Clinical Update

ATRIUM

Joint Commission Patient Safety Goals

The Joint Commission has established 2 new patient safety goals for 2008. Each has a one-year phase-in period with milestones to be reached at three, six, nine, and 12 months, with full implementation in place by January 2009. The first is part of medication safety, and requires organizations to implement plans to reduce the likelihood of harm to patients associated with anticoagulant therapy. As of March 31, 2007, medication errors made up 9.3% of Sentinel Events reported since January 1995, meaning 392 patients died or had a permanent loss of function as a result of a medication error. The top "high-alert" medications include: anticoagulants, opiates, insulin, and sodium chloride solutions greater than 0.9%. Injectable potassium chloride solution was on the list but when errors persisted even after packaging changes, it was removed from nursing units.

The second new goal requires organizations to establish mechanisms to quickly recognize and respond to changes in patients' conditions, and to enable staff members to directly request assistance from specially trained people when a patient's condition appears to be worsening. Many hospitals have already addressed this need by setting up Rapid Response Teams that can be summoned by anyone, including patients' family members.

The healthcare-associated infections section has been modified to allow organizations to use the hand hygiene guidelines from the World Health Organization (WHO) or the Centers for Disease Control and Prevention as standards.

Chest tubes are addressed specifically in three elements of Joint Commission standards. In Critical Access Hospital 2006 Medication Management, Standard MM.2.30 states "Emergency medications and/or supplies, if any, are consistently available, controlled, and secured." Elements of performance A 11. states, "equipment and supplies available for treating emergency cases consist of at least airways, endotracheal tubes, ambu bag/valve/mask, oxygen, tourniquets, immobilization devices, nasogastric tubes, splints, IV therapy supplies, suction machine, defibrillator, cardiac monitor, *chest tubes* and indwelling urinary catheters."

FAQs for the 2007 Patient Safety Goals specifically mentions chest tubes in two places. First, it mentions chest tubes as a potential risk factor for falls, under the category of equipment attached to the patient. Clinicians can reduce this risk by updating chest tube management policies and procedures to reflect the latest research showing patients do not routinely need to have chest drains attached to wall vacuum in order for the chest tube to remove air and fluid from the chest. In addition, using smaller, mobile chest drains such as Express Mini 500™ can also help reduce the patient's fall risk because the drain can be gently strapped to the body. Second, the FAQs address site marking during bedside procedures, such as chest tube insertion. Since bedside procedures carry significant risk of a wrong site or wrong patient procedure, the clinician should consider the timing of the procedure and the continuity of contact between the patient and the practitioner performing the procedure. If the practitioner is with the patient from the time the decision to insert the chest tube is made, until consent is obtained and the procedure begun, site marking is not required. However, if the practitioner leaves the patient at any time, the site should be clearly marked and verified before the procedure commences. In an emergency situation, patient safety should not be compromised by any delay that can be caused by site marking. Typically, the practitioner is in constant attendance in these sorts of emergency situations. However, unless the risk outweighs the benefit, a "time out" to verify the correct patient, site (right/left) and procedure with other team members is appropriate.

In review, the National Patient Safety Goals include the following, with specific criteria established for different patient care settings (2008 items in *italic*):

- Patient identification
- Improve communication
- Medication safety
  - *Reduce the likelihood of harm associated with anticoagulation therapy*
- Healthcare-associated infections
  - Comply with CDC *or WHO* hand hygiene guidelines
- Reconcile medications
- Reduce falls
- Influenza and pneumococcal disease
- Surgical fires
- Implement National Patient Safety Goals
- Patient involvement
- Pressure ulcers
- Risk assessment
- Change in patient condition
  - *Improve recognition and response to changes in patients' conditions*
  - *Establish a method that enables staff to directly request assistance from specially trained people when a patient's condition appears to be worsening*
- Universal protocol for preventing wrong site, wrong person, wrong procedure surgery

Check Your Knowledge...

