

# The Source™

FOR JOINT COMMISSION COMPLIANCE STRATEGIES



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## Spotlight on Success

### A MULTIDISCIPLINARY APPROACH TO IMPROVEMENT IN CHRONIC KIDNEY DISEASE CARE

For patients with chronic kidney disease (CKD), properly coordinated, multi-disciplinary care ensures high-quality, comprehensive treatment to a complex population and can vastly improve patient outcomes. But because multidisciplinary care is expensive and resource-intensive, it can be difficult to get the kind of leadership buy-in required to support such a program. Institutional support is vital to successful delivery of care. So how can health care providers obtain it?

Linda Awdishu, PharmD, MAS, and associate clinical professor of pharmacy and medicine at the University of California, San Diego Skaggs School of Pharmacy and Pharmaceutical Sciences, says the first step to getting institutional buy-in is establishing a framework for routinely evaluating outcomes of coordinated care. “This drives improvement by creating awareness,” she explains. “It really helps to get institutional buy-in to improve research allocation.”

In 2007, Awdishu and her colleague, Dr. Danuta Trzebinska, opened a program at the University of California, San Diego Health System to deliver multidisciplinary care to patients with CKD stage 2 through 5. The program consists of two half-day clinics that operate in the same location as other nephrology clinics. Patients are seen every 1 to 6 months, depending on how severe their disease is. The multidisciplinary team consists of a nephrologist/medical director, pharmacist/program administrator, nurse, dietitian, social worker, and patient education coordinator. They developed the program’s CKD guidelines using [Kidney Disease Improving Global Outcomes](#) (KDIGO) guidelines, the National Kidney Foundation’s [Kidney Disease Outcomes Quality Initiative](#) (KDOQI), and Joint National Commission hypertension guidelines, American Diabetes Association guidelines, American Heart Association guidelines, and others.

Using the “Performance Measurement” (DSPM) chapter of the Joint Commission’s Certification Manual for Disease-Specific Care, the team developed measures to evaluate the quality assurance and performance improvement (QAPI) of the program. They also created a CKD registry in the electronic health records that enabled automated reporting of outcomes. Both the multidisciplinary program and the QAPI plan were designed to provide a pathway to disease-specific certification in [advanced chronic kidney disease](#) from the Joint Commission.

Since 2010 and through several certification cycles, the team has worked closely to identify which new indicators are important to clinical care and where there are gaps, Awdishu says. When the team identifies a potential gap in care, this becomes the basis for a quality indicator with effort concentrated on performance improvement. “By making that our QAPI goal, we then receive support from our institution from an informatics side,” she says. “Without it being a QAPI goal, then it would go onto a wish list of many things people want to see. Joint Commission standards and reporting quality indicators help to raise the importance of this particular initiative and guarantee resources to implement it.”

### **Getting buy-in**

Establishing a robust outcome reporting system and QAPI plan was vital to obtaining institutional buy-in for the multidisciplinary program. Educating organization leaders about improving quality of care was key to success.

“Patients with chronic kidney disease really benefit from having services from a dietitian, social worker, nurses, and other specialists,” Awdishu says. “But it’s quite expensive, and in the current health care system it’s not reimbursed.” Without reimbursement, she says, it’s very important for providers to ensure that their institutions understand the return on the investment in the form of improved patient outcomes and fewer emergency department visits.

Quality assurance and performance improvement are themselves resource-intensive. Awdishu's team had to collect data, then meet outside the clinic to discuss indicators and performance improvement, and then dedicate resources to those projects. The performance improvement projects alone were costly, and so it was important to have the metrics to justify them to the institution.

"Centers still struggle with how to define an indicator and show its relevance to the care of these patients," she says. In their process, Awdishu says the center greatly improved the documentation of patient care and outcomes. "Just by having the Joint Commission standards and going through the process of coming up with new measures as to what works as a quality indicator and what doesn't, is very helpful."

