Purpose of the Joint Commission’s NPSG program is to promote specific improvements in patient safety.

The Goals highlight problem areas, describe evidence and provide expert-based solutions.

Focus is on **system-wide solutions**.
National Patient Safety Goals
The NPSG

• Joint Commission provides us with implementation expectations and guidance on how to effectively comply.
  • Each year, the NPSG are revised.

• Again, some National Patient Safety Goals have been incorporated into Standards.
  • As with all Standards – compliance IS EXPECTED. They are included here as a reference, and reminder.

Remember.... COMPLIANCE = PATIENT SAFETY
(Goals 4-6, 10-13 & 16 moved to standards or are not applicable)

**Goal 1:** Improve Accuracy of Patient Identification

**Goal 2:** Improve Effectiveness of Staff Communication

**Goal 3:** Improve Safety of Using Medications

**Goal 7:** Reduce the Risk of Healthcare-Associated Infections

**Goal 8:** Accurately and Completely Reconcile Medications Across the Continuum of Care (will be revised 7/11)

**Goal 9:** Reduce risk of patient harm resulting from Falls

**Goal 15:** Identify Risks in Our Patient Population

**Universal Protocol:** Prevention of Wrong-Site, Wrong-Procedure, and Wrong-Person Surgery
Goal 1

NPSG.01.01.01 - Use at least 2 identifiers when providing care, treatment, and services.

NPSG.01.03.01 - Eliminate transfusion errors related to patient misidentification.
Rationale:

Wrong-patient errors occur in all stages of registration, diagnosis and treatment.

The intent of this goal is two-fold...

- **1st** - to reliably identify the individual as the person for whom the treatment is intended, and
- **2nd** - to match the treatment to that individual.
Use of Two (2) Patient Identifiers

- At BH, the staff use at least two (2) patient identifiers; (patient's name, DOB, admission number)
- The staff will ask the patient their name and DOB, and check the admission number on armband
  - when administering meds, blood, blood components,
  - collecting blood samples and other specimens for clinical testing, and providing treatment.
- The patient's room number or physical location is NOT used as an identifier.
- Label containers used for blood or other specimens in the presence of the patient. (INTER-P-140)
Before initiating a blood or blood component transfusion:

- Match the blood or blood component to the order
- Match the patient to the blood or blood component (Patient Name & Hollister Band verification)
- Use two-person verification

When using a two-person bedside verification process, one person must be the qualified transfusionist who will be administering the blood or component to the patient.

The second person must be qualified to participate in the process. (INTER-P-202 and Nurse-B-140)
Improve the Effectiveness of Communication Among Caregivers

Goal 2
Goal 2: Effective Staff Communication

NPSG.02.01.01 - Readback and Verify telephone or verbal orders
*Now a Standard*

NPSG.02.02.01 - Standardized DNU List
*Now a Standard*

NPSG.02.03.01 - Timeliness of Critical Test and Result Reporting

NPSG.02.05.01 - SHARQ Standardized Hand-off Communication
*Now a Standard*
“...Before taking action on a verbal order, or verbal report of a test result, staff uses a record and “read back” process to verify the information.”

- At BH, the staff receiving verbal or telephone orders **Write** down the order or enter it into a computer and then **Read** it back and **Receive Confirmation** from the individual who gave the order.
  - Read Back and Verify “R & V” (INTER-T-140)
At BH, the staff will not use any unapproved abbreviations in all orders or medication-related documentation.

If any order is unclear, it must be clarified. (INTER-A–100)
# The JC’s “DNU” List