Q. Should an X be used to mark the correct surgical or procedure site?

Answer on other side

In The Literature

Recognize Stress, Then Manage It

The current issue of *Nursing Economic$* reports on a study from Old Dominion University in which professors of nursing leadership examined the effect stress has on productivity and nurse retention. Today, in addition to the usual stressors of too much work, not enough time, and physical challenges, intergenerational conflict has been added to the mix. While the authors do not offer a single solution to the problem, they point out that it is critical that nurse executives actively acknowledge stress and its consequences as a major challenge for nursing staff and provide a variety of ways for nurses to individualize their stress management strategies.

Source: Milliken TF, Clements PT, Tillman HJ: The impact of stress management on nursing productivity and retention. *Nursing Economic$* 2007;25(4):203-210.

Factors Associated with UTI

Researchers from Brisbane, Australia and Houston, TX collaborated to publish a study on analysis of a general hospital population to determine the factors associated with healthcare-associated UTI. Through sophisticated statistical analysis, the authors identified the following patient characteristics as risk factors for developing UTI: prolonged length of stay, presence of a urinary catheter, male, unresolved spinal injury, fracture/dislocation, transfer from or to another hospital, underlying neurological disease, some assistance with ADLs required prior to admission, and previous stroke. The first three risk factors are well documented in the literature, but the remaining were not as well reported. Other reported factors such as diabetes, ethnicity, and other infections were not found to be statistically significant in this study of 4157 consecutive hospital admissions.

Source: Graves N, Tong E, Morton AP, et al.: Factors associated with health care-acquired urinary tract infection. *American Journal of Infection Control* 2007;35:387-392.

Reducing MRSA Harm

The Institute for Healthcare Improvement is committed to improving healthcare quality by reducing the 40,000 incidents of "medical harm" that happen daily in the US health system. The VA Pittsburgh Healthcare System was able to reduce MRSA infection in two acute care units over a four year period. A report in the current issue of *Nursing Management* describes how they did it. After some traditional approaches on pilot units, interventions were expanded to other units by using the model of positive deviance; that is, the belief that certain individuals or groups practice in such a way as to find better solutions to common problems than their peers, even with equal access to resources. This model builds on internally generated successes. It worked: in eight months, the number of MRSA surgical site infections dropped from 40 to two.

This quick-read will help you learn how to facilitate change in your organization.

Source: Forsha B, Richmond I: Best-practice protocols reducing harm from MRSA. *Nursing Management* 2007;38(8):22-27.

On the World Wide Web

National Patient Safety Goals

The Joint Commission has set up a single Web page from which you can access a variety of information on patient safety goals. Here, the goals are outlined for each program (practice setting), you can download an updated PowerPoint presentation that includes the new goals for 2008, read frequently asked questions and a wealth of additional resources.

http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/

Hand Hygiene

We all learned in school that handwashing is the number one way to reduce the risk of healthcare-associated infections. The Joint Commission has added the hand hygiene guidelines from the World Health Organization to the guidelines from the Centers for Disease Control and Prevention as acceptable standards on which organizations can base their policies and procedures. Here are links to the WHO published guideline, and to the CDC entry page on hand hygiene, from which you can link to the guidelines, slide shows and other tools to help remind your clinical staff of the importance of hand hygiene.

http://www.who.int/patientsafety/events/05/HH_en.pdf

http://www.cdc.gov/handhygiene/

Look for a new blog written by newsletter editor Pat Carroll. Called Nurses' Wisdom From the Break Room, the blog is designed for discussion of clinical topics, challenging situations, and as a place to get clinical questions answered.

You can find it at http://nursing.advanceweb.com
In the navigation bar to the left, look for Community, then click on Nurse POV blog.

Check Your Knowledge...

A. An X should never be used to mark a surgical or procedure site because it could be misinterpreted as a mark indicating not to operate in that location. The Joint Commission suggests using the word YES to indicate the correct site, as it is unambiguous.

Source: http://www.jointcommission.org/NR/rdonlyres/98572685-815E-4AF3-B1C4-C31B6ED22E8E/0/07_HAP_NPSGs.pdf