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NPSG

Gather data and consider standardizing some alarm parameters to meet 2016 deadline

The deadline to meet the second and final phase of The Joint Commission's National Patient Safety Goal (NPSG) on clinical alarm management may be more than a year away, but start now examining where your hospital stands in regard to alarm management.

Under **NPSG.06.01.01**, hospitals must improve the safety of clinical alarm systems by meeting four elements of performance (EPs), the first two of which — leadership establishing alarm

(see **NPSG**, p. 5)

Survey readiness

Ensure the key players on your accreditation team have well-prepared understudies

Designate backup players and prepare staff now in case a Joint Commission team decides to deliver the gift of a holiday survey.

Remember that surveys are unannounced. When key members of your accreditation team schedule time off, especially during the holidays, you must have people trained to step into their roles to provide surveyors the access to the documents, people and places they will need.

(see **readiness**, p. 8)

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*HIPAA***Chart outlines rules for sharing PHI with patients' friends, family members**

Use this chart from HHS' Office for Civil Rights (OCR) to determine when and how providers can share patients' information with the patients' friends, family members and others involved in the care or payment for care. Review and share this chart with employees, medical staff and others in light of OCR's new guidance on the rights of people in same-sex marriages and their dependents (*See p. 2*).

Situation	Family member or friend	Other person
Patient is present and has the capacity to make health care decisions	Provider may disclose relevant information if the provider does one of the following: (1) obtains the patient's agreement (2) gives the patient an opportunity to object and the patient does not object (3) decides from the circumstances, based on professional judgment, that the patient does not object Disclosure may be made in person, over the phone or in writing.	Provider may disclose relevant information if the provider does one of the following: (1) obtains the patient's agreement (2) gives the patient the opportunity to object and the patient does not object (3) decides from the circumstances, based on professional judgment, that the patient does not object Disclosure may be made in person, over the phone or in writing.
Patient is not present or is incapacitated	Provider may disclose relevant information if, based on professional judgment, the disclosure is in the patient's best interest. Disclosure may be made in person, over the phone or in writing. Provider may use professional judgment and experience to decide whether it is in the patient's best interest to allow someone to pick up filled prescriptions, medical supplies, X-rays or other similar forms of health information for the patient.	Provider may disclose relevant information if the provider is reasonably sure that the patient has involved the person in the patient's care and in his or her professional judgment, the provider believes the disclosure to be in the patient's best interest. Disclosure may be made in person, over the phone or in writing. Provider may use professional judgment and experience to decide whether it is in the patient's best interest to allow someone to pick up filled prescriptions, medical supplies, X-rays or other similar forms of health information for the patient

*Infection control***Take 'Lessons From Texas' to heart to prepare for potentially infectious patients**

Use the recent intense national focus on hospitals' preparation to care for Ebola cases to review your own readiness to handle highly infectious diseases because other such concerns are looming, recommends Dr. Alexander Isakov, MPH, executive director of the Office of Critical Event Preparedness and Response at Emory University.

As the main facility to care for the recent spate of Ebola patients in the United States, Emory has become one of the leading authorities and guides on preparation for and care of highly infectious patients. Isakov was the main speaker during a webcast last Tuesday sponsored by the

Association of Health Care Journalists, one of the many such educational sessions sponsored in the last few weeks to fill an information gap for not only the public, but also for hospital officials concerned about beefing up their own readiness.

Calling for more beds to be made available nationwide for patients with communicable diseases, Isakov noted that while Ebola has been very public, other infectious diseases such as SARS-CoV, MERS-CoV and influenza could have an even more significant impact on hospital readiness if any of those reach epidemic levels.

In that respect, he said, the recent preparedness push has been "a good investment" to insure that communities across the country have the capacity needed to respond to an epidemic.

Review new guidelines frequently

Another webcast, sponsored by the Texas Nurses Association along with the American Association of Nurses, featured advice from health officials involved in or familiar with recent events in Texas, where Thomas Eric Duncan was seen at a Dallas hospital but sent home before being officially diagnosed as having Ebola. He died, and two nurses involved in his care at Texas Health Presbyterian were infected, but successfully treated.

