**Joint Commission's (JC) National Patient Safety Goals (NPSG)**

The Joint Commission (JC)

- An independent, not-for-profit organization
- Founded in 1951
- The nation's oldest and largest standards-setting and accrediting body in health care
- Evaluates and accredits more than 20,000 health care organizations and programs in the United States
- Accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards
- Mission: To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.
- Vision: All people always experience the safest, highest quality, best-value health care across all settings.
- To earn and maintain The JC's Gold Seal of Approval™, an organization must undergo an on-site survey by a JC survey team at least every three years

Benefits of JC Accreditation and Certification

- Help organize and strengthen patient safety efforts
- Strengthens community confidence in the quality and safety of care, treatment and services
- Provides a competitive edge in the marketplace
- Improves risk management and risk reduction
- May reduce liability insurance costs
- Provides education to improve business operations
- Provides professional advice and counsel, enhancing staff education

The purpose of the JC NPSG is to **promote specific improvements in patient safety**

What if institutions don't comply?

- Failure to demonstrate compliance with JC directives will result in a **Type 1 recommendation**, the most serious action the Commission can take
- Can lead to a loss of accreditation for the institution
- Would impact reimbursement of services and hence financial viability of the institution
- Public Disclosure of Compliance with Standards and the NPSG
- www.qualitycheck.org, launched in 1996, allows consumers to:
    - Search for accredited and certified organizations
    - Find organizations by type of service provided within a geographic area
    - Hospital performance measure results

National Patient Safety Goals

- Purpose: improve patient safety, making goals focused on problems in health are safety and how to solve them
- Gaps in numbering indicate a goal is not applicable to the institution or has been "retired".
- Allowing gaps in numbering assures the goal always has the same number, and thus can be tracked more easily.
- Change Yearly
- The first NPSG's were developed by The JC in July 2002
- The Patient Safety Advisory Group advises The JC on the development and updating of NPSGs

Patient Safety Advisory Group

- Comprised of a panel of widely recognized patient safety experts, including nurses, physicians, pharmacists, risk managers, clinical engineers, and other professionals with hands-on experience in addressing patient safety issues in a wide variety of healthcare settings

- Advises The JC how to address emerging patient safety issues in NPSGs, *Sentinel Event Alerts*, standards and survey processes, performance measures, educational materials, and Center for Transforming Healthcare projects

How patient safety goals are chosen

- Chosen from a larger pool of safety goals identified by the JC Sentinel Event Advisory Group
- **Must meet specific selection criteria:**
  - **Have potential for immediate improvement**
  - **Evidence based or by expert consensus**
  - **Practical, cost-effective, and well defined enough to be actionable**

**Sentinel Event: an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.**

- Potassium chloride
- Wrong site surgery
- Suicide
- Restraint deaths
- Infant abductions
- Transfusion errors
- High alert medications
- Op/post-op complications
- Fatal falls
- Infusion pumps
- Home fires ($O_2$ therapy)
- Kernicterus
- Look-alike, sound alike drugs
- Medical gas mix-ups
- Needles & sharps injuries
- Dangerous abbreviations
- Ventilator-related events
- Delays in treatment
- Bed rail deaths & injuries
- Nosocomial infections
- Surgical fires
- Perinatal death and injury
- Anesthesia awareness
- Patient controlled analgesia
- Vincristine administration errors

**National Patient Safety Goals:**

1. **Identifies patients correctly**
2. **Improve staff communication**
3. **Uses medicines safely**
4. **Uses alarms safely**
5. **Prevent infection**
6. **Identify patient safety risks**

- Identifies patients correctly
  - Two patient identifiers (NPSG 01.01.01)
    - Name and DOB
    - Matching correct service or tx to appropriate individual
- Improve staff communication
  - Report critical results and diagnostic procedures on timely basis (NPSG 02.03.01)
    - Within 45 minutes at Beebe
    - Promote timely tx to pt in possible life-threatening situation
      - i.e. ICH, PE, Pneumothorax, abnormal lab value (K+ 2.0, TNI >.03, BS >400)

