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Joint Commission National Patient Safety Goals, 2014

By Joe Murphy, M.S., APR, NCPS public affairs officer

The Joint Commission has approved one new National Patient Safety Goal (NPSG) that focuses on clinical alarm systems for hospital and critical access hospital accreditation programs, effective Jan. 1, 2014. During 2014, providers are tasked to identify the most important alarm signals to manage.

An Element of Performance (EP) for NPSG 7 has also been revised: NPSG.07.05.01: Implement evidence-based practices for preventing surgical site infections.

2014 NPSG Overview

Goal 1 – Improve the accuracy of patient identification.

- No changes to EPs for the following:

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

NPSG.01.03.01: Eliminate transfusion errors related to patient misidentification. (Note 1)

Recommendation: Staff should reference VHA Directives and local policies for guidance.

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. (Note 2)

- No change to EPs

Goal 3 – Improve the safety of using medications. (Note 3)

- No changes to EPs for the following:

NPSG.03.04.01: Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

NPSG.03.05.01: Reduce the likelihood of patient harm associated with the use of anticoagulation therapy. (Note 4)

NPSG.03.06.01: Maintain and communicate accurate patient medication information. (Note 5)

Goal 6 – Improve the safety of clinical alarm systems.

NPSG.06.01.01: Improve the safety of clinical alarm systems. The new goal is effective as of Jan. 1, 2014.

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. As alarm system management solutions are identified, this NPSG will be updated to reflect best practices (Note 6).

- EP 1: As of July 1, 2014, leaders establish alarm system safety as a [critical access] hospital priority.
- EP 2: During 2014, identify the most important alarm signals to manage based on the following (Note 7):
 - 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
- EP 3: As of Jan. 1, 2016, establish policies and procedures for managing the alarms identified in EP 2 above that, at a minimum, address the following (Note 8):
 - 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

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(Continued from page 1)

- 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, and detectability
- EP 4: As of Jan. 1, 2016, educate staff and licensed independent practitioners about the purpose and proper operation of alarm systems for which they are responsible.

Goal 7- Reduce the risk of health care-associated infections.

- No changes to EPs for the following:
NPSG.07.01.01: Comply with either current Centers for Disease Control and Prevention (CDC) hand-hygiene guidelines or World Health Organization (WHO) hand-hygiene guidelines.
NPSG.07.03.01: Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals.
NPSG.07.04.01: Implement evidence-based practices to prevent central line-associated bloodstream infections.
 - Change to one EP below
NPSG.07.05.01: Implement evidence-based practices for preventing surgical site infections.
 - EP 5 revised: Measure surgical site infection rates for the first 30 or 90 days following surgical procedures based on National Healthcare Safety Network (NHSN) procedural codes. The organization’s measurement strategies follow evidence-based guidelines.” (Notes 9,10)
NPSG.07.06.01: Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTIs). (Notes 11,12,13)
 - No change to the EPs.
- Surveillance may be targeted to areas with a high volume of patients using indwelling catheters. High-volume areas are identified through the hospital’s risk assessment as required in IC.01.03.01, EP 2: The hospital identifies risks for acquiring and transmitting infections based on the

following: care, treatment and services. (Notes 14, 15)

Goal 9 – Reduce the risk of patient harm resulting from falls.

NPSG.09.02.01: Reduce the risk of falls.

- No change to EPs

Goal 14 – Prevent health care-associated pressure ulcers.

NPSG.14.01.01: Assess and periodically reassess each patient’s risk for developing a pressure ulcer and take action to address any identified risks. (Note 16)

- No change to EPs

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

- No changes to EPs for the following:

NPSG.15.01.01: Identify patients at risk for suicide.

NPSG.15.02.01: Identify risks associated with home care oxygen therapy, such as home fires. (Note 17)

Universal Protocol (UP) for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery. (Notes 18, 19)

- No changes to EPs for the following:

UP.01.01.01: Conduct a pre-procedure verification process.

UP.01.02.01: Mark the procedure site.

UP.01.03.01: A time-out is performed before the procedure.

