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February 16, 2005

Dennis S. O’Leary, MD

President

Joint Commission on Accreditation of Healthcare Organizations

One Renaissance Blvd

Oakbrook Terrace, IL 60181

Dear Dr. O’Leary:

The American College of Emergency Physicians (ACEP) appreciates the opportunity to review the proposed 2006 Hospital National Patient Safety Goals. The College represents more than 23,000 emergency physicians and supports JCAHO’s focus on patient safety. With over 114 million visits to emergency departments (EDs) per year the potential for the proposed requirements to improve patient safety is obvious but with this comes increased staff work load. It is imperative that the Patient Safety Goals that are adopted for 2006 provide for flexibility in implementation.

Questions were raised about the additional resources required for implementation of some of the requirements in the ED. Although many of these requirements may be appropriate for the inpatient setting they should not be required in the emergency department.

The experts that reviewed the proposed 2006 Patient Safety Goals and responded to the questionnaire expressed the following concerns:

- Providing medication administration records to patients in the ED is not appropriate due to the nature of care provided (emergent) and time required for producing the record.
- Labeling of all medications and medication containers could be interpreted to apply to the ED and this would delay care provided to patients.
- Requiring influenza and pneumococcus vaccination protocols in the ED setting would require additional resources in an already crowded system and slow treatment for patients waiting for care.
- Implementation of requirements without a clear assessment of priorities, practicality, evidence base and expense.

Attached is the completed field review questionnaire from ACEP on the proposed goals. Please contact Margaret Montgomery, RN, MSN at 972-550-0911, extension 3230 if you have any questions.

Sincerely,

<signed>

Robert E. Suter, DO, MHA, FACEP

President

2006 Proposed Hospital National Patient Safety Goals Field Review

Section 1 – Demographics

1. Reviewers Name:
2. Organization: American College of Emergency Physicians
3. In which one of the following capacities are you primarily responding?
Other: Professional Medical Society
4. If you are primarily representing an accredited organization, which (one) category best describes your role in that organization?
Chief Executive Officer
Medical Director/Medical Staff President
Governing Body Member
Nurse Executive/Nursing Management
JCAHO Coordinator
Other Administrator
Quality Improvement/Risk Management
Other (please specify) Committee member
5. Please check the box that reflects your professional discipline, if applicable:
Physician – Primarily administrative
Practicing Physician
Non-physician direct care provider

Section 2 - Questions Specific to the Proposed 2006 NPSGs

Instructions: Please review the proposed 2006 National Patient Safety Goals and associated Requirements before answering the questions below. The field review questions are specific to the proposed new NPSG Goals and Requirements.

2006 Proposed Hospital National Patient Safety Goals Field Review

6. For each potential new NPSG requirement, select one of the following options which most closely reflects your position.

The proposed requirement will:

	Significantly improve patient safety and is achievable.	Significantly improve patient safety but needs additional clarity or definition.	Significantly improve patient safety but needs additional research.	Should be removed from consideration as a NPSG.
Requirement 2E		X		
Requirement 3D	X			
Requirement 3E	X			
Requirement 3F		X		
Requirement 3G		X		
Requirement 3H	X			
Requirement 3I				X
Requirement 3J		X		
Requirement 3K				X
Requirement 3L	X			
Requirement 3M	X			
Requirement 9B	X			
Requirement 10A		X		
Requirement 10B		X		
Requirement 11A		X		
Requirement 13A		X		
Requirement 13B		X		
Requirement 13C		X		
Requirement 13D		X		
Requirement 13E	X			
Requirement 13F	X			
Requirement 14A				X
Requirement 14B			X	
Requirement 14C		X		
Requirement 14D		X		
Requirement 14E		X		
Requirement 14F	X			
Requirement 15A		X		
Requirement 15B			X	
Requirement 15C		X		
Requirement 16A	X			
Requirement 16B	X			
Requirement 17A	X			
Requirement 18A	X			
Requirement 18B				X

