Accreditation Program: Long Term Care

National Patient Safety Goals

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NPSG

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.

Elements of Performance for NPSG.01.01.01

	EP	Requirement		Category
Ⓜ	1.	Prior to any specimen collection, medication administration, transfusion, or treatment, the organization actively involves the resident and, as needed, the family in the identification and matching process. When active resident involvement is not possible or the resident's reliability is in question, the organization will designate the caregiver responsible for identity verification. Note: The involvement of a single caregiver is acceptable as long as the other components of resident identification are satisfied.	△3	C
Ⓜ	2.	Two resident identifiers are used when administering medications, blood, or blood components.	△3	C
Ⓜ	3.	Two resident identifiers are used when collecting blood samples and other specimens for clinical testing.	△3	A
Ⓜ	4.	Two resident identifiers are used when providing other treatments or procedures.	△3	C
	5.	The resident's room number or physical location is not used as an identifier. (See also MM.05.01.09, EPs 8 and 11)	△3	A
Ⓜ	6.	Containers used for blood and other specimens are labeled in the presence of the resident.	△3	A

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NPSG.01.02.01

Prior to the start of any surgical or 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 surgical or invasive procedure. **A**

(M) 2. The final verification process involves the entire team, uses active communication, and includes the following: **A**
- Correct resident identity
- Correct side and site
- Agreement on the procedure to be done
- Correct resident position
- Availability of correct implants and any special equipment or special requirements

3. (D) The process is briefly documented using a method such as a checklist. **A**
Note: The organization determines the type and amount of documentation.

4. The organization has processes and systems in place for reconciling differences in staff responses during the final verification process. **A**

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Goal 2

Improve the effectiveness of communication among caregivers.

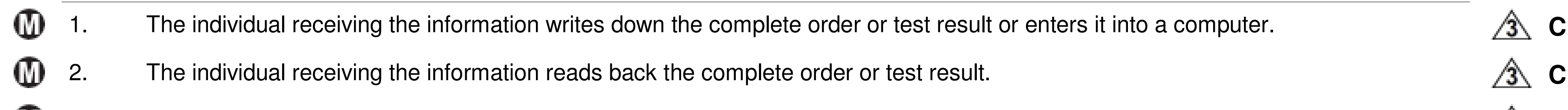
NPSG.02.01.01

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



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

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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. (D) The organization develops a standardized list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization. **A**

2. The current list of abbreviations, acronyms, symbols, and dose designations not to be used includes the following: **A**
- 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.

(M) 3. The organization 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. **C**

4. The organization does not include any abbreviations, acronyms, symbols, and dose designations identified as not to be used on preprinted forms. **A**

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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 organization defines critical tests and critical results and values.	**A**
2.	The organization defines the acceptable length of time between the ordering of critical tests and reporting the results of these tests, whether normal or abnormal.	**A**
3.	The organization defines the acceptable length of time for reporting the results of routine tests with critical abnormal values or findings.	**A**
4.	The organization defines the acceptable length of time between the availability of critical tests and critical results and values and receipt by the responsible licensed caregiver.	**A**
5.	The organization collects data on the timeliness of reporting critical test results and critical results and values from routine tests.	**A**
6.	The organization 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.	**A**
7.	The organization 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.	**A**

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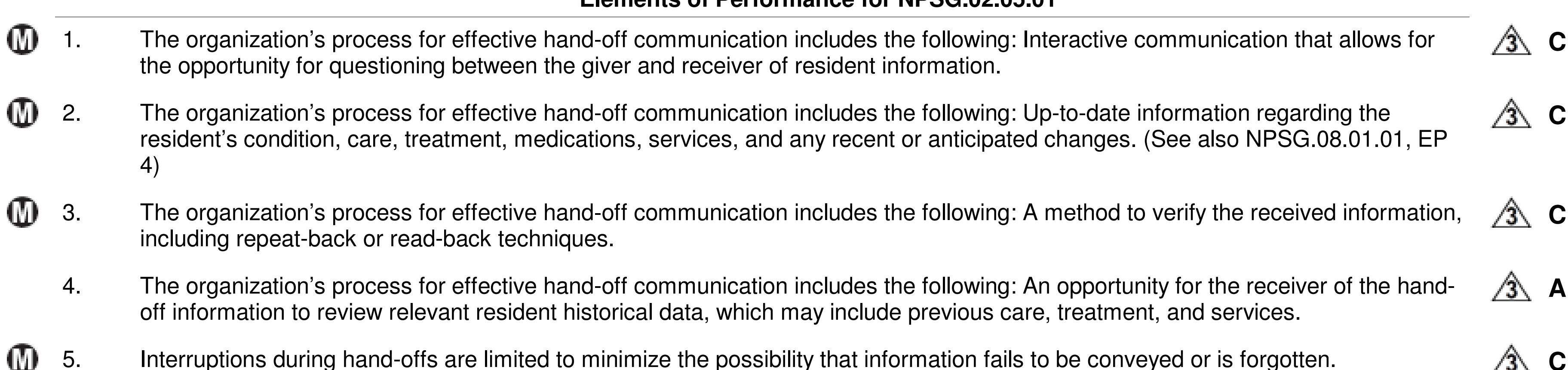
NPSG.02.05.01

