National Patient Safety Goals
from
The Joint Commission
After completion of this module, participants will be able to:

- List at least five National Patient Safety Goals that are required in a healthcare organization
- Describe how goals apply to the individual’s work role
National Patient Safety Goals at a Glance

- Identification
- Communication
- Reporting Critical Results
- Medication Safety
- Infection Prevention
- Medication Reconciliation
- Prevention of Falls
- Patient Involvement
- Suicide Prevention
- Recognition of Changes in Patient’s Condition
- Universal Protocol
Patient Identification

**Goal:** improve the accuracy of patient identification.

- For patient identification use **two** of the following identifiers
  - name
  - DOB
  - MR#

- The patient’s room number or physical location is **NEVER** an identifier.

Remember that identification of the patient is a **two-step** process
- Knowing and using the two identifiers
- Comparing the identifiers to an official source such as the MAR or an order, etc.
Patient Identification

- Must use 2 patient identifiers when providing care and services. Examples include:
  - Administering Blood
  - Giving medications
  - Performing any treatment or procedures
  - Documenting or filing documents in patient’s record
  - Processing patient orders in the computer
  - Drawing blood or other specimens for clinical testing
  - Labeling Specimens

- Containers used for all types of specimens must be labeled in the presence of the patient.
Effective Communication Among Caregivers

- Communication issues are the #1 cause of sentinel events or disastrous outcomes

- There are four goals that specifically address communication:
  - Verbal and telephone orders
  - Critical tests and critical values
  - Abbreviations
  - Patient hand-offs
When receiving verbal or telephone orders:

- Write down the order.
- “Read back” the complete order.
- Wait for confirmation from the individual who gave the order.

Documentation:

- Record telephone orders as “TORB Dr. Jones/S. Smith RN”.
- Record verbal orders as “VORB Dr. Jones/S. Smith RN”.

Verbal and Telephone Orders
Abbreviations

- Abbreviations can be a source of confusion and error.
- A list of unapproved abbreviations has been established. These abbreviations must not be used in the medical record. (see next slide)
<table>
<thead>
<tr>
<th>Unacceptable Abbreviation</th>
<th>Potential Problem</th>
<th>Preferred Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (for unit)</td>
<td>Mistaken as zero, four or cc.</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>IU (for international unit)</td>
<td>Mistaken as IV (intravenous or 10 (ten).</td>
<td>Write “international unit”</td>
</tr>
<tr>
<td>Q.D., Q.O.D. (Latin abbreviation for once daily and every other day)</td>
<td>Mistaken for each other. The period after the Q can be mistaken for an “I” and the “O” can be mistaken for “I”</td>
<td>Write “daily” and “every other day”</td>
</tr>
<tr>
<td>Trailing zero (X.O. mg), Lack of leading zero (.X mg)</td>
<td>Decimal point is missed.</td>
<td>Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (O.X mg)</td>
</tr>
<tr>
<td>MS MSO4 MgSO4</td>
<td>Confused for one another. Can mean morphine sulfate or magnesium sulfate.</td>
<td>Write “morphine” or “magnesium”</td>
</tr>
<tr>
<td>µg (for microgram)</td>
<td>Mistaken for mg (milligrams) resulting in one thousand-fold dosing overdose.</td>
<td>Write “mcg”</td>
</tr>
<tr>
<td>T.I.W. (for three times a week)</td>
<td>Mistaken for three times a day or twice weekly Resulting in an overdose.</td>
<td>Write “3 times weekly” or “three times weekly”</td>
</tr>
<tr>
<td>A.S., A.D., A.U. (Latin abbreviation for left, right or both ears) O.S., O.D., O.U. (Latin abbreviation for left, right or both eyes)</td>
<td>Mistaken for each other (e.g., AS for OS, AD for OD, AU for OU, etc.)</td>
<td>Write: “left ear,” “right ear” or “both ears;” “left eye,” “right eye,” or “both eyes”</td>
</tr>
</tbody>
</table>
Critical Test Results

- **Critical tests**: Certain test results that must be communicated to the physician every time, normal or abnormal.

- **Critical results**: Results of any test that are considered “panic”. Must be communicated to the physician.

- The two types of results described above
  - must be reported within the timeframe outlined in the organization’s policy.
  - must be reported to a licensed caregiver.

