Changing colors
Unifying wristband use improves patient safety

Rubber wristbands have become a ubiquitous sight in the U.S. Whether supporting a cause or memorializing a friend, these colored wristbands are seen every day, and every one of them means something different. But they also appear in hospitals, where they have a very different meaning—signifying a patient’s conditions, needs, or other factors in his or her care. And in many states, the meaning of a wristband with a particular color can vary from hospital to hospital. As staff move between facilities and organizations, this color sharing can be risky.

The Pennsylvania Safety Authority has led the country with a simple but extremely effective method to bring area hospitals together to unify the use of these wristbands, making colors and their meanings consistent across multiple organizations to prevent errors and misunderstandings.

The recommendation came out of a very specific incident reported to the Pennsylvania Safety Authority for analysis. One Pennsylvania nurse had been splitting her time working in two facilities. Both of those facilities used color-coded wristbands, but in facility A, a yellow wristband meant a restricted limb, and in facility B that same yellow wristband signified a DNR order.

Fortunately, this commonality was noted before any patients were harmed, but the incident was reported as a near miss and went to the Pennsylvania Safety Authority for review.

Fran Charney, RN, MSHA, CPHRM, CPPS, CPHQ, CPSO, DFASHRM, director of educational programs for the Pennsylvania Safety Authority, was
a safety officer at the time and took note when the story surfaced.

“This was an excellent failure mode effects analysis,” she says. “You were required to do one by The Joint Commission when something like this happens, but we thought, ‘Wow, this has never happened in my organization, but there’s a risk there. Let’s look at this in a proactive fashion.’ ”

The solution to prevent future incidents was clear. “We said, ‘Let’s standardize the colors,’” says Charney. “If you’re going to use one for DNR, it needs to be blue, for example.”

The group polled organizations to collect recommendations for which wristband colors should be used to signify selected conditions. Interestingly, the Authority’s research caught the attention of healthcare organizations nationally before the standardization even had a chance to become official in Pennsylvania.

“A lot of states have adopted this recommendation for standardized wristbands. The Department of Defense has adopted it,” says Charney.

One of the goals, however, was to avoid making policy into law. The Pennsylvania Safety Authority worked with legislators to gain support, but it wanted to avoid making the wristband policy mandatory.

“We wanted it strongly encouraged, but not legislated,” says Charney. The Authority needed a level of flexibility to react to changes in the environment that legislation would hamper. “What if we had to change it?” she says.

For example, the popularity of Livestrong wristbands not only impacted how yellow wristbands were used in hospitals, they also helped popularize the use of wristbands in general, which meant that in the future, another color might become so popular as to require a change in how hospitals used it.

“It was so tempting to have it legislated, but we were facing those [non-healthcare] bands and what they were conveying. People come in and won’t take them off,” says Charney.

Overall, the benefits of an agreed-upon system of colored wristbands had an immediate impact on safety. “It’s very nice for the continuum of care,” says Charney. “Patients going from one facility to a rehab facility to a nursing home” can be assured of consistent wristband use.

Organizers still marvel at how simple a change could have such a noticeable effect.
well for DNR wristbands.

“We did it for the sake of safety so there is a national standard for that,” says Charney. “We wanted it to be consistent across the country.”

News of the Pennsylvania Safety Authority program spread rapidly across the country, often by word of mouth. Even wristband manufacturers became involved.

“We had vendors come forward and ask us to endorse them, though we didn’t choose to do that,” says Charney.

The challenges that arose surrounding implementation were mostly ones the group had anticipated. Patients refusing to take off symbolic wristbands, for example, required some additional processes.

“Healthcare systems are doing good things like this all the time. To do something proactive, before harm can occur, is an awesome place to be. There was a lot of discussion, a lot more than I would have ever perceived there to be.”

— Fran Charney, RN, MSHA, CPHRM, CPPS, CPHQ, CPSO, DFASHRM

“The Livestrong bands gave us the most issues,” says Charney. “What we did was cover them with gauze if they wouldn’t remove the band.”