2006 Proposed Hospital National Patient Safety Goals Field Review

7. Regarding Proposed Requirement 2E:
Are there types of patient care transitions where poor communication placed the patient at risk?
Yes
In the emergency department (ED), transfer of care for patients between shifts where the incoming team is not aware of the treatment plan or data can be a patient safety issue. Physicians often stay until well after their shift ends in order to reduce the number of transfers, but often a transfer is required, especially when a patient is waiting in a queue for a test such as abdominal CT, which often requires a prolonged wait. These patients are by their nature often the sickest and have the least certain diagnosis, thus least likely to be accepted by the inpatient physicians or surgeons, but are also most likely to harbor a serious disease. No matter how good the accepting physician is, he/she has just arrived and will be accepting a large number of other new patients. The transferred patient will thus be low in the oncoming physician's cognitive space. Poor communication may leave the patient's pain untreated, changes in vital signs unobserved, and test result interpretation delayed.
8. Regarding Proposed Requirements 3D & 3E:
What actions to minimize the risk of infection should be required when using a multiple dose vial?
Minimize the number of multi-dose vials used or use the vial for one patient only.
9. Regarding Proposed Requirements 3F, 3G & 3H:
Which of these proposed requirements if implemented properly would have the greatest impact on reducing the risk of wrong line connections?
Requirement 3G
Identify connections that can be made inappropriately and don't stock lines that could be interconnected inappropriately. Use a color code just like the electricians do to avoid mistakes. For example – NG tubes – brown; Feeding tubes – green; foley tubes – red; peritoneal dialysis – blue, etc.
10. Regarding Proposed Requirements 3F, 3G & 3H:
Are there other specific actions which would decrease the risk of wrong line connections?
Staff education; stocking catheters that can't be physically connected inappropriately; putting a tag on each line that identifies it just like a luggage tag.
11. Regarding Requirement 3I:
Should all services which administer medications intrathecally be included in Requirement 3I?
Not applicable to emergency medicine.
12. Regarding Proposed Requirements 3I, 3J, 3K & 3L:
Which of these proposed requirements if implemented properly would have the greatest impact in reducing errors in the administration of intrathecal medication?
Not relevant to emergency medicine practice.
13. Regarding Proposed Requirement 3M:
Are there additional, specific requirements you would recommend to address medication safety in perioperative settings?
No

2006 Proposed Hospital National Patient Safety Goals Field Review

This would be challenging to do in an emergency and during procedures that require sterility. Keeping labels sterile (normal saline, lidocaine, etc.) would be difficult. For simple procedures where only one medication or solution (saline) is to be administered, the process of labeling the syringe will add time to completion of procedures. Labeling syringes where multiple medications are to be given is useful and a good patient safety measure. Companies that manufacture sterile supplies such as central lines, lumbar puncture kits, suture kits, etc should be the ones mandated to provide sterile labels in their kits if there is evidence that this is a safety risk in the ED. By proposing a blanket statement that all medications and medication containers should be labeled could result in patient harm by encouraging physicians and nurses to attach unsterile labels to sterile equipment exposing patients to potentially increased rates of deadly infections.

Section 3

14. Regarding Proposed Requirement 9B:
Should this requirement be expanded to the Hospital Program?
Yes
This is a good idea and is already being done to some degree.
15. Regarding Proposed Goal 10 and Requirements 10A & 10B:
Should this goal and requirement be expanded to the Hospital Program?
Yes
Should be part of inpatient practice, but not an emergency department requirement. Requiring flu and pneumococcus vaccination protocols in the ED setting would require additional resources in an already crowded system and slow treatment for patients waiting for care.
16. Regarding Proposed Goal 11 and Requirement 11A:
Should this goal and requirement be expanded to the Hospital Program?
Not relevant to emergency medicine practice.
17. Regarding Proposed Requirements 13A through 13F:
Will your organization be able to meet these requirements?
Yes
A and B are very possible, C is much too vague as to what “external” means, E and F are good and very possible, and to some degree already being done.
18. Regarding Proposed Requirements 13A through 13F:
What is your organization currently doing to create a culture of safety?
Members report that there are information sessions, emails etc. that are conducted through their hospitals and medical staff.
19. Regarding Proposed Requirements 13A through 13F:
Which of these proposed requirements if implemented properly has the greatest impact in creating a culture of safety?
Requirement 13F
A systematic, non-threatening, non-personal, non-discoverable investigation – eg, root cause analysis - of disastrous outcomes is an effective way to demonstrate lessons learned. The hospital quality department should assist with this type of analysis when indicated.