<table>
<thead>
<tr>
<th>Do Not Use</th>
<th>Potential Problem</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (unit)</td>
<td>Mistaken for “0” (zero), the number “4” (four) or “cc”</td>
<td>Write &quot;unit&quot;</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for IV (intravenous) or the number 10 (ten)</td>
<td>Write &quot;International Unit&quot;</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd (daily)</td>
<td>Mistaken for each other</td>
<td>Write &quot;daily&quot;</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d, qod (every other day)</td>
<td>Period after the Q mistaken for &quot;I&quot; and the &quot;O&quot; mistaken for &quot;I&quot;</td>
<td>Write &quot;every other day&quot;</td>
</tr>
<tr>
<td>Trailing zero (X.0 mg)*</td>
<td>Decimal point is missed</td>
<td>Write X mg</td>
</tr>
<tr>
<td>Lack of leading zero (.X mg)</td>
<td></td>
<td>Write 0.X mg</td>
</tr>
<tr>
<td>MS</td>
<td>Can mean morphine sulfate or magnesium sulfate</td>
<td>Write &quot;morphine sulfate&quot;</td>
</tr>
<tr>
<td>MSO₄ and MgSO₄</td>
<td>Confused for one another</td>
<td>Write &quot;magnesium sulfate&quot;</td>
</tr>
</tbody>
</table>

1 Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

*Exception: A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.
Rationale:

Critical results of tests and diagnostic procedures may indicate a life-threatening situation. The goal is to ensure that the patient can be promptly treated...

• 1st – by providing these results to the physician (or responsible clinician)

and

• 2nd – by providing these results within the established time frame.
NPSG.02.03.01
Report Critical Results of Tests and Diagnostic Procedures on a Timely Basis

• Develop **written procedures** for managing critical results:
  • Definition of critical results
  • By whom and to whom critical results are reported
  • Acceptable length of time between the availability and reporting of critical results

• Implement procedures and track timeliness.

• *Critical Results Report Form developed to help track communication.*
  
  *Target is 30 minutes (INTER-C-390)*
• It is a standardized process to receive or share patient information when patient is referred to other providers of care, treatment or services (internal or external). *(INTER-H-112)*

• Hospital’s hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information.
  - *May include patient’s condition, care, treatment, medications, services, and any recent or anticipated changes to any of these.*
Our approach is SHARQ

**S** - Situation (including current medications)

**H** - History

**A** - Assessment

**R** - Recommendations / Results

**Q** - Questions
Goal 3
Goal 3: Safe Use of Medications

NPSG.03.03.01 - Now a Standard
Annually review look alike/sound alike medications.

NPSG.03.04.01 - Label all medications/containers/solutions on and off the sterile field.

NPSG.03.05.01 - Reduce likelihood of patient harm associated with use of anticoagulant therapy.
We review list at least annually for new medications and formulary changes.

We take action to prevent errors involving the interchange of medications on the LASA list. Examples:
- TALLman lettering
- Storage solutions
NPSG.03.04.01
Labeling of All Medications and Medication Containers

Rationale:

Medications or other solutions in unlabeled containers are unidentifiable, and have resulted in tragic errors. Labeling all medications, containers and other solutions is a....

• 1\textsuperscript{st} – risk-reduction activity and
• 2\textsuperscript{nd} – addresses a risk point in the administration of medications in perioperative and other procedural settings.
In perioperative and procedural settings on and off the sterile field, label **ALL** medications and solutions that are not immediately administered, even if only one (1) is used.

Labeling occurs as soon as it is prepared (unless it is immediately administered) and includes:

- medication name, strength, quantity, diluent and volume (if not apparent), expiration date, expiration time (if < 24 hours), and date if > 24 hours.

Verify all labels verbally and visually by two persons qualified to participate in the verification procedure. Immediately discard anything found unlabeled.

All meds, containers and labels reviewed by all staff responsible for med administration. Remove all containers, discard at end of procedure. (INTER-L-120)
Reduce likelihood of harm associated with therapeutic and long-term prophylactic use of anticoagulant therapy

Rationale:

Anticoagulation medications are more likely than others to cause harm due to complex dosing, lack of monitoring, and problems with patient compliance. Better outcomes will be achieved by...

- 1st – Use of protocols for initiation and maintenance, managing food/drug interactions
- 2nd – Educating staff, patients, families
- 3rd – Evaluating, improving and measuring effectiveness of anticoag safety practices.
NPSG.03.05.01

Reduce likelihood of harm associated with therapeutic and long-term prophylactic use of anticoagulant therapy

- Use of:
  - Only oral unit dose, pre-mixed infusions, infusion pumps
  - Established monitoring procedures, including use of INR
  - Approved protocols for initiation and monitoring of anticoagulation therapy.
  - Policies for baseline and ongoing lab tests for heparin, LMW heparin therapies.

