2010 JOINT COMMISSION NATIONAL PATIENT SAFETY GOALS

1. Improve the accuracy of patient identification.

Use at least two patient identifiers when providing care, treatment, or services.

Rationale: 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.

2. Improve the effectiveness of communication among caregivers.

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.

3. Improve the safety of using medications

Label all medications, medication containers, and other solutions on and off the sterile field in peri-operative and other procedural settings. Note: Medication containers include syringes, medicine cups, and basins.

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. This unsafe practice neglects basic principles 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 peri-operative and other procedural settings.

7. Reduce the risk of health care–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.

Rationale: 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 health care organization. Consequently, health care-associated infections (HAIs) are a patient safety issue affecting all types of health care organizations. One of the most important ways to address HAIs is by improving the hand hygiene of health care 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.

8. Accurately and completely reconcile medications across the continuum of care.

Ensure a process exists for comparing the patient's current medications with those ordered for the patient while 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 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.

15. The hospital identifies safety risks inherent in its patient population.

Identify patients at risk for suicide.

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.

Introduction to the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™

The Universal Protocol applies to all surgical and non-surgical 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.***

Universal protocol requires:
1. Conduct a pre-procedure verification process.
2. Mark the procedure site.
3. A time-out is performed before the procedure.

Further explanation of the 2010 Joint Commission National Patient Safety Goals can be found at www.jointcommission.org