

The Joint Commission's National Patient Safety Goals

Implications for Home Care and Hospice Organizations



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This article describes how home care and hospice organizations can implement the recommendations found in the Joint Commission's new National Patient Safety Goals. Even if your organization is not accredited through the Joint Commission, the suggestions made here can help staff increase safety practices and decrease potential for liability.

The Joint Commission's new National Patient Safety Goals (NPSG) must be met by accredited home care and hospice organizations, as they apply to their scope of services. The NPSGs are not standards, but are considered evidence-based practices with one or two prescriptive recommendations that must be fully implemented, with a track record beginning January 1, 2003.

If during a regularly scheduled or random unannounced survey, the surveyor identifies that a home care or hospice organization has not fully implemented one or more of the applicable recommendations, a special type I recommendation will be given. As follow-up to a special type I recommendation, the home care or hospice organization will be required to submit a written progress report (WPR) to demonstrate full compliance with the recommendation(s). If a special type I deficiency is not cleared on the second submission of a WPR, then the organization is considered Conditionally Accredited.

Now that you know why you need to comply with the NPSGs, in addition to wanting to do the right thing for your patients and provide as safe care as possible, this column provides you the information and strategies for compliance by covering three areas:

- the six NPSG for 2003 (as they may change from year to year),
- the Joint Commission's recommendations for implementation (if an alternative has not been preapproved by the Joint Commission), and
- how these will be reviewed during the scope of a home care or hospice survey, so that you can avoid a special type I recommendation.

NPSG #1. Improve the Accuracy of Patient Identification

Joint Commission Recommendation: #1a

"Use at least two patient identifiers whenever taking blood samples or administering any route of medication or blood products (JCAHO, 2003b)." Patient identifiers may include, but are not limited to: the patient's address; telephone number; date of birth; social security number; asking the patient to state his or her name; and then once the staff member has had at least one prior contact with the patient, just "visually recognizing" the patient (JCAHO, 2003a).

Survey Process

When the surveyor selects home visits to observe care, the surveyor is most likely to pick a visit where the staff member is going to administer medications, blood, or blood products; obtain a blood sample; or perform an invasive procedure. During the home visit, the surveyor will observe the patient identification process when the staff are going to administer medications or blood or blood products, or obtain a blood sample.

If a nurse will be administering medication, two patient identifiers from either the medication label or a medication-related document (i.e., CMS 485, verbal order form, medication profile, plan of care) should be used to check against an additional two identifiers at the time and place of medication administration (i.e., the patient's place of residence). For example, the nurse may ask the patient to state his/her name and date of birth and then match those two same patient identifiers (name and date of birth) with those on the medication label or medication-related document. The nurse should also check that the name and dose of the drug to be administered as ordered by the physician and documented on the medication-related document match the name and dose of the drug printed on the medication label.

If medication is not scheduled to be administered or blood is not scheduled to be drawn, then the surveyor may interview field staff to have them describe their process for properly identifying the patient. Therefore, staff should be prepared to explain to the surveyor which two identifiers are used and describe a consistent identification process used by all staff within the home care or hospice organization.

For a hospital-based home health agency or hospice, the same two identifiers do not have to be used throughout the healthcare system. However, the same two identifiers should be consistent within each setting (e.g., home care). This means that all home care staff should be using the same two patient identifiers.

Joint Commission Recommendation: #1b

Prior to the start of any invasive procedure, conduct a final verification process, such as a "time out," to confirm the correct patient, procedure, and site, using active-not passive-communication techniques (JCAHO, 2003b). For home care and hospice organizations, an invasive procedure may include, but not be limited to:

- indwelling or suprapubic catheter insertion,
- wound debridement,
- G-tube replacement, and
- accessing a port-a-cath.

Venipuncture to obtain a blood sample or administering medication via an invasive approach (i.e., subcutaneous or intramuscular injection) are also addressed in recommendation 1a, and therefore the patient's identification must also be confirmed using two identifiers.