For patients who would not remove a wristband, or alternatively refused to wear a wristband at all, the organization developed a waiver. “If a patient won’t wear a wristband, they’re putting themselves at risk. We use it as a communication tool,” says Charney.

Staff buy-in was not without its small challenges, either.

“We heard a lot of pushback saying, ‘If it’s not broken, don’t fix it,’ ” says Charney. “But the great thing about [the Pennsylvania Safety Authority] is you can take the data, share the story, [and] present it as, ‘Would you want to have this event occur in your organization?’ ”

To avoid falling prey to naysayers, Charney recommends marrying the story of potential errors to proactive risk prevention techniques and strategies.

“If people understand why you’re making these...
changes, it’s more embraced,” says Charney. “We need to create more flawless systems in facilities every day. This is just one more step.”

Standardization is always intended as a tool toward error prevention and safety improvement, she notes.

“This is how we become highly reliable, preoccupation with failure,” says Charney. “It’s our role as patient safety experts to make our systems easier to operate so that our patients are discharged in a better state than when they arrived whenever possible.”

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To err is human—to prevent errors is culture
Advocating organizational changes to prevent point of care harm

Continuing Education Objectives

After reading this article, you will be able to:

- Describe how proper use of the electronic medical record can help eliminate errors
- Discuss the benefits of a Patient Safety Organization for identifying process improvements
- Identify ways to show leadership the financial benefits of proactive error prevention

It’s an easy, if incorrect, argument to make: More errors could be prevented if everyone was simply more careful. But humans are fallible, and the most careful provider will eventually have a near miss or even an actual medical error. So how do we shift the culture away from individual blame and into process change?

We start, says Barbara Rebold, director of patient safety, risk, and quality with the Plymouth Meeting, Pennsylvania–based ECRI Institute, by admitting that we’re human.

ECRI Institute has examined millions of events as part of its work on event reporting and error prevention. “Safe and quality patient care is like a three-legged stool,” says Rebold. “You need the correct culture, the correct processes, and the correct measures to prevent errors. If one leg is missing or broken, the stool will fall.”

The first leg of the stool, culture, is not just about human behavior. The individual person or provider, in any given situation or time when an error or near miss occurs, is trying to do the right thing. But, says Rebold, there are all kinds of system issues around that person at that time.

“If something happens, we don’t need to remind that person to do better, we need to know what was going on with the system or process at that time that led them to forget a step or make a certain choice,” says Rebold. “What can we do to mitigate the human errors that are going to occur?”

Understanding the true root of the event is crucial—as is acknowledging that not every error can be prevented.

“We believe you cannot completely eliminate human errors, but you can reduce harm,” says Rebold. “You have to be relentless in trying to get to the root cause of what caused a particular event to occur.”

For example, is the system or process simply relying on the individual to remember steps or actions, or are there systems in place to make it easy for an individual to do the right thing to provide good care?

The Joint Commission requires both proactive and reactive root cause analyses. Most human factors, Rebold says, need to be taken into consideration, and the way to do that is to both reactively and proactively analyze how things can go wrong or did go wrong. The Joint Commission requires organizational leadership to consider potential risks to patients when designing...
or modifying services. Here, proactiveness is absolutely called for. There are several ways to perform proactive risk assessment. Rebold uses the example of the electronic medical record (EMR) as a situation where proactive analysis can prevent errors.

“In a proactive approach, you try to set up the system correctly in the first place. Take into account everything, the human factors on the front line as well as the technical issues of setting the system up, and then you can identify what you need to adjust to prevent or reduce the possibility for harm,” says Rebold.

This also involves workflow. A proactive and broad view of EMR processes can help staff continue to provide patient care—and continue to use the EMR to assist in that care—without taking a large amount of focus away from the patient.

“In a proactive approach, you’d flow-chart out their workflow and you’d identify how the medical record needs to be utilized, and then spend time figuring out what needs to be changed to make both workflows focused on patient care,” says Rebold.