- The provider of the results and the receiver must document the reporting of the results.
Hand-off Communication

- Don’t let patients’ information fall through the cracks!
- **Goal**: provide accurate information about a patient’s care, treatment, and services, current condition and any recent or anticipated changes.
- There must be an opportunity to ask and respond to questions.
- Interruptions in the process should be minimized.
- Examples of hand offs:
  - Shift to shift
  - Physician to physician
  - ED to floor
  - Surgery to PACU to floor

- Tools used for hand off communication may vary from site to site.
Look alike sound alike drugs

- Drug names may look or sound the same, which can be a source of confusion and could lead to possible error.
- A list of look alike sound alike drugs is found on the Tau Net.
- Pharmacy reviews the list annually and adds or removes drugs as needed.
- Steps taken to alert staff to a look alike sound alike drug:
  - TALL MAN lettering
  - **Bold** font
  - Separation of drugs in the ADU
Medication safety

Medication Labeling

- Medications, medication containers, and solutions, both on and off the sterile field, are labeled even if there is only one medication being used.
- Labeling occurs when any medication or solution is transferred from the original packaging to another container.

Labels must include:

- Drug (Medication/Solution name)
- Strength (concentration)
- Amount
- Expiration date (when not used within 24 hours)
- Expiration time (when expiration occurs in less than 24 hours)
**Goal:** maintain an accurate medication list throughout the patient’s visit to prevent errors such as duplicate medication orders, missed medication, etc.

- Create a list of the patient’s current medications at admission/entry.
- Compare the patient’s current medications with those ordered.
- Compare the complete list against new medications ordered for discharge.
- The patient’s medication list is communicated to the next provider of service.
- A complete list of medications is given to the patient upon discharge.
Follow protocols to prevent healthcare associated infections related to:
- Drug resistant organisms
- Central line infections
- Surgical site infections

Most importantly – **clean hands often!**

If you think a patient has been harmed by an infection, report it to your department director.
Prevention of Patient Falls

- Assess patients for risk of falls on admission and/or with a change in condition.
- Educate patients and families about fall risks.
- Take measures to prevent patients from falling (keep items close, frequent or 1:1 observation, frequent rounding).
- Take measures to prevent injuries from falls (low bed, floor mats).
- Sites use symbols to show which patients are at high risk of falling. Please become familiar with the symbols used at the site(s) where you work.
Patient Involvement in Care

- **Goal:** Involve patients and families in their care.
- **Rationale:**
  - Informed patients and families are an important source of information about potential adverse events.
  - Involving patients and families in their care improves outcomes and patient satisfaction.
- **How to involve patients and families:**
  - Inform and encourage patients and families to report safety concerns.
  - Teach patients about hand hygiene, respiratory hygiene, contact isolation (as applicable) and surgery safety (as applicable) (new teaching requirement for 2009)
Prevention of Suicide in the Healthcare Facility

- **Goal:** identify safety risks inherent in its patient population, specifically to identify patients at risk for suicide.

- **Rationale:**
  - Suicide ranks as the eleventh most frequent cause of death in the U.S.
  - Suicide of a patient while in a healthcare facility has been the most frequently reported type of sentinel event to the Joint Commission since 1996.
How do we do this?

- Identify patients at risk based on diagnosis (suicide attempt, mental health diagnosis).
- Address the patient’s immediate safety needs and place patient in most appropriate setting for treatment (1:1 observation).
- Provide information about resources for individuals and family members to use during crisis situations.
Rapid Response Team

**Goal:** Recognize changes in a patient’s condition and obtain assistance in responding to the patient’s situation.

- Medical Response Team available to assist with assessment and interventions.
- Individual process varies from site to site. Please become familiar with the process at your work site.
Universal Protocol

- **Goal:** Prevent wrong site, wrong side, wrong person surgeries or procedures
  - Verification of correct patient, procedure, equipment, etc. before the start of the surgery
  - Site marking by the physician before starting the procedure
  - Time out – all members involved in the case take a brief pause to verify name, procedure, site, etc.

- Universal Protocol applies to bedside procedures too!
Patient Safety Activities at Sites

- Occurrence reporting system for real and near miss situations
- Policies and processes to ensure that safety goals are followed
- Patient Safety Committee that reviews, highlights and educates about patient safety activities on a regular basis
- Committees to review errors that cause serious harm to patients and take steps to prevent reoccurrence
Patient safety belongs to everyone

- Know and follow the National Patient Safety Goals as they apply to your job
- Create a Culture of Patient Safety
  - Correct/report unsafe situations
  - Report occurrences, including near misses
  - Maintain equipment and use in a safe manner