

Striving to Eliminate HAIs and The Culture of Safety

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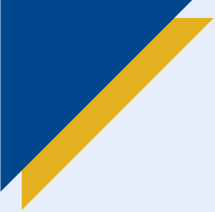


Introduction

- ▶ Joint Commission's emphasis on building a Culture of Safety
- ▶ HAIs - moving towards “elimination”
- ▶ 6 years of expanding requirements towards eliminating HAIs

Creating a Culture of Safety

- ▶ A setting where all participants believe it is their obligation to eliminate errors and create a safe environment
- ▶ Striving to eliminate HAIs is integral part of creating this culture
- ▶ Success requires enterprise-wide cooperation – good barometer of prevailing culture



A Decade of Moving Towards a Culture of Safety

- ▶ Reporting of Sentinel Events
- ▶ Expectation to perform a Root Cause Analysis of Sentinel Events
- ▶ Creation of National Patient Safety Goals
- ▶ 2009 - LD.03.01.01
 - Leaders Create a Culture of Safety



Impact of a Culture of Safety

- ▶ Significant progress towards elimination of:
 - Medication errors
 - Wrong side surgeries
 - Healthcare associated infections



Timeline of HAI-Focused Joint Commission Standards

- ▶ 2004 – Hand Hygiene Standard
 - Supported 2002 CDC Hand Hygiene Guideline
 - Example of TJC implementing CDC Guideline
 - Within 18 months, survey indicated 90% of hospitals had installed alcohol rub dispensers
- ▶ 2005 – Hand Hygiene becomes a NPSG
 - Shines a spotlight on important requirements

2005 - Rewrite of IC Standards

- ▶ Leadership involvement: Securing resources
 - People
 - Laboratory facilities
 - Information (IT)
- ▶ Organization-wide program (customized to org)
 - Integration of clinical and non-clinical
 - Surveillance program (required to identify outbreaks)
 - Identifies risks
 - Program addresses risks
 - Evaluates annually
 - Reports goes to governing body

2007 – Influenza Vaccination of Staff

- ▶ Vaccine must be available and offered to all staff
- ▶ First accreditation requirement of this type
- ▶ Includes staff and physicians
- ▶ Education program
- ▶ Annually evaluates vaccination rates
- ▶ Takes steps to improve rates

2007 -*The Compendium of Strategies to Prevent Health Care-Associated Infections in Acute Care Hospitals*

- ▶ Core membership
 - SHEA (Society for Healthcare Epidemiology of America)
 - IDSA (Infectious Diseases Society of America)
 - APIC (Association for Professionals in Infection Control)
 - AHA (The American Hospital Association)
 - The Joint Commission
- ▶ Review of all evidence-based data to create “Implementation Strategies”
- ▶ Summarizes strategies derived from >1200 recommendations

2007 -*The Compendium of Strategies to Prevent Health Care-Associated Infections in Acute Care Hospitals*

■ Site related

- Surgical Site Infections
- Catheter related blood stream infections
- Urinary catheter infections
- Ventilator associated pneumonia


■ Organism related

- Clostridium difficile (C Dif)
- Methicillin-resistant Staph aureus (MRSA)

2009/2010 - NPSGs derived from Compendium

- ▶ Surgical Site Infection
- ▶ Catheter related blood stream infections
- ▶ Multi Drug Resistant Organism (MRSO)
- ▶ 2009 -Assemble resources; implement in one unit
- ▶ 2010-Full implementation

Patient-Center Resources

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- ▶ Patient Guides on HAIs
 - SHEA with collaboration of CDC
 - Tracks Compendium
 - ▶ Speak-Up Campaign –for consumers
 - 5 Things You Can Do To Prevent Infections

Next Steps



- Add VAP and Urinary Catheters to NPSG

- Maintain Compendium with key stakeholders

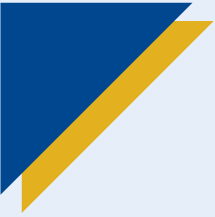
- Coordinate efforts with other stakeholders

- Suppliers – sterile kits for central line insertion

- Influx of infectious patients

- Pandemic

- Biological attack



QUESTIONS?

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