National Patient Safety Goals 2025

Improve Patient Safety

What are they important?

- National Patient Safety Goals (NPSG) focus on problems in Health Care Safety and how to solve them.
- Every Healthcare site that is Joint Commission Accredited must comply
- Evidence of compliance is in policy and procedure or processes put in place – Elements of Performance
- NPSG support and promote *Patient Safety*

There are National Safety Goals for all types of healthcare settings; in this resource we discuss primarily the hospital goals. Review the goals for other types of facilities on the attached handout or at https://www.jointcommission.org/standards/national-patient-safety-goals/

History of NPSG…

- The Joint Commission implemented the first set of National Patient Safety Goals in January 1, 2003.

Accreditation is dependent on compliance to these NPSG

- Compliance is seen in Elements of Performance.

Identify patients correctly – Improve the accuracy of patient identification

Use at least two ways to identify patients. For example, use the patient's name *and* date of birth.

Rationale: Make sure that the *right* patient gets the *correct* medicine and treatment.

Improve the effectiveness of staff communication

Report critical results of tests and diagnostic procedures on a timely basis

Rationale:

Critical results of tests and diagnostic procedures fall significantly outside the normal range and may indicate a life-threatening situation. The objective is to provide the responsible licensed caregiver these results within an established time frame so that the patient can be promptly treated.

Improve the safety of using medications

This NPSG speaks to safety of medications in various areas:

- Medication labeling in Peri-operative and Procedural areas
- Reducing patient harm with the use of anticoagulant therapy
- Medication Reconciliation - Maintain and communicate accurate patient medication information

Improve the safety of using medications – Labeling in Peri-op and Procedural Areas

Label all medications, medication containers (Including syringes, medicine cups and basins), and other solutions on and off the sterile field in perioperative and other procedural settings.

Rationale:

Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. The labeling of all medications, medication containers, and other solutions is a risk-reduction activity consistent with safe medication management.

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Improve the safety of using medications - Reducing patient harm with the use of anticoagulant therapy

Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

Rationale:

Anticoagulation therapy can be used as therapeutic treatment for several conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implant. However, it is important to note that anticoagulant medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance.

To achieve better patient outcomes, patient education is a vital component of an anticoagulation therapy program. Effective anticoagulation education includes face-to-face interaction with a trained professional who works closely with patients to be sure that they understand the risks involved with anticoagulation therapy and the precautions they need to take. The use of standardized practices for anticoagulation therapy that include patient involvement can reduce the risk of adverse drug events associated with heparin (unfractionated), low molecular weight heparin, warfarin, and direct oral anticoagulants (DOACs).

Improve the Safety of using medications-

Maintain and communicate accurate patient medication information-

Medication Reconciliation

Introduction to Medication Reconciliation

In medication reconciliation, a clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolves any discrepancies.

It can be difficult to obtain a complete list from every patient in an encounter, and accuracy is dependent on the patient's ability and willingness to provide this information.

A good faith effort to collect this information is recognized as meeting the intent of the requirement.

Safety of using medications- Maintain and communicate accurate patient medication information- *Medication Reconciliation*

Rationale:

There is evidence that medication discrepancies can affect patient outcomes. Medication reconciliation is intended to identify and resolve discrepancies—it is a process of comparing the medications a patient is taking (or should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose.

Use alarms safely – reduce the harm associated with clinical alarm systems

Make improvements to ensure that alarms on medical equipment are heard and responded to on time.

Rationale:

Clinical alarm systems are intended to alert caregivers of potential patient problems, but if they are not properly managed, they can compromise patient safety. This is a multifaceted problem. In some situations, individual alarm signals are difficult to detect. At the same time, many patient care areas have numerous alarm signals and the resulting noise and displayed information tends to desensitize staff and cause them to miss or ignore alarm signals or even disable them. Other issues associated with effective clinical alarm system management include too many devices with alarms, default settings that are not at an actionable level, and alarm limits that are too narrow. These issues vary greatly among hospitals and even within different units in a single hospital.

