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VA NCPS Topics in Patient Safety®

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Lessons Learned: Fall and Fall Related Injury Prevention Virtual Breakthrough Series

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VA facilities have been working to reduce falls for years. Sometimes staff share that they have run out of new ideas about how to make further improvements. To help VA facilities continue to improve fall prevention programs, we conducted a Virtual Breakthrough Series (VBTS).

Methods

The Breakthrough Series (BTS) is designed to help organizations close the gap between "what we know and what we do." Further details and history of this model have been described elsewhere.[1-4] In 2011, the VA National Center for Patient Safety (NCPS) adapted the BTS model for virtual use.

Fifty-five VHA medical centers participated; four sites had two teams resulting in 59 teams. The settings included 36 community living center (CLC) units, 23 acute care units, 13 behavioral health units, five teams focused on home-based primary care, and one state Veteran home.

As teams prepared for the project, they designated a multi-disciplinary team to lead changes. These teams included clinicians such as nurses, rehabilitation therapists, patient safety managers, quality managers and others. During the six-month action phase, teams were given evidence-based changes to reduce falls and injuries due to falls, attended learning sessions, implemented changes using Plan Do Study Act (PDSA) cycles,[5] submitted monthly reports, and attended small group calls to discuss team changes, accomplishments and challenges. At the end of the action phase teams presented a summary PowerPoint.

Evaluation and Analysis

Final team reports were used to quantify new or modified interventions. We compared fall and fall-related major injury rates from IPEC pre to post-intervention using the Poisson Regression Model. Rates for participating sites were also compared to all non-participating sites. The rates were calculated using the total number of falls (or major injuries) divided by the total bed-days of care from all units.

Results: Interventions

Most Frequent Interventions. The most frequently implemented changes (Tables 1A and 1B)[6-12] were staff education (54%, N=32), post-fall huddles (53%, N=31), tracking data (37%, N=22), classifying falls by type of fall,[13] handoff communication and intentional rounding[14] (all at 34%, N=20). Many teams implemented the same interventions in more than one unit or in different ways. Interestingly, eliminating sharp edges and use of raised toilet seats were two interventions that no teams reported as implementing or modifying during this project.

Interventions were grouped by domains: safer environment, modification of patient-specific fall risk factors, and injury risk reduction (N=18). The remaining interventions were grouped into expected/other (N=14) and miscellaneous (N=21). Some examples of specific miscellaneous interventions are:

- Updated or developed falls policy (implemented by seven teams)

QSV VHA OFFICE OF QUALITY, SAFETY AND VALUE
NCPS VA National Center for Patient Safety — Safer Systems • Safer Care

- Random audits/rounds for fall order implementation (implemented by five teams)
- Following falls guidelines such as American Geriatric Society[12] (implemented by four teams)
- Documentation changes only, without an associated new or modified action (implemented by four teams)
- Orthostatic vital sign protocol (implemented by three teams)
- Interventions for repeat fallers (implemented by three teams)

Interventions aimed at reducing fall-related injuries were also implemented by teams such as use of injury risk assessment (14%, N=8), hip protectors (12%, N=7), floor mats (10%, N=6), low beds and helmets both (8%, N=5).[9] While these were implemented at a lower rate than other interventions, we recognize that many of these actions required several steps including ordering and purchasing. Some interventions also required patient acceptance such as helmets and hip protectors.

Outcomes Assessment

Data on rates of falls and fall-related injuries were available for 53 of the 59 teams that participated in the project. Many teams focused on more than one unit resulting in data analysis for 72 units in total. Settings of care included 36 CLC units, 23 acute care units, and 13 behavioral health units. The 72 participating units were compared to all other non-participating units that submitted data to VHA (N=291). The mean falls rate did not change significantly from baseline to follow-up for participants (p=0.42) nor for nonparticipants (p=0.21). The mean fall-related major injury rate for participants did change significantly from baseline to follow-up: 6.8 to 4.8 per 100,000 Bed Days of Care (BDOC) (p=0.02). Five major injuries were avoided per month for the participating units. The mean aggregated fall-related major injury rate for nonparticipants did not change significantly from baseline to follow-up (p=0.22).[5]

Lessons Learned

There are several lessons learned from this project. First, teams that participated in the VBTS made changes in their fall prevention program and experienced improved outcomes. Interventions related to injury risk reduction may have been more challenging to implement than other interventions as they often required purchasing items such as floor mats or padding for sharp edges. Despite this challenge, teams still reduced their major injury rates.

