Suicides were the third most common sentinel event of 2015, with 95 reported cases in 2015’s Sentinel Event Statistics. The total number of patient suicides reported to The Joint Commission is now up to 1,184 since the start of the decade.

That said, only 2% of sentinel events are reported to The Joint Commission, and the cases reported are only the ones that occurred inside a healthcare facility or within 72 hours of discharge. Nationally, suicide is the 10th leading cause of death, with 9.3 million adults having suicidal thoughts, 1.3 million attempting suicide, and 41,149 deaths in 2013. In addition to the loss of life, suicides cost $51 billion in combined medical and work costs annually.

In February, The Joint Commission released Sentinel Event Alert 56 (www.jointcommission.org/sea_issue_56) to highlight the detection and treatment of suicidal patients. The accreditor found that 21.4% of accredited behavioral health organizations and 5.14% of accredited hospitals are noncompliant with National Patient Safety Goal 15.01.01, which focuses on suicide prevention. The alert calls on healthcare facilities to improve suicide prevention compliance by establishing suicide screening programs (SSP) to identify at-risk patients.

Universal screening

Many hospitals fall short in screening for suicidal ideation, if they screen at all, says Julie Goldstein, PhD, director of health and behavioral health initiatives at the Suicide Prevention Resource Center (SPRC) for the past three years. She also leads the organization’s Zero Suicide Initiative.

Industry attitudes toward suicide screening have changed, Goldstein says.

“Up until recently, the U.S. Preventive Services Task Force [USPSTF] only recommended screening in the event that there were services available to support the screening results,” she says. “So they said you should
screen, but you should only really screen when you have those available services. Because you can’t screen positive and then have nowhere to make the referral. That’s a real limit.”

The USPSTF has since changed its stance and now recommends universal screening, as does The Joint Commission. Goldstein says these endorsements will hopefully aid suicidal patients in finding help.

First screening program in the U.S.

In 2014, the Parkland Health and Hospital System in Dallas became the first in the nation to establish a universal SSP in all its departments. The health system was one of the few organizations acknowledged in Sentinel Event Alert 56 for making significant progress in suicide prevention.

Celeste Johnson, DNP, APRN, PMH CNS, director of nursing and psychiatric services at Parkland, helped create the SSP. “The Joint Commission said you really should be screening everybody and coming up with an evidence-based tool,” Johnson says. “So we started meeting with them and developed a tool for everyone at Parkland. We pulled together all the stakeholders: IT, nurses, social workers, and there was lots of communication with administration.”

The program had been proposed a few years prior to implementation by Kimberly Roaten, PhD, director of quality for safety, education, and implementation in the hospital’s Department of Psychiatry. Roaten has a background in suicide prevention training and was a big part of the SSP’s development and implementation.

“From my perspective, the biggest hurdle was making sure of what resources would be needed to respond if a patient screened positive,” Roaten says. “Part of that was getting people in place to respond, and the biggest part was building our own clinical response algorithm.”

The Joint Commission classifies patient suicides as ones that occur inside a hospital or within 72 hours of discharge. However, that metric omits those who commit suicide in the days, weeks, and months after that 72-hour window. It also doesn’t show the number of patients who have suicidal thoughts or intentions, making it difficult to discover the percentage of patients who are at risk.

After the program’s first year, Parkland created a data sheet revealing the percentage of its patients who
experienced suicidal ideation. Of the 243,000 patients to visit the hospital’s ER and inpatient units in 2015, 4% were moderate suicide risks and 2% were high risk. Of the 259,000 screened in the hospital’s community-oriented primary care facilities and correctional health programs, 2% were moderate risk and 0.15% were high risk.

Simply put, out of the 502,000 patients that Parkland saw in one year, 14,900 were at moderate risk and 5,249 were at high risk for suicide. That’s equal to one out of every 25 patients experiencing suicidal thoughts, many of whom wouldn’t have had those thoughts acknowledged without screening in place. Parkland also found that within the year prior to their death, 77% of people who committed suicide had contact with a primary care physician, 40% had contact with an ER physician, and 24% had contact with a mental health provider.

Use a standardized screening tool on everyone

An SSP must be standardized and applied universally to all patients, Goldstein says. While patients may not show some of the risk factors associated with suicidal ideation, it’s dangerous to assume you have the complete picture of their mental health.