- Dietary management of potential food/drug interactions.
- Education to staff, patients, families: importance of follow-up monitoring, compliance, diet, ADR, interactions.
- Evaluating, improving and measuring anticoagulation safety practices.
Reduce the Risk of Health Care-Associated Infections

Goal 7
Goal 7: Reduce Hospital-Acquired Infections

NPSG.07.01.01 - Comply with WHO or CDC hand hygiene guidelines.

NPSG.07.03.01 - Implement evidence-based practices to prevent healthcare-associated infections due to multidrug-resistant organisms.

NPSG.07.04.01 - Implement evidence-based practices to prevent central line-associated bloodstream infections.

NPSG.07.05.01 - Implement evidence-based practices to prevent surgical site infections.
Goal 7:
Reduce the Risk of Healthcare-Acquired Infections

• At BH, alcohol hand cleanser is readily available to staff.
• All employees complete mandatory in-service on hand hygiene. (*P-8-160, HR-8-115 and P-1-145*)
• Initiatives in place to reduce post-operative, central line, and ventilator-associated infections.
• MRSA screening performed on admission to and transfer from ICU.
• Mortality Review Audits include cases of health-care acquired infections.

For Additional Information – Contact Infection Prevention and Control at ext 9544
Reconcile Medications Across the Continuum of Care

Goal 8

(INTER-M-200)
Goal 8: Reconcile Medications Across the Continuum of Care

- On Admission
- During Hospitalization
- At Discharge
Goal 8: Reconcile Medications Across the Continuum of Care

Medication Reconciliation Inter-M-200

NPSG.08.01.01 - Ensure a process exists for comparing the patient's current meds with those ordered while the pt is under the care of the hospital.

NPSG.08.02.01 – When a patient is referred to or transferred from one hospital to another, the patient's most current reconciled list of meds is given to next provider of service.
Goal 8: Reconcile Medications Across the Continuum of Care

NPSG.08.03.01 – When the patient leaves the hospital, a complete and reconciled list of meds is given to the patient, and to family as needed, with instructions and explanation.

NPSG.08.04.01 - In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are used.
Compare patient’s current medications with those ordered while the patient is under the care of the hospital

Rationale:

• Patients are at high risk for harm from adverse drug events when communication about medications is not clear.
  • The chance for communication errors increases whenever individuals involved in a patient’s care change.

• Communicating, making sure it is accurate, and reconciling any differences whenever a change is made are essential to reducing risk of transition-related adverse drug events.
NPSG.08.01.01

Compare patient’s current medications with those ordered while the patient is under the care of the hospital

- Complete list of medications the patient is taking (dose, route and frequency) is created and documented at time patient enters hospital or is admitted. Patient and, as needed, family are involved in creating this list.
- List is compared with medications ordered for the patient, with discrepancies reconciled and documented while patient is under care of hospital.
- When patient care is transferred, current provider informs receiving provider of the up-to-date list and documents the communication. (in all Hand-offs)
Upon transfer of patient to another hospital, the complete reconciled list of medications is communicated to the next provider of service.

**Rationale:**

- Accurate communication of a patient’s reconciled med list reduces risk of transition-related adverse drug events.
- Communication enables the next provider of service to receive thorough knowledge of the patient’s medications and to safely order / prescribe other medications that may be needed.
- Communication is especially important when the patient is transferred to another organization.
Upon transfer of pt to another hospital, the complete reconciled list of medications is communicated to the next provider of service.

- The current list of reconciled medications is provided to the next provider of service, either within or outside the hospital. Communication is documented.
- At the time of transfer, the transferring hospital providers the next provider of service how to obtain clarification on the list of reconciled medications.
When the patient leaves the hospital’s care, a complete reconciled list of medications is given directly to the patient, the patient’s family (as needed) and explained.