### *Measuring risk and patient outcomes*

Prior to the program's development of risk estimations, nephrologists had to be subjective in counseling their patients about progression of end-stage renal disease, Awdishu says. Quantifying risk is a significant factor in educating CKD patients and their caregivers during treatment and when preparing patients for transitions in care. But a subjective risk assessment could make it difficult to persuade a patient of the importance of adhering to essential treatments. With the development of two-to-five-year risk estimations ([Tangri et al., 2011](#); [Tangri et al. 2016](#)), this became easier. "Being able to quantify risks and either alleviate concerns or impress upon the patient the importance of adherence to certain therapies, is helpful," Awdishu says.

Awdishu's team took a unique approach to estimating risk to patients by developing and integrating risk calculators into patients' electronic health records (EHRs) and auto-estimating these risks within the office visit progress notes.

The team initially looked for risk calculators online but found nothing that could be incorporated into EHRs. Eventually, the team developed equations to estimate risk and worked with the informatics team at University of California–San Diego to develop algorithms that could be used for the study. For example, the team automated the estimation of risk for cardiovascular disease and end-stage renal disease so that clinicians could estimate risks within the office visit progress notes. "These two interventions vastly improved clinician awareness of risk for two critical issues pertaining to the care of CKD patients," Awdishu says.

### *Evaluating the program*

In early 2018, Awdishu's team completed a retrospective single-center analysis of all adult patients receiving care in the multidisciplinary CKD care program from July 2011–2016. Team members obtained data from electronic health records, including 440 patients in their analysis. They chose different indicators for each of their Joint Commission certification cycles in 2010, 2013, 2015, and 2017, and evaluated patient satisfaction using The Consumer Assessment of Health Providers and Systems surveys. Quality indicators such as blood pressure control, estimation of cardiovascular risk, and others showed consistently high performance among patients in the program. Documentation of risk factors also improved under the multidisciplinary care program. Providers improved office visit

documentation of atherosclerotic cardiovascular disease to 82% in the program's first quarter and 100% in subsequent quarters. Since 2012, 94% of patients have replied "yes, definitely" when asked if they were likely to recommend the program to others.

A standard method for delivering or facilitating coordinated care is critical to the success of any multidisciplinary care program. Coordination of care can improve clinical outcomes, enhance existing treatment plans and clinical practices, and identify and close gaps in delivery of care. It also ensures a health care organization is safeguarding patient rights and privacy.

Without Joint Commission certification and the high quality of care the center provides, Awdishu says the program might have been under financial scrutiny. Demonstrating that the program was providing high-quality care and continuously achieving Joint Commission certification "changed our position in the institution," she says. "The health system recognized that we were delivering high-quality levels of care to a complex patient population."

### *Looking forward*

Awdishu says her team plans to perform a comparative study that would evaluate patient outcomes for the center's multidisciplinary care program against those of patients who see a nephrologist only. They believe the team approach should result in improvement of care. "That's our hypothesis, but we don't have the data to prove that yet," she says. She intends to compare quality and costs of care among patients in the UC San Diego Health System program to patients with CKD and a similar mix of comorbidities who are treated only by a primary care physician or only a nephrologist.

"We hypothesize that maybe this type of resource-intensive coordinated care would result in less utilization of other expensive hospital-based resources like ER visits, admissions, and so forth," Awdishu says. "It's extremely important that we study this area so that we can provide a financial argument for multidisciplinary care of CKD patients to become common nationwide, she adds. 

For more information on certification in chronic kidney disease as well as other certification programs, visit the [Joint Commission Certification](#) home page.

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# Partnering for Solutions

## PREVENTING HOSPITAL-ACQUIRED PRESSURE ULCER/INJURY

Despite an ongoing focus on preventing hospital-acquired pressure ulcer/injury (HAPU/I), pressure injuries continue to be a challenge for health care providers. According to a study by the Agency for Healthcare Research and Quality (AHRQ), although the overall rate of hospital-acquired conditions decreased by 8 percent from 2014 to 2016, the rate of hospital-acquired pressure ulcers/ injuries (HAPU/I) increased by 10 percent during that time.<sup>1</sup>

More than 2.5 million acute-care patients in the United States develop HAPU/I every year. These skin lesions, which can result from body positioning as well as positioning of medical devices, result in pain, increased risk of infection, and increased health care services. As many as 60,000 HAPU/I sufferers die from related complications each year.

