Strategic Planning In Patient Safety Goals

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Introduction

Patient safety improves when an organization treats it as a strategic operating system rather than a collection of annual slogans. A strategic plan converts broad commitments—preventing harm, communicating clearly, controlling infection, using medicines safely—into measurable responsibilities, resources, and learning routines. It must connect the board, executives, clinical leaders, frontline staff, patients, families, and support services. (World Health Organization, 2021)

The original discussion emphasized measurable goals, informatics, infection prevention, and emergency preparation. Those priorities remain important, but one major update is necessary. For hospitals and critical-access hospitals, the Joint Commission replaced its former National Patient Safety Goals chapter with National Performance Goals effective January 1, 2026. The planning process should use the current framework while remaining attentive to CMS requirements, local risks, and evidence from the organization's own patients. (The Joint Commission, 2026)

Establish a Safety Governance Structure

The board is accountable for oversight, while executives are responsible for creating conditions in which safe care is possible. A patient-safety committee can coordinate strategy, but responsibility should not be isolated in one department. Pharmacy, nursing, medicine, infection prevention, information technology, facilities, quality, human resources, and patient representatives must participate. (World Health Organization, 2021)

Governance should define who owns each goal, how often performance is reviewed, and when an issue is escalated. Leaders should hear not only summary dashboards but also patient stories, near-miss reports, staffing concerns, and evidence of workarounds.

Conduct a Current-State Assessment

Before choosing goals, the organization should examine incident reports, claims, infection data, medication events, falls, pressure injuries, diagnostic delays, readmissions, mortality reviews, staff surveys, and patient complaints. Data should be stratified when possible by unit, population, language, race, disability, and other relevant factors. (World Health Organization, 2021)

Numbers alone are insufficient. Direct observation, interviews, process mapping, and chart review can

reveal why the problem occurs. A low reporting rate may reflect fear rather than high safety. The assessment should therefore consider culture and reporting reliability.

Use the 2026 National Performance Goals Appropriately

The Joint Commission's 2026 National Performance Goals organize hospital and critical-access-hospital requirements into measurable topics. They replace the former NPSG chapter for those programs. Other accreditation programs may continue to use program-specific goals, so organizations should confirm which framework applies. (The Joint Commission, 2026)

Accreditation requirements are a minimum structure, not a complete strategy. A hospital with a high rate of maternal harm, delayed sepsis recognition, or wrong-patient imaging should address those local risks even if they are not the most visible national campaign.

Patient Identification

Wrong-patient errors can occur during medication administration, laboratory collection, imaging, procedures, registration, and documentation. The plan should require reliable use of at least two identifiers in applicable workflows and design systems that make errors difficult. (The Joint Commission, 2026)

Technology such as barcode scanning can help, but workarounds must be monitored. Similar names, temporary newborn names, language barriers, and emergency conditions require special controls. Patient involvement—asking individuals to state identifying information—adds another layer.

Medication Safety

Medication strategy should address prescribing, reconciliation, preparation, dispensing, administration, monitoring, and discharge. High-alert medicines require standardized concentrations, independent checks where effective, smart-pump libraries, and clear protocols. (The Joint Commission, 2026)

Medication reconciliation should identify what the patient actually takes, not merely copy an old list. At transitions, the patient needs an understandable explanation of which medicines changed and why. Pharmacy participation is especially valuable for complex regimens.

Infection Prevention

Strategic goals may include hand hygiene, device-associated infection reduction, surgical-site infection prevention, vaccination, environmental cleaning, and antimicrobial stewardship. The selected measures should match local risk and use accepted definitions. (World Health Organization, 2021)

Frontline teams need supplies, staffing, training, and rapid feedback. A policy that requires a practice without making it feasible invites workarounds. Infection prevention should also coordinate with facilities on ventilation, water safety, construction risk, and emergency preparedness.

Communication and Handoffs

Incomplete handoffs can cause missed tests, duplicate treatment, or delayed response. Structured tools such as SBAR, check-backs, read-backs, briefings, and standardized handoff templates help teams create a shared mental model. The tool should support clinical judgment rather than become a box-checking exercise. (Agency for Healthcare Research and Quality, n.d.)

Communication with patients is part of safety. Qualified interpreters, accessible formats, teach-back, and clear discharge instructions reduce misunderstanding. Family caregivers should be included with the patient’s permission. (Agency for Healthcare Research and Quality, n.d.)

Procedural Safety

Wrong-site, wrong-procedure, and retained-object events require strong preprocedure verification, site marking, time-outs, counting processes, and escalation when information conflicts. A time-out should be an active team confirmation, not a ritual led by one person while others remain silent. (The Joint Commission, 2026)

Scheduling, consent, imaging, implants, and pathology information must agree. Any team member should have authority to stop the process when there is uncertainty.