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



	No.	Element of Performance		Category
M	1.	The organization’s process for effective hand-off communication includes the following: Interactive communication that allows for the opportunity for questioning between the giver and receiver of resident information.	3	C
M	2.	The organization’s process for effective hand-off communication includes the following: Up-to-date information regarding the resident’s condition, care, treatment, medications, services, and any recent or anticipated changes. (See also NPSG.08.01.01, EP 4)	3	C
M	3.	The organization’s process for effective hand-off communication includes the following: A method to verify the received information, including repeat-back or read-back techniques.	3	C
	4.	The organization’s process for effective hand-off communication includes the following: An opportunity for the receiver of the hand-off information to review relevant resident historical data, which may include previous care, treatment, and services.	3	A
M	5.	Interruptions during hand-offs are limited to minimize the possibility that information fails to be conveyed or is forgotten.	3	C

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Goal 3

NPSG

Improve the safety of using medications.

NPSG.03.03.01

The [organization] identifies and, at a minimum, annually reviews a list of look-alike/sound-alike medications used by the [organization] and takes action to prevent errors involving the interchange of these medications.

Elements of Performance for NPSG.03.03.01

1. (D) The organization identifies a list of look-alike/sound-alike medications used by the organization. The list includes a minimum of 10 look-alike/sound-alike medication combinations selected from the tables of look-alike/sound-alike medications posted on The Joint Commission website at http://www.jointcommission.org. **A**
2. The organization reviews the list of look-alike/sound-alike medications at least annually. **A**
3. The organization takes action to prevent errors involving the interchange of the medications on the list of look-alike/sound-alike medications. (3) **A**

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NPSG.03.05.01

Reduce the likelihood of [patient] harm associated with the use of anticoagulant therapy.
Note: This requirement applies only to [organization]s that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the [patient]'s laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for venous thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the [patient]'s laboratory values for coagulation will remain within, or close to, normal values.

Rationale for NPSG.03.05.01

Anticoagulation therapy poses risks to patients and often leads to adverse drug events due to complex dosing, requisite follow-up monitoring, and inconsistent [patient] compliance. The use of standardized practices for anticoagulation therapy that include [patient] involvement can reduce the risk of adverse drug events associated with the use of heparin (unfractionated), low molecular weight heparin, and warfarin.

Elements of Performance for NPSG.03.05.01

1. The organization implements a defined anticoagulation management program to individualize the care provided to each resident receiving anticoagulant therapy. (3) A

2. To reduce compounding and labeling errors, the organization uses only oral unit dose products, pre-filled syringes, or pre-mixed infusion bags when these types of products are available.
Note: For pediatric residents, pre-loaded syringe products should only be used if specifically designed for children. (3) A

(M) 3. (D) The organization uses approved protocols for the initiation and maintenance of anticoagulant therapy appropriate to the medication used, to the condition being treated, and to the potential for medication interactions. (3) C

4. For residents starting on warfarin, a baseline International Normalized Ratio (INR) is available, and for all residents receiving warfarin therapy, a current INR is available and is used to monitor and adjust this therapy. (3) A

(M) 5. When dietary services are provided by the organization, the service is notified of all residents receiving warfarin and responds according to its established food/medication interaction program. (3) C

6. When heparin is administered intravenously and continuously, the organization uses programmable infusion pumps in order to provide consistent and accurate dosing. (3) A

7. (D) The organization has a written policy that addresses baseline and ongoing laboratory tests that are required for heparin and low molecular weight heparin therapies. (3) A

