The Joint Commission 2008 National Patient Safety Goals

Distinguish Your Community through Enhanced Resident Safety

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After individuals and their families have made the tough decision to move into an assisted living (AL) facility, they are then faced with finding the right community to meet their needs. This hurdle can be just as difficult to surmount. While cost, location, aging in place, and amenities are high on everyone's list of considerations, resident safety is usually the greatest concern. When seniors and their children begin to research safety in AL organizations, they are advised to inquire about the community's efforts to create and maintain a safe environment. One of the appealing approaches to creating a safe community is the adoption of The Joint Commission's (formerly JCAHO) 2008 National Patient Safety Goals (NPSGs).

National Patient Safety Goals were first developed by The Joint Commission in 2002, after the Institute of Medicine (IOM) identified medical errors as one of the nation's highest healthcare priorities. Since then, NPSGs have been widely endorsed and adopted by organizations around the world, whether accredited or not. The NPSGs are derived from informal recommendations made by patient safety experts including nurses, physicians, risk managers, pharmacists, and other professionals having practical experience in promoting safety issues. The panel of experts uses sentinel event information, other available databases, and literature to identify and update safety issues to be addressed.[1] Even though The Joint Commission has discontinued its accreditation program for assisted living, the 2008 NPSGs were recently announced for communities still within their current accreditation period. However, the questions remain:

- Can community adoption of the wildly accepted tenets of the NPSGs benefit our residents by identifying systems and processes that reduce injury and improve the quality of care?
- Can the implementation of NPSGs in our community ease the minds of our residents and families, knowing we have enhanced our safety program to exceed our customer's expectations?
- Can we prove that with the adoption of NPSGs, we are a safer community than the competition?

To answer these questions, let's review the 2008 NPSGs. There are

15 goals, 7 of which are applicable to AL facilities (Table 1).

Goal 1 ***Improve the accuracy of resident identification.*** This goal recommends the use of at least two identifiers when providing care, treatment, or services and a final verification process to confirm the correct procedure and site, using active, not passive communication. Asking residents to tell you their name or their date of birth are examples of active patient communication for identification. Using a room number or location for resident identification is passive and risky. In a stable community with staff longevity, up-to-date photos may be a useful tool for resident identification. A good example of when to conduct a final verification process is with insulin use. Taking a "time out" to identify the resident once more before injecting their insulin offers an additional opportunity to confirm this is the right resident, using the right drug at the right dose, at the right site of injection and at the right time.[2]

Goal 2 ***Improve the effectiveness of communication among caregivers.*** This second goal advises that when taking verbal or telephone orders or results of critical lab values such as potassium levels or international normalized ratios (INRs) for residents using warfarin anticoagulant therapy, the receiver should record the information and then "read back" the written order or test result to the other person to verify its accuracy. Further, this goal suggests we standardize our list of "Do Not Use" abbreviations, acronyms, symbols, and dose designations (Table 2). For example using the symbol "µ" for micrograms can be misunderstood as "units," a "zero," or "grams." Using a trailing zero in a dose (eg, 2.0) can cause a 10-fold error in a dose of medication if the figure is misread as "20." Another important aspect of effective communication is a standardized ap-

Table 1.
2008 National Patient Safety Goals: Assisted Living Program[5]

Goal 1	Improve the accuracy of resident identification.
1A	Use at least two resident identifiers when providing care, treatment or services.
1B	Prior to the start of any surgical or invasive procedure, conduct a final verification process, (such as a "time out") to confirm the correct resident, procedure and site, using active—not passive—communication techniques.
Goal 2	Improve the effectiveness of communication among caregivers.
2A	For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result.
2B	Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.
2E	Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions.
Goal 7	Reduce the risk of health care–associated infections.
7A	Comply with current World Health Organization (WHO) Hand Hygiene Guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
7B	Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care–associated infection.
Goal 8	Accurately and completely reconcile medications across the continuum of care.
8A	There is a process for comparing the resident's current medications with those ordered for the resident while under the care of the organization.
8B	A complete list of the resident's medications is communicated to the next provider of service when a resident is referred or transferred to another setting, service, practitioner, or level of care within or outside the organization. The complete list of medications is also provided to the resident on discharge from the facility.
Goal 9	Reduce the risk of resident harm resulting from falls.
9B	Implement a fall reduction program including an evaluation of the effectiveness of the program.
Goal 10	Reduce the risk of influenza and pneumococcal disease in institutionalized older adults.
10A	Develop and implement a protocol for administration and documentation of the flu vaccine.
10B	Develop and implement a protocol for administration and documentation of the pneumococcus vaccine.
10C	Develop and implement a protocol to identify new cases of influenza and to manage an outbreak.
Goal 13	Encourage residents' active involvement in their own care as a resident safety strategy.
13A	Define and communicate the means for residents and their families to report concerns about safety and encourage them to do so.