Survey Process

During a home visit in which an invasive procedure is being performed, the surveyor will observe the final verification process used by the staff member to confirm that the correct procedure will be performed on the correct patient prior to the staff starting care. In home care, this final check may simply include reviewing the physician's orders or care plan in the home to validate the procedure to be performed.

It is not expected that the patient be included in the final verification process. To validate the procedure verification process, the surveyor may also interview multiple staff to assure that the process is being performed consistently by all staff. Thus, be sure that all staff are familiar with (and if necessary, can verbalize) the new procedures being implemented.

NPSG #2: Improve the Effectiveness of Communication Among Caregivers

Joint Commission Recommendation: #2a

"Implement a process for taking verbal or telephone orders that requires a verification 'readback' of the complete order by the person receiving the order (JCAHO, 2003b)." This read back process applies to all verbal and telephone orders involving the patient's care, not just those involving medication.

In taking the verbal or telephone order, simply repeating the order back is not enough. It is expected that the staff member taking the verbal or telephone orders, write it down, read it back, and ask for verbal confirmation from the person who gave the order. If the verbal orders are filed in the clinical record in handwritten format, the orders also need to be legible for all staff to interpret. If the orders are not legible, the orders need to be reverified.

Survey Process

During clinical record review, the surveyor will be assessing hand-written orders to determine if they are legible. The surveyor may also review the process used by staff when taking verbal orders by listening and observing staff both in the office and in patient's home, and possibly in the staff's vehicle while driving out to make home visits.

If there is no opportunity for the surveyor to observe a staff member taking a verbal order, staff permitted to take verbal orders may be interviewed to determine the process in place for confirming the accuracy of verbal orders.

"Implement a process for taking verbal or telephone orders that requires a verification 'readback' of the complete order by the person receiving the order."

Joint Commission Recommendation: #2b

"Standardize the abbreviations, acronyms and symbols used throughout the organization, including a list of abbreviations, acronyms and symbols not to use (JCAHO, 2003b)." This recommendation applies to all abbreviations and symbols, not just those related to medication. Most home care and hospice organizations have a list of acceptable abbreviations; however, this list will need to be expanded to also include those abbreviations that are **not** to be used.

The Joint Commission recognizes the Institute for Safe Medication Practices (ISMP) as an authoritative source of information about the safety considerations relating to medications. As such, accredited home care and hospice organizations should refer to the ISMP's list of dangerous abbreviations in (Table 1) to guide them in their development of abbreviations not to be used.

Home care and hospice organizations are not "officially" mandated to use ISMP's list; however, if any of the dangerous abbreviations are used by the home care or hospice organization, management should be able to explain to the surveyor the organization's rationale for why dangerous abbreviations continue to be used. Ultimately, the abbreviations not to be used are defined by the organization.

Survey Process

The surveyor's first action will be to review the list of abbreviations developed by the organization. Staff who document in the clinical record may also be interviewed regarding their knowledge of which abbreviations not to use. This does not have to be a closed book, oral exam. The staff are welcome to have their "list of abbreviations to use and not to use" handy should they need to reference the information.

It is helpful for staff to have this information, so that it's available, if needed, when documenting in the clinical record and that errors do not have to be corrected following a review of clinical records

