

The Joint Commission's Patient Safety Initiatives

**Global Healthcare User Group (HUG)
Princeton, November 30, 2005**

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Joint Commission International Center for Patient Safety



The Joint Commission on Accreditation of Healthcare Organizations

The mission of the Joint Commission on Accreditation of Healthcare Organizations is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.



Joint Commission International

Joint Commission International (JCI) extends the Joint Commission's mission worldwide. Through international consultation, accreditation, publications and education, Joint Commission International helps to improve the safety and quality of patient care in more than 60 countries.



Role of Accreditation in Patient Safety

- “Accreditation is, at its core, a risk reduction activity.”
 - ◆ **Setting standards & evaluating performance**
 - ◆ Implementing the Sentinel Event Policy:
 - ◆ reporting, analyzing, learning
 - ◆ Sharing “lessons learned”
 - ◆ Informing the public
 - ◆ Influencing national policy
 - ◆ Other roles:
 - ◆ Convener
 - ◆ Collaborator
 - ◆ Investigator
 - ◆ Educator
 - ◆ Publisher



Systems Analysis in Health Care

A systematic evaluation of a health care organization's systems and processes

- To identify vulnerabilities and hazardous conditions that could (and, over time, will) impact patient safety and quality of care.
- To inform the redesign of those systems and processes to improve patient safety and quality of care.



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Joint Commission International Center for Patient Safety

~ Partnering for Solutions in Systems Improvement ~

- Co-sponsored by Joint Commission & JCR
- Initiated in March 2005
- National & International priorities
- Domestic and International collaboration
 - ◆ WHO Collaborations (Taxonomy; Solutions)
 - ◆ Regional Advisory Groups
 - ◆ Potential PSO partnerships





**World Alliance
for
Patient Safety**

World Alliance for Patient Safety

- Formed by W.H.O. in May 2004
- Six Action Areas:
 1. Global Safety Challenge 2005-2006
 2. Patient and consumer involvement
 3. **Developing a patient safety taxonomy**
 4. Research in the field of patient safety
 5. **Solutions to improve health care safety**
 6. Reporting & learning to improve safety
- <http://www.who.int/patientsafety>



The Joint Commission Patient Safety Event Taxonomy: A Unified Patient Safety Language

Center for Patient Safety Research

Division of Research

Joint Commission on Accreditation of Healthcare Organizations



Need for Interoperability

Data Collection

- Electronic Medical Record
- Incident Report Form
- Repositories

Data Sharing

- Messaging
- Reporting

Retrieval & Aggregation

- Analysis, Knowledge management
- Alerts & Response



Design Considerations

- Scientifically sound
- Common and easily understood language
- Comprehensive (all events)
- Integrates existing classification schemas
- Sufficient detail to be of practical use
- Front-end data reporting framework
- Back-end interoperable framework
- Flexible to enable modification
- Stable to support ongoing uses



Joint Commission Public Policy Position on Reporting & Managing Medical Errors

- In order to measurably improve patient safety, the Joint Commission supports
 - ◆ Creation of an effective national reporting system (mandatory or voluntary)
 - ◆ Conditioned on the following:
 1. Standardized definition of a reportable medical error or event
 2. Requirement for in-depth analysis of each error/event
 3. Federal protection from disclosure of the resulting information
 4. Requirement for action plan with follow-up
 5. Sharing of event-related information with oversight bodies



The Joint Commission's Sentinel Event Policy

- Established in January 1996 with the following goals:
 - ◆ To have a positive impact in improving care
 - ◆ To focus attention on underlying causes and risk reduction
 - ◆ To increase the general knowledge about sentinel events, their causes and prevention
 - ◆ To maintain public confidence in the accreditation process



Sentinel Event Experience to Date

Of 3343 sentinel events reviewed by the Joint Commission, January 1995 through September 2005:

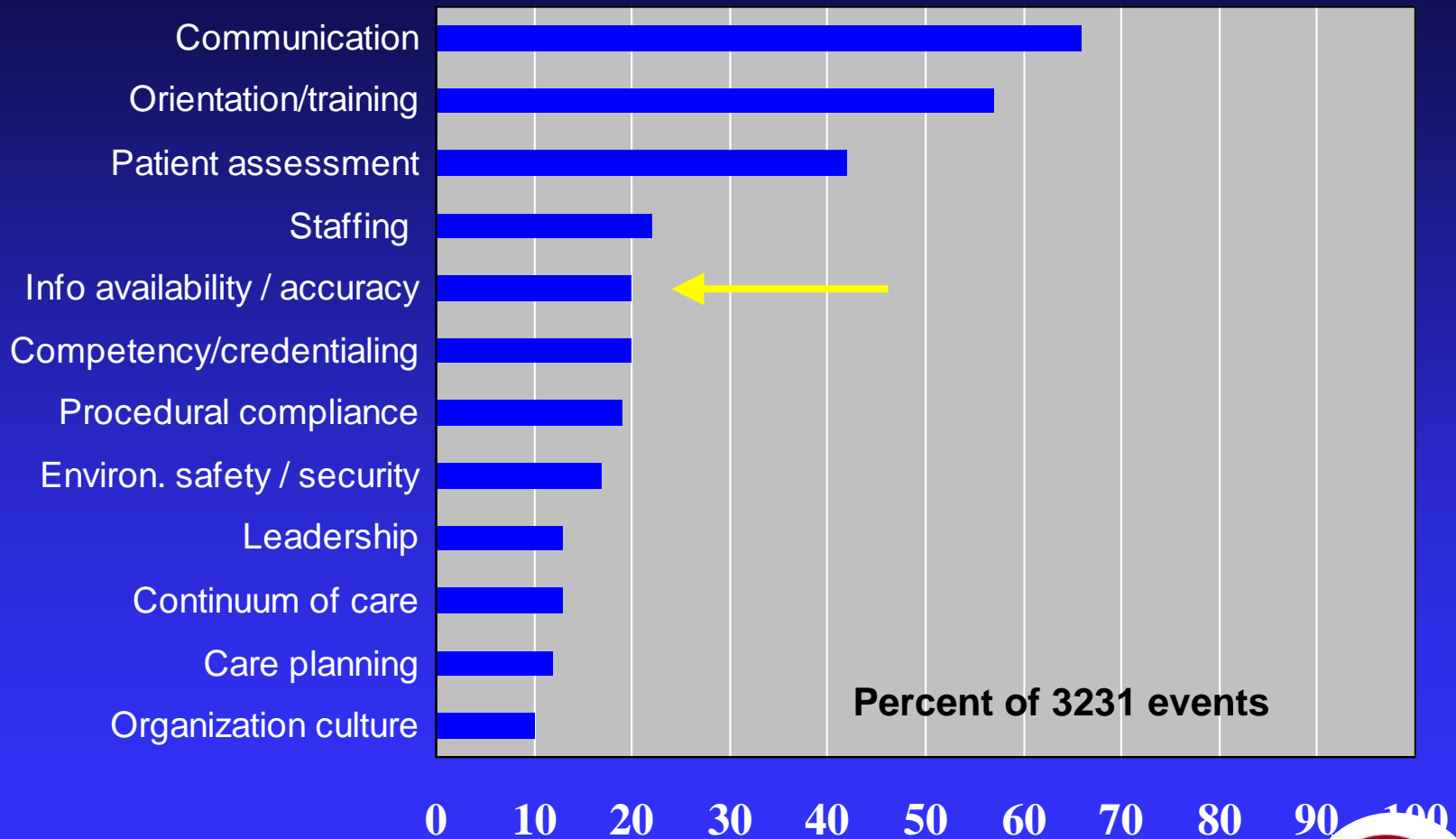
- 446 inpatient suicides
- 427 operative/post op complications
- 418 events of surgery at the wrong site**
- 352 events relating to medication errors**
- 254 deaths related to delay in treatment
- 173 patient falls
- 132 deaths of patients in restraints
- 113 assault/rape/homicide
- 103 perinatal death/injury
- 91 transfusion-related events**
- 65 deaths following elopement
- 65 infection-related events
- 62 fires
- 55 anesthesia-related events
- 587 "other"

= 3343 RCAs



Root Causes of Sentinel Events

(All categories; 1995-2005)





Joint Commission
on Accreditation of Healthcare Organizations

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SENTINEL EVENT ALERT

A publication of the Joint Commission on
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Issue One
2-27-98

"The way to prevent tragic deaths from accidental intravenous injection of concentrated KCl is excruciatingly simple - organizations must take it off the floor stock of all units. It is one of the best examples I know of a 'forcing function' -- a procedure that makes a certain type of error impossible."

Lucian L. Leape, M.D.

New Publication

We are pleased to introduce the first issue of *Sentinel Event Alert*, a periodic publication dedicated to providing important information relating to the occurrence and management of sentinel events in Joint Commission-accredited health care organizations. *Sentinel Event Alert*, to be published when appropriate as suggested by trend data, will provide ongoing communication regarding the Joint Commission's Sentinel Event Policy and Procedures, and most importantly, information about sentinel event prevention. It is our expectation and belief that in sharing information about the occurrence of sentinel events, we can ultimately reduce the frequency of medical errors and other adverse events.

