

## Joint Commission 2006 National Patient Safety Goals Home Care Applicability Grid

**Note:** National Patient Safety Goals requirements applicable to home care services are marked by an "X." This grid is intended to provide general applicability information only. Applicability in each service is determined by whether or not the service provides a specific type of care/service/treatment.

Goals	HH	PC/SS	HSP	Pharm Dispen	C/C Pharm	LTC Pharm	Amb Infusion	HME	CRS	RT
<b>1. Patient Identification</b>										
1a Two patient identifiers	X		X				X		X	
1b Invasive procedure-patient verification	X		X				X			
<b>2. Communication</b>										
2a "Read back"	X	X	X	X	X	X	X	X	X	X
2b Abbreviations	X	X	X	X	X	X	X	X	X	X
2c Timeliness of reporting critical test results	X		X	X	X		X		X	
<i>New</i> 2e Implement a standardized approach to "hand off" communications, including an opportunity to ask and respond to questions	X	X	X	X	X	X	X	X	X	X
<b>3. Safety of Medications</b>										
3b Standardize concentrates			X	X		X	X			
3c List of look-alike/sound-alike drugs	X		X	X	X	X	X			
<b>7. Health Care-Associated Infections</b>										
7a CDC guidelines	X	X	X	X	X	X	X	X	X	X
7b Sentinel Event for deaths associated w/ infections	X	X	X	X	X	X	X	X	X	X
<b>8. Reconcile Medications</b>										
8a Document medications on entry	X		X	X	X	X	X		X	
8b Communicate medications to next provider	X		X		X	X	X			
<b>9. Reduce Patient Falls</b>										
<i>New</i> 9b Implement a fall reduction program and evaluate its effectiveness	X	X	X		X	X	X	X	X	X
<b><i>New</i> 13. Patient Safety</b>										
<i>New</i> 13a Communicate concerns about safety	X	X	X	X	X	X	X	X	X	X

### Legend:

HH Home Health Services  
 PC/SS Personal Care and Support Services  
 HSP Hospice  
 Pharm Disp Dispensing Pharmacy Services  
 C/C Pharm Clinical/Consultant Pharmacist Services

LTC Pharm Long Term Care Pharmacy Services  
 Amb Infusion Freestanding Ambulatory Infusion Services  
 HME Home Medical Equipment Services  
 CRS Clinical Respiratory Services  
 RT Rehabilitation Technology

Long Term Care Pharmacy Services  
 Freestanding Ambulatory Infusion Services  
 Home Medical Equipment Services  
 Clinical Respiratory Services  
 Rehabilitation Technology

Goal and Requirement	Rationale and Implementation Expectations	Program Specific Implementation Expectations
<p><b>Goal 1: Improve the accuracy of patient identification.</b></p> <p><b>Requirement 1A:</b> Use at least two patient identifiers whenever administering medications or blood products; taking blood samples and other specimens for clinical testing; or providing any other treatments or procedures.</p> <p><b>Requirement 1B:</b> Prior to the start of any invasive procedure, conduct a final verification process, such as a time out, to confirm the correct patient, procedure, site. This verification process uses active—not passive—communication techniques.</p>	<p><b>Rationale: Wrong-patient errors occur in virtually all aspects 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.</b></p> <p><b>Implementation Expectations: 1A</b> - It is the person-specific information that is the “identifier,” not the medium on which that information resides. Acceptable identifiers may be the individual’s name, an assigned identification number, telephone number, photograph or other person-specific identifier. Bar coding that includes two or more person-specific identifiers (not room number) will comply with this requirement.</p> <p><b>Implementation Expectations: 1B</b> - The “time out,” or immediate preoperative/preprocedural pause, must occur in the location where the procedure is to be done (for example, when the patient is on the operating table). The “time out” should involve the entire procedural team which, at a minimum, includes the practitioner doing the procedure, the anesthesia provider (if any), and the circulating nurse or other assistant. In addition, there should be no barrier to anyone speaking up if there is a concern about a possible error. “Active” communication, in this context, means an affirmation, orally or by some action that the patient, procedure, and site are correct.</p> <p>Certain routine “minor” procedures such as venipuncture, peripheral IV line placement, insertion of NG tube, or Foley catheter insertion are not within the scope of Goal 1. However, most other procedures that involve puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, and endoscopies are within the scope of this Goal. Also see National Patient Safety Goal 4, Requirements 4A and 4B, and the Universal Protocol.</p>	<p><b>1A</b> - In the home care setting, this is much easier and less prone to error than in other settings. Certainly, at the first encounter, the requirement for two identifiers is appropriate in a literal sense. Thereafter, and in any situation of continuing one-on-one care where the staff “knows” the individual, one of the identifiers can be direct facial recognition. In the home, the correct address (an acceptable identifier when used in conjunction with another person-specific identifier) is also confirmed.</p>
<p><b>Goal 2: Improve the effectiveness of communication among caregivers.</b></p>	<p><b>Rationale: Ineffective communication is the most frequently cited category of root causes of sentinel events. Effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient, reduces error and results in improved patient safety.</b></p>	

