The Impact of JCAHO's National Safety Goals on Wound Management Programs

Joint Commission List of Dangerous Abbreviations, Acronyms, or Symbols

(These abbreviations, acronyms and symbols should not be used in any patient record. Your organization should also identify at least 2 other abbreviations, symbols or acronyms annually that are not on the list and include them in your organization-specific list of abbreviations, acronyms and symbols that are not to be used).

Abbreviation	Potential Problem	Preferred Term
U (for unit)	Mistaken as zero, four, or cc	Write "unit"
IU (for international unit)	Mistaken as IV (intravenous) or 10 (ten)	Write "International Unit"
Q.D. (Latin abbreviation for once daily)	Mistaken for each other	Write "daily"
Trailing zero (5.0 mg) Lack of leading zero (.5mg)	Decimal point is missed	Never write a zero by itself after a decimal point (5 mg), and always use a zero before a decimal point (0.5 mg)
MS MSO_4 $MgSO_4$	Confused for one another Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" or "magnesium sulfate"

Source: Source: Joint Commission Resources: Special Report 2005 Joint commission national patient safety goals: Practical strategies and helpful solutions for meeting these goals. Joint Commission Perspectives on Patient Safety 2004;4(9):6.

New Features

With one call to your WoundExpert customer service representative, all patient data can be "inherited" from the previous visit to automatically fill in data entry fields. Staging, debridement, vital signs, lower extremity edema measurements; any data field will automatically populate, and those data fields can still be changed to reflect new information. Spending time entering the same information from visit to visit can be a laborious process. This new feature may be just what you're looking for to increase data entry validity and decrease data entry time. However, it is critical to review each field that automatically populates to ensure that information is still valid for documentation.

As always, if you have any questions about these features or new ideas for future enhancements, please contact our customer support team at 800.411.6281 x13.

Please Welcome the Following Facilities to Our Family of Clients:

- Wound Healing Center at Woodland Heights Medical Center
  Lufkin, Texas
- St. Mary's Comprehensive Wound Healing Center
  Jefferson City, Mo.
- St. Vincent's Wound Treatment Center
  Indianapolis, Ind.

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WoundExpert Times

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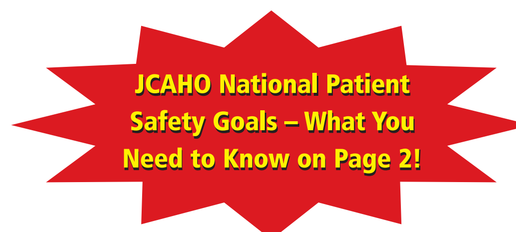


Welcome to the WoundExpert Times.

The goal of this publication is to explore wound care topics with knowledgeable professionals in our Professional Profile, to educate and inform our users all around the country about WoundExpert updates, and to provide a forum for frequently asked questions. Make sure to share all issues of WoundExpert with your wound care team. If you have questions or story ideas, or you wish to participate in our interview, contact: ideas@woundexpert.com. We look forward to hearing from you.

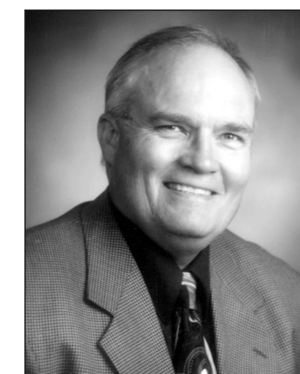
Company Updates

Net Health Systems is pleased to announce the addition of Mary Ann Smeltzer to our team as Director of Clinical Operations. Mary Ann is a Masters prepared nurse and certified in wound care by WOCNB with over 25 years of nursing experience, over eight of those in wound care. She has provided clinical support, education and quality oversight to more than 22 wound programs. Ms. Smeltzer is also a Disease Specific Care Program Reviewer for JCAHO and an adjunct faculty member at Community College of Allegheny County.

"We are delighted to add Mary Ann to our team," said Patrick Colletti, President of Net Health Systems. "Her clinical expertise, combined with her experience in establishing strong standards in compliance systems, will be a valuable asset in the continued success of our EMR initiative, educating our new and existing clients, and assisting them in productivity."

Professional Profile: Daniel R. Rustvang RN, MSN, FNP-C

Technical Coordinator, Chronic Wound Clinic
Altru Main Clinic, Grand Forks, North Dakota



What led you to the wound care industry?

I was recruited by Dr Rolf Paulson, a chronic wound care visionary, who provided me the opportunity to start practice in this specialty 3 1/2 years ago. I was able to become experienced in a relatively short period of time in a clinic that had started in 1998.