Table 2. Do Not Use Abbreviations

Dangerous Abbreviation or Dose Expression	Intended Meaning	Misinterpretation	Correction
Lack of a leading zero—zero before decimal point (eg, .1 mg)	0.1 mg	Misread as 1 mg	Always use a zero before a decimal when the dose is less than a whole number.
Trailing 0 (eg, 1.0)	1 mg	Misread as 10 mg if the decimal point is not seen.	Do not use terminal zeros for doses expressed in whole numbers.
U or u	Unit	Read as a zero (0) or a four (4), causing 10-fold overdose or greater. (4U read as 40 or 4u read as 44)	Unit has NO acceptable abbreviation. Use "unit", spelled out.
IU	International Unit	Both I and U can be misread as additional digits (eg, 10) or mistaken for IV	IU is not acceptable. Units must be written completely.
µg or µg	Microgram	Misread as "mg"	Use "microgram." Spelled out completely. Note: mcg is acceptable for use in computer databases if needed.
q.d. or QD	Every day	Can be misread if the period after the "q" or the tail of the "q" is misread as an "I" or an "o"	Write directions out completely. Use "every day" or "daily."
q.o.d. or QOD	Every other day	Misread as q.i.d (four times daily)	Write directions out completely.
MS, MSO4, MgSO4	Can mean morphine sulfate or magnesium sulfate	Can be confused for one another.	Write out either "magnesium sulfate" or "morphine sulfate" completely.
> or <	"Greater than" or "less than"	Unfamiliarity with these symbols can result in confusing one for the other	Write out either "greater than" or "less than."
A.S., A.D., A.U.	Left ear, right ear; both ears	Mistaken for O.S., O.D., O.U	Write out "left ear," "right ear," "both ears," "left eye," "right eye," or "both eyes."
Drug name letters and dose numbers run together (eg, Inderal40mg or Toprol x l 5 0 mg	Intended as: Inderal 40 mg or Toprol XL 50 mg	Misread as Inderal "140" mg or Toprol XL "150" mg	Always make certain there is adequate space between drug name, dose, and unit measure.

proach to "hand off" when a resident's care is transferred from one person to another—for example, during a change of shift—from physician to physician, or during transfer from one community to another organization. A good example of effective communication includes a shift report, instructions from care coordinators to community aides, and the opportunity to ask questions of community staff during the resident transfer.[3] Always provide the community's contact information.

Goal 7 ***Reduce the risk of health care-associated infections.*** Communities are urged to follow

the current hand hygiene guidelines from the Centers for Disease Control and Prevention (CDC) or from the World Health Organization (WHO). While we all know handwashing is the most important step that caregivers can take to prevent infection, informing our residents about proper handwashing, tissue use, and toilet hygiene is a fundamental step in involving our residents in their own personal infection control program. Useful posters on appropriate handwashing technique may be downloaded from the CDC Web site at no cost (www.cdc.gov/ounceofprevention/). Additionally, this goal advises the community to manage all unanticipated death or major permanent loss of function related to a healthcare–associated infection as a sentinel event, performing root cause analysis and process review with modification, training, and continuous monitoring to prevent the occurrence from happening again.

Goal 8 ***Accurately and completely reconcile medications across the continuum of care.*** The community should develop a process for comparing the resident's current medications with those ordered while in the community's care. A monthly review of the medication list with the medications on hand is one approach for reconciliation. A complete list of the resident's medications should be communicated to the next provider of service when the setting, service, or provider is outside of the community's organization. A complete list of medications, including over-the-counter drugs, vitamins, and herbs, should be provided to the resident on discharge from the residence.

