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Joint Commission National Patient Safety Goals, 2012

By Joe Murphy, M.S., A.P,R., NCPS public affairs officer

The Joint Commission has approved one new National Patient Safety Goal (NPSG) for 2012. The new goal, NPSG.07.06.01, is focused on catheter-associated urinary tract infections (CAUTI). During 2012, plan for the full implementation of this new NPSG by January 1, 2013.

CAUTI is the most frequent type of health care-acquired infection (HAI), and represents as much as 80 percent of HAIs in hospitals. (Note 1)

No other changes have been made.

2012 NPSG Overview

Goal 1 – Improve the accuracy of patient identification.

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

- No change to Elements of Performance (EPs)

NPSG.01.03.01: Eliminate transfusion errors related to patient misidentification. (Note 2)

- No changes to EPs
- 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 change to EPs

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

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

- No change to EPs

NPSG.03.05.01: Reduce the likelihood of patient harm associated with the use of anticoagulation therapy. (Note 5)

- No change to EPs

NPSG.03.06.01: Maintain and communicate accurate patient medication information.

- No change to EPs (Note 6)

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

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.

- No change to EPs

NPSG.07.03.01: Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals.

- No change to EPs

NPSG.07.04.01: Implement evidence-based practices to prevent central line-associated bloodstream infections.

- No change to EPs

NPSG.07.05.01: Implement evidence-based practices for prevention of surgical site infections.

- No change to EPs

NPSG.07.06.01: Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTIs) (Note 7,8)

- EP 1. During 2012, plan for the full implementation of this NPSG by January 1, 2013

Planning may include a number of different activities, such as assigning responsibility for implementation activities, creating timelines, identifying resources, and pilot testing.

- EP 2. Insert indwelling urinary catheters according to established evidence-based guidelines that address the following:

  - o Limiting use and duration to situations necessary for patient care

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(Continued from page 1)

- o Using aseptic techniques for site preparation, equipment, and supplies
- EP 3. Manage indwelling urinary catheters according to established evidence-based guidelines that address the following:
  - o Securing catheters for unobstructed urine flow and drainage
  - o Maintaining the sterility of the urine collection system
  - o Replacing the urine collection system when required
  - o Collecting urine samples
- EP 4. Measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas by doing the following:
  - o Selecting measures using evidence-based guidelines or best practices
  - o Monitoring compliance with evidence-based guidelines or best practices
  - o Evaluating the effectiveness of prevention efforts

Surveillance may be targeted to areas with a high volume of patients using in-dwelling 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. (Note 9)

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 10)

- No change to EPs

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

NPSG.15.01.01: Identify patients at risk for suicide.

- No change to EPs

NPSG.15.02.01: Identify risks associated with home care oxygen therapy, such as home fires. (Note 11)

- No change to EPs

Universal Protocol (UP) for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery. (Notes 12 & 13)

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

- No change to EPs

UP.01.02.01: Mark the procedure site.

- No change to EPs

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

- No change to EPs

Notes

Note 1. Joint Commission, new national patient safety goal: *http://www.jointcommission.org/new_2012_national_patient_safety_goal_cauti/*

Note 2. 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 3. VHA Directive 2009-019, Ordering and Reporting Test Results: *http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1864*

Note 4. VHA Pharmacy Handbook 1108.06, Inpatient Pharmacy Services

Note 5. VHA Directive 2010-020, Anticoagulation Therapy Management: *https://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2234*

Note 6. VA employees can visit the Medication Reconciliation National Workgroup SharePoint site

Note 7. 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 8. CDC Guideline for Prevention of Catheter-associated Urinary Tract Infections, 2009: *http://www.cdc.gov/hicpac/cauti/001_cauti.html*

Note 9. Joint Commission Readiness for Infection Control and Prevention: *http://www.pharmacyonesource.com/images/sentri7/JointCommissionIP.pdf*

Note 10. VHA Handbook 1180.2, Assessment and Prevention of Pressure Ulcers: *http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2422*

Note 11. 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 12. VHA Directive 2010-023, Ensuring Correct Surgery and Invasive Procedures: *https://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2243*

Note 13. Joint Commission 2010 Universal Protocol: *http://www.jointcommission.org/standards_information/up.aspx*

(All of the sites above were retrieved from the Web on December 5, 2011.)

Preventing fires in the OR

By Joe Murphy, NCPS public affairs officer

OR fires are rare, but can have serious and debilitating consequences.

Fortunately, they occur in an extremely small percentage of the approximately 65 million surgical cases each year. Extrapolating from data published by the Pennsylvania Patient Safety Authority in 2007, the ECRI Institute estimated that there are 550 to 650 surgical fires nationally each year.[1]

For a fire to start, three factors must be present: an oxygen source, a fuel source, and an ignition mechanism.[2]

For instance:

- Nitrous oxide
- Alcohol-based skin preps
- Cautery pens

In oxygen-enriched atmospheres, such as occur in the OR, a phenomenon called "surface fiber flame propagation" (SFFP) can occur. In this phenomenon, the fine surface fibers of fabric, nap of cloth, or body hair can be ignited, causing a flame front to rapidly flash over the surface and ignite more massive fuels at the edges of the surface. Even in only 50 percent oxygen concentrations, heat from many surgical instruments and procedures is sufficient to initiate SFFP, often beginning with a spark or flame and an audible pop at the ignition point.[3]

In an effort to prevent fires in the OR, the San Francisco VA Medical Center developed a checklist, "The Surgical Fire Assessment Protocol," which has been placed on the reverse side of the Medical Team Training preoperative checklist. Both checklists are available online in conjunction with a related article in the November/December 2010 TIPS.[4]

Along with the references noted below, an article in the August/September 2003 TIPS, "Surgical Fires and Patient Surgical Burns,"[5] provides readers with detailed information on the causes and prevention of surgical fires.

Numerous other sources of information are available online, such as from the Anesthesia Patient Safety Foundation[6] and the Joint Commission.[7]

NCPS recommends "strong actions" whenever possible to prevent adverse events. Such an action is more likely to eliminate or greatly reduce the likelihood of an event, as it uses physical plant or systemic fixes in conjunction with the application of human factors principles.

In the case of fires in the OR, an example of one such action is the use of fire-retardant surgical drapes.[2]

What is a fire? The definition of fire used in the fire protection community is "a rapid, self-sustaining oxidation, emitting smoke, heat, or light.[5]

References

1. ECRI Institute: Surgical Fire Prevention. Retrieved December 5, 2011 from *https://www.ecri.org/Products/Pages/Surgical_Fires.aspx?sub=Customized%20Services*
2. American College of Surgeons: Fires in the operating room. Retrieved December 5, 2011 from *http://www.facs.org/about/committees/cpc/oper0897.html*
3. ECRI Institute: Fires from Oxygen Use during Head and Neck Surgery. Retrieved December 5, 2011 from *http://www.mdsr.ecri.org/summary/detail.aspx?doc_id=8212*
4. TIPS Nov/Dec 2010: A New Effort to Promote Fire Safety in the OR. Retrieved December 5, 2011 from *http://www.patientsafety.gov/pubs.html#tips*
5. TIPS Aug/Sept 2003: Surgical Fires and Patient Surgical Burns. Retrieved December 5, 2011 from *http://www.patientsafety.gov/pubs.html#tips*
6. The APSF collaborated with the ECRI Institute to develop a free 18-minute video about OR fire safety: *http://www.apsf.org/resources_video.php*
7. The Joint Commission: Preventing surgical fires. Retrieved December 5, 2011 from *http://www.jointcommission.org/assets/1/18/SEA_29.PDF*

2012 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 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**