Medication Error Prevention -- Potassium Chloride

In the two years since the Joint Commission enacted its Sentinel Event Policy, the Accreditation Committee of the Board of Commissioners has reviewed more than 200 sentinel events. The most common category of sentinel events was medication errors, and of those, the most frequently implicated drug was **potassium chloride (KCl)**. The Joint Commission has reviewed 10 incidents of patient death resulting from misadministration



Sentinel Event Alert

1. Potassium chloride
2. Policy issues
3. Policy issues
4. Policy issues
5. Policy issues
6. **Wrong site surgery**
7. Suicide
8. Restraint deaths
9. Infant abductions
10. **Transfusion errors**
11. **High Alert Medications**
12. Op/post-op complications
13. Impact of *SE Alert*
14. Fatal falls
15. **Infusion pumps**
16. Proactive risk reduction
17. Home fires (O2 therapy)
18. Kernicterus
19. **Look-alike, sound-alike drugs**
20. Kreutzfeldt-Jakob disease
21. **Medical gas mix-ups**
22. Needles & sharps injuries
23. **Dangerous abbreviations**
24. **Wrong-site surgery #2**
25. **Ventilator-related events**
26. Delays in treatment
27. **Bed rail deaths & injuries**
28. Nosocomial infections
29. Surgical fires
30. Perinatal deaths
31. Anesthesia awareness
32. Kernicterus #2
33. **PCA by proxy**
34. Intrathecal vincristine
35. **Wrong route / wrong tube**
36. *Medication reconciliation*



National Patient Safety Goals

- Each year, a set of Goals will be identified from topics published in *Sentinel Event Alert*
- A small number of specific requirements for each of the Goals will be identified for survey the following year
- The Goals and their requirements will be published by mid-year
- Selection of the Goals and requirements will be guided by a panel of experts: the Sentinel Event Advisory Group



The Joint Commission 2005 National Patient Safety Goals

1. Patient identification
2. Communication among caregivers
3. Medication safety
4. Wrong-site surgery
5. Infusion pumps
6. Clinical alarm systems
7. Health care-associated infections
8. Reconciliation of medications
9. Patient falls
10. Flu & pneumonia immunization
11. Surgical fires
12. NPSG implementation by network components



New Goals & Requirements for 2006

- ◆ Add to Goal 2: Standardize “Hand-off” communications
- ◆ Add to Goal 3: Label meds on sterile field
- ◆ New Goal 13: Patient involvement in safety
- ◆ New Goal 14: Pressure ulcer prevention



The JCAHO 2006 National Patient Safety Goals

Goal #1: Improve the accuracy of patient identification.

Requirement #1.a.

Use at least 2 patient identifiers (not the patient's room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing; or providing any other treatments or procedures.

Requirement #1.b. (Universal Protocol)

Prior to the start of any surgical or invasive procedure, conduct a verification "time out" to confirm the correct patient, procedure, and site.



The JCAHO 2006 National Patient Safety Goals

Goal #2: Improve the effectiveness of communication among caregivers.

Requirement #2.a.

Implement a “read-back” process for taking verbal or telephone orders, or reports of critical test results.

Requirement #2.b.

Standardize a list of abbreviations, acronyms, and symbols that are not to be used throughout the organization.



Official “Do Not Use” list:

- u
- IU
- qd
- qod
- Leading decimal point
(always use a Leading zero)
- Trailing zero
- MS
- MSO_4
- MgSO_4



The JCAHO 2006 National Patient Safety Goals

New !

Goal #2: Improve the effectiveness of communication among caregivers.

Requirement #2.e. [All programs]

Implement a standardized approach to “hand-off” communications, including an opportunity to ask and respond to questions.



The JCAHO 2006 National Patient Safety Goals

Goal #3: Improve the safety of using medications.

Requirement #3.a.

Remove concentrated electrolytes from patient care units (including KCl, K_3PO_4 , NaCl > 0.9%)

Requirement #3.b.

Standardize and limit the number of drug concentrations available in the organization.



The JCAHO 2006 National Patient Safety Goals

Goal #3: Improve the safety of using medications.

Requirement #3.c.

Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.



The JCAHO 2006 National Patient Safety Goals

**Goal #3: Improve the safety
of using medications.**

New!

Requirement #3.d. [Hospital, Amb., OBS]

Label all medications, medication containers (e.g., syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings.



The JCAHO 2006 National Patient Safety Goals

Goal #4: Eliminate wrong-site, wrong-patient, wrong-procedure surgery. [The Universal Protocol]

Requirement A

Use a pre-op verification process, such as a checklist, to confirm appropriate documents are available.

