



Walter Reed National Military Medical Center

Continuous Survey Readiness Guide

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Quality of Care Concerns



The Walter Reed National Military Medical Center
wants to know if you have a concern.

The Joint Commission encourages you to bring your concerns to the attention of your healthcare organization's leaders.

Staff members should use their chain of command, or the Quality Management Department to express concerns about quality of care or patient safety.

If this does not lead to a resolution, you may take your concerns to The Joint Commission - without fear of retribution.

The Joint Commission's Office of
Quality Monitoring is at
1-800-994-6610
complaint@jointcommission.org



WRNMMC Vision Statement

We are the Nation's Medical Center.

We create extraordinary experiences for patients, families and staff while driving tomorrow's healthcare advances.

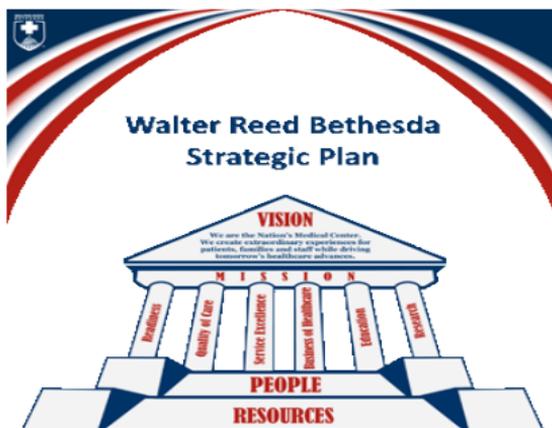
WRNMMC Mission Statement

Walter Reed Bethesda leads military medicine through outstanding patient-centered care, innovation, and excellence in education and research. We provide comprehensive care to prevent disease, restore health and maximize readiness.

We are:

- Accountable to our Patients and Staff
- Preferred for our Performance
- Admired for our Service

WRNMMC Strategic Plan



Walter Reed Bethesda...What I Do Matters!

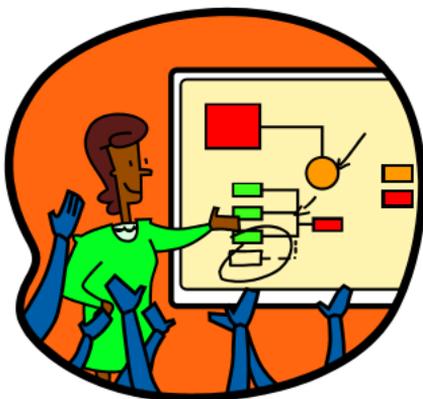


Our Quality System

1. Our Performance Improvement (PI) Plan is our Annual Plan
 - Where we're going
2. NNMCIINST 6010.3j describes our PI System
 - How we get there
 - Quality Council
 - Ensure efforts add value
 - Monitor results (dashboard)
 - Resource efforts if needed

With the Quality Council, we

- Shift from multiple, discrete PI activities to fewer, integrated efforts.
- PI is driven by Strategic and Annual Goals.
- Reduce the administrative burden of PI.
- Instant, multi-channel communication on PI issues.
- One line of authority, with better resourcing of stalled efforts.





Quality Council

Purpose

The Quality Council

- Assesses and describes WRNMMC's posture relative to selected industry benchmarks for health care quality and patient safety.
- Identifies and implements effective strategies to improve and sustain our performance against these benchmarks.
- Serves as the primary forum for effective, instant and multi-channel performance improvement and patient safety communications among invested organization leaders and stakeholders.



Chartering Authority

The WRNMMC Quality Council (QC) is chartered by the Director, Walter Reed National Military Medical Center, and is co-chaired by the WRNMMC Chief of Staff and the Assistant Chief of Staff for Quality,

Scope of Authority

The WRNMMC Quality Council is a decision-making body, subject to the guidance of the Board of Directors and the Hospital Director.



Important Phone Numbers

- Base Police/Public Safety.....295-1246
 - Cardiac/Respiratory Arrest (Base Phone).....777
 - Cardiac/Respiratory Arrest (Any cell).....(301) 295-0999
- Rapid Response Team (RRT).....321
- Non-Emergent Dispatch.....(301) 295-1246
- Command Duty Office.....295-4611
- Fire/Emergency/Hazardous Spill.....777
- ITCS Help Desk.....295-6300
- Judge Advocate.....295-2215
- Patient Relations.....295-0156
- Poison Control..... 800-222-1222
- Patient Safety.....295-6236
- Safety Department.....319-4558
- Security295-1246/7
- Trouble Desk/Facilities.....295-1070

Know the Code

RED = FIRE

ORANGE = HAZMAT SPILL

BLACK = BOMB THREAT

BLUE = CARDIAC/RESPIRATORY ARREST

PURPLE = LOST PERSON OR ELOPEMENT

PINK = INFANT OR CHILD ABDUCTION

YELLOW = UNDETERMINED THREAT

GRAY = VIOLENT/COMBATIVE PERSON

WHITE = ACTIVE SHOOTER

GREEN = MASS CASUALTY EVENT



Inpatient Rapid Response Team Calling the Team

1

Dial **321** to bring the RRT to the bedside

2

State: Building, floor, room #

3

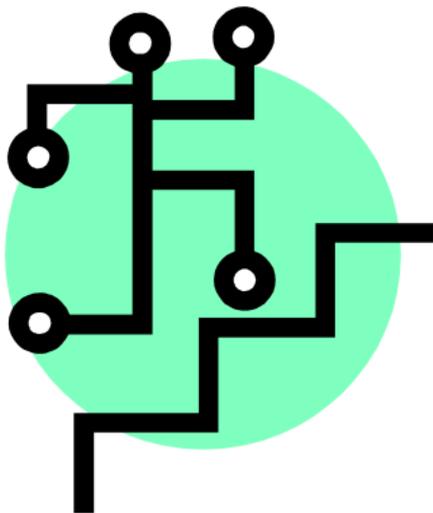
Call patient's attending service

4

Document in Essentris RRT note

**Early detection of a patient's changing condition
can prevent a code situation!*

Don't hesitate to make that call!