Interventions that might have included additional documentation such as intentional rounding or post-fall huddles were more difficult to implement. One option would be to encourage staff to implement such processes without adding a documentation burden. Assessment of implementation could then be accomplished through periodic observations. In addition, teams that were less familiar with falls data collection devoted a significant amount of time to developing this skill, which may have delayed implementation of clinical practice interventions.

Multi-disciplinary teams were important for making changes. Sites using one or two people instead of a true team approach struggled to implement new interventions. Leadership support is crucial for implementing changes. For example, teams with leadership support to purchase new items improved the ability to successfully implement those changes. Changes that didn't require purchasing new items or changing the electronic medical record were more easily implemented. Some examples include improved handoff communication, conducting post-fall huddles and intentional rounding.

It is important to implement a multi-component fall prevention program. Supporting the need for these types of programs, a recent systematic review on fall prevention programs found that multi-component programs with leadership support are effective at reducing falls by as much as 30 percent.[15]

Seldom in patient safety do we suggest stopping activities or removing responsibilities. One example is no longer conducting intentional rounding on all patients, whether they need it or not. Instead staff could individualize the rounding plan based on patient need.[14] Another example would be no longer conducting fall risk screening every shift or every day, instead they could base the need for reassessment on patient condition.[16]

Given the emphasis on making clinical changes at the point of care, we were pleased to see that a small number of teams only implemented administrative tasks such as policy or documentation changes. Moving forward we recommend continuing the emphasis of only implementing administrative changes when coupled with clinical care improvements.

Conclusion

The VHA Fall VBTS was associated with a decrease in major injuries related to falls. Teams also made changes in fall prevention programs such as classifying how they analyze falls and implementing injury reduction strategies. The approaches used by teams show promise for reducing fall-related harm. We recommend focusing on clinical changes at the bedside guided by the patient's individual need to save time and prioritize high value-added activities.

Related Resources:

1. American Geriatric Society guidelines for multi- factorial fall risk assessment of older adults: http://www.americangeriatrics.org/health_care_professionals/clinical_practice/clinical_guidelines recommendations/2010/
2. NCPS national Falls Toolkit: http://www.patientsafety.va.gov/professionals/onthejob/falls.asp
3. AHRQ falls toolkit, Preventing Falls in Hospitals: https://www.ahrq.gov/professionals/systems/long-term-care/resources/injuries/fallspx/index.html
4. VISN 8 PSCI falls website: http://www.visn8.va.gov/patientsafetycenter/fallsTeam/default.asp
5. Sentinel Event Alert 55: Preventing falls and fall-related injuries in health care facilities: https://www.jointcommission.org/sea_issue_55/

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16. Quigley PA. Evidence Levels: Applied to Select Fall and Fall Injury Prevention Practices. Rehabilitation Nursing: the official journal of the Association of Rehabilitation Nurses 2016; 41:5-15.

Table 1A: Interventions by Domain

DOMAIN	INTERVENTIONS	NUMBER OF TEAMS IMPLEMENTED
	Raised toilet seats	0
	Toilet versa frames/grab bars	2
	Self-locking wheelchairs/rolling seated walkers	4
SAFER ENVIRONMENT	Footwear for preventing slipping and tripping	8
	Helmets	5
	Wheelchair related safety	6
	Equipment (body pillows, pool noodles, etc.)	14
	Change environment	14
MODIFICATION OF PATIENT	Medication review	9
SPECIFIC FALLS RISK FACTORS	Occupational or Physical Therapy evaluation	13
	Examine environmental safety	11
	Intentional Rounding	20
	Injury risk assessment	8
	Low beds	5
INJURY RISK REDUCTION	High-risk injury precautions for special populations	1
	Floor mats	6
	Hip protectors	7
	Eliminate sharp edges	0
	Total Interventions implemented	**133**