(M) 8. The organization provides education regarding anticoagulant therapy to staff, residents, and families.
Note: Resident/family education includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse drug reactions and interactions. (3) C

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9. The organization evaluates its anticoagulation safety practices, takes appropriate action to improve its practices, and measures the effectiveness of those actions on a regular basis. **A**

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Goal 7

NPSG

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 organization complies with current World Health Organization (WHO) or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.
Note: Organizations are required to comply with 1A, 1B, and 1C of the WHO or CDC guidelines. **C**

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 the following 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 organization 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 organization conducts a root cause analysis). **C**

2. The root cause analysis addresses the management of the resident before and after the identification of infection. **A**

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NPSG.07.04.01

Implement best practices or evidence-based guidelines to prevent central line–associated bloodstream infections.
Note 1: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.
Note 2: This requirement has a one-year phase-in period that includes defined expectations for planning, development, and testing ("milestones") at three, six, and nine months in 2009, with the expectation of full implementation by January 1, 2010.

Elements of Performance for NPSG.07.04.01

	#	Element		Category
	1.	As of April 1, 2009, the organization's leadership has assigned responsibility for oversight and coordination of the development, testing, and implementation of NPSG.07.04.01.		A
	2.	As of July 1, 2009, an implementation work plan is in place that identifies adequate resources, assigned accountabilities, and a time line for full implementation of NPSG.07.04.01 by January 1, 2010.		A
	3.	As of October 1, 2009, pilot testing in at least one clinical unit is under way for the requirements in NPSG.07.04.01.		A
	4.	As of January 1, 2010, the elements of performance in NPSG.07.04.01 are fully implemented across the organization.	(3)	A
(M)	5.	As of January 1, 2010, the organization educates health care workers who are involved in these procedures about health care–associated infections, central line–associated bloodstream infections, and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in these procedures is added to an individual's job responsibilities.		C
(M)	6.	As of January 1, 2010, prior to insertion of a central venous catheter, the organization educates residents and, as needed, their families about central line–associated bloodstream infection prevention.		C
(M)	7.	As of January 1, 2010, the organization implements policies and practices aimed at reducing the risk of central line–associated bloodstream infections that meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).	(3)	C
	8.	As of January 1, 2010, the organization conducts periodic risk assessments for surgical site infections, measures central line–associated bloodstream infection rates, monitors compliance with best practices or evidence-based guidelines, and evaluates the effectiveness of prevention efforts.		A
	9.	As of January 1, 2010, the organization provides central line–associated bloodstream infections rate data and prevention outcome measures to key stakeholders including leaders, licensed independent practitioners, nursing staff, and other clinicians.		A
	16. (D)	As of January 1, 2010, use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports.	(3)	A
	17.	As of January 1, 2010, evaluate all central venous catheters routinely and remove nonessential catheters.	(3)	A

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NPSG

Goal 8

Accurately and completely reconcile medications across the continuum of care.

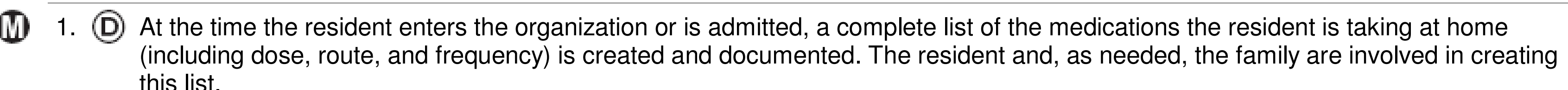
NPSG.08.01.01

A process exists for comparing the [patient]'s current medications with those ordered for the [patient] while under the care of the [organization].

Rationale for NPSG.08.01.01

[Patient]s are at high risk for harm from adverse drug events when communication about medications is not clear. The chance for communication errors increases whenever individuals involved in a [patient]'s care change. Communicating about the medication list, making sure it is accurate, and reconciling any discrepancies whenever new medications are ordered or current medications are adjusted are essential to reducing the risk of transition-related adverse drug events.