Inpatient Rapid Response Team

The Early Warning System for Adults

- Acute changes in Heart Rate to <40 or >130 BPM
- Acute changes in Respiratory Rate to <8 or >28
- Acute changes in Systolic Blood Pressure (SBP) to <90 or >220 mm/

Hg

- Acute drop in Pulse Oximetry to $<90\%$ despite supplemental O₂
- Acute changes in consciousness or mental status
- Staff member concern
- Patient or family member concern about patient



WRNMMC's Oryx Measures

Acute Myocardial Infarction (AMI)

- Aspirin prescribed at arrival and at discharge
- Beta blocker prescribed at discharge
- Median time to fibrinolysis
- Fibrinolytic therapy received within 30 minutes of hospital arrival
- Median time to primary PCI
- Primary PCI received within 90 minutes of hospital arrival



WRNMMC's Oryx Measures

Heart Failure (HF)

- Discharge instructions
- Evaluation of LVS function
- ACEI or ARB for LVSD

Venous Thromboembolism (VTE)

- VTE Prophylaxis
- ICU VTE Prophylaxis
- VTE Patients w/Anticoagulant Overlap Rx
- VTE Patients Receiving Unfractionated Heparin w/Dosages/Platelet Count Monitoring by Protocol
- VTE Discharge Instructions
- Incidence of Potentially-Preventable VTE

Pneumonia Care

- Pneumococcal Vaccine
- Influenza Vaccine
- Blood Culture Timing
- Antibiotic Timing & Selection

Surgical Care

- Antibiotic Timing & Selection
- Control of Post-Op Glucose
- Hair Removal
- Beta Blocker Therapy
- VTE Prophylaxis
- Perioperative Temperature Management
- Post-Op Catheter Removal



WRNMMC's Oryx Measures

Perinatal Care

- Elective Delivery
- Cesarean Section
- Antenatal Steroids
- HAI in Newborns
- Exclusive Breast Milk Feeding

Hospital-Based Inpatient Psychiatric

- Admission screening
- Hours of physical restraint
- Hours of seclusion
- Patients discharged on multiple antipsychotic medications
- Post Discharge plan created
- Post Discharge plan transmitted

WRNMMC's National Quality Initiatives

- Central Line Infection Reduction
- Indwelling Catheter UTI Reduction
- Ventilator Associated Pneumonia Reduction
- Decubiti Reduction
- Hand Hygiene Compliance

WRNMMC's HEDIS Measures



- Diabetes Lipid Measurement
- Diabetes Hgb A1c Measurement
- Diabetes Hgb A1c Management
- Diabetes Lipid Control
- Cardiac Patient Lipid Measurement
- Cardiac Patient Lipid Management
- Breast Cancer Screening
- Cervical Cancer Screening
- Screening for Tobacco Use
- Antidepressant Medication Management - Acute Phase
- Antidepressant Medication Management - Continuous Phase
- Low Back Pain Imaging
- Mental Health Follow-Up 7 Days
- Mental Health Follow-Up 30 Days
- Well Child Visits





WRNMMC Patient Care Initiatives

- **The Patient CaringTouch System** spans all care environments
- Ensures quality care is delivered carefully, compassionately
- Delivered in accordance with standards for best practice
- Comprised of five elements which guide, gauge, and ground patient centered care

Communication, Clinical Capability Building,
Evidence-Based Practices, and
Healthy Work Environments





WRNMMC Patient Care Initiatives

- **TeamSTEPPS** spans all care environments
- System to promote patient safety and minimize error
- Delivered in accordance with standards for best practice
- Comprised of four elements which guide, gauge, and ground patient centered safety through healthcare teamwork

Leadership, Situational Monitoring
Communication, and
Mutual Support



Team STEPPS—Communication



Technique	Function	Example
Brief	Plan Team Activities	Day 1 discussion for team orientation
Debrief	Analyze an interim event	Recap of events at the end of a shift
Huddle	Problem solve	Planning for a procedure
Cross-Monitoring/ Feedback	Improve performance	Commenting about a decision (selected test)
Assertive Statement	Advocate for safe, high quality care	Recognizing a potential error
Check-Back	Ensure accurate information transfer	Reading back a verbal order
Handoff	Transfer care and responsibility	Transitions of care





Effective Handoffs

- Leader, assigned roles
- Unambiguous transfer of responsibility
- Protected time and space
- Standardized format
- Up-to-date, accurate, relevant information
- Awareness of participants'
 - Learning styles
 - Knowledge of patients
 - Level of training
 - Clinical experience
- Creation of a shared mental model through active participation of receiver

Effective Verbal Handoffs

- Face-to-face
- Structured format, beginning with high-level overview
- Appropriate pace
- Closed-loop communication → shared mental model

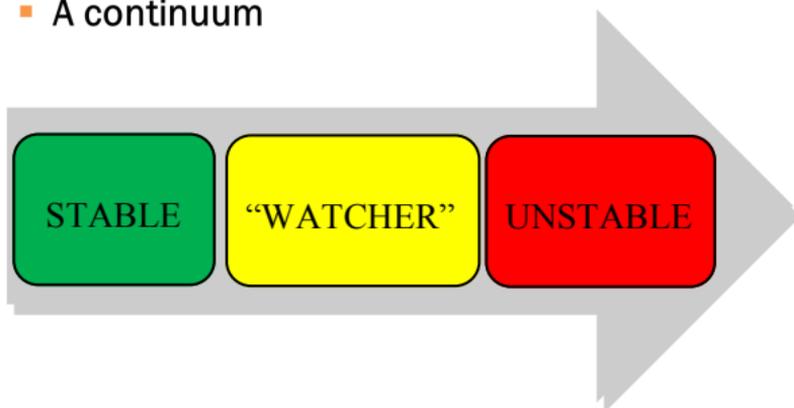


The I-PASS Mnemonic

- I Illness Severity**
Stable, “Watcher,” Unstable
- P Patient Summary**
Summary statement; events leading up to admission; hospital course; assessment; plan
- A Action List**
To do list; timeline and ownership
- S Situation Awareness & Contingency Planning**
Know what’s going on; plan for what might happen
- S Synthesis by Receiver**
Receiver summarizes what was heard, asks questions; restates key action/to do items

I = Illness Severity

- Why is it important to classify?
 - Focus attention appropriately
 - Use standard language
- A continuum





P = Patient Summary

It's flexible, as long as it's complete!

Patient Summary

Summary Statement

Aedfijikj; aedfj a;ldofa; akjefakj;kljafjja akjfakidfakja;kljfa;skf; akjed;fkajdc;fkjadfkh jascdfja;lskdfja;ldfj a;kljfa;lkodfja;klfakjf a;klfakidfja;clhf. Aedfijikj; aedfjja;ldofa; akjefakj;kljafjja

Events Leading Up to Admission

Aedfijikj; aedfjja;ldofa; akjefakj;kljafjja akjfakidfakja;kljfa;skf; akjed;fkajdc;fkjadfkh jascdfja;lskdfja;ldfj a;kljfa;lkodfja;klfakjf a;klfakidfja;clhf ja akjfakidfakja; kljfa;skf; akjed;fkajdc;fkjadfkh jascdfja;lskdfja; ldfj a;kljfa;lkodfja;klfakjf a;klfakidfja;clhf. Aedfijikj; aedfjja;ldofa;

Hospital Course

Aedfijikj; aedfjja;ldofa; akjefakj;kljafjja akjfakidfakja;kljfa;skf; akjed;fkajdc;fkjadfkh jascdfja;lskdfja;ldfj a;kljfa;lkodfja;klfakjf a;klfakidfja;clhf ja akjfakidfakja; kljfa;skf; akjed;fkajdc;fkjadfkh jascdfja;lskdfja; ldfj a;kljfa;lkodfja;klfakjf a;klfakidfja;clhf. Aedfijikj; aedfjja;ldofa;