“Many times when people screen, they aren’t using a standardized screening tool,” she says. “Sometimes screening to them is saying, ‘You’re not thinking about suicide, are you?’ or, ‘You’d never kill yourself. Right?’ Which is kind of the opposite of how we want people to act. What that says to an individual is, ‘I’m not sure what I’ll do with your answer,’ or, ‘I’m unprepared,’ or, ‘I’m really hoping you’ll say no.’ And as hard as it is to disclose suicide, if the other person on the receiving end of that conversation doesn’t want you to say ‘Yes,’ then people will often not say ‘Yes.’”

Goldstein also notes that many informal screening programs only ask a patient once about suicidal ideation. If you only screen once and something changes in the person’s life three months later, a physician may not realize the patient has become a suicide risk, she points out.

Roaten says that Parkland’s call to action came when an unscreened inpatient with a substance abuse problem attempted suicide. Afterwards, Parkland started using the Columbia Suicide Severity Rating Scale (C-SSRS) to screen adults and the Ask Suicide-Screening Questions (ASQ) tool for children aged 12–17. Both tools are freely available for facilities to download and use, as are dozens of others that can be found at the SPRC’s website (www.sprc.org). See p. 4 for the ASQ tool.

Parkland and the SPRC say a key part of an effective SSP is how screening tools are embedded into the electronic health record (EHR). At Parkland, Johnson and Roaten worked with their IT department to create an EHR that would prompt a user to ask the SSP questions, display a safety “banner” to identify the patient’s risk level, and provide instructions on what to do next.

“A nurse is prompted to ask the [screening] questions immediately,” Roaten says. “And if they can’t ask at that moment, they can silence that ‘best practice’ alert and it will pop up again a short while later. We also built a flag in EHR for anyone who’s high risk: They list out warning signs, plus a mental health facility to call.”

Ideally, the EHR is programmed so that staff can’t skip over the screening questions, or so they will be continually prompted until the questions have been asked and documented. When Parkland first implemented the EHR, Johnson and Roaten would email unit managers a list of the names of people who hadn’t been screened that week. As staff grew better at following the prompts, those emails were replaced with the number of people successfully screened.

Have next steps planned

Don’t forget to look ahead.

“[It’s important] that everybody in the hospital system really understands what happens next,” says Goldstein, “because if you screen people and they are at risk for suicide, there should be ongoing protocols and activities that happen next that everybody’s aware of, including the patient.”

Educate patients as to why they are being screened and what will happen if they screen positive, Goldstein says. The conversation should be like the one you give about a recent cancer diagnosis or high blood pressure, explaining the expectations for what happens next and what the ongoing care will be. Parkland’s EHR categorizes patients as being at “no risk,” “moderate risk,” or “high risk” of suicide and gives on-the-spot recommendations on how to proceed. Moderate-risk patients meet with a psychiatric social worker for assessment and referral, while high-risk patients are immediately sent to a behavioral healthcare provider.
ASQ suicide screening tool

Suicide Screening Questions

1. In the past few weeks, have you wished you were dead?
   - Yes
   - No
   - No response

2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
   - Yes
   - No
   - No response

3. In the past week, have you been having thoughts about killing yourself?
   - Yes
   - No
   - No response

4. Have you ever tried to kill yourself?
   - Yes
   - No
   - No response

If yes, how?

When?

If the patient answers yes to any of the above...

5. Are you having thoughts of killing yourself right now?
   - Yes
   - No
   - No response

Source: National Institute of Mental Health
Q&A: What 2015’s sentinel event stats mean to hospitals

The Joint Commission released its 2015 Sentinel Event Statistics in March; based on 936 reported events, the accreditor found the most common sentinel events were unintended retention of a foreign body (116), wrong-site/wrong-side/wrong-procedure surgery (111), falls resulting in death or permanent loss of function (95), and patient suicides (95). The most common root causes for these events were human factors (999), leadership failures (849), communication failures (744), patient assessment (545), and physical environment (202).

Joe Kiani, founder of the Patient Safety Movement Foundation and chair and CEO of the Masimo Corporation, discusses what the statistics mean for patient health and the steps facilities should take in response.

BOAQ: What is the big takeaway from The Joint Commission's sentinel event statistics for 2015?