The cost of treating a single severe pressure ulcer/injury can be as high as \$70,000. Total costs for treatment of pressure ulcer/injury in the United States are estimated at \$11 billion annually, and CMS and other payers do not reimburse for hospital-acquired injury costs.

Prevention of bed sores is one of the Joint Commission's ongoing National Patient Safety Goals® (NPSG) for nursing care centers. However, this should also be a safety focus in intensive care units and other settings with patients who are confined to beds or wheelchairs for long periods or who require medical devices.

### Addressing the Root Cause

The Joint Commission [Center for Transforming Healthcare](#), created to address health care safety and quality problems that have proven to be difficult to solve, has launched an initiative in partnership with teams at The Johns Hopkins Hospital, Kaiser Permanente South Sacramento Hospital, and Memorial Hermann Southeast Hospital to identify root causes and solutions to reduce HAPU/I rates in hospitals. Previous problems tackled by the Center have included fall prevention, hand hygiene, hand-off communication, and more.<sup>2</sup>

“What the Center has found is that the usual approach, where health care organizations use protocols and checklists, has evolved into bundles,” says Michael King, a Lean Six Sigma Black Belt at the Center. “This one-size-fits-all model may result in some improvement, but for some problems like pressure injuries, that improvement is usually modest. Without targeting improvement efforts to address your organization's specific root causes, it's difficult to get to zero and difficult to sustain that improvement.”

HAPU/I can have many different causes within different organizations, King says, so no single solution will be effective across the board. The question we're trying to answer is, “How much does this root cause affect your organization's ability to prevent HAPU/Is?”

“Organizations have been working on this for decades and millions of dollars have been put toward it, but solutions haven’t been sustainable in the way they have for other hospital-acquired conditions,” he says. “The Healthcare Research Education and Trust conducted an initiative across 20 states, and they found that not only is the process complex, it is also very technical. It’s highly affected by turnover, hard to standardize, and doesn’t get the attention it should.”

## Targeted Tools and Techniques

The Center is working to develop a Targeted Solutions Tool® (TST®) to help organizations find the solutions that will work best for them by identifying the root causes of the problem. The TST is a web-based application that guides health care organizations through process improvement using a step-by-step approach to accurately measure their organization’s actual performance, identify their barriers to excellent performance, and direct them to proven solutions that are customized to address their particular barriers. “The Center works with organizations to define and measure the impact of the problem for them, walk them through the tools and techniques that we’ve found to be effective in getting to the specific causes of the problem, then generate solutions targeted to each specific cause,” King explains.

King notes that it takes time to develop a TST because in addition to working with a small group of organizations on an intense project in the beginning, the Center also ensures that the developed solutions will translate to other organizations that need to address the same root cause.

In the meantime, as the HAPU/I TST is being developed, Joint Commission-accredited organizations can explore the other TSTs. The Center currently offers TSTs on Hand Hygiene, Preventing Falls, Hand-Off Communications, Safe Surgery, and (coming in early 2019), Reducing Sepsis Mortality. Organizations can also undertake some efforts now to ensure that they are doing as much as possible to prevent HAPU/I.

## Teamwork

HAPU/I prevention is often considered a nursing issue, but it includes many different disciplines, according to Shirley Legaspi, RN, MSN, patient safety specialist at the Joint Commission. “There should be a multidisciplinary approach. Physicians, physical therapists, nutritionists, and others need to be involved. It’s about patient care, and patient care is a team effort,” she says.

Communication should be one of the primary focuses of that team, she adds. “One of the top causes of sentinel events is communication breakdowns. Identification is key, but if you don’t communicate your findings to the right people, it doesn’t help. When a pressure injury, or an increased risk for one, is identified, it should be communicated to the whole team. Family should also be included.”

## Assess and Address Early

Element of performance (EP) 3 of NPSG.14.01.01 requires that organizations conduct a validated risk assessment, using a tool such as the Braden Scale or the Norton Scale to identify residents at risk for developing pressure ulcers. Most assessment tools require that initial assessment be done on the patient at the time of admission; subsequent reassessment is recommended on a weekly basis, as well as whenever the resident's condition changes or deteriorates.

