

Contents

Pages 1 and 2:
Joint Commission National
Patient Safety Goals, 2015

Page 3: System Challenges
in the Inter-Facility Transport
Process of VA Patients

Page 4: 2015 Joint
Commission National Patient
Safety Goals Poster



VA National
Center for
Patient Safety

P.O. Box 486
Ann Arbor, MI 48106-0486

Phone: (734) 930-5890

Fax: (734) 930-5877

E-mail: NCPS@va.gov

Web Sites:

Internet: ...www.patientsafety.va.gov

Intranet: ...vaww.ncps.med.va.gov

Robin R. Hemphill, M.D., M.P.H.
VHA Chief Safety
and Risk Awareness Officer
Director, VA National Center
for Patient Safety

Editor
Joe Murphy, M.S., APR
Public Affairs Officer

Graphic Design and Copy Editing
Deborah Royal
Visual Information Specialist

TIPS is published bimonthly
by the VA National Center for
Patient Safety. As the official
patient safety newsletter of the
Department of Veterans Affairs, it
is meant to be a source of
patient safety information for
all VA employees. Opinions of
contributors are not necessarily
those of the VA. Suggestions and
articles are always welcome.

Thanks to all contributors and
those NCPS program managers
and analysts who offered their
time and effort to review and
comment on these TIPS articles
prior to publication.

Joint Commission National Patient Safety Goals, 2015

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

The Joint Commission has revised National Patient Safety Goal (NPSG) 15.02.01 for home care facilities, which concerns home oxygen use and will be effective January 1, 2015.

A new chapter on hospital accreditation that focuses on patient safety has also been published on the Joint Commission's website. The "Patient Safety Systems" chapter emphasizes importance of leadership in fostering and maintaining an organizational safety culture. (Note 1)

2015 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 2)

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 3)

- No changes to EPs

Goal 3 – Improve the safety of using medications. (Note 4)

- 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 5)

NPSG.03.06.01: Maintain and communicate accurate patient medication information. (Note 6)

Goal 6 – Improve the safety of clinical alarm systems.

NPSG.06.01.01: Improve the safety of clinical alarm systems. (Note 7,8,9)

- No changes to EPs

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.

NPSG.07.05.01: Implement evidence-based practices for preventing surgical-site infections. (Note 10,11)

NPSG.07.06.01: Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTIs). (Notes 12,13,14)

- No changes to 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 15, 16)

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

NPSG.09.02.01: Reduce the risk of falls.

- No changes 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 17)

- No changes to EPs

Joint Commission National Patient Safety Goals, 2015

Continued from page 1

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

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.

Revisions to National Patient Safety Goal NPSG.15.02.01 that address risks associated with home oxygen use will be effective January 1, 2015 for accredited home care organizations.

The goal was established in 2007 after reports that patients were injured or killed as a result of home fires related to oxygen use. Data from recent years showed that one in 10 organizations were not in compliance with NPSG.15.02.01.

The Joint Commission analyzed survey findings, conducted focus groups with surveyors and accredited organizations, and reviewed current literature to assess the situation. This analysis resulted in revisions that were sent for field review and approved. The changes include:

- A new EP requiring periodic reevaluation of fire risks in the home. The new requirement allows organizations to establish the intervals for reevaluation based on evidence of unsafe practices in the home.
- A new EP requiring organizations to implement strategies to improve compliance with oxygen safety precautions when unsafe practices are observed in the home. Depending upon patient and family circumstances, the strategies may include notifying the licensed independent practitioner ordering oxygen, conducting additional education, writing reminders in various locations, and exploring alternative living arrangements.

An expanded rationale for NPSG.15.02.01 that describes the fire risks associated with oxygen, explains the importance of the home risk assessment, and emphasizes the responsibility of every organization providing services in the home to assess safety risks.

- A new note to EP 1 that states home care staff may test the detectors if they are accessible and if testing does not pose a safety risk (although they are not

required to do so). Alternatively, home care staff may verify the functioning of the alarms with the patient and family.

- Clarification of documentation requirements for the NPSG. Documentation provides a record of steps taken to reduce patient risk, and this information is important for communication among those providing home care services. (Note 18,19)

Universal Protocol (UP) for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery. (Notes 20,21)

- 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

All sites below were retrieved on Nov. 25, 2014.

Note 1. Read the chapter: http://www.jointcommission.org/new_hospital_accreditation_chapter_puts_heightened_focus_on_safety/

Note 2. VHA Directive 2011-011, Transfusion Verification and Identification of Requirements for All Sites: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2388

Note 3. VHA Directive 2009-019, Ordering and Reporting Test Results http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1864

Note 4. VHA Pharmacy Handbook 1108.06, Inpatient Pharmacy Services: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1446

Note 5. VHA Directive 2010-020, Anticoagulation Therapy Management: http://www.va.gov/vhapublications/viewpublication.asp?pub_ID=2234

Note 6. VA employees can visit the Medication Reconciliation National Workgroup SharePoint site: <http://vawww.infoshare.va.gov/sites/MedRecon/default.aspx>

Note 7. 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 8. For more information on manag-

ing 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 9. For more information, refer to Standard EC.02.04.03: The hospital inspects, tests, and maintains medical equipment, <http://canainc.org/compendium/pdfs/D%201.%20JC%20Standards%202010.pdf>

Note 10. Surveillance may be targeted to certain procedures based on the [organization's] risk assessment.