Kiani: Surprising and disturbing! It is truly amazing that the sentinel event list is topped by “retained foreign body” and “wrong-patient/side procedure.” This is on the same level as forgetting to lower the flaps before take-off in an MD-80 [commercial jet], which has happened twice—both times with fatal results. [The] aviation [industry] responded with procedures that should prevent that event from ever happening again—yet we are still leaving sponges in the abdomen and operating on the wrong side with apparent regularity. I know of a case where a patient had a malignant tumor in one kidney and the other kidney was normal. Surgeons removed the wrong kidney—the normal one. The fact that fires even made the list [10th most reported event in 2015 with 23] is also disturbing.

BOAQ: How can accreditation professionals use this information to improve Joint Commission compliance?

Kiani: The first step is to share this information with the leaders in the hospital setting and have them run through these items and understand their root causes and create checklists/solutions that can be easily and quickly implemented. These are simple things—for example, counting the number of instruments and surgical sponges before closing the abdomen. Creating a culture of safety from the top down is what we have seen in the hospitals that are making significant strides in eliminating preventable patient deaths and medical errors.

BOAQ: What are the top steps that facilities can take to tackle the issue of retained surgical objects?

Kiani: That is the question, and here comes the broken record: Use a checklist! Very much like taking off and landing an airplane, each required step is on the list. The team (either the flight crew or the operating room staff) reads the checklist out loud and verifies that each step is done. “Sponge count: number on table before surgery = number on table before closure.” It’s not rocket science, but it has to be a bit obsessive-compulsive.

BOAQ: What are the top steps that facilities can take to tackle the issue of wrong-site/wrong-side surgery?

Kiani: Same answer as above. In this case, the true test must involve multiple sources, not just the patient consent form, which is sometimes wrong. Before making the incision to start surgery, most hospitals now use a “timeout” procedure, during which a checklist is read and each step is confirmed. This should be rigorously observed and enforced.

BOAQ: What resources should an accreditation professional look to when trying to improve compliance on these issues, aside from accreditation standards?

Kiani: These professionals should examine the specific tools being used to prevent each of these sentinel events; that is, look at the actual checklists and review exactly how, when, and where they are used, and actually observe their use in the appropriate site, including the operating room. They need to also connect themselves with the Patient Safety Movement Foundation. We have, through collaboration with some of the best clinicians and hospital administrators around the world, identified top problems—and continue to do so at our midyear meetings—and provided actionable patient safety solutions.

BOAQ: Was there anything you were surprised to see in the statistics this year? Something that wasn’t a
The cultural cure to sentinel events

In 1998, The Joint Commission made wrong-site surgery the topic of Sentinel Event Alert 6. The alert said that every facility must conduct a comprehensive systematic analysis when a wrong-site surgery occurs and proposed several solutions to the problem. But the issue persists in healthcare. In 2015, almost two decades after the alert was retired, an Iowa health system had four wrong-site surgeries in under 40 days. Then in March 2016, a Connecticut patient sued her surgeon for removing the wrong rib, lying about it, then charging her double after removing the correct rib.

Despite numerous resources, training courses, webinars, standards, and regulations, certain sentinel events continue to happen with alarming frequency. In the 2015 Sentinel Event Statistics (see related story on p. 5), several of the top 10 reported events, including unintended retention of a foreign body, patient suicide, medication errors, and wrong-site/wrong-side/wrong-procedure surgery, were classified as “never events”—things that should never occur.

Kenneth Rothfield, MD, MBA, CPE, CPPS, system vice president and chief medical and quality officer at St. Vincent’s Healthcare of Ascension Health in Jacksonville, Florida, says the same major categories of patient harm have continued to top the sentinel event list year after year.

“Things like retained surgical instruments and fires, those are all problems that I think healthcare professionals thought would be fixable early on,” he says. “I like to call these the never events that never stopped occurring.”

Rothfield says that after years of trying to eliminate these issues, the healthcare industry’s problem isn’t a lack of solutions.

“The reality is that we’re dealing with a social problem with these patient injuries, not so much a technical problem,” he adds. “Without a culture that will support the technical solutions, the technical solutions don’t work.”

As an example, he points to a 2009 U.S. study showing morbidity and mortality rates go down when checklists are used. However, even in facilities that have adopted preoperative checklists, wrong-site surgeries still continue to be relatively common.

