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## Joint Commission National Patient Safety Goals, 2013

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

In 2012, the Joint Commission approved one new National Patient Safety Goal (NPSG) that focuses on catheter-associated urinary tract infection (CAUTI) for the hospital and critical access hospital accreditation programs. This goal required organizations to plan in 2012 for full implementation starting January 1, 2013. No new NPSGs became effective in 2012 for the other accreditation programs and no new NPSGs were added for 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)

### 2013 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). Last year, there were four EPs. EP 1 indicated that facilities should “plan for full implementation of this NPSG by January 1, 2013.” That requirement has been removed and the remaining EPs have been renumbered, but remain otherwise unchanged. (Notes 7, 8)

- EP 1. Insert indwelling urinary catheters according to established evidence-based guidelines that address the following:
  - Limiting use and duration to situations necessary for patient care
  - Using aseptic techniques for site preparation, equipment, and supplies

# Joint Commission National Patient Safety Goals, 2013

(Continued from page 1)

- EP2: Manage indwelling urinary catheters according to established evidence-based guidelines that address the following:
  - Securing catheters for unobstructed urine flow and drainage
  - Maintaining the sterility of the urine collection system
  - Replacing the urine collection system when required
  - Collecting urine samples
- EP 3: Measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas by doing the following:
  - Selecting measures using evidence-based guidelines or best practices
  - Monitoring compliance with evidence-based guidelines or best practices
  - Evaluating the effectiveness of prevention efforts

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 9, 10)

## 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 11)

- 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 12)

- No change to EPs

## Universal Protocol (UP) for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery. (Notes 13, 14)

**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 report on Catheter-associated urinary tract infections: [http://www.jointcommission.org/r3\\_issue2/](http://www.jointcommission.org/r3_issue2/)

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](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](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](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: [http://www.cdc.gov/HAI/ca\\_uti/uti.html](http://www.cdc.gov/HAI/ca_uti/uti.html)

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

Note 10. Associated Infections in Acute Care Hospitals: <http://www.shea-online.org/about/compendium.cfm>

Note 11. VHA Handbook 1180.2, Assessment and Prevention of Pressure Ulcers: [http://www1.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=2422](http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2422)

Note 12. Directive 2006-021, Reducing the Fire Hazard of Smoking When Oxygen Treatment is Expected: [http://www1.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=1407](http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1407)

Note 13. VHA Directive 2010-023, Ensuring Correct Surgery and Invasive Procedures: [https://www1.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=2243](https://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2243)

Note 14. Joint Commission 2010 Universal Protocol: [http://www.jointcommission.org/standards\\_information/up.aspx](http://www.jointcommission.org/standards_information/up.aspx)

(All of the sites above were retrieved from the Web on Nov. 19, 2012.)

# Enhancing safety through the development of standard operating procedures and cognitive aids

By Kristen Miller, M.S.P.H., D.Ph., NCPS patient safety fellow

An aggregated review regarding specimen labeling at the VA Ann Arbor Healthcare System determined that unknown and inconsistent processes for labeling specimens potentially resulted in discarded samples and delays in patient care.

The aggregated review process is a method of analyzing a group of similar incidents or event types to determine common causes. Issues and incidents reviewed via aggregated reviews are those that do not require individual RCAs.

Aggregated reviews serve two important purposes: first, they provide a way to show trends not noticeable in individual case analysis; second, they make wise use of an RCA team's time.

A series of incident reports, pertaining to inconsistent processes for labeling, the selection of containers, and the documentation of specimens, shed light on patient safety concerns regarding specimen collection.

The patient safety team, led by Patient Safety Manager Cynthia Paterson, R.N., Ph.D., took action, standardizing these processes across facility units and departments. This included best practice recommendations and creation of a cognitive aid on specimen labeling procedures.

To aid clinicians through the decision-making process and encourage adherence to best practices, Linda Rubley, R.N., M.B.A., facility patient safety specialist, worked with infectious disease and laboratory personnel to create Standard Operating Procedures (SOP) to systematize the process.