- Uses medicines safely
  - Before a procedure, label medicines that are unlabeled (NPSG 03.04.01)
    - I.E. syringes, cups, basins
    - Prevent errors due to unlabeled solutions/medicines
    - **All personal medications must be verified by pharmacy prior to administration**
      - **Ensure patient has order**
        - I.E. birth control, medication not carried by hospital pharmacy, vitamins
  - Reduce the likelihood of patient harm associated with the use of anticoagulant therapy (03.05.01)

        - Prefilled/ premixed
            - Programmable pump for IV Heparin
        - Follow protocol
        - Baseline INR for new Coumadin starts
        - Programmable pumps for IV Heparin
        - Educate patient, family, healthcare staff
            - i.e: importance on follow-up, compliance, drug-food interactions, adverse rxn

    - Maintain and communicate accurate patient medication information (03.06.01)
        - Be thorough on initial medication list
        - Compare orders vs. routine meds to resolve discrepancies
        - Med Rec on d/c
- Uses alarms safely
    - Ensure that alarms on medical equipment are heard and responded to (NPSG 06.01.01)
        - Difficult to detect
        - Alarm fatigue
        - Noncompliant with use
        - **Personal equipment brought in by patient must be inspected by BioMed before use in the hospital**
            - I.E. personal CPAP machine
- Prevent infection
    - Comply with CDC or WHO hand hygiene guidelines (NPSG 07.01.01)
        - Prevent Healthcare associated infections (HAI)
    - Use proven guidelines to prevent infections (multi-drug resistant organisms) (NPSG 07.03.01)
        - Hand hygiene
        - Appropriate disinfection of equipment
        - Contact precautions
        - Risk assessment, alert system for readmits
            - VRE alerts
    - Prevent infection central lines associated blood stream infections (CLABSI) (NPSG 07.04.01)
        - Follow protocol and checklist
        - Educate patient/family
        - Assess need for CL routinely
        - Fem line is last resort
    - Prevent infection after surgery (NPSG 07.05.01)
        - Educate patient and family
        - Monitor surgical incision for infection
        - Prophylaxis abx as indicated
    - Prevent infections of urinary tract caused by catheters (CAUTIs) (NPSG 07.06.01)
        - Nursing protocol to ensure quick d/c
        - Follow protocol (sterile technique)

- Identify patient safety risks
    - Identify patients at risk for suicide (NPSG 15.01.01)
        - Routine risk assessment
        - Address immediate safety concerns
        - Provide resources
        - Follow policy and procedures
            - 1:1
            - Supervisor notified

        - Room check for safety
        - Removed of belongings, in gown
- Prevent mistakes in surgery (Universal Protocol)
    - **Correct surgery performed on correct place on patients body (UP 01.01.01)**
        - **Pre-procedure verification process**
    - Make the correct place on the patient's body where surgery is to be done (UP 01.02.01)
        - Appropriate limb is identified with surgeon initials if lateral option
        - Involve patient
    - Time out prior to surgery (UP 01.03.01)

**Universal Protocol:**

- **Used for all surgical procedures**
- Not only OR
    - Chest tube insertion, central line insertion, cath lab
- Universal protocol is part of preoperative process to insure the intended site of surgical procedure (not to be confused with universal precautions)

## Retired Goals:

Previous goals that have been reached or moved to "standards"

**Retired: Improve Communication**

NPSG.02.01.01: For verbal or telephone orders or for telephone reporting of critical test results, the individual giving the order verifies the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result.

NPSG.02.02.01: There is a standardized list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.

PROHIBITED ABBREVIATIONS- Beebe Healthcare currently has a list of prohibited or "do not use" abbreviations

| | |
|---|---|
| • U | Write "Unit" |
| • IU | Write "international unit" |
| • Q.D., QD, q.d., qd | Write "daily" |
| • Q.O.D., QOD, q.o.d., qod | Write "every other day" |
| • Trailing zero (X.0 mg)* | Write "X mg" |
| • Lack of leading zero (.X mg) | Write "0.X mg" |
| • MS | Write "morphine sulfate" |
| • MSO4 | Write "morphine sulfate" |
| • MgSO4 | Write "magnesium sulfate" |