Ongoing Assessment by Problems/Diagnoses

- *klj a;klf; akidfja;clhf. Aedfijikj; aedfjja;ldofa; akjefakj;kljafjja akjfakidfakja;kljfa;skf;*
- *klj a;klf; kljfa;skf; Aedfijikj; aedfjja;ldofa; akjefakj;kljafjja*

Plan by Problems/Diagnoses

- *klj a;klf;kljfa;clhf. Aedfijikj; aedfjja;ldofa; akjefakj;kljafjja akjfakidfakja;kljfa;skf;*
- *klj a;klf;kljfa;clhf. Aedfijikj; aedfjja;ldofa; akjefakj;kljafjja akjfakj*



BETTER HAND OFFS



A = Action List

- To do list
- Includes specific elements:
 - Timeline
 - Level of priority
 - Clearly-assigned responsibility
 - Indication of completion
- Needs to be up-to-date
- If no action items anticipated, clearly specify “nothing to do”



*Team***STEPPS**
Team Strategies & Tools to Enhance Performance & Patient Safety





Team level

- “Know what is going on around you”
 - Status of patients
 - Team members
 - Environment

Patient level

- “Know what’s going on with your patient”
 - Status of patient’s disease process
 - Team members’ role in this patient’s care
 - Environmental factors
 - Progress toward goals of hospitalization



Effective Contingency Planning

- Identify concerns
- Articulate what might go wrong
- Define the plan
 - List interventions that have/have not worked
 - Identify resources for assistance
- For stable patients: “I don’t anticipate anything will go wrong.”

S = Synthesis by Receiver

- Brief re-statement of essential information in a cogent summary
 - Demonstrates information is received and understood
- Opportunity for receiver to
 - Clarify elements of handoff
 - Have an active role in handoff process



I-PASS
BETTER HANDOFFS. SAFER CARE.



Remember,
TeamSTEPPS elements and
effective handoffs go hand-in-hand.





Clinical Learning Environment Review (CLER)

What is CLER?

As a component of its next accreditation system, the Accreditation Council of Graduate Medical Education has established the **CLER** program to assess the GME learning environment of each sponsoring institution and its participating sites.

CLER emphasizes the responsibility of the sponsoring institution for the quality and safety of the environment for learning and patient care, a key dimension of the 2011 ACGME Common Program Requirements.

The **CLER** program's ultimate goal is to move from a major targeted focus on duty hours to that of broader focus on the GME learning environment and how it can deliver both high-quality physicians and higher quality, safer, patient care.

How does the ACGME assess how we're doing?

ACGME conducts site visits, not unlike the TJC surveys every 18 months. We receive notification approximately two weeks in advance of the visit.

The site visitors will speak to staff throughout our hospital about **CLER**. Thus, we want everyone to know what **CLER** is and how we address the six focus areas.



Clinical Learning Environment Review (CLER)

Do the six focus areas apply only to our house staff?

No! These six areas apply to learners throughout the facility. Medical students and nursing, allied health and technician trainees all learn the principles of patient safety, quality, care transitions, work hours, supervision, and professionalism, and they are expected to apply those lessons from the start.

The focus areas of CLER are really the foundation of good healthcare, and good healthcare is everyone's responsibility.



Clinical Learning Environment Review (CLER)



CLER assesses sponsoring institutions in the following six focus areas:

1. **Patient Safety.** We use the PSR system to report errors and near misses and encourage reporting at every level.
2. **Quality Improvement and reduction of disparities of care.** We have house staff on our quality and safety committees and work groups and mentor and support their QI projects.
3. **Transitions of Care.** We use the IPASS system for transitions. IPASS stands for Illness severity, Patient demographics and key info, Action list, Situational awareness and contingency planning, and Synthesis by the receiver.
4. **Duty Hours.** We adhere to the duty hours guidelines of the ACGME and have a committee that reviews violations and resident concerns.
5. **Supervision.** We have residency program supervision policies and the list of house staff who can perform procedures at set levels of supervision on the command Intranet.
[Supervision Policies](#)
[Resident and Intern Privileges](#)
6. **Professionalism.** We hold our house staff to the highest standards of professional conduct, just as we do with all our WRNMMC staff.









Partnership For Patients (PfP)

Better Care.

Lower Costs.

A new public-private partnership that will help improve the quality, safety, and affordability of health care for all Americans.

The Partnership for Patients brings together leaders of major hospitals, employers, physicians, nurses, and patient advocates along with state and federal governments in a shared effort to make hospital care safer, more reliable, and less costly.

GOAL: Keep patients from getting injured or sicker

-By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved over three years.

-Decrease hospital readmissions by 20% by end of 2013.

The Department of Health and Human Services (HHS) has identified nine preventable hospital-acquired conditions to be measured.

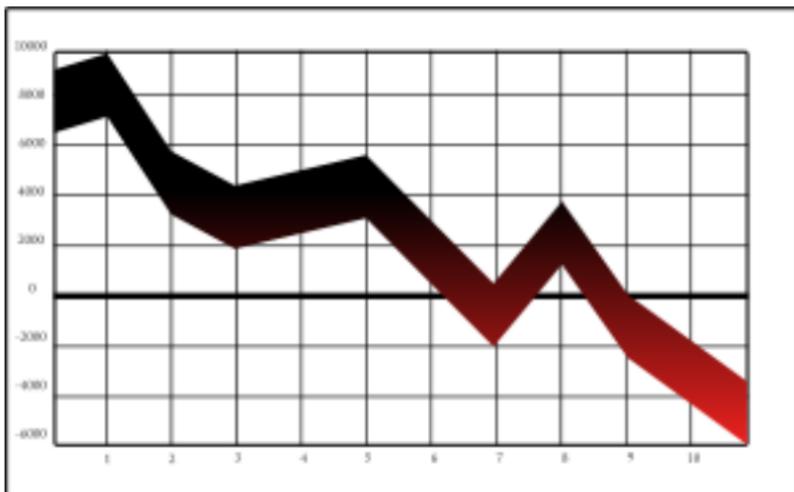


Partnership For Patients (PfP)

REDUCE

1. Surgical Site Infections (SSI)
2. Venous Thromboembolism (VTE)
3. Ventilator Associated Pneumonia (VAP)
4. Obstetrical Adverse Events
5. Central Line Associated Bloodstream Infections (CLABSI)
6. Catheter Associated Urinary Tract Infections (CAUTI)
7. Adverse Drug Events
8. Falls
9. Pressure Ulcers

REDUCE 30 Day Readmissions – Re-engineering Discharge (**Project Red**)





National Patient Safety Goals

Goal 1 – Improve the accuracy of patient identification.

NPSG.01.01.01: Use at least two patient identifiers when providing care, treatment or services

- Patient's **Full Name** and **DOB** are WRNMMC's two identifiers

NPSG.01.03.01: Eliminate transfusion errors related to patient misidentification

- *Match the blood or blood component to the order*
- *Match the patient to the blood or blood component*
- *Use a two person verification process*

Goal 2 – Improve the effectiveness of communication among caregivers

NPSG.02.03.01: Report critical results of tests and diagnostic procedures on a timely basis.