**Skip steps now, pay later**

Businesses, including healthcare, are under constant pressure to get things done and meet external indicators or accreditation requirements. This pressure to turn things around quickly often leads to delayed, missed, or skipped steps, which in turn can lead to more work on the back end.

“Then you have events which must be addressed on the reactive side, and you have to flow out why the event occurred and what needs to be changed to prevent it from happening again,” says Rebold.

Dealing with these events on the back end is often more costly than working them out up front, but you need farsighted leadership support to push for these issues to be dealt with in advance. And this, of course, leads back to culture.

“Leadership needs to say, ‘We want to do this right and we know that if we do it right the first time, not only will it help provide quality patient care,’ ” but it will also have a financial impact, says Rebold.

A chief financial officer told Rebold once that you can usually make the numbers say whatever you want them to say, but if you know you’re doing things right the first time, patient safety and quality are going to result in savings. Better patient safety and quality translates to improved length of stay, fewer incidents of medical malpractice, and fewer avoidable complications that lead to a financial drain on healthcare institutions, she adds.

**Where to look for improvements**

To implement cultural shifts, Rebold says, one rarely has to reinvent the wheel. An organization somewhere has faced similar problems as you; hopefully, that organization has started the reactive process that can help your own organization approach the issue proactively. She sees this happen even within her own organization.

“I’ve heard from organizations who say that through their participation in a [Patient Safety Organization], they become aware of problems experienced elsewhere across the country that they might not even be aware are potential problems. They’ve had the good fortune to not have a certain kind of event, but because they are able to see the impact such an event has on another organization, they get what we call a free lesson,” says Rebold. “You avoid these dangers yourself by learning from other organizations’ experiences.”

But don’t just focus on the negatives, she says. If you need to nudge leadership in the right direction toward a proactive culture, celebrate your successes.

“Success breeds success. It’s one way of getting leadership to see it can happen,” says Rebold. “It’s proof of concept.”

When leadership wants to see impact in terms of the bottom line, it may be necessary to show how the soft costs of an avoided disaster compared to actual

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**Questions? Comments? Ideas?**

We at BOJ value and welcome your feedback and opinions. Do you have a response to any of this month’s articles? An idea for a best practice or success story you’d like to share, or a recent survey experience you would like to recount? We would love to hear from you.

Contact Senior Managing Editor Matt Phillion
Email: mphillion@hcpro.com
costs. Show how removing unnecessary steps that would otherwise have become hazards prevented future expenditures.

It may also benefit the organization to have leadership actively participate in the proactive assessment process. This process can sometimes be particularly drawn out to be thorough, but by choosing the level of detail to share and keeping leadership informed, you can more fully engage leadership.

“Most proactive risk analyses calculate the potential for risk,” says Rebold. “In that situation, you can share with leadership that you have a decision to make—you can implement a process immediately but may need to go back and fix issues as they arise, or you can delay implementation in order to do it right, which over the long run will save” a certain amount of money.

You have to put the work in to point out the benefit to leadership, so that leadership can make the decision based on all the facts.

“You need to point out the facts of patient care, but also do so in terms of value of the investment in time and additional resources made in taking a little longer,” says Rebold.

Implementing change

Change comes from the top, says Rebold, but “the top” can mean all levels of leadership and management. The front line, she says, views the top as the middle management who manages their day-to-day activities. But for middle management, the top is represented by the leadership above them.

There not only needs to be a fostering of a culture of safety, but an active de-escalation of a culture of fear, particularly about errors.

“That culture of fear is not only coming from the top, but also from peers and from one’s own expectations of themselves,” says Rebold.

Even the fact that fear is coming from these places is something that can only be changed from the top, she says. If you create an environment where peer-to-peer blame or self-blame is not tolerated in deference to an opportunity to explore system issues, this will lead to an improved approach to organizational culture.

“The most successful programs I’ve seen have started with the CEO and COO saying, ‘As part of our mission, our goal is to be first in quality and patient safety,’ ” says Rebold. “We are going to improve and be No. 1 in our area. I think anyone in an organization, especially middle management or administrative departments, can help support their leadership to do that.”