Table 1B: Interventions by "Other and Miscellaneous"

DOMAIN	INTERVENTIONS	NUMBER OF TEAMS IMPLEMENTED
	Classifying falls (anticipated, unanticipated physiological, accidental)	20
	Staffing increase/scheduling changes	9
	Data display and/or feedback	3
	Signage for high-fall or high-injury risk	12
	Data tracking	20
EXPECTED/OTHER	Alarms (use of)	12
	Alarms: decreased use or elimination	2
	Education (staff)	31
	Education (patient/family)	15
	Hand-off communication	17
	Post-fall huddles (and safety huddles)	29
	Post-fall assessment template for home-based primary care	3
	Interdisciplinary meetings or falls committee; prevent falls	17
	Falls risk assessment for home-based primary care	8
MISCELLANEOUS	Number of unique miscellaneous	48
	Total other and unique miscellaneous interventions implemented	**246**

Alberta Province Implements VA's Mental Health Environment of Care Checklist

The province of Alberta, Canada is implementing the Mental Health Environment of Care Checklist (MHEOCC) created by the VA National Center for Patient Safety (NCPS). Since its inception in 2007, the MHEOCC has contributed to an 82 percent decrease in deaths by suicide in VA inpatient mental health units throughout the United States.

The checklist is used to evaluate the safety of the environment of care of inpatient mental health units to ensure there are not hazards, such as anchor points for hanging, which patients could use for self-harm or harm to others. Every acute mental health unit throughout the Veterans Health Administration (VHA) is required to be inspected using the checklist every six months. If there are any hazards identified, the inspection team develops a plan to abate the hazard. These plans are then sent to NCPS for monitoring and also to create a shared mental model of potential hazards around the nation.

"The use of the MHEOCC in VHA has been associated with a reduction in the rate of inpatient suicide on mental health units. I am hopeful that the use of the MHEOCC by Alberta Health Services will help the province reduce their rates of inpatient suicide on their mental health units as well," said Dr. Peter Mills, MHEOCC manager and director of the VA NCPS Field Office in White River Junction, Vermont.

Alberta Health Services (AHS) recently conducted a Quality Assurance Review to address the increased number of elopements from mental health inpatient units. A recommendation from the review was that an environment risk assessment be conducted on all units throughout the province. The MHEOCC was selected as the tool of choice.

An interdisciplinary working group with representation from AHS' five zones was established to review the checklist. Nine questions were added to specifically address the elopement risks. The checklist was also revised to include AHS practices and Canadian standards to make it more applicable for the desired use.

"The decision to use the Mental Health Environment of Care Checklist was based on its validation and comprehensiveness. It was also based on the Veterans Health Administration and the author's collaboration and flexibility to add questions to further assess the risk of elopement," said AHS Manager of Zone Integration Fran Barnes.

The MHEOCC will continue to be used in VHA to ensure that Veterans needing acute mental health treatment will receive that care in a safe, healing, recovery-oriented environment. The flexibility of the checklist will allow VHA and other agencies like AHS to adapt to the ever-changing mental health environment and the patients that we collectively have the honor to serve.

Balancing Blood Sugar

Hypoglycemia Causes Concern Among VA Providers

One in four Veterans suffer from diabetes. Many try to manage the disease through diet, exercise, stress reduction and medication. But what is a safe blood sugar level?

The VA and the Department of Defense recognize that the ideal blood sugar (glucose) level may differ from person to person. Finding a "safe" level depends on medication side effects, age, preferences and other medical conditions. Medications, like insulin and some types of oral medications (sulfonylureas), lower blood sugar. But, these can also lead to levels that are too low which can cause hypoglycemia.

Who is at risk for hypoglycemia?