- *Notify Licensed Independent Practitioner (LIP) in less than 1 hour*
- *Collect and assess compliance data*
- *Take action to improve response*
- Inpatient RNs use the Essentris “Critical Results Note” to document the result and time.
- Outpatient results go to an RN or, for Interventional Radiology and Respiratory Therapy, directly to the provider.



National Patient Safety Goals, cont'd

Goal 3 – Improve the safety of using medications

NPSG.03.04.01: Label all medications, med containers (syringes, med cups, basins, etc) or other solutions on & off the sterile field in all perioperative and other procedural settings.

- *Drug name*
- *Strength*
- *Amount*
- *Diluents and volume*
- *Expiration date when not used within 24 hours*
- *Expiration time when expiration occurs in less than 24 hours*

Note: Medication containers include syringes, medicine cups and basins.

Note: This expectation does apply even if only one medication and/or solution is being used.



b. All medications or solutions are verified by two qualified individuals both verbally and visually when the person preparing the medication or solution is not the person administering it.



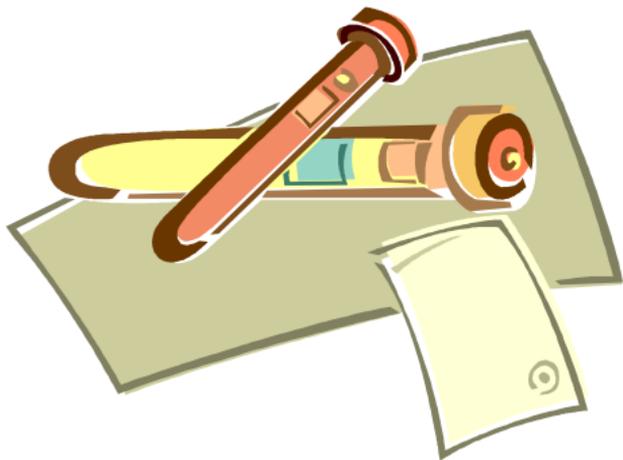
Two Patient Identifiers For Specimen Labeling

Use at least two patient identifiers whenever administering medications or blood products, taking blood samples or other specimens for clinical testing, or when providing treatment or procedures.

The patient's Full Name and Date of Birth are WRN-MMC's two identifiers.

Locator information (room#, bed #) are NEVER to be used.

Label containers used for blood and other specimens
IN THE PRESENCE OF THE PATIENT.





National Patient Safety Goals, cont'd

NPSG.03.05.01: Reduce the likelihood of patient harm associated with the use of **anticoagulation therapy**

- Use an approved protocol for anticoagulation therapy
- Use oral unit dose and pre-mix infusions.
- Monitor baseline and current INRs to adjust therapy
- Inform dietary services of patients on warfarin
- Use programmable infusion pumps for intravenous heparin
- Define baseline and ongoing lab tests required to monitor patients on heparin therapy & low molecular-weight heparin (LMWH)
- Evaluate anticoagulation safety practices

NPSG.03.06.01: Maintain and communicate accurate patient medication information

1. Obtain information on the medications the patient is current taking when he or she is admitted to the hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications.

2. Define the types of medication information to be collected in non-24-hour settings and different patient populations.



National Patient Safety Goals, cont'd



3. Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies.

4. Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose).

5. Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.



National Patient Safety Goals, cont'd

Goal 6—Reduce the harm associated with clinical alarm systems

Clinical alarm systems are intended to alert caregivers of potential patient problems, but if they are not properly managed, they can compromise patient safety. This is a multifaceted problem. In some situations, individual alarm signals are difficult to detect. At the same time, many patient care areas have numerous alarm signals and the resulting noise and displayed information tends to desensitize staff and cause them to miss or ignore alarm signals or even disable them.

Other issues associated with effective clinical alarm system management include too many devices with alarms, default settings that are not at an actionable level, and alarm limits that are too narrow. These issues vary greatly among hospitals and even within different units in a single hospital.

There is general agreement that this is an important safety issue. Universal solutions have yet to be identified, but it is important for a hospital to understand its own situation and to develop a systematic, coordinated approach to clinical alarm system management.

Standardization contributes to safe alarm system management, but it is recognized that solutions may have to be customized for specific clinical units, groups of patients, or individual patients.

This NPSG focuses on managing clinical alarm systems that have the most direct relationship to patient safety.



National Patient Safety Goals, cont'd

1. As of July 1, 2014, leaders establish alarm system safety as a hospital priority.
2. During 2014, identify the most important alarm signals to manage based on:
 - Input from the medical staff and clinical departments
 - Risk to patients if the alarm signal is not attended to or if it malfunctions
 - Whether specific alarm signals are needed or unnecessarily contribute to alarm noise
 - and alarm fatigue
 - Potential for patient harm based on internal incident history
 - Published best practices and guidelines
3. As of January 1, 2016, establish policies & procedures for managing the alarms identified above that, at a minimum, address the following:
 - Clinically appropriate settings for alarm signals
 - When alarm signals can be disabled
 - When alarm parameters can be changed
 - Who in the organization has the authority to set alarm parameters
 - Who in the organization has the authority to change alarm parameters
 - Who in the organization has the authority to set alarm parameters to “off”
 - Monitoring and responding to alarm signals
 - Checking individual alarm signals for accurate settings, proper operation, and
 - detectability



National Patient Safety Goals, cont'd

4. As of January 1, 2016, educate staff about the purpose & proper operation of alarm systems for which they are responsible.

Goal 7 – Reduce the risk of health care associated infections

NPSG.07.01.01: Comply with current WHO hand-hygiene guidelines.

1. Healthcare acquired infections causing death must be reported to Patient Safety.

2. The hospital has a process for conducting periodic risk assessments to prevent healthcare-associated infections.

3. All staff, visitors, patients and their families will be educated on the importance of hand hygiene and the infection control policies and procedures that prevent surgical site infections, device-associated infections, and the transmission of multidrug resistant organisms (MRSA, Acinetobacter, ESBL, C.diff, VRE, etc).

4. Implement best practices or evidence-based guidelines to prevent central line-associated blood-stream infections.

5. Implement best practices for preventing surgical site infections.



HAND HYGIENE

“Clean Hands In—Clean Hands Out”

No artificial nails in patient care areas.

Keep nails trimmed to 1/4” length.

Alcohol-Based Hand Rub

- Apply product to one palm
- Spread thoroughly over both hands, including nails and under jewelry
- Rub hands together vigorously
- Continue rubbing until hands are dry
- Store products away from heat or flame



Handwashing with Soap

- Only when hands are visibly soiled, or if patient has *Clostridium difficile*
- Vigorously rub hands up to wrists for 15 seconds.

**Practicing Hand Hygiene is Your
Professional Responsibility**



National Patient Safety Goals, cont'd

Goal 7 – Reduce the risk of health care associated infections

NPSG.07.03.01: Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms (MDRO) in acute care hospitals.

