

The Joint Commission National Patient Safety Goals

By Ivy K. O'Rourke, RN, BSN, MBA, CEN

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The ECI Nexus[®] is devoted to exploring "hot topics" in emergency medicine. NEXUS describes the role that care providers have in the health care arena: the NEXUS between the emergency care and the patient, between one ancillary department and another, between patients and their family members, and between EMS and the hospital. We hope this newsletter offers you information that is timely and useful. We invite you to submit articles or story ideas to ECI at any time.

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The Joint Commission is the regulatory body under which the vast majority of ECI-affiliated facilities are accredited. Even if your facility is accredited under the American Osteopathic Association's (AOA) Healthcare Facilities Accreditation Program (HFAP), you can use The Joint Commission Pre-Survey Guide and other information provided by ECI's Education Department to make sure that you are compliant with all standards and requirements. In general, HFAP's standards are somewhat less stringent, so if you meet The Joint Commission's standards you will be in good shape for HFAP as well.

The Joint Commission is issuing an entirely new manual in the near future that will be effective as of January 1, 2009.

The pre-print files are currently available on The Joint Commission's website at www.jointcommission.org and can be downloaded for free. The Education Department will be sending out additional information to all of you near the first of the year.

The National Patient Safety Goals (NPSG) for 2009 have also been released and contain some additions for the upcoming year. This article discusses those changes, but please bear in mind that it is not a complete list of the NPSG, only the changes that affect the emergency department. Many of these are similar to, if not the same as, the HFAP Patient Safety Initiatives issued in December 2006. We have added some comments which are in red.

NPSG.01.03.01 **Eliminate transfusion errors related to patient misidentification.**

Elements of Performance for NPSG.01.03.01

1. 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.

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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.

2. 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.
3. When using a two-person bedside or chair-side verification process, the second individual conducting the identification verification must be qualified to participate in the process.

NPSG.03.04.01

Label all medications, medication containers (for example, syringes, medicine cups, basins), or other solutions on and off the sterile field.

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. *This would apply if you set up a tray ahead of time and pour a solution such as Betadine® or Hibiclens® in a cup on the tray.*
2. Labeling occurs when any medication or solution is transferred from the original packaging to another container. *An example would be pouring saline into an irrigation bottle to irrigate a foley cath, NG tube, or a bag for lavage of an overdose patient.*
3. Medication or solution labels include the medication name, strength, amount (if not apparent from the container), expiration date when not used within 24 hours, and expiration time when

expiration occurs in less than 24 hours. *Don't forget that this applies to IVs as well as other meds. Pour saline must be discarded 24 hours after opening.*

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. No more than one medication or solution is labeled at one time.
6. Any medications or solutions found unlabeled are immediately discarded.
7. All original containers from medications or solutions remain available for reference in the perioperative or procedural area until the conclusion of the procedure.
8. All labeled containers on the sterile field are discarded at the conclusion of the procedure.
9. At shift change or break relief, all medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting personnel.

NPSG.07.03.01

Implement evidence-based practices to prevent health care associated infections due to multiple drug-resistant organisms in acute care 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.

Note 2: This requirement has a one-year phase-in period that includes defined expectations for planning, development, and testing (milestones) at three, six, and nine months in 2009, with the expectation of full implementation by January 1, 2010.

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Elements of Performance for NPSG.07.03.01

1. As of April 1, 2009, the hospital's leadership has assigned responsibility for oversight and coordination of the development, testing, and implementation of NPSG.07.03.01.
2. Number 2 – 5 not included here – not applicable to the ED.
6. As of January 1, 2010: Based on the results of the risk assessment, the hospital educates staff and licensed independent practitioners about health care associated infections, multi-drug 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 hospital. (See also HR.01.05.03, EP 4)

7. As of January 1, 2010: The hospital educates patients, and their families as needed, who are infected or colonized with a multi-drug resistant organism about health care associated infection strategies. **This should be covered in the after-care instructions given to the patient at discharge.**

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.

Note 2: This requirement has a one-year phase-in period that includes defined expectations for planning, development,



and testing (“milestones”) at three, six, and nine months in 2009, with the expectation of full implementation by January 1, 2010.