I thoroughly enjoy working with patients who are seeking treatment for their chronic wounds; patients with a sense of frustration and desperation in the reality that a simple looking wound has not healed with conventional methods. I like being in the position to apply developing science and technology to effect positive outcomes and patient satisfaction with getting their wound closed.

What types of advanced therapies are you currently using and why?

Our approach is always to try to determine the cause of the wound. This guides our treatment approach. If there is adequate blood supply, and pressure and edema are controlled, we move into the specifics of dressings for optimum wound bed management. Getting the wound "ready to heal" is paramount. We use absorptive silver dressings and products that maintain wound bed moisture. This makes up over 80% of our therapies. We do use the VAC and have even used maggot therapy.

In your current position, what are your goals or initiatives?

We intend to have a totally digital medical record that will meet our requirements for billing, communication of progress to our referral providers, and wound outcomes tracking that we can use for research and sharing of best practices and evolving science in this specialty.

What tools do you use to stay educated?

Wound & Skin Care journals, regional education seminars, networking with others in our region in the chronic wound care field, and national meetings. In October 2003, I attended an outstanding national wound meeting in Chicago; some great networking opportunities and a chance to bring in the latest science [to our clinic].

We would like to thank Dot Weir for her participation for our last profile.

Mary Ann Smeltzer, MS, RN, CWCN
Director of Clinical Operations

Judging by the feedback comments and calls coming in to us lately, a number of you are scheduled for your JCAHO accreditation reviews in the near future. The information I'm providing comes from Issues and Strategies for Nurse Leaders: Meeting Hospital Challenges Today, a Joint Commission Resource book that was just published and released this month. Among other valuable insights into how you can demonstrate compliance with JCAHO's standards, the book focuses a chapter on the National Patient Safety Goals for 2005 which is the subject of most of the questions we are getting.

> **"Remember, it is the actual performance of the goal and their requirements, *not the documentation*, that surveyors will evaluate during an on-site survey."**

I'd like to highlight some of the information in Chapter 5: "The Nurse's Role in Patient Safety and Care Outcomes" for you here but if you'd like to order the book itself or find out what other resources are available to help you stay up to date on JCAHO standards, you can go to www.jcrinc.com.

The intent of the National Patient Safety Goals is to make hospitals aware of problematic areas in health care and to provide evidence and expert-based solutions for those problems. The Goals are updated annually and modified to address particular areas of practice such as Inpatient, Ambulatory Care, Home Health, Long Term Care, etc.

Most outpatient wound clinics are reviewed under the Ambulatory Care Standards. The Goals that do not apply in a particular setting are not scored by the Surveyor reviewing that setting (visit www.jcaho.org to find the list of applicable Goals for your specific type of program — refer to the FAQ section of the website for clarification of the how Goals are applied to your particular area of practice).

In the list of 2005 Goals, you can see that several do not apply to most wound management programs, such as #5 – Improve the safety of using infusion pumps. Likewise, when you are considering debridement of all existing wounds during a patient encounter, there is no need to mark the surgical sites as these are self evident and, generally, the physician or licensed independent practitioner who will perform the debridement has been present for the assessment and decision to debride, precluding the possibility of debriding a wound wrongfully.

Please note, however, that if multiple wounds are present and not all will be debrided, there should be a means to identify those wounds that WILL be debrided during that encounter. Obtaining the patient's agreement on which wounds will be debrided as part of the timeout procedure is a good way to assure that the correct wounds are treated.

2005 National Patient Safety Goals

1. Improve the accuracy of patient identification: use at least 2 patient identifiers, neither of which can be the patient's room number, whenever administering medications, blood products, taking blood samples and other specimens for testing, and prior to treatments and procedures.

2. Improve the effectiveness of communication among caregivers: The person receiving verbal or telephone orders and critical test results must "read back" the information to the person giving the order or test results to insure it is correct. There must be a standard list of abbreviations, acronyms, and symbols that **are not** to be used (see back page). Measures to improve timeliness of reporting and receipt of critical test results and values to the responsible caregiver should be undertaken.

3. Improve the safety of using medications: Remove concentrated electrolytes from patient care units. Standardize and limit the number of drug concentrations available in an organization. Identify and annually review a list of look-alike/sound-alike drugs used and take action to prevent errors involving interchange of these drugs (N/A for most wound management programs).

4. Adherence to the Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery: Conduct a pre-operative verification process, (such as a checklist), to assure all information and consents necessary to the procedure are present and complete per policy. Mark the operative site, (unless all wounds present are included in the procedure). Conduct a "timeout" immediately before starting the procedure. (N/A for facilities and programs that do not perform any type of surgical intervention).