Those at higher risk for hypoglycemia include patients over age 75 and those who have had diabetes for many years. They may also be those on insulin, those who often skip meals or don't eat regularly, or those who have other significant medical conditions. Even healthy individuals can have a serious reaction. Sometimes people can tell their blood sugar is dropping, but not always. Symptoms may include:

- Weakness
- Shakiness
- Hunger
- Sweating
- Lightheadedness
- A feeling of "not being right"

If using a home test, a number less than "70" often means you are experiencing hypoglycemia.

Tailored solutions

The Department of Health and Human Services and the VHA Choosing Wisely Hypoglycemia Safety Initiative (HSI) encourages health care providers to individualize diabetes management for their patients. A high-risk patient may need to aim for an A1c blood sugar target (average blood sugar target over three months) of 7-8 percent or even 8-9 percent rather than "tight control" (<7 percent). But low blood sugar can occur at any time. How patients manage their diabetes is their personal choice.

"Health care providers need to fully inform their patients of their options, using a process known as Shared Decision Making. They should allow patients and their families to decide what's best for them," says Dr. Brian Burke, chief of diabetes services at the Dayton VAMC.

A provider may also recommend that a patient switch their medication, even if it seems to work. Some glucose-lowering medications, such as sulfonylureas and all insulins, can cause hypoglycemia. Changing the dosage or switching to another medication could help reduce that risk.

Originally featured in the Winter 2017 VISN 10 Veterans Health Magazine

Patient Safety Centers of Inquiry Update: New Patient Safety Measurement Display

Amy K. Rosen, Ph.D., director of PSCI on Measurement to Advance Patient Safety; article by Alexis Greenan and Jeffrey Chan

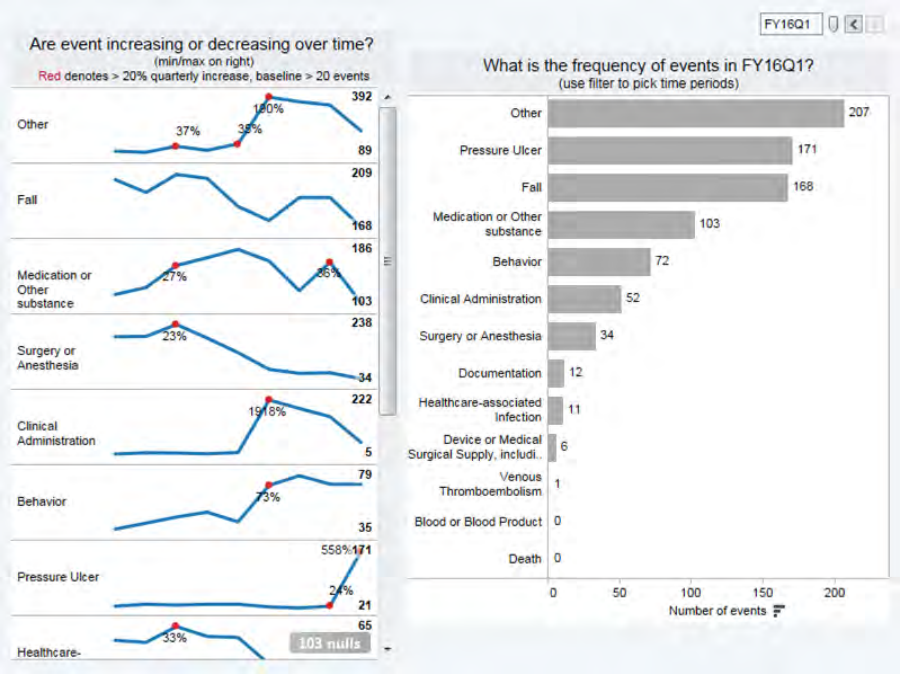
The VA National Center for Patient Safety (NCPS) funds several Patient Safety Centers of Inquiry (PSCI). These centers develop, disseminate, and implement clinically-relevant innovations that improve patient safety throughout the Veterans Health Administration (VHA).