Elements of Performance for NPSG.07.04.01

1. As of April 1, 2009, the hospital's leadership has assigned responsibility for oversight and coordination of the development, testing, and implementation of NPSG.07.04.01.
2. As of July 1, 2009, an implementation work plan is in place that identifies adequate resources, assigned accountabilities, and a time line for full implementation of NPSG.07.04.01 by January 1, 2010.
3. As of October 1, 2009, pilot testing in at least one clinical unit is under way, for the requirements in NPSG.07.04.01.
4. As of January 1, 2010, the elements of performance in NPSG.07.04.01 are fully implemented across the hospital.
5. As of January 1, 2010: The hospital educates health care workers who are involved in these procedures about

health care associated infections, 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.

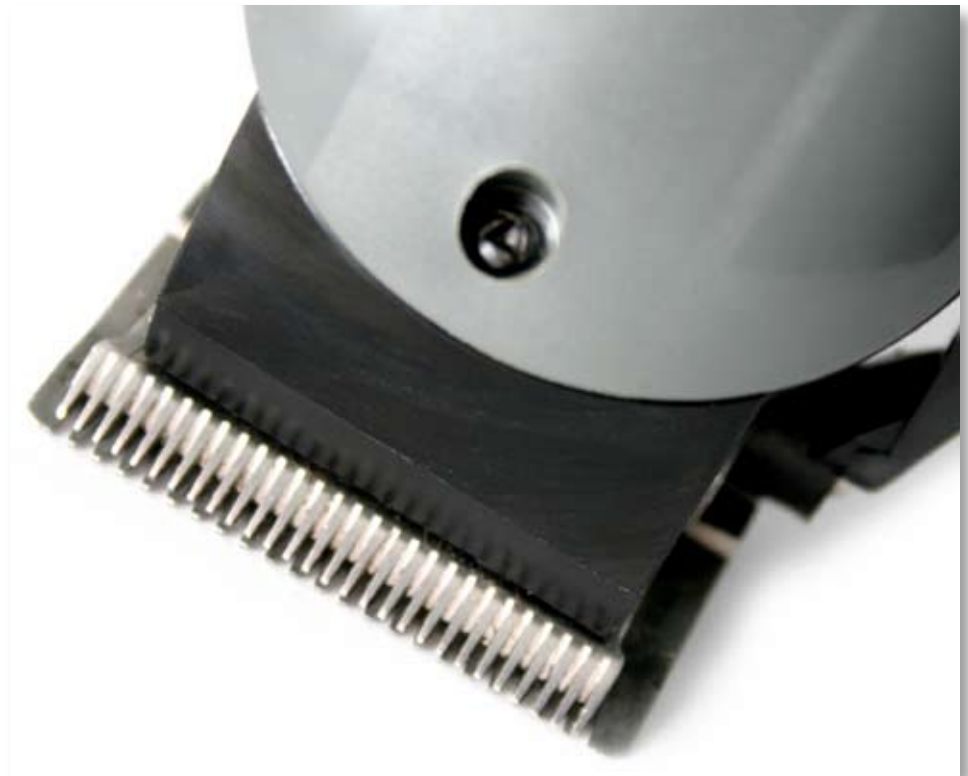
6. As of January 1, 2010: Prior to insertion of a central venous catheter, the hospital educates patients, and their families as needed, about central line-associated bloodstream infection prevention. **You may find that you need a written document and hospitals will most likely require a separate consent form that states the patient has been educated.**
7. As of January 1, 2010: The hospital implements 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).

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8. As of January 1, 2010: The hospital conducts periodic risk assessments for surgical site infections, measures central line-associated bloodstream infection rates, monitors compliance with best practices or evidence-based guidelines, and evaluates the effectiveness of prevention efforts.
9. As of January 1, 2010: The hospital provides central line-associated bloodstream infections rate data and prevention outcome measures to key stakeholders including leaders, licensed independent practitioners, nursing staff, and other clinicians.
10. As of January 1, 2010: Use a catheter checklist and a standardized protocol for central venous catheter insertion.
Look for this to come in the future.
11. As of January 1, 2010: Perform hand hygiene prior to catheter insertion or manipulation.
12. As of January 1, 2010: For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable.
13. As of January 1, 2010: Use a standardized supply cart or kit that is all inclusive for the insertion of central venous catheters.
14. As of January 1, 2010: Use a standardized protocol for maximum sterile barrier precautions during central venous catheter insertion.
15. As of January 1, 2010: Use a chlorhexidine-based antiseptic for skin preparation during central venous catheter insertion in patients over two months of age, unless contraindicated.
This means you will be using Hibiclens® or a similar product rather than Betadine® for skin prep on a routine basis.
16. As of January 1, 2010: Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports.
As of January 1, 2010: Evaluate all central venous catheters routinely and remove nonessential catheters.