SEE PAGES 23—25



NPSG.07.04.01: Implement evidence-based practices to prevent central-line associated bloodstream infections.

Note: This requirement covers short- and long-term venous catheters and peripherally inserted central catheter lines.

NPSG.07.05.01: Implement evidence-based practices for preventing surgical site infections.

NPSG.07.06.01: Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).

Note: This requirement is not applicable to pediatric populations. Research resulting in evidence-based practices was conducted with adults, and there is not consensus that these practices apply to children.



Goal 15 – The organization identifies safety risks inherent in its patient population.

NPSG.15.01.01 Identify patients at risk for suicide

- *Risk assessment identifies specific factors may increase or decrease risk for suicide*
- *The patient's immediate safety needs and most appropriate setting for treatment are addressed*
- *The organization has crisis hotline information located on the intranet under clinician tools.*

All patients presenting for primary care services will be screened, against WRNMMC-approved criteria, for suicide risk. When indicated by the results of this screen, patients at-risk will be referred to Behavioral Health Services for a complete suicide risk assessment and appropriate management, as indicated.



Universal Protocol For Preventing Wrong Site, Procedure or Person Surgery



1. Pre-operative verification process

Verification of the correct person, procedure and site occur. Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following:

- Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and pre-anesthesia assessment)
- Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed
- Any required blood products, implants, devices, and/or special equipment for the procedure

2. Mark the operative site

- Marked by the surgeon or provider performing the procedure in conjunction with the patient.
- The surgeons will use his/her initials to mark the operative site except where contraindicated.
- Mark all cases involving laterality, multiple structures (fingers, toes, lesions), or multiple levels (spine)





Universal Protocol, continued

3. Conduct a “Time Out”.

- Must be done in location of procedure
- Involve the entire surgical team
- Correct patient
- Correct procedure
- Correct site and side
- Correct position
- Availability of implants

The Time-Out must be performed in a consistent manner where team members take an active role. In fact, all team members must agree on all pre-procedural elements reviewed, thereby incorporating the teamwork necessary to ensure patient safety.

The completion of the Time-Out process must be documented in the medical record.





WRNMMC MDRO Practices

1. Infection Control staff education and training will be done annually via e-learning programs and as needed with in-services and briefs.
2. Infection Control visitor, patient and family education will be done by nursing and medical staff upon admission to the ward and as needed during their hospital stay and documented in the Essentris Patient Teaching Note under the Infection Control section.
3. The hospital has an alert system in Essentris for notifying clinical staff the need to isolate patients with multidrug resistant organisms (MDRO). The MDRO, VRE, or MRSA flag is located in the free text H&P, the nursing hx & assessment, the nursing shift assessment and the patient admission data screen in Essentris. The MDRO flag in Essentris will auto-populated from the CHCS system. Infection Prevention and Control staff (IPaC) staff will enter and remove all the multidrug resistant flags in CHCS.
4. Patients with a MRSA, VRE or MDRO flag will be immediately placed on Contact Precautions upon admission to the ward
5. The physician will write an order for the Contact Precautions.
6. IPaC staff will write an IC Consult Note in Essentris. The type of isolation precautions (Contact,



Airborne, or Droplet) will auto-populate from the IC Consult Note to the Nursing Status Board. This is specific for each MDRO (see clearance protocol in the WRNMMC Infection Control Manual).

MRSA by collecting MRSA PCR nares specimens on admission. Patients with positive MRSA or MDRO cultures are placed on Contact Precautions.

7. All MedEvac patients admitted to the hospital will have war surveillance cultures done (i.e. bilateral groin culture and a MRSA PCR nares swab) and will be placed on Contact Precautions until war surveillance cultures confirmed negative and IC has cleared patient from isolation precautions.

8. All patients admitted to the hospital (except for psychiatric patients and infants born at the hospital) will have a MRSA PCR nares swab.

9. Infection Prevention and Control Staff (IPaC) review the microbiology lab data and admission roster daily to identify and multidrug resistant organisms or communicable diseases that require inpatients to be on isolation precautions (Contact, Airborne, or Droplet). The IP will immediately notify the ward staff of any patients that will need to be on isolation precautions.

10. The microbiology lab will notify the ward staff of any patients with positive multidrug resistant cul-



WRNMMC MDRO Practices, *cont'd*

tures. Staff may institute the appropriate isolation precautions per the IC Manual 2011 – Annex D without a physician order. The physician should be notified to write the isolation precautions orders as soon as possible.

11. The hospital implements “bundles” to prevent device-associated infections (central line associated bloodstream infections (CLABSI), ventilator associated pneumonia (VAP) and catheter associated urinary tract infections (CAUTI) and other evidence-based guidelines to prevent surgical site infections and the transmission of multidrug resistant organisms. Bundles include the VAP bundle, Central Line Insertion Practice bundle, and CAUTI bundle.

POP QUIZ

My area’s hand hygiene compliance rate is: ___ %

My area’s hand hygiene target rate is: ___ %





Abuse or Neglect

WRNMMC personnel will report ALL incidents of known or suspected child abuse or neglect to FAP and to civilian Child Protective Services and law enforcement as required by DOD Directive 6400.1.

In addition, refer cases of suspected child abuse and neglect to the Armed Forces Center for Child Protection for forensic interviews and examinations (301) 295-2150 or 301-295-4100.

Cases of known or suspected spouse/intimate partner abuse should be discussed with FAP and guidance offered as to whether the patient wants a restricted or unrestricted report to FAP.

This encompasses physical, emotional, or sexual abuse, as well as neglect to include nutritional and medical neglect, lack of immunizations or timely medical care, poor hygiene, etc.

Child maltreatment includes physical, sexual, or emotional abuse, as well as neglect of any form including lack of/or delay in appropriate medical care, lack of immunizations, lack of proper nutrition, poor hygiene, etc.

In case of child, spouse, family member, or elder abuse, the victim's safety is the primary concern. Documentation is critical, use the patient's "own words" if possible, do not interject your own personal opinions or judgments.

If you witness a violent or abusive act, notify WRNMMC Security immediately.



Pain Re-Assessment

- Re-assessment is performed in the context of the treatment, target/threshold and includes overall symptom management (nausea, dyspnea, etc.)
- Pain re-assessment must be timely, usually within 20 minutes for fast-acting routes of administration (IV, IM) and within 60 minutes for slow-acting (PO).
- The reassessment must also be documented..

Documentation is required!



Continuity

- Pain needs are also assessed at time of discharge
- Assessment includes overall symptom management (nausea, dyspnea, etc)
- Assure staff competence in pain assessment
- When pain cannot be managed, patients are referred for appropriate treatment.