Elements of Performance for NPSG.08.01.01



Ⓜ 1. Ⓓ At the time the resident enters the organization or is admitted, a complete list of the medications the resident is taking at home (including dose, route, and frequency) is created and documented. The resident and, as needed, the family are involved in creating this list. △3 **C**

Ⓜ 2. The medications ordered for the resident while under the care of the organization are compared to those on the list created at the time of entry to the organization or admission. △3 **C**

Ⓜ 3. Any discrepancies (that is, omissions, duplications, adjustments, deletions, additions) are reconciled and documented while the resident is under the care of the organization. △3 **C**

Ⓜ 4. When the resident's care is transferred within the organization, the current provider(s) informs the receiving provider(s) about the up-to-date reconciled medication list and documents the communication. (See also NPSG.02.05.01, EP 2)
Note: Updating the status of a resident's medications is also an important component of all resident care hand-offs. △3 **C**

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NPSG.08.02.01

When a [patient] is referred to or transferred from one [organization] to another, the complete and reconciled list of medications is communicated to the next provider of service, and the communication is documented. Alternatively, when a [patient] leaves the [organization]'s care to go directly to his or her home, the complete and reconciled list of medications is provided to the [patient]'s known primary care provider, the original referring provider, or a known next provider of service.
Note: When the next provider of service is unknown or when no known formal relationship is planned with a next provider, giving the [patient] and, as needed, the family the list of reconciled medications is sufficient.

Rationale for NPSG.08.02.01

The accurate communication of a [patient]'s reconciled medication list to the next provider of service reduces the risk of transition-related adverse drug events. The communication enables the next provider of service to receive thorough knowledge of the [patient]'s medications and to safely order/prescribe other medications that may be needed. This communication is especially important at transitions in care when a [patient] is referred or transferred from one organization to another.

Elements of Performance for NPSG.08.02.01

1. The resident's most current reconciled medication list is communicated to the next provider of service, either within or outside the organization. The communication between providers is documented. **C**

2. At the time of transfer, the transferring organization informs the next provider of service how to obtain clarification on the list of reconciled medications. **C**

NPSG.08.03.01

When a [patient] leaves the [organization]'s care, a complete and reconciled list of the [patient]'s medications is provided directly to the [patient] and, as needed, the family, and the list is explained to the [patient] and/or family.

Rationale for NPSG.08.03.01

The accurate communication of the [patient]'s medication list to the [patient] and, as needed, the family, reduces the risk of transition-related adverse drug events. A thorough knowledge of the [patient]'s medications is essential for the [patient]'s primary care provider or next provider of service to manage the subsequent stages of care for the [patient].

Elements of Performance for NPSG.08.03.01

1. When the resident leaves the organization's care, the current list of reconciled medications is provided and explained to the resident and, as needed, the family. This interaction is documented. **C**
Note: Residents and families are reminded to discard old lists and to update any records with all medication providers or retail pharmacies.

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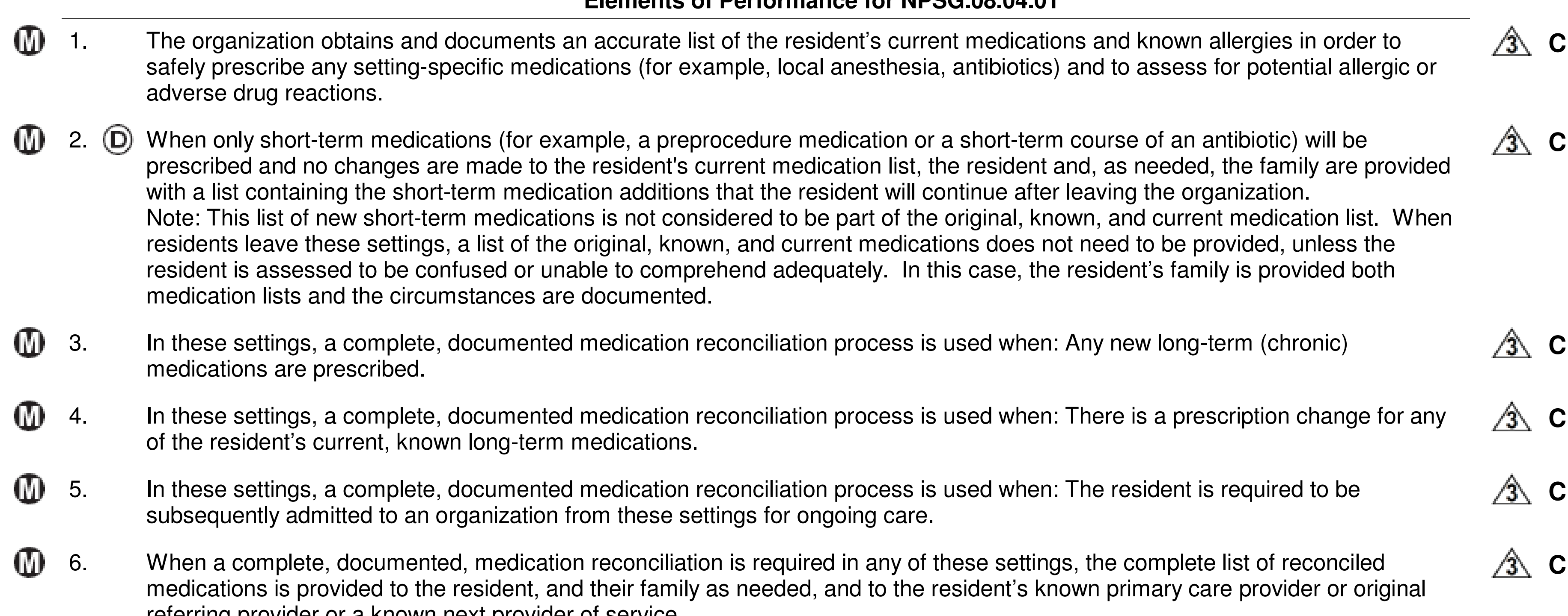
NPSG.08.04.01