The PSCI on Measurement to Advance Patient Safety (MAPS) is located within the Center for Healthcare Organization and Implementation Research (CHOIR), an HSR&D Center of Innovation at the VA Boston Healthcare System. The PSCI's overall goals are to improve measurement of patient safety by facilitating better standardization and integration across existing patient safety measures, and to develop and test new measures that improve on traditional approaches. The Center's projects span the patient safety measurement field, encompassing three themes critical to improving safety measurement and advancing the field: 1) global measurement; 2) automation of safety event detection; and 3) development of new measures. One project, "Development and Assessment of Guiding Patient Safety (GPS) Data Display Tools," examines how existing patient safety measures in VA can be used together to provide a "big picture" view of the occurrence and frequency of inpatient safety events. Through partnerships with both national and local stakeholders at four VA hospitals, the GPS team has developed and pilot tested a patient safety display tool that provides data on safety events based on each facility's safety measures. The resulting GPS data display is designed to help facilities identify and effectively target areas for quality improvement (QI) and promote safe practices.

Using an iterative "bottom-up" approach to promote stakeholder engagement and buy-in, the GPS tool was refined and adapted to reflect the broad spectrum of safety measures used by each of the four GPS pilot facilities. Measures include safety events from facility-specific incident reports (e.g., falls), the Agency for Healthcare Research and Quality's Patient Safety Indicators (AHRQ PSIs), hospital-acquired infections (HAI), hospital-acquired pressure ulcers, and VA Surgical Quality Improvement Program (VASQIP) postoperative adverse events. While not yet fully integrated into facilities' formal QI processes, the GPS is shared across patient safety, quality and nursing staff, as well as senior leadership at each facility to inform QI activities such as falls and HAI prevention.

The GPS project has recently transitioned to a second phase of development that includes two steps: 1) creation of a standardized GPS template that can be used across VA hospitals nationwide, and 2) development and pilot testing a GPS toolkit that can guide stakeholders using the GPS template to target QI and improve their safety performance. PSCI staff continue to work with the four GPS pilot facilities to analyze and understand the different ways these sites prioritize their hospital's patient safety activities, while also reconciling their disparate needs. Lessons learned from pilot facilities will inform toolkit development and help transition the GPS to a standardized template using Tableau software. This user-friendly software, recently licensed for use across VA, allows for more efficient GPS production and greater visualization options (Figure 1 below).

Figure 1: Example of Tableau-based GPS Tab Displaying Safety Events at One Hospital



Once the GPS template and toolkit (i.e., GPS bundle) are developed, the team will assess the usefulness of the bundle in guiding "actionable" patient safety activities. The PSCI plans to expand implementation of the initial GPS bundle to two additional VA facilities; this will involve working directly with facility staff to pilot test, adopt, refine and evaluate the tools. The GPS team is currently identifying VA facilities with potential interest in implementing the GPS data display and toolkit. For additional updates or for more information on implementing the GPS bundle at your facility, please contact Jeffrey Chan (jeffrey.chan@va.gov).

Rocky Top Journey To High Reliability

Lori Hagen, RN, MHA, CPHQ, chief quality management, Denise Rohman, systems redesign coordinator, Teresa Pickett, RN, MHA, patient safety manager
Mountain Home VA Healthcare System

Sixteen years have passed since the Institute of Medicine's report "To Err Is Human" was released and health care facilities continue to deal with adverse and sentinel events. With the guidance of The Joint Commission article "High-Reliability Health Care: Getting There from Here," the Veterans Health Administration's (VHA) strategic initiatives and programs, and the use of Baldrige Criteria – the Mountain Home VA Healthcare System (MHVAHCS) has continued its journey toward high reliability. Over the past nine years, this journey has and continues to empower staff, transform the organizational culture and enhance care to Veterans. MHVAHCS has focused on the core tenets of high reliability in health care to include just culture, leadership commitment, high-functioning teams, understanding complexity and the environment of care. There was also a focus on other elements of a high-reliability organization such as implementing new technologies (e.g. electronic medical record, computer physician order entry, and bar-coded medications), evidence-based practice (i.e. standardization and simplification of processes, understanding and measuring current processes), and process optimization and standardization (PDSA, lean, six sigma).

