Breakfast Briefings: The Joint Commission Infection Prevention and Control Standards and National Patient Safety Goals for Hospitals – Update 2010

Joint Commission Resources
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Presented by:

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Learning Objectives

Upon completion of this program, participants will be able to:

- Describe the CMS and Joint Commission coordination of findings
- Describe the IC Standards and the NPSGs for 2010
National Patient Safety Goals

The purpose of the Joint Commission’s National Patient Safety Goals is to promote specific improvements in patient safety.

The Goals highlight problematic areas in health care and describe evidence and expert-based solutions to these problems.

Recognizing that sound system design is intrinsic to the delivery of safe, high quality health care, the Goals focus on system-wide solutions, wherever possible.

Key message: The NPSGs are high-priority requirements which have a special focus.
# National Patient Safety Goal #7

<table>
<thead>
<tr>
<th>.07.01</th>
<th>All Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>.07.03 (MDRO)</td>
<td>HAP and CAP</td>
</tr>
<tr>
<td>.07.04 (CRBSI)</td>
<td>HAP, CAH, LTC, LT2</td>
</tr>
<tr>
<td>.07.05 (SSI)</td>
<td>HAP, CAH, AHC, OBS</td>
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</tbody>
</table>

.07.02 Sentinel Event
Has been deleted
Goal 7: Healthcare-associated infections

Three new requirements for 2010

- NPSG.07.03.01 – multidrug-resistant organisms (MDRO)
- NPSG.07.04.01 - central line-associated bloodstream infection (CLABSI)
- NPSG.07.05.01 – surgical site infection (SSI)

These were based in part on the *Compendium of Strategies to Prevent Healthcare Associated Infections in Acute Care Hospitals*

- [http://www.shea-online.org/about/compendium.cfm](http://www.shea-online.org/about/compendium.cfm)
Compendium Participants

Compendium of Strategies to Prevent Healthcare Associated Infections in Acute Care Hospitals-Published by the HAI Allied Task Force

• American Hospital Association (AHA)
• Association of Professionals in Infection Control and Epidemiology (APIC)
• Infectious Disease Society of America (IDSA)
• The Joint Commission
• Society of Healthcare Epidemiology of America (SHEA)

http://www.shea-online.org/about/compendium.cfm
The goal of the compendium is “the development of practical, evidence-based implementation strategies based on current scientific guidelines and recent research, supported by the major professional organizations invested in decreasing HAIs in the acute care setting”
The compendium is available for free download at: 
http://www.preventinghais.com

Six Primary Focus Areas
- Catheter-Associated Bloodstream Infections
- Catheter-Associated Urinary Tract Infection
- Clostridium difficile
- Methicillin-Resistant Staphylococcus aureus
- Surgical Site Infections
- Ventilator-Associated Pneumonia
## Compendium and NPSG Comparison

<table>
<thead>
<tr>
<th>Compendium Strategies</th>
<th>HAI NPSG 7 (Full implementation 2010)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strategies to prevent Central line associated bloodstream infections</td>
<td>NPSG 07.04.01: Implement best practices or evidence-based guidelines to prevent central line–associated bloodstream infections.</td>
</tr>
<tr>
<td>2. Strategies to prevent Ventilator associated pneumonia</td>
<td>No</td>
</tr>
<tr>
<td>3. Strategies to prevent Catheter-associated urinary tract infections</td>
<td>No</td>
</tr>
<tr>
<td>4. Strategies to prevent Surgical site infections</td>
<td>NPSG 07.05.01: Implement best practices for preventing surgical site infections.</td>
</tr>
<tr>
<td>5. Strategies to prevent <em>Methicillin-resistant S. aureus</em></td>
<td>NPSG 07.03.01: Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.</td>
</tr>
<tr>
<td>6. Strategies to prevent <em>Clostridium difficile</em> infections</td>
<td>NPSG 07.03.01: Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.</td>
</tr>
</tbody>
</table>
Goal 7
Healthcare-associated infections

NPSG.07.01.01
- Comply with current CDC or WHO hand hygiene guidelines
Hand Hygiene - .07.01.01

Comply with either the current CDC or WHO hand hygiene guidelines

EP 1 - Implement a program that follows categories 1A, 1B, and 1C of either guidelines

EP 2 - Set goals for improving compliance with hand hygiene guidelines

EP 3 - Improve compliance with hand hygiene guidelines based on established goals (for organizations that provide physical care)
Hand Hygiene Evaluation

Purchase of alcohol hand sanitizer

Rate per 1000 patient days*

*excludes CRC & Nursery

Month/Year

First HH Campaign, Purell brought into UMHS
Second HH Campaign
Third HH Campaign
Added to ORs

Joint Commission Resources
Strategy to Increase Hand Hygiene

- Ensure written policy is consistent with CDC HH guidelines
- Evaluate location and acceptability of soap, waterless handrub
- Ensure products available: soap and waterless handrub
  - Check that ordering process in place for each location
- Develop publicity and education
- Develop means to quantify use of soap, waterless handrub
- Develop means to observe HH practice
  - difficult in most outpatient settings
- Collect data and give feedback to staff
- Get leadership involved
- Make HH an organizational priority
Hand Hygiene - .07.01.01 - Example

Decontaminate hands after removing gloves
Category 1B

Goal: A minimum of 95% of persons will wash hands after removing gloves

Compliance: Achieve 92%: increase from 78% from previous time period

Establish Baseline Performance, Set Goal
Perform Intervention, Measure, Report

Organizations must choose one or the other, not some components of each
MEASURING HAND HYGIENE ADHERENCE: OVERCOMING THE CHALLENGES
Hand Hygiene: Toolkit for Implementing the National Patient Safety Goal

Designed to help infection control practitioners and patient safety officers across all types of health care organizations instruct staff on the importance of hand hygiene,

Addresses how to create and implement an effective hand hygiene program and offers advice on how to monitor compliance.