When a patient is identified as being at risk for a HAPU/I, a multicomponent preventative approach is recommended. The plan of care should include the following:

- Skin inspection, skin cleansing, care for dry skin, use of moisture barriers, and massage
- Nutritional support based on an individualized nutritional needs assessment
- Avoidance of skin injury from friction or shear forces through the use of evidence-based positioning, transferring, and turning techniques
- A plan to maintain and, when appropriate, to increase mobility and activity level
- Improvement in positioning, repositioning, transferring, and turning techniques to reduce skin injury caused by friction and shear force
- Use of repositioning devices, mechanical loading, and support surfaces to reduce skin injury caused by friction or shear force
- Staff educational programs on the assessment, prevention, and treatment protocols<sup>3</sup>

## Focus on Devices

The longtime use of the term *bed sores* has led to the false impression that only bed-confined patients are at risk for pressure injuries.

“People think that it’s just patients who are lying down for a long time, or it’s shear,” Legaspi says. “But any patient with a device is at risk for a pressure injury.”

Many medical devices cannot be removed for a skin assessment, so caregivers must have ways to adjust the device to inspect the point of contact with the patient’s skin. Facilities should also have procedures in place for when a device-related HAPU/I (or risk for one) is identified. Pressure-relieving implements are available if it isn’t possible to move the device.

“Education is key,” Legaspi adds. “Many patients go home with medical devices, so they and their caregivers need to understand how to check for pressure injuries and what to do if an injury develops. Teamwork, risk assessment, and early intervention are the keys to preventing these injuries,” Legaspi says. 

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## References

- 1 Agency for Healthcare Research and Quality. *AHRQ National Scorecard on Hospital-Acquired Conditions Updated Baseline Rates and Preliminary Results 2014–2016*, June 2018. [https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/natlhacratereport-rebaselining2014-2016\\_0.pdf](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/natlhacratereport-rebaselining2014-2016_0.pdf). Accessed Dec. 3, 2018.
- 2 Center for Transforming Healthcare. *Targeted Initiatives*. <https://www.centerfortransforminghealthcare.org/projects/projects.aspx>. Accessed Dec. 3, 2018.
- 3 The Joint Commission, *National Patient Safety Goals (NPSG) (Nursing Care Center / Nursing Care Center): Pressure Ulcer - Prevention Actions*. [https://www.jointcommission.org/standards\\_information/jcfaqdetails.aspx?StandardsFAQId=818&StandardsFAQChapterId=117&ProgramId=0&ChapterId=0](https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=818&StandardsFAQChapterId=117&ProgramId=0&ChapterId=0). Accessed Dec. 4, 2018.

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## Proven Tools for Assessing HAPU/I Risks

The [Braden Scale](#) is one of the most preferred clinical scoring tools for evaluating a patient’s risk for pressure injuries. It assesses a patient on six categories of risk, including sensory perception, moisture, activity, mobility, nutrition, and friction/shear. These factors are assigned a numerical score, which identifies whether the patient is not at risk, needs preventive interventions, is at moderate risk, is at high risk, or is at very high risk. The purpose of the scale is to help health care professionals, particularly nurses, assess a patient’s risk for developing a pressure injury. The scale includes intervention protocol for each level of risk and requires clinical judgment for implementing suggested protocols.

The [Norton Scale](#) is used to predict the likelihood that a patient will develop a pressure ulcer or injury. It also evaluates patients on categories of risk, but includes five risk factors: physical condition, mental state, activity, mobility, and incontinence. Patients are evaluated on each of these risk factors, using a numerical scale of 1 (low risk) to 4 (high risk).

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# Medication Management in an Urgent Care Center

Effective medication management (MM) is a cornerstone of a safe health care organization. While a well-working system covers the entirety of medication management—planning, selection and procurement, storage, ordering, preparing and dispensing, administration, monitoring, and evaluation—certain specifics of how that system is shaped may depend on the organization’s setting and the care and treatment needs of the patients being served.

