



National Patient Safety Goals 2010 for Hospitals

Allied, Nursing and Non-Licensed Personnel Inservice

Inservice = 1 Credit Hour

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Please review the material, sign the acknowledgement form
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National Patient Safety Goals 2010 for Hospitals

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***Non Licensed Personnel are required to review only the following goals:**

Goal 1, Goal 7, Goal 15, and Universal Protocol

Allied and Nursing Personnel are required to review all goals.

National Patient Safety Goals 2010 for Hospitals

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems involving healthcare safety and how to solve them.

Goal 1

Improve the accuracy of patient identification.

Use at least two (2) patient identifiers when providing care, treatment, and services.

Wrong-patient errors occur in virtually all stages of diagnosis and treatment. The intent for this goal is two-fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual. Acceptable identifiers may be the individual's name, an assigned identification number, telephone number, or other person-specific identifier.

Demonstration of Compliance to Goal #1 Includes:

1. Use at least two (2) patient identifiers when administering medications.
2. Use at least two (2) patient identifiers when administering blood, or blood components.
3. Use at least two (2) patient identifiers when collecting blood samples.
4. Use at least two (2) patient identifiers when collecting other specimens for clinical testing.
5. Use at least two (2) patient identifiers when providing treatments or procedures.
6. The patient's room number or physical location is not used as an identifier.
7. Label containers used for blood and other specimens in the presence of the patient

Goal 2

Improve the effectiveness of communication among caregivers.

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

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.

Demonstration of Compliance to Goal #2 includes:

1. Develop written procedures for managing the critical results of tests and diagnostic procedures that address the following:
 - The definition of critical results of tests and diagnostic procedures
 - By whom and to whom critical results of tests and diagnostic procedures are reported

- The acceptable length of time between the availability and reporting of critical results of tests and diagnostic procedures
- 2. Implement the procedures for managing the critical results of tests and diagnostic procedures.
- 3. Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.

Goal 3

Improve the safety of using medications.

Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

Note: Medication containers include syringes, medicine cups, and basins.

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. This unsafe practice neglects basic principals of safe medication management, yet it is routine in many organizations.

The labeling of all medications, medication containers, and other solutions is a risk-reduction activity consistent with safe medication management. This practice addresses a recognized risk point in the administration of medications in perioperative and other procedural settings. Labels for medications and medication containers are also addressed at MM.05.01.09.

Demonstration of Compliance to Goal #3 includes:

1. In perioperative and other procedural settings, both on and off the sterile field, label medications and solutions that are not immediately administered. This applies even if there is only one medication being used.
Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.
2. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.
3. In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following:
 - Medication name
 - Strength
 - Quantity
 - Diluent and volume (if not apparent from the container)
 - Preparation date
 - Expiration date when not used within 24 hours
 - Expiration time when expiration occurs in less than 24 hours

Note: The date and time are not necessary for short procedures, as defined by the hospital.

4. Verify all medication or solution labels both verbally and visually. Verification is done by two (2) individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.
5. Label each medication or solution as soon as it is prepared, unless it is immediately administered.

Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.

6. Immediately discard any medication or solution found unlabeled.
7. Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.

Note: This does not apply to multiuse vials that are handled according to infection control practices.

8. All medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting staff responsible for the management of medications.

Goal 7

Reduce the risk of healthcare associated infections.

Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.

According to the Centers for Disease Control and Prevention, each year, millions of people acquire an infection while receiving care, treatment, and services in a healthcare organization. Consequently, healthcare-associated infections (HAIs) are a patient safety issue affecting all types of healthcare organizations. One of the most important ways to address HAIs is by improving the hand hygiene of healthcare staff. 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 HAIs. To ensure compliance with this National Patient Safety Goal, 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, and monitors compliance and provides feedback.

Demonstration of Compliance to Goal #7 includes:

1. 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.
2. Set goals for improving compliance with hand hygiene guidelines.
3. Improve compliance with hand hygiene guidelines based on established goals.

Implement evidence-based practices to prevent healthcare-associated infections due to multi-drug resistant organisms in acute care hospitals.

Note: This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), and multidrug-resistant gram-negative bacteria.

Patients continue to acquire healthcare-associated infections at an alarming rate. Risks and patient populations, however, differ between hospitals. Therefore, prevention and control strategies must be tailored to the specific needs of each hospital based on its risk assessment. The elements of performance for this requirement are designed to help reduce or prevent healthcare-associated infections from epidemiologically important multidrug-resistant organisms (MDROs).

Note: Hand hygiene, contact precautions, as well as cleaning and disinfecting patient care equipment and the patient's environment are essential strategies for preventing the spread of healthcare associated infections.