Divided into lessons, it includes quizzes, group discussion questions, helpful margin notes, and case studies.

It is a hands-on resource that helps learners grasp the subject matter quickly and comprehend its concepts with confidence.
Other helpful resources

Hand Hygiene Posters

INVPST04 - EASY REMINDERS FOR STAFF ABOUT THE IMPORTANCE OF HAND HYGIENE IN PREVENTING INFECTIONS! Use these four posters to communicate the importance of hand hygiene to your health care staff... a different aspect of hand hygiene, including: the human and monetary cost of infections; the recommended ...

Hand Hygiene Buttons: Stopping Infection is in Our Hands

Before and after patient encounters. With the use of these hand hygiene buttons, organizations can ...

“Ask Me If I’ve Washed My Hands” buttons

"HHB05 - The CDC estimates that the annual costs of hospital-acquired infections are $6.7 billion. Use these hand hygiene buttons to prevent the spread of infections in your health care organization... and reduction through proper hand hygiene. Our most popular languages, English and Spanish
http://www.cdc.gov/handhygiene/training/interactiveEducation
The Hand Hygiene Project focuses on improving and sustaining hand hygiene compliance.

Hand hygiene solutions were developed by eight leading, highly respected organizations, which have a great deal of experience using Robust Process Improvement™ tools such as Lean Six Sigma and change management processes.

Solutions: Effective hygiene is in our HANDS (Habit, Active Feedback, No One Excused, Data Driven, Systems)

http://www.centerfortransforminghealthcare.org/projects/about_hand_hygiene_project.aspx
The Joint Commission Launches Targeted Solutions Tool™

Joint Commission-accredited hospitals now have access to an interactive tool that simplifies the process for solving the most persistent health care quality and safety problems that exist within our health care system.

https://jcextranetapps.jointcommissionconnect.org/CTH/Roadmap/HandHygiene/Hospital/Step1.aspx
.07.03.01 – Multidrug Resistant Organisms (MDRO)
We can never rest .....  

Latest threat: 

New Delhi metallo-beta-lactamase (NDM-1)  
- Enterobacteriaceae: E.coli – Klebsiella pneumoniae  
- UTI common presentation  
- India, Pakistan  
- Cases increasing in U.S.  
- Spreading capability via plasmids into highly drug-resistant organisms.
NPSG.07.03.01
CAH, HAP only

“Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.”

Includes:
- MRSA
- VRE
- Clostridium difficile
- Gram negative MDRO
NPSG.07.03.01 EP 1

“Conduct periodic risk assessments (in time frames defined by the organization) for multidrug-resistant organism acquisition and transmission.”

This may be part of or distinct from the general IC risk assessment required in IC.01.03.01.

General risk assessments are done at least annually per the IC chapter.

Resource: Sample Risk Assessment For MDROs in the Free Toolkit on JCR Website: MDRO Toolkit http://www.jcrinc.com/Learning-Community-Home/
Based on the results of the risk assessment, educate staff and licensed independent practitioners about health care–associated infections, multidrug-resistant organisms, and prevention strategies at hire and annually thereafter.

Note: The education provided recognizes the diverse roles of staff and licensed independent practitioners and is consistent with their roles within the organization.

Education will be different for different providers. Each organization may determine its own educational approach and content.
“Educate patients, and their families as needed, who are infected or colonized with a multidrug-resistant organism about health care-associated infection strategies.”

This is focused education for those individuals who are infected or colonized.

See also PC.02.03.01

- Documentation
- Assessment of understanding

Strategies may include

- Hand hygiene
- Transmission-based precautions
- Antimicrobials
“Implement a surveillance program for multidrug-resistant organisms based on the risk assessment.

**Note:** Surveillance may be targeted rather than organization-wide.”

Please see FAQ-This may be targeted surveillance.

[http://www.jointcommission.org/AccreditationPrograms/Hospitals/Standards/09_FAQs/NPSG/Healthcare_associated_infections/NPSG.07.03.01/multiple_drug_resistant.htm](http://www.jointcommission.org/AccreditationPrograms/Hospitals/Standards/09_FAQs/NPSG/Healthcare_associated_infections/NPSG.07.03.01/multiple_drug_resistant.htm)
“Measure and monitor multidrug-resistant organism prevention processes and outcomes, including the following:

- Multidrug-resistant organism infection rates using evidence-based metrics
- Compliance with evidence-based guidelines or best practices
- Evaluation of the education program provided to staff and licensed independent practitioners

*Note: Surveillance may be targeted rather than organization-wide.”

Monitoring encompasses both outcome and process measures

Will vary significantly from one organization to another

*FIGURE 5.6. The relationship between a normal distribution and a control chart.*
“Provide multidrug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.”

