International Patient Safety Goals

Goal 1 : Improve the Accuracy of Patient Identification

Wrong-patient errors occur in virtually all stages of diagnosis and treatment. The intent for this goal is twofold: 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.

- Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier.
- Label containers used for blood and other specimens in the presence of the patient.
- Use distinct methods of identification for newborn patients. Note: Examples of methods to prevent misidentification may include the following: - Distinct naming systems could include using the mother's first and last names and the newborn's gender (for example, "Smith, Judy Girl" or "Smith, Judy Girl A" and "Smith, Judy Girl B" for multiples). - Standardized practices for identification banding (for example, using two body sites and/or bar coding for identification). - Establish communication tools among staff (for example, visually alerting staff with signage noting newborns with similar names).

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.

- 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
- Implement the procedures for managing the critical results of tests and diagnostic procedures.
- Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.

Goal 3 : Improve the Safety of using Medicines

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

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.

- 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
- 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.
- In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following:
  - Medication or solution name
  - Strength
  - Amount of medication or solution containing medication (if not apparent from the container) - Diluent name and volume (if not apparent from the container)
  - 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
- Verify all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.
- 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.
- Immediately discard any medication or solution found unlabeled.
- 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.
- 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 4 : Reduce patient harm associated with clinical alarm systems.

Improve the safety of clinical alarm systems

Clinical alarm systems are intended to alert caregivers of potential patient problems, but if they are not properly managed, they can compromise patient safety

- Leaders establish alarm system safety as a hospital priority.
- Identify the most important alarm signals to manage based on the following:
  - Input from the medical staff and clinical departments
  - Risk to patients if the alarm signal is not attended to or if it malfunctions
  - Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue
  - Potential for patient harm based on internal incident history
  - Published best practices and guidelines
- Establish policies and procedures for managing the alarms identified in EP 2 above that, at a minimum, address the following:
  - Clinically appropriate settings for alarm signals
  - When alarm signals can be disabled - When alarm parameters can be changed - Who in the organization has the authority to set alarm parameters
  - Who in the organization has the authority to change alarm parameters
  - Who in the organization has the authority to set alarm parameters to “off”
  - Monitoring and responding to alarm signals
  - Checking individual alarm signals for accurate settings, proper operation, and detectability
- Educate staff and licensed independent practitioners about the purpose and proper operation of alarm systems for which they are responsible.

Goal 5 : Reduce the risk of health care–associated infections

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

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

- Set goals for improving compliance with hand hygiene guidelines.
- Improve compliance with hand hygiene guidelines based on established goals.

Goal 5 : Prevention of Wrong Site, Wrong Procedure, and Wrong Person Surgery

Conduct a pre-procedure 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 as follows:

- 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.

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. 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.

- Conduct a time-out immediately before starting the invasive procedure or making the incision.
- 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.

- 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
- Document the completion of the time-out.
  Note: The hospital determines the amount and type of documentation.