Welcome to the National Patient Safety Goals annual training.

The Joint Commission annually defines and approves a set of National Patient Safety Goals for all accredited organizations. The goals provide defined approaches to help organizations reduce or eliminate significant risks to a patient’s safety. Compliance is mandatory to maintain Joint Commission accreditation.

This course was designed to inform you of The Joint Commission’s National Patient Safety Goals so you can positively impact patient safety.
Upon completion of this course, you will be able to:
• List the Joint Commission’s National Patient Safety Goals (NPSG) requirements, 
• Apply the National Patient Safety Goals in clinical practice, and 
• Identify processes implemented to comply with the National Patient Safety Goals.
All accredited organizations are surveyed for compliance with these goals during random unannounced surveys (RUS), “for cause” surveys, and regular re-accreditation and re-certification surveys.

Each NPSG requirement has specific Implementation Expectations (IE) that must be implemented and consistently practiced by all accredited healthcare organizations. Each requirement is based on evidence-based practice and/or expert recommendations.

Since January 1, 2006, all onsite surveys are unannounced. Onsite surveys are conducted every three years. During a Joint Commission survey, an organization that does not comply with any one of the NPSG requirements will receive a Requirement for Improvement (RFI) during onsite survey for EACH NPSG Implementation Expectation that is not met.
There are several changes from the 2009 to the 2010 National Patient Safety Goals. These changes include the movement of specific goals to the appropriate standards.

The National Patient Safety Goals that have moved to standards include:
- Do Not Use Abbreviations
- Hand Off Communication
- Look Alike/Sound Alike Drugs
- Reducing Harm Due to Falls
- Active Patient Involvement
- Response to Patient Conditions

A National Patient Safety Goal that has been deleted for 2010 is Infections Causing Unanticipated Death and Loss of Function.
In the following section, you will learn more about the 2010 National Patient Safety Goals.
Goal 1: Improve the accuracy of patient identification
- 01.01.01 Patient Identifiers
- 01.03.01 Transfusions

Goal number 1 is to improve the accuracy of patient identification.
To improve the accuracy of patient identification, use two identifiers to verify the patient identity. Both name and date of birth must always be used for the following processes:

- Medication administration
- Blood administration
- Blood draws (no longer driven by medical record number)
- Specimens for clinical testing (these must be labeled in the presence of the patient) and
- Providing treatment or procedures

The two pieces of identifying information are compared between two distinct information sources. Proper use of bar-coding meets the two identifier requirement. The patient needs to be included in the verification process by asking the patient to state their name and date of birth.
The purpose of this goal is to eliminate transfusion errors related to patient misidentification.

Before administering blood or blood products, a two person verification is conducted at the bedside to verify the patient information. At least two unique patient identifiers, such as name and date of birth, should be used to identify the patient.

The two person verification is conducted by staff approved to participate in the process of verifying blood. One person conducting the identification verification must be the qualified staff person that will administer the blood or blood component to the patient. The other person participating in the patient verification process must be qualified to participate in the process.
Goal number 2 is to improve the effectiveness of communication among caregivers.
Critical Test Results and Values

- All critical laboratory, electrocardiogram and diagnostic radiology results are to be:
  - Reported to nursing unit or directly to treating physician
  - Documented on the yellow Critical Value/Result Reporting form and READ BACK
  - Communicated to the licensed caregiver (nurse/physician) who will act on the results
  - Measured related to timeliness of reporting and improved as necessary

When a qualified staff member receives a critical lab value, EKG reading, or x-ray reading, he or she must write the result on the yellow “Critical Value Report” chart form and READ it back, word for word to the person providing the information. Results must be reported to the physician as soon as they are obtained.
Goal number 3 is to improve the safety of using medications.

