ACTUALIZING PATIENT SAFETY PROGRAMS

The emphasis on patient safety initiatives has brought about several technological improvements; however, hospitals continue to struggle with the human behavior element.

Communication is the greatest challenge because it is responsible for most of the inefficiencies, frustrations and errors found in healthcare today.

Literature Review Findings:

1. "Best Practice " standards were not as effective in producing sustained changes in behavior as initiatives identified and supported from within the organization.
2. Successful interventions involved multiple, repeated sessions where staff were provided the opportunity to discover and practice concrete solutions to specific safety concerns.
3. When an internal member of the group provided leadership and acted as a change agent, behaviors of the group improved in consistency and duration.
4. If a particular task was the responsibility of one group (such as nurses, pharmacists, or respiratory therapists), that group consistently created a "safety net" within its own scope of responsibilities. Unfortunately, no single group created the same safety net where responsibilities intersected with another group.

Successful Initiatives:

1. Training sessions on human factors that included effective communication, teamwork, minimizing hierarchy within the group and management of identified errors.
2. Involve patients, talk to patients, listen to patients and expect patients to participate in the safety program.
3. Implemented weekly walking rounds wherein specific safety questions were asked of staff and reinforcement of previous training on safety concepts and reporting was provided.

Hospitals continue to struggle with the human behavior element.

4. Individual groups investigated the impact of stress, fatigue, multitasking, poor lighting and noisy settings upon the delivery of care systems. When potential risk points were identified, they attempted to build in systems to prevent, buffer, absorb or mitigate errors.
5. Interdisciplinary patient safety team which includes all levels of providers.

Above all, it was imperative that leadership actively support a non-judgmental working environment where staff, physicians and patients are comfortable reporting errors, near misses and adverse events.

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New National Patient Safety Goal Will Put Spotlight on Infection Control *(Continued from Page 2)*

With so few reports to review, JCAHO has been unable to draw conclusions or provide recommendations related to these events. JCAHO hopes increased submission and review of infection-related reports will generate more useful information about managing patients with nosocomial infections and patients at risk for infection.

Failure of an organization to implement either one of the requirements associated with this new national patient safety goal will result in a JCAHO special Requirement for Improvement.

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Compliance News

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A Newsletter for Healthcare Executives and Facility Managers on Issues Related to Accreditation and Regulatory Compliance

It is too late to prepare after the failure has occurred.

In This Issue:

Patient safety, a healthcare industry crisis.

Page 1 Utility and Emergency Management
New National Patient Safety Goal
Page 2 Communication Systems
Page 3 New JCAHO Survey Process
Page 4 Actualizing Patient Safety Programs

PATIENT SAFETY, UTILITY & EMERGENCY MANAGEMENT

Patient safety is not just about medications and infection control. Hospital managers who integrate their utility management and emergency management programs can create safer patient care environments. Patient safety is enhanced when lessons learned from both unplanned outages and planned renovation or maintenance shutdowns are used in future emergency planning. Very brief examples of normal power (NP) and critical branch (CB) power shutdowns below illustrate some of these concepts.

Hospital engineers know it is usually necessary to have more equipment operating during an NP shutdown than just the code-required equipment connected to emergency power (EP). This equipment is required by the operating requirements of the hospital, and the equipment must be temporarily wired for the shutdown if it is not on EP. Shutdown preparation should also include responding to failures of EP while NP is not available. These same contingency plans should then be documented for future outages. *(Continued on Page 3)*

NEW NATIONAL PATIENT SAFETY GOAL WILL PUT SPOTLIGHT ON INFECTION CONTROL

In an effort to reduce the occurrence of nosocomial infections and increase the reporting frequency of infection-related sentinel events, JCAHO will begin enforcing a new National Patient Safety Goal on January 1, 2004. The new goal states that healthcare organizations shall reduce the risk of healthcare-acquired infections. Two specific requirements are included with the new goal:

1. Comply with current CDC hand hygiene guidelines; and
2. Manage, as sentinel events, all identified cases of unanticipated death or major permanent loss of function associated with a healthcare-acquired infection.

The first requirement regarding hand hygiene relates to the new CDC Guidelines for Hand Hygiene in Healthcare Settings published October 25, 2002. The guidelines recommend the use of alcohol-based hand rubs to decontaminate hands that are not visibly soiled. "Clean hands are the single, most important factor in preventing the spread of dangerous germs and antibiotic resistance in healthcare *(Continued on Page 2)*

PATIENT SAFETY, HOSPITAL COMMUNICATION SYSTEMS AND YOU

Flick a switch, light comes on. Turn a faucet handle, water flows. We take utilities for granted. Maybe the questions should be: What if the light doesn't come on? What if the water doesn't flow?

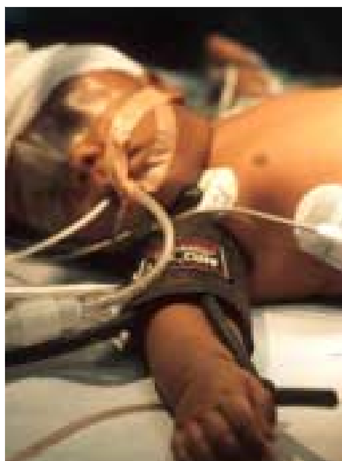
Are we asking the right questions?

