

**STATE COMMISSION ON PATIENT SAFETY
ROUND ONE RECOMMENDATIONS
APRIL 28, 2005**

Category: Setting Performance Standards and Expectations

Code: SafeStand – The submitted testimony recommends establishment of standards, guidelines, principles, or rules by agencies with acknowledged authority over the health services providers referenced in the standards, guidelines, etc to guide the design of processes and procedures related to patient safety.

Recommendation #: C.28 (SafeStand).1

Patient Safety recommendations call for establishment, adoption and implementation of safety standards following clinical and structural guidelines across care settings that includes long-term care facilities, inpatient and outpatient health care providers, and by the State of Michigan.

Rationale: Safety standards across the continuum of care are imperative for the delivery of quality of health care. In Michigan, lack of primary care physician knowledge on latest research in fall prevention and delirium leads to increased costs and adverse outcomes. Even though nursing homes are regulated, lack of enforcement lead to closures, and exposes patients to serious illnesses, depression and mortality risks. Maintaining simple one page tools that capture the diagnoses, medications, drug allergies, and others is efficient, and standardized methods of transferring the information among providers is cost effective. Errors in diagnosing suicidal symptoms among children and adolescents can lead to treatment errors, thereby compounding the risks to patient safety. Children receiving health care by untrained/inadequately trained or volunteers without the supervision of a professional, places children’s safety at risk, and school staff at risk for liability issues. Setting standards for professionals in the acupuncture-procedures can reduce injuries, sometimes with fatalities.

Evidence and/or information on comparable initiatives being carried out in other states: Although there are many kinds of standards in health care, especially those enforced by licensing agencies and accrediting organizations, few standards focus explicitly on issues of patient safety. According to the IOM report: *To Err Is Human*, 1999, all existing regulatory and voluntary standard-setting organizations including professional groups and leaders can establish norms and facilitate improvements in performance through educational, convening and advocacy activities. In the health care industry, standards and expectations about performance are applicable to health care organizations, health professionals, and drugs and devices.

Performance standards and expectations for health care organizations (HCOs):

- Regulators and accreditors should require HCOs to implement meaningful patient safety programs with defined executive responsibility.

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- Public and private purchasers should provide incentives to HCOs to demonstrate continuous improvement in patient safety.

Performance standards and expectations for health professionals:

- Health professional licensing entities should implement periodic reexaminations and relicensing of key providers based on knowledge of patient safety; and work with certifying and credentialing organizations to identify unsafe providers and take action.
- Professional societies should make a commitment to patient safety by establishing a permanent committee dedicated to safety environment.

Performance standards and expectations for FDA:

- Develop and enforce standards for the design of drug packaging and labeling.
- Require pharmaceutical companies to test proposed drug names to identify and remedy potential sound-alike and look-alike confusion with existing drug names.
- Work with physicians, pharmacists, consumers and others to establish appropriate responses to problems identified through post-marketing surveillance.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) announced its Sentinel Event Policy in 1996, where sentinel events were defined as an unexpected occurrence involving death or serious physical or psychological injury. In 1998, a periodic newsletter identifying specific sentinel events would be published. JCAHO set up the National Patient Safety Goals (NPSG) in July 2002 and the Universal Protocol for preventing wrong site surgery was to be established in 2004. The NPSG # 9 on Patient Falls was to assess and periodically reassess each patient's risk for falling, including the potential risk associated with the patient's medication regimen, and take action to address any identified risks.

The Missouri Commission on Patient Safety reported in July 2004 that in the absence of proper standards, most purchasers of healthcare have not identified patient safety as a priority for contracting for services on behalf of employees and other consumers. In an effort to encourage all healthcare organizations in Missouri to adopt minimum standards, all insurers including the state government will be allowed to provide contract incentives for those organizations and professionals that emphasize safety. Florida's Commission on Excellence in Health Care, established in 2000 would evaluate regulatory issues relating to the pharmacy profession and recommend changes necessary to optimize patient safety. The Commission would also recommend procedures to incorporate recognized patient safety considerations into practice guidelines and into standards related to the introduction and diffusion of new technologies, therapies and drugs. Maryland's Health Care Commission (MHCC) reported that their risk management regulations should be revised to strengthen hospital

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Patient Safety programs, but does not indicate any specific directions towards setting safety standards in the health care industry. Connecticut's Department of Public Health (DPH) required establishment of a quality of care program in 2003, with no particular emphasis on safety standards.