“We had a lot [of people] say this [preop checklist] was going to be our salvation,” Rothfield says. “But when we have wrong-site surgeries, what we find, frequently, is that the surgeon isn’t engaged with the process. This is something done by the rest of the teammates, without involving the surgeon. You have a tendency to do that in healthcare. You have a lot of ancillary support so the doctors can spend their time doing that critical, technical thing that only they can do, and we delegate a lot of patient safety functions to other people.”

He points out that when the same checklist study was conducted in Canadian hospitals and facilities, the study found the checklist had no impact on morbidity and mortality rates. If the tool itself were the only thing needed to improve safety and quality, he argues, then it wouldn’t matter where it’s used or who uses it.

“In the Canadian study, I think the healthcare professionals involved viewed this as something given to them by the people in the C-suite, and they [checklists] were not adopted with enthusiasm,” says Rothfield. “They didn’t have leadership support.”

The key lesson from the checklist studies and the sentinel event statistics is that culture is everything, he says. On the 2015 sentinel event list, the top three root causes of sentinel events were human factors (e.g., staff supervision), leadership (e.g., organizational planning), and communication failures with either patients or administration. These three categories accounted for 2,592 of the 3,713 root causes identified by the statistics. In other words, there was a 70% chance that a sentinel event in 2015 was caused by poor staff interaction, organization, communication, or guidance.

“The Joint Commission points out that leadership is the No. 1 or No. 2 cause leading to these sentinel events,” Rothfield says. “When I talk about leadership, I particularly like to emphasize physician leadership. This is a great opportunity for physicians to get in the game and be leaders. That means understanding more deeply what it means to interact with a team, what it means to support other team members, flatten hierarchy, and encourage open communication.”
The cultural cure to sentinel events (cont.)

Rothfield says the first step in quality care is critically assessing and confronting your culture. He compares today’s healthcare industry to the airline industry in the 1970s. Airlines of that era abdicated a lot of their authority to their pilots, he says, allowing them to run their planes as they wished. Notably, commercial airline crashes were much more common at the time.

“I don’t think twice about my personal safety when I get out of that Southwest jet because commercial aviation has really achieved high reliability,” Rothfield says. “There were a lot of high-profile commercial airline crashes, and that was because back in the ‘70s they had a very pilot-centric culture, where the pilots truly were the captains of the ship. They [were] allowed much more latitude in terms of autonomy and entitlement, and the results were a lot of safety events. Because what we’ve learned is that when there’s a lot of variability, the results are usually not very good.”

In 1977, the airline industry was spurred to change after a plane crash on the island of Tenerife killed 583 people. Nearly 22 years later, the Institute of Medicine report *To Err Is Human* caused an uproar among the medical community when it found that 100,000 patients die each year because of preventable medical harm. Most agreed that the real number was actually much higher, Rothfield says.

“The real number was somewhere between 250,000 and 440,000 patients [per year],” he says. “So I think that was the beginning of the wake-up call for the industry, and we’ve certainly had lots and lots of high-profile deaths. But I don’t think it’s going to be one event that will become the tipping point for the industry. I think we’ve already had our wake-up call, but the industry is just moving way too slow.”

Rothfield points out that the airline industry solved its safety problem by creating a culture that flattened hierarchy and allowed for more open communication among airline personnel without fear of reprisal. This permitted safety issues and concerns to be voiced by crew and staff before the issues became life threatening.

“Healthcare organizations have started to adopt that [management style], but it hasn’t become a deeply embedded part of our culture,” he says. “Until we get to a culture where everybody finds it easy to speak up without fear of retaliation, we’re going to continue to have things like wrong-site surgeries or retained foreign bodies. Because usually in a lot of these events, somebody knows that something is wrong, but feels very intimidated about speaking up about it.”

St. Vincent’s has the surgeon perform the final read-through of the preop checklist aloud to his or her team, thus making sure everyone is on the same page and nothing has been missed. Making surgeons the final quality control check gets them actively engaged in the process, Rothfield says, and spurs the rest of the team to ensure everything goes as planned.

“The reason why it’s so important to get the active engagement of leadership of surgeons and proceduralists is that anybody can load the gun in a wrong-site procedure, but it’s always the surgeon pulling the trigger,” he says. “After the patient, surgeons have the most to lose in a wrong-site surgery procedure, so it doesn’t make sense to delegate the preop checklist to other people.”

