Agenda

• Joint Commission Accreditation Survey Results

• Sustaining Patient Safety and Quality Performance
Joint Commission Accreditation
Joint Commission Accreditation Survey

• Four Days
• Three surveyors: Physician (lead), Nurse, Life Safety Engineer
• Keen focus on:
  - Ligature risk
  - High level disinfections
  - Operative venue
  - Performance improvement/data analytics
  - Environment of care
  - Provision of care
“18 Exceptional Leading Practices”

Handling surgical instruments/sterilization
Streamlining disinfection sites from 11 to ultimately 1
Exceptional organization around life safety
Facilities management outstanding
High level staff performance
Excellence in standards of care/documentation, especially anesthesia
Good medication management
Use of distress tool for patient assessment
Use of brain code
STAT antibiotics process
Pain management
Evaluation of patients for emergencies
Very well-kept hospital, cleanliness spectacular
Performance evaluation for LIPs
Imaging guidelines and high level of confidence in radiology
Best infection control plans; excellent HES, major improvements hand hygiene, staff vaccinations
ProjectSEARCH
Excellent emergency management programs for disasters
<table>
<thead>
<tr>
<th>Category</th>
<th>Risk Factor</th>
<th>Likelihood to Harm/Scope</th>
<th>Total Standards Cited</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Eyewash station in dialysis</td>
<td>Immediate Threat to Life (ITL)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Flammable clutter in hallways near labs</td>
<td>ITL</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Fire extinguisher monthly inspections lapses</td>
<td>ITL</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Lack of labeling of electrical panels in interstitial</td>
<td>ITL</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Lack of labeling of O₂ staging racks</td>
<td>ITL</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>EKG electrodes storage, no expiration date</td>
<td>ITL</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Lapse in MD documentation of conscious sedation</td>
<td>ITL</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Time out did not include all staff</td>
<td>ITL</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Time out conducted for multiple procedures</td>
<td>ITL</td>
<td>1</td>
</tr>
<tr>
<td>Moderate</td>
<td>Emergency power shut off mounted externally***</td>
<td>ITL</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Housekeeping (vents, ice machines, clutter under sinks)</td>
<td>ITL</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Laryngoscope storage; wire racks without protective shelf</td>
<td>ITL</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Fire door propped open</td>
<td>ITL</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Fire wall penetrations</td>
<td>ITL</td>
<td>6</td>
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<tr>
<td></td>
<td>HLD/Sterilization (ultrasound probes; transport of)</td>
<td>ITL</td>
<td>8</td>
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<tr>
<td>Low</td>
<td>Visual only fire pull test conducted</td>
<td>ITL</td>
<td>0</td>
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<tr>
<td></td>
<td>Main drain testing – alternative process used***</td>
<td>ITL</td>
<td>1</td>
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<tr>
<td></td>
<td>Power strips in OR not configured appropriately</td>
<td>ITL</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Egress blocked (desks and boxes)</td>
<td>ITL</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Sprinklers used as supports</td>
<td>ITL</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Unlocked anesthesia cart</td>
<td>ITL</td>
<td>7</td>
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<tr>
<td></td>
<td>Patient supplied food stored without labels</td>
<td>ITL</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Fire drills schedule too predictable</td>
<td>ITL</td>
<td>0</td>
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<tr>
<td></td>
<td>Specimen refrigerator temp not monitored</td>
<td>ITL</td>
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</tr>
<tr>
<td></td>
<td>Documentation lapses re: annual fuel quality testing</td>
<td>ITL</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Lack of documentation of time frames related to goals</td>
<td>ITL</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Lack of documentation of patient’s progress to goals</td>
<td>ITL</td>
<td>4</td>
</tr>
</tbody>
</table>

**TOTAL # Standards Cited:** 28
Focus on Ligature Risk: Findings

• High Risk/Widespread
• Centerpiece of risk mitigation: “Organizational Risk Assessment” document
• NIH CC Findings:
  • “Ligature resistant” beds
  • Bathroom doors
  • Door handles in common spaces
  • Dresser and desk drawers
  • Closet/armoire doors
Focus on Ligature Risk: Context is Key

Unique Patient Population and Care Management

• Chronic versus acute population
• Planned admissions; strict eligibility requirements
• Rigorous assessment and intervention practices
  • One to One Monitoring
• Nurse:Patient staffing ratio is 3:1

Patient Dignity and Study Participation
**Focus on Ligature Risk: Post Survey**

- Engaged the Joint Commission leadership early

- Presented a cogent plan for risk mitigation
  - Includes a strong monitoring plan

- Joint Commission accepted our plan; will continue forward with furniture renovations and fixture replacements

- On-going performance monitoring will be rigorous
Focus on Sustaining Performance.....
Hand Hygiene Adherence
Hand Hygiene Adherence

Percent Adherence

2017-Q1 2017-Q2 2017-Q3 2017-Q4 2018-Q1 2018-Q2 2018-Q3
THE POWER OF CLEAN HANDS

- All staff are engaged in training and compliance
- Saying TOP10 reminds us all to do hand hygiene
- Patients are partners in hand hygiene