Falls, Pressure Injuries, and Mobility

Fall prevention should be individualized. Excessive restriction can cause weakness, delirium, and loss of independence. Teams should address medicines, vision, footwear, toileting, environment, mobility assistance, and patient preferences.

Pressure-injury prevention requires risk assessment, repositioning, skin inspection, nutrition, moisture management, and appropriate surfaces. Measures should focus on reliable care rather than blaming

staff after harm.

Suicide and Behavioral Health Risk

Organizations need processes for identifying suicide risk in relevant populations, conducting evidence-based assessment, creating safe environments, and arranging follow-up. Screening is not sufficient if positive results do not lead to timely evaluation and care. (The Joint Commission, 2026)

Behavioral-health safety also includes trauma-informed communication, prevention of restraint where possible, and coordination after discharge. Patients in medical settings can have serious mental-health needs even when psychiatric care is not the primary reason for admission.

Diagnostic Safety

Diagnostic error may result from delayed testing, failure to follow up results, poor communication, bias, or fragmented responsibility. Strategic planning can establish closed-loop result management, referral tracking, escalation of critical results, and opportunities for diagnostic second opinions.

Case review should examine system and cognitive contributors without assuming that one clinician alone caused the problem. Patients can support diagnosis by reporting change and asking what to expect next.

Data, Informatics, and Cybersecurity

Electronic records can provide alerts, standard orders, and surveillance, but poorly designed systems create alert fatigue, copy-forward errors, and usability problems. Informatics teams should test changes with frontline users and monitor unintended effects.

Cybersecurity is a patient-safety issue because unavailable systems can delay medicines, imaging, and communication. Downtime plans must be practiced, paper tools maintained, and restoration priorities defined.

Emergency and Hazard Preparedness

Preparedness should address infectious outbreaks, extreme weather, fire, utility failure, mass casualty, supply shortage, and cyberattack. Hazard-vulnerability analysis helps prioritize scenarios. Plans should include vulnerable patients, staff family responsibilities, evacuation, sheltering, and communication. (World Health Organization, 2021)

Exercises should test actual decisions rather than merely confirm that a plan exists. After-action

review should assign improvements and verify closure.

Safety Culture and Reporting

A just culture distinguishes human error, at-risk behavior, and reckless behavior. It avoids punishing honest mistakes while maintaining accountability for conscious disregard of substantial risk. Staff must be able to report near misses and hazards without fear of retaliation. (World Health Organization, 2021)

Leaders demonstrate culture through response. If reporting leads only to blame or no visible action, participation declines. Feedback should explain what was learned and changed.

Measures and Improvement Method

Each goal needs outcome, process, and balancing measures. For falls, the outcome may be injurious falls, the process may be completion of individualized plans, and a balancing measure may be mobility restriction. Targets should be ambitious but realistic.

Plan-Do-Study-Act cycles, human-factors methods, FMEA, and root-cause analysis can support improvement. The method should match the problem. Serious-event review should produce system actions with owners and dates, not vague recommendations to “reeducate staff.”

Patient and Family Partnership

Patients and family caregivers often notice changes, medication differences, or conflicting instructions before the system does. Strategic planning should create reliable ways for them to raise concerns, participate in rounds, review discharge plans, and report harm. Involvement must be voluntary and adapted to health literacy, disability, language, and cultural preferences. (World Health Organization, 2021)

Patient representatives can also participate in safety committees and design reviews. Their role should be substantive rather than ceremonial. Organizations should compensate community members where appropriate and explain how their input changed policy.

Equity as a Safety Requirement

Safety events are not distributed evenly. Language barriers, disability, bias, poor access, and fragmented records can increase risk for particular groups. Measures should therefore be stratified when sample size and privacy permit. An overall improvement can hide worsening outcomes in a

smaller population. (World Health Organization, 2021)

Equity work should be integrated with the main safety plan instead of assigned to a separate initiative. Interpreter availability, accessible equipment, respectful communication, and standardized escalation affect both quality and fairness.

Resource Allocation

A safety plan is not credible without budget, staffing, equipment, analytics, and training time. Leaders should identify which goals require capital and which require workflow redesign. Unfunded expectations can increase risk by adding tasks to already overloaded teams.

Conclusion

Strategic patient-safety planning links national expectations with local evidence. In 2026, hospitals and critical-access hospitals should recognize the Joint Commission's transition from National Patient Safety Goals to National Performance Goals while continuing to meet other regulatory and clinical responsibilities. (The Joint Commission, 2026)

The strongest plan integrates governance, patient identification, medication safety, infection prevention, communication, diagnostics, behavioral health, informatics, emergency readiness, and culture. Safety becomes sustainable when goals are measurable, frontline conditions are addressed, patients participate, and leaders verify that improvement actions changed the system. (World Health Organization, 2021; Agency for Healthcare Research and Quality, n.d.)

References

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