NPSG.02.05.01: The organization implements a standardized approach to hand-off communications, including an opportunity to ask and respond to questions.
Student Nurse Responsibilities:

- Hand off Communications – Shift Report
    - Provide a concise, yet thorough & specific shift report
    - Allow opportunity for questions between giver and receiver
    - Include up-to-date information regarding care, treatment, services, condition, and any recent or anticipated changes
    - Limit interruptions during hand-off; if this does not occur, provide written report
    - Provide opportunity for receiver to review data prior to leaving the clinical area
    - No change in care between 0645-0715 and 1845-1915
- Hand off Communications – Transfer Conditions

- Do not assume the responsibility to give report to any receiving unit or institution.
- Students are not permitted to relay information or "hand off" information to other disciplines - this is the responsibility of licensed personnel only

**Retired Goal 16: Changes in Patient Condition**- Improve recognition and response to changes in a pt condition

Beebe Healthcare Actions

- Developed the Rapid Response Team (RRT) to enable health care staff members or the patients' family to directly request additional assistance from a specially trained individual(s) when the patient's condition appears to be worsening.
- Rapid Response Team # 3333
  *Give Security personnel the room number and tell them that you need the Rapid Response Team*
- Security will activate the team, via alpha numeric pagers

When to call the RRT: ACUTE change in one or more of the following:

- Heart rate (<40 or >130)
- SBP (<90mmHG)
- SpO2 (<90%)
- RR (<8 or >24)
- Altered mental status or change in level of consciousness
- New or prolonged seizures
- Acute or significant bleeding
- The primary nurse has no real clinical indicators, however is concerned or worried about the patient.

Who responds to a RRT?

- Hospitalist (and/ or Denise Pecora, A.N.P.)
- ENIT nurse
- Critical Care Nurse
- Respiratory Therapist
- Primary Nurse
- EKG tech

**JC NPSG**
**Resources**

www.qualitycheck.org
www.jointcommission.org

# Official Joint Commission "Do Not Use" List

| *DO NOT USE* | **Potential Problem** | **USE INSTEAD** |
|---|---|---|
| **U (for unit)** | Mistaken for "0" zero, the number "4" (four) or "cc" | Write "Unit" |
| **IU (International Unit)** | Mistaken as IV (intravenous) or the number 10 (ten). | Write "International Unit" |
| **Q.D., QD, q.d., qd (daily)**<br>**Q.O.D., QOD, q.o.d., qod**<br>**(every other day)** | Mistaken for each other. Period after Q can be mistaken for an "I" and the "O" can be mistaken for "I". | Write "daily"<br><br>Write "every other day" |
| **Trailing zero (X.0 mg)*, Lack of leading zero (.Xmg)** | Decimal point is missed. | Write X mg<br>Write 0.X mg |
| **MS**<br>**$MSO_4$**<br>**$MgSO_4$** | Can mean morphine sulfate or magnesium sulfate. Confused for one another | Write "morphine sulfate"<br>Write "magnesium sulfate" |

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.

**Pharmacy Tools**
**Lexicomp**
**Look-alike / Sound-alike Drugs**
**Heparin protocol (wt based formula)**

**Ensure you are always giving the right medication by following the 10 R's -**
- **Right Medication**
- **Right Route**
- **Right Dosage**
- **Right Time**
- **Right Patient / Client**
- **Right Documentation**
- **Right Assessment**
- **Right Evaluation**
- **Right Client Education**
- **Right to Refuse**

**Additional Abbreviations, Acronyms and Symbols**

| (For possible future inclusion in the Official "Do Not Use" List) **Do Not Use** | *Potential Problem* | **Use Instead** |
|---|---|---|
| > (greater than) | Misinterpreted as the number "7" (seven) or the letter "L" | Write "greater than" |
| < (less than) | | Write "less than" |

| | | |
|---|---|---|
| | Confused for one another | |
| Abbreviations for drug names | Misinterpreted due to similar abbreviations for multiple drugs | Write drug names in full |
| Apothecary units | Unfamiliar to many practitioners<br>Confused with metric units | Use metric units |
| @ | Mistaken for the number “2” (two) | Write “at” |
| cc | Mistaken for U (units) when poorly written | Write “mL” or "ml" or “milliliters” (“mL” is preferred) |
| µg | Mistaken for mg (milligrams) resulting in one thousand-fold overdose | Write "mcg" or “micrograms” |