From front line staff to board members

Surveillance indicators are dependent on risk assessment (see EP 5)
Recommendations for Metrics for Multidrug-Resistant Organisms in Healthcare Settings: SHEA/HICPAC Position Paper

Adam L. Cohen, MD, MPH; David Calfee, MD, MS; Scott K. Fridkin, MD; Susan S. Huang, MD, MPH; John A. Jernigan, MD; Ebbing Lautenbach, MD, MPH, MSCE; Shannon Oriola, RN, CIC, COHN; Keith M. Ramsey, MD; Cassandra D. Salgado, MD, MS; Robert A. Weinstein, MD; for the Society for Healthcare Epidemiology of America and the Healthcare Infection Control Practices Advisory Committee
“Implement policies and practices aimed at reducing the risk of transmitting multidrug-resistant organisms.

These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).”

Organizations should compare their existing P&P with relevant guidelines and update as needed.

As new guidelines evolve, they should be incorporated within a reasonable period of time (see IC.01.05.01 EP 1).

Also check legal and regulatory requirements.
Antibiotic Resistance Common in LTCFs

- S. aureus
  - HA-MRSA
  - CA-MRSA, VRSA

- Enterococci
  - VRE

- Pneumococci
  - multi-drug\(^R\)
  - ESBLs, cipro\(^R\)

- Gram (-) rods

- C. difficile
  - quinolone\(^R\)?
“When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients with multidrug-resistant organisms.

**Note:** *The alert system may use telephones, faxes, pagers, automated and secure electronic alerts, or a combination of these methods."

*Turnaround times for reporting should be determined based on needs related to both isolation and treatment.*

*“New” means both new admissions and new culture results.*

*Daily batching of reports is discouraged.*
When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multidrug-resistant organisms.

Note 1: The alert system information may exist in a separate electronic database or may be integrated into the admission system. The alert system may be either manual or electronic or a combination of both.

Note 2: Each organization may define its own parameters in terms of time and clinical manifestation to determine which re-admitted patients require isolation.

This means that all patients must be identified, but it does not mean that isolation is appropriate/required in all circumstances.
The Cost of Antibiotic Resistance: What Every Healthcare Executive Should Know

www.jcrinc.com

Learning Community
Staff Pocket Guide to MDROs: Dr. Stephen Weber, Editor

- Special features:
  - Important facts to know about specific MDROs
  - Tips for managing patients with MDROs
  - Standard infection control procedures, including hand hygiene and environmental precautions
  - Tips for patient screening and isolation practices
  - Protocols for putting on and taking off personal protective equipment
  - Staff strategies for bedside interactions with infected patients
  - Guidelines for what staff should do immediately if exposed to an MDRO or if infected with an MDRO
Superbug ‘to kill 150,000’

Minister orders his health chief: Solve deadly NHS crisis

URGENT action to combat the killer hospital bug MRSA was demanded last night by Health Secretary John Reid.

He acted as a leading expert warned the infection could kill 150,000 patients over the next two years.

Dr Reid asked the Chief Medical Officer, Sir Liam Donaldson, to bring forward publication of his report into the spread of MRSA “as a matter of urgency”. The report is expected to heavily criticise hospital hygiene standards and call for a major shake-up in the way wards are cleaned.

The move comes as a Professor Hugh Pennington, turn to page 5.
A Vision for the Future?
MRSA in Denmark

What Does the Evidence Tell Us?

Target Modes of MRSA Transmission

- Person-person via hands of health care providers
- Personal equipment (e.g., stethoscopes, PDAs) and clothing
- Environmental contamination
- Airborne transmission
- Carriers on the hospital staff
  - Rare common-source outbreaks

www.IHI.org
Prevent Infection and Colonization

Colonized patients

- Reservoir for transmission
- Nearly 1/3 develop infection, often after discharge
- Long-lasting and can transmit MRSA to patients in other health care settings (e.g., nursing homes) and family members

High rates of MRSA colonization complicate empiric antibiotic therapy (e.g., vancomycin)

www.IHI.org
Human and Financial Impact

- Over 126,000 hospitalized persons infected annually
  - 3.95 MRSA infections per 1,000 hospital discharges
- Over 5,000 patients die as a result of these infections
- Over $2.5 billion excess health care costs attributable to MRSA infections

On average, each patient with MRSA infection has:
- 9.1 days excess length of stay (LOS)
- Over $20,000 excess cost per case (range $7,000 – $32,000)
- 4% excess in-hospital mortality

www.IHI.org
Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006

Jane D. Siegel, MD; Emily Rhinehart, RN MPH CIC; Marguerite Jackson, PhD; Linda Chiarello, RN MS; the Healthcare Infection Control Practices Advisory Committee

Acknowledgement:

The authors and HICPAC gratefully acknowledge Dr. Larry Strausbaugh for his many contributions and valued guidance in the preparation of this guideline.
07.04.01 - Central Line Associated Bloodstream Infections
NPSGs and Existing IC Requirements

- NPSG .07.04.01 is an example of the purpose and focus of National Patient Safety Goals: high priority and focused topic

- All requirements in the new NPSG 7 were previously included in the IC chapter, although with a lower degree of specificity
  - Risk-based IPC planning
  - Interventions based on scientific guidelines
  - Education
  - Surveillance and data
The Joint Commission Recognized that:

- Unacceptably high incidence of CLABSI
  - Medical ICU: 1.9/1000 central line days
  - Burn ICU: 5.5/1000 central line days
  - Surgical ICU: 2.3/1000 central line days

- A high proportion of CLABSI are attributable to multi-drug resistant organisms (MDRO)
  - 56.8% of *S. aureus* methicillin resistant
  - 36.4% of *Enterococcus* vancomycin resistant
  - 23.0% of *Pseudomonas* carbapenem resistant