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<p><b>Requirement 2A:</b> For verbal or telephone orders or for telephonic reporting of critical test results, verify the complete order or test result by having the person receiving the order or test result “read-back” the complete order or test result.</p> <p><b>Requirement 2B:</b> Standardize a list of abbreviations, acronyms, and symbols that are not to be used throughout the organization.</p> <p><b>Requirement 2C:</b> Measure and assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.</p>	<p><b>Implementation Expectations: 2A</b> - Simply repeating back the order or test result is not sufficient. Whenever possible, the receiver of the order should <b>write</b> down the complete order or test result or enter it into a computer, then <b>read</b> it back, and receive confirmation from the individual who gave the order or test result.</p> <p>“<b>Critical test results</b>” are defined by the individual health care organization and will typically include “stat” tests, “panic value” reports, and other diagnostic test results that require urgent response.</p> <p><b>Implementation Expectations: 2B</b> - An official list of dangerous abbreviations, acronyms, and symbols has been approved by the Joint Commission and must be included on each organization’s “Do not use” list. The official list is available at: <a href="http://www.jcaho.org/accredited+organizations/patient+safety/dnu.htm">http://www.jcaho.org/accredited+organizations/patient+safety/dnu.htm</a>. Additional items may be added to an organization’s “do not use” list at the organization’s discretion.</p> <p>The “do not use” list applies to all orders and other medication-related documentation when handwritten, entered as free text into a computer, or on pre-printed forms. It does not currently apply to computer-generated forms or displays.</p> <p>Trailing zeros may be used in non-medication-related documentation when there is a clear need to demonstrate level of precision, such as for laboratory values, imaging study measurement of lesion sizes, or catheter and therapeutic tube sizes.</p> <p><b>Implementation Expectations: 2C</b> - The organization will need to determine its current turn-around time for reporting.</p> <p>The Joint Commission expects an organization to define the acceptable length of time: a) between the ordering of critical tests and reporting the test results and values, and b) between the availability of critical results/values and receipt by the responsible licensed caregiver. The organization then assesses these data, determines whether there is a need for improvement in the timeliness of reporting and, if so, takes appropriate action to improve and measure the effectiveness of those actions.</p>	<p><b>2A</b> - Voicemail orders are not acceptable within the context of the National Patient Safety Goals. When not received directly, the appropriate licensed practitioner must call the prescriber back to get the order directly, including a “read-back.”</p>