According to Robert Campbell, PharmD, Clinical Director of Standards Interpretation of Hospital / Ambulatory Programs and Director of Medication Management at The Joint Commission, the urgent care center should first and foremost "ensure that areas of potential risk are attended to such as with medication storage, technology, diversion, staff training, and leadership oversight," says Campbell.

## Potential Challenges to Patient Safety

Safe medication storage continues to be a compliance challenge for the urgent care setting. Campbell primarily attributes this to issues including inconsistent approaches to safe practices, such as monitoring and checking the temperatures of refrigerated medication to ensure proper storage in accordance with manufacturer’s guidelines. This can be an issue when the urgent care center is part of a larger hospital system. “Because the center is often located outside the hospital, there could be inconsistent approaches to staff training and monitoring in relation to medication storage, particularly if the processes have come from the hospital setting and not appropriately integrated into the center’s setting,” he explains. He recommends that staff are clearly trained and supported on the correct handling and approach to safe medication storage and that hospital leadership take a more active role in oversight and support.

Another challenge relating to medication storage is the handling of and responsibility for stocking medications. Appropriate, consistent staffing has an important role to play in this area. “If a pharmacist is on site, this can ensure a more consistent approach to appropriately restocking cabinets, looking at orders, and assisting with other medication storage issues,” explains Campbell. Storage and restocking also relate to what emergency medications the center should hold: “It can be good practice to start with a model of what medications would be in an emergency department and then evaluate what would be most relevant for the urgent care setting based on the population being served,” adds Campbell.

Technology factors into the issues surrounding storage, such as when the center uses an automated dispensing cabinet. Campbell refers to two new Environment of Care standards that centers should be aware of: “One requires that organizations have a process in place to continue dispensing medication in the event of power loss, and the other requires that centers identify what refrigerators require back-up emergency power.” Effective oversight and leadership can help ensure

these elements are factored in. Staff training and education are also critical to the process, stresses Campbell. ‘A big mistake is that staff are not always trained appropriately on how to use the technology, and that becomes a patient safety issue.’

Related to technology is the importance of a reliable and accessible system to monitor, track, and report on adverse medication events. Campbell recommends a system that feeds into the wider patient safety and quality improvement activities at the center or beyond if the center is part of a system.

Another risk factor can be drug diversion, an issue about which centers must remain vigilant. “An area that surveyors look at while on site is the potential for drug diversion,” Campbell explains. “We look at whether the center has an established process for how it monitors for diversions, not just narcotics but others that have abuse or street value potential.” He recommends that attention be paid to how a center monitors medication usage and whether it has a diversion prevention strategy.

### Leadership Is Key

Improving these areas requires effective leadership. Campbell recommends focusing on communication and improved leadership oversight to support a center’s approach to medication management. “When leadership is engaged in the process and understands how medication should be managed in the center, they will use techniques such as communicating clearly, conducting medication management rounds on a regular basis, and ensuring staff are well supported and trained to complete the roles of their position.” He adds that if the center is part of a larger hospital, then hospital leadership should treat the center as another department or floor of the hospital and ensure that appropriate pharmacy oversight is in place.

When performing a medication management systems tracer in this setting, Campbell notes that “The medication management tracer in an urgent care center typically considers two critical areas: the environment in which care is provided and the safety of the care being provided. A surveyor’s priority is ensuring the continuum of medication management, including that medications are safely secured, appropriate emergency medication and response items are available, and that an effective handling of prescribing and monitoring is in place.” 

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# TRACER 101

## Methodology

### Medication Management in a College Campus Urgent Care Center

*The bracketed numbers throughout this mock tracer scenario correspond to the questions in the tracer question bank below.*

This mock tracer scenario took place in an urgent care center located on a college campus in a midsized city in the Midwest. The college is part of a faith-based system, which also runs a regionwide health network, including one of the local hospitals and the college's own urgent care center. The center is predominantly used by the students and, in some cases, by college staff. During an accreditation survey of the hospital and its network, surveyors visited the urgent care center as part of the overall survey. A medication management systems tracer was conducted to better understand and explore the center's processes to manage the medications. [1] The surveyor chose to explore the medication management system by following the experience of one patient, a 20-year-old male student with type 1 diabetes who had come to the center three days earlier complaining of sore throat and fever and was prescribed antibiotics. The surveyor initially met with the center's director and onsite pharmacist and later met with the physician assistant (PA) who was responsible for the patient's care.