MHVAHCS explored three major changes that health care organizations would have to take in order to progress toward high reliability (Chassin): 1) the leadership's commitment to the ultimate goal of zero patient harm; 2) the incorporation of all the principles and practices of a safety culture throughout the organization; and 3) the widespread adoption and deployment of the most effective process improvement tools and methods.

The ***first*** major change included ensuring the leadership's commitment to the ultimate goal of zero patient harm. MHVAHCS focused on:

- Participation of leadership in performance improvement training, Rapid Process Improvement Workgroups, senior executive programs, lean training, and team champions on chartered teams.
- Implementation of Baldrige Criteria to perform a self-assessment of the health care system. This engaged staff to benchmark practices and outcomes to other high-performing facilities which helped to produce the following results:
  - VA Robert W. Carey TROPHY Award (Achievement and Excellence Award)
  - Tennessee Center for Performance Excellence Awards (state Baldridge awards)
- Monitoring of patient events with actions for improvement. Example: restructured the medication safety committee and the use of "MAP-Its" for easy reporting of medication incidents.

The ***second*** major change included the incorporation of all the principles and practices of a safety culture throughout the organization. MHVAHCS implemented the following practices:

- Offered the **VA National Center for Patient Safety's (NCPS) Clinical Team Training (CTT)** with a curriculum that covered topics such as team leadership, assertive communication, standardized communication, situational awareness and team decision-making. Teams learn how to practice safety behaviors and implement countermeasures to manage threats and risks in the operational environment.
- For the past seven years, staff has been positively recognized through our **"Good Catch"** program when they report a safety concern, close call or adverse event.
- Strong Root Cause Analysis (RCA) process and staff participation
- **Seven consecutive NCPS "GOLD" Cornerstone Recognition Awards**
- Completion of RCAs on "close calls" are encouraged and completed
- Participation in the new NCPS "**My VOICE Matters**"(MVM) program:
  - MVM is a comprehensive program which aims to create high reliability through a fair and just culture. It also assists in the establishment of a climate where staff is actively engaged in identifying and reporting potential hazards to leadership.
  - MVM has eight elements. Implementation of the first three elements is required. The remaining five are optional adjuncts that will help to strengthen and sustain the initiative.

The ***third*** major change included the widespread adoption and deployment of the most effective process improvement tools and methods. MHVAHCS has promoted a robust systems redesign program:

- **Physicians** are essential to the success of any quality initiative and our physicians routinely champion quality improvement initiatives.
- **Sharing Best Practices** – by engaging staff to participate and seek innovation, MHVAHCS has received the following recognition:
  - Shark Tank - Gold Promising Practices - 1st and 2nd Shark Tanks
  - Winner of the 3QFY16 Under Secretary for Health (USH) Access Priority Award program

- **Root Cause Analysis Training for frontline staff** with reporting of RCA team findings to the executive leadership team.
- Robust performance improvement **"belt" training program** achieving the results below:
  - 100 percent of staff (approximately 2,230 employees) trained in lean principles as a part of New Employee Orientation (NEO).
    - White Belt - 458 staff trained
    - Green Belt - 298 staff trained
    - Yellow Belt - 489 staff trained
    - Black Belt - 99 staff trained
- The use of **annual "themes"** which focus all staff on specific performance improvement tools and activities.
- 2012 MUDA (elimination of waste) - focus on waste and lean principles
- 2013 MURI (overburdening people or equipment) - focus on error proofing and standardized work
- 2014 MURA (unbalanced work flow) - focus on value stream mapping and flow
- 2015 ACCESS - focus on access
- 2016 MyVA project
- 2017 SAMAE ("Shark") - focus on elimination of waste
- The sharing of outcomes and results through such avenues as monthly systems redesign project recognition at director's staff meetings. The executive leadership team focuses on key survey results and identifies opportunities for improvement, and remembers to celebrate efforts and successes.

The implementation of all the various methods and tools has helped achieve improved staff engagement to achieve a culture of patient safety and a pathway toward high reliability.