Crash Cart Checks

- Daily crash cart checks, cleaning and monthly inventories must be conducted to ensure our best response to a Code Blue (cardiac/respiratory arrest).
- These checks must become part of daily routine and must be documented.
- We must be in a constant state of preparedness to respond to a cardiac arrest or code blue drill. Daily checks and periodic inventories are critical to maintaining this readiness.
- If you are responsible for checks, ensure they are done as required and appropriately documented. If you work in an area with a crash cart, ensure you know the location of the cart, the cart's contents, and check periodically to make sure that daily checks are being performed and that the cart is CLEAN.
- Do your checks, document them.
- Double check your teammates' work.
- Know where the cart is located.
- Know what is in the cart.



Multi-Dose Injectable Vials (MDV or MDIV)

Multi-dose injectable vials (MDVs or MDIVs) must be

- Labeled with the expiration date (28 days from opening, or earlier depending upon mfg's instructions), and
- Must be labeled with the expiration time, if it expires less than 24 hrs from opening.



PRN Medication Orders

An indication for use must be included with each PRN Medication order.

When two meds are ordered for the same indication, it should be clear which drug is to be administered first.

If this is unclear, the ordering provider must be contacted for clarification of the order.



Provider Privilege Notification System (PPNS)

The registered nursing profession, as the primary advocate for the patient's safety, is expected to ensure that providers are working within the scope of their defined clinical privileges and under an active medical staff appointment.

Therefore, RNs will be competent in the use of the online **Provider Privilege Notification System**, available through a link from WRNMMC's Intranet Home Page.

For house staff, the privileges, by specialty and PGY, shall be made available in each setting in which residents provide care, and are referenced anytime there is a question regarding a resident's scope of practice.





Storage Under Sinks

Store only cleaning materials under sinks. No food, beverages, reagents, medications, etc.

No hazardous materials should be stored under the sink. Rather, these materials must be appropriately stored in the Hazardous Materials Locker.

Material Safety Data Sheets (MSDS)

It is more than simply knowing the location of the MSDS (that yellow and black binder), but also **how to use it.**

For example, is bleach listed under bleach, Clorox, sodium hypochlorite, etc.?

Also, what exposure types are to be considered (ingestion, topical, eye, inhalation, etc.) and the treatment for each?

In short, the MSDS tells you who made it, what it's called, what's in it, its properties, how it reacts, what the hazards are, how exposure affects you, its toxicology and ecological effects, first aid, what to do if it spills, fire fighting measures (Fire Bill takes precedence), how to handle and store it, and how to dispose of it

Know HOW to use your MSDS before you really need to!



Equipment Maintenance Is YOUR RESPONSIBILITY

It is YOUR responsibility to ensure that any medical equipment you use is in proper working condition, and CLEAN.

This is done by inspecting the equipment prior to its use, to ensure that it is in good working order and that its preventive maintenance (PM) status is current.

If the PM status is expired or unknown, the equipment shall be red-tagged, sequestered and BioMed Repair notified.



notified

“The eyes you save may be your own!”

Check and flush eye wash stations weekly, for 5 minutes, and document these checks.

Ensure temperature of water is tepid: not too hot or too cold to the touch.



KEEP PASSAGEWAYS CLEAR

Picture your exit passageway filled with smoke, while you are attempting to evacuate patients during a fire, or having to rapidly navigate that passageway with a crash cart during a code blue response, and you can appreciate the importance of maintaining an obstacle-free evacuation route.

As you tour your spaces, ensure that egress (or exit) passageways are maintained clear to their constructed width.

These passageways are identified by the presence of one or more "Exit" signs (which must be illuminated).

The only exceptions allowed are wheeled crash carts, wheeled isolation carts, and wheeled carts "in use."

"In use" is a cart that is accessed no less frequently than every 30 minutes.





Fire Extinguishers & Fire Response

- Are required fire extinguisher checks current on all extinguishers?
- Are all extinguishers appropriately mounted?
- Have all staff received required training on the use of fire extinguishers?
- Are staff knowledgeable on the procedure for securing (shutting -off) medical gases in the event of a fire/ drill?
- Are all fire evacuation routes maintained clear of obstructions to the width constructed?
- Are staff able to rapidly extricate patients from a locked space when an alarm is sounded?



Security & Courtesy Challenge Visitors

- Are all staff knowledgeable on the need and justification for challenging individuals to provide appropriate identification, when indicated?
- Do staff challenge visitors appropriately and courteously?



STAFF IDENTIFICATION BADGES

All staff must wear their ID badge and the badges must be visible.

Staff should challenge any individuals who appear “out of place,” and have patients or visitors identify themselves.

ID badges also meet patient rights expectations, and therefore shall be visible to a patient/visitor.



RESPONSE TO CALL BELLS

Often times housekeeping staff may knot the patient call bell cords in restrooms, so as not to get them caught in mops during cleaning.

Ensure cords can be reached by a fallen patient, that the alarms work, and that you can locate the key or other mechanism to open the door in a timely manner.

Drill this activity!



Histories & Physicals

Never more than 30 days prior to admission or registration

No Exceptions

The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.



For a medical history and physical examination that was completed within 30

days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.

If no changes are identified, this must also be documented.



Operative Reports

A brief operative procedure note must be written prior to release from the PACU or other recovery area.

Why?

The patient has just undergone a significant change, or challenge, to their physiology, and the patient's updated status must be made known to the receiving unit in order to ensure continuity of care.



An operative or procedure reports will include:

- the name of the physician
- the name(s) of assistant(s)
- the procedure(s) performed
- a description of the procedure(s)
- any clinical findings
- estimated blood loss (EBL)
- specimens removed
- postoperative diagnosis
- complications



SBAR

Hand Off Communication should occur during shift change, lunch breaks & other transfers of care that may occur between healthcare providers. A good patient Hand Off must include an opportunity for questioning between the giver and receiver of patient information.

In addition to I-PASS, WRNMMC also uses the **SBAR** model for ensuring good communication during certain hand-offs, particularly when requesting an intervention.

Situation—What is the situation?

“Dr. Smith, I have Eddie Thomas in Room 6.”

Background—What is the clinical background?

“Eddie Thomas is a 56-year old with congestive heart failure, multiple ED visits. He looks pale and diaphoretic. BP is 90/65 verified with manual cuff. Pulse 100. We’ve got him on O2.”

Assessment—What is the problem?

“I think he may be having an MI.”

Recommendation—What do I recommend or request be done?

“We need you to see him now.”



Informed Consent

Is informed consent properly documented and in the medical record **prior to performing diagnostic, therapeutic, or surgical procedures that place the patient at more than minimal risk?**

Are all signatures present?

- Provider
- Witness
- Patient/Guardian/Legal Surrogate

Is the Patient/Guardian/Legal Surrogate signature



dated and timed?

Ensure the Consent Form is stamped with, or contains, the patient's addressograph information.

Ensure that there is also a corresponding physician's progress or counseling note, which outlines the specific risks, benefits and alternatives (RBA) discussed with the patient and/or guardian/family.



Interdisciplinary Care Planning

Are interdisciplinary team activities such as the plan of care and discharge planning being consistently documented?

Are you aware of which of your patients are under the care of an interdisciplinary team? Do you (and, as indicated, the patient and their family) have a full understanding of the interdisciplinary care plan for these patients? Is this plan reflected in the medical record?

