

2008 National Patient Safety Goals Long Term Care

National Patient Safety Goals

This chapter addresses the 2008 National Patient Safety Goals, requirements, and implementation expectations. The purpose of The Joint Commission's National Patient Safety Goals is to promote specific improvements in patient safety. The goals highlight problematic areas in health care and describe evidence and expert-based consensus to solutions to these problems. Recognizing that sound system design is intrinsic to the delivery of safe, high quality health care, the goals generally focus on system-wide solutions, wherever possible.

A broadly representative Sentinel Event Advisory Group works with Joint Commission staff on a continuing basis to prioritize and develop goals, requirements, and implementation expectations. As part of this development process, candidate goals, requirements, and implementation expectations are sent to the field for review and comment. The Advisory Group annually recommends selected existing and new goals, requirements, and implementation expectations to the Joint Commission's Board of Commissioners for review and approval.

If an organization thinks that an alternative approach meets the intent of the requirement and wishes to implement such an alternative, the organization must obtain Joint Commission approval of the alternative. The Sentinel Event Advisory Group also assists the Joint Commission in evaluating potential alternatives to goal requirements that have been suggested by individual organizations.

Organizations providing care, treatment, and services relevant to these goals are responsible for implementing the applicable requirements or effective alternatives. Compliance with these requirements is assessed throughout the accreditation cycle, through on-site surveys, and the Periodic Performance Review (PPR).¹ When an organization does not fully comply with a requirement, the organization will be assigned a requirement for improvement in the same way that noncompliance with an element of performance generates a requirement for improvement at a standard. All requirements for improvement must be addressed in an Evidence of Standards Compliance (ESC) Report. Failure to resolve a requirement for improvement affects an organization's accreditation decision, which could ultimately lead to a loss of accreditation.

The Joint Commission provides guidance on how to effectively comply with each goal's requirements. This guidance includes detailed answers to Frequently Asked Questions (FAQs), which are posted on the Joint Commission Web site (<http://www.jointcommission.org>).

Goal 1

¹ For those programs required to complete a PPR.

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Improve the accuracy of [patient] identification.

Requirement 1A

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

Rationale for Requirement 1A

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.

Implementation Expectations for Requirement 1A:

(M) C 1. Two [patient] identifiers are used when administering medications or blood products

(M) A 2. Two [patient] identifiers are used when collecting blood samples and other specimens for clinical testing

(M) C 3. Two [patient] identifiers are used when providing other treatments or procedures

A 4. The [patient's] room number or physical location is not used as an identifier.

(M) A 5. Containers used for blood and other specimens are labeled in the presence of the [patient].

Requirement 1B Prior to the start of any surgical or invasive 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.

Implementation Expectations for Requirement 1B

A 1. The final verification process must be conducted in the location where the procedure will be done, just before starting the procedure.

(M) A 2. The process must involve the entire team, use active communication, and must, at least, include the following:

- Correct [patient] identity
- Correct side and site
- Agreement on the procedure to be done
- Correct [patient] position
- Availability of correct implants and any special equipment or special requirements

A 3. The process is briefly documented, such as in a checklist (Note: The organizations should determine the type and amount of documentation).

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

Goal 2

Improve the effectiveness of communication among caregivers.

Requirement 2A

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 information record and "read-back" the complete order or test result.

Rationale for Requirement 2A

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.

Implementation Expectation for Requirement 2A

(M) C 1. The receiver of the information **writes** down the complete order or test result or enters it into a computer.

(M) C 2. The receiver of the information **reads** back the order or test result.

(M) C 3. The receiver of the information **receives** confirmation from the individual who gave the order or test result.

Requirement 2B

Standardize a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.

Implementation Expectations for Requirement 2B

A 1. The organization develops a standardized a list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization.

A 2. The list of abbreviations not to be used includes the following:

- U,u
- IU
- Q.D., QD, q.d., qd
- Q.O.D., QOD, q.o.d, qod
- Trailing zero (X.0 mg)²

² **Exception:** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

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- Lack of leading zero (.X mg)
- MS
- MSO₄
- MgSO₄

(M) C 3. The organization implements the “do not use” list and applies this list to all orders and all medication-related documentation when handwritten or entered as free text into a computer.

A 4. Preprinted forms do not include any abbreviations identified as not to be used.

Requirement 2C

Measure, assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical tests and critical results and values.

Implementation Expectations for Requirement 2C

A 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 critical tests and critical results/and values.

A 3. 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 care giver.

A 4. The organization collects data on the timeliness of reporting critical tests and critical results/and values.

A 5. The organization assesses the data and determines whether there is a need for improvement.

A 6. The organization takes appropriate action to improve and measure the effectiveness of those actions.

Requirement 2D

Not applicable

Requirement 2E

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Implement a standardized approach to “hand-off” communications, including an opportunity to ask and respond to questions.

Rationale for Requirement 2E

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.

In health care there are numerous types of [patient] hand offs, including but not limited to nursing shift changes, physicians transferring complete responsibility for a [patient], physicians transferring on-call responsibility, temporary responsibility for staff leaving the unit for a short time, anesthesiologist report to post-anesthesia recovery room nurse,) nursing and physician hand off from the emergency department to inpatient units, different hospitals, nursing homes and home health care, critical laboratory and radiology results sent to physician offices.