C.28.1.1

To improve patient safety, long-term care facilities should adopt and implement guidelines for 1) fracture and fall prevention 2) caring for patients with delirium as well as 3) comply with state established physical plant and financial standards for facility operation, e.g., [assure] stability, adequate funding and reasonable physical surroundings .

Rationale

Examining the elderly population in community settings, studies have found that age, balance, environmental hazards, and multiple medications are definite risk factors for falls.ⁱ For elderly living in long term care facilities, it has been found that there is an annual 0.6 to 3.6 fall rate per bed.ⁱⁱ In fact, approximately 50% of the 1.7 million people living in nursing homes falls at least once during the course of the year resulting in 10% of those residents suffering serious injury.^{2,iii,iv}

Adding to the complexity of elderly falls is a diagnosis of delirium. Residents who have delirium are at risk for longer hospital stays, longer rehabilitations sessions, poorer functioning after they leave the hospital, placement in nursing homes, and even an increased risk of death.⁵ For the elderly population, delirium is seen in 11-42 percent of those hospitalized.^v When patients have decreased cognitive functioning, they are more likely to be confused and are more apt to fall in unfamiliar surroundings.

However, preventative measures can be taken to avoid these occurrences. In a study conducted by Ray, Taylor, Meador, et al (1997), they found that nursing homes that used fall prevention interventions had 19% less recurrent falls than those who did not.^{vi} These interventions were focused on environmental and personal safety as well as others. These type of interventions are consistent with the recommendation provided above.

Evidence and/or information on comparable initiatives being carried out in other states:

Due to the serious implications falls present for the elderly population, long-term care facilities need to pay particular attention to this safety concern. While long-term care organizations must recognize falls, state law or regulation may define what constitutes a

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fall differently.^{vii} JCAHO, in their Long Term Care Patient Safety Goals, addresses this issue. “Goal: Reduce the risk of resident harm resulting from falls.

- Assess and periodically reassess each resident's risk for falling, including the potential risk associated with the resident's medication regimen, and take action to address any identified risks.
- Implement a fall reduction program, including a transfer protocol, and evaluate the effectiveness of the program.^{viii}

The recommendation made above is in congruence with JCAHO’s standards; although the standards do not encompass the broad array of fall risk factors.

C.28.1.2: *Health care providers can improve patient safety 1) for persons hospitalized by maintaining up-to-date simple, universal, one-page data sheet on their patients, including diagnoses, medications, drug allergies and intolerances and 2) for children and adolescents by developing and disseminating best practice models for assessment and diagnosis, particularly regarding suicidality.*

Rationale

In order to make evidence based decisions, health care providers need the most up-to-date health care information on their patients. In the Institute of Medicine’s (IOM) report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, states that, “The best care results from the conscientious, explicit, and judicious use of current best evidence and knowledge of patient values by well-trained, experienced clinicians”^{ix} The key components of this statement in relation to the recommendation is the “current best evidence.”

In this report, the IOM calls for a rule that focuses on evidence based decision-making. This rule requires that standardization of best practices be used for the patient population.⁷ The recommendation to create more information for health care providers regarding best practices and current information can be derived from this knowledge.

Evidence and/or information on comparable initiatives being carried out in other states:

The recommendation seeks to provide health care providers with the tools they need to improve patient safety. In a study conducted by Thomsen et al. (1994) they investigated the use of computer-generated guidelines for health care providers to use when treating patients. The computer-generated guidelines adapted to the changing condition of the patient.^x They found that when health care providers in the ICU used the guidelines with updated information, the guidelines became more accurate and the health care providers trusted using them.¹⁰ This study found that the use of these

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guidelines increased the survival rate of their patients. Other studies have also used clinical algorithms or updated guidelines to achieve survival rates. Some have reported survival rates up to 75%.^{xi,xii}

Results such as these support the need to incorporate a system where health care providers can receive updated information. However, state laws and regulations for creating these types of standards will differ.