**Look Alike / Sound Alike**

| Potential Problematic Drug Name | Brand Name | Generic Name | Current Changes | Additional Recommendations |
|---|---|---|---|---|
| 1.Concentrated Liquid Morphine Products - Conventional liquid morphine products | ROXANOL,MSIR | Morphine | Concentrated Morphine has been removed from stock.<br><br>We stock only Morphine Oral Liquid | High Alert Messages in AcuDose<br><br>now purchased in unit dose packaging of 10mg/0.5ml and 5mg/0.25 ml |
| 2. Ephedrine - Epinephrine | Adrenaline<br><br>Ephedrine | Epinephrine<br><br>Ephedrine | 1. Pharmacy has labeled items with warnings.<br><br>2. Epinephrine is stock in multidose in vials and paper wrapped clear amps<br>3.Ephedrine is ordered in amber amps<br>4. Epinephrine is stored as Adrenalin in pharmacy | High Alert Messages in AcuDose |
| 3. Hydromorphone Injection - Morphine Injection | Dilaudid<br>Astramorph<br>Duramorph<br>Infumorph | Hydromorphone | 1. AcuDose machines now have an alert that requires a response to insure that the correct product is selected. | Remove Hydromorphine 2mg from formulary. Only Stock 1mg and 2mg strengths. |
| 4. Insulins | Lantus<br><br>Lente<br><br>Humulin<br><br>Novolin<br>Novolog<br>Novolin 70/30<br>Novolog Mix 70/30 | Insulin Glargine<br><br>Insulin Zinc<br><br>Human Insulin<br><br>Human Insulin<br>Insulin Aspart<br>NPH/Reg Mix<br>Insulin Aspart protamine/insulin aspart | 1. Only floor stock insulins are Lantus, NPH, Novolog<br><br>2. All other insulins are labeled patient specific and removed from the unit at discharge<br><br>3. Novo products are formulary choice over Lily products.<br><br>4. Insulins now stored in pharmacy in divided drawers in refrigerator that requires opening drawer to dispense vs reaching in a bin. Infrequently used items are locked in drawers that requires breakaway locks to open | Use HIGH ALERT labels on insulins that are not used routinely.<br><br>Add the words MIX to the product name in the computer system and on MAR |
| 5. Hydralazine - Hydroxyzine | | | Asterisk Lettering in computer; physical separation, high alert tag | High Alert Messages in AcuDose |
| 6. Glipizide - Glyburide | | | Asterisk Lettering in computer ; physical separation, high alert tag | High Alert Messages in AcuDose |
| 7. Dopamine - Dobutamine | | | Reduced to single concentrations of both agents; physical separation, Tallman lettering on containers | High Alert Messages in AcuDose |
| 8. Ketorolac 15mg - Ketorolac 30mg | | | Physical separation, banner across each bin to NOTE STRENGTH. | High Alert Messages in AcuDose |
| 9. Wellbutrin SR - Wellbutrin XL | Wellbutrin SR - Wellbutrin XL | Buproprion | Red Mark on packaging of High Alert Meds; Dispensed via Robotics | |
| 10. Opium Tincture - Paregoric | | | Remove Opium Tincture from Formulary. | |
| 11. Unasyn - Zosyn | | | Move antibitoics to AcuDose Cabinets that are profile driven ; Separate in Pharmacy | High Alert Messages in AcuDose |
| 12. Mucinex - Mucomyst | | | Double Check Verbal Orders | |
| 13. Vitamin K Pediatic vs Adult | Aquamephyton | | Moved Adult Strength to Narcotic Vault | High Alert Messages in AcuDose |
| 14. Hepatits B Pediatic vs Adult | Hep B | | Moved Adult Strength to Narcotic Vault | |
| 15. Omicor - Amicar | | Fish Oil | Omicor has been renamed Lovaza | |
| 16. Lorazepam - Alprazolam | | | Tall Man Lettering | |