Training/Competence

USA TUS DERECHOS PARA SALVAR VIDAS

Por favor pída que se laven las manos

Awareness Raising

Staff Observations

Clinical Center Hand Hygiene Campaign 2018

1. BEFORE TOUCHING A PATIENT
2. BEFORE CLEAN/ASEPTIC PROCEDURE
3. AFTER BODY FLUID EXPOSURE
4. AFTER TOUCHING A PATIENT
5. AFTER TOUCHING PATIENT SURROUNDINGS
Improving On-Time Administration of STAT Antibiotics
(A) Recognition to Initial Order

(B) Initial to Final Order Entry

(C) Final Order Entry to Administration

ABX ORDERED

Order clarified/changed

O/P -- I/P

Allergies
Diluent
Dose
Lip

Pharm

Non-standard Dose

Standard Dose

FINAL ABX ORDER

Clinical Center
America's Research Hospital
STAT Antibiotic Administration

- Percent Compliant <60 Mins
- Average Time for Infusion of Late Drug
- Percent of Late Meds Available in the Omnicell
- Median Time for Infusion of Late Drug
# Focused Analysis Process

- Each overdue antibiotic is analyzed by a Patient Safety Specialist in real-time
- Weekly meeting with key stakeholders to review all instances of non-adherence
- Able to identify recurring/on-going systems issues
- Real-time problem-solving and intervention deployment

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Pt Name</th>
<th>Order Unit</th>
<th>Order Entered</th>
<th>Time To Verify</th>
<th>Timing</th>
<th>Time of drug administration</th>
<th>Elapsed Time</th>
<th>&gt; 60</th>
<th>Reason for delay charted by nursing</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avibactam-ceftazidime powder for injection 0.5 g-2 g - NF</td>
<td>1 dose(s)</td>
<td>XXX</td>
<td>CRC-5SE-N</td>
<td>07/02/2018 22:38</td>
<td>2 Late</td>
<td>07/03/2018 00:26</td>
<td>108 TRUE</td>
<td>medication not available</td>
<td>Delivered @ 23:54 per pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ceftaroline powder for injection 600 mg - NF</td>
<td>1 dose(s)</td>
<td>XXX</td>
<td>CRC-5SE-N</td>
<td>07/02/2018 22:44</td>
<td>1 Late</td>
<td>07/03/2018 00:06</td>
<td>82 TRUE</td>
<td>not available</td>
<td>Delivered @ 23:54 per pharmacy</td>
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<td></td>
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<tr>
<td>Vancomycin Infusion</td>
<td>1000 mg</td>
<td>XXX</td>
<td>CRC-3SW-S</td>
<td>07/02/2018 09:22</td>
<td>11 Late</td>
<td>07/02/2018 12:00</td>
<td>158 TRUE</td>
<td>Limited IV access</td>
<td>blank</td>
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<tr>
<td>Piperacillin/Tazobactam Infusion</td>
<td>3830 mg piperacillin</td>
<td>XXX</td>
<td>CRC-1NW</td>
<td>07/05/2018 09:14</td>
<td>43 Late</td>
<td>07/05/2018 10:20</td>
<td>66 TRUE</td>
<td>Not available</td>
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<tr>
<td>Piperacillin/Tazobactam Infusion</td>
<td>3.375 gram(s)</td>
<td>XXX</td>
<td>CRC-3NW</td>
<td>07/10/2018 19:44</td>
<td>1 Late</td>
<td>07/10/2018 21:00</td>
<td>75 TRUE</td>
<td>cris downtime</td>
<td>E-mail sent to 3NW 7/11 ? If just charted late, CRIS was down</td>
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<tr>
<td>Ceftriaxone Infusion</td>
<td></td>
<td>XXX</td>
<td>CC-OP-12</td>
<td>07/11/2018 14:43</td>
<td>9 Late</td>
<td>07/11/2018 16:01</td>
<td>78 TRUE</td>
<td>Nursing care being done</td>
<td>Email sent 7/12 to OP12 and DH</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Contributing Factors

• MD – RN communication

• RN – RN communication

• “Non-standard” doses

• Preparation/delivery
  - (non-formulary, prep time, IVAU capacity, transport)

• IV access

• Patient care issues
  - (testing, patient off unit, ↑ acuity)

• Peri-Procedure prophylaxis

• Omnicell availability
## Risk Mitigation Strategies

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Risk Mitigation Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Near Term</td>
<td>Assure consistency in nursing practice/knowledge re: medication compatibility and timing</td>
</tr>
<tr>
<td></td>
<td>Actively engage prescribers re: antibiotic selection/dosing and use of STAT (on-going)</td>
</tr>
<tr>
<td>Mid-Term</td>
<td>Improve communication among team members (on-going)</td>
</tr>
<tr>
<td>Mid-Term</td>
<td>Improve medication delivery processes</td>
</tr>
<tr>
<td>Mid-Term</td>
<td>Deploy Vancomycin in Omnicells</td>
</tr>
<tr>
<td>Mid-Term</td>
<td>Expand formulary</td>
</tr>
<tr>
<td>Mid-Term</td>
<td>Standardize dosing options, as appropriate</td>
</tr>
<tr>
<td>Long Term</td>
<td>Expand IVAU production capacity</td>
</tr>
</tbody>
</table>