



*Happy Nurses Day!*

From all of us at C&A, thank you for *caring*.

Enjoy Nurses Week: May 6-12, 2010

C&A E-Newsletter

April 26, 2010

### Modern Healthcare's 100 Most Powerful People

C&A is pleased to nominate Ann Scott Blouin for this prestigious, annual award given by Modern Healthcare.

To nominate Ann Scott Blouin, or the "Most Powerful" person of your choice, [click here](#).



Ann Scott Blouin,  
PhD, RN  
Executive Vice  
President of  
Accreditation  
and Certification  
Operations at  
The Joint  
Commission

## Fostering Proactive Infection Prevention through Regulatory Collaboration

### Reduce the Risk of Healthcare Acquired Infections

By: Nancy McLean, RN, BSN, MHSA, NHA  
Sharon Dills, MSN, RN  
Judy B. Courtemanche, RN, MS

Part 1 of this article, which appeared in the March edition of C&A News, provided the background surrounding the current focus on Healthcare Acquired Infections (HAI) and the Basic Principles related to this topic. Part 2 provides recommendations for increasing the organization's focus on reduction of healthcare acquired infections based on current Infection Prevention and Control studies.

#### Applicable Guidelines:

The Joint Commission, in recognizing this change in focus, altered the title of the chapter on Infection Control (IC) to Infection Prevention and Control in its accreditation manuals. The infection expert in the hospital should consider a change from "Infection Control Nurse" to "Infection Prevention Officer" and from "Infection Control Department" to "Infection Prevention Department." In acknowledging the change, the authors recommend that corresponding changes occur. These changes include:

1. Re-establishing organizational and internal department priorities based on their identified risks.
2. Promoting emphasis on prevention rather than detection and control.
3. Creation of new systems to support the shift from control to prevention.
4. Reallocation of resources from control to prevention.
5. Revision of policies and procedures to incorporate evidence-based guidelines. (8)

In tandem with the selection of the 2008 and 2009 Present on Admission indicator selection the Joint Commission increased the emphasis of Infection Prevention through the addition of both new National Patient Safety Goals (NPSG) and additional elements of

## Check Out C&A's Newly Revised Publications!

[All New - CMS CoP Compliance Forecaster](#)

[Life Safety Document Review Organizer System](#)

[Simplifying Regulatory Compliance: A Crosswalk of TJC & CMS Requirements](#)

[A Quick Reference for Hospital Accreditation](#)

[2010 S.O.A.R to Success \(Score Ongoing Accreditation Readiness\)](#)

## Quick Links

[Consulting Conferences](#)

[Webinars](#)

[Publications](#)

[Resources](#)

[About C&A](#)

performance added to existing NPSGs. NPSG number 7 contained two requirements in 2008, hand hygiene and analysis of deaths related to infections. Three additional sub-goals were added in 2009, prevention of multi-drug resistant organisms (MDROs), prevention of central line blood stream infections (CLBIs) and prevention of surgical site infections (SSIs.) (8) The requirements for all three of these include both a focus on prevention and the use of evidenced based guidelines by the organization to guide in its preventive care and treatment efforts.

It is also notable that Core Measure requirements for both the Joint Commission and CMS include the Surgical Care Improvement Project (SCIP) for surgical infection data reporting. The first seven of the 21 SCIP measures are related to Infections in the surgical patient (2). Core measure data is public data and available to anyone on both the Joint Commission website under "Quality Check" and the CMS website under "Hospital Compare." The informed healthcare consumer has the ability to easily access individual hospital data on these websites. This same consumer can logically select the "best performing" hospital for their healthcare needs.

Hospitals have long viewed the key participants in the success of the organization as a triad comprised of the hospital's governing body, administration and medical staff. We suggest that an organization is successful when all three groups are focused on the same strategic goals and working in harmony with each other to achieve the identified goals. This view of the elements of success is slowly morphing from a three sided figure into a 4 sided figure with the addition of a key group that had little say in healthcare activities in the past; the patient. Depicted in Figure 1, the key to success in healthcare is not the triangle of equal responsibility and accountability for safe, quality healthcare; it is the Diamond.