Implementation Expectations for Requirement 2E

(M) C 1. The organization’s process for effective “hand off” communication includes: Interactive communications allowing for the opportunity for questioning between the giver and receiver of [patient] information.

(M) C 2. The organization’s process for effective “hand off” communication includes: Up-to-date information regarding the [patient’s] care, treatment and services, condition and any recent or anticipated changes.

(M) C 3. The organization’s process for effective “hand off” communication includes: A process for verification of the received information, including repeat-back or read-back, as appropriate.

A 4. The organization’s process for effective “hand off” communication includes: An opportunity for the receiver of the hand off information to review relevant [patient] historical data, which may include previous care, treatment and services.

(M) C 5. Interruptions during hand offs are limited to minimize the possibility that information would fail to be conveyed or would be forgotten.

Goal 3

Improve the safety of using medications.

Requirement 3A

Not applicable

Requirement 3B

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Not applicable

Requirement 3C

Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used by the organization, and take action to prevent errors involving the interchange of these drugs.

Implementation Expectations for Requirement 3C

A 1. Identify a list of look-alike/sound-alike (LASA) drugs used by the organization (the list must include a minimum of 10 look-alike/sound-alike drug combinations selected from the tables of LASA drugs posted on the Joint Commission website).

A 2. Review the list of look-alike/sound-alike drugs used by the organization at least annually.

A 3. The organization takes action to prevent errors involving the interchange of these drugs.

Anticoagulation Therapy

Requirement 3E

Reduce the likelihood of patient harm associated with the use of anticoagulation therapy.

Note: This requirement applies only to organizations that provide anticoagulation therapy.

Rationale for Requirement 3E:

Anticoagulation is a high risk treatment, which commonly leads to adverse drug events due to the complexity of dosing these medications, monitoring their effects, and ensuring patient compliance with outpatient therapy. The use of standardized practices that include patient involvement can reduce the risk of adverse drug events associated with the use of heparin (unfractionated), low molecular weight heparin (LMWH), warfarin, and other anticoagulants.

Note: This requirement has a one-year phase-in period that includes defined expectations for planning, development, and testing (“milestones”) at 3, 6, and 9 months in 2008, with the expectation of full implementation by January 1, 2009.

A 1. As of April 1, 2008, the [organization]’s leadership has assigned responsibility for oversight and coordination of the development, testing, and implementation of NPSG Requirement 3E.

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A 2. As of July 1, 2008, an implementation work plan is in place that identifies adequate resources, assigned accountabilities, and a time line for full implementation of NPSG Requirement 3E by January 1, 2009.

A 3. As of October 1, 2008, pilot testing in at least one clinical unit is under way.

A 4. As of January 1, 2009, the process is fully implemented across the organization.

The Implementation Expectations that will apply beginning January 1, 2009, are provided below.

Implementation Expectations for 3E:

A 1. The organization implements a defined anticoagulant management program to individualize the care provided to each patient receiving anticoagulant therapy.

A 2. To reduce compounding and labeling errors, the organization uses ONLY oral unit dose products and pre-mixed infusions, when these products are available.

(M) C 3. When pharmacy services are provided by the organization, warfarin is dispensed for each patient in accordance with established monitoring procedures.

(M) C 4. The organization uses approved protocols for the initiation and maintenance of anticoagulation therapy appropriate to the medication used, to the condition being treated, and to the potential for drug interactions.

(M) A 5. For patients being started on warfarin, a baseline International Normalized Ratio (INR) is available, and for all patients receiving warfarin therapy, a current INR is available and is used to monitor and adjust therapy.

(M) C 6. When dietary services are provided by the organization, the service is notified of all patients receiving warfarin and responds according to its established food/drug interaction program.

A 7. When heparin is administered intravenously and continuously, the organization uses programmable infusion pumps.

(M) C 8. The organization has a policy that addresses baseline and ongoing laboratories tests that are required for heparin and low molecular weight heparin therapies.

(M) C 9. The organization provides education regarding anticoagulation therapy to staff, patients, and families.

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(M) C 10. Patient/family education includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse drug reactions and interactions.

A 11. The organization evaluates anticoagulation safety practices (see MM.8.10).

**Goal 4
Not applicable**

**Goal 5
Not applicable**

**Goal 6
Not applicable**

**Goal 7
Reduce the risk of health care-associated infections.**

Requirement 7A

Comply with current World Health Organization (WHO) Hand Hygiene Guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines.

Rationale for Requirement 7A

Compliance with the WHO Hand Hygiene Guidelines or CDC hand hygiene guidelines will reduce the transmission of infectious agents by staff to [patients], thereby decreasing the incidence of healthcare associated infections.

Implementation Expectation for Requirement 7A

(M) C 1. Comply with current WHO Hand Hygiene Guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines³.

Requirement 7B

Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.