In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed.
Note: This requirement does not apply to [organization]s that do not administer medications. It may be important for health care organizations to know which types of medications their [patient]s are taking because these medications could affect the care, treatment, and services provided.

Rationale for NPSG.08.04.01

A number of [patient] care settings exist in which medications are not used, are used minimally, or are prescribed for only a short duration. This includes areas such as the emergency department, urgent and emergent care, convenient care, office-based surgery, outpatient radiology, ambulatory care, and behavioral health care. In these settings, obtaining a list of the [patient]'s original, known, and current medications that he or she is taking at home is still important; however, obtaining information on the dose, route, and frequency of use is not required.

Elements of Performance for NPSG.08.04.01



(M) 1. The organization obtains and documents an accurate list of the resident's current medications and known allergies in order to safely prescribe any setting-specific medications (for example, local anesthesia, antibiotics) and to assess for potential allergic or adverse drug reactions. (3) C

(M) 2. (D) When only short-term medications (for example, a preprocedure medication or a short-term course of an antibiotic) will be prescribed and no changes are made to the resident's current medication list, the resident and, as needed, the family are provided with a list containing the short-term medication additions that the resident will continue after leaving the organization.
Note: This list of new short-term medications is not considered to be part of the original, known, and current medication list. When residents leave these settings, a list of the original, known, and current medications does not need to be provided, unless the resident is assessed to be confused or unable to comprehend adequately. In this case, the resident's family is provided both medication lists and the circumstances are documented. (3) C

(M) 3. In these settings, a complete, documented medication reconciliation process is used when: Any new long-term (chronic) medications are prescribed. (3) C

(M) 4. In these settings, a complete, documented medication reconciliation process is used when: There is a prescription change for any of the resident's current, known long-term medications. (3) C

(M) 5. In these settings, a complete, documented medication reconciliation process is used when: The resident is required to be subsequently admitted to an organization from these settings for ongoing care. (3) C

(M) 6. When a complete, documented, medication reconciliation is required in any of these settings, the complete list of reconciled medications is provided to the resident, and their family as needed, and to the resident's known primary care provider or original referring provider or a known next provider of service. (3) C

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Goal 9

NPSG

Reduce the risk of [patient] harm resulting from falls.

NPSG.09.02.01

The [organization] implements a fall reduction program that includes an evaluation of the effectiveness of the program.

Rationale for NPSG.09.02.01

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 evaluate the [patient]'s risk for falls and take action to reduce the risk of falling as well as the risk of injury, should a fall occur. The evaluation could include a [patient]'s fall history; review of medications and alcohol consumption; gait and balance screening; assessment of walking aids, assistive technologies, and protective devices; and environmental assessments.