Table 1. List of Dangerous Abbreviations

Abbreviation/ Dose Expression	Intended Meaning	Misinterpretation	Correction
Apothecary symbols	dram minim	Misunderstood or misread (symbol for dram misread for “3” and minim misread as “mL”)	Use the metric system
AU	aurio uterque (each ear)	Mistaken for OU (oculo uterque–each eye).	Don’t use this abbreviation
D/C	Discharge discontinue	Premature discontinuation of medications when D/C (intended to mean “discharge”) has been misinterpreted as “discontinued” when followed by a list of drugs	Use “discharge” and “discontinue”
Drug names			Use the complete spelling for drug names
ARA°A	vidarabine	cytarabineARA°C	
AZT	Zidovudine (RETROVIR)	azathioprine	
CPZ	COMPAZINE (prochlorperazine)	chlorpromazine	
DPT	DEMEROL-PHENERGAN-THORAZINE	diphtheria-pertussis-tetanus (vaccine)	
HCl	hydrochloric acid	potassium chloride (The “H” is misinterpreted as “K”)	
HCT	hydrocortisone	hydrochlorothiazide	
HCTZ	hydrochlorothiazide	hydrocortisone (seen as HCT250 mg)	
MgSO4	magnesium sulfate	morphine sulfate	
MSO4	morphine sulfate	magnesium sulfate	
MTX	methotrexate	mitoxantrone	
TAC	triamcinolone	tetracaine, ADRENALIN,cocaine	
ZnSO4	zinc sulfate	morphine sulfate	
Stemmed names			
“Nitro” drip	nitroglycerin infusion	sodium nitroprusside infusion	
“Norflox”	norfloxacin	NORFLEX	
µg	microgram	Mistaken for “mg” when handwritten	Use “mcg”
o.d. or OD	once daily	Misinterpreted as “right eye” (OD-oculus dexter)and administration of oral medications in the eye	Use “daily”
TIW or tiw	three times a week	Mistaken as “three times a day”	Don’t use this abbreviation
per os	Orally	The “os” can be mistaken for “left eye”	Use “PO,” “by mouth,” or “orally”
q.d. or QD	every day	Mistaken as q.i.d., especially if the period after the “q” or the tail of the “q” is misunderstood as an “i”	Use “daily” or “every day”

(continues)

by management. During the surveyor’s review of the clinical records, the list of abbreviations not to be used will be reviewed against the CMS 485/487 forms, verbal order forms, medication profile, and visit notes.

NPSG #3 Improve the Safety of Using High-Alert Medications

Joint Commission Recommendation: #3a

“Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium

phosphate, sodium chloride >0.9%) from patient care units (JCAHO, 2003b).” In home care and hospice organizations, patient care units can include the patient’s home, treatment areas within the home care office if patient’s come into the office to receive care, or patient care units in a facility used for hospice general inpatient care or respite care.

Survey Process

In most organizations seeking accreditation for home health or hospice only, concentrated elec-

(table continued)

Abbreviation/ Dose Expression	Intended Meaning	Misinterpretation	Correction
qn	nightly or at bed- time	Misinterpreted as "qh" (every hour)	Use "nightly"
qhs	nightly at bedtime	Misread as every hour	Use "nightly"
q6PM, etc.	every evening at 6 PM	Misread as every 6 hours	Use 6 PM "nightly"
q.o.d. or QOD	every other day	Misinterpreted as "q.d." (daily) or "q.i.d. (four times daily) if the "o" is poorly written	Use "every other day"
sub q	subcutaneous	The "q" has been mistaken for "every" (e.g., one heparin dose ordered "sub q 2 hours before surgery" misunderstood as every 2 hours before surgery)	Use "subcut." or write " subcutaneous"
SC	subcutaneous	Mistaken for SL (sublingual)	Use "subcut." or write "subcutaneous"
U or u	unit	Read as a zero (0) or a four (4), causing a 10-fold overdose or greater (4U seen as "40" or 4u seen as 44")	"Unit" has no acceptable abbreviation. Use "unit"
IU	international unit	Misread as IV (intravenous)	Use "units"
cc	cubic centimeters	Misread as "U" (units)	Use "mL"
X3d	for 3 days	Mistaken for "three doses."	Use "for three days"
BT	bedtime	Mistaken as "BID" (twice daily)	Use "hs"
ss	sliding scale (insulin) or 1/2 (apothecary)	Mistaken for "55"	Spell out "sliding scale"; use "one-half" or use "1/2"
> and <	greater than and less than	Mistakenly used opposite of intended	Use "greater than" or "less than"
/ (slash mark)	separates two doses or indicates "per"	Misunderstood as the number 1 ("25 unit/10 units" read as "110" units)	Do not use a slash mark to separate doses; use "per"
Name letters and dose numbers run together (e.g., Inderal40 mg)	Inderal 40 mg	Misread as Inderal 140 mg	Always use space between drug name, dose, and unit of measure
Zero after decimal point (1.0)	1 mg	Misread as 10 mg if the decimal point is not seen	Do not use terminal zeros for doses expressed in whole numbers
No zero before decimal dose (.5 mg)	0.5 mg	Misread as 5 mg	Always use zero before a decimal when the dose is less than a whole unit