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<p><b>Requirement 3B:</b> Standardize and limit the number of drug concentrations available used by the organization.</p>	<p><b>Implementation Expectations: 3B</b> - When more than one concentration is necessary, the number of concentrations should be limited to the minimum if required to meet patient care needs, such as may be the case in pediatrics or neonatal care, and those concentrations should be standardized.</p> <p>The Rule of Six, which results in individualized concentrations, does not meet the requirements of National Patient Safety Goal 3b. However, the Joint Commission will allow for extension of the current exceptions process for use of the Rule of Six through a transition to the expected use of standardized drug concentrations by all providers no later than December 31, 2008. Requests for exceptions will continue to be considered on an organization-by-organization basis and will require ongoing evidence of progress toward full implementation of the use of standardized drug concentrations. The eligibility criteria for participation in the exceptions process during the transition period are as follows:</p> <ul style="list-style-type: none"> <li>• The exception request applies only to the neonatal or pediatric acute care services provided by the organization.</li> <li>• Emergent and nonemergent admixtures are prepared only by pharmacy staff in a sterile environment.</li> <li>• Calculations respecting the drug solutions are validated during the preparation.</li> <li>• The labeling of solution concentrations and drug per milliliter are clear to all caregivers, and the solution concentration (amount of drug per unit volume of solution) is clearly indicated on the label.</li> <li>• If the Rule of Six is used in a pediatric setting, but standardized drug concentrations are used in other parts of the hospital, guidance aids are made available to caregivers who may not be familiar with one of these systems.</li> <li>• If the organization has a neonatal intensive care unit, the pharmacy is open 24 hours a day to support the admixture service.</li> <li>• Smart pumps are utilized. (A “smart pump” is a parenteral infusion pump equipped with IV medication error-prevention software that alerts operators or interrupts the infusion process when a pump setting is programmed outside of pre-configured limits. Smart pumps are designed to recognize prescription errors, dose misinterpretations, and keypad programming errors.)</li> </ul>	<p><b>3B</b> - These apply to medications stored in the home care organization, not to medications already dispensed by a pharmacy to the patient’s residence.</p>

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<p><b>Requirement 3C:</b> Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.</p> <p><b>Goal 5: Improve the safety of using infusion pumps.</b></p> <p><b>Requirement 5A:</b> Goal 5 and its requirement, 5A, have been retired as a National Patient Safety Goal effective January 1, 2006.</p> <p><b>Goal 7: Reduce the risk of health care–associated infections.</b></p> <p><b>Requirement 7A:</b> Comply with current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines (<a href="http://www.cdc.gov/handhygiene/">http://www.cdc.gov/handhygiene/</a>).*</p> <p><b>Requirement 7B:</b> Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care–associated infection.</p>	<p><b>Implementation Expectations: 3C</b> - There are multiple strategies to identify a list of look-alike/sound-alike drugs used in the organization. Three tables of look-alike/sound-alike drugs have been issued by the Joint Commission, and are posted on the Joint Commission Web site (<a href="http://www.jcaho.org/accredited+organizations/patient+safety/npsg.htm">http://www.jcaho.org/accredited+organizations/patient+safety/npsg.htm</a>).</p> <p>An organization must include on its own list a minimum of 10 look-alike/sound-alike drug combinations from these tables, in accordance with the instructions accompanying the tables. The tables include both generic and drug combination-specific prevention measures. Surveyors will expect to see several of the applicable prevention measures in place for each drug combination on the organization’s list.</p> <p><b>Rationale: Compliance with the CDC hand hygiene guidelines will reduce the transmission of infectious agents by staff to patients, thereby decreasing the incidence of health care–associated infections.</b></p> <p><b>Implementation Expectations: 7A</b> - Staff should know what is expected of them with regard to hand hygiene and should practice it consistently. Implementation of all CDC guidelines with category IA, IB or IC evidence is required. (<a href="http://www.cdc.gov/handhygiene/">http://www.cdc.gov/handhygiene/</a>)</p> <p><b>Implementation Expectations: 7B</b> - A significant percentage of patients 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 the questions, why did the patient acquire an infection and, given the fact of the infection, why did the patient die or suffer permanent loss of function?</p>	

\* Organizations are required to comply with all IA, IB, and IC CDC recommendations.