- Challenge magnified by proliferation of central lines outside of the critical care setting

The Joint Commission Recognized that:

- CLABSI now thought to be largely preventable

  - 108 hospital collaborative in Michigan
  - 1981 ICU months of data (375,757 catheter days)
  - Median CLABSI rate fell from 2.7/1000 catheter days to 0 by 3 months ($p = 0.002$)
  - Mean CLABSI rate decreased from 7.7/1000 catheter days to 1.4/1000 catheter days ($p = 0.002$)
  - Mean rate sustained at 1.1/1000 catheter days after 3 years
Evidence-Based Guidelines

- Catheter Associated Urinary Tract Infection (2009)
- Disinfection and Sterilization (2008)
- Isolation Precautions (2007)
- Multi-Drug Resistant Organisms (2006)
- Tuberculosis (2005)
- Environmental Infection Control (2003)
- Smallpox Vaccination (2003)
- Hand Hygiene (2002)
- Surgical Site Infection (1998)
- Immunization of Healthcare Workers (1997)
Other Guidelines and Scientific Resources for CLABSI

- Association for Professionals in Infection Control and Epidemiology, Inc.
  - www.apic.org

- Infectious Diseases Society of America
  - www.idsociety.org

- Society for Healthcare Epidemiology of America
  - www.shea-online.org
“Implement best practices or evidence-based guidelines to prevent central line-associated bloodstream infections.”

Covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.
Educate staff and licensed independent practitioners who are involved in managing central lines about central line–associated bloodstream infections and the importance of prevention.

Education occurs upon hire, annually thereafter, and when involvement in these procedures is added to an individual’s job responsibilities.

Education should be tailored to the needs and capacity of different providers.

Each organization may determine its own approach and content.

This education is provided to a very focused group.

Note annual requirement.
Prior to insertion of a central venous catheter, the hospital educates patients and, as needed, their families, about central line–associated bloodstream infection prevention.

This is focused education.

See also PC.02.03.01

The hospital provides education and training to the patient based on his or her assessed needs.

Even in an emergency, some basic education is usually possible.
Educational Strategies

- Curriculum development that integrates hospital policy and evidence-based guidelines
- Demonstrate IV system with return demonstration
- Discuss epidemiology of CLABSI employing population based science
- Case studies and scenarios
- Observations of correct technique
- Monitoring performance
- Videos and other visual aides
- Interactive Computer-based didactic training with immediate feedback and test
FAQs about “Catheter-Associated Bloodstream Infections” (also known as “Central Line-Associated Bloodstream Infections”)

What is a catheter-associated bloodstream infection?
A “central line” or “central catheter” is a tube that is placed into a patient’s large vein, usually in the neck, chest, arm, or groin. The catheter is often used to draw blood, or give fluids or medications. It may be left in place for several weeks. A bloodstream infection can occur when bacteria or other germs travel down a “central line” and enter the blood. If you develop a catheter-associated bloodstream infection you may become ill with fever and chills or the skin around the catheter may become sore and red.

Can a catheter-related bloodstream infection be treated?
A catheter-associated bloodstream infection is serious, but often can be successfully treated with antibiotics. The catheter might need to be removed if you develop an infection.

What are some of the things that hospitals are doing to prevent catheter-associated bloodstream infections?
To prevent catheter-associated bloodstream infections doctors and nurses will:
• Choose a vein where the catheter can be safely inserted and where the risk for infection is small.
• Clean their hands with soap and water or an alcohol-based hand rub before putting in the catheter.
• Wear a mask, cap, sterile gown, and sterile gloves when putting in the catheter to keep it sterile. The patient will be covered with a sterile sheet.
• Clean the patient’s skin with an antiseptic cleanser before putting in the catheter.
• Clean their hands, wear gloves, and clean the catheter opening with an antiseptic solution before using the catheter to draw blood or give medications. Healthcare providers also clean their hands and wear gloves when changing the bandage that covers the area where the catheter enters the skin.
• Decide every day if the patient still needs to have the catheter. The catheter will be removed as soon as it is no longer needed.
• Carefully handle medications and fluids that are given through the catheter.

What can I do to help prevent a catheter-associated bloodstream infection?
• Ask your doctors and nurses to explain why you need the catheter and how long you will have it.
• Ask your doctors and nurses if they will be using all of the prevention methods discussed above.
• Make sure that all doctors and nurses caring for you clean their hands with soap and water or an alcohol-based hand rub before and after caring for you.
• If you do not see your providers clean their hands, please ask them to do so.
• If the bandage comes off or becomes wet or dirty, tell your nurse or doctor immediately.
• Inform your nurse or doctor if the area around your catheter is sore or red.
• Do not let family and friends who visit touch the catheter or the tubing.
• Make sure family and friends clean their hands with soap and water or an alcohol-based hand rub before and after visiting you.

What do I need to do when I go home from the hospital?
Some patients are sent home from the hospital with a catheter in order to continue their treatment. If you go home with a catheter, your doctors and nurses will explain everything you need to know about taking care of your catheter.
• Make sure you understand how to care for the catheter before leaving the hospital. For example, ask for instructions on showering or bathing with the catheter and how to change the catheter dressing.
• Make sure you know who to contact if you have questions or problems after you get home.
• Make sure you wash your hands with soap and water or an alcohol-based hand rub before handling your catheter.
• Watch for the signs and symptoms of catheter-associated bloodstream infection, such as soreness or redness at the catheter site or fever, and call your healthcare provider immediately if any occur.

