Clinical staff at TRH are expected to understand their personal responsibilities regarding the Joint Commission National Patient Safety Goals for Critical Access Hospitals. Abiding TRH policies and procedures related to these goals will assure compliance.

The purpose of the Joint Commission’s National Patient Safety Goals is to promote specific improvements in patient safety. The goals highlight problematic areas in health care and describe evidence and expert-based consensus to solutions to these problems. As with Joint Commission standards, accredited organizations, such as TRH, are evaluated for continuous compliance with the specific requirements associated with the National Patient Safety Goals.

TRH is committed to the delivery of safe, high quality healthcare. If you have concerns about patient safety or your role to ensure patient safety, please contact your manager. Your commitment to quality, safe care of patients is expected and appreciated.

The completion of this module and post test is required for all clinical employees upon hire and all students who are involved in the clinical areas.
Accountability in a Just Culture

Rebecca W. Carter, MSN, RN
Chief Operating Officer

Perhaps you, like many healthcare providers, look over the list of National Patient Safety Goals (NPSG) and wonder what all the fuss is about. The requirements are not new, not surprising and with a few exceptions, not complicated. For example, TRH had a policy that required read backs for telephone orders years before The Joint Commission had patient safety goals. So why all the focus, attention and activity about these requirements? Simply put, TRH patient care staff are not being consistent and thorough in attention to these topics. You must recall that, on direct observation, only 66% in 2006, 84% in 2007 and 90% in 2008 of TRH licensed nurses and physicians washed their hands appropriately before and after patient care. Laboratory specimens collected by patient care staff have been mislabeled numerous times. Nurses are cutting corners on medication administration processes by not checking MAR labels against the patient’s arm band.

This educational activity is being offered because TRH patient care staff must improve compliance with these requirements. Through this program, leadership will assure that staff have access to the information they need in order to comply with requirements. It is also an opportunity for each of us to clarify our understanding, ask questions about specific situations and point out any barriers to compliance that need immediate correction.

Following this activity, each member of the TRH patient care staff will be held accountable for making every reasonable effort to comply with the requirements. Each of us is expected to know the standards, incorporate them into our practice and consistently comply with these. And if you do not comply, expect that there will be a consequence.

Managers, charge nurses and others in the organization - even patients and families - are assessing compliance with the standards. If you are involved with a circumstance where there is a safety breech, your manager will carefully review the circumstances to determine a fair and reasonable assessment of the performance of all involved. You should expect that if you could reasonably be expected to meet the safety guideline, but did not, a disciplinary action will follow. The purpose of disciplinary consequences in these circumstances is not to be unnecessarily punitive, but rather to change performance for the better.

We share responsibility for safe practice. If you see a colleague do something risky; remind them, coach them, help them but don’t become involved by participating. For example, if a colleague collects a blood sample from a patient and tries to hand you the tube asking you to label it, offer instead to lend your pen, to do the next task needed or to get a label for that person to check against the arm band. It is difficult to imagine a circumstance where there is time to draw blood but no time to label it at the bedside. If you accept unlabeled specimens agreeing to label them, you become as “guilty” of a safety violation as the person who failed to label them according to standard.

If you see someone come to the bedside to give a medication with no MAR or order sheet to use for verification, interrupt and offer to go get it for them. You may be helping a colleague break a bad habit of unsafely working around the medication administration process. Most of us have habits to change and will need the support of others in doing it.

Safety practices are in place to protect our patients, our colleagues and ourselves. It should be rare for the urgency of a situation to interfere with compliance. One role of leadership will be to determine if negligence, recklessness or willful neglect or intent played a part in failures. Assess your own practice immediately and make a personal commitment to improving. Ask your leaders and colleagues to help you. Choose to succeed for the sake of your patients.
Goal 1  Improve the accuracy of patient identification.

NPSG.01.01.01
Use at least two patient identifiers when providing care, treatment or services.

**Rationale**
Wrong-patient errors occur in virtually all stages of diagnosis and treatment. The intent for this goal is two-fold; first, to reliably identify the individual as the person for whom the service or treatment is intended; second to match the service or treatment to that individual.

Elements of Performance for NPSG.01.01.01
1. Prior to any specimen collection, medication administration, transfusion, or treatment, the critical access hospital actively involves the patient and, as needed, the family in the identification and matching process. When active patient involvement is not possible or the patient's reliability is in question, the critical access hospital will designate the caregiver responsible for identity verification.
   Note: The involvement of a single caregiver is acceptable as long as the other components of patient identification are satisfied.
2. Two patient identifiers are used when administering medications, blood, or blood components.
3. Two patient identifiers are used when collecting blood samples and other specimens for clinical testing.
4. Two patient identifiers are used when providing other treatments or procedures.
5. The patient’s room number or physical location is not used as an identifier.
6. Containers used for blood and other specimens are labeled in the presence of the patient.

A few statistics:
1. Patient or specimen identification errors involving lab specimens cause some 160,000 adverse patient events each year in the United States.
2. Nearly 60% of medical error deaths are reportedly due to patient misidentification--which translates in 2004 that 114,706 people died as a result of "wrong patient" medical errors.
3. Specimen-related errors result in $200 million to $400 million in healthcare expenditures per year in the U.S.

In looking at these staggering statistics, it is not surprising that the Joint Commission has made PATIENT IDENTIFICATION a number one National Patient Safety Goal.

**Two Strategies To Assist With Compliance** of Nursing Basics 101 and JCAHO National Patient Safety Goal 1:

1. **ALWAYS USE AT LEAST TWO IDENTIFIERS.**
   Examples of acceptable identifiers include the patient's name, date of birth, medical record number, and Social Security number. Example--ask patient what is their name and date of birth and compare this information with patient's arm band, MAR, chart. Never use the patient's room number because patients are often moved, so their location is an unreliable identifier. Make sure the identifiers are appropriate to the setting and service and implement a standardized process for labeling.