Quality, safety, and risk are all part of the leadership process, alongside financial decisions, planning, and purchasing.

“When leadership sessions are talking about their objectives, they need to balance quality and patient safety with building projects, bond ratings, and other factors; they also need to realize the impact that financial decisions have on quality and quality has on finance,” says Rebold. “Quality is not just regulatory compliance, it is a commitment to a culture of quality and safety. Leadership sets the tone.”

“Quality is not just regulatory compliance, it is a commitment to a culture of quality and safety. Leadership sets the tone.”

— Barbara Rebold

The next step in the evolution of error prevention, leadership involvement, and quality is for existing research to grow in maturity and visibility.

“You can see many examples of projects that have proven reductions to costs and length of stay,” says Rebold. “I think we have to keep building on that research.”

This also means changing the culture of what is considered proven research. Often leadership will want to wait until a process change has been proven over time, but Rebold notes that there are many early adopters out there who understand the theory behind current research and are already working on implementing these findings in their organization.

“Once others can see the research from those who publish their successes, others will start coming along as those early adopters begin publishing and talking about their success,” says Rebold. “We’ve come a long way. Quality and patient safety has become a science, not an art.”
Addressing the bigger picture of quality and safety (Part 2)

Leadership, process improvement, and a sustainable culture of excellence

Editor’s note: Previously, Sena Blickenstaff, BSN, MBA, principal with Compass Clinical Consulting, discussed how leadership can influence culture to improve patient safety. This month, she continues the discussion to target longer-term fixes and how regulatory and accreditation organizations can influence this process.

To transform the overall culture of an organization is a five- to seven-year journey, Blickenstaff says.

This becomes all the more important with the changing culture of healthcare on the whole and the enhanced regulatory scrutiny on leadership’s role in promoting and fostering a culture of safety and quality. A move from pay-for-performance to pay-for-quality puts a whole new level of expectation on healthcare leadership.

When working with healthcare organizations on regulatory compliance and survey preparedness, Blickenstaff tries to mirror what Joint Commission surveyors will ask during their leadership sessions when assessing leadership involvement in culture and process changes.

She tries to target areas she knows surveyors will inquire about, which includes opportunities for improving quality and safety that are identified during a survey, with one example being “flash” or immediate use sterilization.

“We know flashing is not best practice for high-level disinfecting of surgical equipment and that inappropriate sterilization of surgical instruments or implants increases the risk of infection to the patient. Surveyors will go in and talk to the OR staff and ask, ‘How often do you flash?’ ” says Blickenstaff.

The use of flash sterilization is declining, but not at the rate it needs to, and often Blickenstaff and other quality experts hear from the organization’s staff that there is not enough equipment to avoid flash sterilization.

“This can be an infection control issue for Joint Commission surveyors, but it can also turn into a leadership issue if the perception is that leadership is not providing the necessary resources for staff to provide quality, safe patient care,” she says.

Or are they?

“It is not always about providing more, and in today’s healthcare economic environment, sometimes providing more is a challenge. Instead, think about this strategy,” suggests Blickenstaff. “Is it truly that the organization [leadership] is not providing enough resources, or is this a system or process issue?

“Perhaps your supply chain delivery process needs improvement. Or maybe there is an opportunity to smooth the scheduling of procedures to ensure appropriate resources are available and reduce the need to flash,” she notes. “Then it becomes an issue of managing your supply chain processes and perhaps working with medical staff to make sure the organization has a more streamlined or ‘smoothed’ procedure/OR scheduling process so as not to create supply chain/resource bottlenecks.”

But is the pressure placed on leadership by The Joint Commission and other accreditation organizations working to force process improvement?