Rothfield suggests that hospitals trying to improve their quality and safety compliance look into the ECRI Institute’s Patient Safety Center website and the Patient Safety Movement’s Actionable Patient Safety Solution document. He cites Virginia Mason Hospital and the University of Vermont Medical Center as facilities with great cultures and leadership, as well as a constant focus on quality and safety.

“Einstein defined insanity as doing the same thing repeatedly and expecting a different outcome,” he says. “We’ve kind of done that in healthcare in our approach to these problems. We fool ourselves into thinking that if we just try harder, we’re going to fix things. Trying harder is the strategy that’s prevented the Avis car rental company from ever being No. 1—they’re No. 2 in trying harder. I think the answer is to be like Apple and think different.”
Avoid infectious outbreaks with strong device reprocessing policies

Reusable medical devices carry a special risk of infection if they aren’t properly reprocessed and sterilized. This fact was clarified in recent months when scores of infection outbreaks and dozens of deaths were linked to defective endoscopes. Many of these outbreaks involved drug-resistant superbugs and sparked a national conversation on medical device safety.

How can a healthcare facility design the best reprocessing policies and stay compliant with infection prevention regulations?

The key lies in the device manufacturer’s instructions, says Peggy Prinz Luebbert, MS, CIC, CHSP, CBSPD, co-owner and president of Healthcare Interventions, Inc., who also spent nine years as an infection prevention specialist at Nebraska Orthopedic Hospital. There’s a lot going on in the world of infection prevention, she says, and hospitals are now recognizing the importance of double-checking manufacturers’ reprocessing instructions against what people are actually doing.

“When I do rounds, I will pick a piece of equipment and ask a user if they’ve used it,” Luebbert says. “If they say yes, then [I say], ‘Tell me how you reprocessed it. How you clean it. How you disinfect it.’ Then [I say], ‘Show me the manufacturers’ instructions; I’d like to see if they match what you’ve been doing.’ It’s amazing to me how many times you’ll find discrepancies between the two.”

When developing reprocessing policies, don’t assume anything, she says. Working with the individuals actually doing the reprocessing is key to knowing whether they are following manufacturers’ instructions or cutting corners.

“Typically, you will see basic instructions for general environmental cleaning to be quite good,” Luebbert says. “But it’s that piece of equipment that they rarely use or the piece that they use all the time where shortcuts tend to happen. For example, vaginal probes in an OB-GYN clinic or laryngoscope blades in an operating room are equipment that staff gets so used to that they start taking shortcuts.”

Part of the renewed focus on proper reprocessing, she notes, is due to updated guidelines for device management and a growing awareness of the potential risks associated with improper sterilization and cleaning. One of the issues that brought reprocessing procedures to the forefront was the discovery that duodenoscopes from three manufacturers had a design flaw that prevented them from being properly sterilized, even when the proper instructions were followed.

The scope issue made infection preventionists realize they needed to look deeper into the protocols surrounding other scopes and probes, Luebbert says. In the long run, she adds, it made them focus more time and effort on protocols that are effective for any type of scope or probe, as well as any technique that involves instrumentation.

“Most [infection preventionists] and most of the users thought what they were doing was effective based upon the knowledge we had from both the manufacturer and regulatory [agencies],” she says. “There were people who
Interim Protocol for Healthcare Facilities Regarding Surveillance for Bacterial Contamination of Duodenoscopes After Reprocessing

Outbreaks of bacterial infection associated with endoscopes are often attributed to improperly reprocessed endoscopes. However, recent reports have identified carbapenem-resistant Enterobacteriaceae (CRE) transmission associated with persistently contaminated duodenoscopes for which no breaches in reprocessing were identified (1).

There is currently very limited information to guide the use of surveillance cultures to assess endoscope reprocessing outside of recognized outbreak settings. Surveillance cultures are not a replacement for appropriate training and oversight of endoscope reprocessing practices. Before initiating surveillance cultures, facilities considering their use should involve key facility staff, including the clinical laboratory director, clinical staff, infection prevention staff, hospital epidemiologists, and risk management staff to develop a plan for implementation, and response (e.g., patient notification) to surveillance culture results.

The following considerations are intended for facilities that perform procedures using duodenoscopes to assess the adequacy of reprocessing. While these measures apply primarily for duodenoscopes, they can also be implemented for other flexible endoscopes that have an elevator mechanism (e.g., used to perform endoscopic ultrasound). This document is intended to supplement and not replace or modify manufacturer recommended reprocessing procedures.