2. **ALWAYS LABEL THE SPECIMEN CONTAINER IN THE PRESENCE OF THE PATIENT.**
   The whole point of labeling the container is to match the specimen to the correct patient, so the TWO IDENTIFIERS must be placed on the container (the person who collects, labels) at the time of collection. Label specimen tubes or containers just before or after collection, in the presence of the patient whose specimens they will contain.
Goal 1  Improve the accuracy of patient identification.

NPSG.01.03.01
Eliminate transfusion errors related to [patient] misidentification.

Elements of Performance for NPSG.01.03.01
Before initiating a blood or blood component transfusion, the patient is objectively matched to the blood or blood component during a two-person bedside or chair-side verification process. At least two unique identifiers are used in the process, and it is conducted after the blood or blood component that matches the order has been issued or dispensed.

Note: If two individuals are not available, an automated identification technology (for example, bar coding) may be used in place of one of the individuals.

1. When using a two-person bedside or chair-side verification process, one individual conducting the identification verification must be the qualified transfusionist who will administer the blood or blood component to the patient.

2. When using a two-person verification process, the second individual conducting the identification verification is qualified to participate as determined by the hospital.

Goal 2  Improve the effectiveness of communication among caregivers.

NPSG.02.01.01 has been moved to the JC standards
For verbal or telephone orders or for telephone reporting of critical test results, the individual giving the order or test result verifies the complete order or test result by having the person receiving the information record and "read back" the complete order or test result. *Ineffective communication is the most frequently cited root cause for sentinel events.* *Effective communication that is timely, accurate, complete, unambiguous, and understood by the recipient reduces error and results in improved [patient] safety.*

Goal 02.01.01 was moved to the Joint Commission standards in 2010. TRH has written procedures in our policy that should be reviewed. Remember to always read back all orders taken and document the read back on the orders.
Goal 2  Improve the effectiveness of communication among caregivers.

NPSG.02.02.01 has been move to the Joint Commission standards
There is a standardized list of abbreviations, acronyms, symbols, and dose designa-
tions that are not to be used throughout the [organization].

Elements of Performance for this standard
The critical access hospital develops a standardized list of abbreviations, acronyms, symbols, and
dose designations that are not to be used throughout the critical access hospital.

Note: A trailing zero may be used only when required to demonstrate the level of precision of the value
being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/ tube sizes. It may not be used in medication orders or other medication-related documentation.

The critical access hospital implements the “do not use” list of abbreviations, acronyms, symbols, and dose
designations and applies it to all orders and all medication-related documentation that is handwritten or en-
tered as free text into a computer.

At TRH, the “Do Not Use” Abbreviations list in the MEDITECH Library which includes:

<table>
<thead>
<tr>
<th>Unacceptable:</th>
<th>Acceptable Use:</th>
</tr>
</thead>
<tbody>
<tr>
<td>IU</td>
<td>Write &quot;international unit&quot;</td>
</tr>
<tr>
<td>QD, qd</td>
<td>Write &quot;daily&quot;</td>
</tr>
<tr>
<td>q.o.d., Q.O.D.</td>
<td>Write &quot;every other day&quot;</td>
</tr>
<tr>
<td>MS</td>
<td>Morphine sulfate</td>
</tr>
<tr>
<td>MSO4</td>
<td>Morphine sulfate</td>
</tr>
<tr>
<td>MgSO4</td>
<td>Magnesium sulfate</td>
</tr>
<tr>
<td>U, u</td>
<td>Units</td>
</tr>
<tr>
<td>UD</td>
<td>As directed</td>
</tr>
<tr>
<td>Missing zero before decimal</td>
<td>0.XXXX</td>
</tr>
<tr>
<td>Zero after a decimal</td>
<td>(X.0)X</td>
</tr>
<tr>
<td>Apothecary Nomenclature</td>
<td>Metric</td>
</tr>
<tr>
<td>AvoirDupois Nomenclature</td>
<td>Metric</td>
</tr>
</tbody>
</table>

NPSG.02.03.01
Report critical results of tests and diagnostic procedures on a timely basis.

Rationale for NPSG.02.03.01
Critical results of tests and diagnostic procedures fall significantly outside the normal range
and may indicate a life-threatening situation. The objective is to provide the responsible
licensed caregiver these results within an established time frame so that the patient can be promptly treated.

Elements of Performance for NPSG.02.03.01
1. Develop written procedures for managing the critical results of tests and diagnostic
procedures that address the following:
   - The definition of critical results of tests and diagnostic procedures
   - By whom and to whom critical results of tests and diagnostic procedures are reported
   - The acceptable length of time between the availability and reporting of critical results of
tests and diagnostic procedures
2. Implement the procedures for managing the critical results of tests and diagnostic proce-
dures.
3. Evaluate the timeliness of reporting the critical results of tests and diagnostic proce-
dures.

TRH has defined critical tests and critical results/values and acceptable length of time for reporting.
Goal 2 Improve the effectiveness of communication among caregivers.

NPSG.02.05.01 has been moved to the Joint Commission Standards
The [organization] implements a standardized approach to hand-off communications, including an opportunity to ask and respond to questions.

Rationale for this standard

Health care has numerous types of [patient] hand-offs, including, but not limited to, nursing shift changes; physician transfer of complete responsibility for a [patient]; physician transfer of on-call responsibility; acceptance of temporary responsibility for staff leaving the unit for a short time; anesthesiologist report to post-anesthesia recovery room nurse; nursing and physician hand-off from the emergency department to inpatient units, different hospitals, nursing homes, and home health care; and critical laboratory and radiology results sent to physician offices. The primary objective of a hand-off is to provide accurate information about a [patient]'s care, treatment, and services; current condition; and any recent or anticipated changes. The information communicated during a hand-off must be accurate in order to meet [patient] safety goals.