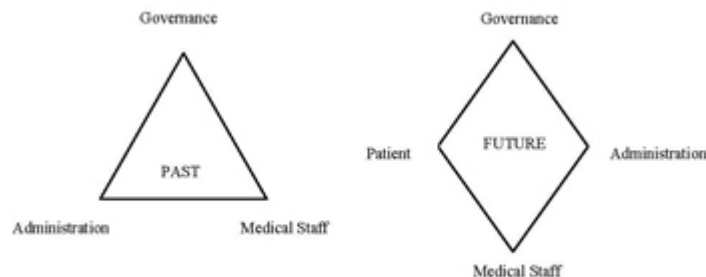


Figure 1

Embracing the patient as the key to prevention of infection requires an acceptance of the patient as an equal participant in the provision of healthcare and is essential to the success of the organization. Patients treated in hospitals today are often more informed on healthcare issues, treatment and services than in the past. The informed patient is not always considered an asset to the provision of healthcare but rather, may be viewed as an "annoyance." Many practitioners and hospital clinical staff continue to manifest paternalism when caring for the patient. If the patient asks the physician or staff to wash their hands, the patient may not receive a positive response or see the provider immediately wash or use hand gel. Instead, the patient may receive a curt remark or look intended to let the patient know they are the patient and the provider should not be questioned about this.

Unfortunately this reinforces a patient's fear about speaking up to prevent infection. Recognition that paternalism and other professional behaviors may exist is necessary to reduce potential barriers to patient involvement in infection prevention. Changing attitudes and practices to accept the patient as a member of the healthcare team is the key to success.

Infection prevention professionals can lead this initiative. In all parts of NPSG number 7 patient involvement and participation assist the organization in achieving success. Resources must be transferred to the prevention side of the equation rather than addressing the infection that occurs. Hand hygiene is one of the basic tenets to prevention success. Educating the patient on hand hygiene reduces infection risk. The hospital needs to provide hand hygiene education based on the hospital experience. The infection prevention professional should provide healthcare professionals with information to teach patients how they can help protect themselves from the introduction of infections. The authors suggest that the following information should be included in orientation to infection prevention:

1. The importance of hand-hygiene for all members (patient included) of the healthcare team
2. The use of hand gels
3. The location of hand gels
4. The need for hand hygiene prior to any direct contact or handling of any tube connected to the patient from a healthcare provider
5. How to politely remind the staff member to use hand gel prior to the provision of direct care or prior to touching any tubing connected to the patient
6. How to assist the healthcare professional in maintaining sterile technique when undergoing a procedure that requires introduction of a tube or percutaneous puncture. (As part of patient involvement, let the patient know that a tube should not come in contact with anything but... Ask the patient to be an additional set of eyes.)
7. Ask the patient to help monitor their own visitors for signs of infection, i.e., respiratory, that could be passed to the patient or staff and explain how they should address it if identified.
8. Request the patient's participation in educating visitors on hand hygiene and the use of hand gels while in the organization.

#### **Trends:**

Third party payers and regulatory and accrediting agencies including CMS, The Joint Commission, and other professional organizations such as Institute of Healthcare Improvement (IHI), American Medical Association (AMA), the American Nursing Association (ANA), the National Quality Forum (NQF) and the Agency for Healthcare Research and Quality (AHRQ), will continue to press hospitals for the elimination of HACs. CMS reduced payments for preventable complications and will continue to work with Congress on legislation to support adjusted payments based on quality outcomes and efficiency of care, also known as "Pay for Performance." The CDC's partnership in the selection of POA indicators will continue to provide evidence on infection related conditions in the POA non-payment category. Preview measures for consideration for 2010 include Ventilator Associated Pneumonias (2).

This focus places the role of the infection prevention professionals or Infection Prevention Officers (IPO) under increased pressure to change organizational practices to eliminate healthcare acquired infections. The resources available to the IPO must be prioritized for prevention activities. To be successful in the prevention of infections the IPO must educate and re-educate licensed independent practitioners working in the hospital, mid-level providers, hospital staff, patients, and visitors.