Notes

- Note 1. VHA Directive 2005-029, Transfusion Verification and Identification of Requirements for All Sites: http://www.ethics.va.gov/docs/policy/VHA_Directive_2005-029_transfusion_ID_verification.pdf
- Note 2. VHA Directive 2009-019, Ordering and Reporting Test Results: http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1864
- Note 3. VHA Pharmacy Handbook 1108.06, Inpatient Pharmacy Services
- Note 4. VHA Directive 2010-020, Anticoagulation Therapy Management: https://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2234
- Note 5. VA employees can visit the Medication Reconciliation National Workgroup SharePoint site
- Note 6. Additional information on alarm safety can be found on the AAMI website <http://www.aami.org/htsi/alarms/>. Also, the ECRI Institute has identified alarm hazards as one of the top technology hazards for 2013; more

information on this hazard list can be found at https://www.ecri.org/Forms/Pages/Alarm_Safety_Resource.aspx

Note 7. For more information on managing medical equipment risks, refer to Standard EC.02.04.01: The hospital manages medical equipment risks, <http://www.hvmcorp.com/wp-content/uploads/2012/12/EC.02.04.01.pdf>

Note 8. For more information, refer to Standard EC.02.04.03: The hospital inspects, tests, and maintains medical equipment, <http://www.canainc.org/compendium/pdfs/D%201.%20JC%20Standards%202010.pdf>

Note 9. Surveillance may be targeted to certain procedures based on the [organization’s] risk assessment.

Note 10. The NHSN is the Centers for Disease Control and Prevention’s health care-associated infection tracking system. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate health care-associated infections. For more information on NHSN procedural codes, see <http://www.cdc.gov/nhsn/CPTcodes/ssi-cpt.html>

Note 11. Joint commission report on Catheter-associated urinary tract infections: http://www.jointcommission.org/r3_issue2/

Note 12. Evidence-based guidelines for CAUTI: Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals: <http://www.shea-online.org/about/compendium.cfm>

Note 13. CDC Guideline for Prevention of Catheter-associated Urinary Tract Infections: http://www.cdc.gov/HAI/ca_uti/uti.html

Note 14. Joint Commission Readiness for Infection Control and Prevention: <http://www.pharmacyonesource.com/images/sentri7/JointCommissionIP.pdf>

Note 15. Associated Infections in Acute Care Hospitals: <http://www.shea-online.org/about/compendium.cfm>

Note 16. VHA Handbook 1180.2, Assessment and Prevention of Pressure Ulcers: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2422

Note 17. Directive 2006-021, Reducing the Fire Hazard of Smoking When Oxygen Treatment is Expected: http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1407

Note 18. VHA Directive 2010-023, Ensuring Correct Surgery and Invasive Procedures

Note 19. Joint Commission 2010 Universal Protocol: http://www.jointcommission.org/standards_information/up.aspx (All of the sites above were retrieved from the Web on Nov. 19, 2012.)

The “All-Day RCA”

A Successful Approach to Quality, On-Time Root Cause Analysis

By Melissa Ball, R.N., B.S.N., patient safety manager, Central Arkansas Veterans Healthcare System

We have been conducting all-day RCAs at our health care system since the spring of 2010, and it has been a very successful approach.

The process was developed for two main reasons:

- Problems with planning meetings that can be attended consistently by staff during a 45-day period
- Problems with recruiting participants who can step away from patient care for an hour, two days a week, for several weeks

We decided that there was nothing in the “rule book” that said an RCA had to be conducted during a 45-day period: completing an effective, quality RCA that improved patient care could be done in a lot less time.

Our Process

As a patient safety manager, I ask various services for participants on the RCA, usually giving them a week to provide the names.

After obtaining the names, I thank them for participating and send them an NCPS PowerPoint, “RCA, Just in Time Training.”¹ After reviewing this, they are free to contact me with any questions and concerns.

I then tell the team about “homework,” which consists of conducting pre-RCA interviews, reviewing evidence-based research articles, and obtaining policies and procedures specific to this particular incident.

I typically do not have trouble obtaining team members to participate, as our facility has an overall positive patient safety culture and staff want to help.

My homework is typing the initial understanding and the initial flow chart. I also fill in the RCA form for facility signature and place it in the Patient Safety Information System, commonly known as SPOT.

Developed by NCPS, SPOT is an internal, confidential and non-punitive system. It allows users to electronically document patient safety information from across the VA so that “lessons learned” can benefit the entire system.

As far as team size goes, I recommend the following:

- 10 or less members for individuals RCAs
- 20 or less members for aggregates

I offer this advice based on past RCAs, because we have found that too many opinions can be counterproductive to developing a timely, quality RCA.

Interviews

We conduct one-on-one interviews. Why? Early-on in my patient safety career I was often told how grueling it felt to be interviewed about a close call or adverse event — even in the non-punitive environment of an RCA. I felt panel interviews, therefore, were a lot more intimidating than one-on-one interviews.