C.28.1.3:

The State needs to support the development and implementation of guidelines and standards of care for school health related services [such as minimum standards for school health services, medications, management of chronic illnesses, confidentiality, delegation, health promotion, communicable diseases, school based health clinics, first aid/disaster response and the implementation of criteria for reporting type, provider classification, accountability, evaluation of health services provided in schools.

Rationale

The concern for health care in schools is defined at many levels. However, the need for the development and implementation of health care standards that assist in providing quality health care services is imperative. Schools must provide routine care to their students. Care that they often provide is the administration of medications because young students are assumed not to have the responsibility to perform this act.^{xiii} Yet, in order for schools to provide this type of care, best practices must be identified. As the IOM indicates standardization of best practices for the patient population, the recommendation to adopt these changes are seen under the scope of institutions such as the IOM.

C.28.1.4: *The State of Michigan should adopt and implement National Council of Acupuncture's standards in appropriate clinical settings.*

Rationale

Currently, in the state of Michigan, the Attorney General has determined acupuncture to be a practice of medicine. Therefore, only medical doctors and doctors of osteopathy can practice or supervise acupuncture. An acupuncturist may treat a patient in the state of Michigan if a medical doctor has seen the patient and the patient wants acupuncture as their method of treatment. The medical doctor who allows the acupuncturist to practice is responsible for all treatment acts. Additionally, acupuncture is not seen within the scope of practice of a chiropractor.^{xiv}

There is no law in the state to regulate the practice. The above recommendation is needed in the state of Michigan because there are no separate training requirements for

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medical doctors to practice acupuncture. The only training required is what physicians receive in their western medical education.⁷ The state should support the licensing of actual acupuncturists by adopting the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) standards.

Evidence and/or information on comparable initiatives being carried out in other states:

The only way to practice Acupuncture in the United States is to attend an accredited or candidacy status program. The Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) is recognized by the U.S. Secretary of Education as a “specialized” accrediting agency. The U.S. Department of Education reviews the ACAOM, a private agency, to ensure that it complies with the department’s requirements.^{xv}

In the United States, those states that do license acupuncturists require that he or she graduate from an accredited program and pass the corresponding qualifying exam. Almost all of the states do require that the acupuncturist pass the national certification exam administered by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). However, some states like Louisiana do not. States such as Idaho, Florida, and Hawaii do require the exam. Each state that recognizes acupuncturists have different requirements, however, of the 39 states that recognize acupuncturists some additional training is needed. While many states do recognize acupuncturists as a certified health care provider, Michigan is not alone in placing its practice under the scope of medicine. Kansas, Nebraska, Oklahoma, Wyoming and others, all place acupuncture under the scope of the medical board.^{xvi}

Recommendations on safety standards related to home care setting and clinical practice of radiology are not yet ready for implementation. They are more at an experimental stage that need to be researched and evaluated. Therefore, the following recommendations have been moved to the Research & Evaluation category of the summary.

- ***Recommendation #C.28 (SafeStand) 1.5:*** All providers, including third party payers need to research home care safety issue in an effort to develop safety standards in home health setting.
- ***Recommendation #C.28 (SafeStand) 1.6:*** In an effort to improve safety in the field of radiology, all health care organizations should (1) share patient-level information between providers and facilities by following standardized methods (HIPAA compliant) of transmitting data and (2) establish, adopt and implement effective patient safety policies with the use of magnets in MRI, spectroscopy, and similar procedures.

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Cost: TBD

Implementation Target Date: TBD

ⁱ Agostini, J.V., Baker, D.I., Bogardus, S.T. (n.d.). Prevention of Falls in Hospitalized and Institutionalized Older People. (chapter 26). Retrieved April 16th from <http://www.ahrq.gov/clinic/ptsafety/chap26a.htm>.