Among other advice offered during “Lessons from Texas: How You Can Help With the Ebola Threat,” was the reminder to frequently review updated guidelines as they are released by the CDC and other authorities.

Dr. Robert Haley, professor of internal medicine and director of the division of epidemiology internal medicine department at UT Southwestern Medical Center, notes that Presbyterian Hospital’s initial approach to the Ebola case was not “wrong,” but demonstrated the nation’s initial lack of knowledge and the need for constant revisions on how hospitals approach the virus.

The CDC’s Ebola index webpage (*see Resources, p. 5*) offers the latest information on Ebola preparation and should be the go-to place for staff to get up to speed on protocols, says Haley. The latest updates feature ambulatory care screening, questions and answers about the CDC’s monitoring and movement guidance, guidelines for Emergency Department preparation and response, and updated handouts detailing how Ebola is spread.

Designate response teams

Establishing an Ebola response team that include staff members knowledgeable in your hospital’s chosen approach to patient screening and treatment is also key to keeping both patients and employees safe when taking in a suspected Ebola patient, says Bob Dent, DNP, MBA, RN, NEA-BC, CENP, FACHE, vice president of Patient Care Services and chief nursing officer at Midland Memorial Hospital, in Midland, Texas.

Establish an initial core team to handle treatment for suspected Ebola patients in order to ensure that a sufficient team is in place to handle suspected Ebola cases and receive updated training in a timely manner. Having a team already selected and trained in current protocol allowed Midland Memorial to quickly and efficiently rule out five patients who were admitted to the hospital under suspicion of Ebola.

Infection control

CDC addressing PPE concerns

If you don’t have immediate access to training on the proper technique for donning and doffing the higher levels of personal protective equipment (PPE) required for dealing with highly infectious patients, the Association for Professionals in Infection Control (APIC and Epidemiology) and Johns Hopkins’ Armstrong Institute for Patient Safety and Quality have made a free online training video available through the CDC’s website. For more information, go to <http://www.cdc.gov/vhf/ebola/hcp/ppe-training/index.html>.

In addition, the CDC recently announced it has ordered \$2.7 million in PPE for the Strategic National Stockpile. Kits are being developed that can be rapidly delivered to hospitals, with each kit capable of providing the PPE needed by clinical teams to manage one Ebola patient for up to five days, according to CDC information. The kits are based on PPE guidance issued by CDC on Oct. 20.

Only 50 kits are being developed so supplies will only help address short-term PPE needs. Purchases include impermeable gowns, coveralls, and aprons; boot covers; gloves; face shields and hoods; N95 respirators; powered-air purifying respirator systems and ancillaries; and disinfecting wipes.

These preparations included committing two 8-hour days entirely to training the team in the use of personal protective equipment (PPE) — four hours of education and four hours of practice putting on and removing the gear. The hospital’s hazmat team, which was typically needed only for chemical spills, was able to serve as trained observers for the Ebola core team while they were donning and doffing PPE.

Texas Health responds

Late in October, Texas Health Resources, the health network that includes Texas Health Presbyterian Hospital Dallas, released a presentation on lessons learned following the Duncan case.

One of the more significant lessons learned was in the demand required in the care for an Ebola patient, officials noted. Whereas the regular nurse to patient ratio is typically 1:4, a single Ebola patient requires 3 or 4 “highly skilled” nurses to effectively provide care. Texas Health also recommends the following guidance for staffing considerations:

*Infection control***Explore health care coalitions for help in financing extra preparedness**

Buying higher levels of personal protective gear and paying for training and education of staff in dealing with highly infectious diseases such as Ebola can be costly. And the question of additional funding for Ebola preparation is still in flux.

However, some resources do exist, particularly in the form of health care coalitions, notes James Blumenstock, chief of public health security of the Association of State and Territorial Health Officials (ASTHO). "There are 5,000 hospitals and many more doctor's offices in this country. You can share resources through a coalition."

Federal government agencies, led by the departments of Health and Human Services and Homeland Security, make funds available to state and local agencies. For example, in the 2014 fiscal year, the HHS Hospital Preparedness Program alone awarded \$255 million to institutions in 62 states, cities, and territories in the nation.