To make the process even less difficult on the interviewee, I do not assign interviews to individuals in the same discipline, since it as sometimes it may be uncomfortable for participants (i.e., physicians interviewing OR techs, emergency response personnel interviewing police, etc.).

Rarely has there been an uncomfortable interview since we began this effort, and I am always available to interview employees if someone feels uncomfortable. We also tell all interviewees that we may have more questions after the interview is presented to the other team members.

The feedback on the interview process has been well received, especially for those that remember the often exhausting panel interviews.

Once complete, the interviews are typed and forwarded to the group one week prior to the RCA meeting, if at all possible.

The Day of the RCA

The morning of the all-day RCA — which I refer to as the lets “hash it out” and we talk about the incident day — we discuss what we discovered in the interviews and any solutions the interviewees may have mentioned.

During this time, I focus on our “ah-ha moments,” lessons learned and possible root cause actions or contributing factors.

The process normally goes very smoothly and I typically have excellent

interaction with RCA team members. After lunch, we develop our root cause/contributing factors and start placing them on Table 19² in SPOT.

If we are running short on time, I finish getting the information into Table 19 in the correct formatting required for SPOT, because most of the time the root cause/contributing factors have already been identified.

Final Thoughts

A recent VISN survey identified that many suicide prevention coordinators and patient safety managers have difficulty obtaining RCA participants.

The biggest positive of this entire process is participation — it’s been great!

I have staff from across the health care system willing to participate, whether it be surgeons, pharmacists, hospitalists, you name it.

This alone is evidence that our all-day RCA process is well worth it. When providers are given adequate time to block a day in their schedule to participate in the RCA process, we all win.

I have received consistently positive feedback about doing the RCA process this way and it has become second nature to us. I could not imagine going back to several one-hour weekly meetings.

Notes

1. “Just in Time Training” is part of the RCA Tool Box and available to VA employees online.
2. SPOT Table 19 includes root causes and contributing factors that caused a close call or adverse event, as well as actions developed by an RCA team to prevent the incident from happening again and outcome measures that will be used to determine the action’s efficacy.



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HAP = Hospital LTC = Long-Term Care BHC = Behavioral Health Care OME = Home Care AHC = Ambulatory Care LAB = Laboratories X = Active

HAP	LTC	BHC	OME	AHC	LAB		
Goal 1 – Improve the accuracy of patient identification							
X	X	X	X	X	X	1. Use at least two identifiers when providing care, treatment and services.	NPSG.01.01.01
X				X		2. Eliminate transfusion errors related to patient misidentification.	NPSG.01.03.01
Goal 2 – Improve the effectiveness of communication among caregivers							
X					X	1. Report critical results of tests and diagnostic procedures on a timely basis.	NPSG.02.03.01
Goal 3 – Improve the safety of using medications							
X				X		1. Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.	NPSG.03.04.01
X	X			X		2. Reduce harm associated with anticoagulation therapy.	NPSG.03.05.01
X	X	X	X	X		3. Maintain and communicate accurate patient medication information.	NPSG.03.06.01
Goal 6 – Improve the safety of clinical alarm systems							
X						1. Improve the safety of clinical alarm systems.	NPSG.06.01.01
Goal 7 – Reduce the risk of health care-associated infections							
X	X	X	X	X	X	1. Comply with hand-hygiene guidelines of CDC or WHO.	NPSG.07.01.01
X						2. Prevent infections due to multi-drug-resistant organisms.	NPSG.07.03.01
X	X					3. Prevent central-line-associated blood stream infections.	NPSG.07.04.01
X				X		4. Prevent surgical site infections.	NPSG.07.05.01
X						5. Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTIs).	NPSG.07.06.01
Goal 9 – Reduce the risk of falls							
	X		X			1. Implement a fall reduction program.	NPSG.09.02.01
Goal 14 – Prevent health care-associated pressure ulcers							
	X					1. Assess and periodically reassess resident risk for pressure ulcers and take actions to address any identified risks.	NPSG.14.01.01
Goal 15 – The organization identifies safety risk inherent to the patient population							
X		X				1. Identify patients at risk for suicide.	NPSG.15.01.01
			X			2. Identify risks associated with home oxygen therapy.	NPSG.15.02.01
Universal Protocol							
X				X		1. Conduct a pre-procedure verification process.	UP.01.01.01
X				X		2. Mark the procedure site.	UP.01.02.01
X				X		3. Perform a time-out before the procedure.	UP.01.03.01