Elements of Performance

The critical access hospital's process for effective hand-off communication includes the following:

♦ Interactive communication that allows for the opportunity for questioning between the giver and receiver of patient information.
♦ Up-to-date information regarding the patient’s condition, care, treatment, medications, services, and any recent or anticipated changes. (See also NPSG.08.01.01,EP 4)
♦ A method to verify the received information, including repeat-back or read-back techniques.
♦ An opportunity for the receiver of the hand-off information to review relevant patient historical data, which may include previous care, treatment, and services.

Interruptions during hand-offs are limited to minimize the possibility that information fails to be conveyed or is forgotten.

Expectations for Hand Off Communication at TRH:
Anytime the responsibility for care of a patient is transferred from one person to another, HAND OFF COMMUNICATION must take place. Hand Off Communications must be done by the person directly caring for the patient and the content will be determined by the needs of the patient. Hand Off Communication must include an opportunity for the receiving care provider to ask questions and clarify information. A healthcare provider should not accept responsibility for the care of a patient without Hand Off Communication except in rare circumstances: a primary provider becomes ill or tied up in an urgent or emergent situation, etc. All providers should plan as much as possible for circumstances which may require someone else to cover his/her patients and do Hand Off briefings: i.e., the nurse will be doing a complex dressing change, the nurse will be assisting a physician with a procedure or monitoring a patient for moderate sedation. Utilize the SBAR tool in Hand Off Communications:

Situation: What is happening?

Background: What information is known?

Assessment: What do you think is happening?

Recommendation: What response do you anticipate? What should happen?

Example: A nurse delivers his/her patient to x-ray for a CT scan. The nurse briefs the CT technician as follows: “Hi Stacey. This is Mrs. Jordan, age 82, who is having a CT scan of her abdomen and pelvis this morning. She has been very nauseated this morning and received IV Phenergan two hours before coming down for the test. She says she is feeling some better but the medicine may make her a little unsteady on transfers so you may need some help in moving her. I have her emesis basin with her. If she should become more nauseated or vomit, please call me and I will see if more medicine is needed. What questions do you have?”
Medication Administration - Basic Safety Principles

A. Is the medication being given to the patient for the first time since it was ordered?
   If so, verify the eMAR information against the original physician order in the patient’s chart. Document that you verified the first documented dose against the order by acknowledging order on the eMAR.

B. You already know, but are you practicing it? **5 Rights**
   1. Make sure you have the **Right Patient**. Ask the patient to state his or her name and birth date. Verify this with the patient’s armband. Verify this with the information on the eMAR. With Med Cart at bedside, scan patient’s armband.
   2. **Right Medication**: Scan medication to be administered to ensure you are giving the right drug.
   3. **Right Route**: Check the eMAR to make sure you are giving the medication via the ordered route.
   4. **Right Dose**: Check the unit dose med package to the eMAR to assure that you have the right dose.
   5. **Right Time**: You must give the medications at the right time as documented on the eMAR. Transylvania Regional Hospital’s policy states that you have one hour before and one hour after the ordered time to administer routine medications.

C. Make sure you perform the Three Checks:
   1. Check the five rights as you remove the meds from the storage unit. Do not open blister packs or draw up injectables until at the bedside. If you must prepare meds prior to going into the room, take the original package or vials with you.
   2. Check the five rights as you remove the meds from the unit dose packet or draw it up. Tell your patient what you are administering and why. If the patient questions the order, verify before administering.
   3. Check the unit dose packets against the MAR as you document what you gave and at which site if indicated.

D. Some high risk medications require two licensed nurses to check them in most settings. Heparin, insulin and PCA settings are examples. Know what is required in your department.

E. **If a medication sounds like** another medication, or **looks like** another medication, you must be extra careful to verify you have the right medication. Our pharmacy has a list of **sound alike / look alike medications** available on each Nursing Station’s Computer, in the Pharmacy Formulary Webpage. Also, these medications are flagged on the MAR in **bold letters**, giving the nurse a “heads up” that you are administering a medication that sounds like another or looks like another. Examples include: prednisone / prednisolone, hydroxyzine / hydralazine and celebrex / cerebrex.
   - PC’s in each nursing department have an icon on their desktop that looks like a pill bottle.
   - This shortcut will connect you to www.formchecker.com.
   - The username is: tvania, the password is: user.
   - Click on the Pharmacy link, then click on the “Recommended” link, and then click on the “Look Alike Sound Alike” link.

**Memory-jog for drug administration:**
Nurses play a key role in preventing complications related to medication and treatment regimens (e.g. drug interactions, allergies, and adverse effects).

Use **TACIT** to remember the key things you must monitor when caring for patients on various treatment and medication regimens.

**Therapeutic effect (Is there a therapeutic effect?)**
**Allergic or Adverse reactions (Are there signs of allergic or adverse reactions?)**
**Contraindications (Are there contraindications to giving this drug?)**
**Interactions? (Are there possible drug interactions)?**
**Toxicity/overdose (Are there signs of toxicity or overdose?)**
TRH Patient Care Orders:

A. You cannot safely implement physician orders if they are not legible, complete and written according to safety principles.

In the following circumstances, you must clarify the order with the physician prior to initiating care:

1. **The order is illegible.** If any question of the content arises, you must clarify it with the writer. Some MDs have notoriously poor handwriting. Offer to review orders with him/her before they leave department. Rewrite any illegible orders and document the date, time and signature of the person who clarified the original.

