FAQs for The Joint Commission's 2007 National Patient Safety Goals

(Updated 1/07)

Questions about goal #7 (Health care associated infection):

[7A] Where can I find the current Center for Disease Control and Prevention (CDC) hand hygiene guidelines?
The full report is available at http://www.cdc.gov/handhygiene/ . The report is extremely detailed and well documented. The specific recommendations referred to in goal #7 are on pages 31 through 34 of the report. [9/05]

[7A] Does The Joint Commission require implementation of all the recommendations in the CDC hand hygiene guidelines?
Each of the CDC hand hygiene recommendations is categorized on the basis of the strength of evidence supporting the recommendation. All "category I" recommendations (including categories IA, IB, and IC) must be implemented. Category II recommendations should be considered for implementation but are not required for accreditation purposes. [12/05]

[7A] What do these categories mean?
Category IA recommendations are strongly supported by well-designed experimental, clinical, or epidemiological studies; category IB recommendations are supported by certain experimental, clinical, or epidemiological studies and a strong theoretical rationale; category IC recommendations are required by regulation; category II recommendations are supported by suggestive clinical or epidemiological studies or a theoretical rationale. The CDC also includes among its recommendations several "unresolved issues" for which it makes "no recommendation." [9/05]

[7A] The CDC Guidelines say that health care personnel should not wear artificial nails and should keep natural nails less than one quarter of an inch long if they care for patients at high risk of acquiring infections (e.g. patients in intensive care units or in transplant units). Will The Joint Commission actually be requiring this?
Both of these recommendations are included in the CDC guidelines. The "artificial nails" recommendation is a category IA recommendation, so will be required for those individuals providing direct care to high-risk patients. However, the "1/4-inch nail tips" recommendation is category II, so should be considered for implementation but will not be required. [12/05]

[7A] Do we have to use alcohol-based hand cleaners?
Accredited organizations are required to provide health care workers with a readily accessible alcohol-based hand rub product (CDC recommendations 8 C&D). However, use of an alcohol-based hand rub cleaner by any individual health care worker is not required. The Guidelines describe when this type of cleaner may be used instead of soap and water. If you choose not to use it, then soap and water should be used instead. [1/04]

[7A] Isn't the alcohol-based hand sanitizing gel flammable? Should we be concerned about a fire hazard?
The typical alcohol-based hand rub (ABHR) dispensers used in the health care setting are of such limited size and volume that their contribution to the development , acceleration or spread of fire

in most situations is small. In a recent survey of 800 facilities reporting a cumulative 1,430 years of hand-rub use, no fires attributable to or involving a hand-rub dispenser were reported. Studies have shown significantly better compliance when the dispensers are located just outside the patient's room (when permissible) rather than just inside. The National Fire Protection Agency (NFPA) has modified Life Safety Code (LSC) requirements to allow for installation of ABHR gel dispensers in egress corridors, subject to certain conditions being met (see below). CMS is in the process of amending its rules to reflect the NFPA's position. The "Interim Final Rule" to permit placement of alcohol-based hand rub dispensers in egress corridors, in agreement with the LSC amendment, was published in the *Federal Register* on March 25, 2005. Note that local or state fire code requirements may differ from the national codes, therefore, you should determine and follow the requirements for your particular locale. The best resource for this information is your local fire marshal. [2/06]

[7A] What are the "conditions" that have to be met to be able to install ABHR dispensers in egress corridors?
Location conditions and permissible volume specifications for <u>gel</u> ABHR dispensers to be installed in egress corridors are as follows:

- The corridor width is 6 feet or greater and dispensers are at least 4 feet apart.
- The dispensers are not installed over or directly adjacent to an ignition source such as an electrical outlet or switch. *Adjacent* is defined as being at least 6 inches from the center of the dispenser to an ignition source.
- In locations with carpeted floor coverings, dispensers installed directly over carpeted surfaces are permitted only in sprinklered smoke compartments.
- Each smoke compartment may contain a maximum aggregate of 10 gallons (37.8 liters) of ABHR *gel* in dispensers and a maximum of 5 gallons (18.9 liters) in storage.
- The maximum individual dispenser fluid capacity is 0.3 gallons (1.2 liters) for dispensers in rooms, corridors, and areas open to corridors.
- The maximum dispenser size for individual dispensers in areas designated as suites of rooms is 0.5 gallons (2.0 liters). [2/06]

[7A] The ruling on placement of ABHR dispensers in egress corridors specifically refers to *gel* ABHR dispensers? We would prefer to use the *foam* product. Do the same rules apply?
The situation is a little different with respect to *foam* ABHR products because all of the testing upon which the NFPA and CMS decisions were based was done on the *gel* product, not on *foam*. However, industry experts and CMS have indicated that small-quantity ABHR *foam* dispensers *may* be handled the same as for ABHR *gel*. Therefore, pending further review, both The Joint Commission and CMS will allow any ABHR *foam* installation that meets the location criteria stated above for ABHR *gel*. Volumes of ABHR *foam* are based on suppliers' recommendations and in no case exceed the permissible volumes for ABHR *gel* as defined above. In the event that subsequent testing demonstrates a safety concern relating specifically to *foam* dispensers in egress corridors, The Joint Commission reserves the right to modify its position on the acceptability of such installations. In that event, previously installed dispensers would be subject to the newer restrictions; that is, they would not be "grandfathered," and noncompliant installations would have to be removed.

