. Selecting measures using evidence-based guidelines or best practices
   b. Monitoring compliance with evidence-based guidelines or best practices
   c. Evaluating the effectiveness of prevention efforts

Hospitals that wish to comment on the proposed NPSGs can go to The Joint Commission’s website at [http://jointcommission.qualtrics.com/] (SE?SID=SV_9Y81ApHtUZ88ehZ).
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