This is an interim protocol and measures outlined below may change as new information becomes available.

- Use of duodenoscope culturing
  - Surveillance: Although routine culturing of endoscopes is not part of current U.S. guidelines, recent outbreaks associated with duodenoscopes have led some facilities to consider regular monitoring to assess the adequacy of duodenoscope reprocessing (see algorithm).
Interim Protocol for Healthcare Facilities Regarding Surveillance for Bacterial Contamination of Duodenoscopes After Reprocessing (cont.)

• The optimal frequency of surveillance cultures has not been established. International guidelines have recommended intervals ranging from every 4 weeks to annually (2, 3). A facility choosing to perform surveillance cultures can consider performing post-reprocessing cultures periodically, e.g., monthly or after every 60 procedures for each duodenoscope. Some facilities could choose to perform duodenoscope cultures weekly (e.g., after procedures on Friday to allow cultures to incubate over the weekend). Alternatively, facilities can choose to perform cultures, after reprocessing, following each use.

• Cultures should be obtained after the duodenoscope has been reprocessed (after drying) and should include at least the instrument channel and the distal end of the duodenoscope (i.e., elevator mechanism and elevator recess for duodenoscopes with sealed elevator wire channel; and elevator mechanism, elevator recess, and elevator channel for duodenoscopes with unsealed elevator wire channels). Facilities may choose other sampling methods (e.g., flush-brush-flush method), or choose to sample additional channels beyond those specified in this approach. The sensitivity of the interim protocol has not been determined. A negative culture does not completely exclude the possibility of a contaminated duodenoscope. However, positive culture results should lead to some action as described below.

– Post-reprocessing cultures of duodenoscopes should be assessed for two types of microbial growth: high- and low-concern organisms. If successfully disinfected, culturing should not detect any high-concern organisms (i.e., organisms more often associated with disease), such as Gram-negative bacteria (e.g., Escherichia coli, Klebsiella pneumonia or other Enterobacteriaceae, as well as Pseudomonas aeruginosa), Staphylococcus aureus, and Enterococcus. Small numbers of low-concern organisms (i.e., organisms less often associated with disease and potentially a result of contamination of cultures during collection) might occasionally be detected (e.g., coagulase-negative staphylococci excluding Staphylococcus lugdunensis, Bacillus species, diphtheroids). The levels of these low-concern contaminants on a duodenoscope can vary depending on the reprocessing, handling, and culturing practices in a facility; levels of such organisms detectable after reprocessing will therefore vary. Facilities can monitor the levels of these bacteria within the first month of surveillance testing to develop an expected baseline for those organisms. Typically, fewer than 10 colony forming units (CFU) of low-concern microbes does not require intervention; interpretation of culture results with ≥ 10 CFU of low-concern microbes should be considered in the context of typical culture results at the facility. Any quantity of high-concern organism (i.e., one colony or greater) warrants further remedial actions as described below. This is consistent with previous recommendations (2, 4).

• Holding duodenoscopes out of use while surveillance culture results are pending could be considered, especially if performing surveillance cultures after each use. Any duodenoscope found to be contaminated should not be returned to use until steps outlined in remedial actions section (below) are addressed.

• Facilities should ensure that each endoscopic procedure is appropriately documented with regard to the specific endoscope used in order to allow identification of exposed patients should microbial growth be detected as described above. Furthermore, results of post-reprocessing duodenoscope cultures should be logged and tracked for each duodenoscope.

• Non-culture methods (e.g., adenosine triphosphate (ATP) bioluminescence assays) have been used to
Interim Protocol for Healthcare Facilities Regarding Surveillance for Bacterial Contamination of Duodenoscopes After Reprocessing (cont.)

Assess duodenoscope reprocessing by detecting residual organic material after cleaning. While individual facilities might choose to use such non-culture assays, more work is needed to interpret their results since non-culture methods lack consistent correlation to bacterial concentrations. They might, however, provide insight regarding the quality of duodenoscope reprocessing if systematically validated (5, 6).

- During outbreaks
  - Surveillance cultures have been used during outbreaks to identify contaminated duodenoscopes and to ensure that ongoing contamination is not occurring.
  - Until the limits of detection are defined, negative surveillance cultures alone should not be used to rule out duodenoscopes as a source of cross-transmission.
  - Following documented transmission of bacteria via a duodenoscope, facilities should consider performing a series (e.g., 3 to 5) of duodenoscope surveillance cultures after reprocessing to ensure that the interventions employed to address the issue have eliminated contamination and are preventing further contamination that could lead to transmission.