[Revised, 1/07]

New—[7A] Is there an expectation for individuals passing patient trays at mealtime to use alcohol-based hand rub between each room?
If the person passing the food tray has, or is likely to have, direct contact with the patient, the answer is yes. The CDC Guidelines also say that individuals should "decontaminate hands after contact with inanimate objects … in the immediate vicinity of the patient," but this is identified as a Category II recommendation. As such, while compliance with the CDC Guidelines is *recommended* for individuals passing meal trays who do not make direct contact with the patients, it is not *required* by NPSG 7A. [New, 1/07]

New—[7A] Do the hand hygiene requirements apply to telemedicine providers?
Good hand hygiene is appropriate for everyone, whether in direct contact with patients or not. However, NPSG 7A requires compliance with the CDC Hand Hygiene Guidelines, which apply to the direct patient care situation as indicated by the repeated references to "contact with the patient" as the trigger for hand decontamination. Therefore, The Joint Commission encourages telemedicine providers to practice good hand hygiene but does not require it under Goal 7A. [New, 1/07]

[7A] How will this "hand hygiene" requirement be surveyed and scored?
Compliance with goal #7A will be surveyed through interviews with caregiver staff and direct observation. Caregivers should know what is expected of them with regard to hand hygiene and should practice it consistently. During tracer activity, if surveyors observe 3 or more instances of non-compliance a Recommendation for Improvement (RFI) will result.
[Revised, 1/07]

New—[7A] The CDC's "Guideline for Hand Hygiene in Health-Care Settings" contains several options for measurement of hand hygiene compliance. What method would be considered acceptable by JCAHO under NPSG 7A?
The CDC Guideline offers two options for measurement of hand hygiene compliance:
- "Periodically monitor and record adherence as the number of hand-hygiene episodes performed by personnel/number of hand-hygiene opportunities, by ward or by service. Provide feedback to personnel regarding their performance." or
- "Monitor the volume of alcohol-based hand rub (or detergent used for handwashing or hand antisepsis) used per 1,000 patient-days."

In general, either of these methods is considered acceptable for routine monitoring. However, only the first method (direct observation) will meet The Joint Commission criteria for corrective action or clarification (see the Accreditation Process chapter of your accreditation manual for details about the "corrective action" and "clarification" processes). [New, 1/07]

[7B] Regarding the "manage as sentinel events" requirement, how do we know which cases should have a root cause analysis?
The intent of this requirement is to manage any unanticipated death or major permanent loss of function as a sentinel event, *even if* the patient acquires a nosocomial infection, not simply because the patient has acquired an infection. This is really a reminder of an existing

requirement, not a new requirement. The decision to designate and review an occurrence as a "sentinel event" should be based on the outcome of the case (unanticipated death or major permanent loss of function), not on any presumptive cause. [9/05]

[7B] If this is not a new requirement, why make it a NPSG?
Even though the requirement for root cause analysis in response to an *unanticipated death or major permanent loss of function* is not new, many cases that meet this definition have not been considered sentinel events—apparently because infection was associated with the outcome. In other words, there has been an assumption that the presence of infection excludes a case from consideration as a sentinel event. This is not, and never has been, an intended exclusion. As a result, there are very few cases of infection-associated sentinel events in the Sentinel Event Database (in relation to other types of sentinel events and to the number of infection-associated cases known to be occurring annually). The Joint Commission believes that managing these cases as sentinel events will provide additional information, not so much about the infection itself, but about managing patients at risk for infection and who have acquired an infection. In this manner, the new goal, while not necessarily a new requirement, will contribute to reducing the risk of patient harm from health care-associated infection. [9/05]

[7B] Many patients who die with nosocomial infections are very sick and may have multiple other problems. How do we determine whether the patient's death was "unanticipated?"
This determination is based on the condition of the patient at the time of admission to the organization. A death or major permanent loss of function should be considered a sentinel event if the outcome was not the result of the natural course of the patient's illness or underlying condition(s) that existed at the time of admission. For example, an otherwise healthy patient who is admitted for an elective procedure, develops a wound infection, becomes septic, and dies should be considered a sentinel event. However, cases in which the patient is immunocompromised or elderly with multiple co-morbidities are more difficult to classify. The knowledge that a certain percentage of patients with a given condition will die does not mean that the death of any one of these patients is "anticipated." If, at the time of admission, the patient's condition is such that he or she has a high likelihood of not surviving the episode of care (e.g., the hospitalization), then that patient's death would not be considered a sentinel event. Otherwise, it should be managed as a sentinel event, that is, a root cause analysis should be conducted. [9/05]

[7B] How should I go about doing a root cause analysis on an infection?
Just as the identification of an occurrence as a sentinel event is not dependent on whether the patient did or did not have an infection, the root cause analysis we are looking for is not just an analysis of the infection (if there was one), but of the event itself, i.e., why did the patient die or suffer major permanent loss of function. It is anticipated that this analysis will identify system and process factors that through appropriate redesign can reduce the risk of serious adverse patient outcomes even as the risk of nosocomial infection remains high. [9/05]

[7B] I am an infection control professional (ICP) and my day is already full with the usual surveillance, analysis and prevention activities. How can I do all these root cause analyses and still have time for my regular important work?
There is no expectation that the burden of conducting the analysis will be placed on the infection control professional, although if there were an associated infection, the ICP's participation on the root cause analysis team could be very beneficial. [12/05]

[7B] Won't this require a significant increase in our surveillance activities?
No, there is no expectation for increased or otherwise modified surveillance activities. [9/05]

[7B] Where is the evidence that root cause analysis will help reduce the risk of health care-acquired infections?
The efficacy of root cause analysis to identify system failures and thus direct improvement has been convincingly demonstrated over the past several decades in most high-risk fields and, more recently, in health care for the broad array of serious adverse events that occur. While it is true that the effectiveness of root cause analysis specifically for reducing harm from nosocomial infections has not been proven, that may be only because it hasn't been given an adequate chance with this specific type of event. Nor has the traditional rate-based approach, by itself, been sufficient. Perhaps a combined approach might move us further along. [9/05]