If you have additional questions, please ask your doctor or nurse.

Co-sponsored by:
What is Adequate Education for staff, patients and families for CLABSI?

- Determined by the institution
- Evidence-based information
- Meets needs of learners
- Test and monitor understanding or competency
- Document education and results
- Standardized vs. Customized
Patient Guide: Preventing Central Line Infections

We care about your health and strive to provide all of our patients with excellent care.

This brochure describes the measures we are taking to prevent our patients from developing central line infections and the things that you can do to help prevent this type of infection.

A central line is needed to provide fluids or medicine into your circulatory system. Your central line will help us provide care to you, but central lines can also act as a pathway for germs to enter your body. Central line infections can come from the germs living on your own skin. Below you will learn about the methods we use to prevent your central line from getting infected.

Implement policies and practices aimed at reducing the risk of central line–associated bloodstream infections.

These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).

Organizations should compare their existing P&P with relevant guidelines and update as needed.

As new guidelines evolve, they should be incorporated within a reasonable period of time (see IC.01.05.01 EP 1).

Determine in the organization the individuals responsible for monitoring
Conduct periodic risk assessments for central line-associated bloodstream infections, monitor compliance with evidence-based practices, and evaluate the effectiveness of prevention efforts.

The risk assessments are conducted in time frames defined by the hospital, and this infection surveillance activity is hospital-wide, not targeted.

This may be part of or distinct from the general IC risk assessment required in IC.01.03.01.

Consider the aspects of care and prevention of CLABSI.

Quantitative or qualitative.
<table>
<thead>
<tr>
<th>Risk Event</th>
<th>Probability the Risk will Occur</th>
<th>Potential Severity if the Risk Occurs</th>
<th>How Well Prepared is the Organization to Address this Risk?</th>
<th>Risk Priority</th>
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<tbody>
<tr>
<td></td>
<td>High</td>
<td>Med</td>
<td>Low</td>
<td>None</td>
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<tr>
<td>Score:</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
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<tr>
<td>Central Line Bloodstream Infections</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Increased rate of CLBSI</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Lack of Staff Education</td>
<td>X</td>
<td></td>
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<tr>
<td>Supply Cart Not Consistently Available</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Staff not following all bundle elements at least 95% of time</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Lines not being removed promptly when no longer needed</td>
<td>X</td>
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<tr>
<td>Checklist not used consistently</td>
<td>X</td>
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## SWOT ANALYSIS: Central Line Associated Bloodstream Infections (CLABSI) Prevention Practices

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<tr>
<th><strong>STRENGTHS</strong></th>
<th><strong>OPPORTUNITIES</strong></th>
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<tbody>
<tr>
<td>Policy evidence-based and current</td>
<td>Education of new staff (nurses and physicians) for all CLABSI practices, e.g., formal education and competency assessments</td>
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<td>Current ICU Staff competent in approved practices based on periodic assessments</td>
<td>Identify nurse and physician champions</td>
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<tr>
<td>Hand hygiene compliance at 94% and improving</td>
<td>Revise procedure to assure availability of supplies at all times to enhance compliance, e.g., cart or kit</td>
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<tr>
<td>Physician leadership interested in patient safety and improving CLABSI practices</td>
<td>Use checklist to assure all tasks are carried out; report analysis to staff</td>
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<td></td>
<td>Address adherence to MSB with physicians using MD Champion</td>
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<tr>
<th><strong>WEAKNESSES</strong></th>
<th><strong>THREATS</strong></th>
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<tbody>
<tr>
<td>Some physicians do not adhere to maximal sterile barriers (MSB)</td>
<td>Abuse to nurses who point out lack of adherence to CLABSI insertion protocol</td>
</tr>
<tr>
<td>Non ICU staff not familiar with central line care</td>
<td>Supplies not consistently available in timely manner for insertion procedures</td>
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<tr>
<td>Non-optimal sites sometimes chosen e.g., femoral site often selected</td>
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<tr>
<td>Residents do not always feel they are well-trained for safe insertion procedures and sites.</td>
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<tr>
<td>Inconsistent removal of central lines when unnecessary</td>
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</table>
Provide central line–associated bloodstream infection rate data and prevention outcome measures to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.

From front line staff to board members

Whole-house surveillance is required per the following FAQ:

Link to FAQ: http://www.jointcommission.org/AccreditationPrograms/Hospitals/Standards/09_FAQs/NPSG/Healthcare_associated_infections/NPSG.07.04.01/central_line_associated_bloodstream_infection.htm
Reporting CLABSI Data

Rationale
- Identify targets for further improvement
- Assess impact of improvement initiatives
- Motivate HCP to enhanced performance
- Permit accountability in performance (incentives)
- Engage key stakeholders

Tools
- Report cards, dashboards and control charts
- Academic detailing with key stakeholders and opinion leaders
- Point of care review
Use a catheter checklist and a standardized protocol for central venous catheter insertion. See FAQ: “The checklist or protocol is not required to be a part of the patient’s medical record. A simple indication that the checklist or protocol was completed, perhaps via a checkbox or brief note, is sufficient.”

FAQ Link: http://www.jointcommission.org/AccreditationPrograms/Hospitals/Standards/09_FAQs/NPSG/Healthcare_associated_infections/NPSG.07.04.01/central_line_associated_bloodstream_infection.htm
Perform hand hygiene prior to catheter insertion or manipulation.

