Joint Commission Announces Patient Safety Goals

By Martin Merritt

Medical practices should be aware of all National Patient Safety Goals, but especially these four in their daily operations.

**Source:** Physicians Practice

The Joint Commission has issued National Patient Safety Goals (NPSGs) effective January 1, 2014. The NPSGs were established in 2002 to help accredited organizations address specific areas of concern in regards to patient safety.

Here are four goals medical practices should be aware of:

**Clinical Alarm Management.** New for 2014 is NPSG.06.01.01 which seeks to improve the safety of clinical alarm systems. It focuses on safe clinical alarm management for hospitals and critical access hospitals which will be introduced in 2014 with a phased implementation. 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.

During Phase One, which begins January 1, 2014, hospitals are required to:
- Establish alarm safety as organizational priority
- Identify the most important alarms to manage based on their own internal situations

As of January 1, 2016, in Phase Two, hospitals will be expected to:
- Develop and implement specific components of policies and procedures
- Educate staff in the organization about alarm system management

Existing patient safety guidelines also continue to be of concern:

**Patient Identifiers.** NPSG.01.01.01 calls for the use of use at least two patient identifiers when providing care, treatment, and services. 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. PSG.01.03.01 seeks to eliminate transfusion errors related to patient misidentification. The intent here is two-fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; and second, to match the service or treatment to that individual. Therefore, the two patient/client/resident-specific identifiers must be directly associated with the individual and the same two identifiers must be directly associated with the medications, blood products, specimen containers (such as on an attached label), other treatments or procedures.

**Improve Communication.** NPSG.02.03.01 addresses reporting critical results of tests and diagnostic procedures on a timely basis. However, it is important to note that anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance. This NPSG has great potential to positively impact the safety of patients on this class of medications and result in better outcomes.

**Medication Safety.** PSG.03.04.01 addresses labelling on all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings. PSG.03.05.01 seeks to reduce the likelihood of patient harm associated with the use of anticoagulant therapy. Anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance. This NPSG has great potential to positively impact the safety of patients on this class of medications and result in better outcomes. PSG.03.06.01 addressed maintaining and communicating accurate patient medication information.