These program funds are then made available as grants to organizations and providers for purchasing equipment and supplies and providing training and other preparatory exercises for various emergency scenarios, including but not limited to, Ebola.

Coalitions can be a good way to spread resources, officials say. According to CDC spokesperson Kristen Nordlund, as of June 2013,

the most recent time for which data was available, there were approximately 490 health care coalitions which included more than 16,000 members nationwide.

"CDC provides ... cooperative agreement funding and assistance to state and local health departments for all-hazards preparedness, including infectious disease outbreaks," Nordlund explains. "This funding and assistance helps public health departments develop capabilities that are applicable to responding to many public health threats."

Though a health care coalition need not exist in order to apply for or secure funding, having a coalition can be advantageous during a competitive process, according to Eileen Kane, spokesperson for the HHS Office of the Assistant Secretary for Preparedness and Response.

For more information on available funds, contact state health associations or hospital associations, Blumenstock suggests. — *Scott Harris* (scottharriswriter@gmail.com)

Resources

- ▶ HHS Hospital Preparedness Program: www.phe.gov/Preparedness/planning/hpp
- ▶ CDC Office of Preparedness and Response: <http://www.cdc.gov/phpr>

• **Gather volunteers for care.** Employees at Texas Health were not required to work with Ebola patients due to the nature of the virus. (Emory also solicits volunteers for patient care teams.)

• **Rely on managers and supervisors to support staff.** This becomes particularly important when shifts must be covered when volunteers are caring for an Ebola patient.

• **Review staffing considerations,** including overtime, PRN requirements and availability, and agency/contract nursing, and remember that the workload will increase dramatically during the course of patient care.

A full rundown of the changes is available online (see *Resources*, below). — *Steven Dashiell* (sdashiell@decisionhealth.com)

Resources:

- ▶ CDC's Ebola index page: <http://www.cdc.gov/vhf/ebola/index.html>
- ▶ Texas Health Resources, Ebola lessons learned: <http://texashealth.org/ebola-virus>, click on 'Ebola Response: Learnings and Lessons' under Latest News at left.

NPSG

(continued from p. 1)

safety as a priority and determining the most important alarms to manage — should have been met as of this year. By 2016, The Joint Commission (TJC) expects hospitals to have in place policies and procedures to manage those alarms and be educating staff about the importance of and procedures related to that management. (*More*, p. 6.)

Ideally, your hospital will have already recognized some of the risk areas in your hospital when it comes to alarm fatigue and desensitization, says Maria Cvach, DNP, RN, FAAN, assistant director of nursing and clinical standards at The Johns Hopkins Hospital in Baltimore.

After Johns Hopkins created an interdisciplinary alarm management committee in 2006, the hospital gathered data from TJC, as well as from the FDA's Manufacturer and User Facility Device Experience (MAUDE) database. Based on that, Johns Hopkins chose to focus on physiologic monitor alarms, ventilator alarms, and nurse call systems as the most important alarms they needed to manage, says Cvach.

Tailored processes are key

Once your hospital has identified which alarms are most important to monitor, review ways of improving the monitoring processes currently in place for those alarms and determining whether they can be made safer and more efficient.

Several organizations have tools to help with that process, including the Association for the Advancement of Medical Instrumentation (AAMI) and ECRI Institute, a patient safety organization located in Plymouth Meeting, Pa. In particular, ECRI offers a one-page, decision-tree tool, notes Sue Sendelbach, Ph.D, RN, CCNS, FAHA, FAAN, and director of nursing research at Abbott Northwestern Hospital in Minneapolis. She also recommends a concise alarm management tool from The American Association of Critical Care Nurses. (*See Resources, below.*)

One of the more effective steps in alarm management involves standardizing alarm default parameters across certain categories of patients, such as telemetry or pediatric patients, notes Cvach, a practice which has proven effective in recent studies.

However, proper research is still necessary to determine parameters of standardization, because not all patients will require the same parameters. Cvach notes that Hopkins collects seven days of alarm data from their monitors, ventilators, bed exits, chair exits and nurse call systems, evaluating them on a weekly basis.

