R3 Report on new clinical alarm National Patient Safety Goal

The Joint Commission's latest R3 Report explains the rationale and references that were employed in the development of the new NPSG that requires accredited hospitals and critical access hospitals to improve the safety of their clinical alarm systems. The goal addresses clinical alarms that can compromise patient safety if they are not properly managed, including alarms from equipment that have visual and/or auditory components, such as cardiac monitors, IV machines, and ventilators. In general, this does not include items such as nurse call systems, alerts from computerized provider order entry, or other information technology systems. The report highlights activities that led up to the development of the NPSG, including a summit co-convened by The Joint Commission, the Association for the Advancement of Medical Instrumentation, ECRI Institute, the American College of Clinical Engineering, and the Food and Drug Administration.

New measures aim to improve osteoporosis management in hospital patients

Three new performance measures are available to improve the management of hospital patients with osteoporosis-associated fracture. The measures are published in the Osteoporosis-Associated Fracture Measures Implementation Guide and will be presented to the National Quality Forum for consideration for endorsement in 2014. For postmenopausal females in North America, the chances of hip fracture due to osteoporosis are greater than the chances of being diagnosed with breast cancer, uterine cancer, or ovarian cancer combined. The economic and personal tolls of osteoporotic fractures are estimated at more than $18 billion per year. Recognizing the significant impact of this under-treated disease, The Joint Commission embarked on a multi-year project to develop evidence-based performance measures for this patient population under the guidance of a Technical Advisory Panel. Six draft measures underwent testing, resulting in three Osteoporosis-Associated Fracture (OAF) performance measures:

- Laboratory investigation for secondary causes of fracture
- Risk assessment/treatment after fracture
- Discharge instructions - emergency department
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Free parenteral nutrition safety recommendations published by A.S.P.E.N.


"Sustainable, effective implementation of a surgical preprocedural checklist: An "attestation" format for all operating team members" by Allison J. Porter, M.D., et al.

See the new blog posts

"High reliability in healthcare," by Paul M. Schyve, M.D., senior adviser. A report in the Journal of Patient Safety estimates the annual number of patient deaths in U.S. hospitals at closer to 440,000 instead of the 98,000 estimate published by the Institute of Medicine in its 1999 report, "To Err is Human: Building A Safer Health System."

"Blameless or blameworthy errors - does your organization make a distinction?" Ronald M. Wyatt, M.D., M.H.A., medical director, discusses the critical components of a safety culture and why it's crucial to your organization's success.

News links

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