2006 Proposed Hospital National Patient Safety Goals Field Review

20. Regarding Proposed Requirements 13A through 13F:
What other requirements would you recommend?

13 E

Section 4

21. Will use of the Medication Administration Record by the patient as described in Requirement 14B, assist the patient with tracking his/her medications?

Yes

Applying this goal to emergency department patients especially those who are demented, unconscious, or mentally delayed/altered in some way would be futile. It takes time to prepare and give a patient this record and will further delay rapid care often needed during emergency treatment of patients. This requirement should not be applicable to emergency department patients.

Better to educate patients about their medications and answer questions as appropriate. Most importantly, patients are often too ill to co-operate in a productive manner.

22. Regarding Proposed Requirement 14B:
Is the Medication Administration Record the only tool which will achieve this?

No

The medication administration record is not the only method to provide patient education about medication. Not appropriate for the emergency department.

23. Regarding Proposed Requirements 15A through 15C:
Are there additional approaches to address healthcare worker fatigue which should be incorporated into a requirement?

Yes

JCAHO should continue to be actively involved on a government level addressing the nursing shortage, and encouraging more educational opportunities. Hospitals are generally well aware of this problem but often a fatigued nurse is better than no nurse at all. This is a difficult problem, and further goals may not be the best use of resources. Forced overtime should not be allowed. The order of shifts scheduled should be addressed. Worker works the shifts day, evening, night rather than night, evening, day.

24. Regarding Proposed Requirements 16A & 16B:
Do you currently have a program in place to prevent decubitus ulcers?

Yes

25. Regarding Proposed Requirements 16A & 16B:
What other requirements would you recommend?

None – Identify and decide how protocol seems appropriate.

26. Regarding Proposed Requirements 18A & 18B:
Would this requirement increase patient safety in your program?

Yes

The requirements are vague and could easily be misinterpreted. Many hospitals do not have the resources within their community to provide all of the services this requirement could be interpreted to include.

2006 Proposed Hospital National Patient Safety Goals Field Review

27. Regarding Proposed Requirements 18A & 18B:

Is there a specific, identifiable group of staff who should be trained in this area?

Yes

Psychiatric nurses, social workers and affiliated staff with appropriate training.

28. If you have any additional comments regarding the proposed 2006 NPSGs, please provide them in the space below, indicating the specific requirement number followed by your comments.

Many of the proposed requirements appear to be appropriate but should not be applied to the emergency department. When emergency departments are experiencing overcrowding and wait times have increased the actual implementation of the goals slow the care provided to patients and evidence based research has not been conducted to demonstrating an increase in patient safety. Efforts to apply the goals to every setting within the hospital is not always effective or appropriate. Proposed requirement 3M states, "Label all medications, medication containers or other solutions on and off the sterile field." The rationale states this is for the perioperative setting but this could easily be interpreted to include a wider application. Would a syringe of saline used to irrigate a wound have to be labeled when no other solution or medication is being used?

Questions were raised about the additional resources required for implementation of some of the requirements in the ED. Although many of these requirements may be appropriate for the in patient setting they should not be required in the emergency department.

The experts that reviewed the proposed 2006 Patient Safety Goals and responded to the questionnaire expressed concern that:

- **Providing medication administration records to patients in the ED is not appropriate due to the nature of care provided (emergent) and time required for producing the record**
- **Labeling of all medications, medication containers could be interpreted to apply to the ED and this could delay care provided to patients.**
- **Requiring flu and pneumococcus vaccination protocols in the ED setting would require additional resources in an already crowded system and slow treatment for patients waiting for care.**
- **Implementation of requirements without a clear assessment of priorities, practicality, evidence base and expense.**