“The data have been enlightening on how unique areas are and what special needs are for a variety of patients,” she observes. “For instance, the alarms from a neonatal intensive care unit are significantly different than from an adult ICU, and thus the settings and alarm features need to be set accordingly for those groups.”

At Abbott Northwestern, efforts recently have focused on addressing alarm management related to blood oxygen saturation levels, says Sendelbach. That effort follows one in which the hospital successfully reduced ECG alarms. The principles in successfully managing alarms settings should remain the same across systems, but the individual settings will differ, she notes, and must be reflected in the documented policies and procedures.

Hopkins has adopted this approach as well, furnishing guidance on approval of requested alarm parameter changes, accountability for alarm management, and the process for primary and secondary alarm notification within the alarm

NPSG

What does TJC say on 2016 deadline?

Hospitals must begin now to push toward clinical alarm management because the second phase of the newest National Patient Safety Goals will be implemented as of Jan. 1, 2016, warned The Joint Commission's Pat Adamski during this fall's Executive Briefings.

To achieve success, Adamski's advice was simple. Hospitals should identify their biggest challenge and “start focusing on that,” recommended the former director of the commission's Standards Interpretations Group who is now projects director for TJC's Division of Healthcare Improvement.

On Jan. 1, 2016, at a minimum, hospitals will be expected to have reviewed and, if needed, changed policies and procedures to answer the following related to management:

- ▶ What are the clinically appropriate settings?
- ▶ When can alarms be disabled?
- ▶ When should parameters be changed, who can set and change parameters, and who can set the parameter to “off?”
- ▶ Expectations for monitoring and responding to clinical alarms.
- ▶ What is the process for checking individual alarm signals for accurate settings, proper operation and detectability? (Note that the requirements outlined in **NPSG.06.01.01** also refer to Environment of Care standards involving medical equipment testing and maintenance.)

In addition, staff responsible for alarm management must be trained in those new policies and procedures. — *A.J. Plunkett* (aplunkett@decisionhealth.com)

management policies. However, all alarm specific information, such as for telemetry or ECG, are baked into the particular overarching protocol in each area.

Stay prepared for 2016

Consider the following advice when preparing for the January 2016 deadline, whether your hospital has already started managing alarms or is starting fresh:

- **Have an effective process improvement system in place** prior to any major changes. It is difficult to put a new policy in place if that improvement process has not been established first, says Cvach. Look to proven processes such as Plan-Do-Study-Act or LEAN for an effective foundation. Cvach also recommends reviewing alarm data regularly and making changes on a small scale, based on the population served first, rather than starting large scale change without having all of the necessary systems in place.

• **Provide ongoing education.** Establishing a regular education program for both existing staff and new members of the team are essential for keeping them abreast of the latest and safest policies and procedures, says Cvach. In the near future, Hopkins intends on creating educational checklists and other teaching tools to assist bedside staff during their orientation.

• **Keep alarm safety fresh in the minds of staff.** Though alarm safety is one of the 2014 NPSGs, the final deadline for the policies and procedures expected to be in place are still a year away. Provide regular feedback and data to staff to keep them invested in alarm safety efforts. Ongoing education also contributes to this awareness, notes Cvach.

• **Look into technological solutions.** Sendelbach notes that several technologies exist that can help reduce the number of alarms in the hospital. That includes both hardware and software. For instance, there are software offerings that can act as a middleman to facilitate communication between the patient calls and individual members of staff. Such so-called “middleware” can cut back on global alarms. Abbott Northwestern has been looking into “surveillance monitoring” systems, which can measure and display ECG, heart and pulse rate, blood oxygen saturation and other vital signs typically found in ICUs.

• **Utilize an interdisciplinary team for planning and implementation,** advises Sendelbach. Alarm management requires a diverse set of skills, including the research and data aggregation that goes

into planning, in addition to the actual training and implementation necessary to execute these changes. Abbott Northwestern found clinical nurse specialists helpful on this team, as they possessed the clinical expertise on both the patient side of the process, as well as how to cope with system changes.

