National Patient Safety Goals from The Joint Commission

Wheaton Franciscan Healthcare

Objectives

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

Verbal and Telephone Orders

- 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".

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)

Unacceptable Abbreviation	Potential Problem	Preferred Term
U (for unit)	Mistaken as zero, four or cc.	Write “unit”
IU (for international unit)	Mistaken as IV (intravenous or 10 (ten).	Write “international unit”
Q.D., Q.O.D. (Latin abbreviation for once daily and every other day)	Mistaken for each other. The period after the Q can be mistaken for an “I” and the “O” can be mistaken for “I”	Write “daily” and “every other day”
Trailing zero (X.O. mg), Lack of leading zero (.X mg)	Decimal point is missed.	Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (O.X mg)
MS MSO4 MgSO4	Confused for one another. Can mean morphine sulfate or magnesium sulfate.	Write “morphine” or “magnesium”
µg (for microgram)	Mistaken for mg (milligrams) resulting in one thousand-fold dosing overdose.	Write “mcg”
T.I.W. (for three times a week)	Mistaken for three times a day or twice weekly Resulting in an overdose.	Write “3 times weekly” or “three times weekly”
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)	Mistaken for each other (e.g., AS for OS, AD for OD, AU for OU, etc.)	Write: “left ear,” “right ear” or “both ears;” “left eye,” “right eye,” or “both eyes”

Critical Test Results

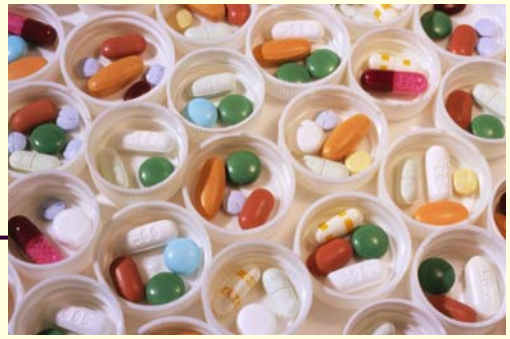
- **Critical tests**: Certain test results that must be communicated to the physician every time, normal or abnormal.
- **Critical results**: Results of any test that are considered “panic”. Must be communicated to the physician.
- The two types of results described above
  - must be reported within 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.

Medication safety



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)

Medication Reconciliation

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.

Reduce Healthcare Associated Infections

- 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

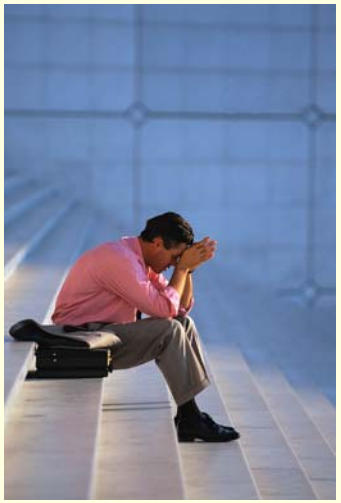
- Assess patients for risk of falls on admission and/or with a change in condition.
- Educate patients and families about fall risks.
- Take measures to prevent patients from falling (keep items close, frequent or 1:1 observation, frequent rounding).
- Take measures to prevent injuries from falls (low 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.

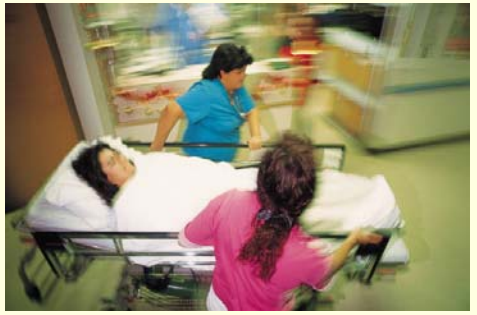


How do we do this?

- 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.



Wheaton Franciscan Healthcare

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