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Joint Commission National Patient Safety Goals, 2011

By *Debora Pfeffer, R.N., M.B.A., NCPS program analyst*

In 2010, the Joint Commission completed an in-depth review of the National Patient Safety Goals (NPSG) in response to concerns from the field about how to effectively address the goals in light of the resources required to remain compliant.¹

After considerable review of the concerns and challenges, the Joint Commission decided to not release any new goals for 2011; however, revisions have been made to five of the elements of performance (EP) that are effective immediately.

This year the Joint Commission is moving from being more to less prescriptive in meeting the goals. This will allow health care organizations to evaluate and incorporate findings from research, as well as any newly accepted clinical practices.

This evolution is evident in several of the revised EPs, which now state clinical practice should be based on methods that are cited in scientific literature or endorsed by professional organizations. An authoritative source is listed as a third option, which may be drawn from a peer-reviewed publication, with an endorsement by a professional organization, or from a governmental agency. In any case, the information must be supported by evidence or broad consensus.

2011 NPSG Highlights

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 changes to EPs

NPSG.01.03.01: Eliminate transfusion errors related to patient misidentification.

- A change in wording addresses the use of bar coding as a second identifier in the blood transfusion process: If two individuals are not available, an automated identification technology, such as bar coding, may be used in place of one of the individuals.
- NCPS recommendation: Staff should reference VHA directives and local policies for guidance.²

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.

- No change to EPs³

Goal 3 – Improve the safety of using medications.

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

- EP 6 revised: “Immediately discard any medication or solution found unlabeled.”

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

- EP 6 revised: “A written policy addresses baseline and ongoing laboratory tests that are required for anticoagulants.”

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.

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 guidelines to prevent central line-associated bloodstream infections.

- EP 11 revised: “Use an antiseptic for skin preparation during central venous catheter insertion that is cited in scientific literature or endorsed by professional organizations.” This revision allows for changes that may occur based on new research.

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

- EP 7 revised: “Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to methods cited in scientific literature or endorsed by professional organizations.”
- EP 8 revised: “When hair removal is necessary, use a method that is cited in scientific literature or endorsed by professional organizations.”

Goal 8 – Accurately and completely reconcile patient medications across the continuum of care.⁵

- No change to EPs
- The Joint Commission announced in December 2010 that Goal 8 will be moving to Goal 3, effective July 1, 2011. Specific language concerning the new goal has not been finalized. More information will be published in a future edition of TIPS.

This standard and the elements of performance are not in effect at this time. The Joint Commission has become increasingly aware of the difficulty in remaining compliant and has placed this goal under review.

Until a final decision has been made, Joint Commission surveyors will continue to evaluate the organization’s medication reconciliation process and provide input for improvement, but will not factor any findings from this goal into an organization’s accreditation decisions. This does not, in any way, release an organization from developing and incorporating a process to ensure ongoing patient safety in the medication reconciliation process.

- NCPS recommendation: Follow VHA directives and local facility policies related to medication reconciliation.

Additionally, facilities should focus on ensuring that patients and family members clearly understand what medications are required during the hospital stay, as well as those required at discharge.

NPSG.08.01.01: A process exists for comparing the patient’s current medications with those ordered for the patient while under the care of the organization.

NPSG.08.02.01: When a patient is referred to or transferred from one organization to another, the complete and reconciled list of medications is communicated to the next provider of service, and the communication is documented. Alternatively, when a patient leaves the organization’s care to go directly to his or her home, the complete and reconciled list of medications is provided to the patient’s known primary care provider, the original referring provider, or known next provider of services.

NPSG.08.03.01: When a patient leaves the organization’s care, a complete and reconciled list of the patient’s medications is provided directly to the patient and/or the patient’s family, as needed, and the list is explained to the patient and/or family.

NPSG.08.04.01: In settings where medications are not used, used minimally, or are prescribed for a short duration, modified medication reconciliation processes are performed.

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.

- No change to EPs⁶

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.

- No change to EPs⁷

Universal Protocol (UP) for preventing wrong site, wrong procedure, wrong person surgery.^{8,9}

UP.01.01.01: Conduct a preprocedure 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

References

1. The Joint Commission (2010). Special Report! 2011 National Patient Safety Goals: The Official Approved Goals and Helpful Solutions for Meeting Them. *The Joint Commission Perspectives on Patient Safety*, 10(9), 1-15.
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
3. VHA Directive 2009-019-Ordering and Reporting Test Results: http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1864
4. VHA Directive 2010-020- Anticoagulation Therapy Management: https://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2234
5. VA employees can visit the Medication Reconciliation National Workgroup SharePoint site.
6. VHA Handbook 1180.2: Assessment and Prevention of Pressure Ulcers: http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1447
7. VHA Directive 2006-021: Reducing the Fire Hazard of Smoking When Oxygen Treatment is Expected: http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1407
8. VHA Directive 2010-023: Ensuring Correct Surgery and Invasive Procedures: https://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2243
9. Joint Commission 2010 Universal Protocol: http://www.jointcommission.org/standards_information/up.aspx

Preventing Wheelchair-Related Falls

By Joe Murphy, APR, NCPS public affairs officer

Though a fall from a wheelchair can result in serious injury, particularly among elderly Veterans, like other types of falls, they are often preventable.