NPSG.07.05.01 **Implement best practices for preventing surgical site infections.**

Note: This requirement has a one-year phase-in period that includes defined expectations for planning, development, and testing (“milestones”) at three, six, and nine months in 2009, with the expectation of full implementation by January 1, 2010.

As of January 1, 2010: When hair removal is necessary, the hospital uses clippers or depilatories.

Note: Shaving is an inappropriate hair removal method.

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 the patient’s family as needed, and the list is explained to the patient and/or family.

Elements of Performance for NPSG.08.03.01

When the patient leaves the hospital’s care, the current list of reconciled medications is provided and explained to the patient, and their family as needed. This interaction is documented. Although this is only required if you are making a change to the patient’s medications, the facility you work at may require you to do this for all patients so that it becomes habit.

Note: Patients and families are reminded to discard old lists and to update any records with all medication providers or retail pharmacies.

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NPSG.08.04.01

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

Note: A number of patient care settings exist in which medications are not used, are used minimally, or 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 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 pre-procedure 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 their family as needed, is provided with a list containing the short term medication additions that the patient will continue after leaving the 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
 - a. any new long term (chronic) medications are prescribed
 - b. there is a prescription change for any of the patient's current, known long-term medications.
 - c. the patient is required to be subsequently admitted to an organization from these settings for ongoing care.
4. 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.

NPSG.13.01.01

Encourage patients' active involvement in their own care as a patient safety strategy.

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, services and patient safety issues.
4. The hospital encourages patients and their families to report concerns about safety.

Although there are a number of changes and additions to the goals, most of the requirements are things that you most likely already do in your daily practice. The easiest way to assure that you are in full compliance when The Joint Commission or AOA make their next visit to your facility is to practice continual readiness, and start making the changes required by the goals a part of your routine practice. That way you will not have to try to remember the "right" way to do things when surveyors are present.

Many of the HFAP standards are very similar to those of The Joint Commission. There are some minor difference and additions. The full list of HFAP's Patient Safety Initiative standards are available on the HFAP website at www.hfap.org and The Joint Commission National Patient Safety Goals are available at www.jointcommission.org.

References:

The Joint Commission. Hospital Accreditation Program - Accreditation Requirements: 2009 National Patient Safety Goals Hospital Program. http://www.jointcommission.org/PatientSafety/NationalPatient/09_hap_npsgs.htm. Updated July 1, 2008. Accessed July 1, 2008

EMTALA Update

By Ivy K. O'Rourke, RN, BSN, MBA, CEN

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal statute that those working in emergency medicine are painstakingly familiar with. The interpretation of the letter of the law continues to evolve due to the influence of occurrences in both the medical and legal fields.

The following is a brief recap of several of the more recent changes to the interpretation of the statute as delineated in the Centers for Medicare and Medicaid Services (CMS) State Operations Manual. This is not an all-inclusive list of changes.

Further information can be obtained at: <http://www.cms.hhs.gov/surveycertificationinfo/downloads/SCLetter08-15.pdf>.

On-Call Requirements and Remote Consultation Utilizing Telecommunications Media

The interpretative guidelines clarify that there is no EMTALA prohibition against the treating physician consulting on a case with another physician, who may or may not be on the hospital's or CAH's on-call list, by telephone, video conferencing, transmission of test results, or any other means of communication.

This does not change the requirement that a physician who is on-call make an in-person appearance in the dedicated ED **when requested to do so** by the treating physician.

Revisions to Special Responsibilities of Hospitals to Accept Transfers

Clarification was made regarding acceptance of patient transfers to a hospital with specialized capabilities, such as a specialty hospital (eg Heart Hospital) that does not have an ED. CMS advises that the facility:

*may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual. **This requirement applies to any participating hospital with specialized capabilities, regardless of whether the hospital has a dedicated emergency department.***

The definition of hospital with specialized capabilities was also clarified as being a hospital that has capabilities that the transferring hospital does not.

“Parking” of Emergency Medical Service Patients

Following reports that several hospitals routinely prevent Emergency Medical Service (EMS) staff from transferring patients from their ambulance stretchers to a hospital bed or gurney, including patients being left on EMS stretchers (with EMS staff in attendance) for extended periods of time, the issue was addressed by CMS.

CMS has stated that the agency “recognizes the enormous strain and crowding many hospital emergency departments face every day; however, this practice is not a solution.” They clarify that a hospital has an EMTALA obligation as soon as a patient “presents” and a request is made on the individual's behalf for examination or treatment of an emergency medical condition. The guidelines further state that CMS considers such practices to be a threat to the health of the community, so it is recommended that you do everything possible to avoid this practice.