Communication, collaboration and coordination are among the most important work habits that must be adopted so that care, treatment and services are provided at the highest level.

All staff involved in these activities should be aware of the requirement for interdisciplinary plan of care documentation.

Interdisciplinary Care Surveyor Assessment

- (To Patient/Family): Who is your (doctor/nurse/corpsman/medic) today? Have you seen and spoken with them today?
- What activities are you scheduled for today?
- (If being DC'd): When would you contact the hospital with concerns after discharge? What side-effects should you look for with the medications you're receiving?



- (To Nurse/Corpsman/Medic): What are the activity orders for this patient? What studies or treatments are scheduled?
- What are some of the treatment goals for this patient and how are they doing? What obstacles are they working through?
- What is the nutrition/dietary status for this patient?
- Can you show me where this information is located in the medical record?

Interpretative Services

Are you knowledgeable on the resources available for providing interpretation services for non-English speaking patients?

Note: The use of a family member is not acceptable when translating critical patient information/education due to the increased likelihood of bias in the translation (even given the best of intentions on the part of the family member).

Bilingual proficiency alone does not qualify a staff member to serve as an interpreter.

As such, interpretive services are to be provided through our contracted service, unless the use of these services would create a delay to such a degree as to compromise the patient's safety.

To access WRNMMC's interpretative services, complete the Interpreter [Request Form](#), contact Patient Administration at 295-2185 or the Quarterdeck at 295-4611



Discharge Planning & Education

- Do your patients (and, as appropriate, their families) express a full understanding of education (meds, activity post-discharge, involvement in treatment plan, etc.)?
- Are patients assessed for D/C planning needs upon admission? Are appropriate and timely referrals taking place?

Medical Record Labeling

All pages of a patient's medical record must contain the patient's identification information, to ensure that information is not lost or misfiled.

When medical record pages are either not labeled or labeled with the incorrect card, there could be potential errors in care which could result in harm.

Staff must label all pages of the medical record with the correct patient information.

Fall Prevention

All staff should know the policies, procedures and strategies for preventing patient falls in their areas. WRNMMC has a falls prevention instruction for adult and pediatric inpatients and an instruction for preventing falls in the ambulatory setting. Goals for preventing falls include:

- Provide a safe environment that minimizes risk for falls
- Identify patients who are at risk for falls



Fall Prevention, Continued

- Implement strategies for the prevention and management of falls
- Document fall risk
- Educate patient and families about fall risk, management and prevention of falls
- Communicate fall risk and prevention strategies across the continuum of care

The Survey Process

The JC Survey Team consists of 5 or 6 specially trained surveyors who will spend 5 days surveying how well WRNMMC performs against Joint Commission standards. We must validate compliance with performance measures set-forth by the Joint Commission. We must also demonstrate the effectiveness of corrective actions and identify areas of excellence within our organization.

The survey team will interview administrators, staff members, patients, family & significant others to determine how well the standards have been met. While the new survey process had greatly reduced the amount of time spent reviewing documents, some policies and procedures will be assessed, particularly if there is a sense that processes suffer from unwarranted variation.



Sample Surveyor Questions

- What is WRNMMC's mission?
- How do you handle Advance Directives?
- How do you participate in PI activities?
- What date/time was this patient admitted?
- What is the plan of care for this patient?
- What is your role/responsibility?
- How do you ensure a safe environment for your patients?
- What are universal precautions?
- What National Patient Safety Goals are important to the care you provide?



Infection Prevention

- Are all food, nutrition, infant formulas, appropriately dated?
- Are all food, nutrition, infant formulas, appropriately within expiration date?
- All patient-specific food items are labeled with the patient's name?
- Are all food, nutrition, infant formulas, etc., stored appropriately (i.e., not co-mingled with culture media, reagents, cleaning solutions [Dispatch], etc.)? Not stored under sinks?
- Are all ice machines clean?
- Hand soap, lotion, alcohol-based hand cleansers are approved and available?



General Instructions

- Understand the plans of care for your patients.
- Keep your spaces **CLEAN!**
- Know your duties and responsibilities within the command and your area.
- Take pride in your appearance.
- [Always wear your ID badge.](#)
- Always be courteous and helpful to visitors, patients, and fellow health care providers/staff members.
- Always address patients and staff by their formal titles.
- Treat patients with courtesy and respect.
- Are all medication rooms and medication carts clean and orderly?
- Are all ceiling tiles in good repair (no water damage, etc.)?
- Are clean and dirty utility rooms appropriately separated?
- Is infectious waste container not overfull?
- Is Unit Infection Control Manual current and complete?
- Are the bottoms of soap/alcohol gel dispensers clean?
- Does an observation of clinical workspaces show no evidence of eating or drinking in these spaces—to include utility rooms?
- Are infectious and non-infectious patients and/or visitors appropriately managed/separated?



General Instructions, Continued

- Are staff wearing appropriate Personal Protective Equipment (PPE) when indicated (or are those goggles still in their original packaging)?
- Are supplies stored ≥ 18 " from ceilings with sprinkler systems?
- Are all floors clean (not sticky, etc.)?
- Is all trash emptied appropriately (not overflowing - no full trash bags stored on the floor)?
- Is there documented evidence that all staff have reviewed the Infection Control Manual?
- Is there a good cleaning policy for furniture and children's' toys and are staff knowledgeable on the process?
- Are all ice machines clean and in good repair?
- Are all sharps containers less than 3/4 full?
- Are all sharps containers appropriately mounted IAW manufacturer's recommendations?
- Are medical and food supplies stored appropriately (ie, separated - not in same refrigerator)?
- Are supplies not being stored directly on the deck (ie, up on palettes or on appropriate shelving)?
- Do all O2 cylinders have appropriate yellow FULL/IN USE/EMPTY tags, are tanks adequately secured?





Workspace Orientation

- Is there documented evidence in the Individual Training Record (ITR) that each staff member has completed Command Orientation within the required timeframe (within 3 working shifts of reporting to the unit, or prior to working independently; whichever is sooner)?
- This is documented using the Workspace Orientation and Life-Safety Checklist available through Staff & Faculty Development?
- Is there documented evidence in the ITR that each staff member has completed the Workspace Orientation & Life Safety Checklist **prior to providing care, treatment or services independently?**





Performance Improvement

- Is performance data from Code drill activities (Blue, Red and Pink) being analyzed to identify improvement opportunities?

Customer Satisfaction Data

- Do you have customer service data on your unit? Is it being analyzed to identify improvement opportunities?

Oryx

- Are any of the services your unit provides captured under our current Oryx initiative? If so, is Oryx data being shared and analyzed to identify improvement opportunities? (page 10.)

PI - Planning

- Do identified initiatives include measurable performance targets?
- Are you knowledgeable on improvement initiatives in your unit?
- Have measurable improvements been realized, and sustained, as a result of performance improvement activities?