Demonstration of Compliance to Goal #7 includes:

1. Conduct periodic risk assessments (in time frames defined by the hospital) for multidrug-resistant organism acquisition and transmission.
2. Based on the results of the risk assessment, educate staff and licensed independent practitioners about healthcare-associated infections, multi-drug resistant organisms, and prevention strategies at hire and annually thereafter.
3. Educate patients, and their families as needed, who are infected or colonized with a multidrug-resistant organism about healthcare-associated infection strategies.
4. Implement a surveillance program for multidrug-resistant organisms based on the risk assessment.
5. Measure and monitor multidrug-resistant organism prevention processes and outcomes, including the following:
 - Multidrug-resistant organism infection rates using evidence-based metrics
 - Compliance with evidence-based guidelines or best practices
 - Evaluation of the education program provided to staff and licensed independent practitioners
6. Provide multidrug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.
7. Implement policies and practices aimed at reducing the risk of transmitting multidrug-resistant organisms. These policies and practices meet regulatory requirements and are aligned with evidence-based standards.
8. When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients with multidrug-resistant organisms.
9. When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multidrug-resistant organisms.

Implement evidence-based practices for preventing surgical site infections.

Demonstration of Compliance to Goal #7 includes:

1. Educate staff and licensed independent practitioners involved in surgical procedures about surgical site infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in surgical procedures is added to an individual's job responsibilities.
2. Educate patients, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention.
3. Implement policies and practices aimed at reducing the risk of surgical site infections.
4. As part of the effort to reduce surgical site infections:
 - Conduct periodic risk assessments for surgical site infections in a time frame determined by the hospital.
 - Select surgical site infection measures using best practices or evidence-based guidelines.
 - Monitor compliance with best practices or evidence-based guidelines.
 - Evaluate the effectiveness of prevention efforts.
5. Measure surgical site infection rates for the first thirty (30) days following procedures that do not involve inserting implantable devices and for the first year following procedures involving implantable devices. The hospital's measurement strategies follow evidence-based guidelines.
6. Provide process and outcome (for example, surgical site infection rate) measure results to key stakeholders.
7. Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to evidence-based best practices.
8. When hair removal is necessary, use clippers or depilatories.
Note: Shaving is an inappropriate hair removal method.

Goal 8

Accurately and completely reconcile medications across the continuum of care.

A process exists for comparing the patient's current medications with those ordered for the patient while under the care of the hospital.

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 about the medication list, making sure it is accurate, and reconciling any discrepancies whenever new medications are ordered or current medications are adjusted are essential to reducing the risk of transition-related adverse drug events.

Demonstration of Compliance to Goal #8 includes:

1. At the time the patient enters the hospital or is admitted, a complete list of the medications the patient is taking at home (including dose, route, and frequency) is created and documented. The patient and, as needed, the family are involved in creating this list.
2. The medications ordered for the patient while under the care of the hospital are compared to those on the list created at the time of entry to the hospital or admission.
3. Any discrepancies (that is, omissions, duplications, adjustments, deletions, additions) are reconciled and documented while the patient is under the care of the hospital.
4. When the patient's care is transferred within the hospital (for example, from the ICU to a floor), the current provider(s) informs the receiving provider(s) about the up-to-date reconciled medication list and documents the communication.

Note: Updating the status of a patient's medications is also an important component of all patient care hand-offs.

In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed.

Note: This requirement does not apply to hospitals that do not administer medications. It may be important for healthcare organizations to know which types of medications their patients are taking because these medications could affect the care, treatment, and services provided.

A number of patient care settings exist in which medications are not used, are used minimally, or are prescribed for only a short duration. This includes areas such as the emergency department, urgent and emergency care, convenient care, office-based surgery, outpatient radiology, ambulatory care, and behavioral healthcare. In these settings, obtaining a list of the patient's original, known, and current medications that he or she is taking at home is still important; however, obtaining information on the dose, route, and frequency of use is not required.

Demonstration of Compliance to Goal #8 includes:

1. The hospital obtains and documents an accurate list of the patient's current medications and known allergies in order to safely prescribe any setting-specific medications (for example, intravenous contrast media, local anesthesia, antibiotics) and to assess for potential allergic or adverse drug reactions.
2. When only short-term medications (for example, a pre-procedure medication or a short-term course of an antibiotic) will be prescribed and no changes are made to the patient's current medication list, the patient and, as needed, the family are provided with a list containing the short-term medication additions that the patient will continue after leaving the hospital.
3. In these settings, a complete, documented medication reconciliation process is used when:
Any new long-term (chronic) medications are prescribed.
4. In these settings, a complete, documented medication reconciliation process is used when:
There is a prescription change for any of the patient's current, known long-term medications.
5. In these settings, a complete, documented medication reconciliation process is used when:
The patient is required to be subsequently admitted to an organization from these settings for ongoing care.

6. When a complete documented medication reconciliation is required in any of these settings, the complete list of reconciled medications is provided to the patient, and their family as needed, and to the patient's known primary care provider or original referring provider of a known next provider of service.

Goal 15

The hospital identifies safety risks inherent in its patient population.

Identify patients at risk for suicide.

Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

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 healthcare organization is an important step in protecting these at-risk individuals.

Demonstration of Compliance to Goal #15 includes:

1. Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.
2. Address the patient's immediate safety needs and most appropriate setting for treatment.
3. When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as crisis hotline) to the patient and his or her family.

Introduction to the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person 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. A hospital should consider its culture when designing processes to meet the Universal Protocol. In some hospitals, it may be necessary to be more prescriptive on certain elements of the Universal Protocol or to create processes that are not specifically addressed within these requirements.