2. **The order is incomplete.** All orders should specify drug, dose, route and frequency. Sound alike drugs should include an indication to help prevent any confusion.

3. **The order includes a range of dosages or frequency without parameters.** If an order is written with ranges, instructions for their use must be included.

   i.e.: *Give 1 percocet for mild pain or give 2 percocets for moderate pain.*

4. **The order includes unacceptable abbreviations.** Clarify and re-write orders with unacceptable abbreviations prior to initiation.

B. **Telephone orders may be taken in the following manner:**

1. The order must be written directly into the patient’s medical record on the order sheet.
2. The written order must be read back in its entirety to the physician.
3. The read back must be documented.

C. **Verbal orders are not acceptable unless:**

1. The physician is involved in a procedure that prohibits stopping to write.
2. The physician is in sterile garb.
3. The patient is in emergent or urgent need.

   **If you accept a verbal order in any of the above circumstances, you should write it on the patient’s medical record, read it back to the physician and document the read back.**

   If a physician is present and attempts to give a verbal order, offer to provide the chart so that the physician can write the order. If you are planning to suggest or request an order, have the chart in hand so the physician can write the order.
Goal 3  Improve the safety of using medications.

NPSG.03.03.01 has been moved to the Joint Commission Standards
The [organization] identifies and, at a minimum, annually reviews a list of look-alike/sound-alike medications used by the [organization] and takes action to prevent errors involving the interchange of these medications.

NPSG.03.04.01
Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

Rationale for NPSG.03.04.01
Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. This unsafe practice neglects basic principles of medication management safety yet has been routine in many organizations. The labeling of all medications, medication containers, and solutions is a risk reduction activity consistent with safe medication practices.

Elements of Performance for NPSG.03.04.01
1. Medications and solutions both on and off the sterile field are labeled even if there is only one medication being used.

2. Labeling occurs when any medication or solution is transferred from the original packaging to another container.

3. In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following:
   - Medication name
   - Strength
   - Quantity
   - Diluent and volume (if not apparent from the container)
   - Expiration date when not used within 24 hours
   - Expiration time when expiration occurs in less than 24 hours
   Note: The date and time are not necessary for short procedures, as defined by the critical access hospital.

4. All medication or solution labels are verified both verbally and visually by two qualified individuals whenever the person preparing the medication or solution is not the person who will be administering it.

5. Label each medication or solution as soon as it is prepared, unless it is immediately administered.

6. Any medications or solutions found unlabeled are immediately discarded.

7. All labeled containers on the sterile field are discarded at the conclusion of the procedure.

8. All medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting staff responsible for the management of medications.
Goal 3  Improve the safety of using medications.

NPSG.03.05.01
Reduce the likelihood of [patient] harm associated with the use of anticoagulant therapy. Note: This requirement applies only to [organization]s that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the [patient]’s laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for venous thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the [patient]’s laboratory values for coagulation will remain within (or close to) normal values.

Rationale for NPSG.03.05.01
Anticoagulation therapy poses risks to patients and often leads to adverse drug events due to complex dosing, requisite follow-up monitoring, and inconsistent [patient] compliance. To achieve better patient outcomes, patient education is a vital component of an anticoagulation therapy program. Effective anticoagulation patient education includes face-to-face interaction with a trained professional who works closely with patients to be sure that they understand the risks involved with anticoagulation therapy, the precautions they need to take, and the need for regular International Normalized Ratio (INR) monitoring. The use of standardized practices for anticoagulation therapy that include [patient] involvement can reduce the risk of adverse drug events associated with the use of heparin (unfractionated), low molecular weight heparin, and warfarin.

Elements of Performance for NPSG.03.05.01
1. Use only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available. Note: For pediatric patients, prefilled syringe products should be used only if specifically designed for children.
2. Use approved protocols for the initiation and maintenance of anticoagulant therapy.
3. Before starting a patient on warfarin, assess the patient’s baseline coagulation status; for all patients receiving warfarin therapy, use a current International Normalized Ratio (INR) to adjust this therapy. The baseline status and current INR are documented in the medical record.
4. Use authoritative resources to manage potential food and drug interactions for patients receiving warfarin.
5. When heparin is administered intravenously and continuously, use programmable infusion pumps in order to provide consistent and accurate dosing.
6. Written policy addresses baseline and ongoing laboratory tests that are required for anticoagulants.
7. Provide education regarding anticoagulant therapy to prescribers, staff, patients, and families. Patient/family education includes the following:
   ♦ The importance of follow-up monitoring
   ♦ Compliance
   ♦ Drug-food interactions
   ♦ The potential for adverse drug reactions and interactions
8. Evaluate anticoagulation safety practices, take action to improve practices, and measure the effectiveness of those actions in a time frame determined by the organization.
Goal 7 Reduce the risk of health care-associated infections.

**NPSG.07.01.01**
Comply with current World Health Organization (WHO) hand hygiene guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

**Rationale for NPSG.07.01.01**
Compliance with the WHO or CDC hand hygiene guidelines will reduce the transmission by staff to [patient]s of infectious agents, thereby decreasing the incidence of health care–associated infections.

**Elements of Performance for NPSG.07.01.01**
1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) or the current World Health Organization (WHO) hand hygiene guidelines. (See also IC.01.04.01, EP 5)
2. Set goals for improving compliance with hand hygiene guidelines. (See IC.03.01.01, EP 3)
3. Improve compliance with hand hygiene guidelines based on established goals.

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**Hand Washing 101 for TRH Staff**

**WHEN**
- Wash hands when reporting for work and when hands look or feel dirty
- Before and after every patient contact (including their environment)
- After using the bathroom
- Before and after preparing food and eating
- Before and after gloving
- After coughing, sneezing or blowing your nose
- If skin or mucous membranes come in direct contact with blood or other body fluids, wash immediately with running water and soap

**HOW**
- Use warm running water, apply soap, wash with vigor for 15-20 seconds, rinse well, dry with paper towel, turn off faucet with paper towel
- The ‘ABC’ song two times through lasts approximately 20 seconds!