- 03.04.01 Labeling medications, solutions, and containers
- 03.05.01 Anticoagulation therapy
Labeling includes:
- Drug/solution name
- Strength/amount
- Initials of person preparing solution
- Any medications/solutions found unlabeled are immediately discarded
- All labels verified by 2 qualified individuals whenever person preparing medication/solution is not person administering it
- Date/time prepared and the diluents for IV ad mixtures
- Expiration date/time if not used within 24 hours

All medications, solutions and containers on and off the sterile field in perioperative and other procedural settings need to be labeled even when there is only one medication.

Labeling includes:
- Drug or solution name
- Drug strength and amount
- Initials of person preparing the solution
- Date and time prepared and the diluents for IV ad mixtures
- Expiration date and time when not used within 24 hours

Any medications or solutions found unlabeled are discarded. All labels must be verified by two qualified individuals whenever the person preparing the medication or solution is not the person administering it.
The purpose of this goal is to reduce the likelihood of patient harm associated with the use of anticoagulation therapy. Anticoagulation therapy poses risks to patients and often leads to adverse drug events due to complex dosing, requisite follow up monitoring, and inconsistent patient compliance.

Standardized procedures for anticoagulation therapy that include involvement of the patient can reduce the risk of adverse drug events associated with Heparin and Coumadin. Utilize anticoagulation protocols whenever possible.

Obtain a baseline INR and monitor the INR for subsequent anticoagulation doses. Always use a pump to administer Heparin intravenously or continuously.

When an order for Warfarin is entered into CAPOE, dietary receives electronic notification.

Provide education to patients and families on adverse effects of anticoagulation as well as the importance of follow up monitoring, compliance, dietary restrictions, and medication interactions.
Goal number 7 is to reduce the risk of healthcare-associated infections.
To reduce the risk of healthcare-associated infections, we follow the Centers for Disease Control (CDC) Guidelines and the World Heath Organization Five Moments for Hand Hygiene. The 5 Moments for Hand Hygiene approach defines the key moments when healthcare workers should perform hand hygiene. The approach recommends healthcare workers clean their hands:

- When entering the room and/or before patient contact
- Before clean/aseptic procedures
- After body fluid exposure risk
- After patient contact and/or when leaving the room
- After contact with the patient’s surroundings

The CDC Hand Hygiene Guidelines state that hands must be washed with soap, running water, and friction or an alcohol-based, waterless hand sanitizer upon entering and exiting each patient room. When hands are visibly soiled, they must be washed with soap and water. With a diagnosis of Clostridium difficile, hands must be washed with soap and water.

Healthcare personnel providing direct care to patients may not wear artificial nails, plastic press-on nails or nail wraps.
Gloves may only be worn for one patient and must be removed after caring for that patient.
Healthcare-associated infection (HAI) is a major problem for patient safety, and its surveillance and prevention must be a top priority for hospitals committed to making healthcare safer. HAI’s affect hundreds of millions of patients worldwide every year and is a major cause of death and disability. Cases of patients acquiring viral and bacterial infections such as MRSA, norovirus and Clostridium difficile while receiving healthcare are well documented. Most infections are preventable. Hand hygiene is the primary measure to reduce HAI’s.

Three of the National Patient Safety Goals address healthcare-associated infections which include:
• Multiple-Drug Resistant Organisms
• Central Line-Associated Bloodstream Infections
• Surgical Site Infections

Further, information and details regarding healthcare-associated infections is presented in the accompanying, Prevention of HAI eLearning Module.
Goal number 8 is to accurately and completely reconcile medications across the continuum of care.
Medication Reconciliation

- Obtain patient’s current medication list at point of entry
- Identify and reconcile discrepancies:
  - Within 24 hours of inpatient admission
  - At any time there is a transfer of care
  - At time of discharge
- Document reconciliation
- Provide reconciled list of medications to:
  - Patient at time of discharge
  - Next provider of care
- Include status of patient medications with all patient care hand-offs
- Inform next provider of how to obtain clarification on the list

Medication lists cannot contain Do Not Use Abbreviations or the statement “resume home meds”

Medications must be accurately and completely reconciled across the continuum of care.

