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Accreditation

New standards FAQs address H&P updates and titration orders
Hospitals, hospital clinics and critical access hospitals will be interested in some new frequently asked questions posted to The Joint Commission’s website this week. The new FAQs provide clarification for the following questions:

- What are the requirements for updating a history and physical when surgery or a procedure requiring anesthesia services is performed at a later point during an admission?
  - Update to hospital and hospital clinics
  - Update to critical access hospitals
- When is an update to a history and physical required?
  - Update to hospital and hospital clinics
  - Update to critical access hospitals
- Does The Joint Commission require specific elements for titration orders when such orders are permitted by an organization and what other quality or safety advances should be considered?
  - Hospital and hospital clinics
  - Critical access hospitals

Scoring for NPSG 15 crosswalks to CoP 482.13
In the March 1 issue of Joint Commission Online, information was provided about The Joint Commission’s approach for surveying and scoring ligature, suicide, and self-harm in accredited psychiatric hospitals and inpatient psychiatric patient areas in general hospitals.

It should be noted that National Patient Safety Goal (NPSG) 15, which requires the organization to identify safety risks inherent in its patient population, now crosswalks to the Medicare Conditions of Participation (CoP) for Patient Rights at 482.13 (c)(2), which relates to patients having the right to be treated in a safe setting. Therefore, any finding at NPSG 15 will not only be rated on the Survey Analysis for Evaluating Risk (SAFER) Matrix™ in accordance with the likelihood to cause harm and how widespread the finding is but also will be scored as either a standard-level deficiency or a condition-level deficiency. (Contact: Nina Smith, nsmith@jointcommission.org)

Patient safety

Making strides: Joint Commission, NQF name recipients of 2016 Eisenberg Awards
A U.S. Department of Veterans Affairs’ (VA) deputy undersecretary, a Boston-based patient safety research group and a Delaware health system have been named recipients of the 2016 John M. Eisenberg Patient Safety and Quality Awards. Presented annually by The Joint Commission and the National Quality Forum (NQF), the awards were presented yesterday at NQF’s 2017 Annual Conference in Pentagon City, Virginia.
The award recipients were:

- **Individual Achievement — Carolyn Clancy, MD**, deputy undersecretary, U.S. Department of Veterans Affairs, Washington, D.C., who led dramatic changes in quality improvement efforts, including the development and publication of the Agency for Healthcare Research and Quality’s annual National Healthcare Quality and Disparities reports to Congress. She also impacted the development and dissemination of practical patient safety and quality improvement tools used across the nation.

- **Innovation in Patient Safety and Quality at the National Level — I-PASS Study Group**, representing more than 150 individuals from across North America and recognized for its national work to improve patient safety by standardizing provider communication and handoffs of care. The group’s initial research study found that across nine hospitals, harmful medical errors (preventable adverse events) fell 30 percent following implementation of the I-PASS handoff bundle.

- **Innovation in Patient Safety and Quality at the Local Level — Christiana Care Health System**, Wilmington, Delaware, was recognized for the development of Christiana Care Care Link, an innovative, technology-driven care coordination program that serves nearly 75,000 Medicare beneficiaries and health plan members in the greater Delaware region. Results included a 62 percent reduction in the number of patients transferred to skilled nursing facilities after total joint replacement surgery.

The patient safety awards program, which launched in 2002, honors the late John M. Eisenberg, MD, MBA, former administrator of the Agency for Healthcare Research and Quality (AHRQ). An impassioned advocate for health care quality improvement, Eisenberg was a member of NQF’s founding board of directors, was chairman of the federal government’s Quality Interagency Coordination Task Force and personally led AHRQ’s grant program to support patient safety research.

The achievements of each award recipient will be detailed in the July 2017 issue of *The Joint Commission Journal on Quality and Patient Safety*.

**RSIs highlighted by former Joint Commission PSO in new advisory**

Retained surgical items (RSIs) remain a challenge for Pennsylvania hospitals, as highlighted in the March Pennsylvania Patient Safety Advisory in an article about RSIs and the serious patient safety concerns those items present. According to the article, “Retained Surgical Items: Events and Guidelines Revisited,” data from 2014-2015 found 112 RSIs that met the definitions of both the National Quality Forum and The Joint Commission, as well as an additional 16 that met The Joint Commission definition alone.

Surgical sponges were identified as the most commonly retained item, and most RSIs were left in the abdomen and pelvis. All events in the study were reported from hospitals and ambulatory surgical facilities.

Ronald Wyatt, MD, MHA, former patient safety officer at The Joint Commission, was interviewed for the report. In the story, Wyatt said that by definition, these are events that may have led to death, permanent harm or severe temporary harm. He listed three common root causes that were directly related to the events, which were limitations in:

- Leadership
- Communication
- Teamwork

“What we typically find is weak or absent leadership,” he said in the report. "We can put in all kinds of processes, but if leadership is not working on building a strong culture of safety, we are going to keep seeing events."

In terms of solutions, The Joint Commission suggests:

- Standardizing counting protocols
- Providing visual cues when sets are incomplete
• Minimizing distractions
• Promoting a systems approach to performance improvement

Learn more about the issue and read what Dr. Wyatt and others had to say on the topic.

April JQPS: Florida-based PSO develops automated all-cause harm trigger system
The April issue of The Joint Commission Journal on Quality and Patient Safety details how the Adventist Health System Patient Safety Organization in Altamonte Springs, Florida, developed an automated all-cause harm trigger system to identify patients who may have experienced harm or may be at risk for harm.

After the system was implemented, combined data from two hospitals during an 11-month period indicated:
• A total of 2,696 harms were acquired, of which almost one-third were acquired outside the hospital
• Hypoglycemia or low blood glucose was the most frequently identified harm
• A nurse reviewer was able to analyze 20 records in 1.5 hours using the automated review process compared to 6.5 hours using the previous manual review process

The study is detailed in “Developing and Evaluating an Automated All-Cause Harm Trigger System,” by Christine Sammer, DrPH, RN, director, Corporate Patient Safety, Office of Clinical Effectiveness, Adventist Health System, and co-authors.

Other articles in the April issue are:
• “Casting a Wider Safety Net: The Promise of Electronic Safety Event Detection Systems” (editorial)
• “From Board to Bedside: How the Application of Financial Structures to Safety and Quality Can Drive Accountability in a Large Health Care System”
• “Improving Glycemic Control Safely in Non-Critical Care Patients: A Collaborative Systems Approach in Nine Hospitals”
• “A Blueprint for Improving Systemwide Inpatient Glucose Management”
• “Using a Systematic Framework of Interventions to Improve Early Discharges”
• “A Systematic Review of Team Training in Health Care: Ten Questions”

Access JQPS.

Resources

New Take 5 podcast details recent survey process changes in relation to LSC deficiencies
When a Life Safety Code (LSC) deficiency is identified during the on-site survey, and that deficiency results in a Requirement for Improvement (RFI), surveyors will inquire as to which Interim Life Safety Measures (ILSMs) the organization will implement to protect patients, staff and visitors until corrective actions are completed. These changes to the on-site survey took effect in late 2016, and in the latest Take 5 podcast, Jim Kendig, LSC field director for the Joint Commission, discusses the recent changes and what they mean. [4:57]

Up in the blogosphere with The Joint Commission
Dateline @ TJC — Top 5 Most Popular Patient Safety Podcasts: The Joint Commission Multimedia Director Gidion Howell shares her favorite patient safety podcasts in this blog.

Learn more about Joint Commission Resources’ offerings online or call 877-223-6866.