**ALCOHOL-BASED HAND RUB  (The preferred hand hygiene technique)**
- Before and after tasks when hands are not heavily contaminated
- May be used up to 10 times before using soap and water
- Rub all surfaces of hands and fingers for 15-20 seconds
- *Do not use if the patient has a spore-forming pathogen like clostridium difficile* — use soap and water instead.

**LOTION**
- A hospital approved lotion is available at TRH to prevent chapped/dry skin on hands
Goal 7 Reduce the risk of health care associated infections.

NPSG.07.02.01 was moved to The Joint Commission Sentinel Event Policy
Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function related to a health care–associated infection.

NPSG.07.03.01
Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in critical access hospitals.

Note 1: This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (CDI), vancomycin-resistant Enterococci (VRE), and multiple drug-resistant gram negative bacteria.

Rationale for NPSG.07.03.01
Patients continue to acquire health care–associated infections at an alarming rate. Risks and populations, however, differ between organizations. Therefore, prevention and control strategies must be tailored to the specific needs of each organization based on its risk assessment. The elements of performance for this requirement are designed to help reduce or prevent health care–associated infections from epidemiologically important multidrug-resistant organisms (MDROs).

Note: Hand hygiene, contact precautions, as well as cleaning and disinfecting patient care equipment and the patient’s environment are essential strategies for preventing the spread of health care–associated infections. Hand hygiene is addressed in NPSG.07.01.01. Contact precautions for patients with epidemiologically significant multidrug-resistant organisms (MDROs) are covered in IC.02.01.01, EP 3. Cleaning and disinfecting patient care equipment are addressed in IC.02.02.01.

Recommendations from the Center for Disease Control (CDC) advise that to avoid MRSA transmission from one patient to another, adequately clean and disinfect reusable patient care equipment (BP cuffs, stethoscopes, etc) after use on each patient. At Transylvania Regional Hospital, "we have Super Sani-Cloths" available for this task.

Additionally, don’t forget to clean your computer keyboard, especially those used by more than one person. William Rutala PhD, MPH, Professor of Medicine at UNC Chapel Hill and Director of the NC Statewide Program for Infection Control and Epidemiology states "Hospital computer keyboards should be disinfected daily (or more often if visibly soiled or contaminated with blood).” Again, using a hospital approved germicidal wipe ("Super Sani-Cloth" at TRH) will effectively kill organisms such as MRSA, VRE, Pseudomonas and Staphylococcus. Information Systems at TRH asks that we please turn computer off or unplug keyboard before disinfecting.
Elements of Performance for NPSG.07.03.01

1. Conduct periodic risk assessments for multidrug-resistant organism acquisition and transmission. (See also IC.01.03.01, EPs 1-5)

2. Based on the results of the risk assessment, educate staff and licensed independent practitioners about health care–associated infections, multidrug-resistant organisms, and prevention strategies at hire and annually thereafter.
   Note: The education provided recognizes the diverse roles of staff and licensed independent practitioners and is consistent with their roles within the critical access hospital. (See also HR.01.05.03, EP 4)

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

4. Implement a surveillance program for multidrug-resistant organisms based on the risk assessment.

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

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

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

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

9. When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred multidrug-resistant organism-positive patients.
   Note: The alert system information may exist in a separate electronic database or may be integrated into the admission system. The alert system may be either manual or electronic or a combination of both.
**NPSG.07.04.01**

**Implement best practices or evidence-based guidelines to prevent central line–associated bloodstream infections.**

Note 1: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

**Elements of Performance for NPSG.07.04.01**

1. Educate staff and licensed independent practitioners who are involved in managing central lines about central line–associated bloodstream infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in these procedures is added to an individual’s job responsibilities.

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

3. Implement policies and practices aimed at reducing the risk of central line–associated bloodstream infections that meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).

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

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

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

7. Perform hand hygiene prior to catheter insertion or manipulation.

8. For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable.

9. Use a standardized supply cart or kit that is all inclusive for the insertion of central venous catheters.

10. Use a standardized protocol for maximum sterile barrier precautions during central venous catheter insertion.

11. Use an antiseptic for skin preparation during central venous catheter insertion that is cited in scientific literature or endorsed by professional organizations. * TRH uses chlorhexidine-based antiseptic for skin preparation during CVC insertion in patients over tow months of age, unless contraindicated.

12. Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports.

13. Evaluate all central venous catheters routinely and remove nonessential catheters.

Footnote *: A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the critical access hospital must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to follow a practice that is not supported by evidence or widespread consensus. During the on-site survey, surveyors will explore the source of the practices the critical access hospital follows.
NPSG.07.05.01
Implement best practice for preventing surgical site infections.

Elements of Performance for NPSG.07.05.01

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

2. Prior to all surgical procedures, educate patients, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention.

3. Implement policies and practices aimed at reducing the risk of surgical site infections that meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines). (See also UP.01.03.01, EP 5)

4. As a part of the effort to reduce surgical site infections
   ♦ Conduct periodic risk assessments for surgical site infections
   ♦ Select surgical site infection measures using best practices or evidence-based guidelines
   ♦ Monitor compliance with best practices or evidence-based guidelines
   ♦ Evaluate the effectiveness of prevention efforts.

5. Measurement strategies follow evidence-based guidelines, and surgical site infection rates are measured for the first 30 days following procedures that do not involve inserting implantable devices and for the first year following procedures involving implantable devices.