You must obtain a patient’s current medication list at the point of entry. Identify and reconcile any discrepancies, including omissions or duplicates, and correct the medication, dose, frequency, route, and/or time. Reconcile this list within 24 hours of inpatient admission, at any time there is a transfer of care, and at time of discharge. In ambulatory settings, reconcile the medication list any time there is a change in medications or a referral to a new provider. Document the reconciliation and communications used to reconcile the medication reconciliation list.

The patient must be given a reconciled list of medications at the time of discharge. The reconciled list must also be provided to the next provider of care. Document that the information was reviewed with the patient and sent to the next provider of care.

Include the status of patient medications with all patient care hand-offs. When a patient is transferred, provide information on how to clarify any questions regarding medications (for example, the name of transferring nurse and phone number).

Medication lists cannot contain Do Not Use Abbreviations or the statement “resume home meds”.
You cannot write an order to resume previous medications for your patients.
In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed. The department obtains and documents an accurate list of current medications and known allergies in order to safely prescribe any specific medications. If no changes are made to the patient’s medications, no list will be provided at discharge. When only short term medications will be prescribed and no changes are made to the patient’s current medication list, the patient is provided with a list containing the short term medication additions that the patient will continue after leaving the hospital. A complete list is provided when there are long term changes, when there are changes to the patient’s current medications or when direct admission from the department to the hospital occurs.
Goal number 15 is for organizations to identify the safety risks inherent in its patient population.
This goal requires that patients who are at risk for suicide are assessed. Any patient with a diagnosis of emotional or behavioral disorders or substance abuse is required to be screened for suicide risk. Screenings will be done in the emergency room and behavioral health and when a patient is admitted to the hospital with a primary diagnosis of emotional/behavioral disorders or substance abuse. Document that the screening and assessment were completed.

If the patient is identified as at risk, psychiatric referral should be obtained and you should consult with psychiatry. Immediately address the safety needs of the patient and provide the patient with Crisis Hotline information. Provide the patient with the appropriate treatment.
The final goal is that the organization meets the expectations of Universal Protocol.
All surgical and invasive procedure areas, including procedures at the bedside, must have a pre-procedure verification process to verify the correct procedure, correct patient, at the current site. The patient needs to be involved in the verification process. This process should be initiated when the procedure is scheduled, for pre-admission testing, and before the patient leaves for the procedure area. Verify patient identification any time responsibility of patient is transferred. You should involve the patient when he or she is awake and aware.
Complete the procedure checklist prior to transfer to the procedure area.
Universal Protocol Site Marking

- Verify site of procedure with the patient
- Site marking needs to be completed for procedures involving laterality, spinal levels, multiple digits/structures, and midline procedures involving laterality
- Site marking is to be completed by physician/proceduralist who will be performing the procedure
- Site marking is done by writing the physician/proceduralist initials at the appropriate site
- Site marking needs to be visible after the patient is draped

Verify the site of the procedure with the patient. Site markings need to be completed for procedures involving laterality, spinal levels, multiple digits or structures, and midline procedures involving laterality. The site marking should be completed by the physician or proceduralist who will be performing the procedure. To mark the site, the physician or proceduralist will write his or her initials at the procedure site. The marking must be visible after the patient is draped.
All surgical, invasive procedure areas and bedside procedures must have a final verification process, or “Time Out”. During the time out, all team members must be present. The entire team pauses and is engaged in the process. Components listed on the checklist are verified and documented. The time out must address patient name, the correct procedure, and correct side or site marked.

A time out is done whenever there is a change in surgical team and for cases where there are two consents completed for the procedure.
What are your responsibilities regarding the National Patient Safety Goals?
You should:
• Be knowledgeable of the National Patient Safety Goals
• Be able to speak to the goals and how to comply
• Be aware of policies involving the National Patient Safety Goals
• Be compliant because it is the right thing to do for your patients, and
• Practice compliance to the National Patient Safety Goals every day
You can find additional resources and information on the National Patient Safety Goals through posters, name tag badges, talking points, and policies located on the LVHN Intranet, and the Joint Commission FAQs.