Please see NPSG.07.01.01, which requires compliance with either CDC or WHO hand hygiene guidelines.

Please note that this applies to insertion and care.
For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable.

Please note this says femoral vein, not femoral artery.

Each organization may determine what constitutes “unavailable”.
“Use a standardized supply cart or kit that contains all necessary components for the insertion of central venous catheters.”

- This may be a custom kit, a mass-market kit, a cart with drawers, or even a bag or box filled with supplies.

- Key message: have everything ready before you start.
Use a standardized protocol for sterile barrier precautions during central venous catheter insertion.

All healthcare personnel
- Mask
- Cap
- Sterile gown
- Sterile gloves

Patient
- Large sterile drape
“Use an antiseptic for skin preparation during central venous catheter insertion that is cited in scientific literature or endorsed by professional organizations.

Important note: This is an expansion of requirements that will allow for options to CHG if evidence-based documentation exists.

Please see the August 2010 edition of Perspectives.
Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports.

This includes both injection and specimen procurement.

See FAQ: “This is not a patient-specific documentation requirement. Surveyors will ask to see each organization’s protocol; this may be in the form of a policy, protocol, etc.”

FAQ Link:
http://www.jointcommission.org/Accreditation Programs/Hospitals/Standards/09_FAQs/NPSG/Healthcare_associated_infections/NPSG.07.04.01/central_line_associated_bloodstream_infection.htm
Evaluate all central venous catheters routinely and remove nonessential catheters.

Each organization may define its own time frame and who will be responsible.

This is one of the most critical requirements for patient safety!!
Catheter Insertion Bundle

- Hand Hygiene
- Maximal Barrier Precautions Upon Insertion
- Chlorhexidine Skin Antisepsis
- Optimal Catheter Site Selection, with Avoidance of the Femoral Vein for Central Venous Access in Adult Patients
- Daily Review of Line Necessity with Prompt Removal of Unnecessary Lines

http://www.ihi.org/IHI/Topics/CriticalCare/IntensiveCare/Changes/ImplementtheCentralLineBundle.htm
07.05.01 – Surgical Site Infections
NPSG.07.05.01
AHC, CAH, HAP and OBS

“Implement evidence-based practices for preventing surgical site infections.”

Each organization may define which surgeries on which to focus its efforts (targeted surveillance).
“Educate staff and licensed independent practitioners involved in surgical procedures about surgical site infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in surgical procedures is added to an individual’s job responsibilities.”

Education will be different for different providers. Each organization may determine its own educational approach and content. This education is provided to a very focused group. Note annual requirement.
“Educate patients, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention.”

- This is focused education.
- See also PC.02.03.01.
- Define minimum content of education for all, may customize by procedure.
“Implement policies and practices aimed at reducing the risk of surgical site infections. These policies and practices meet regulatory requirements and are aligned with evidence-based guidelines (for example, the Centers for Disease Control and Prevention [CDC] and/or professional organization guidelines).”

Organizations should compare their existing P&P with relevant guidelines and update as needed. As new guidelines evolve, they should be incorporated within a reasonable period of time (see IC.01.05.01 EP 1).
As part of the effort to reduce surgical site infections:

- Conduct periodic risk assessments for surgical site infections in a time frame determined by the [organization].
- Select surgical site infection measures using best practices or evidence-based guidelines.
- Monitor compliance with best practices or evidence-based guidelines.
- Evaluate the effectiveness of prevention efforts.

**Note:** Surveillance may be targeted to certain procedures based on the organization’s risk assessment.

This may be part of or distinct from the general IC improvement process required in IC.01.03.01.

IC Program risk assessments are done at least annually per the IC chapter.
“Measure surgical site infection rates for the first 30 days following procedures that do not involve inserting implantable devices and for the first year following procedures involving implantable devices. The organization’s measurement strategies follow evidence-based guidelines.

**Note:** Surveillance may be targeted to certain procedures based on the organization’s risk assessment.”

These time frames are not new; they were included in the 1999 HICPAC SSI document. Most organizations utilize CDC/NHSN definitions.
“Provide process and outcome (for example, surgical site infection rate) measure results to key stakeholders.”

Data is dependent on risk assessment (see EP 4)

From front line staff to board members
NPSG.07.05.01 EP 7

“Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to methods cited in scientific literature or endorsed by professional organizations.”

This is an unprecedented situation wherein a core measure has been brought into an accreditation requirement.

The good news is that most hospitals have been working on this for years.

***This is another change from the August 2010 Perspectives.
When hair removal is necessary, use a method that is cited in scientific literature or endorsed by professional organizations.

This is not new; this was originally published in the 1999 HICPAC SSI document.

Recognize that this is a cultural change for many surgeons and that they will need to see the evidence behind this in order to support the change.

***This is another change from the August 2010 Perspectives.
Safe Surgery Guide

Click here to view sample pages of this product.

Foreword by Peter J. Pronovost, M.D., Ph.D.
What Will the Joint Commission be Looking for When They Come to Survey?

How Can You Prepare to Comply with the New NPSGs?
Risk-Based IPC Planning
Central Line Example

1. Risk assessment
   - Central line infection, SSI and MDRO Infection risk

2. Goals
   - Reduce or eliminate infection

3. Implementation
   - Based on guidelines and organization-specific risk

4. Evaluation
   - Rates reduced?
   - Best practices followed?
   - Implementation complete?
What will the Joint Commission be looking for?