“To some extent,” says Blickenstaff. “The Leadership chapter has grown significantly, as has the accountability expectations at the leadership level, including the governing body, which is ultimately accountable. It is not unusual to hear reports of leadership standards being auto-scored as a finding during a survey where there are, for example, environment of care and infection control issues identified during an actual accreditation survey. The question becomes, ‘Well, leadership, were you aware of these issues in your organization, and if not, why not? Or, if you were, what have you been doing about it?’ ”

This is where promoting and fostering a culture of quality and safety, and embedding within that culture a foundation of proven process improvement methodology, is key. For any process change to work,
be it alarm fatigue, infection control, or any initiative, it will require senior-level management to be a part of the organizations they run rather than sitting above the fray. “It can seem a bit of an overwhelming environment to work in at times,” says Blickenstaff. “There are so many regulatory mandates and consumer expectations around healthcare from patient satisfaction, access, affordability, to quality and safety, but there’s also the dynamics of running a business.”

The pressure on leadership to serve both masters can be incredibly intense. “They have to watch out for the financial success of their organizations in order to keep the doors open, which includes retaining good, quality staff who often need competitive wages and benefits,” Blickenstaff says. “You want to meet your mission and meet the needs of the community.”

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**EMR: Leadership and collaboration**

No conversation about process improvement is complete without bringing up the electronic medical record (EMR) and its lack of consistency across the country.

As the saying goes, Thou shalt have an EMR—so why hasn’t the industry found a way to make the EMR more pervasive and consistent?

“During an accreditation survey, The Joint Commission will ask staff, ‘Where is your patient’s last pain assessment or history and physical prior to a surgical procedure?’” says Sena Blickenstaff, BSN, MBA, principal with Compass Clinical Consulting in Cincinnati. “The expectation is that if you’re putting relevant, pertinent information in the patient’s medical record, you should be able to get it out to ensure that information is used to coordinate safe, quality patient care amongst all involved in the patient’s care.”

And yet healthcare organizations are struggling with this process.

“This goes up to the leadership level as well,” Blickenstaff says. “It’s pervasive and a bit unnerving to watch healthcare professionals struggle to access basic patient information needed to safely coordinate ongoing care activities. Physicians and staff often do not easily have access to the information they need, and we are hearing reports of where this is being scored during accreditation surveys under a Record of Care standard.”

A hard look at your own processes is required to determine where the hitches and glitches in your EMR stand. Is it a leadership issue? Do you need to hold your vendor’s feet to the fire for a more useable record?

One solution might lie in an unexpected place: the VA. “As a former Joint Commission surveyor, I surveyed VA hospitals, which were essentially paperless and used an impressive EMR that translated almost everywhere,” says Blickenstaff. “I remember thinking, ‘That technology is there; why don’t we take it and translate it to other hospitals? Why are there so many different EMRs across the country that do not connect or smoothly transition patient information from one location to another as people travel or move around, such as can be done with the VA EMR?’”

She surveyed one non-VA hospital that reached out to the VA for that system and had it embedded in the system’s hospitals and ambulatory sites.

“They had clinics in schools, dental clinics, mother/baby clinics,” says Blickenstaff. “They were able to take that system and put it in place with a few modifications—and, more importantly, use the system and access patient information to coordinate care as it’s meant to be coordinated.”

Even better, Blickenstaff was able to sit down and navigate the EMR with very little training. “It was so intuitive,” she says.

With so much of the healthcare world going global and becoming more interwoven, it only makes sense to build toward a better flow of information, Blickenstaff says. “If something happens to me in New York and I’m from Idaho, who can have access to my medical records and ensure that I am getting appropriate care based on my unique medical history?” she says.

Unfortunately, the healthcare world has to find a better balance of collaboration and competition for this to truly happen. “We like to say we are collaborative, but even healthcare is a highly competitive industry,” says Blickenstaff. “I think that’s one of the opportunities we have in healthcare.”
FGI updates: What to look for in 2014

Continuing Education Objectives

After reading this article, you will be able to:

• Identify areas where the Facility Guidelines Institute has made recommendations for safety improvement
• Discuss the goals of these recent changes
• Describe the definition of a medication safety area
• Describe the role of needlestick prevention in these recommended improvements

Editor’s note: Elizabeth Di Giacomo-Geffers, RN, MPH, CSHA, is a healthcare consultant in Trabuco Canyon, California, and a former Joint Commission surveyor.