Requirement B

Implement a process to mark the surgical site and involve the patient in the process.

Requirement C

Prior to the start of any surgical or invasive procedure, conduct a verification “time out” to confirm the correct patient, procedure, and site.



Endorsers of the Universal Protocol:

- Accred Council for Grad Med Education
- Agency for HC Research & Quality
- Amer Academy of Amb Care Nursing
- Amer Academy of Cosmetic Surgeons
- Amer Acad of Facial Plastic & Recon Surg
- Amer Academy of Family Physicians
- Amer Academy of Ophthalmology
- Amer Academy of Orthopedic Surgeons
- Amer Acad of Otolaryn—Head & Neck Surg
- Amer Academy of Pediatrics
- Amer Assoc of Amb Surgery Centers
- Amer Assoc of Eye & Ear Hospitals
- Amer Assoc of Neurological Surgeons
- Amer Assoc of Nurse Anesthetists
- Amer Assoc of Oral & Maxillofacial Surg
- Amer College of Cardiology
- Amer College of Chest Physicians
- Amer College of Emergency Physicians
- Amer College of Foot & Ankle Surgeons
- Amer College of Obstetricians & Gynecologists
- American College of Physicians
- American College of Radiology
- American College of Surgeons
- American Dental Association
- American Hospital Association
- American Medical Association
- American Medical Group Association
- American Nurses Association
- Amer Organization of Nurse Executives
- Amer Pediatric Surgical Association
- Amer Radiological Nurses Association
- Amer Society for Surgery of the Hand
- Amer Society of Anesthesiologists
- Amer Society of General Surgeons
- Amer Society of Ophthalmic RNs
- Amer Society of PeriAnesthesia Nurses
- Amer Society of Plastic Surgeons
- Amer Society of Plastic Surgical Nurses
- American Urological Association
- Assoc of American Medical Colleges
- Assoc of periOperative Reg Nurses
- Assoc of Surgical Technologists
- Congress of Neurological Surgeons
- Federated Ambulatory Surgery Assoc.
- Federation of American Hospitals
- Medical Group Management Assoc.
- National Assoc. of Medical Staff Services
- National Patient Safety Foundation
- North American Spine Society
- Radiological Society of North America
- Society of Thoracic Surgeons



The JCAHO 2006 National Patient Safety Goals

**Goal #5: Improve the safety of
using infusion pumps.**

Requirement #5.a.

Ensure free-flow protection on all
general-use and PCA intravenous
infusion pumps used in the
organization.



The JCAHO 2006 National Patient Safety Goals

Goal #6: Improve the effectiveness of clinical alarm systems.

Requirement #6.a.

Implement regular preventive maintenance and testing of alarm systems.

Requirement #6.b.

Assure that alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noise within the unit.



The JCAHO 2006 National Patient Safety Goals

Goal #7: Reduce the risk of health care-associated infections.

Requirement #7.a.

Comply with current CDC hand hygiene guidelines.



The JCAHO 2006

National Patient Safety Goals

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

Requirement #8.a.

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.

Requirement #8.b.

A complete list of the patient's medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization.



Looking Forward to 2007

Topics being considered for future safety goals:

- ◆ Culture of safety
- ◆ Health care worker fatigue
- ◆ **Technological support for patient ID**
- ◆ Patient elopement
- ◆ Specific high-alert medications (anticoagulants, insulin & narcotics)
- ◆ Early recognition & response to failing patient
- ◆ Anticoagulant management
- ◆ Intravascular catheter infections





Search

Patients & Families

Health Care Professionals & Providers

Government & Business Leaders

Patient Safety Goals

Sentinel Event Alerts & Solutions



In focus...

- Sentinel Event Alert: Issue 34 - July 14, 2005 - Preventing Vincristine Administration Errors [More](#)
- Tip of the Week: Ventilator Adverse Events [More](#)
- We Want Your Feedback-- Take our Web Survey [More](#)
- Case Study: Hospital and Ambulatory Care Organizations Work to Prevent Wrong Site Surgery [More](#)
- Guest Commentary: Beyond the Moral Imperative: The Business Case for Patient Safety [More](#)
- Ensuring the Safety of Your Special Patient Populations [More](#)

Networking Communities



- Polling Question: Medication Management
- Patient Safety Forum

Complimentary Patient Safety Resources



Tools, case studies, good practice examples, awards, links to patient safety resources ...[More](#)

Patient Safety Products & Services



Patient Safety Products and Services (audio conferences, publications, education programs, elearning courses, technical assistance)...[More](#)

Partnering for Solutions in Systems Improvement

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