Source: The Institute for Safe Medications; used with permission. For additional information contact: The Institute for Safe Medication Practices, 1800 Byberry Road, Suite 810, Huntingdon Valley, PA 19006; voice: (215) 947-7797; fax: (215) 914-1492; e-mail: ismpinfo@ismp.org; Web: www.ismp.org

trolytes will not be present in the office or in the patient's home. However, during a visit to a patient in a facility providing hospice care or in the home of a home health or hospice patient, the surveyor will review the home environment to determine the presence of concentrated electrolytes.

Improving the safety of high-alert medications is not limited to concentrated electrolytes. It is expected that home care and hospice organizations define what would be

considered a high-alert or high-risk medication. High-risk medications that can be administered in the home may include, but are not limited to:

- chemotherapy,
- narcotics for pain management,
- insulin,
- warfarin sodium (Coumadin™),
- dobutamine, and
- first-doses of IV medications.

During the survey, the surveyor will review what processes are in place to assure that any high-risk medication is administered safely, but the process will not be specifically reviewed against the NPSG.

Joint Commission Recommendation: #3b

“Standardize and limit the number of drug concentrations available in the organization (JCAHO, 2003b).”

Survey Process

For most organizations seeking accreditation for home health and hospice only, drugs will not be available within the office. However, during home visits to a patient in a facility providing hospice care or in the patient’s home, the surveyor will review the environment to determine if drugs with multiple concentration are present.

During the survey, staff and patients may be interviewed to determine whether drugs are mixed in the home. If a home care or hospice organization’s staff is reconstituting drugs in the home, the surveyor will review the processes in place to assure that drugs are properly diluted.

All drugs provided to home care staff or patients/family members to administer should be dispensed their most ready-to-administer state. Only unstable drugs should be reconstituted in the home by the patient/family or staff. Otherwise, a pharmacist should prepare all medications in the pharmacy.

NPSG# 4. Eliminate Wrong-Site, Wrong-Patient, Wrong-Procedure Surgery

Although home care and hospice organizations have not begun performing surgery in the home, this NPSG is applicable when certain invasive procedures that follow are being performed.

Joint Commission Recommendation: #4a

Create and use a preprocedure verification process, such as a checklist, to confirm that appropriate documents are available (JCAHO, 2003).

When performing an invasive procedure on a home care or hospice patient (as discussed in recommendation 1b), a checklist is not required; however, to prevent an invasive procedure from being performed at a the wrong site/location or the wrong procedure being performed, staff should first double-check the physician’s orders or review the care plan before performing the invasive procedure.

Survey Process

The survey process is similar to the process described in recommendation 1b.

Joint Commission Recommendation: #4b

Implement a process to mark the procedure site, and involve the patient in the marking process (JCAHO 2003b).

For home care and hospice organizations, marking the site is not required for all invasive procedures that are performed through or immediately adjacent to a natural body orifice (e.g., inserting an indwelling catheter, nasogastric tube or peripheral [short-line or mid-line] intravenous device) or other situation in which marking the site would be impossible or technically impractical (e.g., packing a wound)(JCAHO, 2003a).

Marking a site is not just limited to procedures that are performed on the right or left side of the body. For example, if a patient has multiple wounds and only one of the wounds needs to be debrided (an invasive procedure), the wound to be debrided would need to be marked with an indelible marker. Obviously, the inside of the wound is not going to be marked, but rather, the outer aspect of the wound on the intact skin could be marked with a pen, marker, or piece of tape. Minor invasive procedures performed in the home, such as venipuncture, inserting a peripheral intravenous catheter, and inserting an indwelling foley catheter, are not included within the scope of this goal.

Survey Process

When the surveyor is selecting patients to make home visits and observe care, as previously discussed, he or she may request to observe care in which an invasive procedure is going to be performed. During the visit, the surveyor will observe for implementation of the patient identification process, the final verification process, and the marking process used by the staff member to confirm that the correct procedure will be performed on the correct patient, prior to the staff starting care.