6. Provide surgical site infection rate data and prevention outcome measures to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.

7. Antimicrobial agents for prophylaxis used for a particular procedure or disease are administered according to evidence-based standards and guidelines for best practices. During the on-site survey, surveyors will explore the source of the practices the critical access hospital follows.

8. When hair removal is necessary, use a method that is cited in scientific literature or endorsed by professional organizations. During the on-site survey, surveyors will explore the source of the practices the critical access hospital follows. At TRH if hair removal is necessary use clippers or depilatories. Note: Shaving is an inappropriate hair removal method.
Goal 8
Accurately and completely reconcile medications across the continuum of care.

NPSG.08.01.01
A process exists for comparing the [patient]’s current medications with those ordered for the [patient] while under the care of the [organization].

Rationale for NPSG.08.01.01
[Patient]s are at high risk for harm from adverse drug events when communication about medications is not clear. The chance for communication errors increases whenever individuals involved in a [patient]’s care change. Communicating about the medication list, making sure it is accurate, and reconciling any discrepancies whenever new medications are ordered or current medications are adjusted are essential to reducing the risk of transition-related adverse drug events.

Elements of Performance for NPSG.08.01.01
1. At the time the patient enters the critical access hospital or is admitted, a complete list of the medications the patient is taking at home (including dose, route, frequency, time of last dose and reasons for use) is created and documented. The patient and, as needed, the family are involved in creating this list.
2. The medications ordered for the patient while under the care of the critical access hospital are compared to those on the list created at the time of entry to the critical access hospital or admission.
3. Any discrepancies (that is, omissions, duplications, adjustments, deletions, additions) are reconciled and documented while the patient is under the care of the critical access hospital.
4. When the patient’s care is transferred within the critical access hospital (for example, from the ICU to a floor), the current provider(s) informs the receiving provider(s) about the up-to-date reconciled medication list and documents the communication. (See also NPSG.02.05.01, EP 2)

Note: Updating the status of a patient’s medications is also an important component of all patient care hand-offs.

NPSG.08.02.01
When a [patient] is referred to or transferred from one [organization] to another, the complete and reconciled list of medications is communicated to the next provider of service, and the communication is documented. Alternatively, when a [patient] leaves the [organization]’s care to go directly to his or her home, the complete and reconciled list of medications is provided to the [patient]’s known primary care provider, the original referring provider, or a known next provider of service. Note: When the next provider of service is unknown or when no known formal relationship is planned with a next provider, giving the [patient] and, as needed, the family the list of reconciled medications is sufficient.

Rationale for NPSG.08.02.01
The accurate communication of a [patient]’s reconciled medication list to the next provider of service reduces the risk of transition-related adverse drug events. The communication enables the next provider of service to receive thorough knowledge of the [patient]’s medications and to safely order/prescribe other medications that may be needed. This communication is especially important at transitions in care when a [patient] is referred or transferred from one organization to another.

Elements of Performance for NPSG.08.02.01
1. The patient’s most current reconciled medication list is communicated to the next provider of service, either within or outside the critical access hospital. The communication between providers is documented.
2. At the time of transfer, the transferring critical access hospital informs the next provider of ser-
NPSG.08.03.01
When a [patient] leaves the [organization]'s care, a complete and reconciled list of the [patient]'s medications is provided directly to the [patient] and, as needed, the family, and the list is explained to the [patient] and/or family.

Rationale for NPSG.08.03.01
The accurate communication of the [patient]'s medication list to the [patient] and, as needed, the family, reduces the risk of transition-related adverse drug events. A thorough knowledge of the [patient]'s medications is essential for the [patient]'s primary care provider or next provider of service to manage the subsequent stages of care for the [patient].

Elements of Performance for NPSG.08.03.01
1. When the patient leaves the critical access hospital's care, the current list of reconciled medications is provided and explained to the patient and, as needed, the family. This interaction is documented.
   Note: Patients and families are reminded to discard old lists and to update any records with all medication providers or retail pharmacies.

NPSG.08.04.01
In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed.

Note: This requirement does not apply to [organization]s that do not administer medications. It may be important for health care organizations to know which types of medications their [patient]s are taking because these medications could affect the care, treatment, and services provided.

Rationale for NPSG.08.04.01
A number of [patient] care settings exist in which medications are not used, are used minimally, or are prescribed for only a short duration. This includes areas such as the emergency department, urgent and emergent care, convenient care, office-based surgery, outpatient radiology, ambulatory care, and behavioral health care. In these settings, obtaining a list of the [patient]'s original, known, and current medications that he or she is taking at home is still important; however, obtaining information on the dose, route, and frequency of use is not required.

Elements of Performance for NPSG.08.04.01
1. The critical access hospital obtains and documents an accurate list of the patient's current medications and known allergies in order to safely prescribe any setting-specific medications (for example, intravenous contrast media, local anesthesia, antibiotics) and to assess for potential allergic or adverse drug reactions.

2. When only short-term medications (for example, a preprocedure medication or a short-term course of an antibiotic) will be prescribed and no changes are made to the patient's current medication list, the patient and, as needed, the family are provided with a list containing the short-term medication additions that the patient will continue after leaving the critical access hospital.
   Note: This list of new short-term medications is not considered to be part of the original, known, and current medication list. When patients leave these settings, a list of the original, known, and current medications does not need to be provided, unless the patient is assessed to be confused or unable to comprehend adequately. In this case, the patient's family is provided both medication lists and the circumstances are documented.

3. In these settings, a complete, documented medication reconciliation process is used when: Any new long-term (chronic) medications are prescribed.

4. In these settings, a complete, documented medication reconciliation process is used when: There is a prescription change for any of the patient's current, known long-term medications.