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<p><b>Goal 8: Accurately and completely reconcile medications across the continuum of care.</b></p> <p><b>Requirement 8A:</b> Implement a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications ordered for the patient while under the care of the organization to those on the list.</p> <p><b>Requirement 8B:</b> A complete list of the patient's medication is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner, or level of care within or outside the organization. This process includes a comparison of the medications ordered for the patient while under the care of the organization to those on the list.</p>	<p><b>Rationale:</b> Patients are most at risk during transitions in care (hand-offs) across settings, services, providers, or levels of care. The development, reconciliation, and communication of an accurate medication list throughout the continuum of care is essential in the reduction of transition-related adverse drug events.</p> <p><b>Implementation Expectations: 8A</b> - Organizations must implement a standardized method for creating an accurate list of medications at admission/entry and transfer. The list should include the full range of medications as defined in the accreditation manuals:</p> <ul style="list-style-type: none"> <li>• Prescription medications</li> <li>• Sample medications</li> <li>• Vitamins</li> <li>• Nutraceuticals</li> <li>• Over-the-counter drugs</li> <li>• Vaccines</li> <li>• Diagnostic and contrast agents</li> <li>• Radioactive medications</li> <li>• Respiratory therapy-related medications</li> <li>• Parenteral nutrition</li> <li>• Blood derivatives</li> <li>• Intravenous solutions (plain or with additives)</li> <li>• Any product designated by the FDA as a drug</li> </ul> <p>Development of a medication reconciliation form, to be used as a template for gathering information about current medications, is one method that can be used to standardize care and prevent errors.</p> <p><b>Implementation Expectations: 8B</b> - The patient's accurate medication reconciliation list (complete with medications prescribed by the first provider of service) is communicated to the next provider of service, whether it be within or outside the organization. Thereafter, the next provider of service should check over the medication reconciliation list again to make sure it is accurate and in concert with any new medications to be ordered/prescribed.</p> <p>At a minimum, reconciliation must occur any time the organization requires that orders be rewritten and any time the patient changes service, setting, provider, or level of care and new medication orders are written. For transitions not involving new medications or rewriting of orders, the organization should determine whether reconciliation must occur.</p>	

Goal and Requirement	Rationale and Implementation Expectations	Program Specific Implementation Expectations
<p><b>Goal 9: Reduce the risk of patient harm resulting from falls.</b></p> <p><b>New Requirement 9B:</b> Implement a fall reduction program and evaluate the effectiveness of the program.*</p> <p><b>New Goal 13:</b> Encourage the active involvement of patients and their families in the patient’s own care as a patient safety strategy.</p> <p><b>New Requirement 13A:</b> Define and communicate the means for patients and their families to report concerns about safety, and encourage them to do so.</p>	<p><b>Rationale:</b> Falls account for a significant portion of injuries in hospitalized patients, long term care residents, and home care recipients. In the context of the population it serves, the services it provides, and its environment of care, the organization should assess, its patients’ risk for falls and take action to reduce the risk of falling and to reduce the risk of injury, should a fall occur.</p> <p><b>Implementation Expectations: 9B</b> - As appropriate to the population served, the services provided, and the environment of care, a fall reduction program may include risk assessment and periodic reassessment of individual patients or of the environment of care. The program should include risk reduction strategies, in-services involving patients/families in education, and environment of care redesign. The program should also include development and implementation of transfer protocols (e.g., bed-to-chair), when relevant.</p> <p><b>Rationale: Communication with patients and families about all aspects of their care, treatment, or services is an important characteristic of a culture of safety. When patients know what to expect, they are more aware of possible errors and choices. Patients can be an important source of information about potential adverse events and hazardous conditions.</b></p>	<p><b>9B</b> - Clinical consulting pharmacies and long term care pharmacies would be able to identify medications the patient might be taking for which there would be side effects of drowsiness, motor disturbances, ataxia, etc., that would make them prone to falls.</p>

\* Effective January 1, 2006.