ⁱⁱ Rubenstein LZ, Robbins AS, Schulman BL, Rosado J, Osterweil D, & Josephson KR. (1988) Falls and instability in the elderly. *J Am Geriatr Soc* 36,266-278 as cited in Agostini, J.V., Baker, D.I., Bogardus, S.T. (n.d.). Prevention of Falls in Hospitalized and Institutionalized Older People. (chapter 26). Retrieved April 16th from <http://www.ahrq.gov/clinic/ptsafety/chap26a.htm>

ⁱⁱⁱ Rubenstein LZ, Josephson KR, Robbins AS. (1994) Falls in the nursing home. *Ann Intern Med* 121,442-451 as cited in Agostini, J.V., Baker, D.I., Bogardus, S.T. (n.d.). Prevention of Falls in Hospitalized and Institutionalized Older People. (chapter 26). Retrieved April 16th from <http://www.ahrq.gov/clinic/ptsafety/chap26a.htm>.

^{iv} Tinetti ME. (1987) Factors associated with serious injury during falls by ambulatory nursing home residents. *J Am Geriatr Soc*, 356,44-648 as cited in Agostini, J.V., Baker, D.I., Bogardus, S.T. (n.d.). Prevention of Falls in Hospitalized and Institutionalized Older People. (chapter 26). Retrieved April 16th from <http://www.ahrq.gov/clinic/ptsafety/chap26a.htm>.

^v Brauer, C., Morrison, S., Silberzweig, S.B., & Siu, A.L. (2000). The cause of delirium in patients with hip fracture. *Archives of Internal Medicine* 160,1856-1860.

^{vi} Ray WA, Taylor JA, Meador KG, et al. (1997). A randomized trial of a consultation service to reduce falls in nursing homes. *JAMA*, 278,557-562 as cited in Agostini, J.V., Baker, D.I., Bogardus, S.T. (n.d.). Prevention of Falls in Hospitalized and Institutionalized Older People. (chapter 26). Retrieved April 16th from <http://www.ahrq.gov/clinic/ptsafety/chap26a.htm>.

^{vii} JACHO (2005) Frequently asked questions (Preventing falls). Retrieved April 16th, 2005 from

http://www.jcaho.org/accredited+organizations/patient+safety/05+npsg/05_npsg_faqs.htm#goal_9

^{viii} JACHO (2005). **2005 Long Term Care National Patient Safety Goals. Retrieved April 16th, 2005 from http://www.jcaho.org/accredited+organizations/patient+safety/05+npsg/05_npsg_ltc.htm**

^{ix} IOM. (2001). *Crossing the quality chasm: A new health system for the 21st century*. National Academies Press: Washington, DC p. 76

^x Thomsen, G.E., Pope, D., East, T.D., et al. (1994). Clinical Performance of a Rule-Based Decision Support System for Mechanical Ventilation of ARDS patients. *Proc Annu Symp Comput Appl Med Care*, 339, 43, 1994

^{xi} East, T.D., Heermann, L.K. Bradshaw, R.L. et al. (1999). Efficacy of Computerized Decision Support for Mechanical Ventilation: Results of a Prospective Multi-Center Randomized Trial. *Proc AMIA Symp* 251-5 as cited in *Crossing the quality chasm: A new health system for the 21st century*. National Academies Press: Washington, DC

^{xii} Lewandowski, K., Rossaint, R., Pappert, D. et al. (1997). High Survival Rate in 122 ARDS Patients Managed According to a Clinical Algorithm Including Extracorporeal Membrane Oxygenation. *Intensive Care Med*, 23, 819-35 as cited in *Crossing the quality chasm: A new health system for the 21st century*. National Academies Press: Washington, DC

^{xiii} IOM (1997). *Schools and Health: Our Nation's Investment*, National Academies Press: Washington, DC

^{xiv} US State Laws Regarding Acupuncture (n.d.) Retrieved April 16th, 2005 from <http://www.acupuncture.com/StateLaws/laws-right.htm>

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^{xv} The Accreditation Commission for Acupuncture and Oriental Medicine. (2005) Frequently asked questions. Retrieved April 16th, 2005 from <http://www.acaom.org/>
^{xvi} US State Laws Regarding Acupuncture (n.d.) Retrieved April 16th, 2005 from <http://www.acupuncture.com/StateLaws/laws-right.htm>