Waiver of EMTALA Sanctions in Hospitals Located in Areas Covered by a Public Health Emergency Declaration

Hospitals with dedicated emergency departments in an emergency area (as defined below) will not, for a 72-hour period starting with each hospital's activation of its hospital disaster protocol, be subject to EMTALA sanctions for:

- “Redirecting individuals seeking an MSE when a State emergency preparedness plan or a pandemic preparedness plan has been activated in the emergency area; or
- Inappropriate transfers arising out of the circumstances of the emergency.”

Conclusion

While the EMTALA statute itself may not necessarily change, the interpretation of the statute utilized by surveyors often does. 🦋

References:

Centers for Medicare and Medicaid Services. State Operations Manual Appendix V- EMTALA. Available at www.cms.hhs.gov. Accessed June 10, 2008.

State Court of Wisconsin. Appeal 2006AP3013. Wisconsin. January 2008. Available at: [http://op.bna.com/bl.nsf/id/bbrk-7b7tm3/\\$File/Wiscourt2008.htm](http://op.bna.com/bl.nsf/id/bbrk-7b7tm3/$File/Wiscourt2008.htm). Accessed June 10, 2008.

The Desert Medic

By Ivy K. O'Rourke, RN, BSN, MBA, CEN with Lieutenant Colonel John Carmack, MD



Lieutenant Colonel John Carmack, MD

Lieutenant Colonel (Dr.) John Carmack, Medical Director at Retreat Hospital in Richmond, Virginia, is currently deployed with the United States Air Force to Southwest Asia supporting our troops. He is part of the 379th Expeditionary Medical Group (EMDG) serving the men and women of Al Udeid Air Base. The 379th EMDG is a well-established organization providing medical care not only to Al Udeid active duty personnel but also supporting the medical needs for many other coalition forces, retirees, and civilian contractors working in the region.

LtCol John Carmack, who has worked mostly in the ED and primary care clinics, reports, "We see approximately 70 to 80 patients per day which keeps our team pretty busy. We see mostly 'in-garrison' type illnesses and injuries, but we have also had some very interesting medical cases, including a case of Eagle's Syndrome, a 35-year-old with

an AMI, a C-130 pilot with a large anterior mediastinal mass, and this week we had two cases of Q-Fever!"

"Our base also serves as a regional referral center for patients needing orthopedic and wound care from improvised explosive device (IED) or shrapnel injuries. The young soldiers in this Wounded Warrior Program are all sent here with the goal to heal them and get them 'back to the fight' within thirty days."

Dr. Carmack has also been working on the flight operations side in the flight medicine clinic, which he says has been very rewarding. "To be the flight doc for so many aircrews flying so many different airframes located in one deployed location is a flight surgeon's dream. I have had the opportunity to treat the aircrews who are taking the fight to the enemy. As an aircrew member, I have also had the opportunity to fly multiple operational missions into Iraq and Afghanistan. The rapid descent and sharp banking turns of a combat landing on a C-130 into a forward operating air base is both exciting and a little scary. The body armor and flight helmets we wear while

flying serve as constant reminders that we are in a combat zone. Watching these aircrews in action exemplifies the skill and professionalism of our Air Force. I have a tremendous amount of respect for all our Airmen serving in this part of the world."

"Routine life here is very hot and very focused. Being in a deployed location has a way of clearing the noise in your life. I am proud to be here and proud to be a part of this history," reports Carmack. Dr. Carmack will be welcomed home by his family and friends later this summer.

I'm sure that all of you join us in extending a huge thanks to Dr. Carmack and all of our troops deployed throughout the world. ✈



▼ **Lieutenant Colonel John Carmack, MD (right) with Technical Sergeant Donald Barr, from Keesler AFB, Mississippi (left)**



Three Cheers!

ECI provides staffing and management services to LLPs in 15 states. These local groups represent emergency departments utilizing over 1,000 physicians, PAs, and Nurse Practitioners at more than 50 facilities. We're all spread out, but we have one thing in common: we care for people. In an effort to salute those who have done just that, we have reserved this space in the ECI Nexus to share accomplishments and kudos.



Debbie Lodes, is an ED patient care tech at Barnes-Jewish St. Peters Hospital. She was recently awarded the honor of “Employee of the Year” for the entire hospital. Debbie sets the bar in how a patient should be treated for all of us in health care. She is loved by coworkers and patients alike, and always does the little extras that brighten the day of patients and ED staff. Recently, Debbie was accepted to nursing school and will be a huge asset to her profession

Congratulations to Debbie for this great achievement and good luck to her in her new endeavors!