SAFE MANAGEMENT OF HIGH-ALERT MEDICATIONS (HAM) NCR-MD - 2014

General Risk Reduction Strategies/Actions

- Only licensed/credentialed staff can administer & verify High Alert Medications
- 2-Person verification & documentation in Essentris is required
- Verify & document medication, concentration, dosage & rate when:
 - Therapy is initiated
 - Syringe/bag is changed
 - Nursing change of shift
- Provide proper medication teaching to patient & family
- Use flow control pumps for continuous infusions

See next page for additional actions to be taken





Additional actions to be taken by medical, nursing and Pharmacy staff

High-Alert Med	Additional Actions
Continuous infusions containing opioids or other narcotics to include patient controlled analgesia and epidural infusions. Fentanyl, Ketamine, Morphine, Hydromorphone, Lorazepam, Midazolam	<ul style="list-style-type: none">• Question all patients receiving opiates about allergies• Do not use “MSO4” to order morphine sulfate• Follow Ketamine protocol (see Ketamine Order Set)
Anticoagulants & Thrombolytics, Heparin bolus/infusion, Argatroban, Lepirudin (Refludan)	<ul style="list-style-type: none">• Do not use “u” to order heparin, use “units” instead• Order by metric weight, not volume or amp• Include dose formula when calculating dose• Follow Heparin/Argatroban protocol
Cancer Chemotherapy	<ul style="list-style-type: none">• Follow local oncology unit guidelines for administration of cancer chemotherapeutic agents
Insulin	<ul style="list-style-type: none">• Do not use “u” to order insulin, use “units” instead• Inform patient that you are administering insulin• Follow insulin protocol
Parenteral nutrition	<ul style="list-style-type: none">• Verification of all ingredients against the original order, the order that is transmitted to the compounding pharmacy, and the product label• Verification of infusion pump rate against the original order and the product label



1. Use of TALL MAN/short man spelling to identify Sound-Alike/Look-Alike Drugs
 - PYXIS, CHCS/AHLTA & Essentris drug lists
 - Pharmacy med storage shelves/bins
 - Pharmacy prepared unit-dose packages
2. Stickers to identify Sound-Alike/Look Alike Drugs in Pharmacy storage shelves/bins and automated drug dispensing cabinets
3. Sound-Alike/Look-Alike Drug identification and acknowledgement in drug dispensing cabinets
4. Sound-Alike/Look-Alike Drug identification in CHCS
5. Monitor continuously for Sound-Alike/Look Alike Drug Errors



Sound-Alike/Look-Alike Drugs (SALAD)

Abelcet, amphotericin B, Ambisome
ALPRAZolam, LORazepam
buPROpion, busPIRone
cloNIDine, clonazePAM, Klonopin
CeleBREX, CeleXA, Cerebyx
CISplatin, CARBOplatin
DOBUTamine, DOPamine
DOXOrubicin HCL, DOXOrubicin liposomal
ePHEDrine, EPINEPHrine
FioriCET, FioriNAL
glipiZIDE, glyBURIDE, glimEPIRIDE
hePARin, HeSPAN
hydrALAZINE, hydroXYzine
HYDROmorphine, Morphine
LamISIL, LaMICtal
lamIVUDine, lamoTRIGine
leveTIRACEtam, levoFLOXacin
metFORMIN, methoCARBamol, metroNIDAZOLE
NovoLOG, NovoLIN, HumaLOG
penicillin, penicillAMINE
oxyCONTIN, oxyCODONE, HYDROcodone
prednisoLONE, predniSONE
ROPINIRole, risperiDONE
serTRAline, serZONE, SEROquel
Solu-CORTEF, Solu-MEDROL, Depo-Medrol
TopAMAX, Toprol-XL
traMADol, traZODone, toRADol
valACYclovir, valGANciclovir
vinBLASStine, vinCRISStine
ZyPREXA, ZyrTEC



“Do Not Use” Dose Designations & Abbreviations

Dangerous Term	Intended Meaning	Potential Problem	Correction
Trailing Zeros	Example: Dose of 1mg written as 1.0mg	Decimal may be misinterpreted or overlooked in handwriting and with the use of carbon and faxed copies, resulting in tenfold overdose	Never use a <i>trailing</i> zero! Warfarin 2mg
Naked Decimals or Lack of Leading Zero	Example: Dose of 0.5mg written as .5mg	Decimal may be misinterpreted or overlooked in handwriting and with the use of carbon and faxed copies, resulting in tenfold overdose	Never use a naked decimal! Always use a zero before a decimal point. Morphine 0.5mg
U or u	Unit	Read as a zero (0) of a four (4), causing a tenfold overdose or greater (4U seen as “40” or 4u seen as “44”)	“Unit” has no acceptable abbreviation. Write out “unit.”
µg	Microgram	Mistaken for “mg” when handwritten	Use “mcg” or “micrograms”
Q.D., QD, q.d., qd, or Q/D	Every Day or Daily	Mistaken for “QID” and drug given 4 times daily	Write out “every day” or “daily”
Q.O.D., QOD, q.o.d, or qod	Every Other Day	Mistaken for QID or QD	Write out “every other day”
MgSO4 MS MS04	Magnesium Sulfate or Morphine Sulfate	Misread as “Morphine Sulfate” Misread as “Magnesium Sulfate”	Use complete spelling for drug names
I.U. or IU	International Units	Mistaken as “I.V.” (intravenous) or “10” (ten)	Write out “International Units”
T.I.W.	Three times a week	Misinterpreted as “three times a day” or “twice a week”	Write out “three times a week”
SS	Sliding Scale or 1/2 (apothecary)	Misinterpreted as “55”	Write out “sliding scale.” Use “one-half” or 1/2

THESE ABBREVIATIONS AND DOSE DESIGNATIONS apply to all orders and all medication-related documentation that is handwritten, including free-text computer entry or on pre-printed forms.



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Helpful Tools and Links

1. [Joint Commission Leaders' Checklist](#)
2. [E-dition Electronic Standards Manuals](#)
3. ["How to Talk With a Surveyor" Training](#)
4. [WRB Perioperative Tracer Assessment Tool](#)
5. [Survey Readiness Periodicals](#)
6. [Joint Commission Resources Booster Paks](#)
 - [Environment of Care \(EoC\)](#)
 - [FPPE and OPPE](#)
 - [Hazardous Waste Management](#)
 - [Medication Storage](#)
 - [Restraint and Seclusion](#)
 - [Sample \(Specimen\) Collection](#)
 - [Suicide Risk](#)
7. [WRB Quality Council Charter](#)
8. [WRB Quality Data System Atlas](#)
9. Quality Improvement Report (QIR) Template
10. QIR Power Point Reporting Template
11. Plan of Action & Milestones (POAM) Template
12. [Joint Commission Sampling Guidelines](#)
13. [DoD Patient Safety Reporting \(PSR\) Portal](#)



Vielen
Dank

Đíky

Merci



Teşekkürler

Grazie



شكراً

Hvala



**THANK
YOU**

ขอบคุณ

Gracias *Obrigado!*

धन्यवाद *Köszönettel*