

January 22, 2007

Dennis S. O'Leary, MD
President
The Joint Commission
One Renaissance Blvd
Oakbrook Terrace, IL 60181

Dear Dr. O'Leary:

The American College of Emergency Physicians (ACEP) represents over 25,000 emergency physicians and appreciates the opportunity to review the Potential 2008 National Patient Safety Goals and Requirements.

The College continues to support The Joint Commission efforts to promote quality patient care but was concerned about some of the Implementation Expectations (IEs) for the Potential 2008 National Patient Safety Goals. The efficacy of implementation of some of the expectations in the emergency department (ED) for all patients was questioned.

Clarification and/or modification for implementation in the ED was identified for the following IEs:

- Goal 3E3 bullet #3 - Notification of dietary about a patient on Warfarin should apply to inpatients only.
- Goal 3E4 bullet #1 - Use of a programmable pump should not be mandated when an initial bolus is ordered.
- Goal 3E4 bullet #2 - Waiting for baseline laboratory in a life threatening emergency could compromise care, baseline PTT is not supported in the literature.
- Goal 3E4 bullet #3 - Should specify this applies to patients admitted to the hospital.
- Goal 3E4 bullet 4 - Unclear exactly what this IE is calling for reviewers felt it should apply to in-patients only.
- Goal 16A2 - Initiation of such a response in the ED prior to notification of the emergency physician who is present could result in delay of conflicting care.
- Goal 16A5&6 - could be combined.
- Goal 17 - This goal should not be implemented without further clarification and research. As written this goal applies to the OR which is appropriate but should not apply to patients treated in the ED requiring moderate sedation.
- Goal 18A3 bullet 3 - is vague and may be very difficult to implement.
- Goal 18A3 bullet 4 - fatigue training was viewed as very appropriate but annual training was not viewed as necessary.
- Goal 19A2 - clarification of the term "hand-off." Reconciliation of lines every 12 hours or at shift change is appropriate.

HEADQUARTERS

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Expert reviewers consistently mentioned the addition of a patient safety goal that addresses measures to reduce crowding and boarding of admitted patients in the ED.

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Despite the current Joint Commission standard on patient flow within the hospital, ED crowding continues to be a problem.

Development of a patient safety goal to address ED crowding would provide additional emphasis on this important issue.

The response form with additional comments is attached. Please contact Margaret Montgomery, RN, MSN, at 972.550.0911, extension 3230 if you have any questions.

Best wishes,

<signed>

Brian F. Keaton, MD, FACEP
President

Attachment

Copy: James J. Augustine, MD, FACEP
Michael D. Bishop, MD
Michael L. Carius, MD, FACEP
David P. John, MD, FACEP

Section 1 – Demographics

1. Reviewers Name: **American College of Emergency Physicians**
2. Organization: **American College of Emergency Physicians**
3. Please indicate the category for which you are primarily responding (select one):
Other: **Physicians’s Professional Organization**
4. If you represent a Joint Commission accredited organization, please indicate the program for which you are primarily responding:
5. If you are primarily representing an accredited organization, which (one) category best describes your role in that organization? N/A

Section 2 – Questions Specific to the Potential 2008 NPSGs

Technology in Assisting with Patient Identification

6. Should Implementation Expectation #5 at Requirement 1A, regarding planning for the use of technology in assisting with patient identification be added as an expectation in 2008?
Yes
- 6c. Is there a potential for unintended consequences if this implementation expectation is adopted in your field.
No

Technology is only as good as the people who use it and is one way to decrease error but it can also precipitate or perpetuate patient identification errors. Backup systems need to be designed for times when technology (inevitably) breaks down.

7. Should requirement 3E, regarding anticoagulation therapy, be added as a requirement in 2008.
Yes with modification.

Overall these requirements may be difficult for rural hospitals with limited resources, and limited pharmacist availability to implement.

IE 3 – Bullet #3 –Notification of the dietary department should apply only for in-patients, as it is not feasible for dietary to respond in the middle of the night, when for example a patient receives an injection of low molecular weight heparin for suspected deep venous thrombosis.

IE 4 – There are many emergency and life threatening conditions that require immediate heparin, such as an acute MI. Waiting for an INR would compromise care. Also the requirement to use a programmable pump should NOT apply for the initial bolus, but could apply for later infusions.

The second bullet requiring baseline testing of PTT, for example, is not supported in the medical literature.

The third bullet requiring a baseline INR, should specify only those patients actually receiving such warfarin in the hospital, and not those patients chronically on warfarin coming in for a scheduled chest ray or unrelated minor injury, for examples.

The fourth bullet item should be changed to apply to INPATIENTS ONLY, with recommendation that the hospital develop processes for selected outpatients.

One reviewer noted that the implementation expectations as divided into segments of the medication process are too cumbersome.

- 7c. Is there a potential for unintended consequences if this requirement is adopted in your field.
Yes

Overall closer monitoring of anti-coagulation is desirable, but the requirement should not extend to all out-patients, especially those for minor tests or emergency care. This would be too onerous, not productive for the patient, costly and compromise care elsewhere.

Recognition and Response to Changes in Patient's Condition

8. Should requirement 16A, regarding recognition and response to changes in patient's conditions, be added as a goal in 2008?