5. In these settings, a complete, documented medication reconciliation process is used when: The patient is required to be subsequently admitted to an organization from these settings for ongoing care.

6. When a complete, documented, medication reconciliation is required in any of these settings, the complete list of reconciled medications is provided to the patient, and their family as needed, and to the patient's known primary care provider or original referring provider or a known next provider of service.
Goal 9—Moved to the Joint Commission Standards
Reduce the risk of [patient] harm resulting from falls.

NPSG.09.02.01
The [organization] implements a fall reduction program that includes an evaluation of the effectiveness of the program. While Goal 9 has been moved to the JC standards of care, it remains in this book as a reminder of its importance and is a current organizational goal for TRH and is a never event.

Rationale for NPSG.09.02.01
Falls account for a significant portion of injuries in hospitalized [patient]s, long term care residents, and home care recipients. In the context of the population it serves, the services it provides, and its environment of care, the [organization] should evaluate the [patient]s risk for falls and take action to reduce the risk of falling as well as the risk of injury, should a fall occur. The evaluation could include a [patient]s fall history; review of medications and alcohol consumption; gait and balance screening; assessment of walking aids, assistive technologies, and protective devices; and environmental assessments.

Elements of Performance for NPSG.09.02.01
1. The critical access hospital establishes a fall reduction program.
2. The fall reduction program includes an evaluation appropriate to the patient population, settings, and services provided.
3. The fall reduction program includes interventions to reduce the patient’s fall risk factors.
4. Staff receive education and training for the fall reduction program.
5. The critical access hospital educates the patient and, as needed, the family on the fall reduction program and any individualized fall reduction strategies.
6. The critical access hospital evaluates the fall reduction program to determine the effectiveness of the program.

Note: Outcome indicators such as decreased number of falls and decreased number and severity of fall-related injuries could be used.

Review TRH Patient Care P&P: Falls Prevention...CLN 200:209
Goal 13—*This goal was moved to the Joint Commission Standards*
Encourage [patient]s’ active involvement in their own care as a [patient] safety strategy.

**NPSG.13.01.01**
Identify the ways in which the [patient] and his or her family can report concerns about safety and encourage them to do so.

**Rationale for NPSG.13.01.01**
Communication with the [patient] and family about all aspects of care, treatment, and services is an important characteristic of a culture of safety. When the [patient] knows what to expect, he or she is more aware of possible errors and choices. The [patient] can also be an important source of information about potential adverse events and hazardous conditions.

**Elements of Performance for NPSG.13.01.01**
1. The patient and family are educated on available reporting methods for concerns related to care, treatment, and services and patient safety issues.
2. The critical access hospital provides the patient with information regarding infection control measures for hand hygiene practices, respiratory hygiene practices, and contact precautions according to the patient’s condition. The information is discussed with the patient and his or her family members on the day the patient enters the critical access hospital or as soon as possible (for example, within 24–48 hours). The patient’s understanding of this information is evaluated and documented.
3. For surgical patients, the critical access hospital describes the measures that will be taken to prevent adverse events in surgery. Examples include, but are not limited to, patient identification practices, prevention of surgical infections, and marking of the procedure sites. The patient’s understanding is evaluated and documented.
4. The critical access hospital encourages patients and their families to report concerns about safety.

Goal 16—*This goal was moved to the Joint Commission Standards*
Improve recognition and response to changes in a patient’s condition.

**NPSG.16.01.01**
The [organization] selects a suitable method that enables health care staff members to directly request additional assistance from a specially trained individual(s) when the [patient]’s condition appears to be worsening.

**Rationale for NPSG.16.01.01**
A significant number of critical inpatient events are preceded by warning signs prior to the event. A majority of [patient]s who have cardiopulmonary or respiratory arrest demonstrate clinical deterioration in advance. Early response to changes in a [patient]’s condition by a specially trained individual(s) may reduce cardiopulmonary arrests and [patient] mortality.

Transylvania Regional Hospital does have a Rapid Response Team in the hospital.

**When to call:**
♦ Anyone who is concerned about a patient’s unexpected declining condition should be encouraged to call the Rapid Response Team
♦ If a noticeable change in the patient occurs that needs immediate attention and the healthcare team is not recognizing the concern.
♦ If there is a breakdown in how care is being given and/or confusion over what needs to be done for the patient in an emergent situation.

**To ACCESS the Rapid Response Team, call 888 on a hospital phone.**
A call to this team provides our patients and families an avenue to call for immediate help if they feel they are not receiving adequate medical attention in an emergent situation!
Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery

The Universal Protocol applies to all surgical and nonsurgical invasive procedures. The Universal Protocol is based on the following principles:
♦ Wrong-person, wrong-site, and wrong-procedure surgery can and must be prevented.
♦ A robust approach using multiple, complementary strategies is necessary to achieve the goal of always conducting the correct procedure on the correct person, at the correct site.
♦ Active involvement and use of effective methods to improve communication among all members of the procedure team are important for success.
♦ To the extent possible, the patient and, as needed, the family are involved in the process.
♦ Consistent implementation of a standardized protocol is most effective in achieving safety.

UP.01.01.01
Conduct a preprocedure verification process.

Rationale for UP.01.01.01
The preprocedure verification is an ongoing process of information gathering and verification, beginning with the decision to perform a procedure, continuing through all settings and interventions involved in the preprocedure preparation of the patient, up to and including the time-out just before the start of the procedure.

The purpose of the preprocedure verification process is to make sure that all relevant documents and related information or equipment are:
♦ Available prior to the start of the procedure.
♦ Correctly identified, labeled, and matched to the patient’s identifiers.
♦ Reviewed and are consistent with the patient’s expectations and with the team’s understanding of the intended patient, procedure, and site.
Missing information or discrepancies are addressed before starting the procedure.

