



The Joint Commission

Laboratory Accreditation Program

2009 Chapter: National Patient Safety Goals

Goal 1

Improve the accuracy of [patient] identification.

NPSG.01.01.01

Use at least two [patient] identifiers when providing laboratory 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.

Elements of Performance for NPSG.01.01.01

- 1 Prior to any specimen collection, medication administration, transfusion, or treatment, the laboratory actively involves the patient, and as needed the family, in the identification and matching process. When active patient involvement is not possible or the patient's reliability is in question, the laboratory will designate the caregiver responsible for identity verification.
Note: The involvement of a single caregiver is acceptable as long as the other components of patient identification are satisfied.
- 2 Two patient identifiers are used when administering medications, blood, or blood components.
- 3 Two patient identifiers are used when collecting blood samples and other specimens for clinical testing.
- 4 Two patient identifiers are used when providing other treatments or procedures.
- 5 The patient's room number or physical location is not used as an identifier.
- 6 Containers used for blood and other specimens are labeled in the presence of the patient.
- 7 The laboratory establishes processes to maintain specimen identity throughout the preanalytical, analytical and post-analytical processes.

NPSG.01.02.01

Prior to the start of any invasive procedure, individuals involved in the procedure conduct a final verification process, such as a time-out, to confirm the correct [patient], procedure, and site using active, not passive, communication techniques.

Elements of Performance for NPSG.01.02.01

- 1 The final verification process is conducted in the location where the procedure will be done, immediately prior to starting the invasive procedure.
- 2 The final verification process involves the entire team, uses active communication, and includes the following:
 - Correct patient identity.
 - Correct side and site.
 - Agreement on the procedure to be done.
 - Correct patient position.
 - Availability of appropriate documents, correct implants, and any special equipment or special requirements.
- 3 The process is briefly documented using a method such as a checklist.
Note: The laboratory determines the type and amount of documentation.
- 4 The laboratory has processes and systems in place for reconciling differences in staff responses during the final verification process.
- 5 The patient's identity is re-established if the practitioner leaves the patient's location prior to initiating the procedure.
- 6 Marking the site is required unless the practitioner is in continuous attendance from the time of the decision to do the procedure and patient consent to the initiation of the procedure (for example, bone marrow collection, or fine needle aspiration).

Goal 2

Improve the effectiveness of communication among caregivers.

NPSG.02.01.01

For verbal or telephone orders or for telephone reporting of critical test results, the individual giving the order or test result verifies the complete order or test result by having the person receiving the information record and "read-back" the complete order or test result.

Rationale for NPSG.02.01.01

Ineffective communication is the most frequently cited root cause for sentinel events. Effective communication that is timely, accurate, complete, unambiguous, and understood by the recipient reduces error and results in improved [patient] safety.

Elements of Performance for NPSG.02.01.01

- 1 The individual receiving the information writes down the complete order or test result or enters it into a computer.
- 2 The individual receiving the information reads back the complete order or test result.
- 3 The individual who gave the order or test result confirms the information that was read back.

NPSG.02.02.01

There is a standardized list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the [organization].

Elements of Performance for NPSG.02.02.01

- 1 The laboratory develops a standardized list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the laboratory.
- 2 The current list of abbreviations, acronyms, symbols, and dose designations not to be used includes the following:
 - U,u
 - IU
 - Q.D., QD, q.d., qd
 - Q.O.D., QOD, q.o.d, qod
 - Trailing zero (X.0 mg)
 - Lack of leading zero (.X mg)
 - MS
 - MSO4
 - MgSO4

Note: A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.
- 3 The laboratory implements the “do not use” list of abbreviations, acronyms, symbols, and dose designations and applies it to all orders and all medication-related documentation that is handwritten or entered as free text into a computer.
- 4 The laboratory does not include any abbreviations, acronyms, symbols, and dose designations identified as not to be used on preprinted forms.

NPSG.02.03.01

The [organization] measures, assesses, and, if needed, takes action to improve the timeliness of reporting, and the timeliness of receipt of critical tests and critical results and values by the responsible licensed caregiver.

