Proposed 2006 National Patient Safety Goals and Requirements and Rationale Statements – Hospital & Critical Access Hospital Programs

Existing Goal 2
Improve the effectiveness of communication among caregivers.

Proposed Requirement 2E
Implement a process to resolve questions concerning hand-off-communications, such as face-to-face interdisciplinary change-of-shift debriefings.

> **Rationale:** Communication has been identified by Joint Commission Sentinel Event and USP MEDMARX databases as one of the common, contributing root causes in sentinel events. Hand-off communication is the transfer of information about a patient's state and care plan. The literature also suggests that nursing shift report and the transfer of information between care providers during transitions in responsibility for patients represent areas for potential improvement.

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Goal 3
Improve the safety of using medications.

~~**Requirement 3A**~~
~~Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride >0.9%) from patient care units.~~

Note: Retirement is being proposed for this NPSG requirement in 2006.

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Existing Goal 3:
Improve the safety of using medications.

Proposed Requirement 3D
Whenever possible, eliminate the use of multiple dose medication vials.

Proposed Requirement 3E
When multiple dose vials are used, take appropriate steps to minimize the risk of transmission of infection between patients.

> **Rationale:** There is a greater potential for multiple dose medication vials to become contaminated and increase the transmission of infections (such as Hepatitis B & C) than single dose vials. Poor technique or lack of knowledge has resulted in contamination and once compromised, a multi-dose vial can spread infection to many patients.

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Existing Goal 3:
Improve the safety of using medications.

Proposed Requirement 3F
Determine the potential for wrong line connections when selecting and acquiring catheters and other clinical lines.

Proposed Requirement 3G
Identify and catalogue catheters and other clinical lines in use throughout the organization with specific attention to the types and interconnectability of connectors.

Proposed Requirement 3H
Identify and take action to minimize the risk of inappropriate clinical line connections.

> **Rationale:** Medications, enteral feedings or other unintended clinical line connections may accidentally be made because many lines look alike. Multiple causative factors (such as numerous lines, distractions, undifferentiated lines with compatible connectors) may contribute to the unintended inter-connection of clinical lines. Sentinel events have been reported from unintended connections including wrong route or wrong source (such as an IV bag or air supply line).

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Existing Goal 3:
Improve the safety of using medications.

Proposed Requirement 3I
Establish a list of medications that can be given intrathecally and ban all other injectable medication from rooms, such as oncology treatment rooms.

Proposed Requirement 3J
Require at least two health professionals to independently verify and document the accuracy of all intrathecal doses before administration.

Proposed Requirement 3K
When dispensing Vincristine Sulfate Injection, the container or syringe (holding the individual does prepared for administration to the patient) must be enclosed in an overwrap bearing the statement "DO NOT REMOVE COVERING UNTIL MOMENT OF INJECTION. FATAL IS GIVEN INTHRATHECALLY. FOR INTRAVENOUS USE ONLY".

Proposed Requirement 3L
Where chemotherapy services are provided, develop and enforce policies and procedures to prevent accidental intrathecal injection of IV drugs.

> **Rationale:** The magnitude of the risk of administrating the wrong medication intrathecally or epidurally is significant.

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Existing Goal 3:
Improve the safety of using medications.

Proposed Requirement 3M
Label all medications, medication containers (e.g., syringes, medicine cups, basins), or other solutions on and off the sterile field**.**

> **Rationale:** This risk reduction activity is consistent with safe medication practices and addresses a recognized risk point in the safe administration of medications in the perioperative settings.

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Goal 5
Improve the safety of using infusion pumps.

~~**Requirement 5A**~~
~~Ensure free-flow protection on all general-use and PCA (patient controlled analgesia) intravenous infusion pumps used in the organization.~~

Note: Retirement is being proposed for this NPSG requirement in 2006.

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

Existing Requirement 8A
~~During 2005, for full implementation by January 2006, develop)~~ Implement a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission**)** to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.

Note: Language updated to reflect 2006 expectations.

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

Proposed Requirement 9B
Implement a fall reduction program, including a transfer protocol, and evaluate the effectiveness of the program.

Note: This requirement is currently applicable to other accreditation programs and is now proposed for inclusion as a requirement for the Hospital Program.

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Existing Goal 10:
Reduce the risk of influenza and pneumococcal disease in older adults.

Proposed Requirement 10A
Develop and implement a protocol for administration and documentation of the flu vaccine.

Proposed Requirement 10B
Develop and implement a protocol for administration and documentation of the pneumococcus vaccine.

Note: This goal, and its requirements, are currently applicable to other accreditation programs and are now proposed for inclusion as requirements for the Hospital Program.

> **Rationale:** The CDC reports a vaccination rate of less than 50% for many populations. In 2004, it is estimated that there were 60,000 cases and 6,700 deaths annually in the United States of Streptococcus pneumoniae. Each year, *S. pneumoniae* infections cause 100,000-135,000 hospitalizations for pneumonia, 6 million cases of otitis media, and over 60,000 cases of invasive disease, including 3300 cases of meningitis. Children, older adults and individuals with compromised health are at greatest risk. Vaccines have proven effective in eliminating or reducing the severity of flu or pneumococcus disease.