- Remedial actions: Any duodenoscope found to be contaminated with any high-concern organisms or unacceptable CFU of low-concern organisms should be reprocessed again with repeat post-reprocessing cultures obtained. The duodenoscope should not be used again until it has been demonstrated to be free of high-concern organisms and has an acceptable level of low-concern organisms. Positive cultures should prompt a procedure review to ensure adherence to the manufacturer’s reprocessing instructions and to ensure cultures are being performed correctly. If a reprocessing breach is identified, appropriate facility personnel (e.g., infection prevention staff) should be notified and corrective actions should be immediately implemented. Refer to the manufacturer’s instructions for evaluating the duodenoscope for defects when bacteria are persistently recovered by duodenoscope cultures (including repeated cultures positive for low-concern organisms). In this situation, the facility can consider having the duodenoscope evaluated by the manufacturer. In addition, when unsuccessful reprocessing is suspected based on surveillance cultures, it might be helpful to review positive cultures among affected patients to determine whether other clusters of relevant pathogens could have been transmitted.

- Patient information and notification: Patients undergoing procedures using duodenoscopes should be informed during the consenting process that there is a risk of patient-to-patient bacterial transmission associated with the procedure, including uncommon transmission of a multidrug-resistant organism. Facilities should document the specific duodenoscope used for each patient to facilitate identification of the exposed patients if needed. If high-concern organisms are recovered from a reprocessed duodenoscope (as described above), the decision to notify patients of their potential exposure should be made in consultation with key facility staff, including involved healthcare providers, infection prevention staff, hospital epidemiologists, and risk management. In instances where a multidrug-resistant organism (e.g., CRE) is cultured from a reprocessed duodenoscope, screening of exposed patients for the organism should be considered (a laboratory protocol for rectal CRE screening is available in the CDC CRE toolkit: www.cdc.gov/HAI/pdfs/labSettings/Klebsiella_or_Ecoli.pdf). This allows for appropriate infection control precautions to be implemented during future admissions to a healthcare facility for any exposed patient with positive screening cultures for the multidrug-resistant organism. Detailed information on patient notifications is available at: www.cdc.gov/injectionsafety/pntoolkit/index.html.

- Staff training and competency: Ensure personnel performing reprocessing of duodenoscopes have received appropriate training with competency verification for re-
No surprises on list of most-cited Joint Commission standards in 2015

Veteran accreditation professionals don’t get too excited with the biannual release of The Joint Commission’s list of most-cited standards because they know what’s coming: safety, safety, and more safety.

For several years, the list has been dominated by safety-related standards, and 2015 was no exception. Eight of the top 10 standards were from the Environment of Care, Life Safety, or Infection Control chapters. Only one of the 10 standards was not on the previously released list.

The list compiles the standards for which surveyors most frequently find facilities noncompliant. Percentages indicate the number of organizations that were given Requirements for Improvement for the standards.

The top 10 most-cited standards of 2015 were as follows, based on 1,447 hospital surveys:

- EC.02.06.01 (maintenance of a safe environment), 62%
- IC.02.02.01 (reduction of infection risk from equipment, devices, and supplies), 59%
- EC.02.05.01 (management of utility system risks), 58%
- LS.02.01.20 (maintenance of egress integrity), 51%
- LS.02.01.30 (building features provided and maintained to protect from fire and smoke hazards), 50%
- RC.01.01.01 (maintenance of accurate, complete medical records for all patients), 47%
- LS.02.01.35 (fire extinguishment features provided and maintained), 46%
- LS.02.01.10 (minimization of fire, smoke, and heat damage via building and fire protection features), 45%
- PC.02.01.03 (lawful provision of care, services, and treatment), 40%
- EC.02.02.01 (management of hazardous materials and waste risks), 39%

For more information, visit [http://goo.gl/uyqT6K](http://goo.gl/uyqT6K) or see the April issue of *Joint Commission Perspectives*. 

References
1. Epstein L, Hunter JC, Arwady MA, et al. New Delhi metallo-
 β-lactamase producing carbapenem-resistant Escherichia coli associated with exposure to duodenoscopes. JAMA 2014;312:1447-1455.