**Exploring medication management in the setting.** The surveyor was interested in understanding how the center managed its medication within the setting and how this related to its managing hospital. [2, 3] The surveyor noted that the center had an onsite pharmacist and securely stored its medications, but that the hospital's pharmacy director had overall responsibility for the center's medication management. The surveyor was interested in how effective the center's storage approach was and noted that documentation monitoring of the temperature of the refrigerator, which included essential medications, such as insulin, was not consistently handled; for example, logs were incomplete. [4, 5] The group discussed the process to transfer patients to the hospital in the event of an emergency and how emergency medications were handled and stored. Discussion also revealed that the pharmacy director had not visited the center for the past three months, which was outside of the framework of the center's medication management evaluation policy. [6]

**Reviewing medication management against the experience of a patient.** At this point, the group was joined by a center physician and PA. The surveyor selected the record of a patient, a college sophomore, to trace who had been in the center two days previously. A review of the record indicated that in addition to having type 1 diabetes, the student was also taking anti-anxiety medication for social anxiety. [7] The surveyor asked the staff how they reviewed and reconciled any pre-existing medications and ensured safe interactions. The staff was able to clearly articulate the process, and this was verified in the record. The surveyor

also asked the staff to explain how medication management risk assessments are performed in the center. The surveyor was able to review and verify that there was an effective process in place to monitor the effect of medication on patients. [8, 9]

**Focusing on medication management storage going forward.** The surveyor and center staff discussed measures to improve their medication management storage and monitoring practices and that hospital leadership would be alerted to inconsistencies in oversight at the center. 

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### **Tracer Question Bank: Medication Management in a College Campus Urgent Care Center**

*The following represent some questions that could be asked during a medication management mock tracer to assess your organization's overall medication management system. Relevant standards addressed in these questions include MM.01.01.01, MM.01.01.03, MM.02.01.01, MM.03.01.01, MM.03.01.05, MM.07.01.01, MM.08.01.01, and NPSG.03.06.01. Use these questions as a starting point to plan your own tracers.*

1. Please describe your system's overall medication management system. What leadership oversight is in place for your system?
  2. How is medication management handled in your center on a daily basis? How does it relate to your wider health system?
  3. How does your center interact with the pharmacy leadership at the hospital? How do they evaluate compliance at the center?
  4. What is your process to safely store medications? How do you manage high-risk medications and emergency medications?
  5. How do you select and procure medications?
  6. What process do you follow to evaluate the effectiveness of your medication management activities?
  7. When a patient enters the center, how do you identify and document any pre-existing medications that the patient is taking? How is this process of reconciliation handled?
  8. How are medication management risk assessments performed?
  9. How do you monitor the effect of medication on your patients?
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# Top News

*A digest of accreditation and health care news*

## **2019 Revisions to National Patient Safety Goals®**

### ***NPSG.15.01.01-Reduce the Risk for Suicide***

In the past 10 years since the Joint Commission began reevaluating National Patient Safety Goal 15, suicide remains the 10th leading cause of death in the United States. Now, following years of research, public field review, multiple panels representing provider organizations, convening of experts in suicide prevention and behavioral health care facility design, *National Patient Safety Goal 15.01.01. Reduce the risk for suicide* has been revised to improve at-risk patient care and prevent suicide.