The Facility Guidelines Institute (FGI) recently posted a set of updates to help introduce changes and additions to the 2014 Guidelines for Design and Construction documents. The guidelines will profile new additions and changes for acute care facilities as well as new materials for residential facilities.

These guidelines came about to, as FGI says, bring “together some of the best minds in our business and through a formal consensus process develops a series of minimum design and construction standards for adoption by federal, state, and private enforcement authorities.” They are a product of more than 200 experts.

This information is provided in two reports, Update 1: Design for Safety, by Ellen Taylor, AIA, MBA, EDAC, and Update 2: Medication Safety Zones, by Eileen Malone, RN, MSN, MS, EDAC. Both are available on the FGI website: www.fgiguide lines.org/2014articles.php.

Update 1

What has changed in the area of designing for safety? To start with, Taylor notes, a topic broached in the 2010 Guidelines for Design and Construction of Health Care Facilities, patient safety risk assessments, will now become a requirement in 2014. This assessment requirement will take into consideration:

• Infection control
• Patient handling
• Falls
• Medications safety
• Psychiatric injury
• Immobility
• Security

This requirement is meant to help “foster a proactive approach to patient and caregiver safety by mitigating risks from the physical environment that could directly or indirectly contribute to harm.”

The goals of such a risk assessment, according to the guidelines, are to “proactively identify hazards and risks and mitigate underlying conditions of the environment that contribute to adverse events,” such as the items listed above. The process must take into account population and scope, as well as:

• Models of care
• Operational plans
• Sustainable/green design elements
• Performance improvement initiatives

The financial implication of harm

Different types of harm have the potential to have different impacts on the healthcare facility they occur in, but all types can lead to significant financial burdens if left undressed. Taylor points to some of the most significant as evidence:

Falls. $13,316: operational costs for fallers with serious injury above and beyond the costs of non-fallers. Length of stay increase: 6.3 days longer.

Delayed ambulation/immobility. 2 days. The number of days earlier patients were discharged when those patients were able to increase their walking by 600 steps from the first 24-hour period to the second.

Healthcare-associated infections. $43,000. The approximate cost to treat patients infected during medical care during medical or surgical stays above and beyond the cost of those patients who were not infected during their stay. Length of stay increase: 19.2 days.
The assessment should also propose environmental solutions.

The 2014 Guidelines go into further detail about these goals, stating that the process should:

- Identify hazards that might contribute to harm, such as physical obstacles
- Examine past data to identify vulnerabilities
- Prioritize the degree of potential harm from those hazards
- Look for features of the environment that contribute to risk (such as light, visibility, or noise) and come up with strategies to reduce, mitigate, or eliminate those features

The end goal, Taylor writes, is to work with planning and design to help create long-term solutions to contribute to an improved, safe healthcare environment.

“While there is no silver bullet that will guarantee a safe facility or elimination of all adverse patient outcomes, the [risk assessment] requirement advances a set of considerations that align with the clinical goals of any healthcare organization: Primum Non Nocere—First, Do No Harm,” Taylor writes.

**Update 2**

Medication use is ubiquitous in the healthcare environment, with activities from prescribing to administering to documenting that touch every aspect of patient care. To help promote accurate medical use, new physical environment requirements have been developed by the Healthcare Guidelines Revision Committee in the 2014 FGI standards.

“To help promote accurate medical use, new physical environment requirements have been developed by the Healthcare Guidelines Revision Committee in the 2014 FGI standards.”
—Eileen Malone, RN, MSN, MS, EDAC

These new additions, Malone writes, follow changes by the U.S. Pharmacopeial Convention (USP), which were released after the 2010 edition of the guidelines. The USP added a chapter to its National Formulary, “Physical Environments That Promote Safe Medication Use,” defining the physical locations where medication processes take place (medication safe zones) and responding to environmental conditions which are known to impact medication error rates:

- Illumination
- Interruptions and distractions
- Sound and noise
- Organization of the workspace

New medication safety zone requirements from the FGI are based not only on the guidelines from the 1998 National Institute for Occupational Safety and Health standards, but also 2001 OSHA guidelines and the 2010 USP National Formulary.