- Demonstrate knowledge of CLABSI rates and trends, SSIs, MDROs in the organization
  - Display data - compare with external benchmarks
- Demonstrate adherence to evidence-based guidelines
- Staff training provided and evaluated
- Show performance improvement efforts
Maintaining Readiness for Surveys

- Know the Elements of Performance for NPSG .07 Do you meet them?
- Review accreditation and regulatory updates on a regular basis
  - FAQs on the JC web site
  - New CMS Interpretive Standards for IC
  - Local and State Regulations
- Integrate activities with patient safety, quality and other departments
  - Cannot maintain readiness in “isolation”
  - No Silos
- Perform tracers
Maintaining Readiness

Sign up for free notifications:
- CDC
- Premier Safety Institute
- Institute for healthcare Improvement (IHI)
- Agency for Healthcare Research and Policy (AHRQ)
- Joint Commission
- APIC
- SHEA
- IDSA
Maintaining Readiness

Periodic, thorough, and honest self-assessment
- Policy review
- Incident reports
- Patient complaints
- Patient satisfaction surveys
- Employee complaints/Hotline
- Executive rounds
- Internal audits (tracers)
- Focus groups
Tracers

- One of the most effective tools to learn what is really going on – trace a patient with a central line
- Include staff in the process for learning
- Identify excellence and the gaps
- Give the feedback to staff and ask for action plan
- Include them as part of the next tracer
2010 Standards for Infection Prevention and Control

Key Areas
Deeming Authority Background

- 1965 Medicare Statute Gave The Joint Commission its Unique Hospital Deeming Authority
- Terminology – “Deemed Status” Vs. “Deeming Authority”
  - National Accrediting Organizations Seek Approval From CMS For the Authority to Deem (Judge) a Health Care Provider as Meeting the Medicare Requirements
The Joint Commission has always incorporated CoPs into the survey process. Surveyors began surveying for these specific requirements in January, 2009. Compliance scoring began in July 2009 including Condition level and Standard Level determination. Organizations will still receive feedback on areas of non-compliance with the new requirements noted by the surveyors. This enables organizations to begin addressing these issues before the July implementation date.
Hospital survey reports also contain CMS Condition of Participation (CoP) language as of July 2009

- Per the June 2009 edition of Perspectives, “The organization receives a written report of the survey findings, which includes any requirements for improvement where the CoPs were not substantially met and Evidence of Standards Compliance (ESC) are required.”
The Survey Process

- TJC tracer methodology has not changed.
- New and Revised requirements are integrated into current survey activities.
- Surveyors may need to verify compliance with TJC elements of performance.
Frequently Scored IC Findings

- Risk assessment
- Goals
- Annual evaluation
- Sterilization and high-level disinfection
- Employee health
2009 Arrangement of IC Standard
Planning

The organization identifies the individual(s) responsible for infection prevention and control
The [organization] identifies the individual(s) responsible for the infection prevention and control program.
“The hospital identifies the individual(s) with clinical authority over the infection prevention and control program.”

- The surveyor will ask - Who has the authority, and how has this been identified?
- Important to know this when determining who has taken action
“When the individual(s) with clinical authority over the infection prevention and control program does not have expertise in infection prevention and control, he or she consults with someone who has such expertise in order to make knowledgeable decisions.”

This is only as needed.
“The hospital assigns responsibility for the daily management of infection prevention and control activities. Note: Number and skill mix of the individual(s) assigned should be determined by the goals and objectives of the infection prevention and control program.”

This is daily responsibility, as opposed to program authority.
“For hospitals that use Joint Commission accreditation for deemed status purposes: The individual with clinical authority over the infection prevention and control program is responsible for the following:

- Developing policies governing control of infections and communicable diseases
- Implementing policies governing control of infections and communicable diseases
- Developing a system for identifying, reporting, investigating, and controlling infections and communicable diseases”
“For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The infection control program is under the direction of a designated and qualified professional who has training in infection control.”
Hospital leaders allocate needed resources for the infection prevention and control program.
EP 1-Information

All programs except BHC

“The hospital provides access to information needed to support the infection prevention and control program.”

- Computer & software
- Resource materials
- Journals
- Other education
The Joint Commission Infection Prevention and Control Handbook for Hospitals

- General Principles
- Departmental Practices
IC.01.03.01 Risk Assessment

“The hospital identifies risks for acquiring and transmitting infections.”

The risk assessment is the cornerstone upon which the IC program is built.
“The hospital identifies risks for acquiring and transmitting infections based on the following: Its geographic location, community, and population served.”
“The hospital identifies risks for acquiring and transmitting infections based on the following: The care, treatment, and services it provides.” e.g.,

- Transplant
- Specialty surgery
- Rehab
- Long-term care

“The hospital identifies risks for acquiring and transmitting infections based on the following: The analysis of surveillance activities and other infection control data.”
“The hospital reviews and identifies its risks at least annually and whenever significant changes occur with input from, at a minimum, infection control personnel, medical staff, nursing, and leadership.”
“The hospital prioritizes the identified risks for acquiring and transmitting infections. These prioritized risks are documented. There must be a method for ranking risk”

Probability and severity are the most common factors utilized

Consider using a similar ranking scheme to the one used for hazard vulnerability analysis

(Example only – table not required)
Performing a IC Risk Assessment

1. **Establish Priorities**
   - JC Req.
   - Limit Number
   - Collaborative

2. **Identify Risk Targets**
   - Organizational
   - Local Community
   - Societal

