# National Patient Safety Goals®
# Effective January 2024 for the Hospital Program

## Goal 1

Improve the accuracy of patient identification.

### NPSG.01.01.01

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

**--Rationale for NPSG.01.01.01--**

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.

Newborns are at higher risk of misidentification due to their inability to speak and lack of distinguishable features. In addition to well-known misidentification errors such as wrong patient/wrong procedure, misidentification has also resulted in feeding a mother s expressed breastmilk to the wrong newborn, which poses a risk of passing bodily fluids and potential pathogens to the newborn. A reliable identification system among all staff is necessary to prevent errors.

**Element(s) of Performance for NPSG.01.01.01**

1. 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. (See also MM.05.01.09, EPs 7, 10; PC.02.01.01, EP 10) R
2. Label containers used for blood and other specimens in the presence of the patient. (See also PC.02.01.01, EP 10) R
3. Use distinct methods of identification for newborn patients. R
   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.

### NPSG.02.03.01

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

**--Rationale for NPSG.02.03.01--**

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.

# National Patient Safety Goals®
# Effective January 2024

5.

# National Patient Safety Goals® Effective January 2024 for the Hospital Program

## NPSG.06.01.01

Improve the safety of clinical alarm systems.

**--Rationale for NPSG.06.01.01--**

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.

There is general agreement that this is an important safety issue. Universal solutions have yet to be identified, but it is important for a hospital to understand its own situation and to develop a systematic, coordinated approach to clinical alarm system management. Standardization contributes to safe alarm system management, but it is recognized that solutions may have to be customized for specific clinical units, groups of patients, or individual patients. This NPSG focuses on managing clinical alarm systems that have the most direct relationship to patient safety.
Note: Additional information on alarm safety can be found on the AAMI website.

**Element(s) of Performance for NPSG.06.01.01**

1. Leaders establish alarm system safety as a hospital priority. R

2. Identify the most important alarm signals to manage based on the following: R
   - 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
   (For more information on managing medical equipment risks, refer to Standard EC.02.04.01)

3. Establish policies and procedures for managing the alarms identified in EP 2 above that, at a minimum, address the following: R D
   - 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
   (For more information, refer to Standard EC.02.04.03)

# Goal 7

Reduce the risk of health care associated infections.

## NPSG.07.01.01

**--Rationale for NPSG.07.01.01--**

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) and/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. To ensure compliance with this National Patient Safety Goal, an organization should assess its compliance with the CDC and/or WHO guidelines through a comprehensive program that provides a hand hygiene policy, fosters a culture of hand hygiene, monitors compliance, and provides feedback.

**Element(s) of Performance for NPSG.07.01.01**

1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) and/or the current World Health Organization (WHO) hand hygiene guidelines. R
   (See also  IC.01.04.01, EP 1)
2. Set goals for improving compliance with hand hygiene guidelines. R
   (See also  IC.03.01.01, EP 1)
3. Improve compliance with hand hygiene guidelines based on established goals. R

## Goal 15

The hospital identifies safety risks inherent in its patient population.

### NPSG.15.01.01

Reduce the risk for suicide.
Note: EPs 2  7 apply to patients in psychiatric hospitals or patients being evaluated or treated for behavioral health conditions as their primary reason for care. In addition, EPs 3  7 apply to all patients who express suicidal ideation during the course of care.

**--Rationale for NPSG.15.01.01--**

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.

# National Patient Safety Goals®
# Effective January 2024 for the Hospital Program

**Element(s) of Performance for NPSG.15.01.01**

1. For psychiatric hospitals and psychiatric units in general hospitals: The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). R D

   For nonpsychiatric units in general hospitals: The organization implements procedures to mitigate the risk of suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient s medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital.
   Note: Nonpsychiatric units in general hospitals do not need to be ligature resistant. Nevertheless, these facilities should routinely assess clinical areas to identify objects that could be used for self-harm and remove those objects, when possible, from the area around a patient who has been identified as high risk for suicide. This information can be used for training staff who monitor high-risk patients (for example, developing checklists to help staff remember which equipment should be removed when possible).

2. Screen all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool. R
   Note: The Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above.

3. Use an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. R
   Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens patients for suicidal ideation and assesses the severity of suicidal ideation.

4. Document patients  overall level of risk for suicide and the plan to mitigate the risk for suicide. R

5. Follow written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, these should include the following:
   - Training and competence assessment of staff who care for patients at risk for suicide
   - Guidelines for reas6 313.06o4.736 392.049 l S  0 0 0 RG 0.aand procedures addressing the care of p

violence.

The elements of performance (EPs) in National Patient Safety Goal NPSG.16.01.01 focus on fundamental processes that will help organizations address health care equity as a quality and

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# Effective January 2024 for the Hospital Program

Hospitals should identify the timing and location of the preprocedure verification and site marking based on what works best for their own unique circumstances. The frequency and scope of the preprocedure verification will depend on the type and complexity of the procedure. The three components of the Universal Protocol are not necessarily presented in chronological order (although the preprocedure verification and site marking precede the final verification in the time-out). Preprocedure verification, site marking, and the time-out procedures should be as consistent as possible throughout the hospital.

Note: Site marking is not required when the individual doing the procedure is continuously with the patient from the time of the decision to do the procedure through to the performance of the procedure.

## UP.01.01.01

Conduct a preprocedure verification process.

**--Rationale for UP.01.01.01--**

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.

**Element(s) of Performance for UP.01.01.01**

1. Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site. R
   Note: The patient is involved in the verification process when possible.

# National Patient Safety Goals®
# Effective January 2024 for the Hospital Program

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# Effective January 2024 for the Hospital Program

**--Rationale for UP.01.03.01--**

The purpose of the time-out is to conduct a final assessment that the correct patient, site, and procedure are identified. This requirement focuses on those minimum features of the time-out. Some believe that it is important to conduct the time-out before anesthesia for several reasons, includinginc ET  Qnc ET  7 9oTcEe8