JOINT COMMISSION™
ELEVATING CARE. TOGETHER.

Right Patient, Right Care

Ensuring that the correct patient receives the correct care at the correct time is foundational to patient safety and the responsibility of everyone who works in healthcare.

Background

Since 2003, Joint Commission—accredited hospitals are required to have patient care protocols and systems in place to ensure the correct patient receives the correct care at all times. The Universal Protocol for Safe Surgical Practices (including verification, site marking, and time-outs) has been required for two decades,[i] and Joint Commission elevated three additional components to National Patient Safety Goals in 2009: correct use of patient identifiers, hand-off communications, and timely critical test reporting requirements. This *2025 National Performance Goal™* adds the management of patient flow, monitoring changes in a patient's condition, and the availability of resuscitation services in this suite of requirements, recognizing that these key elements work together.

Standards

Joint Commission *National Performance Goal* for correct care, correct time focuses on longstanding quality and patient safety issues and ensures (1) the patient is reliably identified as the person for whom service is recommended, and (2) services and treatment are matched to that individual to reduce medical errors. Hospitals must:

- Have a process in place to correctly identify patients when providing care, treatment, and services
- Report critical results of tests and diagnostic procedures in a timely manner (same)
- Manage the flow of patients throughout the hospital
- Have a process for hand-off communications
- Recognize and respond to changes in a patient's condition
- Ensure resuscitative services are available throughout the hospital
- Develop and implement processes for post-resuscitation care
- Review resuscitative care services to identify opportunities for improvement
- Conduct a preprocedural verification process
- Mark the procedure site
- Perform a time-out before the procedure.

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Rationale

- The standards under this goal include interventions to reduce the most common medical errors — surgical errors, diagnostic errors, medication errors, equipment failures, patient falls, hospital-acquired infections, and communication failures.[ii]
- Despite being categorized as "never events," recent literature demonstrates wrong site surgeries are still happening.[iii,iv] Events resulting from wrong site surgeries can include death or lifelong physical consequences for the patient; clinicians involved may face disciplinary and malpractice litigation, reputational damage, and emotional fallout; and hospitals risk liability, loss of accreditation and regulatory sanctions, and financial losses.[v,vi] The Centers for Medicare & Medicaid Services (CMS) have not reimbursed for any costs associated with these errors since 2009.[vi] One of the most commonly identified causes of wrong site surgery is an inability to follow established safety protocols.[vii] Joint Commission standards provide a framework for those protocols.
- Handoffs occur frequently in hospitals and are associated with up to 80% of medical errors. Effective handoffs ensure that each caregiver has the necessary information to continue care seamlessly, reducing the risk of duplicated tests or conflicting treatment.[viii]
- Evidence shows that effectively managing patient flow facilitates safer and timely care.[ix,x]

Related Activities

The Joint Commission "Speak Up" campaign includes a poster and educational materials on The Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person.

i Norton E. Implementing the universal protocol hospital-wide. *AORN J*. 2007;85(6):1187–1197. doi: 10.1016/j.aorn.2007.03.002 **ii** Ahsani-Estahbanati E, Sergeevich Gordeev V, Doshmangir L. Interventions to reduce the incidence of medical error and its financial burden in health care systems: A systematic review of systematic reviews. *Front Med* (Lausanne). 2022;9:875426 **iii** Tan J, Ross JM, Wright D, et al. A contemporary analysis of closed claims related to wrong-site surgery. *Jt Comm J Qual Patient Saf*. 2023;49(5):265–273 **iv** Robinson TP, Bilimoria KY, Yang AD. Understanding a surgeon's worst nightmare: Wrong site surgery. *Jt Comm J Qual Patient Saf*. 2023;49(5):237–238 **v** ECRI. Health System Risk Management. Wrong-site Surgery. December 14, 2020 **vi** Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery. The Joint Commission **vii** Stahel PF, Sabel AL, Victoroff MS, et al. Wrong-Site and Wrong-Patient Procedures in the Universal Protocol Era: Analysis of a Prospective Database of Physician Self-reported Occurrences. *Arch Surg*. 2010;145(10):978—984. doi:10.1001/archsurg.2010.185 **viii** Webster, Kristen LW. et al. Handoffs and Teamwork: A Framework for Care Transition Communication. *Jt Comm J Qual Patient Saf*. 2022;48(6): 343—35. **ix** Fleischman RJ, Kaji AH, Diaz VM, et al. A Simple Intervention to Improve Hospital Flow From Emergency Department to Inpatient Units. *JAMA Intern Med*. 2015;175(2):289–290. doi:10.1001/jamainternmed.2014.6689 **x** Roussel M, Teissandier D, Yordanov Y, et al. Overnight Stay in the Emergency Department and Mortality in Older Patients. *JAMA Intern Med*. 2023;183(12):1378—1385. doi:10.1001/jamainternmed.2023.5961

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**National Patient Safety Goals are now a part of the National Performance Goals.*