5. Improve the safety of using infusion pumps: Ensure free-flow protection on all general use and PCA intravenous infusion pumps. (N/A for most ambulatory care clinics but important in inpatient and some long term care settings).

6. Improve the effectiveness of clinical alarm systems. N/A for hospital direct patient care but can be applicable to Assisted Living or Long Term Care settings.

7. Reduce the risk of health care-associated infections: Comply with CDC hand hygiene guidelines. Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

8. Accurately and completely reconcile medications across the continuum of care: Develop a process for obtaining and documenting a complete list of the patient's current medications, (including over the counter and herbal preparations), involving the patient. Communicate a complete list of the patient's medication to the next provider of service when the patient is referred or transferred to another setting, service, practitioner, or level of care within or outside the organization.

9. Reduce the risk of patient harm resulting from falls: Assess and periodically reassess each patient's fall risk and take actions to address those identified risks.

10. Reduce the risk of influenza and pneumococcal disease in older adults: Develop and implement a program for administration and documentation of flu and pneumococcus vaccines. Identify new cases of influenza to manage an outbreak. (N/A for hospital inpatients but may be applied to other programs performing disease-specific care and managing "at risk" patients such as Assisted Living Programs and Long Term Care).

11. Reducing the Risk of Surgical Fires: (N/A for most wound management settings but can be applied to HBO programs).

Many of you have expressed concerns about a need to add fields to WoundExpert to document compliance with the National Patient Safety Goals. The following is a direct quote from the *Issues and Strategies for Nurse Leaders: Meeting Hospital Challenges Today*, Chapter 5, pages 116-117. (The emphasis added to the quote is mine). It is also included in the FAQs on the JCAHO website regarding the National Patient Safety Guidelines.

> "Although the National Patient Safety Goals are generally more prescriptive than Joint Commission standards requirements, organizations are permitted to design alternative approaches to meeting goal requirements and to request Joint Commission consideration and approval of such alternatives. Remember, it is the actual performance of the goals and their requirements, *not the documentation,* that surveyors will evaluate during an on-site survey. Surveyors might ask how you know that you are in compliance on an ongoing basis throughout the organization. This might involve surveillance or monitoring on your organization's part, although this is not required."

If you are still unsure whether you are required to actually document compliance in the patient record for any JCAHO standard, you can refer to your organization's Standards Manual or call your organization's JCAHO representative or the Standards Division at JCAHO at 630-792-5000.

The National Patient Safety Goals are scored "in compliance" or "not in compliance." Most of the Goals require 100% compliance, that is, the surveyor or reviewer does not find any cases of failure to comply with the Goal. For handwritten "do not use" abbreviations and hand hygiene, at least 90% compliance is required. Joint Commission Surveyors and Disease Specific Care Reviewers have been instructed that 3 or more observations of non-compliance equal a total score of non-compliance with that Goal. Handwritten includes free-text keyboard entry and pre-printed forms must be 100% compliant. After the fact correction of an error still counts as an error but an immediately corrected error is not counted as an error. (i.e., If you make a "slip" while charting and immediately correct it, it is not an error. If the surveyor finds an error and you correct it then, it is still an error). If someone not employed by the organization, or a non-staff physician uses a prohibited abbreviation, it is expected that clarification will be undertaken immediately, and, if done, will not count as an error during the survey.

> **Any time an individual is observed failing to follow the hand hygiene guidelines is a "strike," even if the same person is the only one who repeatedly fails to follow the standard.**

For purposes of calculating the "three strikes," surveyors and reviewers will count as follows. Any time an individual is observed failing to follow the hand hygiene guidelines is a "strike," even if the same person is the only one who repeatedly fails to follow the standard. For prohibited abbreviations, any clinician who fails to follow the standard incurs one "strike" per patient record where the error is identified. Each error by a different clinician is considered a "strike." In the case of medication administration records, when the author is not identifiable, every "slip" is counted as an error.

As those of you who have experienced a JCAHO survey recently can attest, the process has changed markedly from the old days when the surveyors sat with volumes of policy manuals and patient and employee files, judging your paper trail more than your actual quality of care. The current surveys and reviews are more collaborative and comparable to "real life" practice. You can do more for demonstrating your adherence to standards by insuring that staff and physicians practice your policies and can speak to the surveyor about what is usual practice in your facility or program than by spending excessive amounts of time trying to add checkboxes and statements of compliance to your records. While documentation remains an important and essential part of patient care, your JCAHO review focus is now more on demonstrating that you "practice what you preach."

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