It is important for a hospital to understand its own situation and to develop a systematic, coordinated approach to clinical alarm system management. Standardization contributes to safe alarm system management, but it is recognized that solutions may have to be customized for specific clinical units, groups of patients, or individual patients.

Reduce the risk of Healthcare - Associated Infections

Rationale:

Promote compliance with the World Health Organization (WHO) or Centers for Disease Control and Prevention (CDC)hand hygiene guidelines will reduce the transmission of infectious agents by staff to patients, thereby decreasing the incidence of Hospital Acquired Infections (HAIs). To ensure compliance an organization should assess its compliance with the CDC and/or WHO guidelines through a comprehensive program that provides a hand hygiene policy, fosters a culture of hand hygiene, monitors compliance, and provides feedback

Elements of Performance:

- ✓ Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) or the current World Health Organization (WHO) hand hygiene guidelines.
- ✓ Set goals for improving compliance with hand hygiene guidelines.
- ✓ Improve compliance with hand hygiene guidelines based on established goals.

The Healthcare Organization identifies safety risks inherent risk in its patient population

Reduce the risk for suicide.

**Note: EPs 2–7 apply to patients in psychiatric hospitals or patients being evaluated or treated for behavioral health conditions as their primary reason for care. In addition, EPs 3–7 apply to all patients who express suicidal ideation during the course of care.*

Rationale:

Suicide of a patient while in a staffed, round-the-clock care 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.

Universal Protocol- Prevent Wrong Person, Wrong-site, wrong procedure surgery

The Universal Protocol applies to all surgical and nonsurgical invasive procedures. Evidence indicates that procedures that place the patient at the most risk include those that involve general anesthesia or deep sedation, although other procedures may also affect patient safety. Hospitals can enhance safety by correctly identifying the patient, the appropriate procedure, and the correct site of the procedure.

The Universal Protocol is based on the following principles:

- ***Wrong-person, wrong-site, and wrong-procedure surgery can and must be prevented. A robust approach using multiple, complementary strategies is necessary to achieve the goal of always conducting the correct procedure on the correct person, at the correct site.**
- ***Active involvement and use of effective methods to improve communication among all members of the procedure team are important for success.**
- ***To the extent possible, the patient and, as needed, the family are involved in the process.**
- ***Consistent implementation of a standardized protocol is most effective in achieving safety.**

The Universal Protocol is implemented most successfully in hospitals with a culture that promotes teamwork and where all individuals feel empowered to protect patient safety. The three components of the Universal Protocol are not necessarily presented in chronological order (although the pre-procedure verification and site marking precede the final verification in the time-out). Pre-procedure verification, site marking, and the timeout procedures should be as consistent as possible throughout the hospital.

Prevent mistakes in surgery

Conduct a pre-procedure verification process - Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.

Rationale:

Hospitals should always make sure that any procedure is what the patient needs and is performed on the right person

The pre-procedure verification is an ongoing process of information gathering and confirmation. The purpose of the pre-procedure verification process is to make sure that all relevant documents and related information or equipment are as follows:

* Available prior to the start of the procedure
* Correctly identified, labeled, and matched to the patient's identifiers
* Reviewed and are consistent with the patient's expectations and with the team's understanding of the intended patient, procedure, and site

Prevent mistakes in surgery

Mark the correct place on the patient's body where the surgery is to be done.

Rationale:

Marking the procedure site is one way to protect patients; patient safety is enhanced when a consistent marking process is used throughout the hospital. Site marking is done to prevent errors when there is more than one possible location for a procedure.

Examples include different limbs, fingers and toes, lesions, level of the spine, and organs.

Prevent mistakes in surgery

A time-out, pause, is performed before the procedure to make sure that a mistake is not being made.

Rationale:

The purpose of the time-out is to conduct a final assessment that the correct patient, site, and procedure are identified. This requirement focuses on those minimum features of the time-out. During a time-out, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site, and procedure.

A designated member of the team initiates the time-out and it includes active communication among allrelevant members of the procedure team.

The procedure is not started until all questions or concerns are resolved. The time-out is most effective when it is conducted consistently across the hospital.