Joint Commission
2016 NATIONAL PATIENT SAFETY GOALS

NEWEST GOAL
06.01.01
~Make improvements to ensure that alarms on medical equipment are heard and responded to on time

Improve the accuracy of patient identification

01.01.01
~Use at least two patient identifiers when providing care, treatment or services. Label containers used for blood and other specimens in the presence of the patient.

01.03.01
~Eliminate Transfusion Errors
-Two person verification process
-One person – qualified transfusionist (the person who is administering the transfusion)
-Second person – qualified to participate in process

Improve the effectiveness of communication among caregivers

02.03.01
~Report critical results of tests and diagnostic procedures on a timely basis

Improve the safety of using medication

03.04.01
~Label all medications, medication containers, or other solutions on and off the sterile field. Note: medication containers include syringes, medicine cups, and basins.
03.05.01
~ Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.
03.06 .01
~.Maintain and communicate accurate patient medication information.

Reduce the risk of health care-associated infections

07.01.01
~Comply with current CDC hand hygiene guidelines
07.03.01
~ Implement evidence based practices (EBP) to prevent health care-associated infections due to multiple drug-resistant organisms
07.04.01
~Implement EBP to prevent central line-associated bloodstream infections
07.05.01
~Implement EBP to prevent surgical site infections
07.06.01
~ Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI)

The organization identifies safety risks inherent in its patient population

15.01.01
~The organization identifies patients at risk for suicide.

Universal Protocol

UP 01.01.01
~Conduct a pre-operative verification process
UP 01.02.01
~Mark the operative site
UP 01.03.01
~Conduct a "time out" immediately before starting the procedure

Old NPSG's that have moved to standards. Continue to practice in patient care:

Goal 2
~Verbal or telephone order test results
~Do not use unapproved abbreviations
~Implement standardized approach to patient "hand-off"

Goal 3
~Standardize and limit the number of drug concentrations available.
~Identify and review look-alike & sound-alike drugs, and take action to prevent errors involving these drugs.

Goal 9
~Implement a fall reduction program including an evaluation of the effectiveness of the program.

Goal 13
~Communicate the means for patients and their families to report concerns about safety and encourage them to do so.

Goal 16
~The organization selects a suitable method that enables health care staff members to directly request additional assistance from specially trained individual's) when patient's condition appears to be worsening.

UCLA Health System