If there are no home visits regularly scheduled in which a staff member may perform an invasive procedure, the staff will be interviewed as to the procedures that they follow to confirm that the right procedure is being performed on the right patient, at the right location (i.e, on the patient’s person).

NPSG #5: Improve the Safety of Using Infusion Pumps

Joint Commission Recommendation 5a

Ensure free-flow protection on all general-use and ambulatory/patient-controlled analgesia (PCA) intravenous infusion pumps used in the organization (JCAHO, 2003b). This recommendation does not apply to syringe pumps and enteral pumps.

Most home care and hospice organizations have ensured that their patients are protected against free-flow problems by using an administration set that is designed for the specific infusion pump's use, rather than the actual pump. However, add-on devices (such as an in-line dial-a-flow device) that previously met the requirements set forth in the Sentinel Event Alerts no longer meet the requirements of this NPSG. If a home care or hospice organization chooses to use an add-on device, this alternative must be reviewed by Joint Commission and approved as an alternative solution prior to the add-on device being used.

Survey Process

Even if the home care or hospice organization is not directly responsible for providing the patient with an infusion pump, the organization is still responsible for assuring that the medication being infused via an infusion pump to the patient is protected from free-flow problems. During the survey, staff may be asked how they know that their patients are protected.

The bottom line is how does the organization protect the patient from problems associated with the free-flow of medications into the patient. As experienced home care nurses know, many patients (or their family members) can be technically savvy and figure out how to "undo" any free-flow protection mechanism or safety feature. As long as infusion pumps are in compliance with the recommendation, you should have no problems during the survey.

NPSG#6: Improve the Effectiveness of Clinical Alarm Systems

Joint Commission Recommendation 6a

Implement regular preventive maintenance and testing of alarm systems (JCAHO, 2003b). In home care and hospice, this NPSG recommendation would include (but would not be limited to):

- ventilators,
- oxygen concentrators,
- apnea monitors, and
- infusion pumps.

There is a perception that no patient safety problems exist in home care and hospice. There *are* patient safety problems in home care and hospice, though thankfully these problems do not often occur.

However, this NPSG recommendation does not apply to enteral pumps, although basic safety, operational, and function checks (including volumetric checks) are still required to meet the Joint Commission's Environmental Safety and Equipment Management (EC) Standards. In a facility providing hospice care, additional clinical alarms, such a bathroom "panic button" which typically communicate an emergency situation, would need to be tested.

Survey Process

The implementation of NPSG would be reviewed similar to that of reviewing the EC standards through staff interviews and a review of documentation to assure that the home care and hospice organization has implemented a schedule of regular preventive maintenance and testing of the alarms based on a risk assessment of all the alarms in use.

Joint Commission Recommendation 6b

Assure that alarms are activated with appropriate settings and are sufficiently audible with respect to distances and competing noises (JCAHO, 2003b). Alarms can't be evaluated by just checking the decibel level; the patient's environment plays a key role. This means that if a patient is using his or her oxygen concentrator and the concentrator is located in another room, if the alarm sounds it will be heard by the patient or primary caregiver. Likewise, if a patient is receiving medication via an infusion pump or PCA pump, the alarm can be heard by other family members even if the television set is on loudly.

There are no Joint Commission guidelines as to what is considered an excepted decibel level or sufficiently audible, just that the alarm can be heard. Many hospices provide their patients with "baby monitors" to listen for the patient when they are not present in the room. The same devices, if needed, could be used if a problem was identified during testing as to whether an alarm is audible.

Survey Process

During the survey, the surveyor could ask a patient or family during a home visit if they can hear the alarm when it goes off or ask staff to demonstrate how the pump's audibility was tested. The surveyor may also review individual incident report forms to see whether there have been any problems recorded related to medical equipment and clinical alarms. Additionally, the surveyor may request testing of the system in place to make sure that pumps and alarms are functioning.