Elements of Performance for NPSG.02.03.01

- 1 The laboratory defines critical tests and critical results and values.
- 2 The laboratory defines the acceptable length of time between the ordering of critical tests and reporting the results of these tests, whether normal or abnormal.
- 3 The laboratory defines the acceptable length of time for reporting the results of routine tests with critical abnormal values or findings.
- 4 The laboratory defines the acceptable length of time between the availability of critical tests and critical results and values and receipt by the responsible licensed caregiver.
- 5 The laboratory collects data on the timeliness of reporting critical test results and critical results and values from routine tests.
- 6 The laboratory assesses the data on the timeliness of reporting critical test results and critical results and values from routine tests and determines whether a need for improvement exists.
- 7 The laboratory takes appropriate action to improve the timeliness of reporting critical test results and critical results and values from routine tests and measures the effectiveness of those actions.
- 8 Critically abnormal test results are communicated quickly to a responsible licensed caregiver so that prompt action may be taken.
- 9 When the responsible licensed caregiver is not available, a back-up reporting system provides the information in a timely manner to another qualified responsible caregiver to prevent avoidable delays in treatment or response.

NPSG.02.05.01

The [organization] implements a standardized approach to hand-off communications, including an opportunity to ask and respond to questions.

Rationale for NPSG.02.05.01

Health care has numerous types of [patient] hand-offs, including, but not limited to, nursing shift changes; physician transfer of complete responsibility for a [patient]; physician transfer of on-call responsibility; acceptance of temporary responsibility for staff leaving the unit for a short time; nursing and physician hand-off from the emergency department to inpatient units, different hospitals, nursing homes and home health care; and critical laboratory and radiology results sent to physician offices. The primary objective of a hand-off is to provide accurate information about a [patient's] care, treatment, and services, current condition, and any recent or anticipated changes. The information communicated during a hand-off must be accurate in order to meet [patient] safety goals.

Elements of Performance for NPSG.02.05.01

- 1 The laboratory's process for effective hand-off communication includes the following: Interactive communications that allows for the opportunity for questioning between the giver and receiver of patient information.
- 2 The laboratory's process for effective hand-off communication includes the following: Up-to-date information regarding the patient's condition, care, treatment, medications, services, and any recent or anticipated changes.
- 3 The laboratory's process for effective hand-off communication includes the following: A method to verify the received information, including repeat-back or read-back techniques.
- 4 The laboratory's process for effective hand-off communication includes the following: An opportunity for the receiver of the hand-off information to review relevant patient historical data, which may include previous laboratory services.
- 5 Interruptions during hand-offs are limited to minimize the possibility that information fails to be conveyed or is forgotten.

Goal 7

Reduce the risk of health care associated infections.

NPSG.07.01.01

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

Rationale for NPSG.07.01.01

Compliance with the WHO or CDC hand hygiene guidelines will reduce the transmission by staff to [patient]s of infectious agents, thereby decreasing the incidence of health care associated infections.

Elements of Performance for NPSG.07.01.01

- 1 The laboratory complies with current World Health Organization (WHO) or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
Note: Laboratories are required to comply with 1A, 1B, and 1C of the WHO or CDC guidelines.
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NPSG.07.02.01

Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function related to a health care associated infection.

Rationale for NPSG.07.02.01

A significant percentage of [patient]s who unexpectedly die or suffer major permanent loss of function have health care associated infections. These unanticipated deaths and injuries meet the definition of a sentinel event and, therefore, are required to undergo a root cause analysis. The root cause analysis should attempt to answer these questions: Why did the [patient] acquire an infection? Why did the [patient] die or suffer permanent loss of function?

Elements of Performance for NPSG.07.02.01

- 1 The laboratory manages all identified cases of unanticipated death or major permanent loss of function associated with a health care associated infection as sentinel events (that is, the laboratory conducts a root cause analysis).
- 2 The root cause analysis addresses the management of the patient before and after the identification of infection.

Goal 13

Encourage [patient]s' active involvement in their own care as a [patient] safety strategy.

NPSG.13.01.01

Identify the ways in which the [patient] and his or her family can report concerns about safety and encourage them to do so.

Rationale for NPSG.13.01.01

Communication with the [patient] and family about all aspects of laboratory services is an important characteristic of a culture of safety. When the [patient] knows what to expect, he or she is more aware of possible errors and choices. The [patient] can also be an important source of information about potential adverse events and hazardous conditions.

Elements of Performance for NPSG.13.01.01

- 1 The patient and family are educated on available reporting methods for concerns related to care, treatment, services and patient safety issues.
- 4 The laboratory encourages patients and their families to report concerns about safety.