Elements of Performance for NPSG.09.02.01

	#	Element		Category
	1.	The organization establishes a fall reduction program.		A
Ⓜ	2.	The fall reduction program includes an evaluation appropriate to the resident population, settings and services provided.	⚠3	C
	3.	The fall reduction program includes interventions to reduce the resident's fall risk factors.	⚠3	A
Ⓜ	4.	Staff receive education and training for the fall reduction program.		C
Ⓜ	5.	The organization educates the resident and, as needed, the family on the fall reduction program and any individualized fall reduction strategies.		C
	6.	The organization evaluates the fall reduction program to determine the effectiveness of the program. Note: Outcome indicators such as decreased number of falls and decreased number and severity of fall-related injuries could be used.		A

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Goal 10

NPSG

Reduce the risk of influenza and pneumococcal disease in institutionalized older adults.

NPSG.10.01.01

The [organization] develops and implements protocols for administration of the influenza vaccine.

Elements of Performance for NPSG.10.01.01

	1.	(D)	Protocols are developed to determine whether to administer the influenza vaccine to a resident.	(3) A
(M)	2.		Protocols are implemented for residents identified as high risk for influenza.	(3) C

NPSG.10.02.01

The [organization] develops and implements protocols for administration of the pneumococcus vaccine.

Elements of Performance for NPSG.10.02.01

	1.	(D)	Protocols are developed to determine whether to administer the pneumococcus vaccine to a resident.	(3) A
(M)	2.		Protocols are implemented for residents identified as high risk for pneumococcus.	(3) C

NPSG.10.03.01

The [organization] develops and implements protocols to identify new cases of influenza and to manage outbreaks.

Elements of Performance for NPSG.10.03.01

	1.	(D)	Protocols are developed to identify new cases of influenza and to manage an outbreak.	(3) A
(M)	2.		Protocols are implemented for residents displaying signs and symptoms of influenza.	(3) C
	3.		Evidence exists that the outbreak was managed (or identified) and tracked.	A

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Goal 13

NPSG

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 care, treatment, and 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 resident and family are educated on available reporting methods for concerns related to care, treatment, and services and resident safety issues.	**C**
Ⓜ	2.	Ⓓ	The organization provides the resident with information regarding infection control measures for hand hygiene practices, respiratory hygiene practices, and contact precautions according to the resident's condition. The information is discussed with the resident and his or her family members on the day the resident enters the organization or as soon as possible (for example, within 24–48 hours). The resident's understanding of this information is evaluated and documented. (See also PC.02.03.01, EP 25) Note: The information provided to the resident may be in any form of media.	**C**
Ⓜ	4.		The organization encourages residents and their families to report concerns about safety.	**C**

KEY: **A** indicates scoring category A; **C** indicates scoring category C; ▲ indicates situational decision rules apply; △ indicates direct impact requirements apply; Ⓜ indicates Measure of Success is needed; Ⓓ indicates that documentation is required

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Goal 14

NPSG

Prevent health care associated pressure ulcers (decubitus ulcers).

NPSG.14.01.01

Assess and periodically reassess each [patient]'s risk for developing a pressure ulcer (decubitus ulcer) and take action to address any identified risks.

Rationale for NPSG.14.01.01

Pressure ulcers (decubiti) continue to be problematic in all heath care settings. Most pressure ulcers can be prevented, and deterioration at Stage I can be halted. The use of clinical practice guidelines can effectively identify [patient]s and define early intervention for prevention of pressure ulcers.

Elements of Performance for NPSG.14.01.01

1. (D) The organization has a written plan for the prediction, prevention, and early treatment of pressure ulcers, which addresses the following:
   - Identifying individuals at risk for pressure ulcers and the specific factors that place them at risk
   - Maintaining and improving tissue tolerance to pressure in order to prevent injury
   - Protecting against the adverse effects of external mechanical forces
   - Reducing the incidence of pressure ulcers through staff educational programs

   A

(M) 2. An initial assessment for the risk of pressure ulcers is performed for each resident at admission. (3) **C**

(M) 3. A systematic risk assessment for pressure ulcers is conducted using a validated risk assessment tool such as the Braden Scale or Norton Scale. (3) **C**

(M) 4. Pressure ulcer risk is reassessed at periodic intervals. (3) **C**

(M) 5. The organization takes action to address any identified risks to the resident for pressure ulcers. (3) **C**

KEY: **A** indicates scoring category A; **C** indicates scoring category C; (2) indicates situational decision rules apply; (3) indicates direct impact requirements apply; (M) indicates Measure of Success is needed; (D) indicates that documentation is required

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