

The Joint Commission Announces 2014 National Patient Safety Goal

In June 2013, The Joint Commission approved new National Patient Safety Goal NPSG.06.01.01 on clinical alarm safety for **hospitals** and **critical access hospitals**. The box on page 3 displays the new goal and its four elements of performance (EPs). The implementation for NPSG.06.01.01 will occur in two phases:

- In Phase I (beginning January 2014), hospitals will be required to establish alarms as an organization priority and identify the most important alarms to manage based on their own internal situations.
- In Phase II (beginning January 2016), hospitals will be expected to develop and implement specific components of policies and procedures. Education of those in the organization about alarm system management will also be required in January 2016.

The Joint Commission plans to publish the Phase I and II requirements at the same time to provide the field with complete information about the ultimate requirements of NPSG.06.01.01. However, due to changes that could arise from newly emerging evidence about best practices, the field's experience with Phase I requirements, and other developmental work, the Phase II requirements may be enhanced before they are implemented. Any changes to Phase II requirements will be communicated to the field through Joint Commission channels such as field

reviews, *Perspectives*, *Joint Commission Online*, and the *Joint Commission Connect*TM extranet.

In their review of the National Patient Safety Goal, Joint Commission advisory committee members noted that the goal helps focus the field's attention on the safety issue and solutions will be evolving over many years. In fact, The Joint Commission is aware of efforts currently underway that will

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Joint Commission  Requirement	Official Publication of Joint Commission Requirements <h1>National Patient Safety Goal on Alarm Management</h1>
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Effective January 1, 2014

National Patient Safety Goal (NPSG)

NPSG.06.01.01

Improve the safety of clinical alarm systems.

Rationale for NPSG.06.01.01

Clinical alarm systems are intended to alert caregivers of potential patient problems, but if they are not properly managed, they can compromise patient safety. This is a multifaceted problem. In some situations, individual alarm signals are difficult to detect. At the same time, many patient care areas have numerous alarm signals and the resulting noise and displayed information tends to desensitize staff and cause them to miss or ignore alarm signals or even disable them. Other issues associated with effective clinical alarm system management include too many devices with alarms, default settings that are not at an actionable level, and alarm limits that are too narrow. These issues vary greatly among hospitals and even within different units in a single hospital.

There is general agreement that this is an important safety issue. Universal solutions have yet to be identified, but it is important for a hospital to understand its own situation and to develop a systematic, coordinated approach to clinical alarm system management. Standardization contributes to safe alarm system management, but it is recognized that solutions may have to be customized for specific clinical units, groups of patients, or individual patients. This NPSG focuses on managing clinical alarm systems that have the most direct relationship to patient safety. As alarm system management solutions are identified, this NPSG will be updated to reflect best practices.*

* 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 http://www.ecri.org/Forms/Pages/Alarm_Safety_Resource.aspx.

Elements of Performance for NPSG.06.01.01

- A 1.** As of July 1, 2014, leaders establish alarm system safety as a [critical access] hospital priority. **R**
- A 2.** During 2014, identify the most important alarm signals to manage based on the following: **R**
 - Input from the medical staff and clinical departments
 - Risk to patients if the alarm signal is not attended to or if it malfunctions
 - Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue
 - Potential for patient harm based on internal incident history
 - Published best practices and guidelines(For more information on managing medical equipment risks, refer to Standard EC.02.04.01.)
- A 3.** As of January 1, 2016, establish policies and procedures for managing the alarms identified in EP 2 above that, at a minimum, address the following: **R**
 - Clinically appropriate settings for alarm signals
 - When alarm signals can be disabled
 - When alarm parameters can be changed
 - Who in the organization has the authority to set alarm parameters
 - Who in the organization has the authority to change alarm parameters
 - Who in the organization has the authority to set alarm parameters to “off”
 - Monitoring and responding to alarm signals
 - Checking individual alarm signals for accurate settings, proper operation, and detectability(For more information, refer to Standard EC.02.04.03)
- C 4.** As of January 1, 2016, educate staff and licensed independent practitioners about the purpose and proper operation of alarm systems for which they are responsible. **R**

support the field in implementing the second phase of the goal’s requirements. For example, the Association for the Advancement of Medical Instrumentation’s (AAMI) Healthcare Technology Safety Institute (HTSI) is engaged in several activities intended to promote safe alarm system

management, including the following:

- Conducting a survey of hospital practices in setting alarm parameters, followed by a study of alarm parameters
- Posting literature (reviewed in advance by a work group)

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on best practices on alarm system management on the HTSI website at <http://www.aami.org/htsi/alarms/library.html>

- Offering webinars on safe alarm management

ECRI Institute also offers information (such as articles, policies, and webinars) on safely managing alarm systems at http://www.ecri.org/Forms/Pages/Alarm_Safety_Resource.aspx. In addition, The Joint Commission published *Sentinel Event Alert* Issue 50 on alarm management in April 2013 (see May 2013 *Perspectives*, page 1). The *Alert*, which contains sugges-

tions for the field on assessing and managing risks associated with alarms, complements the expectations of the new National Patient Safety Goal on alarm management.

The new goal will appear in the *2013 Update 2* to the *Comprehensive Accreditation Manual* for the hospital and critical access hospital programs as well as their fall 2013 E-dition® updates.

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