Required MVM Elements	MHVAHCS Actions
Patient Safety Culture Analysis	To be reviewed by leadership with focus areas identified
Just Culture Seminar for Leadership	NCPS staff to complete by April 2017
Just Culture Seminar for Frontline Staff	NCPS and trained facility staff to complete by April 2017
Optional Adjunct MVM Elements	**MHVAHCS Actions**
Leadership Walk Rounds	Began GEMBA walks in 2011
Monthly Safety Forums	Short monthly forums to review a summary of select adverse event and/or close call cases; the forum is open to all staff and began in 2016
CTT in Key Areas of the Facility	2012 - Operating room 2013 - Acute care nursing staff 2014 - Open to all clinical staff
Lean Fundamentals	100 percent of staff trained in lean techniques (included in New Employee Orientation (NEO)) - started in 2012
Root Cause Analysis (RCA) Training for Front-Line Staff	"Just-in-time" MHVAHCS facility training NCPS staff provided RCA training

Putting a Face to a Name: Your Patient Safety Team

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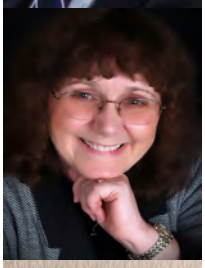

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2017 Joint Commission National Patient Safety Goals

NCPS VA National Center for Patient Safety
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KEY: AMB=Ambulatory Care; BHC=Behavioral Health Care; DME=Home Care; HAP=Hospital; LAB=Laboratory; "X"=Active

AMB	BHC	DME	HAP	LAB	Description	Goal ID
Goal 1: Identify Patients Correctly						
X	X	X	X	X	Use at least two ways to identify patients. This is done to make sure that each patient gets the correct medication and treatment.	NPSG 01.01.01
X			X		Make sure that the correct patient gets the correct blood when they get a blood transfusion.	NPSG 01.03.01
Goal 2: Improve Staff Communication						
			X	X	Get important test results to the right staff person on time.	NPSG 02.03.01
Goal 3: Use Medicines Safely						
X			X		Before a procedure, label medications that are not labeled. Do this in the area where medicines and supplies are set up.	NPSG 03.04.01
X			X		Take extra care with patients who take medications to thin their blood.	NPSG 03.05.01
X	X	X	X		Record and pass along correct information about an individual's medications. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the individual served. Make sure the patient knows which medicines to take when they are at home. Tell the individual served it is important to bring their up-to-date list of medicines every time they visit a doctor.	NPSG 03.06.01
Goal 6: Use Alarms Safely						
			X		Make improvements to ensure that alarms on medical equipment are heard and responded to on time.	NPSG 06.01.01
Goal 7: Prevent Infection						
X	X	X	X	X	Use the hand cleaning guidelines from the Centers for Disease Control and Prevention of the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.	NPSG 07.01.01
			X		Use proven guidelines to prevent infections that are difficult to treat.	NPSG 07.03.01
			X		Use proven guidelines to prevent infection of the blood from central lines.	NPSG 07.04.01
X			X		Use proven guidelines to prevent infection after surgery.	NPSG 07.05.01
			X		Use proven guidelines to prevent infections of the urinary tract that are caused by catheters.	NPSG 07.06.01
Goal 9: Prevent Patients From Falling						
		X			Find out which patients are most likely to fall.	NPSG 09.02.01
Goal 15: Identify Patient Safety Risks						
	X		X		Find out which individuals served are most likely to try to commit suicide.	NPSG 15.01.01
		X			Find out if there are any risks for patients who are getting oxygen.	NPSG 15.02.01
Universal Precaution 1: Prevent Mistakes in Surgery						
X			X		Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.	UP 01.01.01
X			X		Mark the correct place on the patient's body where the surgery is to be done.	UP 01.02.01
X			X		Pause before the surgery to make sure that a mistake is not being made.	UP 01.03.01

Created by External Accreditation and Service Program January 2017. Questions or comments, please contact Donna McGaw at donna.mcgaw@va.gov