3. **Involve Others**
   - ICC
   - Leadership
   - Key Staff
   - Health Dept

4. **Develop Methods**
   - Quantitative
   - Qualitative
   - SWOT
   - Gap Analysis
   - Research

5. **Perform the Assessment**
   - Templates
   - Establish Timelines
   - Collaborative

6. **Leadership**
<table>
<thead>
<tr>
<th>Event</th>
<th>Probability of Event Occurrence</th>
<th>Potential Severity/Risk Level of Failure</th>
<th>Organizational Response</th>
<th>Current State of Preparedness</th>
<th>Risk Level For Org</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency preparedness</td>
<td>H 3</td>
<td>M 2</td>
<td>L 1</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Water Supply Unavail</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Care Supplies Unavail</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evacuation Required</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hi Risk Procedures and Processes</td>
<td>H 3</td>
<td>M 2</td>
<td>L 1</td>
<td>N</td>
<td>Life Threatening 3</td>
</tr>
<tr>
<td>Hand Hygiene Compliance &gt;90%</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endoscope Contamination</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unauthorized Use of SUDs</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inadequate Cleaning/Disinfection of patient care equipment</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inappropriate use of Isolation</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Questions to ask re: risk assessment

Has the organization performed
A thorough IPC risk assessment?
Did staff participate?
Multidisciplinary?
Ranked priorities
Approval by leadership?
Areas to consider for assessing risk

- **External Threats:**
  - events, populations, geography

- **Internal Threats:**
  - device related infections, other infection rates and risks,
  - environment, staff performance, communication, emergencies,
  - education, communication, staffing, other

- Process measures, outcome measures
Risk Assessment for Infection Prevention and Control

- Step-by-step instructions on how organizations can perform a risk assessment
- Information about how to select appropriate risk assessment methods and tools
- Explanation of risk points in health care organizations – areas inside and outside of a health care organization that pose infection risks
- Tools that help organizations assess their compliance with Joint Commission requirements and improve their infection prevention and control program
- Case studies of effective risk assessment plans from domestic and international organizations
IC.01.04.01 Goals

“Based on the identified risks, the hospital sets goals to minimize the possibility of transmitting infections.”

- Prioritized risks
- Limiting unprotected exposure to pathogens
- Limiting transmission of infections associated with procedures
- Limiting transmission of infections associated with use of medical equipment
- Improving compliance with hand hygiene guidelines
***Remember***

Your evaluation must address success or failure of goals. Be sure to consider this when formulating your goals.
IC.01.05.01 Written Plan

The hospital has an infection prevention and control plan.

- Evidence-based national guidelines or expert consensus
- Activities, including surveillance
- Process to evaluate the plan
Updated version of a JCR best-seller, developed in partnership with the Association for Professionals in Infection Control and Epidemiology (APIC), addresses infection prevention and control in all types of health care settings.

Discusses and clarifies Joint Commission requirements for infection control and offers a wealth of tools for organizations to assess and improve their infection control activities.

Edited by infection prevention and control experts Barbara Moore Soule and Kathleen Meehan Arias, and written by a host of infection preventionists
“The hospital describes, in writing, the process for investigating outbreaks of infectious disease.”

*The surveyor will ask-*
- Has this been predetermined?
- Does the method chosen “close the loop”
The organization implements infection prevention and control activities.
IC.02.04.01 Influenza Vaccination

The hospital offers vaccination against influenza to licensed independent practitioners and staff.
EP 1 - “The hospital establishes an annual influenza vaccination program that is offered to licensed independent practitioners and staff.”

***This is surveyed year-round!

EP 2 - Educate staff

EP 3 - “The hospital provides influenza vaccination at sites accessible to licensed independent practitioners and staff.”
“The hospital annually evaluates vaccination rates and the reasons given for declining the influenza vaccination.”
The organization evaluates the effectiveness of its infection prevention and control activities.
Annual Evaluation Process

Plan Evaluation Process
- Establish Timeline

Identify IP Program Evaluation Team

Risk Analysis Goals/Objectives Strategies Evaluation

Design Evaluation Form or Template

Collect Data to Review Goals, Objectives, and Other Activities

Evaluate Objectives Met or Not Met Use
Quantitative or Qualitative Analysis Plan Revisions

Prepare and Disseminate Report

Include all Required Elements From Standards and NPSG
Infection Control Survey Process

Individual patient tracers

- Hand hygiene
- Standard and transmission-based precautions
- Communication and training
- Cleaning, disinfection and sterilization
- Many other issues!
Infection Control System Tracer

- One hour dedicated to the IC system
- Group discussion of the plan and program
- Moving tracer of a patient, preferably one with an IC issue
Tips

- Review your SAG (Survey Activity Guide)
- Review the process with all people who will be in the room for the interview
- Be prepared to answer questions about your program and plan
- Be prepared to speak to issues identified during the survey
- Help the surveyor select a patient
Resources-Joint Commission Website

- Infection Prevention and Control Books
- National Patient Safety Goals – 2009
- FAQs
Infection Prevention and Control Books from JCR
Additional Resources

- Joint Commission Resources
  - www.jcrinc.com
- Centers for Disease Control and Prevention
  - www.cdc.gov
- APIC www.apic.org
- SHEA www.shea-online.org
- Food and Drug Adm www.fda.gov
- American Institute of Architects www.aia.org
- National Quality Forum www.qualityforum.org
Questions

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