Alternatives to the Published Recommendations

As just presented, each NPSG has one or two evidence-based or expert panel-based recommendations that must be implemented. If a home care or hospice organization wants to meet the NPSG using another method of implementation (other than the ones published by the Joint Commission), the organization should submit a written request to the Joint Commission's Sentinel Event Alert Advisory Group and have the requested alternative method approved prior to implementation (JCAHO, 2003c). A one-page form and instruction for submitting a Request for Review of an Alternative are available on the Joint Commission's Web site at www.jcaho.org.

Documentation Requirements

The only NPSG that requires documentation is the list of abbreviations **not** to be used by the organization. Many home care and hospice organizations now require staff to document in the clinical record that the applicable recommendation was implemented.

For example, on the verbal order form, staff may be required to document with abbreviations (e.g., VORBV for "verbal order read back and verified"). Remember, documentation of implementation is not required and if this becomes the organization's policy, then this documentation would be expected on all verbal orders.

If new abbreviations are going to be developed, such as the one noted for repeating back verbal orders, make sure that this new abbreviation is on the organization's list of acceptable abbreviations.

Leadership/Performance Improvement Interview

During the leadership and performance improvement interview, the surveyor may review how your home care or hospice organization works to meet the NPSG recommendations and assures that they

are being met on a day-to-day basis. There are no requirements for collecting data related to the NPSGs, only that there is compliance with the goals and their specific recommendations.

If compliance with a particular NPSG goal requires a significant new design or redesign, standard PI.2 (including its measurement requirements) would be applicable and the surveyor would be looking for data to review. If there was not a significant redesign of existing processes or a new process put in place to meet the recommendations in the NPSGs, then the surveyor will evaluate how the organization monitored their compliance with the NPSGs to ensure that they were being consistently met.

Summary

There is a perception that no patient safety problems exist in home care and hospice. As a Joint Commission surveyor for almost 11 years and a practitioner in the home care field for 25 years, I can tell you from my personal and professional experience that there *are* patient safety problems in home care and hospice, though thankfully these problems do not often occur.

The introduction of the NPSGs is part of the Joint Commission's continued efforts to fulfill its mission of improving the quality and safety of health care to the public. In the future, the Joint Commission home care and hospice standards, as well as the survey process, will be geared much more toward assuring that patients receive the intended care in a safe manner. ■

REFERENCES

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The Joint Commission's National Patient Safety Goals: Implications for Home Care and Hospice Organizations

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CE TEST QUESTIONS

GENERAL PURPOSE: To provide registered professional nurses with an analysis of the new National Patient Safety Goals (NPSG) developed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as they apply to home care and hospice organizations.

LEARNING OBJECTIVES: After reading this article and taking this test, you will be able to:

1. Outline the six NPSGs for 2003 and JCAHO recommendations for implementation.
 2. Discuss the review and follow-up of JCAHO recommendations during a home care or hospice survey.
1. **The new NPSG can best be described as**
 - a. safety standards that apply in both home care and acute care settings.
 - b. evidence-based practices with one or two prescriptive recommendations that must be fully implemented beginning in 2003.
 - c. written progress reports outlining the compliance of hospice and home care agencies with important safety standards.
 - d. JCAHO standards that must be met by agencies before they apply for accreditation.
 2. **After receiving a special type 1 recommendation, a home care or hospice agency**
 - a. is subject to future random, unannounced surveys.
 - b. is considered Conditionally Accredited.
 - c. loses JCAHO accreditation.
 - d. must submit a written progress report showing compliance with the recommendation.

3. When taking blood samples or administering medication or blood products, the JCAHO recommends

- a. "visually recognizing" a patient during the first patient contact.
- b. stating the patient's name before proceeding.
- c. using at least two patient identifiers to assure accuracy.
- d. using any patient identification procedure previously established by the individual agency.

4. According to JCAHO recommendations, when taking verbal or telephone orders,

- a. the read-back process refers only to those orders involving medication.
- b. the read-back process applies to orders for all aspects of patient care.
- c. it is sufficient to only write down the order and read it back.
- d. it is sufficient to verbally repeat the order.