Goal 9 ***Reduce the risk of resident harm resulting from falls.*** Every community should have a fall reduction program in place, but it should also have a method to evaluate the effectiveness of the program. Including residents and families as members of the fall program or safety program is one of the best approaches to meet the needs of those we serve. Aspects of the fall program may include environmental issues such as lighting, clutter, and policies for use of motorized scooters in the facility. Resident-specific considerations include vision, polypharmacy, adverse drug reactions, progression of disease, and worsening of conditions such as continence, cognition, or mood change. Knowing the fall history of residents before they moved into the community is critical in identifying those at risk of fall and implementing a program to keep them as safe as practical. If residents use the pharmacy at the AL facility, the pharmacist is better able to identify medications that may increase the risk of falls due to adverse drug reactions.

Can we prove that with the adoption of NPSGs, we are a safer community than the competition?

Goal 10 ***Reduce the risk of influenza and pneumococcal disease in institutionalized older adults.*** There are 3 aspects of this goal: (1) development of a protocol for administration and documentation of influenza vaccine, (2) development of a protocol to administer and document pneumococcus vaccine, (3) and development of a protocol to identify new cases of influenza and manage outbreak. Unless they are allergic to the vaccines, all seniors are advised to obtain an annual flu shot. While many elders believe that receiving a flu shot can give them the flu, injectable vaccines do not use live virus strains and infection is unlikely. While immunization may not keep a resident from getting the flu, it is likely to reduce the severity of the infection. Most states make flu vaccine easily accessible, often without the need for a doctor's visit. Look for opportunities for immunization in the community. Senior centers, adult day care centers, and even local pharmacies or supermarkets offer flu vaccines. Some states allow qualified pharmacists to administer flu shots, which may be conveniently provided by a consultant pharmacist when a nurse care coordinator is unavailable. Pneumococcal vaccine is usually a one-time immunization for anyone over the age of 65. Influenza vaccine and pneumonia vaccine may be administered at the same time as long as 2 different injection sites are used. When a resident moves into the community is an ideal time to discuss and encourage immunization. Both vaccines are covered under Medicare for beneficiaries. Each community should plan to have its employees immunized for flu annually and encourage family and visitors to become immunized. Immunization posters are free and may be downloaded from the CDC Web site in English and Spanish (www.cdc.gov/vaccines/pubs/flyers-brochures.htm#adult). Additionally a plan for visitation and in-house restrictions may be implemented to stem an outbreak of infection.

Goal 13 ***Encourage residents' active involvement in their own care as a safety strategy.*** In this goal the community is counseled to define and communicate a means for residents and their families to report concerns about safety. To accomplish this, the community must foster a culture of safety. Residents and their families must be made comfortable when they ask questions or report concerns to the community.[4] Communities are encouraged to post information on how to report a concern or how to access the community's Web site to report a concern.

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Provide a system to allow residents and families or employees to anonymously report concerns, service issues, and medication errors. Most important, respond to the person offering an opinion or observation about your community. Managers often address the resident's concerns but may fail to communicate that the provided input is appreciated and taken seriously.

National Patient Safety Goals may seem like commonsense approaches to providing a safe living environment for our residents, but they are derived from real-world events and provide guidance for the initiation of systems for inclusion in your quality assurance program. Consider the benefits of adoption. The NPSGs allow AL communities to identify and implement processes that promote and enhance resident safety and aging in place. They move us to define community-specific strategies for performance improvement while reducing the risk of needless injuries and common infections, more serious in the senior population. They reduce the cost of care by preventing additional healthcare costs associated with infection, injuries, and fracture from falls, drug misadventures, and medical errors. At the same time, they allow our residents to live well and their families to worry less. NPSGs offer opportunity—

National Patient Safety Goals reduce the cost of care by preventing additional healthcare costs.

- Opportunity to be attractive to prospective move-ins
- Opportunity to maintain census
- Opportunity to improve customer satisfaction and referrals
- Opportunity to be recognized as a safe and caring community of excellence. ALC

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