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Existing Goal 11:
Reduce the risk of surgical fires.

Proposed Requirement 11A
Educate staff, including operating licensed independent practitioners and anesthesia providers, on how to control heat sources and manage fuels with enough time for patient preparation, and establish guidelines to minimize oxygen concentration under drapes.

Note: This goal, and its requirements, are currently applicable to other accreditation programs and are now proposed for inclusion as requirements for the Hospital Program.

> **Rationale**: Data from the Food and Drug Administration (FDA) and ECRI, an independent nonprofit health services research agency—indicate that there are approximately 100 surgical fires each year out of two and one-half million operations resulting in up to 20 serious injuries and one or two patient deaths annually. Although the occurrence of fires in surgery is relatively low, it can result in permanent harm or death.

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Proposed Goal 13
Achieve and maintain an organization-wide culture of safety.

Proposed Requirement 13A:
At least annually, use an evidence-based test instrument assessment to assess ~~of~~ the organization's safety culture.

Proposed Requirement 13B:
Implement changes, as appropriate, in response to findings of the safety culture assessment.

Proposed Requirement 13C
Encourage external reporting of significant adverse events.

Proposed Requirement 13D
Use external, expert information when designing new or modifying existing processes to improve patient safety and reduce the risk of sentinel events.

Proposed Requirement 13E
Disseminate lessons learned from root cause analyses conducted by the organization with all staff who provide relevant services or may be impacted by the proposed solutions.

Proposed Requirement 13F
Increase awareness of and access to relevant patient safety literature and advisories for all organization leaders and staff.

> **Rationale**: Research indicates that creation of an organizational culture of safety is widely embraced as a construct towards improving patient and staff safety.

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Proposed Goal 1□:
Encourage patients' active involvement in their own care as a patient safety strategy.

Proposed Requirement 1□A
Assess patients' health literacy level, language skills, and ethnic and cultural factors to guide patient education and involvement in their own care.

Proposed Requirement 1□B
Provide each patient with a copy of his/her Medication Administration Record and assist the patient to use it to track his/her own medication use, such as by checking off medications as they are administered.

Proposed Requirement 1□C

Implement a comprehensive patient involvement program such as the Joint Commission's SpeakUp Campaign.

Proposed Requirement 1□D
Encourage patient participation on organization committees that relate to planning or providing patient care services.

Proposed Requirement 1□E
Engage patients in the process of transitions across the continuum of care, including a dialogue about their expectations and concerns about the next setting of care.

Proposed Requirement 1□F
Define and communicate the means for patients to report concerns about safety and encourage them to do so.

> **Rationale**: Patient involvement in care, treatment and services; as well as patient education and communication need to be appropriate to the patient as well as the patient's interest and ability to participate in his/her own care. Research shows patients who are active participants in their care experience better outcomes than those who are not similarly engaged.

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Proposed Goal 15:
Prevent patient harm associated with health care worker fatigue.

Proposed Requirement 15A
At least annually, assess staff perception of the degree to which fatigue impacts the safety of care and, as appropriate, take action to minimize that impact.

Proposed Requirement 15B
Provide staff education on recognizing fatigue in self and others, and on strategies to minimize and manage fatigue in the health care workplace, with special attention to second and third shift staff.

Proposed Requirement 15C
Provide additional procedural, technological and/or staff support for staff working shifts of more than 12 hours.

> **Rationale:** The use of extended work shifts and overtime has escalated as organizations address professional staffing shortages. Research shows that the risk of making an error significantly increases when a work shift exceeds 12 hours, when overtime was worked or when work hours exceeded more than forty hours a week. Research also shows that interns made substantially more medical errors when they worked frequent shifts of 24 hours or more.

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Proposed Goal 16
Prevent health care associated decubitus ulcers.

Proposed Requirement 16A
Assess and periodically reassess each patient's risk for developing a decubitus ulcer (pressure sore) and take action to address any identified risks.

Proposed Requirement 16B
Identify patients who enter the organization with a decubitus ulcer and provide appropriate medical, physical and nutritional management to facilitate healing.

> **Rationale:** Most pressure ulcers can be prevented and deterioration at Stage I pressure ulcers can be halted. The prevalence rate of decubitus ulcers in skilled and long term care is approximately 23%. In acute care facilities there is a prevalence rate of 9%. Clinical practice guidelines may be used effectively to identify patients at risk and define early interventions for prevention of pressure ulcers

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Proposed Goal 17
Eliminate patient harm associated with the use of anticoagulants, insulin, and narcotic analgesics.

Requirement 17A
Develop, and implement an interdisciplinary plan to assure safe practices in the use of anticoagulants, insulin, and narcotic analgesics throughout the organization.

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Proposed Goal 18
Reduce the risk of harm associated with emotional and behavioral crisis.

Requirement 18A
Provide clients and their families with 24-hour contact information for emotional and behavioral crisis assistance.

Requirement 18B
Train all direct care staff in the organization's process for dealing with clients in emotional and behavioral crisis.

> **Rationale:** Individuals being evaluated or treated for emotional and behavioral issues should have ready access to a 24 hour crisis assistance call center. As part of a proactive, patient safety program, individuals or family members of individuals at risk for emotional or behavioral crisis should readily know what resources are available.