5. Which statement is true?

- a. JCAHO recognizes the Institute for Safe Medication Practices (ISMP) as an authoritative source of information.
- b. JCAHO mandates that all agencies adopt the ISMP list of acceptable abbreviations, acronyms, and symbols.
- c. JCAHO has created a list of acceptable abbreviations that all home care and hospice agencies must implement.
- d. JCAHO has a hands-off policy regarding use of abbreviations, acronyms, and symbols, as long as the home care or hospice agency has a policy in place regarding this issue.

6. The NPSG goal to eliminate wrong-site, wrong-patient, wrong-procedure

- a. has no corresponding application in the hospice or home care setting.
- b. is applicable only when high-alert medications are given in the home.
- c. is applicable when certain invasive procedures are performed in the home.
- d. is limited to procedures previously identified via the sentinel event mechanism.

7. When performing an invasive procedure, marking the site

- a. is limited to procedures performed on the left or right side of the body.
- b. is required for all procedures performed through or adjacent to a natural body orifice.
- c. is required even when it is technically impractical, such as in packing a wound.
- d. is required if a patient has multiple wounds and only one needs to be debrided.

8. The recommendation regarding the safe use of infusion pumps

- a. applies specifically to syringe pumps and enteral pumps.
- b. allows the use of add-on devices, such as an in-line dial-a-flow device.
- c. requires that the agency protect its patients from free-flow problems, regardless of who provides the pump.
- d. places sole responsibility for ensuring free-flow protection with the organization providing the pump.

9. Which statement is true about alternatives to the published JCAHO recommendations?

- a. JCAHO strongly discourages hospices and home care organizations from implementing NPSGs using alternative methods.
- b. JCAHO allows hospice and home care organizations to meet NPSG recommendations using alternative methods provided they have received prior approval.
- c. JCAHO encourages each hospice and home care organization to develop its own methods for implementing NPSGs.
- d. JCAHO believes implementation of its NPSGs will eliminate all unsafe situations inherent in home care settings.

10. The only NPSG requiring documentation concerns

- a. assuring the safe use of infusion pumps.
- b. improving the effectiveness of clinical alarm systems.
- c. providing a list of acceptable abbreviations to be used by the organization.
- d. providing a list of abbreviations *not* to be used by the organization.

Questions 11–14 refer to the Table "List of Dangerous Abbreviations"

11. Of the following dosage expressions used before a medication, which is most likely open to misinterpretation?

- a. 1 mg
- b. .5 mg
- c. 0.5 mg
- d. 10 mg

12. According to the ISMP standards, which usage is correct?

- a. using mcg for microgram
- b. using D/C for discontinue
- c. using AU for each ear
- d. using OS for orally

13. ISMP recommendations for writing drug names include

- a. using the complete spelling.
- b. using generic forms.
- c. using both generic and trade name.
- d. using agency-approved abbreviations.

14. To avoid confusion with use of the apothecary system, ISMP recommends

- a. using the metric system instead.
- b. writing out "dram" instead of the symbol.
- c. using the avoirdupois system instead.
- d. rounding minims up to the nearest ounce.

CE Enrollment Form

The Joint Commission's National Patient Safety Goals: Implications for Home Care and Hospice Organizations

A Registration Information:

Last name _____ First name _____ MI _____
 Address _____
 City _____ State _____ Zip _____
 Telephone _____ Fax _____ email _____
 Registration Deadline: July 31, 2005
 Contact Hours: 2
 Fee: \$14.95

LPN RN CNS NP CRNA CNM other _____
 Job Title _____ Specialty _____
 Type of facility _____
 Are you certified? Yes No
 Certified by _____
 State of License (1) _____ License # _____
 State of License (2) _____ License# _____
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B Test Answers: Darken one for your answer to each question.

A	B	C	D	A	B	C	D	A	B	C	D	A	B	C	D				
1.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	5.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	9.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	13.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	6.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	10.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	14.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	7.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	11.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
4.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	8.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	12.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					

C Course Evaluation*

1. Did this CE activity's learning objectives relate to its general purpose? Yes No

2. Was the journal home study format an effective way to present the material? Yes No

3. Was the content relevant to your nursing practice? Yes No

4. How long did it take you to complete this CE activity? ___ hours ___ minutes

5. Suggestion for future topics _____

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