Note 11. 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 12. Joint commission report on Catheter-associated urinary tract infections: http://www.jointcommission.org/r3_issue2/

Note 13. Evidence-based guidelines for CAUTI: Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals: <http://www.shea-online.org/PriorityTopics/CompendiumofStrategiestoPreventHAIs.aspx>

Note 14. CDC Guideline for Prevention of Catheter-associated Urinary Tract Infections: http://www.cdc.gov/HAI/ca_uti/uti.html

Note 15. The APIC/JCR Infection Prevention and Control Workbook: <http://www.jcrinc.com/the-apic/jcr-infection-prevention-and-control-workbook-second-edition/>

Note 16. Associated Infections in Acute Care Hospitals: <http://www.shea-online.org/PriorityTopics/CompendiumofStrategiestoPreventHAIs.aspx>

Note 17. VHA Handbook 1180.2, Assessment and Prevention of Pressure Ulcers: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2422

Note 18. *Joint Commission Online*, July 2014: http://www.jointcommission.org/assets/1/23/jconline_July_2_14.pdf

Note 19. Directive 2006-021, Reducing the Fire Hazard of Smoking When Oxygen Treatment is Expected: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1407

Note 20. VHA Directive 1030, Ensuring Correct Surgery and Invasive Procedures: http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2922

Note 21. Joint Commission 2010 Universal Protocol: http://www.jointcommission.org/standards_information/up.aspx

System Challenges in the Inter-Facility Transport Process of VA Patients

By Maisha Mims, M.P.H., NCPS program analyst

Background

Transporting patients can be a complex and critical task. Whether planned or emergent, there is a level of planning and coordination necessary to ensure the safe transition of patients to the appropriate care setting or to their next destination.

Even after the establishment of VA transportation directives, common root causes leading to adverse events during the transporting of patients still exist. Some of these events include:

- The delay of delivery and departure of patients
- Patients falling out of wheelchairs while the vehicle is in motion
- Patients delivered to incorrect destinations
- Misidentification of patients
- Elopement of patients during the transfer process

Through examining the root causes of patient transportation adverse events, using the NCPS Patient Safety Information System, we can begin to identify gaps and create action plans for the transportation process.

This database is an internal, confidential non-punitive reporting and analysis system that allows users to electronically document patient safety information from across VA so that actions taken and lessons learned can benefit the entire system. A combined total of more than one million root cause analysis reports and safety reports have been entered into the system since it was established.

The database search focused on adverse events occurring during inter-facility transport of patients by VA staff, contract, volunteer and ambulance drivers and included the date range from 2008 to 2014. The starting date of 2008 was selected to determine if there had been any unexpected changes or improvements in the transport process since the creation of the transportation directives.

The initial search results yielded 291 RCAs and aggregate cases. After eliminating any case not relevant to this topic, 169 RCAs met the search criteria. From this, a summary was developed of

10 common root causes for inter-facility transport adverse events and recommendations to help prevent them.¹

Summary of Recommendations

- Standardize the ordering and scheduling of patient transports to include patient information, mode of transportation and urgency for patient transport
- Design the pickup and drop off locations to be visible and accessible for transportation vehicles and patient mobility
- Identify the correct patient and location of destination(s) by utilizing a timeout process
- Assess the patient for medical status and behavioral needs such as wheelchairs and escorts
- Create a feedback loop to track and communicate patient arrival and departure to proper destinations
- Incorporate safety checks for drivers such as patient identification; wellness checks and ensuring proper belting of patients and wheelchairs

- Designate staffing responsibilities for physicians, nurses and escorts in the transport process
- Prepare drivers for emergency conditions for inclement weather as well as patient medical and behavioral issues
- Update contract manuals for contract drivers and facilities to meet VA standards as addressed in the VHA directives regarding transportation

Conclusion

These types of adverse events can be reduced, controlled or eliminated: But this will require a multidisciplinary approach that coordinates and communicates patient needs across VA staff, contract services, drivers, volunteers and community facilities.

Note

1. VA employees can find more detailed information on this subject by reading the complete RCA topic summary: <http://vaww.ncps.med.va.gov/Initiatives/RCATopics/index.asp>
Summaries are available on a wide range of topics, dating back to 2002.



TIPS[®] ONLINE

<http://www.patientsafety.va.gov>





2015 Joint Commission National Patient Safety Goals

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 |