In addition to the SOP, a cognitive aid for appropriate specimen labeling and specimen collection based on specimen type (i.e., blood, urine, tissue culture) was created to provide visual cues and step-by-step instructions for clinicians.<sup>1</sup>

The cognitive aid has been implemented hospital-wide, led by local champions and the patient safety task force. Post-implementation, specimen labeling incident reports decreased from an average of 115 to 50 per quarter, indicating quantifiable success in improved patient safety.

## Standardization and cognitive aids

Lack of standardization in health care systems impacts communication, equipment, technology – and ultimately, performance. Variations in processes, policies and standard operating procedures not only contribute to adverse events but also create confusion, delays in care, and varying levels in the quality of care.

The complexities of modern medicine, coupled with the inherent limitations of human performance, create unique occupational challenges for clinicians. Human performance relies on cognition, attention, memory, perception and communication – all aspects of mental functions that have constraints.

*Specimen labeling incident reports decreased from an average of 115 to 50 per quarter, indicating quantifiable success in improved patient safety*

The probability that a person will make an error of omission in the absence of a reminder is about 1 percent.<sup>2</sup> Though this number appears small, applied to the number of tasks a health care worker performs each day and the number of steps in each task, the rate of error due to human factors is daunting.<sup>3</sup>

Cognitive aids provide an effective solution to support, enhance, or improve cognition to better “distribute” memory

among team members and manage emergent conditions.<sup>4</sup>

## Developing effective solutions

Ultimately, effective solutions should be high impact, low risk, cost effective and time efficient.<sup>5</sup> The cognitive aid developed at VA Ann Arbor was customized to address routinely collected specimens. It also includes procedures related to tests that demonstrate an increased likelihood for error.

In implementing similar initiatives, a research team must be aware of barriers that would prevent compliance and determine implementation strategies that guarantee comprehension and adherence. The team should also recognize the associated challenges, to include personal, cultural, and social barriers to change, as well as to silos that traditionally exist in hospitals.

The VA Ann Arbor specimen labeling SOP and cognitive aid are just one example of a patient safety initiative that demonstrates the importance of standardization, multi-disciplinary teamwork and local customization – a component that gives the tools a higher utility and makes them more readily accepted.

## References

1. VA employees can contact Cindy Paterson at VA Ann Arbor for a copy of the SOP and/or cognitive aid: [Cynthia.Paterson@va.gov](mailto:Cynthia.Paterson@va.gov)
2. Nolan, T.J. (2000). System changes to improve patient safety. *BMJ*, 320, 771-73.
3. Porto, G. (2001). Safety by design: Ten lessons from human factors research. *Journal of Healthcare Risk Management*, 21(3), 43-50.
4. Jones P., & Nemeth, C. (2005). Cognitive artifacts in complex work. Cai Y. (Ed). *Ambient Intelligence for Scientific Discovery*. Heidelberg: 152-83.
5. Pronovost, P., & Vohr, E. (2010). *Safe patients, smart hospitals: How one doctor's checklist can help us change healthcare from the inside out*. New York: Hudson Street Press.



# 2013 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		
<b>Goal 1 – Improve the accuracy of patient identification</b>							
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
<b>Goal 2 – Improve the effectiveness of communication among caregivers</b>							
X					X	1. Report critical results of tests and diagnostic procedures on a timely basis.	NPSG.02.03.01
<b>Goal 3 – Improve the safety of using medications</b>							
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
<b>Goal 7 – Reduce the risk of health care-associated infections</b>							
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
<b>Goal 9 – Reduce the risk of falls</b>							
	X		X			1. Implement a fall reduction program.	NPSG.09.02.01
<b>Goal 14 – Prevent health care-associated pressure ulcers</b>							
	X					1. Assess and periodically reassess resident risk for pressure ulcers and take actions to address any identified risks.	NPSG.14.01.01
<b>Goal 15 – The organization identifies safety risk inherent to the patient population</b>							
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
<b>Universal Protocol</b>							
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