“When our medical center was completing our aggregate review for falls in 2008,” said Kent Wagoner, patient safety manager, VA Martinsburg Medical Center, W. Va., “we noticed that some of the most significant injuries from falls were wheelchair-related.”

The majority of the falls were taking place at the facility’s Community Living Centers (CLCs). Veterans with chronic stable conditions including dementia, those requiring rehabilitation or short-term specialized services, or those who need comfort and care at the end of life, are served in CLCs.

“Picture someone pulling a chair out from under you when you are about to sit down,” he said. “The residents were not prepared for the falls.” Wagoner also noted that there are usually several points of impact on the human body when a fall occurs: Injuries to the back, coccyx and head are common.

Approximately one-third of all adults 65 years of age and older are reported to fall each year. Those living in institutions fall three times that rate, with as many as 25 percent of institutional falls resulting in fracture or laceration (Mills, 2005).

Wagoner said the majority of falls in the CLCs had to do with a resident failing to lock a wheelchair when rising; or, ensuring it was locked before sitting: “We were really concerned since this was the number one reason for fall-related injuries in long-term care.”

One unit in particular, which served residents with dementia, stood out. “That was always the unit, month after month, that had the highest rate of falls,” Wagoner noted. “On that unit, they are not falling because they are tripping over things, it’s because they are always in motion; in and out of wheelchairs all the time.”

Because eliminating wheelchair use in this unit was out of the question for a number of reasons, the focus became on how best to secure them. When reviewing safe patient handling equipment, he

and his falls reduction team became aware of a wheelchair locking device, which the facility piloted for 60 days. A survey was conducted following the pilot and 94 percent of the staff involved responded positively to the automatic wheelchair locking system.

“It was perfect timing,” Wagoner said, because funding was then available through NCPS’ Patient Safety Initiative (PSI) program. “We received the funding in May of 2009 and purchased 36 wheelchairs with self-locking devices.” The PSI program was established to provide funding to stimulate creative approaches to complex patient safety issues at the local level. Seventy-eight proposals were funded from fiscal year 2006 to fiscal year 2009.

The wheelchairs with self-locking devices were positioned in the facility’s CLCs, not in common outpatient areas.

“As soon as a patient stands up, the wheelchair locks,” he said. “A mechanism engages immediately and prevents the larger wheels from rolling.”

The locks are controlled by sensors that detect the addition or removal of weight on the seat of the wheelchair. When the chair is occupied, the locks are not engaged, and the user may roll about. When the weight is lifted from the seat, the locks engage until weight is applied again. Overrides mounted on the handles of the wheelchair disengage the locks to allow movement of empty chairs. The automatic wheelchair locks do not interfere with fold-

ing the wheelchair for storing or transporting.

“In a typical CLC, you will find a line of wheelchairs circling the nurses’ station,” Wagoner noted. “Sometimes it’s to increase the ability to observe the residents; but residents also tend to interact better with staff there. It’s the social center of the unit.”

“So that is pretty much where we keep our self-locking wheelchairs,” he continued. “Residents that don’t require a self-locking wheelchair are given a standard wheelchair. Locating the self-locking wheelchairs in the CLCs hasn’t been an issue.”

The introduction of the self-locking systems has been a success. “I am very proud to say that since this technology was introduced in the CLCs – I better knock on wood when I say this – we haven’t had any wheelchair-related injuries as a result,” said Wagoner.

He added that due to the success of reducing wheelchair-related falls and injuries, the facility is considering purchasing wheelchairs with self-locking devices for other areas, such as acute care.

Reference

Mills, P., Neily, J., Luan, D., Stalhandske, E., & Weeks, W. (2005). Using aggregate root cause analysis to reduce falls and related injuries. *Joint Commission Journal on Quality & Safety*, 31(1), 21-31.



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2011 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
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
Goal 8 – Accurately and completely reconcile medications across the continuum of care Under review by the Joint Commission							
X	X	X	X	X		1. Compare current and newly ordered medications.	NPSG.08.01.01
X	X	X	X	X	X	2. Communicate medications to the next provider.	NPSG.08.02.01
X	X	X	X	X		3. Provide a reconciled medication list to the patient.	NPSG.08.03.01
X	X	X	X	X		4. Perform a modified medication reconciliation in settings where medications are not used, used minimally, or prescribed for a short duration.	NPSG.08.04.01
Goal 9 – Reduce the risk of patient harm resulting from 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

The Joint Commission announced in December 2010 that Goal 8 will be moving to Goal 3, effective July 1, 2011. Specific language concerning the new goals has not been finalized. More information will be published in a future edition of TIPS.

Questions? Contact Debora Pfeffer, NCPS Management/Program Analyst at (202) 461-5348