Yes, with modification

- 8a. If you responded "Yes, with modification" please elaborate on your response in the space below (if you are commenting on a specific Implementation Expectation (IE) please provide the IE number).

As important as it is to empower patients and families, it should be clear that organizations should not be required to allow families to directly request additional assistance (team response) when there is a concern (IE 3). Families should be empowered to voice their concerns to nursing, physician, and other members of the team, but if families could directly access "additional assistance" from specialized teams, resources could be wasted (by inappropriately activating such teams when patient is appropriately being cared for by primary team) and quality of care could be decreased (if specialized teams, unfamiliar with given patients, are frequently and inappropriately requested).

Some reviewers felt that IE 3 was rather vague and # 5 and 6 could be combined.

- 8c. Is there potential for unintended consequences if this is adopted in your field?
Yes

Concern was expressed about implementation of such a system in the emergency department. In addition to the usual concern about staffing and available resources there is concern about how this would be implemented in the ED. With the presence of the ED physician in the department in most circumstances the process for initiation may need to be different than on a medical floor.

If there is a process to opt out of normal communication channels, and seek external resources/teams, quality of care could actually decrease. If a patient is crashing in the ED, the ED physician taking care of him/her should be notified ASAP in order to secure consulting services etc ... but to allow any staff or family member to access resources without first addressing the issue with the physician that is present in the ED could lead to delayed or conflicting care.

Obstructive Sleep Apnea

9. Should requirement 17A, regarding obstructive sleep apnea, be added as a goal in 2008?

No

- 9a. If you responded “Yes, with modification” please elaborate on your response in the space below (if you are commenting on a specific Implementation Expectation (IE) please provide the IE number).

Clarification is needed about this goal. As written it would apply to patients in the OR which is appropriate but should not apply to patients seen in the ED requiring emergent care.

“Centrally acting anesthetic and/or analgesic agent” MUST BE DEFINED. Does every patient who receives Tylenol or simple oral narcotic and then has a simple laceration repair need this assessment? This would be absurd. The medications and surgical procedures MUST be specified as those in the operating room, or those involving some level of acuity as defined by the hospital.

- 9b. If you answered “No”, please indicate the choice the best reflects your position:

The IE is a low priority.

- 9c. Is there potential for unintended consequences if this is adopted in your field?

Yes

This Goal requires further evaluation and clarification. It is not clear as to what patients require this apnea assessment, and too broad an application would impede care of many out-patients resulting in significant delays in meeting pre-op assessment if sleep studies or other cumbersome requirements are implemented. This goal is not appropriate for implementation in the ED.

Health Care Worker Fatigue

10. Should requirement 18A, regarding health care worker fatigue, be added as a goal in 2008?

Yes, with modification

- 10a. If you responded “Yes, with modification” please elaborate on your response in the space below (if you are commenting on a specific Implementation Expectation (IE) please provide the IE number).

Prolonged on-duty periods should be separated out from “schedules that disrupt normal circadian rhythms.” There should be flexibility to schedule shifts with an emphasis on minimizing worker fatigue.

Annual “fatigue training” was seen as excessive. Implementation of IE 3 bullet 3 as written is extremely broad and would be incredibly cumbersome to implement.

- 10c. Is there potential for unintended consequences if this is adopted in your field?

Yes

Will need more staff and potentially have more care transfers increasing risk of error. This Goal is desirable, but is idealistic and does not reflect the reality of practice in the US.

Catheter Misconnections

11. Should requirement 19A, regarding catheter misconnections, be added as a goal in 2008?

Yes, with modification

11a. If you responded “Yes, with modification” please elaborate on your response in the space below (if you are commenting on a specific Implementation Expectation (IE) please provide the IE number).

Reviewers agreed that line reconciliation is important and should occur every 12 hours or at shift change but should not be required when another staff person is briefly overseeing a patients care such as when a staff member takes a break or for a meal.

19 A-2- bullet 3 was seen by some reviewers as too prescriptive and should be deleted or modified. While labeling of lines is appropriate, labeling all points of connection may not be.

11c. Is there potential for unintended consequences if this is adopted in your field?

Yes

Reconciliation for every “hand off” would be burdensome if this is interpreted to be required every time another staff person was asked to oversee a patient for a short period of time. It would take nurses away from active care of patients which occurs in the ED.

Additional Comments

12. Are there any other issues in your field that should be brought to the level of a National Patient Safety Goal?

Yes

12a. If yes, please describe:

Expert reviewers frequently mentioned the issue of ED overcrowding and boarding of admitted patients in the ED. Although the Joint Commission does have a standard that addresses flow issues, boarding of admitted patients and crowding are still of grave concern and deserve additional focus as a patient safety issue.

13. Please provide in the space below any additional comments you have regarding the potential 2008 National Patient Safety Goals and Requirements.

Joint Commission standards and patient safety goals should be carefully proposed and written so that they do actually improve care, and do not strain limited health care resources even more. Diverting resources to meet these goals and in turn compromising care is always a concern.

It is essential that there is flexibility in the implementation expectation requirements of the patient safety goals to allow for the specific needs of the individual hospitals and emergency departments to ensure patient safety.