Effective July 1, 2019, seven elements of performance (EPs) for [NPSG.15.01.01](#) will be required on which The Joint Commission will review hospitals and behavioral health care organizations during accreditation surveys. These new and revised requirements address the following:

- Environmental risk assessment and action to minimize suicide risk
- Use of a validated screening tool to assess patients at risk
- Evidence-based process for conducting suicide risk assessments of patients screened positive for suicidal ideation
- Documentation of patients' risk and the plan to mitigate
- Written policies and procedures addressing care of at-risk patients, and evidence they are followed
- Policies and procedures for counseling and follow-up care for at-risk patients at discharge
- Monitoring of implementation and effectiveness, with action taken as needed to improve compliance

### ***NPSG.03.05.01-Anticoagulant Therapy***

New and revised EPs for [NPSG.03.05.01](#), addressing anticoagulant therapy will also become effective July 1, 2019. Applicable organizations that will be reviewed on these requirements during survey include hospitals, critical access hospitals, ambulatory health care (medical centers only), and nursing care centers. These requirements apply to organizations that initiate, manage, and adjust dosage for anticoagulation medications, and does not include organizations that are limited to the mechanical treatment of bleeding.

The goal of these revised requirements includes the following:

- Using approved protocols and evidence-based guidelines
- Ongoing patient monitoring
- Patient and family education
- Evaluating organizational safety practices and taking actions to improve those practices.

### **New Study Addresses Unnecessary Health Care Tests**

A study cited in the [December 2018](#) issue of *The Joint Commission Journal on Quality and Patient Safety* demonstrated impressive reductions in unnecessary health care tests following a three-year initiative to reduce costly, unnecessary low-value health care services and raise awareness among clinicians and the public to issues of health care overuse.

Apart from the potential for patient harm from unnecessary tests, and the inconvenience of unnecessary care, the article revealed that overuse of low-value services has been estimated to cost the health care system in the United States more than 200 billion per year.

The multifaceted initiative was implemented across 25 Kaiser Permanente Georgia medical clinics serving approximately 300 members, and specifically targeted decreasing routine blood tests, osteoporosis screening for women who had no indication, and imaging or uncomplicated headaches. Goals for the initiative were to increase the medical office's ability to provide evidence-based care to members, to improve quality by delivering value-added care, to promote meaningful case discussions between patients and clinicians in exam rooms, and to promote meaningful discussions among clinicians about practice variation. Positive results were sustained even after monthly reports to physicians ended.

[The Joint Commission Journal on Quality and Patient Safety](#) (JQPS) is a peer-reviewed journal providing health care professionals with innovative thinking, strategies, and practices in improving quality and safety in health care.

### **Benefits of Developing a Strong Reporting Culture**

In a recent [Sentinel Event Alert](#), The Joint Commission takes a close look at the importance of developing a reporting culture within health care organizations and addresses how trust, having a clear reporting system, eliminating fear of punishment, and learning from errors and close calls *before* they cause harm are critical to creating a culture of safety.

Although some organizations have begun to acknowledge and give positive recognition to staff who report errors, more can be done, as any inaction from organizational leadership to staff reporting unsafe conditions demonstrates complacency toward risk. For this reason, the issue stresses that the responsibility for creating and sustaining a culture of safety lies with leadership. The issue offers several resources to support leadership engagement and accountability,

including real-world examples, tools, videos, and an [infographic](#) that lists the four key elements of a successful reporting culture.