Hospitals should identify the timing and location of the pre-procedure verification and site marking based on what works best for their own unique circumstances. The frequency and scope of the pre-procedure verification will depend on the type and complexity of the procedure. The three (3) components of the Universal Protocol are not necessarily presented in chronological order (although the pre-procedure verification, site marking, and the time-out procedures should be as consistent as possible throughout the hospital).

Note: Site marking is not required when the individual doing the procedure is continuously with the patient from the time of the decisions to do the procedure through to the performance of the procedure.

Universal Protocol

Conduct a preprocedure verification process.

Hospitals should always make sure that any procedure is what the patient needs and is performed on the right person. The frequency and scope of the verification process will depend on the type and complexity of the procedure.

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

- 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.

Preprocedure verification may occur at more than one time and place before the procedure. It is up to the hospital to decide when this information is collected and by which team member, but it is best to do it when the patient can be involved. Possibilities include the following:

- When the procedure is scheduled
- At the time of preadmission testing and assessment
- At the time of admission or entry into the facility for a procedure
- Before the patient leaves the preprocedure area or enters the procedure room

Missing information or discrepancies are addressed before starting the procedure.

Demonstration of Compliance to Goal #15 includes:

1. Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site.

Note: The patient is involved in the verification process when possible.

2. Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following:
 - Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment)
 - Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed
 - Any required blood products, implants, devices, and/or special equipment for the procedure

Note: The expectation of this element of performance is that the standardized list is available and is used consistently during the preprocedure verification. It is not necessary to document that the standardized list was used for each patient.

3. Match the items that are to be available in the procedure area to the patient.

Wrong site surgery should never happen. Yet it is an ongoing problem in healthcare that compromises patient safety. 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. In cases where bilateral structures are removed (such as tonsils or ovaries) the site does not need to be marked.

Responsibility for marking the procedure site is a hotly debated topic. One position is that since the licensed independent practitioner is accountable for the procedure, he or she should mark the site. Another position is that other individuals should be able to mark the site in the interests of work flow and efficiency.

There is no evidence that patient safety is affected by the job function of the individual who marks the site. The incidence of wrong-site surgery is low enough that it is unlikely that valid data on this subject will ever be available. Furthermore, there is no clear consensus in the field on who should mark the site. Rather than remaining silent on the subject of site marking, The Joint Commission sought a solution that supports the purpose of the site mark. The mark is a communication tool about the patient for members of the team. Therefore, the individual who knows the most about the patient should mark the site. In most cases, that will be the person performing the procedure.

Recognizing the complexities of the work processes supporting invasive procedures, The Joint Commission believes that delegation of site marking to another individual is acceptable in limited situations as long as the individual is familiar with the patient and involved in the procedure. These include:

- Individuals who are permitted through a residency program to participate in the procedure
- A licensed individual who performs duties requiring collaborative or supervisory agreements with a licensed independent practitioner. These individuals include advanced practice registered nurses (APRNs) and physician assistants (PAs).

The licensed independent practitioner remains fully accountable for all aspects of the procedure even when site marking is delegated.

Mark the procedure site.

Demonstration of Compliance to Goal #15 includes:

1. Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.
Note: For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intra-operative imaging techniques may be used for locating and marking the exact vertebral level.
2. Mark the procedure site before the procedure is performed and, if possible, with the patient involved.
3. The procedure site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications:
 - An individual in a medical residency program who is being supervised by the licensed independent practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed.
 - A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed independent practitioner performing the procedure (that is, an advanced practice registered nurse (A.P.R.N.) or physician assistant (P.A.)); who is familiar with the patient; and who will be present when the procedure is performed.
4. The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital.

Note: The mark is made at or near the procedure site and is sufficiently permanent to be visible after skin preparation and draping. Adhesive markers are not the sole means of marking the site.

5. A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum).

Note: Examples of other situations that involve alternative processes include:

- Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice
- Interventional procedure cases for which the catheter/instrument insertion site is not predetermined (for example, cardiac catheterization, pacemaker insertion)
- Teeth
- Premature infants, for whom the mark may cause a permanent tattoo

A time-out is performed before the procedure.

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. Some believe that it is important to conduct the time-out before anesthesia for several reasons, including involvement of the patient. A hospital may conduct the time-out before anesthesia or may add another time-out at that time. 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 all relevant 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.

Demonstration of Compliance to Goal #15 includes:

1. Conduct a time-out immediately before starting the invasive procedure or making the incision.
2. The time-out has the following characteristics:
 - It is standardized, as defined by the hospital.
 - It is initiated by a designated member of the team.
 - It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning.
3. When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated.
4. During the time-out, the team members agree, at a minimum, on the following:
 - Correct patient identity
 - The correct site
 - The procedure to be done
5. Document the completion of the time-out



National Patient Safety Goals 2010 for Hospitals

Inservice Acknowledgement

I have received and reviewed the National Patient Safety Goals

Employee Name: _____
Print Name

Employee Signature: _____

Authorized Agency Signature: _____

Name: _____
Print Name

Title: _____

Date: _____