Elements of Performance for UP.01.01.01
1. Verification of the correct person, correct site, and correct procedure occurs at many of the possible times:
   ♦ At the time the procedure is scheduled
   ♦ At the time of preadmission testing and assessment
   ♦ At the time of admission or entry into the facility for a procedure, whether elective or emergent
   ♦ Before the patient leaves the preprocedure area or enters the procedure room
   ♦ With the patient involved, awake and aware, if possible
2. When the patient is in the preprocedure area, immediately prior to moving the patient to the procedure room, a checklist (for example, paper, electronic, or other medium such as a wall-mounted whiteboard) is used to review and verify that the following items are available and accurately matched to the patient:
   ♦ Relevant documentation (for example, history and physical, nursing assessment, and pre-anesthesia assessment)
   ♦ Accurately completed, and signed, procedure consent form
   ♦ Correct diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly labeled
   ♦ Any required blood products, implants, devices, and/or special equipment for the procedure
UP.01.02.01
Mark the procedure site.

Rationale for UP.01.02.01
Marking the procedure site allows staff to identify without ambiguity the intended site for the procedure.

Elements of Performance for UP.01.02.01
1. Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.
   Note: For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level.

2. The procedure site is initially marked before the patient is moved to the location where the procedure will be performed and takes place with the patient involved, awake and aware, if possible.

3. The procedure site is marked by a licensed independent practitioner or other provider who is privileged or permitted by the critical access hospital to perform the intended surgical or nonsurgical invasive procedure. This individual will be involved directly in the procedure and will be present at the time the procedure is performed.
   Note: Final confirmation and verification of the site mark takes place during the time-out.

4. The method of marking the site and the type of mark is unambiguous and is used consistently throughout the critical access hospital.

5. The site marking has the following characteristics:
   ♦ It is made at or near the procedure site or the incision site. Other nonprocedure site(s) are not marked unless necessary for some other aspect of care.
   ♦ It includes, preferably, the surgeon’s or proceduralist’s initials, with or without a line representing the proposed incision.
   ♦ It is made using a marker that is sufficiently permanent to remain visible after completion of the skin prep and sterile draping.
   ♦ Adhesive site markers are not to be used as the sole means of marking the site.
   ♦ It is positioned to be visible after the patient has his or her skin prepped, is in his or her final position, and sterile draping is completed.

6. For spinal procedures, in addition to pre-operative skin marking of the general spinal region, special intraoperative radiographic techniques are used for marking the exact vertebral level.
Elements of Performance for UP.01.02.01

7. A defined, alternative process is in place for patients who refuse site marking or who cannot easily be marked under the following conditions:

♦ For cases in which it is technically or anatomically impossible or impractical to mark the site (mucosal surfaces, perineum, premature infants), an alternative method for visually identifying the correct side and site is used. For example, the critical access hospital may place a temporary, unique wrist band on the side of the procedure containing the patient’s name, and use a second identifier for the intended procedure and site.

♦ For minimal access procedures that intend to treat a lateralized internal organ, whether percutaneous or through a natural orifice, the intended side is indicated by a mark at or near the insertion site, and remains visible after completion of the skin prep and sterile draping.

♦ For interventional procedure cases for which the catheter/instrument insertion site is not predetermined (for example, cardiac catheterization, pacemaker insertion).

♦ For teeth, the operative tooth name(s) and number are indicated on documentation or the operative tooth (teeth) is marked on the dental radiographs or dental diagram. The documentation, images, and/or diagrams are available in the procedure room before the start of the procedure.

♦ For premature infants, for whom the mark may cause a permanent tattoo.

UP.01.03.01

A time-out is performed immediately prior to starting procedures.

Rationale for UP.01.03.01
The purpose of the time-out immediately before starting the procedure is to conduct a final assessment that the correct [patient], site, positioning, and procedure are identified and that, as applicable, all relevant documents, related information, and necessary equipment are available.

The time-out is consistently initiated by a designated member of the team and includes active communication among all relevant members of the procedure team. It is conducted in a standardized fail-safe mode (that is, the procedure is not started until all questions or concerns are resolved).

Elements of Performance for UP.01.03.01

1. The time-out is conducted prior to starting the procedure and, ideally, prior to the introduction of the anesthesia process (including general/regional anesthesia, local anesthesia, and spinal anesthesia), unless contraindicated.
2. The time-out has the following characteristics:
   ♦ It is standardized (as defined by the critical access hospital).
   ♦ It is initiated by a designated member of the team.
   ♦ It involves the immediate members of the procedure team including the proceduralist's), the anesthesia providers, the circulating nurse, the operating room technician, and other active participants as appropriate for the procedure, who will be participating in the procedure at its inception.
   ♦ It involves interactive verbal communication between all team members, and any team member is able to express concerns about the procedure verification.
   ♦ It includes a defined process for reconciling differences in responses.

3. During the time-out, other activities are suspended, to the extent possible without compromising patient safety, so that all relevant members of the team are focused on the active confirmation of the correct patient, procedure, site, and other critical elements.

4. When two or more procedures are being performed on the same patient, a time-out is performed to confirm each subsequent procedure before it is initiated.

5. The time-out addresses the following:
   ♦ Correct patient identity
   ♦ Confirmation that the correct side and site are marked
   ♦ An accurate procedure consent form
   ♦ Agreement on the procedure to be done

6. The completed components of the Universal Protocol and time-out are clearly documented.

Transylvania Regional Hospital is dedicated to safe patient care!!!
Every employee, volunteer, family member, patient, clinical student, non-employee affiliated staff, etcetera is a partner in care when it comes to patient safety.

What are your direct responsibilities and accountability involving quality, safe patient care?
Are you consistently compliant with safety practices?