Rationale for Requirement 7B

A significant percentage of [patients] who unexpectedly die or suffer major permanent loss of function have healthcare 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 (1) why did the [patient] acquire an

³ Organizations are required to comply with all 1A, 1B, 1C CDC or WHO guidelines.

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infection and, (2) given the fact of the infection, why did the [patient] die or suffer permanent loss of function?

Implementation Expectations Requirement 7B

(M) C 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, conducts a root cause analysis).

A 2. The root cause analysis addresses the management of the [patient] before and after the identification of infection.

Goal 8

Accurately and completely reconcile medications across the continuum of care.

Requirement 8A

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

Rationale for Requirement 8A

[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.

Implementation Expectations for Requirement 8A

(M) C 1. The organization, with the [patient]'s involvement, creates a complete list of the [patient]'s current medications at admission/entry.

(M) C 2. The medications ordered for, administered to, or dispensed to the [patient] while under the care of the organization are compared to those on the list and any discrepancies (e.g., omissions, duplications, potential interactions) are resolved.

Requirement 8B A complete list of the [patient's] medications 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. The complete list of medications is also provided to the patient on discharge from the organization.

Implementation Expectations for Requirement 8B

(M) C 1. 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

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(M) C 2. The next provider of service checks the medication reconciliation list again to make sure it is accurate and in concert with any new medications to be ordered/prescribed.

(M) C 3. The complete list of medications is also provided to the [patient] on discharge from the organization.

Goal 9

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

Requirement 9B

Implement a fall reduction program including an evaluation of the effectiveness of the program.

Rationale for Requirement 9B

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, 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. The evaluation could include fall history, medications and alcohol consumption review, gait and balance screening, walking aids, assistive technologies and protective devices assessment and environmental assessments.

Implementation Expectations for Requirement 9B

A 1. The organization establishes a fall reduction program.

(M) C 2. The fall reduction program includes an evaluation as appropriate to the [patient] population, settings and services provided.

A 3. The fall reduction program includes interventions to reduce the [patient]'s fall risk factors.

(M) C 4. Staff receive education and training for the fall reduction program

(M) C 5.) The [patient] and [patient]'s family is educated on the fall reduction program and any individualized fall reduction strategies.

A 6. The fall reduction program is evaluated to determine the effectiveness of the program. (Outcome indicators such as decreased number of falls and decreased number and severity of fall-related injuries could be used.)

Goal 10

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

Requirement 10A

Develop and implement a protocol for administration and documentation of the flu vaccine.

Rationale for Requirement 10A

Influenza and pneumonia combined represent the fifth leading cause of death in the elderly. Along with the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC), the Joint Commission promotes the administration of influenza and pneumococcal vaccines to adult residents in long term care and assisted living facilities, and disease-specific care programs.

Implementation Expectations for Requirement 10A

A 1. Appropriate protocols are developed to determine whether or not to administer the flu vaccine to a [patient].

(M) C 2. There is evidence protocols were implemented for residents identified as high risk.

Requirement 10B

Develop and implement a protocol for administration and documentation of the pneumococcus vaccine.

Implementation Expectations for Requirement 10B

A 1. Appropriate protocols are developed to determine whether or not to administer the pneumococcus vaccine to a [patient].

(M) C 2. There is evidence protocols were implemented for [patients] identified as high risk.

Requirement 10C

Develop and implement a protocol to identify new cases of influenza and to manage an outbreak.

Implementation Expectations for Requirement 10C

A 1. Protocols are developed to identify cases of influenza and to manage an outbreak.

(M) C2. There is evidence the protocols were followed for [patients] displaying signs and symptoms of influenza.

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A 3. There is evidence the outbreak was managed (or identified) and tracked.

**Goal 11
Not applicable**

**Goal 12
Not applicable**

**Goal 13
Encourage [patients]' active involvement in their own care as a [patient] safety strategy.**

Requirement 13A

Define and communicate the means for [patients] and their families to report concerns about safety and encourage them to do so.

Rationale for Requirement 13A

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.

Implementation Expectation for Requirement 13A

(M) C 1.

[Patients] and families are educated on methods available to report concerns related to care, treatment, services and [patient] safety issues.

(M) C 2.

The organization encourages [patient]s and their families to report concerns about safety.

Goal 14

Prevent health care associated pressure ulcers (decubitus ulcers).

Requirement 14A

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 Requirement 14A

Pressure ulcers (decubiti) continue to be problematic in all health care settings. Estimates are that 1.3 to 3 million adults have a pressure ulcer. The cost of treatment is \$500 to \$40,000 per ulcer. The incidence of pressure ulcer is from 2.2% to 23.9% in long term care and 0% to 17% in home care. Most pressure ulcers can be prevented and deterioration at Stage I can be halted. The use of

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clinical practice guidelines can effectively identify [patients] and define early intervention for prevention of pressure ulcers.

Implementation Expectations for Requirement 14A

A 1. There is a plan for the prediction, prevention, and early treatment of pressure ulcers, which addresses:

- Identifying individuals at risk and the specific factors placing 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.

(M) C 2. Initial assessments are performed at admission.

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

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

(M) C 5. Action is taken to address any identified risks.