Rationale:

- Accurate communication of the patient’s reconciled medication list to the patient and family (as needed) reduces the risk of transition-related adverse drug events.
- A complete knowledge of the patient’s medications is essential for the patient’s primary care provider or next provider of service to manage the ongoing and future care of the patient.
The current list of reconciled medications is provided to and explained to the patient, and as needed, to the family – with documentation of this interaction.

**NOTE:** Patients and families are reminded to discard old lists and update any records with all medical providers or retail pharmacies.
In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed.

**Rationale:**

- A number of patient care settings exist in which medications are not used, used minimally, or are prescribed for a short duration.
- This includes patients discharged from ED, outpt radiology, and ambulatory care. In these settings, obtaining a list of the patient’s known, current medications is still important, however obtaining information on dose, route, and frequency of use is not required.
Modified medication reconciliation can be performed in certain settings where medications are minimally used, or prescribed for short duration.

- If short term medication is prescribed with NO changes made to patient’s current med list, *only the original home med list needs to be given back to the patient*.
- **Full medication reconciliation** is required when:
  - Any new long-term medications are prescribed.
  - There is a prescription change for any of the patient’s current, long-term medications.
  - If the patient is required to be admitted to the hospital directly from the setting for ongoing care.
Goal 9

NPSG.09.02.01 – Now in *Multiple Standards*

The hospital implements a fall reduction program that includes an evaluation of the effectiveness of the program.
The hospital provides patient education and training based upon each patient’s needs and abilities.

- The patient education and training will include fall reduction strategies.
Staff participate in ongoing education and training.

- Staff participate in education and training on fall reduction activities.
- Staff participation is documented.
Hospital collects data to monitor its performance.

- Hospital collects data on the effectiveness of all fall reduction activities.
  - Examples: Number of falls, number and severity of falls with injuries.
Fall Risk Assessment

- At BH, staff conduct a Fall Risk Assessment for all patients.
- Fall Risk Assessment Tool is designed to assist in identification of need and implementation of appropriate precautions to ensure patient safety.

(Mosby Fall Prevention)
The organization identifies safety risks inherent in its patient population

Goal 15
Identify patients at risk for suicide

Rationale:

• Suicide of a patient while in a staffed, round-the-clock setting is a frequently reported type of sentinel event.

• Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.
At BH we have a depression and suicide risk screening tool for use by RNs for patients being treated for emotional or behavioral disorders on Med Surg Units.

- Identify specific patient characteristics and environmental features that may increase or decrease risk for suicide.
- Address patient’s immediate safety needs and most appropriate setting for treatment.
- Provision of suicide prevention information on discharge.

Identification of Patients at Risk for Suicide Outside of Behavioral Health Services (NURS-S-200.)
Improve recognition and response to changes in a patient’s condition

Goal 16
Improve recognition and response to changes in a patient’s condition

- Early response to changes in a patient's condition by specially trained individuals may reduce cardiopulmonary arrest and patient mortality.
- Hospital has a process for recognizing and responding as soon as a patient's condition appears to be worsening.
- Based on the hospital’s early warning criteria, staff seek additional assistance when they have concerns about a patient's condition.
- Patients and families are informed how to seek assistance when they have concerns about a patient's condition.
Rapid Response Team

At Bloomington Hospital we have a Rapid Response Team:
- Telemetry / Critical Care Nurse
- Respiratory Therapist

Additional Assistance available from
- Hospitalist/ED Physician
- Pharmacist
- (INTER-R - 110)
Universal Protocol

UP.01.01.01 - Conduct a pre-procedure verification process.

UP.01.02.01 - Mark the procedure site.

UP.01.03.01 - A time-out is performed immediately prior to starting procedures.
“Time-Out” for Patient Identification

At BH, staff is to conduct a final verification process, “time-out”, immediately prior to a procedure to confirm the correct patient, procedure and site, using active communication by members of the staff involved in the procedure.  (INTER-U-140)

For additional information contact the Surgical Services Project Manager at ext 9325
Healthcare Safety is Constantly Evolving

At IUH Bloomington, we must challenge ourselves continually to seek safer and more effective methods of providing care to our patients.

Because it’s ABSOLUTELY the right thing to do!