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.
The National Patient Safety Goals course fulfills the training requirements set by The Joint Commission. The course should take approximately 20 minutes to complete. If you have any questions, please contact the appropriate number listed on this screen. Remember, all technical questions should go to the Help Desk at 610-402-8303.

To review the navigational features of the course, click on the Navigation tab at the top of the screen.
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.

If you feel you have already mastered the content described in the course objectives and would like to demonstrate your knowledge, you may click the “Demonstrate Knowledge” button and move directly to the course test. You must earn a score of at least 80% on the test to successfully pass this course.

However, it is suggested that you review the content as it has been updated. To continue onto the course content, please select the next button located at the bottom of the screen.
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.
In the following section, you will learn more about the 2013 National Patient Safety Goals.
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
- Specimens for clinical testing (these must be labeled in the presence of the patient)
- 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, if able to do so.
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 2: Improve the effectiveness of communication among caregivers

- 02.03.01 Critical Test Results and Values

Goal number 2 is to improve the effectiveness of communication among caregivers.
What do you do with all critical laboratory, electrocardiogram and diagnostic radiology results?
- Report to nursing unit or directly to treating physician.
- Document on the yellow Critical Value/Result Reporting form and READ BACK.
- The nurse will verify laboratory results by reviewing results in Centricity.
- Communicate to the provider who will act on the results.
- Monitor timeliness of reporting to determine areas for improvement.

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 back results, word for word to the person providing the information. The nurse verifies laboratory results by reviewing the results in Centricity. 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
- 03.06.01 Medication Reconciliation
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
- Expiration time if expiration occurs in less than 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 the importance of follow up monitoring, compliance, drug/food interactions, potential for adverse drug reactions and interactions.
It is important to maintain and communicate accurate patient medication information. You must obtain a patient's current medication list at the point of entry. This list includes current medications and those taken on an as-needed basis. 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 and at time of discharge. In ambulatory settings, reconcile the medication list any time there is a change in medications. 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 or at the end of an outpatient encounter if there are medication changes. Explain the importance of managing medication information to the patient when discharged or at the end of a patient encounter. This includes instructing the patient to give a list of medication to the next provider of care and to update the information on the list when medications are discontinued, doses are changed or new medications are added (including OTCs). Document that the information was reviewed with the patient. Include the status of patient medications with all patient care hand-offs.

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.
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 Health 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 (Gel upon entry and exit). 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. Most infections are preventable. Hand hygiene is the primary measure to reduce HAI's.

Four of the National Patient Safety Goals address healthcare-associated infections which include:

- Multiple-Drug Resistant Organisms
- Central Line-Associated Bloodstream Infections
- Surgical Site Infections
- Catheter Associated Urinary Tract Infections

Further information and details regarding healthcare-associated infections is presented in the accompanying, Prevention of HAI eLearning module.
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.
Verify the site of the procedure with the patient. Site markings need to be completed for procedures involving laterality, spinal levels, multiple digits/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. If site marking cannot be placed on skin, or patient refuses, apply a grey wrist band. The physician will indicate site on the wrist band located on limb that is same side as planned procedure.
All surgical, invasive procedure areas and bedside procedures must have a final verification process, or a “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.
You should now be able to:

- List the Joint Commission’s National Patient Safety Goals requirements,
- Apply the NPSG in clinical practice, and
- Identify processes implemented to comply with the NPSG.

If you need to review, you can select the Outline tab and click on any topic. If you are ready to start the final test, click the Test button. You must earn a score of at least 80% on the test to successfully pass this course. If you do not pass on your first attempt, you may go back and try the test again. Good Luck!
Question 1 of 10

Select the two pieces of information that are acceptable to use as identifiers:

- Room number
- Patient name
- Date of birth
- Procedure
Congratulations!
You have successfully completed the National Patient Safety Goals course

You can close this window to exit the course