Are we taking our hospital communication systems for granted, just like utilities? Are we asking the right questions?

What if the patient calls for a nurse using the nurse call system and it doesn't work? What if the
……cardiac monitoring system fails?
……code blue system fails?
……infant protection system fails?
……paging system fails?
……phone switch system fails?

Communication systems are becoming so integrated into day-to-day patient care delivery that we have to remind ourselves they are not utilities, that patient safety could be compromised by system failure. What can you do?

1. Increase staff awareness of the correlation between patient safety and communication systems.
2. Create contingency/backup plans for real/potential system failure.
3. Maintain systems/infrastructure and conduct tests on an ongoing, regular basis.
4. Upon new purchases or upgrades to communication systems, review with patient safety in mind:
   - Create a team of qualified people to make system selection decisions.
   - Plan for redundancy.
   - Look for satisfactory records on "up-time."
   - Complete and document testing prior to going live.
   - Check for a history of quality for the system and all elements involved in its operation, such as cabling, servers, power, etc.
   - Assure the technical design is customized to your requirements.
   - Require installation be completed to technical specifications.



Providing for patient safety means taking nothing for granted and asking, "What if . . . ?"

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New National Patient Safety Goal Will Put Spotlight on Infection Control *(Continued from Page 1)*

settings," said Dr. Julie Gerberding, Director of the CDC. The guidelines state that alcohol-based hand rubs take less time to use, cause less skin irritation and are more effective than hand washing at reducing bacteria counts on hands.

One primary concern with the use of alcohol-based hand rubs is the increased fire risk because they are usually 60% to 95% alcohol. Consequently, most of these products are classified as flammable liquids. Hospitals must ensure that their use and storage of the alcohol-based products are in accordance with local fire prevention codes.

The second requirement addresses nosocomial infections that result in patient deaths or permanent loss of function. This is not a new JCAHO requirement; it has met the sentinel event criteria since 1996. However, through January 2003, healthcare organizations had submitted only 10 infection-related reports to JCAHO for review under the sentinel event policy. *(Continued on Page 4)*

JCAHO BEGINS NEW SURVEY PROCESS IN JANUARY 2004

JCAHO will begin utilizing the Shared Visions-New Pathways approach to survey readiness beginning January 1, 2004. This new process is significantly different from the previous survey process and will appreciably impact the entire organization.

There will no longer be a formal document review session, which means you no longer have to prepare those function books! The former Human Resource Review will be replaced with the competence assessment process. Previously, surveyors scheduled visits to patient care settings and functional areas. Under the new process the visits will now be random and based on information obtained through open medical records selected through the Tracer Methodology. The previous building tour is now an environment of care review guided by the Statement of Conditions and its Plans for Improvement. Functional interviews are replaced with system tracer sessions on topics that are a high priority for the individual organization.

The Tracer Methodology begins with an individual patient and "traces" that patient's path through the hospital services from admission to discharge. This approach will provide the surveyors a realistic picture of how different functions such as provision of care, treatment, services, information management, and human resources interact in the organization. An individual tracer crosses departments, units, services and may expose common system issues. Surveyors may ask multiple staff members on different units for a particular policy to ensure that each unit has the same policy, and that the policy is the latest version.

System tracers for 2004 will most assuredly always include medication management, infection control, and national patient safety goals. It is anticipated that surveyors will spend 50-60% of their time utilizing the tracer methodology to review the organization. A full JCAHO 3 day survey with 3 surveyors would probably yield a total of 11-12 individual and system tracers.

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Patient Safety, Utility & Emergency Management *(Continued from Page 1)*

Emergency management of internal disasters should consider different utility failure points, not only those at the mains. This approach is necessary because the responses can be different depending on the failure. *It is too late to prepare after the failure has occurred.*

For example, some hospitals only consider power failures at the NP mains. In this case the emergency power supply system is available, most critical care equipment will already be plugged into the CB outlets, and patient care continues at a reduced state until NP returns. Because there have also been cases where generators have failed to start or tripped off line, some hospitals also consider generator failures.

Other types of failures may be more difficult to plan for because of their seemingly endless variety. One example is the failure of a CB riser that feeds several floors of a critical care wing. Hospital renovation projects spend a lot of time and effort planning CB shutdowns. Issues such as switching ventilators, monitors and nurse station equipment from the red CB outlets to the NP outlets, and temporarily rewiring hardwired CB equipment, such as Pyxis™ machines and X-ray viewboxes, should be documented for utility management purposes.

Often planned shutdowns reveal opportunities for operational or capital improvements with direct patient safety benefits that can then be reflected back into the utility management plans.

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(Also refer to David's article, ***Joining Forces - integrating utility and emergency management for better patient safety,*** published in the April 2003 issue of *Health Facilities Management*. Reprints are available.)

JCAHO FOCUS AREAS FOR 2004

Staffing
Infection Control
Medication Management
National Patient Safety Goals