• **Remind staff of the benefits of greater alarm management.** Though the ultimate goal of alarm management is increased patient safety, a hospital with fewer alarms will be a quieter, more pleasant and less stressful place to work, says Cvach. — *Steven Dashiell* (sdashiell@decisionhealth.com)

Resources:

- ▶ ECRI Institute alarm safety management tree: https://www.ecri.org/Documents/Monitor%20Alarm%20Safety_Poster%20Presentation.pdf
- ▶ American Association of Critical-Care Nurses alarm management: <http://www.aacn.org/wd/practice/docs/practicealerts/alarm-management-practice-alert.pdf>
- ▶ Association for the Advancement of Medical Instrumentation: <http://www.aami.org/htsi/alarms>

readiness

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“We frequently see this as a problem in the mock surveys we do,” says Jennifer Cowel, RN, MHSA, vice president of Patton Healthcare Consulting in Glendale, Ariz., and a technical adviser to *Inside the Joint Commission*.

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PAS 2014

A survey team expects the hospital to function all days, all shifts, regardless of who is working at the time. That includes going through accreditation. “When key material is not presented, it starts going bad quickly,” she observes.

Some hospitals prescribe to the notion of having a single “leader” that is responsible for particular aspects of survey requirements and documentation, a practice that can become problematic should that leader be absent, says Joseph A. Gordon, founder of Survey Resources in Manchester, N.J.

“Because the surveys are unannounced, the odds are pretty good that one or more of the people that the hospital identifies in advance as their strongest players and who their leads would be...may simply not be there.”

Appoint and train backup team

Instead of relying on just one staff member for each particular survey need in the hospital, Gordon recommends emulating the theater and implementing understudies. Unfortunately, hospitals don’t often perform as good of a job as the theater when identifying who can step in for the primary leads. “That understudy role tends to be picked at the very last moment, and may or may not have the practice and the rehearsal, if you will, to put on a good show.”

The hospital’s survey coordinator should assign these understudies to the main point of contact for each required aspect of the survey requirements so that they may shadow them during the course of their role, says Gordon. This means that the understudies must also have the same access privileges as the staff member they are studying under, including passwords.

Cowel agrees, noting that each main point of contact should have two individuals as backups for each key role in the hospital. These key roles include infection control, medical staff, human resource competency, data use, pharmacy or medication management, and preparation of the day-one documents, as well as the environment of care and life safety documentation.

Backup staff should also participate in all mock survey activities in preparation for the real thing, or even “lead the session, just to give them the experience,” says Cowel.

First impressions are everything

Understudy preparations should extend to your front desk, as well. All of those personnel need to be prepared for when surveyors walk through that door, says Cowel,

noting that often the first people to greet visitors are hospital volunteers who are under-prepared. “I don’t know” will not be an answer that surveyors will accept for any question, she warns.

“There should be training and printed instructions at the desk on how to handle a visitor from the state or the Joint Commission,” she says.

Consider placing a member of the survey prep team near the front door to welcome the survey team in to ensure a strong introduction. Also, be on the lookout for surveyors that don’t enter through the door you expect them to use. Let your facilities staff know what to do if they spot a group of suits with clipboards in the hospital – that way “they can alert the survey coordinator that the team is entering...allowing you to welcome the team and have those first few moments look smooth,” explains Cowel.

Keep documentation updated, accessible

Ensure that backup staff and the survey coordinator know where the reports and documents the surveyors will need are located, and have the ability to access them, says Cowel. You don’t want to have key documentation locked up in a staff member’s office, and that staff member be out for the week, she notes.

“I suggest keeping a centralized [electronic] file with the path and file name where key documents can be found and accessed,” advises Cowel. This same principle can be applied to hard copy documentation, with centralized, accessible binders housing the required documentation.

For the list of documents your hospital needs to provide to surveyors, the Survey Activity Guide on the Joint Commission website offers a two-page list of required day-one documents.

Review and update your documentation quarterly, suggests Cowel, including both the electronic folder as well as the physical binder. The physical binder should only be updated within the hospital, however — allowing a staff member to take the binder home to update can lead to lost or misplaced documentation. — *Steven Dashiell* (sdashiell@decisionhealth.com)

Resource

- Joint Commission Survey Activity Guide:
www.jointcommission.org/2014_survey_activity_guide

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