



Accreditation Program: Behavioral Health Care

National Patient Safety Goals

Goal 1

NPSG

Improve the accuracy of [patient] identification.

NPSG.01.01.01

Use at least two [patient] identifiers when providing care, treatment, or 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

- | | | |
|----------|--|-------------------|
| M | 1. Prior to any specimen collection, medication administration, transfusion, or treatment, the organization actively involves the client and, as needed, the family in the identification and matching process. When active client involvement is not possible or the client'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 client identification are satisfied. | 3 C |
| M | 2. Two client identifiers are used when administering medications. | 3 C |
| M | 3. Two client identifiers are used when collecting blood samples and other specimens for clinical testing. | 3 A |
| M | 4. Two client identifiers are used when providing other treatments or procedures. | 3 C |
| | 5. The client's room number or physical location is not used as an identifier. (See also MM.05.01.09, EPs 8 and 11) | 3 A |
| M | 6. Containers used for specimens are labeled in the presence of the client. | 3 A |

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

Goal 2

NPSG

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 |





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

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 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: <ul style="list-style-type: none"> - 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. |  A |
|  | 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 |

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

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 |

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

In behavioral health organizations that provide twenty-four hour care, treatment or services, a number of hand-offs may occur, such as from teacher to child care worker, at change of shift, or from clinical staff to program staff. 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

- | | | |
|----------|---|-------------------|
| 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 client information. | 3 C |
| M | 2. The organization's process for effective hand-off communication includes the following: Up-to-date information regarding the client'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 client historical data, which may include previous care, treatment, or 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 |

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. |  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 Web site 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. |  A |

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

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 when providing services to a high-risk population, or administering physical care.

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

- M** 1. The organization complies with current World Health Organization (WHO) or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines when providing services to a high-risk population, or administering physical care.
Note: Organizations are required to comply with 1A, 1B, and 1C of the WHO or CDC guidelines.

3 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

- M** 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).
2. The root cause analysis addresses the management of the client before and after the identification of infection.

3 C**A**

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

Goal 8

NPSG

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

- | | | |
|----------|---|-------------------|
| M | 1. D At the time the client enters the organization or is admitted, a complete list of the medications the client is taking at home (including dose, route, and frequency) is created and documented. The client and, as needed, the family are involved in creating this list. | 3 C |
| M | 2. The medications ordered for the client 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 |
| M | 3. Any discrepancies (that is, omissions, duplications, adjustments, deletions, additions) are reconciled and documented while the client is under the care of the organization. | 3 C |
| M | 4. When the client'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 client's medications is also an important component of all client care hand-offs. | 3 C |

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

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

- | | | | |
|----------|----|---|-------------------|
| M | 1. | The client'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. | 3 C |
| M | 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

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

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, or 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 client's current medications and known allergies in order to safely prescribe any setting-specific medications (for example, intravenous contrast media, 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 client's current medication list, the client and, as needed, the family are provided with a list containing the short-term medication additions that the client 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 clients leave these settings, a list of the original, known, and current medications does not need to be provided, unless the client is assessed to be confused or unable to comprehend adequately. In this case, the client'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 client's current, known long-term medications. | 3 C |
| M | 5. In these settings, a complete, documented medication reconciliation process is used when: The client 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 client, and their family as needed, and to the client's known primary care provider or original referring provider or a known next provider of service. | 3 C |

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, or 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

- | | | |
|----------|---|----------|
| M | 1. The client and family are educated on available reporting methods for concerns related to care, treatment, or services and client safety issues. | C |
| M | 4. The organization encourages clients 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; **M** indicates Measure of Success is needed; **Ⓢ** indicates that documentation is required

Goal 15

NPSG

The organization identifies safety risks inherent in its [patient] population.

NPSG.15.01.01

The [organization] identifies [patient]s at risk for suicide.

Rationale for NPSG.15.01.01

Suicide of a care recipient while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.

Elements of Performance for NPSG.15.01.01

- | | | |
|----------|--|-------------------|
| M | 1. The risk assessment includes identification of specific client factors and environmental features that may increase or decrease the risk for suicide. | 3 C |
| M | 2. The organization addresses the client's immediate safety needs and most appropriate setting for treatment. | 3 C |
| M | 3. The organization provides information such as a crisis hotline to individuals at risk for suicide and their family members. | 3 C |

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