The development of a strong partnering culture of healthcare safety among physicians, hospital staff and patients establishes the foundation for cultural change and will be the hallmark of successful organizations. The IPO can strongly influence the organization by embracing "partnering" through a prevention program focused on the patient as a partner.

**Summary:**

After the advent of antibiotics, hospitals developed a culture of complacency related to hospital acquired infections. If a patient develops an infection, antibiotics are provided. The infection is logged and monitored. Control activities are put into place to prevent the spread. Investigation is completed to try and efforts are made to determine the source and prevent future infections from the identified source. The challenge today is based in changing reactive approaches to proactive ones. Engaging patients as partners in care is the first step in developing proactive cultures of safety. Embracing regulatory requirements as guideposts to meet infection challenges head on facilitates the cultural change in the organization that supports risk reduction.

Organizations can develop cultures of safety that focus on prevention rather than reacting to issues that arise. Infection prevention becomes part of the culture of safety, harnessing proactive prevention rather than control. Involving the patient as a vital member of the healthcare team is imperative to the success of the organization. Shifting the focus of the infection prevention professionals to prevention and education on prevention is critical to the success of the organization in both quality and financial terms. Welcome, embrace and celebrate the patient as a vital member of the healthcare team and the key to elimination of healthcare acquired conditions and the organization will be successful.

References:

1. The Budget Deficit Reduction Act of 2005 (PL 109-171, or DRA)
2. CMS Office of Public Affairs. Quality Measures for Reporting in Fiscal Year 2009 for 2010 Update, April 14, 2008
3. Comorbidity measures for use with administrative data Elixhauser A, Steiner C, Harris DR, Coffey RM. Med Care. 1998 Jan; 36(1):8-27
4. Federal Register / Vol. 73, No. 84 / Wednesday, April 30, 2008 / Proposed Rules
5. Federal Register / Vol. 73, No. 193 / Friday, October 3, 2008 / Notices

6. Identifying Potentially Preventable Complications Using a Present on Admission Indicator. John S. Hughes, M.D., Richard F. Averill, M.S., Norbert I. Goldfield, M.D., James C. Gay, M.D., John Muldoon, M.H.A., Elizabeth McCullough, M.S., and Jean Xiang M.S. Health Care Financing Review/Spring 2006/Volume 27, Number 3

7. To Err is Human: Building a Safer, Health System by Committee on Quality Health Care in America. Kohn, Linda T., Corrigan, Janet M., Institute of Medicine/April 15, 2000.

8. 2008 The Joint Commission on Accreditation of Healthcare Organizations. 2009 Comprehensive Accreditation Manual for Hospitals

9. [www.cms.hhs.gov/HospitalAcqCond/](http://www.cms.hhs.gov/HospitalAcqCond/)

10. [www.cms.hhs.gov/apps/media/fact\\_sheets.asp](http://www.cms.hhs.gov/apps/media/fact_sheets.asp).

11. [www.leapfroggroup.org/media/file/Leapfrog\\_hospital\\_acquired\\_infections\\_release.pdf](http://www.leapfroggroup.org/media/file/Leapfrog_hospital_acquired_infections_release.pdf) Leapfrog Group Hospital Survey. (2007). The Leapfrog Group 2007.

12. [www.qualityforum.org](http://www.qualityforum.org) NQF (2008) National Quality Forum website

13. [www.cdc.gov](http://www.cdc.gov) Centers for Disease Control and Prevention. (2008).

14. [www.hcup-us.ahrq.gov/reports/statbriefs/sb36.pdf](http://www.hcup-us.ahrq.gov/reports/statbriefs/sb36.pdf)



## Were You Aware?

- The Joint Commission has provided a clarification regarding the requirement at IM.02.02.01, EP2 that organizational policies include hospital-approved terminology, definitions and abbreviations as well as prohibited abbreviations in the April 21st edition of Joint Commission Online. It is not TJC's intent that organizations create a list of approved abbreviations. The language for this EP will be clarified effective July 1, 2010 and require organizations to use "standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations."
- It is expected that all Environment of Care management plans and objectives be reviewed and approved by the governing body of the organization.
- Organizations selecting Periodic Performance Review (PPR) Option 1 are no longer required to seek legal counsel for that selection. In addition, hospitals selecting Option 1 must use the online PPR tool to input their self-assessment findings and action plans. See the Comprehensive Accreditation Manual for Hospitals, 2010 for the current requirements regarding this PPR option.