But what is the organization’s role in developing medication safety zones? Malone writes, “During the planning phase of a design or construction project, those with legal responsibility for operating the healthcare facility (the governing body, often the owner) will identify medication safety zones as part of an overall safety risk assessment. A medication safety zone is a room or an area in a room where medication use system activity occurs.”
Once those zones have been identified, Malone writes, the project team will follow the guidelines developed for its specific facility type.

**Needlestick safety**

Needlestick prevention and staff safety is also addressed under these latest guideline updates. Needlesticks is one of the most common occupational hazards for hospital-based healthcare, writes Malone. Not only do roughly 80% of accidental exposures to blood occur during sharps injuries, but studies show that at least half of the occupational sharps injuries occurring are not reported by healthcare workers, she adds.

But where are these injuries occurring?

According to the National Surveillance System for Healthcare Workers (2011), the majority of needlestick injuries happen on inpatient units (40%) or in the operating room (25%). Take a look at the situational occurrences of needlesticks:

- In transit to disposal: 4%
- During sharps disposal: 12%
- Collision with a worker or sharp: 10%

“Needlesticks is one of the most common occupational hazards for hospital-based healthcare. Not only do roughly 80% of accidental exposures to blood occur during sharps injuries, but studies show that at least half of the occupational sharps injuries occurring are not reported by healthcare workers.”

—Eileen Malone, RN, MSN, MS, EDAC

The 2014 Guidelines follow the lead of the existing OSHA Bloodborne Pathogens standard, requiring containers for contaminated sharps to be located “as close as feasibly possible to the immediate area where sharps are used or can be reasonably anticipated to be found.”

Factors built into these requirements to improve safety include the ability to see the opening at the top of a sharps container.

What does FGI expect as a result of these new requirements?

The guidelines “provide a framework for a predesign safety risk assessment and minimum design requirements (with supporting appendix language) to guide design and construction of medication safety zones across the continuum of care with the goal of supporting safe medication use systems,” writes Malone.

### References


What should I be doing now?

Month five post-survey tips

Editor’s note: In this new feature, BOJ advisor Jodi Eisenberg, MHA, CPHQ, CPMSM, CSHA, manager of accreditation, clinical compliance, and policy management for Northwestern Memorial Healthcare in Chicago, explains the steps and goals survey coordinators will want to take at a given point in their survey cycle. This month, Eisenberg examines month five post-survey.

The 60-day evidence of standards compliance is now submitted, and you continue to track the measures of success to ensure ongoing compliance through your next survey. Pay attention to your monthly compliance to ensure that you have reached 90% compliance or are trending upward to achieve it at the end of your four-month measurement period.

Last month, you took a step back and began to think about the big picture. One of the most important initiatives to include in your ongoing readiness plan is communication.

How do you achieve communication continuous readiness?

- Do you have a standard organizationwide communication vehicle?
- Do you have functional committees or groups that take ownership for some of the more specific communication (e.g., environment of care, life safety, infection prevention, patient rights)?
- Have you integrated the appropriate requirements into orientation and mandatory annual education and training for all staff?

Take the time to ensure consistency. All messages that are communicated to staff, whether within an organizationwide communication vehicle or individually by a committee or group, should be consistent with the standards, regulations, and hospital policy. Remember, the most stringent of the above applies. Staff need to be able to easily articulate what they do, and what they do should be in line with what you say (in policy or procedure). Make sure the message is less about meeting the standards and more about meeting the expectations of patients. This connection will resonate with your staff—they come to work to take care of patients, not to meet regulatory requirements.

Integrate fun into the process! Many organizations have created games such as Jeopardy, Name That Alarm, Wheel of Regulations, and the like. This is a great way to engage frontline staff throughout the accreditation cycle.

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Matt Phillion
Senior Managing Editor

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