Jude Reed, MD, FACEP
Emergency Department Medical Director
Barnes-Jewish St. Peters Hospital
St. Peters, MO

I would like to recognize **Rebecca Bauer, PA**. She works many shifts for us in the ED here at Missouri Baptist Sullivan. She goes “above and beyond” each shift she works. She is very compassionate to our patients, and the nurses love working with her. She always comes to work with a positive attitude. She sees patients promptly and meets their needs accordingly. It is a pleasure to have her working on our team.

Zelda Shelton, RN
ED/Med/Surg/CCU Manager
Missouri Baptist Hospital-Sullivan
Sullivan, MO

Stephanie Sears, PA, and **Shelley Woodley, NP**, both have gone above and beyond for Virginia Emergency Physicians. We started our ED Express process at Henrico Doctors’ Hospital in September 2007. We had not previously worked with mid-level

providers. All of our mid-levels have been great as we work through a new process and hire enough staff to accomplish everything.

Both of these mid-levels also volunteered to be on committees to improve our processes, including our ED Express Team and our ED Triage Registration Team. They come in weekly to contribute to these teams as well as working overtime to be sure we are fully staffed. Their attitudes are positive, and I continuously hear from doctors and nurses in the ED about how great they are to work with. They have truly been an asset as we move forward in our goal of being the “Premier ED in the Richmond area.”

Tamera Barnes, MD, FACEP
Medical Director, Emergency Department
Henrico Doctors’ Hospital-Forest Campus
Richmond, VA

Van Tetidrick, RN, is one of our long time Charge Nurses and deserves recognition for his exceptional work. Recently, a child came in with parents who were afraid the child had eaten poisonous mushrooms. Van found a 1-800 number for poisonous mushroom consultants. He then had security take pictures of the mushrooms the child’s parents had brought with them and e-mailed the pictures to a poisonous mushroom expert in Chicago. The expert then called us in the ED to tell us the mushrooms were harmless. THREE CHEERS FOR VAN!

James Ellis, DO, FACEP
Chairman
Emergency Medicine
Provena Covenant Medical Center
Urbana, IL

Three Cheers! continued...



Mary O'Brien, RN, at Provena United Samaritans Medical Center in Danville, IL is an excellent clinical leader. She is an expert in Emergency Nursing and role models standards of care in her practice on a regular basis.

Mary recently received a Guardian Angel award from a patient who wrote eloquently about his experience under Mary's care, confident that her early recognition and response to his condition saved his life. During the presentation of this award, the Foundation noted that this was the most significant contribution made since the start of the Guardian Angel program.

Mary consistently arrives early to be available for night shift, demonstrating care and

concern by listening and following up on issues and concerns. She conducts chart reviews to identify opportunities for improvement and coaches staff respectfully about these opportunities. Mary also looks for opportunities to recognize staff for a job well done and encourages growth and development on an individual and team level. She works diligently to develop a nursing schedule that achieves maximum staffing and demonstrates fairness in scheduling decisions. Mary accepts responsibility for her actions and enjoys the opportunity for personal growth and development.

She recently completed the instructor course for the Trauma Nurse Core Curriculum with plans to offer this ENA-supported

training to our staff locally in an effort to reduce travel to enhance our staff's work-life balance. Her pursuit of this instructor level position also supports our value of Stewardship, as her commitment to this initiative will reduce training expenses associated with out-of-town training and registration.

Mary was a recipient of the Clinical Nurse Excellence award in the fall of 2007 for her excellence in the provision of competent, compassionate care. Mary advocates for her patients as if they were family members, anticipates their needs, and expedites care. She is also an advocate for staff; listening, investigating, reserving judgment, and then following up with support, encouragement, education, and sometimes a loving kick in the butt when necessary. Mary is respected by many for her clinical expertise, her work ethic, and her direct approach to problem resolution. She role models appropriate utilization of resources to achieve department goals, especially when she is in the Charge Nurse role, managing an overcrowded ER.

Staff enjoy her communication style, especially the smiley faces that have now become animated. Mary's number one priority is to make a difference in the lives of the patients we serve, one employee, one patient, one family member at a time. Evidence of this is found in her story published by the Studer Group in 2007 in their book, *What's Right in Health Care: 365 Stories of Purpose, Worthwhile Work, and Making a Difference*.

Nicole Boose, RN
Director of Emergency Services
Provena United Samaritans Medical Center
Danville, IL