- TJC has published several new Frequently Asked Questions (FAQ) during the first several months of 2010. To access the full content of all FAQs, visit <http://www.jointcommission.org/Standards/FAQs/>. FAQs not only provide guidance to organizations as to how to comply with challenging standards but also are used in determining compliance during survey. Some brief highlights include:
  - Leadership – Contracted Services:
    - These requirements pertain to contracted services directly related to the provision of patient care
    - Organizations must evaluate services provided by contract and address issues where performance does not meet expectation
  - Medical Staff – Ongoing Professional Practice Evaluation:
    - The frequency of data collection and review is to be defined by the organization. It is noted that 12 months would not be acceptable.
    - Data must be collected on all practitioners – including those who don't "fall out" on screening criteria
    - For practitioners performing a low volume of procedures or services at an organization, data from another organization may be used as supplemental information, however, organization-specific data must also be collected and reviewed
  - National Patient Safety Goals – Medication Labeling
    - Labeling must occur in all procedural settings – including OR, prep and pre-op locations, PACU, imaging services, endoscopy, dental services and anywhere procedures are done – including those done at bedside
    - "Immediate use" means the medication is removed from its original container and used immediately – without any break in process. Pre-filled, pre-labeled syringes, as purchased, are acceptable. Pre-labeling syringes and other containers for filling at a later time is not acceptable – i.e., marking basins as "saline."
  - Human Resources – Qualifications & Primary Source Verification for Lab Personnel
    - Applicable to laboratory and point-of-care testing personnel
    - Qualifications must be consistent with CLIA requirements
    - Primary source verification is required for licensure for non-waived testing. It is not required for education. Primary source verification is only required in some situations for professional credentials – i.e., where the credential is required by state or federal regulations.

## Technology Risks to Patient Safety

### Sources & Solutions

Technology-associated healthcare risks are real and will be familiar to many readers – they are the topics of discussion at safety and quality committee meetings in healthcare organizations across the country.

Over the next several editions of C&A News, we will highlight these risks and provide mitigation recommendations based on a recent publication of ECRI (1) as well as our own experiences in working with healthcare organizations to improve patient safety.

- Contamination from Endoscopes – A high volume endoscopy suite with limited space for cleaning, disinfecting and storing endoscopes can create potential for cross-contamination. Strategies to reduce that risk include:
  - Access and adherence to manufacturers' recommendations for cleaning and disinfecting for each piece of equipment.
  - Regular review of re-processing protocols to assure they are consistent with current recommendations, provide for optimal workflow and are a detailed process for staff to follow.
  - Training and competency assessment should be done on hire, when new equipment is added and periodically, as determined by the organization, to assure proper technique. Training should include not only those staff responsible for re-processing, but all who are responsible for set-up and handling of equipment as well.
  - The transport of endoscopes from clean storage areas to procedure rooms to decontamination rooms should be reviewed to assure there is no opportunity for cross-contamination. Consideration should be given to the use of covered bins, physical separation of "dirty" and "clean" spaces and other means to decrease risk.
  
- Clinical alarm failures – Disabling of clinical equipment alarms, desensitization of alarms and a lack of understanding of critical alarms can cause significant risk to patient safety. Some tips for addressing this issue:
  - Consider alarm features when purchasing new equipment. Assure mitigation of "nuisance" alarms which lead to desensitization and resulting lack of response.
  - Assure staff knowledge and competency related to alarm functions and settings to avoid staff unintentionally disabling or muting critical alarms.
  - Pay attention to factors related to the physical environment and technology. Patient room location, interaction with remote communication stations, unit configuration and other factors can detract from hearing critical alarms.
  - Assure all staff understand that alarms are just that – a trigger there may be an problem. Non-clinical staff should know to notify an appropriate staff member should they hear a clinical alarm sounding.

Reference: [www.ecri.org](http://www.ecri.org), Health Devices, November 2009, Vol. 38, No. 11