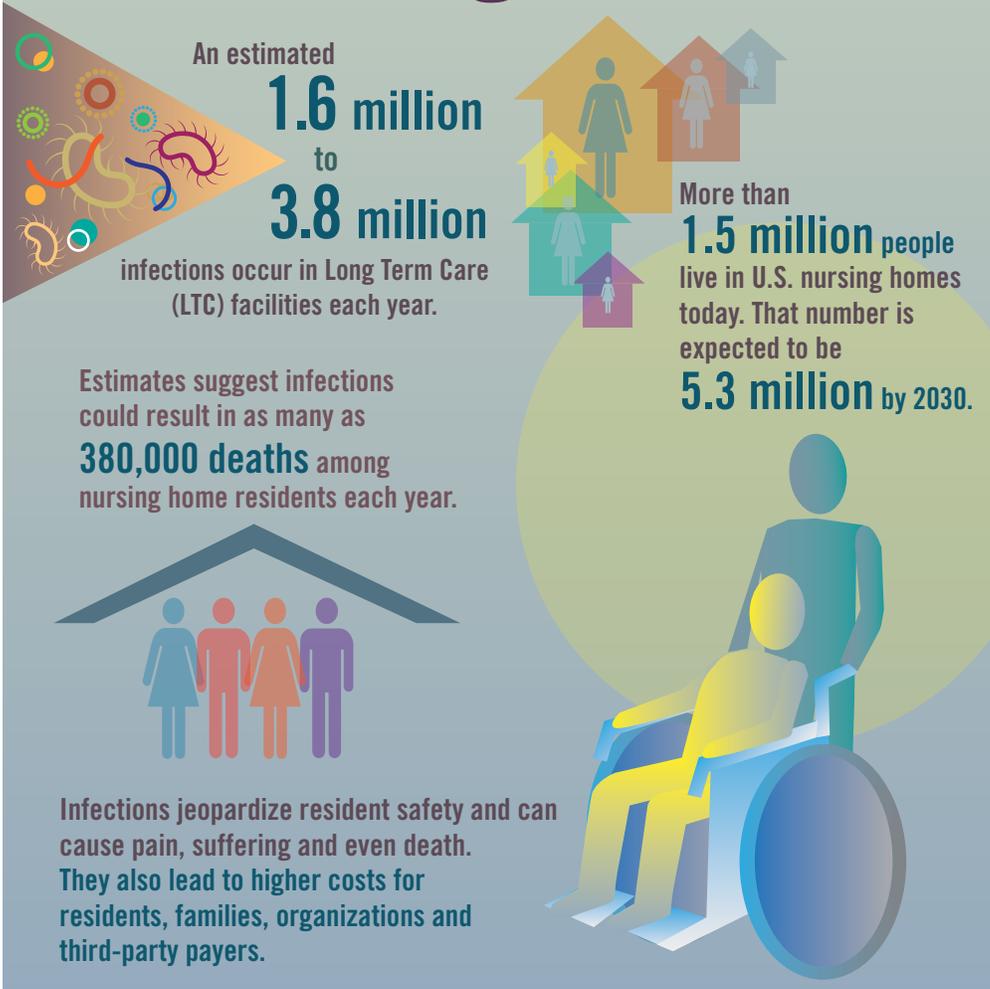
1. **Establish trust**
2. **Encourage reporting**
3. **Eliminate fear of punishment**
4. **Examine errors, close calls, and hazardous conditions**

**NEXT** ↓

# Infographic

HIGH RELIABILITY IN LONG TERM CARE

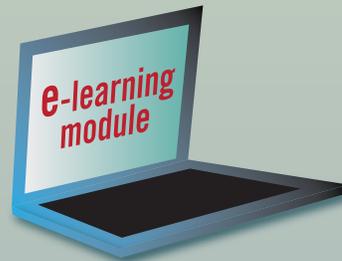
## Moving Toward Safer Long Term Care: Preventing Infections



# How Can You Apply High Reliability Principles to Prevent Infections?



**Learn** about high reliability from organizations in industries that operate under hazardous conditions while maintaining exemplary safety records, such as commercial aviation and nuclear facilities.

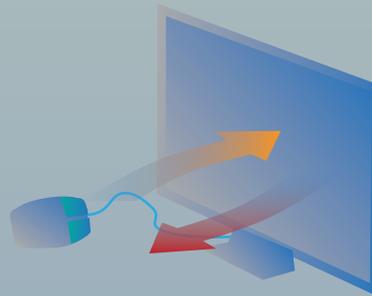


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## 2019 WEBINARS

### **National Patient Safety Goals®**

**12:00pm-1:00pm CST**  
Wednesday, March 20, 2019  
Wednesday, June 12, 2019  
Wednesday, September 11, 2019  
Wednesday, December 04, 2019

### **CMS Readiness Webinar Series**

**12:00pm-1:00pm CST**  
Wednesday, January 23, 2019  
Wednesday, February 20, 2019  
Wednesday, March 27, 2019  
Wednesday, April 24, 2019  
Wednesday, May 22, 2019  
Wednesday, June 19, 2019

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